BLANCHARDSTOWN

DRUG

TASK

FORCE

ACTION PLAN

2001 - 2005

June 2001

Francis Byrne

Addendum

Since the attached plan was completed it has come to the attention of the Blanchardstown Local Drugs Task Force that four LDTF Actions/Projects that were mainstreamed in January 2001 in the Blanchardstown Area have not been allocated sufficient funding to allow them to implement the recommendations outlined in the notification of mainstreaming.

These Actions/Projects are:

- Blakestown/Mountview Youth Initiative
- Corduff/Mumuddart Community Drugs Team
- Mountview/Blakestown Community Drugs Team
- Hartstown/Huntstown Community Drugs Team

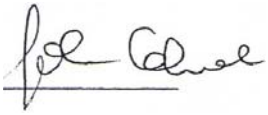
Each Action/Project has projected budgets for the year. The projections are higher that the budgets allocated in the mainstreaming process. The Northern Area Health Board does not have the resources currently to meet the shortfall.

It has been agreed at the Blanchardstown Local Drug Task Force that, once the Northern Area Health Board has agreed each of-the project budgets, one of the following options should be pursued:

(1) The extra allocation required by each of the Actions/Projects to allow it to implement the mainstreaming recommendations for the remainder of 2001 should be committed to the projects as part of this plan. The Northern Area Health Board will then include the increased Action/Project cost for subsequent years as part of its projected budgets from 2002 onwards.

(2) The extra allocation required by each of the Actions/Projects to allow it to implement the mainstreaming recommendations for the remainder of 2001 and in subsequent years should be committed to the Actions/Projects as part of this plan.

The projected increased costs for these are to follow as soon as they are agreed with the Northern Area Health Board.

Signed:  Dated: 12/6/01

John Cahill
Chairperson

BLANCHARDSTOWN DRUG TASK FORCE
Action Plan 2001-2005

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1. INTRODUCTION

Blanchardstown Drug Task Force was established in 1997 as one of fourteen Local Drug Task Forces set up to facilitate a more effective response to the drug problem in areas experiencing the highest levels of drug and in particular heroin abuse. In line with the Governments drugs policy the aim of Task Forces is to provide an integrated response to the problems posed by drug misuse. Key objectives of that policy include:

- ◊ To reduce the number of people turning to drugs in the first instance through comprehensive education and prevention programmes;
- ◊ To provide appropriate treatment and aftercare for those who are dependent on drugs;
- ◊ To have appropriate mechanisms in place aimed at reducing the supply of illicit drugs; and
- ◊ To ensure that an appropriate level of accurate and timely information is available to inform the response to the drug problem

In terms of contributing to this overall strategy Blanchardstown Drug Task Force devised and implemented its first drug strategy for the area seeking to co-ordinate all relevant programmes and addressing, through development of a range of new projects and extension of existing projects, identified gaps in service provision. Importantly the Task Force sought to develop a partnership- based approach which would harness the relevant strengths of local communities, State and voluntary organisations. Progress in respect of the first action plan (1997 -2000) is subsequently reported on in this document. Its development and delivery has had immense impact in tackling drug issues at local level whilst simultaneously providing valuable learning to be capitalised on in this plan.

The Approach:

The approach throughout the process of developing this plan (2001-2005) has been to try to ensure that the plan, in its entirety, is needs based, specifically that the plan is based on the needs of clients be they young people, drug users, families of drug users, etc.

Consistent with this principle the aim was to identify programme components, needs, activities, target groups, objectives and expected outcomes. A key advantage in this is that it seeks to show cause and effect relationships between activities and outcomes.

Systems thinking is also embedded in the approach towards development of this plan. Of particular importance has been clarification of the following systems as described by Pinkus and Minahan in describing a systems approach:

- The Client system: Those expected to benefit from the service.
- The Target system: The system that must change if goals are to be achieved.
- The Action System: Comprises people through which agreed tasks and goals are to be achieved.
- The Change Agent System: The person or group responsible for pursuing the stated objectives.

Awareness of various systems will allow actions to be focused on targets other than the client and still have demonstrable validity in addressing client needs. The plan is ultimately written from the perspective of the Task Force as the change agent. In this regard the role of the Task Force will be to assume responsibility for delivery of the plan through action systems be they agencies, projects or consortia. In the current context it is viewed as critical not only that needs are identified but that clarity exists as to who appropriately should be addressing such needs. The creation of new projects as fragmented responses to needs is viewed as inappropriate, particularly if it supplants or undermines legitimate fulfilment of that role by a more appropriate provider.

In this regard the Task Force will endeavour to maintain a balanced agenda ensuring integration and co-ordination of services to strategically address the local drugs problem, whilst developing new innovative responses of particular relevance to emerging needs.

Resources:

To do this effectively will require that adequate resources are available to the Task Force to perform the catalyst role required of it. The servicing and facilitating of the various committees and structures of the Task Force, the clarification of issues which will arise during the implementation phase, the development of good management, practices and the pursuing of key stakeholders to deliver what is included in this plan will require a co-ordinator, development worker and secretarial support being employed on a full time basis. This support team is seen as critical and of utmost importance in framing this plan.

If such resources are not available at an annual estimated cost of £110,000 then the effectiveness of this plan to tackle, at local level, what is the single biggest national ill will be seriously limited to where efforts may even prove counter productive.

2. PROCESS FOR DEVELOPMENT OF THIS PLAN

A feature of early thinking in respect of this plan was that was that it was understood to be required within a short time frame. In some respects this may have contributed to some underestimation of the work involved. Concurrently there may have been some overestimation of this Task Forces degree of preparedness in undertaking the task. Addressing the task accordingly required some re-negotiation of the time frame, was iterative, requiring a series of reviews of approach and ultimately flexibility.

It was established during the process that the plan would be meaningful and useful in direct proportion to the extent to which it reflected the considered contribution of key stakeholders working together in a process and ultimately resulting in a shared understanding and agenda.

In this regard the Task Force, with approval of the National Drug Strategy Team, engaged in a lengthened process incorporating extensive engagement by Task Force members and sub groups in clarifying issues, gaps in services and appropriate actions, The current plan reflects the contribution of Task Force and Sub Group members who committed significant time and energy to this process and who consequently should possess a greater degree of ownership of the plan and responsibility for its implementation.

The following elements of the process contributing to the plan can be itemised:

- Review of Task Force Processes (Community Action Network: May 2000)

  The purpose of this review, which was attended by 19 members of the Task Force, was to:
  - ◊ Look at the Task Force itself, its membership, systems and structures and identify what each member brings to the Task Force.
  - ◊ To build on strengths identified.
  - ◊ To develop strategies to address weaknesses and gaps in the Task Force.

- Review of Blanchardstown Drug Task Force individual Project evaluations, (NDST 2000)
  Initiated by the National Drug Strategy Team, Task Force projects were externally evaluated and reported on. Recommendations from this process were incorporated into the mainstreaming process. Findings and knowledge gained from this process formed an important backdrop for the formation of this Plan

- Mainstreaming processes. (2000) which facilitated identification of additional actions and resource issues.

- Community consultation/invitation for proposals. (BDTF July 2000)

  The Task Force called for submissions and proposals to be considered in the development of the plan from any group or individual working with or having an interest in any area of drug misuse (see appendix). In excess of thirty written responses were received to this call.

- Review and analyses of Blanchardstown Area Partnerships Social Inclusion Plan 2000-2006 affording a focused socio-economic profile of the area and identification of social exclusion issues.

- Agency consultations by an external consultant. (September/October 2000)

The consultant briefed with the writing of the plan met with key agency personnel **to** explore their understanding of the nature and extent of the local drug problem, to explore their role, identify services and any development plans in train. This was with a view to assisting in identification of gaps and opportunities for synergy of supports within and across the Task Force. Agencies consulted with included:

- Northern Area Health Board
- FAS
- Fingal County Council
- Probation and Welfare Service
- Gardai Siochana

- Consultation with mainstreamed Task Force projects to identify updated needs/proposals. (January 2001). This element which was responded to by all mainstreamed projects sought to:
  - ◊ Ascertain the impact/development as a result of mainstreaming.
  - ◊ Identify unmet needs.
  - ◊ Furnish additional proposals in response to identified needs.
  - ◊ Develop a preliminary costing of additional proposals.

- Facilitated sub group workshops. (October 2000 - March 2001)
  These workshops sought to develop in respect to each theme a clear understanding of the main components of service responses, development of a clear picture of needs and gaps in service, formulation of process and short term objectives, identification of long term outcomes and performance measures as appropriate. A series of facilitated workshops were conducted with each of the following groups:
  - Education/Prevention Sub Group
  - Health Sub Group
  - Rehabilitation Sub Group
  - Supply/Control Sub Group
  - Planning/Evaluation Sub Group

- Analyses of third party consultation processes & reports by:
  - West Blanchardstown Integrated Drug Prevention Plan: A Submission to Young Peoples Facilities and Services Fund (1998)
  - GBRD Drugs & Community Research Report (March 2000)
  - Evaluation of Local Drug Task Force Projects (Policy Research Centre of the National College of Ireland, September 2000)
  - Blanchardstown Advocacy Group: Patients Charter
  - External Review of Services For "The Eastern Health Board" (January 2000)

3. PROFILE OF BLANCHARDSTOWN TASK FORCE AREA

The Task Force Area is described hereunder in terms of its socio-economic and demographic profile. Much of this analyses has been drawn from work undertaken by Blanchardstown Area Partnership in preparation for its Social Inclusion Plan 2000, Additional analyses is drawn from West Blanchardstown Integrated Drugs Prevention Plan - A submission to The Young People's Facilities and Services Fund (October 1998). The latter was prepared by Manahan and Associates on behalf of a Local Development Group on which Blanchardstown Drugs Task Force, County Dublin VEC, and Fingal County Council are represented.

The Area:

Blanchardstown Drugs Task Force has operationally defined its area remit as Blakestown (Huntstown/Hartstown), Corduff, Coolmine (Blakestown/Mountview) and Mulhuddart. This area is seen as part of Greater Blanchardstown. It is important to bear in mind that Designated Electoral Districts (DEDs) are used only in an electoral context and are not definitions of areas in common currency. Given that the statistics are tabulated on the basis of DEDs, as well as from 1996 Census reports, they are, best seen as indicative of the area rather than as precise measures of the current situation.

Features of the area:

As an area Blanchardstown has experienced considerable growth since attaining "New Town" status in the 1972 County Dublin Development Plan. The Greater Blanchardstown area has grown from a small rural village of less than 3,000 people in 1970 to in excess of 38,600 in 1996. Most of this growth has been witnessed in the Task Force area, which, in 1996 accounted for in excess of 75% of the Blanchardstown population. More recently, despite a modest growth rate during the early 1990s an accelerated growth rate was seen from 1996 and it is now estimated that the current population lies in the region of 50,000.

