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Research and Practice

Evaluation of Tallaght Local Drug and Alcohol Task Force Crack Cocaine projects

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1 Introduction

In early 2018, CARP submitted a request for funding to the HSE to support a treatment programme specific to crack cocaine users in Tallaght. CARP's proposal highlighted the devastating effect of crack use in the local Killinarden community over the last five years. The HSE agreed to the project if Tallaght Drug and Alcohol Task Force (TDATF) funded it.

The TDATF Executive Board argued that a project of this kind required a tender process in order to be fair, particularly as cumulative funding cuts over the years has meant that TDATF projects, overall, have been unable to fully respond to emerging needs. There were three criteria in the invitation to tender, as follows:

- Proposals had to be a new initiative responding to increasing crack cocaine use, and not an extension of an existing programme or project;
- Proposals had to reference the TDATF strategic plan (2017 – 2020), and the relevance to a specific theme or action; and
- Proposals had to include a completed logic model framework, based on the template provided (Appendix 1).

CARP, JADD, and NHRC submitted proposals in July 2018, which were reviewed by the TDATF Chair, the TDATF Coordinator, and the SDC Partnership Finance Manager. Each project was granted funding to deliver a 12-week crack cocaine-specific programme. TDATF made available €29,560 from its Development Fund which was divided between each project based on their proposals.

The evaluation of each pilot was carried out in early October, during week 2 of project delivery, and in January 2019, after each pilot had ended. The aim of the first stage was to clarify each project's aims and objectives, and its unique strengths, challenges, and opportunities. The second stage examined retention and progress of participants, experience of staff, value for money, and the extent to which each project had been able to contribute to TDATF's strategic aim of strengthening family support initiatives.

1.1 Crack and cocaine as national emerging trends

In 2017, The Centre for Public Health at Liverpool John Moores University published a report of the trends in drug use in Ireland between 2005 and 2017 (Bates, 2017). The report findings indicated that among high risk populations, including sex workers, the homeless, and prisoners, there was a much higher prevalence of crack and cocaine use than in the general population, with a 74.2% lifetime prevalence of cocaine, and 35.6% lifetime prevalence of crack use amongst prisoners, particularly female prisoners. The findings also showed high rates of polydrug use among cannabis, amphetamine, and cocaine users, with simultaneous use of alcohol being very high. Among high risk populations, the report evidenced very high rates of injecting cocaine and sharing of injecting equipment among sex workers, and a very high risk of injecting drug use among female prisoners.

In terms of demand for treatment, the report evidenced a marked increase in cocaine treatment cases in 2015.

In November 2016, health workers examining chest X rays of homeless people in Dublin noted scarring in the lungs which was identified as being a result of crack use (Irish Times report, July 8th 2017). The Irish Times article also reported Minister for Justice Michael McDowell expressing concern that a crack epidemic in Dublin was unfolding, similar to one that ravaged inner cities of the USA in the 1980s.

In July 2018, the HSE launched a campaign aimed at harm reduction in the crack cocaine using population. Dr Eamon Keenan, Clinical Lead, HSE Addiction Services, described the increase in cocaine prevalence since 2013 as a reflection of the recovering economy, but emphasised that,

although cocaine use can sometimes have a glamorous image, it is associated with significant physical and mental health issues.

The Ana Liffey project reported a significant increase in crack cocaine drug use in the first three months of 2018, with 19% of clients who accessed needle exchange at Merchant's Quay reporting the use of crack and cocaine.

1.2 Trends in crack cocaine use in Tallaght

In March 2016, the Echo newspaper reported a serious crack problem in Tallaght, with crack being available 'on every street corner', and children being taken into care due to crack addiction in the home.

In March 2017, The Independent newspaper published an article highlighting the 'epidemic' of crack cocaine use in Tallaght, with evidence that children aged 13 were smoking it, and being groomed as suppliers. Fettercairn Drug Rehabilitation Project (FDRP) suggested there was a 50% increase in use in the local area since 2016.

In October 2018, project coordinators interviewed for the evaluation reported a considerable increase in crack cocaine users presenting to services; evidence of neglect in the children of crack cocaine users, and its widespread availability and accessibility, with 'dealers openly selling on street corners'. Grace Hill, TDATF Coordinator, explained that WASP has recently set up a facilitator led carer's group to provide support for grandparents who become carers for their grandchildren because of crack cocaine use by parents. Tusla and Barnardos also confirmed an increase in crack use in family and child protection cases. There is evidence of crack houses in the Tallaght area, and the coordinator of CARP reported that Killinarden has become a 'no go area' because of the social breakdown due to prevalent crack cocaine use.

1.3 Crack cocaine projects in Dublin

On October 2nd, 2018, the Irish Examiner reported on a harm reduction initiative set up by Clondalkin Drugs and Alcohol Task force, Clondalkin Tus Nua, An Garda Síochána, and Irish Rail to address the increasing numbers of people, 60-65% of whom are female, travelling by train from Cork, Limerick, Galway, Laois, Kildare, and Northern Ireland to source crack cocaine and other drugs, which is resulting in anti-social behaviour, public drug use, and drug litter at Clondalkin train station. The Safe Campaign offers information, signposting to services, needle and syringe packs, and crack pipes.

The Ana Liffey Project began distributing reusable crack pipes in April 2017, and Merchants Quay has provided crack pipes since July 2018. Merchants Quay reported that while the majority of its clients' smoke crack, there is a small cohort who inject into the neck. CARP, in Tallaght, has been providing crack pipes since the start of 2018 and was the first service in Tallaght to do so. JADD also provides crack pipes.

1.4 Health implications of crack and cocaine use

The effects of crack, cocaine, and other stimulants, and the methods of using are different. Cocaine rarely leads to physical dependence although psychological dependence can be deep-seated and difficult to treat (Neale & Robertson, 2004). In contrast, crack users often develop powerful physical and psychological dependence. Physical dependence can cause severe cravings and render users unstable and/or violent. Psychological dependence may lead to an intense fear about stopping (Emmet and Nice, 1996; Neale and Robertson, 2004).

Crack cocaine users rarely present to services until they are in crisis by which time they may experience serious physical health issues, including risk of heart attack, risk of stroke, brain damage, respiratory problems such as crack lung, susceptibility to TB, impaired liver function, impaired immune function, weight loss, and skin problems (RCGP guidelines, 2004).

