

**Northern Birmingham Mental Health NHS Trust**

**A Study of Crack Cocaine Services of the  
Bronx New York, Los Angeles,  
California and Barbados, West Indies.**

**January 17<sup>th</sup> – 29<sup>th</sup> 1998**

**Grantley Haynes & Andy McWilliam**

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## **Acknowledgments**

We both would like to thank the Northern Birmingham Mental Health NHS Trust and the various organisations, which very kindly welcomed us to America and Barbados. It is without question, that a lot of careful timing and planning was undertaken prior to our visit. We were very impressed with all of the agencies that we visited, particularly those with a community focus. Consequently Andy and I were very fortunate in successfully achieving our aims as well as making some friends. We hope that they may be encouraged to visit the United Kingdom, where we will be happy to provide our friendship and assistance.

Thanking you all.

**Grantley Haynes & Andy McWilliam**

## 1. INTRODUCTION

In the mid 80's Robert Stutman a police officer from the USA provided dire warnings that crack cocaine would reach the same epidemic proportions in this country that it was reaching in parts of the USA. Although, thankfully, this prediction has not come true to the extent prophesied, it is without doubt that crack has now become a major feature in many parts of Britain today, causing many problems not only to the user but also to many others who are affected by its use.

The majority of drug services in this country have been ill prepared to deal with the demands that this drug poses. Most services are geared towards the needs of opiate users, providing prescribing services, needle exchanges etc. With Crack there has been a feeling of dis-empowerment amongst workers as there are few effective ways of treating crack dependence and it is very problematic to use a harm reduction approach, as there, is no real safe way to use crack. The main lead to the development of services for crack users has come from the USA, as due to the severity of the problem there they have had to pioneer radical treatment methods, as well as innovative ways of providing community initiatives to respond to its use. For instance the use of auricular acupuncture was pioneered at the Lincoln Clinic in the New York a project which now sees on average 500 crack users a day. The use of outreach has also been pioneered there, and in other parts of the States, as well as assertive primary health care initiatives, as TB has now been identified as a major health risk to crack users.

In the States, as in this country, Crack disproportionately affects black people and unlike opiates affects women equally as it does men. Drug services in the UK, as stated before, tend to be targeted towards opiate users who statistically, 70% are usually white and male. So again, the expertise in working with a group of people who have differing cultural, as well as gender needs are not as well developed in this country as in the States and parts of the Caribbean.

It is for these reasons that we propose it would be extremely worthwhile for the development of the new Crack team in Birmingham, if we were to the visit the USA and Caribbean. This would enable us to learn from the hard-learnt lessons that they have gained from their considerable experience, to inform the delivery of the new service here.

To achieve this we decided to visit California, New York, and finally Barbados, which provided the opportunity to examine a range of varying services in differing environments, with various ethnic groups. The visit was undertaken by the Crack Outreach Team Leader Grantley Haynes and the Chair of the Crack Team Steering Group Andy McWilliam. Andy has been

instrumental in developing the service along with other members of drug agencies in Birmingham England. The visits took place between January 17<sup>th</sup> through 29<sup>th</sup> 1998. Prior to the new outreach team members commencing their employment on April 6<sup>th</sup> 98, with the Northern Birmingham Mental Health NHS Trust. Having completed this, we now present our findings.

It is intended that this report will outline recommendations as to the development of the new service.

## 2. SUMMARY

Study Visit to Crenshaw, Los Angeles, California, Barbados, West Indies and Bronx, New York

**17<sup>th</sup> – 31<sup>st</sup> January 1998**

In this report we shall endeavour to show from our invaluable experience of being able to visit the diverse range of services, both in the USA and the Caribbean, what we can take and use in Birmingham. Not only to develop the new crack team but also to inform and change the existing drug services.

We shall describe how the relatively newly introduced drug courts, first pioneered in Miami and now being used in Los Angeles and elsewhere, are working and what are the lessons to be gained, if they are to be implemented here.

Neighbourhoods such as Crenshaw in South Central Los Angeles, an area notorious for its gang violence and high prevalence of crack use, gave us a priceless insight on how to provide services, which not only gained the respect and trust of the community, but also manage to be sensitive to the culturally diverse nature of the population. The emphasis that these projects displayed in working with people not just as individuals but as people who are part of a community, was reflected in their use of group-work, either to increase social skills, provide drug education and to avoid relapse. This is contrasted in Birmingham where the majority of services work with people on an individual basis, often excluding the family and others from the rehabilitation process.

What was very noticeable was that the services visited had very little medical or psychiatric input. The main emphasis was not on prescribing drugs, such as methadone, but was aimed at helping people either become or remain drug free through the extensive use of acupuncture, massage, exercise and other relaxation techniques. This was complimented by the provision of counselling, group work and by projects which helped people gain employment.

The objective was firmly upon becoming drug-free and remaining drug free and the 12 step Minnesota Method was the most commonly used techniques to achieve this. Especially on part of a court imposed sentence were attendance at N.A. groups was mandatory.

There was some scepticism about the use of replacement drugs, which was generally viewed as attempting to quench a fire with petrol. Despite this, there was an acceptance that harm reduction interventions were needed with injecting drugs to reduce the spread of HIV/AIDS and these services are still very much in their infancy in Los Angeles due to legal constraints on the provision of needles and syringes.

The Deacons Road Project in Barbados and the Lincoln Clinic in New York both impressed us in how they were started from the 'street level' and this has been crucial to their development and survival in what can be a very hostile environment. They underlined the need that the community has to feel that they have some kind of ownership. This is so that they do not feel that these services have been imposed upon them by professionals who may lack they knowledge or understanding of the sufferings of the communities and neighbourhoods which people come from.

It is this last point which we feel will be crucial in the development of the Crack Team. It will mean that they will need to work to gain the trust and involvement of not only crack users but also the communities affected by its use. It will need to pioneer a community-focussed outreach, which will strive to empower groups and individuals so that they can take an active involvement in the development of the service.

This will also necessitate that it will be vital that other services, both medical, legal and social, are also encouraged to collaborate with the team to operate in a manner which is not see as oppressive, but as accountable and responsive to their needs.

## **LESSONS LEARNT**

### **Key Issues**

- \* Community Involvement
- \* Provide a Holistic Service
- \* Client Centred Approach
- \* Working with the C.J.System
- \* Viewing the client in a holistic manner in seeing them in their historical/social/political/economical/racial/gender etc. context
- \* Recognising how this effects people self-image etc.
- \* Working from grass roots level
- \* Resourcing Rehabilitation more effectively
- \* Taking calculated Risks

3. **RECOMMENDATIONS**

Implement group work programmes

Acupuncture to be available 5 days a week - need to co-ordinate this across drug service.

Implement a strategy to involve community involvement/consultation in Crack Team.

Liaise with CJ agencies to explore use of a drug court system in Birmingham - could we pilot one?

Specific Employment/Training Project for drug users.

**Grantley Haynes, Crack Outreach Drug Team Manager**

Andy McWilliam, Mary Street Community Drug Team Manager

#### **4. INTRODUCTION TO CRACK OUTREACH TEAM**

The problems associated with crack/cocaine use are legion for not only the individuals, but also the wider community, (see appendix 1). This report will recommend that a specific service will need to be established to make contact with crack/cocaine users, and the communities affected, to identify needs, provide on the spot assistance and recommend the development of services to meet these needs.

A consultation exercise has already been undertaken with crack users and it was clear that many of their needs are not being met by existing services. This is partly due to the fact that the community drugs services are perceived to be geared to the needs of opiate users and also the fact that many crack users are very suspicious of services which are seen to be part of the “establishment”.

In addition to this crack cocaine use is perhaps less visible than many other forms of drug use. Crack is often used behind locked doors and closed curtains. Reaching this client group will provide a considerable challenge to an outreach service and will mean that traditional forms of outreach work will have to be modified and developed to make contact with this ‘hidden’ group.

It is clear that there is no magic wand, which can be waved at this problem, and it is obvious that a crack outreach service by itself will not be able to solve the many problems that this drug brings. It will be crucial that this service works in close liaison with existing services, both statutory and non-statutory, so as to develop effective collaborative working practices leading to an integrated service for people who are affected by this drug.

The recommendation made by the former CORE Group has been successful in gaining funding for a crack outreach service which is being managed by the Northern Birmingham Mental Health Trust. The service has been operational since the April 6<sup>th</sup> 1998.

#### **Crack Steering Task Group (1998)**

##### **Aims and Objectives of Crack Outreach Service**

The problems posed by crack/cocaine have been discussed at length by the drug and associated services in Birmingham. Several suggestions have been made as to what the response should be; these have ranged from providing a 24-hour crisis service to the development of homeopathic services. All these suggestions have been made from a position of relative uncertainty, as this report has shown there is little currently known as to the size of the problem, the nature of the needs, and how they should be met. This has led to the recommendation, which has been accepted that a Crack Outreach Team be established to provide a: -

*High quality/low threshold/ first contact service for crack cocaine users who are not in contact with, or having their needs met by any other drug service in Birmingham, so as to reduce levels of drug related harm not only to individuals but also to those affected by its use.*

- ◆ By achieving this, the team will contact people affected by crack cocaine on their territory, or peripatetically via other community services.
- ◆ The team will provide advice, information, support, and a referral service for crack cocaine users.
- ◆ The team will also provide information on the prevalence of crack cocaine use, new trends in use and advise on the specific needs of crack cocaine users to other statutory agencies.
- ◆ The team will also contribute to the development of services for crack users and provide awareness training and consultancy for other services and community organisations.
- ◆ The team's uniqueness will be it will be that it will target specifically, but not exclusively, primary crack cocaine users. The definition of a primary crack user will be:

**“A person whose drug use of choice is crack cocaine, whether they use it in a recreational or dependent fashion”.**

**5. AIMS AND OBJECTIVES OF STUDY TRIP**

- (1) To gain an in-depth understanding, of the various models and interventions which currently respond to the treatment, of Crack Cocaine Misuse.
- (2) To liaise with community drug workers and gain an intrinsic acknowledge of the requirement related to the face to face approach to outreach work from a “Bottom up” community perspective. This will enable the Birmingham Crack Service to learn from the experience and play a significant part in the delivery of service.
- (3) To shadow along side community drug workers, and engage in the delivery of some of the day to day services offered to user groups in order to gain hands on exposure.
- (4) To meet face to face with service users in order to gain first hand knowledge of the effectiveness of the treatment service offered and to receive their recommendations.
- (5) To explore the policies associated with the Health and Safety of outreach workers, when engaged in, potentially highly volatile/dangerous situations. To discover the working practices in place for responding to drug users and members of the public who may display challenging behaviour and emotional problems in relation to provision of Crack Cocaine service delivery.
- (6) To compile an observation report, based on the visit, providing an insight to how communities have responded to the problem.
- (7) To produce some firm recommendations for the development of the service.

