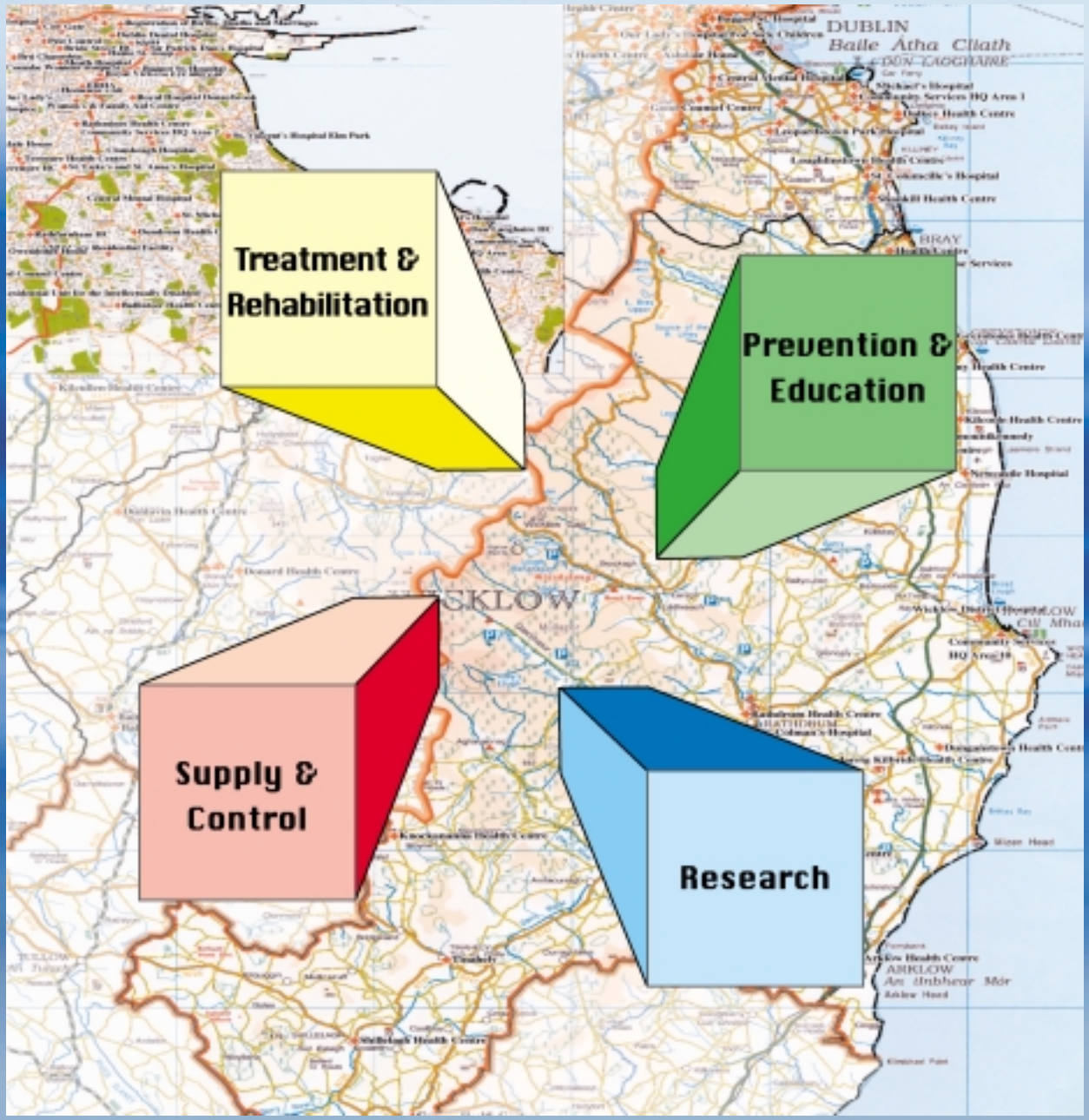
East Coast Regional Drugs Task Force

Action Plan 2005-2008



THE EAST COAST REGIONAL DRUGS TASK FORCE WAS ESTABLISHED IN 2003 AND IS MADE UP OF COMMUNITY, VOLUNTARY AND STATUTORY REPRESENTATIVES WORKING IN PARTNERSHIP TO ADDRESS THE DRUG ISSUES WITHIN ITS REGION. FOR MORE INFORMATION OR ASSISTANCE, CONTACT:

MS SIOBHAN TURNER,
EAST COAST REGIONAL DRUGS TASK FORCE,
BLOCK B, THE CIVIC CENTRE, MAIN STREET, BRAY, CO. WICKLOW.
TEL. NO: 01 274 4238, FAX. NO: 01 274 4277
Email: siobhan.turner@maild.hse.ie
www.drugsinfo.ie
DRUGS HELPLINE FREEPHONE: 1800 459 459

Drugs. There are answers.

TABLE OF CONTENTS

Foreword		**2**
Section 1:	**Nature and Extent of Drug Misuse**	**4**
Section 2:	**Profile of Existing Service Provision Statutory, Voluntary and Community.**	**19**
Section 3	**Extent to Which Current Service Provision Meets Identified Need.**	**31**
Section 4	**Measures Necessary to Address Gaps in Service Provision.**	**47**
Section 5	**Developing and Prioritising Specific Proposals**	**55**
Section 6	**Evaluation**	**95**
Section 7	**Cross Task Force Issues and Learnings from LDTF**	**101**
Appendix 1		**105**
Appendix 2		**163**
Appendix 3		**185**

FOREWORD

It is my honour to present on behalf of the East Coast Regional Drugs Task Force (ECRDTF) our first Action Plan for the region. The Action Plan endeavours to provide a strategic framework towards providing services to drug users, their families and the whole community.

I would like to take this opportunity to thank a number of individuals and groups, firstly to thank the team from Inclusion Training and Consultancy Services for their assistance and advice in putting this report together. Secondly a word of thanks should be extended to members of the public, groups, services, services users and statutory providers who took part in the wide range of public consultation work for the plan. Their views on the drugs situation within their communities was invaluable to the work of the Task Force. And lastly, to each and every individual member of the Task Force, including all subcommittee members for their time, enthusiasm and expertise that they gave in developing this plan.

The plan is a beginning for the Task Force and we wish to acknowledge the immense amount of good work already undertaken by statutory, community and voluntary groups dealing with addiction problems within the region. The Task Force plan takes on board the work currently taking place and has tried where possible to recommend proposals in areas where there is a gap in services or where complimentary services to existing services can be developed.

As we are all aware, drug misuse is one of the greatest problems of our time, and affects the lives of individuals, families and communities. Drugs impact on the physical and mental health of the user; they also impact on families, who often cannot cope with the guilt, shame, helplessness and fear associated with drug misuse. Communities are also affected and fear the behaviour of individuals under the influence of drugs. The drugs problem affects us all and everyone can play a role in tackling the drug problem in this region.

The ultimate goal of the East Coast Regional Drugs Task Force is to provide a holistic approach in the provision/support of services for individuals and their families affected by addiction.

The Task Forces overall aim is to significantly reduce the harm caused to individuals and communities by the misuse of drugs. We hope to establish, maintain and support services to enable individuals who misuse drugs to achieve and maintaining a drug free outcome. However the Task Force recognises that not all individuals will achieve the aim of a drug free state, therefore a variety of interventions are recommended to empower an individual with a drug misuse problem to live as normal a lifestyle as possible.

The Task Force is aware that the multi-faceted problem of drugs will not be solved purely through the implementation of this plan, and that work in key areas of drug misuse will require further investigation in the future work of the Task Force. However, the Task Force hopes that this plan will be the step forward towards significant changes in service delivery to individuals and communities. The work of the Task Force will be ongoing and long term and we hope that this Plan is the initial stepping stone to addressing the drug misuse problems within our area.

John O' Brien,
Chairperson.

Section 1

Nature and Extent of Drug Misuse

Work Package 1: The Headlines

- **Lifetime prevalence rates of drug use in the Health Services Executive East Coast (HSE East Coast Area) region are consistently above National rates for illicit drug use**

- **There has been a steady/consistent increase in numbers attending clinics, GP's and Pharmacies for treatment in the HSE East Coast area, rising by 4.5%, 5.7% and 4.7% respectively in a 9 month period**

- **Probation and Welfare report a high concentration of Heroin users in South County Wicklow (Arklow)**

- **HSE East Coast Area Addiction Services further confirm the increased numbers of opiate users in the Arklow area**

- **East Coast has the highest level of Cocaine use throughout the country**

- **Cannabis is the most widely used illegal drug in ECAHB area followed by sedatives/ tranquillisers/ anti-depressants, cocaine, magic mushrooms, ecstasy, amphetamines and LSD. Heroin, although relatively lower still exceeds the National level (National Advisory Committee Drugs (NACD) 2002/2003 Lifetime Prevalence Figures)**

- **Usage is consistently higher for males although the gap between males and females narrows somewhat in relation to Heroin misuse**

- **In April 2004 HSE East Coast Area staff reported that 30% of those in touch with outreach services are under 18 years of age. Primary drugs of young people/children are speed, Hash and ecstasy.**

- **Gardai confirm a high level of cannabis use in 15-24 year olds. However Cocaine and Heroin become the dominant drugs of choice between 20 – 29 years of age.**

Methodology

Information presented in this section of the document was gathered from a variety of secondary sources. This data was analysed for its relevance to the East Coast Regional Drugs Task Force (ECRDTF) area and that which was considered appropriate is outlined below.

Limitations of the Study

Information gathered for this section of the document was drawn from a number of secondary sources. One of the main limitations of this study was the difficulty in locating data that pertained to the specific area represented by the ECRDTF. There is a general lack of research in the drug area and what data exists is patchy. Some of the data presented below dates back to 1998, however this was the only available data on the particular issue under discussion. This presents obvious limitations when conclusions are being drawn from this data. Due to the scant, fragmented and dated nature of some of the data presented below, it would be wise to consider conclusions drawn as indicative.

Prevalence of Drug Misuse

The term prevalence refers to the proportion of a population who have used particular illegal drugs over a period of time. The prevalence of drug misuse in Ireland is usually an estimated calculation using the known numbers of those who present themselves for various types of treatment, are arrested on drug-related charges, and die from drug-related causes. These figures will not accurately reflect to total numbers within the population who are misusing drugs, but they provide evidence for the best possible estimate. Some studies, however, use representative samples from the general population, including a study by the National Advisory Committee on Drugs (NACD) published in 2004, which is referred to later in this Section.

Illicit Drug Use in a National Context

In a survey conducted on behalf of the NACD (2004) which reports on prevalence rates for illicit drug use across Ireland in 2002/2003 19% of the population reported using any illicit drug over their lifetime. A smaller percentage (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.

Treatment for drug misuse nationally is consistently shown to be concentrated in the greater Dublin area. Table 1.1 below illustrates data on drug misuse treatment for 1998, broken down by Health Board Area. The data shows that 85% of those receiving treatment at that time were resident in the Eastern Health Board (EHB) area, which includes the greater Dublin area. The EHB later evolved into the Eastern Regional Health Authority (ERHA), of which the East Coast Area Health Board (ECAHB) is part. In January 2005, the Health Boards were abolished and the Health Services Executive now governs the Health Services of which the ECAHB is part, now know as the HSE East Coast.

Table 1.1: Numbers Receiving Drug Misuse Treatment by previous Health Board Area: 1998 (NDTRS data)

	EHB	SHB	NWHB	MHB	WHB	MWHB	NEHB	SEHB	Total
N	5,076	303	48	96	14	96	128	201	6,043
%	85%	5.1%	0.8%	1.6%	0.2%	1.6%	2.1%	3.4%	100%

The Central Treatment List (CTL), which records the numbers in receipt of methadone maintenance in Ireland, is compiled by the ERHA. Methadone maintenance is a medical treatment for those using heroin and can be managed through clinics, addiction centres and by GPs. Table 1.2 below shows the numbers receiving methadone maintenance over the past number of years. It is clear from these figures that there has been an increase in the number of people receiving methadone maintenance every year. At the end of December 1999, the number of heroin users on methadone maintenance programmes in Ireland was 4,332 (a rise of 20% from 1998), with the majority still residing in the ERHA region. By December 2000, this figure had risen to 5,032 (16% increase) with a further 469 people on the waiting list to receive treatment in the ERHA area.

The numbers in the ERHA area account for by far the largest proportion of those receiving methadone maintenance across the country and reflect the fact that the majority of heroin users reside in the Dublin area. In 1999 the numbers availing of methadone maintenance in the ERHA area (both in clinics and from GPs combined) had risen 21% (648) from 1998 and in 2000, the numbers had risen again by 18% (669) over the previous year.

Table 1.2: Numbers Receiving Methadone Maintenance (CTL Data)

Data	1998	1999	2000
ERHA clinics	1,939	2,502	2,849
ERHA GPs	1,167	1,252	1,574
Other clinics	504	515	554
Other GPs	Not known	63	55
National	3,610	4,332	5,032

The number of people entering treatment for drug use outside Dublin has also increased. The Health Research Board (2003) reported a three-fold increase from 25 cases per 100,000 in 1998 to 70 cases per 100,00 in 2002.

The increase in numbers availing of methadone maintenance from year to year throughout the country can be partially explained by the increase in availability of treatment and the development of these services, which has encouraged many to present themselves for treatment. Increased availability cannot fully account for the increase in numbers, therefore an increase in the prevalence of heroin misuse can still be inferred from the data.

Drug Misuse in the East Coast Area

The seizure of illicit drugs by the Gardai is a good indicator of the prevalence of drug misuse in certain geographical areas and also it can establish a good profile of those using particular types of drugs. The management of operational policing with the HSE East Coast Area is the responsibility of the Superintendents in each of the Garda Districts of Donnybrook, Blackrock, Dun Laoghaire, Bray, Wicklow Town and Gorey (covering Arklow and Carnew).

An analysis of all seizures in each of the Garda Districts covering the geographical area of the HSE East Coast Area was conducted for the 12 months period beginning on 1st November 2002 and ending 31st October, 2003. Table 1.3 outlines the number of seizures in each of the areas in the HSE East Coast Area and the types of drugs seized.

In line with national surveys, cannabis is the most widely used drug in the HSE East Coast Area. The main town centres in the HSE East Coast Area are where the greatest number of seizures of illicit drugs occur, however, as can be seen from Table 1.3 a significant number of seizures of illicit drugs were made in less populated areas.

Table 1.3: Garda seizures by location within the HSE East Coast Area

Location	Cannabis	Heroin	Cocaine	Ecstasy	Amphet.	Methadone
Donnybrook	22	3	2	2	0	1
Ringsend /Sandymount	7	0	3	0	1	0
Belfield	1	0	1	0	0	0
Clonskeigh	3	0	1	0	0	0
Blackrock	18	0	0	0	1	0
Stillorgan/Kilmacud	11	0	0	1	0	0
Dundrum/Ballinteer	32	1	4	1	0	0
Sandyford	19	1	0	0	0	0
Churchtown	1	0	0	0	0	0
Booterstown	3	0	0	0	0	0
Monkstown	5	0	0	0	0	0
Deansgrange	1	0	0	0	0	0
Sallynoggin	11	0	2	5	0	1
Dun Laoghaire	56	24	6	4	2	4
Stepaside	1	0	0	0	0	0
Cabinteely	12	0	2	0	0	0
Ballybrack /Loughlinstown	22	1	2	4	1	0
Shankill	15	1	1	0	0	0
Dalkey	6	1	1	1	1	1
Killiney	9	1	1	1	0	0
Bray	25	19	4	4	0	2
Greystones/Kilcoole	18	1	0	0	0	0
Roundwood	2	0	0	1	0	0
Ashford	7	0	3	3	0	0
Rathnew	3	0	0	1	0	0
Wicklow Town	26	0	0	1	1	1
Magheramore	6	0	1	4	0	0
Glenealy	3	0	1	0	0	0
Rathdrum	2	2	1	0	0	0
Aughrim	2	0	0	0	0	0
Redcross	1	0	0	0	0	0
Arklow	21	4	1	1	0	1
Knockrobbin	5	0	0	2	0	0
Total	**376**	**59**	**39**	**38**	**7**	**11**

A survey conducted on behalf of the NACD (2004) documents prevalence of drug use in the HSE East Coast Area for 2002/2003. This survey reports that over a quarter of the population (25.8%) in this area had taken an illegal drug at some point in their lifetime, while 6.4% had done so in the last year, and 4.1% had done so in the last month. These are consistently above the national rates for illicit drug use (see Table 1.4). Prevalence data for those who had used illicit

drugs in the last year showed sedatives/tranquillisers/anti-depressants to have been used by 6.9%, cannabis by 6.2%, ecstasy by 2.5%, cocaine by 2.4%, heroin and other opiates by 0.6% and solvents by 0.2%.

Table 1.4: Prevalence of Drug Misuse in the HSE East Coast Area and Nationally (NACD, 2002/2003)

	Percentage of Population		
	Lifetime Prevalence	**Last Year Prevalence**	**Last Month Prevalence**
HSE East Coast Area Population	25.8%	6.4%	4.1%
National Population	19.0%	5.6%	3.0%

In the absence of accurate and up to date information on prevalence rates, numbers in treatment have been taken to be the best estimate of the number of people misusing illicit drugs. The report *"Estimating the Prevalence of Opiate Drug Use in Dublin, Ireland during 1996" (*Comiskey) outlines a formula for calculating prevalence rates from an analysis of the numbers in treatment.

Non-residential treatment services in the HSE East Coast Area include clinics, addiction centres, treatment from GPs and pharmacies, needle exchange and outreach services. The extent of residential treatment available to those presenting to the HSE East Coast Area is outlined in Table 1.5. This includes detoxification and rehabilitation programmes within and outside of the HSE East Coast Area. These services are available on a regional basis and take referrals from the HSE East Coast Area through a referral committee.

Table 1.5: Residential Treatment Currently Available to those in the HSE East Coast Area region (2003 data)

Treatment Type	Number of Places Available
Residential Detox	
St Michael's Ward, Beaumont	10
Chun Dara, Cherry Orchard	17
Subtotal	27
Residential Rehabilitation	
Coolmine	80
Rutland Centre	36
Keltoi	20
High Park, Merchant's Quay	12
Subtotal	112
Residential Services Available outside ERHA	
Coolamber, Longford	20
Merchant's Quay, Tullow	11
Marist Centre, Athlone	15
Kedron, Edenderry	1
Ashling, Kilkenny	3
Chun Mhuire, Athy	12
Subtotal	62
Total	**201**

The most recent information on waiting lists for addiction clinics/centres/ projects in the HSE East Coast Area pertains to November 2003. There were only 4 people on waiting lists that month, all of whom were male. Three of these individuals were aged 20-24 years and 1 was aged 30+ years. All 4 individuals were on the waiting list for less than 3 months. The small number on the waiting list and relatively short waiting time is characteristic of the services in the HSE East Coast Area over the previous few years. In November 2002, for example, the number on HSE East Coast Area waiting lists for addiction services was also 4. Table 1.6 displays the numbers on waiting lists for all clinics/ addiction centres and drug projects in the HSE East Coast Area from January to November 2003.

Table 1.6: Waiting Lists for Drug Clinics/Projects in HSE East Coast Area, 2003 (CTL Data)

Location	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov
Baggot St	0	1	0	1	1	5	3	4	3	2	1
Irishtown	0	0	0	0	0	0	0	0	0	0	0
Young Persons Project	0	0	0	0	0	0	0	0	0	0	0
Dundrum	0	0	0	0	0	0	0	0	0	0	0
Patrick St, Dun Laoghaire	1	1	0	0	6	6	4	2	0	1	0
Ballywaltrim Project	0	1	0	0	1	1	0	1	0	0	0
Fassaroe Project	0	0	0	0	2	4	0	0	0	0	1
Kilarney Road	-	-	-	-	-	-	-	-	-	-	1
Loughlinstown	0	0	0	0	0	0	0	2	0	0	0
Mobile Bus	0	0	0	0	0	0	0	0	0	0	0
Sallynoggin	1	1	0	1	0	0	0	0	0	1	1
Strand Rd, Bray	0	0	0	0	0	0	1	0	0	0	0
Total	**2**	**4**	**0**	**2**	**10**	**16**	**8**	**9**	**3**	**4**	**4**

It must be noted that the numbers availing of services or small numbers on waiting lists are not an indication that services are adequately catering for the number of drug misusers in the area. It is likely that there are other individuals in need of services who live in areas from which it is not easy to access service locations, who have not yet presented for treatment, or who believe that there are large waiting lists and therefore it is not to their benefit to put their name down.

The most up to date information from the Central Treatment List for drug treatment in the HSE East Coast Area span from September 2003 to June 2004 and show a steady increase at each interval in the numbers attending clinics, GPs and pharmacies (Table 1.7). The number attending HSE East Coast Area clinics rose by 4.5% over this time, from 398 in September 2003 to 416 in June 2004. The number attending GPs also rose over this time, by 5.7%, while the number attending pharmacies rose by 4.7%.

The data available on outreach services in the HSE East Coast Area pertains to April 2004, when 165 people were reported to be involved in the service. The majority of these individuals (97) were male and opiates were their primary drug of misuse. There were approximately 144 individuals availing of needle exchange services in the area in April 2004, across 5 centres (Sallynoggin, Dundrum, Arklow/van, Dun Laoghaire and Bray). Each centre gave out about 60 exchanges over the month, a total of about 300 exchanges for the HSE East Coast Area. This shows an average of 2 needle exchanges per month for each person availing of the service.

Table 1.7: Numbers Receiving Drug Treatment in HSE East Coast Area (CTL Data)

Service	Sep 2003	Dec 2003	Feb 2004	Mar 2004	Apr 2004	May 2004	Jun 2004
HSE East Coast Area clinics	398	401	405	412	-	414	416
HSE East Coast Area GPs	294	300	305	298	-	308	311
HSE East Coast Area Pharmacies	522	536	539	535	-	537	547
Outreach Services	-	-	-	-	165	-	-
Needle Exchange	-	-	-	-	144	-	-

Informal reports from the Probation and Welfare Service working with individuals in the area of Wicklow/Arklow show a high concentration of heroin users in Arklow (25) as compared to other areas. They also show a relatively high concentration of Probation and Welfare clients using other illicit drugs in Arklow (30), compared to 34 outside of Arklow/Bray who were misusing drugs. These figures pertain to the 2-year period from 2003 to July 2004. Information from the HSE East Coast Area Addiction Service confirms the significant number of opiate abusers in the Arklow area and highlights the need to provide locally accessible services.

Information from the NACD report suggests that the East Coast area has the highest level of cocaine use throughout the country. The HSE East Coast Area, however, do not report any significant increase in the numbers presenting for treatment for cocaine use. A number of factors must be considered when linking prevalence and treatment rates for cocaine use: firstly, there is currently

no medical treatment available for cocaine use; secondly, cocaine is often used socially and therefore those who use it may not consider themselves to require treatment; an thirdly, cocaine has, until recent times, been mainly associated with middle class drug users who, if they do decide to present for treatment, may avoid publicly funded services and opt instead for private treatment.

Type of Drug Misuse

Lifetime prevalence data for Ireland from the NACD survey (2004) showed that cannabis was used by 17.6% of the Irish population, sedatives and anti-depressants by 12.2%, magic mushrooms by 4%, ecstasy by 3.8%, cocaine by 3.1%, other opiates by 3.1% and heroin by 0.5% (see Table 1.8)

Table 1.8: Lifetime Prevalence of Specific Drug Misuse: National & HSE East Coast Area (NACD, 2002/2003)

	National	HSE East Coast Area
Cannabis	17.6%	24.4%
Sedatives/ tranquillisers/ anti-depressants	12.2%	14.2%
Magic Mushrooms	4.0%	6.0%
Ecstasy	3.8%	5.4%
Cocaine	3.1%	6.3%
Other Opiates	3.1%	3.9%
Amphetamines	3.0%	4.8%
LSD	3.0%	4.7%
Poppers (amyl- or butyl-nitrite)	2.6%	3.7%
Solvents	1.8%	2.5%
Heroin	0.5%	0.7%

Lifetime prevalence data for the HSE East Coast Area reports higher rates of use for all drug types when compared with the national figures (Table 1.8). As reported in the national figures, cannabis is the most commonly used illicit drug in the HSE East Coast Area (24.4%), followed by sedatives/ tranquillisers/ anti-depressants (14.2%). HSE East Coast Area figures indicate that the next most commonly used drugs differ somewhat from the ranking of those most commonly used nationally: HSE East Coast Area figures are cocaine and magic mushrooms (6% each), ecstasy, amphetamines and LSD (5% each), poppers (3.7%) and solvents (2.5%). The level of heroin use (0.7%) was relatively low compared to other drug types but still higher in this area when compared to the national level.

Profile of those who Misuse Drugs

When considering prevalence rates it is useful to consider the profile of those who misuse drugs as this gives some indication of trends which can be useful in predicting future rates of drug use amongst certain sectors of the population. These trends can provide those developing strategies to combat illicit drug misuse with useful indicators for the targeting of service provision.

Gender

National lifetime prevalence rates for drug misuse in Ireland show the rates among males to be consistently higher than rates of misuse among females. Lifetime prevalence for any illicit drug was 24.4% for males and 13.5% for females (NACD, 2004).

In the HSE East Coast Area, males reported lifetime prevalence rates double that of females (34% compared to 17%). This gender difference was even more pronounced in relation to recent and current use, with males reporting rates up to four times higher than females (NACD, 2004). The most recent figures from the Central Treatment List (Jan-Mar 2004), recording those availing of methadone maintenance from clinics and GPs in the HSE East Coast Area region, show that out of 748 service users, 525 (70%) were male and 223 (30%) were female. Males outnumbered females in similar ratios across all age ranges.

The analysis of Garda seizures within the HSE East Coast Area also shows that the prevalence rates for drug misuse in the HSE East Coast Area is consistently higher among males than among females. (Table 1.9 refers). Seizures of cannabis from males account for the greatest number of drug seizures within the HSE East Coast Area. However, the ratio of heroin seizures between males and females is not as great as that of other drugs. Male's account for 61% of heroin seizures while females account for 39%. When compared to cannabis seizures, heroin use among females appears to be at a higher level. Eighty nine percent of cannabis seizures were from males while the remaining 11% of the seizures were from females.

Table 1.9: Prevalence of drug misuse by gender – HSE East Coast Area – Garda seizures

Gender	Cannabis	Heroin	Cocaine	Ecstasy	Amphet.	Methadone
Male	330	36	38	36	5	8
Female	43	23	1	2	2	3
Total	**373**	**59**	**39**	**38**	**7**	**11**

Age Group

Results of a study conducted by the National Youth Council of Ireland in 1998 shows that over half (53%) of young people in Ireland have tried an illegal drug and recent statistics have shown an increase in the number of young people presenting for treatment. A report by the South Eastern Health Board (now know as the HSE South Eastern) (2004) shows that the majority of those seeking treatment in the area in 2003 were in the 20–29-year age group while 18% were in the 10–19 year age group (a rise of 3% from 2002). Most of the teenagers seeking help are abusing ecstasy, followed by alcohol and cannabis. HSE East Coast Area outreach staff report that 30% (29) of those in contact with the outreach services in April 2004 were 'underage' and their primary drugs of misuse were speed, hash and ecstasy.

A study of the age of the person, from whom the Gardai in the HSE East Coast Area seized illicit drugs, shows that there is a high level of cannabis use among young people from 15 years to 24 years of age (Table 1.10). Heroin and cocaine use is most prevalent among people between 20 and 29 years of age. Based on the Garda seizures ecstasy is a drug favoured by young people. By and large young people account for the majority of seizures of illicit drugs by the Gardai.

Table 1.10: Garda seizures in the HSE East Coast Area by age

Age	Cannabis	Heroin	Cocaine	Ecstasy	Amphet.	Methadone
10 – 14 yrs	7	0	0	0	0	0
15 – 19 yrs	141	6	3	11	3	1
20 – 24 yrs	129	19	13	18	1	4
25 – 29 yrs	38	20	12	5	0	3
30 – 34 yrs	20	8	7	1	1	1
35 – 39 yrs	15	2	3	1	2	2
40 – 44 yrs	7	1	1	1	0	0
45 yrs plus	2	2	0	0	0	0
Total	**359**	**58**	**39**	**37**	**7**	**11**

A further survey conducted by the NACD (2004) reports a breakdown of prevalence of illicit drug use in the HSE East Coast Area, over lifetime, according to age. Prevalence of drug misuse was shown to be higher in the younger age range (15-34 year olds) with a rate of 35.8% as compared to the older age range (35-64 year olds) with a rate of 17.7%, across all drug types. Within the HSE East Coast Area, the latest figures for the Central Treatment List (Jan-Mar 2004) for those availing of methadone maintenance from clinics and GP services shows a concentration of individuals in the 25-29 age range receiving treatment. Their breakdown by age range is shown in Table 1.11.

