Strategy Document

South West Regional Drugs Task Force

February 2005

Chairman's Foreword

The South Western Regional Drug Task Force has been established to address the drugs issue in the former South Western Area Health Board region. The Regional Drug Task Force has been charged with developing a strategy that will address the issue of drug misuse across a region that has a population of over 500,000 people and includes the urban areas of South and West Dublin, the commuter towns of Kildare and West Wicklow and a large swathe of Counties Kildare and West Wicklow. This has been a challenging task to which the members of the Regional Drug Task Force have responded. They have worked hard to ensure that the strategic plan they have developed will play a key role in dealing with drug misuse in the region.

The damage caused by drugs and drug use to individuals and communities has been well documented. The Regional Task Force represents a partnership approach between the community, voluntary and statutory sectors in addressing the multifaceted issues related to drugs and drug misuse. I believe that it is only through this type of joint working that an issue as sensitive and complex as drug misuse can be addressed.

This strategic plan is informed by the National Drug Strategy and aims to address the issue of drug misuse under the following headings; treatment / rehabilitation, prevention / education, supply control, research. It is my view that actions are needed under each of the headings listed above if we are to bring a co-ordinated strategic approach to the problems of drug misuse. It is essential that our young people receive the appropriate education to prevent them becoming involved in drug misuse and that those who have become enmeshed in drugs have access to appropriate treatment and rehabilitation options. It is also essential that the supply of drugs is reduced and where possible eliminated. Lastly, research can inform us on the nature and extent of the problem and how best to tackle it.

Our work on the Task Force has given me hope for the future. I have learned that there are solutions to the problems of drugs and drug misuse. While solutions are complex and require hard work and commitment to bring them to fruition, they do exist. Tackling drug misuse also requires that we tackle the social problems that contribute to misuse. This requires that all the citizens of the country work together to make a better life for all. I believe this plan and the partnership model utilised in its development demonstrate the power of joint working between the community, voluntary and statutory sectors.

I wish to thank all those who have been involved in the development of both the Regional Drug Task Force and this strategic plan. The Regional Drug Task Force has put a considerable effort into drafting the plan. We await a positive response from Government so that the actions in this plan can be funded and the Task Force can begin to make a demonstrable difference in the region.

Fr Sean Healy

Contents

Section 1

Nature and Extent of Drug Misuse

Headlines

- Almost a quarter of the sample population in the former South West Area Health Board reported that they had used drugs (lifetime prevalence), (NACD Survey, 2004)

- The former South West Area Health Board had the 3rd highest lifetime prevalence rate nationally, (NACD Survey, 2004)

- The former South West Area Health Board had the second highest figure for last month prevalence when compared to other Health Boards, (NACD Survey, 2004)

- Over half of those presenting for drug treatment in the Eastern region live in the former SWAHB area

- Between 1998 and 2002 the total number of treated cases in the South West Regional Drugs Task Force Area rose by over 19%. (National Drug Treatment Reporting System)

- Within the SWRDTF the Kildare area accounted for 9% of all new presentations. (National Drug Treatment Reporting System)

- 49% of all cases in Kildare were new presentations (National Drug Treatment Reporting System)

- Across the SWRDTF region between 1998 - 2002 Kildare saw a substantial increase in the numbers of patients presenting with opiate problems

- In June 2004 the former South West Area Health Board had 115 people on their waiting list for methadone treatment, This figure represents almost 40% of all those on methadone waiting lists in June 2004.

Introduction

This section examines the extent and nature of drug misuse within the area of the South Western Regional Drugs Task Force (SWRDTF). It also presents the issue in the SWRDTF in the context of drug misuse in the ERHA region and nationally. Information regarding drug misuse in the SWAHB area is used in the section to describe drug misuse in the SWRDTF, since their geographical areas coincide. Indicators of the level and extent of drug misuse in the region have been taken from the criminal justice system (regarding Misuse of Drugs Act Offences), prevalence and treatment data.

Data Sources

Data for this review was gathered from a wide variety of different sources including Annual Reports of An Garda Siochana, the South Western Area Health Board, the Drug Treatment Centre Board, and the European Monitoring Committee for Drugs and Drug Addiction, along with the Service Plan for 2005 for the Eastern Regional Health Authority, and reports compiled by the National Advisory Committee on Drugs on cocaine use and drug prevalence (2002 & 2003). The Statistical Bulletin compiled by the National Drug Treatment Reporting System for 1997 and 1998 was also consulted as were the regional results of the National Health and Lifestyle Surveys SLAN and HBSC (2003) produced by the Department of Health and Children. Data from the Central Statistics Office Population and Migration Reports, the Irish Deprivation Index, and the submission made by Focus Ireland in 1999 to the review of the National Drug Strategy. Other reports published by Government departments along with research studies carried out were also consulted. A full list of data sources, appropriately referenced, are available at the end of this text.

Definitions

The Health Research Board has defined the term *drug misuse* or *problem drug use* as drug use that causes 'social, psychological, physical or legal difficulties as a result of an excessive compulsion to continue taking drugs'. This definition identifies the problem by its consequences, which can affect the individual as well as their family, community and society and has been used to guide the research on which this report is based. Data on the misuse of alcohol has not been included in the report as this is not the primary remit of the Regional Drugs Task Force. The Task Force is awaiting guidance from government on how best to proceed in relation to the issue of alcohol.

The true extent of drug misuse is difficult to ascertain. It is general practice to use data on the prevalence of drug misuse to provide the most accurate estimate of the extent of drug misuse and this is the approach taken in this research. The term prevalence refers to the proportion of a population who have used particular illegal drugs over a period of time. These figures represent an estimated calculation using the numbers of those who present themselves for various types of treatment, are arrested on drug-related charges and die due to drug-related causes. These figures will not accurately reflect the total numbers within the population who are misusing drugs, but they provide evidence for the best possible estimate. There are some studies, however, that use representative samples from the general population to estimate the prevalence of drug misuse, including a study by the National Advisory Committee on Drugs (NACD) published in 2004, which is referred to later in this report.

Methodological Difficulties

The analysis of available data for this report presented some difficulties. Data on prevalence and treatment rates compiled by different sources can differ and breakdowns of data according to geographical divisions do not necessarily correspond between different data sources (e.g. geographical divisions used in Garda statistics, divisions within the Dublin Metropolitan area, Local Drug Task Force areas and District Electoral Divisions do not match).

Prevalence of Drug Misuse Across Ireland

A survey conducted on behalf of the NACD (2004) reports prevalence rates for illicit drug use across the population of Ireland in 2002/2003. The proportion of the national sample that reported using any illicit drug over their lifetime was 19%. A smaller proportion (5.6%) reported having used an illicit drug over the previous year and a smaller percentage again (3%) reported having used drugs in the previous month.

Cannabis

Many studies concur that the most commonly used illegal drug among the population in Ireland is cannabis, in line with EU statistics (Gleeson et al, 1989; Moran et al, 1997; NACD, 2004). Regional results from the SLÁN Survey (Survey of Lifestyles, Attitudes and Nutrition, 2003) showed significant regional variation in cannabis use. The highest rate of cannabis use in the previous 12 months was

within the Eastern Region (ERHA). The East Coast Area Health Board showed almost 16%, followed by the South West Area and Northern Area (11% each).

Opiates

A study by Dr Alan Kelly and associates for the NACD (2003) indicates that in 2001 14,452 people were using heroin in Ireland, 12,456 of these were in the Dublin area. This figure had decreased somewhat from 1996 but methodological uncertainties make it difficult to draw firm conclusions about the apparent downward trend. The main change appeared in a decrease in the number of younger people (aged 15-24 years) using heroin/ opiates and a concentration in the age groups 25-34 and 35-44 years. This shift in concentration to older age groups can be partially explained by population changes over time and the availability of treatment but is most likely to be the result of the ageing of the current population of opiate users and the fact that they are not being replaced young people engaging in opiate use. No breakdown of these findings by Health Board area is available. The decrease in the number of younger people using heroin (aged 15-24 years) may imply that this age group are turning to other types of drugs, since the overall figures for younger people misusing drugs is on the increase. However there is no data available regarding this issue.

Cocaine

An Overview of Cocaine Use in Ireland, compiled by the NACD (2003) provides substantial evidence of an increasing trend of cocaine use in Ireland. Research findings would indicate that cocaine use is not confined to one geographical area or social class, is usually related to poly-drug misuse (particularly with alcohol), is widely considered to be a 'safe' drug, and users do not tend to consider themselves as being in need of treatment. Only approximately 1% of all those who present for treatment nationally report cocaine as being their primary drug of misuse.

The Drug Treatment Centre Board's (DTCB) annual report (2003) shows that 8.6% of drug tests carried out in 2003 were positive for cocaine. Earlier figures for 2002 and 2001 were 6.9% and 4.4% respectively. This amounts to almost a doubling of cocaine detection over 2 years. The DTCB report proposes that increased use of cocaine is partially due to the fact that heroin addicts in disadvantaged areas inject the two drugs together; a combination, known as a 'speedball'.

Solvents/ Inhalants

The EMCDDA (2003) Annual Report highlights the problem of solvent use among young people, which they say is often overlooked:. EU figures would indicate that after alcohol and cannabis, solvents are the most commonly used illicit substance by 15 to 16-year-olds with the highest rate of use throughout the EU being in Ireland (22%). The number of deaths related to such substances recorded among young people suggests that solvent use is an acute health risk for young people. It is widely acknowledged that solvent use is primarily a problem which manifests itself in the early teens but which tends to be discontinued by those in older age groups.

Groups Most at Risk of Drug Misuse

In 1998 the National Drug Treatment Reporting System (NDTRS, 1998) compiled a profile of those who misuse drugs in Ireland that provides information on the groups most at risk of drug misuse:

- approximately 70% of those misusing drugs in Ireland are male;
- over one third of those receiving treatment for drug misuse were aged 20 - 24 years;
- over 3/4 of those presenting for treatment left school by the age of 16;
- over 70% were unemployed;
- almost 3/4 of those presenting for treatment had tried their primary drug of misuse before the age of 19;
- over 30% had been regularly using their primary drug of misuse for 2-3 years.

National lifetime prevalence rates for drug misuse in Ireland (NACD, 2004) show the rates among males (24.4%) to be consistently higher than those among females (13.5%). However the gap between males and females is reducing.

A link between drug misuse and poverty has been highlighted by a number of studies, including research conducted by O'Higgins for the Combat Poverty Agency (1998). Conclusions from their research suggest that poverty and deprivation tend to encourage drug misuse and the misuse of opiates (including heroin) is most associated with areas of deprivation, particularly in the Dublin area.

The homeless population and those engaged in prostitution were identified as being particularly at risk of drug misuse. Focus Ireland (1999) estimated that over one third of homeless people in contact with them were misusing drugs. A study by the Women's Health Project of the Eastern Health Board (1999) shows over 84% of women who are involved in prostitution to be injecting heroin and most reported poly-drug use. This study and others have concluded that the vast majority of women involved in prostitution do so to gain money to fund their drug habit (and often to fund a partner's drug habit also). The Gay Men's Health Project

(1997) reports that drug misuse is also high among those engaging in male prostitution.

Prevalence of Drug Misuse in SWRDTF Area

The most recent data on drug prevalence from the NACD (2004) pertain to a survey conducted in 2002/2003. The NACD survey involved a total national sample of 4,925 people aged between 15-64 years of age, of which 605 resided in the SWAHB area. Results of the survey include 'lifetime prevalence' rates (i.e. those who reported ever having used drugs at some stage over their lifetime). Lifetime prevalence does not indicate that a person is currently using drugs, that a person has used a drug over a long period of time, or that they will do so in the future. Results of the survey also include 'last year prevalence' (i.e. the proportion of the sample who report using drugs at any time in the year prior to the survey) and 'last month prevalence' (i.e. the proportion who report using drugs in the 30 day period prior to the survey). Last month prevalence is referred to as current use, including occasional users and first-time users as well as more habitual users. Prevalence rates for each health board area including the SWAHB along with national data are illustrated in Table 1.1 below.

Table 1.1: Prevalence of Drug Misuse in each Health Board Area and Nationally (NACD, 2004)

	Percentage of Population (2002/ 2003)		
	Lifetime Prevalence	Last Year Prevalence	Last Month Prevalence
NAHB	29.5%	8.5%	5.4%
ECAHB	25.8%	6.4%	4.1%
SWAHB	24.1%	7.5%	4.3%
NEHB	19.1%	6.4%	2.5%
National Population	19.0%	5.6%	3.0%
SEHB	18.9%	6.8%	3.1%
WHB	15.1%	2.8%	1.9%
MWHB	12.5%	3.2%	1.6%
SHB	12.3%	4.7%	2.1%
NWHB	11.3%	2.6%	0.5%
MHB	11.2%	2.8%	1.0%

Lifetime Prevalence

The NACD survey (2004) shows that the proportion of the sample in the SWAHB who reported ever having used any illegal drugs (lifetime prevalence) was 24.1%: almost a quarter of the population in the area. This is well above the national average for lifetime prevalence referred to earlier, which stands at 19%. The SWAHB shows the 3rd highest average lifetime prevalence when compared to all other health board areas nationally. Only the ECAHB and the NAHB show higher lifetime prevalence rates (of 25.8% and 29.5% respectively). These 3 health board areas constitute the ERHA. Within the ERHA region, therefore, the SWAHB has the lowest lifetime prevalence of the 3 area health boards. Within the national context, however, the SWAHB lifetime prevalence proportion is significantly above average.

Last Year Prevalence

The NACD (2004) reports that the last year prevalence proportion for the SWAHB was 7.5% at the time of their survey in 2002/2003 in comparison to the national last year prevalence proportion, which stood at 5.6%. The last year prevalence figure for the SWAHB was the second highest nationally, when compared to proportions in all other health board areas.

Only the NAHB had a higher proportion among its sample (8.5%), 1% above that of the SWAHB. The SWAHB has the second highest proportion among the ERHA health board areas, with the NAHB 1% above it and the ECAHB 1% below it. These figures indicate that, while a smaller proportion of those in the SWAHB had ever used illicit drugs when compared to the ECAHB, recent use (last year prevalence) is a more significant issue among those in the SWAHB than in the ECAHB.

Last Month Prevalence

The last month prevalence proportion for the SWAHB, reported in the NACD survey (2004), was 4.3%. This is 1.3% above the national last month prevalence proportion, which stood at 3.0%. The SWAHB figure for last month prevalence was the second highest nationally, when compared to all other health board areas. The lowest proportion of any health board area (0.5%) was reported in the NWHB. The SWAHB proportion was almost 4% above this lowest proportion.

The highest proportion of last month prevalence, 5.4%, was to be found in the NAHB (forming part of the ERHA area). The SWAHB was next to this in ranking, just over 1% less in its proportion of those who reported using illicit drugs in the month prior to the study. Third in the rank was the last of the ERHA health board areas, the ECAHB, which showed a proportion of 4.1% for last month prevalence.

