

Strategic Plan 2008

CLONDALKIN DRUG TASK FORCE

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Introduction

This executive summary provides an overview of the full report and outlines the main conclusions that can be drawn. It also provides a framework, in terms of suggestions and recommendations, for the future content and direction of the Clondalkin Drug Task Force's (CDTF) Strategy.

The Clondalkin Drugs Task Force over the course of 2007 entered into its third strategic review/planning phase in line with the development of the next National Drugs Strategy (NDS), due to be tabled in late 2008. Therein the objectives of the research report were to:

- Act as a stocktaking exercise of the needs to be addressed in Clondalkin to ensure that current service provision meets these needs under the five pillars of the NDS.
- Identify and qualify emerging trends and issues to develop strategic capacity to respond to those issues.
- Inform partnership/collaborative working amongst community, agencies and statutory bodies for the delivery of essential local services and to determine future priorities.
- Identify and enhance the strategic capacity of the CDTF to inform policy development at both local and national level.

The key processes set out by CDTF in the development of the strategic plan were as follows:

- Carry out internal analysis regarding the effectiveness of the CDTF structures
- Carry out an analysis of the existing strategies at the local level
- Outline the current extent and nature of drug problems in the area, having regard to likely trends.
- Profile existing and planned service provision in statutory and community/voluntary sectors.
- Assess the adequacy of existing services against emerging and predicted trends.
- Identify strategic priorities.

The methodology for the research emphasised balancing systematic data, such as statistics, prevalence figures and community indicators of drug use, with qualitative perceptions based on the experiences of well placed stakeholders including those with drug related problems and members of families affected by drug problems. The quantitative aspect of this was also greatly enhanced by parallel research undertaken by Merchants Quay Ireland (MQI) on the nature and extent of drug use in Clondalkin. Overall, these methods allowed both elements to complement each other and give a comprehensive picture of prevalence and service needs. From here, the research method sought to develop dialogue with the members of Task Force over the draft strategy so as to arrive at a locally understood and owned strategic approach.

Clondalkin Drugs Task Force

The Clondalkin Drug Task Force is one of 14 LDTFs located mainly in the greater Dublin region. Their overall role is to prepare and implement action plans which identify existing and emerging gaps in services in relation to education/prevention, treatment, rehabilitation and curbing local supply.

To date the Clondalkin Drug Task Force The Task Forces has drawn up two Area Actions Plans based on intensive consultations (1997/8 and 2001). The plans represent a consensus on the priority issues to be addressed in the community in terms of problematic drug use. Each plan included a range of measures in terms of treatment, rehabilitation, education and prevention, and curbing the local supply of drugs. The initial Action Plan focused on education and prevention strategies and actions in response to the identified need for innovative community based education programmes in Clondalkin. CDTF's most recent Area Action Plan was developed in 2001 and entitled 'Making Progress'. In the development of the this Action Plan, the Task Force reflected on the lessons learned from implementing the initial plan and developed a number of strategies and actions that focused on Treatment & Rehabilitation.

Prevalence of Drug Problems in clondalkin

The research shows that drug use in Clondalkin is perceived to have become more problematic. The prevalence survey suggested that there are greater quantities and varieties of drugs available and there has been an increase in the proportion of younger people using drugs than was the case in the past. The respondents to the survey feel that drug dealing has become more visible in the locality. Drug consumption mostly occurs in the user's place of residence and the first encounter with illicit drugs typically occurred in the company of friends.

Heroin is the overwhelming primary problematic drug of use. Yet, there has been a notable increase in the problematic use of cocaine, alcohol and prescription drugs. Cocaine has become a frequently used recreational drug in Clondalkin. There is some indication in the survey that crack cocaine is an emerging problem drug.

The survey highlights how polydrug use is the norm. There are a wide variety of polydrug use patterns: heroin combined with either cannabis, cocaine, benzodiazepines, alcohol or crack cocaine, are the most common patterns of use. The typical pattern for recreational drug users was cocaine combined with either cannabis or alcohol. The injection of cocaine by injecting heroin users was another emerging trend.

This research suggests there are 1,591 opiate users in the area. Heroin was overwhelmingly the main problem drug for this cohort. The typical problematic drug user (especially opiates) in Clondalkin is most commonly a male, Irish, single, unemployed, early school leaver between the ages of 15 and 24 years. The MQI research indicates that in contrast to heroin users, recreational cocaine users come from all age groups and all social strata. The majority of problem drug users do not seek treatment until their late twenties and early thirties.

This research suggests that there is an obvious lack of data available on drug use among ethnic minorities. This emerges through the lack of engagement by those from new communities with existing treatment services and also lack of general knowledge on the part of community and statutory services of the profile of new communities in Clondalkin.

This report reveals that the causes of drug problems were perceived as wide, differed depending on the respondent's relationship with drugs and ranged across a number of factors such as contact with problematic drug use; family dysfunction; lack of education, low self-esteem and peer influences; curiosity, adolescent experimentation and an awareness of the pleasurable aspects of drug use.

Hepatitis C is quite prevalent among Injecting Drug Users (IDUs) according to the survey. In addition, one fifth of those interviewed had been diagnosed with a psychiatric illness and have accessed mental health services. A significant minority of IDUs reported not being aware of needle exchange services in Clondalkin.

MQI also show that there was a marginal decrease in the numbers of individuals accessing drug treatment services over the three year period, 2004-2007. It is perceived that services have improved over the past 5 years, due to the increase of facilities. Criticisms of current services included the lack of a 'moving on' or progression mechanism as well as the lack of input of clients to their drug treatment. There was widespread agreement that there is a lack of drug treatment services in the Clondalkin area and insufficient numbers of detoxification programmes available. The research also suggests that there is a clear need for a local homeless service in order to provide suitable facilities for homeless drug users.

There was a perception that drug related violence has increased significantly in recent years. There was a notable increase in simple possession and possession for sale and supply incidents from 2005 to 2006. Participants in the research perceived that there is a lack of Garda personnel dedicated to tackling drug related crime in Clondalkin.

The effects of drug problems on families include: physical and psychological stress; financial burden of payment of drug debts; grandparents who are taking care of their grandchildren; and, concerns for children of drug users in relation to their early exposure to drug addiction. The effects of drug problems on the community include: the crime element of drug use and the openness of dealing; fear of using public amenities; and that community anti-drug activism appears to have diminished due to fatigue.

Consultation with Stakeholders & Funded Projects

A number of interviews were conducted with community, voluntary and statutory stakeholders as part of the strategy development process. The main priorities identified for CDTF to undertake under its strategic plan centred on the following broad areas:

- Consolidate existing services
- Move from project based to programmatic approach
- Focus on polydrug use in existing and new projects
- Cocaine, including research, pilot responses and new sites for specialised services
- Placing a continuum of care approach at the centre of CDTF treatment strategies
- Co-ordination and collaboration including exploration and development of systems and agreements
- The introduction of a multi methods approach to prevention
- Addressing crisis intervention/windows of opportunity for motivated drug users seeking treatment
- Naming of target groups
- Provision of services for children and adolescents
- Developing social capital among the community in Clondalkin

- Addressing drug related crime, violence and community safety.
- A focus on realistic activities in respect of drug supply and drug demand.
- Animation of responses in geographic and among groups in which there is no current response
- Research and evaluation of supports, projects and new services
- Improving the profile of the task force

Consultation with Drug Users & Family members

A central part of the strategy development process was the carrying out of consultations with drug users and family members who are affected by drug problems. This part of the research added a realistic and valuable depth to the overall research and complemented the findings of the consultations with service provider and related stakeholders. The following are the areas noted by those interviewed which would serve to improve drug/addiction services in Clondalkin:

- Detoxification options
- Development of responses for the homelessness
- Responses to limit time on waiting list and related provision of crisis intervention services
- Rehabilitation and aftercare (in terms of a continuum of care model)
- Ancillary supports alongside treatment (accommodation, training, life skills, therapy, education, supported employment etc)
- Harm reduction around needle exchange, safe injecting, responsible batch preparation, sexual health, general and mental health, outreach, referrals, case management, and information.
- Additional services for drug users in the community
- Understanding and response to dual diagnosis/mental health problems in services for drug users
- Outreach to individuals and families not engaged with services
- Animation of responses and proactivity on the part of drugs services
- Options for aftercare outside of the immediate Clondalkin area

1.1 Background to the report and Strategy

The Clondalkin Drugs Task Force (CDTF) was established in 1996 in response to recommendations made in two Ministerial Reports on Measures to Reduce the Demand for Drugs, 1996 and 1997. The establishment of LDTFs were at the forefront of the response to dealing with drug problems in the 14 areas which were identified as having a significant opiate misuse problem. CDTF issued its first Area Action Plan in 1997 and this was followed by an updated plan in 2001. Over the course of 2007, the Clondalkin Drugs Task Force entered into its third strategic review/planning phase in line with the development of the next National Drugs Strategy (NDS), due to be tabled in late 2008, early 2009.

Aims and Processes

As part of this process, the task force has set down a range of aims for the development of its strategic plan, these are to:

- Act as a stocktaking exercise of the needs to be addressed in Clondalkin to ensure that current service provision meets these needs under the five pillars of the NDS.
- Identify and quantify emerging trends and issues to develop strategic capacity to respond to those issues.
- Inform partnership/collaborative working amongst community, voluntary agencies and statutory bodies for the delivery of essential local services and to determine future priorities.
- Identify and enhance the strategic capacity of the CDTF to inform policy development at both local and national level.

The key processes set out by CDTF in the development of the strategic plan were as follows:

- Carry out internal analysis regarding the effectiveness of the CDTF structures
- Carry out an analysis of the existing strategies at the local level
- Outline the current extent and nature of drug problems in the area, having regard to likely trends.
- Profile existing and planned service provision in statutory and community/voluntary sectors.
- Assess the adequacy of existing services against emerging and predicted trends.
- Identify strategic priorities.

This report brings together the outcomes of the strategic planning and review process in order to underpin and clarify the strategic plan and its priorities for the work, focus and actions of the Task Force over the coming three to five years.

1.2 Report Structure

The report is structured around nine chapters, Chapter Two looks at the wider drug situation with reference to national level issues. It identifies the policy and service responses to drug problems including the NDS, together with the role and function of the LDTFs. From here, it explores Clondalkin DTF in terms of its development, its objectives and projects. This will be followed by a section on current national prevalence in trends for problem drug use. Chapter Three explores the current national prevalence trends for problem drug use.

Chapter Four provides an overview of the socio and economic profile of Clondalkin. This chapter addresses in particular its population, household structure, educational background, social class, employment and deprivation. The next chapter, Chapter Five, presents a summary of the work carried out by Merchants Quay Ireland on a complementary piece of research looking on the prevalence of drugs in Clondalkin, using both secondary and primary sources. The core of this research was the carrying out of a survey of 150 drug users from the local area.

Chapter Six provides feedback from interviews with members and staff of the Task Force, related statutory agencies, community and voluntary groups and services providers and funded projects.

Chapter Seven reveals the key findings stemming from consultations with problem drug users and those affected by problem drug use, including family members.

Chapter Eight provides a summary and analysis of the key findings of the research in context of the aims and objectives outlined at the outset. This chapter also sets out the main conclusions arising out of the research and their implications for the strategy and therefore for the work and activities of the CDTF in the short and medium term future.

1.3 Methodology

The methodology for the research took place over a number of integrated phases. The approach to the development of the strategy placed an emphasis on balancing systematic or quantitative data on drug prevalence, socio-economic data for Clondalkin, policy and context information of relevance to the current and future work of the CDTF with qualitative information derived through consultations with drug users, families of drugs users and relevant community, voluntary and statutory stakeholders.

This methodology allowed for a comprehensive picture of service provision, experiences, gaps and needs in respect of drugs and problem drug use to be developed for Clondalkin. This method is referred to as triangulation whereby the views and experiences of key 'stakeholders' are explored alongside valid information sources in order to give a thorough and multidimensional representation of drug and drug related problems in Clondalkin. The aim of this method was ultimately to inform the thinking and analysis leading to the Task Force's strategy for the coming years. From here, the draft findings of the strategy development process were discussed and debated by the members of CDTF so as to arrive at an understood, realistic, valid and above all locally 'owned' strategy.

The main phases of the research process were as follows:

- The first phase discussed the brief for the research and the suggested approach with a steering group established by CDTF for the purposes of overseeing the development of the strategic plan.
- The second phase collated relevant statistical and policy/issue related information. This phase also developed the various research tools used to guide the consultations.
- The substantive phases of the research revolved around consultations with stakeholders. In each of these consultation phases a number of themes were used to guide the discussions. These were adapted so as to suit the perspective and experience of each of the different clusters of those consulted. The makeup of each of these clusters was chosen to include a range of informed perspectives on drug and related problems in Clondalkin. The main topics put to stakeholders in these consultations were the following: relationship to drugs and drug related problems in the area; form of drug problems; approach of CDTF to date; effectiveness of strategies; approach of CDTF required in the future; achievement of objectives of CDTF; national issues; impact of projects; relationship of task force's work to the NDS; adequacy of existing services; collaboration; structures and processes; policy development, research and advocacy; and, priorities for the future. The groups consulted included:
 - Eight interviews with members of the Task Force as well as its staff
 - Interviews took place with stakeholders and projects.
 - Six interviews were conducted with statutory stakeholders representing the local authority, the Garda Síochána, Probation and Welfare Service, and the Health Services Executive.
 - Three interviews and one focus group (11 participants) took place with community and voluntary stakeholders.
 - Five focus groups, accounting for 23 individuals, took place family support group and service user groups. A further twelve interviews took place with individuals drug users.

Parallel to the development of this strategy, a more extensive survey based research was undertaken by Merchants Quay Ireland (MQI) on the nature and extent of problem drug use in Clondalkin. The MQI complemented the process of developing the strategy and the played a key role in informing the prevalence chapter and other findings leading to the strategy.

4. The final phase of the research process involved the analysis of the data collected and development of the draft strategy. This draft report contained the main findings of the research and its implications for the future strategy of CDTF. This document served as the final discussion document that was used to inform specially convened meetings of the Task Force for the purposes of debate and prioritisation of the strategy for CDTF.

2. Context of the Task Force's Work

2.1 Introduction

Clondalkin Drug Task Force is one of 14 Local Drug Task Forces (LDTFs) in the state. This chapter presents an overview of the social and policy context in which the task force operates, which includes an overview of the National Drugs Strategy 2001-2008 (NDS), the role of LDTFs and specific information about CDTF. The overall aim of this chapter is to set the context for the research findings and the resulting strategy.

o National Drugs Strategy

The overriding policy framework for LDTFs is the National Drugs Strategy 2001-2008 (NDS). The main aim of the NDS is:

“To significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and rehabilitation and research”.

The Strategy is delivered through what it terms 'pillars'. The pillars are interconnected clusters of actions around the following themes:

- supply reduction
- prevention (through education and awareness)

- treatment (including rehabilitation and risk reduction)
- research

Under each of the pillars, a range of actions and responsibilities are set down. Central to this approach is the bringing together of key agencies, both statutory and community/voluntary, in the implementation of the strategy.

The implementation structures for the NDS, its various activities and responsibilities for completing the agreed actions are attributed to a number of lead agencies. In addition to the lead agencies, there are a range of other bodies that play a role in the overall implementation of the NDS. These include government committees, interdepartmental groups and the lead Department for the NDS (Community, Rural and Gaeltacht Affairs) and a dedicated National Drugs Strategy Team (NDST).

The NDST is drawn from Departments and Agencies involved in the drugs field. It also contains representatives from the community and voluntary sectors. Its purpose is to oversee the work of the Local and Regional Drugs Task Forces, address and make recommendations on issues arising and to report on progress in this area.

The delivery infrastructure of the NDS also includes: an assessment committee for the Young Peoples Services and Facilities Fund as well as local development groups for this fund in the various LDTF communities and at the local and regional level; LDTFs; and the recently established Regional Drugs Task Forces.

In more recent times, the NDS has been reviewed and assessed. The mid-term review of the NDS was published in mid 2005. It recommends a number of additions and amendments to the 2001-2008 NDS. Overall, the review saw no need to change the aims and objectives of the strategy. The success of the strategy varies across its respective pillars. The review recommended the addition of eight new actions, replacement of ten actions and the amendment of seven. One of the main changes was the addition of a fifth pillar, rehabilitation, alongside supply reduction, prevention, treatment and research.

Of particular note in the context of this research, the review recommended the following amendments and additions to update the 2001 NDS:

Pillar of NDS	Recommendations
Supply reduction:	<ul style="list-style-type: none"> • Garda resources in LDTF areas to be increased including additional resources to community policing • community policing fora to be put in place in all LDTF areas
Prevention:	<ul style="list-style-type: none"> - substance use policies in schools in LDTF areas - ongoing training and supports to teachers to deliver Social Personal & Health Education (SPHE) - Prioritise SPHE - prevention education to be included in curriculum - investigate substance use programmes in non-school settings - factual and easily accessible preventative information for parents and families on substance use - Home School Community Liaison Scheme to be expanded to engage with families affected by drug problems
Treatment:	<ul style="list-style-type: none"> - auditing treatment availability and assessing treatment needs - responding to polydrug use by increasing availability of treatment options - rehabilitation to become the 'fifth pillar' of the NDS - implementation of guidelines on working with under 18s - wider time and geographic availability of harm reduction services such as needle exchange - consideration of employment of medical staff by voluntary and community based drug services
Co-ordinating structures:	<ul style="list-style-type: none"> - exploration of alcohol and drugs and the potential for better co-ordination
Cross-pillar:	<ul style="list-style-type: none"> - implement the recommendations of the NACD Family Support Report.