Crack and cocaine suppress appetite and can be implicated in eating disorders (RCGP guidelines, 2004; Gray, 2004a).

Crack and cocaine are frequently used in combination with other drugs, especially alcohol and heroin and there are severe risks associated with synergistic effects of polydrug use (RCGP guidelines, 2004). For instance, alcohol combined with cocaine and/or crack leads to a 24-fold increase in the risk of heart attack (Gray, 2004b).

COCA warns that the extent of crack and cocaine use is not detected by treatment services and stimulant use may not become apparent until a client is on a maintenance methadone script. If undetected, physical health risks may also go undetected. There is also recent evidence (Carnworth and Bottomley, 2004) that methadone/crack cocaine combination has adverse behavioural effects.

There is currently no substitute medication for stimulants although many have been tried (RCGP guidelines, 2004). Instead, emphasis is placed on the development of protocols for short term intervention for mood stabilisation.

1.5. Psychological implications of stimulant use

Crack, cocaine and other stimulant use can lead to a range of psychological problems. Underlying psychiatric conditions such as Attention Deficit Hyperactivity Disorder, bipolar disorders, personality disorders, and schizophrenia can be exacerbated (RCGP guidelines, 2004).

Crack and cocaine deplete serotonin and dopamine levels, so suicide ideation amongst clients poses severe risk. Some US studies indicate that a high proportion of stimulant related deaths are from suicide (Gray, 2004a).

Users may present to services with exited delirium, thought to be caused by elevated dopamine levels after extensive crack use. The symptoms include bizarre and violent behaviour, hyperactivity, hypothermia and extreme paranoia. The capacity to contain clients experiencing these kinds of symptoms is a skill of crack cocaine specialist workers that is not sufficiently acknowledged.

1.6 Crack and cocaine interventions

Unlike opiates, there are no medical models for treating crack and cocaine use. Users, particularly crack users, may present to services in states of extreme need but with very limited capacity to commit to a structured treatment programme, remember what is being asked of them, or adopt behaviours that facilitate change. This can make habitual crack and cocaine use very difficult to address within a community-based treatment setting.

1.6.1 Rugby House

The National Treatment Agency for Substance Misuse in the UK commissioned experts in the field to develop a range of psycho-social interventions to assist practitioners in treatment provision. Known as the Rugby House model, and developed by Rugby House, the Blenheim Project, and COCA, the model provides two interventions, the first of which is a two-session Brief Intervention, psycho-educational approach focusing on harm reduction and designed for active crack and cocaine users. The second is a 12-session programme for clients who wish to achieve abstinence and consists of a

range of interventions based on Cognitive-Behavioural Relapse Prevention techniques which is designed to run parallel with key working. However, the national standards body in the UK, the National Institute for Health and Clinical Excellence (NICE), does not recommend the use of cognitive behavioural therapy (CBT) because there is insufficient research evidence for its efficacy with crack and cocaine users. The Rugby House programme therefore urges caution in using the model because, although likely to be effective, it may not be suitable for all crack and cocaine users. For this cohort, primarily those who do not want abstinence, it is recommended that a cycle of Brief Intervention is offered instead.

1.6.2 Contingency Management

Contingency Management (CM) is based on human behaviour where a specific response will have a greater likelihood of occurring if it is immediately followed by a reinforcing consequence. Using this model for drug treatment, CM interventions offer systematic rewards, such as monetary vouchers, contingent upon specific responses (e.g., evidence of reduced use).

A recent paper (Miguel et al., 2018) studied 27 crack cocaine users who were assigned to 12 weeks CM treatment in which participants were encouraged to attend treatment sessions three times a week. Each participant provided a urine sample at each treatment session, and were given a monetary voucher if the sample tested negative. The monetary value of the vouchers increased if consecutive samples were negative and were reset to the original value, if not. The treatment over 12 weeks was evaluated using structured questionnaires and descriptive analyses.

The findings showed that 93% of participants found it very easy to understand the CM protocol; all participants liked the experience, and 81.5% stated that CM helped them considerably. Over 92% said they thought CM would help other crack and cocaine users.

2 Evaluation of TDATF pilot crack cocaine projects

2.1 Evaluation methods

Semi-structured interviews were held with project coordinators and project leads on the 9th October 2018, and questions to facilitate the interviews were sent by email three weeks before the interview date. The questions included the following topics:

1 Needs analysis: why is the project needed in your local community?
2 Why is a separate crack cocaine project necessary (rather than being part of the overall treatment and support services your project offers)?
3 What does your project do, what is its approach, and who is your client group?
4 To what extent has the project met its intended outputs and outcomes based on the logic model framework you provided in the application for funding? What have been the challenges to meeting these outputs and outcomes?
5 What is the theme or action in the TDATF strategic plan that your project meets? How and why?
6 What is your project fit with the National Drug Strategy?
7 How has the project met TDATF's strategic theme of providing family support in the community?
8 Has the project been value for money?

Specific questions sent beforehand are covered in Section 5, Table 3.

Project Coordinators participated in each project interview. Project Leads also participated at CARP and NHRC. In addition, the TDATF Coordinator and the TDATF Rehabilitation Coordinator were interviewed in September at the outset of the evaluation.

Prior to the interviews, the TDATF Coordinator provided the researcher with background information, including each project's logic model, and the Rehabilitation Coordinator provided a document outlining recommendations arising from initial discussions with each project.

2.2 Shared features and differences between each project

Following discussion with the TDATF Rehabilitation Coordinator, the three projects agreed to share the following features:

- Project duration: 12 weeks, from September to December 2018
- Pilot would be evidence-based
- CARP to use the CM model; JADD and NHRC to use the Rugby House model
- All to use the Community Reinforcement Approach (CRA)
- Each project to use eCASS as its data collection method
- Each project to use its current service provision to enhance the pilot capacity
- Each project to use National Rehabilitation Framework (NRF) protocols
- Each project was funded for 2 staff providing crack cocaine specific supports for 13 h a week for 12 weeks

The three projects differed in their chosen target group and approach in the following ways (Table 1).

