'Beyond Rehabilitation'

'An exploration of workers' experiences in delivering drug services within the Special Drugs Rehabilitation Community Employment programme.'

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A Dissertation Presented in Fulfilment of the Requirements

for the

Award of Professional Doctorate in Education (Ed.D)

Dublin City University Institute of Education

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July 2020

Declaration/Disclaimer

I hereby certify that this material, which I now submit for assessment on the programme of study leading to the award of Doctor of Education is entirely my work, and that I have exercised reasonable care to ensure that the work is original, and does not to the best of my knowledge breach any law of copyright, and has not been taken from the work of others save and to the extent that such work has been cited and acknowledged within the text of this work.

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Date: 29th July 2020

Dedicated

To my Ma and Da, Margaret and Leo for making me believe.

Acknowledgements

I offer my sincere gratitude to those who, knowingly or not, have helped me on this amazing journey. Thanks to my fellow students, who in the early stages of the programme provided the enthusiasm and good humour to keep the 'fire lit'.

A sincere 'Thank You' to all the staff at DCU, academic and administrative who provided unwavering professionalism and friendliness in assisting me to navigate university life. An extra special thanks to all the DCU library staff for going above and beyond the call of duty. My gratitude to Professor Joe O'Hara, who as my supervisor, bore his lot with gracious good humour, while providing sagacious advice, guidance, encouragement and admonishment in proper measure.

I am deeply indebted to my extended family, including Helen for services rendered, and a particular word of thanks to Dr Paul Curley for his insightful and practical advice. A special thanks to my wife Leonora for her extraordinary patience and support over the long haul, I owe you big time.

Finally, to all SCE workers, not least those who took the time to participate in this study, I wish to express my thanks and admiration at the great job you do in such difficult circumstances.

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List of Abbreviations

Abbreviation	Full Title
AA	Alcoholics Anonymous
AnCO	The Industrial Authority
CBT	Cognitive Behavioural Therapy
CE	Community Employment
CityWide	National Network of Community Activists and Organisations
DRSCE	Drug Rehabilitation Special Community Employment
DESP	Department of Enterprise and Social Justice
DSP	Department of Enterprise and Social Justice
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
FÀS	Foras Áiseanna Saolthair
GDP	Gross Domestic Product
GDRP	General Data Protection Regulation
HIV	Human Immunodeficiency Virus
HSE	Health Services Executive
ILO	International Labour Organisation
LDTF	Local Drugs Task Force MI Motivational Interviewing
MQI	Merchants Quay Ireland

NDATC	National Drugs and Alcohol Treatment Centre
NDRIC	National Drug Rehabilitation Implementation Committee
NDRF	National Drugs Rehabilitation Framework
NDS	National Drugs Strategy
NEDTF	North Eastern Drugs Task Force (Regional)
NIDA	National Institute for Drug Abuse
NQF	National Qualification Framework
NRB	National Research Board
QQI	Quality and Qualifications Ireland
SCE	Special Community Employment
Urrús	National Community Drugs Training Centre
WHO	World Health Organisation
WISE	Work Integrated Social Employment

Abstract

Psychoactive drug use is a significant problem for most Western societies. It has been a growing problem in Ireland over the last five decades, causing a multitude of problems for individuals and communities. One of the primary rehabilitative responses available for individuals in Ireland desiring to undertake recovery is the drug rehabilitation Special Community Employment (SCE) programme. The SCE programme supports almost one thousand individuals in their recovery by maintaining stabilisation, reinforcing recovery, providing education and skills training, and developing recovery capital enabling the participant to re-enter society as a contributing member.

A review of the literature on SCE indicates that several issues have arisen around funding structures, administration, governance and operations (Bruce 2004; Lawless 2006; CityWide 2013). However, little action has been taken over the last decade to address these issues. The studies referred to, adopted a broad view of the SCE programme. They examined activity across a wide range of stakeholders, including participants, families, workers, community boards and state bodies. While these studies provided excellent information, there was an evident paucity of research focused on the professional and support staff who deliver SCE in local community projects.

This research study was undertaken in response to that gap in the literature.It sought to provide some insight into the SCE workers' experiences, which would contribute to the debate on operations and practices in SCEs and policy formation in the broader rehabilitation field.

The research used a mixed-methods design methodology consisting of an initial questionnaire to gather quantitative data and a series of semi-structured interviews that provided qualitative data, which enhanced and elaborated on the data gathered at the quantitative phase. This mixed-methods design provided a pragmatic approach that saw both qualitative and quantitative data generated and analysed.

Results suggest that SCE workers at all levels have experienced significant challenges to their effectiveness in work and their professional training and development needs. These issues are perceived to arise from the policies, procedures, administration and working conditions under which they operate within the SCE programmes. This research revealed that while social, economic policy and drug policy in Ireland has changed radically over the past decade, the SCE programme has failed to adapt in a way that adequately meets the needs of this changing environment. Several recommendations are made on foot of this study, which if adopted, would improve working conditions, enhance worker training and development and increase the effectiveness of service delivery.

Chapter 1: Introduction

> '*Begin at the beginning, "the King said, very gravely", and go on till you come to an end: then stop*'. (Lewis Carroll, *Alice in Wonderland*)

1.0. Introduction

This thesis explores the experiences of workers delivering the Drug Rehabilitation Special Community Employment (DRSCE) programme; for legibility and convenience, the DRSCE programme will hereafter be referred to as the Special Community Employment (SCE) programme. The researcher will use the word *programme* to refer to the SCE operating at a national level and *project* to refer to local SCE community schemes. This chapter introduces the reader to the background, rationale and need for this study and provides insight into this researcher's motivation in undertaking it. It will introduce the research question and sub-questions and provide an outline of the research cohort's profile and an overview of the study's structure.

1.1. Choice of Topic

According to Newman et al. (2003), the choice of topic in any piece of research is formed through the lenses and filters of the individual researcher, and these lenses and filters represent the researcher's autobiography—their lived experiences, gender, age and the many other variables that constitute the person undertaking the research. The focus of this study is the delivery of rehabilitation services through SCE projects. This topic has been chosen, among other reasons, because of the researcher's professional experience and personal interest in the field and the importance of drug rehabilitation to addicted individuals and society. There is also an imperative to hear the voices of those who work in this field.

The researcher spent 16 years (1994–2011) in various positions, including project worker, supervisor and programme manager on several SCE projects. During this time, the researcher was anecdotally aware of these projects' inherent problems (e.g. cultural dissonance, systemic friction and incompatible recruitment protocols), which negatively affected SCE service delivery. Many of these problems were believed, rightly or wrongly, to have been caused by the co-optation of the existing Community Employment (CE) mechanism, with its specific policies, procedures, protocols, staffing structures and training content, as the main instrument for engaging former drug users in a rehabilitation process.

More recently, the author has worked as a lecturer and trainer with Urrús (the National Community Drugs Training Service), which provides drug education programmes and continuing personal development courses, up to and including third-level qualifications for those working and volunteering in the drug sector. The nature of this work has brought the researcher into contact with a significant number of SCE project managers and staff members. A recurring theme in conversation with these SCE workers, both individually and as a group, is their perception that they are impeded or frustrated in delivering the type and quality of service they feel necessary. Ideally, they would rather spend their time, 'supporting and assisting drug users in their preparation for and gaining access to the labour market' (Department of Social Protection [DSP] 2015, p. 1). This cohort articulates these constraints as too much bureaucracy, little understanding of addiction recovery among DSP staff assigned to projects, insufficient flexibility in budgetary discretion and inadequate training and career development opportunities. The frictional nature of this relationship was first officially recognised in the Bruce Review (Bruce 2004), a review commissioned by Foras Áiseanna Saothair (FÁS), the reporting agency for the SCE projects at that time. Bruce (2004) identified several issues that needed to be addressed, including that:

'CE only makes sense if it is delivered as part of a coherent and interlinked programme of rehabilitation and support for this client group' and the presence of a 'tension between rehabilitative and training dimensions which can lead to neither set of objectives being fully achieved' (pp. 86-87).

The report also found that there was no 'clear structure and framework for the operation of the schemes' (DSP 2015, p. 2).

In large part due to his research brief parameters, the breadth of Bruce's (2004) study may be seen to dilute the 'voice' of the SCE workers by the inclusion of a broad spectrum of stakeholders. Thus, the workers' contributions to the report were subsumed into an overall systemic review. Lawless (2006) conducted a comprehensive and informative study for the Dublin North East Drugs Task Force (NEDTF). This report took an in-depth look at SCE in that catchment area and attempted to 'bring together clients' diverse opinions and experiences of support workers, volunteers, funders, community representatives, and service providers' (Lawless 2006, p. 6). While delivering a comprehensive review of the SCE in the NEDTF area, its overarching nature leaves the voice of the SCE staff competing with the 'noise' of other stakeholders for a proper hearing.

The desire to establish the specific issues affecting the work-life of former SCE colleagues motivated this investigation. It is also noteworthy that, from the paucity of academic literature on SCE, little or no research has been conducted on SCE delivery since 2006. This dearth of research indicates that the research will provide a necessary and up-to-date picture of current issues facing those on the front line of service delivery.

In 2015, the DSP, which is currently responsible for SCE programmes, published a 'Programme Framework for CE Drug Rehabilitation Schemes'. This framework, among other things, recognises that '[n]o single agency has the range of competencies or expertise to provide all the varying support needed to assist clients to complete their rehabilitation' (DSP 2015, pp. 10-11). It also notes that the 'response under SCE requires an integrated, collaborative effort across a range of stakeholders (statutory, community and voluntary) to be effective' (ibid).

1.2. Overview of the Study

Drug misuse has long been a serious social problem in Ireland and the rest of the developed world (Best 2017; Gossop 2017; Lindesmith 2017; Bellrose et al. 2011; O'Gorman 1998; Butler 1991). Substance dependency, while physically and mentally

degenerative in and of itself, often coexists alongside a range of conditions, such as homelessness (Ceannt et al. 2016; Schütz 2016; Tsemberis 2011; Lawless et al. 2003), psychiatric illness and associated problems (Fazel et al. 2008; Glasner-Edwards et al. 2008; Rodríguez-Llera 2006; Zweben et al. 2004), viral infections and other physical illnesses (McGowan et al. 2017; Martin et al. 2015; Zibbell et al. 2015; Nutt et al. 2010) and family breakdown and accompanying problems (Flacks 2019; Schneider et al. 2009; Mallett et al. 2007; Copello et al. 2005), as well as maladaptive behaviours, such as self-harming (Glynn et al. 2017; Haw and Hawton 2011; Borges and Loera 2010), violence and criminality (Bean 2014; Stevens 2011; Campbell 2010; Bennett and Holloway 2008) and sex work (Ditmore 2013; Aral et al. 2005; Lowndes et al. 2003; Dehne and Kobyshcha 2000). These conditions and associated behaviours create problems at the social, economic (Brewer and Freeman 2018; Kiriakidis 2008; Andlin-Soboki and Rehm 2006) and political levels (Cambell and Ettorre 2011; Punch 2005).

Dealing with a multi-faceted problem of this scale requires a multi-agency policy approach (Hanson et al. 2011; Chassin 2006). Since 2001, successive Irish governments have engaged the problem of widespread drug misuse with a policy initiative that attempts to meet the complexity of the drug problem with a collaborative interdisciplinary approach titled the National Drug Strategy (NDS). The first NDS covered the period 2001–8, the second covered 2009–16, and the current iteration spans the years 2017–25.

As an element of the 'Treatment and Rehabilitation' pillar within the first NDS (2001), a pre-existing labour market activation mechanism known as the CE programme was officially adopted. This CE programme has been in existence since 1999, and the government uses it as the main instrument for the delivery of rehabilitation for long-term drug users. This initiative involved the establishment of SCE programme community projects throughout the country. These programmes offered 1000 places nationally for drug users to engage in a rehabilitation programme (NDS 2001–7, p. 64). The current NDS (2017–24), titled 'Reducing Harm, Supporting Recovery', commits the DSP's SCE programme to support the development of personal and employment skills and acting as the labour market element in the continuum of care; it has ring-fenced one thousand places nationwide specifically for SCE applicants (DSP 2017; NDS 2017).

With the potential for dealing with one thousand participants at any one time, the projects constitute a significant investment in both human and financial terms. Thus, it is surprising that a more substantial number of academic studies have not been conducted on the policy, theory and practices of SCE projects. The few studies that do exist have been used to support reports like the 'Programme Framework for CE Drug Rehabilitation Schemes' (DSP 2015), 'National Drugs Rehabilitation Framework' (Doyle and Ivanovic 2010) and 'Social Reintegration as a Response to Drug Use in Ireland' (Keane 2007). The lack of up-to-date primary data focussed on the operation of SCE provided the impetus and illuminated the need for the current study.

Little work has been published looking at SCE from the point of view of drug workers. Hence, this research considers the issues that affect the delivery of SCE programmes from the perspective of the people staffing these projects—managers, supervisors, assistant supervisors, project workers and volunteers. It examines staff structures, duties attached to various positions, staff training needs, barriers to the effective programmes delivery, participant interaction, job satisfaction and self-care. This investigation's findings can provide a basis for identifying operational, administrative, and resource enhancement opportunities within projects. It is also intended that this study will indicate directions, strategies, training and development opportunities, which will strengthen the programmes and contribute to a better working environment for employees and an augmentation of existing and future service provision.

1.3. Significance of the Research Topic

According to Merchants' Quay Ireland (MQI), the most comprehensive addiction and homeless service in Ireland, there were approximately 20 000 opiate users in Ireland in 2017/2018, with about 10 000 seeking treatment (MQI 2018). The Health Research Board (HRB 2019) figures indicate that 736 people died drug-related deaths in 2017. According to the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA 2019), approximately 0.08% of the national gross domestic product GDP (amounting to €241 million) was spent on drug-related issues in that year, divided between 'demand reduction' (68%)—which includes prevention, education, treatment and recovery—and 'supply reduction' (32%)—which encompasses legal sanctions, customs seizures and

interdiction processes. According to the same report, along with these stark statistics, there were 16 800 drug-related criminal offences in 2017. There is also a strong correlation between drug misuse and mental illness (NIDA 2017; Weaver et al. 2002) as a contributor to homelessness (Glynn et al. 2016), an agent in family breakdown (Copello et al. 2010) and a catalyst in social decline.

The negative impact of drug misuse can be seen and felt in Ireland today. As a society, the way we go about dealing with the phenomena of drug use, its treatment and recovery will have long-term consequences for us all. Therefore, this research looks at the SCE programme, which is one of our primary recovery and rehabilitation mechanisms, from the perspective of those working in delivering services, to provide insight and up-to-date information. This insight will inform discussion and subsequent action on how we deliver rehabilitation services. The thesis will also examine the efficacy of service delivery, formulation of outcomes, provision of adequate resources and financing, staff training, employment status, and remuneration. Hopefully, it will contribute to the evidence base to inform change.

1.4. Research Questions

1.4.1. Dissertation Title

The title chosen for this study is 'An exploration of workers' experiences in delivering drug rehabilitation services within the Special Drugs Rehabilitation Community Employment programme'.

1.4.2. Research Question

This dissertation seeks to answer the following research question:

'Explore the working experiences of staff members engaged in delivering drug rehabilitation Special Community Employment programme within the Dublin region.'

This question will be used to provide insight into the focus of the study, and a series of sub-questions will be introduced to structure the inquiry.

1.4.3. Specific Sub-Questions

- Identify a demographic profile of those working in the field.
- Establish the perceived effectiveness of the SCE programme from a practitioner's viewpoint.
- Document the perceived barriers to effective service delivery.
- Identify project workers' professional training and education needs.
- Identify opportunities for the improvement of programmes.

1.5. Special Community Employment Programme

As we have already seen, SCE programmes are the primary means of rehabilitation intervention administered by the DSP in support of the NDS. An SCE scheme differs from the mainstream CE scheme in that participants are referred to the programme by a recognised drug service or agency as part of their recovery regimen. A report by the Department of Community, Rural and Gaeltacht Affairs (2007) underlined the importance of the SCE programme as follows:

'It is recommended that the relative success of Drugs Task Force CE Projects be built upon. CE Drug Projects have been designated as 'special' projects in recognition of the fact that they are not operating as a labour market mechanism in the same way as mainstream CE, but rather as a support mechanism through which drug rehabilitation programmes can be delivered. Nine key adjustments have been made which differentiate CE Drug Projects from mainstream CE, and these adjustments are based on the needs of the target group of recovering drug users.' (p. 36)

The DSP (2020) defines an SCE scheme as a

'Drugs Rehabilitation Scheme that provides a rehabilitation training and development opportunity for individuals recovering from substance misuse and referred to a place on CE. The CE rehabilitation schemes are delivered within the remit of the national response with

a specific focus on opportunities for training and development for participants working towards recovery and reintegration into active community and working life.' (p. 3)

According to the DSP (2013), the SCE programme was modified to meet this target group's complex needs. These modified conditions covered participant eligibility, referral, programme delivery, staffing and expected outcomes (see Appendix 1). These programmes are specifically designed to develop work experience and training, integrated with other support services. They are directed at former addicts who are ready to engage with employment support services. Currently, the SCE programme has one thousand ring-fenced drug rehabilitation places on dedicated and mainstream CE schemes funded as part of the CE budget. There are '47 dedicated drugs schemes, of which 35 are in the Dublin region' (DSP 2013, p. 2). These participants are being cared for and administered to by workers in the specific community drugs service.

1.6. Who are the Special Community Employment Workers?

There are three main categories of workers involved in delivering SCE programmes and who form the focus of this research. These are managers, supervisors/assistant supervisors and project workers, and they are each described below.

1.6.1. Managers

Project managers are predominantly community drug service managers who have one or more SCE programmes running within their agency. They report to the organisation's Board of Management and have responsibility for running all services conducted by the organisation (e.g. stabilisation, outreach, aftercare, counselling, family supports, CE). Managers look to the strategic development of their organisation and the role SCE rehabilitation plays within their overall continuum of care provision. Managers typically have one or more supervisors reporting to them concerning running the SCE programme (*see job description Appendix: A)*.

1.6.2. Supervisors/Assistant Supervisors

Schemes are administered and coordinated by supervisors, sometimes assisted by one or more assistant supervisors, who would typically have some experience in the field of drug

treatment and rehabilitation. Supervisors and assistant supervisors are front-line managers with day-to-day responsibility for the smooth running of the SCE programme. These responsibilities include participant welfare, health and safety; participant assessment; developing 'Individual Training Plans'; course delivery; therapeutic interventions, liaising with Quality and Qualifications (QQI), DSP and other relevant state and not-for-profit agencies; maintaining discipline; supervising project workers; and financial administration of material and training budgets among others. They report both to their manager and the DSP officer responsible for their geographic area *(see job descriptions Appendix: B & C).*

1.6.3. Project Workers

Project workers, also known as key-workers report to the supervisor/assistant supervisor and provide services directly to the participants. These services include relapse prevention (RP), recovery support and advocacy, course session delivery, conducting interventions, maintaining discipline and escorting participants on field trips. The project workers can be full-time and paid employees of the organisation, or volunteers who give their time and skills for free. They can be engaged on a part-time basis as participants of the SCE, which means they are employed on the same terms as the recovering participants but are acting as support-workers for them *(see job description Appendix: C).* Support workers are 'Project Workers' who are employed as CE participants. Their role is to support staff in their duties, more often than not these 'Support Workers' (see job description Appendix: D) undertake the same duties as regular project workers and are for the sake of this study included in this subset of the cohort.

1.7. Research Process

This study is a mixed-methods study chosen, as described below, to give as comprehensive an overview of the experiences and insights of the professionals working in the SCE programme as possible. The term 'mixed-methods' refers to a research methodology that proposes the systematic integration, or mixing, of quantitative and qualitative data within a single investigation or study. Wisdom and Creswell (2013)

suggest, 'The basic premise of this methodology is that such integration permits a more complete and synergistic utilisation of data than do separate quantitative and qualitative data collection and analysis' (p. 1).

A mixed-methods approach was chosen for this study for three main reasons, which are as follows:

- To gather a substantial amount of demographic data quickly. While the research question lent itself to a qualitative inquiry, little or nothing is known about the individuals in the sample groups' demographics.
- To use qualitative data to explore quantitative findings, or what Wisdom and Creswell (2013) describe as 'explanatory sequential design' (p. 2). This design typically contains an initial quantitative exploratory phase followed by a qualitative data collection phase, where the qualitative phase builds directly on the results from the quantitative phase. In this way, the quantitative results are explained in more detail through the qualitative data.
- To validate findings. Mixed methods can provide triangulation; such an approach 'involves using one type of data to validate or confirm conclusions reached from an analysis of the other type of data' (Palinkas 2010, p. 49).

This mixed-methods study can be divided into four distinct stages, which are described below.

1.7.1. Stage 1: Identification and Formulation of Research Topic: *Personal experience, anecdotal evidence and literature review.*

In this stage, this researcher was mindful of Janesick's (2000) suggestion that all research and qualitative research, in particular, begins with a question or at least an intellectual curiosity if not a passion for a particular topic' (p. 382). This researcher's dual passions for education and addiction recovery and the role the former plays in the latter gave rise to a curiosity about the efficacy of current efforts in this area, or as Charmaz (2006) puts it, a simple question of 'What is going on here?' (p. 20). This curiosity initiated a search to formulate a question that made sense of 'what was going on'; however, this search soon centred on SCE projects, which are the primary instrument for rehabilitation delivery. Creswell's (2007) dictum that 'good qualitative questions should invite a process of

exploration and discovery' (p. 25) helped focus this question on the exploration of the experiences of those who work in delivering these services and trying to understand what is going on. Even with careful consideration in the initial wording of the question, an amount of change occurred as the research process evolved, leading to a clarification in the wording and intent of the question, informed by practicability, the evolution of thinking, acquired insight and ethical considerations, among other things. Flick (2006, p. 106) coalesces this concept as follows: 'The result of formulating questions is it helps you to circumscribe a specific area of a more or less complex field which you regard as essential'.

1.7.2. Stage 2: Planning: *Identification of issues and questions pertinent to the research topic through discussion and engagement with relevant stakeholders, designing questionnaires, developing interview questions, identification of the cohort, obtaining ethical approval, scheduling implementation of interviews and collation of resulting data.*

It was imperative to engage with as many stakeholders as possible to gather diverse viewpoints and an accurate picture of the subject at the planning phase. It was also important to identify 'who' I was going to research; my research question suggested that my cohort would be workers within the SCE projects. Light *et al.* (1990) stress the importance of considering different types of respondents to broaden the view of the phenomenon under consideration. It was decided that a stratified sample of managers, supervisors and project workers for each SCE project would provide a more accurate picture. A questionnaire was developed, and a pilot study was conducted with a sample of $n = 11$. Changes emerging from pilot feedback were incorporated into the final design before dissemination to the studies' target projects, including separating specific questionnaires for the three respondent groups—managers, supervisors and project workers. All SCE projects in the Dublin target region were contacted, and 22 out of 35 agreed to participate.

1.7.3. Stage 3: Action: *Disseminating and collecting questionnaires, conducting and transcribing interviews, focus groups, coding, entering and collating data*

Having agreed to a schedule of activities with the relevant academic supervisor, the dissemination of questionnaires was initiated. The questionnaire consisted of two double-sided pages containing fifty questions *(see Appendix: I)*. In most cases, these were

hand-delivered by the researcher to the senior contact in the different projects. This personal dimension in delivery and collection was deemed necessary to enhance response rates. Interviews were subsequently conducted with representatives from the three respondent groups individually and independently. The interviews were mostly held in the respondent's project premises. The researcher initially entered data from the questionnaire to the spreadsheet; these raw data informed the formation and nuance of subsequent interview questions by providing quantitative data indicating areas of concern for workers. The researcher personally transcribed the interview tapes and notes to achieve immersion in the emerging data, thus developing a general feel and understanding of the data. All questionnaires were anonymous by design and designated a random number for collation purposes, maintaining confidentiality as agreed with participants. Similarly, all transcriptions of tapes allotted numbers to respondents; both questionnaires and tapes were secured in a locked environment accessible only to the researcher at all times.

1.7.4. Stage 4: Analysis: *Organising and structuring quantitative and qualitative information from derived datasets, representing quantitative data obtained from different questionnaires completed by managers, supervisors and project workers. Interpreting and deriving meaning from the results and inter-relating the two different datasets to draw inferences and conclusions*

A detailed and comprehensive data analysis strategy was developed. Nominal and ordinal quantitative data were tabulated for the different variables in the dataset, and percentiles were calculated. Qualitative data were coded and analysed using keywords and statements derived from the initial qualitative findings; this was done to illuminate and enhance the understanding of the quantitative data. While analysing the data, the following types of questions, delineated by the National Science Foundation, were used to interrogate the dataset: What patterns/common themes emerge around specific items in the data? Are there any deviations from these patterns? What interesting stories emerge from the data? Do any of the study questions need to be revised? Do the patterns that emerge support the findings of other corresponding qualitative analyses that have been conducted? (NFT, 1996).

1.7.5. Stage 5: Report:

The report consists of a written thesis document, containing an exploration of the research question, a statement of the purpose and value of the study, explanation of the theoretical framework used, and methodology employed, along with a comprehensive literature review, data analysis, discussion of research findings, recommendations and conclusions.

1.7.6. Rationale for Choice of Research Method

When considering methods and approaches for undertaking this inquiry, the researcher considered several approaches which might be used to answer the research question. An ethnographic approach was ruled out due to the amount of time available, the type of information required and access to the study cohort. Likewise, a Case-study format was considered too narrow in its approach and did not provide the scope to gather demographic data. Action research was considered briefly, and a short discussion of its deselection is deserved.

The concept of action research is commonly associated with Kurt Lewin, who posited that:

'The research needed for social practise can best be characterised as research for social management or social engineering. It is a type of action-research, which is comparative of conditions and effects of various forms of social action, and research leading to social action. Research that produces nothing, but books will not suffice' (Lewin 1946, reproduced in Lewin 1948, p. 202-3)

There are two different concepts of 'Action Research,' referred to in the literature, firstly:

'Action research is simply a form of self-reflective enquiry undertaken by participants in social situations to improve the rationality and justice of their practices, their understanding of these practices, and the situations in which the practices are carried out' (Carr and Kemmis 1986, p. 162). The concept of action research is closely linked to it is firmly located in the realm of the practitioner (infed.org 2020), and it is based on self-reflection.

Secondly: 'The systematic collection of information designed to bring about social change' (Bogdan and Biklen 1992, p. 223). As Thomas (2017, p.) put it, the central aim is change, 'and the emphasis is on problem-solving in whatever way is appropriate'.

a) Can be used with quantitative, as well as, qualitative data;
b) to gain in-depth knowledge about the problem.

(BRM: 2020, p.1)

When assessing and rejecting an action research approach, the research was cognisant of the three most common issues raised against AR are:

1) Difficulties in distinguishing between action and research and ensure the application of both
2) Delays in completion of action research due to a wide range of reasons are not rare occurrences.
3) Lack of repeatability and rigour

(BRM: 2020, p.2)

Notwithstanding difficulties in distinguishing between action and research, this research is in part commitment to a doctoral degree with a two-year deadline. Therefore, any delays as described by issue 2) cannot be easily accommodated. Finally, in presenting this research as a dissertation for a doctorate, the process's rigour had to be beyond reproach. Thus, an action research approach was considered unsuitable in this instance, and a mixed-methods study was considered more appropriate to the parameters outlined above.

As already stated, this study is a mixed-methods study chosen to provide a comprehensive picture of the experiences and perceptions of the professionals working in the SCE programme projects. The term 'mixed-methods' refers to a research methodology that proposes the systematic integration, or mixing, of quantitative and qualitative data within a single investigation or study. Wisdom and Creswell (2013) suggest, 'The basic premise of this methodology is that such integration permits a more

complete and synergistic utilisation of data than do separate quantitative and qualitative data collection and analysis' (p. 1).

The last 20 years have seen an increase in mixed-methods as a research methodology (McKim 2015; Dunning et al. 2008; Creswell and Plano Clark 2007; Creswell 2003). While there are many reasons for this popularity, one commonly mentioned factor is that integration (of both methods) provides a sense of robustness and greater confidence in results and conclusions (O'Cathain *et al.,* 2010). Others go so far as to state that mixed-methods research is the only way to ensure findings (Coyle and Williams 2000; Sieber 1973) and interpretations (Morse and Chung 2003; Tashakkori and Teddlie 2003) are valid.

1.8. Delimitations and Limitations of the Study

1.8.1. Delimitations

The Greater Dublin Area was selected as the research survey's geographic locus because of its accessibility and concentration of SCE projects in this area.

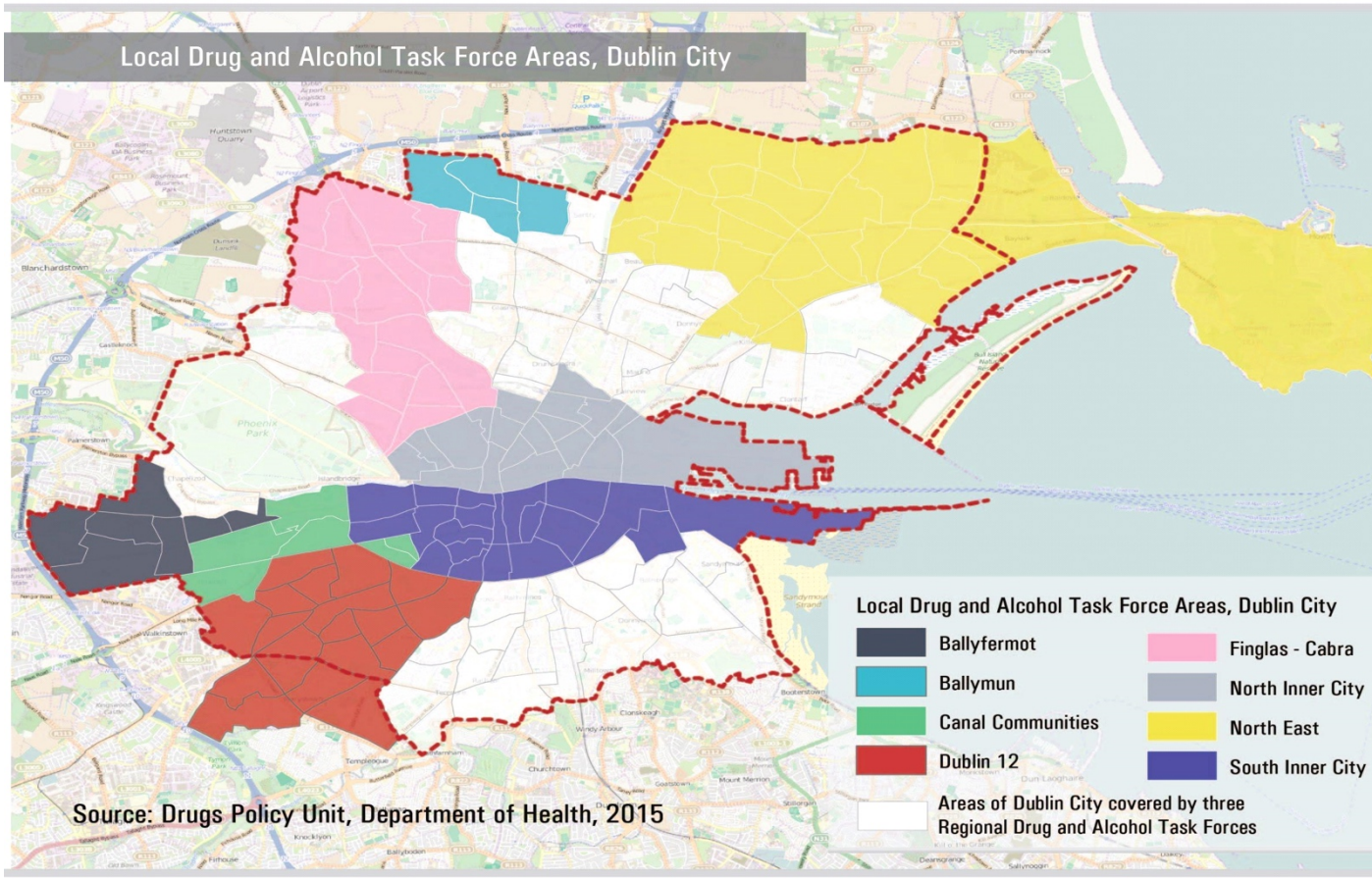


Fig. 1.1 *Source: Drugs Policy Unit, 2016.*

The Greater Dublin Area consists of eight Local Drugs and Alcohol Task Force areas and three Regional Drugs and Alcohol Task Force areas (see Fig. 1.1). There are *n* = 36 SCE projects across these areas, and this study engaged *n* = 22 of these projects, with at least *n* = 1 project from each area represented.

1.8.2. Rationale for Limiting Research to SCE Workers

Several earlier studies (Van Hout & Bingham 2012; Van Hout & Bingham 2013) have investigated aspects of the SCE participant group milieu and (Lawless 2006; Citywide 2013) had covered a broader constituency of SCE stakeholders; this study sought to conduct a narrower and more in-depth study of the drug worker group. This study can be viewed as part of a larger piece of work that could use the same methodology to gather demographics and experiences from a) SCE participants, b) Community Sponsors and c) Policymakers. The logistics, access and scope of this more extensive piece of work were

deemed beyond the parameters of time and resources available for this study. Thus, a more feasible and comprehensive study was adopted.

1.8.3. Limitations

A potential limitation of the research is the introduction of bias since the researcher is heavily involved in the process of data collection and analysis. Stake (1995) warned of the need to remain aware of personal bias. While some would take the position that bias and subjectivity should be eliminated from a study (Ratvitch and Riggan 2012), others posit that awareness and recognition of potential bias can minimise its effects. However, bias can be ameliorated via critical reflexivity, and in this study, reflexivity was achieved, by maintaining a reflective journal throughout. The study's limitations and the researcher's position is discussed in greater detail in the methods section.

1.9. Dissertation Structure

The substantive core of this thesis consists of five chapters, as described below.

1.9.1. Chapter One: Introduction

In chapter one, the researcher provides a comprehensive introduction and overview of this research study. The chapter includes a statement of purpose, rationale, and justification for the study. It defines the aims and objectives that underpin this study and introduces the primary research question. It also describes the five-stage process of the research and identifies the delimitations and limitations inherent in the inquiry's scope and methodology. The final section of the chapter provides an overview of the study structure and sets a context by providing a background to the origins and evolution of the SCE programme.

1.9.2 Chapter Two: Literature Review

Chapter two consists of a thorough review of relevant literature, providing an overview of the themes explored; moreover, as described in Fink (2014), it demonstrates how this thesis fits within a larger field of study by positioning it in the context of its contribution to the research problem being studied.

This chapter describes and defines the relationship between various study areas under review and their respective contributions to this research's theoretical framework. It also identifies new ways to interpret prior research while delineating areas of previous scholarship to prevent duplication of effort. Finally, it seeks to reveal gaps in the literature and identify areas for additional research.

1.9.3. Chapter Three: Research Methodology

Chapter three describes and discusses the conceptual framework the researcher adopted to provide a theoretical roadmap for this study. It also describes the actions taken to investigate the research questions and 'the rationale for the application of specific procedures or techniques used to 'identify select, process, and analyse information applied to understand the problem' (Kallet 2014, p. 129) Thus, allowing the reader to evaluate the study's overall validity and reliability critically. It elucidates the following: a) how the data were collected/generated, b) how the data were analysed and c) how conclusions were derived.

This chapter provides the reader with a sense of the reliability of the procedures undertaken and methods used, underpinning the resultant findings' validity. It also articulates why particular procedures or techniques were chosen while verifying that the data used were collected or generated in a consistent manner, using accepted practice in the field of study. Finally, this chapter highlights and discusses problems, foreseen and unforeseen, which arose before and during the study and identifies the actions taken to prevent or deal with these challenges.

1.9.4. Chapter Four: Results

This chapter reports the findings of the collated and analysed data for both quantitative and qualitative elements of the study. It uses written, numerical and graphic formats to compare, contrast and illustrate the findings. As Annesley (2010, p. 2068) describes, it

'[states] the findings of the research arranged in a logical sequence without bias or interpretation'. However, comments are provided for explanation and elucidation.

1.9.5. Chapter Five: Discussion, Conclusion and Recommendations

The objective of this chapter is to interpret and describe the significance of the findings from the survey. It also identifies new understandings or insights that have emerged from the research (USC 2018). It is intended to inform debate in both academic and practical policy approaches to rehabilitation while identifying efficient operational initiatives for worker training and working conditions.

The chapter highlights this research's relevance and examines SCE workers' experiences and focuses on its broader implications for SCE project participants, rehabilitation services, and policy formation. It provides a 'synthesis of key points' (USC 2018, p. 52) by drawing together salient elements to underscore their relevance and relative importance. It takes the opportunity to identify gaps in the research that may warrant further investigation, espoused by Bunton (2005). It also makes positive suggestions for improving the SCE programme and the enhancement of services, which will encourage debate and may influence policy considerations.

1.10. Summary of Introduction

This chapter presented an overview of the research project. It looked at why this research area and topic were chosen and explained what the DRSCE programme is, what it does and how it was initially adopted to respond to an identified need via a pre-existing programme with a distinct origin and direction. Empirical and anecdotal evidence suggests that this melding of community-based drug rehabilitation initiatives with a structured labour activation programme has given rise to problems at the service, inter-agency, structural and operational levels, providing stimulus for this research.

This chapter also outlined the aim and critical questions asked in this study; it identified and discussed the work roles of the cohort that made up the research sample and provided an exposition of the design, methodology, execution and analytical processes adopted in this study. Finally, it gave an overview of the structure and format of the thesis.

Chapter 2: Review of Literature

'If the only tool you have is a hammer; every problem looks like a nail'. (Maslow 1956)

2.0. Introduction

This chapter reviews the existing literature with a direct bearing on enabling this study to answer the research question, which is as follows:

'What are the issues facing staff members engaged in delivering the SCE programme within the Dublin region?'

The literature review addresses three main themes:

- National Policy: Economic and drug policy, related to the creation, inception, adoption and evolution of the SCE programme.
- Drug Rehabilitation Service: Patterns of drug use, addiction theories, recovery models, rehabilitation and reintegration.
- Community Response: Evolution of community drugs movement, principles and practices informing the current community response to the drug problem, vocational training and development n community setting.

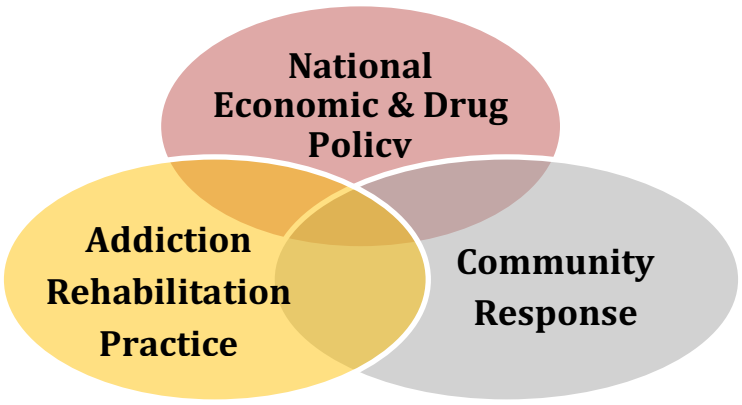


Fig. 2.1: (*Interrelationship between the three areas in this literature review).*

The duties of an SCE drug worker are situated at the nexus of these three broad strands. The strands combine to create a bureaucratic architecture of distinct and divergent 'corporate' cultures, ethae, principles, protocols and practices. SCE workers, including managers, supervisors and project workers, find themselves working within these often-different organisational paradigms and amid different organisational cultural parameters while developing and delivering a practical working model for service user rehabilitation.

At the core of this investigation is the search for an understanding of the lived experiences, challenges, problems and concerns of those delivering SCE community-based rehabilitation services against the background of this uneasy organisational construct. This chapter's literature review is divided into three main strands outlined above and provides a conceptual framework in which to situate this research and its findings.

2.1. Government Policy

This section provides an overview of the economic and social policy developments that gave rise to SCE and continue to inform the operation of the SCE programme today.

2.1.1. Economic Policy

Knowledge of the economic policy that created the principles underpinning CE, (and SCE by extension), is essential to understanding this study's premise. The concept underpinning CE programmes has its origins in active labour market programmes (ALMPs), which were introduced in the 1970s to respond to rising unemployment (Callan and Nolan 1997). This ALMP policy subsequently became one of the central political strategies to address and manage the high unemployment levels prevailing in the 1980s (Murphy 2010). According to Dwyer (2010), the concept of *labour activity* has a wide range of interpretations, and these approaches can be situated on a spectrum from 'fully conditional' sanction-driven interventions with no payment unless specific requirements are met; to wholly voluntary schemes, where supports are provided without being linked to conditionality. Thus, depending on the philosophical outlook, labour activation can be

viewed as an economic stimulus or an attempt to blame unemployment on the unemployed.

Murphy (2010), cites the National Economic and Social Council (NESC 2011, p. 3) as stressing that the objective of labour activation is ensuring *'that the payment of income supports to people who do not have a job is directly linked to the equally, if not more important task, of supporting such people in their pursuit of employment and pursuing their life chances'* (Murphy 2010, p. 33). More specifically, the DSP (2011), the department with ultimate responsibility for implementing labour activation defines it as;

'a social contract where the claimant commits to engage with services in the process of active case management to develop and implement a personal progression plan and where failure to engage can lead to the withdrawal of payment' (p. 10).

As discussed below, a sanction-driven programme is counterproductive in dealing with recovering drug users. However, it is probably more politically expedient in selling the idea of payments of any kind to the public.

2.1.2. Work Integration Social Enterprises

Work Integration Social Enterprises (WISEs) are a subset of ALMP. They are a European-wide phenomenon characterised by two specific service goals to the community and work integration for disadvantaged groups (Borzaga and Loss 2006). There are three main types of Irish WISEs, which are as follows: sheltered workshops, local development and social economy. (Drug rehabilitation SCE schemes are situated in the last category.) These social economy interventions are the main form of State support to social enterprises in Ireland. This approach emphasises local and community development as a solution to long-term unemployment and direct employment schemes to support WISEs engaged in locally based development projects (O'Hara 2001).

2.1.3. Community Employment

As we know it today, CE was established in 1994, when unemployment figures were extremely high, and the long-term unemployed were caught in a vicious cycle. The longer one remained unemployed; the less likely one was to gain employment (DSP 2015, p. 3). This cycle had a detrimental influence on communities, losing the capacity to function as a *'cohesive social structure'* (DSP 2015, p. 13). CE schemes took their lead from

organisations like the International Labour Organisation (ILO), which summarised their approach to the inclusion of education and training as part of market activation as follows:

'Education and training have an important role in promoting labour market integration and the social inclusion of population groups that face discrimination... However, education and training cannot by themselves solve the problems of unemployment and underemployment, and poverty and social exclusion. To be effective, they must constitute an integral element of economic and social policies that promote employment-intensive and equitable economic growth and progress.' (ILO 2000, p. 3)

Hence, the strategy adopted by successive governments was to combine social and charitable community endeavours (sponsors) with the training and market activation (know-how) of a State-sponsored body, FÁS. This strategy would provide long-term unemployed people with training and work experience, enhancing their employability. At the same time, communities would have the opportunity to develop relevant local social initiatives and schemes deemed necessary for the community's sustained well-being. At the same time, it provided employment, learning opportunities and skill development for participants. Thus, at the core of this strategy lay the dual purpose of developing employment interventions and training for the individual with community services provision as espoused by the WISE.

As it has developed and evolved, the CE programme has encompassed several new dimensions, one of which is a *'strong social inclusion element'* (Oireachtas 2019,p.16). CE is often the primary and only response available to address the needs of adults who are experiencing social exclusion, social isolation and physical or mental health issues that may impede their entry into mainstream employment. The emphasis on community and partnership was evident in Flood's (1999) statement that *'CE scheme's, should provide communities with an opportunity to participate in the design and delivery of the response to the problems in their areas'* (p. 18).

At its peak in 1997, the number of CE participants nationwide amounted to approximately '39,100; spread across nearly 2,500 projects involving a national expenditure of almost €370 m' (Deloitte & Touche 1998). According to the most recently published figures, there are approximately 11,500 community and voluntary sector

organisations extant in Ireland (O'Connor 2016), of which almost 900 are sponsoring CE programmes (South Dublin Community Platform 2016).

2.1.4. National Drug Policy

Kirkpatrick (2000) defined drug policy as *'A system of laws, regulatory measures, courses of action and funding priorities concerning illicit psychoactive drugs and promulgated by a governmental entity or its representatives'* (cited by European Monitoring Centre for Drugs and Drug Addiction [EMCDDA] 2013, p. 5). However, the evolution of drug policy in Ireland has a long, intricate and tortuous history (EMCDDA 2013; Randall 2011; Butler 2005; Butler 2002) that *is 'broadly comparable to the experience of other western countries'* (Randall 2011, p. 385). While it would serve little useful purpose to retrace it in any detail for this thesis, the reader must understand the broad sweep of drug policy development. This understanding will enhance the readers' appreciation of where rehabilitation is situated in the broader drug strategy context and position SCE within that context.

2.1.5. National Drug Policy: 1960–95

According to Butler (2002), before the 1960s, the singular instrument of drug-related policy in Ireland was the Mental Treatment Act (1945), and its references to addicts were primarily aimed at alcoholics. Since 1971, drug policy has been centred on a few reports, notable among them being the 'Report of Working Party on Drug Abuse' (1971). This report concluded, among other things, that rehabilitation was an essential part of any strategy, and interventions, such as counselling, self-development and education/vocational training, should be part of any recovery programme. However, in the 1980s, policymakers focused their attention on an expanding drug problem. Between 1979 and 1982, the National Drug Advisory and Treatment Centre saw an almost fivefold increase of problem drug users, rising from 319 to 1307, (European Drug Policy Profiles 2012). Large-scale drug dealing, an increase in heroin usage and the emergence of an 'injecting culture' gave rise to a marked change, particularly in Dublin. There was a concomitant rise in drug-related crime.

Furthermore, according to Quigley (2012), 27.8% of the 636 people tested by the National Drugs and Alcohol Treatment Centre (NDATC) in 1985 tested positive for human immunodeficiency virus (HIV). Apart from the economic recession that was gripping the

country, the ongoing political instability of the time (e.g. three general elections between 1981 and 1982) converged to create a vacuum in drug policy and practical actions. The Bradshaw Report, commissioned by the Irish government (1983, p. 36), made specific reference to the lack of community rehabilitation centres. The Special Government Task Force on Drug Abuse (1983) comprised no less than six ministers of state. However, the focus of the subsequent legislation on foot of this report was not on community rehabilitation; instead, it focussed supply reduction measures, including the Misuse of Drugs (Amendment) Act (1984; Butler 2002). Butler noted that there was a shift in the health-related response to drugs with the rise of HIV, albeit low key and certainly not part of a government strategy as such (Butler and Mayock 2005). This informal provision of services, such as needle and syringe exchange, condoms and advice on usage, was finally consolidated in the Government Strategy to Prevent Drug Abuse (Department of Health 1991). In 1991, drug policy was articulated for the first time in a strategy (National Coordinating Committee on Drug Abuse 1991). According to a top-level policy document, Ireland mirrored developments in other European countries, where drug policies were beginning to be carefully defined (Butler 2002). This new strategic direction also acknowledged that, to have any chance of success, *'treatment programmes for drug misuse must be linked to the provision of adequate social and employment skills'* (Keane 2007, p. 29). The report went on to suggest that the Drug Treatment Centre Board (DTCB) should take on a significant 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; Keane 2007).

2.1.6. National Drug Policy: 1996–2000

The next significant developments in drugs policy were initiated against a background of continuing concern about the increased incidence of injecting-related HIV transmission, the increasing mobilisation of communities against drug use (Quigley 2010; Butler 2007) and an escalating increase in drug use with a concomitant increase in drug-related crime (Kelly et al. 2007; Cominsky 1998; Keogh 1997). The coincidence of this increase in HIV, drug use and crime with the initiation of a new cross-departmental civil service structure called the Strategic Management Initiative gave rise to the Ministerial Task Force on Measures to Reduce the Demand for Drugs in 1996. Their report initiated significant

structural changes, which were to have lasting effects. These changes included the establishment of a cabinet sub-committee, below which sat an Inter-Departmental Group on Drugs. Beneath this tier sat a National Drug Strategy Team (NDST), which managed the newly established Drugs Task Forces and reported to the NDST. This report also reiterated a need for a *'coordinated approach to provide stabilised drug users with options for vocational education and social integration '(*Bruce 2004, p. 31). The then Minister for Enterprise and Employment agreed to a policy statement emphasising the following three key findings of the report: a) recovering Drug addicts who are linked to recovery services should be given priority status on CE schemes, b) work-ready former addicts should be given CE priority and c) FÁS/LES should work with employers to provide employment opportunities for people in these categories. This initiative saw community groups and the State agency working together to meet these aims. Randall (2011) suggests that this approach was to 'culminate in the publication of Building on Experience National Drugs Strategy 2001–2008 (2001); this *epitomised the "managerialist" approach to drug policy'* (p. 287).

2.1.7. National Drug Strategies: 2001–8

The first of three to date, the NDS strategy titled 'Building on Experience' (2001–8) was adopted in May 2001 by the Inter-Departmental Group on Drugs with the mission of 'reduction of harm caused to individuals and society by drugs misuse' (NDS 2001, p. 114). This first national strategy was instituted within the context of various international and EU agreements. Moran *et al.* (2000) suggest that the Political Declaration on the Guiding Principles of Drugs Demand Reduction (UN Special Session on Drugs, held in New York 1998), the UN Conventions on Narcotic Drugs and Psychotropic Substances, the EU Action Plan on Drugs 2000–2004 (Commission of the European Communities 1999) and the EU Drugs Strategy 2000–2004 (CORDROGUE 64 1999) influenced its drafting. This strategy's mission was *to 'provide an effective, integrated response to the problems posed by drug misuse and to work in partnership with the communities most affected by the drugs problem in tackling the issues raised'* (Moran and Pike 2009, p.42). It had designated agencies with specified targets, assigned tasks, reporting mechanisms, and built-in reviews to manage the process for the first time.

The objectives of government policy articulated in these various reports are condensed in the four pillars of the first NDS:

1) Prevention: Reduce the number of people turning to drugs in the first instance through comprehensive education and prevention programmes; 2) Treatment: Provide appropriate treatment and aftercare for those who are dependent on drugs; 3) Supply Reduction: Bring to bear appropriate mechanisms at a national and local level aimed at reducing the supply of illicit drugs; 4) Education: Ensure an appropriate level of accurate and timely information is available to inform the response to the problem. (Building on Experience 2001, p. 42)

The overriding principle of this NDS document was that the best way to approach the growing drug problem was to have a comprehensive strategy consisting of a suite of responses that addressed the causes of drug misuse and not just the consequences. It also identified a need to engage with community groups and voluntary organisations to leverage the 'experience and knowledge they have developed over the decades of working with drug use at a local level' (NDS 2001, p. 136).

The national strategy document identified the need for an inter-agency approach among all agencies that have a role in responding to the drug problem to effectively coordinate their individual and collective endeavours and contributions to form part of an overall coherent and integrated approach. It also recognised that the communities' expertise and experience could be brought to bear to respond to the drug problem.

A mid-term review of the NDS (2005) recommended, among other things, that *'rehabilitation become the fifth pillar of the Strategy'* (Keane 2007, p. 1). It also noted that calls had been made for the; 'development of a more comprehensive and interlinked approach to rehabilitation under the NDS' (p. 36); it went on to recognise the excellent work done by SCE projects in rehabilitation while noting the recommendations of the recently completed Bruce Review (Bruce 2004). In effect, while recognising some shortcomings identified by Bruce (2004), this mid-term report copper-fastened the SCE programme's use as a rehabilitation mechanism.

A subsequent report by the Working Group on Drugs Rehabilitation in June 2007 led to establishing the National Drug Rehabilitation Implementation Committee (NDRIC). This new committee was responsible for the implementation of the Working Groups recommendations. The salient recommendations for SCE programmes were that 'the

number of CE places should be increased from 1,000 to 1,300. A pre-stabilisation initiative, focusing on preparation for CE, should be developed' (HSE lead). Keane (2007) commented, *'These services should build on the strategy's achievements thus far and contribute to the social reintegration of current, stabilised and former drug users'* (p. 2).

2.1.8. National Drug Strategy: 2009–16

A review of the 2009–16 strategy indicates three relevant developments concerning SCE, which are as follows: 1) the *'implementation of the 4-tier rehabilitation model*' (p. 13), under which vocational training, education and supports fall into tier-1 interventions; 2) the proposed development *of 'national training standards for all involved in the provision of substance misuse services'* (p. 20); and 3) the announcement of plans *to '[c]oordinate training provision within a single national substance misuse framework. It will include the continued development of responsive training and educational courses and modules for people working in treatment and rehabilitation services to meet current and emerging needs*' (p. 20). These recommendations are examined further when considering the findings.

2.1.9. National Drug Strategy: 2017–25

The salient recommendations in the 2017–25 iteration of the NDS (Department of Health 2017) was a commitment to *'[examining] the range of progression options for those exiting treatment, prison, and CE schemes including key skills training and community participation to develop a new programme of supported care and employment*' (p. 86). These recommendations would imply the inclusion of SCE as part of this more comprehensive review. This document also recommends taking steps *to 'identify and remedy the barriers to accessing the range of educational, personal development, training and employment opportunities and supports, including gender-specific barriers and the lack of childcare provision, for those in recovery.'* (p. 86)

A key concept that pervades these three strategy documents is social partnership, particularly in state agencies and community organisations, especially in SCE projects. Concerning the functioning of social partnerships, Chomski's (2020) recommendation was to:

'ensure that all voices had an equal opportunity to be heard and to ensure that priority actions identified from the wider sources of evidence were not lost during the extended process. The breath of the partnership aided this. While we have succeeded in developing a sound strategy, success will depend on continuing support from the partnership and appropriate resourcing from the ministries.' (p. 8)

2.1.10. Special Community Enterprise

The DSP describes a dedicated drug rehabilitation scheme as a;

'*scheme where participants are referred to the project by a recognised drug rehabilitation service or agency' and the 'focus of the scheme is on rehabilitation, training and development; multi-agency co-operation is important for achieving successful outcomes of participants'* (DSP 2013, p. 3).

The use of an existing market activation initiative (e.g. CE) as a conduit for rehabilitative interventions may have initially looked attractive and facilitated almost immediate implementation. However, it required an alliance between community-based rehabilitation initiatives, where the focus had traditionally been on the individual's recovery, with FÁS's market-focused CE programme, with its focus concentrating on the labour supply and employment market. Not surprisingly, fault lines began to emerge almost immediately between FÁS and community sponsors on a whole range of issues, including age and employment status eligibility, attendance criteria (with no allowance made for participants who may briefly relapse) and employment outcome expectations.

