MAPPING RETROSPECTIVE OUTCOMES AND EXISTING PROCESSES OF THE DUBLIN SIMON COMMUNITY DETOXIFICATION UNIT IN ORDER TO INFORM CLIENT NEEDS AND FUTURE SERVICE DEVELOPMENTS.

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1.0 Introduction

This report was commissioned by the Dublin Simon Community management and leadership team with a view to objectively and independently assessing their service's needs from the perspectives of their clients, staff and governance and procedural processes. This research was conducted by a team from Trinity College Dublin in early 2020 during the COVID-19 pandemic. Fortunately, the analysis of all retrospective databases and governance systems were not impacted by this and all interviews with clients and staff were conducted on a one to one but remote basis.

1.1 Background and context

Dublin Simon Community works to prevent homelessness in Dublin and surrounding counties. They provide services at all stages of homelessness and enable people to move to a place they call home. In addition, people living with addiction are at increased risk of homelessness due to the possibly chaotic nature of their addiction, and a reduced capacity to achieve and maintain employment, leading to instability in their lives and the lives of those around them. The Dublin Simon Community's detoxification unit was set up to mitigate these risks and provide a comprehensive service to homeless clients focusing on health and addiction outcomes as a priority. It is the existing care pathways, processes and outcomes from this unit that is the focus of this research. The mission of Dublin Simon Community is to: Empower people to access and retain a home by providing housing, prevention, addiction treatment, emergency response and other targeted interventions, through advocacy and partnership. The values underpinning this mission are Community; Respect & Empowerment; Excellence & Innovation; Accountability & Integrity.

The 2016 report published by the Health Service Executive (HSE) on homelessness, health and drug use (Glynn, 2016), provided shocking evidence on the impact of drug use on homelessness. Drugs and alcohol deaths increased from 2004 (n= 933) to 2013 (n= 1465), of which 494 deaths were people registered as homeless. Interestingly, 65% of these deaths were reported in Dublin (Glynn, 2016). One of the primary reasons for becoming homeless in 2011 was drug and alcohol addiction (approximately 36%). More recently it was reported that older people who use substances are more likely to experience homelessness and be socially and economically disadvantaged (Comiskey, 2019). There are very few services in Ireland which provide a cross-sectoral integrated care approach to addiction and homelessness, Dublin Simon Community is among the few organisations to provide both services.

Medical detoxification (detox) programmes have been the main types of addiction treatment in Ireland for the past 20 years, in particular methadone detoxification treatment (Delargy *et al.* 2019). A timeline of the development methadone treatment programme is provided in the figure below. Detox programmes provide supervised substance withdrawal which reduces the severity of withdrawal symptoms and other serious medical complications (Timko *et al.* 2014). Detox programmes can be provided in short-term treatment settings (WHO & UNODC, 2020). There is evidence to suggest that detox alone leads to poorer outcomes in comparison to those who receive detox and additional treatments (Timko *et al.* 2014).

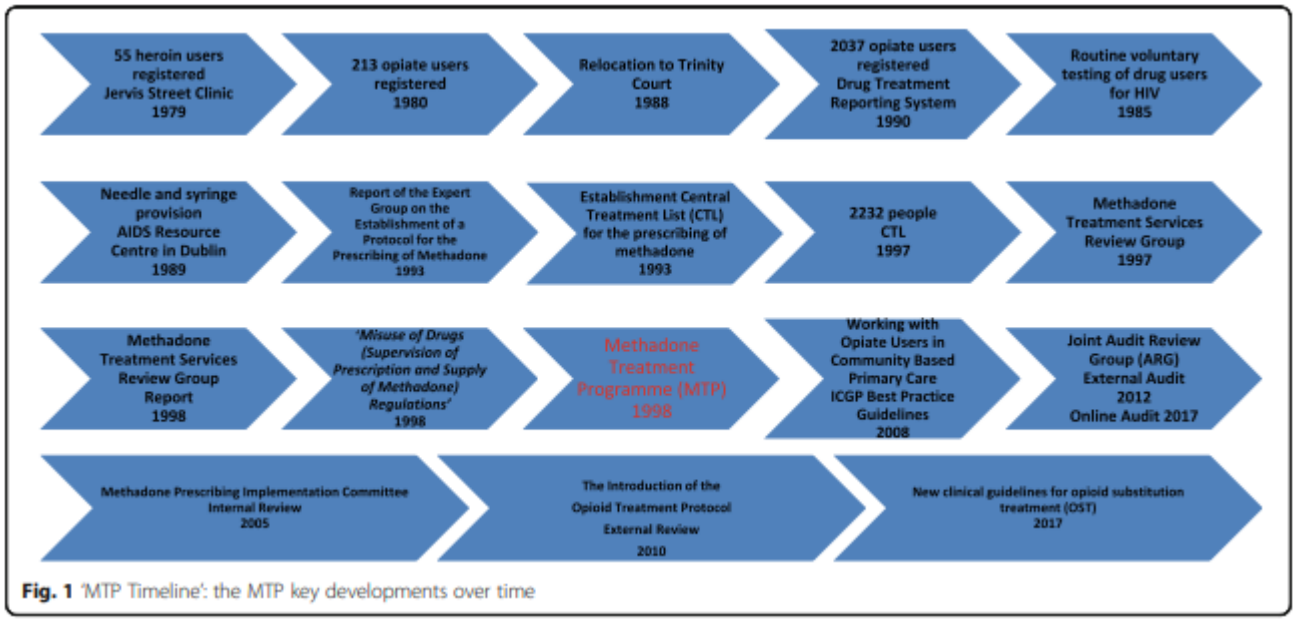

Figure 1: Timeline of Methadone Treatment Programme Development (Delargy et al. 2019)

There are a number of enablers and barriers to accessing detox programmes (Gerassi *et al.* 2018 & Timko *et al.* 2016). According to Gerassi et al (2018), individual level enablers include motivation, health problems or legal problems, loss of housing or relationship (Raven *et al.* 2010). There are two main characteristics of barriers and these are programme-level (e.g. bed availability) and system-level (e.g. lack of coordination between services) (Timok *et al.* 2016). Barriers include stigma, believing that the problem will resolve itself, being treated poorly during the process, waiting times, or providing patient identification (Gerassi *et al.* 2018). A key barrier, mentioned before, includes the transitioning process between services, e.g. moving from a detox programme to a drug treatment programme (Timko *et al.* 2016).

1.2 Aim and objectives of the evaluation

The aim of this research is to identify from the perspective of the client, staff and leadership future service needs by retrospectively mapping existing outcomes and processes of the Dublin Simon Community detox unit in light of its key mission and in line with the value systems of the organisation.

Objectives:

1. Retrospectively audit and analyse, anonymised client needs, care pathways and outcomes over a five-year period from 2015 to 2019 inclusive from existing data systems.
2. The detoxification unit has differing referral pathways. Our second objective is to provide an in-depth analysis of those pathways and to identify from the perspective of the client and the staff, examples of good practice and examples of gaps which need to be targeted.
3. Analyse governance, management and leadership to identify needs going forward.

2.0 Methodology and ethical considerations

The aim of this research was to identify from the perspective of clients, staff and leadership, future service needs. To achieve this, the research was planned within the context of an implementation science framework with emphasis on Stage 4 of the implementation process. Stage 4 is full implementation**.** Implementation science can be defined as "the study of the process of implementing programmes and practices that have some evidence from the research field to suggest they are worth replicating. It is the study of how a practice that is evidence-based or evidence-informed gets translated to different, more diverse contexts in the real world" (Metz, Naoom, Halle, & Bartley, 2015, p. 1). The work of Comiskey and colleagues was drawn upon because of its relevance to implementation within healthcare contexts (Comiskey et al., 2015; Comiskey & Sheehan, 2017; Sheehan, Comiskey, Williamson, & Mgutshini, 2015). Using an implementation science framework, enablers and barriers to implementation were explored.

2.1 Study design

A concurrent mixed methods study design was conducted. Both quantitative and qualitative approaches were fitting involving both an objective measurement of need and processes from the existing client database, an objective review of need as evidenced assessment of need from the perspective of the client and staff within the service.

2.2 Methods and data analysis

The methods varied according to the objectives of the evaluation. The methods included:

- ***To address objective one*** a quantitative retrospective audit and analysis of an anonymised database of client needs, care pathways and outcomes over a five-year period from 2015 to 2019 inclusive from existing data systems took place. The data was provided in an irrevocably anonymized format by Dublin Simon Community service. A descriptive analysis summarising the key features of the client database over the five-year period was carried out. Changes in client characteristics and processes and outcomes over time are presented. Where possible longitudinal outcomes for the cohort of returning clients are described. The sample includes all client pathway data for all clients who attended the detox unit from 2015 to 2019.
    - **Database management** protocol consisted of data cleaning, data conversion from excel to SPSS, and visual data checks to ensure accuracy. The data conversion was completed in consultation with Dublin Simon staff to ensure accurate interpretation of client information, e.g., categories of source of referral varied across the five years. In consultation with the staff member, a list of categories was finalised.
    - **Descriptive analyses** were conducted on key variables across the five years, these included frequencies, percentages, minimum, maximum, mean and standard deviation.
    - **Inferential analyses** were also conducted on the key variables across the five years, these included Mann Whitney U tests and Chi Square tests where appropriate.

- **Longitudinal findings** are reported for five clients who has accessed the services between 2015 and 2019. Results are reported in two formats: Firstly, aggregated findings of four clients (tables in appendix) and secondly a detailed care pathway using infographics is used to present the journey of one illustrative client journey.

- ***To address objective two*** qualitative one to one telephone interviews with relevant staff, and clients were conducted. The original plan for the research involved face to face interviews, but in light of COVID-19 restrictions, a decision in relation to health and safety of clients and staff, resulted in telephone interviews being the suitable method. The sample the client interviews were drawn from, was purposive. The detox unit has varying referral pathways, hence three case studies involving client telephone interviews and numerous relevant staff telephone interviews took place. The Head of Treatment selected one indicative case per each of three possible clinical care pathway and the personnel involved in these three cases were invited to participate in the research. Data arising from these interviews was audio recorded using a dictaphone and transcribed. A thematic analysis cognisant of the mission and values was conducted to elicit from the staff and client perspective where the greatest needs and gaps or barriers to services were present across the varying case study scenarios.

2.3 Ethical and other considerations

The research team were aware of the challenges of conducting sensitive evaluations in real-life settings. The research team also had extensive experience in the application of good research practice, of ethical clearance criteria and of Irish and EU data-protection legislation. Team members were familiar with the Trinity College Dublin Policy on Good Research Practice and with The World Medical Association's Declaration of Helsinki, which sets out ethical principles for the conduct of medical research involving human subjects. The study obtained ethical approval from Trinity College Dublin, the University of Dublin.

2.4 An implementation science framework

The findings from the various data sources were applied within the implementation-science framework. Comiskey and Sheehan (2017) have discussed the use of implementation science in healthcare. Referring to the key literature, they note that implementation has been described as "making it happen", rather than simply "letting it happen" or "helping it happen". Implementation science focuses on the strategies that can promote implementation success and on the theoretical underpinnings of these strategies. Metz, Naoom, Halle, & Bartley (2005, p.1) define implementation science as "the study of the process of implementing programmes and practices that have some evidence from the research field to suggest they are worth replicating." These authors further characterise implementation science as "the study of how a practice that is evidence-based or evidence-informed gets translated to different, more diverse contexts in the real world." Much of the recent implementation-science research has focused on understanding factors that facilitate and hinder successful implementation.

There is an emerging body of research, that defines the key components and processes involved in effective and successful implementation. In particular, the research indicates that the implementation process is accompanied by distinct stages of development and particular activities.

2.5 Stages of implementation

The research shows that implementation is a process that takes time and occurs in incremental stages, each requiring different conditions and activities. Different authors assign different labels and meanings to the various stages of implementation. In summary, however, the research points to four stages of implementation. The first two stages (stages 1 & 2) involve exploratory and planning activities. Following this, the innovation is implemented (stage 3), before it is fully embedded in the system and evaluated (stage 4). Within the current evaluation, the Dublin Simon Community service is at Stage 4, Full Implementation.

Each stage is essential to the implementation process and cannot be skipped. However, those implementing the innovation may need to revisit earlier stages to address challenges and ensure continued support and capacity. Implementers must also be mindful of adopting realistic timeframes. The literature indicates that completing the four stages of implementation (stages 1-4) typically takes two to four years. The four stages, as summarised by Fixsen et al (2005) are illustrated and described in Figure 1 below.

Figure 2: The Four Stages of Implementation Adapted from Fixsen et al. (2005)

Another trend in the implementation literature is the examination of the factors which facilitate effective implementation. A range of terms are used in the literature to refer to these factors, including implementation enablers, drivers, facilitators, and the core components of implementation. For the sake of simplicity, we refer to them here as implementation enablers. Despite the field not yet reaching a consensus on the exact enablers, certain factors emerge consistently from the research, as illustrated in Figure 2.

What is also clear is that certain implementation enablers are required throughout different stages, in the process to drive implementation, and that the integration of these factors is vital to implementation success. The relative importance of each of the implementation enablers will vary depending on the innovation being implemented, and the context and setting in which it is implemented. Key implementation enablers and the stages at which they typically come into play are illustrated and described in Figure 3.

Implementation Enablers	Stages of Implementation			
	1. Exploring & Preparing	2. Planning & Resourcing	3. Implementing & Operationalising	4. Business as Usual
Stakeholder consultation and buy-in				
Leadership				
Resources				
Implementation teams				
Implementation plan				
Staff capacity				
Organisational support				
Supportive organisation culture				
Communication				
Monitoring and evaluation				
Learning from experience				

Figure 3: Implementation Enablers and Stages, adopted from Burke, Morris and McGarrigle (2012)

According to Burke, Morris and McGarrigle (2012), barriers to implementation are grouped under three headings, namely, the external environment, vested interests, and resistance to change. The framework in figures 2 and 3 above were used to summarise the process evaluation data arising from the multiple methods and to synthesise the findings on implementation.

The range of data sources captured were selected to ensure that sufficient evidence would be available to adequately map the process of implementation of the detoxication service against the contents of the framework. A triangulation approach was used to analyses all the data that was accessed. Triangulation is the continual process of collecting and cross-checking information. Using a combination of different methods and different data sources, a crosscheck was

carried out to check for contradictions, conflicts or consensus between different data sources. At roundtable discussions involving the full research team, the various data sets were repeatedly compared. This ensured that any inconsistencies in the data were identified.

2.6a Key stakeholder staff interviews

The detox unit has three main referral pathways hence three client case studies representing each of these pathways was chosen for the study. In order however to ensure that the voice of female clients was also captured where possible, this resulted in two client cases being selected for one of the care pathways - one male, one female. Staff who were involved in the delivery of care of these clients were invited to take part in the interviews. A total of five staff were involved in the service delivery process of these four clients. All five staff consented to taking part in the one-to-one interviews.

Interview duration averaged 45 minutes. The interviews yielded a total of ninety pages of transcribed text. The following is an outline of the key topics the participants were asked about during the interviews.

- The main enablers for successful navigation of the clinical care pathways for clients – what works well
- The main barriers for successful navigation of the clinical care pathways for clients
- Capacity of the organisation to meet client needs and respond to new and emerging challenges
- Key needs of the service
- Changes that are needed to ensure best experience for clients
- Alignment of service to the values underpinning the service mission

This thematic analysis of these interviews was informed by the science-of-implementation framework's enablers and barriers and guided by the methodology of Braun and Clarke (Braun & Clarke, 2006).

2.6b Key stakeholder client interviews

Four clients took part in one-to-one telephone interviews. The sample the client interviews was drawn from, was purposive.

Clients were asked about their experience of their care pathways, exploring what worked well, and what needs to be improved. The following is an outline of the key topics the clients were asked about during the interviews.

- Describe their journey within Dublin Simon Community service in terms of the care pathway they had been through- what worked well, what were the positive aspects of the service, and what were the main challenges
- From their experience, what were their key needs during the process and whether they were met by the service
- Were any changes needed and where changes were needed, was there an opportunity to voice those suggestions, what was the experience of being able to raise those issues and the outcome of the process

- What were key needs and were they being met by the service
- Alignment of the service with the values underpinning the service mission
- Key needs for future service delivery

2.6c Retrospective monitoring analysis

Retrospective outcome measures were analysed quantitatively using Dublin Simon Community monitoring data from 2015 to 2019. Descriptive and inferential analyses were conducted (see section 3.1.1) and longitudinal analyses were conducted for five cases. An in-depth analysis was conducted for one client, and this is reported in section 3.1.2.

3.0 Findings

3.1 Retrospective analysis of client pathways and outcomes (2015-2019)

This section presents the findings from the audit and analysis of anonymised client needs, care pathways and outcomes over a five-year period from 2015 to 2019 inclusive from existing data systems. The database consists of 5 years of data with 178 entries for 2015, including repeat admission from the same clients. This increased in 2016 (n=189), 2017 (197), and in 2018 (n= 203). However, in 2019 there was a drop in client data entries to 182.

Table 1 below provides an overview of the key demographic variables of the clients from 2015 to 2019. From this we can clearly see a slight but significant decrease in the age of clients accessing the service during the five-year period from an average age of 49 in 2015 to an average age of 44 in 2019. More importantly we can also see that the duration of periods of homelessness have increased from 63.5% reporting periods of homelessness of more than one year in 2015 to 89.1% reporting this in 2019. A small but significant increase in repeat attenders as opposed to new clients was also observed in the results between 2015 and 2019. Finally, while not statistically significant a large increase in the proportion of clients reporting substance use was observed with 33.5% reporting substance use in 2015 and 91.9% reporting this in 2019.

Further analysis of clients' participation in various programme provided by Dublin Simon Community, including discharge and referral data was conducted and details are provided in the appendix. No major changes were observed in the five-year period. Finally, a summary of the demographic findings is provided in section 3.1.1.

