



An Roinn Sláinte
Department of Health

A Health-Led Response to the Issue of Drugs and Alcohol: Building a Regional System that Delivers for Communities

Report of
Future Search Workshop
June 24, 25, 26 2026

Michael Donnelly & Tara Haughian



An Roinn Sláinte
Department of Health

The views and opinions expressed in this report reflect those shared by participants during the consultation process. They do not necessarily represent the views, positions, or policies of the report authors or the Department of Health.

Future Search Workshop Report – Regional Response to Drugs and Alcohol



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A Health-Led Response to the Issue of Drugs and Alcohol - *Building a Regional System that Delivers for Communities*

Introduction

This report documents the proceedings and outcomes of *A Health-Led Response to the Issue of Drugs and Alcohol: Building a Regional System that Delivers for Communities*, a three-day Future Search workshop held at the Law Society in Dublin from 24 to 26 June 2026.

The report is presented in Four Distinct Sections.

Section One – Executive Summary

Section Two – Summary of proceedings

Section Three – Common Ground Agreement and Blueprints for Regional Structures

Section Four - Full Narrative Output of Each Session

The workshop was convened by the Department of Health, under the auspices of Jennifer Murnane O'Connor, Minister of State with special responsibility for Public Health, Well Being and the National Drugs Strategy. It was independently facilitated by Michael Donnelly of Second Nature, Co-Director of the Future Search Network, working alongside co-facilitator Tara Haughian, using the Future Search methodology.

Context and mandate

The workshop's mandate traces back to the Letter of Determination, the directive the Minister for Health issues each year to the Chair of the HSE following the Budget, setting out the government's policy position for the coming year. This year's Letter asked the HSE to *create regional structures to coordinate drug and alcohol responses, across both HSE and community-based services, in order to address treatment disparities and support the National Drugs Strategy*. This instruction is in turn reflected in the draft National Drugs Strategy itself, which sets out three levels of governance and oversight for the strategy. The third of these levels is the set of regional structures the workshop was convened to design.



The rationale for this approach is to align the new National Drugs Strategy with the wider reform of health services, in support of a "health-led" response, which at its core is the principle that people seeking support for drug use should be viewed and treated with the same regard as people presenting with any other non-acute health condition. Sláintecare, the most significant reform of health and social care in the history of the state, provides the overarching lens through which all services are now organised and funding allocated, and has created the geographical structures, the six HSE Health Regions, through which decisions are made and services delivered. Aligning the drug and alcohol response with these structures offers the opportunity to put it on an equal footing with responses to other health issues; the risk of not doing so is that it remains, in effect, an issue resulting in marginalisation and stigma.

The last substantial review of the structures for delivering drugs policy to communities was the Rabbitte Report, which turns thirty in October. A great deal has changed since then, in the nature of the drug issue itself, once regarded as a largely urban problem, and in Irish society more broadly. The ambition for this workshop is to design structures robust enough not only to support the current National Drugs Strategy but potentially to guide the response for a decade or more beyond it.

Participants and method

In keeping with the Future Search approach of bringing "the whole system in the room," the workshop brought together seventy-three participants drawn from across the sector, organised into nine Stakeholder Groups reflecting the diversity of the field: Lived and Living Experience; Drug and Alcohol Task Forces; Marginalised Groups and Thought Partners; Community Service Providers; Medical Service Providers; Government Departments; HSE; Education and Prevention; and Justice. This breadth of representation was intended to ensure the structures designed would be informed by the full range of perspectives, expertise, and experiences across the system, and that any resulting agreements would carry the legitimacy of having been reached collectively rather than imposed.

Flow of the workshop

The three days followed the specific Future Search task sequence. Day one opened with a welcome and overview, followed by a Focus on the Past, in which participants traced personal, global, and sector-specific timelines to surface a shared history, before moving into a Focus on the Present, naming the external and internal realities shaping the current response to drug and alcohol use.



Day two continued the Focus on the Present, including a mapping of key trends and a "Prouds and Sorries" exercise in which participants took ownership of what was working well and what was not. The afternoon shifted to a Focus on the Future, in which Stakeholder Groups projected themselves ten years ahead to 2036 and described, concretely and often creatively, a regional system that was equitable, responsive to population need, and built on genuine engagement. The day closed with participants beginning to identify common ground across these preferred futures.

Day three opened with the group confirming and refining this common ground before turning to action planning, in which mixed groups worked to translate the agreed principles into the operational and strategic shape of the proposed Regional Forums, closing with participants identifying next steps and action commitments to carry the work forward.

Introduction to Future Search

Future Search is a unique planning method used world-wide by organisations and communities. The method enables large diverse groups to (1) confirm a common-ground vision, (2) take responsibility for action, and (3) commit to ongoing steps. The method is especially useful in complex settings when it is important that everyone have the same big picture to act responsibly. Because it is largely culture free, Future Search is used successfully in North and South America, Asia, Africa, Australia, Europe, and India to create umbrellas for social, technological, and economic planning.

A Future Search may involve up to 100 people. Participants work in small groups as "stakeholders." This means they have a shared perspective. Participants also work in mixed groups that are a cross-section of the whole. The meeting is managed so that the entire group can be in dialogue at different times. Every person has a chance to speak and listen. This makes possible a deeper understanding of the issues than anyone had coming in. Everyone's experience contributes to the learning. The minimum length is five sessions, spread across three days to allow for "soak time." One intensive planning meeting can set the stage for projects that continue with high involvement for years.

How Future Search Works

Future Search follows tested principles derived from six decades of research and experimentation with what it takes to enable people to act cooperatively without having to defend or sell their own agendas or give up cherished values. The first principle involves "getting the whole system in the room"--meaning people with authority, resources, expertise, information and need. The second involves putting the focal issue



in global perspective, helping each person to see a bigger picture than usual. The third requires seeking common ground and desirable futures, while treating problems and conflicts as information, not action items. The fourth asks people to manage their own small groups and take responsibility for acting on what they learn. Future Search features working sessions among a wide range of parties who together have what is needed for principled action if they choose to take it.





Section One – Executive Summary

Seventy-three participants from across the drug and alcohol sector spent three days (June 24-26, 2026) designing the Regional Structures called for in the draft National Drugs Strategy. Working through Future Search's structured sequence - past, present, future, common ground, and action planning. The workshop produced a strong, whole-system consensus on both the principles the new structures should embody and, in outline, how they should operate. This summary draws together the conclusions that ran across all sessions and the actions they point to.

Key Conclusions

- There is genuine, whole-system agreement that the response must become health-led in substance, not just administratively relocated - people seeking support for drug use should be treated with the same regard as anyone with a non-acute health condition.
- Addiction is consistently linked by participants to poverty, deprivation, trauma and stigma.
- Regionalisation under Sláintecare is broadly welcomed as an opportunity to coordinate the response and close treatment disparities – it came to be recognised as a devolution of authority and decision making from central structures. However, it carries a risk: participants raised concerns that the voice of local communities could be diluted or lost in the transition.
- Workforce recruitment, retention and pay parity - particularly between community/voluntary and statutory (HSE) roles - is a shared vulnerability across every stakeholder group and a potential constraint on any new structure's success.
- People with lived and living experience are named by every part of the system as central to legitimate decision-making, yet groups were candid that this is not yet happening in practice and risks being tokenistic unless roles are structured and powered to influence outcomes.
- Marginalised communities (LGBTQ+, Traveller and Roma, racialised, disabled, migrant) face disproportionately higher rates of addiction, are least represented in current structures, and are least likely to access treatment - a gap participants said policy has not yet named or addressed.



Section Two – Summary Report of Proceedings

A Health-Led Response to the Issue of Drugs and Alcohol

Building a Regional System that Delivers for Communities

Summary Report — Future Search Workshop, Law Society, Dublin, 24–26 June 2026

This is a summarised version of the full narrative report. It retains the structure of the original but condenses each session to its key points, highlights the main contributions from individual groups, and draws out the points of commonality that emerged across the workshop.



Focus on the Past

Participants built three timelines: personal, world events, and milestones in the drug and alcohol response, stretching back to 1986 and before. Mixed groups then told stories and drew out insights and implications from what they saw.

Group 1 & 2 – Personal Timelines

- Common threads: diversity of personal experience, disparity (from stability to addiction), the pull of family and community, and the recurring presence of trauma alongside education and recovery.
- Strong sense that "it means something to everyone" - participants engage from both personal and professional perspectives, with more similarity than difference across the room.
- Calls for a genuine "prevention first" and whole-of-government response.



Group 3 & 4 – World Events / Global Timeline

- A clear line was drawn from economic cycles (Celtic Tiger, 2008 recession, cost-of-living crisis) to patterns of addiction and to Task Force funding, which saw an average 40% cutback after 2008.
- Globalisation, technology and, more recently, war and displacement were seen as continually reshaping drug markets and access - a problem no longer confined to Dublin or to urban areas.
- COVID-19 was flagged as a turning point: a positive, coordinated health response but also increased isolation, disconnection and rising cocaine use.
- Implication drawn: recovery plans need to be dynamic, person-led and adaptable to where someone is in their own journey, with genuine (non-tokenistic) respect for lived experience.

Group 5 & 6 – Response to Drugs and Alcohol Timeline

- Traced a shift from a Dublin-centric, punitive, heroin-focused response in the 1980s (alcohol largely unaddressed as a "cultural norm") through the 1996 Rabbitte Report and establishment of Task Forces, to a more humane, health-oriented approach post-2017.
- Noted that the response outside Dublin was slow to develop, and that newer drug trends (cocaine, NPS, synthetics, vaping) have consistently outpaced policy recognition.
- Recent milestones: the 2024 Citizens Assembly, Joint Oireachtas Committee report, and growing recognition of dual diagnosis.

Group 7 & 8 – Connecting the Three Timelines

- A clear link was drawn between economic cycles and community-level addiction, and between class, deprivation and the early framing of the "drugs problem."
- Called for the response to get ahead of trends rather than remain reactive, to invest in what is already working, and to use data to target community need.
- Core drivers named: poverty, early school leaving, adverse childhood experiences (ACEs), imprisonment and intergenerational trauma - reinforcing the case for a genuinely health-led, whole-of-system response.

Points of commonality

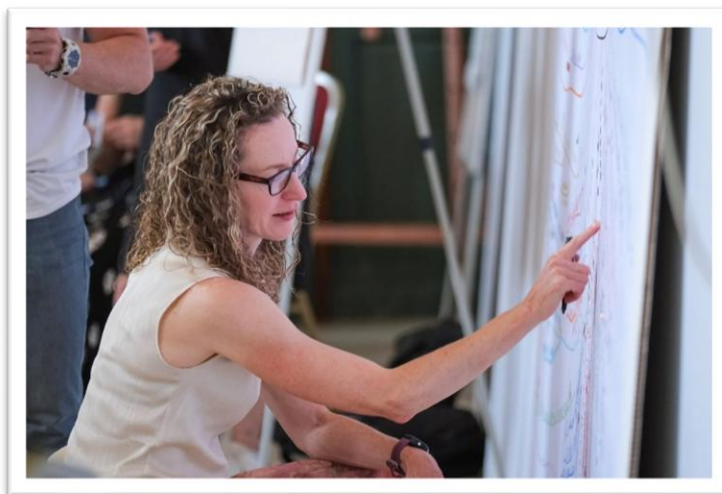
- Addiction is consistently linked to poverty, deprivation and trauma, not treated as an issue in isolation.
- The response has historically been Dublin-centric and reactive; participants want it to become nationally consistent and anticipatory.
- A shift in framing - from criminality to health, from one-size-fits-all to person-led recovery - runs through every group's story.
- Lived and living experience should shape the response, not simply be drawn on to promote services.



