Expenditure Review of the Local Drugs Task Forces

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Summary

Goodbody Economic Consultants were appointed by the Department of Community, Rural and Gaeltacht Affairs to carry out an expenditure review of the Local Drugs Task Forces (LDTFs). The purpose of the review was to:

- Establish the outputs, effectiveness and efficiency of the LDTF Programme;
- Make recommendations to improve effectiveness and efficiency; and
- Define performance indicators and baselines in order to measure the work of the LDTFs in the future.

Funding totalling €120 million has been allocated to support measures under the Local Drugs Task Force Programme in the period from late 1997 to end 2005. The total minimum annual funding requirement going forward is predicted to be of the order of €28.5m annually at 2003 prices, if all Round 1 and Round 2 Task Force measures currently in place were to be processed for mainstreaming.

Given the scale of funding, it is essential that financial reporting arrangements continue to be strengthened through regular reporting of expenditure by projects and the furnishing of audited annual project accounts.

It is considered that the LDTF Programme has been very effective for a number of reasons:

- A large number of measures have been implemented to address the drug problem at the local level;
- This has resulted in many new community projects and new activities being put in place;
- The measures adopted have been highly relevant to the objectives set for the National Drug Strategy;
- The measures have largely focused on activities such as education and prevention and, particularly, treatment and rehabilitation that have been shown to be effective abroad;
- The fact that LDTF funding has delivered new projects and activities with regard to treatment and rehabilitation is especially noteworthy, as international research indicates that the costs to society of drug abuse are very high, and that there are immediate and substantial savings to the economy when drug users enter treatment regimes;
- There is clear evidence of higher levels of trust emerging between local communities and the statutory agencies concerned with drug abuse. As the LDTF Programme is a major vehicle for contacts between the community and the statutory agencies, it is likely to have been instrumental in effecting this change.
- The numbers of persons in LDTF areas in receipt of methadone and other treatments rose rapidly in the years immediately after the establishment of the LDTF Programme. A higher proportion of drug users is now being treated locally.

- More recently, the number of new cases attending treatment in LDTF areas has been declining.

- The focus of the LDTF Programme is on the Dublin area, and drug related deaths, drug related HIV infections, and discharges from hospitals of patients with drug related illnesses have all reduced significantly in the Dublin area in the post 2000 period.

- The costs to society arising from drug abuse are very high and the benefits of treatment correspondingly large. As a result, drug intervention programmes with strong treatment and rehabilitation elements such as the LDTF, have high cost benefit ratios.

However, there are a number of areas where the efficiency and effectiveness of the Programme could be enhanced. . These include the following:

- Establishment of clearer reporting relationships and related monitoring systems between projects, funders and Task Forces;

- Development of standard monitoring templates to be used by projects to monitor progress against agreed plans;

- Allocation of the required level of annual funding to meet the core costs of mainstream projects and a review of related programming costs;

- Provision of greater resources at Task Force level so as to improve supports to projects, to draw greater learning from the projects, and to undertake more detailed evaluation of the drug problems in their local area. Access to resources to encourage greater cross Task Force and cross project networking and learning, including provision for cross task force projects (e.g. outreach services) and interaction with wider drug-related initiatives;

- Development of stronger evaluation processes in relation to future mainstreaming decisions, backed up by good monitoring data on process/outputs including performance indicators, and by mechanisms aimed at ensuring that weaknesses identified in the review process are addressed.

- Carrying out of long-term follow up surveys of clients to better establish project outcomes and factors that influence successful outcomes

- Access to resources to research and analysis at NDST level to derive high-level policy analysis, conclusions and directions from the LDTF process.

- Development of clear lines of responsibility for monitoring and evaluating the projects in receipt of mainstream funding and putting in place a system of quantitative performance indicators.

A system of twenty-four performance indicators is now proposed. These are appropriate for measuring performance in relation to projects, LDTF processes, the LDTFs individually, and the LDTF Programme as a whole. As well as monitoring progress, these will form a valuable input into the evaluation of projects, LDTFs and the Programme as a whole.

The Department of Community, Rural and Gaeltacht Affairs, in co-operation with other relevant Departments, is implementing measures to improve focus and cohesion across community and local development initiatives. In this context, the cohesion process provides real opportunities for LDTFs to share learning, access enhanced administrative supports and to improve service delivery for their target groups at the local level. Some €7m is provided to support cohesion actions over 2005 and 2006.

While it is clear that considerable success has been achieved in addressing the drug problem in the Dublin area, much remains to be achieved. The LDTF Programme continues to be relevant to combating the drug problem. However, realistic targets for the Programme should be set going forward.

1. Introduction

1.1 Terms of Reference

Goodbody Economic Consultants were appointed by the Department of Community, Rural and Gaeltacht Affairs to carry out an expenditure review of the Local Drugs Task Forces (LDTFs). The terms of reference required the consultants to:

- Examine the objectives of the LDTFs and the extent to which they have been achieved;

- Measure the outputs, and as far as possible, the outcomes of the LDTF process and projects;

- Assess the overall effectiveness of the expenditure with particular reference to:
  - the numbers of drug users, families and others in the community assisted;
  - the quality of that assistance;
  - the level and nature of services provided;
  - whether those services meet the defined needs of the LDTF areas;
  - whether the measures accord with the aims, objectives and targets of the National Drugs Strategy 2001-2008;
  - the extent to which the community, voluntary and statutory sectors have become involved in the process;
  - the preventative achievements of the process; and,
  - the impact on the communities as a whole.

- Define performance indicators and baselines in order to measure the work of the LDTFs in the future;

- Review the effectiveness of the mainstreaming process with particular reference to the cost implications; and

- Review the overall costs and staffing resources associated with the process and make recommendations in relation to improving the efficiency and effectiveness in the context of the resources allocated to the LDTF process.

1.2 Approach of the Consultants

From the outset it was evident that there were serious data deficiencies that would hinder the conduct of this expenditure review. In particular, a standardised system for measuring the output and impact of the projects had not been put in place, nor were there standardised profiles of the projects or measures that had been allocated funding. Expenditure data for the projects were lacking, although the financial allocations made to the projects at various stages were known. The absence of evaluative work relating to the costs and benefits to society at large of the measures undertaken was another issue that arose.

As a result of these deficiencies, the consultants undertook a number of specific pieces of work:

- Information on financial allocations was collated and analysed by purpose and task force area (reported in Section 3 of this report);

- A survey was carried out to profile the measures funded under the LDTF Programme (reported in Section 4);

- A survey of the international literature on the costs and benefits of drug countermeasures and the costs imposed on society by drug abuse was undertaken (Section 5);

- Statistics and indicators to illustrate impacts at Task Force area level were compiled (Section 6); and

- Case studies were undertaken of four of the LDTF areas to *inter alia* gain a better understanding of the impacts of the Programme on the quality of life, health and well-being of drug users and their families. The four areas chosen were Canal Communities, Clondalkin, Finglas-Cabra and North Inner city.

Goodbody Economic Consultants produced a final draft copy of their report in March 2005. Further discussions were held with the Department in mid to late 2006. The report was updated and a revised version of the report was produced in October 2006.

1.3 Organisation of the Report

The report is organised as follows. Section 2 sets out the background to the development of the LDTF Programme. Section 3 then analyses the data available on funding allocations to Task Force areas. The work carried out by the LDTFs is profiled in Section 4. Section 5 considers the international literature on the costs and benefits of drug interventions. The effectiveness of the LDTF programme is examined in Section 6 while Section 7 looks at the programme efficiency. Performance Indicators that should be applied going forward are developed in Section 8. Section 9 presents an overview of findings, addresses the continuing relevance of the LDTF Programme, and makes proposals for change.

2. Background

2.1 Introduction

This section of the report considers the background to the development of the LDTF Programme, how projects were selected for funding, the processes involved and the supports that are now in place.

In the late 1980s and early 1990s, a number of measures were taken to tackle the growing drug problem in Ireland, and in Dublin in particular. However, by 1996 the problem had continued to grow to such an extent that the Government established a Ministerial Task Force on Measures to Reduce the Demand for Drugs. The main objective of the Ministerial Task Force was to make recommendations for a range of initiatives that would address the areas of treatment, rehabilitation, education and prevention, and supply control. The first report of the Task Force made a number of key recommendations for the establishment of a Drugs Initiative to include:

- A Cabinet Committee on Drugs to give overall political leadership;
- A National Drugs Strategy Team (NDST) to ensure effective co-ordination between Government Departments and Agencies; and
- Local Drugs Task Forces to develop co-ordinated local responses to the drug problem.

These recommendations were accepted by Government and €12.7 million (IR£10 million) was allocated to support the Local Drugs Task Forces initiative. The principal behind the initiative was that LDTFs would bring together organisations and individuals from the statutory, community and voluntary sectors to develop an integrated locally based response to drug misuse in a number of designated areas.

Between October 1996 and May 1997, Local Drugs Task Forces were established in thirteen areas[1], twelve of which were in Dublin, the other one being in Cork City. Later, in 2000, a fourteenth Local Drugs Task Force was established in Bray.

The key objectives of the LDTFs were threefold:

- To develop an appropriate range of responses to drug misuse based on current and accurate information;
- To ensure the co-ordinated delivery of those responses; and
- To carry out this work in partnership with local communities.[2]

It was envisaged that the LDTFs would propose measures relating to the four pillars of drug intervention:

- Education and prevention;
- Treatment and rehabilitation;
- Supply Reduction; and

[1] The thirteen Task Force areas were: Ballyfermot, Ballymun, Blanchardstown, Canal Communities, Clondalkin, Cork, Dublin 12, Dublin NE, Dun Laoghaire/Rathdown, Finglas-Cabra, North Inner City, South Inner City and Tallaght.
[2] Review of the Local Drugs Task Forces: Report from the National Drugs Strategy Team. December 2002.

- Research and information.

2.2 Measures

To meet the objectives set out for them, the LDTFs drew up action plans. These were based on an informed analysis of the local drug situation within the area and widespread local consultation. The approach used was to identify key needs and related gaps in provision and to propose strategies for addressing these gaps. In practice, these strategies revolved around the four pillars identified above. Following this analysis, the LDTFs identified suitable measures for funding. Such measures were aimed at building on local community initiatives in the area.

The type of measures identified included support for:

- Local information, advice and support centres for drug users and their families;
- The establishment of local treatment and rehabilitation services;
- Special projects aimed at children/young people involved in drugs or at risk;
- Drugs training programmes for community groups, teachers, youth workers and other professionals; and
- Initiatives to allow local communities to work with the State Agencies in addressing the issues of supply in their areas.

These measures were to support existing community projects or to establish new projects. [3]

As already mentioned, €12.7 million had been allocated by Government to support this first round of measures proposed by the LDTFs. The original intention was that the funding would be used to develop the measures over the course of a year, at which point they would be independently evaluated for direct funding by government departments or statutory agencies, a process called mainstreaming.

This initial funding was channelled through government departments or agencies, so that the projects that were funded through the measures could develop working relationships with them from the start. It was anticipated that the establishment of such relationships so early on in the process would facilitate the whole mainstreaming process. The main departments and agencies included:

- Department of Education and Science;
- Department of Health and Children;
- Department of the Environment and Local Government;
- Department of Justice, Equality and Law Reform;
- Eastern Regional Health Authority;
- Health Boards; and
- FÁS

In the event, the majority of projects did not commence as soon as had been originally envisaged. In some cases, with the short lead-in time given, projects required further development. In other cases, projects met with opposition from the local communities, particularly where their work centred around local treatment and

[3] In this report, the term 'measure' is used to refer to the individual initiatives that were funded by the LDTFs; 'Projects' refer to the community bodies that received funding under these measures. In some cases, the implementation of the measures gave rise to new projects.

rehabilitation facilities for drug users. The Government subsequently approved an allocation of interim funding to support the measures to a point where they could be evaluated.

In 2000, the evaluation of measures for direct or mainstream funding commenced and mainstreaming occurred from 2001 onwards. Once mainstreamed, the responsibility for monitoring and evaluating the projects involved no longer lay with the LDTFs, but with the relevant departments or agencies through which funding was being channelled.

In the same year, LDTFs were requested to develop another set of plans, to identify a second round of measures for funding. These Round 2 measures were to build on the work already done, and were aimed at filling any remaining gaps in service provision. At this stage, another Task Force had also been established in Bray.

2.3 Processes

The Local Drug Task Forces typically operate as a committee, which is made up of representatives from statutory agencies[4], the voluntary sector, representatives of the local community and local public representatives. Task Forces usually meet on a monthly basis. The mix of people on the committee supports the co-ordination of services, while at the same time facilitating the participation of local community and voluntary organisations in the planning, design and delivery of such services.

Each Task Force has a chairperson, who works on a voluntary basis, and a co-ordinator. The co-ordinator is recruited and employed by the relevant Health Board. The Task Force co-ordinators help to prepare local action plans. They also act as an essential support to the projects and occasionally as an intermediary between them and the statutory agencies, often helping them with the preparation of their applications for funding.

Within the LDTFs, sub-committees or working groups are often established to address each of the four pillars of drug intervention. Some LDTFs have other standing working groups in addition to those mentioned above or establish ad –hoc working groups to deal with issues as they arise.

2.4 Supports

The National Drug Strategy Team (NDST) was initially established to ensure effective co-ordination between government departments and agencies, and to identify and consider policy issues for referral to the Inter-Departmental Group[5]. It also has responsibility for overseeing the establishment and operations of the Local Drugs Task Forces.

The level of resources allocated to the NDST, when it was first established, were sufficient for the employment one Executive Officer and one Administrative Assistant only. More recently, the NDST has been given additional resources to employ a Director, a Development Worker and a Finance/Research Officer. This enables the NDST to focus more on co-ordination and strategic development as well as giving much greater support to the LDTFs. The position of the Development Worker in particular was created to provide induction, training and ongoing support for LDTF

[4] Statutory agencies represented on Local Drugs Task Forces would include the Health Boards, the Gardaí, the Probation and Welfare Service, the relevant Local Authority, the Youth Service and FÁS.

[5] The Inter-Departmental Group was established following a recommendation made in the First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs, mentioned in Section 2.1 above. The primary role of the Inter-Departmental Group is to address policy issues and review progress.

members. The NDST meets on a regular basis with the Chairs and the Co-ordinators of the LDTFs to review progress and to identify issues that need to be addressed.

Task Force Chairpersons and Co-ordinators' networks have also been established to share experiences and address issues of mutual interest.

2.5 Previous Reviews and Evaluations

A number of reviews and evaluations of the LDTF Programme have been carried out since its inception in 1997. These are briefly summarised below.

2.5.1 Evaluation of Drugs Initiative, 1998

In October 1998, PA Consulting Group carried out an evaluation of the Drugs Initiative for the Department of Tourism, Sport and Recreation. The report sought to establish whether the Drugs Initiative had achieved the objectives set out for it and to make proposals to improve the overall effectiveness of the initiative.

The evaluation found that, overall, the Drugs Initiative had proved successful in the short term. In particular, it had resulted in an improvement in the level of co-ordination and co-operation between the government departments and Agencies and, furthermore, that the involvement of local community groups on Task Forces was a critical factor in the success and credibility of the Initiative. It also found that the Local Drugs Task Forces had provided a focus for tackling drug issues in target areas and had reduced the feeling of isolation felt by many local communities.

The report made a number of recommendations, many of which were centred around the need for more formalised structures to be put in place for the running and monitoring of the Local Task Forces. It advocated that an updated development plan be drawn up for each Task Force, which would include a clear statement of the local needs of each area, as well as clearly setting out the objectives for the Task Forces for the next two years. It also recommended that more formalised communication structures be put in place between the various Task Forces, and also with the various governmental departments and agencies.

2.5.2 Annual Report of the Comptroller and Auditor General, 2000

The annual report of the Comptroller and Auditor General for the year ended 31st December 2000, included an audit of the Drugs Initiative. The primary objectives of the audit were to review overall management and control of the Initiative and to review effectiveness in the context of projects funded.

Among other things, the audit found that inadequate consideration had been given to the development of performance indicators from the outset. The audit also found that administrative and financial control arrangements were inadequate prior to funding, and that funding agencies did not exercise sufficient financial management and control over projects. The channels used to fund projects were found to be unnecessarily complex, and it was considered that this complexity had distanced the Department from its accountability for funding of the Initiative.

New procedures addressing the issues raised by the Comptroller and Auditor General have been in place since 2002.

2.5.3 Evaluation of Local Drugs Task Force Projects: Experiences and Perceptions of Planning and Implementation, 2000

The Policy Research Centre, National College of Ireland, was commissioned by the Evaluation Sub-Committee of the NDST to oversee the evaluation of the projects funded by the LDTFs. The main purpose of the study was to explore the experiences and perceptions of the planning and implementation stages of project development, with a focus on the first stages of project development.

The primary need identified in the report was for a consolidation of work being carried out by projects. The report stated that such consolidation would involve a two-dimensional approach, which would involve the projects themselves, the LDTFs and the NDST. Firstly, weaknesses identified in the running of the projects needed to be addressed. Secondly, the provision of appropriate support by external agencies was deemed necessary to enable the projects to build their capacity and enhance their expertise.

The importance of research and information gathering as an integral aspect of the projects was also identified. It was recommended that training and guidance be made available to projects to ensure that the necessity of research and information gathering be understood, and put into practice. It was further recommended that this research be built into projects' budgets from the start, and that financial and personnel resources be made available to the projects by their funders.

Following this study, a handbook on Planning and Implementation of Community Based Projects was published and widely disseminated, to support future ongoing planning and implementation of LDTF projects.

2.5.4 Operations and Management Study of the National Drugs Strategy Team and Drugs Strategy Unit, October 2001

PA Consulting Group were commissioned to carry out an organisation and management study of both the NDST and the Drugs Strategy Unit to assess the level of support and resources that would be needed to carry out the mandate of the then newly published National Drugs Strategy 2001-2008. The Strategy had made recommendations that were likely to significantly increase the workload of both the NDST and the Drugs Strategy Unit.

The report found that, overall, the NDST's role had expanded significantly as a result of the new National Drugs Strategy, in particular, in its new responsibility for setting up, supporting and monitoring the ten new Regional Drugs Task Forces. The report also found that the level of operational support available to the NDST was inadequate for the Team's new and wider role. A recommendation of the final report was that the NDST be supported by an appropriately staffed executive support function.

Arising from this study, the Government approved three posts to support the work of the Team, viz. Director, Development Worker and Finance/Research Officer. These posts were filled during 2003/4.

2.5.5 Review of Local Drugs Task Forces, March 2002

Rita Burtenshaw was commissioned by the National Drugs Strategy Team as an external facilitator to assist the 14 Local Drug Task Forces to review their systems and structures with a view to identifying and eliminating any deficiencies inhibiting

their development.

Burtenshaw made a large number of recommendations including:

- Greater clarification of the roles of community and voluntary representatives;
- Improved co-ordination of the work of the Task Forces to build on their individual achievements; and
- Improved resourcing of Task Forces.

The outcomes of this internal review formed the basis of an NDST report published December, 2002.

2.5.6 Review of the Local Drugs Task Forces, December 2002.

In December 2002, the NDST produced a review which was aimed at ensuring the development of the LDTFs in terms of their structures, procedures and capacity to prepare and implement their drug strategies. A very large number of recommendations were made including:

- Improved financial and reporting arrangements for LDTF funded projects, including mainstreamed projects;
- The NDST to disseminate models of best practice arising from the work of the LDTFs;
- The further resourcing of LDTFs through the appointment of a project development worker and a full time administrative assistant; and
- The development of a framework to evaluate the impact of the LDTFs.

Arising from this report, a range of measures were implemented to support LTDFs/projects including the securing of additional funding for a number of mainstreamed projects (2004), the development of agreed operational guidelines (2005), and a package of development worker/admin supports (2005).

2.6 The Role of this Review

The terms of reference for this review emphasise the need to examine the effectiveness and efficiency of the LDTF Programme, its continuing relevance, and its use of performance indicators.

Previous reviews have largely been concerned with the implementation of the Programme and the adequacy of the structures put in place. This review seeks to shed more light on the monies expended on the Programme and its use, the impact of the measures undertaken, the cost-benefits of these measures, and the elaboration of performance indicators that will enhance appraisal of the Programme going forward. The next section of the report starts this work by examining the financial allocations made under the Programme and the likely funding requirements going forward.

