South East Regional Drug Task Force

2010 Report to the Office of the Minister for Drugs

Introduction

In 2010, the South East Regional Drug Task Force (SERDTF) commissioned an evaluation and roadmap report, "A Roadmap for the Future: A Rapid Assessment Response (RAR) on the Needs and Service Evaluation of the South East Regional Drugs Task Force" (the Comiskey Report) from Professor Catherine Comiskey. This report provided a detailed overview of the drug problem in the South East, examined emerging trends, provided an evaluation of projects funded by the SERDTF and proposed priority development areas. The above report, with the addition of data released since its publication, will form the basis for this report.

PART 1: An Overview of the Drug Problem in the South East

Detailed profile of drug usage in the South East

The following is an extract from the Comiskey report;

> The scale of the drug problem can be ascertained by examining local census statistics and reports on estimates of proportions using drugs based on national population surveys and more refined statistical estimates of specific drug use. We examined the size and change in the population in the SERDTF region aged between 15 and 64 years. We then estimated the number of drug users based on the proportions using drugs as estimated by the NACD Population survey (http://www.nacd.ie/publications/Final2006-7_CIs_B2_Res.pdf pages 23:25), and the NACD Opiate Prevalence Survey (http://www.nacd.ie/publications/prevalence_opiate.html). Results on the change in the population size are provided in Table 3.1 below. Clearly there has been a substantial increase in the population within all counties and the increase in three of the counties (Wexford, Carlow and Kilkenny) was above the national average across all counties.

Table 3.1 Change in the size of the SERDTF Population from 2002 to 2006

SERDTF Area	Persons 2002	Persons 2006	Persons Aged 15- 64 2006	Actual change 2002-2006	Percentage change 2002-2006
Carlow	46,014	50,349	34,481	4,335	9.4%
Kilkenny	80,339	87,558	58,713	7,219	9%
Wexford	116,596	131,749	87,187	15,153	13%
South Tipperary	79,121	83,221	55,042	4,100	5.2%
Waterford	101,546	107,961	72,370	6,415	6.3%
Waterford City	44,594	45,748	31,441	1,154	2.6%
Waterford County	56,952	62,213	40,929	5,261	9.2%

Total in SERDTF			**307,793**		
State	**3,917,203**	**4,239,848**		**322,645**	**8.2%**

The size of the population aged 15 to 64 in the region in 2006 is also provided in column 4 of Table 3.1 above.

The NACD population survey (NACD, 2009, Table 14.2) provides both the percentage and the lower and upper 95% confidence interval estimate of all individuals in the SERDTF region aged between 15 and 64 years who used *any illegal drug* in the past year. Based on this proportion and the number of 15 to 64 years olds in the SERDTF region, the number of individuals using any illegal drug in 2006 was estimated and is provided in Table 3.2 below.

Table 3.2 Estimates of Numbers Using *Any Illegal Drug* in the Last Year *

SERDTF County	Number of Persons Aged 15-64 In 2006	Lower Estimate of Illegal Drug Using Prevalence in 2006	Point Estimate of Illegal Drug Using Prevalence in 2006	Upper Estimate of Illegal Drug Using Prevalence in 2006
Carlow	34,481	1,448	2,724	4,551
Kilkenny	58,713	2,466	4,638	7,750
Wexford	87,187	3,662	6,888	11,509
South Tipperary	55,042	2,312	4,348	7,266
Waterford Total	72,370	3,040	5,717	9,553
Waterford City	31,441	1,321	2,484	4,150
Waterford County	40,929	1,719	3,233	5,403
Total in SERDTF	**307,793**	**12,927**	**24,316**	**40,629**

*(Based on the NACD Population Survey 2006, SERDTF Region, Table 14.2, page 24)

Based on the results in Table 3.2 above we can see that there is great variability in the results from approximately 13,000 to over 40,000 numbers of individuals using illegal drugs in the region in 2006.

Using the NACD report on opiate prevalence (Kelly et al, 2009 page 25, Table 15) it possible to estimate the numbers of opiate users in region in the 15 to 64 age group. These results are provided in Table 3.3 below.

Table 3.3 Estimates of Numbers Using Opiates in the Last Year in 2006 *

SERDTF County	Number of Persons Aged 15- 64 In 2006	Point Estimate of Opiate Prevalence in 2006
Carlow	34,481	100
Kilkenny	58,713	170
Wexford	87,187	253
South Tipperary	55,042	160

Waterford	72,370	210
Waterford City	31,441	91
Waterford County	40,929	119
Total in SERDTF	**307,793**	**893**

*(Based on NACD Kelly, et al Report 2009, page 25, Table 15, Rest of Ireland Region of 2.9 per 1000 individuals using opiates in the 15 to 64 age group in 2006)

The results in the tables above help provide some information on the scale of the problem and are an essential first step in any needs analysis. Detailed below is a summary of the numbers in treatment in the region and this data contributes to building the picture of the nature of the drug problem and the context.

3.3.2 Treatment Demand Indicator Data, Annual Report 2008

In order to identify the drug service needs for the region a review of the Kidd (2009) regional report of treatment demand and other data was conducted and key points relating to the WHO criteria on a rapid assessment response and needs highlighted.

Population Groups Affected

In terms of the population groups affected Kidd (2009) notes in the annual returns of the treatment data for 2008 that the percentage of treated females has shown a slight increase in each of the reporting years since 2000, and has continued to show an increase in 2008. Treated females in the South East accounted for 24.5% in 2004 and have since risen to 31.8% in 2008, an increase of 7.3% in 4 years. In terms of the ages of clients Kidd (2009) notes that when looking at both the assessed and treated clients for the South East, the majority of clients were in the 20-24 year age group at 35.1%, followed by those in the 30-34 year age group at 27.7% then by those in the 25-29 year age group at 23.4%. However from closer examination of the distribution of ages it can be seen in table 4(page 8 of Kidd, 2009), that the proportion and numbers of young people treated in the region in 2008 was 319 or 13.4% and these numbers have important implications for the intervention/prevention pillar of the National Drug Strategy (2009).

