

Drug Treatment: **An Assessment of Needs in the North East Region**

for

North East - Regional Drugs Task Force

*Research and Report by Niall Watters,
Unique Perspectives
2008*

Table of Contents

1. INTRODUCTION	
1.1 Background to the Report and Research	1
1.2 Overall Aims of the Research	1
1.3 Methodology	1
1.4 Report Structure	3
2. CONTEXT OF THE NE-RDTF'S WORK	
2.1 Context of the NE-RDTF's Work	4
2.2 National Drugs Strategy	4
2.3 Defining Treatment	5
2.4 Regional Drugs Task Forces	7
2.5 North East Regional Drugs Task Force	8
2.6 Drug Use Prevalence & Trends	10
2.6.1 National Prevalence Survey	10
2.6.2 Opiate Use	11
2.6.3 Cocaine	12
2.6.4 Treatment Statistics	13
2.6.5 Garda Síochána National Statistics	13
2.7 Summary & Conclusion	15
3. PROFILE OF THE NORTH EAST	
3.1 Introduction	16
3.2 Area Makeup & Population	16
3.3 Household Structure	18
3.4 Education	20
3.5 Social Class	20
3.6 Employment	21
3.7 Deprivation	21
3.8 Summary & Conclusion	22
4. PREVALENCE OF DRUG PROBLEMS IN CAVAN, LOUTH, MEATH & MONAGHAN	
4.1 Introduction	24
4.2 Drug Treatment	24
4.3 Drug Prevalence	31
4.4 Garda Statistics	33
4.5 Summary & Conclusion	35
5. CONSULTATIONS WITH STAKEHOLDERS	
5.1 Introduction	37
5.2 Profile of Respondents	37
5.3 Nature & Extent of Drug Use	37
5.4 Treatment Services & their Impact	39
5.5 Gaps & Needs in Treatment Services	42
5.6 Indirect/Related Needs	44
5.7 Structural Organisational & Administrative Issues	45

5.8 Suggestion of Future Treatment Services	46
5.9 Summary & Conclusion	47

6. CONSULTATIONS WITH DRUG USERS & FAMILY MEMBERS

6.1 Introduction	50
6.2 Role in Respect of Drugs in the North East	50
6.3 Nature & Extent of Drug Use	50
6.4 Factors Contributing to Problem Drug Use	51
6.5 Experiences of Services	52
6.6 Gaps & Needs in Treatment Services	54
6.7 Related & Indirect Needs to Treatment	54
6.8 Summary & Conclusions	55

7. CONCLUSIONS AND RECOMMENDATIONS

7.1 Introduction	57
7.2 Conclusions	57
7.2.1 Number and Profile of Drug Users in the Region	57
7.2.2 Assessment In-Patient and Out-patient Drug Treatment Services	59
7.2.3 Needs of Drug Treatment Service Users and their Families/Gaps in Service Provision	60
7.3 Recommendations	61
1. The Provision of Residential Detoxification Facilities	61
2. Information and Promotion of Services	62
3. Continuum of Care and Tailored Case Management	62
4. Collaboration, Multiagency Responses including Open Dialogue and Consultation between Statutory & Community/Voluntary Services	62
5. Integrated, Holistic Treatment Options and Services	63
6. Provision of Ancillary or Parallel Supports	63
7. Overhaul/Restructuring of HSE Addiction Services including Increases in Resourcing including Staffing of HSE Services	63
8. Monitoring, Learning and Tracking Systems	63
9. User Involvement and User Led Services including the Development of Complaints Procedures	64
10. Out of Hours Services	64
11. Improvement in the Location and Appropriateness of Premises/Treatment Facilities	64
12. Incorporating Polydrug Use to Treatment	64
13. Focus on Harm Reduction Approaches including Outreach	64
14. The Provision of Crisis and Early Interventions	65
15. Focussing on Adolescents	65

REFERENCES

APPENDICES

Appendix 1:	North Eastern Regional Drugs Task Force - Draft Theme Sheet to Guide Semi-Structured Interviews, NERDTF Stakeholder/Addiction Interviews
Appendix 2:	North Eastern Regional Drugs Task Force - Draft Theme Sheet to Guide Semi-Structured Interviews, Families and Drug Users

Tables/Figures

Table 2.1: NACD National Prevalence Survey 2006/07, Ireland	11
Table 2.2: Central Treatment List, July 2007	13
Table 2.3: Number and Annualised Percentage of Misuse of Drugs Act Offences by Drug Type	14
Table 3.1: Population of the North East, 1996 – 2006	17
Table 3.2: NE-RDTF Population aged 15-44, 2006	17
Table 3.2: Task Force Population aged 0-14, 1996 – 2006	18
Table 3.4: Nationality	18
Table 3.5: Lone Parent Households	19
Table 3.6: Household Tenure	19
Table 3.7: Level of Cessation of Education (Excluding Not Stated)	20
Table 3.8: Social Class	21
Table 3.9: Unemployment Rate	21
Table 3.10: Relative Deprivation Rate	22
Table 4.1: Number of all Treatment Contacts by Treatment Area and Area of Residence of Clients, 1996 – 2000	25
Table 4.2: Main Drug of Misuse of all Treatment Contacts treated in the NEHB, 1996-2000	25
Table 4.3: Number (%) of Cases Treated and by Treatment Status in the North Region, 1998 – 2002	26
Table 4.4: Main Problem Drug Reported by New Cases in the North Region, 1998 – 2002	26
Table 4.5: Numbers of Substance Misusers in the North East Region Referred and Assessed by Services	31
Table 4.6: Numbers of Substance Misusers Treated by GPs or assigned to Pharmacies, July 2007	31
Table 4.7: Lifetime Prevalence of Drug Use, North East Region 2002/2003	33
Table 4.8: Garda Statistics on Drug Offences (No. & %) for Cavan, Meath, Monaghan and Louth	34
Table 4.9: Lifetime Prevalence of Drug Use North East Region 2006/2007	34
Figure 3.1: N-RDTF Catchment Area	16
Figure 3.2: % of population change 1996 – 2002 – 2006	17
Figure 4.1: Figures in All Treatment Contact Rates for 15-39 Year Olds by Former Health Board Region of Residence, 1996 – 2000	26
Figure 4.2: Average Annual Incidence of Treatment for an Opiate as a Main Drug Problem among 15 - 64 Year Olds by County per 100, 000 of Population, 1996 – 2000	27
Figure 4.3: Average Annual Incidence of Treatment for an Opiate as a Main Drug Problem among 15 – 64 Year Olds by County per 100,000 of Population 1996 – 2000	28
Figure 4.4: Average Annual Incidence of Treatment for Cannabis as a Main Drug Problem among 15 – 64 Year Olds by County per 100,000 of Population 1996 – 2000	29
Figure 4.5: Average Annual Incidence of Treatment for Cannabis as a Main Drug Problem among 15 – 64 year olds by County per 100,000 of population 1998 – 2002	30
Figure 4.6: Prevalence of Drug Problems in NERDF Area as per Survey 06/07 (Lifetime, Last Year & Last Month)	32
Figure 4.7: Garda Statistics on Drug Offences (Nos.) for Cavan, Meath, Monaghan and Louth, 1990 – 2005	34
Figure 4.8: No. of Drug Offences by Type of Drug and Year in North East Region	

Foreword

On behalf of the North Eastern Regional Drugs Task Force, I warmly welcome this timely and comprehensive report. It provides us with an in-depth review of addiction services here in the north east and a remarkable insight in to the views and experiences of people working on the frontline and those that rely on these crucial services.

From the outset, members of the North Eastern Regional Drugs Task Force were keen to hear the opinions of those groups that remain largely hidden from policy makers and governmental bodies, particularly those that are most affected by problematic substance misuse; people who currently use illicit substances, those currently attending treatment & rehabilitation services, and their families.

We were especially pleased that Niall (the researcher) was able to link in directly with so many people, including frontline service providers and other key stakeholders. This dialogue is essential if we are to gain a true understanding of what frontline services could and should provide for some of the most vulnerable, socially excluded people in our communities. This invaluable link will continue in the future through the family support network, service user and addiction service providers fora.

The task force would like to thank everyone who participated for their time and their honest and forthright contributions about experiences, both good and bad. While some of the concerns raised here make uncomfortable reading for those charged with developing and delivering comprehensive addiction treatment and rehabilitation services, they do provide us with a way forward as we look to develop our next regional action plan.

The Regional Drugs Task Force accepts the key findings and recommendations, and will reflect on how we can work more strategically together to address the gaps in service provision highlighted here. While there have been a number of positive developments since this research was commissioned, we recognise that there is still much to do. These recommendations provide us with a comprehensive list of priorities and an agreed way forward.

Michael Wash
Chairperson

1. INTRODUCTION

1.1 BACKGROUND TO THE REPORT & RESEARCH

The North Eastern Regional Drugs Task Force (NE-RDTF) is an inter-agency partnership incorporating community, voluntary and statutory representatives. NE-RDTF was established in 2003 to ensure the development of a co-ordinated and integrated response to tackling drugs problems in Counties Cavan, Louth, Meath and Monaghan.

The catchment of the NE-RDTF therefore covers the former operational area of the North Eastern Health Board prior to the establishment of the HSE. According to the last Census (2006), this catchment had a population of 394,098.

As part of its strategic focus on drug problems in the north east region, the NE-RDTF commissioned this needs assessment study which relates to both in-patient and out-patient drug treatment services of the task force catchment/the HSE Dublin/North East area.

1.2 OVERALL AIMS OF THE RESEARCH

This research process has a number of aims as follows:

- to assess the number and profile of drug users in the region
- to assess in-patient and out-patient drug treatment services
- to explore needs of drug treatment service users and their families
- to identify gaps in service provision
- to make recommendations for future service development and resources required

In addition, the research sought to carry out a number of qualitative investigations with treatment and rehabilitation service providers, drug treatment service users and their families. The study reviewed the available literature in the area, including information on social inclusion, perceived barriers to services, clinical needs of service users and dual diagnosis, and the specific needs of adolescent and female services users.

Based on these aims, this report outlines some of findings from research and looks at how these issues might be responded to in terms of future service development.

1.3 METHODOLOGY

The methodology for the research involved four phases. The overall approach to the research was to balance systematic data, such as statistics and prevalence figures, with qualitative perceptions based on the experiences of well placed stakeholders (community/voluntary service providers, drug users, family members), and also those with drug related problems and those affected by problem drug use such as family members. This method allows both elements to complement each other and give a comprehensive picture of experiences, trends, service development and ultimately treatment needs. The method used in the research is sometimes referred to as 'triangulation' whereby the views of different gradings of key positioned stakeholders on the issue were sought. This yields valuable information that also complements the statistical data uncovered in the relevant phases of the research.

The main phases of the research, in chronological order, are as follows:

1. The initial phase discussed the project in detail with the NE-RDTF Research and Evaluation sub-committee, identified and clarified the key issues to be addressed during the research process and the relevant stakeholders to be consulted.

2. The second phase of the research reviewed literature, studies and statistical data relevant to the research. This included details of the prevalence of drug use in the Catchment of the NE-RDTF, socio-economic data on the region, the policy and service delivery context of the Task Force and treatment services. This allowed for all background and context information to be collected and digested in order to inform the overall research, its research tools, implementation and also its findings. This phase also developed semi-structured interview schedules which guided the consultations with stakeholders and drug users, and the stage also finalised the sample of groups and individuals to be consulted.
3. The third and substantive phase of the process was the field consultations. The main stages in this field research phase were with the following groups
 - *HSE*

The main representatives of the addiction services of the HSE in the region as well in the four counties and the various urban centres were interviewed in order to get their views and insights. Included among the interviewees here were the drugs strategy facilitator, addiction counsellors, outreach workers etc. These interviews served to develop a baseline of current services, responses, referrals, capacity as well as new trends and emerging needs. In addition, other HSE staff members - including clinicians - were interviewed in the area of health promotion. Finally a number of the GPs involved in the methadone maintenance programme were also interviewed. In total, 18 interviews took place in this stage.
 - *Other/statutory*

A number of representatives of non HSE statutory services were also interviewed as part of the research. This phase included interviews with members of the Task Force itself that do not naturally fit in under one of the other categories, including TF staff. Altogether, five interviews took place under this heading.
 - *Community & Voluntary*

Representatives of community and voluntary groups were interviewed using the semi-structured interview schedule. These groups included those with a direct relationship to drug problems - in terms of services and advocacy - as well as those who work in and represent areas in which drug use and therefore drug treatment services are an issue. Again, these interviews took place in all four counties comprising the catchment of the Task Force. Some 20 interviews took place under this heading.
 - *Drug Users*

Using NE-RDTF and its statutory and community/voluntary contacts as a 'gateway', in particular substantial support and assistance from HSE staff and clinicians, a number of individual drug users were consulted in a non invasive way. The aims of these interviews were to get this perspective on drug issues and compare this with that coming from other sources. This stage added a key practical and valid dimension to the other findings in the research. Thirty drug users took part in the consultations for the research.
 - *Families/family members*

Finally, in addition to the interviews with clients of drug treatment services, a range of focus groups and interviews took place with members of the family support groups in the region. Consultations were also held with the regional network as well as with individual family support groupings in various locations throughout the region. Thirty seven members of family support groups took part in the focus groups and interviews in five locations.
4. The final phase of the research process involved the analysis of the data collected and of the subsequent drafting of a research report. This draft report contained the main findings of the research and its implications for future treatment services. In practice, this document served as the final discussion document to which amendments and clarifications were made resulting in the final research report.

These interviews for the most part took place over two periods: February-June and September-October 2007. There was a delay in the research caused by hiatus between these two periods of the research. This was mainly due to some

difficulties in contacting some individuals and service providers who were fundamental to assisting in gaining access to and permission to interview clients of treatment services.

1.4 REPORT STRUCTURE

Following this opening chapter, the next chapter (2) outlines the context of the Task Force's work in terms of the extent of the drug problems nationally, treatment and the policy responses made by the Government. The third chapter provides a social and economic profile of the North East Region. The following chapter is the first of the feedback chapters from the consultations and explores the outcome of the interviews with statutory, community/voluntary and what we have termed 'other' stakeholders. Chapter 5 recounts the views of drug users and those affected by drug use including family members. The final chapter draws together the key points made throughout the research and reaches a range of conclusions and following this, sets out a range of options for future actions of the Task Force based on the research on treatment needs.

2. CONTEXT OF THE NE-RDTF'S WORK

2.1 INTRODUCTION

North Eastern Regional Drugs Task Force is one of 10 RDTFs in the state. The RDTFs were initiated on foot of the recommendations contained in the National Drugs Strategy 2001-2008, 'Building on Experience'. RDTFs were established in the areas not covered by the Local Drugs Task Forces and operated on a regional basis in line with the former health board structures. This chapter presents an overview of the social and policy context in which the NE-RDTF and other RDTFs work. It firstly looks at the National Drugs Strategy, secondly at the role of the RDTFs, thirdly, at some specific information about NE-RDTF and finally, at general information on treatment for problem drug use. The overall aim of this chapter is to set the context for the research findings and the resulting recommendations.

2.2 NATIONAL DRUGS STRATEGY

The overriding policy framework for RDTFs is the National Drugs Strategy (NDS). The strategy was initially launched in 2001, hence its time frame: 2001-2008. The main aim of the NDS 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 rehabilitation and research".

The Strategy was initially delivered through what it terms 'pillars'. The pillars are interconnected clusters of actions around the following themes:

- supply reduction
- prevention (through education and awareness)
- treatment (including rehabilitation and risk reduction)
- research

The objectives of each of the pillars are as follows:

Pillar of NDS	Objectives
Supply reduction	<ul style="list-style-type: none">• 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• - To significantly reduce access to all drugs that cause most harm amongst young people, especially in those areas where misuse is most prevalent
Prevention	<ul style="list-style-type: none">• To create societal awareness about the dangers and prevalence of drug misuse• - 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 & Rehabilitation	<ul style="list-style-type: none">• 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• - To minimise the harm to those who continue to engage in drug-taking activities that put them at risk.
Research	<ul style="list-style-type: none">• To have available valid, timely and comparable data on the extent of drug misuse amongst the Irish population and specifically amongst all marginalised groups• - To gain greater understanding of the factors which contribute to Irish people, particularly young people, misusing drugs

Under each of the pillars, a range of actions and responsibilities are set down. Central to this approach is the bringing together of key agencies, both statutory and community/voluntary, in the implementation of the strategy. Given the present context, it is worth outlining the Treatment pillar in particular. The lead agencies for this pillar are indicated below.

Pillar of NDS	Objectives
Treatment (& Rehabilitation)	<ul style="list-style-type: none"> - <i>Department of Health & Children</i> - <i>HSE</i> - <i>FAS</i>

In addition to the lead agencies, there are a range of other bodies that play a role in the overall implementation of the NDS. These include government committees, interdepartmental groups and the overall lead Department (Community, Rural and Gaeltacht Affairs) and a dedicated National Drugs Strategy Team (NDST).

The NDST is a cross-departmental Team from Departments and Agencies involved in the drugs field. It also contains one representative each from the community and voluntary sectors. Its purpose is to oversee the work of the Local and Regional Drugs Task Forces; address and make recommendations on issues arising, and to report on progress in this area.

In addition, under the NDS there are assessment committees for the Young Peoples Services and Facilities Fund as well as local development groups for this fund in the various communities. At the local and regional level, there are the LDTFs and the recently established Regional Drugs Task Forces respectively.

In more recent times, the strategy has been reviewed and assessed. The mid-term review of the NDS was published in mid 2005. It recommends a number of additions and amendments to the 2001 NDS. The review saw no need to change the overall aims and objectives of the strategy. The success of the strategy varies across the various pillars. The review recommended the addition of eight new actions, replacement of ten actions and the amendment of seven. One of the main changes is that rehabilitation becomes a stand alone and new fifth pillar in the overall strategy.

Of particular note in the context of this research, the review recommended the following amendments, additions to update the 2001 NDS:

Pillar of NDS	Recommendations
Treatment:	<ul style="list-style-type: none"> • <i>auditing treatment availability and assessing treatment needs</i> • <i>responding to polydrug use by increasing availability of</i> • <i>treatment options</i> • <i>rehabilitation to become the ‘fifth pillar’ of the NDS</i> • <i>implementation of guidelines on working with under 18s</i> • <i>wider time and geographic availability of harm reduction services such as needle exchange</i> • <i>consideration of employment of medical staff by voluntary and community based drug services</i>

What is interesting about the recommendations is that they provide national perspectives on some of the areas that were seen as missing from the NDS. They also serve therefore as a wider context to some of the findings outline as part of this research.

2.3 DEFINING TREATMENT

The above sections give an overview of the main policy context or framework of the RDTFs including therefore NE-RDTF. Before looking at issues of relevance to NE-RDTF, it is worth briefly exploring what is meant by the term ‘treatment’ in relation to drug problems and affected individuals.

At the outset, ‘treatment’ as used in response to problem drug use is difficult to define. This is caused by the term’s broad use in different contexts. For instance, it is used when referring to single types of interventions, over particular

periods, and is often differentiated by where it starts and finishes relative to stabilisation and rehabilitation. In other words, it is a loaded term in the sense that one perspective on treatment does not tally with the next and so on. There are therefore a wide variety of interventions that are referred to as treatment: some can best be described as medical, some are psycho-social etc. Indeed, the problems in defining treatment are also evident in the NDS where at the point of its initial publication treatment included rehabilitation. However, since the mid term review of the NDS and the subsequent report of the rehabilitation working group of the NDST, rehabilitation is a one of the five pillars of the NDS in its own right and has been taken out of the treatment pillar.

It is worth turning to look a number of key definitions that are currently used.

Firstly, the NDTRS defines treatment as:

'any activity which is targeted at people who have problems with their drug use and which aims to ameliorate the psychological and medical and social state of individuals who seek help for their drug problems. This activity may take place at specialised facilities for drug users, but may also take place in general services offering medical/psychological help to people with drug problems. Various therapies are used in treatment of clients. These range from medical treatment, such as detoxification, methadone substitution programmes or drug free programmes to non medical therapies which can include addiction counselling, group therapy and psychotherapy. Apart from specialised centres, drug treatment may be provided in hospitals, therapeutic communities, residential centres, out patient clinics, community facilities, street agencies, prison and general practitioners.¹

Secondly, Raistrick et al (2006) when referring to Alcohol, though still relevant, suggest the following definition:

'treatment is used in the traditional sense of some specific agent, psychosocial or pharmacological, which is usually delivered by a suitably qualified individual with the intention of alleviating or resolving problems related to alcohol misuse. Treatment is something that happens within a context and it is important to understand that it is one small contributor to a much wider process of change. Equally, it is important to understand that how treatment is delivered may be as important, if not more important, than what is delivered.'

Another account² defines treatment as the following:

'a range of interventions which are intended to remedy an identified drug problem or condition relating to a person's physical, psychological or social (including legal) well being'.

In the European context, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) suggest that

'formalised treatment in a physical setting in the community with specific medical and/or psychological techniques aiming at reducing or abstaining from illegal drug use thereby improving the general health of the client.³

The United Nations provide the following definition:

'treatment can be defined in general terms as the provision of one or more structured interventions designed to manage health and other problems as a consequence of drug abuse and to improve and maximise personal and social functioning.⁴

An earlier report from the United Nations Office for Drugs and Crime went in to more detail about what treatment means. This account suggests that treatment is:

'providing persons who are experiencing problems caused by their use of psychoactive substances with a range of treatment services and opportunities which maximise their physical, mental and social abilities, these persons can be assisted to attain the ultimate goal of freedom from drug dependence and to achieve full social integration. Treatment services and opportunities can include detoxification, substitution/maintenance therapy, and /or psychological therapies and counselling. Additionally, treatment aims at reducing the negative health and social consequences caused by, or associated with, the use of substances.⁵

¹ NDTRS, 2004: 2

² National Treatment Agency, 2002.

³ EMCDDA, 2002.

⁴ UNODC, 2003: 11.2.

⁵ UNODC, 1999: 73.

Finally, the World Health Organisation suggests that treatment of drug problems is:

‘the process that begins when psychoactive substance abusers come into contact with a health providers or any other community service, and may continue through a succession of specific interventions until the highest attainable level of health and well being is reached.’⁶

Thus, treatment in its most general sense then can therefore include a range of features, such as:

1. Detoxification: longer duration through pharmacotherapy and shorter term through short stay in patient methods.
2. Stabilisation
3. Relapse prevention
4. Aftercare

It can also be one or more of the following:

1. Medical: focused on biological/physiological addiction
2. Therapeutic: targeted at psychological processes
3. Other supports: focused on social/environmental/personal issues (including risk or contributory factors to problem drug use)

As the report progresses, this understanding of treatment will form the backdrop of the findings and references to treatment.