2.1.11. The Bruce Review: 2004

The Bruce Review (Bruce 2004) was commissioned by FÁS (which had responsibility for the CE Programme before the transfer to the DSP in 2012) to provide a review of the SCE programme. The terms of reference for this review were as follows: 1) examining progression from SCE to the labour market in terms of effectiveness; 2) assessing whether SCE fit with broader aims of the drugs task force strategy and 3) determining at what point in the rehabilitative process market-oriented training should take place? (adapted from Bruce 2004, p. 5).

After consultation with a broad range of stakeholders, the Bruce Review drew several conclusions around 'Best practice, Inter-agency focus, Participant outcomes and Operational issues' (Bruce 2004, p. 86). In terms of best practice, Bruce (2004) noted that

'standardised staff training and development is a critical issue in terms of both rehabilitative and labour market remits' and *'[t]here is a lack of structure in the operation of some schemes'* (p. 87). Concerning inter-agency collaboration, it concluded: 'There is a lack of [an] integrated approach to resourcing projects where health agency involvement is present in addition to FÁS' (p. 88). In the section dealing with 'participant outcomes; ' Bruce (2004) states, *'CE is the main vehicle of response, and sometimes the only response, to the rehabilitative needs of clients'; moreover, '[e]ducational/training attainments and adult education methodologies are highly successful in promoting recovery, skills and progression'* (p. 91).

When discussing operational issues, Bruce (2004) points out that CE supervisors often provide therapeutic and rehabilitation inputs, noting that staff training and professionalism vary significantly from project to project. The report also highlights that funding and resources are not adequate to meet all the training, guidance, vocational and support needs required for a viable employment orientation. Finally, it concludes that many projects lack adequate premises and resources. In the discussion chapter of this dissertation (chapter five), we compare the findings of this review with the conclusions of this research to identify any change.

1.2.12. The National Drugs Rehabilitation Framework

The 'Report of the Working Group on Drugs Rehabilitation' (2007), recommended among other things the development and implementation of an 'Integrated Care Pathway' for those in recover from drug misuse. It acknowledged that *'If services are not co-ordinated, service users can have difficulty negotiating the complex service network, 'fall between the cracks,' fail to receive the help they need, and/or be subjected to unnecessary delays, frustration, trauma, and intrusion into their lives.'* (Doyle & Ivanovik, 2010, p.5). The National Drugs Rehabilitation Implementation Committee (NDRIC) was established as a coordinating group which would *deliver 'increased co-operation across the care continuum and that agreed interagency working arrangements would help create a common reference point for agencies to work to common goals for the service user, resolve any disagreements, or issues which in the long run only serve to disrupt the effectiveness of any drug intervention.'* (Ibid, p.6).

NDRIC propose a four Tier model:

Tier 1: interventions include the provision of drug-related information and advice, screening and referral to specialised drug treatment services. They are delivered in general healthcare settings (emergency departments, liver units, antenatal clinics, pharmacies, or in social care, education or criminal justice settings [probation, courts, prison]).

Tier 2: interventions are delivered through outreach, primary care, pharmacies, and criminal justice settings as well as by specialist drug treatment services, which are community- or hospital-based. The interventions include information and advice, triage, referral to structured drug treatment, brief interventions and harm reduction e.g. needle exchange programmes.

Tier 3: Interventions are mainly delivered in specialised structured community addiction services, but can also be sited in primary care settings such as Level 1 or Level 2 GPs, pharmacies, prisons, and the probation service. Typically, the interventions consist of community-based specialised drug assessment and coordinated, care-planned treatment which includes psychotherapeutic interventions, methadone maintenance, detoxification and day care.

Tier 4: interventions are provided by specialised and dedicated inpatient or residential units or wards, which provide inpatient detoxification (IPD) or assisted withdrawal and/or stabilisation. *(Adapted from the National Drug Rehabilitation Document: 2010, p.12).*

It would appear from this Tiered model that the work delivered by SCE while situated in Tier 1 has also got a lot in common Tier 3, which might create confusion.

2.2. Drug Recovery and Rehabilitation

2.2.1. Addiction Recovery and Rehabilitation Theory

The term *addiction* has a broad meaning that can be applied to a range of activities associated with both substance misuse (chemical; Singh and Gupta 2017; Everitt 2016) and behavioural (non-chemical) problems (Valero-Solís 2018; Andreassen 2015; Gainsbury 2015). For some researchers, addiction only involves drug-taking behaviour. However, there are strong reasons for extending the concept to other activities, such as gambling. Some would also argue that it can be extended to using the internet, consumption of palatable foods, purchasing behaviour, and sexual behaviours (Padwa and Cunningham 2010). By definition and choice, this study is only concerned with chemical addiction.

Defining substance addiction is not a simple task, and it is the source of much dispute inside and outside the drugs field. For example, Badiani (2004, p. 2923) suggests 'many different' ways we currently define addiction. At the end of the 19th century, it was used as a medical term to indicate pathological, compulsive drug use (e.g. Huntly 1896; Mattison 1892). At present, the *Oxford English Dictionary* (2020) defines addiction as *an 'inclination or proclivity for certain habits or activities, in both its positive and negative connotations, including excessive drinking and smoking'*. Addiction can also be used as a psychological construct to indicate a compulsive motivational drive (e.g. Lewis 2017; Kenneth et al. 2013; Robinson and Berridge 1993), or most recently, as a neurobiological pathology (Mertens 2019, p. 3). Given the wide range of definitions and the differing opinions of pathology and causation, it is proposed that this study avoids the diagnostic and semantic debate by concentrating on tangible manifestations of drug uses (e.g. physical and mental impacts related to and behaviours associated with drug-taking). This will provide a practical understanding of addiction for this dissertation, and the following section posits and discusses the behavioural model used in this study.

2.2.2. Drug Use, Misuse and Abuse

The nomenclature surrounding the taking or use of substances can be confusing, with definitions of drug usage ranging from the terse, e.g. *'the use of a substance for a purpose not consistent with legal or medical guidelines'* (World Health Organization [WHO] 2006,

p.23). To the broader concept of substance *misuse*, *'a condition may cause an individual to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption, and dependence'* (ACMD 1998, p. 165). However, the use of prefixes in '*ab*-use' and '*mis*use' can be unnecessary and pejorative. Therefore, in the interest of clarity, the Irish Health Promotion Unit's definition of drug use is employed for this study, where drug use is the:

'use of any drug, legal or illegal, which damages some aspect of the user's life; whether it is their mental or physical health, their relationship with their family, friends or society in general or their vocational functioning as students or as workers both inside and outside the home.' (p. 98)

This definition includes not only the use of illegal drugs but also the dangerous use of legal drugs, such as consumption of alcohol, the use of tobacco and the harmful use of prescribed medicines by exceeding the recommended prescribed dose, as well as the illegal use of legal drugs, such as drinking and driving or smoking cigarettes in a non-smoking area' (Corrigan 2004, p. 4). Viewing drug use as a continuum of behaviours with distinct stages, reasons and consequences ranging from therapeutic to dependency frees us from competing definitions, labels and assumptions while concentrating on the issues (see Table 2.1).

Table 2.1 Continuum of Drug Use (shaded areas represent areas of harmful use)

Stage	Drug Use	Reasons	Consequences
Beneficial Use	Pharmaceuticals, coffee/tea to increase alertness, moderate consumption of red wine, ceremonial use of tobacco	Health, spiritual or social benefit	Positive health, spiritual or social impact
No Use	None	Personal choice, religious or cultural beliefs, health-related concerns	No health/social consequences
Experimental Use	Use is often only at weekends, limited to the first couple of times the person tries a drug	Curiosity; peer/social pressure; to rebel	Minimal consequences: occasional hangover Gain status and new friends

Occasional/ Social Use	Occurs 1–3 times per month or less Use is never excessive	Social Positive effects	Minimal consequences Never severe negative results
Regular Use	Use becomes more frequent May occur daily, before work, lunch, etc. Stronger drugs are sometimes tried Person still using substance responsibly and in controlled manner	Becoming an integral part of person's life; friendships are developed with people who are using	Some negative effects Beginning carelessness about time, work, rules, personal responsibilities and relationships No major interference in any area of life
Problematic Use	Usage tends to become excessive; higher doses may be used due to tolerance, or the individual may try stronger drugs or combine drugs Habit or pattern of substance use is developed and becomes the norm around which activities must revolve	Use becomes a lifestyle preference to cope with negative withdrawal symptoms or avoid stress, feelings, responsibilities, family and other relationship conflicts	Physical problems: loss of weight, blackouts, sickness Psychological problems Mood swings, anxiety, aggression Illegal activities such as robbery or prostitution
Addiction or Dependency	Drug use becomes a preoccupation, and is the centre of any interaction Inability to predict or control drug use Periods of abstinence tend to be short-lived and very traumatic Activities other than drug use are avoided Extreme intoxication is common Previously unthinkable methods of using the drugs	To feel acute chemical intoxication to avoid both physical and psychological pain of withdrawal To feel normal To be able to function To forget To medicate mental illness	Serious negative consequences arise in many areas of life Person has difficulty understanding and accepting that drug use may because of many problems Physical problems: weight loss, blackouts, sickness, uncontrollable behaviour like aggression, extreme feelings of guilt and self-hate Illegal activities, such as robbery or prostitution

	become possible		Avoidance of school, work, family, friends and users Isolation

Table 2.1 (Source: 'Core Addictions Practice – Participant's Resource Guide'; Fraser Health Authority, Vancouver Island Authority, Interior Health Authority; June 2008).

We can visualise drug *misuse* as a subset of the continuum ranging from experimentation to dependency (*see Fig. 2.2*).

Fig. 2.2

This conceptual framework of drug use as a process provides a more precise tool by which different types of drug usage can be more accurately assessed to target interventions. The first three stages in this process, while not being without consequences (see Table 2.1 above), have minimal to manageable effects on drug users' lives. The remaining two phases, problematic use and dependency, are the areas where the participants who populate SCE projects are situated; therefore, these areas are the focus of our research cohort's work. We now explore them in more detail.

Problematic drug use is not solely defined by the quantity or frequency of substance usage, but rather, it is related to the problems it creates in the individual's life. These problems can range from mental health problems (Park-Lee 2017), job loss (Henkel 2012), to family breakdown (Drugs.ie 2020) and financial issues. Dependent use combines all the issues associated with problematic use with a raft of other issues, such as physical health issues (Smyth et al. 2004; Smyth et al. 1998), mental health issues

(Mackesy-Amiti 2015), past trauma (Garami et al. 2019; Berg et al. 2017), homelessness (Thiyagarajan et al. 2018; Johnson and Fendrich 2007), compulsion, criminality (McClellan 1997) and stigma (Young et al. 2005). Along with the concomitant feelings of, for example, guilt, low self-esteem and anxiety (Giacomucci 2020; da Silveira 2018; O'Connor et al. 1994), and behaviours like aggression, argumentation and isolation (Mustafa 2019; Walker et al. 2019), these issues manifest in SCE participants. In reality, they shape the day-to-day work of the managers, supervisors and drug workers of this research sample, who are required to function within this complicated interpersonal milieu. This complexity is exacerbated by the delicate balance between developing a therapeutic relationship and simultaneously managing a power differential of employer and trainer.

2.2.3. SCE Participant Demographics and Drug Use

The last report by DSP (2013) provided a breakdown of participant numbers, ages and educational attainment from January to 2012; at that time, there were 824 participants attending drug rehabilitation places on SCE programmes. There was no decrease in participation in drug rehabilitation programme nationally in the 12 months from January to December 2012.

This report *indicates 'distribution of drug rehabilitation places by age and gender at December 2012; Males take up 56 per cent of drug rehabilitation places in SCE and females 44 per cent'* (DSP 2013, p.6).

The same report goes on to find that:

'over three-quarters of participants (79%) are between 25-54 years of age. Thirty-four per cent of places (278) are taken up by participants between 25 and 34 years of age. A further 35 per cent of places (287) are taken up by participants in the age category 35-44 years of age, and 10 per cent (86) by participants in the age category 45-54. Eight per cent of participants are 55 years and over' (ibid, p.6).

Just 3 per cent of participants are under 25. While the minimum age for participation on a standard CE programme is 25 years of age, this requirement was reduced for those participating in drug rehabilitation projects to recognise the specific needs of SCE participants.

The DSP reported participants' education level on drug rehabilitation places in December 2012 as follows:

'nearly sixty per cent of participants had FETAC level 3 or below on entry to CE. A quarter of participants (208) had completed primary level education (level 2) or had no education; a further 33 per cent had completed a FETAC level 3 course such as the Junior Certificate or equivalent. Eighteen per cent had achieved a Leaving Certificate or equivalent' (DSP 2013, p.6). While:

'thirteen per cent had a 3rd level qualification. There was no education level entry recorded for 11 per cent of participants. There is an inverse relationship between educational attainment and gender. 22 per cent of females had Leaving Certificate level education compared to 14 per cent of males. Conversely, 39 per cent of males had Junior Certificate level education compared to 26 per cent of females. 27 per cent of males had primary level/no education compared to 23 per cent of females'(Ibid, p.7).

The following figures outline the welfare status of participants in drug rehabilitation places in December 2012. Participants in receipt of Job Seekers Allowance (341) and Job Seekers Benefit (40) made up 46 per cent of all participants. Participants in receipt of a disability payment (Disability Allowance, Illness Benefit and Invalidity Pension) made up 30 per cent of all participants. Participants in receipt of the One Parent family Payment made up:

'18 per cent (150) of all participants, almost all of these participants were female, except for four males. Together these three cohorts made up 94 per cent of all participants in drug rehabilitation places. Of the males participating in drug rehabilitation places over a half (56%) received Jobseekers Allowance and Job Seekers Benefit' (Ibid, p.8).

Surprisingly there are no statistics available which specifically relate to drug use patterns SCE participants, indicating an area which requires future research. However, to provide the reader with some sense of SCE participant drug usage, overall drug use figures for the period 2013-2019 are included hereunder.

According to the National Drugs Treatment Reporting System (NDTRS), 67,875 cases of problem drug use we treated, and *the 'treated cases recorded increased from 9,006 in 2013 to 10,664 in 2019'* (HRB 2019, p.1). Apart from alcohol, the main drugs problem drugs in this period were:

1) **Opiates:** Mainly Heroin, was the most commonly reported problem drug. There was a slight decrease in the proportion of new cases among opiate users from 38.6% in 2013 and 37.3% in 2019 (HRB 2019, p2).

2) **Cocaine:** Mainly insufflate (Snorted), with growing evidence of smoking, was the second most common drug reported in 2019, having ranked third since 2015. The proportion of cocaine cases increased *'from 7.9% in 2013 to 24.0% in 2019'* (Ibid, p2).

3) **Cannabis:** Including resin and weed, was the third most common primary drug reported in 2019. The proportion of cases treated decreased from; *'28.7% in 2013 to 23.5% in 2019'* (Ibid, p.2). *Cannabis was the most 'common primary drug among new cases in 2019'* (Ibid, p.4).

4) **Polydrug use:** The proportion of polydrug use cases decreased from 62.9% in 2013 to 55.0% in 2019. The most commonly reported combination drugs were *'Alcohol (37.3%), cannabis (37.0%), benzodiazepines (35.6%), and cocaine at (32.9%)* respectively (Ibid, p.2-3).

Thus, among the national drug use figures between 2013-2019, we can see an 11.5% increase in overall numbers reporting problematic drug use. A slight decrease in heroin use which is still the primary problem drug reported to NDTRS and cocaine use overtook cannabis to become the second most commonly reported drug problem. Reported cannabis use problems were third in the HRB bulletin with a drop of 5.2% over the period 2013-2019; however, it was the most common drug reported among young users in 2019. Polydrug use was down by 7.9% for 2013-2019, with alcohol being the main secondary drug.

While the above figures do not pretend to analyse drug use patterns on SCE projects, they will, in the absence of specific data on SCE, provide a broad picture of drug types, usage and trends generally for the past seven years.

2.2.4. Opiate Substitution Treatment and Methadone Maintenance

Opiate Substitution Treatment OST first appeared in Europe in the late 1960s in response to emerging and later expanding heroin use (Verster & Buning, 2000) and in Ireland in 1969 (Keane 2001). The fourfold aim at the time according to Solberg et al. (2002) were (a) reducing infectious diseases such as hepatitis and HIV/AIDS; (b) improving the general health of problem drug users; (c) reducing drug-related crime, public nuisance and raising urban safety; and, (d) complementing traditional addiction care by diversifying treatment options to meet the needs of clients more effectively.

"Methadone maintenance treatment is the most common form of treatment for opiate dependency in Ireland and is generally provided by specialised clinics under medical supervision" (Van Hout and Bingham 2011, p. 5). It has displayed effectiveness in enhancing the quality of life, reducing overdose and restricting the spread of HIV and Hepatitis virus among intravenous drug users (Cox 2007). Van Hout and Bingham (2011) cite research by (Ball *et al.*, 1988; Sorensen and Copeland, 2000; Corsi *et al*., 2002; Esteban et al., 2003; Sheerin *et al.,* 2004; Teesson *et al*., 2006; Gowing et al., 2006; Mattick *et al.,* 2009) in supporting their contention that MMT has an impact on *'reducing drug use and risk activities such as needle sharing, improving health outcomes and reducing mortality, reducing criminal activity, and stimulating social, educational and employment engagement'* (p.5). It is an essential component of community-based approaches insofar that the treatment is offered on an outpatient basis, resulting in significant treatment retention rates and capacity to successfully address health issues, psychological problems, family relationships, housing, employment and financial issues (Ibid, p.11)

McLennan et al. (2015, p254) suggest that *'Treatment of heroin addiction does not fit an acute care paradigm, with the objective of cure, but is better conceptualised as the management of a chronic condition'* and that there is a range of opiate substitutes available to medical practitioners including commonly prescribed partial agonists buprenorphine and Methadone. Opiate substitution provided through Methadone Maintenance Treatment (MMT) is *'the most common form of treatment for opiate dependence in Ireland'* (Van Hout & Bingham 2014, p.49). Since 1992, it has been prescribed in Ireland and medically managed by doctors in addiction clinics under formal protocols (Butler 2002). Van Hout and Bingham (2013) cite Amato et al. (2011) and Ward et al. (1999) in support of MMT having positive outcomes including *'stabilise the opiate user's lifestyle, reduce criminality, polydrug use and harms related to injecting drug use'* (Van Hout and Bingham 2014, p.49). Svikis *et al.* (2012) and Dunlap *et al.* (2009) identified low employment rates, lack of prior employment history and employment-related skills, low motivation, poor literacy and numeracy skills as being prevalent among MMT recipients. Van Hout and Bingham (2014) found that *'client participation in MMT both assisting and hindering uptake and participation in vocational and educational training'* (p.53), this paper also identifies dosage levels as being an issue perceived by

participants as affecting their ability to engage and partake in training activities. However, in general, participants saw SCE as a *'Good thing'* (p.56).

Gossip et al. (2001), Lawless (2006) and Van Hout and Bingham (2012b); all confirmed the positive view taken by service providers concerning MMT, which they all saw as providing benefits. Including the capacity to improve the individual's functional ability, while presenting '*a window of opportunity for the individual to create a new daily routine, create new relationships with partners, children, peers and friends, and improve readiness for engagement in learning, vocational training and employment directed outcomes*' (Van Hout and Bingham 2014, p.57)

However, Van Hout and Bingham (2014) highlights stakeholder concerns around long term provision of Methadone and high dosage *'which were observed d to hamper social activity, engagement and retention of information when in vocational training, job seeking and employment prospects on exit'* (p.56). Van Hout and Binghams' (2014) research also supports points made by Lawless (2006); indicating the need for debate about the direction of SCE, and its role. On the one hand, it is seen as therapeutic, capacity building, enhancing wellbeing, and quality of life; while on the other there is a need for the more market-focused specific work-related skill and job opportunities.

Van Hout and Bingham (2014) concurred with Cork Simon Community (2012); who described the need to provide housing to underpin recovery. While, (Binswanger *et al.,* 2011; EMCDDA, 2012; Prison Drug Treatment Strategy Review Group, 2010) indicated a similar need for pre- and post-prison release recovery planning for prisoners undertaking a recovery programme. The literature indicates a need to foster relationships with minority communities to research their detox and recovery experiences, prison release, housing, vocational educational pathways, and social reintegration. (Beddos *et al.*, 2010; Maycock *et al.,* 2009; Van Hout, 2011 and Van Hout & Bingham 2014)

In Ireland (on foot of EU recommendations in 2012) clients who stabilise on MMT are encouraged to partake in SCE programmes. According to Van Hout and Bingham (2013) 'outcomes for SCE schemes in terms of their approach, ethos, drug-related stabilisation, abstinence, community rehabilitation and employment are mixed' (p.50).

Both Van Hout and Bingham (2012b) and Lawless (2006) found some evidence that participants in SCE programmes had some positive outcomes in developing social capital, wellbeing and training activity. They also found that 'outcomes in providing assistance to secure employment were poor' (van Hout and Bingham 2014, p.50).

From a medical perspective, the literature indicates differences of opinion on MMT (Van Hout 2014b; Gjersing et al. 2010; Lloyd 2010). With some doctors viewing MMT viewed as using one drug to replace another (Lloyd 2010) most experience difficulties in *'patient uptake, retention and organisation of treatment'* (Van Hout & Bingham 2014b, p227).

2.2.5. Legal Highs, Head Shops and Novel Substances

In common with many European countries, Ireland in around 2009 experienced the emergence of 'Head Shops' or establishments which sold legal highs (van Hout & Brennan 2011; Hillebrand *et al*.,2010). Legal Highs can be described as 'psychoactive drugs which, while not in themselves illegal, mimic the effects of commonly used illegal drugs' (Ryall & Butler 2011, p. 303). The authorities' initial attempts to apply existing legal control systems to head shop products were frustrated because once a specific compound was identified and banned under existing drug legislation. On foot of public debate, 2010 saw the banning of a range of psychoactive substances available in Head Shops under the 1977 Misuse of Drugs act.

These included:

'synthetic cannabinoids (commonly known as 'Spice'); benzylpiperazine (BZP) derivatives; and mephedrone, methylone and other related cathinones often referred to as 'Meow Meow' or 'Snow'" (Ryall & Butler 2011, p. 304). In addition, the 'Irish government also enacted new criminal justice legislation – the Criminal Justice (Psychoactive Substances) Act 2010' (Ibid, p. 304).

However, Van Hout and Brennan (2011) among others suggest a change in the patterns of drug use; noting that research has indeed identified a displacement in drug transitions from illicit drug use toward that of 'legal high' consumption (Hammersley, 2010; Measham *et al.,* 2010). Van Hout and Brennan (2011), go on to point out the high street availability, quality, cost-effectiveness and perceived legality have created a new population of drug users 'subterranean drug cultures involving teenage gatherings, polydrug repertoires of seasoned clubbers' (Moore 2004, p33), psychonauts (Newcombe,

1999, 2008), and Internet users over 40 years old*, 'many with no previous experience of illicit drug use'* (Measham *et al.,* 2010,p.16).

The emergence and adoption of these novel drugs into common usage has led to a need for updating treatment methods for drug workers encountering this type of substance use. Network, NPTU. (2015) identified a need for guidance in managing individuals using club drugs and novel psychoactive substances including 'detection, identification, assessment, management and harm reduction' (Ibid, p.5).

To understand the complexity of the work undertaken by employee's on SCE projects the next section provides a brief overview of addiction models, encompassing a wide range of overarching theories about the causes of addiction and how to go about enabling recovery. Different SCE sponsoring bodies adhere to distinct addiction models, and therefore, they use model-appropriate approaches and interventions to achieve recovery. The SCE workers in our sample are required to work within one or sometimes more of these models.

2.2.6. Theories and Models of Addiction

'All models are wrong, but some models are useful.' (Box 1997, p.35)

This section provides an overview of addiction's theoretical models to provide insight into the range of approaches drug workers working within the SCE projects employ in their day-to-day work. Rasmussen (2000) contends that there are three broad categories of theoretical models, which are as follows: a) conventional, b) contemporary and c) comprehensive. Each category contains a subset of model concepts. While by no means exhaustive, this overview of the literature can provide a working description of the multiplicity of theoretical lenses through which drug addiction is viewed and their concomitant recovery strategies and interventions. It also contextualises and places the research cohorts' working practices within a conceptual framework

a) Conventional Theories of Addiction

West (2013) contends that, in the category of conventional theories of addiction, pathologies exist due to *'abnormalities in the "motivational system" which exist*

independently of the addictive behaviour' (p. 230), such as anxiety, personality, character and sense of spirituality.

a.1 Moral Model

The moral model suggests that a person who possesses moral strength would have the required strength of will and character to resist or desist from using a degenerative substance. It is often assumed that this moral strength is found in the ethical base of religion. Corrigan (2009) argues*, 'Believing someone is responsible for his or her mental illness or drug-related disease suppresses helping behaviour'* (p. 140). Moreover, Henderson and Dressler (2017) contend that the stigma attached to the moral model has two distinctive features. First, it views drug use as a choice, also known as *volitional*, even for addicts. Second, it adopts a critical moral stance against this choice. Thus, when addiction is viewed as volitional, those who are addicted are considered people of bad character with antisocial values: They are selfish and lazy, and they supposedly value pleasure, idleness and escape above all else, which they are willing to pursue at any cost to themselves or others. Studies in the United Kingdom found that a common conception among the public was that drug 'addicts' were unpredictable and dangerous and believed that drug addiction was self-inflicted (Crisp *et al.* 2000, Luty & Grewal 2002). The 'recovery' process inherent to the moral model requires abstinence, atonement, penitential elements and spiritual enlightenment. While few modern practitioners would use this model as a basis for their practice; e.g. *'We do not consider this model to be a therapeutic model'* (Marino 2006, p. 215). However, it does implicitly or explicitly contribute to, and to some extent, justify the shaming, prejudice, and injustice that societies worldwide tend to exhibit toward those who use drugs (Pickard 2016). Attitudes based on the Moral Model impact SCE participants in their everyday lives. The workers within the SCE projects must be cognisant of how this social negativity impacts participants, including stigmatisation for attendance on programmes, to media portrayal. Thus, SCE workers need to provide an environment which is non-judgemental and encouraging of unconditional positive regard.

a.2. Disease Model of Addiction

The disease model suggests that dependent drug use is a mental disorder or brain pathology (Cicchetti 1999; Glantz & Hartel 1992; Jellinek 1960). This introduction of a

medical paradigm shifted the emphasis from apportioning blame to offering a practical methodology of diagnosis and prognosis and viewing the addict as a victim of illness. Kincaid and Sullivan (2010) describe the medical model in its purest form as viewing addiction as having the following features: a) the individual has a set of characteristic observable symptoms, b) the symptoms are caused by a physical condition that is a deviation from normal functioning, c) the deviation can be situated in the body and d) the physical condition is necessary and sufficient to have a disease. Hymen and Malenka (2001) noted in a meta-analysis that there was agreement among many addiction researchers that *'addiction can appropriately be considered a chronic medical illness'* (p. 695). However, there are many arguments against this model, not least in that the causation must be centred within the individual (no external influences). By linking social/economic factors to addictive behaviours, Ross et al. (2007) provide some evidence to support the notion that not all addictions conform to this definition of the medical model.

More recently, neuroscience has impacted substance abuse theory, and brain disease theory, particularly Pickard's (2015) research, which has identified a range of such neurological changes. These include (but are not limited to) the long-term depression of reward circuitry and increased activity in anti-reward circuitry of the brain (Koob and Le Moal 2008). The disease's recovery regimen dictates abstinence, external and professional help, diagnosis, medication and psychiatric and physical support and care.

The disease model is the model underpinning the HSE's approach to addiction. As a significant financial contributor to community projects, this model has resonances within the project who have an SCE recovery programme as part of their service. Most participants presenting for SCE would be in the medical treatment of some form. SCE participants indicate that methadone maintenance can stabilise and enhance motivation to engage (Van Hout & Bingham 2012), which is harnessed by SCE workers deployment of MI skills (Miller & Rollnick 2014). However, strong evidence shows that people undergoing MMT exhibit psychomotor and cognitive impairment (Pirastu et al., 2006; Prosser *et al.,* 2009; Specka *et al.,* 2000). This evidence requires SCE workers to be particularly aware of issues regarding 'attention, working memory and episodic memory' (Rass *et al.,* 2014) when engaging and working with participants. Van Hout and Bingham (2012) found that MMT patients *'ran an additional risk of continued use of non-opioid*

substance' (p.64) such substances could include the use alcohol, cannabis, prescribed medication such as benzodiazepines (Kelly *et al.*, 2006, Cox *et al.,* 2007). This additional polydrug use requires vigilance and appropriate interventions from Our cohort of SCE workers.

a.3 Minnesota Model of Addiction

According to Cook (1988), the Minnesota model of addiction, named after the state in which the Hazeldine Foundation first promulgated this concept, has many different appellations. These include a 12-step *programme*, the *abstinence model* and *fellowship*. However, all these iterations stipulate abstinence and are similar in many respects. The most common system based on this model is Alcoholics Anonymous (AA) and its offshoots, Narcotics Anonymous (NA) and Cocaine Anonymous (CA). The history of AA is well described elsewhere (Robinson 1979; Leach and Norris 1977; Alcoholics Anonymous 1976); it suffices to say that it has its core the disease or illness concept of alcoholism or drug addiction (Wells 1987; Anderson 1981; Siegler et al. 1968). It also involves aspects of the moral model; as (1999) puts it, *'it is in the sense of the alcoholic's responsibility to act: to admit, ask, accept, confess, pray, etc.'* (p. 11). In a criticism of AA, Milam and Ketcham (1983) argue that the organisation has *'fixed the blame for contracting the disease squarely on the victim'* and *'mistaken the psychological consequences of alcoholism for its causes'* (p. 140). However, its unique selling point is that it 'clearly points to the agency of a higher power' (Miller and Kurtz, 1999, p. 11).

The Minnesota model has widespread support among American psychiatrists (Miller and Francis 1986). However, it is probably subject to more criticism in European countries (e.g. Glatt 1976). Notwithstanding, many of the participants who enter SCE programmes for rehabilitation have conducted their detoxification under the Disease/Minnesota model and continue to attend meetings. Therefore, our drug worker cohort requires knowledge of, and sensitivity to, the tenets of this recovery modality, which may have been transformative for participants, who may find it disconcerting or challenging to work within other modalities.

b) Contemporary Theories of Addiction

The range of psychological models of addiction span the depth and breadth of the psychology research spectrum. Including psychopathological, behaviourism, cognitive

and psychoanalytic psychotherapy, each with its pillars and tenets of practice. This section examines the most commonly applied models pertinent to our understanding of the practices most relevant to our research cohort.

b.1 Psychopathological Model of Addiction

The psychopathological model views the causation of addiction as a mental disorder (e.g. Glantz 1992; Block et al. 1988; Kandel 1978). This model includes cognitive difficulties, mood disturbances and other mental illnesses. It is common for a co-morbidity of addiction and a mental condition to present in a dependent user. According to Miller et al. (2011), approximately 50% of people seeking help or treatment for drug addiction will also have another significant mental disorder. Related to psychopathology is the concept of an *addictive personality*, and while this concept as a singular condition is refuted by most researchers (Clark 2007; Saulsman and Page 2004); it can be more accurately thought of as a *'conceptualisation of personality disorders based on different combinations of underlying traits'* (Pedrero-Pérez 2011, p. 3). It contends that addiction occurs at a higher frequency among individuals with certain personality disorders, such as paranoia (Miller et al. 2001) and antisocial personality disorder (Verheul et al. 2005). Psychotherapy attempts to identify and resolve these underlying psychological disorders. It may include restructuring the personality and improving a person's cognitive and emotional functioning.

Dual diagnosis or co-morbidity of mental illness provides unique challenges for the SCE drug worker, not least around identification and first-line response to suicide ideation and self-harm. While referral to a psychiatric medical professional is always advised, many SCE participants exhibit pronounced symptoms such as paranoia, psychosis and delirium while in the project.

b.2. Behavioural Models of Addiction

Behavioural models of addiction in psychology emphasise the importance of learning and learned behaviours. According to Stepney and Ford (2000) and Loughran (2011), they are based on the early work by Pavlov (1849–1936), Watson (1878–1958) and Skinner (1904–90). Many classic experiments relating to addiction were interpreted through the paradigm of classical or operant conditioning, reward and reinforcement. More recent interpretations of addiction for the behaviourist have been more egalitarian. McAteer et

al. (2006, cited by Webb et al. 2010) suggest *that 'the mechanisms of developing addiction or substance dependence involve cognitive, emotional and physiological processes, the manifestations of addiction are largely behavioural'* (p. 291).

Intervention strategies based on behavioural models include cognitive behavioural therapy (CBT), which looks at the following:

'1) How people become motivated to change behaviour (e.g. form an intention), 2) how they translate this motivation into actual behaviour change, and 3) how they maintain newly adopted behaviours and reduce the risk of relapses' (Webb 2010, p. 1880).

The core premise of this treatment approach, as pioneered by Beck (1970) and Ellis (1962), holds that maladaptive cognitions contribute to the maintenance of emotional distress and behavioural problems.

CBT refers to a family of interventions that combine various cognitive, behavioural and emotion-focussed techniques (e.g. Hofmann 2011), including RP. RP focuses on identifying and preventing high-risk situations (e.g. favourite bars, friends who also use). An individual may be more likely to engage in substance use (Marlatt & Gordon 1983). Contingency management (CM) approaches are grounded in operant learning theory and involve the administration of a non-drug reinforcer (e.g. vouchers for goods) following demonstration of abstinence from substances (McHugh *et al.*, 2010). Like CM, the community reinforcement approach (CRA) as described by Meyers *et al.* (2011) and Hunt & Azrin (1973) focuses on altering contingencies within the environment. These contingencies (e.g. inclusion of favourable non-alcohol-related activities in the patient's daily schedule) make sober behaviour more rewarding than substance use. Evidence from numerous large-scale trials and quantitative reviews supports the efficacy of CBT for alcohol and drug use disorders (Magill 2009; Carroll *et al.*, 1994).

Motivational interviewing (MI), developed by Miller and published by Miller and Rollnick (1991, 2012), is closely associated with work by Prochaska and DiClemente (1982) on how change happens, and it involves working with clients to enhance self-efficacy and self-belief in changing drug habits. Although these strategies greatly emphasise cognitive factors, physiological, emotional and behavioural components are also recognised for their role in maintaining the disorder. There is an evidence base that an integrated approach that combines mental health and substance use approaches (such as cognitive

behavioural therapy and motivational interviewing) can be beneficial for people with severe mental health and substance use problems (Barrowclough 2001; Kavanagh 2004). Therefore, it is incumbent on drug workers generally and therefore SCE workers to possess knowledge and skills of MI and CBT (Roth and Pilling 2007) to provide brief interventions and facilitate reflection.

b.3. Psychoanalytic Model of Addiction

Khantzian (1974), Khantzian et al. (1974) and Wurmser (1974), among others, suggests that the origins of addiction might lie in deep-rooted childhood trauma. Psychoanalytic and psychodynamic theorists have been prominent in developing theories of drug dependence based on personality factors. The psychoanalytic model is based on ego theories embedded in human behaviour, and therefore, sees addictive behaviour as maladaptive. According to Loughran (2011), the concepts of psychoanalytic theories derived from the original work of Freud (1900), and they were subsequently developed by the post-Freudians (Adler *et al.,* 1956), specifically, Lacan (1958), Jung (1936), Stevens, (1994) Erikson, (1950), Klein (1927) and Looes (2003). Loughran (2011, p. 36) argues that *'the (overarching) goal of psychoanalysis is the restructuring of the personality through the freeing of the unconscious, and the therapist's role is as a non-directive passive observer and interpreter'*. According to Aguilera (1990), psychotherapy's goal is to 'remove specific symptoms and *aid the prevention of developing deeper neurotic or psychotic symptoms*' (p. 25). While psychoanalysis is a profession with distinct qualifications and codes of conduct, the SCE drugs worker must be cognisant of the potential unconscious dimension of a service user's makeup. Understanding the concepts and manifestations of transference and countertransference can prevent boundaries issues and interpersonal relationships difficulties between project workers and participants.

Psychological and mental health issues are common among drug treatment clients. (Lee, 2011). Gournay *et al.* (1997) and (Bailey 2020), stress the importance of early and integrated treatment for co-morbidity by front line drug workers. Drugs and Alcohol National Occupational Standards (DANOS 2008) posits several critical functions for drug workers including; to *'Promote, monitor and maintain health, safety and security in*

the working environment'(p.14). *'Assess and act upon the immediate risk of danger to substance users'*(ibid, p.15) both of which imply working with mental health issues, personality and wellbeing requiring a least a basic understanding of psychological models. While a fully integrated mental health and drug treatment system would be ideal, financial, political and structural impediments exist. (Burnam & Watkins 2006), thus much of the burden falls to front line services and SCE drug workers.

b.4 Sociological Model of Addiction

The sociological model of addiction turns its lens outward, towards the environment. Lindesmith's (1969, 1940, 1938) studies are considered seminal in the understanding of addiction from the sociological perspective of groups; these groups can include families (Hawkins *et al.,* 1992), organisations, social ritualism (Waldorf 1991) and cultures (Bourgois & Schonberg 2009). From this perspective, addiction is a harmful behaviour that affects both the individual and the group. As such, we can only understand and correct addiction within the context of the groups in which it occurs. Socio-cultural theories emphasise the importance of social attitudes towards addiction and point to those attitudes surrounding alcohol and drugs as the cause of many people's decision to start abusing these substances (Ciarrocchi 1993). The ambivalence of Irish people towards excessive alcohol consumption is a prime example of this socio-cultural context.

Pattison and Kaufman (1989) and MacNeice & DiNitto (1998) offer a multivariate model that encompasses a 'constellation' of environmental and social causes for addiction. However, healthcare and human service professionals have advocated for the public health model. This model attempts to encompass many possible causes of addiction and involves looking at the agent, host, and environment interaction. The National Association of Social Workers (cited by Abbott 2000) suggests that social workers should consider that *'social, economic, and environmental factors contribute to alcohol, tobacco, and other drug abuse'* (p. 911). The SCE drug worker has a close affinity with this aspect of the milieu by being embedded in the community they serve; and as such are acutely aware of the social and environmental stressors affecting the SCE participants. Much SCE time is spent working to identify these stressors such as peer pressure, availability and social marginalisation is a prime responsibility of the SCE workers' job.

c) Comprehensive Theories of Addiction

A report by the DSP (2015) underlines the importance of comprehensive models in that;

'…it is recognised that addiction is a complex, bio-psycho-social phenomenon. Accordingly, there is no single rehabilitation model that suits all individuals. A range of factors will affect a participant's progression towards recovery, with relapse a recognised feature of this process' (p. 11).

c.1 Bio-Psycho-Social Model

Implicit in the bio-psycho-social model's rather unwieldy title is a concept that intends to encompass all the models discussed above. The three elements of this compound word can be understood as follows: The *bio* element contains the disease, medical, biological and neurobiological models, among others; *psycho* comprises the elements relating to the psychological, psychoanalytic and personality models; and the *social* element represents models that view the influences of drug use as social functioning, family coping and social deprivation.

Goodman (1995) suggests that the problem of addiction embraces many facets, including biological, behavioural, social-interpersonal and psychodynamic issues; however, most treatment modalities and providers are trained to specialise in delivering treatment within just one or two of those models. This view is supported by Becoña (2018), who cites Hall *et al.* (2015) in saying that 'addiction is a complex biological, psychological, and social disorder that needs to be addressed by variety clinical and public health approaches' (p. 109). While Skewes and Gonzales (2013) note that *'biological/genetic, psychological, and socio-cultural factors contribute to substance use, all must be taken into consideration in prevention and treatment efforts'* (pp. 61–62).

The bio-psycho-social model, which is used to describe many combinations of mental disorders, psychological dysfunctions, biological pathologies and social influences, is arguably the most prominent construct used to conceptualise addiction, particularly among community response groups (Alonso 2004). It is by far the most prevalent model used by the SCE projects involved in this study. This model's holistic nature is attractive and encourages a broad spectrum of recovery approaches, including medical interventions, counselling, family support, RP, and building recovery capital (RC). Skewes and Gonzalez (2013) posited, *'Recovery from addiction requires a bio-psycho-social approach with attention paid to biological, psychological, and social aspects of addiction'* (p. 68).

2.2.7. Recovery

As recovery is at the core of the work done by SCE managers, supervisors and project workers, a clear understanding of the theories and practices around the area of recovery will provide us with an armature on which to situate the work done by, and the experiences of, our research cohort. The literature exhibits some confusion around the concept of recovery (Ashford 2019; White 2008; Kelly 2004; Milgram 2004). This confusion can affect the programme delivery; in that, the absence of a commonly accepted definition of recovery can cause ambiguity and variance in the reportage of treatment outcomes (Ashford 2019; Maddux & Desmond 1986). This situation can result in, at best, confusion, frustration and a lack of clarity among stakeholders, and at worst, undermining of service delivery. The British vision of recovery, developed by the United Kingdom Drug Policy Commission (2008), is characterised as *'voluntarily sustained control over substance use, which maximises health and well-being and participation in society's rights, roles, and responsibilities*' (p. 6). In contrast, the Betty Ford Clinic (2008) suggests that recovery is a '*voluntarily maintained lifestyle characterised by sobriety, personal health and citizenship'* (p. 12). However, White (2007) stresses that the complexity of the subject requires that defining recovery contains wording that can encompass four quite different uses of the term, which are as follows:

'(a) recovery as the lived experience of individuals and families; (b) recovery experience within communities sense of recovery; (c) recovery as an outcome that can be measured by scientists and those responsible for monitoring and evaluating behavioural health care systems, and (d) recovery as both an organising vision/goal and a benchmark of accountability for complex service systems.' (p. 233)

Meeting all these criteria in a definition is no small feat; however, White (2007) offers the following definition, which will be used for this study:

'Recovery is the experience (a process and a sustained status) through which individuals, families, and communities impacted by severe alcohol and other drug problems utilise internal and external resources to voluntarily resolve these problems, heal the wounds inflicted by AOD-related problems, actively manage their continued vulnerability to such problems, and develop a healthy, productive, and meaningful life.' (p. 236)

It is important to acknowledge that the idea that recovery is a process conveys the view that resolving severe drug use problems is more than a point-in-time decision and that the achievement of long-term recovery requires sustained effort. Depicting recovery as a

process conveys that recovery initiation and recovery maintenance are qualitatively different processes (Best 2019; Best 2016; Humphreys *et al.*, 1995; Snow *et al.,* 1994). It is also implicit in this understanding that there is a distinction between the observable recovery (that which we can see), in terms of abstinence, sobriety and responsibility; and the experiential process that effects change in the quality of life, self-esteem, hope, belonging and education, which are of significance in maintaining recovery (Best and DeAlwis 2017; Slade 2010; Dennis *et al.,* 2005). This aspect of recovery, which was initially conceived as resilience to relapse, has been reframed as RC, involving growth in spirit and capacity (White 2009; Granfield & Cloud 2001; Granfield & Cloud 1999).

2.2.8. Recovery Capital

The introduction of RC into the addiction recovery literature has provided a new framework for thinking about recovery. Granfield and Cloud (1999, cited by Kelly and Hoeppner 2014) define RC as *'the breadth and depth of internal and external resources that can be drawn upon to initiate and sustain recovery'* (p. 3). As individuals progress through their recovery journey, RC should increase, which is likely to augment ongoing remission in the drug user (Kelly & Hoeppner 2015; White & Kurtz 2005; Hagan & McCarthy 1997; Teachman *et al.,* 1997). Varga *et al.,* (2017) find two main themes to this motivation, which are as follows: 1) the desire to develop or enhance their skills to return to employment and 2) the motivation to develop personally to the extent that will enable them to address their addiction issues. There is also an element which adds a structured time component which provides an anchor for a hitherto chaotic life.

Best and Laudet (2010) argue that there are three domains of recovery capital: personal capital (qualities like self-esteem and resilience); social capital (based on the networks and supports that the individual can draw on); and community capital (e.g. reasonable housing, training and employment opportunities). While it is an integral part of the drug worker role to foster the development of RC in the service user, it is equally important to note that RC is not equally distributed across individuals and social groups. Members of historically disempowered groups seeking recovery from addiction often lack recovery capital, which is taken for granted by those seeking recovery from a position of privilege (Cloud & Granfield 2001). These disadvantages may include homelessness (Manning

2019), mental illness (McGaffin 2018), unemployment (Hanson 2017) and legal issues (Connelly *et al.,* 2017).

The drug worker must always be aware of post-treatment recovery check-ups, and when needed, early re-intervention can help preserve the RC developed through addiction treatment (Dennis *et al.,* 2003). The importance of the community element, and by extension, those who deliver community rehabilitation, has been stressed in numerous studies (Moos & Moos 2007; Moos *et al.,* 2006). These studies are underpinned by findings that long-term recovery outcomes for those with the most severe substance use problems may have more to do with family and community RC than the attributes of individuals or a treatment protocol (Chen 2018; Mankowski & Moos 2001; Humphreys & Cohen 1997; Bromet & Moos 1977).

2.2.9. Wheel of Change: Trans-Theoretical Model of Recovery

Given that this research has already conceptualised drug misuse as a range of behaviours, it is apposite that we use a recovery model that can be stated in terms of behavioural change. Regardless of the influence or causation of change, the underlying need or desire for change is driven by the motivation to change current behaviours. This section offers a model by which we can view our sample cohort's rehabilitation work from the viewpoint of behavioural and motivational change.

Before the 1990s, a patchwork of intervention theories emerged (Rogers 1954; Skinner 1953; Freud 1949) on how people change behaviours, particularly addictive ones. Prochaska and Clemente were seminal in developing a trans-theoretical model (Di Clemente 2003; DiClemente & Prochaska 1982; Prochaska & DiClemente 1982; Prochaska 1979). Part of this model describes the recovery process as a set of discrete stages of motivational change. The model forms the basis of most SCE schemes' theoretical framework, and thus, it is a core part of our cohorts understanding of how to approach their work.

There are six phases of motivational change, often referred to as the 'Wheel of Change'. Going through the whole process takes a different amount of time for everyone, as they can get stuck in a phase or slip back to a previous one (see Fig. 2.3).

The Cycle of Motivational Change

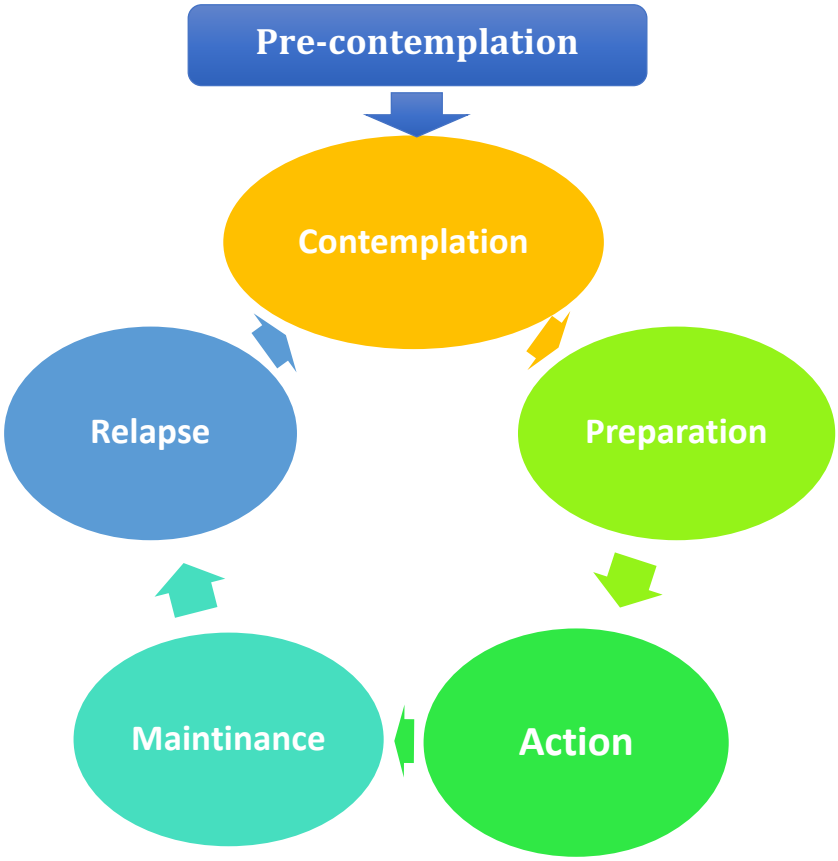


Fig. 2.3. (*Cycle of motivational change: Di Clemente 2003)*

Stage One: Pre-Contemplation

The pre-contemplation stage represents a period before the consideration of change by the drug user. Negative consequences may not have manifested yet, and there is usually strong denial exhibited. The drug user will ignore advice and use defence mechanisms,

such as minimisation, to explain negative consequences. According to Prochaska *et al.* (2014), during this stage, there is

'no intention of changing, and the addict may deny having a problem and exhibit resistance to change. As the negative consequences develop and adverse life events can no longer be ignored, the user may start to move towards the contemplation stage.' (p. 62)

Janis and Mann (1977) suggest that the drug worker's job is to make interventions with the individual that will move forward this evaluation process, resulting in tipping the balance towards supporting positive change, confronting ambivalence and spelling out consequences.

Stage Two: Contemplation

At the contemplation stage, the individual has begun to see the pattern of their drug misuse and realises that their behaviour may be out of control; therefore, they may contemplate change. This change can be in the form of cutting back on substance use or perhaps even quitting altogether. The individual is more likely to embrace advice and to learn more about how to make changes. At this point, there is little or no action taken, but the thought and understanding that there is a problem are present. Unfortunately, someone can remain in this stage of recovery for an indefinite period. Therefore, Prochaska and Diclemente (1982) suggest that the drug worker can help reduce resistance by proffering hope, support in taking small steps and assisting the participant in focussing on the solution rather than the problem. The intervention should also help the client clarify the advantages and disadvantages of continuing to use the substance.

Stage Three: Preparation

After the decision to change has been made, it is time to begin the preparation or planning phase. Miller and Rollnick (2013) stress that the clinician should make sure the client is

'*considering their life circumstances and drawing on their experience with change, [and then] the clinician guides the client in developing change strategies. A menu of possible options must be available from which the client can choose, as not all recovery strategies will suit everyone.'* (p. 157)

This stage provides the worker with an opportunity to prepare an agreed plan with the service user for dealing with urges, cravings and stress induced by cessation.

Stage Four: Action

The action stage requires considerable commitments of time and energy from both the client and worker. The worker plays an active role in making sure the right people have been contacted to confirm that the much-needed support systems are in place at this critical juncture. Continuity in the provision of support as behaviour starts to transform is essential.

Stage Five: Maintenance

At the maintenance stage, the client often expresses a strong desire to keep making progress to reinforce and maintain their intentions and goals. There may be long periods of abstinence or limits to their usage. Because this is a highly challenging phase, complacency can set in, and relapse becomes a threat. The memory of how well substances seemed to help with coping is recalled and may provide the impetus to use again. At this phase, an enormous amount of our research cohort's work takes place, including supporting efficacy, encouraging the development of new lifestyle patterns, delivery of education and training, enhancing resilience, and developing contingency strategies with clients.

Stage Six: Relapse

Relapse is an ever-present threat during recovery (Rollnick & Miller 2014). Crombag *et al.,* (2008) suggest that *'exposure to environmental contexts previously associated with drug intake often provokes relapse to drug use'* (p. 234); this relapse can come in many small and manageable episodes or one significant and out-of-control relapse. The duration will depend on the individual. There are many reasons for relapse; the literature suggests the following are among the commonest: re-exposure to the substance of choice (de Wit 1996), familiar drug cues (e.g. smells, seeing paraphernalia; Childress *et al.,* 1993) and stress (Sinha 2001). The drug worker's job here is to help the client identify these triggers as quickly as possible and act to ameliorate circumstances where these triggers might arise, stressing the positive achievements already gained in recovery and recycling

the individual back to the Wheel of Change as quickly as possible (Snow *et al.,* 1999). The drug worker can help participants recognise the achievements made and that not all is lost. Again, this requires intensive interpersonal work on the part of the drug worker.

2.2.10. The Rationale for the use of this Transtheoretical Model

The inclusion of the transtheoretical recovery model in this thesis provides a conceptual framework used by many current practitioners in the drug work field, including SCE workers. The HSE who are the main funders of most community addiction responses and lead in the National Drug Recovery Framework recommend using Brief Intervention techniques in their SAOR I (2009) and SAOR II (2017). Indeed, the World Health Organization (WHO) recommends a brief intervention (BI) as an intervention to address patients' problematic substance use (Humeniuk *et al.,* 2010)

The brief intervention relies heavily on MI (Rollnick and Miller, 1995) and motivational enhancement therapy (MET), which are directive, client-centred and aimed at resolving ambivalence through provider feedback to elicit behaviour change (Miller et al., 1995). MI and MET are evidence-based treatments for substance use disorder with strong research support (Sahker *et al.,* 2020). BIs are underpinned by a theoretical framework drawing primarily on; 1) the principles of the Stages of Change model (Prochaska & Diclemente 1989] identifying patients' level of motivation to change, and 2) Miller and Rollnick's 'Motivational Interviewing' (2002). The key concepts are eliciting change talk and moving patients through change stages, incorporating the FRAMES technique (Feedback, Responsibility, Advice, Menu of Options, Empathy, Self-efficacy). A transnational study of BI efficacy in addressing illicit drug-use a sample of over seven hundred patients recruited from primary care settings in Australia, Brazil, India and the United States. After receiving a BI, 82.8 % of the sample attempted to reduce their illicit drug use, with 60.2 % succeeding in maintaining this reduction at 3-month follow-up (Humeniuk et al.,2008). *'Within motivational interviewing quite typically the Stages of Change 'wheel' can be presented to patients to assist in determining where?(sic); in the process of change that individual patient sits'* (Darker *et al.,* 2016, p. 373).

Brief Intervention (BI) under the acronym (SAOR) is an evidence-based psychosocial intervention that aims to effect behavioural change in persons experiencing problematic

substance use and has been rolled out by the HSE since 2009 as a first-line intervention. It is described as a comprehensive set of supports that address the context, causes and maintenance of problem substance use. It can be delivered in multiple settings and with a range of substances and levels of need. (Kelleher 2017, p. 31). It also supports workers from their first point of contact with a service user to enable them to deliver brief interventions and facilitate those presenting with more complex needs with entry into treatment programmes as per the National Drugs Rehabilitation Implementation Committee NDRIC protocols (2011). It is supported by the NDRIC, which has placed particular importance on services delivered across the four tiers engaging service users in their treatment and rehabilitation journey (O'Shea & Armstrong 2017). The four MI processes (engaging, focusing, evoking, and planning) are engaged in SAOR to move the individual through the transtheoretical model of motivational change.

2.2.11. Social Integration and Insertion

March *et al.* (2006), identified the emergence across Europe of new forms of social marginalisation for those engaged in drug-misuse. These included, *'long-term unemployment, a loss of social bonds, and the growth of a population that has enjoyed neither the benefits stemming from society's progress in general nor any of the services available within society'* (p.34). Social exclusion is defined as a situation whereby a person cannot participate in their society's everyday activities, including those that affect decision making.

