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Chairperson's Foreword

I am pleased to introduce the Midland Regional Drug & Alcohol Task Force three year Drug and Alcohol Strategic Plan 2017 - 2019. This Strategic Plan sets out a wide range of actions which were developed following a comprehensive consultation process throughout the counties of Longford, Westmeath, Laois and Offaly.

The Task Force and its sub-structures bring together members, representing the community, voluntary and statutory sectors, public representatives and key interest groups to develop and co-ordinate a collective and integrated response to drug and alcohol issues across the midland region. This Strategic Plan clearly identifies a range of key actions in line with the National Drug Strategy and Substance Misuse Strategy, that the Task Force are committed to rolling out over the next three years.

One of the key roles of the Task Force is to support and strengthen a community based response to drug and alcohol misuse at a local level. By supporting the delivery of relevant actions within this plan it will assist in raising awareness of the issues surrounding drug and alcohol misuse, help strengthen and support a community based focus to the problem and more importantly mobilise a partnership based responses at a local and regional level.

I would like to thank all members of the Midland Regional Drug & Alcohol Task Force for their commitment, contribution and time given by all in overseeing the development of the Strategic Plan.

Gratitude is also expressed to all those who made a submission, attended meetings or attended the public consultation days held in Longford, Westmeath, Laois and Offaly.

A special word of appreciation to Antoinette Kinsella, Co-ordinator and Josephine Lee, Administrator of the Midland Regional Drug & Alcohol Task Force, who assisted the Task Force Committee in co-ordinating the development of the Plan.

I would like to take the opportunity to thank the author of the plan, Kealan Flynn, Cicero Communications for his dedication and professionalism in developing the plan in consultation with the Task Force.

The role of the Task Force is to coordinate the implementation of the National Drugs Strategy in the context of the needs of the midland region. I believe that this Strategic Plan points us in the right direction in terms of supporting individuals, families and communities who are affected by drug and/or alcohol misuse.

I would also like to thank the Health Service Executive and Drugs Policy Unit, Department of Health for their support. I welcome the opportunity to acknowledge the financial funding which was allocated towards the development of the Strategic Plan which was provided by Pobal under Dormant Funds.

Peter McEvoy

Peter McEvoy
Chairperson
Midland Regional Drug & Alcohol Task Force
December 2016

Literature Review

The Midland Regional Drug and Alcohol Task Force brings together community, voluntary and statutory organisations, and public representatives, to ensure a collective response to drug, alcohol and substance misuse in counties Laois, Longford, Offaly and Westmeath.

This Task Force is one of 24 bodies implementing the National Drug Strategy and a joined-up approach to supply reduction, prevention, treatment and rehabilitation, and research.

Local Drug and Alcohol Task Forces were first set up in areas experiencing highest levels of substance misuse. Since the Regional Drug and Alcohol Task Forces were set up, under the first National Drugs Strategy (2001-2008), all parts of the country are covered. There are 14 Local Drug and Alcohol Task Forces (LDATFs) and 10 Regional Drug and Alcohol Task Forces (RDATFs). In the main, LDATFs coordinate the response in and around the largest urban areas, while RDATFs typically coordinate across a number of counties.

The original **Terms of Reference** required Drug Task Forces to assess the scale and scope of the drug problem, and to develop and monitor joined-up, evidence-based action plans dovetailing with national strategies and structures. All Drug and Alcohol Task Forces now work to a standard terms of reference, which may be simply stated as:

- Coordinating the National Drug Strategy to respond to local / regional needs.
- Giving effect to the actions that have been assigned specifically to Task Forces.
- Ensuring evidence-based responses and the exchange of best practice.
- Supporting and strengthening community-based responses.
- Knowing the up-to-date nature and scale of alcohol, drug and substance misuse.
- Highlighting emerging issues and advocating policies and actions to address them.
- Monitoring and evaluating the impact and relevance of funded projects and recommending the changes judged to be necessary in funding allocations.

Members of the MRDATF come from a variety of backgrounds and organisations representing the statutory, voluntary, community and political sectors, including:

- Health Service Executive
- An Garda Síochána
- Probation Service
- Local Authorities
- Revenue and Customs
- Education and Training Boards
- Statutory, Community and Voluntary Sectors and Public Representatives

The Statutory Representatives have a range of responsibilities including:

- Assisting in developing the Task Force's response to illicit drug and alcohol use.
- Updating the Task Force of changes in their organisation's working or reporting.
- Informing their own organisation (or colleagues in others) of changes in policy or practice, which are agreed by the Task Force for ensuring effective coordination.

The great strength of the Voluntary Representatives is their knowledge of the local drug and alcohol scene and their bottom-up commitment to dealing with it. In addition to this role, they:

- Keep the voluntary sector informed about the work of the Task Force.
- Organise discussions and debates on that work with the sector.
- Contribute to the development of policy.

The third partner is the Community Representatives who also:

- Bring in-depth knowledge of the local drug and alcohol problem.
- Assist in developing policy and services with a community-based perspective.
- Represent the views of their communities to the Task Force and keep their communities informed about the work of the Task Force.

Public Representatives are the fourth partner. As well as bringing knowledge of the problem in their own Municipal Districts, local public representatives also play a part in consulting communities about Task Force strategy and winning public support for it.

Strategy and accountability are vital and increasingly visible obligations for the Task Force:

- Every three years, it has to develop a strategy reflecting regional needs and circumstances, to support the National Drug Strategy in the Midlands.
- Once a year, it must identify priorities and actions in line with national goals.
- Once a quarter and on an annual basis, it accounts for the spending of its funding allocation, jointly with the HSE, Drugs Policy Unit at the Department of Health, and Longford-Westmeath Education and Training Board.

In supporting the Task Force to fulfil its remit, members are expected to provide all information available in their organisations for a 'Community Profile'. This could include:

- A profile of the range of drugs used. This is informed by e.g. the HSE's Methadone Treatment Programme and the HRB's National Drug Treatment Reporting System.
- A profile of the local housing situation, including threatened and actual evictions, and the general community environment, including use of public spaces.
- A profile of drug-related deaths.
- A profile of crime and community safety, including criminal justice e.g. seizures, arrests and charges for public order offences, anti-social behaviour and stolen property, and data on known opiate users in the possession of the Garda.
- A profile of social capital / informal social support networks, including structure, density, size, and composition by age, gender and ethnicity.
- A profile of school attendance.

Many of these elements can be seen in the Task Force's annual report and the main points and their impact are presented in the section on 'Current and Emerging Trends'.

Policy Context

The work of the Task Force is guided by national strategies:

- National Drug Strategy 2009-2016
- National Substance Misuse Strategy 2012
- National Health and Well-Being Framework 2013-2025

The work of the MRDATF will also be guided by the new National Drug and Alcohol Strategy, which is currently being developed and is scheduled to be published in 2017.

The **National Drug Strategy** aims to:

- Reduce the supply and availability of illicit drugs.
- Minimise problem drug use throughout society.
- Provide suitable and timely substance treatment and rehabilitation services (including harm reduction services), tailored to individual needs.
- Ensure the availability of accurate, timely, relevant and comparable data on the extent and nature of problem substance use in Ireland.
- Have in place an efficient and effective framework for implementing the National Substance Misuse Strategy.

While the Task Force focused initially on drug misuse in the midlands, its remit was broadened to include alcohol misuse on foot of a government decision in late 2013. The value of this decision is underlined by recent statistics from the National Drug Treatment Reporting System which, in 2013, identified that the greater number of people who presented for assessment in the Midlands did so for alcohol rather than drug misuse.

The third strategy, **Healthy Ireland** (2013), brings a wider health and well-being perspective to tackling drug-taking and problem drinking. According to that report:

- Use of illegal drugs was reported to be at least 7% of adults aged 15-64 years.
- Drug use was the direct and indirect cause of 534 deaths in 2008, including deaths attributed to heroin, methadone, benzodiazepines, medical and trauma deaths.
- Between 1998 and 2007, benzodiazepines were implicated in nearly one-third (31%) of all deaths by poisoning, with the annual number increasing from 65 in 1998 to 88 in 2007. In 2010, over 900,000 GMS prescription items related to benzodiazepines.

With regard to alcohol, **Healthy Ireland** finds that:

- Ireland has one of the highest rates of alcohol consumption in Europe.
- Alcohol is responsible for around 90 deaths every month, including many alcohol-related cancers and heart diseases. In addition, high alcohol consumption may contribute to obesity, through extra calories consumed by regular drinkers.
- Alcohol is a contributory factor in half of all suicides.

The problems associated with drug and alcohol misuse underline the need to ensure the pathway connects to mental health services. According to the **Healthy Ireland** report:

- By 2030, in high-income countries including Ireland, depressive mental illnesses will be the leading cause of chronic disease. In addition, one in every four people will experience mental health problems during their lifetime.

- More Irish young people die by suicide than in other countries. In Ireland, the mortality rate from suicide in the 15-24 age group is the fourth highest in the EU, and the third highest among young men aged 15-19.

- One in 20 aged over 50 years in the TILDA study on ageing reported a doctor's diagnosis of depression, with a similar number reporting a diagnosis of anxiety.

- Levels of depression and admissions to psychiatric hospital are higher among less affluent socioeconomic groups. Mental health problems are also related to deprivation, poverty, inequality and other social and economic determinants of health. Economic crises, like the Great Crash of 2008, are a high risk to the mental wellbeing of the population and to the people affected and their families.

Demographic Profile

The Midlands comprises the four counties of Laois, Longford, Offaly and Westmeath.

- The most populous county, Westmeath, had 86,164 people in 2011, 1.9% of the State and 31% of the Midlands.

- Laois is the second most populous county, recording 80,559 people in 2011, 1.8% of the State and 29% of the Midlands.

- Offaly had a population of 76,687 at the time of the last census in 2011, 1.7% of the State and 27% of the Midlands.

- Longford is the least populated of the four counties. In 2011, it had just 39,000 people, 0.8% of the State and 14% of the Midlands.

Population

Place	2011	% of State	% Change 1996-2011	% Change 2006-2011
State	4,588,252	100.0%	27%	8%
Midlands	282,410	6.2%	37%	12%
Westmeath	86,164	1.9%	36%	9%
Laois	80,559	1.8%	52%	20%
Offaly	76,687	1.7%	30%	8%
Longford	39,000	0.8%	29%	13%

Table 1.1: Population, Midlands, County, 2011 (Source: CSO)

Although the population of the State grew 27% in the 25 years from 1986-2011, in the Midlands an increase of 37% was recorded. Laois has grown the most (52%), followed by Westmeath (36%), then Offaly (30%) and finally Longford (29%).

As the Murtagh Report[1] noted, "despite this impressive growth, Longford has the second smallest population in the State and the three others are in the lower half of the rankings. Westmeath is 20th, Laois 21st and Offaly 22nd out of 30 measured counties/areas. Size is also reflected in lower than average population density figures in the Midlands. The average number of people per km^2 in the State is almost 80 while Longford has 35.7 persons, Offaly 38.3, Westmeath 46.7 and Laois 47.8".

This highlights the difficulty of getting services to people widely dispersed, as do the figures on the relative balance of population between urban and rural areas. The CSO data shows the 10 largest towns have just 40% of the regional population:

Town & Environs	County	Population
Athlone	Westmeath	20,153
Portlaoise	Laois	20,145
Mullingar	Westmeath	20,103
Tullamore	Offaly	14,361
Longford	Longford	9,601
Portarlington	Laois	7,788
Edenderry	Offaly	6,977
Birr	Offaly	5,822
Mountmellick	Laois	4,735
Clara	Offaly	3,242
Total 10 Largest Midlands Towns		**112,927**

Table 1.2: 10 Largest Towns, Midlands (Source: CSO)

In other words, 6 in every 10 people in the Midlands live in rural areas. As Murtagh notes, while "there is no precise data on urban/rural prevalence (drug and alcohol) in Ireland there are indications that problematic alcohol use in particular, has always been significant in rural areas, and increasing evidence that the availability and consumption of other drugs are no longer confined to urban centres."[2]

The new service models coming on stream in 2017 which will be funded by both MRDATF and HSE CADS aim to ensure that prevention, early intervention, treatment and rehabilitation, and family supports for drug and alcohol misuse are effectively focused, equitably targeted and efficiently provided, given what is known about the incidence and prevalence of drug and alcohol misuse.

Ensuring fairness, and effective, efficient services means matching resources with need, **bearing in mind population trends decades ahead:**

	0-14	15-24	25-44	45-64	65+	Total
Midland						
2016	70,000	34,000	81,000	71,000	38,000	**294,000**
2021	69,000	36,000	75,000	78,000	45,000	**303,000**
2026	63,000	38,000	69,000	83,000	54,000	**307,000**
2031	56,000	40,000	66,000	85,000	62,000	**309,000**

Table 1.3: Population Projections, Midlands, 2016-2030 (Source: CSO)

[1]Murtagh & Partners (2015) Evaluation & Roadmap, p.16.
[2]Murtagh & Partners (2015) Evaluation & Roadmap, p.17.

Three points are worth noting from the Census of Population for 2011:

1. The Midlands' population was projected to increase from 294,000 in 2016 to 309,000 in 2030, which is fewer than 1,100 people a year on average. In other words, only a modest population increase was projected to 2030.

2. The projected distribution by age group by 2021 showed that:
   * 23% would be aged 0-14 years
   * 12% would be aged 15-24 years
   * 25% would be aged 25-44 years
   * 25% would be aged 45-64 years
   * 15% would be aged 65+

3. As many as 60% could still be living in rural areas by 2021.

As it happens, the increases projected for 2016 have not occurred. The preliminary census data for 2016 show there are 282,410 people in the Midlands, rather than the 294,000 projected in 2011. That said, population in all four counties is higher:

- Laois – up 4,173 to 84,732, an increase of 5.2%
- Longford – up 1,810 to 40,810, a rise of 4.6%
- Westmeath – up 2,232 to 88,396, an increase of 2.6%
- Offaly – up 1,316 to 78,003, a rise of 1.7%

Deprivation Index[3]

On top of the demographic profile, there is a deprivation challenge. Historically, services were set up where problem use became apparent, typically in high-density urban areas. However, as Murtagh (2015) notes, "while it is acknowledged that the impact and outcomes of addictions are not necessarily restricted to any neighbourhood or social status, current social research suggests that areas which are measured with lower deprivation indices can be at higher risk of problematic drug and alcohol outcomes and behaviour."[4]

The **Pobal HP Deprivation Index,** based on the 2011 Census, reveals relative affluence and deprivation at a very local level, including small areas and electoral divisions. A score is given to the area based on a national average of zero and ranging from approximately -35 (being the most disadvantaged) to +35 (being the most affluent). In addition to this, percentage data for the area is given under the following categories:

- Population Change
- Age Dependency Ratio
- Lone Parent Ratio
- Primary Education Only
- Third Level Education
- Unemployment Rate (male and female)
- Proportion living in Local Authority rented housing

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[3]Courtesy Murtagh & Partners (2015) Evaluation and Roadmap, pp. 17-20.
[4]Murtagh & Partners (2015) Evaluation & Roadmap, pp. 8-9.

There are 98 EDs in Laois, 55 in Longford, 87 in Offaly and 108 in Westmeath.

The table below shows that, while the Midlands is "marginally below average" on the absolute and relative scores, it is the third most deprived region in the State.

Location	Absolute HP Index Score 2011	Relative HP Index Score 2011	Status
Dublin	-3.26	3.74	Marginally Above Average
Mid East	-5.45	1.51	Marginally Above Average
South West	-6.08	1.02	Marginally Above Average
West	-7.40	-0.35	Marginally Below Average
Mid West	-8.14	-1.11	Marginally Below Average
Midlands	-10.18	-3.17	Marginally Below Average
South East	-10.25	-3.25	Marginally Below Average
Border	-11.00	-3.99	Marginally Below Average
State	-6.78	0.24	Marginally Above Average

Table 1.4: Absolute and Relative HP Index Scores of Deprivation, 2011[5]

Moreover, Longford and Offaly experience higher deprivation than Laois and Westmeath:

Location	Absolute HP Index Score 2011	Relative HP Index Score 2011
State	-6.78	0.24
Midlands	-10.18	-3.17
Longford	-12.12	-5.12
Offaly	-11.65	-4.61
Laois	-9.30	-2.28
Westmeath	-8.82	-1.84

Table 1.5: Absolute and Relative HP Index Scores of Deprivation, Midlands 2011[6]

County Longford

County Longford is the most deprived of the four local authority areas within the Midlands region and the fourth most disadvantaged local authority area in Ireland.

Most (44) of the 54 EDs are marginally below average in County Longford, while only six EDs are marginally above average and four EDs fall into the disadvantaged category.