These recommendations provide national perspectives on some of the areas that were seen as missing from the NDS. They also serve therefore as a wider context to some of the findings outlined as part of this research. Thus in more recent times, along with the pillars relevant to the LDTFs, the review of the NDS suggests that LDTFs would add a number of focuses to their work including exploring alcohol co-ordination, family support and rehabilitation.

2.2.1 Rehabilitation

The importance of the additional or 'fifth pillar' of the NDS, rehabilitation, was underlined earlier in 2007 with the publication under the NDS of the 'Report of the Working Group on Drugs Rehabilitation'. The working group was chaired by the Drugs Strategy Unit of the Department of Community, Rural and Gaeltacht Affairs and comprised members from the NDST, NACD, community sector, voluntary sectors, FAS, the HSE and the Departments of Health and Children, Education and Science, Justice, Equality and Law Reform.

The Report defines rehabilitation as:

'a structured developmental process whereby individuals are facilitated to become fully involved in the process of regaining their capacity for daily life from the impact of problem drug use; providing a 'continuum of care' to

problem drug users enabling them to address their needs, as most appropriate for them (these needs may include health, social, housing, employment, educational and/or vocational); being aimed at maximising their quality of life, and that of their families and communities; and, enabling their re-integration into their community.

The aim of this holistic process is to empower people so that they can access the social, economic and cultural benefits of life in line with their needs and aspirations. Drug rehabilitation, therefore, encompasses interventions aimed at stopping, stabilising and/or reducing the harm associated with a person's drug use as well as addressing a person's broader health and social needs'³

The report notes that in LDTF areas rehabilitation service provision has evolved around four themes, namely: community drug teams; provision of therapeutic support; employment access, training and education; and, ancillary supports in respect of the families, childcare, housing and welfare. Overall, the working group suggests that a wide range of services are already available which support the rehabilitation of drug users. However, like many services in the area of problem drug use, these are disparate, uncoordinated and have different approaches to their clients and understanding of, or approaches, to rehabilitation.

The suggested approach therefore for the delivery of rehabilitation services for problem drug users in the future highlights the need for increased co-ordination of services, development of a quality standards framework and identifying and addressing staff training needs. The suggested structure for rehabilitation emphasises client centeredness. This suggested structure will include a National Drug Rehabilitation Implementation Committee. This committee will develop the national protocols required; local protocols would be in the remit of the treatment and rehabilitation sub groups of LDTFs, on which the Rehabilitation coordinator for the area would sit. In addition, service level agreements would be monitored locally by the relevant LDTF sub committees. Overall, the key points made in the report focus on:

- an effective interagency approach based on a continuum of care for the individual
- an expansion of the range of treatment options
- building on the rehabilitation impact of CE schemes
- factoring in broader life issues including medical support, access to employment, education housing, particular issues relating to offenders, childcare, research and the role of families in rehabilitation.

2.3 Local Drugs Task Forces

The Clondalkin Drug Task Force is one of 14 LDTFs located mainly in the greater Dublin region. They have been at the forefront of local and national efforts to tackle drug problems in communities. Their overall role, as envisaged by the NDS, is to prepare and implement action plans which identify existing and emerging gaps in services in relation to education/prevention, treatment, rehabilitation and curbing local supply.

Due to their membership (community, voluntary, statutory and elected interests) the LDTFs also provide a mechanism for the co-ordination of mainstream services in their areas while also providing a forum which facilitates local community and voluntary organisations to participate in the planning, design and delivery of local services and responses.

In addition to this, the Task Forces work to aid the development of community based initiatives and to link in with, and, add value to, the programmes and services already being delivered or planned by statutory agencies, such as the HSE.

This is seen in part to be done on the basis of the interagency membership of LDTFs. As noted, the make-up of the task forces includes representatives from all the relevant agencies such as the HSE, the Gardai, the Probation and Welfare Service, the Department of Education and Science, the Local Authority, Youth Services, FAS as well as the representatives of local community and voluntary groups.

The Task Forces have to date drawn up two actions plans based on intensive consultations (1997/8 and 2001). The plans represent a consensus on the priority issues to be addressed in the community in terms of problematic drug use. Each plan included a range of measures in terms of treatment, rehabilitation, education and prevention, and curbing the local supply of drugs.

In the context of their wider role as part of the NDS, the key objectives of the LDTFs are centred on the aims of the Government's drugs policy which as noted seeks to provide an effective, integrated response to the problems posed by drug misuse in local communities. The key objectives of that policy are:

- To reduce the numbers of people turning to drugs in the first instance, through comprehensive education and prevention programmes;
- To provide appropriate treatment and aftercare for those who are dependent on drugs;
- To have appropriate mechanisms in place at national and local level, aimed at reducing the supply of illicit drugs;
- To ensure that an appropriate level of accurate and timely information is available to inform the response to the problem;
- To support measures aimed at reducing the harm to those actively using drugs; and
- To support families and communities affected by drugs.

The LDTFs were evaluated in 1998 and from this the NDST established a working group to examine the aims, objectives, roles and responsibilities of LDTFs. This led to the publication in 2000 of a handbook for the operations of the LDTFs. From this, the following are their revised terms of reference for LDTFs:

- To oversee and monitor the implementation of projects approved under their existing action plans;
- To ensure the formal evaluation of these projects with a view to their "mainstreaming", i.e. their continued funding through State Agencies in accordance with agreed procedures;
- In accordance with agreed guidelines, to prepare updated action plans which:
 - update the area profile and take into account any changes in the drug problem since the preparation of their original plans;
 - ensure that emerging strategic issues are identified and policies or actions are proposed to address them; and
 - provide for the implementation of a local drugs strategy, in consultation with appropriate State Agencies and voluntary, community and residents groups;
- To ensure appropriate representation by voluntary and community sectors on the Task Force;
- To identify any barriers to the efficient working of the Task Force;
- To develop networking arrangements for the exchange of information and experience with other Task Forces, as well as for the dissemination of best practice;
- To identify the training needs of Task Force members and take the necessary steps to meet such needs through appropriate training courses, etc.;
- To take account of and contribute to other initiatives aimed at tackling social disadvantage under the aegis of the Cabinet Committee on Social Inclusion, including the Integrated Services Process, the Area Partnerships, the Young People's Facilities and Services Fund and the Report of the Task Force on the Integration of the Local Government and Local Development systems; and
- To provide such information, reports and proposals to the National Drugs Strategy Team as may be requested from time to time.

The following seven functions were identified by the NDST in 2005 as part of the 'operational guidelines' issued to each of the LDTFs to further enhance the role of the LDTFs going forward, complementing their original function: "to develop and implement a drugs strategy for their areas which co-ordinates all relevant programmes and addresses any gaps in services" (Local Drugs Task Force Handbook) which also takes into account the recommendations arising from the NDST mainstreaming document.

- **Information gathering and dissemination:** Overall responsibility for ensuring that an appropriate level of accurate and timely information on drugs misuse is available, identifying emerging needs among drug users in their community, early identification of emerging trends & issues and reporting back to the NDST.
- **Strategic and policy development:** Maintaining a strategic overview of service provision ensuring they have a positive and focused impact on tackling drugs misuse (a) to ensure the efficacy of such services (b) to seek to influence policy through the NDST-IDG, and the Cabinet Committee on Social Inclusion.
- **Development of Local Plans:** Adopting a pro-active role in developing and revising quality proposals to address gaps in services.
- **Evaluation:** Engaging both in strategy review and project evaluation processes, in conjunction with the NDST
- **Implementation and monitoring of plans:** Maintaining ongoing contacts with projects through monitoring and support of projects pre and post mainstreaming with this to be specified in service agreements. To mediate, where necessary, if problems arise between the project promoters and agency
- **Training and support:** Where needed, to facilitate the provision of technical support to management committees and staff of individual projects to meet their service agreement requirements e.g. arranging access to training.
- **Networking:** To foster and build linkages with agencies and groups focussed on supporting drug users to integrate them into society by enhancing education, housing, social supports and labour market opportunities.

2.4 CLONDALKIN DRUGS TASK FORCE

2.4.1 CDTF Action Plan 1997

CDTF's initial plan, entitled Local Development Plan 1997-1999, identified its two key aims as:

- To support the community to create a climate which would reduce the demand for drugs by bringing together community, voluntary and statutory organisations in a collaborative way.
- To provide a range of treatment options to enhance the opportunities for drug users to become drug free and minimise the level of chronic drug use and its effect on the community.

In the initial planning period, there was an emphasis of education and prevention over treatment and rehabilitation actions. This was in response to the identified need for innovative community based education programmes in Clondalkin. The Task Force suggested that problem drug use was overwhelmingly concentrated among young males in the 15 to 24 age range, and while the problem existed in most communities in Clondalkin, it was largely concentrated in particular estates in North Clondalkin.

This Plan was designed to complement the then Eastern Health Board's service plan which focused on preventive strategies. In this regard, it noted that innovative and community based education programmes were required. In addition, the first action plan also stressed that initiatives were required to address problems of poor school attendance and to provide support to families. Regarding drug availability, the 1997 plan highlighted the importance of workable structures that would allow the Gardai, community and local authority address the problem on a partnership basis. Treatment and rehabilitation requirements were analysed in some detail and herein the Task Force highlighted the need for networking and co-operation in the development of responses for drug users and their families. In 1997, the Task Force also noted isolation of drug users. Strategies to facilitate the transition from treatment to reintegration into community life were seen as key in this respect. Furthermore, drug users were seen to need access to a wide range of appropriate treatment options that would be complemented by locally based rehabilitation programmes. Table 1, shown below, outlines the various actions and projects developed or supported under the 1997 Area Action Plan:

MAINSTREAMED CDTF PROJECTS (as of 2007)		
PROJECT	AIM	FUNDING CHANNEL
Education Programme	<i>The Programme provides a range of drug education/ prevention measures together with the following funds: Bursary Fund; Community Training Fund; In- Service Fund; Drug Project Training Fund; Parent Group Fund; and School Resources Fun.</i>	HSE
Cairdeas Project	<i>Cairdeas advocates on behalf of drug users who may be experiencing difficulties as a result of their drug use. It facilitates a drug user's forum in order to empower drug users to represent themselves.</i>	HSE
Cumas Project	<i>Cumas provides support to young people and families affected by drug misuse through individual and group work.</i>	HSE
Treatment & Rehabilitation Fund	<i>The fund provides the following:</i> <ul style="list-style-type: none"> ▪ <i>Bursary Fund – Grants to support drug users in recovery to attend accredited courses</i> ▪ <i>Residential Fund – Grants to agencies to facilitate their clients in accessing residential treatment services</i> ▪ <i>Counselling Fund – Grants to agencies only to provide access to counselling for their clients</i> 	HSE
CASP (Clondalkin Addiction Support Programme)	<i>CASP provides the following services:</i> <ul style="list-style-type: none"> • <i>Methadone Programme</i> • <i>Counselling</i> • <i>Outreach</i> • <i>Group Work</i> • <i>Family Support</i> • <i>8. Key working Programme-</i> • <i>Aftercare</i> • <i>Nursing care</i> • <i>Community development and networking</i> • <i>FAS and Jobs Initiative Community Employment</i> • <i>Administration</i> • <i>Cleaning</i> 	HSE

	<ul style="list-style-type: none"> • Training • Management of Service 	
BY&FSG (Bawnogue Youth & Family Support Group)	<p>The BY&FSG provide the following services:</p> <ul style="list-style-type: none"> ▪ Counselling: Identify issues for client and link with appropriate Counsellor/ agency; ▪ Parent Support Group: Continue to develop the Parents Support Group; ▪ Key working: One to one's, referral to relevant agencies and daily support; ▪ Drop in: Twice daily drop ins ▪ Staff training: Update the training needs of each staff member; ▪ Raise the profile of the Bawnogue Youth & Family Support Group 	HSE
Clondalkin Travellers Development Group	To provide youth diversionary and health promotion activities to young Travellers	VEC
Community Safety Forums	The aim of the forums is the bring together for the benefit of the community all relevant community, statutory, voluntary and public representatives to share information, discuss issues of local concern, influence local policy and develop Garda -community relations.	South Dublin County Council

2.4.2 CDTF Action Plan 2001

CDTF's most recent Area Action Plan was developed in 2001 and entitled 'Making Progress'. In the development of the 2001 Action Plan, the Task Force reflected on the lessons learned from implementing the 1997 action plan. The following issues were identified:

- Role of the Task Force - *the role of the Task Force is to support the development of appropriate local responses to the drug issue, not to develop a comprehensive integrated service for drug users and their families. Thus that Task Force's effectiveness depends greatly on the effectiveness of the state's response.*
- Project Promoter Supports - *it was agreed that the Task Force did not anticipate the extra supports required by the project promoters in order to successfully implement proposals. These extra supports included such things such as staff, establishment of proper financial procedures and project development support.*
- Monitoring and Evaluation Procedures - *no monitoring or evaluation tools were developed for projects implemented in the first plan, as a result it was difficult for both the Task Force and the National Drug Strategy Team to assess the effectiveness/ impact of the various strategies.*
- Multiple Strategies - *some organisations promoted a number of projects from different strategies. It was agreed that this mechanism led to confusion and difficulty during the evaluation/ mainstreaming process.*
- Community Representation - *the Task Force agreed that there has been a lack of resident representation on both the Task Force and its various sub-groups while acknowledging the high participation of locally based organisations. The Task Force has actively tried to identify other structures to facilitate meaningful resident representation through the development of quarterly meetings with Resident Associations.*
- Task Force Projects - *due to the lack of appropriate community infrastructure, the Task Force had to take direct responsibility for the development and the employment of staff for a number of projects. The Task Force agrees that although this process has been very successful in developing effective working projects, the Task Force did not predict the extra supports required for the management and financial requirements.*

The 2001 Action Plan - 'Making Progress' - therefore sought to build on the work of the Task Force to that point whilst also addressing new issues and challenges. That action plan took as its vision the following:

'The Clondalkin Drug Task Force brings together a range of representatives to design and implement an integrated, holistic strategy which seeks to address the context and consequence of problem drug use in Clondalkin. The Task Force places community participation at its centre, and seeks to harness and build on the commitment and good will shown by the statutory, community and voluntary organisations to work together to achieve this end'.

Table, shown below, summarized the projects initiated and/or supported by the 2001 Area Action Plan:

EDUCATION/PREVENTION			
PROJECT PROMOTER	ACTION	AIM	FUNDING CHANNEL
Catholic Youth Care Ronanstown Youth Service	<i>Youth Activities in the Evenings</i>	<i>To provide late night youth diversionary activities for at risk youth</i>	County Dublin Vocational Education Committee (CDVEC)
Clondalkin Drugs Task Force	<i>School Drugs Worker</i>	<i>To facilitate and support schools in the Task Force area to develop substance use policies and to develop resources that will support teachers to implement the Substance Use module of the Social, Personal & Health Education Programme</i>	CDVEC
Clondalkin Drugs Task Force	<i>Public Information</i>	<i>To provide on-going accurate information in relation to local drugs issues and services and to promote the work of the Clondalkin Drug Task Force</i>	Health Services Executive (HSE)
Carline Project	<i>Social Care Worker</i>	<i>To provide support to early school leavers to help them in building their self esteem and confidence along with providing them with educational programmes</i>	HSE
Clondalkin Travellers Development Group	<i>Young Male Traveller Initiative</i>	<i>To address the needs of young male Travellers who may be at risk of drug misuse due to the impact of exclusion from health, employment, education or youth initiatives</i>	HSE

TREATMENT			
PROJECT PROMOTER	ACTION	AIM	FUNDING CHANNEL
Clondalkin Addiction Support Programme	<i>GP Counsellor</i>	<i>Employment of a counsellor to work as part of the counselling team with specific responsibility to support individuals being maintained on methadone by level 1 and level 2 GPs in Clondalkin</i>	HSE
Bawnogue Youth & Family Support Group	<i>Gender Specific Support Groups</i>	<i>To provide a safe and confidential environment to confront gender specific issues, aid development of life skills and enhance personal development</i>	HSE
Clondalkin Addiction Support Programme Bawnogue Youth & Family Support Group	<i>Complimentary Therapies</i>	<i>To provide a range of complimentary therapies to service users and Acupuncture detoxification programme for clients</i>	HSE
Ronanstown Youth Service Dublin Simon Outreach Service	<i>Homeless Outreach Workers</i>	<i>To employ homeless outreach workers to provide care and support to homeless drug users and those at risk in Clondalkin</i>	HSE
Clondalkin Addiction Support Programme	<i>Drop-In Service for Active/Homeless Drug Users</i>	<i>To employ an outreach worker and nursing receptionist/security on a sessional basis to establish two drop ins or contact points for active drug users in Clondalkin</i>	HSE
Clondalkin Addiction Support Programme	<i>Prison Links Worker</i>	<i>To employ a community prison links worker in order to significantly improve the choices of drug users in prison or on remand who wish to address or continue to address their addiction when incarcerated or on their release from prison</i>	Probation and Welfare Service
Cumas Project	<i>Subsidised Childcare</i>	<i>To provide child care, respite and family therapy costs for parents and grandparents living with addiction</i>	HSE
Cumas Project	<i>Childcare Workers</i>	<i>To employ two childcare workers to provide planned needs based therapeutic interventions for children of drug users on an individual or group basis.</i>	HSE
Cairdeas Project	<i>Drug Users Forum</i>	<i>To create an environment whereby service users can gain skills and knowledge to improve their confidence to represent themselves on policy making bodies</i>	HSE
Clondalkin Addiction Support Programme	<i>Family Support Workers</i>	<i>To employ two family support workers to co ordinate and develop a family support team responsible for</i>	HSE