## 6. REVIEW OF LITERATURE

There is little accurate data as to the size and scale of the problem of crack cocaine use in Birmingham. It is clear that the dire warnings of Robert Stuttman in 1989 and Kleber in 1988, when they warned of the havoc that this drug could cause if it was allowed to spread across the UK unchecked, have not been realised to the extent that they prophesied. It has also been established by studies conducted by Stimson et al (1993); Bean and Pearson (1992) and Gossop et al, (1994); that there has been an increase in the use of this drug and that it tends to be restricted to the major cities. It is also accepted as shown by Green et al (1985), there are differing kinds of crack users, some recreational, some dependent and some that use the drug in addition to many other substances. The majority of the drug services in Birmingham would agree that they have all identified an increase in the use of crack cocaine by their clients, but the percentage of those whose primary use is crack cocaine is relatively small.

There have been various reasons suggested to account for this. Shapiro (1994) in an article in Druglink stated that it was partly due to existing services being unable to provide an appropriate response, and Release have pointed out in a review of drug services in 1993 that there is a lack of direct service provision for crack users.

In addition issues of race have also been stated as reason for low attendance of crack users at drug services. Projects visited by Floyd Davidson (Chair CTG), in London, Liverpool and Manchester have reported a high prevalence of crack use among the Afro Caribbean population, both male and female. Current activity data shows that there is a relatively low take up rate from this client group among services in Birmingham, with contact running on average 10% or less. The reason stated for this is that the services are geared more to the needs of Heroin users who tends to be mainly white male and that many black drug users are very suspicious of these services due to fears that they may be confined or reported to the police.

### **Existing Services/Shortfalls**

At present there are four statutory community drug teams, two voluntary sector drug projects, Birmingham Drugline and Parents for Prevention, a tertiary drug dependency service, and Addictive Behaviour Centre, in the city of Birmingham. Recent reports have indicated that all of these services are under incredible pressure responding to the current epidemic use of Heroin. Several of the services have had to close their 'books' and are unable to offer treatment services other than to users with special needs. This has meant that in addition to the already mentioned theories as to why crack users do not access services to the same extent as Heroin users, they do not physically have the resources to cope with existing demands, much less address the needs of primary crack users.

This is due to the fact that crack users tend to have a number of characteristics uncommon in the heroin using population; for example, many crack users start their use early in their drug using careers in the mistaken belief that the drug does not cause dependency. Consequently crack users are often 'taken by surprise' both by the seriousness of their problem and the rapidity of its onset. Regular heroin users tend to use on a daily basis, whilst crack users tend to binge until their finances are exhausted and then enter a highly distressing phase of withdrawal, (the crash). Crack users, therefore, tend to enter periods of crisis where very rapid access to service is required.

This is very difficult for existing services to respond to due to the current level of demand from heroin users.

7. **ITINERARY FOR GRANTLEY HAYNES/ANDY MCWILLIAM**

**SATURDAY 17th**

Depart Birmingham 6.00am to Heathrow Airport  
Arrive Heathrow approx. 9.15am Check In: -

Depart Heathrow Airport to - Los Angeles LAX, Sat. 17th Jan 98, 11.05am  
Arrive at 3.00pm Local time, Clear U.S. Customs.

Collect Alamo - Hire Car and drive to Hollywood - Roosevelt, Los Angeles,  
Check in approx., 8.00pm Local.

Hours from Birmingham to Hollywood, (21 hrs)

**SUNDAY 18th Day off**

**MONDAY 19th**

**Time: 10.30 a.m.**

**Place: Delancy Street Foundation (formerly LA Midtown Hilton  
Hotel)**

**Contact: Diane Sanders**

**Address: 400 North Vermont Ave  
Los Angeles**

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**Time: 2.00 p.m.**

**Place: Project Recovery**

**Contact: Isabelle (outreach)**

**Address: 133 E. Haley  
Santa Barbara**

This visit had to be cancelled due to public holiday.

**TUESDAY 20th**

**Time:** 9.30 p.m.

**Place:** Matrix

**Contact:** Vicky Illias

**Address:**

Los Angeles

**Schedule:** 9.30 to 12.30

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**Time:** 1.30 p.m.

**Place:** Rio Hondo Drug Court

**Contact:** Commissioner Jose Rodriguez (Judge)

**Address:** 11234 East Valley  
El Monte  
Los Angeles

**Schedule:** 1.30 p.m. Drug Court  
2.30 p.m. Talk with Jose

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**Time:** 5.30 – 9.30 p.m.

**Place:** AADAP (Asian/American Drug Abuse Program)

**Contact:** Mike Watanabe – Executive Director

**Address:** 5318 South Crenshaw Blvd  
90043 (Crenshaw area)

AADAP is the most comprehensive programme in Southern California

**WEDNESDAY 21st**

**Time:** 9.15 a.m.

**Place:** AADAP Asian American Drug Abuse Program

**Contact:** Becky

**Address:** 3850 Martin Luther King Blvd #201  
**LA 90008**  
(In the Crenshaw area)

**Schedule:** 9.15 a.m. Meet Becky  
9.45 a.m. "Special Deliveries" Acupuncture Group  
11.00 a.m. Topic Group.

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**Time:** 1.30 p.m.

**Place:** LA Drug Court

**Contact:** Raymond May

**Address:** 210 Temple St  
Criminal Courts Building  
Division 42  
(Downtown)

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**Time:** 3.00 p.m.

**Place:** IMPACT - Drug Court treatment facility

**Contact:** Raymond May

**Address:** 510 New High Street

**Between Spring and Main, Downtown**

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**Time:** 4.30 p.m. 6.30pm

**Place:** Leanne Audette (Facilitator and Co-Ordinator of Californian Visits)

**THURSDAY 24<sup>th</sup>**

**Time: 10.30a.m.**

**Place: Chrysalis**

**Address: Santamonica**

**IN TRANSIT TO NEW YORK**

**8.30 pm. Drive to LAX and return Hire Car, board transit bus to LAX and Check for domestic “red/eye”, night service flight to (New York JFK)**

7. 20 am Arrive at JFK.

8. 30 am Connect for flight, departing for Barbados.

2. 30 pm Arrive in Bridgetown, Barbados. Clear Barbados Customs Transit to the Kings Beach Hotel, Barbados.

6. 00 pm Arrival Time.

**SATURDAY 24th Free day**

**SUNDAY 25<sup>th</sup>**

**Time: 10 am**

**Place: C.B.C – T.V Studios – The Pine**

Arnon Dyle: News Producer T.V News C.B.C

Time: 3 pm

Place: Golden Sands Hotel  
Maxwell  
Barbados

**Contact: Dawn Bennett, The Advocate News Paper**

### **MONDAY 26th**

- 8.30 - 9am Confirm appointments.
- 9.30 - 5pm National Drug Resource Center,  
St. Michael, Barbados.
- Contact: Mrs. Tessa Chadderton-Shaw**

### **TUESDAY 27th**

- 8.30 - 9am Confirm appointments.
- 9.30 - 2am Depart for Teen Challenge,  
Speightstown, Barbados.
- 2.30 - 5pm Area Community Observation, with Teen Challenge workers.

### **WEDNESDAY 28th**

- 1.30pm - Check in - at Grantley Adams International Airport.
- 3.30pm - Depart Barbados to New York (JKF)
- 7.40pm - Arrive and Clear Customs - Transit to  
The Amerianti Hotel  
Manhattan, New York.  
USA.

### **THURSDAY 29th**

- 8.00 pm- Confirm appointments.
- 9.00 - 7pm Depart for, The Lincoln Memorial Hospital Clinic  
Bronx,  
New York,  
USA.
- Contact: Dr Michael O Smith M.D**

**FRIDAY 30th**

6.15pm Depart for (JFK International Airport)

9.15pm Depart for London Heathrow.

**SATURDAY 31st**

9.20am Arrive London Heathrow - Clear British UK Customs,

10.30am 3 hrs to Birmingham - Arrive - 1.30pm.

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8. **20<sup>TH</sup> OF JANUARY 1998 1<sup>ST</sup> VISIT LOS ANGELES**

**DELANCEY STREET RESIDENTIAL REHAB UNIT**

Our first visit was the Delancey Street Project, which was set in what appeared to be a five star hotel! In fact, it was intended to be a Five star hotel being built for the Los Angeles Olympic Games. Due to it not being completed in time the building was purchased by the Delancey Foundation.

The Delancey foundation was started by a group of people who believed that they could re-educate themselves to become a productive and meaningful part of society. At that point, they all worked at jobs outside of the foundation and pooled their resources to be able to rent places to live, pay for the food and set up a communal atmosphere. They then extended to the point where they were able to develop their own business training schools. Delancey Street is an extremely heirachal society so the longer you are here, the more you learn and the more you've grown and changed, the more input you have in the running of the foundation. Nobody here receives a salary as every one is a resident, so no one goes home at 9.00 p.m. No one gets off work and changes their way of thinking everyone here is a 24 hour a day integral part of the organisation and is subject to the criticism and the learning processes as if you were brand new.

There are a two different phases in Delancey Street. Phase 1; when you are first accepted into Delancey Street. They take people from all walks of life, from prisons, from the street, from good families. They have an interview / assessment process and once you have passed that interview process and are accepted into Delancey Street they require a two year commitment. They also make a two-year commitment to providing food, clothing and shelter, whatever teaching facilities they have to offer whether it is educational, interpersonal or just basic ethics on how to live a decent life. Everyone from that point starts off working what Delancey call maintenance, which is a description of the job that they do. It's menial work - they do the laundry, they serve the meals, they clean the house they keep busy enough so that they don't have time to think about how they would really like to go out and get loaded. And at the same time they learn to get up on time. They learn to follow directions from the person who is in charge of them. They learn that they can't always be by themselves that they have to work together as a group otherwise it doesn't work as well so they learn the basic skills in a 2 to 3 month period.

From there they go onto the second phase; which means that they get a job for set hours maybe 8 to 5 maybe its a different shift and they work in a specific training school department. It could be food service, it could be construction, landscaping, they could make some of the hand crafting products that they sell, they might also learn basic clerical skills.