2.4 REGIONAL DRUGS TASK FORCES

One of the key recommendations of NDS was the establishment of RDTFs throughout the country. The Strategy proposed that RDTFs be set up in each of the then 10 Health Board areas (prior to the establishment of the HSE) to develop appropriate policies to deal with problem drug use in the regions. At the present point in time, despite some delay in their set up, RDTFs are fully established in each of the areas. The RDTFs, in a manner similar to the LDTFs and the localisation of social partnership, bring together all the State agencies involved in the field of problem drug use as well as the voluntary and community sectors.

Each RDTF is responsible for putting in place a strategy to tackle drug misuse specifically in their respective region. Their establishment represents an innovative approach to tackling the drug problem on a regional basis.

The role of the RDTFs is to research, develop and implement a co-ordinated response to problem drug 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; Local Authority;
- VEC;
- Health Board;
- Department of Education and Science;
- Department of Community, Rural and Gaeltacht Affairs;

⁶ WHO, 1998: 3.

- 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 and Local Drugs Task Forces

The NDS outlines a range of objectives and work areas for the RDTFs. These include considering the development and implementation of community-based initiatives to raise awareness of drug use and drug problems. The goal of such initiatives it is suggested in the NDS is to develop best practice models which send a clear and consistent message and which are capable of being mainstreamed. In the communities where problem drug use is most prevalent and where there is considerable knowledge about all aspects of the drugs issue, the NDS suggests for instance that schools could tap into and use this knowledge as a beneficial aspect of their programmes. By contrast, the NDS points out that there are communities that have a very limited knowledge of the nature or manifestations of drug misuse. In these areas, it is suggested that the school, the health promotion officer, GPs, pharmacists, the Gardaí and others might take the lead in creating a greater awareness of drug misuse.

In addition, the NDS suggests that another goal of the RDTFs is to enable user groups in Task Force areas to play a role in the generation of a greater societal understanding of problem drug users and drug misuse issues. For those problem drug users who may not be in contact with mainstream agencies, these groups can help foster awareness about support services available e.g. treatment options, needle exchanges etc.

It is also pointed out in the NDS that RDTFs include local publicity about the nature of their work and the type of measures/initiatives being put in place by them as a key element of the work of Task Forces and as part of their action plans and that this information should be disseminated as widely as possible.

2.5 NORTH EAST REGIONAL DRUGS TASK FORCE

In the context of the above, the regional drugs strategy of the NE-RDTF was published in December 2004 and covers the years 2005 to 2008 inclusive. The regional strategy suggests that the greatest challenge it faces is to examine the extent to which current services provisions meets identified needs under the pillars of the NDS and to thereafter highlight gaps in service provision within the North East.

The core objectives of the NE-RDTF are as follows:

‘to significantly reduce the harm caused to individuals, families and society in the North East, by the misuse of drugs through a concerted focus on supply reduction, prevention/education, treatment and research’⁷

Under the strategy there are strategic objectives set down for each of the pillars of the then NDS, that is prior to the introduction of the fifth pillar (rehabilitation) following the review of the NDS. They are under therefore supply reduction, prevention/education, treatment and research.

It is worth looking in particular at the strategic objectives under the treatment pillar. They are:

1. 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.
2. To minimise the harm to those who continue to engage in drug taking activities that put them at risk.

This indicates that treatment within the work of the NE-RDTF focuses on responding to drug problems with a goal of drug abstinence as well as a focus on harm reduction for those who may continue to use drugs.

⁷ NE-RDTF Strategic Plan, 2004

In the consultation process that was undertaken in the development of the NE-RDTF's strategic plan, the main areas that were identified under the treatment theme were as follows:

- Detoxification units, residential and community based (still needed)
- Multi-disciplinary treatment teams in towns throughout the region (still needed)
- Increase in range of methods for detoxification (still needed)
- Improved links between addiction services and pooling of resources (still needed)
- Capacity building and training for staff involved in treatment (still needed)
- Programme that respond to 'relapse' (still needed)
- Aftercare services (still needed)
- Needle exchange (still needed)
- Family support (still needed)
- Day programmes including drop in centres (still needed)
- Alcohol (still needed)
- Treatment responses for under 18s (still needed)
- To factor in social exclusion issues and processes (still needed)
- Community basing of initiatives (still needed)
- Complimentary therapies (still needed)

From this the strategic plan, a number of smaller gaps were identified under the treatment pillar. For the most part, these responded to the issues coming out of the consultation and also factored in the analysis of current services in the region and the prevalence of drug use. Thus key actions to respond to gaps cited in the strategy included:

- Exploring the development of residential and day care treatment and detoxification
- Following a model of care based on the individualised continuum of care including progression
- Development of a protocol for the treatment of under 18s
- Development of quality standards for treatment/rehabilitation
- Production of a services directory
- Increases in the G.P. and pharmacist involvement in treatment
- Inclusion of family therapy and community integration in treatment
- Development of drop in, respite and residential services to reduce relapse
- Development of needle exchange services
- Peer support groups
- Development of social integration activities and paths.

As part of the strategic plan, a degree of prioritisation of the strategic gaps took place. This included nearly all of the above strategic gaps underlining their importance. In the present research, it is interesting to assess the extent to which the findings related to those indicated in the initial strategic plan.

In the North East region to date, the Task Force has initiated and supported a number of projects.

Current projects are detailed below:

Turas (Aftercare Programme and Counselling Service): Provision of a 20 week therapeutic day care programme for recovering drug users including alcohol if under 18 years. Clients are referred by the HSE addiction services and other agencies. Provision of counselling for referred clients.

Cavan Drugs Awareness (CDA): This project aims to increase the availability of parental/adult drug education through a parent to parent programme, other presentations and family support. Provision of treatment using NADA model for clients affected by substance misuse. CDA also provide young people with access to information on substance misuse issues, both in the centre and on an outreach basis.

Crossroads Project: Provision of drop in information and referral centre for current drug users including a social care and drug education/harm reduction programme. Provision of a structured day programme for drug users in recovery, including counselling and social/vocational activities.

South Meath Alcohol and Substance Misuse Response: This project looks to expand the provision of family support groups and increase the availability and uptake of parental/adult drugs education programmes it also provides access to drug related information at community level. It provides counselling for post primary pupils affected by substance misuse through the 'open space' project.

Foroige Drugs Education Initiative (Cavan/Monaghan): This project provides drug education, information and outreach services as well as drug education programmes to young people at risk. It also concentrates on peer education and supports child and family development.

North East Family Support Network: The network supports the growth and development of family support groups in the region. It publishes information leaflets and guides for groups and provides training for group facilitators and members. The longer term goal of the network is to provide respite accommodation and counselling.

Service Users Forum: The forum brings together drug users in treatment to discuss issues about services and provide peer support.

Other core project grants are to the following:

- Tabor House
- Positive Youth Education (Dundalk)
- Traveller Outreach Project
- New Start Programme (Drogheda)

The NE-RDTF has also provided small grants to the following groupings:

- Cavan Drug Awareness (volunteer professional development)
- Cavan RAPID Youth Project (peer education programme)
- Drogheda Community Drug & Alcohol Forum (awareness events)
- ISPC Monaghan (youth awareness event)
- Louth Traveller Development Group (volunteer professional development)
- Drogheda Community Forum (volunteer professional development)
- Aisling Group (training programme)
- Ait na nDaoine (intervention counselling)
- Crossroads (volunteer training)
- Drogheda Community Forum (education events)
- ISPC Monaghan (youth awareness event)
- Meath Youth Fed (driving ambition project)
- Drogheda Women's Refuge (volunteer training)
- SW Cavan CDP (drug awareness events)
- Meath Opportunities for Training (hardship fund)
- Crossroads (CPI training)
- NE Family Support Network (AGM)
- NE Family Support Network (facilitator training)
- NE Family Support Network (intervention counselling)
- Dundalk Simon Community (research)

2.6 DRUG USE PREVALENCE & TRENDS

In order to create a context for the work of the TF, the national trends in drug prevalence are briefly outlined in this section. This will allow for a comparative aspect of the local research to be drawn out.

A wide range of sources are used below to give a sense of the nature and extent of drug misuse nationally.

2.6.1 National Prevalence Survey

To date, two national surveys of prevalence rates for illegal drugs have been commissioned by the National Advisory Committee on Drugs (NACD) and Drug Alcohol Information and Research Unit (DAIRU) of Northern Ireland.

The most recent survey was carried out in 2006 and 2007 and first overall results were published in January 2008. This survey is of particular value as it provides a comparative aspect to the prevalence survey from 2003 to 2007, which is examined in the chapter four of this report as it relates to the North East region. The most recent survey has just released the first of a number of bulletins and this does not go into detail in respect of any one drug or geographic location in Ireland.

Nevertheless, the 2006/7 survey reveals that the use of illegal drugs among adults aged 15 to 64 increased from 19% to 24% of the population. In 2007 therefore, the survey shows that one in four persons reported using illicit drugs over the course of their life. This represents an increase on the 2003 figure of 26%. The proportions reporting 'lifetime' use of cannabis increase from 17% to 22%, of 'magic' mushrooms from 4% to 6% and of cocaine from 3% to 5%. The increase in the proportions reporting use of cocaine from 2003 to 2007 is therefore in the order of 67%.

Table 2.1: NACD National Prevalence Survey 2006/7, Ireland.

Area	Lifetime 15-64 yrs	Lifetime 15-34 yrs	Lifetime 35-64 yrs	Recent 15-64 yrs	Recent 15-34 yrs	Recent 35-64 yrs	Current 15-64 yrs	Current 15-34 yrs	Current 35-64 yrs
Ireland	24%	34%	17.6%	7.2%	12.1%	2.9%	3%	4.8%	1.2%

Source: NACD/DAIRU, 2008: 11, 14.

Overall, the national trends suggest that men and young age groups (<34 yrs) reported higher lifetime prevalence rates than other groupings.

Again the value of this study is that it will allow for an analysis of trends and changes in drug use over time which is seen below in respect of the 2006/7 survey. In terms of specific drugs, the following are some of the relevant findings coming out of the bulletins released under the 2002/3 prevalence survey (opiate use is dealt with separately below)

Cocaine (including Crack)
<ul style="list-style-type: none"> 5.3% of 15-64 year olds reported taking cocaine at some point in their lives. Only 1.7% used these drugs in the last year and 0.5% in the last month.
<ul style="list-style-type: none"> On average, life time prevalence rates were higher for young people: 8.2% in the 15-34 age group. Prevalence rates for the 35-64 age group were 2.7%. In any one age group, the highest rate of lifetime prevalence is seen in the 25-34 age group at 9.3%.

Source: NACD/DAIRU, 2005.

Cannabis
<ul style="list-style-type: none"> 21.9% of 15-64 year olds reported taking cannabis at some point in their lives. 6.3% used cannabis in the last year and the corresponding figure for use in the last month was 2.6%.
<ul style="list-style-type: none"> Lifetime prevalence is highest among those in the 15-34 age group (28.6%). 16.1% of those ages 35 to 64 reported use.
<ul style="list-style-type: none"> Life time prevalence rates were higher for young people: 31.9% in the 25 to 34 age group. Prevalence rates for the in the preceding age group, 15-24 was 24.8% and 24.4% in the 35-44 age group.

Source: NACD/DAIRU, 2005.

2.6.2 Opiate Use

Research carried out on the number of opiate users (NACD, 2003) in 2001 reveals there were 14,452 opiate users nationally and of those, 12,446 were located in Dublin. This survey reveals national prevalence rates of 5.6 per thousand in the 15-64 age group and 16 per thousand in this age group in Dublin. Comparing 1996 and 2001, this survey shows the prevalence in 2001 at 18.2 which compared to 21 per thousand in 1996. The opiate prevalence data presented suggests that there is an aging of the opiate using population nationally and thus points to reduced take up of opiate use in the younger age groups. What is clear is that this data is somewhat out of date. Another national research looking at repeating this research is currently underway and will give a more up to date picture for 2007/8.

The above NACD/DAIRU surveys from 2006/7 reveal that 0.4% of the population aged 15 to 64 reported heroin use. Use of other opiates⁸ during the 'lifetime' was 6.2%. In terms of heroin, there was no difference in the prevalence of lifetime use among young adults (15-34) and older adults (35-64) at 0.4%. Interestingly, the highest rate of prevalence is seen in the 25-34 (0.6%) and the 35-44 age groups (0.7%).

2.6.3 Cocaine

As is evident from the most recent NACD/DAIRU survey and its comparison to the previous one completed in 2003, cocaine has emerged as a significant problem drug, supported firstly through anecdotal evidence and secondly this and other pieces of research. It is at forefront of drug problems and the related media focus in more recent times. However, the 'emergence' of Cocaine as a problem is perhaps better understood less in terms of an 'emerging' issue and rather as contemporary issue in its own right. Traditionally, the response to drug problems in the state and as envisaged in the NDS and Methadone Treatment Protocol has focused on opiates. The arrival of Cocaine has resulted in a number of pilot projects being established, ones for instance in Tallaght and Dublin 12, and the recent joint publication by the NDST and NACD of a report entitled 'An Overview of Cocaine Use in Ireland: II'. This follows the initial publication of a Cocaine report by the NACD in 2003, which could be seen as representing the emergence phase of Cocaine problems in Ireland. It is worth giving an overview of some of key aspects of the most recent report in order to inform the current strategic plan.

As a starting point, the report reveals that problems related to polydrug use have increased in Ireland since 2003. Cocaine is one of substances used here along with cannabis, ecstasy and alcohol.

In the Irish context, the most recent NACD/DAIRU Drug Prevalence Survey (2006/7), noted above, reveals that 5% of the population - aged 15 to 64 - used cocaine at least once in their life. This represents a 67% increase on the measure recorded in 2002/3.

The cocaine report points to analysis by the state laboratory of samples referred to it by the coroner's court and criminal cases that show the detection of cocaine in samples has increased by six times from 2000 to 2006.

From Garda statistics, the report is able to show that cocaine is second only to cannabis (resin) as the most trafficked drug. Cocaine is the drug increasing in this case while there has been a relative stabilisation in the supply of heroin and cannabis and moreover, a fall off in the supply of amphetamine and ecstasy. Cocaine accounts for almost 13% of all offences under the relevant drugs legislation, revealing a six fold increase over the last ten years. The incidence of seizures and offences is markedly higher in eastern seaboard or greater Dublin region than elsewhere. This clearly shows the incidence of supply, and by implication, demand for cocaine. This gives a sense that cocaine has come to replace the use of amphetamine and ecstasy in parts of the population.

The numbers seeking treatment have increased from 1998 to 2003 by close to 300% and there has been an increase of 364% over that period where cocaine is reported as an additional problem in poly drug use. For those that reported cocaine as their main problem drug in 2003, 92% could be described as poly drug users. There is also a five-fold increase in the numbers of new cases presenting for treatment whose primary problem drug is cocaine. For users of cocaine presenting for treatment, 39% reported using the drug between two and six days per week. Almost one in four (23%) reported using cocaine on a daily basis.

Cocaine according to published statistics is usually snorted (70%), this is followed by intravenous use (17%) and smoking (11%). Evidence presented in official urinalysis suggests that - in recent years - many individuals who are on the methadone maintenance programme test positive for cocaine, which although expected underlines the prevalence of the drug in communities.

The ROSIE study (overseen by the NACD) shows that 92% of the opiate users recruited to the longitudinal study reported having used cocaine. In addition, 58% of respondents stated that they have used 'crack' cocaine. Overall, nearly half (48%) of study participants reported the use of cocaine in the recent past. It should be noted that the one year follow up

⁸ Opium, temgesic, diconal, napps, MSTs, pethidine, DF118, buprenorphine, morphine, codeine, kapake, diffs, dikes, peach, fentanyl and oxycodone.

of clients in the ROSIE study suggested less use and an increase of abstinence. This, while very positive, does not take away from the evidence about the prevalence of cocaine in general and thus for those who are outside the (opiate) treatment loop.

The report also shows how cocaine use is evident in various sectors of the wider population such as Travellers, prisoners, new communities and among the homeless. Cocaine is a problematic drug in more ways than one, its treatment is difficult and it has widespread health implications for its users including behavioural problems. One aspect of the report illustrates the widespread view that 'drug treatment' is mainly 'opiate treatment', which is a particular challenge. There is the sense also from this report that due to the absence of a pharmacological treatment for cocaine, lower numbers present for treatment than the numbers who may otherwise might etc.

2.6.4 Treatment Statistics

The Central Treatment List deals with a register of individuals receiving methadone. The following table provides a breakdown of cases treated by HSE region and other centres of treatment for July 2007.

Table 2.2: Central Treatment List, July 2007

HSE Region/Other Area	Total Patients
Clinic	
Dublin Mid Leinster	2427
Dublin North East	1891
West	109
South	46
Prisons	577
Drug Treatment Centre Board (Trinity Court)	525
GP	
Dublin Mid Leinster	1859
Dublin North East	1019
West	96
South	70
Total	8619

Source: Drug Treatment Centre Board

The CTL numbers receiving methadone has increased over the years. The number in the eastern region is higher although parts of the country have seen very large proportionate increases. This may be due to better reporting, more treatment places as well as an increase in prevalence. It is worth noting, that at any given time there are a number of people on the waiting lists for services for treatment.

The lion's share of clients presented for treatment is aged between 20 and 34 years of age and after that, is in the 35-44 age range. There appears to be very few opiate users under the age of 20. This may be because of a time lag in seeking treatment or more optimistically, a reduction in the number of new users in this age cohort relative to older age ranges.

Overall there has been an increase in the number of opiate cases seeking treatment.

2.6.5 Garda Síochána National Statistics

The figures in the table and chart below detail the offences detected by the Garda according to their annualised statistics over the last 15 years nationally. These show the overall number of offences for each drug type and also the proportion of all offences that a drug type makes up.

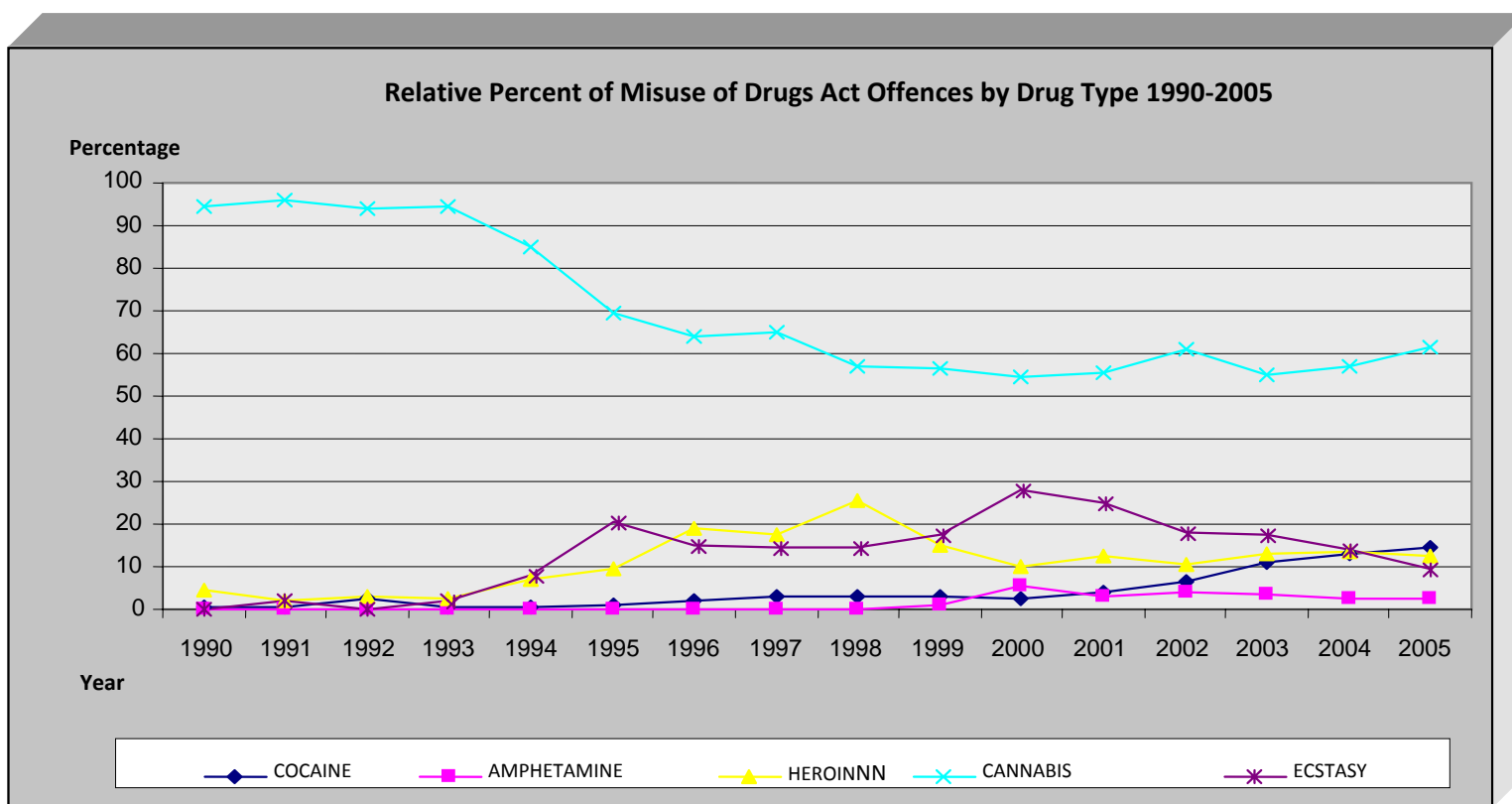
The percentages of each drug type per year are telling. They suggest for instance that although cannabis resin is by far the main drug type under which offences occur (some 5,133 in 2005), this has decreased in proportion from over 90% in 1990 to close to 60% in 2005. The figures suggest the number of offences for all drugs, except ecstasy, is on the increase and this is a trend that needs to be monitored.