Bawnogue Youth and Family Support Group		<i>implementing a range of services that support parents, family members and partners living with addiction</i>	
Beacon of Light Counselling Services	<i>Locally Based Counselling</i>	<i>To support clients and their families through one to one counselling, group therapy, holistic therapy and relevant education programmes.</i>	HSE
Clondalkin Addiction Support Programme Bawnogue Youth and Family Support Group	<i>Late Night Drop In – Families</i>	<i>To provide Drop In services for adult family members and partners of drug users to access information, support and crisis intervention</i>	HSE
Clondalkin Addiction Support Programme	<i>Respite House</i>	<i>To provide a safe and comfortable place for short breaks for families, overnight and day trips for client groups and staff training and development outside Clondalkin</i>	HSE
Clondalkin Addiction Support Programme	<i>Therapeutic Day Programme</i>	<i>To facilitate therapeutic groups providing support and development aimed at progressing clients on methadone programme towards recovery</i>	HSE
Cumas Project	<i>Cumas Programmes</i>	<i>Individual and group interventions for young people affected by drug misuse in the family</i>	HSE
Dochas	<i>Family Support</i>	<i>To provide counselling and support to families affected by drug misuse in order to strengthen the family unit and assist children and young people to remain successfully in their home, school and community</i>	HSE
Clondalkin Partnership	<i>Incredible Years Programme</i>	<i>To provide family support and assistance through the provision of a therapeutically based parental training programme. The programme will focus on discussion, identification and implementation of behaviourally based parental training strategies designed and tailored to address specific and more general problems associated with parenting and child rearing in the current climate</i>	HSE
Ronanstown Youth Service - GRAFT	<i>GRAFT Programme North and South West Clondalkin</i>	<i>To support parents of young people involved in anti social behaviour. The programme will concentrate on developing skills in dealing with difficult behaviour and support them in developing new boundaries at home</i>	Department of Justice Equality and Law Reform

REHABILITATION

PROJECT PROMOTER	ACTION	AIM	FUNDING CHANNEL
Bawnogue Youth and Family Support Group	<i>After Care Programme</i>	<i>To provide one to one support sessions to clients in recovery, aftercare support group and relapse prevention programme</i>	HSE
Cairdeas project	<i>Step Ladder Programme</i>	<i>To support members of the drug using community to access pre-development training with a view to progressing to mainstream training or employment</i>	HSE

Finally, the main new services with respect to drug problems planned for Clondalkin is the set up of a drug treatment clinic on the site of St. Loman's Hospital. There is some talk of a homeless hostel, although it is unclear how far progressed this suggestion is with South Dublin County Council. A rehabilitation project, as noted earlier, has been proposed for Bawnogue, however there has been no movement on this to date from FAS. In addition, a family functioning therapy project is in the early stages of implementation under the aegis of Clondalkin Partnership. There is also some mention of the establishment of a cocaine project in CASP.

2.5 Conclusion

This chapter has provided an overview of the wider context in which the Clondalkin Drug Task Force operates. The main areas covered in the chapter were firstly, the policy context of the LDTFs provided by the NDS and in particular the new fifth rehabilitation pillar of the national strategy, secondly the background and function of the LDTFs themselves, and finally, an overview of the development and initiatives of CDTF since 1997.

3. Drug use Prevalence

3.1 Introduction

In order to create a context for the work of the TF, the national trends in drug prevalence are briefly outlined in this Chapter. A wide range of sources are used to give a sense of the nature and extent of drug misuse nationally together with the emerging trends in drug use at national, regional level.

3.2. National Prevalence

3.2.1 Drug Prevalence Surveys

The first national survey of prevalence rates for illegal drugs was commissioned by the National Advisory Committee on Drugs (NACD) and Drug Alcohol Information and Research Unit (DAIRU) of Northern Ireland in 2002/3. The revised bulletin of results for the 2002/3 survey was published in mid 2005.

This survey found that one in every five people has used drugs (19%) in their life time. In the last year, one in eighteen - or just under 6% - reported ever using illicit drugs and 3% stated they were current users. The regional dimensions of the national prevalence survey demonstrates that rates of use are much higher in east of the country, the so called greater Dublin area, than elsewhere. Rates for all measures of prevalence – lifetime, last month and current use - were higher in the east of the country than elsewhere.

From this survey, it is apparent that cannabis is the most used illegal drug, used by 17.4% in their lifetime. 5% had used cannabis in the previous year and 2.6% stated they were current users. The prevalence of other drugs however was considerably lower and seen mostly in younger age ranges. Lifetime prevalence of drugs included: magic mushrooms (3.9%), ecstasy (3.7%), amphetamines (3%), cocaine and LSD (2.9%). Half of one percent reported using heroin in their lifetime.

In age band terms, the highest life time prevalence is seen in the 25-34 age group. The exception to this is for drugs such as cocaine, ecstasy, poppers and solvents which are highest in the 15-24 age group. Furthermore, the use of sedatives and anti-depressants is most prevalent in the 55-64 age range. In respect of gender, this survey suggests that men use illegal drugs twice as much as women.

In terms of specific drugs, the following are some of the relevant findings coming out of the bulletins released under the 2002/3 prevalence survey (opiate use is dealt with separately below)

Cocaine

- 3% of 15-64 year olds reported taking cocaine at some point in their lives. Only 1.1% used these drugs in the last year and .3% in the last month.
- On average, prevalence rates were higher for young people: 4.7% in the 15-34 age group. Prevalence rates in Ireland are highest in the former Dublin health board areas. For instance, the former Northern Area Health Board demonstrates prevalence rate of 5.2%.
- There is no apparent association between cocaine use and any one socio-economic grouping, although slighter higher lifetime use rates were seen in lower socio-economic groups. Respondents who rent accommodation from a private landlord were more likely to use cocaine, those who own their property were least likely to use cocaine.
- Those who attained higher education levels reported higher prevalence rates, lifetime and last year, than those with lower levels of educational attainment. This suggests that the biography of cocaine users goes across the board.

Source: NACD/DAIRU, 2005.

Cannabis

- 17% of 15-64 reported taking cannabis at some point in their lives. One in 20 or 5% used cannabis in the last year and the corresponding figure for use in the last month was 3%.
- Prevalence is highest among those in the 15-34 age group (24%). 11% of those ages 35 to 64 reported use.
- Cannabis is widely used across all socio-economic groups and is not higher in lower income groupings. Those at work are more likely to use cannabis.
- Respondents who rented their accommodation from a private landlord and/or local authority had higher prevalence rates than those that owned their own home.
- Those who left education aged 20 or over have higher life time prevalence rates.

Source: NACD/DAIRU, 2005.

2006/7 Drug Prevalence Survey

The most recent survey was carried out in 2006 and 2007 and first overall results were published in January 2008. This survey is of particular value as it provides a comparative aspect to the prevalence survey from 2003 to 2007. The survey is the first of a number of bulletins and does not go into detail in respect of any one drug or geographic locations in Ireland.

Nevertheless, the survey reveals that the use of illegal drugs among adults aged 15 to 64 at some point in their life increased from 19% to 24% of the population from 2002/3 to 2006/7. In 2006/7 therefore, the survey shows that one in four persons reported using illicit drugs over the course of their life. This represents an increase on the 2003 figure of 26%. The proportions reporting 'lifetime' use of cannabis increased from 17% to 22%, of 'magic' mushrooms from 4% to 6% and of cocaine from 3% to 5%. The increase in the proportions reporting use of cocaine from 2003 to 2007 is therefore in the order of 67%, which also tallies with anecdotal evidence. By and large, the national trends suggest that men and young age groups (<34 yrs) reported higher lifetime prevalence rates than other groupings.

In terms of specific drugs, the following are some of the relevant findings coming out of the bulletins released under the 2002/3 prevalence survey (opiate use is dealt with separately below)

Cocaine (including Crack)

- 5.3% of 15-64 year olds reported taking cocaine at some point in their lives. Only 1.7% used these drugs in the last year and 0.5% in the last month.
- On average, life time prevalence rates were higher for young people: 8.2% in the 15-34 age group. Prevalence rates for the 35-64 age group were 2.7%. In any one age group, the highest rate of lifetime prevalence is seen in the 25-34 age group at 9.3%.

Source: NACD/DAIRU, 2008.

Cannabis

- 21.9% of 15-64 year olds reported taking cannabis at some point in their lives. 6.3% used cannabis in the last year and the corresponding figure for use in the last month was 2.6%.
- Lifetime prevalence is highest among those in the 15-34 age group (28.6%). 16.1% of those ages 35 to 64 reported use.
- Life time prevalence rates were higher for young people: 31.9% in the 25 to 34 age group. Prevalence rates for the in the preceding age group, 15-24 was 24.8% and 24.4% in the 35-44 age group.

Source: NACD/DAIRU, 2008.

3.2.2 Opiate Use

Research carried out on the number of opiate users (NACD, 2003) reveals in 2001 there were 14,452 opiate users nationally and of those, 12,446 were located in Dublin. This survey reveals national prevalence rates of 5.6 per thousand in the 15-64 age group and 16 per thousand in this age group in Dublin. Comparing 1996 and 2001, this survey shows that the prevalence in 2001 at 18.2 compared to 21 per thousand in 1996. The opiate prevalence data presented suggests that there is an aging of the opiate using population nationally and thus points to reduced opiate use in the lower age groups. What is clear is that this data is somewhat out of date. Another national research looking at repeating this research is currently underway and will give a more up to date picture for 2007/8. Nevertheless, there appears to some stabilisation over recent times in opiate use.

The NACD/DAIRU surveys from 2006/7 discussed above reveals that 0.4% of the population aged 15 to 64 reported heroin use. Use of other opiates during the lifetime was 6.2%. In terms of heroin, there was no difference in the prevalence of lifetime use among young adults (15-34) and older adults (35-64) at 0.4%. In keeping with earlier trends, the highest rate of prevalence is seen in the 25-34 (0.6%) and the 35-44 age group (0.7%).

3.2.3 Cocaine

Because of the emergence of cocaine as a significant problem drug in recent years, supported firstly through anecdotal evidence and other pieces of research. The emergence of cocaine perhaps now is better understood less in terms of an 'emerging' issue and rather as contemporary issue in its own right. Traditionally, the response to drug problems in the state and as envisaged in the NDS and Methadone Treatment Protocol has focused on opiates. The emergence of cocaine has resulted in a number of pilot projects being established, ones for instance in Tallaght and Dublin 12, and the recent joint publication by the NDST and NACD of a report entitled 'An Overview of Cocaine Use in Ireland: II'. This follows the initial publication of a cocaine report by the NACD in 2003, which could be seen as

responding to the emergence phase of cocaine problems in Ireland. It is worth giving an overview of some of key aspects of the most recent cocaine report in order to inform the current strategic plan.

As a starting point, the report reveals that problems related to polydrug use have increased in Ireland since 2003. Cocaine is one of substances used here along with cannabis, ecstasy and alcohol. In the Irish context, the most recent NACD/DAIRU Drug Prevalence Survey (2006/7) noted above reveals that 5% of the population -aged 15 to 64 - used cocaine at least once in their lives, while the prevalence rate was highest, just over 9%, for those in the 25-34 age group. This first national survey from 2002/3 suggests that of those who use another drug with cocaine (polydrug use) 92% use alcohol, 63% use cannabis. This report also points to analysis by the state laboratory of samples referred to it by the coroner's court and in criminal cases which show that figures for the detection of cocaine in samples has increased by six times from 2000 to 2006.

From Garda statistics, the report is able to show that cocaine is second only to cannabis (resin) as the most trafficked drug. Cocaine is the drug which is increasing in these terms while there has been a relative stabilisation in the supply of heroin and cannabis and a fall off in the supply of amphetamine and ecstasy. Cocaine accounts for almost 13% of all offences under the relevant drugs legislation, revealing a six fold increase over the last ten years. The incidence of seizures and offences is markedly higher in eastern seaboard or greater Dublin region than elsewhere. This clearly indicates the supply and by implication demand for cocaine. There is a sense that cocaine has come to replace the use of amphetamine and ecstasy by parts of the population.

According to this report the numbers seeking treatment for cocaine problems increased from 1998 to 2003 by close to 300%, and by 364% over that period where cocaine is reported as an additional problem drug in the case of poly drug use. For those that reported cocaine as their main problem drug in 2003, 92% could be described as poly drug users. There is also a five-fold increase in the numbers of new cases presenting for treatment whose primary problem drug is cocaine. For users of cocaine presenting for treatment, 39% reported using the drug between two and six days per week. Almost one in four (23%) reported using cocaine on a daily basis.

Evidence presented in official urinalysis reports suggests that in recent years many individuals who are on the methadone maintenance programme test positive for cocaine, which although expected underlines the prevalence of the drug in communities. The Research Outcome Study in Ireland or 'ROSIE' study, overseen by the NACD, shows that 92% of the opiate users recruited to the longitudinal study reported having used cocaine. In addition, 58% of respondents stated that they have used 'crack' cocaine. Overall, nearly half (48%) of study participants reported the use of cocaine in the recent past. It should be noted that the one year follow up of clients in the ROSIE study suggested less use and an increase of abstinence. This while very positive does not take away from the evidence about the prevalence of cocaine in general and thus for those – the majority of drug users - who are outside the (opiate) treatment loop.

The report also shows how cocaine use is evident in various sectors of the wider population such as Travellers, prisoners, new communities and the homeless. Cocaine is a problematic drug in more ways than one; its treatment is difficult and it has widespread health implications for its users including behavioural problems. The community aspect of the report illustrates the widely held view that 'drug treatment' is mainly 'opiate treatment', which is a particular challenge. There is the sense also from this report that due to the absence of a pharmacological treatment for cocaine, lower numbers present for treatment than the numbers who may otherwise might.

3.2.4 Treatment Statistics

The Central Treatment List deals with a register of individuals receiving methadone. The following table provides a breakdown of 2000, 2003 with this the 2006 figure culminating at the end of September 2006, that is, for a period of nine as opposed to 12 months.

Table 3.3: Central Treatment List ERHA, 2000-part 2006

Area	2000	2003	2006(9 mths)	NAHB
Former ERHA Clinics	2,849	3543	4039	1839
National Clinics	41	123	195	
Trinity Court	513	501	526	
Prisons	-	402	406	
GPs Former ERHA	1574	2160	2539	810
GPs National	55	154	261	
Total	5032	6883	7560	-

Source: Drug Treatment Centre Board October 2006, Dept. of Community, Rural and Gaeltacht Affairs, 2004: 15.

The numbers receiving methadone has increased over the years. There has been an increase in the number of treatment centres outside the former ERHA area, which has led to an increase in the numbers using the services listed outside the

eastern region. It has been noted that the increase in the availability of places leads to more users coming forward for treatment.

The majority of clients are aged between 20 and 34 years of age. There appears to be few opiate users under the age of 20 according to the Central Treatment List. This may be because of a time lag in seeking treatment or more optimistically, a reduction in the number of new users in this age group as opposed to older age ranges.

For the most part, there has been an increase in the number of opiate cases seeking treatment in both the eastern region and elsewhere in the state. The number in the eastern region is higher although other parts of the country have seen very large proportionate increases. This may be due to better reporting, more treatment places as well as an increase in prevalence. It is worth noting, that at any given time there are a number of people on the waiting lists for treatment services.

3.2.5 *Garda Síochána National Statistics*

The figures in the table and chart below detail the offences detected by the Garda according to their annualised statistics over the last 15 years nationally. These show the overall number of offences for each drug type and also the proportion of all offences that a drug type makes up.