There are several barriers to the social inclusion of problem drug users. These are divided between personal and structural including personal-level barriers such as limited or no qualifications, low levels of literacy and numeracy; poor employment histories; criminal records precluding specific careers (e.g. police, teaching, working with children, financial institutions); chronic mental and physical ill-health; insecure housing circumstances (Klee *et al.,* 2002; Baum *et al.,* 2003; Hasluck & Green, 2007; UKDPC, 2008a, 2008b). Besides, there are structural-level barriers such as a requirement to attend treatment daily; inadequate opening hours of treatment services that are incompatible with working hours; lack of interagency coordination; Etc. Some structural barriers affecting problem drug users are common to other socially excluded groups, for

example, stigmatising and discriminative views, actions and procedures among the general public (Lloyd 2010; EMCDDA 2010a; Neale & Kemp 2010; Monaghan 2010).

Meadows (2008) found that unemployed people in general (not only drug users) benefited from programmes addressing a wide range of issues and were more effective than those that address employment alone. An EMCDDA annual report (2003) distinguishes treatment and social reintegration. It states that the '...latter does not include medical and psychosocial components but focuses on providing housing, education, vocational training and employment supports' (Keane (2006, p.33). EMCDDA 2013 suggests that supporting problem drug users to access secure housing, education (including vocational training) and long-term employment are crucial elements of preventing social exclusion and promoting social reintegration.

A further EMCDDA meta-analysis of drug-related social reintegration literature (2013) identified a wide range of approaches in Europe, the USA and Asia. This report identified eight broad categories which encompass these approaches as follows: *'(1) general vocational rehabilitation, (2) drug treatment, (3) criminal justice interventions, (4) housing support, (5) education and (vocational) training, (6) employment support, (7) general policy and (8) advocacy'* (p.15). The report points out that there is little evidence to support an assertion of 'What works'. However, it does recognise that concerning social reintegration *interventions 'social attitudes to drug users, local and national economic prosperity, living standards in the general population, professional training, stability in problem drug users' lives, etc., were significant moderators of success.'* (ibid, p., 15). This section will examine social reintegration, also referred to as social reinsertion, approaches from several perspectives. These will include opiate substitution, purposeful living, quality of life, abstinence, treatment adherence, community reinstatement while focusing on the experience of service users, health and community professionals and policymakers. EMCDDA (2013) found that *'providing drug treatment alone, e.g. (substitute prescribing) without additional support or services had only limited and inconsistent effects on employment outcomes'* (ibid, p16).

2.2.12. Reintegration and Housing

Homelessness among drug users may arise from many causes, e.g. being in unstable or temporary accommodation (e.g. staying with a relative or friend) or breakdown of relationships, after leaving residential treatment services or upon being released from an institution (e.g. prison, hospital) among others (Dyb 2016). Some *'homeless persons never had a stable life before starting on a pathway of drug use and living on the streets'* (ibid, p.77). It is recognised in the literature that substance misuse may occur both before and after homelessness, but it is likely to escalate when living on the streets and in hostels (Cheng *et al.,* 2014; Didenko & Pankratz, 2007). Also, there is strong evidence that in Ireland drug use and injecting heroin use are common among the homeless population (Keane 2007; Cox & Lawless 1999; MQI 2015; Feeney *et al.,* 2000; Cleary *et al*., 2004).

EMCDDA (2013) recognises a complicated relationship between drug use and homelessness; it is also recognised that attaining housing stability makes achieving employment more likely Ferguson (2004). Homelessness among drug users may arise from many causes, e.g. being in unstable or temporary accommodation (e.g. staying with a relative or friend) or breakdown of relationships, after leaving residential treatment services or being released from an institution (e.g. prison, hospital) among others.

Most *'countries reported the availability of housing interventions that were accessible to drug-using populations, albeit usually only upon fulfilment of certain conditions'* (EMCDDA 2013, p. 84). These interventions fall into three categories, i.e. 1) Emergency accommodation; 2) Supported housing, halfway houses and supported living; 3) long-term accommodation. For example, Norway's, 'The Pathway to a Permanent Home 2005–2007' was the first in the EMCDDA area that provided houses to homeless people without demanding abstinence or lifestyle changes (Dyb *et al.,* 2008). Currently, Norway is implementing a comprehensive national scheme 'Housing for Welfare' (2014–2020), which also assists people discharged from institutions to find housing (ibid, p. 18). Many other countries followed with a housing-led approach (Benjaminsen *et al.,* 2009). Housing First, a model where housing and support are provided regardless of substance use and mental illness and based on the consumer's choice (Tsemberis *et al.,* 2004), came from the US to Europe around a decade ago and was adopted rapidly among service

providers, governments and researchers. Implementation of the Housing First model has taken different and has taken many forms (Busch-Geertsema 2013; Pleace 2011).

The Housing First model may be a useful tool to promote a housing-led approach for homeless persons with addiction to alcohol and drugs. Regarding the high number of patients breaking off treatment, housing and support are probably an alternative for many homeless individuals referred to treatment. (Hansen & Löfstrand, 2010; Hansen & Löfstrand 2012; Johnsen & Teixeira 2012; Dyb 2016).

In Ireland, accessing drug and alcohol services for homeless clients can be challenging (Pleace *et al.,* 2000; Kennedy *et al.,* 2001; Randall & Brown, 2002; Drugscope 2002). However, these problems are not confined to the homeless population (Lawless & Carr 2005). Lawless and Carr also found that homelessness exacerbates drug use and propensity for recidivism and relapse (2005). In line with European thinking, the official commitment to a 'housing-led' approach to addressing homelessness, was set out in by government (Dept of Environment, 2013). The housing First programme in Dublin *'aims to enable people who have been homeless for a long time, and who may have multiple needs, to obtain permanent secure accommodation, with the assistance of a support team to help them address their needs'*(McVerry 2017, p.22). However, there remains a gap between the stated approach and actual policy. McVerry (2017) pointed this out saying *'Yet even as a 'housing-led' approach was adopted as Ireland's official response to homelessness, the mainstream housing policies being pursued were increasingly making this approach unrealisable'* (p.29). He went on to point out that *'Nearly five years after the publication of the Homelessness Policy Statement, Ireland now has its highest ever level of recorded homelessness, with twice as many people in emergency accommodation in August 2017 as had been at the beginning of 2015'* (p.30). SCE participants, workers and other SCE related stakeholders experience the real barriers to reintegration and reinsertion posed by homelessness in all its manifestations (Lawless 2006; Van Hout & Bingham 2014).

2.2.13. Purposeful Living and Quality of life

The literature provides a small number of longitudinal studies which have suggested that vocational rehabilitation and steady work is associated with improved psychosocial outcomes and improvement in the quality of life (Mueser *et al.,* 1997, Bond *et al.,* 2001),

In Ireland, a review conducted by CityWide community forum (2014) found that the *'most important benefit of SCE as identified by participants was the stability, structure, and routine these projects provide. These benefits were identified as principal reasons for taking up positions on SCE*'. (p.13).

Gainful employment is recognised as beneficial to recovering drug users and conducive to maintaining sustained recovery and avoidance of relapse (Hoytln et al.,2015; Magura et al., 2004; Ginexi *et al.,* 2003; Sterling *et al.,* 2001). However, according *to Van Hout and Bingham (2012):*

'…whilst a majority of ex-drug users report a strong interest in employment training, their expectations are often unrealistic, with low rates of employment due to poor literacy and employment-related skills; lack of prior employment history, lack of access to transport and childcare, poor motivational levels and co-morbidity' (p. 64).

Hoyltn (2015) points out that *'standard drug-addiction treatments rarely result in increased rates of employment'* (p.67) citing among others (Hubbard *et al*., 2003; Magura *et al.,* 2004; Schildhaus *et al.,*2000). However, Magura (2003) suggests that providing employment interventions in conjunction with drug-addiction treatment may be necessary to promote job-seeking, employment, and retention.

2.2.14. Reintegration and Employment:

The extant literature indicates lack of experience, the paucity of applicable skills, criminal record and personal appearance are often cited by recovering drug users in their inability to gain a job. (Van Hout, 2014; Lloyd, 2010).

The concept of employment and having a job is central to many lives (Berg, 2003). Platt (1995) found that stabilised drug users who retain employment had better treatment outcomes. However, a counterintuitive finding was reported in a study by McHugo *et al.,* 2012) which found that *'over the long term, clients who did not work nevertheless achieved similar non-vocational outcomes as those who were steady workers'* (p.277).

2.2.15. Treatment outcomes and abstinence:

Hammer et al. (1985) reported a significant relationship between vocational training and reduced substance abuse, while similar observations are made by Lusk *et al.* (2008). Several, studies have found significant improvement in areas such as symptom control

(Burns *et al.,* 2009, Kukla *et al.,* 2012), self-esteem (Mueser *et al.,* 1997, Bond *et al.,* 2001), and global functioning (Mueser e*t al.,* 1997, Burns *et al.,* 2009). The associations are usually weak; the period of these studies is relatively brief (1 or 2 years), and the duration of employment varies considerably.

2.2.16. Vocational Rehabilitation and Employment

Vocational rehabilitation has impacted the recovery developments and significant life changes for people with substance use disorders. Hammer *et al.* (1985), found a positive correlation between vocational training and later employment activity among young addicts who completed a vocational training programme.

A more recent study reports that '*Employment is essential during the treatment and recovery process for individuals with substance use disorder'* (Lusk *et al.,* 2018, p 4).

Perhaps, the completion of vocational training might lead to more work activity resulting in positive life-changing situations, which could be related to reduced substance abuse. (Gomaz *et al.,* 2014). Vocational rehabilitation (including vocational assessment, post-secondary or vocational training, job placement, supported employment, job accommodations) is a potential vehicle for linking the documented value of gainful employment to the substance abuse recovery process. (Walls 2009). However, the craving, loss of control, and physical dependence pose severe challenges to sustaining employment. However, these challenges have been demonstrated to be reduced through employment concepts, employment training, and employment, which can interact with residential, medication, or substance-free outpatient therapies (e.g., Adamson, *et al.,* 2009; Durkin 2002; Magura, 2003).

Several studies link employment with an increased likelihood of treatment engagement, completion, decreased chance of relapse; improved relationships and positive peer interactions; restored self-esteem; and increased participation in constructive activities (e.g., leisure, education). Individuals with substance use disorders are more likely to remain engaged in treatment and complete treatment when employment services and opportunities were made available (Magura 2004; Melvin *et al.,* 2012).

Personal barriers may include low self-efficacy; lack of motivation and decreased stamina; difficulty managing stress and concentrating; problems with self-regulation;

physical and psychiatric disabilities; unrealistic expectations and attitudes, learned helplessness, and dependence (Hollar *et al.,* 2008; Shepard & Reif, 2004; Walls *et al.,* 2009). Barriers related to education and training include a lack of access to such programmes and low cognitive functioning (Sigurdsson *et al.,* 2012). A lack of "soft skills" (e.g., interview skills, appropriate dress, timeliness), societal or structural barriers include increased incarceration rates, prejudicial hiring practices; lack of availability of appropriate jobs (Hollar et al., 2008; VanderWaal et al. 2008). So, employment is noted as a *protective 'treatment factor in that it helps increase treatment retention and decrease relapse rates. It is also a protective post-treatment factor because it contributes to sustained recovery, healthier lifestyles, and the development of positive, sober relationships'* (Lusk et al. 2008, p. 9).

2.2.17. Social Reintegration and the Justice System:

Van Hout and Phelan (2014) cite (Morgan *et al.,* 2009; Nichols & Crow, 2004; Seefeldt & Ewing, 2002; Gatz *et al.,* 2002; Smith, 2003; Weiss & Stuntz, 2004; Jamieson & Ross, 2007) among others in supporting the contention that:

'young adult offender participation in sports can reduce crime and recidivism and promote abstinence ("maturing out" of crime) due to its alternative focus, time occupation, positive peer socialisation, and intermediate sporting outcomes, such as heightened self-esteem, positive identity, connectedness, empowerment, and acquisition of new skills, problem-solving and decision-making skills, teamwork, goal setting, leadership, and discipline' (p. 125).

Findings by (Roessler, 2010; Strong *et al.,* 2005; Taylor & Faulkner, 2008; Weinstock, Barry, & Petry, 2008; World Health Organization, 2004) also indicate the benefits of physical activity on 'mental health, social functioning, physical fitness, recreational networks, and community integration and can reduce drug-taking and criminal activity' van Hout & Phelan (2014). Sports programs can be open access, targeted outreach, and focused (Coalter, 2007a). Activity-based programmes like sports are optimised in recovery and reintegration when aligned with; *'skill-based, team-focused, and relationship building and other opportunities for positive peer mentoring'* (Van Hout and Phelan 2014, p.126). Also, beneficial is social competence training, develop cognitive capacity building and stimulating behaviour change (Sheehan *et al.,* 2002; Andrews & Andrews, 2003; Asquith *et al.,* 1998).

2.2.18. Social Integration: An International Perspective

According to Sumnall and Brotherhood (2013), in their EMCDDA report, 21 EU countries, including Ireland, have specified action plans for a reintegrative component in their national drug strategies. It goes on to specially mention:

The Czech Republic's strategy provides *'guidelines on the systematic referral of drug users from treatment and prison settings to aftercare/reintegration programmes' (Ibid p.49). Croatia's objectives include educational programmes for specific unemployed persons, including those who have completed drug treatment.* These aim to increase their employability and competitiveness in the open labour market. Cyprus's objectives include: *'the development of cooperative actions between social integration programmes and other organised groups to deliver financial assistance, vocational training and job rehabilitation' (ibid p.49).* Slovenia aims for social reintegration by: *'...developing a network of therapeutic communities and a network of social reintegration programmes, employing drug users, improving housing provision and improving the framework of basic, specialised and in-service training of professionals providing medical, psychological and social care to problem drug users' (ibid p.50).* While Romania's objectives include the *'development of the necessary legal framework and resources for the development and strengthening of outpatient medical services to guarantee access to health and social care for problem drug users, as well as the development of legislative and institutional frameworks to ensure the provision of integrated support programmes' (ibid p.50).* (EMCDDA 2013, p. 49-50)

However, as a general observation, social reintegration is not necessarily perceived as either the last step in the treatment process or a post-treatment intervention. Instead, it is a separate and independent intervention, with its own goals and means, which is offered for both former and current problem drug users. This intervention indicates that social reintegration does not necessarily have to occur after treatment but can occur irrespective of prior treatment. An equally important implication of social reintegration for both current and former drug users is that it is an intervention for the whole spectrum of clients as a target group, ranging from well-functioning 'clean' former addicts to very deprived street addicts.

In summary, national and European drug strategies recognise that social reintegration is an essential part of the broad range of drug use responses. However, the actual availability of social reintegration services is limited. Some examples of integration in specific European countries are:

Belgium: Various terms are used to describe reintegration interventions in the Flemish community, including aftercare, re-socialisation, both reintegration, and social workplaces (EMCDDA 2003) The concept of reintegration encompasses services such as housing/accommodation; guidance in finding employment; social workplaces; education guidance; support and guidance upon leaving prison; advice to older drug users and their families; money advice; and case management (ibid). Specific training and educational courses are available. While facilitating reintegration into the workforce is the specific goal of some government departments, other departments help find accommodation with a number of these initiatives explicitly aimed at drug users. It is noted that general policy is improving, on the whole, however 'there seems to be inconsistency in approach and application of policy' (EMCDDA 2003).

Spain: Programmes aimed at facilitating the social reintegration of people with a drug dependency can ECMAAD 2004 be classified into three categories: education and training (formacion), employment (incorporacion laboral) and housing (apoyo residencial). Furthermore, several programmes are organised in the area of criminal justice. These services do not exclusively target people with an addiction problem but are accessible to anybody. More than half (58.6 %) of the total number of drug users who attended training programmes in 2010 took part in these activities (National Report, 2011). Special employment programmes, including workshop schools (Escuelas-Taller), craft workshops (Casas de Oficios) and employment workshops (Talleres de empleo). These three types of programmes combine training and employment, and a salary paid to the individuals (for six months or a year).

Reintegration housing is managed through the organisations responsible for housing are always NGOs. The regional (autonomous communities) and local administrations finance the NGOs' services. In 2000, 3,055 individuals were accommodated in supported apartments or lodgings. The legal framework for these actions with respect of those who are part of the legal system is defined in the Spanish Constitution, which establishes that

prison sentences and security measures must aim to re-education and social reintegration of individuals and protect their health.

Italy: Amongst its priorities in the Italian national drug strategy is expanding socio-rehabilitative services and an increased focus on social reintegration, including education, vocational training and employment interventions. *'The planning and delivery of local health care services is the responsibility of the regions. This approach allows a degree of flexibility to reflect local needs within the framework of national guidelines'* (ECMAAD 2004, p. 43). Social reintegration is broadly seen as including preparation for re-entering society undertaken as part of the residential/semi-residential therapeutic programme and specific projects with defined objectives. It is assumed from the limited documentation available that there is an intention to seamless link together the therapeutic programme and reintegration projects.

Vocational training and employment experience are both provided within the prison system. These are available to convicted prisoners and aim to provide skills and work experience in preparation for release and reintegration into society. Most activities are focused on developing the client's capacity to enter and remain in employment. This regime may involve returning to full-time education, vocational/professional training, employment in a supportive environment or counselling, guidance and support to enter the commercial employment market.

In general, supported accommodation is not provided. For those in residential treatment, the 're-entry' phase often consists of a continuous residence period whilst starting work, training or education, followed by a non-residential but supported transition period to full independence. The available data on drug users' accommodation status in treatment suggests that homelessness is a relatively rare condition and that treatment services help clients secure accommodation on completion of the residential treatment period. There appears to be little or no provision of legal aid or advice, for those with drug problems.

Sweden: In principal, social services are responsible for long-term rehabilitation and other interventions providing support and help. The health service is responsible for detoxification and treatment of the psychological side effects of substance misuse. The Swedish services are relatively comprehensive. The social services provide five main types of programme: housing assistance, individually means-tested outpatient care, care

in private homes, voluntary institutional care and compulsory care. These services generally include social reintegration interventions for rehabilitation, such as training apartments, work training, 'motivational homes' and social support. It is common for such interventions to fall under a broad heading of 'social reintegration' and are usually not exclusive to drug users. A mixture of public bodies and private social agencies provide social integration interventions for drug users.

Croatia: In Croatia, social support and recovery-oriented programs can help solve the lack of psychosocial support for people with problems with addictive behaviours detected during the study. Identifying stakeholders from different stages, agencies and organisations (including the experience of drug users in different severities of addictive behaviours*) 'allows access to a global perception and perspective about drug problems and solutions in Croatian*' (Fernandez 2020, p. 48).

2.2.19. Novel approaches to Recovery

Club Health began in 1997 in Liverpool, a city that twinned with Dublin also in 1997. It has been hosted in partnership with organisations, government departments and agencies in many countries ever since, including the Netherlands, Italy, Australia, Slovenia, Spain, the Czech Republic, Switzerland, the USA, and in 2015 in Lisbon. (drugs net). Some of the issues addressed are policing, public health, pill testing, harm reduction campaigns, and NPS testing and responses. Also examined are such as chemsex and responses within and to specific communities, e.g. lesbian, gay, bisexual and transgender (LGBT), and social exclusion.

The EMCDDA. (2016) undertook an extensive research piece; the sample included over 12000 youths aged 15–24, randomly selected across the 27 EU Member States. Overall, 5% of the participants reported having used NPS: Ireland (16%), Poland (9%), Latvia (8.8%) and United Kingdom (8%) were way above the mean, while Italy (0.8%), Finland (1%) and Greece (1.6%) were at the bottom of the list (European Commission, 2011). On the other hand, our recent Italian data showed a higher percentage of NPS consumption in healthy subjects and a considerably higher percentage in psychiatric patients. This finding may be due to selection biases, but it is also possible that the extent of NPS consumption may be growing or it was previously underestimated (Martinotti *et al.,* 2014).

However, natural recovery research identifies that meaningful activities are vital in resolving alcohol and drug problems (Granfield & Cloud, 2001; Crabb 2000; Landale & Roderick 2014). Despite the benefits which programmes of exercise potentially offer, "mainstream funding has favoured pharmacological and psychological interventions which have focused on reducing the harms associated with alcohol and drug misuse" (Landale & Roderick 2014, p. 6). However, reviewing the role of sports-based interventions and social inclusion, Coalter (2007) asserts that some programmes help some people only some of the time.

Morton *et al.,* 2016 reviewing a recovery programme based are a boxercise theme found enhanced personal, educational and social capital in participants underpinned a desire for recovery. A subsequent paper Morton *et al.,* (2017) indicated that engagement in the boxercise element although challenging*, 'appeared to create opportunities for personal growth, self-awareness and self-knowledge amongst participants, all important aspects of sustained recovery'* (p. 552). They go on to make the point that *'participating in boxing skills training offered participants the opportunity to reframe existing identities and, at times, seek rapprochement with their community; a "boxer" rather than "addict" identity seemed to bridge this space'* (p.553).

2.3. Community

The third theme of this literature review is that of community and its influence on our sample cohort, policy and practice. It examines the community as a movement for a local response to drug problems, its ethos and principles and its evolution from a quasi-vigilante movement to partnership in the NDS. The ethos of community development that guides day-to-day work in SCE projects can often be at variance with a specific addiction modalities' tenor. Most commonly, with the overarching and top-down nature of the state and semi-state sectors policy and practice. This non-alignment of culture and paradigms can often emerge in what Bruce (2004) describes as 'friction'; this might also be described as frustration, incomprehension and subversion among the community group and state agencies involved. One observer suggests, *'These difficulties owe their origin to the differing motivations for participation'* (Brodrick 2002, p. 108). To better understand the underlying reasons for the tension in these relationships, which often result in challenges

for workers on the ground, we can consider the origin and evolution of the drug-related Community Response movement.

As discussed above, the 1960s and 1970s saw many high-level discussions initiated in response to a nascent drug problem. Among others, these included the discussions of the Commission of Inquiry on Mental Illness in 1966 (Bushe 1968), the Working Party on Drug Abuse in 1971 and the Working Party on Drug Abuse in 1972. According to O'Gorman (2002), the 1960s and 1970s saw an increase in overall illicit drug use in Ireland, and research found evidence of the use of amphetamine (Walsh 1966), cannabis and LSD use (Nevin *et al.,* 1971; Masterson 1970) and heroin (Murphy-Lawless 2002). However, neither these research findings nor other drug use indicators (i.e. seizures, prosecutions and treatment) caused any real concern at the national or local levels. O'Gorman (1998) quotes a Department of the Taoiseach (1996) report stating:

'The drug problem is concentrated in communities that are also characterised by large-scale social and economic deprivation and marginalisation. The physical/environmental conditions in these neighbourhoods are poor, as are the social and recreational infrastructures. Abuse and addiction are associated with crime. There are also problems with drug-related disease (e.g. AIDS and hepatitis. Life in these estates for many has become nasty, brutish and short.' (p. 162)

Murphy-Lawless (2002) suggests that there was a lack of effective action by the state because it was confined to a cohort who had;

'little or no (political) voice or trust in national politics... [Suffice] it to say little or nothing of a tangible nature was done to correct matters' (p. 101).

Perhaps this absence of an adequate response from the statutory bodies that 'residents of the inner-city areas most affected by the opiate epidemic mobilised in a social movement called the Concerned Parents against Drugs' (O'Gorman 1998, p. 158).

By the early 1980s, the inertia displayed by successive governments had become intolerable to the communities affected by the epidemic of heroin use, so they undertook unilateral action. This frustration led to the mobilisation of 'residents of the most affected areas coalescing under the banner of "Concerned Parents against Drugs" (CPAD)'; according to O'Gorman (1998), this organisation's main activity was initially confined to *'vigils and patrols to deter visible drug dealing'* (p. 162). Several large meetings were organised, and during these meetings, a group of active drug dealers was identified. These

'dealers' were confronted in mass marches and given a choice to quit dealing or leave the area. After some initial success in certain areas, CPAD was accused by both the Garda and some sections of the media (rightly or wrongly) of infiltration by the paramilitary-linked Sinn Fein and the provisional IRA (Lyder 2005). These accusations of vigilante-type activities, including intimidation, shooting alleged drug dealers and mistakenly beating innocent people, resulted in the movement falling into disrepute, dwindling and ultimately disappearing. However, its demise gave birth to a new, more mature and rational movement that sought drug information and drug education to inform their actions properly; they sought to understand rather than just confront. This paradigm change gave a new focus to communities providing treatment and rehabilitation for those in their communities who were addicted to drugs, many of whom were small-time dealers who dealt only to support their addiction. McCann (1999) mentions several community reports, including those of the Rialto Development Association (1990), ICON (1994), Women's Action Group (1995), Co-operation North (1996) and Community Response (1997). Furthermore, contends they are all relevant to the emergence of a community response would give rise to SCE projects as rehabilitation initiatives embedded within the broader Community Development paradigm.

2.3.1. Community Development Principles

As the name suggests, SCE projects are based in local communities, and their work is imbued with community ethos and principles (e.g. collaboration, equality, empowerment, social action). Hawtin *et al.,* (1999) provide the following definition of a community:

'A community may refer to the idea of something common to or shared by a section of the population.' Communities may be based on 'geographic areas or localities or have other characteristics age, gender, ethnicity or nationality.' Other bonds might create a sense of belonging to a community, for example, having a shared problem.' (p. 36).

Schwergart (2002) argues that community development must navigate the converging streams of power flowing between the broader culture of societies and the local cultures of communities; between government administration and civic organisations' operation and between overarching public institutions and clusters of families. This dichotomy reflects the sense of detachment experienced by the nascent community drugs movement and the state's institutions. Such ambivalence continues to this day, and it may contribute to the fraught relations between community rehabilitation projects and the state sector

(Powell *et al.,* 2018; Le Ber & Branzei 2010; Schweigart 2002; Rafferty 1991). Schweigart (2002) goes on to suggest that there are two fundamental principles in

'social justice at the heart of community development, namely solidarity and subsidiarity: Solidarity refers to shared membership characterised by mutual care and mutual respect, that is, a sense of belonging enriched by a commitment to human dignity—to love one's neighbour as oneself. Subsidiarity is understood as a guide for social action, directing decision making to the social level that is most effective, with particular respect for the power of local and communal levels of society.' (p. 34).

These two principles are at the core of the mission and objectives of most SCE projects, and thus, provide a different worldview from the views espoused by semi-state agencies, such as the HSE and governmental departments. Nevertheless, the drug worker must 'navigate' these converging streams.

This community movement did not see itself as a blank and inert canvas on which the tapestry of drug use, addiction and recovery was overlaid; rather, as Sung and Richter (2006) would have it, the

'community is the soil in which such problems grow or fail to grow and in which the resolutions to such problems thrive or fail to thrive over time. That soil contains promoting and inhibiting forces for both addiction and recovery. The ratio of such forces can tip the scales of recovery initiation efforts toward success or failure'. (p. 103).

Thus, the community drugs movement takes responsibility for the husbandry of this 'soil' and demands the state to make available the necessary policy and resourcing at the community level, which will enhance the chances of recovery. Such community empowerment can be perceived as challenging if not downright usurping to statutory agencies' paternalistic and power-centred culture. This power struggle may also be stated as a top-down or bottom-up approach to policy, a question of who knows best—the professionals or the community groups on the ground. This scenario has played out in many situations over many years; it still has resonance, with community activists and workers in the drug sector feeling the statutory 'tail' is wagging the community 'dog'.

2.3.2 Community Rehabilitation

At this juncture, there is strong evidence to indicate that recovery initiation in institutional settings does not assure sustained recovery maintenance in natural community environments (White 2009; Weisner *et al.,* 2003; Westermeyer 1989). In

other words, a recovery undertaken in the 'unreal' environment of a traditional clinical rehabilitation facility has less chance of sustainability for the client than one undertaken while dealing with the real-life environment in which they exist before and after the process. White (2009) suggests; *'The greater the physical, psychological, and cultural distance between a treatment institution and its clients' natural environments, the greater is the problem of transfer of learning from the institutional to the natural environment' (p.232)*. Moreover, Makas (1993) argues that community reintegration is enhanced by service organisations whose facilities resemble the surrounding community and the expected post-treatment environments. Thus, SCE schemes have emerged from a community perspective, which recognises that rehabilitation is a more extensive and enduring process than just treatment. A recalibration of the relationship with traditional recovery models and the community-centred ones; along with affirmation of the powerful role community plays in the rehabilitation process, is at the heart of this vision. (White 2007b; White 2006a; Else 1999; Morgan 1995).

McKinght (1995) suggests:

'Where professional institutions and services have been overdeveloped (e.g. have taken over the natural support functions of families, extended families, and indigenous helping institutions), they may inadvertently erode natural support structures and, in so doing, inflict long-term injury on the community.' (p.235).

In a National Economic and Social Forum document, Broadrick (2002) argues that one of the primary challenges facing community development groups in Ireland is to 'articulate their difference and wrest themselves from the smothering embrace of partnership'. He suggests, *'The partnership model of governance allows only the expression of a superficial consensus'* (NESF 1997, p. 45).

The community and voluntary sector must balance participating in social partnership, campaigning, advocacy, and protest. The Irish government proposed integrated development to combat poverty and inequality as far back as the late 1980s. Doubt was expressed then that integrated development was possible, given the centralised nature of the state. Although more than three decades have elapsed, the partnership of state and community can still be fraught and has created many difficulties.

2.3.3. Drug-Related Vocational Rehabilitation Programmes

As early as the mid-1960s, Dole and Nyswander (1965) recognised that vocational training played a role in drug rehabilitation. Since then, vocational rehabilitation has gained a growing evidence base (Webster *et al.,* 2014; Comerford 1999; Room 1998; Deren and Randell 1990). It is generally viewed as an effective means of refocussing drug abusers toward the world of work. Re-entry into mainstream society and building self-esteem, self-support, education and skills capital reinforce recovery by treatment professionals.

Many drug workers view employment as a potential facilitator of recovery, a factor in preventing relapse and an indicator of separation from a former drug-using lifestyle (Barberei *et al.,* 2016; Magura *et al.,* 2004). Indeed, according to a Council of Europe report (2000), *'Vocational rehabilitation is a reasonable and effective measure enabling drug-using or drug dependent persons to participate in regular occupation and mainstream society. Vocational rehabilitation programmes include assessment of individual vocational needs, counselling, skills training and job placement*' (p. 19).

Rehabilitation typically includes assessing individual vocational needs, counselling, skills training and job placement (Doostian *et al.,* 2019). Pratt (1996) considers rehabilitation programmes to provide one or more of a range of interventions, including supported employment, job placement, training in job-seeking skills and employment-readiness training, concluding that employment is essential to the social rehabilitation of addicts, and employment should be established as one reasonable measure of treatment success. However, this conclusion has been challenged by Magura *et al.* (2004), who found that vocational intervention was not as effective as might have previously been supposed. In contrast, Duffy and Baldwin (2013) aimed at investigating the risk factors for relapse; they concluded that social support and employment are among the essential issues to prevent relapse after treatment. Therefore, while employment after treatment does not guarantee the avoidance of drug abuse at this time, evidence shows that individuals not engaged with constructive roles, such as job or education, have a higher risk of relapse (Sau *et al.,* 2013), and this is supported by studies that show that the absence of adequate problem-solving skills exacerbates the stress and anxiety experienced by the addict. In

the workplace, this lack of skills and emotional stress may result in work failure for the ex-addict (e.g. Hermalin *et al.,* 1990; Platt and Metzger 1987).

According to Platt (1996), vocational rehabilitation programmes fall into the three following types:

- Programmes that combine job skills, training, general skills training and sometimes job-site intervention. These programmes are intended to give drug-dependent persons a daily structure and prepare them for regular work.
- Skill-building programmes provide a range of activities, such as generic skills training, problem-solving and coping skills development. They aim to provide improvement in social competence and confidence.
- Job placement programmes with an emphasis on job-seeking and job-retention skills.

The ILO has also recognised the importance of vocational rehabilitation for problem substance users (Ref), pointing to the need to educate employer and worker groups on substance abuse issues and engage community groups with employment links. They classify vocational rehabilitation as follows:

'*…training/retraining the recovering addict for suitable and viable employment, selective placement, on job assistance and follow-up, sensitising key employers and workers' groups to addiction as a safety and health problem and forging relationships with community groups that have a business and employment orientation.'* (Cited by Murthy, Developing Community Drug Rehabilitation and Workplace Prevention Programmes 2002, Report for ILO and UNOCD, Section 2)

2.3.4. Integration and Vocational Training:

This section will review the relevant literature on social integration and reinsertion and its relationship with vocational training in general and SCE's in particular. It will also look

at the evidence concerning recovery, purposeful living, quality of life, abstinence and treatment adherence, planned reinsertion and relationship with methadone maintenance treatment (MMT). Van Hout & Bingham, 2014 reported essential specialist treatment and rehabilitation service providers' thoughts and views on MMT client recovery and participation in SCE schemes within the Dublin North East Regional Drugs Taskforce (DNEDT) area. This study concurred with (Lawless 2006, Van Hout & Bingham 2012; and Gossip 2001) that MMT provided a useful stabilisation tool. It provides a*: 'window of opportunity for the individual to create a new daily routine, create new relationships with partners, children, peers and friends, and improve readiness for engagement in learning, vocational training and employment directed outcomes'* (Van Hout & Bingham 2012, p.56). Van Hout & Bingham (2014) suggest a need for an; 'integrated community services tackling treatment, housing, cultural minorities, prison release, vocational training, supported employment and volunteering initiatives will improve ex-addicts' successful reintegration into society' (p.57); and *'that SCE must diversify from their fundamental approach as an adjunct therapeutic mechanism toward that of targeted work-based development, active citizenship and transitioning into the employment market'* (ibid,p.57). In an earlier report, Van Hout and Bingham in an earlier study for the CNEDT found that their research underscored *'the need for an extensive revision of the ethos and direction of existing "Special Community Employment" schemes in Ireland'* (Van Hout & Bingham 2012, p. 71).

The majority of countries reported the availability of programmes or services providing education or vocational training to drug users. However, the coverage of these interventions according to the target population's needs appeared below (ECMDDA 2013).

'Vocational rehabilitation' refers to all those processes, *'ideas or interventions that enable people with functional, psychological, developmental, cognitive and emotional impairments or health conditions to overcome barriers to accessing, maintaining or returning to employment or other useful occupation'* (EMCDDA 2012)

Keane (2006) found that in Ireland 'Vocational training contributes to a reduction in drug use and better treatment outcomes' (p.102), he notes that completion of vocational programmes strongly correlates with employment opportunities and educational

progress and positive improvements in quality of life. Keane (2006) also identifies that the 'dedicated' (p102) staff interventions showed effectiveness in gaining employment for participants. In general, individually targeted vocational interventions seek to improve both 'human and social capital' (Koo *et al.,* 2007). EMCDDA (2012) cites (Koo *et al.,* 2007, p. 1036) in describing 'Human capital' as activities that 'influence future monetary … income by increasing the resources in people' (Koo *et al*., 2007, p. 1036). This increase in human capital has been beneficial in many ways. Not least that Clients who are employed after treatment report more perceived control over their lives, and less depression, when controlling for these variables at admission to treatment (Kingree, 1997). Self-esteem is also enhanced by employment (Kerrigan *et al.,* 2000; Platt *et al.,* 1998; Schottenfeld et al., 1992), which may decrease substance misuse. Schottenfeld et al. (1992) also found that vocational education leading to employment positively affected self-confidence, economic wellbeing, enhanced social functioning, and enhanced social status.

There has been an emergence of similar forms of social enterprise in many European countries, including the introduction of new programmes such as the ' *finalite sociale'* in Belgium (1995), the social solidarity cooperative in Portugal (1998), the social initiative cooperative in Spain (1999), the social cooperative with limited liability in Greece (1999), and the *societe cooperative d'interet collectif* (SCIC) in France (2001). The replication of social co-ops in other countries has been an intended development, and since similar terminology is used in each country, mapping such developments is relatively easy. The approaches can be split into two fields: those concerned with social enterprise and those concerned with work integration.

The development of a complete treatment network for addictive behaviours has to include harm reduction programs (as buprenorphine and methadone maintenance programs) and recovery programs (as social recovery, peer-to-peer support programs, psychosocial support programs and therapeutic communities), based on evidence and previously validated. This perspective coincides with indications of the United Nations office of drugs and crime in quality standards for drug dependence treatment and care services (UNODC (2012). In practice, the transfer of programmes from other European countries (such as Spain, Italy, Belgium or Sweden) can improve the quality of services and standards of care (Barzanti 2017a; Barzanti 2017b)

In Croatia, social support and recovery-oriented programs can solve the lack of psychosocial support for people with addictive behaviours during the study. Identifying stakeholders from different stages, agencies and organisations (including the experience of drug users in different severities of addictive behaviours) allows access to a global perception and perspective about drug problems and solutions in Croatian reality (and with similar experience, in other European countries).

Recovery models have to integrate social support, active participation, gender perspective, and social integration. It is also necessary to create specific actions for several collectives, such as developing evaluation systems to validate recovery-oriented programmes' efficiency and adequacy. Adequate socio-health and psychosocial intervention are essential to reduce these problems (Tiburcio et al. 2011; ECMAAD 2014).

The Greek equivalent of Irelands SCE is the OKANA, where the Specialised Vocational and Social Reintegration Centre (EKKEE) implements workshops in vocational training. At the same time, Luxembourg initiated a 'START' programme in 2007, promoting drug users' reintegration into the employment market via training and education (Lambrette, 2009). A European report notes: *'A case management approach is adopted, and counsellors provide job coaching and other activities aimed at helping clients to find work or professional training (e.g. establishing contact with companies, preparing job interviews, editing of résumés)'* (EMCDDA 2013, p.95)

While international evidence shows integration on a training scheme and a focus on employment has tangible benefits, the issue is timing and sequencing within the recovery process.

2.4. Summary

In this chapter, we looked at the literature relating to the three main areas of study that affect the working milieu of our study sample, which are as follows: a) national economic, social and drug policy; b) drug misuse and recovery, theory and practice; and 3) community-based drug rehabilitation. The first section described the economic policy that led to an existing market activation initiative, the CE programme, which was 'drafted in' as a rehabilitation mechanism to meet the objectives of the first NDS (2001–8). This

appropriation, in turn, generated a hybrid programme known as the SCE programme. This examination provided the reader with an appreciation of the origins of 'inappropriate' bureaucratic demands and incongruous policies placed on SCE projects and staff by the systems created out of the exigencies related to a rapid response to the need for action to deliver a viable recovery programme and its unforeseen consequences on operational demands and service delivery.

The second section of this chapter examined the literature, past and current, on the various theories, strategies and intervention methodologies in use nationally and internationally around addiction and recovery. It reviewed a broad range of models that drug workers use to assess participants and choose suitable interventions and discussed communities' understanding of an appropriate model of approach that might differ from that of government and state bodies, such as the HSE.

The final part of this chapter considered the community element of this literature review. It examined the origin and evolution of the community movement and how, in turn, this has informed the ethos, policies and practices of community projects and provided an understanding of how the state and semi-state sector does not quickly or readily embrace community empowerment or share the communities underlying principles of social change. The subset of mutual interest between the state and the community and the voluntary sector is limited, leading to joint initiatives which are weak from the outset and further exacerbated by the intrinsic power differentials between the two parties. The community and voluntary sector remain trapped by a pre-conception on the state's part that 'it knows best'. This power imbalance is highlighted by McCann's (1999) observation that the state is often:

'a community's only source of funding for a community organisation, youth work, or other activities, involvement in them can cause a switch in focus from development work with local groups to management and administration of community-based training and employment schemes.' (p. 37)

It also reviews the literature on drug rehabilitation in relation to reintegration and social reinsertion along with vocational training nationally and internationally and its role in recovery and reintegration.

The Discussion, Conclusion and Recommendations chapters of this dissertation will analyse the areas of friction and contention between the demands of a market activation initiative, community principles and best practice in delivering a drug rehabilitation

service more deeply. Furthermore, they will consider their consequences for the work practices of those working in SCE programmes, and ultimately, the service users.

Chapter 3: Methodology

'Always using the same methods is not God's way.' (Sunday Adelaja 1997)

3.0. Introduction

This chapter discusses the choice of a conceptual framework, paradigm, methodology, and analytical methods employed in this research and the reasons for their use. Specifically, it looks at the ontological basis, epistemological assumptions, methodological approaches, and procedures used in this inquiry. This chapter also explains why a subjective pragmatist philosophical position was adopted and provides a rationale for using a mixed-methods approach as the correct method of investigation for this inquiry. This chapter also discusses the research design, sampling strategy, questionnaire development, interview scheme, analysis systems, validity, and potential bias sources. Finally, it looks at the ethical issues considered in the planning and conducting of this research. Salient literature is used throughout to elucidate on and support the choices made and research directions taken.

3.1. Conceptual Framework

Bogdan & Biklen (1982 p.30) suggest that a conceptual framework is*:* 'a loose collection of logically held together assumptions, concepts, and propositions that orientates thinking and research'; while Guba & Lincoln (1994 p.105) succinctly describe it as: '..a basic belief system that guides the investigation'.

These assumptions, beliefs and concepts form an intricate relationship which provides a structural framework to underpin an investigative journey as Dewey (1938, p.64) stated: 'If we view undertaking a piece of research as taking a journey of exploration, then the conceptual framework can be considered a map'. Therefore, in the initial phase of this research, it was essential to establish reference points which provide a context to begin the exploration and an intellectual compass to guide the journey.

The following chapter outlines the conceptual architecture underpinning this research; its use in providing a shared theoretical framework to situate this study, and provide a blueprint to guide the reader's interpretation of this work. It also act as a bridge linking the conclusions and findings of this study with a broader academic and social landscape.

3.1.1 Paradigm:

For a research piece to have structural and contextual validity, a philosophical lens or worldview, it must first establish an underlying theoretical foundation and an intellectual armature on which a meaningful academic investigation can be constructed. This philosophical and practical route map to guide a study is often referred to as a paradigm.

The word paradigm has its root in Latin '*paradigm*' which means pattern. Thomas Kuhn (1962) used the term to describe concepts that provided researchers with a common model for examining problems and finding solutions. Kuhn (1970) defined a paradigm as '…the entire constellation of beliefs, values, techniques and so on shared by the members of a given community'. Green (2007) uses the term Mental Model to capture the concept, while the term world view is suggested in papers by both Teddlie & Tashakkori (2009, p.84) and Carswell et al. (2007, p.21) among others. Thus, a paradigm implies a construct, a pattern, a design, a structure (Olson 1992) or a system of scientific and academic beliefs, ideas, values, and assumptions (Schwandt 2001, p. 183-4).

A research paradigm has an inherent structure where stances and positions are adopted, decisions made, and views taken. According to Guba (1990), this process can be formally conceptualised as a series of cascading domains: Ontology, Epistemology, Theoretical Perspective, Methodology, Methods and Sources.

The flowchart below illustrates these elements of the paradigm in graphical form.

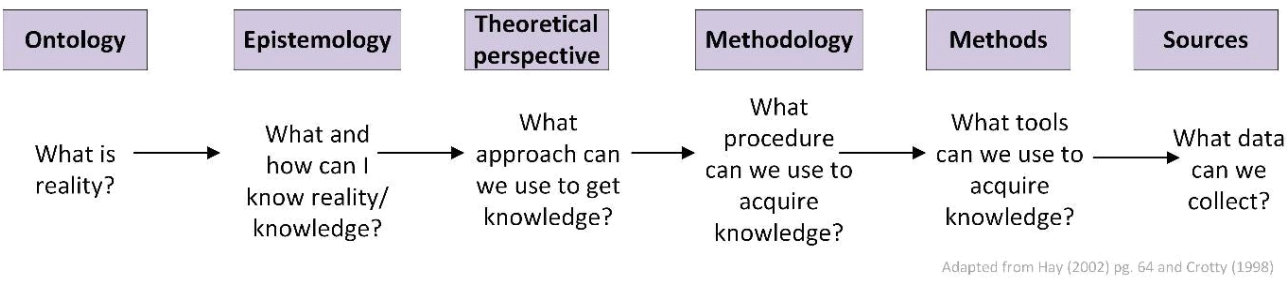


Figure: 3.1 (Adapted from Hay, 2002, p.64)

3.1.2. Ontological Position

Ontology is the branch of philosophy concerned with being and what exists in the world, and it makes assumptions about the form and nature of that reality. In other words, 'It considers what types of things there are in the world and what 'parts' or 'substances' the world can be divided into' (McQueen & McQueen 2010, p.151). It also, addresses what, if anything, it is possible to know about the world and what assumptions we can reasonably make about it (Snape & Spencer 2003; Richards, 2003; Crotty 2008).

According to Al-Saadi (2011 p.7), there are two central ontological positions. The first, objectivism, asserts that reality exists independently of our beliefs or understanding. It suggests that reality can be observed directly and accurately. Social phenomena and their meanings cannot change, and that life is defined in measurable terms rather than inner experiences. The second, constructionism, contends that external reality exists but is only known through the human mind and socially constructed meanings. It argues that there is no shared social reality, only a series of different individual constructions and that reality is subjective; and that meanings are produced through social interaction and are in a constant state of revision.

This inquiry focused on the lived human experience of SCE workers and their subjective experiences, and it is concerned with making sense of their reality. Therefore, it is contended that this research takes an ontological position based on constructionism.

3.1.3 Epistemological Stance

Having chosen an ontological position which seeks to answer the question; what is reality? It was essential to identify an epistemological stance. Epistemology asks the fundamental and connected question – 'what is the meaning of knowledge within this reality?'. Bryman (2008) defines epistemology as concerning '...the question of what is (or should be) regarded as acceptable knowledge in a discipline' (p.13).

Thus, epistemology is concerned with possibilities, nature, sources and limitations of knowledge in the field of study. Epistemology has been described as; 'the study of the criteria by which the researcher classifies what does and does not constitute the

knowledge.' (Hallebone & Priest 2009, p. 256).

Al-Saadi asserts that there are two broad schools of epistemology. The first of these, positivism, asserts that facts and values are distinct and separate. An objective and value-free inquiry is possible; knowledge is seen as concrete, tangible, and objective. It concludes that knowledge is arrived at through gathering of facts. Quantitative research method would best suit the positivist premise that objective reality exists independent of human perception (Sale *et al.,* 2002). This school argues that the investigator can study a phenomenon without influencing it or being influenced by it (Denzin & Lincoln 1994; Deshpande 1983; Sale *et al.,* 2002). It also views validity as correspondence between the data and the independently existing reality, which the data reflects (Guba & Lincoln 1994). Quantitative research findings are viewed as accurate or valid if prescribed, (objective) procedures are rigorously followed (Slevitch 2011).

Interpretivism, which is the second of these broad schools or approaches, contends that the researcher and the social world impact each other and that facts and values are not distinct. It suggests that objective and value-free inquiry is impossible since the researchers' perspectives and values inevitably influence findings. Knowledge is seen as personal, subjective and unique and that the researcher understands the social world using both his/her and the participants' understanding.

As an epistemological stance, interpretivism is associated with qualitative investigative methods (Deshpande 1983; Sale *et al*., 2002). Qualitative research is described as *subjectivist*: facts cannot be separated from values; absolute objectivity is viewed as unattainable and truth as a matter of socially and historically conditioned agreement (Smith 1983; Smith 1986). Therefore, qualitative scientific investigation aims to better understand the phenomena from the point of view of study participants (Bryman 1988). The emphasis is on a detailed description of the phenomenon through meanings, interpretations, processes, and contexts (Guba & Lincoln 1994) A third epistemological stance appears in the literature, is that of pragmatism (Maxcy 2003; Pansiri 2005; Ormerod 2006). Arguing that knowledge is at a fundamental level based on experience, pragmatism argues for an approach to philosophically engaged and practically focused research. It is premised on the "...proposition that researchers should use the philosophical or methodological approach that works best for the particular research

problem being investigated" Kaushik & Walsh (2019 p.3 cites Tashakkori & Teddlie 1998). Pragmatism focuses on the research aim, question, and results rather than on the methods employed to achieve them (Creswell & Clark 2011). Proponents of "Pragmatism" contend that while there is an objective reality, this reality can only be encountered and interpreted through human experience (Goles & Hirschheim 2000; Morgan 2014; Tashakkori and Teddlie 2008). Denzin and Lincoln (1994) and Morgan (2007) describe pragmatism as a potent research tool due to its usefulness, adaptability, and flexibility. The adaptability of pragmatism has been closely associated with mixed-methods (Johnson and Onwuegbuzie 2004; Maxcy 2003; Biesta 2010), which entails combining qualitative and quantitative methods (There is a thorough discussion of mixed-methods in the next section of this chapter).

3.1.4 Theoretical Perspective

The research question driving this study focused sharply on the perceptions and experiences of the research cohort. Significantly in this context, Marshall and Rossman (1999) and Holloway and Wheeler (2009) contend that qualitative methods focus on the subjects in their natural social, and professional context provides a better insight into human experience. For this reason, this study should be situated firmly in the qualitative realm. This view is supported by the fact that this research is intended to gain insight and understanding of the issues affecting the delivery of SCE drug rehabilitation services from the managers, supervisors and workers who deliver these services. Hammarberg & Kirkman (2016, p.449) suggest that 'qualitative methods be used to answer questions about experience, meaning and perspective, most often from the participant's standpoint. These data are usually not amenable to counting or measuring'. Another attractive feature of qualitative methods is that it recognises that the researcher's working experience and background is part of the study. As Creswell (2014, p.8) has pointed out '…researchers recognise that their backgrounds shaped their interpretation, and they position themselves in the research to acknowledge how their interpretation flows from their personal, cultural and historical experiences."' Hence, the development of an information-rich picture of this research cohort's work, including the researcher's role and experiences, further supported a qualitative perspective for this study.

When seeking to define quantitative approaches to research Carswell (1994) chose to highlight its concentration on *'explaining phenomena by collecting numerical data that are*

analysed using mathematically based methods (in particular statistics)' (p.52). Many involved in this approach to research, including Ayer (1959); Maxwell & Delaney (2004); Popper (1959); Schrag (1992) and Burke *et al.* (2004) have argued that there is little or no place for qualitative methods in deriving answers to a social phenomenon. This approach also emphasises the need for separation of subject and researcher. The emphasis on statistics (at the cost of experiential narrative) and lack of a position for the researcher in the study, would on the face of it militate against the adoption of quantitative measures as a central philosophical focus of this study design. However, so little research was conducted in this area indicated a prima facie demand for quantitative data to provide demographic information on areas such as size, makeup, and scale of the research sample and to 2wquantify and prioritise issues. This quantitative data provides a basis for further exploration. Thus, there is a need for quantitative data which sheds light on critical phenomena within the study without a need for an epistemological stance that only values this type of data. This dilemma is a challenge that faces many social science researchers and has been addressed by a series of authors who argue that the researcher should not *'be the prisoner of a particular [research] method or technique'* (Robson 1993, p. 291). Feilzer (2010) points out that 'Using ...additional qualitative data that emerge in survey responses enabled some more general reflections on the limitations of survey questions. What do survey respondents mean or what are they thinking about when answering Likert scale–type questions?' (p.10). Therefore, in essence, they argue for pragmatism at the levels of ontology, epistemology, and study design.

Pragmatism, therefore, provided a comfortable theoretical perspective which conforms to the requirements of this study in three main respects:

1) A preliminary literature review for this thesis showed a lack of demographic information relating to the research cohort; indicating that this research required the gathering of quantitative data to provide a detailed picture of the research group. A qualitative inquiry also provided a base-line understanding of the group's experiences, which identified questions that acted as starting points for further exploration and elucidation through further qualitative analysis.

2) It accommodated the researcher's relationship to the area of research and consequent

potential bias. Given, this researcher's work for the last two decades has brought them into close working relations with SCE workers and projects. Therefore, this researcher cannot be thought of as an impartial observer of the milieu under investigation. However, as Mertens (2005, p.247) suggests within a pragmatist epistemology '… the researcher himself is (or can be) the research instrument.' Chiliast and Kawulich (2019) observe that the researcher is inevitably influenced by, and in turn, influences the values, choice of subject and topic, the methods chosen to collect and analyse data. Therefore, the researcher will have *a priori* assumptions, predisposition, viewpoint, and learning, which influences all they do.

3) It accommodated qualitative inquiry to elicit the perceptions and experiences of the research group. Thus, enriching the study with insightful perspectives by providing 'real' and 'personal' vignettes to support hard quantitative figures. Adopting this pragmatic approach to the design of this research has led inexorably to choosing a mixed-methods.

2.1.5 Methodology: Mixed-Methods

'Mixed-methods time has come'. Morse *et al.* (2009, p.16)

In addition to the questions what and the why? Research needs to examine the what and the how of generating and understanding data. This is usually described as the methodology underpinning the study, and, in this case, it will be argued that the most appropriate methodology is a mixed-method one.

According to Morse *et al. (2009)*, a mixed-method methodology consists of a 'core component (the primary scientifically rigorous core method used) and the additional component that is not complete in itself' (p.18). he suggests mixed-methods as particularly useful in 'situations whereby the phenomenon cannot be described in its entirety by a single method' (ibid, p.15).

Morse (2016) points out the growing popularity of mixed methods in many fields, e.g. Politics (Caracelli 2006); Education (Green 2006); Health Services (Johnstone 2004); and Evaluation (Chen 2006). This broad and enthusiastic adoption of mixed-methods as a working model is underlined by Johnson and Onwuebuzie (2004 p14).

There are many definitions of mixed-methods research, all with distinct and nuanced differences. However, the following definition by Johnson *et al*. (2007) provides the best *exemplar of mixed methods for this study:*

'Mixed-methods research is the type of research in which a researcher or team of researchers combines elements of qualitative and quantitative research approaches (e. g., use of qualitative and quantitative viewpoints, data collection, analysis, inference techniques) for the broad purposes of breadth and depth of understanding and corroboration.' (p. 123).

