

overview

Social reintegration as a response to drug use in Ireland

5

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Health Research Board

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Overview series publications to date

Long J, Lynn E and Keating J (2005) *Drug-related deaths in Ireland, 1990–2002*. Overview 1. Dublin: Health Research Board.

Connolly J (2005) *The illicit drug market in Ireland*. Overview 2. Dublin: Health Research Board.

Connolly J (2006) *Drugs and crime in Ireland*. Overview 3. Dublin: Health Research Board.

Long J (2006) *Blood-borne viral infections among injecting drug users in Ireland 1995 to 2005*. Overview 4. Dublin: Health Research Board.

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List of abbreviations

BOND	Blanchardstown Offenders New Directions
BITC	Business in the Community Ireland
CE	Community Employment
CES	Customised Employment Support
CSO	Central Statistics Office
DATs	Drug Action Teams (UK)
DORIS	Drug Outcome Research in Scotland
DTCB	Drug Treatment Centre Board
ECDL	European Computer Driving Licence
EDDRA	Exchange on Drug Demand Reduction Action
EIU	Effective Interventions Unit (Scotland)
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
FÁS	Foras Áiseanna Saothair (the National Training and Employment Authority)
FETAC	Further Education and Training Awards Council
FIS	Family Income Support
HOST	Homeless Offenders Strategy Team
HPU	Homeless Persons Unit
HSE	Health Service Executive
LESN	Local Employment Service Network
LDTFs	Local drugs task forces
LIP	Labour Inclusion Project
MQI	Merchants Quay Ireland
MSC	Motivated Stepped Care
NACD	National Advisory Committee on Drugs
NDST	National Drugs Strategy Team
NESF	National Economic and Social Forum
NDTRS	National Drug Treatment Reporting System
NRB	National Rehabilitation Board
NSI	Next Step Initiative
PPF	Programme for Prosperity and Fairness
PWS	Probation and Welfare Service
RCTs	Random controlled trials
RDI	Rinn Development Initiative
RDRD	Ringsend and District Response to Drugs
RDTFs	Regional drugs task forces
RFW	Ready for Work
SAOL	Seasamhact, Ábaltacht, Obair agus Leann (Stability, Ability, Work and Learning)
SWA	Supplementary Welfare Allowance
TEOs	Training and employment officers



Executive summary



Social exclusion, in the form of homelessness and insecure accommodation, inadequate education and poor employment skills, is closely associated with problematic drug use. As a response, social reintegration has emerged as a key aspect of drug treatment and rehabilitation in order to provide responses to accommodation, education, vocational training and employment support needs of problem drug users. Over a period of three years, the author monitored and reported on the availability and accessibility of accommodation, education and employment support among drug users in Ireland and examined social reintegration responses in other countries.

The findings presented in this Overview are based on in-depth interviews with service providers, data from the National Drug Treatment Reporting System and an extensive literature search.

The key findings to emerge are:

Of cases commencing treatment for problematic drug use in Ireland in 2003, just under 20% were in employment, compared to the national average of 65%, and 61% were unemployed, compared to the national average of 4.6%. The review of international research indicates that drug users view employment as an important part of recovery and that they do not see methadone maintenance as a barrier to being employed. Drug users who are employed use their main problem drug less frequently and report better drug treatment outcomes than their unemployed counterparts. International research indicates that the transition from drug treatment to full employment can take up to three years. In addition, studies have shown that personal and structural barriers can prevent drug users from furthering their education, improving their vocational skills, and getting a job.

Irish research indicates a strong link between problematic drug use and homelessness. Family breakdown, leaving state care, and imprisonment are key factors leading to the initial experience of homelessness among both individuals and families. Exposure to homelessness is associated with an escalation in the use of drugs and progression to patterns of chaotic drug misuse. Homeless drug users associate their experiences of emergency hostel accommodation with their more chaotic periods of drug use. They have poorer physical and mental health than homeless people who do not use drugs.

In Ireland, measures to improve educational levels and employability among drug users have been presented in policy documents since 1969. The report of the Steering Group for the mid-term review of the National Drugs Strategy (2005) recommended including rehabilitation (which includes social reintegration) as a fifth pillar of the Strategy. On foot of this recommendation, the Report of the working group on drugs rehabilitation was launched in June 2007. It set out the structural arrangements required to respond to homelessness, inadequate education and poor employment skills among current, stabilised and former users.

Irish and international research highlights the urgent need for an inter-agency approach to tackling the accommodation needs of homeless drug users. Current homeless services in Ireland are not

equipped to respond to the needs of homeless drug users. Models of good practice identified in Scotland indicate that services for homeless drug users should include diverse and flexible elements; improved inter-agency working; increased professional training; greater use of care plans, contracts and confidentiality policies; and more service-user involvement. The Report of the working group on drugs rehabilitation supports these components of good practice. In a number of cities in the US, homelessness was successfully tackled through a clear strategic plan using an integrated community-wide approach and including the provision of low-demand, permanent, supported housing.

Evidence from the US suggests that vocational training contributes to a reduction in drug use and better treatment outcomes. Supported work interventions and dedicated employment counsellors demonstrate good levels of effectiveness in getting drug users into employment. Evidence from vocational rehabilitation interventions in Ireland suggest that participants have made educational and vocational progress by improving their literacy, achieving accredited training certificates and progressing to work placement and, in some cases, to paid employment. Participants in vocational programmes claim that such interventions are a positive experience and are active in improving quality of life.

According to the National Economic and Social Forum, labour market vulnerability is a reality for individuals with drug and alcohol dependencies and this vulnerability can be reduced through providing targeted employment support mechanisms. Enhancing employability involves matching the demands of the labour market with the attitudes and capabilities of the individual, and the needs and expectations employers. The employment of career development officers in social reintegration projects helps to achieve employability; this has been implemented in a small number of projects in the North Inner City of Dublin. Employability cannot be achieved unless problematic drug use has been brought under control.

The objectives outlined in the Report of the working group on drugs rehabilitation support the Council of the European Union statement that homelessness and unemployment are two social risks for drug users, and failure to address them can undermine treatment gains and lead to social exclusion.

1 Introduction



The Council of the European Union recognises that responding to the health and social risks associated with problematic drug use is a key responsibility of EU member states. Homelessness and unemployment are two such social risks, and failure to address them can undermine treatment gains and lead to social exclusion. According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), responses such as the provision of housing and accommodation and job training can reduce these risks and improve the social reintegration of problematic drug users. This Overview presents the evidence for this claim and examines the extent to which Irish drug policy and practice respond to the accommodation and job market needs of problematic drug users.

Social reintegration of problematic users is not a new concept; indeed, it has been around since the early 1960s (United Nations 1961). Since 2000, the Council of the European Union has asked member states to improve availability of, and access to, social reintegration services. Since 2003, the EMCDDA has promoted the provision of accommodation supports and job training as key parts of social reintegration and has asked member states to monitor and report on the situation.

The Alcohol and Drug Research Unit (ADRU)¹ of the Health Research Board (HRB) has collected information on social reintegration responses in Ireland and reported it to the EMCDDA on an annual basis. In addition, ADRU collects information on the current situation in relation to homelessness and unemployment and their association with problematic drug use. This information is also reported annually to the EMCDDA.

This Overview brings together this information on the social risks of homelessness and unemployment and their association with problem drug use in Ireland and examines how we have responded to these risks. It also presents evidence showing that responses that address accommodation, education and job training needs can improve the chances of social reintegration for problematic drug users.

Chapter two gives details of the data sources used in compiling this Overview. Chapter three presents the background to the development of social reintegration as a concept and examines the extent to which drug policy and services in Ireland have understood the concept. Chapter four examines the employment status of problematic drug users in Ireland, how drug users perceive employment and the barriers they experience when trying to improve their chances of finding employment.

Homelessness and drug use are strong indicators of social exclusion. Chapter five presents research from Ireland that shows the levels of social exclusion experienced by homeless drug users. Policy and practice have often been slow in the past to respond to the accommodation needs of homeless drug users; chapter six presents examples of recent shifts in policy and practice on drugs and homelessness which suggest that the situation is improving.

1 The Alcohol and Drug Research Unit (ADRU) was formerly named the Drug Misuse Research Division (DMRD).

Vocational rehabilitation is about developing the personal competencies and improving the employability of the recovering drug user. Chapter seven presents the theory behind vocational rehabilitation. Chapter eight presents the evidence to show that treatment outcomes can be improved when clients are assisted in developing their vocational skills. Chapter nine develops the concept of employability and provides a framework for service providers to map the progression of clients in vocational training projects. Finally, chapter ten presents a model of social reintegration that predicts the different phases of recovery that drug users can experience.

The publication of this Overview is timely in that it follows the recently launched *Report of the working group on drugs rehabilitation* (Working Group 2007). This report highlights the need to respond to the accommodation and employment needs of drug users. It is hoped that the evidence presented in this Overview on both the social risks of homelessness and unemployment and the ways in which these risks can be reduced will help to inform the implementation of the rehabilitation strategy.

2 Data sources



An extensive range of data sources was used in compiling the information for this Overview.

Face-to-face interviews were held with 11 local drugs task force co-ordinators. The interviewer used a semi-structured interview schedule designed specifically for the interviews. The interviews lasted between 60 and 90 minutes and were tape recorded.

Face-to-face group interviews were conducted with three persons from FÁS and two persons from the Local Employment Service Network (LESN). The interviewer used a semi-structured interview schedule and recorded key points by writing the information in a specially prepared template under relevant key headings. The interviews lasted between 60 and 90 minutes.

Face-to-face interviews were held with 10 project managers in local drugs task forces. The interviewer used a standardised questionnaire. The interviews lasted approximately 60 minutes.

Unstructured telephone interviews were held with 10 persons involved in designing and delivering aspects of social reintegration services to drug users. These included persons from the statutory sector (HSE) and the community and voluntary sectors. These interviews lasted for between 15 and 35 minutes. The interviewer used a semi-structured questionnaire. Data were recorded in writing, using shorthand.

Data from the National Drug Treatment Reporting System (NDTRS) on the employment status and accommodation status of cases treated for problem drug use in Ireland between 2001 and 2003 were analysed. Data profiling a number of case studies representing promising practice in reducing demand for drugs in Ireland were taken from the Exchange on Drug Demand Reduction Action (EDDRA) database.²

An extensive amount of literature was retrieved and searched for relevant information, including:

- Local drugs taskforce (LDTF) documentation, including service development plans, action plans and evaluations of LDTF-funded projects
- Documents relating to the development of Ireland's policies on drugs and on homelessness
- Research reports exploring the association between health and drugs and homelessness in Ireland
- Annual reports from statutory, voluntary and community organisations working in the drugs and homelessness sectors in Ireland
- Journal articles and book chapters relating to drugs and vocational rehabilitation and employment, and drugs and homelessness.

2 Developed by the EMCDDA, the EDDRA database is an online information system providing details of a wide range of evaluated response programmes in the EU. The database can be accessed from the EMCDDA website at www.emcdda.europa.eu/



3 Explaining the concept of social reintegration



3.1 Introduction

This chapter will introduce social reintegration through the lens of the international, European, national and local perspectives. The chapter will introduce the international context for social reintegration, referring to the work of the United Nations (UN) and the European Union (EU) that has contextualised social reintegration as part of a broad treatment and rehabilitation approach to the needs of drug users. In particular, the chapter will refer to the UN drug control treaties and the EU drugs strategy and action plans. The definition of social reintegration used in this Overview comes from the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Finally, the chapter will look at the relevance attributed to social reintegration in Ireland, and how social reintegration is defined and conceptualised at national and local level.

3.2 The international context

A number of international drug control treaties to which Ireland is a signatory highlight the need to focus on social reintegration as an important area of intervention in tackling the issues facing drug users.

Article 38(1) of the UN Single Convention on Narcotic Drugs 1961 states:

The Parties shall give special attention to and take all practicable measures for the prevention of abuse of drugs and for the early identification, treatment, education, after-care, rehabilitation and **social reintegration** of the persons involved and shall co-ordinate their efforts to these ends.

Article 38(2) of the Single Convention states:

The Parties shall as far as possible promote the training of personnel in the treatment, after-care, rehabilitation and **social reintegration** of abusers of drugs.

These statements are reiterated in the UN Convention on Psychotropic Substances 1971 (Article 20, sections 1 and 2).

The Single Convention was further strengthened by the amendments introduced by the 1972 Protocol, which stressed the need to balance supply reduction with demand reduction measures, and the need to develop treatment and rehabilitation responses, including social reintegration, as part of an overall demand reduction approach.

The UN Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988 highlights the need to provide social reintegration measures for individuals convicted of drug-related offences. Article 3(4)(d) states:

The Parties may provide, either as an alternative to conviction or punishment, or in addition to conviction or punishment of an offence..., measures for the treatment, education, aftercare,

rehabilitation or **social reintegration** of the offender.

The EU Drugs Strategy 2005–2012 (Council of the EU 2004) includes social reintegration as part of a comprehensive demand reduction approach to the problem of illicit drug use in the EU and Norway, within the broad aim of achieving the following concrete, identifiable, measurable result:

measurable reduction of the use of drugs, of dependence and of drug-related health and social risks through the development and improvement of an effective and integrated comprehensive knowledge-based demand reduction system including prevention, early intervention, treatment, harm reduction, rehabilitation and **social reintegration** measures within the EU Member States. (p. 10)

The *EU Action Plan on Drugs 2000–2004* (Council of the EU 2000) and the *EU Drugs Action Plan (2005–2008)* (Council of the EU 2005) require the EU member states and Norway to improve access to and coverage of social reintegration programmes, and contracts the EMCDDA to monitor and report on the availability and accessibility of social reintegration measures in EU member states. In response, the EMCDDA, in collaboration with national focal points, implemented a number of complementary projects to map the availability of social reintegration measures in member states. As part of this work, an in-depth study of social integration in the EU and Norway was undertaken (Verster and Solberg 2003). In the report of this study, the authors defined social reintegration as

any attempt to integrate drug users into the community. (p. 3)

For the purpose of collecting information on social reintegration measures, the authors drew a distinction between treatment and social reintegration. They made the point that the latter does not include medical or psycho-social components but focuses on the provision of housing, education, vocational training and employment supports for drug users. This definition was later endorsed at a number of expert group meetings convened by the EMCDDA during 2003 and 2004 for the purpose of designing a structured questionnaire capable of collecting comparable information on the availability and accessibility of social reintegration measures in EU member states.³ It is this definition that will be used in the discussion of social reintegration throughout this Overview.

Homelessness, early school leaving and unemployment have long been associated with individuals who engage in problematic drug use. The provision of housing, education, vocational training and employment supports is vital to the reintegration of drug users into mainstream society. In practice, there is often a degree of overlap between education and vocational training measures. In effect, social reintegration is concerned with creating the conditions whereby persons affected by drug misuse have access to the social norms, such as employment and a place to live. Neale (2002) explains the rationale to this approach very well:

Recovery will only occur if drug users believe that abstinence has more to offer than addiction. Accordingly, recovering drug users must find a purpose in their drug-free lives. To this end, they need meaningful roles and activities that offer them self-respect and pride, and daily

3 The author of this Overview participated in the expert group on behalf of the Alcohol and Drug Research Unit.

routines that do not involve criminal or drug using activities...the conditions that seem likely to facilitate successful rehabilitation are the same kinds of conditions that probably prevent drug misuse in the first place. That is, access to a decent income, adequate housing, employment opportunities; family relationships and being connected to community networks. These are key factors that motivate most non-addicted members of society. (p. 219)

3.3 Irish drug policy and social reintegration

The first attempt to include social reintegration measures in Irish drug policy occurred in the 1971 *Report of working party on drug abuse* (Working Party on Drug Abuse 1971). This working party proposed that a rehabilitation programme including measures to address accommodation, education and self-development and vocational guidance and counselling be put in place. However, there is no evidence that much was done in the following years to act on these proposals.

The 1991 *Government strategy to prevent drug misuse* (Department of Health 1991) acknowledged that, to be successful, treatment programmes for drug misuse must be linked to the provision of adequate social and employment skills. The strategy noted the absence of structured liaison and co-ordination between treatment, rehabilitation and welfare services, and proposed to develop improved formal liaison arrangements between the relevant bodies. In particular, the strategy proposed that the Drug Treatment Centre Board (DTCB) play a major role in the social and occupational rehabilitation of drug misusers and develop arrangements for such rehabilitation in close liaison with health boards and agencies responsible for rehabilitation and placement, such as FÁS and the National Rehabilitation Board (NRB).

The *First report of the ministerial task force on measures to reduce the demand for drugs* (Ministerial Task Force 1996) referred to measures being taken to promote a reduction in demand for drugs, including employment and vocational training initiatives. However, the report did not provide any evidence to show:

- whether efforts were being made to improve formal liaison between the DTCB, FÁS and the NRB as proposed in the 1991 strategy, or
- the effectiveness or otherwise of such efforts.

Instead, the 1996 report noted that the priority of the health service to date had been to provide access to treatment facilities for drug users. The report summarised the development and delivery of generic employment and training initiatives within the Department of Enterprise and Employment and referred to departmental involvement in the provision of some employment and training initiatives targeting drug users. The report also noted the success of two rehabilitation and social reintegration projects, *Soilse* and *SAOL*,⁴ and recommended that they serve as models for other such projects. The report concluded that more emphasis should be placed on providing options for stabilised drug

4 See section 8.3.2 for details of these two projects.

users by way of occupational and social skills training.

Following consultation with FÁS, the Minister for Enterprise and Employment agreed a policy statement which is reiterated in the Task Force report's recommendations:

- priority status will be given to all Community Employment [CE] applications offering work experience/training for recovering addicts that are integrated with other support services, and every effort will be made to accommodate same;
- priority status will be given to all Community Employment [CE] applications offering work experience/training for former addicts who are employment ready, and every effort will be made to accommodate same; and
- FAS and LES will work closely and establish special links with the sponsors of Community Employment [CE] projects providing opportunities for former drug addicts who are employment ready, with a view to providing every assistance to the participants to progress to a mainstream job. (p. 42)

The National Drugs Strategy 2001–2008 noted the progress made on foot of these recommendations, in particular, the action by FÁS to set aside 1,000 places for recovering drug users on the Special Drugs Community Employment Programme. The Strategy also pointed to the need for FÁS to work in partnership with employer organisations, trade unions and key government agencies to develop mechanisms to increase employment opportunities for former drug misusers. Of the 100 actions outlined in the National Drugs Strategy, three related directly to the provision of vocational rehabilitation measures. These actions, with the agency responsible and progress made to date, are shown in Table 3.1.

Table 3.1 National Drugs Strategy actions directly related to vocational rehabilitation

Action	Agency responsible	Progress to date
74) Increase the number of training and employment opportunities for drug misusers by 30% by end 2004, in line with the commitment to provide such opportunities in the PPF and taking on board best practice from the special FÁS Community Employment (CE) scheme and the Pilot Labour Inclusion Programme.	FÁS	54 drug-related Community Employment (CE) projects up and running 900 places filled, from some 1,120 places that have been 'ring-fenced' Drug awareness training programme developed with Merchant's Quay
75) Examine the potential to involve recovering drug misusers in social economy projects and other vocational training.	FÁS	One social economy project based in Tullow Farm, Co Carlow, approved by FÁS
76) Monitor the participation of individuals on such programmes and review their overall effectiveness. Alternative models to be developed where appropriate.	FÁS	Review of FÁS Special Programme for Drug Users completed (Bruce 2005) Special working group developed to monitor and review progress on CE for drug users

The report of the Steering Group for the mid-term review of the National Drugs Strategy (2005) recommended including rehabilitation as a fifth pillar of the Strategy, as it was seen as a critical issue and was a recurring theme throughout the consultation stage. The strategy already includes the four pillars of prevention, treatment, supply reduction and research. The view was expressed during the public consultation stage that drug users should not be kept on methadone indefinitely, but should be assisted in 'moving on' towards social reintegration. However, receiving methadone and 'moving on' can occur concurrently where education, employment and accommodation supports are in place.