The SWAHB has the second highest proportion among the ERHA health board areas, with the NAHB 1% above it and the ECAHB very slightly below it for last month prevalence. This middle ranking in relation to other ERHA health boards was also the case for the SWAHB in relation to last year prevalence.

Overall, the results of the NACD survey show that not only is there an above-average proportion of people living in the SWAHB area who have used drugs at some point in their lives, but there is also an above- average proportion of people in this area who have been using drugs over the last year and in the last month.

Prevalence Data by Type of Drug

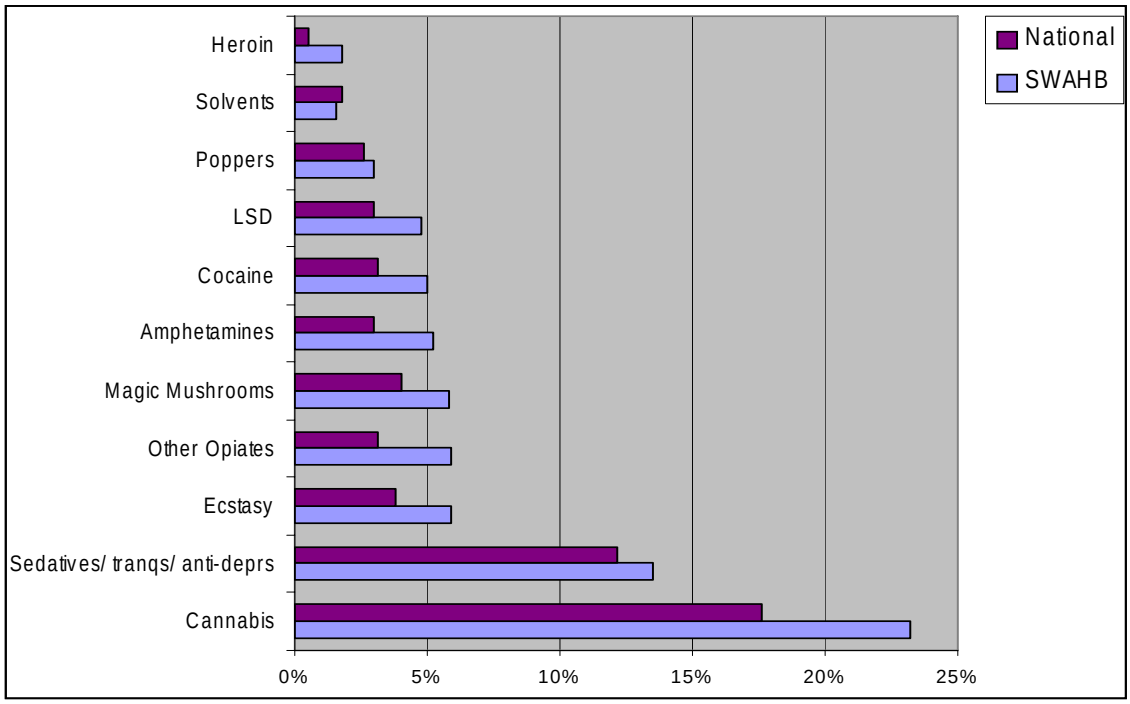
Lifetime Prevalence by Type of Drug

Lifetime prevalence data for the SWAHB area show higher rates for almost all drug types when compared with national figures (Table 1.2 and Figure 1.1). Solvent use was the exception to this, with a marginally lower prevalence in the SWAHB (1.6%).

Table 1.2: Lifetime Prevalence of Specific Drug Misuse: SWAHB & National Percentages (NACD, 2004)

	SWAHB Population	National Population
Cannabis	23.2%	17.6%
Sedatives/ tranquillisers/ anti-depressants	13.5%	12.2%
Ecstasy	5.9%	3.8%
Other Opiates	5.9%	3.1%
Magic Mushrooms	5.8%	4.0%
Amphetamines	5.2%	3.0%
Cocaine	5.0%	3.1%
LSD	4.8%	3.0%
Poppers (amyl- or butyl-nitrite)	3.0%	2.6%
Solvents	1.6%	1.8%
Heroin	1.8%	0.5%

Figure 1.1: Lifetime Prevalence of Specific Drug Misuse: SWAHB & National Rates (NACD, 2004)



Using lifetime prevalence figures, cannabis is the most commonly used illicit drug in the SWAHB (23.2%), followed by sedatives/ tranquillisers/ anti-depressants (13.5%). These are also the most commonly misused drugs in the national figures. The next most commonly used drugs in the SWAHB area were other opiates and ecstasy (5.9% each), magic mushrooms (5.8%), amphetamines (5.2%), cocaine (5%), LSD (4.8%), poppers (3%), heroin (1.8%) with solvents having the lowest prevalence rates (1.6%). The level of heroin use (1.8%) was relatively low in the region when compared to other drug types, but still higher in this area when compared to national figures. Despite the relatively low this prevalence of heroin use, opiates (which include heroin) are the main drug mentioned in treatment cases it is likely that this is due to the fact that the damage caused by heroin and cocaine is much more significant than that caused by other illicit drugs. The harm caused to the individuals themselves, their families and the wider community may be a major factor in heroin users presenting for treatment in higher numbers than those who misuse other substances.

Last Year Prevalence by Type of Drug

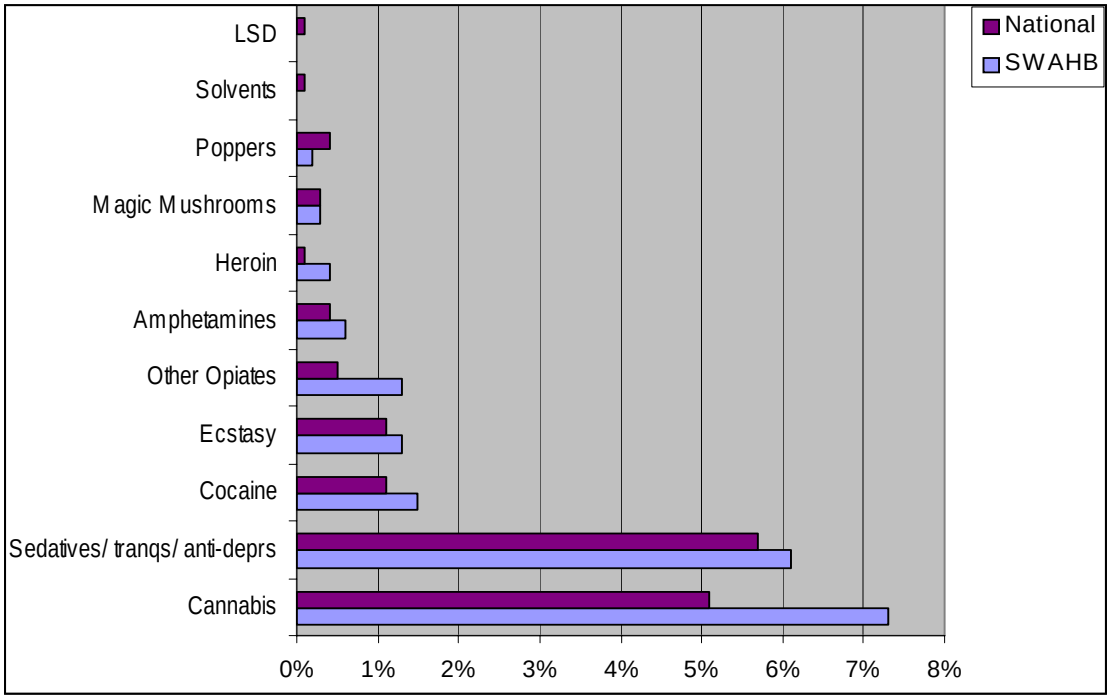
In relation to last year prevalence rates, the SWAHB was still above the national rates for most drug types including cannabis, sedatives/ tranquillisers/ anti-depressants, cocaine, ecstasy, amphetamines and heroin. Table 1.3 and Figure

1.2 illustrate these differences in 'last year prevalence' rates. Cannabis use in the SWAHB area in the last year was still strikingly above the national rate. Use of sedatives/ tranquillisers/ anti-depressants is more prominent in the 'last year' prevalence rates than it was in the 'lifetime' prevalence rates, indicating that they are more common drugs of choice in recent times.

Table 1.3: Last Year Prevalence of Specific Drug Misuse: SWAHB & Nationally (NACD, 2004)

	SWAHB Population	National Population
Cannabis	7.3%	5.1%
Sedatives/ tranquillisers/ anti-depressants	6.1%	5.7%
Ecstasy	1.3%	1.1%
Other Opiates	1.3%	0.5%
Magic Mushrooms	0.3%	0.3%
Amphetamines	0.6%	0.4%
Cocaine	1.5%	1.1%
LSD	-	0.1%
Poppers (amyl- or butyl-nitrite)	0.2%	0.4%
Solvents	-	0.1%
Heroin	0.4%	0.1%

Figure 1.2: Last Year Prevalence of Specific Drug Misuse: SWAHB & Nationally (NACD, 2004)



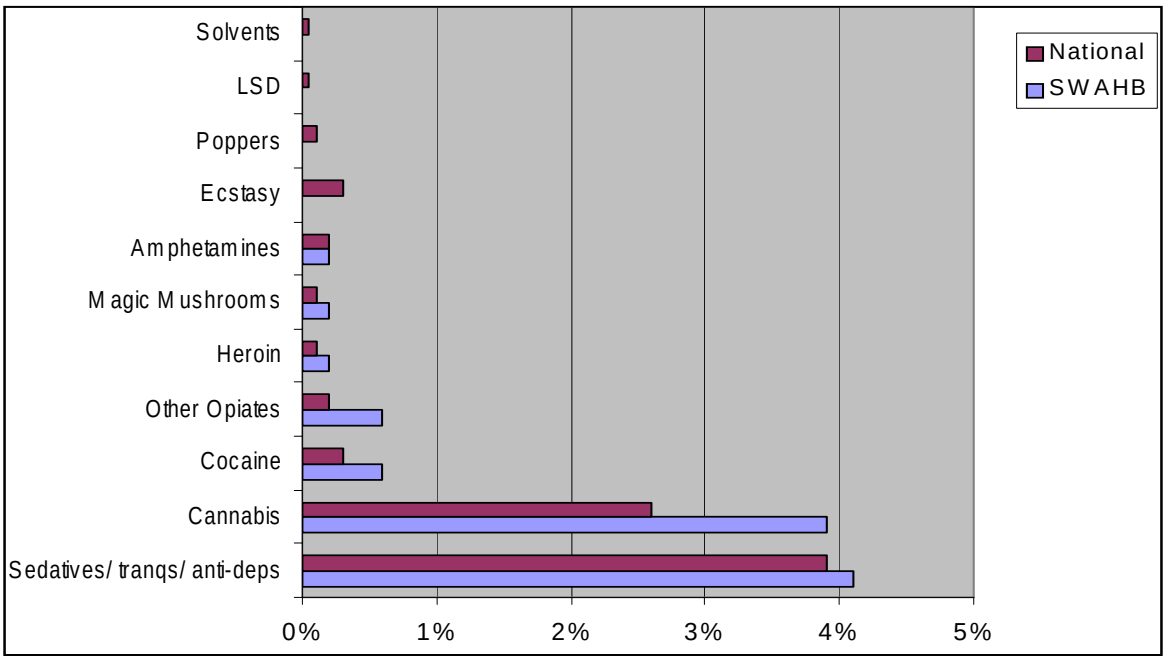
Last Month Prevalence by Type of Drug

Last month prevalence rates show the same trend as lifetime and last year prevalence rates, with the SWAHB having higher rates than those found nationally. Table 1.4 and Figure 1.3 display 'last month' prevalence rates for the SWAHB, according to drug type, alongside national figures. Sedatives/ tranquillisers/ anti-depressants were the most commonly used drug within the last month, nationally and in the SWAHB. Cannabis continues to have a much higher prevalence rate compared to the national figure. Cocaine, heroin, other opiates and magic mushrooms are still above national rates in relation to last month prevalence. Use of ecstasy, poppers, solvents and LSD, however, are somewhat below the national rates in this case.

Table 1.4: Last Month Prevalence of Specific Drug Misuse: SWAHB & Nationally (NACD, 2004)

	SWAHB Population	National Population
Sedatives/ tranquillisers/ anti-depressants	4.1%	3.9%
Cannabis	3.9%	2.6%
Cocaine	0.6%	0.3%
Other Opiates	0.6%	0.2%
Heroin	0.2%	0.1%
Magic Mushrooms	0.2%	0.1%
Amphetamines	0.2%	0.2%
LSD	-	0.05%
Ecstasy	-	0.3%
Poppers (amyl- or butyl-nitrite)	-	0.1%
Solvents	-	0.05%

Figure 1.3: Last Month Prevalence of Specific Drug Misuse: SWAHB & Nationally (NACD, 2004)



Drug Treatment in the SWRDTF

Drug treatment services provided by the SWAHB include inpatient and outpatient detoxification and methadone maintenance programmes. Treatment services are part of a broader range of addiction services available that includes outreach, harm reduction, information, education, counselling, rehabilitation and support services.

Over half of those presenting for drug treatment in the Eastern Region live in the SWAHB area (SWAHB Annual Reports 2002 & 2003). The number of people in treatment is continually growing with figures showing a 6.5% increase in 2003 over the previous year, giving a total of 2,588 people in treatment.

All Treated Cases in the SWRDTF

According to data compiled by the Health Research Board, for the National Drug Treatment Reporting System (NDTRS) the total number of all treated cases for drug misuse in the SWRDTF area, over a 5-year period from 1998 to 2002, was 12,326. The data show a 19.2% (433 cases) increase in treated cases over the 5 years in the SWRDTF area. The increase did not occur steadily over the 5 years

but rather, the number of cases fell on two of the years in question. The figures for these 5 years in isolation, therefore, indicate a somewhat erratic yet generally rising trend in treated cases of drug misuse in the SWRDTF (Table 1.5).