Table 1: Demographic Findings for 2015 to 2019

Variables		**2015** (n= 178)	**2016** (n= 189)	**2017** (n= 197)	**2018** (n= 203)	**2019** (n= 182)	χ^2 **/ t-test 2015 & 2019**
		n (%)	n (%)	n (%)	n (%)	n (%)	
Age	Min - Max	28 – 70	32 – 70	28 – 68	25 – 83	24 - 66	
	Mean	48.95	48.67	48.31	46.45	44.50	***p< .001***
	Standard Deviation	9.36	8.64	8.83	9.61	8.52	
Gender	Male	134(78.8)	142(86.6)	160(86.0)	162(85.7)	156(85.7)	
	Female	36(21.2)	22(13.4)	26(14.0)	27(14.3)	26(14.3)	*p= .295*
	Unknown	-	-	-	-	-	
Household Type	Single Male	87(51.2)	123(75.0)	153(82.3)	159(84.1)	152(83.5)	
	Single Male with Children	22(12.9)	3(1.8)	5(2.7)	-	-	
	Single Female	18(10.6)	20(12.2)	21(11.3)	23(12.2)	25(13.7)	
	Single Female with Children	11(6.5)	1(0.6)	3(1.6)	-	-	-
	Couple	11(6.5)	2(1.2)	3(1.6)	7(3.7)	5(2.7)	
	Couple with Children	2(1.2)	2(1.2)	1(0.5)	-	-	
	Unknown	19(11.2)	12(7.9)	-	-	-	
Ethnicity	Irish	144(84.7)	125(76.7)	152(81.7)	149(78.8)	134(73.6)	
	UK	-	-	1(0.5)	4(2.1)	1(0.5)	
	EU – EEA	20(11.8)	37(22.7)	30(16.1)	29(15.3)	45(24.7)	
	EU – Non-EEA	2(1.2)	-	1(0.5)	1(0.5)	2(1.1)	-
	Non-EU	1(0.6)	1(0.6)	-	5(2.6)	-	
	Traveller Community	1(0.6)	-	2(1.1)	1(0.5)	-	
	Unknown	2(1.2)	-	-	-	-	
Duration of Homelessness	< 6 Months	17(10.0)	18(10.9)	17(9.4)	15(8.0)	3(1.6)	
	7 Months – 1 Year	11(6.5)	14(8.5)	16(8.8)	9(4.8)	11(6.0)	
	1 to 2 Years	24(14.1)	25(15.2)	37(20.4)	27(14.4)	34(18.7)	***p< .001***
	3 to 5 Years	23(13.5)	26(15.9)	40(22.1)	43(22.9)	40(22.0)	
	5 Years >	61(35.9)	40(24.4)	71(39.2)	94(50.0)	88(48.4)	
	Unknown	34(20.0)	37(22.6)	-	-	4(2.2)	
Prior Admissions	Min - Max	0 - 13	0 - 15	0 - 17	0 - 12	0 - 17	
	Mean	1.35	1.91	1.91	1.53	1.79	-
	Standard Deviation	2.223	2.864	3.052	2.030	2.744	
New to Service	Yes	75(44.1)	74(45.1)	76(41.1)	80(42.3)	75(41.2)	
	No	95(55.9)	90(54.9)	109(58.9)	109(57.7)	107(58.8)	***p= .043****
Substance Use	Yes	57(33.5)	132(83.0)	-	186(98.4)	158(91.9)	***p= .009****
	No	113(66.5)	27(17.0)	-	3(1.6)	14(8.1)	

*** p <.05 ** p<.001**

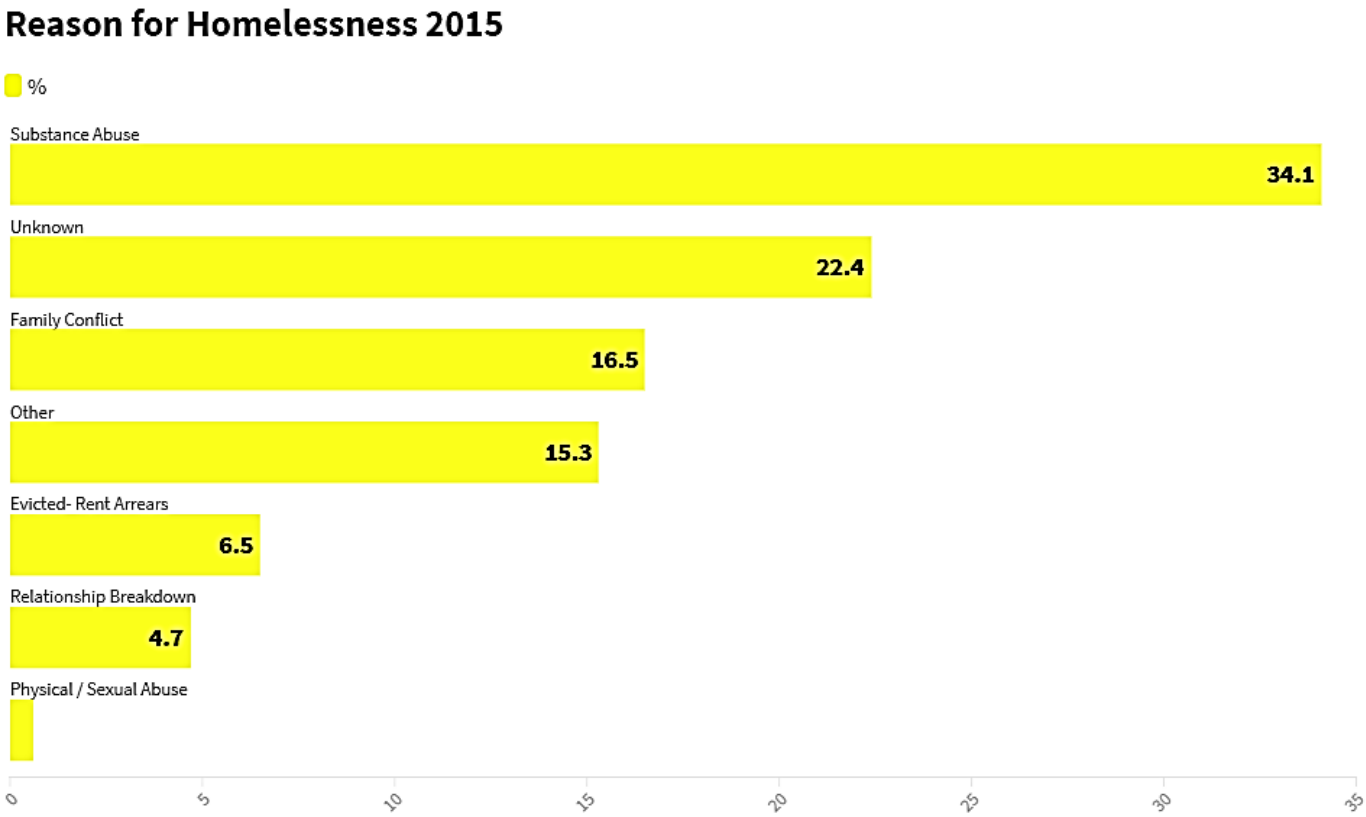

Figure 4: Reason for Homelessness 2015

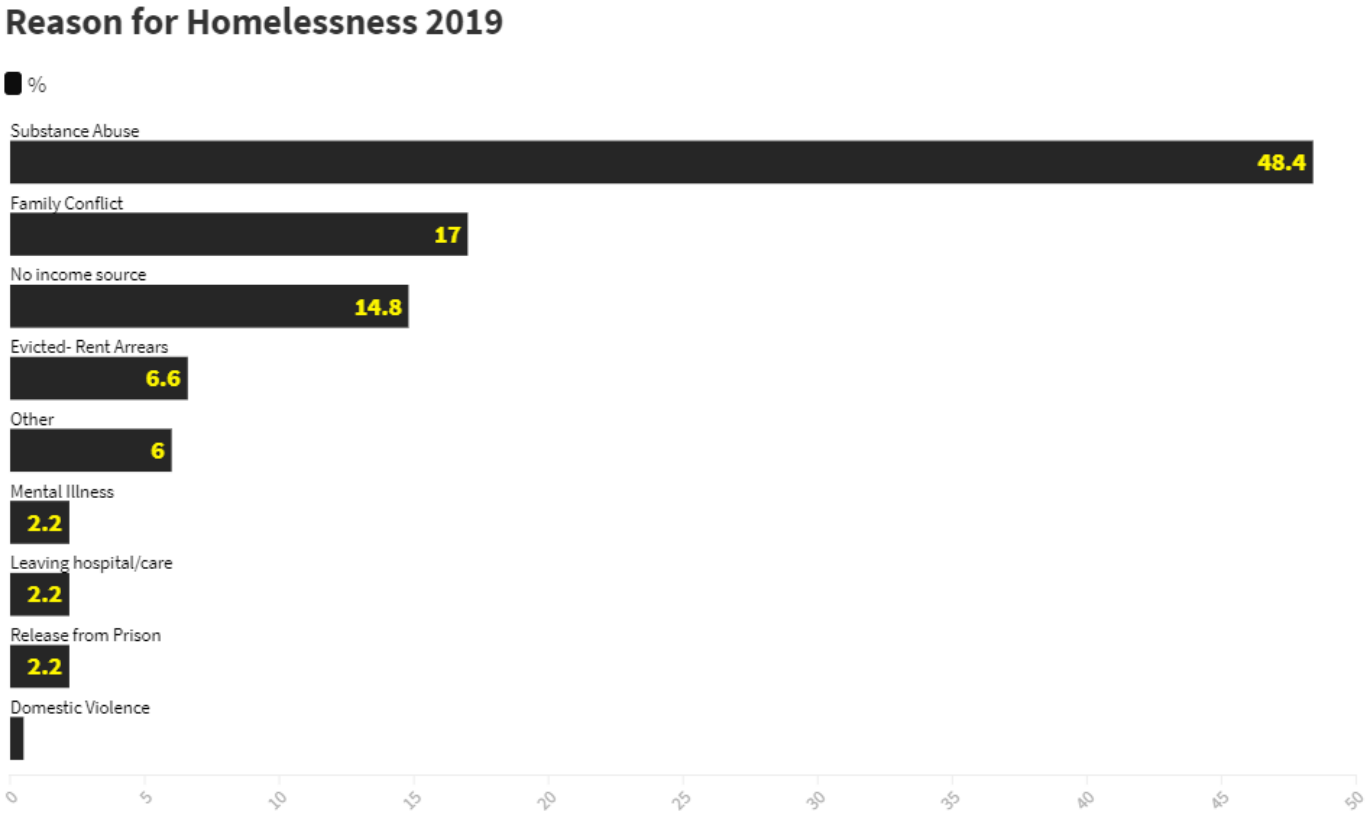

Figure 5: Reason for Homelessness 2019

3.1.1 Descriptive findings between 2015 to 2019

In 2015, there was a total of 178 client entries in the database, including repeat admission from the same clients. This increased in 2016 (n=189), in 2017 (197), and in 2018 (n= 203). However, in 2019 there was a drop in client data entries to 182.

The average age decreased over the five-year period, from 48.95 in 2015 to 44.50 in 2019, indicating that clients are accessing the DSC services at a much younger age than in previous years. This age difference was found to be statistically significant (*p<.001*) as shown in table 1. Higher proportions of male clients attended the service compared to female and this was observed at all timepoints. No statistically significant association was found between 2015 and 2019 in relation to the gender breakdown. The majority of clients were single with no children, and this was consistent across the years. Higher proportion of clients were Irish (84.7% in 2015 to 73.5% in 2019) and the second highest proportion of clients were EU-EEA (11.8% in 2015 to 24.7% in 2019). A slight increase in EU-EEA nationals can be seen. In relation to duration homelessness, a statistically significant (*p<.001*) association was found between 2015 and 2019. Higher proportions of clients have been homeless for more than 1 year in 2015 (79.4) compared to 2019 (72.2). Slightly higher proportions of clients were new to the DSC service in 2015 (44.1) compared to 2019 (41.2) and this was found to be statistically significant (*p=.043).*

As shown in table 2, the majority of clients participated in physical wellbeing programmes and learning development programmes. However, most clients did not access methadone programmes. Completion of detox programmes were only reported for 2018 and 2019, 71.7% of clients completed the 3 weeks detox programme in 2018 while 51.9% completed the programme in 2019, no significant association was found. While the medical detox was completed by 81.3% of clients in 2018 and 82.6% in 2019, no association was found between the 2 years. No statistically significant association was found in relation to clients' participation in programmes and having a medical card between 2015 and 2019. Most of the clients' local authority were Dublin County Council and higher percentage of clients were successfully discharged across all years.

The most common source of referral were other homeless services (61.2% in 2015 and 26.4% in 2019), and other Simon services (23.5% in 2015 and 26.9% in 2019). After discharge, most clients were referred to other homeless services (27.3%) and drug treatment centres (25.5%) in 2015. While in 2019 clients were discharged to other Simon services (22.7%) or they returned to the same service they were referred from (48.3%). Interestingly, the most common reason for homelessness is substance use and this is consistent across the 5 years. The key findings are reported in figures 6 and 7 below.

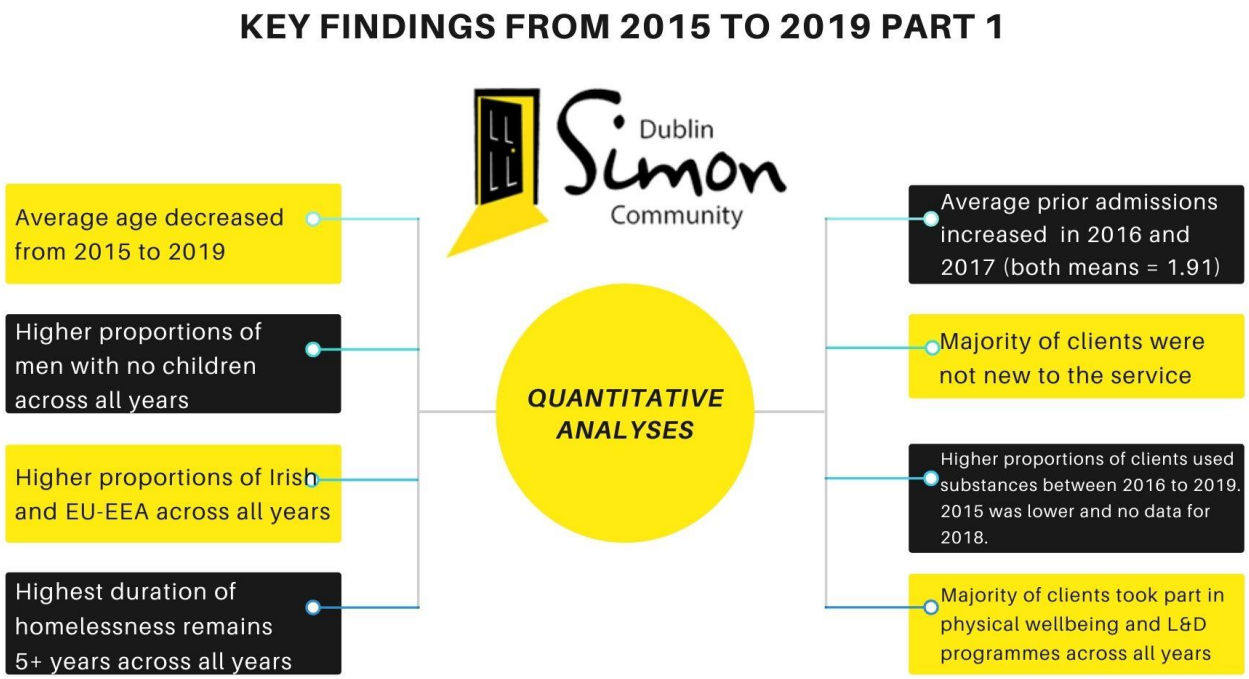

Figure 6: Key findings from 2015 to 2019 Part 1

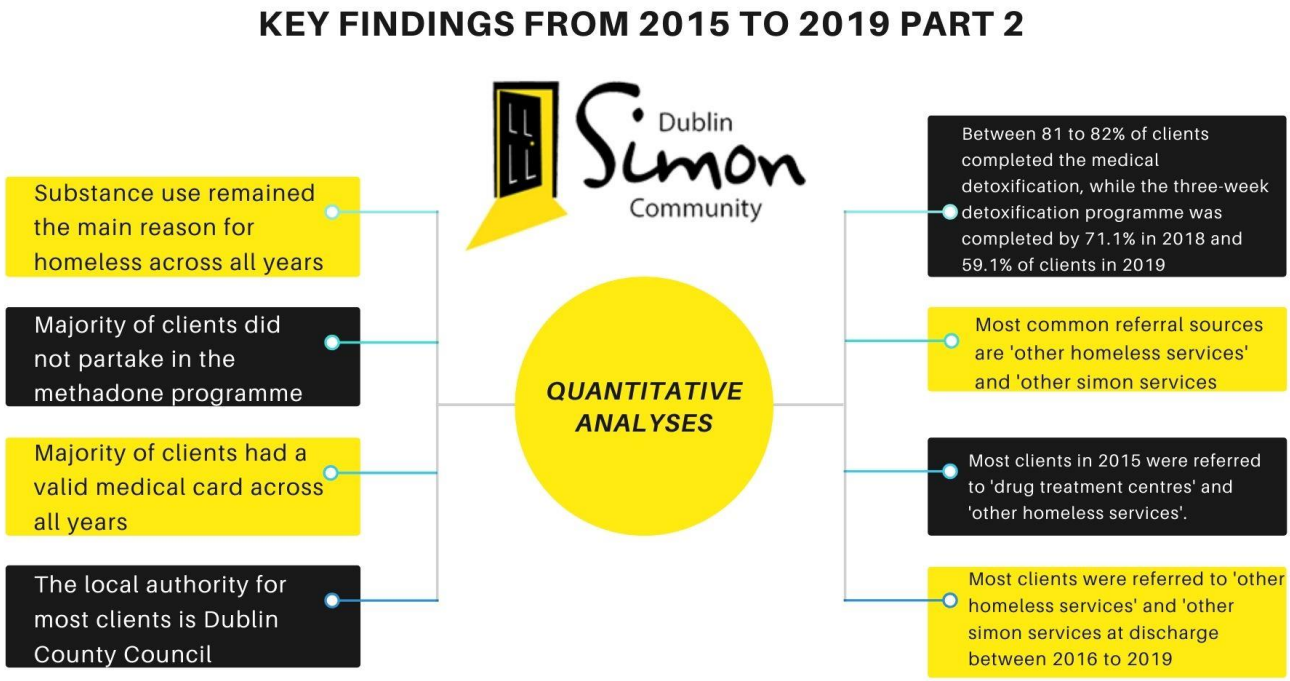

Figure 7: Key findings from 2015 to 2019 Part 2

3.1.2 Longitudinal analyses: care pathways between 2015 to 2019

While the section above looks at changes observed over the five-year period from 2015 to 2019 this section presents the longitudinal findings from 5 sample clients. These 5 clients were selected as longitudinal data over the period were available for them. Please note that the data management is an issue due to inconsistencies across the 5 years when following up client longitudinally. The data is presented in 2 ways; a detailed care pathway analysis for 1 client and an aggregated summary of 4 clients. This section firstly presents the case study, following the journey of client 1 (C1). Followed by the aggregated longitudinal findings for C2-5.

