Evaluating a Community-Based Initiative

The Drugs & Irish Mobility Project

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Executive Summary...

Positively Irish Action on AIDS (PIAA) is a community-based initiative working with Irish people in Britain affected by HIV/AIDS, and is an active member of the European Network of Organisations working with Migrants. This report describes a pilot evaluation project of a community-based initiative responding to the needs of mobile Irish drug users, affected by HIV/AIDS.

International mobility can have an important impact on the spread of HIV and there is an urgent need for specific programmes to address this factor. When individuals migrate from one country to another, there can be a number of consequences: (a) migrants may not have been exposed to the same health education programmes as people in the country of destination; (b) within the migrant group there may be specific needs which are not catered to in the country of destination; (c) mobility itself may affect health behaviour (people may take more or less risks). All of these factors apply to the Irish in Britain, affected by drug use/HIV.

The needs of migrant communities affected by HIV/AIDS often remain invisible in HIV prevention programmes of both the host country and the country of origin. Community-based initiatives have a vital role to play in reaching these hidden populations and developing appropriate harm reduction and risk minimisation strategies.

If the needs of migrant communities are to be addressed in public health resources, it is important to have an understanding of the specific issues which affect particular communities, to facilitate the development of responsive services and to address differences in patterns of epidemiology between the community and the host population. Community-based organisations are uniquely placed to elicit grass root knowledge and expertise on the needs of specific migrant groups affected by HIV/AIDS. An action research model, using monitoring and evaluation programmes, can enable a community-based organisation to identify and promote the needs of migrant groups to a wider audience, facilitating health policy and service developments to be informed by grass root expertise.

This report describes the application of PIAA's action research model to a community-based initiative which aims to respond to the needs of Irish people who use drugs intravenously, and are mobile between the Republic of Ireland and Britain. The strategies employed to achieve this aim were: the employment of indigenous workers to undertake outreach and facilitate access to the client group; the development of a referral service to facilitate access to mainstream services; networking with service providers in both Member States to develop a referral base; and the development of advocacy and support interventions to help clients sustain contact with services.

The evaluation of the initiative provides the organisation with an opportunity to describe what we did, why we did it, who participated, how we designed it, how we did it, the problems, the easiest part, the hardest part and the results/outcomes. To reflect a range of issues and service interventions provided by the organisation a computerised monitoring system was developed, which also collected basic socio-demographic data on the client population. The monitoring data presented in this report relates specifically to work undertaken between December 1993 to June 1994, with clients who disclosed intravenous...
drug use. This amounts to approximately 50% of the total client population in contact with the organisation during this period. The evaluation puts the quantitative monitoring data into a qualitative framework to explore some of the issues faced by Irish people affected by HIV/AIDS, the strategies adopted to respond to those needs and development issues addressed by the organisation.

Through this evaluation, the report identifies a number of areas, where the monitoring system has been able to inform strategies and development priorities within the organisation. This has been evident in the work with gay men, women, and Irish families. In particular the monitoring system identified a group who all too often remain invisible within drug services. 24% (n=42) of the male clients appearing in this report, identified as gay or bisexual. This information has been able to specifically inform outreach priorities within the organisation and the development of appropriate service responses.

The monitoring system also highlighted issues around another group who often remain invisible within drug services. 43% (n=74) of clients appearing in this report are women, yet 54% (n=909) of service interventions recorded in this report were to women. The Monitoring System clearly indicated that women in the client population of this report, required a higher input of resources and face a wider range of issues than men appearing in this report. This evaluation has provided the organisation with an opportunity to explore in more detail some of the issues facing Irish women affected by HIV/AIDS and living in Britain.

The monitoring data is also able to highlight a significant issue being faced by Irish men and women in this report. 55% of clients have children; 49% (n=41) of whom are men and 51% women. Irish families will become increasingly evident in mainstream services dealing with children affected by HIV/AIDS and the monitoring system has identified the need for PIAA to identify a strategic role in the development of services which are responsive to the needs of Irish families. The evaluation has highlighted the impact HIV has on Irish families and the important role many families play in the care and support of Irish people affected by HIV/AIDS.

This evaluation also identifies a number of limitations of monitoring systems. The increasing reliance on monitoring systems to monitor performance, service users needs and outcomes of service interventions, needs to be met with caution. Monitoring systems are inherently reductionist in their nature, therefore they cannot address the quality of service provided, nor reflect the complexity of need of the target population. They cost time, money and resources for an organisation if they are to be effectively maintained and this can provoke a conflict in terms of development priorities for community-based initiatives. The conclusion is that whilst quantitative monitoring data can play a role in indicating need, it cannot demonstrate need, which requires more qualitative data to gain a deeper understanding of the quantified results.

This report strives to communicate the important role community-based organisations have in preventing the spread of HIV/AIDS amongst migrant populations. It describes some of the strategies employed to develop a community-based initiative, the issues identified and the client population served. Its highlights some of the organisational models used to inform the development and progress of the initiative, emphasises the importance of a flexible and responsive service, and describe some of the difficulties encountered by the organisation.
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The Drugs & Irish Mobility Project facilitates access to services for Irish drug users and promotes continuity of care for drug users who travel between Ireland and the UK.

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- Summary of Service interventions
- Summary of Client data

Summary of Recommendations...

EUROPEAN LEVEL

1 The needs of migrants and mobile populations are often invisible within the health priorities of host governments. The Europe Against AIDS Programme has a vital role in ensuring the needs of this group remain at the fore of HIV prevention campaigns.

2 Migrant and mobile populations are potentially a significant population at risk of HIV infection/transmission, and resources should be available to specifically target their needs.

3 This requires the development of community-based initiatives to develop appropriate harm reduction strategies for the target population.

4 Development of services in response to the needs of mobile/migrant drug users, should include a community-based action research programme, to elicit grass roots expertise and knowledge of the community.
5 Sufficient resources need to be available to enable community-based organisations to develop appropriate management information and monitoring systems.

6 Priorities in targeting resources should include addressing the needs of migrant women, ensuring appropriate treatment and care options are available to them.

COMMISSIONING PRIORITIES

1 Purchasers and commissioners of health and social services need to recognise the unique role community-based initiatives have in accessing hard-to-reach populations and facilitating the dissemination of grass roots knowledge on identified needs.

2 Purchasers should ensure financial and technical resources are available for organisations working with ethnic and minority communities, to meet the demands and challenges of the new ‘contracts culture’.

3 The service and treatment needs of crack users need to be researched, ensuring a gender dimension, and where necessary, appropriate responses developed.

4 Lesbians and gay men who use drugs should be addressed within drug prevention campaigns, care services and treatment options.

5 Research & Development within the NHS needs to ensure that the vital grass roots expertise of community-based initiatives is incorporated into research commissioning priorities.

6 The important role indigenous workers have in providing a cultural dimension to care, needs to be recognised in community care planning and District Health Authorities purchasing plans.

SERVICE DEVELOPMENT

1 For PIAA to secure appropriate resources to continue the development of this project and the completion of the evaluation programme.

2 Review the Monitoring System at PIAA to address the following issues:
   - the way in which time is recorded within the Monitoring System.
   - HIV risk behaviour indicators used in the Monitoring System at PIAA.
   - the need to identify couples and family relationships.
   - to identify ways in which to record work around Networking and Support.
   - to identify ways in which to make the presentation of data more accessible and categories of service interventions more explicit.

3 For PIAA to secure appropriate resources to undertake a one year assessment project on the needs of Irish parents and children, and planning appropriate service responses.

4 To review services provided to Irish women with a history of drug use and to identify appropriate strategies and development plans.
Evaluating a Community-Based Initiative...

Drugs & Irish Mobility Project

Positively Irish Action on AIDS (PIAA) is a community-based initiative working with Irish people in Britain affected by HIV/AIDS, and is an active member of the European Network of Organisations working with Migrants. If appropriate measures to prevent and control the spread of HIV infection in Europe are to be effective, community-based initiatives such as PIAA can provide a valuable source of information and strategies. These need to be disseminated on a wider European level, to enable policy and service developments to be informed by grass-root issues. It is now widely recognised that Member States need to address the relationship between HIV, drug use and mobility. The Drugs & Irish Mobility Project is an important contribution to this debate and provides an opportunity to assess and evaluate one model of working with a mobile drug using population, which can be disseminated on a European level.

The Drugs and Irish Mobility Project facilitates access to services for Irish drug users and promotes continuity of care for drug users who travel between both Member States. This report describes Phase 1 of the implementation, development, monitoring and evaluation of a community-based project working with mobile Irish drug users, their families and partners and includes monitoring data which was collected between December 1993 to June 1994. During this period basic socio-demographic data was collected on 74 Irish people who disclosed participating in intravenous drug use or had a history of such drug use. In addition to this, 909 service interventions were recorded with the client group to reflect a range of issues and service responses. The Project was funded by the European Commission for 9 months and this report aims to address each key question of the evaluation and where necessary, to make recommendations to the appropriate authorities.

What is Evaluation?

The National Research Council (1989:318) has stated:

A successful evaluation of an intervention program must provide answers to several key questions:

- What were the objectives of the intervention?
- How was the intervention designed to be conducted?
- How was the intervention actually conducted?
- Who participated?
- Were there any unexpected problems?
- What parts of the program were easier to conduct than was anticipated?
- What parts were harder?
- What outcomes were observed, and how were they measured?
- What were the results of the intervention?

This report provides PIAA with an opportunity to describe what we did, why we did it, who participated, how we designed it, how we did it, the problems, the easiest part, the hardest part and the results/outcomes.

Rhodes et al (1991:12) suggest that evaluation aims to address the feasibility, effectiveness and efficiency of an intervention in achieving stated aims and objectives. They divide the evaluation process into four components: the evaluation and assessment of clients needs; the monitoring of
baseline information and the measurement of change; the evaluation of an intervention's implementation and process functioning; and the evaluation of an intervention's impact and outcomes. In general, evaluations are either process or outcome orientated. The evaluation presented in this report could be described as process evaluation in that it attempts to describe the context in which the interventions occur and the processes involved in arriving at particular outcomes.

The Aims, Objectives, Methods and Expected Results of the Project were stated in the submission to the European Commission to fund Phase 1 of the project and these provide useful measurements against which to evaluate the project.

Objectivity of Evaluation

This evaluation provides the organisation with an opportunity to review development during the first phase of the project, and represents only one aspect to the evaluation programme. Phase II will provide an opportunity to involve service users and service providers in a review of the project's development. Therefore, it is important to recognise this report represents only one of the participants in the project – the organisation. The data presented in this report is based on the team’s evaluation, as well as field notes collected throughout the project. Monitoring Data is used to quantify the work, and research data is used to place it within a more qualitative framework.

Information Sources for Phase 1 of the Evaluation

- **Consultation through:**
  - Team Meetings
  - Management Committee Meetings
  - Development Meetings
  - Networking Visits

- **Field Notes from:**
  - Consultation Meetings
  - Local & Health Authority Contract Applications
  - Supervision Notes
  - Reports to Purchasers

- **Data:**
  - Computerised Monitoring System using FileMaker Pro database package

- **Research:**
  - Research Reports, Studies and relevant Publications
What we did...

Stated Aims of the Project

➤ AIM 1
To develop effective interventions to drug users who are mobile between the Republic of Ireland and England, to ensure access to harm reduction and risk minimisation services

➤ AIM 2
To ensure drug users, their family and partners, affected by HIV/AIDS, gain access to appropriate care and support.

➤ AIM 3
To provide advocacy and support to drug users approaching services to ensure continuity of care.

➤ AIM 4
To network and liaise between service providers in both the Republic and England to establish care packages for drug users leaving or returning to the Republic.

➤ AIM 5
To disseminate education and information to drug users moving between both Member States.

Strategies Employed to Meet the Aims

Referral Service
There are four main components: Assessment, Referral, Advocacy, Support

Networking
To develop a data base of organisations, services and agencies which are accessible, appropriate and culturally supportive to Irish clients.

Service Development
Development work with agencies, to enable them to work effectively with Irish clients.

Monitoring System
A computerised monitoring system to record the supply and demand for services as well as collating socio-demographic data on the client population of PIAA.
AIM 1

To develop effective interventions to drug users who are mobile between the Republic of Ireland and Britain, to ensure access to harm reduction and risk minimisation services.

We developed a Referral Service to undertake outreach to the Irish community, and provide assessment and referral to services, and advocacy and support to facilitate access. The Referral Service offers a culturally appropriate service which aims to be responsive to people affected by HIV/AIDS and works with traditionally ‘hard to reach’ groups within the Irish community. The employment of indigenous workers was vital to the success of PIAA’s outreach initiative, accessing different social networks within the Irish community. Rhodes et al (1991a) define outreach as that which targets individuals and groups who do not seek (or else do not have easy access to) existing services, working with them in their own communities and local settings with the aim of facilitating improvement in health and a reduction in the risk of HIV transmission. At PIAA it is this community-based model of outreach which we have found to be appropriate to working with mobile drug users, who often do not have the knowledge, information or confidence to access health and social services in the host country.