Table 1.5: All Treated Cases for Drug Misuse from 1998 - 2002 in the SWRDTF (NDTRS data)

	1998	1999	2000	2001	2002	Total
Total	2,255	2,482	2,467	2,434	2,688	12,326
Increase/ decrease on previous year	unknown	+ 227	- 15	- 33	+ 254	+ 433
% increase/ decrease on previous year	unknown	+ 10.1%	- 0.6%	- 1.3%	+ 10.4%	+ 19.2%

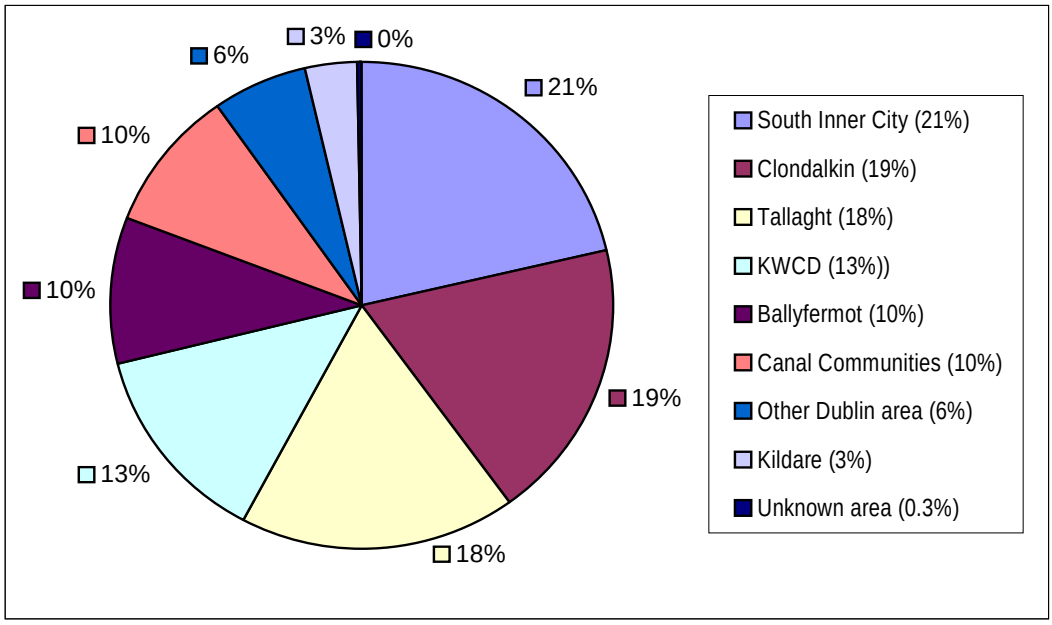
Breakdown of All Treated Cases by Area within the SWRDTF

The National Drug Treatment Reporting System (NDTRS) provides a breakdown of treated cases according to different areas within the SWRDTF. These areas include the 6 Local Drug Task Force (LDTF) areas, namely Ballyfermot, Canal Communities, Clondalkin, Kimmage-Walkinstown-Crumlin-Drimnagh (KWCD, Dublin 12), South Inner City and Tallaght. The HRB also indicate figures for treated cases outside these Local Drug Task Force areas, namely other Dublin areas and Kildare. The breakdown for treated cases of drug misuse in these areas is shown in Table 1.6 below and illustrated in graph form in Figure 1.4 and.

Table 1.6: All Treated Cases by SWRDTF Area from 1998 - 2002 (NDTRS data)

SWRDTF Area	1998	1999	2000	2001	2002	Total
Local Drug Task Forces:						
Ballyfermot	255	298	206	214	218	1,191
Canal Communities	230	177	247	225	290	1,169
Clondalkin	393	467	422	524	493	2,299
KWCD (Dublin 12)	289	280	368	319	358	1,614
South Inner City	449	502	512	540	646	2,649
Tallaght	439	503	443	376	428	2,189
Other areas:						
Other Dublin area	144	167	148	141	154	754
Kildare	56	82	108	82	95	423
Missing location data	0	6	13	13	6	38
Total	2,255	2,482	2,467	2,434	2,688	12,326

Figure 1.4: Areas within the SWRDTF as Percentage of the Total Treated Cases from 1998-2000.



Treated cases in the South Inner City Local Drug Task Force area accounted for the largest proportion (2,649 or 21%) of all treated cases in the SWRDTF from 1998-2002. The second largest proportion was to be found in the Clondalkin Local Drug Task Force area (2,299 or 19%), followed closely by the Tallaght Local Drug Task Force area (2,189 or 18%). The KWCD Local Drug Task Force area accounted for 13% of all treated cases during that time, while Ballyfermot and Canal Communities Local Drug Task Force areas each accounted for 10%. These areas correspond with the areas that were found to have high proportions of 'most deprived' scores in the Irish Deprivation Index (SAHRU, 2004). Areas that fall outside the Local Drug Task Force areas accounted for smaller percentages of all treated cases, with 6% found in other Dublin areas and 3% in Kildare. However the aforementioned 3% should be treated with caution in light of the fact that Kildare accounted for 9% of all new cases between 1998 and 2002 and that 49% of those presenting were new cases.

The general rise in treated cases of drug misuse in the SWRDTF from 1998-2002 (shown in Table 1.5 above) is not reflected in all of areas within it. Areas that displayed a rise in treated cases over the 5 years were South Inner City LDTF, Clondalkin LDTF, KWCD LDTF, Canal Communities LDTF, other Dublin areas, and Kildare. South Inner City LDTF showed the largest increase in numbers over the 5 years (+197 cases) followed by Clondalkin LDTF (+100 cases).

Areas that displayed a fall in treated cases of drug misuse over this period, were Ballyfermot LDTF and Tallaght LDTF. Ballyfermot showed the largest fall: 37 cases (15%) between 1998 and 2002. . The number of treated cases in Tallaght also fell but only by 11 cases (2.5%), over the 5 years in that area.

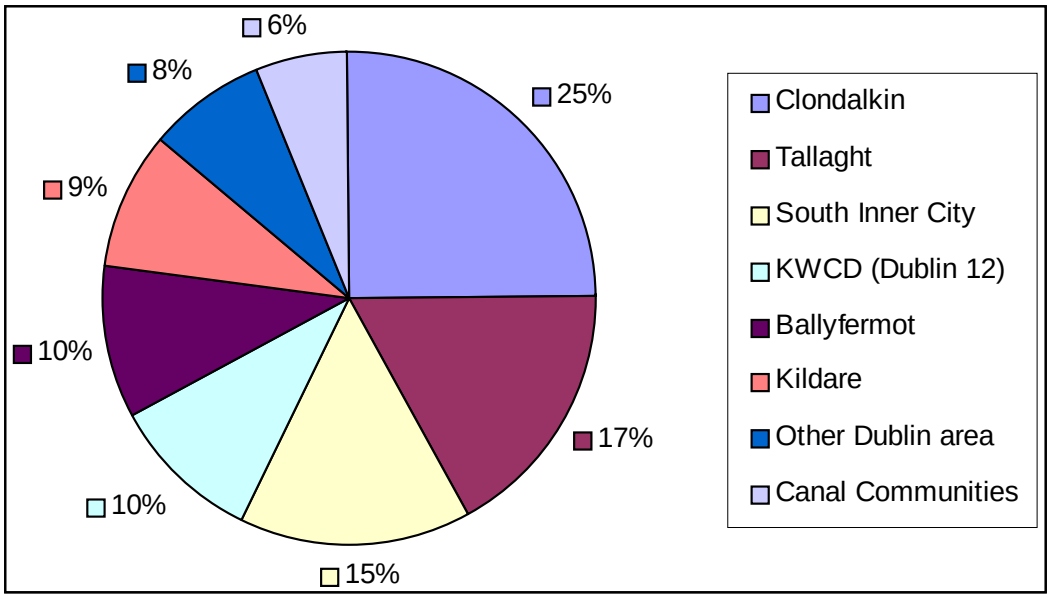
New Presentations for Treatment within the SWRDTF

NDTRS data show a total of 2,160 new presentations for treatment in the SWRDTF region over the years from 1998 to 2002, which accounts for 18% of all treated cases in the region over those 5 years. Table 1.7 below displays a breakdown of new presentations and shows them as a percentage of all new presentations in the SWRDTF region and as a percentage of all treated drug misuse cases in an area. Figure 1.8 charts how each area in the SWRDTF contributes to the total number of new presentations for treatment in the region. Clondalkin was the area that accounted for the largest percentage of new presentations (25%), this was followed by Tallaght, which accounted for 17%, the South Inner City for 15% and KWCD and Ballyfermot each for 10%. Kildare (9%), other Dublin areas (8%), and Canal Communities (6%), accounted for the lowest percentages of new presentations for treatment in the region.

Table 1.7: New Presentations for Treatment by Area with the SWRDTF (1998-2002)

	1998 - 2002			
SWRDTF Area	All Treated Cases	New Presentations	New Presentations As % of All New Presentations in Region	New Presentations As % of All Treated Cases in Area
Local Drug Task Forces:				
Ballyfermot	1,191	212	10%	18%
Canal Communities	1,169	129	6%	11%
Clondalkin	2,299	530	25%	23%
KWCD (Dublin 12)	1,614	208	10%	13%
South Inner City	2,649	323	15%	12%
Tallaght	2,189	378	17%	17%
Other Areas:				
Other Dublin area	754	165	8%	22%
Kildare	423	205	9%	49%
Missing data	38	10	-	-
Total	12,326	2,160	18%	-

Figure 1.5: New Presentations for treatment in SWRDTF Areas as Percentage of All New Presentations in Region, (1998-2002)



The 3 areas that accounted for the highest proportions of all treated cases in the SWRDTF region also accounted for the highest proportions of new presentations in the region from 1998 to 2002: Clondalkin, Tallaght and South Inner City. The new presentations for treatment in these 3 areas (Clondalkin, Tallaght and South Inner City) amounted to over half (57%) of all new presentations in the SWRDTF from 1998 to 2002.

The last column in Table 1.7 shows new presentations for treatment in an area as a percentage of all treated cases in the area. Figure 1.5 also illustrates this in graph form. As previously stated (P. 12) the Kildare area, accounted for only 3% of all treated cases in the region (from 1998-2002) but accounted for 9% of all new presentations as almost half of its cases were new. Kildare showed the highest level of new presentations among its cases (49%). Both Clondalkin (23%) and other Dublin areas (22%) had the next highest level with over one fifth of their cases comprising of new presentations (from 1998 to 2002).

The proportions of new presentations for treatment in Ballyfermot (18%) and Tallaght (17%) were closely aligned with that of the general proportion of new presentations in the region (18%). Areas with the lowest level of new presentations among their treated cases were KWCD, South Inner City and Canal Communities (11%-13%). Proportions in these regions were considerably below the regional proportion. This is noteworthy in the South Inner City area in particular, as it has the largest number of treated cases of any area in the SWRDTF.

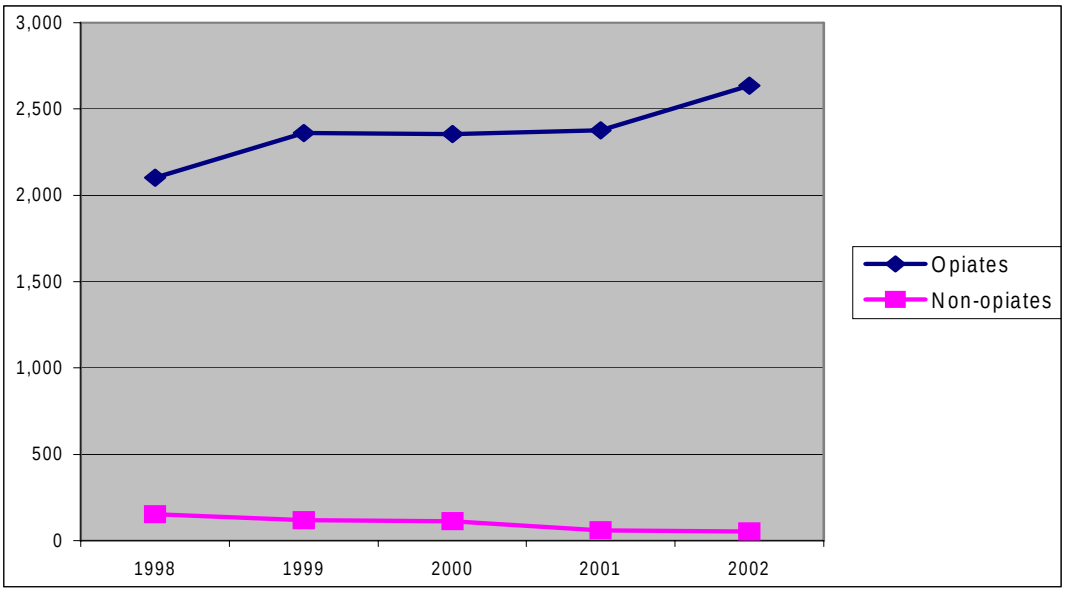
Drug Treatment by Type of Drug

Table 1.8 displays data compiled by the NDTRS for all treated cases for drug misuse in the SWRDTF area from 1998 to 2002 according to whether or not they used opiates, and if not, what other type of drugs they were using. Figure 1.6 provides this data in graph form. The demand for opiate treatment rather than treatment for the use of any other drug is clear from the graph.

Table 1.8: Type of Drug Misuse by those Treated in SWRDTF Region - 1998-2002 (NDTRS data)

Type of Drug Misuse	1998	1999	2000	2001	2002	Total
Opiates	2,103	2,362	2,355	2,375	2,635	11,830
No mention of opiates:						
Ecstasy	15	27	21	15	3	81
Cocaine	20	11	9	9	14	63
Amphetamines	7	9	1	0	0	17
Benzodiazepines	12	4	16	8	5	45
Volatile inhalants	6	3	2	1	0	12
Cannabis	79	63	62	25	29	258
Other substances	6	3	1	1	2	13
Missing data	7	0	0	0	0	7
Sub-total no mention opiates	*152*	*120*	*112*	*59*	*53*	*496*
Grand Total	2,255	2,482	2,467	2,434	2,688	12,326

Figure 1.6: Type of Drug Misuse by those Treated in SWRDTF Region from 1998-2002



Opiate-related Treatment

The vast majority of those who were receiving treatment mentioned opiates as being their major drug of misuse (11,830 or 96% of all treated cases from 1998-2002). Poly-drug misuse (i.e. the use of more than one drug) is a known phenomenon among those availing of treatment in clinics within the area (ERHA Service Plan 2005), and so it is likely that these people were also misusing other types of drugs as well as opiates.

Only 4% (496) of treated cases over the 5-year period did not mention opiates as a drug of misuse. It is noteworthy that heroin and other opiates were shown to be among the least commonly used illicit drugs in the SWAHB (with lifetime prevalence rates of 1.8% and 5.9% respectively), and yet these drugs types are mentioned in relation to 96% of all treated cases in the region once again it is important to stress that this may be due to the relative significance of the damage caused by heroin misuse.

Non-Opiate-related Treatment

When opiates were not mentioned as a drug of misuse, the most common drug for those treated over the 5 years in the SWRDTF region was cannabis (258 or 2% of any drug mentioned). Half of those who did not mention opiates said that they used cannabis. The next most common drugs, for which treatment was received in this category, were ecstasy (0.7% of any drug), cocaine (0.5% of any drug) and benzodiazepines (0.4% of any drug). Amphetamines, volatile inhalants and other substances were mentioned by even smaller percentages of the overall number treated (0.1% each). The issue of poly-drug misuse should be noted again in this instance. It is possible that many of these people receiving treatment were misusing more than the drug that they mentioned as their dominant or primary drug of misuse.