We asked whether the residents were given any choice – and we were told, ‘not really at first’ - that at the first job they usually put you where they needed you, and as you establish yourself and they start to get to know you and you open up and start getting involved. Then maybe they can identify potential. It

may not be something that they are already skilled at, it may be a skill they didn't realise that they had, maybe this guy would be really good in this area, we think he can do it and he of course doesn't have the slightest clue that he can do it, wouldn't it be great if he learned that he had more options than just painting a house or whatever he has done for the last 20 years for money. They stress that the building of self-esteem is crucial – and that they try and start that from day one. If you came in at 2 o'clock and someone else came in at 4 o'clock they then put you in a position where you have to teach the person that came in behind you everything that you know even if it's only that you get off at 3.30 p.m. They encourage each resident to be responsible not only for learning from people that are around him/her but teaching people who are around him/her. Some people may come in educated, some people come in with no education, those who read on a college level they put in positions to teach people who don't know how to read at an 8th grade level who in turn mentor someone who cannot read at all. So each step that goes on is designed so that it increases a person's confidence in themselves. The founder of Delancy Street, Mimi Silver, has a doctorate in Psychology and Criminology. For a long while she worked actively in the prison system, counselling people. Each day she would go home patting herself on the back, "oh I did something to help somebody else, I feel really good about myself," until one day she said "what about the people that I'm helping - how horrible for them. Always having to be helped, what if they in turn could help somebody else, what difference would it make to them in their lives?" And so Delancy Street was the product of some of that thinking and has evolved into the concept that every one has a key part to play - *once you are there you are responsible* .

### ***The Referral Process***

You get into Delancy Street in a number of different ways, some people hear about them by word of mouth and call and ask to come in for an interview. Some people are in prison and hear about them from someone they are in jail with and they write a letter and then they will go to the prisons and interview them. Then it is up to the court whether or not they want to release them to Delancy or send them to prison. In a lot of cases if it is a drug-related crime they will send them to Delancy Street. Increasingly, if they have a history of drug-related crime there are judges who believe enough in the Delancy Street Foundation to let them come as part of a mandatory treatment package.

### **How is it paid for - if I was a crack user or heroin addict - would I have to pay for treatment?**

By the time you come to Delancy Street you have no money - that is a basic assumption - and Delancy Street does not rely on Government funding - nor does it rely on the client to pay for the service. They are a kind of a grass roots organisation which supports itself and over the years they have developed a number of business training schools which not only serve to generate income but also serve as a teaching facility for the residents. So if your first job is in food service you learn how to cook for a large group of people, if your first job is clerical then you learn clerical skills. Whatever your job, you gain the

experience while you work, soon you are generating an income which everyone benefits from. For example they have three major areas of income. They have a **sales business, a moving company and catering business**. If you go out on a moving job you do not get paid. It is not you who receive the money; the money comes back into the foundation. There are no paid professionals at Delancy Street, except for the President who has her doctorate. Everyone here is a resident, all at different stages of their stay at Delancy Street, but everyone is a resident. There is a very definite hierarchy and they don't think of themselves as a treatment programme. They think of themselves as a huge extended family where the residents that are here all the time are like the grandmother and the grandfather, who have a little bit more wisdom to share with the people that are newer. They're are not superhuman creatures - they still make mistakes - they still get held accountable for the mistakes that they make - but they serve as the structure, the nucleus of the family. And then as it grows you have layers and layers of people who come in at different stages and at different times who make up the structure, so that there is very definitely a hierarchy. It is like climbing a mountain. You are in a chain you reach out to the person in front of you for your strength and reach behind to provide those strengths for the person below you. (The Phoenix centre in UK is based similarly like this) But unlike Phoenix, the average length of stay is three to five years!

### **What happens when a client leaves?**

It is set up so that as you learn, you grow, and establish a foundation for yourself, build confidence and you then leave and go out and build your life. You can always come back and help out, always come back and just sit and talk and go through some of the struggles you went through while you were here and some of what life is like once you leave. So, you are constantly setting an example for the people that are still here. What they do when someone is ready to leave is have them enter what they call a Workout Phase. Here they get a job and they continue to live here for a three-month period. During that time they leave everyday, go to work on their own, they find a job on their own. They save their money for three months in order to have a nest egg ready to start a new life. They don't just kick you out of the door. It's like leaving a family, the step is gradual, eventually, you start off by re-establishing yourself in society and Delancy remain as the support for those who leave. The foundation demands total abstinence from drug usage. There are three rules, that if broken, would result in you being asked to leave, no violence, no threats of violence and no drugs - they also expect abstinence when you leave Delancy Street

### **How do you help someone coming into Delancy Street with a drug/violent/alcohol background? What support do you give?**

The foundation has confrontational groups where if you mad at someone because they did something to you or you think you did something to them this can be discussed in the safe environment of the group. Clients are also held accountable by the group process but can grow to realise that although

violence may have always been an integral part of their life it does not always have to be that way. They have to learn that they can not keep using this as an excuse but instead have to explore how to move on.

We pointed out that we have the same sort of problem in Birmingham. People in the same cycle of drugs and violence, have found that they need to go through the process that has just been talked about in order to identify what went wrong previously so that that they can work towards recovery. But what you normally find in England is that clients are continually held accountable for what they do but it never works the other way round; because society does not give them a chance. Maybe it works in US because they have time to adjust to the new way of life.

Delancy provides an environment that says that none of this (drugs/alcohol/violence) exists right now - you are here you cannot communicate with your friends/family at least for the initial period - you have no strings that society imposes (rent/bills/car etc) there is no need to go out on your own and find a job, we are going to give you a job we are going to take care of all your needs. What you have to do in exchange is to start trying to be different and if you act like a different kind of person long enough then you will become different. Those things will become natural reflexes; they will become part of you. 60/70% of the residents at Delancy Street are court committed, either they are directly committed by the court, which means they have a sentence still hanging over their heads or they are on parole and their parole agent insists that they complete Delancy Street. So you do not have that option, you cannot blow it; you cannot break something over someone's head because you will go back to prison. Which in most cases people say that prison is the easier option. They also make sure that you understand that you are taking the easy way out again. They encourage people not to give up on themselves, not to just say, "forget it it's not worth it." If at the end of your stay at Delancy Street you decide you like being a drug addict and a 'jerk' better than you like being a responsible person, the same drug dealer is still on the same corner and they bet you can still find him if you want. While you are there you have to try it their way and they will not allow you not to. The peer pressure is positive, so even if you want to be an idiot they are going to call you an idiot sooner or later if you do not try to change.

Delancy Street currently holds about 250 residents, with a varying ethnic mix, differing kinds of dependency on illegal and prescription drugs and alcohol. It is the way of thinking and living and patterns set for yourself before you get to Delancy Street that seems to have a common thread most of the time. They do not expect their clients to be polite, well behaved acceptable individuals for the most part they are not. They do not detox. They put them in a room and get them to work; some detox that way when there is no medical back up on site.

**What about clients possibly 'fitting' coming off drugs** - they will usually tell us when we interview them what they were using if they think that they need a medical detox then they will go and do that and come back. If

somebody slips through and we find there is a problem then we send him or her to the hospital.

**What about dual diagnosis (mental health/drug problem)** - we do not have the facilities here to cater for this kind of resident therefore we do not accept them onto this programme so we refer them to another facility which is better suited for their needs.

*To conclude, our philosophy is to teach others in order that they can build their self-esteem and learn to care about other people. One of the greatest assets of being in Delancy Street is to watch someone come in and see them go through the different phases in Delancy Street and watch them leave successful in their lives doing whatever makes them happy and learning to realise their potential and learn to fill their lives that makes them proud and happy people*

9. 22<sup>nd</sup> January 1998 2<sup>nd</sup> Visit **West Los Angeles - Vicki Illias**

**Diversion Programme**

On the second day we visited a diversion programme in West Los Angeles. This transcript is based on an interview with Vicki Illias. This is a twelve-month day treatment programme. Most clients are attending this establishment as part of a probation or parole order there are also a few self-referrals. They also have an outpatient division that deals with DUI (driving while under influence), DV (Domestic Violence) which is also court ordered. This is an education programme that lasts for a period of 20 weeks focusing on drug education.

**Drug treatment**

They provide education dealing more with social interaction and mental health issues. There are different types of treatment some may work in a residential context, and some may not work in out patients. For instance they do not want a client to walk out the door after opening a can of worms which could then trigger them to go out and get loaded. They believe that some addicts are 'stunted' i.e. they stop growing at a certain age emotionally, and have few coping skills. Lets say there was a family tragedy they consequently got loaded and have never had the chance to work through these issues. The addict gets clean and brings up the issue of the family tragedy. This may trigger off the pain, and because addicts do not deal well with this feeling, it is important that counselling or self -help is provided. This is because it helps to nurture them and gets them through to the other side. A person who does not use drugs can become an addict in other ways - workaholic, fitness or something to 'self-preserve' themselves - addicts use drugs.

**Counselling - do you use skills or themes?**

Vicki replied, "That It depended - on what sort of addiction - I was an addict for many years have been clean for many years, things were very different then many years ago. They had very few treatment programmes 15-16 years ago and now there are a lot of studies about the treatment of addiction. For instance the MATRIX is currently studying addiction and they give different kinds of medication to try and stop the craving."

**What is MATRIX** – "MATRIX is a facility in West Los Angeles which prescribes drugs to block the action of addictive drugs such as Methadone.

**How are you funded?**

"We are County funded organisation but the current treatment programme is not County funded so we do have some fees. It works on a sliding scale, what the addict can afford to pay."

“We ask for an enrolment fee of US\$25.00 (£15.00), which covers their physical and medical component here. Many addicts neglect themselves and most addicts do not visit a doctor they tend to self medicate. My role is to see that they visit a doctor, dentist and get followed up. We encourage them to set goals for themselves and make sure they complete them.”

### **Out patients**

There are various phases for each client. They are told what is expected of them, during their time in treatment, then objectives are set and should be completed. Be it NA (Narcotics Anonymous), CA (Cocaine Anonymous), whichever programme they feel comfortable in. They do not have to go to these but they must have a sponsor before completion and also write their life history, they are expected to because it is part of the treatment programme.

### **Who are your contacts - where do you get your referrals?**

“We have contact with the Santa Monica Probation Service, the Department of Child and Family Services and the Parole Board. We do a lot of networking with these agencies letting them know of any changes regarding the clients, Including if they relapse, relapse is part of recovery process not everyone can do it through outpatients”.

### **Have you a typical profile of the addicts who use the service?**

“ No - they come from all walks of life “.

**Would the treatment for a crack addict be different to someone using opiates? In Birmingham opiate users would be more patient, though in need, to wait for an appointment and most would be happy with methadone where as a crack addict would not because they come down quicker, become more demanding, spend more money - how would you deal with it here?**

“Not as far as treatment goes, it would depend on the individual addict’s needs. Most of the addiction here is Meth-amphetamine, which can cause a lot of damage with continual use whereas with crack cocaine, the addiction is quicker. When an addict is down, it can be much harder to motivate them. It is important to take a view of them as a whole. Depression is different with opiate users than crack addicts. When they go into a depression they remain in this state longer, this can become a trigger for them to go out and get loaded more frequently”.

“ I tell a client to call every day so I can check on them. I try to move them to alternatives i.e. Acupuncture - we recommend they go to acupuncture as this helps to lower their stress levels”.