The Steering Group noted the many different views and definitions of 'rehabilitation', ranging from therapeutic approaches on the one hand to training and social re-integration on the other. However, the Group agreed that, in general, rehabilitation includes personal development, training, community integration, access to housing and employment. The mid-term review recommended that a working group be established under the aegis of the Department of Community, Rural and Gaeltacht Affairs to examine this area comprehensively and to develop an integrated rehabilitation policy as part of the National Drugs Strategy.

The Report of the working group on drugs rehabilitation was launched in June 2007 (Working Group 2007). It set out the structural arrangements that are required to deliver on a number of key recommendations. The overall goal is to provide an integrated rehabilitation service to current, stabilised and former drug users. The Working Group recommended that the job training, employment, education and accommodation needs of drug users be addressed as part of an overall rehabilitation policy. When developed and delivered, these services should build on the achievements of the National Drugs Strategy thus far, and contribute to the social reintegration of current, stabilised and former drug users. Some of the recommendations contained in the report are discussed in the concluding chapter of this Overview.

3.4 Social reintegration: the view from the local drugs task forces

In collecting information for this Overview on how social reintegration is defined and operated at local level, semi-structured interviews were conducted with local drugs task force (LDTF) co-ordinators in 2005. LDTF areas were selected because the 1996 report of the Ministerial Task Force on measures to reduce the demand for drugs underlined the high correlation between areas where the drug problem was most acute and areas which had been identified as economically and socially disadvantaged. The Task Force report also drew attention to the view expressed in statutory and voluntary submissions that drug misuse in these areas was closely associated with unemployment, poor living conditions and low educational attainment.

The interviews conducted for this Overview, almost ten years after the publication of the Task Force report, set out to establish the extent to which LDTF plans and service development acknowledged this association between socio-economic disadvantage and drug misuse at local level and the extent to which responses included measures to reduce or modify the effects of this disadvantage.

3.4.1 Strategic focus on social reintegration at local level

All LDTF co-ordinators reported that their respective plans to tackle illicit drug use at local level had been developed in line with the main pillars of the National Drugs Strategy, in particular the two pillars covering prevention/education and treatment/rehabilitation. One co-ordinator noted,

We have spent the last four to five years focusing on treatment, so haven't given it [social reintegration] much thought. (Interview with LDTF co-ordinator 2005)

In addition, LDTF plans had a particularly strong focus on developing prevention and education and prevention responses, as illustrated by the following quote:

If you see the action plan from 2000, you'll see that to date the majority of projects have been in the education/prevention domain. (Interview with LDTF co-ordinator 2005)

These views are consistent with the findings of Ruddle *et al.* (2000), who reported that the majority of projects funded under the first phase of local drugs task force plans came under the prevention/education pillar or the treatment/rehabilitation pillar.

This focus on the prevention and treatment pillars is understandable given that the LDTFs were developed at a time when there was an acute shortage of drug prevention and treatment options available in these local areas. Indeed, the public consultation process that preceded the development of the National Drugs Strategy in 2000 clearly identified the areas of drug prevention/education and treatment as the key gaps in service provision at that time (Department of Tourism, Sport and Recreation 2001). In addition, when drawing up their plans for service development in their respective areas, LDTFs were encouraged by the National Drugs Strategy Team to develop their plans within the main pillars of the strategy (Aoife Davey, personal communication, 2006).

Furthermore, LDTFs have developed a number of sub-committees to monitor and develop responses under the main pillars of the National Drugs Strategy and, again, the focus has been on prevention and education and treatment/rehabilitation. In the case of the treatment/rehabilitation pillar, there was scope for developing social reintegration options as part of a developed rehabilitation response. However, in reviewing the service development plans and action plans from the LDTFs, it is clear that there is little attention paid to social reintegration. As one co-ordinator explained:

We haven't used the word social reintegration much and we've never had a discussion about it round the task force table. (Interview with LDTF co-ordinator 2005)

3.4.2 Definition of social reintegration at local level

There was a degree of consensus among some of the LDTF co-ordinators interviewed on the merits of including education, vocational training and accommodation supports as part of social reintegration programmes. However, it should be noted that this consensus arose primarily from prompting during the interviews and in few cases did co-ordinators volunteer this conceptualisation. Indeed, co-ordinators were more likely to offer a two-dimensional definition, with the emphasis

on the more abstract notions of ‘helping’ and ‘facilitating’ clients. For example, one co-ordinator agreed that employment and education were important social reintegration goals, but also saw social reintegration as being

about helping them [the clients] to move on to whatever next step they perceive as being their next step. (Interview with LDTF co-ordinator 2005)

Another co-ordinator supported the improvement of the social conditions of clients, including housing, and was also of the view that social reintegration was about

facilitating or supporting somebody who has been or is drug using to allow them, whether it’s through treatment or further on rehabilitation, to participate in a productive and active way in their own community. (Interview with LDTF co-ordinator 2005)

These definitions provided by LDTF co-ordinators to explain their understanding of social reintegration belong to the discourse that has come to surround the treatment of drug misuse in Ireland. Terms such as ‘supporting’ and ‘facilitating’ clients to ‘move on’ are common in the language of psycho-social approaches such as motivational interviewing and are prominent throughout LDTF service development strategies and action plans. However, they do not correspond with the distinction drawn by the EMCDDA between treatment and social reintegration, which states that the latter does not include medical or psycho-social components but focuses on the provision of housing, education, vocational training and employment supports for drug users.

3.4.3 Individual or structural change: where does the balance lie at local level?

Most task force co-ordinators interviewed expressed the view that the social reintegration of drug users involved a mix of individual and community shifts. For example, most agreed that individual drug users should be treated and stabilised prior to or in conjunction with a reintegration approach. On the other hand, one interviewee stated

I think a lot of work has to be done on the community and things as well because it’s fine to say that somebody is integrating back, but communities can be very unaccepting of people and that they’re changed. (Interview with LDTF co-ordinator 2005)

This symbiotic approach reflects the view expressed in the National Drugs Strategy that the ‘successful rehabilitation of a recovering drug user is also contingent on societal attitudes towards drug misusers’ (p. 103).

Some co-ordinators expressed the view that drug users’ forums, comprising former drug users, could play a vital role in educating and informing the wider community by articulating their experience of using drugs and their attempts to move beyond their drug use. Methods of articulation could include art, sculpture, poetry and literature that would reflect and convey the complexities of the drug scene.

Other co-ordinators expressed the view that the focus of reintegration is the individual client and not the community. For example, empowerment emerged from some interviewees as a key concept in the process of reintegration of clients. One co-ordinator argued that reintegration was about ‘empowering the individuals to become self-determined agents’. Another co-ordinator reiterated this viewpoint and added that, in both rehabilitation and reintegration, empowerment was key:

It shouldn't be called rehabilitation, because you have to empower people that when they go back to the environment that they're empowered so they can do something else. And the same thing about reintegration, there's no point reintegrating people into a situation that they got all their problems from in the first place. (Interview with LDTF co-ordinator 2005)

3.4.4 Availability and accessibility of social reintegration measures at local level

In response to questions on the availability and accessibility of social reintegration measures (using the EMCDDA definition) specifically designed to target drug users, almost all co-ordinators spoke about clients ‘linking in’ with the Local Employment Service Network (LESN) and with FÁS. There was an implied perception that this approach was adequate to address the educational and vocational training needs of drug users. This view reflects the position as outlined in the National Drugs Strategy whereby FÁS and the LESN are given responsibility for delivering vocational training and employment support to clients of drug treatment services.

However, as the interviews revealed, there were wide variations in the nature and extent of LESN involvement with LDTFs. For example, some interviewees reported that the LESN was represented on the treatment/rehabilitation sub-committee of their LDTF and was prominent in delivering targeted educational and vocational employment supports to clients referred from the LDTFs. There was some evidence from the task forces in Ballymun and Bray to support this claim (see sections 8.3.2 and 8.4.2); however, in other areas it appeared that LESN involvement was not well developed.

FÁS is given responsibility for providing the bulk of vocational training and educational supports for clients through the CE scheme in LDTF areas. However, an evaluation by Bruce (2004) on the operation of this scheme in these areas reported that the majority of participants and service providers were of the view that CE served primarily a therapeutic function and was not viewed as being vocational in the main. In addition, the evaluation highlights the difference in the nature and extent of FÁS involvement across LDTFs. This would suggest that, despite the perception among co-ordinators that the existing approach was adequate, it may be the case that access to vocational training for drug users was not evenly spread across the LDTFs.

This raises a fundamental question regarding the wisdom of relying on mainstream social exclusion models, such as the FÁS CE scheme and the LESN approach, which were developed to respond to the needs of both short-term and long-term unemployed people. Neale (2006), while accepting that there are dimensions of social exclusion, such as unemployment and homelessness, closely associated with drug misuse, cautioned against the move to target drug misuse through the lens of

social exclusion by arguing that

the most effective policies and strategies to tackle drug problems will be those that are driven by drug misuse per se and not those that are filtered through some other policy lens such as social exclusion... . There is a danger that allowing a social exclusion agenda to determine our drug policies will skew services heavily towards those that attempt to prevent crime, reassure the frightened and promote employment – that is, away from those that prioritize the complex needs of people who are actually addicted. (p. 14)

Co-ordinators reported limited involvement in the development of housing or accommodation options for drug users. In some cases, co-ordinators reported sporadic links between Dublin City Council and their LDTF, but there was little evidence that this was part of a strategic approach to the accommodation problems faced by drug users. The lack of hostels and accommodation supports in general throughout the LDTFs meant that the only option for clients facing eviction and homelessness was referral to the centralised services in the city centre, which meant being exposed to the risks associated with the urban ‘drug scene’.

3.5 Summary points

- Social reintegration is defined as any attempt to integrate drug users into the community. Measures include the provision of accommodation, education, vocational training and employment supports, but do not include medical or psycho-social components.
- The United Nations and the Council of the European Union see social reintegration as part of an approach to reducing the demand for drugs.
- In Ireland, measures to improve educational levels and employability among drug users have been promised by government working parties, task forces and policy documents since the early 1970s. In practice, social reintegration did not figure prominently in the operations of local drugs task forces before 2005. There is a clear need to extend the discourse of drug responses to include social reintegration.



4 Employment status and perceptions of employment among recovering drug users



4.1 Introduction

This section includes an analysis of data on the employment status of cases treated for problem drug use in Ireland between 2001 and 2003. The data were collected by the National Drug Treatment Reporting System (NDTRS). The NDTRS is an epidemiological database on treated problem drug use in Ireland. It is co-ordinated by the Alcohol and Drug Research Unit (ADRU) of the Health Research Board (HRB) on behalf of the Department of Health and Children. Up to and including 2003, compliance with the NDTRS required that a form be completed for every person who received treatment for problem drug use at each treatment centre in a calendar year. According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and the Pompidou Group,⁵ treatment is defined as

Any activity targeted at people who have problems with substance use, and which aims to improve the psychological, medical and social state of individuals who seek help for their problem drug use.

The NDTRS collects data on employment status in accordance with the *Treatment Demand Indicator: Standard Protocol 2.0*. According to the NDTRS protocol, people attending treatment who report that they work part time or full time, or that they are self-employed, are classified as being 'in paid employment'. There is also a possibility that people engaged in Community Employment (CE) schemes may report that they are in full-time employment, as the status of CE is quite ambiguous, with some interpreting it as vocational training and others referring to it as employment.

4.2 Employment status and the implications for treatment outcomes

According to Caplovitz (1976),

The common image of an addict is that of someone who has dropped out of normal society, who moves within a highly deviant street culture of crime and drugs. (p. 313)

This image would seem to suggest that employment and drug use are at opposite ends of the spectrum in the everyday lives of drug users. However, the evidence indicates that this is not always the case and that employment is a normative aspiration for many drug users. Data from the NDTRS presented in this chapter show that a significant minority of drug users who report for treatment are in employment. In addition, Platt (1995) suggests that drug users who manage to stabilise their drug use and retain employment often have better treatment outcomes than those who are unemployed.

Being employed is an established social norm in contemporary society and something that the majority aspire to for financial benefits and social status. As Berg (2003: 205) points out, 'The idea that one's job is the most central component of one's life is a norm that most people defend and practice.'

⁵ The Pompidou Group is a multidisciplinary co-operation forum to prevent drug abuse and illicit trafficking in drugs, set up in 1971 and incorporated into the Council of Europe in 1980.

Drug users, too, aspire to the norm of employment and are aware of its benefits. Neale (2002) reported that drug users in Scotland identified the benefits that legitimate employment could bring them, such as self-esteem, pride and a means of avoiding stigma. In addition, they believed that having a job was central to the process of recovery, since working provided a distraction and, often, an alternative structure to their days. Klee *et al.* (2002) reported that clients were well aware of the benefits that employment could bring. For example, they identified a higher income, greater respect, being more active and having an interesting life and more confidence as positive aspects of getting a job. Just over half believed that getting a job would make it easier to get off and stay off drugs, primarily because their time would be occupied.

However, research also shows that drug users are not always prepared to accept menial jobs. Eley (2007) conducted group interviews with 29 offenders with a history of substance abuse who were undertaking community-based court orders in Scotland. The interviewees acknowledged the importance of employment to recovery but were not keen to accept low-paid manual jobs. Most aspired to self-employment and several had pursued this route with success, for example as taxi drivers. This research is a reminder that drug users' aspirations in relation to employment and the need for autonomy are similar to those of the general population.

Platt (1995), in reviewing the evidence base on the role of employment in drug treatment, found that persons in employment stayed in treatment longer and achieved better outcomes than their unemployed counterparts. Earlier research, by Platt and Metzger (1985), found that methadone-maintained individuals in employment were likely to be more successful than their unemployed counterparts, not only in securing employment in the first instance but also in having shorter or fewer periods of incarceration and longer periods of abstinence from illicit drug use.

Ginexi *et al.* (2003) examined the employment status of participants in a substance abuse treatment programme in Chicago over the course of three years, including clients in outpatient drug-free treatment, methadone maintenance and inpatient drug-free treatment. Those in the study sample were interviewed using an augmented version of the Addiction Severity Index (ASI) at entry and at six, 24 and 36 months. The sample size declined from 1,326 at entry to 1,216 at 36-month follow-up. Participants were predominantly African American and the majority (59%) were female. More participants were working, or looking for work, at each follow-up than was the case at study entry. The gains in labour force participation relative to non-participation were greatest at six months, while the gains in terms of employment relative to looking for work were greatest at 24 months. This suggests that the transition from treatment to work can take up to three years. Participants who continued to seek treatment and continued to use drugs or reported psychological problems were far more likely to be out of the labour force at the time of follow-up interviews. By far the greatest barrier to labour force participation and employment during the entire three-year period was continued illicit drug use compounded by mental illness.

The search strategy used for this Overview did not reveal any research carried out in Ireland to examine the employment status of individuals engaged in problematic drug use. As mentioned in the introduction to this chapter, the NDTRS does record the employment status of individuals in

treatment for problematic drug use. For the purpose of this Overview, data for the years 2001–2003 on the employment status of cases entering treatment for the first time, or returning to treatment after an absence of more than one month, were analysed. Of the 5,250 cases who commenced treatment in 2003, just under 20% (1,028) were in paid employment (Table 4.1). This figure is far less than the national rate of 65% in 2003 (Table 4.2). Of the 1,028 cases in paid employment, 79% (813) were male (Table 4.4), which is higher than the proportion of the population entering drug treatment who were male (71%) (Table 4.3).

Table 4.1 Employment status of cases entering drug treatment*, 2001–2003

Employment status	Year		
	2001	2002	2003
Total	4877	5150	5250
In paid employment	1206 (24.7%)	1083 (21.0%)	1028 (19.6%)
Unemployed	2925 (60.0%)	3069 (59.6%)	3203 (61.0%)
FÁS scheme or other training course	186 (3.8%)	216 (4.2%)	215 (4.1%)
Student	259 (5.3%)	368 (7.1%)	442 (8.4%)
Housewife/husband	57 (1.2%)	82 (1.6%)	62 (1.2%)
Retired/unable to work/disability	57 (1.2%)	73 (1.4%)	85 (1.6%)
Other	35 (0.7%)	63 (1.2%)	95 (1.8%)
Not known	152 (3.1%)	196 (3.8%)	120 (2.3%)

*Cases entering drug treatment include both new cases and cases returning to treatment after a period of absence.

Source: Unpublished analysis from the NDTRS

Table 4.2 Percentage of national population in employment, 2001–2003

	2001	2002	2003
Total	65.2	65.1	65.1
Males	76.2	75.0	74.7
Females	54.0	55.2	55.3

Source: Adapted from Central Statistics Office (2005)

Table 4.3 Gender of cases entering drug treatment*, 2001–2003

Gender	Year		
	2001	2002	2003
Total	4877	5150	5250
Male	3581 (73.4%)	3699 (71.8%)	3746 (71.4%)
Female	1252 (25.7%)	1288 (25.0%)	1297 (24.7%)
Not recorded	44 (0.9%)	163 (3.2%)	207 (3.9%)

*Cases entering drug treatment include both new cases and cases returning to treatment after a period of absence.

Source: Unpublished analysis from the NDTRS

Table 4.4 Employment status of cases entering treatment, by gender, 2001–2003

Employment status	Gender	Year		
		2001	2002	2003
In paid employment	Male	963 (79.9%)	888 (82.0%)	813 (79.1%)
	Female	231 (19.2%)	166 (15.3%)	168 (16.3%)
	Not recorded	12 (1.0%)	29 (2.7%)	47 (4.6%)
	Total	1206	1083	1028
Unemployed	Male	2167 (74.1%)	2184 (71.2%)	2298 (71.7%)
	Female	735 (25.1%)	795 (25.9%)	792 (24.7%)
	Not recorded	23 (0.8%)	90 (2.9%)	113 (3.5%)
	Total	2925	3069	3203
FÁS or other training	Male	114 (61.3%)	127 (58.8%)	140 (65.1%)
	Female	71 (38.2%)	78 (36.1%)	68 (31.6%)
	Not recorded	1 (0.5%)	11 (5.1%)	7 (3.3%)
	Total	186	216	215
Student	Male	169 (65.3%)	252 (68.5%)	283 (64.0%)
	Female	86 (33.2%)	99 (26.9%)	142 (32.1%)
	Not recorded	4 (1.5%)	17 (4.6%)	17 (3.8%)
	Total	259	368	442
Housewife/husband	Male	0 (0.0%)	6 (7.3%)	2 (3.2%)
	Female	56 (98.2%)	75 (91.5%)	57 (91.9%)
	Not recorded	1 (1.8%)	1 (1.2%)	3 (4.8%)
	Total	57	82	62
Retired/unable to work	Male	44 (77.2%)	60 (82.2%)	57 (67.1%)
	Female	12 (21.1%)	10 (13.7%)	21 (24.7%)
	Not recorded	1 (1.8%)	3 (4.1%)	7 (8.2%)
	Total	57	73	85
Other	Male	21 (60.0%)	43 (68.3%)	75 (78.9%)
	Female	14 (40.0%)	18 (28.6%)	18 (18.9%)
	Not recorded	0 (0.0%)	2 (3.2%)	2 (2.1%)
	Total	35	63	95
Not known	Male	103 (67.8%)	139 (70.9%)	78 (65.0%)
	Female	47 (30.9%)	47 (24.0%)	31 (25.8%)
	Not recorded	2 (1.3%)	10 (5.1%)	11 (9.2%)
	Total	152	196	120

Source: Unpublished analysis from the NDTRS

Table 4.5 Employment status of cases entering treatment, by frequency of use of main problem drug, 2001–2003

Employment status	Use of main problem drug	2001	2002	2003
In paid employment	No use in last month	236 (19.6%)	264 (24.4%)	256 (24.9%)
	Once a week or less	112 (9.3%)	94 (8.7%)	103 (10.0%)
	2–6 times per week	218 (18.1%)	198 (18.3%)	203 (19.7%)
	Daily	589 (48.8%)	475 (43.9%)	433 (42.1%)
	Not known	51 (4.2%)	52 (4.8%)	33 (3.2%)
	Total	1206	1083	1028
Unemployed	No use in last month	512 (17.5%)	676 (22.0%)	765 (23.9%)
	Once a week or less	192 (6.6%)	241 (7.9%)	256 (8.0%)
	2–6 times per week	419 (14.3%)	402 (13.1%)	505 (15.8%)
	Daily	1671 (57.1%)	1622 (52.9%)	1587 (49.5%)
	Not known	131 (4.5%)	128 (4.2%)	90 (2.8%)
	Total	2925	3069	3203
FÁS or other training	No use in last month	42 (22.6%)	60 (27.8%)	66 (30.7%)
	Once a week or less	27 (14.5%)	25 (11.6%)	20 (9.3%)
	2–6 times per week	45 (24.2%)	54 (25.0%)	53 (24.7%)
	Daily	66 (35.5%)	69 (31.9%)	68 (31.6%)
	Not known	6 (3.2%)	8 (3.7%)	8 (3.7%)
	Total	186	216	215
Student	No use in last month	49 (18.9%)	79 (21.5%)	79 (17.9%)
	Once a week or less	50 (19.3%)	72 (19.6%)	82 (18.6%)
	2–6 times per week	93 (35.9%)	109 (29.6%)	160 (36.2%)
	Daily	54 (20.8%)	93 (25.3%)	107 (24.2%)
	Not known	13 (5.0%)	15 (4.1%)	14 (3.2%)
	Total	259	368	442
Housewife/husband	No use in last month	6 (10.5%)	20 (24.4%)	17 (27.4%)
	Once a week or less	6 (10.5%)	5 (6.1%)	7 (11.3%)
	2–6 times per week	2 (3.5%)	14 (17.1%)	5 (8.1%)
	Daily	40 (70.2%)	35 (42.7%)	31 (50.0%)
	Not known	3 (5.3%)	8 (9.8%)	2 (3.2%)
	Total	57	82	62
Retired/unable to work	No use in last month	18 (31.6%)	20 (27.4%)	31 (36.5%)
	Once a week or less	4 (7.0%)	9 (12.3%)	4 (4.7%)
	2–6 times per week	7 (12.3%)	11 (15.1%)	11 (12.9%)
	Daily	24 (42.1%)	32 (43.8%)	34 (40.0%)
	Not known	4 (7.0%)	1 (1.4%)	5 (5.9%)
	Total	57	73	85
Other	Total	35	63	95
Not known	Total	152	196	120

Source: Unpublished analysis from the NDTRS

4.3 Association between employment status and reduced frequency of problem drug use

According to Platt (1995), people who are regularly employed have lower rates of substance misuse than those who are sporadically employed or unemployed. Analysis of data from the NDTRS on frequency of drug use supports this finding. Of cases commencing treatment for problem drug use in 2003, 1,028 were in paid employment and 3,203 were unemployed (Table 4.1); 42% of the employed cases used their main problem drug daily, compared to 50% of the unemployed cases (Table 4.5). This analysis suggests less frequent drug use among employed cases than among unemployed cases.