Changes in Drug Treatment Figures

The total number of all treated cases in the SWRDTF region showed a 19% increase over the 5 years from 1998 to 2002. Those who said that their main drug of misuse was opiates had a much higher increase, of 25%, while treated cases who did not mention opiates actually decreased by 65% over the 5-year period this decrease may be explained by the fact that there is increasing awareness of the damage caused by opiate use relative to other drug misuse and there may therefore be a bias towards providing treatment for those who present with opiates as their main drug of misuse. The increase in the number of services for opiate misusers may also be a factor in this decrease and in the increase of the numbers mentioning opiates as their main drug of misuse. The overall increase in treated cases in the region from 1998-2002, therefore, can be fully accounted for by cases where opiates were the main drug of misuse.

Table 1.9: Trend in Treatment by Type of Drug Mentioned, in SWRDTF Region from 1998-2002 (NDTRS data)

Type of Drug Misuse	1998	1999	2000	2001	2002	5 Yr. Total
Opiates (n)	2,103	2,362	2,355	2,375	2,635	11,830
Increase/ decrease	-	+ 259	- 7	+ 20	+ 260	+532
% Increase/ decrease	-	+ 12%	- 0.3%	+ 0.9%	11%	+ 25%
No mention opiates (n)	152	120	112	59	53	496
Increase/ decrease	-	- 32	- 8	- 53	- 6	- 99
% Increase/ decrease	-	- 21%	- 6%	- 47%	- 10%	- 65%
Grand Total (n)	2,255	2,482	2,467	2,434	2,688	12,326
	-	+ 227	- 15	- 33	+ 254	+ 433
% Increase/ decrease	-	+ 10%	- 0.6%	- 1%	+ 10%	+ 19%

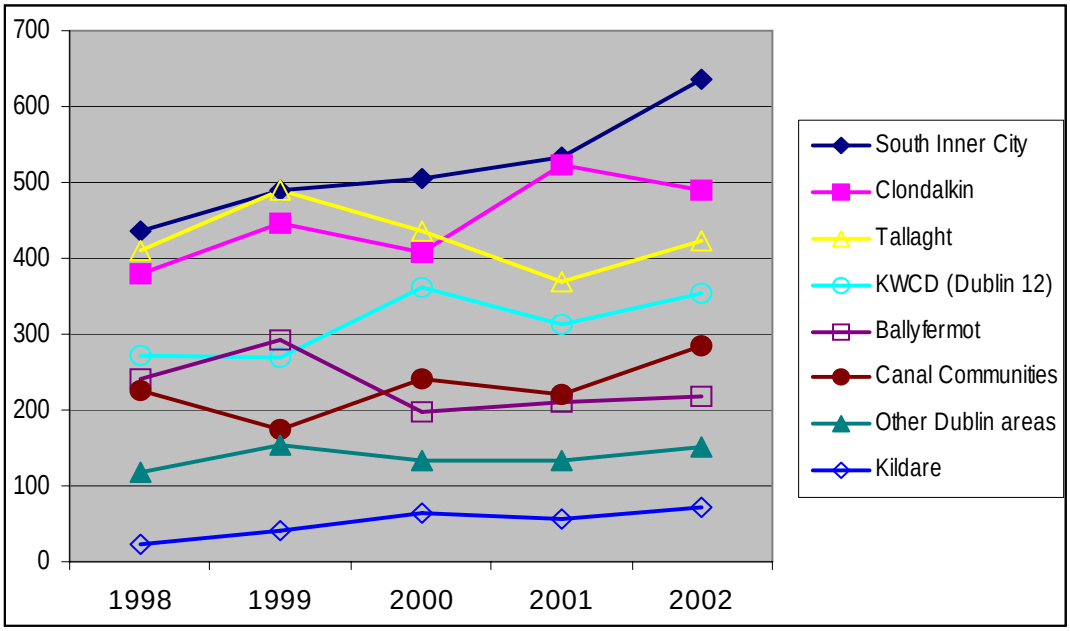
Table 1.9 illustrates the increase in treated cases where opiates were mentioned across the different areas within the SWRDTF region for the years from 1998 to 2002. When divided according to area, the data for opiate-related cases show a pattern very similar to that of the total numbers of treated cases in the region (discussed earlier in the report).

The South Inner City area accounted for the most cases where opiates were mentioned with the number of these cases increasing by 46% over the 5-year period in question. Clondalkin had the next highest number of cases and its numbers increased by 29% over the 5 years. This was followed by Tallaght, which increased by 3% over the 5 years. KWCD had a smaller number again of cases where opiates were mentioned but had increased by 30% over the 5 years. Canal Communities increased by 26% while other Dublin areas increased by 28%. Kildare, while it had the smallest number of cases where opiates were mentioned, increased by 217% this would indicate that there is a growing opiate problem in Kildare. However one must be cautious in drawing such conclusions as these figures relate to treated cases only and these figures may equally reflect an increase in the level of service provision in the Kildare area leading to more availability of treatment for opiate use Ballyfermot was the only area within the SWRDTF to show a drop in the number of cases where opiates were mentioned (drop of 10%) from 1998 to 2002.

Table 1.10: Treated Cases where Opiates are mentioned, by Area in SWRDTF (NDTRS 1998-2002)

	1998	1999	2000	2001	2002	Total
Local Drug Task Forces						
South Inner City	435	491	505	534	635	2600
Clondalkin	379	445	407	522	490	2243
Tallaght	410	490	435	370	423	2128
KWCD (Dublin 12)	272	269	362	314	355	1572
Ballyfermot	241	293	197	211	218	1160
Canal Communities	225	174	241	221	284	1145
Other Areas						
Other Dublin areas	118	153	133	134	151	689
Kildare	23	41	64	57	73	258
Missing data	0	6	11	12	6	35
Total	2103	2362	2355	2375	2635	11830

Figure 1.7: Treated Cases where Opiates are mentioned, in each SWRDTF area (NDTRS 1998-2002)



Data from the Central Treatment List (CTL) for the years 1997 to 2003 shows the numbers receiving methadone treatment in the SWRDTF region (Table 1.11 below). It can be assumed that methadone treatment is only used in opiate-related cases however this data, does not correspond with the NDTRS data shown in Table 1.10 above. The CTL figures for methadone treatment from 1998 to 2002 outnumber the NDTRS figures for treated cases where opiates are mentioned. This mismatch in figures can be explained by the fact that two different data sources were used by the different agencies. Both sets of figures, however, do concur in their indication of a steady increase in the numbers receiving methadone treatment/ treated cases where opiates are mentioned across the last 6 to 7 years.

Table 1.11: Numbers Receiving Methadone Treatment in SWRTF (CTL data 1997-2003)

SWRDTF Area	1997	1998	1999	2000	2001	2002	2003
Ballyfermot	221	285	314	335	356	379	387
Canal Communities	124	163	184	226	252	257	267
Clondalkin	208	327	373	463	567	563	597
KWCD (Dublin 12)	202	256	260	345	389	411	427
South Inner City	463	561	618	724	800	834	857
Tallaght	285	388	414	463	564	648	672
Other Dublin area	85	128	144	160	197	208	220
Kildare	24	46	49	68	92	96	116
Total	1,612	2,154	2,356	2,784	3,217	3,396	3,543

Waiting Lists

The number of people on waiting lists for methadone treatment in the Eastern Region was 270 in June 2004. This figure represents a drop of 7.5% from the number waiting for treatment the previous year (June 2003) and is most likely to be a result of an increase in the availability of services during this period. The SWAHB had 115 people on their waiting list for methadone treatment in June 2004. This number represents almost 40% of all those on methadone waiting lists in the Eastern Region. The other health board areas in the Eastern Region had far smaller waiting lists in June 2004 (ECAHB had 16 people waiting and NAHB had 44 people waiting). Waiting list figures would indicate that there is considerable demand for the services that are currently available and it can be inferred from this that drug users in the area consider these services to be valuable.

The length of time on waiting lists for those in the Eastern Region was usually less than 6 months (67% of people were waiting up to 6 months). A smaller number were waiting between 6 and 12 months (15%) and even fewer still were waiting over a year (approximately 9%). No breakdown of waiting times is available specifically for the SWRDTF area. Reports from those working on the ground in treatment services would indicate that due to the large number of drug users in the South West region waiting times are relatively long.

Section 2

Profile of Existing Service Provision

Headlines

- The majority of treatment and rehabilitation services cater for people living in the “core” urban area of the region
- Developments in service provision in recent years has served to highlight the extent of drug misuse in areas such as Kildare and West Wicklow and a corresponding need for increased services.
- A large majority of treatment and rehabilitation initiatives did not list sub-urban commuter towns such as Maynooth, Naas and Kildare in their catchment areas
- Sub-Urban commuter towns appear from the data collected to have a much lower level of service provision, particularly in education / prevention initiatives
- There is an almost exclusive focus on education as the primary method of prevention, which is worrying given the correlation between drug misuse and early school leaving (NDTRS, 1998).
- While it is generally acknowledged that the age of first drug use is decreasing the consultation revealed that many measures are targeted at adults (over 18), and this is particularly noteworthy in the area of education/prevention
- In the areas of treatment and rehabilitation only just over one third of providers target services at those under the age of 18 which may suggest a reactive rather than pro-active response
- Most service provision appears to focus on treatment rather than rehabilitation
- With the exception of statutory addiction services none of the service providers consulted with provided needle exchange services.
- The consultation process suggested that while there is some existing rehabilitation provision in the southwest there is room for further development in relation to rehabilitation.

Introduction

There are a range of addiction/ drug services available in the former S.W.A.H.B. region. The statutory addiction treatment services for the area have been provided by the former S.W.A.H.B., which had statutory responsibility for the provision of services. This is now the responsibility of the H.S.E. Other statutory agencies have also been involved in the drugs issue notably the Garda, FAS and Probation and Welfare services. Additionally there is a large and active voluntary sector some of which have central offices within the South West but also provide services beyond the immediate southwestern area. There are also six Local Drug Task Forces that provide supports and funding to a range of agencies dealing with drugs issues within the region. This section will detail the statutory provision in relation to addiction services. It will then detail the services available and discuss them along with service levels.

Statutory Addiction Provision

Treatment Centres – Dispensing*
Dr Steeven's, Addiction Service Clinic, Dublin 8.
Cork Street Clinic, Cork Street, Dublin 8.
Castle St Clinic, 37 Castle Street, Dublin 2.
Fortune House, Cherry Orchard Hospital, Dublin 10.
Aisling Clinic, Cherry Orchard Hospital, Dublin 10.
Old County Road Health Centre, Crumlin, Dublin 12.
Curlew Road Treatment Centre, Drimnagh, Dublin 12
National Drug Treatment Centre, Pearse St, Dublin 2
Inchicore Health Centre, 124E Emmet Road, Inchicore, Dublin 8
JADD, Fortunes Way, Jobstown, Tallaght, Dublin 24
Irishtown Health Centre, 1A Irishtown Road, Irishstown, Dublin 4.
CASP, Ballyowen Meadows, Fonthill Road, Clondalkin D.22
Glenabbey Centre, Belgard Road, Tallaght, Dublin 24

*Dispensing refers to the dispensing of medication on the premises. This will take place only in the context of a full addiction service being provided to clients.

Satellite Treatment Clinics – Non Dispensing
Merchants Quay Ireland, 4 Merchant's Quay, Dublin 8.
Brookfield Addiction Support Programme (BASP), Tallaght, Dublin 24.
Jobstown Assisting Drug Dependency (JADD), Jobstown Community Centre, Dublin 24.
St. Aengus Project, Unit 3 Castle Tymon Shopping Centre, Tymon North. Tallaght, Dublin 24.
Community Addiction Response Programme (CARP), Killinarden, Tallaght, Dublin 24.
Fettercairn Drug Rehabilitation Programme, Kilmartin Crescent, Fettercairn, Dublin 24.
Addiction Response Crumlin, (ARC), 101 Cashel Road, Crumlin, Dublin 12.
Rialto Community Drug Team, St. Andrew's Community Centre, 468 South Circular Road, Rialto, Dublin 8.
Deansrath Health Centre, Bawnogue, Clondalkin, Dublin 22.
Bride Street Health Centre, 36A Bride Street, Dublin 8.
Rathmines Health Centre, 36 Upper Rathmines Road, Dublin 6.

In many of the cases indicated above services are delivered with partner providers in the voluntary / community sector. This will account for an apparent duplication between the statutory and community / voluntary listings.

Statutory / Voluntary Residential Services

The following details the in-patient drug treatment places within the former S.W.A.H.B. area and beyond the S.W.A.H.B. area some of which are utilised by the Addiction Service of the former S.W.A.H.B. A number of these services are also utilised by the community / voluntary sector.

Chan Dara Unit (Cherry Orchard Hospital)
17-bed unit offering a six-week detoxification programme

Rutland Centre (Dublin 15)
36-contract bed unit per annum offering a six-week rehabilitation programme

Beaumount Hospital (St Michaels Ward)
10-bed unit offering a three-week detoxification programme

Keltoi (Phoenix Park Dublin)
20 contract-bed unit offering a post detoxification residential programme

Chan Mhuire (Athy)
12 contact beds offering detoxification and rehabilitation programmes

Coolmine (Dublin 15)
60 contract beds offering rehabilitation programmes

Merchants Quay Ireland (Dublin 8)
12-contract bed unit offering three-month rehabilitation programme
11 contract bed unit (Tullow) offering a follow on one-year rehabilitation programme

St James Resource Centre Kildare
12 bedded unit offering a 12-week residential treatment.

Voluntary / Community Sector Treatment / Rehabilitation

This following is a list of the main services providers in the community / voluntary sector operating in the S.W.A.H.B. region. These projects provide a range of services in relation to treatment / rehabilitation – many also provide additional services. The following is not intended as a comprehensive list of services. More extensive details of these projects will be available from the projects or from the National Drug Strategy Team database. This database will be based on the scoping exercise carried out by the Regional Drug Task Forces on behalf of the NDST.

