

SOUTH EAST REGIONAL DRUGS TASK FORCE

FEBRUARY 2005

STRATEGIC DEVELOPMENT PLAN

2005 - 2008



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TABLE OF CONTENTS

1. INTRODUCTION	4
SOUTH EASTERN REGIONAL DRUGS TASK FORCE	4
STRATEGIC PLAN	6
2. METHODOLOGY	8
PRIMARY RESEARCH	8
Interviews with Key Informants	8
Consultation with Local Drugs Task Forces	8
Changed Operating Environment in Last Ten Years	9
SECONDARY RESEARCH	10
Scoping Exercise	11
REPORTING	11
3. STRATEGIC CONTEXT	12
THE NATIONAL DRUGS STRATEGY	13
The Pillars of the National Drugs Strategy	13
Projects Funded - Historical	14
Independent Evaluation	14
Summary	17
SOCIO-DEMOGRAPHIC PROFILE - SOUTH EAST REGION	18
Total Population	18
Age Distribution	18
Population Migration - Urban/Rural	19
Deprivation	20
PREVALENCE	23
ESPAD Summary of the 2003 findings	24
Methodology	24
Data quality	25
Tobacco	25
Alcohol consumption	26
Binge Drinking	28
Illicit drugs	29
Conclusions	31
USE OF CANNABIS IN EUROPE 15 - 34 YEAR OLD AGE GROUP - OTHER PREVALENCE RESEARCH	32
Other Research Sources Relating to Prevalence	34
Conclusion	42
4. CURRENT RESPONSES AND INTERVENTIONS TO DRUGS MISUSE IN SERDTF AREA	44
SOUTH EAST DRUG CO-ORDINATING COMMITTEE	44
COMMUNITY PSYCHIATRIC SERVICES SERDTF AREA	49
AISÉIRÍ TREATMENT CENTRE	49
AISLINN ADOLESCENT ADDICTION TREATMENT SERVICE	49
CORNMARKET PROJECT, WEXFORD	50
COMMUNITY BASED DRUG INITIATIVES	50
AN GARDA SIOCHÁNA	51
REVENUE COMMISSIONERS - CUSTOMS & EXCISE	52
5. STRATEGIC AIMS AND OBJECTIVES	54
AIMS AND OBJECTIVES THE EU DRUG STRATEGY 2001 - 2004	55
AIMS AND OBJECTIVES OF NATIONAL DRUGS STRATEGY	55
Context	55
HARM REDUCTION PRINCIPLES	56
SERDTF STRATEGIC AIMS AND OBJECTIVES	57
Strategic	57
Operational	57
STRATEGIC IMPORTANCE OF SERDTF RE-STRUCTURING FOR PLAN DELIVERY	58
6. IDENTIFIED SERVICE GAPS	60
WATERFORD LOCAL DRUGS TASK FORCE	60
WEXFORD LOCAL DRUGS TASK FORCE AREA	64
Process	65
Analysis	65
Proposal Categories	66
Proposals	66
Treatment and Rehabilitation	66
Education and Prevention	68
Supply Control	69
Lobbying	69
Garda Drug Squad for County Wexford	69
CARLOW/KILKENNY LDTF	71
One Voice LDTF	71
SOUTH TIPPERARY LDTF	74
REGION-WIDE ACTIVITY	77
PROJECTS SUMMARY	78
7. IMPLEMENTING THE PLAN	79
DEVELOPMENT WORKERS	79
Job Description	79
BASELINE RESEARCH	80
SMALL GRANTS BUDGET	80
FINAL BUDGET	81

1. INTRODUCTION

One of the key recommendations of the National Drugs Strategy 2001 - 2008, was the establishment of Regional Drugs Task Forces throughout the country. The Strategy proposed that RDTFs be set up in each of the 10 Health Board areas to develop appropriate policies to deal with drug mis-use in the regions. The RDTFs are tasked with bringing together all the State agencies involved in the field of drug mis-use as well as the voluntary and community sectors.

Each RDTF is to be responsible for putting in place a strategy to tackle drug misuse specifically in their regions. Their establishment on a regional basis represents the extension of an innovative approach adopted in the nineties to tackle the drug problem mainly in and around the capital, Dublin. The role of the RDTFs is to research, develop and implement a co-ordinated response to drug mis-use through a partnership approach. Their terms of reference are as follows:

- to ensure the development of a co-ordinated and integrated response to tackling the drugs problem in their region;
- to create and maintain an up-to-date database on the nature and extent of drug misuse and to provide information on drug-related services and resources in the region;
- to identify and address gaps in service provision having regard to evidence available on the extent and specific location of drug misuse in the region;
- to prepare a development plan to respond to regional drugs issues for assessment by the NDST and approval by the IDG;
- to provide information and regular reports to the NDST in the format and frequency requested by the Team; and
- to develop regionally relevant policy proposals, in consultation with the NDST.

The RDTFs include representation from the

following sectors:

- Chair;
- Regional Drug Co-ordinator of the Health Board (providing secretarial/administrative support);
- Local Authority;
- VEC;
- Health Board;
- Department of Education and Science;
- Department of Community, Rural and Gaeltacht Affairs ;
- Gardaí;
- Probation and Welfare Service;
- FÁS;
- Revenue Commissioners - Customs and Excise Division;
- Voluntary Sector;
- Community Sector;
- Public Representatives (nominated by Local Authority in accordance with normal procedures); and
- Area Based Partnerships.

SOUTH EASTERN REGIONAL DRUGS TASK FORCE

The South Eastern Regional Drugs Task Force (SERDTF) was established in January 2003 and comprises many of the key agencies, including the community and voluntary sectors involved in the drugs issue. It has met on eighteen occasions and has made valiant efforts to convene the range of interests involved in the drugs issue with a view to seeking the constructive collaboration and co-operation necessary to achieve its objectives. Its membership is detailed in the following table, Table 1.

The boundaries of the SERTDF are co-terminus with those of the South Eastern Health Board and comprise the



Member	Agency	Role
Mr Cyril D'Arcy		Chair
Dr Derval Howley	National Drugs Strategy Team	Liaison Rep (Non-Voting)
Mr Tony Barden	South Eastern Health Board	Co-ordinator
Ms Margaret Tierney	Carlow Development Board	Member
Ms Marie Scally	Kilkenny Development Board	Member
Mr Martin Hayes	South Tipperary Development Board	Member
Ms Maureen Walsh	Waterford Development Board	Member
Mrs. Angela Parker	Family Support Representative	Member
Ms. Breda Cahill	Aislinn Treatment Centre, Ballyragget	Member
Sr Eileen Fahey	Aiseiri Treatment Centre, Cahir	Member
Mr Joe McGran	St Francis Farm Project, Carlow	Member
Mr Martin Ryan	Ossory Youth, Kilkenny	Member
Mr Kieran Donohoe	FDYS, Wexford	Member
Ms Mary Doyle	Carlow Regional Youth Service	Member
Ms Breda Fell	Waterford Local Committee	Member
Ms Catherine Lawlor	Carlow/Kilkenny Local Committee	Member
Mr. Paul Delaney	Wexford Local Committee	Member
Ms Cicely Roche	Pharmaceutical Society of Ireland	Member
Mr Ronan Mulhall	Department of Education & Science	Member
Mr Lawrence J. Kavanagh	Carlow VEC	Member
Mr Frank Lally	Customs & Excise Rosslaire	Member
Mr Sean Moriarty	Probation & Welfare Service	Member
Insp Tom Duggan	An Garda Síochána	Member
Cllr. Davy Hynes	Area Partnerships, Wexford	Member
Ms. Anne Cuffe	South Tipperary Local Committee	Member
Ms. Lindsey Butler	Community & Enterprise, Kilkenny	Member
Mr. Tommy Redmond	Wexford Development Board	Member

counties of Carlow, Kilkenny, Waterford, Wexford and South Tipperary.

The Region has a population of 423,616 persons (Census 2002) which represents 10.8% of the population of Ireland.

There are four local drugs task forces/drug committees which have been in existence for many years in different forms and which are now based on the Community Care Area structure of the SEHB as it existed prior to the introduction of the reformed Health Service Executive arrangements introduced in 2005.

The SEHB has led the response to the growing drugs issue in the south east and

has established a range of initiatives including the SEHB Substance Misuse unit which has a Regional Co-ordinator and four Local Co-ordinators in each of the Community Care areas of the South Eastern Health Board in Waterford, Wexford, Carlow/Kilkenny and South Tipperary.

The SEHB Substance Misuse Team has a total resource complement of some forty direct and indirect personnel including the community projects in which it is involved. It is community-based and acts as a veritable interface between the SEHB statutory service provision and the communities in the south east.

One of the key functions of the four

Substance Misuse Co-ordinators has been to develop the local responses to drugs, and to that extent, they have been crucial in the work of the four Local Drug Task Forces/Committees for some time now.

Since its establishment, the SERDTF has been gathering and collating the information necessary for the development of the Regional Strategy Plan. This has been effected largely through the auspices of four Local Drug Task Forces/Committees.

STRATEGIC PLAN

The South East Regional Drug Task Force now has to prepare the Regional Drug Strategic Plan for submission to the National Drug Strategy Team later in 2005. The need for the preparation of such a plan recognises that there are emerging challenges for drugs strategy providers and gaps in current drugs service provision arising from:

- An ever-changing and more complex working environment for vulnerable young people, drug users, drugs suppliers, policy makers and service providers;
- The need for community-based responses to tackling drugs issue;
- Recognition that the success of any strategy requires inter-agency co-operation and partnership;
- The evidential strong correlation between alcohol consumption/abuse and drugs abuse trends in Ireland;
- Required funding within statutory agencies to meet all social and community needs not being available;
- Enhanced knowledge from the emergence of an increasing wealth of national and international research on efficacious drugs services and approaches;
- Acute differences in the nature of drug abuse trends in the South East from other areas particularly Dublin;
- Marked differences in the current interventions and programmes provided by statutory, voluntary and community organisations in the South East from Dublin;
- Different solutions being required for rural and small town communities and larger urban ones;
- Statutory agency structures not facilitative of expedient responses and strategic intervention demanded by drugs trends and needs.

The resultant plan will determine the funding level for the implementation of the regional drugs response in the South East for the 2005 – 2008 period and will seek to:

- Ensure administrative and development support for the Local Drug Taskforces/Committees;
- Encourage the implementation of a community development-led programme of project implementation;
- Ensure continued and enhanced local involvement in the strategic approach to tackling the drugs issue through the Local Drugs Taskforces/Committees;
- Implement projects which add value to the existing initiatives and services;
- Establish projects and initiatives which are innovative and pioneering;
- Undertake Region-wide qualitative and quantitative baseline and ongoing research;
- Undertake pilot projects;
- Translate the history of inter-agency working at local level to more active project implementation and outworking;
- Assist statutory, community and voluntary agencies to develop their local and regional service plans to include the project work of the SERDTF.

A sub-committee of the SERDTF was established and it appointed Murtagh & Partners, Economic Development Consultants, (M & P), to complete the Strategic Plan.

This is the consolidated Strategic Plan for the South Eastern Regional Drugs Task Force.

The first section sets out the approach (methodology) undertaken in the course of the assignment to prepare the analysis and

report, followed by the strategic context and a profile of the Region and its four Local Drugs Taskforce areas. An overview of the current responses and interventions is presented in Section Four while the steps to be taken to address them, including the aims and objectives, follow in Sections Five and Six. Section Six also presents twenty-five proposed projects which have been identified by the LDTF/County Drug Committees, as priorities for Year One of the Plan implementation.



2. METHODOLOGY

The approach taken to prepare the strategic plan was based on primary and secondary research techniques.

PRIMARY RESEARCH

Interviews with Key Informants

The Primary Research included a number of face-to-face (FtF) interviews with members of the SERDTF and a series of workshops with the County Drug Committees. In the South Eastern Region, there are four Local Drugs Taskforces/Committees which have been involved in addressing the drugs issue for many years, and workshops were held with each. All of the Co Drug Committees are structured on the basis of the four pillars of the National Drugs Strategy and have sub-committees for each as follows:

- Supply reduction involves mainly the Gardaí, the Department of Justice, Equality and Law Reform and Customs & Excise;
- Prevention involves the Department of Education and Science, HSE, Substance Misuse Education Officers, Department of Health and Children;
- Treatment involves the Department of Health and Children and the health boards, FÁS, the Community and Voluntary Sector; and
- Research involves the national advisory committee.

This consultation involved FtF meetings with ten members of the SERDTF including the four SEHB Substance Misuse County-ordinators and a further sixty people from the Co Drug Committees. One workshop was held in South Tipperary while two were held in Carlow/Kilkenny, Waterford and Wexford. The main purpose of the interviews was to assess the extent to which the statutory agencies were contributing to tackling of the drugs issue, to identify the gaps in service provision and to identify proposed responses and interventions.

Consultation with Local Drugs Task Forces

One of the key assumptions of the consultative process was that the County Drug Committees had been involved in research, consultation and the planning process for the past number of years and that a preferred way forward, including the formulation of a range of responses and interventions in the form of projects and activities, had been worked up for implementation.

Although all four Co Drug Committees had operated effectively over the period, this assumption turned out to be premature. While the County Drug Committees will be profiled later, it is relevant at this point to state that they had carried out their business in a manner which reflected the demands of the time including the rationalisation/combination of the Carlow and Kilkenny Local Drug Committees into *One Voice LDTF*, the developing services and initiatives being implemented by the statutory agencies, schools and community organisations, the Young People's Facilities and Services Fund (YPFSF) and the preparation of the impending Regional Drugs Task Force Strategic Plan.

Person	Position	Agency
Tony Bardon	Regional Co-ordinator	SEHB
Pat O'Neill	Substance Misuse Co-ordinator	SEHB Waterford
Chris Purnell	Substance Misuse Co-ordinator	SEHB Wexford
Catherine Lawlor	Substance Misuse Co-ordinator	SEHB Carlow/Kilkenny
Johnny Casey	Substance Misuse Co-ordinator	SEHB Sth Tipperary
Members	20	S Tipperary DTF
Members	9 + 9	Carlow/Kilkenny DTF
Members	16 + 11	Waterford DTF
Members	12 + 12	Wexford DTF
Lawrence Kavanagh	Director	Carlow VEC
Derval Howley	Manager NDS (Eastern Region)	ERHA Directorate of Planning
Seán Morriarty	Director	Probation & Welfare
Ronan Mulhall	Assistant Principal	Dept of Education & Science
Peter Kieran	Programme Manager	SEHB Childcare Programme

To that extent, local people and the statutory, community and voluntary agencies had been involved within the context of the County Drug Committees, in discussions and forums on addressing the drugs issue locally. All County Drug Committees had sub-committees based on the National Drugs Strategy's four pillars and met regularly. Although the County Drug Committees were cognisant of most of the drugs initiatives being developed within their locality, there were few, if any, examples of the type of inter-agency projects, initiatives or way of working envisaged in the National Drugs Strategy. However, it is also necessary to point out that the environment and circumstances in which the inaugural Local Drugs Task Forces were established in Dublin in the nineties, contrasted sharply with those prevailing early in the new millennium for the County Drug Committees in the South East.

The workshops assisted greatly in assessing the stage the Taskforces were at in meeting their own aims and objectives and the extent to which they had contributed to the development of policies and strategies to address the drugs issue in their community care/county area. To that extent, the outcomes of the workshops identified the gaps and considered a range of possible responses.

Changed Operating Environment in Last Ten Years

The chronological development of drugs policy in Ireland is well documented in Shane Butler's *Drug Problems and Drug Policies in Ireland: A Quarter of a Century Reviewed* (Journal of the Institute of Public Administration, Ireland 1991, Vol 39, No 3). Essentially Butler recorded that although the statutory agencies had established responses as early as 1971 following the publication of the *Report of the Working Party on Drug Abuse*, and that legal and health approaches had developed into and throughout the eighties, they were largely

inadequate and probably based on somewhat confused and defective assumptions.

These policy development assumptions largely ensured that conventional drugs strategies were not integrated into the mainstream functions of statutory agencies and drug taking was regarded as deviant behaviour where individuals had the choice of experimenting with hard drugs in the full knowledge that s/he would become hooked. *"No effort was made to establish clear conceptual and practical distinctions between drug control policies, which are the responsibility of the criminal justice system, and health and welfare policies which operate on a radically different value system and are the responsibility of health and social welfare institutions,"* (Butler 1991)

Concepts such as "harm reduction", "community-based drugs teams and strategies", were regarded as liberal ideas and were in sharp conflict with the conventional approach of punishment and the medical model of "curing".

In the mid-eighties there seems to have been recognition that there was a causal relationship between drug abuse, a high crime rate, high levels of unemployment, poor and overcrowded housing, low levels of educational attainment and the lack of social and recreational amenities. This link between drug misuse, poverty and its attendant characteristics, as well as a move away from the law and order and drug control emphasis reflected in the Misuse of Drugs Act 1984, to a more humane approach where the health and care of drug users was paramount, impacted eventually on public policy and began to influence development models. However, by that time, communities in inner city Dublin and Ballymun had developed their own responses and when community-based Local Drugs Task Forces were established, all of this history determined their (leading) role, their influence on intervention and budget

priorities.

In particular, the statutory agencies, including the relevant health boards, did not have appropriate developed responses to the rapid rise in drugs misuse in Dublin at that time, and the profile of the drugs misuse was substantially different with the emergence of a very large and growing cohort of heroin users dominating and leading the response. With the rise in heroin use and the myriad of concomitant health, social and economic outcomes for drugs misusers injecting intravenously, their families, children and communities, there was a clear vacuum to be filled at the intervention level and the Local Drugs Task Forces slotted into this lead role.

By contrast, in the South East by 2005:

- the statutory agencies have developed their responses and interventions;
- the South Eastern Health Board has an established and effective Substance Misuse Team;
- there have been education and prevention programmes operating in schools and youth groups throughout the Region for the best part of ten years;
- there are Community Based Drug Initiatives (CBDI's) in specific areas at risk;
- there is a greater understanding of the problem within the Gardaí who implement community diversionary projects and have a (limited) network of Juvenile Liaison Officers and other officers fighting drugs;
- There are a number of YPFSF projects and initiatives;
- Customs & Excise have been active in seeking the assistance of the community in its work around the coast and have been successful in detecting large hauls of illegal imported drugs.

In addition to this progress, some agencies have formed alliances to devise mutually beneficial no-cost/low-cost initiatives to support their service plans. Examples of these would be the Substance Misuse Teams

and the Licensed Trade, Youth Services and FÁS.

However, despite the changed environment, there is still a rise in drugs misuse in the Region, a rising use of heroin and a need for a more sophisticated and dynamic response mechanism, and the role of the SERDTF is substantially different to those established in the last millennium. The challenge remains the same although the working environment is more complex but hopefully more aware of best practice and what works and what doesn't. It was against this background that the LDTF/County Drug Committee workshops were convened. In the invitation to participants, the aims of the workshops were set out as follows:

- To involve key stakeholders in the formulation of the Plan;
- To blend the work and experience of the Task Force into the strategy.

to be achieved by:

- Identifying the current profile of the area – socio-demographic, etc;
- Detailing current and anticipated trends in drug misuse;
- Outlining identified local impact of drugs misuse on young people, families, and communities;
- Putting forward actions across the four pillars detailed in the National Drugs Strategy for consideration.

The primary research was particularly useful in ascertaining the extent to which drugs services, particularly those provided by the South Eastern Health Board, had developed and matured since the mid-nineties.

SECONDARY RESEARCH

The secondary element of the research concentrated on consulting a range of documents and reports in order to ascertain:

- Relevant research on drugs prevalence and trends in the Region, nationally, Europe and internationally;

- The extent to which statutory and non-statutory agencies had built strategic drugs work into their local/Regional service plans;
- The historical development of the Local Drugs Task Forces in the Region;
- The range of projects, interventions and services targeted at drugs misuse in the Region; and
- The identification of evidenced gaps in service provision.

Scoping Exercise

The SEHB Substance Misuse Team has carried out a Scoping Exercise of all of the agencies and organisations involved in addressing the drugs issue in the Region. It was assembled on foot of submitted responses by organisations to a questionnaire. The Plan has made reference to the detail of the Scoping Study where necessary and the entire publication has been made available to all groups, agencies and organisations in the Region. It was recorded on software available from Central Government and conforms to a particular format which records the facts about an organisation. It was not intended to be an evaluation of the agencies' effectiveness in the field, rather a summary of their location, staffing levels, aims and objectives and main activity. Most of the 87 agencies located across the Region are either 'Drug Specific' or dealing with 'At Risk' circumstances. The remainder are generic organisations which have a brief for drugs to some degree and include agencies such as Waterford City Council.

REPORTING

M & P retained a good level of contact with the Reference Group and advised it and other members of the SERDTF, in particular the Substance Misuse Co-ordinators, of the progress of the assignment. M & P required a significant amount of co-operation from the Substance Misuse Co-ordinators and other key informants in order to access information

and detail and these discussions were used usefully to update them on the direction of the plan on an ongoing basis. As a result, two meetings with the Reference Group and one with the whole Task Force were presented with interim developments leading to a number of progress recommendations being made, accepted and implemented.

This facilitated the agreement by the SERDTF of the need for the appointment of two Development Workers, some re-structuring of the Task Forces and the commencement of a discussion on the undertaking of high quality, Region-wide research which would be used by policy makers and as a baseline for the implementation of the strategy.

The next section sets out the strategic context of the plan.

Location of Organisation	No of Orgs
SEHB Regional	23
Waterford	21
Wexford	17
<i>Carlow 9</i>	
<i>Kilkenny 11</i>	
Carlow/Kilkenny	20
South Tipperary	6
Total	87

3. STRATEGIC CONTEXT

The Government has placed its response to the drugs issue at the top of its agenda and it has remained there, culminating in the National Drugs Strategy 2001 - 2008, an integrated and co-ordinated plan based on addressing a compendium of issues associated with the range of complex problems arising from drugs misuse.

The strategy recognises the impact of drugs misuse across a number of key areas and the resulting complex of relationships between ill-health, crime (supply- and demand-related), unemployment, poverty, low educational attainment, family relationships and breakdown, homelessness, premature mortality and community order and stability. With this in mind, any response required an integrated approach and to that end, the NDS was developed on a Government Inter-departmental basis with widespread consultation throughout the community.

The implementation of the Strategy is similarly structured, both inter-departmentally and in association with communities. The four pillars of the Government's response are detailed below along with the agency with principal responsibility. It is worth noting here that there is a well-developed level of co-operation and co-ordination between agencies in the strategy implementation.

To that extent, the monitoring and evaluation processes undertaken by Government involves a wide range of stakeholders and

partners.

Local Drugs Task Forces, comprising a partnership between the statutory, voluntary and community sectors, were established in 1997 in the areas experiencing the worst levels of opiate misuse. These were: Ballyfermot, Ballymun, Blanchardstown, the Canal Communities, Clondalkin, Dublin North Inner City, Dublin South Inner City, Dublin 12, Dun Laoghaire/Rathdown, Finglas-Cabra, Cork City, North East Dublin and Tallaght. Bray was designated as an LDTF area in 2000.

The LDTFs prepared their first action plans in 1998 which included a range of measures in relation to treatment, rehabilitation, education, prevention and curbing local supply. The Government allocated €12.7 million to support the implementation of 234 separate measures contained in the plans.

The focus of these plans has been on the development of community-based initiatives to link in with and add value to the programmes and services already being delivered or planned by the statutory agencies in the LDTF areas. In addition, the LDTFs provide a mechanism for the co-ordination of services in these areas, while at the same time allowing local communities and voluntary organisations to participate in the planning, design and delivery of those services.

The strategic context of the SERDTF Plan lies within five key areas:

Pillar	Lead Department/Agency	Other Key Actors
Supply Reduction	Dept. of Justice, Equality & Law Reform An Garda Síochána Customs & Excise Service in the Office of the Revenue Commissioners Prisons Service Naval Service	Dept. of the Environment & Local Government Local Authorities Community & Voluntary Sectors
Prevention	Dept. of Education & Science Dept. of Health & Children Regional Health Boards	An Garda Síochána Community & Voluntary Sectors
Treatment	Dept. of Health and Children Regional Health Boards FÁS	Prisons Service Probation & Welfare Service Community & Voluntary Sectors
Research	Health Research Board National Advisory Committee on Drugs	

- The National Drugs Strategy;
- Socio-demographics of the South East Region;
- Enhanced availability of Drugs-related research nationally and internationally; and
- Rising Trends of Drugs Misuse in the South East Region;
- Service Plans of the statutory agencies.

In this section, the document sets out the strategic context or background for the necessity to present and implement the plan.

THE NATIONAL DRUGS STRATEGY

The overall strategic objective of the Strategy is:-

To significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research.

Its overall strategic aims are:-

- to reduce the availability of illicit drugs;
- to promote throughout society, a greater awareness, understanding and clarity of the dangers of drug misuse;
- to enable people with drug misuse problems to access treatment and other supports and to re-integrate into society;
- to reduce the risk behaviour associated with drug misuse;
- to reduce the harm caused by drug misuse to individuals, families and communities.
- to have valid, timely and comparable data on the extent and nature of drug misuse in Ireland; and
- to strengthen existing partnerships in and with communities and build new partnerships to tackle the problems of drug misuse.

The Pillars of the National Drugs Strategy

The objectives for the Strategy are

summarised under the four pillars and are as follows.

Supply Reduction

- To significantly reduce the volume of illicit drugs available in Ireland, to arrest the dynamic of existing markets and to curtail new markets as they are identified; and
- To significantly reduce access to all drugs, particularly those drugs that cause most harm, amongst young people especially in those areas where misuse is most prevalent.

Prevention

- To create greater societal awareness of drug misuse; and
- To equip young people and other vulnerable groups with the skills and supports necessary to make informed choices about their health, personal lives and social development.

Treatment

- To encourage and enable those dependent on drugs to avail of treatment with the aim of reducing dependency and improving overall health and social well-being, with the ultimate aim of leading a drug-free lifestyle; and
- To minimise the harm to those who continue to engage in drug-taking activities that put them at risk.

Research

- To have available valid, timely and comparable data on the extent of drug misuse amongst the Irish population and specifically amongst all marginalized groups; and
- To gain a greater understanding of the factors which contribute to Irish people, particularly young people, misusing drugs.
- Drugs Strategy.

Some of the key issues relating to each of the pillars have been identified as:

Supply Reduction Issues

- Partnership with communities

- International co-operation
- Policing
- Customs
- Courts
- Prisons
- Legislation on tackling drug related crime

Prevention Issues

- Early intervention
- Schools programmes
- Targeting of vulnerable young people
- The needs of young people and their parents
- General public awareness
- Creation of accessible, positive alternatives to drug misuse

Treatment Issues

- Substitute treatment
- De-tox programmes
- Drug free approaches
- Harm reduction
- Polydrug use
- Changing nature of drug use
- Young people
- Rehabilitation/moving on opportunities
- Community concerns
- Family support

Research Issues

- Comparative data availability
- Availability of research to inform policy and strategic interventions and supports
- Planned programme of research
- Dissemination of and understanding of available research in communities.