3. Funding of the Local Drugs Task Forces

3.1 Introduction

This section of the report examines the financial data available on funding allocated under the LDTF Programme. Funding in respect of Round 1 and Round 2 measures is analysed separately. Consideration is given to the initial funding allocated to measures, the interim funding and subsequent funding under the mainstreaming process that began in 2001. Account is also taken of the area of focus of the measures funded, and the distribution of funds across LDTF areas. Finally, a brief analysis is given of the Round 2 data, taking account of the initial funding allocated and the interim funding allocations that have been made to date.

A short summary of the funding for the individual LDTF areas in respect of Round 1 measures is presented in Appendix A of this report.

3.2 Approach Taken

The NDST provided the consultants with data sheets containing financial data on the measures funded in each LDTF area in both Round 1 and Round 2.

The data for Round 1 indicated the original amount of funding allocated to each measure from October 1997, as well as the total interim funding allocated. The mainstream funding allocated in each year between 2001 and 2003 was also included.

Where problems arose that resulted in a measure, or elements of a measure, not commencing, some or all of the funds allocated to that measure could be reallocated to another measure within the same Task Force area. The data were adjusted by the consultants to reflect these reallocations.

It should be noted that all of the financial data in this section of the report relate to funding allocated to measures, as opposed to the actual amounts drawn down for each measure. The latter information was not available to the consultants. For each tranche of funding allocated, an application for further funding could not be processed until the most recent allocation has been fully drawn down.

3.3 Overview of Funding of Round 1 Measures

In total, €24.3 million in initial and interim funding was allocated to support measures in Round 1 of the Local Drugs Task Force initiative. Initial funding was allocated to 228[6] core measures across thirteen Task Force areas. The majority of these measures were further supported with interim funding allocations, before a number of them were moved onto mainstream funding in 2001. Between 2001 and 2003, mainstream funding allocated to Round 1 measures amounted to €32.2 million. Over the period from October 1997 to the end of 2003, a total of €56.5 million was allocated to Round 1 projects. This represents an average annual allocation of approximately €9 million. Table 3.1 below summarises the overall funding that was allocated under Round 1 of the initiative.

[6] A number of measures did not get off the ground and so their funding was reallocated to other measures within the Task Force area. These measures are not included in this figure. Furthermore, some of the 228 measures were subdivided into additional measures, but only the core measure is included in the figure.

Table 3.1 Summary of Round 1 Funding

Funding Type	€ millions	Number of Measures Supported
Initial Funding Allocated	12.1	228
Interim Funding Allocated	12.2	147
Mainstream Funding Allocated 2001	11.1	119
Mainstream Funding Allocated 2002	10.3	108
Mainstream Funding Allocated 2003	10.8	116
Total Round 1 Funding Allocated to end 2003	**56.5**	

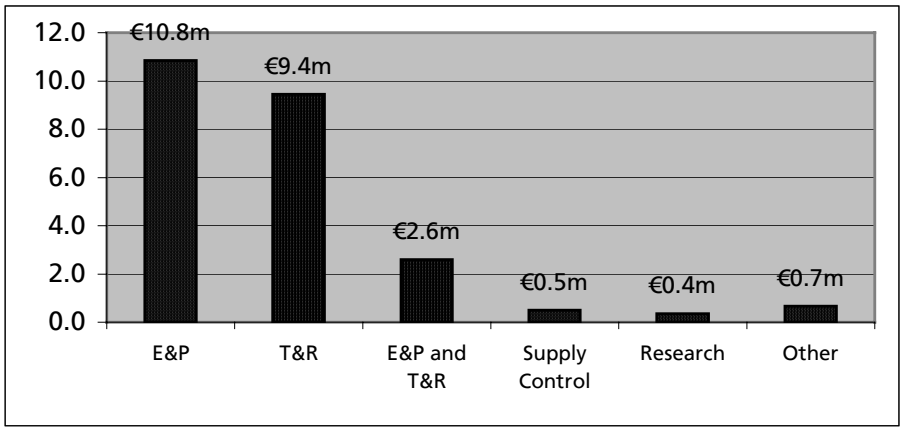
Source: Compiled from NDST data.

3.3.1 Distribution of Initial and Interim Funding under Round 1 Measures

Initial and interim funding allocated to support Round 1 measures amounted to €24.3 million. Funding of €12.1 million was initially allocated to support 228 core measures, and then 147 of these measures went on to receive €12.2 million in interim funding.

The thematic areas of focus for the measures included Education and Prevention, Treatment and Rehabilitation, Supply Control and Research. Figure 3.1 below illustrates the distribution of initial and interim funding across different the different thematic areas.

Figure 3.1 Initial and Interim Funding Allocations by Theme (Round 1)

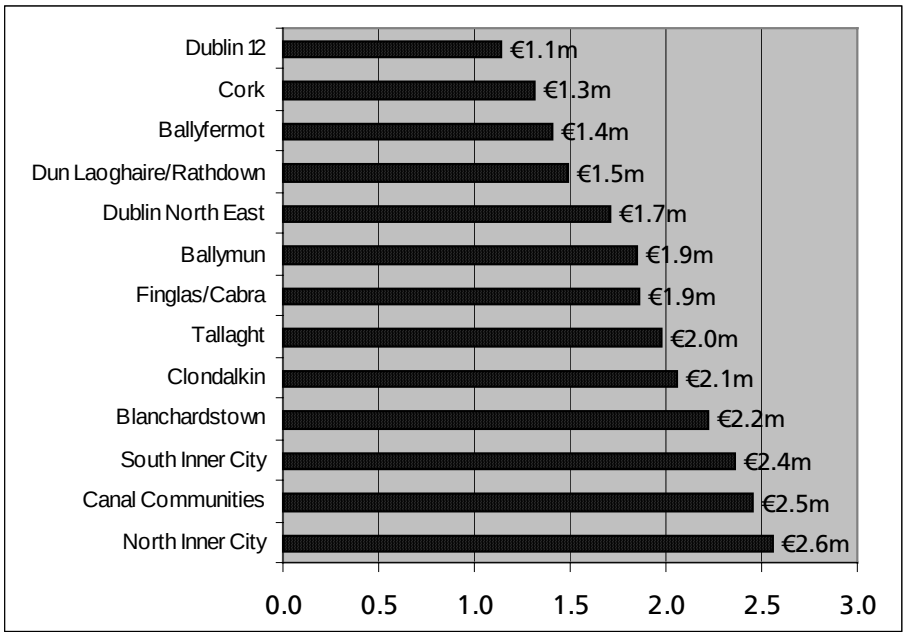


Source: Compiled from NDST data.

The greatest proportion of this funding (44.3 per cent, or €10.8 million) was given to support measures that had a focus on Education and Prevention. Measures relating to Treatment and Rehabilitation were allocated €9.4 million (38.5 per cent) of the funding and measures that addressed both of these areas were allocated €2.6 million (10.7 per cent). Thus €22.8m or 94 per cent of total funding addressed these areas.

Figure 3.2 below illustrates the distribution of the initial and interim funding combined, by Task Force area.

Figure 3.2 Initial and Interim Funding Allocations by Task Force Area (Round 1)



Source: Compiled from NDST data

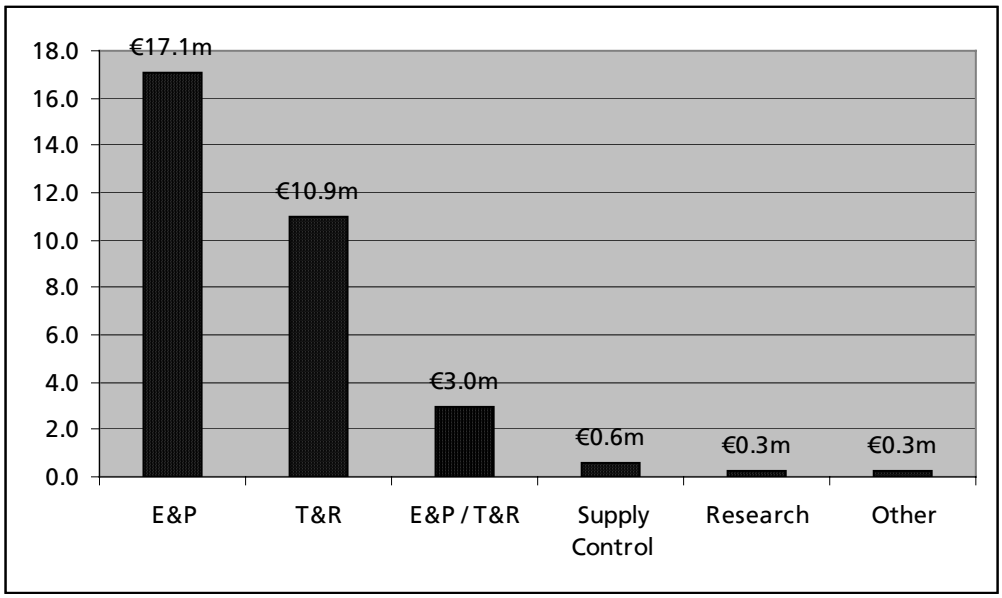
Over the initial and interim funding periods, the North Inner City Task Force was allocated the largest amount at €2.6 million, or 10.7 per cent of the total funding. The Local Drugs Task Force for Dublin 12 was allocated the smallest proportion of the funding, €1.1 million or 4.5 per cent.

3.3.2 Mainstreaming of Round 1 Measures

Of the 228 measures that received initial funding, 119 went on to receive mainstream funding. Once mainstreamed, the measures no longer operated under the Local Drug Task Forces, but under the mainstream agencies that were to continue funding them.

Some measures went straight from the initial funding stage to being mainstreamed, but the majority of measures received some level of interim funding, before they were evaluated for mainstreaming. The mainstreaming of measures began in 2001 and the NDST data provide annual amounts of mainstream funding that were allocated to the end 2003. Figure 3.3 illustrates the levels of mainstream funding allocated in total across each thematic area of focus between 2001 and 2003.

Figure 3.3 Mainstream Funding Allocations in Total by Theme, 2001-2003



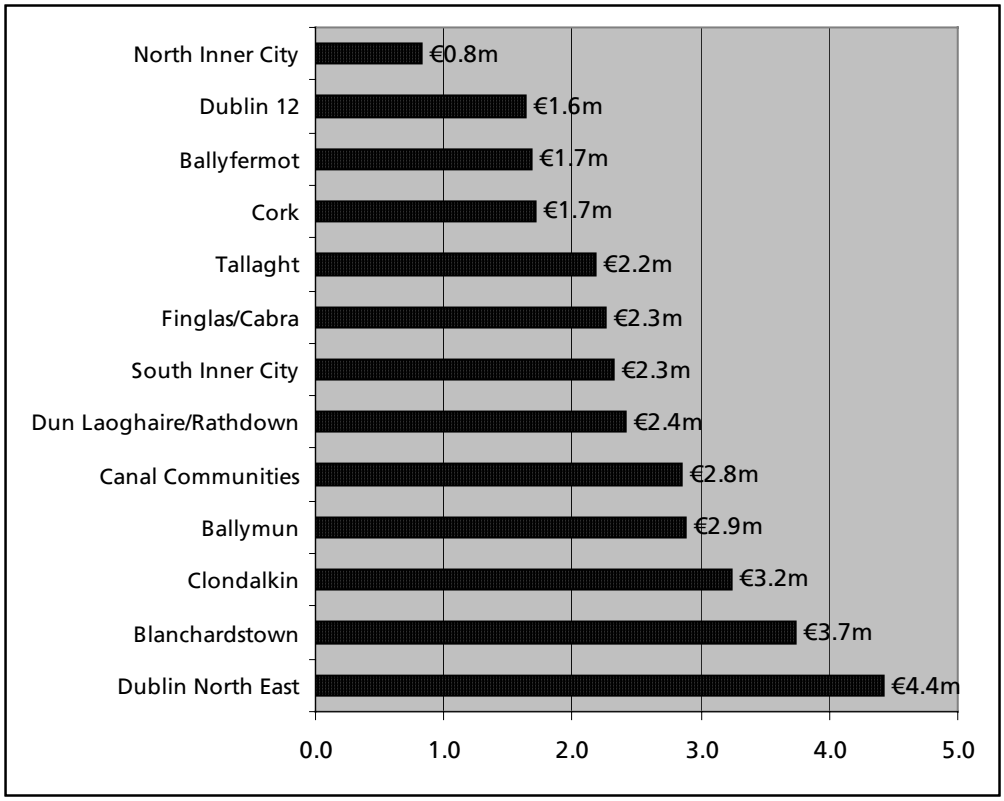
Source: Compiled from NDST data

As one would expect, the distribution of the mainstream funding across the various thematic areas of focus is not dissimilar to the distribution of the initial and interim funding. Measures concentrating on Education and Prevention were allocated 53.1 per cent (€17.1 million) of the total mainstream funding between 2001 and 2003. Measures focusing on Treatment and Rehabilitation were allocated 33.8 per cent (€10.9 million), and measures addressing both of these thematic areas were allocated 9.3 per cent (€3.0 million) of the funding during the same period.

Using the data provided by the NDST, it is also possible to track the mainstream funding allocations by Local Drugs Task Force Area. This is illustrated in Figure 3.4 below.

In terms of mainstream funding, measures developed under the Dublin North East Task Force were allocated the greatest proportion of monies between 2001 and 2003 (13.7 per cent or €4.4 million). Measures developed under the Blanchardstown Task Force were allocated €3.7 million (11.5 per cent) and those developed under the Clondalkin Task Force were allocated €3.2 million (9.9 per cent) of total funding for the period. At the other end of the scale, measures developed under the North Inner City Task Force were allocated €0.8 million in mainstream funding between 2001 and 2003, and measures developed under the Task Force in Dublin 12 were allocated €1.6 million.

Figure 3.4 Mainstream Funding Allocations in Total by Task Force Area, 2001-2003



Source: Compiled from NDST data

3.4 Overview of Funding of Round 2 Measures

To date[7] a total of €27.5 million has been allocated to Round 2 measures under the Local Drugs Task Force initiative. When Round 2 began, an additional Task Force area had been established in Bray bring the total number of Local Drug Task Forces to fourteen. Similarly to Round 1, an initial allocation was made to a number of measures across the fourteen Task Force areas. The majority of these measures have been in receipt of further support from interim funding allocations.

The initial funding allocated to Round 2 measures under the Local Drugs Task Force initiative amounted to €15.6 million. This funding supported a total of 256[8] measures across a number of themes similar to those addressed by Round 1 measures. Interim Funding allocated to date amounts to €11.9 million. Of the 256 measures that had been allocated Initial Funding, 146 have already drawn this down and have been allocated additional financial support.

[7] The Round 2 data used in this Section of the report referred to the period up to July 2004.
[8] This figure relates to the number of core measures. Some of these core measures were subdivided into more numerous, sub-measures.

Table 3.2 Summary of Round 2 Funding

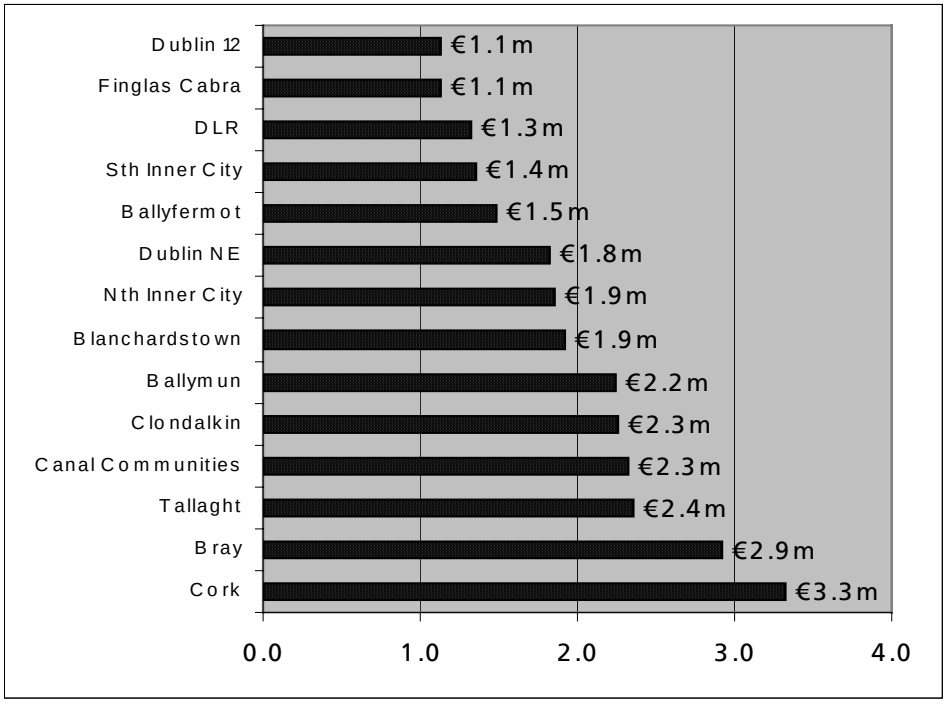
Funding Type	€ millions	Number of Measures Supported
Total Initial Funding Allocated	15.6	256
Total Interim Funding Allocated to end July 2004	11.9	146
Total Round 2 Funding Allocated to end July 2004	27.5	

Source: Compiled from NDST data

The Round 2 data provided by the NDST did not categorise measures by the theme that they addressed[9]. However, the data collected by the consultants, and described in Section 4 of this report, indicate that the distribution of Round 2 measures by theme was quite similar to that of Round 1.

In terms of the actual funding allocated to Round 2 measures, it is possible to look at the distribution of this funding across the fourteen Task Force areas. Figure 3.5 below illustrates the breakdown.

Figure 3.5 Round 2 Measures in Receipt of Initial Funding by Task Force Area



Source: Compiled from NDST data

Of the fourteen geographical areas included in Round 2, the Local Drugs Task Force in Cork has been allocated the greatest proportion of Round 2 funding distributed thus far (12 per cent or €3.3 million). The Dublin 12 and Finglas Cabra Task Forces have each been allocated the lowest proportions (4 per cent or €1.1 million).

[9] At the time of writing, the NDST are in the process of developing a Management Information System that will enable the capture of this data and more, going forward.

Comparing Round 1 and Round 2 initial funding levels reveals that Dublin 12, Dun Laoghaire –Rathdown and Ballyfermot are among the five lowest funded areas in both rounds, while Canal Communities and Clondalkin are consistently in the top five.

3.5 Future Funding Requirements

The mainstreaming of measures means that the State is undertaking to support drug intervention projects on an ongoing basis. It is of interest, therefore, to assess the extent to which the LDTF Programme will give rise to annual funding requirements if the process of mainstreaming both Round 1 and Round 2 measures were to be followed through.

In 2003, there were 116 measures mainstreamed at an annual cost of €10.8m. Assuming that outstanding Round 1 measures were to experience the same success rate in achieving mainstreaming status as those already considered, then it is estimated that the cost of mainstreamed Round 1 measures will rise to a minimum of €12.1m annually.

With regard to Round 2, as none of these measures have yet been mainstreamed, it is necessary to estimate future funding requirements by comparison with Round 1 outcomes. Assuming that the 256 measures in Round 2 achieve the same success rate in achieving mainstreamed status as Round 1 measures, it is estimated that they will incur some €16.1m in expenditure annually.

3.6 Financial Reporting

The lack of data on expenditure under the Programme has been noted. The absence of such data was first noted by the Comptroller and Auditor General in his year 2000 report and by the NDST in its review undertaken in 2002. If the State is to be faced with annual commitments of the order of magnitude indicated above, then the need for such data becomes all the more pressing. It is only through the provision of such data that progress in relation to the implementation of measures will become transparent and value for money issues can begin to be addressed. In Section 8, a number of core financial and other performance indicators that are crucial to this task are set out. It is essential that steps be taken as a matter or urgency to ensure that such data are collected. In addition, it is essential that projects in receipt of funding adopt professional practices in relation to financial matters. The furnishing of audited financial accounts to the mainstreaming agencies should be a minimum requirement in this regard.

3.7 Conclusions

Between Round 1 and Round 2, funding totalling €84.0 million has so far been allocated to support measures under the Local Drugs Task Force initiative in the period since 1997 to July 2004.

A total of €24.3 million was given to support Round 1 measures under the Local Drugs Task Force initiative. Of that, €12.1 million was allocated as initial funding to 228 core measures across thirteen Task Force areas. Of the 228 core measures, 147 went on to receive additional interim funding support. In total €12.2 million was provided in interim financial support for these measures. The main theme for measures in receipt of both initial and interim funding was Education and Prevention, followed by Treatment and Rehabilitation.