Organisation	Services	Location/ Catchment
Addiction Response Crumlin	A range of treatment / outreach services	Dublin 12
Athru Crumlin	Rehab Day Programmes	Dublin 12
Barnardos	A range of services to the children and families of drug users	Dublin
Brookfield Addiction Support Programme	A range of support services for drug users and families	Tallaght
Bawnogue Youth and Family Support Group	A range of support services for drug users and families.	Bawnogue, Clondalkin
Ballyfermot Star	A range of rehab/ education services.	Ballyfermot

Organisation	Services	Location / Catchment
Cairdeas Clondalkin	Supports a drug users forum	Clondalkin.
CARP Community Addiction Response Killenarden	A range of treatment to drug users.	Tallaght
CASP Clondalkin Addiction Response Programme	A range of treatment to drug users.	Clondalkin
Casahdh	Rehabilitation services in Dublin 8	Dublin 8
Clondalkin Treatment / Rehabilitation Programme	Supports drug users in accessing residential treatment.	Clondalkin
Community Addiction Programme. Dublin 8.	Provides rehab to recovering drug users	Dublin 8. Oliver Bond Complex.
Community Lynks Project	Support for drug users accessing C.E. programmes	Canal Communities
Coolmine House	Drug free residential treatment.	Based in Dublin 2. National service.
Cumas Clondalkin	Support services for families of drug users	Clondalkin
Donore Community Drug Team	Support services for drug users and their families	Donore Ave / Dublin 8
FDRP Fettercairn Drug Rehabilitation Programme	Services for drug users.	Fettercairn Tallaght
Inchicore Community Drug Team	Treatment / support services for drug users.	Inchicore / Dublin 8
JADD Jobstown Assisting Drug Dependency	Treatment services for drug users.	Jobstown / all Tallaght.
Merchants Quay Ireland	A wide range of services including residential to drug users / homeless.	Dublin 8 offering a national service.
RDRD Ringsend District Response Drugs	Treatment services for drug users.	Ringsend / Dublin 4.
Rialto Community Drug Team	A range of treatment services for drug service.	Rialto / Dublin 8

Organisation	Services	Location / Catchment
RINN Development	A rehab initiative	Ringsend
St Aengus Tallaght	A range of treatment / rehab services for drug users.	St Aengus Community / Tallaght.
St Dominics Tallaght	A range of treatment / rehab services for drug users.	St Dominics / All of Tallaght.
St James Resource Centre	Residential treatment for drug users.	Based in Kidare. National Service.
Tallaght Rehabilitation Programme	Dedicated rehabilitation services	Tallaght wide service
TURAS Inchicore Dublin 8	Dedicated rehabilitation services	Canal Communities / Dublin 8

Prevention / Education

As with services for treatment and rehabilitation there are a range of services available within the southwestern region in relation to the issues of drug education and prevention. It is important to note that while these terms are often used interchangeably these activities are separate, with education being a tool to promote prevention. There are a range of providers in the formal and informal education sectors and in the voluntary / community sectors. The following list gives an indication of the numbers of providers that are in operation in the region. It should be noted that a number of the groups identified in the treatment section may have an educational component, however, the following is intended to focus on organisations / groups with a primarily drugs educational brief. It should be noted that there are many organisations, which target at risk youth, whose activities have a significant impact on the numbers of this population who engage in drug misuse. The following includes groups / projects in both the statutory and voluntary sectors.

Organisation	Services	Location / Service Area
Addiction Services S.W.A.H.B. - 3 Education Officers	▪ Education & training programmes specifically for those who work with youth i.e. parents, teachers, youth organisations etc., ▪ Certificate in Addiction Studies (NUIM) ▪ School Substance Use Policy development (in partnership)	All of South West
Addiction Services S.W.A.H.B. Outreach Team	Training in relation to harm reduction.	All of South West
Addiction Services Training Unit	Professional development training in the eastern region	All eastern Region
Dept of Education	▪ Responsibility for formal education sector including all SPHE interventions. ▪ Partnership with HB regarding School Substance Policy	National
Crosscare	▪ A range of training and a website. ▪ Certificate in Addiction Studies (NUIM)	National
Barnardos	Education and training in Dublin.	Dublin
Catholic Youth Care	A range of drug training.	National
Clondalkin Drugs Task Force	▪ Local drugs education. ▪ Partnership with DES & HB regarding School Substance Use Policy	Clondalkin
Community Response	A range of training including Certificate in Addiction Studies (NUIM)	South Dublin
Community Awareness Drugs	A range of drug training – specifically parents	National
Foroige	A range of drug training.	National
Killenarden Drug Primary Prevention Group	A range of drug training.	Tallaght
Tallaght Youth Services	A range of drug training.	Tallaght

Organisation	Services	Location / Service Area
Aids Care Education and Training	A range of HIV related training.	Dublin
Crew Network	A range of drug training and education.	National
Merchants Quay	A range of drug training.	Dublin
Star Project	A range of drug training.	Ballyfermot
Turas	A range of drug training.	Canal Communities
Shanty	A range of drug training.	Tallaght
Trinity College Dublin 2	Addiction Education at Diploma and Masters level.	National

Supply Control

Responsibility for supply control rests primarily with the Garda and Customs. The following indicates the human resources employed by these agencies in relation to controlling the supply of illicit drugs.

Organisation	Resources	Location
Garda	Resources allocated as required	Dublin / Kildare
Customs	Between 10 and 80 Officers	These staff are located in Dublin Port and Airport and provide a round the clock service 365 days a year.

Research

A wide range of organisations have undertaken research into the issue of drugs and related issues. By its nature research is not confined to particular geographical areas. However the following chart lists some of the “main players” in relation to research into drugs issues in the southwestern region.

Organisation	Types of Research
National Advisory Committee on Drugs	Research into all aspects of drug misuse.
Addiction Research Centre Trinity College	Research into addiction related issues.
Merchants Quay Ireland	Research into drugs / homeless issues.
Health Research Board	Research into drugs issues.

Consultation

In order to supplement the above documentary information regarding the services which exist in the South Western region, the Regional Drugs Task Force carried out a comprehensive consultation exercise.

Methodology

A list of 112 service providers currently operating in the Regional Drugs Task Force area was compiled to ensure that as wide a consultation process as possible was carried out.

The list was broken down into sub-groups under the 4 pillars of the National Drug Strategy as follows:

- 30 Education and Prevention Service Providers
- 67 Treatment and Rehabilitation Service Providers (this included 6 Statutory providers in this area)
- 13 Gardai Superintendents representing the Supply Reduction Pillar
- 2 Research organisations

Data Collection

Named individuals in each organisation were telephoned to ask if they were willing to take part in the consultation process. Due to time constraints, those who were not contactable after three attempts were eliminated from the sample. Those who were willing to participate were asked a series of questions regarding the service provided by their organisation and their responses were recorded.

Response Rate

The response rate in each category was as follows:

Education/ Prevention

- 14 service providers were consulted
- 11 individuals were not contactable and therefore eliminated from the consultation process
- 5 of the services represented duplications on the list and were therefore eliminated from the consultation process

Treatment/ Rehabilitation

- 40 service providers were consulted (three of which were to statutory service providers)
- 24 individuals were not contactable and therefore eliminated from the consultation process
- 3 individuals declined to take part in the process

Supply Reduction

It was not possible to make contact with Garda Superintendents on the list provided therefore a decision was made to consult with the Chief Inspector in each Garda station included in the list

- 13 Garda Chief Inspectors were consulted

Research

- 1 research organisation was consulted
- 1 individual was not contactable and was therefore eliminated from the consultation process

Data Analysis

Data was analysed quantitatively using the SPSS computer based statistical package and a discussion of the findings of the consultation process follows.

Discussion

Catchment Area

Data collected indicates that the majority of treatment and rehabilitation services cater for people living in the core urban areas of the region (for example: Tallaght, Clondalkin, Inner City, Canal area). Education/ prevention services appear to be more patchy throughout this core area with service provision in some but not all locations. Supply reduction activities throughout this core area are localised in

Garda stations which provide for all areas in the urban core of the South West Region.

The sub-urban commuter towns (for example Maynooth, Naas, Newbridge) located on the periphery of this core area appear from data collected to have a much lower level of service provision, particularly in terms of education/ prevention initiatives. A large majority of treatment and rehabilitation initiatives that engaged in the consultation did not list these sub-urban commuter towns among their catchment areas. Drug misuse has been identified as a growing problem in areas such as Kildare and West Wicklow and this consultation process highlighted the fact that there are very few services provided locally for those in these areas. In terms of supply reduction activities, once again, where there was a Garda station in the area, some supply reduction activities took place.

The rural part of the region appears, from data gathered through the consultation process, to be the most poorly serviced area in terms of education/ prevention and treatment and rehabilitation initiatives. These areas were not specifically mentioned by any service consulted with but it can be inferred that they are provided with some level of service provision by the minority of service providers that said they cater for people from the entire country. In terms of supply reduction activities, once again these are catered for by the Gardai where there is a local Garda station. However, it is often the case that these rural stations are shared among a wide number of small towns and villages and therefore service provision in this area is diluted.

Services Provided

Education/ Prevention
As expected, educational training was the only service provided by all of those who engaged in the consultation process. Less than half were involved in health promotion activities and very small numbers provided information, family support, or diversionary activities as a preventative measure. This almost exclusive focus on education as the primary method of prevention may need to be revised and provision made for increasing the number of initiatives providing other preventative services to ensure that those who do not for whatever reason avail of education, or those who are outside the educational arena are also targeted by preventative measures.

Treatment and Rehabilitation
The range of treatment and rehabilitation services available in the area is broad and ranges from full residential services to family support, and childcare. However, most service provision appeared to be centred on treatment rather than rehabilitation.

Counselling was provided by a large majority of the initiatives with which the Task Force consulted with much smaller numbers focusing on physical treatment methodologies. However, counselling on its own, without some form of treatment for the physical side of addiction is unlikely to be effective as a treatment or rehabilitation methodology.

Methadone maintenance programmes were the most frequently provided service in terms of physical treatment methodologies, followed by stabilisation. None of the service providers consulted with, with the exception of the Statutory addiction services provided needle exchange services. However the number of individuals that these services can cater for must be taken into account when conclusions are being drawn regarding the adequacy or otherwise of the range of services provided in any area.

The majority of treatment and rehabilitation services in the region are non-residential. The number of services providing residential treatment/ rehabilitation programmes may be low considering the size of the geographical area covered.

The number of treatment and rehabilitation services providing educational training as part of their service portfolio was high, indicating that there is some overlap between education/ prevention service provision and treatment and rehabilitation service provision. This would merit further investigation to ensure that there is no duplication of services.

Relatively few of the service providers that engaged in the consultation process were engaged in rehabilitative activities such as vocational training and employment. Most service provision related to dealing with the individuals' addiction specifically rather than the wider difficulties they may experience if and when they become drug free or stable on a harm reduction programme. The social exclusion experienced by those who are addicted continues long after their physical and psychological addiction has been dealt with. Many will have left school early with few educational qualifications and will have low levels of skill and scattered work experience if any. Such individuals, if they are to fully integrate into society require substantial assistance in the areas of vocational training, education, and employment.

Supply Reduction

Supply reduction is a complex area to assess with fluidity in markets both national and international making it difficult to carry out concentrated supply reduction activities in any one geographical location over time. Changes in supply and demand require flexibility on the part of those attempting to address this issue with short-term results difficult to obtain despite considerable effort expenditure. The Task Force acknowledge the difficult task faced by the Gardai and will continue to give full support to their initiatives.

Supply reduction activities in the region centre mainly on the activities carried out by the Gardai. Gardai engage in three main activities, two of which relate specifically to supply reduction: activities carried out by the drug squad and those engaged in under the juvenile liason officer scheme. The third service mentioned was referral. The juvenile liason scheme appears to be available across the area with 12 of the 13 respondents stating that it was available in their catchment area. However, not all areas are serviced by localised, dedicated drug units.

Research

It was not possible to ascertain what level of research is currently underway in the South West Region from the consultation process conducted. Research that is carried out either on a local or a national basis tends to be issue defined rather than based on tight geographical areas and this poses problems when attempting to ascertain the nature and extend of the problem and the success or otherwise of attempts to address it in a particular area. National research data is available and this is of use in identifying general trends but locally based research information is important in pinpointing regional differences and trends. It is essential that regionally based information is gathered to ensure that funding and resources are deployed in a manner most likely to achieve desired results.

Research in the form of evaluation is also vital to ensure that existing services and programmes are achieving their objectives and most importantly are meeting the needs of the clients they are there to serve. Evaluation data can be used to inform best practice in the area, to identify and remedy any implementation difficulties, to ensure that resources are deployed where they can be of most use, and to ensure that quality standards are maintained in terms of service delivery. A strict evaluation procedure should be built into any existing or new service. Evaluation should occur on an ongoing basis according to a timescale tailored to the service/ programme in question and should focus on process, content, and outcome issues.

Target Group

Age

In general it would appear from the results of the consultation process that adults (those over 18 years) are better catered for in terms of service provision than young people. This is noteworthy in terms of education/ prevention activities where the majority of service providers engaged with adults. It would be reasonable to expect that preventative measures would be targeted at those most vulnerable to forming a drug misuse problem, primarily those under the age of 16. However over half of those who engaged in the consultation process said that their services targeted families/ concerned others which might indicate that there is a perception that these individuals will have an influence on their at risk family members in terms of prevention. The capacity of family members to exert their influence with regard to preventing young people from becoming involved in drugs, or in terms of

early identification may need to be examined to ensure that resources are being deployed in the most efficient and effective manner in this regard.

The vast majority of treatment and rehabilitation services are targeted at those over the age of 18 years and just over a third cater for those under 18. This is interesting in light of the many studies which have been carried out which indicate that the age of first drug use is decreasing with cannabis being used by children as young as 10 and 11 years of age and alcohol a definite problem in the pre- and early teen years. There is a clear need to review current practice to ensure that there is adequate service provision for children and young people in terms of treatment and rehabilitation.

Sex

The vast majority of those who engaged in the consultation process provide services to both males and females. The gender balance of those availing of all services would merit some study to ensure that this is in line with the gender balance of those involved in drug misuse to ensure that services are being targeted at those in most need.

Type of Individuals Catered For

The majority of those providing education/ prevention services catered for parents/ concerned others while half each catered for those with drug problems, and those at risk of developing drug problems. Once again the rationale for and the impact of providing services for higher numbers of parents/ concerned others than for those either at risk of developing or those with current drug problems would merit some investigation to ensure that this is the most effective use of resources.