Table 1.11: Age Breakdown of Individuals Attending HSE East Coast Area Clinics & GPs (CTL Jan-Mar 2004)

Age	Number	Percentage of Total (rounded)
15 - 19 yrs	7	1%
20 - 24 yrs	147	20%
25 - 29 yrs	241	32%
30 - 34 yrs	143	19%
35 - 39 yrs	107	14%
40 - 44 yrs	67	9%
45 + yrs	36	5%
Total	**748**	**100%**

At Risk Groups

A link between the prevalence of 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 this research suggest that poverty and deprivation tend to encourage drug misuse, rather than discourage it. Use of opiates (including heroin) is most associated with areas of deprivation, particularly in the Dublin area.

They also identified specific groups, whom they considered particularly at risk of drug misuse: the homeless population, the Traveller Community and those engaged in prostitution. It is difficult to quantify the exact extent of drug misuse among these specific groups. Focus Ireland (1999) estimated that over one third of homeless people in contact with them were misusing drugs. Pavee Point (1999) conducted a survey that shows a trend of drug misuse among the Traveller Community very similar to that of young people in the general population, with an emphasis on cigarettes, alcohol, cannabis, ecstasy, amphetamines and solvents. Opiate use among the Traveller Community appears quite limited. 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) also reports that drug misuse is high among those engaging in male prostitution.

Section 2

Profile of Exiting Service Provision Statutory, Voluntary, and Community

Section 2: The Headlines

- **235 service providers were identified in the ECRDTF region and each service was sent a "scoping" questionnaire.**
- **Of the 235 - 29 were identified as drug specific services, 91 were initiatives targeting those "at risk" and 115 were classified as "general initiatives".**
- **95 service providers returned the questionnaire comprising of 24 drug specific initiatives, 33 initiatives targeting those "at risk" and 38 "general initiatives**
- **43% of identified service providers came under the 2 LDTF areas.**
- **Highest concentration of Drug Specific initiatives are in Bray and Dun Laoghaire.**
- **Many areas across the region were not represented at all in terms of drug specific initiatives**
- **Only 3 respondents said they were engaged in drug treatment and there was virtually no evidence of rehabilitation services in the region.**
- **A large number of education/prevention initiatives were identified, although many have a precarious financial existence, depending on donations or year to year funding**
- **Apart from Education/Prevention all other "pillars" of the National Drugs Strategy (NDS) were under represented in terms of service provision.**

Methodology

The ECRDTF used the Scoping Document to profile the service provision that currently exists in the Region. A list of 235 service providers was compiled which was considered to reflect all services available to those at a disadvantage in the region while paying particular attention to the issue of substance misuse.

The list was broken down into three sub-groups as follows:

29 Drug specific initiatives
91 Initiatives targeting those at risk of drug use
115 General initiatives

The Scoping Document was sent to each of the service providers on the drug specific and at risk lists. A less detailed one-page questionnaire was sent to each of the general initiatives on the list.

Response Rate

The survey questionnaire was returned by a total of 95 service providers. These 95 responses were broken down over the three groups as follows:

24 Drug specific initiatives
33 Initiatives targeting those at risk of drug use
38 General initiatives

Survey responses are detailed in the body of this report according to these three groupings.

Limitations of the Study

When interpreting the results of this survey it is important to consider the limitations of the study. Many of the questions on the survey questionnaire were very broad and invited open ended responses. It became clear when data was being analysed that respondents interpreted the meaning of some of these questions differently from each other. In effect this means that in their replies, respondents were in fact answering different questions. The question regarding service user involvement is a case in point. Some respondents took this to mean, “what service do you provide to service users?” while others interpreted the question as “what involvement do service users have in the design and development of activities/ services?” and still others took it to mean, “what involvement do service users have in the evaluation of services?” Analysis of these responses was therefore difficult and conclusions drawn can be only considered as tentative. This was the case for a number of other questions and where this has occurred it is referred to in the appropriate section of the report.

Contextual Information

The scoping document was sent to all service providers in the region which at the time of the survey fell into the three broad categories outlined above. Of the 235 projects surveyed, 102 (or 43%) fall within the two Local Drug Task Force areas. These projects were almost evenly distributed across the two areas with 53 falling within the catchment area of the Dun Laoghaire Rathdown LDTF, and 52 in the catchment area of the Bray LDTF.

When considered from the perspective of the three groupings to which the scoping document was sent, the figures break down as follows:

Drug Specific
Fifteen (52%) of the twenty-nine drug specific services that received the scoping document were in the catchment area of one of the two Local Drug Task Forces. Nine of these were in the Dun Laoghaire Rathdown LDTF area and 6 were in the Bray DTF area.
The remaining 14 included 9 questionnaires relating to the same organisation (CAD).

At Risk
Fifty (55%) of the at risk initiatives that received the scoping document were in the catchment area of one of the two Local Drug Task Forces. Twenty-nine of these were in the Dun Laoghaire Rathdown LDTF area and 21 were in the Bray DTF area.

General
Thirty-seven (32%) of the at risk initiatives that received the scoping document were in the catchment area of one of the two Local Drug Task Forces. Twenty-three of these were in the Bray DTF area and 14 were in the Dun Laoghaire Rathdown LDTF area.

Drug Specific Initiatives

The survey questionnaire was returned by 24 out of the 29 drug specific initiatives in the survey population which represents a response rate of 82%. It is important when analysing the results of this study to note that 9 of the returned questionnaires related to the same organisation Community Awareness of Drugs but pertained to the different services they provide. Reports from CAD indicate that although some of the services provided by them did not involve individuals or organisations from the ECRDTF area in 2004, these services are open to all. Records regarding the number of people attending these services from this Region are unavailable, however CAD have reported that three of these services were directly provided to individuals/ organisations from the ECRDTF area (see Appendix 1, p5. for details).

These questionnaires were analysed separately to ensure that as accurate a picture of available services was reflected in the report, however for the purposes of some questions, particularly those pertaining to organisational issues, the 9 CAD responses were taken as one response.

Results of this survey (Table 1.1, Appendix 1) represent a limited geographical spread. Major centres within the ECRDTF area were not represented in the sample. The highest concentration of drug specific initiatives was in the Bray area with Dun Laoghaire and Arklow representing the next highest concentrations among those who returned the questionnaire.

Most respondents came from the voluntary sector (6 which includes the 9 CAD respondents as one), five statutory bodies responded to the survey and a further three respondents reported that they were community-based. This highlights the importance of the voluntary and community sector in tackling the drug problem. The allocation of funds to this sector is essential if problems are to be dealt with on the ground where they can be most effective.

There would appear to be to be an over representation of education based initiatives in the area compared to initiatives carrying out other functions (Table 1.2, Appendix 1). Besides the education/prevention pillar of the National Drugs Strategy, the remaining pillars were under represented in the sample (Table 1.6, Appendix 1). Only three respondents said that they were engaged in treatment. This may be because many of those seeking treatment avail of services outside the catchment area such as Trinity Court, Merchants Quay or the Rutland Centre, or it may be that there is a lack of treatment facilities in the ECRDTF area. This coupled with the low number of respondents reporting that they offered rehabilitation needs further consideration if the drug problem in the area is to be addressed in a comprehensive way taking into account local needs and difficulties.

While extensive research is carried out by the NACD, this pertains, in general, to the National picture and does not provide detailed local information. The numbers of respondents reporting involvement in research-based activities in this survey was small (4) further underlining the lack of localised data collection. If resources to tackle the drug problem throughout the country, and more specifically in the ECRDTF area are to be properly allocated, then well-conducted, locally based research into the problem is essential. This is even more relevant in an area as wide and diverse as that covered by the ECRDTF. This research should not only focus on the nature and extent of the problem, but should assess the success or otherwise of initiatives that are currently in place. In general, funding is only allocated to research if it is considered that services are adequately financially supported (although some grant aid is available through the NACD and the Health Research Board) and this leads to a situation where research activities remain low on the agenda. This is an issue which needs to be addressed if the allocation of resources to services is to be carried out in the most effective and efficient manner.

When asked to list the purpose and objectives of their initiative/service most respondents listed more than one main purpose and several objectives and responses were wide-ranging and varied (Table 1.4, Appendix 1). The highest number of responses made regarding both purpose and objectives once again fell into the broad category of drug education/ training.

When considered under the pillars of the National Drugs Strategy the recorded responses again show an over representation of education/ prevention initiatives. The dearth of treatment, rehabilitation, and research purposes and objectives stated is a matter of concern in particular when this is considered in proportion to the relatively high number of education initiatives. These results represent a narrow perspective which will need to be widened if the drug problem in the area is to be addressed in any comprehensive or coherent way by the ECRDTF.

When asked to outline the methods they used, once again responses were many and varied and reflect the broad nature of the question asked (Table 1.11, Appendix 1). The highest number of responses in this section fell into the category information giving; the next most frequently mentioned methods were psychotherapy/counselling, and education/ training. One would assume that psychotherapy/counselling which is listed as a method by a drug specific initiative would be considered rehabilitative or preventative, however this is not reflected in other results from this survey. Counselling has a long tradition in the addiction area and as such is widely used. The ERHA has recently carried out a review of counselling in regard to addiction within the Health Boards. When projects are being assessed as providing counselling this review needs to be taken into account along with recognised qualifications and membership of professional bodies.

There would appear to be a good deal of interagency and co-operative work being carried out among respondents in the area. However the nature of this working arrangement was not explored in any detail in the Scoping Document so it is difficult to draw any conclusions on the extent and nature of the co-operation or the benefits of this interagency work. The partners in this interagency work named by the different initiatives came from a broad range of areas (Table 1.3, Appendix 1). This range is encouraging as it indicates a level of interest in drug related issues by many diverse groups not all of whom would be expected to be directly involved.

The majority of drug specific initiatives in place were targeted at adults/those over 18 years of age although initiatives did cater for people from the age of 7 years (Table 1.7, Appendix 1). Anecdotal evidence would suggest that the age of first drug use is decreasing therefore it would be important that any new initiatives, particularly those which are prevention based are targeted at a younger age group with whom they can have most impact.

The small number of respondents stating that they targeted individuals with current drug/ alcohol problems reflects the preponderance of education-based initiatives and the small number of treatment and rehabilitation initiatives run by respondents (Table 1.8, Appendix 1). It could be argued that initiatives that work with families and friends of drug users have the potential to impact on the drug problem. However evidence suggests that this is not as effective as targeting the individuals themselves since it is they and only they who can make the decision to stop misusing drugs. While running initiatives aimed at families and friends is useful, they should not take the place of or outnumber initiatives targeted at individual drug users themselves.

When asked to state their selection criteria and referral process respondents did not clearly distinguish between the two. Responses were, however, analysed based on the two categories. There was a wide variety of selection criteria mentioned by respondents most of which were specified by single initiatives. By far the most commonly mentioned selection criteria was that the service was demand led (7 respondents). Three respondents each said that their selection criteria was that the individuals taking part had to be affected by issues of drug misuse, and that they had to live in the local community. It is clear from these results that the initiatives run by respondents have flexible and open selection criteria. This may be seen in either a positive or a negative light. It is positive from the point of view of providing open access to all, however such open access may result in valuable places on programmes being allocated to individuals on an ad hoc basis and not to those most in need or to those whose needs can be best catered for by the initiative in question. If initiatives are set up based on sound research which has established an area of need, and on evidence that the approach taken can meet these needs, then their selection criteria should reflect this. So, while open access is useful for some initiatives, others should be targeted at very specific areas of need and therefore should apply more stringent selection criteria.

Data on the referral process indicates that self-referral is the most common referral method (Table 1.10, Appendix 1). Only one initiative listed the Local Drugs Task Force as a referral source. This issue should be considered further but may again reflect the high number of education/training initiatives and the small number of initiatives targeted specifically at those with a current or potential drug problem themselves which might seek referrals from other sources.

Funding sources mentioned were varied with most respondents citing a number of different funding sources (Table 1.13, Appendix 1). The most frequently mentioned funding source was Government Departments with funding from the Department of Health and Children featuring highly as expected. The Local Drugs Task Force was also listed as a funding source by over half of those who responded to the survey. The fact that 10 initiatives relied on donations to fund or part fund their initiatives reflects the patchy nature of funding in the drugs

area. Resources are scarce and the wide range of funding sources named by respondents, most of whom were from the voluntary and community sector, and most of whom existed based on funds from more than one source, leads to a certain level of instability for these initiatives. Concerns about funding or the need to re-secure funding on an ongoing basis can often overshadow the day to day work carried out by initiatives which affects their ability to cater to the needs of service users in a meaningful way.

When respondents were asked to comment on the outcome of their initiative for those who take part, responses were very varied. When asked to outline the learning or outcome that had been achieved for the initiative responses were once again scattered. The largest number of respondents (13) for any response category said that the service was meaningful/valued/worthwhile. The lack of very specific details regarding outcomes for the initiative or the individual may reflect the poor level of evaluation reported by most initiatives. Services are monitored through their service plans, and evidence from this survey would suggest that projects would welcome evaluation of their effectiveness and efficiency however funding for evaluation activities is not always readily available to them.

When they were asked to state how their service was evaluated over a third said that they hoped to do an external evaluation at some time in the future indicating that this had not yet occurred. Seven respondents each said that they got feedback from service users, and that they carried out an internal evaluation. Four respondents said that they did not carry out any sort of evaluation while one said that they would love to carry out an external evaluation but did not have the funding to do so.

The role of evaluation in any initiative cannot be overstated. As already stated, when resources are scarce, it is important that they are targeted where they can do most good. It is often the case that initiatives continue to be funded on an ongoing or even a year-to-year basis as a matter of course rather than based on any evidence of their effectiveness as ascertained through an evaluative process. Evaluation is essential if the most and least effective aspects of any successful programme/initiative are to be ascertained. Ongoing evaluation, the results of which are compared to research carried out on the needs of target groups, can be used to ensure that initiatives are still relevant and that they are flexible enough to adapt to meet changing needs of service users.

At Risk Initiatives

The survey questionnaire was returned by 33 out of the 91 at risk initiatives in the survey population representing a response rate of 36%.

Most respondents in this category came from the voluntary and community sector with only 18% stating they were statutory agencies. The highest concentration of at risk initiatives was in the Dun Laoghaire area (10), followed by Bray (6), and Arklow (4) (Table 2.1, Appendix 1). The remaining spread was relatively wide and included a number of areas which are not covered by the ECRDTF.

Results indicate that there was an equal split between the initiatives that described themselves as interagency initiatives and those that did not. The VEC was the most frequently listed partner, with the ECAHB coming next followed by FAS and the Local Drugs Task Force. A number of youth related agencies were also mentioned.

Respondents were asked to outline the function and purpose of their organisation. The most commonly stated functions were education/return to education, and youth work (Table 2.2, Appendix 1). Other commonly reported functions included Child and Family intervention/ support, and counselling/ support. Again responses to the question about the purpose of the initiative most commonly related to drug education even though these were not drug specific initiatives.

When asked about the objectives of the initiative, responses were somewhat inconsistent with the above with the most frequently mentioned objective being support/counselling followed by family support/services to families. Education/training regarding drugs and drug issues and activities for young people were less frequently mentioned objectives. It may be that the types of purpose and function which were highlighted were influenced by the fact that questionnaires related to the Regional Drugs Task Force, while objectives represented the broad objectives of the service.

With regard to the pillars of the National Drugs Strategy equal numbers of initiatives said that their initiative/project related to the Prevention pillar and the Education pillar (Table 2.6, Appendix 1). Four initiatives related to the Treatment pillar, three to the Rehabilitation pillar and two to the Research pillar. Supply Reduction was not mentioned by any initiative.

Respondents were asked to indicate what age group their services were aimed at. The largest number of respondents reported that they catered to individuals of any age with other initiatives stating that they catered for those from 3 years of age upwards (Table 2.7).

When other demographic information which was provided by 27 of the 33 respondents was considered it would appear that at risk initiatives in the area are catering to a wide range of needs (Table 2.8, Appendix 1). Target groups ranged from families/ parents, people living in the area, early school leavers, and disadvantaged people, to people with an addiction problem or at risk of alcohol/ drug misuse.

When asked to describe their selection criteria and referral process most respondents did not clearly distinguish between the two. By far the most common referral method was self-referral/voluntary participation followed by referrals from voluntary and community agencies (Table 2.10, Appendix 1). The broad nature of these selection criteria and referral processes appear to reflect a general openness, however it may also be a signal that initiatives are not specifically targeted at meeting the needs of any one group and may be too general in their remit.

When asked to outline how they were funded most respondents cited a number of different funding sources. The most frequently mentioned funding sources were the Local Drugs Task Force, and a variety of HSE Areas or representatives of such (Table 2.13, Appendix 1). A third of respondents said that their funding came from the VEC and a smaller number said they were funded by a variety of different Government Departments. Once again the reliance on funding from a variety of sources to run any initiative is problematic. Each funding source has its own criteria for allocating funds and voluntary and community sector agencies relying on funding from a number of different sources are often forced to tailor their services to meet the needs of their funders rather than the needs of their clients if they are to remain in existence.

With regard to outcomes for both the individual and the initiative, a wide range of outcomes were listed. The most common response regarding outcomes for the individual was that individuals benefit from the point of view of personal development issues (including being more confident/ improved self esteem, knowing how to voice their opinion, personal development, more responsible) (Table 2.14, Appendix 1). Other individual outcomes listed included that individuals were integrated into mainstream employment/education/training, that the lives of children were improved, that individuals are more aware/ knowledgeable regarding drug issues, that they impacted on the parenting skills of participants, and that they could avail of a supported environment/ support structures.

With regard to the learning or outcome that had been achieved for their initiative, responses were once again many and varied. The largest number of respondents for any response category said that the service was meaningful/ worthwhile/ works well.

Research results regarding evaluation indicate that this is much more a feature

of at risk initiatives than it was for drug specific initiatives. Several initiatives indicated that they carried out external evaluations, and those whose evaluations were internal were much more specific regarding the type of evaluative process they implemented. This is very encouraging and is a practice which should be encouraged and supported. Adequate funding should be ear marked for evaluation when resources are being allocated by the Regional Drugs Task Force.

General Initiatives

The scoping questionnaire which was sent to general initiatives asked two main questions. A total of 38 general initiatives out of the 115 surveyed returned the questionnaire representing a response rate of 33%.

The geographical spread of the initiatives that responded to the survey was wide, stretching from Carlow to Capel Street (Dublin 1) (Table 3.1, Appendix 1). By far the highest concentration of respondents was in the Bray area, followed by Arklow, Wicklow Town, and Dun Laoghaire.

When asked to state their function, most respondents in this category cited a number of different functions (Table 3.2, Appendix 1). Once again the most commonly mentioned function was training/ education followed by information/ advice, and services to the community. The range of services provided by general initiatives reflects the number of services at work in local communities.

Conclusions

The lack of treatment and rehabilitation services in the area is of grave concern particularly outside the LDTF areas. Without these services the efforts of those who attempt to educate and encourage people to cease their drug misuse will be ineffective. There is a clear need for locally based treatment and rehabilitation services which are targeted at specific groups in the community.

There is a significant amount of research undertaken in the drugs field on a national basis by the NACD. The results of this survey highlight the lack of research in the drugs field in the local area. The lack of a co-ordinated approach to research by locally based services needs to be reviewed to identify the changing needs within the RDTF area. A co-ordinated research strategy needs to be developed and implemented. Research and evaluation activities in accordance with this strategy must be included in all projects approved for funding by the RDTF.

The broad nature of most of the initiatives that responded to the survey is an issue which would merit further consideration. Responses which target specific

needs and run according to clear aims and objectives are required if the drug problem in the area is to be addressed. Services must be tailored to the needs of service users if meaningful change is to occur.

The practice of evaluating existing services is not implemented in any coherent way, particularly in relation to drug specific issues. This needs to be remedied if the ECRDTF is to ensure that services are being provided in line with their stated objectives and resources are being employed effectively and efficiently. It must be noted that projects that responded to this survey are fully supportive of and would welcome the opportunity to engage in evaluation activities, however the funding for these activities is not always readily available to them.

The above factors should be taken into account by the ECRDTF in making decisions regarding resource allocation to ensure that the Task Force operates in the most effective manner possible and the issue of evidence based practice should be a primary consideration when potential projects are being evaluated.

Section 3

Extent to Which Current Service Provision Meets Identified Need

Section 3: The Headlines

- **The Task Force engages in extensive consultation process to identify to what extent current provision meets identified need, in other words where are the ”gaps” in service provision?**

- **People using addiction services, service providers, parents, members of the Travelling Community, Task Force members and interested members of local communities discuss their perceptions of the current problem, the “gaps” in services and say what they think is needed**

- **The Task Force acknowledges that this exercise invites a range of opinions that may not reflect current “best practice”. However Task Force members consider this feedback an essential tool in making informed decisions about the gaps in service provision**

- **A consensus view emerges that there is no problem accessing a range of drugs, that people commute to Dublin to buy drugs and dealers commute into local areas to deal**

- **A commonly held view is that prescription drug misuse is a growing problem and that Cocaine and Heroin use are on the increase, particularly in South County Wicklow**

- **A number of respondents said that there is a need for a range of locally based treatment and rehabilitation services**

- **A continuum of rehabilitation and support services were identified as being needed, including residential, non – residential, outreach, drop-in plus pre-vocational and vocational training and progression routes**

- **Many of those responding believed there is a need for more drug education and diversionary activities, particularly for young people**

- **Task Force members believe there is a need for a more co-ordinated drug education and prevention strategy across the region**

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 (Section 1)
Research on existing service provision within the Region (Section 2)
Extensive stakeholder consultation
Identifying gaps in current service provision

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 different stakeholders in different ways to ensure that as broad a spectrum of views as possible was captured. The stakeholders consulted were:

People currently using addiction services in the region
Parents/ concerned others
Service providers (voluntary and community based)
Members of the Travelling Community
Members of the general public
Members of the Regional Drugs Task Force

Consultation Process

People Currently Using Addiction Services in the Region

A questionnaire was drawn up to ascertain the views of people currently using addiction services in the Region. This questionnaire was administered to service users. Staff in two clinics used the questionnaires in face-to-face interviews with service users who volunteered to take part with no incentive provided to encourage participation. Every effort was made to record responses verbatim onto questionnaires. Results were analysed using the SPSS statistical package.

Parents/ Concerned Others

A questionnaire was drawn up for use in individual interviews with parents/ concerned others to ascertain their views. A list of parents/ concerned others from the Arklow area who were willing to attend face-to-face interviews to provide their views was compiled by the Arklow Community Addiction Team. Teams of two interviewers conducted face-to-face interviews with the 10 individuals/couples on this list. Interviews lasted approximately 1 hour and no incentive was offered to those who took part. Responses were recorded on the questionnaire. Interviews were content analysed to extract common themes.

Voluntary/ Community Based Service Providers
A focus group template was drawn up for use with voluntary/community based service providers to ascertain their views. The Regional Drugs Task Force assembled a group of service providers from across the region, willing to take part in a focus group in the Wicklow area. A team of two facilitators ran a focus group with these individuals that was of approximately two hours duration. No incentive was offered to those who took part. Responses were recorded on the focus group template. The responses recorded were content analysed to extract themes.

Members of the Travelling Community
A focus group template was drawn up for use with members of the Travelling Community to ascertain their views. The CEART Traveller Centre assembled a group of Traveller women willing to take part in a focus group in the Wicklow area. A team of two facilitators ran a focus group with these individuals that was of approximately two hours duration. No incentive was offered to those who took part. Responses were recorded on the focus group template. The responses recorded were content analysed to extract themes.

Members of the General Public
ECRDTF placed several advertisements in local newspapers inviting individuals and groups to express their views on drugs issues within the region and received 17 views and comments on current drug issues within the region.
Two half-day clinics (one in Arklow and one in Wicklow) were held to ascertain the views of the general public on current needs. These clinics were advertised locally and in the press stating that all were welcome to speak to a member of the Regional Drugs Task Force about their views on needs in relation to the current drug problem in the area. 3 individuals attended the clinic in Arklow while 1 attended the Wicklow clinic. Responses were recorded by the Task Force member present. The responses recorded were content analysed to extract themes.

Members of the Regional Drugs Task Force
The questionnaires drawn up for use with the focus group sessions described above were provided to the sub-committees of the Regional Drugs Task Force that are representative of the 4 pillars of the National Drugs Strategy. Responses to these questions were elicited by the chairperson of each sub-committee at a sub-committee meeting. These responses were recorded and are reported below. Responses were returned from the Education/ Prevention and Treatment/Rehabilitation sub-committees. Returned questionnaires were content analysed to extract themes.

The findings of the consultation process are outlined in summary form below and a full account is provided in Appendix 2.

Consultation Findings

This section presents the findings from a wide-ranging consultation process and represents a summary of the major themes emerging from that process. The Task Force were cognisant of the need to hear the voice of the local community. However it should be noted that the opinions expressed by various stakeholders represent their *views* and do not necessarily represent current thinking regarding best practice. However the continuum of opinion provided the Task force with invaluable feedback regarding the perception of a number of stakeholders in local communities that the Task Force represent.

Findings are presented as below:
General Comments
Perception of current drug problem
Perception of need presented under each of the NDS "pillars"

Each heading contains summaries of the viewpoints of various stakeholders.

General Comments
General comments made by a number of service users recounted the perception that people will use drugs if they want to and that there is nothing that can be done to stop them.

There was a perception by parents/concerned others that all the help they received was self-initiated and that they did not know where to go for help. They highlighted difficulties in getting information and services.

The view that what's needed is "joined up thinking" between the services was expressed. The need for holistic responses backed up by a co-ordinated and wholly integrated system was highlighted.

The location of addiction centres was raised by parents/concerned others with suggestions that these services be moved elsewhere perhaps to a resource centre in the local community or health centre where you go for all health related problems.

There was a view that Travellers are not inclined to access services because of the stigma associated with them and that what is required is a holistic approach for Travellers that involves education, employment and anti-discrimination activities.

Service providers highlighted the necessity of monitoring and evaluating any service that is provided.

There was a perception that there is a major gap in the services for those under 16 and a recommendation that services are targeted at those aged 8 – 9 years

Perception of Current Drug Problem

Some Drugs Task Force members perceived there to be an increase in the spread of drug problems in the region due to the lack of treatment facilities available.

There was a generally held perception that there is no problem accessing drugs across the whole area and people also commute to Dublin to buy drugs. It was felt that dealers were travelling to local areas from Dublin to deal alongside local people.

There was a commonly held perception that prescription drug use is a current and growing problem in the Region. Heroin and cocaine use were perceived to have increased in Wicklow (County and Town). It was felt that members of the Travelling Community are now dabbling in drugs at a younger age (approximately 12 – 13 years)

Drug Task Force members felt that the death of young people using drugs was an issue along with the potential for the spread of viral diseases (such as Hepatitis and HIV).

Drug Task Force members referred to particular social problems, which they believe, are linked to the drug problem in the region such as unemployability, homeless, an increase in crime, the stigmatisation of families, and debt within families. The retention of children in the school system and early school leaving were also mentioned in this context along with a lack of facilities for young people.

Perception of Need

General issues raised by Regional Drugs Task Force members were the need to build stronger links between organisations currently providing services within the area. Ongoing work of the ECRDTF and particularly the subcommittees will ensure that there is an awareness of best practice and will enable and encourage development of consistent policy standards within the region.

Task Force members felt that there was a need to actively encourage the ongoing development of drugs policies within schools, clubs, youth organisations and businesses.

Education/ Prevention

Drugs Task Force members said that there should be consistent drugs education policy standards and that there is a need for a co-ordinated drug education and prevention response across the region.

The Drugs Education/Prevention response should be concerned with building networks with current providers and ensuring drugs education is provided in areas where there is no current service. Task Force members who expressed this view felt that this could be achieved through a designated post for the ECRDTF, possibly attached to a Community Addiction Team.

Education for Young People

The majority of those who responded to the survey believe that there is a need for more drugs education, particularly in schools. Those who attended focus groups echoed this view and felt that prevention programmes should start in National Schools and should target young teenagers and early pre-teens. Drugs education should be a critical element across the curriculum and not just addressed in Social, Personal and Health Education. As such it should be compulsory involving both young people and their parents. According to Task Force member's additional support to schools in relation to addiction is required and could be provided by brief intervention/ student guidance on addiction issues, and increasing the ongoing training of teachers in the SPHE programme. The importance of providing continued support for the full implementation of the SPHE programme within the region was highlighted by Task Force members and it was recommended that the SPHE forms part of the core curriculum for student teachers and that all youth workers and those currently working with early school leavers be trained in the SPHE Programme. They also advocated providing continued support for the ongoing teaching of Walk Tall and On My Own Two Feet within schools in the region, along with the ongoing enhancement and expansion of the Schools Completion Programme.