In 2001, a mainstreaming process began whereby a number of efficient and effective measures moved from being funded under the Local Drugs Task Force initiative, to being funded by mainstream agencies. In total, 119 core measures were mainstreamed. The majority of them had been in receipt of both initial and interim funding, but there were some that had just been in receipt of initial funding up to this point. Between 2001 and 2003, a total of €32.2 million in mainstream funding was allocated to support these measures.

Over the period from October 1997 to the end of 2003, a total of €56.5 million was allocated to Round 1 projects. This represents an average annual allocation of approximately €9 million.

In Round 2, a total of 256 core measures were allocated initial funding support amounting to €15.6 million. Of the 256 Round 2 measures that were allocated initial funding support, 146 have also been allocated interim funding. Interim funding of Round 2 measures is ongoing and to date a total of €11.9 million has been allocated. Up to July 2004, a total of €27.5 million has been allocated including initial and interim funding under Round 2.

Given the scale of funding, it is essential that financial reporting arrangements be improved through regular reporting of expenditure by projects and the furnishing of audited annual project accounts.

4. Measures Undertaken by the LDTF Programme

4.1 Introduction

The measures undertaken by the LDTFs generally related to the four pillars or thematic areas of the National Drugs Strategy. However, it was recognised that the drug problem needed to be addressed at a number of levels, focusing not only on drug users themselves, but also on their families, on young people at risk of drug taking, on the statutory bodies involved in providing relevant services, and on the community as a whole. Figure 4.1 provides an overview of the main actors in the process.

Measures adopted by the LDTFs in their plans were aimed at meeting the needs of each of these actors in the process. Many of the measures recognised that significant work was required to encourage the various actors to be involved in the process and support the provision of the various treatment, rehabilitation, education and other supports that were being made available. They also recognised that the latter services needed to be staffed by appropriately trained workers and supported by relevant research. Table 4.1 provides an outline of the main categories into which measures fell and the type of activities undertaken. The list is not intended to be exhaustive, but to give an idea of the range of activities undertaken.

In order to assess the effectiveness and efficiency of the LDTFs, it was essential to first establish *inter alia* the:

- Number of measures by theme or purpose;
- Number of measures by target group;
- Current status of measures;
- The extent to which the measures supported new projects and activities; and
- The failure rate of projects supported by the measures.

Unfortunately, data on the measures were poor and the consultants had to develop such data *ab initio.* [10] Appendix B indicates how these data were collected.

The next sections profile the measures funded under the LDTF Programme along a number of the above dimensions. Separate consideration is given to Round 1 and Round 2 measures. In total, data were received in relation to 186 Round 1 measures and 253 Round 2 measures. Two Task Force areas were unable to provide information in relation to Round 1 measures, while one Task Force did not provide information regarding Round 2 measures. Apart from these missing LDTF measures, data were received for all other measures funded via the LDTF Programme.

[10] It should be noted that at the time of writing, the NDST is implementing a computerised project management information system that will address these information needs.

Figure 4.1: Overview of Main Actors in LDTF Programme

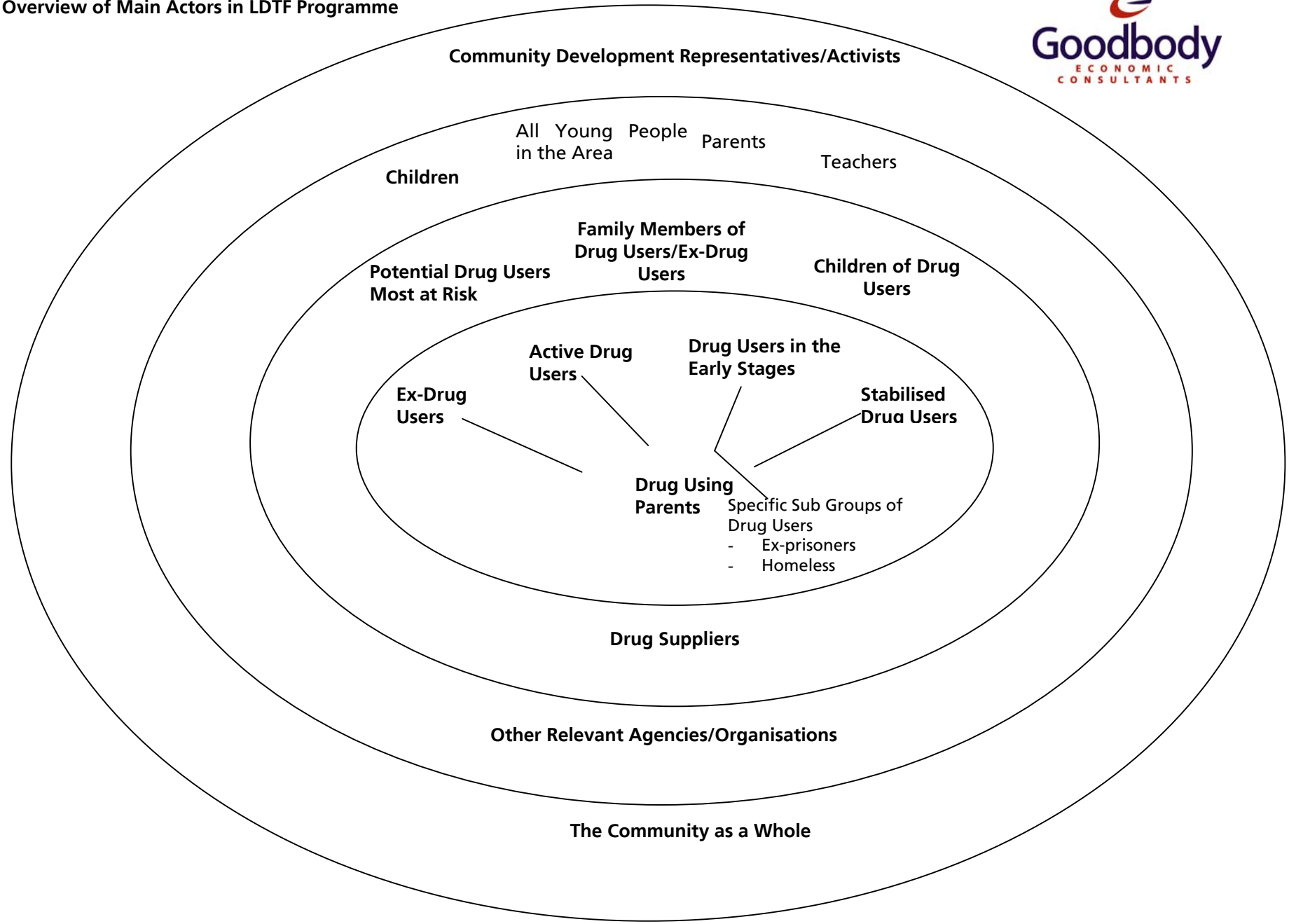


Table 4.1: LDTF Measures and Type of Activity

Measure Category	Types of Activity
Access to Treatment and Rehabilitation	Outreach
	Assessment and Referral
	Pre-induction programmes
	Drop-in services
	Attending local resident groups/community groups
	Mail shots and other advertising
	Contacting drug users in prison
Treatment and Harm Reduction	Methadone dispensing service
	One to one counselling
	Group therapy
	Holistic therapies
	Needle exchange
Rehabilitation	Stabilisation programmes
	Job seeking skills
	Vocational training
	Prison link services
Education and Prevention	Group Education
	Drugs awareness courses/sessions
	Parenting skills
	Information dissemination
	Information events (open days etc)
	Personal development of young people
	Improving school attendance
	Early school leaver programmes
	Youth diversion programmes
	Develop peer drug educators
Family Support	Information and advice
	One to one counselling
	Group counselling
	Discussion groups
	Residential respite breaks
	Childcare services
	Drop in services
Supply Control	Community information
	Community policing fora
Education and Training of Drug Workers	Community addiction training courses
Research	Research Studies

4.2 Current Funding Status of Measures

With regard to Round 1 measures, none of the measures are currently in receipt of initial funding. Some 11 per cent of measures have progressed to and are currently on interim funding, while the vast bulk (57 per cent) have been mainstreamed. No Round 1 measures were recorded as having failed to start, while just under 11 per cent have their funding withdrawn or reallocated. The latter was largely due to under performance of the projects that were in receipt of the funding. Some eight per cent of Round 1 measures constituted once-off payments, such as a research projects, and so were not eligible for mainstreaming.

Table 4.2: Proportion of Round 1 Measures by their Current Status

Current Status	Proportion of Measures (%)
Initial	0.0
Interim	10.8
Mainstreamed	56.8
Not commenced	0.0
Funding Reallocated	2.2
Funding Withdrawn	8.6
Once-off payment	8.1
Other	13.5
Total	100.0

Source: Compiled by Goodbody Economic Consultants

Under Round 2, 10 per cent of measures are still in receipt of initial funding. There has been no mainstreaming of Round 2 measures to date, and as a result the vast bulk of all Round 2 measures are currently in receipt of interim funding (73 per cent). Six per cent of Round 2 measures were once-off payments, for actions such as research and information awareness campaigns. A further 4 per cent of measures have not commenced or have had their funding reallocated or withdrawn.

Table 4.3: Proportion of Round 2 Measures by their Current Status

Current Status	Proportion of Measures (%)
Initial	9.5
Interim	73.0
Mainstreamed	0.0
Not commenced	2.4
Funding Reallocated	1.2
Funding Withdrawn	0.8
Once off payment	6.0
Other	7.1
Total	100.0

Source: Compiled by Goodbody Economic Consultants

4.3 Measures by Theme

In terms of the four National Drug Strategy pillars or themes, the largest proportions of Round 1 measures have education and prevention (54 per cent) and treatment and rehabilitation (33 per cent) themes. In addition, 17 per cent of Round 1 measures are

family support measures. A very small proportion of Round 1 measures, approximately 4 per cent in each case, relate to supply control, training of drug workers or research.[11]

Table 4.4: Proportion of Round 1 Measures by Theme

Theme	Proportion of Measures (%)
Education & Prevention (E&P)	53.9
Treatment & Rehabilitation (T&P)	32.9
Family Support (FS)	16.8
Research (R)	3.6
Supply Control (SC)	3.6
Training of drug workers (T)	4.2
Other (O)	15.6

*Some measures relate to more than one themes, hence the total of all the proportions is greater than 100.
Source: Compiled by Goodbody Economic Consultants

Under Round 2, the education and prevention and treatment and rehabilitation themes are dominant again, with 43 per cent of measures relating to education and prevention category and 39 per cent of measures to treatment and rehabilitation category. A slightly higher proportion of Round 2 measures fall into the category of family support (20 per cent) than was the case for Round 1. Under Round 2, as under Round 1, small proportions of measures fall under the pillars of supply control (5 per cent), research (4 per cent), and training of drug workers (4 per cent)

Table 4.5: Proportion of Round 2 Measures by Theme

Theme	Proportion of Measures (%)
Education & Prevention (E&P)	43.0
Treatment & Rehabilitation (T&R)	39.3
Family Support (FS)	20.2
Research (R)	4.1
Supply Control (SC)	5.4
Training of drug workers (T)	3.7
Other (O)	4.1

*Some measures fall into more than one category hence the total of all the proportions is greater than 100.
Source: Compiled by Goodbody Economic Consultants

4.4 Type of Activity

Forty five per cent of Round 1 measures gave rise to new projects, while some 23 per cent represent new activities. This indicates that almost 70 per cent of Round 1 measures were in respect of new areas of support for drug users and their families.

[11] In interpreting these data, it should be noted that the allocation of measures to specific themes was undertaken by task force co-ordinators. As a result, there is an element of subjectivity involved.

Similar proportions of Round 2 measures were in respect of new areas of support (69 per cent). However, in Round 2, a relatively higher proportion of measures was in respect of new activities rather than new projects. This implies that Round 2 funding focussed to a significant degree on developing new activities in existing projects.

In both Round 1 and Round 2, approximately one in five measures supported the expansion of existing activities.

Table 4.6: Proportion of Round 1 and Round 2 Measures by Funding Impact

Funding Impact	Proportion of Round 1 Measures (%)	Proportion of Round 2 Measures (%)
New Project	45.1	27.4
New Activity	23.2	42.0
Existing Activity	22.6	19.2
Other	9.1	11.4
Total	100.0	100.0

Source: Compiled by Goodbody Economic Consultants

Table 4.7 looks specifically at the treatment and rehabilitation measures funded under both Round 1 and Round 2.

Under Round 1, over 67 per cent of treatment and rehabilitation measures were new projects or new activities. Of the 67 per cent, the higher proportion of measures were new projects. This, perhaps, reflects the lack of treatment and rehabilitation services in place when Round 1 plans were drawn up.

Under Round 2, a similar proportion of treatment and rehabilitation measures are categorised as new projects and new activities (72 per cent). However, under Round 2, a higher proportion of measures are new activities. This implies that Round 2 funding focussed to a significant degree on developing new activities in existing treatment and rehabilitation projects.

Table 4.7: Proportion of Round 1 and Round 2 Treatment and Rehabilitation Measures by Funding Impact

Funding Impact	Proportion of Round 1 T&R Measures (%)	Proportion of Round 2 T&R Measures (%)
New Project	56.4	25.3
New Activity	10.9	46.2
Existing Activity	25.5	25.3
Other	7.3	3.3
Total	100.0	100.0

Source: Compiled by Goodbody Economic Consultants

4.5 Funding Sources for Projects

Under Round 1, 63 per cent of the projects supported were wholly funded by LDTF monies. This proportion increased to 77 per cent under Round 2.

Table 4.8: Proportion of Round 1 Measures by Funding Source

Funding Source	Proportion of Round 1 Measures (%)	Proportion of Round 2 Measures (%)
Wholly LDTF Funded	63.3	76.5
Partly LDTF Funded	36.7	23.5
Total	100.0	100.0

Source: Compiled by Goodbody Economic Consultants

4.6 Target Groups

As outlined in Table 4.9, over one third (36 per cent) of Round 1 measures target drug users, 26 per cent target their families, 43 per cent target young people at risk and their families, while 23 per cent target the community as a whole.

Under Round 2, the proportion of measures targeting the drug using population is relatively unchanged at 39 per cent. The proportions of Round 2 measures targeting families of drug users also remained stable at 23 per cent. The proportion of measures targeting children/young people at risk and their families is significantly lower in Round 2 (29 per cent). The proportion of projects targeting community residents is also lower at 14 per cent.

Table 4.9: Proportion of Round 1 Measures by Target Group

Target Group	Proportion of Measures (%)
Adult drug users	17.4
Young drug users	11.4
Recovering/Stabilised drug users	6.0
Prisoners and recovering prisoners	0.0
Homeless Drug users	0.0
Families of drug users	25.7
Children/young people (at risk) and their families	42.5
Service providers	10.2
Community residents	22.8
Other	0.0

Source: Compiled by Goodbody Economic Consultants
*****Some measures have more than one target groups, hence the total of all the proportions is greater than 100.

Table 4.10: Proportion of Round 2 Measures by Target Group

Target Group	Proportion of Measures (%)
Adult drug users	21.5
Young drug users	6.2
Recovering/Stabilised drug users	7.4
Prisoners and recovering prisoners	2.9
Homeless drug users	1.7
Families of drug users	23.1
Children/young people (at risk) and their families	29.3
Service providers	7.4
Community residents	13.6
Other	2.9

Source: Compiled by Goodbody Economic Consultants
*Some measures have more than one target groups, hence the total of all the proportions is greater than 100.

4.7 Type of Project Expenses Funded

The majority of measures in receipt of funding use LDTF monies to support general project expenses. A large proportion of measures also use LDTF monies to support staff costs (63 per cent in Round 1 and 57 per cent in Round 2).

While 13 per cent of Round 1 measures use LDTF monies to fund the costs of premises, the corresponding proportion in Round 2 is five per cent.

Only a minority of Round 1 and Round 2 measures use LDTF funding to fund research costs.

Table 4.11: Proportion of Round 1 and Round 2 Measures by Use of Measure Funding

Use of funding	Proportion of Round 1 Measures (%)	Proportion of Round 2 Measures (%)
General Project Expenses	71.7	67.8
Premises	12.7	5.0
Staff costs	63.3	57.4
Research	1.8	3.7
Other	5.4	7.4

Source: Compiled by Goodbody Economic Consultants
Note: Expenditure under “premises” relates to operating costs associated with premises.

*Some measures have more than one target groups, hence the total of all the proportions is greater than 100.

4.8 Conclusions

- The vast majority of measures under Round 1 and Round 2 were successfully implemented. Only 10.8 per cent of measures under Round 1 related to projects that did not commence or had their funding withdrawn or reallocated. The equivalent proportion for Round 2 was 4.4 per cent.
- Approximately 57 per cent of Round 1 measures are now mainstreamed, with a further 11 per cent on interim funding. No Round 2 measures are as yet mainstreamed.
- Over 45 per cent of Round 1 measures supported new projects, while 23 per cent supported new activities. Under Round 2, a similar proportion of measures was new projects or new activities (69 per cent). However, under Round 2 a relatively higher proportion of measures were in respect of new activities rather than new projects. This suggests that Round 1 measures were largely focussed on developing new projects, while Round 2 prioritised new activities in existing projects.
- For the majority of projects funded under both Rounds 1 and 2, the LDTF Programme was the sole source of funding.
- The majority of measures had either education and prevention or treatment and rehabilitation as their themes. Almost 54 per cent of Round 1 measures related to education and prevention and 33 per cent to treatment and rehabilitation. With regard to treatment and rehabilitation measures under Round 1, 56 per cent were in respect of new projects. Under Round 2, such measures tended to fund new activities rather than new projects.
- Over one third (36 per cent) of Round 1 measures targeted drug users, 26 per cent targeted their families, 43 per cent targeted young people at risk and their families, while 23 per cent targeted the community as a whole. With regard to Round 2, the major difference was that a smaller proportion of measures targeted young people at risk or the community as a whole.
- The measures under both Rounds 1 and 2 were typically used to fund general project expenses and staffing. Premises costs and research activities were less often supported.

5. Measuring the Impact and Value for Money of Drug Intervention Programmes and Measures

5.1. Introduction

Measuring the impacts and value-for-money of drug intervention programmes requires:

- Measurement of the costs of implementing such programmes;
- Quantifying the impact of the programme; and
- Putting money values on those impacts.

Whereas measurement of the costs of the programme is usually a fairly straightforward affair, the other two are more problematic. Quantifying the impact of the programme requires a linking of the programme activities with impacts, so that cause and effect is established. This is difficult for two reasons:

- Firstly, the programme in question may be just one of a number of programmes and policies aimed at achieving the same outcome and distinguishing the impact of the programme in question may be difficult; and
- Second, impacts may take some time to occur and or may be long-lived. This means that measurement of full impacts may require adoption of a long-term perspective. Policy-makers may not be prepared to fund or wait for research over such a time horizon.

Even where impacts are known and quantifiable, difficulties arise in putting monetary values on them. This is because the data may not be available or the benefits are relatively intangible in nature.

In particular, there are a range of benefits that arise for drug users and their families that are not readily amenable to monetisation. These relate to improvements in quality of life and health status, and increased self-esteem. In assessing value for money studies, it must be recognised that they will encompass only a subset of all benefits. Because of this, it is clear that the economic returns as calculated by such studies underestimate the full benefits arising.

Because of these difficulties, there are relatively few examples of studies that measure drug intervention impacts in monetary terms. Partly as a result of these difficulties, evaluators of the effectiveness of drug programmes have often taken a different approach. This consists of the measurement of the total costs of drug abuse to society and the consequent estimation of the average costs of per drug abuser. These average costs may then be compared to programme costs. This provides a perspective on how large the impacts of the Programme would have to be to justify its costs. This is usually termed the macro-economic approach.

5.2. Costs and Benefits of Drug Intervention Initiatives

5.2.1 Introduction

In Section 4, it was indicated that the LDTF projects were dominated by those involving treatment and rehabilitation and education and prevention. It is therefore crucial to establish whether such interventions are effective and efficient. As there has been no significant primary research on this issue in the Irish context, it is

necessary to consider international evidence in relation to this matter. This sub section presents an over view of that evidence, focussing on studies in a cost-benefit or cost effectiveness framework. The evidence in relation to treatment and prevention initiatives is considered in turn.

5.2.2 The Costs and Benefits of Drug Treatment Initiatives

In recent years, an increasing number of studies have attempted to assess the costs and benefits of different drug treatment regimes. While methadone maintenance has been the treatment most subject to analysis, in-patient and out-patient drug free approaches and social model treatments have also been analysed[12]. The general approach of these studies is that of analysis of before and after experience of a group of people who have been subject to treatment, either with or without control group comparisons. A number of problems have arisen in implementing these studies:

- The before and after time frames have usually been very short, so that benefits have often been biased downwards;
- Where control groups have not been utilised, there has been scope for exaggeration of benefits [13]; and
- There have been data inadequacies associated with failures to fully capture intermittent participation on treatment programmes, and relapse and maturation effects.