Section 3

The Extent to Which Current Service Provision Meets Identified Needs

Headlines

- SWRDTF engaged in a consultation process with a range of stakeholders across the region
- Service users, family members and Statutory and Non Statutory service providers were consulted in focus groups sessions
- Task Force members also took part in a facilitated workshop
- All those consulted were asked to share their experiences and perceptions of the current problems associated with drug misuse, gaps in service provision and what actions are needed to fill those gaps.
- The Kildare area was highlighted as having a growing drug problem
- The issue of how to most effectively and efficiently deliver information and services into rural areas was raised as requiring particular consideration
- The low level services for those under 18 years of age throughout the region was highlighted
- The need to adopt a community development approach was expressed
- A number of respondents spoke about waiting lists for treatment services that they believed to be too long
- The need for a range of locally based accessible treatment and rehabilitation services that adopt a more holistic approach was voiced
- A number of people expressed the view that there were relatively few rehabilitation progression routes available and accessible to the recovering addict. Stated examples of rehabilitation measures ranged from activation, through pre-vocational to vocational

Introduction

The Task Force engaged in a series of activities in order to ascertain the extent to which current service provision meets identified need:

- Research on the extent and nature of the problem within the Region (see Section 1)
- Research on existing service provision within the Region (see Section 2)
- Extensive stakeholder consultation
- Identifying gaps in current service provision

This chapter is concerned with the following:

1. Detailing the process by which stakeholders were consulted and the major themes emerging from that consultation.
2. Outlining the procedure adopted by the Regional Drugs Task Force to synthesise information gathered on the extent and nature of the problem, the profile of existing service provision, and the views of stakeholders into conclusions on the extent to which current service provision meets identified need.

Stakeholder Consultation

The Task Force carried out a comprehensive consultation process to ascertain perceptions of need and perceptions of the extent to which current service provision meets these needs. Information was sought from the different stakeholders in different ways to ensure that as broad a spectrum of views as possible was captured. It is important to note that the views of stakeholders that were recorded verbatim do not necessarily represent the views of Task Force members. Notwithstanding this the stakeholder consultation process provided an invaluable opportunity to hear and reflect upon the views of a wide range of stakeholders. The stakeholders consulted were:

- Members of the Regional Drugs Task Force
- People with lived experience of addiction
- Service Users
- Service providers (Kildare area)
- Statutory Service Providers

Data Collection

Focus Group Sessions

A focus group template was drawn up to ascertain the views of the above groups. Individuals were invited to attend a series of two-hour focus group sessions. Two facilitators ran each focus group, one of which posed the questions and the other acted as scribe. No incentive to participate was offered to those who took part. Responses were recorded on the focus group template. The responses recorded were content analysed to extract common themes.

Telephone Interviews

A questionnaire was drawn up for use in telephone interviews with Statutory Service Providers and individual members of the Regional Drugs Task Force. The Regional Drugs Task Force compiled the names of a sample of 5 Task Force Members and 6 Statutory Service Providers and they were telephoned to ask for their views. Due to time constraints, individuals who were not contactable after the third attempt were eliminated from the sample. The achieved sample consisted of 3 Task Force Members and 3 Statutory Service Providers. Telephone interviews were conducted with these individuals and their responses recorded on the questionnaire. The Responses recorded were content analysed to extract common themes.

The common themes arising from this consultation process are outlined under each of the stakeholder groups.

Consultation Findings

Members of the Regional Drugs Task Force

General Comments

Regional Drugs Task Force members highlighted the large geographical spread in the Region and the difficulties in ascertaining needs and the extent to which current service provision is meeting these needs due to the demographic and geographical differences between areas. They view the Region as breaking down into three distinct areas:

- Urban core- Inner City, Tallaght, Clondalkin. Which has a relatively well established problem and response
- Sub-Urban - commuter towns which are rapidly growing.
- Rural – these are areas which lie beyond urban and commuter areas they are smaller more scattered villages which are harder to engage with.

Perception of Current Problems in Region

Task Force members were of the view that poly drug use is prevalent in the region. The primary drug of choice at primary school level (age 11 – 12 years) according to Task Force members is alcohol, solvents are being used by children as young as 10 years of age and the use of cannabis starts at around 13 years. Cannabis is the main drug used, which may lead to progression to other drug use. Recreational drug use is prevalent and the use of alcohol and ecstasy are widespread.

Drug Task Force members were of the opinion that dealers may live outside the region but operate within the region with the major supply centres located in the LDTF regions, which are areas of high use. They highlighted the view that the problem originated from Dublin and spread out and is now expanding to other areas of the region. There is anecdotal evidence of an emerging opiate use problem in Kildare and Athy and it was felt that the dance culture in Naas has contributed to the problem in this area.

Perception of Gaps in Service Provision – Urban Core Area

The Role of the Task Force
The role of the Task Force needs to be clarified and interventions targeted and focused.

Harm Reduction
Drugs Task Force members perceived a need for harm reduction responses throughout the region. The need for syringe exchange services was highlighted in particular in this regard. An accessible safe place for usage was also felt to be needed.

Education/ Prevention
Drugs Task Force members perceived education and prevention to be under resourced and to be less effective than they could be. The reason for the ineffectiveness of education and prevention initiatives is not known. However, the difficulties of accurately measuring the impact of drugs prevention / education work was seen as contributing to the lack of clarity about the effectiveness of prevention interventions. Youth work should be core funded with additional input / expertise from other areas as a preventative measure. There is a need for early preventative services such as education, and schools based programmes concentrating on primary schools according to Task Force members.

Evaluation/ Transfer of Learning
There was a perceived lack of evaluation of the level and quality of service implementation. Drug Task Force members considered it important to consider how to transfer the learning, both positive and negative, from the LDTF's.

Detoxification
Drug Task Force members were of the opinion that Detoxification needs are not currently being met within the urban core area of the region.

Research
Task Force members highlighted a need to identify risk factors at different life stages and then build / tailor responses to those risks.

Responses to Particular Drug Problems
Cocaine use is an emerging issue, which requires a particular response according to Drug Task Force members. A holistic, multi-disciplinary response to poly drug use is needed according to the Drug Task Force. The problem of prescribed medication misuse needs to be tackled according to Task Force members.

Rehabilitation
There are large gaps in the post opiate treatment stabilisation phase, pathways to other support were perceived by the Drug Task Force as either non-existent or insufficient.

Under 18's
There was a perception that those under the age of 18 need local services.

Early Identification
The early identification system is inadequate and responses need to consider how to stem the demand for drugs.

Perception of Gaps in Service Provision – Sub Urban Areas

Information
Drug Task Force members perceived there to be gaps in information regarding what the exact problem is in these areas. A further information gap highlighted related to drugs and services and Task Force members believe it is necessary to educate and influence attitudes among people living in these areas.

Education/ Prevention
There was a perception that although there are some services in existence in these areas there is a need for education and prevention initiatives. Drugs Task Force members felt that parents need to be engaged in both education and parenting initiatives in the sub-urban areas and that parent support groups should be set up subsequent to this.

Early Identification
Early identification in sub-urban areas of the region was perceived to be a gap in service provision by Drug Task Force members.

Locally Based Services
A major gap highlighted by Drug Task Force members was locally based services which are accessible to people in sub-urban areas who currently have to travel to Dublin to access the services they require. Task Force members expressed the view that services should be available locally and accessible to service users.

G.P. Based Services
Drug Task Force members felt that G.P. level 1 and 2 responses were required where the G.P. treats the client and dispensing occurs at the pharmacy as part of an overall package of services in sub-urban areas.

Perception of Gaps in Service Provision – Rural Areas

Infrastructure
Drug Task Force members perceived the same infrastructure issues to exist as in the commuter areas but these are magnified level in rural areas. There is a gap in terms of getting information and services to users in locations that are accessible to them.

Information
Drug Task Force members consider there to be a gap in terms of the way information is provided to those in rural areas and felt that information should be provided from one clearly identifiable source that can give an overview of what is available. There should be guides, hotlines and other such information sources available.

Early Identification
Early identification was considered to be important by Task Force members who felt that careful consideration of what happens once someone at risk has been identified is required

Out of Hours Services
Task Force members highlighted the fact that most services operate on a 9 – 5 basis. However they noted that addiction is not a 9 – 5 problem so there is a gap in service provision in terms of out of hours services.

Services to Individuals
Drug Task Force members were of the view that many services are developed based on group models however there is a need for services which can cater for individuals in rural areas.

Service Users

Perception of Current Problems in Region

People with lived experience of addiction considered the main problems in the region to be heroin, crack, and cocaine use. They perceived there to be a major problem with prescription drug use in the area and stated that these drugs have become increasingly available. They believe that people are coming into the area from other locations with the purpose of dealing drugs.

There was a perception that there is little policing of drugs in the area and that children come out of school and witness dealing going on the streets and learn from that. Focus group members perceived boredom to be a major contributing factor to the drug problem in the area and also cited homelessness as a huge issue.

Suicide was perceived to be a growing problem in the area, which was felt to be linked to drug use. However, what this link is was not known. Focus group participants believe that the suicide rate will increase if access to treatment does not improve.

Perception of Gaps in Service Provision

Locally Based Services
People with lived experience of drug use perceived there to be a gap in service provision in terms of locally based residential treatment services so that people do not have to travel to the city centre to access such services. They also perceived a need for a methadone clinic and for locally based detoxification services

Harm Reduction
There was a perception that there is a service provision gap in terms of needle exchange.

Counselling
Counselling both individual and group was perceived to be a service gap as was psychological services which would help people to deal with personal problems such as bereavement.

Respite
People with lived experience of drug use perceived there to be a need for a respite centre, which would be located somewhere outside the city.

Rehabilitation
There was a perception that people need something to progress to after detoxification or residential treatment, some kind of rehabilitation that is ongoing or open ended was suggested. A further gap in service provision highlighted by focus

group participants was the need for more courses like Youth Reach and FAS courses but specifically designed to meet the needs of those recovering from addiction. Courses are needed to help recovering addicts get a job. These programmes need to be flexible enough to ensure that people are given time to get their methadone etc. Courses would also have to be meaningful.

Prevention
There was a perception that activities for young people are required in the area. These services should be provided for children as young as toddlers for example: playgrounds for toddlers, youth clubs, something for early school leavers. Drop in centres for younger teenagers.

Accommodation
People with lived experience of drug use perceived a need for some kind of a hostel to deal with the homelessness problem in the area, particularly for young teenagers.

Education
Educational programmes in school were perceived to be needed and there was a suggestion that these should be run by people who have been addicted themselves/ are addicted currently.

Policing
There was a perception that there needs to be more policing, CCTV cameras etc to stop dealing in the area.

Aftercare
Aftercare and ongoing support was perceived to be a service gap by people with lived experience of drug use who advocated the use of a key worker system.

Alternative Treatments
Alternative treatments (e.g. acupuncture) should be made available particularly for young early users according to focus group participants.

G.P. Services
There is a need for more G.P. services according to focus group members.

Research
People with lived experience of drug use felt that there needs to be research to meet the growing need for a planned response to cocaine use.

Waiting Lists
The perception that there needs to be a reduction in waiting times for services.

Services for People Leaving Prison
A further perceived service gap was provision for people leaving prison who are either addicted are who have come off drugs while in prison.

Family members

Perception of Current Problems in Region

The family members consulted perceived cocaine use to be a problem and said that heroin is openly for sale on the streets. Ecstasy is also a problem as is methadone. These drugs were perceived to be accessible to children from 14 years up with hash available to and used by children from the age of 10 or 11 years. They also perceived there to be a market for prescribed drugs on the street. Family members considered doctors to be too lenient in terms of prescribing methadone and believe that they prescribe it to excess.

Drugs were felt by family members to be more hidden now than before and not as openly sold as before. There was a perception that people are getting caught in the system and that there aren't enough places for help.

Perception of Gaps in Service Provision

Services for Under 18's
Family members perceived assistance for young people aged 14 to 16 years who are using cocaine to be a current gap in service provision. They noted that children fall through the net because there are no trained personnel to deal with them.

Counselling
Family members noted that waiting lists for programmes vary between 3 and 6 months and perceive there to be a need for support and counselling services for those on waiting lists. There a need for access to more trained counsellors in general according to family members.

Detoxification
Family members perceived there to be a need for residential detoxification programmes and stated that the waiting list for residential programmes is too long.

Immediate Access
There was a perception that people need immediate access to G.P. services, counselling, and detoxification.

G.P. Services
Family members believe that there is a need for all G.P.'s to support detoxification programmes. There was a perception that many G.P.'s won't help people with drug problems and that others are not equipped to provide the help required.

Education
Family members perceived a need for a vocational and education programme where people are told what is on offer to them in terms of services. They believe

that a more systematic approach to prevention-based education In schools is also required.

Supply Reduction
A more visible Garda presence to reduce the supply of drugs in the area is required according to family members who took part in the focus group.

Prevention
Family members consulted with believe that there is a need to offer children an alternative to drugs for example, football, but there are no facilities in the area to offer these activities.

Community Information
Family members highlighted the need to bring the community along when services are being developed and said that there should be open days and information days, and that people should be informed about what's going on all along the way. Services need to be well advertised and accessible according to family members.

Support Groups
Support groups for family members are required according to the family members who took part in the consultation process. They also pointed out that respite weekends for families are very helpful but more support in this area is required.

Service providers (Kildare area)

Perception of Current Problems in Region

Service providers in the Kildare area noted that the profile of addicts has changed over time and that there is more cocaine and heroin use in Kildare than heretofore and that alcohol abuse is still a serious problem among young people. The number of those misusing drugs in the area has increased over the last 2 years according to service providers in the area and the drug supply is mainly from Dublin.

There was a perception that there are less services in the Kildare area because it is seen as an adjunct of Dublin and there is no real understanding of the problems in Kildare. Service providers noted that most treatment services are based in Dublin and there are difficulties regarding transport to these services for those living in the Kildare area leading to a feeling of isolation.

There are long waiting lists for services in Dublin according to service providers in Kildare who also stated that these services are not well known or well advertised. They highlighted the view that parents in the area are not as knowledgeable about drugs as their counterparts in Dublin and had the perception that there are no education or prevention programmes in the area.

Service providers believe that there are a number of social problems in Kildare that together create a major impact and contribute to the problem and these include: the influence of the Curragh Camp; family separation; the fact that there is a lot of wealth as well as a lot of poverty in the area; overcrowding in schools; and isolated housing estates with poor services.

Perception of Gaps in Service Provision

Treatment Options
Service providers in Kildare perceived there to be a need for different treatment options for people living in the area including: residential treatment/residential detoxification programme/juvenile residential unit; needle exchange; methadone maintenance services; GP services; hostel for people undergoing treatment; peer programmes/ education programmes; and a drop in centre which is not specifically for drugs but for wider community services. G.P's need to expand their knowledge and training regarding drug addiction according to service providers in the Kildare area.

Localised Services
Services need to be more localised according to service providers in the Kildare area.

Service Structure
Service providers in the Kildare area perceived a need for a more cohesive structure for services.

Holistic Approach
A wider, more holistic approach needs to be taken when tackling addiction, e.g. counselling for drugs, bereavement, suicide, and this is a service gap according to service providers in the Kildare area.

Research
Service providers perceived a need for research into the particular problems in the Kildare area.

Alcohol
According to service providers in the Kildare area the alcohol problem needs to be addressed at a social level with educational and family responses in particular.

Wider Community Response
According to service providers in the Kildare area a wider community response is required to tackle the drug problem in the area. It was their perception that because Kildare has specific socio-geographic needs these can be best addressed through its own Local Drugs Task Force.