Model of a Community Based Initiative

The Referral Service is also a cost effective model for working with mobile drug users, because it avoids duplication of service provision and facilitates access to mainstream services. The Referral Service plays a key role in facilitating the integration of Irish people to mainstream services and service interventions have four main components: Assessment, Referral, Advocacy and Support. PIAA is not seeking to duplicate services, but rather to ensure that Irish people gain access to services and that those services are able to respond to the needs of Irish clients. The thrust of response and responsibility must come from mainstream British based statutory and voluntary organisations working in the field. This can most effectively be done by devising an equal opportunities policy and programme that includes the Irish as an integral part. PIAA’s role is to target British service providers, highlight the needs of Irish clients and facilitate development of an Irish dimension to Equal Opportunities within service provision.
AIM 2

To ensure drug users, their family and partners, affected by HIV/AIDS, gain access to appropriate care and support.

The Advisory Council on the Misuse of Drugs (ACMD 1993) recommend that in terms of HIV prevention, the greatest benefits are to be obtained by maximising brief contacts with drug users who are out of touch with services. This implies a front-line role for outreach, with the emphasis on short-term contacts and/or referrals to other helping agencies. Irish people become clients of PIAA through contacting the Referral Service directly, or through a worker in a different agency in Britain or Ireland. The client's needs are then assessed, through an appointment, visit or telephone conversation. The client subsequently decides with the Referral Worker, which approach is necessary to respond to the identified needs. The range of needs with which clients approach PIAA varies widely. Some approach the Referral Service with a simple and straightforward request. Many others have not been in contact with any services prior to approaching PIAA, and are in need of ongoing support and advocacy work to help sustain their contact with the services PIAA has referred them to.

The focus of PIAA's work is on the clients needs, not just their drug problem. Within the resource limitations of the organisation, PIAA has developed a client-centred/user led model in which a flexible, confidential and non-judgemental service is offered to support clients in exploring their needs and the potential options available to them. This flexible approach is vital for people who often present with a complexity of problems and the issue of drug use may come further down the list of pressing problems faced by the client, e.g. lack of housing, income or social isolation.

AIM 3

To provide advocacy and support to drug users approaching services to ensure continuity of care.

O'Brien (1993:16) highlights that despite the important work of many service providers in Ireland to provide non-judgmental drugs and HIV/AIDS services, some Irish people who are HIV+ have been undermined and disempowered by judgmental attitudes in services they have come in contact with in the past. This is particularly the case with drug users or ex-drug users, those in contact with the Criminal Justice System in Ireland and Britain, and some of the statutory services in Ireland. For this reason, advocacy and support are an important part of the work in the Referral Service. Clients are often accompanied by a Referral Service worker when approaching new services, and introduced to a worker who can cater for the client group or has had previous contact with PIAA. This may occur during the first two or three visits, until the client feels comfortable in that agency. It may also occur with existing clients whose health status alters, and are therefore in need of approaching new services. Finally advocacy takes place with clients who may feel they need support when dealing with medical staff to discuss issues such as prescriptions or medication. Advocacy and support are both time intensive for the Referral Service, however they enable clients to sustain contact with services, and develop successful relationships between clients and mainstream service providers over a long period of time, resulting in stable care and support for clients.
AIM 4

To network and liaise between service providers in both the Republic and Britain to establish care packages for drug users leaving, or returning to the Republic.

Rhodes et al (1991:168) stress the urgent need to provide tangible and realistic opportunities of service provision for the hard to reach and those without equal access to general health care and HIV specific services. There remains a need to provide a comprehensive and integrated network of service provision in an attempt to bridge gaps between existing service responses. This necessitates an element of collaboration between those with experience and expertise in providing community-based interventions and those without such experience and expertise but with a range of services to offer.

Models of Networking

Networking is a mechanism for an agency to access and utilise the skills, resources and services of other organisations. For community based initiatives, with limited resources, this strategy is particularly relevant. Networking involves the following stages:

1. Identifying arenas for meeting with or finding out about relevant organisations

2. Identifying organisations which are relevant to your work

3. Meeting a representative from an organisation you wish to network with

4. Exchanging information on resources available

5. Establishing ways of working together

6. Developing the network by utilising the organisation the next time the need occurs

For networking to be effective all these stages need to occur.

At PIAA, networking with agencies in both Member States has been an integral strategy to the development of the service. We identified a specific model used by the service to establish and develop its network. A computerised data base at PIAA, linked into the Monitoring System, has been developed and now lists over 400 agencies and named contacts PIAA has developed networks with, including 10% of which are based in Ireland.

AIM 5

To disseminate education and information to drug users moving between both Member States.

Advice and information has been disseminated at PIAA in a number of ways: the distribution of two leaflets both aimed at Irish people on safer drug use and safer sex, with the second listing agencies in Ireland and Britain which offer services for people affected by HIV/AIDS. The leaflets have been distributed in both Member States and a conscious strategy has been to include...
information on abortion in Britain, to enable Irish women to have the opportunity to make informed choices about their health and well-being.

Irish drug users arriving in London could be vulnerable to a number of dangers and harm reduction work of PIAA also involves providing, 'street information'. Where appropriate, PIAA informs clients of the different street scene in London compared to Dublin, and the potential dangers that exist. For example, the difference in the quality of drugs, particularly the stronger mixture of heroin on the street in London compared to that in Dublin. The cocaine derivative crack has not yet appeared on the streets of Dublin and for many users arriving in London, they have little information about the dangers of crack or harm reduction strategies. PIAA is able to make clients aware of some of the dangers, and where appropriate, facilitate access to clean injecting equipment and/or information on safer drug use/safer sex is made available. In particular, workers encourage clients to be aware of safer injecting use and the range of services available to facilitate this.

**Developing a Monitoring System**

To enable the organisation to have some measurement of the services provided and of the clients contacting PIAA, a computerised Monitoring System was developed. A database was designed and piloted to collect basic socio-demographic information on clients, when they initially contact PIAA. A second database was designed and piloted to record the number and type of service intervention with each client, to inform service provision and future priorities, including the demands being made on the service, the needs being presented to the organisation and the outcome from contact with PIAA.

**Developing a Monitoring System**

| ASSESSMENT | Assess the range of information needs to be monitored, including the needs of service users, the organisation and purchasers/funders. |
| CONSULTATION | Consultation with workers to assess the service to be monitored, including identifying current working practices. |
| QUANTIFYING PROCESS | Defining criteria for recording data, including identifying and quantifying the range of service responses, ethnographic and socio-demographic information which can effectively be collected. |
| DESIGN | Designing specification for computerised data base. |
| PILOT | Designing and piloting computerised data base. |
| TRAINING | Training and induction for service providers on implementing the system and adapting the system into the current work load. |
| REVIEW | Quarterly meetings to review information needs and implementation of the data system, including identifying difficulties in maintaining the system, negotiating easier ways to record data, re-negotiating service definitions and identifying new categories. |
| IMPLEMENTATION | Maintaining monitoring records of service interventions and clients in contact with the service. |
| REVIEW & UPDATE | Six monthly meetings to review data collected and identify data which has not been monitored and update the system accordingly. |

Rhodes et al (1991b:11) write that at its simplest, descriptive monitoring records the extent, locations and type of client contact and the extent and nature of project activities. While this gives an indication of the volume of project work, it is often impossible to assess realistically the
proportion of the target groups actually reached because estimates of their true size are generally very crude. More sophisticated process performance indicators include data on the extent of successful referrals, uptake of services offered, rates of client re-contact, and knowledge of the project within targeted populations. The Monitoring System at PIAA cannot provide detailed research data on the client population; the nature of the service does not facilitate access to such in-depth analysis of peoples lives. The Monitoring System is just one aspect of PIAA's action research programme and its specific role is to provide a profile of some of the Irish people in Britain living with the realities of HIV/AIDS, and in some way attempts to quantify their needs. The monitoring system can at least act as a guide and indicator of the range of work involved in meeting the complexity of needs of Irish people living with HIV.

The monitoring data presented in the report specifically relates to work undertaken during December 1993 - June 1994, with clients who had identified as drug users or have a history of drug use. It amounts to approximately 50% of the total client population in contact with PIAA during this monitoring period. It is important to recognise that the data represented in the Monitoring System does not represent the total number or range of services provided to clients; nor can it reflect the quality of service provided. Inevitably there is a conflict for workers on the frontline, often dealing with extremely complex, emotive and distressing cases, to quantify the range of issues and responses made in each particular case. Later in this report we go on to highlight some of the limitations of monitoring systems, and will conclude here by summarising the benefits of such systems.

What are the benefits of a Monitoring System?
• identifies trends and patterns being presented to the service
• provides quantitative data to inform purchasing and commissioning priorities
• helps to inform strategic planning in the organisation
• monitors the gaps in service provision and records areas of unmet need.
### positively irish action on aids

**client record**

<table>
<thead>
<tr>
<th><strong>Date of Contact</strong></th>
<th><strong>LA Code</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Code</td>
<td>DHA</td>
</tr>
<tr>
<td>PostCode</td>
<td>RHA</td>
</tr>
</tbody>
</table>

#### Age Range
- Under 18
- 25-34
- 45-54
- 60-64
- 18-24
- 35-44
- 55-59
- Over 65

#### From (in Ireland)
- To (in Ireland)

#### Years in Britain
- Yes
- No

#### Receiving Service at First Contact
- Yes
- No

#### Prev Contact with PIAA
- Yes
- No

#### Ethnic Origin
- White
- Black Carrib.
- Black African
- Indian
- Pakistani
- Black Other
- Chinese
- White Irish
- Black Irish
- Bangladeshi

#### Sexual Orientation
- Gay
- Heterosexual
- Child
- Lesbian
- Bisexual
- Missing

#### HIV Status
- HIVP = HIV asymptomatic
- SY = HIV+ symptomatic
- A = AIDS
- HIVN = HIV negative
- U = Unknown

#### Place of Diagnosis
- Great Britain
- Republic of Ireland
- Not applicable
- Northern Ireland
- Europe
- Not applicable

#### Date Diagnosed
- Male
- Female

#### Intravenous Drug Use
- User
- Ex-User
- No History

#### No. of Children
- Agency
- Self
- Parent
- Other

#### Referral Source
- Yes
- No

#### Registered with G.P.
- To get support
- Legal Probs
- Methadone Prescription
- Accom Probs
- ? London Services
- Funeral Arrangements
- Financial Probs
- Relatives in London
- Client's Relative
- Medical Probs
- ? Irish Services
- Family Probs
- Return to Ireland

#### Notes
Evaluating a Community-Based Initiative

Why We did it...

The Irish in Britain

The Irish are a well established community in Britain, who have experienced migration over an exceptionally long and continuous period of time. It is estimated that between Irish born (830,453 in 1991 census analysis (1.52% of the population of Britain) and second generation, there are up to two million Irish people in Britain, making them one of the largest ethnic minorities in Europe (Institute of Irish Studies, Liverpool University, U.K. 1991). Between 1981 and 1991, the Irish born population in Britain grew by 1.5% (Irish Trade Board, 1993). The Irish, as a group, have a distinctive identity and historical set of experiences, from the host population in Britain. There is evidence to suggest that the Irish experience disadvantage in the fields of housing, employment and health in Britain. (See: AGY 1992, Haringey Council 1991, London Irish Women's Centre 1993). Although as an ethnic minority and migrant group, the Irish have full legal rights in Britain, they make up the largest single ethnic group among the homeless, and the majority of Irish migrants still come to Britain to work in unskilled work on building sites and roads. Raftery et al (1990) have demonstrated, using census results that there is a marked deterioration in the health of first and second generation Irish people subsequent to migration to Britain. An additional problem in Britain is the Prevention of Terrorism Act (PTA), an act targeted specifically at Irish people. Irish community groups estimate that over 50,000 Irish people are stopped and questioned every year. This act has resulted in a reluctance of many Irish people to identify with Irish issues. It has to some extent disempowered the community.