Referrals

It is also interesting to note the wide variety of referral sources highlighted in Kidd (2009, table 6, page 10). These include not just self referrals but referrals from General Practitioners, Psychiatrists, Accident and Emergency Departments, the courts etc. Numbers referred from these sources are substantial and are perhaps an indicator that the clients are suffering harm/risk to self and community before they come to notice of treatment services. It is also interesting to note the proportions referred from mental health facilities. Kidd (2009) states that 'the main source of referral for treated clients living in the South East was, self referral at 31.1%, followed by referrals from a mental health facility at 11.5% and then GP at 8.8%. The percentage of referrals for treated clients in the South East from Court/Probation/Police has fallen from 14.8% in 2007 to 8.1% in 2008. Part of this decrease may be as a result of incomplete reporting...'

Characteristics and Drugs Used

In terms of drugs used in the region Kidd (2009) reports that alcohol continues to be the main problem substance that clients in the South East are treated for at 61.7%. However over the last number of years alcohol as the main problem substance has fallen and this trend continued in 2008. Treated alcohol clients in the South East fell from 64.2% in 2007 to 61.7% in 2008. In 2007 and previous years, cannabis was the second highest treated drug of misuse in the South East but in 2008 heroin has taken this position at 12.5% or n=293, followed then by cannabis at 10.7% and cocaine at 5.6%. The number of clients treated for cocaine use in 2007 was 154 but this fell to 124 in 2008.

Health and Risk

In terms of risks, proportions ever injecting drugs and sharing needles were low and while the overall total number of deaths in the region were in line with the national treatment outcome study (the ROSIE project, see http://www.nacd.ie/publications/index.html) and were 0.6% n=11 in the region compared to 0.5% n=2 in the ROSIE study at 1 year post opiate treatment intake, numbers for individual counties were higher. However as numbers reported by Kidd (2009) table 8, page 14, unlike the ROSIE study were not all opiate related and therefore cannot be directly compared with the ROSIE results.

3.3.3 Prison Data

Population Groups Affected

Summary non computerised data on 1,059 prisoners attending training within Mountjoy prison in 2006 was available for analysis (Private communication, Pugh 2009). From this data some information on bullet points one and two above were available (population group effected and characteristics). From these 1,059 records of prisoners attending training, 20 (1.9%) were identified as being from the south eastern region (Tipperary, Carlow, Kilkenny, Wexford and Waterford) and 100% or all 20 were identified as drug users. Within Dublin 99.3% of prisoners were identified as drug users and 99.7% of prisoners from other regions were drug users. These proportions indicated that proportions of drug users among prisoners did not differ across the three regions. The range in ages among prisoners from the south east was 19 to 36 years compared to 18 to 57 years among Dublin prisoners and 18 to 54 years among those from other or unspecified regions.

Characteristics and Drugs Used

Drugs used by prisoners from the south east included heroin, hash, cocaine and ecstasy. Within the south eastern region however, the proportion of drug users attending training within Mountjoy identified as heroin users was highest, with 75% (n = 15) of drug users from the south east identified as heroin users, 69.4% amongst prisoners from the Dublin region and 57.1% from other or unspecified regions. In contrast to this pattern the proportions identified as on a methadone programme and from the south east region was lowest with 20% (n =4) of those from the region described as being on a methadone programme compared to 41.9% of

those from the Dublin region and 62% from the other or unspecified regions. In addition to heroin use, alcohol use was also highest amongst prisoners from the south eastern region (20% in south east vs 16.7% in Dublin and 12.7% in other or unspecified regions).

Health and Risk

Little or no data was available on the health of the prisoners attending training however whether or not a prisoner had a psychiatric condition was often recorded. Among prisoners from the south east the presence of a psychiatric condition was highest when compared to the other two regions (20% (n=4) in the south east vs 7.1% (n=30) in Dublin and 8.2% (n=50) in other or non specified regions.

While some differences between the regions are striking, results must be viewed in light of the limitations in this prison data. Numbers of prisoners from the south eastern region were very small (n=20) compared to the Dublin (n=426) and other or non specified regions (n=613). Similarly the data source has not been audited for quality assurance purposes and was collected merely as a record of prisoners attending training courses in Mountjoy in 2006. However, results do perhaps provide possible indicators on drug users from the region and their needs and these can either be rejected or verified from other data sources.

3.3.4 Police Data on Cocaine

Population Groups Affected

Data was available on cocaine use noted in Garda records in the pulse system in 2006 at national level (Private communication, Garda Research Centre). A total of 3,106 individuals were identified at national level through the pulse record system. As part of the record the Garda division or region originated in is noted. From this it was observed that a total of 28 divisions were recorded including a liaison/protection division. From these 28 regions the divisions within the south eastern region could be collated and statistics prepared and compared nationally. Of the 3,106 individuals 13.5% (n=419) were identified within the south eastern region. Of these 9.1% (n=38) were female which was statistically different ($\chi 2$ =7.53, p=0.0223) to proportions of females in other regions (7.7%), and the Dublin region (10.9%). The mean age of clients in the system was 27 years and this did not vary across regions. Proportions of cocaine users described as having no fixed abode were lower in the south eastern region (0.7%, n=1) when compared with other regions (1.4%, n=5) or the Dublin region (1.4%, n=11).