With regard to the benefits measured, these have usually comprised some or all of the following: health costs, criminal justice costs, and loss of productivity costs including those arising from death.

The economic return from treatment as measured in these studies has usually been couched in terms of the ratio of discounted benefits to discounted costs or the benefit-cost ratio. A benefit-cost ratio in excess of unity indicates that treatment has a net positive economic benefit after costs have been taken into account.

There have been two recent surveys of these cost-benefit studies. A study for the Department of Health and Human Services in the USA analysed studies that measured the economic return to treatment of alcohol as well as drug abuse. [14] This survey identified 58 relevant studies. The survey concluded that "there is increasingly strong evidence that substance abuse treatment probably does pay for itself ". Of more direct relevance is a similar survey conducted by Cartwright, which focussed in particular on drug treatment. [15] This survey reported very high benefit-cost ratios, in the range of 2 to over 20, for drug treatment. All types of treatment recorded strongly positive cost-benefit ratios. Insufficient studies were available to determine which of the various treatment types exhibited the highest return, although there was some evidence that drug-free programmes had particularly high returns. The author concluded that:" In 18 cost-benefit studies, a persistent finding is that the benefit-cost ratio is greater than one. These findings are compromised by many studies with weak research designs. However, the benefits of drug abuse treatment are so robust that it appears that the conclusion of positive economic returns to society will stand as better studies are implemented".

[12] Social model treatments focus on recovery in communal sober living and peer support.

[13] Through regression-to-mean effects.

[14] Cost Effectiveness and Cost Benefit Analysis of Substance Abuse Treatment: A Literature Review. National Evaluation Data Services, Department of Health and Human Services, 2002.

[15] Cost-Benefit Analysis of Drug Treatment Services: Review of the Literature. The Journal of Mental Health Policy and Economics, 3, 2000.

5.2.3 The Costs and Benefits of Drug Prevention Initiatives

In general, the problems associated with measuring the costs and benefits of treatment initiatives also apply to drug prevention initiatives. The latter, however, suffer from an additional complexity arising from the fact that many such initiatives are focused on school children and young people, whereas addiction to heroin or cocaine will not typically occur until late teens or early twenties. As a result, the benefits of such initiatives may only be gauged after some time has elapsed. Most studies rely on indicators of the immediate impact of the initiative on attitudes and short-term behaviour, and extrapolate from these to ultimate lifetime drug addiction behaviour.

Another issue that arises is the extent to which there are spillovers from drug prevention initiatives. For example, drug users may induce others to start drug use, so that successful prevention may have a multiplier effect. This is difficult to quantify.

Initially, evaluations of drug prevention initiatives were concerned with establishing whether such initiatives had positive impacts on drug use. The initial findings of research were not encouraging in this regard. However, more recent analysis, which has focused on the different types of drug prevention programmes, has concluded that programmes using an interactive approach, which applies social influences, have proved to be efficacious. [16]

While well designed intervention initiatives have been proven to have an impact, this does not mean that such programmes are effective in terms of making an appreciable difference to the drug problem, or efficient in the sense of providing value for money. Cost-benefit analyses provide information on value for money and a small number of such studies have been undertaken. A recent comprehensive study focussed on school-based intervention programmes. [17] This concluded that:

- Well-designed school based prevention programmes yield benefits at least twice the level of costs;
- Most of the benefits are in terms of reduction in alcohol and tobacco use, but benefits still exceed costs even if drug use only is reckoned;
- Prevention schemes are value for money not because the benefits are high but because the costs are very low; and
- Given the modest level of benefits achieved the contribution of this type of initiative to alleviating the drug problem as a whole is limited.

5.3. Macro-economic Costs of Drug Abuse

5.3.1 Content of Macro-Economic Studies

The macro-economic approach entails estimating the costs of substance abuse or the social cost of illness. Generally speaking, the costs considered are those falling on the State or society as a whole. Studies undertaken in other countries often embrace the use of alcohol and tobacco as well as pharmaceuticals and illicit drugs. The elements of cost that are included usually embrace some or all of the following:

[16] See: Meta-analysis of Adolescent Drug Use Prevention Programs. National Institute on Drug Abuse, 1997.

[17] School-Based Drug Prevention: What Kind of Drug Use Does It Prevent? J Caulkins et al., Rand Corporation, 2002

- Cost of treatment;
- Prevention;
- Research;
- Law enforcement;
- Lost productivity; and
- Some measure of quality and extent of life.

These costs are usually estimated in contrast to a counterfactual where there is no substance abuse. A fundamental difference among these cost studies is whether they measure:

- The costs as they relate to prevalence of drug abuse i.e. they are measuring the costs that would be avoided if drug use were reduced to zero from levels recorded in a particular year; or

- Current and future costs arising from the number of **new** cases of drug abuse in a given year.

Most studies use the former approach.

The World Health Organisation has established a set of guidelines for conducting such studies, which sets out these cost elements and a methodological approach to their estimation. [18] It is recognised by practitioners in the field that estimating the costs of abuse in relation to drugs is much more problematic than for alcohol or tobacco. This is because, as drugs are illegal, there are no official data on their use, unlike, say, tobacco, where consumption is recorded as a result of the indirect taxes imposed.

5.3.2 Results of the Macro-Economic Studies

USA

The Office of National Drug Control Policy in the USA has made estimates of the annual economic cost of the abuse of illicit drugs in that country. The overall cost of drug abuse was estimated at $160.7 bn or €174.0m for the year 2000.[19] This is equivalent to 1.5 per cent of the GNP of the USA for that year. Table 5.1 presents a breakdown of this figure. Over two-thirds of costs are in the form of productivity losses. These are losses arising from premature death, illness, unemployment, and low levels of on-the-job productivity. The major elements in “other costs” are the costs of policing, the judiciary and imprisonment.

[18] E.Single at al. International Guidelines for Estimating the Costs of Substance Abuse, 2001 Edition. WHO, 2001.
[19] Adjusted to Euros at the then prevailing exchange rate.

Table 5.1: Costs of Drug Abuse in the USA, 2000

Cost Category	Cost €m	Proportion of Total (%)
Health Care Costs	16,131	9.3
Productivity Losses	119,631	68.8
Other Costs	38,192	22.0
Total	173,954	100.0

Source: Office of National Drug Control Policy. The Economic Costs of Drug Abuse in the United States, September 2001.

Canada

An estimate of the costs of substance abuse in the form of alcohol, tobacco and illicit drugs was made for the year 1992. This study provided estimates for each type of abuse separately. The study found that the costs of substance abuse amounted to Can€18.45bn in that year, or 2.7 per cent of GDP. With in this total, the costs of tobacco (Can$7.5bn) and alcohol (Can$9.6bn) far exceed that of illicit drugs (Can$1.4bn). As a proportion of GDP, the costs of drug abuse amounted to 0.2 per cent. The authors indicated that they adopted a very conservative stance to cost estimation and that several cost categories were omitted for lack of data. As a result, they regard their figures as under-estimates. [20] Once again, productivity losses accounted for the bulk of the costs (60 per cent).

France

A very similar study has been undertaken for France.[21] This estimated the social costs of alcohol, tobacco and illicit drugs at FF218 bn for 1997 or 2.7 per cent of GDP. Again alcohol (FF 115bn) is the substance that imposes the highest cost, with tobacco next in importance (FF 89bn), followed by illicit drugs at FF 13bn. The costs associated with illicit drugs are the equivalent of 0.16 per cent of GDP. Productivity losses accounted for 46 per cent of the total costs of illicit drug abuse.

With regard impact on the Exchequer, the French study indicates that 15.5 per cent of all social costs are borne by Government.

United Kingdom

Recent research in the UK has concentrated on the social costs of Class A drug use (crack, crack cocaine, heroin, and synthetics). [22] However, as Class A drug users give rise to the most severe productivity losses and medical costs, the estimates provided by this study are likely to comprise a very high proportion of the total costs of illicit drug use. The data in the study relate to England and Wales only. It is estimated

[20] Eric Single et al. The Costs of Substance Abuse in Canada. Canadian Centre on Substance Abuse, 1996

[21] P Feneglio et al. The Social Cost of Alcohol, Tobacco and Illicit Drugs in France, 1997. European Addiction Research, Volume 9, 2003.

[22] C.Godfrey et al. The Economic and Social Costs of Class A Drug Use in England and Wales, 2000. Home Office Research Study 249, 2002.

that the social costs of drug abuse in England and Wales in the year 2000 was £12bn (€19.7bn). This is the equivalent of 1.6 per cent of GDP. [23]

On a per capita basis, social costs amount to £6,564 (€10,765) for each Class A drug user and £35,456 (€58,148) for each problem drug user.

UK research also throws light on two important issues viz. the extent to which

- Problem drug users impose costs on the Exchequer; and
- Treatment of drug users reduces social costs.

With regard to the first issue, of the €58,148 of social costs imposed by each problem drug user, 29.3 per cent or €17,059 is imposed on the Exchequer.

With regard to the second issue, the UK research compares costs for problem drug users not in treatment and for those in treatment for less than and more than one year. The results indicate, for example, that those in treatment impose costs on the health service on average some 40 per cent below those imposed by those not in treatment. Cost savings are realised across the spectrum of health services – primary care, A &E, and in-patient care.

With regard to criminal justice costs, the savings are equally impressive. Those in treatment impose criminal justice costs on average 50 per cent below those not in treatment.

These figures indicate that there are significant immediate cost savings in terms of health and criminal justice costs when problem drug users receive treatment.

Australia

An estimate of the social cost of drugs is available for 1992 for Australia. [24] This indicates that the social costs of illicit drug use amounted to Aus$1.68bn in that year. This is equivalent to 0.4 per cent of GDP. Productivity losses amount to approximately 50 per cent of the total, with criminal justice costs the next most important at 27 per cent of the total. The Exchequer (in the form of the federal and state governments) is estimated to bear 29 per cent of the total costs.

5.3.3 Overview of Macro-economic Studies

Table 5.2 presents a summary of the estimates of the social cost of illicit drug use in the countries for which information is available. This indicates that social costs, as a proportion of GDP/GNP, vary considerable across countries from a low of 0.2 per cent to a high of 1.6 per cent.

[23] Or more precisely 1.6 per cent of Gross Value Added.

[24] D.Collins and H Lapsley. The Social Costs of Drug Abuse in Australia in 1988 and 1992. National Drug Strategy Monograph Series, No. 30, 1996

Table 5.2: The Social Costs of Drugs: International Comparisons

Country	Social Costs as a Proportion of GDP (%)	Year
USA	1.5	2000
Canada	0.2	1992
France	0.2	1997
England and Wales	1.6	2000
Australia	0.4	1992

Source: Collated by Goodbody Economic Consultants

It is not clear why the social costs vary so much, however a number of explanations may be offered:

- The extent of the drug problem may differ across countries and over time. It is noteworthy in this regard that the higher estimates (UK and USA) are in respect of a more recent year;
- The methodologies employed may differ. This is particularly the case for the measurement of productivity losses, which form a high proportion of total costs;
- The coverage of costs may differ. For example the estimates for England and Wales embody a particularly exhaustive examination of criminal justice costs.

Apart from the scale of costs, some other conclusions may be drawn:

- Productivity losses account for the largest share of total costs, with criminal justice costs next in importance;
- A considerable proportion of total costs are borne by the Exchequer – ranging from 15.5 per cent in France to approximately 29 per cent in both England and Wales and Australia; and
- When drug users enter treatment, the costs they impose reduce significantly.

5.3.4 An Irish Cost Estimate

The above studies show considerable variation in methodology, coverage and valuation of parameters such as the value to be placed on loss of life. It is also clear that such studies require the collection of a range of data, not all of which are readily available. Accurate estimation of the social costs of drugs in an Irish context would thus require a number of data collection exercises to be put in place. As a result, such an estimate lies outside the scope of this study.

5.4 Conclusions

LDTF projects are dominated by those involving treatment and rehabilitation and education and prevention. It is therefore crucial to establish whether such interventions are effective and efficient.

In recent years, an increasing number of studies have attempted to assess the costs and benefits of different drug treatment regimes. While methadone maintenance has been the treatment most subject to analysis, in-patient and out-patient drug free approaches and social model treatments have also been analysed

The economic return from treatment as measured in these studies has usually been couched in terms of the ratio of discounted benefits to discounted costs or the benefit-cost ratio. A benefit-cost ratio in excess of unity indicates that treatment has a net positive economic benefit after costs have been taken into account.

The available studies have reported very high benefit-cost ratios, in the range of 2 to over 20, for drug treatment. All types of treatment recorded strongly positive cost-benefit ratios.

Initially, evaluations of drug prevention initiatives were concerned with establishing whether such initiatives had positive impacts on drug use. The initial findings of research were not encouraging in this regard. However, more recent analysis, which has focused on the different types of drug prevention programmes, has concluded that programmes using an interactive approach, which applies social influences, have proved to be efficacious.

There is evidence that well-designed school based prevention programmes yield benefits at least twice the level of costs. Most of the benefits are in terms of reduction in alcohol and tobacco use, but benefits still exceed costs even if drug use only is reckoned. Prevention schemes are value for money not because the benefits are high but because the costs are very low. Given the modest level of benefits achieved the contribution of this type of initiative to alleviating the drug problem as a whole is limited.

Analysis of the burden that drug use imposes on society indicates that social costs, as a proportion of GDP/GNP, vary considerable across countries from a low of 0.2 per cent to a high of 1.6 per cent. Productivity losses account for the largest share of total costs, with criminal justice costs next in importance. A considerable proportion of total costs are borne by the Exchequer – ranging from 15.5 per cent in France to approximately 29 per cent in both England and Wales and Australia. When drug users enter treatment, the costs they impose reduce significantly.

6. Effectiveness, Impact and Relevance of the LDTF Programme

6.1 Introduction

This Section of the report seeks to establish the effectiveness, impact and continuing relevance of the LDTF Programme. To assess the Programme's effectiveness, it is necessary to establish whether it has largely achieved the objectives set for it. This is done by:

- An evaluation of the relevance of LDTF measures and actions to the objectives and goals of both the National Drugs Strategy and the LDTF process itself and rate of successful implementation of such measures; and

- An assessment of findings from the case studies of particular LDTFs and the interviews undertaken with Task Force Co-ordinators. [25]

The ultimate impact of the LDTF Programme is then assessed through an examination of data on LDTF areas that would throw light on the extent to which treatment levels have progressed and harm reduction and other effects have altered in the period since the commencement of the LDTF process in 1997 and 2003.

Finally, there is a need to consider whether the LDTF Programme continues to be relevant as a means of combating the drug problem.

6.2 Objectives of the LDTF Programme

Any analysis of the effectiveness of the LDTFs must be predicated on the objectives set for them. In this regard, it was recognised that the LDTFs were part of the National Drugs Strategy. The LDTFs were set three specific short-term goals viz. to:

- Develop an appropriate range of responses to drug misuse

- Significantly upgrade the level of drugs services in their areas; and

- Involve local communities in this work.

In particular, the LDTFs were seen as a vehicle through which local communities would become receptive to the establishment of local treatment and rehabilitation facilities and become involved their provision. The establishment of local facilities and the involvement of the community would also encourage drug users to embrace treatment, thereby bringing significant benefits in terms of harm reduction for drug users and their families and reductions in crime levels for society as a whole.

The National Drugs Strategy is built on the four pillars of education and prevention, treatment and rehabilitation, supply control and research. The Strategy sets out a number of objectives under each of these headings. One measure of the

[25] The extent to which effectiveness can be established has been limited by the lack of hard quantitative data available on targets, outputs and impacts. In relation to projects providing direct drug treatment related services, no standardised data on number of clients using these services is available. These difficulties are further compounded when one looks at projects that provide services, which only indirectly impact on the local drug problem. For example, significant funding has been allocated to the provision of alternative activities for young people at risk of drug abuse, to train community representatives in drugs awareness and to educate school children in general on the dangers of drug abuse. No mechanisms would appear to be in place to attempt to measure the impact of such initiatives on the target groups involved.

effectiveness of the LDTF Programme is the extent to which it contributes to these objectives.

6.3 Relevance and Successful Implementation of the LDTF Measures and Actions

The data presented in Section 4 indicated that the Education and Prevention and Treatment and Rehabilitation pillars of the National Strategy form the dominant themes of the LDTF measures. Education and Prevention is a theme for 54 per cent of all measures and treatment and rehabilitation for 33 per cent under Round 1. Section 3 highlighted the fact that €20.2m or 83 per cent of Round 1 initial and interim funding went to measures with these themes. Thus, there was substantial congruence between the LDTF measures and two of the pillars of the National Strategy.

The LDTFs played a much less prominent role in addressing measures under the other two themes. Only 3.6 per cent of Round 1 measures have supply control as their theme, accounting for €0.5m or 2 per cent of initial and interim funding allocations. This is not too surprising an outcome, as it is more difficult to structure projects in this area and involvement carries risks for community participants. Of somewhat more concern is the low level or research activity associated with the measures. Only 3.6 per cent of Round 1 measures had research as a theme accounting for €0.4m or 1.6 per cent of initial and interim funding. These figures understate the level of research attributable to the LDTFs as a whole, as significant research was undertaken by the LDTFs in drawing up their strategic plans. However, one of our findings, as set out in Section 7 below, is that the LDTF Programme as a whole needs to devote more resources to researching and monitoring the underlying drug problems and drawing out the policy and good practice lessons from the whole process.

It is evident that the LDTFs achieved a high success rate in getting measures off the ground. Only 11 per cent of Round 1 measures had their funding reallocated or withdrawn, falling to 4.4 per cent for Round 2 measures. The measures were also very heavily focussed on establishing new projects or new activities under existing projects, building on available community infrastructure. Forty-five per cent of Round 1 measures were in respect of new projects, while another 23 per cent were new activities. This supports the view that the LDTFs encountered considerable success in achieving one of the short-term goals viz. developing the range of responses to drug misuse. It also reduces the possibility that the LDTF funding simply replaced other funding sources, a view supported by the fact that 63 per cent of Round 1 projects and an even higher percentage of Round 2 projects were wholly funded from the LDTF.

The broad conclusion is that LDTF measures have been strongly focussed on National Drugs Strategy themes of education and prevention and treatment and rehabilitation, that a high degree of success in implementing measures was achieved and that the bulk of the measures supported new projects or activities.

6.4 Effectiveness: Evidence from the Case Studies and Interviews with Key Actors

6.4.1 Introduction

This study evaluated the effectiveness of the LDTF Programme through interviews with key actors and through four in-depth case studies of LDTF areas. The latter involved the collation of documentary evidence, interviews with stakeholders, and assessments of individual projects. As part of the latter, recipients of the services of the projects were interviewed. While some quantitative data were available, the assessment of the consultants as set out below had to rely largely on informed judgement.

Using the NDST strategic objectives, the extent to which LDTFs have assisted in achieving these objectives can be gauged. In elaborating the effectiveness of the LDTF Programme below, reference is made to the data gathered in the case studies by way of illustrating the points made.

6.4.2 Objective 1: Supply Reduction

The number of measures aimed at this objective were few and the financial allocations modest. Nevertheless, the Community Policing Forum project initiated in the North Inner City Task Force is an example of a particularly effective project that has mitigated the impact of dealing on the local community.

The work of the Task Force with local communities has reduced the extent to which open drug dealing is a normal occurrence within specific parts of the areas concerned. This in turn has reduced access to such drugs by young people in these areas.

This is because Task Force working processes have

- Significantly improved the level of trust between local communities and an Garda Síochána;
- Increased co-operation between local communities and Gardaí;
- Provided a forum whereby drug supply issues arising in the community can be addressed;
- Helped focus Garda resources on the problem; and
- Introduced an element of Garda accountability to and partnership with the local community.

However, the issue of the resources available to the Gardaí to combat local drug dealing in these areas needs to be addressed. Work carried out by Task Force funded community development workers, such as in the flat complexes in the Canal Community area, has highlighted the need for more resources in this area to support community based actions and initiatives.

6.4.3 Objective 2: Prevention

Objective 2a: Creating greater social awareness about the dangers of drug misuse

As was demonstrated in Section 3 of this report, the LDTF has invested significantly in a wide range of education and prevention measures aimed at raising awareness of the dangers of drug abuse. Such programmes have been run in schools and community centres for the benefit of children, young people and parents. The Awareness FC project in the Finglas/Cabra Task Force area has been very successful in increasing local children's awareness of drugs and drugs related issues as well as combating misinformation regarding drugs. There is a widespread perception that such actions have been partly responsible for the reduction in new heroin users in these areas, as better-informed younger siblings of drug users choose not to experiment with heroin.