Focus on the Present — External Trends

All participants contributed to a mind map answering: "What are external trends affecting our response to drug and alcohol use that we need to be aware of?" Dot-voting then identified the highest priorities:

- Social deprivation - the increasing gap and rise in child poverty (26 votes)
- Mental health need exceeding substance-use capacity, including homelessness, isolation and diagnosis (25 votes)
- Stigmatisation of drug use, and drug-related deaths, harm and violence (21 votes)
- Difficulty recruiting and retaining staff in addiction services (20 votes)
- Regionalisation of health services / Sláintecare reform (19 votes)



Focus on the Present — Stakeholder Groups

Nine Stakeholder Groups mapped how the key trends affect their work, what they are already doing in response, and what they want to do but are not yet doing. They then identified their "Prouds" (what they are proud of) and "Sorries" (what they own as needing to change), reported below as highlights rather than the full verbatim lists.

Community & Voluntary

- Priority issues: staff recruitment/retention and competition with statutory bodies for the same workforce; gender-responsive services for women with children; parity of esteem, and pay, with statutory services.
- Proud of: the innovation and commitment shown by community services on limited resources, and improving standards of care.



- Sorry that: large national organisations can crowd out small local initiatives; lived and living experience is not consistently part of decision-making; people still slip through gaps.

Drug and Alcohol Task Forces (DATF)

- Priority issues: regionalisation risks eroding independent, functioning Task Force models unless explicitly protected in policy; youth-focused threats (grooming, county lines); need for stronger local data and needs analysis.
- Proud of: prevention and youth work, strong local networking and needs analysis, and a growing recovery culture.
- Sorry that: successes aren't well communicated, engagement with HSE on regionalisation has lagged, and links with new communities need strengthening.

Education and Prevention

- Priority issues: equity of access, funding that doesn't undermine informal/community-based education, and the need for better evidence and data to match programmes to what's actually happening on the ground.
- Proud of: responsiveness to emerging trends, empowering young people, and successful university partnerships.
- Sorry that: successes and data aren't well captured, inherited practices persist out of fear of change, and stigma and funding pressures push staff to breaking point.

Government Departments

- Priority issues: realising the coordination potential of regionalisation; better use of existing data (e.g. wastewater monitoring, longitudinal databases); multiannual funding for the community and voluntary sector.
- Proud of: expanding CE drug rehab placements, prevention-focused research and interventions.
- Sorry that: recovery data collection has been under-prioritised, national coverage is inconsistent, and closer collaboration with the HSE is needed.

HSE

- Priority issues: how a health-led response squares with authority and resources sitting elsewhere (housing, homelessness); how Sláintecare regionalisation will actually break down to addiction services; interdepartmental coordination.
- Proud of: expanded and evidence-based services, harm reduction achievements, lives saved, and a growing social-justice framing that pushes back on stigma.
- Sorry that: co-production hasn't happened early enough, national provision remains inconsistent, and recruitment delays persist.



Justice

- Priority issues: normalisation and stigma; data sharing and early-warning systems for emerging drug trends; the intersection of addiction with child exploitation and criminal exposure.
- Proud of: Ireland's global standing on policing safety, diversification of options beyond conviction, interagency and all-Ireland working.
- Sorry that: Gardaí don't carry naloxone, and post-release supports and continuity of care remain weak.

Lived Experience Community

- Priority issues: progression pathways and paid peer roles; stigma that varies depending on where someone is in their journey; recognition of dual diagnosis without power imbalance between services and the people they support.
- Proud of: genuine top-down/bottom-up collaboration, peer-to-peer naloxone training, and a peer partnership framework that puts peers in the lead on change.
- Sorry that: collaboration remains under-coordinated, recording and admin requirements eat into contact time, and part-time/limited capacity roles constrain what peers can do.

Marginalised Groups

- Priority issues: marginalised communities (LGBTQ+, Traveller and Roma, racialised, disabled, women) face higher rates of addiction yet are least represented and least likely to receive treatment; funding needs to be sensitive to class and stigma, not just multiannual.
- Proud of: participation, resilience, and person-centred, evidence-based advocacy.
- Sorry that: organisational capacity is limited, lessons from past experience aren't applied, and trust in political and system leadership is fragile.

Service Providers (Medical)

- Priority issues: mental health/addiction overlap and neurodiversity; regionalisation's practical impact on staffing, funding and pathways for different substances; vulnerable groups (pregnant women, older people, Travellers, migrants, LGBTQI); staff retention and succession planning.
- Proud of: embracing new treatments (e.g. Buprenorphine, Buvidal Depot), reducing waiting lists, and dispersing services beyond Dublin.
- Sorry that: treatment pathways for cocaine and novel agents lag behind, and engagement with service users on decisions still needs to be more meaningful.

Points of commonality

- Workforce recruitment, retention and pay parity, especially between community/voluntary and statutory staff, came up in nearly every group.



- Stigma was named repeatedly as a barrier to both access and to genuine inclusion of people with lived experience.
- Regionalisation and Sláintecare are widely seen as an opportunity, paired with real anxiety about local structures (Task Forces) being diluted or under-resourced in the transition.
- Groups consistently called for better data, evidence and evaluation to drive decisions rather than habit or funding pressure.
- A persistent Dublin/regional disparity in service coverage was raised across sectors.
- Every group wants lived and living experience represented meaningfully in decision-making, not used only to promote services.



Discovering Common Ground

Working in groups, participants distilled up to eight common-ground elements each — values, structures, and practices they believed everyone in the room could support for the new Regional Structures. Across all groups, the following headline agreements emerged:

- Prevention first - an upstream, resourced strategy, not an afterthought.
- A genuinely whole-system, health-led (not "health only") approach, with strong interdepartmental working.
- Data- and evidence-driven, needs-led delivery, with space for innovation and shared practice.
- Foundational values: dignity, respect, equity, integrity, empathy, human rights, and stigma eradication — with explicit inclusion of LGBTQ+, women, Traveller, Roma, migrant and lived/living-experience communities.



- Clear Terms of Reference for Regional Structures: standardised, strategic, accountable, with an independent chair, meaningful ongoing consultation, and shared decision-making that gives people who use drugs, families and communities real influence over policy.
- Equity of access - a "no wrong door" system, accessible by time and geography, with low-barrier, low-stigma entry points.
- A recovery-oriented system with clearly communicated pathways.
- Investment in the workforce, including paid roles for people with lived experience.

Action Planning

In the final session, mixed groups used the common-ground agreements as raw material to design the operational and strategic shape of the proposed Regional Structures/Forums.

Group 1

- Structure built around shared values, equity of access (outreach, mobile, online, translation), and workforce standards aligned with "Better, Safer Care."
- Regional Executive Officer (REO) accountable to the national structure and Minister, with an independent chair and clearly defined roles, integrated with existing structures (LCDC, CYPSC, Homeless Fora) rather than siloed.
- A dedicated recovery strand: recovery hubs, paid and voluntary lived-experience roles, and a continuum from harm reduction through treatment to community step-down.

Group 2

- A prevention-led framework with a standardised structure across regions and clear communication channels between regional and local levels; a Grade VIII lead for prevention sitting within Public Health in each Health Region.
- Governance underpinned by a national mandate, MOU and Ministerial approval to the REO, guided by a human-rights principle.
- A shared data platform (area profiling, deprivation index, service data, emerging trends) to drive priorities, and attention to practical barriers to participation (protected staff time, expenses, outdated GP contracts).

Group 3

- Wide membership spanning housing, education, justice, local authority, HSE, Task Forces, and lived/living experience (with capacity building).
- An independent, skilled, rotating chair, locally interviewed, DoH-endorsed, non-political and supported by an operational coordinator.



- Sub-group structure covering prevention, data, governance/accountability, recovery and intervention, underpinned by dignity, respect, human rights and specific attention to vulnerable groups.

Group 4

- Each Regional Structure accountable for prevention delivered to best practice, linking regional and national levels and aligned with Sláintecare geographies.
- Data-driven, to actively eliminate inequity; membership includes ministerially-mandated statutory bodies alongside lived experience, families, marginalised communities and Task Forces, with voluntary members paid or reimbursed.
- Clear governance documentation for consistency, with an explicit commitment to avoid tokenism.

Group 5

A tiered structure diagram: Taoiseach's Office / Minister for Health / Department of Health at the top, linked departments (Justice, Education, DSP, Children, Finance) committed at senior level, then a National Clinical Lead and national threat-assessment function.



- Each region to have its own clinical lead, prevention coordinator, operational lead and coordinator, plus wide regional membership (GPs, primary care, mental health, Gardaí, local authority, Tusla, Task Forces) and an independent chair.
- Feeds from and into local structures - Task Forces, community safety partnerships, LCDC, CYPSC - with an explicit "not tokenistic" commitment.



Group 6

- Debated who should sit at the table: strong pushback on political/elected representation ("this is far more important than politics"), preference for an independently appointed chair via a public appointment service.
- Membership to include statutory organisations, Task Forces, children's/young people's voice, a regional clinical lead, community services, and lived experience - with data (not just HSE data) driving decisions.
- Called for a governance manual and an equal vote for everyone at the table; queried whether monthly meetings are realistic.

Group 7

- Proposed a Regional Forum with an executive HSE lead for prevention, recovery and harm reduction, meeting monthly with representation from all stakeholders.
- Statutory partner engagement to be mandated at a high level, with investment in bringing people to the table who genuinely represent their communities - including lesser-heard voices, new communities and young people.

Group 8

- Two structural diagrams: one linking government, NIMC, REO, an independent chair and a stakeholder forum through to prevention, clinical and service-delivery roles based on population need; the other tracing lines from DoH/DoJ/DoE down through HSE, CHOs, Task Forces and local reps.
- Read together: national structures set mandate, direction and accountability; the REO links national to regional; an independent chair supports the Forum's governance; and population need and data flow upward from local communities while mandate and accountability flow down.





Section Three - Blueprint for Setting Up Regional Structures

The content of this Blueprint Summary is drawn entirely from the Future Search workshop flipcharts from the final day - The Common Ground and the Mixed Group workshops.

1. Regional Structures - What are they and where they fit

Each Regional Structure is one of six, and sits as the third tier used to implement the National Drugs Strategy:

Tier 1 Minister for Health (Drugs Strategy)

Tier 2 National Implementation Committee or National Forum for planning, review and accountability

Tier 3 Six Regional Structures

Each Regional Structure is mandated by the Minister. It is health-led, but not health-only meaning it works as part of a whole-system approach bringing statutory and community/voluntary partners together. The Regional Structure will be responsible for implementing the relevant actions of the National Drugs Strategy whilst also focusing on population need, providing responsive services, prevention, recovery, ensuring equity of access to services, accountability and involving communities.