Table 2.3: Number and Annualised Percentage of Misuse of Drugs Act Offences by Drug Type

YEAR	COCAINE	%	AMPHETAMINE	%	HEROIN	%	CANABIS RESIN	%	ECSTASY	%
1990	11	0.74	n/a	0	71	4.75	1413	94.52	-	0
1991	7	0.29	n/a	0	45	1.84	2354	96.04	45	1.84
1992	77	2.74	n/a	0	91	3.23	2643	93.92	3	0.11
1993	15	0.49	n/a	0	81	2.65	2895	94.70	66	2.16
1994	15	0.45	n/a	0	230	6.86	2848	84.91	261	7.78
1995	30	0.94	n/a	0	296	9.31	2209	69.47	645	20.28
1996	42	1.86	n/a	0	432	19.16	1441	63.90	340	15.08
1997	97	3.00	n/a	0	564	17.45	2096	64.85	475	14.70
1998	88	2.87	n/a	0	789	25.74	1749	57.06	439	14.32
1999	169	2.90	464	1.22	887	15.23	3281	56.34	1023	17.57
2000	180	2.43	391	5.27	730	9.84	4031	54.34	2086	28.12
2001	297	4.06	207	2.83	908	12.42	4053	55.44	1845	25.24
2002	478	6.36	300	3.99	796	10.59	4595	61.10	1351	17.97
2003	607	11.10	180	3.29	719	13.15	3003	54.91	960	17.55
2004	764	13.06	160	2.74	778	13.30	3335	57.01	813	13.90
2005	1224	14.68	191	2.29	1022	12.26	5113	61.33	787	9.44

Source: Garda Síochána Statistics

The data in the table below shows a substantial increase in offences for cocaine over the period. This increase has been stark in the last number of years; the number of cocaine offences has quadrupled over the last four to five years. This is evidenced by the fact that for the first time since data was captured cocaine offences were higher than heroin offences in 2005. Indeed, heroin offences have stabilised up to 2005 when it saw an increase, it still is a lesser drug in offence terms than cocaine. Ecstasy, although still not insignificant, is declining in numerical and proportionate terms. Overall, the move toward cocaine is perhaps the most important aspect of the data and suggests a shift in drug use patterns, notwithstanding cannabis, away from heroin and ecstasy and toward cocaine.



Source: Garda Síochána Statistics

It should be noted that due to rearrangements in the compilation of crime statistics, with responsibility now given to the Central Statistics Office for analysis of the Garda Pulse data system, it is not possible to update the information provided above for 2006 at this point in time.

2.7 SUMMARY & CONCLUSION

This chapter has provided an overview of the wider context in which the North East Regional Drug Task Force is situated. The main areas covered in the chapter were the policy context of the drugs task forces provided by the NDS, secondly the background and function of the RDTFs themselves.

The chapter explored some definitions of treatment in order to give a general grounding to the research. This showed that treatment can have a range of features and approaches. It can focus on detoxification, stabilisation, relapse prevention and/or aftercare. In addition, treatment can take on medical, therapeutic or social support modality in its approach, all of which can focus on single issues or the wider life issues of a problem drug user.

The chapter then turned to look at the role of the RDTFs. This showed how the RDTFs are charged with co-ordinating an integrated response to drug issues in their respective regions. They seek to identify and address gaps in services and supports for drug and drug related problems as well address wider policy and operational issues that are in keeping with their regional remit.

This in turn led to an examination of the strategy of the NE-RDTF. A key part under the treatment pillar of the Task Force's work is to investigate and develop residential and day care treatment, continuum of care approaches which focus on the client focused care plans and progression, quality standards in treatment, and increasing the involvement of GPs and pharmacies in the provision of treatment in the region. They also look to develop harm reduction approaches and integrate services and supports for individuals and families.

Wider drug prevalence trends were broached in this chapter so as to set the context for the findings of the research. This looked in particular at the most recent national prevalence survey. This survey, from research in 2007, shows that life time drug prevalence has increased from 19% of the population in 2003 to 24% in 2007. In particular, this research shows that the rate of increase in the life time use of cocaine since 2003 is 67%. With this in mind, the chapter focused on cocaine in a dedicated section. This section underlined the stark increase in indicators of cocaine use nationally. It also emphasises that cocaine use is part of a wider poly drug use culture which includes ecstasy, cannabis and alcohol.

With the findings of this chapter as context for the research in mind, the next chapter adds another dimension to the context of the Task Force and the later findings and in examines the socio-economic profile of the North East region.

3. PROFILE OF THE NORTH EAST

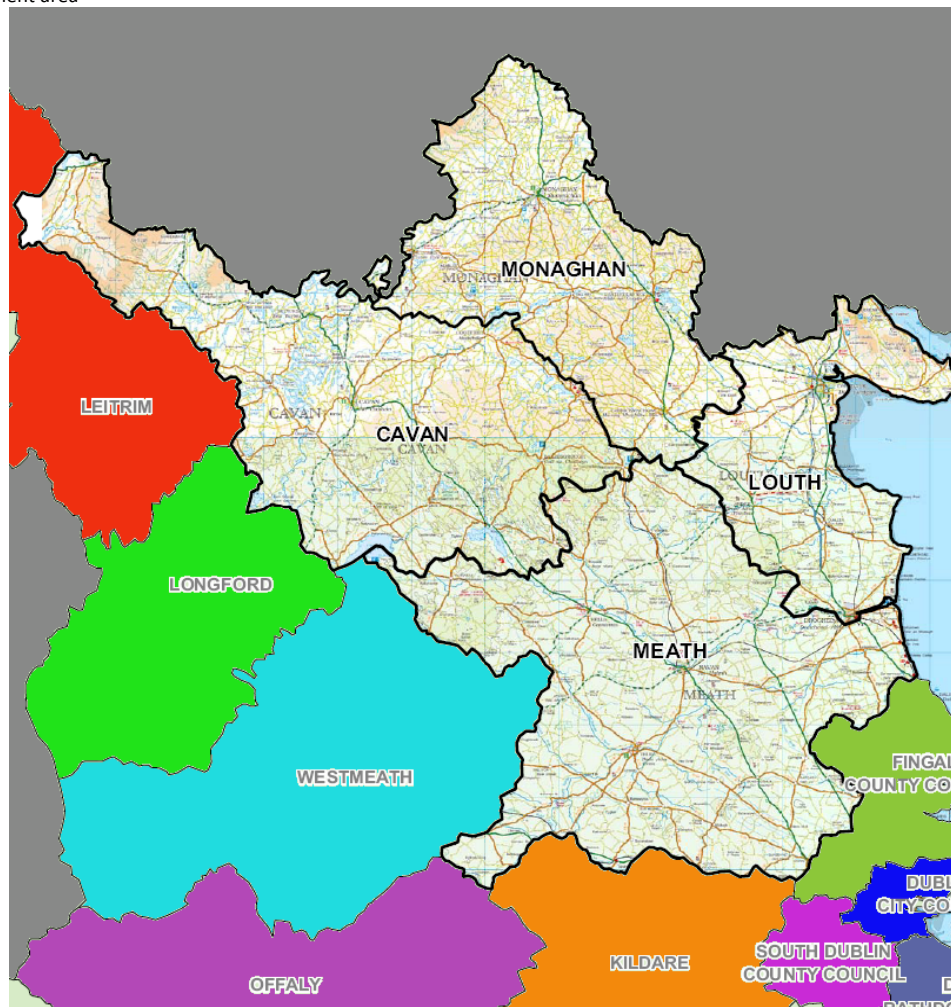
3.1 INTRODUCTION

This chapter profiles the main social, economic and demographic characteristics of the NE-RDTF catchment area. The chapter provides an overview of the area and its population, household structure, education, social class, employment and deprivation. The final part of the chapter summarises the main issues brought out in the chapter and provides some conclusions. The overall aim of this chapter is to provide a socio-economic picture of the context in which the task forces operates.

3.2 AREA MAKEUP & POPULATION

The first thing that should be said about the catchment area of the Task Force is that it was originally moulded on the operational area of the former North Eastern Health Board. In other words, it covers the counties of Cavan, Louth, Meath and Monaghan. The Task Force offices are located in Navan, Co. Meath. The catchment of the Task Force now comprises a substantial part of the Dublin/North East region of the Health Services Executive. As noted, the catchment of NE-RDTF comprises the four counties and due to the size of the catchment, the level of analysis undertaken here will not in general explore data at the electoral division level⁹. Figure 3.1 below depicts the outline of the four counties comprising the North East region.

Figure 3.1: NE-RDTF catchment area



⁹ Electoral division analysis is often more appropriate when looking at smaller contained areas such as Area Partnership catchments, towns etc

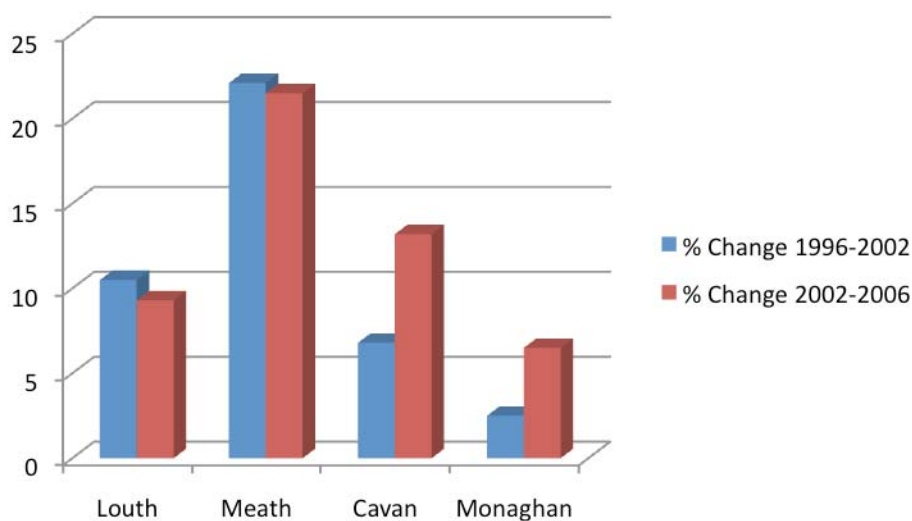
Table 3.1: Population of the North East, 1996-2006

Area	Pop. 1996	Pop. 2002	Pop. 2006	% Change 1996-2002	% Change 2002-2006
Louth	92166	101821	111267	10.5	9.3
Meath	109732	134005	162831	22.1	21.5
Cavan	52944	56546	64003	6.8	13.2
Monaghan	51313	52593	55997	2.5	6.5
NE-RDTF	306,155	344,695	394,098	12.7	14.3
Ireland	3,626,087	3,917,203	4,239,848	8	8.2

Source: Census 1996, 2002 & 2006

Table 3.1 shows that the current population of the North East region is just under 400,000 at 394,098. The most populous county in the region is Meath (162,831) followed by Louth (111,627). Overall, the region witnessed a 14.3% increase in its population since 2002 and the population has grown by 29% over the decade 1996 to 2006. All of the counties revealed population increases although both Meath and Cavan had the largest proportionate increases in their respective populations.

Figure 3.2: % of population change 1996-2002-2006



Source: Census 1996, 2002 & 2006

Most of those affected by problem drug use (traditionally with opiate related problems) are in the age range of 15-34 or further to 44 years, traditionally see low educational attainment and limited or no employment experience. In this context, it is worth noting the areas in the region which most match this profile and where special attention should be paid in terms of the location of services and responses for the future.

As table 3.2 reveals the proportion of the overall population aged between 15 and 44 is 46.3% which is slightly less for the state as a whole. At county level, Meath exhibits a higher proportion of its population in this age range than the regional average or the corresponding national figure. At the other end of the scale, the proportion of the population falling into this range is lowest in Cavan at 42.9%.

Table 3.2: NE-RDTF Population aged 15-44, 2006

Area	Pop. 2006 aged 15-44 (%)
Louth	46.4
Meath	48.7
Cavan	42.9
Monaghan	46.7
NE-RDTF	46.3
Ireland	46.7

Source: Census 2006

In addition it is worth noting the makeup of the population of the Task Force catchment in the light of the overall population trends that are aged 14 years and below. This group are those for whom drug problems are unlikely to have manifested themselves given their age and this again has implications for the direction of preventative activities particular in terms of prevention education.

As the table below shows, the overall proportion of those aged 0 to 14 in the North East in 2006 was 22.6%. This measure is above that for Ireland. Moreover, the proportion of the population aged under 14 in each of the four counties comprising the North East region is 14 years above the national measure. The highest such proportion is seen in Meath (23.4%) and the lowest in County Monaghan at 21.2%.

Table 3.3: Task Force Population aged 0-14, 1996-2006

Area	Pop. 2006 aged 0-14 (%)
Louth	22.1
Meath	23.4
Cavan	22.3
Monaghan	21.2
NE-RDTF	22.6
Ireland	20.4

Source: Census 2006

In recent times, there has been a significant increase in the numbers coming to live in Ireland from Europe and elsewhere. For this reason, it is worthwhile getting a sense from Census 2006 of the numbers of people resident in the North East from new communities. The table below illustrates the makeup of the population of the task force catchment by nationality.

Table 3.4: Nationality

Area	Irish	UK	Polish	Lithuanian	Other EU 25	Rest of World	Not stated
Louth	90.8%	1.8%	0.6%	0.9%	1.4%	3.5%	1.0%
Meath	90.2%	2.4%	1.2%	1.4%	1.3%	2.7%	0.8%
Cavan	90.0%	3.0%	1.3%	1.2%	1.4%	2.1%	1.1%
Monaghan	89.8%	2.0%	1.2%	3.0%	1.5%	1.6%	0.9%
NE-RDTF	90.2%	2.3%	1.0%	1.6%	1.4%	2.7%	0.8%
Ireland	88.8%	2.7%	1.5%	0.6%	1.8%	3.4%	1.2%

Source: Census 2006

This table shows that the North East has a lower proportion of people from new communities than is seen in the state. The biggest proportion of those from new communities comes from the category 'rest of world' (2.7%). The next biggest group according to this categorisation, 2.3%, come from the UK.

At the county level, there are some clear differences in the general trend. The most obvious ones being in Monaghan; where 3% of the population are from Lithuania which is well above the proportions seen in other counties. In addition, 3.5% of Louth's population are from the 'rest of the world' which maybe reflects the growth in housing development in the County's urban areas. For the most part, those counties such as Louth with the largest relative proportion of private rented accommodation are those with the greatest proportion of new communities as a proportion of their overall population. This is of note in devising ways to engage with new communities around drug use issues and problems.

3.3 HOUSEHOLD STRUCTURE

Household structure refers to the broad make up of households in the region. It refers to the ownership of households, type of households, and persons (adults and children) in each household as noted in Census 2006. The total number of households in the North East according to Census 2006 was 133,225.

Table 3.5: Lone parent households

Area	Total Households 2006	Lone Parent Households (% of all households) 2006
Louth	38703	12.9
Meath	53938	9.6
Cavan	21929	10
Monaghan	18655	11.1
NE-RDTF	133225	10.9
Ireland	1469521	10.4

Source: Census 2006

The table above shows the areas with higher concentration of lone parent households who are increased risk, according to research, from poverty and thus problems related to drug use within the household. In 2006, the number of lone parent households in the region was 14,465. Counties with proportions of lone parent households above the catchment average of 10.9% - which is marginally higher than the national figure - in 2006 were Louth (12.9%) and Monaghan (11.1%).

Looking at housing tenure also allows for an insight into possible areas of disadvantage in which there is a high correlation with problematic drug use. This connection comes from an assortment of research which illustrates a relationship between housing tenure and social disadvantage. However, there is also a new phenomenon in many areas of the country relating to private rented accommodation that may not have been as prevalent in the 2002 and earlier Census's.

The table below details the number of owner occupied households with and without a mortgage, those rented or being purchased from a local authority and, finally, those rented in the private rental sector.

Table 3.6: Household tenure¹⁰

Area	Owner Occupied (%) ¹¹	Being purchased or rented from Local Authority (%) ¹²	Rented in Private Rented Sector (%) ¹³
Louth	75.6	9.4	10.5
Meath	82.5	5.3	8
Cavan	78.3	6.9	7
Monaghan	79.	6.5	7.3
NE-RDTF	79.4	6.5	9.3
Ireland	75.2	11.6	15.3

Source: Census 2006

The data on housing tenure reveals that the area is not homogenous in housing tenure terms as is natural given the size and population of the region. 79.4% of households are owner occupied. This score is higher than the corresponding national figure. Within the counties, there is some difference in the proportion of households that are owner occupied. For instance, 82.5% of households in Meath are owner occupied which is greater than the regional and the national averages. While most of the counties reveal proportions of owner occupations above the national measure, Louth is only just above the national measure and is less than the regional task force average.

Across the region, 6.5% of households are rented from the local (authority although some of these are in the process of being purchased). This is a lower proportion than seen nationally (11.8%). The proportion of social housing at county level is lowest in Meath (5.3%) and highest in Louth (9.4%). This measures at the higher end and the lower end in respect of Meath and Louth respectively is a feature of the profile of the region and probably reflects the urbanisation of Louth and growth of Dundalk and Drogheda and the allied clustering of social housing.

¹⁰ These figures do not tally to 100% as data not included here area households which are recorded as occupied free of rent in the Census of where the type of occupancy is not stated.

¹¹ Includes those who are owner occupiers with, and with no, mortgage.

¹² Includes those currently renting, and in the process of purchasing a property, from a local authority.

¹³ Includes those renting furnished and unfurnished dwellings.

In terms of private rented households, the overall proportion for the region is 9.3%. This is marginally less than the corresponding proportion seen at national level (15.3%). Louth is the county with highest comparative proportion of households rented privately (10.5%). The Louth measure is statistically some way above the measures seen in the other three counties. The remaining counties exhibit a proportion of private rented households lower than the national proportion.

3.4 EDUCATION

Education attainment data demonstrates variations in levels of education in different parts of the area and lends some evidence to targeting of resource in areas in which educational attainment, thus skill levels, employment and ultimately income prospects, is low with a corresponding higher risk of concentrations of problem drug use. By the same token, it also allows for differences in approach, if needed, in areas where educational profiles are more advanced etc. Generally, it contributes to the overall understanding of the profile of an area.

Table 3.7: Level of cessation of education (excluding not stated)

Area	No formal or primary education (%)	Junior secondary ed. Only (%)	3 rd level education (%)
Louth	21.7	24.3	14.8
Meath	15.6	22	17.4
Cavan	25.6	23.4	12.3
Monaghan	25.1	23.4	12.3
NE-RDTF	20.3	27	13.3
Ireland	14.9	21	28.4

Source: Census 2006

The table above outlines the data available from the most recent Census for the region of when education ceased. Overall, it is important to note that those who had no formal education are those who are statistically most likely to experience difficulties in terms of employment and income and thus risk of social exclusion. This is also the case for those who left school before completion of the junior cycle of second level (15 or under also known as an 'early school leaver'). In contrast, those who have attained completion of second level or higher are less likely to be at risk of disadvantage. This is most obviously the case comparatively for those who have completed third level education.

The RDTF catchment area shows a higher rate for those with no formal/primary only or junior second level education only than that seen nationally. The proportion attaining third level education is also significantly less than the national average. This suggests that the region is disadvantaged in educational attainment terms.

There are some interesting differences in the region at the county level. Monaghan and Cavan reveal rates of those whose education was completed at primary level, or who have no formal education, at around one quarter of all of those whose education ceased in the respective counties. This is significantly above the national average and probably reflects the rural setting of the areas. It follows that each of these counties also shows the lowest rates for completion of third level education. On the other hand however, Meath demonstrates rates of education attainment generally in keeping with the national average in respect of no formal/primary education and junior secondary education. However, the proportion of those whose education was completed at third level is significantly lower than the national measure for 2006.

3.5 SOCIAL CLASS

Although social class is a contested issue in terms of where one starts and finishes and its relationship to income and poverty, it does provide a valuable overview of what categories of social class are most evident in the make up the region and therefore relationships with affluence and disadvantage. For the purposes of description, the seven social classes enumerated as part of the Census 2006 are collapsed in the table below into:

1. *Professional workers, managerial and technical occupations,*
2. *Non-manual and skilled manual workers and,*
3. *Semi/unskilled workers and others gainfully occupied such as those who have not been in paid employment or in who live in households where no one is in paid employment.*

Table 3.8: Social class

Area	Prof. workers, Man. & Technical (Soc. Class 1 & 2)	Non manual & skill manual (Soc. Class 3 & 4)	Semi/unskilled (Soc. Class 5,6 & 7)
Louth	29.1%	36.2%	39.7%
Meath	35.3%	37.3%	27.4%
Cavan	28.3%	38.6%	33.1%
Monaghan	28.8%	38.7%	32.5%
NE-RDTF	31.4%	37.3%	31.3%
Ireland	32.9%	34.1%	31.6%

Source: Census 2006

The proportion of the catchment falling into the professional, managerial and technical occupations, social class 1 and 2, for the region is 31.4%. This is marginally less than the corresponding proportion seen in Ireland (32.9%). In keeping with the earlier trend, the highest proportion seen at county level for these classes is in Meath (35.3%), which is greater than the corresponding proportion nationwide.

The number of residents in the region assigned in Census 2006 to social class three and four (non skilled and skilled manual workers) was 37.8%. This is greater to the corresponding proportions seen nationally (37.3%). Each of the counties reveals proportions above the national average.

31.3% of the catchment's population are characterised as belonging to social class five, six and seven. As outlined, these classes encompass semi-skilled, unskilled and those without occupation. Those occupying these social classes are at particular risk to un/underemployment at times of economic tightening and decreases in the buoyancy of certain sectors of the economy, in particular the construction industry, as in the case in recent times indicating that the area may be particularly vulnerable to economic downturn. The score for Meath is below the regional measures as well as that national proportion. The measure for Louth however is well above both the regional and national averages for these occupational classes.

3.6 EMPLOYMENT

Unlike recent decades, until recently at least, unemployment is less indicative of disadvantage and consequential social and economic problems for individuals and communities. This is due to the relatively low overall unemployment levels seen in recent years. Nevertheless, taken together with the other measures noted in this chapter, it still goes some way toward giving a more comprehensive picture of the socio-economic and demographic profile. The table below illustrates the unemployment rate for the region.

Table 3.9: Unemployment Rate.

Area	Unemployment Rate
Louth	11
Meath	6.5
Cavan	8.2
Monaghan	7.7
NE-RDTF	8.2
Ireland	9.3

Source: Census 2006

The unemployment rate in the NE-RDTF region was therefore 8.2% in 2006. This is less than the corresponding measure for Ireland (9.3%). In fact, each of Counties Meath, Monaghan and Cavan exhibit unemployment rates in 2006 below the national average. This contrasts with Louth for which the unemployment rate according to Census 2006 was 11%, nearly twice that of Meath and generally out of line with its neighbouring counties.

3.7 DEPRIVATION

Many of the measures in some way contribute to the calculation of deprivation. Deprivation has been measured in the last number of Censuses using the Haase index. This brings a number of measures together to develop one measurement of deprivation in given areas whether that is respect to just one electoral division or collection of divisions

making up the catchment of in this case the Task Force across the four counties. This approach uses similar measures over the course of a range of Censuses so that deprivation can be measured over time and between areas. The underlying dimensions of deprivation such as social class, demographic and labour market deprivation are factored into the score. In the table below, outlined is the relative position of each county in respect of each other at Census 2002 and Census 2006. The scale for describing relative deprivation range over the following:

- *Very Affluent*
- *Affluent*
- *Marginally Above Average*
- *Marginally Below Average*
- *Disadvantaged*
- *Very Disadvantaged*
- *Extremely Disadvantaged*

Table 3.10: Relative Deprivation Rate.