The four pillars of the national Drugs Strategy are the accepted components of most drugs strategies throughout Europe and each region will require a different mix of emphasis

within the four pillars depending on its socio-demographic profile, prevalence experience, supply and demand factors, culture, and strategy delivery structure.

Projects Funded - Historical

The type of projects receiving support as part of the plans of existing Local Drugs Task Forces include local information, advice and support centres for drug users and their families, Community Drug Teams, special projects aimed at children involved in drugs or at risk, the production of drug awareness materials, drugs training programmes for community groups, teachers, youth workers and other professionals, rehabilitation programmes and initiatives to allow local communities to work with the State Agencies in addressing the issues of supply in their areas.

Independent Evaluation

An independent evaluation of the initiative, concluded in June 1998, found that the LDTFs had achieved a considerable degree of success in the short time since they were established, not least in reducing the feelings of frustration and isolation previously felt by many communities in the affected areas. In July 2000, the Cabinet Committee on Social Inclusion approved further funding for this initiative to enable the LDTFs to update their action plans. While some reservations of this evaluation have been expressed, it is felt that some of the technical and auditing elements of it are relevant to the SERDTF Plan preparation. Some of these are presented here to provide some background within the Strategic Context section.

In 2001, over 120 of the original projects were mainstreamed through the relevant State Agencies thereby ensuring their continued funding.

The Cabinet Committee on Social Inclusion began approving projects in the new LDTF

action plans in January 2001. To date, over €14 million has been allocated, on an annual cost basis, to implement the second round of plans.

The LDTF's were mandated to develop a locally-based, integrated response to the drug problem. Each LDTF prepared for its area an action plan, which focused on the development of community-based initiatives which would link with, and add value to the services already being delivered or planned by state agencies. These plans were then submitted to the NDST. The Government on the advice of the NDST allocated £10m to implement over 200 separate projects detailed in the plans. The projects were categorised under the themes of: education, prevention, treatment, rehabilitation and reduction of local supply.

Implementation of the approved projects began in the latter part of 1997 and has continued to date. Following the review of the LDTF's in July 1998, the Cabinet Committee allocated a further £15m over the period 2000 - 2001 to support the implementation of updated plans. There is wide variation in the range and type of projects and in their size. The majority were set up to be ongoing but some are one-off projects.

Project Characteristics

There is great diversity in the projects undertaken under the auspices of the LDTF's. While the NDST classifies drugs projects into the four pillars, these are not intended to be rigid categories and, in practice, projects may be engaged in services covering more than one field of activity. Of the projects involved in the evaluation study, the most frequent field of activity was education and prevention with approximately one half (51%) engaged in these types of activities (Figure 3.1).

The education and prevention field included activities such as 'stay in school' programmes, after school/homework clubs

and a roadshow.

Treatment and rehabilitation was the second major field of activity with over one third (36%) carrying out activities in this area. The kind of activities carried out by projects in this category included the placement of a community development worker, community based 'links' programmes and counselling services.

A further seven per cent provided services in both the education and prevention and the treatment and rehabilitation fields.

A very small number of projects (3%) were involved in supply control and research and information. Examples of projects in the former field include estate management and in the latter include research projects and employment of a development officer.

The majority of projects (75%) provided multiple services but there was also a significant number of single service projects (25%). Education and training projects were more likely to be part of a larger programme than a standalone project, whereas treatment and rehabilitation projects were equally likely to be stand alone or part of a larger project (Table 3.1 a)

Project Promoters

One of the elements in the overall structure for the National Drugs Strategy is the Project Promoter. Projects funded by the LDTF's were "promoted" by some body through which the funding to be allocated was channelled. Among the projects evaluated, voluntary/community organisations feature prominently as promoters; with 58 per cent promoted by such a group and a further twenty-two per cent promoted by a voluntary-statutory partnership (Table 3.1). A small number of projects were promoted by a statutory agency (6%). Fourteen per cent of projects were promoted by some "other" type of body including, for example, companies

limited by guarantee and a Task Force.

Type	Voluntary/Community	Partnership of Voluntary and Statutory	Statutory	Other	Total
%	58%	22%	6%	14%	100%

Voluntary/community organisations are equally likely to be promoters of education and training or treatment and rehabilitation projects (27% and 25% respectively). Partnerships of voluntary and statutory agencies are more likely to be promoters of education and training projects, than treatment and rehabilitation projects.

Legal Form of the Projects

Most frequently the projects are constituted as companies limited by guarantee (47%). Twenty per cent are unincorporated associations. An additional twenty-two per cent say their project is 'sponsored' by the promoter. The remaining projects (11%) have some other structure such as committees.

Length of Time in Existence

The great majority are young projects with 58 per cent in operation for 1 - 2 years and a further 22 per cent set up 3 - 4 years ago. A small number were in operation for less than one year.

Sixty-one per cent of projects came into existence with LDTF funding. Over one quarter (27%) had already been in operation and a further 13 per cent had been at least partly in operation prior to LDTF funding.

Geographical Area Served

Most frequently a project serves a sub-area of the LDTF (47%). Spread coincides with the LDTF region in 40 per cent of cases. A small number of projects serve an area larger than an LDTF area (9%) or cuts across LDTF's (4%).

Management of the Projects

Over three-quarters of the projects are run by a management committee (78%). The size of the committee varies but usually is no bigger than 10 members and no less than seven. With regard to the composition of the management committee, the great majority indicate the presence of a community representative (84%); 58% indicated there was representation from some statutory agency (for example, Garda, Eastern Health Board and probation and welfare services); 50% indicated there was representation from the voluntary/community sector (for example, Crosscare, Barnardos, YMCA and Saoilse) and 36 per cent have a representative from the local schools. Forty per cent of projects note some "other" kind of representation on the committee such as staff, clients, parents of clients, the legal profession or local business.

The twenty-two per cent of projects which are not run by a management committee, function with a mixture of set-ups such as: advisory committees, a consensus model (where decisions are made by a majority), reporting directly to the promoter and, in a small number of cases, 'informal' methods.

Guiding Principles

In an attempt to explore underlying philosophy, the project managers were asked to indicate the three most important principles that guide the project. Content analyses of the responses revealed much diversity with 10 different types of principles being identified. While no one principle predominates, the most frequently mentioned principle (20%) is that the project is "needs driven". Among other principles accounting for at least 10 per cent of all responses, two are concerned with the users of the services:

"development of the users' potential/user empowerment/user integration" and

"respect for users/valuing of users/care for

users/dignity of user's."

Principles	N*	%	Cum. %
Needs driven	66	20%	20%
Development of user's potential/user empowerment/integration	48	14%	34%
Involvement of the local community/community support	45	13%	47%
Respect of users/value/dignity/care/confidentiality	41	12%	59%
Local Community empowerment/capacity-building	31	9%	68%
Integrated, co-ordinated approach. Co-operation/partnership	29	9%	77%
Holistic, multidimensional, comprehensive approach	27	8%	85%
Pragmatism, practical/adaptability/affordability	19	6%	91%
Other answer	19	6%	97%
Influence policy-makers/awareness raising	12	3%	100%
Total	337		

The principle of "involvement of the local community" accounts for 13 per cent of all responses.

Summary

The consultation process appealed to the contents of the evaluation to provide a profile of the types of project that had been funded under the previous funding phases of the National Drugs Strategy.

The following paragraphs set out the socio-demographic profile of the South Eastern Region.

SOCIO-DEMOGRAPHIC PROFILE – SOUTH EAST REGION

This section will set out the socio-demographic data for the Region insofar as it is relevant to the development of the strategy. The information has been drawn from the South Eastern Health Board population data and the Census data from the Central Statistics Office.

Total Population

The total population of the Region is 423,616 people representing just over 10% of the

SE Region	1981	1986	1991	1996	2002
CARLOW/KILKENNY	97,456	100,281	100,670	102,452	111,320
TIPPERARY (S.R.)	81,261	82,394	80,151	80,612	84,257
WATERFORD	96,777	99,747	100,298	104,082	111,443
WEXFORD	99,081	102,552	102,069	104,371	116,596
TOTAL	374,575	384,974	383,188	391,517	423,616

State. It has grown by 8.2% since the 1996 and by 10.5% between 1991 and 2002. This is roughly in line with the growth of the State's population between the same periods of 8% and 11% respectively. According to available population growth estimates, the population in the South East is due to increase by a factor of 5% to a high of 445,000 (adjusted for actual out-turn) by 2016 and commence to decline from then.

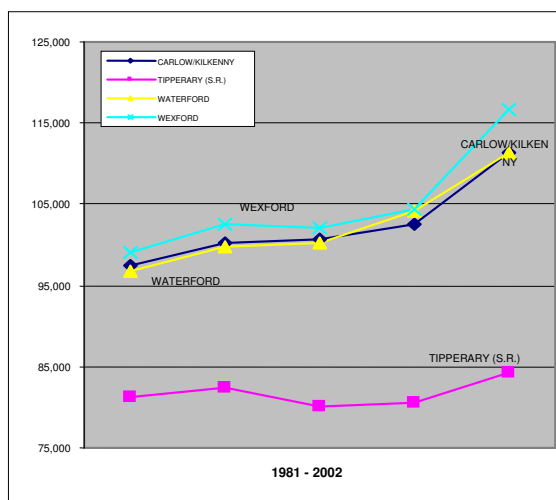


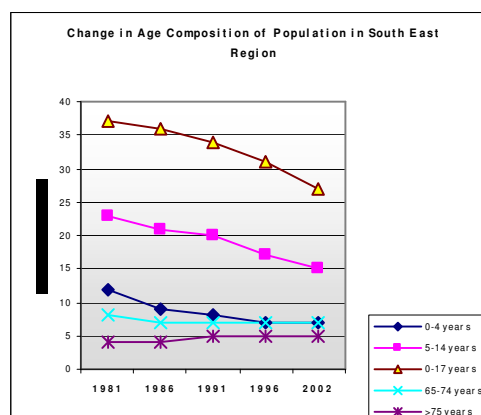
CHART 1 POPULATION BY COUNTY SE REGION 1981 - 2002

Age Distribution

For the past twenty years there have been two notable trends in the distribution of ages in the SEHB (1981 - 2002). Generally, the numbers of young people (0 - 17 years) have been decreasing, whilst those at the older stage (over 65 years) have been increasing. The number of children aged 0 - 17 years decreased by 4% since the previous Census (1996). The number people aged over 74 years increased by 12 % since 1996.

County/Region	0 - 4 yrs	5 - 14 yrs	0 - 17 yrs	65 - 74 yrs	≥75 yrs
Carlow	7%	14%	27%	6%	4%
Kilkenny	7%	15%	28%	6%	5%
Wexford	8%	15%	28%	7%	5%
S. Tipperary	7%	15%	27%	7%	6%
Waterford	7%	14%	26%	7%	5%
SEHB	7%	15%	27%	7%	5%
State	7%	14%	26%	6%	5%

Despite the fall in numbers of young people 0 - 17 years, the number of children aged 0 - 4 years has increased by 14% since 1996, indicating an increased birth rate in the SEHB. This is the first time in twenty years that the birth rate has increased in the SEHB (1981 - 2002). The percentage increase for children aged 0 - 4 years is most notable in Co. Carlow (+22%) and Co. Wexford (+20%).



Population Change

All four areas have experienced population

	Area Hectares	Population	Density Hectares per 100	% of Total SE Population
Waterford	185,871	101,546	55	24%
Carlow	89,790	46,014	51	11%
Wexford	236,527	116,596	49	28%
Kilkenny	207,169	80,339	39	19%
Tipp S	225,794	79,121	35	19%
SERDTF Region	945,151	423,616	45	

increases since the previous Census. The largest change was in Wexford where the population increased by 12%. Tipperary South had the lowest population change and only increased by 4.5%. Both Carlow/Kilkenny and Waterford have experienced 11% population growth since the 1991 Census.

Population Migration – Urban/Rural

There has been a gradual drift from rural to urban areas and it is now recorded that some 43% live in towns of over fifteen hundred people. The large towns with the highest percentage increase since 1996 are Gorey, Co. Wexford (34%) and Carlow, Co. Carlow (23%).

County	Urban %	Rural %
Carlow	51%	49%
Kilkenny	28%	72%
Wexford	33%	67%
Tipperary SR	39%	61%
Waterford	63%	37%
SERDTF Region	43%	57%

The urban/rural mix across the Region masks some differences within counties and therefore the patches of the Local Drugs Task Forces. So while Carlow and Waterford have the majority of their population in the urban setting, Kilkenny, Wexford and Tipperary SR have a significantly greater concentration of their population in rural areas. This should have a major impact on the type of services, projects, their design implementation and resources needs.

	Population			
Towns	2002	1996	Change Actual	% Change
Co. Carlow				
Carlow	18,487	14,979	3,508	23%
Muinebeag	2,728	2,695	33	1%
Tullow	2,417	2,364	53	2%
Total Urban	23,632	20,038	3,594	18%
Rural (notional)	22,382	21,578	804	4%
County Total	46,014	41,616	4,398	11%
Co. Kilkenny				
Kilkenny	20,735	18,696	2,039	11%
Thomastown	1,600	1,581	19	1%
Total Urban	22,335	20,277	2,058	10%
Rural (notional)	58,004	55,059	2,945	5%
County Total	80,339	75,336	5,003	7%
Co. Wexford				
Wexford	17,235	15,862	1,373	9%
Enniscorthy	8,964	7,640	1,324	17%
New Ross	6,537	6,147	390	1%
Gorey	5,282	3,939	1,343	34%
Total Urban	38,018	33,588	4,430	13%
Rural (notional)	78,578	70,783	7,795	11%
County Total	116,596	104,371	12,225	12%
Co. Tipperary SR				
Clonmel	16,910	16,182	728	4%
Carrick-on-Suir	5,586	5,217	369	7%
Tipperary	4,964	4,854	110	2%
Cashel	2,770	2,687	83	3%
Cahir	2,794	2,236	558	25%
Total Urban	33,024	31,176	1,848	6%
Rural (notional)	51,233	49,436	1,797	4%
County Total	84,257	80,612	3,645	5%
Co. Waterford				
Waterford	46,736	44,155	2,581	6%
Dungarvan	8,305	7,175	1,130	16%
Tramore	7,452	6,536	916	14%
Dunmore East	1,750	0	0	0
Total Urban	64,243	57,866	6,377	11%
Rural (notional)	37,303	36,814	489	1%
County Total	101,546	94,680	6,866	7%
Total Urban	181,252	162,945	18,307	11%
Rural (notional)	242,364	228,572	13,792	6%
SERDTF Total	423,616	391,517	32,099	8%

The table above calculates the relative population density of each area of the Region and further demonstrates that Waterford and Carlow have a more accessible population than is the case in Wexford, Kilkenny and Tipperary South.

The large table above shows the urban/rural breakdown by county and details towns which have a population in excess of fifteen hundred people. This analysis will also assist in the formulation of policies, services and projects although more detailed scrutiny of the Census 2002 data will reveal suburban populations also and may assist in defining specific areas which can usefully be combined for targeting and service delivery efficiency purposes.

This aspect is very important in the approach to drugs services in particular. In a recent study (released January 2005) carried out by Professor McKegney on the drugs situation in Scotland, it was noted that the incidence of heroin addiction which afflicts 1½ % of the Scottish population, has been migrating from the large conurbations to rural parts of the country. This is happening despite a reduction by some 5% in the number of drugs misusers throughout the country.

This development has presented the health and social services and voluntary agencies in Scotland with new challenges regarding prevention, treatment and support services. First of all the support services for drugs misusers are necessarily visible in such small towns and the stigma of being seen attending them actually deters most people in need. So, for treatment and support, many drugs misusers have to attend centres in other towns or cities – or don't attend at all. Even centres which are set up in anonymity become known as the "drug house" and very soon end up only being able to provide a limited service.

From the supply point of view, one of the

reasons that this migration is occurring is the fact that dealers (of hard drugs such as heroin) are finding it more difficult to find new outlets in a declining market. Added to the increasing preference and propensity for young people living in rural areas to arrange their social lives in urban areas where drugs are more readily available, the research is suggesting that they domicile the drug habit in their home town which is then supplied by themselves, as well as the dealers who see the opportunity for extending their market in rural areas.

Since there are similar risks associated with the situation in the South East Region and indeed elsewhere in Ireland outside the large conurbations, any information such as population density and social behaviour that informs planning, policy and practice in the South East should be carefully considered.

Deprivation

The analysis of deprivation is extracted from the New National Deprivation Index prepared by the Department of Public Health and Primary Care in Trinity College Dublin. The analysis is based on Small Area Population Statistics (SAPS) and is employed to construct a weighted combination of indicators of unemployment, social class, type of housing tenure, car ownership and overcrowding to produce an Index of Deprivation.

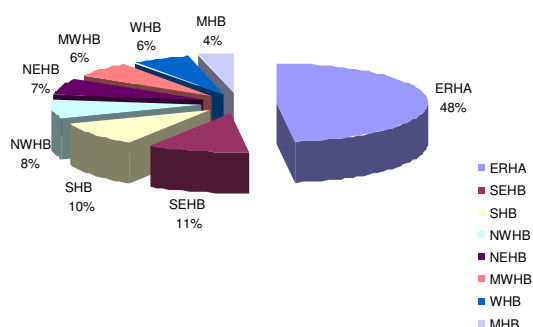
The data is derived from the SAPS available for the 3,422 Electoral Divisions (ED) in Ireland as collected and presented through the 2002 Census. As such, the Index is probably the most appropriate available for Ireland and facilitates the purposes of this strategy. It is anticipated that the analysis presented here will inform the targeting of Regional drugs services at those communities most in need. Policymakers and planners working at local levels are urged to consult the detail of the Index to assist with

identifying priority areas within their Local Drugs Task Force area.

The Regional analysis of deprivation will commence by looking at the country as a whole and ending by looking at each of the areas of Carlow/Kilkenny, Waterford, Wexford and Tipperary South.

In 2002, 692,023 (18%) of the population of Ireland lived in the top decile (10%) of most deprived ED's (there are 3,422 EDs in total).

% of Persons Living in Top Decile of Deprivation by Health Board Area



Health Board Area	% of Persons Living in Top Decile of Deprivation by Health Board Area
ERHA	48
SEHB	11
SHB	10
NWHB	8
NEHB	7
MWHB	6
WHB	6
MHB	4

The chart and table above demonstrate that 48% of the 692,023 people living in the most deprived EDs are in the Eastern Regional Health Authority area. The regional health authority with the next highest number of people in the top decile of deprivation is the

South Eastern Health Board where 11% of the 692,023 live. Therefore, in terms of the established causal link between deprivation and drugs misuse, the SERDTF has compelling evidence to ensure that it implements appropriate strategic drugs interventions.

Area	No of EDs in Most Deprived Decile	%
Dublin City	76	22.2
Donegal County	50	14.6
Cork City	33	9.6
Limerick City	22	6.4
Mayo County	22	6.4
Waterford City	17	5
Galway County	16	4.7
South Dublin	11	3.2
Tipperary SR	8	2.3
Kerry County	7	2
Louth County	6	1.7
Wexford County	6	1.7
Carlow County	5	1.5
Dun Laoghaire-R'Down	5	1.5
Galway City	5	1.5
Cavan County	4	1.2
Clare County	4	1.2
Fingal	4	1.2
Laois County	4	1.2
Leitrim County	4	1.2
Longford County	4	1.2
Waterford County	4	1.2
Wicklow County	4	1.2
Kildare County	3	0.9
Kilkenny County	3	0.9
Limerick County	3	0.9
Offaly County	3	0.9
Westmeath County	3	0.9
Monaghan County	2	0.6
Sligo County	2	0.6
Cork County	1	0.3
Meath County	1	0.3
Roscommon County	1	0.3

The table above identifies the location of the most deprived ten per cent EDs. Therefore Waterford City has 5% or 17 of these EDs, Tipperary SR 2.3% (9), Wexford County 1.7%

[6], Carlow County 1.5% [5], Waterford County 1.2% [4] and Kilkenny County 0.9% [3]. To add to the overall picture and appreciate where the SERDTF area fits into the national data, the following table shows the number of EDs in each area and the percentage of them which are in each Deprivation Index Level.

Region	ERHA	MHB	MWLB	NEHB	NWLB	SEHB	SHB	WHB
No of EDs/Dep Index	493	343	406	295	306	515	564	500
1	20	5	11	5	4	8	14	7
2	10	10	15	9	3	10	10	10
3	10	10	13	9	2	11	11	12
4	6	14	10	12	6	11	12	9
5	5	14	11	10	6	13	10	11
6	6	11	9	14	12	10	9	11
7	6	12	8	15	9	10	10	11
8	7	10	9	12	13	9	10	11
9	10	9	7	9	25	10	6	9
10	21	4	7	4	18	8	7	9

In the table above, 8% of the 515 EDs within the South Eastern Health Board area (SEHB) are designated as Deprivation Level 10 – the most deprived. One more table combines the data to indicate the percentage of EDs in the most deprived decile and the % population in the most deprived decile in order to view a national picture on a relative basis.

Region	No Eds	Population	No EDs in 10th Decile	% EDs in 10th Decile	Population in 10th Decile	% Population in 10th Decile
ERHA	493	1,401,441	103	20.9	333,718	23.8
MHB	343	225,363	14	4.1	26,556	11.8
MWLB	406	339,591	29	7.1	38,959	11.5
NEHB	295	344,965	13	4.4	49,875	14.5
NWLB	306	221,574	56	18.3	55,491	25
SEHB	515	423,616	43	8.3	78,226	18.5
SHB	564	580,356	41	7.3	68,136	11.7
WHB	500	380,297	44	8.8	41,062	10.8

The foregoing has set out the profile that the SERDTF area has within the national context

of deprivation. The next section analyses the index within the area and attempts to identify the priority areas of need to as much detail as possible based on relative deprivation indices.

Deprivation Decile	No Eds	Carlow	Kilkenny	Tipperary SR	Waterford	Wexford
1	51	6%	51%	14%	24%	6%
2	51	12%	31%	22%	20%	16%
3	52	12%	29%	17%	15%	27%
4	51	12%	20%	20%	24%	25%
5	52	6%	33%	12%	19%	31%
6	51	12%	8%	29%	20%	31%
7	52	13%	15%	19%	21%	31%
8	51	14%	4%	14%	33%	35%
9	52	10%	23%	23%	23%	21%
10	52	10%	6%	17%	50%	17%

The table above illustrates the percentage of EDs within given deprivation deciles by county. One can see that 50% of the EDs which have the most deprived Index of 10 are in Waterford, whereas Kilkenny has 51% of the least deprived EDs.

Deprivation Index Level	Carlow	Kilkenny	Tipperary SR	Waterford	Wexford
No Eds	54	113	96	128	124
1	6%	23%	7%	9%	2%
2	11%	14%	11%	8%	6%
3	11%	13%	9%	6%	11%
4	11%	9%	10%	9%	10%
5	6%	15%	6%	8%	13%
6	11%	4%	16%	8%	13%
7	13%	7%	10%	9%	13%
8	13%	2%	7%	13%	15%
9	9%	11%	12%	9%	9%
10	9%	3%	9%	20%	7%

This table sets out the proportion of EDs within each decile by county/region. So 7% of the 124 Wexford EDs are in the most deprived index level, while 20% of Waterford's 129 also are and 23% of Kilkenny's 113 EDs are in the least deprived

index level. Similarly 28% of Tipperary SR's 96 EDs are in the three most deprived

ED Name	County	Score
Bilberry	Waterford City	2.24
Enniscorthy Rural	Wexford	2.26
Ballybricken West	Waterford City	2.27
Kilcommon	Tipperary South	2.31
Ballingarry	Tipperary South	2.33
Rosbercon Urban	Wexford	2.42
Ardmore	Waterford County	2.43
Buolick	Tipperary South	2.46
Ferns	Wexford	2.51
Cashel U.D.	Tipperary South	2.54
Muinebeag Urban	Carlow	2.66
Kilmacthomas	Waterford County	2.69
Centre B	Waterford City	2.73
Urlingford	Kilkenny	2.76
Slievekeale	Waterford City	2.78
Poleberry	Waterford City	2.78
Taghmon	Wexford	2.79
Tulow Urban	Carlow	2.82
Killenaule	Tipperary South	2.82
Callan Urban	Kilkenny	2.87
Wexford No. 1 Urban	Wexford	2.93
Graigue Urban	Carlow	2.93
Kilkenny No. 1 Urban	Kilkenny	2.97
Grange South	Waterford City	3.13
Kingsmeadow	Waterford City	3.14
Ballyruckle	Waterford City	3.19
Clonmel West Urban	Tipperary South	3.40
Carlow Urban Area	Carlow	3.53
Rathvilly	Carlow	3.53
Wexford No. 3 Urban	Wexford	3.57
Kilmeadan	Waterford County	3.65
Enniscorthy Urban	Wexford	3.73
Morrisson's Ave East	Waterford City	3.98
Farranrory	Tipperary South	4.04
Military Road	Waterford City	4.05
Wexford No. 2 Urban	Wexford	4.14
Dungarvan No. 1 Urban	Waterford County	4.15
The Glen	Waterford City	4.22
New Ross Urban	Wexford	4.31
Shortcourse	Waterford City	4.32
Morrisson's Ave West	Waterford City	4.41
Tipperary East Urban	Tipperary South	4.78
Carriek-on-Suir Urban	Tipperary South	5.59
Mount Sion	Waterford City	5.67
Lisduggan	Waterford City	6.11
Morrisson's Road	Waterford City	6.58
Roanmore	Waterford City	6.68
Newport's Square	Waterford City	6.70
Custom House A	Waterford City	6.93
Custom House B	Waterford City	7.55
Larchville	Waterford City	7.55
Ballybeg North	Waterford City	10.14

deprivation levels while 27% are in the least deprived three.

Index Level	No. EDs	Population	% Total Pop.
1	51	34,633	8.18
2	51	24,139	5.70
3	52	24,777	5.85
4	51	20,425	4.82
5	52	40,155	9.48
6	51	29,529	6.97
7	52	44,141	10.42
8	51	56,926	13.44
9	52	54,217	12.80
10	52	94,674	22.35

The table above indicates the population which live in each deprivation decile level. Thus we can see that the EDs in the higher levels of deprivation from, say decile 7 - 10, comprise 59% of the population.

The table on the left identifies the EDs in the SERDTF which are in the decile representing the most deprived areas. Within decile 10, it also sets out each EDs Deprivation Index when measured across the five variables. These are the EDs to which the SERDTF plan is most germane, although as in all statistical analyses, even small area population data can mask pockets of deprivation.