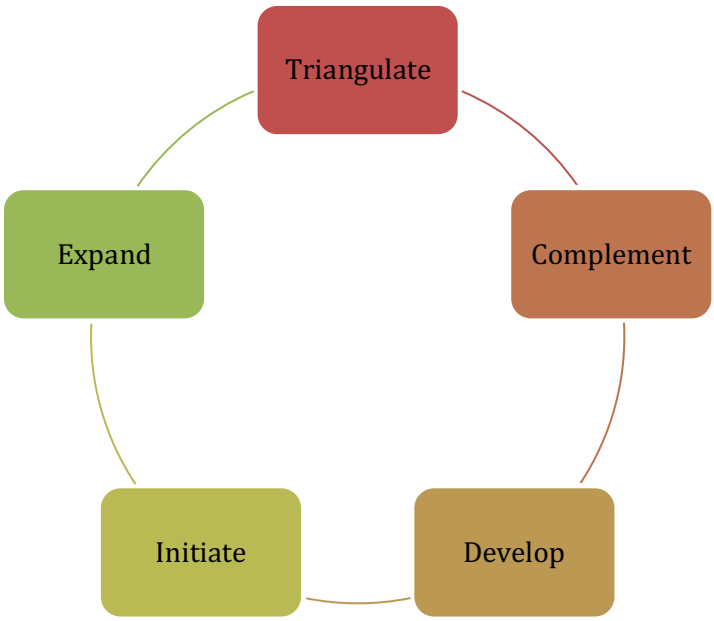


Fig: 3:2 (*Mixed method, five-point model: Adapted from Green 1989, p. 259*)

Greene *et al.* (1989) provided a five-point model (Fig: 3:1), which was adopted to guide the implementation of the mixed-methods approach used in this study: 1. *Triangulate,* provided a basis to compare, corroborate and reinforce results from different methods, 2. *Complement,* provided substantiation, illustrated, clarified and enhanced results from one method with the results from the other methods, 3. *Develop,* the results from one method,(e.g. quantitative), to help inform the form and structure of the other methods used; 4. *Initiate* the discovery of latent paradoxes and contradictions, new perspectives and frameworks, the recasting of questions or results from one method with questions or results from the other methods and 5. *Expand*, extending the breadth, range and richness

of the inquiry by using different methods for different inquiry components. The potential richness, breadth, and corroboration of data across these five parameters confirmed the adoption of mixed methods as an approach in this study.

Both qualitative and quantitative data collection methods were employed in this research. While 'quantitative research may be mostly used for testing theory, it can also be used to explore an area and generate hypotheses and theory' (Blaxter *et al.,* 2002, p.65) using both methodologies to inform and thereby enhance this investigation comprehensively. The qualitative data contributes to this study's narrative, while the quantitative data provides a skeletal structure to underpin the qualitative data. A mixed-methods approach provides complementary views of the same subject, as Ritchie & Lewis (2006) put it: *'qualitative and quantitative research should not be seen as competing and contradictory but should instead be viewed as complementary strategies appropriate to different types of research question'* (p.15).

Therefore, both qualitative and quantitative methods increased the research method's rigour and validity while enriching and enhancing its findings.

3.2. Research challenges

A significant challenge of mixed-method research is melding the data gathered by quantitative and qualitative means. Green (2006) asks how it is possible to unite and coalesce data from two different and incompatible paradigms. Morse *et al.* (2009, p. 19) note that 'How the researcher combines the qualitative and quantitative components in a single project is an essential consideration if rigour is to be maintained.' To this end, this study used a cascading process collecting and analysing broad qualitative data from a questionnaire, which identified areas and issues of concern. In turn, these concerns formed the basis for developing a suite of specific questions that formed the content of semi-structured interviews. These interviews yielded rich data about these identified issues. This study's discussion and conclusions element combined the quantitative and qualitative data into syntheses of issues identified in the quantitative questionnaire and elaborated on in the interview responses. These syntheses consolidated the study around eleven "headline" themes that drew on quantitative and qualitative research.

3.3 Ethical Consideration

3.3.1 Ethical Issues and Considerations

Three core principles guide ethical choices in this research process - beneficence, respect, justice and integrity (Sieber 1993). The principle of beneficence states that the researcher must always maximise the positive outcomes of research while at the same time avoiding any harm, risk, or wrongdoing to the research participants. The principle of respect suggests that the researcher should protect the autonomy of research participants. Finally, the principle of justice requires that the researcher ensure that the research is conducted fairly and justly.

It is widely acknowledged that social science researchers must be particularly sensitive to the power relations within their research – those implicated in that which they are investigating and those power relations between the researchers and those with whom they have dealings (Piccolo 2009; Fine *et al.,* 2000; Flyvbjerg 1998). Cresswell (2013), argues that ethics are part of the fabric of qualitative research and are integral to each phase of the investigative process. Thus, the following framework represents the approach taken to ethical considerations in this study.

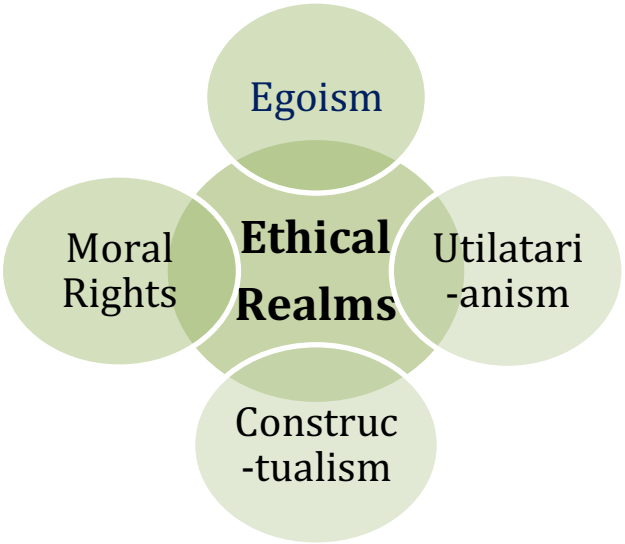


Fig 3:3 *(Relationship between ethics and research adapted from Singer 1981)*

The diagram in Fig: 3:2 is the model adopted as the ethical framework for this study. Here egoism is essentially about protecting the researcher and includes reporting misconduct,

avoiding plagiarism, and justifying decisions. Contractualism articulates reasons, explains motives, and protects data. Moral rights give concerns to participants' informed consent, assess vulnerabilities, and right to withdraw. Utilitarianism underpins the commitment to treating people fairly and humanly, providing supports where required and having responsibility for respondents.

Bell (2010), asserts that ethical research in practice must embody these principles: a) Informed consent of those a researcher intends to conduct the research on b) Negotiating and agreeing upon the uses of this data c) How its analysis will be reported and disseminated. Most recently was added the legal requirements under 2018 GDPR to safeguard sensitive personal electronic data.

This investigation adopted fully the theory, principles and procedures outlined above, to ensure compliance with the spirit and letter of academic and moral protocols while adhering to international ethical best practice.

3.3.2 Measures Adopted to Protect Research Participants

Negative aspects of research participation include discomfort, inconvenience, risk, and a perceived lack of impact of research findings (Barratt *et al.*, 2007). Therefore, it was imperative to communicate to those taking part in this research how participation in this research may inform and influence policies and enhance interventions responding to local and community practice in drug rehabilitation. Participants were made aware that this, in turn, could be beneficial to practitioners, participants and the broader community. Participants were protected throughout the research process by ensuring that their consent to participate in the research was informed and voluntary, and by the security which assured their participation remained anonymous and confidential. The risk of harm to the research participant was minimised through these measures, and no harm resulted.

3.3.3. Informed Consent

An ethical issue of concern in drug use research concerns the ethics of informed consent. In this study, participants were informed of what they are consenting to both verbally and in writing. Furthermore, they were requested to provide consent both verbally and in writing by signing a consent form. Potential research participants were provided with a written research information sheet or plain language statement *(see*

Appendix: F). This statement contained information on the purpose of the research, the data collection methods (i.e. a semi-structured interview), the estimated length of the interview and the number of research respondents involved. The information sheet also stated that participation in the research was completely voluntary and that consent to participate could be withdrawn at any time throughout the research process. When participants agreed to participate in the research, they were again verbally informed of the research purpose, data collection method, analysis, and what was expected of them through their participation.

They were also informed on how their data is stored; what will happen to the data once the research project has been completed; and data dissemination parameters. All participants were provided with the opportunity to ask questions and seek clarification about the research and its process. When in agreement to participate in this research, all participants signed a 'Consent Form' (Appendix: G), that is also counter-signed by the researcher conducting the interview or focus group. All consent forms were held on file in a secure filing cabinet in research's office. The participants were reminded throughout the research process that they could withdraw their consent at any time. The researcher was aware of non-verbal signs of distraction, disinterest, agitation and irritation (Rodgers, 1999), indicating the participants wished to withdraw from the research. These were dealt with sensitively, as they arose.

3.3.4. Anonymity

All research participants were assured of anonymity (i.e., any information they shared will not be identified or attributable to any individual). All research participants were assigned a unique identifier with all transcriptions and quotes identified in this way to ensure anonymity and confidentiality. This Anonymity allowed a greater exploration of sensitive issues. Assurance of Anonymity was included in the research information sheet (see Appendix: F). Interview audio recordings and the written interview and focus group transcriptions were held on file electronically on a password-protected computer with hard copies stored in a secure filing cabinet in the research office. Participants were also aware that some or all the data held might be used for research and subsequent reports and publications. Finally, participants were assured that all data and other related documentation collected in the study would be held securely only for as long as

required by the University for academic purposes. The researcher will securely destroy it.

3.3.5. Confidentiality

Research into drug-related issues has become increasingly difficult to conduct due to confidentiality and the extent to which confidentiality can be assured to research participants (Fitzgerald and Hamilton 1996, Corrigan 2003). Ethical dilemmas regarding confidentiality must be given consideration when research is conducted by 'practitioner-researchers' defined as 'those who have responsibilities as health/social care practitioners and who are conducting research' (Bell & Nutt 2007, p.70). Guidelines for researchers dealing with disclosures of confidential information have been identified by the Dublin City University's Research Ethics Committee's and highlight the disclosures that may present challenges throughout this research process. These include, but are not limited to, the disclosures that the individual or someone they know is at risk of harm or abuse; the disclosure of a past offence they have knowledge of or have committed; disclosure of impending danger to third parties; and disclosure of the commission of a criminal offence (DCU Research Ethics Committee 2010). Disclosures of this nature were dealt with following best practice guidelines, which recommend that researchers inform the research participants of limits of confidentiality as outlined above (DCU Research Ethics Committee 2010).

Confidentiality and the limits of confidentiality were discussed as part of the informed consent process, and the following steps were taken to ensure confidentiality: an explicit statement about who will have access to the data; information on how the data will be retained; and what measures were taken to ensure the research participants identity remains anonymous.

3.3.6. Reduction of Harm and Risk

Reducing the likelihood of harm throughout the research process was a key consideration. There are four main types of potential risk for the research participant and the researcher (Craig *et al*. 2000); the risk of physical threat or abuse, risk of

psychological trauma, risk of accusation of improper behaviour and increased risk of exposure to general risks of everyday life (e.g. infections or disease).

The following is a list of potential and theoretical risks identified as inherent in this study and the actions taken to minimise their chances of occurrence.

- Physical threat or abuse - interviews and focus groups were conducted in researcher's offices or a local drug service premises with which the research participant was already familiar.
- Risk of psychological trauma - following the interview, participants were provided with the option of seeing a counsellor, if they appeared upset or expressed emotional distress at any point.
- Risk of an accusation of improper behaviour - interviews and focus groups took place at the research office or local drug service premises that the research participant was already familiar with and under the usual office protocols of respect, dignity and appropriateness.
- Increased risk of exposure to general everyday life risks - it was not envisaged that data collection would give rise to any additional risks that would not be encountered in the day-to-day work participants in which they were already engaged.

3.3.7 Ethical Approval

An ethical approval submission was made to the ethics committee of Dublin City University. A research information sheet, an informed consent form, an interview, and a focus group topic guide were developed and included in the submission. The committee approved this submission (see Appendix: H).

3.4 Research Design:

3.4.1 Overall Approach:

To maintain cohesion, manageability and internal integrity the design of this research adhered strictly as possible to the principles of conducting a robust mixed-methods study, suggested by Morse *et al.* (2009, p.21);

1. Work with as few data sets as possible. (Keep it simple)

2. Recognise and respect the project's theoretical drive.

3. Recognise the role of the supplemental component.

5. Adhere to the methodological assumptions of each method.

6. Carefully consider the pacing of components

7. Sample must be compatible with the assumptions belonging to the method it serves.

8. Mixed method design is systematic.

9. Keep the two data sets (Qualitative & Quantitative) separate until the point of interface at the discussion

10. If measurable, measure. Keep limitations in mind.

11. Whatever is being coded or counted must make sense.

This overall approach provided a theoretical scaffold that supported and shaped this study's planning, structure, and conduct.

After the adoption of the above approach, it was necessary to identify a research sample, the next section we will look at the decisions that were made with regards to sampling and then explore each of the research methods used:

- Focus groups

- Questionnaires
- Semi-structured interviews
- Reflective journal

before finally moving onto the modes of analysis employed.

3.4.2 Research Sample and Recruitment Methods

To gain access to an appropriate research cohort, 'key individuals or gatekeepers' (Maykut & Morehouse 1994, p.71) were approached across various potential participating organisations to support the study. Research sample sizes should be large enough to obtain enough data to sufficiently describe the phenomenon of interest and provide comprehensive insight into the research questions. Researchers' goal should be to attain saturation, which is said to occur when adding more participants to the study does not result in additional perspectives or information (Glaser & Strauss 1967; O'Reilly & Parker 2013). For studies of the type undertaken in this thesis, Creswell (1998) recommends 5 to 25 interviewees while Morse (1994) suggests a minimum of at least six, bearing in mind that the size of the sample depends on the consideration of several factors including:

'The quality of data, the scope of the study, the nature of the topic, the amount of useful information obtained from each participant, the number of interviews per participant, the use of shadowed data, and the qualitative method and study design used' (Morse 2000, p.3).

3.4.3. Focus Groups Sample

The focus group samples were made up of three strata of workers; e.g. managers, supervisors and project workers. The participants were selected randomly, from those indicating a willingness to partake in the session, and reflected the ratio of positions which occurred in the workplace. The participants were recruited from 4 different task force areas across the study catchment area to provide a broad geographic view of situational issues.

Group 1: This first focus group consisted of one manager, one supervisor, one assistant supervisor and three project workers.

Group 2: The second group consisted of two supervisors, one assistant Supervisor and five project workers.

3.4.4. Quantitative Sample

To gain access to the appropriate research cohort, *'key individuals or gatekeepers'* (Maykut & Morehouse 1994, p.71) in potential participating organisations across the Dublin, Regional and Local Drugs Task Force area were contacted. These individuals acted as supports for the study, helping with liaison, organisational ethical approval and access to individual drug workers. All n=34 organisations in the Dublin, Regional and Local Drugs Task Force area which sponsored a SCE project were contacted by email or phone, and n=22 of these projects agreed to participate in the study. Upon confirmation of the agreement, the researcher briefed all staff on the study's aims and objectives. The ethical and logistical elements of the study were also conveyed. The research questionnaire was distributed to all staff members, and a prepaid stamped envelope included for return. Participation was voluntary for each individual who chose to participate in the study and identity of those who completed questionnaires and returned questionnaires was anonymous for individuals. The researcher retained a key which identified the project for continuity of subsequent qualitative sampling.

The n=22 projects yielded a response of 73 questionnaires, one of which was spoiled, and two others were illegible; thus, the quanta of completed and usable questionnaires was n=70. These (n=70) comprised of:

Managers = (n=17)

Supervisors = (n=22)

Project Workers = (n=31)

Creswell (1998) suggests that qualitative research sample sizes should be large enough to obtain enough data to sufficiently describe the phenomenon of interest and provide comprehensive insight into the research questions. The goal of researchers should be the attainment of "saturation" referred to earlier in this chapter. For studies of the type

undertaken in this thesis, Creswell (1998) recommends 5 to 25 interviewees while Morse (1994) suggests a minimum of at least six, bearing in mind that the size of the sample depends on the consideration of several factors including: 'quality of data, the scope of the study, the nature of the topic, the amount of useful information obtained from each participant,' (Morse 2000, p.3), a researcher in consultation with supervisor agreed on an initial interview sample of n=9. This number provided an optimum spread of three (n=3) interviewees across the three employment strata, and geographically diverse (n=9 locations) enough to represent the catchment area of the study, e.g. one interviewee from each Local Drugs Task Force areas (n=8) and one from an Area Drugs Task Force (n=1).

All responding projects in the nine geographic areas (n=18) were asked for interview participants. Twelve projects responded with a total of 21 potential interviewees. The breakdown of potential interviewees was six Managers (n= 6), eight Supervisors (n=8) and seven Project Workers (n=7). Using the geographic and employment status criteria referred to earlier, nine (n=9) candidates representing n=3 managers, n=3 supervisors and n=3 project workers were randomly selected. One back-up from each stratum (n=3) was also selected and nominated to replace any individual from their strata who might not complete the interview process.

Nine (n=9) semi-structured interviews were conducted as follows:

Managers = (n=3)

Supervisors = (n=3)

Project Workers = (n=3)

3.5. Research Structure:

3.5.1 Phase 1: Focus Groups

Patton (2002) defines a focus group as 'A focus group interview is an interview with a small group of people on a specific topic. Groups are typically six to eight people who participate in the interview for one-half to two hours.' (Patton 2002, p.385). This

investigation used an initial focus group format comprising two groups (each manager, two supervisors and three or four drug workers). These focus groups were convened to identify broad areas and themes of interest and concern amongst SCE workers. The areas of concern raised in these group conservations helped inform the focus of the future work in the project, including guiding the development of a questionnaire.

This combination of the focus group, literature review, interviews with key stakeholders and informal discussion with project workers was used to gather a broad preliminary view of the issues salient to the investigation. Subsequently, this information was used to create a set of questions used for the questionnaire. The use of a questionnaire had the following benefits: it produced a large amount of data on a topic in a short time; provided access to topics that might be otherwise unobservable; ensured that data directly targets the researcher's topic and provided access to comparisons that focus group participants make between their experiences.

3.5.2 Phase 2: Questionnaire Development:

Developing a questionnaire is a critical step in many investigations and must be carefully structured, designed and administered for the best effect; its importance is stressed in many works (Saris & Gallhofer 2014; Blalock 1990). The type(s) of information obtained from a questionnaire can vary widely and may include:

> Data on personal characteristics; data on work qualifications and practices; data on working conditions and resources; or background information about the person and his or her attitudes, beliefs, or opinions on specific issues." Anderson (2008 p.100)

The questionnaire must be carefully designed to ensure that the most appropriate and useful information is collected and careful consideration of how this data will be analysed and reported, what the findings might contribute and whom this might affect.

The questionnaire design should clearly describe what kinds of data will be collected, how the data will be analysed and reported, what the findings might contribute and whom this might affect. This thesis has adopted the structure illustrated in Table:3.1 below.

Component	Description	People Involved
1. Purpose	This questionnaire is designed to generate a demographic profile of the study sample and provide information on the issues and concerns which impact their work. This information will help to identify problems and develop solutions.	Policy makers; key stakeholders; managers; supervisors; project workers.
2. Blueprint	The respondent group identified areas of focus generated from "Focus groups", question themes chosen, provisional graphic layout created, and logistics of administration decided upon.	Focus group; researcher; key stakeholders
3. Item	Develop questionnaire items. Refine and clarity questions, cross reference with themes and research question.	Researcher: Academic Supervisor.
4. Data analysis plan	Processing Information: Data coded transferred from questionnaire to "Excel" spreadsheet. Data collated and processed. Production of quantitative statistical results related to coded data fields.	Researcher; Supervisor.
5. Pre-test	Designed, produced, and proofread questionnaires. Pilot test Conducted.	Researcher; pilot test group.
6. Final questionnaire	Refine questionnaire and administration instructions on basis of pre-test data and feedback from pre-test administration. Produce a final form of questionnaire.	Researcher; Academic Supervisor; study participants.

Table 3:1 *(Adopted from Anderson et al. 2008, p .101)*

Further guidance on constructing questionnaires came from the BRUSO model of Peterson (2000), where a good questionnaire should be 'Brief, Relevant, Unambiguous, Specific, and Objective".

This study's questionnaire was designed around three themes that emerged from focus groups and the literature: 1) Demographic Questions: (e.g. age group, gender, grade). 2) Job-Related Questions: (e.g. induction, supervision, inter-agency relationships). 3) Training and Development (e.g. training to-date, level of training, barriers to further training). For full details on questions in the questionnaire (see Appendix: F)

3.5.3 Phase 3: Interviews

Despite an era of new interview media and computer-mediated communication, the face-to-face research interview is the 'pre-dominant interview technique in the field of qualitative research' Opdenakker (2006, p.1). Qu & Dumey (2011) argue that the research interview is still: 'one of the most important qualitative data collection methods available' (p.238). Kvale (1983, p.174) defines the qualitative research interview as 'an interview, whose purpose is to gather descriptions of the interviewee's life-world with respect to interpretation of the meaning of the described phenomena'. While Arksey and Knight (1999) suggest that 'Interviewing is a powerful way of helping people make explicit things that have hitherto been implicit- to articulate their tacit perceptions, feelings and understanding' (p.32). Thus, face-to-face interviews formed an essential part of the methodology for this study, along with the use of focus groups and a questionnaire.

An interview is more than just a conversation; indeed, it is more than a formal conversation. Instead, an interview involves taking a position, making assumptions and understandings about a situation which are not generally associated with a simple conversation (Silverman 1985).

According to Bernard (1988), semi-structured interviewing is best used when the researcher will not get more than one chance to interview someone and when the researcher will be sending several interviewers out into the field to collect data. The semi-structured interview guide provides a clear set of instructions for interviewers and can provide reliable, comparable qualitative data.

Semi-structured interviews are preceded by observation, informal, unstructured interviewing or focus groups (as is the case with the current research methodology). This preliminary inquiry is conducted to allow the researchers to develop a keen understanding of the topic of interest necessary for developing relevant and meaningful semi-structured questions.

During preparation for the interview phase of this research, potential interviewees were identified, contacted and enlisted with the group's cooperation which had made

up the questionnaire respondents. It was also essential to engage and motivate potential interviewees' by discussing the importance of work. During the initial engagement with the interviewees, the researcher clarified the objectives, method, nature and scope of the questioning in order that the individual could assess their desire to participate. Each potential interviewee had read the "plain language statement" (Appendix C) for this study and signed an informed consent form when satisfied that they wished to continue.

Due to the nature of the assignment and awareness of not introducing biases by a tightly focused set of questions, it was decided to opt for a semi-structured interview format. According to (Denscomb 1998) when dealing with semi-structured interviews, the interviewer still maintains an exact list of issues to be addressed and questions to be answered. However, the interviewer is prepared to be flexible in how the topics are considered and, perhaps more significantly to let the interviewee develop the ideas. The inclusion of open-ended questions and the interviewers' ability to follow relevant topics that may stray from the interview guide provides an opportunity to identify new ways of seeing and understanding the topic at hand.

This approach was deemed most appropriate for this study, given the desire to elicit frank and intimate interviewees' responses.

Interview Schedule:

These semi-structured interviews were carried out to deepen, elaborate upon, clarify, correct, and enrich the data obtained from the questionnaire. As the interview questions evolved from and were informed by, the responses to the questionnaire, the interview schedule conformed to the following broad areas,

1) Current role and function in the SCE programme:
2) Training & Education
3) Personal Development (*See Appendix: J for a full list of questions*)

3.5.4 Keeping a Reflective Journal

The concept of reflective practice, frequently associated with the work of Schon (1983), has received increasing attention among a growing cohort of professional practitioners in the field of social work and education, with the aim, of integrating the theme of reflective thinking as a means of learning, into professional practice and research. (Gould

& Taylor 1996; Gould 2000; Howe 1998; Lishman 1998; Martyn 2000; Powell 1996).

The Oxford English Dictionary describes a journal as 'A daily record of news and events of a personal nature; a diary'. Moon (2003) goes on to elaborate on this definition suggesting that; 'journals, logs, diaries, portfolios are containers for writing that is recorded over a period. This writing may accompany a programme of learning, work, fieldwork, or a research project.' (p.2)

A Critical Reflective journal was maintained (see Appendix:6) throughout the data gathering months for this research. This record provided the researcher with an insight into the learning gained in the experiential process of the research itself. Wolf (1989) describes this process as taking something from inside ourselves and making it explicit, suggesting that it is a means of discovering who we are, that we exist, and change and grow.

3.5. Triangulation:

Triangulation is a method used to increase the credibility and validity of research findings (Cohan *et al.*, 2000). Denzin (1970) argues that there are four types of triangulation, i.e. data triangulation, researcher triangulation, theory triangulation and of relevance to this study 'methodological triangulation, which promotes the use of several data collection methods such as interviews and observations' (p.301).

Bekhet and Zauszniewski (2012) state that methodological triangulation or mixed-methods research uses more than one kind of method to study a phenomenon. There are two types of methodological triangulation: 'within method' and 'across method' (ibid, p.2). Within-method studies use two or more data-collection procedures, quantitative or qualitative, but not both. Across-method studies, the technique chose for this study combine quantitative and qualitative data collection techniques (Casey and Murphy 2009).

Triangulation has limitations when used to combine research methodologies; triangulation may not be achieved in a uniform or consistent manner (Noble 2020). Additionally, researchers may not adequately explain their techniques for blending results and have created overly complicated research designs (Murdock 2019).

3.5.6. Position of Investigator

A crucial aspect of this research is 'the assumptions made about the nature of, and

relations between, subjects, the texts they produce and the conceptual tools and strategies used to analyse them' (Davies & Gannon 2003, p. 7).

This research project was primarily interview-based, and therefore the researcher was the main 'instrument' of data collection. Like Ortlipp (2008, p. 697), I had misgivings in the overly simplistic linear research process expressed by (Glensne & Peshkin 1992; Patton 1990). In essence, this suggested all would be well if the researcher followed the rules and paid attention to reliability, validity, and objectivity.

This researcher is aware that he is not a neutral participant in this study. Instead, he is a participant with experiences, concerns and opinions about the SCE programme. The researcher aspires for the project's success and hopes for what it will achieve or discover. Thus, this researcher cannot be seen as an objective, inert gatherer and processor of data. Harrison *et al.,* (2001, p. 325) suggest the researcher *'make it clear how the researcher's own experiences, values, and positions of privilege in various hierarchies have influenced their research interests…'*Scheurich (1997, p.255) proposes that research interviewing can be reconceptualised in keeping with a postmodern approach by making the 'baggage' we bring to the research visible. Opening the researcher's history, values, and assumptions to scrutiny. Not as an attempt to control bias, but to make it visible to the reader.

From an epistemological perspective, the old pillars of internal and external validity, reliability and objectivity are challenged by Guba and Lincoln (1994) theories. The new paradigm uses criteria such as: Credibility (results of qualitative research are credible or believable from the perspective of the participant in the research); Dependability (whether we would obtain the same results if we could observe the same thing twice); Transferability (the degree to which the results of qualitative research can be generalised or transferred to other contexts or settings, and Confirmability (Confirmability refers to the degree to which the results could be confirmed or corroborated by others) to establish validity.

The researcher has also been clear from the outset of this document as to his position concerning this study; providing the reader with sufficient understanding of the stance and position taken, that when provided with the structure, methodology, procedures

and of this study they can make their mind up as to the robustness of its findings.

NB: Relevant excerpts from this reflective journal and their import on this study are written-up in the Reflective Journal section of the discussion in chapter five.

3.6 Analysis of Research

3.6.1 Quantitative Analysis:

In all cases where a usable questionnaire was returned the data was divided into separate sets for managers, supervisors and project workers, each of these sets was again divided into themed question categories (i.e. Demographics; Work-related issues and Training and development) thus producing a total of nine sets of data. These data were coded, checked for errors and entered on Microsoft Excel spreadsheet.

3.6.2 Interrogating Data:

The data was labelled, formatted and ranges coded (Elliot *et al.,* 2006), the data was then treated in two ways. Firstly, a combined data set for managers, supervisors and project workers were used to give an overall picture of the sample group in terms of demographics was generated. Secondly, separate datasets for managers, supervisors and project workers were used to provide more precise data relating to those specific sub-groups. The coded data were statistically processed for totals, means, and standard deviations to summarise the data and allow meaningful comparisons between the different sub-groups.

3.6.3 Data Presentation

The data which emerged from the questionnaire analysis was processed, graphed and documented firstly for the entire sample (n=70) and then for the managers (n=17), supervisors (n=22) and project workers (n=31). The data from the demographic questions were presented as graphs and discussion. Due attention was paid to amount of data presented (Gillan 1998), the mix of graphic and numerical data (Loftus 1993) and the level of detail required to meet reader demands (Gillan 1998; Hink *et al.,* 1998). The data relating to Work-Related Issues and Training and Development were aggregated and

presented as a numerical hierarchy of concerns. A group of numerically significant issues from both the Work-Related Issues and Training and Development sets were selected and formed into themes for further investigation at the study's qualitative phase.
All graphs and figures were produced in Microsoft Excel, while tables were generated in Microsoft Word.

3.7 Qualitative Analysis:

Creswell *et al. (*2006), make the point that the qualitative component of a mixed-method design is not merely an adjunct, 'It is also helpful to note that within any given mixed-methods study, the priority (Morgan 1998) or weight' (p.3). Thematic analysis was used to understand the lived 'experiences, meanings and the reality of participants' (Braun & Clarke 2006, p.81). The themes that emerged from the qualitative work and were elaborated upon in the qualitative interviews. The following five steps process was used for analysis.

3.7.1 Data Familiarisation:

Patton (2015 p.523) suggests that the researcher 'begin analysis during fieldwork'. This researcher used notes throughout the interview process; thus, the transcription contained verbatim transcription with notes providing the essence of what the participant conveyed in the interview. The researcher personally typed the interview transcription to gain emersion in the raw data and was conscious that the 'choices that researchers make about transcription enact the theories they hold and constrain the interpretations they can draw from their data' (Lapadat & Lindsay 1999, p.1).
In preparing the data, the researcher-initiated pre-coding by circling, highlighting or underlining important words or sentences and adding notes on personal observations and reflections (*See Appendix: M*).

3.7.2 Initial Code Generation:

Eleven main themes had emerged through the quantitative element of this research (see Results). Therefore, during the initial coding cycle, the researcher used the transcription process to identify, ascribe and map participants relationships, interactions, conditions,

constraints, consequences and assumptions to each specific thematic area (Saldaña 2013).

The second cycle of coding was what Patton (2015, p.551) identifies as 'Content Analysis' in which this researcher identified statements, observations, feeling and concerns which were felt to contribute understanding to one of the eleven themes. Where ambiguity arose and clarity was required, interviewees were re-contacted to elucidate further on their contributions.

3.7.3 Reviewing Themes:

The emerging qualitative data was merged with the themes and were listed and reviewed by the researcher who identified concurrences, contradictions and anomalies. These, in turn, were noted and results used to review the themes derived from the quantitative results. These themes were subsequently affirmed, modify or adjust considering new data.

3.7.4. Reporting:

The thematic analysis of the qualitative data is reported under eleven themed headings separately from the quantitative findings. In chapter five, the two sets of findings are synthesised under the 11 themes. The combined findings are then analysed, discussed in supporting literature, conclusions are formulated, and recommendations proffered (Patton 2015; Goodall 2008; Walcott 2010).

3.7.5. Reflection on Quantitative Research

This study sought to understand SCE professionals' experiences, thus, the theoretical approach taken to this research's qualitative element was phenomenology. '

'Phenomenology is a school of thought that emphasises a focus on people's subjective experiences and interpretations of the world. That is, the phenomenologist wants to understand how the world appears to others' (Trochim 2020, p. 2).

The use of phenomenology in research extends as far back as the 1950s, and it became increasingly popular in the late 1970s, and 1980s (Giorgi, 1970; van Manen, 1997). Cohen (2000) suggested that phenomenology is most useful when the 'task at

hand is to understand an experience as understood by those having it'. A phenomenological enquiry has two main streams: descriptive (eidetic) phenomenology, which draws more heavily on the work of Edmund Husserl (1859-1938) and, more recently, Amadeo Giorgi; and interpretative (hermeneutic) phenomenology, drawing on the work of Martin Heidegger (1989–1976) and later Max Van Maanen.

Reflection in action:

'… During the individual interview processes, it was difficult to manage digression, I was always wondering if enough relevant data was being generated, and within the specific themes to provide a basis for any real conclusion to be drawn, I made a conscious effort to stick to the rota of questions and avoid any small talk or body language that might influence a response' (Learning Journal 6/6/19).

Reflection on-action:

Descriptive phenomenological researchers believe that each lived experience has a "descriptive emphasis" (Todres & Holloway, 2006, p. 181) or features that define a phenomenon most generally. Husserl (1931) coined the phrase essential structure to refer to these experiential commonalities. This essential structure can be achieved: *'by focusing on a specific lived experience in several variations; it is thus, possible to identify insights that are common throughout experiences, and that can be applied more generally beyond the cases within the study in order to emphasise the universal themes held within the lived experiences'* (Mayoh & Onwuegbuzie 2015, p.9). They conclude that 'descriptive phenomenologists aim to make a conscious effort to minimise the researcher's role in the data' (Ibid, p.10).

'The issues which emerged from the quantitative questionnaire provided a basis on which to construct the semi-structured interview questions. There was concerned that so many differing points of view and issues might arise that it would be impossible to make any sense of the data. It has provided a sense of security that there is a valid connection between the data from the questionnaire and the data which will hopefully emerge from the interviews' (Learning Journal 16/5/19).

Mayoh & Onwuegbuzie (2012) found that a quantitative element of inquiry feeding into

a qualitative study was a popular approach for a phenomenological approach. Perhaps because the essentially focussed nature of phenomenological research; which requires the researcher to be orientated towards a specific experience before data collection occurs. In many Quantitative/Qualitative/Phenomenological studies, preliminary quantitative data collection is used to construct interview schedules, identify questions and provide orientation. It can also help identify participants for the qualitative phase who can provide information-rich experiential accounts (Dean, Hudson, Hay-Smith, & Milosavljevic, 2011; Hamdan-Mansour *et al.,* 2011; Mayoh *et al.,* 2012; Thornton, Baker, Johnson, & Lambkin, 2011).

3.8 Chapter Summary:

In this chapter, we have looked at this project was planned and executed. It provides a philosophical basis for anchoring this inquiry and a sound conceptual framework to support and guide this investigation. It provides an overview of the research's architecture and offers a rationale and explanation for the methodology and methods chosen to gather both quantitative and qualitative data. It also looks at the consideration given to ethical issues and the measures taken to address these concerns.

Chapter 4: Research Results

'However beautiful the strategy, you should occasionally look at the results.' (Winston Churchill 1944)

4.0. Introduction

This chapter examines the quantitative and qualitative data gathered in this mixed-methods study, producing results for analysis and discussion. It will document and illustrate the data drawn from the quantitative survey questionnaires and the qualitative data amassed from the researchers' thematic analysis of the semi-structured interviews (Appendix: J). It will also integrate and inter-relate the findings from the two distinct investigative methodologies employed in this study to produce a cohesive set of interpolations that will provide a basis for this document's discussion section.

Chapter four is subdivided into two main sections; 1) Quantitative findings and 2) Qualitative findings. Each subsection is divided into three domains to assist integration and comparison of both study elements; these sub-sections illustrate broad categories of sample response: a) Demographics; b) Work-Related Themes and c) Training and Education Related Themes. A summary of each subsection's findings is given at the end of each section; this will enable the reader to easily connect the findings from one section to the other and appreciate how the quantitative findings informed the qualitative inquiry process.

The population of the study sample in total is n=70 (100%). This sample comprises three categories of worker, corresponding to project Workers, supervisors and managers. Each of these strata was identified and analysed separately in both the quantitative questionnaires and the semi-structured interviews due to their differing duties, responsibilities, perspectives and relationship with the SCE programme. This specification provided a very accurate picture as it provided the ability to identify differences of opinions, perception and nuisance at each grade. It also lent itself to

varying combinations and comparisons of grades, to create a rich picture of the experiences.

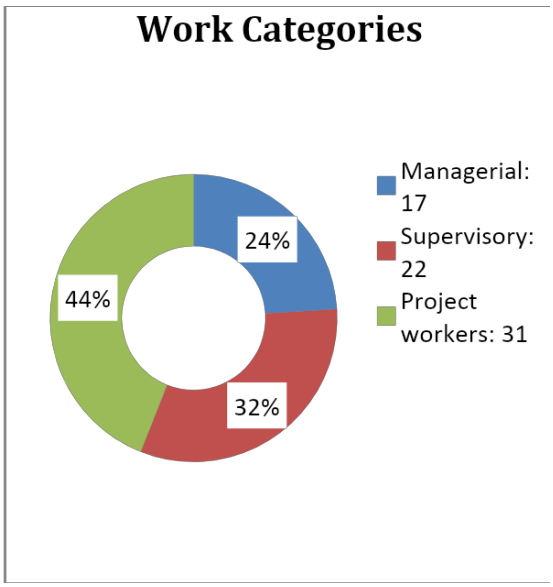
4.1. Quantitative Results:

As outlined in the previous chapter 3.5.2, the quantitative element of this study consisted of a survey questionnaire which contained a mix of multiple-choice and open-ended questions, designed to elicit data under the three broad headings a) Demographics: This established a picture of the people that populate our study sample, including their gender, job, age and education. b) Work-Related Issues: Under this heading we look at the experience of the group as they relate to the workplace, including supports, frustrations, and barriers to service delivery and c) Training and Development: Looks at training issues relating specifically to professional skills, personal development, and career advancement and generically to health and safety.

The data gathered was coded into datasets, and the following information was extracted from the datasets.

4.1.1. Demographics

This section will provide the reader with an introduction to the overall survey sample and provide a graphic display of this demographic structure. The overall survey sample is N=70 (100%) individuals and contains three broad categories of worker, i.e. managerial 24% (n=17), supervisory 32% (n=22) and project workers 44% (N=31) (see fig: 4.1).



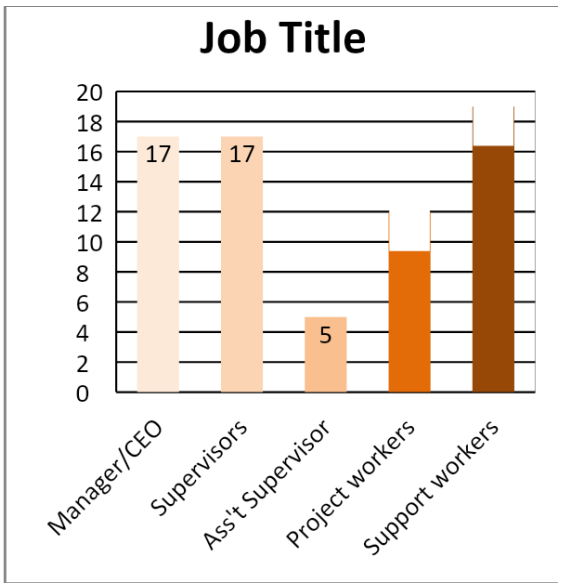


Fig: 4.1 (*Sample numbers by work categories.*)

Fig: 4.2 (*Sample numbers by job title*)

Age Profile

The age profile of our sample is as follows: 24% (n=17) fell within the 22 to 42-year-old age bracket; 44% (n=31) were in the 42 to 51-year-old bracket; 26% (n=18) indicated the 51 to 60 range while 6% (n=4) were over 60 years of age (see fig: 4.3).

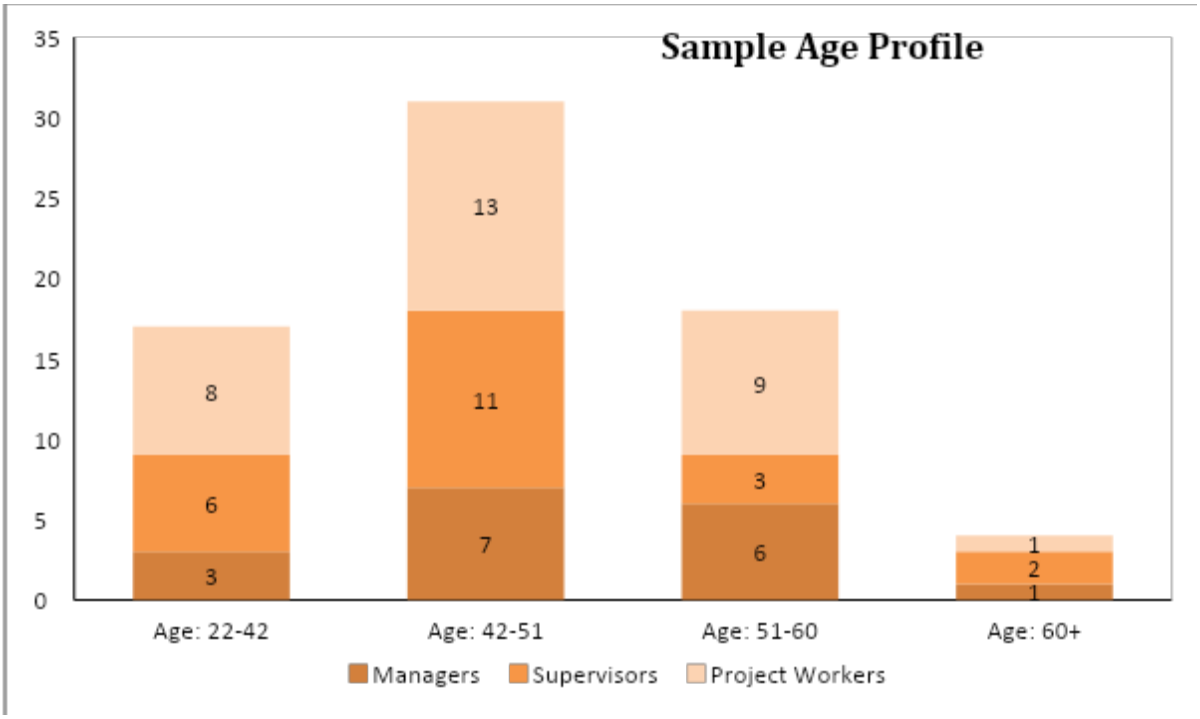


Fig: 4.3 *(Age profile of sample)*

The respondents ranged in age from 22 to 60-year-old plus; however, none of the respondents was under 22 years, and six were over 60 years old.

45% of the project worker group fell within the 42 to 51-year-old age category; while the 22 to 41-year-old and 52 to 60-year-old age categories represented 25.8% respectively. The Supervisor group reported 11% (n=4) of respondents were from the 22 to 41-year-old age group 41% (n=9) indicated they were in the 42 to 51-year-old category, 32% (n=7) indicated the 52 to 60 age group and 9% (n=2) fell within the 60+ age bracket. The average age of entering SCE work was 39 years. While the managers' group reported that 35% (n=6) were aged in the 52 to 60 age bracket, 41% (n=7) noted that they were in the 42 to 51-year-old category and 18% (n=3) respondents indicated that they fell into the 22 to 41-year-old and 6 %(n=1) represented the 60 plus-year-old category.

Work Experience in the Drugs Field

When asked about their working experience in the drugs and addiction field, the response of the sample100% (N=70) was as follows: 41% (n=28) fell in the 0 to 5 years range; 21% (n=15) were within the 6 to10 year bracket; 24% (n=17) indicated the 11 to15 year slot; 13% (n=9) selected the 16 to 25 year range and 1.4%(n=1) individual had worked in the field for more than 25 years (see fig; 4.4).

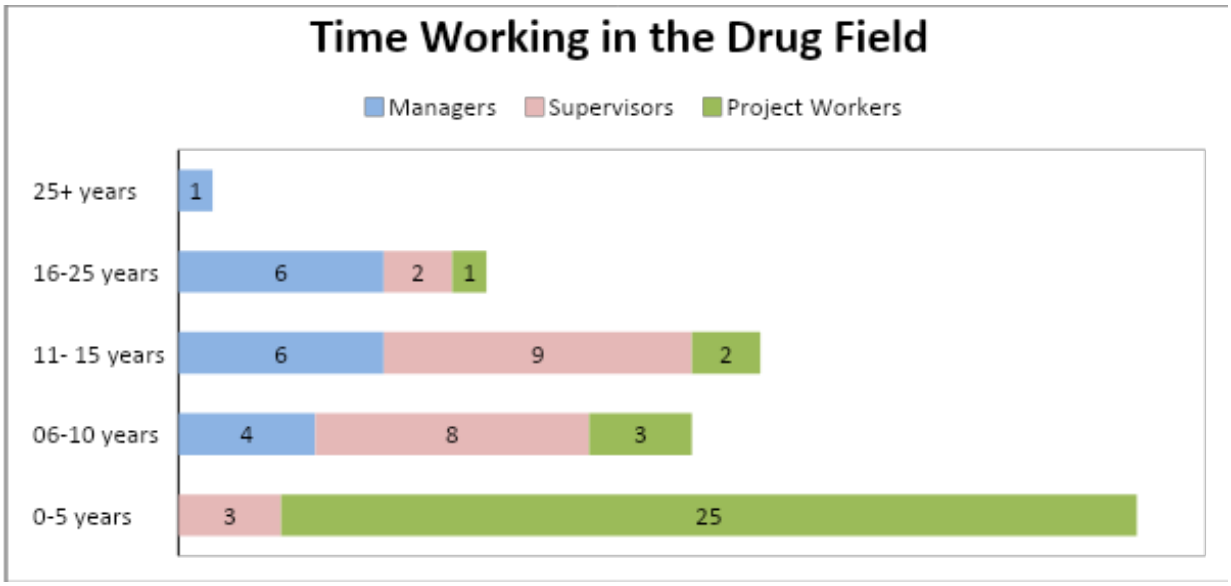


Fig: 4.4. (*Time working in drug and addiction field*)

In response to the question asking, *'How long have you been working in the drugs field*?', the project worker sample n=31(100%) provided the following data: 81% (n=25) indicated that they fell within the 0 to the 5-year band, while 10% (n=3) were between 6 and 10 years in their current employment. 6% (n=2) were in the 11 to the 15-year range with a further 6% (n=2) between 16 and 25 years with their SCE project. Supervisor data N=22 (100%) indicated: 14% (n=3) in the 0 to 5 slot, 36% (n=8) in the 6 to10-year slot, another 41% (n=9) in the 11to15-year range and 9% (n=2) in the 16 to 25-year band. The manager group" N=17 (100%) findings were: 18% (n=3) fell into the 6 to 10-year category, while 35% (n=6) had between 11to15 years in-service experience, another 41% (n=7) had between 16 to 25 years' experience in the drugs field; and 6% (n=1) had more than 25 years working in the drugs field.

Education Level to Date

Figure 4.5 provides a graphic illustration of the sample current education level on the National Qualification Framework ten-point scale. On the lower end 3% (n=2) reported qualification of level 4 or less, while 11% (n=8) indicated level 5, 10% (n=7) reported level 6, 29% (n=20) held a level qualification, 31% (n=22) attained level 8 and 16% (n=11) respondents possessed a level 9 qualification. It is noteworthy that 23% (n=17) of respondents are below level 7 attainment.

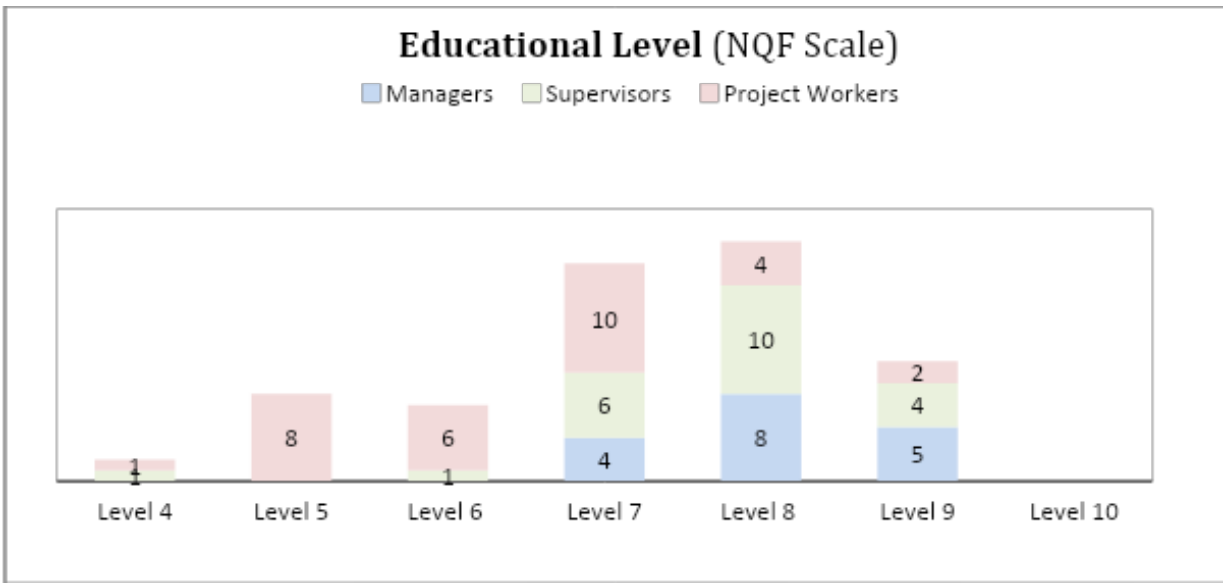
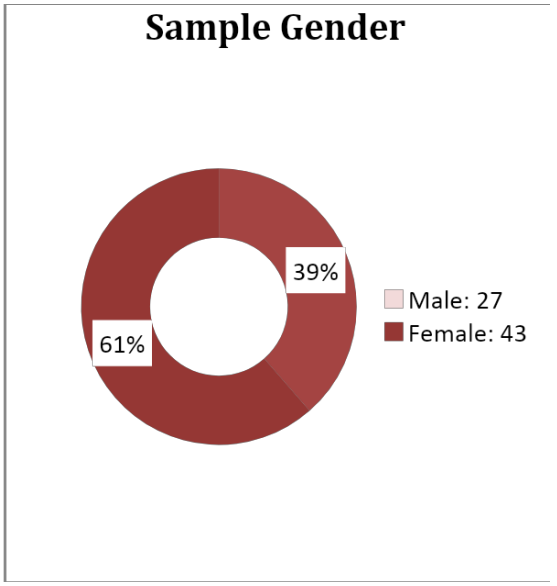


Fig: 4.5 (Education by employment category)

Project workers data on NQF level: 3% (n=1) indicated level 4 or less, 26% (n=8) had attained level 5, 19% (n=6) held a level 6 award, 32% (n=10) held a level 8, while 13% (n=4) had obtained a level 9 award. Among the Supervisor group 5% (n=1) had attained level 4 or less, n=0 responded with level 5, 5% (n=1) indicated level 6, 27% (n=6) reported level 7, 45% (n=10) had gained level 8 awards and 19% (n=4) had reached level 9. The manager group reported 24% (n=4) holding a level 7 award, 47% (n=8) holding a level 8, and 29% (n=5) with a level 9 award.

Gender:

The gender balance of the combined sample is 61% female and 39% male (see fig: 4.6).



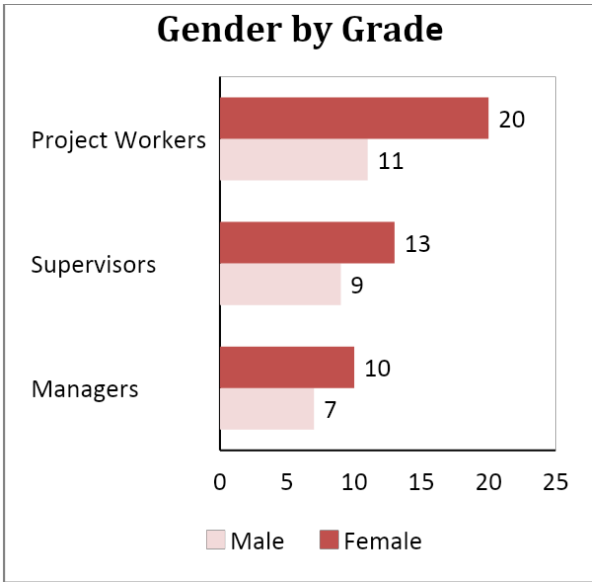


Fig: 4.6 *(Gender of sample)* Fig: 4.7 (Gender by employment category)

For gender breaks down across the work categories (see fig: 4.7) as follows:

All 31 of the Project Worker respondents who completed and returned the study survey 11 were male, and 20 were female or 66% female and 34% male which is reflective of the group as a whole. Of the n=22 (100%) of supervisors who responded, 41% (n=9) were male and 59% (n=13) were female and of the 17 (100%) of managers who responded 41% (n=7) were female and 59% (n=10) were male.

Comments on Demographic Findings

The quantitative demographic findings provide a picture of a mature group with the average age being 40 years old, and for 95% of whom, SCE was not their first job. This

statistic implies a maturity of character and a high degree of life skills and previous work experience among the cohort.

The question about time working in the drugs field indicated that project workers had 3.8 years of drug work experience on average. In comparison, Supervisors had, on average, 12 years' experience in this field and Managers showed an average of 15 years of drug work experience.

An overall gender ratio of 61% (female) and 39% (male), when analysed by sub-group, showed that: Project workers showed a 65% to 35% female/male differential, while both the supervisor and manager sub-groups showed a 59%/41% split for female /male gender. This predominance of female workers is reflective of the caring professions in general.

Educational data showed that 76% (n=53) of the sample held a level seven award or higher, with 16% (n=11) holding a postgraduate qualification. Project workers (not surprisingly) were at the lower end of attainment with 48% (n=15) holding a level 6 or below with 26% having gained a level 5 award. 91% (n=20) of Supervisors had attained a level 7 award or higher with 64% (n=14) with honours degree status or higher. 100% (n=17) of managers held a level 7 or higher award with 76% (n=13) with level 8 or higher. These statistics indicated a well-educated sample group with a strong emphasis on education, particularly in the leadership and management roles.

The picture emerging from these data is a sample cohort of mature individuals with life and past work experience. It also shows a sample who are well educated and have substantial on the job experience this is particularly true of the supervisory and manager grades.

4.1.2. Work-Related Issues:

Supports:

Evidence emerged from the researchers work with the focus groups and stakeholders that there were evident concerns that drug work involved potentially damaging levels of stress, pressure and interpersonal problems. This concern is supported by alcohol and

drug worker stress studies (e.g. Griffith *et al.,* 2000; Layne *et al.,* 2004), emphasising the importance of emotional and psychological supports (Duraisingam *et al.,* 2009; Kavanagh *et al.*, 2002) in reducing workplace stress and burnout. Hence the survey asked the sample 'Were do you receiving workplace support?' and 'What form does it take?' the answers are, as follows.

All N=70 respondents agreed that emotional and personal 'support' was essential to doing their job. 98% (n=69) noted that they received some form of support (fig: 4.8) and 91% (n=63) found this support to be adequate for their needs (fig: 4.9).

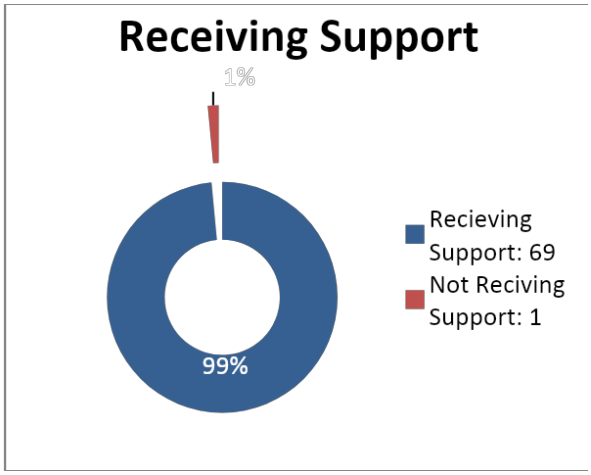


Fig: 4.8 (Numbers receiving support.)