4.4 Unemployment levels among drug users in treatment

According to Platt (1995), individuals enrolling for treatment for drug misuse tend to have high rates of unemployment and continue to experience difficulty in improving their chances of employment during or after treatment due to limited qualifications, employer bias and welfare disincentives. Data from the NDTRS clearly show that there are very high rates of unemployment among individuals attending drug treatment in Ireland. For example, of the 5,250 cases entering treatment in 2003, 61% (3,203) were unemployed (Table 4.1) and 72% (2,298) were male (Table 4.4). According to the Central Statistics Office (2005) the Irish national unemployment rate fluctuated between 3% and 4.6% in the three years 2001–2003. One of the few estimates of unemployment among drug users in treatment across Europe is provided by the EMCDDA (2003). They estimate an average unemployment rate of 47% among drug users entering treatment in the EU and Norway. The rate for Ireland is considerably higher than this average.

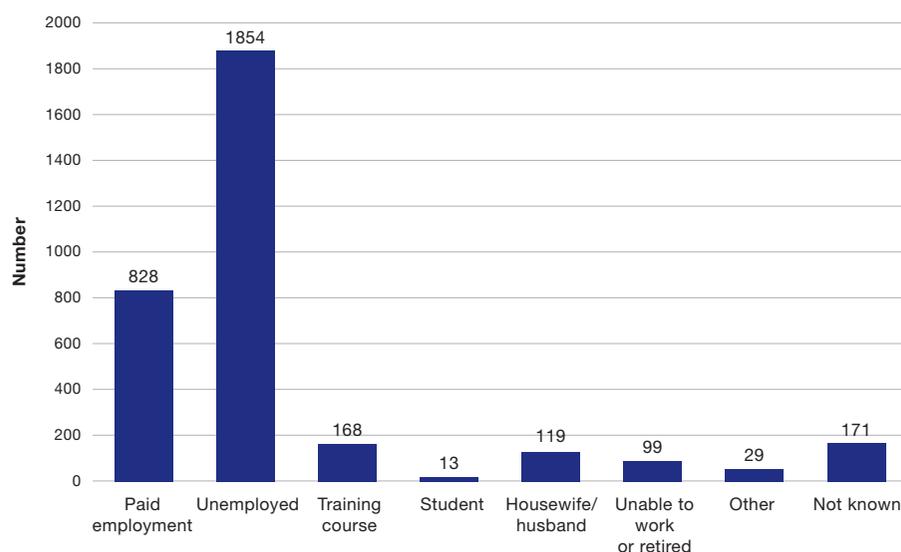


Figure 4.1 Number of cases on methadone maintenance on 31 December 2002, by employment status

4.5 Employment status and methadone maintenance

When NDTRS data on individuals who continued in treatment from the preceding year was analysed by employment status and treatment modality, it was clear that those who were on methadone maintenance programmes were capable of obtaining and remaining in employment. In 2003, 3,542 cases continued in treatment for problem opiate use from the previous year. Of these cases, 3,281 (92.6%) were receiving methadone maintenance, of whom 828 (25.2%) were in paid employment, 1,854 (56.5%) were unemployed and 168 (5.1%) were in FÁS or other training schemes (Figure 4.1).

Indeed, the pioneers of methadone treatment for opiate addiction noted the role that methadone could play in helping clients to obtain employment. In their report of early trials of substitution treatment in the case of 22 people addicted to heroin, Dole and Nyswander (1965) noted that methadone satisfied the physical cravings of addiction but did not make users high or subject them to violent mood swings. Their studies showed that people with heroin addiction could be maintained on prescribed doses of methadone, whereby they remained physically dependent on the drug but were able to conduct otherwise normal lives. When treated with methadone and a comprehensive program of rehabilitation, patients returned to education, obtained jobs and became reconciled with their families. The authors emphasised that treating the medical needs of people addicted to heroin with methadone should be complemented by giving equal attention to the social reintegration needs of the same patients. They went on to say: 'The most important services needed during this [initial] phase of treatment were help in obtaining jobs, housing and education.'

However, research by Platt and Metzger (1985) demonstrated that methadone clients are not a homogenous group. Their research showed that methadone clients who secured employment tended to share similar characteristics in that they valued employment, they believed that job opportunities did exist, they had realistic goals and were confident and motivated in their search for employment and able to face rejection when it came. The authors argued that drug users moving into employment must engage in what they called a cultural transition from the drug scene (drug culture) to the world of paid employment. Long-term drug users might require significantly longer-lasting and more intensive supports to facilitate the transition from treatment to employment.

4.6 Women in treatment and employment

One of the more noticeable trends in employment levels in the general population over recent years has been the increase in the proportion of women in employment. According to the Central Statistics Office (2006) the employment rate for women in Ireland increased by almost 15 percentage points over the period 1996 to 2005. Data from the CSO (2005) show that 55% of women in Ireland were employed in 2003 (Table 4.2). According to NDTRS data for 2003, 13% (168/1297) of women entering treatment for problem drug use were employed. When this is contrasted with the national female employment rate of 55% in 2003, we can see that the advances made by women in general in securing employment have not been equally spread. However, poor employment rates for women in treatment for drug misuse are not solely an Irish problem. Ginexi *et al.* (2003) examined work status

patterns over the course of three years among participants who enrolled in publicly funded substance abuse treatment programmes in the US. This research found that the female participants were significantly less likely than the male participants to be in the labour force at six and at 24 months after intake, allowing the authors to conclude that employment was one domain in which women appeared to experience less improvement than men after treatment.

4.7 Barriers to education, training and employment

Understanding the barriers, real and perceived, between recovering drug users and the world of employment is crucial for both service providers and clients. Service providers cannot deliver effective vocational rehabilitation services unless these barriers are identified and addressed. Clients cannot be expected to progress towards the job market unless they too are encouraged to identify and address the personal and systemic barriers that stand between them and any realistic chance of employment.

A number of international and Irish studies have identified the main barriers affecting access by drug users to vocational rehabilitation and employment (Platt 1995; Kemp and Neale 2005; Klee *et al.* 2002; EIU 2001; Bruce 2004; Lawless 2006; Lawless and Cox 2000). The barriers identified can be grouped into two broad categories – individual and systemic.

Individual barriers

- Fear of failure, low expectations, poor confidence and fear of relapse
- Fear of stigma and lack of trust in society
- Poor physical and mental health, insecure accommodation and homelessness
- Poor education, including a low level of literacy or numeracy
- A criminal record
- Poor employment history

Systemic barriers

- Potential loss of secondary benefits such as medical card and supplementary rent allowance
- Negative attitudes by employers towards drug users
- Changing labour market demands, including different skill requirements
- Treatment philosophy and priorities, staff development and co-ordination, programme approach, criminal justice issues and information dissemination issues

Research by the Effective Interventions Unit (EIU) of the Scottish Executive (2001) involved focus groups of clients and service providers. Clients reported fear of losing welfare and secondary benefits

as a major barrier to entering education, training and employment. Lawless (2006) identified similar fears among participants in CE projects in the Dublin North East Drugs Task Force area. These participants were concerned about the possibility of losing their rent, fuel, dietary and back-to-school allowances while participating in CE training. The 'catch 22' of CE is that money earned on the scheme is treated as income from work, and therefore other benefits are means tested against it, but CE participants do not qualify for Family Income Supplement (FIS) because they are not seen as being in employment. Secondary benefits are handled on a purely discretionary basis by community welfare officers and the decision-making process lacks transparency. Removal or reduction of secondary benefits can lead to a reduction in the levels of real income.

However, this anomaly could be addressed by a partnership approach, with policy makers and state agencies working in tandem for the benefit of clients. For example, recent commitments from the Irish Prison Service, the Revenue Commissioners, the Department of Social and Family Affairs and the Department of Finance mean that individuals released from prison can retain a number of secondary benefits for the first three years of their employment, including their medical card, fuel allowance and up to 75% of their rent allowance. Employers who give employment to a released inmate can avail of a double deduction of the employee's income from their company's taxable income for up to three years, provided that the employee remains with them for that period. Similar measures could benefit individuals who are engaged with drug treatment services and seeking to improve their employment opportunities.

Research by Klee *et al.* (2002) included the views of 70 current, former and recovering drug users attending education, training and employment schemes in the greater Manchester area. Fear of relapse and, in some cases, of exposure of their criminal past to potential employers, were the common barriers experienced among this group. Clients worried that work might reduce income and that relapse would necessitate renegotiating benefits. Similar barriers to progression were identified by clients in local drugs task force areas (Bruce 2004; Lawless 2006). Both authors make the point that these deterrents can perpetuate the state of unreadiness in those who, with sufficient support, could have made progress towards employment.

Tackling and overcoming individual barriers are important goals in treatment plans for drug users. However, of equal importance is recognising and challenging the many systemic barriers that prevent clients making progress to education, vocational training and employment. According to Buchanan (2004),

one of the biggest hurdles problem drug users face is breaking through the barrier of social exclusion, prejudice and discrimination. (p. 394)

Discrimination in the labour market against certain marginalised groups is not a myth. According to Campbell (2000),

employers may discriminate against certain groups in the labour market on the basis of certain

observable characteristics e.g. disability, post code...in addition discrimination may operate through screening mechanisms which label the unemployed as 'inferior' to those with more recent employment experience... [while] domestic circumstances may prevent some people from full participation in the labour market. (p. 26)

Klee *et al.* (2002) conducted interviews with education, training and employment professionals working with drug users to improve their employability and make them ready for work. These interviews revealed that staff perceived potential employers as discriminating against their clients, with the result that very few approached employers directly on their clients' behalf. Research by Scott and Sillars (2003) surveyed 33 employers from two social inclusion partnerships in Glasgow about their attitudes to employing members of socially excluded groups, including former drug users and the homeless. The survey revealed significant negative attitudes towards drug users, with 70% of respondents saying they would not employ a person who was on a methadone programme.

4.8 Summary points

- Employment is a normative aspiration among most drug users, and is seen as an important part of their recovery.
- Being in employment is associated with less frequent use of the main problem drug and improved drug treatment outcomes.
- Methadone maintenance is not a barrier to finding employment.
- The transition from drug treatment to work can take up to three years.
- Just under 20% of cases commencing treatment for problematic drug use in Ireland in 2003 were in employment, compared to a national average of 65%.
- Sixty one per cent of cases commencing treatment for problematic drug use in Ireland in 2003 were unemployed, compared to the national average of between 4% and 6.3%.
- Thirteen per cent of women commencing treatment for problematic drug use in Ireland in 2003 were in employment, compared to the national average of 55%.
- Research has shown that personal and systemic barriers can prevent drug users from improving their education and vocational skills and from getting a job.
- Drug users experience individual and systemic barriers to gaining employment. These include:
 - physical and mental health issues
 - personal development issues
 - poor employment history
 - criminal record
 - links between treatment and employment

- reduced social welfare benefits
- employer attitudes
- changing labour market requirements.



5 Homelessness and drug use: situation and consequences



5.1 Introduction

Homelessness has been identified by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) as both a social correlate and a consequence of problematic drug use. This chapter will examine the association between homelessness and drug use, drawing on research conducted in Ireland among the homeless population. The majority of the studies reviewed here were designed to explore the effects of homelessness on the health and well-being of the homeless population; they have, indirectly, provided data that show that there are clear implications and risks for homeless people who use illicit drugs.

5.2 Homelessness among drug users entering treatment

Data from the NDTRS indicate that 383 (7.3%) of problem drug users entering treatment in 2003 were homeless, and a further 214 (4.1%) were living in unstable accommodation (Table 5.1).

Table 5.1 Type of accommodation of cases entering treatment, 2001–2003

	Year		
	2001	2002	2003
Stable accommodation	3879 (79.5%)	4023 (78.1%)	4263 (81.2%)
Institution (prison, clinic)	59 (1.2%)	125 (2.4%)	142 (2.7%)
Homeless	332 (6.8%)	303 (5.9%)	383 (7.3%)
Other unstable accommodation	177 (3.6%)	207 (4.0%)	214 (4.1%)
Not known	430 (8.8%)	492 (9.6%)	248 (4.7%)
Total	4877	5150	5250

Source: Unpublished analysis from the NDTRS

5.3 Prevalence of drug use among the homeless population

Research consistently shows that illicit drug use, and, in particular, heroin injecting, are common among the homeless population. Cox and Lawless (1999) found that the vast majority of clients presenting to Merchants Quay Ireland (MQI) and experiencing homelessness reported using heroin as their primary drug, with 98% reporting intravenous heroin use. Feeney *et al.* (2000) found that 18% of homeless men in hostels reported having used heroin at least once during their lifetime, 12% having injected it. Smith *et al.* (2001) reported that, among 100 homeless women in emergency accommodation, 45% were opiate dependent. Lawless (2003), investigating the health status of 17 female drug users, of whom 11 were homeless, found that 13 were polydrug users. Hickey and Downey (2003), investigating the food intake, diet and nutrition of people who were homeless in Dublin, reported that 26% had used heroin in the 30 days prior to the study. In a study of 20 young homeless men in Dublin, Cleary *et al.* (2004) found that 65% were heroin users, and 35% of these were current injectors of the drug. Crawley and Daly (2004) interviewed 17 homeless people in

Tallaght and found that all respondents had experience of injecting, with heroin and cocaine the drugs being injected.

A national study of drug use among the homeless population (n = 355) by Lawless and Corr (2005) revealed that 22% were current heroin users, with 52% of these reporting daily use. Thirty-five per cent of the total study population reported having injected drugs, with 19% of these having injected heroin in the last month. The study found higher rates of drug use among those who were sleeping rough than among hostel dwellers or those in bed and breakfast accommodation. Of those who were sleeping rough, 34% reported current use of heroin, 25% current use of cocaine, and 7% current use of crack.

5.4 Drug use as a factor contributing to homelessness

Research clearly shows that the use of illicit drugs, in some cases combined with alcohol, is a major contributory factor to exposing families and households to the initial experience of homelessness. Houghton and Hickey (2000) carried out secondary data analysis on information collected on households⁶ placed in bed and breakfast accommodation in Dublin in 1999. The research revealed that drug addiction was the second most commonly cited reason for households becoming homeless in the first instance; family conflict was the most commonly cited reason. O'Brien *et al.* (2000) conducted structured interviews with 14 homeless families availing of transitional housing, 12 of which were headed by the mother in the role of lone parent. The families reported that difficulty in sustaining the family unit was the major reason for becoming homeless, with four families citing heroin addiction as the main reason. Overall, drug addiction was cited as the second most common reason for becoming homeless, with 43% of the mothers reporting that they were addicted to alcohol and drugs. Halpenny *et al.* (2002), using semi-structured interviews with 20 families in bed and breakfast accommodation, found that addiction issues within the family were cited as a key factor in the incidence of homelessness.

Health-related research among individuals using drugs and accessing day support services for the homeless also reveals the key role of drug misuse in the initial exposure to homelessness. Cox and Lawless (1999) reported that 64% of homeless people accessing the services of Merchants Quay Ireland attributed their leaving home to problems surrounding their drug use. Holohan (1997) reported that substance use, including that of alcohol, was the most common reason given for the initial experience of homelessness, particularly among young people. This research was based on data collected by means of structured questionnaires administered to people using emergency accommodation, food centres and soup runs.

Feeney *et al.* (2000) interviewed 171 men from three Dublin hostels and found that addiction problems were cited by 18% as the primary reason for their initially becoming homeless. Lawless

6 Households included single adults (33%), couples with children (8%), lone parents (39%), two parents with children (18%), unknown family status (2%).

and Corr (2005) reported that personal drug use was cited as the second most common reason for becoming homeless; however, 87% of the research sample reported having used drugs prior to becoming homeless. Cleary *et al.* (2004) conducted in-depth interviews with 20 men between the ages of 18 and 30 who were attending a drop-in centre for homeless men in Dublin. The research revealed that the majority had engaged in drug misuse prior to becoming homeless, with some participants stating that their drug-related anti-social behaviour and criminal activity were the cause of their removal from the family home. Crawley and Daly (2004), in the course of in-depth interviews with homeless people in Tallaght, found that a majority felt their drug use contributed to their initial experience of homelessness. Over half reported that their families were unable to cope with their drug use, while evictions under anti-social behaviour legislation and relationship breakdown were cited as additional factors contributing to their initial experience of homelessness. Perris (1999), using semi-structured interviews and group discussion with young people (aged 14–24), found that over 50% reported drug use, including familial drug use, as contributing to their initial experience of homelessness.

As part of a recent review of the Homeless Strategy (Fitzpatrick Associates 2006), 33 service users were interviewed between March and May 2005. Family breakdown and associated problems of alcohol and substance abuse were cited as the primary reasons for becoming homeless in the first instance. Many of the interviewees reported that they had relapsed when accommodated in homeless hostels, after having been drug or alcohol free for a considerable period of time. A number of interviewees reported that they had had to wait for between six and nine months to join a methadone programme.

The point is made in some of these studies that, while the homeless people interviewed may have identified illicit drug use as a major contributory factor in their initially becoming homeless, it was likely that a number of underlying factors existed.