### **What about drugs i.e. Prozac?**

“Drugs can tend to mask the problem, I am not saying drugs don’t help... that is only my personal opinion. An addict needs to be off drugs for at least a 6 to 12 month period to give a good evaluation. Just putting them on alternative drugs hoping it will go away does not help. I’m not saying it is not a good idea. In the short term perhaps but drugs like Meth- amphetamines can do so much damage to your brain that if you were not depressed before, you would be.”

### **Do you have many suicides?**

“No, but we do have a lot of paranoia, lack of trust, and mental breakdown, or people become mentally ill when they are using. The brain cells are used at a more rapid rate and it can take up to 2 weeks to build them back up again and some people do not produce the same amount again and if they are not producing anymore that would create a chemical imbalance.”

“You need to get to know your client so they do not fall in the cracks, as if they are not treated effectively they could relapse.”

### **Do you have facilities for women and ethnic minorities?**

“ As our agency has limited staffing we do not have specific facilities for this. With the Domestic Violence work we deal with the perpetrators and the victims are referred to the appropriate agencies”

### **What is your staffing levels and caseload?**

“We have 3 members of staff and my current caseload is 15 Domestic Violence, 8 Driving under the influence, and 13 in the out-patient treatment programme.”

### **Who do you refer to?**

“There is a Community Resources Centre in West LA which we call in regularly, and there is a residential programme to go and get treatment. It is important that a small assessment is done to make sure that they are referred to the right agency so that their needs are met. They do not always tell you everything; they do not tell you that they are on psychotropic drugs. They do not tell you that they have children and there is no one to take care of them. David is good at getting the information updated, we have staff meetings once a week to information share and go over clients.”

“We also get GR (General Relief) clients. This is a payment that people get to help them to survive but is not to become a way of life. They get US\$212 per month and US\$100 per month food stamps. The homeless tend to be on GR and many have drug problems. John tries to find different referral agencies for treatment across West Los Angeles. In addition we also have a Diversion

programme, that is for 1st offenders on the DUI programme, and for 2nd offender there is an 18 month programme.”

“We also provide drug education and we also drug test through the out-patients. service”

**How?**

“It’s a urine test which we send to the lab”

**Do you think it is important?**

“Yes it gives an incentive to them to stay clean and prove themselves.”

**What about marijuana use?**

Marijuana is a big problem and a chronic user does not see this as a major problem - from their perspective they are clean (i.e. not using crack/opiate) that it is a herb, comes from the ground, but traces can be in the system for up to two weeks.”

“We expect total abstinence from any mind altering drug for a client to remain in the treatment programme.”

**10. RIO HONDO COURT LOS ANGELES – INTERVIEW WITH COMMISSIONER JOSE ANGEL RODRIGUEZ OF THE MUNICIPAL COURT OF THE RIO HONDO JUDICIAL DISTRICT**

**COURT DIVERSION PROGRAMME**

**What sorts of drugs are commonly used here?**

Crack cocaine, Amphetamine because it is easily manufactured reasonably priced and lasts a good while longer than crack - 20-30 mins for crack while amphetamines would give a high for 8-10 hours.

Three years ago we were told that ‘ICE’ (Meth-amphetamine) would become the next big drug but has not become as prevalent as first thought - it is an highly addictive drug and I understand that there is a big problem in Hawaii with this.

**The UK are looking at the possibility of introducing Drug Courts - how does yours work?**

California used to have a **Diversion Statute** on its books but they now have a **Deferred Entry of Judgement Statute**. Under the old law it meant that if you were a 1st offender for possession of cocaine and certain types of illegal prescription drugs. Either for the purpose of personal use or the cultivation of

marijuana for personal use and you come before the court but had no violent felony conviction within the past 5 years or had not been diverted within the last 5 years, you were eligible for the Diversion Programme.

It consists of educational/counselling for 32 hours and 20 sessions of NA (Narcotics Anonymous) meetings - it costs about US\$500 and takes about 4-5 weeks to complete and when they come back to court the case may be dismissed or discharged. There is a special activity clause - this is Court ordered - that if they fail to comply with the conditions then the court would then have the power to take away the diversionary programme reinstate criminal proceedings and then follow through with the person.

With effect of January the 1st of this year instead of it being a pre plea diversion where the person enters a plea of guilty/not guilty that used to be the diversion programme. Now this is a post plea diversion. The person has to first plead guilty to the charge and then if they successfully complete the programme, which is now a maximum of three years and a minimum of 18 months, then the case is dismissed. If the person fails to complete it then the court can have the right to sentence the person. Felony can be 3 years state prison or it could be 1-year county jail unless probation is granted and on misdemeanours it could be up to 1 year in jail and most misdemeanours carry a minimum of 90 days in jail for drug offences. So the whole purpose of that is to give the people an incentive to comply with the order.

The programme that you will see is called the **DRUG COURT PROGRAMME**. This programme goes beyond what we have done here. People who come to our programme have already either gone through diversion and failed. Alternatively they have gone to diversion and successfully completed it but have picked up a new drug case over the last 5 years. They also may not be eligible for a programme under Deferred Judgement or Diversion. This is because either they have been convicted of a felony within 5 years or have been diverted before; or they have been previously convicted of a drug offence in the past and so they do not qualify for this programme. So we basically get people who have been through the system twice. This programme here is much different than the minimal supervision programme of the past. This is a 12-month programme that involves three different phases.

The first phase is testing on a daily basis; you do two group-counselling sessions a week and five NA meetings a **week so you are busy every day doing treatment**. You are offered acupuncture and there is the 1:1 counselling sessions. ***It is a system of graduated rewards and graduated sanctions.***

The system we had before would be that someone would get a felony case-would enter a plea of guilty, get put on probation, or get a jail sentence. The Probation Department would have the person randomly tested; the person would call in every day and according to what your code is you would be tested that day. You pick up 6 times you call in and your codes are clear. A true addict is going to run the risk and then maybe a couple of days late, he

may be called in and he thinks that as he is 'dirty' he would not go in and test. Failure to test is considered a dirty test - a positive test is a dirty test and what would happen then is the case would go to Superior Court for sentencing for a positive test and they get sent out to State prison. Violent offenders do not qualify for entry into this programme.

Drug Court is different, our idea is that it did not take a day for a person to become an addict and it does not take a day for them to stop being an addict. If you get people to stay clean for 8 - 12 months then they are probably going to make it. In order to graduate from our programme people have to be totally clean for 8 months, alcohol is included, ***no alcohol and no drugs for 8 months***. From the first phase of testing every day they move to the second phase where they test three times a week. If someone is using three times a week we will pick it up and the third phase is less testing and less counselling. Before they can graduate they have to be involved in the job search or have a job or some educational assignment and part of the things that we do here is that we realised that education is the key to the whole thing. This is because a lot of our people are not very literate and have a lot of trouble with education and so part of what we do is group counselling sessions, which involve helping people in literacy skills, and job application skills etc.

### **Graduated Sanctions and Rewards**

Some people when they go from one phase to another people will clap and give encouragement as they are moving up or making an advance. A negative sanction would be if someone does not show up to do their testing or refuses to take a test, does not go to meetings, we may then impose some consequences. Somebody may pick up a positive test or two; we do not give up on that person based upon that. What we do is impose consequences. They could be going back a phase, or you could be put in jail for two weeks, thirty days, or you could be ordered to do a 'live in' programme for certain amount of days or you may be required to go and be tested on a daily basis. Everybody's case is different. It could be that you are out of the programme altogether. That is usually a last resort when there is no other alternative. We have one of our gentlemen who tested positive and I had to impose sanctions by sending him out to a programme known as CRDF (Central Regional Detention Facility). Instead of just sending them to jail we send them to the programme in the jail and its counselling, treatment and acupuncture 7.00 am 'til 9.00 p.m. so they get very focussed help. They come out after two weeks there as if they had been in a rehab hospital with a profoundly different view of life. They realise that the purpose is not to punish them but to focus them back on to treatment

### **Opiate users would you sentence them to a Methadone programmes?**

No. Methadone is just synthetic heroin and people take that and get addicted to the Methadone just as bad as they do with heroin. It may curb the need for usage but it isn't quite the same thing as a 'rush' intravenously that the users are addicted to so you find a lot of people who are using Methadone on a daily basis but still pick up drugs here and there. The problem with Methadone is

that they are only required to be tested randomly. Methadone was a way of weaning them off over a short period of time, with counselling, but the problem that we have here now is people remaining on the drug for years. For instance we have a young lady on our programme now that was on Methadone for 8 years and she used heroin initially for 13 months.

**Isn't that a problem of the programme and not the Methadone - the programme not being supervised enough?**

No - the programmes are supervised by the State Of California they have to be certified and registered.

**What about the ethnic population?**

It depends on which court you are in. Here for example we might get 30% Anglo, 60% Mexican American 10% a mixture of other You go downtown and its 70% African American, 20% Chicano, 10% Anglo. There is a very heavy Hispanic concentration in the Valley and Los Angeles has enclaves of different ethnic groups with drugs every place, we have ethnic and gender statistics and it differs from each court. If you generalise you will find there are more minorities in Drug Court. What does that say that there are more minorities using drugs or that they are more likely to get arrested? We keep statistics on re-arrests, when people graduate from the programme we make a big thing out of it as if they are graduating from college, as this is their first big accomplishment Being a year clean, going to meetings everyday, testing 3 times a day doing acupuncture. I would recommend acupuncture; this is a major accomplishment in treatment of addicts. One of the major things about heroin and amphetamine use and alcoholics is that they cannot sleep. Acupuncture helps them to sleep it also calms them down. When people get up and tell their stories it is mind boggling and tearful, we have their families there, sometimes the press, and politicians. Because the whole purpose is that once people see that they can get clean then they bring their brothers, cousins, every person that is clean brings in five people.

**Is this a cheaper option?**

Yes it costs US\$36,000 to house a person in county jail or state prison. This programme costs between US\$2,000 to US\$4,000 so its plain to see - its a lot more work for the courts but the bottom line is that it is cost effective.

**How do you re-integrate them back into the community after they have graduated?**

That is part of the educational component. We have vocational projects that will help them get jobs, if one person gets a job and has been honest and says that he came out of recovery and he does a good job then someone else is taken on.

**Do you find that there are problems - contacting dealers and the pressure they may have to deal with after finishing the programme?**

Yes. Part of the order to stay in Drug Court is that you have to stay away from people who are using or selling - that could be your wife, father, brother who could be using/selling they have to learn to cut away some of the friendships - because if you are around it you are going to use it. There are times when the environment is not conducive to recovery we keep them in residential for a while and help them relocate get them started in the right direction - they are assessed and treatment plans etc are drawn up. You also have some people who walk straight out of court to a safe place to a job, so they could start out patient treatment immediately. We do monitor them and probably see some up to 6 times a week.