Characteristics and Drugs Used

Client records on the pulse system for cocaine use also had information on additional opiate or alcohol association. Analysis revealed that proportions reported as having alcohol or opiate associations were statistically higher among those residing in the south east (93.6%, n=392, $\chi 2$ =33.99, $p \leq 0.0001$) when compared to other or non specified regions (92.6%, n=888) or the Dublin region (86.4%, n=1,493). Unfortunately the use of alcohol and opiates were not separated and from the data it could not be determined which of the two substances the clients were using.

3.4 Results: The Subjective Prospective Needs Survey

In addition to a detailed overview of the existing data sources on drug treatment and crime in the region, an outline needs analysis survey was conducted as recommended by the WHO in the design of a Rapid Assessment Response. The aim of this needs analysis was to ascertain the population groups affected, the characteristics of the health/drug problem, the settings and contexts, the health and risk behaviours, and the consequences of substance misuse in the region from the perspective of the service providers working closely with service users on a regular basis.

The design of the survey questions was deliberately open ended. This was to ensure that the perspective on needs held by the research team did not pre-empt or prompt the perceived needs of the service providers responding. All thirty services funded in 2008 and/or 2009 were invited to respond and twenty one did so. In addition, prior to the analysis of the needs survey it was suggested by the SERDTF steering committee for the evaluation that members of the task force might also like to have an opportunity to review the survey and respond. All members were emailed the survey for their information and were invited to respond if they so wished. A very tight return time for their responses was requested and no responses were received.

2009 Data Update

Overall there was an increase in numbers between 2008 and 2009, partly due to increase in reporting agencies e.g. CASA employees and partly due to full year reporting from services that had not been providing information in 2008 e.g. Cornmarket Project.

Females still increasing and increased by 0.3% in 2009.

The majority of clients attending the services are still in the 20-24 age group, followed by those in the 25-29 year age group. There was an increase in 10-19 year olds contacting services with south east addresses from 281 12.5% in 2008 to 452 15.9% in 2009.

The main source of referral in 2009 continued to be self. However this was followed by A & E Other and then Mental Health Facility etc - as opposed to mental health facility and GP in 2008. Court, Probation, Police referrals increased from 8.1% in 2008 to 9.1% in 2009, which could be due to full year reporting from the Cornmarket Project, as a majority of their referrals from Court/Probation/Police.

Alcohol still main substance in 2009, however followed by cannabis and heroin instead of heroin and cannabis in 2008. Cocaine numbers increased to 129 in 2009 an increase of 5.

Central Treatment List data

Despite acknowledged difficulties for clients accessing Methadone Prescribing Services in the South East, where waiting lists to access such services have been in excess of two years, there has been an increase of over 30% in the number of individuals receiving treatment from methadone prescribing services during 2010 (245 individuals during the period) when compared to 2008 (185 individuals during the period). This data also indicates that a slightly smaller proportion of women access methadone services than the proportion of women that access substance misuse services generally, and that the age of those accessing methadone services is slightly older than the ages of those accessing substance misuse services generally.

Profile of Emerging Trends in Drug Use

The following is an extract from the Comiskey report;

> In addition to a detailed overview of the existing data sources on drug treatment and crime in the region, an outline needs analysis survey was conducted as recommended by the WHO in the design of a Rapid Assessment Response. The aim of this needs analysis was to ascertain the population groups affected, the characteristics of the health/drug problem, the settings and contexts, the health and risk behaviours, and the consequences of substance misuse in the region from the perspective of the service providers working closely with service users on a regular basis.
>
> The design of the survey questions was deliberately open ended. This was to ensure that the perspective on needs held by the research team did not pre-empt or prompt the perceived needs of the service providers responding. All thirty services funded in 2008 and/or 2009 were invited to respond and twenty one did so. In addition, prior to the analysis of the needs survey it was suggested by the SERDTF steering committee for the evaluation that members of the task force might also like to have an opportunity to review the survey and respond. All members were emailed the survey for their information and were invited to respond if they so wished. A very tight return time for their responses was requested and no responses were received.
>
> *Setting, Context and Emerging Drug Trends*
>
> The average length of time of respondents in the service was over 5.5 years and this time ranged from 6 months to 12 years. Services targeted a range of age groups from 12 years of age to adults. Of the 21 services responding 16 said they catered for both genders of clients but 4 said they had males mainly and 1 had males only. When asked what the primary drug of misuse of the services client group the majority (15 of 21) of services stated that alcohol was the main drug of misuse and for these 15 services, 10 services stated that cannabis was the second most frequent drug of misuse. Four of the 21 services said that opiates were the main drug of misuse.
>
> When asked about emerging trends the majority of services highlighted the increase in heroin use as the main emerging trend in the region. Details are provided in Table 3.4 below.

Table 3.4 Primary Emerging Trends Identified by Service Providers in Descending Order.

Main Emerging Trend	Frequency
More Heroin	10
More Head Shop Products	4
More Cocaine	2
More Females	1
Polydrug Use	1
Street Methadone	1
Stronger acceptance by young people that cigarettes, alcohol and cannabis are ok	1
Young males willingness to take anything	1
Total Number of Services	21

Health, Social and Educational Consequences

Service providers were asked to provide information on what they believed to be the primary health consequences of drug use in their client populations. While many services providers provided several responses, the primary consequence identified by service providers are provided below in Table 3.5

Table 3.5 Main Health Consequence of Drug Use as Identified by Service Providers in Descending Order of Priority

Health Consequence	Frequency
Mental health issues	5
Overdose	3
Chaos all areas	3
Rowing and being assaulted	2
Infectious diseases	1
Poor diet and weight loss	1
Low self esteem	1
Injury due to drug use	1
Damaged veins	1
Dependency	1
Reduced ability to make healthy informed decisions	1
Total Number of Services Responding	20

It is interesting to note that there is a clear commonality amongst some service providers that mental health issues including say low self esteem are an importance health consequence. Similarly in Table 3.6 below it can be observed that there is a clear agreement among service providers that early school leaving and low levels of skills are the primary educational

consequence and in Table 3.7 the main social consequence is identified as the breakdown in family relations.