5.5 The association between leaving state care, homelessness and drug use

Recent research by Mayock and Vekic (2006) presented data from the first phase of a two-phase longitudinal cohort study of young homeless people. The study used ‘life history’ interviews with 40 young people recruited through homeless services and street settings. The research focused on a cohort of young people living in Dublin for at least six months prior to the commencement of the study. Twenty of the young people were aged between 15 and 17 years. Nineteen reported becoming homeless initially at the age of 14 or younger, while 12 initially became homeless at the age of 15. The research identified leaving state care as one pathway into homelessness and drug use. Forty per cent of the cohort reported a history of state care of varied duration in foster homes, residential care placements and residential placement homes. In addition, they reported moving between a range of care settings. The trauma of being in institutional care when young and the emotional conflict of such an experience were identified as key factors that could contribute to later problematic drug

use. When exposed to the experience of homelessness over an extended period, young people can become heavily involved in using drugs and committing crime on a daily basis to finance their drug use.

At the time of conducting the interviews, only eight of the cohort of 40 were not using illicit drugs, with the average age of first drug use being 11.5 years for males and 13 years for females. Fifty per cent of the cohort reported having used heroin, with almost all reporting their heroin use as problematic to the point of dependency. The majority of those who used heroin had first experimented with it after they became homeless.

5.6 Drug use and homelessness among prisoners and ex-prisoners

Research shows that, for some homeless people committed to prison, the use of illicit drugs is quite high. Seymour and Costello (2005) reported that 90% of prisoners homeless on committal were using illicit drugs, with cannabis, heroin and cocaine the most prevalent. The authors also reported that the majority of these prisoners cited their drug use as a factor in rendering them unable to maintain employment or accommodation. In addition, the prisoners reported that they were reluctant to use hostels as this experience tended to escalate their drug use, so they slept rough instead. They anticipated that, when released, finding a job and a place to live and resisting drug use would remain their main problems. Hickey (2002) interviewed 46 individuals (14 female, 32 male) who were homeless and had experienced periods of imprisonment and found that levels of current and past drug use in the group were quite high. For example, 31 respondents reported current use of illegal drugs, of whom 68% reported polydrug use. O'Loingsigh (2004) carried out 20 in-depth interviews and four focus groups with ex-prisoners. This research highlighted the crucial nature of the first 24 hours after release when, according to participants, exposure to homelessness and the risk of a return to drug use and crime were heightened. Failure on the part of prison authorities to prepare prisoners adequately for release, in terms of linking them in with accommodation and drug treatment services, was cited by individuals as being a key factor in their becoming homeless and returning to drugs and crime following their release.

5.7 Injecting-related risk behaviour among homeless people

Lawless and Corr (2005) estimated that 19% of homeless people inject drugs. Research shows that drug users experiencing homelessness are likely to be exposed to high levels of injecting-related risk behaviour, such as sharing used equipment, injecting-related injuries, poor dietary habits and the risk of drug-related overdose. Cox and Lawless (1999) reported that 49% of the homeless people they interviewed had shared filters and spoons in the four weeks prior to interview. Feeney *et al.* (2000) found that two-thirds of homeless men living in hostels who were injecting drugs reported sharing needles, while Lawless and Corr (2005) found that 53% of current injectors reported sharing injecting paraphernalia in the previous four weeks. Smith *et al.* (2001) found that, among 100 homeless women, 13% of heroin injectors reported sharing needles in the previous 12 months.

In addition to being exposed to the risks associated with sharing injecting equipment, homeless people using drugs are exposed to the risk of soft tissue damage. Lawless and Corr (2005) reported that 71% of current injectors experiencing homelessness reported scarring and bruising of the injecting site and 32% reported abscesses or infections of the site.

5.8 Risk of drug overdose among homeless drug users

Cleary *et al.* (2004) reported that chaotic drug use carried major risks for some young homeless men in Dublin, with a number of participants experiencing overdose leading to hospitalisation. Lawless and Corr (2005) found that 20% of homeless current injectors reported accidental overdose in the three months prior to interview. Crawley and Daly (2004) found that, among 17 homeless heroin users in Tallaght, five reported overdose resulting in hospitalisation. Health-related risks are also heightened among homeless injectors. Injecting while alone, often in an isolated location, can be a risk factor for overdose, if difficulties occur, there is no one to summon medical assistance. In the study by Lawless and Corr (2005) 46% of the homeless people interviewed reported that they were normally alone when injecting, with males significantly more likely to report this being the case.

5.9 Physical and mental health status of homeless drug users

Research shows that, among homeless people, those engaged in problematic drug use are more likely to suffer poor physical and mental health than those who do not use drugs. Lawless and Corr (2005) found that 51% of homeless drug users reported being hepatitis C positive, compared to 23% of the total study population. Problematic drug users reported higher levels of poor physical health compared to the total study population. In addition, homeless drug users were less likely to report having a medical card. Hickey and Downey (2003), looking at the diets of homeless people, reported poor dietary habits among those using drugs, with a tendency towards foods with high fat and sugar content. Homeless people who were problematic drug users were more likely to report psychiatric health concerns than their non-drug-using counterparts. A study by Smith *et al.* (2001) reported mental health problems among homeless women using heroin.

5.10 Homelessness as a risk factor for increased and/or chaotic drug use

It is clear from a number of studies that the experience of homelessness is associated with an escalation in drug use and that using emergency accommodation such as hostels can contribute to chaotic patterns of drug use among those who are trying to maintain some control over their use. Cox and Lawless (1999) reported that 56% of homeless drug users reported an increase in their use of drugs since becoming homeless. Cleary *et al.* (2004), interviewing young homeless men, heard that the experience of homelessness contributed to more chaotic drug use, which then became the main obstacle to moving out of homelessness. Crawley and Daly (2004) found that the experience of becoming homeless greatly exacerbated drug use among homeless drug users in Tallaght in West Dublin. For example, the transition to using heroin intravenously was strongly associated with

becoming homeless and staying in emergency hostels or sleeping rough. Most agreed that their drug use created a barrier to moving out of homelessness, with all but one reporting having been evicted from hostels and bed and breakfast accommodation because of drug-related incidents. All interviewees repeatedly stated that their drug use escalated in hostels, and most associated emergency hostels with their most chaotic periods in terms of drug use. Lawless and Corr (2005) noted that changes in drug-using patterns as a result of becoming homeless were reported by 77% of current users. Among the changes cited were initiation into drug use (for a minority), changes in primary drug and routes of administration, increased frequency or quantity, and associated lifestyle behaviour changes.

5.11 Injecting in public places

Persons experiencing homelessness and engaged in intravenous drug use are more likely to inject in public places. Research by Lawless and Corr (2005) among the homeless population revealed that 54% of current injectors were street injectors, with males more likely to report injecting in public places. This is by no means a recent phenomenon, as research by Cox and Lawless (1999) among homeless service users at Merchants Quay Ireland revealed that 66% reported injecting in public places. Injecting in public increases the risk of drawing the attention of the gardaí, and the likelihood of injecting paraphernalia being discarded. The sight of a person injecting in public is also likely to be an unwelcome experience for the passer by.

5.12 Implications for the welfare of young children

A study of homeless women by Smith *et al.* (2001), found that, between them, 80 of the participants had a total of 173 children aged under 18, and 90 of these children were living with their mothers in emergency accommodation. Research published by the Tallaght Homeless Advice Unit (Crawley and Daly 2004) involved a group of 17 service users who had experienced homelessness, 11 of whom were currently homeless; between them, the group had 27 children, the majority of whom were aged four or under. These findings, although limited to two studies, raise serious questions as to the future of these children and the impact of homelessness and drug misuse on their lives.

5.13 Risks arising from the centralisation of services

Crawley and Daly (2004) reported that interviewees repeatedly identified the lack of accommodation for homeless people in Tallaght as a factor in exacerbating their drug use, as travelling into the city centre to access emergency accommodation increased the likelihood of involvement in the 'drug scene'.

5.14 Summary points

- Drug misuse and family breakdown are key factors in exposing individuals and families to the initial experience of homelessness.
- Exposure to homelessness is associated with an escalation in the use of drugs and progression to patterns of chaotic drug misuse.
- Leaving state care is a key risk factor in exposing young people to drug use and homelessness.
- Ninety per cent of prisoners who were homeless on committal in the Dublin Metropolitan area were misusing drugs.
- Social exclusion and the risk of a return to drug use upon release are key concerns among prisoners.
- Homeless drug users have poorer physical and mental health than homeless people who do not use drugs, and are at heightened risk of accidental overdose.
- Homeless drug users associate their experiences of emergency hostel accommodation with their more chaotic periods of drug use.



6 Responses to the accommodation needs of drug users



6.1 Introduction

This section will document the responses from policy and practice in Ireland to the housing and accommodation needs of drug users. It will draw on a review of policy documents, including the National Drugs Strategy 2001–2008 and the homeless strategies and a review of annual reports, research reports and personal communications from service providers.

6.2 The Irish policy context

The National Drugs Strategy 2001–2008 highlighted the need to tackle the accommodation needs of drug users as part of an overall approach to improving the effectiveness of drug treatment. The strategy states:

The effectiveness of treatment and the goals of rehabilitation are often undermined by the failure to ensure that recovering misusers have access to accommodation. (p. 103)

In particular, the Strategy highlights the need for closer liaison between treatment providers and local authorities to address the accommodation needs of the target group. This reference to the need for greater inter-agency work is particularly pertinent as current statutory responsibility for provision of emergency accommodation and overall housing stock rests with local authorities, while health boards are responsible for health and in-house care needs. Statutory responses to the accommodation needs of drug users must include both the provision of ‘bricks and mortar’ and the development of measures to improve health and provide social support. However, the Strategy fails to include specific guidelines or actions to develop this suggested close liaison. Moreover, among the 100 actions included in the Strategy, just two pertain to tackling the accommodation needs of drug users (Table 6.1).

Table 6.1 Actions in the National Drugs Strategy relating to the housing needs of drug users, and progress to date

Action	Agency responsible	Progress report (2004)	Mid-term review (2005)
26) To monitor and evaluate homelessness initiatives in relation to drug issues in the context of the Homeless Strategy and, particularly, in relation to the Dublin Action Plan	Department of the Environment and Local Government	Included in NACD research as per Action 98	Completed/ ongoing task
61) To consider developing drop-in centres, respite facilities and half-way houses, where a clear need has been identified, as such facilities have been found to be useful in the prevention of relapse	Health Boards	Drop-in and aftercare services are provided by boards and agencies funded under section 65 grants. A pilot drug-free aftercare programme has commenced in the Northern Area Health Board. The health boards will assess the current level of services and identify gaps and needs in conjunction with homeless strategies during 2003 and the RDTFs will also have a role to play in this.	Considerably more progress required

There has been some progress on Action 26 of the Strategy, represented by the publication of research by Lawless and Corr (2005) that examined drug use among the homeless population in Ireland. This research highlighted a number of important factors that prevent existing homeless initiatives responding in a meaningful way to the accommodation needs of individuals affected by problematic drug use.

- Problematic drug users were more likely to have problems accessing homeless services and more likely to be refused access to homeless services compared to the total homeless population.
- Few of the homeless services interviewed had official policies on illicit drug use, possession and dealing.
- The general perception among providers of homeless services was that these services did not adequately meet the needs of homeless drug users.
- Service providers and service users were of the view that emergency accommodation (in hostels) was unsuitable for individuals trying to tackle their illicit drug use. Both parties identified a lack of move-on options from emergency accommodation, which often meant that individuals in treatment were being exposed to an active drug scene when they availed of hostels.
- There was little evidence of inter-agency working between homeless service providers and drug treatment services.

Recent evaluations of the operation of the FÁS Special CE scheme in local drugs task force areas (Bruce 2004; Lawless 2006) highlight the lack of inter-agency working between drug treatment providers, local authorities and other agencies responsible for the care and welfare of drug users. Action 61 of the National Drugs Strategy identified the need to provide a range of respite places and half-way houses. However, the mid-term review of the Strategy noted that ‘considerably more progress’ was required on this action.

Homelessness: An Integrated Strategy (2000) and the *Homeless Preventative Strategy (2002)* highlight the association between drug use and the risk of being exposed to homelessness among some vulnerable groups. For example, the *Integrated Strategy (2000)* identified individuals leaving custodial and health-related institutional care (psychiatric care and care for vulnerable young people) as a group at risk of becoming homeless. Actions 9 and 11 of the strategy require statutory and voluntary agencies to provide a mix of suitable emergency accommodation for homeless women, couples, families and homeless persons with substance addictions, as well as high-support hostels for persons affected by substance addictions.

The recent review of the implementation of the *Integrated and Preventative Strategies (Fitzpatrick Associates 2006)* does not contain any specific information to show that emergency accommodation has been made more available or more accessible to homeless individuals engaged in drug misuse.

Indeed, recent research has shown that such individuals continue to experience both personal and systemic barriers to accessing emergency accommodation (Seymour and Costello 2005; Lawless and Corr 2005). In addition, a review of temporary accommodation by Courtney (2005) found that, although there was a reduction in the number of individuals sleeping rough in the Dublin area and the number of referrals of individuals with low-support needs had decreased, there was an increase in referrals of those with multiple needs, usually involving substance abuse and physical or mental health problems, which can result in chaotic or challenging behaviour. This would indicate that current strategic responses to the accommodation needs of homeless drug users are inadequate.

The *Homeless Preventative Strategy*, which developed from Action I of the *Integrated Strategy*, identified ex-offenders as being at risk of homelessness on leaving custodial care. The association between drug use and imprisonment has been well documented (Hickey 2002; Dillon 2001; Seymour and Costello 2005). The recent review of the implementation of the Integrated and Preventative Strategies (Fitzpatrick Associates 2006) reported that a specialist unit, the Homeless Offenders Strategy Team (HOST), has been established by the Probation and Welfare Service (PWS) to assist ex-offenders find accommodation. However, there is little information available as to the nature and extent of this support or its success to date.

The latest strategy, designed to tackle homelessness in the Dublin area in the period 2005–2010, is *Preventing homelessness* (Pillinger 2006). This strategy seeks to build on measures outlined in *Making it home* (Homeless Agency 2004), which reported that clear agreement existed within the homeless sector that temporary accommodation does not address homelessness and that efforts must be concentrated on developing strategies that will prevent people from becoming homeless and improving interventions for people who do become homeless.

The key objectives of *Preventing homelessness* are: (a) to prevent a crisis that results in homelessness; (b) to prevent people remaining homeless; and (c) to prevent recurring homelessness. Section 7 of this strategy details a number of specific actions that seek to prevent homelessness among people affected by drug misuse. In particular, the strategy highlights the need to develop and sustain an inter-agency approach. In this case, Pillinger recommended that the Health Service Executive (HSE), the National Advisory Committee on Drugs (NACD) and the National Drugs Strategy Team (NDST) combine their efforts to tackle this double-sided problem of drug misuse and homelessness. Table 6.2 shows key actions outlined in *Preventing homelessness* that aim to prevent and/or respond to homelessness among individuals affected by the use of illicit drugs.

The Homeless Agency recently launched its action plan to eliminate long-term homelessness and the need to sleep rough in Dublin by 2010 (Homeless Agency 2007). Individuals with mental health problems, addictions (alcohol and drugs) and dual diagnosis (addiction and mental health) needs have been identified as needing healthcare and other interventions as part of the strategic aim to prevent homelessness and reduce the risk of becoming homeless. The action plan also states:

The Health Service Executive and National Drugs Strategy Team (with the Department of Community, Rural and Gaeltacht Affairs) will develop a national plan for the expansion of detox and rehabilitation services for active drug users, arising from the recommendations from consultations currently taking place. (p. 51)

Table 6.2 Actions in *Preventing homelessness* that aim to prevent and/or respond to homelessness among individuals affected by the use of illicit drugs

Objective	Action	Agency responsible	Timescale	Performance indicator
An integrated approach to homeless prevention	On foot of the review of the National Drugs Strategy, link local drugs and alcohol strategies to local homeless strategies	Health Service Executive (HSE)	Commenced March 2006	Evidence of links made at local level
	Implement the findings of the NACD research on drugs and homelessness	HSE, NACD, RDTF, NDST	Ongoing, monitored regularly	Actions implemented regularly
Improve guidance and services for people with dual diagnosis	Provide guidance on how to assess effectively the needs of a person who has multiple problems/dual diagnosis and enhance specialist service provision	Health Service Executive (HSE)	Completed December 2005	Evidence of guidance and tailored services

Source: Pillinger (2006)

The issue of residential treatment capacity also arose during the recent deliberations of the Working Group on Drugs Rehabilitation. In response, the Health Service Executive (HSE) established its own working group in September 2006 to examine the issue in depth. As an interim measure, the government Working Group recommended an increase in the current stock of residential detoxification beds from 23 to 48. Also essential, in terms of relapse prevention and progress towards social reintegration, is the provision of transitional housing supports following treatment/detox. Service users interviewed during the development of the action plan stressed the importance of appropriate accommodation, including transitional housing, after treatment as a first step in relapse prevention.

6.3 The impact of legislation

An impact assessment of the Housing (Miscellaneous Provisions) Act 1997 by Memery and Kerrins (2000) reported that there had been an increase in evictions by Dublin Corporation based on drug-related anti-social behaviour since the introduction of the Act. The authors reported that these evictions can lead to drug users living on the streets or in hostels, with a danger of escalating their

drug use, taking more risks around using drugs and sexual activity and becoming marginalised from mainstream society. In addition, individuals from this group can become part of the 'hard to reach' group of drug users on the streets, where failure to link into services becomes the norm.

This legislation also means that drug users evicted from local authority housing can be prohibited from securing supplementary rent allowance that would support them in securing accommodation in the private rental sector. Section 16 of the Act gives discretion to health boards to refuse or withdraw Supplementary Welfare Allowance (SWA), rent or mortgage supplementation for private housing in the case of persons evicted, excluded or removed from, or refused housing on the grounds of anti-social behaviour. In addition, people accessing generic transitional housing in Dublin are required to register on Dublin Corporation's Housing List. This has implications for individuals who have been evicted from local authority housing under the Act because such people are prohibited from registering on the Housing List.

The exclusionary nature of this legislation has recently been acknowledged by the Homeless Persons Unit (HPU), which is responsible for determining homeless status and is the main agency for referral to accommodation services in Dublin. Cited in Bergin *et al.* (2005: 13), the manager of the HPU stated: 'If the person is evicted for anti-social reasons, according to the (Housing Miscellaneous Provisions) Act, 1997, rent allowances may be restricted. In practice people are excluded from rent allowance and placed in emergency accommodation instead.'

Despite the numerous policy aspirations to address the accommodation needs of individuals affected by the use of illicit drugs, relatively little has been translated into concrete action. In particular, the needs of homeless drug users are not being addressed in any meaningful way. It would appear that the two main factors prohibiting progress on this issue are: a) the lack of a meaningful inter-agency approach, and b) the constraints of anti-social behaviour legislation. The latter could be tackled by drawing on the recommendations made by Lawless and Cox (2003) who suggested using an integrated approach in dealing with anti-social behaviour.

6.4 Good practice responses to homelessness among drug users

Two pieces of research, from the UK and the US, have highlighted some of the key components of good practice responses to the needs of homeless drug users.

In the UK, Neale and Kennedy (2002) summarised the key components that are generally recommended to improve service provision for homeless drug users. These included more diverse and flexible services; improved inter-agency working; increased professional training; greater use of care plans, contracts and confidentiality policies; and more service-user involvement. The authors carried out semi-structured interviews with staff and clients of drug treatment and homeless services. Both staff and clients identified factors contributing to good practice that could be grouped under five headings: support provided; agency environment; staffing; agency aims and objectives; and

service delivery. Service providers prioritised staffing-related issues and service delivery, while service users emphasised the various kinds of support on offer and the nature of the agency environment. Neale and Kennedy (2002) concluded that such findings suggested that definitions of good practice tended to reflect the interests of the different individuals expressing a particular opinion and the differing standpoints from which those individuals were making their assessments. Accordingly, the authors suggested that the most useful and all-encompassing good practice guidelines were likely to be arrived at by regular consultations with a diverse range of stakeholders, including both clients and staff.