Population size and growth in terms of the specific DEDs within the Task Force catchment area is mapped below:

DED	POP.	GROWTH 1986-96	GROWTH 1991-96
Blakestown	15131	53%	27.10%
Coolmine	7969	2%	-0.78%
Corduff	4725	-8%	-7.57%
Mulhuddart	1245	15%	-5.90%
Tyrellstown	1473	450%	26.98%
Total 30543			
Blanchardstown		18%	7%
Fingal		21%	10%
Dublin	1058264	4%	3.21%
State	3626087	2%	3%

Source: 1996 Census of Ireland

Gender Distribution for the Task Force area is reflected as follows:

DED	1996		1991	
	Male	Female	Male	Female
Blakestown	7308	7823	5779	6126
Coolmine	3946	4023	3953	4079
Corduff	2299	2426	2476	2636
Mulhuddart	601	644	651	672
Tyrrelstown	662	811	537	623
Total:	14816	15727	1:3396	14136
Dublin	508,966	549,298	492,432	532,872

Assuming reasonable economic conditions a population growth of 3.5% to 4% is expected possibly extending to near 6%. The 1999 county development plan states that the ultimate target population is 100,000 (although Blanchardstown Area Partnership cites re-evaluation of this figure upward up to 125,000). It is clear that Blanchardstown will continue to be one of the main population growth areas in Dublin for the next six to ten years. The rate of growth, in excess of three times the rate for the Dublin Region, will continue to have significant implications for planning service provision, transport and local development. *(Blanchardstown Area Partnership)*

Past development features have included the construction of large numbers of Local Authority housing estates which have subsequently evidenced a high prevalence of single parent households, a high prevalence of unemployment, and high deprivation ratings. The entire wards of Tyrrelstown, Mulhuddart, Coolmine and Corduff are entirely or mostly comprised of housing estates with very high levels of social and economic disadvantage. Notably the Ministerial Task Force on Measures to Reduce Demand for Drugs (1996, 1997) acknowledges the existence of a direct link between social and economic disadvantage and drug use. Reflecting the extent of disadvantage two the aforementioned DEDs Tyrrelstown and Mulhuddart and part of Corduff DED have been included in the recently announced RAPID programme. Relative deprivation nationally for the Task Force DEDs is mapped as follows:

Relative Deprivation Nationally:

DED	DEPRIVATION RANK SCORE	
	1996	1991
Blakestown	2	3
Coolmine	10	9
Corduff	9	10
Mulhuddart	10	10
Tyrrelstown	10	10

Youth Population:

Blanchardstown has a significantly younger age profile compared to the rest of the state. This clearly skews the demand for different social services compared to the average profile of demand in urban Ireland. In Blanchardstown some 32% are under 15, 19% aged 15 - 24, whilst only 3% are aged over 65. The youth population is distributed as follows in the Task Force area:

Percentage Share of Population: 1996

	Pop.	**0-4**	**5-9**	**10-14**	**15-19**	**20-24**	**0-24**
		%	%	%	%	%	%
BIakestown	15131	10.8	11.8	11	7.4	5.6	46.59
Coolmine	7969	8.5	10.5	14.5	13.8	9.2	56.57
Corduff	4725	7.9	10.8	13,5	14.6	9.4	56.14
Mulhuddart	1245	11.1	17.5	21	12.7	5.3	67.71
Tyrrelstown	1473	15.3	20	15.9	6.6	5.4	63.24

A relatively high youth dependency ratio is evidenced and distributes social burdens quite differently than a normal dependency ratio, i.e., a relatively high level of financial pressure on families. In relation to the Task Force area the dependency ratios are mapped as follows:

Youth Dependency: 1996

DED	**Dependency Ratio**	**Youth Dependency Ratio**
BIakestown	0.56	0.52
Coolmine	0.55	0.52
Corduff	0.52	0.49
Mulhuddart	1.02	1.0
Tyrrelstown	1.33	1.09
Dublin	0.47	0.32
State	0.54	0.37

This necessitates the need for a very different profile of social service provision in the area compared to the state or city average. What is clear is there exists a high youth population, e.g., 67% and 63% under the age of 24 in Mulhuddart and Tyrrelstown respectively, and also notably high in Coolmine and Corduff at 56% and BIakestown at 46%. It is clear also that a high youth population can be predicted over the life-span of this plan with significant numbers in high risk age groups.

Whilst it will be imperative to analyse 2001 Census data at an early date the above observations are made in the context of each age cohort having moved into the next age bracket at point of developing this plan. This crude mechanism has taken account of the on-going expected population growth over coming years.

Unemployment:

A high level of unemployment remains in Blanchardstown and particularly so within specific DEDs where figures rising to 40% and 45% in some areas is evidenced. Young people aged 15-24 are particularly over represented in the unemployed numbers and again more alarmingly so in some areas.

DED	Unemployed	Over 2 yrs	Over 1 yrs.
Blakestown	10%	4%	5%.
Coolmine	32%	13%	16%
Corduff	28%	13%	16%
Mulhuddart	40%	21%	23%
Tyrrelstown	45%	19%	23%
G'Blanchardstown	18%	7%	9%
Fingal	11%	4%	5%
Dublin	15%	6%	7%
State	15%	6%	7%

Source: 1996 Census

Age cohorts as a percentage of total unemployed

	15-24	25-34	35-44	45-54
Blakestown	19.8	31.1	26.9	16.3
Coolmine	25.4	23.3	30.4	17.6
Corduff	26.8	22.5	23.3	21.8
Mulhuddart	30.4	19.2	36.8	10.4
Tyrrelstown	24.5	39.0	24.4	8.8
G'Blanchardstown	25.3	26.0	26.7	17.0
Dublin	22.7	28.3	21.9	17,3
State	20.8	27.3	23.3	18.8

Source: 1996 Census

Significant decreases in unemployment have been evidenced since 1996. The FAS Dublin North Regional Plan 2000 cites 44.2% reduction in the numbers unemployed in the Dublin l5 area from July 1996 to December 1999. On-going positive economic trends and the new town centre played a role in this reduction at local level, but

unemployment estimates at between 7 % and 9% remain significantly higher, perhaps as much as twice that of the National average. In the most disadvantaged DEDs of Tyrrelstown, Mulhuddart, Coolmine and Corduff unemployment and particularly long -term unemployment are above state averages and remain a source of grave concern.

Lone Parents

The number of lone parent households is significantly higher than the Dublin (12%) and Fingal percentages and in some districts twice and three times that percentage is evidenced. Two DEDs have exceptionally high numbers of single parent households, Tyrrelstown (35%) and Mulhuddart (29%), while two others, Coolmine (21%) and Corduff (21%) have quite high numbers. These statistics are presented in an appendix to this document. Fingal County Council has 363 lone parents on its housing waiting list as at April 2000, of which 266 have indicated Blanchardstown as their first preference. In many instances these single family units had more than one child.

The above statistics indicate an unusually high demand for childcare in the Blanchardstown area and this is expected to remain a persistent need. The absence of subsidised childcare entails most people on modest incomes having to rely on the informal economy, the social economy, or family and friends for their childcare. Absence of childcare adversely affects take up of employment, training, education and development opportunities.

Education:

On the broader educational front particularly high early school leaving rates have been recorded in some DED areas despite the overall rate for Blanchardstown being lower than the Dublin rate whilst higher than the Fingal rate. Again the same specific DEDs reflect consistently bleak profiles. It is speculated that abundant availability of part time Jobs may worsen the early school leaving problem or at least damage academic performance. Some DEDs have very low third level participation rates.

Age education ceased - percentage of total population:

	Less than 16	Greater than 19
Blakestown	29.0%	9.5%
Coolmine	42.9%	7.0%
Corduff	44.4%	4.2%
Mulhuddart	61.7%	2.2%
Tyrrelstown	54.3%	1.8%
G'Blanchardstown	33.5%	10.3%
Dublin	48.9%	18.7%
State	34.5%	14.7%

Large variations are evident within this table. Mulhuddart and Tyrrelstown are the most disadvantaged although Coolmine and Corduff have very low levels of educational participation. Evidence suggests that abundant availability of part-time jobs may be worsening the early school-leaving problem.

Travellers:

Statistics from Fingal County Council (March 2000) indicate 202 Traveller Families in the Blanchardstown area. This implies an approximate Traveller population of 885 people. Though this number is small relative to the overall population of Blanchardstown it is imperative to recognise the degree to which they are socially and economically disadvantaged and alienated from essential services and supports. As a group they experience high degrees of unemployment, low levels of education and frequent exclusion from social and recreational opportunities. Travellers have a lower than average life expectancy, experience higher levels of ill health, suffer the highest levels of infant mortality in Irish society, and tend to have larger than average numbers of children per family. Most Traveller families in the area live in temporary or unofficial halting sites. Given the compounded nature of disadvantage experienced by Travellers the Task Force will endeavour to consult extensively with them in determining their needs and developing appropriate responses in relation to drug issues.

Homelessness:

The report "Think Twice: Homelessness in Blanchardstown", February 1999 (Blanchardstown Area Partnership/Blakestown Mountview Youth Initiative) found that thirty individuals were identified as homeless in the Blanchardstown area during a three week survey period. A further three were identified as at risk of becoming homeless. This is an alarming number in itself but of even greater concern given the number of persons unlikely to seek services and given that drugs was the greatest cause of homelessness, accounting for some 24% of cases.

Refugees/Asylum Seekers:

The actual number of persons falling into this category is difficult to assess though some 350 persons are recorded in NAHB accommodation. On the basis of Blanchardstown having relative availability of rented accommodation in the middle-price range, and owing to the Health Boards disposition to place such persons in rented accommodation, Blanchardstown Area Partnership assess it is reasonable to expect that there will be an increasing proportion of the local population being accounted for by refugees and asylum seekers over the next few years. Whilst this target group will have many and varied needs it is premature to assess the degree to which drugs will become an issue. Given the compounded nature of disadvantage experienced by this group it will be important that their needs are monitored.

4. PROGRESS IN IMPLEMENTING PREVIOUS PLAN

Blanchardstown Drug Task Force's first plan was developed not just to deal with the immediate needs of active chronic drug abusers in the short term, but to compliment and integrate services in the community. It aimed to set up measures that were educative and preventative in addition to those measures that would support drug users gain access to appropriate treatment responses. Treatment was defined by the Task Force as direct service provision to drug users and their families which encompass support, counselling, referral, outreach, detoxification, methadone substitution, stabilisation and drug free options.

A key issue identified in developing the first plan was the desperate lack of suitably trained 'coal face' workers on the ground. In this context the focus of the first plan was development of a range of new projects or enhancement of existing projects which would address evident need and which would be monitored and evaluated by the Task Force. Subsequently, approved projects included:

- Corduff/Mulhuddart Community Drug Team.
- Blakestown/Mountview Community Drug Team.
- Huntstown/Hartstown Community Drug Team.
- Blakestown/Mountview Neighbourhood Youth Project. (Family Support/Community Development services).
- Blakestown/Mountview Youth Initiative.
- Pilot Peer Drug Prevention Programme.
- Blanchardstown Early School Leavers Programme.
- Working to Enhance Blanchardstown (WEB).
- GBRD Drugs Research Project.
- GBRD Roadshow.
- Drug Information and Community Education (DICE).
- Coolmine Community Support Group.
- Combined Secondary School's Drug Education Prevention Programme.
- Community Action on Drugs course (CAD).

A proposal in respect of funding administrative/secretarial support to the Task Force Co-ordinator was not approved in the first plan. Secretarial support was however provided by the NAHB. Notwithstanding this the administrative aspects of core supports to the Task Force were identified as an area of significant weakness. This weakness was further compounded by difficulties in respect of turnover in the post of Task Force Co-ordinator and delay in effectively filling this post on its vacation. The management and accountability of the support team were issues clarified in the course of delivery of the first plan.

During 2000 the National Drug Strategy Team initiated a comprehensive external evaluation of all save the latter two listed projects. The Schools project was evaluated locally by the Task Force, whilst the CAD project is still undergoing review by this

Task Force. With exception of the Coolmine Community Support Project and CAD initiative all projects were mainstreamed. The external evaluator found that the portfolio of projects has made a significant contribution to the development of needs based services in the respective communities. Successes cited included:

- Development of extensive education initiatives in the formal and non- formal sectors.
- Delivery of preventative initiatives to targeted and at risk young people.
- Establishment of three community based drug teams capably engaging with clients in their own communities.
- Initiation of Peer Education responses to drugs issue with young people.
- Delivery of family supports to parents/guardians of young people at risk.
- Development of awareness within communities of drug issues and harnessing positive contribution to addressing the problem
- Setting and maintaining drugs on the agenda.
- Development of inter-agency working practices.

The efficacy of projects is documented more rigorously within individual evaluations. It is clear that projects embarked on a learning curve as they began to develop/expand services within the community. Issues faced by projects included; the winning of support within the local community, acquisition of premises and negotiation of entry into community settings, development of clear objectives and strategies, staff recruitment, gaining the confidence and trust of service users, clarification of the basis and methodology of inter-agency functioning.

As indicated in individual evaluation reports large measures of success in these areas was obtained by most projects. The evaluation report concluded that projects had established themselves as valid and valued local community responses to the drug's problem at local level.

Significant as the individual project actions are in themselves the first plan established as its aim the complimentary integration of services. In reviewing overall Task Force effectiveness a number of themes emerge:

The Task Force benefits from a considerable level of contribution and commitment from personnel from all sectors. This has manifested itself in significant resource investment by individuals and agency professionals. Whilst the extent of delivery of new service initiatives have been positively commented upon, the Task Force is acutely aware of the key issues of addressing the need for integration and coordination between services and sectors and the influencing of policy to ensure strategic service responses. The Task Force has necessarily refocused its energies to ensure this critical and parallel agenda is addressed.