As an example, the ED Tulow Urban is ranked 481 on the Deprivation Index (out of 515 SE Regional ED's) and is in the most deprived decile. It has an unemployment rate of 7%, 32% are in the lower socio-economic groupings, 29% have no car, 21% rent or have purchased their accommodation from the Local Authority and 55% of the housing is deemed over-crowded. These data would be the average measurements for the variables across all 51 EDs in the most deprived decile.

Details of Deprivation Index for all 515 EDs in the SERDTF area are available for planning purposes from the Public Health Dept. The next section examines drug prevalence data.

PREVALENCE

One of the critical factors in any strategic plan is the need to establish mechanisms of

measurement. These are necessary not just to set SMART objectives but to measure the extent to which the strategy has been successful. In addition, more knowledge of the drugs environment by those directly and indirectly involved in the implementation of the plan, generates a confidence that the actions taken are the correct ones and that their impact can be evaluated. Also in the drugs field, there is a need to be as accurate as possible in presenting drugs data and use to the public. All too often, the public and many others in policymaking and service delivery organisations tend to arrive at an incorrect perception of the prevalence level of drug use. In many cases, the presence of drugs in communities is presented as, *"...available at every street corner..."*, or *"...all of my children have been offered drugs at school..."*, or *"...they're (drugs) everywhere..."*. Parents cannot be blamed for these perceptions in the absence of other more erudite and informed counsel, but sometimes it is little wonder that groups of young people are observed with suspicion and that such perceptions pervade and over-ride the positive attributes of young people.

This section sets out some data which is relevant to the SERDTF, the preparation of the Plan and to other research discussions. First of all a European overview is presented which refers to the map alongside, and which sets out prevalence data for cannabis use within the 15 – 34 year old age group. The section will proceed by setting out initial published findings of the ESPAD 2003 survey which covers Europe and deals with adolescents only (school based survey). Following that, some aspects of the growth and pre-dominance of cannabis use in Ireland is discussed finishing with some local research. It must be said that there is a research gap for the SERDTF area and it is hoped that one of the key outcomes of this plan will address this.

ESPAD Summary of the 2003 findings

Data on young people's alcohol and drug habits have been collected in three waves of the European School Survey Project on Alcohol and Other Drugs, ESPAD. The first study was conducted in 26 countries in 1995. The second survey was done in 1999 and reached 30 participating countries. The focus of this section is on the findings from the surveys that were performed in 35 countries in 2003.

The participating countries include Austria, Belgium, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, the Faroe Islands, Finland, France, Germany (6 Bundesländer), Greece, Greenland, Hungary, Iceland, Ireland, Isle of Man, Italy, Latvia, Lithuania, Malta, the Netherlands, Norway, Poland, Portugal, Romania, Russia (Moscow), the Slovak Republic, Slovenia, Sweden, Switzerland, Turkey (6 cities), Ukraine and the United Kingdom. The project is a collaborative project between independent research teams in the participating countries. More than 100,000 students participated in the 2003 data collection.

The behaviours measured are cigarette smoking, alcohol consumption, drunkenness and use of illicit drugs.

Methodology

The surveys were conducted with a standardised methodology and a common questionnaire to provide as comparable data as possible. Data were mainly collected during Spring 2003 and the target population was students born in 1987. Thus, the age group studied turned 16 during the year of data collection. Data were collected by group-administered questionnaires in schools on nationally representative samples of classes. Teachers or research assistants collected the data and the students answered the questionnaires anonymously in

the classroom under conditions similar to a written test. The sample sizes in participating countries range between 555 in Greenland to almost 6,000 in Poland. However, small study groups are only found in small countries where no sampling was done. In all remaining countries, the sample size was close to or above the recommended number of 2,400. The results of the survey were reported in a standardised format. These country reports form the basis of the content of the report.

Data quality

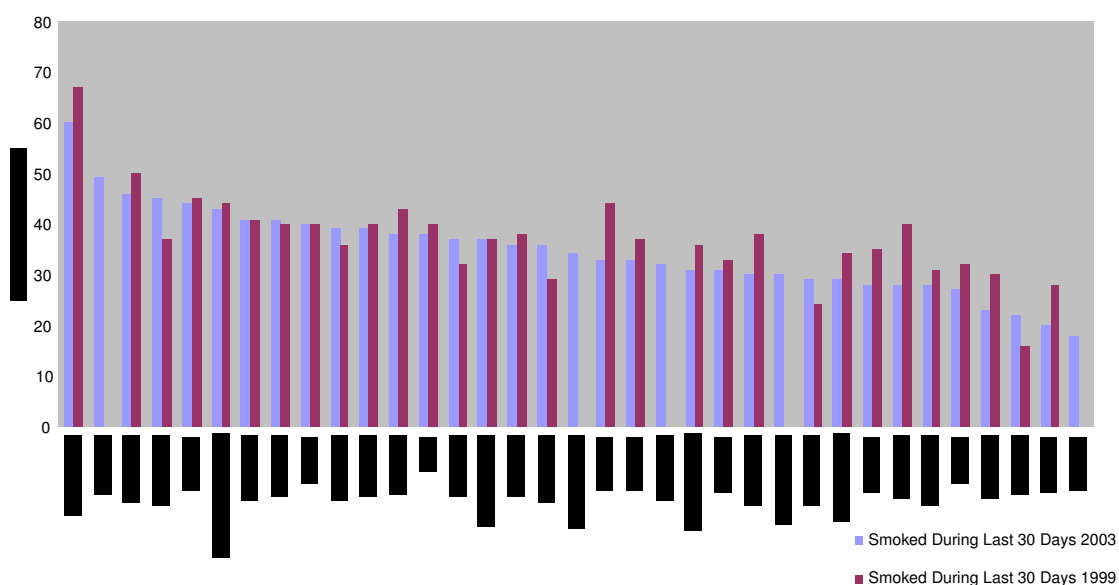
Every effort was made to standardise the methodology of the ESPAD project across countries. Nevertheless, some methodological issues inevitably arise in a comparative survey of 35 countries. The validity is deemed to be high in most ESPAD countries. The cultural context in which the students have answered the questions has most probably differed between countries. However, this does not necessarily indicate large differences in the willingness to give honest answers. A few countries have

necessary to seriously threaten the comparability of results. For various reasons it was not possible to give precise levels of statistical significance in this report. Small differences in point estimates between countries or over time should therefore be interpreted with caution. However, given the size of the national samples and the sampling methods employed, differences of more than a few percentage points can with considerable confidence be considered significant.

Tobacco

The use of cigarettes 40 times or more in lifetime and the 30 days prevalence rates are presented in the summary tables. In nearly all ESPAD countries 50–80% of the students had smoked cigarettes at least once in their lifetime, and those who had smoked 40 times or more are mainly found in countries where the lifetime prevalence is high. In Austria, the Czech Republic, the Faroe Islands, Greenland, Germany, Lithuania and Russia (Moscow) about 40% had smoked 40 times or more in

% Young People Smoking 2003 and 1999



experienced modest validity problems, but such problems are not of the magnitude

their lifetime. The lowest prevalence rates are found in Turkey [13%], Malta [16%],

Iceland and Portugal (18% each). In eight of the 35 ESPAD countries more boys than girls had smoked 40 times or more in their lifetime. These countries are mainly found in the eastern parts of Europe such as Estonia, Latvia, Lithuania, Poland, Romania and Ukraine, but also in Cyprus and Turkey. Large differences in the other direction with more girls reporting this behaviour are mainly found in two northern islands, Greenland and the Isle of Man. The highest percentage of students, which reported smoking during the last 30 days is found in Greenland, which stands apart from other countries on this variable (60%). High rates are also found in Austria, Bulgaria, Germany, Russia (Moscow) and the Czech Republic (43–49%). Particularly low proportions are found in Cyprus, Iceland, Sweden and Turkey with figures ranging between 18 and 25%. Countries with substantially higher rates of last month smoking among boys include Cyprus, Latvia, Lithuania, Turkey and Ukraine. **Considerably higher rates among girls are found in Greenland, Ireland, Isle of Man and the United Kingdom.**

The smoking habits of students in Ireland, while still high at 33% in 2003 is down from the 1999 level of 37%. Since the survey preceded the introduction of the smoking ban in public places, it is thought that the level has reduced even more by now in 2005.

Alcohol consumption

Prevalence of alcohol consumption 40 times or more in lifetime, 30 days prevalence of alcohol consumption 10 times or more, as well as the 30 days prevalence of consuming beer, wine and spirits 3 times or more are analysed in the report. In two thirds of the ESPAD countries the vast majority (90% or more) of the students have drunk alcohol at least once in their lifetime. However, these students do not all drink on a regular basis. A student who has been drinking at least 40 times can be labelled as more of a regular

consumer. The prevalence rates of this frequency of drinking are much lower than the total lifetime prevalence. The highest rates reporting use of alcohol 40 times or more in lifetime are primarily found in the same countries as reported the highest lifetime figures. They include Denmark, Austria, the Czech Republic, Isle of Man, the Netherlands and the United Kingdom (43–50%) – **Ireland 36%**. The lowest proportion is reported from Turkey (7%) followed by Greenland, Iceland, Norway and Portugal (13–15%). More boys than girls report this level of alcohol consumption. In a few countries, Isle of Man, Finland and Norway, the gender distribution is about equal. However, no country reports prevalence rates among girls that exceed those of the boys. A higher frequency of alcohol use is revealed among students who had consumed alcohol 10 times or more during the last 30 days, i.e. at least every third day on average. About one quarter of the students in the Netherlands (25%) and about one fifth of the respondents in Austria, Belgium, Malta and the United Kingdom (17–21%) reported this frequency of alcohol use – **Ireland 14%**. In some countries, this drinking frequency is hardly reported at all. Proportions of 3% or less were found in Finland, Greenland, Iceland, Norway and Sweden. Thus, the very low prevalence rates are mainly concentrated to the Nordic countries. Many students report rather frequent beer consumption.

The percentages of students who had consumed beer 3 times or more during the last 30 days varies between 10 and 44%. The highest figures are found in Denmark, Bulgaria, the Netherlands and Poland (40–44%) – **Ireland 25%**. The smallest proportions were reported from Norway and Turkey (10 and 14% respectively). Other countries where less than 20% had consumed beer that often include Finland, Hungary, Iceland and Portugal. Drinking beer is a predominantly male behaviour in most

ESPAD countries. The only exceptions are two countries in the North Atlantic, Greenland and Iceland, where almost equal proportions of girls and boys report frequent beer drinking. A smaller number of students had been drinking wine than beer during the last 30 days. The proportions of students reporting a wine consumption frequency of 3 times or more during last 30 days are in most cases lower than 20%. However, one country stands out in this respect, as one third (35%) of the students in Malta reported this frequency of wine drinking. Other high prevalence countries include Austria, the Czech Republic, Greece, Italy and Slovenia (21–23%). The lowest proportions that reported this frequency of wine consumption are found in Finland, Iceland, Norway and Turkey (5% or less).

The number of students who had been drinking spirits during the last 30 days varies considerably between the ESPAD countries. This also holds true also when looking at the number of students who had been drinking 3 times or more during last month. **The UK, Ireland and the Isle of Man are at the top but also two Mediterranean countries.** The highest proportion is found in Malta, where 43% of the students reported this frequency of spirits consumption. The countries that come next include the Faroe Islands, Greece, **Ireland (46%)**, Isle of Man and the United Kingdom (37–39%).

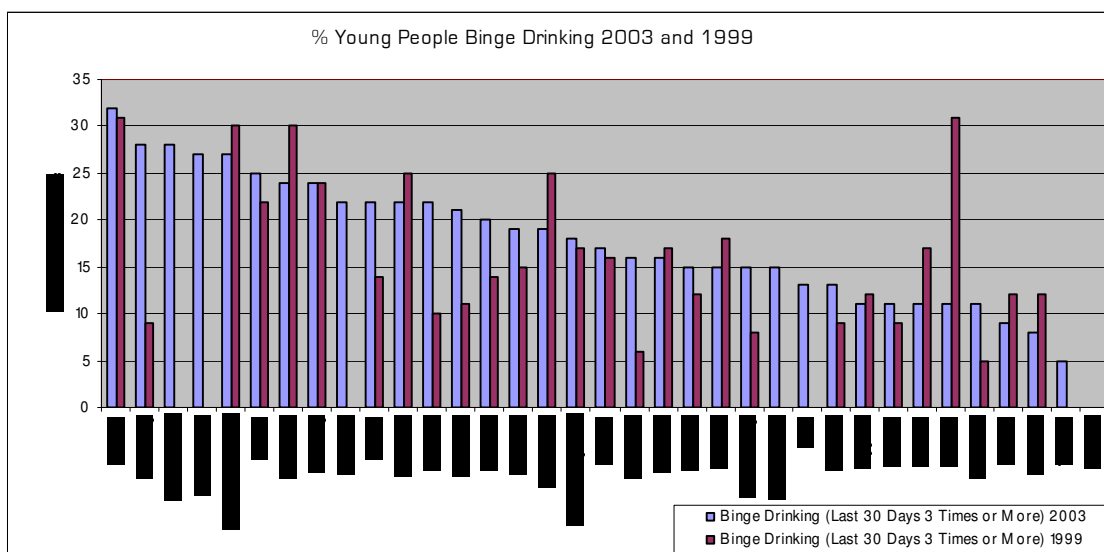
In about half of the countries, more boys than girls report such frequent consumption of spirits. However, almost the same number of countries report prevalence rates that are equal or almost equal between the sexes. Only three countries report proportions among the girls that exceed those of the boys. These countries are all high frequency countries and they are all parts of the British Isles, i.e. **Ireland**, Isle of Man and the United Kingdom.

Some students have a rather limited

experience of getting drunk, while others get intoxicated more frequently. However, in 30 of the 35 countries studied a majority of the students have been drunk at least once. **The countries with the highest percentages indicating that they had been drunk 20 times or more in lifetime include Denmark, Ireland (29% - second highest percentage), Isle of Man, the United Kingdom, Estonia and Finland.** In other countries only a few report this frequency of drunkenness. In Turkey only 1% had been drunk 20 times or more and in Cyprus, France, Greece and Portugal this was reported by about 3% of the students. In a majority of the countries there are more boys than girls that report this frequency of intoxication.

In no country are the girls in majority. However, in relatively many countries the gender distribution is rather even. These countries include Finland, the Faroe Islands, Iceland, Ireland, Isle of Man, Norway, Sweden and the United Kingdom. The number of students who have been drunk 3 times or more during the last 30 days is of course much smaller, but the highest ranked countries are in most cases the same. Thus, in Denmark and Ireland about one fourth of the students had been drunk that often. Other countries with high prevalence rates include Isle of Man and the United Kingdom.

However, in about half of the ESPAD countries the number of students reporting this frequency of intoxication is 10% or less. The lowest figures are reported from Cyprus, France, Greece, Portugal and Turkey (1–4%).



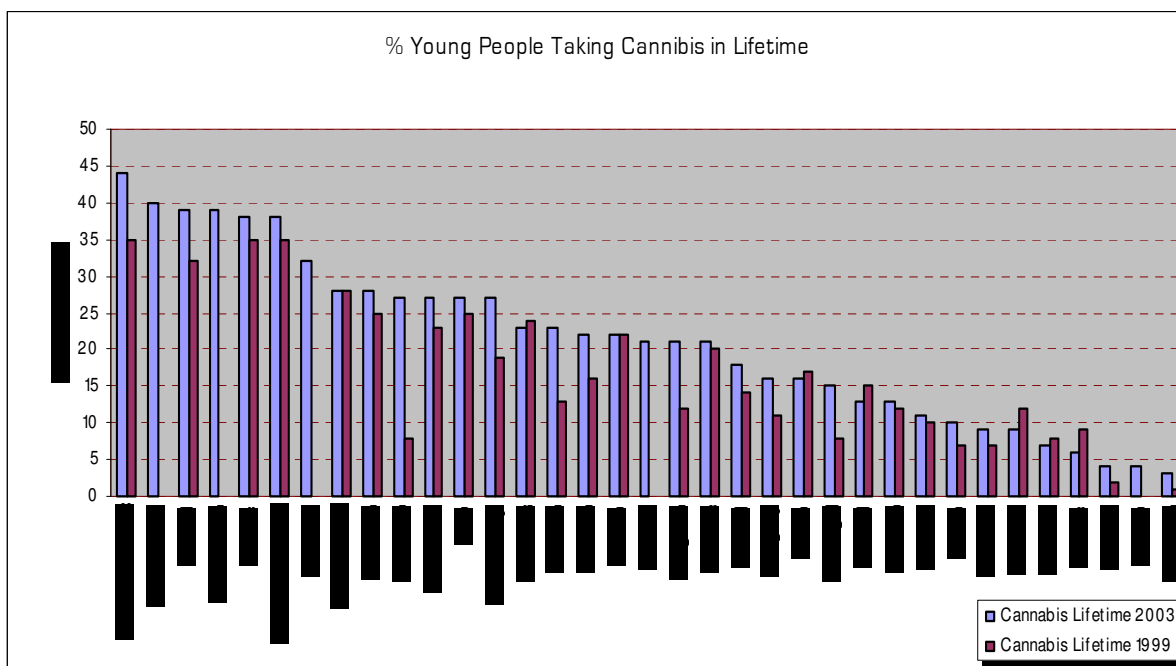
Binge Drinking

The frequency of having 5 or more drinks in a row, sometimes referred to as “binge drinking”, provides an alternative measure of heavy alcohol use. The proportion indicating such consumption 3 times or more during the last 30 days vary considerably over the ESPAD countries. This is reported by one fifth to one third of the students in about half of the ESPAD countries.

The highest number of students reporting this behaviour is found in Denmark, **Ireland**, Isle of Man, Malta, the Netherlands, Norway, Poland and the United Kingdom (24–32%). Thus, there is a concentration of countries to the northern and western parts of Europe with Malta as the only exception.

Countries with the lowest binge drinking figures are Cyprus, France, Greece, Hungary, Iceland, Romania and Turkey (5–11%).

Ireland has maintained its position at the head of the binge drinking table in this survey. In fact its binge drinking record has seen a marginal increase since 1999 and is well ahead of the UK.



Illicit drugs

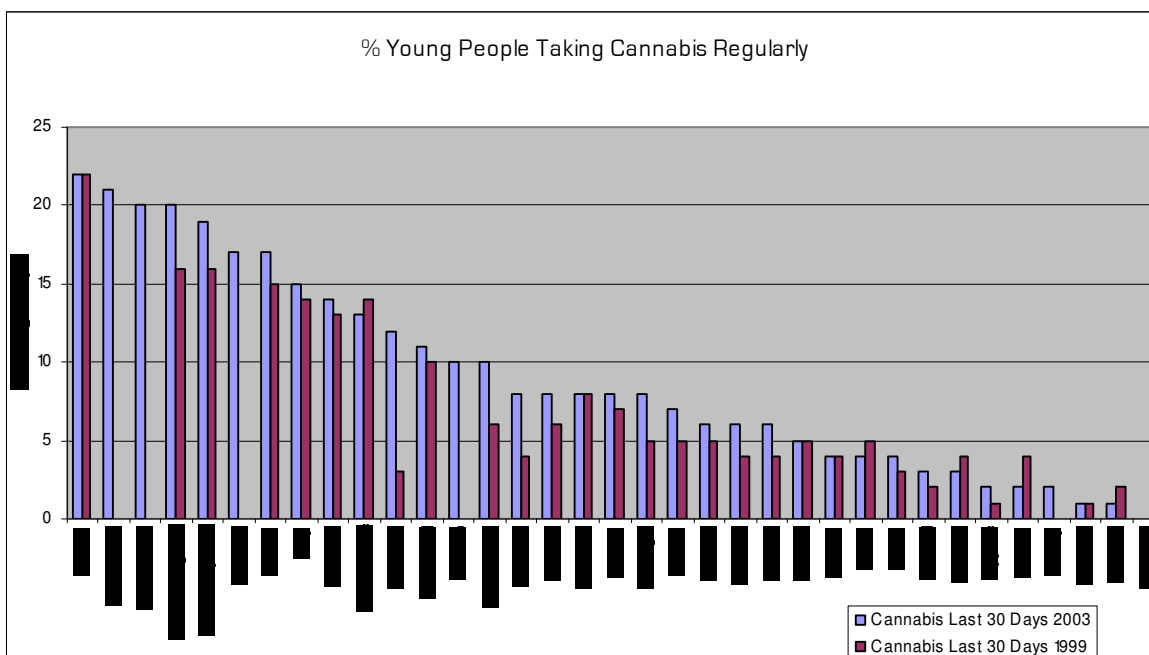
Lifetime use of various illicit drugs are presented in the summary tables, including cannabis, amphetamines, LSD, Ecstasy, tranquillisers or sedatives without a doctor's prescription and the use of inhalants. In addition the 30 days prevalence of cannabis is included. The vast majority of students in all ESPAD countries that have tried any illicit drug have used marijuana or hashish. Thus, the number of students reporting cannabis use is almost identical with the total illicit drug

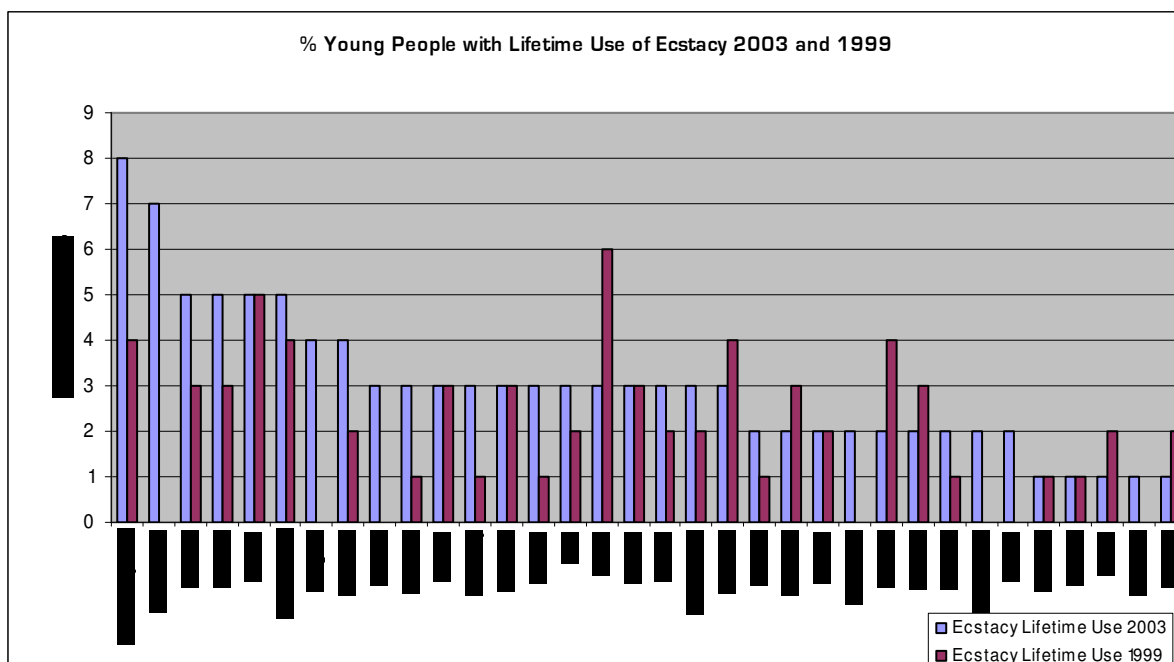
prevalence.

Ireland's overall measurement of both regular use and ever used are very high and have increased from 15 % to 17% and 32% to 39% respectively. This seems to concur with a number of other studies.

Cannabis

The top country in this respect is the Czech Republic where 44% of the students have used marijuana or hashish. High prevalence rates are also reported in France, Ireland (39%), Isle of Man, Switzerland and the





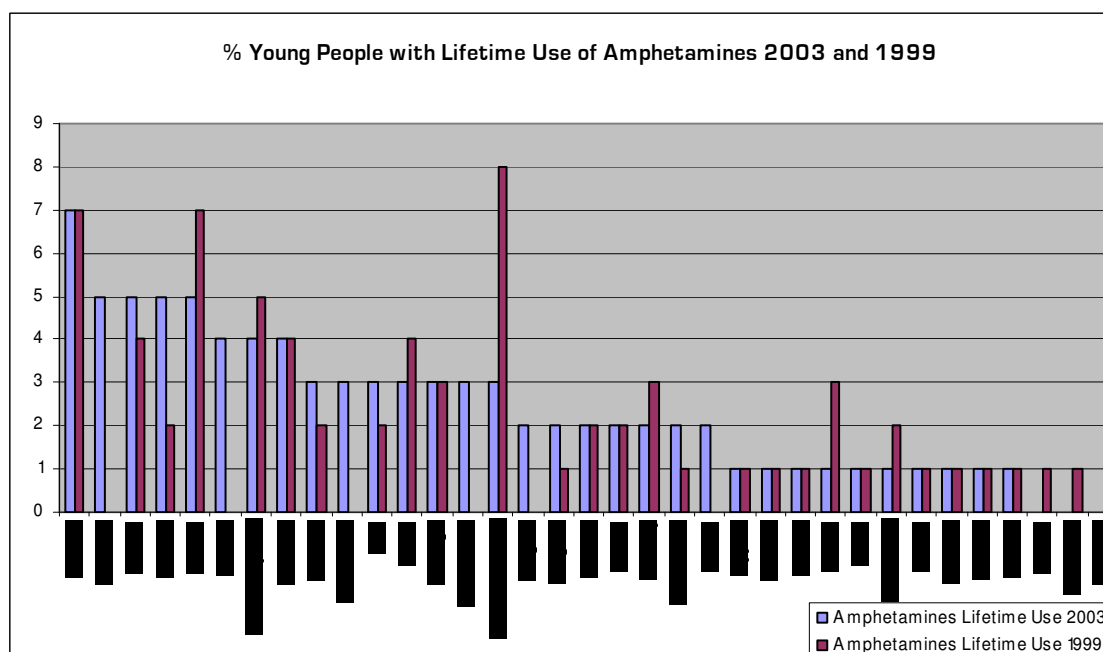
United Kingdom (38–40%). Other countries where more than 25% have used cannabis include Belgium, Germany, Greenland, Italy, the Netherlands, the Slovak Republic and Slovenia (27–32%). Lowest levels are reported in Cyprus, Greece, Sweden, Romania and Turkey (3–7%), but also in the Faroe Is, Finland and Norway (around 10%).

The use of cannabis during the last 30 days may indicate regular use. In some countries about one fifth of the students report this, in others much lower prevalence rates are noted. The countries with the highest 30 days prevalence include the Czech Republic, France, Isle of Man, Switzerland and the United Kingdom (19–22%) – **Ireland 17%**.

In most ESPAD countries there are more boys than girls who have used cannabis. However, the **gender differences are small in Bulgaria, Croatia, Greenland, Hungary, Iceland, Ireland, Russia (Moscow) the Slovak Republic and Slovenia.**

Amphetamines

The countries with the highest percentages of students reporting use of amphetamines are Estonia, Germany, Iceland, Lithuania and Poland (5–7%). In 13 countries 1% or less reported use of amphetamines. **Ireland has reduced its use of amphetamines to 1%.** The ESPAD students do not use LSD very frequently. The highest percentages are



frequent drunkenness in Mediterranean countries such as Cyprus, France, Greece, Portugal, Romania and Turkey.