Table 1 Summary of different approaches between each of the three projects

	CARP	JADD	NHRC
Target groups	Women	Parents	Men
No. clients participating	8–12	16–20	16–20
Model	CM	Rugby House	Rugby House
Long term goal	Attendance	Abstinence	Abstinence
Childcare		2 staff for 6 h /week for 12 weeks	
Outreach			10 h a week
Rewards system	€20 for attendance each week		

2.3 Description of each project

2.3.1 CARP

CARP is located in Killinarden, an area of social disadvantage and vulnerability with high levels of unemployment, single parents, and poor standard housing. The devastating effect of crack in the community has been evident for the last five years, and the project coordinator and project lead emphasised that the deterioration in physical and mental health seen in clients when crack becomes a habit is dramatic, shocking, and very rapid. They described a community policed by dealers, with high levels of intimidation, nine-year olds groomed to carry and deliver crack, and 14-year olds dealing, and using crack. They expressed concern for the children of crack users who present with evidence of neglect, *'unfed, unwashed, and lost'*.

CARP was the first service in Tallaght to offer crack pipes in order to reduce harm, and the service has engaged more than 100 crack users in 2018.

2.3.3.1 Findings of evaluation

The pilot is based on the CM model, low-threshold, with monetary incentives to encourage attendance.

Treatment sessions were facilitated group work, held once a week on a Friday immediately following CARP's homeless drop-in. Expectations of this client group were low because of the impact crack has on a person's capacity to live a normal life. CARP's criteria for participation were attendance, no violence, and no selling of drugs on the premises. To encourage participation and to support attendance, CARP offered the following incentives:

- A reward system of €20 for each week a client attended, with the reward given at the end of the 12 weeks.
- Voluntary urine analysis with a monetary reward for each week a urine sample is negative. The coordinator explained that most clients can stay clean for a maximum of 2–4 days. Urine analysis requires 5–6 days to give a clean result. The promise of a financial reward (€15 per clean sample, but participants are not told the value) was an incentive to encourage participants to try and stay clean for the week.
- A Christmas hamper was given to each participant attending in the first week as an additional incentive, and with the aim to ensure that the participant's children would have access to food. A second hamper was given half way through the course.
- Each participant was given a certificate on completion of the 12 weeks.

- A safe space to come, with signposting to key working, counselling, holistics, and access to a mental health nurse. Two HSE Outreach workers attended the group each week.
- The Friday morning group work, held after the homeless drop-in, aimed to engage crack users who are experiencing homelessness.
- Hot meal each week.
- Washing and shower facilities.

The Coordinator explained that a harm reduction and abstinence model, such as Rugby House, is unlikely to be successful for the client group attending CARP, because crack use has become too habitual, and the levels of disadvantage and feelings of hopelessness are too high.

CARP requested funding to provide group work for six clients in the original proposal; TDATF requested the project aim for 12. Prior to the start of the pilot, CARP assessed nine women, and six wanted to participate, a proportion of whom are or have been sex workers. The six women have children and one is pregnant. They are crack and heroin, or crack and tablet users.

Four women completed the course; one dropped out because of complications during pregnancy, and another chose, instead, to go into family therapy with her two children.

The project coordinator emphasised from the outset that the aims of the pilot were to provide low threshold care and to engage with this cohort of vulnerable women in whatever way was possible. The coordinator described the women as living '*very lonely lives, hiding away from everyone; not wanting friends and family to know about their drug use, and not wanting friends with whom they might have to share their drugs'.* To stay away from crack use while continuing to live in the community is challenging because it is *'too hard to battle with dealers who torment them, inflict a constant barrage of texts with special offers, and allow them to run up debt.'* Hoping to achieve abstinence is challenging because '*they get a double addiction, addiction to crack and addiction to the drugs they use to come down off crack, which include heroin and tablets.'*

Engagement with the four participants was achieved. The project coordinator described the sessions as being *'full of laughter and fun'*. Participants engaged well in some sessions, particularly when a woman in recovery shared her experiences, and on the outing which included a meal and a trip to a bowling alley. Participants appreciated the visit from the public health nurse, the HSE session on harm reduction, and the talk given by Des Corrigan, the HSE Outreach Officer. Only one participant attended the relapse prevention session, so this was changed to a key working session. One participant attended the treatment pathways session, but she had been assaulted shortly beforehand and CARP called an ambulance because of the severity of her injuries. SWAN Family Support provided a session of auricular acupuncture, but only one participant attended. None of the participants wanted to take up the options of counselling or key working support. Nevertheless, application of the Happiness Scale showed an improvement for all four participants over the duration of the pilot, and one participant achieved two clean urines.

The project coordinator described the pilot as making a small but important contribution to TDATF's family support initiatives. Participants were given two substantial hampers of dried food; one woman went into family therapy with her children, and all participants recognised the support and care that CARP offers if they wish to engage further. The participants want the project to continue.

The project coordinator described the pilot as *'challenging, yet providing a vital service'.* Future delivery of the project will consider alternating sessions at CARP with outreach to participants' homes, and the project coordinator expressed the intention to work closely with HSE Outreach.

The project had an underspend because of the low number of participants attending. An intervention of this kind is unlikely to be measurable in terms of staff inputs versus client outcomes; nevertheless, the four participants improved on the Happiness scale; they learned how to stay safe, and they have improved knowledge of, and access to, service supports.

Table 2 CARP's incentive-based structured programme

Session Date	Them/Activity Type	Attendance Women
28/09/2018	Intro/Services Offered/Programme content/Rules for group and staff/Happiness Scale.	**5**
05/10/2018	Check In /Hair and Make up	**4**
12/10/2018	Check In/Mental Health Nurse Advice	**2**
19/10/2018	Check In/HIV HepC Harm Reduction Session	**3**
26/10/2018	Check In/ Speaker Des Corrigan Effects of Crack	**4**
02/11/2018	Happiness Scale/ Check In/Recovery Speaker	**4**
09/11/2018	Check In/Outing Bowling Alley/Meal	**2**
16/11/2018	Check In/Relapse Prevention Session Did Key-Working with the one client.	**1**
23/11/2018	Check In 2x Girls Makeover Treatment Options/Pathways.	**2**
30/11/2018	Check In Auricular Acupuncture	**1**
07/12/2018	Check In/Programme Review	**2**
14/12/2018	Check In/Happiness Scale/Certs/Vouchers Presentation/Meal Celebrations.	**4**

2.3.2 JADD

JADD is located in the heart of Jobstown, another deeply disadvantaged area of Tallaght. The JADD coordinator reported a marked rise in the number of people presenting with crack cocaine issues in recent years. Of the 55 clients attending the methadone program, 22 (40%) have self-reported current crack use since January 2018. Since December 2017, of the 24 service users who are not engaged with the methadone clinic, 17 (70%) have self-reported using crack regularly, and described it as their primary substance.