Additional issues identified by the Task Force include:

- Multi -annual funding to allow strategic development of services and reduce cash flow uncertainties. Such uncertainties lead to operational difficulties but also foster a climate in which competition for resources takes precedence over cooperation in service delivery.

- Introduction of service agreements with funding bodies to clarify expectations of projects and create a framework by which project development can be planned and co-ordinated. The absence of service agreements facilitates fragmented service development without strategic focus and with tension or conflict when ambiguous boundaries are perceived to be breached. Provision of counselling service is one key example where such conflict may arise between projects and funding agencies.
- A framework within which the Task Force would continue to hold and develop its role in the monitoring and evaluation of projects actions and actions of the Task Force itself is seen as crucial.
- Networking has placed a huge strain on personnel across the Task Force. Statutory agencies are not sufficiently resourced to play a full role within the Task Force. Invariably such personnel are too over stretched to bring the strengths of their agency to the work of the Task Force at the required level. In such instances they may serve as gate keepers for agency policy in the absence of fuller role mediating between the objectives of the Task Force and the agency.

  In this context it is too easy for issues to be skirted around rather than addressed. Within the community/voluntary sector training may be appropriate to critically evaluate current networking and determine opportunities for improved effectiveness and added value. The Task Force in light of this assessment should seek mechanisms to ensure value- added networking within the Task Force and across sectors.
- Need for proper community representation structures and feedback mechanisms to the communities in question,
- Means by which the community base of projects could be validated and supported in their role and not marginalised "poor relatives" of major service providers need to identified.
- The absence of inroads into the development of a treatment centre for the area has proven a consistent source of disappointment within the Task Force and remains a critical issue for the new plan.

In addressing the previous Plan, efforts were hindered by lack of specificity of objectives, which resulted in focus on new or extended project actions. In some instances objectives were not supported by designated actions. Inconsistent engagement levels by some members with the Task Force and Sub Groups contributed to a "one step forward, two steps back" type dynamic hindering the capitalisation on effective work in some fora. At points this contributed to some frustration among members, though without a clear basis to challenge the source of such frustration. Inadequacy and consequent ineffectiveness of core supports to the Task Force further contributed to and compounded these difficulties.

In relation to communication and decision making the following features inhibited performance of the Task Force as identified in the Review Process (May 2000)

Though some actions have been taken to address these difficulties some residual difficulties remain to be addressed:

◊ Agenda: A mechanism is needed for input onto the agenda and to avoid last minute "bombshells" being landed at the end of meetings leaving no time to discuss important issues.

◊ Sub Groups not working: No reports given; Terms of reference need to be defined; Lack of continuity of people involved.

◊ Lack of continuity of people involved in full Task Force led to attempts to rescind decisions.

◊ Lack of clarity of purpose for new members (inadequate induction processes).

◊ Conflict of roles for certain members e.g. managing projects or actions of the Task Force since coming onto the Task Force.

Many of the above issues have been picked up on by the Planning and Evaluation Sub Group, Co-ordination and integration of services within and between sectors and across themes remains a major objective. It is felt that the process of developing this Plan will have assisted in identifying tangible actions to address this agenda.

5. EXTENT AND NATURE OF THE LOCAL DRUG PROBLEM

As at October 2000 there were 215 persons from the area identified as being 'hard' drug users and who had sought treatment. It is acknowledged that this would represent the 'tip of the iceberg' insofar as many others will not have engaged with treatment services for a variety of reasons, and others will have engaged with services outside the area. Given the population distribution of the area it is estimated that up to three times that number of users would be a more realistic estimate and thus reflect 645 users. One service provider estimated that the level of usage might more realistically be as high as five to one. The number attending services is expected to rise as services become available in the area.

Such figures are, given the nature of drug misuse, very difficult to-substantiate. Data is only currently collected on the basis of those presenting for treatment. The Greater Blanchardstown Response to Drugs (GBRD) Study "Drugs and Community" (D'Arcy 2000) summarises a range of reasons contributing to difficulty in obtaining definitive data. Some of these include:

- ◊ The current system of data collection identifies heroin users presenting for treatment, therefore users who are not accessing treatment will not feature in this data.
- ◊ The Data Reporting System does not include waiting lists.
- ◊ Not all agencies take part in the drug reporting system.
- ◊ Information obtained concerning illegal drug use is difficult to obtain and may be distorted and inaccurate.
- ◊ Confidentiality creates-a barrier for agencies that would otherwise engage in information sharing. Therefore, multiple counting may exist e.g. individuals may be presenting for treatment in more than one agency.
- ◊ Drug users may be presenting to private GPs, which makes it difficult to assess the numbers in treatment.
- ◊ There are criteria for acceptance to a methadone treatment clinic, which can exclude some people.
- ◊ Drug use numbers would of course be further and considerably amplified if the probable instance of 'soft' drug usage was quantified or indeed abuse of legal substances.
- ◊ Persons who are homeless may not be accurately recorded in the data system.

Two important sources of data relating to the extent of the drug problem are:

(a) The Health Research Board Drug Misuse Research Division: Provisional figures for 1999.

(b) Greater Blanchardstown Response to Drugs: "Drugs and Community" (March 2000

The GBRD "Drugs and Community" study found that of 128 participants presenting for treatment from the Blanchardstown area in excess of 50% of them came from the Corduff/Mulhuddart area, with the remaining areas represented almost equally in the

sample. The HRB figures for 1999 suggest a different distribution but identify the expected number for a previous year.

The age profile the six Task Force areas confirmed the profile given from the Greater Dublin area. The 18 - 21 and 21 - 24 year age groups were highly represented in the sample.

Drugs and Community found that 37.5% of the sample left school at the age of 15 or under. The educational qualifications of respondents in this study is tabulated as follows:

	Frequency	**Percent**
Inter/Junior Certificate	46	35.9
Leaving Certificate	14	10.9
Third Level	6	4.7
FAS	4	3.1
PLC	19	14.8
No qualification	23	35.9
Youthreach	16	12.5
Total	128	100

Clearly a pattern is established between people leaving school early and with little or no qualifications.

The marital status of participants within the Drugs and Community sample is tabulated below:

Variable	**Frequency**	**Percent**
Married	12	9.4
Single	76	59.4
Co-habiting	40	331.3
Total	128	100

From the above data it is not possible to conclude how many people are affected by the behaviour of substance abusers. That some 87,5% of participants were living with a spouse/partner or with parents suggest that a high number of parents, partners, children and siblings are affected and in need of appropriate supports. That parents of drug users become consumed with the needs of their drug using child implies the needs of siblings may often be neglected. 43.8% of the sample reported no dependants.

The Anna Liffey project (Annual Report) points to factors, which may lead to the neglect of children:

◊ Being exposed to drug use of their parents.
◊ Having a parent who is a member of a HIV high-risk group and the possibility of parental bereavement.

◊ Having a parent who, while being able to provide for basic needs may not be in a position to provide for the emotional and developmental needs. This places a serious disadvantage on the children in terms of social and educational development.

The majority (61.7%) of those using drugs lived in Local Authority housing. Peer pressure and curiosity combined account for 75% of explanations from participants for first using drugs. 63.3 % of participants were unemployed, 18.8% were in part time work and the remainder were working full time. A stark contrast is evidenced between the unemployment level of drug users and the rapidly declining average employment figure for Dublin. Whilst the high correlation between unemployment and drug use exists it is difficult to determine whether or which one causes the other. Therefore while unemployment is likely to precede drug use, sustainable long-term work is difficult to achieve while using drugs.

The majority of those in this study (43.8%) report having been in their current treatment for over one year and some 13,3% had been in treatment for over five years. Some 68% had experienced some form of prior treatment intervention. The study found that some 31.2% reported using heroin at least occasionally during the last month despite being part of a treatment programme. Alcohol and Hashish were widely used at 75% and 79.7% respectively during involvement in a treatment programme. An alarming finding was that some 67.2% of respondents report using benzodiazapines and prescribed medicines frequently at levels far in excess of prescribed levels. The implications for abuse here are enormous with potential for destabilising a patient who is on a methadone treatment programme.

The primary drug of use is tabulated below:

Variable	Frequency	Percent
Heroin	100	78.2
Methadone	14	10.9
Benzodiazapines	14	10.9
Total	128	100.

(D'Arcy 2000)

59.6 % of respondents report first using their primary drug between the ages 16-20 years. This data refers to primary drug use and does not refer to the age individuals commenced on their path into drugs.

Age first used any drug:

Variable	Frequency	Percent
Below 10	18	14.1
10-12	20	15.6
12-14	35	27.3
14-16	47	36.7
16-18	4	3.1
18-20	4	3.1
Total	128	100

Duration of regular use:

Variable	Frequency	Percent
Less than a year	15	11.7
More than two years	29	22.7
More than five years	74	57.8
More than ten years	10	7.8
Total	128	100

Strong correlation is noted between drug use and criminal behaviour. The participant group reports the following involvement in criminal activity,

Variable	Frequency	Percent positive
Property crime in last month	34	26.6
Property crime ever	85	66.4
Crimes against person in last month	6	4.7
Crime against person ever	33	41.4
Involvement in selling drugs in last month	20	15.6
Involvement in selling drugs ever	75	58.6
Fraud in last month	22	17.2
Fraud ever	43	33.6

These statistics presented not alone suggest significant problems for health service providers but also reflect a much broader negative effect on the wider community. The high correlation between crime and drug use incurs a high social and economic cost on areas already suffering disadvantage.

Opiate related deaths in the Blanchardstown Drug Task Force area were five in 1998 and four in 1999 as cited in Ray Byrnes research into opiate related deaths investigated by Dublin City and County Coroners. This figure seems significantly understated as that piece of research appears to take account only of Blanchardstown-Blakestown DED. It is anticipated that when Coolmine, Corduff, Mulhuddarf and

Tyrellstown are taken into account figures would more accurately reflect local perceptions. In most of the documented fatalities more than one drug was implicated.

Offenders:

There is a high level of overlap between drug use and criminal activity and this has been confirmed by local Gardai analyses. A large proportion of drug users become involved in law breaking and get caught up in the criminal justice system. Drug use is also prevalent in Irish jails. It is estimated that 73% of those with criminal records have a history of drug use. Similar statistics apply to those clients of the probation service coming from the Blanchardstown area where 50% of the probation caseload as at October 2000 possess heroin abuse histories.

Detected crime	**% user of 'hard' drugs**
Aggravated burglary	85%
Robbery	84%
Taking of cars	84%
Ordinary burglary	82%

Blanchardstown Area Partnership: Social Inclusion Plan 2000

Garda Anti -Drug activity:

From The 13th of July 1999 to August 6th 2000 Blanchardstown Garda Station in respect of Blanchardstown has reported the following Garda activity:

Premises searched	186
Street Searches	60
Station Searches	97
Checkpoints	7
Number of drug seizures	120

Of drugs seized cannabis, cocaine and heroin were ranked highest in street value. A total of 261 persons were arrested. The number prosecuted or with prosecutions pending was 148 represented by:

	Male	**Female**
Under 17	2	0
17-21	38	1
Over 21	97	10

6. OVERVIEW OF REVISED STRATEGY

In relation to service development over recent years it is notable that the Eastern Health Board (now in part the Northern Area Health Board) has achieved a major expansion of drug services. The programme of service expansion has been commented upon as probably one of the more innovative community drug service programmes in Europe. The evaluation of EHB drug services conducted last year comments "This level of rapid expansion is a major achievement that involves an all-consuming level of managerial and administrative involvement. The services are now likely to require opportunity for consolidation and planning for the next level of development." (Farrell, Gerada & Marsden January 2000)

The same report comments upon the high levels of enthusiasm, skill, and commitment evidenced by staff but suggests there is risk of considerable duplication and overlap of function within teams when it comes to the management of individual clients.

A number of similar developments can be identified within and across Task Force projects as well as within other statutory agencies playing a role in addressing the drug problem. High levels of enthusiasm, commitment and activity have been evidenced, as projects become highly credible community resources. A period of extensive growth and development has been evidenced with new services being offered and increasing numbers of people being drawn into them.