Table 3.4: Number and Annualised Percentage of Misuse of Drugs Act Offences by Drug Type

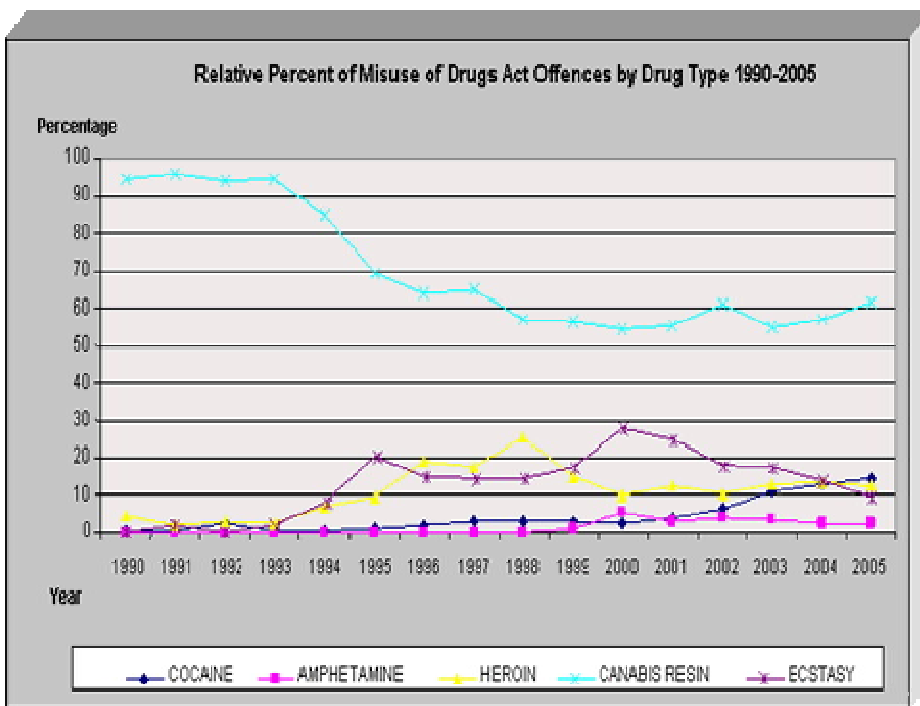
YEAR	COCAINE	%	AMPHETAMINE	%	HEROIN	%	CANABIS RESIN	%	ECSTASY	%
1990	11	0.74	n/a	0	71	4.75	1413	94.52	-	0
1991	7	0.29	n/a	0	45	1.84	2354	96.04	45	1.84
1992	77	2.74	n/a	0	91	3.23	2643	93.92	3	0.11
1993	15	0.49	n/a	0	81	2.65	2895	94.70	66	2.16
1994	15	0.45	n/a	0	230	6.86	2848	84.91	261	7.78
1995	30	0.94	n/a	0	296	9.31	2209	69.47	645	20.28
1996	42	1.86	n/a	0	432	19.16	1441	63.90	340	15.08
1997	97	3.00	n/a	0	564	17.45	2096	64.85	475	14.70
1998	88	2.87	n/a	0	789	25.74	1749	57.06	439	14.32
1999	169	2.90	464	1.22	887	15.23	3281	56.34	1023	17.57
2000	180	2.43	391	5.27	730	9.84	4031	54.34	2086	28.12
2001	297	4.06	207	2.83	908	12.42	4053	55.44	1845	25.24
2002	478	6.36	300	3.99	796	10.59	4595	61.10	1351	17.97
2003	607	11.10	180	3.29	719	13.15	3003	54.91	960	17.55
2004	764	13.06	160	2.74	778	13.30	3335	57.01	813	13.90
2005	1224	14.68	191	2.29	1022	12.26	5113	61.33	787	9.44

Source: Garda Síochána Statistics

The percentages of each drug type each year are telling. They suggest for instance that although cannabis resin is by far the main drug type under which offences occur (some 5,133 in 2005), this has decreased in proportion from over 90% in 1990 to close to 60% in 2005 of all offences.

Of course, as the figures suggest the number of offences for all drugs, except ecstasy, is however on the increase and this is a trend that needs to be monitored.

The data in the table below shows a substantial increase in offences for cocaine over the period. This increase has been stark in the last number of years; the number of cocaine offences has quadrupled over the last four to five years. This is evidenced by the fact that for the first time since data was captured cocaine offences were higher than heroin offences in 2005. Indeed, heroin offences have stabilised up to 2005 when it saw an increase, it still is a lesser drug in offence terms than cocaine. Ecstasy, although still not insignificant, is declining in numerical and proportionate terms. Overall, the move toward cocaine is perhaps the most important aspect of the data and suggests a shift in drug use patterns, notwithstanding cannabis, away from heroin and ecstasy and toward cocaine. This reflects findings in other drug prevalence research outlined in this chapter.



Source: Garda Síochána Statistics 1990-2005

o **Conclusion**

This chapter has provided an overview of the wider context in which the Clondalkin Drug Task Force is situated. The main areas covered in the chapter were data on the national prevalence of drugs problems, treatment statistics and Gardaí drug offences. The chapter revealed how national drug prevalence surveys have shown that there has been an increase in the numbers reporting use of drugs over the last five years, and in 2007 almost one in four people reported the use of illicit drugs. It was also reported that the prevalence of drug use is higher in younger age groups, in the greater Dublin region and among men. Polydrug use or the use of two or more drugs is the most common mode of drug taking. It was highlighted that in contrast to heroin use, there is no apparent association between cocaine and cannabis

4. Profile of the Clondalkin Task Force Area

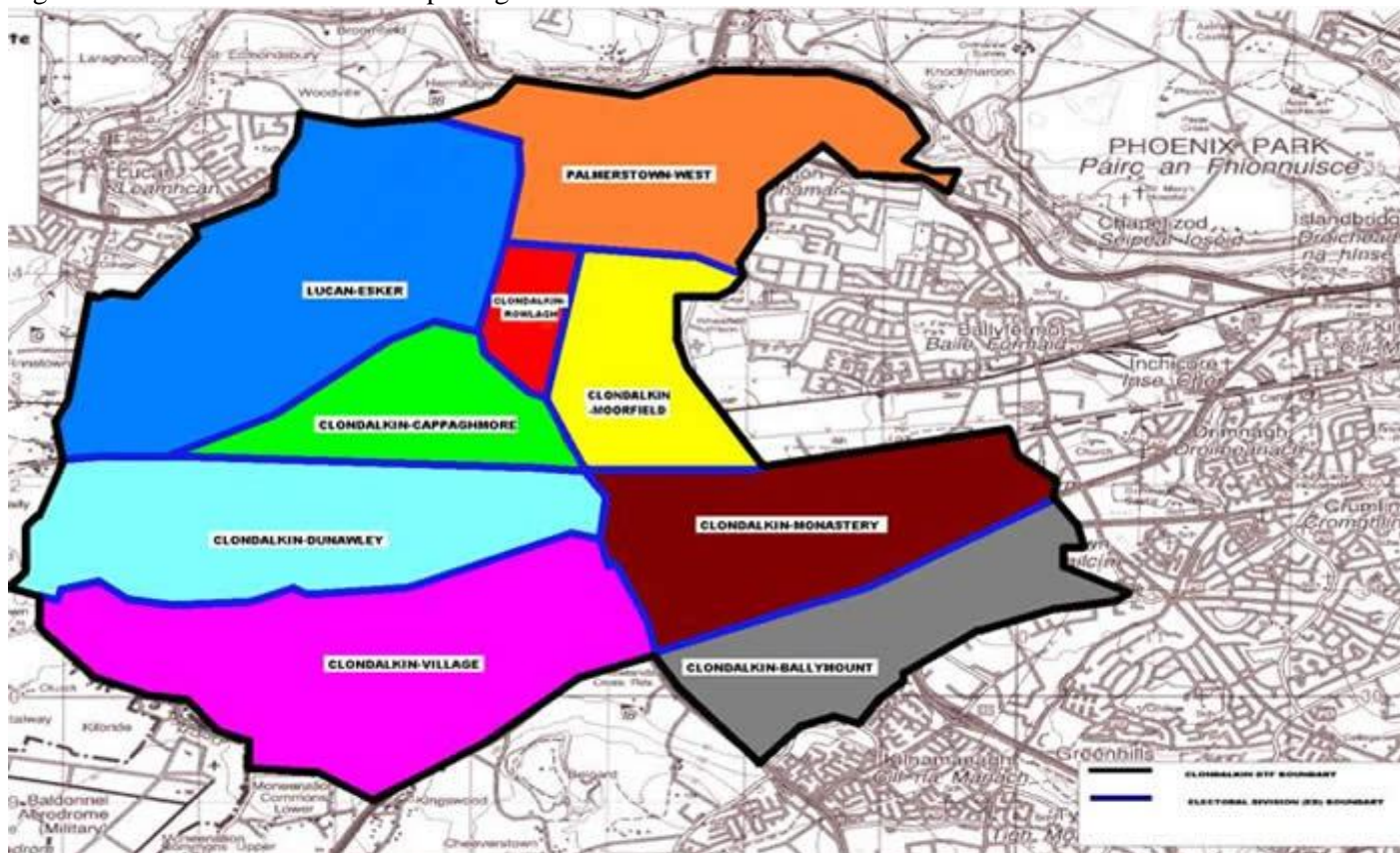
4.1 INTRODUCTION

This chapter presents a profile of the main social, economic and demographic characteristics of the Clondalkin Drug Task Force catchment area. In so doing, the chapter provides an overview of the area’s population, household structure, education, social class, employment and deprivation. The aim of this chapter is to provide a socio-economic picture of the context in which CDTF operates.

4.2 AREA MAKEUP & POPULATION

The catchment area of Clondalkin DTF is located to the west of Dublin City and is part of the administrative area of South Dublin County Council. It is bordered to the north by Lucan, to the east by Ballyfermot and the M50 and to the south by Tallaght and the Naas Road. The catchment is comprised of eight electoral divisions (EDs) of South Dublin County Council, namely: Clondalkin-Cappaghmore, Clondalkin-Dunawley, Clondalkin-Monastery, Clondalkin-Moorefield, Clondalkin-Rowlagh, Clondalkin-Village, Lucan-Esker, and Palmerstown West. Locally, clondalkin is often understood in terms of north and south clondalkin. The areas that make up north Clondalkin are Clondalkin-Moorefield, Clondalkin-Rowlagh, and parts of Clondalkin-Cappaghmore, Lucan-Esker and Palmerstown West. South Clondalkin takes in the EDs of Clondalkin-Village, Clondalkin-Monastery, Clondalkin-Dunawley and part of Clondalkin-Cappaghmore. Figure 4.1 below depicts the various EDs that comprise the catchment of Clondalkin Drug Task Force.

Figure 4.1: Electoral Divisions comprising the CDTF catchment area



Adapted from Area Development Management/Gamma, 2004.

It should be noted that- in similarity to Clondalkin Partnership –the Task Force covers areas in only part of Palmerston-West and Lucan-Esker. The Quarryvale and Balgaddy areas are in Clondalkin and thus in the catchment of the Task Force; these are both local authority housing areas. The remainder of these two EDs contain by and large private housing and this has the effect of skewing the trends in the overall ED which may not necessarily reflect the profile of the parts of these EDs within the catchment of the Task Force. The Balgaddy and Quarryvale areas are likely to have a profile more in keeping with EDs to their south such as Clondalkin-Rowlagh and Clondalkin-Moorfield.

Over the 1996 to 2006 period, the catchment of Clondalkin Drug Task Force had a population increase of 35.6% which was significantly larger than the state (16.8%) and South Dublin (11.4%). This suggests that the CDTF area is a growing one and growing to a greater extent in population terms than the surrounding County. This at the outset has broad implications in terms of resources and service provision. However, this masks some contrasting population trends seen at ED level.

In Census 2002, a number of EDs reveal a significant population increase while others reveal a significant population decrease. The most obvious change is in the case of Lucan-Esker: population increase of 71% from 1996 to 2002. Clondalkin-Moorfield and Clondalkin-Rowlagh recorded population decreases of 11% and 20% respectively. In Census 2006, these trends while still evident have lessened with the rate of population increase and decrease waning. Clondalkin-Monastery, Lucan-Esker and Clondalkin-Cappaghmore exhibited significant population increases of over 10% while there is a continued trend of population decrease in Clondalkin EDs of Moorfield and Rowlagh.

Table 4.1: Task Force Population 1996-2006

Electoral Divisions	Pop. 1996	Pop. 2002	Pop. 2006	% Change 1996-2006	% Change 2002-2006
Clondalkin-Cappaghmore	1,825	1,609	1,925	5.5	19.6
Clondalkin-Dunawley	9,289	10,710	10,873	17	1.5
Clondalkin-Monastery	8,633	9,363	10,362	20	10.7
Clondalkin-Moorfield	6,697	6,246	5,966	-10.9	-4.5
Clondalkin-Rowlagh	5,238	4,504	4,187	-20	-7.0
Clondalkin Village	8,123	8,595	8,718	7.3	1.4
Lucan-Esker	7,451	20,807	25,828	243	24.1
Palmerston West	8,449	8,130	7,719	-8.6	-5.1
TOTAL CDTF	55,705	69,964	75,578	35.6	8
South Dublin	218,728	238,835	246,919	11.4	3.3
Ireland	3,626,087	3,917,203	4,239,848	16.8	8.9

Source: Census 1996, 2002 & 2006

The breakdown of the population of the Traveller Community is not yet available from Census 2006. However, from Census 2002 and subsequently, the Interagency Strategy Document on Travellers in South County Dublin, it is estimated that the population of Travellers in the South Dublin is 1,824 accounting for 498 families. The location of the Traveller population, by family unit, is as follows: 153 live in standard council housing, 58 are in Group Housing Schemes (Oldcastle Drive, Kimmage Manor, Greenhills Grove and Kiltipper); 63 are in Residential Caravan Parks (Brookfield, Ballycragh, Ballyowen, Belgard Road, Cherryfield, Turnpike and Owendoher); 68 are in Temporary sites (Lynches Lane, St. Maelruan's Field and Oldcastle Park); and 36 are in emergency accommodation (Balgaddy, Kishogue, Cookstown Lane, Fonthill –two sites, Whitestown and Foxdene). The remaining families are living in private rented accommodation.

As noted in the previous section, most of those affected by problem drug use (traditionally with opiate related problems) are in the age range of 15-44 years, have low educational attainment and limited or no employment experience. The proportion of the overall population aged between 15 and 44 is 52.9% which is down from the corresponding measure seen in 2002. At ED level, Lucan-Esker is the ED with the largest proportion of its population falling into the 15 to 44 age range, however this has decreased since 2002. The make up of the population in this age range is above that seen in South Dublin and also nationally but is moving toward these measures which have remained stable between 2002 and 2006.

In addition it is worth noting the makeup of the population of the task force that are aged 14 years of age and below. This group are those for whom drug problems are unlikely to have manifested itself given their age and this again may have implications for the direction of preventative activities particular in terms of prevention education. One quarter of the population of the catchment are aged between 0 and 14, this is greater than that for the County (21.7%) and for the state (20.4%)

In recent times, there has been a significant increase in the numbers coming to live in Ireland from Europe and elsewhere. For this reason, it is worthwhile getting a sense from Census 2006 of the numbers of people resident in Clondalkin from new communities. The table below illustrates the makeup of the population of the task force area by nationality.

Table 4.4: Nationality

Electoral Divisions	Irish %	UK %	Polish %	Lithuanian %	Other EU 25 %	Rest of World %	Not stated %
Clondalkin-Cappaghmore	95.7	1.2	0.5	0.5	<1	1.1	<1
Clondalkin-Dunawley	86.3	1.5	2.4	1.1	1.2	6.5	1
Clondalkin-Monastery	81.5	1.4	4.8	2.8	1.8	6.5	1.1
Clondalkin-Moorefield	93	1.1	1	<1	1	2.4	1.8
Clondalkin-Rowlagh	95.5	<1	<1	<1	<1	1.2	1.4
Clondalkin-Village	85.4	1.8	3.6	1.6	1.8	5	<1
Lucan-Esker	77.9	1.8	1.7	1.9	2.2	13.4	1.1
Palmerstown West	90.5	1.1	1.1	<1	<1	3.2	2.9
TOTAL CDTF	84.6	1.5	2.2	1.4	1.5	7.6	1.2
South Dublin	88.5	1.4	1.5	0.8	1.3	5.1	1.4
Ireland	88.8	2.7	1.5	0.6	1.8	3.4	1.2

Source: Census 2006

This table reveals that the CDTF area has higher proportion of people from new communities than both South Dublin and the state. The biggest proportions of those from new communities come from the category 'rest of world' (7.6%). The next biggest group are Polish accounting for is 2.2% of the overall residents.

At the ED level, there are some clear differences to the general trend. The most obvious ones being 13.4% of Lucan Esker ED is accounted from by persons whose nationality is categorised as 'rest of world category'. A number of EDs have an Irish population which is proportionately less than the local and wider averages and this suggests a greater proportion of new communities in these EDs. For the most part, those EDs with the largest relative proportion of private rented accommodation are also those with the greatest percentage of new communities as a proportion of their overall population.

4.3 HOUSEHOLD STRUCTURE

Household structure refers to the ownership of households, type of households, and persons (adults and children) in each household as noted in Census 2006.

The total number of households in the CDTF catchment according to Census 2006 was 24,050. Of this, 3,412 were headed by lone parents. This represents 14.2% of households. The corresponding proportion in South Dublin was 13%

and nationally, 10.4%. Thus Clondalkin reveals a higher overall proportion of lone parent households than elsewhere even relative to the increased trend in South Dublin as a whole.

Table 4.6 above shows the areas with higher concentration of lone parent households and also those whose proportion of lone parent households increased in 2006 relative to the previous Census. The relationship between lone parenthood and disadvantage has been long established and underlines the importance of dovetailing social inclusion activities with those concerning problematic drug use.

Electoral Divisions	Lone Parent Households (% of all Households) greater than CDTF average	Above CDTF Average Lone Parent Households (% of all Households) increased 2002 to 2006
Clondalkin-Cappaghmore	?	?
Clondalkin-Dunawley	?	
Clondalkin-Monastery		
Clondalkin-Moorfield	?	
Clondalkin-Rowlagh	?	
Clondalkin Village		
Lucan-Esker		
Palmerston West	?	?