Such awareness is also seen to have given local parents, teachers and community representatives a greater understanding of the early signs of drug misuse and has supported them to take action aimed at reducing the number of young people experimenting with opiates. The results of this work are evident, for example, in the flat complexes in the Canal Community area where community development workers, funded by the LDTF and since mainstreamed, have helped to empower local communities within these areas to counter the high level of open drug dealing within these estates.

Objective 2b: To equip young people and other vulnerable groups with the skills and supports necessary to make informed choices about their health, personal lives and social development.

Some 42 per cent of Task Force funded projects have targeted young people and others at risk to assist them in maintaining drug free lives. Such supports have included funding of after-school programmes, alternative activities for young people in their area through youth clubs, as well as support for youth workers to work with young people and to develop relevant training and education programmes. For those most at risk, outreach and drop-in facilities have been funded which encourage such young people to explore alternative life styles and to ensure that they are well informed of the effects of drug misuse. The effect of this type of work can be seen in the After Schools Education Support programme in the North Inner City area where after school support is offered to children aged 7-9 years in the Sheriff Street area in the form of homework supervision, indoor and outdoor pursuits and creating awareness regarding drug abuse and anti-social behaviour. It can also be seen in the Canal Communities area where the Inchicore Community Drugs Team have developed an outreach service for young people most at risk of drug misuse. Such outreach work encourages young people to participate in other services provided by the Drug Team and to consider more positive personal and career goals.

6.4.4 Objective3: Treatment

Objective 3a: To encourage and enable those dependent on drugs to avail of treatment …. with the ultimate aim of leading a drug free life style.

A key change that has occurred in the period since the LDTF Programme commenced is an increase in the availability of treatment, and particularly, methadone treatment services in local areas. The LDTF programme has played a significant role in this process. By involving the local community in a partnership with

the statutory agencies, the LDTFs have contributed to the establishment and increased use of treatment centres through:

- Increasing understanding in the community of the nature of the drug problem;
- Overcoming fears that the community might have in relation to the establishment of treatment centres in their areas;
- Increasing the level of trust between the community and the Health Boards; and
- Encouraging drug users to avail of the treatment facilities available.

These outcomes have been documented in the case studies undertaken and supported by the statistics available of numbers in treatment (See Section 6.6 below). For example, the Community Policing Forum in the North Inner City, CASP in Clondalkin and the Inchicore Drug Team in Canal Communities have made significant progress in breaking down local resistance to their services. Local community representatives are now actively engaged with these projects and support their work within the local area. Participants on the programmes spoke highly of the effectiveness of the service provided in stabilising their drug misuse and assisting them in the recovery process.

Task Force funding has in particular underpinned the development of a range of supportive therapies for those stabilised on methadone, and supported such drug users to remain stable and to consider other long term changes they might make in their lives.

In addition to this, Task Force funded projects have provided much needed supports for the children and families of drug users. Provision of services for children is seen as particularly important in encouraging stabilised drug users to "normalise" their lives, as it requires the self discipline of bringing children to the crèche or other services on a regular and timely basis. Cumas in Clondalkin is an example of the type of specialist services that have been provided for the families of drug users – their parents, siblings and children. Participants on Cumas programmes emphasised both the practical supports they received, which helped them to obtain legal and financial support for their grandchildren, and of the emotional and peer support which has helped them to cope with the problems which drug misuse in their family have created. Cumas and Inchicore CDT both also provide childcare services for the children of drug users. Such services are considered to have very positive effects on the social, personal and educational development of these children, helping them cope with the stigma of drug misuse and also to get on with the rest of their lives.

A number of "Drug Free" workers have been appointed under Round 2 to already established projects. However, overall, limited funding has been made available to support movement to a drug free life style. There are significant differences of opinion regarding the potential for such drug users to achieve drug free lifestyles and on the relative merits and dangers of detox programmes.

Some stakeholders are of the view that methadone is the only effective treatment for most drug users and that long term dependence on methadone is compatible with a relatively "normal" life style. Others see long term methadone treatment as problematic and consider that alternatives should be more widely available. In their view, more supports should be in place to encourage the development and implementation of long-term individual plans to become drug free. Most of those consulted in the course of the study would support the development of more options around treatment and rehabilitation of drug users.

Much greater research and debate would appear to be needed in this area. An added complication is the growing use of cocaine either as an alternative to heroin or in association with other drug use. Poly-drug use, including prescribed drugs and alcohol, is also seen as a growing problem. These drug use patterns cannot be dealt with as effectively through the medical methadone model. Again further research and debate is required in this area.

Object 3b: To minimise harm to those who continue to engage in drug taking activities.

Task Force projects place considerable emphasis on minimising the harm of drug abuse. They recognise that most addicts will work through a cycle of relapse and crises before they become fully stabilised or drug free. Supports are in place to assist drug users to go through this process, such as counselling, after care, and alternative therapies. There is also an increasing focus on providing both basic and specialist health services to drug users, including access to dentists, GPs, psychologists and to specialist HIV and Hepatitis C clinics. Needle exchange centres are increasingly accepted within local communities, facilitated by the work the Local Drugs Task Forces have done to convince local communities on the benefits of such facilities. Both CASP in Clondalkin and Inchicore CDT in Canal Communities would be good examples of services that have been funded by the Task Forces to provide an increasing range of services to drug users and ex-drug users to support them in the long process of rehabilitation and recovery.

A further focus of Task Force measure is on supporting drug users' families who are often highly stigmatised within their local communities – at least one in six measures have such a family support objective. Many projects work to support such families to achieve and maintain "normal" lives and in this way to reduce the knock on effects of drug misuse within the family. For instance, the Community Development workers in the flat complexes, Cumas in its Family Support Centre, and the Community Policing Forum in the North Inner City all work to ensure that the families of drug users are not driven from their homes through supporting them in their dealings with the housing authorities and in providing a greater understanding of their situation among local residents.

6.4.5 Objective 4: Research

Our review indicates that there have been relatively few measures in this area with very modest financial allocations. While a number of research projects have been carried out aimed at examining the factors involved in drug misuse these have to date been very local involving small numbers and consequently it has proved difficult to extrapolate from these results in any meaningful way. Further large-scale, cross-drug force research is therefore required.

However, it should be noted that the small scale research projects carried out for instance in the Canal Communities, Clondalkin, Finglas/Cabra and North Inner City areas have provided much needed information on the profile of drug use and drug users and on how this profile is changing over time.

In relation to data on the extent of drug misuse, some figures are available. However, such figures are fragmented and do not provide a comprehensive or coherent picture of the situation on the ground. Drug prevalence statistics are available but they do little to indicate trends in drug misuse. Available statistics primarily relate to those on methadone and related treatments. Again large-scale surveys would seem to be required in order to establish a comprehensive baseline position from which trends can later be drawn. This in turn will require agreement from all the key actors

involved - doctors, other service providers, and drug users to co-operate in collecting the necessary data.

6.4.6 Objective 5: Co-ordination

The Task Forces appear to have been effective fora for ensuring co-ordination of local services in the drug related area. The extent of co-ordination in each Task Force area is seen by the stakeholders interviewed in connection with this study in the case study area to be largely influenced by the individual representatives on the Task Force – their interest, their knowledge, and their power to influence decisions within their parent organisations.

Cross Task Force co-ordination would appear to be an area where only limited efforts have been focused to date. More cross task force co-ordination would help to ensure the development of best practice, to minimise duplication, and would facilitate the provision of difficult - to - provide services, such as after hours services and night time outreach. Discussions are currently being held in South Dublin on how such services can best be provided across the relevant Task Forces areas. Such co-ordination could be considered in other areas, for example, in relation to the development of training programmes, school-based supports, and awareness raising activities.

6.5 Impact of the LDTF Programme

6.5.1 Introduction

As indicated above, performance indicators for the LDTF Programme have not been developed, at either the project, area or programme levels. Particularly lacking are any comprehensive large-scale surveys of the prevalence of drug use within the LDTF areas.

This meant that area-based data had to be assembled specially for this study. A number of sources and indicators were considered for this analysis. These were:

Indicator	Source
1. The number of drug users treated	The Health Research Board
2. The number of persons on methadone treatment	The Eastern Regional Health Authority
3.The number of persons treated for drug-related illnesses	Department of Health and Children/ESRI
4.The number of drug related offences	An Garda Síochána
5.The number of drug related deaths	General Mortality Register, CSO
6. The number of drug related infectious diseases	National Disease Surveillance Centre

It is only in regard to the first two indicators that data proved to be available by District Electoral Division and thus capable of aggregation to Task Force area level. With regard to the number of persons treated for drug related illnesses, the data are available at postal code level only. In relation to drug related offences, Garda district is the lowest level at which data are available. Drug related deaths are available at county level only, while data relating to the number of drug-related infectious diseases is available on a Health Authority level basis.

6.5.2 Persons in Treatment in LDTF Areas

In 1998, to control the prescribing and dispensing of methadone, the Methadone Treatment Protocol (MTP) Scheme was launched. Under the Scheme each patient is registered with a named general practitioner (GP) and a designated community pharmacy. A central confidential database of all patients receiving methadone, referred to as the Central Treatment List (CTL), is maintained by the Eastern Regional Health Authority on behalf of the Department of Health and Children. Once entered on the central register, each patient receives a laminated card with the patient details including a photo ID. The card also lists the name and address of both the prescribing GP and the dispensing pharmacist. The card is held at the pharmacy and only this pharmacy can dispense methadone to the client. Only one nominated GP can prescribe methadone for the registered client. Under the Methadone Protocol only doctors who have been specially trained and accredited by the health board can prescribe methadone. Table 6.1 outlines the number of clients, for each Local Drug Task Force area in Dublin, on the Central Treatment List (CTL) over the period 1997 – 2003.

Table 6.1: Number of Clients per Task Force Area in Receipt of Methadone Treatment, 1997 – 2003

Task Force Area	1997	1998	1999	2000	2001	2002	2003
Ballyfermot	221	285	314	335	356	379	387
Ballymun	211	327	379	417	450	468	496
Blanchardstown	69	134	172	194	207	218	264
Bray	29	48	68	81	114	115	122
Canal Communities	124	163	184	226	252	257	267
Clondalkin	208	327	373	463	567	563	597
Dun-Laoghaire-Rathdown	197	262	292	346	397	434	481
Finglas/Cabra	195	264	287	345	425	473	486
Dublin 12	202	256	260	345	389	411	427
North Inner City	547	678	735	815	905	961	988
Dublin North East	167	238	353	419	472	476	521
South Inner City	463	561	618	724	800	834	857
Tallaght	285	388	414	463	564	648	672
Total	2,918	3,931	4,449	5,173	5,898	6,237	6,565
% annual change		34.7	13.2	16.3	14.0	5.7	5.3

Source: Special Analysis of the Central Treatment List

For Task Force areas as a whole, the number of persons in receipt of methadone treatment more increased from 2,918 in 1997 to 6,565 in 2003 – a more than doubling of treatment levels. The rate of increase in numbers treated was particularly rapid in the period up to 2001, but now shows signs of slowing down. Substantial increases have been recorded across all LDTF areas. [26] A feature of the results is that numbers in treatment increased most rapidly in LDTF areas where numbers were initially low. This most probably relates to the initial lack and subsequent development of local treatment facilities.

[26] It is not possible to extract the number of new cases from this data source.

The National Drug Treatment Reporting System operated under the Health Research Board provides data on the extent to which problem drug use in Ireland is treated. The data gathered are regarded as a direct indicator of demand for treatment services. Where supply of such services has been constrained, as was the case in Ireland certainly in the early years of the LDTF programme, the data can also be an indicator of the extent to which demand is being met. It should be noted that the data provided are based on returns made by treatment facilities and GPs and are subject to under-reporting as a result, and that clients who attend needle exchange services are excluded. The totals are not directly comparable with those on methadone treatment for these reasons.

The data of Table 6.2 indicate that the total number of cases in treatment rose by 23 per cent in the period 1998 to 2002. Again, there was a tendency for areas with initially low numbers of persons treated to grow more strongly.

Table 6.2: The Number of Cases Attending Treatment in Each Task Force Area, 1998-2002

Task Force Area	1998	1999	2000	2001	2002	% change, 1998-2002
Cork	248	280	437	543	604	143.5
Ballyfermot	255	298	206	214	218	-14.5
Ballymun	400	329	381	417	292	-27.0
Blanchardstown	166	140	186	146	155	-6.6
Bray	22	20	66	130	114	418.2
Canal Communities	230	177	247	225	290	26.1
Clondalkin	393	467	422	524	493	25.4
Dun Laoghaire-Rathdown	191	286	308	321	378	97.9
Finglas-Cabra	279	234	286	339	364	30.5
Dublin 12	289	280	368	319	358	23.9
North Inner City	695	643	641	807	693	-0.3
Dublin North East	363	410	366	390	385	6.1
South Inner City	499	551	543	588	712	42.7
Tallaght	439	503	443	376	428	-2.5
Total	4,469	4,618	4,900	5,339	5,484	22.7

Source: special analysis undertaken by the NDTRS; refers to cases residing in each area.
Note: There is potential for some double counting due to the fact that some cases may present in more than one area.

The number of new cases arising in each year is useful indicator of the extent to which the drug misuse problem is on the increase. Table 6.3 shows that between 1998 and 2002, the number of new cases declined by 23 per cent. Four Task Force areas – Cork, Finglas-Cabra, Dun Laoghaire-Rathdown – showed an increase, with most of the remainder recording a decline of between one-third and one-half. With regard to Finglas-Cabra, a factor may have been the relatively late development of treatment facilities in that area.

This data source also provides information on the type of treatment provided (see Table 6.4). As well as the rise in the numbers in treatment, there has been an increased tendency for such treatment to be provided on an outpatient basis or in the community through local GPs. Opiates continue to be the dominant substance abused. However, analysis of new cases presenting for treatment indicates a move

away from opiates to other substances most notably cannabis, ecstasy and cocaine (See Table 6.5).

Table 6.3: Number of New Cases Attending Treatment in Each Task Force Area, 1998-2002

Task Force Area	1998	1999	2000	2001	2002	% change 1998-2002
Cork	13	47	86	108	99	661.5
Ballyfermot	71	56	35	28	22	-69.0
Ballymun	85	74	35	45	28	-67.1
Blanchardstown	47	47	35	17	27	-42.6
Bray	7	4	7	40	14	100.0
Canal Communities	30	40	28	12	19	-36.7
Clondalkin	112	125	125	108	60	-46.4
Dublin 12	50	43	65	34	16	-68.0
Dun Laoghaire-Rathdown	35	48	47	66	91	160.0
Finglas – Cabra	49	46	37	57	56	14.3
North Inner City	112	92	75	65	52	-53.6
Dublin North East	85	122	70	53	49	-42.4
South Inner City	71	74	69	75	66	-7.0
Tallaght	93	94	78	60	53	-43.0
Total	931	986	861	843	718	-22.9

Source: Special analysis undertaken by the NDTRS

Table 6.4: Type of Treatment Attended by All Cases in Task Force Areas, 1998-2002

Type of Treatment	1998	1999	2000	2001	2002	% change, 1998-2002
Outpatient	3,563	3,443	4,044	4,660	4,903	37.6
Residential	711	669	398	352	309	-56.5
Low threshold	169	215	260	197	116	-31.3
General practitioner	24	285	198	130	151	529.1
Other	2	6	0	0	5	150.0
Total	4,469	4,618	4,900	5,339	5,484	22.7

Source: Special analysis undertaken by the NDTRS

Table 6.5: Distribution of All and New Cases in Task Force Areas by Type of Substance Abused, 2002

Type of Substance	Proportion of All Cases (%)	Proportion of New Cases (%)
Opiates	86.3	74.1
Ecstasy and other mdma	1.1	2.1
Cocaine	1.4	2.8
Amphetamines	0.0	0.3
Benzodiazepines	1.0	1.4
Volatile inhalants	0.4	0.5
Cannabis	9.4	18.4
Other	0.4	0.5
Total	100.0	100.0

Source: Special analysis undertaken by the NDTRS

6.5.3 Other Indicators

Other indicators are available at levels of aggregation above that of the DED only. However, as the Task Force Programme is largely focused on the Dublin area, indicators that are available at the Dublin county level or for other sub-areas such as postal districts are of value in determining trends in drug use and its effects. [27]

Drug Related Deaths

While the absolute number of drug–related deaths is subject to errors arising from misclassification of deaths, the trend in such deaths should nevertheless be an indicator of *changes* in the severity of the problem and the degree of harm engendered.

In 1997, the year in which the LDTF Programme commenced, the number of drug related deaths in Dublin County stood at 62. Deaths continued to grow to reach a peak of 87 in 1999, but fell sharply thereafter to 36 in 2003. Drug related deaths are now just under 60 per cent below their peak level, and over 40 per cent below their 1997 level. The value to the economy from a reduction in loss of life has recently been put at €2m per person (at 2002 prices)[28]. A crude estimate of the saving to the economy of the reduction in drug related deaths in the Dublin area from its peak in 1999 is therefore €98m per annum.

The trends in the Dublin area were contrasted with the situation in the rest of the country, which has seen deaths grow from low levels of 20 per annum in 1997 to 49 in 2003. While there is some evidence that drug deaths have stabilised in the rest of the country since 2001, the rapid decline experienced in Dublin has not occurred. No doubt there are many reasons for the disparity in performance as between Dublin and the rest of the country, not least the gradual spread of drug misuse from Dublin to other parts of the country. However, the progress made in Dublin is nevertheless impressive.

[27] It had been hoped to include data on drug related offences by Garda district, but these data were not forthcoming by the time of completion of this draft report.

[28] Cost Benefit Parameters and Application Rules for Transport Investments, Goodbody Economic Consultants, 2004.

Table 6.6: Number of Drug Related Deaths in the Dublin Area, 1997 – 2003

	1997	1998	1999	2000	2001	2002	2003
Dublin	62	73	87	85	50	49	36
Rest of Country	20	33	36	36	53	47	49
Total	82	106	123	121	103	96	85

*Figures for 1997-2001 are by year of occurrence and figures for 2002 & 2003 are by year of registration and are provisional. The drug related deaths analysed in Table are 'Drug Dependence (ICD code 304.0-9)' deaths and 'Non-dependent drug abuse (ICD code 305.2-9)' deaths.
Source: CSO, General Mortality Register

Newly Diagnosed Drug Related HIV Infections

Table 6.7 outlines the number of newly diagnosed HIV infections among injecting drug users over the period 1997 – 2003, as reported by the National Disease Surveillance Centre (NDSC). [29] It should be noted that these figures do not represent the numbers of people infected with the HIV virus in Ireland, but rather provide information on the number of new diagnoses in a given time period.

Table 6.7: Newly Diagnosed HIV Infections among Injecting Drug Users in the ERHA area, 1997-2003

	Unknown	ERHA	Non-ERHA	Total
1997	na	Na	na	21
1998	na	Na	na	26
1999	na	Na	na	69
2000	1	75	7	83
2001	0	31	7	38
2002	9	36	5	50
2003	0	43	4	47

Na: not available
Source: National Disease Surveillance Centre (NDSC)

The bulk of HIV infections among drug users occur in the Eastern Regional Health Authority area. There is evidence that HIV infections peaked in that area in 2000, when 75 diagnoses occurred and had fallen by over 40 per cent to 43 infections in 2003.

Drug Related Discharges from Hospitals

The Hospital In-Patient Enquiry (HIPE) system operated by the Department of Health and Children and Monitored by the ESRI provides data *inter alia* on the number of

[29] The National Disease Surveillance Centre (NDSC) is Ireland's leading specialist centre for the surveillance of communicable diseases. The centre was set up in 1998 conjointly by Ireland's eight Health Boards. Doctors report data on a voluntary basis to the NDSC. The data on drug-related infectious diseases such as HIV and Hepatitis C available from the NDSC can thus be used to provide an indication of drug use and risk behaviours.

discharges from acute public hospitals with a principal diagnosis of poisoning by opiates, sedatives, hypnotics, stimulants and psychotrophic agents. This data is in theory available on a postal district basis, but in practice confidentiality rules operated by the ESRI prevent an analysis at that level. Table 6.8 provides an overview of the data at ERHA and the rest of the country levels. By 2002, the level of drug related discharges from hospital in the ERHA area had declined by 25 per cent to 713 from a base level of 950 in 1997. Discharges were down 15 per cent on their peak level of 844 in the year 2000. Once again, the ERHA area fared better than the rest of the country, where, at best, drug related discharges have stabilised.