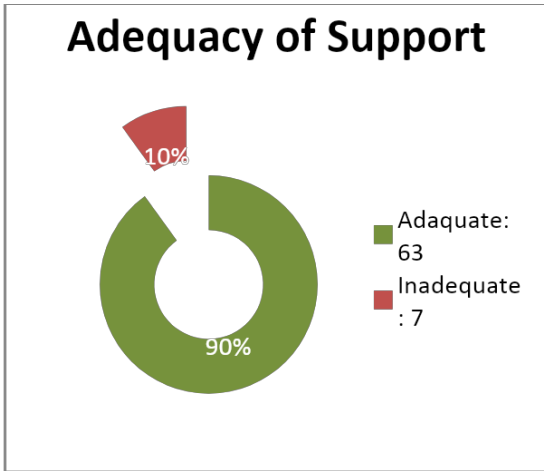


Fig: 4.9 (Perceived adequacy of support.)

When asked what form? These supports took the sample answers fell into five modes as follows (Fig: 4.10.):

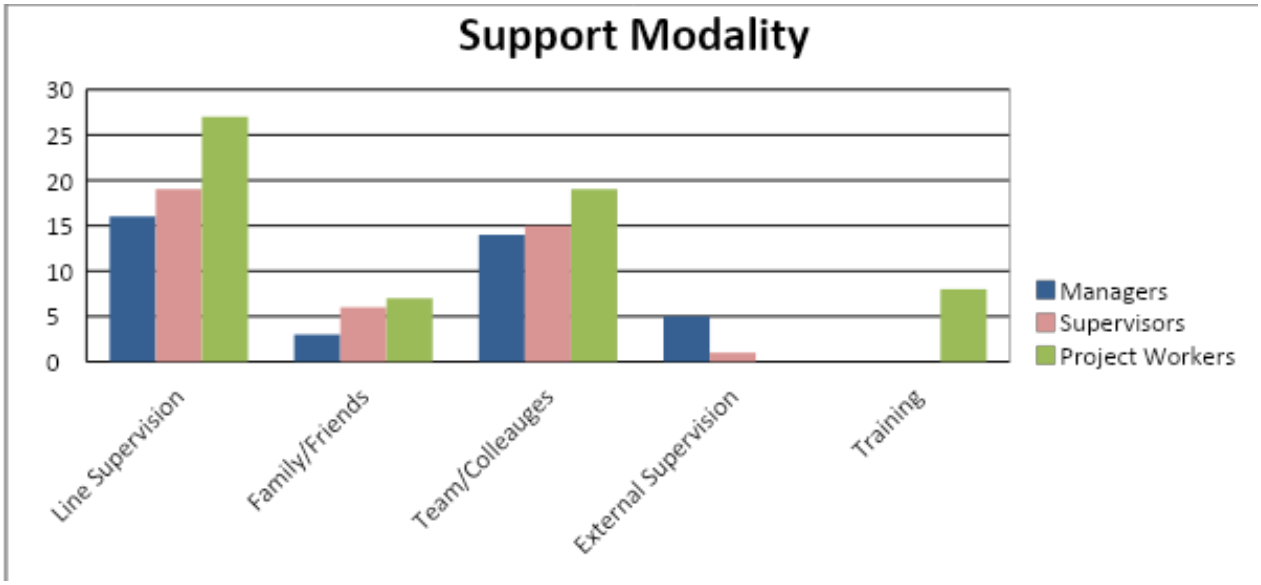


Fig: 4.10 *(Form of supervision used)*

Formal Line Supervision was the most commonly used mode for all groups, with 88% (n=62) accessing support in this mode. Colleagues and team members were used for support by 69% (n=48) of our sample. Friends and family provided support to 23% (n=16), while 11% (n=8) found that training provided them with part of the support the needed and 9% (n=6) had external supervision.

Some respondents availed of more than one mode of support the graph in the figure: 4.11 illustrates this usage:

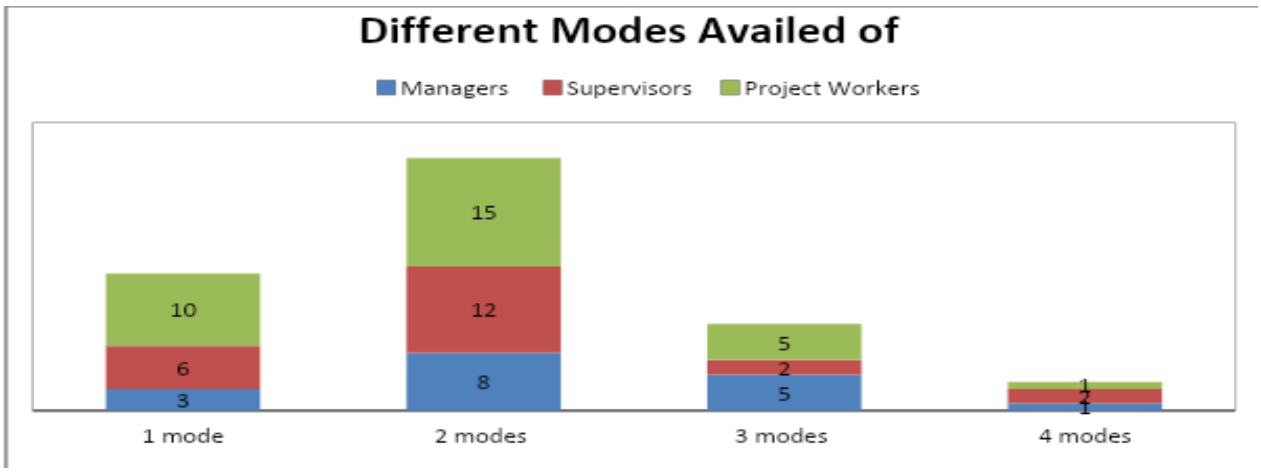


Fig: 4:11 *(Number supervision types used)*

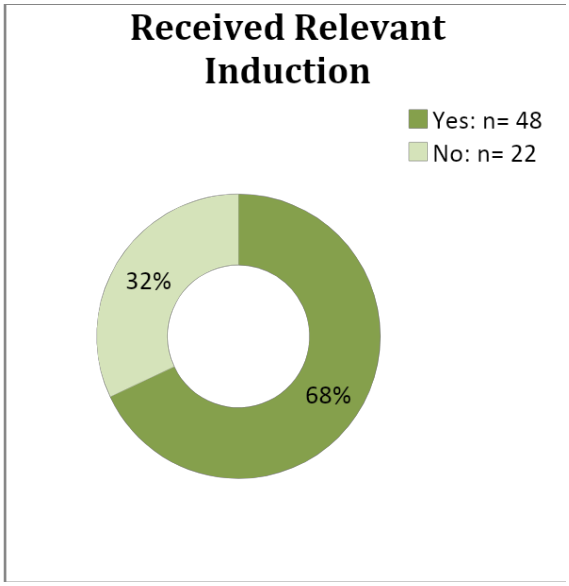
27% (n=19) of the sample indicated that they received at least one mode of 'support' and 73% (n=51) reported that they received two or more modes of support. The frequency of the formal supervision was generally monthly; other modes were generally *ad hoc.*

The findings on supports indicate that potential dangers relating to emotional health, personal well-being and work stress are well understood on the projects. Many different non-exclusive and complementary modes providing support have been deployed.

Induction

Work-related stress and anxiety can be effectively moderated by good workplace induction programmes (Louw-Potgieter & Hendricks 2012; Derven 2008; Wanous & Reichers 2000), data on the provision and content of 'Induction' is as follows:

All 70 (100%) of the sample responded to the question' Did you receive an induction to your current job?" 80% (n-56) indicated they 'had' while 20% (n=14) indicated they "had not". Of the 80% (n=56) who received an induction 87% (n=48) said they found the induction relevant. This result implies that while 68% (n=48) of the total sample had received a relevant Induction programme, 32% (n=22) did not receive a satisfactory Induction (figure: 4.12). A breakdown of this by grade is illustrated in Figure 4.13.



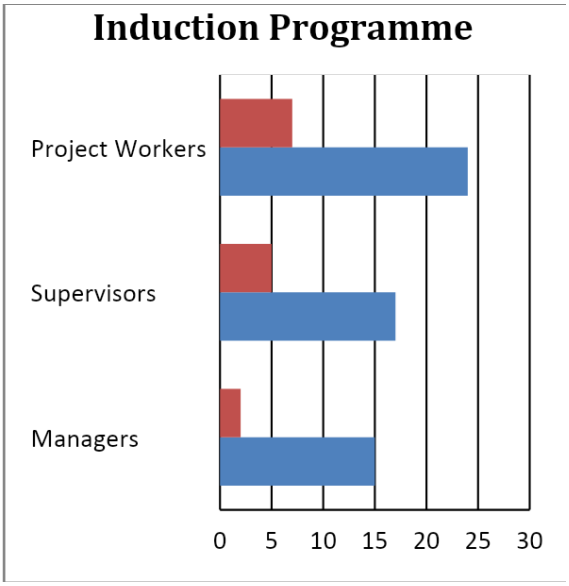


Fig: 4.12 (Number thought induction relevant.) Fig: 4.13 (Numbers receiving induction)

While this lack of adequate induction is revealing in itself; the follow-up question; 'What was your induction programme's content?' produced the following. Of the 56

respondents who had received an induction of any kind, 89% (n=50) answered this question (see fig: 4.14). Respondents could choose more than one answer.

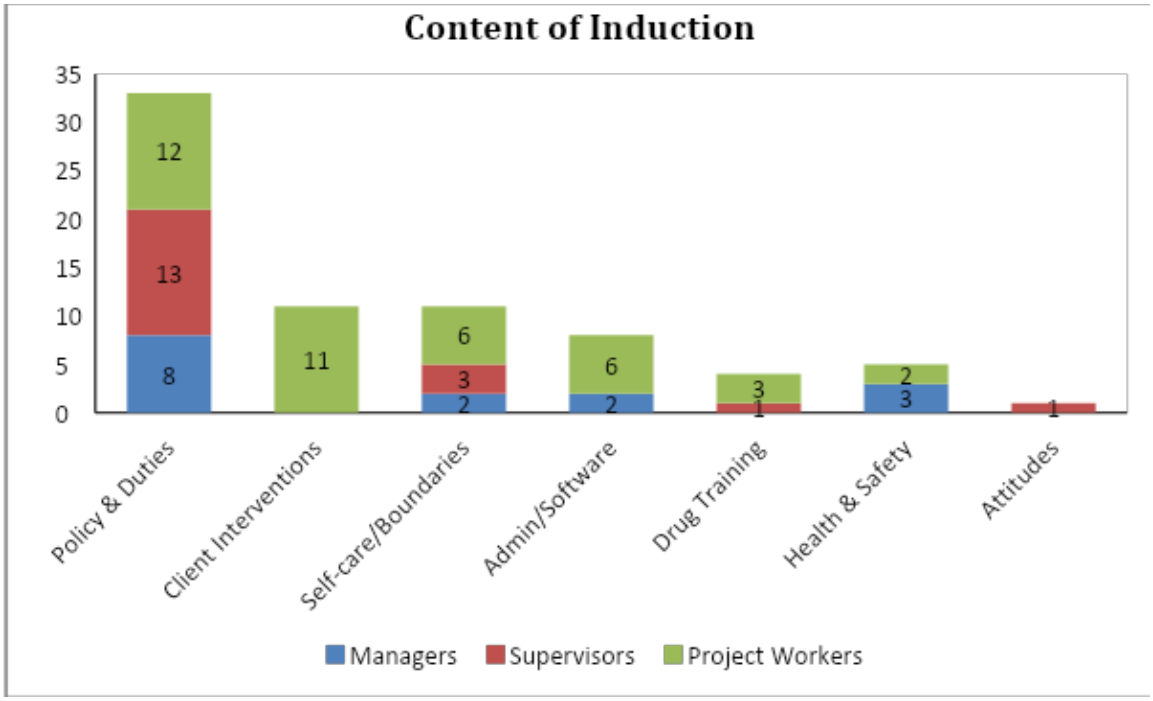


Fig: 4.14 (Induction content)

There would appear to be a heavy emphasis on the policy and duties element of induction and relative weakness in the self-care and boundaries element. At the same time, there is a concerning lack of input on health and safety.

Issues Affecting Programme Delivery:

The question 'What Issues are affecting the delivery of your SCE programme?' was followed by a blank space, to provide the respondent with an open-ended question. This space was provided to garner the broadest possible range of issues and concerns that the sample could provide. After data clean-up, these issues and concerns were coded and assigned nine broad categories for sense-making purposes. These categories are a) Lack of funding: Including material, capital and training budgets, b) Staffing Issues: Including selection, recruitment and retention of support and project workers; c) Participant Issues: Mental health, homelessness, behavioural issues; d) Relationship with DSP: including policy, procedure, administration, leadership and interpersonal issues; e) Premises: including issues of adequacy, security, safety and health; f) Participant recruitment: Incentives, disincentives, changing demography of service users. g)

Training: Perceived lack of adequate training, access to relevant courses and personal development; h) Stress, burnout and pressure; interagency issues.

The following chart (fig: 4.15) illustrated the compiled quantitative data from this question, 91% (n=64) of the sample provided usable answers to this question, and more than one answer was permitted.

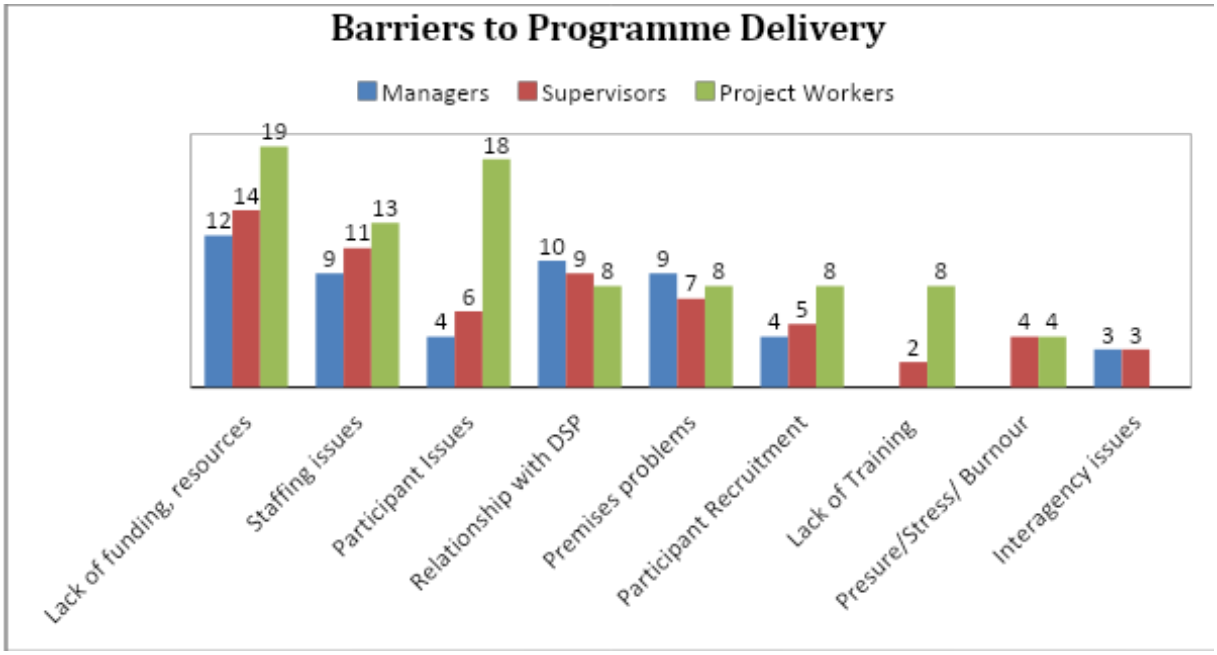


Fig: 4.15 (*Barriers to programme delivery*)

The organisation of data to enable the integration of this quantitative data with the qualitative data in this mixed-method study; required consolidation as follows: a) 'inter-agency issues' is expunged for its small response; b) 'Stress and Burnout' will be dealt with within the qualitative dimension of Supervision and Induction, and c) 'lack of training' will be incorporated into the next section of this report on Training and Education. Finally, premises issues will be subsumed into the Funding and Resources section for brevity. This configuration provides five key areas of concern to be explored at the interview stage. (Table 4.1)

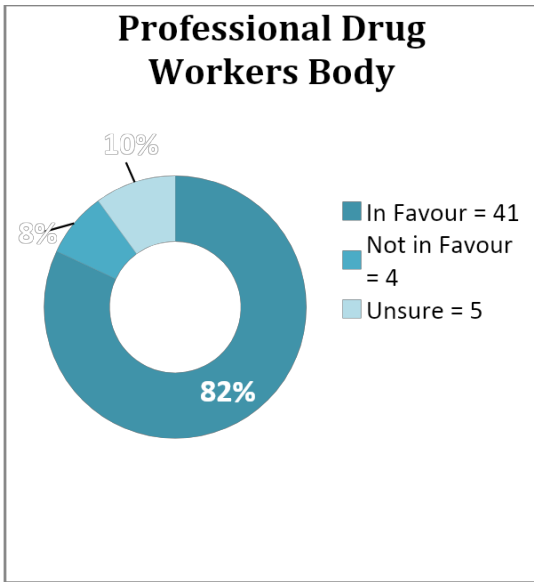
	Barriers to Programme Delivery	Quant
1	Lack of finances, resources and adequate premises.	69
2	SCE staff recruitment and retention	33

3	Participant Issues	28
4	Relationship with DSP	27
5	Participant recruitment	17

Table 4.1 (*Concerns by numerical frequency*)

General Questions

When asked about the need for a professional body to represent drug workers' interests and set professional and educational standards? 82% (n=41) of those who responded were in favour of such a body being established, 8% (n=4) were not in favour, and 10% (n=5) were unsure at this time (see fig: 4.17) The last question in this section is 'How does society value drug work?' and 86% (n=43) of respondents felt 'Too little'; 8% believed society placed 'no-value' on drug work; 4% (n=2) perceived society to value drug work 'Too highly', and 2% (n=1) felt it was just right (see fig:4.18).



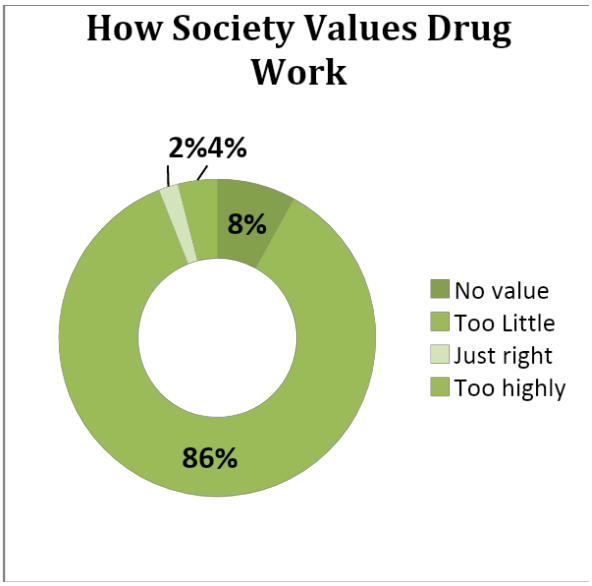


Fig: 4.16 (*Numbers in favour of professional body.*) Fig:4.17 (Social value of drugs workers)

4.1.3. Comments: Work-Related Results

Support: The dangers of stress, work pressure and anxiety seem to be well understood in SCE projects. The relationship between managing these issues and providing support is also well understood. There is a broad range of formal and informal support modalities provided for and encouraged among staff. The respondents felt they were adequately supported in this area.

Induction: What might be less understood by SCE projects is the relationship between induction and stress. While there is an attempt to provide an Induction in most cases reported, it would appear that this an induction is not conducted with the consistency and rigour that one might expect from a professional rehabilitation programme. Many who receive induction are unable to see its relevance, and those who find relevance are not provided with a structured, comprehensive, or homogenous programme. The importance of an induction programme to the integration and well-being of staff demands that this area be investigated in greater detail at the qualitative stage.

Programme delivery Issues: Using hierarchical statistical selection to order and consolidate the panoply of issues raised by respondents in this section, five key issues were derived. a) Premises/Resources, b) Staff recruitment, c) Participant issues, d) Relationship with DSP, e) Participant recruitment along with the issue as mentioned earlier around induction process will form the structural basis for further enquiry at the qualitative stage.

General: There was overwhelming agreement at 86%, that society placed little or no value on the drug worker's work, which indicates a lack of a sense of professional esteem. There was also significant agreement at 82% that there was a need for a professional body to enhance this image, provide direction and set educational and professional standards.

4.1.4. Training and Development Issues

As noted previously, the lack of training was an issue for 26% (n=8) of the project worker group. Due to the limitations of this study's scope and scale, this section of the research confined itself to issues surrounding training and development for project workers as a group.

The quantitative results assessing previous training and education's strengths and weaknesses, as reported by project workers, are mapped below. The data were subdivided into three categories: knowledge, skills and attitudes presented in figures 4.18, 4.19 and 4.20.

Knowledge area deficits

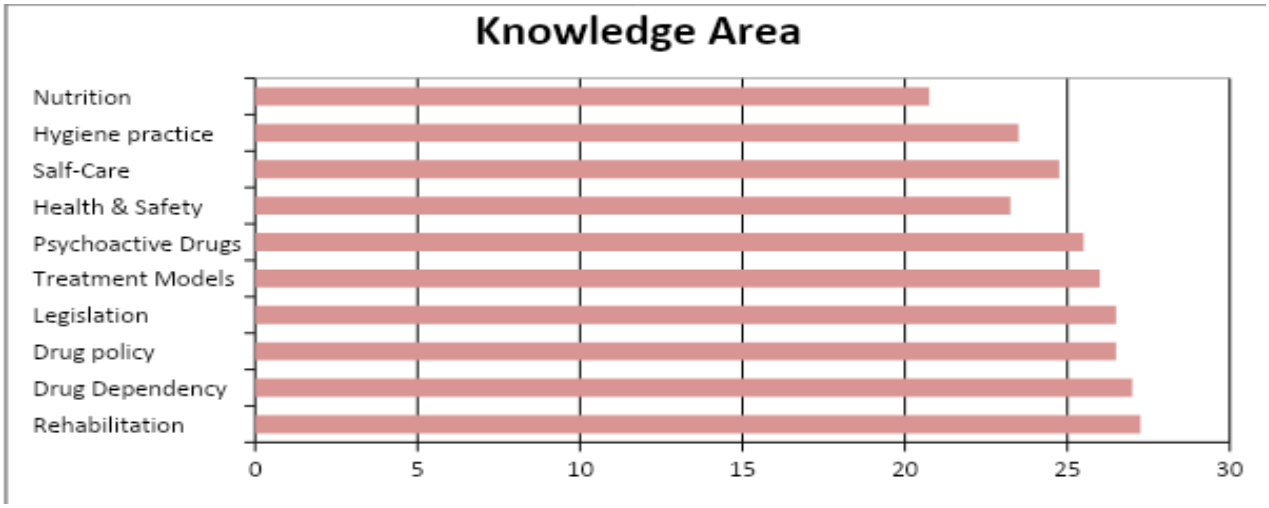
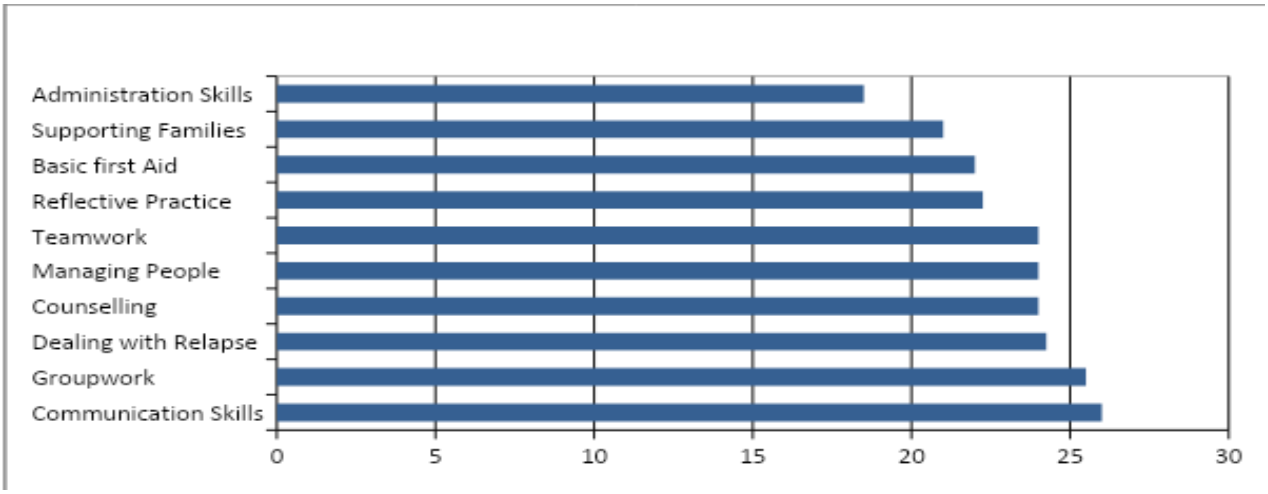


Fig: 4.18 *(Areas of knowledge deficit)*

Knowledge: The four areas from this category with the lowest scores are; a) Nutrition; as it relates to service user diets and eating habits, b) hygiene; best practice in hygiene standards for interaction with service users, c) self-care: avoiding burnout, and stress and d) health and safety: Best practice in maintaining a safe and healthy working environment.

Skills area deficits



Fig; 4.19 (Areas of skills deficit)

Skills: Areas scoring low in the skills category are, a) reflective practice; ability to access and assess experience to improve work performance, b) first aid; ability to correctly respond to incidents where basic medical aid is required, c) supporting families, ability to working with and provide support to service users families, d) administration; Including familiarity with relevant soft-ware, DSP processes financial documentation and training documentation.

Attitudinal area deficits

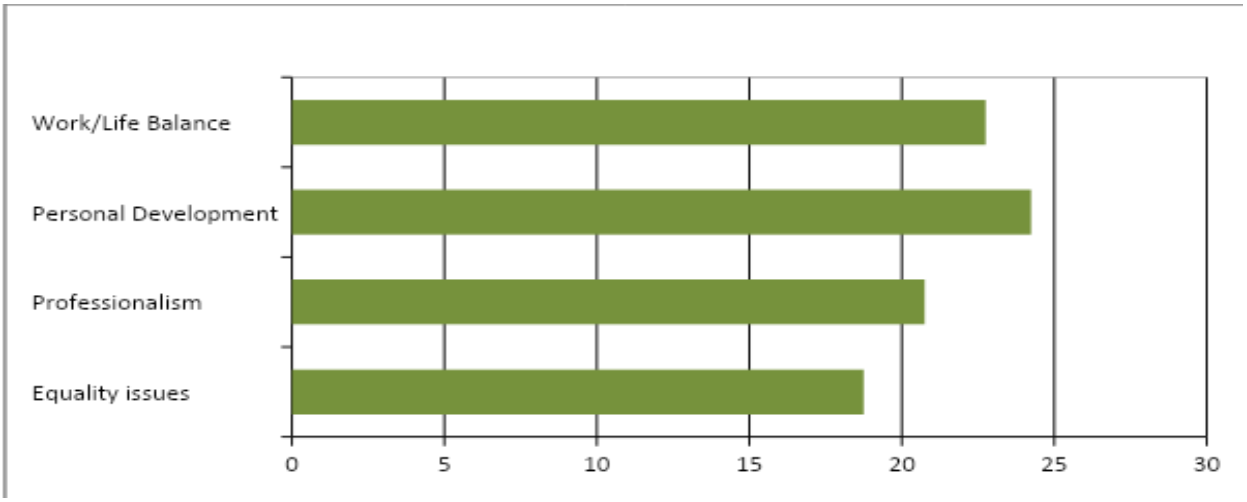


Fig: 4.20 (*Attitudinal area deficits*)

Attitude: The attitudinal area reported low scores in, a) work/life balance; ability to 'switch off', resilience and mindfulness, b) Professionalism; Encompassing concerns

about status, job dignity and self-confidence, c) equality issues; including gender issues, racial and ethnic differences; religion and lifestyle choices.

What is noteworthy from the section above is the quantity and variety of education and training subject areas involved. It provides a comprehensive picture of the amount of knowledge, skills and attitudes required to function in this field. It is also evident from this data that while our sample has arrived at this point via a variety of education and training programmes varying from qualifications in addiction studies, social care, accounting, arts administration, carpentry and hairdressing, there is no common or standard qualification for this level (or any level) of drugs worker

The lowest scoring areas identified are graphed below (fig: 4.21) to provide a picture of critical areas which need enhancement through training, education or structured on the job experience.

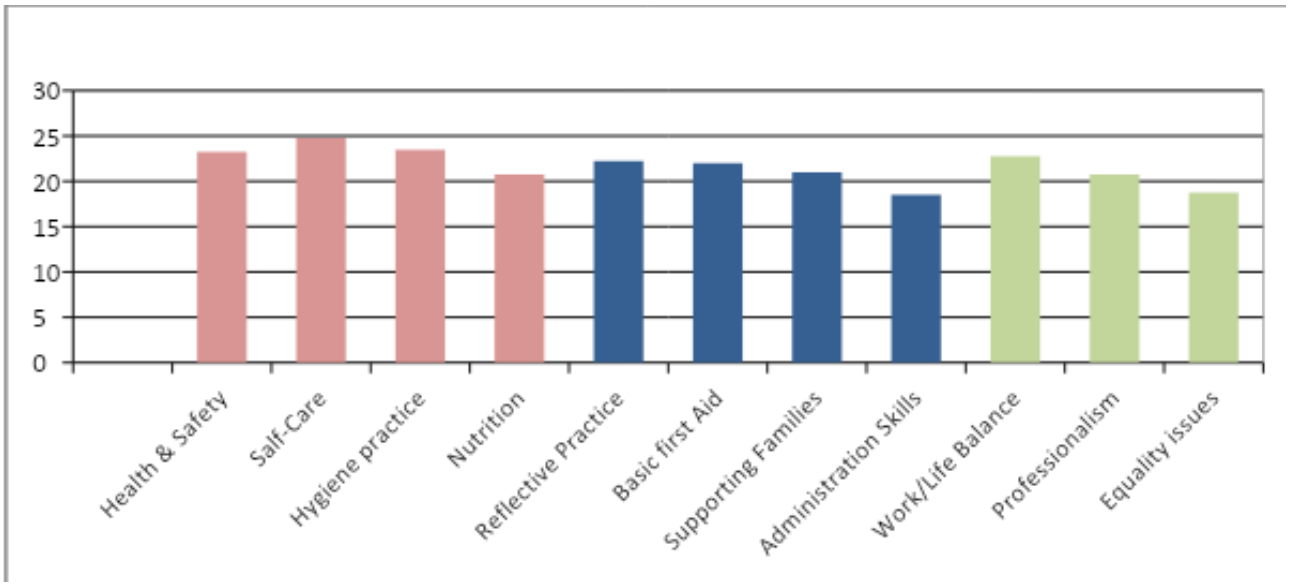


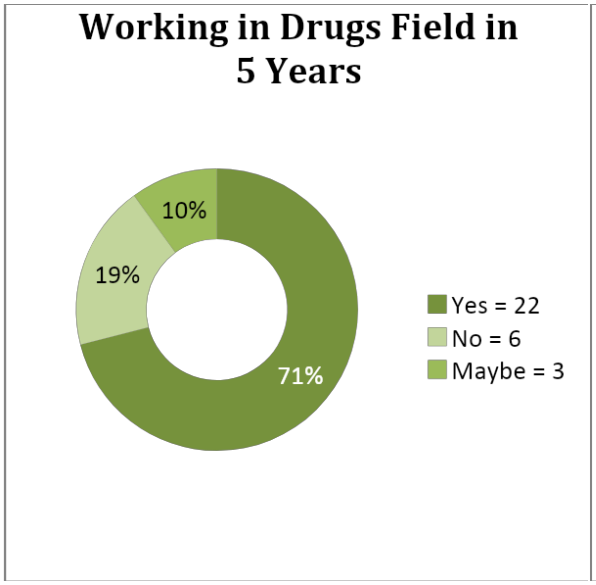
Fig: 4.21 (*Combined areas education and training deficit*)

Consideration should be given to the future investigation of these areas to enhance education and training programmes in the drugs field.

Future Training Required

The project worker sample was asked 'If they saw themselves working in the drugs field?' 72% (n=22) said they did (see Fig: 4.22). When followed up with the question

'Would their current qualification be sufficient for their future career?' almost half of the sample; 48% (n=15) felt that their present qualifications and training would not be sufficient for the career development



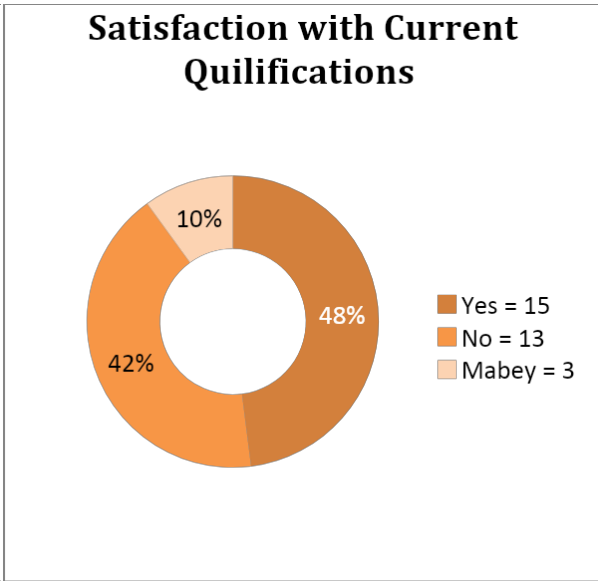


Fig: 4.22 (*Future in the drug field.*)

Fig: 4.23 (*Satisfaction with current qualification*)

The project worker sample was asked 'What training would assist in their professional development?' and 31(n=100%) of respondents answered this question. The responses broke down as follows; 39% (n=13) saw mental health related training as necessary to their future development ; 27% (n=9) saw counselling type training (e.g. Cognitive behavioural therapy(CBT), community reinforcement approach (CRA) and motivational interviewing (MI) as beneficial to their future development; 18% (n=6) of sample members indicated Group-work; 18% (n=6) of sample chose an addiction studies level 7 (NQF) type programme as salient to their future education and training, it is interesting to note that these six individuals are all within the 1to 2 year point in their career; another 18% (n=6) indicated a need for key-working and care planning type training; a further 15% (n=5) pointed to a level 8 (NQF) degree in Social Science as a future goal; while 9% (n=3) indicated a desire for further training in rehabilitation; 9% (n=3) felt that some kind of management skill would benefit their development; another 9% (n=3) indicated facilitation and training skills: 6% (n=2) expressed interest in "Choice theory" for further training; and 3% (n=1) felt that human resource training might benefit their future (fig: 4.26).

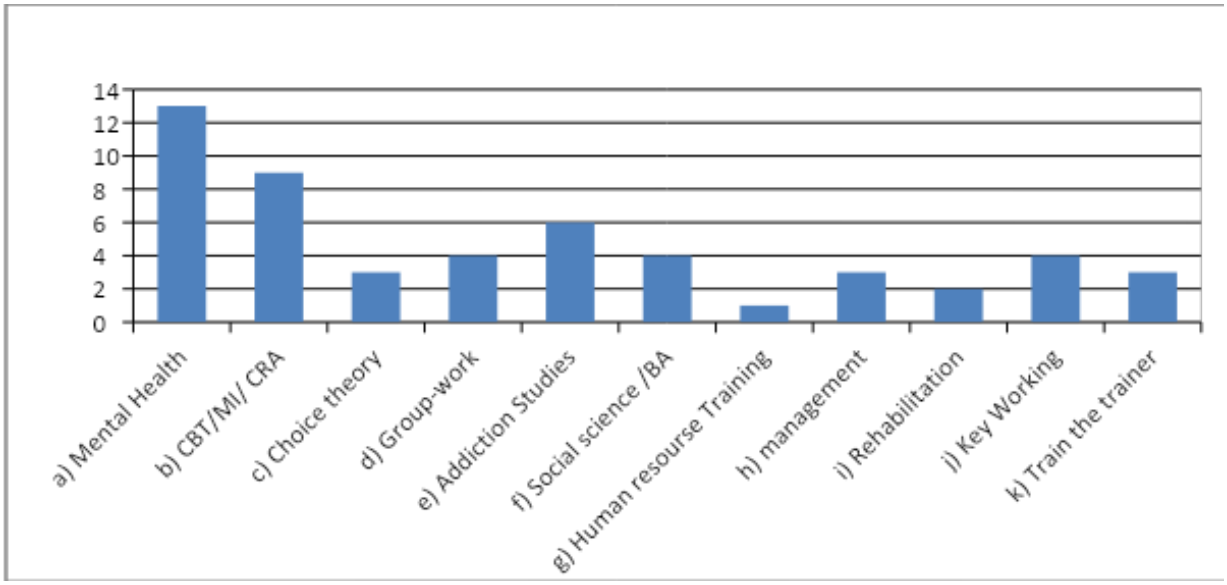


Fig: 4.24 (*Identified training need*)

A mixed bag of training and development needs are expressed in these findings, ranging from specific work-related training. Key working and care planning, train the trainer, and counsel qualifications in CBT and CRA and the broader education awards such as Addiction Studies and Social work at university level. Again, this indicates a level of incoherence in training provision and a lack of a clear progression route to a professional qualification for project workers.

Barriers and Challenges to Further Training and Development

When asked 'What, if any, obstacles might prevent further education and training?' 31 (100%) of the sample responded as follows: 55% (n=17) participants chose finance as an obstacle to pursuing further training and education; 35% (n=11) of the sample indicated Time or Family constraints; 13% (n-=4) of the sample pointed to lack of self-confidence as an obstacle; 10% (n=3) of the sample group felt that "distance to training location" might be a problem and 7% (n=2) respondents felt that motivation might be an issue for them.

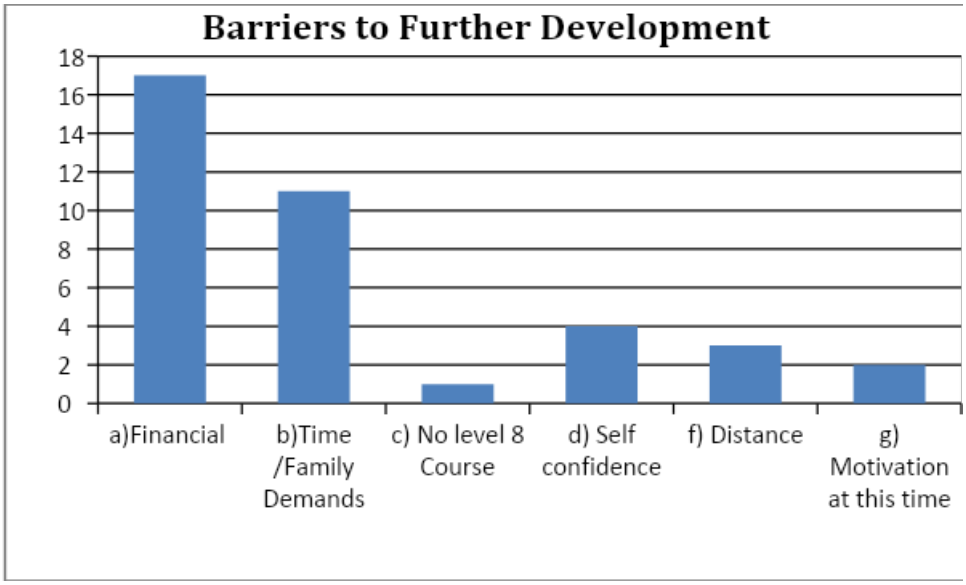


Fig: 4.25 (*Barriers to further education and development*)

Minimum Professional Qualification:

On the question of the 'minimum qualification that a professional qualified (NQF) drugs worker should hold' the project worker cohort responded: 9% (n=3) indicated "Level 5 QQI" was sufficient; 12% (n=4) favoured "Level 6"; 61% (n=20) selected "Level 7" while 18% (n=6) chose "Level 8."

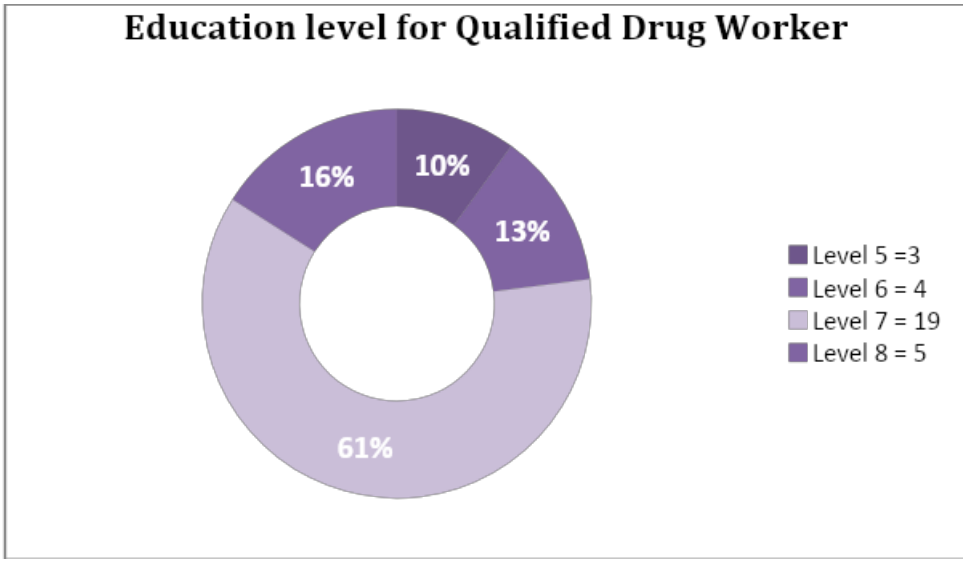


Fig: 4.2 (*Educational level for qualified drug worker*)

4.1.5. Comments: Training and Education Results

Training and education to date: It is clear from the quantitative data that a drug worker's educational and training skill set is a broad and comprehensive curriculum. The data also suggests that the sample came to drug work through diverse and varied routes. They also possess an eclectic set of educational qualifications, training and life skills which greatly enhance and enrich the projects in which they are employed. However, but lack the homogeneity and cohesiveness of professional status. It would be interesting to establish a sample of opinion on what training and education might be considered optimal for professional qualification as a drugs worker.

Further training needs: The quantitative results in this section indicate a complex set of requirements. Personal requirements were ranging from self-actualisation, and second-chance education to career advancement, professional competence. These broad-based needs are perhaps again indicative of the absence of a clear professional education and training pathway for drug workers.

Barriers to further education: The quantitative response to 'What are the barriers to further training and education?' generated six themes: financial constraints and family and time pressure accounted for 90% of responses. These themes are quite broad and need further investigation for clarification at a quantitative stage.

This quantitative section of the study has provided a more rounded understanding of the demographic concerning age, gender, education, experience and aspirations. It also generated results under work-related and education and training related headings, which coalesced several themes, requiring further and more in-depth investigation in qualitative terms.

These themes can be categorised as follows:

Work-related issues

Emerging Theme	**Number of Sample** **Raising this Issue**	**Derived Question for Interview phase**
Resource related issues including finance, material budgets, allowances, premises	50	"What issues do you have around resources and finance?" "Do you have any issues with premises?"
Quality and content of induction programme and related issues	49	"What was your induction, and what did you do?"
Relationship issues with Department of Social Protection	37	"What's your relationship with the DSP like?"
Lack of suitably qualified support staff and staff turnover at that level.	34	"What is staff recruitment like for support workers?" "Why is that?"
Participant Issues, including mental health, behaviours: acting out, aggression and homelessness.	28	"Are you experiencing any emerging or recent challenges with participants?" "If so, what are they and what do they think is the cause and resolution of these issues?"
Participant recruitment issues.	24	"Are you experiencing any recruitment problems with participants?" "What do you think is causing this?"

Table: 4.2 (*List of emerging work-related themes*)

One further portmanteau question was added which did not emerge from quantitative findings but identified from the researcher's "journal" and the noticeable gap in the questionnaire's data and was deemed relative to enhancing the subsequent qualitative findings.

The perceived effectiveness of SCE in addressing the rehabilitation of recovering drug addicts	Added	"In your opinion, is the SCE programme 'Fit for Purpose'"?

Table: 4.3 (*Supplementary work-related question)*

Education and Training Related Issues

Emerging Theme	**Number of Sample Raising this Issue**	**Derived Question for Interview phase**
Issues around training to date and further Training and Education	51	"What is the ideal Education and Training for Professional "Drug Work"?
Barriers to Undertaking further Education and Training	43	"What might prevent you from continuing with training and Education"? "What might help remove the barriers"?

Table: 4.4 (*List of Education and training related themes*)

The following two themes emerged as gaps identified in the quantitative survey and were logged in the research journal. A good deal of data emerged around what training and education a project worker has and should have. However, due to the questionnaire's limitations, very little information was gained about personal qualities and life skills that make a good potential drug worker. Given that people are being asked to go straight from job seekers to a support drugs-working position, it would be valuable to know what 'minimum skill set is required for a SCE support worker?'. It was decided to add these two themes to the qualitative interview stage to enrich and contextualise the 'support worker' role.

Desirable personal qualities, attributes, personality traits and life-skills for a potential SCE "Support worker".	Added	"What do you see as the ideal personal qualities and skills of a candidate support worker?"
Minimum training for effectiveness and competence in contributing to the project as a support worker.	Added	"What do you believe is the minimum training level required to become effective as a support worker?"

Table: 4.5 (*Supplementary education and training related themes)*

The eleven themes identified above formed the semi-structured interview's core and provided a framework for integrating this study's quantitative and qualitative elements.

The manager cohort of the research sample saw their training and development requirements being in the areas of management practice, fundraising skills and governance along with academic education to masters and doctoral level. However, as their training plans, academic leave and funding are entirely dependent on the sponsoring agency, and are not related to the SCE programme or the DSP, this cohort's education and training issues will not be included in the summery and further analysis. However, their opinions on and practices concerning staff training and development were valuable sources of insight and rich information which is factored into this summary.

4.2. Qualitative Results

4.2.1. Introduction:

The following are the qualitative data's annotated results amassed from the researcher's thematic analysis (Appendix: L), of the semi-structured interviews. This section is structured around interview themes; each of the eleven themes is derived directly or indirectly derived from this study's quantitative element. A commentary under each theme heading accompanies the result. These commentaries provide details on majority and minority positions within the narratives; compares perspectives and are framed where appropriate, by observations from the researcher's journal. These observations provided clarity, insight and a greater understanding of the ideas and opinions expressed by interviewees. The findings are divided into two main parts; Work-related and education and training related.

Consolidated themes and issues

Themes	Issues
Work-Related Issues:	
Topic 1: Finance and Resource Issues	Resource related issues including finance, material budgets, allowances, premises
Topic 2: Relationship with DSP	Relationship issues with Department of Social Protection
Topic 3: Staffing Issues	Lack of suitably qualified support staff and staff turnover at that level.
Topic 4: Participant Issues	Issues impacting participant engagement such as mental health problems, homelessness and childcare
Topic 5: Participant Recruitment	Issues relating to changes in terms and conditions for participants and the effect on recruitment and participant profile
Topic 6: Staff Induction Programme	Quality, quantity, methodology and comprehensiveness of trainee induction and its ramifications for staff and organisation.

Topic 7: Is SCE "Fit for Purpose"	Respondents perceptions and views on the effectiveness and suitability of SCE programme to deliver sustained recovery
Education and Training Related Issues:	
Topic 8: Desirable Qualities in SEC Workers	Traits, qualities, values and life skills which predispose an individual to working in the drug field
Topic 9: Minimum level of Training and Education for Effective Project Worker	Qualification and skills respondents would deem the "minimum acceptable" for a practising project worker on an SCE project
Topic 10: Ideal Specific Training for Professional Drug Worker	Qualifications and skill respondents would deem to be ideal for professional drug work
Topic 11: Barriers to Further Education	Respondents views on what might prevent them from undertaking further training and education in the drugs area.

Table: 4.6 (*List of research themes and attendant issues*)

4.2.2. Work-Related Themes

Theme 1: Finance, Resources and Premises

The quantitative survey indicated serious concerns about the SCE budget level and its ability to fund an effective rehabilitation programme adequately. Further investigation at the qualitative stage unearthed a range of specific concerns including; suitability of premises, facilities, materials, health & safety, therapeutic and vocational outcomes, participant training and support worker training. Project staff across the board felt the practical stresses of a static budget that is continually reduced by inflation, specific price

rises like insurance and the cost of accessing quality accredited training. They feel they are being asked to do more and more with less and less. One manager articulated this frustration as a conflict service demands and finances, having to tap other streams of finance to support SCE:

'One of the main problems for me is insecurity. What is happing with the whole area is anyone's guess. There was supposed to be a review last year (2019), I haven't heard anything about it since. So, there is this issue of uncertainty.... where are we going? and what are we doing.'? (Manager 1)

These comments crystallise a feeling, particularly among managers of 'how can we plan and manage' in such an uncertain environment. Another manager put his feeling thus:

'The SCE money is not sufficient to run a programme if we did not have other revenue streams we could barely afford to run....deliver and administrate the programme.....(combined with)....the cutbacks in other streams have put severe pressure on the programme, we've not been able to deliver what would be an optimum intervention for rehabilitation by any means.' (Manager 2)

These statements encapsulate a common theme among the interview sample of exasperation at knowing the level of service required to be effective and unable to deliver it, after a decade of budgetary cuts and constraints.

A supervisor was quite specific in identifying the problems in trying to run a programme on the material allowance per participant, which is in effect the projects capital budget:

'The biggest problem as I see it is the material grant which at 9.98 per week per participant it's a joke, not in a funny way. Insurance alone devours over 30% of that budget and our project by its nature is a material "hungry" project we never have enough to make ends meet from the DSP budget. We have to plunder other budgets or beg, steal and borrow to drive the project forward.' (Supervisor 1)

Again, there is a sense here of frustration at having to run what in effect is a medical programme on a "shoestring" budget. Concerning facilities and premises, one project worker confided the dissatisfaction with the premises and facilities as follows:

'I am just glad to be doing what I'm doing at the moment, but yeah, I do see that the premises are a more than bit shabby, and some of the staff are pissed off about the lack of facilities, there is not enough space for privacy outside the counselling rooms, and basically the place is not fit for purpose. We've had a major rodent infestation which is ongoing. Most people

here have not had a raise in a long time and are getting worn out by the lack of funding and general situation'. (Project Worker 4)

A service manager described his projects premises as follows:

'It's falling apart, to be honest. We have no space for group process, there's dampness in all the walls, and we have a chronic vermin infestation. Yet, the powers that be feel it is perfectly suitable. This might tell you a bit about their attitude to SCE.' (Manager 2)

It was evident to the researcher during project visits that the standard of SCE projects premises varied enormously; from modern and purpose-built, too shabby, unsuitably located, inadequately structured and ill-suited to the purpose. Unfortunately, there were too many of the later (Research Journal)

One service manager put it thus:

'The cutbacks in other streams have put severe pressure on the programme; we're not able to deliver what would be an optimum intervention for rehabilitation by any means.' (Manager 2)

A project worker makes the point that:

'...premises are more than a bit shabby, and some of the staff is (sic) pissed off about the lack of facilities, there is not enough space for privacy outside the counselling rooms, and basically, the place is not fit for purpose. We've had a major rodent infestation, which is ongoing. Most people here have not had a raise in a long time and are getting worn out by the lack of funding and the situation in general.' (Project Worker 4)

In answer to a question posited in the quantitative questionnaire about barriers to completing the job, 77% of respondents indicated that constraints in financial support, premises and resources necessary to provide a programme to the highest standard were significant impediments to the effective delivery of SCE programmes. 15% were satisfied with conditions, and 7% were unsure. Approximately 95% of the sample concurred on the material allowance's inadequacy (effectively the projects operational budget). In contrast, others saw the dwindling value of the training budget, which has remained unchanged for a decade, as a severe problem, particularly for support staff.

One service manager put it thus:

'The cutbacks in other streams have put severe pressure on the programme; we're not able to deliver what would be an optimum intervention for rehabilitation by any means.' (Manager 2)

A project worker makes the point that:

'...premises are more than a bit shabby, and some of the staff is (sic) pissed off about the lack of facilities, there is not enough space for privacy outside the counselling rooms, and basically, the place is not fit for purpose. We've had a major rodent infestation, which is ongoing. Most people here have not had a raise in a long time and are getting worn out by the lack of funding and the situation in general.' (Project Worker 4)

While a minority among the interviewed expressed some degree of satisfaction with the physical premises, the majority had experienced problems of adequate space, suitability and equipment. These findings concur with Lawless (2006), which represented that views of not just workers but service users also. These findings pointed to the need for more and better-equipped space to integrate line facilities such as counselling rooms, meditation and mindfulness spaces, and ancillary service areas, e.g. Kitchen, wet utility room, and exercise space. Lawless (2006) goes onto recommend a 'minimum standard' (p.87) for SCE programme premises and service users also found quality and size of premises a source of frustration (ibid, p. 66). On another level, the well-being and productivity of the individual worker may be an issue as Nip et al. (1998), found that self-satisfaction, and perceived ability to cope with work in the future were associated with workspace satisfaction. Studies have established that physical dimensions, natural lightning, orientation, regulation of lighting, temperature, noise level, amount of space, visual privacy, furniture, colours, textures, and cleanliness all significantly influence employee behaviour well-being. (Kim & de Dear 2012; Baričič et al., 2014).

A CityWide report (2014) also found the problems issues raised around the inadequacy of resources and funding, noting that:

'This level of insecurity and uncertainty is seriously detrimental to the planning and delivery of structured rehabilitation programmes, in particular at a time when DRPs (SCE) are trying to adapt and respond to the needs of changing target groups and in the long run affects the future viability of projects' (p.31).

This study's findings indicate that the lack of funding and inadequacy in providing resources, combined with some premises' unsuitability, has created a sense of

uncertainty, frustration, abandonment, and anger among many respondents. These feelings if left unassuaged, can create enormous problems for the individual and the project. These issues will be dealt with in more depth in the discussion section of this study.

Theme 2: Relationship with DSP

There seems to be a perceived disconnect between the projects' objectives and those of the DSP, which manifests in a lack of a clear shared vision, purpose and means of achieving rehabilitation. They are aware and glad that there is a system; however, they feel the system is one-sided and imposed instead of being a cooperative partnership.