Source: Census 2002 & 2006

An assortment of research has illustrated the relationship between housing tenure and social disadvantage and, in most cases, this relates to social housing rented from the local authority. In addition, research has also underlined the relationship between social housing areas and problem drug use. This highlights the important role exploring housing tenure in profiling the CDTF catchment.

On the whole, the data from the most recent Census on housing tenure reveals that the catchment of Clondalkin is not homogenous in social terms. 72.1% of households are owner occupied, this is a slightly less than the corresponding measure for South Dublin and is higher than the national figure. Within the EDs, there is significant difference in the proportion of households that are owner occupied. Three EDs have proportionate rates greater than the County measure (Clondalkin-Monastery, Clondalkin-Village and Lucan Esker), while the remaining five are lower than the County measure with two – Clondalkin-Cappaghmore and Clondalkin-Rowlagh) revealing less than 50% of all households being owner occupied.

Across the catchment, 13.8% of households are rented from the local authority (although some of these are in the process of being purchased). This is a reduction on the proportion of all social housing in the catchment in comparison to 2002. However, it is still a higher proportion than seen in the County (11.2%) and nationally (11.6%). The three EDs with the highest proportions of owner occupation are also those with the lowest proportion of social housing, ranging from just 2.6% to 3.5%, which is significantly less than the county or national averages. In contrast, EDs such as Clondalkin-Cappaghmore and Clondalkin-Rowlagh have proportions of social housing close to 50% of all households in the respective ED. Other EDs with proportions of social housing well above the task force average include Clondalkin-Dunawley, Moorfield and Palmerstown West. These five EDs therefore are likely to have higher concentrations of disadvantage, due to the nature of tenure in the Irish social housing system, and thus related drug problems.

In terms of private rented households, the proportion for CDTF is 14.1%. This is a key feature of the catchment's profile: this figure is over twice the proportion seen in the rest of the County in 2006 and larger than the national measure. The EDs with high comparative proportion of households which are rented privately are Clondalkin EDs Dunawley, Monastery, the Village and also Lucan-Esker. The remaining EDs exhibit a proportion of private rented households lower than the national proportion but in keeping with the measure seen in South Dublin.

4.4 EDUCATION

Education attainment data demonstrates differences in levels of education across CDTF's catchment and lends some evidence to targeting of resource in areas in which educational attainment, thus skill levels, employment and ultimately income prospects, is low. It is important to note that those who had no formal education and those who left school before completion of the junior cycle of second level (15 or under) are those who are statistically most likely to experience difficulties in terms of employment and income and thus the risk of social exclusion.

The table below outlines the data available from the most recent Census on each of the EDs and also for the wider areas in terms of a number of individual biographies of when education ceased

Table 4.8: Level of cessation of education (excluding not stated)

Electoral Divisions	No formal or primary education (%)	Junior secondary ed. Only (%)	3rd level education (%)
Clondalkin-Cappaghmore	22.5	33	8.5
Clondalkin-Dunawley	18.1	25.1	9.8
Clondalkin-Monastery	12.6	22.6	16.7
Clondalkin-Moorfield	25.5	32	6.5
Clondalkin-Rowlagh	32.8	32.6	3.3
Clondalkin Village	12.8	23.9	14.6
Lucan-Esker	5.6	13.6	31.8
Palmerston West	19.4	26.2	13.8
TOTAL CDTF	13.7	21.7	19
South Dublin	14	20.7	20.7
Ireland	14.9	21	28.4

Source: Census 2006

The task force catchment area shows a similar rate to the County of those who left school with primary or no formal educational qualification. This rate (13.7%) is marginally less than the national total. However, at the ED level there is a good deal of diversity. Firstly, there is the sense that the sheer population size of Lucan-Esker and the comparatively low rate of those who have not attained at least primary education has the effect of skewing the average measure for the catchment of the task force as a whole. This is a feature of the profile of the area and is seen in relation to some of the other indicators investigated here. For instance, if the Lucan ED is discounted from the catchment, the measure in terms of those not completing formal or primary education increases from 13.7% to 20.1% which is significantly greater than the County and national average.

Turning to those whose education ceased at junior level secondary education only (typically to Intermediate, Group or Junior Certificate levels), the measure for the task force is similar to the county and national figures. At ED level, there are differences ranging from 33% in Clondalkin-Cappaghmore to 13.6% in Lucan-Esker. The former ED along with Clondalkin-Moorfield and Clondalkin-Rowlagh exhibit proportions of those whose education ceased at junior secondary level above 30%. This indicates a lower level of educational attainment among residents in these areas in 2006 than the other parts of the catchment. It is of note also that many of the areas with higher rates of ceasing education on or before the completion of the junior cycle at second level are also those areas with high comparative levels of persons who had no formal educational attainment or completed primary education category only.

Finally, just under a fifth (19%) of the catchment's resident who finished education did so at third level. This is slightly lower than the similar measure for the surrounding county and significantly lower than that seen nationally. However, one ED (Lucan-Esker) displays proportions whose education ceased at third level above both county and national proportions. Again there is a sense that this ED skews the collective measure for the task force due to its size and different socio-economic and demographic makeup relative to the other EDs. In a trend seen above, there are also lower proportions attaining third level education in a number of clustered EDs. This is most significant, less than 10%, in Clondalkin-Cappaghmore, Clondalkin-Dunawley, Clondalkin-Moorefield and Clondalkin-Rowlagh. These latter four EDs are areas of particular need when it comes to interventions therefore.

4.5 SOCIAL CLASS

Although social class is a contested issue in terms of where one starts and finishes, its relationship to income and poverty etc., it does provide a valuable overview of what categories of social class are most evident in the various communities that make up the task force catchment. For the purposes of description, the seven social classes enumerated as part of the Census 2006 are collapsed into three categories as follows:

1. *Professional workers, managerial and technical occupations,*
2. *Non-manual and skilled manual workers and,*
3. *Semi/unskilled workers and others gainfully occupied such as those who have not been in paid employment or in who live in households where no one is in paid employment.*

The proportion of the catchment falling into the professional, managerial and technical occupations, social class 1 and 2, is 26.9%. This is less than the corresponding proportion seen in South Dublin (32%) and Ireland (32.9%). In line with the trend seen earlier, the proportion falling into these social classes in Lucan-Esker is well above the task force average and also within the county and nationally. All of the other EDs in the catchment exhibit proportions falling into these social class groups below the national and South Dublin average. This is less than one fifth in the Clondalkin EDs of Cappaghmore, Dunawley, Moorfield and Rowlagh.

The number of residents in the task force assigned in Census 2006 to social class three and four was 36.4%. This is similar to the corresponding proportions seen in South Dublin and nationally. Beyond this there are no obvious differences at ED level.

36.7% of the catchment's population are characterised as belonging to social class five, six and seven. As outlined, these classes encompass semi-skilled, unskilled and those without occupation. This score for the catchment is higher than the corresponding figure for South Dublin County (31.6%) and also the state (31.6%). This suggests that there is a large concentration unskilled and low skilled persons in the population of the catchment. At the ED level, this is more acute with two EDs (Clondalkin-Cappaghmore and Clondalkin-Rowlagh) showing that over half of their number are categorised as belonging to social class 5, 6 and 7. This is followed in the case of Clondalkin EDs of Dunawley, Moorfield and then Palmerstown West with over 40% of their number falling into these class. Overall, these five EDs taken together are the location of high relative indicators of deprivation and, in this case, labour marker skills deficits and are thus more vulnerable to any downturns economically.

4.6 EMPLOYMENT

Unlike recent decades, today unemployment is less indicative of disadvantage and consequential social and economic problems for individuals and communities. This is due to the relatively low overall unemployment levels seen nationally up to more recent times. Nevertheless, taken together with the other measures noted in this chapter, it still goes some way toward giving a more comprehensive picture of the socio-economic and demographic profile of CDTF's operational area. What the data suggests what is that the rate of employment has increased and the rate of unemployment has decreased over the years. This is keeping with picture elsewhere in the state. The table below illustrates the unemployment rate for the Task Force area and also the labour force participation rate.

The unemployment rate in the Task Force area was 12.4% in 2006. This is more than the corresponding measure for South Dublin City (9.6%) and Ireland (9.3%). This is still the case even given the lower rates revealed in Lucan-Esker and Clondalkin-Village.

Table 4.10: Unemployment and Labour Force Participation Rate.

Electoral Divisions	Unemployment Rate	Labour Force Participation Rate
Clondalkin-Cappaghmore	24.5	61.2
Clondalkin-Dunawley	20.7	71
Clondalkin-Monastery	9.9	71.5
Clondalkin-Moorfield	19.9	66
Clondalkin-Rowlagh	26.6	66
Clondalkin Village	8.8	70.1
Lucan-Esker	7.8	81.2
Palmerston West	13.7	64.8
TOTAL CDTF	12.4	72.8
South Dublin	9.6	67.8
Ireland	9.3	62,3

Source: Census 2006

The Labour Force Participation Rate (LFP) is the percentage of a population over 15 years who are active in the labour market that is who are at work, seeking a first job or unemployed. For the Task Force, the LFP rate was 72.8 in 2006. This was more than the surrounding county and national totals. It is noticeable that one ED – Lucan-Esker - exhibits LFP rate which is considerably higher than the average for the task force. In addition, those areas showing relatively high levels of unemployment are those with the lowest LFP rates

Another helpful tool in understanding the importance of employment in given areas is the economic dependency rate (EDR). The EDR is the proportion of the population in a given area who are not in the labour force relative to those who are at work. The implication of the EDR is that those in the labour force and at work are the economic providers for the former groups. As such, the higher the EDR the greater the resource and services needs in such areas for those in the labour force and also social and other service providers. The EDR for the Task Force area is 0.5 which is less than that for south Dublin and the state. Again the effect of the Lucan ED is evident here. EDs with higher EDRS than corresponding measures, ranging from 0.8 to 1 are Cappaghmore, Moorfield and Rowlagh.

4.7 DEPRIVATION

Many of the measures have in some way made a contribution to the calculation of deprivation. Deprivation has been measured in the last number of Censuses using the Haase index. This brings a number of measures together to develop one measurement of deprivation in given areas whether that is respect to just one ED or collection of EDs making up the catchment of in this case the Task Force. This approach uses similar measures over the course of a range of Censuses so that deprivation can be measured over time and between areas. The underlying dimensions of deprivation

such as social class, demographic and labour market deprivation are factored into the score. It is worth noting that measures of deprivation are not as indicative as they once were in light of the overall improvement in the generalised affluence of Irish society over the past decade. Thus, use of relative measures, EDs compared with each other, is a better means to allow deprivation indicators have more descriptive and analytical value. In the table below, outlined is the relative position of each ED in respect of each other at Census 2002 and Census 2006. The scale for describing each of the EDs in Clondalkin range over the following:

- *Very Affluent*
- *Affluent*
- *Marginally Above Average*
- *Marginally Below Average*
- *Disadvantaged*
- *Very Disadvantaged*
- *Extremely Disadvantaged*

Table 4.12: Relative deprivation at ED level, Census 2002.

EDs	Relative Deprivation 2002	Relative Deprivation 2006
Clondalkin-Cappaghmore	<i>Disadvantaged</i>	<i>Disadvantaged</i>
Clondalkin-Dunawley	<i>Marginally Below Average</i>	<i>Marginally Below Average</i>
Clondalkin-Monastery	<i>Marginally Above Average</i>	<i>Marginally Above Average</i>
Clondalkin-Moorfield	<i>Disadvantaged</i>	<i>Disadvantaged</i>
Clondalkin-Rowlagh	<i>Very Disadvantaged</i>	<i>Very Disadvantaged</i>
Clondalkin Village	<i>Marginally Above Average</i>	<i>Marginally Above Average</i>
Lucan-Esker	<i>Affluent</i>	<i>Affluent</i>
Palmerston West	<i>Marginally Below Average</i>	<i>Marginally Below Average</i>

Source: Haase and Pratschke 2005: 36 & <http://www.pobal.ie/live/dep/1002.html>

This suggests therefore that the area of Cappaghmore, Moorfield and especially Rowlagh are disadvantaged with the latter being the most deprived EDs in the state. These therefore require extra and more intensive targeting than other area or at least a different type of approach. However, it is worth noting (and is somewhat surprising) that there was no movement in the deprivation/affluence indices for any of the EDs between 2002 and Census 2006.

4.8 CONCLUSION

On the whole, the data presented in this chapter suggests that the CDTF catchment is not homogenous in social and demographic terms. These demonstrates that the area is a mixed one with pockets of disadvantage, normally characterised by social housing, alongside these areas are more affluent areas and those closer to the national average. The areas where there is a relative concentration of affluence, higher levels of relative educational attainment, private housing, concentrations of social classes one to 4 etc., are generally in the Lucan part of the catchment and around the village areas. Those locations with a concentrations of contrasting area attributes such as social housing, deprivation, low educational attainment, membership of social classes five, six and seven etc., are centred in north Clondalkin and south west Clondalkin. These areas (the five EDs of Clondalkin-Cappaghmore, Clondalkin-Dunawley, Clondalkin-Moorfield, Clondalkin-Rowlagh and Palermerstown-West) are those that generally are likely to have the largest concentrations of social circumstances that are related to problem drug use and therefore might be viewed as priority areas for on the ground services availability and related interventions.

5.1 Introduction

This chapter provides a summary of the main information and data available on the prevalence of drug use and drug related problems in Clondalkin. It is a summary of the report prepared by Merchants Quay Ireland under commission from the Clondalkin Drug Task Force on the 'Nature and Extent of Drug Use in Clondalkin'. This report was completed in late 2007/early 2008 and the primary research took place over the late summer months of 2007.

- Both quantitative and qualitative research methodologies were employed in undertaking the study. The research model involved three means of data collection, namely:
 - Secondary analysis of existing statistical data to develop a picture of community and drug use;
 - 150 surveys were administered by 9 peer research assistants from the Clondalkin area. The surveys gathered in-depth information from problematic drug users under a number of key headings; and
 - Five focus groups were conducted with groups of problematic drug users, family members affected by drug use and community members to illicit broad qualitative data in respect of drug use and its effects.

5.2 Contemporary Clondalkin drug scene

From the prevalence survey, it appears that drug problems in Clondalkin are perceived to be becoming more problematic every year. There appears to be greater quantities of drugs, more varieties of drugs and younger people using drugs. Related to this, drug dealing is perceived to be more obvious and visible in public spaces. All types of drugs explored in the survey (i.e. heroin, cannabis, cocaine, benzodiazepines, crack and ketamine) are readily available

in Clondalkin. According to the research all of the aforementioned drug types, excluding ketamine, are currently more available and easier to source in Clondalkin, when compared to five years ago.

From the survey, it is suggested that occasional drug droughts are usually caused by increased police activity and typically result in prices rising and the quality of drugs decreasing. These droughts also result in individuals using and in some cases developing problems with other substances (i.e. during a heroin drought cocaine may be used instead).

The research suggests that drug dealing is well co-ordinated and organised in the area. There is some sense from the research also that children may be used as 'runners' by some of those involved in drug dealing.

In contrast to the increase in visibility of drug dealing in public, the consumption of drugs has become more invisible. Respondents observed that drug consumption mostly occurs in the user's place of residence or public parks. However, the survey suggests that there is a significant use of cocaine in night time social venues. All the drugs examined are typically consumed in the company of others, except for crack. However, since the introduction of personal 'sin bins', the findings show that injecting equipment is less visible in public areas.

Respondents' first encounter with illicit drugs typically occurred in the company of friends, where they smoked cannabis at the age of 14 years old. The first incidence of injecting drugs typically occurred at the age of 20 years and heroin was the substance used. In relation to other personal drug use issues, most of the sample stated that they have a history of problematic drug use in their families, have not overdosed and do not have a store or 'stash' of drugs.

5.3 Drugs of choice

Under this theme the survey reveals that heroin is overwhelming the primary problematic drug of use. Yet, there has been a notable increase in the problematic use of cocaine, alcohol and prescription medicines.

Cocaine has become a frequently used recreational drug in Clondalkin that is perceived to be sociable, harmless and fashionable. Although numbers using the substance has increased, both the price and quality have decreased. The research indicates a double standard of sorts exists between cocaine users and heroin users: cocaine users differentiate themselves from drug users who inject heroin. However, the effects of heroin on the user (i.e. lethargy) were perceived to be less invasive when compared to the paranoid, violent behaviour associated with cocaine use. There was a high level of fear expressed about possible future increases in cocaine and crack related violence. In this regards, crack rather than ketamine is the new emergent problem drug.

The sample of people taking part in the survey believed that most crack cocaine in the area is made by the dealers and is smoked rather than injected. The negative effects such as paranoid behaviour and the desperation for the next 'hit' were underlined. Steroids are also being used problematically, albeit not as prominently as cocaine and crack.

5.4 Polydrug use patterns

In tandem with earlier findings in the report, the Clondalkin survey reveals that polydrug use has become the norm. There was a wide variety of polydrug use patterns suggested. In descending order of prominence, heroin combined with either cannabis, cocaine, benzodiazepines, alcohol or crack are the most common patterns of use.