## 11. ASIAN AMERICAN DRUG ABUSE PROGRAM - REHAB

I grew up in the sixties - a period of counter culture movement, lots of drug use - I lost a lot of friends to overdoses I eventually got drafted to the Vietnam War, it was a choice of two deaths. When I came out of the service I went back to school, and trained as a social worker. With my drug background and my experiences in Vietnam which was a very racist kind of experience, working in the Asian American community seemed the natural thing to do, so I chose to work with the Asian Americans who have drug problems.

### **What services do you provide for drug users here?**

We have a variety. We work with the very young to very old we work with parents and the community. We have prevention programmes, community education programmes where we are trying to organise communities to fight drug abuse. We are trying to get the youth involved by educating them in not becoming involved in drug use. We try to mobilise businessmen, local organisations and other volunteers to help us to make an impact in our community. We have counselling programmes for the young we have a unique programme called Minibikes where we focus on high risk users - very poor families mostly African-American and Latino youth. We teach them how to ride little motorcycles, we teach them how to repair them, we take them out to the desert - it is supplement it tutoring, counselling, parent groups/family counselling. They are required to stay in school and maintain a 'c' average and as long as they continue that they can remain part of the minibike programme - its a carrot and stick thing - and it works very well.

We have out patient counselling for addicts- mostly crack-cocaine users, mostly African American in this neighbourhood - we have a day treatment programme- this is a peri-natal programme for women who are pregnant, post partum or parenting with young children in the family, there again mostly cocaine users. They come to the programme about 4 hours a day, they live in the community but they come to the programme we provide child-care while they go through a schedule of treatment activities. We give a comprehensive service from acupuncture to medical attention, as most of them are on welfare we help them to find work. Then we have the intensive residential treatment programme. Our programme is very much like Delancy Street, it is a fairly traditional therapeutic community and it is long term between 12 -18 months and although we have shortened the programme over the last couple of years it is still very long. Helping people to learn how to deal with reality out in the community is a vital part of the treatment. We have a Drug Court as well based in our out patient unit.

### **How do you find helping users and their family/and friends to stay off drugs or to reduce their use of drugs when the dealers are right 'in their face' so to speak?**

The theoretical base is to create a microcosm of the world outside and that microcosm has all of the relationships, interactions, responsibilities, demands

of the world outside except that it is observable. In creating this microcosm the intent is to manipulate that artificial environment in such a manner that the impact of what you control and what you manipulate is what matters. In order to do that you have to have a tie-in as there has to be group identification, group solidarity, and a group commitment. So it is not easy - it takes time for people coming in to make that transition from individuals in that community to become a member of this artificial community. Once you have made that then the group impact on the behaviour of that individual becomes very powerful. If an individual in this therapeutic community were to talk to a dealer this therapeutic community would come down on them and that is how you can do it in an environment like that as long as you can develop that dynamic among the members of the community.

**How do you deal with dealers who feel they are losing their 'power' on that individual?**

Dealers deep down inside understand the problem that they are part of and they understand that if one of his customers cleans up there is a part of him that is happy for that person because of the misery he knows. As long as there is an abundance of other customers that is not really a problem. The other side of it is that people in the neighbourhood know us - we have been here a long time, they have seen us help people that they know. They see that we are not trying to hurt anyone so there is a healthy respect for what we do and even though they may be using, having a programme which is positive and a resource that they may exercise use of is some thing that they support.

**You talked about doing work with the communities to help them resist drugs - what do you think is the most important ingredient when working with the communities to help deal with the problem of drug abuse?**

**Self-determination without a doubt.** When you are working with communities and trying to organise them they have to be empowered they have to determine what gets done and where it goes. People coming in from outside the community telling them what they should do will not work. When people are taught the skills of self-empowerment then the participation is there for them and it is their community group, their programme.

**In parts of England and Ireland, some communities decide that the solution to drug abuse and drug dealers is vigilante action - organise, take to the streets, literally burn out the dealers. It's paradoxical because in Ireland they have a lot of money to invest in drug services but they cannot physically open them because the community threatening to burn the project down if it opens. They say they do not want anything encouraging drug addicts in their community although it is their children who are the drug addicts - does that happen here?**

It happens here now and then - but it does not work - it usually ends in some kind of violence. It has not gained the support of the majority of the

community. We have a saying here called the 'NIMBY' phenomenon (not in my back yard) and that goes on here too.

### **How do people get into the project?**

Most are word of mouth - occasionally referral from the probation department, hospitals, churches just a variety of different places that most of the people that enter have heard about AADAP for some time before actually contacting us. As it is residential most do not work fees are based on ability to pay - we are publicly funded; service contracts. Very few of our staff is qualified, most of them are former graduates.

### **What agencies do you directly collaborate with?**

We have the Homeless Task Force. That is an umbrella of a variety of agencies within the West Los Angeles area that have shelters for men and women. There are some agencies that have their own guidelines and regulations on which they take on- some are not as stringent than others are. There are places for residents which maybe more isolated, they may have children, others for domestic violence.

### **What is your relationship with the Criminal Justice System?**

They court asks clients whether they want to go to jail, or do you want to go on the programme? Someone takes them from there and takes them to the detox be it 30,60 or 90 days- the court systems works with us.

We take it into another genre with regards to the DUI (driving under the influence) if they lose their licence and compounded by the tickets issued which have accumulated so ultimately bench warrants are issued. If you are on the street you are issued with jay walking ticket and cannot pay it, you get another one. You drink and all of a sudden you have US\$2-3,000 that has to be paid in tickets and you could be out walking to your job and for whatever reason they may pull you over and take you back to jail. So what we do when we get them in here is ask them if they have a licence if they say they do not we find out why and we can help them get their licence back and that is encouraging to them because they have not heard that before. We write a letter to the agencies that they have the tickets with (DUI) and express to them that we need to get the licence in order to get them a good job so they can pay their tickets and we are also going to ask the court that if they will accept them doing community service we would supervise it and that is encouraging to them. The court usually waives the fines and sometimes waives to just do the community service but by and large most of these people wind up getting their driving licences again and that they did the work and we just supported and encouraged them.

### **Do you have particular employers you work with?**

No. Most of them do not care about the persons past. They will work with Chrysalis because now we produce a product and when we ask if they have any openings we send people down for interviews. It's all about building self esteem and self worth though we have to do it very carefully, people are reactive to that. We direct them to go to the interviews explain to them that it is alright, that the employer knows us don't mention about the drug alcohol and that all the employer is concerned about is that you can do the job. Those who get jobs we still support them over a period of 2 - 5 years always checking on their job making sure that they are ok that they are going to their meetings. Any changes of circumstances i.e. address, telephone, so we can keep our records up to date- every month they get calls or notices in the mail letting them know of things we are doing and inviting them along so we are always in contact with them. It also helps people come to terms with things that have happened to them in the past that they would not initially admit to. They can talk about it at meetings and how they have overcome it and that information can maybe help someone else coming into the programme with similar problems.

### **How are you funded?**

We are a private organisation - we go around and tell organisations what we are about - we have just had an article published in People magazine, which explains all about us.

We do not get any state funding. We started as volunteers and now some of us are paid.

We have do have an outreach service - we have a director who goes out and deals with all the other agencies as a small percentage of this is funded i.e. two positions are funded for a period of 2-3 years.

We have a system that if a homeless person is in a shelter and here is the job placement agency, we need to know what he is doing within that system so we do not have duplication of resources. We are getting to the point that we will have on-line computers so we will know where that person is and what he is getting; some people will work the system and this is a way of stopping this.

### **Do you do any specific outreach work?**

We go to highschoools - we take an example of a person who has been here went through the same situation, maybe take 2-3 people who are working now and are stable and go to the highschoools and give talks. Sometimes we are invited to dinner with the city and we take examples and we let they city know about us.

### **Do they have to live in this area to access your service?**

Yes. We have a youth programme 18-21 years and the city gives us some money but you need to take people from this city only to provide them with jobs - so in order to get this funding they lay down strict guidelines to us. We have another Chrysalis, which is downtown, and that is bigger and a different clientele - the people that come here about 60% is marketable; some have degrees tend to be more academic. Downtown it is more skid row and the crack is there and the majority are labourers so it is different altogether.

### **What about clients with children?**

It is difficult here because this facility does not have a nursery and the women who are 18-25 with maybe 3,4,5 kids no husband and we cannot cater for them. This is because with children then state comes in and there is tighter scrutiny, what we are doing - it is a separate discipline and surprisingly those women are very marketable, very sharp and very willing to be helped and they could be very good success stories.

### **How do you respond to minorities?**

Surprisingly America is very prejudiced and very discriminatory and it is a fact of life and it is accepted and there are people who have good marketable skills but are somehow because of whatever, does appear to go with the culture of the working place where they can hire. With a Latino population because they do not know English, they do not have documentation sometimes, they are very hit and miss. They come in, they work them a little bit and they disappear. With the black people here we have maybe 50% black, 50% white. On a personality scale colour does not matter because business just look at the bottom line, is this going to make me money. That is my observation, the attitudes behind that they will stand up quite quickly so ultimately a lot of black people will come in with an attitude. Sometimes rightly so because of so many years of racial strife, but somehow if they have the marketable skills they will be picked.

## 12. BARBADOS

We are considered the implementing arm of the council's work. It is a statutory board. They have some flexibility to develop its own programmes and to have a certain creativity that it may not have were it say set up in a ministry. We fall under the office of the Attorney General who is basically the 'conductor' for the supply side of drugs and our focus here at the NVRC is demand reduction. Under supply you have Customs, Law Enforcement, Coast Guard there is a lot of regional co-operation in the works right now. This establishment really took shape in 1996. However our agreement which is with the Government of Barbados and the United Nations Drug Control Programme. We really started in 1995 but very little was done so in terms of U.N.C.P.'s accounting process. We are now in the third year of our project but because of a lot of delays it did not come together until July 1996.

We have full time staff, which includes an accountant, administration and field officers.

We have two field officers, a drug education officer and a programme officer. We started with a team of 8 staff but it became very apparent early on in the project that we could not reach Barbadians on a national scale with just two people in the field, we have a school drug liaison officer. We are in the throes of Drug Awareness Month and Brian is at Barbados Youth Service, who is a centre for delinquent youth or potential dropouts, kids who are not doing well, and our liaison officer is going to a school today.