This case was chosen for presentation for two reasons. Firstly, longitudinal data was available for this case and secondly this person had the greatest number of prior admissions in 2015 and their journey in and out of the Dublin Simon and other services illustrates the complexity within some cases and the level of resources, inter agency working and case management required for complex cases.

C1 is a man aged 51. He is Irish and single with no children. He was admitted three times in 2015, twice in 2016, 2017 and 2019, and once in 2018. Reason for homelessness for all 5 years was substance use. C1 was referred by other Simon services and discharged to other homeless services in 2015, however the last discharge in 2015, he was referred to a drug treatment centre. In 2016, C1 was referred from other Simon services and was discharged to a drug treatment centre at first discharge and to an Approved Housing Body at last discharge in 2016. In 2017, C1 was admitted twice, and, on both occasions, he was referred by Other Simon Services and moved to Other Homeless Services. C1 was admitted once in 2018, referred by other Simon services and at discharge C1 returned to the same service. Finally, in 2019, C1 was admitted twice and was referred by other Simon services on both occasions and returned to the same service at both discharges. In 2018 and 2019, C1 voluntarily disengaged from the service.

In 2015, C1 had 6 prior admissions and did not receive the methadone programme, but did participate in the physical wellbeing, and learning and development programmes. C1 continued to participate in the physical wellbeing and learning and development programmes between 2016 to 2018, however, this data was not available for 2019. In 2018, C1 successfully completed medical detox. In 2019, C1 returned to other Simon services. Based on the data, it is unclear which specific service C1 was discharged to. Figure 8 illustrating a sample client journey and case complexity over a five-year period from 2015 to 2019.

Figure 8: Client 1's Journey

Similar stories can be observed for clients 2,3,4 and 5. C2 is an Irish male, aged 40 and in a relationship with no children. The client is not new to service and has had 2 prior admissions in 2015. C3 is also an Irish male, aged 55 and single with no children. C3 is not new to the service only has only had 1 prior admission in 2015. C4 is an Irish female, aged 57 and in a relationship with no children. C4 is also not new to the service and had 2 prior admissions in 2015. Finally, C5 is an Irish male, aged 60 and he is single with no children. C5 is not new to the service and has 1 prior admission in 2015.

With these 4 clients, the majority participated in physical wellbeing programmes and learning and development programmes. However, only client 5 participated in the methadone programme in 2017, while the rest did not receive any methadone programmes between 2015 to 2019. Most of the clients had a valid medical card throughout the five years. On most occasions, the clients were successfully discharged from the service, however, C4 voluntarily disengaged from the service in 2019, while C5 had his service withdrawn, reason for service withdrawal was not provided in the database. Details of their journeys are provided in the appendix below.

3.2 Client perspective, care pathways and fidelity

Section 3.2a presents the findings in relation to the client interviews. During the interviews, clients were asked their experience of the care pathway, identifying what worked well and what aspects required attention. While the central focus of the research at earlier planning stages was to capture the client experience of the detox unit, a broader view of the care pathway was deemed essential as the detox process is just one step on the pathway to recovery. Section 3.3 thus contains an analysis of data from the 4 clients in relation to their own care pathway journey.

The results are presented below across two main phases- firstly the experience in terms of the pathway into the detox service incorporating initial engagement with, and attendance at the detox unit, and secondly, the experience of exit pathways from the detox service on to other pathways. Clients reported enablers and challenges to their care pathways at different levels- some were individual to the client, some were service specific, and others were wider system level issues. All viewpoints were captured.

The four case studies were selected on three pathways out of the service as follows:

1. One client moved from the Dublin Simon detox unit to the Dublin Simon recovery unit to independent living and attends the aftercare service at Dublin Simon.
2. One client who was a regular attendee of the Dublin Simon detox unit proceeded onto the Dublin Simon community low threshold recovery unit while waiting for a short stay admission to a HSE facility (Keltoi) to do in-depth work on a drug addiction. From here the client returned to the Dublin Simon recovery facility to continue the recovery journey and eventually moved to a licence agreement accommodation with only visiting support. The next stage of this journey is independent living.
3. One client, following the Dublin Simon detox process went straight to an external provider- Merchants Quay Ireland (MQI) for rehabilitation (higher threshold than Dublin Simon recovery).
4. One client moved from Dublin Simon detox unit to a Dublin Simon visiting support recovery unit after very short stay in a 24-hour support in recovery.

In terms of the detox unit specifically, key stages related to the initial engagement with the detox service (section 3.2.1), the experience of the detox service itself (section 3.2.2), and finally the experience of pathways on exiting the detox service (section 3.2.3). Alternative pathways are available, and experiences of these pathways varied depending on the needs of clients, and the stage of addiction clients were currently at. The research looked at positive aspects, challenges and potential changes

the clients felt would enhance the pathway experience. Clients reported different circumstances and motives for engaging initially with the service. Clients also reported different support pathways into the service.

3.2.1 Dublin Simon detoxification unit: entry pathways

1. Client background: previous treatment engagement, substance use, living situation, and engagement process

In terms of client background prior to engagement, the clients had variations in their substance use treatment history, homelessness situation and pathway into the detox service (Table 5). One client had only ever used alcohol, one had used alcohol and cocaine, but cocaine use didn't require treatment, and the remaining two clients had used a mix of drugs and alcohol and were both using methadone immediately prior to engagement with Dublin Simon. One of the clients had never engaged with treatment previously. The remaining three clients had engaged in various treatments, involving a mix of detoxification units, and recovery services with alternative service providers. One of these clients' previous treatment engagement involved multiple attendances at the Dublin Simon Detox unit over a 10-year time frame. In terms of living situation immediately prior to engagement, while all clients were homeless, only one client was rough sleeping, the remaining clients were availing of hostels. Duration of being homeless prior to engagement varied. All clients were in the age range of 35 to 58 years old, three clients were male, and one client was female. Two clients also had children, with one child per client.

2. Enablers and challenges to accessing the Dublin Simon detox service

The following section describes the clients care pathway experience in terms of challenges and enablers encountered during the process of accessing the service. Clients reported challenges specific to the service and wider system level issues.

Enabler: readiness for change and interagency collaboration

In terms of the reason for, and process of engagement with the Dublin Simon detox service, all clients reported effective engagement skills of service workers, interagency collaboration, and readiness for change of clients, as the key ingredients to decision making to access the service and capacity to do so.

Two of the clients life circumstances resulted in hospitalisation prior to engagement, and the combination of these significant life events and effective initial engagement with clients (Merchants Quay Ireland (MQI) Keyworker, and Social worker in hospital), and subsequent effective interagency collaboration with DSC, were encouraged and facilitated to engage with Dublin Simon.

The other two clients' engagement was initiated and facilitated through their respective counsellors. Clients' motivation for engagement consisted of a mixture of life events, encouragement for service providers, and readiness for change. Transition into the service from initial referral was seamless for three of the four participants, facilitated through effective interagency collaboration with a range of services and these three clients were successfully admitted to the detox unit within three to four weeks of initial referral procedures being initiated. One client however experienced a long delay of four months.

Challenge to accessing detox: requirement to be registered as homeless

One client however experienced a longer delay of four months, but this reflected the fact that while he was homeless, he wasn't registered as homeless. The criteria of needing to be registered as homeless before entering the service can act as a challenge to initial access to the detox. This was only the case for one of the four clients as the remainder were already registered. This was compounded for the client by the fact that he reported finding the required information difficult. However, this issue was resolved, and engagement was facilitated.

Enabler to accessing detox: low-cost service

For one client the low cost of Dublin Simon detox service was noted as an enabler to accessing a service as other services were out of price range due to recent loss of employment and change to living circumstances.

Client: "In 2016, I started this journey and realised that I had to stop drinking but it wasn't going to be easy. At that time when I was looking, a lot of it was to do with finances because the Simon was free, well weren't free but much cheaper and service X which I attended before was a 141 euros per week and you were getting maybe a 185 on the dole so a huge chunk of your money. And the Simon was 56 per week." (Client 3)

Challenge to accessing detox: messaging, accessing information, and readiness for change

A second challenge that was reported however, reflected a wider system level issue and was not specific to Dublin Simon, yet still noteworthy. Clients reported that while excellent work is being done across services in terms of outreach and keyworkers, both in terms of reaching clients to encourage engagement, and in terms of facilitating engagement through interagency collaboration, that in many cases, the message being delivered in terms of what is actually available and what treatment actually entails, may require attention. Clients spoke of not actually being aware of what treatment really entailed and the various options available until they engaged with the service.

Client: "…You really do need to be guided by the hand into seek the help that you need. People had mentioned it in the past, in the few hospitals that I had been to and there were always suggestions that 'oh we will make the application for you' and nothing was really done as a priority. You just kind of agreed, that was the conversation over and then you didn't really hear anything of it again. If somebody had actually explained to me at the time exactly what the Simon was, how it works and the possibilities of what I could gain from a recovery programme, I probably would have been interested but all that was ever thrown at me was treatment, treatment, treatment. And I hadn't a clue, I didn't grow up in addiction, I didn't grow up with – like I hadn't clue about anything other than I knew I had a problem with alcohol as I couldn't stop drinking it." (Client 3)

Another client mentioned that he wasn't aware of what was actually available in services until he accessed services. And even with this, a lot of the information is found out from other clients.
Client: "You find out information from other clients, for example I had a doctor, but others wouldn't have a doctor to know about Merchants Quay. They have doctor and dentist. You can get this help, but you have to ask for it. I don't know why that is. Places to eat for example, three places. There is lots of places out there – focus to cheap lunch. A lot of the information I found out was through other clients, not here. And there is amazing stuff not just Simon, Focus, Peter McVerry, Crosscare, but they just don't advertise it." *(Client 3)*

Some of the clients, in conjunction with the Dublin Simon Client Action Group (CAG) are addressing the issue by creating a map of Dublin, similar to a tour map, with landmarks of key information e.g., places to eat, places to access toiletries, hostel opening times, free meals, soup runs, harm reduction etc. This is being carried out in conjunction with a graduate student project.

The need for this can be seen in the quote below which illustrates the range of services available but also the lack of clear information on what is available and where.

Client: "…There is this other place …. They will have shower gel, toothpaste and toothbrush and underwear and sock. And it happens every week, but nobody knows about it and the only way you know about it is through other clients. We are working on this map, so we are working with the other services, and it is amazing what we are getting. It is amazing that it is taking so long. All we are doing is gathering this information and it will be on a map and hopefully we will have the maps in all hostels, and it will give opening times, and meals – not all meals are free, but it will give opening times. Different things happening, soup runs at night-time and sometimes they are on North Earl Street and sometimes they

are outside the GPO. Needle exchange and on the back, it will have the doctors, vets and all the opening times." (Client 3)

One specific barrier listed referred to service access for homeless people with pets. Where homeless people have a pet, this client reported that there are no service provision options available and that this is a This is a significant barrier to accessing treatment. To try and address this, the group are making people aware of free veterinary services that are available. *(NOTE: it is important to note here that clients are in fact allowed to attend the detox service with their dogs, but this information only came to light following the review of the report findings, this will be addressed in the recommendations section of the report).*

However, clients also acknowledge that the issue of messaging may be impacted by the importance of "readiness for change" as much as messaging, as many clients also simultaneously reported phases of not being ready for treatment, having ulterior motives for engaging initially and only engaging when crises arose. The quote below from one of the clients captures this complexity.

One client however, also reported an inappropriate advance from an outreach worker, from an external service, that resulted in disengagement from a service and a reluctance to re-engage with other services. This ties in with a broader issue which will be reported on in the next challenge below.

Client: "Yeah, like various stages through my homeless career, you would meet various outreach workers. I met one outreach worker that was supposed to be helping me get into treatment. I remember he inappropriately ringing me one night and told me that his wife has left him and that he had a hotel room and did I want to come and meet with him one night. So that was a bad experience. So, I obviously left that service and didn't go back there. And yeah a few of the hostels I stayed in, there would have been key workers there mentioning treatment to me. In fairness, these key workers are over stretched and dealing with clients that come and go, it's like revolving doors. So, it's very hard for them really as well." (Client 1)

In conclusion the enablers and challenges highlighted above provide insight into the experience of accessing service provision, and the factors that interplay during this time. Enablers included initial engagement, interagency collaboration, low cost of service and readiness for change. Challenges included requirement to be registered as homeless, accessing information, framing of messaging, yet this may also be impacted by the clients' own stage in the process, and readiness for change. Steps are being taken to address the perceived challenges in relation to communication of key information through Dublin Simon. The issue of the significant barrier of service provision for homeless people with pets, however, remains unresolved.

An outline summary of client characteristics is provided below for additional context.

Table 2 Client Profile and engagement process

ID	Gender	Age	Treatment History	Drug Use Recent History	Situation Prior to Engagement	Significant life event prior to engagement	Engagement process	Motivation for Engagement	Waiting Time to access service
01	F	30-40	No previous Treatment	Alcohol/cocaine but cocaine use didn't require treatment	Rough Sleeping few months	Hospitalization	MQI Key worker suggested DSC as way to get off streets. DSC visited client in hospital. Referral made.	Backed into a corner, Treatment or back to streets, but also ready for change.	3 weeks after leaving hospital
02	M	30-40	1st detox with DSC Detox 2008 –multiple engagements but readiness for change initially a barrier, and subsequently addressing methadone use barrier for a number of years in terms of pathways.	Alcohol and drugs including methadone	Homeless	Relapse – counsellor suggested DSC	Counsellor suggested it after a relapse & had engaged previously	Crying out for help – ready for change.	
03	M	50-60	Residential Detox-(x 2); Residential Recovery +1 yr. (non-DSC)	Alcohol only – Never used drugs	Hostels	Hospitalization	Social worker in hospital suggested it/referral made.	Health deteriorating and lower cost of DSC detox than other facilities.	4 months as wasn't registered as homeless
04	M	40-50	In Trinity court clinic (walk in day clinic for drug Tx)	Methadone, and other street drugs and possibly alcohol as does DSC detox	Hostels	Nothing significant - counsellor in Trinity court suggested DSC	Trinity Court counsellor suggested it/referral made	Ready and committed to change.	1 month

3.2.2 Detoxification unit experience

1. Description of detox service

The Dublin Simon Detox unit is a medically supervised residential setting designed to facilitate alcohol and benzodiazepine detox. The average duration of the program is three weeks, but this can vary depending on client needs. The service is a mixed gender service and participants must be over 18. The service is the only low threshold detox unit for the homeless in Ireland. The detox unit has a capacity of 11 beds. The service provides detox treatment for clients who misuse alcohol and or benzodiazepines, and tailor the medical intervention to the client's needs dependant on their addiction. It is a low threshold service targeted specifically at adults who are homeless and meet the criteria for admission (By 'Low Threshold' there is no cut off point on methadone maintenance, and the service does not demand a urine sample free of substances). Clients are allowed to leave the program for restricted times after the first week within the unit. The services tend to work with people often excluded from other services due to medication management, poly substance misuse and associated behavioural issues. The programme is of three to five weeks duration. There is a qualified nurse on duty 24 hours a day who will support clients to manage their withdrawals safely. The key worker provides case management support in liaison with the referral agent.

While client needs on engaging with service varied by substance use, living situation, reasons for engaging and treatment history, the client experience of the Dublin Simon Detox unit overall was very similar, and a very positive experience of the service delivery was reported by all clients. However, some variations in service experience were also reported.

2. Enablers within the detox service: staff, process, ethos and facilities

All clients reported extremely positive feedback in relation to the staff and the process they use, and overall ethos in relation to the Dublin Simon detox service.

Enabler: staff approach and skill set

Staff were praised repeatedly for their approach, which included being friendly, approachable, non-judgemental, inclusive, encouraging, highly experienced and skilled in their work in how they related to clients and managed group dynamics, including de-escalation of clients, of being fair, consistent, and always open to listening to and addressing client concerns or queries. This can be seen in the quotes below.

Client: "There was hard times, unstable moments. You take urines, breath tests. Do all that sort of thing. It is coming down and that, I suppose it was hard, but it wasn't as hard as people said. In your head you think "this is going to be horrible", but I knew that I needed to do it. To try and get stable, and they worked with me as they knew I wanted to change. They seen that I was committed. Yeah, it wasn't easy, it was hard. All the necessary nurses there that have seen it and know their stuff and knew what

I was going through. The psychosis and all that. Dealing with life problems as well. In terms working with me, I had a great team with me. Great manager. Counsellors and nurses there every morning." (Client 4)

Client: "I got on well with the staff. I felt very comfortable to voice any concerns or opinions that I had, and I felt the staff were generally encouraging as well. I never felt too pushed." (Client 1)

Enabler: the process-non-judgemental, non-intrusive, and supportive

The process within the detox service was reported as being fair, well-paced to client needs, non-intrusive with nothing being forced upon clients, informative, supportive and helpful. The group information sessions were repeatedly reported as being very helpful and providing great insight for clients. This can be seen in the remarks below.

Client: "The groups that are there are small which is for us the people that have come off the streets. It is nice that we are eased into it, sitting down talking and concentrating and engaging with other people. There is the gym which is great- bit of exercise. I think the ideal world, it would be nice to bring people on detox for walks or something to get fresh air. But I don't know how practical that is." (Client 1)

Client: "There is a meeting where someone could come and talk about psychology or addiction, things like schemas etc. To try and train our minds into rethinking. It's interesting. And the process does work, people are coming and maybe they aren't used to talking and it's amazing, you become a lot more outspoken, even me. It could be complaining about things. You ask more questions and contribute more to the group. You get you confidence and start asking questions." (Client 3)

The rules within the service were also reported as being necessary, appropriate and administered fairly. Help was also provided within the detox service around next steps including recovery options and help with education and employment.

Client: "It was a great life lesson. There were some rules that at the time you can't understand why you have to follow them; they seem petty and feels like you were in school, and people complain about them, but you have to learn. It is all learning process that you have to follow rules and learn how to become a normal functioning member of society again because when you are homeless, you have no structure, no rules and you can do what you want. You can't do that and achieve normally so." (Client 1)

Client: "When you are there, you are assigned a key worker – She would have a chat with you, and she would find out your plan and what you want to do. They do all these other services like CV's, help people with CV while they are doing the three week course and give them information on college course and give them general information on what's available to them and what they are entitled to and things like that. And some people might take them up on that and other might not be ready for – it's a bit longer with the help. A lot happens in three weeks for you to get your head around." (Client 1)

Enabler: organisation ethos

Clients reported that the ethos of the organisation was supportive and non-judgemental and needs led with important touches like being allowed to smoke in the bedroom for the first 24 hours.