2. Governance and leadership

Each structure is to be led by an Independent Chair (one per region, six in total), recruited through an open call and an interview/selection process, then endorsed by the Minister.

Each structure is to have clearly defined roles and operational procedures, and a standardised governance framework / governance manual, so all six work consistently. Decision-making is strategic, looking at the totality of need in the region and making the best use of resources, with a high level of accountability. Political buy in is essential. The Regional Structures can draw on lessons from the existing Community Safety Partnership model.

3. Regional roles

Each Structure will need to have a number of key roles, some paid and some could be voluntary or managed through sub groups. The Key roles include:

1. REO – seen as the key link between regional and national levels.
2. Clinical Lead.
3. Recovery Coordinator.
4. Prevention Coordinator / Prevention Lead.



5. Operational Lead (suggested at Grade 8) in each region, a taskforce coordination role.
6. Research lead with an early warning role were proposed - perhaps through sub committees or as paid roles.

4. Who should be at the table – The Stakeholders

The structure should bring together statutory bodies, including the HSE, an REO representative, Primary Care, Mental Health, Social Inclusion, the Garda Regional Chief Superintendent, Local Authority such as City and County Managers, the Department of Education, a Tusla regional manager, the DSP, Justice, Probation, and Housing, alongside local partnership structures such as the Task Force, LCSP, LCDC, CYPSC, Community Safety Partnerships, and local government. Alongside these sit the community and lived-experience voice: community representatives, community and voluntary providers, families, people with lived experience, young people, Traveller representatives, family support representatives, migrant representatives, NUDAS, and other marginalised groups, including LGBTQI people, migrants, women, Traveller and Roma communities, and people who use drugs.

Particular significance is reserved for people with lived or living experience, whose presence was repeatedly reinforced throughout the Future Search as something requiring extra, deliberate effort rather than passive inclusion



5. The principles that guide the work

Lived values: dignity, respect, human rights, equity and inclusion, integrity, empathy, social justice, eradicating stigma, person-centred practice, valuing lived and living experience across all ages, equal opportunity, co-production, ground-up working, local voice in decisions, and involving marginalised communities, without being tokenistic.



These values are not intended as a statement of intent alone; they are meant to shape how the Structure is organised, who is involved, how decisions are made, how meetings are run, how data is used, and how power is balanced. Participants were clear that a shared understanding of these values needs to be actively built and maintained across all stakeholders, through induction, training and workshops, reflective practice, and internal and external supervision, and reinforced in how the Structure implements its work, evaluates progress, and responds to emerging issues. Stigma was named as something to be addressed deliberately, through the language and culture the Structure uses, shifting toward a culture of hope that celebrates recovery rather than reinforcing shame.

For people with lived and living experience specifically, living these values in practice means more than consultation: it means places on the Regional Structure itself, with equal standing in discussion and decision-making, not confined to separate advisory groups. It means paid roles, including paid peer-worker positions, and payment or reimbursement for voluntary members, alongside practical supports such as accessible meeting times and language, preparation support, and clear role descriptions, so that participation is genuinely accessible rather than an additional burden. Avoiding tokenism was raised repeatedly as something the Structure must actively guard against, with local structures and routes built in specifically to support marginalised communities' involvement, rather than relying on goodwill alone.

Whole-system working: health-led but not health-only, inter-departmental, bringing statutory and community/voluntary providers together, and integrating with, rather than duplicating, existing infrastructure.

Partnership and participation: parity of esteem, shared decision-making with real representation, ongoing and meaningful consultation, an equal voice at the table for everyone, and active attention to balance of power and conflicts of interest. These same principles apply to how day-to-day decisions are made, with participants suggesting this be made concrete through transparent decision-making, shared criteria, a clear separation between statutory accountability and shared influence, and explicit management of power and conflicts of interest, set out in the Terms of Reference and governance document rather than left implicit.

6. What the structure actually does

The structure exists to ensure the right stakeholders are engaged and to assess and respond to need using shared, consistent data. It carries out regional work planning, setting clear actions and reporting and monitoring progress regularly, monthly or otherwise, for oversight and accountability. It responds to emerging issues, with a defined escalation route for when actions become static or stuck, and it shares good practice and partnership, creating space for innovation across agencies and departments. Critically, it integrates with existing local structures rather than working in



isolation, linking into the Task Force, LCSP, LCDC, CYPSC, Homeless Structures, and wider community networks.



7. The core work programme

Prevention — The structure should take an upstream, preventative approach, built on public education and awareness, a National Threat Assessment and Early Warning function, training, and a named Prevention Coordinator or Lead accountable for delivering this in line with best practice.

Recovery — A recovery-oriented approach is needed that builds and communicates recovery through lived experience, a culture of hope, and visible, celebrated recovery stories, supported by sustained, holistic care across the continuum with shared care plans and clear progression pathways into employment, training, education and housing, ultimately ending the "revolving door."

Equity of access — The system must ensure no wrong door and no exclusions, with services accessible by time, geography, outreach, mobile delivery and online, supported by interpretation and translation, and delivered through low-barrier, low-stigma services that include a recognised role for GPs beyond opioid treatment alone.

Informed practice — Data must sit at the heart of the work, with a data-driven, needs-driven approach in which all responses are evidence-led, data shared and



made visible across agencies including housing, education and DSP, area profiling using CSO and deprivation-index data, and links to bodies such as the Addiction Research Network Ireland and the HRB.

Workforce — The structure requires sustained investment in staff, including paid roles for lived experience and paid peer workers, minimum standards and mandatory ongoing training, protected time in contracts for reflective practice and supervision, and a clear focus on staff retention.





Regional Structures: Common Ground Agreement

These are the Common Ground Agreements made by all the participants.

Prevention First: A Shared Commitment Across Sectors — Participants agreed that an upstream, preventative approach, including public education and recognition of GPs' preventative role, should be a core strategy rather than an afterthought.

A Whole System Approach — The group called for a genuinely health-led, inter-departmental response built on shared data, evaluation, and evidence, with integrated supports, IT, and room for innovation rather than constantly chasing new funding streams.

Foundations of Our Work / the Values We Stand For — Participants grounded the structures in shared values of dignity, respect, equity, empathy, inclusivity, and human rights, with a commitment to eradicating stigma and ensuring co-production and person-centred care for people of all ages.

T.O.R. for Regional Structures — The group agreed the regional structures need a standardised, strategic design that addresses total population need, makes best use of resources, and carries high-level accountability, built on identifying key stakeholders and tapping into existing infrastructure.

Framework & Governance — Participants agreed the structures should be governed through ongoing, meaningful consultation and genuine partnership, with independent chairs, clear actions and reporting, and shared decision-making that actively supports people who use drugs, families, and communities to influence policy.

Equity of Access — Participants agreed the system should offer a "no wrong door" experience, with clear, accessible entry points and a guarantee that, once someone is in the system, they progress rather than being passed between services.

Recovery Oriented — The group agreed that recovery pathways should be built, supported, and actively communicated as part of the regional response.

Invest in Your Workforce — Participants agreed that investment in the workforce, including paid roles for people with lived experience, is essential to delivering the new structures.



Section Four – The Narrative Report

Introduction

This report documents the proceedings and outcomes of *A Health-Led Response to the Issue of Drugs and Alcohol: Building a Regional System that Delivers for Communities*, a three-day Future Search workshop held at the Law Society in Dublin from 24 to 26 June 2026. It is presented as a verbatim account of the group reports at the workshop.

Workshop Agenda

Workshop Managers: Michael Donnelly and Tara Haughian

Day 1, JUNE 24th, 2026

1:00 pm	Welcome and Overview
	Focus on the Past: Highlights and Milestones
	Focus on the Present: External / Internal Realities
6:00 pm	End of Day 1

Day 2, JUNE 25th, 2026

9:00 am	Focus on the Present continues
	What we are doing now, What we want to do
1:30 pm	Focus on the Future: Preferred Scenarios
	Discover Common Ground: What we want
6.00 pm	End of Day 2

Day 3, JUNE 26th, 2026

9:00 am	Confirm Common Ground
11:00 am	Action Planning
1:00 pm	Next Steps and Action Commitments
2:00 pm	Close of Meeting



FOCUS ON THE PAST

For the “Focus on the Past” session participants completed three separate timelines, each around 8 metres long going back to 1986 and before, up to today. The three timelines were completed using these prompts:

Think about the past from these three perspectives.

- Personal: Key experiences that shaped your life.*
- World: Events that have shaped our global society.*
- Milestones that have shaped our response to drug and alcohol use.*

Participants were invited to use a marker to put their items on the timelines on the wall, using words and/or pictures.



Figure 1: Writing on Timelines

When the timelines were completed participants worked in mixed groups to develop stories and insights to the timelines they had created. They were asked to tell a story of the timeline and the implications for the work they were here to do.

Two mixed groups worked on each timeline and two groups worked to discover threads and themes across all of them. Each group prepared a report that was delivered to the whole group. The section below sets out what each group discussed.



Group 1 - Personal Timeline Story

1. Diversity
 - A web of experiences
 - A fabulous tapestry of cultural multiplicity
2. Disparity
 - From 'living the dream' to living nightmares
 - From buying homes to migration: a spectrum
 - Recovery to addiction
3. Culture
 - Music, art, education and more, hum through the entire timeline
4. Community
 - Family, work, pets, relationships
 - Diverse communities
5. Trauma
 - Violence, homelessness, deprivation, abuse, recession, stigma, grief
6. Education
 - Positive and negative experiences
 - Formal and informal BA-PHD
7. Recovery
 - Lived experiences in many forms: personal, familial, community





Group 2 – Personal Timeline

A

- Family
- Can't match stories to our stakeholder group
- Education
- Disadvantage and adversity
- Repression and 'hush hush' society – changed
- Diversity
- Spectrum of drug and alcohol use
- Motivated and passionate to respond to needs – eg set up services, training
- Mainly positive journeys from adversity
- More social capital
- Missing perspectives? Immigrants
- People find a way and move forward

B

- It means something to everyone
- People care – from personal and/or professional perspectives
- In a bubble, but varied experiences
- Understanding of wider determinants and environment
- Prevention first
- Not one size fits all – needs whole of government response
- Positivity
- More similarity than difference
- Role of state/government
- Ensure youth voice informs the work (missing participation of YP)