Table 3.6 Main Education Consequence of Drug Use as Identified by Service Providers in Descending Order of Priority

Education Consequence	Frequency
Early school leaving	12
Poor skills and lack of qualifications	2
Literacy	1
Varying prevention education standards	1
Lack of interest from parents and teachers	1
Lack of Health and safety awareness of dangers of drug, poly drug and IV use	1
Harm not reduced due to lack of harm reduction education	1
Total Number of Services Responding	19

Table 3.7 Main Social Consequence of Drug Use as Identified by Service Providers in Descending Order of Priority

Social Consequence	Frequency
Breakdown in family relations	7
Isolation	4
Social Exclusion	2
Kept in cycle of disadvantage	1
Stigmatisation	1
Lack of self esteem	1
Homelessness	1
Delayed Development of personal / life skills	1
Decisions made through changed priorities due to drug misuse hamper future life chances	1
Total Number of Services Responding	19

Priorities for Prevention, Treatment and Rehabilitation

In contrast to the clear agreement among service providers on the primary consequences there was less agreement on priorities for treatment and prevention as can be seen in Tables 3.8 and 3.9 below. Table 3.10 shows agreement on the need for family supports as a priority for rehabilitation.

Table 3.8 Priorities for Treatment of Drug Use as Identified by Service Providers

Priority	Frequency
Methadone (or other replacement) Service	2
Needle Exchange Service	2

Detoxification Service (Residential or Other)	2
Community based services	2
G.P.s / Health care professionals	2
Drug education	2
Mental Health	1
Long term support in drug free environment	1
Reduction / Abstinence	1
A&E	1
Crisis intervention	1
Access to opiate treatment services	1
Families to be seen as clients in own right	1
More mainline and specialised support available to young people to engage them in their own community	1
CBDI who can refer to appropriate service or the person's G.P.	1
Total Services Responding	21

Table 3.9 Priorities for Prevention of Drug Use as Identified by Service Providers

Priority	Frequency
SPHE Programme / Schools	4
Retention in school	3
Drug and Alcohol education	3
Early intervention	2
Education	1
Enhancing protective factors	1
Training and Accreditation for Trainers	1
Community based programmes	1
Parenting programs	1
Engage client into Education ie Youthreach, Pathways	1
Harm reduction eg needle exchange	1
Drug Awareness programmes for younger age 10-11 year olds	1
Effective support that engages clients	1
Total Services Responding	21

Table 3.10 Priorities for Rehabilitation of Drug Users as Identified by Service Providers

Priority	Frequency
Family support	6
Training and rehabilitation Programs	1
Needs assessment	1
Reintegration into community	1
Education opportunities	1

Alcohol and substance misuse education needed	1
SPHE work with young people	1
Remove barriers to treatment	1
Identify those at risk	1
Greater intervention and supports for young people	1
More wet hostels	1
Day programs for drug users / those in recovery	1
Conflict resolution	1
Program to deliver basic personal development life skills (CVs, Hygiene, diet etc)	1
Total Services Responding	19

Summary and Discussion on Needs

From the census data we can see that the size of the population in the region has grown at a greater rate than the national average and numbers of individuals have increased in all five counties of the region. Furthermore the estimates of prevalence based on national studies demonstrate the scale of the drug problem in the region and it was estimated that between approximately 13,000 and 40,000 individuals were using illegal drugs in the region in 2006. In terms of high risk opiate drug use it was estimated conservatively that approximately 900 individuals were using opiates in the region in 2006. It must be stressed that the estimate of 900 opiate users is most likely an under estimate as the estimate was based on data from 2006 and that data from the treatment demand indicator has shown that numbers using heroin have continued to increase over the recent past.

Data from the treatment demand indicator points out that alcohol continues to be the main problem drug of use, however the data also demonstrated an increase in the numbers treated for opiates and the fact that heroin use has replaced cannabis as the second most common drug of misuse in the region in 2008, with a total of 293 individuals treated for heroin use in 2008. It is also of interest to compare this treated figure of 293 with the estimated number of 893 opiate users in the region. Based on these figures it could be estimated that only one third of all opiate users in the region are in treatment - that is for every one individual in opiate treatment there are 2 hidden and not in treatment. This is a realistic estimate as it reflects national estimates whereby Kelly et al (2009) estimates that outside of Dublin for every 1 opiate user known of through treatment, Garda or hospital records, there are 1.5 others hidden and not counted.

The treatment demand indicator data (Kidd, 2009) also highlighted increasing numbers using cocaine and increasing numbers of females seeking treatment. The numbers using cocaine were also counted from police records. It was observed that 419 individuals from the region had cocaine notes in their records in 2006. This again contrasts with the 154 who were treated for cocaine use in 2007.

It is encouraging to find that the trends emerging objectively from the centralised data sources are reflected in the survey of the service providers. In terms of emerging drug trends, service providers clearly identified the main emerging trend as being greater heroin use. With the

exception of the emerging trend of more head shops the other emerging trends identified also reflected the data and included more cocaine use, greater numbers of females using, poly drug use, more street methadone and young people using.

Service providers appeared to be in some agreement in terms of the main health, educational and social consequences of drug use and the main consequences were mental health issues, early school leaving and family breakdown.

In contrast to this degree of agreement on consequences, opinions among stakeholders varied regarding the priorities for treatment and prevention. However, there was a level of agreement on priorities for rehabilitation where 6 of 19 service providers prioritised family supports as necessary for rehabilitation. In interpreting this data it is important to recall the sentiments of the EMCDDA where it is stated that demands from stakeholders to initiate an action are often based on a preconceived perception of the problem.