The realistic setting included being allowed your phone after 24 hours and being allowed restricted times out of the service after the first week. One client noted how realistic this feature was in that in a previous setting he was in, he remained "cut off from the real world" as access to real life street environment and temptation was not an option, and while during detox and the subsequent one year recovery process he engaged in, whilst he never relapsed, as soon as he re-entered a real world environment he relapsed instantly. This client did acknowledge that this access to outside world during detox could be a 'double edge sword' as the temptation may be too much for some clients. But that overall, the capacity to leave the service for these durations was an important feature. In particular it facilitated the client being able to meet with family or friends where that was an option for them. These points can be seen in the quote below'

Client: "No, I wouldn't change anything. It was great to have the phone back. That you just lose it for a day. I think that's quite important that you don't have it for a day. It is too distracting, and it is too distracting for your friends and your family and its only one day. But it is important that you do have your phone because in other service I attended you weren't allowed your phone and it's too restrictive and not realistic. And also, in Simon, for the first week, you stay there, and you can't leave the premises except when you want to go down, to Christ church for example. A tour once a week. But then the second week, you are allowed out for hours on your own- 2 hours Monday to Friday. And Saturday and Sunday -you can stay out for 4 hours where I would go see my family." (Client 3)

In terms of the facilities themselves, examples of additional positives also included provision of safes for storage of personal belongings and clients repeatedly praised the high quality of the food and having access to security and warmth. The cost of the service was reported as being affordable and an enabler to accessing service, and where help was needed in securing welfare payments to meet the costs, the help was available and effective. A secondary benefit of paying for the service related to being taught about budgeting and responsibility and preparing one for the real world.

Overall, the experience of clients during the detox service was overwhelmingly positive with customised needs led responses being reported. One example of this was that when a female client engaged who had previously completed an alcohol detox during her hospital visit. However, she was still allowed to attend the detox unit for the short time she needed to provide protection which she required. Following this short stay, the client was offered a place in the recovery unit and transitioned smoothly into it.

Client: "I was in their detox unit. Now I had medically detoxed in the hospital as I was in there for three weeks. So, when I went into the detox unit, I wasn't on any Librium anymore as had already completed Librium detoxification in the hospital, which is normally what is used to detox people from the alcohol the first couple of weeks. So, I stayed in the detox unit for a week while they were protecting me and stuff like that. And then I was assessed for the recovery which is the next step after detox. And then I was offered a place in recovery then, so I stayed in Simon through my recovery as well." (Client 1)

3. Challenges in the detox service

However, as expected in any real-world setting, some challenges were reported.

In relation to the facilities, two issues were raised, both of which the clients acknowledged cannot be changed. One related to the building itself as being "big and ugly", the second related to the location of the detox service beside a Guinness brewery, the smell of which could act as a trigger for people struggling with alcohol addiction.

Two overarching challenges arose in relation to the detox service, the first was in relation to the experience of the service from a female client's perspective, and the second was the experience of clients of being in a detox service that addresses benzodiazepine use as well as alcohol use. A further challenge related to pathways exiting the detox unit. The first two challenges are reported below, the latter will be discussed in the final section.

Challenge: male oriented service

When recruiting for these interviews, it was important for the steering committee to ensure that the voice of female clients was captured. While Dublin Simon accommodates both males and females, the service is predominantly accessed by males. Thus, the findings below reflect the experience of the female client. However, the issues reported also reflect the specific life circumstances of the client on engagement with the service above and beyond the gender of the client. The two are often inextricably linked. The issues reported below commence with being specific to the experience within the Dublin Simon community service, as this is the context of the study, but the issue of gender specific service response in many cases, can reflect a much wider systemic issue in terms of gender sensitive service provision. This has been repeatedly reported in the literature. The experience of a female client can be seen below.

Client: "… this is one of the issues that I would like to raise with this conversation…. I have been quiet vocal about it. It is the lack of services for woman. It is a very male orientated service, it's a very male orientated recovery programme. There is very few females throughout my time using the services residentially. And even aftercare as well. So, I think that, how it has been explained to me in the past is that. A lot of women have other commitments. They can't just upstick and leave their kids to go into a treatment programme. But again, I think that is something that really needs to be looked at because

mothers need recovery even more so than others in a lot of ways as they have others relying on them as well." (Client 1)

Challenge: feeling uneasy in male dominated environment

This client also reported that initial engagement was quite "scary", and that she felt nervous being around the male clients at this stage in the process for various personal reasons. However, the client also reported that she was provided with a single room for her accommodation which she felt was to accommodate the fact that she was female, and it was very much appreciated. One negative side of the accommodation experience however was that at night, the rooms would be checked by whoever was on duty and if this person was male, then it meant a male was entering the room at night. This made the client feel uncomfortable and uneasy. This can be clearly seen in the quote below.

Client: "There was night safety room checks just for comfort as well having a man walk in at night was quite uncomfortable even when I was in the recovery and didn't like that at all. There is a mix of man and female." (Client 1)

In relation to the gender issue this experience continued into other service pathways. In line with the experience of females accessing services, an earlier experience of an inappropriate advance from an outreach worker resulted in her decision to disengage from the service she was linked in with at the time and created an emotional barrier to re-engaging with services for a significant period of time.

Challenge: free basic care packs not provided

Within Dublin Simon Detox service, while food and accommodation were provided to every client, there was no basic care pack available on arrival. This was reported by the female client as being 'embarrassing', resulting in her having to borrow a towel from one of the male clients, and clothes from another client. This client was the only client to report this experience and details of the experience are provided below.

Client: "I didn't have nothing of my own. No clothes, no towel. There was no towels provided by the Simon and I remember that as I had to borrow a towel from a guy there. Yeah, well like basically, when I went into the detox unit. I came straight from the hospital and straight from the streets. I had literally nothing. No toiletries. No clothes. No nothing. So, no payment. I don't think there was adequate provision for someone like me. In an ideal. I know it is funding and all that, but I do think it is a priority to make people feel comfortable. And I think the basic essentials – like a care pack be given when someone arrives – toiletries, a fresh towel, pyjamas, like you are going to spend a lot of time in bed and you are sweating when you are detoxing, it is not pleasant. And encouraging personal hygiene – and a

big part of recovery is starting to take care of yourself. I don't understand why that is not a made a priority to provide that. They have washing machines, and dryers to clean clothes but there are no clothes in them. 1)

How did you manage that?

I came with literally the clothes on my back. There was a girl there that I knew from the streets, and she leant me a pair of jeans and a top I think or something. I was brought to the Simon charity shop, and I was allowed to get something from the charity. I was brought my nurse I think and then I got something there. I eventually got my welfare payment sorted out and then I was eventually able to buy myself some. It all took a little while and it wasn't pleasant. It didn't make things easy." (Client 1)

"How did that whole process make you feel?"

"Embarrassing. You already feel like you are on the floor. I felt proper homeless at that stage. The illusion of the alcohol created that everything was okay, and it didn't matter. And then suddenly I realised that I look like a tramp." (Client 1)

However, this client was also both the only female interviewed, and the only client of the four to have been rough sleeping prior to entry to the service. Thus, as result of her situation prior to engagement, bringing her own toiletries and a basic care pack were not feasible for this client. Potentially in this situation, if borrowing from another female was an option, this experience may have been mediated by this. Thus, the situation preceding engagement compounded this experience, and the gender specific nature of borrowing form a male may have added to the significance of this experience.

During the interviews with the male clients, a comment made also highlights the variation in experience by some who may present in terms of basic care packs in that the client reported that while he had experienced no issues with accessing toiletries, clothing or towels, he had both received the letter in advance, and had the financial capacity to purchase what he needed prior to entering, and even if he didn't, he had the financial capacity to purchase the items upon entry.

Challenge: non-family focused

One final issue that was raised by the female client was the lack of family engagement in the service. The female client was the mother of a young child. The client reported that the consequence of this can be that the child then experiences heightened anxiety as they do not know where their mother is, and that attempts to explain that she is in a safe place are unsuccessful as the child is aware that previous situations have not been safe. This can be seen in the quote below.

Client: "My biggest thing – my daughters biggest thing – all that she wanted to do was see my room. Children worry about their parents, and she just wanted to know that I was safe, and she couldn't see where I was, so she didn't know. And she knew, kids know, that I had been in awful situations before. It was quite difficult to put her at ease. She never really knew where I was even though I was telling her she wanted to see it for herself." (Client 1)

The issues with regards to children were not necessarily client gender specific and may also be influenced by other considerations such as the age of the child as can be seen in the quote below.

Client: "There is nothing provided for the child. I know that there is a lot of men in the services that have children as well and a lot of them as soon as they get sober, they expect to come part of their children lives again. And obviously, children aren't allowed in the services. It is quite difficult, because the child knows, and they are aware where the parent is and can't see their parent. And that can cause insecurity with the child as they can't stay in mummy or daddy's house. And why can't they be there or see them? So, I think that something could be provided to allow the family to be more engaged with the child as well." (Client 1)

A suggested future change related to re considering if there are any possible ways to facilitate short family visitation sessions where family members can see where the client is. However, another client reported that the issue of family involvement never arose for him and that he was happy enough with that approach. The involvement of family at this stage of the process may simply reflect different client situations. In some cases, family can be a challenge for the client at this early stage when they need to focus on detox

Challenge: dual purpose detoxification unit

The Dublin Simon detox service facilitates a dual detox process for both alcohol and benzodiazepine use. However, some clients reported that for those on benzodiazepines, they can test positive for the tablets due to Librium being the medication for the alcohol detox process, but that they may be using additional non prescribed tablets, and this can be disruptive for other clients who are trying to be sober. This is evidenced in the quote below'

Client: "What I would say in terms of people using the sleeping tablets that people were taken – because people came into the detox under the pretence of alcohol when in fact they had tablet addictions and you can get away with tablet addictions in the detox services because you are allowed to test positive for benzos because you are on Librium which comes up as a benzo so a lot people ended up even through the detox, off their faces on tablets and its quite uncomfortable for people who are trying to

be sober. With people messing around and off their face on tablets all the time. It definitely is an issue that needs to be addressed." (Client 1)

One client reported raising this with staff but that a solution to the issue is not straightforward. In line with this, other clients reported that the primary focus may be alcohol detox, but information and the procedures in relation to other drug use, is limited and this included information on reducing methadone use as illustrated in the quote below.

Client: "…There needs to be more information as well for the people coming in of what you can and can't do? I would have found out through the counsellor that I was seeing. And word of mouth, listening to other people. And eventually I would have found out about the methadone detox. But I was never told anything about it in Dublin Simon like….
…I was coming down off the methadone, I could have been on 80mls, and I had to get down to 50. And as I was coming down, at the time I don't think they even wanted me coming down because it has to be supervised by a doctor. But I just kept doing it anyway. It was my path. That's the way it was, and I must have been in there 7 or 8 times through the years." (Client 2)

Challenge: accessing Service for ulterior motives

However, clients also reported that this issue of people misusing the service is not straight forward, as they also reported that what may be at play is clients whose motivation for using the service being driven by ulterior motives, thus the desire to become sober can be compromised and this can cause disruption for other clients. Ulterior motives reported included the desire for respite, food warmth and shelter, the need to meet external demands such as probation requirements, or partner demands.

Client: "Look, to be honest with you, the first time I went in there I was just basing it on the drink, and I just wanted to get in there to get in and off the streets. And listen it was for respite; you get food in there and you get your own room and hmm to be honest with ya I didn't know what I wanted. Which is understandable as well yeno? I would have been in my late 20's yeah. DSC detox is 100% to keep people alive yeno. You have to understand as well that some people aren't ready for that road yeno which the times that I went in there I wasn't ready yeno. And I got a few hot meals and shower and that and a bit of peace and quiet for a couple of weeks yeno. Emm I was ready." (Client 2)

3.2.3 Pathways out of detoxification service

Pathways out of the detox process differ depending on client need, client readiness for change, and service availability.

Firstly, not all clients successfully complete the detox process. However, for the client case studies in this research, this was not the case. The issue of what happens clients who don't successfully complete detox is reported on in the staff interview section. For clients who successfully complete the detox process, theoretically there are a number of exit pathways available. However, accessing these pathways can be complicated depending on client status and service availability. Access onto these pathways can vary by virtue of client readiness to engage in options available, and or the availability of a pathway in terms of service provision.

The main options available to clients upon completion of the Dublin Simon detox process are:

1. Accessing additional detox services in cases where client is using substances other than alcohol/benzodiazepines and wishes to come off them, followed by treatment and housing.
2. To progress onto recovery and rehabilitation treatment (either within Dublin Simon or externally)
3. To address housing needs- recovery housing, transitional housing, leading ideally to full independent living.

From the case studies reviewed for this research, three of the four clients experienced very smooth transitions between exiting the Dublin Simon detox process, across their chosen pathways. For one of the clients, the journey was more challenging. This client was one of the two clients who was also using methadone, and experienced challenges bridging the gap between the Dublin Simon service and gaining access to the first step on the pathway – entering methadone detox. These challenges are reported below.

However, despite these specific challenges all four clients navigated their clinical care pathway with support from Dublin Simon and other services, and accessed additional detox services where needed, recovery and treatment services, and finally housing services which included accessing recovery housing, transitional housing, and in some cases, independent living arrangements. For example, one of the clients is now living independently with full access to their child and accessing aftercare services in Dublin Simon. These positives are illustrated in the summary provided by client below.

Client: "Everything I got from doing the programme properly. I have my daughter back in my life properly. My daughter loves me and wants to be around me. I am happy in myself. I am content. I am much more able to handle my emotions than I was before, and I am able to handle situations. This is all stuff I have learned from the programmes and therapies that I have been doing with Simon. These are lifelong skills that I have learned. They had very good help to get through for addiction, but they

also help you through life as well. I look at some people that haven't gone through addiction. I just think you look at things in a different way. A lot more relaxed. I think that would be it. I am in a permanent housing association. I have a child who is X. Sometimes when I am doing up my house now, I think of when I was walking around phoenix park and sometimes, I didn't even have a sleeping bag. It is crazy what my life was like. Huge change." (Client 4)

Another client interviewed was about to move from a recovery house into their own home and has gained full custody of their daughter which was facilitated through service supports and interagency collaboration. The client highlighted that Dublin Simon know exactly how to help you meet your needs, know the right people and have the connections, and between the two services, they (DSC) have turned their life around. Another client was due to move into independent living prior to COVID and was awaiting the final arrangements on this, and another interviewee was currently living in recovery housing with one year remaining on a two-year agreement. These sentiments can be seen in the quote below.

Client: "The Simon have connections with all these sorts of places, they know what will be best for you. They want to send to the right place that can change your life." (Client 4)

All clients repeatedly praised the high level of supports that were available from the staff and services in both the recovery process and the housing arrangements. For the two clients who progressed straight into a recovery program from the Dublin Simon Detox, the experience of the transition into the recovery service, and the recovery service itself was very positive. Only two key challenges were reported. One related to the gender issue and the second related to the family issue, which were highlighted above.

For the female client, on completion of Dublin Simon Detox process she transferred into the recovery unit which provides access to a gym and a swimming pool. However, while gym gear is available in the charity shop, the available clothing was male. However, the client still found some running gear that she could use from the male stock. For the swimming gear however, no female swimming gear was available, and this created a barrier to accessing the swimming pool. Similarly, in terms of accessing transitional housing, the houses are mixed gender, and based on this, the client refused to access one of these houses.

However, despite these challenges, the overall experience was very positive, and supportive.
Where additional challenges were reported, these were in relation to one of the two clients who was also on methadone. Experience of this pathway is reported on below.

1. Accessing additional detoxification services

In relation to the first pathway, in the case studies reviewed for this study, two clients were also on methadone, and both clients wished to detox off their methadone following completion of their Dublin Simon Detox. The experience of a clinical care pathway varied significantly for these clients. One client who completed the Dublin Simon Detox process, transitioned smoothly straight into a methadone rehabilitation detox service, which included ongoing treatment.

Client: "…. I learned a lot in the lantern and in the Simon, they taught me the basics around what I need to change and what I needed to work on. …They sent me on to there – door to door.... And they said it was 11-week programme and I stayed there 17 weeks. I have spent my time – knew I needed to do it. So, it was a 11 week programme, I came off the methadone at 4 weeks, some people are different and could be 6 weeks and then you take 2 weeks, obviously you stay in the facility but you then do into a recovery for 7 weeks or so." (Client 4)

The client spoke of learning a lot of skills within both Dublin Simon and the Lantern, including help with getting his child back, and credited the great connections that Dublin Simon have with these other agencies and their capacity to know where is best to access for your needs, as being life changing. At each stage of the process, the client reported that while the work was challenging, there was significant support available at all junctures, including help getting reunited with his child which culminated in securing full custody. The client however did warn that transitioning from residential rehabilitation process into recovery housing can be a vulnerable time as the supports in place up until this point are very protective. The recovery house is independent living, with no staff on site and you are responsible for yourself. This is illustrated in the quote below.

Client: It's like you are in a bubble, with supports and all that around you. And then you have to come back out into the big bad world. It takes a while; it takes a few weeks. You have your own choice. You don't have agenda that you have to stick to. You have to face the world. Be very aware, it is bit fast. Everything down there is so relaxed and therapeutic, so have to be careful. People are there to help you and when you come out of that, you are alone and do your own thing. There is only 4 of us in it. Two double rooms and a single room. I am the longest here. It is independent living. No staff on site, you have to take care of it. Teaches you how to cook clean, how to pay your bills, how to wash your clothes, and that sort of thing." (Client 4)

This client is still engaged with Dublin Simon counselling services and credits the strong relationship he built with the counsellor there as being integral on his road to recovery and maintaining sobriety. He

also credits Dublin Simon service with helping him deal with family services in relation to his child. The gym and leisure activities have also been integral to his recovery.

2. Challenges accessing the pathway to methadone detoxification

However, for the second client who was using methadone, a different pathway experience occurred. The key challenge reported was that when the client *was ready* for change, the pathway into recovery services was not possible for a number of reasons, which he predominantly states was attributed to his own "chaotic" state, and that accessing methadone detox services was not available for two years, during which time, significant additional harm came to the client. The age of the client at first engagement, and the lack of readiness for change at various junctures across the clients' pathway, and access to services when ready for change may have all contributed to the different experience of bridging pathways which emerged. This can be seen in the client's words below.