Area	2002	2006
Louth	Marginally Below Average (-2.7)	Marginally Below Average (-2.9)
Meath	Marginally Above Average (7.4)	Marginally Above Average (6.5)
Cavan	Marginally Below Average (-3.2)	Marginally Below Average (-3.2)
Monaghan	Marginally Below Average (-3.0)	Marginally Below Average (-3.0)

Source: Haase and Pratschke 2005: 36 & <http://www.ie/live/dep/1002.html>

This shows that Meath is generally more affluent in relative terms than the other three counties in the region. There is little difference between each of Louth, Cavan and Monaghan all of which score as marginally below average in terms of their indicators of deprivation. It is worth noting also, perhaps as early indicator of more recent economic problems, that there was a retrenchment in affluence and a marginal increase in deprivation in Meath and Louth respectively between 2002 and 2006.

3.8 SUMMARY & CONCLUSION

This chapter presented a brief profile of the North East region based on a range of measures taken from the most recent census of population. The profile did not look in detail at the internal demographics of each of the counties but rather focused on the regional aspect and trends evident therein.

The profile shows that the region has undergone significant population growth, nearly 15%, since 2002 and just under 30% since 1996. In particular, Meath and Cavan exhibited strong growth in population. This will have implications for service provision and will increase trends across most areas including those related to drug use.

The North East has experienced lower growth in the population of new communities than in the country as a whole. However, the largest proportions of members of new communities are seen in Louth which also has the highest proportion housing which is rented privately.

Across the region, the proportion of households headed by a lone parent is higher than that seen nationally. The largest proportions of lone parent households are in Louth. The proportion of lone parents in this county largely account for the regional figure being larger than the national average and suggest that this area may be the location of more intensive support activities for families who may experience problems related to drug use.

The proportion of owner occupied houses is higher in Meath than the corresponding regional and national figures, although the regional proportion is larger than that seen nationwide. The greatest concentration of social housing in the region in proportionate terms is seen in Louth. The associate of Louth with some relative indicators of disadvantage and Meath with relative indicators of affluence is a feature of the profile of the region as conveyed by the 2006 census. This is seen in respect of social/occupational class makeup and also in terms of educational attainment. The region has lower comparative educational attainment levels than is seen nationally. Cavan and Monaghan in particular exhibit high relative proportions of their population whose education has ceased completing their education at primary level or having had no formal education. The region exhibits significantly lower levels of the population attaining third level education than is the case nationally.

Unemployment in 2006 in the region was lower than seen nationally, however and in keeping with trend seen elsewhere the unemployment rate in Louth was markedly higher than the regional as well as national measure. This underlines the particularly vulnerable status of Louth in comparison with the other counties in the catchment of the Task Force.

Meath is generally more affluent in relative terms than the other three counties in the region. There is little difference between each of Louth, Cavan and Monaghan all of which score as marginally below average in terms of their overall county average indicators of deprivation.

4. PREVALENCE OF DRUG PROBLEMS IN CAVAN, LOUTH, MEATH & MONAGHAN

4.1 INTRODUCTION

This chapter provides a summary of the main information and data available on the prevalence of drug use and drug related problems in the North East Region. The understanding of prevalence here is based on that used by the National Advisory Committee on Drugs¹⁴: *'prevalence is a measure of how many drug users there are in a community...and how they are distributed across the population e.g. by age, gender, geographical location of type of drug use'*.

The aim here is provide an overview of the number of drug users and the type of drugs being used in the catchment. Nevertheless, it is important to outline the limitations of this approach at the outset. As is officially accepted, drug users are often a hidden grouping due to the nature of drug use and the consequences of addiction. In addition, there is no 'census of drug use' and drug users. As such, the ideal way to gather information on drug use in a given geographic area is to conduct a full-scale primary research survey. In view of the problems logistically and in resource terms to carry out such surveys – such research in respect of drug use is mainly carried out at national level - estimations of prevalence of drugs use in a given area are derived from a number of sources which while individually are partial, collectively provide a best available overview of drug prevalence in the catchment.

The two mains sources of data on drug prevalence can be referred to as routine and non-routine data sources¹⁵

1. Routine Data Sources:
Garda and Justice Data, Drug Treatment Data, Drug-related Mortality Data and Data on Drug-related illness
2. Non-routine data sources:
Relevant local surveys, Focus group/area surveys and local network or qualitative information

For the most part, the research has looked to access, using this model, what data is available in respect of the region. However, that data is outlined below comes with something of a 'health warning'. The reasons are as follows:

- What data is available is not specific to the area of the RDTF. It does not always refer to the Counties that comprise the catchment of the RDTF. It may relate to the operational areas of another entity such as the HSE, Garda district, local authority or be county wide etc.
- The data is not necessarily comparative, that is that sources of data may use different definitions and understandings of one drug, addiction, a problem drug user or may have been taken at different times etc.
- The data is somewhat out of date. It refers to periods in the past and cannot be seen as a contemporary reflection of prevalence and in the main relates to people who have presented for treatment which is a logically only a portion of all problem users in a given area such as the North East region.

Overall, what data can be presented is the best statistical picture available on the prevalence of drug use in the catchment. It is for this reason (and for the purposes of getting a qualitative or human and organisational view) that we complement the data presented here with findings from in-depth consultations with stakeholders and drug users. This data should be viewed in cognisance also of the national level prevalence data presented in chapter two above.

This chapter is structured as follows: Drug Treatment; Drug Related Garda Statistics; and the final section of the chapter provides a summary of the findings and draws a number of conclusions.

4.2 DRUG TREATMENT

The National Drug Treatment Reporting System (NDTRS) is referred to as an 'epidemiological database' on treated problem drug use in the state. In the NDTRS, treatment is defined as *'any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for tier drug problems'* (HRB 2005:5). The NDTRS is

¹⁴ Cox, 2003:1

¹⁵ *ibid*, 2003:4

comprised of information collected for each person who receives treatment for problem drug use at treatment centres in a given year. This information is compiled at national level by the DMRD of the HRB¹⁶.

In the NDTRS, drug treatment data is viewed as an indirect indicator of drug misuse as well as a direct indicator of demand for treatment services. This data is used at national and European levels to provide information on the characteristics of clients entering treatment, and on patterns of drug misuse, such as types of drug used and consumption behaviours. In 1996 NDTRS data was used to identify a number of local areas with problematic heroin use¹⁷. These areas were later designated as Local Drugs Task Force Areas and are continuing to provide strategic responses to drug misuse in their communities¹⁸. O'Brien et al (2002) point out - and depicted in the chart below - that prior to 1998, people who lived in the North Eastern Health Board region (hereafter the North East) who received treatment for problem drug use did so outside the region and mainly in and around Dublin. The figures were 46 for 1996 and 47 in 1997. As of 1998, the numbers presenting for drug treatment in the North East was 71 and this rose to 250 by 2000. A further 14 residents of the North East received treatment outside the region, putting the total for the region in 2000 at 264.

Table 4.1: Number of all treatment contacts by treatment area and area of residence of clients, 1996-2000

Year	Total treated in NEHB	NEHB residents treated in NEHB	NEHB residents treated elsewhere	Others treated in NEHB	Total NEHB residents treated
1996	Na	Na	49	Na	49
1997	Na	Na	94	Na	94
1998	71	69	59	2	128
1999	123	123	32	0	155
2000	250	243	22**	7	265**

Source: O'Brien et al, 2002: 2.

Furthermore, at the time the vast majority of North East residents were receiving treatment for the first time, indicated the relative newness of the drug problem in the region. At that time, cannabis accounted for 61% of those seeking treatment as their main drug of treatment, ecstasy for 17% and opiates for 14%. However, the number of each group increased over the course of 1998 to 2000 as part of the overall increase in number seeking treatment, as indicated in the table below.

Table 4.2: Main drug of misuse of all treatment contacts treated in the NEHB, 1996-2000

Main Drug of Misuse	1996		1997		1998		1999		2000	
	N	(%)	N	(%)	N	(%)	N	(%)	N	(%)
Opiates	Na		Na		21	(30)	29	(24)	36	(14)
Cocaine	Na		Na		0	(0)	1	(1)	5	(2)
Ecstasy	Na		Na		7	(10)	15	(12)	42	(17)
Amphetamines	Na		Na		8	(11)	7	(6)	2	(1)
Benzodiazepines	Na		Na		1	(1)	3	(2)	2	(1)
Volatile Inhalants	Na		Na		3	(4)	9	(7)	9	(4)
Cannabis	Na		Na		31	(44)	58	(47)	153	(61)
Other substances	Na		Na		0	(0)	1	(1)	1	(0)
Total	Na		Na		71		123		250	

Source: O'Brien et al, 2002: 4.

Kelly et al go on to state that the data shows that new clients were more likely to be using cannabis and ecstasy and less likely to be using an opiate. However, the data also shows that opiate use (heroin) was increasing also.

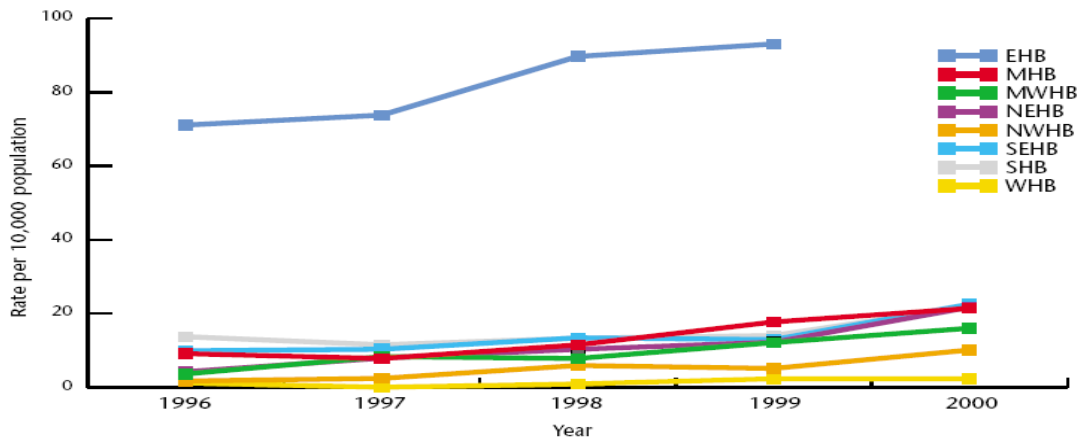
In comparative terms, the North East region generally exhibited a similar rate of treated drug misuse in comparison to the other health board areas with obvious exception of the eastern (Dublin) area which showed much higher rates.

¹⁶ For the purpose of the NDTRS, Clients who attend needle-exchange services are not included in this reporting system. Up to 2004, clients who reported alcohol as their main problem drug were not included in this reporting system. Treatment options include one or more of the following: medication (detoxification, methadone reduction and substitution programmes), addiction counselling, group therapy, psychotherapy and/or life skills training. Treatment is provided in both residential and non-residential settings. In Ireland, data returns to the NDTRS for clients attending treatment services during 2003 were provided by 187 treatment services: 170 non-residential and 17 residential

¹⁷ Ministerial Task Force, 1996

¹⁸ The monitoring role of the NDTRS is recognised by the Government in its document *Building on Experience: National Drugs Strategy 2001-2008*. Data collection for the NDTRS is one of the actions identified and agreed by Government for implementation by the former health boards: 'All treatment providers should co-operate in returning information on problem drug use to the DMRD of the HRB (Department of Tourism, Sport and Recreation 2001: 118)

Figure 4.1: Figures in all treatment contact rates for 15-39 year olds by former Health Board region of residence, 1996-2000.



* Trends for 1996-1999 only in the EHB due to incomplete returns for 2000

** Population figures for each health board are based on the Census for Population 1996, Central Statistics Office

Source: O'Brien et al, 2002: 7.

Table 4.3: Number (%) of cases treated and by treatment status in the North Region, 1998-2002

Case type	1998	1999	2000	2001	2002
All Cases	73 (9.3%)	131 (13.5%)	254 (16.3%)	367 (18.6%)	310 (13.7%)
Previously Treated Cases	2 (0.7%)	41 (10.6%)	76 (13.5%)	137 (18.4%)	123 (13.9%)
New Cases	1 (0.2%)	82 (14.7%)	172 (18.1%)	208 (18.2%)	167 (13.1%)

Source: Long et al, 2004: 6.

According to the NDTRS, there were 44,767 cases treated in Ireland between 1998 and 2003. The most recent report, 2004, summarising drug prevalence data from 1998 to 2002, has a number of findings about the North Eastern Region.

Table 4.4: Main problem drug reported by new cases in the North Region, 1998-2002

Main problem drug	1998
Cannabis	385(61.1%)
Opiates	116 (18.4%)
Ecstasy	80 (12.7%)
Inhalants	18 (2.9%)
Benzodiazepines	9 (1.4%)
Cocaine	8 (1.3%)
Amphetamines	7 (1.1%)
Other substances	7 (1.1%)

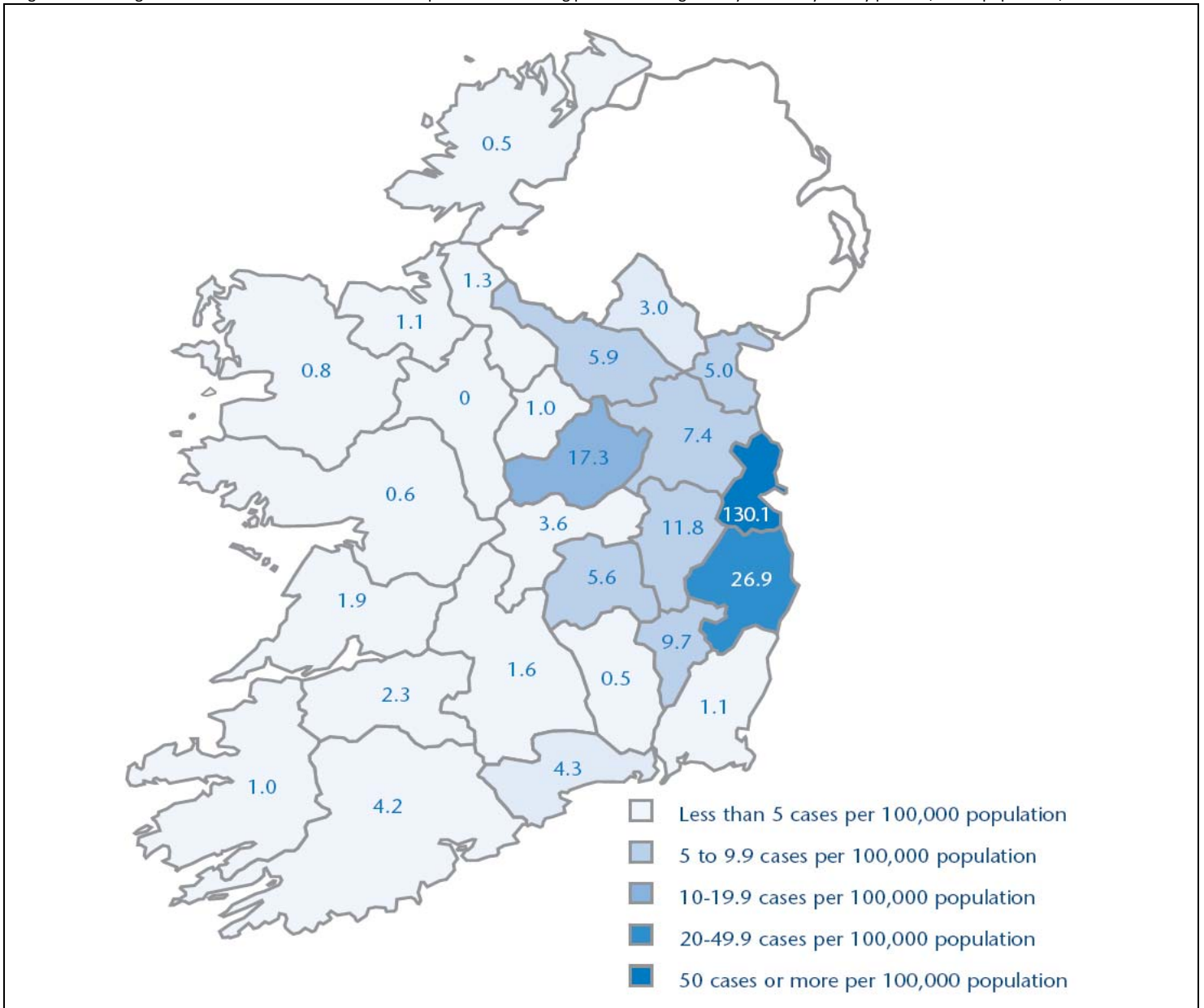
Source: Long et al, 2004: 10.

Each of the figures below related to incidence rates per 100,000 of population aged 15 to 64 in the North East region:

- There were 1,135 treated for problems drug use between 1998 and 2002.
- There was an increase of 76% of persons treated for drug misuse between 1998 and 2002 with a peak in 2001.
- Cannabis, opiates and ecstasy accounted for 92.2% of drug problems, from 1998 to 2002. Cocaine accounted for just over 1% of cases as the main problem drug.
- The incidence of treated problem drug use in the North East region across 1998 to 2002 was 50.1 cases per 100,000.

Turning to look at opiate use, the following figure outlines the annual rate of new opiate cases between 1996 and 2000.

Figure 4.2: Average annual incidence of treatment for an opiate as a main drug problem among 15-64 year olds by county per 100,000 of population, 1996-2000



Source: Long et al, 2004: 8.

This illustrates that the Dublin and Wicklow areas are by far the locations of the highest rates of prevalence in respect of new cases of opiate users between 1996 and 2000. However, It shows that the North East region are in the second tier of incidence rates, and that the North East region is located in a wider area of higher incidence centred on Dublin and the surrounding counties. The respective incidence rates for the four counties that make up the region for new opiate cases from 1996 to 2000 were as follows:

- Meath: 7.4 per 100,000
- Cavan: 5.9 per 100,000
- Louth: 5.0 per 100,000
- Monaghan: 3.0 per 100,000

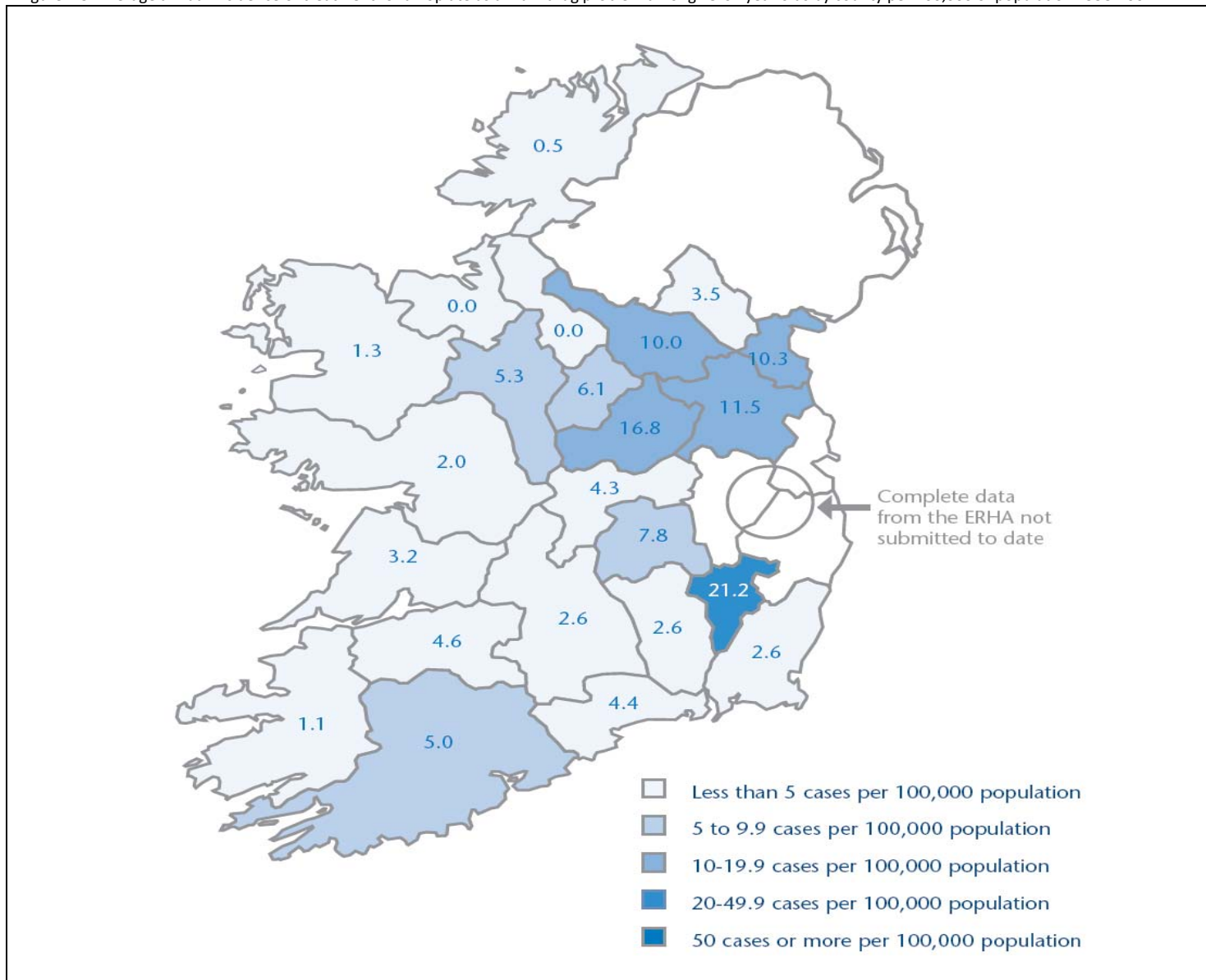
The following map undertakes the same analysis, new cases of opiate users presenting for treatment, but this time the period is the five year duration from 1998 to 2002. The Dublin data was not available at the time of this HRB publication however the maps indicates an increase in new opiate cases throughout the country with significant increase in the

North East. Indeed in this publication, Long et al highlight the North East in their commentary suggesting ‘that large increases were noted in Meath, Louth and Cavan’ (2004: 9).