Most of the service users who advocated school based education programmes said that it should be as graphic as possible and that this type of education should be delivered by addicts or recovering addicts. Others felt that this could

be achieved through visits to places like Trinity Court or through spending time with addicts. Some suggested information leaflets which are realistic and vivid and TV advertisements.

Education for Parents
Members of the Travelling Community felt that family support and education from counsellors so that parents know how to deal with family members who are addicted is essential.

Service providers felt that there should be a course for parents that tell them how to live with an addicted person and Drug Task Force members advocated the development of parent education programmes.

Information
Many of the service users surveyed said that there should be more information on health related issues such as Hepatitis, HIV, Aids, and Sexually Transmitted Infections. A small majority said there was a need for Information on methadone and its effects.

Other respondents felt that information on services should be freely available to everyone from a variety of different sources. The Traveller women focus group felt that 'Traveller men need to be specifically targeted regarding information and peer support to get them involved with services'.

Some Task Force members saw an up-to-date network of information on existing services within the region, which is fully accessible to members of the public and community, voluntary, and statutory service providers as essential.

Diversionary Activities
A large number of those whose views were sought said that there should be more activities available for young people in the area. The activities mentioned included youth clubs/centres, sport, social activities, and activity of any sort. This was felt to be necessary as a preventative measure as "boredom plays a large part" in drug misuse.

For those who leave school early Task Force members recommended the establishment and support of Early School Leavers Programmes in areas throughout the ECRDTF region. It was also recommended that the lack of youth and community facilities run by qualified staff outside of the two Local Drugs Task Force Areas be addressed and that training for youth workers in addiction issues should be fully supported.

Training
A large number of those who responded to the survey advocated the provision of training for those who were attempting to deal with their addiction. Training mentioned included back to work skills, vocational skills, parenting, budgeting,

coping skills, social skills, how to spend your leisure time, and “anything to occupy an addicts time”.

Support

A school support referral system to provide psychosocial measures as appropriate was seen as necessary to fill the current gaps in service provision by Task Force members.

Treatment/ Rehabilitation

Some general comments that were made by service users included a need for clinics to be friendlier and for services to be more accessible. It was also felt that existing services in general should be expanded and developed and a pro-active approach taken. A more rapid pro-active response to definitively assess, recommend and refer an individual, if appropriate, was considered necessary.

Support Groups

In terms of treatment and rehabilitation, many of those whose views were sought said that more support groups were needed. Narcotics Anonymous was mentioned specifically by a small number of individuals. A range of stakeholders also believed that support groups for parents would be useful. Drug Task Force members advocated the expansion of family and child support services and the establishment of similar services in areas that do not currently have them to ensure that they can take referrals from clients with addiction problems and their families.

Counselling

A large number of those who gave their views said that there was a need for more counselling to be made available. If was felt by some that this should take place more frequently than once a week. One to one counselling was specifically mentioned rather than group therapy/counselling.

Locally Based Services

A small number of the service users surveyed said that a drug clinic in their local area was needed. Service providers echoed this view and said that there was a need for a rehabilitation centre for people in their own area.

Drug Task Force members also supported the need for a comprehensive range of locally accessible treatment services including harm reduction services such as needle exchange, outreach work, and health promotion.

Detox/ Methadone

Service users felt that there was a need for more detox units and that these should not have long waiting lists. Locally based methadone, subutex and needle exchange services, which are well policed were the most common suggestions made by parents/concerned others and service providers.

Residential Treatment

Residential treatment was considered a need by a number of those who were consulted along with something to keep the individual going while they were waiting to get in to this treatment.

Outreach/Drop in/Aftercare

Accessible outreach was considered necessary by service users along with late night drop in and aftercare services. The need for outreach staff to work in pairs for ethical and safety reasons was suggested. Travellers felt that services

should operate on an outreach basis to meet the needs of members of their community and highlighted the need for them to be run by people who understand their culture.

Rehab

Service users expressed the view that more beds should be made available in rehabilitation units and that more services should be provided for people after they finish Rehab. The main area of need highlighted by Drugs Task Force members was locally accessible non-residential rehabilitation services which could provide and support progression routes for people at all stages of drug use.

A number of parents/concerned others and service providers suggested having something the addict could attend during the day, for example training for work or sheltered employment.

Supply Reduction
Parents/concerned others recommended that the Gardai take a harder line and treat drug misusers more harshly. A pro-active response by the Gardai regarding dealing was considered necessary along with a harder line from judges. There were suggestions to limit access to specific places where it is known that drugs are used. There was a call for stricter monitoring of the prescribing and handing out of medication by GP's.

Research
No comments were made by service users, any of the individuals who took part in the interviews or focus groups.

Identifying Gaps

Process
The results of the consultation process were fed back to the Regional Drugs Task Force and discussed at sub-committee level. During this process Task Force members analysed the following:
Results of research carried out on the extent and nature of the drug problem in the region (Section 1)
The profile of existing service provision compiled from the results of an analysis of the scoping document (Section 2)
The perception of 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 across the region and these are presented below under the "pillars" of the NDS.

Education and Prevention:

- A lack of accessible psycho-social support services to schools, youthreach, etc for children and young people at risk.
- A shortage of accredited qualified counsellors to undertake work with Under 18s
- The need to ensure that SPHE is part of the core curriculum for student teachers and the subsequent release of teachers to undergo in-service training in SPHE.
- Limited availability of Schools Completion Programme
- A lack of fully developed Drugs Policies within schools, clubs, youth organisations and businesses.
- A lack of awareness of drugs and drug issues throughout the ECRDTF region with a corresponding lack of parent/adult education programmes.
- No up-to-date network of information on existing services within the region, which is fully accessible to members of the public and community, voluntary and statutory service providers.
- Limited accessible information on drugs and drugs issues particularly in relation to minority groups.
- Outside of Local Drugs Task Force Areas a lack of youth and community facilities run by qualified staff.
- Lack of awareness of training opportunities in addiction issues that is available to youth workers and others working with people at risk
- Lack of Early School Leavers Programmes in areas throughout the ECRDTF region.
- Unification of quality standards in the voluntary, community and statutory sector within drugs education/prevention.
- Limited monitoring and evaluation of prevention and education programmes.

Treatment and Rehabilitation:

- The lack of Addiction Treatment services south of the two LDTF areas
- No recent review and needs analysis of detox facilities and review of alternatives to present models.

- No Community Based Rehabilitation, support and re-integration services in the Regional Drugs Task Force area to provide a continuum of care, encompassing the distinct needs of the adult population and adolescent population.
- Limited child and family support services in some parts of the region with other areas not covered.
- Limited availability of accredited drugs counsellors and subsequent lack of service within the area.
- Lack of clarity regarding progression routes from reducing methadone to attending rehabilitation (e.g. for individuals who would previously not be known to the HSE East Coast Area)
- Limited transport options to enable clients to access services
- Lack of appropriate child care provision to enable parents with children to access a range of services.
- Limited mobile needle exchange service and no centre based needle exchange service outside of the LDTF areas
- Lack of a properly supervised urinalysis service established for Probation and Welfare. (Dept of Justice and Law Reform)
- No recent review of alternatives to Methadone, the prescribing of diamorphine and other prescribed drugs.
- Reviewing and implementing harm reduction measures within the area.
- Lack of service users network for the Task Force region.
- No recent review of the needs of carers within the ECRDTF area who are looking after children of drug users, (i.e. grandparents, etc.)
- Limited monitoring and evaluation of services.

Supply and Control:

- Community Drugs Projects cannot access financial resources from assets confiscated by the Criminals Assets Bureau in relation to drugs.
- Limited Drugs Court (pilot project)
- In south County Wicklow, no current community policing fora exists.
- Extremely limited prosecution of licensed and off-licensed premises when charged with providing alcohol to those under 18 years of age.

- Extremely limited prosecution of any adult supplying or buying alcohol for any person under 18 years.

- No harm reduction measures implemented within the criminal justice system.

Research:
The ECRDTF believe that the need for more localised research is a priority, e.g. establishing a database system to collate information from local services on extent of drug misuse.

Section 4

Measures Necessary to Address Gaps in Service Provision

Section 4: The Headlines

- **Task Force engages in a series of meetings to synthesise work to date into a list of interventions that will contribute to addressing the "gaps" in service provision**

- **Task Force prioritise the list and organise priorities under each pillar of the National Drug Strategy**

- **Task Force engage in further reflection and debate regarding their role and subsequently make a distinction between priorities that they may support or recommend (but which are outside of their scope) and priorities that they choose to propose an action in order to provide a complimentary and cross regional response.**

- **Task Force recognise that a number of important issues remain outstanding and list these for future attention if resources are made available**

Introduction

In the process of identifying gaps in service provision, the Task Force developed an extensive list of areas that needed to be addressed (see Section 3).
A series of discussions and debates took place at Task Force and Subcommittee level. Based on the knowledge and expertise of Task Force members and taking cognisance of the work being carried out by the Local Drugs Task Forces in the area, the original list was sub-divided into two categories:

Measures which are necessary to fill the gaps identified
Areas for future work

The priorities of the Task Force in each of the two areas are outlined below.

Measures Necessary to Fill the Gaps in Service Provision

The following list of measures considered necessary to fill the gaps in service provision was compiled by the Task Force based on their consideration of the extent to which current service provision meets identified need and the identified gaps in service provision.

The list is presented under the “pillars” of the NDS and in two sections, those measures that require action and those measures supported and recommended by the Task Force.

The list pertains to issues which are considered priority areas for the Task Force and which they consider require immediate action if they are to fulfil their function.

Prevention and Education: Actions to be Taken

- Develop accessible psycho-social support services to schools, Youthreach, etc for children and young people at risk. (NDS Action(s) 31, 60)
- Address the shortage of accredited qualified counsellors to undertake work with Under 18s (NDS Action(s) 44,49, 59, 60) (Strategic Task Force on Alcohol (STFA) R7.5)
- Raise awareness of drugs and drug issues throughout the ECRDTF region, through supporting local drugs awareness groups and providing drugs education/training in areas where there is currently no service. (NDS Action(s) 35, 38, 42, 95, 96)
- Develop parent/adult education programmes within the region (NDS Action(s) 35)
- Encourage training for youth workers, etc in addiction issues (NDS Action(s) 72)
- Actively encourage the development of Alcohol and Drugs Policies within schools, clubs, youth organisations and businesses. (NDS Action(s) 43) (STFA R4.7, R4.9)
- Provide an up-to-date network of information on existing services within the region that is fully accessible to members of the public and community, voluntary and statutory service providers. (NDS Action(s) 52, 92(2)) (STFA R7.9)
- Ensure that access to information on drugs and drugs issues are accessible to all, including minority and ethnic groups, as far as practicable. (NDS Action(s) 35, 38, 46, 52)
- Develop quality standards in the voluntary, community and statutory sector within drugs education/prevention. (NDS Action(s) 95)

Treatment and Rehabilitation: Actions to be Taken

- Carry out a review of detox facilities available to ECRDTF clients and alternatives to present models. (NDS Action(s) 48, 55,57)
- Develop a range of appropriate Community Based Rehabilitation, support and re-integration services in the Regional Drugs Task Force area so as to provide a continuum of care, encompassing the distinct needs of the adult and adolescent populations. Including support for access to progression options such as education, training and employment. (NDS Action(s) 47, 48, 54, 74, 75)
- Clarify the progression route from reducing methadone to attending rehabilitation (e.g. for individuals who would previously not be known to the HSE East Coast) (NDS Action(s) 46)

- Review and provide creative ways of making services accessible in the rural/urban divide (i.e. transport options)
- Family Support – to carry out a needs analysis in areas not receiving this service and provide service/recommendations as far as practicable. (NDS Action(s) 49/54/60) (STFA R4.1-R4.4)
- Review alternatives to Methadone, the prescribing of diamorphine and other prescribed drugs. (NDS Action(s) 48, 55, 99)
- Ensure that all services are fully accessible to parents with children, providing childcare/parental skills, both residential/non-residential. (NDS Action(s) 54)
- Develop, implement and support counselling services within the area. (NDS Action(s) 44/48/49/59)
- Review and implement harm reduction measures within the area. (NDS Action(s) 62, 64, 69)
- Develop a Code of Professional conduct to ensure Client centred good practice
- Carry out proper monitoring and evaluation of services.
- Develop quality standards in service provision within Treatment and Rehabilitation projects.

Supply and Control: Actions to be Taken

- The establishment of a community policing fora within the Arklow area on a pilot basis this would help to develop community and Gardai relations in the fight against drugs supply and control. This forum would link with the Customs Drugswatch Programme. (NDS Action(s) 5, 11, 15)

Research: Actions to be Taken

Please see Section “Areas for future Work”

Prevention and Education: Support and Recommend

- Support the continued implementation of SPHE in all national and post primary schools and recommend ongoing training for Teachers to teach the programme. (NDS Action(s) 31/33) (STFA R6.1, R6.2)
- Recommend that the SPHE is part of the core curriculum for student teachers (NDS Action(s) 31)
- Encourage the establishment and support of Early School Leavers Programmes in areas throughout the ECRDTF region, prioritising areas of need. (NDS Action(s) 37)
- Address the lack of youth and community facilities run by qualified staff outside of the two Local Drugs Task Force Areas (NDS Action(s) 3) (STFA R3.15, R3.19, R3.20)
- Continue the ongoing extension and enhancement of the Schools Completion Programme (NDS Action(s) 36)

Treatment and Rehabilitation: Support and Recommend

- Recommend the establishment of an Addiction Treatment Centre/Satellite Clinic in the towns of Arklow, Wicklow, Rathdrum and the Tinahely/Carnew area. (NDS Action(s) 44, 45, 48)
- Expand existing child and family support services to ensure that they have the capacity to accept all referrals of clients using rehabilitation/addiction treatment services. (NDS Action(s) 49, 54, 60) (STFA R4.1-R4.4, R6.4, R6.5)
- Provide Harm Reduction Services, such as an enhanced mobile needle exchange service and additional centre based needle exchange services. (NDS Action(s) 62, 64)
- Develop a system whereby recommendations by the court can be implemented in the community with the proper resources (e.g. to ensure urine analysis is used most effectively) (NDS Action(s) 6)
- Recommend that a properly supervised urinalysis service be established for Probation and Welfare. (Dept of Justice and Law Reform) (NDS Action(s) 6)
- To recommend a review and needs analysis of detox facilities and the increasing of facilities as indicated.

Supply and Control: Support and Recommend:

- Recommending that assets confiscated by the Criminals Assets Bureau in regard to drugs be given to community projects dealing with addiction issues.
- Recommending that the Drugs Court (pilot project) be expanded to include areas outside of Dublin. (NDS Action(s) 20)
- The encouragement and support of the prosecution of licensed and off-licensed premises when charged with providing alcohol to those under 18 years of age. (STFA R1.5)
- The encouragement and support of the prosecution of any adult supplying or buying alcohol for any person under 18 years. (STFA R1.5, R1.6)
- Recommending that harm reduction measures be implemented within the criminal justice system. (NDS Action(s) 22)

Areas for Future Work

Due to its large geographical area, the Task Force has identified priority issues for the region at present (outlined above).
It is acknowledged that further investigation and review is also considered to be necessary in a number of areas as listed below. Notwithstanding the aforementioned comment resources will inevitably limit progress and Task Force progression in these areas will reflect the level of resource allocation.

- Dual Diagnosis – Addiction & Mental Health
- Prevention/youth diversion programmes within the area;
- Responding to Accident and Emergency (i.e. what can be done to assist Accident and Emergency Services)
- Housing issues – Homeless, half-way house, etc.
- Development and Implementation of a co-ordinated information system on drug misuse from local services – Probation and Welfare, HSE East Coast, Gardai, community/voluntary services, etc.
- Community Representatives Support Network for towns and rural areas – to build a system whereby the Community Representatives of the Task Force can feed back into local communities and receive information from them in

return. Providing a support mechanism alongside this for the Community Representatives on the Task Force and allowing a future way of nominating community representatives to the Task Force.

- Community Policing Forum – carry out a review of the outcome from the existing pilot project and develop recommendations from its findings. The Task Force feel that the building of relations between community and policing are essential in terms of supply and control issues.

- Service Users Network – to establish and develop a service users network for the Task Force region.

- To review the needs of carers looking after children of drug users, (i.e. grandparents, etc.)

- Research and establish a local data base system to collate data from local service providers on extent of drug misuse

- To review the needs of young mothers (and pregnant women) in relation to addiction issues

This is by no means an exhaustive list but it does contain some of the areas which the Task Force believe need consideration and investigation at a future date. The Task Force is committed within reason to a flexible response to issues that may emerge.

Section 5

Developing and Prioritising Specific Proposals

Section 5: The Headlines

- **The Task Force placed several advertisements in local Newspapers inviting views and submissions**
- **27 specific proposals are received, 18 under the Education/Prevention pillar and 9 under the Treatment and Rehabilitation pillar**
- **Each submission is allocated to a Subcommittee for consideration**
- **Task Force members apply agreed selection criteria**
- **Task Force supports a total of 11 specific proposals, 6 under Treatment and Rehabilitation and 5 under Prevention/Education**
- **Treatment and Rehabilitation support the direct provision of a continuum of care service encompassing the distinct needs of the adult and adolescent populations, including support for access to progression options such as education, training and employment**
- **Prevention and Education Subcommittee support a strategic, co-ordinating role in relation to current provision while also identifying areas where they can play a complimentary role**
- **Task Force respond to Two specific proposals by making recommendations in relation to Young Persons Services and Facilities Fund.**
- **Task Force receive 3 proposals with a National scope. Recommendations are made for funding direct from the National Drugs Strategy Team (NDST)**

Introduction:

This section of the plan is concerned with how the Task Force selected and prioritised specific proposals and what proposals subsequently emerged from that process.
This Section also includes costings to support the Task Force in 2005.

The Selection Process
The necessity for community consultation was a priority for the Task Force from the outset of the planning process. However they were also acutely aware of time scales in terms of final submission. With this in mind the Task Force engaged in a parallel process of working on the early sections of the report and at the same time inviting views and submissions from individuals and groups that would inform later sections, including the selection of specific proposals.
The Task Force placed several newspaper advertisements as follows:

Southside People:

Full Page Ad (1st September)
Half page Ad (8th September)

Wicklow People (covers South Wicklow)

Full page Ad (2nd September)
Half Page Ad (9th September)

Wicklow Times

Full page Ad (7th September)
Half page Ad (21st September)

The advertisements served a dual purpose. Firstly to invite views and opinions regarding perception of need, which were included as a strand of the consultation process and informed Section 3.
Secondly to invite individuals and/or groups to make specific submissions to the Task Force.

In addition to the newspaper advertisements, letters of invitation were also sent to GP's, services identified through the Scoping Document from outside of LDTF areas, local Accident and Emergency Consultants and Consultant Psychiatrists within the Task Force geographical area.

The Task Force received **27** specific project proposals in total, **18** under the Education/Prevention pillar, and **9** under the Treatment and Rehabilitation pillar.

Each proposal/submission was allocated to a Task Force subcommittee for detailed consideration. The subcommittee then applied agreed Task Force selection criteria to each proposal.

The selection criteria were:

- The extent to which the project reflects Task Force priorities and at the same time is currently not delivered or is under – delivered

- The need to avoid duplication of effort and resource and to remain aware of the role of the RDTF as indicated by the NDST. For example, Task Force members decided not to fund projects that fell within the geographical area of the 2 Local Drug Task Forces (Bray and Dun Laoghaire)

- The appropriateness of the proposal bearing in mind that responsibility still rests with statutory agencies to deliver programmes and services within their own area.

- The level of detail and clarity of thought contained in the proposal. Proposals needed to be, as far as reasonably practicable, costed and clear in terms of inputs, outputs, outcomes and impact

- The geographical location of the base and service delivery of a project. Projects needed to be based in and provide services in the ECRDTF area in line with the Task Force priorities

- The extent to which the proposal related to Actions under the NDS

Treatment and Rehabilitation Subcommittee:

The Treatment and Rehabilitation Subcommittee comprises a wide range of professionals in the health care sector, Probation and Welfare, Bray Partnership Local Employment Service Network and other professional services dealing with progression issues. A full list of members can be found in Appendix 3.

This Subcommittee were acutely aware of the fact that there is little or no addiction treatment or rehabilitation services outside of Northern Bray and Dun Laoghaire Rathdown (both LDTF areas) and the majority of services in existence are in South Dublin. One member commented:

" …the phrase lack of services means services do not exist, services have not been set up, as opposed to services that are probably lacking in quality or effectiveness"

In referring back to section 1 the lack of services has to be set against the fact that lifetime prevalence rates for illicit drug use in the ECRDTF area are consistently above National rates. More targeted reports from professionals working in specific areas show a high concentration of Heroin users in Arklow plus report of a high concentration of Probation and Welfare clients using other illicit drugs in South County Wicklow. Addiction services further confirmed a significant number of opiate users, particularly in the Arklow area.
Lack of services extends into support services and the Task Force Treatment and Rehabilitation Subcommittee highlighted the fact that south of Bray and Dun Laoghaire (LDTF areas) there is one addiction team with a part-time co-ordinator, one full time worker and an administrator.

The subcommittee based their identification of need on their collective wealth of experience, shared, refined and clarified over a period of months. Research and the previously described consultation process further informed them. This process led to a decision being reached and the over-arching priority of the Treatment and Rehabilitation Subcommittee being summarised as:

Outside of the Local Drugs Task Force areas, the Regional Drugs Task Force area has no locally – accessible, addiction treatment, rehabilitation and support services. The Subcommittee supports the immediate implementation of a range of locally-accessible comprehensive treatment, rehabilitation and support services"

The Subcommittee reviewed the proposals they received and decided that none of the proposals addressed the full continuum of service that is required, With this in mind Task Force members developed a proposal using their professional and practical experience of the nature and extent of the problem, supplemented by the earlier consultation process and informed by the network of other professionals operating on a daily basis in the ECRDTF area.

The proposals ultimately developed and / or selected by the Treatment and Rehabilitation Subcommittee and endorsed by the full ECRDF are presented overleaf.

Table 4.1 Provides a summary overview of the proposals and each proposal is then further developed.

Table 4.1 Summary of Treatment and Rehabilitation Proposals

Treatment & Rehabilitation – Listed by Priority			
1	Rehabilitation	County Wicklow Community Addiction Team – Arklow/Wicklow	€ 901,557
2	Treatment/ Rehabilitation	Drop in Crèche/Transport	€ 195,410
3	Treatment/ Rehabilitation	Counselling Services – Total Wicklow Child & Family Project Living Life Centre Budget 2 days per wk Counselling – Under 18s – ISPCC	€ 194,737
4	Rehabilitation	County Wicklow Rehabilitation Project	€ 614,172
5	Treatment/ Rehabilitation	Education/Employment access fund	€ 10,000
6	Rehabilitation	Wicklow Trade Union Centre for the Unemployed	€ 22,672

Treatment and Rehabilitation: The Proposals

Proposal 1

Title: **County Wicklow Community Addiction Team (Arklow/Wicklow)**

Aim: To work with local drug users and their families using a community development approach to provide quality professional services that ideally lead towards a drug free lifestyle. At the same time creating an environment of acceptance and respect for those who are unable to achieve a drug free lifestyle. To work with the community to raise drug awareness issues and network with existing services i.e. mental health, prisons services to provide support on addiction issues.

Target Group:

1. Services for Drug Users
2. Services for Families of Drug Users
3. Services for the Community

Proposal: The proposal is to extend the existing Arklow Community Addiction Team and establish a second CAT for the Wicklow region with one Management Committee.

Please see attached staffing structures.

Arklow Arklow CAT to cover Arklow Town, Avoca, Carnew, Tinahely, Shillelagh and Knockananna.

Arklow has a very serious addiction problem relative to its size and rural location. As a support to the proposed HSE East Coast Area Addiction Treatment Centre, The ECRDTF propose to extend the current Community Addiction Team to provide structured activities and programmes for drug users and their families. This service will link with services currently being run within Arklow Town and its environs. These services are Arklow Springboard (Family Support), Arklow Youthreach, Arklow Jobs Club, the proposed Carnew Early School Leavers Programme, along with statutory run services, Housing, Probation and Welfare, HSE East Coast Area and Gardai, VEC (VTOS, adult education)

Where possible the expanded service will interlink with current service provision and provide a unified service to the client, family and community.

Wicklow

Wicklow CAT to cover Wicklow Town, Brittas Bay, Barrandarrig, Redcross, Rathdrum, Newcastle, Glenealy, Ashford, Rathnew, Roundwood, Newtownmountkennedy, Kilcoole, Greystones and Enniskerry.

As part of the Task Forces submission process, concern was expressed by the Focus Group who work with At Risk Groups that there was no Community Addiction Team covering the vicinity of Wicklow Town and its environs. This was identified as a need not only by this focus group but also by the Task Force Subcommittee on Treatment and Rehabilitation.

During the submission process, the Task Force also received 4 submissions, expressing the concern at the increase of drug misuse and its effects on the family in the Rathdrum area. Unfortunately, there is no identified service providing Family Support Services within this area

Another area identified by the Subcommittee on Treatment & Rehabilitation is the Carnew/Tinahely area and the lack of an identified service providing family support services within this region. During the submission process, one submission included an indication of 70 early school leavers within the Carnew area (Figs. From Carnew Enterprise Centre). In order to address gaps in service provision it was proposed that the Wicklow and Arklow Community Addiction Teams would incorporate areas (smaller towns/villages) within the region and provide services as appropriate.

Objectives:

1. Develop services for Drug Users.
2. Develop services for families of drug misusers and network with existing Family Support Services.
3. Referral/Support structure for young people
4. Provision of co-ordinated education and prevention programmes for adults and parents throughout the region.

Develop services for Drug Users:

- Engage individuals in support services and address harm reduction and possible treatment issues.
- One to one support services
- Referral services to clients and networking with existing services

- Drop in – café style facility
- Health Promotion (networking with HSE East Coast)
- Day services (HSE East Coast)
- Prison Liaison
- Where relevant young persons (school liaison)
- To encourage the establishment of local based medical treatment for service users in areas reviewed as having a need.
- To maintain links with medical treatment services once established.
- To provide access to counselling for service users (through HSE East Coast Area, Living Life Centre/Wicklow Child and Family Project, ISPCC)
- Programmes for Service Users – understanding of their addiction, harm reduction, parenting skills, peer groups, etc.

Develop Services for Families:

The Wicklow Child and Family Project and Arklow Springboard Project currently provide Family Support Services within Wicklow Town and Arklow Town. The proposed projects will link with existing services and in addition provide the following:

- Outreach Family Support in areas where there is currently no Family Support Services – Rathdrum, Carnew / Tinahely area.
- Provide drop in services for families of drug users.
- Family Support Programme in conjunction with Arklow Springboard/Wicklow Child and Family Project)
- To provide a support system for families in conjunction with current services and especially in areas where no family support services are present.
- Sibling/concerned others Projects – to cater for siblings, parents and children of drug users.

Develop Services for the Community:

- Education: The employment of a specific drugs education worker who will review education programmes and buy in the service as required.

- Community Awareness – to build links with the current Local Drugs Awareness Groups and work towards raising awareness throughout the county.
- Young Persons Referrals – to support pupils, schools and Gardai in regard to drugs and drugs issues – providing brief intervention/guidance (psychosocial supports) and/or referral to main stream services of young people who come to the attention of the school or Gardai in relation to addiction issues.
- Ensure the community has up-to-date information on drugs and drug issues.
- Ensure a directory of service provision is maintained and kept up-to-date within the area in relation to relevant support services for addiction.
- Prison services – to provide support and link with clients who are entering or leaving the prison service ensuring continuation of care and other social issues.

Resources Requested:

Negotiation with the HSE (Health Services Executive) to continue to fund the 3 existing staff.
Premises – Arklow - negotiations to be undertaken with HSE East Coast Area regarding current premises.
Wicklow – premises to be identified.
Staffing (see organisational chart)
Set up costs, running costs and programme costs.