The illicit drug use is dominated by use of marijuana or hashish. Frequent use is mainly reported from countries in the central and western parts of Europe, where more than one third of the students have used it. The high prevalence countries include the Czech Republic, France, Ireland, Isle of Man, Switzerland and the United Kingdom. The low prevalence countries are found in the north as well as the south of Europe. Mediterranean countries. The highest proportion is found in Malta, where 43% of the students reported this frequency of spirits consumption. The countries that come next include the Faroe Islands, Greece, Ireland, Isle of Man and the United Kingdom (37 – 39%).

USE OF CANNABIS IN EUROPE 15 - 34 YEAR OLD AGE GROUP – OTHER PREVALENCE RESEARCH

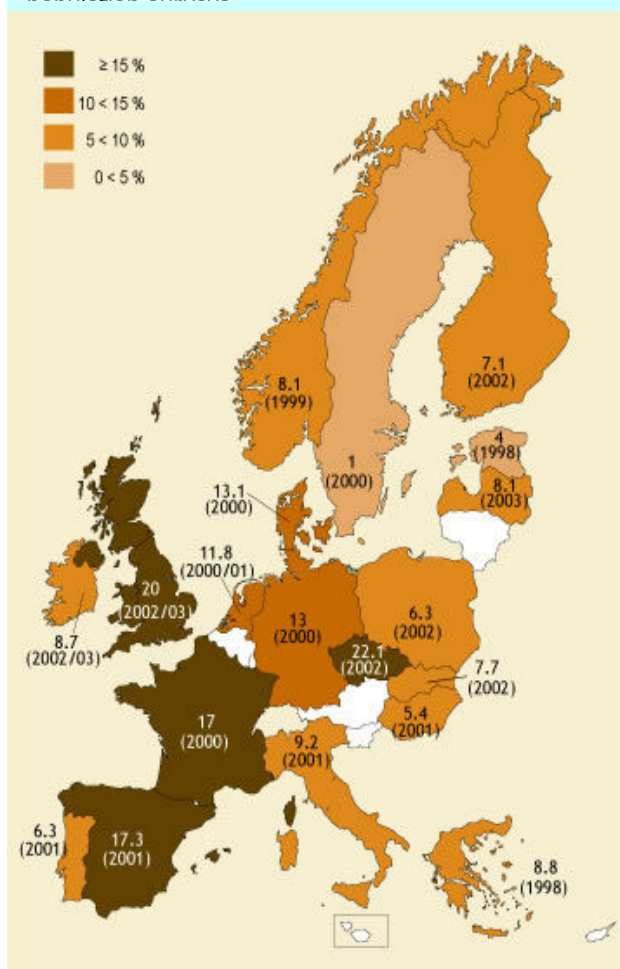
Drug use in the general population is assessed through surveys, which provide estimates of the proportion of the population that has used drugs over defined periods of time. Recent population surveys indicate that a significant proportion of the European adult population (aged 15–64 years) have tried the substance at least once, ranging from 5–10 % in Belgium, Estonia, Hungary and Portugal to 24–31 % in Denmark, Spain, France and the United Kingdom. For comparison, in the 2002 United States national household survey on drugs, 40 % of adults (12 years and older) reported having tried cannabis or marijuana at least once, and 11 % reported having used it during the previous 12 months.

Surveys indicate that cannabis use is concentrated among young adults (aged 15–34 years), and particularly among people in their 20s. Rates of cannabis use are notably higher among males than among females.

National surveys also suggest that use is more common in urban areas or areas with a high population density. Some of the national differences noted might, in part, reflect differences in levels of urbanisation.

The numbers of 15- and 16-year-old school students who perceive cannabis to be easily or very easily available are consistently much higher than the numbers who report lifetime experience of cannabis use, but both measures show the same geographical variations. Differences between countries are considerable. Recent surveys of 15-year-old school students indicate that lifetime prevalence of cannabis use ranges from less than 10 % in Greece, Malta, Sweden and Norway to over 30 % in the Czech Republic,

Recent use (past year) of cannabis among young adults (15–34 years) as measured by national population surveys



Spain, France and the United Kingdom. The highest prevalence rates are found among boys in England (42.5 %), with slightly lower rates (38 %) among girls in England. The difference in cannabis use between boys and girls also varies between countries and tends to be less pronounced in northern Europe. For example, in Sweden, lifetime prevalence rates are 7.7 % for boys and 6.6 % for girls, while the corresponding figures for Greece are 8 % and 2.7 %. A large proportion of cannabis use tends to be occasional, or to be discontinued after some time.

It should be said at the outset that the vast body of research on the consequences of cannabis use does not lend itself to simple and easy conclusions. This is partly because the substance is itself a very complex one in terms of its chemical composition. In addition, cannabis use is often associated with use of other substances (legal and illegal) so that the exact part played by cannabis is difficult to pinpoint. Even more complex is the issue of other factors (personality, social factors) which are frequently associated with beginning to use cannabis and which may have an influence on the very outcomes that are sometimes attributed to cannabis use.

There have been suggestions that because cannabis use has become such a routine feature of many young people's lives, it is no longer regarded by such young people as a deviant form of behaviour. As evidence of this 'normalisation', some people point to the relatively high prevalence rate and the perception that such behaviour is common among their friends and peers. There is evidence, particularly in certain social contexts, that cannabis use is an accepted feature of social events and does not meet with outright rejection. However, such acceptance should be seen in the context of the views of the general public, especially older age groups, which are dramatically at

variance with 'normalisation'.

Cannabis is the most commonly used illicit drug in Ireland and elsewhere (Moran et al., 2001; ESPAD, 2003; Brinkley et al., 1999; NACD & DAIRU, 2003) and the third most widely used drug, after alcohol and tobacco. Studies conducted throughout Ireland confirm the popularity of cannabis (O'Brien et al., 2000). Selected studies in Dublin, the Midland Heath Board region, Kildare/Wicklow, Cork, Kilkenny, Longford, and the North Eastern Health Board Region found cannabis to be the most common illicit drug (North Eastern Health Board region included solvents). Moran et al. (2000) stress the importance of distinguishing between lifetime and current use of drugs.

It is argued that recent or current use of a drug is a more accurate indicator of frequency. Lifetime experience of a drug simply measures if a sample has ever used the drug in question, while recent use assesses drug experiences within the last year, last month, etc. Therefore, the lifetime measure may fluctuate very little from year to year, behaving as a poor indicator of trends within a population. Prevalence rates indicating lifetime use are nonetheless employed because of their widespread availability and usefulness in making comparisons (International Scientific Conference on Cannabis, 2002).

It is also important to distinguish between use/user and misuse/problem drug user. Problem drug user as defined by Bryan et al. (2000) is "a drug user who experiences social, psychological, physical or legal difficulties as a result of an excessive compulsion to continue taking drugs". *Use* refers to any aspect of the drug taking process, while *misuse* "...refers to the use of illegal substances in a manner that results in physical or mental harm or loss of social well-being for the individual, for other individuals, or for society at large". Of those who use

cannabis, most only do so occasionally. A minority are chronic users and experience difficulties. One out of ten users will become dependent on cannabis (reported by Degenhardt et al., 2000; Hall & Babor, 2000). Over one-fifth (21.4%) of young people aged 20 - 24 from the Nordic region reported lifetime use of cannabis, but almost 90% of those lifetime users had tried it only a et al. (2001) also stressed the important distinction between occasional use and dependence. Dependence, not occasional use, was associated with use of other drugs and legal problems relating to cannabis in this longitudinal study. They conclude *"occasional use does not appear to present a serious problem, [but] cannabis dependence among users is a serious public health issue that warrants immediate action"*. Moran et al. (2000) say that the proportion of people presenting for treatment for cannabis use has been between 11% and 16% of those seeking all treatment, since 1990.

Lifestyle and Personality Factors

A National Household Survey conducted in Australia found that cannabis use was strongly related to the respondent's gender, age, tobacco-smoking and alcohol-drinking behaviour. Eighteen per cent of the males surveyed reported that they had used cannabis compared with only 8 per cent of the females (Trimboll & Coumarelos, 1998). Cannabis use was highest and most frequent among the younger age groups while another Australian study found that daily cannabis users tended to be male (Hall et al., 1994).

A study which examined the personal student background and college characteristics associated with cannabis use found that use was higher among students at non-commuter colleges and at colleges with pubs on campus (Bell et al., 1997). Student characteristics associated with marijuana use included being single, white, spending more time at parties and socialising with

friends, and less time studying.

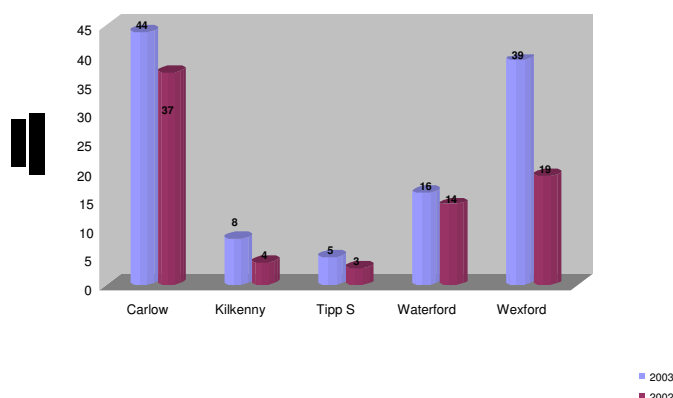
Cannabis use was also found to be higher among students who participate in other high risk behaviours such as binge drinking, cigarette smoking and having multiple sexual partners, and among students who perceive parties as important, and religion and community service as not important. Another study identified early smoking and experimentation as risks for cannabis use (Ellickson et al., 2001). Miller and Plant (2002) found that heavy cannabis users as a whole were more likely to go out to discos, parties etc. than light users.

Other Research Sources Relating to Prevalence

The data presented in the ESPAD 2003 Survey is reasonably consistent with the results of others undertaken and known to M & P. Cannabis is by far the drug of choice and roughly over one-third of young people have tried it at some time and fewer than one-fifth take the drug regularly.

The prevalence study undertaken by Kilbarrack Coast Community Programme 2004 confirms these data. In that study, "A Prevalence Study of Drug Use by Young People in a Mixed Suburban Area", 37% of respondents had used cannabis at some stage in their lives while 33% had used it

People Seeking Treatment in SEHB Area - Heroin



within the last year and 21% within the last thirty days. Of the same group, 76% had

drunk alcohol at some time in their lives, approximately two-thirds in the last year and 50% in the last thirty days. Sixteen per cent had used inhalants ever, while eight per cent had done so in the past year and four per cent in the past thirty days. Six per cent had used cocaine ever and in the last year while 2½% had used it within the past thirty days. Fewer than 1% had reported that they had ever used heroin.

Other sources of prevalence data are Gardai statistics and Treatment data generated by the SEHB.

SEHB Treatment Services

The SEHB data is collated from a form supplied by the Drug Misuse Research Division of the Health Research Board and is part of the national Drug Treatment Reporting System which is an epidemiological database on treated drug and alcohol misuse in Ireland. One of these forms must be completed for each person treated during the 12-month period January to December. They include data from the SEHB Treatment Services, Drug Treatment Clinics in Carlow and Waterford, Aiséirí – Cahir and Wexford, Aislínn, Kilkenny and the Cornmarket Project.

In the Region, 2,345 people sought or attended for treatment during 2003 which was a 6.2% increase on 2002 figures. Unfortunately the data do not shed any light on prevalence for the Region since there is a combination of factors that influence them.

- The data include people seeking treatment and information;
- The number of people attending will depend on the availability of counsellors;
- Different centres have different capacities for service provision;
- Services in some areas are more accessible than others;

- The 2002 and 2003 data were collated at a time when services were being introduced and developed.

The data in the table below must be treated with great caution and care, not on account of inherent inconsistencies arising from the factors mentioned above but because they do not outline a trend nor any other information relating to prevalence. However, they do indicate that 112 people sought treatment for heroin use as their main drug and 401 for cannabis in 2003. On the basis of the presentation of the data, it is not possible to ascertain the incidence of heroin or cannabis by county. Indeed Government data (National

Main Drug	2003	2002	% Change
Alcohol	1284	1281	0%
Heroin	112	67	67%
Cannabis	401	289	39%
Cocaine	32	12	167%
MDMA	74	81	-9%
Benzodiazepines	9	15	-40%
Amphetamines	18	18	0%
Barbiturates	1	0	0%
Codeine	0	4	-100%
Hallucinogen	1	0	0%
Hypnotic	1	0	0%
Other Opiate Type Drugs	6	9	-33%
Prescribed Medication	4	2	100%
Volatile Inhalants	3	5	-40%

Central Treatment List) also indicate that 74 people were accessing a methadone treatment programme in the SEHB area in August 2004.

The trends of treatment uptake reveals that there were significant increases for heroin, cannabis and cocaine use of 67%, 39% and 167% respectively. The chart above outlines the location of people seeking heroin treatment in the SERDTF area and identifies Carlow and Wexford as accounting for over two-thirds of the total. It is also noteworthy that there have been increases in all counties but moreso in Wexford and Carlow.

The profile for cannabis treatment

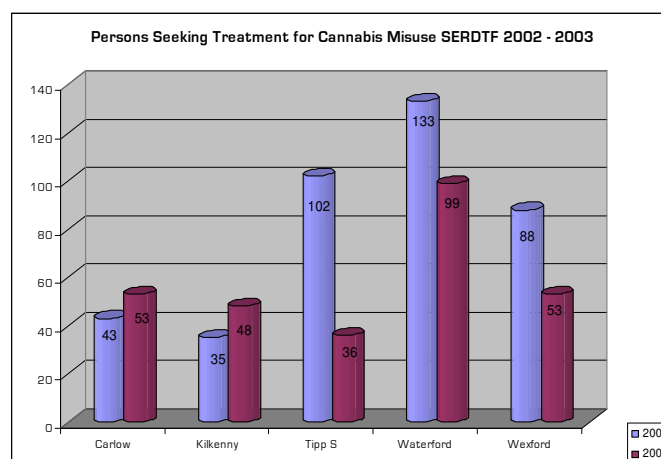
demonstrates a different picture where there have been large incidences in Waterford, Wexford and South Tipperary with the latter county experiencing a threefold increase between 2002 and 2003.

The table also shows an almost threefold increase in people seeking treatment for cocaine misuse from 12 in 2002 to 32 in 2003. Thirteen of these cases were in Wexford, eight in Carlow and seven in Waterford.

Health Research Board Data

The chart/map below is an extract from Occasional Paper No 14, 2004, of the Drug Research Misuse Division of the Health Research Board and it indicates the average annual incidence of treatment for cannabis as a main problem drug among persons aged 15 to 64 years by county of residence per 100,000 population (Central Statistics Office 2003) based on returns to the NDTRS, 1996 to 2000. The general pattern is one of high rates extending from the north-east through to the midlands, the mid-west and the south of the country. The highest rate was observed in Waterford (74.3 per 100,000 population), followed by Westmeath (36.1), Cork (34.5) and Carlow (27.6). The lowest rates were observed in the west and in the north-west with the exception of Sligo. Although the trend is based on data going back four years there is an indication that the both the incidence and prevalence of treated problem cannabis use more than trebled during the reporting period. For example, the incidence (new cases) increased from 14.7 per 100,000 of the population aged between 15 and 64 years in 1998 to 50.5 per 100,000 in 2002. This observed increase may be explained by a combination of:

- a possible increase in cannabis supply between 1996 and 2001;
- an increase in access to treatment services; or

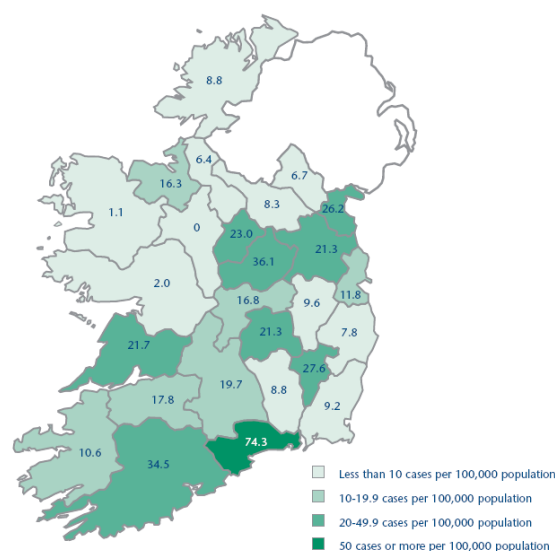


- an increase in the numbers of centres reporting cases to the NDTRS.

The age by which half of new cannabis cases reported first using cannabis was similar to the age by which new cases reported that they had commenced using illicit drugs indicating that cannabis is the first drug used by many of those treated. Other observations of the data were:

- Despite a large increase the provision of services to address problem substance use, for new cases reporting cannabis as their main problem drug, the time interval between first commencing cannabis use and starting treatment increased over the period under review, from four years in 1998 to five years in 2002.
- There was a small decrease in the proportion of cannabis cases who reported using other drugs as well as cannabis, from 83 per cent in 1998 to 78 per cent in 2002, although polydrug use remained a common practice. (Polydrug use is associated with poor treatment outcomes and needs to be addressed during treatment.)

- E



were the most common second drugs used in conjunction with cannabis as a main problem drug. In 2002, alcohol replaced ecstasy as the most common second drug used. This suggests that cannabis use is commonly associated with social events and is used in conjunction with alcohol and ecstasy.

- The main problem drug was examined by selected socio-demographic characteristics and some important patterns were identified. The proportion of new cannabis cases under 18 years of age increased substantially from 21 per cent in 1998 to 31 per cent in 2002.
- Although the vast majority of new cases who reported cannabis as a main problem drug were male, there was an increase in the proportion of females reporting cannabis as a main problem drug. Over the reporting period, an increasing proportion of new cannabis cases reported that they were still attending school. A higher proportion of new cannabis cases (36%) were employed than were their previously treated counterparts (29%), indicating that those with chronic problem cannabis use may have greater difficulties securing or retaining employment.

The trends identified in this research have major implications for the scope and type of interventions for treatment and for education and prevention programmes and it is hoped that this will be reflected in the projects proposed in this plan. However, it is also worth noting that the high level of treatment for the Waterford area, at twice the national picture, is no indication of prevalence patterns there. It is believed that this is more to do with the accessibility of services there in Waterford City, the successful networking between statutory and voluntary agencies involved in the drugs work and the range of innovative projects that have been put in place under the YPFSE.

Drug Use in Ireland & Northern Ireland 2002/2003 Drug Prevalence Survey

A useful piece of research which has regional and national significance is that commissioned by the National Advisory Committee on Drugs (NACD) in Ireland and

the Drug and Alcohol Information and Research Unit (DAIRU) within the Department of Health, Social Services and Public Safety (DHSSPS) in Northern Ireland. It was undertaken in late 2002 and early 2003. A selection of data is presented here for the South Eastern Health Board Region and compared against the national data.

The survey sampled a representative number of people aged between 15 and 64 during late 2002 and early 2003 and was undertaken by MORI MRC according to standards set by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The results relate to drug prevalence on a lifetime (ever-used), last year (recent use), and last month (current use) basis for illegal and other drugs including alcohol and tobacco for each Health Board (HB) in Ireland and Health and Social Services Board (HSSB) in Northern Ireland and are broadly comparable with the ESPAD methodology.

The main focus of the survey was to obtain prevalence rates for key illegal drugs such as cannabis, ecstasy, cocaine, heroin, etc. on a lifetime (ever used), last year (recent use), and last month (current use) basis. Similar prevalence questions were also asked of alcohol, tobacco, and other drugs (e.g. tranquillisers); attitudinal and demographic information was also sought from respondents.

The questionnaires were administered through face-to-face interviews with respondents aged between 15 - 64 normally resident in households in Ireland and Northern Ireland. Fieldwork for the survey was carried out between October 2002 and April 2003 and the final achieved sample was 8,442 (4,925 in Ireland and 3,517 in Northern Ireland). The response rate for the survey was 70% in Ireland and 63% in Northern Ireland weighted by gender, age, Health Board in Ireland and Health and Social

Ireland	Lifetime Prevalence					Last Year Prevalence (%)					Last Month Prevalence (%)				
	All adults 15 - 64 yrs	Males	Females	Young adults 15 - 34 Yrs	Older adults 35 - 64 Yrs	All adults 15 - 64 yrs	Males	Females	Young adults 15 - 34 Yrs	Older adults 35 - 64 Yrs	All adults 15 - 64 yrs	Males	Females	Young adults 15 - 34 Yrs	Older adults 35 - 64 Yrs
<i>Total Sample (unweighted)</i>	4925	2159	2766	1998	2927	4925	2159	2766	1998	2927	4925	2159	2766	1998	2927
Any illegal drugs	19.0	24.4	13.5	26.4	12.3	5.6	7.7	3.4	9.7	1.9	3.0	4.1	1.8	5.2	1.0
Cannabis	17.6	22.5	12.5	24.4	11.4	5.1	7.1	3.0	8.7	1.8	2.6	3.4	1.7	4.4	1.0
Heroin	0.5	0.7	0.3	0.7	0.3	0.1	0.1	0.2	0.2	0.0	0.1	0.1	0.1	0.1	0.0
Methadone	0.4	0.4	0.4	0.7	0.1	0.2	0.2	0.2	0.4	0.1	0.1	0.1	0.2	0.2	0.1
Other Opiates	3.1	2.1	4.0	3.0	3.1	0.5	0.0	0.5	0.5	0.4	0.2	0.2	0.1	0.1	0.2
Cocaine (total including crack)	3.1	4.5	1.7	4.8	1.6	1.1	1.7	0.5	2.0	0.2	0.3	0.7	0.0	0.7	<0.5
Crack	0.4	0.6	0.1	0.5	0.2	0.1	0.1	0.1	0.2	0.0	0.0	0.0	0.0	0.0	0.0
Cocaine Powder	3.0	4.3	1.7	4.7	1.5	1.1	1.7	0.5	2.0	0.2	0.3	0.7	0.0	0.7	<0.5
Amphetamines	3.0	4.1	1.9	4.9	1.2	0.4	0.7	0.2	0.8	0.1	0.2	0.2	0.1	0.3	<0.5
Ecstasy	3.8	4.9	2.6	7.1	0.7	1.1	1.5	0.6	2.2	0.0	0.3	0.6	<0.5	0.6	0.0
LSD	3.0	4.6	1.5	4.6	1.6	0.1	0.2	0.2	0.2	0.0	<0.5	<0.5	0.0	<0.5	0.0
Magic mushrooms	4.0	5.9	2.1	6.2	2.1	0.3	0.6	0.1	0.6	0.1	0.1	0.1	0.0	0.1	<0.5
Solvents	1.8	2.3	1.2	3.4	0.3	0.1	<0.5	0.1	0.1	0.0	<0.5	<0.5	0.0	0.1	0.0
Poppers	2.6	3.9	1.3	4.7	0.7	0.4	0.4	0.4	0.7	<0.5	0.1	0.1	<0.5	0.2	0.0
Sedatives, Tranquillisers, Anti-depressants	12.2	9.3	15.1	8.3	15.7	5.7	4.0	7.3	3.7	7.5	3.9	2.9	5.0	2.1	5.6
Alcohol	90.5	92.6	88.3	92.6	88.6	84.0	86.1	81.9	86.6	81.5	74.2	78.5	69.8	75.0	73.4
Tobacco	60.9	62.3	59.5	58.4	63.2	38.6	38.8	38.4	43.6	34.0	33.6	33.8	33.4	37.3	30.2
South Eastern Health Board Area	Lifetime Prevalence					Last Year Prevalence (%)					Last Month Prevalence (%)				
	All adults 15 - 64 yrs	Males	Females	Young adults 15 - 34 Yrs	Older adults 35 - 64 Yrs	All adults 15 - 64 yrs	Males	Females	Young adults 15 - 34 Yrs	Older adults 35 - 64 Yrs	All adults 15 - 64 yrs	Males	Females	Young adults 15 - 34 Yrs	Older adults 35 - 64 Yrs
<i>Total Sample (unweighted)</i>	606	260	346	216	390	606	260	346	216	390	606	260	346	216	390
Any illegal drugs	18.9	25.3	12.2	27.5	11.8	6.8	9.3	4.3	13.6	1.3	3.1	4.4	1.7	6.9	0.0
Cannabis	17.1	22.5	11.5	25.9	9.8	5.8	7.9	3.6	11.2	1.3	2.1	2.5	1.8	4.7	0.0
Heroin	0.2	0.5	0.0	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Methadone	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Other Opiates	1.0	1.4	0.6	1.2	0.9	0.4	0.3	0.6	0.6	0.3	0.1	0.0	0.3	0.3	0.0
Cocaine (total including crack)	2.5	3.4	1.5	4.2	1.1	1.7	2.5	1.0	3.8	0.0	0.0	0.0	0.0	0.0	0.0
Crack	0.2	0.3	0.0	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Cocaine Powder	2.3	3.1	1.5	4.2	0.8	1.7	2.5	1.0	3.8	0.0	0.0	0.0	0.0	0.0	0.0
Amphetamines	4.7	6.1	3.2	7.9	2.0	0.9	1.0	0.8	2.0	0.0	0.2	0.0	0.5	0.5	0.0
Ecstasy	4.3	6.4	2.1	9.2	0.2	1.2	2.5	0.0	2.8	0.0	1.2	2.5	0.0	2.8	0.0
LSD	4.9	7.6	2.1	9.0	1.6	0.3	0.5	0.0	0.6	0.0	0.0	0.0	0.0	0.0	0.0
Magic mushrooms	5.7	9.4	1.8	9.3	2.8	0.5	1.0	0.0	1.1	0.0	0.0	0.0	0.0	0.0	0.0
Solvents	1.1	1.9	0.3	2.0	0.4	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Poppers	3.0	4.3	1.7	6.1	0.5	0.5	0.5	0.5	1.1	0.0	0.3	0.5	0.0	0.6	0.0
Sedatives, Tranquillisers, Anti-depressants	14.2	8.6	20.0	10.9	16.8	7.7	4.5	11.0	5.4	9.6	5.0	3.6	6.5	2.6	6.9
Alcohol	89.4	90.0	88.8	90.1	88.8	83.8	85.4	82.2	86.4	81.7	74.0	77.5	70.3	73.3	74.6
Tobacco	61.3	66.4	56.1	65.6	57.9	38.6	39.7	37.3	50.1	29.3	32.9	34.4	31.5	40.8	26.5

Services Board area in Northern Ireland, to reflect accurately the general population. The tables above compare the lifetime, last year and last month prevalence data for the SE Region and Ireland as a whole.