The respective incidence rates for the four counties that make up the region for new opiate cases from 1998 to 2002 were as follows:

- Meath: 11.5 up from 7.4 per 100,000
- Cavan: 10.0 up from 5.9 per 100,000
- Louth: 10.3 up from 5.0 per 100,000
- Monaghan: 3.5 up from 3.0 per 100,000

Figure 4.3: Average annual incidence of treatment for an opiate as a main drug problem among 15-64 year olds by county per 100,000 of population 1998-2002

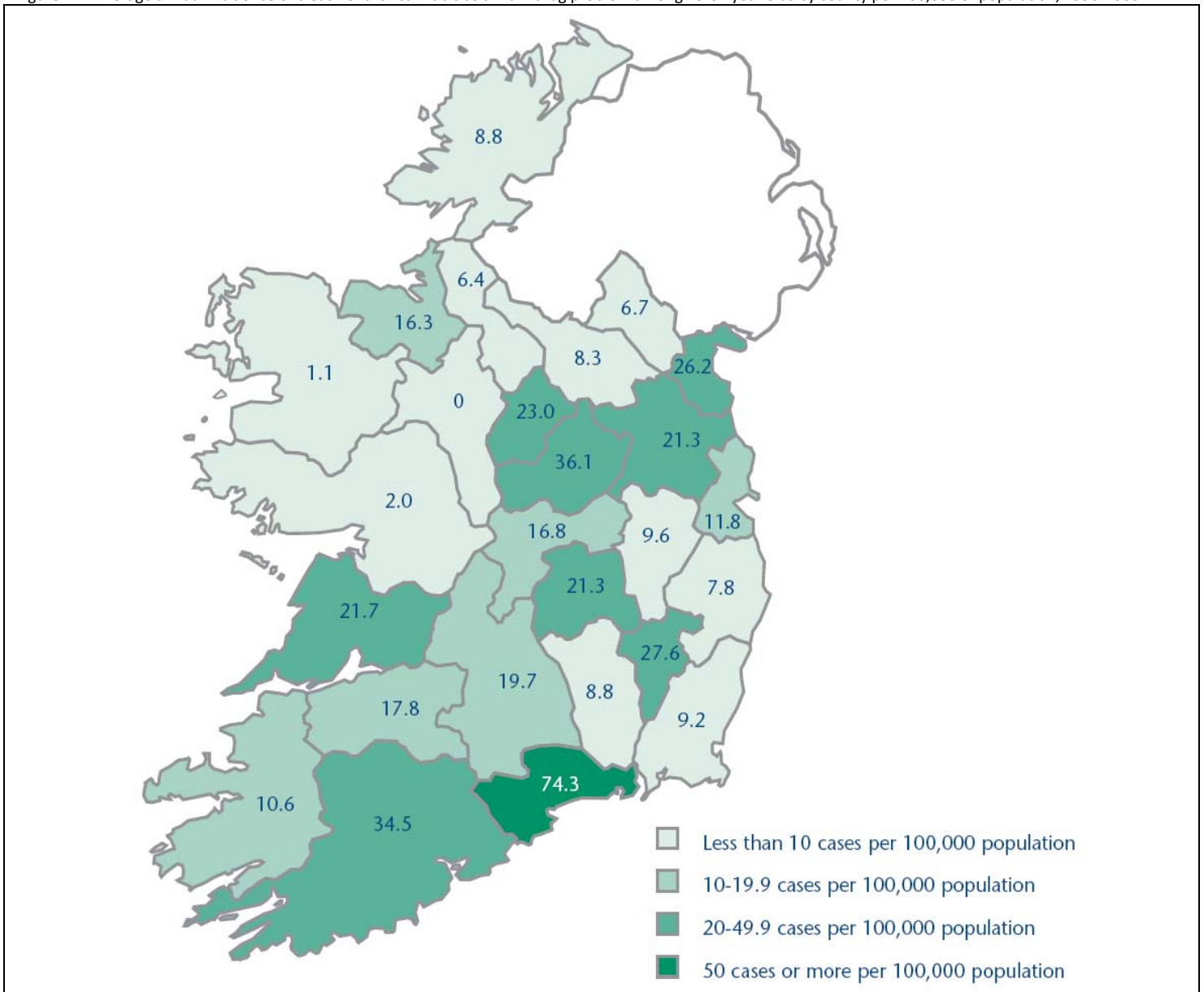


Source: Long et al, 2004: 9.

This shows in particular that Louth had a higher rate in 2002 than Cavan, which had a higher rate than the former county over the 1996-2000 periods. Apart from Monaghan, there was an increase in the number of cases from 1996-2000 to the 1998-2002 periods of over 50% in the case of each county.

The NDTRS undertook the same type of analysis as seen above with opiates for cannabis also.

Figure 4.4: Average annual incidence of treatment for cannabis as a main drug problem among 15-64 year olds by county per 100,000 of population, 1996-2000



Source: Kelleher et al, 2004: 8.

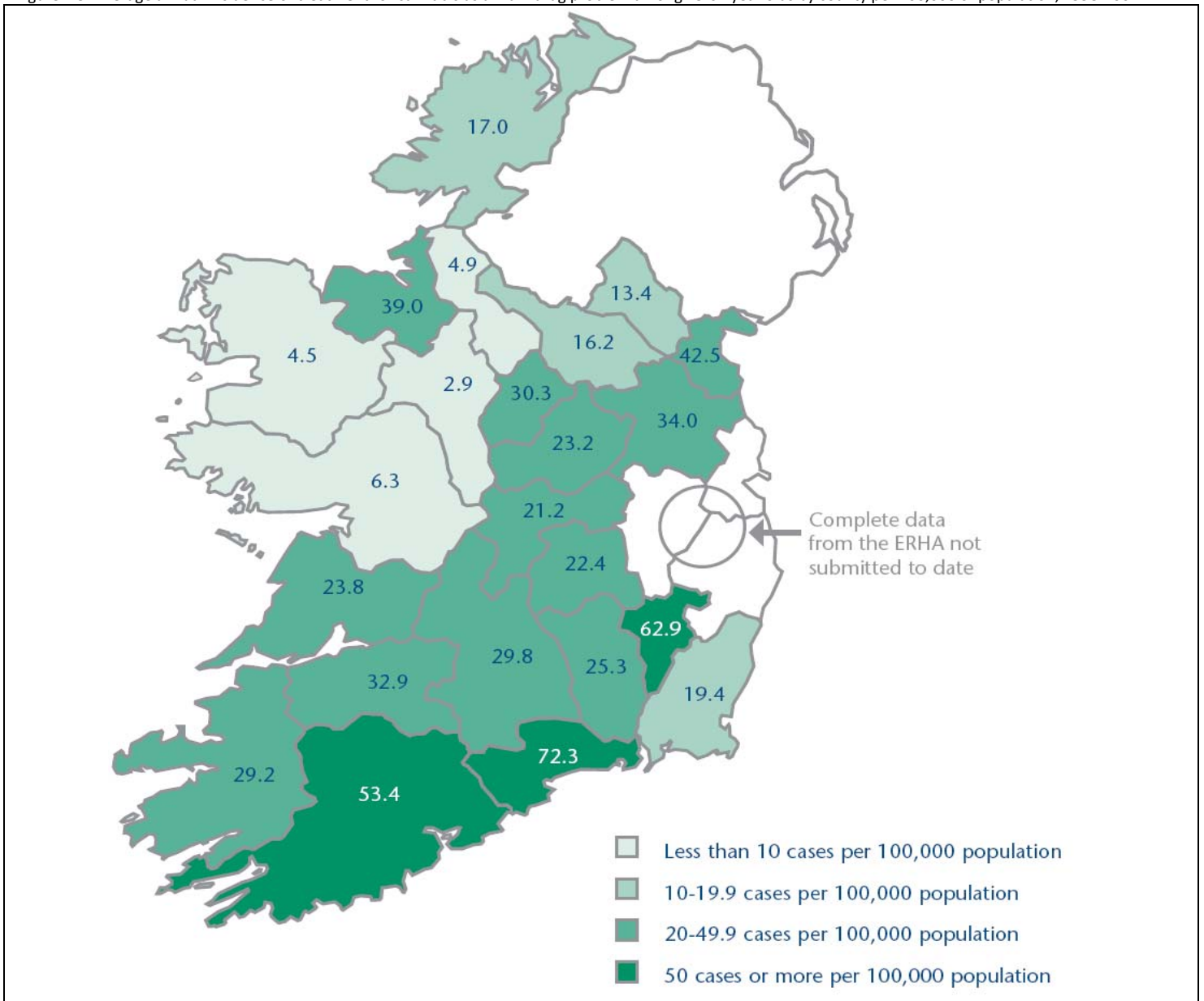
This map shows high rates in the North East region in particular. It is noticeable that the rates in the North East are higher than the Dublin area and demonstrate a particular concentration in Meath and Louth. The annual rates per 100,000 of population for those presenting for treatment with cannabis as the main drug for all four counties in 1996 to 2000 was:

- Meath: 21.3
- Cavan: 8.3
- Louth: 26.2
- Monaghan: 6.7

In similarity to the opiate data, this analysis was also applied through returns under the NDTRS for the five years from 1998 to 2002 inclusive. This, figure 4.6, demonstrates a dramatic increase in the incidence of treatment for cannabis throughout the country but particularly in a sweep from the North East to the South East. The annual rates for all four counties in the North East region from 1998 to 2002 were:

- Meath: 34 up from 21.3 per 100,000
- Cavan: 16.2 up from 6.3 per 100,000
- Louth: 42.5 up from 26.2 per 100,000
- Monaghan: 13.4 up from 6.7 per 100,000

Figure 4.5: Average annual incidence of treatment for cannabis as a main drug problem among 15-64 year olds by county per 100,000 of population, 1998-2002



Source: Kelleher et al, 2004: 9.

The increases in the incidence of those seeking treatment for cannabis is dramatic from the two periods, ranging from a 60% increase in Meath to a 157% increase in Cavan.

As noted in the introduction to this chapter, much of the published NDTRS data refers to periods in the past although the publication themselves are in the last three to four years. It is worth therefore looking some more up to date information with reference to the North East region which is not yet published but which takes into consideration more recent data returns to the NDTRS.

There is information available from the Drug Treatment Centre Board which outlines the total number of patients receiving treatment. However this is only broken down to HSE regions, which are larger than the former health board regions. Therefore, the HSE Dublin/North East region reveals 3010 patients receiving treatment in July 2007. However, this includes all of North Dublin City and County and therefore the extent to which this can tell us about drug treatment statistics in the North East is extremely limited given the extent of drug problems in Dublin and the obvious population disparities.

However, albeit from an earlier date, the following table shows the number of patients in Cavan, Louth, Meath and

Monaghan as at the start of 2007.

Table 4.5: Numbers of substance misusers in the North East Region referred and assessed by services

Type	Number
Referred/Assessed by services	184
Under 18s referred/assessed by services	12
Total	196

Source: HSE returns to NDTRS, 4th quarter 2006.

In the North East, there are currently seven GPs involved in the methadone maintenance protocol and 52 pharmacies dispensing methadone under the scheme. The table below outlines the total numbers of problem drug users in receipt of treatment assigned to GPs and pharmacies in the region. It should be noted that these number refer to opiate users and do not therefore include others who may have come into contact with services with problems related to another substance such as cocaine, cannabis etc.

Table 4.6: Numbers of substance misusers treated by GPs or assigned to pharmacies, July 2007.

GP/Pharmacy	Number
GPs	144
Pharmacies	154

Source: Central Drug Treatment List, Drug Treatment Centre Board.

Earlier Drug Treatment Centre Board data – the central drug treatment list – does relate numbers in treatment to the various health board areas such as the North East. This data is however out of date, autumn 2006, but reveals that there were 140 patients in the North East availing of methadone maintenance through GPs.

In general, the NDTRS data is partial in that it only refers to those in treatment and is some way out of date. This is an ongoing difficulty for Drugs Task Forces around gathering information about prevalence as opposed to treatment of drug problems in their respective areas. Most prevalence work is carried out at a national level through the aegis of the NACD. The lowest area that this information is collated by is the former health board areas and while this is of no use to for instance LDTFs it is worthwhile for the RDTFs.

4.3 DRUG PREVALENCE

In chapter two, a summary was provided of the data coming out of the recently published first bulletin of the NACD/DAIRU all Ireland population survey of drug prevalence covering the years 2006 and 2007. The results from this survey are only recently available for both national and regional areas. This survey complements that undertaken in 2002/3. This section presents the findings of both surveys and some comparative analysis.

Table 4.7: Lifetime prevalence of drug use, North East region, 2002/2003

GP/Pharmacy	% All adults 15-64	% Young adults 15-34	% Older adults 35-64
Any illegal drugs	18.9	32.5	7.2
Cannabis	17.8	30.4	6.7
Heroin	0.4	0.9	-
Other opiates	1.3	0.8	1.7
Cocaine (incl. Crack)	1.2	2.1	0.5
Amphetamines	2.6	4.0	1.4
Ecstasy	2.6	4.9	0.5
LSD	2.0	3.5	0.7
Magic Mushrooms	3.2	5.6	1.1
Solvents	3.3	7.1	-
Poppers	5.0	9.2	1.4
Sedatives, tranquilisers & anti-depressants	5.7	2.7	8.2
Alcohol	87.6	90.6	85.1
Tobacco	57.6	58.9	56.4

Source: NACD/DAIRU, 2006

The survey covers prevalence of drug use on the basis of life time, last year and last month use. Table 4.6 above reveals that just under one in five people in the North East region have used illicit drugs at some point in their lives. However, the numbers are analysed in terms of age group are more telling: while 7.2% of those aged 35-64 indicated they had used drugs over their life time, the proportion of 15-34 year olds was 32.5%. In other words, nearly one third of those under 34 (and above 15) have used illicit drugs in their life time.

Looking at individual drugs, there are also a number of interesting findings. For instance, similar proportions as those who have report using any illicit drug are shown to have used cannabis. The proportion in the 15-34 age range reporting cannabis use is again over 30%. However, 6.7% of over 35s indicated use of cannabis indicating the wider use of illicit drug across age ranges. It seems reasonable to assume that the lion's share of those who reported use of illegal drugs are made up of cannabis users.

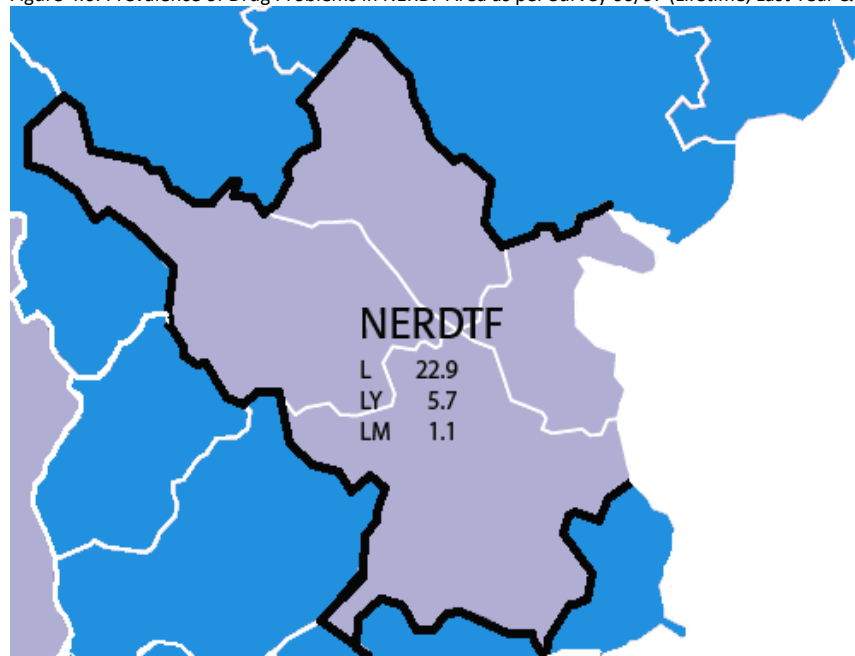
The proportions reporting use of heroin is relatively low in real terms at less than half of 1%. However nearly all of this group, accounting for nearly 1% of the age group, are aged 15-34. This indicates the profile of heroin users in 2003 and is in keeping with other research.

Cocaine use in 2003 is likely to be less than what it might be in the 2007 national survey. 1.2% overall indicate cocaine use in their life time in 2003, while the corresponding measure for those aged 15-34 using cocaine is 2.1%.

Other key findings include that most users of ecstasy and amphetamines are aged 15-34 (4.9% and 4% respectively). This trend is seen also in respect of the life use of magic mushrooms, and solvents. Sedatives, tranquilisers and anti depressants have an overall prevalence as per the 2003 survey of 5.7% in the North East. However, 8.2% of 35-64 year olds reported use of these drugs as opposed to 2.7% of 15-34 year olds. This is probably related to the prescribing of such medicines to older adults for anxiety, depression and other related illnesses.

Finally, nearly nine out of ten people (87.6%) reported consumption of alcohol over the course of their lifetime. The proportions are only marginally larger among younger adults than those over 35 and suggest that alcohol is by far the most used of all drugs. This has key implications for drug treatment especially in view of apparent increases in polydrug usage.

Figure 4.6: Prevalence of Drug Problems in NERDF Area as per Survey 06/07 (Lifetime, Last Year & Last Month)



Source: NACD/DAIRU (b), 2008

The second wave of the national prevalence survey is of particular interest in that it allows for a contrast be made overtime in respect of trends in prevalence. The figure above shows that in 2006/7 of those aged between 15 and 64, lifetime (L) use of illicit drugs in the North East was 22.9%, last year (LY) use was 5.7% and last month (LM) use was 1.1%.

Table 4.8: Lifetime prevalence of drug use, North East region, 2006/2007

GP/Pharmacy	% All adults 15-64	% Young adults 15-34	% Older adults 35-64
Any illegal drugs	22.9	29.2	17.6
Cannabis	19.5	25	14.9
Heroin	0.5	0.8	0.3
Other opiates ¹⁹	4.2	4.8	3.6
Cocaine (incl. Crack)	5.6	10.2	1.8
Amphetamines	3.3	5.8	1.4
Ecstasy	5.4	9.8	1.7
LSD	3.0	3.9	2.2
Magic Mushrooms	5.0	8.3	2.2
Solvents	2.0	3.5	0.8
Poppers	3.1	5.1	1.4
Sedatives, tranquillisers & anti-depressants	9.2	3.4	17.4
Alcohol	90.6	89.1	91.9
Tobacco	58.1	57.3	58.7

Source: NACD/DAIRU (b), 2008

The measures for 2006/7 therefore show that the proportion of the population in the 16 to 64 age band who indicated use of any illegal drug over the course of their lifetimes increased from 18.9% in 2002/3 to 22.9% more recently. Surprisingly, the proportions in the 15-34 age range decreased marginally from 32.5% to 29.2% from 2002/3 to 2006/7. However, the overall measure may be partially accounted for by the increase in the proportions citing 'lifetime' use in the 35-64 age cohort, 7.2% to 17.6%. Overall, this suggests the drug use is generally seen in those aged under 40 (due to the time between prevalence surveys) in the north east region.

This trend is borne out by the proportions citing use of cannabis over the two survey periods. The overall measure rose for lifetime cannabis use from 17.8% in 2002/3 to 19.5% in 2006/7. Again, the most recent survey reveals a marginal decrease in the proportion using cannabis in the 15-34 age range and a significant increase in the 35-64 age range (6.7% to 14.9%). A similar trend is also seen in the case of heroin.

However, it is in respect of use of cocaine that the most obvious change has occurred. Lifetime use of cocaine in the 02/03 survey was 1.2%. This rose in 2006/7 to 5.6%, nearly a fivefold increase, which is significant by any standard. In particular, the proportion citing use of this drug rises to 10.2% in the 15-34 age group.

The 2006/7 survey shows that the region differs in drug prevalence trends when compared with established local drugs task force areas in Dublin. The survey shows that there have been increases in the use, since 2002/3, of amphetamines, ecstasy, LSD and magic mushrooms in the north east, all of which are decreasing in the LDTF areas.

In terms of over the counter or prescription drugs, there were increases in the general population and also in the age ranges for the use of these drugs in the prevalence survey. Finally the most recent survey reveals marginal increases in the proportions of the relevant population citing use of tobacco and alcohol.

Thus prevalence measures demonstrate that regardless of treatment data, the vast majority of drug users do not present for treatment given the disparities between the proportion presenting for treatment and reporting drug use. Since national measures for 2007 suggest that drug use and in particular cocaine use has dramatically increased since 2003, there is therefore likely to be an increasing demand for treatment of drug problems over the coming years. However, the treatment demand is likely to be one that goes beyond opiates to problems related to a range of drugs and particularly cocaine. This is the earlier indication of the challenge that is facing drug treatment services and what is becoming evident in other areas²⁰.

4.4 GARDA STATISTICS

In the earlier chapters, national Garda statistics were reported in respect of drug offences. In this chapter, statistics relating to North East region are assessed. However, this is a complicated analysis on the basis that the counties that

¹⁹ A different definition and hence measurement of opiates is used in the 2007 survey than used previously in the 2003 national prevalence survey.

²⁰ For instance, see Watters (2008a, & 2008b) which shows the clear emergence of cocaine problems in areas of Dublin as part of the strategic planning process for LDTFs.

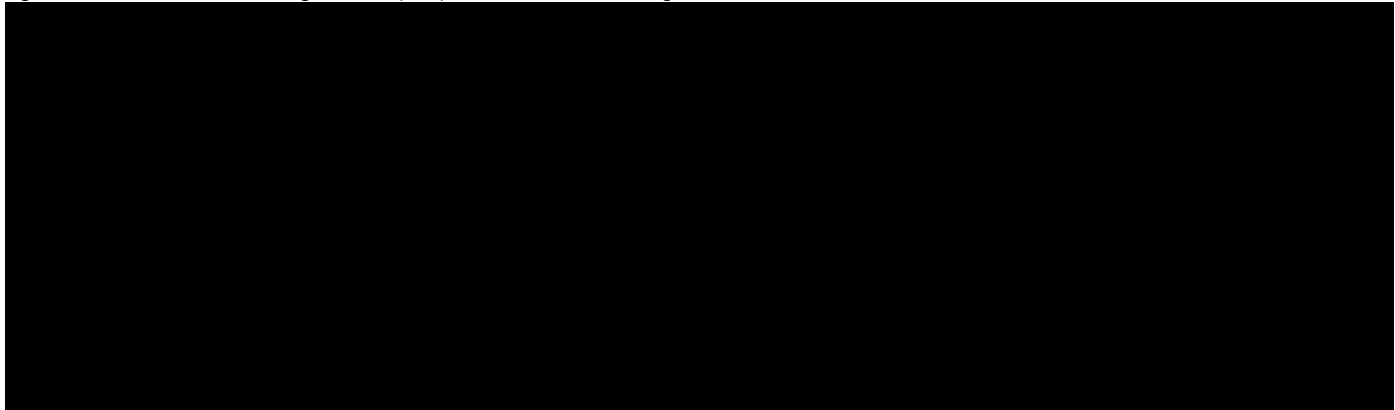
make up the North East are located in two regions of the overall Garda structure: Louth/Meath is included in the Eastern region along with Carlow/Kildare, Laois/Offaly and Longford/Westmeath; Cavan/Monaghan is included in the Northern region alongside Sligo/Leitrim and Donegal. It is also worth noting that the Louth/Meath division covers North County Dublin, although there are plans for this area to be moved into the Dublin Metropolitan Region. In the main therefore, the statistics related to the data that is available on each county and tallied for the North East region, that is Cavan/Monaghan and Louth/Meath, is as follows.