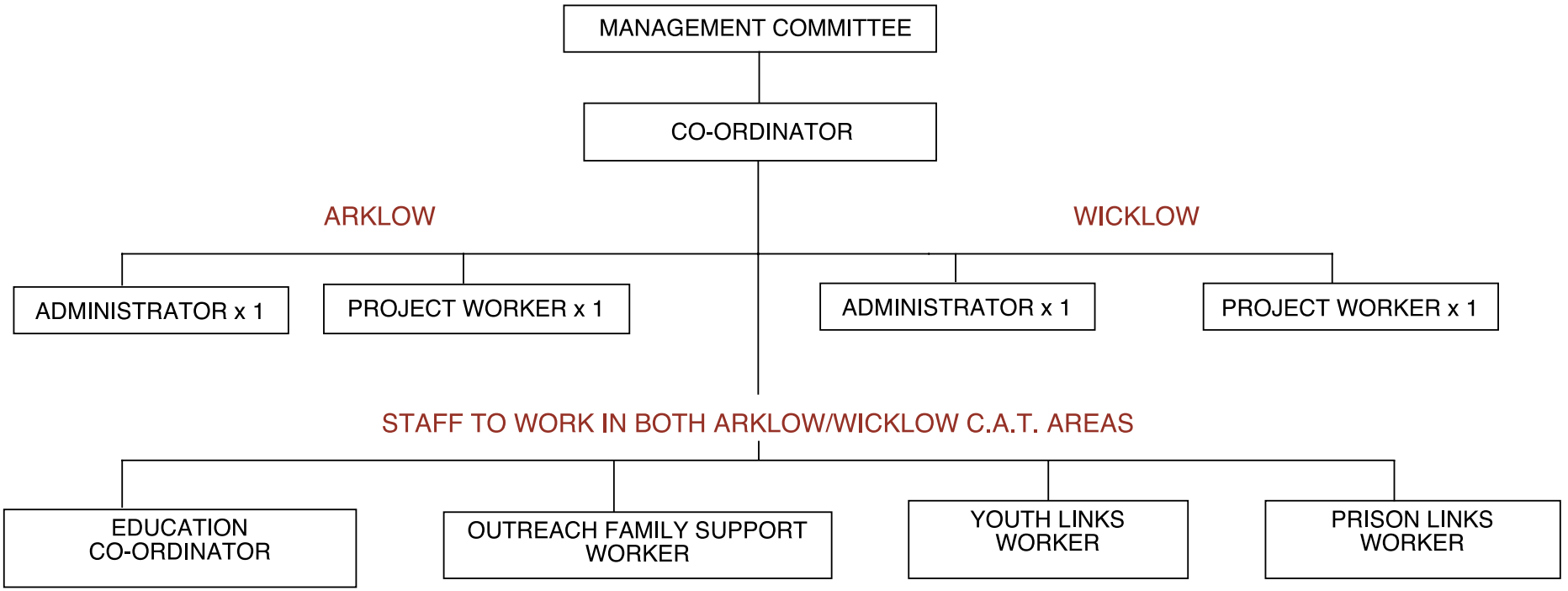
Recommended By: Subcommittee Treatment & Rehabilitation
Subcommittee Prevention & Education

Monitoring & Evaluation:

The project will be monitored by the Management Committeecomprising of community and statutory representatives in conjunction with the Co-ordinator and will be externally evaluated quantitatively by the numbers accessing the service and qualitatively by the experience of those accessing the service and those referring service users to the facility.
Please see Section 6: Evaluation, for further information.

Proposal 1

COUNTY WICKLOW COMMUNITY ADDICTION TEAM – ARKLOW/WICKLOW



NETWORKED WITH (Not all services listed)

Wicklow Drugs Awareness Group
Arklow Drugs Awareness Week
Training Organisations

Wicklow Child & Family Project
Arklow Springboard

Schools (Primary & Secondary)
Gardai/Juvenile Liaison
Youth Diversion Project

Probation & Welfare
Prison Services
(Incl. Shelton Abbey)

EAST COAST REGIONAL DRUGS TASK FORCE

Proposal 1 **County Wicklow Community Addiction Team - Arklow/Wicklow**

Estimated Costs

Staff:

Manager/Co-ordinator (VII)			53,166		53,166		
Administrator/Secretary (IV) x 2			28,029		56,058		
Project Worker x 2			35,660		71,320		
Prison Links Worker x 1			35,660		35,660		
Youth Links Worker x 1			45,342		45,342	*	
Education co-ordinator x 1			43,683		43,683		
Outreach Family Support Worker x 1			45,342		45,342	*	350,571
PRSI Contributions	10.75%						37,686
				Total Staff Costs			388,257

*If SW Qualified

Shared Resources

Counselling - (See proposal 3)

Set Up Costs

Once off set up costs x 2					120,000		
Recruitment costs					10,000		
				Total Set Up Costs			130,000

Running Costs

Premises x 2		(1000 per wk)			104,000		
Lighting/Heating/telephone - running costs					75,000		
Mileage & Subsistence					€30,000		
Training					€13,500		
Supervision					€10,800		
				Total Running Costs			233,300

Programme Costs -

Family Support Outreach Costs					20,000		
Programme Costs - Centre based					80,000		
Education Co-ordinator - budget					50,000		
				Total Programme Costs			150,000
				Total Operational Costs			**901,557**

Health Board Subsidy (HSE 01/01/05) - Subject to Negotiation

Co-ordinator			53,166				
Project Worker			35,660				
Administrator			28,029				
Lease of Arklow Building			52,000				
Set up costs x 1			60,000	228,855			
PRSI Contributions				18,152			-247,007
				Subject to Negotiation with HSE			**654,550**

Date: November 2004

Proposal 2

Title: **Childcare and Transport Proposals**

Aim: Ensuring accessibility to clients attending the Community Addiction Team (Arklow) and County Wicklow Rehabilitation Project.

Target: Service for Drug Users
Services for children of Drug Users
Service for Families and Siblings

Proposal: To provide transport to services from pick up points around the county. This service will allow accessibility to services from individuals/clients in rural areas ensuring access to services by those who require them.

Providing a drop in crèche to parents attending proposal 1 and 4 and ensuring that childcare does not become an obstacle in an individual's recovery.

The above two proposals go hand in hand with proposal 1 and 4. It is crucial that both transport and childcare arrangements are in place to provide a holistic service to clients who will avail of these services.

Geographical Area: Catchment area – Proposal 1 – ECRDTF region.

Objectives

1. Develop transport options to clients/families attending Proposal 1 and 4 and ensuring access to services.
2. Develop childcare options for clients/concerned persons attending Task Force services.

Resources Requested:

1 15 Seater Mini-bus (converted for wheel chair users) €53,000 + 1 driver (€27,000), Insurance & Maintenance (€5,000) = Total €85,000

Please Note:
This funding has been estimated on buying a mini

bus. Before providing this service a tender process may take place to see if this could be sourced by an existing service within the price. If not funding will be provided for a mini bus and driver (with negotiation with the HSE East Coast Area for a relief driver to cover holidays/sick leave)

2. Childcare Workers x 3 W.T.E. (€33,470) =100410
+ Running costs & Equipment €10,000
Total €110, 410

Please Note:
A crèche facility is currently run by Arklow Springboard at a cost of approximately €24,000 x 2 part-time staff, €1,500 (Insurance), Equipment & materials €7,000 = €32,500

This crèche is for 2 years and up and open from 10am to 1pm.

Estimated costs above are to provide a service for babies upwards running through the day and evenings (on occasion). If funding received negotiations with Springboard to provide additional services may be decided upon or alternative services provided at one of the proposed developments. This will be fully investigated upon receipt of funding.

Funding Required: Drop in Crèche: **€110, 410**
Mini Bus **€85,000 Total: €195,410 (per annum)**

Recommended By: Subcommittee Treatment & Rehabilitation

Monitoring & Evaluation: The project will be monitored by the Management Committee comprising of community and statutory representatives in conjunction with the Manager and will be evaluated quantitatively by the numbers accessing the service and qualitatively by the experience of those accessing the service and those referring service users to the facility.
Please see Section 6: Evaluation, for further information.

Proposal 3:

Counselling Services

Title: **3(a) Wicklow Child & Family Project – Counsellor (0.5 Post)**

Aim: To provide a community based counselling service for individuals and families affected by addiction issues.

Target Group: Services for Families affected by addiction issues

Proposal: To employ a part-time counsellor to provide counselling/support to families who are affected by addiction problems. Counselling may also be offered to clients with addiction problems. This project will be linked with Proposal 1 (Co. Wicklow CAT – Wicklow) and accept referrals from same.

Geographical Area: Wicklow Town and its environs.

Resources Requested: €20,000 (Counsellor) + €1,000 (Administration Costs)
Total €21,000 (Year 1)
(Year 2 & 3 – Public Pay Awards + Inflation)

Recommended By: Subcommittee Treatment & Rehabilitation

Note:
Funding will only be given for a qualified, accredited counsellor with addiction experience.
Hours of counselling to be negotiated for funding received.

Title: **3(b) Living Life Counselling**

Aim: To provide counselling to people in addiction, people recovering from addiction, families of people with addiction issues and young people at risk of addiction.

Target Group: Individuals affected by addiction issues.
Families affected by addiction issues
At Risk Young People

Proposal: To provide counselling and supportive services to those affected by addiction issues within the Arklow area. The Living Life Centre has recently established a service in Arklow and recognise a need for additional addiction related counselling in the Area.

Link: Probation Service, Psychiatric Services, FAS, Local Development Companies, and Arklow Community Addiction Team.

Geographical Area: Arklow and its environs.

Resources Requested: €10,000 per annum (Year 1 + Inflation year 2/3)

Recommended By: Subcommittee Treatment & Rehabilitation

Both Prevention & Education and Treatment and Rehabilitation Subcommittees have identified a gap in service provision in regard to access to counselling. All counselling submission will be prioritised as a significant need for the area.

Note:
Funding will only be given for a qualified, accredited counsellor with addiction experience.
Hours of counselling to be negotiated for funding received.

Title: **3(c) Budget for Counselling Services**

Aim: To provide a budget for people to access counselling within their local area and to ensure access to counselling for those in crises.

Target Group: Individuals affected by addiction issues.
Families affected by addiction issues

Proposal: To provide a sum of money to be accessed by the County Wicklow Community Addiction Team and County Wicklow Rehabilitation Project for clients who are from rural areas within the region to access locally based counselling. It has been identified by the Subcommittee for Treatment and Rehabilitation that rural areas within our region are not currently covered by existing Family Support Services and this will allow direct access to purchase counselling sessions if and when required. The prison links worker (Proposal 1 T&R) will also have access to provide sessional counselling to clients in the local open prison. Criteria for accessing this funding will be drawn up by the Subcommittee for Treatment and Rehabilitation and would be the responsibility of the Co-ordinator/Manager for the County Wicklow Community Addiction Team.

Link: Probation Service, Psychiatric Services, FAS, Local Employment Services, and County Wicklow Community Addiction Team – Wicklow/Arklow.

Geographical Area: East Coast Regional Drugs Task Force Region

Resources Requested: €50,000 per annum for initial set up of counselling to be reviewed on a yearly basis and increased as need arises. (2 days counselling per week on a sessional basis)

Recommended By: Subcommittee Treatment & Rehabilitation

Both Prevention & Education and Treatment & Rehabilitation Subcommittees have identified a gap in service provision in regard to access to counselling. All counselling submissions will be prioritised as a significant need for the area.

Note:
Funding will only be given for a qualified, accredited counsellor with experience in addiction.

Title: **3(d) Training and Awareness Officer Service I.S.P.C.C.**

Aim: To work with children at risk of early school leaving as a result of drug/alcohol abuse.

Target Group: Under 18s

Proposal: To provide therapeutic work with children and their families in their own homes for a period of approximately 6 months. Mentoring programme where children are paired with a volunteer mentor for approximately 6 months.

Links: Proposal 1 (County Wicklow CAT), Gardai Youth Diversion Project, Juvenile Liaison Officers, HSE East Coast Area, Schools, Early School Leaving Projects.

Geographical Area: Wicklow (Area to be negotiated)

Resources Requested: €113,737 (1st year) + inflation (2nd and 3rd year)

Recommended By: Subcommittee Prevention & Education
Subcommittee Treatment & Rehabilitation

Note:

1. Referrals will be accepted as priority from the Youth Links Worker (Proposal 1) and/or Task Force funded projects.
2. Funding will be made available to cover clients from the Task Force area.
3. Staff to have experience/qualifications in addiction issues.
4. This service was in Arklow and is provided by one member of staff in Wicklow. The criteria for funding is the increase of two additional staff and not existing staff.

Monitoring & Evaluation (All Counselling proposals):

The project will be monitored by the Management Committee comprising of community and statutory representatives in conjunction with the Manager and will be evaluated quantitatively by the numbers accessing the service and qualitatively by the experience of those accessing the service and those referring service users to the facility.
Please see Section 6: Evaluation, for further information.

Proposal 4

Title: **County Wicklow Community Rehabilitation**

Aim: To provide a structured process whereby individuals, whose lives have become affected by drug misuse, are facilitated in a process of regaining their capacity for daily life.

Target Groups:

Programme 1.	Active Drug Users	-10 Places
Programme 2.	Stable Methadone	-10 Places
Programme 3.	Drug Free	-5 Places

Proposal: To establish a County Wicklow Community Rehabilitation Project in the South of the County, preferably Arklow. This Community Rehabilitation Project will provide a non-residential rehabilitation option to clients within our area who currently have no access to this service.
Programmes 1 & 2 will be developed using the same premises, but alternating the times of the programmes. A Drugs Free Programme will also be developed and places reviewed yearly, upon demand. The Drugs Free Programme will not be within the same premises, but a review of local services – statutory and voluntary may facilitate this programme on their premises.

The Rehabilitation Project will provide up to 25 CE Places – 15 CE places held within the community by both clients and concerned persons affected by addiction and managed by the Project. It is hoped that the CE Supervisor/Ass CE Supervisor would be funded through FAS, and the scheme undertaken in conjunction with FAS.

Objectives:

1. To provide a progression route to clients not only in relation to their addiction but in all aspects of their lives, personal, family and social.
2. To provide training on life skills and work skills.
3. To provide structured day programmes to provide stability within clients lives.
4. To promote a progression for all drug users and actively recruit clients through contact with drug

treatment services, County Wicklow Community Addiction Team, Probation Services, etc.

5. To provide a low risk, non threatening supportive environment to clients using a structured programme that is made in consultation with clients to ensure a range of choices to each individual.
6. Provide financial stability to clients through participation through CE Scheme.
7. To provide a continuum of care for clients from treatment to rehabilitation.
8. To support concerned persons affected by addiction through work on CE schemes and building relationships between the client and concerned others.

Recommended By: Subcommittee Treatment & Rehabilitation

Resources Requested:

Premises: In the south of County Wicklow, preferably Arklow**.**
Staffing: (see organisational chart)
Set up costs, running costs and programme costs.

Monitoring & Evaluation:

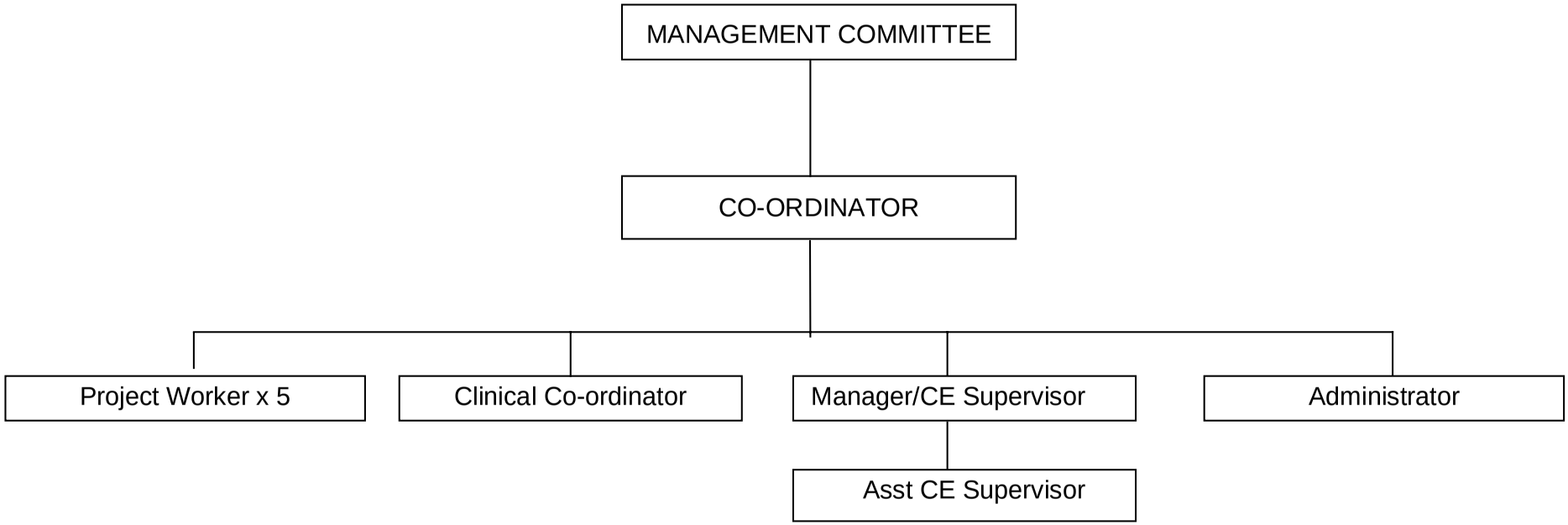
The project will be monitored by the Management Committee (County Wicklow Rehabilitation Project) comprising of community and statutory representatives in conjunction with the co-ordinator and will be externally evaluated quantitatively by the numbers accessing the service and qualitatively by the experience of those accessing the service and those referring service users to the facility.

Please see Section 6: Evaluation, for further information.

Proposal 4

COUNTY WICKLOW REHABILITATION PROJECT

(Organisational Chart)



EAST COAST REGIONAL DRUGS TASK FORCE

Proposal 4 **County Wicklow Rehabilitation Project**

Estimated Costs

Staff:

Manager/Co-ordinator			53,166		53,166		
Administrator/Secretary (VI)			28,029		56,058		
Project Worker x 5			35,660		178,300		
Manager/CE Supervisor = 575.44 per wk			29,923		29,923	(Rate on 25+_	
Asst CE Supervisor + 404.44 per wk			21,031		21,031	(Asst CE Supervisor for 25+ on CE Scheme	
					338,478		
PRSI Contributions	10.25%				34694		373172

Shared Resources

Counselling - (See proposals 3-5)

Set Up & Running Costs

Premises x 1	(1500 per wk)				78,000		
Once off set up costs x 1					60,000		
Recruitment costs					10,000		
Lighting/Heating/telephone - running costs					37,000		
Insurance					6000		191,000

Programme Costs -

Programme Costs - centre based (incl equipment)			50,000		50,000

614,172

Dated: November 2004

Proposal 5

Title: **Education and Training Access Progression Fund**

Aim: To provide once off funding for clients trying to access training/job preparation with small payments to cover incurred small expenses (i.e. clothing for interview, transport, etc)

Target Group: Clients within the ECRDTF area

Proposal: To provide funding for unexpected expenses that may prevent an individual from progressing within their rehabilitation/progression route. Criteria in accessing this funding to be developed by the Subcommittee for Treatment and Rehabilitation. Funding if approved will be accessed through the ECRDTF Co- ordinator/Office.

Links: Local Employment Services, Jobs Club (Arklow), County Wicklow CAT, Co. Wicklow Rehabilitation Project, Local Development Companies.

Resources Requested: €10,000 (1st year) + inflation (2nd – 3rd year)

Recommended By: Subcommittee Treatment & Rehabilitation

Monitoring & Evaluation: The project will be monitored by the Subcommittee Treatment & Rehabilitation, ECRDTF in conjunction with the Co-ordinator and will be evaluated quantitatively by the numbers accessing the fund and the funding required. Please see Section 6: Evaluation, for further information.

Proposal 6

Title: **Computer Skills and Job Preparation Course**
Wicklow Trade Union Centre for the Unemployed

Aim: To provide computer skills and job preparation course in the County Wicklow area.
(20 wks x 10 participants)

Target Group: Service Users - Adults

Proposal To provide a progression route to clients from the County Wicklow Rehabilitation Project (Proposal 4) as a progression route to mainstream employment.

.

Links: HSE East Coast Area, VEC, and Proposed Rehab. Project, Bray LDTF, FAS.

Resources Requested: €22,672 per annum + inflation (2nd & 3rd year)

Recommended By: Subcommittee for Treatment & Rehabilitation

Monitoring & Evaluation: The project will be monitored by the Management Committee (County Wicklow Rehabilitation Project) comprising of community and statutory representatives in conjunction with the Manager and will be evaluated quantitatively by the numbers accessing the service and qualitatively by the experience of those accessing the service and those referring service users to the facility.
Please see Section 6: Evaluation, for further information.

Education and Prevention Subcommittee

The Education and Prevention Subcommittee is comprised of Statutory, community and voluntary representatives combining to share opinion, information and best practice regarding Education and Prevention initiatives.

It was important to members of the Education and Prevention Subcommittee to take cognisance of the valuable education and prevention initiatives already taking place within the region. Research carried out in Section 2 (p9) did highlight the existence of a number of initiatives, however some projects are hampered by little or no funding.

With this in mind the Education and Prevention Subcommittee believed their role to be particularly strategic in nature. In essence they prioritised the need to co-ordinate current provision and identify areas were they can play a complimentary role.

The subcommittee based their identification of need on their collective wealth of experience, shared, refined and clarified over a period of months. Research and the previously described consultation process further informed them. This process led to them identifying 13 major areas of recommendation, some of which were statements of support and encouragement to existing organisations and programmes

In terms of specific actions the Education and Prevention Subcommittee further distilled their priorities as:

- Greater prevention and education activities in areas outside of LDTF areas
- A more co-ordinated approach to the provision of accessible and comprehensive information
- Increased early intervention initiatives for “at risk” youth in a range of settings inside and outside of school
- A range of education initiatives for adults and parents. In particular increased educational opportunities for adults including activation, pre-vocational and vocational initiatives

The criteria for selecting submissions were:

- The extent to which the project reflects Task Force priorities and at the same time is currently not delivered or is under – delivered

- The need to avoid duplication of effort and resource and to remain aware of the role of the RDTF as indicated by the NDST. For example, Task Force members decided not to fund projects that fell within the geographical scope of the 2 Local Drug Task Forces (Bray and Dun Laoghaire)
- The appropriateness of the proposal bearing in mind that responsibility still rests with statutory agencies to deliver programmes and services within their own area.
- The level of detail and clarity of thought contained in the proposal. Proposals needed to be, as far as reasonably practicable, costed and clear in terms of inputs, outputs, outcomes and impact
- The extent to which proposals reflected current thinking in relation to best practice
- The geographical location of the base and service delivery of a project. Projects needed to be based in and provide services in the ECRDTF area in line with the Task Force priorities
- The extent to which the proposal related to Actions under the NDS

The Education and Prevention Subcommittee received 18 proposals. The subcommittee held an initial selection meeting on 19th October and considered each proposal in relation to the aforementioned selection criteria.

The initial 18 proposals were subsequently reduced to 5. A summary of the 5 proposals selected is provided in tabular form below and each proposal is then developed in further detail.

Education and Prevention: The Proposals

Table 4.2 - Summary of Education and Prevention Proposals

Prevention & Education – Listed by Priority			
1	Prevention /Education	Designated Education Co-ordinator –Incorporated in proposal 1 above	(See proposal 1 Treatment & Rehabilitation)
2	Prevention/ Education	Wicklow Travellers – Youth Worker	€ 33,300
3	Prevention/ Education	Small Grants Fund - Drugs Awareness Events	€ 20,000
4	Prevention/ Education	Educate through sport	€ 18,000
5	Prevention/ Education	Early School Leavers – Carnew Enterprise Centre	No funding required

Proposal 1

Prevention & Education

Title: **Designated Education Co-ordinator – ECRDTF region**

Aim: To provide a co-ordinated and networked response to providing prevention and education programmes within the region.

Target Group: Young people, parents and the whole community.

Objectives:

1. To develop and keep up-to-date database of drug education and prevention programmes in the area.
2. To review the existing training within the area and identify the areas where there is or has been no drug prevention education.
3. To review/needs analysis on training of adult facilitators and buy in service as required.
4. Arrange drug/education prevention courses for adults throughout the area.
5. Link with Youth Link Worker (Proposal 1 T&R) in identifying schools and out of school settings who may require additional drugs education programmes, complimentary to the SPHE programme – buy in service as required from existing groups.
6. Build a support network for local drugs awareness groups to co-ordinate an ongoing response in Prevention & Education and provide assistance in activities.
7. Review submissions received by the Task Force in regard to Prevention and Education and provide service as required.
8. To link with the Local Drugs Task Forces and identify projects which are best practice within their area and review the need within RDTF area.

Links: Drugs Education Workers Forum, Co. Wicklow Community Addiction Team (Proposal 1 T&R), Co. Wicklow Rehabilitation Project (Proposal 4 T&R), VEC, FAS, Schools, Youth Groups,

Geographical area: East Coast Regional Drugs Task Force area.

Reasons for providing this post:

1. There is a number of prevention and education programmes taking place within the Task Force area. This person will be responsible for ensuring that the Task Force is aware of what is taking place and provide (buy in) a service where there is a gap identified or need identified.
2. To support all local drug awareness groups to ensure their ongoing work in Prevention and Education.
3. The Task Force received 3 submissions for a Drugs Education and Prevention Worker – the subcommittee decided that a designated drugs co-ordinator for the region could provide this service.
4. The Subcommittee for Prevention and Education recognised best practice for schools and out of school settings is teacher based programmes. The designated Education Co-ordinator will link with the Youth Link Worker to identify individuals who require support and/or additional drugs prevention programmes.

Resources Requested: (See Proposal 1 T&R)

Please note that it is essential in providing this post that a budget is allotted to ensure the availability of funding programmes as needs arise.

(Please see proposal 1 Treatment & Rehabilitation)

Recommended By: Subcommittee for Prevention and Education
Subcommittee for Treatment & Rehabilitation

Monitoring & Evaluation: The Designated Education Co-ordinator will be monitored by the Management Committee comprising of community and statutory representatives in conjunction with the Manager.

The project will be evaluated externally on an ongoing basis, by an evaluator who will evaluate all projects recommended by the Task Force in a realistic time frame or as set down by the National Drugs Strategy Team.

Please see Section 6: Evaluation, for further information.

Proposal 2

Prevention & Education

Title: **Youth Worker – Wicklow Travellers Group**

Aim: To research the extent of drug misuse among the local Traveller Community.
To develop drug awareness and education in a culturally sensitive manner.
To provide preventative measures to young people.

Target Group: Young Travellers 13-25 years

Objective: To provide funding for two part-time staff with relevant youth work qualifications, knowledge and experience in relation to the Traveller Community.

Links: Proposal 1 T&R – County Wicklow Community Addiction Team

Geographical Area: Wicklow Town and its environs

Resources Required: €33,300

Recommended By: Subcommittee Prevention & Education
This group currently receive no funding to provide drug education prevention work within the Travelling Community

Note:
(Criteria for Funding) Individuals funded must have training in addiction issues.

Monitoring & Evaluation: Subcommittee Prevention & Education, ECRDTF and externally in a realistic time frame or time frames set down by the NDST
Please see Section 6: Evaluation, for further information.

Proposal 3

Prevention & Education

Title: **Small Grants Fund - ECRDTF area**

Aim: To provide funding to existing and new community drugs awareness groups within the ECRDTF area.

Target Group: Young People, Parents, and the whole community.

Proposal: To encourage and support the drug education/prevention responses developed by local community groups within the ECRDTF area. To ensure the continued development and implementation of these activities. This fund will raise the profile of the Task Force and provide funding for small projects where no other funding is available.

This proposal is directly linked with Submissions received from the Wicklow Drugs Awareness Group and the East Wicklow Youth Service and also provides small additional funding for areas not currently covered by the above groups activities.

The small grants scheme will be held by the Task Force Co-ordinator and administered by application to them.

Resources Requested: € 20,000

Recommended By: Subcommittee Prevention & Education

Monitoring & Evaluation: The project will be monitored by the Subcommittee Prevention & Education, ECRDTF in conjunction with the Co-ordinator and evaluation of the groups receiving funding will be ongoing. The project will be evaluated externally on an ongoing basis, by an evaluator who will evaluate all projects recommended by the Task Force in a realistic time frame or as set down by the National Drugs Strategy Team.
Please see Section 6: Evaluation, for further information.

Proposal 4

Prevention & Education

Title: **Education Through Sport Programme**
Arklow Healthy Towns.

Aim: To enable at risk young people in Arklow and its environs to continue to have a diversion programme – education through sport (self esteem, life skills).

Target Group: Under 18s

Proposal: To fund the continuation of the education through sport programme funded this year through a grant from the European Union as well as the extension of the project.

Links: Funded Task Force Projects, Arklow Springboard, Juvenile Liaison Officers, HSE East Coast Area, Schools, Early School Leaving Projects.

Geographical Area: Arklow

Submission Received:

1. Education through sport programme
2. Extension of the Project

Recommendation of the Subcommittee:

1. Funding to continue the current sports programme – to ensure diversion programmes to at risk young people.
2. The Subcommittee decided that several of the suggested extensions to this project were currently being undertaken within the area and therefore linking in with current service provision would be more appropriate.

Resources Requested: €18,000 (1st year) + inflation (2nd and 3rd year)

Recommended By: Subcommittee Prevention & Education

Criteria for Funding: The catchment criteria for referrals will also include young people referred from Task Force funded projects.
Wider sports interests – to cover a variety of sports.

Proposal 5

Prevention & Education

Title: **Early School Leavers**
Carnew Enterprise Centre

Aim: To engage early school leavers in Carnew and its environs and progress them to further education and employment.