Group 3 – World Events – Global Timeline

World Events 80's-90's

- Heroin epidemic
- AIDS/HIV
 - Local marches/protests against drugs
 - Harm reduction – Physeptone (1) / Meth (2)
- Drugs Task Force (93...) Local
 - All Dublin based
- Celtic Tiger
 - More money -> greater divide between those who had/had not
 - Access to drugs
 - Criminality
 - Technology boom -> greater accessibility -> international crime organisations
- Establishment of Regional DATF
- Globalisation
 - Drugs available from other countries
 - New drugs
 - Coming through ports
 - Now rural and urban problem
- Recession (2008+)
 - Austerity / IMF
 - Avg 40% cutback of Task Force funding
 - Unemployment levels peaked
 - FAS moved to DSP -> LE drug rehab framework
 - Upsurge heroin use – new cohort of drug users
 - NPS drugs (2010+)
- Brexit (2016)
- Housing crisis
- Covid 19 (2020+)
 - Cocaine
 - Socialisation issues – disconnection
 - Health response positive
 - Better together – online hub 2020+
- Afghan/opium (2019) Americans pulled out 2020
- Ukraine war (2022)
- Drones (drug drops) -> new technology
- Manosphere -> domestic violence, social media



- Cost of living crisis
- Israel/American war (2026)
- Fuel shortages

Implications

- Dynamic recovery plan
 - Focuses on what the person needs
 - Recognises the different stages of recovery and moves/adopts to where/stage the person is at
 - Person leading the recovery
 - Allows for adaptability
 - Respect the voice of lived experience not tokenistic
- Greater need for inter-agency/departmental
- Responses to recovery
 - Housing
 - Childcare
 - Payments
 - Family support – women and children
 - Transport issues
- Response to assist with drug debt
 - Family intimidation
 - Stigma
 - Drive project
- Migrants/immigrants entering with addictions



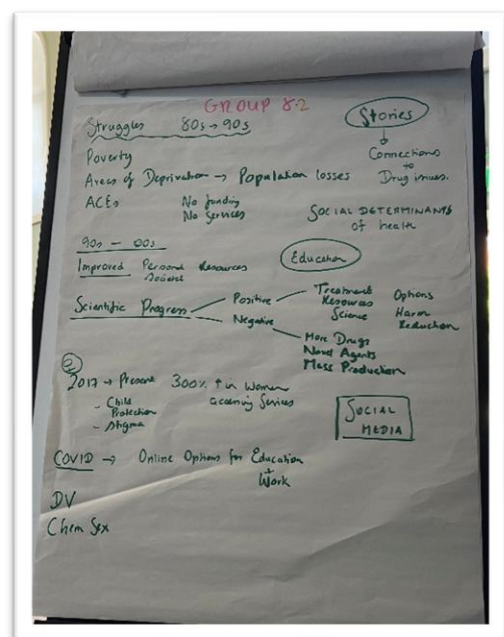
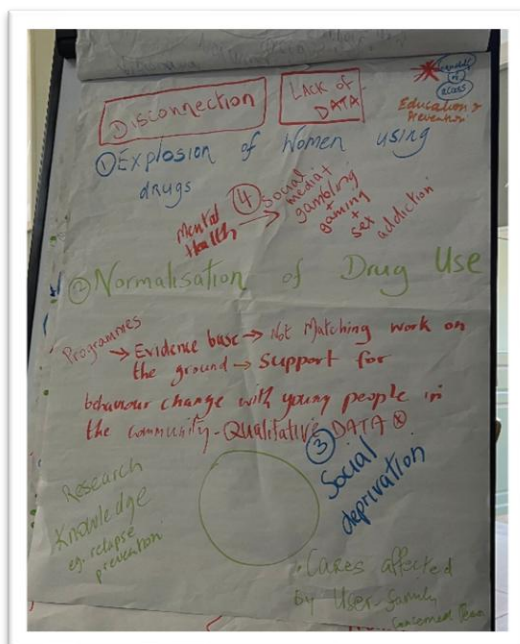


Group 4 - World Events – Global Timeline

Current situation – globalisation

World, mobilisation

- Drug market
- Equal movement
- Technology – communications – social media; impact on €\$£
- Celtic tiger
- Brexit
- Emigration to immigration



'80 – early '90

- Unemployment
- Recession
- Famines globally
- Troubles
- British Empire – colonialism
- Implications
 - Poverty – trauma – drugs and alcohol
 - Access to services?
- Social evolution operating how society works
- Policy not supporting those that need?
- State gave power to sections/sectors of society



All Periods Leave People Behind

	Impact
Colonialism EEC War on Drugs (USA)	Inequality Free markets Emigration Poverty 1977 Misuse Drugs Act HIV - AIDS
Internet / mobiles ARTS – culture - sport	Easy access Belief and identity MTV
Celtic Tiger	Income Services ‘wealthy’ Services ‘poor’ Cocaine Cap – inequality Homeless – MH – addiction
Music Covid	Global power – impact mobilisation information – narratives Loneliness – exasperated existing issues

Group 5 – Response to Drugs and Alcohol Timeline

1986 + before

1977 Misuse of Drugs Act / UN/ODC

- Dublin centric view – focus on young men, disadvantaged areas and heroin
- No focus alcohol – seen as cultural norm
- Services started 70’s + 80’s
- Other drug use not acknowledged
- Illegal to be gay
- Institutional abuse
- Mass emigration – recession
- AIDS/HIV

1990 ->

- HIV/AIDS – response, services opened early 90’s
- RAVE
- Opiate crisis in communities
- CAD and Marches / Merchants Quay opened
- Citywide Est



- Veronica Guerin 1996
 - Rabbitte Report 1996 – 1st recognised need for community response (comm)
 - CAB launched
 - 1997 First Drugs Task Force / 13 were established
 - 2003 Regional DTF expanded
 - 2000 – Power Point – 1st drug and alcohol programme for Travellers
 - 2001 – 1st National Drugs Strategy
 - Minister for Drugs / Taoiseach's Office responsibility
 - NDST Team

2000 +

Emergency of Social Media Use

- Gangland murders and feuding: Limerick / W Dublin / Crumlin ~ Drimnagh
- Emergence of NPS / Head Shops – very low quality – MDMA – slow response
- HSE established in 2025
- Austerity and impact on families/services, etc; demise of CDPs
- Treatment focus of National Drugs Strategy
 - 2007 -> detrimental to prevention
 - No alcohol focus / drugs.ie established
- NDST disbanded – no progress
- Naloxone / Comm detox / needle exchange
 - Tablet culture emerged / crack 2016
- 2017 National DA Strategy
 - First mention of alcohol and health promotion approach
- Public Alcohol Health Bill
- Regency Hotel

Chem det -> GHB

2020

- Covid 19 and impact of same
- Citizens Assembly 2024
 - Dual diagnosis
 - Recovery Academy
- Joint Oireachtas Committee Report
- Drug market changed – synthetics, vaping
- Safey Nightlife Programme
- Nitazenes
- MSIF
- OAT progress



- Safety consultations





Group 6 – Response to Drugs and Alcohol Timeline

- Policy development went through significant change, from punitive, criminal approach to post – RABBITTE (1996) to a >humane policy, a more mature society.
- Diverse communities (eg LGBT) emerge at midway point
- RAVE mentioned but not new as significant (affect perception of heroin as a ‘come down’)
- Alcohol appears, but very separate. However, unawareness of alcohol-related harm much more recognised
- No cocaine prior to 2000. Significant that cocaine and other stimulant not reflected on board
- Mid 1990’s+, seen as idyllic, timing, hope and action. HIV decrease, etc very positive
- Shift in societal attitude: delinquency -> health issue
- Problem outside Dublin not recognised. 8 Dublin DTEs; 1 in Cork. Very much a Dublin issue and preparation not made for emergence of problem in rest of country. Does not recognise shift in link to deprived communities. Cannabis, stimulants etc not classified

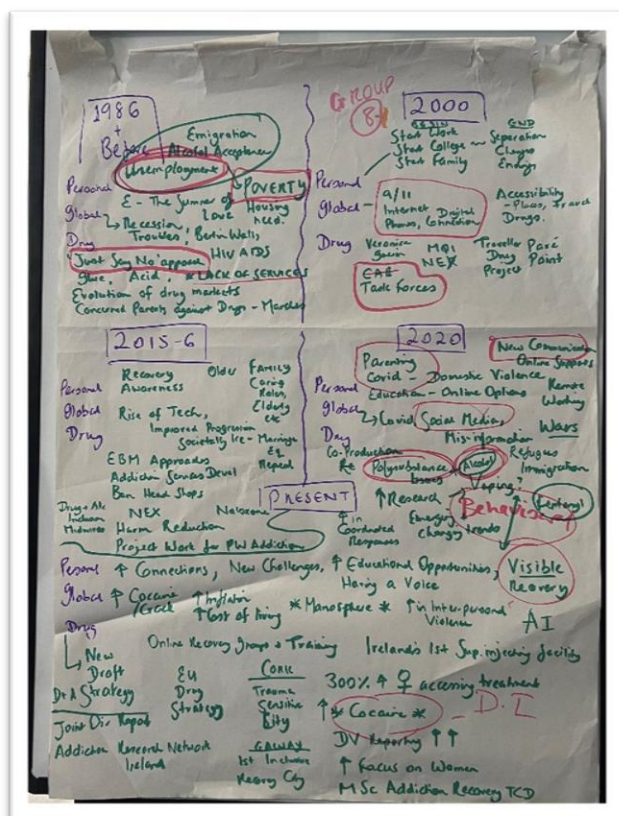


Group 7 – Report on All Three Timelines

1. Across the three time-lines, tell a story of the connections you see
 - Clear link between economic cycles and addiction in communities
 - Personal story – recreational use
 - Products of where we are born into
 - Always reaching – no foresight
 - Lack of treatment options – prevalence of blood borne viruses
 - Few vs the many
 - Growing complexity both the issues and the responses
 - Identity – there's an individual – has been recognised as time gone on
 - Strong class element – initially working-class area problem
 - Class based analysis to the early part of the drugs response – we've moved away from it
 - Need to get ahead – not be reactive
 - If we focus what we are doing good and invest in them
 - Use data to improve needs in communities
 - Address core driver of addiction
 - Poverty, early school leavers, ACE's imprisonment, intergenerational trauma etc
 - Health promotion
 - Collaboration
2. Breath of the influences on substance issue – not just health issues – health led
 - Cultural values – stripped bare
 - Nobody is shocked anymore
 - Lack of treatment options / social conservatism
 - Drugs have different effects on behaviours / psychology – need different responses
 - Need to look at protective factors
 - What could we strengthen to build resilience, universal response
 - Knowledge and understanding of communities
 - Takes a village to raise a child



Group 8 – Report on All Three Timelines



1986 + before	2000																														
Personal - Emigration - Alcohol Acceptance - Unemployment - Poverty - E – The summer of love - Housing needed Global - Recession - Troubles - Berlin Wall Drug - HIV/AIDS 'Just say no' approach - Glue - Acid - Lack of services - Evolution of drug markets - Concerned parents against drugs – marches	<table><thead><tr><th>Begin</th><th>End</th></tr></thead><tbody><tr><td>Personal</td><td></td></tr><tr><td>Start work</td><td>Separation</td></tr><tr><td>Start college</td><td>Change</td></tr><tr><td>Start family</td><td>Endings</td></tr><tr><td>Global</td><td></td></tr><tr><td>9/11</td><td></td></tr><tr><td>Internet</td><td>Accessibility</td></tr><tr><td>Phones</td><td>- places, fraud</td></tr><tr><td>Digital connection</td><td>Drugs</td></tr><tr><td>Drugs</td><td></td></tr><tr><td>Veronica Guerin</td><td>Traveller drug project</td></tr><tr><td>MQI</td><td>Pavee Point</td></tr><tr><td>NEY</td><td></td></tr><tr><td>Task Forces</td><td></td></tr></tbody></table>	Begin	End	Personal		Start work	Separation	Start college	Change	Start family	Endings	Global		9/11		Internet	Accessibility	Phones	- places, fraud	Digital connection	Drugs	Drugs		Veronica Guerin	Traveller drug project	MQI	Pavee Point	NEY		Task Forces	
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MQI	Pavee Point																														
NEY																															
Task Forces																															