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[5]The 2011 Pobal Deprivation Index for Small Areas, Trutz Haase and Jonathan Pratschke, August 2012.
[6]The 2011 Pobal Deprivation Index for Small Areas, Trutz Haase and Jonathan Pratschke, August 2012.

The eastern part of the county is below the national average.

The six most affluent EDs in County Longford are:

- Crosagstown (3.7)
- Caldragh (3.4)
- Longford No. 2 Urban (3.0)
- Mountdavis (1.8)
- Ardagh East (1.5)
- Forgney (0.2)

The most disadvantaged EDs are:

- Longford No. 1 Urban (-14.7)
- Foxhall (-13.4)
- Lislea (-12.6)
- Sonnagh (-11.8)

County Offaly

County Offaly is the second most deprived of the four local authority areas in the Midlands region and the fifth most disadvantaged local authority area in Ireland.

Its relative position has worsened significantly – from the tenth in 2006 to the fifth most disadvantaged local authority in Ireland in 2011.

Of the 86 EDs in the county, most (66) are marginally below average, while 17 are marginally above average and three fall into the disadvantaged category. The most affluent parts are the wider environs of Tullamore and to a lesser extent Kilcormac, but not the towns themselves. There is a slightly higher occurrence of disadvantage surrounding the towns of Kilcormac and Ferbane. The rest of the county is almost entirely just below the average of the overall affluence to deprivation spectrum.

The most affluent EDs (though none of them is classified as 'affluent') are:

- Durrow (6.0)
- Silverbrook (5.9)
- Tullamore Rural (4.9)

The most disadvantaged EDs (all of which are classified as 'disadvantaged') are:

- Srah (-14.3)
- Gallen (-11.4)
- Kilcormac (-10.2)

County Laois

County Laois is the second most affluent of the four local authority areas in the Midlands region and the 21st most affluent local authority area in Ireland in 2011.

Its relative position has significantly worsened – from the 17th in 2006 to the 21st most affluent local authority area in Ireland in 2011.

Of the 97 EDs in the county, the majority (64) are marginally below average while the remaining 33 EDs are marginally above average.

The county is not characterised by particular extremes of affluence or deprivation; nor are there any strong spatial patterns in the distribution of affluence and deprivation. There is a slightly higher occurrence of disadvantage in more urban areas e.g. Mountrath, Mountmellick, Portlaoise, Stradbally, Abbeyleix, Borris-in-Ossory and Rathdowny, but the whole county is in the middle field of the overall affluence to deprivation spectrum.

The most affluent EDs (though none of them is classified as 'affluent') are:

- Ballybrittas (8.4)
- Vicarstown (6.3)
- Nealstown (5.5)

The most disadvantaged EDs (though none of them is classified as 'disadvantaged) are:

- Caher (-9.7)
- Rathdowney (-9.4)
- Dangans (-9.1)

County Westmeath

County Westmeath is the most affluent of the four local authority areas in the Midlands region and the 17th most affluent local authority area in Ireland in 2011.

Its relative position of Westmeath has marginally improved – from the 18th to the 17th most affluent local authority area in Ireland.

The county is not characterised by particular extremes either with regard to affluence or deprivation. The most affluent parts are the wider environs around Athlone and Mullingar, but excluding the towns themselves and their immediate surroundings. The rest of the county is broadly in the middle field of the overall affluence to deprivation spectrum.

The most affluent EDs (though none of them is classified as 'affluent') are:

- Castle (9.9)
- Glassan (9.6)
- Owel (8.4)

The most disadvantaged EDs (all of which are classified as 'disadvantaged') are:

- Mullingar North Urban (-12.0)
- Finnea (-10.8)
- Milltown (-10.4)

Evolving Service Model

One reason for a new service model is the need to improve relative access to services and, by implication, to re-balance the distribution of resources in the four counties. The evidence of imbalance is set out in stark terms in the Murtagh Report. This states:

- More than half of funded resources (52%) are in Westmeath, yet this county has less than one-third (31%) of the Midlands population and the best HP score, at -1.84
- Only 14% of funded resources are allocated in Laois, even though this county has 29% of the Midlands population and the second best HP score, at -2.28
- Just 12% of funded resources are operational in Offaly, which has around-quarter (27%) of the Midlands population and the third best HP score, at -4.61
- Only 22% of funded resources are allocated to Longford, which has 14% of the Midlands population, but the worst HP score, at -5.12

In short, Westmeath has gained most from the allocation of resources, given its proportion of the population and deprivation score. In contrast, Laois and Offaly have gained least, given their numbers on both criteria. And while Longford has a greater percentage of resources relative to its population, it also has the worst deprivation score.

The new service model aims to target resources equitably, effectively and efficiently.

Current and Emerging Priorities

Although the Task Forces were initially concerned with drug misuse, their remit was broadened to include alcohol misuse following a report by an expert group led by the government's Chief Medical Officer.[7] That report and the National Drug Strategy **together** are intended to provide a single, joined-up response to drug, alcohol and substance misuse. However, the four pillars of the National Drug Strategy remain the touchstones for action by the Task Forces, locally and regionally. These four pillars are:

- Supply Reduction
- Treatment and Rehabilitation
- Prevention
- Research

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[7]Department of Health, Steering Group Report on a National Substance Misuse Strategy. Dublin: Government Publications Office, 2012. Web. 2 May 2016.

At the time of planning, the expectation is that the forthcoming national strategy may keep a priority focus on drug-taking and problem drinking and preserve the four pillars. In the event of any major policy change in the forthcoming national strategy, this strategy and action plan will be adapted accordingly. Moreover, in 2017, the MRDATF is restructuring services in line with regional needs, with a focus on prevention and treatment support services. Given expected national priorities and planned local changes, the intent here is to develop and deepen the Task Force's capability in areas like:

- Service performance and policy

- Community support and engagement

- Observatory, information and communication

The following snapshot of the drug and alcohol problem in the Midlands has been extracted from the National Drug Treatment Reporting System (NDTRS) for 2014.

- **Treatment Setting:** Over 95% of people were treated in three settings in 2014: outpatient (up 13% on 2013), inpatient (up 20%) or low threshold (up 627%). **This shows that demand is rising and supply is responding, especially low threshold.**
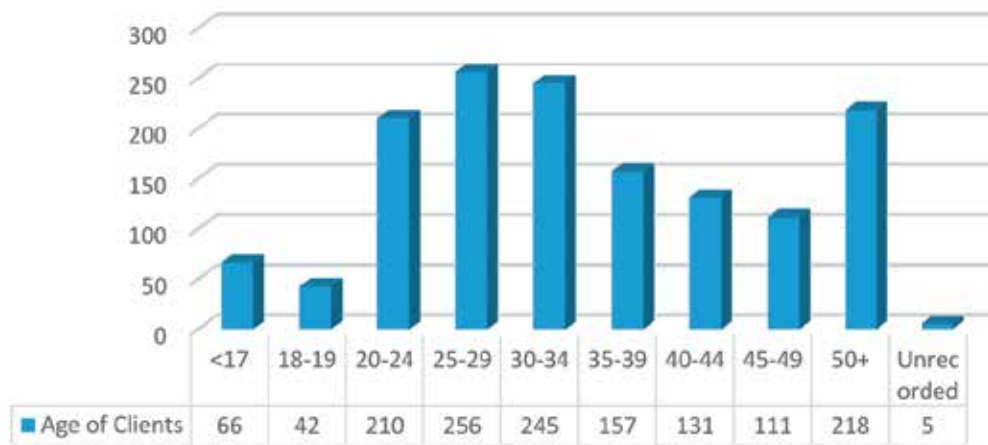

Figure 1.1 - Treatment Setting, MRDATF Area, 2014
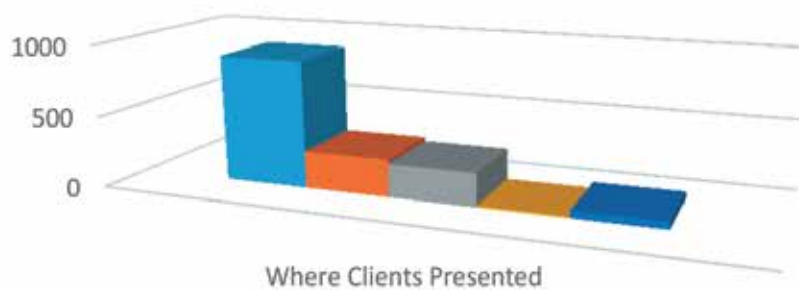
|	Where Clients Presented
Outpatient	891
Inpatient	261
Low Threshold	232
General Practitioner	7
Prisons	50

- **Age:** Almost half of all people treated in 2014 were aged 20-34; more than one-quarter were aged 35-49; and one in seven were aged over 50. This picture is unchanged on 2013, except for a small rise in the 35-49 age group. **These figures highlight that mostly people of working age are being treated, which underlines again the need for prevention, early intervention and rehabilitation.**

Figure 1.2 - Age of Clients in Assessment / Treatment, MRDATF Area, 2014

	<17	18-19	20-24	25-29	30-34	35-39	40-44	45-49	50+	Unrecorded
Age of Clients	66	42	210	256	245	157	131	111	218	5

- **Gender:** Two-thirds of clients assessed/ treated in 2014 were male and one-third were female. This is unchanged on 2013. **It underlines the need to engage males in particular, with prevention and early intervention to avoid the need for treatment in the first place, and suitable rehabilitation for those leaving it.**

Figure 1.3 - Gender of Clients in Assessment / Treatment, MRDATF Area, 2014

	Male	Female	Unrecorded
Clients	940	496	5
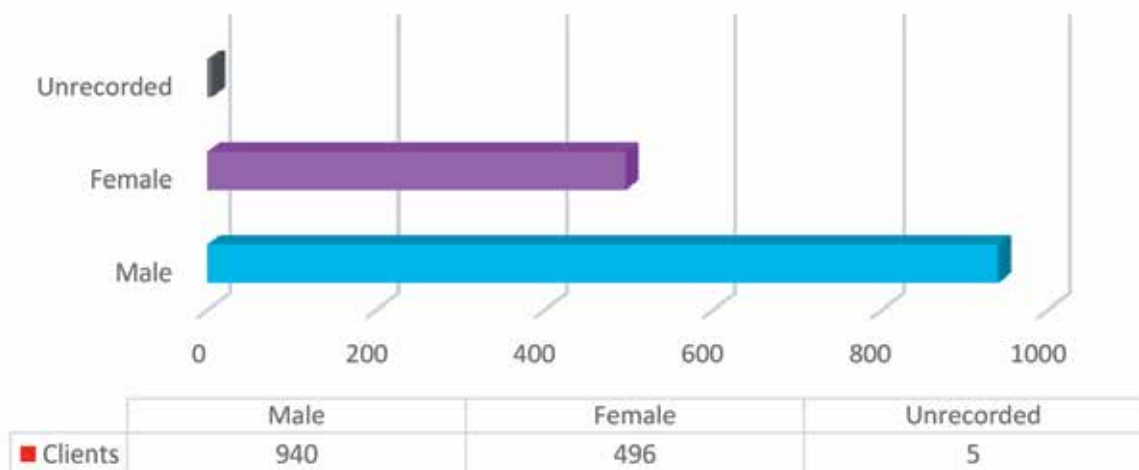
- **Nationality:** Over 95% of clients treated in 2014 were Irish. The other nationalities most extensively represented in the figures were Poland and the UK.

Table 1.6 – Nationality of Clients in Assessment /Treatment, MRDATF Area, 2014

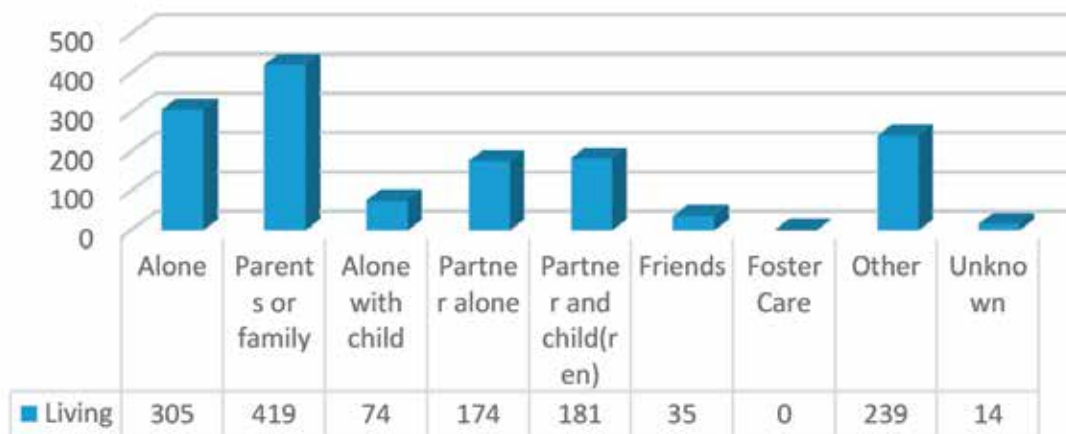|	
Republic of Ireland	1,360
Poland	38
Great Britain and Northern Ireland (UK)	19
Croatia	<5
Italy	<5
India	<5
Iceland	<5
Lesotho	<5
Lithuania	<5
Latvia	<5
Slovakia	<5
USA	<5
Unknown	10
Total	**1,427**

Source: NDTRS, 2014

- **County of Residence:** In 2014, 17% of people in treatment were resident in Longford (up 1%), 22% in Laois (down 3%), 26% from Offaly (up 1%) and 36% from Westmeath (up 2%).

Figure 1.4 - County of Residence of Clients in Assessment / Treatment, MRDATF Area, 2014

|	Longford	Laois	Offaly	Westmeath
Address	245	315	369	512

- **Living Arrangements:** Some 30% of those treated in 2014 were living with parents or family (down 1%); another 18% were living either alone with a child or with a partner and children (down 4%); and a further 21% were living entirely on their own (unchanged). **These figures underline the importance of effective outreach.**

Figure 1.5 - Living Arrangements of Clients in Treatment / Assessment, MRDATF Area, 2014

	Alone	Parents or family	Alone with child	Partner alone	Partner and child(ren)	Friends	Foster Care	Other	Unknown
Living	305	419	74	174	181	35	0	239	14

- **Type of Accommodation:** Almost 77% of those treated in 2014 were in stable accommodation, while a further 15% were homeless or at risk of it. **The provision of accommodation is a vital part of the response to drug and alcohol misuse.**

Figure 1.6 - Type of Accommodation for Clients in Assessment / Treatment, MRDATF Area, 2014

	Stable Accommodation	Institution (e.g. Prison, Clinic)	Homeless	Other Unstable Accommodation	Unknown
Clients	1105	104	115	93	24
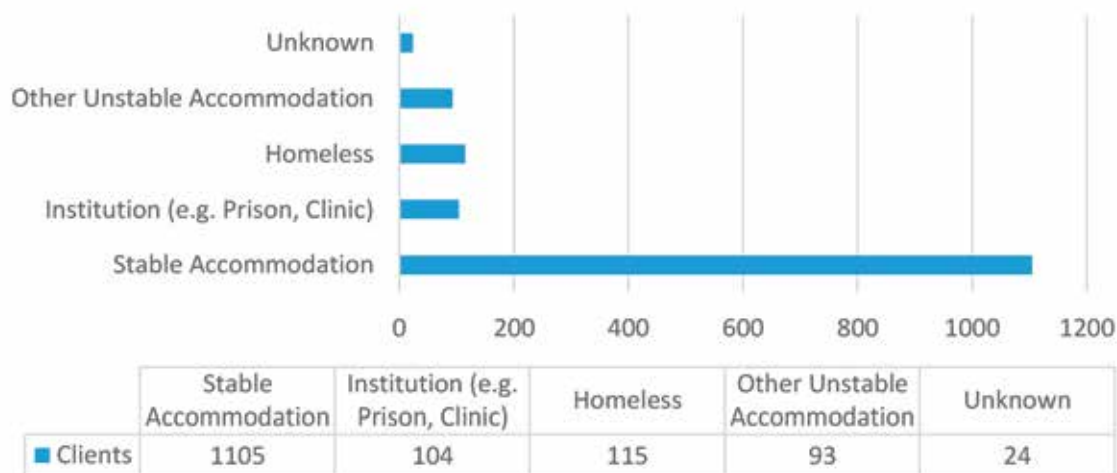
- **Age Leaving School:** Around 15% of people in treatment in 2014 had left school by age 14, while over 63% finished at 15 or over. A small number were still at school.