In the US, research commissioned by the Department of Housing and Urban Development (Burt *et al.* 2004) highlighted a number of key elements that should underpin an approach to reducing chronic homelessness. The aim of this research was to identify successful community-wide approaches to reducing homelessness and achieving stable housing for the difficult-to-serve people who routinely live on the streets. The definition of chronic street homelessness included severe or persistent alcohol and/or drug abuse problems. The research identified 11 key elements in the seven communities visited. The most important element was a paradigm shift in the goals and approaches of the homeless assistance network. The old paradigm did not see the end of chronic street homelessness as a feasible goal and believed that individuals should be cared for by charities and religious organisations through the provision of emergency accommodation. The new paradigm emphasises reducing and eventually ending chronic street homelessness through an integrated community-wide approach based on strategic planning. The provision of low-demand permanent supported housing on a broad scale in place of emergency accommodation is part of this new paradigm.

The US report also stated that, if a community is intent on reducing chronic street homelessness, it is vital that it takes steps to build the capacity of service providers to work with people who have co-occurring disorders. For example, homeless providers need to develop dual competence and dual certification – mental illness and substance abuse issues need to be handled together. Mainstream mental health and substance abuse agencies need to have an integrated approach to mental illness and substance abuse among people who are chronically homeless. Mainstream agencies also need to accept that stable housing contributes significantly to their clients' well-being – possibly as much as medication or other official treatments.

6.5 Transitional housing options

Transitional housing can prevent relapse among former problematic drug users who have either completed residential drug treatment or been released from prison. Even where individuals have the opportunity to return to the family home, a period of respite in transitional housing can be beneficial. Little information exists on the accommodation status of individuals emerging from residential drug treatment in Ireland; therefore, it is hard to estimate the number that might require transitional accommodation. The case for transitional housing options was made in Action 61 of the

National Drugs Strategy, which put the onus on health boards to oversee the provision of a range of transitional and respite supports for individuals following residential treatment. However, as reported in the mid-term review of the Strategy in 2005 'considerably more progress' was required on this particular action.

There is also a scarcity of information regarding the accommodation status of individuals being released from prison. Research by Seymour and Costello (2005) found that 90% of prisoners who were homeless on committal to prison were illicit drug users prior to committal. This highlights the association between the experience of homelessness, drug use and committal to prison and suggests that, unless interventions occur during the period of imprisonment, it is likely that a sizeable proportion of the prison population will be at risk of or experience homelessness on release.

However, there are some transitional housing options in Ireland that cater specifically for the needs of former problematic drug users who may be at risk of or experiencing homelessness. These options have been developed primarily by the voluntary sector, with financial support from the statutory sector. For example, Merchants Quay Ireland (MQI) provides a transitional housing intervention for former drug users who have completed residential drug treatment. Accommodation is provided for a period of up to 24 weeks. During 2004 and 2005 there were 12 residents in the house at any one time. The Arrupe Society, a voluntary organisation working with homeless drug users, provides transitional accommodation through the Avoca Project. Residents include individuals who have completed residential treatment (Fr Peter McVerry, personal communication, 2004). There has been a recent development in inter-agency working between the HSE Northern Area Rehabilitation/ Reintegration Service (RIS), the Keltai treatment centre and Focus Ireland to provide the Stepdown programme, consisting of seven six-month placements in assisted housing units for vulnerable individuals leaving the Keltai centre (Rita Smith, personal communication, 2006). The Sisters of Mercy in Cork provide transitional housing to men and women who have completed residential drug treatment through the Fellowship House and Renewal House respectively (Sr Cait O'Leary, personal communication, 2005). A short profile of the Renewal House programme is provided below.

The Renewal House programme for women

This programme was developed by the Sisters of Mercy and the Tabor Lodge treatment centre in Cork. The service is responding to the needs of women who have completed residential treatment for drug misuse and of women who require a supportive, residential environment to assist in the early stages of recovery. Renewal House has accommodation for 10 women. Length of stay is approximately three months. Residents are encouraged to find part-time or voluntary employment. Family participation is welcomed and encouraged. Residents are expected to attend weekly aftercare sessions. The programme emphasises personal responsibility, peer support, participation in a twelve-step programme and life-style changes. The programme is based on the Minnesota abstinence model. Group sessions and one-to-one counselling form the therapeutic base of the programme. The FÁS Community Employment Scheme provides training and work experience programmes for the women.

The Probation and Welfare Service (PWS), in conjunction with a number of voluntary organisations, provides a small number of transitional accommodation options for individuals released from prison or under PWS supervision. Two examples are Padua House, a residential component of the BOND programme in Blanchardstown, providing accommodation for eight young male ex-offenders, and Tús Nua (New Start), operated by the Depaul Trust and the Society of St Vincent De Paul, providing accommodation for six female ex-offenders. Both services operate a key worker and care system where issues such as previous drug use are addressed.

6.6 Emergency accommodation options for active drug users

Emergency accommodation in hostels and bed and breakfast premises is generally the main option for individuals at risk of or experiencing homelessness and actively using drugs. However, there is no comprehensive data available on the number of active drug users that access emergency accommodation in Ireland, nor is there systematic data available on the availability or accessibility of emergency accommodation for active drug users. However, there is some evidence to show that active drug users do access emergency accommodation. For example, Lawless and Corr (2005) reported that, among occupants of bed and breakfast accommodation, 30% reported current use of heroin and 20% reported current use of cocaine powder compared to 18% and 14%, respectively, of hostel occupants.

Regarding accessibility, Lawless and Corr (2005) reported that almost one-third of current drug users staying in emergency accommodation reported difficulties accessing such services due to their drug use. Few of the homeless service providers interviewed had official drug-related policies. The general perception among service providers was that homeless services did not adequately meet the needs of homeless drug users. In addition, service providers highlighted the lack of move-on options from emergency accommodation for homeless drug users.

From the limited research available, it would appear that the current stock of generic emergency accommodation is ill equipped to respond to the needs of active drug users. In most cases, service providers can require drug users to cease illicit drug use prior to accommodating them however for many drug users this may not be a feasible option. The result usually is that they can either remain homeless or disguise their drug use and risk getting caught and eventually removed for what can be extended periods. However, a recent report from Shelter in the UK (McKeown 2006) highlights a third option, one that

...acknowledges that compliance with treatment and support is unlikely while people are street homeless or living in accommodation where they feel they have to hide their drug use... [Continued] direct or indirect exclusion from housing for problematic drug users is likely to have serious negative consequences for users themselves and the wider community. (p. 11)

The Shelter report recommends the development of an approach that seeks to house homeless drug users in supported accommodation while they are actively using and to help them to reduce the risk and associated harm around their drug use. However, for such an approach to be implemented in Ireland, service providers would require assistance in clarifying the legal implications that may arise from individuals possessing illicit drugs on the premises.

Overall, emergency accommodation specifically targeting active drug users is thin on the ground in Ireland. One of the few such facilities is the Clancy Nightshelter operated by the Depaul Trust, described below.

The Clancy Nightshelter

The Nightshelter is open seven nights a week and provides shelter, food, shower facilities and a locker for personal belongings to 'rough sleepers' aged 18–35 with drug and alcohol related issues. Individuals accessing the Nightshelter are likely to be excluded from other hostels due to their active drug and alcohol use. The Nightshelter accommodates 17 individuals. During 2005, 87 male and 9 female clients were accommodated – numbers similar to those in 2004. The service includes a dedicated key worker who links in with each service user to provide advice, assistance and guidance on access to day centres, and a weekly medical clinic. Regular cinema trips and a library have been organised for service users. The service is provided by 11 fully trained staff, assisted by part-time volunteers. The Trust's 2005 annual report acknowledges there remains a lack of move-on accommodation for clients of the Nightshelter, as is the case in all Trust projects (Depaul Trust 2005).

The provision of emergency accommodation specifically for young homeless drug users remains sparse in Ireland. Research by Smyth and O'Brien (1999) revealed that 6.5% of all under-18 contacts with drug treatment services were homeless, compared with 1.9% of adult treatment contacts. In particular, it was noted that young heroin users were more likely than their adult counterparts to be female and homeless. One of the few dedicated services targeting young people is the Caretakers Hostel operated by Focus Ireland. The bulk of referrals to this hostel come from the Trinity Court Young Person's Programme (YPP) that provides drug treatment to under-18s. Other services used by the YPP include the HSE Northern Area out-of-hours service in Lefroy House that provides emergency social work services to young people aged between 12 and 18 years who present as out-of-home outside office hours. (Seamus Noone, personal communication, 2006).

A short description of the Caretakers Hostel is provided below.

The Caretakers Hostel

The Caretakers Hostel is a partnership project operated by Focus Ireland with the Society of St Vincent De Paul. The hostel provides a service to out-of-home young people aged 16–21 who are misusing drugs. The hostel has nine beds and during 2005 a total of 49 young people used the service. Most of the young people accessing the hostel use heroin, and many of them have typically experienced chaotic family lives and have a history of state care predating their homelessness. Where drug use is suspected on the premises, clients are usually given a warning; if the warning is not heeded, they may be expelled for a night (Angie Wallace, personal communication, 2006).

6.7 Summary points

- Provision of accommodation for drug users is included in the National Drugs Strategy as being an integral element of treatment.
- Both international and national research highlights the urgent need for an inter-agency approach in tackling the accommodation needs of drug users, particularly those who are homeless.
- Current homeless services are not equipped to respond to the needs of homeless drug users.
- Drug users, particularly those with high-support needs such as mental illness, face personal and systemic barriers in accessing all forms of accommodation.
- The 2006 homeless preventative strategy calls on all agencies working on behalf of drug users to form an inter-agency response to prevent them becoming and remaining homeless.
- Models of good practice in responding to the needs of homeless drug users should include diverse and flexible services; improved inter-agency working; increased professional training; greater use of care plans, contracts and confidentiality policies; and more service-user involvement.
- Chronic street homelessness needs to be tackled by a clear strategic plan using an integrated community-wide approach and including the provision of low-demand permanent supported housing.

7 The theoretical assumptions underpinning vocational rehabilitation of drug users



7.1 Introduction

The provision of vocational rehabilitation measures to improve the employability of drug users is a key part of social reintegration. The long-term aim of these measures is to improve the individual's chances of securing meaningful employment; the short-term aims are to improve education and skills and help individuals adjust to a host of other demands associated with the world of employment, such as punctuality, dress code and workplace policies. This chapter will introduce the theory behind vocational rehabilitation. Drawing on the international literature, a number of key theoretical approaches that underpin the role of vocational training and the pursuit of employment in drug treatment and rehabilitation will be presented.

7.2 Theoretical models of the role of employment in drug treatment and rehabilitation approaches

It is important to explain why vocational training and employment supports should be part of drug rehabilitation, and what can be expected from this inclusion. One of the most regularly cited authors in the field, Magura (2003), described four models that explain why employment and vocational training should be pursued as part of a drug rehabilitation approach.

The *Work as Positive Outcome* model

This model explains the conventional way that the drug treatment system has approached the issue of work for clients. The model assumes that the benefits of being employed will be self-evident to the client, who will believe that having a job is socially responsible and personally beneficial.

The model is based on the assumption that reducing substance misuse through treatment will also improve employment chances for clients. However, this assumption is not well supported by the evidence. Magura *et al.* (2004) summarise the findings of two national studies in the US and conclude that standard substance abuse treatment does not result in increased rates of full-time employment. A number of factors are advanced to explain this failure, such as a lack of vocational training schemes in drug treatment programmes, a lack of specialised staff to provide vocational training, and the fact that employment is not seen as an achievable objective for clients in standard treatment programmes where, perhaps, maintenance and stability are the predominant goals.

The *Work Infusion* model

This model conceptualises work as being a therapeutic factor for the client in drug treatment. The model is not used very often as it is based on the idea of 'infusing' work into the treatment programme, whereby clients acquire full-time work or education as they progress. This allows them to experience the rewards that can accrue from employment during treatment, rather than anticipating, in an abstract way, the rewards achievable after treatment. The model assumes that legitimate work can

- compete with drug seeking by giving structure to the client's day
- introduce clients to non-drug-users
- promote a socially responsible and positive self-image that is incompatible with drug use
- provide an alternative, rewarding lifestyle
- give the client something 'worth losing' in life.

The *Contingent Sanctions* model

This model assumes that a client's behaviour can be shaped by making rewards and punishments contingent on certain behaviours. Furthermore, it assumes that clients see value in being in treatment and will respond to a threat of discharge; therefore, making continued treatment contingent on finding employment should increase employment rates.

The Motivated Stepped Care (MSC) approach, based on this model, has been evaluated by Kidorf *et al.* (2004). Working with unemployed persons in outpatient methadone maintenance treatment, the MSC approach requires all clients who complete one year of treatment to secure work, with continued treatment with methadone contingent on their securing employment. The approach includes a highly intensive job seekers' skills-training group where specialists motivate clients to tackle the personal barriers between them and employment, with the objective of developing the self-efficacy of the clients so that they take responsibility for their job-seeking behaviour. Eligibility is based on the client showing that they are physically and mentally capable of participating in constructive activity such as employment. If the client is unsuccessful in finding a job following two months of highly intensive counselling, the methadone dosage is reduced and eventually tapered off. When employment is secured then methadone treatment resumes as before.

The MSC approach could certainly be viewed as controversial, and raises ethical issues in relation to subjecting clients in receipt of methadone to any form of sanction, such as reduction of dosage or discharge from treatment. However, the evaluation by Kidorf and colleagues clearly showed that these sanctions only came about following a long and intensive series of steps within a treatment programme that included medical and psychosocial treatment in addition to intensive vocational counselling. Clients were informed of the requirement to find work following one year of treatment and work can include involvement in voluntary and community work. Results from the intervention evaluated show that 93% of eligible participants were engaged in constructive activity, with 70% of these in full-time employment and 19% in part-time work.

As this evaluation did not use a random control trial design, care must be taken in interpreting these findings as they may not be generalised to a wider population. However, this study suggests that integrating tangible incentives with employment goals may improve employment outcomes for some drug users. However, securing employment will also depend a lot on the attitudes of employers towards drug users.

The *Work as Reinforcement* model

This model also assumes that clients' work behaviour can be shaped by applying positive reinforcement. The model is based on the premise that a client values having access to paid work activities, thus, by making easy access to paid work contingent on remaining abstinent from illicit drugs it is assumed that abstinence will increase. Work is linked to material gain and rewards, i.e. having money to spend. A study by Silverman *et al.* (2001) involved women drug users in methadone treatment. Women randomly assigned to the group that received job-skills training for three hours a day in return for vouchers provided a higher number of clean, drug-free urine samples than women assigned to standard treatment. It would be interesting to see if similar results have been found among male methadone patients.

There is no evidence that any of these models have influenced the inclusion of training and employment in Irish drug treatment and rehabilitation programmes.

7.3 Vocational rehabilitation and abstinence

Magura *et al.* (2004) identified two contrasting approaches to the question of abstinence in providing vocational services for drug users.

The high-threshold approach

In this approach, clients are not viewed as being able to benefit from vocational assistance until they have achieved stable abstinence. Without abstinence, the client's ability to perform work satisfactorily may be undermined and the likelihood is that employers will not want to employ a person who is still using drugs.

The low-threshold approach

Practitioners taking this approach assume that early intervention in the form of vocational assistance will increase clients' efforts towards abstinence by giving them the incentive of concrete employment prospects and reinforcing their self-image as productive members of society.



8 Vocational rehabilitation for drug users: the evidence base



This chapter presents the evidence for vocational rehabilitation interventions. Drawing on the international literature and case studies from Ireland, examples of a number of promising approaches to working with drug users are presented. The chapter includes a comprehensive discussion on the quality of the evidence. A number of summary points from the evidence presented conclude the chapter.

8.1 The evidence for the effectiveness of vocational rehabilitation

According to Springer (2003), vocational rehabilitation, both in terms of treatment approaches and research interest, has received sporadic but insufficient attention. In reviewing the literature, it becomes clear that the bulk of interest originates in the US. Magura *et al.* (2004) conducted a critical review of three decades of research on specialised vocational interventions for clients in treatment for substance use in the US. The authors concluded that no vocational intervention had been universally adopted for any client population or treatment modality in the field. The interventions evaluated tended to be particularistic, making it difficult to identify the elements that were common to the more or less successful interventions. The authors identified a number of limitations to the evaluations of the interventions under review, such as lack of standardisation of definitions and indicators, scant attention to biases in follow-up samples, inadequate validation of employment reports and, finally, the unknown effects from uncontrolled variables.

Similar limitations apply to evaluations of vocational rehabilitation interventions in Ireland. For example, the case studies presented in this chapter are mainly based on information derived from evaluations and reviews that examine the implementation of the intervention and how well it is being received by the target group(s). The information on nine of these case studies was collected using a standardised questionnaire and submitted for inclusion on the Exchange on Drug Demand Reduction Action (EDDRA) database co-ordinated by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The information was collected by means of face-to-face interviews with project managers, site visits to projects and analysis of evaluation reports, annual reports and documents relevant to the operation of the project. These case studies were selected as they had been evaluated and could provide evidence that they were meeting some of their objectives. They have been included on the EDDRA database as examples of promising practice in reducing demand for drugs in Ireland. For the purpose of this Overview, information on these case studies was updated. This new information was requested and received through project reports and personal communication with project managers. The remaining case studies presented in this chapter have not been evaluated and the information provided comes from annual reports and personal communication. These examples were selected because they show innovative ways of working with socially excluded groups, including, in many cases, drug users. When evaluations are completed, these projects will be assessed for inclusion on the EDDRA database.

8.1.1 Limitations in the design of process evaluations

A process evaluation does not normally look at outcomes or assess the impact or effectiveness of the intervention. Process evaluations include questions such as: How is the project operating? Has it been designed to respond to the initial problem(s)? Is it being used by the target groups? If so, do they see its relevance to the problems identified in the initial situation that affected their lives? In some cases, the final report of these evaluations will provide information on the short-term progression of clients, such as improvements in literacy or achievement of accredited training certificates. Others may report long-term outcomes such as progression to further education or into gainful employment. However, reference to these indicators of progression in evaluation reports must be treated with caution as progression reported in this way cannot be attributed solely to the intervention. These indicators are not the outcomes from random controlled trials or before-and-after experiments, where the intervention can be credited with being primarily responsible for the outcome. Nonetheless, the interaction between the population and the intervention does sometimes result in changes in the population and in such cases it is assumed that these changes are in some way related to the intervention. This assumption is often manifested in self-reporting from participants and service providers. The design of process evaluations does not allow for an assessment of the assumed relationship between the changes in the population and the intervention.

8.2 Types of vocational rehabilitation intervention operating in Ireland

The interventions that operate in Ireland can be grouped under two broad headings:

- **Personal development interventions**

These seek to improve personal competency and educational and vocational skills in clients for the purpose of preparing them for further education, training and, in a limited number of cases, employment.

- **Work-specific interventions**

These seek to improve job-specific skills, job-seeking skills and chances of job placement and employment.

The first group of interventions tends to focus on the personal development of clients and on improving their life skills through education and vocational training. These interventions tend to be long-term and are aimed at improving the life-chances of clients, with the ultimate aim of progression to further education, training and meaningful employment. The second group of interventions can be both short-term and long-term and tend to concentrate on preparing clients for the labour market by focusing both on specific elements of training and on providing and supporting the provision of real work experience. Although, in theory, the latter group of interventions is designed to be more specialised, there can, in practice, be an overlap of components from both groups.

8.3 Personal development interventions

8.3.1 The international evidence

The evidence base on the effectiveness of personal development interventions is scarce, mainly because the bulk of evaluated interventions belong to the work-specific category that focuses on improving the short-term employment opportunities for clients. However, Platt (1995) highlights a study that recruited clients from a large drug treatment programme that included different treatment modalities and randomly assigned them to vocational training (experimental) or control groups. Clients assigned to vocational training showed a reduction in drug use and better treatment outcomes, but did not differ from controls in terms of retention in treatment or involvement in criminal behaviour. Clients in the vocational training group worked full-time more often and earned higher salaries but did not differ from controls in terms of the number of weeks worked.