Target Group: Early School Leavers

Proposal: To provide training that is participant driven as a progression to other programmes.

Linkages: FAS, VEC, Local Development Companies.

Recommended By: Subcommittee Prevention & Education

Support and recommend establishment of Programme by the VEC and FAS and provide for costs.

YOUNG PEOPLE SERVICES AND FACILITIES FUND

Following the scoping document exercise highlighting services and identifying gaps. A gap within the East Coast Regional Drugs Task Force area that has been identified is young peoples facilities, including drop in centres and diversional activities for young people.

Through the community consultation process the Task Force received 2 submissions requesting funding for young peoples facilities.

We recommend that the Young People Services and Facilities Fund is extended to included areas identified by Regional Drugs Task Forces as having a need for young people services.

We further recommend that the composition and structure of the Development Group allocating monies from this fund be reviewed with the possibility of decisions regarding financial allocation being channelled through the Task Forces.

The following proposals received would be recommended should this funding become available in the future:

Rev Roland Heaney – Redcross
Mr Dirk Van Der Flier – Wicklow Town

There are also other areas within the East Coast where community development has not taken place, particularly rural areas where young peoples facilities will be required in the next 3-5 years to ensure prevention and diversional programmes are in place.

Table 4.3 Young Peoples Services and Facilities Fund

Young Peoples Services and Facilities Fund – Recommendation to extend fund to cover RDTF area		
	Youth Facilities - Redcross	? (Capital Costs) €40,000 (running costs)
	Wicklow Chamber of Commerce Youth Initiative	€1.5m (Capital Costs) 150-200,000 (running costs)

Proposal A	**Considered but not recommended at this time**
Title:	**Youth Club**
Aim:	To provide a safe environment for young people to have fun and learn life skill that will help to give them the confidence to make quality and informed choices for life.
Target Group:	12-22 years
Geographical Area:	Redcross – currently meet in Wicklow Town
Recommendation:	The Task Force currently don't have the capacity to recommend the funding of this project without accessibility to the Young Peoples Services and Facilities Fund.
Funding Required:	€ 40,000 (Youth Worker) + Capital Costs (not known at this time)

Proposal B	**Considered but not recommend at this time**
Title:	**Wicklow Chamber of Commerce Youth Initiative**
Aim:	Provision of a youth facility within Wicklow Town – homework study club, provision of nutritious meals, drop in centre.
Target Group:	12-22 years
Geographical Area:	Wicklow Town
Recommendation:	The Task Force currently doesn't have the capacity to recommend the funding of this project without access to the Young Peoples Services and Facilities Fund.
Funding Required:	1.5m (Capital Costs) 150,000-200,000 (running costs)

PROJECTS RECOMMENDED FOR NATIONAL FUNDING

The Task Force received 3 submissions incorporating areas outside their remit. These were discussed by the Subcommittees and by the main Task Force and there was broad consensus that these projects should be funded directly by the NDST as these projects are of significant importance on a National level. With this in mind they are presented below:

Table 4.4 – National Projects recommended for funding

National Projects Recommended – Not prioritised - recommend funding direct from NDST			
1	Prevention/ Education	Establishment of a national information system on services in addiction and connected services – DAP, Crosscare	€ 5,000
2	Treatment/ Rehabilitation	Dublin Opiate Overdose Reduction Strategy – Harm Reduction	€ 81,380
3	Research	Drugs Rehabilitation Services for Women with Children South side Women's Action Network	€ 12,000

Proposal 1 **Cross Task Force/National Project**

Title: Statutory/Voluntary/Community Database for Local Drugs Education and Treatment Organisations – Drugs Awareness Programme, Crosscare.

Submission Received: To provide internet access to information on local drug education and treatment organisations – to be accessed by individuals and service providers. To provide a comprehensive list of services and contact details which will be easily accessible nationwide.

Target Group: Individuals and Service Providers

Geographical Area: Nationwide

Links:	All Voluntary, Community and Statutory organisations providing a service in relation to addiction.
Recommendation by:	Subcommittee Prevention & Education: The Subcommittee recommend this proposal as a national proposal and will recommend approval of same if the majority of RDTF areas agree to fund. It should be noted that a Health Portal on all health issues is currently being established and this project may need to be linked with same.
Funding Required:	€5,000 (1st year) + inflation (2nd and 3rd year)

Proposal 2	**Cross Task Force/Eastern Regional Proposal**
Title:	Dublin Opiate Overdose Reduction Strategy
Aim:	To reduce the number of opiate related deaths occurring each year.
Proposal:	To provide a strategy in prevention of opiate related deaths through information within the Dublin region.
Recommended By:	Subcommittee Treatment & Rehabilitation The Subcommittee recommend that it is essential that this harm reduction strategy is put in place within the Dublin Region and would recommend funding on this basis.
Funding Required:	€81,380 (1st year) + inflation (2nd – 3rd year) Divided by 3 for each region

Proposal 3	**Cross Task Force/National - Research**
Title:	Drugs Rehabilitation Services for Women with Children South side Women's Action Network
Aim:	To research residential drug rehabilitation for women who wish to keep their children with them.
Proposal:	To find out if it is feasible to provide residential rehabilitation services for women who have young children. This service would need to cater for children at the residential centre so that the young women involved would be supported to complete their own rehabilitation.
Criteria for funding:	(a) Recommendations on best practice to be given following research.
Recommended By:	Subcommittee Treatment & Rehabilitation
Funding:	€12,000 (1 year costs only)

EAST COAST REGIONAL DRUGS TASK FORCE

TASK FORCE SUPPORTS REQUIRED - BUDGET 2005

Estimated Costs

Staff - (Costed DoH rates of pay. (1.12.04 - 5th point of salary)

Host Organisation HSE, Area Partnership, Legal Entity (to be decided)					
Interim Co-Ordinator			46,728		
Employers PRSI @ 10.75%			5,023		
Sustaining Progress 1.5% 01.07.05			700.92		
Superannuation 7%			3270.96		55723
Project Worker (Grade V)			40,525		
Employers PRSI @10.75%			4356.44		
Sustaining Progress 1.5% 01.07.05			607.88		
Superannuation 7%			2836.75		48326
Administration/Researcher (Grade IV)			31,467		
Employers PRSI @10.75%			3382.7		
Sustaining Progress 1.5% 01.07.05			472		
Superannuation 7%			2202.69		37524

Mileage & Subsistence

Mileage - Comm. Rep./Chairperson (7)			10,000		
Mileage - (Co-ord./Proj. Worker/Admin (3))			10,000		
Subsistence/Childminding (€500 x 6)			3,000		23000

Running Costs

Premises			30000		
Lighting/Heating/telephone/insurance			20000		
Stationary/Post			5000		55000

Training

NUI Cert in Addiction Studies			2000		
Training & Supervision Staff/Task Force			5000		7000

Seminars/Advertising/Publicity

Advertising/Publicity (2004 figs.)			13800		13800

Task Force Meetings - Meeting Rooms

Task Force Meetings (as per figs 2004)			10000		10000
		Overall Operational Costs			**250373**

Set Up Costs

Once off set up costs - Computers, Office Furn, & Equip.					30,000

Total for 2005 **280,373**

It should be noted that the above estimated costs are for a stand alone service.

*Please note travel expenses for voluntary agencies not included.

Section 6

EVALUATION

The Evaluation Process

Evaluation is a formal process of checking whether the organisation is operating in the way they aim to operate, doing what they say they are doing, and meeting their objectives. If this is not the case then evaluation assesses why not and recommends what remedial action may be taken. In some cases if internal or external circumstances have changed evaluation allows for reflection and flexibility, e.g. to change the original objectives.

Evaluation is a control mechanism to stop the organisation going off course or limping along ineffectively. The process of evaluation should be seen as an essential component to any programme design. Although evaluation is seen as important by most community based initiatives, the money to carry it out in any meaningful way is often begrudged, as though it was a luxury, rather than a prerequisite to further development. For this reason, 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. Indeed the Task Force believe the lack of thorough evaluation could be construed as a service delivery "gap" in need of addressing.

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 an integral part of each project and provides an important tool in terms of:

- Reviewing and reflecting on practice
- Ensuring that you are meeting the needs of clients and assisting them to achieve their desired outcomes
- Informing further planning and practice
- Sharing and disseminating experiences, learning and good practice
- Being accountable: Using resources appropriately and effectively
- Making a case for further funding

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. It is mainly concerned with how the project is run rather than with its outcomes. 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 must 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. These do not need to be formal theories but can also be 'practitioner based' i.e. theories arrived at by practitioners based on their personal experience. The theory on which a project is based will determine the actions or interventions that the project delivers.

The second issue with which an evaluation must concern itself 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 project may have more than one aim and each aim may vary in its centrality to the core business of the project, however all must be clearly stated at the outset if best practice in project design is to be followed. A consideration of the aims of a project will affect the criteria that are adopted to measure its success.

All evaluations must look at the means by which an outcome is achieved as well as at the outcome itself because if this is not clearly understood it will be impossible to replicate the intervention 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. It is important to document where changes have been made in practical terms to meet the evolving needs of clients to ensure that a project is not evaluated based on what originally stated it was doing but on what it actually does.

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 cannot be based on hard outcomes alone and must also consider health and social gain. This can only be done if baseline measures are taken which tap into the participants position at intake in a holistic way.

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

Many project managers and staff who 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 ECRDTF.*

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:

Planning for Evaluation	€10,000	
Per Project (€7,000 x 10)	€70,000	**Total Requested €80,000**

Section 7

Cross Task Force Issues and Learnings from LDTF's

Section 7 Cross Task Force Issues and Learnings from LDTF's

The ECRDTF is aware that it is essential for a co-ordinated and cohesive action plan to work closely with the two Local Drugs Task Forces (Bray and Dun Laoghaire) within its region.

The ECRDTF has 5 members that are also represented in various workings on the Dun Laoghaire Rathdown LDTF and 6 members in the same capacity from Bray LDTF. The two LDTF Co-ordinators are represented officially on the ECRDTF.

The workings therefore of the ECRDTF are interlinked with the two LDTF's within the region and this has built the capacity for furthering best practice within the area and looking at emerging issues/prevalence within our area.

The ECRDTF will maintain and develop existing links with the LDTF's and address with them any emerging issues that affects the region.

In addition to formal cross representation members of the ECRDTF and the LDTF's will explore the possibilities for collaborating further as appropriate.

For example:
The ECRDTF are in the process of negotiating with the Dun Laoghaire LDTF to provide support for clients from Baggot Street Drugs Treatment Clinic or surrounding treatment clinics within their proposed Dundrum Community Addiction Team. These clients do not reside in the Dun Laoghaire LDTF area but fall within the remit of the ECRDTF.

The possibility of working in partnership with Dundrum CAT to cater for clients from the area outside of the Dun Laoghaire LDTF area needs to be further reviewed as to its viability and a needs analysis of clients availing of the service to ensure future needs within this area are addressed. The ECRDTF has not requested funding in relation to this proposal at this time and will review the option of facilitating this work through Proposal 1 (Section 5). However it should be noted that following a needs analysis further input into providing supports and programmes to clients from this area might require additional resources.

Current channels of communication between the ECRDTF and the two LDTF's in the region allow for the dissemination of best practice and the ECRDTF is particularly aware of the need to learn from the experiences of the LDTF's in relation to effective and efficient service provision.

_____
John O' Brien
Chairperson
East Coast Regional Drugs Task Force

_____
Jim Ryan
Chairperson – Prevalence/Supply & Control Subcommittee
East Coast Regional Drugs Task Force

_____
Ruth McClaughry
Chairperson – Treatment & Rehabilitation Subcommittee
East Coast Regional Drugs Task Force

_____
Andy Ogle
Chairperson – Prevention & Education Subcommittee
East Coast Regional Drugs Task Force

_____
Siobhan Turner
Interim Co-ordinator,
East Coast Regional Drugs Task Force.

Appendix 1

Profile of existing service provision (statutory, voluntary, and community)

Methodology

The East Coast Regional Drugs Task Force used the Scoping Document to profile the service provision which currently exists in the Region. A list of 235 service providers was compiled. These groups were chosen to reflect all services available to those at a disadvantage in the region while paying particular attention to the issue of substance misuse. The list was broken down into three sub-groups as follows:

- 29 Drug specific initiatives
- 91 Initiatives targeting those at risk of drug use
- 115 General initiatives

A detailed questionnaire (scoping document) was sent to each of the service providers on the drug specific and at risk lists. A less detailed one page questionnaire (scoping document) was sent to each of the general initiatives on the list.

Response Rate

The survey questionnaire was returned by a total of 95 service providers representing a response rate of 36.6% which is just above what would normally be expected from a postal survey. These 95 responses were broken down over the three groups as follows:

- 24 Drug specific initiatives
- 33 Initiatives targeting those at risk of drug use
- 38 General initiatives

The responses the survey are detailed in the body of this report according to these three groupings.

Limitations of the Study

When interpreting the results of this survey it is important to consider the limitations of the study. Many of the questions on the survey questionnaire were very broad and invited open ended responses. It became clear when data was being analysed that respondents interpreted the meaning of some of these questions differently from each other. In effect this means that in their replies, respondents were in fact answering different questions. The question regarding service user involvement is a case in point. Some respondents took this to mean “what service do you provide to service users?” while others interpreted the question as “what involvement do service users have in the design and development of activities/ services?” and still others took it to mean “what involvement do service users have in the evaluation of services?”. Analysis of these responses was therefore difficult and conclusions drawn can therefore be only considered as tentative. This was the case for a number of other questions and where this has occurred it is referred to in the appropriate section of the report.

Contextual Information

The scoping document was sent to all service providers in the region which at the time of the survey fell into the three broad categories outlined above. Of the 235 projects surveyed, 105 (or 45%) fall within the two Local Drug Task Force areas. These projects were almost evenly distributed across the two areas with 53 falling within the catchment area of the Dun Laoghaire Rathdown LDTF, and 52 in the catchment area of the Bray LDTF.

When considered from the perspective of the three groupings to which the scoping document was sent, the figures break down as follows:

Drug Specific

Fifteen (52%) of the twenty-nine drug specific services which received the scoping document were in the catchment area of one of the two Local Drug Task Forces. Nine of these were in the Dun Laoghaire Rathdown LDTF area and 6 were in the Bray DTF area.

At Risk

Fifty (55%) of the at risk initiatives which received the scoping document were in the catchment area of one of the two Local Drug Task Forces. Twenty-nine of these were in the Dun Laoghaire Rathdown LDTF area and 21 were in the Bray DTF area.

General

Thirty-seven (32%) of the at risk initiatives which received the scoping document were in the catchment area of one of the two Local Drug Task Forces. Twenty-three of these were in the Bray DTF area and 14 were in the Dun Laoghaire Rathdown LDTF area.

Drug Specific Initiatives

The survey questionnaire was returned by 24 out of the 29 drug specific initiatives in the survey population. This represents a response rate of 82% which is significantly higher than would normally be expected of a postal survey and means that responses can be taken as broadly representative of the survey population. However it is important when analysing the results of this study to note that 9 of the returned questionnaires related to the same organisation Community Awareness of Drugs but pertained to the different services they provide. When these are taken as one initiative, the response rate is substantially lower at 43% but this is nonetheless a very positive response rate.

Reports from CAD indicate that although some of the services provided by them did not involve individuals or organisations from the ECRDTF area in 2004, these services are open to all. The questionnaires returned pertained to nine different service areas one of which may have been provided to individuals from the area but records regarding this are unavailable, and three of which were directly provided to individuals/ organisations from the ECRDTF area, as follows:

- Inter-Agency Project Advisory Group – includes a representative from the ECAHB Drug Education Officers

- Parenting for Prevention Programme - During 2004 one session of this six-session programme was delivered in the ECAHB area, but was postponed due to ill health after the third week. Several parents from Arklow attended a programme run in Gorey.

- Parenting for Prevention Booster Day – run in October 2004 with 27 out of the 108 participants coming from the ECAHB area

- Advisory & Referral Service – The telephone number/website is listed in a number of directories and calls are received from all over Ireland. There is currently no breakdown of calls/emails by area available.

- Drug Education and Training for the Community & Voluntary Sector (2 day programme) – the training planned for 2004 was cancelled

- Drug Education and Training for the Community & Voluntary Sector (1 day programme) – although this is open to organisations from all areas, no one from the ECAHB area attended the last programme

- Support for Drug Prevention and Awareness Groups – there were no requests for training from the ECAHB area in 2004

- Drug Awareness Presentation for Adults – no presentations have been run in the last 12 months

- In House Tailored Drug Education and Training for Adults – no training programmes were run in the ECAHB area in 2004 but CAD are in negotiations with two organisations with regard to training in 2005

Since all services are open to those residing or working within the ECAHB area these questionnaires were analysed separately to ensure that as accurate a picture of available services was reflected in the report, however for the purposes of some questions particularly those pertaining to organisational issues, the 9 CAD responses were taken as one response.

Legal Status

When the 9 questionnaires returned by CAD are considered as one 11 of the 15 individual drug specific initiatives who took part in the survey were constituted as legal bodies while three were not.

Location

The CAD initiatives were taken as one therefore the number of initiatives reported on in this section is 15. The highest concentration of drug specific initiatives was in the Bray area (4) with Dun Laoghaire (3) and Arklow (2) representing the next highest concentrations among those who returned the questionnaire (Table 1.1). This represents a limited geographical spread with three of the initiatives falling outside the catchment area of the ECRDTF. Major centers within the ECRDTF area were not represented in the sample.

Table 1.1 Location of Drug Specific Initiatives

Location	Number
Bray 4	
Dun Laoghaire	3
Arklow	2
Dublin 2	1 (9 CAD)
Sallynoggin	1
Drumcondra (D 9)	1
Navan Road (D 15)	1
Wicklow Town	1
Greystones	1
Dalkey	1

Function

Respondents were asked to outline the function of their organisation. The majority of initiatives stated that their function was solely running drug education/ training programmes (10). Other initiatives outlined differing functions which have been grouped under a number of headings to aid analysis (Table 1.2).

Table 1.2 Function

Function	Number
Drug education/ training programmes	10
Information	2
Education related to prevention	2
Treatment	2
Initiatives focusing on legal aspects	2
Accreditation of addiction counsellors	1
Prevention, rehabilitation and reintegration	1
Promote a positive response to the use of illegal drugs among travelling young people	1
Support prevention initiatives in the area	1
Comprehensive addiction service	1
Address the drug problem in the area	1

For the two respondents that gave information as their function this related to spreading the message of recovery and raising awareness of drug issues in the community respectively. Those who mentioned education related to prevention specifically wrote about a substance misuse prevention training course and, more generally, education/ prevention. The treatment related responses were taking a non-medical approach towards treating alcohol and other drug problems and, more generally, treatment and rehabilitation. Legally based responses came from the Gardai (prevention and detection of crime) and the Customs and Excise service (prevention, detection, interception and seizure of drugs which are smuggled).

Sector/ Partnership

Most respondents came from the voluntary sector (15 which includes the 9 CAD respondents), five statutory bodies responded to the survey and a further three reported that they were community-based.

When the 9 CAD responses are taken together as one, results indicate that the majority of drug specific initiatives in the survey were interagency initiatives (9) with 6 stating that they were not. However when it came to listing partners in these interagency initiatives, some of those who indicated that they were not interagency also listed partners so the figures presented are somewhat skewed.

Table 1.3 lists the partners named by the different initiatives which came from a broad range of areas. This range is encouraging as it indicates a level of interest in drug related issues by many diverse groups not all of whom would be expected to have an involvement in this area.

As can be seen from Table 1.3 the East Coast Area Health Board had involvement in 3 different named initiatives, while Bray Youth Service and the Probation and Welfare Service were mentioned as partners by 2 initiatives each. Two more said that they had a variety of relevant community and state agencies of partners.

Respondents who had partnership arrangements were asked to state the type of partnership they were involved in. Some respondents who reported that they were not interagency projects answered this question also. The majority of respondents said that their partnership was arranged as a Network (9, 37%), two each said that their arrangement was co-ordination and collaboration while one reported that their partnership arrangement was based on co-operation.

Table 1.3 Partners

Partner	Number
East Coast Area Health Board	3
Bray Youth Service	2
Probation & Welfare Service	2
Relevant Community and State Agencies	2
SPHE Support Services (Post Primary)	1
Education (unspecified)	1
Home School Liaison Service	1
School Completion Programme	1
Youth Reach	1
AONTAS	1
Bray Drugs Awareness Forum	1
Cross Care Drugs Awareness Programme	1
Narcotics Anonymous/ Alcoholics Anonymous	1
Pavee Point	1
Wicklow Travellers	1
Arklow Community Enterprise	1
Arklow Healthy Towns	1
Bray Area Partnership	1
Walk Tall Support Services	1
Youth Workers (service unspecified) Education Officers from the 3 Eastern Region	1
Health Authorities/ Health Boards	1
Gardai	1
Doctors	1
FAS	1
Homeless Agency	1

Purpose of the Initiative/ Service

When asked to state the purpose of their initiative/ service most respondents listed more than one main purpose and responses were wide-ranging and varied. In order to extract meaningful information from the wide range of data presented, where possible responses have been grouped into broad types (Table 1.4). The highest number of responses made regarding purpose fell into the broad category of drug education/ training (10 respondents). Five respondents each mentioned raising awareness of drug issues and encouraging or referring clients into care or the most appropriate services for them. This was followed by helping each other to stay clean/ providing support (4) and training or accrediting drug workers/ counsellors (3).

Other responses which did not fall into these groupings and were given by single respondents included long distance support for community based groups, highlight issues related to drugs in the area, assertiveness programmes, prevention, to foster prevention initiatives through grant aid, and to develop contact with as many drug users as possible. One respondent said that this question did not apply to them.

Table 1.4 Purpose

Purpose	Number
Drug Education/ Training	10
Drug Awareness	5
Encourage/ Refer Clients to care/ appropriate services	5
Help stay clean/ support	4
Train Drug Trainers/ Accredit Drug Counsellors/ Workers	3
Provide comprehensive services/ integrated response to drug problem	2
Reduce the availability of illicit drugs/ protection for the community (crime perspective)	2
Enable people to make informed choices regarding drug use	2

Objectives

When asked to outline the objectives of their initiative, most respondents outlined a number of objectives and the types of objectives listed were many and varied. Again broad categories have been used to group response types to aid analysis (Table 1.5). Drug education/ training was the most frequently mentioned objective (11 respondents). Law enforcement objectives were mentioned on seven occasions and included such matters as enforcing the law in relation to drugs, investigating crime in general, responding to emergencies, improving road safety and improving state security. Awareness raising was mentioned as an objective on 6 occasions while training for drug workers/ staff and support/ counselling/ providing a key worker service were each mentioned 4 times. Objectives which were mentioned three times each were working in collaboration with other agencies and the provision of information regarding drugs/ drug related issues.

Table 1.5 Objectives

Objectives	Number
Drug education/ training	11
Law enforcement (drugs and general)	7
Awareness raising	6
Training for Drug workers/ staff	4
Support/ counselling/ key worker service	4
Work in collaboration with other agencies	3
Information	3
Support/ assist with development of local drug awareness groups	2
Prevention programmes	2
Provide/ improve treatment services	2
Referral to appropriate services	2
Provide info on substance use in area	2
Drop in service	2
Support the aims of health promotion related strategies	2

The Provision of support/ assistance with the development of local drug awareness groups, prevention programmes, providing/ improving treatment services, referral to services, the provision of information on substance use in the area, a drop in service and supporting the aims of health promotion strategies were all mentioned as objectives on two occasions each. One respondent said that the question did not apply to them.

Drug Strategy Pillar

Respondents were asked to indicate which pillar of the National Drugs Strategy their initiative/ project related to. As outlined in Table 1.6 the majority of initiatives said that their initiative/ project related to the Prevention pillar (87%) with the next highest number indicating the Education pillar (83%). The Rehabilitation pillar was indicated by a quarter of respondents (6) while 4 respondents (17%) each mentioned Research and Supply Reduction as the pillars that their initiative/ project related to. The Treatment pillar was relevant to the least number of respondents (3, 12%).

Table 1.6 National Drugs Strategy Pillar

Pillar	Number	Percentage
Prevention	21	87
Education	20	83
Rehabilitation	6	25
Research	4	17
Supply Reduction	4	17
Treatment	3	12

Demographic Details of Target Groups

Respondents were asked to indicate what age group their services were aimed at. One respondent did not indicate an age group and another said that this question was not applicable to them. Ten of the respondents in this survey reported that the target group for their service was adults or people over the age of 18 years. Eight initiatives indicated that their service was open to all regardless of age. Table 1.7 outlines the above and age groups targeted by other single initiatives.

Table 1.7 Age Group

Age Group	Number
Adults/ over 18	10
Open to all regardless of age	8
Young people (age not specified)	1
10 – 12 years	1
9 – 14 years	1
7 – 25 years	1
Not applicable	1

Twenty-three out of the twenty-four responses indicated that their service was open to both males and females while the remaining one did not answer.

Only three respondents indicated the numbers of individuals they provide a service for. Those who did indicate numbers did not specify whether this was the number of individuals they could cater for at any one time or whether this was their annual total.

Ten respondents said that their target population was parents/ carers/ friends/ family of drug users, while 8 said that they targeted individuals working in the drug area. Five targeted people who either had a current problem with drugs/ alcohol or were at risk of developing one, 4 said that their target group was community and voluntary agencies and a further 4 said that their service was targeted at people living in the area. Two said that their target group was criminals involved in the supply of drugs or anyone involved in smuggling drugs (Table 1.8).

Table 1.8 Other demographic information relating to target group

Demographic Information	Number
Parents/ carers/ friends/ families of drug users	10
Individuals working in the drug area	8
Current problem with drugs/ alcohol or at risk	5
Community and voluntary agencies	4
People living in the area	4
Criminals involved in the supply of drugs/ anyone involved in smuggling drugs	2

Service User Involvement

As already mentioned in the limitations section of this report, the responses to this question were based on a number of different interpretations of the meaning of service user involvement. Some respondents interpreted this question to relate to the amount of service user involvement in the design and delivery of services, others took it to mean the involvement of service users in the evaluation process, while still others saw it as relating to the type of service provided to service users. Responses are reported as they were given (Table 1.9). The highest number of responses (6) related to the involvement of service users in the design and development of the service and included the responses "prior consultation" and "designed by parents for parents". A further 6 responses related to service users involvement in the evaluative process with responses in this category including "involved in evaluation", "focus groups" and "feedback sought from participants". Another response category (4 respondents) related to the participation of service users in group discussion type activities such as "group work" and "draw on the knowledge of participants on training programmes" while 4 others said that service users had their needs analysed or assessed. A further 4 respondents said that service users received an agreed action plan or care plan. Two respondents said that service users had no involvement in their service.

Table 1.9 Service User Involvement

Demographic Information	Number
Involved in design & development of service	6
Involved in evaluative process	6
Group work	4
Needs analysis/ assessment	4
Agreed action plan/ care plan	4
No involvement of service users	2

Selection Criteria and Referral Process

The results of this section of the questionnaire have been difficult to analyse because most respondents did not clearly distinguish between the selection criteria and the referral process. Most answers related to either the selection criteria or the referral process with very few providing information on both. Responses were, however, analysed based on the two categories.

There was a wide variety of selection criteria mentioned by the initiatives which returned the questionnaire most of which were specified by single respondents. By far the most common response to the question about selection criteria was that the service was demand led (7 respondents). Four respondents said that this question did not apply to them and 3 each said that their selection criteria was that the individuals taking part had to be affected by issues of drug misuse, and that they had to live in the local community. Other selection criteria mentioned by single respondents included that the individual must be nominated by the Local Drugs Task Force, that they had to choose to stay clean, that they had to be in primary school in the Local Drugs Task Force area, and that they had to be over 18 years of age. Individual respondents also said that they approach potential service users themselves, that they have an assessment process, that the individual must be eligible for a Community Employment Scheme, that they must be affected by issues of drug misuse, must be experiencing difficulties with drugs, or must be a young person who is a member of the travelling community. Still more individual responses included that they must be an area-based project addressing the needs of the target group, and that they must demonstrate the ability to deliver project objectives.

Data on the referral process was somewhat easier to analyse although this data was not supplied by every respondent. Table 1.10 outlines the main referral

methods. By far the most common referral method was self-referral (8 respondents). Six respondents said that this question did not apply to them and 3 each said that their referral method was the community and voluntary sector, statutory groups in the area (includes the Probation & Welfare Service and the ECAHB), and "anyone who is acting on behalf of the person" including family members. Two respondents said that their phone number and email are widely available and a further two said that their main method of referral was through professional groups (including GP's).

Table 1.10 Referral Process

Referral Process	Number
Self-referral	8
Not applicable	6
Community and voluntary sector	3
Statutory groups in the area	3
Anyone acting on behalf of the person/ family members	3
Our phone number and email are widely available	2
Professional groups (including GP's)	2

Methods Used by Service

When asked to outline the methods they used, once again responses were many and varied and reflect the broad nature of the question asked. In total, 44 different response types were given and these have, where possible, been grouped into broad categories to aid reporting (Table 1.11).