Nineteen per cent of respondents reported they had ever taken an illegal drug, 7% had done so in the previous year and 3% in the previous month. These rates were broadly similar to the national rates. Cannabis use accounted for most illegal drug use – 17% reported ever taking cannabis, 6% had done so in the previous year and 2% in the previous month. Apart from cannabis, highest lifetime levels of use were recorded for magic mushrooms (6%); LSD and amphetamines (each 5%); ecstasy (4%); poppers (3%); and cocaine powder (2%). Minimal lifetime rates of heroin and crack (each 0.2%) were recorded by those surveyed. The lifetime prevalence rates recorded for magic mushrooms, LSD, amphetamines and ecstasy were higher than average with the rates reported by male respondents particularly high.

In the past year, the highest levels of use were recorded for cocaine powder (2%); ecstasy and amphetamines (each 1%); magic mushrooms and poppers (0.5%). The last year prevalence rate for amphetamines, cocaine and ecstasy were higher than the corresponding national rates.

In the month prior to the survey, ecstasy was the most widely reported drug used (1%) aside from cannabis. No heroin or cocaine use was reported in the previous month by those surveyed.

Fourteen per cent of respondents reported ever using sedatives, tranquillisers and anti-depressants, 8% had done so in the previous year and 5% in the previous month. Highest rates were reported by females and older adults; all rates were higher than the corresponding national rates.

Eighty nine per cent of the SEHB residents surveyed reported that they had ever taken an alcoholic drink, 84% had done so in the previous year and 74% in the previous month. A slightly higher proportion of older adults (75%) than younger adults (73%) reported current use of alcohol; this pattern was at variance with most other health boards.

Sixty one per cent of respondents reported ever smoking tobacco, 39% had done so in the previous year and 33% in the previous month. Prevalence rates among younger adults were consistently higher than the corresponding national rates.

Gardaí Data

Sometimes Gardaí data are used for prevalence rates. Once again, they are unreliable for this purpose on account of a number of factors:

- Do not take account of detection variances between areas and districts;
- Do not reflect different levels of resources in Gardaí units;
- Do not take account of Gardaí crime detection priorities between areas; and
- Only relate to incidence rather than drug use itself.

An Gardaí Síochána itself admit that their detection/conviction data may only be the tip of the iceberg although this may be a somewhat alarmist view also in the absence of any alternative evidence.

This section displays some of the Gardaí data for the State and compares the outcome for the South Eastern Region. The Gardaí South Eastern Region is not coterminous with the SERDTF but it is a reasonable representation of facts for the area.

The table below, extracted from the An Gardaí Síochána Annual Report 2003 (The 2004 Report is not available at the time of writing) highlights the activity of the Gardaí in

the State and compares it with the South Eastern Region.

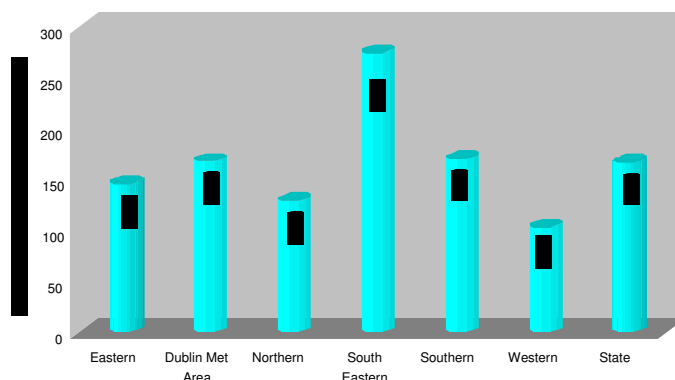
The table below shows the number of offences where proceedings commenced by drug type and division. Most (83%) of the heroin offences were recorded in the Dublin Metropolitan Region. The Southern and Dublin Metropolitan Regions accounted for 23% and 31% of the 3,003 offences involving cannabis. The South Eastern, Eastern and Western Regions recorded 9%, 13% and 8% for this offence. The Northern Region recorded the lowest at 6%.

The Eastern, Dublin Metropolitan and South Eastern Regions accounted for 25%, 23% and 20% of offences involving ecstasy. The three remaining Regions recorded offences ranging between 14% and 8%.

The quantity of drugs seized by the Gardaí indicate that cannabis was involved in 58% of cases while heroin was involved in 10% of cases. Ecstasy cases accounted for 17% of the total and cocaine accounted for 9%. A number of seizures arose from joint operations involving An Garda Síochána and the Customs Service. Possession offences accounted for 67% of the total, while supply offences accounted for 25%. The proportion of supply offences varied between 16% and 34% across the regions. They accounted for 16% in the South Eastern Region, 17% in the Northern Region, 18% in the Southern Region, 26% in the Eastern Region and 34% in the Dublin Metropolitan Region. Obstruction accounted for 5%. The 3% other offences deal with offences such as importation, allowing a premises to be used, cultivation of cannabis plants and forging a prescription to obtain drugs.

The data indicate that the number of persons against whom proceedings for drug offences were commenced by age and gender.

2003 Prosecutions for Drugs per 100,000



Approximately 8% of persons were less than 17 years of age, 35% were aged 17 to 21 years while the remaining 58% were aged over 21 years. The majority [92%] of persons were male and were the same as 2002. The total number of persons prosecuted in 2003 decreased by 10% when compared with the previous year. In 2003 the number of persons prosecuted in the Dublin Metropolitan Region accounted for 30% of the State total. The number of persons prosecuted increased by 5% in the Eastern Region and decreased in all other regions. The decreases ranged from 6% in the Northern Region to 26% in the Western Region.

The chart above shows the numbers of persons prosecuted per 100,000 of population in each of the regions. The incidence for the South Eastern Region was the highest at 275 per 100,000 of population. The remaining regions recorded rates between 103 and 170 per 100,000 of population. It is also noted from the Gardaí data that of the 1,519 "Gardaí Lectures" delivered in 2003, 536 [35%] were in the South Eastern Region.

Combining the prosecutions record of 275 per 100,000 population which is 65% greater than the average for the State and the highest by far, and the concentration of "lectures" delivered, one could draw the conclusion that the Gardaí are allocating a

	Cannabis	Cannabis Resin	Cannabis Plant	Heroin	LSD	Ecstasy	Amphet	Cocaine	Other	TOTAL
EASTERN REGION	138	333	2	75	0	243	29	72	20	962
Carlow/Kildare	27	130	1	6	0	74	15	35	15	303
Laois/Offaly	22	105	0	41	0	68	12	27	4	279
Longford/Westmeath	0	81	1	26	0	44	1	3	1	157
Louth/Meath	89	67	0	2	0	57	1	7	0	221
DUBLIN MET. REGION	413	764	11	600	5	217	14	362	149	2535
Eastern	9	167	0	42	0	17	0	24	7	266
North Central	97	58	4	79	0	35	0	49	76	398
Northern	125	164	4	43	0	36	6	101	26	505
South Central	38	64	1	188	1	72	0	77	26	467
Southern	95	204	0	57	0	33	8	50	10	465
Western	49	107	2	191	4	24	0	53	4	434
NORTHERN REGION	25	201	4	3	0	99	13	17	21	383
Cavan/Monaghan	18	43	0	1	0	37	2	3	4	108
Donegal	4	113	1	2	0	43	10	4	11	190
Sligo/Leitrim	3	45	1	0	0	19	1	10	6	85
SOUTH EASTERN REGION	84	670	2	14	2	191	85	35	62	1145
Tipperary	35	111	0	0	0	69	35	14	24	288
Waterford/Kilkenny	13	422	2	6	1	94	43	15	18	614
Wexford/Wicklow	36	117	0	8	1	28	7	6	20	243
% Analysis South Eastern Division	7.3%	58.5%	0.2%	1.2%	0.2%	16.7%	7.4%	3.1%	5.4%	100%
SOUTHERN REGION	109	759	13	20	0	137	32	106	100	1276
Cork City	6	361	0	3	0	39	0	58	0	467
Cork North	7	55	6	0	0	28	17	2	55	170
Cork West	31	121	0	0	0	26	9	11	17	215
Kerry	10	66	2	0	0	22	5	11	11	127
Limerick	55	156	5	17	0	22	1	24	17	297
WESTERN REGION	83	226	4	7	3	73	7	15	39	457
Clare	13	70	1	3	1	18	3	5	15	129
Galway West	34	105	2	4	1	18	3	8	21	196
Mayo	27	27	1	0	0	19	0	2	0	76
Roscommon/Galway East	9	24	0	0	1	18	1	0	3	56
Total	852	3003	36	719	10	%0	180	607	391	6758
% Analysis State	12.6%	44.4%	0.5%	10.6%	0.2%	14.2%	2.7%	9.0%	5.8%	100%

considerable level of effort and perhaps resources to control the growth of drugs misuse in the South Eastern Region.

Cannabis

One of the key growth areas is cannabis

misuse and while much of the recent research questions the “stepping stone” and “gateway” theories of its impact on drugs misuse, there seems to be a strong association between cannabis use and poor educational outcomes (especially early school leaving). It is likely that part of this

relationship is due to other factors although the link still remains even when controls are applied to a range of factors like social background, parental expectations and supervision. The research suggests that cannabis can affect cognitive capacity but this effect comes about only after intense and prolonged usage. Another factor might be motivation and the evidence on the damaging effects of prolonged use of cannabis on motivational processes is especially relevant. However, the effect of cannabis on motivation again applies only to very heavy use. It is likely that the mediating links are complex involving personality factors, embracing an alternative lifestyle and rejection of conventional values including, possibly school success.

The national reports of the Member States point out that a rise in the number of cannabis treatment demands probably reflects an increased level of problems particularly associated with intensive cannabis use. It should be noted, however, that systematic and comparable data on the problems experienced by cannabis users are largely lacking. The scientific knowledge base in this area is still developing but does provide increasingly convincing evidence of an association between cannabis use and a range of problems, although the nature of the causal linkage is not always clear.

It is important to distinguish between the acute (short-term) effects of cannabis and the long-term or chronic impact of the drug. A range of both positive and negative acute effects have been reported. Negative effects include deficits in attention and concentration difficulties, adverse effects on motor function (reflexes, coordination), short-term memory problems, anxiety and panic attacks and depression. Positive effects include euphoria, relaxation and increased sociability. The acute effects of the drug which arouse the greatest concern are short-term drug-induced psychosis or severe panic attacks, an

increased risk of accidents, particularly when driving or in hazardous work environments, and, among young people, a negative impact on school performance.

Understanding the chronic effects of cannabis is more complex for a number of reasons, not least because it is difficult to separate the effects of cannabis from the effects of chronic use of other illicit drugs, tobacco and alcohol. However, among the key concerns in this area are an increased risk of lung cancer and other respiratory diseases and an association with the development of long-term psychiatric health problems, including depressive illness, psychosis and schizophrenia. An additional concern with chronic use is the possible development of dependent behaviour. The extent to which the evidence suggests that cannabis use is a risk factor, a causal factor or simply associated through some more complex relationship with these problems is a matter to which the research is increasingly turning but about which there is little clear direction as yet.

One interesting point emerging in recent research is that cannabis use is involved in a large number of suspensions/expulsions from school. It indicates that students who were suspended or expelled were found to be much more likely than their peers to use cannabis, alcohol and other drugs. It is also of interest to note that students suspended from school are less likely to have access to further education, thus contributing to the relationship between poor educational achievement and cannabis use.

Conclusion

This section has outlined the strategic context for the formulation of an integrated drugs strategy to complement the current work based on multi-agency co-operation and complementarity of purpose where the drugs issue is concerned. The SERDTF area has all

of the ingredients for the continued growth of drugs misuse. While a significant amount of work has been done, it requires continual effort and sophisticated techniques and approaches to try to keep on top of the development within the market. No one agency can achieve the concerted and focused momentum required to provide proactive responses and interventions and the input of the community is vital. Over 11% of the State's population live in the most deprived Electoral Districts of the South East. Alcohol and drugs misuse continues to be a leading risk factor for young people not just in Ireland (particularly Dublin and the Eastern Region) but in the south-east also, and opiates use seems to be growing in the south east.

The next section looks at the approaches and responses to the drugs issue in the Region.

4. CURRENT RESPONSES AND INTERVENTIONS TO DRUGS MISUSE IN SERDTF AREA

In this section, the plan will set out a profile of the services which are primarily targeted at addressing the drugs issue in the SERDTF area. Where possible, region-wide services will be presented – which is the case for some agencies – but others will be presented within the context of the area covered by the Local Drugs Task Force/Committee.

The key agencies involved in the provision of services are:

- SEHB Substance Misuse Team;
- Educational/School Initiatives;
- Community Based Drug Initiatives;
- An Garda Síochána;
- Cornmarket Project Wexford;
- Aislinn and *Aiséiri* Treatment Centres;

in addition to a range of community and voluntary organisations some of which are specifically set up to address drugs issues.

SOUTH EAST DRUG CO-ORDINATING COMMITTEE

The SEHB established the SE Regional Drug Co-ordinating Committee in June 1996. It comprised senior representatives from many agencies operating within the Region and included GP's, Dept of Education, Association of Principals of Community and Comprehensive Schools, National Youth Council of Ireland, Probation and Welfare Service, National Parents' Council, Secretariat of Secondary Schools, Aislinn Treatment Centre, Public Health Dept SEHB, Waterford Psychiatric Services, Waterford Drug Helpline, Wexford Drug Prevention Partnership, Health Promotion SEHB, and Addiction Counselling Services SEHB. The terms of reference for the Committee were

- To act as a forum for co-operation between the various agencies (community, voluntary and statutory)

involved in demand reduction measures for drugs;

- To agree an appropriate range of education and prevention measures to facilitate the maintenance of a drug-free community;
- To recommend strategies for the treatment, rehabilitation and on-going support of persons who misuse drugs;
- To consider trends in substance abuse and, in the light of this, to review the effectiveness of current policies and responses;
- To advise on appropriate areas of research aimed both at understanding the underlying causes of drug misuse and the effectiveness of the responses.

Funding was successfully sought from the Department of Health and Children for €630k to implement drug demand reduction measures which provided resources to:

- Appoint 4 Outreach/Health Education Posts for additional preventative work in community settings;
- Recruit 1 Co-ordinator of Data and Information for the development of a data-base in drug misuse in S.E.H.B. area;
- Upgrade skills of ten existing Alcohol and Drug Counsellors;
- Provide general co-ordination and support for local communities in the form of non-pay support for their programmes and initiatives in awareness and prevention work;
- Upgrade the skills of professionals providing community treatment facilities and for training of general practitioners and other Health Care Professionals and Allied Professions.

In the allocation of funding for 1998, the Department made available a further £75,000 (€94,936) for drug demand reduction measures, to meet the full year costs of the 1997 developments and to continue the focus on drug prevention programmes and early intervention. Community and voluntary initiatives providing demand reduction interventions and responses were also supported at this time. Sub-committees reflecting the four pillars of

the National Drugs Strategy were also established and their recommendations built into a draft Drug and Alcohol Misuse Prevention Strategy for the Region. As early as 1998, the Regional Co-ordinating Committee developed their strategy for demand reduction measures around many of the following key elements:

- Treatment and Rehabilitation;
- Research and Audit;
- Professional Staff Training;
- Improvement of Demand Reduction Programmes;
- Development of Research Proven Intervention;
- Health Research Board;
- Peer Training Programmes;
- Drug Questions - Local Answers;
- Family Communication and Leadership Training Programme;
- Parenting for Prevention;
- Barnardos;
- Drug Helpline;
- National Alcohol Policy Plan;
- Methadone Treatment;
- European Drug Prevention Week;
- Counselling and Treatment.

Community groups and voluntary organisations were encouraged to participate in the development process and the services were also recommended for inclusion in the Health Promotion Strategy. Following the appointment of Mr. Tony Barden as Regional Drug Co-ordinator in 1997 with responsibility for strategic planning and development of services for people with drug and alcohol related problems, a range of projects and initiatives were established in Waterford, Wexford Area Partnership area, Wexford Town itself and Carlow.

The Board on three occasions engaged the Pyramid Theatre Company to present the Drugs Awareness Play for parents/family in the South Eastern Health Board and the Board was in active discussions on possible partnerships on drug and alcohol initiatives with local organisations in South Tipperary (mainly Clonmel), Kilkenny City and Carlow.

The Board's Social, Personal and Health Education Programme (SPHE) which was available to all second level schools was being continually supported.

Discussions between the Board, the Department of Health and Aislinn on the provision of residential in-patient treatment facility for young people were continuing, and the Board would continue to provide support for peer education for parents. Discussions were initiated with Youth Services throughout the Region with the intention of co-ordinating the development and delivery of out of school training and education in the South Eastern Health Board.

Drug Co-ordination Unit

The Regional Co-ordinator also established the Regional Co-ordination Unit which appointed two Drugs Education Officers and a Regional Data Co-ordinator for the Region in 1999/2000. Community Based Drug Initiatives (CBDI's) began to be established in 1997 and soon grew to number nine in the Region. They were based in Wexford, Kilkenny City and County, Carlow, Tipperary Town, Clonmel, Carrick-on-Suir and West Waterford. In most cases, the CBDI's were funded under the SEHB Section 65 Grants Programme and managed in partnership with the Regional Youth Services. The main aim of the CBDI's was to support the communities in their awareness of drug related issues and to develop strategies to reduce the demand for drugs.

The effort to tackle drugs in the South East

involved many of the agencies and organisations in the area formed into Local Co-ordinating Committees and it is felt that they played a key role in keeping the response to drugs at the top of the agenda locally. One of the key outcomes of the Unit was the preparation of the Treatment and Rehabilitation 2001 – 2006 Strategy Report in 2000 by the T & R Working Group.

The key recommendations of the Report were:

- A Substance Misuse Unit, would be established in each of the four Community Care Areas of the SEHB, and would comprise:
 - Drug Education Workers
 - Education Officers
 - Counsellors (Adult/Adolescent)
 - Psychiatrist
 - Drug Treatment Clinic (methadone)
 - Voluntary Services
 - Outreach Workers
 - Other Treatment Facilities
 - Probation & Welfare
 - Health Promotion
 - Social Worker
 - G.P. Liaison/Co-ordinator
 - Family Therapists

The Local Substance Misuse Co-ordinator would lead the Team of Drug Education Officers, Counsellor: Community Based Drug Initiatives and would also provide support to the Local Co-ordinating Committees.

- That a regional counselling policy be developed which would be community based and easily accessible, particularly to under-eighteen year olds. These services would facilitate self-referral, specialist assessment and intervention.
- That outreach services would be developed to target at risk community members who may not access treatment for various reasons.
- That locally based treatment services should include harm reduction, counselling, interventions, support services, family services, aftercare rehabilitation, and detoxification.

- That one-stop shops should be established where different services are represented and young people feel relaxed about making inquiries. This should involve multi-agency partnerships. The information should also be available on a website.
- Uniform client assessment should be developed for all drug services in the South East.
- Health Board services should support clients before and after treatment in voluntary residential treatment programmes.
- The Health Board should support the development of supervised Halfway Houses.
- Co-ordinated aftercare should be developed for those coming from residential/in-patient treatment programmes.
- Health Board staff should be supported in on-going staff training.
- Existing counsellors who are not members of the I.A.C.T. or I.A.A.A.C. should be supported in achieving accreditation. Counsellors appointed in future to Health Board services should be members of the I.A.C.T. I.
- Harm reduction programmes should include methadone and needle exchange to maximise the number of heroin misusers achieving stabilisation and recovery.
- The difficulties in accessing treatment for drug users who are homeless, in prostitution or pregnant need to be addressed.
- The specialist psychiatric services have an important role in the assessment and treatment of persons with co-existing drug misuse and serious mental disorder.
- The establishment of support groups/self-help groups for parents and close relatives of drug users is vital and should be encouraged.
- All hospitals in the South East region should have clear protocols for the management and referral of drug misusers admitted to hospital.
- The "Key Worker Role" should be established within the treatment model.
- The Board should identify from local needs assessment the likely demand for in-patient programmes and

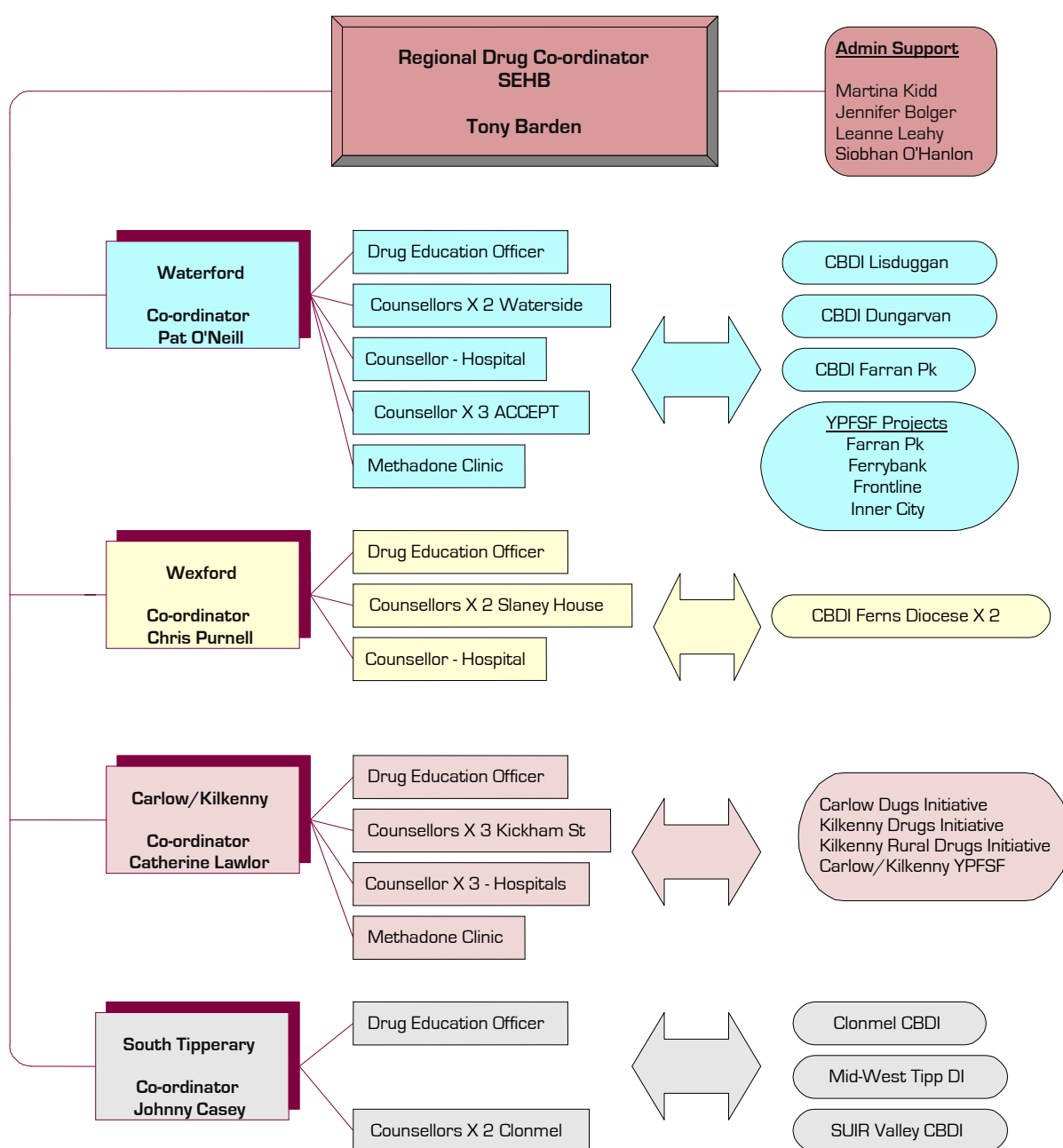
contract for the level in advance so that such services can undertake proper planning and evaluation to meet the expected level of need. Access to services should be through a designated key worker.

- A system of on-going evaluation needs to be developed for treatment services.
- A range of new treatment models will need to be considered as needs assessment and consumer needs dictate.
- Local communities have an important role in providing information to and consulting with the Health Board as

part of a genuine partnership.

- A partnership approach should be developed for the provision of prevention, treatment and aftercare programmes.
- Joint policies, procedures, share care protocols and service agreements should be in place between all service providers in contact with people with substance misuse problems.

Funding was put in place for the implementation of the Report which was launched by the Minister of State, Eóin Ryan, Department of Tourism, Sport and



Recreation, in July 2001. The strategy has been implemented since 2001 and has been instrumental in generating additional funding for drugs interventions (€530k in 2001) through the Young People's Facilities and Services Fund which has provided seed funding to a range of organisations around Waterford. The process was a good example of local statutory/community partnerships in action and went a long way to contribute to meeting up to 68 Inter-Board Performance Indicators in 2002 rising to 75 in 2003.

Drug Clinics

The two drug treatment clinics which provide addiction services to opiate dependent people are in Carlow and Waterford. GP's also provide a drug treatment service but this is limited. Three GP's and twenty pharmacies provide medication and treatment in the Region.

Based on data received from the Clinics, 31 people sought treatment at the Carlow clinic and 26 at the Waterford clinic during 2003 (61% male and 39% female). There was no year on year change in these figures for Carlow but there was an increase of 17 clients on 2002 figures at the Waterford clinic.

The highest numbers of those attending for treatment were in the 20 - 29 age group. 30% were in the 30 - 39 age group, 16% in the 40 - 49 age group, 5% between the ages of 18 and 19 and 3% in the 50 - 59 age group. The majority had first used opiates between the ages of 15 and 19 age (51%) while 17% between 20 and 24 years and 10% between 13 and 14 years.

While the majority lived in stable accommodation - 97% Carlow (90% in 2002) and 89% Waterford (89% in 2002) - almost two-thirds of the clients were unemployed.

As the table below suggests, 92% of those

receiving treatment reside in the Carlow, Wexford and Waterford areas, probably indicating that the availability of services close by is effective. Treatment data continuously reveal higher take up rates in opiates and cannabis in Carlow and Wexford and it is not known whether this also reflects higher prevalence rates. Despite Carlow and Wexford being closer to Dublin, and the fact that Wexford is a holiday destination for many people from urban areas who may introduce the drug into the area, the real reason for such non-uniformity must be researched. It may also be that other areas such as South

% Clients Receiving Opiate Treatment by Residence at Clinics				
County	2003	2002	2001	2000
Carlow	42%	56%	65%	50%
Kilkenny	3%	5%	3%	6%
South Tipperary	2%	3%	5%	17%
Waterford	25%	10%	13%	22%
Wexford	25%	26%	14%	6%
North Tipperary	3%	5%	4%	0%

Tipperary and Kilkenny do not have clinics and support services as accessible as those in the areas displaying the higher rates. This proper analysis based on good research would be crucial in assisting decision-making on service provision.