Personal development interventions can include counselling on how to improve employment opportunities. Reif *et al.* (2004) examined the effects of employment counselling on treatment participation, post-discharge abstinence and post-discharge employment among a nationally representative sample of 988 clients discharged from outpatient non-methadone treatment that included individual and group therapy and self-help groups. Data were obtained from treatment records and from interviews with clients one year, on average, after treatment. Urinalysis reports were used to test the validity of abstinence claims. The research showed that clients who needed and received employment counselling had both better treatment participation and greater likelihood of employment after discharge than clients with unmet needs. Employment counselling was not demonstrated to influence abstinence post discharge. However, it is not clear what type of employment counselling was offered to participants in this study as no precise definition is provided.

Kemp *et al.* (2004) report on the evaluation of four strategies used to improve job opportunities for offenders released early from custody to enrol in outpatient drug treatment programmes. Completion of vocational programmes was strongly associated with obtaining employment 12 months post enrolment, and ex-offenders described vocational programmes as playing an integral part in their improved overall functioning. Supported work options were reported by clients to be a key motivating factor in completing training. High levels of support from parole officers, drug counsellors and vocational counsellors helped greatly, as did maintaining links with generic employment supports.

Lidz *et al.* (2004) demonstrated that, where a relaxed rather than an intensive approach to vocational training is taken, results can be quite discouraging for clients. This research evaluated a programme that randomly assigned people in treatment at baseline to one of three approaches: vocational problem solving, job-seekers' workshop, or a combination of these two. Follow-up at six and at 12 months post-baseline did not show any significant improvement in employment levels or greater advances in rehabilitation among methadone-maintained patients. However, rather than suggesting that the clients might not have been ready to engage with the labour market, the authors drew attention to other factors, such as the manner in which staff provided ancillary employment supports.

They raised questions about the way the training was delivered, as there was little evidence that vocational training was integrated into the overall treatment plan or that there was intensive support available for individuals to pursue employment. In addition, there was little evidence to suggest that the delivery of the intervention took into consideration the extent to which clients were ready to engage in the labour market.

8.3.2 Examples from the Irish context

There are a number of personal development interventions run by statutory and voluntary groups in Ireland. Examples of such projects in the Dublin area, chosen from the EDDRA database are presented in this section. Confidence-building strategies, educational modules and vocational skills training are common components of these projects. It would appear that successful projects have a clear vision and committed leaders, and are willing to examine the success or failure of an intervention and adapt their programmes accordingly.

The STAR women's project

The STAR women's project in Ballymun uses the FÁS Community Employment model to provide two years' intensive training, education and support to 16 women from Ballymun while they are trying to stabilise their drug use. In addition, the project provides an addiction support group, a parenting programme and regular arts and crafts classes.

An evaluation of the project by Murray (2000) reported that a number of participants were awarded accredited training certificates in 1999 following completion of training and education modules. The evaluation found that participants had improved their overall confidence, made new friends outside drug-using circles and managed financial debts, and had participated with some success on work placements.

More recent data on participants in the project reveals that 11 of the 16 participants in 2004 had left school early with no educational qualifications. Nonetheless, participants have achieved high levels of accreditation. For example, they were awarded 30 FETAC certificates in 2001; 17 in 2002; 24 in 2003 and 28 in 2004 (Carmel Kelly, personal communication, 2005).

The Rinn Development Initiative

In 2002, the Rinn Development Initiative (RDI) received funding from the South Inner City Local Drugs Task Force to undertake a pilot programme providing sail training to recovering drug users. The RDI used its ship, *Rinn Voyager*, to assist in the rehabilitation of recovering drug users through the medium of sailing. The aim was to develop the confidence and self-esteem of participants and improve their capacity to operate as part of a team. Participants underwent safety training on board the ship and went on a sailing voyage that included a number of overnights aboard. An evaluation of the pilot phase by McAteer Associates (2002) interviewed managers of projects in which

participants were engaged in drug treatment. According to the project managers, the experience of sailing offered relaxation and enjoyment to clients who were engaged in challenging therapeutic treatment programmes. Managers also expressed the view that teamwork was extremely beneficial to clients, as it endorsed the principles of community living, working together and helping each other. In addition, some managers felt that clients had learned some basic survival skills and overcome personal fears and challenges during their time on the sail training exercise.

The Ringsend and District Response to Drugs

The Ringsend and District Response to Drugs (RDRD) is a community-based project supporting drug users and their families in the Ringsend area of Dublin in pursuing, and ultimately achieving, a drug-free lifestyle. Set up in 1995, the project moved its operations in 2004 to a newly refurbished building, the Spellman Centre, named in memory of the late parish priest Fr Paul Spellman, a founding member of the RDRD. The project shares this centre with a number of other local community groups. Supporting clients to pursue education, training and job opportunities is a major goal of the work of the RDRD.

An evaluation by Doherty (2000) reported that the project was well designed, well implemented and well attended by the target group. It found that the project provided valuable support to clients in securing employment and in obtaining Junior and Leaving Certificate qualifications and accessing further education options. For example, a scholarship grant was secured to finance one client to attend the Gaiety School of Acting.

The Daytime Programme at RDRD, funded through the FÁS Special CE scheme, allows participants to develop individual training plans aimed at improving their educational and vocational skills. According to the RDRD's annual report (2004), some participants have progressed to external educational and vocational training options. For example:

- Three female clients were receiving training in childcare studies with the aim of developing a 'buddy system' to enable them to support other women in recovery.
- One participant was completing the first year of a recognised counselling course.
- Two participants were taking a diploma in women's studies.
- One male participant graduated through the health board as a crisis intervention instructor.
- With external assistance the project was able to fund four participants to study for a diploma in addiction studies with the Addiction Training Institute.

In an attempt to counter resistance to the project from some sections of the local community, the project holds an annual public ceremony to celebrate the graduation of clients from the project who have managed to maintain drug-free status for more than twelve months. A recent report revealed that eight clients graduated in 2005–2006 (RDRD 2006). This public event, which is attended by

sections of the local community, is a visible demonstration of the success of the project in reducing demand for drugs at local level.

The Soilse project

Soilse was established in 1992 to provide a rehabilitation and social reintegration service to individuals affected by the misuse of illicit drugs. The key objectives of the Soilse project are to provide the supports that will enable clients to tackle their addiction; to provide vocational training and educational opportunities; and, ultimately, to improve participants' prospects of employment and social reintegration. Based in the north inner city of Dublin, the programme consists of a part-time phase that supports clients through detoxification for approximately eight weeks while assessing their suitability to engage in the full-time phase of the programme, which runs for six-months and requires clients to remain drug-free. It is during this latter phase that clients get the opportunity to engage with the educational and vocational options that Soilse provides.

An evaluation of the early years of the Soilse project (Harrison and McCormack 1994) interviewed participants regarding their personal experience of the service. Participants expressed a high degree of satisfaction with the adult education modules used on the project and agreed that the modules were relevant to their educational needs. In most cases, participants acknowledged that their experience of education at Soilse was much better than their experience of the mainstream model, which had been negative. In addition, participants reported a marked improvement in quality-of-life issues such as self-esteem and relationships, and a reduction in their perceptions of marginalisation.

Updated information provided by Soilse (Gerry McAleenan, personal communication, 2006) reveals that the programme has employed a career guidance counsellor to work with clients moving from post-Leaving Certificate to the Trinity Access Programme. In conjunction with the City of Dublin Vocational Educational Committee, Soilse has also employed an education development worker (at PhD level) to support clients in pursuing further options, such as the Trinity Access Programme. Soilse also provides a dedicated maths tutor and can refer clients on for specialised intervention, for example, in the case of a client who is studying engineering or advanced maths. A key educational and vocational activity in the Soilse project is the production of a magazine, *Hyper*, by participants (see section 8.4.2).

The SAOL project

SAOL was established in Dublin's north inner city in 1995 as the first gender-specific drug rehabilitation intervention in Ireland. Research by Dunne (1994) reported that female drug users were not accessing mainstream drug treatment services due to the lack of educational support services and childcare. The overall goal of the project is to assist women to sustain stability in their lives, particularly around the use of illicit drugs, and move towards employment through training, education and personal development.

An interim evaluation of the SAOL project by Bowden (1997) reported unanimous agreement among clients that the project was a very positive experience in their lives. Clients also reported improvement in self-esteem and literacy skills and their educational development was viewed as the most important change to their lives. Clients also felt their ideas and opinions were valued within the project. The SAOL project has been innovative in developing meaningful links with external organisations and institutions. For example, extensive links have been developed with University College Dublin where a number of SAOL participants have successfully completed the Women's Studies Certificate Programme and have been conferred at the university. This is a notable achievement, given that the profile of women attending the SAOL project is characterised by early school leaving and low levels of educational attainment. For example, information released from the project (Joan Byrne, personal communication, 2005) shows that, of a total of 69 women who had been through the programme up to 2004,

- 13 (27%) left school between the ages of 10 and 13
- 27 (56%) left school between the ages of 14 and 15
- 8 (17%) left school between the ages of 16 and 18
- 37 (77%) never sat the Junior or Group Certificate
- 9 (19%) reached Junior Certificate level
- 2 (4%) reached Leaving Certificate level

Of these 69 women, 48 completed the two-year programme, 14 were deemed unsuitable and their contracts were terminated, four left the project voluntarily and three participants died. Of the 48 women who completed the two-year programme, the following outcomes pertain:

- 14 increased their education levels by one grade (e.g. Junior to Leaving Certificate level)
- 8 increased their education levels by two grades (e.g. pre-Junior to Leaving Certificate level)
- 14 increased their education levels by three grades (e.g. pre-junior to third level)
- 24 increased their literacy levels by one grade
- 10 increased their literacy levels by two grades
- 3 increased their literacy levels by three grades

Both the Soilse and SAOL projects use the experiential educational approach pioneered by Paolo Freire (1970) that situates the learning experience in the social and cultural context of the clients. This means that clients who often have had negative experiences of the mainstream educational curriculum and the inherent didactic approach of teaching professionals are given the opportunity to engage with a learning process that provides more interactive opportunities, with content that is more relevant to adult education.

The Get Going initiative

The Get Going initiative is run by Ballymun Job Centre and targets individuals who are trying to stabilise their drug use while exploring vocational options. Applicants to the service attend four assessment interviews over a period of two weeks, where their presentation and punctuality is monitored. The initiative is run by an addiction worker with ten years' experience in the field and one career guidance/mediation officer with extensive experience of working with socially excluded groups (Brendan Murphy and Jennifer Hughes, personal communication, 2006). Participants attend the job centre on weekdays for three hours and have their travel expenses covered.

Participants can avail of tutoring in a number of core modules, including a foundation course in maths (FETAC accredited), literacy, basic computing, and a specially designed module addressing clients' hopes and fears around entering the mainstream workplace and learning basic workplace skills. Other modules, such as an introduction to photography, consumer awareness and arts and crafts are also provided. Intensive one-to-one career advice and guidance is provided, as well as a weekly stress-management class.

8.4 Work-specific interventions: vocational and job-seeking skills

8.4.1 The international evidence

The Customised Employment Support (CES) intervention has been designed specifically for working with persons who have stabilised their drug use through methadone maintenance. The model involves CES counsellors working intensively with a small caseload of clients to overcome vocational and non-vocational barriers to employment. The primary goal of the intervention is to enable the client to attain rapid placement in competitive employment. Blankertz *et al.* (2004) reported on a randomised trial over a 29-month period in which 121 opiate users in two methadone programmes were randomly assigned to a group receiving CES counselling or to a group receiving standard vocational counselling. The evaluation found that, when compared with the group that received standard vocational counselling, participants in the CES group were more likely to be in competitive employment. However, the evaluation did not differentiate between mainstream employment and employment that was 'off the books' or in what is termed the 'black economy'.

The CES intervention is based on a number of key assumptions that merit consideration by providers of vocational services for this client group. For example, long-term heroin use can predispose a person to distrust those who have a more conventional lifestyle. This means that CES counsellors need to use innovative engagement techniques, such as assertive outreach work (ASW), to engage the client and maintain this engagement for an extended period of time to allow for meaningful intervention. A counsellor using ASW techniques will meet with the client in the community, rather than solely in the relative safety of the office or clinic. For instance, the counsellor might accompany the client to a local housing authority office or employment centre.

Blankertz *et al.* (2004) identified as one of the strengths of the CES approach the fact that, using ASW techniques, CES counsellors had the opportunity to work with clients to reduce non-vocational barriers while supporting them in identifying and pursuing employment options. In addition, regular meetings, around three times a week, and smaller caseloads were important differences between the CES model and standard vocational counselling.

In summary, the CES model seeks to increase clients' self-efficacy and help them realise their 'change agent' potential, primarily through the adoption and use of five key techniques. These are:

- Encourage clients to master given tasks and behaviors, such as turning up for appointments – positive reinforcement through praise is required
- Role modeling – where the counsellor demonstrates that they are reliable and trusting
- Persuasion – get beyond the anxiety and ambivalence of the client
- Cognitive restructuring – replace self-defeating thoughts often held by the client
- Minimise emotional arousal – minimise anticipatory anxiety, as before a job interview; focus on strengths and on how clients can incorporate new learning from hobbies, e.g. guitar playing – learning new chords.

Platt (1995) reports on a number of studies of job-seekers' workshops offered to methadone maintenance clients to improve their job-seeking and job-interview skills. One study involved 49 methadone-maintained clients who were randomly assigned to an experimental group that received a specialised 12-hour programme or to a control group receiving one hour's information on local employment resources. Three months later, 50% of those in the experimental group, compared to 14% of controls, had found employment or placement in a training programme. In addition, higher scores were attained by the experimental group in both interview skills and ability to complete application forms.

In a follow-up study, 60 methadone-maintained clients were assigned to an experimental group where they received workshop training of 11 hours over a four-day period, or to a control group that received information only. At three-month follow-up, 15 of the 30 experimental participants had found employment, compared to nine of the control group. In a study using a modified version of the job-seekers' workshops, involving 55 ex-offenders with histories of heroin abuse, three months after the intervention ended 86% of participants assigned to the experimental group had found employment, compared to 54% of the control group.

A further study reviewed by Platt (1995) assigned specialist employment counsellors to work with clients in methadone treatment, residential drug-free treatment or outpatient programmes. Control groups were matched with experimental groups. The results showed no significant differences in employment rates between the groups; however, significant improvements in treatment retention and reduced illicit drug use were found in the experimental groups that received the assistance

of the employment counsellors. In another study of the same intervention, 92 methadone patients were randomly assigned to one of three groups. One of the groups, referred to as the 'enhanced methadone treatment' group, employed a half-time employment counsellor. The results show that participants in the 'enhanced' group had significant improvements from baseline to six months in the number of days worked and the percentage of participants working.

8.4.2 Examples from the Irish context

There are a number of vocational training programmes for drug users in Ireland. These programmes offer training modules leading to vocational qualification, and work experience within a vocational setting (usually on site). The characteristics of the more successful interventions emulate those of a normal training and working environment.

Merchants Quay Ireland (MQI) vocational training services

MQI's Catering Training Programme provides 'on the job' training in culinary skills to clients experiencing homelessness or in recovery from addiction. The training provided includes modules in hygiene, cookery, food service and additional module-based training in life-skills. Participants assist in the cooking and preparation of food that is used to provide meals for up to two hundred people per day in the refectory kitchen at MQI and in the open-access drop-in service. According to MQI (2005), 22 individuals participated in the programme in 2005 and 20 of this group registered with Fáilte Ireland for certification through the FETC National Certificate in Culinary Skills.

St Francis Farm Social Economy Project at MQI is a residential therapeutic facility for individuals with a history of problematic drug use. A unique feature of the project is that it is situated in a farming environment. Service users gain experience in animal care, vegetable production and general farming methods. The food produced at the farm is used to supply the kitchens at the various Merchant Quay centres and can go towards feeding up to 300 people every day. According to MQI (2005), the project had 26 participants in 2004 including three women. Four residents moved on, with support from the team, following completion of individual care plans of 6 to 12 months duration. Eight participants left after completing 3–4 months at the farm and four left after completing 1–2 months. Ten participants remained and planned to complete the programme.

The Stepping Out project

The key objectives of the Stepping Out project are to provide vocational exploration, work based training, supported employment and supported training programmes for people under the supervision of the Probation and Welfare Service (PWS), those referred by the courts and ex-prisoners in the community. The programme is run by the National Learning Network⁷ in partnership with

⁷ The National Learning Network is part of the Rehab group and is Ireland's largest non-Governmental training organisation providing training to people marginalised from the workforce.

the PWS. The overall aims of the project are to prevent recidivism, increase opportunities for employment, increase access to further education, and provide social and life skills development to the target group. The programme draws up an individual action plan with each client, based on a comprehensive assessment of their needs and goals, and assists participants in making the life changes necessary for them to move beyond crime/substance abuse. The project is funded by the Department of Justice, Equality and Law Reform and FÁS, who fund the training allowances. The local Vocational Education Committee provides ten hours a week to the project, contributing to the educational outcomes.

The project worked with 22 participants in 2005, of whom nine completed the programme, four progressed to employment (one part-time) and one to voluntary work, three to further training and one to further education; 10 of the 22 achieved certification from FETAC. Areas where certification was achieved included: computer literacy, information technology, personal and interpersonal skills, food and nutrition, work orientation, ceramics, and maths. A number of participants achieved exceptionally high levels of certification in 2005 in Information Technology (FETAC Level 4) and the European Computer Driving Licence (ECDL). For many of the participants, experience of chaotic use of alcohol and drugs was common, with some attending treatment while on the project. However, the majority (14) had attendance rates of over 65% and seven had attendance rates of over 80% (National Learning Network 2005).

The Gateway project

The Gateway project operates in Dublin's north inner city and works with women from surrounding areas. The project offers a percentage of places to former drug users who have either stabilised their drug use or are currently pursuing abstinence. Most of the women who attend the project come from areas associated with socio-economic disadvantage and have experience with poor or insecure housing, homelessness, low levels of educational attainment, poor vocational skills and work histories, low income levels, and lack of confidence or self-esteem (Carmel Brien, personal communication, 2006).

The project provides training and education in three stages, which are: (i) assessment and orientation; (ii) basic skills and general education: and (iii) job seeking skills and employment supports. The project provides certified education and skills training ranging from basic keyboard skills to advanced computer training and from basic communication skills to Junior Certificate English. The project is also a FETAC⁸ Level 5 accredited course provider. Gateway is also working with the Dublin Institute of Technology to deliver IT training to Internet Computing Core Certification (IC3) level. This course is a global, validated, standards-based training and certification of computer and Internet literacy. It takes a person from the very beginning of computing to understanding the computer environment, the terminology used, file management, and up to an Intermediate standard in Microsoft Word, Excel,

8 FETAC was set up as a statutory body in 2001 to make quality-assured awards in accordance with national standards within the national framework.

and Outlook and Internet Explorer.

Twenty-four women received education and training with the project in 2005 and an additional four women were seconded to the Blackhall Crèche. In total, 78 FETAC portfolios were examined and passed in 2005, including

- 13 at Level 3 and 65 at Level 5
- Six participants received their NCHSX Childcare Certificate
- Seven received Pitman qualifications
- Ten received ECDL certification
- One passed Junior Certificate English
- 24 took part in a self-defence course.

In addition, work experience placements were secured in childcare, youth work, clerical work and receptionist work for participants during 2005. Outside training placements were secured in anger management, theatre make-up, manual handling, and travel and tourism diploma and self-defence courses during 2005; five participants' secured employment during the year.

The HYPER project

In 1998, Soilse set out to develop the technical and social skills of young participants using the medium of magazine production. The magazine, *Hyper*, is the result of this initiative. The overall aim of this project is to develop a youth paper with a specific focus on drug education and information, with the editorial, journalistic and technical functions being carried out by young former drug misusers with the assistance of an editorial team. An evaluation of the pilot phase by Donoghue (2000a) reported a good level of interest from participants, good retention rates and the production and dissemination of five issues of the magazine. In addition, Donoghue (2000b) developed a handbook based on the experiences of the pilot phase as a good practice guide for professionals working with young drug users. *Hyper* won the Total Publishing Award 1999 (UK) for design innovation of the year, out of 400 entries. A key objective of the magazine is to educate and inform about drug-related issues and the challenge of recovery. Magazines are disseminated to primary and secondary schools, colleges, local drugs task forces, regional and national youth services, drug services, prisons and youth detention centres. Participants can learn skills from modules in journalism, photography, art, information technology, video production and personal development.