Client: "…They probably thought that I was suitable for it ... You are judged on what way you are getting on and all that. Emmm you can refuse the recovery and all that? I probably wasn't up to scratch, when I look back at it. I was fairly chaotic like. I was on a lot of poly drug use; I was on a lot of benzos and that. Emm and it is understandable that I wasn't ready for it and that.....That was the main thing to get off everything when I was ready. But it was just how long it took like. I was nearly dead from it. I was in hospital a few times through that time with my pancreas and all that. Serious health problems. But like at this stage I was like really ready to go into treatment three years before that, but it was just hitting brick walls. I was after surrendering and I couldn't get taken in anywhere." (Client 2)

The client attributed this challenging experience to a combination of both individual level and service level issues, his own lack of readiness for change at different junctures, combined with a lack of service availability when ready, long waiting lists for clients to access stabilisation and methadone detox , the unrealistic entry requirements to external services in terms of "stability", a lack of interagency collaboration potentially motivated by competing funding, and an outdated approach to poly drug use across services. This client reported significant barriers to accessing methadone detox treatment across his clinical care pathway, barriers which he said had severe ramifications for him, and that the process felt like "climbing out of greasy pit."

Client: "…The problem with me was that I was also on methadone. And it's a very – there is a lot of poly drug use today. And there was not bridge for me to get to Dublin Simon. Eventually I did but that was after 10 years. And to get from Dublin Simon into methadone detox like I was coming in and coming off the alcohol and back out into a homeless hostel if I didn't get the recovery. Hmm and basically, it

was trying to climb out of a greasy pit. I was still going to the methadone clinical, so I was still around the same people. The transition like, it just out a block on me for years." (Client 2)

Over the years, the clients' substance use changed, and different substances were being used including alcohol, benzodiazepines and methadone. The emergence of poly substance use complicated the pathways for this client, specifically the methadone usage and stability status. The client experienced a two-year waiting list and a requirement to show stability, which the client felt was not possible given his living status. The clients' life remained chaotic until he was eventually accepted into xxx. At this stage, the client remained in the detox service for 3 months instead of the prescribed 6 weeks due to extenuating health conditions exasperated he believed by the extended waiting time to access the service.

Client: "…the bridge between getting from there to xxx to do a medical methadone detox. I was two years on the waiting list. They wanted me to show stability. How could I show stability and I walking the streets all day and put out of the hostel and 7:30 in the morning. It is very very hard to show stability with no roof over your head so I was just chaotic then for another two years until eventually xxx said that they would take me, so I went back into the Dublin Simon Detox, done 5 week alcohol detox and into the back of a taxi and out to xxx and that was two years ago now. it's a six-week programme, I ended up there for 3months because my health was very bad. My pancreas was gone, and my liver was in the red, things like that..." (Client 2)

However, the experience of accessing pathways was also impacted by the clients' own readiness for change at previous junctures. But that when he was ready, that it was a very difficult journey to access what he needed. The client while recognising that he was not always ready for change when options were available, also attributes his experience as being related to a lack of interagency collaboration, possibly motivated by competing funding, and a lack of knowledge of other services available. This can be seen in the comment below.

Client: "I don't think the services connect with each other enough. Like a lot of them are businesses these days to be honest with ya. I don't like saying that but that the reality like they don't connect with each other and a lot of the workers, don't know the ins and outs of other treatment centres." (Client 2)

However, despite these challenging experiences and the potential individual level, service and system level factors that may have contributed to this, the client went on to achieve full sobriety and is now living in recovery housing facilitated through Dublin Simon. However, the contract for the house is a

two-year contract and having completed one year of this, the next step is ensuring long term accommodation.

Following completion of the detox process in xxx, the client moved to yyy for two months, a residential therapeutic rehabilitation programme for problem opiate users, emphasising occupational work and with a strong focus on after-care and living drug-free. On exit from this rehabilitation program the client moved into a Dublin Simon recovery house, and currently is living in different housing facilitated by Dublin Simon. The client has been living there for one year now and shares the accommodation with one other person who has been on a similar journey. However, he is concerned about what will happen him when he has completed his allotted two year stay in the house as evidence din the quote below.

Client: "I'm not too sure what will happen after that. I'm only here for two years so not too sure what will happen after that. it is time limited. You sign a lease for two years. If you don't have a place by that time. You have to get a HAP place or something like that.... I'll be going on my own after this. I think it's time to leave the system. But look, even now its grand. I have keys to my own door, have a house. I get up in the morning and walk to the open the fridge. Small things you take for granted. And I love it here, it's a nice area." (Client 2)

3. In summary

Overall, the findings reported throughout this client pathway section reflect a complicated system, yet a system where key service providers have managed, despite these adversities, to provide consistent ongoing support to their clients. The resilience of both staff and clients is overwhelming.

This section of the report looked at enablers and challenges at key junctures of the clients clinical care pathway- these included the initial engagement process and access into the detox service, the experience of the detox process itself, and the exit pathways out of the detox service. In terms of initial engagement and access, effective engagement skills and interagency collaboration were highlighted. Challenges related to wider system issues of messaging of service providers around what is actually available for people not yet engaged with the services. However, Dublin Simon CAG are working in conjunction with clients to address this and the challenges for people who are homeless but not registered as homeless.

In terms of the client experience of the detox service itself, the overall feedback from the clients about their experience was overwhelmingly positive of the service provision from Dublin Simon, and the

agencies it collaborates with. The staff, the process, and the ethos were repeatedly reported as supportive, non-judgemental, non-intrusive, highly skilled, well-paced and extremely effective. However, as expected in any service embedded in a system this complex, key challenges were also reported in terms of the male-oriented nature of the services and how this can impact on the experience of females in the service, including the need to possibly consider trauma informed service provision, the differing needs of clients in terms of basic care packs, the possible impact on clients in relation to other clients who may have ulterior motives for engagement or who may be abusing the system in terms of their benzodiazepine use, and finally the consideration of family involvement.

Finally, the exit pathway for clients out of the detox service were considered. These pathways include accessing recovery services and treatment, and housing. Overall, the client cases reviewed here reported very positive experiences of the process at all stages. However, some challenges that existed related again to the gender and family issue, both in treatment and housing, and the issue of poly drug use and accessing suitable services to address this.

3.2.4 Future service needs

In terms of future needs for service provision, in addition to issues highlighted in the sections above, the clients reported the following overarching system wide issues – updating services to respond to polydrug use issues to reflect the current reality, addressing the lack of methadone beds, and exploring the response to COVID in terms of impact on drug users.

1. Polydrug use response needed

In terms of future service needs, the client suggested that services should be updated to reflect the current drug use status on the streets. This can be seen below.

Client: "I think the services should be updated, 10 years ago you would have your average heroin addict on the street but now you would have heroin and crack, a lot more complex drug addicts, mental health and all that too. I do definitely think they should be talking to each other more. And to be honest with ya, some people walking in there wouldn't know much about the other services. Not enough building blocks there …. Most fellas that were on heroin for 10 years aren't even on heroin anymore, they are on crack……Whatever is in the crack, it just takes over." (Client 2)

2. Improving pathways to methadone detox and recovery services in times of COVID-19

At a wider system level, the client reported that the proportion of people on methadone to beds available is limited, and that bridging between services is limited. This service provision gaps are

compounded by the recent COVID outbreak, where services are closing its doors to address COVID issues. Deaths are occurring, and it raises the question if these deaths are related to these closures.

Client: "Yeah 100 methadone beds in the country, xxx are 12 beds, they aren't even taking people in out there at the moment with the COVID. They shut that treatment centre down. To use it for COVID. And when they shut it down, 2 people died having to leave. You would be thinking, would they have died if it was still open." (Client 2)

The findings above have provided insight into the clients' experience of their pathways and the significant support received from services in relation to this. The following section explores the service providers experience of these clients care pathways.

3.3 Staff perspective, care pathways and fidelity

This section presents the findings in relation to the staff interviews and their experiences of the client care pathways.

In terms of the detox unit specifically, key stages related to the initial engagement with the detox service (3.3.1), the experience of the detox service itself (3.3.2), and finally the experience of pathways on exiting the detox service (3.3.3). Alternative pathways are available, and experiences of these pathways varied depending on the needs of clients, and the stage of addiction clients were currently at.

The research looked at positive aspects and enablers, challenges, and potential changes that staff felt would enhance the pathway experience.

3.3.1 Dublin Simon detoxification unit: entry pathway

The following sections explore the enablers and challenges that staff encounter in their work with clients across the care pathway. The research looks at these enablers and challenges at three key junctures- the pathway into the Detox Service, the enablers and challenges within the detox service, and finally the enablers and challenges inherent in the client pathway out of the detox service. The enablers and challenges reported by the staff overall mirror very closely the issues raised in the client interviews. However, some variations are also reported.

1. System level challenge: funding governance

During the staff interviews a key system level issue was reported that impacts on the capacity of the service to function as effectively as desired. This issue is highlighted first and relates to system level funding governance, and DS not being "stitched in" to the system. This can be seen below.

"Even funding aside, we always kind of feel we are on the edge somewhere, we are not quite stitched in anywhere. And we have to balance it as yes, we are a homeless service, but others are claiming to be homeless services, but they might be firmly stitched in in the addiction. It is a dilemma. …so, we are a bit caught in that we are straddling homeless and addiction. We have a foot in both camps bit not firmly fixed in either." (Staff 4)

Dublin Simon provides an integrated holistic approach to meet the clients' needs ranging from addressing the presenting addiction need and proceeding to address the complexity of additional support needs on the clients care pathway including housing needs. The service works on the full pathway in terms of homelessness. However, securing funding is an on-going challenge for the service, due mainly to its precarious funding status and structure within the wider system. The precarious nature of the funding structure is based on the perceived status of Dublin Simon in terms of where it belongs in the wider governance structure.

Dublin Simon currently spans the area of both addiction and homelessness, yet the service, from a funding perspective is perceived as not belonging fully in either domain. The main funding provided for the Detox service is Health Service Executive (HSE) funding, and a small amount of funding from the Dublin Region Homeless Executive (DRHE) , but the current funding covers only about 40% of what it costs to run the detox unit, the remaining funding is through fund raising. The service is not always recognised as an addiction service and there is a lack of support to provide detox and recovery services to clients.

Staff: "…so we are a bit caught in that we are straddling homeless and addiction. We have a foot in both camps bit not firmly fixed in either.... Our main funding for the detox is the HSE and a little bit from the DRHE but it probably 40% of what it costs to run the detox unit." And "All of these are brilliant ideas, but they have no funding." (Staff 4)

Dublin Simon changed how they operated to accommodate client needs, e.g., changing the rehab to recovery, but while the concept was supported theoretically, financial support is not forthcoming.

Staff: "We changed our rehab to a recovery to be able to accommodate clients who, for e.g., come into detox from alcohol but are on methadone and will remain on methadone. We changed to recovery to accommodate that, that created its own issues because in that everyone was staying in recovery was really good because previously people relapsed quickly and left because it was to highly structured. But while everyone thinks that it is a great idea. Nobody is supporting us around it." (Staff 4)

It has taken ten years to secure a small amount of funding from Tier 4 funding, with the argument being that they are not located in the addiction services. This issue is an ongoing systemic issue and a key challenge in ongoing service provision.

Bringing in systemic change of this magnitude to meet the client needs was a huge step for the organisation, both in terms of cultural shift and mindset change, and significant resources and time, but this exponential growth in response to client need, is creating additional challenges now for DS as there is nowhere to send clients onto, and funding is not forthcoming.

Staff: "So it turned out was that client coming in to detox from alcohol also had other drug issues and they would do well to stay off alcohol but then they would go into the unit, it was so highly structured that if you sneezed you would be asked to leave and it just wasn't realistic. They weren't able for that high structure So we had to develop something that was going to suit the client that we were meeting that were coming from the streets and we set up the recovery unit and we spent a lot of time training staff because there is obviously a huge cultural shift and mindset change that we needed to bring in particularly with staff who had a model in their mind so we worked on that for a number of years and eventually launched it in 2015… there is nowhere to send them and we are not funded. But there is nowhere for them to go, and it is not a good idea for them to stay too long in the recovery. Because they can stagnate and could reverse." (Staff 4)

2. System level issue: stitching the service in and access to Housing/Housing First

This issue of the dual focus of Dublin Simon has additional governance challenges at the wider system level in terms of suitability for housing, in particular, Housing First, for their clients. There are current challenges with recognising the clients who have come into the detox service get recognised as Housing First clients, but DS are meeting consistent barriers in relation to this.

Staff: "we are constantly trying to have our clients that come into detox brought in under housing first because surely they are housing first people. They must qualify for HF. We are taking them from the street. They have mental health issues, they have physical health issues, they have addiction issues. Lots of issues – would qualify to be in HF. It's almost as if once they come into detox, it's like – its grand,

they are over there in DS. It is almost like we do a bit of disservice to ourselves and possibly to the clients as well... and we have argued this with DRHE and xxx in housing first, that all the clients coming into detox should be eligible for HF. They are all coming from the street." (Staff 4)

DS has repeatedly raised the challenges with moving clients on and accommodation.
The issue of housing is reported on further in the final section – Challenges Exiting Detox.

3. Pathway into detox service: enablers

The following section explores the enablers and challenges that staff reported in relation to client pathway into the Detox service. The responses from staff in relation to enablers for the client pathway into the detox service consisted of engagement procedures, entry criteria and referral processes.

Enabler: additional staff

The staff reported that in recent years new staff position of a Project liaison worker/ Intake coordinator were created to facilitate referrals into the service, and this has served to increase the occupancy rate, decrease the Did Not Attend (DNA) rate, and provide a connection for the client with somebody in the detox unit. This can be seen in the quote below

Staff: "What has been improved is having the assigned intake coordinator who have been working with all the other referring agencies to try and get them in quickly and get rid of any roadblocks when they come in so that certainly helped." (Staff 3)

Enabler: outreach team

In addition to this, because Dublin Simon works on the full pathway in terms of homelessness, they also have their full outreach team on the streets, in addition to their soup run team. These workers build relationships with people with the aim of encouraging them into the service and make direct referrals to the service. This is evidence din the quote below.

Staff: "We have outreach workers and so on who will be in contact with them and build a relationship with them to get registered. So, majority have been. The criteria registered homeless, they would be in a catchment, they would be homeless or risk of losing their house. We do take that into account as well." (Staff 3)

Enabler: interagency collaboration

Dublin Simon staff also reported having good connections with General Practitioners and external homeless agencies as an enabler for client engagement with the service. The combination of these factors aims to increase engagement with clients and facilitate referrals into the service.

Enabler: lower threshold entry criteria

The service also has lower threshold entry criteria than most other services, meaning that people in need can access their service for help and supports where other service entry criteria may have prevented them from doing so. DS does not require a completely clear urine sample, is responding to poly drug use by being the only service who has a no threshold policy for methadone. While the service does not cater for a methadone detox within its detox service, it does facilitate the tapering of methadone in consultation with clients' external providers. This can be seen below.

Staff: "…medically low threshold in terms we accept people who are on methadone and who are on higher doses of benzodiazepine from other detoxes and because of that I think we are also more willing to work with challenging behaviour and slips, we usually don't discharge if they have a slip while they are on the unit." (Staff 2)

Staff: "I really liked that about the service, they didn't put too much emphasis on the client having to give a completely clean urine going in because if was client by client bases. I think that can never be counterintuitive as we are asking clients to nearly be clean before that entering a service that is supposed to help and support people to do that." (Staff 1)

Enabler: no threshold for methadone/lower threshold than other agencies for benzodiazepines

DSC also does not have a threshold for methadone. This means that clients who are prohibited from accessing services in other agencies because of their methadone use, can get the help and support they need in DSC.

Staff: "DS would be the only service that I know of that you can access if you are on methadone." (Staff 1)

"Because we take people on any dose of methadone, we don't have any restrictions, the majority of detox or recovery services across Ireland would stipulate that you are on 50mls or below to access a service. We don't have that stipulation." (Staff 4)

Enabler: polydrug response to alcohol and benzodiazepine

The DS detox service is for alcohol and benzodiazepines, while a methadone detox is not provided, but the service facilitates clients who wish to detox from alcohol and benzodiazepines, whilst concurrently being on methadone.

"We have accepted people on very high doses of methadone have moved right through recovery and into their own place and they are stable. Then they eventually start working themselves with their GP to reduce the methadone." (Staff 4)

The inclusion of benzodiazepine within the detox was in response to the reality of substance use of clients and to try to support these clients to access the help they needed. DS reported that its more benzodiazepine stabilisation, than detox as this is the reality of providing support for this cohort. For stabilisation purposes, the client usage cannot exceed the Librium dosage required for the alcohol detox process but assistance with tapering is provided within DS.

Staff: "I can say the big new and emerging thing, the new generation team to be poly substance rather than just one substance use. So that is something that has changed. And we didn't usually do the benzo detox, but we do now to accommodate them because there is so much benzo being used." And "It has probably been the last two and half, three years." (Staff 3)

Enabler: no fixed abode of habitual residency required

Within DS, the client is not required to have a fixed address or to meet the habitual residency criteria to access the service.

Staff: "…you don't need to have a fixed address to be service user it is specifically provided to people who are homeless" and "we would have taken in some clients who don't meet the habitual residency criteria" (Staff 1)

Enabler: prioritises vulnerable cohorts (women, rough sleepers, ill clients)

While acknowledging that all homeless are vulnerable in different ways, there are certain categories that are more vulnerable. These include for example, women, rough sleepers, ill clients. DS strive to prioritise these cohorts when arranging access to the service.

Staff: "We do try and fast track those who are rough sleeping because they are head to keep in contact with. You want to get them while they are available. We prioritise at risk females because rough

sleeping for those is much more dangerous and those who have been hospitalised. We do try and get those who have been physically sick and rather than be discharged back to wherever the situation was, we try and get them in." (Staff 3)

Enabler: referral procedure such as shortened form and weekly meetings

The referral form was shortened to facilitate busy clinicians and make the process as easy as possible for them. It had been noted that when the form included too many questions, it wasn't getting filled out by clinicians and was a barrier. In addition to this, weekly meetings take place to review the waiting list and prioritise the most vulnerable.

4. Pathway into detox service - challenges

The following section looks at the challenges that staff reported in terms of accessing the detox service. Challenges were reported with initial engagement and entry criteria.

Challenge: messaging around services available

In terms of initial engagement, one of the 5 staff reported that the there is something getting lost in translation in relation to the communication of information about what services are available. When clients are surveyed, they report not having knowledge of what is available, this is despite all the processes that are in place to facilitate clear messaging and communication.