Table 1.11 Methods Used in Service

Method	Number
Information giving	7
Psychotherapy/ Counselling	6
Education/ training	6
Discussion/ group facilitation	4
Projects/ competitions/ quizzes	4
Support/ telephone support	3
Youth/ community work	3
Brief interventions (unspecified)	3
Drama/ role play/ games	3
Referral to appropriate agencies	3
Motivational interviewing	2
Life skills	2
Explore attitudes, beliefs and decisions regarding drug misuse	2
Health screening/ promotion	2
Arrest/ detention	2
Harm reduction/ controlled drinking	2
Not applicable	2

Seven respondents said that one of the methods they used was information giving, the next most frequently mentioned methods (6 respondents each) were psychotherapy/ counselling (including Motivational Enhancement Therapy, Solution Focused Therapy, Cognitive Behaviour Therapy, and Reality Therapy), and education/ training. Four respondents each mentioned discussion/ group facilitation and projects/ competitions/ quizzes. Methods mentioned by 3 respondents each were: support/ telephone support, youth/ community work, brief interventions (unspecified), drama/ role play/ games, and referral to appropriate agencies. Motivational interviewing, life skills, exploring attitudes, beliefs and decisions regarding drug misuse, health screening/ promotion, arrest/ detention, and harm reduction/ controlled drinking were each mentioned by 2 respondents. Two respondents said that this question did not apply to them.

Duration

Respondents interpreted the question asking them to state the duration of the initiative in a variety of ways. Some took the question to relate to the length of time their service had been in operation, while others took it to relate to the length of time a service is provided to a service user for. This difference in interpretation has made any meaningful interpretation of data gathered difficult, however, responses are reported as they were given.

Three respondents gave answers relating to the length of time their service had been in operation as follows: one was started in 1999, another in 2000 and the third in 2002.

Four respondents said that this question was not applicable to their service.

Of those who interpreted the question to relate to the length of time they engage with a service user for, four respondents said that this depended on the level of need and one said that it was ongoing. Others specified specific time periods which are outlined in Table 1.12 from the most brief to the lengthiest intervention.

Table 1.12 Duration

Duration	Number
1.5 – 2.5 hours	1
1 day	2
2 days/ 16 hours	3
Once a week for 10 weeks	1
6 weeks	1
1 year	1
Up to 3 years	1

Modules

Only 5 respondents specified modules in answer to this question. Others either indicated that the question did not apply to them (9) or left this section blank (10). This may be attributed to the fact that modules usually relate to training or educational programmes and not other types of service and therefore the question was not seen as relevant outside of this context. Of the respondents who did answer this question, three said that they run a module on “the

pharmacological aspects of drug use", a further 3 said that they cover "the impact of addiction on the individual and the family" and 3 mentioned "personal experiences of people in recovery" as a module. The harm drug use can cause to the community and in the workplace was a module covered by 1 initiative and 1 said that they had not yet decided what modules to run.

Funding Sources

Funding sources mentioned were varied with most respondents citing a number of different funding sources. The most frequently mentioned funding source was through Government Departments (24 respondents) with specific departments being mentioned as follows:

Table 1.13 Exchequer Funding Sources Specified

Exchequer Funding Source	Number
Grants from Government Departments (unspecified)	9
Core funding under the 1953 Health Act	9
Department of Education and Science	2
Exchequer funded (unspecified)	1
Department of Health and Children	1
Department of Community, Rural & Gaelteacht Affairs	1
Department of Justice, Equality, and Law Reform	1

Other statutory agencies were also mentioned and are listed with other funding sources below (Table 1.14). The Local Drugs Task Force was mentioned as a funding source by 13 respondents, while 10 said that they relied on donations (individual/ charitable/ corporate) for their funds. Nine respondents each mentioned the Home School Liaison Service, and Community Drug Teams as sources of funding. The ECAHB was listed by 4 respondents, and 2 respondents mentioned the VEC.

Table 1.14 Other Funding Sources

Funding Source	Number
Local Drugs Task Force	13
Donations	10
Home School Liaison Service	9
Community Drug Teams	9
ECAHB	4
VEC	2

Cost Per Individual

Respondents were asked to provide information regarding the cost of their initiative per individual service user. Once again this question was interpreted differently by different respondents. Some took the question to be asking what the cost to the individual was, while others took it to be asking what the cost per individual of running the service was.

Seven initiatives said that this question did not apply to them. Of those who answered the question from the point of view of the cost to the service user, 6 said that there was no cost to the individual/ group/ organisation, while 2 said that organisations using their service gave a donation. Other amounts specified as costs to service users by single respondents included €5, €10, €60 and €100. Of those who took the question to relate to the cost per individual again responses varied and all were given by single respondents and included €380, €193, €230, and €380. One respondent said that their service was sponsored by the Local Drugs Task Force.

Outcomes for the Individual

Once again responses were very varied with most responses given by small numbers of respondents. Four respondents each gave the following responses: an open attitude to those with drug related problems, Integration into the mainstream (including the community/ education/ training), raised awareness of drug prevention issues, enhanced communication on a wide range of drug prevention issues. Three respondents each listed the following outcomes: participants are helped to make informed decisions, and it is beneficial at a professional level/ the development of new skills to use in day-to-day work. User friendly information, stay clean/ relapse prevention, children have greater knowledge about drug use/ misuse, it is beneficial at a personal level, it is a stepping stone to other professional development in the drug area, and a care plan/ development plan were mentioned by 2 respondents each.

Four respondents said that this question did not apply to them and a further one said that their programme had not yet been run so they could not comment on this issue.

Evaluation

When initiatives were asked to state how their service was evaluated over a third said that they hoped to do an external evaluation at some time in the future (9). Seven respondents each said that they got feedback from service users, and that they carried out an internal evaluation. Four respondents said that this question did not apply to them and a further four said that they did not carry out any sort of evaluation. Single responses included ongoing evaluation, and an external evaluation. One respondent said that they would love to carry out an external evaluation but did not have the funding to do so.

Learning or Outcome for the Initiative

Respondents were asked to outline the learning or outcome that had been achieved for their initiative. Once again responses were many and varied with 32 different response categories given. The largest number of respondents (13) for any response category said that the service was meaningful/ valued/ worthwhile. Nine respondents said that they had learned that their initiative could be sustained over time with appropriate funding. The fact that all issues had been addressed/ the service has made a difference in the lives of service users was mentioned by 3 respondents. Two respondents each said that there is a need/ demand for more drug awareness programmes, and that there is a clear need for drug education.

Other learning points mentioned by single respondents included: that bio-psycho and social issues are addressed, local communities are empowered to look at their own drug awareness and education needs, and that the concept of traveller led and consultation is easily transferred to other marginalised groups. Individual respondents also said that: we have developed the scope of our training, networking has improved our work, we need to expand our courses to younger age groups, we achieved an 87% progression rate, there is the potential to bring the target group (young travellers) in line with the settled community, we have achieved our objectives, the project is cost effective because of capacity building, and the drug use of participants has reduced. Six respondents said that this question did not apply to them and a further one said that their project had not run yet and therefore they could not answer this question.

Key Qualifications of Staff

The qualifications of staff working in the services provided by respondents were very varied. Some respondents listed particular qualifications while others listed job titles. All are reported below (Table 1.15). The most frequently mentioned staff qualification was in the area of trainer/ tutor/ adult education (9). This was followed by volunteers (6), addiction studies (4), counselling (4), and community/ youth work (4). Three respondents mentioned facilitation skills while two each said that staff had the following qualifications: CAD course, parents in education course, Social Science/ Social Worker, outreach/ peer outreach worker, and drug education and prevention officer.

Table 1.15 Key Qualifications of Staff

Qualification	Number
Trainer/ tutor/ adult education	9
Volunteers	6
Addiction Studies	4
Counselling	4
Community/ youth work	4
Facilitation skills	3
CAD course	2
Parents in Education Course	2
Social Science/ Social Worker	2
Outreach/ peer outreach worker	2
Drug education and prevention officer	2
Professional in the drugs area	1
Rehabilitation officer	1
Professional in health promotion	1
Nurse	1
Pharmacist	1
Understanding of how to work with young people with drug issues	1
Group psychotherapy	1
GP	1
Motivational interviewing	1
Holistic therapy	1
No staff	1
Not applicable	4

At Risk Initiatives

The survey questionnaire was returned by 33 out of the 91 at risk initiatives in the survey population. This represents a response rate of 36%.

Legal Status

Twenty-five (76%) of the 33 at risk initiatives who took part in the survey were constituted as legal bodies while 6 were not.

Location

The highest concentration of at risk initiatives was in the Dun Laoghaire area (10) followed by Bray (6) and Arklow (4) (Table 2.1). The remaining spread was relatively wide and included Shankill (2), Wicklow Town (2), Drumchondra (2).

Table 2.1 Location of At Risk Initiatives

Location	Number
Dun Laoghaire	10
Bray	6
Arklow	4
Shankill	2
Wicklow Town	2
Drumchondra	2

The remaining seven locations were represented by one respondent each and they were: Baggot Street, Whitechurch (D. 16), Glenageary, Loughlinstown, Rathfarnham (D. 14), Newcastle, and Ballybrack.

Function

Respondents were asked to outline the function of their organisation. An equal number of initiatives stated that their function was education/ return to education (9), and youth work (9). Functions which were reported by 4 initiatives each included Child and Family intervention/ support, and counselling/ support while three initiatives reported their function as personal development. Two initiatives each said that their function was working with young people at risk of becoming involved in crime, supporting young people at risk of becoming marginalised, vocational/ work skills training, and drug training/ education (Table 2.2).

Table 2.2 Function

Function Number	
Education/ return to education	9
Youth work	9
Child and family intervention/ support	4
Counselling/ support	4
Personal development	3
Working with young people at risk of becoming involved in crime	2
Supporting young people at risk of becoming marginalised	2
Vocational/ work skills training	2
Drug education/ training	2

Sector/ Partnership

Most respondents came from the voluntary sector (16, 48%), 11 (33%) were community sector initiatives and the remaining 6 (18%) were statutory agencies.

Results indicate that there was an equal split between the initiatives that described themselves as interagency initiatives (16) and those that did not (16). However when it came to listing partners in these interagency initiatives, some of those who indicated that they were not interagency also listed partners so the figures presented are somewhat skewed. As expected this list was much broader and longer than that of the drug specific initiatives being representative of the range of at risk initiatives that responded to the survey.

As can be seen from Table 2.3 the VEC was the most frequently listed partner (6), with the ECAHB being the next most frequently mentioned (4). Three initiatives each mentioned FAS, and the Local Drugs Task Force while two each mentioned Faroige, and the Southside Partnership.

Other partners mentioned by one initiative each some of which can be grouped together under general headings:

Youth Agencies

- Catholic Youth Care
- Catholic Youth Council
- Dun Laoghaire Youth Information Service

Statutory Agencies

- FAS
- Northern Area Health Board
- Gardai
- Probation and Welfare Service
- Social Welfare Service

Government Departments

- Department of Justice, Equality and Law Reform
- Department of Social, Community and Family Affairs

Other initiatives mentioned by one respondent each which do not fit into the above broad categories include Crosscare, St. Anne's Parish, Wicklow Working Together Ltd., Family Support Agency, Dun Laoghaire Outreach Project, Southside Local Employment Service, Women's Aid, and Legal Aid.

Table 2.3 Partners

Partner	Number
VEC	6
ECAHB	4
FAS	3
Local Drugs Task Force	3
Faroige	2
Southside Partnership	2
Catholic Youth Care	1
Catholic Youth Council	1
Dun Laoghaire Youth Information Service	1
FAS	1
Northern Area Health Board	1
Gardai	1
Probation and Welfare Service	1
Social Welfare Service	1
Department of Justice, Equality and Law Reform	1
Department of Social, Community and Family Affairs	1
Crosscare	1
St. Anne's Parish	1
Wicklow Working Together Ltd	1
Family Support Agency	1
Dun Laoghaire Outreach Project	1
Southside Local Employment Service	1
Women's Aid	1
Legal Aid	1

Respondents who had partnership arrangements were asked to state the type of partnership they were involved in. Twenty two respondents answered this question indicating that some respondents who had already reported that they were not interagency projects answered this question also. The majority of respondents said that their partnership had a co-operative working arrangement (11), four each said that their arrangement was a network, and collaboration while three reported that their partnership arrangement was based on co-ordination.

Purpose of the Initiative/ Service

When asked to state the purpose of their initiative/ service most respondents listed more than one main purpose and responses were wide-ranging and varied. In order to extract meaningful information from the wide range of data presented, where possible responses have been grouped into broad types (Table 2.4). The highest number of responses made regarding purpose fell into the broad category of drug education (7 respondents). Five respondents mentioned involving young people in their own development. Drug support/ counselling was mentioned by 4 respondents while three each said that their purpose was to provide a range of services/ supports to people with HIV/ AIDS, provide youth work services, encourage/ foster cross project learning, and provide a family support service. Other purpose statements made by three initiatives each included education/ training, probation services, counselling, and to provide an integrated and preventative support programme to young people.

Table 2.4 Purpose

Purpose	No
Drug education	7
Involve young people in their own development	5
Drug support/ counselling	4
Provide a range of services/ supports to people with HIV/ Aids	3
Youth work services	3
Encourage/ foster cross project learning	3
Family support service	3
Education/ training	3
Probation services	3
Counselling	3
An integrated and preventative support programme to young people	3

Other responses which did not fall into these groupings and which were given by two respondents each included diverting young people who are at risk of becoming involved in crime/ marginalised, provide assistance/ support in getting a job, and promoting and respecting the rights of children.

Objectives

When asked to outline the objectives of their initiative, most respondents outlined a number of objectives and the types of objectives listed were many and varied. Again broad categories have been used to group response types to

aid analysis (Table 2.5). Support/ counselling was the most frequently mentioned objective (10 respondents). Six respondents each mentioned family support/ services to families, and education/ training regarding drugs and drug issues as an objective while four initiatives each mentioned diverting young people from crime/ anti-social behaviour, and increasing self-esteem/ personal development.

Table 2.5 Objectives

Objectives	Number
Support/ counselling	10
Family support/ services to families	6
Education/ training regarding drugs and drug issues	6
Divert young people from crime/ anti-social behaviour	4
Increase self-esteem/ personal development	4
Referral	3
Provide services/ support to people with HIV/ AIDS	2
Youth work	2
Share learning/ expertise	2
Outreach	2
Return to education/ educational guidance	2
Sex education	2
Assistance with job seeking	2
Contribute to policy	2

Three respondents stated referral as an objective while two each mentioned providing services/ support to people with HIV/ AIDS, youth work, sharing learning/ expertise, outreach, and return to education/ educational guidance. Other objectives mentioned by two initiatives each were sex education, assist with job seeking, and contribute to policy. Two respondents indicated that this question was not applicable to them.

Drug Strategy Pillar

Respondents were asked to indicate which pillar of the National Drugs Strategy their initiative/ project related to. As outlined in Table 2.6 equal numbers of initiatives said that their initiative/ project related to the Prevention pillar and the Education pillar (16 each) with the next highest number indicating the Treatment pillar (4). The Rehabilitation pillar was indicated by 3 respondents while 2 mentioned Research. Supply Reduction was not mentioned by any initiative.

Table 2.6 National Drugs Strategy Pillar

Pillar	Number
Prevention	16
Education	16
Treatment	4
Rehabilitation	3
Research	2
Supply Reduction	0

Demographic Details of Target Groups

Respondents were asked to indicate what age group their services were aimed at. Three respondents did not indicate an age group. The age ranges given by the different initiatives did not appear to follow any set pattern. The largest number of respondents reported that they catered to individuals of any age (8 respondents). Four initiatives said that they catered for the 10 – 18 year age group while three each said that they catered for the following age profiles: 15 – 20, adults/ over 18, and 12 – 18. Two said that their initiative was targeted at people in the 10 – 21 year age range. Table 2.7 outlines the above and age groups targeted by other single initiatives.

Table 2.7 Age Group

Age Group	Number
Any age	8
10 – 18 years	4
15 – 20	3
Adults/ over 18	3
12 – 18	3
10 - 21	2
Under 16 years	1
15 – 18 years	1
3 – 5 years	1
5 – 12 years	1
13 – 16 years	1
15 – 25 years	1
7 – 18 years	1

Thirty out of the thirty three respondents indicated that their service was open to both males and females, two said that they were exclusively targeted at females and one said that theirs was a male only initiative.

Only 9 respondents indicated the numbers of individuals they provide a service for. Those who did indicate numbers did not specify whether this was the number of individuals they could cater for at any one time or whether this was their annual total. Single respondents each said that they catered for 11, 15, 16, 17, 18, 30, 45, 172, and 305 individuals respectively.

Five respondents each said that their initiative catered for families/ parents, people living in the area, and early school leavers (Table 2.8). Disadvantaged people, and people at risk of alcohol/ drug misuse were mentioned by four initiatives each while three each mentioned individuals at risk of offending/ anti-social behaviour, adolescents/ young people, and people with an addiction problem/ drug users.

Table 2.8 Other demographic information relating to target group

Demographic Information	Number
Families/ parents	5
People living in the area	5
Early school leavers	5
Disadvantaged	4
People at risk of alcohol/ drug misuse	4
At risk of offending/ anti-social behaviour	3
Adolescents/ young people	3
People with an addiction problem/ drug users	3

Service User Involvement

The responses to this question were based on a number of different interpretations of the meaning of service user involvement. Some respondents interpreted this question to relate to the amount of service user involvement in the design and delivery of services, others took it to mean the involvement of service users in the evaluation process, while still others saw it as relating to the type of service provided to service users.

Responses are reported as they were given (Table 2.9). The highest number of responses (10) related to the involvement of service users in the evaluation process and included such responses as “complete evaluation forms”, “service users give feedback” and “involved in evaluation”. The next highest response category related to the involvement of service users in the planning/ design/ implementation of the service (8). A further 7 responses related to service users attendance at counselling/ therapy sessions. Another response category (5) related to the participation of service users in programmes or training and included responses such as “get training”, “attend programmes which meet their needs”, and “parenting skills training” while 3 others each said that service users get 1 – 1 consultations, and that they are consulted (the type of consultation was not specified). Two respondents each said that service users participate in group activities on a weekly basis, that they have daily contact (unspecified), and that the service runs an outreach programme.

Table 2.9 Service User Involvement

Demographic Information	Number
Involved in evaluation process	10
Involved in the planning/ design/ implementation of the service	8
Attend counselling/ therapy sessions	7
Participate in programmes/ training	5
Get 1-1 consultations	3
Are consulted	3
Participate in group activities on a weekly basis	2
Daily contact	2
We run an outreach programme	2

Selection Criteria and Referral Process

The results of this section of the questionnaire have been difficult to analyse because most respondents did not clearly distinguish between the selection criteria and the referral process. Most answers related to either the selection criteria or the referral process with very few providing information on both. Responses were, however, analysed based on the two categories.

There was a wide variety of selection criteria mentioned by the initiatives which returned the questionnaire most of which were specified by single respondents. Five respondents said that they gave priority to children who were exposed to

drugs through their family/ parents or the area they live in. The second most common response to the question about selection criteria was that the individual must be disadvantaged in some way (4 respondents). Two each said that individuals availing of their services had to be early school leavers/ out of school, that they had to be at risk of drug/ alcohol misuse, and that they had to be at risk generally or in relation to crime.

Data on referral criteria was somewhat easier to analyse although this data was not supplied by every respondent. Table 2.10 outlines the main referral methods. By far the most common referral method was self-referral/ voluntary participation (13 respondents). Nine respondents said that referrals came through voluntary and community agencies while 4 said that theirs was through the Gardai Juvenile Liaison Officers/ Probation and Welfare Service. Three initiatives each said they got their referrals from the Health Board, and from other professional bodies while two each said theirs came from family members, the courts, social workers, St. John of Gods, GP's, and home school liaison co-ordinators/ officers. A further 2 said that they had no referral criteria and were open to all.

Table 2.10 Referral Process

Referral Process	Number
Self-referral/ voluntary participation	13
Voluntary and community agencies	9
Gardai JLO's/ Probation & Welfare Service	4
Health Board	3
Other professional bodies	3
Family members	2
The courts	2
Social workers	2
St. John of Gods	2
GP's	2
Home school liaison co-ordinators/ officers	2
None/ open	2

Methods Used by Service

When asked to outline the methods they used, once again responses were many and varied and reflect the broad nature of the question asked. In total, 39 different response types were given and these have, where possible, been grouped into broad categories to aid reporting (Table 2.11).

Sixteen respondents said that one of the methods they used was psychotherapy/ counselling (including Brief Therapy, Cognitive (Behaviour) Therapy, NLP, counselling/ therapy, individual therapy, Family Therapy, and Reality Therapy. The next highest response categories which were each mentioned by 11 respondents were training, and leisure/ recreational activities (this category includes such responses as entertainment, sport, visits, recreational classes/ leisure, art/drama, and play).

Table 2.11 Methods Used in Service

Method	Number
Psychotherapy/ counselling	16
Training	11
Leisure/ recreational activities	11
Life skills/ social skills	10
Assessment	7
Support	5
Information giving	4
Motivational interviewing	3
Discussion	3
Development/ education programmes	3
Health education	2
Parenting skills	2
Youth work	2
Homework club	2
Challenge problem behaviour	2
Drugs education	2

Ten respondents said that they provide life skills/ social skills programmes (this category included personal development and confidence building). Seven respondents referred to assessment related methods and responses in this

category included skills analysis, psychometric testing, and needs identification/ assessment. Five respondents said that they provide support and 4 mentioned information giving. Three each mentioned motivational interviewing, discussion, and development/ education programmes. Health education, parenting skills, youth work, homework clubs, challenging problem behaviour, and drugs education were each mentioned by two respondents.

Duration

Respondents interpreted the question asking them to state the duration of the initiative in a variety of ways. Some took the question to relate to the length of time their service had been in operation, while others took it to relate to the length of time a service is provided to a service user for. This has made any meaningful interpretation of data gathered difficult, however, responses are reported as they were given.

Six respondents did not specify a duration. Nine said that the duration was variable or was provided for as long as it was needed and a further 9 said that it was ongoing. Two respondents said that their initiative lasted 52 weeks and one each specified three, seven, and eight week durations. One said that their initiative lasted for 16 sessions but did not specify how long a session was and one each said that their duration was one hour per week or 2 hours per week but again did not specify the number of weeks (see Table 2.12). One respondent answered by referring to the length of time their service had been in operation and stated that it had been in place since 2002.

Table 2.12 Duration

Duration	Number
No duration specified	5
Variable/ as long as needed	9
Ongoing	9
52 weeks	2
8 weeks	1
7 weeks	1
3 weeks	1
16 sessions	1
1 hour per week	1
2 hours per week	1

Modules

Only 8 respondents specified modules in answer to this question. The remaining 25 left this section blank. This may be attributed to the fact that modules usually relate to training or educational programmes and not other types of service and therefore the question was not seen as relevant outside of this context. Of the respondents who did answer this question, 7 said that they run modules in recreational/ leisure activities including drama/ art, play, dance, and sport/ leisure. Six initiatives run life skills modules and 5 carry out training/ educational activities including CSPE, health education, parent training and the general category of education/ training. Three respondents said that their modules include drug awareness/ managing drug related issues and a further 2 ran modules on relapse prevention/ prevention and education strategies. Single initiatives mentioned addiction studies, youth club, and a summer project.

Funding Sources

Funding sources mentioned were varied with most respondents citing a number of different funding sources. The most frequently mentioned funding sources each cited by 13 respondents were the Local Drugs Task Force, and a variety of Health Boards or representatives of such (this response category included the NAHB (2), ECAHB (8), EHB (1), ERHA (1), and the Director of Community Care (1)).

Ten respondents said that their funding came from the VEC and a further 8 said they were funded by a variety of different Government Departments

(Department of Education & Science (1), Department of Justice, Equality and Law Reform (4), Department of Community, Rural, and Gaelteacht Affairs (1), and Department of Social, Community and Family Affairs (2)) (See Table 1.13). Five relied on their own funds/ fundraising activities while 4 said they got funding from FAS. Two initiatives each mentioned the following funding sources: school completion programme, weekly subscription from members, donation/ contribution from service users/ families, Young Persons Facilities and Services Fund, the Probation and Welfare Service.

Table 2.13 Funding Sources

Funding Source	Number
Local Drugs Task Force	13
Health Boards	13
VEC	10
Government Departments	8
Own funds/ fundraising activities	5
FAS	4
School completion programme	2
Weekly subscription from members	2
Donation/ contribution from service users/ families	2
YPFSF	2
Probation & Welfare Service	2

Cost Per Individual

Respondents were asked to provide information regarding the cost of their initiative per individual service user. Once again this question was interpreted in different ways by respondents. Some took the question to be asking what the cost to the individual was, others gave the total cost of running their service, while still others took it to be asking what the cost per individual of running the service was.

Seven initiatives did not answer this question and three said that this question did not apply to them. Of those who answered the question from the point of view of the cost to the service user, 9 said that there was no cost to the individual/ group/ organisation, while 3 said that the cost was unknown. Single respondents said that the cost depends on the programme, and that individuals

make a donation. One initiative said that the cost to the service user was € 1.50 per week. Other costs to service users specified by single respondents included € 15, € 30, and € 40. Other single respondents gave figures such as € 400, € 580, € 900 and € 2,409 but it was unclear whether this was the cost to the service user or the cost per service user. One initiative said that it cost € 31,000 per annum to run their service.

Outcomes for the Individual

Once again responses were very varied with most responses given by small numbers of respondents. There were a total of 46 different response categories which have been grouped to aid analysis.

Eight respondents said that individuals benefit from the point of view of personal development issues (including being more confident/ improved self esteem, knowing how to voice their opinion, personal development, more responsible) (Table 2.14). Seven respondents each said that individuals were integrated into mainstream employment/ education/ training, and that the lives of children were improved (responses in this category included children are involved in appropriate social networks, children feel safe, secure and cared for, children reach their educational potential, children receive the services they need, and there is a reduction in the number of children going into care). Five respondents said that individuals are more aware/ knowledgeable regarding drug issues (responses in this category included more aware regarding drug issues, have explored issues around addiction and coming off drugs, and helped maintain a drug free lifestyle). Four respondents each said that they impacted on the parenting skills of participants (parents better equipped as parents, improved parenting skills, better parent child relationships), and that they could avail of a supported environment/ support structures. Three respondents said that outcomes for their service users included individual action plans. Other responses given by 2 respondents each included having stabilised, gaining a FETAC certificate, a reduction in their contact with the law/ offending behaviour, policy development, professionals are better at their drug related work (including the ability to facilitate drug awareness programmes), parents are more aware (of signs and symptoms and of support services available), better coping skills and increased awareness (unspecified).

Table 2.14 Outcomes for the Individual

Outcome for the Individual	Number
Personal development	8
Integrated into mainstream employment/education/training	7
Lives of children improved	7
More aware/ knowledgeable regarding drug issues	5
Improved parenting skills	4
Supportive environment/ support structures	4
Individual action plans	3
Stabilised	2
FETAC Certificate	2
Reduction in contact with law/ offending behaviour	2
Policy development	2
Professionals better at their drug related work	2
Parents more aware	2
Better coping skills	2
Increased awareness (unspecified)	2

Evaluation

When initiatives were asked to state how their service was evaluated 9 respondents said that they did external evaluations, 6 said that ran consultation/ question and answer sessions with service users, and 5 said that they gave questionnaires to trainees. Four respondents said that they carried out internal/ self-evaluations while 3 each said that they carried out evaluations (type not specified), and that they got feedback on the training they ran (but again did not specify how this feedback was obtained). Two initiatives said that they carry out regular reviews of service user progress. Single responses included observation of participant behaviour, social benefits audit with all stakeholders, quantitative and qualitative analysis, keep within budget, and renewal of contract by FAS. Three initiatives reported that evaluations have not yet taken place.

Learning or Outcome for the Initiative

Respondents were asked to outline the learning or outcome that had been achieved for their initiative. Twenty out of the 33 respondents replied to this question. Once again responses were many and varied with 32 different response categories given and most responses given by single respondents. The largest number of respondents (8) for any response category said that the service was meaningful/ worthwhile/ works well. Seven initiatives gave responses which referred to improvements in the lives of service users and have been categorised as such (individual responses in this category included "improvement in trainees outlook on life" (1), "improved self esteem of trainees" (1), "trainees better able to deal with peer pressure" (1), "has changed the behaviour of trainees" (1), "the positive effect on service users is visible" (2), and "there have been reduced levels of offending" (1). Four respondents reported that they had learned that their project is sustainable while 3 referred to the need for staff training with the responses "training of staff is essential" and "staff need more training". The fact that the initiative has the biggest waiting list in the city/ is sought after in the community was mentioned by 2 respondents.