We have a project document that was signed by the Government of Barbados and the United Nations Drug Control Programme, the focus of which is integrating demand reduction and this is a method that they use throughout the region and most of their projects. The UNSCP also funding projects in other countries, which are more on the supply side, i.e. law enforcement officers, etc. Ours is really about public education, building self-esteem and positive values, providing skill-training programmes to specific communities. This project was actually conceived under the former administration (the Democratic Labour Party) and it took a long time before things really came together and the Act of Parliament was passed. Apparently these six communities had submitted proposals to the Government and they decided to start with these six since there was alleged high drug usage and a lot of other attendant social problems. This project falls into 4 different components - co-ordination and research, co-ordination is really putting this national drug resource centre together, i.e. staffing, equipment etc. The Government decided to fund these activities and the UN also added some funding and that is how it works. I am unsure as to what will happen re funding after June 1998, which is the end of the three year cycle, I hope they will continue to fund it but my understanding is that the Government is committed to it. We have a serious problem here and I hope things continue to grow and expand.

We are currently engaged in a Rapid Assessment Study of the drug phenomena in those six communities and that will be finished in April of this year. This should have been done at the outset so at least we knew what the problems were.

The next component would be school demand reduction. This is basically going into the primary and secondary schools to deliver an educational presentation. We work with the administration to develop curriculum, manuals, and whatever it takes to deal with kids. I think that this is really has to be our main focus because we have lost a lot of generations and I think that if we can impress upon teaching staff, parents and children at a very young age that they must stay away from drugs and discuss all other issues not 'just say no to drugs' but to have parents understand things like why it is important to have your child to build self-esteem to communicate and all those other issues which are hard things to work on, and our liaison teacher with working together with the 85 primary schools and we have 23 secondary schools. We have made some inroads but there is still a lot of work to be done in terms of training the teaching staff. This month we would have reached about 40 primary schools.

The next component would be the community. Community based projects where training programmes have been established and proposals come from the communities themselves. The projects are very difficult to manage because you could remove all of the substance abuse part of it and you are basically dealing with community building and development and getting people to interface with the organisation.

Deacons' Farm was formally a primary school and one of the biggest projects and the Government gave a lot of support to it. There are several skills training programmes in their community - we did not impose anything on them - this is what they wanted. The problem is getting them to understand that are responsible for the equipment, that they are accountable to us and that the project belongs to the community. One of the things that have not happened is that these communities do not have strong bodies/councils to guide them. In some cases you may have one person who may be well intentioned and cares for his community but maybe he may not be consulting with a board or with his council members - we are trying to rectify this now. However, the objective is that you will provide skills training programmes for young adults so that they may be employable, have skills that may help them start their own businesses. They vary from project to project, one is very sport oriented, At Deacons Farm they have a large computer room, a carpentry workshop, culinary arts, teaching foreign languages - it is quite an ambitious project. Five of these projects have been implemented and the sixth is about to get off the ground.

The last component is treatment. We have done no work in this area at all and it is a big gap in the services in Barbados. We have the psychiatric hospital, and also a drug rehab unit called Tamarind House. There is a tremendous stigma attached to going to Tamarind House and it is referred to

by many names - they're hoping to relocate Tamarind House to somewhere more pastoral and serene and not within the confines of a mental health institution. Team Challenge was opened in June last year and they are mainly focusing on men. They are being funded privately by an organisation called the Substance Abuse Organisation. I think the religious based nature of the centre is another thing they have to think seriously about because as much as we have a church for every rum shops the religious thrust is not going to work for everybody. But I think they are getting through to some people; and of course some people would feel more comfortable going there than the drug rehab unit. They also do not, even though they want clients to pay for the services, insist on payment so they look for support from the community. There plans to set up a facility for women and they are located at St Johns. There are of course private doctors that people who can afford it go to, and of course the same confidentiality issue comes up again in this very small society where people talk. And there are people who go abroad for treatment, some go to other island but most tend to go to Miami treatment centres.

We offer very limited counselling here, as we do not have the facility to and we do not get into any long term counselling as such. We get calls every so often from parents, Mothers in particular who are at their wits ends. Not knowing what to do about their sons, who may be aggressive, stealing and you hear stories from people in here who come here and do research because they have a special interest in it though I would very much like to see it happen here.

The four educators are mostly in the field working in schools and working with the projects. We have been well received so far, though there is a lot more work to be done in terms of doing PR and as much as I am wary of the media we need the media but they also need a lot of education. For example our media people here all to often refer to AIDS patients as victims. We have done some work with CBC television, also taken part in discussions but this has to be maintained.

Our board is government appointed - there are 13 members and I would say more than half are appointed by the Attorney General, and also members of the community have appointed half. There is a board meeting every month with a progress of the project. We also have a Substance Abuse Network, which includes members' form the Police. We hope to have someone from the Prison service, there are NGOs who have small amounts of funding. There is a group called PRIDE (Parents Resources Introducing Drug Education), we have a National Committee for the Prevention of Alcohol Drug Dependency. They are small organisation but they are looking at us as leaders because we are the National Drug Commission. We are the only one with some structure, but also in attending that meeting we have people from the Probation and Welfare Services, Children Care Board. PARADOX which does a lot of peer education because these groups and agencies are also dealing with this issue and so collaborate and share information and find out what is happening.

Generally I would say that there is still a lot of fragmentation. Because at the

community level now you have people called youth commissioners and you have community development officers and these are people who should be in the field day in and day out but I really do not have a good sense of them really taking on this issue seriously. They are also dealing with other issues, there is a poverty alleviation programme, but they will be dealing with other issues that confront families not just drugs, but still I wished we had collaborated and co-ordinated on what we were doing much better.

The next thing would be to look nationally at the whole drug vibe and the whole effort - there is not much linkage between the supply and demand side. One of the recommendations of this Rapid Assessment Study is that the two parties come together and information-share - the Board does not seem to want to bring the two parties together. I think that they need to come together but regionally now, Barbados is going to be one of the serious players for the war on drugs, a lot of things will come together by the year 2000. There is a lot of collaboration with the United Nations agencies - they have set up offices in this region and have funded and supported a lot of efforts. You also have the European Commission and in fact they will be giving a lot of assistance in the area of treatment and rehabilitation. They have consultants here looking at the treatment and rehabilitation needs on a couple of other islands and are looking to put funding in those as well. Funding will always be a touchy issue - our funding has been cut and a lot of juggling goes on and we try our best but what we are doing is taking the message out to schools and communities. We get calls from parent/teacher associations, community groups etc. Small groups who are concerned about what is happening in their community and they want people to be knowledgeable so we do a lot of that but getting the community projects to be strong is where there is a serious weakness. What I like to get some structure in place that they become legal entities, have bank accounts because we have to let go at a certain point we cannot continue to carry them.

### **Will you be doing any outreach work?**

We have talked about it, certain members of staff have real concerns, re security issues, a lot would depend on the Neighbourhood of what is going on in the community. A little has been done - One has to be very careful it's not something we are going to do at present - its something that may not work here - we are still a very personal culture - people do not share willingly here and its not an easy thing they do.

13. **DEACONS FARM**

I deal with children aged between 4-20 years old. There is a group aged between 15 and 17 terrorising the area. They deal drugs, they also have access to sophisticated weapons, I mean 9mm etc., - guns seem to come into the country undetected; people who sell drugs have the money to do anything. What I do is about getting these young people into an organised structure and the whole concept that I have is that we will develop with modern technology, find things to occupy their minds. They go to school between 9am-3pm, and we have a homework centre. We are trying to organise, with a little difficulty a steel band to teach music, the problem is that it takes about B\$30,000 to get a compliment. The powers that be do not see it necessary to buy steel pans, - I mean if steel bands are indigenous to the Caribbean then that they should be the instrument that should be used to teach music with – why not use the rhythms that people associate with. I have now got accreditation so that they can do exams. The whole thrust of the programme is to divert the attention of the young people from what they see others doing and teach them something wholesome and that there are other avenues rather than what they see. They have this now that if you go to prison there is a sense of pride that you are a hero, you have violated the authorities. The youth are very anti-police and in order to change that you have to start at a very early age. There are some age groups that you may never reach. But I believe there is such a thing called a ‘comeback’ trail, like someone who has had an injury and has been out of action and is ready to return – so what I am saying is that the same sort of concept should work here. We have a prison system, but we do not have the avenue where we can re-educate them and help bring them back into the society –you come out as a prisoner - so the only things these men have is what they know, selling drugs, violence etc., keeping their prison image. It is hard, because you are now seeing an upsurge in the teenage pregnancy rate - the morality of the country as a whole has dropped. It has taken a lot to build the centre to what it is now but there’s a long way to go. I get satisfaction is that you talk about poverty and so on and I read a report in which it suggests that people from a particular background plays soccer. This particular area is sports oriented community and when they see sports stars doing drugs they try to emulate them. But on the positive side why not encourage them to have sport as a career but with an education behind it. If there is a problem within the community you are going to need money y in order to change it for the better. I do not get paid – I volunteer my time – my payment is that when I am old that I can walk the streets safely.

#### 14. TEEN CHALLENGE

Teen Challenge is 40 years old and one of the oldest and largest programmes of its type. We have over 300 facilities worldwide; there are 3 in England. Our treatment processes are exclusively Christian in nature and definitely they are surrounded by religious implications from beginning to the end. One of the things we have found out about Teen Challenges is that we know worldwide the climbing scale over the years that the recovery rate for hard core drug addicts is very small. One thing found in a study of addicts that had graduated from the Teen Challenge programme and discovered that 6 years after leaving the programme that 83% of them were still clean. What we do here works very well.

There are two elements to our programme. One is discipline this is a very highly structured and disciplined programme. We demand the best of each student, appropriate behaviour is demanded at every single level and the second part is the religious training that we give at different level. We also have a 12-step programme called 'Living free' the principles of which are the same as NA and AA though the wording to the steps is slightly different. We here at Teen Challenge in Barbados believe that these principals were God inspired and they work in the different kinds of programmes used around the world for people and we are in not in opposition to AA. For many people these are life-changing things so we obviously support those principles.

We are hoping to set up facilities in other Caribbean islands including Cuba.

Are there specific services you provide for crack cocaine users?

The first thing that we have found out about addiction is that it is not a singular disease in that one person is affected; the disease affects every person's life that the addict touches. Obviously if the addict is married, the wife is affected, if they are children if they are still at home, the parents are affected. So one of the things we try and do is that we try to involve the whole family at different levels, we counsel with family members. During the last 90 days of the programme we bring the whole family into the picture and draw up an after care plan and we make the family a part of all of that. We not only talk to the student that is here seeking help but we also talk to family members and ask for their input. What do they think their son/father/husband needs, what do we need to tell him, what does he need to do. No one knows better than the client of the process that needs to happen. This is because they lived the past with them and one of the critical things which is advantageous is that they are absolutely honest so they have nothing to lose and everything to gain- we will listen to them and we will hear what their concerns are.

When we write the plan with the student we will write it with all those full implications and concerns, so we actually follow the student for a full 2 years.