The Labour Inclusion Project (LIP)

The Labour Inclusion Project (LIP) was developed by the Northside Partnership in Dublin to provide vocational training to individuals from North Dublin who had stabilised their drug use. The pilot phase of the project consisted of seven weeks of job-skills training, followed by 6–7 weeks of job placement. An interim evaluation (McLoughlin 2002) reported that, of the 16 individuals taking part in the pilot, four moved on to further work experience, two moved to employment and one returned to full-time education. An evaluation of the second phase revealed a somewhat less positive picture. McLoughlin (2003) concluded that the vast majority of participants referred to the second phase were unable to engage with a structured, intensive and focused job-training programme. Subsequently, the project was suspended so that staff could reflect on the lessons learned from the evaluations (Cepta Dowling, personal communication, 2004). Following a visit to a similar project in Liverpool, the third phase of the project commenced using a different approach that support clients on a one-to-one basis, replacing the previous model in which 16 clients were trained and supported by one or two project workers. The third phase will be staffed on a full time basis by a co-ordinator, a project support worker and administrative workers. It will employ a number of sessional workers on a part-time basis to deliver a mix of training and therapeutic modules and supports to clients on site. Rather than relying solely on referrals the project will require clients to make personal appointments (Cepta Dowling, personal communication, 2006).

Bray Employment Service support programme for substance misusers

One of the few dedicated responses to the vocational needs of drug users was developed by the Local Employment Service Network (LESN) in Bray, Co Wicklow. The LESN mediator works in conjunction with the Bray Community Addiction Team (CAT) and FÁS to respond to the needs of clients referred to the LESN service. In 2004, the LESN service benefited from a grant of €10,000 received from the Bray Local Drugs Task Force for the development of a dedicated fund to support the education and training needs of clients. This meant that clients could be supported to receive training (external to FÁS) in construction skills, multimedia, photography and a range of alternative therapies. Of the 22 people referred to the LESN mediator in 2004, (16 male, six female), nine found employment, four progressed to further education and training, one joined the FÁS CE scheme, three dropped out and five remained in mediation. In addition, a number are engaged in third level study (Mary O'Carolan and Maura Foskin, personal communication, 2006).

8.5 Work-specific interventions: job placement and supported work

8.5.1 The international evidence

Supported work refers to subsidised employment characterised by intensive ongoing support for clients. Supported work involves job-site training, on-going assessment and, often, job-site interventions. It generally involves on-site rather than classroom training and takes place in a real work setting, with wages and benefits comparable with those earned by other workers of similar experience.

A number of studies reviewed by Platt (1995) show evidence of the effectiveness of the supported work approach in improving employability and increasing employment rates among drug users. For example, Platt reviewed evaluations of three supported work interventions among former drug users. The first study randomly assigned ex-addicts mostly on methadone and ex-offenders to an experimental group engaged in supported work or to a control group receiving other support services. Data collected at intake and at intervals over three years showed that the longer individuals were involved in the programme the more likely they were eventually to find non-subsidised jobs.

The second study included 1,124 former drug users along with other unemployed individuals from 15 states throughout the United States. Ex-addict participants were randomly assigned to an experimental group on supported work for up to 18 months or to a control group in regular employment settings. Follow-up at 36 months showed that 48% of the experimental group were in employment, compared to 32% of the control group.

The third study included 1,200 former drug users, mainly on methadone treatment programmes. The study randomly assigned former drug users to an experimental group with 12-month supported work followed by assistance in finding employment or to a control group. At one-year follow-up, ex-addict participants from the experimental group had worked more hours than the controls and had higher employment rates.

A fourth study reviewed by Platt (1995) placed 422 former drug users in jobs, including professional and service positions, in four cities in the United States. Almost 79% of employers rated the performance of employees who were former drug users as the same or better than that of their own employees. In addition, the attitude of former drug users towards the job, their ability to relate to co-workers and their desire to succeed were rated very highly in comparison to those of other employees.

8.5.2 Examples from the Irish context

Supported work interventions are scarce in Ireland; however, there are a number of interventions that incorporate a modified version of supported work. Clients are provided with real-life work experience and are supported in engaging with this experience; they then progress to further employment where intensive support is also provided. These supported work interventions generally take place in the context of a bigger project with a host of ancillary supports also available. Profiles of a selection of these interventions are provided below.

The Liberties Recycling Training and Development project

This is a textile-recycling project that provides people affected by drugs with work experience and skills training to support a move into mainstream further education, training or employment. The project employs seven supervisors, two of whom are former participants and currently has 50 places funded by FÁS serving persons from a number of areas in Dublin, including the Liberties in the south

inner city, Ballyfermot, and areas within the Canal Communities Local Drugs Task Force area. Used textiles, mainly clothing and footwear, are collected from charities and collection points and by door-to-door collectors. Once collected, the textiles are graded and sorted from one to three in terms of quality. Grades one and two are exported to Africa and Grade three and soft toys are exported to Asia.

In the quarter from April to June 2005, the following qualifications were obtained by trainees: FETAC computer literacy, 4; FETAC information technology, 4; Certified forklift course, 4; Sage payroll, 2; Parenting skills, 1; and Health and safety, 4. Between June and September 2005, the following achievements were recorded by participants on the project: five trainees went to employment (two with the project), one went to further education and two joined other projects.

The Ready for Work programme

A review of the Ready for Work (RFW) programme published by Business in the Community Ireland (BITC 2006) demonstrated the success that targeted interventions can achieve with socially excluded groups. The RFW programme provides work experience opportunities to unemployed homeless adults. This involves two days' pre-employment training, two weeks' unpaid work experience with in-house support, and follow-up support from training and employment officers and job coaches. Programmes are run three times a year and serve as a first step for candidates who have been through the homeless services and, in some cases, the addiction and related support services, and are re-entering the world of work.

The review included a number of candidates' stories highlighting the personal and social progress made in the course of their involvement with the RFW programme. Some described the positive impact of treatment for alcohol and drug misuse in assisting the candidates to move beyond their experience of homelessness towards engagement with the programme. The review also included information on progress made by participants from the 12 programmes run over the period 2002–2006. Overall, 118 candidates started the programme, of whom 53 progressed to employment, 44 accessed further training and education, and 19 are now living independently.

The review highlights a number of key features of the programme that are useful in understanding how it works internally and the factors that seem to work with clients. These include:

- The development of a strong partnership approach between participants, the business sector and homeless service providers such as the Homeless Agency. Some 20 corporate supporters offer funding, facilitators, job coaches or work experience placements. A minimum of 20 homeless service providers are engaged with and support RFW.
- The programme has input from a steering group of members of the business community. The remit of the steering group is to increase awareness of the RFW programme among employers, to increase the pool of companies involved, to communicate issues faced by candidates to

prospective RFW companies, and to ensure productive two-week placements by matching skills to jobs.

- The programme offers job coaching by matching a volunteer from the business sector to a candidate who has completed a programme, in a six-month coaching relationship.

The Linkage programme

The Linkage programme was set up and funded by the Probation and Welfare Service (PWS) in January 2000. The overall aim was to prepare, plan and implement training and/or employment placements for offenders referred to the programme by the PWS. An internal review of the pilot phase established that the intervention had achieved some success in placing referrals in work and further education. In particular, it was felt that the approach adopted, consisting of one-to-one intensive work sessions between clients and Training and Employment Officers (TEOs), contributed greatly to the early achievements of the intervention. Towards the end of 2000 the programme became a joint initiative between Business in the Community Ireland (BITC) and the PWS, with the ultimate aim of assisting clients to secure employment. The Linkage Programme recognises that mainstream vocational training programmes often do not address specific personal development issues experienced by clients referred to the programme. The programme now has 15 TEOs based in various PWS offices throughout the country, including one assigned to the prisons.

According to Business in the Community Ireland (2005), between February 2000 and December 2005, 4,133 clients were referred to the TEOs working on the programme; 2,800 (68%) of these clients engaged and 1,992 were placed. Of those placed, 1,035 (52%) were placed in employment, 615 (31%) commenced training, 254 (13%) went back to education and the remaining 88 (4%) went onto a CE scheme.

The Bridge to Workplace initiative

Bridge to Workplace is a new work experience and placement stimulation initiative targeting individuals that are seeking to stabilise their drug use. The initiative aims to stimulate change towards a positive experience in the workplace. This is a multi-agency collaborative venture operating primarily in the areas of Ballymun, Blanchardstown, Finglas/Cabra and the North Inner City of Dublin. The key agencies involved include the Local Area Partnerships and Local Employment Service Networks from each area, the Northside Partnership, FÁS and the Health Service Executive Northern Area Rehabilitation/Integration Service. The initiative is based on the assumption that clients should be engaged in a work experience programme as part of a structured progression plan, with the ultimate aim of entering the workforce through part-time or full-time employment. Intensive support is provided to both clients and employers involved in the work placement.

During 2006 there were over 30 clients participating in the programme. One difficulty experienced in the initial stages related to working with some general practitioners, who, in some cases, were reluctant to sign off on a client who was on methadone maintenance before work placement could

commence. This can result in missed opportunities for clients and perhaps could be addressed in future reviews of the Methadone Protocol (Joanne Ralph, personal communication, 2006). This initiative is currently in the final stages of evaluation.

8.6 The FÁS Community Employment scheme in local drugs task force areas

The National Drugs Strategy 2001–2008 endorsed the FÁS CE scheme as the main mechanism through which to address the vocational training needs of drug users. This section profiles this CE intervention and highlights some of the key findings from recent reviews that examined how the scheme operated in local drugs task force areas. The CE scheme is a labour market intervention designed to provide short-term work experience and training for the ‘long-term unemployed’, that is, those receiving social welfare payments for one year or more. FÁS is charged with co-ordinating the scheme on a national basis. In 1997, following the recommendation of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996), FÁS ‘ring-fenced’ some 1,100 CE places to accommodate the training needs of drug users. This allowed projects that had been developed through the local drugs task forces to provide dedicated education and training options for clients. These options were funded by FÁS at CE rates and clients received a weekly allowance for attending 19.5 hours’ training. Since then, the CE model has emerged as the dominant medium through which education and training and a limited form of supported employment are provided for drug users in local drugs task force areas.

In response to Action 76 of the National Drugs Strategy, a comprehensive review of the FÁS CE scheme in the local drugs task force areas was commissioned in 2004. The review involved an examination of the implementation and operation of the scheme and surrounding perceptions of clients and staff. The review by Bruce (2004) revealed that, as of 30 January 2004, 812 places on the scheme were being actively used, considerably fewer than the 1,100 places ‘ring-fenced’ by FÁS. Bruce highlights a number of issues, one of which is gender representation. Analysis of NDTRS data indicates that higher proportions of females than males participated in FÁS CE schemes. For example, in 2003 5.2% (68/1,297) of women in treatment participated in a FÁS CE scheme, compared to 3.7% (140/3,746) of men. This would suggest that male drug users are under-represented in vocational training. This raises questions regarding male drug users’ perceptions and experiences around the relevance and accessibility of this training.

As with employment, analysis of data from the NDTRS indicates that participation in vocational training is associated with less frequent use of the main problem drug, both on a daily basis and during the past month, compared to treated cases that are unemployed (Table 4.6). For example, a lower proportion of cases entering treatment and participating in a training scheme reported using their main problem drug on a daily basis (32%, 68/215) compared to the proportion who were unemployed (50%, 1587/3,203). A higher proportion of such cases reported no use of their main problem drug in the past month (31%, 66/215), compared to the proportion that were unemployed (24%, 765/3,203).

8.6.1 Perceptions of FÁS CE in local drugs task force areas: vocational or rehabilitative?

One of the key issues to emerge from the review by Bruce (2004) was the apparent difference of opinion between FÁS and the participants and staff regarding the main objectives of the CE intervention. On the one hand, FÁS aims to provide vocational training aimed at enhancing the labour market prospects of clients. While, on the other hand, as Bruce (2004) reports:

The most common theme for participant respondents were that, for them, CE was rehabilitative rather than job oriented. Many saw employment as a worthy but essentially remote aspiration. Most were focused on staying stable – with others aiming to become drug free as soon as possible. This would appear to stem from the immediacy of medical and personal needs rather than any rejection of employment outcomes per se. (p. 59)

Such conflicting views are best understood by reference to the thinking that separates vocational and therapeutic interventions. Vocational interventions are focused on improving the employability of persons and can include specific job-skills training and liaison with potential employers, whereas therapeutic interventions are very much focused on the individual client by improving their life skills and their capacity to cope without resorting to illicit drugs. Indeed, as Bruce (2004) points out,

Many CE supervisors dealing on a daily basis with the many complex personal issues of participants found difficulty in articulating a vocational or employment perspective in any realistic sense. (p. 48–49)

In addition, a recent review by Lawless (2006) focusing on the role of FÁS CE in the Dublin North East Drugs Task Force area exposed a similar difference of opinion regarding the objectives of FÁS CE. Most of the respondents were aware of CE's role as a labour market intervention, but believed that the ethos of local drugs projects with specially designed CE places focused on personal development and supports to rehabilitation, rather than to the open labour market. The majority of respondents viewed CE as the main mechanism in the delivery of drug rehabilitation, with the therapeutic function as its primary role, with advice and support as secondary, and education and training as the least important of its three roles. Even the minority that included education and training in the CE model believed that therapeutic and advocacy functions were central to its effective operation.

Such views, while held strongly by staff and participants alike, have implications for the effectiveness of the FÁS CE scheme as a vocational training mechanism. If FÁS CE places are primarily serving a supportive therapeutic function, they are unlikely to provide the training that will improve or teach skills to improve employment opportunities.

8.6.2 The role of progression within FÁS CE in local drugs task force areas

It would appear that the notion of progression beyond participation in the CE scheme has not been developed by either participants or staff. According to Bruce (2004),

Most [project workers] responded that meaningful progression to the labour market was not an option for the majority of participants or that, if it were, it could take substantially longer than three years. When asked to state exactly how long such a programme should take to develop job readiness, these respondents mentioned between five and seven years. (p. 52)

Staff reported that too many additional problems existed in people's lives for them to realistically contemplate work until these had been addressed.

For most of our participants, progression means going on to another CE scheme. The main motivation is security and stability and a job just does not enter into it. (CE scheme supervisor) (p. 49)

Lawless (2006) reported similar views from projects in Dublin north east regarding the lack of progression options for clients, with the predominant view being that few suitable progression routes were open to clients and that three years was not long enough to support clients to become ready for work.

Nonetheless, there was some evidence to suggest that some participants had made progress in personal development, but there was no systematic attempt to measure and report the nature and extent of this progression. However, according to Bruce (2004),

One of the most consistently valued elements in CE participation reported by respondents was the growth in levels of personal self-esteem and confidence. Many expressed delight at their ability to make some progress in a very short time. Particularly with regard to educational activities, respondents found participation to be of benefit. The mere fact of having something structured to do on a daily basis was hugely significant for many. The ability to see progress and to be valued for achieving progress had a positive impact. (p. 61)

8.6.3 Health board (HSE) involvement in the FÁS CE scheme

Although it was a stated aim of drug policy as far back as 1991 that health board involvement was crucial to the success of vocational rehabilitation for persons affected by the misuse of illicit drugs, it would appear that such involvement remains peripheral, at least according to the views expressed on local projects. According to Bruce (2004),

Strong opinions were expressed about the Health Boards' lack of consistency or strategic involvement in the area. In consequence, this was seen to leave FÁS with an unfair share of the responsibility in meeting the many and complex needs – only some of which were admittedly labour market oriented. (p. 54)

Additional observations from CE staff interviewed by Bruce (2004) reiterate the serious effect of this sporadic involvement by the health boards:

We need substantially more resources from the Health Boards and clinics. There is so little coordination. We cannot do all this on our own and prepare people for work too. These clients are vulnerable and really do get messed around when they try to get support or help. It is natural that they turn to us. (p. 56)

These concerns regarding the nature and extent of health board involvement were reiterated in a later report. Lawless (2006) reported that the majority of respondents believed that the HSE should be responsible for drug rehabilitation as FÁS was not equipped to do this work. Respondents were also critical of the HSE for abdicating responsibility and leaving the work to FÁS. In addition, some respondents expressed the view that local community groups were out of their depth in trying to do the work they were involved in. It must be noted here that when Bruce carried out his review in 2004 the structures that governed the involvement of the health boards were a lot clearer than those pertaining since the amalgamation of the various health boards within the new structures of the Health Service Executive (HSE). In the former case, health board involvement, or indeed the lack of it, was more transparent, whereas in the latter case accountability is in its infancy. Nonetheless, it would appear that the treatment and rehabilitation needs of persons affected by drug misuse are not being satisfactorily addressed within the designated structures, and this means that clients are presenting with physical and psychological needs to employees who are meant to be delivering vocational training.

8.6.4 Standards in implementing, operating and monitoring of the FÁS CE scheme in local drugs task force areas

A general concern expressed by Bruce (2004) was the absence of agreed standards around the operation of FÁS CE in local projects. For example, it was reported that projects varied greatly, not only in terms of outcomes, which were felt to be inadequately monitored anyway, but also in terms of process and operation. Particular concerns were expressed by most respondents about assessment criteria, identification of needs and the structure of activities to meet these needs. There was a concern that FÁS resources were called upon to meet a range of social, personal and economic needs for which it had neither the expertise nor the resources. As Bruce (2004) notes,

Poor levels of professionalism in projects worried many; programmes loosely put together and not set against outcomes. Respondents felt more training was needed for project staff; lack of career guidance in projects was noticeable. (p. 71)

Lawless (2006) sounded a similar call for greater levels of staff training and better-developed monitoring and evaluation systems. In particular, there was a strong demand for protocols relating to assessment, progress indicators and referrals. There were also calls for the local drugs task forces to facilitate an annual staff training programme, develop inter-agency protocols and secure funding for core supports. Similar issues have been raised by Ruddle *et al.* (2000) and Goodbody Consultants (2006).

8.6.5 The value of education as a vehicle of personal development

Bruce (2004) points out that the high value placed by all respondents on education and the recognition of certification attained shows that these longer-term perspectives on vocational reintegration are not absent. Participants displayed strong awareness of and pride in their achievements to date. Perhaps this is not surprising given that many of these participants would see the scheme as a second chance at education. Bruce (2004) also reports that CE supervisors also emphasised the value of education to this target group.

We emphasize education and learning from the outset. Most are from really desperate circumstances and multiple problems. There is a strong emphasis on education, learning and actually doing things. Certification is the key to success and nothing can equal the sense of achievement they display when they secure this. Only after that can you meaningfully talk about some kind of work. (pp. 52–53)

8.6.6 Relapse prevention

Many respondents expressed concern about their ability to stay clean and avoid relapse. According to Bruce (2004),

Great uncertainty and even fear was expressed about the half-days when they were not participating on CE. Some even confined themselves to home to avoid the danger of contact with environments that might lead to relapse. Much of the time was reported as being spent just trying to prevent relapse. Several respondents mentioned this also as a key purpose of CE. In this regard the CE allowance was seen as a stabilizing mechanism to prevent relapse. Relapse rates were mentioned as being quite high. CE was often seen as ‘holding the line’ against relapse or recidivism. Many respondents mentioned the lack of linkage and coordination among frontline agencies in acting to assist the recovery of participants. (pp. 60–61)

8.6.7 FÁS CE in local drugs task forces in Dublin and in North Cork

The Bruce review (2004) highlighted the difference between Dublin and Cork in terms of the way that the FÁS Special CE scheme for drug users is structured and implemented. For example, in Cork, the majority of projects do not operate in a community setting but are sponsored by the local Community Enterprise and Training Centre. Prior to admission to the CE scheme, participants must undertake a structured programme of rehabilitation and are expected to be in recovery. The pre-admission programme runs for three months. Clients are screened and assessed in a comprehensive and standardised manner. Issues relating to progression are introduced very early and work experience placements and employer linkage are prioritised.