Figure 1.7 - Age Left School of Clients in Assessment / Treatment, MRDATF, 2014

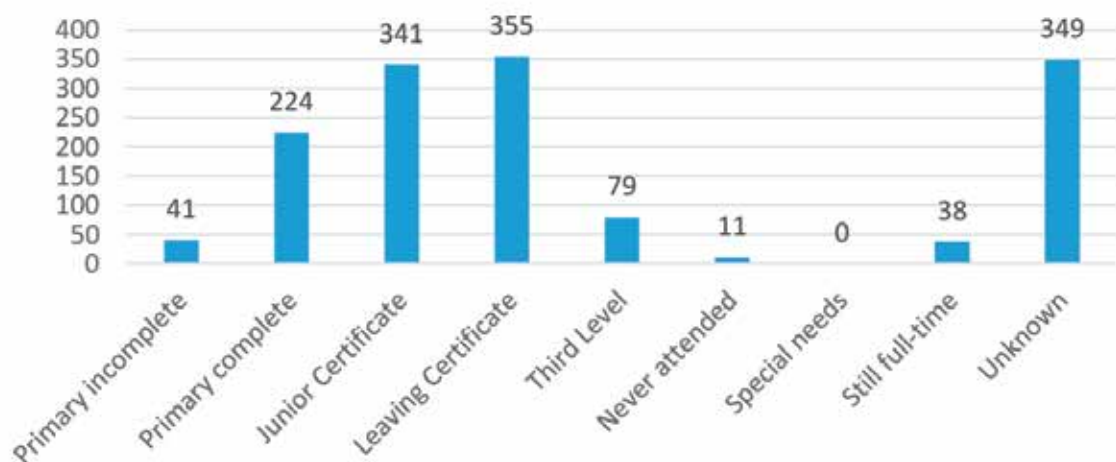|	≤14	≥15	Never Attended	Still at School	Unknown
Age Left School	211	831	11	28	360
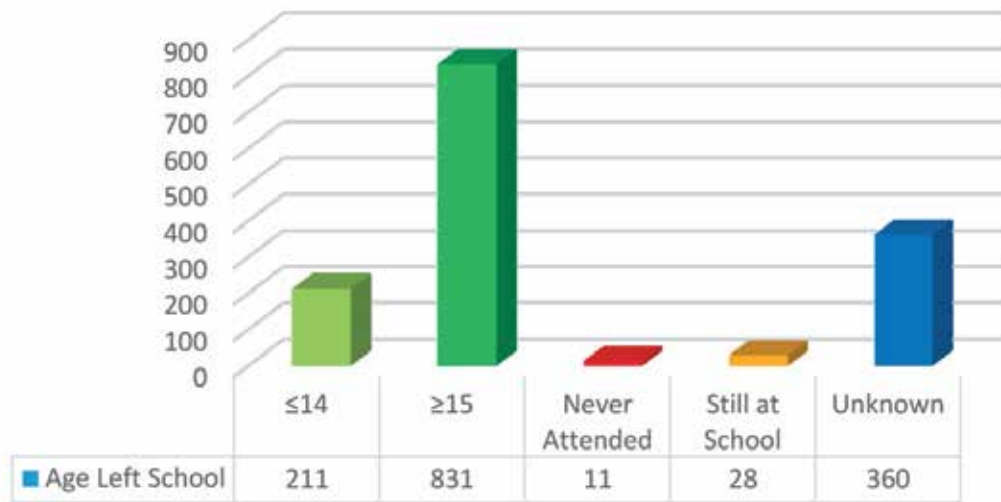
- **Level of Education:** While 25% of those in treatment in 2014 had the Leaving Certificate, the proportion with the Junior Certificate fell sharply (from 30% to 23%) compared to 2013. The proportion with complete or incomplete primary education also fell slightly, from just under 20% to just over 18%. In addition, the number in the unknown category almost doubled, from 187 in 2013 to 349 in 2014. **This underlines the need for earlier intervention to encourage (and track) young people dropping out (or at risk of it), to stay at school longer, by opening up new opportunities e.g. a trade or vocational qualification for those who may be struggling academically.**

Figure 1.8 - Highest Education, Clients in Assessment / Treatment, MRDATF Area, 2014

Primary incomplete	Primary complete	Junior Certificate	Leaving Certificate	Third Level	Never attended	Special needs	Still full-time	Unknown
41	224	341	355	79	11	0	38	349

- **Employment:** Just over 10% are in paid employment, while a staggering 60% are out of work. **Again, this underlines the need for the service continuum to include e.g. a pathway back to work, or a first job, or a vocational or trade qualification.**

Figure 1.9 - Employment Status, Clients in Assessment / Treatment, MRDATF Area, 2014
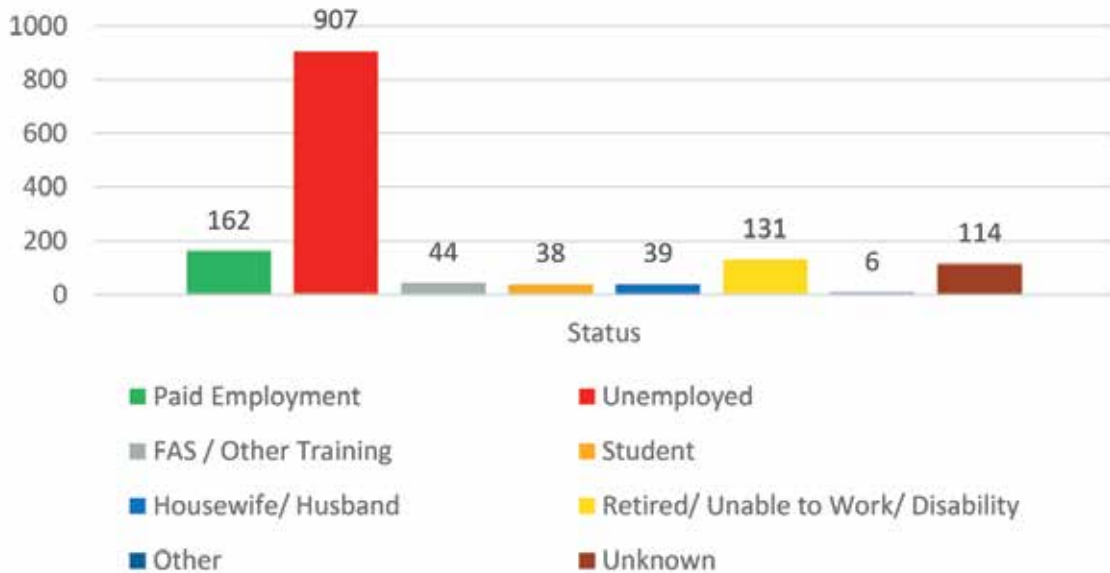
- **Drug Use:** Slightly more people present with an alcohol problem (728) than a drug problem (713), continuing the trend from 2013. **This underlines the need for the Task Force to ensure both drugs and alcohol receive equal priority in service provision.**

Figure 1.10 - Problem Usage, Clients in Assessment / Treatment, MRDATF Area, 2014
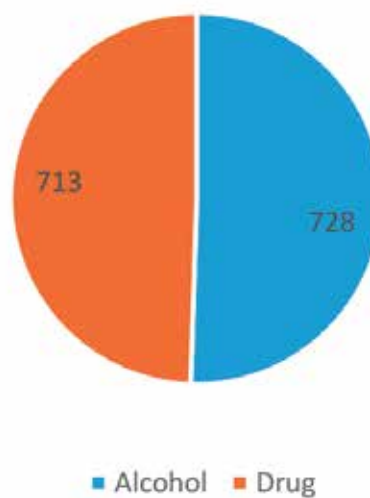
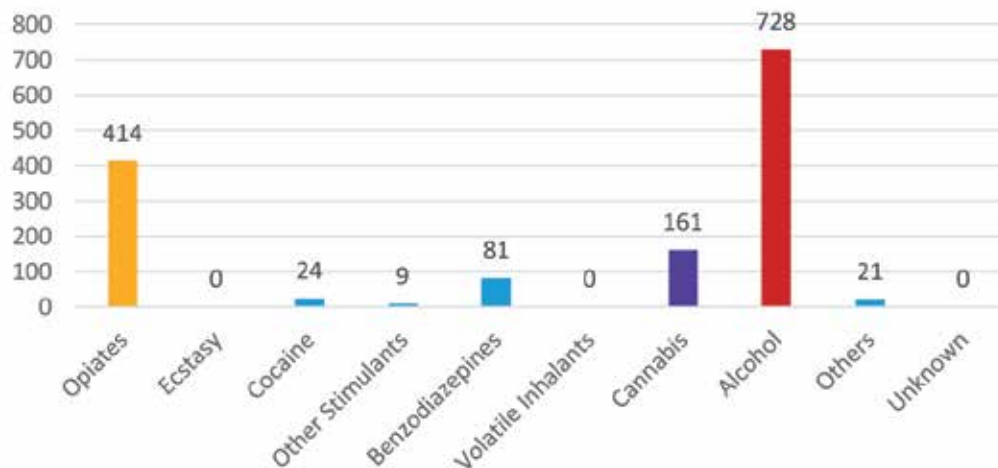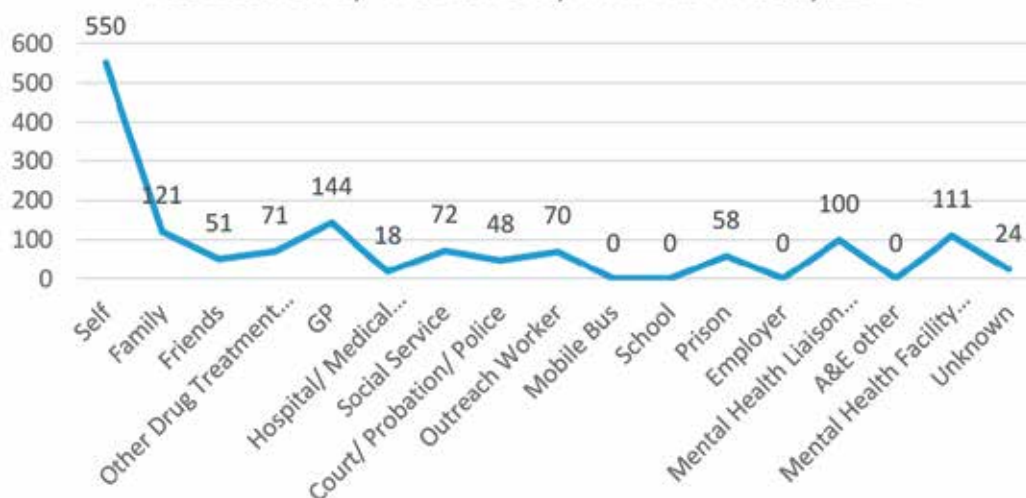- **Drug Type:** While a great variety of illicit drugs are used, the principal ones indicated by the data are alcohol, opiates and cannabis. **As well as highlighting the variety of drugs used by those assessed / treated, these numbers suggest the Gardaí may wish to redouble their efforts to address the supply of alcohol, opiates and cannabis.**

Figure 1.11 - Type of Drug, Clients in Assessment / Treatment, MRDATF, 2014

Drug Type	Value
Opiates	414
Ecstasy	0
Cocaine	24
Other Stimulants	9
Benzodiazepines	81
Volatile Inhalants	0
Cannabis	161
Alcohol	728
Others	21
Unknown	0

- **Referrals:** Although wide-ranging, the stand-out sources are self-referral or referral by GPs and mental health services and staff. **Families, corrective services and social services also feature prominently. This highlights the need to ensure the widest range of service providers are fully informed about the pathway to services and how to access them. This needs a strong messaging and media capability.**

Figure 1.12 - Referral Sources, Clients in Assessment / Treatment, MRDATF Area, 2014

Referral Source	Value
Self	550
Family	121
Friends	51
Other Drug Treatment...	71
GP	144
Hospital/ Medical...	18
Social Service	72
Court/ Probation/ Police	48
Outreach Worker	70
Mobile Bus	0
School	0
Prison	58
Employer	0
Mental Health Liaison...	100
A&E other	0
Mental Health Facility...	111
Unknown	24

- **Treated Cases:** According to the NDTRS, 1,373 people received treatment in 2014 and 90% of these had alcohol, opiates or cannabis as their main problem drug.

Figure 1.13 - Treated Cases, Main Problem Substance, MRDATF Area, 2014

Substance	Value
Others	21
Alcohol	696
Cannabis	151
Volatile Inhalants	0
Benzodiazepines	79
Other Stimulants	9
Cocaine	22
Ecstasy	0
Opiates	392
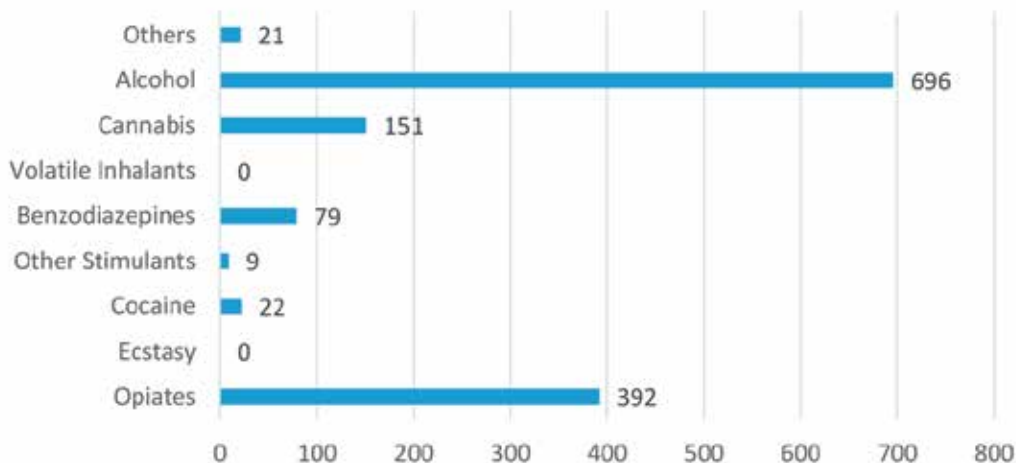
- Around three-quarters of people were treated for misuse of a single drug; the remainder received treatment for misusing more than one drug.

Figure 1.14 - Treated Cases, Number of Drugs Used, MRDATF, 2014

Number	Value
One	954
Two	244
Three	121
Four	54
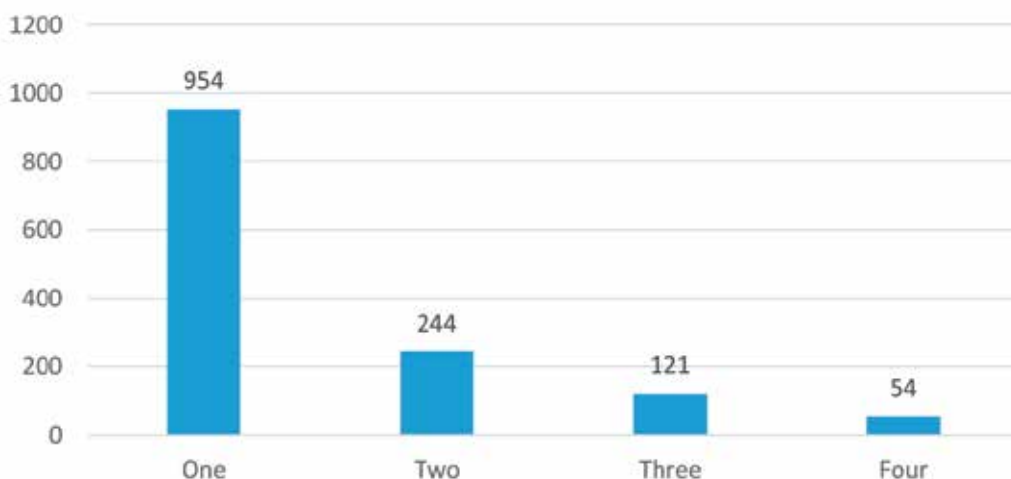
- Over 73% of people treated had never injected; most of the others had.
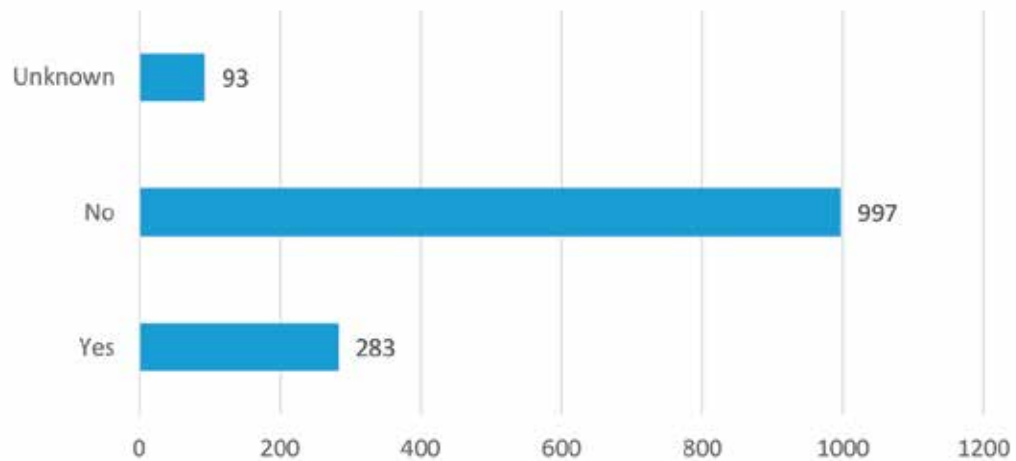
Figure 1.15 - Treated Cases, Ever Injected, MRDATF, 2014

Category	Value
Unknown	93
No	997
Yes	283

- Among those treated who had injected, 50% did not know the age they first did so.