Staff: "We have all these processes in place but when we do a survey with the client, they haven't heard of any of these. So, you are like okay, something is getting lost in translation. I'd love to tighten that up in a way that they know what that is my key worker, that is the person that helps me with my plans and goals." (Staff 4)

This is an important finding, as in the client interviews also, this issue was also reported. However, a factor that may be at play is a lack of readiness for change at the level of the individual, as in the message may only be heard when the client is ready to hear it. In the client interviews, it was reported that they often weren't interested on what was on offer at different junctures, and or only became interested when a significant life crisis arose. During the client interviews it was also reported that clients in conjunction with DS Community Action Group are designing a Map of services available to address this gap.

Challenge: long waiting lists

Staff reported long waiting lists. These waiting lists have been compounded by COVID-19 and impacted also by clients not knowing beforehand what they want. This issue of clients not knowing what they want may be impacted in part, by the issue raised above in terms of messaging.

Staff: "Yeah there is a lot on the waiting list, and I suppose in a perfect world someone would know beforehand what they want but often people don't and that is probably really hard that someone will come in and the detox maybe off alcohol, that they do want to detox off methadone and there is a really long waiting list." (Staff 1)

Staff: "That is [COVID] making the list longer. That would be the main thing getting access to us and because the waiting list – getting to us in a timely manner. …there are roadblocks with people getting into the service. We have a waiting list unfortunately. People drop off that list." (Staff 3)

Challenge: not registered as homeless

Other challenges reported related to the barrier to service when the client is not registered as homeless, and the challenge of bed capacity.

Staff: "The other roadblock would be that some may not be registered as homeless, and they have to be to access the service. They may be homeless but have not gone through the registration process or be eligible for the reason." (Staff 3)

The issue of not being registered as homeless also was raised in the client interviews. In this instance, while all the other clients were admitted within a 3-4-week timeframe, the client who was not registered as homeless, had to wait four months before gaining access due to his registration status needing to be addressed. This client reported finding information on this issue difficult.

Challenge: bed capacity and COVID

Bed capacity can sometimes be an issue for staff where client referrals are received, but there is no bed for the client. This issue is compounded by the current COVID situation requirements.

Staff: "The problem would be when they are ready to come in, sometimes it is the time when we don't have a bed available." (Staff 3)

Staff: "Yeah, with COVID 19 we have had to reduce our beds" (Staff 3)

Challenge: methadone specific challenges

DSC operate a no threshold entry criteria for people on methadone to facilitate this cohort gaining access to support and help needed. However, this process is complicated by system procedures.

There can be a significant time delay between receiving the referral and gaining access to the methadone for the client, this delay can be up to 10 days. The quote below illustrates this.

Staff: "People coming into us on methadone not to detox on methadone because we don't do detox methadone, just coming in to have an alcohol or benzo detox and coming on a dose of methadone. The time it takes for them to get treatment card, from the local pharmacy so that we can get them in, that can take up to 10 days. So that means that we are ready to go but the methadone is not ready to be transferred across." (Staff 4)

This issue is compounded by different criteria across the agencies, lengthy cumbersome forms which vary by agency, and a lack of joined up systems in terms of external addiction treatment centres. The quotes below clearly articulate these system challenges.

Staff: "…and from a nursing point of view we had to do up a methadone process, big, long form – it just helps the nurses to keep on track in terms of the different preadmission day, discharged protocols that exist between trinity court, north Dublin methadone clinic, independent GP prescribers, castle street and places like that." (Staff 4)

Staff: "They all have different criteria so to navigate that is a minefield." (Staff 4)

Staff: "I had to follow the whole log to see what you would do if you came from trinity, if you come from castle street, I have to go down another line, it is not joined up in terms of external addiction treatment centres." (Staff 4)

Challenge: no pharmacist leading to time delays for client and resource intensive for nurses

There is also currently no pharmacist within Dublin Simon, and this is a significant barrier. If the service had their own pharmacist, clinicians would be able to send the information directly. The availability of a pharmacist would also free up nursing time as currently nurses spend about 80% of their time with medication management.

Staff: "We don't have a pharmacist and that's a big block, if we had a pharmacist on site that would resolve that issue. Because a pharmacist - all clinicians in the addiction centres would be able to send it directly to our pharmacist on site that would also relieve that pressure that is on our nurses. So, they spend about 80% of their time with medication management, especially with control drugs. And that is a lot of time spent on medication management. Again, if we had a pharmacist that would reduce that bit in terms of the pathway in that has been a barrier" (Staff 4)

Dublin Simon have been arguing the case for a pharmacist and the issues with the methadone process and the discussions are ongoing.

3.3.2 Detoxification unit experience

Once clients' referrals have been addressed, suitable clients are given access to the detox unit. Within the detox unit, staff reported several enablers and challenges inherent in the process that can impact the clients care pathway.

1. Enablers in detox service

Staff reported a range of enablers within the detox service that facilitates a better client care pathway. These consisted of staffing, and process components.

Enabler: strong leadership and management

Staff reported that that the DS detox consists of strong on the ground leadership, and excellent management structures, a culture where clients and staff and listened to and staff ideas are encouraged and nurtured. This is evident form the quotes below.

Staff: "I think my manger went above and beyond accommodate the people. I suppose the get the service to fit the people instead of the people fit in the service." And "It me loving my post was definitely to do with my manager and leadership." (Staff 1)

Staff: "We take leadership form our manager. She is very on the ground. She very involved in how we deal with things. So, she would kind of lead us in that way." (Staff 2)

Enabler: voice of staff encouraged and nurtured

The voice of staff members is also heard, encouraged and nurtured. New ideas are embraced and supported.

Staff: "Yeah I do think the staff voice is heard. Certainly, that was my experience anyway. What I found quite unique about DS it was that if you had an idea or felt that something would help the function, you were really encouraged to pursue that. And nurture that and give you the space to take it on and build on it.... I really like that. A great way to be, great for your own personal development but a development for the service as well." (Staff 1)

Enabler: good staff and resources

According to staff interviews, the detox consists of a good team of staff, both clinical and non-clinical, with adequate staff and resources, and access to in-house training both mandatory core training and additional training as and when needs arose.

Staff: "We have plenty of nurses… we have social workers, we have counsellors, … we have accommodation support as well." (Staff 5)

Enabler: in-house training for staff equipped for role

Staff reported that there is a good training component, with core mandatory training in place and any additional training needs which arise are supported.

Staff: "There is [training]. We do it in-house. I do it with them. I do an introduction where we go over addiction, we go over withdrawal syndrome, the post withdrawal phase, so we do an education for our nurses. The key workers usually are coming from a degree in social sciences, so they are quite up to date in terms of area. So, the nurses may never have worked in this setting before. We do a mentoring where for the first 6 months we are spending time with the nurses and discussing and issues that may come up." (Staff 3)

2. Enablers in detox processes

Staff reported a number of enablers in relation to processes within the service. These consisted of strong alignment with core values and organisation mission, and a need led service which encourages and supports client autonomy.

Enabler: in line with core mission and values

All staff reported that Dublin Simon operates within its principles and values, cultivating a sense of community, and ensuring the needs of the client and key to service delivery.

Staff: "Yes, Dublin Simon is very in line with its mission and values…" (Staff 3)

Staff: "Oh yes I would think so, we always ask for … we respect every care need … and organise accordingly, and we review the care plans weekly." (Staff 5)

Staff: "But that is one thing that people feel like – I feel like I have a support network." And "So, I do think we are aligned with our values." (Staff 4)

Enabler: client autonomy and empowerment encouraged

Within DS detox, client autonomy and empowerment are central to the work ethos. Clients are encouraged to make their own decisions in a supportive environment. This can be seen below.

Staff: "I quite like that we weren't pushing an agenda on people, allowed people to have the space to make the decision themselves about what they wanted which I thought was important that we are giving people autonomy with themselves" (Staff 1)

Staff: "…the decisions of the clients are definitely at the centre of what we try to facilitate so it is very much – more of an empowerment approach…" (Staff 2)

Enabler: tailored to client's needs as a result of low threshold

The service response is a tailored response, based on client needs.

Staff: "…thing that worked well was that it was quite low threshold so often we made decisions on a client-to-client basis, so we made decisions to best suit the client coming into the service." (Staff 1)

The client's voice is heard and supported. Client feedback forms are being created to capture direct feedback from clients. The current research is also integral to capturing the client voice. This is seen below.

Staff: "And then I suppose on an organisation level, I suppose it was to do with clients voices which is part of DS ethos and I definitely felt that in the service." (Staff 1)

Enabler: flexible tailored needs led service

DS provide a flexible, inclusive, realistic service, tailored to client needs, a service that doesn't force conformity. This is seen below.

Staff: "…I worked in [other] services where it was very strict and clients had to conform – the service users signed up to a treatment service and I guess there wasn't a lot of flexibility around maybe sobriety being the end goal" and "…[Dublin Simon Community] is a much more inclusive service because it ends up offering lots of different types of different care to people" and "Yeah in general I would have found the detox quite flexible when working around things with the snow and stuff and the whole country shut down and we just held on to the service users and we would have just extended out there discharge dates and that." (Staff 1)

Through this flexibility, DS endeavours to meet their clients' needs in whatever way possible. It won't always be possible, but every possible avenue is explored intensely, and clients receive all the support and resources available to meet their needs.

Staff: "…the biggest thing when they come into us is the move on plan where they are going oy go afterwards. So, in that regard what works well I think is being able to be flexible which something we are able to and sometimes we are not, that can be really tough on clients." And "Which was good thing that we had that flexibility to hold someone that bit longer and getting a positive move on." (Staff 2)

Enabler: DS model/community family land client dignity

The model DS operates from is from a community perspective, inclusive, a family type environment, supportive, the opposite of what clients may experience on the streets. This was an enabler as seen below.

Staff: "*I think the model that we are, it is more of a community fitting. We try have a family like. We don't have a staff dining room for example- we are eating with the clients. I think that works well. We don't have a lot of problems here in terms of behavioural problems and violence maybe because we are providing a place of human dignity and I don't think you get that on the streets." (Staff 3)*

Enabler: counselling services available

DS supports client needs across the entire care pathway. One of the supports available to clients involves a counselling service available in DS. A unique feature of this service is that the counselling remains available to clients after they have detoxed, and even if they are no longer using any other DS services.

Staff: "It [counselling service] is actually provided by DS, they actually come to us and do one-to one counselling here. They also run groups on mental health. But they go to all the other DS services as well.

The one thing that is different is that they can access counselling once they have detoxed so they do have that as a support. Even if they aren't going into another DS service." (Staff 3)

Staff: "Typically, it is weekly.... They also offer us emergency counsellor 24-hour service for someone who is acute. So, if someone comes to us and says that they are actively suicidal, we can actually contact the sure step counsellors and see if they can see the same day for an emergency session and then set them up for appropriate sessions after that." (Staff 3)

In the client interviews, clients reported the significant life changing benefits for them of the supports available in DS, and in particular the critical role of the counsellor being available even when they had completed treatment and no longer using other DS services. The counselling is available weekly and there is also 24-hour emergency access for clients that need it.

Enabler: language barrier managed through interagency collaboration

The changing profile of Ireland means that language can be a barrier in services. However, DS work closely with an external agency to respond to any language related issues that arise.

Staff: "We work very closely with a service called Mendisity, which is not actually specifically for non-nationals, but a huge proportion of the non-national homeless population use that service and they have PW who speak Polish, Russian, Romanian.... And if we were looking at admissions, we would try to say, if we knew we were taking in a Polish person, we usually try and have at least one other polish person in there so at least they have some kind of company. And sometimes they would be able to do some translating for day-to-day bits obviously not private matters." (Staff 2)

Enabler: detox process works well with high completion rate

Staff reported that the detox service works well and has a high completion rate, with 80% of clients completing their detox program. The service has good protocols in place for managing the clinical complexity that presents. This can be seen from staff quotes below.

Staff: "80% of the clients complete their detox programme" (Staff 5)

Staff: "The alcohol detox works well. It is well established." (Staff 3)

Staff: "We have a really good care path... for each and every perspective of their care" (Staff 5)

Staff: "We help refill their confidence in them [clients] and to immerse back into the society." (Staff 5)

In summary, in terms of the enablers for the detox service, the key enablers relate to the organisational ethos, strong supportive leadership, care and nurturing of staff, the emphasis on prioritising client need and encouraging autonomy, the flexible nature of the service, and the community culture.

3. Challenges in detox service

Challenges with staffing

While in the enablers section of the detox, a key enabler related to the high-quality staff, and the management and organisational structures that facilitate this, there were still some challenges reported within the service relating to management structures and staffing.

Challenge: flat structure

One staff member at a senior management level reported that the organisation has a very flat structure, which needs to be addressed. This issue was not reported from any of the other staff. On the contrary, staff interviewed reported satisfaction with the management. In relation to the nurses in particular, one staff member reported that introducing different levels of nurse management is under consideration.

Staff: "I would like to see there is a bit of different levels of nurse management so whether that is a nurse who is really interested in the patient flow, a nurse who is really interested in education of the staff. We have student nurses from UCD and DCU, but they really take control of the whole education side, whether that is nurses, new nurses, longer serving nurses. So, I would love to see those two strands improve. And then someone who does the operations and the rotas. It is hard enough to get the mangers in the first place, I don't know how we would manage to track and retain those positions." (Staff 4)

Currently the nurse manager is responsible for all tasks with the exception of rotes and operations.

In addition to this, currently 80% of the nurse role is consumed with medication management, which in the previous sections staff reported that the availability of a pharmacist would help alleviate this burden. The consideration of creating different levels of nurse management is to address the currently challenges inherent within the nursing addiction field in terms of skill deficit in the area, extensive upskilling, and lack of interest in pursuing specialisation in the area. These are flagged in the following section.

Challenge: intensive up-skilling of staff required

While staff composition and training available were reported as a strong enabler of the service in the previous section, the level of training and upskilling being provided is very resource intensive. The skills needed to work with this client group in terms of complexity of presenting issues, requires specific skill sets, which staff in many cases, do not present to the service with.

Staff: "… we don't have people coming into us with those skills." (Staff 4)

One staff member also made a future suggestion in terms of additional training dealing with behavioural concerns, including de-escalation skills.

Staff: "More training on all staff with dealing with behavioural concern situation. We do a map of training which is half a day, but I don't think that is – a lot of it is physical. It doesn't really get into the de-escalation, strength-based interventions and that sort of thing and sometimes that can get dragged into almost a verb fight with clients. Things like this, how to de-escalate situations and deal with behaviours of concern." (Staff 2)

Challenge: staff retention and roles

In conjunction with this, this intensive investment in upskilling can be diluted by high staff turnover within the service. Group training was introduced to try to address this issue, but ultimately, staff retention issues have left the organisation feeling vulnerable in terms of reliance on the expertise and support of other organisations (MQI in this instance). This issue can be difficult for managers who invest so much time and resources in upskilling, to then have staff leave the post as can be seen from the quote below.

Staff: "…keeping people – like we went through about 5 years where we were just broken down by you train people up you came in with the skill and you train them further and they leave and you start all over again so we just had to do something to keep the service going so what we decided to do to keep the service going was to train a number of people together. And we think, we can't keep doing this and it is soul destroying for the managers as they would invest so much time and they would be so excited about having someone with a proper skill and then they are gone, and you are just left starting all over again." (Staff 4)

The retention of nurses in particular, is an issue. DS reported experiencing significant challenges finding, and paying for, skilled staff. There are 10 nurses in the detox unit, and the sourcing and cost of funding of these staff is a big challenge for the organisation.

DS staff also reported that a compounding factor appears to be the lack of availability of further education courses specialising in addiction. This can be seen below.

Staff: "*And unfortunately, here in Ireland there is not a designated post graduate degree for nurses that want to do addiction studies. I don't think so anyhow. Some of the nurses have actually gone off and done the masters in addiction studies but I'm not aware that there is any specific one for addiction studies for nursing." (Staff 3)*

However, this issue appears to be further compounded by a lack of interest by nurses in pursuing specialisation in the area. DS have tried to encourage and support further education but none of the nurses have taken up that offer.

Staff: "*What surprises with our nurses is that none have them have taken up our offer to become clinical nurse specialist in the area of addiction or do further study. To me, they might not be as interested in addiction a much as I would like them to be. To me that is a pity because to me, it is an amazing place to be. While some of the nurses are really engaged, but when it comes to further education, they are not choosing to do that, and I think there is loads of opportunities as clinical nurse specialists. We would be willing to support no matter how hard – I'm not getting any interest." (Staff 4)*

In terms of additional strategies to try and address nurse staff retention, DS have targeted overseas nurses s and provide sponsorship. This has improved staff retention rates but only within a 2-3-year timeframe. In addition to this, this solution is resource intensive for DS.

Staff: "I…We have recruited from overseas and suppose people are reliant – I suppose we are sponsoring them, so they have to at least give a year, but they tend to give two to three years. I think our employer and people do like staying with us, but it comes a point to move on for their own sake; more money; more experience; living in different in other locations. I do think that we are supportive our staff." (Staff 4)

One other issue in relation to staff that was raised by one staff member, was that there is no longer a budget for support workers, and that the service provided by these staff provided a really good support for the clients.

Staff: "I think one thing is to look at the supporting roles and not just nursing staff. The clients really benefited from the twilight workers because they had that background, they would do things at the weekend like bring them out to the cinema. We don't have a budget for it anymore. We got more nurses. We are going to have a volunteer for a month, I think. But yeah, they were a really good support for the client. It is nice for the clients to have someone who is just there, who is present around the building and might just watch television with them or sit in the smoking area with them. Who aren't really under pressure to do other duties?" (Staff 2)

Overall, it was flagged that the system can be a tough system to work in overall.

4. Challenges with process in detox

Staff reported a number of challenges that exist with service provision, both at an organisational level and within a process level.

Challenge: gender needs

One staff member raised concerns that the service needs of female clients may not be being met.

Staff: "I don't know what it is but for females in the service, I don't think we are meeting their needs. We aren't, and it is something we need to look at." (Staff 4)

Currently the ratio of males to females accessing the service is about 3:1. Responding to female clients presents unique challenges for the organisation, an example of this might be relationships between clients. In addition to this, responding to couples can be difficult. A phased approach is needed as articulated below.

Staff: "Sometimes couples would come in – we would stagger them. One would come in first and go through the detox and the second would come in and detox while the other gone to recovery." (Staff 4)

The experience of females on the street can be very different also to a male's experience. The reason why they ended up on the street, and many women may have children that they are responsible for. This is illustrated in the quote below.

Staff: "I think their experiences on the street are different, maybe they aren't but they seem different. The reason why they ended up on the street might be different and they also seem to have children that they are somewhere connected with and have the responsibility of the child." (Staff 4)

Women may also have higher relapse rates due to these external pressures.