The typical pattern for recreational drug users was cocaine combined with either cannabis or alcohol. The injection of cocaine by injecting heroin users was another emerging trend. Two is the most common number of times injecting cocaine users inject in one session. However, a number of individuals indicated that they inject cocaine 5, 6, 8 and even 10 times in one session. This typically occurs in a group setting, which has serious health implications in terms of blood-borne diseases. Half of these individuals reported that they have injected a mixture of cocaine and heroin.

5.5 Prevalence and demographics

Research has estimated that the prevalence of opiate users in Clondalkin is 20.5 per 1,000. Therefore, it is possible to infer from these statistics that there may be up to 1,591 opiate users in the area. 363 individuals from the CDTF area availed of drug treatment services in 2006. Heroin was overwhelmingly the main problem drug for this cohort.

A demographic profile of the typical problematic drug user (especially opiates) in Clondalkin was constructed from the findings. This individual is most commonly a male, Irish, single, unemployed, early school leaver between the ages of 15 years and 24 years. Recreational cocaine users come from all age groups and all social strata.

The majority of those accessing drug treatment services are similar demographically except that they are in an older age bracket of 25 to 34 years. The findings suggest that although people begin using opiates at the mean average age of 20 years, the majority do not seek treatment until their late twenties and early thirties.

Most of the individuals surveyed reside in North Clondalkin. South West Clondalkin appears to have less pronounced problematic drug use. Clondalkin village is perceived as the district with the lowest level of illicit drug use.

Generally, participants reside in the family home and do not share their accommodation with another drug user. Only a minority live alone. A high proportion of respondents have at least one child under the age of 18 years that they currently live with.

5.6 Ethnic minorities and drug use

The survey implies that there is gap in data on the use of drugs among ethnic minorities. In this regard, ethnic monitoring is not conducted by agencies compiling statistics on problematic drug users.

Only one respondent to the survey questionnaire was of Asian descent, the remainder were white, settled Irish. However, ethnic minority members contributed to the focus groups. For this group, concealment, denial and unawareness surround the use of illicit drugs. This further contributes to the problems of learning about drug use among ethnic minorities in the area. The findings indicate that the concealment of drug issues may be due to a fear about the State taking their children into care if a drug problem is discovered.

Additionally, from the research a large proportion of dealers socialise with users and thus it is difficult to determine who is selling and who is buying. Nonetheless, the findings show that self-medicating for depression with illicit substances relates to the shame resulting from a diagnosis of mental ill health among minority cultures.

5.7 Causes of problematic drug use

A range of explanations were put forward to account for the development of drug problems. These explanations were dependant on the level of personal contact and experience individuals had with problematic drug use. Those who do not have a personal relationship with problematic drug users or their families were more likely to suggest that family dysfunction was the main reason for developing an addiction. Community members and relatives who are familiar with drug users suggested a wider variety of reasons, including lack of education, low self-esteem and peer influences. Drug users provided the most diverse and complex explanations such as relationship breakdown, curiosity, adolescent rebellion and an awareness of the pleasurable aspects of drug use.

5.8 Drug related health issues

The survey yielded a limited level of data available on drug related health issues. Where comments were made, they suggested that Hepatitis C is quite prevalent among Injecting Drug Users (IDUs) from the CDTF area. This blood borne virus is at a much higher level than hepatitis B among this same cohort. HIV and AIDS were believed to be quite prominent in the Clondalkin area. However, most participants perceived their general health to be satisfactory.

Mental health concerns were an issue for a significant number of participants. Feeling depressed, anxious and isolated occurred quite frequently. A fifth of those interviewed has been diagnosed with a psychiatric illness and have availed of mental health services. It was suggested also that drug related deaths in the form of both overdosing and suicide are common occurrences in the CDTF.

5.9 Risk behaviours and drug use

Under this theme, the research shows that most injecting occurs in the home, with public parks being the next most popular place. The vast majority of the sample reported that they do not share injecting paraphernalia. The authors noted that this finding may be influenced by social desirability effects around reporting high risk behaviours.

A large proportion of the sample reported injecting in the arm and never in the groin. Generally, respondents are in the company of others when they inject, but may also inject on their own from time to time.

Most of those surveyed are sexually active, do not always use condoms and have regular partners that are not intravenous drug users. Such a lack of safe sex tendencies may lead to the spread of sexually transmitted diseases.

5.10 Local drug treatment services

The survey also explored the experiences and perceptions of the respondents on treatment services in Clondalkin. The findings indicate that there appears to be a marginal decrease in the numbers of individuals accessing drug treatment services over the past three years. It is perceived that services have improved over the past 5 years, due to the increase in the number of facilities.

In terms of awareness of local services, the survey respondents were most familiar with CASP and the Aisling clinic and least knowledgeable about Cumas and the Drug Users Forum. Most of the intravenous drug users (IDUs) indicated that they source their injecting equipment in needle exchanges, mostly in Clondalkin. A significant minority of IDUs

reported that they do not know of the needle exchange in Clondalkin. Clients of exchanges stated that would like more information on safer injecting and abscess care.

Of those surveyed that avail of a methadone maintenance programme, most are participating in the programme for over 5 years. It took less than 3 months for the programme to begin in most cases. The most recent data suggests that the mean average length of time on the methadone waiting lists for the Aisling Clinic and Fortune House was 4.5 months. The majority wanted methadone maintenance rather than detoxification when they started their programme. A large proportion of the sample receives their prescription and methadone from clinics as opposed to a G.P. and pharmacy.

Although most of those currently on a methadone maintenance programme are either satisfied or very satisfied with the process, the ineffectiveness of the methadone maintenance programmes as a form of drug treatment was voiced across all focus groups. Major criticisms included the lack of a 'moving on' mechanism for those on the programme as well as the lack of control and input that clients experienced in relation to their drug treatment. Negative side-effects such as lethargy were underlined. Nevertheless, the stabilising effect of the programme on an individual's lifestyle was acknowledged.

Many alternatives to the current methadone programme were suggested, ranging from enforced 'cold turkey' detoxification to counselling complimenting methadone maintenance to the prescribing of heroin and consumption rooms. The majority of those surveyed have attempted to detoxification either at home alone or with family. They believe that there are insufficient numbers of detoxification programmes available. The most attractive types that they would like to see implemented are inpatient detoxification and outpatient G.P. or drug clinic based detoxification.

There was widespread agreement that there is a lack of drug treatment services in the Clondalkin area. In particular, the long waiting lists, lack of aftercare services and small number of educational programmes were highlighted.

5.11 Drug related crime

The findings suggest that drug related violence has increased significantly in the area, in particular "gangland" crime. Personal 'muggings' are felt to have become more commonplace, with house break-ins decreasing in occurrence. Yet, Garda statistics indicate that this type of personal theft is among the least common of incidences of theft more generally.

Public order offences and searches were the most common types of reported drug-related crimes in 2005 and 2006. There was a notable increase in possession and possession for sale and supply incidents from 2005 to 2006.

Drug related crime was put forward as the cause of negative perceptions of problematic drug users. However, there was acknowledgement that drug users are frequently subjected to vicious physical assaults due to drug debts. The increase in gun crime has been associated with drug deaths as well as hostility between drug dealing gangs.

Participants perceived that there is a lack of Garda personnel dedicated to tackling drug related crime in Clondalkin. In this regard, the respondents believed that the police force's main concern is on big drug hauls rather than targeting dealers operating in the locality. Some believed that Gardai hold negative stereotypes of citizens from Clondalkin, especially the young people from the area. There was a general consensus arising out of the research that the justice system has been ineffective in responding to the drugs issue, in particular with regard to lenient sentencing.

5.12 Housing and homelessness

This research cites data from South Dublin County Council which suggests that there has been a decrease in the number of Local Authority evictions and warnings in 2007.

Although the majority of drug users in treatment appear to be residing in stable accommodation, it was indicated that there is a significant population of homeless drug users in the Clondalkin area. It was pointed that there was a lack of dedicated services for the homeless in Clondalkin.

What data is available from homeless services reveals that a large number of 'rough sleepers' seem to be using illicit drugs and in particular, engaging in poly-drug use. Alcohol, heroin and benzodiazepines are the most common drugs used by this group. A small number are currently on methadone maintenance programmes. The demographic profile of rough sleepers using illegal drugs is the same as for problematic drug users in secure accommodation (i.e. male, single, Irish, aged 25-34 years).

5.13 Detrimental effect of addiction on families

Among the effects of problem drug use on families were the stress caused by finding out about a family member's drug use followed by a lack of knowledge about services on discovering the existence of a drug problem. In general,

the physical and psychological stress experienced by parents with children who are addicted to drugs was a key concern.

The financial burden of payment of drug debts was another source of anxiety. The research reveals that no member of the family of drug users appears to be immune from intimidation by drug dealers due to drug debts.

The emotions cited as accompanying having a family member (mostly a child) with a drug problem included sadness, shame, guilt, anger, feelings of failure and hostility among siblings. Families also felt isolated by neighbours and Gardai. The whole family's need for therapy and healing was a recurrent theme.

Grandparents who are taking care of their grandchildren as a result of drug addiction spoke of major problems they are encountering. Their lack of legal status and financial support from the State is a source of anger and frustration. In this regard, difficulties around protecting grandchildren from addiction but ensuring they maintain a relationship with their parents was an issue.

Respondents expressed serious concern for children of drug users in relation to their early exposure to drug use and drug addiction, their lack of supervision and the loss of a parent through overdose or residential rehabilitation.

5.14 Effect of problematic drug use on the community

As drugs are used primarily in the home, from the research the concerns of the wider community appear to be focussed on the crime element of drug use and the visibility of drug dealing. Crime in this case refers to personal muggings and "gangland" crime as well as the consequential fallout from that by the media emphasising the negative side of life in Clondalkin.

In addition, the research showed that there is a fear of using public amenities such as parks, shops and walkways, in case of physical assault. Residents indicated that the children of the locality have become normalised to aspects of the drug culture, including drug related violence. Finally, this research reveals how community anti-drug activism appears to have lessened due to fatigue on the part of community members.

5.15 Conclusion

This chapter has presented data and findings on the prevalence of drug use in Clondalkin. The chapter is based on findings of a parallel research process to the development of the strategic plan on the nature and extent of drug use in Clondalkin, carried out by MQI. The findings suggest that drug problems in Clondalkin have deteriorated over recent years. In particular, it was noted that drug dealing is now more visible and organised and drug use tends to take place, with the exception of cocaine, in private. There appears to be a greater variety of drugs available in the area, cocaine was a particular issue due to its wide use across social strata and polydrug use is now conceived as the norm. There remains a significant cohort of heroin users in the catchment, although most do not seem to be accessing locally based treatment. This maybe due to the fact that heroin users do not seek treatment until their late twenties, nevertheless there is some evidence that younger age groups are not in general using heroin to the same extent as their older counterparts. The causes of drug problems were perceived as wide and differed depending on individual circumstances. There was widespread agreement that there is a lack of drug treatment services in the Clondalkin area and an insufficient numbers of detoxification programmes available. The chapter also outlined what are viewed as the effects of drug problems on families and the community in Clondalkin.

6. Consultations with Task Force Stakeholders & Funded Projects

6.1 Introduction

This section of the report summarises the views, insights and perceptions of a range of key stakeholders (statutory and voluntary) in respect of needs, gaps, activities etc., of CDTF and also in respect of drug problems in Clondalkin. The chapter is broken down into a number of sections that by and large keep with the theme of each of the questions asked in the interviews or consultation. In all, some 40 interviews took place during this part of the research (see appendix 1 for a profile of respondents.

The main areas covered in this chapter include: relationship to drugs and drug related problems in the area; form of drug problems; approach of CDTF to date; effectiveness of strategies; approach of CDTF required in the future; achievement of objectives of the task force; national issues; impact of projects; relationship of task force's work to the NDS; adequacy of existing services; collaboration; structures and processes; policy development, research and advocacy; and, priorities for the future.

6.3 Problem drug use in Clondalkin

A key theme put to the various consulted groups was their experience of drug problems in Clondalkin. This was done to complement the findings from the prevalence research outlined in the previous chapter and in order to provide a more comprehensive picture of drug problems in the area.

The general view expressed was that Clondalkin continues to have a significant drug problem but that this is offset by the presence of services that were absent in the past. However, the extent of the drug problem is viewed by some as getting worse and others as staying static. The main trend in views expressed is that drug problems in the area have not improved. Moreover, it is felt that the drug problem today is different from in the past. The respondents suggest that in present times more people are using drugs, come from different social strata and that there is diversity in the drugs being used along with significant polydrug use. Finally, the drug problem in the area is seen as widespread, no longer centred in North Clondalkin but has spread to south west Clondalkin also, although there is a degree of denial in such areas that have not traditionally been identified as having a drug problem.

Polydrug use

The findings highlight that polydrug use was seen as the 'normal' process of drug taking. In fact, the research with these respondents suggested that the taking of one drug was the exception.

Heroin

It was suggested that heroin use has stabilised in recent years and that younger people were in general not presenting as new clients. There was a belief therefore that heroin use will decline in numerical terms over coming years.

Cocaine

In contrast to heroin, cocaine use was perceived as being significant and increasing. The group that were involved in the use of cocaine were for the most part a younger, more diverse group than those that traditionally used heroin. Among this group, it was suggested that unlike heroin there were no class or age limits. Furthermore, cocaine users for the most part do not present for treatment, which may be seen as associated mainly with heroin addiction by this group. The responses intimate also that the use of cocaine has replaced ecstasy as the recreational drug of choice. Cocaine in large part is used in conjunction with alcohol by large numbers in Clondalkin. The respondents also observe that cocaine use is not seen as problem or harmful drug by users.

Alcohol

Alcohol was seen as a key problem. It was reported that there is obvious street drinking and significant use in younger age groups. The high use of alcohol was seen to be linked to its availability, and thereafter, its use along with cocaine. From the responses, there was a sense of there now being a similar relationship between alcohol and cocaine to that seen in the past between alcohol and cannabis.

Crime

The responses suggested that in Clondalkin there is a high incidence of drug related crime. From the perspective of those consulted, this increase in crime is accompanied by increases in the viciousness of crimes and also gun related crimes.

Normalisation

The responses also make clear that drug use has become normalised in Clondalkin. This is particularly so in the case of alcohol, followed by cannabis and more recently cocaine.

Housing & Accommodation

A number of those interviewed were concerned that in housing areas in which there is concentrations of drug use, this is accompanied by increases in anti social behaviour. In this regard, some housing estates/areas were seen as containing particularly high incidences of drug use and drug related incidents.

Economic base

The responses also intimate that there is an attraction for young people to dealing in drugs and this is based on the relative large amount of money that can be accumulated and the association of drug dealing with wealth portrayed by older high profile drug dealers in Clondalkin. In turn, the findings highlight that drug dealing is seen as a business and a legitimate form of income in the absence of easily available alternatives especially for those that have left school early or who have been in difficulty with the judicial system.

Visibility

In recent years, drug use, public intoxication and dealing are seen to be more visible, open and accepted in the area. Drug dealers are perceived as increasingly turning to cocaine and are more blatant about dealing drugs in public places.

Benzodiazepines

There is, in the view of those interviewed, significant use and availability of benzodiazepines especially among heroin/former heroin users. In addition, there appears to be a 'street market' caused by prescription 'leakage'.

Characteristics and risk factors

The findings suggest that the factors which are likely to lead to drug use include early school leaving, family functioning, drug use by siblings other family members, peer and socialisation processes and low self esteem/confidence.

Community

The effects on the community noted in this phase of the research include an increased sense of fear in the community, lack of trust and neighbourliness, intimidation if perceived to intervene, apathy and tolerance of drug problems.

Hard to reach groups

Another core issues raised here was that some social groups remain hard to reach for current services. Named in particular in the responses were Travellers, new communities, the homeless and ex-prisoners.

Young people

The research suggests that drug use is becoming more prevalent among young people and is appearing earlier in terms of use biographies. The key drugs are first and foremost alcohol, along with this - as young people move through their teens - there is polydrug use including cannabis and cocaine. As noted, there is less incidence of heroin use though among young people.

Ancillary problems

From the responses, there are a wide range of problems that are ancillary or closely related to drug use problems in Clondalkin. These include debts, relationship problems, bereavement, illness and health, and poverty.

6.4 Appropriateness of the response of CDTF

In the context of the nature and extent of drug problems in Clondalkin, respondents were to assess the appropriateness of the work CDTF. The responses can generally be put into two groups, the positive and the critical.

The main view is that the TF has worked well. It has been particularly good for those who availed of the projects and services it has provided/supported. This has resulted in saved and improved lives, not to mention prevention of further or additional problems. The areas where the TF is seen have had a positive response: its openness to changing circumstances, supports and involvement in projects, promotion of treatment services, prevention in formal and informal setting with young people, and its recent focus on networking.

In terms of more critical responses, the feedback suggests the following areas are those in which the Task Force's work has not been as appropriate as it might have been: over focus on opiates and not therefore on polydrug use including alcohol, not an adequate level of involvement by members of the community, limited promotion of and visibility of the task force in the community, limited focus on rehabilitation supports and services, not leading the responses to new and emerging issues, lack of targeting of specific groupings such as new communities, Travellers etc., limited input to lobbying, advocacy and influencing relevant policies, narrow education prevention while not addressing wider family and community prevention work, limited review of project outcomes and research of drug problems locally, not working on a collaborative and interagency basis to the degree required and finally, not adopting an approach to problem drug use which emphasises progression and a continuum of care.