Lennon et al (1988:30) in their study of Irish women's lives in Britain describe the impact emigration has had on Irish people. "The tradition of emigration from Ireland is reflected in our culture. The experience has touched every Irish family's life. Irish women grow up knowing they have relatives in many distant places; Irish people have emigrated to every part of the world. Evidence of this is not just in the songs, stories and poetry of Ireland but all around them. At certain periods, whole villages have been deserted, and often communities have recreated themselves in other parts of the world as people gradually leave to join those who have already gone, to places they already feel connected to through a long line of emigrants. This continues to be true at the present time. The closeness of Britain also makes emigration easier. It allows for the illusion that it is possible to come and stay for a short while, and eventually return home". In PIAA we are working with people who would perceive themselves as being in Britain on a 'temporary' basis. Additionally, the client population referred to in this report would be highly mobile, travelling frequently between Ireland and Britain.

Irish people in Britain affected by HIV/drug use, face particular difficulties. Taylor (PIAA 1990:7) on Specialist Services for the Irish in Britain stated that:

- HIV/AIDS is a reality of life in all communities today, including the Irish; HIV is an added disadvantage to an already disadvantaged minority.

- Haemophiliacs, IV drug users, bisexual and gay men have to date had particularly high rates of infection in many western societies. These groups are also discriminated against, stigmatised and negatively labelled in society. To be Irish in Britain, and an IV drug user, or gay or haemophiliac and to also be HIV+ is to have a multiplicity of negative identities and potentially a multiplicity of negative experiences.

Drug Use & Mobility

O'Brien (1993:2) has indicated the important implications of movement from one area or country with a different HIV prevalence, namely: (1) migrants may not have been exposed to the same health education programmes as people in the country of destination; (2) within the
migrant group there may be specific needs which are not catered to in the country of destination; (3) mobility itself may affect health behaviour (people may take more or less risks). All of these factors apply to the Irish in Britain, affected by drug use/ HIV. The AIDS & Mobility Project (1993) states that "a failure to address mobility issues may lead to increased risk behaviours with serious consequences for all EC Member States".

One of the implications of mobility is that migrants are often isolated from the host society; and in addition, those whose behaviour could put them at risk of HIV infection, often find themselves marginalised from their own communities. Consequently, migrant groups are not always effectively reached by existing services and health education channels. Rhodes et al (1991a:1) present a range of research which concludes that although the hard-to-reach are a relatively small proportion of the total population, they are likely to be important in the transmission dynamics of HIV. This arises both from the prevalence and frequency of HIV transmission behaviours which occur among them and from their high level of mobility and interchange, occurring across different social networks and geographical areas. Targeted campaigns such as PIAA have an important role to play in reaching mobile populations and facilitating access to mainstream services.

Farrell & Strang (1992:180) recognise that the needs of drug users from cities and countries with high levels of HIV seroprevalence among injecting drug users, are often invisible. Discussion of addressing the needs of Italian, Irish or Spanish seropositive drug users are often avoided for reason of political sensitivity and fear that mention of the subject may result in counterproductive racial harassment. They identify that the social and health care needs of these individuals may present particular demands to services and conclude that adequate service resources need to be available to stabilise such users, both medically and socially and ensure the promotion of safer sexual and drug using behaviour. Community-based organisations such as PIAA, can play a vital role in facilitating access to services for marginalised groups.

Epidemiology

The epidemiology of HIV/AIDS differs between Britain and Ireland in some important ways. Compared to Britain, Ireland has a higher rate of those known to be infected with the HIV virus, or diagnosed as having AIDS, who give drug use as the route of transmission, (Ireland 50% and UK 12%). Ireland is also thought to have a higher proportion of women who are HIV+. In the United Kingdom, by June 1994 14% of the population infected with HIV are women. To date, official statistics from Ireland fail to provide gender specific information. However, a gender breakdown is given for those who have an AIDS diagnosis – 17% of the population diagnosed as having AIDS are women. In the UK 9% of the AIDS population are women.

AIDS Diagnosis Comparison of Women

<table>
<thead>
<tr>
<th></th>
<th>United Kingdom</th>
<th>Republic of Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0% 2% 4% 6% 8% 10% 12% 14% 16% 18%</td>
<td></td>
</tr>
</tbody>
</table>

Source for UK: PHLS AIDS Centre, CDSC.
Source for Ireland: Department of Health, Dublin.
The UK has a higher percentage of those known to be HIV+ who give sex between men as the probable route of transmission (UK 61% and Ireland 19%). Drug use is high in inner city areas of Dublin, and this is accompanied by extremely high rates of HIV infection in specific areas of the city. In these areas many members of one family may be HIV+ or have AIDS related illness.

Comparison of Epidemiology of HIV/AIDS

<table>
<thead>
<tr>
<th></th>
<th>Britain</th>
<th>Republic of Ireland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex between Men</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injecting Drug Use</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Source for UK: PHLS AIDS Centre, CDSC.
Source for Ireland: Department of Health, Dublin.

O'Brien (1993:20) in her examination of the differing epidemiology in Ireland and the UK, addresses issues concerning migration and the socio-economic position of the Irish living in Britain, and concludes that Irish people living with HIV in Britain may not be able to find services appropriate for their needs. Community-based initiatives have an important role in highlighting the impact of different epidemiologies on service need, and promoting the development of responsive services from mainstream agencies. For example, in Ireland HIV/AIDS has affected women and children to a greater degree than in Britain and O'Brien's study is able to highlight this, and recommend the development of emergency respite childcare, liaison services for families and children in Ireland and Britain, and long term fostering and adoption options to be established for families in both Member States.
Who Participated...

PIAA - The Organisation

The Advisory Council on the Misuse of Drugs (1993) in reviewing the success of the strategy of HIV and drug prevention, report that the rapid expansion of community-based advice and treatment services which occurred during the mid to late 1980's, in response initially to growing drug problems and then to the additional and significant threat of HIV and AIDS, has been central to the overall strategy to curb the spread of HIV among drug injectors.

Positively Irish Action on AIDS (PIAA) was established in early 1989 by a group of Irish HIV and drug workers, Irish lesbians and gay men, who were increasingly concerned about the number of Irish people with drug and HIV problems presenting themselves to British agencies; the number of Irish people becoming involved in high risk behaviour on arrival in Britain with little knowledge of the danger of HIV infection/transmission; and the lack of awareness among Irish migrants of available services in Britain. The aims and objectives of the organisation are:

1. To identify and highlight the needs of Irish people in Britain affected by HIV/AIDS;
2. To produce culturally specific education and information around HIV/AIDS issues;
3. To facilitate the use of existing service by operating a referral service for Irish people;
4. To compliment existing services by offering a culturally specific support network;
5. To network and liaise between service providers in Ireland and Britain;
6. To run culturally specific training seminars for agencies and Irish people affected;
7. To coordinate monitoring programmes on the level of HIV incidence in the Irish community in Britain.

PIAA has been operating on a full-time basis since April 1990, when it employed a development worker. In July 1994 PIAA has six full-time workers and the staff team structure is: a Director, Referral Service Team Leader, 2 Referral Service Workers, an Administrator and a Researcher.

Team Structure at PIAA

Indigenous Workers

The National Research Council (1989:364) identify that research aimed at the design, implementation, and evaluation of AIDS interventions depends in some important ways on the organisations that can represent and reach the communities that are the targets for those interventions. Beyond providing entry into these communities, collaboration with organisations and individuals in the community can enrich the research process and improve the chances that
the interventions will be effective. To help foster this crucial collaboration, the committee believes that talented, well trained, and dedicated workers should be recruited from within the communities in which interventions will be conducted. These workers should be involved in decision making at all levels, from central coordination and funding, to local outreach and education.

The ACMD (1993:28) in their Update Report recommend that when recruiting staff, employers should take account of their previous experience, and of the target population in terms of gender, sexuality, and ethnicity. In Britain, under Section 5(2)(d) of the Race Relations Act an employer may specify the required racial or ethnic origin of the postholder. This can only be done where it is a genuine occupational qualification for the postholder to be of a particular ethnic origin (Haringey Council 1991:11). Permanent, full-time staff of the Referral Service Team at PIAA are recruited using Section 5(2)(d) of the Race Relations Act. This was in acknowledgement of ensuring a cultural dimension to the service, and targeting relevant professionals whose cultural background and networks may facilitate access to the client group. Rhodes et al (1991b:27) in their guidelines for policy and practice in outreach initiatives, identify that workers must be accessible to both target populations and to the range of service sectors involved. They recommend the use of indigenous workers to aid contact and communication with target groups. Professional and community workers also clearly have a role in outreach in negotiating with different service sectors and in providing professional services. A plurality in approach is recommended. PIAA has been successful in attracting talented individuals from within the Irish community, with professional and personal experience of dealing with many of the issues clients present with, and knowledge of the service sectors involved.

The Client Population

This report relates specifically to our work with Irish people who use drugs intravenously or have a history of intravenous use, and are affected by HIV/AIDS. The monitoring data relates specifically to work undertaken with this group between December 1993 and June 1994, which amounts to approximately 50% of the total client population recorded in the monitoring system during this period. Clients are categorised in the Monitoring Data under the category of Intravenous Drug Use, using the terms 'Drug User' and 'Ex-Drug User'; clients who have used drugs intravenously in the past, but have stabilised their drug use and are receiving substitute oral prescribing, would also appear in the category of Drug User. These two categories help to act as a general indicator to the organisation of exposure to risk behaviour by the client population. More detailed data on risk behaviour amongst Irish drug users is being collected in the Mobility Project, a European Commission funded Research project PIAA is undertaking and will appear in a separate report. For the purposes of this report, the category Drug User, indicates exposure to HIV risk behaviour through injecting drug use. Through this evaluation it has highlighted the need to consider using more explicit indicators of HIV risk behaviour, and the organisation needs to review whether it is appropriate to incorporate such indicators into the Monitoring System.

Intravenous drug use of Clients in this Report

<table>
<thead>
<tr>
<th>Drug Use</th>
<th>Ex User</th>
<th>Drug User</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=74</td>
<td>18%</td>
<td>82%</td>
</tr>
</tbody>
</table>
RECOMMENDATION
To Review HIV risk behaviour indicators used in the Monitoring System at PIAA.

Through this evaluation, a gap has been identified in the monitoring data which results in a significant percentage of the client population relevant to this report not being visible within the data. In the monitoring system there is no code to identify relationships between clients. Family members, partners and carers, who have not disclosed intravenous drug use, would therefore not be identified in the data of this report. Therefore, the vital liaison and support role PIAA fulfils with family members, partners and carers is not highlighted in the data, however we try to address this within the qualitative framework of this report.

RECOMMENDATION
To Review the use of identification codes for family members, partners and carers of clients who use drugs.

There is a high HIV prevalence rate amongst the clients recorded in the monitoring period of the report: 77% (57) were diagnosed as HIV+, 3% (2) were HIV negative and in 20% (15) of records HIV status was unknown. Butler & Woods (1992:59) in identifying those most affected by HIV in Ireland found that the burden of HIV, rather than being randomly distributed, bore most heavily on those from a lower socio-economic background who were already unusually disadvantaged. They point out (ibid:52) that Irish responses to HIV and AIDS must be considered against the background of the country's long-standing social policy on marriage, sexuality and reproduction, and its more recent policies on drug problems. For fifty years the law in Ireland had clearly reflected the teaching of the Catholic Church; abortion, contraception and homosexual activity were all prohibited by statute. It was only following the arrival of HIV that condoms became legally and widely available and furthermore, there was no change in the teaching of the Catholic Church on this issue. It was only in 1993 that consensual sex between adult men finally became legal in Ireland. Ironically, PIAA's information leaflet, Young & Irish - AIDS KNOW THE FACTS could be considered illegal in Ireland because it lists the name and address of the British Pregnancy Advisory Service. Technically, providing information on abortion is still illegal in Ireland, in spite of strident campaigns by the Irish women's movement.

HIV Status of Clients in this Report

<table>
<thead>
<tr>
<th>HIV Status</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV Negative</td>
<td>3%</td>
</tr>
<tr>
<td>HIV+</td>
<td>77%</td>
</tr>
<tr>
<td>HIV Status Unknown</td>
<td>20%</td>
</tr>
</tbody>
</table>

(N=74)

Drug Use & Gay/Bisexual Men
The monitoring data also indicates an important group who all too often remain invisible within drug services: that 23% (10) of all Male clients in this report, who disclosed intravenous drug use or had a history, also identified as gay or bisexual. 12% of service interventions recorded in this report were to gay and bisexual men. Of these service interventions, the largest percentage were for support – 18%, and 14% under the category of 'Health Care'. The dominance of stereotypical media and prevention campaigns in the late eighties promoted...
dangerous stereotypes of high risk groups. It made those whose risk behaviour exposed them to a number of groups invisible within those groups. Safer sex information was targeted at gay men, not drug users. Safer drug use campaigns were aimed at drug users, not gay men. The comparative nature of the Monitoring System at PIAA enables us to gain a wider profile of the client population we are working with. PIAA has always recognised the importance of providing information which promotes safer behaviour and does not delineate this information by social group. Therefore, *Young & Irish – AIDS KNOW THE FACTS* contains information about both safer sex and safer drug use in one publication. As a consequence of the evaluation undertaken at PIAA a strategy is being implemented to target gay media and organisations, to raise awareness of PIAA and develop service responses appropriate to the range of needs of gay men, including drug use. This provides a useful example of how monitoring systems can help to inform strategies and development priorities for community-based organisations.