Statutory Service Providers

Perception of Gaps in Current Service Provision

Access to Services
Statutory service providers perceived there to be a difficulty accessing services for people with dual diagnosis. They believe that community treatment services should include homeless people and travellers, which is not the case at the moment.

Homelessness
Homeless people with addiction difficulties need a different approach to detoxification and residential treatment according to statutory service providers who believe that current mainstream services are not very successful with this client group. They also saw the lack of drug-free hostels as a gap in service provision.

Evaluation
All programmes should be evaluated on an annual basis according to statutory service providers.

Education
Statutory service providers perceived there to be a need for more drug education and awareness programmes.

Rehabilitation
Counselling is required at the level of rehabilitation according to statutory service providers who also felt that alternative therapies should be considered as part of rehabilitation.

Harm Reduction
Statutory service providers perceive the lack of harm reduction initiatives available in the area to be a gap in service provision.

Responses to the Use of Specific Drugs
There is a need for a response focused on cocaine and poly-drug use according to statutory service providers.

Treatment
Statutory service providers believe that treatment services should be expanded and that this expansion should include maintenance, residential and non-residential services, stabilisation, and detoxification. They perceive that there are service gaps in all these areas and they also state that current needs for medical intervention are not being met.

Synthesis

Process

The raw data from the consultation process were fed back to the Regional Drugs Task Force where they were reflected upon and discussed. During this distillation process Task Force members analysed the results of research carried out on the extent and nature of the drug problem in the region, the profile of existing service provision, and the perception of need and of the extent to which current provision meets this need from the consultation process outlined above. Based on this data and using their collective knowledge and experience the Task Force agreed on the gaps in current service provision which need to be addressed in the immediate future across the region.

The main service provision gaps that the Task Force considered necessary to address arising from this process are:

- The lack of treatment responses in the Kildare area
- Gaps in treatment responses in non Local Drugs Task Force areas in Dublin
- Quick access to services and the requirement for long waiting lists
- The lack of localised treatment services
- The lack of harm reduction services regionally
- A lack of responses to the emerging issue of cocaine
- A lack of services for those under the age of 18 years
- A lack of early intervention
- Problems with access to premises for organisations such as Narcotics Anonymous
- A lack of residential treatment options
- Little action on alcohol
- The lack of a regional strategy on rehabilitation
- A gap in education responses focused on non Local Drugs Task Force areas particularly in those with high youth populations
- A lack of drug awareness programmes in commuter areas of the region and in particular those areas which are most disadvantaged
- Difficulties enforcing existing legislation regarding supply control
- Gaps in actions to reduce the supply of prescription drugs
- The lack of information regarding trends in consumption and the effectiveness of interventions
- A lack of information regarding the needs of people throughout the region but particularly the needs of those in the more rural parts of the region

Section 4

Measures Necessary to Address Gaps in Service Provision

Headlines

- Based on all work to date Task Force members engaged in a facilitated workshop to clarify service delivery “gaps” and to prioritise these guided by the matrix of greatest need least met.

- 11 priorities are listed under treatment and rehabilitation, 1 under rehabilitation, 3 under Education / Prevention, 2 under Supply Control and 2 under Research

- Task Force members recognise that not all priorities can be addressed in the immediate future. Members then engage in a workshop to further distil priorities being guided by the matrix of greatest need and least met.

- The process results in 5 main priorities being identified. Two horizontal themes are contained in each of the 5 major themes.

- Task Force members are keen to ensure that themes not initially addressed are still recognised as priorities and that the Task Force will subsequently develop a specific action to address these issues. It is the intention of the Task Force that those themes not immediately addressed would be dealt with by an emerging needs fund similar to that operated in the LDTF areas.

Introduction

At the end of Section 3 the Task Force had identified and synthesised the major gaps in service provision. The process of reaching this outcome had involved Task Force members in:

- Analysing the results of research carried out on the extent and nature of the drug problem in the region.
- Studying the profile of existing service provision.
- Contributing to the consultation process regarding SWRDTF members perception of the problem and their perception of service delivery gaps.
- Listening to and reflecting on the perception of need and the extent to which current provision meets need from the perspective of a range of stakeholders.
- Taking part in a facilitated workshop

Based on this data and using their collective knowledge and experience the Task Force agreed on the gaps in current service provision which need to be addressed in the immediate future across the region.

The main issues that the Task Force considered necessary to address arising from this process are presented overleaf under headings that reflect the pillars of the National Drug Strategy and have been ranked in order of priority:

Measures Necessary to Address "gaps" in Service Provision:

Treatment and Rehabilitation

1. Improved treatment response in Kildare
2. Improved Treatment for non LDTF areas in Dublin
3. Reduction in Waiting Lists
4. Localisation of waiting lists
5. Improved access to harm reduction services regionally
6. Responses to the emerging issue of Cocaine
7. Services for under 18's developed
8. Improved access to premises for organisations such as Narcotics Anonymous
9. Residential treatment options need to be developed
10. Action on Alcohol
11. Need for a regional strategic rehabilitation response

Education / Prevention

1. Regional education response that will focus on non-LDTF areas with special attention for those areas with high youth populations
2. Drug awareness courses targeted at commuter towns / areas of region, particularly areas of disadvantage
3. Early interventions in relation to prevention.

Supply Control

1. Enhanced enforcement of existing legislation
2. Action to reduce the supply of prescription drugs being diverted

Research

1. Need for an information system that will highlight trends in consumption and measure the effectiveness of interventions. Lack of management information impedes an effective response.
2. Research to establish needs in more rural parts of the region.

There was a consensus view that although it was necessary to address all of these gaps in service provision over time, it was not possible to tackle all of these areas in the immediate future.

As such the Task Force decided to further prioritise the number of gaps they would address. This was done to ensure that ultimately the measures taken would provide an effective solution and that adequate resources would be available for the priority areas.

It should be noted that Task Force members are acutely aware that the consequence of further prioritisation is that some measures will not be addressed in the immediate future. However the need to address all of the identified issues remains and this issue is re-addressed in Section 5 Action 7.

Through a process facilitated by Inclusion Drug Task Force members gave careful consideration of each service gap on the original list. They discussed and debated each area and were essentially guided by the document *"Guidelines for Development of RDTF Strategy Plans"* and specifically the decision matrix of greatest need, least met.

The following decisions were made:

Treatment

1. There was consensus among Task Force members that treatment responses in Kildare/ West Wicklow was an area of high priority and that measures should be taken to address gaps in service provision in Kildare / West Wicklow in the immediate future.

2. It was agreed that themes 2, 3 and 4, i.e. improved treatment in non Local Drugs Task Force areas, reducing waiting lists and the localisation of treatment services could be condensed into one theme and that measures taken in these areas would fall under the heading “Improved Treatment” with particular emphasis on responses in non Local Drugs Task Force areas.

3. Improved access to harm reduction services regionally was considered a priority by the Task Force.

4. It was agreed that responding to the emerging issue of cocaine would be deferred. The outcomes from 4 pilot projects currently underway will inform more specific actions of the Task Force in the future to ensure that any actions taken by the RDTF are in line with the findings of these pilots.

5. Services for the under 18’s and taking action on alcohol were considered by all to be horizontal themes, i.e. that actions taken in any other priority area would also include actions for under 18’s and on the issue of alcohol. While the Task Force recognise the cross cutting nature of interventions for under 18’s they believe specific programmes could be developed in years 2 and 3 of the Action Plan

6. The RDTF acknowledged the need for improved access to premises for organisations such as Narcotics Anonymous and stated that this would be facilitated in any way possible.

7. It was agreed by the RDTF that the theme “Residential Treatment Options” merits careful consideration but would not be actioned at this stage because of the requirement to clarify need in this area.

Rehabilitation

It was agreed that rehabilitation was a theme under which measures would be developed to fill the gaps highlighted as part of this strategic plan.

Education/ Prevention

Two themes were highlighted in this area (see page 3 above). The Task Force agreed that these would be condensed into one theme – Prevention, of which Education is a component.

Supply Control

Two themes were highlighted under the heading Supply Control (see page 3 above). The Task Force recognise the importance of both themes "enhanced enforcement of existing legislation" and "action to reduce the supply of prescription drugs being diverted". Task Force members agreed that these issues would remain firmly on their agenda and that they would take actions to ensure that effective channels of communication between themselves and the Gardai in relation to supply control were maintained and enhanced. The Supply Control sub-group of the RDTF will play an active role in supporting the Gardai in their supply control efforts and will take any actions that are deemed necessary in this area in the future.

Research

The need for ongoing research both at local and national levels was recognised by the Task Force. It was ultimately agreed that research would not be prioritised as a stand-alone theme but that it would provide the vehicle for delivering actions 3 and 4 identified in section 5 of the plan.

Task Force members also agreed that monitoring and evaluation would be an integral part of any action taken or supported by the RDTF. Monitoring and evaluation activities would include the collection of baseline data in all cases and this information could be used centrally by the RDTF to form a statistical picture of the drug problems in the region. Monitoring and evaluation actions have the potential to provide the Task Force with valuable information on the output and outcomes of any action taken.

Measures Necessary to Fill the Gaps in Service Provision Identified

As a result of the facilitated process described above Task Force members compiled the following prioritised list of measures they considered necessary to fill the gaps in service provision:

1. Treatment in Kildare/ West Wicklow
2. Prevention of which Education is a component
3. Harm Reduction
4. Rehabilitation
5. Improved Treatment Responses in non LDTF areas

Note: As stated above services for the under 18's and action on alcohol were considered by the Task Force to be horizontal themes which would be addressed in the context of actions to address the 5 priority areas.

Section 5

Actions Proposed to Address Gaps in Service Provision

Action 1

Establish a Community Drug Team for Kildare/West Wicklow

Rationale:

It has been identified that there is a considerable amount of drug use in County Kildare and West Wicklow (section 1; P12, 14, 17, Section 2 p. 11) with insufficient treatment to meet demand. As there is no Local Drugs Task Force covering Kildare / West Wicklow, it is important to fill this gap.

Aims:

To establish a Community Drug Team for Kildare / West Wicklow.

Core Objectives:

To expand and complement the local existing response to the drug issue in Kildare/ West Wicklow. To provide additional treatment places and ancillary services related to treatment.

Target Group:

The core treatment response will be targeted at drug users. However the issues of providing a response to young people in the early stages of drug misuse, and families, are also important and so synergies will be developed between the key posts in the Community Drug Team and Action 2 The Education Officer / Co-ordinator.

Methodology:

In order to ensure the service is fully integrated into the social infrastructure the Task Force will adopt a community development approach, actively involving the population of Kildare / West Wicklow in the development of a response to the drug issue. It is recommended that the Regional Drugs Task Force Co-ordinator would do preliminary work on the development of a management structure of the Kildare / West Wicklow Community Drug Team.

Project Promoter & Staffing:

The Task Force itself will be the project promoter. The key initial task will be the development of a management committee with local involvement. The RDTF Co-ordinator in conjunction with the Project Co-ordinator will develop an appropriate and inclusive management team and a wider advisory group.

The staffing of the CDT would be a Co-ordinator, a Development / Project Worker and Research / Administrative Worker[1].

Costing:

Item	Cost
Co-ordinator	€55, 106.24
Dev / Project Worker	€48,471.36
Research / Admin	€42,918.40
Non Pay	€ 65,000.00
Total	**€211, 496.00**

[1] These staff grades are related to H.S.E. Administrative Grades 6,5,4 respectively and include employers PRSI at 12%. Relativity to these grades will be maintained throughout the actions.

Action No. 2

Establish a more comprehensive Prevention /Education Response in the region

Rationale:

There is a need for more primary prevention work to reduce the numbers of people who become involved in drug use. There is some activity in the formal education sector. However, there are prevention gaps that need to be addressed in both the formal and the informal education sectors. It is accepted that there are co-ordinating efforts in the formal sector this co-ordination is not as developed in the informal sector.

Core Objectives:

The Task Force aims to reduce the numbers of young people becoming involved in drug use in the region. The Task Force believes building the capacity of Parents / Carers in the area of prevention/ education and early intervention is an essential objective to support the reduction in new drug users. It has been shown that there is some prevention / drug education in the formal sector. Therefore the Task Force will develop and provide responses in the informal education sector with a primary focus on youth work.

Methodology:

A prevention co-ordinator will be employed and will be managed by the RDTF co-ordinator. The co-ordinator will establish and co-ordinate a cross-region Education/Prevention forum and sees representation of 6 LDTF's on the forum as crucial to ensuring non-duplication and that actions provide added value and complement existing provision. The co-ordinator will also work with other professionals in researching and developing and applying a model of best practice prevention and early intervention so that it can be applied across the region and nationally.

Project Promoter and Staffing:

The Task Force will identify an appropriate Youth Service to be the Project Promoter for this action. Staffing will be a Prevention Co-ordinator and the RDTF office or the Project Promoter will provide administrative supports for this initiative.

Costing

Item	Cost
Prevention Co-ordinator	€55106.24
Support Costs	€25,000
Programme Costs	€25,000
Total	**€105,106.24**

Action No. 3

A regional study to ascertain the feasibility of introducing harm reduction measures

Rationale:

The NACD Report (2004) on harm reduction identified a serious shortfall in harm reduction services, particularly in relation to needle and works exchange and low threshold interventions for chaotic injectors. The Task Force believe that this is a cross cutting issue and has the potential to inform National best practice regarding the feasibility of introducing harm reduction measures.

Core Objectives:

The objective is to determine the best way to introduce Harm Reduction on a comprehensive basis in the region, taking into account existing harm reduction services and the level of existing needs.

Methodology:

A one-off, non-recurring research project. The methodology will involve a range of stakeholders and methodologies including face-to-face interviews, documentary analysis, questionnaire and focus groups. The research will output a report to include recommendations on the best way to introduce harm reduction services across the region.

Project Promoter and Staffing

SWRDTF will act as the project promoter and will contract with an external company to carry out the research and produce the final report.
The choice of external provider will be subject to external tender

Costing:

€40,000 once off amount

Action 4

Research into Improved Treatment in Non- LDTF Areas

Rationale:

In recent years there has been improved treatment provision, particularly in Local Drugs Task Forces areas. However some areas in the southwestern region remain poorly serviced in relation to addiction treatment of both opiate and non-opiate drug misuse. This research will provide a more qualitative assessment of treatment needs and will ultimately impact on service provision.

Core Objective:

To carry out research to establish how best to provide treatment outside LDTF areas.

Methodology:

A one-off non-recurring research project using a variety of methodologies with a range of stakeholders.