One manager describes this relationship as being:

'...unyielding and inflexible at worst. The DSP inherited a system from FAS who had developed some flexibility and understanding of the special needs of SCE after 20 years (of running it), that "Herd memory" is lost and a new group of career civil servants began to administer the programme. They also (sic) have unrealistic ideas about outcomes and are driven by the model; their outcome targets are crazy and particularly given the training budget, material allowance and lack of suitable staff.' (Manager 1)

There would appear to be an over-dependence on the interpersonal relationship between project staff and DSO and the degree of flexibility any individual DSO will allow. Of course, this can change if personal change and is not beneficial to a systemic approach. A supervisor described this situation in the following terms:

'On a personal level the CDO is just doing the job they are assigned.' and 'The DSP has failed to train their staff to a sufficient level of drug recovery knowledge that could make them a valuable team player instead of an umpire, they spend their time making sure every rule is obeyed to the letter.' (Supervisor 2)

Some project employees find they face a dilemma between their engagement with clients on a therapeutic level and acting as "boss" in levying sanctions dictated by the DSP. They are often left to carry the can when things go wrong. As another supervisor put it:

'.... we seem on the outside, it's like we're not on the same team, they are the masters, and they like to let you know it.....they are sitting on top of a fence and micromanaging, if something is going well they will claim the credit, if it goes wrong, it's all yours. It's all very wrong. (Supervisor 1)

A project worker bit it this way:

'All's I know is we enforce their (DSP) crazy rules and get the backlash'(Project Worker 4)

It is clear from the comments above that the relationship between the sample group and the DSP is not an ideal working relationship. Opinions range from workable personal relationships at a local level; to exasperation at "managerialism" from the DSP.

Managers tended to be more exercised by this frustration. It impinged on what they perceived as their commitments to outcomes driven by other stakeholders, and their financial dependence on the DSP. Supervisors had a more direct, interpersonal and working relationship with the CDO and needed to maintain a working relationship for the good of the project. Supervisors expressed a sense of isolation, combined with the belief that they were caught in the middle. This belief gave rise to feelings of resentment at being made a scapegoat for the shortcomings of bureaucrats.

The majority of respondents indicated a problematic relationship with the CDO and the DSP, in general, noting it was a relationship based on mistrust and suspicion of motives. There is a perceived attitude of 'them and us' between the community sector workers and the state agency that is not conducive to working together. This dichotomy may be based on misunderstanding or power-balance dynamics of the relationship. These issues will form the bases of the discussion of the differentials of power inherent in community/ State relationships and the negative consequences of their dysfunction. Similar issues were identified in Bruce 2004 and Lawless 2006.

However, project workers issues were more generic and less personal, mostly because they had little or no interaction with the CDO.

Theme 3: Staffing Issues

There was agreement across the sample that staff recruitment difficulties present a real challenge in maintaining the quality of service and activity levels in projects and the increased staff workload due to this staff shortage. The reasons given for this recruitment problem were the high level of employment, reducing the pool of available potential support workers, and the quality of applicants? The frustration at this situation was voiced thus by one respondent:

'Getting competent support staff through the SCE process is impossible, I don't mean this in any bad way, but with the level of employment at present, we are at the "bottom of the barrel..... it's obvious now that we should have been investing in real, sustainable jobs for professional drug workers. Would any other sector put up with it, would you let CE participants tend a psychiatric patient or an injured /sick person, no, people would be appalled?" (Manager 2)

Another put it bluntly:

'Getting competent support staff through the SCE process is impossible, I don't mean this in any bad way, but with the level of employment at present we are at the bottom of the barrel'. (Manager 1)

It was also felt that there was no shared understanding of what constituted the 'personal profile' of a potential candidate, and this gave rise to unsuitable. Sometimes unwilling candidates being sent for interview:

'We are getting people sent over (from DSP) who are patently unsuitable; there is a disconnect between the DSP employment officers and their understanding of the role and indeed the character of a support worker.' (Manager 3)

There was a distinct perception that DSP job-centres were sending unsuitable "Job Seeker" candidates to interview for project worker positions. In a note from the study journal, (of a conversation with a supervisor), it was felt that candidates "sent forward" by the DSP may or may not be motivated to do drugs work. However, they are afraid not to attend because they might lose their allowances. This situation puts the onus on the project to say "no" to the candidate, whom they believe should never have been sent forward in the first place. Another hidden issue raised here is that because of a per capita ratio relationship, between participants, support workers and supervisors, the lack of support workers has a financial implication for projects.

One supervisor described the rigid DSP rules which disallowed new social graduates from gaining experience (with SCE allowance):

'Yes, it's very difficult at present, it's not so much that nobody wants to do it (SCE Support Worker), but they are restrained by CE eligibility. I know a young girl, a recent graduate with a degree in social science, would love to do the job for the experience but does not qualify for CE. She is not long enough on the dole.' (Supervisor 1)

Some respondents also expressed concern at retaining support staff once they became experience and trained, because of allowances and conditions on SCE.

'You hardly have the project worker inducted and trained, and you know, working as a full member of the team and their time is up, or they are poached by other services which you can't blame...' (Project Worker 3)

Another felt that this situation might have health and safety implications for current workers. One of who put it this way:

'We are being sent people who are in no way suitable or even want to engage with this type of work but feel they will be cut off the register if they don't come to interview, can you imagine any other profession, say social work or nursing where you employ people who are just sent to your interview by shotgun' (Supervisor 2)

While it is apparent that staffing levels and skills mix vary considerably across the projects, there was a convergence of opinion across the three strata of interviewees; which saw a systemic threat to the operation of SCE in both the short and long term. This treat was due in the main to the shortage of suitable Support-worker candidates. This precarious situation is exacerbated by the apparent absence of a shared interpretation of a support worker 'Job Description' between DSP 'Job Centres' and the project management. It was also felt that staff shortages and high turnover created a potential health and safety issue for the remaining staff. This concern is justified in light of findings by Lawless (2006):

'It is clear that the success of the [SCE] projects to date has depended upon the skill and drive of the supervisors and workers rather than the SCE system' (p.59). CityWide (2016) also noted issues in SCE staffing reporting; 'difficulties in recruiting and maintaining support worker positions and unsurprisingly, the reasons for these difficulties are consistent with those in recruiting for rehabilitation places, with the loss of the concurrent payment as the major disincentive to participation' (p.27).

A decrease in participant numbers (inadvertently driven by governmental policy), has the knock-on effect of reducing staffing levels. Which, in turn, has implications for quality of service.

A report by CityWide (2016) found that:

'*This level of insecurity and uncertainty is seriously detrimental to the planning and delivery of structured rehabilitation programmes, in particular at a time when DRPs are trying to adapt and respond to the needs of changing target groups and in the long run, affects the future viability of projects'* (CityWide 2016, p. 59).

This issue had particular import for the Supervisors and Assistant Supervisors in the interview cohort. These concerns are analysed further within the national and international context in 'Theme 3' section of the discussion chapter.

Theme 4: Participant Issues

Two main issues stood out in this theme; 1) Drug-related mental health, i.e. Psychosis, paranoia, manic episodes and the associated behaviours of aggression, acting-out, verbal abusiveness. This emerging challenge was ascribed to a changing clientele; young people using more stimulants and more potent cannabis products. One manager explained:

'Well, the demographic has certainly changed over the last number of years. The move with new participants is away from opiate, and towards cocaine and weed, this is reflected in the stats published nationally. This shift to stimulants has implications for mental condition and behaviours of participants; we have more and more participants exhibiting mental health issues than when we were dealing with mainly opiate users' (Manager 1)

Several supervisors capture the feeling thus:

'Yes, young people with weed (cannabis) psychosis, is a real issue for us at the moment, the can get very, I don't want to say aggressive, but I guess they get very demanding which can be intimidating, with staff shortage and lack of experience among staff it can be a volatile environment if you know what I mean.' (Supervisor 2)

Another added:

'...we regularly get participants who have various degrees of mental disturbance, we have one girl who is still self-harming and cannot get seen in a proper psychiatric facility.' (Supervisor 2)

While some project workers noted:

'... I do feel that paranoia and psychosis is noticeable more now among participants, it might be the weed, I take note and report it to the persons key-worker.' (Project Worker2)

'We had a couple of incidents of "acting –out" and well serious enough to frighten staff and get a new policy from senior staff. One participant had serious self-harming issues and tried to pour boiling water on himself and a staff member who intervened…' (Project Worker 3)

One respondent also saw the implications for staff within these changes, particularly the challenges faced by frontline staff in dealing with aggression and abusive behaviours. Personal well-being and safety training are being cited as a requirement, and up-dated training and policy around dealing with these kinds of behaviours are required.

'We are not psychiatric nurses or (psychiatric) workers! ; …CE support workers need strong boundaries.....from stress; …We had a couple of incidents of "acting –out" and were serious enough to frighten staff"; One participant had serious self-harming issues and tried to pour boiling water on himself and a staff member; There's a fair amount of aggravation due to paranoia and stuff. We're not trained or equipped to deal with this!' (Project Worker 4)

The statements and anecdotes above give a sobering insight into an escalating issue of drug-related mental health and associated behaviours. This situation is of urgent and growing concern for drug workers generally and SCE specifically. These psychological and behavioural issues were unsurprising, given more import and emphasis in the interviews with supervisor and project worker strata. Many had experienced their manifestations first-hand and were well aware of the inadequacy of training to respond in these situations. The existence of comorbidity of mental illness and drug use (Van Hout, 2014; Martinotti *et al.,* 2014) is exacerbated by Novel Psychoactive Substances (NPS) use among SEC participants.

The most popular NPS across Europe is cathinone derivatives, other amphetamine-type substances, and synthetic cannabinoids (Caudevilla 2016; EMCDDA 2016). This situation creates a new set of issues, e.g. weight loss, depression and paranoid disorders (van Hout *et al.,* 2018). An increase in crack cocaine usage is becoming apparent in marginalised populations here in Ireland (O'Reilly & MacCionnaith 2019); Therefore, there is potential for another layer of issues to manifest themselves. NPS and crack users reported psychiatric type symptoms and an increase in violent behaviour (Pachado

2017). This development has implications for SCE workers in their clinical practice, health and safety, and mental well-being.

These issues will be given greater scrutiny and analytically discussed in chapter five of this document.

2) Homelessness, in all its manifestation (e.g. Being thrown out of the family home, eviction for rent default, staying in temporary shelter, rough sleeping, and couch surfing) was identified as a problem across projects and respondents. These varying states of homelessness impacted upon the participant's ability to join a programme. If they are already on an SCE scheme, it dramatically impacts their ability to optimise the benefit they get from the programme. This rise in homelessness was believed a consequence of the current economic situation and ineffectiveness of government policy to deal with it. As one respondent puts it:

'Like other walks of society homelessness is a big issue for our services, I don't remember it so bad, two participants have become homeless while on the programme, we have been doing our bit to help them, but it is difficult as we don't have a dedicated homeless section and referral is often not responded to.' (Supervisor 3)

A manager added:

'Today, we are dealing with far more homeless, dislocated people than ever before in my long memory. You don't have to be 'Maslow' to understand that without a home... Shelter, a base, a door; it is almost impossible to do further rehabilitative work.' (Manager 2)

While a project worker explained:

*'We have three participants who became homeless over the last two months, and it's nearly impossible for them to hold their places on the scheme because they have so much going on in their lives, they miss classes or work sessions and have to be sanctioned. Just when they need help, they are sanctioned, that's not what it's about, is it? In fact, I know one of my colleagues, who is a support worker and is currently homeless, living in temporary accommodation. It's everywhere.'. (*Project Worker 3)

Another added:

'We only have one person on at the moment who is using a hostel, it's tough for him, when he's not here he's walking the streets. He loves it here. Another 'fella' (man) who just left, was thrown out of his home by the family, his attendance here fell off as he was sleeping rough most of the summer.' (Project Worker 4)

While homelessness is endemic in our society today, it has its specific implications for those who have drugs and alcohol problems. The impact of homelessness on the individual participant is of paramount concern. However, the implications for those working within drug and alcohol rehabilitation services, including SCE projects, are many. Not least concerning workload, personal safety concerns, and maintaining recovery motivation in the service user. Lawless, (2006) notes that 'even those clients (participants) who have access to hostel accommodation experience major difficulties with hygiene and nutrition, find it almost impossible to participate in SCE' (p.75)

The international literature indicates that homelessness is associated with many, if not all, of the problems that have been identified as domains of recovery (Gillis *et al.,* 2010), including health (Lawless & Corr, 2005), stress and trauma (Kim & Ford, 2006; Lee *et al.,* 2010), socially isolated (Ware *et al.,* 2007). Borg et al., (2005) suggest that homeless individuals, experiences of poverty, unemployment, trauma, and illness alone are likely to undermine or decrease feelings of mastery and thus their motivation to engage in change. The added condition potentially creates another layer of resistance which compounds the therapeutic and rehabilitative efforts of project workers.

Theme 5: Participant Recruitment

There was agreement within and across sample job groups that there is a significant fall-off in recruiting over 25-year-old opiate users and female participants in the last three years. This fall-off is not because of any identifiable reduction in these cohort's numbers. However, it is ascribed directly to the reduction in the allowances available for this category of the participant. The extra allowances on top of the basic 'Job Seekers' allowance provided an added incentive for those who were considering changing behaviour and encouraged them in taking that necessary first step. As one respondent noted:

'We've seen a big drop off in the over 25's in the last two years; it's down to money and decrease in payments. There has been an increase in 18-25 participation because of extra payment; it is either a good thing, or it's not, it's indiscriminate. Focus is now on the young, what about the older ones with little or no hope of jobs, what do they do?' (Supervisor 3)

Others comment on the rate of childminding allowance for loan parents:

'Childminding allowance went nowhere towards providing adequate child care for 19.5 hours a week.' (Project Worker 2)

Another noted:

'A lot of users are just saying it's not worth coming on the programme if anything happens you lose money, like if you have a bad day or so. We have only two girls on the project at present, no one to look after the kids and nothing to attract them.' (Project Worker 3)

A majority of the sample indicated growth in the numbers of under twenty-five-year olds registering for the programme. This phenomenon was partly attributed to the introduction of a financial incentive. One supervisor put it this way:

'18-25's (year olds) get the double allowance, so we have a good pick-up in the presence in that age group." And another put it this way: *"Numbers are very flat there too, more young people with weed and cocaine issues but we're down on heroin and the older user'. (Supervisor 2)*

A majority of respondents agreed on this changing demographic due to loss of benefits; this opinion is supported by the Citywide report (2016) which found that 'the most commonly cited impact of Social Welfare Act: 2012 (SWA: 2012) was a reduction in the number of applicants for vacancies. Which, in combination with the incentives for younger participants' (p.21). Gives rise to several issues; one issue concerns the approaches and strategies for dealing with a younger group with different drug usage patterns and different associated behaviours than were previously the norm. There are also implications in the SWA:2012 which disincentivise single parents and disabled people from applying which CityWide (2016) noted as a drop-off in people*; 'from people on One-Parent Family Payment or Disability payments'* because of recent changes to entitlements' (p. 30). Many interviewees indicated a sense (noted in Research Journal) that the older drug users were not receiving an adequate incentive to engage with the programme due to the allowance structure and recruitment procedures.

Topic 6: Staff Induction Programme

While managers felt that they were providing an adequate if not ideal induction, project workers felt that their induction was not optimal. There appeared to be induction policy in place, but it was not being implemented fully. An example from a manager is:

'We provide a session on health and safety, of course, and the basics of the job and they then shadow an experienced worker for a long time. There can be a problem with giving time over to the type of induction I would like, but we would never put a worker new or old in harm's way' (Manager 1)

All groups agreed that time and human resources were a limiting factor in the comprehensiveness of induction.

'New staff members get a grand tour of the premises and a whistle-stop guide to staff, who's who and duties and responsibilities. There's normally a senior staff member appointed for them to shadow. It can take a bit of time to get them fully ensconced.' (Supervisor 3)

It was apparent from the responses across groups that the "shadowing" system was extensively used to ease new staff into the job and their responsibilities.

One project worker describes their experience:

'Not really, we got a few minutes on policy early on; I can't remember what it was about, to tell the truth. I only know when something goes wrong (laugh). Look and learn from people with experience.' (Project Worker 3)

A manager stressed the showing policy as follows:

'Gaining experience through working with the team and shadowing experienced workers is essential.' (Manager 3)

Projects differed in the latitude in the type of work they would allow an untrained worker to engage in. All agree that participants and staff's Health and Safety was of critical importance and should not be compromised. A manager emphasised:

'We have a programme for full induction which covers health and safety, policy and procedures and all the rest...' (Manager1)

A worker added:

'I had an induction, it was on the first two days, my supervisor introduced me to the team and the duties, you know the type of thing rules, regulations and the like, some health and safety. If I needed to know, I could ask my supervisor. You just learn mostly on your feet.' (Project Worker 4)

There appeared to be induction policy in most projects, but it was not being implemented fully. All groups agreed that time and human resources were a limiting factor in the comprehensiveness of induction. It was apparent from the responses across groups that

the “shadowing” system was extensively used to easing new staff into the job and their responsibilities. Projects differed in the latitude in the type of work they would allow an untrained worker to engage in. Notwithstanding this, the international literature attests that a ‘good induction, increase staff motivation and commitment to the job, and hence improve the quality of services’ (Topss 2001, p. 1). It is also acknowledged that ‘Starting a new job can be an overwhelming experience requiring a period of transition and adjustment to the change of role’ (Bradley 2008, p.351),

Guidance and minimum standards for induction of social care staff in England have been available since 2001 (Topss 2001); however, there is little evidence that these have been applied systematically. They have been superseded by new standards for adult social care (Skills for Care, 2005) which might be applicable in this case. A key aspect is ‘to encourage common induction processes within the first 12 weeks of appointment; that will be signed off by an authorised person’ (Bradley 2008, p. 252).

However, an international literature search by Maher et al. (2003) concluded that there had been little research that quantifies the 'influence induction has had on confidence, retention and standards of social work practice' (p. 2). An example of developing good practice in the literature is a document 'intended as a template to assist employers in developing their programmes (NSWQB, 2004), which identifies several critical actions, e.g. allocating a named person to be in charge of the induction, providing details of policy and procedures.

Most of the respondents in this research said that they learned best from observing and talking to experienced staff, whom they respected. Learning often took the form of shadowing the immediacy of practice, and two respondents emphasised that this was 'the best way of learning' (Research Journal).

A large majority of respondents concurred that the Health and Safety of participants and staff were of essential importance and should not be compromised. However, only three interviews felt sufficiently competent in these areas. The importance of induction will be picked up again in the discussion section in chapter five.

Theme 7: Is the SCE Programme Fit for Purpose

It is clear from the discussions with interviewees that there is board agreement that, as it stands SCE programme is entirely sub-optimal not least because the DSP is perceived as 'not listening' to people on the ground and setting outcomes which are based on some economic model and not on the time-scale and to the best interests of the majority of the participants. Words like 'not fit' for purpose, 'broken' and 'passed its sell-by date' give a sense of the strength of feeling around this point. Nevertheless, this is tempered by the underlying feeling that the programme, although not ideal, has provided significant service in the rehabilitation framework.

One moderate opinion was put thus:

'Yes and no! I think it has some merit for use within the (Rehabilitation) framework for certain people. Those in good recovery and who are in a space to use the training benefits of the SCE as a springboard to further education or employment.'(Manager 1)

Another manager suggests:

'These participants have been failed once by the formal education systems and processes, and now we are failing them again. Many of our people need the stability of an accepting environment, not one modelled on a "get on your bike" and "get-a-job" mentality. Many people coming to rehabilitation have not had that space to mature and develop as adults. Part of rehabilitation is providing that space. This cannot be done in a quasi- work environment, docking wages, strictures, controls, and unrealistic outcome measures in unrealistic time periods.' (Manager 2)

A supervisor thought that:

'Maybe it was once; I don't know, but now...? Strung up on rules, not serving the community goals that it was originally set up to do. I don't know what to replace it with, but it is broken, but we need to start a conversation on that.' (Supervisor 2)

There was a sense that the SCE programme was lacking vision and was now a 'tick box' exerciser in which participants and staff members alike are forgotten.

Two supervisors noted that:

'The whole SCE system and approach to rehab is long due to a real overhaul; it's been a lame duck for a long time....' (Supervisor 3)

'No, there is very little leadership, in where SCE is going, as far as I can see, either from the DSP, Community management or the HSE. We are the "meat in the sandwich" working in a no man's land and being treated like second class citizens.' (Supervisor 1)

There is a belief that some current participants can benefit from the current model, but the majority are failed by it. Therefore, a new rehabilitation vehicle needs to be developed with close consultation and cooperation with the service users and "Community Drug" services.

'Well..., it worked for me you see, and I'm biased maybe. But, it was different then, three or four odd years ago. It is more hectic now, not enough resources, not enough time. SCE could be good, but something happened, and I don't know what's going to happen in the future.' (Project Worker 4)

There is a strong belief in some respondents that SCE can be reformed; and a new, better model can evolve from the current system. Others suggest that a more radical approach is required, and a new community-based rehabilitation mechanism is required. One custom-designed to meet all drug users' current rehabilitation needs; founded on best practice principles in rehabilitation; and community recovery principles. A system focused and centred on the service user. This culture, created predominantly in response to government policy that requires financial accountability and performance management at the local level, is sanctioned by external audit and review (Cowan, 1999; Gibbs, 2000).

4.2.3. Training and Development Themes

Theme 8: Desirable Qualities in Potential SCE Workers

The question of 'what makes a suitable support worker?'; emerged at the focus groups and questionnaire stages, and again in the researcher's informal conversations with respondents about personal qualities in staff. It is aimed at establishing what this sample mean when they talk about the right stuff.

Understandably, when answering this question, managers focused on work-related traits like dependability, team-work and common sense:

'Dependability is a major quality I look for, motivation to work in the area and an ability to be flexible. I think you need a calm and mature temperament to last and thrive in the drugs field. Team working is a must and some knowledge of the drugs field.' (Manager 1)

And:

'Sound judgment and common sense (as uncommon as that is) are a basic requirement. A balanced, mature and savvy person. Some of the people we have been sent by DSP recently were vulnerable people themselves and could be really damaged by being in a service environment. Basic cop-on as regards boundaries, if people have that you can develop a professional attitude to work but if not it's extremely difficult, and the helper or worker becomes a "liability" I am afraid to say.' (Manager 2)

There was recognition of the basic requirements of caring emotions:

'(Having)... Compassion, empathy and a sense of purpose, to their work. An ability to think on their feet and a sense of humour helps too. It is important that they have a steady, grounded sort of personality and a willingness to learn.' (Supervisor 1)

Project workers focused on client interface abilities and attitudes like a non-judgemental mindset, caring, loving communicating.

'Mostly patience, (laugh). "stickability" (resilience), empathy and unconditional care. You have to feel for the person and their recovery.' (Project Worker 1)

And:

'You have to have the ability to love them (participants) as people, you can't be judgemental, and you need emotion. I feel I understand having been there myself, but you need to know what you're doing, that's where training and experience come in.' (Project Worker 4)

There were a broad and diverse set of opinions in response to this question—the majority of managers emphasising team qualities such as; flexibility, adaptability and motivation. Unsurprisingly, supervisors showed a preference for qualities that would prevent harm, like good boundaries, common sense, mature and steady, project workers emphasised interpersonal qualities such as kindness, empathy and love.

It might be worth viewing these differences in terms of therapeutic commitment (TC). The concept of TC as posited by Cartwright (1980) has three distinct but related attitudinal factors: a) perceived willingness to work with alcohol users; b) perceived expectations of work satisfaction in working with these clients and c) perceived self-esteem (SE) about performing the specific task of working with alcohol users. Cartwright contends that the TC a worker has is a function of the degree of role security (RS) workers perceive in their task. (Albery, 2003)

Eligibility criteria for joining an SCE programme was also of immediate and practical concern for supervisors. The groups concurred that there was a paucity of candidates

with these attributes; given the current economic climate. This theme will also be picked up in chapter five.

Theme 9: Minimum Training/Education for Effective Project Worker

Given that we have established some kind of picture of the quality's desirable in a support worker it seemed useful to the researcher to ascertain the samples ideas about what minimum level of training was required for the support worker to become effective in their post.

Respondents felt that a level 5(NQF) in either Drug studies, Addiction studies, Social care or their equivalent was a minimum starting point at which a support/project worker become effective. It was agreed that if the person were "right" then with on-the-job learning and experience, level 5 (NQF) would supply a fundamental theoretical basis for work and further study in the field. There was a general sense of satisfaction at the quality and cost of current level 5 (NQF) programmes.

One manager suggested:

'Ideally, a level 5 or 6 social care or addiction certificate with some volunteering experience would be the minimum for being (an) effective worker. But it's important to get the right person with the right attitude also; we can provide on-the-job learning.' (Manager 3)

Another supervisor thought that a:

*'Minimum of level 5 QQI…addiction studies or similar ...to work to any degree of autonomy and make a professional contribution to the team.' (*Supervisor, 2).

While this project worker felt that a:

'Minimum would be level 5 addiction studies ...something like that. Everyone is going on to level 7 and 8 so if you want to stand a chance of getting a job, you know……. Some form of counselling skills, like a brief intervention. I think group-work skills are essential too.' (Project Worker 2)

Another thought:

'*Experience is a big factor; I learned by looking and learning. I suppose an understanding of drugs; the process of addiction and some approaches would be the academic basics. We sent our new workers on the Community Addiction Studies course (level 5 NQF) as soon as possible to give them basic understanding.'* (Project Worker 4)

There was a concurrence among the respondents, that level 5 (NFQ) Addiction or Social Studies type programme would prove a minimum qualification for a competent drug worker to function well with supervision. This opinion is supported by the objectives of the level 5 NFQ award which are to:

'…develop a broad range of skills, which are vocationally specific and require a general theoretical understanding. They are enabled to work independently while subject to the general direction of senior staff. The majority of certificate/module holders at Level 5 take up positions of employment. They are also deemed to meet the minimum entry requirements for a range of higher education institutions/programmes' (NFQ 2002, p.5).

From an international perspective the Federation of Drug and Alcohol Practitioners (FDAP) in the UK, suggest that all Drug workers, volunteering, part-time and full-time have a 'role profile' which among other things stipulate; a) 'the range of 'competences' they require (i.e. the tasks and activities they need to be competent in) to do their job properly; b) the knowledge, understanding and skills (know-how) needed to perform each of these to the required standard' (FDAP 2020,p. 1). This report says that 'All frontline workers (including volunteers) should be subject to ongoing CPD (Continuing Professional Development) based on their role profiles, and be receiving regular supervision. None of the respondents mentioned role profiles and continuing CPD appeared to occur *ad hoc*, and dependent on finances (Research Journal).

There is no minimum education and training standard in Ireland presently. However, putting this in perspective, Uchtenhagen (2008), in an international study including (Australia, Austria, Finland, France, Germany, Greece, Italy, The Netherlands, Scotland, Switzerland, and the United States), found no standard or base-level training requirement for drug works in these countries.

There was also a strong emphasis on "On-the-Job" experience, which has its advantages, e.g., cost-effective, time-efficient, repeatability; and disadvantages, e.g. dependent on trainers' knowledge and ability, and no independent evaluation of validation to mention a few (Engetau 2017).

Ahadi and Jacobs (2017) found that On-the-job training and development could be effective when highly structured. They had a maximum effect when 'The involvement of

stakeholders, management team, human resource experts, executive training specialists.' (p.343).

The following chapter will look at available basic drug training programmes; their content suitability and the effectiveness of on-the-job learning.

Topic 10: Ideal Specific Training for Professional Drug Worker

There is broad agreement among respondents on the importance of Key-working/Care planning (perhaps because of its adoption by HSE as "Gold Standard"). Group-working skills, including facilitation, was prominent on the list along with interventions using CRA and MI skills also scored high in ideal training requirements.:

'....key-working skills are so important, we do a lot of group sessions here, it's more cost-effective for us, and it makes effective use of our limited staff time. So, for this service, I see Group-work, Therapeutic Group-work and Group skills in facilitation work are a vital asset to use here.' (Manager 1)

While Supervisor (1) notes that:

'Key working and care planning along with CRA or CBT would be fantastic, after two years. That with two years' experience is a sound worker.' (Supervisor 1)

A project worker adds:

'I would like to think that I could do key-working and care planning to develop my chances of full-time work in this field. I need to do computer (e-cass) training and Motivational Interviewing as well; this would develop my confidence in doing my job.' (Project Worker 3)

There was agreement across the grades that up-to-date drug knowledge and developing trends was fundamental:

*'An understanding of drugs signs and symptoms and the reason people use them is a good start. Understanding the process of recovery and relapse...that sort of thing, and the types of interventions that can be made to engage a user in change and maintaining change behaviour MI, CRA etc.' (*Supervisor 3)

Project workers saw a need for computer and computer systems skills, which is understandable as some support workers have been out of the mainstream employment system for some time.

'I was asked to enter someone's details on the computer system last week, and I felt embarrassed that I did not know-how. I asked my team leader who gave me 20 minutes training and left me to it, I was useless at it, and they took me off it. That's the training I got.' (Project Worker 3)

The Project worker cohort also saw issue around safety, self-care and well-being as an area in which they require training:

"In an ideal world I would also see training in well-being and mindfulness, keeping safe is an important skill." (Project Worker 2)

This sample's views on "what training and education a professional drugs training worker" should have and what qualification they should possess will be looked at in light of available literature and discussed further in chapter 5.

Topic 11: Barriers to Further Education:

Supervisors acknowledged a problem in taking time from their workday to undertake elective training:

'At present, I'm unable to undertake training outside work hours, and as you can see, we are understaffed, and I would be unable to take the time out during the day. So, it's a case of biding my time for the present.' (Supervisor 1)

Others had family commitments which would prevent them from undertaking education and training in their own*:*

'...and I have a young one at home which can make it difficult to make time for everything.' (Supervisor 3)

While some were constrained by the cost of undertaking this training privately, e.g.:

'Unless they pay for it from here, and I can't see that happening. I don't have the funding for it.' (Supervisor 2)

Project workers were very motivated to undertake further training much of the content and timing of this training was dictated by the project and was work-related this, however, did not exclude this training being in line with long term-goals e.g.

'Well none really, I'm single, and I now have the time and motivation, I suppose if the job were not paying for this course (level 7 NFQ), I would not be able to do it.' (Project Worker 2)

Single part-time workers seem to have the least number of barriers while most shared the same issues as Supervisors, e.g. family commitments:

'I've put in for a key working and care planning course, I sure I'll get that; I was asked to do a computer course in my own time, and because of my home situation I can't avail of that though I'd love to.' (Project Worker 3)

Concerning finance to undertake independent study:

'I'd like to do counselling, I feel I'd be good at it, but it's very expensive, and my youngest lad is still in primary. " (I) A few years if I can get the cash, please god!' (Project Worker 4)

Managers saw their education and training needs in two-way a) Consistently updating knowledge base with short courses and conferences on specific and relevant themes and b) higher studies consisting of level 9 (NQF) or higher. While generally well trained in their jobs' administration element, supervisors indicated issues around finding the time and getting financed to undertake more clinical courses.

Money and the cost of training and education was a common theme running through this section for all respondents. It emerged that Supervisors feel constrained by taking time off to do elective courses for personal development due to the time pressure of the job. In most projects, there is no ring-fenced budget for supervisor training, and thus self-development is paid for by the individual.

Many project workers were currently engaged in training and development paid for by the SCE training budget. However, they remained constrained in doing "out of work hours" and personal development training due to family issues and childminding. We will discuss these issues further in chapter 5.

4.3 Summary: Chapter Four

Chapter four is a chapter of two halves representing quantitative and qualitative data, respectively. In section one of this chapter, we took the data sets generated by the survey questionnaire and using statistical methods such as percentages, means, standard

deviation and ratio's extracted nominal and ordinal data. These data were then measured, compared and analysed for concurrence, divergence and aberration to extract information. The information emerging provided a demographic profile of the survey sample as a relatively mature, experienced and skilled cohort, who in the main, who saw their foreseeable career in the drug-work field and who had a desire for further training and professionalisation of their work.

This information also provided insight into the experience of working in SCE projects, some of which can be stressful. In this regard, it was established that the provision of formal and informal support was a high priority for projects and was delivered professionally in most cases. Induction or 'on-boarding' was less successful and delivered in a more *ad hoc* and unstructured fashion. It emerged that lack of adequate finances, premises and resources was a real challenge for most respondents with creating significant problems for them. It emerged that relations between SCE projects and DSP were not what they might be with the inevitable consequence. Changes in Government social welfare policy have had a significant (unintentional) effect on participant profile and numbers as has employment growth on support staff quality. The results also identified the effect that a changing drug-use environment has on the participant behaviour and the challenges this poses for staff.

This section also yielded valuable information on SCE worker training and education levels and needs. It provided a snapshot of current training and education in the sample group which produced an eclectic collection of the qualification levels and disciplines, pointing towards a need for rationalisation in this area. It also provided an insight into the sample's opinions on the minimum and optimum education and training for support and project workers and barriers experienced in pursuing further education and personal development.

These findings were consolidated into the eleven themes (see Fig: 4.31 above) which formed the basic structure for further inquiry in the qualitative process.

The second section of this chapter has taken the eleven themes which emerged from the qualitative results and explored the personal opinions and lived experiences of sample members using qualitative methods. This qualitative inquiry was conducted employing semi-structured interviews, which enabled a group of respondents to elucidate, elaborate

and expand on the earlier quantitative findings. It also provided background, texture, and detail, while giving voice to issues affecting respondents working lives on SCE. It details poor working conditions, and what funding deficits mean to those on the ground. It provides background observations on the changes in participant and support-worker profiles. It gives insight into the participant's situation, behaviours and their perceptions of the relationship between SCE's and the DSP.

The qualitative findings also contribute to our understating of what the cohort considers minimum and optimum drug worker training and education standards while elaborating on the barriers which affect their continued professional and personal development.

Analysis of salient issues arising from the findings in both quantitative and qualitative sections of the chapter is discussed under the next chapter's eleven thematic headings. This analysis will meld the information derived from the mixed methods and use selected findings supported by relevant literature to draw conclusions and offer recommendations.

Chapter 5: Discussion, Conclusions and Recommendations

'I love it when a plan comes together' (Colonel John 'Hannibal' Smith)

5.0. Introduction

This chapter contains a discussion of the combined quantitative and qualitative findings of this investigation, draws some conclusions from this discussion, and makes a series of recommendations to improve the SCE programme based on these conclusions. It will also serve to consolidate the findings of the quantitative and qualitative data and elaborates on some of the concepts, ideas and issues that these findings gave rises to as it seeks to meet the aims and objectives of this study. Therefore, it would be useful at the outset of this chapter to reiterate this study's aim to provide a datum by which to judge the conclusions.

Research Question:

To 'explore the working experiences of staff members engaged in delivering drug rehabilitation Special Community Employment programme within the Dublin region.'

The study aimed to answer the following questions:

Sub-questions:

1) Identify the demographic profile of those working in the SCE field.
2) Establish the perceived effectiveness of the SCE programme
3) Document the perceived barriers to effective service delivery.
4) Identify opportunities for the improvement of programmes.
5) Identify project workers' professional training and education needs.

Using the quantitative and qualitative data described earlier and the syntheses and discussion in this chapter, several conclusions were consolidated around the central research question. These conclusions used the information gleaned to develop and frame answers to the research questions and sub-questions.

From this study, it is clear that SCE staff's experiences are often ones of frustration, stress, and disempowerment. There was a broad agreement that in its current form, the SCE is not fit for purpose. However, there was also a worry that the SCE programme could be discontinued, and there will be nothing to replace it. The following discussion, conclusions and recommendations are set within this ambiguity.

The chapter is structured around the 11 topics that emerged in the findings (see Chapter four); and is divided into two sections focused around 1) job-related issues, and, 2) education and training-related issues.

Section 1: Job-Related Issues

5.1. Lack of Finance, Premises and Resources

5.1.1. Synthesis of quantitative and qualitative findings	In answer to a question posited in the quantitative questionnaire about barriers to completing the job, 77% of respondents indicated that constraints in financial support, premises and resources necessary to provide a programme to the highest standard were significant impediments to the effective delivery of SCE programmes. The qualitative findings revealed that the unsuitability of many premises was a common issue. While some projects had excellent physical premises, others were seriously inadequate form the point of view of size, layout, lighting, configuration, equipment, location, personal health

	and safety. Some spoke of the inadequacy of the material allowance (which is effectively the projects operational budget). In contrast, others saw the dwindling value of the training budget, which has remained unchanged for a decade, as a severe problem, particularly for support staff. One service manager put it thus: *'The cutbacks in other streams have put severe pressure on the programme; we're not able to deliver what would be an optimum intervention for rehabilitation by any means.'* (Manager 2) A project worker makes the point that: *'...premises are more than a bit shabby, and some of the staff is (sic) pissed off about the lack of facilities, there is not enough space for privacy outside the counselling rooms, and basically, the place is not fit for purpose. We've had a major rodent infestation, which is ongoing. Most people here have not had a raise in a long time and are getting worn out by the lack of funding and the situation in general.'* (Project Worker 4)

5.1.2. Discussion

Identifying issues such as the inadequacy of premises, financial constraints, and lack of resources should be viewed not, as an unreasonable desire for an ideal working situation. Instead, they can be seen as a situation where an individual's work values, expectations and practices, gained through personal and professional experience, are not met by the conditions and practices extant in the more extensive system in which people pursue their work (Lieter 2009). The issues of inadequacy in capital supports, premises and other necessary resources are noted as being detrimental to the provision of effective services in SCE's (Bruce 2004; Lawless 2006; van Hout & Bingham 2014; CityWide 2016) and the findings of this research add the voice of those working in the service to this canon.

In a broader sense, we can view these findings on lack of resources as illustrating an

incongruence and imbalance between two variables: on the one hand, there are job demands, which Schaufeli (2004 p.269) describes as 'physical, psychological, social, or organisational aspects of the job that require sustained physical and psychological costs'; and on the other hand, job resources, which Bakker *et al*. (2005, p.665) refer to as the 'physical, psychological, social, or organisational aspects of the job that either (1) reduce job demands and the associated physiological and psychological costs; (2) are functional in achieving work goals; (3) stimulate personal growth, learning and development'. It is essential to recognise that 'resources are not only necessary to deal with job demands, but they also are important in their own right' (Hobfoll 2002, p.307). Effectively, when the job resources are negatively out of line with the job demands as is the case here, the result is stress (Schaufeli 2017). This stress can manifest itself as "negative outcomes such as sickness absence, poor performance, impeded workability, and low organisational commitment" (Schaufeli 2017, p.121).

What is of concern are workplace incongruities in job demands and job resources, and their effects on the individual SCE workers at all grade levels. Including adverse psychological and physical effects of occupational exposure to inadequate conditions.

For the past 30 years, there has been a growing body of research around understanding the relationship between, what Bakker *et al*. (2005 p.667) described as unfavourable job characteristics and work-related stress and burnout (Bakker et al. 2003; Demeroutiet *et al.,* 2001; Lee & Ashforth 1996; Schaufeli & Enzmann, 1998; Lieter 2009). These studies have examined how the existence of incongruities between job demands and job resources can cause the worker to experience any one or more of the following: work overload, absence of support, a paucity of training, lack of autonomy, unmanaged interpersonal conflicts, inadequate environment, emotional demands, low levels of social support, lack of job security, role ambiguity, and challenges to their value system, most of which were indeed reported by staff working in the SCE field. Any one of these, either singly or in combination with others, can result in feelings of exhaustion, apathy, negative feelings in the workplace and stress. If left and neglected and ignored, these feelings may result in burnout (Maslach 1993; Maslach & Schaufeli 1993).

5.1.3. Conclusions

Many respondents indicated their grave concern about under-resourcing of individual project SCE projects and the programme as a whole, and the potential impact on service delivery and participant well-being. This lack of staff, the paucity of facilities, inadequacy and unsuitability of premises and lack of financial wherewithal impact the workers at all employment levels. A concern supported by earlier studies by Lawless 2006 and more recently by CityWide 2016 recommended that a mechanism be put in place to provide adequate financial support for capital investment and operational costs and a set of minimum standards established for project premises.

International literature indicates that substandard and inadequate physical conditions, in which some projects must operate can give rise to several issues relating to health and safety, quality of service delivery and staff turnover (Bakker *et al.*, 2005). Moreover, a raft of international studies points to the negative consequence of an imbalance between job demands and job resources can increase stress and stress-associated symptoms among staff. This unhealthy stress has the potential to reduce work efficiency, increase sickness and absenteeism and have negative impacts on not just on the work done but, more importantly, on the individual worker, the service provided and the service user (Demeroutiet *et al.,* 2001; 1998; Leiter 2009; Charlesworth & Marshall 2011)

All workers indicated they had support, both formally and informally. However, the effects of long-term resource deprivation can have a detrimental effect on the individual SCE workers' mental condition (anxiety, motivation levels) but also more broadly on the project's "service delivery, e.g. poor performance, lack of engagement" (Schaufeli 2017, p.121).

5.2. Relationship Between the Project and DSP

5.2.1. Synthesis of quantitative and qualitative findings	The quantitative analysis indicated that >50% of the study cohort identified problems with their relationship with DSP, including a lack of vision, inf flexibility and a lack of understanding in the effective delivery of the SCE programme. The findings that over half the

	respondents consider the DSP/SCE relationship as a barrier to their work is a salient and significant finding of this study. The qualitative findings indicate a perceived disconnect between the SCE projects' objectives and those of the DSP. This dissociation manifests as a lack of a clear and shared mission, purpose and, indeed, the means of achieving drug rehabilitation. Respondents are aware and to some extent, happy that there is a system (i.e. DSP); however, they feel the system is one-sided and imposed on them instead of it being a cooperative partnership. There would appear to be an overdependence on the interpersonal relationship between project staff and community services officer (CSO), the DSP official responsible for local oversight of SCE projects. There is significant variation in the degree of flexibility any individual CSO will allow. This situation can change if personnel change and is not beneficial to a systematic approach to the efficient delivery of SCE schemes. Many project workers reported that they face a dilemma between their engagement with clients on a therapeutic level and then acting as a 'boss' in levying sanctions dictated by the DSP.

5.2.2. Discussion

During this study, the researcher became aware that there was a significant issue in the relationship between SCE project workers at all levels and the DSP. This intuition became manifest in the responses to 'What are the barriers to effectiveness?' and 'Current and future issues'?' The quality of the relationship between the SCE and the DSP lies at the heart of SCE programmes functioning and effectiveness. It is, therefore, was further explored during the qualitative interview stage. The results of these findings are discussed in more detail below.

Given the complex cross-departmental, interagency structure of our national drugs strategy, there is inevitable friction at the interface between disparate organisational

cultures, methods and practices. This disparity is never more evident than between community-driven social endeavours and government agencies. It is therefore essential that this interface is effectively managed as this will determine the effectiveness of programmes.

The relationship problems between SCE projects and the DSP emerging from this study were identified at a national level as far back as Bruce 2004, and again by Lawless in 2006 and most recently by CityWide 2016, however, as of yet, there has been no effective strategy implemented that might ameliorate this issue.

In a more abstract sense, the issue of power imbalance and its implications for the relationship between state bodies or (providers) and Community bodies or (receivers) has generated a body of literature internationally.

As Huxham and Vangen (1996) put it,

'Those who work in voluntary or public organisations and those involved with a community group that has a concern for issues of this type are thus almost certain to find they are working with people in other organisations and groups. Members of voluntary organisations and community groups frequently find themselves at least communicating with people in public agencies or government bodies, because they will always have some role in addressing societal issues and because they tend to have financial resources available.' *(p7).*

In the same study, Huxham and Vangen identified six common themes which arise in these kinds of relationships: *'...(often called 'partnerships' or 'alliances') which are: managing aims; compromise; communication; democracy/equality; power/trust and commitment*' (1996, pp. 7 - 15). Problems on these themes were echoed again and again in the interviews with managers, supervisors and project workers (Chapter 4).

a) Lack of clarity around common aims:

"One of the main problems for me is insecurity. What is happening with the whole area is anyone's guess. It was supposed to be reviewed last year (2019), and I have not heard anything about it since. So, there is this issue of uncertainty (about) where we are going and what are we doing." (Manager 1)

b) Lack of Communication

"The DSP has failed to train their staff to a sufficient level of drug recovery knowledge that could make them a valuable team player instead of an umpire; they spend their time making sure every rule is obeyed to the letter." (Project Worker 4)

c) Compromise

"The system is unyielding and inflexible, at worst. The DSP inherited a system from FAS who had developed some flexibility and understanding of the special needs of SCE after 20 years." (Manager 2)

d) Problem with Democracy and Equality

"We seem on the outside; it is like we're not on the same team; they are the masters, and they like to let you know it... They are sitting on top of a fence and micromanaging; if something is going well, they will claim the credit. If it goes wrong, it's all yours. It's all very wrong." (Supervisor 1)

e) Issues around Power and Trust

"In short, we are being micromanaged into the ground. Supervisor's time is totally absorbed by the training plans and administration." (Manager 2)

f) Issues of Commitment

"*...DSP (Dept of Social Protection) don't care, they tell you that's it's the responsibility of the project how it's run."* (Project Worker 3)

5.2.3. Conclusion:

This study unearths difficulties at several levels in the relationship between the SCE programme workers and the DSP. As evidenced in the qualitative results, the relationship's quality is too often dependent on the flexibility, understanding and interpretation the local CSO puts on the DSP's policy. The nature of this prerogative, in turn, is dependent on the personality, background and training of the local officer. There is a deep feeling of inequality of treatment, on the part of SCE staff; in particular the

relationship between SCE workers and the DSP. The relationship is perceived as a top-down approach with a lack of consultation and mutuality. Such unilateralism is not conducive to effective interagency working relationships and can lead to avoidable problems.

A stark example of this lack of consultation and communication could have on the sample group is the respondent's lack of clarity on the future of SCE. Indeed, many confided that SCE workers have no clear vision of the future direction of SCE programmes, and thus there is a sense of abandonment apparent in the workers' responses.

5.3. Lack of Suitable Staff

5.3.1. Synthesis of quantitative and qualitative findings	Problems and issues around staffing and recruitment and retention of support workers was a concern for 50% of respondents across all worker grades (i.e. managers, supervisors and workers) within SCE schemes. Both issues were identified as important factors in limiting SCE projects' workload, increasing pressure on existing staff and creating critical and significant service provision gaps. Recruitment and retention have a particularly pronounced effect on the support workers. Policy constraints on eligibility for SCE employment, low pay and conditions and a depletion of the pool of potential workers due to the buoyant employment market (in 2019), and the high turnover of staff have all led to the reduction in the numbers of suitability qualified staff. Concern was voiced, that DSP employment officers were being indiscriminate in sending patently unsuitable candidates for support worker position interviews, thus wasting everyone's time and displaying a lack of essential understanding of the job requirements.

5.3.2. Discussion

A consultation document on 'Special Community Drugs Rehabilitation Programmes' (i.e. SCE) produced by CityWide (2014) noted that projects had 'reported difficulties in recruiting and maintaining support workers positions' (p.27). This report also found there were "fears that the reduction in support worker applications will lead to projects losing their entitlement to these posts if they remain unfilled" (*ibid, p.28*). This report went on to pinpoint changes in payment policy from 2012 which, in effect, meant that SCE projects were asking people to work for 19.5 hours a week for just €20.00 more than their unemployment benefit, coupled with a potential loss of secondary benefits. This reduction in terms and conditions and increasing costs such as childcare, travel, and subsistence has severely impacted recruitment and retention. In the years between 2014 and 2019, the Irish economy improved and by January 2020 had attained statistically notional full-employment which has contributed to the recruitment and retention problems.

Lack of suitable staff has several important implications for those currently employed in SCE projects, not the least of which is stress. Ullrich (1990) points out that: "occupational stress occurs when there is an imbalance between the demands of the workplace and a worker's ability to cope" (p.1017), while Mosadeghrad (2013) suggests that: "occupational stress is a crucial factor influencing employees' job satisfaction and organisational commitment, which are key turnover predictors..." (p.169) thus indicating that a lack of adequate staffing causes stress for those who are doing the job and can, in turn, lead to high levels of turnover, which in turn leads to staff shortages.

A manager put it as follows:

"It is obvious now that we the system should have been investing in real, sustainable jobs for professional drug workers. Would any other sector put up with it? would you let CE participants tend a psychiatric patient or an injured /sick person, no, people would be appalled..." (Manager 2)

International studies note the importance of 'interprofessional collaboration,

professional accountability and expert skill development together with appropriate staffing and workload to ensure high-quality patient outcomes (Kane et al. 2007, Beal et al. 2008, Kramer & Schmalenberg 2008) to minimise stress among staff.

Stress is usually defined from a 'demand-perception response' perspective (see Bartlett 1998). Lazarus and Folkman (1984) integrated this view into a cognitive theory of stress that has become the most widely applied theory in the study of occupational stress and stress management (Lehrer & Woolfolk 1993, Rick & Perrewe 1995). 'The basic concept is that stress relates both to an individual's perception of the demands being made on them and to their perception of their capability to meet those demands. A mismatch will mean that an individual's stress threshold is exceeded, triggering a stress response (Clancy & McVicar 2002)' (McVicar, 2004,p.45).

The implications for understaffing, particularly in the interpersonal and caring professions, has serious implications for overworked staff members.

5.3.3. Conclusion:

Due to a combination of prevailing economic circumstances and inappropriate referral, inadequate pay, and poor conditions, staff recruitment and retention have become a serious issue for this research sample. Particularly the recruitment of support-worker grade.

Pressure caused by a lack of adequate staff can have severely deleterious effects on the remaining staff members, their performance and their well-being. Indeed 62% of respondents felt that staffing issues were putting barriers in their way of the programme's effectiveness, had caused a curtailment of services and the postponement of new initiatives. Many expressed the serious concern about the problem of stress and burnout resulting from inadequate staffing.

Ireland signalled it is adopting a medically oriented approach to treating addiction with the publication of the 2017-2025 National Drug Strategy entitled 'Reducing Harm, Supporting Recovery: A health-led response to drug and alcohol use in Ireland 2017–2025'. The stated vision of this strategy is to provide;

'A healthier and safer Ireland, where public health and safety is protected, and the harms caused to individuals, families and communities by substance misuse are reduced, and every person affected by substance use is empowered to improve their health and well-being and quality of life' (Department of Health 2017, p. 8).

However, it is noteworthy that SCE support workers, who are delivering a healthier and safer Ireland, and providing a health-centred service while reducing harms caused by drug use are paid, just a little above, the basic job-seekers (unemployment) allowance.

5.4. Participant Issues

5.4.1. Synthesis of quantitative and qualitative findings	Among the participants in this study, 40% (n=28) considered participant issues a problem in their service delivery. Some respondents noted behavioural issues, mostly related to a change in the age profile of participants. With younger people attracted to the service due to enhanced payments, workers find they are dealing with a different range and combination of drugs of choice. Stimulants, alcohol, and potent cannabis would seem to be more prevalent among this group than the older heroin user who made up most past participants. Behaviour such as aggression, acting-out and emotional outbursts are more common. A supervisor observed, '*young people with weed (cannabis) psychosis, is a real issue for us at the moment, they can get very, I don't want to say aggressive' (Supervisor 2)* A support worker added; '*We had a couple of incidents of "acting –out" and well serious enough to frighten staff.' (Project Worker 2)*

	A related phenomenon is an increase in mental health related issues; one project worker put it thus: *'... I do feel that paranoia and psychosis are noticeable more now among participants…"* while a project manager said, *"we have more and more participants exhibiting mental health issues than when we were dealing with mainly opiate users.' (Project Worker 1)* Finally, participant homelessness was a genuine concern for SCE workers, for without stability, how can rehabilitation begin? This issue is underlined by a manager who said; *'Today, we are dealing with far more homeless, dislocated people than ever before in my long memory.' (Manager 1)* A project worker added; *'We have three participants who became homeless over the last two months, and it's nearly impossible for them to hold their places on the scheme because they have so much going on in their lives, they miss classes or work sessions and have to be sanctioned.' (Project Worker 3)*

4.4.2. Discussion

The change in demographics noted by our sample is confirmed by the work of Smyth *et al*. (2019) who states: "Alcohol and cannabis are the primary substances contributing to referrals of adolescents to substance abuse treatment services" (p.72). International studies have evidenced that alcohol consumption increases aggression in adults (Giancola *et al.* 2002); adolescents (Dembo *et al.* 1998), sexual violence (Testa 2002), mental health (Glass & Marshall 2016) and suicide (Bachmann & Silke 2018).

Work by Cocaine & Stokes (2017) indicates that; "It is evident that cocaine use is increasing again among this vulnerable cohort. With increased numbers of patients attending OST also using cocaine, treatment needs to be". Ireland is recorded as one of the countries with the highest prevalence of crack cocaine use in Europe (EMCDDA 2018). The literature indicates the increasing prevalence of crack cocaine use nationally and

internationally (O'Reilly & MacCionnaith 2019, p.16).

With regards to cannabis, studies are suggesting that *'Serious aggression is associated with regular cannabis use and reduced behavioural inhibition'* (Harris, 2010, p.83). Other drugs such as methamphetamine and novel 'head-shop' substance associate with a younger group also have significant adverse mental health and behavioural consequences (Plüddemann *et al*., 2010; O'Reilly *et al*. 2010).

Many workers saw homelessness as an issue for some participants, and while homelessness is currently a serious problem nationally, it has pertinence for those working in recovery. A more cohesive interagency response is required to provide an appropriate and timely response for SCE participants who become homeless while on the

5.4.3. Conclusion:

A combination of: a) policy initiatives which successfully attract young people (under 25-year old's), along with their specific drug use choices can give rise to aggression and; b) an increase in usage of stimulants among the drug-using population has led to a new, and more complex working milieu for SCE workers. This new working environment is associated with a greater incidence of participants act-out, displaying anxiety and aggression and more prevalent manifestations of mental health concerns, e.g. paranoia, psychosis.

This situation has profound implications for individual workers and needs addressing across many areas of project management, including health & safety, supervision and training. There is the question of whether an SCE project is the correct venue for dealing with mental health problems at all?

Another complicating factor which has emerged and grown worse over time is homelessness. While not all homeless people have drug problems, there is a substantial cross over between drug use, homelessness and mental health. (Citation needed)

5.5. Participant Recruitment

5.5.1. Synthesis of quantitative and qualitative findings	While there are no accurate figures published recently, nearly a quarter (i.e. 24%) of respondents reported a sharp decline in participant numbers, particularly among the over 25-year age group, who traditionally would have made up the bulk of the programme participants. This decline in participant numbers was attributed to the cutback in participant allowances, fear of loss of ancillary benefits, concern about sanctions and "docking". One supervisor put it thus: *'We also have a huge issue with recruiting participants, particularly over 25's because there is no incentive for them; there are no allowances (ability to maintain secondary benefits). The up-take by females has fallen off like crazy, because of childcare or lack of it as far as I can see. They must pay 15 Euro for Crèche for the 19.5 hours; then there is pick-up time and delays, it's not worth their time. The Eighteen to twenty-five-year olds get a double allowance, so we have a good presence in that age group.'* (Supervisor 2) There was also concern about the cost of childcare and its impact on the numbers of mothers taking up SCE projects. As a project worker explained: *"A lot of users are just saying it's not worth coming on the programme if anything happens you lose money, like if you have a bad day or so. We have only two girls on the project at present, no one to look after the kids and nothing to attract them." (Project Worker 2)*

5.5.2. Discussion:

A CityWide (2014 p.21) report underpins the respondents' concerns for participant recruitment, as it found participant drop off in specific categories in referrals of as much as 24% between 2012 and 2013. The current work shows that this continues to be a significant issue and further indicated that the loss of secondary benefits, and the overall reduction in allowances in real terms, had a significant adverse effect on participant recruitment. The literature supports these empirical observations. For example, a study by Stitzer *et al.* (2010 p.68), underpins the efficacy of material and financial incentives in

increasing motivation among drug users to undertake meaningful rehabilitation, while Lussier *et al.* (2006) found that the efficacy of material incentivisation was dependent on the magnitude of the reward. McKay *et al.* (2017) put it thus: *'Findings from neuroscience, which demonstrate how addiction "highjack's" the reward centres of the brain... make an even stronger case for the importance of increased incentives for abstinence.'* (p.753). Cutting back support for SCE schemes can therefore be a false economy on government's behalf given the overall cost to the exchequer of drug-related issues, e.g. crime, imprisonment, medical care and social incapacitation.