Notwithstanding this it can be argued that a period of consolidation is required where the integration of services, focus on quality, prioritisation of needs and clarification of roles are a healthy prerequisite to further service expansion. Summary findings of Evaluations of Local Drug Task Force Projects confirm the local evaluator's findings that this is a critical concern. The former report suggests that if consolidation and integration of projects is to occur there are several issues that need to be addressed. These include; planning, staffing, funding, premises, networking, and community involvement.

ISSUES:

The generation of mechanisms for identification of changing needs and integration and co-ordination of services to respond to these are at least as, if not more important in the short term than on-going service expansion. A challenge is suggested in managing this paradox of consolidation and growth at the same time. A balanced plan addressing these objectives is sought; one in which service expansion is built upon consolidation, i.e., a two-phased plan.

In this framework priority actions in the new plan relate in the main to development of effective means of co-ordinating and integrating services, to initiating actions by appropriate agencies and not just projects. To support this Task Force developing a strategic approach much of its workload has been delegated to five Sub Groups:

- Planning/Evaluation
- Education/Prevention
- Health
- Rehabilitation
- Supply/Control – Justice

Within this process each sub group was briefed to examine actual need levels in respect of each theme, to identify gaps in provision with reference to current and anticipated need, and to identify process and outcome objectives and actions through which those needs could be addressed. Whilst some actions require extension to an existing project or development of new projects an important criterion was determining the extent to which these actions would be strategic and result in greater integration and co-ordination of services.

An overview of existing services indicates the predominant thrust of activity across the Task Force has been of an Education/Prevention nature. Valuable work has been initiated and much remains to be addressed. The absence of a treatment centre, the, imminent closure of the existing if inadequate facility, continued waiting lists, restricted treatment options, insufficiency of prescribing/dispensing services, all mitigate towards treatment being the key strategic priority for this plan.

Development of the Northern Area Health Board's Rehabilitation service gives cause for encouragement but much remains to be addressed. Important issues in respect of the Justice theme are outlined.

It is notable that the extent to which a theme has traditionally been seen as the province of one key agency has been conversely reflected in the degree to which this Task Force has made inroads in a multi- agency, cross sectoral approach. In this regard and with a view to each theme being fully integrated within this Task Force each sub group was invited to operationalise a vision statement. A brief overview offered in respect of each theme is outlined below:

6.1 THE PLANNING AND EVALUATION THEME:

A vision that the Planning and Evaluation sub group holds for the Task Force could *be operationally described as: "A dynamic purposeful Task Force with effective processes and structures that enable it to optimally respond to current and emerging drug related needs and meet the legitimate expectations of all its stakeholders."*

The mission of the Planning and Evaluation sub group, *is to advise and assist the Task Force in the development of effective processes and structures and to generate and deploy planning and evaluation systems which support and enhance Task Force performance.* In this regard this group will operate as a learning resource to the Task Force. It will proactively engage in critical reflection on Task Force (& sub groups) effectiveness, taking a lead role in offering guidance and recommendations where appropriate.

A key challenge facing the Task Force is to find ways in which the broad range of stakeholders can work together in a partnership that results in the sum of their efforts being more than the total of their respective contributions. Dimensions of "Added Value" could be characterised by terms such as integration, comprehensiveness, community supported, co-ordinated, seamless, duplication free, etc. Partnership based working requires significant commitment and investment. In particular it is essential to have clear understanding of what respective partners bring to the equation. It

becomes important to understand respective expectations and what it is that serves as the basis for shared activity. Personalities, hidden agendas, agency cultures, professional mind-sets and communication difficulties all present barriers to the development of effective partnership working. Addressing such concerns is a major strategic issue and one, which impacts on the effectiveness of the Task Force and all sub groups as well as on inter-agency and inter-sectoral working.

The Task Force's current stage of development has previously been described in this document as one requiring a period of consolidation to precede the subsequent growth phase that will be necessary to respond to the increasing demand for appropriate and effective drug services. Much of this consolidation will build upon the foundation of actions outlined under this theme.

6.2 EDUCATION PREVENTION THEME:

The core principle under this theme is defined as

"Drug prevention and drug education is part of a sustained on-going approach in the development of individuals and communities. Prevention and education strategies should respect individual civil liberties, operate within existing legal frameworks and he available to the whole community whilst prioritising those most at risk,"

Drug prevention strategies should incorporate the following principles:

- *"Empowering individuals through building their personal capacities.*
- *Supporting, encouraging and facilitating .the physical, psychological, spiritual and socio-economic development of communities.*
- *The reduction of harm to individual drug users, families and communities as a result of drug misuse".*

Education strategies should reflect the following:

- *"The content/information of drug education programmes should be planned, accurate, consistent and age appropriate.*
- *The approach to drug education should be a developmental one involving cooperation, co-ordination and planning within and between community, voluntary and statutory agencies.*
- *Drug education should be delivered by appropriately skilled persons."*

Extensive work was undertaken towards understanding these needs, the strengths and weaknesses of existing provision, gaps in provision and resource issues impacting on addressing the above principles. An inventory of existing services was produced as at June 1999 and this document is a valuable resource in need of regular updating. (An

Inventory of Drug Education/Prevention Initiatives in the Blanchardstown Area, June 1999)

Key concerns in respect of services identified for inclusion in this plan were that they should be:

- Planned, implemented, evaluated and co-ordinated drug education and prevention initiatives for Blanchardstown.
- Comprehensive, integrated and well resourced programmes in community, youth, family and educational settings.
- Community will have awareness of and access to information and services.
- Services will be needs based and flexible and responsive to current and emerging needs.
- Aims and objectives will be based on a common set of principles.
- Shared ownership will apply in terms of responsibility and accountability for the problem.

6.3 HEALTH THEME:

An operational mission statement for the Health Sub Group is outlined as follows:

"A range of community, voluntary and statutory stakeholders working together in partnership in providing co-ordinated, locally based, high quality, accessible, inclusive and respectful services responsive to identified health related needs of persons experiencing problems of drug misuse."

6.4 REHABILITATION THEME:

An operational mission statement for this group is:

"On the basis of an effective partnership between statutory agencies, the voluntary sector and communities, to ensure delivery of an integrated and holistic rehabilitative service that will empower participants to achieve improved quality and control in their lives."

This group has adopted the following definition of rehabilitation:

"Rehabilitation/integration is a structured process whereby individuals, whose lives have become marred by drug misuse, are facilitated in the process of regaining their capacity for daily life. The aim of the process is to enable people access the social, economic, and cultural benefits of life in line with their aspirations. Assisting individuals to realise their potential to live independently and responsibly is the core of our response."

6.5 SUPPLY/CONTROL THEME

The Supply Control sub group formulated the following mission statement:

"The development of a clear, effective and just system between relevant agencies and the community which will assist in the reduction of the supply of, and demand for, drugs so that all residents can develop themselves and their community free from intimidation and She adverse effects of a drug culture".

This mission is held against the background of a significant local drug problem, as outlined, and in the context of an expectation that this will increase as the population of the area continues to grow.

In relation to addressing this mission it was felt that the drug issue should not be seen solely as a Gardai problem. It's resolution will require effective co-operation between the Gardai, local communities as well as a range of other agencies.

7. SPECIFIC ACTIONS T0 ADDRESS REVISED STRATEGY

The Task Force has identified a number of Actions under each of the previous themes. Where actions reflect significant new proposals additional supporting documentation and a breakdown of expenditure is available to the Task Force. Actions are costed on an annual basis, unless otherwise stated. These costs are to be projected across the lifespan of this plan. It is further required that funding for these actions should be index linked with inflation and cost of living requirements.

7.1 PLANNING AND EVALUATION:

Specific action areas have been identified that would add value to overall Task Force functioning are outlined hereunder. The agendas are set on the basis of a model of a Learning Board (Garratt 1996) as a framework to ensure all aspects of Task Force responsibilities are addressed in a planned manner. (See model as appendix)

Agenda 1: Policy

1. Develop a shared vision as to the role of this Task Force.
2. Articulate values subscribed to by Task Force.
3. Define the "ethos" of the Task Force, i.e., "the way we do things" and determine policies to elaborate this. (E.g., issues of concern policy, Equal Opportunity Policy.)
4. Recognise values held across sectors/agencies and identify processes by which differences can be addressed.
5. Obtain explicit individual and agency commitment to Task Force objectives articulating their role and contribution and clarify how they will be held to account for failure to meet obligations.
6. Clarify strategies for attainment of objectives.
7. Develop mechanism for reviewing/anticipating and planning for impact of change in the environment.

Objectives:

- 1& 2. By Spring 2002 the TF will have deployed an external facilitator to enable it articulate vision, mission and values statements which will be adhered to by the Task Force and guide its activities.
- By May 2002 the TF will have documented its ethos through a number of working and/or policy documents which may include (i.) membership agreement, (ii.) issues of concern/grievance policy, (iii.) equal opportunity policy, (iv.) committee operating procedures, (v.) communications framework.
- By June 2002 the TF will have undergone exercises to identify impediments to inter-agency operation, have developed improved understanding of how difficulties may arise and committed to development of strategies to overcome such difficulties.
- Membership review to be facilitated by Planning and Evaluation Sub Group in 2001 in order to clarify and/or legitimise mandates, their term, the expected

commitment from respective members and their agencies and mechanisms for accountability in respect of commitments entered into.

- All Sub Groups and Task Force to review broad objectives and ensure strategies are put in place for their attainment, e.g., programme logic model, which seeks clear links between needs, target groups, objectives, processes and outcomes.

- The Task Force and each sub group to systematically scan on a regular frequency developments in field, emerging needs, etc., to ensure on-going relevance of objectives within this plan.

Agenda 2 Strategy:

1. Annually undertake a Strengths & Weaknesses, Opportunities & Threats review.
2. Regularly review ways in which Task Force adds value to delivery of local drug services.
3. Establish clarity as to strategic priorities for Task Force.
4. Allocate resources to match priorities.

Objectives:

- Organise a cycle of TF meetings which ensures that an annual SWOT review **is** undertaken by the TF and each of the sub groups.
- In a review cycle look to identify ways in which value is added (and could be further, added) to local drug services delivery by assessing inter agency activity, networking effectiveness,, shared resources, community support and prevalence of problem agenda points.
- Assess degree to which priorities for the TF are assessed, agreed and documented and hold implications for focus of TF activity.
- Develop and implement process by which resource decisions will be processed to ensure priorities are addressed.
- Develop support capacity to assist in development of proposals to ensure priorities are addressed in any new actions.

Agenda 3 Management:

1. Create management systems for Task Force functions.
2. Create systems for management and support of staff.
3. Create information and performance measurement system.
4. Ensure timely and accurate information is available to the Task Force and Sub Groups to facilitate decision making.
5. Introduce project monitoring/reporting system to ensure projects are addressing objectives as agreed with funding agencies and the TF.
6. Support projects to identify and report on a relevant portfolio of performance indicators.
7. Develop annual reporting and evaluation system to monitor projects progress.

8. Introduce financial management systems to ensure effective financial monitoring and control.
9. Ensure subgroups have annual plan and cycle on which they report to Task Force.
10. Ensure evaluation is an inherent objective for all actions undertaken within TF

Objectives:

- P&E Sub Group to devise and recommend to TF a system of reporting from all sub groups to TF as part of an annual cycle of activity.
- P&E to formalise procedures for management of Co-ordinator and any other staff or contractors engaged by TF.
- P&E to introduce, and maintain via nominated staff person (co-ordinator) a performance measurement system in relation to all TF objectives.
- Introduce agreed procedures for all communications e.g., notification of meetings, agendas, minutes, circulated reports, finance records etc, and ensure files are responsibly kept.
- Initiate meetings with funding agencies and individual projects to develop monitoring, evaluation and reporting structures for mainstreamed and new projects.
- Through appointment of Evaluation/Development resource worker to assist projects to work towards development of performance measurement systems and identification of relevant portfolios of key performance measures.

Agenda 4: Accountability

1. Ensure members have clear understanding of their duty to the Task Force.
2. Ensure members have clear mandate from an agreed and specified nominating body.
3. Ensure members accountability to each.
4. Clarify responsibilities and accountabilities of members.
5. Standards, competencies and behavioural expectations of each other must be clarified and all role descriptions documented.
6. A code of practice for Task Force members should be devised.
7. Induction training for all new members should be mandatory.
8. Devise process to ensure Stakeholder expectations are articulated, understood and reported on.
9. Mechanisms for mediating conflicts between stakeholders should be developed.
10. Clear mechanisms should be deployed for holding Task Force accountable to respective stakeholders.