Table 6.8: Number of Discharges from Acute Public Hospitals with a Principal Diagnosis of Poisoning by Opiates, Sedatives, Hypnotics, Stimulants and Psychotrophic Agents,

Health Board Area	Year					
	1997	**1998**	**1999**	**2000**	**2001**	**2002**
ERHA	950	825	803	844	732	713
Rest of Country	1,620	1,599	1,608	1,747	1,769	1,674
Total	2,570	2,424	2,411	2,501	2,501	2,387

Source: ESRI

6.6 Overview of Effectiveness and Impact

Establishing the effectiveness and impact of the LDTF Programme in a definitive manner is very difficult. This is not only because of the lack of data on the outputs of the Programme, but also because of the difficulties in disentangling the effects of the Programme from other elements of the National Drug Strategy. For example, a key beneficial change that has occurred since 1997 is the expansion in the number of locally based treatment centres and in the range of therapies offered. This is the result of the actions of the health boards in conjunction with the local community supported by LDTF measures. It is not possible to attribute the success of this policy to any of these elements separately.

However, it is considered that the LDTF Programme has been very effective for a number of reasons:

- A large number of measures have been implemented to address the drug problem at the local level;
- This has resulted in many new community projects and new activities being put in place;
- The measures adopted have been highly relevant to the objectives set for the National Drug Strategy;
- The measures have largely focused on activities such as education and prevention and, particularly, treatment and rehabilitation that have been shown to be effective abroad;
- The fact that LDTF funding has delivered new projects and activities with regard to treatment and rehabilitation is especially noteworthy, as international research

indicates that the costs to society of drug abuse are very high, and that there are immediate and substantial savings to the economy when drug users enter treatment regimes;

- There is clear evidence of higher levels of trust emerging between local communities and the statutory agencies concerned with drug abuse. As the LDTF Programme is a major vehicle for contacts between the community and the statutory agencies, it is likely to have been instrumental in effecting this change.

- The numbers of persons in LDTF areas in receipt of methadone and other treatments rose rapidly in the years immediately after the establishment of the LDTF Programme. A higher proportion of drug users is now been treated locally.

- More recently, the number of new cases attending treatment in LDTF areas has been declining.

- The focus of the LDTF Programme is on the Dublin area, and drug related deaths, drug related HIV infections, and discharges from hospitals of patients with drug related illnesses have all reduced significantly in the Dublin area in the post 2000 period.

6.7 Continuing Relevance of the LDTF Programme

While it is considered that the LDTF Programme has been effective, there is still a need to consider whether it continues to be relevant going forward. This issue is determined by a number of factors:

- The extent to which there is continuing to be a drug problem that must be addressed;

- The appropriateness of an area and community based response to the problem;

- The feasibility of continuing to implement such a response; and

- The relative efficiency of the LDTF Programme.

With regard to the first issue, it is clear that considerable success has been achieved in addressing the drug problem in the Dublin area in particular. However, it is also clear that much remains to be achieved. While the number of persons on methadone treatment has increased, there is as yet little evidence of substantial success in increasing the numbers of persons who remain drug free. In addition, the extent of abuse of cocaine is apparently on the increase, while few persons are as yet presenting for treatment for this addiction. Moreover, treatment of cocaine abuse will be more complicated than that for opiates requiring the use of a range of therapies, which could be effectively delivered in a community setting. Families and local communities continue to need support to cope with the ongoing realities of drug misuse. An area and community based response would seem to hold an number of advantages from the point of view of encouraging cocaine abusers to access treatment and developing and a piloting a range of therapies.

The key concerns surround feasibility and efficiency. With regard to feasibility, there is a widely held view that the energy and capability of the community to engage in drug interventions is subject to limits. This indicates that relatively realistic targets for the LDTF Programme should be set going forward. The remaining issue of ensuring that the LDTF constitutes an efficient response and one which provides value for money is taken up in the next section of this report.

7. Efficiency of the LDTF Programme

7.1 Introduction

This section of the report examines the efficiency of the LDTF in terms of value for money or the extent to which the benefits of the Programme exceed the costs.

The benefits of drug intervention measures are difficult to fully capture for a number of reasons viz.

- Some of the benefits do not accrue for a number of years;
- Others begin to accrue immediately, but are long lived;
- The benefits encompass impacts other than those on drug abuse; and
- The benefits do not accrue solely to drug users and their families

Because of this, very structured studies are required to establish the cost-benefit of drug interventions, and these have not been undertaken in the Irish context. We reviewed the international experience of such studies in Section 5 of the report and in this section consideration is first given as to how that international research informs a view as to the efficiency of the Programme. Next, the processes of the LDTF Programme are reviewed to identify factors that have contributed to overall efficiency and those that have militated against it.

7.2 Evidence from International Research

In Sections 3 and 4, it was established that both Programme measures and expenditures were dominated by measures aimed at treatment and rehabilitation and education and prevention. In Section 5, it was established that:

- Drug interventions aimed at treatment and rehabilitation exhibit a very high cost-benefit return, largely because the benefits to society in terms of reduced productivity losses and costs of crime are very large. Moreover, significant benefits accrue once drug users enter treatment.
- Well-structured drug interventions aimed at education and prevention also have high cost-benefit ratios, and this is primarily because they have low costs.

These factors would argue for the view that measures adopted under the Programme have a high cost benefit return.

7.3 The Task Force Process and Programme Efficiency

7.3.1 Factors Effecting Efficiency

The consultations and case studies undertaken for this study have identified a number of strengths and weaknesses in the Task Force process that impinge on efficiency. Positive and negative factors that have been identified as likely to have had an effect on cost effectiveness are outlined below.

Positive Factors

The extent of voluntary participation in the Task Force process and on the management committees of projects.

The case studies have shown the high level of voluntary and community involvement on the Task Force itself and on the management committees of individual projects. For instance local community and voluntary representatives, including service users, participate in the management committees of the Community Policing Forum in the North Inner City, CASP in Clondalkin, the Inchicore Community Drug Team and Cumas. Such participation involves attendance at management committee meetings and sub committees and participation in review days, as well as an involvement in other local organisations and meetings with service providers and funders.

The high level of time inputs delivered by project staff, many working in the evenings, at weekends.

For instance CASP and Inchicore CDT are involved in evening based outreach activities and home visits, while the Community Development Workers in the flat complexes in Canal Communities attend a wide variety of evening and weekend meetings with the local community. The SNUG Counselling and Information service in the North Inner City also provides advocacy, home/off-site visits, family support and crisis intervention services to its clients, many of which are provided outside normal nine-to-five hours.

The responsiveness of community based projects to clients changing needs, backed up by Interim Task Force funding, and the allocation of 2nd Round Task Force funding in the main to the enhancement and development of existing projects thus reducing the extent to which such additional funding is needed for administrative costs and overheads.

The case studies have highlighted how Task Force funded projects have evolved over the period since 1997. In particular an analysis of Round 2 projects in Clondalkin and Canal Communities clearly shows how projects have used Round 2 funding to expand the range and reach of their projects. Examples of this are the appointment of specialist childcare workers, outreach workers, drug free workers and prison links workers. Furthermore an examination of Task Force funded treatment centres in Clondalkin and Canal Communities clearly shows how they have developed their services to meet the growing needs of poly drug users and cocaine users for example through the provision of complementary therapies – and also have provided increasing supports for the families of local drug users.

The relatively low costs of prevention measures which harness "captive" audiences in schools, youth clubs and community groups.

An analysis of the Case Study Task Force areas clearly shows how preventive measures have focused on providing drug awareness programmes in local schools, youth clubs and in local community centres and in harnessing existing arts based initiatives to help put over the anti drugs message. Awareness FC in the Finglas/Cabra Task Force area has been particularly successful in implementing its drug awareness programme in all primary schools in the area. The programme is currently being extended to secondary schools in the Finglas/Cabra area.

The way in which treatment services are being developed to provide a range of options to clients within the same premises.

As referred to above, Task Force funded treatment services operate a holistic service. Projects like CASP and Inchicore CDT provide ongoing and long-term support to local drug users in a "one stop shop" type setting where local clients can access methadone treatment, counselling, group therapy, complementary therapies and after care support.

The increasing focus on provision of childcare and family based supports within treatment projects thus enabling all those most affected by drug misuse to benefit from such services.

Round 1 projects that are now mainstreamed are developing a range of supports for children and other family members of drug users. For instance, in Inchicore CDT specialist childcare services are provided on site to enable clients to participate in counselling sessions and group therapy and also, in time to access more mainstream education and training programmes. The obvious benefits that accrue to such children from participating in the childcare projects also work to reinforce their parents commitment to stabilising their lives and planning a life beyond drugs.

The way in which participation on the Task Force has encouraged more positive community/state agency interaction and has helped to break down community resistance to local based drug treatment services.

The four Case Study areas provide concrete examples of how the Task Force process has enabled locally based drug treatment facilities to be provided in the heart of the affected communities and has lead on to a situation where local community representatives are actively engaged in promoting these projects. This can be seen, for example, in the case of CASP and Inchicore CDT.

Negative Factors

Factors that are likely to have had a negative effect on cost effectiveness include:

Lack of professional organisational skills and experience among projects.

Given the ethos surrounding Task Force funded projects, most have a high level of community and voluntary involvement. Such participants while obviously having strong and vital community linkages, often have little in the way of formal training and or experience in managing an organisation and in supervising and supporting staff. This, in turn, can lead to a situation in which the respective roles of the management committee and of the co-ordinator/staff are blurred and where there are few formal policies and procedures in place for the day to day running of the project. Such situations can adversely affect the efficiency which projects are run and can result in high levels of staff turnover as well as weak project planning, management and monitoring systems. Such issues have been identified in a number of the mainstreaming project evaluations.

Difficulties within projects in establishing, maintaining and learning from proper financial, monitoring and review systems.

The case studies, supported by the interviews with mainstream funders and Task Force members, highlight the lack of quantitative information available on the outputs and outcomes of the funded projects. This finding is further supported in the mainstreaming evaluations. While progress in this area is being made, it is being hampered by a lack of specialist support as well as by the lack of time and resources available within projects to carry out this work. The Cumas, CASP, Inchicore CDT, Millennium Carving and SNUG Counselling and Information service case studies provide clear evidence of the lack of such information and the adverse effects of this

situation on attempts to plan, manage and evaluate both Task Force and mainstream funded projects.

Difficulties at Task Force level in supporting the work of the projects and in deriving models of good practice.

Discussions with Task Force co-ordinators and with Task Force members have highlighted the low level of resources available to the Task Force to formally monitor and evaluate the projects that it is funding. While efforts have been made to address this situation by a number of the projects, to date, most have been unable to allocate adequate resources to develop or implement proper monitoring and evaluation systems. Concerns have been expressed as recorded in the case studies, regarding the impact of this situation on the ability of funders to adequately account for their expenditure. The Task Forces have called for the appointment of Development Workers to support co-ordinators in this area and also for advice and direction on this area from the NDST.

Turnover in Task Force Co-ordinators and the lack of back-up staff to maintain services during periods when no co-ordinator was in place.

As referred to above, a number of Task Forces have experienced periods when no co-ordinator was in place, due to delays in the recruitment process. This has had the effect, in some instances, of seriously damaging the extent to which Task Forces were able to perform their functions, at least on a temporary basis. For example, the Finglas/Cabra co-ordinators position was left vacant for approximately one year following the drawing up of the second Finglas/Cabra LDTF plan. Strategies to retain Task Force co-ordinators and to ensure speedy replacement when staff leave would lead to efficiency improvements in this area.

Lack of mechanisms to share the learning, resulting in potential for duplication overlap, reinventing the wheel, and repeating mistakes.

One of the potential dangers of locally based initiatives is that they can result in a situation whereby similar initiatives are developed and tested in a number of different areas without any of the areas being able to profit from the experience of others. One way of addressing this potential problem is to develop mechanisms for sharing experiences and best practice across the local areas involved. In the case of the Local Drugs Task Forces there would appear to be very limited interaction across the Task Force areas to date and little or no resources available to support cross-task force initiatives or networking. This is likely to have had a negative effect on the overall efficiency of the Programme.

Improving Existing Levels of Efficiency

Existing levels of efficiency could be improved in a number of ways. These would include the following:[30]

- Establishment of clearer reporting relationships and related monitoring systems between projects, funders and Task Forces;

- Development of standard monitoring templates to be used by projects to monitor progress against agreed plans;

[30] The need for many of these changes was recognised in the Burtenshaw and NDST Reviews and the NDST is currently giving consideration to implementation of a number of them.

- Access to the required level of annual funding to meet the core costs of mainstream projects and a review of related programming costs;

- Access to resources at Task Force level so as to improve supports to projects, to draw greater learning from the projects, and to undertake more detailed evaluation of the drug problems in their local area.

- Access to resources to encourage greater cross Task Force and cross project networking and learning, including provision for cross task force projects (e.g. outreach services) and for interaction with wider drug-related initiatives;

- Development of stronger evaluation processes in relation to future mainstreaming decisions, backed up by good monitoring data on process/outputs including performance indicators, and by mechanisms aimed at ensuring that weaknesses identified in the review process are addressed.

- Carrying out of long-term follow up surveys of clients to better establish project outcomes and factors that influence successful outcomes

- Allocation of resources to research and analysis at NDST level to derive high-level policy analysis, conclusions and directions from the LDTF process.

The Department of Community, Rural and Gaeltacht Affairs, in co-operation with other relevant Departments, is implementing measures to improve focus and cohesion across community and local development initiatives. The core objective of the cohesion process for 2005/2006 is the alignment of local, community and rural development organisations to achieve full city/county coverage by the end of 2006. The current process builds on the improvements in linkages, cohesion and sharing of resources achieved during the 2004 round. Partnership companies are expected, under the current round of funding, to further strengthen linkages with/supports to community-based projects, including Local Drug Task Forces, in their areas. In this context, the cohesion process provides real opportunities for Local Drug Task Forces to share learning, access enhanced administrative supports and to improve service delivery for their target groups at the local level. Some €7m is provided to support cohesion actions over 2005 and 2006.

7.4 Mainstreaming

7.4.1 Background

The terms of reference for the study required specific consideration of the mainstreaming process. The mainstreaming process has created a situation whereby projects evaluated as successful have been provided with a mainstream, long-term funding source. This funding allows projects to provide the services originally funded by the Task Force. Such projects can and often do access additional funding from the Task Force with which to expand and develop their services.

Access to mainstream funding to cover core costs is generally a key concern for local and community based projects in a wide variety of situations. Therefore the availability of such a fund for Task Force projects is of very significant benefit to such projects in ensuring continuity of service and maintenance and development of staff.

A number of concerns have been raised however, about the mainstreaming process that was used for Round 1 projects and on reporting arrangements and responsibilities since mainstreaming has occurred.

7.4.2 Effectiveness and Efficiency of Mainstreaming Process

Our review of the mainstreaming process has highlighted a number of issues of concern for the efficient operation of the mainstreaming process. These issues were reinforced by the case studies of the four Task Force areas:

- The evaluations carried out prior to mainstreaming were hampered by lack of data and by lack of resources and time to generate such data. The extent to which the evaluators could judge the "success" of a project in any objective and quantitative way was therefore limited. Examples of these difficulties can be found for instance in the case studies of Cumas and CASP.

- A number of evaluators referred to such difficulties and also to areas where projects could improve their service or ways of working. However, no mechanism appears to have been put in place to ensure that such projects, or their funding agencies, followed up on the proposals made by the evaluators. The case studies revealed that projects often had not received copies of the evaluation reports and that mainstream funding agencies lacked the resources with which to ensure that mechanisms were in place to address identified weaknesses.

- Mainstreamed projects are currently not being formally monitored or evaluated by either the Task Force or their funding agency. This is due to a lack of clear lines of responsibility between projects and their funders and also to a lack of resources on the part of all concerned to develop, implement and manage effective monitoring and evaluation systems.

- Mainstreamed projects have tended to be under-resourced. In this scenario, programming budgets are being used to supplement wage-related budgets. This is having a detrimental effect on services to clients and is demotivating for the staff involved. The effect of this situation is that co-ordinators, mainstream funders and the NDST are all spending considerable amounts of time sourcing alternative funding, including through fundraising. Such time is taken away from time spent managing the project, on developing appropriate planning and review mechanisms and on developing the service in response to evolving clients needs.[31] These difficulties were highlighted in the Cumas, CASP and Inchicore CDT case studies. Where programme funding had to be used to make up for shortfalls in the wages budget. Such projects were able to identify the effect of such reduced programme budgets on attendance of clients for treatment (for example in Inchicore CDT the lack of funding for the provision of meals to clients was seen to have reduced attendance at the project).

These are issues of particular concern in the context of the potential cost of mainstreamed measures. In Section 3 of this report, it was estimated that if both Round 1 and Round 2 measures are mainstreamed, annual expenditure is likely to rise to a minimum of €28.5m annually and could be as much as €35m annually. In these circumstances, it is essential that there are clear lines of responsibility for monitoring and evaluating the projects in receipt of mainstreamed funding. In this context, the next section of the report considers the quantitative performance indicators that should be put in place.

[31] This issue has subsequently been addressed by the NDST.

8. Performance Indicators

8.1 Introduction

The absence of a system of performance indicators and ongoing monitoring of the Programme was noted in Section 6. This lack of performance monitoring was presaged in the brief, in that the terms of reference placed an emphasis on the need for this study to develop a system of performance indicators for future use. This section addresses this part of the brief.

The LDTF Programme involves area-based measures, some of which provide 100 per cent support for projects on the ground. Others support projects, which have already been in existence, to expand their activities. LDTF funding may be only one source of Government funding for such projects, which may also be supported by private funds or resources. In such circumstances, it is more appropriate and feasible to develop performance indicators for the projects rather than the measures, although it is recognised that the two will often coincide.

8.2 Previous Initiatives to Develop Performance Indicators

While a system of performance monitoring has not yet been put in place in relation to the Programme, the need for such a system has been recognised by a number of stakeholders and actors in the LDTF Programme. Work on performance indicators has been undertaken by consultants engaged by the responsible department and by individual LDTFs, and has also been undertaken directly by some LDTFs. A brief review of some of these analyses is presented below.

8.2.1 PA Consulting Group

At an early stage in the life of the Programme, PA Consulting Group undertook an Evaluation of the Drugs Initiative. [32] As part of this evaluation study, recommendations with regard to suitable project performance indicators were made. Performance indicators for each of three themes – Education and Prevention, Treatment and Rehabilitation, and Supply Control – were identified. Over 80 performance indicators were devised across the three themes. As might be expected given the number identified, these performance indicators captured all of the relevant aspects of project performance. In the event, however, these performance indicators were not implemented, due to *inter alia* lack of supporting resources.

8.2.2 NEXUS Consultants

NEXUS consultants were commissioned by Clondalkin LDTF to develop a set of indicators at project and programme level. A comprehensive set of input, output and impact indicators were proposed. A feature of the approach is that the impact indicators proposed were subjective in nature to be compiled by project managers. They thus present problems for the consistent monitoring of project performance over time.

8.2.3 The LDTFs

A number of LDTFs undertook work to devise a set of performance indicators. Two particularly good examples to hand are those of the Ballyfermot and Cork LDTFs.

[32] PA Consulting Group. Evaluation of the Drugs Initiative. October 1998.

Ballyfermot LDTF considered performance indicators in the context of drawing up its second strategic plan. [33] This plan proposed a set of input, output and impact indicators. Over 60 performance indicators were identified. A welcome feature of the indicators proposed is that they capture very fully the impacts that the projects could have on individuals, families and the community as a whole. A drawback is that these impacts are rarely couched in a form that is amenable to quantification.

Cork LDTF has recently implemented a performance monitoring system. This is aimed at capturing information on project activities along a number of dimensions – one-to-one work, group work, street work, and work with parents. The performance indicators devised are of the input and output rather than impact type. The system as devised is also aimed at profiling clients, so that it extends beyond pure performance monitoring. The approach is very clearly to define indicators that are capable of ready measurement.

8.2.4 Mainstreaming Agencies

A number of mainstreaming agencies have laid down performance indicators in the context of project service plans. The indicators used are of an input and output nature. The output indicators typically record the number of hours of service provided and or the number of participants at group and one-to-one counselling, treatment and education sessions.