2015-6	2020
Personal • Recovery Awareness • Older family caring roles • Elderly etc Global • Rise of Tech • Improved Progression • Societally Ire – marriage equality Drug • EBM Approaches • Addiction Services Development • Ban Head Shops • Drug & alcohol inclusion midwives • NEX • Naloxone • Harm Reduction • Project Work for PW Addiction	Personal • Parenting • New communication online support • Covid – domestic violence • Education – Online Options • Remote working Global • Covid • Social Media • Misinformation • Wars Drug • Co-Production • Polysubstance use issues • ↑ Research • Alcohol • Vaping? • Behavioural • Fentanyl • Refuges • Immigration • Emerging and changing trends Other notes • Domestic Violence • New Communication • Online Supports • Remote Working • Wars • Refugees • Immigration • Energy changes trends • AI
Personal • ↑ Coordinated responses • ↑ Connections • New Challenges • ↑ Educational Opportunities • Having a voice • Visible recovery Global • ↑ Cocaine / Crack • ↑ Inflation • ↑ Cost of living	



- Manosphere
- ↑ Inter-personal Violence
- AI

Drug

- Online Recovery Groups + Training
- Ireland's 1st supervised injecting facility
- New Draft D&A Strategy
- Joint Dir Report
- Addiction Research Network Ireland
- EU Drug Strategy
- Cork - Trauma Sensitive City
- Galway - 1st Inclusive Recovery City
- 300% ↑ women accessing treatment
- Cocaine - DI
- DV reporting ↑↑
- Focus on women
- MSc Addiction Recovery TCD



Struggles (80s → 90s)

- Poverty
- Areas of deprivation → Population losses
- **Stories** - Connections to drug issues
- ACEs - No funding / No services
- Social Determinants of Health

90s – 00s

Improved

- Personal resources
- Societal
- Education

Scientific Progress

Positive

- Treatment
- Resources
- Science
- Options
- Harm reduction

Negative

- More drugs
- Novel agents
- Mass production

2017 → Present

- 300% ↑ in women accessing services
- Child protection
- Stigma

Social Media

COVID

- Online options for education + work

DV

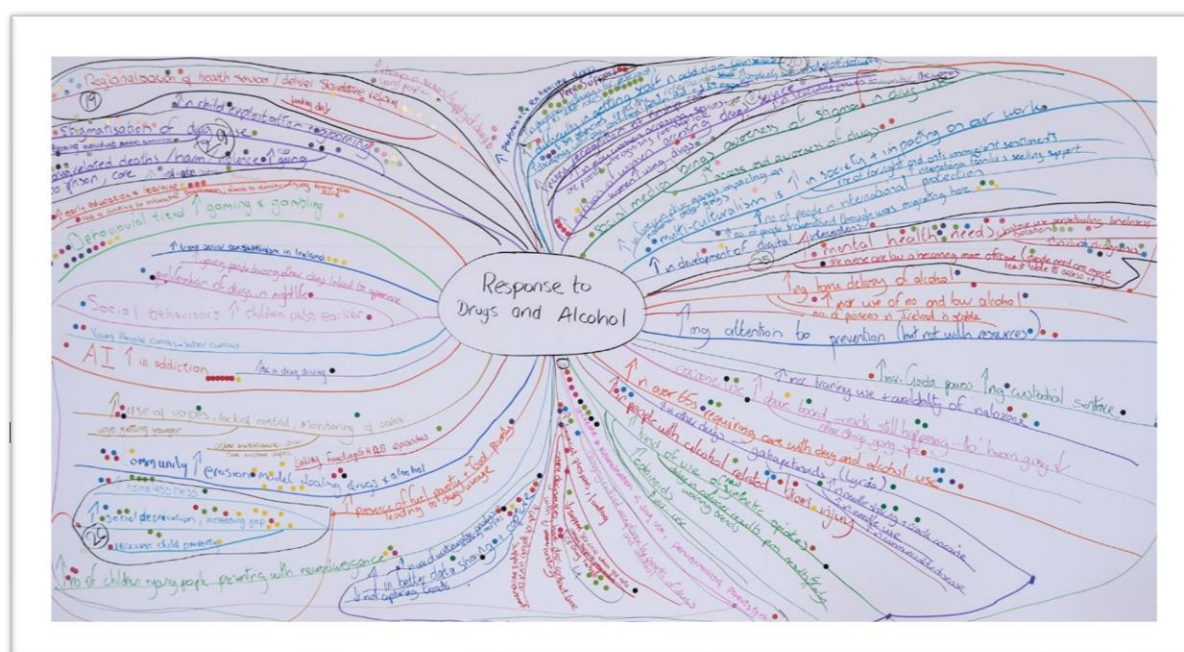
Chem Sex

FOCUS ON THE PRESENT – EXTERNAL TRENDS

All participants helped to create the mind map of trends affecting our response to drug and alcohol use. As trends were identified they were scribed onto the map and linked where participants identified links. The question used to create the content of the map was:

What are external trends affecting our response to drug and alcohol use that we need to be aware of?

Once completed, participants put dots onto the mindmap to indicate what for them was the highest priority.





Emerging Key Trends from the Mindmap

- 26 dots - Social deprivation, increasing gap / increase child poverty
- 25 dots - Mental health need > substance use, with homelessness / isolation / incl. diagnosis
- 21 dots - Stigmatisation of drug use / drug-related deaths, harm, violence
- 20 dots - Difficulty in getting staff in addiction services
- 19 dots - Regionalisation of health services / Sláintecare reform



FOCUS ON THE PRESENT – STAKEHOLDERS

In the next phase of the workshop, participants turned their attention to the present. The purpose of the “How Trends Affect What We Do” session was to help interest groups make connections between the key trends they had identified and their current work in responding to drug and alcohol use in Ireland. Each group selected the trends of greatest concern to them, mapped how these trends were related, and considered what they are already doing, individually and collectively, in response. They also named what they are not yet doing but want to do. This enabled participants to see patterns across



the system, rather than treating each trend as a separate issue, and to begin identifying where current action is strong and where further work is needed.

Participants then worked on “Prouds” and “Sorries”, a task designed to support shared responsibility for the present. In interest groups, they identified what they are proud of in their current contribution to Ireland’s response to drug and alcohol use, and what they are sorry about in terms of actions not taken, opportunities missed or ways of working that need to change. The emphasis was on ownership rather than blame. Groups selected their most significant prouds and sorries and reported these to the whole group. Together, these two sessions helped build a shared picture of current realities: what is already being done, what people value and want to build on, and what participants recognise needs to be faced more honestly as the work moves forward.

Community Voluntary Group – Focus on the Present

Staff

- Skills, pay, retention, recruitment agencies competing for staff eg Tusla
- Create pathways for peer workers
- Focus on hiring ‘project workers’
- Use community development training to have new workers
- Need Urrús back (level 7)

What are we doing now?

- ACI is useful
- Agencies developing staff themselves through education
- Services developing and sharing their own training
- HSE funded train the trainer

What do we need?

- In person Level 7 -> university partnerships/Urrús
- Recognition of community services
- Create pathways for peer workers
- Take pathways for peer workers
- Take community development approach to training staff
- Stand-alone work force development strategy
- Stand-alone trainers



Women with children accessing services

- Whether they have their kids or have lost their kids they need gender responsive care
- Feedback is that they'll bring their kids but not to something labelled addiction centre

What are we doing now?

- Ashley House – also responds to child
- Gender specific services especially in regions eg Wexford
- Janes Place and the gender specific funded roles
- Ballyfermot family services – wide range
- Community good practice – on limited resources
- Drug liaison midwives – need engagement with Tusla

What do we need?

- Less stigmatised services – now down alleyways
- Need equity of access to gender responsive services with childcare in women's own community
- Recognition of the work, community, agencies do for women
- Childcare in the treatment

Parity of esteem for community-based services

What we have

- Funded to take on work with lower resources and high case loads
- Professional inequity
- Struggle for pay parity

What we need

- Recognition that we are best placed as the first option to do certain specialist work
- Equality when around case work
 - Service design tables with statutory
- Equal pay, terms and conditions and training



Criminalisation

Stigma and blame

Drug use / trauma

Health led / alternative to short sentences for non-violent crime (drug related)

Short sentences lead to more trauma, more stigma, more barriers (employment, travel, education), family breakdown



Proud

- Lengths community services go to, to innovate and respond to the impact of drugs and alcohol on people, families and communities
- The ongoing commitment of staff, support vast numbers of people, families and communities even with limited resources
- Improvements in standards of care and impact

Sorry

- Large national organisations dominating services that subsume small local initiatives
- Not including lived and living experience in decision making structures
- People slipping through

Community Services

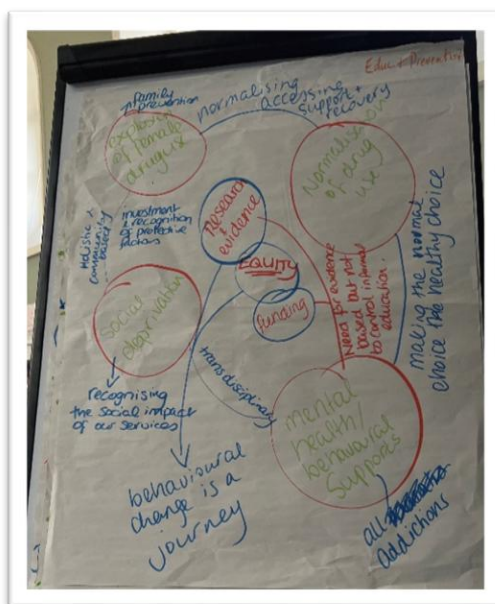


Proud

- Lengths community services go to, to respond (and remain agile) to drug and alcohol use
- Number of people supported with the resources made available (shoestring)
- Innovation – coming from services responding on the ground
- Commitment of services and staff teams

Sorry that

- Have not focussed meaningfully on recovery
- Waitlists – inequality of access
- Dublin-centric services (spokespeople)
- Disparity in services – Dublin / Regional
- Not meaningfully including people with lived + living experience (usually used to promote services – need to be part of decision making)
- Services pitted against each other for funding causes territorial silos
- Large national organisations – community dominating
- The people who slip through