SERDTF

In April 2003, the South Eastern Regional Task Force was established and it assumed the responsibilities formerly held by the Regional Co-ordinating Committee and the chart above sets out the current HSE Substance Misuse Delivery for the SERDTF area. The broad summary of the structure is that it comprises four Substance Misuse Co-ordinators, four Drugs Education Officers, seventeen Counsellors, ten CBDI's, and four community-based YPFSF projects. These functions come under the umbrella of the HSE Substance Misuse Team which is headed by The Regional Substance Misuse Co-ordinator.

It is estimated that through this structure, that 85% of all direct resources applied to the drugs issue in the Region comes under the auspices of the HSE.

COMMUNITY PSYCHIATRIC SERVICES SERDTF AREA

The data for in-patient psychiatric services are unreliable as indicators. This is on account of two main factors. First of all, there are seven hospitals where services can be accessed, while St Senan's, Enniscorthy is the only one participating in the National Drug Treatment Reporting System, an epidemiological database on treated drug and alcohol abuse in Ireland. All psychiatric services in the Region record and report these data, but it is not necessarily drug/alcohol-defined and this could lead to double counting and other methodological inconsistencies. However, the available data suggests that there were 619 people treated with alcoholic disorders and 123 with drug dependence across the seven hospital/Psychiatric Units in 2002.

AISÉIRÍ TREATMENT CENTRE

Aiséirí was founded in 1983 by Sr. Eileen Fahey R.S.M. The residence was leased by the Sisters of Mercy to a Board of Trustees and is a registered charity located in Cahir, Co. Tipperary, providing quality treatment in a therapeutic environment, for alcoholics, other chemically dependent people and gamblers. In September 1987, the service was extended to Roxborough, Wexford, and Céim Eile {Another Step} Extended Care Facility was opened in Waterford in 2003.

Aiséirí is a recognised provider of high quality addiction services and all its counsellors are members of the I.A.A.C. or an equivalent national professional body whose aim is to promote ethical and professional standards in the field of addiction.

The 28-day residential programme is augmented by weekly sessions of Aftercare

for a period of two years. A 'recovering person' and a spouse facilitate aftercare groups for which there are special facilitators training courses available. 36 Aftercare Groups are established in 10 centres throughout the country and a ten-week outpatient Relapse Group is compulsory for those who relapse before returning to Aftercare.

Céim Eile serves as a bridge for the people who are chemically dependent and who have completed primary treatment programmes and desire sober productive lives. It addresses the transition from primary treatment to community living which can be fraught with difficulties. It provides high quality temporary accommodation and housing management services and provides a safe and caring environment for more vulnerable people. The programme is targeted towards people with housing problems, barring orders, clients who lack motivation, low self-esteem, and poor social skills. Life skills training is a primary component. The programme is deliberately highly structured and provides a real sense of order for drugs misusers who have been living chaotic lives. Day to day problems are discussed and an opportunity to examine behaviour, attitudes and values. The therapeutic value of one drugs misuser helping another is highly regarded as effective.

Its services are targeted at people over 20 years of age, and in 2003, it provided services to 263 people. The main treatment was for alcohol for 85% of clients, cannabis 8% and Heroin 2% at Cahir and 9% at the Wexford Centre. Services are provided nationally but most of the clients are from the Region.

AISLINN ADOLESCENT ADDICTION TREATMENT SERVICE

The Centre opened in 1998, at Ballyragget, Co. Kilkenny with support from the SEHB.

The service offers a drug free 12 bed residential treatment centre for male and female adolescents between the ages of 15 to 21 years. It is a two year programme, commencing with six weeks residential followed by two years aftercare and family based programme. Almost one-third of the 185 clients who sought treatment in 2003, were from the SEHB area. Within the SEHB area, 25 came from S Tipperary, 8 came from Kilkenny and 8 from Kilkenny County, 8 from Wexford, 5 from Waterford City and smaller numbers from Carlow and Waterford County. Almost a half of the clients (47%) had alcohol as their main drug of misuse, with over one third (36%) cannabis, 10% heroin and for the first time in 2003, cocaine 3%. 29% of people assessed did not take up treatment.

CORNMARKET PROJECT, WEXFORD

The Cornmarket Project is a voluntary service and offers free and confidential counselling for substance misuse and other behaviours, structured day programmes for substance misusers and family support services. It is now funded by the Probation and Welfare Service. The service comprises two strands:

- Strand 1. Individual Counselling for people with substance misuse and anti social behavioural issues

Strand 1 is primarily for low risk offenders who usually do well without intensive treatment and respond positively to counselling intervention designed to elicit and enhance their motivation for change;

- Strand 2. Core skills development in small group settings along with differentiated treatment and individual tuition in literacy ICT and task management skills. Diploma in Substance Misuse and Delinquency - Counselling and Interventions Skills for people working in the voluntary and statutory sector.

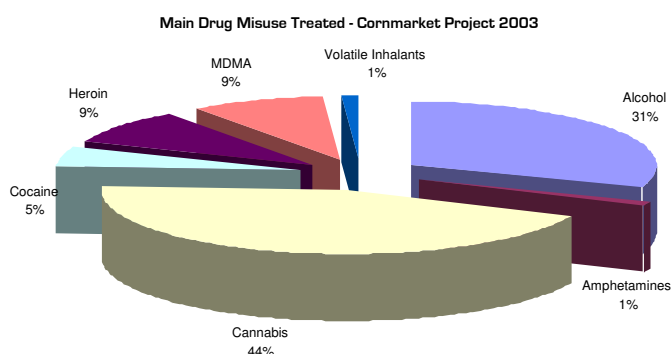
Strand 2 is the structured day programme and is designed for high risk offenders in order to achieve the greatest reductions in

recidivism.

Aims & Objectives:

- To provide an accessible, free, confidential and immediate response to people with substance misuse and antisocial behavioural issues;
- to foster public safety and promote the common good by positively influencing the behaviour of offenders
- To cause offenders to address their antisocial offending behaviour (including Substance misuse);
- To support offenders in pursuing a crime free way of life and enhance access to mainstream provision by providing them with pro-social skills while taking into account their specific difficulties and lifestyles.

The Cornmarket Project provided treatment for 151 people from the Wexford area – 54% urban, 46 rural]. Almost one-third were under 19 years and a further 40% between



20 and 29 years. The main drug treated was cannabis followed by alcohol, heroin and MDMA's. The pre-dominance of cannabis and the emergence of cocaine are particularly noticeable in the Wexford data.

The Project also provided advice to 37 concerned parents, friends and family, and received 238 calls for support and advice on their confidential telephone line.

COMMUNITY BASED DRUG INITIATIVES

There are ten C.B.D.I. projects in the Region with a total of eleven project workers. The

projects are:

- Carlow C.B.D.I.,
- Kilkenny City Drugs Initiative,
- Kilkenny Rural Drugs Initiative
- Clonmel C.B.D.I.,
- Mid West Tipperary Drugs Initiative,
- Waterford C.B.D.I.,
- County Waterford C.B.D.I.,
- Southside Drugs Initiative, Waterford,
- Wexford C.B.D.I and
- Suir Valley C.B.D.I, Carrick-on-Suir, Co. Tipperary.

The aim of the Community Based Drug Initiatives is to support local communities in increasing their awareness of drug related issues and to assist in developing strategies to reduce the demand for drugs in Communities.

There were a total of 387 individual contacts made to the services in 2003 (495 in 2002) but this figure is understated as there is a considerable amount of data missing as no project workers were employed for periods of time during the year at Carlow C.B.D.I, Kilkenny City Drugs Initiative, Clonmel C.B.D.I, County Waterford C.B.D.I and Southside Drugs Initiative, Waterford.

Over all the Services, 51% of the contacts were women and these were the only services where there was a higher percentage of female contacts than male contacts or indeed as high a percentage of women.

It is possible that the role of the CBDI's may be re-defined within the context of the implementation of the Strategic Plan. There is an enhanced need to involve local communities in the actions of the plan, the undertaking of the collaborative research and in the developmental stages of planning and implementing drugs projects and initiatives in communities. This would add a significant community development aspect to the work

of the CBDI's which is a necessary component of this strategy and any successful drugs strategy.

AN GARDA SÍOCHÁNA

The year 2003 witnessed the continuation of the role out of the Garda Restorative Justice Programme in accordance with sections 26 and 29 of the Children Act. In total there were 118 restorative events in various locations throughout the country. This brings the total of restorative events to 147 since the Children Act became law in May 2002.

Every child who is admitted to the Diversion Programme receives a caution. The caution can be either formal or informal. An informal caution is used where the act committed by the child is of a minor nature. The caution is administered by the local J.L.O. and it is normally given at the offender's home and in the presence of parents or guardians. Where the offence is of a more serious nature, a formal caution is administered. This caution may be given by the local Superintendent or a J.L.O. trained in mediation and is normally given in the Garda Station. In certain cases the Director can direct that the victim be invited to attend the formal caution as outlined under section 26 of the Act. This type of caution is referred to as a restorative caution. A child who is given a formal caution is placed under Garda supervision for a period of 12 months. Of the 7,950 individuals referred to the National Juvenile Office in 2003 and dealt with by way of caution during the year, 1,246 (16%) were in the Garda South Eastern Region.

In November 2003, Garda Schools Programme Liaison Inspectors were appointed in each Division to ensure that the programme operated as effectively and responsively as possible and was cognisant of specific local needs. In order to ensure that the relationship between Gardaí and young people is not lost after primary school, a

second level Schools Programme has been developed, in conjunction with the Departments of Education and Science and Health and Children. The Garda contribution forms part of the Social, Personal, Health and Education (S.P.H.E.) programme.

In the South Eastern Division, Gardaí are involved in the Local Drugs Task Forces and many of the community-based drug initiatives through the Juvenile Liaison Officer presence and a range of diversion projects. While the effectiveness of the Gardaí is resource dependent, the co-operation between agencies, the community and projects has a positive effect on the management of the drugs arena. Young drug offenders and young people at risk are sometimes identified at an early stage and the JLO's can work with the statutory and community-based agencies, along with local projects and diversion projects to re-direct them. In some areas, the Garda presence and the JLO service could work with better co-ordination to foster better working links with the young people but overall, Gardaí involvement with the initiatives is producing mutually beneficial outcomes.

REVENUE COMMISSIONERS - CUSTOMS & EXCISE

The Plan will be influential in prevention, treatment and research, while supply will very much depend on the national policy and resources of Customs and Excise and An Garda Síochána. This is more important for the South East whose geographic location on the coast comprises two key ports of Rosslaire and Waterford. They handle over one million passengers, three hundred and fifty thousands cars, five thousand coaches, over one hundred thousand lorries and thousands and tens of thousands of containers of freight. Rosslaire alone handles almost four and a half thousand arrivals and departures by Passenger Ferry and Freight Ferry from Fishguard, Pembroke, Cherbourg, Roscoff and Le Havre.

Revenue's Customs Service and An Garda Síochána have a shared responsibility in relation to drugs law enforcement in the State, underpinned by a Memorandum of Understanding (MOU), which was signed jointly by the Garda Commissioner and the Chairman of the Revenue Commissioners on 12 January 1996. The MOU seeks to foster better inter agency co operation and its ethos is very much in keeping with Action point 14 of the National Drugs Strategy. Under the terms of the MOU, the Customs Service has primary responsibility for the prevention, detection, interception and seizure of controlled drugs intended to be smuggled or illegally imported into the State. The supply reduction targets set out in the National Drugs Strategy have been adopted by the Revenue Commissioners and have been given a high priority in the Office's Statement of Strategy 2003 – 2005.

Revenue's Customs Service has signed over 40 MOU with companies in the international travel and trade business sectors. The MOU programme is based on the principal of partnership, mutual respect and recognition. Revenue's drug precursor programme has developed closer co operation with the chemical industry.

In January 2003 Revenue Commissioner Josephine Feehily re-launched the Customs Drugs Watch Programme. This established a confidential reporting mechanism through which maritime and coastal communities can report suspicious activity to Customs on a dedicated confidential free phone line. Revenue has undertaken a number of initiatives to improve international co-operation. The Customs and Excise (Mutual Assistance) Act, 2001 and the Naples 2 Convention has broadened and deepened co-operation and collaboration arrangements among Customs Services of the EU.

A Customs Officer has been assigned to the Europol National Unit at Garda Headquarters

in accordance with the Europol Act, 1997. Revenue is seeking to have a Customs Officer assigned as a Europol Liaison Officer in Europol Headquarters in the Hague.

A Customs Officer has been assigned to the Irish Embassy in London.

Revenue's Customs Service continues to police points of entry at our major ports, airports, land frontier and postal centres throughout the State and continues to develop professional working relationships with an Garda Síochána, the Naval Service, and the Air Corps in drugs law enforcement and to second officers to the Criminal Assets Bureau. Revenue recently acquired and commissioned a Revenue Customs Cutter "Suirbheir" to patrol and monitor our internal waters, territorial sea and adjacent waters. The office is currently putting in place the final arrangements for the provision of a mobile container x-ray scanner which will be utilised for detecting illegal drugs in commercial containerised traffic.

The proposed extension of existing powers under Section 38 of the Criminal Justice Act, 1994 will enable Customs to seize cash/money intended for use in any criminal activity. Revenue still awaits the introduction of regulations to make provision for the participation of Customs Officers in the questioning of arrested persons as provided for in Section 6 of Criminal Justice (Drug Trafficking) Act, 1996.

The SERDTF has the full participation of the Customs & Excise in the Supply Reduction sub-committees at both Regional and local drug task force level. What is most crucial about the synergy between both Gardaí and Customs & Excise in this regard is the extent to which the agencies can influence the supply of drugs to the communities in the South East. The ports and to an extent, the associated work of the Gardaí, have a direct influence on the levels of importation of drugs

and other addictive substances into Ireland, the United Kingdom and perhaps beyond and the Plan must be clear on the extent to which these agencies can individually and severally influence the local supply situation. It is felt that the national brief tasked of the Customs and An Garda Síochána, while essential, may actually be distractive to the implementation of initiatives in the context of the Local Drugs Task Forces and the Regional Drugs Task Force. One of the consequences of this is the lack of community-led responses to supply-related issues which must go hand-in-hand with the demand reduction interventions and programmes in communities and supply interventions of national significance.

It is recognised within the scope of this plan that the resources available to the Customs and Excise and An Garda Síochána are insufficient to address levels of drugs supply despite the very significant hauls of both drugs and alcohol at Rosslaire and Waterford ports. It is suggested that the supply reduction sub-committees of the Regional DTF and the Local DTF's are re-structured to re-focus supply analysis and action at local community level rather than national level as at present. The issues which prevail upon the importation of drugs into Ireland and arise at regional/local level as experienced by the Customs and Excise and An Garda Síochána should be accommodated in another forum which is more appropriate to their ambition and outcomes.

5. STRATEGIC AIMS AND OBJECTIVES

If there is one single change which has affected the wellbeing of individuals, families and the wider community over the last 30 years, it is the substantial growth in the use of drugs, and the hard drugs that kill in particular. The misery this causes cannot be underestimated. It damages the health and life chances of individuals; it undermines family life, and turns law-abiding citizens into thieves, including from their own parents and wider family. The use of drugs contributes dramatically to the volume of crime as users take cash and possessions from others in a desperate attempt to raise the money to pay the dealers. In addition, otherwise decent people become dealers in pyramid selling, as they persuade friends, acquaintances and strangers to take on the habit, so that they themselves can fund their own addiction. Very often jobs and homes are lost and friendships and family ties are broken. Where children are involved there is the danger of abandonment and neglect. Day-to-day functioning becomes a matter of good fortune in terms of income, the availability of treatment and rehabilitation, and the point at which help is available. Quite simply, drug misuse contributes enormously to the undermining of family and community life – more than any other single commodity or social influence.

Overall, Class A drug use is stable, but there are worrying increases in the use of cocaine and crack. This is why there must be clear and unequivocal messages about cocaine, crack, heroin and ecstasy; the clampdown in policing, intelligence, and Customs to back this up; and new policies to break the trafficking routes and the intermediate market between the dealer on the street and international criminal organisations. Achievements must realise real reductions in the level of problematic use if the lives of affected individuals and their communities

are to improve. This Strategy is a chance to build on what has been learnt to date. Prevention, education, harm minimisation, treatment and effective policing are the most powerful tools in dealing with drugs.

- All problematic users must have access to treatment and harm minimisation services, both within the community and through the criminal justice system.

The evidence overall is that the availability of treatment nationally is growing and waiting times are coming down. However, provision of treatment is still patchy and variable and accessing rehabilitation support after treatment can be a lengthy and difficult process. These are challenges for the South Eastern Region. Direct support to parents and families are additional regional challenges.

- Young people remain the highest priority.

They need good quality drug education, information and advice based on a credible assessment of the damage drugs do, within a framework which makes clear that all controlled drugs are harmful and will probably remain illegal.

- To prevent them from turning to drug misuse, they must also be protected from drug dealers and the pressures of living in neighbourhoods where drugs are too often an everyday reality.

The measures being taken to tackle demand need to be complemented with measures to reduce supply. This is a national problem over which the SERDTF and the providers currently working locally have little influence but the aim is to prevent drugs entering the country, tackle their distribution within the country and to make Ireland a difficult and undesirable country in which to traffic drugs.

- Central also to this strategy is the reality that tackling the drugs problem in the South East is not starting from scratch - far from it.

Work commenced in the mid-nineties on the issue with the establishment of the county drug committees. They worked on a voluntary basis initially, supported by a range of agencies with resources being supplied by the SEHB when required. It is a crucial component to the preparation of this report not only because much has been achieved in that period but that some services are at a relatively mature state of development.

At the same time, there are still gaps in service provision, more resources required within the statutory and voluntary providers, the requirement for a more effective community-based planning approach and the need for more meaningful inter- and multi-agency co-operation.

The SERDFT strategy will address many of these issues in a systematic way in order to ensure that local momentum is maintained and that the local activities continue to learn from and build on the achievements elsewhere in Ireland and beyond. In that way, future generations may never have to face the dangers, threat and harm that drugs present to the young people of Ireland, their families and their communities today.

AIMS AND OBJECTIVES THE EU DRUG STRATEGY 2001 – 2004

To put the objectives into context, it is useful to state those at European Union level. The aims and objectives adopted for the EU Drug Strategy 2001 – 2004 were:

- to reduce significantly over five years the prevalence of drug use, as well as new recruitment to it, particularly among young users under 18 years of age;
- to reduce substantially over five years the incidence of drug-related health damage (HIV, hepatitis, TBC etc.) and the number of drug-related deaths;
- to increase substantially the number of successfully treated drugs misusers;
- to reduce substantially over five years the availability of illicit drugs;

- to reduce substantially over five years the number of drug-related crimes; and
- to reduce substantially over five years money-laundering and the illicit trafficking of precursors.

It is recognized that the achievement of these objectives at national and local, SERDFT level, must then be set within the context of the development of infra-structure and capacity as it exists in 2005.

AIMS AND OBJECTIVES OF NATIONAL DRUGS STRATEGY

The stated aims and objectives of the National Drugs Strategy are:-

- to reduce the availability of illicit drugs;
- to promote throughout society, a greater awareness, understanding and clarity of the dangers of drug misuse;
- to enable people with drug misuse problems to access treatment and other supports and to re-integrate into society;
- to reduce the risk behaviour associated with drug misuse;
- to reduce the harm caused by drug misuse to individuals, families and communities.
- to have valid, timely and comparable data on the extent and nature of drug misuse in Ireland; and
- to strengthen existing partnerships in and with communities and build new partnerships to tackle the problems of drug misuse.

Context

The aims and objectives of the SERDFT must be set within the terms of reference of its capabilities and responsibilities. It has a regional brief and it is recognised that it has a key role to play in all four NDS pillars of prevention, treatment, research and supply, but that the first three are the ones over which it has the most direct control.

The implementation of the RDTF Plan should be the catalyst for investment to tackle the harm drugs cause communities, families and

individuals and should be initially focused in the most disadvantaged communities. The full range of education, prevention, enforcement, treatment and harm minimisation initiatives should be concentrated in these communities and when time and resources and permit, extend them across the Region in due course.

The vision is that in the most deprived areas, currently suffering or at risk from the rise in drugs misuse:

- Parents, carers and families will have greater access to advice, help, counselling and mutual support in relation to drug misuse.
- Those young people who are most at risk of developing drug problems will be helped through increased outreach and community treatment.
- They could also benefit from new initiatives including drug testing, referral to innovative and increasing treatment facilities, drop-in centres, mentoring and one-to-one counselling facilities as well as awareness raising programmes.
- The community should be seeking confidence measures generated by augmented policing activity which could include cross-regional work to tackle middle market supply and the strengthening of local policing to disrupt supplies on the street.
- Drug misusing offenders in the community could be identified and engaged in treatment and support at every opportunity via the criminal justice system, enhanced initiatives such as the Frontline Project and other outreach work.
- The JLO service will continue to ensure that drug-misusing offenders are taken out of the criminal justice system and provided with the treatment and support they need – when they need it through the diversionary projects and referral to community support initiatives.
- All those in the community who need treatment and support services will have help available when they need it and appropriate to their individual needs.
- Those leaving prison and treatment will benefit from a new aftercare and

through care system to ensure they receive the support/treatment they need and do not return to drug misuse and offending, or start out on the whole system again.

- Communities should continue to demand and support the development of youth facilities that provide alternative pursuits and activities in communities.

■

The Strategy is predicated on the adoption of the Harm Reduction Model of addressing drugs misuse, the principles of which are set out below:

HARM REDUCTION PRINCIPLES

- Accepts, for better and for worse that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Understands drug use as a complex, multi-faceted phenomenon that encompasses a continuum of behaviours from severe abuse to total abstinence, and acknowledges that some ways of using drugs are clearly safer than others.
- Establishes quality of individual and community life and well-being - not necessarily cessation of all drug use - as the criteria for successful interventions and policies.
- Calls for the non-judgmental, non-coercive provision of services and resources to people who use drugs and the communities in which they live in order to assist them in reducing attendant harm.
- Ensures that drug users and those with a history of drug use routinely have a real voice in the creation of programs and policies designed to serve them.
- Affirms drugs users themselves as the primary agents of reducing the harms of their drug use, and seeks to empower users to share information and support each other in strategies which meet their actual conditions of use.

- Recognizes that the realities of poverty, class, racism, social isolation, past trauma, sex-based discrimination and other social inequalities affect both people's vulnerability to and capacity for effectively dealing with drug-related harm.
- Does not attempt to minimize or ignore the real and tragic harm and danger associated with licit and illicit drug use.

SERDTF STRATEGIC AIMS AND OBJECTIVES

While the SERDTF supports and adopts all of the EU Action Plan on Drugs and National Drugs Strategy aims and objectives, it is useful at this stage to put them into the context of the capacity of the SERDTF and to add those which will be instrumental to their achievement.

Strategic

- to promote throughout society, a greater awareness, understanding and clarity of the dangers of drug misuse;
- to enable people with drug misuse problems to access treatment and other supports and to re-integrate into society;
- to reduce the risk behaviour associated with drug misuse;
- to reduce the harm caused by drug misuse to individuals, families and communities;
- to contribute to the reduction of the availability of illicit drugs in the SERDTF communities;
- to have valid, timely and comparable data on the extent and nature of drug misuse in Ireland; and
- to strengthen existing partnerships in and with communities and build new partnerships to tackle the problems of drug misuse.

Operational

- Re-structure Local Drugs Task Forces and the SERDTF to facilitate implementation and continuous planning imperatives;

- Re-structure the sub-committees of the four pillars in each LDTF/County Drug Committee and the SERDTF to facilitate participation and consultation;
- Build and support the development of informed and active community-based organisations and groups to tackle drugs locally;
- Resource and strengthen Local Drugs Task Forces;
- Develop and encourage enhanced and meaningful inter-agency participation, working and co-operation;
- Develop modalities and protocols to ensure that the regional and local service plans of statutory, community and voluntary agencies are 'drug misuse proofed' in line with the level of understanding and co-operation required for the development of successful partnership working;
- Resource the establishment of a range of projects which are not fundable within the current financial or corporate service plans of the relevant statutory and voluntary agencies but which address the strategic objectives of the SERDTF;
- Establish a Small Grants Fund which for projects up to €5,000 per project which will be administered by each of the four Local Drugs Task Forces, accountable to the Regional Drugs Task Force;

While the strategic aims and objectives of the Plan are more or less generic, the operational ones are based on a developmental approach referred to above. The Regional Plan is not starting from scratch – rather it a development of the work of the Regional Co-ordinating Committee and the Local Drugs Task Forces. Based on the recognised principle that strong communities are a pre-requisite to addressing the drugs issue, it is crucial to expedite the establishment of local groups which are resourced to articulate the needs of their communities regarding drugs.

This is a two-way method of working and steps must be taken through the development and dissemination of sound and meaningful research within the Region to

equip all stakeholders, community activists, and drug workers with accurate and up-to-date research and information. In turn, the availability of such research and interpretations of it, will further equip parents, teachers, youth workers and young people to address drugs with a more comprehensive understanding and knowledge of their availability, outcomes, prevention techniques and projects, treatment methodology and accessibility, and support where required. The development of a baseline research programme similar to the Kilbarrack Study which will produce prevalence data which is comparable to national and European data should provide an evaluation baseline from which the strategy can be measured. If an approach similar to the Kilbarrack Study can be adopted, additional trends of drugs misuse and incidence could be generated which may be useful to policy makers, planners, social workers, probation officers, Gardaí, youth and community workers as well as people working directly in the field of drugs.

STRATEGIC IMPORTANCE OF SERDTF RE-STRUCTURING FOR PLAN DELIVERY

The subject of re-structuring of the SERDTF and the County Drug Committees has been discussed in the interim reporting cycle of the development of this report and is based on the feedback from participants across the Region. It is also a requirement for the successful implementation of the Plan. Implementation of the Plan will require the input of specific people and specific agencies to deliver what is required and agreed and the SERDTF and County Drug Committees will have to develop management techniques which will involve delegation of functions and responsibilities so that achievements can be expedited. The current 'flat' decision-making structures which involve sometimes up to thirty or forty people are cumbersome and do not facilitate the level of early agreement and operating consensus to make things happen quickly. The accepted involvement of

agencies and individuals in the implementation and planning process should be on the basis of what they can contribute to the process – not what they can reap from it. From that point of view, people who attend meetings should be in a position to commit part of their corporate business to the DTF process and to effect change in it reciprocally on their return. The need for continuity of commitment is also crucial to the implementation process and the practice of committing different people to attend the meetings must be interpreted as symptomatic of a lack of commitment since the necessary continuity of knowledge and action is seriously disrupted and/or absent. This leads to inertia through the deferment of action until the previous incumbent is consulted or returns, and implementation and outcomes become distant and infrequent.

The type of commitment and structure envisaged leads to accountability and responsibility resting with specific people to deliver, and should ensure that the strategy implementation does not flounder and that it adopts a proactive and dynamic way of working. Any agreed adjustment to the current structure must be seen as a development of the current system which has served the process very well in its early years and which must be preserved in other ways.