The differing opinions on the priorities for treatment may in fact reflect not so much differing opinion but rather the fact that there is a need for a wide range of differing services in the region, from needle exchange to methadone to detoxification services and enhanced GP services. Similarly for prevention, there did appear to be some consensus that more education was needed but services differed in their opinions on how that education should be delivered and to whom it should be targeted.

To conclude, based on this outline Rapid Assessment and Response analysis of needs, the key points emerging are

- There is a need for SERDTF to recognise the scale of the illegal drug use problem with at least 13,000 and possibly up to 40,000 individuals using illegal drugs in the region.
- Service providers and planners need to recognise that the size of the opiate using problem is *moderately* estimated at approximately 900 individuals and only one third of these are in some form of treatment
- As not all opiate users are ready for a particular type of treatment a range of treatment services from needle exchange to methadone to detoxification to rehabilitation need to be put in place to meet the urgent needs of these opiate users
- Services need to plan for and make provision for mental health services for drug users
- Services need to be able to adapt their service and be aware of and respond rapidly to emerging trends in drug use, with greater cocaine use, more females, and head shops emerging as current drug trends.
- Prevention and education intervention services need to agree on priorities for their services and these should be based on agreed needs of the users and families and most importantly on international evidence of what works.

PART 2: DTF strategy to address these issues

The major element of the SERDTF strategy, agreed in 2010, is the regional implementation of the National Drug Strategy (NDS). The SERDTF has initiated a system whereby agencies that have Lead

responsibility for NDS Action Point implementation, produce updates for the SERDTF on their implementation plans and progress to date.

In most cases agencies with responsibility for the implementation of national drug Strategy Action points provide local updates on their plans and progress, and these are detailed in Appendix 2.

2.2

The SERDTF are using the Comiskey report, and in particular the Roadmap element of this report as their current strategy. One of the recommendations of the Comiskey report is to translate the Roadmap element of the report into a five or six age strategic document, and this task has been given to the Regional Treatment and Rehabilitation Sub group and to the Regional Prevention Sub Group to prepare. These have not yet been completed.

2.3

- Dial to Stop Drug Dealing – the SERDTF again co-ordinated the regional implementation of this national campaign, with the distribution of leaflets, posters etc, with press releases going to all local media and interviews with our local campaign spokersperson.
- Regional Implementation of the National Drug Strategy – the main improvement in Co-ordination for the SERDTF has been the focus on the regional implementation of the NDS. Agencies that have lead responsibility report on their implementation plans and any progress made at SERDTF meetings, allowing other agencies to co-ordinate their activities to support the implementation of the Action points.
- Community Representative reporting format – SERDTF Community reps now have a standardised format with which to make reports to the SERDTF, improving the ability of the SERDTF to respond more effectively to their concerns.
- The SERDTF has worked with FAS and voluntary sector agencies to negotiate and implement Bridging Programmes and Special CE programmes for recovering drug users.
- Discussions with Local Authority representatives has resulted in a number of housing units being made available for substance misusers in recovery, with agreements in place between substance misuse specific services and Housing Departments in relation to tenancy support.
- In conjunction with the SRDTF and the HRB, the SERDTF has developed a Service User Involvement Strategy, which will be implemented in conjunction with the QuADS initiative in the South East.
- As a result of the work undertaken in the South East in piloting the NDRIC initiative, effective links have been made with the Homeless Action Teams, and joint training has been delivered with joint inter agency case management meetings for housing and substance misuse staff planned.

2.4

The following is an extract from the Comiskey report;

Services identified a number of barriers to the provision of a continuum of drug services in the region. These are outlined below.

Detox Services

The lack of detox services in the region was consistently identified in service interviews as a barrier to service provision. Service providers highlighted the fact that where community detox services do exist there are generally no service level agreements between drug services and GP's. It was also reported that few G.P.'s are willing to engage with drug users in the community resulting in significant challenges to service providers in the region.

Methadone Maintenance Services

As has already been highlighted in other documents, the lack of methadone maintenance services in the region is a considerable gap in services. Currently the waiting list for access to methadone services has been reported to be in the region of 18 months. This gap impacts negatively on the degree to which frontline services can appropriately meet the needs of services users accessing their services.

Needle Exchange

The lack of needle exchange services was also identified as being a gap that impacts negatively on the provision of appropriate services in the region.

Access to Residential Rehabilitation Services

The dearth of community based detox services in the South East Region has implications for routes of access to residential rehabilitation services for some individuals. Most residential rehabilitation services require that individuals are drug free prior to admission to the residential service and many drug users require the support of a symptomatic detox in order to reach this goal.

Homeless Accommodation/ Supported Housing

Homelessness was an issue that was identified as being on the rise among drug users in the region. The lack of appropriate homeless accommodation was highlighted; in addition to the need for post residential rehabilitation supported /sheltered housing for vulnerable individuals in recovery from their drug use. Accommodation for homeless people is essential if they are to positively engage with drug services.

Education/Training and Job Initiatives

The need for better access to education/training and job initiatives for drug users was also identified. While some such initiatives do exist it was felt that the level of demand was not being met. It is crucial that initiatives which are developed are flexible, and accessible to the client group.

Funding Related Barriers

Some services reported having to source additional funding in order to be able to run their services on a day to day basis. Often the funds for covering items such as phone calls and mileage were not available to the service, even where these items were crucial to the running of the service. This was reported as having an impact upon the degree to which services could meet the original aims and objectives of their funding agreement. This may be due to

increases in salary costs not being matched by increases in project funding. It may also be due to previous funding cuts. This is discussed further in Chapter 5.

4.3.2. The SERDTF processes and support systems

This section presents the findings which relate to the interaction between service providers and the SERDTF central administration.