DATF Group – Focus on the Present

Trends

- Regionalisation
 - Funding in one pot



- Erosion of independent
- Health Board model not optimum before
- Need explicit mention in Policy
- Concern over loss of functioning model eg, TF's – what is one role then?
- Youth
 - Grooming – DRI/gangs -> couriers etc
 - County lines – moving to new areas
 - Prevention seems important but clarity on how it will work needed – what model?
 - Families – protective factor
- Data
 - Strong needs analysis – local
 - Include deprivation
 - Promotional data

What we're doing

- Local needs assessments
- Participating / Advocating for community / TF approach
- Lobbying Oireachtas – Citizens Assembly
- Developing responses to youth and other trends, drive, cocaine, etc, etc
- Being proactive with loads of data

What we're not doing

- Communicating successes
- Liaising with HSE around Regionalisation due to disruption/delays in implementation of Slaintecare
- Increase / improve links with community and other stakeholders especially new communities

Proud	Sorry
New responses / better responses Under 18s work Prevention work Planet youth Continuum of care Assessments Serving vulnerable communities Community violence work	External challenge Losing staff to HSE Pilot projects not continued Opportunities to intervene Outreach and N Exchange Not engaging other groups Governance Admin Box Admin time



CSP work Community policing work Linkages/glue Staying around NDS process Strong networking Recovery culture Needs Analysis	Board difficulties Annualised funding GAA research wasn't published
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Education and Prevention – Focus on the Present

All interconnected

- Equity
 - Transdisciplinary
- Funding
 - Need for evidence based but not to control informal education
- Research and evidence
 - Mental health / behavioural supports – all addictions
 - Behavioural change is a journey
- Normalisation of drug use
 - Normalising accessing support and recovery
 - Making the normal choice the healthy choice
- Explosion of female drug use
 - Family prevention
 - Investment and recognition of protective factors
 - Holistic and community based
- Social Deprivation
 - Recognising the social impact of our services

Disconnection

Lack of Data

Equity of access

- Explosion of women using drugs
- Normalisation of drug use



- Programmes – evidence based – not matching work on the ground – support for behaviour change with young people in the community – Qualitative data
- Social deprivation
 - Research
 - Knowledge eg relapse prevention
 - Cares affected by user – family concerned person
- Mental Health
 - Social media and gambling and gaming and sex addiction

Prouds	Sorries
Responsive to emerging trends (waiting for policy) Unseen difference we make Confidence due to training and making changes Success in collaboration and partnership in university setting Empowering young people Scholarship Trinity Championing prevention in my communities Pushing proper staffing – ‘boots on the ground’ Developing programmes that impact – sharing these / youth identity toolkit Leading planet youth survey - Lifestyle & behaviour (needs) Cavan	Celebrating our successes Capturing data Qual – time and money / valued Having space to listen to service user experiences Using inherited practices – fear of changing things Lack of T.I.A. - Stigma - Mandated training Stigma Accepting existing limiting system - Funding - Lack of respect - Stretching to breaking point to meet systems and expectations - Not saying no Young people – represented and consulted with respectfully and in their way



Government – Focus on the Present

- Potential of Regionalisation
 - Enhance coordination
- Funding and staffing resources
- Data and information
 - Qualitative and quantitative – lived experience
 - Interagency sharing and interdepartmental
- Preparedness and unpredictable and adaptability
- We are here – get on board
 - Pobal report
 - Aligning relevant other geographies
- Better profile of existing funding C&V strategy – multiannual +DoH to HSE – change law
- Pobal Report – PBRA
 - Data equality strategy – collaboration
 - Parent support services mapping
 - Tusla, HSE
 - Better use of existing data eg GUI work and welfare longitudinal database
- Increased monitoring eg
 - wastewater checking
 - drugs watch – coordination
 - review of prevention system
 - EUDA coordination
 - foresight exercise
- Evaluation of interventions eg prevention and treatment
 - Controlled coordination
- System of multiannual funding for C&V
- Cross departmental collaboration, research, data sharing
 - Increase awareness of services across departments

Proud	Sorries
Getting people onto schemes	Cont provide options
Prevention and interventions DCDE	Cont directly fund services
NDTRS coverage NDRD focus on prevention	NDRDI is delayed
ARNI	Valuable things not looked at
	Haven't pushed gathering recovery data



EWET Research on treatment - Inter - 1,000+ CE drug rehab places, 46 projects Drugs prevention fund	Not in every county - Need collaboration with HSE+ Should of offered training first Getting distracted
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HSE – Focus on the present

Slaintecare

- Non-health structure – how do they link?
- Regionalisation
- Funding PCCC and Acutes
- National structures
- Resources
- How does it break down to addiction?
- Social determinants of health
- Interdepartmental relationship/partnerships
- Health led but? ...
 - of authority and resources, responsibility -> TX, Homelessness, recovery, no housing

What are we doing now?

- Planning
 - Geography
 - Population
 - Resources
 - Needs based
- Advocate for appropriate
 - Senior people to empower/drive
 - Structures

Not doing but we want

- Mismatch re: regions and different domains
- Co-ordination
 - HSE
 - Interagency
 - Synergy
 - Cohesion
- Addiction
 - Resources and posts – funding coming down to regions is ring-fenced

Proud	Sorry
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Expansion of services Evidence based programmes Harm reduction work Lives saved Staff Social justice approach v stigma (dehumanising language etc) Advocates SDOH call out Collaboration nitazines approach Opening for interagency Inclusion (voices of LE) Advocacy for complex cases Advances in treatment (Buvidal, etc) MSIF Housing first U18 services Clinics progress in DD across regions	Co-production earlier Ethnic monitor of gender (push harder) Mistakes made National inconsistencies in access and provision Opioid Alcohol treatment Recruitment delays People's experience of our services (120k staff)
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Justice – Focus on the Present

All sections interlinked

Normalisation / stigmatisation • Early-stage work with communities • Education on impact ○ Individual/family/community ○ HSE/recovery awareness	Data Sharing / Early Warning National response alert group Early warning emerging trends / collaborating Safer nightlife programme Quicker legislation (controlled drugs) Review vape shops
DRI/Child Exploitation Drive/drip - collaboration Training frontline workers Whole of government - collaboration Shared resourcing Dependent on resources at local level (Task Force) Data sharing – not new	Increase in drug/alcohol related crimes leading to prosecutions/ convictions Diversion – collaboration Resource Diversionary Probation JLO Drug Court (Regional) Restorative justice Safe driving programme



Proud	Sorry (not proud)
Keeping people safe Protected from harm #5 in global policing index Diversification of supports available to people in prison/actively using options other than conviction Drive Interagency working Data collective Global leaders Early warning system Collaborative approach All-Ireland approach	AGS not carrying Naloxone and on release to prisoners Access to alternative options in the community Post release supports and planning Continuum of care



Lived Experience Community – Focus on the Present

- Progression pathways
 - Focus on community development
 - Be aware of power imbalance
- Lived / living experience roles
 - Recovery capital



- Stigma
 - Negative – structural, self
 - Positive – those that have overcome adversity
 - Rural – not accessing services
- Structural conditions: poverty, homelessness
- Mental Health: co-exist
 - Dual diagnosis
 - Impact on families
- Progression pathways / peer roles
 - Capturing the tension -> not to over professionalise
 - Power sharing to create psychological safety
 - Peers are important across the spectrum
 - Community development model
- Stigma
 - Power
 - Stigma is different depending on where a person is on the continuum – drug user, <-> recovery - it exists across the board
- Mental Health
 - Dual diagnosis – recognition
 - No implementation
 - Psych <-> A&D supp <-> Person
 - Recognition that there are barriers

Not Doing

- Listening to peers – have a recognised body/network
- Community over competition
- How do we capture the barriers to access – capacity: staff, stigma, power
- Further evidence base – research
- Variety of roles and responsibilities that Lived Exp/peers can be involved in
- Variance across continuum of care of peer work

Right now proud of

- Developing collaborations top down <-> bottom up
- Cross collaboration
- True co-production including dual diagnosis open access
- Data Collection
- Peer mentorship
- Continuity under challenges to funding and recognition



- Peer-2-peer Naloxone training in clinics
- Development of internship programme valuing peers in paid positions
- Freedom of creative control uniqueness
- Peer partnership for change framework ensures that peers are leading out on change

Sorry

- Lack of co-ordinated collaboration
 - We have limited community space - open access restricted
- Haven't advocated strongly enough for freedom to speak up more
- Time / resourcing to access the gaps to follow up on people and build relationships
- Recording requirement taking up contact time
- Capacity – part-time roles
- Skills gap – need for researcher involvement
- Took so long to register as a CLG

Marginalised Groups – Focus on the Present

Empowerment, advocacy, change, trust

- Intersectionality
 - we are the least represented focus group
 - marginalised communities face drastically higher rates of addiction yet are least represented
 - LGBTQ+, Traveller and Roma, racialised, disabled, communities, and women, need highlighted focus and funding
- Health Equity
 - The people who need the treatment the most are the least likely to receive it. Data + education
 - The system doesn't favour complex needs: disability, migration, race, transness, neurodiversity
 - Barriers to access, cultural language, stigma
- Funding
 - Robust and responsive multi-annual funding which is sensitive to the class-based and stigmatised reality of addiction in marginalised communities



- Policy to date has not effectively addressed realities for marginalised groups. We must be named, not erased

Prouds	Sorries
Participation Resilience (on org's and personal level) Person-centred, holistic approach Trust of communities in us Advocacy and developing evidence-based leadership	Not enough org's capacity Not learning from previous experience Trusting in system and political leaders Lack of scientific progress in eliminating addiction

Service Provider (Medical) – Focus on the Present

4 Trends

1) Mental Health

- Neurodiversity
- Lack of connection
- Improve collaborative working
- Change inclusion criteria addiction and mental overlap
- Culture change
 - Medical and nursing training
 - Placement
 - Modules – addiction
 - Pharmacy – structures
 - Counsellor – include addiction -> shared with key worker
- Acknowledge cocaine/other drugs

2) Regionalisation of service

- Opioid based
 - Staffing }
 - Funding } Alcohol, cannabis, cocaine, other - Benzos
 - Pathways }
- Population (deprivation-based planning)
- Data capture – new trends and response
- Digital intervention – rural access and support
- Non-medical focus -> social deprivation supports



3) **Vulnerable Groups**

- Women/pregnant
- Older population
- Adolescents
- Travellers
- Migrant
- Peer Co-designed service (not just peer represented)
- LGBTQI

4) **Staff Focus**

- Psychology, OT, Family Therapy
- Retention and MDT make-up
- Succession planning
 - Career progression nurses/pharmacists/doctors/non-clinical
 - Blended roles – clinical and managerial
- Attract new staff
 - Mentorship – digital tech
 - Incorporate into undergrad
 - GP shortage

Proud	Sorry
1) Communication of services (SE) and all areas - availability to consultant and team 2) The way we have embraced new treatments - Buprenorphine SL and Buvidal Depot - NEX, harm reduction equipment pharmacies, Naloxone, crack pipes 3) Avoidance of waiting list - accessibility - dispersing service outside of Dublin (Limerick) - Integrated alcohol service	1) Not having better treatment pathways for cocaine, cannabis etc novel agents 2) For not being able to provide holistic assessment and management for complex presentations eg neurodiversity - lack of MDT – OTs - lack of awareness from non-addiction colleagues – SWs / Psychology 3) That we have not had more meaningful engagement with service users, power imbalance - common viewpoints * Front facing HCPs * Lived experience * Marginalised groups





DISCOVERING COMMON GROUND

Regional Structures: Common Ground Agreement

In the exercise to discover Common Ground participants worked in groups to create a list of up to eight common ground elements that reflects what they believe everyone present wants. It could include values, norms, structures, programmes, and procedures that shape the regional structures and what they do.