8.2.5 Overview

All of the above work has proved valuable in determining the proposed approach to performance indicators as set out below. In particular, they provide good information on the range of outputs and impacts that may arise from projects. However, there are a number of drawbacks, which are evidenced to a degree in some of the systems devised:

- In the attempt to encapsulate a wide range of outputs and impacts, a very large number of indicators are proposed;
- Some impacts considered are not amenable to quantification;
- There is a tendency to under-specify indicators, so that the precise approach to their measurement is not clear; and
- Responsibilities for collecting and analysing performance indicators are not made clear.

8.3 Approach to Performance Monitoring

8.3.1 Guiding Principles

The experience gained from previous initiatives with regard to performance monitoring together with experience in other areas, suggest a number of principles that should guide the development of performance indicators. These are that performance indicators:

- Should encapsulate the main inputs, outputs, results and impacts, where these are amenable to quantification;

[33] Ballyfermot has a Drug Problem. Ballyfermot Drug Task Force Strategic Plan 2001 –2002. Undated.

- Be relatively few in number so as to reduce the estimation burden; and

- Be set in an institutional framework that clearly identifies those responsible for the provision of such indicators, their analysis, and their dissemination to stakeholders.

8.3.2 Purpose of Performance Monitoring

Before making proposals in relation to performance indicators, it is useful to set out the purposes for which the indicators are needed viz. for monitoring the performance of:

- Projects;
- Individual LDTFs; and
- The LTDF Programme as a whole.

Each LDTF activity comprises a number of **projects** and a **management process** that is related to specific **areas.** These areas form the LDTF **programme** as a whole. The performance of the LDTF activity may thus be assessed at four levels:

- Project;

- Process;

- Area; and

- Programme.

Performance indicators are required at all four levels if a comprehensive performance assessment is to be made.

8.3.3 Types of Performance Indicators

Normally, performance indicators comprise the following:

- Input indicators: these refer to the resources used;

- Output indicators: these refer to activity levels;

- Result indicators: these relate to direct and immediate effects; and

- Impact indicators: these refer to consequences beyond the immediate effects and direct beneficiaries.

All of these types of indicators are relevant to the monitoring and evaluation of the Programme.

8.3.4 Aggregation and Comparability of Performance Indicators

Ideally, project and process indicators should be capable of aggregation so that they can be used to develop area and programme-wide indicators:

- At the project level, performance indicators will contribute to project monitoring, control and evaluation and ideally should feed into indicators at the level of the Area and the Programme.

- The process indicators will relate to each Task Force area and will support an analysis of the performance of each Task Force. They should be capable of aggregation, so that Programme-level performance of the LDTF process can be assessed.

Measurement of the performance of the LDTF approach at the Area level cannot rely on process indicators combined with aggregated project indicators alone. This is because there are wider community effects arising from these projects and processes viz.

- Projects supported by the LDTF approach act in synergy with projects supported by other funding sources to achieve community or area-wide effects; and

- The beneficial impacts of projects spill over into the wider community.

Thus, there is a need to consider Area-wide performance indicators that capture these synergistic and spillover impacts. These performance indictors at Area level would help the monitoring and evaluation of impacts on the community as a whole.

Finally, Area level indicators, both those derived from project level indicators and others focusing on community impacts, can be aggregated across all the LDTF areas to derive Programme level indicators.

8.3.5 Limiting the Number of Performance Indicators

It may be seen from the above that we are concerned with indicators at four levels and four types – 16 potential indicator categories. As the activities under the LDTF are diverse, there will be a need for a number of specific indicators within each of these categories. For example, if only two indicators were provided in each category for each of the four pillars of drug prevention activity, then a total of 128 (8x16) indicators could potentially be required.

In practice, there is a need to limit the number of indicators and this can be done in a number of ways:

Firstly, not all types of indicators are relevant to all levels of activity. For example, it would not be practical to seek impact indicators at the level of the project, as impacts would only be fully realised beyond the time scale and boundaries of project activities, and individual projects would not have the resources to assess such impacts.

Secondly, the effects of LTDF process, in terms of results and impacts are probably best gauged at the Area level. While all four types of indicator are relevant to Areas, some of these will be obtained simply by aggregation from project and process indicators. Additionally, as the impacts of the LDTF are likely to take some time to have effect, some Area indicators would need to be compiled at intervals rather than annually.

Table 8.1 summarises the relevance of indicator types to different indicator levels.

Table 8.1: Relevance of Indicator Types

Type of Indicator	Indicator Level			
	Project	**Process**	**Area**	**Programme**
Input	X	X	X	X
Output	X	X	X	X
Result	X	X	X	X
Impact			X	X

Thirdly, The performance monitoring process may be made even more tractable, by adopting the concept of **Core Indicators**. This is the approach suggested by the European Commission where there is a need to make a comparison between different measures or where, as in this case, there is a need to ensure that project level indicators can be aggregated to higher levels. [34] The European Commission notes that "generally speaking, the number of core indicators must be small to ensure that they are appropriate and manageable with regard to programme monitoring and comparative or thematic analyses".

8.4 Defining Indicators and Sources

In light of the above a number of steps must be taken in order to make performance indicators a reality. These are:

Establishing a precise definition of the indicator

This will ensure consistency in calculation across activities and over time and establish the precise data needed.

Identifying the data sources

This will identify existing data sources or indicate how the data should be sourced.

Indicating the body or individual responsible for compiling the indicator

This will ensure that someone is responsible for compiling the indicator.

Establishing the frequency at which the indicator will be calculated

This will vary. However, it is unlikely that there will be a need to compile indicators more frequently than annually.

[34] The New Programming Period 2000-2006: Methodological Working Papers. Working Paper 3:Indicators for Monitoring and Evaluation – An Indicative Methodology. European Commission DGXVI, undated.

Providing for analysis and feedback of performance indicator information

Unless the performance indicators are collated and analysed, they cannot be used for monitoring purposes at the level of the Area or the Programme. Unless they are fed back to project managers and Taskforce Co-ordinators, the latter will not have an incentive to continue compiling them. Analysis and feedback should take place at various levels.

8.5 Defining Project Level Indicators

8.5.1 Categorising Projects

This section sets out a number of core indicators for use at project level. It does this by considering input, output and result indicators in turn.

In Section 3 a listing of the types of activities undertaken by projects was given. Projects were identified as falling under a number of functional areas as follows:

- Access to treatment and rehabilitation;
- Treatment and harm reduction for drug users
- Rehabilitation of drug users
- Education and prevention;
- Family support;
- Supply control;
- Education and training of drug workers;
- Research; and
- Other

As a first step in the process of performance monitoring, each project or activity being monitored should be assigned to one of these categories. This will permit collection of performance indicators for each of these types of functional areas. While it is recognised that some projects will have features of a number of such functions, for the purposes of aggregation to area and programme level, it is important that each project be assigned uniquely to its primary function. It is envisaged that the Task Force Co-ordinator or the responsible person in the mainstreaming agency would agree with each project manager, the category into which the project would fall. Projects would be assigned to the "other" category in extremely exceptional circumstances only e.g. in the case of a very innovative project that addresses a new or emerging need.

Section 3 also set out the types of persons for whom the projects provided services. These were:

- Persons at risk of drug use;
- Drug users;
- Young people in education;
- Families of drug users;
- Drug workers;
- The community at large; and
- Other

The same procedures would apply as for the functional areas outlined above, with projects being uniquely assigned to one of these target populations.

Looking across the range of projects, it is clear that a broad distinction can be made between projects that are provided on an individual basis or in a group environment. As services delivered to groups are sessional in nature and are not provided on an on-demand basis, they offer scope for collection of more detailed performance indicators. Thus, the core indicators set out below differ as between projects delivering services to individuals or groups. Project co-ordinators and project managers will adopt a different set of indicators, depending on the nature of the project under consideration.

8.5.2 Input indicators

Three input indicators are proposed. These relate to project expenditure, allocations from the LDTF and employment levels. These are appropriate to projects across all functional areas with the exception of research. In the case of the latter, it would be sufficient to record the number of research projects successfully completed.

Table 8.2: Project Input Indicators

Indicator Name	Definition
Project expenditure	Quarterly expenditure on the project in €
Allocation from LDTF	Annual allocation from LTDF to the project in €
Project employment	Full time equivalent person years of employment. Part-time and seasonal employment converted to person-years on the basis of a 7 hour day, a five day week and a 220 day working year

The sources and responsibilities for these indicators are as follows.

Data Sources: Project accounts and records

Responsible entity: Project Manager

Frequency of reporting: Annually

Entity responsible for analysis and feedback: Project manager, LTDF area co-ordinator, responsible official in mainstreaming agency.

8.5.3 Output Indicators

Two output indicators are proposed for projects delivered on an individual basis and two for projects delivered on a group basis.

Table 8.3: Project Output Indicators

Indicator Name	Type of Project	Definition
Number of cases	All projects	Number of separate individuals to whom services were provided within the year
Number of visits or consultations	Projects delivered on an Individual Basis	Number of times the service was used during the year
Number of session-hours	Projects Delivered on a Group Basis	Number of sessions in the year by their duration in hours
Number of participant-hours	Projects Delivered on a Group Basis	Annual number of attendances at sessions by duration of attendance in hours

The sources and responsibilities for these indicators are as follows.

Data Sources: Project records

Responsible entity: Project Manager

Frequency of reporting: Annually

Entity responsible for analysis and feedback: Project manager, LTDF area co-ordinator, responsible official in mainstreaming agency.

8.5.4 Result Indicators

Five result indicators are proposed. These are aimed at identifying the successful throughput of cases in the year. These indicators will not apply to certain services, such as drop-in services, where a case based or session-based approach is not adopted.

Table 8.4: Project Result Indicators

Indicator Name	Type of Project	Definition
Number of cases closed	Provision of individual services	Number of cases in the year where the education, training, treatment, rehabilitation or family support service offered to the client was successfully delivered and service is no longer availed of. Successful delivery means that the client is no longer regarded as being in need of that particular service.
Numbers completing courses	Provision of group services	Number of individuals in the year who successfully completed courses in education, training, treatment rehabilitation or family support services and who no longer avail of that particular service. Successful completion means that the person attended at least 65 per cent of the sessions offered.
Client satisfaction rating	All services offered on an individual case or group basis	Number and proportion of clients exiting services or courses who expressed themselves 'satisfied' or 'very satisfied' with the service offered, when asked to rank the service on the usual Likert scale.
Client quality of life rating	All services offered on an individual case or group basis	Number and proportion of clients exiting services or courses who considered that the services offered were "beneficial" or "very beneficial" to their quality of life, when asked to rank the service on the usual Likert scale.
Numbers in drug substitution treatment that are not misusing drugs	Methadone treatment services	Numbers and proportion of those in drug substitution treatment that are not misusing drugs at end September of each year

The sources and responsibilities for these indicators are as follows.

Data Sources: Project records and customer survey

Responsible entity: Project Manager

Frequency of reporting: Annually

Entity responsible for analysis and feedback: Project manager, LTDF area co-ordinator, responsible official in mainstreaming agency.

8.6 Defining Process Indicators

Input and result indicator measures are considered appropriate, as impact indicators need to be considered at the area level. The indicators proposed are as follows.

Table 8.5: Process Input, Output and Result Indicators

Indicator Name	Definition
Number of meetings	Number of meetings attended by LDTF members annually
Number of person-days	Number of persons-days of attendance at meetings by LTDF members annually
Number of LDTF co-ordinator external meetings	Annual number of non-project related meetings attended by the LDTF co-ordinator with entities external to the Task Force
Stakeholder satisfaction rating	Number and proportion of LDTF members who expressed themselves 'satisfied' or 'very satisfied' with the LDTF process, when asked to rank the process on the usual Likert scale.

The sources and responsibilities for these indicators are as follows.

Data Sources: LDTF records and survey

Responsible entity: LDTF Co-ordinator

Frequency of reporting: Annually

Entity responsible for analysis and feedback: LTDF area co-ordinator, National Drugs Strategy Team.

8.7 Defining Area Indicators

8.7.1 Aggregated Indicators

With regard to Task Force Area indicators, the project input, output and results indicators will be obtained by aggregation. Thus, for each area the following will be obtained.

Aggregated from Project Indicators

- Aggregate project expenditure
- Aggregate project allocations
- Total FTE employment in supported projects
- Total number of individual cases for whom services were provided
- Total number of client visits or consultations
- Number of session hours delivered
- Number of participant hours at courses
- Number of cases closed
- Numbers completing courses
- Overall client satisfaction rating
- Overall quality of life rating
- Numbers in methadone treatment that are drug-free

Aggregated from Process Indicators

- Number of meetings
- Number of person-days
- Number of LDTF co-ordinator external meetings
- Stakeholder satisfaction rating

As projects will be differentiated by function and target group, it will be possible, where meaningful, to present performance indicators by function and target group.

8.7.2 Impact Indicators

In addition to the above, it is at the Task Force level of aggregation that impact indicators may be meaningfully assessed. Impact indicators should be focussed on the extent to which the services delivered through the LTDF programme reduce or mitigate the drug problem and improve the quality of life of drug users, their families, and the community at large. This requires LDTF area based information.

The starting point was to consider data from official sources that could be collated on a regular basis for LDTF areas. Section 6 of this report indicated the efforts that were made to derive LDTF area based information from official sources. The data sources considered were:

- Health Research Board (NDTRS) statistics on numbers in treatment;
- Garda Síochána data on drug related offences;
- The Central Treatment List data on numbers receiving methadone treatment;
- The Department of Health and Children's Hospital In-Patient Enquiry system data on numbers treated for drug problems; and
- The Central Statistics Office data on deaths caused by drugs.

As was indicated in Section 6, data on a Task Force Area basis are available only from the first three data sources.

Accordingly, it is proposed that the following indicators be collected on an area basis from official sources.

Table 8.6: Impact Indicators

Indicator	Definition	Source
Number of cases treated for problem drug use by main drug problem treated	Number of cases treated for problem drug use by main drug problem treated at end September of each year	Health Research Board
Number of new cases treated for problem drug use by main drug problem treated	Number of new cases treated for problem drug use by main drug problem treated at end September of each year	Health Research Board
Number of cases treated for problem drug use by type of treatment centre	Number of cases treated for problem drug use by type of treatment centre at end September of each year	Health Research Board
Number of Patients in receipt of methadone treatment	Number of patients on the central treatment list at end September of each year	The Drug Treatment Centre Board
Number of drug related offences	The number of Possession, Supply, Obstruction and Other offences (under the Misuse of Drugs Act) for the year.	An Garda Síochána
Number of persons prosecuted for drug related offences	The number of persons prosecuted for Possession, Supply, Obstruction and Other offences (under the Misuse of Drugs Act) for the year.	An Garda Síochána

The sources and responsibilities for these indicators are as follows.

Data Sources: As per Table 8.6

Responsible entity: As per Table 8.6

Frequency of reporting: Annually

Entity responsible for analysis and feedback: **National Drugs Strategy Team.**

8.8 Defining Programme Level Indicators

There are two key aspects of effectiveness of the LDTF Programme that none of the above indicators yield information on. These are the extent to which LDTF Programmes are

- Helping to reduce the extent of the drug problem in the LTDF areas; and
- Adding to the quality of life of the families of drug users and the community as a whole.

In order to assess these impacts, it is proposed that primary research be carried out at intervals of, say, every three years. This research would consist of a household interview survey of drug prevalence and drug impacts in LDTF areas. With regard to prevalence, this would be similar to the recent research carried out by the NACD.[35] With regard to impacts, it would contain bespoke questions directed at households eliciting their views on:

- The extent of the drug problem in their area;
- Whether they are directly or indirectly affected by the problem;
- The extent to which it impinges on their quality of life; and
- Their assessment of actions taken to address the problem in their area.

In order to keep the costs of such a survey manageable, it is suggested that it be based on the population of LDTF areas as a whole, and the sample be random but stratified by LDTF area.

This process will give rise to two key indicators:

- Proportion of people in LDTF areas reporting use of an illegal drug in the last month; and
- Proportion of people in LDTF areas reporting that their quality of life was negatively impacted by drug related problems in the last month.

In practice, the survey will provide an opportunity to derive further and more nuanced indicators.

Table 8.7 summarises the performance indicators for the LDTF programme as a whole that will be made available, if the above system is implemented.

[35] Drug Use in Ireland and Northern Ireland, 2002/3. Bulletin no.1, 2003

Table 8.7: Overview of Programme Performance indicators

Indicator	Frequency
Total project expenditure	Quarterly
Total allocation from LDTF	Annually
Total project employment	Annually
Total number of cases handled	Annually
Total number of visits or consultations	Annually
Total number of session-hours	Annually
Total number of participant-hours	Annually
Total number of cases closed	Annually
Total numbers completing courses	Annually
Overall client satisfaction rating	Annually
Overall client quality of life rating	Annually
Total numbers in methadone substitution treatment that are drug free	Annually
Total number of LDTF meetings	Annually
Total number of person-days at LDTF meetings	Annually
Total number of LDTF co-ordinator external meetings	Annually
Overall LDTF stakeholder satisfaction rating	Annually
Number of cases in LDTF areas treated for problem drug use by main drug problem treated	Annually
Number of new cases in LDTF areas treated for problem drug use by main drug problem treated	Annually
Number of cases in LDTF areas treated for problem drug use by type of treatment centre	Annually
Number of Patients in LDTF areas in receipt of methadone treatment	Annually
Number of drug related offences in LDTF areas	Annually
Number of persons prosecuted for drug related offences in LDTF areas	Annually
Proportion of people in LDTF areas reporting use of an illegal drug in the last month	Triennially
Proportion of people in LDTF areas reporting that their quality of life was negatively impacted by drug related problems in the last month.	Triennially

8.9 Responsibility for Analysis and Feedback

Implementation and maintenance of the performance indicator system will not take place unless responsibilities and roles with regard to analysis and feedback are made clear.

The role of each of the actors in this regard is as follows:

Project Manager

- Comparison of project performance indicators over time;
- Communication of project performance indicator information to project workers.

Task Force Co-ordinator

- Comparison of project performance indicators over time and across projects;
- Communication of comparative project performance indicator information to project managers.

Mainstreaming Agency

- Comparison of project performance indicators over time and across projects;
- Communication of comparative project performance indicator information to project managers.

National Drugs Strategy Team

- Comparison of process indicators across Areas
- Communication of comparative process performance indicator information to project co-ordinators
- Aggregation of project performance indicators across areas
- Aggregation of process performance indicators across areas
- Communication of Area and Programme Level indicators to Programme participants.

8.10 Overview

A system of twenty-four performance indicators has been devised. These are appropriate for measuring performance in relation to projects, LDTF processes, the LDTFs individually, and the LDTF Programme as a whole. As well as monitoring progress, these will form a valuable input into the evaluation of projects, LDTFs and the Programme as a whole. It is important to recognise that these performance indicators, while attempting to capture quality of life impacts to some degree cannot hope to encapsulate these in total. As a result, evaluations of the Programme and its constituent parts must continue to embrace qualitative assessments.

9. Conclusions and Recommendations

Funding totalling €120 million has been allocated to support measures under the Local Drugs Task Force Programme in the period from late 1997 to end 2005.

Given the scale of funding, it is essential that financial reporting arrangements are improved through regular reporting of expenditure by projects and the furnishing of audited annual project accounts.

Over 45 per cent of Round 1 measures supported new projects, while 23 per cent supported new activities. Under Round 2, a similar proportion of measures was new projects or new activities (69 per cent). However, under Round 2 a relatively higher proportion of measures were in respect of new activities rather than new projects. This suggests that Round 1 measures were largely focussed on developing new projects, while Round 2 prioritised new activities in existing projects.

The majority of measures had either education and prevention or treatment and rehabilitation as their themes. Almost 54 per cent of Round 1 measures related to education and prevention and 33 per cent to treatment and rehabilitation. With regard to treatment and rehabilitation measures under Round 1, 56 per cent were in respect of new projects. Under Round 2, such measures tended to fund new activities rather than new projects.

In recent years, an increasing number of studies have attempted to assess the costs and benefits of different drug treatment regimes. The available studies have reported very high benefit-cost ratios, in the range of 2 to over 20, for drug treatment. All types of treatment recorded strongly positive cost-benefit ratios.

There is also evidence that well-designed school based prevention programmes yield benefits at least twice the level of costs. Prevention schemes are value for money not because the benefits are high but because the costs are very low. Given the modest level of benefits achieved the contribution of this type of initiative to alleviating the drug problem as a whole is limited.