Other learning points mentioned by single respondents included: that the initiative could sustain 1 session per week of drug education, that it is possible to run an age appropriate programme on drug misuse for children, research pays off, counselling helps identify the issues underlying addiction, and that progression routes have been established for clients. Other single respondents said that the club addresses many of the issues of members, we need to constantly revise/ update the programme, we need to become more

professional in our approach, we struggle with a poor volunteer support network, addiction is not tolerated in communities, and our data collection methods help us to identify cause and effect in clients lives. Other single initiatives said that they are developing a strategy for working with young people at risk, that applied psychology can make a measurable difference, collaborative mainstreaming is required to sustain the project, we have developed a model of good practice, and we work with the highest numbers of adolescents using drugs and homeless. Individual respondents also said that they have learned that their programme can be extended to other areas, that each initiative is vital to the overall outcome, and that clients need placement in appropriate treatment.

Key Qualifications of Staff

The qualifications of staff working in the services provided by respondents were very varied. Three of those who returned the questionnaire did not supply details of staff qualifications, some of those who did listed particular qualifications while others listed job titles. All are listed below (Table 2.15). The qualification mentioned by the largest number of respondents (10) has been categorised as psychotherapy/ counselling and includes such qualifications as certificate in Reality Therapy, post grad. in Psychoanalysis, certificate in Art Therapy, Diploma in Counselling and Psychotherapy, Certificate in Bereavement Counselling, Family Therapy, and counselling training (unspecified). Volunteers made up the next most frequently mentioned staff qualification (7) along with co-ordinator/ manager (7). Five respondents each mentioned diploma/ certificate in Addiction Studies, Psychology Degree (including BA/BSc, Clinical M.A., and M.A. in Work and Organisational Psychology). Four mentioned drugs/ AIDS skills but did not specify what these were. Three each said staff had qualifications in nursing, and a certificate/ diploma in Youth and Community Work. Social work, housing skills, Masters in Social Policy, youth worker, child protection and guidance, and ECDL/ Administration qualifications were each mentioned by two respondents.

Table 2.15 Key Qualifications of Staff

Qualification	Number
Psychotherapy/ counselling	10
Volunteers	7
Co-ordinator/ manager	7
Diploma/ certificate in Addiction Studies	5
Psychology Degree	5
Drugs/ AIDS skills	4
Nursing	3
Certificate/ diploma in Youth and Community Work	3
Social work	2
Housing skills	2
Masters in Social Policy	2
Youth worker	2
Child protection and guidance	2
ECDL/ Administration qualifications	2

Other staff qualifications listed by single respondents included: CSPE trainer, psychiatrist, facilitator, literacy tutor, certificate in Addiction Counselling, outreach worker, and women's development worker. Single respondents also mentioned MSc/ HDip in Adult and Community Education, Faroige leadership training, arts officer, SAP/ SSP, CE workers, family worker, researcher, business diploma, play officer, and childcare worker. MSc in Drug and Alcohol Policy, support worker, certificate in health promotion, diploma in Special Needs Teaching, Mediation Studies, Marte Meo method, supervisor training, National Diploma in Personnel Management, and Acupuncture were each mentioned by one respondent.

General Initiatives

The scoping questionnaire was also sent to 115 general initiatives in the area. This questionnaire was one page long and asked two main questions the responses to which are outlined below along with additional comments made by some respondents. A total of 38 general initiatives returned the questionnaire representing a response rate of 33%.

Location

The geographical spread of the initiatives who responded to the survey was wide stretching from Carlow to Capel Street (Dublin 1). Table 3.1 outlines the areas represented by respondents. By far the highest concentration of respondents was in the Bray area (9), followed by Arklow (6).

Table 3.1 Location

Location	Number
Bray	9
Arklow	6
Wicklow Town	5
Dun Laoghaire	4
Greystones	2
Kilcoole	2
Loughlinstown	2
Capel Street (D. 1)	1
Dundrum	1
Avoca	1
Newtownmountkennedy	1
Laragh/ Glendalough	1
Co. Carlow (Hacketstown)	1
Eniskerry	1
County Wicklow	1
Newcastle	1

Five respondents came from Wicklow Town and 4 from Dun Laoghaire. Two respondents were from each of the following areas: Greystones, Kilcoole, and Loughlinstown.

Function

When asked to state their function, most respondents cited a number of different functions resulting in a broad range of response categories. There were 69 response categories in all which have been grouped where possible to aid analysis. The most common response was training/ education (13 respondents) this generic response was not grouped with other training or education responses as these related more specifically to particular courses. This was followed by information/ advice (11 respondents) and a group of responses which have been categorised as services to the community (9) and which include the responses: community services (2), free legal aid service (1), financial/ money advice (3), and library (1). Seven respondents each mentioned social/ cultural/ leisure activities, responses which have been grouped as training/education in specific skills (including: parenting/ childcare courses, volunteer tutor training programmes, tourism education, computer courses, Safe Pass/ health and safety courses), and services to people with disabilities (this category includes the following responses: service for adults with learning disability, employment for people with learning disability, voluntary service for people with physical disabilities, respite services for people with disabilities and their carers, promote positive mental health, and support those with mental health problems, their families and friends). Five respondents said that they were involved in local authority type functions including trying to improve the village lay out and development, local authority functions for example housing, roads, and drains, work with the Council regarding environmental and housing issues, hazardous waste collection, and estate management.

Four respondents each said that they provide adult career and educational guidance and referral services, and facilitate the involvement of/ represent the interests of disadvantaged groups at policy level (including the responses: represent the interests of disadvantaged communities in local decision making processes, lobby for resources to address social exclusion, facilitate the involvement of disadvantaged communities in policy making). Three said that they provide specific types of education including literacy, second chance education for adults, and family learning programmes. A further 3 respondents said that they provide services for women such as employment for women both traveller and settled, a women's support group, and enable women to reach their full potential. Three further initiatives each said that they provide advocacy services, and playgroups/ pre-schools.

Table 3.2 Function

Function	Number
Training/ education	13
Information/ advice	11
Services to the community	9
Social/ cultural/ leisure activities	7
Training/ education in specific skills	7
Services to people with disabilities	7
Local authority type functions	5
Adult career & educational guidance & referral services	4
Facilitate the involvement of/ represent the interests	
of disadvantaged groups at policy level	4
Specific types of education	3
Services for women	3
Advocacy	3
Playgroup/ pre-school	3

Two respondents each said that they provide services for offenders in the community, outreach, promote and resource local development activity, youth work, a low cost service for the disadvantaged, a homework club, personal care/ assistance. Single respondents mentioned assisting asylum seekers to integrate, providing emotional and practical support for victims of crime, visiting families, run a group programme for men who are violent/ abuse domestically, support children at home and in school, and run a resource center for the gay, lesbian, transsexual and bisexual community. Other single respondents said that they provide the following services: focus on key target groups (disadvantaged), ran a drug awareness week, prevent early school leaving, provide care, community development, refer at risk children to the appropriate service, counselling, summer projects, and an active retirement group.

Additional Comments

Fifteen of the 38 initiatives that responded to the survey made additional comments most of which were made by single initiatives. The only comment to be made by more than one respondent (3) was that the particular initiative has no involvement in the drugs area. Some of the other single responses related to additional services run by the initiative which they had not previously listed such as “we also run a mother and toddlers group”, “we run an alcohol and

offending behaviour programme", and "we can provide additional courses on request". Others referred to the broader function of the organisation/ initiative such as "we are an umbrella organisation and also responsible for policy making", "we have a youth sub-group", "we have 33 member organisations throughout Wicklow", and "substance misusers are one of our target groups". Single initiatives also made comments on funding such as "some courses are funded by FAS" and the Council allocate € 25,000 to spend on projects". Other single responses included "if our clients need support regarding drug issues we would get the appropriate help", "we played a key role in the development of the Local Drugs Task Force", "we would like to know more about the Regional Drugs Task Force and how we might help", "we are looking to find different groups to see what training they need", and "we would like someone to talk to a group of young people about drugs".

Discussion

Drug Specific Initiatives

The survey questionnaire was returned by 24 out of the 29 drug specific initiatives in the survey population. This represents a response rate of 82% which is significantly higher than would normally be expected from a postal survey and means that responses can be taken as broadly representative of the survey population. It is important when analysing the results of this study to note that 9 of the returned questionnaires related to the same organisation Community Awareness of Drugs but pertained to the different services they provide. These questionnaires were analysed separately to ensure that as accurate a picture of available services was reflected in the report.

Results of this survey (Table 1.1) represent a limited geographical spread with three of the initiatives falling outside the catchment area of the ECRDTF. Major centers within the ECRDTF area were not represented in the sample. It is therefore difficult to draw any conclusions regarding the scope and breadth of drug specific initiatives in the area covered by the ECRDTF. The highest concentration of drug specific initiatives was in the Bray area with Dun Laoghaire and Arklow representing the next highest concentrations among those who returned the questionnaire.

When the 9 questionnaires returned by CAD are considered as one the majority (11) of the 15 individual drug specific initiatives who took part in the survey were constituted as legal bodies. Most respondents came from the voluntary sector (6 which includes the 9 CAD respondents as one), five statutory bodies responded to the survey and a further three reported that they were community-based. This highlights the importance of the voluntary and community sector in tackling the drug problem. The allocation of funds to this sector is essential if problems are to be dealt with on the ground where they can be most effective. However, the use of these funds needs to be carefully monitored to ensure that there is no unnecessary duplication of services (as there would appear to be from this survey) and that any initiative seeking funding does so on the basis of research which has clearly established a need for the service they provide, and on evidence that the approach they are proposing can meet this need.

There would appear to be to be an over representation of education based initiatives in the area compared to initiatives carrying out other functions as

most reported that their function was running drug education/ training programmes (Table 1.2). When these results are taken together with reports of the relationship between initiatives and the different pillars of the National Drugs Strategy it is clear that much of this education has a preventative purpose. The remaining pillars were under represented in the sample with few saying they were involved in any of the other activities (Table 1.6). Only three respondents said that they were engaged in treatment. This may be because many of those seeking treatment avail of services outside the catchment area such as Merchants Quay or the Rutland Center, or it may be that there is a lack of treatment facilities in the ECRDTF area. Again this is difficult to ascertain from the results of this survey. This coupled with the low number of respondents reporting that they offered rehabilitation needs further consideration if the drug problem in the area is to be addressed in a comprehensive way taking into account local needs and difficulties.

While extensive research is carried out by the NACD, this pertains, in general to the National picture. Research regarding drug issues in local areas is scant. The numbers of respondents reporting involvement in research-based activities in this survey was small (4) further underlining the need for localised data collection. If resources to tackle the drug problem throughout the country, and more specifically in the ECRDTF area are to be properly allocated, then well-conducted, locally based research into the problem is essential. This is even more relevant in an area as wide and diverse as that covered by the ECRDTF. This research should not only focus on the nature and extent of the problem, but should assess the success or otherwise of initiatives that are currently in place. The issue of research is a complex one, locally based research is best carried out on the ground by community groups and local service providers. However, there is a general lack of funding available for research (although some grant aid is available through the NCAD and the Health Research Board) which needs to be addressed. Although it was not covered by the scoping document, the knowledge base, and research expertise of local services wishing to carry out research must be taken into consideration and adequate supports provided for their research activities.

When asked to list the purpose and objectives of their initiative/ service most respondents listed more than one main purpose and several objectives and responses were wide-ranging and varied (Table 1.4). In order to extract meaningful information from the wide range of data presented, where possible responses were grouped into broad types. The highest number of responses

made regarding both purpose and objectives once again fell into the broad category of drug education/ training.

When compared to the pillars of the National Drugs Strategy the recorded responses again show an over representation of drug education/ training based initiatives. Few initiatives stated that their purpose or objective was prevention although many said that their initiative related to this pillar of the National Drug Strategy. This may in some part be explained by the similarity in numbers who said that they targeted the education and the prevention pillar. Education and prevention may be seen by respondents as one in the same thing with the content of educational programmes aiming at prevention.

The dearth of treatment, rehabilitation and research purposes and objectives stated is a matter of concern in particular when this is considered in proportion to the relatively high number of education initiatives. These results represent a narrow perspective which will need to be widened if the drug problem in the area is to be addressed in any comprehensive or coherent way by the ECRDTF.

When asked to outline the methods they used, once again responses were many and varied and reflect the broad nature of the question asked (Table 1.11). The highest number of responses in this section fell into the category information giving; the next most frequently mentioned methods were psychotherapy/ counselling, and education/ training. One would assume that psychotherapy/ counselling which is listed as a method by a drug specific initiative would be considered rehabilitative or preventative, however this is not reflected in other results from this survey. Counselling has a long tradition in the addiction area and as such is widely used. The ERHA has recently carried out a review of counselling in regard to addiction within the Health Boards. When projects are being assessed as providing counselling this review needs to be taken into account along with recognised qualifications and membership of professional bodies.

There would appear to be a good deal of interagency and co-operative work among respondents in the area. Results indicate that the majority of drug specific initiatives in the survey were interagency initiatives. However the nature of this working arrangement was not explored in any detail so it is difficult to draw any conclusions on the extent and nature of the co-operation or the benefits of this interagency work.

When it came to listing partners in these interagency initiatives, some of those who indicated that they were not interagency projects also listed partners so the figures presented are somewhat skewed. The partners named by the different initiatives came from a broad range of areas (Table 1.3). This range is encouraging as it indicates a level of interest in drug related issues by many diverse groups not all of whom would be expected to have an involvement in this area.

The ECAHB was listed as a partner in only 3 initiatives, this is surprising considering the relationship between health and drugs, however it is less surprising in the light of the finding that most respondents were involved in drug education/ training. The fact that the Area Partnership was only mentioned by one respondent when partners was being listed also merits consideration as they have a mandate to work with all disadvantaged groups in a variety of ways and drug related issues are firmly on their agenda. However, their indirect involvement in establishing local committees and groups such as Local Drug Task Forces may not be reflected in this study based on the questions asked in the scoping document. This questionnaire only asked about direct involvement in project activities and this must be taken into account when interpreting results.

Respondents who had partnership arrangements were asked to state the type of partnership they were involved in. Some respondents who reported that they were not interagency projects answered this question also. The majority of respondents said that their partnership was arranged as a Network (9, 37%), two each said that their arrangement was co-ordination and collaboration while one reported that their partnership arrangement was based on co-operation. Once again there was not enough detail requested on the questionnaire about the nature of these working arrangements to speak to their usefulness.

The majority of drug specific initiatives in place were targeted at adults/ those over 18 years of age although initiatives did cater for people from the age of 7 years (Table 1.7). Anecdotal evidence would suggest that the age of first drug use is decreasing therefore it would be important that any new initiatives, particularly those which are prevention based are targeted at an age group with whom they can have most impact.

Results from this survey make it difficult to ascertain the number of individuals catered for by the drug specific initiatives in the area. Only three respondents

indicated the numbers of individuals they provide a service for. Those who did indicate numbers did not specify whether this was the number of individuals they could cater for at any one time or whether this was their annual total.

The low number of respondents stating that they targeted individuals with current drug/ alcohol problems reflects the preponderance of education-based initiatives and the small number of treatment and rehabilitation initiatives in the area (Table 1.8). It could be argued that initiatives that work with families and friends of drug users have the potential to impact on the drug problem in the area. However evidence suggests that this is not as effective as targeting the individuals themselves since it is they and only they who can make the decision to stop misusing drugs. While running initiatives aimed at families and friends is useful, they should not take the place of or outnumber initiatives targeted at individual drug users themselves.

When asked to state their selection criteria and referral process respondents did not clearly distinguish between the two. Most answers related to either the selection criteria or the referral process with very few providing information on both. Responses were, however, analysed based on the two categories.

There was a wide variety of selection criteria mentioned by the initiatives which returned the questionnaire most of which were specified by single respondents. By far the most common response to the question about selection criteria was that the service was demand led (7 respondents). Four respondents said that this question did not apply to them and 3 each said that their selection criteria was that the individuals taking part had to be affected by issues of drug misuse, and that they had to live in the local community. It is clear from these results that the initiatives run by respondents have flexible and open selection criteria. This may be seen in either a positive or a negative light. It is positive from the point of view of providing open access to all, however such open access may result in valuable places on programmes being allocated to individuals on an ad hoc basis and not to those most in need or to those whose needs can be best catered for by the initiative in question. If initiatives are set up based on sound research which has established an area of need, and on evidence that the approach taken can meet these needs, then their selection criteria should reflect this. So, while open access is useful for some initiatives, others should be targeted at very specific areas of need and therefore should apply more stringent selection criteria.

Data on the referral process indicates that self-referral is the most common referral method (Table 1.10). A relatively high number of respondents said that this question did not apply to them but it is unclear as to the reason for this. It could be that they have no formal referral process or possibly that they do not take referrals as their service does not cater for individual clients but for organisations. Only one initiative listed the Local Drugs Task Force as a referral source. This issue should be considered further but may again reflect the high number of education/ training initiatives and the small number of initiatives targeted specifically at those with a current or potential drug problem themselves which might seek referrals from other sources.

Funding sources mentioned were varied with most respondents citing a number of different funding sources (Table 1.13). The most frequently mentioned funding source was through Government Departments (24 respondents) with funding from the Department of Health and Children featuring highly as expected. The Local Drugs Task Force was also listed as a funding source by over half of those who responded to the survey. The fact that 10 initiatives relied on donations to fund or part fund their initiatives reflects the patchy nature of funding in the drugs area. Resources are scarce and the wide range of funding sources named by respondents, most of whom were from the voluntary and community sector, and most of whom existed based on funds from more than one source, leads to a certain level of instability for these initiatives. Concerns about funding or the need to re-secure funding on an ongoing basis can often overshadow the day to day work carried out by initiatives which affects their ability to cater to the needs of service users in a meaningful way.

When respondents were asked to comment on the outcome of their initiative for those who take part, responses were very varied with most responses given by small numbers. Most response categories were vague and some did not relate to outcomes for service users. When asked to outline the learning or outcome that had been achieved for the initiative responses were once again scattered with 32 different response categories given. The largest number of respondents (13) for any response category said that the service was meaningful/ valued/ worthwhile. The lack of very specific details regarding outcomes for the initiative or the individual may reflect the poor level of evaluation reported by most initiatives. Services are monitored through their service plans, and evidence from this survey would suggest that projects would welcome evaluation of their effectiveness and efficiency however funding for evaluation activities is not always readily available to them.

When they were asked to state how their service was evaluated over a third said that they hoped to do an external evaluation at some time in the future indicating that this had not yet occurred. Seven respondents each said that they got feedback from service users, and that they carried out an internal evaluation. Four respondents said that this question did not apply to them and a further four said that they did not carry out any sort of evaluation. One respondent said that they would love to carry out an external evaluation but did not have the funding to do so.

The role of evaluation in any initiative cannot be overstated. As already stated, when resources are scarce, it is important that they are targeted where they can do most good. It is often the case that initiatives continue to be funded on an ongoing or even a year-to-year basis as a matter of course rather than based on any evidence of their effectiveness as ascertained through an evaluative process. Evaluation is essential if the most and least effective aspects of any successful service are to be ascertained in order that they can be further tailored to meet the needs of the target group. Ongoing evaluation the results of which are compared to research carried out on the needs of target groups can be used to ensure that initiatives are still relevant and that the required changes are made to meet the changing needs of service users. It is essential that any new project funded under the ECRDTF has a built in evaluation system.

At Risk Initiatives

The survey questionnaire was returned by 33 out of the 91 at risk initiatives in the survey population. This represents a response rate of 36%.

The majority (76%) of the 33 at risk initiatives who took part in the survey were constituted as legal bodies. Most respondents came from the voluntary and community sector with only 18% stating they were statutory agencies. The highest concentration of at risk initiatives was in the Dun Laoghaire area (10) followed by Bray (6) and Arklow (4) (Table 2.1). The remaining spread was relatively wide and included a number of areas which are not covered by the ECRDTF.

Results indicate that there was an equal split between the initiatives that described themselves as interagency initiatives (16) and those that did not (16). The VEC was the most frequently listed partner, with the ECAHB being the next most frequently mentioned. FAS and the Local Drugs Task Force were the next most commonly cited partners. A number of youth related agencies were also mentioned.

Respondents were asked to outline the function and purpose of their organisation. The most commonly stated function was education/ return to education, and youth work (Table 2.2). Other commonly reported functions included Child and Family intervention/ support, and counselling/ support. Again responses to the question about the purpose of the initiative most commonly related to drug education even these were not drug specific initiatives. Once again work with young people was a common response. Responses to the question regarding the objectives of the initiative were somewhat inconsistent with the above with the most frequently mentioned objective being support/ counselling followed by family support/ services to families. Education/ training regarding drugs and drug issues and activities for young people were less frequently mentioned objectives. It may be that the types of purpose and function which were highlighted were influenced by the fact that questionnaires related to the Regional Drugs Task Force, while objectives represented the broad objectives of the service, however this is unclear.

With regard to the pillars of the National Drugs Strategy equal numbers of initiatives said that their initiative/ project related to the Prevention pillar and the Education pillar (16 each) (Table 2.6). This is consistent with the most common responses relating to function and purpose (education and youth work) as

outlined above and was expected from initiatives targeting those at risk rather than those with a current problem. The Treatment pillar was mentioned by 4 respondents, however treatment featured very infrequently in responses relating to function and purpose. Once again this finding was to be expected in light of the fact that respondents came from a population of at risk initiatives. The Rehabilitation pillar was indicated by 3 respondents while only 2 mentioned Research. Supply Reduction was not mentioned by any initiative. Once again the small number of respondents saying that the research pillar was related to their initiative is a cause for concern for the reasons already outlined when discussing the outcomes of the drug specific survey.

Respondents were asked to indicate what age group their services were aimed at. The largest number of respondents reported that they catered to individuals of any age with other initiatives catering for those from 3 years of age upwards (Table 2.7). This represents the very broad range of initiatives that responded to the survey.

It was difficult to ascertain the number of individuals catered for by the at risk initiatives that responded to the survey since only 9 respondents indicated the numbers of individuals they provide a service for. Those who did indicate numbers did not specify whether this was the number of individuals they could cater for at any one time or whether this was their annual total.

When other demographic information which was provided by 27 of the 33 initiatives which responded to the survey is considered it would appear that at risk initiatives in the area are catering to a wide range of needs (Table 2.8). Target groups ranged from families/ parents, people living in the area, early school leavers, and disadvantaged people, to people with an addiction problem or at risk of alcohol/ drug misuse.

When asked to describe their selection criteria and referral process most respondents did not clearly distinguish between the two. There was a wide variety of selection criteria mentioned by respondents most of which were specified by single respondents. By far the most common referral method was self-referral/ voluntary participation followed by referrals from voluntary and community agencies (Table 2.10). Once again the broad nature of these selection criteria and referral processes may reflect a general openness, however it may also be a signal that initiatives are not specifically targeted at meeting the needs of any one group.

When asked to outline how they were funded most respondents cited a number of different funding sources. The most frequently mentioned funding sources each cited by 13 respondents were the Local Drugs Task Force, and a variety of Health Boards or representatives of such (Table 2.13). A third of respondents said that their funding came from the VEC and a further 8 said they were funded by a variety of different Government Departments. These funding sources were to be expected and their broad range reflects the variety of initiatives that responded to the survey. Once again the reliance on funding from a variety of sources to run any initiative is problematic. Each funding source has its own criteria for allocating funds and voluntary and community sector agencies relying on funding from a number of different sources are often forced to tailor their services to meet the needs of their funders rather than the needs of their clients if they are to remain in existence.

With regard to outcomes for both the individual and the initiative, a wide range of outcomes were listed. The most common response regarding outcomes for the individual was that individuals benefit from the point of view of personal development issues (including being more confident/ improved self esteem, knowing how to voice their opinion, personal development, more responsible) (Table 2.14). Other individual outcomes listed included that individuals were integrated into mainstream employment/ education/ training, that the lives of children were improved, that individuals are more aware/ knowledgeable regarding drug issues, that they impacted on the parenting skills of participants, and that they could avail of a supported environment/ support structures.

With regard to the learning or outcome that had been achieved for their initiative responses were once again many and varied with 32 different response categories given and most responses given by single respondents. The largest number of respondents for any response category said that the service was meaningful/ worthwhile/ works well. Other frequently mentioned outcomes referred to improvements in the lives of service users, having learned that their project is sustainable, and that there is a need for staff training.

Research results regarding evaluation indicate that this is much more a feature of at risk initiatives than it was for drug specific initiatives. Several initiatives indicated that they carried out external evaluations, and those whose evaluations were internal were much more specific regarding the type of evaluative process they implemented. This is very encouraging and is a practice which should be encouraged and supported. Adequate funding

should be ear marked for evaluation when resources are being allocated. Rigorous evaluation of outcomes against stated objectives provides extremely valuable information regarding the capacity of any initiative to meet the needs of its service users.

General Initiatives

The scoping questionnaire which was sent to general initiatives asked two main questions. A total of 38 general initiatives returned the questionnaire.

The geographical spread of the initiatives who responded to the survey was wide stretching from Carlow to Capel Street (Dublin 1) (Table 3.1). By far the highest concentration of respondents was in the Bray area, followed by Arklow, Wicklow Town and Dun Laoghaire.

When asked to state their function, most respondents in this category cited a number of different functions resulting in a broad range of response categories (Table 3.2). There were 69 response categories in all which were grouped where possible to aid analysis. Once again the most commonly mentioned function was training/ education followed by information/ advice, and services to the community. The range of services provided by general initiatives reflects the number of services at work in local communities in general and the wide geographical spread of those who responded to this questionnaire.

Conclusions

The lack of treatment and rehabilitation services in the area is of grave concern particularly outside the LDTF areas. Without these services the efforts of those who attempt to educate and encourage people to cease their drug misuse will be ineffective. There is a clear need for locally based treatment and rehabilitation services which are targeted at specific groups in the community.

There is a significant amount of research undertaken in the drugs field on a national basis by the NACD. The results of this survey highlight the lack of research in the drugs field in the local area. The lack of a co-ordinated approach to research by locally based services needs to be reviewed to identify the changing needs within the RDTF area. A co-ordinated research strategy needs to be developed and implemented. Research and evaluation activities in accordance with this strategy must be included in all projects approved for funding by the RDTF.

The broad nature of most of the initiatives who responded to the survey is an issue which would merit further consideration. Responses which target specific needs and run according to clear aims and objectives are required if the drug problem in the area is to be addressed. Services must be tailored to the needs of service users if meaningful change is to occur.

The practice of evaluating existing services is not implemented in any coherent way, particularly in relation to drug specific issues. This needs to be remedied if the ECRDTF is to ensure that services are being provided in line with their stated objectives and resources are being employed effectively and efficiently. It must be noted that projects which responded to this survey are fully supportive of and would welcome the opportunity to engage in evaluation activities, however the funding for these activities is not always readily available to them. When evaluation systems are being designed a realistic time frame for their implementation must be agreed to ensure that projects are evaluated on an ongoing basis as they grow and develop.

The above factors should be taken into account by the ECRDTF in making decisions regarding resource allocation to ensure that the Task Force operates in the most effective manner possible and the issue of evidence based practice should be a primary consideration when potential projects are being evaluated.

Appendix 2

Perception of Need
Full Reports

Methodology

A number of different approaches were taken when an assessment was being made of the extent to which current provision meets identified need and the types of initiatives required to address any gaps identified. Information was sought from a variety of different groups in different ways to ensure that as broad a spectrum of views as possible was captured. The information sources accessed were:

- People currently using addiction services in the region
- Parents/ concerned others
- Service providers (voluntary and community based)
- Members of the Travelling Community
- Members of the general public
- Members of the Regional Drugs Task Force

Data Collection

People Currently Using Addiction Services in the Region

A questionnaire was drawn up to ascertain the views of people currently using addiction services in the Region. This questionnaire was administered to service users who volunteered to take part with no incentive provided to encourage participation. The questionnaire was administered by staff in two clinics through face-to-face interviews. Every effort was made to record responses verbatim onto questionnaires.

Parents/ Concerned Others

A questionnaire was drawn up for use in individual interviews with parents/ concerned others to ascertain their views. A list of parents/concerned others from the Arklow area who were willing to attend face to face interviews to provide their views was compiled by the Arklow Community Addiction Team. Teams of two interviewers conducted face to face interviews with the 10 individuals/couples on this list. Interviews lasted approximately 1 hour and no incentive was offered to those who took part. Responses were recorded on the questionnaire.

Voluntary/ Community Based Service Providers

A focus group template was drawn up for use with voluntary/community based service providers to ascertain their views. A group of service providers willing to take part in a focus group in the Wicklow area was assembled by the Regional Drugs Task Force. A team of two facilitators ran a focus group with these individuals that was of approximately two hours duration. No incentive was offered to those who took part. Responses were recorded on the focus group template.