Support from the Task Force

Many of the services identified a need for more support from the SERDTF. Service providers reported that much of their link with the SERDTF currently is in relation to the collection of monitoring data. Services identified the need for regional level supports which would enhance information sharing across drug services, facilitate the development of common working methods/approaches, help identify and meet training needs, and play a role in acknowledging the value of the process of service provision along with outcomes.

Monitoring Data

Many of the services highlighted that meeting the monitoring requests put to them by the SERDTF were time consuming and resource heavy. Services generally felt that the monitoring exercise should be standardised and simplified. Some projects felt that meeting the SERDTF requests for progress reports and monitoring data were excessive in light of the small amounts of money that they had received.

While recognising the resource implication for projects the evaluation team fully supports the collection of this data from projects and a recommendation in this regard is highlighted in section 5.3 and 5.4 of Chapter 5.

RDTF-1 Application Forms (Aims & Objectives)

The evaluation team noted that in some cases the aims and objectives set out by services in the RDTF application forms were not clear and/or tangible.

The EMCDDA state that *"Deciding how to measure outcome is not always easy, but it is a crucial decision……In order to know whether the intervention has reached its goals, you must obviously have a clearly defined criterion for those goals. In other words, it must be 'operationalised' and clearly defined in measurable terms"*.

The evaluation team supports this sentiments and a recommendation in this regard is made within Chapter 5 section 5.3.

Target Groups

It was noted that in many instances the target groups of services identified in the RDTF1 application forms were different to those set out in the service level agreements. In addition, many services identified a wider range of target groups than was in their job description. It would be useful if services were more specific and targeted in relation to the groups that they are working with.

Standardised Approaches to Working

It was found that different approaches to working were being employed by similar services across the region. Best practice recommends that service provision should be standardised

regardless of where a person accesses that service. There is a role here for the SERDTF to ensure that working practices are standardised within and between services. For example, roles and responsibilities of the service provider; needs assessments; care planning and review processes; educational information etc. This would to ensure consistency in clients experiences of accessing services across the region. It is recommended that working practices and learning materials are reviewed, to ensure consistency with the aims and objectives of the national and regional drugs strategies, and to ensure equitable service access to all.

Regional Funding of National Services

There are a number of SERDTF funded services that have a national remit. This is particularly relevant in relation to residential rehabilitation and residential family support. services. There is a question in relation to the appropriateness of regional funding being used to support these projects. This issue should be examined at task force level in relation to the terms of reference and objectives set out for the Local Drugs Task Forces Handbook.

Internet/ Modern Technologies

The evaluation noted the under utilisation of the internet and modern technologies in the delivery of drugs education and awareness programmes. Section 3.48 of the National Drugs Strategy recommends that awareness campaigns should '*optimise the use of ICT in drugs awareness initiatives (e.g. through internet search engines and social network sites)*'.

2.5

As previously stated, the Comiskey report (attached at Appendix 1) has provided a roadmap for future development for the SERDTF, and a brief strategic plan is being developed by the Regional Prevention and Regional Treatment and Rehabilitation Sub Committees.

In addition, the SERDTF has agreed the following objectives for 2011;

Priorities

National Drug Rehabilitation Implementation Committee (NDRIC)

a) Continue the development of the County Kilkenny pilot
b) Examine the potential for a County Wexford pilot
c) Access training for the Kilkenny pilot for Inter-Agency case management and the adoption and training in a standardised assessment tool.
d) Co-operate with NDRIC Evaluation
e) Accept Kilkenny County Development Board adoption of the NDRIC process.

Implementation of the Comiskey report

a) Establish the Regional Treatment & Rehabilitation and Prevention Sub Groups
b) Each sub group to translate the relevant sections of the Comiskey report into 2 – 3 page strategic plans.
c) Executive Committee to pull complete strategic plan together.
d) Propose to the SERDTF.

Service Quality Standards

a) SERDTF consider support for QuADS Support Project work with South East services.
b) Organise QuADS information seminar for service managers
c) Continued support for QuADS Support project and for services engaged in the process
d) SERDTF consider achievement of QuADS standard, or other agreed quality standard, as pre-requisite for funding.

Prevention Quality Standards

a) Re-arrange the DEWF Quality Standard training, postponed from December 2010.
b) Ensure all Drug Education Officers (DEOs) and Community Based Drug Initiative (CBDI) Workers receive training in the DEWF Quality standard.
c) Continue the DEWF Quality standard training roll out by DEOs and CBDI Workers, begun in Kilkenny in 2010.

Service Development Matrices/Prevention Pyramid

Continue to populate the two Service Development Matrices and the Prevention Pyramid

a) Link desired service developments to NDS Action Points and Lead Agencies
b) Check accuracy of Service Development Matrices/Prevention Pryramid with service providers
c) Focus attention on converting red squares to orange, and from orange to green, at County level.

Links

Links with Joint Policing Committees

a) SERDTF Public Reps to link with Public Reps on JPCs in their Counties.
b) SERDTF to seek quarterly reports/minutes from Drug and Crime Sub groups of JPCs.
c) SERDTF to provide County breakdown of NDS Implementation operating template to Drug and Crime Sub Groups of JPCs.

Links with County Development Boards

a) TF Office to make presentations to County Development Boards – to focus on NDS Implementation Operating Template
b) Inform CDBs of pilot process and progress in Kilkenny.
c) Provide County by County breakdown of responses to NDS Implementation Operating Template.
d) Request CDB minutes/reports in relation to social inclusion and other relevant issues.

Links with Young People's Services and Facilities Funds Development Groups

a) YPSFF Development Groups to provide SERDTF with quarterly updates – to inform TF of funded projects, and identified needs.
b) SERDTF to consider unmet needs identified, potential duplications of funding, and best fit with SERDTF funded projects.