Prevention First: A Shared Commitment Across Sectors

Preventative approach (upstream)

Prevention as a key strategy.

Educate the Public

prevention of harms

Recognition of G.P. for Preventative Role

A Whole System Approach

Health led not "Health only"

Inter-departmental

Informed Practice

Data driven delivery of service

Data collecting + sharing

Use of data + evaluation

Data Driven to Needs driven

Services able to focus on doing what works + do it well - rather than feel need

to keep doing something different + attract funds

All responses (by the structures) are evidence led

Integrated supports + use of IT

Space for innovation and sharing of practice

Foundations of Our Work / the Values we Stand For

Dignity



Respect

Equity/inclusion

Integrity

Empathy

Inclusivity + social justice - LGBTQ+, Women, Traveller, Roma, Migrants, Lived / Living experience

Stigma Eradication

Safe vibrant communities where everyone has equal opportunities

Co-production

All Ages

Human Rights Approach

Person centred

T.O.R. for Regional Structures

Standardisation of approach required for roll out of reg. structures

Structure needs to be strategic for the region

Looks at totality of needs + makes best use of resources. Stakeholder inv. is key - High level decision making

Structure needs to have high-level of accountability -> learning from Comm Safety Pship model

(political will needed)

Identify key stakeholders – interagency

tap into existing infrastructure

Framework Governance

Ongoing + meaningful consultation

Community development, Local Voices, regional structures + national

Partnership - parity of esteem

Independent Chair x6

Have clear actions + reporting/monitoring

Shared decision making process with collaboration + representation

People who use drugs (PWUD), families, communities are supported to develop + influence policy

Equity of Access

No Exclusions - "no wrong door"

Equity of Access

System should be clear - No wrong door into System.



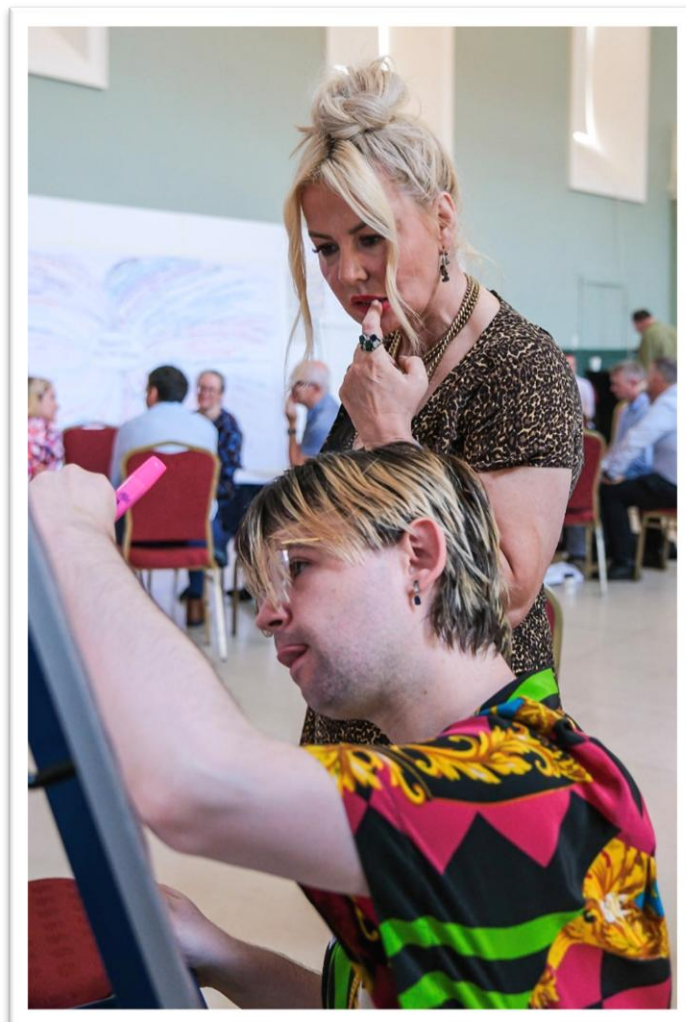
Once in system – progress from that Point - not pushed from Billy to Jack
Recognition of G.P. for Low Barrier low stigma addiction services
Accessible: times, geography

Recovery Oriented

Build + Communicate Recovery
Recovery Pathways

Invest in Your Workforce

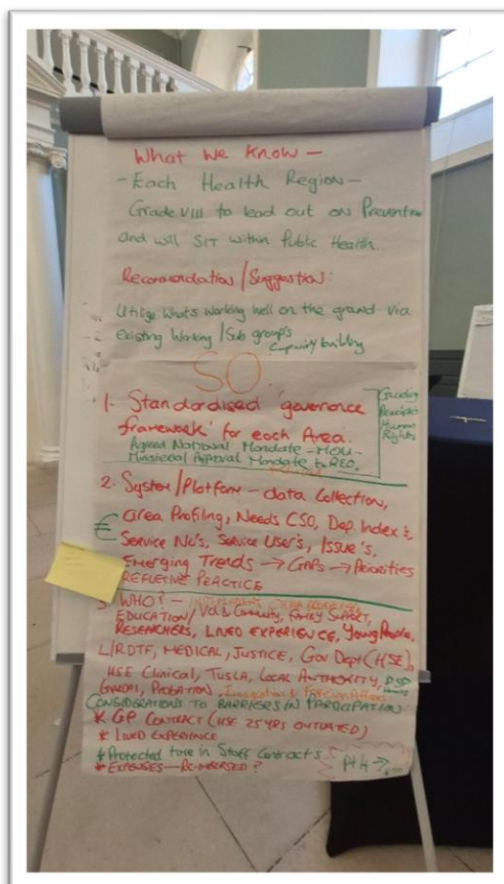
Invest in your workforce
Paid roles for Lived Experience





ACTION PLANNING

For the last session participants worked in Mixed Groups to turn the common ground into reality. They were asked to use all of the common ground agreements as raw material, to put shape on the operation of the Regional Structures. This was to include its operational and strategic features and what they proposed for making it a success on an ongoing basis.



Group 1 – Blueprint for Regional Structures

VALUES (How structure operates)

All stakeholders have shared understanding of values

Process:

communications

Human Rights

training & workshops

reflective practice

induction



supervision (internal / external)
implementation
evaluation
responding to emerging issues
accountability
ensuring balance of power within decision making + conflicts of interest

EQUITY OF ACCESS

outreach
mobile services
online
access to interpretation + translation
review of criteria + threshold
opening times
rural needs included
visibility in community of the service

WORKFORCE

minimum standards + ongoing training → mandatory
in line with “Better, Safer Care”
fidelity of best practice + feedback mechanism
reflective practice + supervision
upskilling + staff retention
S39 etc in line w/ peers in HSE

Additional notes / post-its:

include peer evaluation / impact
payment progression
voice of community
who structure to include?

T.O.R. FOR REGIONAL STRUCTURES

REO accountable to Nat structure / Minister
Alignment with the National Strategic Structure
co-ordination of all stakeholders & engaging + representing voices with equity



clearly defined roles
regional maps, assets, needs
clearly defined operational procedures
governance + independent chair appointed by the national
accountability
partnership + shared good practice
action + responsibility
integration with other structures (not to be siloed):
LCDC
CYPSC
Homeless Fora
partnerships
comm. networks

Post-its / notes:

legislation
DoJ nationally / agency of regionality / local
ToR at point of delivery
How is REO accountable
mandated nationally

RECOVERY

Recovery Hub
Build recovery communities
Lived experience (paid and vol)
stigma — culture / language - to culture of hope and inspiring people, celebrate
recovery
clarity of roles & responsibilities
peers + lived exp.
harm reduction → treatment transition → step down community → ongoing options
recovery housing → engagement with housing bodies
education & awareness of many pathways to recovery
sustained support available + accessible across continuum of care, holistic approach,
shared careplans + case management
progression pathways
training & education (attach education to role)
employment



Group 2 – Blueprint for Regional Structures

Create a framework that is underwritten by the Guiding Principle's — Prevention (Protection)

So “who” needs to be at the table?

needs to be a standardised structure across the “Area's”
with communication channels between the Regional & local structure's

What we know

Each Health Region — Grade VIII to lead out on prevention and will sit within Public Health.

Recommendation / Suggestions:

utilise what's working well on the ground via existing working / sub groups
capacity building



SO...

Standardised governance framework for each Area

agreed national mandate

MOU

Ministerial approval / mandate to REO

guiding principle: human rights

System / Platform — data collection, area profiling, needs CSO, deprivation index, service no's, service users, issues, emerging trends → gaps → priorities, reflective practice

Who?



Independent Chair, Vol. & Community, Family Support, Education, Researchers, lived experience, young people, LRDTE, Medical, Justice, Gov Dept (HSE), HSE clinical, Tusla, Local Authority, DSP, Probation, Immigration & Foreign Affairs,

Considerations to barriers in participation

GP contract (HSE 25 yrs outdated)

lived experience

Protected time in staff contracts

Expenses — reimbursed?

Group 3 – Blueprint for Regional Structures

Incl. People across system - Who is relevant to the system?

People / bodies named:

Housing

Tusla

Social

Education

DSP

Community & voluntary sector

Taskforce

Level 8 Grade?