**Sexual Orientation of Male Clients**

![Sexual Orientation of Male Clients](image)

- **Gay:** 21%
- **Bisexual:** 2%
- **Heterosexual:** 77%

**Irish Women**

Another group which the Monitoring Data has highlighted, who all too often remain invisible within drug services, are Women. Powis et al (1994:2) in their study of the differences between male and female drug users, conclude that structural differences in patterns of drug use found amongst female drug users and the influence of male sexual partners are likely to play an important role in determining appropriate treatment options for drug users. The results of the study indicate that the complex interactions which occur between sexual and drug taking risk behaviour, indicate that gender issues can no longer be ignored by those involved in the planning and provision of care to drug users, nor by those involved in the study of these groups (ibid:15). 43% of clients recorded in the Monitoring System were Women (32) yet, 51% of hours recorded (294.5) were to Women; indicating a higher input of resources to address the needs of this particular group. This particular aspect of our work is outlined later in the evaluation, where we try to place the monitoring data within a qualitative and quantitative framework. Although Lesbians do not appear in this period of the monitoring data, it important to note that 2% (4) of the client population recorded in the monitoring period of April 1993 – March 1994, were recorded as Lesbians, and 25% (1) were recorded as Drug User.

**Gender of Clients in this Report**

![Gender of Clients in this Report](image)

- **Women:** 43%
- **Men:** 57%

*(N=74)*
How we Designed It...

PIAA’s Model of Development

In all of the projects which are undertaken at PIAA a specific strategy of development informs their design and implementation:

1. Identify target population.
   Ensure that the target population includes service providers

2. Identify aims & objectives to respond to the target population and recruit appropriate expertise from within the community

3. Build research and evaluation into service delivery of the organisation to:
   (a) understand target population,
   (b) ensure service development remains appropriate and responsive to clients

4. Utilise indigenous workers to develop the service and appropriate outreach to the community

5. Establish a Referral Service which avoids duplication of services but rather facilitates access to existing services

6. Outreach to the target population
   (a) through existing services,
   (b) through community organisations of target population
   (c) through other appropriate organisations such as gay organisations/ media/ drug agencies

7. Develop networks with service providers to ensure their services are accessible and responsive to the needs of the target population

8. Develop social networks for the target population affected by HIV/AIDS if perceived as a need by that target population

9. Disseminate research and evaluation on a local, national and international level to ensure expertise developed through working with the target population can be incorporated into prevention policies and service developments.

Stated Methods of the Irish Drugs & Mobility Project

- Action research model which promotes a symbiotic relationship between research and service development.
- Monitoring of client contact, including ethnographic data.
- Ongoing evaluation of the development of the project, through consulting with service providers as well as clients, on the appropriateness and effectiveness of interventions.
- Networking with service providers in both Member States to ensure changing needs and new developments can be met through the network, and clients are able to access appropriate services.
Rhodes et al (1991:24) highlight the dearth of evaluation material about the effectiveness of outreach and recommend the systematic monitoring and evaluation of outreach programmes. Evaluation designs should be tailored to service needs and developments, ideally combining qualitative and quantitative methods, and incorporating process and outcome measures. They identify evaluation to be of most use if it is integrated into the overall design of a project from the outset, if it is developed in conjunction with workers and managers, and where action-orientated research can inform the ongoing formulation and implementation of intervention. The Drugs & Irish Mobility Project was designed to monitor and evaluate a community-based service provided to Irish drug users, who are mobile between Ireland and Britain. From the outset, the project had stated aims, objectives, methods and expected results/outcomes, to act as a measurement during the evaluation.

The Action Research Model at PIAA

The stated methods of the Project say that the Action Research Model will be used in this evaluation. Stimson & Power (1992:463) describe the main features of an Action Research Model and highlight its interactive nature, its potential for short-term feedback and its flexibility in evaluating any given service intervention. The design of the model is such that information can be fed back to service providers with the potential for them to reassess and adjust stated objectives and strategies. This model has been adapted to the needs of PIAA and facilitates a strategic framework to inform planning and development priorities. Particular ways of working and the purpose of PIAA's model could be described as:

- Issues which arise in the client service are fed back to the Researcher(s).
- Researcher(s) highlight those issues to a wider audience to ensure an Irish dimension to policy and debates in the drugs/HIV sector.
- Researcher(s) in turn, brings to the agency up to date information on research, trends and issues in the drugs/HIV sector.
- Researcher(s) enable the organisation to put its work within a structured framework, facilitating strategic planning and informed development.
- Grass Roots work becomes accessible to the academic/research world to inform policy and debates.

Although the model facilitates a two-way information flow, the impetus of PIAA's model is directed by the community service, not the research.

Action Research Model at PIAA
Methodology Used in the Project

(a) A computerised database was designed and piloted to collect basic socio-demographic and ethnographic information on drug using clients contacting PIAA.

(b) A second database was designed and piloted to record the number and type of service contact with each client, to inform service provision and future priorities, including the demands being made on the service, the needs being presented to the organisation and the outcome from contact with PIAA.

(c) Team Meetings to facilitate regular feedback between the research/management team and Referral Service Team, particularly on trends identified through the research and monitoring, as well as new issues being addressed by the Referral Service Team with drug using clients.

(d) From the issues identified through the data and consultation process, research was undertaken into reports, studies, books and publications which could put the issues into a more qualitative framework.

A Qualitative Framework

In undertaking this evaluation, and reflecting on the various strategies and methods which have been employed to develop the project and monitoring system, ethnographic techniques would best describe how information was gathered about the service being provided and the issues being addressed. Through combining epidemiological and ethnographic research methods with service development, service interventions can be based on in-depth knowledge about social, community and local settings. Moody et al (1991:9) describe ethnography as the method most suited to process evaluation. This is because ethnography usually involves the evaluator participating directly in the activity under evaluation; in this report, the evaluator's participation has been through managing the Project. Through this participation, field notes and documents were collected to develop a qualitative framework in which to quantify information to be recorded within the Monitoring System. However, Moody et al (ibid) also highlight the limitations of such an approach: its in-depth nature limits the amount of data collected, and furthermore, the validity of this approach is heavily dependent on the researcher's interpretation of the information collected. At the outset of this report, we have stated the limitations of this evaluation as a result of only one of the project participants being involved.

Reinharz (1992:46) describes contemporary ethnography as multi-method research which includes observation, participation, archival analysis and interviewing. The methods used at PIAA included participant observation, semi-structured interviews, consultation and development meetings and field notes. The gathering of information using ethnographic techniques, informed the 'quantifying process'. The quantifying process identified key words which were commonly used in the teams' description and the evaluator's field notes. Initially, there were 15 categories to define a service intervention and by the end of July 1994 there were 30 categories to quantify the issues and service responses the agency was addressing. Through consultation meetings and semi-structured interviews work was reviewed to identify any new categories which needed to be included to describe the range of work being undertaken. This Evaluation has highlighted the need to review how to distinguish categories between types of interventions and issues, to make presentation of the data more accessible.

Understanding the definition behind each category is an important aspect to the system. For example, the category of Networking has a particular meaning at PIAA; it describes the way we work with agencies in developing our network of referral bases. For a new member of the team, who was qualified in social work (MSoC.Sc. CQSW), networking was a very different concept which described a support network surrounding a client - this would be recorded as Family Support in PIAA's system. Therefore clarifying definitions and judgments and assumptions involved in the recording process is a vital aspect in developing a monitoring system.
MONITORING RECORD FOR SERVICE INTERVENTIONS

<table>
<thead>
<tr>
<th>Date</th>
<th>Agency</th>
<th>Client</th>
<th>Client Borough</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Gender</th>
<th>Hours</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>LA</th>
<th>Client Borough</th>
<th>Agency Local Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>DHA</td>
<td>Client District Health Authority</td>
<td>Agency District Auth</td>
</tr>
<tr>
<td>RHA</td>
<td>Client Regional HA</td>
<td>Agency Regional HA</td>
</tr>
</tbody>
</table>

- Accommodation
- Advice/Info
- Advocacy
- Agy Exch Visit
- Arriving UK
- Assessment
- Bereavement/Loss
- Children
- Counselling
- Crisis Grant
- Education
- Family Support
- Funerals
- GP Allocation
- Health Care
- Hospitality Scheme
- Household Mtcet
- Legal Advice
- Networking
- Referral
- Repatriation
- Research
- Return Home Temp
- Return Home Perm
- Return UK
- Social Worker Alloc'n
- Support
- Support Group
- Training
- Transport Services
- Voluntary Work
- Welfare Benefits
- Welfare Fund (piaa)
- Social Worker Alloc'n

<table>
<thead>
<tr>
<th>Worker Initials</th>
<th>AS</th>
<th>GB</th>
<th>GH</th>
<th>LT</th>
<th>DOB</th>
<th>SN</th>
<th>TSB</th>
<th>TD</th>
<th>LD</th>
<th>Relief</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Contact via</th>
<th>Agency Visit</th>
<th>Home Visit</th>
<th>Office Visit</th>
<th>Phone Out</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Fax</td>
<td>Letter</td>
<td>Phone In</td>
<td>Other</td>
</tr>
</tbody>
</table>

Form used to record the number and type of service contact with each client.
How we did it...

Stated Objectives of the Project

"Objectives... outline the desired outcomes of the intervention" Stimson and Power (1992)

- Offer advice and information to drug users on services in both England and Ireland.
- Assess clients' needs and refer them to appropriate harm reduction and risk minimisation services.
- Provide advocacy and support for clients approaching services, to facilitate equal access.
- Facilitate visits in London for relatives from Ireland, to ensure Irish drug users have access to cultural support networks.
- Provide culturally specific support groups and social events for Irish drug users.
- Facilitate repatriation of deceased individuals to the Republic of Ireland.
- Facilitate development of services for children of HIV+ drug users, particularly fostering and long-term child care services.
- Network with services in the Republic for drug users returning there, to facilitate continuity of care.
- Provide information and education materials which promote HIV prevention including safer drug use and safer sex.

OBJECTIVE 1

- Offer advice and information to drug users on services in both Britain and Ireland.

Strategies Employed to Achieve Objective:

(a) Clients contacted the agency and were informed on the range of services available and the way in which to use those services.

'Word of Mouth' networking is a feature of Irish society, and monitoring data would indicate that the majority of clients are reached in this way. The Monitoring System at PIAA has recorded that under the category of 'Referral Source', 53% (27) of clients contacting PIAA referred themselves, 41% (21) were referred by Agencies and 6% (3) were referred by Family members. 23 records were missing.

Referral Source of Clients in this Report contacting PIAA

<table>
<thead>
<tr>
<th>Referral Source</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Member</td>
<td>6%</td>
</tr>
<tr>
<td>Agency Referral</td>
<td>41%</td>
</tr>
<tr>
<td>Self</td>
<td>53%</td>
</tr>
</tbody>
</table>

(b) Networks with potential service providers relevant to PIAA's client population were identified and developed.

From December 1993 to June 1994, the Monitoring System had a record of 82 clients referred to 43 agencies. In comparing the range of agencies which clients were referred to, 42% of service interventions recorded were with Drug Services; second highest was 19% of
interventions with statutory Social Services; records of Health Care Services and Housing Services both amounted to 9% of service interventions with agencies; 11% of service interventions were with HIV Services; 12% of service interventions were with agencies in Ireland. This helps to indicate the range of issues the organisation addressed, from housing, benefits, health, support in the community, and contact with home.

\[
\begin{array}{c|c|c|c|c|c|c|c}
\text{Range of Services Clients in this Report were Referred to} & \text{Range} & \text{%} \\
\hline
\text{Children's Services} & 0 & 0 \\
\text{Drug Agency} & 5 & 10 \\
\text{Health Care} & 15 & 30 \\
\text{Housing Service} & 20 & 40 \\
\text{HIV Service} & 25 & 50 \\
\text{Legal Services} & 30 & 60 \\
\text{Social Services} & 35 & 70 \\
\end{array}
\]

OBJECTIVE 2

Assess clients' needs and refer them to appropriate harm reduction and risk minimisation services.

Strategy Employed to Achieve Objective:

84 service interventions were recorded under the category of Assessment – taking up 9% of recorded hours. The Monitoring System indicated that Men required a higher input than Women, 47 interventions to 37. 44% of the interventions recorded to men, were with gay and bisexual men.