Figure 1.16 - Treated Cases, Age First Injected, MRDATF, 2014

Age	Value
<19	78
20-24	67
25-70	57
Unknown	174
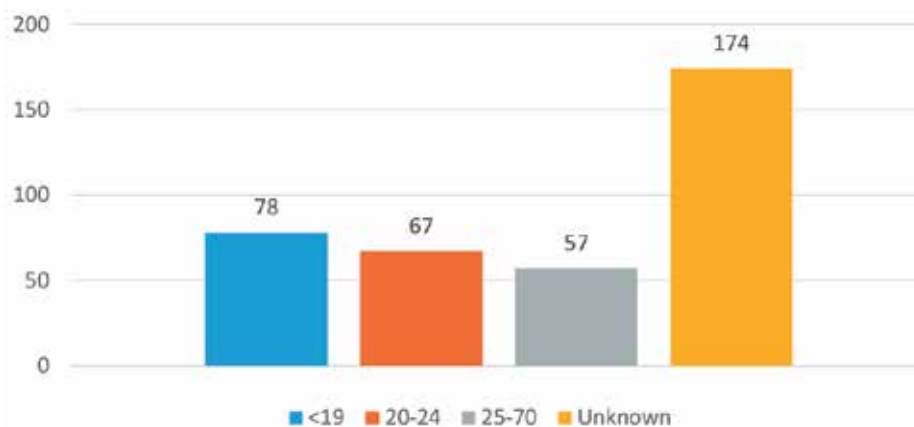
- Moreover, of those treated who had injected, the number who were certain they had shared equipment was only slightly smaller than the number who were sure they had not, while one-third did not know one way or the other.

Figure 1.17 - Treated Cases, Ever Shared Injecting Equipment, MRDATF, 2014

Category	Value
Yes	117
No	120
Unknown	139
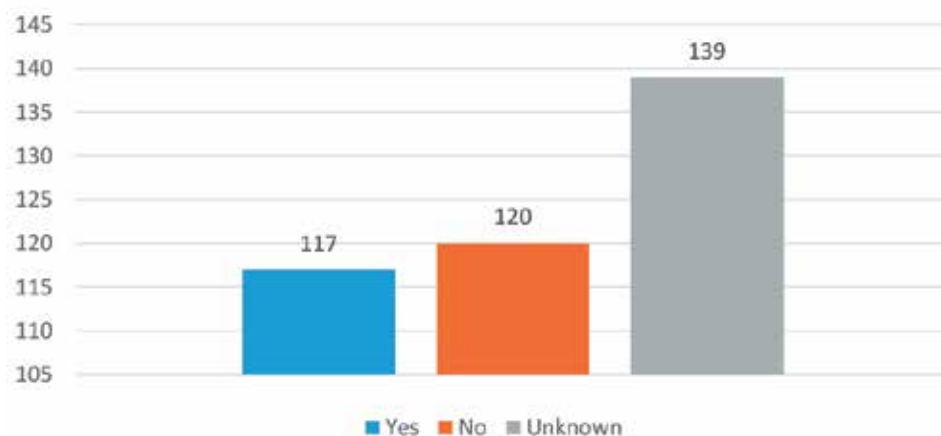
- **Treatment Interventions:** The NDTRS advises that a client may receive many interventions during their treatment episode. Services are asked to identify the main treatment intervention provided and those figures are quoted here.

Table 1.7: Main Treatment Intervention, MRDATF, 2014	Total
• Brief Intervention	132
• Alcohol Detoxification	74
• Benzodiazepine Detoxification	<5
• Detoxification Symptomatic Medication	6
• Opiate Detoxification (Buprenorphine)	0
• Opiate Detoxification (Iofexidine)	0
• Methadone Detoxification	14
• Substitution (Methadone)	16
• Other Substitution (excluding Methadone)	0
• Medication-Free Therapy	89
• Psychiatric Treatment	0
• Individual Counselling	417
• Group Counselling	15
• Social and/or Occupational Reintegration	18
• Family Therapy	32
• Individual Education/Awareness Programme	18
• Group Education/Awareness Programme	16
• Aftercare	0
• Complementary Therapies	<5
• Medication to maintain alcohol-free status	0
• Strengthening Families	0
• Other Detoxification	0
• Key Worker appointed	0
• Case Manager appointed	0
• Care Plan	0
• Facilitated Detox	0
• Unknown	0
• Exited treatment but no exit information provided	<5
Total	**852**

- **Treatment Outcomes:** While 41% finished their treatment in 2014 (up 6% on 2013), almost the same proportion (40%) did not wish or refused to attend further treatment. **People make a free choice, which is their right, but the high number not wanting or else refusing treatment, underlines how hard it can be to be to keep people engaged, and may indicate user problems with services provided.**

Table 1.8: Treatment Outcomes, MRDATF, 2014

	Total
Treatment Completed	351
Treatment Stable	34
Treatment Unstable	15
Client did not wish further treatment	130
Client refused / did not return for further treatment	212
Premature exit from treatment for non-compliance	21
Released from prison but not linked to other treatment site	11
Died	<5
Sentenced to prison	24
Other	<5
General medical transfer or medical issue	5
No longer lives in the area	13
Mental health transfer	<5
Prison to prison transfer	8
Unknown	17
Client exited treatment but no exit information provided	<5
Total	**852**

- **Poisoning Deaths:** Regrettably, there have been dozens of deaths as a result of poisoning in the Midlands between 2004 and 2012. **These figures should encourage all service providers to want to redouble their efforts to do everything possible to minimise harm and fatalities as a result of the misuse of drugs and alcohol.**

Table 1.9: Poisoning deaths from 2004 to 2010 in the Midlands RDATF area as per the NDRDI 2014.

	2004	2005	2006	2007	2008	2009	2010	2011	2012
Midlands	12	15	17	17	21	26	19	26	14

Literature Review: Main Points and Indicative Priorities

1. The Task Force is the coordinating body for statutory, community, voluntary and political representatives with a remit under the National Drug Strategy. **The role it has and value it adds is in giving leadership and coordination on core priorities.**

2. The current National Drug Strategy continues the four-pillar approach of its predecessor, while the National Substance Misuse Strategy has added coordinated action on alcohol misuse to the Task Force's remit. In addition, the most recent statement of intent from the Department of Health tends to indicate it may continue the four-pillar, two-priority approach in the next National Drug Strategy. **This plan follows the current national four-pillar, two-priority approach.**

3. The fact that alcohol is responsible for more than 1,000 deaths a year in Ireland and is a contributory factor in half of all suicides, underlines the strain which alcohol addiction is putting on people, communities and society. In addition, the number assessed and treated for problem drinking in the Midlands has exceeded the number assessed and treated for problem drug use for at least two successive years. **Accordingly, alcohol misuse should have the same priority as drug misuse in policy, action and funding. Where a mental health issue arises in either case, there needs to be a clear referral pathway and access to those services.**

4. Although the population of the Midlands is set to grow by fewer than 1,100 a year to 2030, around half will be mid-30s or younger in 2021. In addition, if the current trend continues, about 60% will still be living in rural areas. **As well as effective prevention and early intervention, effective outreach is a high priority.**

5. Historically, services developed piecemeal in response to emerging need, typically in high-density urban areas. Given what is now known about the mismatching of resources to need, the incidence and prevalence of alcohol and drug misuse, the link between deprivation and misuse, and the benefits of intervening earlier rather than treating later, **it is fitting that there has been a restructure of resources by the MRDATF and HSE which is consistent with e.g. need, population, deprivation and emphasis on prevention and treatment supports in the Midlands.**

6. The NDTRS data underlines a number of issues:

   a   Although demand for assessment and treatment is rising, supply is responding especially low threshold. This underlines the need to develop, monitor and measure a continuum of targeted, accessible, quality services.

   b   The large numbers of people of working age who are presenting highlights a need for targeted prevention and early intervention, and a need to engage employers / prospective employers about rehabilitation.

   c   Outreach is essential given e.g. the 60/40 rural/urban split, the great variety of living arrangements, and the possibilities offered by telecom technology.

   d   There are too many young people leaving school too soon with too little education and ending up unemployed. This underlines the need for prevention and early intervention to begin in school and continue in e.g. community and sports groups, as well as for alternatives e.g. trade or vocational qualification for those at risk of dropping out.

e   The number presenting for alcohol misuse has exceeded the number presenting for drug misuse in 2013 and 2014. The general societal acceptance of alcohol (and disapproval of drugs) obscures the incidence and prevalence of alcohol misuse, but challenges the Task Force (and its partners) to prioritise both equally in policy, action and funding.

f   The great variety of referral sources underlines the importance of clarifying and communicating the service pathway throughout the Midlands.

g   While the majority were assessed and treated for one drug and had never injected, the evidence that 7 out of 10 had either shared injecting equipment or didn't know if they had, is worrying. This highlights the importance of continuing the needle-and-syringe exchange initiative, which includes harm reduction advice and support. This will also benefit those injecting image and performance-enhancing drugs. They may not see themselves as chaotic drug users, but this choice exposes them to additional, avoidable risk.[8]

h   Finally, even though a great variety of interventions are offered and a high proportion of people complete their treatment, almost the same proportion don't wish to have further treatment or refuse it altogether. While they are undoubtedly making a free choice, there is a need for services to question if there are reasons to do with the service that may be an issue.

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[8] D'Arcy, Ciarán. "Ireland's Steroid Boom Among Young Gym Goers". The Irish Times 2016. Web. 6 June 2016.

Consultation

Consultation is an ideal way to gather, analyse and respond to people, groups and organisations that have an interest in an issue or idea, views on how to address it, or resources to progress it. As the government guidelines on consultation put it, "by ensuring that interested parties can express their views about a particular proposal, the decision-making process becomes better informed, more rigorous and more accountable."[9]

There have been four strands to the public consultation for this strategy:

1. A questionnaire provided to individuals and organisations that are regularly contacted or consulted by the Midland Regional Drug and Alcohol Task Force.
2. A series of public meetings – one in each of the four counties – in May 2016.
3. A focus group of students at Athlone Institute of Technology – in June 2016.
4. A series of one-to-one meetings with a number of stakeholders – in June 2016.

The findings are set out under two headings:

1. 'Numbers': the rank ordered preferences of respondents to the questionnaire.
2. 'Narrative': the views and suggestions of those that filled in the questionnaire, or attended the meetings or focus group, or coordinate / commission services.

'Numbers': What the Quantitative Research Reveals

A questionnaire based on the four pillars of the National Drug Strategy was developed by the consultant, approved by the MRDATF Finance and Governance Subcommittee, and distributed by email to a large number of people and groups, including staff of the HSE, General Practitioners, Family Resource Centres, Youth Organisations and others.

Survey Monkey was used to generate the questionnaire and analyse the results. By Friday 27th May, a total of 130 responses had been received. The survey had four questions (one for each pillar of the National Drug Strategy), an optional blank space for comments and suggestions, and an optional space for respondents to detail their job and organisation.

For each of the 'pillar' questions, respondents were given a set of options and asked to vote for as many (or as few) as they wished. In all cases, the participant ranked all options presented. **The higher the number each option received, the more it was preferred.**

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[9]Department of An Taoiseach, REACHING OUT: Guidelines on Consultation for Public Sector Bodies. Dublin: Stationery Office, 2004. Print.

1. Identify drug hot-spots using e.g. arrest and crime records, emergency call records and public surveys.

2. Press for more Garda enforcement e.g. covert surveillance, visible patrols, test-purchase operations, raids and sweeps.

3. Support communities and agencies to 'reclaim' community space e.g. removing drug litter, as dealing is detected and displaced.

4. Partner with relevant agencies for the roll-out of national / regional programmes e.g. National Drug-Related Intimidation Reporting Programme.

5. Promote the Freephone 1800 25 00 25 'Dial to Stop Drug Dealing' across the region.

6. Strengthen Joint Policing Committees to build trust between communities and the Garda.

7. Partner with Joint Policing Committees to ensure drug and alcohol issues are treated as a priority.

8. Monitor drug and alcohol related trends, including details of seizures, to support actions in response.

Supply Reduction (Pillar 1)

Answered: 130   Skipped: 0

Category	Weighted Average
Drug Hotspots	4.78
Garda Enforcement	5.44
'Reclaim' Spaces	5.26
Reporting Intimidation	4.57
'Dial to Stop Drug Dealing'	3.20
Strengthen JPCs	4.98
Focus of JPCs	4.52
Monitor Trends	3.26

Figure 2.1: Weighted Average, Options for Supply Reduction

Six of the eight options rank close together; from highest to lowest priority, these are:

1. Increase Garda enforcement.

2. Reclaim community spaces.

3. Strengthen Joint Policing Committees.

4. Identify drug hotspots.

5. Tackle intimidation.

6. Focus Joint Policing Committees.

Aside from the priority given to clamping down on dealing and intimidation, the strong view is that Joint Policing Committees are essential for building trust between Gardaí and communities, and focusing action on drug and alcohol misuse. The other two options i.e. monitoring trends and promoting the Freephone are ranked perceptibly lower.

In summary, from the answers to this question, respondents' priorities are:

- **Visible, agile and responsive policing to tackle dealing and intimidation.**
- **Strong Joint Policing Committees to ensure focus, link community knowledge with visible enforcement, and build trust between communities and Gardaí.**
- **Reclaim the community's physical space as criminal elements are driven out.**

Prevention (Pillar 2, National Drug Strategy)

1. Develop new and revise current drug, alcohol and substance misuse-related information ensuring a user focus.

2. Utilise a full range of channels - print, audio, video, internet and social media - to communicate this information.

3. Lead / coordinate national / regional drug and alcohol awareness campaigns e.g. drug and alcohol awareness week.

4. Partner with formal and non-formal education settings in the provision of information on drugs and alcohol, including e.g. binge drinking and cannabis use.

5. Support the development of a pathway for ensuring timely access to a range of family and parenting supports.

6. Identify and prioritise the needs of communities most at risk of drug and alcohol problems with community-based responses.

Prevention & Early Intervention (Pillar 2)

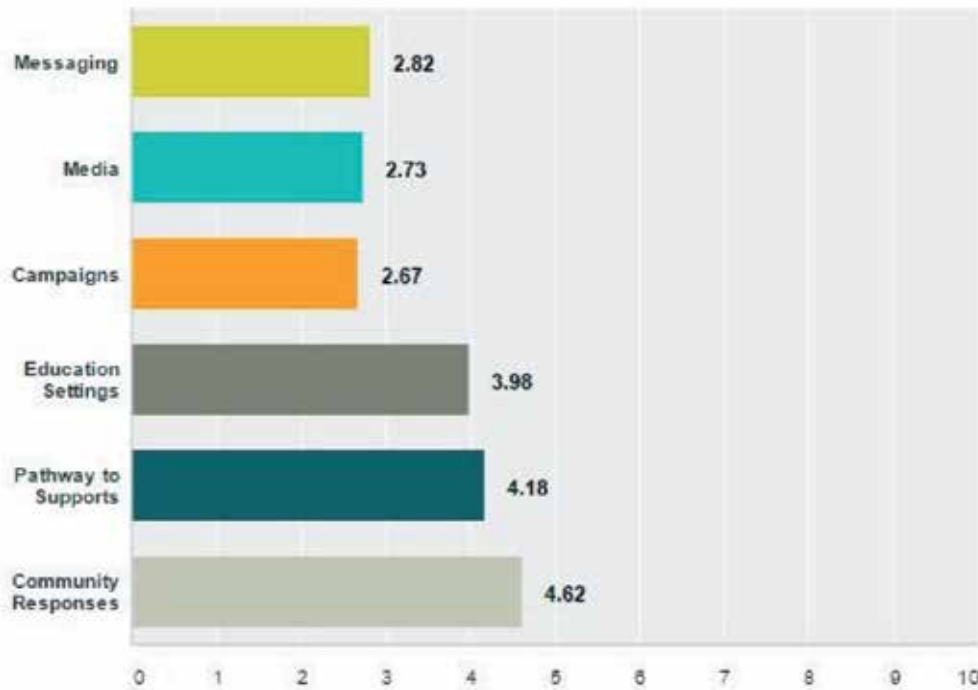Answered: 130   Skipped: 0

Figure 2.2: Weighted Average, Options for Prevention & Early Intervention

Three of the six options here score perceptibly higher than the remainder:

      1. A community-based response for communities most at risk.
      2. A pathway for timely access to family and parenting supports.
      3. Education through formal and non-formal education services.