While studies have shown that motherhood can be a powerful motivator to undertake recovery and rehabilitation (Seay *et al*., 2017, p.197), the cost of childcare can be an issue particularly for mothers contemplating recovery and rehabilitation. For example, Brogly *et al*. (2018), found that 49% of women perceived childcare as a barrier to their entering rehabilitation. Thus, the inadequacy of the child allowance and the inability to access affordable childcare represents a further challenge to women's recruitment to SCE schemes.

5.5.3. Conclusions:

The numbers applying for courses have fallen, particularly among over 25-year old's and women. This may be due to the reduction in participant allowances, the inadequate allowance for childcare and the lack of affordable childcare availability. This situation throws up a few issues, including disincentives, to potential applicants to enrol on recovery programmes. The reality of lower numbers on courses is that it reduces the per capita material budget available to projects, creating a vicious cycle. This lack of participants also reduces the number of support staff based; also related to a per capita ratio of participants to staff; this inevitably puts pressure on the remaining staff.

The level at which child care is catered for creates a significant barrier for mothers with young children from entering the programme.

5.6. Is the SCE Fit for Purpose?

5.6.1. Synthesis of quantitative and qualitative findings	Many respondents were ambiguous about the functioning of SCE in the past, 92% of respondents indicated, that in its present form, SCE is not 'fit for purpose'. As one manager put it: *'To answer your question in short, it (SCE) works for the few, but something else is required for a large portion of our potential clientele, particularly the older ones who find it hard to engage with learning or new skill work but, yet, value the social support, security and recreation activity it provides in support of their ongoing recovery. These can be on high dosages of methadone also.'* (Manager, 1). Several respondents expressed the belief, that while the SCE provided a useful service, they believed that it was a product of an outdated paradigm. It was inflexible in its operation, culturally insensitive to drug users and communities' needs, and structurally unable to respond effectively to a changing drug landscape. A project worker noted: *"It worked for me (when I was on drugs). I'm clean (now), I know what I want, and it provides that for me now. However, most of the participants are nowhere near ready for this kind of programme. Perhaps a pre-SCE course or some more selective, (sic) way of assessing participants. But, as it stands, it's not fit for anythin*g." (Project Worker 3)

5.6.2 Discussion:

When answering this question; the respondents were basing their answer on several issues discussed already.

As we have seen, there has been a substantial change in drug use patterns in Ireland over the last decade. The last decade has seen an increasing trend in cannabis weed, methamphetamine, cocaine hydrochloride, crack cocaine and Novel Psychoactive

Substances (NPS) use is evident among Irish 15-34-year-olds (Lynn 2017; EMCDDA 2017; Van Hout *et al.* 2017). This growth in novel and stimulant type drugs has seen some of these users' experience anxiety, paranoia and depression (Van Hout 2017; O'Reilly, 2019). These conditions are exacerbated when there is even moderate alcohol use in combination (Yurasek 2017). Alcohol, methamphetamine and cocaine are also associated with aggression and violence (Gladwin *et al.* 2017; Leslie *et al.* 2018; Czermainski *et al.,* 2020). It was apparent from the responses to both the quantitative and qualitative investigation that this changing pattern of drug use is reflected in the research samples perception of participant behaviours. It raises that question of the adequacy of the structure of the SCE as it currently stands to deal with the challenges this new environment creates.

According to Citywide (2014), the DSP's policy changes in 2013 saw a 66% reduction in training and materials budget, raising the supervisor to participant ratio to 1:25, and centralisation of financial budgets contrive to reduce the effectiveness of programme delivery. These measures were compounded by the governmental budget (2013), which reduced the incentive (above basic Job seekers allowance) from €208 to €20. The reduction in ancillary benefits "including the Household Package (namely, reductions in allowances for telephone, fuel allowance) have exacerbated the effects of financial difficulties" (CityWide,2014, p18). Hence there is a lack of participants, which has a knock-on effect of reducing the material budget even further. It is abundantly apparent that this model of financing SCE is not fit for purpose.

Van Hout and Bingham (2014) recommended improvements to the structure of SCE including revision of *'scheme goals in each project, and identify whether the project is dedicated to therapeutic and relapse prevention supports, or dedicated to specific vocational training and employment initiatives'* (p.47). This two-stream approach is in agreement with recommendations from Lawless 2006 *'the development of a re/integration model of SCE in areas where the demand exists'* (p.91). Van Hout and Bingham (2014) also suggested SCE improvements; *'in relation to the development of timely assessment procedures in order to provide individual care planning, specific vocational training and employment-related skills base, provision of work placement or volunteering supports and assistance in curriculum vitae and interviewing skills'* (p.47).

5.6.3 Conclusions:

As discussed in the literature review, the genesis of the problem with SCE may be found in its inception and co-opting a labour force activation mechanism as the principal method for delivering sustained recovery and rehabilitation from drug misuse. As the country has shifted towards a medically driven model of addiction, it is still using, what is essentially a neo-conservative labour market activation construct to deliver drug services. This Procrustean solution may have seemed attractive and expedient in the 1990s; however, it has for some time has been very clear, not least to those who work at the sharp end of service delivery, that it is no longer an ideal tool for delivery of modern community-based rehabilitation services. Given these changes

Section 2: Training & Development Themes

5.7. Ideal Qualities Desirable in Potential SCE Drug Worker?

5.7.1. Synthesis of quantitative and qualitative findings	A lack of suitable potential support staff recruits emerged at the quantitative stage, with 50% of the respondents identifying this as a critical issue for the effective functioning of SCE schemes. This problem prompted a further investigation at the qualitative stage of the essential qualities desirable in a potential drug worker? One of the key points coming across at this interview stage was that due to available job-seekers (i.e. virtually full employment), job-centres were frequently sending highly unsuitable candidates for interview. This situation has the potential not alone to be harmful to the participants and project, but the job seeker themselves. So, what are the ideal characteristics that a potential drug worker should have? Personality traits like maturity, stable personality, strong boundaries, common

	sense, empathy and motivation were mentioned time and again as being essential prerequisites. A manager captures some of the issues thus: *'Sound judgment and common sense (as uncommon as that is) are a basic requirement, a balanced person, mature. Some of the people we have been sent by DSP recently were vulnerable people themselves and could be damaged by being in a service environment. Basic cop-on as regards boundaries, if people have that you can develop a professional attitude to work but if not, it's difficult, and the helper or worker becomes a "liability" I am afraid to say.'* (Manager 2)

5.7.2. Discussion:

Due to a lack of specific studies around traits or attributes required for a successful drug worker, research studies centred on similar occupations such as addiction nurses, social careers and social workers were used to conceptualise issues and inform discussion around this topic. A search of the international literature in analogous areas of work proved more fruitful. Kinman and Grant (2010), state that: *'Although research findings suggest that social workers gain considerable satisfaction from their work, they tend to report higher levels of work-related stress and burnout than many other occupational groups'* (p.261). Similarly, working in the field of substance misuse can also be stressful (Clancy 2007, p.195) suggesting having a robust, mature and resilient personality would be of significant benefit to those engaged in face-to-face drug support work. This finding is supported by Matheson *et al*. (2004), whose study of Scottish addiction nurses, revealed a mature and senior workforce. Indeed, having a mature personality has been shown in several studies to be a significant occupational asset in maintaining the employee's well-being (e.g. Krampe *et al*. 2008; Skomorovsky & Sudom, 2011; Eakman & Eklundan, 2012).

Empathy is a complex emotion which Gerdes *et al.* (2011) describes empathy as having

"four albeit, subjective, constituent elements; (1) affective response, (2) self–other awareness, (3) perspective-taking, and (4) emotion regulation." (p.203)

The broader issue affecting SCE projects is the inability to recruit the best or right person for a support worker's positions. However, it would appear from the current findings candidates with the desired abilities remains a currently significant and increasing challenge due to an unfortunate mixture of policy, procedure and circumstance. As Rahman & Islam (2012) so pertinently put it: *'...while internal forces or factors are the factors that can be controlled by the organisation. External factors are those factors which cannot be controlled by the organisation.'* (p51).

5.7.3 Conclusions:

The current situation is that SCE projects are facing a dwindling pool of potential workers due to economic growth and a suite of government policies which on the one hand disincentivises candidates from engaging with SCE; and on the other unwittingly coerces unsuitable candidates (on Unemployment Assistance?) to apply for positions, for which they may have little or no aptitude or motivation. This situation may change with the changing economic environment created in the wake of Covid-19. However, many respondents felt that people from the live register were being used to provide cheap labour to do a complicated and stressful job. The feeling was that if the government is to take the rehabilitation of drugs users seriously, it must commit to funding for trainee and professional posts.

5.8. Minimum Qualifications for Drug Workers

5.8.1. Synthesis of quantitative and qualitative	In this study's quantitative element, this question's response yielded a broad range of possible minimum qualification levels (from 5 to 8), which provided mixed results. On reflection, it was realised that respondents could interpret this question to mean either minimum

findings	training to function or minimum training to function professionally. Thus, the topic was divided into two different questions in the qualitative interview. This question is specifically about the minimum training level and qualification with which a person might be expected to contribute to the team and project's functioning, with a high to moderate level of supervision. Subsequently, 95% of the entire study sample suggested level 5 QQI Addiction Studies or Social Care as this base qualification level. It is noteworthy that 91% of the SCE support workers sampled were qualified to level 5 (NFQ)or above with 48% holding a relevant qualification at level 7(NQF) or above. However, most stressed that learning on-the-job or experience by 'shadowing was fundamental. One manager felt that the: *'Ideally, a level 5 social care or addiction certificate with some volunteering experience would be the minimum for being (an) effective worker. But, it's very important to get the right person with the right attitude also; we can provide on-the-job learning.'* (Manager 2) While a Supervisor suggested that a: *'Minimum of level 5 (NQF)…addiction studies, to work with any degree of autonomy and make a professional contribution to the team.' (Supervisor 2)*

5.8.2. Discussion

This question was asked to identify the respondent's thoughts on qualifications and standards. There is currently no clear minimum standard of education or training for any person charged with working with recovering drug misusers. Strangely while chronic drug misusers are often described as being physically and psychologically ill, socially vulnerable to the extent that Garda vetting is required to engage in working with such individuals, there are no professional or vocational standards that apply. This situation is

particularly striking given the positive correlation between evidenced skill levels, qualifications, treatment outcomes and service quality. (Dagger *et al.*, 2007; Oyetunji *et al.,* 2011). Pidd *et al. (*2012) found that *'Establishment of a minimum qualification is one strategy employed to up-skill the* (Alcohol & Drug) *workforce and ensure a qualified workforce into the future.'* (p.515)

Many of the respondents emphasised the importance of on-the-job learning and experience in developing their professional competency. However, this experiential learning, while a significant part of the workers' education, has its drawbacks. It can lead to over-reliance on situation-specific tasks, over contextualised examples and overdependence on received wisdom. These issues can diminish the learners understanding of underlying theories and principles; inhibit the transfer of skills in unfamiliar contexts and undervalue the access to academic debate in the field. (Priest 2009; Wheelahan 2008; Hagern 2004; Gonzi 2004; Hunter2001).

5.8.3. Conclusions:

Learning on-the-job has its value; however, there are limitations to this process. It is evidenced that structured vocational and educational training and education enhance both the individual's professionalism and sense of vocation, while also providing for better outcome and quality of service delivery. Currently, there is no statutory minimum education or training standard stipulated for drug workers. However, the respondents to this survey coalesced around a level 5 standard award, emphasising social care and addiction components, as being a minimum for effective engagement with clients at a junior level while under adequate supervision.

5.9. Adequacy of Induction

5.9.1. Synthesis of quantitative and qualitative findings	The quantitative research found that while 80% of Project Workers had undergone some form of Induction. However, there was a wide variance in the content, structure and delivery of "Induction" programmes with large inconsistencies from project to project. While 83% of the project worker cohort found their induction relevant (in so far as it went) contents ranged varied widely from briefings to duties and policies to discussions on boundaries and supports. Just 8% receiving any induction on health and safety. There was also a concern that the project often liked the time to carry out a structured Induction programme. The responses from the interviews mirrored the quantitative results: *"...we got a few minutes on policy early on, I can't remember what it was about, to tell the truth. I only know when something goes wrong (laugh). Look and learn from people with experience."* (Project Worker 1) Furthermore, a manager noted that: *"We have a programme for full induction which covers health and safety, policy and procedures and all the rest, but to be honest, we do not have the staff or the time to implement it as I would like. "* (Manger 2) Therefore, it is clear that while there is an understanding amongst all staff that induction is essential, the level and degree to which this importance is being transferred into the actual delivery of a high-quality induction programme varies significantly. In many cases, the implementation of induction is moderated by factors such as lack of time, lack of staff available and lack of prioritisation by individual SEC schemes.

5.9.2. Discussion:

Induction - sometimes referred to as organisational socialisation, or more recently Onboarding can be defined as '*any arrangement made to familiarise the new employee with the organisation, safety rules, general conditions of employment, and the work of the section or department in which they are employed*' (Skeats 1991, p.16). Research suggests that most organisations implement induction to help new employees familiarise themselves with their jobs (Wesson & Gogus 2005).

The comprehensiveness and thoroughness of induction processes/programmes will, of course, affect the speed at which the employee becomes competent in their work and set the tone for future working life within the organisation (Ragsdale & Mueller, 2005; Brodie 2006; Derven 2008). Several researchers have demonstrated that a comprehensive, well-run induction programme increases the inductee's job satisfaction, motivation and integration, and increasing commitment and positive attitudes towards the organisation (Kotze & Du Plessis 2003; Dessler 2013; Hunter 2008). Both Snell (2006) and Wanous and Reichers (2000) stress the importance of covering health and safety in the induction. As pointed out by Akpan (2011 p.161), for health and safety system to be effective*: 'management must show leadership and commitment to the topic'* (Akpan 2011, p.161)'. Thus, the best way to provide this leadership and indicate the seriousness with which the organisation treats it is by putting health and safety at the centre of the induction process.

In contrast, to the *ad hoc* nature of the SCE induction, the Health Service Executive (HSE 2017), who has ultimate responsibility for drug rehabilitation in Ireland, has developed a comprehensive induction strategy. They have a comprehensive induction plan mandated for delivery to all employees at corporate, departmental and site (project) level. The project level is perhaps the most appropriate for our comparison purposes and represents best practice in induction practice. The topics covered by this verifiable induction programme are; the recruitment process, employment policies, health and safety policies, workplace health and well-being, data protection, risk management, communications process, security, education and development, quality safety, diversity, equality and inclusion, organisational overview, other relevant departments and

organisations. (Adapted from HSE 2017)

5.9.3. Conclusion:

The SCE induction process is at best haphazard, and there is a lack of consistency in content and delivery across projects. It is vital to both the individual and the agency that a thorough and comprehensive induction be conducted to improve integration, lay foundation of understanding of policy and practice, and provide comprehensive health and safety training. As Ireland shifts into a medical-based response to addiction in general and a new concentration on rehabilitation, it behoves those ultimately responsible for SCE service delivery (Government, Dept. of Health, HSE and DSP) to provide adequate finance and support for a systematic verifiable induction programme.

5.10. Ideal Education and Training for Professional Drug Workers

5.10.1. Synthesis of quantitative and qualitative findings	As discussed in Section 5.8.1., this question was separated to specifically addresses respondents' ideas on the level of certified education and training which one might expect (or want) a professional drug worker to have. This standard would enable them to perform their work at an acceptable level with a minimum of supervision. When asked "What minimum level of qualification (NQF), is acceptable for a professional drug worker": 61% the entire sample felt that Level 7 would be right. 23% felt a Level 8 (NQF) was appropriate, and 13% felt a Level 4 to 6 (NQF) was adequate, 3% felt that no qualification was required. The majority of respondents recognised the need for a standardised professional drug worker qualification. This study's qualitative element showed a wide range of opinions on the possible structure,

	design, and content of a professional education and training qualification. There was broad agreement that Key-working and care planning form an essential part of the project workers critical skills set, as was some form of verbal intervention training (e.g. Motivational Interviewing). Similarly, a sound understanding and knowledge of addiction issues and drugs was also considered essential. Apart from these areas, there was a wide range of subject areas and content offered by respondents. These varying responses indicate the need for dialogue around defining, rationalisation, developing, evaluating and implementing a standardised "professional drug worker" training and education framework. The research's quantitative element found that; 90% of respondents felt that society put a low value on drug work. Furthermore, 92% believed that establishing a professional body to represent professional drug workers' interests, set standards for practice and education would be a good idea and help the 'professionalisation' of staff employed in SCE schemes.

5.10.2. Discussion:

The educational path to becoming a professional drug worker currently has no clearly defined route. Indeed, as indicated by this study, most individuals who come to drugs work have worked in various areas and thus bring a welcome breath of life experience. However, there appears to be an absence of a universal or even nationally accepted set of core competencies to construct a relevant educational syllabus. There are currently a limited number of Level 4 and 5 QQI "primers" that provide basic understanding and knowledge of addiction for those at entry-level. There is a broader range of third-level courses offered by community educators, technical colleges and universities at both Levels 7 and 8 all of which have developed their curricula.
A U.K. study by Boys *et al*. (1997, p.299) found that the *'absence of a national training strategy has been a serious missing component to our response to the drug problem*'; it goes on to state that *'If recommendations for national training strategies are to be developed,*

there is an urgent need to assess the current level of training among staff working in drug agencies' (*ibid*, p.229). Unfortunately, these words over twenty years old can still be applied to the paucity of educational opportunities for current drug workers and SCE support worker in Ireland currently. Within Ireland, the Advisory Council on the Misuse of Drugs as far back as 1990 identified '… the need for training at three levels: at a basic level, advanced training, and specialist training with an integrated substance problems approach.' (Ferrall 1990, p.1560). Lawless (2006) noted that the work undertaken by SCE employees is:

'...highly skilled work with specific and specialised competencies and skills required. The work can, by its very nature, become highly personalised, leading to a high degree of burnout, disillusionment and exhaustion. Only high-level of (Education) training, support and supervision, combined with lengthy experience can provide staff with the skills to sustain such challenging work" and goes on to recommend a *three years centrally coordinated training and development programme for CE support workers.' (p.82)*

5.10.3. Conclusions

There is broad agreement among the sample that a level 7 QQI qualification would be a minimum qualification for an effective professional drug worker. It is also noted that there are several courses among various educational institutions which provide a range of suitable programmes from level 5 to 8 QQI. However, it would appear from the research finding that there is no clear path for a worker to structure a career education, training and development plan. There is no professional body to standardise professional grades and educational qualifications. Currently, the project workers education and training content and level are ultimately at the discretion of the DSP, HSE, community sponsor group and Centre manager.

5.11. Barriers to future Education and Training:

5.11.1. Synthesis of quantitative and qualitative findings	When asked in the qualitative questionnaire, 'What they perceived to be the barriers to undertaking training and education they needed for the future?'; the research sample's response showed that most respondents wanted the opportunity to undertake further personal and professional development. However, a minority had concerns about the ability to finance these studies and make the time commitment necessary.

5.11.2. Discussion

SOLAS, the state agency charged with responsibility for further education and training policy and practice in Ireland, noted that *'Skills have become the global currency of 21st century'* (SOLAS 2018, p.5). They also commented on the *'importance of enabling those in employment to improve their skills has been recognised internationally for quite some time.'*(*ibid,*p.5). A variety of independent studies (e.g. Cardon and Valentin, 2017; Nolan and Garavan 2016; Short and Gray 2018), have found that continuing personal training and development of staff in small agencies, businesses and organisations are typically neglected primarily due to factors focused around time pressure, a lack of training and education budget coupled to lack of management vision. Dhar (2015), examined the associations between training, organisational commitment and service quality and found that employee perception of 'training accessibility, support and benefits' had a 'positive impact on their levels of organisational commitment which, in turn, was positively related to customers' perceptions of service quality' (p.424). SCE projects managers and Supervisory Boards need to be aware of this correlation and its impact on service users and staff morale and understand that savings made at the expense of staff training are often a false economy.

Practical training and education support such as providing paid time off for courses and seminars, covering fully or contributing to the cost of courses, materials and transport, along with showing flexibility in making staff available to undertake further study and

training signals to the workforce that senior management are committed to supporting employee participation in their training and development. (Maurer & Lippstreu 2008; Lancaster & Di Milia 2014). Investing effort, time, and money to develop a learning-oriented culture among management and staff can bring about improved performance; both in regards to improved internal and external relationships, as well as in financial terms (Skerlavaj *et al.* 2007). Other researchers (e.g. McCracken 2005; O'Connor *et al.,* 2006; Lancaster & DiMilia 2014) have also found that senior management buy-in is crucial to creating a positive organisational culture supports learning. Garvin *et al.* (2008 p.112) suggested that the developing a learning culture is a three-stage process which includes supporting and facilitating an ongoing learning process among staff, providing concrete learning processes, staff development policies and providing leadership that value, reinforces and rewards learning. Bates and Kasawaneh's (2005 p.107) definition of a learning culture, as one that "embodies a shared pattern of values and beliefs about the importance of learning, its dissemination and application" highlight the importance of organisational values and beliefs in defining what the core beliefs of an organisation.

5.11.3. Conclusion:

Given that most respondents were willing to engage in further training and development and saw themselves as having a long-term future in the drug field, the lack of support, particularly financial support and paid-time allotted to undertaking training and development programmes is especially disappointing and impacts negatively on staff morale. This finding echoes the SOLAS (2018) report, which said that the: *'Costs and time are two key barriers reported internationally to (Individuals) participation in employee development'* (p.28). It also notes that "lack of advice, information or guidance" (*ibid*) is a significant barrier to employee's undertaking training and development.

While the rationalisation and enhancement of remuneration in terms of pay, and conditions in the SCE projects is well over-due, it is beyond this study's scope. Nevertheless, it is important to note that terms and conditions of SCE staff are a hodgepodge of HSE Section 39 workers scales, full-time project workers on specific SCE salary scales, and support workers who survive on CE allowance. It was evident

throughout this research process that pay and conditions, while important, was not the reason that SCE workers did their jobs. This vocational loyalty of SCE workers is very ill-served by organisations not providing the culture, resources and support to enable staff to enhance the skill and knowledge in further training and development.

5.12. Recommendations

The following recommendations emerged from the discussion and conclusion in the previous section of this chapter. The recommendations are divided into the two main headings used throughout, i.e. Job-Related and Training and Development related.

5.12.1. Job-related Recommendations

1) The findings of this study lend support to the suggestion by van Hout and Bingham 2012 that their *'...research underscores the need for an extensive revision of the ethos and direction of existing "Special Community Employment" schemes in Ireland'* (p.72) and in line with best current international practice. Lawless (2006) findings went further and suggested that *'SCE drug rehabilitation projects, should, in theory, be the responsibility of the HSE'* (p.51). This suggestion has gained new traction in light of the current drug policy shift towards a medically driven response.
   Establish a national-level committee with representatives from SCE projects, drug users' fora, community drug workers, HSE and the DSP to develop a five-year plan for the future of SCE schemes. This plan should be based on a root and branch independent review of the SCE programme and a remit to fully explore all mechanisms that might enhance the role which SCE currently plays in the National Rehabilitation Framework. It would provide an opportunity to reimaging SCE and how it might reposition its services and staff to meet current and national drug policy requirements. The committee should utilise this report and the other extant research relevant to SCE to develop a new shared vision for the element of rehabilitation catered for currently by SCE. This new system would include

protocols and practices to provide clarity at the strategic level and guidance at an operational level and mechanisms for resolving interagency frictional problems at both local and national levels. There should be a balance of community and state representatives on this committee to ensure all stakeholders' buy-in. Van Hout & Bingham (2012), make the point that;

'*Future research efforts should involve a democratic and participatory approach with all key stakeholders, in order to clearly distinguish responsibilities and avoid duplicity between health and addiction services, and that of the vocational education provider within an interagency rehabilitation framework*' (p.71).

In line with findings by (Lawless 2006; Van Hout & Bingham 2012); international research results, e.g. (Demeroutiet *et al.,* 2001; 1998; Leiter 2009; Charlesworth & Marshall 2011) and the finding of this study, which all emphasise the necessity for adequate and appropriate accommodation to house projects. Therefore, the study recommends that all SCE project premises undergo a fitness for purpose audit, including benchmarking against minimum standards in health and safety, lighting, adequacy of space for numbers of people, and kitchen facilities. Project premises found to fall below this minimum standard should be provided with the resources to remedy the existing structure or helped with the acquisition of suitable premises.

2) Lawless 2006, van Hout & Bingham 2012, and CityWide 2016 found inadequacies in funding methods and structure;

'Funding directives are needed to further develop this existing scheme structure in terms of improved vocational outcomes, and building on its success in terms of therapeutic value and advocacy functions.' (Van Hout & Bingham, 2012, p.71)

The SCE material allowance and its direct linkage to participant numbers needs to be addressed. Along with an upward revision of the provision levels to realistically finance a quality drug rehabilitation service. The DSP should be an immediate introduction of enhanced payments and secondary benefits to SCE support workers to stabilise the current staffing situation. It should also, introduce an incremental payment scale for SCE support workers to incentivise recruitment and encourage retention of current staff. DSP criterion for support worker

eligibility should be extended to permit recent graduates in social science, and other relevant disciples gain paid experience while providing valuable service.

There is a manifest need expressed in this study for governmental financial provision, through a relevant agency (e.g. HSE), to provide full-time staff positions on SCE and an accessible career structure with career mobility the rehabilitation and health sector generally.

3) There should be an immediate restoration of participants allowances and benefits to the 'pre-2012' rate to provide incentive along with food provision and other creative enticements to engage and maintain participation.

4) Van Hout & Bingham (2012) found that there were inter-agency difficulties in addressing client homelessness. All participants described these difficulties as negatively impacting treatment outcomes and vocational training retention; with 'drug-free' or 'stable' individuals often housed alongside active drug users' (p.53). Thus, Cooperation between housing services, mental health services and SCE project at a local level must be enhanced to deal promptly and effectively with emerging participant issues in these areas.

5.12.2. Training and Development Recommendations

5) This study concurs with the recommendation by Lawless (2006) for the need to "develop a three-year centrally coordinated training and development plan for SCE support workers with accredited core modules" (p.85). The development of this plan's content should be agreed by all stakeholders, including CityWide, National Union for the Unemployed, HSE, DSP and Dept Education.

6) Development of an agreed and standardised induction programme for SCE support workers containing organisational socialisation elements, health and safety and boundaries, and personal well-being. This recommendation is in line with recommendations made in a report by Lawless 2006 for a study of SCE in the Dublin Northeast Regional Drugs Taskforce catchment area, which asked for the development of a 'centrally coordinated training and development programme for SCE support workers' (p.85). A formal induction process should be an integral part of a 3-year training programme and maintained delivery records.

7) Both DSP and Community projects need to show learning leadership by adopting, embedding and supporting a personal development ethos within the SCE programme and at the local project level. This cultural leadership would need to be led and championed from management's highest echelon and adequately resourced.

8) The provision of in-time and time off in lieu for employees undertaking training and development, along with adequate funding for job-related development, should ameliorate some of the current barriers to training expressed by this study's respondents. The adaptation of incentives such as enhanced pay rates, increments, qualification bonuses, clear promotional and career progression pathways would encourage and reward SCE workers in their professional development.

9) Training for SCE staff in HSE/DSP procedures and *vice versa* should be introduced, including staff's secondment between the two agencies. DSP/HSE staff tasked with working on SCE schemes should undergo basic-level training in community and addiction studies.

5.13. Critical Reflection on the Research Process

Critical reflection or self-reflection is defined as '...the capacity to reflect on action to engage in the process of continuous learning...' (Schon 1983, p.102), and '...paying critical attention to the practical values and theories which inform everyday actions, leading to developmental insight...' (Bolton 2010, p.6). Raelin's (2001, p. 11) definition of reflective practice as 'the practice of periodically stepping back to ponder the meaning... [of] what has recently transpired' (see also Ron et al., 2006).

Schön distinguishes between 'reflection-in-action' and 'reflection-on-action'. Whilst reflection-in-action takes place '…in the moment, in a way that decreases its chronological–physical separation from the action, such that reflection can usefully be said to take place during action' (Yanow & Tsunkas 2006, p. 1340). Reflection on-action 'entails an ex-post orientation – by definition, one reflects on something that has already transpired. Raelin's (2001, p. 11) definition of reflective practice as 'the practice of periodically stepping back to ponder the meaning... [of] what has recently transpired' captures this sense of the concept (see also Ron *et al.,* 2006; Yanow & Tsunkas 2006).

It is clear from the literature of the past twenty years that criteria for establishing rigour and validity in qualitative work have moved from the previously accepted measures used in the quantitative paradigm. As a consequence of this, Jasper (2005) suggests *that:*

'The centrality of the role of the researcher to qualitative studies is paramount — reflective writing within journals and research logs establishes that centrality and often contains the clues to the creativity and interpretation within the work that discovers and describes new understandings of people's experiences' (p. 257).

The following section provides an insight into the practice and reflection on practice by this research in the methods used in the preparation, design, analysis and construction of this study. The model used in this deconstruction is a modification of Kolb's reflection cycle, and the 'Reflections in-Action' passages are taken from the author's reflective journal.

Kolb' Reflective Model:

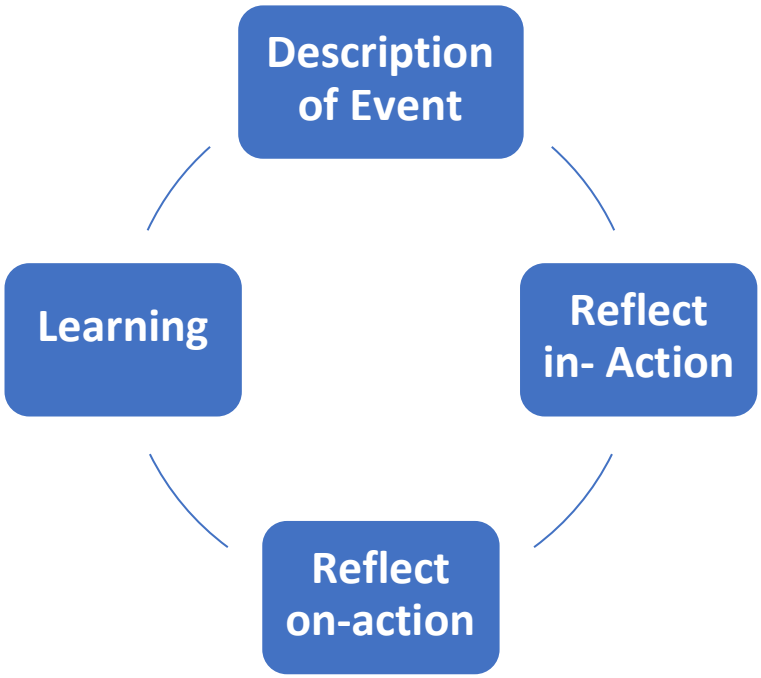


Fig: 5.1

Preparation

As noted in the methods chapter, two focus groups were selected from a group of respondents for research participants in a ration relating to their numerical proportion. Focus groups can be defined as *a 'carefully planned discussion designed to obtain perceptions on a defined environment'* (Kreuger 1998, p.88) *or 'an informal discussion among selected individuals about specific topics'* (Beck *et al.,* 1986). This research had one objective from its informal focus groups, i.e. to generate discussion around issues concerning the focus groups experience of doing their job and the barriers they experienced. The researcher was aware of and adapted to the notion that the moderator (of a focus group) is expected to strike a balance between generating interest in and discussion about a particular topic, while not pushing their research agenda ending in confirming existing expectations (Vaughn *et al.,* 1996; Sim 2002; Smithson 2008).

However, the researcher was also aware that the moderator can never be a neutral bystander and should instead aim for reflexivity and awareness of how their characteristics and behaviour may influence the group (Wilkinson & Kitzinger 1996; Stokoe & Smithson 2002; Smithson 2008).

Focus Groups Reflection:

Description: The focus group was made up of 3 strata of workers managers, supervisors and project workers and were selected to reflect the ratio which occurred in the workplace, it was assumed that this would provide an accurate view of situational issues. The researcher noted at the time that managers seemed to talk more often and more freely.

After an open question about 'what were the key issues facing them as SCE drug workers' members of the focus group slowly began to voice issues, however, it was apparent that there were talkers and those who remained relatively quiet. Things quickly became anecdotal with people relating 'war stories' and worst-case scenarios to illustrate general points and the noise level became extremely loud. While the researcher took handwritten notes, there was an awareness that the tape recording might be of little value, due to the background noise and detail would be lost.

Reflection In-Action:

'It proved difficult to control the direction of the conversation and stop the group descending into a 'gripping session' while maintaining a neutral stance; the research had hoped not to be too directional. The participants' emotion was understandable, given the pent-up frustration; however, at times, the group sought to provide the worst possible scenarios to illustrate problems and issues faced. Not entirely in control of conversational flow and direction under time pressure, a need to take charge and direct the vector of discussion, not towards a particular narrative or outcome, but to concrete and tangible concerns that could be crystallised into issues'. (Reflective Journal 15/6/2018)

"The researcher also perceived (and noted in the research journal) a difference in speaking order, and a reluctance to contradict or provide ideas that ran counter to higher grades stated opinion. Having different grades of worker, i.e. managers and project workers, seemed inhibited in responding to the issues openly and candidly". (Reflective Journal 15/6/2018)

Reflection on-Action:

In hindsight, closer attention might have been paid to focus group make-up insofar as uniformity of status within the group Morgan (1988) and Kreuger (1998), suggest that

groups should be homogenous, e.g. on a specific course, or have a similar job. Consideration might have been given to choosing the groups with *'members with comparable characteristics, to permit cross-group comparability'* (Smithson 2008, p.358). This researcher would also consider a higher degree of structure in the questioning style or as Myers (1998) points *out 'the constraints on talk do not invalidate focus group findings; in fact, it is these constraints that make them practicable and interpretable'* (p. 107).

Reflective Learning:

Group formation and selection should consider the information required and the group's internal dynamics; closer attention should be paid to process and dynamics as well as the task. Reflecting on the focus group's task, several salient and substantive issues that could form nodes for further questioning and exploration emerged. Conducting a more thorough pre-study and spending time in the field, getting to know the work environment, and stakeholders working in that industry and the business itself would prove beneficial. More extensive reading, particularly around ancillary and analogous data, would be adopted in preparing a future study. The researcher separated the manager from the Focus Group for the conduct of the second focus group, which allowed a more natural flow of information with less inhibition.

The researcher felt more relaxed about letting the focus group discussion go 'where it may' keep notes and consciously refrain from identifying themes and guiding participants towards presumed discussion lines.

Questionnaire Design and Administration.

Description: After a thematic analysis of the data derived from the Focus Groups, a series of issues emerged which the researcher consolidated into questions. A preliminary reading of extant literature relating to SCE revealed a paucity of data around the specific research cohort's demographics. Thus, it was felt that the questionnaire should contain some questions to elicit salient demographic data also.

The initial questionnaire was constructed containing both types of questions, and a pilot was conducted with 10 SCE workers attending a conference. Based on these ten participants' feedback, and analysis of the returns for comprehension, positioning, legibility, and after some adjustments, a final research questionnaire was drafted and distributed to the projects that had agreed to participate in the study.

Reflection in-action:

'The researcher was aware that the questionnaire's pilot group did not represent a cross-section of the larger cohort the questionnaire for whom intended for, however, it represents an analogue in terms of work type and educational level. It was noted that the questionnaire did take an inordinate amount of time (over 30 minutes) to complete. The researcher noted that his presence, while the participants completed the document, appeared to elicit a reverse placebo effect, where the participant tried to please the researcher by completing the form at all cost.' (Learning Journal 10/12/2018)

'Two questions caused a level of confusion among the group and needed the researcher to explain. There was also a notable 'speeding up' of candidates answering questions towards the last pages of the questionnaire, where participant seem to put less care or consideration into the answer.' (Learning Journal 16/12/2018)

Reflection on-action:

Designing and constructing a valid questionnaire is an iterative process, many questionnaires as Einola and Alvesson (2020) suggest cause *'ambiguity, mixed feelings, or misalignments of some sort'* (p.4) in their design. This researcher agrees with Granlund and Lukka (2017, p. 65) in that *'the question of reliable and valid measures is always, in principle, an open one" and like Einola & Alvesson suggest it does not help 'if we collectively maintain a discourse of false objectivity'* (p.6). The decision to leave the paper at a completion time was vindicated; based on a review of Bogen's (1996) literature finds no clear association between questionnaire length and survey participation.

Learning:

Attention needs to be paid to the process as well as desired outcomes from the administration of questionnaires. It is also improbable that the researcher will design the perfect instrument on their laptop. Getting a reasonable draft to pilot is a sound objective. One or more pilots might be scheduled into the research plan to refine the instrument to the structure, language, and optimise data gathering capacity. Some

questions were misinterpreted in the pilot for this study, and some questionnaires rendered unusable due to ambiguity. Several questions were rewritten in 'plain language' while some questions which were seen to be repetitive were removed. Consideration must also be given to in-text instructions as Iarossi (2006) puts it 'Instructions are critical both for the administration of the form and the collection of accurate data' (p.99), particularly where the research will not be curating the completion of questionnaires.

Reflections on Collation and Analysis of Questionnaires.

The raw data from the questionnaire were numerically coded and transferred to a spreadsheet for further analysis. With 70 completed questionnaires of 40 questions, each created a base data set of 2800 cells. Formulae to calculate summation, percentiles and other quantifications were used to compare numbers. The questions fell into two categories: demographics covering age, gender, education, experience, which were multiple choice and work-related concerns which were open-ended, allowing respondents to identify the specific issues concerning them. This design created another 1400 data cells; this data was then coded, for summarisation into meaningful categories and aid identification of patterns. The demographic data provided the basis for producing a quantitative profile of the cohort, and numerically identified the most common and frequently recurring themes and issues.

Reflection in-action:

The coding and populating of the data set entail more time than expected, however, provided opportunity to make connections and get a sense of the data was saying, it provided a feel for what was emerging and a more profound sense of understanding. The researcher was cognisant of Iarossi (2006*) 'important that questions with answers in the same range be coded in the same way and the same order throughout the instrument'* (p.189). While it may have been easier for collation purposes to provide multiple choice type questions for identifying issues*, 'it did, however, provide a level of objectivity in that the resulting data was unconstrained or influenced by the researcher's*

parameters' (Research Journal). In effect, this approach generated new data that would describe the detailed demographic of the chosen cohort and provide issues of concern, which would become topics for further exploration at the interview phase. Entering the data, the researcher could get a sense of the topics as they emerged.

Reflection on-Action

The time allotted to the editing process, which consisted of checking that the information collected is complete, accurate, and consistent was crucial and time well spent.

Early problems encountered in coding 'unclear responses' were resolved by developing a process which distinguishes between NA (not applicable), NP (not provided), DK (do not know), and REF (refuse to answer). As Iarossi (2006) notes 'confusion among answers can be avoided if negative three-digit numbers are used to identify the aforementioned values in the data set'.

An essential element that the researcher had not given much aforethought but made itself necessary was quality control. The need for putting in place measures to monitor numerical data such as; range checks (Iarossi 2006), logic checks (Grosh and Muñoz 1996), reliability and internal consistency (Iarossi 2006) became apparent. As Grosh and Muñoz (1996) put it '*setting up the boundaries for the range checks, other numeric variables is an art'* (p. 131).

Learning:

The researcher gained a greater understanding of quality assurance QA) and its contribution to the study's overall validity and robustness. This appreciation for the elements required to undertake a thorough QA process will be factored into future research project schedules, and the provision of sufficient time and resources to undertake such a rigorous process.

Design, Administration and Conduct of Interviews

Description:

The interview sample selection was based on optimum representation from across the research population's dimensions and demographics (Morse 1998).

In selecting the 'appropriate' number of candidates for this study, the researcher bore in mind studies by Morse (2006) which indicated that a) Inverse relationship between the amount of data obtained and the number of interviewees and the greater the diversity inherent in the topic under study the longer it takes to reach saturation.

The completed data analysis produced some areas of concern that provides topics for use as starting points for the questions used in the semi-structured interviews. An interview aims to understand the interviewees working lives on SCE as they see them (Schwandt 2001; Lambert & Loiselle 2008, Schultze & Avital 2011). The interview was flexible, with open-ended questions to provide a chance to explore issues that arose spontaneously and minimised interviewer bias. (Berg 2009, Ryan *et al.,* 2009) and an interview scheme or guide was developed to collect similar types of data from all participants and provide order (Bridges *et al.,* 2008, Holloway & Wheeler 2010)

Reflection in-Action:

'*The researcher's concern during today's initial interviews was controlling the flow and direction of the conversation. The first interviewee was talkative and digressed from the question very often. While talking a lot, the second person seemed to provide very little useful information as far as I could perceive, perhaps I will be pleasantly surprised on listening to the tapes. (Research Journal)'. And: 'I found it difficult to wind-up that particular interview, it went on for an hour, will have to tighten up on time management.' (Research Journal).*

Reflection on-Action:

Central to conducting research and more specifically, qualitative research is the researcher as a research instrument (Denzin & Lincoln 2000; Marshall & Rossman 1995). The researcher as an instrument can be *the 'greatest threat to trustworthiness in qualitative research if time is not spent on preparation of the field'* (Poggenpoel & Myburgh

2003, p. 320). Smith *et al*. (2009) contended that it is impossible to achieve a perfect interview technique, but this will improve with practice. Perhaps a pilot study would be useful; *'so-called feasibility studies which are "small scale version[s], or trial run[s], done in preparation for the major study'* (Polit *et al.,* 2001, p. 467). However, a pilot study can also be the pre-testing *or 'trying out'* of a particular research instrument (Chenail 2011, p.257).

Better attention paid to journaling, the process of writing and recording and reading/listening can help researchers identify unclear or unrecognised thoughts, feelings, and impressions which might have led to bias in the study if unchecked.

Learning:

In hindsight a pilot would have served several purposes 1) practice in administering the questions in the same way as in the main study 2)Recognition that the subject's feedback would help identify ambiguities and challenging questions. The Qualitative Report January 2011 suggests that the researcher 'calculate the time taken to complete the interview, decide whether it is reasonable, and better record participants' time commitments and discard all unnecessary, complicated or ambiguous questions. Van Teijlingen & Hundley (2002) suggest that the researcher assess whether each question gives an adequate range of responses and establishes that replies can be interpreted in terms of the required information.

Collation and Analysis of Interview Data

Description:

In keeping with Field & Morse (1985) contemporaneous notes around the situation and disposition of interviewee were made before and during the interview, and post-interview notes were jotted as aid memoir. These notes were made to afford objectivity and consistency in subsequent interviews and the transcription of the interview tapes. Transcripts were read through and notes made, throughout the reading, on general themes within the transcripts as suggested by Rogers (1956). Transcripts were reread, and as many headings as necessary were written down to describe all aspects of the

content. This stage is known as open coding (Berg 1989); categories are freely generated. The new list of categories and sub-headings is worked through, and repetitious or very similar headings are removed to produce a final list. Each transcript is worked through with the list of categories and sub-headings and 'coded' according to category headings. The researcher then started with the first section, selects the various examples of data that have been filed under that section and offers a commentary that links the examples together.

Reflection in-Action:

As this stage *'I am finding that it is difficult to conceptualise how, I might integrate the notes taken before, during and after the interview sessions into the thesis. Did I let them influence my view of what themes were emerging and what emphasis they were given in the coding process*?.' (Research Journal)

'I'm glad the qualitative research provided some structure in terms of topic areas to provide an underlying structure, I suspect it would be far more difficult to code and extract information from the interview data if I were looking for themes to emerge from the interview responses. At least I have categories into which I can sort the response and provide some shape.' (Research Journal).

Reflection on-Action:

With respect of collation and validity, Glaser and Strauss (1967) suggest, ethnomethodological and phenomenological research aims to offer a glimpse of another person's perceptual world, then the researcher should attempt to offset his own bias and subjectivity that must creep through any attempt at making sense of interview data.

In this regard, the researcher was glad that the objectivity of the information gathered by this research's quantitative element provided an added element of structure and rigour to validate the interview process.

Learning:

Burnard (1996) suggests two methods a) use a trained friend to read the material and comment on any inconsistencies, assumptions or bias. Secondly, checking validity may be aided by asking some interviewees to read through the transcripts of their interviews and

asking them to jot down what they see as the main points that emerged from the interview.

Results:

Description: There are two approaches to writing up findings concurrent with analysis or consecutive (Burnard 1991, p.464) this researcher chose to write up the findings, using verbatim examples of interviews to illustrate the various sections and themes which were identified in the qualitative element of the study. Discussion and analysis were purposely kept at a minimum at this point. Discussion and analysis were written-up as a separate section, which linked those findings to the literature on the topic and made comparisons and contrasts.

Reflection in-Action:

'Maybe separating the findings and from discussion and conclusions is elaborating and making the process longer and more complex than necessary to write up, but it should make the thinking and assumption behind my thought process more explicit and transparent' (Research Journal).

*'If I focus on what the interviewees said and the patterns of the issues and the concerns, the meaning will emerge when viewed as a whol*e' (Research Journal).

Reflection on-Action:

While at the time, this consecutive approach appeared logical and attractive in the structure of the thesis. It may have caused some misunderstanding from the reader's point of view; in that they finish the Findings (of the data collation) Chapter, wondering where was the analysis, linkage to literature and practice which followed under Discussion and Conclusions chapter. In trying to create a logical intermediate step, it may have created confusion.

Learning:

Sandelowski & Leeman (2012), suggest that *'The identification of themes is foundational to qualitative research of all kinds. Indeed, we could not think of any qualitative method that does not inherently entail thematic analysis'* (p.1404). Once again maintaining objectivity in deciding on themes is crucial to the validity of the study. It is worthwhile bearing in mind that *'the onus is on the researcher to make their relationship to the material clear and ground analysis in participants own accounts'* (Madill et al., 2000, p.17)

Merging and Making Sense of Results

Description:

The researcher was aware that while much of the research was a serial set of endeavours, one is making connections, categorising and summarising mentally contemporaneously with all stages. This mental ordering was one of the most challenging stages for this researcher; trying to envisage or design (in minds-eye) a structure to combine the two distinct quantitative and qualitative elements of this study. The question *was 'How to combine the quantitative and qualitative data such that it made sense and merged to produce useful, meaningful and valid information? '*(Research Journal)

Reflection in-Action:

'It's not an easy conceptual task. Trying to marry numbers and narrative, not having done this before, I naively imagined it would be far easier. I'm not sure I'm going the right way about this. I'll finish this section for my supervisor and see how he responds to my synthesis' (Research Journal).

'If I compartmentalise the synthesis, blend the two and let the qual's support the quants, then analyse for discussion, it might be a better approach.' (Reflective Journal)

Reflection on-Action:

There are many approaches to this type of analysis, and it is far harder to find on that suits this study than this researcher had assumed. It would be a good idea to give some

thought to how this phase will work at the outset, rather than assume it would fit together like a jig-saw.

Learning:

This researcher's primary learning was that resolving a mixed-method study into a cohesive unit can produce robust and surprising findings. As Bryman (2007) puts it *'The key issue is whether, in a mixed-methods project, the end product is more than the sum of the individual quantitative and qualitative parts'* (p.8). However, Greene *et al.* (1987) found that the majority of the 57 articles they examined did not integrate the quantitative and qualitative data. Moreover, in a review of mixed methods articles in the education field, Niglas (2004) concluded *that 'substantial integration of qualitative and quantitative data during the analysis was exercised very rarely'* (p. 98). The author has gained a greater appreciation for the time, structure and workload to analyse a mixed-method study. More weight of consideration will be given in future research design and scheduling.

Bryman (2007, p. 20), puts it as follows *'practitioners may consider designing their studies in such a way that recognises in advance the implications of the different timelines and rhythms of quantitative and qualitative investigations. In this way, it may be possible to build in greater opportunity to bring the two sets of findings together and for the quantitative and qualitative components of projects not to drift apart in terms of the phasing of the various stages of the overall research process.'*

Writing-up

Description:

Roberts (1995) observed that *'writing is the sharpened, focused expression of thought and study'* (p.69). Samara (2007, p. 6) observed, that the design of a paper *'is much more than simply to assemble, to order. . . To add value and meaning, to illuminate, simplify, clarify, dignify, [and] to persuade'*. It is worth bearing in mind that qualitative findings can become less comprehensible when *'the desires for self-expression and artfulness trump expression that is comprehensible to others, and when simplified writing is mistaken for oversimplification of the complexity of the experiences, events, and the like targeted for study'* (Sandelowski & Leeman 2012, p. 1405),

Reflection in-Action:

The writing-up process presented good and bad days and indeed weeks the following series reflections in-action is an attempt to provide a sample of these occasions:

'Got a good run today, more than 2000 words flowed onto the paper, feeling the shape of the whole thing coming together.'

'Disaster, just reread three days work, and it does not make any sense, the words are there but do not get to the nub of what I am trying to say, I'm not sure what I am trying to say, sleep, get some sleep'.

'Got some feedback on chapter five and its back to the drawing board, how am I going to tackle it, how am I going to face it?'

'Tried throwing everything at it this morning, gathered all written material on this chapter and cut them into pieces, made a jig-saw and started to arrange the material anew in some logical, structure and compensable way. It seems to have worked.'

'I have a strong outline structure to work on at last'.

Reflection on-Action:

Much valuable time was used in what felt like forging this chapter out of the findings.

'I felt I had wasted so much time working on this chapter without any clear design or structure. It was like building a house without blueprints.' (Research Journal)

Once again, time might have been saved if more aforethought, had gone into planning how might be done. It is vital to avoid what Elliot (2007) noted of a particular learned paper; *'although it combines results from the more qualitative and quantitative aspects of their research, these are still largely compartmentalised into separate chapters. This means that qualitative and quantitative results are not integrated into the writing process, as they might be'* (p. 185).

Learning:

In conclusion, to quote Sandelowski & Leeman (2012); '*simplifying the presentation of qualitative health research findings does not violate the qualitative research mandate to*

capture the experiential and social world's complexity targeted for inquiry. Indeed, by making complexity more comprehensible, simplification serves that end' (p.1410).

In genuinely integrated studies, the quantitative and qualitative findings will be mutually informative.

5.14. Summary

This chapter examined the eleven specific themes identified in this mixed-method study and discussed findings in the context of a supportive body of relevant studies. It also developed recommendations based on these findings and framed with the extant body of supporting literature. It also provided an example of the reflective process used throughout the conduct of the study.

There were ambiguous feelings expressed about the efficacy of the SCE programme in its current form. The respondents' experiences in this study were centred mainly on their concern for the quality of service due to lack of financial resources, lack of suitable premises, and facilities. There was a clear perception that the relationship between the community projects and the DSP was not conducive to effective partnership programme for several reasons. These difficulties, coupled with government policy and drug use patterns, have only complicated the problems.

This study aims to answer the research question, and establish;

'What are the issues facing staff members engaged in the delivery of the SCE programme within the Dublin region?'

This investigation has identified eleven salient issues in answer to this question. While this list may be incomplete, it is both extensive and severe enough to warrant urgent attention and effective action at a governmental level. The vital role that SCE projects play in the lives of thousands of people on their journey to recovery from problematic drug use is too important to be ignored. It is a matter of life and death.

The study has answered the sub-questions posited at the outset, by established a demographic profile of those working in Dublin's SCE projects by age, gender, work status

and educational attainment. It identified several barriers to effective programme delivery including, participant recruitment, homelessness and mental health.

The research also revealed some significant challenges in staff education and training, most remarkably the lack of a comprehensive and uniform induction programme for new staff, potentially negative consequences for staff retention and personal health and safety. It also determined that the absence of an agreed and clearly defined professional training standard for drug workers combined with a lack of financial resources to implement such education and training is a serious threat to service delivery quality.

Finally, it highlighted an evident desire amongst SCE workers for either a complete review and overhaul of the current system.

5.15. Further Research

This study did not attempt to be definitive; instead, it sampled a defined regional section of a population to provide an up-to-date picture of SCE drug workers' issues. In the process, some areas that could benefit from the future investigation were identified. Firstly, there is a need for research into the training needs and educational standards in the drug-work field to establish requirements, identify curricula, and suggest programme delivery methods. Secondly, an independent study of the service users experience of the SCE programme would enhance and give a broader perspective to currently available research. Van Hout and Bingham 2014 indicated the need for research efforts involving *'democratic and participatory approach with all key stakeholders, in order to clearly distinguish responsibilities and avoid duplicity between health and addiction services, and that of the vocational education provider within an interagency rehabilitation framework'* (p.71).

5.15. Overall Reflection

In reading this dissertation, one might be struck, by the number of challenges SCE staff must deal with, most of which distract from their primary role as drug rehabilitation workers. The SCE system seems to be putting barriers in the way of their effectiveness in delivering a service. From reading the edited interview transcripts, one might think that these issues are uppermost in these workers' minds; however, nothing could be further from the case. The workers were committed, dedicated and focused on the recovery, rehabilitation and human development of their service users. In many cases, these workers, many of whom are earning a job-seekers allowance, use their humanity, decency, innate good humour, and intervention skills to compensate for the lack of provision of adequate resources. These SCE workers are at the coalface of Ireland's attempt at rehabilitation and surely deserve better treatment from us. It is with great respect and humbled awe that this researcher thanks everyone involved.

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Appendices

Appendix A: Job Description Project Manager

Manager Position

The Board of (This Service) is seeking applications for the post of Manager, based at:

This is a full-time permanent position: Grade VI, 9 months' probation. 39 hours per week, some evening work. 25 days annual leave.
This service provides a range of programmes including low-threshold entry, structured stabilisation supports, and a drug free community employment work programme.
More information at www.sankalpa.ie.

The post holder will:

- Lead the development and delivery of Addiction Services with agreed targets and outcomes;
- Manage and monitor the day-to-day running of all aspects of the service, including financial administration;
- Provide leadership, supervision and support to all staff members;
- Ensure effective governance and accountability is in place;
- Oversee case management both within the service and with external agencies;
- Update company policies;
- Work closely with the staff team, service users, community, voluntary and statutory sector partners, the funders and board of management;
- Create an outcome focused culture;
- Report to the board on a monthly basis.
-

Essential Professional Qualifications / Experience

- A third level degree in Addiction Studies, Social Science, Management or related field.
- A minimum of 3 years' experience managing a community-based service working with vulnerable / marginalised groups.
- Knowledge and experience of evidence-based treatment approaches in the addiction field.
- Staff supervision and performance management.
- Working knowledge of charity governance and regulation.
- Financial management using an accounting software package.
- Procurement for cost effectiveness.
- Office administration.
- Working to a voluntary board of management.