Figure 4.8: Garda Statistics on Drug Offences (no. & %) for Cavan, Meath, Monaghan and Louth

Drug type	1999		2000		2001		2002		2003		2004		2005	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Cannabis	209	61%	372	49%	268	60%	253	66%	217	66%	183	59%	377	78%
Heroin	2	1%	2	0%	23	5%	9	2%	3	1%	15	5%	15	3%
LSD	2	1%	6	1%	0	0%	1	0%	0	0%	0	0%	1	0%
Ecstasy	92	27%	308	41%	113	25%	92	24%	94	28%	54	17%	47	10%
Amphetamine	29	8%	62	8%	28	6%	13	3%	3	1%	20	6%	1	0%
Cocaine	6	2%	4	1%	7	2%	4	1%	10	3%	31	10%	42	9%
Other	3	1%	3	0%	5	1%	15	4%	4	1%	9	3%	0	0%
Total	343		757		444		387		331		312		483	

Source: Garda Síochána Annual Reports, 1999-2005.

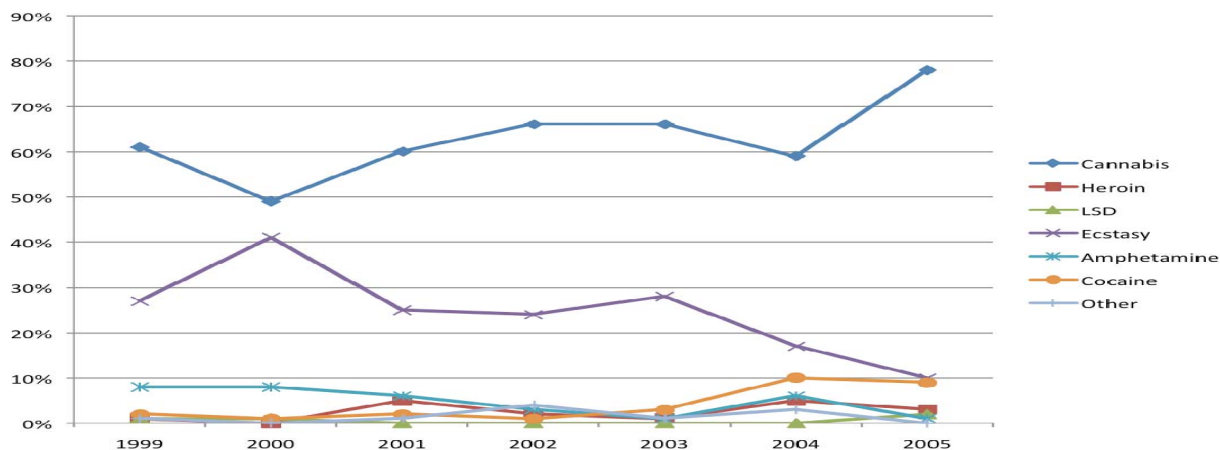
Figure 4.7: Garda Statistics on Drug Offences (nos.) for Cavan, Meath, Monaghan and Louth, 1990-2005



Source: Garda Síochána Annual Reports, 1999-2005.

Turning to the first chart, this shows that the number of drug offences in 1999 was 343. This rose to peak in 2000 at 757, decreased to its lowest recording in 2004 at 312 and again rose considerably in 2005. As noted, the data from 2006 on – in this detail – is not available. However, some information further on in the chapter suggests that the most recent increase in trends has continued nationwide and it is reasonable to assume that this is the case also in the division overall.

Figure 4.9: No. of drug offences by type of drug and year in North East region.



Source: Garda Síochána Annual Reports, 1999-2005.

This data on drug offences by drug type suggests that drug offences have changed their dynamics over the years. Cannabis remains the most significant drug in terms of offences. This has increase to some 78% of offences in 2005.

Heroin has stayed remarkably static with only minor increases in 2004 and a decrease in 2005. A very obvious trend is in respect of ecstasy and other dance culture oriented drugs which have decreased significantly in drug offence terms. The clearest upward trend apart from the increase in cannabis is the increase in cocaine, both in the number of offences and its proportion of all offences. This increased each particularly from 2003 to 2005. This of course begs the question about what has happened with these trends since 2005.

The responsibility for the analysis of statistics on crime is now, since 2006, the responsibility of the CSO. Unfortunately, it is not possible at this point to have the detail of information on drug offences etc., as seen in the Garda statistics up to 2006²¹. However, according to the CSO headline statistics report for the final quarter of 2007, drug offences showed increases over the year. Overall, recorded headline drug offences in 2007 rose by 791 (21.8%). The largest offence type in this category, *Possession of drugs for sale or supply*, increased by 595 (19.7%) while recorded *Cultivation, manufacture or importation of drugs* offences increased by 79 (58.5 %) over the year²².

In addition, it is also reported that the scale of drug seizures in 2007 was the highest to date worth an estimate €170M compared with €100M in 2006²³.

4.5 SUMMARY & CONCLUSION

This chapter has presented a range of data on the prevalence of drug use in the North East. At the outset however, it was reported that prevalence data on drug use and drug related problems is at best partial and at worst questionable in terms of their relationship with contemporary practices. In order to examine the prevalence of drug use and drug problems in a given region it is necessary to carry out a population survey, but since this level of survey is only carried out at national level it is often difficult to get comprehensive and timely data on drug use in a specific area or region. For this reason, a range of other sources are used. However these sources relate different periods of time, may be therefore out of date, refer to different operation areas and use different definition etc.

The first source examined in the chapters was the National Drug Treatment Reporting System. The NDTRS is both an indirect indicator of use of drugs and also demand for treatment. The NDTRS shows that prior to 1998, people resident in the North East with drug problems received treatment outside of the region and mainly in the Dublin area. The number presenting for treatment for the region in 1996 was 46 and this rose by 2000, when treatment was available in the North East, to 264.

The chapter relayed how in 2000, according to NDTRS publications, that most of those who presented for treatment did so with problems related to cannabis, ecstasy or opiates. The trend of treatment of drug use in 2000 was generally in line with other health board areas, with the exception of the eastern region (Dublin).

The most up to date published NDTRS analysis for the region dates from 2004 and covers the periods 1998 to 2002. This shows that 1,135 people were treated for drug use over that period. It also shows that cannabis, opiates and ecstasy accounted for 92% of all treatment cases while cocaine was the issue in one percent of cases. Between 1998 and 2002, the overall incidence of drug use according to treatment demand (NDTRS) was 50.1 for every 100,000 persons.

It was also shown how the incidence of opiate use recorded in the region in the 1996 to 2000 period was 5 per 100,000 and that this rose dramatically in all four counties in the period 1998 to 2002. This was part of a wider trend seen in the east/north east of the country. In the region the highest rates per 100,000 of population are seen in Cavan (10), Louth (10.3) and Meath (11.5).

The chapter looked at the same analysis applied to the use of cannabis. Again, this showed a dramatic increase in use between the five year periods of 1996-2000 and 1998-2002. At the county level the highest measures for cannabis use area seen in Meath, (34/100,000 population) and Louth (42.5). Moreover, although the rate in Cavan was lower than the former counties, it registered a 157% increase in cannabis use between the two periods in question.

²¹ Correspondence from the CSO to researcher following enquires.

²² http://www.cso.ie/releasespublications/documents/crime_justice/current/headlinecrime.pdf

²³ http://www.ndc.hrb.ie/directory/news_detail.php?cat_id=&news_id=3841&pointer=0

More contemporary raw figures are supplied by the Central Treatment List show that there were at the time of carrying out the research in 2007, 7 GPs and 52 pharmacies were participating in the methadone maintenance scheme in the region. In mid 2007, they were treating between 144 and 154 patients. These patients are those whose main drug problem relates to opiate use and does not therefore include non opiate users, who as we have seen make up the majority of drug users.

In recognition of the limitations of treatment data, the chapter turned to look at the most recent prevalence survey which includes data on the North East. In short, two surveys have been carried out by the NACD which looked at prevalence in the region in 2002/3 and 2006/7. The surveys reveal that the proportion who indicated use of any illegal drug increased from 18.9% in 2002/3 to 22.9% more recently. The surveys suggest that drug use is generally seen in those aged under 40 in the north east region.

The measure for lifetime cannabis use rose from 17.8% in 2002/3 to 19.5% in 2006/7. It is in respect of use of cocaine that the most obvious change has occurred: lifetime use of cocaine in the 02/03 survey was 1.2% and by 2006/7 this had increased to 5.6%. This represents an increase of 466%. The proportion citing use of cocaine was in 2006/7 at 10.2% in the 15-34 age group, which accounted for the majority of the increase.

The results for 2006/7 shows that there has been increases in the use, since 2002/3, of amphetamines, ecstasy, LSD and magic mushrooms in the north east, all of which are decreasing in the Dublin area. This suggests perhaps the drug use in the region can be seen in the context of trends that existed in parts of Dublin in past decade. The most recent survey reveals marginal increases in the proportions of the relevant population citing use of tobacco and alcohol, however these are significant measure overall, six out of ten and nine out of ten people for tobacco and alcohol respectively.

What this prevalence data shows, when placed alongside the treatment data, is that the vast majority of drug users do not present for treatment. It implies at any time that there are multiples of drug users in the community for every drug user who seeks treatment.

The final part of the chapter looked at Garda statistics on drug offences from 1999 to 2005 for the Counties in the North East. These show that cannabis offences accounted for 78% of all drug offences in the region in 2005. This data also showed a general decrease in the number of ecstasy and other 'dance culture' drugs. Along with the upward trend in cannabis there was also a less obvious increasing trend in the number of cocaine related offences, highlighting the change over from ecstasy use to cocaine over the last number of years. Although this level of drug crime data is not available from 2006 on, the most recent national data from the CSO suggests that drug offences in general have increased with 2007 being one of the highest on record. This underlines again the general upward increase in drug use national and in all likelihood in the North East also.

This chapter therefore establishes there is an ongoing increase in drug use in the North East. Up to date figures suggest an increase in drug use. The key drugs of note are cannabis, cocaine, and alcohol, with also the use of heroin/opiates, but at lower levels.

5. CONSULTATIONS WITH STAKEHOLDERS

5.1 INTRODUCTION

This section of the report looks at the views, insights and experiences of a range of stakeholders on the main themes of the research. The emphasis of the chapter is therefore on the perceptions of key stakeholders (HSE, other/statutory, community and voluntary) in respect of treatment services, needs and gaps in services.

The chapter is broken down into a number of sections that by and large keep with the theme of each of the questions asked. As noted in the opening chapter, some 45 interviews took place with the above categories of stakeholders.

The main sections of the chapter are as follows:

- *Role in respect of drugs and/or the NE-RDTF*
- *Nature and extent of drug use*
- *Treatment services and their impact*
- *Gaps and needs in treatment services*
- *Related and indirect needs to treatment*
- *Structural, organisational and administrative issues*
- *Suggestions on future treatment*

The chapter closes with a summary of the main findings.

5.2 PROFILE OF RESPONDENTS

The purpose of this question was to develop a profile of, and/or type of activities that the interviewed groups were engaged in. This is important as it allows for a sense of what groups, services etc, were consulted and this should therefore be kept in mind when considering some of the more substantive issues discussed further on in the chapter.

The groups/stakeholders consulted can be categorised into the following:

- *Voluntary sector homeless service*
- *Community development organisation*
- *Voluntary counselling service*
- *Aftercare service for drug users*
- *HSE addiction service (clinical)*
- *HSE addiction service (counselling)*
- *HSE addiction service (outreach)*
- *Area partnership*
- *Support and development services for young people (including those at risk)*
- *HSE management: administrative and clinical*
- *NE-RDTF: non aligned members and staff*
- *Community based drug support service*
- *Voluntary residential treatment service*
- *Voluntary outpatient treatment service*
- *General practitioners*
- *Non health statutory service providers*

5.3 NATURE & EXTENT OF DRUG USE

In order to develop a picture of drug use in the region from the perspectives of those working 'on the ground' in a service provision capacity or within communities affected by drug use, each of the stakeholders were asked to outline their experience of the extent and thereafter that nature of drug use in the areas, locations for which they are most familiar.

Earlier in the report, the published evidence on the extent of drug use in the North East area was explored. In that chapter, it was noted there that much of the information about the actual extent of drug use was limited, partial and inconsistent in purely statistical terms. It is therefore hard to come to a definitive measure of the extent of drug use with any certainty. In the absence of such data, the best model at the local level to get a sense of the extent of drug problems is to balance what systematic data is available with anecdotal information from reliable sources in the various communities as well as relevant service providers. This is the thinking underpinning this part of the research.

Turning firstly to the extent of drug use, the responses obviously varied from county to sub county area depending on the interaction of the respondent with drug problems personally or professionally. Nonetheless, there are a number of key themes which tie many of the responses together and therefore reflect some consensus in the responses to this question. In prevalence terms, the stakeholders view is that drug problems are worse than was the case in the region in the previous five or ten years. Although the extent of the problem is not always seen as more critical for those already using, it is suggested that a wider group of people are using drugs than was the case in the past. In addition, it is suggested that there is a larger variety of drugs being used in contemporary times also. Problem drug use is therefore viewed as a growing problem in the region. For some, it is seen as the primary issue in some areas, namely clusters of social housing. Although problem drug use is not at a level seen in Dublin for instance, in the case of heroin parallels are drawn to the Dublin experience in the past but with some modern features such as the problem use of cocaine, cannabis and particularly alcohol.

During the consultations, additional views were sought as to the nature as opposed to the extent/prevalence of drug problems. Looking firstly at drug types, the main drugs cited in the responses are cannabis, heroin, cocaine, prescription drugs (mainly benzodiazepines) and alcohol.

The following looks at the issues raised in more detail:

- It is felt that the use of cannabis is widespread and has become for many 'normalised' in a manner similar to alcohol. It is viewed as the first drug that most people use and is particularly prevalent among teenagers. The findings suggest that cannabis is not seen as a 'drug' in the same way as cocaine or heroin.
- Heroin is conceived as a drug that is expanding in use in the North East region. However, this is seen mainly in respect of those migrating to the region who are existing heroin users, some indigenous heroin users among Travellers, in social housing areas in towns and larger urban centres, and in some pockets in rural areas. It is suggested in the responses that most opiate users are not participating in the methadone maintenance programme. There is also a close relationship between heroin and cocaine use in some social housing areas in the larger towns in the region.
- Cocaine, like in most parts of the state, came into for particular mention in the research consultations. This drug is perhaps the drug whose use is increasing more significantly than others. Key to the use of the cocaine is the apparent 'classlessness' of its users. In other words, disadvantage, affluence, young and older adults (16-40 years), males and females are using cocaine. It is also prevalent throughout the region. A key aspect of the use of cocaine is its recreational setting. In this sense, it is seen as clearly linked to recreational consumption of alcohol in recreational setting such as pubs, clubs and parties in residential settings.
- This in turn leads to alcohol. The key points coming out of the research is that consumption of alcohol is increasing especially among younger age groups and those who are under 18. Alcohol, it is observed, is not viewed as drug or harmful. Again, the consumption of alcohol is normalised.
- It was also noted in the consultations that drug taking is more 'open', obvious and blatant in the region today than in the past.
- Along with the perception of increased drug use, there is a sense coming from the interviews that there has been a concomitant increase in drug related violence, intimidation and anti social behaviour.
- At the level of communities and in some families, increased drug use has led (especially in the case of cocaine) to increases in debt.
- There is also significant use of prescription drugs related mainly to benzodiazepines. It is felt in particular that there is a black market for prescription drugs. Allied to this, the consultations also point to increase use of 'over the counter' drug such as codeine and use of steroids.
- In general, it is felt that drugs are more readily available and affordable in the region. Of particular note, the use of drugs cannot, in the view of those consulted, be disaggregated from poly drug use. The use of two or more drugs – cannabis, alcohol, cocaine, benzodiazepines and heroin – is seen as the normal manner of drug use in the region across all age groups and social strata.
- Finally, a particularly important suggestion is that drug use in the region is closely related to the increase of social networks with Dublin. Therein, it is suggested that migration of former Dublin residents to towns and areas in the North East has opened up a social link to drug use trends and relations in Dublin. This is particularly the case in the new housing developments in Meath and

Louth and areas that are close to the urban sprawl expanding out from Dublin. This type of social networking of drug use is also seen in some areas of Cavan and Monaghan such as Kingscourt and Carrickmacross

5.4 TREATMENT SERVICES AND THEIR IMPACT

As part of the consultation each of the stakeholders was asked to indicate what services, in and outpatient, they are aware of in the region for drug use.

As one might imagine, a long list of services were named during the course of the consultations, the main outpatient services noted included the following:

- GPs overseeing methadone patients
- Turas aftercare, Dundalk
- HSE clinics, outreach and counselling services (Drogheda, Navan, Dundalk, & Monaghan) with satellite clinics
- Cavan Drugs Awareness
- Aisling/Bradain Programme, Navan
- Tabor House, Trim
- Crossroads, Drogheda
- St. Brigid's Hospital (alcohol) Ardee
- AA and Al Anon
- Oakdene Counselling, Dundalk
- Homeless Aid
- Simon Community, Dundalk
- Family support service/group, Dundalk
- Drug and Alcohol Forum
- South Meath Alcohol and Substance Misuse Response
- Drogheda Partnership, CE Scheme
- Pillar Family Support, Drogheda
- Drogheda Youth Development
- Meath Youth Federation
- Navan Family Support group
- Victory outreach

While this list does not cover each and every treatment service in the region, nor all those currently supported by the NE-RDTF, it does cover a substantial proportion. It is noticeable also that some of the above organisations/services may not be traditionally considered as treatment per se and there was some obvious differences in the types of services that respondents identified as treatment. Finally, some of those services are small relative to wider services such as those under the aegis of the HSE.

Following this, the respondents were asked to indicate what if any inpatient services were available for drug users in the North East. The stark finding is that there are no dedicated in patient services available for illicit drug users, as opposed to alcohol, in the region. There appears to be some alcohol detoxification capacity in acute hospitals or mental health facilities notably Monaghan General Hospital and St. Brigid's, Ardee. However, it was suggested that there may be up to two beds dedicated to alcohol and drug treatment in each acute hospital which would cover those located elsewhere in the region including Drogheda and Cavan.

However, when it comes to inpatient treatment those consulted painted a picture of a complex system of relationships with residential in patient treatment services located adjacent to the region or at some length. It appears that each strand in the services - from community to voluntary or statutory - has a working relationship or understanding with one or more residential, in patient treatment service providers. Services noted here included:

- Aisleri, Wexford and Tipperary
- The Rutland Centre
- Cuan Mhuire, Athy, Co. Kildare and Bruree, Co. Limerick
- Cuan Dara, Cherry Orchard Hospital
- Keltoi, Pheonix Park, Dublin
- Peter McVerry Trust, Lantern, Garristown
- Merchant's Quay, High Park, Drumcondra, Dublin
- St. James Camino Network, Enfield, Co. Meath

- Aislinn Adolescent Treatment Centre, Ballyragget, Co. Kilkenny
- Bushypark, Ennis, Co. Clare
- Tabor House, Trim

What is interesting is that many of these services do not fall under the medical definition of inpatient treatment, whereby there is high levels of specialist services available. Most of these services fall under the general ambit of residential treatment. This is an interesting finding in the consultations and suggests a level of confusion about what is meant by inpatient treatment, detoxification, residential treatment and outpatient treatment. It is the case that some services deemed outpatient by some of the respondents are also cited as inpatient services by others. The above services can be differentiated according to the level of need in terms of problem drug use and psychological/medical issues they cater for, residential settings for those who require high levels of psycho-social (but less intensive medical) support, and abstinence based (drug free) residential settings. In short, of the above only Cuan Dara would be understood as inpatient and the others divide into residential settings and abstinence based residential settings. Regardless of this, it is clear that at present no inpatient or community based detoxification residential programme is currently available in the North East Region. This was very clear to all of those consulted and is the basis for the complex system of referrals to the above facilities.

Turning to views of on the capacity of existing outpatient and inpatient services, it was pointed out by some respondents that there is a good deal of diversity in the quality standards that can be used across the various treatment services cited. This relates to professional qualifications, standards of client care and experience in treatment. In addition, the approach of the various services was seen as differing also as to a focus on drug free, abstinence based treatment model, a religious/evangelical-Minnesota 12 step models and a stabilisation/harm reduction model.

In particular, it was pointed out that the capacity of the mainstream HSE services was limited by staffing levels, resources and the numbers of level 1 and, more critically, level II GPs participating in the methadone protocol. It was suggested that in some counties – Cavan and Monaghan – a different approach to drug treatment is pursued (focusing on alcohol and illicit drugs) to that seen for instance in Meath and Louth. In the research, it was suggested that this leads to less of a focus on outreach in the former areas than in the latter, which are based on community clinic settings. It was also noted that there are differences in the linkage between HSE services and allied areas in the health service of relevance to addiction across and between different regions and setting. Finally, questions were also asked about the interactions of adolescents with the various treatment services.

This issue naturally leads into a discussion of the impact of treatment services in the region, and more precisely, what in the view of those consulted has worked well and not so well? At the outset, it is important to state that a number of those consulted felt that it is difficult to gauge the impact of treatment services in the region in the absence of systems to measure progress and, allied to this, the establishment of key performance indicators and targets. This would seem to be a key issue for the future of treatment services in the region and not only to evaluate the effectiveness of services, but also to identify issues, the needs of clients and best practice all of which would add to the value and efficacy of treatment services.

Nonetheless, because of the nature of the topic, there was a larger focus on the areas that are viewed as not working well in treatment services. Before looking at these, and for the sake of balance, it is worth firstly exploring what the respondents viewed as areas those who have worked well in the treatment services they are aware of.

The main areas noted are:

- Outreach services operated by the HSE addiction services
- The holistic approach adopted by organisations such as CDA
- The linkages between mental health and addiction services in Cavan and Monaghan, allowing for a focus on dual diagnosis.
- The status of those availing of the methadone maintenance programme alongside psycho-social supports provided by HSE counsellors.

However, as noted, areas conceived as ‘not working well’ is by its nature a longer list than the one above. There was a significant volume of responses under this heading and the main areas of consensus were included that firstly in general, the north east region lags somewhat behind the treatment infrastructure that is evident in the LDTF areas in and around

Dublin. Secondly there is a limited focus on harm reduction approaches across treatment services and more crucially, the respondents noted that there is no clear continuum of care policy or model evident at present in the treatment services that are currently provided. Thirdly a related point to this is one about cohesion: in this respect it was noted in the research that there is little formal linkage and networking between treatment services. Further the existence of follow on care paths from treatment is available in some areas and not in others and there seems to be a barrier between integration and referral from HSE services to community/voluntary services.