The other three options, on messaging and media, do need to be addressed. The Task Force needs, for example, to make its website more person- and problem-focused. It can do this by reusing information already available, by licensing sematic web technology to present it better, and by using Social Media to have a conversation with people while pointing them back to essential information on the revamped website.

In summary, from the answers to this question, respondents' priorities are:

- **A community-based response for communities at risk.**

- **A pathway for timely access for family and parenting supports.**

- **Education through the formal and non-formal education services.**

Treatment & Rehabilitation (Pillar 3, National Drug Strategy)

      1. Ensure service performance criteria include maximum waiting times for equitable access to effective, efficient treatment, rehabilitation and family supports, for funded projects.

      2. Support the development of a pathway for ensuring timely access to prevention and early intervention services, with referral to treatment and rehabilitation where necessary.

3. Support the development of a pathway to ensure vulnerable groups, such as homeless people and former prisoners, have access to the treatment and rehabilitation supports they need.

4. Support the development drug-specific Community Employment Schemes.

5. Involve service users, including minorities, in the Task Force sub-committee governing treatment and rehabilitation.
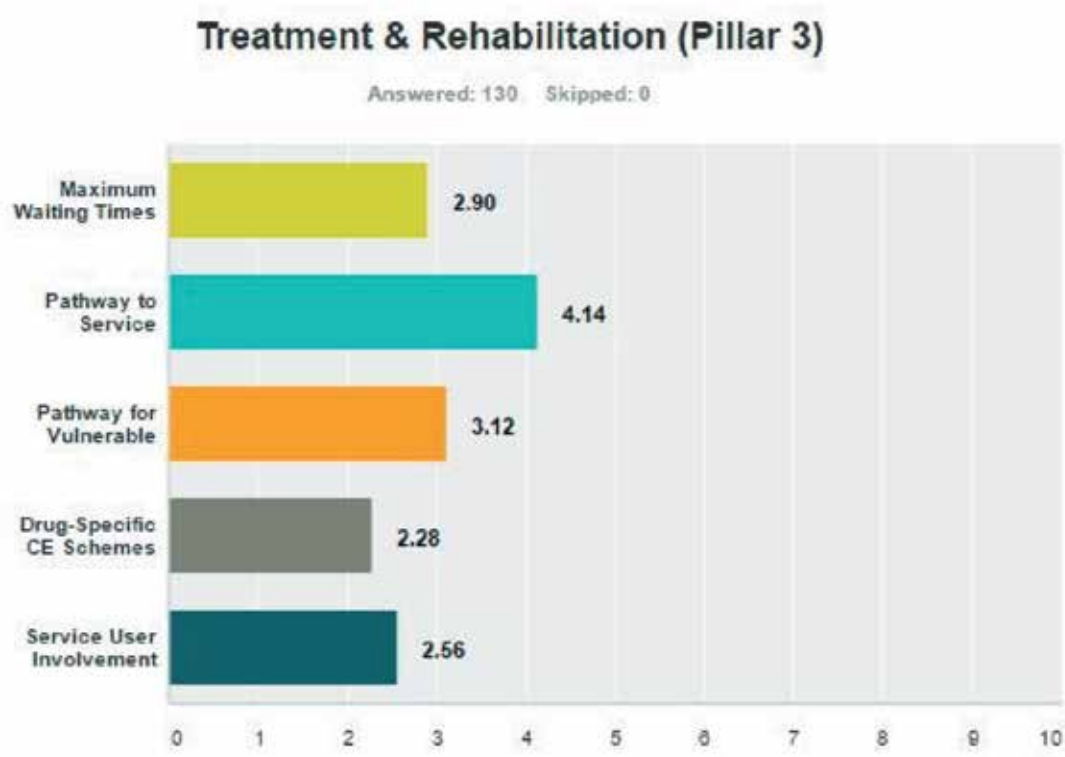

Figure 2.3: Weighted Average, Options for Treatment & Rehabilitation

The top three options in order respondents ranked them are:

1. A pathway to a service continuum.

2. A pathway for vulnerable groups.

3. Maximum waiting times in funded projects.

The development of drug-specific Community Employment schemes and involvement of service users were ranked somewhat lower by respondents. In the case of the Community Employment schemes, there may be limited awareness of what is currently a small scheme that could have big potential. The limited support for service user involvement seems like an outlier because the most supported options in the research pillar are the service user perspective informing service innovation and a Citizens Panel advising the Task Force.

In summary, from the answers to this question, respondents' main priorities are:

- **A pathway for timely access to a continuum of prevention, early intervention, treatment and rehabilitation supports, including for vulnerable groups.**
- **The application of maximum waiting times in funded projects.**

1. Include the service user perspective with a view to adapting and innovating services, in funded projects.

2. Set up a 'Citizens Panel' for service users, families and communities to advise the members of the Task Force.

3. Maximise the quality, quantity and accessibility of information on drugs and alcohol, and the information about drug and alcohol services in the midlands, using print, audio, video, interne and social media.

4. Carry out research on emerging issues with drug and alcohol misuse.

Research (Pillar 4)

Answered: 130   Skipped: 0

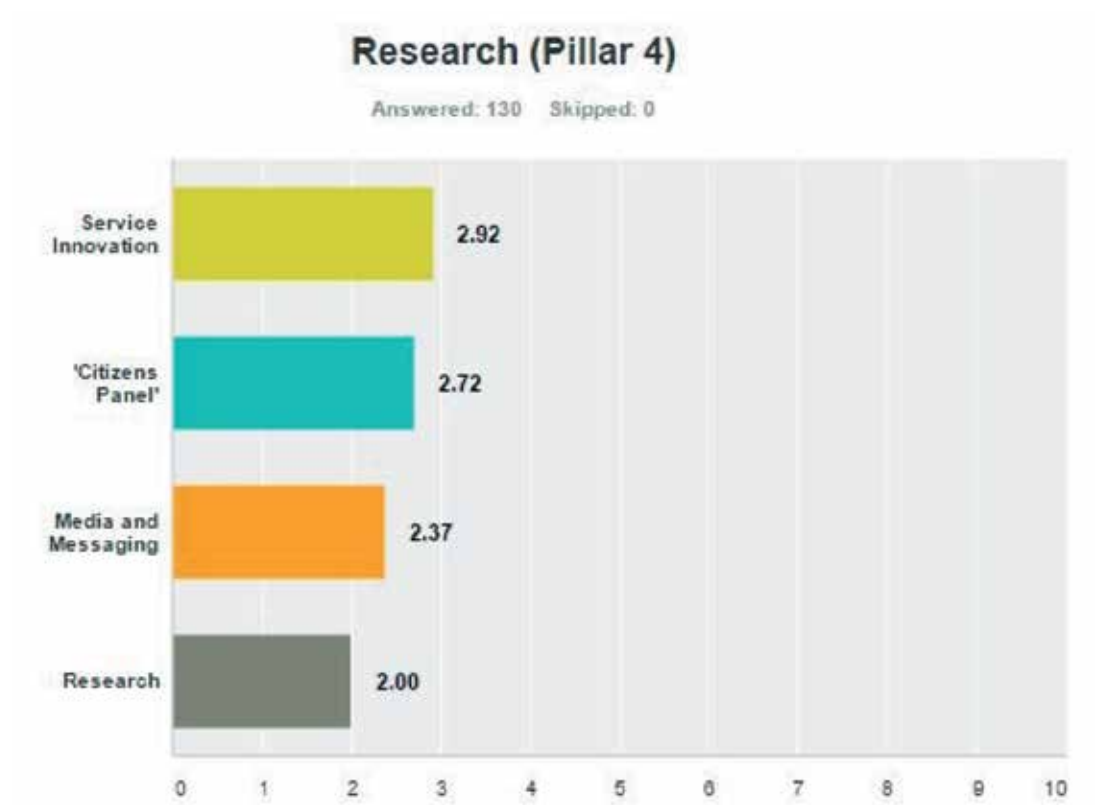| Category	Weighted Average
Service Innovation	2.92
'Citizens Panel'	2.72
Media and Messaging	2.37
Research	2.00

Figure 2.4: Weighted Average, Options for Research

In summary, from the answers to this question, respondent's main priorities are:

- **The service user perspective and the Citizens Panel.**
- **The quality of information and range of media for providing it.**

Narrative: What the Qualitative Research Reveals

The numbers in the previous section indicate how people voted on the options in the questionnaire. The narrative in this section refers to the views and suggestions of those who completed the questionnaire, or who attended the public meetings or focus group, or who are involved in coordinating / managing the drug and alcohol service response.

The Task Force organised, and advertised extensively in local print and broadcast media, four public meetings for people to offer their views and suggestions for the strategy:

- Longford, Longford Arms Hotel, 18th May 2016
- Athlone, Prince of Wales Hotel, 18th May 2016
- Tullamore, Bridge House Hotel, 19th May 2016
- Portlaoise, Heritage Hotel, 19th May 2016

A strategy workshop was organised with members of the Task Force on 18 April.
A focus group with students was held at Athlone Institute of Technology on 15 June.
Interviews with service coordinators / commissioners were also done on 15 June.
The views and suggestions offered are grouped here by theme.

Social Inclusion

One participant in the coordinator / commissioner group said the rural nature of the Midlands is a real problem: "Across the spectrum of social inclusion, one of the biggest disadvantages we have is we're a rural area. The Dublin mindset still hasn't got a grip of the rural dimension – homelessness, addiction associated with exclusion." Targeting resources geographically does not always achieve the best results and a population health approach to prevention and early intervention is preferable. This would be on a continuum including parenting skills, education settings and community capacity, this person stated.

The need for a holistic approach for people with co-occurring addiction and mental health issues was flagged. Some highlighted the positive role that an organisation like the Task Force could have in advocating an integrated model that addresses the co-occurring issues, as well as housing and employment needs, in a community-based framework.

Service Modernisation

A number of people at the public meetings spoke about the need to reach people that are hard to reach i.e. who may not know how to ask or where to go for help, or who "don't want to put their problems out there." Services need to "meet people where they are at" i.e. psychologically when they are ready to ask for help, and geographically either in/near their own home or in a group setting. The need for effective outreach was emphasised.

The view of the students at Athlone Institute of Technology was similar. The drug and alcohol services, this group said, need to recognise the difficulty that people feel about asking for help. Various reasons were put forward e.g. a fear of being seen as weak, a fear that they will be judged or ostracised, or a fear of legal consequences. "They want to help themselves but feel the problem is too big, or it's too late now."

People, this group added, will take drugs if they want to and may continue if they don't perceive there are ill-effects, or if they feel it is not affecting their daily living. One young woman said she was put off taking drugs because a close family member had a drug problem. Another said she was afraid of drugs because she had heard stories and seen advertisements that they could adversely affect her physical and mental health.

The importance of an advocate, a "voice", was highlighted by this group for ensuring access to information, access to services, and access to supports for family and friends who need to know "what to do and what not to do." Their priorities included:

- "Side with the person with the problem".
- "The service shouldn't be hidden".
- "Help needs to be available in the moment" i.e. when the individual decides to ask.
- "Fill the need" e.g. if more than a set number of counselling sessions is needed.
- Provide social and skills-based supports to "increase tolerance levels" i.e. to be able to cope with the situation / trigger that led to misuse before it was treated.

These are the kinds of issues the Task Force is trying to address by changing the service model. At its heart, this is about applying evidence-based interventions and driving up standards – "doing the right thing and doing it the right way" as one participant said.

A view was put that networks are good for dealing with complexity, especially as it is often the same individuals or families accessing many services. "A town may be big, but a community is small", said one attendee in Portlaoise – meaning it should not be too hard for a range of agencies to plan and organise a service for those who may be seeing them separately. In Dublin, said another, agencies seem more willing to talk to each other, because they recognise it's often the same people presenting in different places.

The establishment of a Service Users Forum was strongly supported, as it was in the questionnaire.

Community Engagement

At the meetings and focus group and in the questionnaire, there was a clear consensus on the need for agencies to engage with one another and respond to communities.

Agencies were urged to work together, communicate better, and exchange information more. One voluntary service provider urged continued twice-yearly networking of services, to review new trends and upskill workers on e.g. chemsex, legal highs and crack cocaine. Others urged agencies to "listen to the community", to "empower communities to reclaim their neighbourhoods by providing practical, tangible support", and to "support multi-agency projects working directly with drug users using a service user-led approach."

Equally, if communities are having a meaningful role in the Task Force, said one interviewee, they are going back to their PPNs and influencing community actions to ensure outcomes are effective. Examples of such evidence-based approaches include:

- Communities that Care[10]
- Developmental Assets Framework[11]
- National Hidden Harm Project[12]
- Positive Parenting Programme[13]

This last programme, **"Triple P"**, has effectively replaced a raft of parenting programmes previously offered in the Midlands, because parents said they found them hard to access. PPP, said one participant, is now "rippling out … by word of mouth … peer influence".

The need for on-the-ground support for communities and families in crisis was mentioned often: "… there needs to be an identifiable person working in the community that clients and the community can trust to get information and support … the link would also support the other agencies … prevention and support creates a more sustainable approach to tackling alcohol and drug issues", said one. Another said this "could bridge many gaps between professionals and those who are experiencing addictions." Another urged "more outreach and communication, inclusion and networking" with community and voluntary groups, and "more open forums for former addicts to share their experiences."

The service coordinators / commissioners emphasised that the new service model is aimed at providing a more responsive, personalised, outcome-driven approach for under-18s and over-18s. They also emphasised the need for capacity building in the statutory, community and voluntary sectors, so that everyone with a part to play in the response to drugs and alcohol is aware of current issues and initiatives, including:

- National Drug-Related Intimidation Reporting Programme
- SAOR – screening and brief intervention for problem alcohol and substance use
- Injection of image and performance-enhancing drugs, like steroids and skin tans.

Steroids and tans, as well as the "legal highs" that were sold in "head shops" before these were closed down, are easily available online. With some users presenting to services, there is a need for continuing capacity building, to help them recognise and respond.

The capacity of communities could also be improved with more Local Drug Networks.

One area where the Task Force could advocate and lead would be in bringing together different groups with separate funding streams, to agree common goals and achieve better outcomes by pooling resources and acting collectively. In Athlone, said one participant, there are as many as 20 Community Development Workers, all doing valuable work but not necessarily achieving specific, measurable outcomes. The Task Force could map all available resources and draw up an agreement, where all could agree to pursue common goals in order to achieve clear outcomes with evidence-based programmes.

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[10]Communities That Care employs a proven, community-change process for reducing youth violence, alcohol and tobacco use, and delinquency – through tested and effective programmes and policies.

[11]The Developmental Assets Framework identifies a set of skills, experiences, relationships, and behaviours that enable young people to develop into successful and contributing adults.

[12]The National Hidden Harm Project is a joint HSE / Tusla service planning and improvement initiative for "hidden harm", which is the experience of children living with, and affected by, parental substance use.

[13]Triple P, or the Positive Parenting Programme, is one of the most effective evidence-based parenting programmes in the world, backed up by more than 30 years of ongoing research. Triple P gives parents simple and practical strategies to help them confidently manage their children's behaviour, prevent problems developing and build strong, healthy relationships. Triple P is currently used in 25 countries and has been shown to work across cultures, socio-economic groups and in many different kinds of family structures.

During late 2015 the MRDATF secured funding from Pobal through the Dormant Accounts Fund to facilitate a community mobilisation process that promoted prevention and awareness initiatives associated with alcohol and drug misuse in County Westmeath. This initiative seen the development of a community based drug and alcohol action plan for County Westmeath and the establishment of a County Stakeholder Action Group (CSAG) for County Westmeath in 2016. It is proposed that this initiative pending completion of the evaluation, would be rolled out in the other counties of the midland region.

- **Additional Local Drug Networks would support the rollout of a community mobilisation approach to information and education; and County Stakeholder Action Groups could help build community support for best practice.**

Prevention and Early Intervention

People spoke variously about the need to "get out there", to "get them early" or to "get them before you lose them" by channelling prevention and early intervention through positive alternatives, such as youth clubs, sports clubs, community centres, and the Community Games. While this would help promote positive mental health and well-being, there is a need also to "strictly disconnect the links between sport and alcohol."