Members of the Travelling Community

A focus group template was drawn up for use with members of the travelling community to ascertain their views. A group of Traveller women willing to take part in a focus group in the Wicklow area was assembled by the CEART Traveller Centre. A team of two facilitators ran a focus group with these individuals that was of approximately two hours duration. No incentive was offered to those who took part. Responses were recorded on the focus group template.

Members of the General Public

ECRDTF placed several advertisements in local newspapers inviting individuals and groups to express their views on drugs issues within the region.

Two half-day clinics (one in Arklow and one in Wicklow) were held to ascertain the views of the general public on current needs. These clinics were advertised locally and in the press stating that all were welcome to speak to a member of the Regional Drugs Task Force about their views on needs in relation to the current drug problem in the area. The clinic in Arklow was attended by 3 individuals while 1 attended the Wicklow clinic. Responses were recorded by the Task Force member present.

Members of the Regional Drugs Task Force

The questions drawn up for use with the focus group sessions described above were provided to the Subcommittees of the Regional Drugs Task Force which are representative of the 4 pillars of the National Drugs Strategy. Responses to these questions were elicited by the chairperson of each Subcommittee at a Subcommittee meeting. These responses were recorded and are reported below. Responses were returned from the Education/ Prevention and Treatment/Rehabilitation Subcommittees.

Data Analysis

Data from the survey of drug service users was analysed using a statistical package (SPSS) to elicit quantitative information which is reported under the four pillars of the National Drug Strategy in the section titled Views of Service Users below.

Data from the individual interviews with parents/concerned others, the focus groups with voluntary/community based service providers and Traveller women, and the information recorded by Task Force members who held clinics were content analysed to extract common themes. These themes are reported together under the four pillars of the National Drug Strategy in the section titled 'Interviews/ Focus Groups' below.

Data from the Regional Drugs Task Force Subcommittees were content analysed to extract common themes and are reported below under the four pillars of the National Drug Strategy in the section titled Regional Drug Task Force Responses below.

Views of Service Users

General Comments

General comments made by a number of respondents recounted the perception that people will use drugs if they want to and that there is nothing that can be done to stop them.

Education/ Prevention

Education for Young People

The majority of those who responded to the survey believe that there is a need for more drugs education, particularly in schools. Most of those who advocated this type of education said that it should be as graphic as possible and their comments included:

"Show young people what drug use does to you "show them 6 months before they use and the results 6 months after they use, the graphic details, no matter how bad they look, the visual disintegration would be effective".

"Shock treatment – show them a documentary, an addict trying to find a vein through an abscess"

"Education in schools, kids have to know that drugs are great and make you feel great but only for a short period…. and made to understand that the flip side of the coin is no life for anyone to lead, no matter how much money they have because eventually the money runs out."

Some felt that this type of education should be delivered by addicts or recovering addicts:

"A talk from someone that went through it that lost everything – they should talk to kids"

"More in your face information, seeing and meeting people with drug problems."

Others felt that this could be achieved through visits to places like Trinity Court or through spending time with addicts. Some suggested information leaflets which are realistic and vivid and TV advertisements.

Information

Many of those surveyed said that there should be more information on health related issues such as Hepatitis, HIV, Aids, and Sexually Transmitted Diseases.

A small majority of respondents said that what was needed was Information on methadone and its effects.

Diversionary Activities

Many service users who responded to the survey said that there should be more activities available for young people in the area. The activities mentioned included youth clubs/centres, sport, social activities, and activity of any sort. This was felt to be necessary as a preventative measure as “boredom plays a large part” in drug misuse.

Training

A large number of those who responded to the survey advocated the provision of training for those who were attempting to deal with their addiction. Training mentioned included back to work skills, vocational skills, parenting, budgeting, coping skills, social skills, how to spend your leisure time, and “anything to occupy an addicts time”.

Treatment/Rehabilitation

General Comments

Some general comments which were made included a need for clinics to be friendlier, and for services to be more accessible.

Support Groups

In terms of treatment and rehabilitation, a number of those interviewed said that more support groups were needed. Narcotics Anonymous was mentioned specifically by a small number of individuals.

Counselling

A large number of the service users who responded to the survey said that there was a need for more counselling to be made available. If was felt by some that this should take place more frequently than once a week. One to one counselling was specifically mentioned rather than group therapy/ counselling.

Locally Based Services

A small number of the service users surveyed said that a drug clinic in their local area was needed.

Detox

Service users felt that there was a need for more detox units and that these should not have long waiting lists.

Methadone

A methadone clinic, for maintenance and detox, was also felt to be necessary.

Outreach/Drop in/Aftercare

Accessible outreach was seen to be a need along with late night drop in services and aftercare services.

Rehab

There was a perceived need for more beds to be made available in rehabilitation units and for more services for people after they finish Rehab:

"Greater after rehab services – its not the getting off, it's the staying off"

Supply Reduction

No comments were made relating to supply reduction activities

Research

No comments were made relating to research activities.

Interviews/ Focus Groups/ Clinics

Drug Problems Experienced

Parents/concerned others living in the Arklow area reported that alcohol and hash were the main precursors to the abuse of other, harder drugs. Most said that alcohol and hash use had commenced at an early age (the earliest being 13 years) with progression to harder drugs commencing at about 18 years of age. Prescription drug use was also perceived by parents/concerned others to be a problem in the area. There was a perception that this was followed by addiction to other drugs with heroin once again being the most frequently mentioned drug.

Heroin was seen as the drug of choice at the moment in Arklow and heroin use was considered to be a huge problem in the area. There are a number of specific places in the area where it is known that people go to use drugs.

The drug problem was seen to start in schools, which were not considered to be effective at spotting problems with pupils. Unemployment was cited as a reason for the current drug problem in Arklow. Some considered judges to be too lenient on drug dealers and the gardai were criticised for not being pro-active enough with dealers. A number of respondents reported that in the past addicts had travelled to Dublin to buy drugs but that now there was a lot of dealing in Arklow.

A focus group of service providers in the County Wicklow area reported that Heroin and cocaine use have increased in the Wicklow area. The abuse of prescription tablets was also perceived to be a problem. Drug abuse was seen to cross age and social barriers, and the view that there is no problem accessing drugs across the whole area was voiced along with the assertion that people also commute to Dublin to buy drugs. They reported that there is more acceptance about drug taking now, particularly hash, although there is still some fear about using heroin among young people in Wicklow. Service providers in the area report that they know who is dealing drugs locally. Heroin addicts are also coming from Dublin and Newcastle to the area to deal. There was a perception that the people who are pushing drugs to feed their own habit did not have the supports available to them when they needed them and they are now dealing drugs in the area.

A group of Traveller women who attended a further focus group reported that Travellers are now dabbling in drugs at a younger age (approximately 12 – 13 years). They reported a perception that there is a serious drug problem along the East Coast but there is not a big drug problem among Travellers in Wicklow Town. In South Dublin there are Traveller men abusing drugs but they are not openly selling amongst themselves, they get drugs outside their own area. In this area it was reported that there are 20 serious addicts from among the Travelling Community seeking treatment but only two are receiving it. It was felt that the increase in drug abuse among the Travelling Community was due to a number of issues brought about by lifestyle changes. The issues mentioned included the fact that people are not on the move as much and there is a certain level of frustration at having to live in settled areas. Peer pressure was also cited as a cause along with the high school drop out rate, with many children leaving school from the age of 12.

Perception of the Types of Services Currently Available

General Comments

A number of parents/concerned others reported that they did not know where to go for help in the early stages. One individual said that they did not even realise there was a problem until their family member started using heroin and then it was too late. Difficulties in getting information and services were highlighted and one individual commented that *"you are constantly losing time, early intervention is vital, it's too late by the time help is offered to you, you need a fast response".* Another said that *"You search and search for your box but no one will put you in one in case it's the wrong one"*, a further individual commented *"I have no plan, X leads me to Y but I don't know where to go until each stage leads me to it".*

A recurring theme from the interviews with parents/concerned others interviewed was that all the help they got was self-initiated. When asked what help they or their family member had received to date, many said that there was no real help available or that they had looked for help but received none. Family support was considered vital and one individual commented that this was the only type of support that works.

The lack of availability of appropriate services was a recurring theme amongst parents/concerned others with some saying that they had been referred to programmes or services both for themselves and their family member that did not meet their needs. The generic nature of the services provided was also mentioned and the issue that services are not tailored to meet the needs of each individual was highlighted. One individual made the comment that *"you get a very impersonal response, a formula, the response should acknowledge the problem and ask how they can help, not send out lists in the post"*. There was a general perception that families are not listened to by services.

Education/Prevention

Family members/concerned others, service providers, and members of the travelling community who attended interviews or focus groups did not mention education prevention initiatives when they were asked what services are in existence.

Treatment/Rehabilitation

Counselling/drug counselling was the service most frequently available to drug misusers mentioned by parents/concerned others. However the counselling received was not seen to be of value by most of those who had received this service. Service providers noted that there is a counsellor in Wicklow but that this person does not have the backup of an addiction centre and this limits their effectiveness.

A small number of parents/concerned others reported that their family member had been provided with residential treatment but in these cases the individual left before the end of the programme. The fact that the individual must be clean before they will be accepted into most residential treatment centres and that for many this was extremely difficult to achieve was highlighted by parents/ concerned others. The point that the individual should receive assistance when they ask for it was raised.

The lack of availability of methadone maintenance in the local area was mentioned by a number of parents/concerned others who also highlighted difficulties in travelling to Dublin for this service. This was echoed in comments made by service providers in the Wicklow area who mentioned Bray as the nearest location where a methadone service was available.

Parents/concerned others highlighted the importance of peer support and many said that talking to other parents in the same boat was very useful to them.

From a positive point of view, the support provided by Arklow Addiction Team was mentioned by two parents/concerned others, however the lack of availability of counselling at the Centre was highlighted and this was perceived to be due to lack of resources.

In terms of a medical response to the addiction problem, service providers reported that this was not readily available in the area. Newcastle Hospital is psychiatric and does not offer drug services. If the person also has a drug problem this is passed on. Wicklow Hospital only caters for minor problems. GP's in Arklow were seen as positive by service providers who said that they are supportive and refer people on to appropriate services. In Wicklow however the perception was that the service provided by GP's is not good.

Supply Reduction

Supply reduction services were not mentioned by any of those who attended focus groups or took part in interviews. This may be because these are services or initiatives that are not apparent to them on a daily basis nor do they provide services to which these individuals can look for assistance.

Research

No current research initiatives were mentioned by any of those who took part in the interviews or focus groups. This may be because they do not see research as having direct impact on them or their family members.

Perception of the Services Required

General Comments

According to one parent/concerned other what's needed is joined up thinking between the services. This was echoed by others who noted that responses should be holistic and backed up by a coordinated and wholly integrated system. It was suggested that *"services should be under an umbrella and work together in a complimentary way".* Networking among services was seen as essential. The comment that *"No one listens or takes responsibility, there are a few very good people but they move on and they're lost"* highlighted perceived difficulties in the area of service provision. Service providers in Wicklow also supported this view with their perception that there are some services in Arklow, but there are a lot of agencies involved and they need a coordinator so that all are linked. The services need to be unified so that the person is not pulled in all directions. There is a need for an umbrella organisation. They also felt that services are not meeting the needs in the local area.

Services or supports to families arose as a significant theme in the focus group with parents/concerned others with suggestions that respite care be provided for families who had family members who were addicted. The suggestion was that the addicted person be provided with respite care for periods of up to 2 weeks to give parents a break. Providing a carers allowance for where the addicted person was living at home was also suggested as a way of giving families a break. Another suggestion was for *"regular family counselling with the person and mediated by an external person".* The individual who attended the Wicklow clinic expressed concern at the increase of drug misuse in Rathdrum and the lack of family support services in the area as family support services in Arklow and Wicklow do not cover Rathdrum.

The location of the addiction centre was raised by parents/concerned others with suggestions that the addiction centre be moved elsewhere since "Arklow people prefer to go outside the area". This was contradicted by a call for a resource centre in the local community or health centre where you go for all health related problems.

Respondents from the travelling community commented that travellers experience difficulties in accessing services for a variety of different reasons including discrimination. They are not inclined to access services because of the stigma associated with doing so. Travellers are a close knit community and don't want to be seen going to addiction centres. What is required is a holistic

approach for Travellers that involves education, employment and anti-discrimination activities.

Service providers felt that each town or village should be responsible for their own problem. If there is community responsibility, communities should be involved in initiatives that are funded by the Task Force. It is very important that the community admit that they are responsible if projects are to be set up by the community.

Service providers also highlighted the necessity of monitoring and evaluating any services that are provided.

Education/Prevention

Prevention was the most popular suggestion among parents/concerned others when they were asked what services were required to address the drug problem in Arklow. Prevention should start early and many said that it should start in school before the individual develops a drug problem. This was echoed by service providers who said that this programme should start in National Schools and should target young teenagers and early pre-teens. This education should be a critical part of the curriculum not just SPHE. Parents/ concerned others felt that these drug education programmes should be compulsory and should involve both young people and their parents. Both parents/concerned others and service providers felt that these programmes should be run by ex- and current addicts or by parents of people who misuse drugs. Supervised community based activities which give young people a purpose and stopping early school leaving were also mentioned. Drug screening in schools was seen as an important service by one parent/ concerned other.

The perception of service providers was that there is not enough education for parents in recognising the signs of drug use in their children and consequently, they find out too late. They said that there are no local support/ information services and that there should be a drop in centre where you can confirm whether there is a problem. This type of information should be available from a variety of different sources including schools and GP's rather than being localised to one centre. An attendee at the Arklow clinic felt that an addiction studies course for parents would help them to understand the issues.

Respondents from the Travelling Community felt that family support and education from counsellors so that parents know how to deal with family members who are addicted is essential. There should be information on

services freely available to everyone. Traveller men need to be specifically targeted regarding information and peer support to get them involved in centres and services. Because men are the main providers they need to be incentivised to get involved.

Service providers commented that there should be a course for parents that tells them how to live or not to live with an addicted person as parents and family members can enable a person to get worse. Addicts need to be given responsibility for their own addiction and made to suffer the consequences.

Service providers said that there was a need for counselling specifically for the children of addicts. They commented that children often start out with behavioural problems that develop and put them at risk of addiction if they are not dealt with. They recommended the development of homework clubs and other locally based activities to keep young people occupied in a productive manner. Their perception is that the Health Board (HSE – East Coast Area) only deal with the 16+ age group regarding addiction, social workers deal with those in the younger age group, however they can do nothing unless a child is at risk. They saw this as a major gap in the services and recommended that service are targeted at those aged 8 – 9 years

Respondents from the Travelling Community advocated the provision of alternatives to drugs in the form of community initiatives like sports, peer outreach, leadership, and training. These types of initiatives were also suggested by service providers. It was felt that workers on these types of Traveller projects should be paid (like CE workers rather than work as volunteers) and therefore able to contribute to their family income as there are high unemployment rates among the Travelling population.

Treatment/Rehabilitation

Support groups were the most frequently mentioned service required by parents and those addicted. Suggestions were for peer support groups and for support groups where parents could go to be listened to, where they could share with other parents, and where they would be asked what they needed by service providers. Another suggestion was for a group where *"the parent and the addict can go together so the addict can hear what parents are saying".*

Parents/concerned others highlighted the stress having an addict in the family causes for the entire family. Some said that what would be useful to them would be for the EHB to provide accommodation for their family member and

this was echoed by service providers. One parent/concerned other commented that *"parents have all the responsibility" and that if they exclude the individual from their home there is nowhere else for them to go and this might lead to the individual committing suicide".* One parent who attended one of the clinics suggested that if a child/children involved in drugs is still living with his/her parents and receiving treatment then it would be useful if the parent could have some indication of how he/she is progressing without breaching confidentiality. They felt that this would ease the stress levels of family members.

The perception among service providers in the Wicklow area was that there are not enough Counsellors available. They felt that Wicklow Town needs a Community Addiction Team. They also noted that there are not enough project workers in Wicklow Town, these types of services are not available. There was a perception that Arklow Community Addiction Team needs more Counsellors and adequate funding.

In terms of treatment, methadone, subutex and a needle exchange service which are well policed where the most common suggestions made by parents/ concerned others. The requirement for a locally based methadone treatment programme was also highlighted by the service providers interviewed. One parent/concerned other suggested making test kits available free to parents of young people and also to schools. Residential treatment was also mentioned and one individual said that their family member would need something to keep him/her going while they were waiting to get in to this treatment. Service providers noted that when someone is referred on to treatment services the waiting lists are too long and there are too many hoops to jump through. An individual who attended one of the clinics said that a locally based detox facility was required as there are waiting lists for the clinics that already exist.

Service providers felt that existing services should be expanded and developed, there should be treatment centres to medically treat people which are run by a team including nurses and doctors but which also had outside agencies involved. Each person should be assigned a case manager who would carry out a needs assessment from which an agreed plan would be drawn up. This care plan would then guide the services the individual received. Travellers want the addiction services to come to them, it is vital that those employed as outreach workers deal specifically with travellers and understand their culture. These outreach workers should act as links for service referral. A drop in centre for travellers is vital but it would have to include other services so that there is no stigma attached with attending.

A pro-active approach was also considered necessary for people who were already addicted. A number of parents/concerned others suggested having something the addict could attend during the day for example training for work and in decision making. Others suggested that this would give them somewhere to go during the day and if these programmes were integrated that they would get them mixing with non drug addicts. These programmes should be long term and could also include sheltered employment for those who needed it. This was also suggested as a form of follow up or after care for those who have detoxed and come out of treatment which was echoed by service providers. Comments such as *"have something for them at the end of treatment, education, jobs, courses, supervision, without them knowing the supervision is there"* were made by those who supported this view. Service providers echoed this view and said that what was needed was a rehabilitation centre run for people in their own area. This would operate like a half way house to provide services such as job programmes and vocational training for people they come out of the local treatment centre. A drop in centre was mentioned by one person who attended the Arklow clinic.

The speed of response of services arose as a major theme among parents/ concerned others. A more rapid response with someone to definitively assess, recommend and refer if appropriate was considered necessary with one individual stating *"we lose time, after assessment it should move fast, straight into a programme with a week or two of detox, counselling and activation"*.

Supply Reduction

Law enforcement was a theme which arose among parents/concerned others with recommendations for the Gardai to take a harder line and treat drug misusers more harshly. A pro-active response by the Gardai regarding dealing was also considered necessary along with a harder line from judges. It was suggested that judges should insist on rehabilitation or prison in response to drug related offences. There were also suggestions to limit access to specific places where it is known that drugs are used. There was also a call for more strict monitoring of the prescribing and handing out of medication by GP's.

Research

None of the individuals who took part in the interviews/focus groups mentioned a requirement for research initiatives.

Regional Drug Task Force Responses

Drug Problems Experienced

Drug Task Force members felt that the deaths of young people using drugs was an issue along with the potential for the spread of viral diseases (such as Hepatitis and HIV). They also believe that there has been an increase in psychological/psychiatric problems for individuals, families and the community. They noted that there was an increase in the spread of drug use in the region due to the lack of treatment facilities. It was also felt that there was a lack of co-ordinated information on drugs and services available to address drug misuse and noted that there was a lot of misinformation about.

They referred to particular social problems which they believe are linked to the drug problem in the region such as unemployability, homeless, an increase in crime, the stigmatisation if families, and debt within families. The retention of children in the school system and early school leaving were also mentioned in this context along with a lack of facilities for young people which would assist with prevention.

Perception of the Main Areas of Need in the Region

General Comments

Responses all related to either the area of education/prevention or to treatment/rehabilitation. No needs in relation to supply reduction or research were mentioned by Regional Drug Task Force Members.

General issues raised were the need to build stronger links between organisations currently providing services within the area and continued meetings of the Subcommittee to ensure that they are aware of the issues and to develop protocols.

Education/Prevention

According to Task Force members education needs could be met by providing brief intervention/student guidance on addiction issues, increasing the ongoing training of teachers in the SPHE programme, adult/ parental education programmes, and consistent drugs education policy standards.

In the area of prevention it was felt that current needs include an extension of the School Completion Programme, and accessibility to youth diversion

programmes such as homework clubs and drop in centres.
It was felt that there was a need for a co-ordinated drug education and prevention response to cover areas currently lacking in provision in this area.

Treatment/Rehabilitation

Drug Task Force members felt that there was a need for a comprehensive range of locally accessible treatment services including harm reduction services such as needle exchange, outreach work, and health promotion,

In terms of rehabilitation the main area of need was felt to be locally accessible non-residential rehabilitation services which could provide and support progression routes for people at all stages of drug use.

It was also felt that the establishment of family and child support services in areas that do not currently have them to ensure that they can take referrals from clients with addiction problems and their families.

Perception of the Current Gaps in Service Provision

Education/ Prevention

Education/prevention was the only area commented on by Drugs Task Force Members when asked to provide their perception of the current gaps in service provision.

Some members of the Drugs Task Force Members felt that a gap in service provision was a school support mechanism providing brief intervention/student guidance. Support to access community based programmes was also mentioned along with inadequate funding of education/ prevention initiatives.

There is a shortage of short-term adult courses in addiction according to some Drugs Task Force Members while others said that there was a lack of support to access community based programmes.

The lack of a co-ordinated information system on service provision/drug information within the area was highlighted along with a co-ordinated response to drug education and prevention in areas not currently covered by a Local Drugs Awareness Group.

Drugs Task force members noted that there was a lack of youth facilities and that school completion programmes are not available in many of the schools within the ECRDTF region.

A lack of set standards on drug education prevention was also highlighted.

Perception of the Services Required

General Comments

Some Task Force members said that Family and Child Support Services should be provided in areas that do not currently have this service and that these services should be expanded in the areas where they are currently provided to ensure they have the capacity to accept referrals from clients with addiction problems and their families.

It was felt that the Treatment and Rehabilitation Subcommittee of the Regional Drugs Task Force should continue to meet to ensure that there is an awareness of issues, that protocols are developed, etc. Continued meetings of Prevention and Education Subcommittee were also seen as necessary to ensure continued awareness of best practice and the development of consistent policy standards in Drugs Education within the region.

Education/Prevention

An up-to-date network of information on existing services within the region which is fully accessible to members of the public and community, voluntary and statutory service providers was seen as necessary by some Task Force members. The need to ensure that access to information on drugs and drugs issues is accessible to all, including minority and ethnic groups.

Adequate funding of Drugs Awareness Groups providing a service within the region, was considered necessary along with support for adult/parent drugs education programmes.

Drugs Education/Prevention should be co-ordinated within the region, building networks with current providers and ensuring drugs education is provided in areas where there is no current service. It was felt that this could be achieved through a designated post for the ECRDTF, possibly attached to a Community Addiction Team. This designated person would have responsibility for reviewing current courses on offer and buying in these services, as far as practicable.

The importance of providing continued support for the full implementation of the SPHE programme within the region was highlighted and it was recommended that the SPHE forms part of the core curriculum for student teachers and that all youth workers or those currently working with early school

leavers be trained in the SPHE Programme. Further recommendations with regard to school based education/ prevention initiatives included continued support for the ongoing teaching of Walk Tall and On My Own Two Feet within schools in the region, along with the ongoing enhancement and expansion of the schools completion programme. A school support referral system to provide psycho-social measures as appropriate, was seen as necessary to fill the current gaps in service provision.

It was felt that there was a need to actively encourage the ongoing development of drugs policies within schools, clubs, youth organisations and businesses.

For those who leave school early it was recommended that the establishment and support of Early School Leavers Programmes in areas throughout the ECRDTF region, prioritising areas of need should be encouraged. It was also recommended that the lack of youth and community facilities run by qualified staff outside of the two Local Drugs Task Force Areas be addressed and that training for youth workers in addiction issues should be fully supported.

Treatment/Rehabilitation

Some Task Force members felt that there was a need for a comprehensive range of locally accessible treatment services. These should include locally accessible non-residential rehabilitation programmes that can provide and support progression routes for people at all stages of drug use, from active users and those who are methadone stable, to individuals who are drug free.

Harm reduction services for people who are active drug users – e.g. needle exchange, health promotion, outreach work were also seen as essential by Regional Drugs Task Force members.

Supply Reduction

The Regional Drugs Task Force members who gave their views regarding supply reduction highlighted the need to expand the drugs Courts outside of the Dublin area and the need to further explore the possibility of expanding the Community Policing Fora in the region.

Research

The Regional Drugs Task Force members who gave their views highlighted the need for more localised research on the nature and extent of drug misuse within the region.

APPENDIX 3

MEMBERSHIP OF
THE EAST COAST REGIONAL DRUGS TASK FORCE
(Nov. 2004)

APPENDIX 3

MEMBERSHIP OF THE EAST COAST REGIONAL DRUGS TASK FORCE (Nov. 2004)

Mr John O' Brien	- Chairperson
Ms Mary O' Toole	- Community Representative, Wicklow Community Network
Ms Iolanda McAuley	- Community Representative, Parents Making Children Aware
Mr Brendan Gilroy	- Community Representative, Wicklow Community Network
Ms Catrionia Roche	- Community Representative, Wicklow Working Together
Ms Maggie Blake	- Bray Travellers Community Development Group
Mr Joe Clifford	- Community/Service User Representative
Mr Andy Ogle	- Voluntary Sector - Drugs Education Workers Forum
Mr Michael McDonagh	- Voluntary Sector - Drugs Education Workers Forum
Ms Ruth McClaughry	- Voluntary Sector - Dun Laoghaire Rathdown Outreach Project
Ms Mary Forrest	- Voluntary Sector - Voluntary Drugs Treatment Network
Mr Kevin Lewis	- County Wicklow VEC
Mr Michael Ormonde	- FAS
Inspector Pat Ward	- Garda Siochana
Cllr Nicky Kelly	- Public Representative
Cllr Pat Vance	- Public Representative
Cllr Eugene Regan	- Public Representative
Cllr Nessa Childers	- Public Representative
Mr Tommy Maher	- Customs and Excise
Ms Marie Egan	- Local Authority - Dun Laoghaire
Mr Joe Egan	- Director of Community & Enterprise, Wicklow
Ms Eileen Hughes	- Liaison Person - National Drugs Strategy Team
Ms Anna Rynn	- Probation & Welfare
Mr Jim Ryan	- Health Services Executive East Coast Area (HSE East Coast Area)
Ms Marie Carroll	- Area Based Partnerships
Ms Niamh McAlinden	- Co-ordinator, Bray Local Drugs Task Force
(vacant position)	- Co-ordinator, Dun Laoghaire Rathdown Local Drugs Task Force
Mr John Moloney	- Department of Education & Science
Ms Siobhan Turner	- Interim Co-ordinator

SUBCOMMITTEE – EDUCATION/PREVENTION

Mr Andy Ogle	- CAD/DEWF
Ms Maggie Blake	- Travellers Groups Representative
Ms Ruth McClaughry	- Dun Laoghaire Rathdown Outreach Project
Ms Mary O' Toole	- Community Representative
Mr Michael McDonagh	- D.A.P./D.E.W.F.
Mr Kevin Lewis	- VEC
Mr John Moloney	- Dept of Education
Ms Iolanda Mc Auley	- Community Representative
Mr Stephen Harding	- HSE East Coast Area
Ms Louise Cadwell	- Catholic Youth Care
Ms Angie Howell	- Arklow Community Addiction Team
Ms Aileen O' Brien	- Southside Partnership
Ms Siobhan Foster	- S.P.H.E.

SUBCOMMITTEE – PREVALENCE/SUPPLY & CONTROL

Mr Jim Ryan	- HSE East Coast Area
Insp. Pat Ward	- Garda Siochana
Mr Brian Riddick	- Dun Laoghaire/Rathdown Co.Co.
Ms Mary Forrest	- Teen Counselling/VDTN
Mr Tommy Maher	- Customs & Excise
Maurice Hanlon	- An Garda Siochana Arklow
Des Nichols	- Town Clerk, Arklow Town Council
Iolanda McAuley	- Community Rep
John O' Brien	- Chairperson, ECRDTF

SUBCOMMITTEE – TREATMENT & REHABILITATION

Ms Ruth McClaughry	- Dun Laoghaire Rathdown Outreach Project
Mr Michael Ormonde	- FAS
Ms Niamh McAlinden	- Co-ordinator, Bray Local Drugs Task Force
Ms Caitronia Roche	- Community Representative
Dr Cathal O' Sullivan	- GP Co-ordinator
Mr Noel Dillon	- Rehabilitation Manager, HSE East Coast Area
Ms Carina Keogh	- Outreach, HSE East Coast Area
Ms Bernadette Byrne	- Arklow Springboard
Sr Maureen Freyne	- Aiseiri
Ms Mary Carolan	- Bray Local Employment Service
Mr Seamus Halpenny	- Probation & Welfare
Ms Vivienne O' Brien	- Bray Community Addiction Team
Ms Maggie Blake	- Bray Travellers Community Development Group