It is suggested that the four pillars of the SERDTF and the County Drug Committees are based on a 'forum-type' structure where membership is relatively open depending on the skills and information that they can bring to the subject matter. The imperative is not just driven by the requirements of drugs interventions which are expeditious, but by the geography of the Region. It is difficult enough to convene meetings within counties for the County Drug Committees but on a Regional basis, it would be more efficient and more efficacious for fewer people to meet

more often.

The Plan recommends this re-structuring on the basis that the strengths of the current structure are not lost.

The next section sets out some of the specific gaps in service needs within the LDTF/County Drug Committee areas and details the proposed actions and projects that have been developed within the planning process to implemented in the first phase of the strategy.

6. IDENTIFIED SERVICE GAPS

In the course of the preparation of this plan, a number of workshops were held in the Local Task Force Areas and gaps in service provision were identified.

WATERFORD LOCAL DRUGS TASK FORCE

Apart from Waterford City whose population increased by 6% to 46,736 in 2002, the most densely populated DEDs were Dungarvan No1 Urban (3,748 per square mile), Dungarvan No2 Urban (2,996 per square mile) and Tramore Rural (896 per square mile). The lowest densities were found in the upland DEDs of Mountstuart (8 per square mile), Rathgormack (12 per square mile) and Ballydurn (13 per square mile). Dungarvan and Tramore are the two largest electoral areas followed by Lismore; Kilmacthomas and Suir are of a similar size.

The electoral area of Tramore has experienced the highest rate of growth, followed by Dungarvan. The electoral areas of Kilmacthomas, Lismore and Suir experienced declines in population of a marginal nature. In this respect the continuing urbanisation of the population is evident. As the largest population centre in the county of Waterford, Dungarvan UDC registered a population of 8,305 in 2002 (+16% on 1996), followed by Tramore at 7,452 (+14% on 1996).

Other towns and villages have smaller population centres, some of which have experienced strong growth. Dunmore East experienced 37.8% growth and Ardmore experienced 16.3% growth. Other key towns either experienced modest to marginal growth (e.g. Ballinroad at 7.7% and Cheekpoint at 7.4%) or a decline in population; the population of Lemybrien declined by 11.3% and the population of Tallow declined by 6.5%.

In the broad discussions in the Waterford

LDTF/County Drug Committee workshops, there appeared to be recognition that Waterford City enjoyed a good network of active community groups and initiatives, service provision, access to services and inter-agency working while County Waterford had not developed in the same way. The main organizations in Waterford involved in addressing the drugs issue as a prioritised function of their organization are:

- Ballybeg Community Development Project;
- Larchville/Lisduggan Community Development Project;
- Inner City Community Development Project;
- Farran Park and St.Catherine's Grange Community Group;
- Kilcohan/St.Herblain Community Development Group;
- Southside Community Drugs Initiative;
- Ferrybank Youth Project;
- Frontline Project;
- Community Drugs Initiative;
- Ball Project (Garda Diversionary);
- Sway Project (Garda Diversionary);
- Manor St.John Special Youth Project;
- Children's GroupLink;
- Treo Project;
- Waterford Regional Youth Services;
- Ossory Youth Services;
- Foróige
- Waterford Community Development Constituency;
- Shy Project;
- Ballybeg Special Youth Project;
- Inner City Youth Project;
- Waterford & District School Support Project;
- Waterford Garda;
- Waterford City Council.

Some of the projects are targeted across the city while most are located in the areas

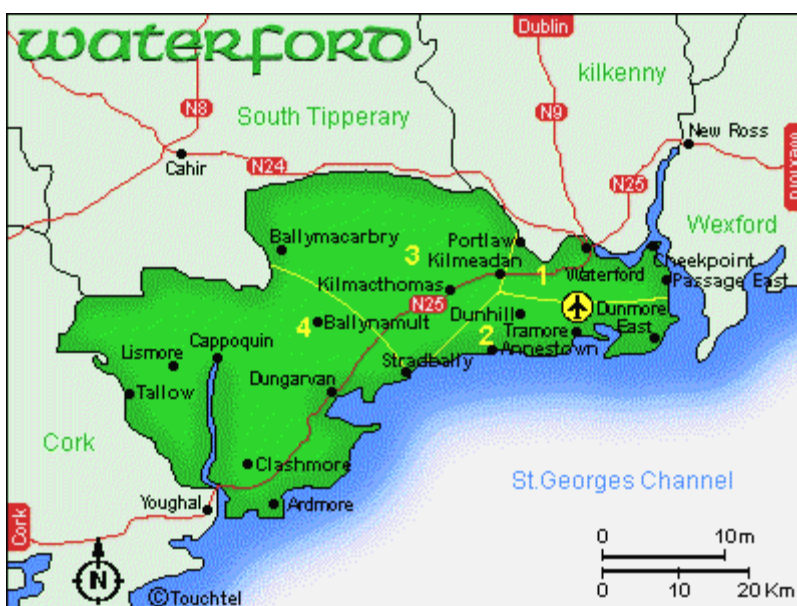
where the greatest disadvantage is experienced.

This is not surprising since reference to the Deprivation Index data will reveal not only that 22 out of the most deprived 511 Enumerated Districts (ED's) in the SEHB area are in Waterford City but that the worst 9 are there also, having the highest Deprivation Indices. 20% of the ED's in Waterford are in the most deprived decile while the figures for the other areas are Tipperary South, 9%, Carlow 9%, Wexford 7% and Kilkenny 3%.

Indeed at the national level, Waterford City has 5% or 17 of these EDs, (Tipperary SR 2.3% [9], Wexford County 1.7% [6], Carlow County 1.5% [5], Waterford County 1.2% [4] and Kilkenny County [0.9% [3]] of the most deprived wards in the country. The prevalence data and the treatment data also indicate the highest rates in the Region also, so it is not surprising that there are more groups, interventions and programmes in Waterford City than elsewhere in the Region.

There is some evidence that the resources allocated within Waterford as a whole have been dictated by the imperative level of need within the City limits. While this could be interpreted as an imbalanced allocation in its favour, it is probably more true to assert that there is still considerable need within the City and County of Waterford.

The following paragraphs are a summary of the issues raised in the second workshop of the Waterford LDTF/County Drug Committee. The group decided to identify the gaps and where possible, provide an action or suggested response to the issue.



Gaps & Actions

- Ferrybank – need to absorb the area into mainstream Waterford City programmes and planning cycles;
- Facility to stabilise homeless people, live safely, work with intensively researched - Halfway house;
- Diversionary programme with health board through courts;
- Schools education programme – more and better instruction required;
- Better communications for drugs programmes and drugs issues;
- More resources for JLO's and Projects;
- Consultation by Government on Intoxicating Liquor Act;
- Improve data flow of drugs research;
- Duplication of services by committees – rationalise;
- More communication and co-operation needed between agencies;
- Explore treatment options;
- Drug (urine) screening need by parents etc – human rights implications etc re consultation and confidentiality;
- Explore alternative therapies – acupuncture & heroin;

- Activities for children at/ not at risk and the need for more places for young people to go;
- SPHE delivery not effective enough;
- Social Services Dept – response very slow, all referred families are drug involved and urgency required for greater impact and effectiveness;
- More specialised training needed for adolescents;
- Educating young people – develop self-esteem;
- Integrated case working – who is lead agency?;
- Drug recoverers – integration into community wide programme – recovery and aftercare – like the probation hostel – halfway house – range of aftercare options;
- Drop-in centre for drug users – city;
- Continued drugs education awareness;
- Drugs education and awareness training for people involved in the area – eg people on drugs taskforce;
- CBDI areas – more needed in rural and urban centres;
- Alcohol-free venues;
- Bar staff training on alcohol and drugs policies, Liquor Act and bouncers;
- Increased range of treatment options;
- Family therapy needed – none in Waterford rural areas;
- Facilities needed for children not at risk;
- Stay at School Programme – expand and follow up;
- Transition from primary to secondary schools;
- Need support for family members of drug misusers;
- Extend Frontline and CBDI;
- Advocacy for Young People;
- Programme for JLO;
- Programme on cannabis use based on Swedish Model – Motivation and counselling NACD;
- More young people on committees;
- User Forums.

Geographical

- Rural v City;
- Treatment & Rehab;
- County Needs - Tramore, Dungarvan and Lismore;
- Travel needs etc of CBDI Workers in county;
- Outreach work required – stigma of going to local service;
- Other ways of delivering services across pillars;
- How to involve people in rural areas.

Information & Knowledge

- Capacity deficiency of information and knowledge of drugs prevalence and trends locally and nationally, at all levels of management and operational areas;
- CBDI Programme – understanding issues;
- How appropriate is the Training - (Gardaí and Schools);
- Capacity for organisations and the break in continuity of different people going to meetings of the same sub-group.

What is Strategy Attempting to Achieve?

- Implement NDS Strategy in Waterford;
- Reduce harm of drugs – individuals;
- Reduce prevalence;
- Increase access to services;
- Reduce rate of increase of drugs and alcohol misuse;
- Reduce supply of drugs;
- Working together to address problem;
- Be proactive.

Many of the issues detailed above are the responsibility of specific agencies which can be addressed with them directly under the auspices of the work of the LDTF/County Drug Committee. However, the Waterford LDTF/County Drug Committee has developed nine specific responses and interventions which seek funding of €201,688 and which are outside the scope of the mainstream

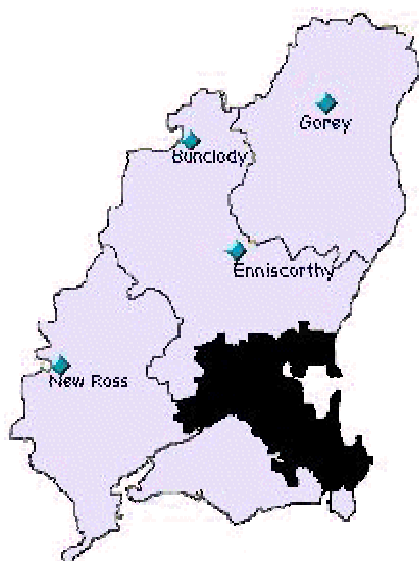
funding sources. Of the major projects, three are Education & Prevention and one is Treatment & Rehabilitation. The five smaller projects are all Education & Prevention.

A summary of the projects is detailed here and a full presentation of all the proposed projects is available as an Appendix in a separate document.

Waterford LDTF Proposed Projects			NDS Pillar
Major Project Title	Aim	Cost	
County Waterford Community Based Drugs Initiative	To support local communities in increasing their awareness of drug related issues and to facilitate the development of strategies to reduce the demand for drugs in communities.	€50,000	Education/Prevention
Inner/City Ferrybank Community Based Drugs Initiative	To provide drug education and awareness throughout the target area and support the communities to identify and address issues related to substance misuse, within their areas.	€50,343	Education/Prevention
Extension of the Frontline Drugs Project into County Waterford	To provide support, mentoring and outreach services to young people in County Waterford who are involved in high risk drug misuse and who are experiencing exclusion because of their drug use.	€28,065	Treatment/Rehab.
Local Outreach Worker	Substance Misuse Counselling	€50,000	Education/Prevention
Minor Project Title	Aim	Cost	
Waterford Community Drugs Network	To support local people concerned and affected by drugs misuse from across Waterford City to come together and work collectively.	€3,400	Education/Prevention
Southside Community Based Drugs Initiative	To provide an opportunity for unattached young substance users to take part in an Art Programme and through exhibiting their work, to recognise their potential.	€4,680	Education/Prevention
Facilitation Training Programme	To provide a Facilitation Training Programme which will equip community members with the skills necessary to deliver a drug information and awareness programme in their own area thus enabling communities to participate in measure to reduce the demand for drugs in their locality.	€4,600	Education/Prevention
Ballybeg Community Drug Awareness Week	To help improve the quality of life for those living in the Ballybeg community, to encourage participation of the whole community in Drug Awareness Campaign; to provide an opportunity for the community to collectively participate in education and recreational activity and to introduce alternative activity to drug use.	€8,350	Education/Prevention
Young Persons Guide to Survival: Drugs & Decision Making	The focus of this guide is to be informative whilst also being entertaining and something young people can understand and relate to. The concept is to keep it simple but informative. Its aim will be to guide, inspire and inform young people to make the correct decision for them.	€2,250	Education/Prevention
Total Waterford		€201,688	8 E/P, 1 T/R

WEXFORD LOCAL DRUGS TASK FORCE AREA

Wexford is a predominantly rural county with a strong well-spread pattern of interdependent towns and villages connected by the national and regional road networks. The principal towns provide employment and services to the surrounding dispersed rural community. Wexford Town has the largest population at 17,235 (+9% on 1996) followed by Enniscorthy 8,964 (+17% on 1996), New Ross 6,537 (+1% on 1996) and Gorey 5,282 (+34% on 1996). There is a



considerable number of smaller villages and settlement clusters with populations below 1,500 persons. Some of these have witnessed rapid population growth in recent years, most notably Rosslaire Harbour/Kilrane, Rosslaire, Ferns, Castlebridge, Curracloe, Courtown Harbour, Blackwater, Piercetown, Fethard-on-Sea and Kilmuckridge. These areas continue to experience severe development pressure.

The County is characterised by a high number of holiday homes and second homes owned by people from outside the County. Much of the growth in housing output and of work in progress is related to holiday homes, concentrated in and around coastal settlements. There is increasing evidence of commuting from the towns and villages of the

County to the Greater Dublin Area.

Rapid household formation has been a feature of demographic change in the 1990s. This trend is expected to continue because of the large numbers entering the household forming 20 – 35 age groups and the move towards one and two person households due to smaller family sizes, an ageing population, family break-up and the greater affluence and independence of young people.

Nine of the fifty-one most deprived ED's in the SEHB area are in Wexford and indeed six of these are in the ten percent most deprived in the State. Wexford also has high treatment uptake levels and it is known that a number of heroin dependent people have to travel to Waterford for Methadone Treatment.

The LDTF/County Drug Committee has experienced mixed fortunes in its development since the late nineties. The County Wexford Co-ordinating Committee for Drugs first met in early 2000 as a sub structure of the Regional Co-ordinating Committee for Drugs. In its early days there was confusion about the role of the Wexford Committee, with some believing it to be a steering committee for the County Wexford CBDI, and others believing it had a wider co-ordinating role. At this time (2000 – 2001) the CBDI Project Workers provided administrative support to the Committee, the Regional Drugs Co-ordinator attended the meetings, and the Community Care Manager, Con Pierce, chaired the Committee.

Attendance was initially quite good, but over the 2 years, attendance dropped off from most members. This was due to a lack of clarity about the aims of the meetings/structure and due to delays in establishing the RDTF. In 2002, the post of the Substance Misuse Co-ordinator was created, and the task of administering and chairing the committee fell to the new post.

At the end of 2004, there were three sub-

committees meeting (Education and Prevention, Treatment and Rehabilitation and Supply Control, memberships previously supplied), as well as the County Committee.

In preparation for the construction of the SERDTF Plan, two workshops were held by the Wexford LDTF/County Drug Committee and they sought direction and suggestions within the community by placing an invitation in the local press for submissions.

The main organisations involved in addressing the drugs issue in Wexford are:

- Co Wexford CDBI;
- Community Addiction Service St Senan's Enniscorthy;
- Wexford County Development Board;
- Young Women's Project FDYS;
- Suan Training Services – NTDI;
- Customs Service of Revenue Commissioners;
- Probation & Welfare Service – Wexford;
- Gorey Community Youth Project;
- Ferns Diocesan Youth Service;
- Enniscorthy Community Youth Project, FDYS;
- Coolcots Community Youth Project;
- Cornmarket Project;

In response to the South East Regional Drug Task Force's (SERDTF) request for submissions from County Drugs Committees/Local Drug Task Forces for inclusion in the RDTF Strategic Plan, the County Wexford Co-ordinating Committee for Drugs undertook a consultation exercise and considered the various responses received. The following is the result of this process, and comprises the submission from the County Wexford Co-ordinating Committee for Drugs to the SERDTF.

Process

The County Wexford Co-ordinating Committee for Drugs, and its three sub-

committees (Education and Prevention, Treatment and Rehabilitation, and Supply Control), decided to consult as widely as possible on this issue as was possible within the time-frame available.

Advertisements were placed in local media, questionnaires were circulated to all Committee and Sub-Committee members, and to approximately 450 community and voluntary groups linked to the County Development Board's Community Forum. As a result, the Substance Misuse Co-ordinator received 93 individual proposals.

These responses were considered by the membership of the three Sub-Committees, and recommendations made to the County Committee. The County Committee considered these recommendations at its meeting of October 27, 2004, and agreed the following as its submission to the SERDTF.

Analysis

Proposals divided into groups, according to which pillar of the National Drug Strategy, and were considered by the sub-committee relevant to that pillar. The proposals were considered firstly in relation to their match with the National Drug Strategy. Only proposals that could be clearly linked with an existing actions or objective from the National Drug Strategy were considered. Proposals relating to Research and Audit were not considered as there was no sub-committee locally established to consider these (all Research and Audit proposals will be forwarded to the regional Research and Audit Sub-Committee when it is established).

Proposals were then allocated to one (or more) of three categories; "Resources", "Internal" and "Lobbying". A small number of proposals were identified as requiring SERDTF resources to enable them to be implemented, and a larger number were identified as being the responsibility of existing local agencies (Internal), and some

proposals were considered beyond the scope of the County Committee or RDTF, but were included as an issue that the RDTF may be able to address through lobbying other agencies.

It was acknowledged that none of the proposals would meet many of the SERDTF's initial draft criteria for assessing proposals, but that the flexibility given by the SERDTF at its meeting of October 12th, 2004, would allow proposals to be developed between the time that they were included in the SERDTF plan and the time when funding approval may be given.

Proposal Categories

Resources.

The proposal will require additional resources, and that these resources should be applied for through the Regional Drug Task Force's planning process.

Internal.

The proposal may well be deliverable by one or more existing agencies involved locally in the RDTF or local structure. Resources may or may not be required. Agencies may need to change their work programmes, or to work together to achieve the objective. The proposal may well require resources, but that these resources should be identified/reallocated through the agency's normal budgetary procedures, not through the Regional Drug Task Force. This may well also involve a high degree of lobbying.

Lobbying.

The proposal will require the RDTF to lobby agencies/individuals/government that are not part of the RDTF process locally to alter budget allocations/work practices/agency organisation, etc. Resources may well be an issue, but not sought from the RDTF budget allocation.

Proposals

General

Resources

Independent Full-Time RDTF Co-ordinator

It was proposed that an independent, full-time RDTF Co-ordinator be appointed to work for the RDTF and its local structures.

Small Grants Fund

It was also proposed that a small element of the RDTF funding should be set aside as a small grants fund. The grants fund would enable a relatively large number of organisations to directly benefit from the first stage of the RDTF process, and could assist with capacity development to enable groups to formalise their proposals.

Lobbying

Include Alcohol in the RDTF Remit

The members of the County Wexford Co-ordinating Committee for Drugs, and the membership of its sub-committees strongly feel that alcohol should be included in the remit of the RDTF. Members feel that the separation of drugs and alcohol in the current arrangements cannot be rationally justified and leads to missed opportunities in responding to both issues.

Treatment and Rehabilitation

Resources

Community Detoxification and Halfway House

Action Points 44, 47, 48, 51, 55, 57, 61

The major gap identified through the consultative process and by the Sub-committee members themselves, was for a community based residential facility within which individuals could complete detoxifications prior to accessing other

treatment services, where clients could transfer to following residential rehabilitation elsewhere, where clients could access training and education based rehabilitation, and that could offer respite to the more chaotic clients.

Drop-in Centre

Action Points 44, 61

The other major identified gap was in terms of a drop-in centre where clients could access a range of services. This was recommended for RDTF funding due to the inter-agency nature of the proposal, and the need for additional resources to allow the project to be implemented.

Internal

b1] Detoxification – Inpatient and outpatient

Action Points 44, 48, 51, 57, 61

In addition to clients completing detoxification in a proposed Community Based Detoxification centre, there will be a number of clients who for medical reasons would be best be detoxified in an in –patient hospital setting. Wexford General Hospital was identified as the most suitable provider of this type of service, and the Wexford Committee felt that the RDTF should include this in its plan as an objective for the SEHB.. There would also be clients who would have the necessary supports to complete an out-patient detoxification, and that it is proposed that the RDTF include in its plan the call for the SEHB to formalise current out-patient detoxification procedures.

Methadone service and protocol

Action Points 45, 56

A large number of proposals were concerned with the provision of a methadone service for County Wexford. Concerns were expressed about the problems of people travelling to Waterford to receive this service, and of the

delays in accessing this vital service. Problems were also expressed concerning the availability and speed of urinalysis, both in terms of methadone provision and for other purposes. Sub-committee members felt that any service developed should adhere to all aspects of the Methadone Protocol. Again it is proposed that the RDTF include in its plan the call for the SEHB to develop this methadone, urinalysis and associated services for County Wexford.

Low Threshold Access to services

Action Points 44, 59

Concerns were expressed about the problems accessing services for people with substance misuse problems. Although additional resources may be required by agencies providing treatment and rehabilitation services, it was felt that much could be achieved through better co-ordination between existing services. It is proposed that the Wexford section of the RDTF plan includes a commitment for services to work together to improve local access to services.

Alternative Models of Treatment

Action Point 55

It is proposed that a wider variety of treatment models be provided locally. Currently residential rehabilitation services provide treatment based on the Minnesota model, whereas non-residential services rely heavily on counselling as the main service response. Committee members felt that services should be developed to offer alternatives to these two main models.

Temporary Housing/Accommodation for Clients

Action Point 68

It is proposed that the RDTF include in its plan, the provision, by the Local Housing Authority, of temporary accommodation for

service users engaged in or leaving treatment services. There are a number of clients that require accommodation on leaving residential rehabilitation, as well as clients that would benefit from alternative accommodation during the course of their outpatient treatment.

Employment and Training as part of Rehabilitation

Action Points 48, 74, 75, 76

It is proposed that agencies such as FAS and the VEC provide schemes and courses that are designed to meet the needs of drug and alcohol users as part of their rehabilitation, and that this call be included in the SERDTF plan.

Education and Prevention

Resources

a1] Additional Resources for Co. Wexford Community Based Drugs Initiative

Action Points 7, 19, 31, 35, 59, 64

Additional resources would be needed to enable the Co. Wexford CBDI to implement the recommendations of their local research, to utilise their volunteers more effectively and to allow greater outreach work to take place.

Health and Activity Programme for Young people

Action Points 34, 35, 42, 59, 64, 66

It is proposed that a programme be devised utilising Peer education methodologies that give young people both a range of healthy activities, and also generic health, health care and positive living education.

Support Service for the Children of Substance Misusers

Action Point 54

It is proposed that the RDTF provide funds to develop a support service for children and young people effected by the parents'

substance misuse problems

Internal

b1] Training re: Hepatitis and HIV for all workers

Action Point 39

Committee members are requesting that training in Hepatitis, HIV and other drug related viruses be provided to counsellors, project workers, youth workers, etc etc. It was proposed that this could be delivered by the Hepatology department of the SEHB.

Expand the delivery of parenting workshops

Action Points 34, 35, 42

Committee members felt that more parenting courses should be available. As the Education and Prevention Sub-Committee were already considering this issue, attempts will be made to promote the courses that are currently available from existing local agencies.

Information sessions for schools, youth clubs and parents

Action points 31, 32, 33, 34, 35, 42

The Committee members supported the call for more information courses for the above groups. Further work to co-ordinate the activities of the agencies involved in the delivery of these courses was required to make them as effective as possible.

Substance Misuse issues to be included in Personal Development Programmes of FAS, VEC, Youthtrain, etc

Action Point 31, 32, 33, 34, 37

It is proposed that existing providers of training and educational interventions include drug and alcohol issues within their existing personal development courses, with assistance of local substance misuse education providers.

RDTF Communications Strategy

Action Point 73

The RDTF should co-ordinate a communications strategy for the region, to encourage local media to play a greater role in highlighting the issues of substance misuse, and incorporating the work of local groups.

Lobbying

SPHE

Action Point 33

The RDTF should lobby the Department of Education and Science to investigate how Social, Personal and Health education could be given greater emphasis, credibility and profile within the school curriculum.

After School Activities

Action Point 71

The RDTF should lobby the Wexford County Development Board to include in its plan the opening of schools in the late afternoons and evenings, to facilitate homework clubs and a range of activities for young people in a safe social environment.

Public Service Advertisements

Action Point 38

The RDTF should liaise with the Health promotion Department nationally to ensure that greater use is made of advertising media such as cinemas, theatres, buses, hoardings, etc., and that campaigns are signalled well in advance to allow local support initiatives to be developed and delivered in tandem with this advertising.

Juvenile Liaison Officers

Action Point 7 [see also Supply Control, c2]

The RDTF should lobby the Department of Justice, Equality and Law Reform to increase the number of Juvenile Liaison officers in

County Wexford to the level that each Garda District has one full-time Juvenile Liaison Officer.

Supply Control

Resources

There were no RDTF resource based proposals in this section.

Internal

Target dealing in and around pubs and clubs

Action Points 27, 28

Empower publicans, club owners/managers and bar staff to work with Gardaí to identify and tackle drug dealing in and around licensed premises.

Drugwatch/Coastwatch

Action Points 7, 10, 14, 15

To promote and co-ordinate the existing confidential telephone reporting system to tackle drug dealing and smuggling.

Garda deployment

Action Point 5, 8, 27

The Garda Síochána to engage with community groups to discuss the policing plan for the area, to include discussion of deployment issues at peak times, such as week-ends/closing times.

Lobbying

Garda Drug Squad for County Wexford

Action Point 7, 10, 12

The RDTF should lobby the Department of Justice, Equality and Law Reform to provide the resources to establish a dedicated Drug Squad for County Wexford.

Community Gardaí and Juvenile Liaison Officers

Action Points 5, 7, 8, 11 (see also Education and Supply, c4)

The RDTF should lobby the Department of Justice, Equality and Law Reform to provide the resources to the Gardaí to enable them to provide both a Juvenile Liaison Officer and a Community Garda in each District. This would allow the work of Community policing to continue without impacting on the work of the Juvenile Liaison Officer.

the volume of traffic passing through the port.

By the end of the first phase of its planning cycle, the Wexford LDTF/County Drug Committee had prioritised three key projects as detailed in the following table and the remainder are in the process of being worked up or negotiated with the relevant agency for their consideration. Two are under the Education and Prevention pillar and the other, Treatment and Rehabilitation.

Benzodiazapine Protocol

Action Point 41

The RDTF should lobby the Department of Health and Children to implement the remaining aspects of the benzodiazapine report, to reduce the over-prescribing and leakage of these drugs.

Methadone Protocol

Action Points 45, 56 (see also Treatment and Rehabilitation, b2)

The RDTF should lobby for the full implementation of the Methadone protocol in the South East.