The importance of age-appropriate education at primary and secondary was mentioned often, and the value of after-school activities for children in at-risk communities, and of information and training for community workers and groups, was also highlighted.

Another person emphasised the importance of an earlier step i.e. interventions like education on "drug and alcohol abuse prevention among high-risk groups and the general population, paying attention to risk and protective factors for alcohol and drug misuse."

The service coordinators / commissioners emphasised the new county-based service provision for under-18s and over-18s would play a vital part in outreach and family support. One early challenge is how to engage those schools that currently expel students caught in possession of drugs. Alternatives would include onward referral from school, or from youth services, or by the Gardaí. There is not currently an "arrest referral" in the Midlands, but this could be supported by the Task Force when it is rolled out by the Gardaí.

The theme of prevention and early intervention in assisting young people was also raised by one voluntary service provider, which proposed a five-point plan:

1. **Systematic Needs Assessment** and matching services, including problem-solving and communication skills, and social activities for improving life satisfaction.

2. **Targeted Interventions** diverting from risky drug use or involvement in the drug trade e.g. motivational interviewing, mentoring for positive choices, and motivation-to-change, decision-making, self-reflection and goal-setting skills.

3. **Universal Interventions** promoting personal development and civic engagement e.g. responsibility, leadership, entrepreneurship, health and well-being, and parent information and awareness. These 'early detection' interventions also provide 'step down' support and 'safe space' for young people coming out of treatment.

4. **Training** for the non-school sector, for quality, consistency and an outcomes focus.

5. **Quality Assurance** for the non-school sector, through training, monitoring and evaluation to ensure coordination and consistency with the school sector.

Information and Communication

While the first port of call is information, not all information required is readily available:

- There is not an even spread of services across the four counties.
- The service pathway is not clear or fully marked out.
- The volume of service provided is limited, especially in rural areas.
- The adolescent-focused service that is provided is not widely known.

One coordinator / commissioner noted there are three elements to information:

- Knowledge – of the scene and of what substances people are accessing;
- Attitudes – of others, who have trouble coping or think in stereotypes;
- Skills – what they need to do to support an affected individual.

In terms of knowledge, there are many misconceptions; in attitudes, many stereotypes; and in life skills, many deficiencies. Services may assume people know more than they do, this person said, or that they have a positive attitude, or that they have the skills to know what to do next. To bridge the gap, evidence-based interventions are essential.

One respondent urged "the most accurate and honest information be provided to service users. A lot of this survey refers to people having a drug problem, as opposed [to] drug misuse. Lots of people have drug problems but are not associated with addiction. Also a lot of people consume these illegal drugs and do not have addiction problems – but they certainly have the danger of falling into misuse. The whole attitude against drug taking is an issue and there is so much misinformation. If an attitude is taken by the Task Force that all drug taking is bad and will ruin your life … then a lot of addicts / young people / possible service users will not listen to what this Task Force has to say and will not be as likely to take advice on board. This would be a shame due to the huge potential good this Task Force could achieve."

Others said, however, that messages must challenge the **personal belief** that negative effects "won't happen to me". Messages, said one attendee at the meeting in Longford, need to "give [people] a true picture of what they're like" when drunk or high, and emphasise the consequences for e.g. health, college, work or driving license.

Adults need to be informed about their role in the "cultural acceptance" of alcohol. "We as individuals have to begin to start having a level of accountability and responsibility for our own actions. Start by making small changes in our own family units for the benefit of all society", said one participant. Another highlighted the need for a drive to educate the media about "glorifying drinking, drunkenness and hangovers, in the hours, days and weeks following great sporting occasions and events … as "Irish culture".

Priority should be given to providing information and communication around particular social events or days of the week. Emphasise that social occasions don't have to involve drugs or alcohol: "I had a great time and took nothing", as one attendee put it; or "It's cool to say no and make my own choices", which was remarked by someone else.

For young people, there is a need to continually drip-feed age-appropriate information which promotes "being, becoming and belonging" and is tied in to mental health. There also needs to be a strong interactive (and peer competitive) element e.g. in video-making and role-playing in SPHE, sports and clubs. **SpunOut.ie** got positive mentions.

In the case of school-based activities, for example, some emphasised the need to have parents, kids and teachers all involved. Talks could be given by Garda and HSE but there is a need to follow through – not just to provide information at the event itself but also to highlight what supports are available and where to find them, if they are needed.

Leaflets have the problem of being dated almost as soon as they are done, especially with the drug scene changing so much and so fast. Media that can be easily updated are essential. The Task Force's website was said not to be very user-focused. Some said it needs attention-grabbing content that informs about specific substances, uses arresting statistics (1 in 10 who took this … / 1 in 5 who took that …), and contains personal stories from people who were affected and recovered and give the message, "you can too".

In summary, values-based and impact-driven messaging is required across a range of media, including the internet and social media, which need to be suitably resourced to achieve their full potential. Adults need to listen, be vigilant and act responsibly, while people seem likely to respond best to messages that recognise the choice they make and highlight the impact of it. At the same time, there is a need to avoid 'lecturing'. In addition, particular problems faced by early school leavers were recognised by those at third-level, who said they needed not just information, but also skills to make sense of it.

- **The HSE's 1800 459 459 national drugs and alcohol helpline should be widely promoted, the Task Force's website should be user-focused, and its presence in social media should be developed and resourced appropriately.**

Treatment & Rehabilitation

A number of speakers highlighted the potential of CE Schemes for "rebuilding life". One person instanced two people who had progressed from CE, one going on to third-level education, the other into hairdressing training. People who could go into rehabilitation shouldn't lose the opportunity because of e.g. child-minding needs, said another.

Yet another remarked that a "dedicated, recovery-focused CE Scheme would be brilliant", especially for people in rehabilitation following addiction and homelessness. The ideal kind of scheme would be regionally-provided rather than town-focused, have a clear programme of activities and mentoring support, and be capable of developing into a social enterprise. Examples are to be found in Athens, where health services are said to award a certain proportion of cleaning contracts to social enterprises that are staffed by people in recovery. In east London, comedian Russell Brand has opened a venture called the Trew Era Café, which is staffed by people in abstinence-based recovery.

One person asked for 6-8 short detox beds for alcohol and benzodiazepines and said even two in the medical setting and two more in the psychiatric setting would be helpful.

Another called for more uniform service provision in the region. Counselling must be "more extensive than one call per week"; and the open door / drop-in facility in Athlone should also be available in Mullingar, Tullamore and Portlaoise (for young heroin users who wouldn't engage with a GP out of fear their family would be told).

The link between homelessness and drug and alcohol misuse was emphasised. One Irish study has found that personal drug use (19%) and personal alcohol use (13%) were among the most common reasons for becoming homelessness. In addition, a majority of those experiencing homelessness first used drugs before becoming homeless.[14]

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[14] Marie Lawless and Caroline Corr (2005): Drug Use Among the Homeless Population in Ireland. Report by Merchants Quay Ireland for the National Advisory Committee on Drugs. Dublin: Web. 22 June 2016.

The Midlands Simon Community is using the "Housing First" model to get people with an addiction disorder or psychiatric disability into their own homes as soon as possible.[15] With public and private funding, it has housed around 20 clients with dual diagnosis, and achieved a 48% success rate in housing stability / not relapsing into homelessness. The organisation believes a success rate of 67% is achievable, if addiction, mental health and other services adapt to deliver in a consistent, coordinated way in the community.[16]

Another area where the Task Force could lead is by writing the current, three-prong protocol for timely assessment, inter-agency care planning and home visits into Service Agreements with funded projects that aim to help people out of homelessness.

Suggestions from the Questionnaire

The questionnaire had a section for suggestions. Most replies were about filling service gaps. One person also emailed highlighting a gap in residential treatment services.

The Task Force hopes to address as many as possible through the new service model and as many of the remainder as is feasible when implementing this strategy.

The gaps highlighted in the questionnaire are as follows:

1. A residential stabilisation service.

2. Supports for prison leavers e.g. Community Prison Link Worker, transitional supported accommodation (Tus Nua and PACE), and low threshold residential unit.

3. A substance user and family member on the Task Force Subcommittee.

4. A focus on communities most at-risk, and the same services at each one.

5. A range of thresholds available to individuals (and families and communities) to best meet where they are at in their addiction e.g. open access, street outreach, aftercare, transitional support, family support, psychological interventions.

6. A list of available services where there is not timely access to those supports.

7. Low threshold open access services in the four counties for under-18s and over-18s.

8. Detox and residential treatment services for under-18s and over-18s, including a detox facility which offers a bed while a person is in addiction.

9. Low threshold housing provider.

10. An arrest referral service.

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[15]The "Housing First" model provides housing first, then combines that with supportive treatment services in the areas of mental and physical health, substance abuse, education, and employment. Housing is provided in apartments scattered throughout a community. This "scattered site" model fosters a sense of home and self-determination, and helps speed the reintegration of pathways clients into the community.

[16]Midlands Simon Community has advised that among the 20 or so people accommodated under "Housing First", 80% have a drug or alcohol addiction and 77% have a diagnosed mental health issue. It has been said to us that where they present to Mental Health Services, they are told the behavioural problem is caused by the addiction, which must be addressed first for the mental health problem to be treated effectively.

11. Clear referral pathways for assessment and treatment for children, adolescents and adults, with easy, free and faster access for all age groups (including to inpatient treatment), and mentoring of service users while rehabilitating.

12. Access to rehabilitation services that are not religious-based.

Supply Reduction and Drug-Related Crime and Intimidation

Parents needed to be empowered to feel they can challenge anti-social behaviour and drug-related intimidation. One person spoke about "grasping a good story" i.e. building on examples of good engagement between communities and Gardaí, so that when they are notified of e.g. dealing near a school, they are seen to act on the crime and do some prevention at the same time e.g. engaging with kids being targeted by dealers.

Another said there is an "urgent need to tackle ignorance and innocence among young people … from all walks of life (and their parents) about the strategic approaches being adopted by local drug dealers to engage young people in sampling of drugs and how this leads to a rapid spiral of debt, threat and families bailing their children out. I am repeatedly hearing of this process locally and farther afield with non-traditional-at-risk groups targeted, possibly because of innocence and parents ability to source funding to pay debts."

Strategy

"Need is always a reason but by itself it is not enough. There also have to be results."
Peter Drucker, Managing the Non-Profit Organization, 1990.

A range of issues, with supporting statistics, are highlighted in previous chapters.

From the literature review, the most important points are:

- The role of the Task Force is to coordinate the response of statutory, voluntary, community and political actors to drug and alcohol misuse in the Midlands. The greatest value it adds is in providing strategic inter-agency leadership. The Task Force is unique in being the only organisation in the Midlands with this role.

- Three national policy blueprints guide its operation:

    1. National Drug Strategy 2009-2016

    2. National Substance Misuse Strategy 2012

    3. National Health and Well-Being Framework 2013-2025

- In essence, the two strategies provide for a four-pillar, two-priority approach. The two priorities are drug and alcohol misuse. The four pillars are supply reduction, prevention, treatment and rehabilitation, and research. The framework is about improving health and well-being across Irish society.

- A new National Drug and Alcohol Strategy is being prepared and is set to be published in 2017. This will provide further valuable guidance for the MRDATF.

- The Midlands has a small, thinly spread, largely rural population. For this reason, services need to pivot to ensure they reach urban and rural areas.

- Projections from the CSO suggest the Midlands' population will grow only modestly, by around 1,500 a year to 2021. In addition, around 60% will be aged 44 years and under, and around 60% may still be living in rural areas. As current misuse strategies favour early intervention over late reaction, 6 in 10 are living in rural areas, and socio-economic deprivation scores are known for all areas, there is a need to ensure resources are allocated so as to account of these factors.

- The new service model coming in 2017 aims to ensure that prevention, early intervention, treatment and rehabilitation, and family supports for drug and alcohol misuse are evidence-based, effective, efficient and equitable.[17]

- The need for a holistic approach for people experiencing co-occurring addiction and mental health issues requires integrated care spanning mental health and primary care. With 30% of people in assessment / treatment also homeless in the region, there is an urgent need for some agency, like the Task Force, to advocate for an approach that addresses co-occurring issues, housing and employment, so as to maintain treatment success, prevent relapse and meet life needs.

- More generally, while demand for drug and alcohol assessment / treatment is rising in all settings in the Midlands, the increase is most acute in low threshold.

  Those being treated and assessed in 2014 are mostly of working age. This highlights the value of prioritising prevention, early intervention and rehabilitation.

- The 2:1 ratio of males to females in assessment / treatment might suggest males are at most risk. However, women experience greater health risks from alcohol and the onset of alcohol-related health problems begins earlier. In practical terms, men and women must get equal priority in policy, action and funding.

- The figures on living arrangements (most people living with family, or living alone or with children) highlight the need for effective outreach.

- With three in every 10 in assessment / treatment leaving school early, and fewer than one in four having the Junior Certificate, the service priority must be to keep them in school longer or guide them to e.g. a trade or vocational course.

- With six in every 10 in assessment / treatment out of work, the service continuum must include e.g. a pathway to work or a trade or vocational course.

- As roughly equal numbers are presenting for drug and alcohol misuse, both problems should have equal priority in policy, action and funding.

- As alcohol, opiates, cannabis and benzodiazepines are the main problem drug in the vast majority of cases, supply reduction needs to target those four.

- The pattern where referrals come from a wide variety of sources highlights the need to define and clarify the service pathway and communicate it clearly.

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[17]The report by Murtagh and Partners identified a number of gaps and opportunities in the MRDATF area where evidence-based improvements could be considered in existing and emerging models e.g.
  * A four-tier model of brief intervention.
  * Behavioural Motivational Skills and Motivational Interviewing.
  * Multi-Systemic Family Therapy (MSFT).
  * Community Reinforcement Approach (CRA).
  * Community Reinforcement and Family Therapy (CRAFT).
  * Self-Management and Recovery Training (SMART).
The Task Force is addressing this by implementing a new service model for the Midlands:
  1. A community-based drug and alcohol prevention and treatment service for individuals under 18 years and their families.
  2. A community-based drug and alcohol treatment support, family support, harm reduction, rehabilitation and aftercare service for individuals over 18 years and their families.
These changes reflect Murtagh's recommendations that there be more service harmonisation, as well as case management for merging services into themes, personalised education and prevention, comprehensive family and child support / therapy, and inter-agency action to coordinate addiction and homelessness services.

- With a significant number injecting, and many either sharing equipment or unsure if they have done, the needle-exchange initiative is vital to health and well-being.

- A great variety of treatments are offered to people. Five types – brief intervention, alcohol detoxification, medication-free therapy, individual counselling and family therapy – account for close to 90% of interventions across all cases.

- More than four in 10 complete their treatment but almost as many do not wish further treatment or they refuse / do not return for further treatment.

From the questionnaire, the most important points are as follows:

- In terms of **supply reduction,** three priorities are strongly supported:

  1. Visible, agile and responsive policing to tackle dealing and intimidation.
  2. Strong Joint Policing Committees for focus, to link community knowledge with visible enforcement, and build trust between communities and Gardaí.
  3. Reclaiming the physical space from which criminals have been driven out.

- For **prevention and early intervention**, the options that get most support are:

  1. A community-based response for communities at risk.
  2. A pathway for timely access for family and parenting supports.
  3. Education through the formal and non-formal education services.

- In the case of **treatment and rehabilitation**, the options with most support are:

  1. A pathway for timely access to a continuum of prevention, early intervention, and treatment and rehabilitation supports.
  2. The application of maximum waiting times in funded projects.

- In the case of research, the main priorities are:

  1. The service user perspective and forum for capturing and acting on it.
  2. The quality of information and range of media for providing it.

From what people said in group or at one-to-one meetings:

- To promote **social inclusion,** a population health approach should be pursued.

- With regard to **modern services,** effective outreach is vital for reaching people, families and communities psychologically, socially and geographically. The new service model needs to be able to navigate people to supports.

- A Service Users Forum ensures the **service user perspective** informs service provision and innovation. The service pathway needs to be defined and clearly communicated. There also needs to be concerted effort to close service gaps, to ensure services are as uniform as possible across the Midlands.

- A commitment to **community mobilisation** supports, evidence-based intervention, service innovation, and priority-setting. The new service model should engage with Public Participation Networks and Local Drug Networks.

- In addition, the Task Force can lead and advocate in bringing different groups with disparate resources together e.g. by persuading them to agree common goals and to pool their resources to achieve more by acting collectively.