In the past, crack and cocaine use would normally present as 'other', and not the main problematic substance in treatment statistics. However, over the last two to three years it has been reported increasingly as a primary drug of choice. This is particularly the case among females.

The coordinator reported that almost all crack users attending JADD are taking some form of CNS depressant, with a high prevalence of pregabalin use (Lyrica).

Like CARP, the project coordinator described the rapid and devastating negative impact of crack. Whereas people could manage their lifestyles and their children when taking opiates, crack renders lives with immediate and complex needs. For example, of the 13 clients engaged in the programme through either the harm reduction sessions and / or the abstinence programme, five self-reported previous engagement in sex work.

As in Killinarden, crack dealers are selling in visible public places, group texts are used to alert users to availability, and 'special deals' recommending quality and price are frequently offered. The coordinator explained that these group texts are causing service users considerable problems because it becomes easy to rack up large bills, and it is almost impossible to stop the group texts.

Welfare concerns for children of crack parents are considerable. Services are cut off in homes because bills are not paid; sex work may take place in the home, and children are presenting to JADD's childcare facility hungry and unwashed.

2.3.2.1 Findings of evaluation

The pilot is based on Rugby House interventions (Section 1.6.1) which has two themes: harm reduction, and abstinence.

JADD recruited 20 clients to the pilot, which was delivered over 16 weeks. All participants attended the harm reduction sessions. Thirteen regularly attended group work and key working. Of the 13, eight were female and five were male. Ten were parents.

Six harm reduction sessions and 32 group sessions (16 sessions for men, and 16 for females) were delivered. JADD allocated 208 key working sessions to the pilot, but only 145 sessions were used. The coordinator explained this was because of the chaotic nature of participant's lifestyles, which made it challenging to arrange appointments in advance and expect the client to attend. Instead, the pilot used a high number of Brief Interventions (416) to support participants.

Overall, the pilot was successful in terms of reduced use. Of the 13 participants, 11 reported a reduction in their use over the 16 weeks, which they attributed to the information provided in the harm reduction sessions. Of the 11, 10 participants (five female, five male) succeeded in stopping their cycle of use for multiple days, and two have stopped using since completing the programme.

Participants described the harm reduction sessions as very helpful, and the facts they learned encouraged them to reflect on their use and identify ways to reduce harm. They have reduced risky behaviour by recognising the impact of their environments, including learning to disengage from crack houses, and to avoid certain places and days when they would be most likely to encounter dealers. The coordinator explained that, whereas males are likely to purchase drugs by going to a dealer's home, females are more likely to buy in the streets. For instance, dealers target people coming out of the post office; trying to avoid this interaction may be more challenging for females than males. Other ways participants have reduced harm is by using crack pipes obtained from needle exchange, learning to rest more, and trying to stay drug free during the day.

The coordinator explained that the group work sessions did not work well. There were in-house challenges because some participants were involved in 'partnership' arrangements with other services users. Females were more likely to be part of a partnership, in which several people support each other in purchasing and using crack. Females also found it more difficult than men to sustain presence and concentration during a group session. In contrast, key working sessions were very successful as long as staff could maintain a high level of flexibility to respond to a participant's needs as and when it was required, rather than allocating specific appointment times.

The coordinator highlighted the value of the Rugby House Client Monitoring Forms (CMF), which he had not predicted at the outset. The CMF is a self-reporting form which is completed by a participant each week with the support of a key worker. It examines lifestyle relating to drug use, with a set of multiple-choice questions that have a point system connected to the answers. Participants became

motivated to try and reduce their number of points each week, which they could achieve in a variety of ways. For instance, a participant may have felt they could not reduce their use in any one week, but they were able to reduce their points by getting more rest, or taking time to eat well.

From a service perspective, the coordinator described the pilot as putting considerable pressure on staff, all of whom worked many additional unpaid hours just to keep on top of the number of Brief Interventions that were needed. Compared to a client presenting with alcohol issues, the coordinator explained that a client presenting with crack misuse is three times more intensive in terms of staff input.

Nevertheless, the programme has led to an increased level of transparency within the service and it has led to more meaningful dialogue with clients about their drug use. Before the pilot, there was a tendency for clients to avoid discussing crack issues, but now they are more comfortable seeking support. The Coordinator described this as the biggest benefit to JADD.

Two children engaged with childcare. When questioned about this low number, the coordinator explained that this may be due to parents' concerns about child welfare issues.

2.3.2.2 JADD's recommendations for future delivery of the intervention

The project coordinator and staff working on the pilot are strongly motivated to continue with delivery of this crack-specific intervention and they highlighted the value of the pilot in identifying what works well and what does not. Sadly, now the pilot has ended, it is almost inevitable that some participants will relapse.

Future delivery of the intervention raises several resource issues:

- A dedicated worker is required to meet the needs of this cohort of vulnerable people who require intensive support over several months, not weeks.
- The pilot has been successful because of the dedication and determination of the JADD team, but it required intensive effort which could not be maintained without additional resources.
- Key workers and other staff require an extensive range of skills in order to meet the needs of crack users, including group facilitation and drug counselling skills, with specific expertise in suicide, self-harm, sex work, intimidation, and trauma. Further staff training is essential.