Objectives:

- Develop a clear description of the role of TF members and officers as part of the TF operating guide and included as part of induction of all new members.
- Seek a written mandate for all members (copy available to Chair) and gain agency's commitment to resourcing individuals to play a full and active role in the Task Force.

- Negotiate and document methods by which members (and their mandating body) will be held to account for obligations as part of TF.
- Through a period of consultation agree with stakeholders a list of priority expectations held of the TF and a means by which these can be reported on. E.g. social auditing.
- Ensure that mechanisms for working with the community as a stakeholder are developed and adhered to. (e.g. how is the community represented, consulted with, and seen as an important stakeholder in evaluating Task Force services in its community? Social Auditing is an approach worth consideration in this context.)

The Task Force has been dependent solely on the services of a co-ordinator. This support resource is assessed as inadequate to the full and expanding role of the TF. Specifically administrative support is crucial to develop and maintain effective communication systems. A more developmental role is also suggested in terms of working with projects developing proposals, performance measurement systems and evaluation frameworks. Dynamic sub groups functioning will require additional servicing and create a developing workload which may suggest appointment of a development worker alongside the co-ordinator. Finance is required to support the critical agenda established under this theme.

A suggested new TF staffing structure would accordingly comprise:

- Co-ordinator.
- Development/Evaluation worker.
- Administration worker.

The role of co-ordinator, effectively delivered, is crucial to the on-going development and success of the Task Force. That the Task Force has maintained, indeed if not increased momentum over recent months in the absence of a Co-ordinator is a credit to the huge commitment of Task Force members. Filling the role of Co-ordinator is a priority at this juncture to support finalisation and delivery of the plan. Costings for the other two new posts and attendant administrative costs are pending but likely in the region of £80,000. This is framed as a specific proposal of this plan.

Action 1

Client:	The Task Force, internal stakeholders, service agencies and their clients.
Target:	National Drug Strategy Team for funding support.
Actor:	Planning & Evaluation Sub Group
Action:	Appointment of core support team of three workers to the Task Force
Resources required:	£110,000 p.a. for three posts (Co-ordinator, Development Worker & Administrator) and appropriate support costs. The figure is therefore inclusive of NAHB funding of T.F. Coordinator costing circa £30,000 p.a.

Action 2

Client:	Blanchardstown Drug Task Force and sub groups.
Target:	BDTF
Actor:	Planning & Evaluation Sub group
Action:	Obtain mandate from TF for new role as per Learning Board Model, adopt schedule/programme of activity to implement objectives on systematic/cyclical basis.
Resources:	TF commitment and support from core staff team above to Planning and Evaluation Group plus £1,000 p.a. for training input.

Action 3

Client:	Service users/staff/overall system
Target:	BDTF
Actor:	Planning and Evaluation group
Action:	Obtain support for and establish an Equal Opportunity working group to devise a policy to ensure Gender Proofing and best practice equal opportunity systems. Incorporate introduction of TF Minority Group Liaison Role
Resources:	TF core support team and commitment from TF plus £1,000 p.a. for training input.

7.2 EDUCATION/PREVENTION THEME

Objectives for this theme have been identified under each of the following headings:

1. Formal Sector
2. Youth Sector
3. Community/Adults
4. Workplace.

7.2.1 FORMAL SECTOR

Target Groups:
Children and young people in the formal educational setting; Teachers; School authorities. Department of Education and Science.

OBJECTIVES

1. To lobby the Department of Education and Science to ensure that drug education is included as part of the core curriculum within the context of a wider personal, social and health education programme.
2. Lobby the Department of Education towards their facilitation of school- based personnel being released to develop school-based programmes and to network towards development of responses within and between schools,
3. To support schools in lobbying for appropriate resources to develop innovative drug prevention strategies with potential for mainstreaming and to provide direct support to schools (with primary focus on designated schools) with a view to their developing such initiatives.
4. To organise and ensure delivery of an appropriate training programmes for teachers and obtain 100% participation in this over the life span of this plan.
5. To ensure delivery of drug education programmes that are consistent with agreed standards but delivered flexibly and in response to local issues and concerns.
6. To develop a mechanism to ensure that all drug education programmes are evaluated and developed on an on-going basis.
7. To encourage schools to avail of the expertise of local drug services in their delivery of co-ordinated drug educational programmes.
8. To develop a facilitation mechanism whereby schools would be supported m development of appropriate and informed drug policies.

FORMAL EDUCATION ACTIONS

Action: 4

Client:	Young people in schools, parents, teachers.
Target:	School system
Actor:	Education Prevention Sub Group/Task Force Development worker and schools representatives.
Action:	Support all schools in TF area in addressing drug related issues through availability of fund to pilot and develop new and innovative ways of working with client groups in formal sector. Identified initiatives include: Summer course for national schools, in-service training, parent training via Home School Liaison scheme, after schools programmes fund.
Resources:	£25,000 p.a.

Action 5

Client:	Young people in formal education sector.
Target:	School system, principals, teachers & parents.
Actor:	Education/Prevention sub group
Action:	Employ two education co-ordinators to support schools to develop an integrated approach (policy and training) to drug education and to interface effectively with existing local resources.
Resources:	Appointment of two Task Force Education Co-ordinators mandated to role with schools. Cost of initiative £70,000 per annum. One post (£35,000p.a.) to be seconded from the Department of Education and Science.

7.2.2. YOUTH SECTOR

TARGET GROUPS

General youth population, Targeted "at risk" groups of young people, local communities. Youth leaders. Funding agencies/Departments.

OBJECTIVES

1. To communicate availability of services.
2. To facilitate opportunities for young people to play active, responsible and leadership roles with their peer group and in their communities, e.g., through peer educational programmes.
3. To attract increased numbers of young people aged 10 to 18 into appropriately resourced drug prevention education programmes.

4. To design and deliver educational responses to combat the recreational use of drugs by young people.

5. To provide accurate information re: health, social and legal Implications of drug use.

6. To develop and implement tailored programmes for at risk target groups including drug users and their families.

7. To deliver family supports and therapeutic services in an integrated way to young people and families most at risk.

8. To provide relevant education and prevention training courses to all personnel in local youth and sport groups in the voluntary sector.

9. To assess local need and campaign with relevant bodies to ensure that adequate facilities are in place and available for the recreational and leisure needs of young people.

10. Through effective networking to facilitate inter-agency co-operation and integration of services at local level.

YOUTH ACTIONS:

Action 6

Client:	Families in need of support..
Target:	Family systems.
Actor:	WEB Project
Action:	Provide family support to targeted families as part of broader WEB programme and extension to existing services
Resources:	£45,000 per annum

Action 7

Client:	Young people at risk in disadvantaged communities.
Target:	Peer groups.
Actor:	Blanchardstown Youth Service
Action:	Extend delivery of peer education approaches to additional areas and thereby influence young people's knowledge/skills and attitudes in respect of drug issues.
Resources:	£35,000 additional to current funding per annum.

Action 8

Client:	Young Offenders aged 16-23.
Target:	Young offenders
Actor:	BOND project
Action:	Engage participants, identified as high risk, in Outdoor Pursuits programmes to support diversion from risk taking behaviours and involvement with drugs.
Resources:	£15,000 for programme cost reimbursement p.a.

Action 9

Client:	Young people at risk of drug involvement
Target:	Peer groups
Actor:	Blakestown Mountview CDT arid Blanchardstown Youth Service
Action:	Harm reduction peer education work with identified target group**.**
Resources:	Co-ordination from above agencies and £9,950 for programme costs p.a.

7.2.3 COMMUNITY/ADULTS

OBJECTIVES:

1. To inform the community of the nature, extent and changes in the local drug situation.

2. To provide information and develop an understanding within the community of the broad range of strategies and services available to drug users and their families and the community.

3. Through community based education and awareness sessions to support the community in understanding and accepting the positive and influential role they can play in addressing drug issues in their community.

4. To establish and utilise effective structures and consultative mechanisms whereby the community can, be updated and become involved in the various drug prevention education and initiatives in their area.

5. To obtain increased support within the community for delivery of responsive drug education and prevention strategies.

6. To identify groups and organisations already in place where education programmes may be introduced, e.g., adult and further education services, resident

associations, parent organisations, family support groups, targeted clubs which may have a role in respective of potential or actual drug users or their families.

7. To increase the capacity of the community to provide, participate in and lead diversionary programmes, leisure, sporting, arts activities and summer programmes for young people and for specific target groups with identified needs.

8. To provide community based preventative programmes for specific target groups, e.g., Travellers.

9. To utilise local media and publicity opportunities within community and public places, resource centres to maximally spread awareness of drug issues and local services.

COMMUNITY ACTIONS:

Action 10

Client:	Agency professionals in Blanchardstown
Target:	Drug prevention/treatment agencies and services.
Actor:	Blakestown/Mountview Community Drugs Team with support from other Community Drug Teams.
Action:	Establish a Drug Education Resource Facility for the entire Task Force area.
Resources:	£94,200 p.a.

Action 11

Client:	Persons with current or potential need of drug services, their family, peers, siblings who may be unaware of services or how to access these.
Target:	Broad community with strong focus on youth.
Actor:	Education Prevention Sub Group
Action:	Develop a media marketing strategy for the Task Force with a variety of marketing actions including circulation of a newsletter three times yearly.
Resources:	Task Force development worker plus £20,000 p.a. for external; consultancy and production costs.

Action 12

Client:	Agency personnel and drug activists.
Target:	For tender.
Actor:	Education/Prevention Sub Group
Action:	Hold annual conference on relevant themes to support fuller, shared understanding of drugs situation. Identify new and best practice approaches and facilitate networking.
Resources:	Development worker & £3,000 p.a. action costs.

Action 13

Client:	Potential/actual drug users, friends, peers and relatives.
Target:	Broad community
Actor:	LDTF/Education/Prevention Group
Action:	Develop and maintain a website for the Task Force and drug services.
Resources:	£5,000 p.a.

Action: 14

Client:	CE Participants/Parenting Courses/Health Ed. Participants
Actor:	CDTs and Health Board
Action:	Develop and deliver drug training modules in integrated way with other training providers.
Resources:	Development worker, financial costs to be explored

Action:15

Client:	General public
Target:	General public
Actor:	Fingal Community Arts & steering group.
Action:	Utilise Community Arts week and European Drugs Week to highlight drugs issue.
Resources:	£4,000 p.a. for programme costs.

Action 16

Client:	Parents in need of support in developing parenting skills
Target:	Parent groups
Actor:	Child care workers, family support services & LDTF projects personnel.
Action:	Pilot Early Play Intervention Programme
Resources:	£5,000 p.a. plus effective network of agency personnel.

7.2.4. WORKPLACE

TARGET GROUPS

Local employers.
Employer networks
Employees in targeted firms

OBJECTIVES

1. To provide information through various schemes/forums (e.g. specific courses for employers) on available services and supports and preventative education programmes and resources.

2. To work with local employer networks in order to ensure that increasing numbers of drug users have equal access to the jobs market.

3. To educate employers as to the specific needs and support structures of stabilised drug users, and keep them up to date on all relevant developments.

4. To ensure that employees have an option and are encouraged to participate in drug prevention programmes, in house, and in consortia of interest including employer and union organisations.

5. To lobby employer organisations (Local and National) through concerted efforts with other Local Task Forces to influence the development of positive policies regarding the employment of drug users.

WORKPLACE ACTIONS:

Action 17

Client:	Local Employers
Target:	Local employers
Actor:	LDTF Development officer, IBEC, Small Firms Association.
Action:	Support firms develop policies and competencies in dealing with drug issues, advise of services and referral processes.
Resources:	LDTF development worker

Action 18

Client:	Local work forces.
Target:	Employers and small firms.
Actor:	Education Prevention subgroup/Development worker
Action:	Provide short term training to workers on health issues incorporating drug education within the workplace.
Resources:	Development worker with support from FAS/Rehab. & £8,000 p.a.

7.3 HEALTH THEME

This Sub Group addressed identification of needs and priorities under the following headings:

1	Pre-Treatment
2	Medical Treatment
3	Alternative Treatments.

7.3.1. PRE TREATMENT:

Notwithstanding the significant development of services over recent years a review of current needs has identified the following gaps in provision:

- Centralised treatment facility.
- Dedicated separate services for young people.
- Flexibility of services.
- Inter agency links/referrals.
- Crèche facilities.
- Needle exchange services.
- Increased volume of outreach work.
- Harm reduction/low threshold interventions.