While the responses to the areas in which the Task Force was not seen to have provided an appropriate responses are valid in their own right, it should be noted that some (not all) of these issues are outside the capacity of what the Task Force can do on its own given resources and wider organisational responsibilities for drug problems. Nevertheless, these areas are identified needs in terms of drug problems on the ground in Clondalkin.

6.5 effectiveness of strategies

The areas where the Task Force were seen as effective include its supporting role for community based projects; its education prevention work; its response to new and emerging gaps in terms of information; its building of the capacity of community representatives; the provision of community addiction studies courses; the focus given to community safety by its support of the relevant forum; its support for the establishment of the drug user's fora; its own sub committee structures and overall, its support and initiation of a drug response infrastructure in Clondalkin.

According to the consultations, the areas in which the strategies of the Task Force were seen as less effective include: the outcomes of 'soft' projects such as those on family support; its reliance on a project based approach including staff

turnover in projects; development and maintenance of linkages with statutory services particularly the HSE; strategies or projects not begun; ongoing consultation with communities and agencies; progression of clients in terms of a continuum of care; a more multifaceted approach to prevention beyond education prevention to prevention work at the family and community level; harm reduction; promotion of CDTF in communities; targeting of children and adolescents; supply and control; and finally, in terms of treatment waiting list and the subsequent loss of windows of opportunity of those drug users who may be motivated to seek treatment but lose this motivation due to the length of time waiting to access treatment.

6.6 relevance

The last Action Plan of Clondalkin DTF was published in 2001. Due to the gap between that plan and the present strategy development process, the research asked those consulted if the Task Force has changed in line with the changing nature of drug problems? The first thing that is evident from the responses is that the task force is seen to have attempted to adapt, especially in more recent times. This is a positive development however there is a feeling that the services infrastructure developed remains focused on opiates and methadone maintenance. Among the response, this is seen as national policy issue and related to the NDS, statutory services and funding regimes. Despite this, there is belief coming out of the consultations that more work is required to overhaul existing services and direct new services towards the contemporary environment and if possible attempt to plan for emerging problems such as crack cocaine.

6.7 objectives

The original objectives of the task force were set down in 1997 and remained in the 2001 action plan with some additional principles. As part of the research, stakeholders were asked to assess the extent to which the objectives have been progressed. The two objectives are:

- To support and enhance the community to create a climate which would reduce the demand for drugs by bringing together community, voluntary and statutory organisations in a collaborative way.
- To provide a range of treatment options to enhance the opportunities for drug users to become drug free and minimise the level of chronic drug use and its effect on the community.

The general view coming out of the research is that the task force has been partially effective in progressing objective two. This is particularly the case in respect of the provision of treatment options and minimising chronic use. However, questions were raised the extent to which drugs users have become drug free and also the effects on the community. Again, the implications of these latter issues point to the need for progression in terms of a continuum of care and additional efforts to tackle the perceived increase in recent times of the negative effects of drugs in the community.

In terms of the first objective, and as noted earlier, the majority of views suggested that there has been no reduction in the demand for drugs in the community and, if anything, this demand has increased. Questions were raised as to how the task force could impact on this issue. In turn, it was suggested that the first objective could not be achieved by the task force as many of the processes were outside of its capacity alone.

According to the responses, it is generally felt that collaborative work has not been as effective in practice and that the required seniority of and meaningful input of the various statutory agencies was not apparent and this has had the effect of stifling the potential of the task force to credibly reduce the demand for drugs. This was not seen as failure on the part of the task force but rather one that came from weaknesses in the structure of the task force and the direction and prioritisation at more senior level from the state, the various government departments and their agencies.

6.8 impact of projects

The findings suggest that funded projects have had a mixed impact. In general, treatment projects are seen as effective and soft, support based projects were seen as less effective. This view depended on the perspective of the various stakeholders consulted. The more visible treatment projects were viewed as more valuable than soft support projects using a family support or counselling approach. However, the importance of the work of support type projects is valued by a significant minority but there is a sense that what they do is misunderstood and not made clear to a wider audience.

In addition, it was evident from the responses that there is difficulty in gauging the effectiveness of projects in the absence of output data and information, and as a consequence, the true value of the projects is not being drawn out.

While projects are seen as the first line of the defence and provide a wide range of essential services, there is scope for greater networking and co-ordination. On the flip side of this, it was suggested that there may be overlap and duplication in some of the projects, but with the lack of proper data there was no way for those consulted to tell.

The issue of the set boundaries of community based projects was also noted. In this regard, it was suggested that often projects need to provide alternatives due to stigma reasons for individuals who do not want to access services in their immediate locality.

The over dependence of some projects on CE staff was seen as unsustainable especially in the context of the need to introduce a continuum of care, case management approach and a more central focus on polydrug use.

6.9 relationship to NDS Pillars

It was outlined previously in the report the content and aims of the now five pillars of the NDS. Special attention therein was paid to rehabilitation, the fifth pillar, in view of its adoption as part of the NDS in more recent times. During the consultations, the various stakeholders were asked to outline the relationship between the pillars of the NDS and the work of the TF.

The main specific issues emerging from the consultation in this regard were the following:

- There is widely held view that more could be achieved under the supply and control pillar. It is felt that this is left to An Garda Síochána with the exception of the some poster campaigns and the community safety forum.
- Under the research pillar, it was suggested that this pillar is very focused on the national level and that national level research, carried out by the NACD and HRB, is disconnected from and therefore of questionable value to the local level.
- The prevention work undertaken by CDTF is mainly focused on education prevention and linkages with schools.
- The treatment work of the task force, while viewed as vital and valuable, is often hampered by resources and structural problems such as the role of GPs in the services.

6.10 adequacy of existing services & gaps

In similarity to the MQI research outlined earlier, services that are available for drug problems in Clondalkin are seen as valuable. Some services however are viewed as questionable in terms of the full range of needs of clients. The interviewees suggest first of all that existing services need to be maintained and consolidated, albeit with some improvements.

6.11 Strategic working

The development of the strategy is based on the principle of ensuring that the future work and approach of the task force is strategic. In other words, that it is based on analysis, balancing of options, identifying problems, selecting objectives and actions to reach objectives. In this light, the consultations explored the extent to which the task force has been strategic in the past and moreover how the task force might be more strategic in the future. From the comments there is some confusion around what a strategy is and what it means to be strategic.

Nevertheless, the main ideas suggested by the respondents are that the task force has been strategic, but only up to a point. Its strategic role is seen to be more evident in recent times and in contrast to earlier periods where it was described as being more reactive rather than proactive. The contemporary improvement in the strategic capacity of the task force is seen as being related to the team based approach of the staff, additions to the staff and being located in the one location. It is seen nevertheless to be hampered in this by the structures of the NDST, the lack of buy-in in terms of outputs by statutory agencies and by capacity issues related to staffing levels, time pressures, lack of research/appropriate data and over emphasis on the local management of supported projects.

6.12 structures, operations & procedures

Most of the stakeholders were positive about the structures, processes and ways of working of the task force. On the positive side, it was accepted that the task force has policies, line management and supervision in place internally. The task force's sub committees have terms of reference and have been restructured in recent times to be more advisory committees to keep the focus on strategic issues rather than funding applications alone, which are now dealt with by a separate sub committee. There is recognition also that community representation has improved following some additional supports put in place.

However, on the negative side, the respondents suggest there is little reporting of information back to the task force in terms of projects and their outputs and that for community representatives the structures can seem very formal and intimidating. In addition, for new members coming on to task force structures, they are often unprepared and are not aware of their role in terms of how the task force operates.

Therefore, the main areas suggested for improvement are the following:

- improved systems of communication
- set terms for representatives, especially community representative to facilitate fresh perspectives
- introduction of formal induction for new members especially community representatives
- adoption of a more proactive approach by the task force
- more meaningful input from state agencies
- more openness of the central task force
- introduction of annual reviews

In addition, the suggestions common to all sub groups/committees centred on the following:

- Each would develop a work plan annually that would be in keeping with the overall TF strategy
- The role of the sub groups would be to work at a focused and expert level to discuss policy issues and innovation. As such, it might include the addition of experts in the various fields in as far as possible.
- Review latest developments in policy and research with relevance to their specific areas
- In as far as feasible, it is also suggested that the various sub groups might include members of the users sub group with appropriate induction and training. If this is not possible, a structured process of consultation should be initiated to get the views of users and those affected by drug use.

6.13 Collaboration

The findings from the consultations under this theme suggest the collaboration of the task force with its projects and at a day to day level with allied services are good and are a valuable asset in their work. The main issue raised in the responses focused on the partnership nature of the task force. Some felt at this level that the task force collaborates well at the local level is less effective at decision making levels.

It was also observed that there are no linkages in the structure of the task force with the national level in any meaningful sense. It was noted that statutory agencies often have no system in place to play a meaningful role on the CDTF in terms of inputting into actions etc. In this case, often the representatives of agencies are not decision makers and often the extent of that agency's input is left to the person. A number of respondents reported a belief that task forces are not taken seriously by statutory agencies.

6.14 policy development

In response to the questions of the extent to which the task force informed policy development and passed on local learning to ultimately national level, the research established that no formal systems are in place within CDTF at present to develop research and related documents to inform policy. It is suggested that often policy development is dependent on the calibre of and time available to the staff and in particular, the task force co-ordinator. Some respondents felt that some policy development work is undertaken, however it was felt that this was normally in response to requests from the NDST and from which no obvious outcome occurred. Suggestions made in this respect include:

- Policy development is made a central part of the remit of the task force
- There is a need to develop complementary data collection systems, mentioned elsewhere, to inform policy documents
- The process of disseminating local learning and their implications for policy required a well thought through approach that used multiple methods such as literature, conferences, networking, the internet, and communications to elected representatives, the NDST and government departments.

6.15 Impact of national issues on clondalkin

Throughout the feedback from stakeholders there have been a number of areas that have been touched on that are seen to impact on drug problems and related areas in Clondalkin but are outside the control or capacity of the task force to respond to. The main areas noted by respondents were the following:

- lack of Garda resources and capacity
- deprioritisation of drug problems at national/governmental level and perceived watering down of the power of the NDST
- Treatment waiting lists
- housing policies, evictions, rent supplement, anti social behaviour and homelessness
- Preschool and early intervention services for children
- Limited detoxification services
- Holistic and interagency approaches and protocols. This includes the role of state agencies and local partnership structures such as task forces
- Income inequality, poverty and the black economy

- Methadone, pharmacies, opiate focus and lack of alternatives
- Decreased sense of 'community' and loss of social capital in communities

6.16 Suggested approach for the future

As part of the dialogue with stakeholders, and following on from the previous themes covered, the areas suggested in which the Task Force should focus on in the future were explored. From analysis, it is possible to identify the following broad themes_:

- Consolidation of existing services and projects
- Move from project based to programmatic approach. This would therefore also involve a focus on smaller number of multidimensional projects. As part of a strategy this would also expand to include annual implementation or action plans
- The introduction of a multi methods approach to prevention including early intervention and focus on risk factors and strengthening protective factors at individual, family and community levels.
- The introduction of a continuum of care approach including therefore a focus on a case management approach. This would also introduce the provision of parallel supports to families and in terms of related issues to addiction of continuum of care path
- Research and evaluation of supports, projects and new services. This includes monitoring outcomes and drawing out learning which is not just focused on evaluative aspects. This would also include the development of KPIs based on set aims and objectives. This would also look to develop more annualised prevalence research. This area would also look at advocacy, lobbying and policy issues.
- Animation of responses in geographic areas and with interest groups in which there is no current response or project promoter
- Provision of specific activities to include members of hard to reach groups such as Travellers, new communities, and the homeless
- Development of community social capital through community development activities and collaborations
- Improving the profile of the task force and its work through communications and promotions
- Co-ordination and collaboration (systems and protocols). This also included a focus on the role of the NDST, statutory agency input and central government direction/action.
- Increases in the capacity of HSE services
- The development of services for Cocaine including research, pilot responses and new sites for specialised services This centred on the wider profile of use of this drug, its link to alcohol and the perceived difficulty in getting problem cocaine users to access treatment/support.
- Increases in the staff and resourcing of projects/services and related improvements in C&V sector capacity, management, standards and continuity.
- Introduction of more appropriate housing policies, including services for the homeless
- Provision of crisis intervention supports for families and individual drug users in order to avoid being placed on waiting lists when interventions and support are initially sought
- Provision of more comprehensive needle exchange and other harm reduction approaches
- Putting polydrug use including alcohol at centre of the approach to addiction adopted by relevant services
- Development of responses to ease the transition from prison to the community for drug users
- Development of early interventions for children of drug users and services for adolescents. This also includes facilities for both communities and young people.
- Provision of ancillary supports (holistic approach) alongside a continuum of care path for individuals
- The development of early warning and contingency planning for emerging drug problems such as crack cocaine and methamphetamine
- Increased focus on the supply and control of drugs including greater interaction with the Gardai and accompanying education on community matters and processes for Garda.

6.17 Conclusion

This chapter presented findings from research among community, voluntary and statutory stakeholders in respect of drug problems in Clondalkin. On the whole, the findings are similar to and support those made in the earlier chapters on trends in drug use nationally and also the dedicated prevalence study for Clondalkin carried out by MQI. At the core of the findings is the that drug problems in the area have not improved - and if anything has increased in recent times – and are characterised by a wider and more diverse social group of drug users and also wide variety in the types of drugs used. The concept of polydrug use is also very much to the fore. The stabilisation of heroin, the emergence of significant cocaine use and its relationship with alcohol are all features of the findings which reflect the findings in earlier chapters also. Along with this, the chapter suggests that there has occurred a normalisation of illicit drug use in the community along with increases in drug related crime and gun crime. In addition special attention was paid to the use of alcohol and the increasing use of this and illicit drugs by younger people. In respect of the CDTF, there are generally positive views about its input to drug problems; however key areas of work or gaps were identified which

need to be addressed. The chapter also outlined the views of respondents across a range of themes or elements of CDTF's work and culminated in a range of key issues/needs to focus on and approaches to adopt as CDTF develops its 2008 strategic plan.

7. Consultations with DRUG USERS & family groups

7.1 Introduction

An important phase of the research and strategy development process was to consult with drug users and those affected by drug use. The aim of this was to establish the views and experiences of this group on the reality of drug use in Clondalkin. This looked to assess the gaps in services as experienced by the group and the limitations on existing services. It also explored that nature of past and current drug problems, their availability, related problems and the implications of this for the future priorities of the Task Force.

For this phase of the research, five focus groups, accounting for 23 individuals, took place with family support and service user groups. A further twelve interviews took place with individual drug users.

7.2 form of drug use

Firstly, this group were asked to outline what form drug use takes in Clondalkin based on their experiences. In keeping with the earlier findings, the responses stressed that cocaine was the main drug that was currently being used in Clondalkin. In similarity also, these findings suggest that a 'new' group of people are using cocaine. This group by and large are different to those who traditionally may have used heroin, although some of this latter group also use cocaine. The use of cocaine is believed to take place on a recreational basis and use in pubs is commonplace. The feedback here suggests that the numbers using cocaine is increasing. Again, keeping with earlier findings, the feedback also noted that cocaine has come to replace 'E' as the illegal recreational drug of choice.

The respondents report the widely held perception that there exists no treatment for cocaine. This is furthered by a collective belief that cocaine users are not 'problem' drug users in the same manner as heroin users and, as such, are less likely to present to drug support services conceived, rightly or wrongly, as catering for opiate users exclusively.

Underage drinking also figured in the responses and this was seen in the context of wider use of alcohol in Clondalkin. In similarity to earlier findings, this was felt to be at a much greater levels than at times in the past. Related to this, the majority of those interviewed suggested that in Clondalkin people are using drugs of all varieties earlier in their lifetime than was previously the case.

7.3 factors contributing to drug use

In line with earlier findings in the report, the reasons suggested for the use of drugs varied around a number of key subjects. The first was the existence of an addictive personality. In this regard, it was felt that some people are either psycho-socially and/or bio-chemically predisposed to developing addictions following drug use. Another factor identified by the respondents was that drugs, regardless of their dangers, are enjoyable to take and create a sense of pleasure. In other words, taking drugs was part of a 'buzz' and was in keeping with the social and recreational practices of many in the community. Related perhaps to the 'buzz' factor, many of those interviewed observed that curiosity and experimentation are also key reasons in why some people use drugs.

Some of the respondents pointed out that some people may take drugs, and subsequently develop drug problems, due to low self esteem. This is complex process where on the one hand, some people may take drugs to overcome their feelings of low self esteem and on the other hand - due to their low self esteem - others find it difficult to refuse to take drugs when others, peers etc., are also taking drugs. It was also evident in the responses that people may take drugs to counter emotional (including mental illness) and physical trauma.

The responses also suggest that socialisation or peer processes play a key part in drug use. This is a key issue which is probably a factor in many of the other reasons noted in this section. In this relation also, it is evident from the responses that when drug users see their peers using drugs and not (in their view) developing related problems, this serves to concrete the view that only some people - who are unlucky, have personal difficulties or who may be predisposed to addiction - will be those who are likely to develop problems rather than others who do not have these attributes.