Justice

Gardaí

IPS

Probation / diversion

Local Authority

Lived and Living Experience (with capacity building)

HSE — medical, managers

Independent Chair - skilled (rotating)

recruitment:

local level interview



DoH endorsed
not political
sits on Nat / DS comm.
quarterly + move to different regions
Operational Coordinator

Subgroup structure

prevention
data
governance / accountability
recovery
intervention

Values:

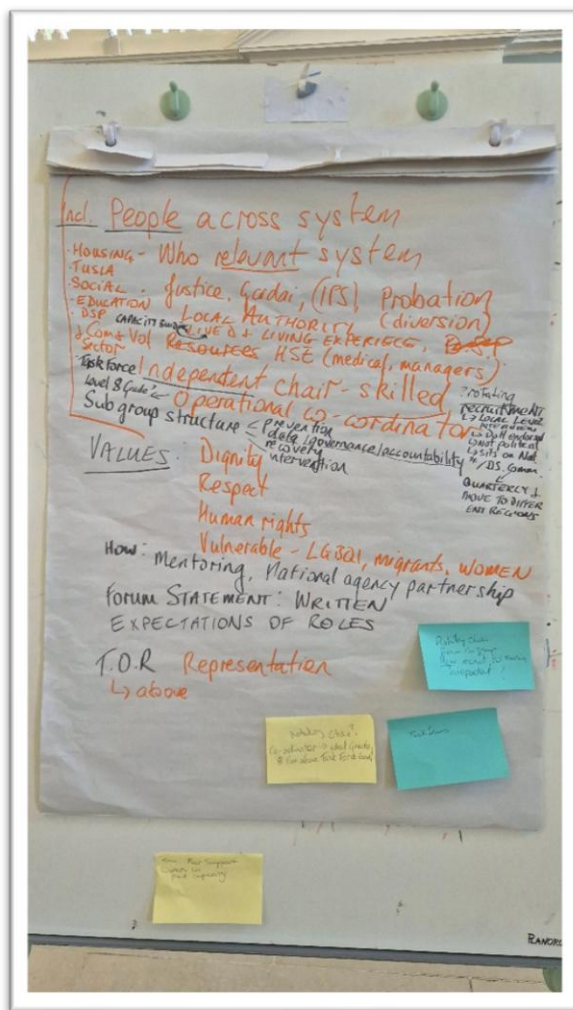
Dignity
Respect
Human rights
Vulnerable — LGBTQI, migrants, women

How:

Mentoring
national agency partnership
Structure statement: written expectations of roles
T.O.R. representation - above

Post-its:

Rotating chair?
How recruit to remain independent?
Nothing chair?
Co-ordinator → what grade, 8 or above / Task Force lead?
Task forces
Peer support workers in paid capacity



Group 4 – Blueprint for Regional Structures

Each Regional Structure will...

be accountable to ensure prevention is delivered in line with best practice

link between regional and national

Be guided via a collaborative process

be aligned with the values of DRCPG/CYI

be led by an independent chair

be aligned with Sláintecare geographies & sub-units

be data-driven to eliminate inequity

contain members from statutory bodies who have been ministerial mandated

include:

people with lived experience

families

marginalised communities

community & voluntary providers (HSE policy)

Task Forces



pay/reimburse voluntary members
be governed by a clear governance document providing consistency

Additional notes around the chart:

Local structures for involving marginalised communities
Ground up
Consistency & sharing of data
Task forces
Strong focus on statutory bodies
Avoid tokenism (annotated around lived experience)

Group 5 – Blueprint for Regional Structures

Structure Diagram

Taoiseach's Office - Minister for Health (Drugs Strategy) - Department of Health

Connected departments include (Top levels commit to process):

Department of Justice
Department of Education & Youth
DSP
Department of Children
Department of Finance

Then

National Clinical Lead
Minister for Health (Drugs Strategy)
HRB / HDS - National Threat Assessment & Early Warning

Then...

Regional - Each Region should have...

Leadership

Clinical lead in each region
Prevention coordinator
Operational lead in each region
Coordinator in each region



Membership

New people who get (s@&t) done

Include:

RHO representative
GP / Psychiatry / addiction specialist
Primary Care
Mental Health
Social Inclusion
Lived experience
Garda Regional Chief Superintendent
Local Authority
City & County Managers
Department of Education
Representatives from target groups
Tusla Regional Manager representative
Taskforce

Other notes

Workforce development
Recovery coordinator
Researcher
Early warning
Local staff group
Health & Wellbeing Scheme
Not tokenistic

Bottom:

Task Force
LCSP
LCDC
CYPSC

(Post-it)

Task Forces in Dublin must engage with HSE REOs.
Community safety partnerships
Local government
Community reps



Each Region Should Have

an Independent Chair

National Forum for planning, review & accountability

a checklist for addiction operations

Group 6 – Blueprint for Regional Structures

Membership of each Regional Structure

Main items on flipchart:

Political / Elected Representatives (several say Absolutely No! This is far more important than politics!)

Independent Chair (someone asks Who decides who independent Chair?)

Public appointment service for chair / structure

All Statutory Organisations

Task Forces

CSA

Children's / Young People's Perspective

CYPSC

Regional Structure

Clinical lead in each region

Community Services

Lived Experience of M.O.

through poverty analysis

At what level?

has to be senior decision makers

Other notes on the flipchart:

Data driving decisions not just HSE / HRS

Meeting every month? - some say thats too often

There will be substructures based on pillars?

Social Deprivation Analysis @ the table always

Governance Manual Required

Everyone has an equal vote at the table



Post-it notes on this sheet

Constructive dialogue between Local DATF's + REO / IHA Leads in HSE

REO

HSE

DSP

Housing

Justice

CHO

CA / GA

Tusla

Dept Children

Co-ordinator Operational Lead — Grade 8

Prevention Co-ordinator overseeing training, education & evidence-based interventions

Agreed representation among Task Force

Capacity building in a paid role to be in the space

Put a call out for chair — interview + select — endorsed by Minister

Marginalised communities mentioned too

Local voice included in decision making

Mandate from membership [partly unclear]

Generally decision making role? [partly unclear]

Subgroups

Bring user voice / reference as local group [partly unclear]

Group 7 – Blueprint for Regional Structures

REGIONAL FORUM

Executive: HSE Manager of:

Prevention

Recovery

Harm Reduction

Forum: meets monthly, reps:

All stakeholders

Chaired by managers?



Engagement on Forum / Taskforce for statutory partners mandated at high level.

Investment in bringing individuals to the table who have a mandate to represent all voices from their area.

Incl. community, lived exp, young peoples, new communities, lesser-heard voices.

Group 8 – Blueprint for Regional Structures

National / Regional / Local diagram

Diagram includes:

Level 1 — Government

Level 2 — NIMC

REO (between Regional and National as a link)

Independent Chair

Forum — All Stakeholders

assess need + response to need

Prevention Lead

Clinical Lead

mix of Sec 39 + HSE prevention projects / workers

Project Sec 39 Service Providers

HSE Service Providers

PWUD (People Who Use Drugs)

Population Need

Additional notes:

treatment

harm reduction

recovery

equitable

visible

value staff and service users



DoH / DoJ / DoE / Regional Forum diagram

Diagram includes:

DoH
board
HSE CEO
REO
IHA
CHO / CHN
DoJ
DoE
Regional Forum
Regional + Local
TF
HSE
C&V
Youth
Education
Community
local reps

Post-its / notes:

does Forum carry out actions of what need / coming from pop?

Independent chair

prevention represented on regional table

Task Force model should be built into the structure with equal authority + responsibility

how actionable — who's responsible

Task Force coordination role

engage with CSO re administrative data

how do LDATF fit?

Taken together, the diagrams describe this operating picture:

- Government / national structures provide mandate, direction and accountability.
- REO links the national structure to the regional structure.
- Regional Forum / Regional Structure brings all stakeholders together.



- Independent Chair supports the Forum's governance and independence.
- Prevention Lead, Clinical Lead and HSE management roles connect prevention, treatment, harm reduction and recovery.
- Task Forces, statutory partners, C&V, community, youth, local reps and service providers are represented.
- Population need and data inform the work of the Forum.
- Provider / frontline services deliver and respond to identified need.
- Local structures and representatives connect the regional structure to communities.
- The system works both ways: national mandate and accountability flow down; local need, data and community experience flow up.





Attendees

Organisation	Name	Surname
Alcohol Forum Ireland	Orla	Fagan
An Garda Síochana	Andrew	Lyons
An Garda Síochana	Det. Sup. Seamus	McCormack
An Garda Síochana	Sgt. Gary	Dunne
Ana Liffey	Dawn	Russell
Ballymun Drug and Alcohol Task Force	Mary	Taylor
Better Together	Laura	Hardiman
Better Together	Will	Crampton
Better Together	Sean	McDermott
Blanchardstown Drug and Alcohol Task Force	Jim	Doherty
BRACE	Dermot	King
Cáirde	Tonya	Myles
Carlow Regional Youth Service	Kathryn	Wall
Cavan and Monaghan Education and Training Board	Maureen	McIntyre
Children and Young People's Services Committee Dublin North	Mary	O'Brien
Clare Youth Service	Margaret	Slattery
Clondalkin Drug and Alcohol Task Force	Trevor	Bissett
Clondalkin Drug and Alcohol Task Force	Eddie	Mullins
Community Safety Partnership Programme	Grainne	Berrill
Coolmine Therapeutic Community	Anita	Harris
Cornmarket Project	Paul	Delaney
Cuan Mhuire	Nicola	Kelly
Department of Social Protection	Dr Dev	Singh
Department of Social Protection	Dr Teck	Tai
Department of Children Disability and Equality	Stephen	Jaffray
Department of Health	Brian	Dowling
Department of Health	Richie	Stafford
Department of Health	Jim	Walsh
Department of Rural Community Development	Deirdre	Kelly
Department of Social Protection	Oriel	Glancy
DRIVE	Siobhan	Maher
Drug & Alcohol Education Workers Forum	Sarah	Linnie
Dublin Drug Treatment Court	Karen	Dowling
Dublin North East Drug and Alcohol Task Force	Aisling	Holland
Familibase	Fiona	Kearney
FARI	Mick	Mason
Galway - Recovery City	Mags	Dillon
General Practice	Niamh	O'Brien



Organisation	Name	Surname
Health Research Board	Brian	Galvin
Health Service Executive – Dublin & South East	Lisa	Robson
Health Service Executive – National Health & Wellbeing	Dr Aisling	Sheehan
Health Service Executive – South West	David	Lane
Health Service Executive – National Social Inclusion	Joe	Doyle
Health Service Executive – Dublin & North East	Brian	Kirwan
Health Service Executive – Adolescent Consultant Psychiatrist	Bobby	Smyth
NIC Dublin LDATF	Sonya	Dillon
Health Service Executive Mid-West	Rory	Keane
Health Service Executive - National Social Inclusion	Nicki	Killeen
Health Service Executive – West & North West	Patricia	Garland
Health Service Executive – National Pharmacist	Norma	Harnedy
Health Service Executive – National Public Health	Diarmuid	O'Donovan
Health Service Executive – Dublin & Midlands	Brian	Kearney
Irish College of General Practitioners	Bernard	Kenny
Irish Prison Service	David	Joyce
Merchants Quay Ireland	Niamh	McGuinness
Mid Western Regional Drug and Alcohol Task Force	Colm	Walsh
Midlands Regional Drug and Alcohol Task Force	Michael	Durcan
MQI MSIF / Merchants Quay	Dan	Iacobe
New Communities Partnership	Tetiana	Petryshyna
North East Regional Drug and Alcohol Task Force	Nazih	Eldin
Outhouse	Caleb	O'Connor
Pavee Point	John Paul	Collins
Pobal	Martin	Quigley
Probation Service	Lena	Timoney
Recovery Academy	Claire	Naughton
S.U.P.P.O.R.T.	Joe	Buckley
St. James' Hospital	Clíodhna	Ní Cheallaigh
Student of Higher Education Institution	Aoife	Garde
Trinity College Dublin	Jo-Hanna	Ivers
UISCE	Andy	O'Hara
University of Limerick	William	O'Connor
University of Limerick	Eva	Devaney
Western Regional Drug and Alcohol Task Force	Joe	O'Neill