Assessment provides an opportunity for client and worker to explore the range of issues and service options available, and using informal counselling skills to facilitate the decision-making process. Assessment aims to be client-centred and needs-led. Assessment occurs around the presenting problems, but workers also use it as an opportunity to check out other issues around, for example, accommodation, health care, counselling and support, and input from statutory social work departments. Coulshed (1990:66) points out that this direct contact with people, listening to their views about felt need and service provision sought, as well as all the informal networks of care, begins to give a picture of the level of provision required and the means by which service goals might best be met.

The ACMD (1993:11) have recognised the key position outreach workers are in, to assist with the identification of individual needs, particularly for drug users who are not currently in contact with services and are considered hard to reach. They identify evidence which suggests that the health and social care needs of outreach clients vary greatly: HIV may be viewed as one of a number of concerns, with clients often identifying their most pressing needs as social rather than medical (primarily accommodation, legal and financial). 151 Reasons for first contact were recorded in the monitoring system. 24% came for support; 23% related to information on London services; 10% related to Returning to Ireland; only 3% related to methadone prescription. Yet in comparison, 29 service interventions were monitored under the category of methadone prescription – 3% of recorded hours. As a new problem arises, clients return for assessment to be referred onto different services or to provide advocacy with existing services to meet the new needs.
Assessment can often occur over a period of time, giving clients an opportunity to build up confidence and trust to reveal the full nature of their situation. This is particularly the case for those who might have experienced judgmental and punitive treatment from drug services in Dublin in the past. Irish drug users have a reputation in some British agencies, as a highly chaotic group whose drug use is extremely difficult to stabilise. Because Irish drug users are experienced in using services which have in the past emphasised an abstinence model, they are often reluctant to disclose the full extent of their drug use which can sometimes result in inappropriate substitute prescriptions. Additionally, this past experience results in an unwillingness to discuss deviation from treatment ('using on top') because of a fear of being removed from treatment. At PlAA we would argue that working with Irish drug users successfully requires a sensitive understanding of cultural and treatment issues as experienced by clients in Ireland and Britain. As part of our harm reduction strategy, during the Assessment phase at PlAA, workers try to create a safe environment and build up a rapport with the client to enable them to disclose the true nature and extent of their drug use, without fear of judgment or reprisal. This information is vital if PlAA is to provide a supportive service to clients accessing treatment options.

OBJECTIVE 3

Provide advocacy and support for clients approaching services, to facilitate equal access.

Strategy Employed to Achieve Objective:

PIAA undertakes a range of service interventions under the category of Advocacy. Interventions with clients who have approached PIAA to advocate on their behalf has involved accompanying a client on their first visit to a service; liaising with the service on developing an appropriate care package in response to client needs; and negotiating client needs with the provider when clients feel unable to assert their needs. For those clients who are categorised as Ex-Drug Users, PIAA plays an important role in accessing a range of services that can facilitate stabilisation in the community. The category of Advocacy can be recorded to describe the work involved in advocating on behalf of clients trying to access appropriate methadone maintenance; it can also describe PIAA's advocacy role when we are requested to participate in case conferences; negotiating with a Housing Association to obtain nominations for clients; liaising with Social Service departments to facilitate appropriate Community Care Assessments; liaising with Child Protection Officers on behalf of clients; or simply ensuring that Irish clients get an appropriate and responsive service. A sense of familiarity with clients social and cultural networks is vital for the workers to provide a responsive service in this area, and this includes understanding ways of communicating. For example, a worker at PIAA who was requested to participate in a case conference as an advocate of the client, was described as the 'interpreter'.

How we did it...
OBJECTIVE 4

Facilitate visits in London for relatives from Ireland, to ensure Irish drug users have access to cultural support networks.

Strategy Employed to Achieve Objective:

Butler & Woods (1992:61) found in their Dublin study that the family and community support for people who were HIV+ or who had developed some AIDS-related illness was of major significance. The participants of the study concluded that the burden of care for those suffering from HIV related illness was being primarily borne by families. There was evidence that the ‘buddy system’ which had been developed in other countries, was not in operation to any appreciable extent in Dublin. Instead, regardless of previous intrafamilial conflict, Dublin families appeared to close ranks and offer an impressive level of care and support to their sick members. For many of the clients at PIAA, the family can provide a vital support network in living with HIV. This aspect of our work would be categorised under Family Support to describe the one-to-one work that might occur with an individual family member, particularly when dealing with a bereavement. For clients whose HIV infection has restricted their mobility, PIAA is able to liaise with the family in Ireland and facilitate visits to London. During the seven month monitoring period 60 service interventions were recorded under the category of Family Support – 7% of time.

OBJECTIVE 5

Provide culturally specific support groups and social events for Irish drug users.

Strategy Employed to Achieve Objective:

Through undertaking this evaluation, we discovered that this aspect of our work is not accounted for in the Monitoring System. Yet it is a time intensive aspect to our work. This may help to explain the low percentage of hours recorded in the Monitoring System as discussed in the section entitled The Hardest Part... In a service user's evaluation undertaken by PIAA (1993:16) clients were asked to identify services which they would like PIAA to provide. The majority of suggestions related to support. Providing a support service to clients is time intensive and provokes a conflict in terms of priorities for the agency, given that the aims are primarily based on brief interventions to reach a wide range of the community. As discussed in the section entitled: The Problems..., rationalisation of services is particularly evident in this aspect of our work. PIAA has tried to address the conflict of priorities, through providing structured support facilities which can be planned and organised into the workload, including Social Evenings, Support Groups and Open Lunches. The Social Evenings and support groups, occur on average once a month and enable groups of clients to meet each other and establish informal social networks, or to develop ideas around the kind of support they feel they need. Indigenous workers with an awareness of social networks and intergroup conflicts, are vital to ensuring the success of these gatherings. It was through these organised gatherings that a Women's Support Group came into being, as well as a Gay Men's Support Group planned for later in the year. The Women's Group now meets once a month and provides the women with an opportunity to participate in activities which focus on relaxing and having fun, rather than on their HIV status. 100% of the women attending the Support Group, are recorded in the monitoring data of this report.
OBJECTIVE 6

Facilitate repatriation of deceased individuals to the Republic of Ireland.

Strategy Employed to Achieve Objective:

This aspect of our work goes beyond the objective and deals also with relatives who are buried in Britain. When the death of a relative occurs in Britain, PIAA plays a vital coordinating role between agencies in Britain and family members in Ireland, or arriving in Britain to organise the funeral. A sensitive understanding of family networks and awareness of intrafamilial conflicts can be vital here in providing a responsive service, hence the importance of indigenous workers with appropriate personal and professional skills. PIAA is also an important support service to clients in Britain whose relatives have died in Ireland, facilitating access for the client who returns home for the funeral and to access familial support networks. The majority of this work would be categorised under Family Support. In April 1994, we added the category of Funerals, and 6 interventions (1% of time) have been recorded under this category.

OBJECTIVE 7

Facilitate development of services for children of HIV+ drug users, particularly fostering and long term child care services.

Strategy Employed to Achieve Objective:

55% of clients recorded in this monitoring period had children. 49% of men had children and 51% of women had children. It is relevant to note here that the Monitoring System does not distinguish couples and that the agency should review the need to record this data. All too often when addressing children's issues, men remain invisible, and women become synonymous with children, neither are addressed as individuals within their own right. At PIAA, we are an adult-centred agency, addressing the needs of individuals and families. When dealing with issues around the client's children, the primary focus is on the needs of the father or mother who present to the agency. Where necessary, PIAA participates in referrals for children of clients, to relevant child-centred services. Social support is also provided to children of clients, through the social evenings and open lunches, which children often attend. For children whose parents are in Ireland, PIAA has been able to facilitate visits home for them.

55% of Clients in this monitoring period had children

<table>
<thead>
<tr>
<th>Men with Children</th>
<th>49%</th>
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<tr>
<td>Women with Children</td>
<td>51%</td>
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45 service interventions were recorded under the category of Children, 5% of hours recorded in the Monitoring System. This category is recorded to describe the work usually undertaken with parents who are trying to address issues around their children; this may be in regard to dealing with social services; or facilitating access to services which help parents plan for when they die; participating in case conferences; networking with families/services in Ireland, where clients children may be staying/living; or liaising with children's services on behalf of the client.
RECOMMENDATION
Review the need to identify couples within the Monitoring System and family relationships.

The issues around adoption and long term fostering require a more considered strategy by the organisation and there are a number of policy issues PIAA needs to address before it can play a developmental role; however, lack of resources have impeded progress on this issue. Development meetings at PIAA have outlined a strategy, and raised awareness within the organisation of some of the policy implications which need to be addressed, including: the Children Act 1990, child protection issues, legal issues and structures in Ireland, and developing networks with appropriate agencies in Ireland. The issues are complex and require a thorough assessment to define PIAA's role and develop appropriate service responses and networks.

RECOMMENDATION
For PIAA to secure appropriate resources to under-take a one year assessment project on the needs of Irish parents and children, and planning appropriate service responses.

OBJECTIVE 8
Network with services in the Republic for drug users returning there, to facilitate continuity of care.

Strategy Employed to Achieve Objective:
In this monitoring period, 46 agencies appear in the Monitoring System, 15% (7) of which were in Ireland. In addition to this 8 (1% of hours) service interventions were recorded under the category of Networking.

Agencies recorded in the Monitoring System
December 1993 - June 1994

* AIDS Alliance Cork
* AIDS Help West
* Aisling Clinic
Avian Housing
Barnados
* Belfast Social Services
Cara Housing Association
Central Assessment Unit
Chelsea and Westminster DDU
Chicago and Westminster SS
Druglink
Fountain Project
Globe Centre
GP – Hurley Clinic
GP – Myatts Field Health Centre
GP – Dr Whitney
Greenwich Homeless Persons Unit
Griffin Project
Hammersmith Social Services
Immunity
Kilburn Probation Office
Lambeth Housing Department
Total = 44 Agencies

Lambeth Social Services
Landor Road DDU
London Lighthouse
Maudsley Hospital DDU
* Merchants Quay Project
Middlesex Hospital
Middlesex Hospital Social Work Dept
* Mountjoy Prison Probation Service
* Mountjoy Prison
Positive Options
Riverhouse
Roma
Shepherdess Walk Social Services
Southwark Social Services Disability Team
Southwark Social Services HIV Team
St Mary's Hospital
St Thomas' Hospital
Stockwell Project
Strutton Housing Association
Terrence Higgins Trust
Westminster Social Services
Woolwich Social Services
* = Agency in Ireland
Given the range of agencies and health professionals which appear in our database (400 – 10% of which are in Ireland), the evaluation has clearly highlighted that this aspect of our work is not being recorded in the Monitoring System. Networking visits to Ireland occur on average once a month, when PIAA attends the AIDS Liaison Forum in Dublin, which brings together professionals from throughout the country working with people affected by HIV/AIDS. Membership of the Forum enables PIAA to remain up to date on service and policy developments in Ireland and ensure the needs of Irish people in Britain remain on the agenda.

Networking, has enabled agencies in Ireland to become more aware of emigration and helping prepare people who have decided to emigrate. This has a considerable impact on our work with newly arrived clients, and referrals to services can be achieved more quickly. This can provide more of an opportunity for the client to stabilise in the community, during the first vulnerable months of being in Britain. When networking with agencies in Ireland, we ensure that they have up to date information on the relevant documentation clients need in Britain, including birth certificate (to access benefit entitlements); confirmation of HIV status to access services; and where relevant, confirmation of medication to access prescribing services.

**RECOMMENDATION**

To identify ways in which to record work around Networking within the Monitoring System.

**OBJECTIVE 9**

*Provide information and education materials which promote HIV prevention including safer drug use and safer sex.*

**Strategy Employed to Achieve Objective:**

Traditionally when seeking to target specific communities, it has been organisations representing those communities which have been approached. Yet the client population PIAA works with, and particularly drug users, are invariably marginalised and isolated from those traditional cultural networks. An organisation such as PIAA can be a bridge between the traditional community networks and drug users, and can work to achieve an acknowledgement that drug use does exist within the community. PIAA has been raising awareness amongst traditional community organisations and facilitating them to address issues, including demystifying drug use and challenging stereotypes about drug users.

As already highlighted, where appropriate, PIAA provides HIV prevention information to clients contacting the service, and in particular encourages clients to be aware of the agencies available to facilitate safer drug use. This aspect of our work could be recorded under Advice/Information. During the monitoring period, 33 service interventions were recorded under this category, accounting for 3% of hours recorded.
Working with Irish Women...