The high availability and prevalence of drugs, in particular cocaine, was also felt to be a key reason. Lack of knowledge or belief in the dangers of drug use was another factor suggested. In this regard, it is viewed by those consulted that many people who take drugs, especially recreationally, are not aware of the inherent dangers. Areas also mentioned as contributory factors to drug use are early school leaving, boredom, and homelessness.

7.4 perceptions of CDTF

What is evident overwhelmingly from the responses is that many of those interviewed are not aware of the Task Force or what it does. Where the respondents were aware of various community based projects and services in Clondalkin, they were generally not aware of the relationship between the projects and CDTF.

For those that are aware of the Task Force, some viewed a number of the projects supported and carried out by the task force as ineffective. In the main, the rationale here was around the visibility of the outputs of certain projects. This supports what was seen in the previous chapter on the questioning by some of those consulted of the value of 'soft' family support, counselling type projects.

There was a view expressed also that some of the areas in which it was perceived that task force would carry out activity and implement projects, little was done in practice. The lack of what people termed 'feedback' was also a negative view given about the Task Force.

Mirroring earlier findings, some of those consulted believed that the drug problems that the Task Force seeks to respond to are generally outside of its control and capacity.

Finally, the responses suggest that those individuals who are engaging with projects were generally satisfied and positive about the projects, its services and staff.

7.5 Changes in drug trends, 2001-2007

The main changes identified by those consulted here revolved around a number of points. The first is that drug use is no longer something that is done by people who may have been described as 'disadvantaged' in the past. Second, over recent times, therefore, it is believed that drug use has become 'normalised' and goes across all social strata, from those employed, professionals, to unskilled persons and the unemployed etc. Third, the respondents also report increasing use of drugs by young people with a particular emphasis on alcohol.

Noted also in the feedback was the increased use of benzodiazepine through prescriptions and also 'on street' markets, normally based on prescription leakage. It was suggested here that heroin is still present as a problem drug and that there remains a demand for it. The change however is that heroin is one of a number of drugs that people are currently using and this underlines the diversity of drug use, or more precisely polydrug use, and of those using drugs.

There were also suggestions made about the increased violence associated with drug problems in Clondalkin in more recent times and the difficulties that families can often face when a member develops drug related debts and is unable to pay.

Finally, cocaine was also mentioned in this relation. Again, it was seen as the main change in terms of illicit drug problems in 2001 and in 2007. As an addendum, it was also pointed out by some users that in the last one to two years there is growing evidence of crack cocaine use in Clondalkin.

7.6 impact of national issues on clondalkin

The main national issues which impact on drug problems in clondalkin identified by drug users and family members centred on the following:

- Crime
- Homelessness
- Lack of rehabilitation
- Economy of drugs – alternative income/seen as a 'lucrative' option
- Housing
- Community and youth facilities
- Anti social behaviour

7.7 Suggestions/priorities for the future

Under this theme, the core suggestions were firstly, it was felt that many services for drug users (and families of drug users) are not holistic. By this what is meant is that services were perceived only to deal with the drug addiction aspect of an individual. It is felt that there are a range of allied issues that should also be factored into the supports drug users in treatment receive. These include housing, employment, counselling, mental and general health, progression, aftercare and so forth.

Secondly, a number of those consulted pointed out the drug problems are not a weekday occurrence only; a need in service provision exists therefore at weekends and night time.

Thirdly, responding to the waiting lists system was viewed as a fundamental area to respond to. It was felt that waiting lists proved particularly detrimental to those chaotic users who may at some point become motivated to seek treatment. As noted elsewhere in the report, the waiting list system means that individuals in these cases may, due to the waiting time (3-6 months) for receipt of treatment, revert to their normal routine of drug use and ultimately miss the so called 'window of opportunity'. This is particular distressing for the families of drugs users who suggest when they first sought support, they did not know the 'system' operates and this caused significant distress by the placing their family member on a waiting list at time when the family is often in crisis.

Fourth, the lack of detoxification places was also highlighted as a priority. This was felt to limit the opportunities for drug users to address their drug problem. Issues were also raised in this regard about discrimination against those who could not afford private treatment and were forced to wait for access to detoxification beds.

A general suggestion was to put in place services and/or activities that might overcome the lack of information about what services were available for drug users. In this regard, there is a sense from the findings that information dissemination should be integrated and use a multiple media approach (rather than rely on brochures etc.) including the use of peer mechanisms and word of mouth.

Some respondents observed that treatment should also be available outside of the immediate Clondalkin area. This was based on the wish of some drug users to avoid attending drug treatment and supports services in their immediate locality. This was also emphasised in particular as an important option for cocaine users who may want to seek treatment away from existing drug treatment centres in view of their association with opiates.

Many of those consulted felt that the overriding focus of services on opiates was not in keeping with current drug use trends especially in the context of polydrug use, thus it was suggested that services should focus on polydrug use and in particular, the use of cocaine and alcohol.

The provision of a progression or care path was also prominent suggestion in the responses. This focused on the provision of aftercare for those who might successfully come through detoxification and/or treatment. This was introduced in the responses therefore in as part of what is termed a continuum of care approach.

It was felt that services were required for those who are drug users in prison and the transitional process on their release back into the community.

In similarity, some of those consulted, especially family members, identified the need for greater and more advanced family support services and where desired, family involvement in the treatment of families members.

A number of respondents suggested that a more comprehensive harm reduction approach was required in Clondalkin. This included aspects such as needle exchange, safe injecting, responsible batch preparation, sexual health, general health, mental health, outreach, referrals, case management, and information. The responses also suggested that services in the future should be more proactive to unmet needs and emerging trends than has been the case in the past.

Finally, in terms of aftercare and successful completion of treatment/detoxification, it was suggested that many of persons are often placed back in the social setting in which they had used drugs. This it was argued had the effect for many of causing relapse due to peer pressures, availability and elements of trauma. Thus this required a programme or set of actions which would allow those leaving treatment to be placed in different environments and in transitional accommodation which were 'clean' of drugs.

7.8 Conclusion

In this chapter, the views and experiences of drug users and family members on the reality of drug use was explored. The findings mirror the findings in earlier chapters and therefore go along way to verify and validate the overall findings presented across the report. The chapter highlighted the prevalence of cocaine across all social groups in the area, the pre-eminence of polydrug use, the younger age at which people in the area begin to use drugs and in particular alcohol, that drug use has become cultural normalised in Clondalkin and the growing violence and crime associated with drugs in the area. The chapter also outlined the range of factors that are felt to contribute to drug use which point to the areas that prevention work might look to target. It was also reported that most those affected by drug use are not directly aware of the CDTF and its work and the responses also suggest in this regard a range of areas for CDTF to include in its future work. Finally, the chapter outlined a range of needs identified by the interviewees and in turn set out what they saw as the priorities for future drug services and supports in Clondalkin based on their experiences.

Conclusions and Suggestions for Strategy

This report endeavoured to answer a range of questions set out at the beginning of the research process leading to the development of a strategic plan for the CDTF. What the research findings tell us is that CDTF is in the midst of a changed, and changing, drug use context. This differs to the late 1990s when CDTF was originally established, and also the early years of this decade when - more importantly - its current strategic plan was developed. In this regard, opiate use, namely heroin, is still prevalent but has arguably stabilised and the research has shown how more people are using drugs now than in the past and that these drugs include increasingly cocaine, alcohol and cannabis. The group that are using the latter types of drugs are different from those that are traditional opiate users. They include people from a range of social backgrounds and across a wide age range. The types of drug problems emerging, their manifestation, and consequences are complex and multi-factorial. A key trend underpinning the findings is the consolidation of drug use in the form of use of two or more drugs simultaneously, also known as poly drug use.

The research findings are validated and verified by the emergence of these issues across each of the phases of the research, from the prevalence study undertaken by MQI to the consultations with stakeholders and problem drug users/family members affected by drug use in Clondalkin. This suggests that the issues that comprise the nature of drug use in Clondalkin presently have been comprehensively identified by the strategy development research. As such, these are the areas also that will form the challenge for the Task Force's strategy.

The challenge to the Task Force arising from the research findings points to a new and dynamic problem drug use reality. This seems to require a new approach, and a formal move in the strategic direction of balancing operational and policy work as part of the overall response, that the Task Force has arguably been moving toward especially in more recent years.

This strategic direction therefore must recognise that many of the problems that the Task Force looks to deal with are not of an operational nature solely and are not in its capacity alone to address. Accordingly this opens up the need to work at both an operational level as well as at a more strategic level in terms of policy issues and related lobbying and advocacy. The research has analysed the current role, context and operations of CDTF and has consequently identified the key areas of need that should inform the focus of its work over the next number of years.

The following are the key themes identified through the strategic planning process which should inform the CDTF strategic plan:

- Develop and implement strategies to identify and respond to emerging trends.
- Adopt a strategic approach to planning and developing services which will shift the focus from a project based approach to one which operates across a number of themed programmes.
- Adopt a more strategic approach to addressing issues outside the capacity of the CDTF on an operational level and engage in more effective lobbying, advocacy and policy development.
- Adopt and strengthen interagency and collaborative approaches to addressing drug issues and responding to the needs of individuals, families and the community.
- Develop and implement effective systems for regular reviews and monitoring progress at both operational and strategic level.
- Put in place mechanisms to review the effectiveness of the existing task force structures with regard to representation and engagement from all sectors particularly the community sector.
- Place the concept of continuum of care approach at the centre of all service provision and strengthen the capacity of projects focus on progression aftercare as well as prevention, harm reduction, stabilisation and treatment.
- Strengthen the capacity of services to provide broader family support services which encompass therapeutic work, childhood development and education intervention's youth work, community development, parent education and home based parent and family supports families
- Assist services in moving towards a continuum of care and case management approach and improve their capacity to develop and implement appropriate systems for monitoring outcomes and mapping client's progression
- Work to consolidate existing services, and take a proactive approach in responding to emerging drug issues in particular Cocaine.
- Strengthen project's focus on poly drug use and increase their capacity to improve standards, and respond to new and emerging drug issues.
- Review the role and potential of CDTF with regard to developing strategies to addressing crime, anti social behaviour and supply in conjunction with the Gardai and other relevant authorities.

Strategy

Vision & Principles

The strategic planning process has gone some way toward identifying the areas in which the Task Force needs to focus on as part of its future operations and activities. The Strategy is structured into an overall vision. This is in turn followed by a number of programmes under which are presented a number of objectives, each of which contains key goals to achieve each objective and ultimately implement the programme. The set of programmes are cognisant and informed by the core vision and is informed by the findings and suggestions arising out of the report.

VISION

'The vision underpinning the strategy of the Clondalkin Drug Task Force for 2008 to 2011/13 is to protect against and reduce drug problems in the area through prevention, harm reduction, treatment, rehabilitation, social integration and aftercare activities which are tailored to meet the specific needs of individuals, families and communities'

Principles guiding the work of CDTF under its Strategic Plan:

- Placing communities at the forefront of our work
- Implementing a client centred approach based on a continuum of care
- Collaboration with key agencies and service providers
- Influencing policies based on the experiences of individuals, families and communities
- Developing and implementing evidence based responses
- Learning from outcomes

Programme: *Strategy for operational and organisational development*

Objective 1: Improve current operational structures and create structures for future development

Key Goals:

- Develop theme based programmes
- Review progress based on systematic data collection and development of annual action plans
- Develop new projects in the absence of appropriate project promoters
- Promote the work of the Clondalkin Drugs Task Force and relevant issues through the development of internal and external communication strategies
- Ensure the implementation of a client centered approach in all new and existing programmes
- Identify and co-ordinate appropriate responses to new and emerging drug problems
- Examine the development of shared services provision among projects

Objective 2: Continue to work effectively and in collaboration with all key stakeholders

Key Goals:

- Continue to build links and work in collaboration with relevant organisations at local, national and regional level
- Develop frameworks and protocol with statutory and other agencies for effective collaboration and interagency working
- Develop and enhance support systems for projects regarding management, finance, HR and training needs
- Continue to develop and implement programmes to facilitate the participation of drug users in developing responses to drug issues.
- Continue to support and enhance community participation
- Ensure the needs of specific target groups are identified and addressed

Objective 3: Create a learning organisation

Key Goals:

- Build the capacity of projects to draw out learning, issues and best practice
- Develop key performance indicators and systems to monitor progress, identify learning and inform future development across programmes
- Provide technical support for the development and implementation of progression and activity monitoring systems within service provision
- Collate and disseminate evidence based research and information among key stakeholders

Objective 4: Continue to influence policy development at all levels through lobbying and advocacy work

Key Goals:

- Develop policy research, collection and analysis and improve the capacity of Clondalkin Drugs Task Force to lobby more effectively
- Provide training and develop the capacity of local services to influence policy and engage in more effective lobbying, advocacy and representation activity

- Support the development and implementation of models of good practice regarding advocacy work within service provision

PROGRAMME: *PREVENTION*

Objective 1: Strengthening Protective Factors for Individuals, Families and Community

Key Goals:

- Continue to develop and implement drug education prevention programmes and strategies with individuals, families and communities
- Strengthen prevention programmes and support increased engagement in these programmes within formal and informal settings
- Continue to strengthen preventative family support and community development actions
- Support the development of research training and consultation regarding good prevention practice
- Provide training and build the capacity of service providers to deliver drug prevention and education programmes based on models of good practice

Objective 2: Continue to enhance community well being and develop social capital

Key Goals:

- Develop programmes focusing in particular, but not exclusively, on under 35's to draw them into community and civic activities
- Continue to support programmes and activities to facilitate the participation of the community in developing responses to drug issues
- Develop community activities and programmes in partnership with key stakeholders in Clondalkin

PROGRAMME: *TREATMENT & REHABILITATION: CONTINUUM OF CARE*

Objective 1: Provision of a continuum of care model for drugs users in the area

Key Goals:

- Identify and develop a range of options for individual clients and their families as part of a continuum of care approach
- Ensure the development of linked harm reduction, stabilization, detoxification, rehabilitation and aftercare supports to individuals and families
- Coordinate the development of key performance indicators and mechanisms for assessing and facilitating progression for individual clients and their families
- Provide access to effective education, training and employment opportunities to recovering drug users
- To provide structured support and interventions for drug users and their families in times of drug related crises

Objective 2: To support projects to strengthen their focus on poly drug use

Key Goals:

- Assist projects in reorientation of their services to focus on poly drug use.

Objective 3: To provide improved services for under 18s

Key Goals:

- Develop pilot psycho-social support projects for under 18s in collaboration with the HSE

Objective 4: Develop responses to new & emerging drug issues

Key Goals:

- To strengthen the capacity of projects to respond to new and emerging drug issues

PROGRAMME: *SUPPLY REDUCTION*

Objective 1: To create opportunities for safe dialogue between the community and the Gardai to explore options to address drug related crime

Key Goals:

- To work in partnership with key agencies including the Gardai to reduce the level of drug dealing in the area
- To create a safe environment to discuss ways of addressing drug supply and control issues
- To identify barriers and solutions to addressing drug related crime in order to inform national policy
- To highlight the links between local drug economies, underage crime and social exclusion

PROGRAMME: *FAMILY SUPPORT*

Objective 1: Continue to provide sustainable family support programmes and services

Key Goal:

- To identify and develop appropriate and sustainable family support services in response to changing needs
- Support the development and implementation of early interventions for children of drug using parents

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- **Appendix 1 Profile of Respondents**
- The groups/stakeholders consulted for this part of the research can be categorised into the following:
 - CDTF staff
 - National Drugs Strategy Team
 - Treatment Clinic
 - Local Authority
 - Generic youth services
 - Local development organisation
 - Counselling services
 - Justice and probation statutory organisations
 - Community representatives
 - Community and voluntary service providers
 - Family support services for drug users and their families
 - Advocacy service for drug users
 - Community safety
 - Drug services clinic and support groupings
 - Drug support services for minority ethnic groupings
 - Mainstream education and family liaison
 - Tailored support services for young people who have left school early
 - Statutory health services.

The 14 LDTFs have been joined in the last two years by Regional Drugs Task Forces which cover the areas, normally the former catchments of the Health Boards, not covered by the LDTFs.

Watters, N., et al, 2004.

NACD/DAIRU: 2008.

This survey refers to prevalence in terms of lifetime use, recent use (< 12 months) and current use (< 1 month)

NACD/DAIRU: 2008.

Opium, temgesic, diconal, napps, MSTs, pethidine, DF118, buprenorphine, morphine, codeine, kapake, diffs, dikes, peach, fentanyl and oxycodone.

Commiskey and Cox, 2006-2007. The full title of ROSIE is Research Outcome Study In Ireland: Evaluating Drug Treatment Effectiveness 2006-2007.

The EDR is the ratios of the inactive population in terms of the labour market (children under 14, unemployed, 1st time job seekers, home duties, retired, students and those unable to work) to those at work.

Kelly, Carvalho & Teljeur, 2003

It was worth noting that it was not always seen as vital that the work of the TF directly relates to the pillars of the NDS. By this what is meant is that the work at local level, while taking cognisance of the NDS in substance and direction, can be named differently or spread across a number of actions or projects.

Although it should be noted that many of the themes have much in common and to an extent overlap, this is in general a finding seen across the findings in this section of the report.