- A high priority is put on **information and education** about drug and alcohol misuse, and information and education about the services for it. The kind of information that appears to be most valued would be factual, non-judgmental, age-appropriate, up-to-date, and informative of the effects, risks and consequences of personal choice. A wide range of media and social media would be used.

- With regard to **treatment and rehabilitation**, there are calls for e.g. a residential treatment facility, and a recovery-focused CE Scheme / social enterprise.

To develop a strategy, which informs a plan, we use a number of frameworks:

- **PEST** – analysis of the political, economic, social and technological issues, essentially a picture of the world facing the Task Force, as it is and is developing.

- **Principal Drivers** – the critically important factors arising from that analysis.

- **SWOT** – the strengths and weaknesses of the Task Force from an internal point of view, and the opportunities and threats it faces from an external perspective.

- **Mission** – the answer to the question, "what is our reason for being?"

- **Vision** – the answer to the question, "where do we want to be?"

- **Values** – what will be our enduring principles, no matter what?

- **Goals** – a high-level statement of our objectives.

- **Actions** – the steps we will take to achieve our goals.

PEST Analysis

So, what is the likely environment influencing the Task Force to 2020 Analysis of the political-legal, economic, socio-cultural and technological influences paints a picture of how the world is changing and of the principal factors driving the change.

Political-Legal

- A new National Drug and Alcohol Strategy is to be ready in 2017. As this gets only a brief mention in the "Programme for a Partnership Government", in "Better Health, Improving Healthcare", and in "Rebuilding Ireland: Action Plan for Housing and Homelessness"[18] , and as alcohol misuse has recently been added to the remit of the Task Forces, the two-priority, four-pillar approach may continue.

- There is a commitment in the Programme for Government to pivot towards a health-led approach, including legislating for supervised injecting facilities.

- The Programme for Government also promises more funding for youth services. The Youth Diversion Programme is to expand and inter-agency cooperation targeting early school-leavers with e.g. apprenticeships, is to be funded.

- The Public Health (Alcohol) Bill is to be signed into law. There is a commitment to tighten the regulation of alcohol advertising targeting children.

- The Action Plan for Housing and Homelessness notes that the new National Drug and Alcohol Strategy will help homeless people with addiction issues, by ensuring "the drug rehabilitation pathway is linked to sustainable supported tenancy arrangements."[19]

Economic

- The economic environment is currently stable. The Government believes it can deliver its own budget plans for 2016 and 2017. This means the Task Force can plan ahead, knowing its current funding levels should be maintained for now.

- GDP (total value of all goods and services we produce) and GNP (minus the multinationals) have returned to 2007 levels. However, the EU Stability and Growth Pact limits the Government's freedom to spend more on public services. In other words, the Task Force should not expect to get a big budget boost.

- Unemployment is at its lowest since 2008 but the number without a job for five years or longer is rising. This could impact in at least two ways. Some may experience drug or alcohol misuse because they have more spending power. Others may experience it because they have less money – and may experience it more acutely because they are isolated socially, rurally or both.

[18]Government of Ireland (2016), Programme for a Partnership Government. Web: 3 July 2016;
Department of Health (2016), Better Health, Improving Healthcare. Web: 3 July 2016; and Department of Environment, Community and Local Government (2016), Rebuilding Ireland: Action Plan for Housing and Homelessness. Web: 18 July 2016.

[19]The Action Plan for Housing and Homelessness is explicit about current thinking at national level on homelessness and addiction, and the resources provided for change. "The HSE Service Plan for 2016 commits to ensuring that arrangements are in place and working effectively to ensure homeless persons have access to primary care services where required, and that in-reach services are provided to emergency accommodation settings and long-term supported accommodation for people with high-support needs. Additional funding of €2m is being provided to the HSE this year for the provision of case management and support for homeless people with chronic and enduring health needs, in collaboration with mental health services. This will be increased to €6m next year and the HSE will identify appropriate Pathfinder projects to help guide the delivery of these services into the future. In addition, there will also be a particular emphasis on significant projects providing drug and alcohol detoxification programmes and enduring services supporting long-term recovery."

Social-Cultural

- The population of the Midlands is projected to rise only modestly – by around 1,500 a year between 2016 and 2021. By 2021, around 60% of people will be under 45 years and around 60% are likely still to be living in rural areas. This will challenge the Task Force to ensure services reach people of working age and in rural areas.

- In Irish society and culture, the general disapproval of drugs contrasts sharply with the general acceptance of alcohol. Yet, in the Midlands, more people have presented with a drink problem than a drug problem in 2013 and 2014. The Task Force faces a major challenge in tackling both kinds of misuse, but its success in any case is certain to be tempered by the free choices people make.

- The scene changes often. While alcohol, opiates, cannabis and benzodiazepines still account for most cases in the Midlands, psychoactive drugs remain a worry and there is increasing concern about image and performance-enhancing drugs.

Technological

- The Internet makes it feasible to provide up-to-date information about misuse and information about services for misuse – anytime, anywhere, to any device. In addition, semantic web technologies enable large amounts of website information to be presented in highly intuitive, user-friendly way.

- The rise of social media makes it possible for the Task Force to hold a conversation with people about misuse, by pulling information through from the website and then encouraging people to think about choices, risks and consequences.

Principal Drivers

- In terms of the **political-legal environment**, the current two-priority, four-pillar approach may continue. The pivot to a health-led approach may help reduce stigma on drug misuse. The focus on youth services and early school leavers suggest that one agency e.g. the Task Force, could lead others in mapping a path for youth at risk of misuse. A Public Health (Alcohol) Bill, and curbs on advertising to minors, may cause society to rethink its attitude to alcohol misuse.

- With regard to the **economic environment**, while existing budgets seem likely to be maintained, the public debt brake which has been written into the Irish Constitution will require the Task Force to ensure that all funded projects demonstrate their value and outcomes rigorously and transparently. EU fiscal discipline rules mean there is no pot of gold for the public services.

- In the **social-cultural environment**, the structure and distribution of the population will challenge the Task Force to reach people of working age and in rural areas. The need to give drug and alcohol misuse equal priority in policy, funding and action is evident from the equal numbers presenting. Addressing alcohol misuse may be harder because society is more tolerant of alcohol than of drugs. In any case, because misuse of drugs and alcohol is influenced by the free choices people make, information and communication needs to be sensible and sensitive to be successful. While new substances like psychoactive drugs and injectable image and performance-enhancing drugs, including steroids and tanning agents, are presenting, four "old reliables" (alcohol, benzodiazepines, cannabis and opiates) still account for the vast majority of cases in assessment / treatment.

- The major drivers in the technological environment are the Internet and Social Media which, together, make it feasible to inform and talk to people as never before about drugs and alcohol, as well as choices, risks and consequences.

SWOT Analysis

Strengths

- The Task Force is unique in the Midlands in being the only agency with such a wide representation from those with a role in tackling drug and alcohol misuse. It is ideally situated to lead on coordinating a standards-based, outcome-driven, service response including statutory, voluntary and community organisations. It is also ideally placed to coordinate a community mobilisation approach.

- The restructuring of services in 2016 has been implemented through the commitment of the Task Force and HSE to evaluate needs and ensure an equitable, effective, efficient service is in place for under-18s and over-18s in the Midlands.

- Members of the Task Force are committed to its work and to implementing the national strategies relating to drug and alcohol misuse in the Midlands.

- The Task Force has a good capability in supporting prevention and treatment support services. It leads / coordinates regional / national drug and alcohol misuse campaigns and training. A range of treatment support services are delivered by voluntary service providers. These include the needle-and-syringe exchange programme, harm reduction, family support, rehabilitation and aftercare, and drop-in service. In addition, the Task Force is active in the delivery of a range of prevention programmes at Athlone Institute of Technology.

- The Task Force relies increasingly on evidence from multiple sources in monitoring and responding to misuse e.g. NDTRS, NACD and reports by funded projects.

- As it is accountable for inputs, outputs and outcomes of funded projects, the Task Force, in conjunction with its partners the HSE, Drugs Policy Unit, and Longford-Westmeath ETB, can specify performance measures in service agreements. This enables them to drive up standards and ensure effective, efficient, equitable services.

- Relationships between the Task Force and its partners are strong and positive. The goodwill to support coordinated, collective action is there, especially where a Task Force goal aligns with a partner's interest and strategy. These links are important when advocating on e.g. removing barriers, overlaps or gaps in services.

- Arrangements for good governance have been made. Each new Member receives induction training. There are Standing Orders regulating the composition and term of the Board. Subgroups are chaired by a Member of the Task Force and have Terms of Reference and Standing Orders for effectiveness and focus.

Weaknesses

- Some sectors have left an empty chair at the Task Force and participation at Task Force meetings needs to be stronger. The Task Force needs to continue doing all it can to ensure there is effective representation in place – for example, that all bodies are represented through the relevant nominating structures. In addition, where necessary, the Task Force should advise the Drugs Policy Unit at the Department of Health of issues around ongoing vacancies from certain sectors.

- The culture of the Task Force is that Members rely on the Coordinator (in consultation with the Chair) to set the agenda and pace. Members must understand that their role is to drive strategy and change, whereas the Coordinator's job is to support them as they fulfil that task. Options to solve this problem could include annual team-building, Members putting items on the agenda, and regular sectoral presentations followed by discussion and perhaps advice from the Task Force on a better way to implement.

- Subgroups follow the pillars of the National Drug Strategy but should have a broader remit e.g. service in its widest sense, community engagement and mobilisation, and research including trends, messaging and media.

- The Task Force has profile in the local print and broadcast media but no presence at all in social media. This is a critical weakness because social media like Facebook, Twitter and YouTube lend themselves to informing, engaging and conversing in a way that traditional media simply cannot match.

Opportunities

- Given its unique, regional remit, the Task Force could advocate solutions on e.g.

  1. The referral pathways to treatment and prevention support services.
  2. The volume and location of services – ensuring an even spread of service provision across rural and urban areas of the Midlands.
  3. Awareness of services for all ages and families.

- When the new service model goes live, the Task Force will have additional opportunities to focus on strategic priorities beyond finance and governance e.g.

  1. Service – policy, pathway and performance.
  2. Community – engagement and mobilisation.
  3. Conversation – messaging, media and trends.

- The Task Force is well placed to provide strategic leadership for inter-agency initiatives e.g. it could mobilise various youth services under a Memorandum of Understanding, in which they agree an evidence-based programme, then pool their resources to achieve more by working collectively than acting alone.

- The need for a holistic approach for people experiencing co-occurring addiction and mental health issues provides an opportunity to advocate for an integrated care approach that addresses co-occurring issues, housing and employment, so as to maintain treatment success, prevent relapse and meet life needs.

- There is scope to use Public Participation Networks and Local Drug Networks to improve community capacity in tackling drug and alcohol misuse. There is already a PPN in each county, and LDNs are up and running in Longford, Westmeath and Edenderry. PPNs and/or LDNs would support the Task Force to fund community mobilisation supporting evidence-based prevention and early intervention e.g.

    1. Communities that Care

    2. Developmental Assets Programme

    3. Parenting Programmes

- Social Media provide a new opportunity to inform, converse and engage. There is a wealth of information on sites like www.drugs.ie and www.spunout.ie which could be reused, especially to support a conversation on social media.

- A recovery-focused CE Scheme would be valuable for rehabilitation.

- The Task Force could be restructured as part of the new National Drug Strategy.

Threats

- The failure of some organisations to nominate representatives, and the failure of some representatives to participate, could undermine the capacity of the Task Force to position as the agency best equipped to coordinate the response.

- The HSE advises that it can be difficult to get GPs to participate in the Opioid Substitution Programme. The HSE also advises that it can be challenging to secure Pharmacists to participate in this programme.

Mission

Mission is reason for being – the answer to the question, "why are we here?"

Although the Task Force doesn't make a product or supply a service, it has a competence that is both unique (a regional coordinating remit, mandated by the Government) and valuable (capacity to define the service pathway in its funded services; and advisory in relation to services provided by the organisations that are members of it).

Mission establishes:

- Direction
- Differentiation
- Opportunities to make a difference

The mission is long-term, broad and flexible, aspirational and ambitious yet realistic, and motivates its partners and personnel while appealing to those its remit benefits.

Given its nature and remit, we can express the Task Force's mission as to:

"Act with and through others to overcome drug and alcohol misuse, by applying or advocating what is proven, to achieve what it can, putting the service user first and ensuring best use of public resources."

Vision

Vision is the answer to the question, "where do we want to be?"

The vision of the Task Force expresses an attractive, credible, realistic view of its future, which improves on its world as now exists and how it currently does things.

This future is already coming into view in how the Task Force thinks and manages, which is that the services it funds must be measurable in the outcomes they achieve for people at risk of or experiencing drug or alcohol misuse. This perspective is not unique to the Task Force. Other public sector agencies are trying to do more with less. In addition, the Task Force can only do so much – communities in general can do far more.

The opportunity exists to build on this approach, through fulfilling a coordinating role that is well known and highly regarded in the Midlands. This role seeks to close the gap between what is needed and what is provided, across the full spectrum of health, social and public services for people at risk of or experiencing drug or alcohol misuse.

With this in mind, the Task Force's vision can be expressed as:

"To be the visible hand advocating an evidence-based response to drug and alcohol misuse, a conduit to communities supporting their response to misuse, and a forum for interactive information, communication, and discussion for improvement."

Values

What are the Task Force's enduring principles?

- **Service User Focus:** We exist to support the service user. Our success is determined by how well we ensure, or advocate for, services that bridge the gap between what is needed and what is offered, in health, social and public services and supports.

- **Innovation:** We apply a creative, practical, evidence-based approach to innovation, including the input of individuals and families as service users, so that our partners in service provision are focused on meeting present and developing needs.

- **Collaboration:** We take a collaborative approach with our statutory, voluntary and community partners, recognising the contribution each makes to our collective success, while leading in the search for better collective approaches.

- **Accountability:** We will do what we say we will do, recognising that our coordinating remit requires others to do all they can do. With our statutory, voluntary and community partners, and those we contract to provide services on our behalf, we all have a shared responsibility to do our very best for service users, communities and society.

Goals

We have eight high-level goals or objectives:

1. Contribute to reducing the supply of drugs and alcohol.

2. Contribute to preventing harm caused by misuse.

3. Contribute to developing treatment and rehabilitation options.

4. Contribute to evidence-based, multi-sector, collaborative innovation.

5. Support communities in strengthening their response to misuse.

6. Ensure a "service" focus in service provision and performance.

7. Contribute to a "conversation" on overcoming misuse, through information and communication, observatory on trends, and advisory / advocacy for service-wide, service user-centred improvement.

8. Ensure the Task Force fulfils its strategic remit through commitment to collective action, and that it has adequate resources, effective structures and quality systems and processes.

GOAL 1 - SUPPLY

Contribute to reducing the supply of drugs and alcohol

Actions	Lead Agency	Partner Agencies	Timescales	Outcomes
Listening to Communities 1. Feedback information/intelligence on drug dealing and related matters from communities, to inform discussions at Joint Policing Committees.	MRDATF	MRDATF and Sub-Committees Community, Voluntary and Statutory Sectors Drug and Alcohol Networks	Ongoing	Information and intelligence supplied to An Garda Síochána to inform the local response.
Informing Misuse of Drugs Legislation 2. Support the work of Joint Policing Committees by relaying drug and alcohol-related statistics, so Gardaí have additional evidence when advising changes to Misuse of Drugs legislation and regulations.	MRDATF	HSE Health Research Board Funded Services	Ongoing	Task Force relays up to date information and statistics to inform advisory on legislation, regulation and policy.
Utilising National Drug Treatment Reporting System 3. Ensure drug and alcohol misuse statistics gathered from the NDTRS are available to An Garda Síochána to assist them in priority-setting and response planning.	MRDATF	HSE Health Research Board Funded Services Joint Policing Committees	Ongoing	Gardaí are supplied with relevant and up to date statistical information to assist in priority-setting and response planning.
Supporting Joint Initiatives 4. Support the work of Joint Policing Committees in developing, coordinating and strengthening local and regional drug and alcohol misuse initiatives e.g. Youth Diversion Programmes and Dial-to-Stop Drug Dealing Campaign. 4a. Engage in continuing liaison with Local Drugs Units, as these are established in the Midlands by An Garda Síochána.	MRDATF	Garda Síochána Joint Policing Committees Local Drugs Units of An Garda Síochána Community, Voluntary & Statutory Services	Ongoing	Initiatives for tackling drug and alcohol misuse are rolled out, in line with identified and evidence-based need.