Table 3 JADD's structured programme

Session Date	Them/Activity Type	Attendance Men	Attendance Women
12/09/18	Introduction & 12 week goals	**3**	**4**
19/09/18	How crack and cocaine work	**5**	**6**
26/09/18	How crack and cocaine work	**3**	**3**
4/10/18 **/** 05/10/18	Health implications	**5**	**4**
11/10/18 **/** 12/10/18	Closing the door on scoring	**3**	**5**
18/10/18 **/** 19/10/18	Cycles of use	**4**	**5**
25/10/18 **/** 26/10/18	Patterns of use	**4**	**2**
31/10/18	How Crack and Cocaine work	**2**	**3**
01/1/18 **/** 02/11/18	Triggers	**4**	**2**
08/11/18 **/** 09/11/18	Cravings	**5**	**0**
07/11/18	Art Group	**3**	**4**
15/11/18 **/** 16/11/18	Euphoric recall	**2**	**1**
13/11/18	Art Group	**3**	**3**
22/11/18 **/** 23/11/18	Connections with crime	**5**	**0**
21/11/18	Art Group	**2**	**4**
29/11/18 **/** 30/11/18	Potentially dangerous situations	**4**	**0**
28/11/18	Art Group	**4**	**1**
13/12/18	Graduation closing session	**5**	**4**
19/12/18 **/**20/12/18	Xmas relapse prevention session	**4**	**2**
02/01/19 **/**03/01/19	Group review post Xmas	**2**	**0**

2.3.3 NHRC

Unlike CARP and JADD, NHRC is residential, and it is faith-based with an ethos of Christian values, acceptance into a community, and strong peer support.

The main residential unit has 16 beds for men, and three recovery houses with three residents in each. The standard programme consists of a 12-month residential with GP-facilitated detox during the first four weeks. At six months, residents get their phones back, have access to their own money, and start to participate in education and work-based training programmes. Outcomes are good, and a significant proportion of residents achieve long term abstinence.

The coordinator and programme lead described a significant increase in young service users presenting with crack cocaine issues. They tend not to be opiate users, have not previously accessed treatment services, and they are likely to have been involved in drug dealing and criminal activity. Cocaine may have been their first drug of choice, but they tend to move quickly into more complex drug use patterns.

2.3.3.1 Findings of evaluation

Like JADD, NHRC adopted the Rugby House model although the influence of a residential setting where participants were free of the negative influence of the communities in which they live, had a significant impact on how the model was delivered.

Twelve clients started the 12-week pilot and eight completed the course. Three stopped because of college or employment commitments, and one left because he left the residential programme.

The pilot consisted of a group session each Wednesday morning, which lasted from 9.30 to 12.00. Harm reduction was not included and it was regarded as not relevant because drug use, including tobacco use, is stopped immediately on entry to the residential facility.

The weekly sessions used the tools from the Rugby House model. Overall, staff and participants felt that the interventions were beneficial, with effective motivational tools and goal setting exercises to complete in key working sessions. The coordinator described the Rugby House model as providing 'real focus'. The CMF form, which JADD found useful, was not relevant in an abstinence based residential setting. The coordinator described the amount of written material contained within the Rugby House document as being intensive for the 12-week course, and it would have been easier to deliver if the course had been longer.

The project took the approach of reading the material to participants in each weekly session, followed by discussion. Topics of most interest to participants were triggers, cravings, euphoric recall, connections with crime, and potentially dangerous situations.

NHRC included outreach in the pilot project. Flyers on crack cocaine were prepared and distributed to households in the Tallaght area over four Thursday afternoons, which involved two members of staff over 20 hours. Two members of staff then went into the city centre on Friday nights to meet people face to face, to engage with them around their drug use, and to advise on rehabilitation options. Outreach was conducted for four hours a week over 12 weeks (96 hours). Substance misuse issues encountered during outreach were crack, methadone, heroin, alcohol, benzodiazepines, and cocaine.

Staff feedback on the pilot was positive. They liked the course content and how it was presented. Staff concluded that it will be beneficial to run the course twice a year to enable delivery to all new clients entering the residential setting. It was very beneficial to have a focus on crack cocaine because, although NHRC is abstinence based and clients were not active users, the group session on triggers generated considerable interest. NHRC will include more supports on triggers if the course is delivered again.

The course content raised mixed reactions, emotions and memories for clients. This made some group sessions challenging to facilitate, but it was beneficial for clients to work through issues relating to past use. Staff feel that the Rugby House model is transferrable to all substances and was relevant to all clients, not just crack cocaine users. The group work topics stimulated much interest among staff and clients, and this was very beneficial.

The pilot was challenging to deliver, particularly the requirement to complete all key working sessions within the time frame, and it was felt there was not sufficient time to allow for meaningful individual key working sessions. There was a tendency for key working sessions to be dominated by course material which meant that other aspects of a client's needs were not getting sufficient attention.

Staff endeavoured to follow the course content as closely as possible, although some tools such were not relevant in a residential setting. However, the coordinator emphasised that the course could be optimally effective if a less prescriptive approach is taken and there are minor adjustments to the time frame, with more individual key working sessions, and some topics extended over two weeks.

Table 4 NHRC's structured programme

26.09.18	Session 1 Introduction & 12 week goals
Week 1	1 to 1 key working session
03.10.18	Session 2 How Crack and Cocaine work
Week 2	1 to 1 key working session
10.10.18	Session 3 Health Implications
Week 3	1 to 1 key working session
17.10.18	Session 4 Closing the door on scoring
Week 4	1 to 1 key working session
24.10.18	Session 5 Cycles of use
Week 5	1 to 1 key working session
01.11.18	Session 6 Patterns of Use
Week 6	1 to 1 key working session
07.11.18	Session 7 Triggers
Week 7	1 to 1 key working session
08.11.18	Outreach door to door leaflet drop
09.11.18	Networking with drug services via calls and emails
14.11.18	Session 8 Cravings
Week 8	1 to 1 key working session
15.11.18	Square leaflet drop
16.11.18	Information sharing with homeless services
21.11.18	Session 9 Euphoric recall
Week 9	1 to 1 key working session
22.11.18	Outreach door to door leaflet drop
28.11.18	Session 10 Connections with Crime
Week 10	1 to 1 key working session
29.11.18	Outreach
05.12.18	Session 11 Potentially dangerous situations
Week 11	1 to 1 key working session
12.12.18	Session 12 After care and Support
Week 12	1 to 1 key working session
13.12.18	Last outreach in city before Christmas

2.4 Strengths and challenges of the pilots

The experience and skills of CARP, JADD, and NHRC to deliver the crack cocaine pilots are unquestionable; however, the TDATF Rehabilitation Coordinator expressed some concern that sufficient time was not taken at the outset to ensure the structure of each pilot was fully evidence-based and the outcomes measurable and achievable.