However, unlike in Dublin, the vast majority of participants in the FÁS CE scheme in Cork are not using heroin. Most are using other drugs, primarily marijuana, ecstasy, alcohol, benzodiazepines

and, increasingly, cocaine. The therapeutic and vocational training elements work very closely and in a co-ordinated manner. Supervisors reported strong levels of motivation among their client group. Identified gaps were in the stated need for a specialist placement officer, more specific supervisor training and some form of dedicated career guidance resource. Progression is monitored. Since 1998 there have been 850 participants, of whom 10% have secured open employment.

8.7 Summary points

- Evidence suggests that vocational training contributes to a reduction in drug use and better treatment outcomes.
- Completion of vocational programmes is strongly associated with obtaining employment and improved personal and social functioning among ex-offenders.
- Where a relaxed, rather than an intensive, approach to vocational training is taken, results can be quite discouraging for clients.
- Supported work interventions and dedicated employment counsellors show good levels of effectiveness in getting drug users into employment.
- Evidence from vocational rehabilitation interventions in Ireland suggest that participants have made educational and vocational progress by improving their literacy, achieving accredited training certificates and progressing to work placement and, in some cases, paid employment.
- Participants in vocational programmes claim that they are a positive experience and are active in improving quality of life.

9 Enhancing employability among drug users in treatment: a conceptual framework



9.1 The concept of employability

The National Economic and Social Forum (NESF) published a report in 2006 offering practical recommendations to help create opportunities for vulnerable people in accessing training, education and better quality jobs in the labour market. The report states that ‘labour market vulnerability is not an aberration or a left-over from the early 1990s – rather it continues to be generated today, even in a tight labour market’ (p. x). Four key policy arenas are identified – economic, social, labour market and personal – where barriers interact to produce vulnerability. The report identifies people with drug and alcohol dependencies as one of the marginalised groups particularly prone to experiencing labour market vulnerability on the basis that they face employment barriers such as poor education levels, low skills, and inconsistent job histories and, in some cases, criminal records. In addition, the report states that there is a lack of employment support mechanisms to assist their progression. The report also recommends that service providers should seek to match the skills and training needs of clients to the skills and job requirements of the labour market.

The development of measures to improve employability among drug users can help to overcome some of the barriers to accessing education, training and employment opportunities. Employability describes the combination of factors and processes that enable people to progress towards or get into employment, to stay in employment and to move on in the workplace. The term is mainly used in association with groups that have difficulty entering the labour market. The Effective Interventions Unit (EIU) (2003) in Scotland provides a working definition of employability:

Employability entails achieving a match between the abilities, attitudes and capabilities of the individual, the needs, expectations and attitudes of employers and the demands of current local labour market conditions. (p. 7)

The EIU has highlighted a number of factors that contribute to employability, including:

Individual factors

- Attributes such as enthusiasm and willingness to learn
- Assets such as skills, qualifications and work experience
- The ability and the opportunity to use both

External factors

- Prevailing local labour market conditions
- Wider economic drivers
- Employers’ recruitment procedures and their attitudes and expectations of employees.

Four fundamental stages on the pathway to employment suggested by the EIU include:

- Employability development and pre-vocational training
- Work experience
- Practical experience of participating in the labour market, e.g. supported employment
- In-work support.

The EIU (2003) outlines a number of key points in relation to the planning and developing of employability services. In particular, it points out that no single agency or intervention operating in isolation can address all the needs of the individual or assist them through the various transitions towards the workplace. They highlight the importance of the message that partnership is crucial to the nature of this work. In turn they have identified the following key principles that should underpin such partnership:

- Recognise that recovering drug users are a diverse group of individuals who are at different distances from the labour market.
- Ensure that the individual gets access to the most relevant services at the right time.
- Combine clear objectives shared by all and develop a shared approach, with flexibility to allow for the individual's needs and circumstances.
- Promote a clear focus on progression, however slow, and measure it.
- Ensure that staff are knowledgeable, skilled and supportive.
- Involve employers in the design and delivery of services to make sure that different needs are met.

One way of approaching this issue in Ireland would be to form an employability team similar to that established in Scotland. This would require specific funding and the team could work with the local and regional drugs task forces in a similar manner to the Scottish service, which works in partnership with the local drug action teams (DATs) in assisting the development of education, training and employment opportunities for drug users. The overall aim of the employability team is to reduce drug-related harm by enhancing routes to training and employment for people with drug problems.

However, Kemp and Neale (2005) point out that employability programmes can only engage realistically with clients who have achieved a consistent state of stabilisation and are in good health and secure accommodation, and that health problems, homelessness and criminal records can prove major barriers to employment, from the point of view of both clients and employers. Investigating data from the Drug Outcome Research in Scotland (DORIS) study, the authors used secondary data analysis on a sample of 559 individuals to question the suitability of clients to move from welfare to work. Sixty-seven per cent of the sample was male and over 90% reported heroin as their primary drug of choice. The authors reported that the majority of the sample was largely detached from the

labour market, with little recent experience of full-time paid employment. In addition, two out of five entering community drug treatment in the study reported being homeless at the time of interview, and just under half of the overall sample had spent time in prison. Poor health and preoccupation with their addiction and with the means of funding it were also common characteristics among this sample. The authors concluded that employment was not a realistic prospect for the majority of individuals in this position. It was further suggested that it is only when clients' dependence is brought under control that welfare to work programmes will have a realistic chance of enhancing their employability and job prospects.

9.2 Monitoring and evaluation of vocational training

According to Dewson *et al.* (2000), monitoring systems for employment programmes targeting unemployed people have traditionally focused on hard, quantitative outcomes, such as the numbers going into jobs or the numbers gaining academic or vocational qualifications. According to the authors these so-called hard measures do not demonstrate whether clients are improving their employability. Furthermore, Randall and Brown (1999) draw attention to an additional weakness in the over-reliance on hard outcomes by pointing out that, when funding is linked directly to hard outcomes, there is the danger of a project accepting and working with the most able clients at the expense of those with greater needs.

Randall and Brown (1999) point out that interventions seeking to improve clients' employment opportunities need to place equal emphasis on 'soft outcomes' as a measure of progress towards employability. Such outcomes can include improvement in the following:

- literacy
- numeracy
- punctuality
- attendance
- presentation and social skills
- team work
- motivation
- communication
- self-esteem
- self-confidence
- ability to plan ahead

Recognising the value of such soft outcomes enables targets to be set that may produce increases in scores between baseline and agreed time intervals. Soft outcomes are a matter of degree rather than absolute measures and can be used to gauge progress towards overall objectives, such as progress to further education, acquisition of academic and vocational skills and the ultimate target of paid employment. In particular, soft outcomes can be used to demonstrate where a client is located on an 'employability index'. This means that clients can be assessed and scored on a job-readiness index. This should indicate how close clients are to moving towards the job market. This approach could be piloted with a number of current FÁS CE projects to assess its feasibility. Currently, there is

little attempt to establish benchmarks or measure progress on these projects and consequently it is difficult for clients to know how far they have travelled since joining the programme and how far they remain from the labour market.

The overview of this area by Dewson *et al.* (2000) highlights some of the issues that need to be covered by practitioners adopting this approach. For example:

- Exercise caution before attributing progress solely to the intervention.
- Take care when using self-report questionnaires as they can often lead to recording information that will understate or overstate achievement and progress.
- Watch out for the personal bias or subjectivity that can materialise in tutor-based assessment; for example some tutors may interpret an improvement in confidence as aggressiveness depending on their experience and relationship with the client.

9.3 Summary points

- Labour market vulnerability is a reality for individuals with drug and alcohol dependencies.
- Labour market vulnerability can be reduced through providing employment support mechanisms and enhancing employability.
- Enhancing employability involves matching the attitudes and capabilities of the individual, the needs and expectations employers and the demands of the labour market.
- Enhancing employability requires a partnership approach with all relevant agencies and actors working together.
- Problematic drug use needs to be brought under control if recovering drug users are to have a realistic chance of enhancing their employability.
- Interventions seeking to enhance employability need to evaluate their work on an ongoing basis, measuring both 'soft' and 'hard' outcomes.

10 Discussion



Buchanan (2004) provides a useful model of the steps a recovering drug user must climb to overcome the ‘wall of exclusion’ and move towards social reintegration (Figure 10.1) This chapter discusses the main findings from research included in this Overview that link aspects of social exclusion with the initial stages of the recovery process. The chapter then discusses how services can assist recovering drug users to navigate the ‘wall of exclusion’ and focus on reorientation towards a vision of social reintegration. This discussion is framed within the context of the recently launched *Report of the working group on drugs rehabilitation* (Working Group 2007), and the implications for the development of drug services to embrace this model are highlighted.

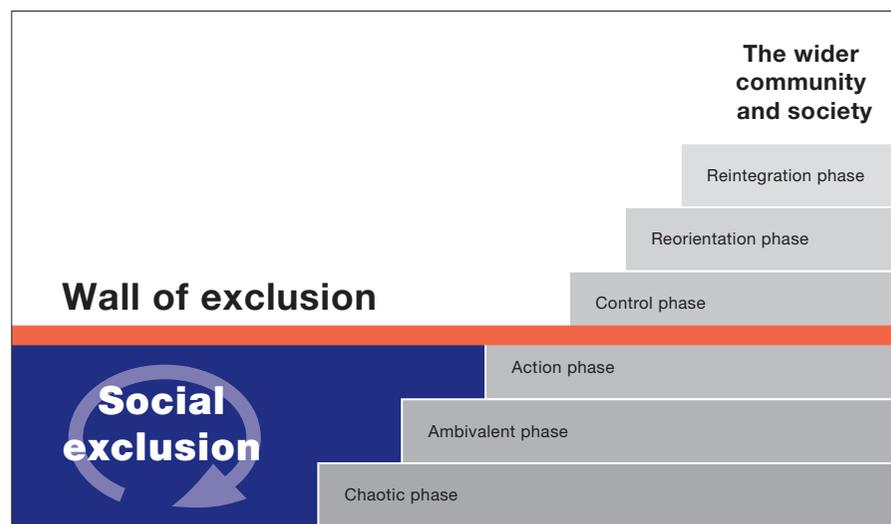


Figure 10.1 Steps to social reintegration (Buchanan 2004)

Buchanan adapted the Prochaska *et al.* (1992) model of the stages of change to identify the different phases that individuals go through as they seek to overcome problematic drug use. He identified six phases that individuals moving from problematic drug use to social reintegration are likely to experience. The first four phases in Buchanan’s model signal changes in the individual and in their use of drugs as they move from chaos to eventual control. The later three phases suggest that, while recovering drug users move towards ‘normal living’, individuals and agencies in the wider society need to change their attitudes and behaviour towards recovering problematic drug users.

Social exclusion and problematic drug use

Buchanan’s model suggests an association between the first four phases of recovery and social exclusion. Research in Ireland has shown that homelessness is associated with an escalation in the use of drugs, changes to chaotic patterns of drug use, and episodes of non-fatal overdose (Cox and Lawless 1999; Cleary *et al.* 2004; Crawley and Daly 2004; Lawless and Corr 2005). In addition, 61% of cases commencing treatment for problematic drug use in Ireland in 2003 were unemployed, compared to the national average of between 4% and 6.3% (NDTRS unpublished data). Opiate users who are overcoming the ambivalent phase and taking action to control their problematic use are likely to be prescribed methadone. Research has shown that methadone maintenance is not a barrier

to finding employment. NDTRS data for 2003 show that, of 3,542 cases continuing in treatment for problem opiate use from the previous year, 3,281 (92.6%) were receiving methadone maintenance, of whom 828 (25.2%) were in paid employment and 1,854 (56.5%) were unemployed (Figure 4.1). It could be argued that the cohort of methadone clients who were employed had managed to navigate the 'wall of exclusion'. However, in the case of the unemployed cohort, further change was necessary to enable them to progress to employment and social reintegration.

Research by Platt and Metzger (1985) suggests that clients on methadone maintenance programmes are not a homogenous group and that those who secure employment are likely to have used drugs for shorter time spans and may have acquired the skills and internal resources suited to the requirements of a 'cultural transition' from treatment to employment.

The reorientation phase

According to Buchanan (2004)

the majority of drug services concentrate their efforts on addressing the needs of problem drug users below the line of exclusion, whereas there is a need to develop more drug services concerned with reorientation and reintegration. (p. 395)

The *Report of the working group on drugs rehabilitation* provides an opportunity to develop drug services with the main focus on reorientation and reintegration targeting current, stabilised and former drug users. For example, the Working Group recommends that a case management approach be taken when dealing with the needs of recovering drug users. This will involve the development of holistic care plans that will address a range of personal, educational, housing and employment needs. In addition, the Working Group recommends that the health and educational requirements of Community Employment (CE) participants should be addressed while they are on the training scheme, with the help of service-level agreements. The number of drug-specific CE places should be increased from 1,000 to 1,300 to reflect demand and the settling down of the regional drugs task forces. A pre-stabilisation initiative, focusing on preparation for CE should be developed.

Buchanan (2004) suggests that drug services geared towards assisting with reorientation and reintegration could include mentoring schemes, structured day programmes, voluntary work and basic adult education. This type of intervention is often categorised as vocational rehabilitation in that the main objectives are to provide a space for personal development, assist with vocational and job seeking skills and provide supported work interventions. Research suggests that vocational training interventions contribute to a reduction in drug use and improved treatment outcomes, and completion of vocational training is associated with improved personal and social functioning and obtaining employment (Platt 1995; Reif 2004; Kemp *et al.* 2004; Blankertz *et al.* 2004). Examples of interventions in Ireland showing promising results in personal development, vocational training, job-seeking skills and supported work are discussed in chapter 8 of this Overview.

The reintegration phase

According to Buchanan (2004)

The final phase is to begin social reintegration within the wider society. This may involve: finding accommodation, employment, securing a place in further education or establishing basic daily social routines.... (p. 395)

It could be argued that this is the phase of recovery that presents the greatest challenge to Irish drug services, particularly in relation to assisting recovering drug users to secure employment and accommodation. For example there is a lack of progression from FÁS CE to the labour market for the majority of recovering drug users (Bruce 2004; Lawless 2006). Research conducted in Ireland and highlighted in this Overview shows that when drug users become homeless they experience great difficulty in resolving their accommodation problems (Crawley and Daly 2004; Cleary *et al.* 2004; Seymour and Costello 2005).

The *Report of the working group on drugs rehabilitation* recommends that employment, access to education and housing form a key part of rehabilitation care plans, with the overall aim

to maximise the quality of life, re-engagement in independent living and employability of the recovering problem drug user, in line with their aspirations. (p.21)

Employment

The Working Group on Drugs Rehabilitation recommends that stronger links with employers, employer organisations and trade unions be established to facilitate ease of access to the workplace for recovering drug users. Access to ongoing support for employers of drug users and for recovering drug users in employment is recommended.

Research by Scott and Sillars (2003) highlighted the negative attitudes towards recovering drug users held by potential employers in Glasgow. Drug services need to develop closer working relationships with potential employers to address these negative attitudes. Randall (2000) highlighted work by Merchants Quay Ireland with potential employers and showed that, by means of education and awareness programmes, service providers could change employers' perceptions of recovering drug users. The author also found that employers of work-placement clients reported positive outcomes.

Access to education

The Working Group on Drugs Rehabilitation recommended that factors that make it difficult for recovering drug users to access education should be identified and removed where possible, and that an education fund for drugs rehabilitation should be established. An outreach approach should be developed by the Vocational Education Committees to identify and develop responses to the adult educational needs of problem drug users in rehabilitation.

Bruce (2004) highlighted the strong commitment to education among recovering drug users in

Ireland, in particular their strong sense of achievement when they were awarded certification. Overall, there is already a steady growth in adult education options for recovering drug users in Ireland - from literacy and numeracy tutoring to third-level studies. As noted in this Overview, Soilse and SAOL have assisted clients to achieve notable progress on a number of educational indicators, including improvements in literacy levels and progression to third-level studies. Both projects are influenced by the Paolo Freire experiential learning approach. Projects such as Soilse and SAOL provide models of promising practice from which important learning can be drawn.

Housing

The Working Group on Drugs Rehabilitation recommended that local authorities liaise with local drugs task forces to facilitate recovering drug users who wish to return to or move into local authority housing in the community. Dedicated, supported accommodation, staffed appropriately, should be provided to cater for clients who have difficulties in an independent living environment. The provision of transitional or half-way housing for recovering drug users should continue to be expanded. The long-term housing needs of problem drug users who are capable of independent living should be addressed. The Working Group recommendations include the key components suggested by Neale and Kennedy (2002) to improve service provision for homeless drug users (see section 6.4). Although not all recovering drug users will experience homelessness, research highlighted in this Overview shows that when homelessness is not addressed it can be a major barrier to recovery and social reintegration, and in some cases can lead to relapse (Fitzpatrick Associates 2006; Seymour and Costello 2005).

Research by Burt *et al.* (2004) in the United States showed that the most important element in improving service provision for homeless people was a paradigm shift in the goals and approaches of the homeless assistance network. For example, the use of a strategic approach to reduce and eventually end street homelessness was advocated. This approach and similar goals are reflected to a large extent in the Homeless Agency's action plan for Dublin and in *Preventing homelessness*. In addition, these two policy documents, as well as the Report of the working group on drugs rehabilitation, emphasise the challenge of improving inter-agency working between the statutory, voluntary and community sectors in responding to the needs of individuals with addiction and accommodation problems. There is also a commitment to provide housing and accommodation for people who have been through the mental health and addiction services and are moving towards independent living.

However, of paramount importance is the need to provide the 'bricks and mortar' to support this combined strategic approach to address the accommodation needs of individuals recovering from addiction and mental health problems. Indeed, this is acknowledged by the Homeless Agency in their action plan for Dublin:

The success or failure of the Homeless Agency Partnership Action Plan is dependent on a dramatic increase over the next four years of secure and sustainable housing for people who are homeless. (p. 53)

Social reintegration complements the goals of drug treatment and rehabilitation. While treatment and rehabilitation address the addiction in the individual by either medical or psycho-social means, social reintegration addresses the key social needs of drug users. These include the need for stable accommodation and employment. Just as is the case with non-drug-users, having stable accommodation and the chance of employment serve both personal and social functions for recovering drug users. On a personal level, recovering drug users in stable accommodation feel secure and this can contribute to prevention of relapse into drug use. On a social level, stable accommodation removes the homeless drug user from the isolation of the street and the insecurity of hostel life and can contribute to a feeling of being part of society as opposed to feeling socially excluded. Employment brings a sense of self-worth and self-respect to recovering drug users and challenges them to move beyond the negative experiences associated with using drugs. On a social level, employment gives recovering drug users a social status that can bring respect from their fellow citizens and opens up for them the opportunity of pursuing mainstream social goals such as maintaining a home, owning a car or going on holiday. To the rest of society, these are fairly normative goals that are pursued by legitimate means; social reintegration is about creating the conditions that allow recovering drug users to pursue and achieve these goals by the same legitimate means. Failure to create these conditions for the recovering drug user may contribute to relapse into further episodes of problematic drug use. According to Buchanan (2004),

for many problem drug users relapse is not simply the result of physical craving or a lack of motivation, but it is a direct consequence of a frustration and inability to secure a position in normal community life and establish everyday routines. (p. 395)

Finally, it is important to hear the voice of the homeless drug user, and to understand his desire for the normal things in life that most of us take for granted (cited in Clery *et al.* 2004).

Once I have a flat then I'll be laughing, that's all I want, a flat, a job and to live a social life and go out every Friday or Saturday night like anybody else does...it wrecks my head, I'm sleeping in a doorway on a Friday or Saturday night, you see everyone going out...and you're thinking to yourself why couldn't I be doing that, you know what I mean, that gives me all the more reason to say to myself 'I'm getting out there and getting a job for meself you know what I mean?' (p. 110)



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