Two priority target groups were identified:

(a) Drug users not yet accessing/requiring treatment services or programmes.
(b) Sub group of above aged 13 to 18 with age specific programme needs.

Pre Treatment Objectives identified were:

1. Develop an integrated (cross service) marketing strategy responsive to individual target audiences, e.g., young people, parents community, agency professionals etc. highlighting appropriate messages to each audience e.g., health promotion as means to obtain community support;

2. Increase the volume of outreach, detached/street work to access increased numbers of target groups.

3. Develop and implement a secondary education model responsive to assessed target group needs.

4. Initiate inter-agency pre treatment education co-ordination meeting on regular basis to assess and prioritise intervention needs and minimise threat of duplication.

5. Develop and support peer education model within an agreed framework as a harm reduction strategy.

6. Develop and adopt referral protocols and initiate training to relevant professionals/bodies to maximise effectiveness in referrals.

7. Assess and address barriers to service take up, e.g. provision of childcare as/when appropriate.

8. Expand needle exchange programme within Statutory and Community Drug Team services.

9. Assess and address needs of excluded minorities overcoming cultural/organisational barriers to client access e.g., needs of Travellers & Refugees.

7.3.2 MEDICAL TREATMENT

The following gaps in service provision were identified :

- Detox – in-patients and out-patients
- Co-operation between all services/sectors. , • Lack of treatment centre.
- Respite care for users and families,
- Inadequate number of dispensing pharmacies.
- Evening methadone clinics.
- Improved communication within the treatment team servicing satellite clinics.

Objectives:

1. Development of a Treatment centre for the area is a priority issue for the NAHB and the Task Force. The Task Force needs to negotiate a role and action plan in respect of this issue, which is clearly critical in the short and longer term.
2. Engage in trilateral discussions T.F./Projects/N.A.H.B. to ensure capacity of services keeps pace with projected and realised demand.
3. Support the NAHB in lobbying to secure an increase in and flexibility of prescribing/dispensing services at local level, e.g. Pharmaceutical Society.
4. Lobby NAHB to introduce a loflexidine maintenance programme locally as a further treatment option to identified target groups of drug users and to recognise a role for CDTs in undertaking a support role to clients in accessing this programme.
5. Seek prioritisation of development service agreement contracts clarifying and defining roles and boundaries between funding bodies and projects.
6. Explore CDT role in care planning and management with keyworkers and social work liaison worker and develop shared care protocols.
7. Devise and implement “issues of concern” procedures for addressing cross-sectoral concerns.

8. Explore potential for respite care provision for users and families.

9. Increase numbers of counsellors, agree accreditation levels and secure good practice criteria.

7.3.3 NON-MEDICAL TREATMENT

A holistic approach to combating the drug problem by affording maximum treatment options to clients, including a range of alternate treatment approaches, is considered vital to this Task Force.

Gaps seen in all the following areas and are compounded by the lack of treatment centre.

- Alternative medicines e.g., acupuncture/recognition of such service.
- Primary care (social)
- Housing/homelessness
- Counselling services.
- Family therapy and support.
- Crises intervention.
- One to one supports.
- Special support for Young People.
- Personal development programmes.
- Inclusion within the community & community involvement.
- Outreach.

Target groups to whom such services are appropriately addressed include:

- Clients seeking non-medical treatment or exploring treatment options.
- Clients engaged in medical treatment seeking additional support.
- Families of clients (with client approval)
- Young drug users/early drug career

Objectives:

1. To expand counselling/family therapy services available locally on the basis of accredited counsellors, working to established and relevant professional standards as recognised by NAHB.

2. To recognise young people as a priority target group and to tailor early interventions to their specific needs.

3. To support Blanchardstown Advocacy Group in its representation of client issues and needs.

4. To increase availability of services to all cultural groupings through staff training, development of equal opportunity policies and practices, accessibility of premises, etc.

5. To market availability of services directly to target/potential target groupings.

6. To ensure client childcare commitments are not barriers to service accessibility.

7. To provide appropriate health education/harm reduction interventions with target groups.

8. Provide innovative alternative therapies within a framework of on-going evaluation of outcomes and documenting the efficacy of such interventions.

9. Establish protocols for inter-agency referral and case management

A number of specific new proposals were determined to furnish appropriate contributions to the above objectives being addressed. These are identified as follows:

HEALTH ACTIONS:

Action 19

Client:	Treatment service users in need of more flexible service delivery.
Target:	Northern Area Health Board
Actor:	Mountview/Blakestown CDT
Action:	Evening prescribing/dispensing service. NAHB to meet with CDT to investigate service development options in CDT premises to generate flexibility of service delivery and reduce waiting lists.
Resources:	Cost absorbed by NAHB/Premises costs absorbed by CD Ts

Action 20

Client:	Treatment clients/family members of service users.
Target:	NAHB/BDTF
Actor:	Health sub group, Huntstown/Hartstown CDT.
Action:	NAHB to second counsellors & family therapists to deliver services in CDT x 3 premises affording community delivery but retaining integrity of clinical team.
Resources:	Staffing cost to NAHB. Premises via 3 CDTs.

Action 21

Client:	Persons exploring/incorporating alternative treatment modalities into treatment programme. Drug services and research community.
Target:	BDTF/NDST/other CDTs
Actor:	Blakestown/Mountview CDT
Action:	(a) Develop complimentary/alternative programme and (b) undertake research programme to assess outcomes of these programmes as significant piece of research
Resources:	(a) £14,200 p.a + (b) £20,000 for two years.

Action 22

Client:	Siblings/children of drug abusers.
Target:	BDTF/NDST
Actor:	Blakestown/Mountview CDT
Action:	Resources to work with and support siblings and children of drug users.
Costing:	£15,000 p.a.

Action 23

Client:	Shared BDTF/social work clients.
Target:	Project and social work personnel
Actor:	Drugs Reference Group
Action:	Social work liaison post to improve Social Work interface between HB and community/voluntary projects. NAHB second social worker.
Costing:	NAHB to second social worker to role, plus £12,000 p.a. (Administration, management costs.)

Action 24

Client:	Persons wishing support advocacy In respect of drug concerns.
Target:	All service with role in relation to service users.
Actor:	Blanchardstown Advocacy Group
Action:	Pilot advocacy project. Part-time administrator + admin. resources to support advocacy.
Resources:	£15,000 p.a.

Action 25

Client:	Family members in need of counselling support in respect of drug use in family
Target:	Family system of drug users.
Actor:	For tender/possibly Corduff Counselling Service.
Action:	Counselling/therapy to family members of drug users- Subject to NAHB standards being met, and on-going (purchase) review by T.F.
Resources:	£25, 000 Contribution towards funding service p.a.

Action 26

Client:	Family members of drug users in need of peer support.
Target:	Current (3) and potential new family support groups operating in Blanchardstown area.
Actor:	Health Sub Group
Action:	Create fund for programme costs to support groups to be applied for in respect of specified purposes/activities.
Resources:	£60,000 (in year 1& re viewable thereafter)

Action 27

Client:	Treatment service users & Blanchardstown communities.
Target:	NAHB/local community/Task Force for support.
Actor:	Health sub group.
Action:	Development of **Treatment Centre** for TF area. This is seen as an absolute priority for the Task Force. The NAHB has committed to this action but serious difficulties remain to be addressed. To progress this agenda the Task Force will establish a separate sub group, which will identify strategies to support and monitor the NAHB progressing of this agenda. The TF to hold this as an agenda item at every meeting to monitor progress in respect of an action plan to be presented by NAHB to the Task Force on foot of appropriate consultation. The Task Force should identify strategies to harness community support for development of this Treatment Centre.
Resources:	Task Force management of this as a key strategic priority, NAHB commitment to working aggressively on this agenda in partnership with the Task Force. Committal of necessary capital and revenue NAHB funding to commission the treatment centre at earliest juncture.

Action 28

Client:	Research and drug services community
Target:	All service agencies/HRB/Health Board
Actor:	Health sub group and NAHB
Action:	Analyse and ameliorate difficulties in respect of sharing of up to date data in respect of drug treatment provision to afford accurate projection of treatment patterns and demands.
Resources:	NAHB/Task Force working group agenda.

Action 29

Client:	Service users in Corduff/Mulhuddart
Target:	Corduff/Mulhuddart Community Drug Team
Actor:	Health sub group and NAHB
Action:	Annualised increase to core grant to establish parity with other CDT core funding and bring in line with appropriate mainstreamed funding.
Resources:	NDST with Task Force approval and support, plus £20,000 p.a.

Action:30

Client:	Drug users in need of treatment and/or support in accessing this.
Actor:	Community Drug Teams and NAHB
Action:	Provide needle exchange services responsive to local demand in each CDT and provide for an additional outreach worker in each CDT to proactively locate and engage with those in need of treatment services.
Resources:	An additional worker (Outreach) to each of the three CDTs costing a provisional figure of £30,000 x 3 per annum, CDT.s to host needle exchange service as part of core programme.

7.4 REHABILITATION THEME

Theme Aims:

◊ To develop an interagency approach to identify, plan, develop and deliver these services as appropriate.
◊ To assess and recommend proposals from the community/voluntary sector to the Task Force for approval.
◊ To support the development of inter-agency co-operation to meet identified needs.
◊ To report to BDTF via group TF representatives.

The Health Boards Rehabilitation Blueprint and Action Plan are seen as formative documents outlining the strategy for the overall development of Rehabilitation services. In these, rehabilitation is seen as the outcome of rather than appendage to the treatment process. Values which underpin the rehabilitation blueprint and which appear echoed in this group's deliberation include:

- It is a holistic process.
- It is about empowering people to lead as full a life as possible consistent with their aspirations.
- It should be based on a complete assessment of an individuals need.
- Assessment should take place at as wide a variety and number of existing locations as possible
- Those involved in assessment should be appropriately skilled and trained to do so.
- Rehabilitation should be, as far as possible, based in the community.
- Programmes need to be flexible to take account of individual needs, e.g. childcare, training subsidies etc,
- It should offer progression.
- It requires co-operation and co-ordination between an array of agencies in delivering individual care plans.

On prioritisation of needs it was felt than an individual assessment of service user needs was the highest priority. This assessment would involve a review of the educational, training and employment history of the person. The desires, aspirations and goals of the person would then be ascertained and be the basis for development of an individualised rehabilitation plan.

The second priority was that of greater accessibility and availability of these services to drug users. Flexibly delivered services should be an integral part of the rehabilitation process. Constrained access to GP services was one example of barriers to participation in rehabilitation programmes.

Intensive, one to one supports offered in user friendly environments were important in the building and maintaining of relationships critical to programme success.

Attitudinal barriers to participation are as, if not more, critical than more tangible difficulties.

A need was identified to have agencies work in a seamless way with each agency having clearly negotiated role in relation to individualised plans. Persons cannot and should not be or feel passed from pillar to post.

Medium priority needs as charted by this group included:

◊ Confidence building - access to training that builds confidence and self-esteem.
◊ Access to Family Supports and Childcare to allow access to programmes,
◊ Job skills training - specific skills training for the labour market.
◊ Career planning & guidance.
◊ Flexible programmes - allow for access to methadone clinics and take into account difficulties in attending programmes from 9-5. Flexibility also required in training methodologies.
◊ Access to mainstream labour market and education programmes, e.g. Community Employment, VTOS, FAS courses. Literacy etc.
◊ Access to quality employment-support of employers.

Lower priorities identified included:
◊ Social skills development.
◊ Literacy training.
◊ Access to psychological services.

GAPS in Services:

A clear gap as identified in respect of needing care plans to be agreed and acted upon in a co-ordinated and integrated way by agencies involved, including generation of a role for CDT personnel.

Outreach services, counselling, increased service options and more flexibly delivered services were also recognised as issues.

Effective working relationships between integration team and existing service providers need to be worked towards from an early juncture.