The strengths of each pilot, and the challenges arising are discussed in this section.

2.4.1 CARP

Intervention approach

CARP's main goal in the pilot was to encourage attendance with the aim that time spent within a supportive and structured setting would provide essential respite to crack cocaine users and their children. CARP adopted the CM approach, which has been proven to be effective, as shown in the study by Miguel et al., (2018) and described in Section 1.6.2. In Miguel's study, participants were encouraged to attend sessions three times a week which included 90-minute group meetings on relapse prevention, including coping skills training, 90-minute occupational therapy sessions, at least one individual session a month with a psychiatrist, and weekly psychotherapy sessions, in addition to the monetary incentive based on negative urine samples at each session.

The CARP pilot differed from Miguel's study in that a monetary voucher was awarded for attendance, and an additional monetary incentive was awarded if and when urine samples were negative. Also, the funding allocation for the CARP pilot was insufficient to facilitate the intensive interventions offered in Miguel's study, and allowed for only one group session a week with signposting to additional treatment services provided for all clients in CARP, including key working.

Client group

CARP was realistic in its expectations of the client group and it used the measure of attendance as the main outcome. Of the six crack cocaine users who started the course, four completed. One participant achieved two consecutive urine samples over the 12 weeks, and all participants improved on the Happiness scale, indicating that the course helped participants to feel a greater sense of wellbeing and support.

CARP's primary intention in delivering the crack pilot was to engage the most vulnerable women in the community in order to provide some safeguard for their children. Teaching crack-using parents about minimising harm in their daily drug-using lives, and providing sufficient support so they could trust the services that CARP offers, were two major achievements. These are not measurable in the short term, but they also represent a vital intervention, which will become an ocean of improved care if replicated a sufficient number of times. Without these low threshold interventions, child welfare and family issues may quickly reach crisis in crack-using communities.

2.4.2 JADD

Intervention approach

JADD's main goal in the pilot was harm reduction, with the expressed intention of safeguarding the children of participants. Part of the funding allocation was dedicated to provision of childcare. The Rugby House model was adopted, starting with sessions on harm reduction and then moving into an abstinence programme, which included group sessions and individual key working.

The six harm reduction sessions and individual key working proved to be successful in engaging participants; Group sessions were difficult, largely because of group dynamics and participants' poor attention spans. Although JADD allocated a significant number of key working sessions to the pilot

and funded childcare provision, these supports were not taken up by participants at the level expected. Instead, staff put in many unpaid hours to deliver the significant number of Brief Interventions that were required. The pilot proved to be resource-heavy in this respect.

Client group

Twenty participants regularly attended the harm reduction sessions, and 13 participants engaged in the group work and key working. Two of 13 participants stopped use as a result of the course and 10 stopped for multiple days. All 13 participants reduced use over the 12 weeks. Sadly, there are likely to be relapses without continuation of the intervention.

2.4.3 NHRC

Intervention approach

Like JADD, NHRC adopted the Rugby House model but within a residential setting. The two settings have created an opportunity to examine the success of the model in the different settings. Reduced use and achievement of abstinence cannot be measured at NHRC because all residents become abstinent on arrival at the residential facility. The harm reduction component of Rugby House was not relevant, and some of the tools, such as the CMF tool were not useful in that setting. However, with some modifications, including delivery over a longer time period (20 weeks rather than 12), the coordinator concluded that the model is a valuable tool and staff felt it led to interesting discussion and insight.

Client group

Twelve participants started the training and eight completed. Participants engaged particularly with the session on triggers, and NHRC recommend that this topic is covered over more than one week in future courses.

2.5 Questions asked before interview

A set of questions were sent to project coordinators prior to interview. Answers are summarised in Table 3.

3 Conclusions

Evaluation of the three pilot studies has facilitated an evidence-based comparison of two crack cocaine intervention models (Rugby House and CRA), and it has also provided the opportunity to examine the delivery of the Rugby House model in two different settings, residential and community.

Both models led to positive outcomes. NHRC pointed out that some of the Rugby House tools are not relevant for a residential setting. All three coordinators felt 12-weeks was too short for effective delivery, and NHRC suggested that 20 weeks would be more suitable.

The coordinators and staff in the three projects highlighted that the delivery of the intervention has brought considerable insight and learning, providing a foundation for effective future delivery. The coordinators are clear about what is needed for future roll-out, as follows:

- A dedicated worker is required to deliver the programme and sustain the high input of Brief Interventions that are required, with sufficient flexibility to meet the needs of clients as and when they are needed. A characteristic of crack users is their inability to maintain structure

in their lives, remember what is expected of them, and attend appointments. Their lives tend to be chaotic and crisis-driven. The capacity to respond to a crack using client with flexibility, patience, and understanding are key factors in successful engagement.

- Ongoing staff training is required to ensure that staff are equipped to effectively relate and support crack clients who are likely to be very vulnerable with complex needs. Training in group facilitation, drug counselling with special emphasis on trauma, suicide, self-harm and intimidation are necessary.
- The programme needs to be sufficiently resourced in order to provide intensive interventions over a period of months. The Miguel study on the CRA approach highlights the level of intervention required.
- NHRC recommended that the programme is delivered twice a year to include all new intakes into the residential facility.
- All programme coordinators stressed the need for the intervention, particularly to meet TDATF's strategic theme of family support. Children of crack-using parents are likely to experience high levels of disadvantage and risk.

3.1 Participant progress

The interventions delivered measurable outcomes, including improvement on the Happiness scale, reduced use, increased awareness of the impact of negative environments, and increased awareness of how to reduce harm. Some participants achieved abstinence and others achieved multiple abstinent days.

NHRC highlighted participants' level of interest in the session on triggers, and will expand on this in future delivery.

Retention was also good. Four of six participants completed the programme at CARP. All twenty participants actively engaged in the harm reduction component at JADD, and 13 participants engaged in group work and key working. The coordinator described key working as successful, but group work failed to engage more than a few participants each week. Eight of 12 participants completed the programme at NHRC.