In collating the monitoring data at PIAA, a difference was identified which we feel is important to highlight. When analysing the number of service contacts recorded, we compared them by gender and identified a higher percentage of service interventions recorded for women. Women make up less than half the client population concerned in this project, 43% (32) and yet 54% (490) of service interventions recorded were to those women, whilst 46% (419) involved men. This indicates that women required a higher input of resources and face a wider range of issues. 69% of the Women clients were HIV+ (22), 3% (1) were HIV - and 28% (9) were unknown. 81% (26) had been categorised as Drug Users and 19% (6) as Ex-Drug User.

HIV Status of Women in this Report

- HIV+ 69%
- HIV- 3%
- Unknown 28%

In exploring some of the issues faced by Irish women in contact with PIAA, it is important to look at the impact gender has on being a woman in Irish society. Anderson (1983:48) defines gender as that which refers to the cultural attributes expected of the sexes, namely femininity and masculinity. It includes learned social and psychological attributes and is a fundamental category of one's experience. Similar to the social categories established by race and social class, it patterns what others expect of women; it establishes in large measures, women's life chances; and it directs social relations with others. The growth of the Women's Movement during the past twenty-five years has been a period of rapid change for women in Ireland. Traditional values and ways have been challenged and changed and every aspect of women's lives has been subject to scrutiny and question. However, defining the role women have in Ireland is still dominated by Catholic teachings and the Irish Constitution. "Woman as a person enjoys a dignity equal with men, but she was given different tasks by God and by nature which perfect and complete the work entrusted to men". Pope John XXXIII. The Irish Constitution states in Article 4.1 In Particular the State recognises that by her life within the home, woman gives to the State a support without which the common good cannot be achieved. Article 4.2: The State shall therefore endeavour to ensure that mothers shall not be obliged by economic necessity to engage in labour to the neglect of their duties in the home. The impact this role, defined by Church and State, has on Irish women is wide-ranging. The way in which the women we work with perceive themselves and their role, and how they manage their disease and care for the different relationships in their lives, has a direct impact on many aspects of our work.

Lennon et al (1988:1) highlight that far more Irish women have emigrated than men during much of this century, and that this is an untypical pattern amongst migrant groups. In their study of Irish women lives in Britain (ibid:16), they identified that women face greater pressures to adapt to British society than men, because of their family role and responsibilities. They are the ones who have to deal with British institutions — they go to the health centres, schools, hospitals, playgrounds and when necessary negotiate these situations. Yet, the authors point out, these are
also the situations where attitudes to the Irish, reactions to Irish accents, are unavoidable, and
have a real bearing on the treatment women receive. The authors conclude that the cost for
Irish women adapting to living in a different society is sometimes very great or simply ongoing
hard work. If one adds problem drug use and/or HIV to this scenario, one can begin to
appreciate the complex pressures and burdens Irish women can face. Certainly this experience
is evident in PIAA's work with women clients.

At PIAA we have not strategically targeted women to attract them into the service; however the
individual make up of the staff team has ensured that women's issues remain high on the agenda
in the agency. Rather than setting targets based on gender, the focus has been on the complex
issues and range of service options necessary to respond to the needs of women contacting the
service.

Records of Main Service Interventions Compared by Gender

<table>
<thead>
<tr>
<th>Service</th>
<th>Men</th>
<th>Women</th>
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<tbody>
<tr>
<td>Welfare Fund</td>
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<tr>
<td>Support</td>
<td></td>
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<tr>
<td>Return Home</td>
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<tr>
<td>Referral</td>
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<tr>
<td>Prescription</td>
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<tr>
<td>Health Care</td>
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<tr>
<td>Family Support</td>
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<tr>
<td>Children</td>
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<tr>
<td>Assessment</td>
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<tr>
<td>Advocacy</td>
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<tr>
<td>Advice/Info</td>
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<tr>
<td>Accommodation</td>
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Interventions include:
- Welfare Fund: Processing applications to the Fund; liaising with travel agents; organising crisis grants.
- Support: One-to-one support for clients and relatives; access to support networks.
- Return Home: Organising a flight home; liaising with service providers in Ireland; liaising with family networks in Ireland; securing financial support for clients to access the Welfare Fund.
- Referral: Referring clients to appropriate services; liaising with service providers during the referral process; accompanying a client to the service.
- Prescription: Facilitating access to prescribing services; supporting clients to access substitute prescriptions; liaising with prescribing services in Ireland for clients returning home.
- Health Care: Identifying appropriate services; referrals to health care services; liaising with health professionals on behalf of the client.
- Family Support: Liaising with family members in Ireland; liaising with relatives in Britain; facilitating access to family support networks in Ireland.
- Children: Referring to child-centred agencies; providing support and referrals to services for families; liaising with service providers re clients' children.
- Assessment: Assessing clients' needs; exploring issues with clients; identifying appropriate referrals.
- Advocacy: Advocating on behalf of clients with service providers; participating in case conferences; negotiating with services in Ireland.
- Advice/Info: Providing information on services in Ireland/Britain; prevention information on safer sex/drug use.
- Accommodation: Applications for flights home, or to Britain, for clients and their relatives; crisis grants for clients and grants to enable clients to access care and support networks.
In understanding the issues behind the service interventions, it is important to describe the kind of women who contact PIAA. Farrell & Strang (1992:167) recognise the growing interest in qualitative research approaches to hidden populations which can provide valuable information on HIV prevention issues for drug users. They promote the use of in-depth ethnographic methods to obtain this information. At PIAA, we have benefited from a Researcher who has training in anthropology and ethnographic techniques. In *The AIDS Affected Community*, O'Brien (1993c) identified that clients at PIAA originate from communities which are based on residence (even territory). These communities are specific limited areas of Dublin, in the inner city, where nearly every household has someone infected with HIV, or at various stages of AIDS related illness. They are geographically specific, to the extent that every house on one side of a street may be affected, but none on the other side. Within the communities people relate to each other in a variety of ways, including through kinship, neighbourhood, employment, generation, religion, socially, sexually, use of alcohol, use of drugs including sharing works and support. These communities could be said to have multiple affiliations, some of which are associated with health risks, and others with care and support. The majority of affiliations, such as kinship, or neighbourhood, do not have any implications in terms of health, or risk with regard to HIV. The lines of affiliation that do carry an associated health risk, drug use and sexual relationships, are again unilinear, in the sense that they exist through one peer group, or generational group. They could be seen as horizontal, while the lines of support and care are vertical as they involve cross generational kinship groups.

Utilising an anthropological technique to describe kinship networks, O'Brien presents a picture which describes the complexity of relationships Irish women affected by HIV may have in their lives. Risk through drug use, (sharing needles) appears to occur through siblings as well as a wider age group. Kinship groups are affected by the virus on a wide scale. For example, a typical family could be described as having the central figure as a grandmother with one son and daughter in law who have died of AIDS related illness, leaving a child uninfected; a daughter ill from AIDS related illness, with two uninfected children, living in London; a second daughter dead from AIDS related illness, with a partner who is ill, and three children, two of whom are uninfected; a son who is diagnosed HIV+, with a partner who has not been tested, and two children, both of who have not been tested; and a daughter who is diagnosed HIV negative. The grandmother could eventually be responsible for 8 children after having nursed and experienced the death of most of her children. 7 people in the extended kinship group are infected, and all 18 members affected. The central figure taking responsibility and giving support and care to this kinship group affected by HIV/AIDS is in most cases a woman.

![Kinship Diagram](image-url)
These complex familial relationships, with multiple experiences of bereavement and illness, are evident amongst many of the clients at PIAA, and the subsequent issues we try to address. For example, under the service category 'Return Home', in PIAA's Monitoring System, 40 service interventions were recorded. This category is recorded to describe the work involved in organising a trip home for the client, and can include liaising with the travel agent; networking with agencies in Ireland, including facilitating access to prescribing services; liaising with family members at home; or funding a trip home for clients to access support and care networks. Once again the Monitoring indicates that the demand for this type of intervention was higher amongst women: 40% of records under this category were for Men (16) whilst 60% (24) were to Women.

McKeown et al (1993:55) in their study of 120 clients attending a drugs/HIV service in Dublin 1989-1992, identified some indicators of the extent of drug taking within the client populations' social networks. In terms of brothers and sisters, more than half 57% of all clients had a brother or sister who has taken drugs. The majority of these 71% have only one brother or sister who has taken drugs although more than a quarter 29% have between two and three. In terms of their neighbourhood, the perception among the majority of clients 71% was that an average of 98 people were taking drugs in their area. Although this was not an exact figure, it provided an indicator of how widespread drug use was perceived by the clients in their immediate environment.

The authors also noted that 99% of those who knew drug users in their neighbourhood also knew neighbours who have died of drugs. The authors conclude that given the known geographical concentration of drug users in selected areas within Dublin's inner city, these perceptions are not surprising. They stress the importance of understanding how these social networks operate and how important they are in understanding some of the factors affecting the lifestyle and life cycle of drug use, its mode of transmission as well as the methods used to cope with its vicissitudes. The Monitoring Data would indicate that PIAA may serve a similar population, with 50% (21) of Men from Dublin and 72% (23) of Women from Dublin; however, data was missing for 24 records. Therefore, the numbers of PIAA's clients originating from Dublin could be even higher.

Where Clients in this Report came from in Ireland

<table>
<thead>
<tr>
<th></th>
<th>Dublin</th>
<th>Outside Dublin</th>
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<tbody>
<tr>
<td>Women</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Men</td>
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Missing Records = 24

McKeown et al conclude from their study that the clients attending the Dublin Project lived in social networks which, by the standards of the majority in Irish society, are inhabited by an
extraordinary large proportion of persons who are drug users, are involved in crime, are HIV+ and by persons who have died from drugs or AIDS (ibid 62). These networks spill into Britain as drug users and their partners and sometimes children, leave Dublin for a range of reasons including: economic reasons, in search of employment, legal difficulties, street harassment, escape from multiple bereavements, family problems, in search of drugs or simply the relative anonymity of city life in Britain.

McKeown et al (1993) sadly, do not include a gender comparison of their data, however, these complex networks of familial relationships are common for many of the women we work with, and impact on the assessment, referral, advocacy and support interventions PIAA has with the women. For example, 'Family Support' is a category which describes the work PIAA undertakes to facilitate access to familial support networks, many of which are in Ireland; it describes the liaison role PIAA fulfills with family members in Ireland, particularly in cases of bereavement; it also describes PIAA's support role with partners or family members of clients. 63% (38) of interventions recorded under the category of Family Support were for women, with 37% (22) recorded for men.

Service Interventions recorded under the category 'Family Support'

<table>
<thead>
<tr>
<th></th>
<th>Men</th>
<th>Women</th>
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<tr>
<td></td>
<td>37%</td>
<td>63%</td>
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(N=60)

Butler & Woods (1992:64) in their study of carers of HIV+ women in Dublin identified a number of gender-specific issues, principally in relation to pregnancy, motherhood and childcare, and the cultural and institution constraints experienced by Irish women in general and HIV+ in particular. The study group appeared to reach a consensus that cultural attitudes towards sexuality and childbearing among working-class Dublin women were equally if not more constraining than any legal or other institutional arrangements. The participants argued that Dublin women who were HIV+ were still primarily concerned with taking care of their husbands, children and other family members and saw their own health problems as being of secondary importance. The women PIAA has contact with primarily originate from Dublin and would be facing similar issues, including choices about pregnancy, care of children, sometimes violent and abusive relationships, caring for a sick partner and/or child. This aspect of PIAA's work would fall into a number of categories: Family Support, Health Care, Children, and Support. It is important to note, that in all of these categories the Monitoring Data indicates a higher level of input for Women clients as compared to that of Men.

In the Butler & Woods study it was found that the implications for the transmission of HIV were worryingly clear in that it seemed that some women would prefer to expose themselves to the risk of HIV rather than deny their men a full sexual relationship. One counsellor argued that things had come full swing – in the sense that the right to choose to have a baby was now increasingly being asserted by HIV+ women. The phrase 'right to choose' is, of course, more conventionally associated with demands for legal access to abortion. Reproductive issues are increasingly evident at PIAA for many of our clients – both women and men. Work in this area appears under the Health Care category which in this case describes referrals for pregnancy...
testing, pre- and anti-natal care; and the category GP Allocation may be recorded for work which accesses pregnant women to primary health care.

At PIAA, this evaluation has highlighted an HIV risk factor which increasing evidence suggests can notably affect women: crack use. Lown et al (1993:90) found that the emergence of crack, in the early 1980's in America, brought a new connection between drug use and HIV transmission. Crack users, even those who do not use needles to inject drugs, face an increased risk of HIV infection through sexual risk taking behaviour. Their research found that 'sex-for-drugs exchange' was a frequent mode of 'payment' for crack using women. Crack is not yet evident on the streets of Dublin, but it is becoming increasingly evident on the streets of London, and Irish drug users arriving in London who have little awareness of the drug can be at risk. Lown et al (1993:91) in their study of the crack epidemic in America, concluded that the crack epidemic presented a particular threat to women. Research on the epidemic, clearly indicated that women comprised one half of all users which is a significant increase compared to other drug epidemics in the 60s and 70s.