Appendix B: Job Description Supervisor (SCE)

DSP Job Description

Community Employment Supervisor (Drugs Project)

Hours: 39 hours per week

Salary: DSP Community Employment Supervisor rates. Point 1.

Reporting to: Centre Manager

To establish, manage and cultivate a community-based Day Programme to support people affected by drug misuse and/or addiction. To provide support and planned interventions on a one-to-one and group basis, in order to encourage programme participants affected by drug misuse and/or addiction to explore their drug use and to increase and fulfil their potential through addressing their social, emotional, educational, spiritual and health needs and through developing effective life skills. To work in a way which promotes a safe, supportive and nurturing environment which is conducive to learning and individual personal development.

Qualifications: Candidates must have attained a Major 3rd level qualification (NFQ Level 6 or higher) and have 3 years supervisory experience

Duties & Responsibilities

1. Manage and supervise the operation of the DSP Community Employment Scheme.
2. Administration of the DSP accounts and budgets.
3. Book keeping.
4. Payroll.
5. Supervise general office duties.
6. Report directly to Challenge Ltd CEO, prepare reports & attend Board meetings.
7. Effect policy in relation to best practice employment of CE participants.

8. Ensure the implementation of all up to date legislation in policies regarding employment of CE participants.
9. Supervision of CE scheme participants.
10. Development of Individual Development Learning Plans for each CE participant.
11. Sourcing of FETAC and other accredited training.
12. Work closely with sponsor groups.
13. Liaise with Community/Business partners to source job opportunities.
14. To perform such other reasonable duties as requested by the CEO and/or Board of Directors
15. Plan the service user daily time table which will include, one to one time, group work sessions and other interventions.
16. Facilitate addiction awareness and relapse prevention sessions along with other social care and life skills modules.
17. Using the Community Reinforcement Approach (CRA) provide a platform where one to one care and goal setting sessions offer service users the setting to explore their potential and address any obstacles which may hinder their personal, social, educational, training and development needs.
18. Work with and support individuals in potential lapse and relapse situations.
19. To record and keep accurate, up to date project records, including participant files, case notes, daily/weekly group feedback sheets, programme reviews, attendance records, intervention records, incident and accident sheets.
20. Organise a platform where participation of team members is encouraged through effective communication. ie. team meetings, clinical meetings, case management meetings, client reviews, programme planning, service reviews, project evaluation and development meetings.
21. Be familiar with and work in line with ENDRIC.
22. To establish and participate in the process of referrals and undertaking assessments.
23. To liaise with external agencies, Doctors and individuals to support and promote the needs of current and potential service users.
24. To raise awareness of and to promote the work of the project through networking and liaising with the relevant agencies and individuals.

25. To commit to a continuous professional development of motivational approaches and effective interventions within an educational and social care setting.
26. To attend identified and appropriate professional training.
27. To work effectively on ones own initiative as well as part of a team in accordance with the projects organisational structures, ethos and procedures.
28. To attend and participate in appraisals and supervision process as required, and to use this opportunity to reflect upon professional practice, to request and receive support and guidance, and to identify strengths, weaknesses and training needs.
29. To provide support and supervision of staff team in line with the above.
30. To participate in the opening, locking and securing of the premises in accordance with guidelines.
31. To work within and adhere to the projects policies, procedures and good practice guidelines.
32. To undertake any other duties as may be reasonably assigned by the team leader or manager from time to time.

Person specification/skills and abilities:

-The ideal candidate will have a relevant qualification (3rd level diploma) and/or equivalent work experience in the area of addiction. An understanding of community development and social inclusion would be advantageous.
-CRA experienced and certified.
-Leadership skills and the ability to be self motivated and a self starter.
-Have excellent verbal and written communication skills.
-The ability to work with participants professionally and with empathy
-The ability to work with in professional boundaries.
-The ability to work as part of a team and on own initiative-Good administration, organisational and time management skills
-Experience in interagency work and service cohesion.
-Be a motivated individual with lots of initiative who will bring real commitment and passion to the work.

Appendix: Job Description Assistant Supervisor (SCE)

DSP Community Employment

Assistant Supervisor (Addiction Practitioner)

Weekly hours: 39 hours weekly Monday to Friday

Pay scale: CE DSP Starting Rates (Point 1 salary scale).

JOB SUMMARY

The main focus of responsibility is to provide support to service users who are struggling with addiction. To work as part of a team through a holistic approach to dealing with the impact of the drug problem within the Dublinarea. Experience of key working, care planning, and experience of one to one and group work within the Rehabilitation framework.

PERSON SPECIFICATION:

QUALIFICATIONS

A relevant 3rd level 6 qualification or professional qualification [Essential]

A full clean driving license [Desirable]

KNOWLEDGE, SKILLS AND ABILITIES

Diligent and meticulous record keeping.

Strong communication and inter-personal skills

Strong IT skills with a strong command of Excel, Word and software programmes.

Proven organisational skills with the ability to prioritise needs and objectives.

Ability to act calmly in emergencies and respond in a professional manner to challenging situations

Knowledge of ECass System for recording daily entries.

Ability to work within ARC's structures.

ATTITUDE

Enthusiastic and committed to providing high standards of services for our service users.

A team player committed to consultative ways of working.

Friendly, approachable and flexible, with a "can do" approach to working.

Commitment to working within an environment which promotes Equal Status and has regard for the Health and Safety of others.

DUTIES AND GENERAL RESPONSIBILITIES

Working as part of a team delivering an addiction treatment model through CBT, CRA, MI, SMART Recovery, NDRIC protocols, the National Drugs Strategy and other tools; all of which are underpinned by trauma informed practice

Engaging with and building a professional trusting relationship with service users; treating individuals with dignity and respect in order to work within the ethos and values of the agency.

Facilitating a wide range of therapeutic groups all of which will be reviewed regularly.

Performing tasks related to the day to day running and maintenance of an effective service Participating in a care and case management model within Addiction Response Crumlin e.g. assessment, key working, care planning, transferring of files and sharing of information internally and agreeing handovers to assist service users to progress towards recovery implementing and reviewing individual support plans and updating Database platforms as required

To show reasonable flexibility in relation to hours of attendance to meet the needs of the Service users, Work during unsocial hours is sometimes required.

Database input daily with the use of platforms e.g., salesforce, ILP,

To participate in internal/external meetings, training events and other functions as directed by your line Manager.

To participate in annual appraisals, and help in identifying your own job-related development and training needs.

To continuously develop the role in conjunction with your line Manager

Appendix D: Job Description Project Worker

Job Description

Project Worker (Drug work)

Hours: 35 hours a week part time (hours arranged between 7am and 10pm Monday to Sunday)

Holidays: 25 days exclusive of bank holidays (pro rata)

Duties:

1.1 To establish effective working relationships with service users on an inreach and outreach basis.

1.2 To treat service users with dignity and respect at all times.

1.3 To offer practical support to service users who access our services.

1.4 To advocate on behalf of service users as appropriate

1.5 To work as part of a Multi -Disciplinary project team engaging with service users in various settings external to the Project.

1.6 To provide assessments, crisis interventions, key working and case management support to service users in accordance with project guidelines.

1.7 To make referrals to internal and external services as appropriate.

1.9 To provide assertive outreach within the Dublin city centre, targeting core client group to provide services, as appropriate.

1.10 To provide harm reduction , relapse prevention, community detoxification and other addiction specific interventions with service user.

1.11 As part of the Multi-Disciplinary Project Team under the guidance of the Team Leader, to participate in the development of new services that enable Ana Liffey to respond to the changing needs of the service users effectively.

1.12 To establish and maintain professional networks with other workers in the same or similar field of work.

1.13 To report any child protection incidents or concerns to the Team Leader.

1.14 To use professional skills within service delivery as directed by the Team Leader.

1.15 To ensure that all services are delivered according to the Ana Liffey quality standards framework.

1.16 To ensure a safe and secure environment and maintain high standards of care.

1.17 To ensure that the complaints procedure is well publicised and operated in accordance with the policy.

1.18 To liaise with, and take a positive active role within the local community.

1.19 To ensure that work carried out is consistent with Ana Liffey's mission, vision, values and ethos.

2. TEAM WORK

2.1 To work as part of a multi-disciplinary team in a 'low threshold – harm reduction' service, in co-operation with other team members with the aim of ensuring that the project delivers the highest quality service possible to our service users.

2.2 To attend and actively participate in team meetings.

2.3 To attend and participate in review days as required.

3. ADMINISTRATION

3.1 To keep and maintain effective record systems in relation to keyworking and other client interventions.

3.2 To assist the Team Leader in the collation of statistics as required.

4. GENERAL RESPONSIBILITIES

4.1 To continuously develop the role in conjunction with your line manager.

4.2 To ensure that all services are being run in an effective and appropriate manner which meets the aims and objectives of the Project.

4.3 To participate in internal/external meetings, training events, conferences and other functions as directed by a manager.

4.4 To participate in regular supervision and annual appraisal, and help in identifying your own job-related development and training needs.

4.5 To ensure that all Project policies and procedures are being adhered to, particularly those relating to Health and Safety, Complaints, Code of Practice and Confidentiality.

4.6 To contribute to the effective implementation of the projects Equal Status Policy as it affects both the Ana Liffey and its work with service users.

4.7 To carry out your work in a professional manner at all times.

4.8 To work in accordance with the aims, values and ethos of the mission

4.9 Undertake any other duties that may be required which are commensurate with the role as directed by a manager.

Appendix E: Job Description Project Support Worker (SCE)

Job Description

CE Project Support Worker

Overall purpose of the position:

To work under the direction the CE Supervisor, Project Manager & Programme Co ordinator , as part of a team to work closely with the participants in relation to key areas of their lives, as identified by the staff team through client team meetings. The purpose of this role is to take direction from the staff team in relation to supporting participants in a range of related and appropriate areas.

Responsible to:

The CE Supervisor & Project Manager who in turn reports to the Board of management.

Key Areas of Work:

- To work in conjunction with the CE Supervisor, Project manager & Programme Co ordinator and the staff team as an effective and supportive team member.
- To take part in the delivery of group work and to assist the staff team
- To carry out crisis intervention and brief interventions as a part of client work as directed by the staff team and with support at all times
- To Co-facilitate group discussion, and provide one to one support with other team members
- Work at all times with an awareness of progression, and work through a consistent plan with each participant to maximise opportunities as directed by the staff team
- To liaise with relevant referral and support agencies, and to liaise with the local community where appropriate as directed by the staff team
- To participate in any training/education/talks as required to support tutors & other staff

- To support clients in/ out of centre work in a range of settings eg court, leisure activities, housing appointments etc as directed by the staff team
- To attend regular planning meetings and staff meetings.
- To do outreach and follow up where appropriate, as required.
- To take part in staff training and development as required.
- To attend internal and external supervision.
- Keep up with current trends & best practice in the field of training & education.
- Any other additional duties relevant to the post as directed.
- Attend a range of meetings as directed where relevant to the work generally.
- Ensure strict confidentiality is maintained at all times so that any matters relating to participants is strictly not discussed outside work.
- To assist and observe on participants break times to ensure safe boundaries are maintained.
- To lead the relaxation and meditation sessions and check – ins & groundings when required.
- To attend any approved training to comply with CE scheme to support progression. Training will be identified through the Individual Learner Plan. (There are a range of recognised QQI Awards or industry equivalent qualifications available to CE participants)

Appendix F: Plain Language Statement

Plain Language Statement

Study Title: **An exploration of workers experiences in delivering a drug services within the Special Drugs Rehabilitation Community Employment programme "**

Study Aim:

To explore the working experiences of staff members engaged in the delivery of the Drug Rehabilitation Special Community Employment programme within the Dublin region in order to achieve the following objectives:

Objectives:

1) Establish perceived effectiveness of the SCE programme from a practitioner's viewpoint.
2) Document the perceived barriers to effective service delivery.
3) Identify opportunities for the improvement of programmes.

Why do this Research:

It is envisaged that the data collected, when analysed, will give an insight into the issues, challenges and opportunities encountered by staff in their day to day organisation and delivery of education/training programmes as part of the Drug Rehabilitation Community Employment Framework. It is hoped that in turn that this information when written up as conclusions and discussion points will, in some small way, inform policy development, operational protocols and inter-agency discussion and afford the participants to give voice to their experiences with a view to improvement and development of services.

What am I volunteering for?

The nature of this research is entirely voluntary and it is important that you are aware that **they can refuse to participate without prejudice and can pull-out of the process at any point.**

It is envisaged that the investigation requires the following of participants:

1) This will entail voluntary completion of questionnaires by staff of participating organisations. (Maximum 20 Minutes at your leisure)
2) Possible participation in Focus group (Maximum time 30 minutes)
3) Possible participation in Interview (Maximum time 30 Minutes)

What will happen the Data & Information?

Once the questionnaires are collated and interview candidates selected all documentation will be anonymised, any information that you have shared will not be identifiable as something that you have contributed. All participants in interviews will be assigned a unique identifier and all transcriptions and quotes will be identified in this way. This will allow for the greater exploration of issues within a confidential environment. Interview audio recordings and written interview/focus group transcriptions will be held on file electronically on a password protected computer and hard copies on file in a secure filing cabinet in my home office. All data will be held and used for the purpose of the research and subsequent report and publications. The raw anonymous date will be held for two years and safely destroyed.

If you wish to take part in this research you are requested to sign the attached consent sheet.

Many Thanks
Noel

Appendix G: Informed Consent Form

Consent Form

Study Title:

"An Exploration of Community Educators Experiences in Delivering the National Programme Framework for Community Employment Drug Rehabilitation"

Conducted by: Noel O'Connor

I confirm that I have read and understand the information form for this study and that I have had the opportunity to ask questions. I understand that my participation is completely voluntary and that I am free to withdraw at any time and without giving any reason. I agree to take part in the study and that my participation will involve participating in a one to one interview and/or focus group. I agree that any information gathered through my participation can be recorded through written notes and audio tape. I also agree to the use of anonymized information can be used in a completed report and other publications.

Participant Name Date Signature

_____ _____ _____

Investigators Name Date Signature

Appendix H: Ethical Clearance

Dublin City University RESEARCH ETHICS COMMITTEE

NOTIFICATION FORM FOR LOW-RISK PROJECTS

Application No. (office use only) DCUREC/2015/

Section A: Applicant Details

PROJECT TITLE: "An Exploration of Community Educators Experiences in

Delivering Educational Elements of Community

Employment Drug Rehabilitation programmes, within the

National Programme Framework"

APPLICANT NAME: Noel O'Connor

SCHOOL/UNIT: School of Policy and Practice, DCU Institute of

Education APPLICANT EMAIL: noel.oconnor49@dcu.ie

If a student applicant, please provide the following additional information: Programme of Study: Doctor of Education (Taught; Part-time) Supervisor Name: Prof Joe O'Hara Supervisor Email: joe.ohara@dcu.ie

Section B: Questions

1. Notification Review is reserved for low-risk social studies that fall under the following classifications. Please indicate your project type below:

Please mark as appropriate:

Anonymous Survey (the topic will not elicit significant difficulties for participants) Observation (without audio or visual recording) of a public setting Questioning participant regarding their opinions on products or services Questioning students about standard educational practices Study will monitor the impact of participants' daily activities X Questioning public figures/professionals in their professional capacity regarding their professional activities Analysis of existing anonymised data which has been provided to the researcher by a third-party Collection of biological samples which are anonymised and do not require invasive techniques (e.g. hair, nails). Other Please explain:

2. Please provide a justification for why your study is considered to be low-risk? : The research will explore the perceptions and experiences of educators working in

Community Drugs Rehabilitation programmes. The research will be limited exclusively to an analysis of the educational aspect of this work including an exploration of the

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content and practice, resources, methodology and teaching / training approach. The participants are professional community education workers and their views will be treated in the strictest confidence and confidentiality, thus it is considered that this process is of low risk to the individual. At no stage will the study discuss the, identify or seek to contact clients of the Community Drugs Rehabilitation programme. Research participants will be explicitly informed that they are not required to discuss client profiles or experiences when engaging with the study. However, the researcher is aware that unforeseen problems may arise for individuals at any time and therefore the process and activity of the research will be monitored closely for issues and any risk factors thus identified will be managed effectively and eliminated speedily.

3. Please describe how your participants will be recruited? The cohort will be drawn from the pool of Drug Rehabilitation Community Employment programme delivery agencies, who have expressed a desire to participate in the study. All individuals within the agency will be recruited on a voluntary basis and with informed consent acknowledged.

4. Informing your participants – Plain Language Statement Please see attached.

Please confirm whether the following issues have been addressed in your plain language statement for participants:

If any of these issues are marked NO, please justify their exclusion:

YES or NO Introductory Statement (PI and researcher names, school, title of the research) Yes What is this research about? Yes Why is this research being conducted? Yes What will happen if the person decides to participate in the research study? Yes How will their privacy be protected? Yes How will the data be used and subsequently disposed of? Yes What are the legal limitations to data confidentiality? Yes What are the benefits of taking part in the research study (if any)? Yes What are the risks of taking part in the research study? Yes Confirmation that participants can change their mind at any stage and withdraw from the study

Yes

How will participants find out what happens with the project? Yes Contact details for further information (including REC contact details) Yes

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5. Capturing consent – Informed Consent Form Please see attached.

Note – IF AN INFORMED CONSENT FORM IS NOT BEING USED, THE REASON FOR THIS MUST BE JUSTIFIED HERE:

Important Notes:

➢ Please ensure you attach any additional relevant documentation to your application: E.G. copy of Survey/Questionnaire, copy of Interview/Focus Group schedule, copy of permission/approval from external sources (i.e. approval to access individuals in an organisation, school, community group) ➢ The application should consist of one electronic file only. The completed application must incorporate the plain language statement, informed consent form and all supplementary documentation ➢ All sections of the application form must be answered. The completed application must be

proofread and spellchecked before submission to REC ➢ Your application must be e-mailed to the DCU Research Ethics Committee at

rec@dcu.ie . Student applicants must cc their supervisor on that e-mail – this applies to all student applicants (masters and postgraduate). The form should be approved and signed by the supervisor in advance of submission to REC.

Applications which do not adhere to these requirements will not be accepted for review and will be returned directly to the applicant. The administrator to the Research Ethics Committee will assess, on receiving such notification, whether the information provided is adequate.

Please note: Project supervisors have the primary responsibility to ensure that students do not take on research that could expose them and the participants to significant risk, such as might arise, for example, in interviewing members of vulnerable groups such as young children. In general, please refer to the REC Guidelines for further guidance on what research procedures or circumstances might make a higher level of ethical approval necessary. See
https://www4.dcu.ie/researchsupport/research_ethics/guidelines.shtml

DECLARATION BY PRINCIPAL INVESTIGATOR(S) In the case of student applicants the Principal Investigator is their supervisor.

The information contained herein is, to the best of my knowledge and belief, accurate. I have read the University's current research ethics guidelines, and accept responsibility for the conduct of the procedures set out in the attached application in accordance with the form guidelines, the REC guidelines
(https://www4.dcu.ie/researchsupport/research_ethics/guidelines.shtml), the University's policy on Conflict of Interest, Code of Good Research Practice and any other condition laid down by the Dublin City University Research Ethics Committee. I have

attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my obligations and the rights of the participants.

If there exists any affiliation or financial interest for researcher(s) in this research or its outcomes or any other circumstances which might represent a perceived, potential or actual conflict of interest this should be declared in accordance with Dublin City University policy on Conflicts of Interest.

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I and my co-investigators or supporting staff have the appropriate qualifications, experience and facilities to conduct the research set out in the attached application and to deal with any emergencies and contingencies related to the research that may arise.

Electronic Signature(s):

Principal investigator(s):

Print Name(s) here: Prof Joe O'Hara

Date: 15/08/18

Appendix I: Research Questionnaire

Research Questionnaire

Please complete before beginning this questionnaire: "I have read and understood the 'Plain language Statement' in relation this piece of research. I am aware that I can pull out at any stage of this process without explanation and I have willingly singed a 'consent form". (*Please tick box if the above is correct*)

1. Please specify your gender Male/ Female

2. Please indicate your general age range: (18 -21): (22-41): (42-51): (52-60) :(60+)

3. Have you worked in the drug sector mainly since first employed? Yes / No

4. What age did you start working in the drug sector: _____

5. What county do you work in: _____

***6.* Are you currently working: a)** *Full-time*; **b)** *Community Employment hours*; **c)** *Volunteering*

7. How many years have you worked in the sector? _____

8. What title best describes your current role in the sector; (please tick as appropriate**)**
Centre Manager: __
Team Leader: __
Deputy Manager: __
Supervisor: __
Project Worker: __
Other (please specify): __

9. What do you see as your key duties/responsibilities?
_____
_____
_____
_____

10. Did you volunteer or do unpaid work in the field before employment in the sector? Yes/ No

11. **If yes, do you think this unpaid work in the field helped you? Yes/ No**

12. **If yes, in what way did this unpaid work help you?**

_____
_____
_____
_____

13. **What do you perceive as the main barriers to your doing your job?**

_____
_____
_____
_____
_____

14. **What do you perceive can be done to overcome these barriers?**

_____
_____
_____
_____
_____

15. **What supports do you have to do your job?**

_____
_____
_____
_____

16. **Are these supports Adequate? Yes / No** (Please Explain):

_____
_____
_____
_____
_____

17. **How many participant on your "Drug Rehabilitation Community Employment Programme"?**

_____

17.1 **How many do you normally deal with?** _____

18. **Please indicate (***tick)* **the type of rehabilitation service offered by your organisation?**

Residential
Day-Programme
Sessional care
Work Focused Recovery Focused
Other: _____

19. **When you started did you receive induction or on-the-job structured training? Yes / No**

20. **What was the main areas covered in your induction training?**

_____
_____
_____
Did you find it relevant?
_____

21. **Was most of your training in drug issues to date: on-the-job, internal or external?**
_____
_____

22. **How would you rate your training so far?**
Very Good;
Good:
Poor:
Very Poor:
23. **Would you like more training? Yes / No**

24. **If Yes, what areas would you like to have more training in?**
_____
_____
_____

25. **What subjects are thought on your Drug Rehabilitation CE Programme?**
_____
_____
_____

26. **How many are QQI certified** (approx.): None------25%------50%-----75%-------100%

27. **What is your highest level of education & in what area?** _____

28. **Where did you study for your highest qualification?** _____

29. **What was your main motivation for following this course of study?**
_____
_____
_____
_____
_____

30. **When you compare your education/training with your job demands what's missing?**
_____
_____
_____

31. **How was your training delivered? on-line / Distance / Classroom Based/ Blended**

32. **How did you cover course fees?**

Fully paid for by you
Part subsidised by work
Fully paid for by work
Other:_____

33. **Do you intend to pursue further Education/Training in drug related field?** Yes / No / Don't Know

34. **If Yes, what specific areas would subject areas would assist your development?**
_____
_____
_____

35. **What if any obstacles might prevent you pursuing this further education/training?**
_____
_____
_____
_____
_____
_____

36. **Do you see yourself doing this job in 5 years from now?**
_____
_____
_____

37. **Will you present qualification be enough to go further in your career?**
_____
_____
_____
_____

38. **How well did your education and training prepare you for the following work areas?**
(Please answer: VW=Very Well, W=Well, NVW+ Not Very Well, NAA=Not At All)

a. Knowledge of Psychoactive substances and their use._____
b. Understanding the process and causation of dependency._____
c. Models of treatment._____
d. Approaches to rehabilitation._____
e. Group work/Facilitation skills_____
f. Motivational Interviewing/Counselling:_____
g. Training the trainer:_____
h. Dealing with relapse:_____
i. Managing people: _____
j. Managing budgets._____

39. **How well did your course prepare you for the following areas?**
(Please answer: VW=Very Well, W=Well, NVW+ Not Very Well, NAA=Not At All)

a) Knowledge of confidentiality and legal limitations._____
b) Knowledge of hygiene practices and procedures. _____
c) Knowledge of health & safety practices. _____
d) Knowledge of nutrition in relation to drug use. _____

e) Ability to perform basic first –aid procedures. _____
f) Knowledge of drug policy and best practice. _____
g) Understanding self-care practice. _____
h) Ability to use reflective practice._____

40. How well did your course prepare you for the following social areas?
(Please answer: VW=Very Well, W=Well, NVW+ Not Very Well, NAA=Not At All)

a) Knowledge of social & environmental factors and their impact on drug use. _____
b) Ability to establish and maintain appropriate relationships with participants._____
c) Ability to support families in coping with addiction. _____
d) Ability to liaise and maintain relations with other agencies, committees, etc.. _____
e) Understanding of equality issues as relating to gender, ethnicity, culture ect.. _____

41. How well did your course prepare you for the following Personal Development areas?
(Please answer: VW=Very Well, W=Well, NVW+ Not Very Well, NAA=Not At All

a) Developing the values, attitudes and disposition appropriate for your role._____
b) Self-awareness, professionalism, self-confidence. _____
c) Ability to identify your own training needs. _____
d) Ability to manage your life work balance._____

42. How well did your course prepare you for the following team-work areas?
(Please answer: VW=Very Well, W=Well, NVW+ Not Very Well, NAA=Not At All)

a) Developed skills as a team worker with other professionals and agencies._____
b) Ability to communicate effectively with participants, other staff, agencies. _____
c) Ability to maintain records, documents and administer effectively._____

43. Please specify any additional areas that you feel should have been included in the education and training programme that led to your qualification?

_____
_____
_____
_____

44. Please specify any areas that were included in your education and training programme that could have been covered in more detail?

_____
_____
_____
_____

45. Did you do a student placement/volunteer as part of your course Yes / No

46. If Yes, Did you find this practical work:

Very beneficial----------beneficial----------not beneficial----------Positively negative

Why?

_____
__

47. **What is the biggest challenges working with participants in a Drug Rehab CE Programmes?**

    _____
    _____
    _____
    _____
    _____
    _____

48. **How does society value the contribution of drug work practitioners to social development?**

    No Value----------Too low----------About right----------Highly----------Too Highly

49. **What do you think should be the minimum qualification for professional drugs workers?**
    Certificate (level 5) -----Diploma (level 6)------Diploma (level 7)------Degree (level 8)----Other____

50. **Is there a need for a professional standards body to promote and regulate the Drug Working profession (Similar to Teachers Council, Law Society or IAAAC)?**

    Yes----------No----------Don't know

Thank you for taking the time to complete this questionnaire. Your contribution is much appreciated. Space is provided below in case you wish to make any additional comments.

Appendix J: Semi-Structured Interview Schedule

Interview Schedule

As these questions will evolve from the responses to the questionnaire the following Interview schedule represents some indicative themes within which the specific 'interview questions' will be situated.

1) Current role in SCE programme:

• What courses are you delivering?

• How are you delivering them?

• What successes and challenges are you experiencing in delivering the courses?

• How do you measure the success?

• How might the challenges be resolve?

2) Training & Education

• How has your education and training to date served you in this position?

• How much of your skills & knowledge were gained on the job?

• Is on-the –job training systematic and relevant?

• Have you identified any gaps in their Training or Education relative to their position?

• What areas of training would you like to undertake to bridge these gaps?

3) Personal Development

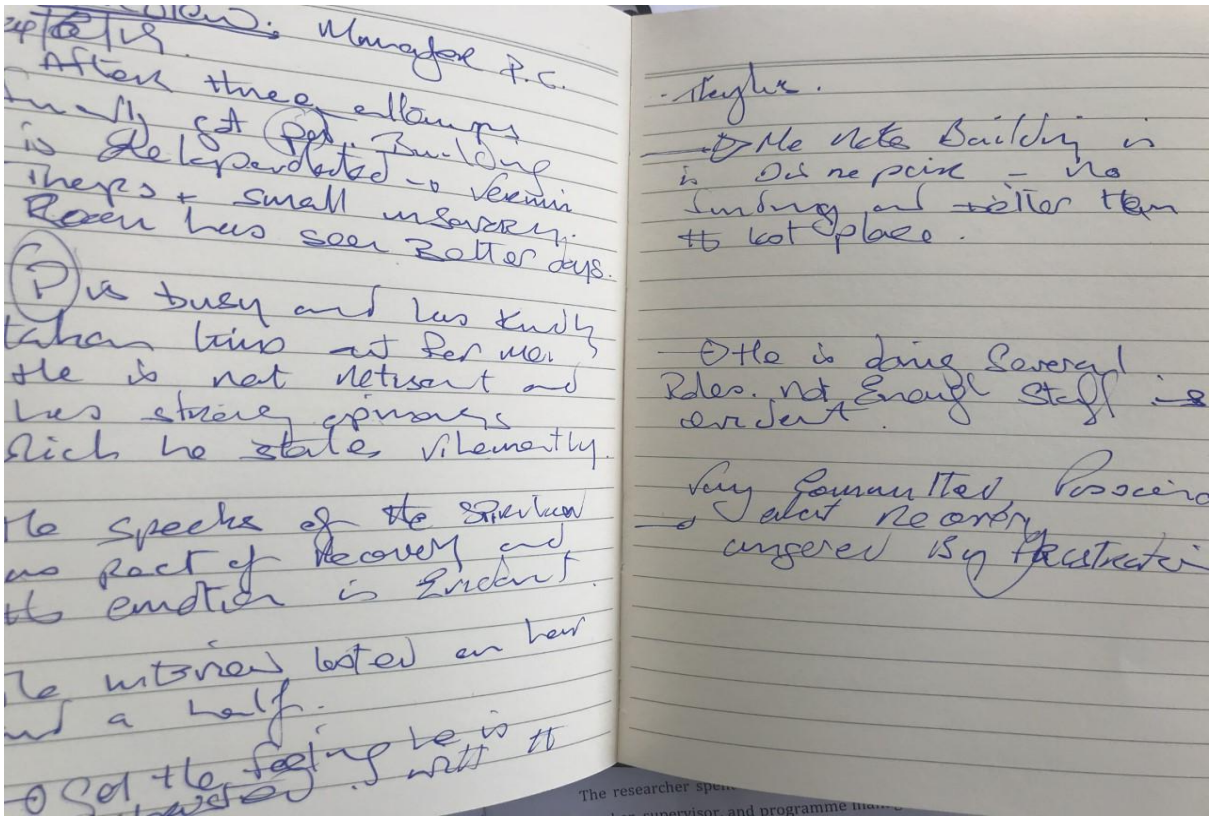
• How do you measure your career and job satisfaction?

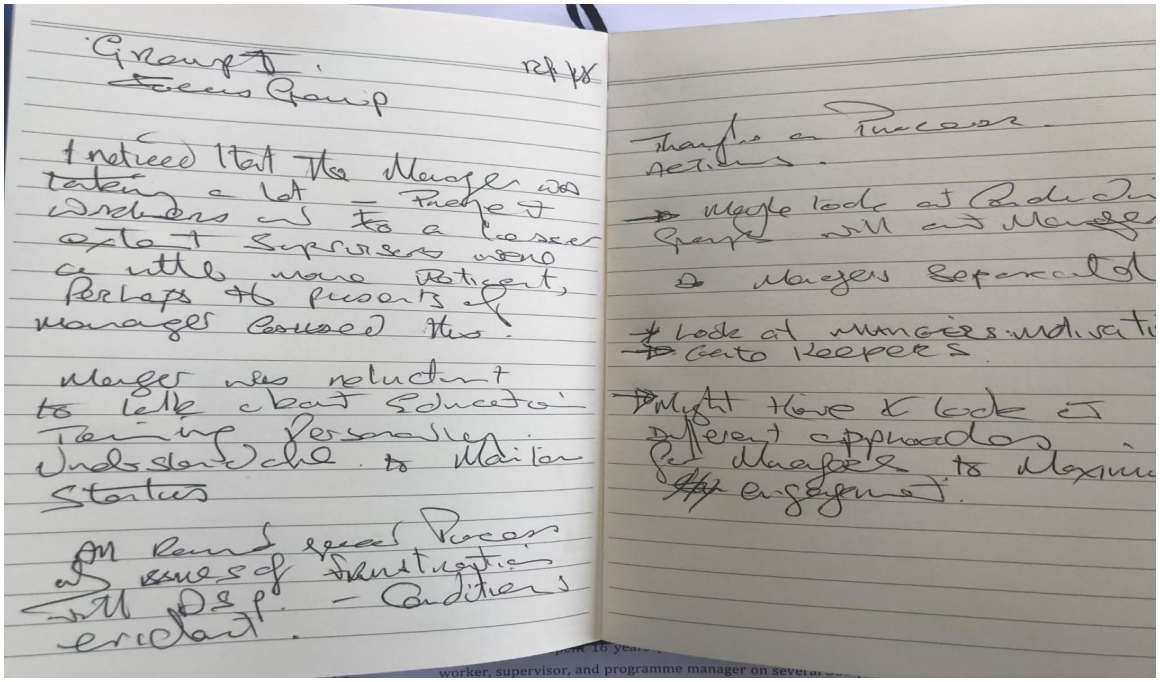
• What are your practices in relation to Self-care.? Have you received formal training in self-care?

• What kind of things do you do to facilitate Life-Work balance?

Appendix: K: Reflective Journal

Sample Pages from Reflective Journal:





Appendix L: Qualitative Analysis (Phase One)

Sample Interview Transcripts:

Interview Manager 1

Q1: What are the key issues for you around SCE programme:

One of the main problems for me is insecurity. What's happing with the whole area is anyone's guess. The was supposed to be review last year (2019) haven't heard anything about it since. So, there is this issue of uncertainty where are we going and what are we doing.

Q1. (a) How is your relationship with the DSP?

We have a decent and understanding CDO, I think it all depends on your CDO, there are some who give a fair amount of latitude and discretion to the projects, and there are some who are ridged and sticklers for the letter of the procedure or rule. In all fairness from what I hear from others our one is a keeper. The supervisors are given a fair amount of discretion around payment issues within reason.

Q1. (b) What about resources and finance

The SCE grants are not sufficient to run a programme, if we did not have other revenue streams we could barely afford to run....deliver and administrate the programme. The cut-backs in other streams has put severe pressure on the programme, we're not being able to deliver what would be an optimum intervention for rehabilitation by any means.

Q2: How is recruitment of support workers?

It's nearly impossible to recruit support workers, they are just not out there anymore. Many of the projects out there depend on support workers to make up staff numbers and to tell the truth they are just not there.

Why is that?

Mainly due to the economic up-swing, the pool of potential candidates is drying up rapidly. Also, we spend our time training them up and they move on to a (better) paying job, fair dues to them, you can't blame them, ideally, we would love to have the finance to pay them. But even in recruitment, we are getting people sent over (from DSP) who are patently unsuitable, there is a disconnect between the DSP employment officers and their understanding of role and indeed character of a support worker.

Q3: What are the important attributes of a potential support worker.

Dependability is a major quality I look for, motivation to work in the area and an ability to be flexible. I think you need a calm and mature temperament to last and thrive in the drugs field. Team working is a must and some knowledge of the drugs field.

Q4: What might be the minimum education?

As I said, attitude and personality are very important, a level five CASC would be ideal, but we can train the right people. Of course, literacy and ability to communicate effectively is important, but other than that, nothing academic.

Q5: What might make them an effective contributing staff member?

Gaining experience trough working with the team and shadowing experienced workers. As much as we can we supply training and over a period of 3 years, money permitting we like to have our workers trained to at least level 5 if not level 7. This is not always possible

on a budget 500/800 Euros but sometimes we can manage to find the rest for the right person.

Q6. Is there any special areas you would like them trained in?

Yes....., we do a lot of group sessions here, it's more cost effective for us and it makes effective use of our limited staff time. So, for this service I see Group-work, Therapeutic Group-work, Group skill and Facilitation as extremely important assit to us use here.

Q7: What are the key issues for you around clients/participants?

Well, the demographic has certainly changed over the last number of years. The move is with new participants is away from opiate and towards cocaine and weed, this is reflected in the stats published nationally. This shift to stimulants has implications for mental condition and behaviours of participants, we have more and more participants exhibiting mental health issues than when we were dealing with mainly opiate users.

The main reason for drop in participant numbers is the cut in allowances,…as an incentive it was massive, it was not the ideal reason for someone to engage (with services) but it was a motivator, particularly for females . The extra payment for young people is a strong incentive for that age group.

On the topic of allowances, how does it work when staff have to "dock" allowances?

Well the introduction of the 30 day "relapse rule" was a help in this. But it is essential for us that we keep the participant/worker relationship at a therapeutic level and I as manager take responsibility for "sanctioning", you know yourself how quickly a working supporting relationship can become toxic with imposing sanctions.

Q8: Do you think SCE is the best method of delivering Drug Rehabilitation?

Yes and No! I think it has some merit for use within the (Rehabilitation) framework for certain people. Those in good recovery and who are in a space to use the training benefits

of the SCE as a springboard to further education or employment. There is a larger more common group of participants who see the SEC not as a stepping stone but as an end in itself, something to do, self-esteem, routine, social etc… and this group can take the end of the programme (after 3 years) as rejection and go off out using again. This concept of three years, particularly with chronic drug users has no evidence base, it arbitrary and can be damaging. It may work for some who are in the right space. But for many it does not., for these the "setting the egg timer" approach is counter-productive. To answer your question in short, it (SCE) works for the few, but something else is required for a large portion of our potential clientele, particularly the older ones who find it hard to engage with learning or new skill work but, yet, value the social support, security and recreation activity it provides in support of their ongoing recovery. These can be on high dosages of methadone also.

Q9: In an Ideal world, what system might be useful for drug rehabilitation?

A structured programme is a good thing, but one designed from the bottom up to meet the rehabilitation and recovery need of the different clients at different points in their "using career" and "recovery cycle". Less emphasis on the economic and more on the social integration of the person. I think also a grater emphasis on a health lead model would be of benefit.

Many Thanks for your participation.

Appendix M: Qualitative Analysis (Phase 2)

Sample Coded Interview Transcripts:

Drawing on the date which emerged from the initial quantitative element of the this research ten key domains emerged which warranted further qualitative exploration at the interview stage. The following are transcripts of interviews with managers, supervisors and project workers. The interviews were semi structured and thus data specific to domains may not fall neatly under the question numbers but rather may emerge in conversation at any multiple points in the interview. Thus I have used colour coding in the transcript to identify relevant data and relate it to specific topic domains, see coding key below. These colour coded data fields are then interrogated in Phase 3: "Sense Making" phase to extract themes and opinions.

Coding Key:

No	Topic	Colour Code

Work Related Topics		
	Relationship with Dept. Social Protection	Colour
	Finance & Resources	Colour
	Staffing Issues	Colour
	Participant Recruitment	Colour
	Participant Issues	Colour
	SCE Models Suitability	Colour
Training/Education Related Topics		
	Minimum Training for Effective Support Worker	Colour
	Induction Training	Colour
	Desirable Personal Qualities of Support Worker	Colour
	Important education and training for Workers	Colour

Interview Transcripts: Managers, Supervisors and Project Workers

---

Interview Manager 1

Q1: What are the key issues for you around SCE programme:

One of the main problems for me is insecurity. What's happing with the whole area is anyone's guess. The was supposed to be review last year (2019) haven't heard anything about it since. So, there is this issue of uncertainty where are we going and what are we doing.

Q1. (a) How is your relationship with the DSP?

We have a decent and understanding CDO, I think it all depends on your CDO, there are some who give a fair amount of latitude and discretion to the projects, and there are some who are ridged and sticklers for the letter of the procedure or rule. In all fairness from what I hear from others our one is a keeper. The supervisors are given a fair amount of discretion around payment issues within reason.

Q1. (b) What about resources and finance

The SCE money are not sufficient to run a programme, if we did not have other revenue streams we could barely afford to run....deliver and administrate the programme. The cut-backs in other streams has put severe pressure on the programme, we're not being able to deliver what would be an optimum intervention for rehabilitation by any means.

Q2: How is recruitment of support workers (staffing)?

It's nearly impossible to recruit support workers, they are just not out there anymore. Many of the projects out there depend on support workers to make up staff numbers and to tell the truth they are just not there.

Why is that?

Mainly due to the economic up-swing, the pool of potential candidates is drying up rapidly. Also, we spend our time training them up and they move on to a (better) paying job, fair dues to them, you can't blame them, ideally, we would love to have the finance to pay them. But even in recruitment, we are getting people sent over (from DSP) who are patently unsuitable, there is a disconnect between the DSP employment officers and their understanding of role and indeed character of a support worker.

Q3: What are the important attributes of a potential support worker.

Dependability is a major quality I look for, motivation to work in the area and an ability to be flexible. I think you need a calm and mature temperament to last and thrive in the drugs field. Team working is a must and some knowledge of the drugs field.

Q4: What might be the minimum education for effective worker?

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Q5: What might make them an effective contributing staff member?

Gaining experience trough working with the team and shadowing experienced workers. As much as we can we supply training and over a period of 3 years, money permitting we like to have our workers trained to at least level 5 if not level 7. This is not always possible on a budget 500/800 Euros but sometimes we can manage to find the rest for the right person.

Q6. Is there any special areas you would like them trained in?

Yes....., we do a lot of group sessions here, it's more cost effective for us and it makes effective use of our limited staff time. So, for this service I see Group-work, Therapeutic Group-work, Group skill and Facilitation as extremely important assist to us use here.

Q6(a): **do you have an induction for new support workers.**

We provide a session around health and safety of course and the basics of the job and they then shadow an experienced worker for a long time. There can be a problem with giving time over to the type of induction I would like, but we would never put a worker new or old in harms ways

Q7: What are the key issues for you around clients/participants?

Well, the demographic has certainly changed over the last number of years. The move is with new participants is away from opiate and towards cocaine and weed, this is reflected in the stats published nationally. This shift to stimulants has implications for mental condition and behaviours of participants, we have more and more participants exhibiting mental health issues than when we were dealing with mainly opiate users.

The main reason for drop in participant numbers is the cut in allowances,...as an incentive it was massive, it was not the ideal reason for someone to engage (with services) but it was a motivator, particularly for females . The extra payment for young people is a strong incentive for that age group.

On the topic of allowances, how does it work when staff have to "dock" allowances?

Well the introduction of the 30 day "relapse rule" was a help in this. But it is essential for us that we keep the participant/worker relationship at a therapeutic level and I as manager take responsibility for "sanctioning", you know yourself how quickly a working supporting relationship can become toxic with imposing sanctions.

Q8: Do you think SCE is the best method of delivering Drug Rehabilitation, is it fit for purpose?

Yes and No! I think it has some merit for use within the (Rehabilitation) framework for certain people. Those in good recovery and who are in a space to use the training benefits of the SCE as a springboard to further education or employment. There is a larger more common group of participants who see the SEC not as a stepping stone but as an end in itself, something to do, self-esteem, routine, social etc… and this group can take the end of the programme (after 3 years) as rejection and go off out using again. This concept of three years, particularly with chronic drug users has no evidence base, it arbitrary and can be damaging. It may work for some who are in the right space. But for many it does not., for these the "setting the egg timer" approach is counter-productive. To answer your question in short, it (SCE) works for the few, but something else is required for a large portion of our potential clientele, particularly the older ones who find it hard to engage with learning or new skill work but, yet, value the social support, security and recreation activity it provides in support of their ongoing recovery. These can be on high dosages of methadone also.

Q9: In an Ideal world, what system might be useful for drug rehabilitation?

A structured programme is a good thing, but one designed from the bottom up to meet the rehabilitation and recovery need of the different clients at different points in their "using career" and "recovery cycle". Less emphasis on the economic and more on the social integration of the person. I think also a grater emphasis on a health lead model would be of benefit.

Appendix N: Sample Thematic Analysis (Phase 3)

Identifying Themes and Issues:

In this phase of the analysis the data extracted from the Phase 2 transcript topic domains are isolated; key themes and concepts inherent in the respondent's answers are identifies. A summary of individual sub-groups (managers, supervisors and project workers) responses along with an overall synthesis of the emerging date is provided at the end of each topic section. These syntheses, augmented by relevant supporting extracts from interviews provide the basis for the qualitative findings chapter.
The analysis is devided into two sections based on question domain, either "work related" or "education & training related".

Work Situation

Topic: Relationship with DSP

Managers:		

Manager 1 One of the main problems for me is insecurity. What's happening with the whole area is anyone's guess. It was supposed to be reviewed last year (2019) and hasn't heard anything about it since. So, there is this issue of uncertainty where are we going and what are we doing.`` "We have a decent and understanding CDO, I think it all depends on your CDO, there are some who give a fair amount of latitude and discretion to the projects, and there are some who are rigid and sticklers for the letter of the procedure or rule. In all fairness from what I hear from others, our one is a keeper." **Manager 2** "In short we are being micromanaged into the ground. Supervisor's time is totally absorbed by the training plans and administration,..." "The system is unyielding and inflexible at worst. The DSP inherited a system from FAS who had developed some flexibility and understanding of the special needs of SCE after 20 years, that "Heard memory" is lost and a new group of career civil servants	• Insecurity • No clear direction • Quality of CDO • Micro-Management	

began to administer the programme. They also have unrealistic ideas about outcomes and are driven by the model, their outcome targets are crazy and particularly given the training budget, material allowance and lack of suitable staff. **Manager 3** We felt that we and our services users were not on the right path by having to adhere to the DSP model, so we chose another model. "...the bureaucracy had gone mad, you know...the rules were becoming more convoluted every year, ... and for an organisation of our size and structure it was taking up too much of our time to administer to DSP and not our client group." "Well, apart from the administration, where there was a demand for particular outcomes which we felt were not always in the best interest of the participant, sometimes it seem like a tick box exercise for the Department, they had criteria for success which were not our measures for success in recovery and rehabilitation, we had different philosophies on how this should and could be achieved."	• Rigidity • Unsympathetic CDO • Unrealistic outcomes • Bureaucratic • Different model	

	• Differing outcome expectations	• No Strategy • Uncertainty • Rigidity • Bureaucratic • Micro-management • Quality of CDO's Outcomes • Differing outcome expectations
Supervisors: **Supervisor 1** "….to be honest a least they do have a system,…" "….we seem on the outside, it's like we're not on the same		

team, they are the masters and they like to let you know it. “ “They are sitting on top of a fence and micromanaging, if something is going well they will claim the credit, if it goes wrong , it's all yours” It’s all very wrong.” **Supervisor 2** “On a personal level the CDO is just doing the job they are assigned.” “The DSP has failed to train their staff to a sufficient level of drug recovery knowledge that could make them a valuable team player instead of an umpire, they spend their time making sure every rule is obeyed to the letter.” “Paperwork, bureaucratic red-tape …… fear. We are lucky in many ways, we have a fairly good CDO now, but it all depends on the personality and attitude of the CDO. We are constantly audited and we don’t know if we are going to run year to year, you can’t plan like that…you know, it's impossible to make long term plans and programme changes when you're under that type of regime.”	• Have a system • Non-partnership • Micro-manage • Blame culture • Personal relationships • Lack of Understanding • Unheard • Not partnership	

"A participant might be in a bad space recovery wise and miss a day and I am instructed to sanction everyone who does not fulfil the letter of the rules. I'm called the " Queen of Mean" sometimes, and while it's a bit of a joke it illustrates the unhealthy position that we are in." **Supervisor 3** "Not the best, I feel and I only speak for myself, that we are treated like second class citizens. Working conditions, allowances, accountability, being heard all of this we are just thrown a bone and supposed to wag our tails and bark nicely. I remember when the community were leading the way in drug treatment, now the self appointed "experts" in the DSP are dictating drug policy from on high."	• Policy shaped by DSP	

		• They have a system • Non-partnership • Micromanage • "Blame" culture • Dependant on personal relationship with DSO • lack of Understanding • Feeling unheard • Not a partnership • Policy shaped by DSP
Project Workers: **Project Worker 2** " I have little enough direct dealings (with DSP). But I have to deal with the fall out of sanctions." **Project worker 3** "Here, everyone seems to be a boss, the manager tells you one thing, the team leaders say you	• Sanctions	

must report to them, the supervisor will want you to do what they want and the DSP (Dept of Social Protection) don't care, they tell you that's it's the responsibility of the project how its run. " "I rang them about what I was talking about (reporting structure) and they batted me back to my project, so not good" **Project Worker 4** "None, really, they pay the wages."	• Unclear in reporting structure • Unsupportive	• Sanctions • Unclear reporting structure • Unsupportive

Synthesis	
Managers	The management cohort were concerned with both strategic issues like Policy, uncertainty, lack of strategy and unreasonable demands for outcomes as well as operational issues such as micromanagement, bureaucracy, and different theoretical models. Many believed that the operational end of things depended on the DSO and their personal understanding and flexibility to make it work
Supervisors	This group agreed with managers in respect of micromanagement and the importance of personal relations with DSO but were also concerned by issues such as lack of partnership (one sided, no voice in partnership), not being heard, blame culture in DSP, a general lack of understanding of their particular problems..
Project Workers	This group had concerns voiced mainly operational issues like feeling unsupported by DSP, having to operate DSP sanctions and unclear in reporting structures.

Observations	There seems to be a perceived disconnect between the objectives of the projects and the DSP, which is manifest in a lack of a clear common vision, purpose and means of achieving "rehabilitation". They are aware and to some extent glad that there is a system, however, they feel the system is one-sided and imposed as opposed to being a cooperative partnership. (note: Community favours partnership and collegiate management as opposed to hirachical DSP). There would appear to be too much dependence on the interpersonal relationship between project staff and DSO and the degree of flexibility any one DSO will allow, this of course can change if personal change as is not beneficial to a systemic approach. Some project employees find they face a dilemma between their engagement with clients on a therapeutic level and acting as "boss" in levying sanctions as dictated by the DSP.

Appendix O: Qualitative Analysis (Phase 4)

Sample of Writing-up Findings:

Qualitative Results

Introduction:

The following is the consolidated findings of the qualitative data amassed from the researchers thematically analyses (see appendix: L), of the semi-structured interviews. This section is structured by interview topic domain and the topic domains were informed by the findings in the quantitative element of this study. The synthesis of the data on each topic area is in some cases supplemented by observations from the researcher's journal, only where they are deemed to provide clarity and further insight to the understanding of the ideas and opinions expressed by interviewees. One again the findings are divided into two main parts; Work related and education and training related.

SCE: Work Related:

Topic: Relationship with DSP

There seems to be a perceived disconnect between the objectives of the projects and the DSP, which is manifest in a lack of a clear common vision, purpose and means of achieving "rehabilitation". They are aware and to some extent glad that there is a system, however, they feel the system is one-sided and imposed as opposed to being a cooperative partnership. (note: Community favours partnership and collegiate management as opposed to hirachical DSP). There would appear to be an over dependence on the interpersonal relationship between project staff and DSO and the degree of flexibility any one DSO will allow, this of course can change if personal change as is not beneficial to a systemic approach.

Some project employees find they face a dilemma between their engagement with clients on a therapeutic level and acting as "boss" in levying sanctions as dictated by the DSP.

Illustrative interview passages:

"On a personal level the CDO is just doing the job they are assigned."
"The DSP has failed to train their staff to a sufficient level of drug recovery knowledge that could make them a valuable team player instead of an umpire, they spend their time making sure every rule is obeyed to the letter." (Supervisor 2)

"The system is unyielding and inflexible at worst. The DSP inherited a system from FAS who had developed some flexibility and understanding of the special needs of SCE after 20 years, that "Heard memory" is lost and a new group of career civil servants began to administer the programme. They also have unrealistic ideas about outcomes and are driven by the model, their outcome targets are crazy and particularly given the training budget, material allowance and lack of suitable staff." (Manager 1)

"….we seem on the outside, it's like we're not on the same team, they are the masters and they like to let you know it.....they are sitting on top of a fence and micromanaging, if something is going well they will claim the credit, if it goes wrong , it's all yours. It's all very wrong." (Supervisor 1)

Topic: Issues around Finance and Resources

There was a common concern expressed about the inadequacy of the SCE budget on many levels, including; Premises, facilities, materials, health & safety, therapeutic and vocational outcomes, participant training and support worker training. Project staff across the board, felt the practical stresses of a static budget which is constantly undergoing attrition from general inflation, specific price rises like insurance and the cost of accessing quality accredited training. They feel they are being asked to do more and more with less and less.

Illustrative interview passages:

"The SCE money is not sufficient to run a programme, if we did not have other revenue streams we could barely afford to run....deliver and administrate the programme..... (combined with)....the cut-backs in other streams have put severe pressure on the programme, we're not being able to deliver what would be an optimum intervention for rehabilitation by any means." (Manager 1)

"The biggest problem as I see it is the material grant which at 9.98 per week per participant it's a joke, not in a funny way. Insurance alone devours over 30% of that budget and our project by its nature is a material "hungry" project we never have enough to make ends meet from the DSP budget. We have to plunder other budgets or beg, steal and borrow to drive the project forward." (Supervisor 1)

"I am just glad to be doing what I'm doing at the moment, but yeah, I do see that the premises are a more than bit shabby, and some of the staff are pissed off about the lack of facilities, there is not enough space for privacy outside the counselling rooms and basically the place is not fit for purpose. We've had a major rodent infestation which is ongoing. Most people here have not had a raise in a long time and are getting worn out by the lack of funding and the situation in general." (Project Worker 4)

Topic: Staffing Issues

There was agreement across the sample that difficulty in staff recruitment presents a real challenge in maintaining quality of service and levels of activity in projects, along with the increased staff workload as a consequence of this staff shortage. Again some felt that this may have health and safety implications for current workers. The reasons given for this recruitment problem, was the high level of employment, in effect reducing the pool of available potential support workers and the quality of applicants. The rigid DSP rules which disallowed new graduates from gaining experience was also cited as cause for this depletion. It was also felt that there was no shared understanding of what constituted the personal profile of a potential candidates and this gave rise to unsuitable and sometimes unwilling candidates being sent for interview and attending because they were afraid to lose their benefits. Some also express concern at the ability to retain support staff once they became experience and trained, because of allowances and conditions pertaining to SCE.

Illustrative interview passages:

"Getting competent support staff through the SCE process is impossible, I don't mean this in any bad way but with the level of employment at present we are at the "bottom of the barrel.....it's obvious now that we the system should have been investing in real sustainable jobs for professional drug workers. Would any other sector put up with it, would you let CE participants tend a psychiatric patient or an injured /sick person, no, people would be appalled.." (Manager 2)

"..... it's very difficult at present: It's not so much that nobody wants to do it, but they are restrained by CE eligibility. I know a young girl, a recent graduate with a degree in social science, would love to do the job for the experience but does not qualify for CE. That's the problem, CE criteria" (Supervisor 1)

'We are being sent people who are in no way suitable or even want to engage with this type of work but feel they will be cut off the register if they don't come to interview, can you imagine any other profession, say social work or nursing where you employ people who are just sent to your interview by shotgun" (Supervisor 2)