Project Promoter and Staffing

SWRDTF will act as the project promoter and will contract with an external company to carry out the research and produce the final report. The choice of external provider will be subject to external tender

Costing:

€40,000 once off amount

Action 5

Development of an Individual Rehabilitation Mentor Service

Rationale:

The lack of vocational rehabilitation services for those misusing drugs has been highlighted earlier in the report (section 2, P12) and was identified as a service delivery gap by a number of those who were consulted. A 1998 National Drug Treatment Reporting System report found that 70% of those who misused drugs in Ireland were unemployed. Each individual recovering from drug abuse is faced with a complex web of barriers and challenges that can combine to exclude them from accessing an independent "mainstream" life. The Task Force considers rehabilitation to be an essential process in facilitating a person to access life in the mainstream. With this in mind and in anticipation of rehabilitation being an important element the National Drugs Strategy for the remainder of the life of the strategy the Task Force wishes to invest considerable resources in this under developed aspect of service provision

Core Objective:

To assist recovering addicts to access services most appropriate to them over time. To develop and provide a one to one rehabilitation "mentor" service that will identify and facilitate a personal progression route for each individual.

Methodology:

The rehabilitation "mentor" will work through a process of exploration and assessment with the individual. This process will develop and output a documented individual rehabilitation action plan. The rehabilitation plan will be implemented by the individual with intensive support and advocacy as necessary from the mentor and other agencies as identified. Plans will be periodically reviewed and adjusted to provide further progression steps in the plan.

Project Promoter and Staffing:

SWRDTF will be the initial project promoter and will identify an appropriate rehabilitation provider to develop and deliver the service. The choice of service provider will be subject to external tender. It is envisaged that a team of 4 Rehabilitation "Mentors" will be deployed across the region in existing premises to maximise synergies. For example the mentor may "sit" in the premises occupied by

the Addiction Team outlined in Action 1 or in other premises as agreed, each "Mentor" will carry an approximate rolling caseload of 30 people.

Costing:

Item	Cost
1 Co-ordinator	€55,106.24
3 Mentors	€145,414.08
Support Costs	€100,000.
Total	**€300,520.32**

Action 6

Support for the Regional Drugs Task Force

Rationale:

In order to fulfil its function the Regional Drugs Task Force will require support. The support roles envisaged will ensure that the Task Force can carry out its work in an efficient and effective manner. The individuals appointed to these roles will liase with projects funded by the Task Force and will, in some cases, take on a monitoring role. They will provide a vital link between Task Force members and front line staff and management and will assist in gathering information throughout the Region which will be used to inform future actions.

Core Objective:

To ensure the Regional Drugs Task Force has sufficient support to implement its role efficiently and effectively

Staffing and Costs:

€50,000 has already been made available to the Health Service Executive for the employment of a Task Force co-ordinator. There is an additional €50,000 available from the Department of Community, Rural and Gaeltacht Affairs. In both cases the Task Force anticipates that the funding stream will continue.

It is envisaged that in the third quarter of 2005 a Grade 6 development worker will be appointed. Anticipated costs for 2006 are a Grade 6 Development Worker, a Grade 4 Administrator and a full time Co-ordinator plus non pay of € 50,000 and programme costs of € 50,000 per annum

Costing 2005:

Item	Cost
Dev Worker (I Quarter)	€12,117.84
Office Costs	€30,000
Total	**€42,117.84**

Costing 2006 (excluding previously allocated €100,000)

Item	Cost
Dev Worker (Full Year)	€48,471.36
Research Admin (Full Year)	€42,918.40
Office Costs	€30,000
Total	**€121,389.76**

Action 7

To Establish and Utilise Effectively and Efficiently an "Emerging Needs Fund"

Rationale:

Despite the fact that themes and actions have been prioritised by the Task Force there are a number of outstanding areas still in urgent need of development.

Objectives:

SWRDTF will produce a second tier of priorities to be developed into actions which will be addressed in the period 2006 - 2008. It is intended that these actions will be resourced through an "emerging needs fund" similar to that in operation for the LDTF areas.

Methodology:

A major element of the SWRDTF Co-ordinators and Development Officer roles will be to develop a second tier of priorities for 2006.

Staffing and Costs:

There will be no financial cost in 2005

Total Costs of Actions

Number	Action	Cost
Action 1	**Community Drug Team**	**€211,496.00**
Action 2	Prevention / Education Response	**€105,106.24**
Action 3 Non Recurring	Research on the Feasibility of Introduction of Harm Reduction	**€40,000**
Action 4 Non Recurring	Research into Improved Treatment in Non LDTF areas.	**€40,000**
Action 5	Development of Rehabilitation / Mentor Service	**€300,520.32**
Action 6 (Full One Year Cost)	Supports for Regional Task Force	**€121,389.76**
Action 7	Emerging Needs Fund	**To Be Established**
Action 8	Evaluation (see final section)	**€34,000.00**
Total Recurring Expenditure*		**€772,512.32**

*This is the expected recurring expenditure with Actions 3 & 4 excluded as these are “once off” actions.

Section 6

Evaluation

The Evaluation Process

According to Rossi (1985) evaluation activities fall into three categories:

1. Analysis related to the conceptualisation and design of interventions
2. Monitoring of programme implementation
3. Assessment of programme utility

He notes that 'unless programmes have a demonstrable impact, it is hard to defend their implementation and continuation' but that impact should be measured both in terms of outcomes for participants and in terms of cost effectiveness.

Evaluations should have both breadth and depth and should provide us with information about what it is about a programme/ service/ intervention that makes it work. According to Pawson and Tilly (1997) evaluation should be based on a number of principles:

1. Evaluators need to attend to how and why programmes/ services/ interventions have the potential to cause change – the evaluator needs to understand the conditions required (reasons and resources) to enable participants to change and whether these have been realised in practice in the particular programme/ service/ initiative in question

2. Evaluators need to penetrate beneath the surface of observable inputs and outputs – evaluators need to understand how the programme/ service/ intervention informs and alters the decision making of participants

3. Evaluators need to understand how the programme/ service/ initiative has removed or countered the causes of social or behavioural problems they are there to change – how have the mechanisms responsible for the original problem been disabled or circumvented

4. Evaluators need to understand the contexts in which the programme/ service/ initiative will work or not work – this will help to identify the people and situations for whom the initiative will be beneficial by focusing on the success and failure of different subgroups of participants

5. Evaluators need to understand what the outcomes are and how they are produced – this will help project promoters to understand if the theories on which they are based are confirmed and will promote the replication of the project or not depending on evaluation results

6. Evaluators need to acknowledge that programmes/ services/ initiatives operate in a changing world and that the effectiveness of any programme may be helped or hindered by factors outside their control or remit.

The process of evaluation should be seen as an essential component to any programme design. However, due to resource and time constraints, evaluation often becomes tacked on as 'monitoring' which is frequently carried out by already stretched project staff who have limited experience in this area and very little time available to carry it out.

The Task Force sees evaluation as essential to every project it supports and therefore has committed to provide adequate funding for meaningful evaluation activities.

The evaluation funding stream requested by The Task Force allows for each project to invest resources not only in carrying out evaluation activities but also in planning for evaluation.

Evaluation is seen by the Task Force as providing an important methodology by which to:

- Review and reflect on practice
- Ensure that the needs of clients are being met and that they are being assisted to achieve their desired outcomes
- Inform further planning and practice
- Share and disseminate experiences, learning
- Develop models of good practice
- Use resources appropriately and effectively
- Make a case for further funding to replicate or further develop programmes that work

The extent to which the evaluation process is successful will depend on a number of factors; not least the extent to which evaluation is seen as essential to the project, not just for funding but also for other reasons as outlined above. The Handbook *"Planning and Implementation of Community Based Projects"* comments

"The ease with which the evaluation is conducted, the level of co-operation obtained and the extent to which it is taken seriously will depend in large measure on the extent to which you have managed to create an evaluation culture within the project and have made evaluation integral to the projects strategies from the beginning" (p. 70)

In the case of each project, evaluation activities will take place throughout the funding period and will address how the work of the project progresses both at process and content levels.

Process evaluation will focus on the effectiveness and efficiency of the work methods employed in the running of the project. Its main concern will be how the project is run rather than what its outcomes are. Of particular importance will be how decisions are made regarding an individual's suitability for participation, how the project engages with its clients, the manner in which it disengages with clients, how it is managed, reporting structures and systems, and internal processes and procedures (including financial).

Content evaluation will focus on the extent to which project activities and outcomes are in line with its aims and objectives. This will include a review of the type and nature of activities carried out by the project, baseline measures used with clients when they engage, measuring how clients have progressed, the outcomes achieved for clients, the particular project activities that achieve the best results (what works and what does not) the extent to which project activities have been revised to meet the needs of clients, and whether or not client needs are being met by project activities.

Evaluation activities undertaken by or on behalf of the Task Force will first and foremost take account of the theoretical basis for the project and how adequate or inadequate this is. If the theory on which a project is based is inadequate then it is highly likely that the project will not achieve its desired outcome. The theory on which a project is based will determine the actions or interventions that the project delivers.

The second issue with which evaluations will concern themselves is what the project is meant to be doing i.e. what its aims are. The clearer the aims of a project are from its inception, the easier the evaluation process will be. A consideration of the aims of a project will affect the criteria that are adopted to measure its success.

All evaluations will look at the means by which an outcome is achieved as well as at the outcome itself because a clear understanding of this will allow for the intervention to be replicated elsewhere. This is of particular importance with pilot projects where the intention is to test a model of practice which if it works will be implemented on a broader scale. Evaluations will document where changes have been made in practical terms to meet the evolving needs of clients to ensure that

they are being evaluated based on what they actually do rather than what was originally stated as their purpose.

The importance of collecting baseline information on project participants at intake cannot be stressed enough. This baseline will provide important data to evaluators both from the point of view of developing a profile of the individuals who participate in project activities and also at measuring distance travelled by each individual. Evaluations will not be based on hard outcomes alone and will also consider health and social gain. This can only be done if baseline measures are taken which tap into the participant's position at intake in a holistic way.

Health and social gain refers to the impact of the project on the general health and well being of the individual and those in immediate contact with them. An example of this would be to look at the changes an individual has made to how they live their life in terms of decision making, diet, exercise, relationships with others etc rather than just at whether they achieved a hard outcome like progressing to a job or training/ educational programme.

Each project supported by the Regional Drugs Task Force will develop and implement an evaluation plan that will use an external and independent professional / organisation to carry out the evaluation role. An external evaluator will be more objective in their view of the project and its activities than someone who is either directly or indirectly involved in running or funding it. The employment of an external evaluator will ensure the integrity of the evaluation process and lend weight to its findings.

Planning for Evaluation

In planning for evaluation cognisance will be taken of the work of the NDST evaluation sub group and the indicators which will be included in the soon to be published expenditure review of the National Drug Strategy. It is recognised that many project managers and staff that are inexperienced in the area of evaluation may see it as an activity which monitors their own success or capacity to do their job rather than that of the project. This misperception can lead to hostility and a reluctance to co-operate with external evaluators. In order to allay these fears and to encourage and facilitate the evaluation process the Task Force has decided to employ an external consultant to facilitate a short series of evaluation planning workshops to be attended by *all projects supported by SWRDTF.*

Each project will have unique features and as such each project will tailor specific evaluation methodologies/ approaches to meet their own particular needs.

The proposed workshops will inform projects about the evaluation process and its purpose, and help them to build a strategic plan for evaluation. Workshops will ultimately be shaped by the needs of participants but typically may include:

- What is monitoring and evaluation and why is it important?
- What questions do we need to ask?
- Who are the stakeholders in your project?
- What to evaluate?
- When to evaluate
- What will evaluation analyse/assess (e.g. Inputs, Outputs, Process and Outcomes)

Participants will also be taught how to develop and document a strategic plan. Workshops will include:

- How to state the aims of your project
- How to develop specific objectives under each aim
- Documenting an annual programme of work that will detail the tasks and actions to be implemented
- Developing quantitative and/or qualitative performance indicators. This will include not only recording and evaluating "hard" measurable data but also capturing "softer" but essential measures of health and social gain
- Organisational structures and roles
- Deciding what to record and monitor – the boundaries
- Creating a system to monitor the project
- Data collection methods and timescales.
- Information management in relation to collection, storage, analysis and usage with due regard to issued of confidentiality.

It is essential that resources are allocated to ensure planning and implementation of systematic data collection to facilitate the evaluation process. If the planning process is correctly carried out it will be easier and therefore less costly in the long run to carry out external evaluations.

The Task Force recognise that for many community-based projects this is a particularly challenging area and believes the generic evaluation preparation workshops described above will provide valuable support in this regard. However, responsibility for developing a project plan, monitoring, and data collection ultimately rests with each project promoter.

The planning for evaluation phase will recommend that each project produces a documented strategic plan which will contain:

- A project "master file containing an overall project plan to include documented aims, objectives, and performance indicators (how will I know this action has been achieved, and how will I know it has contributed to meeting the objective?), along with entry criteria and target participant profile

- An annual programme of work broken down into specific objectives. This programme will be presented in tabular form and will include who will do what where and when in terms of actions, what the performance indicators will be and the corresponding resources required
- Clear organisational flow charts with names attached to areas of responsibility
- Job descriptions / terms of employment
- Records for individual staff members (including absence, holidays, training and development, supervision, performance reviews)
- In projects where it is proposed to utilise a management committee, clearly documented roles and responsibilities and the terms of reference agreed
- All policies (dated and re-visited periodically)
- Progress Reports / minutes of all meetings
- Staff training and development records
- Correspondence/requests to funding body
- External contracts / legal docs/ financial tracking
- Documented monitoring and evaluation plan

Monitoring and Evaluation Plan:

Each project will have a monitoring and evaluation plan developed in the planning / pre-operational phase of the project. The particular methods employed will vary to reflect the individual nature of each project and decision-making regarding this will be supported by the external evaluator.

However the structure of the evaluation plan will be uniform to each project and will contain, inter-alia:

- A table outlining an annual programme of action to include: objectives, performance indicators, who will do what, where and when and resources required.
- Table of a range of data sources. In other words a checklist of what evidence is being collected to support the outcome indicator and demonstrate that the objectives are being met (quantitative and qualitative)
- Timeline for the above mentioned data collection activities
- Allocation of responsibility for monitoring and recording, i.e. who will collect the data as identified above
- When and how often evaluation(s) will take place and by whom – at a minimum this should include one external evaluation annually but may also include interim internal evaluation activities.
- Dissemination of findings. What the project will do with the evaluation in terms of a feedback loop, how findings will be disseminated, to whom and in what formats and for what purpose.

Financial Allocation:

The Task Force has estimated that the cost of engaging an external consultant to develop and carry out the evaluation planning process whereby representatives from all projects and services funded by the Task Force will be brought together in a number of workshops to develop their own evaluation plan will be € 10,000.

The Task Force has allocated a sum of € 8,000 for the external evaluation of each project or service it funds.

Section 7

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