Involvement of Area Partnerships/Development Agencies

a) Consider the representation of Area Partnership/Development Agencies post "Cohesion"

b) Negotiate Area Partnership/Development Agencies' acceptance of Substance misusers as a target group, and develop a joint approach to shared "communities of interest" (travellers, service users, LGBT communities).
c) Negotiate access to Area Partnership/Development Agency Community Representatives, and Community Representatives of RAPIDs, and Joint Policing Committees.
d) Negotiate Area Partnership/Development Agency acceptance of substance misusers as a target group for their Local and Community Development Programme (LCDP).

Community Representation

a) Request Area Partnerships/Development Agencies to develop a "Community Connectors" system, that can seek views from the range of existing Community representatives on various existing bodies (SERDTF, RAPID, JPC, Partnerships) and from groups such as residents associations via Local Authority Housing Departments
b) Request that Partnerships arrange annual Community Connectors seminars to directly engage with Community Representatives on a range of issues.

Request that Partnerships/Development Agencies compile and disseminate a Community report, based on the information gathered from the above processes

Structure

NDS Implementation Operating Template

a) Template to be completed on a six monthly basis (rather than quarterly)
b) SERDTF members and County Committee members to be encouraged to submit written questions on template responses
c) TF office to provide a County by County breakdown of responses received
d) TF office to present County by County Breakdown to County Committees
e) Named lead agency rep to be identified at County level.
f) NDS Implementation Operating Template to form part of proposed SERDTF Annual Report.

Regional Treatment and Rehabilitation Sub Group

a) Establish the SERDTF Regional Treatment and Rehabilitation Sub Group.
b) Sub Group agenda to include;
    - National Drug Rehabilitation Implementation Committee
    - Implementation of the Comiskey report
    - Implementation of QuADS (Quality standards in Alcohol and Drug services)
    - Population of two Service Development Matrices

Regional Prevention Sub Group

a) Establish the SERDTF Regional Prevention Sub Group.
b) Sub Group agenda to include;
    - Population of the service pyramid
    - Implementation of the Comiskey report

- Implementation of DEWF (Quality standards for drug Education and Prevention)
- Strategic Prevention Framework/PERK

County Committees

a) TF office to assist County Committees with the provision of a County by County breakdown of the responses to the NDS Implementation Operating Template.
b) To identify County based Lead Agency representatives with which to progress NDS Action points.
c) Devise a County Committee report structure for delivery at SERDTF meetings.

Monitoring

SERDTF Funded project data collection system

a) Ascertain whether the OMD intend to develop a project Monitoring Tool, as previously indicated.
b) Liaise with the HRB and HSE data collection systems.
c) Investigate Outcome based systems.
d) Propose a system to the SERDTF for implementation.

Annual Report

SERDTF to produce an annual report, based on the above work areas.

PART 3: **Profile of DTF funded projects**

3.1

In addition to the specific evaluations of the individual projects funded by the SERDTF contained within the Comiskey report (attached at Appendix 1), the Comiskey report also made the following more general comments were made in relation to the overall impact of the SERDTF and its projects.

> Observation 1: Monitoring data needs to be regularly monitored. It is important that monitoring and evaluation is an ongoing interactive process between client and service provider rather than an add on at the end of the year.
>
> Recommendation 1: Possibly at 6 months and at 12 months. Perhaps if money is provided in two stages then prior to second stage first six months of data is reviewed. This could be done by an independent blind reviewer group of 3 individuals with relevant experience. If all projects are on an annual basis from January then this review should occur from end of June to early September

Resource implication 1: Half a days work for the review team, plus expenses, plus SERDTF administration cost.

Observation 2: Data is not well defined. It is not clear from the monitoring data if figures are capturing individual episodes of care or unique individuals receiving a service or intervention.

Recommendation 2: Data on the number of unique individuals receiving the treatment or intervention should be stated along with the number of episodes of care for each of these unique individuals. This would provide a better estimate of the true burden of care/treatment placed on the service, and the outcomes of care provision.

Resource Implication 2: Initially an administrative burden on the SERDTF in terms of time taken to redesign the monitoring sheets but this may be introduced gradually over a period of time as each application arises. There would be an administrative burden on the service but this may be compensated by the knowledge that a more accurate picture of the true burden on the service is being presented.

Observation 3: It is not always possible to tell from the data if a client is from within the SERDTF catchment area.

Recommendation 3: The area from which clients are coming should be captured by the SERDTF monitoring data sheet.

Resource Implication 3: Redesigning the data monitoring data sheet (see Resource Implication 2).

Observation 4: The data does not capture the number of unique individuals entering or accessing a service.

Recommendation 4: Seek to implement a unique identifier record system for individuals entering the service. This can be simply initials, date of birth and gender.

Observation 5: Monitoring sheets do not always adequately reflect the stated objectives and outcomes in the service level agreement.

Recommendation 5: Devise new monitoring sheets where necessary to capture and match stated measurable outcomes in service level agreements. The service level agreements need to have clear measurable targeted outcomes that can be appropriately monitored. A specific recommendation in this regard is made in Chapter 5.

Observation 6. Output from the projects can vary substantially over the year with greater numbers possibly appearing quarter 1 or 4.

Recommendation 6: Suggest that realistic milestones and outcomes are planned and stated in the agreement to take this into account and to allocate other work and targets for quieter quarters.

Observation 7. Many out reach and CBDI projects are accessing substantial numbers of individuals and a broad range of client types, most commonly though group and individual sessions.

Recommendation 7: It is recommended that priorities on target groups and numbers of individuals within these groups be set in advance with milestones and outcomes per quarter and that these be based on evidence of priority and demonstrable needs of the region.

Resource implication 7: Services and projects may need to be provided by the SERDTF with the appropriate resources and supports for this. This may take the form of a one day planning meeting with a regional monitoring and evaluation officer/expert.