The Monitoring System at PIAA does not record the type of drug(s) clients are using. However, anecdotal accounts from the team, identified 8 - (11%) of the client population appearing in this report, as having become involved in using crack after arriving in Britain. 50% of these were Women. It also suggest that 'type of drug used' may need to be monitored more explicitly to ensure the organisation can remain responsive and relevant to the women approaching it, and keep track of the changing needs and trends within the community we aim to serve.

Whilst the number of women presented in this report are a small minority, the chaos of their situation can cause a dramatic increase in demands on PIAA's resources. Powis et al (1994:) note that if the UK's cocaine using population continues to grow and if cocaine smoking continues to become an increasingly popular mode of administration, then increasingly treatment providers will have to address the needs of this population. They conclude such a change is likely to increase the numbers of women utilising services.

One of the difficulties in working with crack users is that so few services exist to meet their treatment needs, therefore, limited options exist in how we can work effectively with this client group. The team particularly emphasised their concern that the women had all been forced into prostitution and crime to support their habit, thereby finding themselves in a more chaotic and vulnerable situation than many of them had been in Ireland. Lown et al (1993:97) warn that when crack takes control, the drive to obtain it takes precedence in a woman's life. It can overwhelm a woman's capacity to protect herself sexually, both from abuse and from HIV infection. Whilst the number of crack using women highlighted in this evaluation is small, the issues around crack indicate the detrimental impact mobility itself can have on health behaviour.

Butler & Woods (1992:67) report that participants in their study concluded that HIV+ women, and women in general, did not take up health and social services to the same extent as did men. It was argued, specifically, that HIV+ women did not often avail themselves of such services because they were too busy with child-minding and chores and feared being labelled as 'unfit' mothers. The Monitoring System at PIAA and qualitative evaluation, indicates that the strategies employed were successful in attracting a potentially isolated population of Irish women and facilitating their access into mainstream services. It also indicates that the women experienced PIAA as a safe place, particularly a place where they found it easy to raise childcare issues.
The Problems...

Rationalisation of Services
The advent of the National Health Service and Community Care Act [NHSCC] (1990) has brought with it a new concept: rationalisation of services. Maxwell (1994:15) argues that rationing is inescapable in the sense that the resources fall far short of demand and choices have to be made. And this is not unique to the United Kingdom. As Connah (1994:271) reports, these challenges have to be seen against a background of increasing pressure on Member States to contain resources, evaluate and ensure effective use of new technology, and care for large numbers of elderly people. Client demand often conflicts with the resources PIAA has available to respond to those needs. As Coulshed (1990:68) highlights, in reality, need-led principles cannot work unless there are plenty of resources. She argues that social workers will always be in a position where demand exceeds supply; thus many of the personal social services have had to introduce systems which prioritise (that is ration) which referrals receive what kind of help. At PIAA we are continually unable to fulfil the services required by clients and other service providers. For example, lack of money in the Welfare Fund may mean that we cannot help a client who needs to go home due to a family crisis; lack of staff resources results in PIAA not being able to respond to the request of service providers to provide training input to their organisation; or to support clients who want prison visits or simply wish to pursue an Irish dimension to their care. During the Assessment procedure at PIAA, workers continually stress the limitations of the service and clarify what work can be undertaken by PIAA and what work needs to be dealt with by agencies with appropriate resources. Having to say no to people who contact the agency, is one of the hardest things we face at PIAA. This is particularly when dealing with clients, and can often involve considerable negotiation to find a balance between the needs of the clients and the limitations of the organisation. Throughout the project, this aspect of the work at PIAA has often been described by workers as one of the most difficult and stressful to deal with.

Hard-to-Reach Client Population
A significant percentage of the client population described in this report could be described as 'chaotic' drug users. Coulshed (1988:69) describes this group as living in a state of crisis; they lurch from one appalling state of chaos to another, on the precipice of eviction, fuel disconnection, abandonment and despair. A problem generated by a chaotic client group is that difficulties constantly reoccur, thereby demanding additional resources to sort out missed appointments, etc. A flexible service is integral to the strategy of making the agency accessible to the most chaotic client group. This strategy is informed by the notion that HIV is more important than drug use and that drug users who are not in contact with services are more likely to be employing high risk drug use practices and also have a higher rate of HIV infection (see Power 1989:183, and Mulleady 1992:42).

Being Irish in Britain
Action Group for Irish Youth (1992:6), a community-based initiative promoting the interest and welfare of emigrant Irish youth in London, have identified a distinct factor of being Irish in Britain: Anti-Irish Discrimination. They highlight the important role Irish people play in British society, actively contributing to the development and expansion of Britain's infrastructure and economy. But they also document the extent to which anti-Irish discrimination still exists in British society. Discrimination manifests itself in a number of ways, such as the use of the Prevention of Terrorism Act (PTA); racial stereotyping and caricature; discrimination in access to housing and employment; media prejudice; victimisation and harassment. AGIY assert that one or a combination of these experiences of discrimination can severely impede the life chances of an Irish person in Britain; it can contribute to a level of disadvantage and force a
minority but substantial community into invisibility and silence. In the end, anti-Irish discrimination hinders rather than progresses dialogue and understanding between the two countries and the two peoples. It is not uncommon at PIAA to hear clients describe situations where they did not feel safe to speak for fear of being identified as Irish.
The Easiest Part...

Working with the Irish Community

Working with the Irish community in Britain was one of the easiest and most rewarding aspects to the work. The team identified that a commitment to working with the Irish community is important in terms of both motivation and empathy (ie: having direct knowledge of the client group). In PIAA (1993:17) during an evaluation meeting between the Management Committee and Staff Team, it was identified that PIAA was an organisation which could encompass a diverse range of Irish identities: Lesbian/Gay, Religious/non-Religious, North/South, 1st & 2nd Generation Irish.

PIAA has also benefited tremendously from the voluntary support of many groups and individuals, the majority of whom have Irish connections. The Management Committee is a testament to the richness of talent in the Irish community in Britain. Expertise in Social Work, Project Management, Psychiatry, Pastoral Care, HIV Counselling, and Community Support Services are all represented on the Committee. The Committee is made up of a range of individuals, heterosexual, lesbian and gay, men and women, who identify as Irish or have a close affinity with the Irish community, and who give their time and energy on a voluntary basis to manage the development and public accountability of a community-based organisation.

Practical support also comes to the organisation in terms of fundraising, from gay and lesbian groups in London, and from the Friends of PIAA, a group of business people in Dublin. These groups organise fundraising benefits in aid of PIAA's Welfare Fund. PIAA has established a Welfare Fund for clients needing to access care and support networks. The Fund is able, to provide practical support in a limited number of cases, including, flights home for clients to access familial support networks; flights to London for relatives of Irish people too ill to travel; public travel passes for clients during the referral process to agencies which are often in a range of geographical areas of London.

Working in a Community-Based Initiative

PIAA has attracted a range of talented individuals into the agency and has developed a flexible and evaluative approach to management. This helps to ensure the organisation remains responsive and appropriate. Dr Michael Farrell, Chair of PIAA describes (PIAA 1993:3) the organisation as a small voluntary agency that demonstrates the importance of having flexible and innovative organisation. He concludes that the indefatigable energy and innovative capacities of all the staff at PIAA makes it an exciting, challenging and stimulating work environment where staff feel facilitated to implement and modify existing projects.

The success of PIAA lies in the collaborative nature of working practices, team work, management relationships, and community networks. Strategies to achieve this includes six monthly Staff Reviews, which provide the team with an opportunity to review working practices and policies, including decision-making and consultation procedures within the organisation. Development meetings provide an opportunity to discuss specific issues being faced by clients and plan development strategies and priorities. Consultation meetings occur around specific projects the organisation is involved in, and provide an opportunity to collect ethnographic data on how the agency functions and how networks operate. These forums can involve a range of participants: staff team, management committee, service providers and service users, and are integral to the development of projects and effective organisation.
The Hardest Part...

The Monitoring System

One of the most challenging aspects of PIAA’s work is also one of the hardest: The Monitoring System. The management and organisational issues we face as a community-based initiative are not unique to PIAA. Rhodes et al (1991:8) in their assessment of outreach intervention and health promotion models, report that bottom-up interventions tend to start with the health priorities of communities and involve them as active participants in the process of education, prevention and change. The very nature of community-based initiatives implies that participants in the organisation are motivated by their commitment to the needs of the community; the focus of priorities lie with the community, not the organisation. This provokes a conflict in terms of resources, because the organisation needs to exist to provide the service to the community. This conflict which the Monitoring System brings into PIAA is a useful one to examine more closely.

The Monitoring System plays a crucial role in the management of PIAA. It is the system which enables us to communicate with our ‘purchasers’ – the local and health authorities – who ‘buy’ our ‘product’ (the service) for a specific community which is resident within their locality and for whom they are statutorily responsible. The Monitoring System provides quantitative data which indicates need and facilitates the organisation to generate income to resource the service. Therefore the importance of maintaining the system cannot be underestimated. And this is where the conflict lies: The Monitoring System is in direct response to the organisation’s needs not the community we aim to serve. Given that we are a community-based initiative established to respond to the needs of Irish people in Britain affected by HIV/AIDS, the demands of maintaining a Monitoring System can provoke a conflict in terms of time, management and resources.

The advent of the National Health Service & Community Care Act (NHSCC) 1990 has far reaching implications for community-based organisations in Britain and monitoring systems take on a new significance. Forte et al (1994: 200) note that under the reforms Health Authorities, as purchasers of care for their residents, are expected to assess need and contract with providers (hospital and community units) for appropriate levels of service. In 1993, further legislation introduced similar responsibilities for local authorities, who are now charged with organising and commissioning long-term care for people to be treated in a community rather than institutional setting. This will increasingly include the non medical care requirements of people with HIV and AIDS. Farrell and Strang (1992:157) have noted the fundamental changes in the way care services are planned for and managed, with a clear separation of those responsible for purchasing services from those who actually provide them. District Health Authorities now have a responsibility to meet the health needs of their local population through needs assessment. In assessing the pattern of need it is the responsibility of the purchasers to then prioritise the delivery of care to the identified need (Ibid:165). Contracts are then established with appropriate providers to deliver services in response to the identified needs. Contracts will have as their core, indications as to the amount of care and the kind of services which will be purchased. Farrell and Strang (ibid:168) conclude that monitoring programmes and the development of audit programmes are now seen by many as crucial in the administration of contracts. The Advisory Council for the Misuse of Drugs in their 1993 Update Report state that most services will be provided under contract and providers will be required to monitor their activities in order to ensure that they meet their contractual obligations. The Advisory Council envisage that these new arrangements will give service users a greater opportunity to influence overall service provision. The very nature of community-based initiatives usually entails work with minority populations or minority need. Minority needs receive minority resources.
This increasing reliance on monitoring systems to monitor performance, service users needs and outcomes of service interventions, needs to be met with caution. Whilst monitoring systems can play an important role in indicating need, they cannot be relied upon to demonstrate need. The quantitative nature of monitoring systems, produces results with inherent limitations. At PIAA, we have identified a number of limitations of a monitoring system.

What are the Limitations of a Monitoring System?

- Inherently reductionist in its nature
- Cannot address quality of service provided
- Cannot reflect complexity of need, nor dependency levels of the target population
- Can only indicate quantity of services provided and number of people served by the organisation.

Forte et al (1994: 201) identify that forecasts of people with AIDS in the UK have tended to focus on risk groups (e.g: gay men, drug users) rather than categorising people according to dependency levels. There is an important distinction between the two. Dependency is a function not only of the effects of the medical condition of the patient (e.g: whether Kaposi’s sarcoma is evident, or if there is dementia) but also on the social characteristics of the person and their environment (whether or not the person is a drug user, a child as opposed to an adult, has access to good informal support networks, etc.). The medical and social characteristics taken together are better indicators than risk group alone, of the demand for both quantity and type of services, and of how they might be delivered and by whom, because the demand for services is affected, for example, by the level of support an individual has in the community.

Monitoring systems cannot identify the complex issues and factors which result in dependency, by the fact that they are inherently reductionist. Throughout this report we try to highlight characteristics of the client population PIAA works with, a significant minority population, marginalised from traditional community networks, isolated from familial and kinship networks, potentially involved in high risk behaviour, lacking confidence to utilise services, unaware of how to access services and having a multiplicity of problems and needs, arising from being migrants in post-colonial Britain. These dependency factors cannot be identified through quantifying data alone, and require more qualitative research to draw out the complex issues and factors which result in dependency.