The coordinators all highlighted the problems that crack cocaine users face in their local communities because of the insidious presence of drug dealers. Crack is psychologically and physically addictive and it may be almost impossible to achieve abstinence in an environment of persuasion and intimidation at every street corner. For this reason, NHRC provides an invaluable resource because it provides a strong and positive community-based ethos in a residential setting. This means that participants attending the crack pilot could escape their negative home environments. The intensive four-week detox that all residents go through when they first arrive allowed participants to go through the physical and emotional withdrawal in a safe and supportive setting. The faith-based community helped participants establish new, healthier relationships with their peer group.

3.2 Contribution to family support

The published literature on crack use highlights the child welfare issues that can arise when parents are using crack cocaine, and the reports from the three projects highlight that significant child care concerns exist in Tallaght as a result of crack use. The low uptake of childcare provision at JADD may reflect parents' fear that their children could be taken away from them. Several parents are known by the three services to have children already in care.

The three crack cocaine interventions directly meet TDATF's strategic aim of increasing the level of family support for vulnerable families, particularly in addressing hidden harm. CARP highlighted how crack using women may hide from their families and communities and remain hidden from service support. The CARP and JADD interventions are particularly valuable in this respect because they targeted vulnerable women, and the programmes helped to break down barriers so that women began to trust that help can be available, even if they did not take it up fully during the pilots.

3.3 Value for money

An assessment of each intervention's value for money, based on resource input versus output concludes that the three pilots represented very good value. There were measurable outcomes, and participants and staff benefited considerably from the learning experience.

However, all projects reported that sufficient resources are critical to deliver a crack cocaine intervention on an ongoing basis, because client needs are complex and require intensive support. Given sufficient funding, TDATF could be confident that the three projects will deliver interventions which, from a child welfare perspective, are vital and urgent.

4 Recommendations

The evaluation concludes that CARP, JADD, and NHRC have succeeded in adapting the Rugby House and CRA models over 12–16 weeks to deliver crack cocaine interventions which have resulted in positive, measurable outcomes. The budgets to deliver the pilots were less than €10,000 for each project.

- The pilots made a significant contribution towards meeting TDATF's strategic aim to address family support and hidden harm in Tallaght's communities and, as such, it is recommended that the interventions are prioritised as part of each project's core activities.

- The pilots represented good value in terms of resource input versus client outcomes. However, all projects highlighted the intensive and demanding nature of the work. JADD reported that staff inputted a substantial number of unpaid hours in order to meet clients' needs. Ring-fenced funding is required to deliver these interventions on an ongoing basis, including a dedicated and skilled project worker in each project.

- Each project should be encouraged to adapt the Rugby House and CRA models in a manner that best fits their in-house approach, and based on the evidence arising from the pilots as to what works and what does not. For instance, some of the Rugby House tools are not relevant in a residential setting. Group work at JADD was not successful, but the harm reduction sessions and individual key working worked well.

Table 3 Answers to questions sent before interviews

Question	
Is there evidence for crack use amongst specific groups of people. For example, crack use is frequently linked to women involved in the sex trade, and West Africans and Travellers (frequently linked to crack dealing). If so, has your project been successful in attracting specific groups and how have you achieved this? If not, what can your project do to reach out and engage vulnerable people?	CARP and JADD have focused on vulnerable women, some of whom may use sex work as a way to earn income. NHRC reported that a number of participants would have been involved in criminal activities prior to entry to the residential. A significant proportion of participants attending the pilots at CARP and JADD are experiencing homelessness.
What backgrounds do service users come from, e.g., homeless, professionals, unemployed?	Primarily from disadvantaged backgrounds, with some at risk of homelessness.
Is there evidence for second or even third generation crack use?	CARP and JADD reported second generation crack and cocaine use.
What is the age group of crack cocaine users in your project's experience? Is it changing?	NHRC reported an increasing number of young people (18-23 years) are seeking residential treatment. Five participants were <18 years old when they first used crack/cocaine. CARP reported young teenagers aged 13 and 14 years dealing in crack and some are using it.
What is the nature of crack use. For example, what proportion of users are smoking vs. injecting. Are they engaging in high risk behaviour?	The majority of participants attending the 3 pilots are smoking crack. One CARP participant may be injecting.
How is crack used: with heroin, with methadone, with benzos and other pills? To what extent do users regard crack use as 'other', or have they identified it as a primary problem?	JADD reported that almost all participants are using CNS depressants (e.g., Lyrica). The client group in all 3 projects tend not to be recreational cocaine users, but using crack with heroin, methadone and / or tablets. Of 9 NHRC service users assessed prior to the pilot, 8 combined crack cocaine with heroin, 4 with methadone, 5 with benzos, and 3 with 'other'.
Do crack users use other stimulants?	There is no evidence for crystal meth in the Tallaght community. Of 9 NHRC participants assessed prior to the pilot,6 answered yes to using other stimulants.
What impacts on health have you observed or recorded among service users? Do you provide any specific health-related service; for e.g., opportunity to meet with a nurse or GP, links to other primary health care?	Physical and psychological health impacts are severe. CARP and JADD reported concerns about child welfare among crack using parents. All pilots provide links to GP, public health nurse, mental health nurse and outreach workers.
What outcomes does your project achieve; for e.g., reduction in level of use,	Over the 3 projects there were measurable outcomes, including

drug free periods, reduced risk taking, improved physical health?	improvement on the Happiness scale, reduced use, increased self-care, increased awareness of negative environmental impacts and tactics to reduce them, abstinence over multiple days and, in some cases, abstinence at the end of the programme.
Does your project involve outreach? If so, what are the outcomes? If not, is outreach necessary or desirable, and what is required in order to provide it?	All projects have an element of outreach, via HSE outreach workers who attend group sessions or via internal outreach workers.
Are the project workers involved in the crack project specifically trained in evidence-based approaches? What other training would be beneficial?	All staff delivering the pilot are highly skilled and experienced. However, all coordinators noted that working with crack users is much more intensive than alcohol or opiate users, and considerable skill and knowledge is required in group facilitation, counselling, and understanding of trauma, suicide, and self-harm.
To what extent does your project raise awareness of crack use among other project workers in your service, and in the local community?	This was not included as part of the pilot
What further actions are needed and how would you like to see your project develop?	Dedicated funding allocation Funding for counselling specific to crack cocaine service Appropriate training in harm reduction information
How does your project fit with the TDATF strategic plan (please be specific)?	Theme 1: Increased service user and community outcomes: reduced hidden harm. Theme 3: Increased capacity: increased capacity to respond to polydrug use.