<u>OBJECTIVES:</u>

Objectives can be established at the following levels:

1. Management of inter-agency co-ordination mechanisms to facilitate care plan delivery. (Protocols between rehabilitation and training and education agencies)
2. Rehabilitation/integration team (multi-disciplinary team).
3. Task Force (Performance/monitoring)

4. New innovative actions that improve access to the labour market for substance abusers.

These measures are largely strategic in orientation and will involve extensive and early dialogue with Rehabilitation Team Manager and Staff to establish the appropriate protocols. This is seen as imperative as some risk exists in having unrealistic expectations of me new rehabilitation plan or alternatively engaging is precious behaviour in respect of 'our' clients.

As part of the NAHB Rehabilitation Blueprint the Task Force is required to establish a Rehabilitation/Integration Advisory Group. Specific objectives to be established include:

1. Address the training needs of specific organisations to support their role in rehabilitation activities.

2. Initiate shared training as a way of developing shared understandings of mutual roles and develop working relationships.

3. Initiate a research programme to monitor from its inception the design, development and delivery of the rehabilitation program to support identification of best practices.

4. Identify and remove situational barriers to engagement with the rehabilitation service and closely monitor all departures from the programme to ensure no barriers remain unidentified.

5. Ensure that issues are 'fed up the line' to mitigate towards problems being addressed at organisation/policy level as well as at operational level.

6. Lobby to ensure integration teams are based/operate from within the community, involving personnel from other relevant agencies, not confined to a medical model/environment.

7. Identify and support with FAS potential sponsors for a tailored return to work programme capable of responding to the personal, social, educational and vocational needs of persons working towards planned re entry to the workforce.

8. Continue working as a Rehabilitation Sub Group to develop and support inter-agency actions.

In terms of taking a strategic orientation this group has not as yet proposed new project actions in relation to actual rehabilitation delivery but identifies that pending review new actions may be required to support delivery of the integration plan at local. level. Such actions will be determined by spring 2002.

Rehabilitation Actions:

Action 31

Client:	Rehabilitation service users.
Target:	Inter-agency Rehab forum.
Actor:	Rehabilitation sub group of BDTF
Action:	Convene, during early 2002 facilitated inter-agency rehabilitation meeting to assess needs and develop service protocols.
Resource:	*£2,000*

Action 32

Client:	Policy making and drug service communities.
Target:	To be negotiated.
Actor:	BDTF
Action:	Develop a research proposal, source appropriately skilled research and initiate research of the design, development and delivery of rehabilitative services in a local Task Force.
Cost:	Funding of researcher £15,000 for one year

Action 33

Client:	Rehabilitation service users.
Target:	Agency professionals
Actor:	Rehabilitation sub group.
Action:	Inter-agency training to support development of and familiarisation of protocols for inter-agency work, and support development of working relationships between agencies.
Cost:	£8,000 p.a.

Action 34

Client:	Participants in rehabilitation programmes.
Target:	Pilot projects working with rehabilitation of drug users into the workplace.
Actor:	Rehabilitation sub group and pilot projects (including Mulhuddart Special Status Project) in the first year.
Action:	Provide training/resource funds to the Rehabilitation Sub Group to support pilot projects engaged in rehabilitation actions.
Resources:	£45,000 p.a. Fund and on-going commitment from FAS to such projects.

5 SUPPLY/CONTROL THEME

A key issue and one of vital importance in combating the drug problem is that of community policing. At present two Sergeants and ten Gardai are assigned to this unit. This is estimated to be some 40% less than the level of staffing two or three years ago. Moreover Gardai are frequently diverted from this important role in response to the Juggling of priorities on an on-going basis. Physical presence within communities is viewed as vital if relationships based upon trust and mutual understanding are to be fostered and maintained with the community and young people. This role would also furnish accurate, relevant and timely information to the Gardai and enable greater responsiveness to issues be they supply related, criminal activity or anti-social behaviour and intimidation. A reduction of nearly 90% in number of neighbourhood watch schemes is a negative indicator of the current situation.

Gardai Drugs Unit:
Again the issue of Garda personnel being re-deployed to address conflicting priorities is noted. To be seen to be effective the Drugs unit must be able to hit harder and more often in order to remove the example of high level crime as an attractive 'career', Under cover and specialist Gardai could assist combat the 'deals on wheels' service which was becoming increasingly prevalent in the area, or combat high levels of intimidation where necessary.

Probation and Welfare services:
At present one Senior Probation and Welfare Officer and one and a half equivalent probation officers are deployed to the D 15 area. The service has no local presence but is centrally based in Smithfield. This staffing level and absence of a local base were identified as inadequacies of current provision.

Fingal County Council fEstate Management):
Four staff, one senior and three assistant staff represent the extent of the Estate Management Initiative of the Council. This would equate to approximately two equivalent posts for the Blanchardstown area. Again this is considered wholly inadequate.

Provision of facilities including playgrounds and halls are seen as an essential component for providing alternative outlets on estates, but such facilities would require professional management and maintenance.

Fingal County Council (Community Development):
Recent improvements in staffing levels of this section with particular emphasis on working with areas of social need are to be welcomed. This development will yield a staffing cohort of one full-time Area Community Officer, three Community Officers, and an officer dedicated to working with voluntary groups undertaking large capital developments. It is hoped that with the new Strategic Policy of the Department greater emphasis can be placed on working with communities with extensive drug problems.

Community:
Under the auspices of the Blanchardstown Drug Task Force, as well as with support from Blanchardstown Area Partnership the capacity of community based organisations to address drug concerns has been significantly enhanced. Groups such as Greater Blanchardstown Response to Drugs, the three Community Drug Teams Neighbourhood Youth Project, Blanchardstown Youth Service, BOND, among other all nurture and harness valuable community support in relation to positive responses to drug issues. It will be essential that statutory based personnel develop effective networking relationships and thereby add value to the shared responsibility for addressing drug issues

In the context of the above the role of this group was seen as a strategic one. The mission statement could be given effect through the following areas..

1. Supply
2. And Social Behaviour
3. Community Development
4. Promoting the role of Justice Related agencies.

7.5.1. Supply:

- Increased and sustained commitment to Community Policing,
- Greater flexibility in Gardai deployment.
- More undercover work and greater targeting by the Drug Squad to known drug dealers.
- Introduction of closed circuit T.V. in key locations.
- Commitment to better Gardai response time targets.
- More formalised policy discussions on allocation of tenancies by the Local Authority with established community groups.
- Investigation of supply lines particularly through commercial vehicles in the area for legitimate purposes.

7.5.2. Anti-Social Behaviour:

- The introduction of life-skills programmes from as early as the Primary School level.
- The building of trust with Gardai through their availability, effective communications and opening of Sub-Stations in appropriate areas.
- Developing the legitimate representative groups of community voices, which in turn would be seen to be supported by key agencies such as the Gardai.
- The introduction of formal Resident Participation in Estate Management Programmes with the support of all relevant agencies.
- The development of innovative approaches engaging with ‘youth at risk’ who do not traditionally involve themselves with current forms of organised activity.

- The development of family support and parenting skills programmes for those most in need.
- The building and effective management of facilities in the communities so as to provide alternatives to the "hanging around" culture.

7.5. 3. Community Development:

It was initially stated that if all of the other measures mentioned above were to work then community development work could be undertaken more easily. In a context of intimidation and fear this work would have to be supported on a consistent and long-term basis as part of a package of the integrated solutions to the Supply and Demand Problem in the area.

Training programmes for leaders from The Community and Culture Department of Fingal County Council. These need to be backed up by successes in the initiatives mentioned above under Supply, and Anti-Social Behaviour. An initiative to involve the youth in programmes as part of Resident Participation in Estate Management would be essential.

Facilities should be managed more effectively by supported and funded community leaders. These centres should include particular programmes and services designed in conjunction with drug users and disaffected youth. All of the agencies Gardai, Health Board, Local Authority, Social Welfare, Youth Services, Probation and Welfare and Education, need to be seen to be acting in open and regular structured contact with effective community organisations.

7.5 4. Promoting the Role of Justice Related Agencies:

A scarcity of essential front-line service staff in areas particularly such as probation and welfare, social workers. Juvenile Liaison Officers and community Gardai who could respond on a regular and consistent programme basis and not just in the context of crises being identified is recognised.

It is also believed that the attitude of staff to the public in many agencies shows a lack of empathy to the circumstances and that there should be a mentoring and support role for new staff from more experienced members of their agencies. This would help them cope with the particular problems they are experiencing in operating at the front line in relation to the drug issue.

It is believed that some professionals would benefit from joint training programmes with community leaders in order to develop a greater understanding of the context of their work. More cognisance should be given particularly to the needs of communities rather than the traditional Law and Order problem of crimes against property taking priority.

Medium Term Indicators:
Performance indicators for the first year include:

- An increase of Community Gardai dedicated to community work and an increase in Drug Squad Staff being available in the Dublin 15 area.
- A breaking down of inefficient and traditionalist type barriers to create a more integrated service of all providers be they statutory or newly created community based (through possibly now mainstream) projects.
- A recognition of the role of the new Structures and Services being provided.
- An enhanced probation service would be operable from a Blanchardstown location.
- Probation and Welfare Services to introduce new services to the Prison Service so that the proper post release integration can commence before offenders come out.
- Fingal County Council to establish full-time Estate Officers 'including officers responsible for anti-social behaviour in the Dublin 15 Area.
- That the policy on anti-social behaviour from the Local Authority and other relevant agencies is communicated consistently and effectively to all tenants beyond the initial training programme and distribution of a handbook.
- Drug users would be accepted as part of their community.
- The Bond Project would be supported and developed.
- The Prison Services would be conscious, notwithstanding their internal needs, of linking with workers outside of the prisons.
- The Drugs Court Pilot would be extended to the area as a matter primarily of equity where addicts in all parts of the country are treated similarly.
- Community Wardens could become part of the overall delivery of services in the area.

SUPPLY/CONTROL SUMMARY:

The Supply/Control Sub Group are confident that a clear strategic direction has been mapped in the above objectives. The focus of the groups activity is towards influencing change in the key statutory bodies whilst nurturing a partnership based approach between agencies, sectors and with the community. The group are at an early stage of development in moving towards this agenda. With clarity of focus and a clear commitment to regular meetings with key targeted agency personnel it is felt that this agenda can be established in relevant quarters and progressed. It is also believed imperative that the Task Force assumes and wields its power towards asserting these agendas. In this context no funding is being sought for project actions at this juncture. In committing to an annual review of progress it is felt that new initiative are more appropriately explored at that juncture. This is consistent with this Task Forces view that consolidation and clarity of focus are important precursors to new initiatives.

Supply Control Actions:

Action 35

Client:	Local Communities
Target:	Dept of Justice, Gardai authorities. Probation and Welfare Services.
Actor:	Supply/Control Group & BDTF
Action:	Secure from the appropriate Minister delivery of an effective and dedicated community policing service of not less than twenty community Gardai for this Task Force area. These personnel not to be re-deployed to other duties as this is a priority service/response to the drug issue. Together with this achieve increased drugs squad activity and effectiveness, and ensure that supply agenda objectives are being effectively carried out as critical to the Task Force plan and the integrated fight against drugs.
Resources:	Sub group & BDTF to establish strategic priority of this action towards immediate delivery of resources. Hold series of meetings with key stakeholders to secure commitment and action. Hold statutory players accountable in respect of response and identify performance indicators thereto.