Staff: "Thinking of women over the years and a lot of women would relapse much quicker than the guys because somebody from the outside is constantly contacting them and eventually managed to get them out of the detox for whatever reason, say you have responsibility for their children. And here is a woman trying to get her life together but there is much more of a pull back out from various reasons – family, partner and maybe more vulnerable on the street and to go back on the street. We definitely aren't meeting that need I don't think." (Staff 4)

During this staff interview, in terms of future suggestions for service, reviewing how to respond to female client needs was highlighted by the staff member as being an issue for consideration, but caution expressed in terms of remit of organisation versus desire to meet the needs of female clients. This can be seen in the quote below.

*Staff: "**…**Somewhere where they can stay building that bond again, our service is not designed like that. I suppose a big thing is we don't allow any visitors and it is not that we say you can have visitors, but they certainly can't bring in visitors who are under the influence and most people have nobody else. So, we never see visitors in the detox unit. Not one visitor, which is sad." (Staff 4)*

This issue of responding to female client needs is highlighted further in the following section on the current rules in relation to no visitors being allowed in the service.

Challenge: visitors not allowed

A related component is the current rule of no visitors in the service. In many cases this is not an issue as many people in addiction and receiving detox, at this stage in the process, may only have contact with other peers who are under the influence, who for obvious reasons cannot visit the service. Also, the majority of clients at this stage no longer have contact with family. Thus, even if visiting was provided, there would be little need for it. This is seen in the quote below.

Staff: "That's the thing most people have no family that will come in or engage with because the family is broken by the constant efforts to get the person on track, so a lot of bridge building only happens later, probably more in the aftercare services. But at the detox stage the family has had enough. That why nobody comes to see people. That's the sad part, they are trying their best, but their peer support are people on the streets." (Staff 4)

However, every client case is unique and there are instances where clients do still have contact with their family, this can be a particularly important component for parents in treatment. Currently, people who are in the detox treatment and still in contact with family, are facilitated to meet their children/family externally.

Staff: "It happens external. Obviously, if they have family out and want to go out – that is facilitated." (Staff 4)

Dublin Simon has also facilitated pregnant women in the detox service, who in many cases are not they're of their own decisions but required to be there by social workers. These cases can be challenging but DS have managed these cases successfully to the point of delivery and back to the hospital. However, concerns do exist as to the future well-being of the child in the environment. Finally, while family involvement may not be a presenting need for many clients, be this through visitations, or other avenues, currently DS does not facilitate any family involvement within the service.

Challenge: treatment specific challenges

Staff reported challenges across two main strands these were staffing issues and process issues. Within processes, staff reported overarching issues above such as gender needs led response, and visitation issues.

Treatment specific challenges were also reported. These challenges related to exiting the detox which will be explored in the final section, and challenges within the detox. These treatment specific issues within the detox service are listed below. These issues included time limits on the length of time people can stay, flexibility in the programme and in its duration and a holistic approach in team meetings. These are illustrated in the quotes below.

Staff: "I think there can sometimes be time limits on how long people can stay so typically it is a three to four-week programme so that can be difficult." (Staff 2)

Staff: "So, I don't know, maybe more flexibility around it would kind of be what I would recommend I suppose." (Staff 1)

One staff member also suggested incorporating more recreational activities to encourage more engagement from clients, which would divert clients from their addiction.

Staff: "… if we can make the clients more engaged in the programme by including … recreational things that would be really good for the clients, they will remain… it will keep them active during the day and it would be helpful to diverting their thought from their addiction." (Staff 5)

One of the staff members reported that the service could benefit from a more holistic approach to the team meetings, which currently are quite medically focused.

Staff: "*Some of the other treatment have a referral meeting where they would have a meeting with their doctor, the clinical nurse manger, the doctor, the nurses and staff. And they have a referral meeting once a week were, they go through each client, there medical needs, their move on plan. There medical care plans and psychosocial care plans and we don't really do that because our GP isn't really involved as the other GP's because they are referrals into the service. We have a handover every morning but it's not as in depth and I think one thing that could be helpful would be more involvement from more therapists and counsellors… we review the client in a more review meeting I suppose of the clients where we review their medical care plans and their other care plans as well. Move on plans, social welfare payments, that sort of thing and that could be useful. We talk about their case in a more holistic way could be helpful." (Staff 2)*

In line with this, in terms of being able to plan effectively for clients, it was reported that it would be useful to know before people come in what their plan is after detox.

Staff: "*… could be useful is knowing before people come in what their plan was after detox, was the person intension before they come in to go to further treatment? So that you can start planning that from day 1 of where they are going to go and stuff." (Staff 1)*

However, as reported in earlier sections, and in the client section, clients often don't know what they want after detox, and this can be as a result of both not knowing themselves at this stage what path they wish to take, but also, they actually might not know what options are available after detox, prior to engaging with the service. The issue of messaging around services available has been flagged by both clients and staff as getting 'lost in translation' despite staff have multiple processes to address this.

Challenge: responding to polydrug use and low threshold service/gap in service for some clients

In the earlier section on enablers for the service, the low threshold criteria were reported as an enabler for clients to access support, clients who would usually be unable to engage in services because of their drug use. However, the downside of this feature for some clients can be reflected in a gap in service provision for clients who are on methadone or prescribed benzodiazepines.

Staff: "*So, I think because it's quite a low threshold service, there seems to be gap between in service provision for some of the clients who are on methadone or prescribed benzodiazepines." (Staff 1)*

This issue was also raised in the client interviews who reported that there is little, if any information provided in relation to methadone, the focus being predominantly on alcohol detox and benzodiazepine stabilisation to support Librium administration.

Polydrug use is a growing phenomenon and responding to polydrug use complicates the detox process. This can be challenging for both service providers and the clients. Challenges include managing polydrug use cravings, composition of street drugs, and long withdrawal process for methadone users this is seen in the quotes below.

Staff: "*The thing that is changing, and generational too, is that we are seeing more poly substance users so not just coming off the alcohol or benzos – usually a combination which can make it more complicated." (Staff 3)*

Staff: "*The opioids. We are starting to see a lot more opioids, people smoking heroin and the tablets are not what they say they are. You are getting poly substance use of what's on the streets." (Staff 3)*

Staff: "Their cravings. We are detoxing their drug of choice; we are detoxing someone like giving them decreasing amounts of alcohol. So certainly challenging." (Staff 3)

Challenge: responding to mental health needs/dual diagnosis

The issue of how to respond to the mental health needs of clients, and the lack of access to external supports were reported as key challenges. In-house, while acknowledging that counselling supports are available through DS, and while staff reported it as an enabler for clients, there were time limitations to the mental health supports available. These included limited availability of the counsellor, limitations in the clinician prescribing of anti-depressants to pre-existing prescribed clients only, and no in-house access to a psychiatrist. This is seen below.

Staff: "*…the clinician is not a psychiatrist but will prescribe antidepressants if you have been on them in the past. He won't prescribe them on any psychotics if they haven't been on them in the past. They should be seeing a psychiatrist to do that. So, it is difficult for those clients." (Staff 3)*

External to DS, there is an Access team, which provides psychiatric homeless service. A lot of the clients in DS have dual diagnosis but it can be very difficult to get the client access to the access team. This is illustrated below.

Staff: "*…a lot of our clients are dual diagnosed. So, they might have psychiatric disorders as well but not be treated for them. And it is really hard to get them into the access team which is the psychiatric homeless services. It is really hard to get them to see a psychiatrist. So often when they come off of the substances, they are self-medicating, and the psychiatric disorder is going to flare up and unfortunately over worked mental health system are having a hard time giving them somewhere to go after detox. That puts in a high risk for relapse again." (Staff 3)*

In conjunction with the limitations to in house mental health supports, the challenges with accessing the external mental health supports, and overarching gap identified at the wider system level is a mental health unit for people who are falling through the cracks. This is seen in the opinion expressed below.

Staff: "*There is one big gaping hole and that is for mental health unit for people who are falling through the cracks." (Staff 4)*

Challenge: serving two masters, addiction and homelessness

At the beginning of this chapter, it was reported that the dual purpose of Dublin Simon in terms of addiction and homelessness presents significant difficulties in terms of funding and being in the system. This dual focus can also present challenges on the ground as illustrated below.

Staff: "*We have an issue that we are serving two masses. We trying to get them out of homelessness and at the same time treating addiction. And sometimes the goals don't line up exactly. If it was a straight addiction programme, they might be treated very differently. We are trying to prevent them to going back into homeless and sometimes that doesn't always work – serving two masters." (Staff 3)*

7. Enablers leaving detox: good external collaborations

The final part of the research explored challenges in the client care pathway at the exit point of the detox. The key enabler reported was the good relationships and interagency collaboration between DS and external services that facilitate the clients' transition onto the next step in their care pathway, whether this was onto other recovery services, or on to other detox services. This is illustrated in the quotes below.

Staff: "*We had our own recovery programme, and we would have referred a lot of our clients on to that but as we would have referred our clients on to other services, other rehabilitation services and would have had good working relationships with them and also good working relationship with other accommodations…" and "I think the Dublin Simon recovery service does all the external really well. They help people access education, accommodation and all that." (Staff 1)*

These external service collaboration and relationships included links with outreach workers from the drugs task force who could come in to talk to people in terms of moving on and in terms of alternatives to DS recovery.

Staff: "*…they had an outreach worker- he was from the drug task forces. That person would also come in to talk to people int terms of move on and in terms of alternative to DS recovery." (Staff 1)*

Finally, the aftercare programmes were reported as playing a key role in supporting client additional needs. This is seen below.

Staff: "*In the aftercare programme, where they would work with them on those things, counsellors, attending aftercare groups, occupational that kind of thing." (Staff 3)*

8. Challenges leaving detox

Staff reported a myriad of challenges that exist for clients existing detoxication in terms of accessing the next appropriate pathway. This is particularly the case for DS as they deal with housing as well as the addiction component of the clients care pathway. The ramifications of this barrier are many folds for both the client and the service.

Challenge: internal move on (victim of own success) constant need to expand number of recovery beds

Internally, in terms of pathways out of detox and into the DS recovery there is internal control over the DS places. The DS has however to some extent have become a victim of its own success in that people coming into the detox unit are doing well and want to move onto recovery. The DS want to facilitate this as many of these clients have never been through detox before and are in a good place, however but in order to accommodate this the DS have to keep extending their recovery beds. The number of beds has increased in the past from 12 to 75 and DS believe that they could keep expanding these beds to meet the need, but they are not funded for this. Clients are getting stuck in the system as they have nowhere to move on from recovery. DS in previous years changed their rehab service into a recovery service to accommodate lower thresholds and poly substance use in a response to

needs of clients on the streets. However, this change created its own new challenges as clients now became stuck in the internal DS system in the absence of somewhere else to send the clients to complete their recovery journey, this was particularly the case for methadone clients. This situation is reflected in the quotes below.

Staff: "*We want to give them that opportunity, but we have to keep expending out recovery beds. We started off with 12 and we now have 75 and you could add another 75 and you would be able to fill all the places. But is that the right thing to do? There is a big ownership with DS to provide accommodation and we aren't funded for that always. We just keep adding to the recovery units, people are not moving on from them to their own accommodation which means that they get stuck in recovery. We add on another premises so that we can take more people in but that comes to a point where we have to stop. So, if we don't have that flow through, it does seriously impact on the detox unit. Probably enough considering there are not recovery or rehab beds in the system. And similarly, there are not enough move on accommodation options for people out of recovery. So, it created a back log all the way back to detox." (Staff 4)*

Senior management have raised this issue repeatedly with the appropriate external bodies, and as flagged at the beginning of this chapter, DS have made a high volume of systemic changes as advised to respond to the need, but the required wider system level support is not forthcoming.

Staff: "*So, we are arguing this since I arrived. People say yes and they agree and ask us to change this and that and we have done everything that we have been requested, we changed our rehab to a recovery to be able to accommodate clients who, for e.g., come into detox from alcohol but are on methadone and will remain on methadone. We changed to recovery to accommodate that, that created its own issues because in that everyone was staying in recovery was really good because previously people relapsed quickly and left because it was to highly structured. But while everyone thinks that it is a great idea. Nobody is supporting us around it." (Staff 4)*

Challenge: external move on such as lack of suitable programs/waiting lists

For a number of clients there is a lack of suitable follow-on programs, and this can lead to clients being placed back in an environment where the chance of a relapse is acutely heightened. This is seen below.

Staff: "*And the other issue, the lack of suitable follow-on programmes. We have our own, but they all have waiting lists. We have someone for three weeks; we have to keep them for longer when we are trying to get them into a suitable programme. But for a lot of our clients unfortunately, they do our*

detox, and the hostel they were living in, there are people using around them and the chances are staying sober is poor." (Staff 3)

Staff: "…they go back to addiction as they don't have home support." (Staff 5)

Challenge: waiting lists and repercussions for client and service

Other clients may have found a suitable follow up program, but issues include delays because of capacity and waiting lists, which results in people being left in limbo at a critical timeframe in their recovery journey. This is seen below.

Staff: "*There is this safety in treatment, they are kind of just in limbo waiting to find out what way they can go for them" and "It is generally when people would relapse, while in limbo waiting for bed. Because they just don't know, emotionally detoxing from substances, it is like their safety blanket being removed." (Staff 1)*

In cases where clients have been promised a pathway out, but it doesn't happen, DS end up having to hold the client, which blocks a bed for someone else.

Staff: "*But sometimes the person who is in has been promised a pathway out and it doesn't happen. And it is more the external providers*….and *we can't really keep them in detox because it is not conducive for their recovery or move on, but we also can't send them back out so yeah keeping them also means blocking a bed for someone else." (Staff 4)*

Pathways out of detox for clients on methadone can be particularly acute as use of methadone prevents access to many services. This issue has been reported at length throughout both the client section and the preceding sections of the staff findings. This is illustrated below.

Staff: "*A lot of our clients are on methadone. A lot of programmes won't take them on methadone. A lot of them have a cut off of 40mls per day. So that limits where they can go as well. The reason we so many of those clients is because we have no limit for the people that might be on 50/60/70/80 and drinking." (Staff 3)*

Within Dublin Simon, there is no requirement of clients to be off methadone to access the DS *recovery* service, this is one of the unique differences between the DS recovery programme and other recovery programmes.

Challenge: limited suitable accommodation options/repercussions for service and clients

Limited suitable accommodation options were repeatedly reported by staff as being one the main barriers and challenges for client care pathways. These limitations included a lack of eligibility for housing first for clients who attend the detox, a lack of single accommodation, a lack of family friendly accommodation, a severe lack of dry hostels for people who don't want to engage in further long term residential treatment, but want to remain sober, a lack of private rooms in hostels, and a cumbersome long process to access long term housing. This creates multiple challenges for both services and clients. This is expressed below.

Staff: "*So, have we raised it? Yeah, we have raised it every year and not just from a funding point of view but from the point of trying to get the move on and accommodation - we are constantly trying to have our clients that come into detox brought in under housing first because surely they are housing first people*." *(Staff 4)*

Staff: "*When people come in, they might be single when they are on the street they might not have access but once they come in, they would be building lives with their family and then they would have access and that is one of their big dreams and hopes that they have access to their children but then they won't get the accommodation to accommodate staying with their child." (Staff 4)*

Staff: "S*o sometimes people come on, they have been through rehab before they don't really feel they need to go back, maybe they just come in to give their body a break. They want to get back to work, say they don't want to spend 5 months in a treatment facility… There are basically no dry hostels or anything like that for them to go to so that is not really a part of our service. That is a block*." *(Staff 2)*

Staff: "*A lot of the time they will come on and they will be happy, I don't need further treatment and I am happy to go into a hostel, but I need to go in somewhere with my own room so that I am not sharing with someone who is drinking and that is impossible. It can be done but it is so so rare that we would be able to get that." (Staff 2)*

One other major challenge in relation to housing is in relation to client who are habitual residency condition affected. These clients are from Europe, not Ireland, but they are not entitled to social welfare payment housing as they have not contributed enough tax. This is seen below.

Staff: "There is one big challenge, which I don't really know whether DS detox can address. Its clients who what we call 'habitual residency condition affected' HRCA effected. They are clients form Europe, not from Ireland, and they would have come here let's say, homeless straight away and never worked,

or worked cash in hand and never paid tax. And when they go try get their social welfare payment housing, they can't because they haven't paid enough tax." (Staff 2)

Challenge: insufficient occupational supports

One staff member reported that while there are certain supports in place around meeting the occupational needs of clients, that there needs to be more focus on occupational supports throughout the client pathway, such as an occupational programme.

Staff: "Also need things like occupational training because they have been out if the workplace, they need to be connected to programmes that offer that as well. Even things like money management. We don't do that, not in the detox but on other areas – skills managing finance. So, most of our clients, if we can get them into an intermediate programme where the focus is ongoing treatment for their addiction. But because they have out of work, or left education early. They do need those other skills and they aren't being provided." (Staff 3)

In terms of additional suggestions for future change not already reported in this section, staff reported the need to address capacity issues is important, to revisit the integration of detox and recovery services, to streamline services and to incorporate a holistic rehabilitation programme.

Challenge: ongoing scaling up

It is worth noting that across the findings from the staff, one of the key challenges that emerged related to unintended consequences from systemic changes to the service provision model in response to client need. While this degree of changes was supported theoretically, funding has not been forth coming. These changes required significant cultural and practice developments, and intensive resources from staff within the service. These changes have created challenges in terms of bottlenecks within the DS service, resulting in clients remaining stuck in the system, the possibility of stagnation, and ongoing challenges for staff in terms of managing these bottlenecks. Management is in constant discussions with external bodies to address these issues. The suggestion in relation to bringing in additional management structures within the detox unit was in part to respond to the need for more structure in terms of existing changes. However, despite this, the regulations around charities and management structures at this juncture dictated that these management changes were not required at this juncture. This is seen below.

Staff: "… to see if we can try bring in a structure for the nursing in particular because we are moving to a 100 bed facilitate and we would need more structure as it will be like a mini hospital. It varies from a board level of an organisation to look at those process but up to now we have just had three medical units which is substantial enough but it wasn't enough for a charity to warrant putting in levels, but I do think we were heading in that direction." (Staff 4)

9. Summary

As can be seen from the findings reported above, while challenges exist both at entry pathway into the detox service, and during the detox, the most significant challenges in the client care pathway exist at the exit point from detox in terms of both identifying what pathway the clients wish to take following the detox, and accessing these pathways.

Particular challenges exist for clients on methadone at all junctures, and at exit from detox, in terms of follow-on service access. For all clients, the pertinent challenge relates to accessing suitable accommodation and move on services.