Customs Service Resources

Action Point 18

The RDTF should lobby the Revenue Commissioners to increase the level of resources available to Customs officers in Rosslaire Harbour, to reflect the increase in

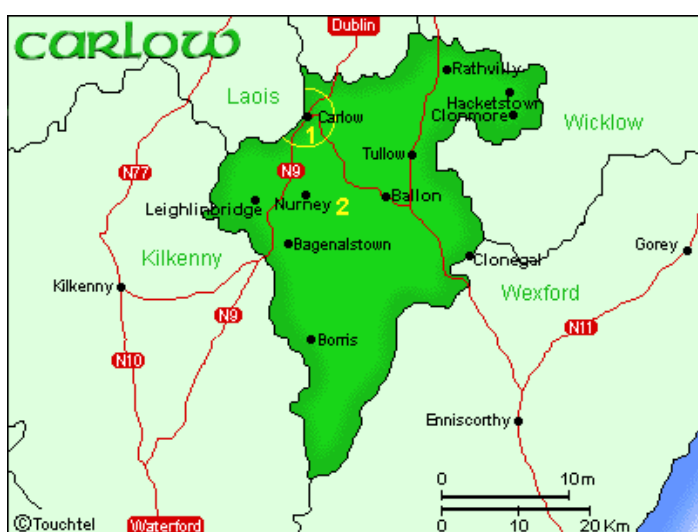
Wexford LDTF Proposed Projects			NDS Pillar
Project Title	Aim	Cost	
Healthy Choices/Healthy Decisions (FDYS/CBDI)	Involvement and training of young people in Peer Education specifically related to Drugs/Health Education (Request includes employing 1 Youth Worker)	€52,223	Education/Prevention
Wexford Area Partnership Cornmarket Project Outreach	To enable street/outreach workers to reach young drug users not in contact with existing services; to provide a drop-in facility for people in difficulty with drugs/and or those currently on treatment clinics offering intensive support.	€180,000	Treatment/Rehab.
Local Outreach Worker	Substance Misuse Counselling	€50,000	Education/Prevention
Total Wexford		€282,223	2 E/P, 1 T/R

CARLOW/KILKENNY LDTF

County Carlow is an inland county bordered by counties Wicklow, Wexford, Kilkenny, Laois and Kildare. The county is 900km² in area and has a population of 46,014 (+11% on 1996). The principal towns within the county are Carlow, Tullow, Bagenalstown (Muinebheag), Hacketstown and Borris. Carlow Town is one of the largest inland towns in Ireland with a population of over

County Kilkenny is situated in the South Eastern Regional Authority Area and is divided into five electoral areas, Ballyragget, Thomastown, Piltown, Callan and Kilkenny. Each electoral area contains a number of DEDs (District Electoral Divisions), there are in total 113 DEDs in County Kilkenny.

Kilkenny City is the main urban centre. Other towns include Thomastown, Piltown which is found close to the Waterford border, Callan in the west and Castlecomer in the upland area in the north.



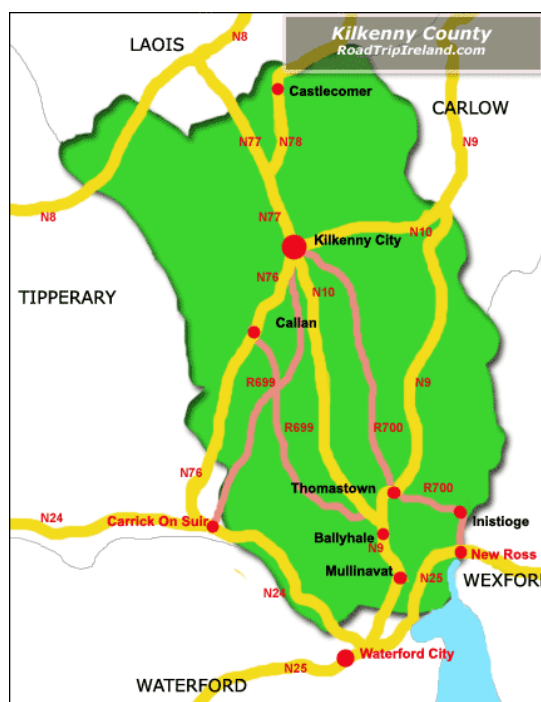
In 2002 there were 80,339 people in County Kilkenny and contained three DED's in the top decile with the most deprivation, Urlingford, Kilkenny No.1 Urban and Callan Urban. It also has the highest number of DED's in the most affluent decile at 23% against 9% in Waterford, 7% in Tipperary SR, 6% in Carlow and 2% in Wexford.

One Voice LDTF

Prior to the establishment of the 'One Voice' committee, each county (Carlow

18,487 (+23% on 1996) within its environs while no other town in the county has over 2,500 people. There are also two third level colleges in the town of Carlow catering for approximately 5,000 students.

County Carlow holds a strategic location in the Southeast, 80km from Dublin and driving takes approximately 90 minutes from Carlow town centre. More people are commuting daily to and from the Capital with several buses leaving Carlow each morning for Dublin, as well as a direct train connection. The town is within easy reach of Kilkenny, Portlaoise and Enniscorthy and is serviced by major roads. Testament to the development within Carlow County is the considerable new housing under construction, with almost 4,000 new dwellings since 1996.



and Kilkenny) had a 'Local Co-ordinating Committee on Demand Reduction Measures for Drugs' which reported back to the Regional Drug Task Force.

Much of the initial work comprised of education around the National Drug Strategy and the four pillars. This work was coloured by a background of disillusionment among local members, which was a product of perceived failures on behalf of the regional structure to deliver on promises.

At this stage many meetings were held with both committees and much of the work was 'motivational' in nature. It became apparent that resources could not sustain two local committees. Finally, a two day team building meeting was held on 16th and 17th September, 2003, with an agreed facilitator. The agreed focus of the two days was to develop a structure and a team approach for Carlow/Kilkenny and to plan for sustainability and effective use of resources, which resulted in one local committee for Carlow and Kilkenny – 'One Voice'.

The birth of 'One Voice' was a huge success and a sense of achievement and team spirit ensued. It is worthy to note that both counties working together for a common goal on the same committee was a historical moment.

A meeting was held on 17th February, 2004, where members finally selected themselves onto subgroups.

A Steering Committee was set up which comprised of the chairs of each subgroup, one other member from each group and the Co-ordinator and Drug Education Officer, each of whom sit on two subgroups and the Steering Committee. Each subgroup decided on one action for 2004.

Education & Prevention:

This sub-committee has completed its action (Drug Awareness Week Carlow/Kilkenny)

and is currently awaiting an evaluation before deciding to run it as a yearly event.

Supply & Control:

Supply and Control has been active in requesting extra community policing, although the N.D.S.T. indicated that responsibility for this lies at national level. A Focus Group, as the key action was then organised, which was a major success in increasing awareness in Carlow.

Treatment & Rehabilitation:

This sub-committee has changed its focus and is currently exploring the need for detox beds and a drug screening facility.

The One Voice LDTF/County Drug Committee arranged two workshops in preparation for the Plan and also placed an invitation in the local media for submissions. The main organisations working to address the drugs issue in Carlow/Kilkenny are:

- Co Carlow VEC – Drugs Worker
- Co Carlow VEC Music Club
- Co Carlow VEC Parent to Parent
- Co Carlow VEC School Tracking Programme
- Co Carlow VEC Talking Drugs
- Co Carlow Community Network
- Carlow Regional Youth Service
- SEHB Substance Misuse Team – Treatment
- SEHB Substance Misuse Team – Education
- Kilkenny Drugs Initiative
- Kilkenny Rural Drugs Initiative
- Kilkenny Addiction Treatment Service
- Kilkenny Garda Youth Diversion Special Project
- Youth at Risk Carlow Project
- County Carlow Drugs Initiative
- Traveller Health Section – SEHB Kilkenny
- The No Name Club Kilkenny
- Ossory Youth Kilkenny

- Loughboy Community Development Project Kilkenny
- Kilkenny Local Authority

One Voice has been very active in generating the awareness not only of the organisation but of the drugs issue itself. It had to commence this task by engaging the active and passive participation of the range of other key organisations – not made any simpler by the amalgamation of the effort across two counties and by the fact that some organisations are administered across both counties. However, with that task now successfully completed, the time is now ripe for the development of more work particularly around the identification of needs and gaps in services. One Voice has identified eight projects to assist its work. Seven of these have been presented for submission to the SERDTF while the eighth, a Screening Facility, is currently being formulated. Seven of the projects are Education and Prevention while the eighth is Research and Audit. The projects, totalling €185,180, are as follows.

Carlow/Kilkenny Projects			NDS Pillar
Major Project Title	Aim	Cost	
CBDI Addiction Worker, Carlow	The county requires an additional drugs worker in order to meet the needs of the growing population.	€57,000	Education/Prevention
Family Support Worker for Children & Parents	To supply a part-time worker to build the capacity of the parents of Substance Misusers to develop positive coping strategies within the family.	€23,405	Education/Prevention
Music Clubs, Carlow	To introduce young people at risk to music as an alternative to substance misuse.	€19,100	Education/Prevention
Carlow/Kilkenny Drug Awareness Week	To raise awareness of the issue of drugs, drug use, services available and alternative activities to the use of drugs that are available in Carlow and Kilkenny amongst the general public.	€11,800	Education/Prevention
Local Outreach Worker	Substance Misuse Counselling	€50,000	Education/Prevention
Minor Project Title	Aim	Cost	
Encourage students to research various aspects of substance misuse	To increase our knowledge base and research evidence by attracting 3rd level students to undertake research in Carlow/Kilkenny encompassing the four pillars of the National Drug Strategy.	€10,125	Research/Audit
Ossory Youth Programme for 15-18 year olds	To support existing youth service staff to directly deliver intensive relevant programmes to groups of young people 15-18 years.	€7,500	Education/Prevention
Rural Outreach Initiative in North East Kilkenny	To provide a part-time worker and create a recreational space for rural men in North East Kilkenny especially focusing on men at risk.	€6,250	Education/Prevention
Total Carlow/Kilkenny		€185,180	7 E/R, 1 R/A

SOUTH TIPPERARY LDTF

The population is increasing after a period of decline in the late 1980s. While 20% of the population is concentrated in Clonmel and almost 40% in the five main urban centres, the County is still rural in nature, with more than 60% of the population living in rural DEDs. The County is sparsely populated with a population density of just 87 people per square mile – as compared with a national average of 135. There has been a gradual

contains a number of District Electoral Divisions (DEDs)^{1[1]} - there are 99 DEDs in total in South Tipperary.

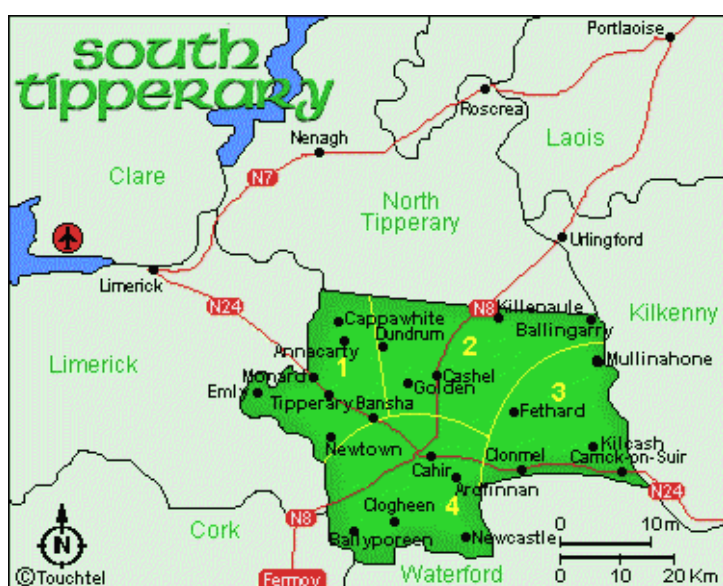
At the last Census in 2002, the population of South Tipperary stood at 84,257 (+5% on 1996). The population had declined by 2% 1986 to 1991, but a modest increase of 0.79% was recorded between 1991 and 1996.

Clonmel is by far the largest centre with a population of 16,910 (+4% on 1996), followed by Carrick-on-Suir, 5,586 (+7% on 1996) Tipperary, 4,964 (+2% on 1996), Cashel, 2,770 (+3% on 1996), and Cahir, 2,794 (+25% on 1996). Together these towns accounted for 39% of the total population of the County.

Population decline during the same period was most marked in the areas north of the Galtee Mountains and west of an axis including Cahir-Cashel-Thurles. Low population density is also particularly marked in the area to the south and west of Cahir and in areas to the north and to the east of Fethard.

The most densely populated DEDs were Clonmel West Urban (7,511 per square mile), Tipperary East Urban (4,940 per square mile) and Cashel Urban (4,731 per square mile). The lowest population densities were found in the upland DEDs of Kilcoran (21 per square mile) and Glengar (21 per square mile).

Despite recent population shifts, over 60% of the population of South Tipperary still live in rural areas. In addition, the County Council is aiming to redress population decline by encouraging spatial distribution of housing, through its settlement and village area plans. These plans will provide an important framework for encouraging a more balanced distribution of development throughout the



migration from disadvantaged rural areas in recent year but the Council is trying to reverse this trend in its Housing and Planning Strategies.

The economic situation has improved significantly in the last decade, but the County still lags behind the national prosperity. Nine of the ED's in Tipperary South are in the top decile of the most deprived in the State. In the SERDTF area this is only second to Waterford City where there are 17 in the most deprived decile in the State.

South Tipperary is divided into five Electoral Areas: Cahir, Cashel, Clonmel, Fethard and Tipperary. Each Electoral Area in turn

County in coming years.

The South Tipperary Housing Strategy anticipates that 3,673 new houses will have been built during the 2001 - 2006 period, with the indicative spatial distribution providing for 2,081 in the main and priority settlements and 1,592 in rural areas and villages. It is projected that 1,040 households will be formed in Clonmel, 312 in Carrick-on-Suir, 208 each in Cashel, Tipperary and Cahir and 105 in Fethard.

As well as being relatively sparsely populated, the geography of the County also means that the main population centres are relatively dispersed. This gives rise to transport difficulties, difficulties in accessing services and problems related to isolation. It also makes it more difficult to coordinate activities at a County level and to encourage people to become involved in County-wide initiatives.

The main organisations involved in tackling the drugs issue around Tipperary South are:

- Clonmel CBDI
- Clonmel Support Group
- Suir Valley CBDI
- SEHB Substance Misuse Team
- Mid-Tipperary Drugs Initiative
- SEHB Drug Education Officer

One workshop was held in Tipperary South to prepare for the Plan and the education and prevention sub-committee had been involved in the implementation of a number of initiatives in conjunction with the Drugs Education Officer.

The main issues which the meeting identified as outstanding were:

- Appointment of independent Chair to the LDTF/County Drug Committee;
- The provision of a continuum of care within the treatment function;
- The development of protocols for prescribed drugs;
- More active engagement of the community in the drugs issue;

- A rationalisation of the number of agencies addressing drugs from different perspectives in the area;
- Development and extension of a range of initiatives including;
 - Alcohol Awareness & Safety Programme in relation to the Junior Cert and Debs nights;
 - Stay on Side Initiative;
 - Parent to Parent Programme;
 - Solvent Awareness Programme;
 - Sporting organisations policy development;
 - Vintners Programme;
 - Family Support Programme;
 - Substance Misuse Training Courses;
- Establish Treatment sub-group;
- Implement Transition Year Programmes;
- Implement education Initiatives;
- Develop media and PR Initiatives.

The preferred projects that the Tipperary South LDTF/County Drug Committee has proposed are in the table below. Three are Education and Prevention and one is Treatment and Rehabilitation and total €115,000.

South Tipperary Projects			NDS Pillar
Major Project Title	Aim	Cost	
Alcohol & Substance Misuse Awareness Campaign for Junior Cert. and Leaving Cert. Students.	To highlight and promote positive extra curricular activities to demote the misuse of underage drinking and illegal substances through the design, development and dissemination of literary appropriate information leaflets targeted specifically at young people. This will be designed in a leaflet format in consultation with focus groups of both age categories and also includes purchase of Videos and DVDs.	€10,000	Education/Prevention
Substance Misuse Counsellor	Currently employs one full time Counsellor in four areas - at saturation point. To continue to provide services the development of a second Counselling post is vital.	€50,000	Treatment/Rehab.
Local Outreach Worker	Substance Misuse Counselling	€50,000	Education/Prevention
Minor Project Title	Aim	Cost	
Parent to Parent promotional brochures and training videos/dvds	To provide materials for an accessible programme for parents to aid them in preventing young people across South Tipperary from engaging in dangerous behaviours such as drug use.	€5,000	Education/Prevention
Total South Tipperary		€115,000	3 E/P, 1 T/R

REGION-WIDE ACTIVITY

There is a large number of organisations which have a region-wide brief and they are detailed here.

- Aiséirí Treatment Centres;
- Aislínn Centre;
- Bishops' Drug initiative;
- Community Awareness of Drugs – Adults, Training, Parenting for Prevention;
- Céim Eile;
- Health Promotion Dept SEHB parents, Smoking Cessation, SPHE, School Education;
- Community Awareness of Drugs Advisory and Referral Service;
- Merchant's Quay Ireland – St Francis Farm Project;
- Department of Education & Science;
- Foróige.5

Representatives from many of these organisations have been involved in the activities of the SERDTF and/or some of the Local Drugs Task Forces. Four proposed projects, four of which are Treatment and Rehabilitation and one, Education and Prevention, have been submitted for consideration for funding of €513,000 from the SERDTF.

Regional & National Projects			NDS Pillar
Project Title	Aim	Cost	
Ceim Eile (Aiseiri)	Half Way House for client care post primary treatment – in pilot mode for 18 months but inadequately funded at present and the future of the project is at risk.	€110,000	Treatment/Rehab.
Aiseiri	To supplement HSE Funding to Aiseiri to allow for greater access for Medical Card Clients to Residential Treatment.	€178,000	Treatment/Rehab.
Croi Nua (Aislínn)	Five day residential programme which offers parents and concerned persons the opportunity to face and express the feelings they have about themselves and the person who is chemically dependent. Funding required to run the centre based on a full capacity for 26 weeks.	€65,000	Treatment/Rehab.
St. Francis Farm	Development of therapeutic training and reintegration programme	€160,000	Treatment/Rehab.
Total Regional		€513,000	4 T/R & 1E/P

PROJECTS SUMMARY

The total cost for the proposed projects is €1,297,091 and is the estimated budget for Year 1 of the implementation.

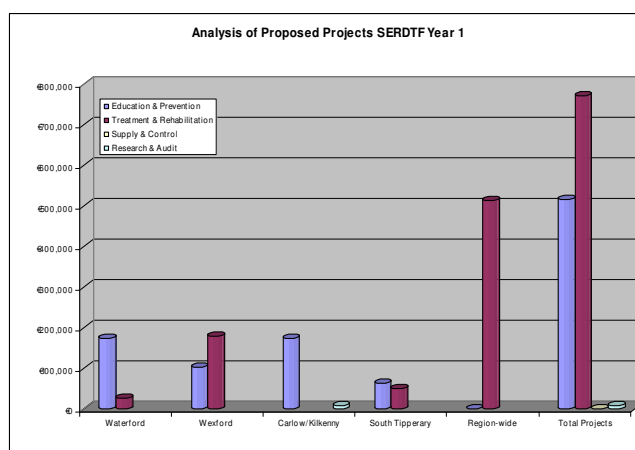
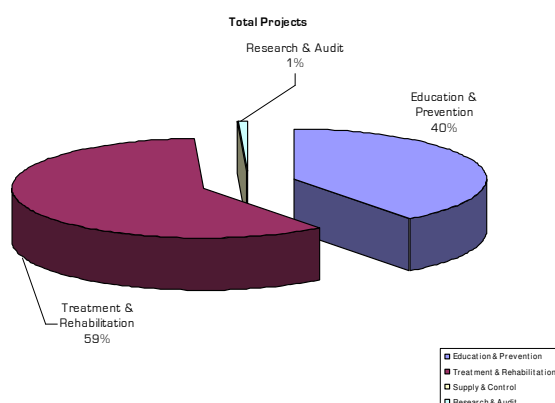
year funding of 40% of the total while Treatment and Rehabilitation requires 59% and Research and Audit, 1%.

Of the 28 projects in total, 20 are Education

Area	Pillars of the National Drug Strategy				Total
	Education & Prevention	Treatment & Rehabilitation	Supply & Control	Research & Audit	
Waterford	€173,623	€28,065			€201,688
Wexford	€102,223	€180,000			€282,223
Carlow/Kilkenny	€175,055			€10,125	€185,180
South Tipperary	€65,000	€50,000			€115,000
Region-wide	€0	€513,000			€513,000
Total Projects	€515,901	€771,065	€0	€10,125	€1,297,091

Years 2 and 3 funding will be based on Year 1 performance and implementation schedules. While Education and Prevention and Treatment and Rehabilitation have been

and Prevention, 7 are Treatment and Rehabilitation and 1 is Research and Audit.



prioritised by the Local Drugs Task Forces for the immediate future, it is clear that the Supply and Control and Research and Audit will provide a focus for the groups in the planning for future years. There is Region wide research planned within the strategy and groups have been awaiting this initiative before planning local approach. Supply and Control discussion has been dominated by the Customs and Excise and Gardaí human resources needs which have been referred to the national governance of these agencies.

The chart above indicates that the Education and Prevention pillar requires first

Area	Pillars of the National Drug Strategy				Total
	Education & Prevention	Treatment & Rehabilitation	Supply & Control	Research & Audit	
Waterford	8	1			9
Wexford	2	1			3
Carlow/Kilkenny	7			1	8
South Tipperary	3	1			4
Region-wide	0	4			4
Total Projects	20	7	0	1	28

The following section provides a summary of the way the plan will be implemented.

7. IMPLEMENTING THE PLAN

This is a short section which provides a complete picture of the implementation of the dPlan which is based on the employment of Development Workers, the undertaking of baseline research and the provision of a Small Grants allocation to the County Drug Committees.

DEVELOPMENT WORKERS

In the course of the preparation of the Plan, it was widely recognised that the County Drug Committees and the SERDTF required resourcing. When discussion had taken place and a way forward had been envisioned, the County Drug Committees had no means of taking the vision forward and developing the activities. It was agreed that this would be facilitated by providing the SERDTF with administrative support and the County Drug Committees with two Development Workers. The administrative support costs for the SERDTF are being met by the HSE Substance Misuse Team based at Beech House Waterford [Jennifer Bolger], while the two Development Workers are to be recruited and funded through the strategy. The Job Description for the Development Workers has been drawn up and will be recruited as soon as possible.

Job Description

The RDTF Development Worker will play a pivotal role in assisting the Coordinator and the Task Force in developing and implementing its regional drug strategy. They will have a vital role in developing and supporting community based projects and facilitating interagency work.

The core function of the post is to support and contribute to the work of the RDTF through project support, support of community/voluntary reps, and policy development.

Project support

- To work closely with the Task Force Co-ordinator to ensure that new and existing project promoters are fully supported as they implement Task Force projects.
- Assist projects in setting up management, administration, staffing, and accounting systems, which comply with procedures set out by funding agencies and by the National Drugs Strategy Team.
- Assist projects in setting out targets, performance indicators and other evaluation procedures.
- Provide support and assistance to projects during the interim funding phase.
- To support and assist projects to address the issue of mainstream funding and the continuation of the project.
- To maintain links with mainstreamed projects, and ensure that any project changes or problems are brought to the Task Force.
- To help identify training supports for the Task Force projects.
- To ensure effective communication between the projects and their channel of funding agency representative on the Task Force.
- To assist new or emerging groups that that can make a contribution to the work of the Task Force.
- To assist in Task Force engagement with the wider community through the organisation of community meetings a couple of times a year, occasional information events and the production of bulletins and newsletters.

Support for community and voluntary reps

- To support community representatives to fulfil their mandate as representatives of the broader community.
- To support and/or establish a projects support network.
- To support voluntary groups to link back and/or develop links with the Voluntary Drug Treatment Network.
- To support voluntary representatives to fulfil their mandate as

representatives of voluntary groups in the region.

- To support representation of 'communities of interest' on the RDTF.

Policy development

- Assist the RDTF in the development and implementation of its policies, initiatives and strategies aimed at reducing existing and future drugs problems in the region.
- To support the co-ordinator to ensure effective communication between the Task Force policies and actions and other social inclusion programmes.

Other

- To support and/or develop a service users forum in the RDTF area.
- Support development of programmes aimed at progression of recovering/stable drug users into employment
- Establishment of Community Fora to hear views
- Any other duties that may be assigned from time to time by the Task Force

Core Competencies: Modelled on HSE Grade 5 equivalent

- Has excellent communication and interpersonal skills with the ability to interact with all levels within the organization.
- Has ability to motivate, supervise and develop staff to reach their full potential.
- Has initiative and analytical skills.
- Can work independently on his/her own initiative and as a member of a team.

Salary range of RDTF Development Worker:

Equivalent to HSE Grade 5 position: €35,178 - €39,730 (€41,082 - €42,430 Long Service 6h Increments) as at January 2005.

It is estimated that the total annual cost for the two Development Workers is €100,000.

BASELINE RESEARCH

It has been outlined elsewhere in the Plan the importance of research for the Region. The baseline research will not only provide essential information which will assist targeting of resources and initiatives along with the demographic and qualitative research, but will assist other professionals in the statutory services to understand the nature and incidence of substance misuse.

The research information presented in this Plan is there to demonstrate the importance of this understanding of substance misuse and how the behaviour in Ireland compares with other developed and less developed economies. More information on the topic of drugs and alcohol misuse which is in the hands of members of the task forces, the statutory agencies, schools, parents and youth agencies provides increased control of the issue and will provide more rapid responses and initiatives.

Therefore it is proposed that a Region wide research project is initiated which will probably rely on the input of the County Drug Committees. The research will be comparable to the ESPAD and other surveys and will be designed and analysed by a Researcher in the Drugs field of some experience. It will provide prevalence data regionally, locally and a range of other information which is contained in the Kilbarrack Research.

The estimated cost for the undertaking of this research is €50,000.

SMALL GRANTS BUDGET

The County Drug Committees have a requirement of speedy access to a small grants fund which will be at their disposal. It is targeted at small projects that need not go through the rigorous application process of the RDTF. It will be at the disposal of the County Drug Committees through the Development Workers and accountable to

the RDTF. It is estimated that Year 1 funding allocation will be €50,000.

There are always small pieces of research, posters, publications, seminars, training and media activity which will have to be commissioned immediately and this Small Grants Fund is designated to provide for this.

FINAL BUDGET

The cost for the implementation of the strategy in Year 1 is €1,497,091 and can commence as soon as the budget is approved.

SERDTF Strategy Cost Summary Year 1	
Element	Cost
Project Costs	€1,297,091
Development Workers X 2	€100,000
Region wide Research	€50,000
Small Grants Fund	€50,000
Total Year 1	€1,497,091