Monitoring Systems cost time, money and staff resources to design, develop and maintain. For community-based organisations like PIAA, there is an inherent conflict in balancing the needs of clients with the needs of the organisation. The conflict around investment of time in maintaining the system, provides a useful example of the limitations of a monitoring system. The Hull-York Research Team (1993:148) in their examination of the implications of HIV infection on service demand, undertook an in-depth analysis of HIV/AIDS service delivery, policy and patterns of five local authorities. They found that the introduction of a monitoring form in one local authority met with some resistance. A substantial proportion of staff failed to return the forms, complaining of the extra work involved. Others were anxious about confidentiality for their clients. Opposition to extra paper work and social work concern over confidentiality issues also arose in another local authority. The Research Team’s experience is not uncommon, and without the commitment of staff, monitoring systems cannot be maintained and important indicators of need can become invisible. Coulshed (199:6) in her study of management in social work, stresses that many aspects of social work rest on a lack of certainty, that unpredictability is the ‘name of the game’ and that, despite clear priorities, computerisation and workload management systems, mistakes will always be made.

Currently, on average, when taking into account Review and System Update meetings, one hour a day is given to maintaining the monitoring system at PIAA – 14% of workers time. The
Monitoring System is not representative of the range and quality of work undertaken at PIAA, rather it is an indicator of the supply and demand for services. In total, resources were received for 1 full-time client worker to develop services for the project; this is 1,050 hours for the 30 weeks of monitoring data in this report, based on a 35 hour week. 577.25 of hours were recorded in the Monitoring System — 55% of the total hours actually worked. This provides yet another indicator of the limitations of monitoring systems. In spite of what was felt to be a high level of compliance by the staff team, it still only resulted in 55% of work time being recorded in the system. Through the evaluation, we have identified two aspects of our work: Networking and Support Networks, which were not being recorded within the system. This can account for some of the missing data, however it has identified a need to review the way in which workers quantify time in the recording of data and identify any elements of the work not categorised in the Monitoring System.

**RECOMMENDATION**

To review the way in which time is recorded within the Monitoring System.

**Lack of Resources**

Another aspect of the conflict at PIAA is the implication monitoring systems have on resources of the organisation. Olearnik et al (1992:266) highlight the importance for community services to utilise computerised, comprehensive information systems to meet the challenges created by radical changes in funding. If community-based initiatives like PIAA are to effectively respond to the contracts culture securing the resources to maintain monitoring systems becomes an additional burden on the organisation. The Monitoring System requires resources if it is to achieve its aim of generating income for the organisation. This includes appropriate computer technology, overhead costs and qualified, trained staff to maintain the system. It is vital that funders and purchasers, recognise this new demand on community organisations and ensure that they can access appropriate resources to meet the demand. PIAA ironically, is now in the position of having an extensive database of monitoring data, but without the resources and time to access it. Therefore, many needs and dependency indicators remain invisible.

**RECOMMENDATION**

Resources should be targeted at community-based initiatives to enable them to develop appropriate monitoring and evaluation systems to indicate need.

The conflict between meeting the needs of clients and those of the organisation also arise when we consider how we use and disseminate the information contained within the system. PIAA’s Confidentiality Policy states that the organisation respects the right of individual clients to control who has access to personal information about their HIV status and a set of guidelines help to ensure that an individual’s right to confidentiality is respected. All clients receive a code when they first contact PIAA; their name and address are recorded separately from this code, and locked in a safe. Clients are entered into the Monitoring System by their code. The monitoring records are based on information the client has disclosed and is collected to provide a profile of the population we serve, the kind of issues being presented to the organisation and the range of service responses being provided by the organisation. The information is presented in such a way that no person is identifiable and anonymity is assured.

Probably one of the greatest sources of conflict within the organisation lies in the Quantifying Process of the Monitoring System. Jayaratne (1993: 116) points out that the dangers of simplistic quantitative research are well known to feminists. While the numbers may be accurate, the simplistic nature of the design can be misleading to the public, if there is not an exploration of
explanatory factors. As already highlighted, the limitations of monitoring systems are far reaching. Tim O'Keeffe, Pastoral Services Coordinator at an HIV Centre in London (personal communication), goes further: Monitoring Systems are inherently reductionist; they reduce intense and complex relationships between client and worker, to 'blips' on a computer screen. The trauma of peoples lives are reduced to categories and statistics. The tragedy becomes silenced. Whittington (1988:201) has pointed out that there is a hard ground where we can make use of research-based theory and technique but there is also a swampy lowland where there are confusing messes incapable of technical solutions; it is the swampy lowland where the problems of greatest human concern lie.

Jayaratne (1993:117) argues that no matter how thorough the questions in quantitative research, quantitative data will yield findings which are superficial in nature, compared to most qualitative data. Even the most complex and sophisticated quantitative research report cannot impart the same in-depth understanding of respondents as, for example, a thorough case history. Therefore, quantitative research could benefit from the addition of qualitative data. Certainly qualitative data can support and explicate the meaning of quantitative research. Jayaratne concludes that every quantitative research project should include some qualitative data, to gain a deeper understanding of the quantified results.

Stimson & Power (1992:464) stress that in the current climate, where resource management and accountability are part of the everyday lexicon of service providers, evaluative research has a clear role to play in the planning of appropriate provision for AIDS prevention. To this end, they recommend the design of evaluative models which provide services with timely and pertinent quantitative and qualitative information relevant to the development of their specific intervention. Through this evaluation report we have aimed to put the quantitative data of the Monitoring System into a qualitative framework, to explore some of the characteristics of clients, the background to issues they face and some of the strategies we have adopted to respond to their needs. In undertaking this evaluation we have identified some of the benefits as well as some of the limitations of monitoring systems.
The Results...

This aspect of the evaluation provides PIAA with an opportunity to compare our expected results which were identified in the initial submission to the European Commission for funding of the project, to the findings of this report.

Expected results of the Project

RESULT 1

*The development of a programme which addresses the needs of mobile Irish drug users, ensuring access to services and promoting continuity of care between Member States.*

In this report we have presented information gathered from a range of sources and intelligence which describes the implementation of a Referral Service for mobile Irish drug users, has provided data to indicate the kinds of issues and the type of client population the organisation works with, and has identified some of the needs of Irish drug users and of a community-based organisation trying to respond to those needs. The organisation established a computerised Monitoring System and the data presented in the Outcomes provides a profile of some of the clients we worked with and the service needs we addressed. We attended the AIDS Liaison Forum on a monthly basis in Dublin, and undertook extensive outreach and networking throughout the island and now have a Pan-Ireland knowledge of a diverse range of agencies and health professionals.

RESULT 2

*The evaluation of a model of working effectively with mobile drug using populations moving between Member States.*

Through the Action Research model at PIAA we have been able to put our work within a theoretical framework and relate some of the models and research we have used to inform the development of this project. In particular we have discussed a model for Networking and its relevance to mobile populations; reported on the development of a Monitoring System; and highlighted the importance of making the needs of Women who use drugs, integral to the development of drug services. We have described how we designed the project, implemented it, evaluated it and relayed some of the difficulties we encountered. We have tried to communicate the importance of resourcing community-based initiatives, and the vital role they can play in a European Action against AIDS.

Recommendations...

EUROPEAN LEVEL

1. The needs of migrants and mobile populations are often invisible within the health priorities of host governments. The Europe Against AIDS Programme has a vital role in ensuring the needs of this group remain at the fore of HIV prevention campaigns.

2. Migrant and mobile populations are potentially a significant population at risk of HIV infection/transmission, and resources should be available to specifically target their needs.
This requires the development of community-based initiatives to develop appropriate harm reduction strategies for the target population.

Development of services in response to the needs of mobile/migrant drug users, should include a community-based action research programme, to elicit grass roots expertise and knowledge of the community.

Sufficient resources need to be available to enable community-based organisations to develop appropriate management information and monitoring systems.

Priorities in targeting resources should include addressing the needs of migrant women, ensuring appropriate treatment and care options are available to them.

COMMISSIONING PRIORITIES

1 Purchasers and commissioners of health and social services need to recognise the unique role community-based initiatives have in accessing hard-to-reach populations and facilitating the dissemination of grass roots knowledge on identified needs.

2 Purchasers should ensure financial and technical resources are available for organisations working with ethnic and minority communities, to meet the demands and challenges of the new ‘contracts culture’.

3 The service and treatment needs of crack users need to be researched, ensuring a gender dimension, and where necessary, appropriate responses developed.

4 Lesbians and gay men who use drugs should be addressed within drug prevention campaigns, care services and treatment options.

5 Research & Development within the NHS needs to ensure that the vital grass roots expertise of community-based initiatives is incorporated into research commissioning priorities.

6 The important role indigenous workers have in providing a cultural dimension to care, needs to be recognised in community care planning and District Health Authorities purchasing plans.

SERVICE DEVELOPMENT

1 For PIAA to secure appropriate resources to continue the development of this project and the completion of the evaluation programme.

2 Review the Monitoring System at PIAA to address the following issues:
   - the way in which time is recorded within the Monitoring System.
   - HIV risk behaviour indicators used in the Monitoring System at PIAA.
   - the need to identify couples and family relationships.
   - to identify ways in which to record work around Networking and Support.
   - to identify ways in which to make the presentation of data more accessible and categories of service interventions more explicit.

3 For PIAA to secure appropriate resources to undertake a one year assessment project on the needs of Irish parents and children, and planning appropriate service responses.

4 To review services provided to Irish women with a history of drug use and to identify appropriate strategies and development plans.
Summary of Outcomes...

During December 1993 and June 1994, the Referral Service at PIAA saw 74 clients reporting currently or previously injecting drugs.

The profile of clients are as follows:

**Age Range**

- 18-24: 68 clients (6 missing cases)
- 25-34: 50 clients
- 35-44: 40 clients
- 40-44: 30 clients
- 50-54: 20 clients
- 55-60: 10 clients
- 60+: 0 clients

**HIV Status of Clients in this Report**

- HIV Status Unknown: 20% (N=74)
- HIV Negative: 3%
- HIV Positive: 77% (N=74)

**Sexual Orientation of Male & Female Clients in this Report**

- Bisexual: 1% (N=72; 2 missing cases)
- Gay: 13%
- Heterosexual: 86%
Gender of Clients in this Report

Women 43%  
Men 57%  
(N=74)

Intravenous drug use of Clients in this Report

Ex User 18%  
Drug User 82%  
(N=74)

Clients with Children in this Report

Clients with no Children 45%  
Clients with Children 55%  
(N=74)
There were 909 Service Interventions Recorded during the Monitoring Period in this Report. Below is a summary of the main interventions.
Evaluating a Community-Based Initiative

Records of Main Service Interventions Compared by Gender

- **Welfare Fund**: Interventions include: processing applications to the Fund; liaising with travel agents; organising crisis grants.
- **Support**: Interventions include: one-to-one support for clients and relatives; access to support networks.
- **Return Home**: Interventions include: Organising a flight home; liaising with service providers in Ireland; liaising with family networks in Ireland; securing financial support for clients to access the Welfare Fund.
- **Referral**: Interventions include: Referring clients to appropriate services; liaising with service providers during the referral process; accompanying a client to the service.
- **Prescription**: Interventions include: facilitating access to prescribing services; supporting clients to access substitute prescriptions; liaising with prescribing services in Ireland for clients returning home.
- **Health Care**: Interventions include: identifying appropriate services; referrals to health care services; liaising with health professionals on behalf of the client.
- **Family Support**: Interventions include: liaising with family members in Ireland; liaising with relatives in Britain; facilitating access to family support networks in Ireland.
- **Children**: Interventions include: referrals to child-centred agencies; providing support and referrals to services for families; liaising with service providers re clients' children.
- **Assessment**: Interventions include: Assessing clients' needs; exploring issues with clients; identifying appropriate referrals.
- **Accommodation**: Interventions include: advocating on behalf of clients with service providers; participating in case conferences; negotiating with services in Ireland.
- **Advocacy**: Interventions include: providing information on services in Ireland/Britain; prevention information on safer sex/drug use.
- **Advice/Info**: Interventions include: applications for flights home, or to Britain, for clients and their relatives; crisis grants for clients and grants to enable clients to access care and support networks.
Clients in this Report came from a wide variety of towns and boroughs throughout Britain and Ireland.
References...


______ (1991b) HIV Outreach Health Education: National and International Perspectives; University of London, Birkbeck College.


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Siobhan Riordan

Thank you for taking the time to read this report and we would welcome any comments you have. If you require further copies, please contact the PIAA office.