Wider system level issues impact this in terms of the current perception of where DS belongs in the wider structure due to its dual purpose, and in terms of funding challenges as a result of this.

The scope of scaling up within DS to respond to client needs, and to endeavour to ensure they provide a service for homeless people who were falling through the cracks due to high thresholds for entry to support, has not taken place without its own challenges for the organisation. DS has in many ways felt that is has become a victim of its own success in that the improvements made have served to create additional barriers for clients, in particular in relation to accessing Housing First.

When combining the client feedback with the staff feedback, it is clear that similar barriers and enablers are reported across the two perspectives. Key enablers across both cohorts related to the staff, culture and ethos of the organisation, and the effective interagency collaboration between DS and external services.

In terms of challenges, similar challenges were reported by both staff and clients indicating an awareness of staff of the issues facing their clients. However, for one of the challenges related to entry into the detox reported by all clients, only one staff other staff member reported this issue- i.e. messaging getting lost in translation.

In terms of challenges reported within the detox service, again, the issue of possibly not meeting the needs of female clients was only raised by two staff members. Reviewing of this issue with staff may be an important development for future consideration.

In terms of challenges at the exit point of detox, more challenges were reported by staff than by clients, with the exception of the client who experienced significant barriers in relation to his methadone use. For the other three client care pathways reviewed in this client section, smooth transitions at key junctures were reported.

However, this may reflect the nature of the requirements for this research in that due to COVID, interviews with clients needed to take place over the telephone, and the interview duration was 30-45 mins. Thus, clients needed to be at a stable point in recovery to be able to engage in the process successfully. In addition to this, while the initial remit of the research was to interview staff in relation to the client case studies, the interview explored both the enablers and challenges of these clinical care pathways, in conjunction with enablers and challenges of care pathways overall. What is undeniably clear from this review is the incredible work that DS are doing, as evidenced from the client feedback, in what is an extremely complicated care path.

4.0 Conclusions and recommendations

To aid the development of evidence-based recommendations arising from the findings, conclusions and resulting recommendations will be reported together using the care pathway process as a framework. Further overarching recommendations will then be posed in support of individual recommendations.

4.1 Entry to the care pathway

While many points were raised by clients and staff at the entry stage of the care pathway process it was clear that for some entry points communication could be improved from the client perspective. This may be as a result of some clients being less ready for change and change coming as a consequence of sudden adverse life events.

> **It is recommended that clients accessing the service as a result of an adverse event such as a hospital discharge receive enhanced communication on what to expect and the process involved.**

Clients and staff on some occasions expressed confusion as to the range and nature of available services from food services to hostels and beyond. It was reported that a city service map is being developed.

> **It is recommended that the production and completion of the planned service availability map be produced and distributed as a priority.**

A further challenge encountered by some clients was the availability of basic care provision on entry. This was particularly challenging if a client had entered as a result of an unexpected adverse experience or if a client was female.

> **It is recommended that the provision of a gender specific personal care package of relevant toiletries be available for clients entering without such item**

To conclude, in summary the entry into the DS system was viewed as working well with both clients and staff and only minimal challenges were encountered.

4.2 The care pathway

Both staff and clients spoke very highly of the DS system, leadership, processes and services. However, some common challenges emerged, and some additional challenges were identified by staff. In terms of commonality both highlighted the need for greater flexibility in the programme delivery and processes and operation. This may include flexibility in the duration of programmes to meet individual client needs and perhaps flexibility in processes in terms of gender sensitivities and past traumas, parental needs s and needs of family.

> **Given the philosophy of a client centred service it is recommend that the DS seek to find compromises where small flexibilities with significant meaning for clients can be introduced into standard practices.**

An ongoing challenge identified by both staff and clients was the issue of dealing with polydrug use while in the DS and dealing with additional medically prescribed drugs that had to be administered while in detox. Polydrug use represented a new challenge and a new profile of client. Staff interviewees strongly felt there was a need for a pharmacist on site to assist with medication management. This is currently being managed by the nursing staff.

> **Given the significant threat or risk medication management might pose within a expanding system of care with DS it is recommended that a pharmacist position be sought as a priority**.

Staffing levels were not identified as a challenge by clients but were highlighted in several instances by staff at differing levels. The challenge of staff recruitment, retention and training and upskilling investment was ongoing particularly in relation to nursing professionals. The investment of time and resources and sustainability of this investment was questioned. Some links with educational colleges have been made to address this on an ad hoc basis. As the DS continues to grow this may need to be formalised for the benefit of both. Relevant departments might include general and mental health nursing, social care, and psychology. Additional staffing challenges were identified with the mental health services. While clients spoke very highly of the counselling service and the work being done there was a recognised need within staff for the provision of a psychiatric service given the nature and seriousness of some of the psychiatric disorders experienced by clients. A linking of the DS with a School of Medicine may also be a long-term solution for access to a pool of trained and training professional personnel.

In response to the challenge with staff recruitment and training it is recommended that DS from key alliances in the form of Memorandums of Understanding with relevant educational organisations containing mutual commitments for delivery.

4.3 Preparing to exit the care pathway

From the staff perspective the greatest challenge experienced by DS was at after the detox process and at the move into and at the end of the recovery process. While the usual challenges of waiting lists, accommodation and additional occupational supports were identified the DS found it had become a victim to an extent of its own success as clients wanted to move onto recovery as a result the DS have to keep extending their recovery beds. Clients are then becoming stuck in the system as they have nowhere to move on from recovery, this was particularly the case for methadone clients.

It is well recognised in the literature that there are many factors for organisations to consider and scaling up requires significant resources and even sacrifices (Weiss, 2010). However, in non-profit organisations identifying and addressing organisational 'mission drift' is perhaps one of the most important factors. Moving in a different direction from an organisation's foundational social mission is a concern and one that requires consideration regarding whether this change in direction is appropriate and in line with organisational values (Dees & Anderson, 2003). For example, identifying ways of expanding services to reach new clients is often a next step of non-profit organisations. If the expansion of client reach is an organisational scaling goal, how an organisation selects and continues to select beneficiaries-and how this leads to the marginalisation of those not selected- is a key consideration for an organisation in terms of mission and values. Similarly, by expanding in this way, to what extent does the organisation take on a government's responsibilities and to what extent does interdependency develop between the organisation and public institutions. Increased need for capital as a result of such upscaling may also lead an organisation into different methods of funds generation i.e., commercial activities, private contributions, government funding). For example, using private funds the goal is often to secure state funding to support this expansion (Frumkin & Andre-Clark, 2000). However, an organisation needs to be mindful of the impact that such a change or scale up can bring. Management Systems International (2016) (see https://www.effectiveservices.org/downloads/ScalingUp_3rdEdition.pdf) provide a checklist for practitioners to consider when planning scale up. Key questions of relevance to Ds might include the following, how strong the support for change is and is there a sustainable source of funding.

Given the nature of the scaling up challenge facing DS it is recommended that DS management and staff organise and externally facilitated strategic planning day possibly

with the Centre for Effective Services Dublin or similar specifically to explore solutions for scale up.

In the course of analysing the findings it was also clear that perhaps the balance of the mission of DS had shifted from detoxification services to recovery services. This may have been a reflection of client need and also importantly Government policy and the changing nature and demography of addiction in Ireland. To some extent the changing nature of clients was found within the retrospective analysis of the client data sets.

Given the greater emphasis on recovery within the service and within wider policy it is recommended that the DS community re-evaluates its role with the National Drug Strategy and seeks to obtain a relevant place within the committee structure of the national policy, this will enable the DS to be viewed within its new and wider mission and role.

Finally, as with any expanding organisation leadership, governance structures and monitoring and evaluation are essential to ensure a quality service for staff and clients. All components were clearly present and highly valued within the staff and client interviews. However, as the organisation expands it is recommended that greater attention be given to governance structures from clinical to managerial to administrative.

It is recommended that as the organisation expands that due attention is given to the establishment of expanded and relevant oversight procedures and governance structures.

In conclusion, the findings from the evaluation demonstrated that a highly motivated team of stakeholders from staff to clients to leadership were involved but further preparation is required to ensure a successful scale up of the recovery care pathway. In the words of Kofi Annan, seventh Secretary-General of the United Nations from January 1997 to December 2006 and co-recipient with the UN of the 2001 Nobel Peace Prize.

'*We need to keep hope alive and strive to do better.'*

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6.0 Appendices

Further quantitative findings are presented below.

Table 3: Participation in Programmes and Discharge Information 2015 to 2019

Variables		**2015** (n= 178)	**2016** (n= 189)	**2017** (n= 197)	**2018** (n= 203)	**2019** (n= 182)	χ^2 **2015 & 2019**
		n(%)	n(%)	n(%)	n(%)	n(%)	
Physical Wellbeing Programme	Yes	119(73.9)	117(76.0)	140(76.1)	159(85.0)	143(78.6)	
	No	42(26.1)	37(24.0)	42(22.8)	28(15.0)	18(9.9)	*p= .685*
	N/A	-	-	-	-	21(11.5)	
Learning and Development Programme	Yes	123(76.4)	118(76.7)	140(76.1)	165(88.2)	155(85.2)	
	No	38(23.6%)	36(23.4)	42(22.8)	22(11.8)	6(3.3)	*p= .195*
	N/A	-	-	-	-	21(11.5)	
Methadone Programme	Yes	27(16.8)	16(10.7)	30(16.3)	38(20.2)	52(28.6)	
	No	134(83.2)	134(89.3)	153(83.2)	150(79.8)	130(71.4)	*p= .125*
	N/A	-	-	1 (0.5)	-	-	
Valid Medical Card at Discharge	Yes	109(67.7)	81(43.0)	147(79.9)	155(82.9)	147(80.8)	
	No	52(32.3)	61(57.0)	37(20.1)	18(9.6)	35(19.2)	*p= .758*
	N/A	-	-	-	14(7.5)	-	
Local Authority at Discharge	DCC	100(66.7)	111(68.9)	113(61.4)	121(64.0)	123(67.6)	
	FCC	2(1.3)	4(2.5)	4(2.2)	12(6.3)	10(5.5)	
	SDCC	14(9.3)	4(2.5)	18(9.8)	21(11.1)	14(7.7)	
	DLRCC	3(2.0)	3(1.9)	13(7.1)	8(4.2)	6(3.3)	-
	Not Eligible	-	-	23(12.5)	21(11.1)	23(13.7)	
	Other	31(15.3)	31(19.3)	13(7.1)	6(3.2)	4(2.2)	
	Unknown	-	8(5.0)	-	-	-	
Reason for Discharge	Successfully Discharged	105(65.2)	118(76.6)	126(70.8)	137(75.7)	119(69.2)	
	Disengaged – Alcohol	17(10.6)	16(10.4)	-	-	-	
	Disengaged – Drug	2(1.2)	1(0.6)	-	-	-	
	Disengaged – Imprisonment	-	1(0.6)	-	-	-	
	Disengaged – Hospital/Nursing Home	-	-	4(2.2)	4(2.2)	1(0.6)	
	Voluntary Disengagement – Unknown	31(19.3)	12(7.8)	-	-	-	-
	Voluntary Disengagement – Accommodation	-	-	1(0.6)	-	-	
	Voluntary Disengagement – Client Decision	-	-	41(23.0)	27(14.9)	30(17.4)	
	Voluntary Disengagement – Rough Sleeping	-	-	5(2.8)	-	-	
	Service Withdrawn	3(1.9)	5(3.2)	1(0.6)	13(7.2)	22(12.8)	

Table 4: Detox Programmes 2018 and 2019

Variables		**2018**	**2019**	χ^2
		n(%)	n(%)	
3 Weeks Detox Programme	Yes	129(71.7)	120(51.9)	
	No	51(28.3)	43(21.2)	*p= .225*
	N/A	-	9(4.4)	
Medical Detox Programme	Yes	165(81.3)	142(82.6)	
	No	19(9.4)	28(16.3)	*p= .458*
	N/A	-	2(1.2)	

Table 5: Service Referred To from 2015 to 2019

Variables		**2015** (n= 161)	**2016** (n= 154)	**2017** (n= 177)	**2018** (n=181)	**2019** (n= 172)
		n(%)	n(%)	n(%)	n(%)	n(%)
Move To	Addiction Service	-	-	-	-	-
	Approved Housing Body	5(3.1)	4(2.6)	-	-	1(0.6)
	Drug Treatment Centres	41(25.5)	4(2.6)	1(0.6)	6(3.3)	13(7.6)
	Garda	-		-	-	-
	Homeless Persons Unit	-		-	-	-
	Hospital	3(1.9)	3(1.9)	3(1.7)	4(2.2)	1(0.6)
	HSE	-		-	-	-
	Local Authority	-		11(6.2)	-	-
	Member of Public	25(15.5)	7(4.5)	12(6.8)	7(3.9)	4(2.3)
	Other Homeless Services	44(27.3)	10(6.5)	41(23.2)	24(13.3)	20(11.6)
	Other Simon Services	5(3.1)	5(3.2)	79(44.6)	63(34.8)	39(22.7)
	Outreach	1(0.6)	2(1.3)	28(15.8)	4(2.2)	3(1.7)
	Prison	-	-	-	-	-
	Probation Service	-	-	-	-	-
	Self-Referral	-	-	-	-	-
	Returned to Same Service	-	-	-	72(39.8)	83(48.3)
	Other	6(3.7)	76(49.4)	2(1.1)	1(0.6)	8(4.7)
	Unknown	31(19.3)	43(27.9)	-	-	-
	Not Applicable	-	-	-	-	-

Table 6: Source of Referral 2015 to 2019

Variables		**2015** (n= 170)	**2016** (n= 164)	**2017** (n= 182)	**2018** (n= 189)	**2019** (n= 182)
		n(%)	n(%)	n(%)	n(%)	n(%)
Source of Referral	Addiction Service	17(10.0)	-	11(6.0)	32(16.9)	24(13.2)
	Approved Housing Body	-	3(1.8)	3(1.6)	-	-
	Drug Treatment Centres	-	11(6.7)	16(8.8)	3(1.6)	13(7.1)
	Garda	-	-	-	-	-
	Homeless Persons Unit	-	-	9(4.9)	-	-
	Hospital	-	-	7(3.8)	8(4.2)	18(9.9)
	HSE	-	-	11(6.0)	1(.5)	6(3.3)
	Local Authority	-	-	1(.5)	-	-
	Member of Public	-	-	1(.5)	-	-
	Other Homeless Services	104(61.2)	74(45.1)	52(28.6)	92(48.7)	48(26.4)
	Other Simon Services	40(23.5)	49(29.9)	52(28.6)	36(19.0)	49(26.9)
	Outreach	4(2.4)	17(10.4)	4(2.2)	1(0.5)	-
	Prison	-	-	-	-	-
	Probation Service	-	-	2(1.1)	1(0.5)	6(3.3)
	Self-Referral	-	7(4.3)	7(3.8)	15(7.9)	17(9.3)
	Other	-	-	3(1.6)	-	1(0.5)
	Unknown	-	-	1(.5)	-	-
	Not Applicable	-	-	2(1.1)	-	-

Table 7: Demographic Information of Participants

Clients	Gender	Age	Ethnicity	Household Type	New to Service	Prior Admissions
Client 2	Male	40	Irish	Couple	No	2
Client 3	Male	55	Irish	Single with no children	No	1
Client 4	Female	57	Irish	Couple	No	2
Client 5	Male	60	Irish	Single with no children	No	1

Table 8: Substance Use on Admission from 2015 to 2019

Clients	2015	2016	2017	2018	2019
Client 2	No	Yes	-	Yes	Yes
Client 3	No	No	-	Yes	-
Client 4	Yes	No	-	Yes	Yes
Client 5	Yes	No	-	Yes	Yes

Table 9: Physical Wellbeing Programme Participation 2015 to 2019

Clients	2015	2016	2017	2018	2019
Client 2	Yes	-	-	Yes	Yes
Client 3	Yes	Yes	Yes	Yes	Yes
Client 4	Yes	Yes	Yes	Yes	No
Client 5	Yes	Yes	Yes	Yes	Yes

Table 10: Learning and Development Programme Participation 2015 to 2019

Clients	2015	2016	2017	2018	2019
Client 2	Yes	-	Yes	Yes	Yes
Client 3	Yes	Yes	Yes	Yes	Yes
Client 4	Yes	Yes	Yes	Yes	Yes
Client 5	Yes	No	Yes	Yes	Yes

Table 11: Methadone Programme Participation 2015 to 2019

Clients	2015	2016	2017	2018	2019
Client 2	No	-	No	No	No
Client 3	No	No	No	No	No
Client 4	No	No	No	No	No
Client 5	-	No	Yes	No	No

Table 12: Valid Medical Card at Discharge 2015 to 2019

Clients	2015	2016	2017	2018	2019
Client 2	Yes	-	Yes	Yes	Yes
Client 3	Yes	Yes	Yes	Yes	-
Client 4	Yes	No	Yes	Yes	Yes
Client 5	Yes	-	No	Yes	Yes

Table 13: Reason for Discharge 2015 to 2019

Clients	2015	2016	2017	2018	2019
Client 2	Successfully Discharged	-	Successfully Discharged	Successfully Discharged	Successfully Discharged
Client 3	Successfully Discharged	Successfully Discharged	Successfully Discharged	Successfully Discharged	-
Client 4	Successfully Discharged	Successfully Discharged	Successfully Discharged	Successfully Discharged	Voluntary Disengagement
Client 5	Successfully Discharged	Service Withdrawn	Successfully Discharged	Successfully Discharged	Successfully Discharged

Table 14: Source of Referrals at Admission and Discharge 2015 to 2019

Clients	**Referrals**	2015	2016	2017	2018	2019
Client 2	Referred From	Other DSC Service	Other DSC Service	Self-referral	Self-referral	Other Homeless Service
	Referred To	Other DSC Service	-	Other DSC Service	Other DSC Service	Returned to same service
Client 3	Referred From	Other DSC Service	Other Homeless Service	Other Homeless Service	Addiction Service	Other DSC Service
	Referred To	Drug Treatment Centre	Other	Local Authority	Returned to same service	-
Client 4	Referred From	Other Homeless Service	Other DSC Service	Other DSC Service	Drug Treatment Centres	Hospital
	Referred To	Drug Treatment Centres	Other	Other Homeless Service	Other DSC Service	Returned to same service
Client 5	Referred From	-	Outreach	Drug Treatment Centre	Other Homeless Service	Addiction Service
	Referred To	Drug Treatment Centres	Unknown	Other DSC Service	Other DSC Service	Other Homeless Service

DSC= Dublin Simon Community