Analysis of the burden that drug use imposes on society indicates that social costs, as a proportion of GDP/GNP, vary considerable across countries from a low of 0.2 per cent to a high of 1.6 per cent. Productivity losses account for the largest share of total costs, with criminal justice costs next in importance. A considerable proportion of total costs are borne by the Exchequer – ranging from 15.5 per cent in France to approximately 29 per cent in both England and Wales and Australia. When drug users enter treatment, the costs they impose reduce significantly.

It is considered that the LDTF Programme has been very effective for a number of reasons:

- A large number of measures have been implemented to address the drug problem at the local level;
- This has resulted in many new community projects and new activities being put in place;
- The measures adopted have been highly relevant to the objectives set for the National Drug Strategy;

- The measures have largely focused on activities such as education and prevention and, particularly, treatment and rehabilitation that have been shown to be effective abroad;

- The fact that LDTF funding has delivered new projects and activities with regard to treatment and rehabilitation is especially noteworthy, as international research indicates that the costs to society of drug abuse are very high, and that there are immediate and substantial savings to the economy when drug users enter treatment regimes;

- There is clear evidence of higher levels of trust emerging between local communities and the statutory agencies concerned with drug abuse. As the LDTF Programme is a major vehicle for contacts between the community and the statutory agencies, it is likely to have been instrumental in effecting this change.

- The numbers of persons in LDTF areas in receipt of methadone and other treatments rose rapidly in the years immediately after the establishment of the LDTF Programme. A higher proportion of drug users is now been treated locally.

- More recently, the number of new cases attending treatment in LDTF areas has been declining.

- The focus of the LDTF Programme is on the Dublin area, and drug related deaths, drug related HIV infections, and discharges from hospitals of patients with drug related illnesses have all reduced significantly in the Dublin area in the post 2000 period.

However, there are a number of areas where the efficiency and effectiveness of the Programme could be enhanced. These include the following:

- Establishment of clearer reporting relationships and related monitoring systems between projects, funders and Task Forces;

- Development of standard monitoring templates to be used by projects to monitor progress against agreed plans;

- Access to the required level of annual funding to meet the core costs of mainstream projects and a review of related programming costs;

- Provision of greater resources at Task Force level so as to improve supports to projects, to draw greater learning from the projects, and to undertake more detailed evaluation of the drug problems in their local area.

- Provision of supports to management committees to ensure that they are in a position to act as good employers and to run their projects in a professional manner (e.g. availability of supports to develop and implement good practice staff and client-related processes and procedures, and to support good staff/management practices);

- Access to resources to encourage greater cross Task Force and cross project networking and learning, including provision for cross task force projects (e.g. outreach services);

- Development of stronger evaluation processes in relation to future mainstreaming decisions, backed up by good monitoring data on process/outputs including performance indicators, and by mechanisms aimed at ensuring that weaknesses identified in the review process are addressed.

- Carrying out of long-term follow up surveys of clients to better establish project outcomes and factors that influence successful outcomes

- Allocation of resources to research and analysis at NDST level to derive high-level policy analysis, conclusions and directions from the LDTF process.

The Department of Community, Rural and Gaeltacht Affairs, in co-operation with other relevant Departments, is implementing measures to improve focus and cohesion across community and local development initiatives. In this context, the cohesion process provides real opportunities for LDTFs to share learning, access enhanced administrative supports and to improve service delivery for their target groups at the local level. Some €7m is provided to support cohesion actions over 2005 and 2006.

There are a number of issues of concern in relation to mainstreaming:

- The evaluations carried out prior to mainstreaming were hampered by lack of data and by lack of resources and time to generate such data. The extent to which the evaluators could judge the "success" of a project in any objective and quantitative way was therefore limited.

- A number of evaluators referred to such difficulties and also to areas where projects could improve their service or ways of working. However, no mechanism appears to have been put in place to ensure that such projects, or their funding agencies, followed up on the proposals made by the evaluators.

- Mainstreamed projects are currently not being formally monitored or evaluated by either the Task Force or their funding agency. This is due to a lack of clear lines of responsibility between projects and their funders and also to a lack of resources on the part of all concerned to develop, implement and manage effective monitoring and evaluation systems. Funders are concerned about the lack of accountability involved and on the potential serious difficulties that could arise in such a situation.

In order to strengthen monitoring and evaluation performance, it is essential that there are clear lines of responsibility for monitoring and evaluating the projects in receipt of mainstreamed funding and that a system of quantitative performance indicators is put in place.

A system of twenty-four performance indicators is now proposed. These are appropriate for measuring performance in relation to projects, LDTF processes, the LDTFs individually, and the LDTF Programme as a whole. As well as monitoring progress, these will form a valuable input into the evaluation of projects, LDTFs and the Programme as a whole.

While it is clear that considerable success has been achieved in addressing the drug problem in the Dublin area, much remains to be achieved. While the number of persons on methadone treatment has increased, there is as yet little evidence of substantial success in increasing the numbers of persons who remain drug free. In addition, the extent of abuse of cocaine is apparently on the increase, while few persons are as yet presenting for treatment for this addiction. An area and community based response would seem to hold an number of advantages from the point of view of encouraging cocaine abusers to access treatment and a range of therapies. The LDTF Programme thus continues to be relevant to combating the drug problem. However, realistic targets for the Programme should be set going forward.

Appendix A: Funding of Measures - Area Summaries for Round 1

A1 Introduction

This Appendix gives a brief snapshot of each of the thirteen LDTF areas that received funding for Round 1 measures. Each summary gives details on the funding received and the numbers of measures funded. Measures varied enormously in their size and nature. A measure could be anything from a once-off community day out, to the employment of a development worker, to a fully operating drop-in centre or crèche, with a full complement of staff. For these reasons a comparison of areas or themes by number of measures is not very informative.

A2 Ballyfermot

The Ballyfermot LDTF received initial funding for 32 measures in Round 1. Eleven of these measures had a focus on Education and Prevention, six concentrated on Treatment and Rehabilitation, and another seven focused on both of these areas. Two measures related to Supply Control and two more had a Research focus.

Table A1 Ballyfermot Summary Table for Round 1 Funding

	€ millions	No. Measures Funded
Initial Funding Allocated	1.1	32
Total Interim Funding Allocated	0.3	5
Total Mainstream Funding Allocated (01-03)	1.7	11

Source: Compiled from NDST data

Of the thirty-two initial core measures, five went on to receive interim funding, while six went straight from initial funding to mainstream funding. Between initial funding and interim funding, the Ballyfermot Task Force was allocated a total of €1.4 million for Round 1 measures. All five of the measures that received interim funding went on to be mainstreamed. Mainstream funding allocated to the Task Force between 2001 and 2003 amounted to €1.7 million.

A3 Ballymun

The Ballymun LDTF received initial funding for 14 core measures in Round 1. The majority (8 measures) had a focus on Education and Prevention, and 35.7 per cent (5 measures) focused on Treatment and Rehabilitation. One measure was research based.

Table A2 Ballymun Summary Table for Round 1 Funding

	€ millions	No. Measures Funded
Initial Funding Allocated	0.8	14
Total Interim Funding Allocated	1.1	10
Total Mainstream Funding Allocated (01-03)	2.9	10

Source: Compiled from NDST data

Of the fourteen initial core measures, ten went on to receive interim funding. Between initial funding and interim funding, the Ballymun Task Force was allocated a total of €1.9 million for Round 1 measures. All ten of the measures that received interim funding went on to be mainstreamed. Mainstream funding allocated to the Task Force between 2001 and 2003 amounted to €2.9 million.

A4 Blanchardstown

The Blanchardstown LDTF received initial funding for 11 core measures in Round 1. Again, the vast majority (9 measures) had a focus on Education and Prevention. One other measure focused on both Education and Prevention, and Treatment and Rehabilitation. There was also a research-based measure. Initial funding and interim funding allocated to the Task Force for Round 1 measures, when combined totalled €2.2 million.

Table A3 Blanchardstown Summary Table for Round 1 Funding

	€ millions	No. Measures Funded
Initial Funding Allocated	0.9	11
Total Interim Funding Allocated	1.3	10
Total Mainstream Funding Allocated (01-03)	3.7	9

Source: Compiled from NDST data

Of the eleven initial core measures, ten went on to receive interim funding. Between initial funding and interim funding, the Blanchardstown Task Force was allocated a total of €2.2 million for Round 1 measures. Of the ten measures that received interim funding, nine went on to be mainstreamed. Mainstream funding allocated to the Task Force between 2001 and 2003 amounted to €3.7 million.

A5 Canal Communities

The Canal Communities Local Drugs Task Force was allocated initial funding for fourteen measures, nine of which could be categorised as Education and Prevention measures. Four measures were Treatment and Rehabilitation measures and one was a research measure.

Table A4 Canal Communities Summary Table for Round 1 Funding

	€ millions	No. Measures Funded
Initial Funding Allocated	1.0	14
Total Interim Funding Allocated	1.4	12
Total Mainstream Funding Allocated (01-03)	2.8	8

Source: Compiled from NDST data

Of the fourteen initial core measures, twelve went on to receive interim funding. Between initial funding and interim funding, the Canal Communities Task Force was allocated a total of €2.4 million for Round 1 measures. Of the twelve measures that received interim funding, eight went on to be mainstreamed. Mainstream funding allocated to the Task Force between 2001 and 2003 amounted to €2.8 million.

A6 Clondalkin

Initial funding was allocated to support fifteen core measures in the Clondalkin Task Force Area in Round 1. Again the two areas most focused on were Education and Prevention (7 measures), and Training and Rehabilitation (5 measures). The area also had one measure that focused on Supply Control.

Table A5 Clondalkin Summary Table for Round 1 Funding

	€ millions	No. Measures Funded
Initial Funding Allocated	1.2	15
Total Interim Funding Allocated	0.9	10
Total Mainstream Funding Allocated (01-03)	3.2	8

Source: Compiled from NDST data

Of the fifteen initial core measures, ten went on to receive interim funding, while one went straight from initial funding to mainstream funding. Between initial funding and interim funding, the Clondalkin Task Force was allocated a total of €2.1 million for Round 1 measures. Of the ten measures that received interim funding, seven went on to be mainstreamed. Mainstream funding allocated to the Task Force between 2001 and 2003 amounted to €3.2 million.

A7 Cork

The Cork Task Force was allocated initial funding for a total of twenty-one core measures. Two-thirds of the measures had a focus on Education and Prevention and another six concentrated on Treatment and Rehabilitation. There was also one measure that had a research focus.

Table A6 Cork Summary Table for Round 1 Funding

	€ millions	No. Measures Funded
Initial Funding Allocated	0.7	21
Total Interim Funding Allocated	0.6	18
Total Mainstream Funding Allocated (01-03)	1.7	10

Source: Compiled from NDST data

Of the twenty-one initial core measures, eighteen went on to receive interim funding. Between initial funding and interim funding, the Cork Task Force was allocated a total of €1.3 million for Round 1 measures. Of the eighteen measures that received interim funding, ten went on to be mainstreamed. Mainstream funding allocated to the Task Force between 2001 and 2003 amounted to €1.7 million.

A8 Dublin 12

The Local Drugs Task Force in Dublin 12 was allocated initial funding for eight core measures. Four of these measures concentrated on Education and Prevention and another two focused on Treatment and Rehabilitation.

Table A7 Dublin 12 Summary Table for Round 1 Funding

	€ millions	No. Measures Funded
Initial Funding Allocated	0.8	8
Total Interim Funding Allocated	0.4	2
Total Mainstream Funding Allocated (01-03)	1.6	5

Source: Compiled from NDST data

Of the eight initial core measures, two went on to receive interim funding, while three went straight from initial funding to mainstream funding. Between initial funding and interim funding, the Dublin 12 Task Force was allocated a total of €1.2 million for Round 1 measures. Both of the measures that received interim funding also went on to be mainstreamed. Mainstream funding allocated to the Task Force between 2001 and 2003 amounted to €1.6 million.

A9 Dublin North East

The Dublin Northeast Task Force was allocated funding for twelve core measures initially. Five of the measures were concentrated on Education and Prevention, four focused on Treatment and Rehabilitation, and two concentrated on research.

Table A8 Dublin North East Summary Table for Round 1 Funding

	€ millions	No. Measures Funded
Initial Funding Allocated	0.9	12
Total Interim Funding Allocated	0.8	7
Total Mainstream Funding Allocated (01-03)	4.4	8

Source: Compiled from NDST data

Of the twelve initial core measures, seven went on to receive interim funding, while two went straight from initial funding to mainstream funding. Between initial funding and interim funding, the Dublin Northeast Task Force was allocated a total of €1.7 million for Round 1 measures. Of the seven measures that received interim funding, six also went on to be mainstreamed. Mainstream funding allocated to the Task Force between 2001 and 2003 amounted to €4.4 million.

A10 Dun Laoghaire/Rathdown

The Dun Laoghaire/Rathdown Task Force Area was allocated initial funding for eighteen core measures. The majority of these measures (12) centred on Education and Prevention. Another five centred on Treatment and Rehabilitation, and one measure was research-based.

Table A9 Dun Laoghaire/Rathdown Summary Table for Round 1 Funding

	€ millions	No. Measures Funded
Initial Funding Allocated	0.8	18
Total Interim Funding Allocated	0.7	11
Total Mainstream Funding Allocated (01-03)	2.4	14

Source: Compiled from NDST data

Of the eighteen initial core measures, eleven went on to receive interim funding, while three went straight from initial funding to mainstream funding. Between initial funding and interim funding, the Dun Laoghaire/Rathdown Task Force was allocated a total of €1.5 million for Round 1 measures. All eleven of the measures that received interim funding went on to be mainstreamed. Mainstream funding allocated to the Task Force between 2001 and 2003 amounted to €2.4 million.

A11 Finglas-Cabra

The Finglas-Cabra Task Force area was allocated initial funding for fifteen core measures. Seven of these measures could be categorised as focusing on Education and Prevention, three on Treatment and Rehabilitation, and another three on both of these areas combined.

Table A10 Finglas/Cabra Summary Table for Round 1 Funding

	€ millions	No. Measures Funded
Initial Funding Allocated	0.9	15
Total Interim Funding Allocated	1.0	10
Total Mainstream Funding Allocated (01-03)	2.3	7

Source: Compiled from NDST data

Of the fifteen initial core measures, ten went on to receive interim funding. Between initial funding and interim funding, the Finglas/Cabra Task Force was allocated a total of €1.9 million for Round 1 measures. Of the ten measures that received interim funding, seven went on to be mainstreamed. Mainstream funding allocated to the Task Force between 2001 and 2003 amounted to €2.3 million.

A12 North Inner City

The North Inner City had twenty-six core measures in Round 1 that were allocated monies in the initial tranche of funding. Fourteen of these measures concentrated mainly on Education and Prevention, six concentrated on Rehabilitation and Treatment, three had a focus on Supply Control and two had a research purpose.

Table A11 North Inner City Summary Table for Round 1 Funding

	€ millions	No. Measures Funded
Initial Funding Allocated	1.0	26
Total Interim Funding Allocated	1.6	21
Total Mainstream Funding Allocated (01-03)	0.8	5

Source: Compiled from NDST data

Of the twenty-six original core measures, twenty-one went on to receive interim funding. Between initial funding and interim funding, the North Inner City Task Force was allocated a total of €2.6 million for Round 1 measures. Of the twenty-one measures that received interim funding, five went on to be mainstreamed. Mainstream funding allocated to the Task Force between 2001 and 2003 amounted to €0.8 million.

A13 South Inner City

Funding was allocated to the South Inner City Task Force to support twenty-three core measures initially. Fourteen of these measures focused on the area of Education and Prevention, with the remaining nine focusing on Treatment and Rehabilitation.

Table A12 South Inner City Summary Table for Round 1 Funding

	€ millions	No. Measures Funded
Initial Funding Allocated	1.2	23
Total Interim Funding Allocated	1.1	17
Total Mainstream Funding Allocated (01-03)	2.3	11

Source: Compiled from NDST data

Of the twenty-three initial core measures, seventeen went on to receive interim funding. Between initial funding and interim funding, the South Inner City Task Force was allocated a total of €2.3m million for Round 1 measures. Of the seventeen measures that received interim funding, eleven went on to be mainstreamed. Mainstream funding allocated to the Task Force between 2001 and 2003 amounted to €2.3 million.

4.4.13 Tallaght

The Tallaght Task Force Area was allocated initial funding to support nineteen core measures. Seventeen of the measures concentrated on Education and Prevention, or Treatment and Rehabilitation, or both. The remaining two concentrated on Supply Control.

Table 4.14 Tallaght Summary Table for Round 1 Funding

	€ millions	No. Measures Funded
Initial Funding Allocated	0.9	19
Total Interim Funding Allocated	1.1	14
Total Mainstream Funding Allocated (01-03)	2.2	13

Source: Compiled from NDST data

Of the nineteen initial core measures, fourteen went on to receive interim funding. Between initial funding and interim funding, the Tallaght Task Force was allocated a total of €2.0 million for Round 1 measures. Of the fourteen measures that received interim funding, thirteen went on to be mainstreamed. Mainstream funding allocated to the Task Force between 2001 and 2003 amounted to €2.2 million.

Appendix B: Collection of Data on Measures

B1 Information Capture

Over 450 measures were allocated funding under Round 1 and Round 2 of the Local Drug Task Force (LDTF) initiative. In order to capture information on these measures, a survey form was issued to the 14 LDTF co-ordinators at an early stage of the review process.

Data sought from the LDTF co-ordinators characterised the LDTF measures along a number of dimensions as follows:

B2 Current Status of Measures

The LDTF area plans identified a number of measures for support. Measures that were accepted for support were allocated initial funding. Measures were then either mainstreamed or provided with interim funding while awaiting evaluation for mainstreaming. Some more measures were allocated funding on a once-off basis for activities such as research. Although accepted for support, a number of measures were not commenced and some others had funding withdrawn. Thus, measures may fall into a number of categories as follows:

- Not commenced
- Funding transferred/redirected
- Funding Withdrawn
- Initial
- Interim
- Mainstreamed
- Once off payment
- Other

B2 Measure by Theme

The four pillars of the National Drug Strategy 2001 – 2008 (NDS) are Supply Reduction; Prevention (including education and awareness); Treatment (including rehabilitation and risk reduction) and Research.

Resulting from our initial contact with a number of LDTF co-ordinators, it became apparent that all LDTF activity could not be categorised under the four NDS pillar headings. Rather some measures, such as measures that provide support to families of drug users, while indirectly supporting the NDS, do not fall directly within the four pillar headings. The list of headings was thus expanded, and all LDTF activities were categorised under the following headings:

- Education and Prevention
- Treatment and Rehabilitation
- Research
- Supply Control
- Family Support
- Training of drug workers
- Other

B3 Funding Impact

In some instances, the measures supported by the LDTF gave rise to new projects. These refer to measures where a new group/organisation was formed to provide a drug-related service, with the aid of LDTF funding. On the other hand, new activities refer to measures where the group/organisation existed prior to LDTF funding, but provided a new drug-related service with the aid of LDTF funding. Some measures fall into the category of expanded activities. Here the group/organisation existed, and the drug-related service was provided, prior to the receipt of LDTF funding, but the service was expanded with the aid of LDTF funding.

New projects and new activities represent the '*value added*' of LDTF activity, as together they represent new areas of support for drug users and their families. New activities on the other hand represent an expansion of supports for drug users and their families that already existed prior to LDTF funding.

LDTF co-ordinators were asked to identify which measures fall into these categories:

- New Projects
- New Activities
- Expanded Activities
- Other

B4 Funding Sources for Measures

Some measures were in respect of projects wholly funded by the LDTF. Other measures were in respect of projects in receipt of funding from numerous sources. LDTF co-ordinators were asked to identify which measures are wholly and which measures are partly funded by the LDTF funding.

B5 Measure Target Groups

Some LDTF measures target the drug using population and their families, while other measures target groups such as young children at risk, their families and the community. The LDTF co-ordinators were asked to identify the target group(s) of each of the measures in receipt of LDTF funding in their area. The following categories of target groups were identified:

- Children/young people (at risk) and their families
- Families of drug users
- Adult drug users
- Young drug users
- Recovering/Stabilised drug users
- Prisoners/Drug-using prisoners /Recovering drug using prisoners
- Service providers
- Community residents

B6 Use of Funding

Some task force measures use LDTF funding to secure premises, while other measures use LDTF monies to fund workers, research or general project expenses. LDTF co-ordinators were asked to identify to what extent LDTF funding was used to fund the following:

- General project expenses
- Premises
- Workers
- Research
- Other

B7 Employment supported by LDTF Measures

Co-ordinators were asked to identify the number of workers supported by each LDTF measure.

The LDTF co-ordinators were asked to provide the above information on all LDTF measures funded in their LDTF area.