In addition, it was suggested that the location, premises and hours of the existing services - community/voluntary and statutory - were not conducive to the needs and requirement of the clients. As such, it was observed that the premises are mostly old and unsuitable for drug treatment and that there is no out of hours or weekend services which would be more in keeping with the needs and biography of problems drug users availing or likely to avail of drug treatment²⁴.

The issue of the lack of integration between services was also raised in this part of the research. It is suggested that services, again statutory and voluntary/community, do not work together to provide a seamless, multifaceted service that would firstly be in keeping with the multidimensional needs of drug users and secondly, in line with model of care based on a continuum. Although this was a clear finding in the research, since the time of the research and perhaps in recognition of this issue, there however had seen development of the existing good level of interagency work between the HSE and voluntary agencies. Regardless of this, this is not always obvious to some stakeholders hence

The overwhelming focus of statutory services on opiate use was also seen as something that has not worked well. In this regard, it was felt that treatment services ought to focus more on a polydrug use which as we have seen would be more in keeping with what is generally felt to be the 'normal' pattern of drug use. The implication of this as noted in the interviews, is that drug treatment services were seen to be services for opiate users solely and, rightly or wrongly, this had the effect of lessening the engagement (or potential engagement) of non opiate problem drug users with existing treatment services.

The issue of waiting lists also came out strongly in the consultations. In this regard, it was suggested that the existence of waiting lists were detrimental to the motivation of some drug users in seeking treatment. In practice, it was noted that the time placed on the waiting list often resulted in a loss of motivation, 'the window of opportunity' to seek and engage in drug treatment and often resulted therefore in individuals causing further harm to themselves (and their families) through continued drug use.

Other areas, of more or less equal importance to the above, which were noted in the research under this heading (that is where treatment has not worked well), were as follows:

- The lack of cohesion (and logic) between HSE addiction and drug services in on the one hand Cavan/Monaghan which is operational under the aegis of mental health and on the other hand, in Meath/Louth which comes under the ambit of social inclusion.
- Limited use of alternative treatment therapies such as cognitive behavioural therapy (CBT) as a treatment option beyond methadone maintenance²⁵.
- Lack of counselling and outreach services provided by HSE addiction services staff in view of the lack of staff/resources to cope with existing client case loads.
- The involvement of parents
- Time scales required to locate needed treatment services in new location due to operational and community attitudinal problems

The reasons put forward as to why treatment services were not seen to have worked as well as might be expected (in addition to what has been previously stated) generally were seen to revolve around: lack of leadership; lack of regional thinking; clinical boundaries, agendas and interests including those of GPs; limited integration with alcohol issues in

²⁴ It should be noted that a regional Methadone Implementation Group has been established under the HSE, including representatives of the NE-RDTF. This group are currently actively seeking to develop appropriate community based services in suitable premises. This is an acknowledgement of this finding and an indicator of current responses to the issue. This issues and the work of the implementation group also reflects feedback from GPs in the region currently participating in the Methadone Maintenance Programme.

²⁵ The HSE is currently rolling out training for all front line staff in CBT and coping skills with a view to upskilling staff interacting with problems related to cocaine. Front line staff includes addiction counsellors and outreach workers.

some areas; low priority of addiction services within health services; statutory – community/voluntary mistrust; transport and access, and planning and referral interagency formal protocols

5.5 GAPS AND NEEDS IN TREATMENT SERVICES

Following the discussion of the stakeholders knowledge and perceived impact of treatment services, this was followed by discussions around what the main gaps or needs, both broad and specific, were in respect of treatment services. Herein, the consultation process also explored what is needed in the region in terms of drug treatment.

By and large, the responses to this question mirrored the responses to what gaps exist in current services addressed above. In order to avoid undue repetition, the main gaps and needs identified in drug treatment services are merged in this section. Overall, the issues identified here reveals details about what responses may be required in the future.

The first thing that is evident in the responses is the degree of overlap with some of the areas that those interviewed identified as not having ‘worked well’ with regard to treatment of drug problems. This is a positive development as it emphasises a degree of coalescing of views around a number of key themes and verifies the overall findings of this part of the research. Some of the responses touched on areas that might better be described as prevention, these are not included for the most part in the paragraphs below but were generally aired by groups with a focus on for instance young people, families etc.

Looking in more detail at the responses, the first thing that should be said is that many of the issues should not be viewed a mutual exclusive or stand alone. In other words by their nature the responses were such that many of the issues raised as gaps in treatment services in the region are interrelated. This in turn suggests filling those gaps requires an equally integrated response.

Two gaps featured significantly in the responses. The first can be referred to as the continuum of care. It is held by many of the respondents that there is gap in terms of progression routes for those accessing treatment for drug problems. This normally means that each service user is assessed based on their situation and needs and are placed on a tailored care path plan which responds to the nature of their individual drug problems and related factors. This form of care, the continuum, requires a system of progression from engagement, assessment, treatment, through to rehabilitation, social integration and aftercare. Of course, the lines between these phases are not always evident but this gives a sense of the phases suggested as a continuum of care. It could also be added here that a perceived gap in treatment is the lack of service user input to treatment regimes and, for some, a perception that problem drug users are not well treated and respected in some current treatment settings in the region.

The second central issue raised in the consultations was the gap around inpatient or residential treatment and detoxification availability in the region. This is it suggested requires regionally based detoxification/residential treatment beds and related step down facilities in the community such as ‘halfway houses’ etc. Again, such facilities would be part of a continuum of care for individual service users based on their respective needs.

Harm reduction approaches were also seen as a gap. This takes into account needle exchange, the provision of information, education on safe drug use, health promotion and easy access to low threshold treatment should a particular user be motivated to access treatment. An issue raised separately in the research but by and large in keeping with a harm reduction approach was the gap that some respondents feel is evident in respect of outreach work with drug users, home visits and ‘on street’ engagement. However, another issue noted as a gap was the perceived polarisation between harm reduction and abstinence based approaches to drug treatment. There are two opposing views around this issue and it is suggested in the consultations that some accommodation is required between the two at service level to allow for a range of options to be made available to drug users based their personal requirements and circumstances.

In keeping with the notion of the continuum of care and tailored care planning in drug treatment, it was also suggested that an accompanying gap in services is the availability of what can be termed as ‘ancillary’ or ‘parallel’ supports. This refers to the supports and interventions which are available alongside each phase of progression along the continuum of

care. This might include personal development, literacy, education/training, accommodation, family support interventions, mediation, employment etc.

This leads therefore into another gap identified: the integration of services among agencies for drug users. This is most apparent in the case of formal collaboration arrangements and multiagency working. However, related to this was the gap identified between understanding and respect between statutory services, specifically HSE, and community and voluntary services. There is a sense of confusion on each side about what it is that the others do, what the nature of the relationship should be and the role the Task Force might or should play therein. An addendum to this point is the suggestion that there may be questions about quality and clinical standards in some community and voluntary services, which is related to the misunderstanding between both groupings.

There was also a gap in services raised in respect of GPs. Here respondents felt firstly that there were not enough level II methadone prescribing GPs in the region, that support for the current GPs was not at the level it ought to be and that GPs, paradoxically, should be vetted to ensure they have the interests of drug users in mind. An issue was also raised in this regard about the level of 'power' that GPs and clinical specialists wield in treatment services. This leads therefore into a gap of sorts identified in respect of the medical and psycho-social treatment modalities. It is suggested here that there is limited treatment options available and supported and those that are available for the most part focus on the medical aspect of treatment associated with methadone maintenance. The suggestion coming from the research is that there ought to be more options in drug treatment which incorporated medical, therapeutic, social, and alternative modalities rather than focus on medical means alone.

Another gap identified by a large proportion of respondents was around treatment services for those under 18, and therefore those under 16 in the form of early interventions along psycho-social and medical lines.

The final major gap noted was the need to focus on a wider definition of problem drug use. Such a definition might be closer to a holistic addiction understanding which in turn looks at polydrug use rather than the present, and legacy based focussing on opiates alone. However, it was noted that there is gap in respect of specialist treatment regimes for cocaine in view of the increase in use of this drug and the unlikelihood that users of this drug, given their social composition and stereotypes associated with existing drug treatment as opiate treatment solely, would access existing treatment services as currently structured and located.

Other gaps noted by a minority of respondents included the following:

- Nurse specialists around hepatitis C and other infections including medical screening
- Access to psychological support and assessment and therefore maintenance of links where they currently exist to psychological services in view of dual diagnosis
- Development of clinical policies and procedures, with appropriate direction, around drug treatment in the region.
- Promotion of drug treatment services including information dissemination
- Lack of appropriate premises and the physical location of treatment services
- Public transport and access to treatment services
- Out of/unsocial hours treatment services
- The underfunding/staffing of treatment services in view of demand, waiting lists and the delivery of appropriate counselling and related supports.
- Family involvement and support in the treatment process.
- Replication of best practice carried out elsewhere.
- Development of mentoring and advocacy services for problem drug users.
- Complaints procedures for service users and monitoring of standards in existing treatment services.

The final part of the discussion of this theme looked at the barriers and/or enablers there were for responding to gaps and needs in current treatment services. Starting off with what respondents considered as enabling processes for the development of drug treatment services, the main area noted was the NE-RDTF. This line of thinking acknowledges that the onset of the Task Force has been valuable whereby its operational area has a treatment services structure (HSE) which covers the same operational area. In LDTF areas, most operate in catchments which cover only a fraction of the operational area of the former health boards or current HSE regions making co-ordination a difficult process in terms of personal contacts, operational responsibilities, service catchments etc. The responses reveal also that the working partnership between RDTF members is valuable and that the HSE plays a key and committed role. In other words, the

partnership and focus which the Task Force processes have brought is a central driver in responding to drug treatment needs in the region.

Related enablers include the funding provided by the Task Force to community and voluntary bodies, the services and experiences they have developed and increasing networking/collaboration as a result. The appointment of single focus full minister of state for drug policy is also seen as an enabler as to is the current development of the successor to the present NDS. It was also suggested that there is a new found acknowledgement that the region has a drug problem which serves to provide a focus on responding to such problems. A further enabler can be added that became apparent over the course of the research: the coalescing of views and understandings on what is needed in terms of responses to problem drug use in the North East.

Turning to the so called barriers to responding to drug treatment needs, the responses reveal a long list of barriers, some of which have been noted in earlier sections. One central barrier relates to internal organisation and operations of the addiction services in the HSE. This issue will be treated more appropriately in the following sections dealing with structures and organisational issues. However, it is worth reiterating that this was considered a central barrier in responding to drug problems. Notwithstanding this, the responses revealed the following as the main barriers in responding to drug treatment needs:

- Attitudes in the wider community/region to drug users and drug treatment clinics/services
- Tensions and mistrust between statutory and community/voluntary service providers/interests
- Tensions and inequality between clinical/medical personnel and lay personnel
- Confusion about the structure and operation of HSE addiction services among the community
- Regionalism/parochialism including within towns
- Fragmented services
- Over focus on alcohol or opiates and not therefore on polydrug use
- Limitations on public findings and therefore service resources including staffing
- Gaps in services with which to implement a continuum of care treatment approach
- Transport difficulties
- Resistance and tensions between abstinence to non abstinence treatment approaches
- Role and commitment of pharmacies
- Links with mental health services the understanding of addiction by mental health specialists

5.6 INDIRECT/RELATED NEEDS

Stakeholders were asked if in their experience there were further related and indirect needs that should be considered as part of responding to drug treatment needs. Such needs might include for instance those concerned with dual diagnosis, young people and adolescents, social exclusion etc?

In similarity to previous sections, there was naturally a wide range of responses however, they have been distilled through analysis to some common themes common to them. The responses reveal a number of interesting issues, chief among these is the almost unanimous view that drug treatment requires an integrated, holistic approach which focuses on the individual drug users, their life world and social setting. In other words, this holistic thesis suggests that responses must be similarly multifaceted. In many ways, there is acknowledgement of this view in the set up and *raison d'être* of the drugs task forces being as they are a partnership of community, voluntary and statutory interests. However, the reality seems to be that it is difficult to integrate services or that there is no 'political' and organisational will to redesignate services from central level to take on a more holistic response. The holistic approach, the respondents suggest, would match treatment services to treatment needs in a manner similar to case management. It requires however formal collaboration and considerable planning followed by appropriate management.

The reasons why this approach is cited are manifold. They include issues around the relationship between mental health and addiction and the need therefore to factor dual diagnosis into responses. On a less acute level of psychological input, issues of self esteem and self confidence are similarly felt to be considerations for treatment responses.

Adolescents came in for particular comment in this phase of the consultations whereby the treatment needs of young people, and engaging with young people, requires an empathetic harm reduction approach and would also need to be cognisant of socialisation and peer processes that may play a part in drug use and continued drug use²⁶.

Additional areas suggested for inclusion in the design and delivery to future treatment includes:

- Factoring in a whole family approach
- Addressing housing, employment, education and training issues
- Engagement with new communities
- Tackling entrenched social and personal problems
- Factoring in criminal issues
- Focusing on individual needs as opposed to organisational needs

5.7 STRUCTURAL, ORGANISATIONAL AND ADMINISTRATIVE ISSUES

As noted earlier, respondents were asked to consider what if any structural, organisational and administrative changes might be required. Earlier it was suggested that many of the barriers to future treatment services which would respond to the expressed needs were internal to the structures and processes of the HSE addiction services. Indeed, among a large section of those interviewed this was a recurring trend and underlines something of the challenge that lays ahead in terms of remoulding treatment services in line with existing and changing needs.

Before looking at treatment services under the HSE, it is important to note the context of these services. Overall, the structures currently in operation and the subject of change are in the main related to the legacy of development of mental health, addiction and community care services over a number of years culminating in the current situation under the HSE. As such, many of the issues noted below are in the process of review. In this regards, the HSE can be said to review on an ongoing fashion its drug and alcohol (addiction) services. All of the services are presently operating under the ambit of primary, continuing and community care.

At the time of the research, the addiction services within the HSE in the North East region differ according to their local health or community care area. For instance in Cavan and Monaghan, the addiction services are under the ambit of mental health services underlining their focus on alcohol and close working relationship with mental health specialists. However, the addiction services in Meath and Louth, while formerly located under health promotion (part of the population health strand of HSE services, the other two are the national hospitals office and primary, continuing and community care), are now placed under social inclusion. Both mental health and social inclusion now fall under primary, continuing and community care (PCCC).

The management of the service differs therefore between the two counties under PCCC and also therefore to differing local health managers. While there is a methadone service with outreach workers and counsellors in Louth and Meath, there services do not exist in Cavan/Monaghan where methadone treatment is primarily under the aegis of GPs. In addition, the addiction response centre in Cavan/Monaghan, due to its integration with mental health services, focuses on alcohol addiction to a greater extent than illicit drugs. The addiction services in Meath/Louth focus exclusively on illicit drugs and mainly opiates in view of the methadone maintenance protocol. Until 2007, residents of Cavan/Monaghan would have to travel to Louth to avail of prescription methadone and some would also travel to areas in Dublin.

In addition, there is some confusion evident from the responses on the role of counsellors, outreach and general assistant staff in the addiction services in Louth and Meath. There does not appear to be a clear or understood team lead structure. It is also the case that the overall manager of the addiction services in the region for the HSE is - in line management terms - answerable to the Local Health Manager in Louth/Meath and not therefore Cavan/Monaghan. In other words, there is no cohesion between the addiction services across the region. This is in the main due to legacy and industrial relations reasons. However, as noted in the responses, this begs the question at the regional level of the consistency of the services in terms of their responses to the needs of clients. For instance, living in one location as opposed to another may result in quite a different experience of drug treatment services.

²⁶ Such processes do not of course limit themselves to adolescents and are prevalent also among adults

Like many health services, there is a waiting list to receive treatment as part of the methadone maintenance programme. It is clear also that the existing services are under resourced and under staffed, resulting in the waiting list, to deal with the current caseload. This has resulted in some outreach workers for instance not fulfilling this role because of more practical needs elsewhere in the services and also less counselling of clients than is planned due to large caseloads. This issue is also complicated by the numbers of Level I and Level II GPs. Finally, in respect of HSE services, questions were also asked of the structure of the GP led methadone treatment protocol and the commitment of GPs to addiction issues and drug users. The views expressed on these issues in the interviews suggest that the region-wide addiction services require an overhaul to ensure they are more consistent and cohesive, and critically, understood by clients, their families, allied services and the community at large.

In tandem with the above issues, the comments made in response to this question centred on the following suggested changes to current structural and/or organisational issues:

- Introduction of systems to monitor clients and service progress, progress indicators and learning
- Replication of successful models in operation elsewhere
- Introduction of formal service level agreements/protocols on co-operation, collaboration and referral
- Training in problem drug use, treatments and the contribution of agency personnel that might make a contribution to an individual's care plan as part of a continuum of care
- Use of more up to date and comprehensive prevalence data
- Greater involvement on non clinical staff in decisions regarding treatment in conjunction with clinicians
- User involvement by right in their treatment options and choices and greater involvement of users in the management of funded projects and activities
- Transformation of treatment services from a service led to a client led service
- Introduction of a comprehensive and accessible complaints procedure for service users and their families
- Consultation structures between HSE staff, NE-RDTF and community/voluntary services and projects
- NE-RDTF to take on a lead, more proactive, role in drug treatment planning
- Participation of HSE staff in sub committees of the NE-RDTF

5.8 SUGGESTION ON FUTURE TREATMENT SERVICES

This final section explores the suggestion of stakeholders on the future of drug treatment in the region. In so doing, the second element of this question asked what enhancements might be made to existing services and where might new treatment options be established.

Again, with a view toward reducing undue repetition, the suggestions coming from this part of the field research is generally in keeping with the findings coming out of the sections above on the impact, gaps and needs in treatment services. They revolve largely around the following:

- Information and promotion of services
- Continuum of care and tailored case management
- Collaboration, multiagency responses
- Integrated, holistic treatment options and services
- Provision of ancillary or parallel supports
- Replication of best practice
- Overhaul/restructuring of HSE addiction services
- Monitoring, learning and tracking systems
- Provision of treatment services for adolescents
- User involvement and user led services including the development of complaints procedures
- Less autonomy for clinicians and emphasis on medical treatment modes alone
- Out of hours services
- Community-based multi service clinics
- Open dialogue and consultation between statutory and community/voluntary services
- Improvement in the location and appropriateness of premises/treatment facilities
- Increases in resourcing, including staffing of HSE services
- Provision of detoxification/residential/inpatient premises in the region
- Increases in the number of prescribing GPs
- Core focus on polydrug use, including alcohol

- Focus on harm reduction approaches, including outreach
- Family support input to treatment

In terms of the location of new services, there were two aspects to the responses; the first looked in general at treatment services while the second focused on residential/inpatient/detoxification services. Regarding the former type of response, the suggestions focused on issues such as locations close to travel nodes, factoring in the main population centres, clusters of drug users, in neutral areas so as not to be associated with one part of a town or create stigma for those attending. The second type of answer the responses were either more circumspect or parochial. By parochial, we refer to the location of such services in the location of those that were interviewed, particularly in the case of community based stakeholders. In addition, those located in Cavan/Monaghan suggested that location, those located in Louth/Meath suggested those counties as the likely location of a residential treatment unit. This is in keeping the respondent's world view and in general, a regional approach was not taken.

However, there are feasibility issues. Residential units are - by the nature of the service, the staff required, capital costs and level of services - expensive. Thus in the current climate, it is perhaps not practicable to look at new builds. Thus this leads to the use of a current building. This requires assessment of the issue of ownership etc, allowable uses, leases etc.

In addition, the provision of such a unit in the region, it is suggested, should look to be placed in a centre of excellence with step down services close by in the community. In this sense, location is not as critical as the provision of step down services and ensuring that the central location is at a high standard. Travel access is a major concern in the north east region, therefore location along public transport nodes, or at least close to them, is key.

Given the cost of such units, some respondents suggested that a residential detoxification unit should be considered in terms of the HSE Region North East/Dublin and not just in the North East region. This would make for a more convincing case given the numbers of potential beneficiaries across the HSE region. There a number of voluntary units in and around the North Dublin including a HSE facility (St. Michaels) in Beaumont Hospital. Therefore the location of a unit in the North east would make sense.

In terms of locations, therefore, the suggestions were Drogheda (in Our Lady of Lourdes Hospital), Dundalk and Navan. In addition, there were a number of suggestions also about St. Brigid's Hospital, in Ardee. This location given the above considerations may prove the most feasible. However, this is dependent on range of variables and the response show in general the types of issues to be considered in this regard. Overall, it would appear that the largest proportion of criteria that any one site fulfils would dictate eventual choices.

5.9 SUMMARY AND CONCLUSION

Chapter five recounted the experiences and views of what are termed stakeholders. This is the first of two strands of qualitative or field research - along with consultations with drug users and families - which was undertaken so as to provide complementary research data to that provided through the prevalence, treatment, policy/organisational context and profile chapters. It was also undertaken in recognition of the limitations of the prevalence data and in order to explore, in more depth, views and experiences on treatment issues.

The findings reveal that drug use and drug use problems are felt to have exasperated in recent years. It is also evident from the responses that the trend is one of increase which is also evident or least indicated in the 'hard' prevalence data. It is viewed as particularly acute in relative terms in areas of clustering of social housing in some of the region's larger towns. In terms of heroin, the suggestions coming out of the interviews point to ongoing problems that, while not at the same scale, drew parallels with the nature of heroin problems in Dublin in the past.

In terms of nature of problem drug use, the chapter revealed that the main drugs used in the region is cocaine, cannabis, alcohol, heroin and prescription drugs - with a particular emphasis on the first three of these. In addition, the chapter showed that in the use of cannabis has been 'normalised' in that it is considered a substance in the same manner as alcohol; heroin is mostly associated with more deprived areas and specific rural areas; cocaine is the recreational drug of choice with the widest user group in terms of social class, education and employment and is closely associated with consumption of alcohol; alcohol consumption is growing with worrying trends in use among under 18s; and finally, the

nature of drug use is according to the findings one of poly drug use. In other words, many of the illicit drugs noted above are routinely taken in conjunction with the use of one or more other/secondary drugs.

The status of treatment services is complicated in the region. There appears to be a complex chain of referral to different residential units in different places due to the absence of dedicated inpatient/residential places in the region. The findings also suggest some confusion over the differences between inpatient treatment and residential treatment.

The chapter noted some views on the divergence of quality standards across outpatient treatment services and facilities as well as contrasts with respect to abstinences based treatment or a harm reduction methodology. Particular mention was made of the HSE addiction services in terms of its perceived lack of capacity. The chapter also recounted some issues in respect of inconsistencies in the approach of the addiction services across the region, where in Cavan and Monaghan there is a focus on alcohol and less so on illicit drug problems and in Louth/Meath the focus is on illicit drug solely with an emphasis on opiates. This was seen to limit outreach activities and counselling for illicit drugs in one area and including a focus on alcohol problems in the other.