Observation 8: Projects encounter a range of users at varying stages of their drug using career and using drugs at various levels. These receive a range of interventions.

Recommendation 8: It would be of great benefit to the SERDTF and other task forces if simple drug use and general health and wellbeing measurements or surveys recorded clients drug use and health prior to and immediately after such an intervention. This would provide additional objective evidence on effectiveness on the work that is being carried out with clients. This data is probably being gathered in an ad hoc manner already. This datas could be formalised and done on paper form initially and analysed by the SERDTF centrally on an annual basis. This would provide excellent data on outcomes and effectiveness of interventions offered in the region.

Resource implication 8: Simple surveys are available at present and are being used elsewhere (for example the Maudsley Addiction Profile or MAP instrument). The SERDTF could analyse this in house if resources allow or have it done externally for a moderate sum.

Observation 9: Drug focused interventions and working practices vary across the outreach workers, community workers and development workers. It is expected that further variation would be evident if HSE funded CBDI's were considered.

Recommendation 9: Streamline the job description and more importantly coordinate, streamline, describe, document and evaluate interventions and the CBDI's in the region, including those CBDI's that are not funded by the SERDTF. The evaluation could be co-ordinated by a joint committee from the HSE and the SERDTF and should include all CBDI's in the region. Best practice suggests that all interventions should be manualised (even brief oral interventions) to ensure uniformity, appropriateness and coverage of information and all should be evaluated.

Resource Implication 9: During the research and implementation phase, this would place a resource burden on the SERDTF and project promoters/ line managers. The development of standardised working practices may also require significant levels of planning and training by project workers. The benefits to projects and to clients would be medium/long-term.

Observation 10: In some services e.g. outreach workers, community workers and development workers numbers of active high risk clients are often provided separate to the overall numbers of clients contacted.

Recommendation 10: It may benefit the SERDTF, the services, and most importantly the client if additional data were provided on these clients, for example number of consultations and more importantly the care pathway provided for these clients. For example the service to which they may have been referred to, whether that referral was actually followed up and the outcome of the referral.

PART 4: Governance

SERDTF Membership (2010)

Name	Agency	Representing
Cahill, Breda	Aislinn Treatment Centre	Vol Sect T (Interim)
Cotter, Audra	Clonmel CBDI, Waterford and S Tipperary Community Youth Service	Community Rep Tipperary
Cummins, John	Waterford City Council	Public Rep
Delaney, Paul	Cornmarket Project	Wexford County Committee
Donohoe, Kieran	Ferns Diocesan Youth Service	Vol Sector E/P
Doyle, Joseph	HSE	DAG Liaison
Foley, Denis	Carlow County Council	Public Rep
Vacant	Administrator	SERDTF
Hearne, John OR Shrubb, Kurt	Waterford City & County Community Drugs Network	Community Rep Waterford
Hearne, Sarah	CBDI Waterford	Waterford County Committee
Horgan, Cora	Tipperary Regional Youth Service	Tipperary County Committee
Barden, Tony	HSE	HSE
Hynes, Davy	Cornmarket Project	Area Partnerships
Jones, Declan	Chairperson	SERDTF
Kidd, Leanne	Forward Steps	Community Rep Carlow
Landy, Denis	Sth Tipperary County Council	Public Rep
Margaret Leahy	Community	Kilkenny County Committee

MacPartlin, Declan	Wexford County Council	Public Rep
Marnell, Richard	CBDI, Carlow Youth Services	Carlow County Committee
McGeever, Fionuala	VEC	VECs
McGettigan, Eamonn	FAS	FAS
McGran, Joe	St Francis Farm	Vol Sect T
Mescal, Mary	Ossory Youth Service	Vol Sect E/P
O'Brien, Paul	Cornmarket Project	Vol Sect T
O'Callaghan, Paddy	Waterford County Council	Public Rep
Parker, Angela	Family Support	Family Support
Phelan, Ann	Kilkenny County Council	Public Rep
Purnell, Chris	Coordinator	SERDTF
Redmond, Tommy	CBDI, Ferns Diocesan Youth Service	Community Rep Wexford
Roche, Cicely	Pharmacist	Pharmacists
Wall, Kathryn	Carlow Regional Youth Service	Vol Sect E/P
Walsh, Michael Insp.	Gardaí	Gardaí
Weir, Michèle	Probation Service	Probation
Vacant	Dept of Education & Skills	Dept of Education and Skills

During 2010 there were five meetings of the full SERDTF. The meetings are generally held quarterly, but an additional meeting was held to make decisions as to required budget reductions. There were also eight meetings of the SERDTF Executive Committee. Executive Committee meetings generally occur monthly, apart from during the summer months, however due to adverse weather conditions in 2010 and with a full SERDTF budget meeting replacing an executive Committee meeting, the full number of executive Committee meetings did not take place in 2010.

During 2010, there were a number of changes in SERDTF membership;

Jarlath Fallon, representing the Department of Education, and the Acting Chairperson, resigned when the Dept of Education regional Office closed. He has not been replaced as Dept of Education representative.
Declan Jones, who had been a Voluntary treatment representative whilst working for Aislinn, was replaced by Breda Cahill on his resignation from Aislinn. He then became first Acting Chair, and subsequently was selected as Chairperson.
Eddie McBride was replaced by john Hearne as Community Rep for Waterford.

Inspector John Hunt was replaced by Inspector Michael Walsh as Garda rep.

4.2 The SERDTF does not produce audited accounts, as no funds are expended directly. All SERDTF funding, including the Operational Budget, is channelled through the HSE.

4.3

Title	Pay rates	Source of Funding	Employing Authority
Co-ordinator	Grade VII	HSE	HSE
Development Worker	Project Worker, Pobal	OMD	Waterford Area Partnership
Administrator	Clerical Grade, Pobal	OMD	Waterford Area Partnership