### How do they come to you?

Some are referred through the court system, some are referred from the probation service sometimes from other counselling services available in Barbados and also churches, family members and other people in the community refer them.

### How is it funded?

Teen Challenge is one of the few private organisations. Chemically dependency treatment is an extremely expensive process. In the US if you go into hospital or medical unit of any kind that has to do with chemical dependency and treatment can cost up to US\$1,000 per day, so we anticipate our costs of running this facility to be B\$1,600 per person per month.. The price difference reflects that we do not have any medical personnel here that would require very large salaries. The people that are here, that are leaders, are pastoral and they come here because of what they believe. So these people do work for very little money and this is a sort of life commitment for them, so we provide what we can, accommodation etc. in kind.

### What agencies do you collaborate with?

We work together with all other alcohol and drug agencies, we sometimes do not agree with all the treatment processes that are used out there. The courts know about and respond well to us - they find Teen Challenge friendly to them because often we would take people that have not received help from any other source. They have to behave at every level, we challenge their behaviour at every level and so doing we deal with a whole person not just the drug addict and try to heal the whole person. Some of them are sent here as part of their court conditions.

We have certain rules about admission to the challenge - we do not allow you to come in and out of the programme, after the second time you are not re-admitted to the programme.

### **Do you have a typical profile for a crack cocaine user here?**

Crack cocaine breaks all the rules. It is like no other drug that I have ever seen. Even heroin users can have some sort of normal life, hold down jobs live in the community etc. and can carry on like this for years. But with crack cocaine if you start smoking it today say in three days time every thing that you may own would be gone. It is highly addictive and according to research in the US where crack addiction is endemic you could be dead in 3 years. We know that it kills at a very high rate with the related violence with crack addiction it makes them highly volatile.

We have to educate children, as young as we can, about drugs and drug addiction. Our programmes must help to strengthen families. One of the things that Teen Challenge believes is that if families are healthy we see lower

at risk children, lower addiction rates. One of the things we have discovered here in Barbados is that 73% of all children born here are illegitimate - without fathers. Obviously that is a recipe for disaster and fathers are important to lead their children and especially their sons as role models but 73% of the fathers in Barbados are not there. One of the sad things here is that most of the fathers are not in a financial position to support their children. Crack cocaine addiction seems to predominately affect the young males in Barbados.

**Is this a male only facility?**

Yes. We have two programmes in this facility - adult men and adolescent boys.

**Do you provide similar facilities for the women here?**

We will be doing that in the future - the only reason why we have not done this so far is because of financial constraints.

One of our greatest problem is community support because when they leave here they would have established strengths but you are dealing with a small society where you interact casually/formally with so many people and what they say to you can either be an eroding factor or strengthening factor. So our support system has to be so well structured in terms of re-establishing the males in the community so you are looking at a holistic way of countering the addiction.

I think that world-wide there are many people today with the advent of crack cocaine who feel that all of these problems that we are dealing with today are insurmountable. That we have gone to far there is no way out and people on many levels, and every race and economic group is affected. People feel hopeless, and we believe that this is a moral issue. That people need a relationship with God. And in that relationship we find that when you have healthy families and healthy spiritual lives, the host of all these problems that we see in the world today they are not predominately evident in those groups. In the last few years I have seen a change in our societies across the world, and I do not believe that we will ever solve this problem until we deal with some of our social issues.

We have sat down with the Government here in Barbados who seem to have adopted a 'not interested' attitude as if they do not want to admit there is a drug issue here and that is also a major part of the problem - the Government seem reluctant to do anything. The problem of crack cocaine in this country has grown rapidly over the years. This drug is highly addictive, which in turn creates more violence and with that more people go to prison, it is a problem that is not going to go away, and no matter how big the Police presence is, they are still going to get the drug through. I feel it is important to educate people in Government and high office, the teachers in schools, leaders etc. about drugs and the misery it can cause not only the children and what we all can do to help combat this. I do not think that there is a programme currently in place

for this. We go into schools to speak to the children and educate them and also some of the children currently on the Teen Challenge programme go into the schools and speak about their experience. We also give talks, hold street rallies go to churches talking about what Teen Challenge does and hopefully by hearing about what we do it might plant a seed in the minds of others who could then go on and create something similar in their community.

One of the things I proposed to the Bajan government when I first came here that I thought would be necessary was a lock up detoxification unit. In the US there is a law called the Baker Act which enables you to admit someone into a secure unit for their own safety without their permission. There is also a law here in Barbados where if a person is examined by two psychiatrists, you can take them off the street and have them locked up without their consent. We did have a situation where we had someone who was so ill that he had to be admitted in this way because if he wasn't he would have died. Although I do not support this type of action, but with a drug such as crack cocaine the rules are different. It takes away all your inhibitions, all the rules of life, and the values that we think are important in a single smoke. All these things are given up it is now but there's a long way to go.

**15. THE LINCOLN MEMORIAL CLINIC, SOUTH BRONX NEW YORK N Y**

The Lincoln Clinic, Bronx, New York, started out as a Methadone program, who then, were treating alcoholics, opiate, PCP and a wide range of other drug misuses. Crack cocaine came into the picture in the mid eighties. This in part was by pure coincidence really, as the program did not have a profile of “the crack cocaine client”. Crack arrived and Lincoln was already treating the same people. Now what was found was that the methods they were using already turned out to be quite a good method, in dealing with crack cocaine. Most of the clients, who attend Lincoln now, are crack cocaine users. Members of the staff at Lincoln informed us that research was important. Lincoln staff continued that while, significant pieces may be planned for the future, the program was based on a client-centered approach. However, what is abundantly clear, from the statistics at Lincoln, is that women and children who get into drug problems are overwhelming using crack cocaine, “that is over 50% of our population” stated a senior staff member at Lincoln. She continued “if anything women use crack more than men”.

Lincoln’s first approach is that first of all they accept everybody that comes in. They do this because they have a high retention rate and a fairly high success rate therefore there is no reason to screen people as unsuitable. Since the Lincoln clinic considers itself at the bottom of the economic barrel, due mainly for the client make up and the area in which it is situated, “Bronx, New York”, there is nowhere else to refer people.

The outpatient program consists of people who come in the first day and are treated with a program of acupuncture, a counselling assessment session and have the necessary paperwork completed. The idea is to encourage the client to come back each day. The truth is, they choose to come back on their own. The aim of the service delivery is about, trying to get away from what clients should do and ought to do. Lincoln states clearly that its method of treating clients is flexible and tolerant and moreover gives people choices, “Acupuncture will help you even if you are in denial”. “If you are in an all herbal program, you have to encourage the client to admit that they need help and acupuncture helps until they get strong enough to admit that they are weak and that is exactly what you have to do. You are not ruining the counselling relationship”.

Andy and I asked about the fear of needles. “Addicts are frightened all the time, they have pain all the time, they are fearful of new things of new people, new situations not needles. “You can get them to take acupuncture easier than you can get them to say hello”.

The program at Lincoln has several components; it started with the acupuncture component in the beginning. There is a facility for individual counselling in the early stages, though some clients do not want to talk during the first few days. “It takes time for our clients to trust people”. Urine samples are taken every day, to assess the activity of the clients patterns of drug use, which are done fairly cheaply through the hospital. As well as crack

cocaine services Lincoln also holds Narcotics Anonymous meetings, with 12 step programs. Lincoln provides support by running specific groups where the clients can have a choice, with a reward at the end. "One great advantage of crack cocaine is that one bad day doesn't lead to two weeks", crack has a much shorter time span, and from my personal knowledge users need to do things pretty quick, they don't want steady lifestyle, they need a steady one but they don't like it. So Lincoln's idea is mainly about reaching people right away.

Carlos Alvarez a senior trainer at the Acupuncture Training Institute in connection with the Lincoln Recovery Center, states "we have been in existence since November 1970. In those days there was a heroin epidemic and there was a need for a program to service the thousands of addicts, that were in the Bronx. Due to the heavy demand the out patient program was born. Nancy Smalls, director of maternal substance abuse services for Lincoln, points out that as well as Lincoln pioneering acupuncture, it was the very first to set up an out patient drug facility totally for women, pre natal substance abuse drug program and a peer counselling program.

In 1970 a neighborhood, Hispanic gang called the "Young Lords" started this program. They went to Lincoln Heights Auditorium and took it over they decided that the community wasn't paying attention to the drug abuse needs in the community, consequently they were going to fix it. As bad as they were, they took over; nobody was going to stop them.

The next year the Young Lords gained support from the Black Panthers the two co-existed very nicely. You would never expect a Hispanic gang and a Black gang to be that congenial but they were such was the problem of crack cocaine. They both stayed on their own turf. Angela Davis, the famous Black activist of the 1960s was on the loose at this time, Nancy remembers, frequently getting arrested, because of their similarities. "I used to wear an Afro and the only thing that saved me was that I didn't have a gap in the front of my teeth". It was a revolutionary program, but sometimes revolutionary's have to put up a resistance and suffer pain, in order to challenge the systems which perpetuate classes of have's and have nots. In short Lincoln started because the people wanted it.

Nancy recalls starting at Lincoln in 1973. "We were a Methadone Detoxification program. We would detox people with 5ml of Methadone every three days. We did it for years, so when folks tell me that they can't do it I don't believe them, 'cos. its a crock (a lie). "You can detox a person with 5mls of Methadone every three days, as long as you don't tell them, because if you tell them you have a problem". "They're throwing up at the end of the table, they fall down, they say this hurts, that hurts, the other hurts so we would take them down to 0 for a week. Then we tell them, your finish time is up, time to go, they could not believe it but in those days we had the old heroin population. I'm talking about the guy's aged 35-40, there were very few women. We were lucky if we had 3 women a week on the program because, in those days women did not do drugs". "I have never known a drug addict to have a 'dirty' woman because whatever little bit you have you got to share, and

men don't share drugs well, so most of the men that I knew had a clean woman”.

“In having these older men they decided that they needed a drug free application because being high every day trying to govern a house and run a community and being an upstanding person, it wasn't working well. As you were aware of Dr Woo bringing his black Box on board. Black box didn't work for our clients because we pinned them up to the Black box and switched it on and nothing happened. Once we took them off the Black box and just pinned them ordinarily everything went rather well. It was impressive to me because we were not using disposable needles we were cleaning them and using them again, and as far as long as I have been here no client has contracted a disease from another client in the program”.

“In the latter part of 1983 in rode Mayor Koch and locked the whole shit down. He put a bicycle chain around the area where we were and they were instructed to arrest us if we were caught on site. I suppose no one told him that it is against the law to cut off people's medication in mid stream, but he didn't care. See we sited ourselves over in this building this was the after care building and we rented this building from the city for \$1.00 a year. So we set up shop. We could not bring the Methadone to this building because it couldn't be appropriately monitored. They would have to deliver it in armored cars bring it before dispensing. And then they would take it back after they told us that there were too many entrances and exits to really keep a lid on it, so they wouldn't bring it over here this meant that with all the Methadone clients that we had with no medication, we had to go full force with acupuncture”.