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Appendix 1 Logic Models

1 CARP

The current situation that needs changing **('the problem statement')**	CARP hopes to put this programme In place, to support the increasing number of female clients presenting to CARP who are struggling with CRACK abuse and the issues that this drug use brings.
Title of Programme /Project or Intervention	CRACK users support group Using the Contingence management approach, one to one support, group support with Contingence Management approach to reward attendance and work towards setting goals
Overall Aim	To engage with CRACK using female clients and offer support in a safe non – judgemental environment using a non – judgemental approach.
Objectives	Engage CRACK using females Provide non-judgemental support in a safe non-judgemental environment Assess the needs of the clients that attend Support the clients to address the needs identified
The needs of the target group?	One to one support: key working, counselling Group support: check in group Crisis management Health support
How were these needs identified? **How were participants /clients involved?**	The needs have been identified by the increased number of female clients presenting to the service struggling with CRACK use and the issues associated with this behaviour. • Engagement through outreach work • Referral from homeless services • Clients attended a support group weekly
Participant's strengths, assets/resources?	• Openness to receive support • Willingness to explore behaviour change
How were these strengths, assets/ resources identified and how were participants/clients	Through engagement when attending CARP for HR services or crisis intervention support Through engagement from outreach work

involved?		
External influences (+ & -)	**Positive external influences (+)** • Children • Family • Non using friends	**Negative external influences (-)** • Increase availability of crack in the area • Social deprivation • Lack of coping skills
Assumptions	It is assumed that by providing non-judgemental support in a safe non-judgemental environment clients will • Feel supported • Receive Nourishment • Engage / reengage with addiction services • Agree to engage with support to address possible health issues • Possibly explore change in behaviour	
The research / evidence i.e. research, evidence of 'what works'	The programme will pull from evidence-based models Contingence management approach CBT MI CRA	

2 JADD

The current situation that needs changing ('the problem statement')	The JADD Project CLG has become aware of an increase in prevalence of Crack Cocaine use within the area and within the service. There is also an increase in incidence of new cases within JADD CLG. • Of the 55 clients attending the Methadone program, 22 (40%) have either self reported current crack use or have been noted by staff to have used since January 2018. • Of the 24 service users who are not engaged with the methadone clinic 17 (70%) have self reported using Crack Cocaine regularly and describing it as their primary substance since December 2017. • JADD needle exchange have regular requests for crack pipes and supports for service users crack use with 126 unique requests since 2016 • There has been 56 unique Harm Reduction clients self referred in to JADD since 2017 reporting Crack use • Total number of service users reporting crack use and children in their care estimated to be 63 of 198 clients (32%) • This is in line with all the feed back in the region of higher numbers presenting to all services. As the impact Crack Cocaine has upon service users lives can become problematic quickly clients are struggling to stay engaged with their care plans and getting periods of stability. • The shift in using trends has put that cohort of client in higher risk as they struggle to engage in their interventions and lose contact with their recovery and rehabilitation supports. • They are also vulnerable to infections and blood borne diseases as they have little access to safe equipment and up to date relevant harm reduction information. Clients are describing in assessment Crack Cocaine use with opiates as a "come down" as well as tablets such as Lyrica. This puts them in a high risk category regarding safety.
Title of Programme /Project or Intervention	Crack Cocaine Program

Overall Aim	To enhance participants Harm Reduction awareness and offer access to crack pipes and safer using practices. Establish positive relationships with the Crack Cocaine using cohort by providing a program where they will build skills in their recovery and develop tools to reduce or stop their use based on evidence based practice. Coinciding with the program the integration of care planning and case management with all JADD interventions and referral to relevant local services/residential services for their broader supports and case management.
Objectives	To understand the participants drug use and respond effectively to their Crack Use with quantifiable outcomes. □ Complete the Drug Use Disorder Identification Test(DUDIT)

3 NHRC

The current situation that needs changing **('the problem statement')**	Concerning Emerging trends in significant increase in Cocaine use in the Tallaght Area and need to address increase in clients seeking treatment for Crack Cocaine addiction from local services.
Title of Programme /Project or Intervention	Crack Cocaine intervention groupwork
Overall Aim	To provide ongoing Cocaine specific groupwork for clients with Cocaine addiction history and preventative measures for clients at risk of Cocaine addiction.
Objectives	• Clients will increase awareness of Cocaine use and behaviours; • Clients will be able to do personal cost benefit analysis on personal cocaine use and how it impacts them, their significant others and local community; • Clients at risk of Cocaine addiction will have been made aware of the dangers of cocaine use and have been given the tools to make informed decisions regarding Cocaine use.
The needs of the target group?	Clients need clear and accurate information about the use of Cocaine, the impacts cocaine has on self, significant others, and society. Clients need to be given resources and tools to support recovery from Cocaine addiction Clients need Cocaine specific focused groups
How were these needs identified? **How were participants /clients involved?**	Through assessment process, current groupwork with clients, client feedback
Participant's strengths, assets/resources?	NHRC has been established in the Tallaght area for 10 years, ECASS stats quickly identify emerging trends, 24 hr staff support for clients in recovery, 24 hr peer support, permanent building, trained and experienced staff
How were these strengths, assets/ resources identified and how were participants/clients involved?	Identified through already established model, assessment process, ongoing feedback, current rehabilitation recovery programme

External influences (+ & -)	• Government legislation/policy/strategy identifying Crack Cocaine problem • Family & Friends encouraging recovery • Social friends in recovery • Local Community pushing for recovery	• Lack of resources and funding from government to meet the demands • Chaotic lifestyle • Drug debts • Family & friends reluctant to support recovery • community
Assumptions	• We assume that if a client is given the appropriate supports that they will be able to recover from Crack Cocaine addiction • We assume that if clients are given the correct information about Crack Cocaine then they will make different, healthier, choices • We assume that if clients at risk of using Crack Cocaine are given correct information then they will be informed and empowered to make right choices regarding first time use of Crack Cocaine.	
The research / evidence i.e. research, evidence of 'what works'	CRA, Cognitive behavioural therapy, MI, matrix Model – National Institute on Drug Abuse Smart recovery	