Action 36

Client:	Local communities/probation clients
Target:	Minister/Dept of Justice
Actor:	Supply/Control Group & BDTF
Action:	Secure from the Minister for Justice, Equality & Law Reform appropriate resources for the Probation & Welfare Service, i.e., a local probation centre and significant increase in staffing levels as critical to Task Force plan.
Resources:	Commitment of sub group/support from BDTF

Action 37

Client:	Local communities
Target:	Fingal County Council
Actor:	Supply/Control Group & BDTF
Action:	Secure from Fingal County Council appropriate resources to support the estate management initiative and provide resources for local amenity improvements and to support and social behaviour being addressed.
Resources:	Commitment from sub group/support from BDTF

Action 38

Client:	Local communities/amenity management groups
Target:	Fingal County Council Community & Culture Dept
Actor:	Supply/Control Group & BDTF
Action:	Support Fingal County Council in targeting the delivery of training & support to community representative involved in management of community resources/facilities.
Resources:	Commitment from sub group/support from BDTF

BLANCHARDSTOWN DRUG TASK ROCE: SUMMARY OF ACTIONS

REF:	ACTION	THEME	ACTOR	COST P.A.	Co-FUNDED	FUNDING CHANNEL
1	Core Supports	T.F. Support	Planning/Evaluation	£80,000	**and NAHB co-ordinator**	B'town Area Partnership/NAHB
2	New Management model	T.F. Effectiveness	Planning/Evaluation	£1,000		BAP
3	Equal Opportunity Policy	T.F. Policy	Planning/Evaluation	£1,000		BAP
4	Support fund to formal sector	Education	Education/Prevention	£25,000		Dept. Education & Science
5	Drug Education Development	Education	Education/Prevention	£35,000	**plus £35,000 D.E.&S.**	Dept. Education & Science
6	WEB Family Support	Prevention	WEB Project	£45,000		Justice, Equality & Law Reform
7	Extend peer Education prog.	Prevention	B'town Youth Service	£35,000		VEC
8	Outdoor Pursuits	Prevention	BOND Project	£15,000		Justice, Equality & Law Reform
9	Harm Reduction Peer Ed	Prevention	BM CDT & BYS	£9,950		VEC
10	Drug Education Resource Facility	Education	Blakestown/M.C.D.T.	£94,000		BAP
11	Marketing strategy	Education	Education/Prevention	£20,000		BAP
12	Annual Drug Conference	Education	Education/Prevention	£3,000		BAP
13	Task Force Website	Education	Education/Prevention	£5,000		BAP
14	Integration of drug training	Education	Education/Prevention	£0		N/A
15	Drug Awareness Events	Education	Education/Prevention	£5,000		BAP
16	Early Ed. In Intervention	Prevention	Education/Prevention	£5,000		
17	Policy support for Employers	Education	Education/Prevention	£2,000		BAP
18	Drug Ed. In Workplace	Education	Education/Prevention	£8,000		BAP
19	Flexible treatment services	Health	BM CDT/NAHB	**XX**	**NAHB**	Northern Area Health Board
20	Counselling services in CDTS	Health	CDTs/NAHB	**XX**	**NAHB**	NAHB
21	Develop/research comp. Therapy	Health	BM CDT	£34,200		NAHB
22	Siblings Children of drug users.	Health	BM CDT	£15,000		NAHB
23	Social work Liaison	Health	Drug Reference Group	£12,000		NAHB
24	Advocacy work	Health	B. Advocacy Group	£15,000		NAHB
25	Counselling Family Therapy	Health	By tender	£25,000		NAHB
26	Peer Support Groups	Health	Health Sub Group	£30,000		NAHB
27	Treatment Centre	Health	T.F./NAHB	**XXX**	**NAHB**	NAHB
28	Improve information/communication	Health	Health Group & NAHB	£0		NAHB
29	Mainstreaming upgrade	Health	Corduff Mulhuddart CD	£20,000		NAHB
30	Needle exchange/outreach	Health	3 x CDTs	£90,000		NAHB

31	Inter-agency rehab meetings	Rehabilitation	Rehab Sub Group	£2,000	NAHB
32	Research Rehab Development	Rehabilitation	Rehab Sub Group	£15,000	NAHB
33	Inter-agency training/support	Rehabilitation	Rehab Sub Group	£8,000	NAHB
34	Training supports to pilot rehabs	Rehabilitation	Rehab Sub Group	£45,000	
35	Double community policing	Supply Control	Supply Control group	**XX** **Justice**	
36	Probation services & centre	Supply Control	Supply Control group	**XX** **Justice**	
37	Estate management improval	Supply Control	Supply Control group	**XX** **Fingal CC**	
38	Improved support to com. Development	Supply Control	Supply Control group	**XX** **Fingal CC**	
TOTAL				**£700,150**	

XX DENOTES COST TO BE ASSESSED BY THE RELEVANT STATUTORY BODY

BREAKDOWN:	
Task Force Supports	£82,000
Education Prevention	£306,950
Health	£241,200
Rehabilitation	£70,000
Supply Control	£0
Total:	**£700,150**

APPENDIX: MEMBERSHIP OF TASK FORCE & SUB GROUPS

TASK FORCE:

Name	Representing
John Cahill	Chairperson
Bernie Cawley	Dublin 15 Community Council
Catherine Durkin	Blanchardstown Area Partnership
Tony Geoghegan	Merchants Quay Project
Derek Hanway	Blanchardstown Area Partnership
Paul Hatton	Coolmine House
Marie Hyland Doyle	Community representative
Joe Higgins	Public representative
Inspector Peter Hughes	Gardai
Phillip Keegan	Community representative
Rosaleen Kinane	FAS
Gerard Lynam	Public representative
Fergus McCabe	National Drug Strategy Team
Seamus McDonagh	Community representative
Rachael Murphy	Blanchardstown Youth Service
Patricia Newham	Neighbourhood Youth Project
Karl O'Brien	Advocacy Group
Michael Q'Donovan	Public representative
Donal O'Sullivan	Probation and Welfare Service
Margaret Richardson	Public representative
Stephen Skelton	Community representative
Isabel SomerviIIe	Northern Area Health Board
Robert Tallent	Community representative
Senan Turnbull	Fingal County Council

Education/Prevention Sub Group

Name	Representing
John Cahill	Blanchardstown Youth Service
Catherine Durkin	Blanchardstown Area Partnership
Margaret Grogan	Department of Education and Science
Trish Newham	Neighbourhood Youth Project
Seamus Noone	Huntstown/Hartstown Community Drug Team
Maureen Penrose	BIakestown/Mountview Community Drug Team
Sheila Reaper Reynolds	Northern Area Health Board
Deirdre Tobin	Primary School Teacher

Health Sub Group

Name	Representing
Niamh Dowdall	Huntstown/Hartstown Community Drug Team
John Flaherty	Corduff/Mulhuddart Community Drug Team
Tony Geoghan	Merchants Quay Project
Paul Hatton	Coolmine House
Brian Jackson	Huntstown/Hartstown Community Drug Team
Stephan Joyce	Blakestown/Mountview Community Drug Team
Bill KelIy	Corduff/Mulhuddart Community Drug Team
Gerry Lynam	Public representative
Seamus McDonagh	Community representative
Maria McKay	NAHB Drugs/Aids Service
Niall Mulligan	Blakestown/Mountview Community Drug Team
Rachael Murphy	Blanchardstown Youth Service
Isabel Somerville	Northern Area Health Board
Oscar Trayner	Northern Area Health Board

Supply - Control (Justice) Sub Group

Name	Representing
Gerry Carrig	Fingal County Council
Bernie Cawley	Dublin 15 Community Council
Brendan Colgan	Corduff/Mulhuddart Community Drug Team
Kevin Jennings	Blanchardstown Gardai
Seamus McDonagh	Community representative
Donal O'Sullivan	Probation and Welfare Service
Stephen Skelton	Community representative
Robert Tallent	Community representative

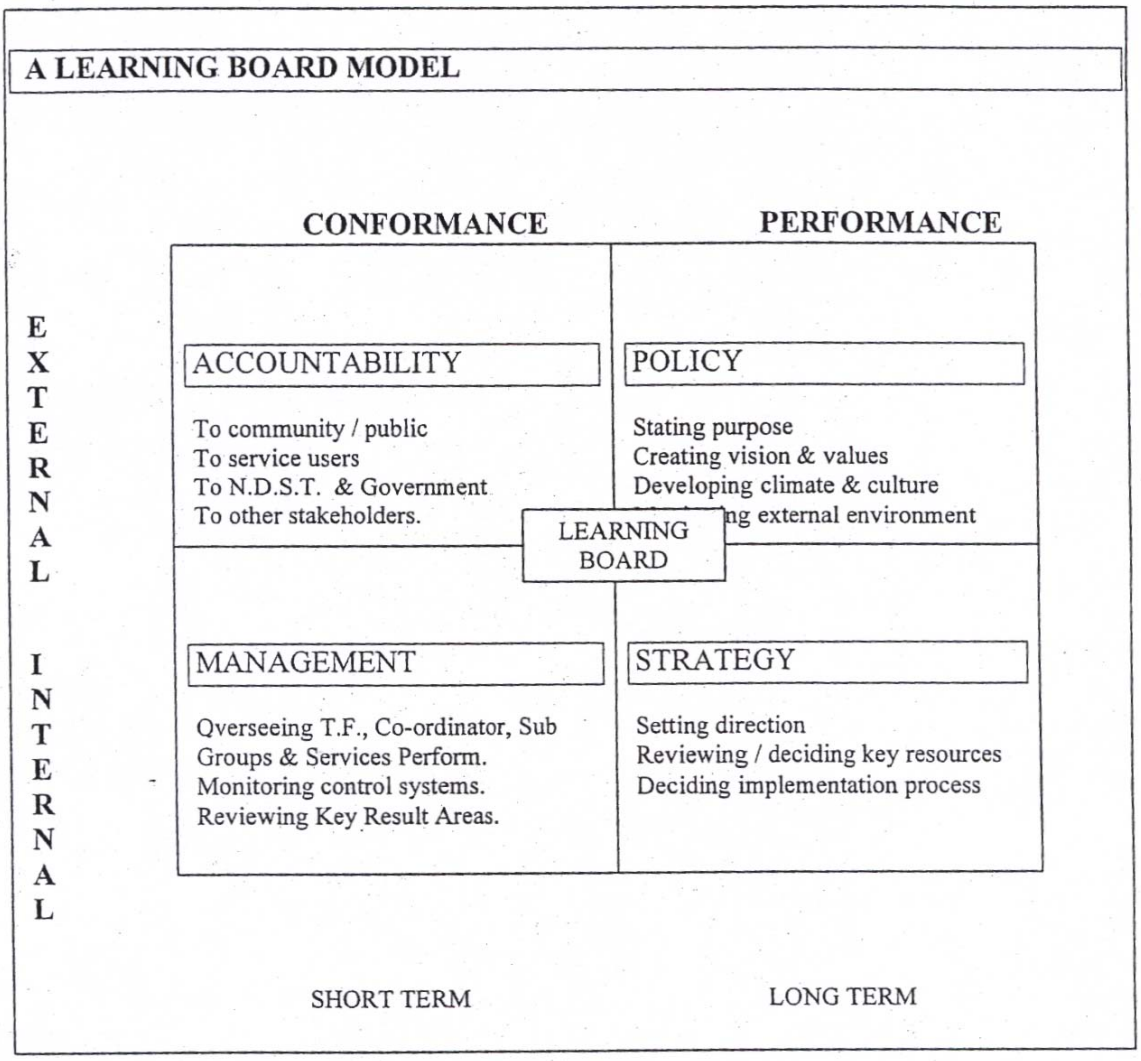
Planning and Evaluation Sub Group

Name	Representing
John Cahill	BDTF Chair
Derek Hanway	Blanchardstown Area Partnership
Peter Hughes	Blanchardstown Gardai
Bernie Kelly	Northern Area Health Board
Phillip Keegan	Community representative
Rosaleen Kinane	FAS
Margaret Richardson	Public representative
Senan Turnbull	Fingal County Council

Rehabilitation Sub Group

Name	Representing
Bernie Cawley	Dublin 15 Community Council
Pat Doyle	BOND Project
Catherine Durkin	Blanchardstown Area Partnership
John Flaherty	Corduff/Mulhuddart Community Drug Team
Derek Hanway	Blanchardstown Area Partnership
Bernie Kelly	Northern Area Health Board
Rosaleen Kinane	FAS
Marian Horkin	Northern Area Health Board
Seamus McDonagh	Community representative
Niall Mulligan	Blakestown/Mountview Community Drug Team
Seamus Noone	Huntstown/Hartstown Community Drug Team
Patricia O'Duigeinn	Coolmine House

APPENDIX:


A LEARNING BOARD MODEL
CONFORMANCE
PERFORMANCE
EXTERNAL
INTERNAL
ACCOUNTABILITY
To community / public
To service users
To N.D.S.T. & Government
To other stakeholders.
POLICY
Stating purpose
Creating vision & values
Developing climate & culture
ng external environment
LEARNING BOARD
MANAGEMENT
Qverseeing T.F., Co-ordinator, Sub Groups & Services Perform.
Monitoring control systems.
Reviewing Key Result Areas.
STRATEGY
Setting direction
Reviewing / deciding key resources
Deciding implementation process
SHORT TERM
LONG TERM