GOAL 2 - PREVENTION

Contribute to preventing harm caused by misuse

Actions	Lead Agency	Partner Agencies	Timescales	Outcomes
Strengthening Outreach 1. Ensure outreach services inform and refer service users onwards to appropriate services where required.	MRDATF	Funded Services HSE Community, Voluntary and Statutory Sectors	2017 and Onwards	Outreach services including the provision of information are provided to individuals and families, with onward referral to appropriate services where required.
Mapping Prevention Services Pathway 2. Provide information on local, regional and national services available and clearly identify access points. 2a. Communicate pathway clearly and widely. 2b. Support the development of a "train the trainer" initiative in line with best practice, to ensure service providers have the necessary skills and knowledge to identify individuals at risk and refer onwards to Tier 2-4 where appropriate. 2c. Gather information about gaps and overlaps in local and regional services, to inform better service provision. 2d. Support the rollout of evidence based parenting programmes in line with identified need.	MRDATF	HSE Longford-Westmeath ETB Community, Voluntary & Statutory Sectors Funded Services	2017 and Onwards	Detail on the range of services available and referral pathways is kept up to date and promoted accordingly. Service Providers are equipped to deliver and adapt services in line with identified needs of service users. Task Force is equipped to advise on gaps and overlaps in services provided, to inform better service provision. Provision of parenting programmes is supported.
Supporting Arrest Referral 3. Support the rollout of the arrest referral programme, once developed for the Midlands.	Garda Síochána	MRDATF Treatment & Rehabilitation Subcommittee	2017-2019	Service Users engaged in the arrest referral programme.
Prevention Supports for Under 18s and Over 18s 4. Support the development and implementation of a prevention service for Under 18s and Over 18s in the Midlands.	MRDATF HSE	Longford-Westmeath ETB Funded Services	2017 and Onwards	Under 18 and Over 18 service users actively engaging in prevention support service, with referral onwards where required.

GOAL 3 - TREATMENT AND REHABILITATION

Contribute to developing treatment and rehabilitation options

Actions	Lead Agency	Partner Agencies	Timescales	Outcomes
Nationally-Led, Locally-Informed Treatment & Rehabilitation 1. Monitor national policy and initiatives, to advocate for equitable, effective, efficient provision in the Midlands. 1a. Ensure Drug and Alcohol Service Users Fora have an opportunity to input identified needs to service provision.	MRDATF	HSE Treatment and Rehabilitation Subcommittee Service Users Fora Funded Services	2017 and Onwards	Task Force-funded treatment and rehabilitation services and supports are consistent with national policy and initiatives. Drug and Alcohol Service Users Fora input identified local and regional needs to service provision.
Mapping Treatment & Rehabilitation Service Pathway 2. Provide information on local, regional and national services available and clearly identify access points. 2a. Communicate pathway clearly and widely. 2b. Support the development of a "train the trainer" initiative in line with best practice, to ensure service providers have the necessary skills and knowledge to identify individuals at risk and refer onwards to Tier 2-4 where appropriate. 2c. Gather information about gaps and overlaps in local and regional services, to inform better service provision.	MRDATF	HSE Funded Services Treatment and Rehabilitation Subcommittee Community, Voluntary and Statutory Sectors Service Providers	2017 and Onwards	Detail on the range of services available and referral pathways is kept up to date and promoted accordingly. Service Providers are equipped to deliver and adapt services in line with identified needs of service users. Task Force is equipped to advise on gaps and overlaps in services provided, to inform better service provision.
Supporting SAOR - Problem Alcohol and Substance Use 3. Continue to support the rollout of SAOR - the national programme for screening and brief intervention for problem drug and alcohol use.	MRDATF	HSE Trained Facilitators	Ongoing	Service Providers are skilled in delivering the screening and brief intervention tool. Training, including refresher training, is scheduled and delivered annually.
Developing Community Employment Schemes 4. Support the development of drug and alcohol rehabilitation CE Scheme(s) in line with identified regional needs.	MRDATF	HSE Department of Social Protection Education and Training Boards Service Providers	2017-2019	Service Users are participating in the CE Scheme with a view to progressing into e.g. paid or self-employment.

Actions	Lead Agency	Partner Agencies	Timescales	Outcomes
Advocating for Residential Facilities 5. Identify the need and advocate for development of appropriate residential facilities in the Midlands.	MRDATF	HSE Funded Services	Ongoing	Need identified and advocated to appropriate agency.
Supporting Care Pathways and Drug Rehabilitation 6. Support the implementation of Integrated Care Pathways and rollout of the National Drug Rehabilitation Framework in the Midlands.	MRDATF	HSE Treatment and Rehabilitation Subcommittee Funded Services	2017 and Onwards	Integrated Care Pathways and National Drug Rehabilitation Framework are implemented and monitored in the Midlands.
Ensuring Family Support 7. Continue supporting family support services in the Midlands.	MRDATF	HSE Funded Services	2017 and Onwards	Families aware of and using support services provided.
Strengthening Harm Reduction 8. Continue supporting the needle and syringe and harm reduction service throughout the Midlands. 8a. Raise awareness of the harm reduction service through e.g. face-to-face contact and Social Media.	MRDATF	HSE Funded Services	2017 and Onwards	Users aware of and use the needle and syringe programme and associated harm reduction service.
Treatment and Rehabilitation Supports for Under 18s and Over 18s 9. Support the development and implementation of treatment and rehabilitation support service for Under 18s and Over 18s in the Midlands.	MRDATF HSE	Funded Services	2017 and Onwards	Under 18 and Over 18 service users actively engaging in treatment and rehabilitation support services, with referral onwards where required.

GOAL 4 - INNOVATION

Contribute to evidence-based, multi-sector, collaborative innovation

Actions	Lead Agency	Partner Agencies	Timescales	Outcomes
Coordinating Collective Action 1. Negotiate a Memorandum of Understanding where different groups with separate funding streams for prevention and education activities, commit to achieving common goals through collective action, applying evidence-based solutions to identified needs.	MRDATF	HSE Education and Training Boards Community, Voluntary and Statutory Sectors	2017-2019	Task Force takes a leadership role in coordinating collective action by funded voluntary and community groups on prevention measures.
Innovating for Co-occurring Addiction & Mental Health Issues 2. Continue advocating with service providers and engaging with service users to ensure people with co-occurring issues have access to mental health services.	MRDATF	HSE CADS HSE Mental Health Services Treatment & Rehabilitation Subcommittee Funded Services	2017-2019	Task Force leads in advocating, on behalf of the service user, the need for a bridge of the gap between mental health and addiction services, so those experiencing addiction co-occurring with a psychiatric disorder receive access to services.
Supporting Early School Leavers 3. Advocate for SOLAS and Education and Training Boards to lead in encouraging early school leavers into further education or training.	MRDATF	Department of Education and Skills SOLAS Education and Training Boards	2017 and Onwards	Early school leavers are engaging with the Further Education and Training Service in the Education and Training Boards.

GOAL 5 - COMMUNITIES

Support communities in strengthening their response to misuse

Actions	Lead Agency	Partner Agencies	Timescales	Outcomes
Supporting Communities 1. Support Local Drug and Alcohol Networks in the Midlands. 1a. Pilot a County Stakeholder Action Group in one county and evaluate with a view to rolling it out to other counties in the region.	MRDATF	HSE Longford-Westmeath ETB Service Providers	2017 and Onwards	Task Force continues support for Local Drug and Alcohol Networks. County Stakeholder Action Group is piloted in Westmeath, implements local actions (including actions arising from regional and national priorities) and is evaluated prior to rollout.
Reclaiming Community Spaces 2. Partner in support of reclaiming community spaces where e.g. dealing, drug litter, intimidation or anti-social behaviour have been addressed.	MRDATF	An Garda Síochána Local Authorities Community, Voluntary and Statutory Sectors	2017 and Onwards	Partnership is developed for initiatives to reclaim community spaces.
Tackling Drug Related Waste and Litter 3. Continue implementing the inter-agency protocol and providing the information leaflet on drug related waste and litter, which was developed for County Westmeath in 2015. 3a. Explore the potential for rolling out this initiative to the other three Midland counties. 3b. Explore the potential for coordinating the delivery of awareness training in tackling drug related waste and litter to community champions.	Midlands Drug Litter Committee	MRDATF HSE Community, Voluntary & Statutory Sectors	Ongoing	Protocol and awareness continued, with ongoing review and monitoring to inform rollout and enhancement in all counties.

GOAL 6 - "SERVICE"

Ensure a "service focus" in service provision and performance

Actions	Lead Agency	Partner Agencies	Timescales	Outcomes
Engaging Service Users 1. Support development of Service User and Drug User Fora to capture service users' input.	MRDATF HSE	Treatment and Rehabilitation Subcommittee	2017 and Onwards	Service Users are active participants in both forums, and active advocates for service improvement.
Advocating for "Service" in Services 2. Use the learnings from the two forums to inform service improvements, and enhance the Service Users Involvement Framework.	MRDATF	HSE Treatment and Rehabilitation Subcommittee Education and Prevention Subcommittee Funded Services Service User Forums	2017 and Onwards	Task Force facilitates regular discussions on improving services and the users' perception and experience of them. Service Providers act on the findings and recommendations of the two forums, enhancing the value of the Service Users Involvement Framework.

GOAL 7 - CONVERSATION

Contribute to "conversation" on overcoming misuse, through information and communication, observatory on trends, and advisory and advocacy for service-wide, service user-centred improvement.

Actions	Lead Agency	Partner Agencies	Timescales	Outcomes
Messaging and Media 1. Provide factual, current, age-related, non-judgmental information on the effects, risks and consequences of drug and alcohol misuse. 1a. Reuse existing content where possible for messaging, and use online as the main medium, pulling as needed from the online resource e.g. posters, leaflets or booklets as required.	MRDATF	Education and Prevention Subcommittee HSE Funded Services Drug and Alcohol Information Providers	2017 and Onwards	Task Force provides a trusted message on the media people use.
Continuing Campaigns 2. Coordinate or support drug and alcohol awareness campaigns in formal and non-formal settings, dovetailing with national campaigns and availing of the opportunities at a range of public events.	MRDATF	Education and Prevention Subcommittee Community, Voluntary and Statutory Sectors Local Drug Networks	Ongoing	Task Force coordinates or supports a range of drug or alcohol awareness campaigns in the region.
Refocus Website for User Needs 3. Redesign www.mrdatf.ie to include a focus on needs of individuals and families for information about alcohol, drugs and related issues.	MRDATF	Task Force Staff Drug and Alcohol Service and Information Providers		Task Force maintains user-focused website providing relevant, up-to-date information on alcohol, drugs and related issues.
Develop Profile in Social Media 4. Sign up for Social Media e.g. Facebook, Twitter, YouTube. 4a. Post often enough to become a recognised, trusted source. 4b. Sponsor e.g. a Regional Award for e.g. best peer-led video on misuse and host the winner's on the Task Force's Social Media.	MRDATF	Drug and Alcohol Information Providers Content Specialists	2017-2019	Task Force is part of the "conversation" on Social Media.
Continue Networking Events 5. Continue and support regular networking events for service providers in drug and alcohol misuse, to review trends and upskill workers' knowledge of e.g. chem sex, legal highs and crack cocaine.	MRDATF	Service Providers	Ongoing	Service Providers have and use the opportunity to network and enhance their knowledge of misuse at regular interagency events.

Ensure the Task Force fulfils its strategic remit through commitment to collective action, and that it has adequate resources, effective structure, and quality systems and processes to implement this plan.

Actions	Lead Agency	Partner Agencies	Timescales	Outcomes
Strategy & Evaluation 1. Adopt MRDATF 2017-2019 strategy and commit to its implementation and evaluation.	MRDATF	Task Force Members All Subcommittees	2017-2019	Members of Task Force committed to collective action and to recommendations, implementation and evaluation of this strategy.
Membership & Attendance 2. Liaise with relevant sectors to ensure representation and participation on the Task Force and all Subcommittees.	MRDATF	Community, Voluntary and Statutory Sectors Public Representatives	Ongoing	Task Force has full membership complement, in line with national requirements e.g. National Drug Strategy and / or guidelines issued by the Drugs Policy Unit.
2a. Amend Standing Orders to provide for members to attend at least 75% of all Task Force and relevant Subcommittee meetings, and for engagement with members falling short of this requirement.				Each Member attends at least 75% of Task Force meetings and meetings of Subcommittee(s) to which they are appointed.
Induction & Training 3. Provide induction pack and briefing to each member on appointment to the Task Force and / or Subcommittee(s).	MRDATF	Boardmatch Ireland	Ongoing	All Members receive induction and training.
3a. Arrange Boardmatch training for Members, Chair and Coordinator.				
Annual Team Building 4. Engage an external facilitator to deliver a suitable programme.	MRDATF		Annually	All Members participate in annual team building day.
Sector Presentations 5. Arrange for each sector to present once a year to the Task Force on its implementation of national drug and alcohol strategies.	MRDATF	Community, Voluntary and Statutory Sectors	Ongoing	Task Force is briefed on sectoral implementation and advises or advocates for improved implementation where appropriate.
5a. Communicate agreed advice on implementation.				

Actions	Lead Agency	Partner Agencies	Timescales	Outcomes
Bidding for Funding 6. Examine potential funding streams e.g. European Union, Dormant Accounts and philanthropic entities, and apply where appropriate.	MRDATF Chair and Coordinator	Finance and Governance Subcommittee	Ongoing	Task Force applies for additional funding where available and ensures evidence-based responses to identified needs in utilising such funds.
Monitoring & Evaluating Resource Usage 7. Monitor funded services to ensure resources are being utilised equitably, effectively and efficiently across the Midlands. 7a. Ensure timely reporting of funded service performance, including activity, finances and other matters, in the format required by the Task Force, HSE and the Drugs Policy Unit.	MRDATF	HSE Longford/Westmeath ETB Finance and Governance Subcommittee Service Governance Committee Funded Services	2017 and Onwards	Services in funded projects are equitable, effective and efficient. Task Force accounts for outcomes of funded projects, spending of public money and regional implementation of national policy. Returns to the Task Force, HSE and the Drugs Policy Unit are submitted in a timely way and in the required format.
Strengthening Role for Education & Prevention Subcommittee 8. Allocate a service, community and conversation brief to the Education and Prevention Subcommittee. (Service in this context means the intangible things that improve the person's experience and feelings about the actual service they have received).	Education and Prevention Subcommittee		2017	Task Force advocates for "service" in services, supports community mobilisation, and is part of a wider "conversation" on misuse.
Schedule of Meetings 9. Arrange meetings of the Task Force once every two months; and meetings of each Subcommittee once a quarter.	MRDATF	Coordinator Subcommittee Chairs	Ongoing	Task Force and Subcommittees meet regularly.

Consultation

The Task Force would like to thank all who participated in the consultation, met with the Task Force's consultant, or responded to the media advertisements, including:

Yvonne Canning, Ana Liffey Drug Project

Sinéad O'Shea, Ana Liffey Drug Project

Angela Garrett, Merchants Quay Ireland

Peter Hennessy, Merchants Quay Ireland Midlands

Tina Elliffe, Athlone Drug Awareness

Anne Cooney, Health Campus Coordinator, Athlone Institute of Technology

Ruth McGarry Quinn, Attic Youth Café

Mona Considine, Attic Youth Café

Ross McCann, Merchants Quay Ireland

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Daragh McCarthy, Youth Project Worker, Extern

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Jim Maher, Foróige

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Longford Community Resources: School Completion; Youth Service; Primary Care Project

Longford Local Development Company

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Jimmy Todd, Community Development Officer, HSE

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Margaret Condron, Tusla – Child and Family Agency

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Bernie Fitzpatrick, Tusla – Child and Family Agency

Frank Horne, Longford Local Drug Network

Fran Byrne, HSE CADS (Community, Alcohol & Drug Service)

Maria Fox, Longford & Westmeath ETB

Membership of Midland Regional Drug and Alcohol Task Force during Strategy Development in 2016

Peter McEvoy, Chairperson

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Josephine Lee, MRDATF Administrator

Statutory Sector

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Maria Conway, An Garda Síochána

Maria Fox, Longford & Westmeath Education and Training Board

Michael Rainey, Laois County Council

Gerard Ryan, Revenue & Customs

Community Sector

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Frankie Keena (Westmeath)

Dave Raftis (Westmeath)

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Tony Geoghegan, Merchants Quay Ireland

Kenneth Higgins, Irish Traveller Movement

Geraldine Lacey, Youth Work Ireland Midlands

Mark Noble, Longford Community Resources

Tony O'Riordan, Midlands Simon Community

Public Representatives

Councillor Pádraig Loughrey (Longford)

Councillor Frank Moran (Offaly)

Councillor Aengus O'Rourke (Westmeath)

Councillor Paschal McEvoy, (Laois)