“Being a nurse by trade it was a case of what's going to happen here? That's when I really began to notice the change in people taking acupuncture. You notice a change in a person within 3 days - they are cleaner look better, can look you in the eye, give up corrective criticism and paid attention to what you were talking about, fine acupuncture example. We had to go full force with acupuncture because we didn't have anything else. Our clients were doing exceptionally well especially after three days”.

In 1980 crack cocaine came into mode. According to the powers that be it jumped up in 1985 which is not true, argues Smalls, it came in 1980 and people were 'free basing' it, to get pure cocaine. Anyone has been to Lincoln will tell you they have a full clinic daily, clients are waiting at the door for the acupuncture shop to open. After a short period Lincoln was attracting women. This large influx where arriving from other programs, not accepting women because nobody could address their needs, for example baby milk, pampers, Kotex, clothes, any of those things. Smalls remembers treating 15 clients in one day before 1 o'clock. Mike O Smith, then suggested a women's group should take place. A working protocol was set up which catered specifically for the needs of the women in question. The women's project has moved forward leaps and bounds since it began in January 1987. Twelve years on, 1998 Lincoln has treated over 8,500 women. 80% of them who lost their

children have now, got them back. What has been developed is a program that is convenient, attractive, and workable to set timeframes around the service users. There is also care fare, and babysitting. Lincoln found that they could not have an all day program for women because of their time constraints. Care fare; is the name given to a part of the program that provides extra monetary support to users with dependant children. The greatest area of need was, babysitting service Lincoln has provided this for years piece to some magnitude. They started with a holding pen, which consequently gave the women the opportunity to attend the program.

A six-week program was developed initially, which consisted of, a mandatory 10 attendance of 10 days, which is still in existence. The conditions included the completion of 7 clean urine samples.

Lincoln has a two-day, mandatory attendance program, running three times a week. If clean urines are delivered they keep the courts happy and the move through the program. Also a part of the Lincoln, building is Narcotics Anonymous (NA), meetings are held everyday, with a couple on days where there cater specifically for Spanish speaking clients. Lincoln was the first to develop a totally woman orientated NA meeting, which runs on Thursday mornings simply because men and women didn't tend to mix in this setting. The dynamics, didn't allow sufficient focus to take place and the message be heard. It was felt that until drug using women had gained enough self esteem to talk in front of a mixed group, it perhaps would set them up to fail. Part of the Lincoln mission is, to keep families together, one parent, and two parents the same parent etc. 90% of women who attend Lincoln have told members of staff, it was their partner who got them on drugs. Lincoln also has a men's group which has the same protocol as the women's except, that it has become a rolling program it never stops. " This is the only group that we do not cut off in mid stream" states a male sessional facilitator.

For pregnant women the Lincoln protocol is three needles instead of five, there is a midwife who attends three times a week and caters for the needs of the pregnant women. Examinations take place for STDs and general checks; it's like a one-stop shop everything is done right there. The kids in the South Bronx seem to be doing very well, Lincoln has found that early intervention is the best thing. Mothers on the program tend to spend up to an hour in the room, here it is possible to map how they interact with their children.

It was discovered that half of Lincoln's clients were either in a shelter or a hotel, this meant that the provision for hot lunches was provided so the staff at Lincoln could make sure that the mother and child were nourished. The programs counselling classes run for twelve weeks, at the end clients receive certification that they have completed, stress reduction, crisis counselling.

In the same vein Lincoln have a parenting skills program, which last for ten weeks, which is certified. The programs focus outlines that; everyone who has children may not always be able to take care of them. The program has no waiting list, Lincoln boasts that they have excellent counsellors, clients get a

lot of TLC, they are concerned about what happens to their clients and I think this allows the paperwork to build up as it tends to follow behind the client. Women in the South Bronx don't think drug abuse is a problem, its not having food, having nowhere to stay, and definitely having no man, that's the problem for women states Smalls of Lincoln's women's group.

Small's points out that there was a 32-year-old female client, well dressed who had a money problem so consequently, resorted to the oldest profession. Smalls discovered, that one of the clients was the women's father, and that she had been sleeping with him since the age of 4 years, and had a child for him at 13. Unfortunately, her mother knew of this and had done nothing. Smalls's main concern was for not the fact that she was a drug addict, but the physiological harm which had taken place. Smalls immediately furnished the facts to ACS to request that this client was removed from this situation and re-housed elsewhere. ACS commented, they could do nothing citing that, because she lived with her parents in privately owned accommodation in the Bronx, there was not need to move her. Later I was also told that her brother also came to her asking if she wanted to make extra money.

Lincoln's 1:1 counselling program continues to be a vital tool in addressing the area of need of vulnerable clients and successful in its efforts which facilitate the processes of self respect and self esteem to be born again in the hearts and minds of Crack Cocaine users.

## 16. LESSONS LEARNT

*One of the key issues facing the crack team in its ability to develop an outreach service for crack cocaine users will be in involving the communities that they will be working in, in the planning and delivery of the service.*

There are many reasons for this. Firstly, many people may be very suspicious of the motives of this team and its host organisation in attempting to work with crack users and others affected by its use. They may quite rightly feel what right do these people have in coming to our locality, visiting pubs and other public places? This will be made worse if these workers are perceived as mental health professionals or agents of the criminal justice system. These kinds of fears if not addressed could make it very difficult for the team to operate and in fact could make it extremely risky.

We asked these questions of organisations such as AADAP who operate drug rehab services in areas such as Crenshaw in Los Angeles. An area noted for its drug and gang related violence. They stated that the reason that their units had not been burnt to the ground was that the community felt that they were on their side, that the service was for them, that it did not patronize them. In fact many of the AADAP workers were from the local community or they had a high awareness of the needs of the community from their own experiences. These people were not psychiatrists or social workers, they were people who had been born and raised in the ghettos and had often overcome an addiction problem themselves.

We were extremely impressed with the informal relaxed atmosphere in the projects, the activities that were being offered from holistic therapies to social skills groups.

These places did not feel threatening even though a good number were attending as part of a court related programme.

The services we visited were not dominated by a particular model either medical or otherwise but tried to offer services which catered for the person as a whole, that recognized that drug problems affected the souls as well as the mind and body.

Many of the groups, which were running, were service user lead using a 12-step model in the provision of relapse prevention.

Unlike many of the services in the UK the clientele were mixed culturally with the services being culturally appropriate to a diverse range of people ranging from white European, to Black American, to Hispanic or Asian. The workers in the projects also reflected this diversity in both race and gender.

Of course there were problems, resources were tight, just like in this country these services are being asked to deal with overwhelming demand with very

limited resources. The moves in the criminal justice system to make treatment a mandatory part of a court sentence was also flagged as an issue in that it could end up draining cash and resources away from the voluntary sector with it being redistributed to the statutory court based programs. This apart from leading to the closure of community services such as AADAP could also make it virtually impossible for clients to access services voluntarily.

Unlike Birmingham, there was a far wider range of community based rehabilitation services. Many of these projects focussed on getting the client back into employment, which involved the building up, and maintenance of partnerships with the private and statutory sectors. In Birmingham the only option at present for rehabilitation is residential which although appropriate for some is not always possible for others. Getting people back into work or training can have an extremely beneficial effect on a person's self-esteem and social position. Leading to the building of new social networks, better accommodation and positive use of leisure time. We were very impressed that there were organisations such as Chrysalis in Santa Monica, to help people back in to work and society.

## 17. **Recommendations**

The crack team is in a very good position to learn from the successes and the mistakes of not only projects in this country but also of the services we visited in the USA.

Many of the drug services in Birmingham and the UK have grown around the culture of the National Health Service, usually being part of a Mental Health Service. This has led in a lot of cases to services being heavily influenced by the medical profession, with an emphasis on drugs not therapy. These services have traditionally taken a Eurocentric model based upon individual focussed treatment in the form of consultations and counselling. In the projects that we visited in the USA there was a greater emphasis on group work, either for treatment or for rehabilitation. Many of these groups were led by recovering drug users who were either staff or ex clients. The message in a lot of cases was self help rather than being treated by a professional. People knew that unless they won the lottery it was unlikely that they were moving neighborhoods. So that this meant that they had to try and take control of their own lives with access to high level, in some cases daily support. The 12-step model was ideal for this in that it is user lead, not expensive and can provide a high level of support.

We recommend that groups providing treatment, education and rehabilitative support should be set up in all of the service environments as well as being encouraged through the self-help model.

The move away from traditional European medical models of treatment, usually involving the prescribing of strong narcotics or potentially toxic anxiolitics, antidepressants and neuroleptics, towards interventions such as acupuncture, aromatherapy, hypnotism and other holistic therapies, gave clients not only an alternative but also showed the commitment to providing services which drew on the cultures of Asia. These alternative therapies also allowed for a spiritual dimension accepting that people needed to find an inner peace within themselves if they were to escape from the self-destructive cycle of addiction. There is much evidence in the USA as to the effectiveness of these treatments but it would be useful to carry out similar research in to their use in Birmingham.

The crack team has already started to implement its strategy of liaison with the communities it is intending to work with. It is the greater challenge that organisations such as the Drug Reference Group, the Drug Action team the Treatment services both statutory and non statutory need to also start identifying and evaluating the ways in which we relate to the local communities.

We were extremely impressed, if not a little shocked, with the workings of the relatively new drug court system. We were impressed that the most powerful nation on earth has accepted that it can not win the drugs war but that it can make a significant difference through the implementation of treatment

services. The drug courts were undoubtedly a very cost effective way of diverting people away from the custodial criminal justice system towards either community or residential treatment and rehab services. There is also no doubt that this country is also now committed to implementing similar programs in the UK. What one of the challenges will be is that similar experiences of the services in the USA are not felt here in that most of the money and resources are funneled in to mandatory treatment programs. One of the comments of the pilot project in Portsmouth was that if you wished treatment for a drug problem, go out and commit a crime because it's the only way you are going to get it.

Lastly but not least, we must develop rehabilitation services for drug users. Too many of our clients end up in the revolving door syndrome because there is not the support available locally to help prevent them relapsing. It seems that the only option that a person has at the moment is to enter a residential service. This may be of great help to some but in a lot of cases it is not appropriate and may in fact set the client up to fail.

The American experience showed us that if you can provide community based rehab projects offering roads back into employment and training which are specifically aimed at drug users can be extremely effective in enabling people to remain drug free.

Maybe the increase in funding for community care announced recently by the government as well as, the S.R.B project in Handsworth, announced recently by the government will enable this to change.

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