In terms of the impact of current treatment services, many suggest that it was difficult to gauge the impact of the services in the absence of data, information about the service and key performance indicators or targets.

The areas in which treatment services were seen to not have not worked well centred on the underdevelopment of the services when compared with best practice and other areas; the absence of thorough continuum of care policy at the heart of treatment; limited networking and collaboration (formal and informal) between services including in particular community/voluntary and statutory/mainstream services; the lack of poly drug use focus; and the ongoing waiting lists and the difficulties this causes for the motivation and harm reduction among problem drug users.

In turn, the chapter identified that the two major gaps in treatment are the absence of continuum of care model of treatment and the absence of residential/inpatient/detoxification facilities in the region. Related gaps noted to these are formal integration between services, integration of medical and psycho/social treatment modality; services for adolescents, and services with a polydrug use focus.

There was general consensus in the findings around the need for a holistic treatment approach that looks at the whole life world of individuals beyond physical addiction and therefore requires the provision of ancillary supports around education, personal and social issues, accommodation etc.

The main organisational or structural issues identified centred on the inconsistencies in the current arrangement of HSE addiction services. As noted, one works under mental health services in two counties and is focused on alcohol use, while the other works under the social inclusion strand and focuses on illicit drug use. The latter only in more recent times was transferred from the public health services division at the HSE area level to PCCC, which includes both mental health and social inclusion. It was noted in the findings that from the users point of view, the type and focus of the addiction services experienced can differ depending on where in the region a person might reside.

The chapter also discusses some of the issues about the provisions of residential treatment in the region. Feasibility issues and needs were touched on and a number of suggestions were made about these issues.

The final part of the chapter outlined the suggestions of stakeholders on the future of drug treatment in the region. The findings are consistent with and summarise those noted elsewhere in the chapter and contain the following key elements:

- Information and promotion of services
- Continuum of care and tailored case management
- Collaboration, multiagency responses
- Integrated, holistic treatment options and services
- Provision of ancillary or parallel supports
- Replication of best practice
- Overhaul/restructuring of HSE addiction services
- Monitoring, learning and tracking systems

- Provision of treatment services for adolescents
- User involvement and user led services including the development of complaints procedures
- Less autonomy for clinicians and emphasis on medical treatment modes alone
- Out of hours services
- Community based multi service clinics
- Open dialogue and consultation between statutory and community/voluntary services
- Improvement in the location and appropriateness of premises/treatment facilities
- Increases in resourcing including staffing of HSE services
- Provision of detoxification/residential/inpatient premises in the region
- Increases in the number of prescribing GPs
- Core focus on polydrug use including alcohol
- Focus on harm reduction approaches including outreach
- Family support input to treatment

6. CONSULTATIONS WITH DRUG USERS & FAMILY MEMBERS

6.1 INTRODUCTION

As noted in the introduction, a central element in the methodology for the research was to undertake consultations with a range of stakeholders focusing on a number of common themes that are key to the research leading to the strategy for the Dublin 12 LDTF. Whereas the previous chapter recounted the views, insights and experiences from stakeholders that have a statutory, community, clinical etc., role and perspective on drug problems, this chapter complements the previous chapter and gives an overview of the findings from interviews with problem drug users in treatment and members of the families of problem drug users.

The general purpose of this phase of the research was to obtain the views and experiences of this group on the reality of drug use. This chapter is based on interviews and/or focus groups that encompassed sixty seven individuals.

The main sections of the chapter are as follows:

- *Role in respect of drugs in the North East*
- *Nature and extent of drug use*
- *Factors contributing to problem drug use*
- *Experiences of services*
- *Gaps and needs in treatment services*
- *Related and indirect needs to treatment*

The chapter closes with a summary of the main findings.

6.2 ROLE IN RESPECT OF DRUGS IN THE NORTH EAST

This question explored the areas in which clients/drug users and their families live and their connection with drug problems. Turning the second part of the question first, the drug users are clients of various services and supports located throughout the North East Region. In similarity, family support groups were used to gain access to family members affected by drug use.

The location of those consulted was as follows:

- Navan
- Cavan
- Trim
- Drogheda
- Dundalk
- Ballieborough

6.3 NATURE AND EXTENT OF DRUG USE

Each of those taking part in this phase of the research were asked to outline, from their experience, the extent followed by the nature of drug problems (in the region).

Looking at the prevalence issues (extent) the overwhelming view across the region is that drug availability and its use is increasing. It is very obvious to see for those that know what to look for in terms of drug paraphernalia, public intoxication etc. In the south east and east of the region, the findings suggest that drugs – of all varieties – are relatively easy to attain for those who know where to look and so on.

In terms of the nature of drug problems in the region, there were a number of clear trends evident in the consultations. As in other areas of the state and as noted earlier in the research, there has been a significant increase in the use of

cocaine. This is generally associated with recreational use and is linked to polydrug use (normally with the use of alcohol and cannabis). It is of note that many of the drug users did not of themselves mention cannabis which underlines the normalisation of this drug. Cocaine is seen to be used by a wide and diverse group starting in the late teens. Cocaine is generally more available in towns and particular in the urbanised part of the region more so than in rural areas. The group of persons who consume cocaine do not in general consume heroin.

However, this contrasts with heroin use. Heroin users report using cocaine in recent times including merging the two drugs for intravenous use, referred to often as 'speedballing'. The heroin users are in general in their twenties which contrasts with the wider age range of cocaine and cannabis users. There is a sense among the interviewees that heroin use is peer based and younger users are introduced to the drug by older peers, including siblings. In areas where there are clusters of heroin users, benzodiazepines are also available for sale on the street.

Ecstasy has decreased in popularity. Part of this is the replacement of this ecstasy by cocaine as the recreation 'drug of choice'.

Other drugs noted included magic mushrooms, herbal ecstasy and crack cocaine. In the case of crack cocaine, this seems to be more prevalent in the urban parts to the south and east of the region in close proximity to Dublin. The research suggests that crack is not yet freely available for sale in these communities as yet.

The final part of this set of questions examined with respondents the types of grouping using drugs and the main locations. For heroin, it is suggested that it is most prevalent in social housing areas and has become more prevalent over the last 3 to 5 years. It was felt that this was particularly the case in Dundalk and Drogheda. In towns such as Cavan, it is felt that heroin has begun to increase in prevalence in the last one to two years.

Alcohol use among adolescents and young teenagers was also mentioned throughout the interviews. This seems to be widespread throughout the region. Some rural towns have a higher concentration of heroin users than would be expected. This seems to be related to social networks over time being established between some residents in these areas with drug users in Dublin and migration of drug users to this setting.

In similarity to earlier findings, there is a considerable link between Dublin and the availability of drugs in towns on the east and south east of the region. A number of interviewees also suggested that those coming out of prison in Dublin who developed drug use problems have brought contacts with them on their release and some have become addicted while in prison in Dublin.

While a number of respondents noted the availability of heroin in Cavan and Monaghan, others suggested that they would have to travel to Ardee and Navan in order to buy heroin. This seems to underpin the social group or network structure of heroin and its use.

Areas noted in which cocaine could be bought included Slane, Dundalk, Drogheda and Navan. There was generally less cocaine for sale in the view of the respondents in Cavan/Monaghan than in these towns.

6.4 FACTORS CONTRIBUTING TO PROBLEM DRUG USE

This section explores what factors in the view of the respondents and based on their experiences contributes to problem drug use in the North East. What is particularly interesting about the findings was the general consensus among all the respondents around a range of issues, each of which give clear indicators for the focus of not only treatment interventions but also for activities with a prevention focus. The reasons why people develop drug problems are manifold and they are discussed in no order of prominence or importance below. In many ways, the causes listed below are by their nature interrelated and more than one factor can be present in an individual's experience.

The main points of consensus in the responses were the following

Perhaps the major factor noted in the research was peer and socialisation processes whereby young people (but not exclusively as is the case in more recent times with cocaine) first use drugs because others are. It effectively becomes an

option or routine in their shared life world. Socialisation can be through friends, acquaintances, the mass media and sub-cultures. It is also evident in the responses that the use of drugs by family members, parents and siblings, is also seen as a causal factor in problem drug use. This also includes lax attitudes to alcohol misuse and the overt consumption of prescription medications in the home. Moreover, the acceptance of drug use among certain social groups and at different ages almost makes some feel that drug use is a normal and acceptable part of social life. The life cycle approach was also mentioned in this regard whereby drug use is common among peers and social acquaintances at different life cycle periods such as adolescence and young adulthood.

Related to peer or socialisation processes, the responses also indicate that drug use is pleasurable, fun and a 'buzz'. It is not obvious that a pleasurable experience can lead to addiction and to more negative experiences as a result. In similarity, drug use is also seen as a rite of passage in which various forms of experimentation whether that be with fashions, views or drugs is commonplace include the use of drugs.

The responses also show a belief in the propensity of some people toward addiction. However, it is suggested that some people's drug use is due to psychological and biological factors which make it more likely for them to develop addictions than others.

Medical problems such as ADHD/ADH were also cited by some respondents. Added to this can be dual diagnosis whereby problem drug use may be closely associated in an individual's biography with depression and other forms of mental illness.

Many of the respondents suggested that they were unaware of the dangers of drug use when they first started to take drugs and they believed there to be little or no information available.

In addition, a number of the responses noted that loneliness, isolation and a sense of having limited respect from authority figures are all contributory factors. This suggests that low self worth and self confidence are contributory factors to drug use problems. Related to this is the sense among some that they do not have a stake in the society in which they live and that their future is bleak in terms of life chances. This therefore relates also to a lack of coping skills and this turning to drug use as a means 'to cope'.

This leads logically into another factor noted in the responses, that of social exclusion. A number of respondents suggested that marginalisation, isolation, lack of work and economic status, low educational attainment can all contribute to problem drug use.

In a not insignificant number of cases, drug use given its pleasurable and/or sedative effects, was a means to counteract negative personal emotions based on physical or psychological trauma, including a means to relax and overcome anxiety, family difficulties, domestic violence etc.

It is also suggested that lack early interventions and diversionary activities can fertilise the ground for drug use through boredom. Related to this, a number of views suggested that the deficiencies in aftercare support for this who had recovered from an early addiction phase to a drug free one can also be a causal factor in drug use especially where an individual is placed in the same social setting in which they were previously a drug user.

Finally, it is clear that there are neighbourhood or area affects in the causes of drug use also. These centre on the easy access to and availability of drugs in any given area following initial use. Thus following the first phases of drug use, addiction is made all the more easy given the general availability and visibility of drugs.

6.5 EXPERIENCES OF SERVICES

This topic examined four interrelated themes in respect of the experiences of those consulted here on current treatment services. The first looked at their knowledge of current treatment services. The second focused on what services respondents sought for drug problems, personally or for a family member. The third aspect explored the accessibility of services and what might improve access to such services in the future. The final area addressed the impact of treatment services.

The knowledge of the respondents of current treatment services was based on their personal experiences of problem drug use and how they might first have gone about accessing treatment or, in the case of family members, support. The services the respondents were most aware of were those provided across the region through the addiction services of the HSE. However, a significant number also noted residential units where they first sought help such as High Park, Drumcondra and Victory Outreach. Also a high proportion named various community and voluntary groups such as CDA, Crossroads, Turas, Homeless Aid etc. A number had initially sought help outside of the region. There was mixed views on the use of GPs to learn about treatment, some indicated that their GPs did not understand addiction, how to refer or where to go etc.

This leads into the next part of the question which looks at what services were sought. Generally, respondents looked to get information on what to do, what steps to take etc., for themselves or a family member. The type of services contacted included family support, providers of residential detoxification, solicitors, Gardai, nurses, social workers, mental health professionals and in some cases the interaction with treatment services where mandated by the courts. Again, a key trend in the responses was the way in which people felt that they were passed around from agency to agency on the basis that many services firstly did not see it as their role to respond and, secondly, were not for the most part aware of who to contact and who to refer to. Some respondents looked for services for different types of drugs, namely cocaine and cannabis, and found these hard to come by. A number of respondents recount being treated as a 'pariah' due to their addiction or the addiction of a member of their family. This particular issue was recounted in a wide number of the responses and mirrors previous findings.

The ways in which this groups of respondents, users and family members, learnt of treatment services is wide in scope and ranged from advertisements, public meetings, religious, teachers, social workers, courts, through to referrals and voluntary support groups. This covers a large minority of those interviewed and underlines the need for greater information dissemination and training on where to refer people for those that come in contact with members of the public as part of their occupational role. However, the majority of clients found out about drug treatment services through 'word of mouth', which is a key finding and has implications for how services can go about promoting themselves and ensuring that the message is accurate and comprehensive.

Above there are a number of criticisms of the lack of knowledge and of referral from various agencies to treatment provider services. The suggestions as to what would make treatment services themselves more accessible include the following:

- Train, inform others in the community providing services about where to receive support and treatment
- All GPs to know as of duty about local and wider treatment services
- Put in place packaged information in wider community information publications
- Ensure that services have time, courtesy and capacity to deal with queries

Finally, each of the consulted was asked what they felt were the impact of drug treatment services based on their knowledge and experiences. There were two general views on the impact of the services. The first was positive and stressed the HSE service was very positive once a drug user began receiving treatment (although there were a number of caveats mentioned which are touched on below). The second highlighted the positive work and experience of those consulted in working with voluntary groups. A number of respondents also were generally positive about the work of some of the GPs and counselling staff.

It is worth noting that in these responses - and those from earlier in the research - there is a sense that community/voluntary and statutory services are not co-ordinated and it is up to the clients to move between the two.

Notwithstanding this, a large number of mainly family members suggested that the addiction services have had limited impact. Thus it would appear that there are a range of perspectives at play here whereby those who receive treatment (mainly as part of the methadone programme) are positive, those who do not or have not participated on the methadone protocol are not positive especially where efforts were made to get support through this avenue and finally, some family members see the ongoing treatment of their child, sibling etc., as a failure of the treatment system in view of family members not becoming drug free.

The main areas identified, apart from the above, in which the respondents believed treatment services in the region had not worked well are the following:

- Confidentiality of individual clients in view of the open nature of methadone clinics
- The lack of ongoing support when tapering methadone prescription levels and when considering detoxification
- The lack of aftercare (including social reintegration and rehabilitative supports) following detoxification
- The provision of tailored care plan for clients based on their needs and experiences
- The time spent on waiting lists (4 to 6 months according to those interviewed) which a number of those interviewed felt led to further difficulties
- The treatment of service users by some pharmacists and the difficulties trying to live a 'normal life' (work, holidays etc.) while having to attend at the pharmacy daily.
- The lack of alternative or wider options for treatment

6.6 GAPS AND NEEDS IN TREATMENT SERVICES

In similarity to the previous chapter, this section examines the responses of the drug users and family members to what gaps they see in treatment services. In this section also, the views of the respondents on what would improve existing services are also set out as to the future needs in treatment services and other areas of support. However, in a manner like that in the previous chapter, many of responses to all three parts of this theme in the interviews provided roughly similar information. Thus, it is possible to list the main topics revealed in the feedback which should therefore be seen simultaneously as a gap in services, a need and an area therefore for improvement.

The following areas were the main areas of consensus as needs, gaps, and likely improvements in treatment services in the region:

- The provision of detoxification beds
- Availability of interventions for crisis situations be it for individual users and/or their families
- Factoring in dual diagnosis to current services
- Early interventions and reductions in waiting times
- Increased counselling for family members and an expansion of more comprehensive family support services
- Implementation of continuum of care approach for those in treatment based on individualised care plans across engagement, assessment, treatment, stabilisation, rehabilitation, social integration and ongoing aftercare stages
- Training for all GPs in addiction and what services are available. This includes training or reskilling for professionals in allied areas such as teachers, Gardai, social workers, nurses etc.
- Better provision of information on treatment services including about how treatment operates
- Greater linking of medical and psycho-social supports
- Screening for blood borne viral infections and health checks for those in treatment
- Greater emphasis on harm reduction approaches including but not exclusive to needle exchange
- Provision of ancillary supports such as in personal development, accommodation etc., alongside progression on a continuum of care
- Greater integration of services for those in treatment between statutory and community/voluntary service providers
- Central focus to be placed on poly drug use problems rather than opiates. This should include alcohol.
- Provision of treatment and intervention services for adolescents
- Increase in the resourcing of treatment services including numbers of GPs, pharmacists, counsellors, outreach and other staff
- Improved respect for service users as customers. The responses suggest that this might include providing service users with a greater say and more weight in their treatment processes and options
- Putting in place new methods of drug testing such as swabbing in order to move away from urinalysis
- More peer based support structures as part of treatment
- Greater emphasis on community based or more localised treatment provision to reduce the need to travel and therefore allow for more normality in the lives of service users including the possibility of employment, education and training

6.7 RELATED AND INDIRECT NEEDS TO TREATMENT

The penultimate section of this chapter recounts the feedback provided by respondents on what, if any, indirect or related needs might play a part responding to treatment for problems drug use. The findings reveal that in similarity to the previous chapter most respondents believe that treatment should be holistic in its approach. This therefore necessitates that the whole life experience of the individual client, including looking at the wide range of contributory

factors to their drug problems, become a part of their system of treatment. Many responses also cited the importance of involving the family in treatment, where this is possible, and also providing supports for families for whom a member has a problem related to drug use. Young people were also noted in the responses. In this connection, it is believed that drug treatment should look at youth culture and see how it can provide appropriate interventions. Other areas noted was the need for advocates for those in treatment around areas indirectly related to treatment such as accommodation difficulties. Finally, although the concept of the continuum of care has figured in the previous section – and indeed throughout the research findings – many of the drug users interviewed emphasised the need for aftercare under this heading. It is felt that aftercare is crucial to successful treatment, relapse prevention and that many drug users are inordinately anxious about coping with ‘life without drugs’ after spending often large proportions and in some cases all of their adult life as a drug user (illicit or as part of methadone maintenance treatment).

6.8 SUMMARY & CONCLUSIONS

In this chapter, the experiences and perception of those with drug problems and family members affected by drug use were recounted. The findings in this chapter therefore provide a realistic assessment of treatment issues and needs and moreover complement earlier findings with a more authentic depth from the service user’s perspective. The findings are therefore a crucial element in the needs assessment process.

In similarity to the findings in the previous chapter, this chapter reiterates the belief that drug problems in the region have increased in recent years. From the interviews, it is apparent that there are more people using drugs and drugs are more available.

The findings suggest that cocaine is particularly prevalent in the region and mirror the earlier findings that cocaine users are a socially diverse group. Cocaine is generally viewed as more prevalent in towns. Polydrug use is a feature of drug use and normally includes alcohol, cannabis and cocaine. In some case, heroin can be added to this mix. Heroin is seen as increasing but mainly in socially deprived urban areas, there is some evidence that heroin is more widely used in the rural and western part of the region in recent, when compared to previous, years. The findings again acknowledge the increasing use of alcohol among adolescents. One of the key findings is that impact of what might be termed the ‘Dublin effect’. This is where areas close to Dublin or which have had large numbers of migration from Dublin have developed a social network of sorts with Dublin. This has resulted in greater use and availability of drugs in these areas of the region than those without this ‘Dublin’ effect.

The findings outlined a range of factors identified as contributing to drug use. These interrelated factors include peer and socialisation processes, a culture of drug use, addictive personal attributes, lack of awareness of the negative consequences of drug use, experimentation and the pleasurable effects of drug use, low self worth and coping skills, physical and emotional trauma and self medication, and neighbourhood effects.

The views of those interviewed on treatment services noted that many felt that they were passed around by agency to group etc., when first looking to access services. The interviews recount some difficulties in finding out about services, where to go and who to contact. The key finding is that agencies and personnel contacted – priests, GPs, Garda, teachers, social workers etc. – did not know where to point those seeking help for drug problems.

The findings highlight an interesting trend: those who are most positive about treatment services in the region are those that have availed of them or are currently doing so, those who were less positive have had great difficulty in getting support and availing of treatment or who see the lack of progression as failure of treatment.

The main gaps/needs and in turn suggestions for future treatment services made in the chapter converged around the following:

- The provision of residential detoxification facilities
- The provision of crisis and early interventions
- Incorporating dual diagnosis
- Delivery of treatment based on a continuum of care
- Incorporating polydrug use to treatment including alcohol
- Greater integration of psycho/social and medical facets of treatment

- Provision of holistic, individualised care plan as part of treatment, including ancillary supports
- Focusing on adolescents
- Greater information on treatment services and training of key workers on treatment services
- Increased use of harm reduction approaches
- Increased peer, group and family counselling and related interventions
- Overall, resourcing of existing treatment services and improving the input and role of service users

7. CONCLUSIONS & RECOMMENDATIONS

7.1 INTRODUCTION

This chapter draws together the key findings made in the report and summarises these in the same order in which they appeared in the report. Before this, it is worth revisiting the key aims of the research in order to set the context for the findings and the conclusions that can be made.

The key questions set out for research were as follows:

- to assess the number and profile of drug users in the region
- to assess in-patient and out-patient drug treatment services
- to explore needs of drug treatment service users and their families
- to identify gaps in service provision
- to make recommendations for future service development and resources required

Each of these questions is answered in turn and this is followed by a final section outlining the recommendations that arise from this research.

7.2 CONCLUSIONS

The questions that were set out for the research are each dealt with in this section.

7.2.1 Number and profile of drug users in the region
The data on drug use and drug related problems is at best partial and at worst questionable in terms of their relationship with contemporary drug use trends. In the report, it was stated that in order to examine the prevalence of drug use and drug problems in a given region such as the North East, it is necessary to carry out a population survey of a representative sample of the population of the region. Since this level of survey is only carried out at national level, and is at any rate expensive and time consuming, it is often difficult to get comprehensive and timely data on drug use in a specific area or region. For this reason, a range of other sources are used however these relate different periods of time, may be therefore out of date, refer to different operation areas and use different definition etc. However, for the North East a number of these sources may not apply such as the data on drug related deaths and coroner's court data.

NDTRS shows that prior to 1998, people resident in the North East with drug problems received treatment outside of the region and mainly in the Dublin area. The number presenting for treatment for the region in 1996 was 46 and this rose by 2000, when treatment was available in the North East, to 264.

In 2000, according to NDTRS publications, that most of those who presented for treatment did so with problems related to cannabis, ecstasy or opiates. The trend of treatment of drug use in 2000 was generally in line with other health board areas, with the exception of the eastern region (Dublin).

The most up to date published NDTRS analysis for the region dates from 2004 and covers the periods 1998 to 2002. This shows that 1,135 people were treated for drug use over that period. It also shows that cannabis, opiates and ecstasy accounted for 92% of all treatment cases while cocaine was the issue in one percent of cases. Between 1998 and 2002, the overall incidence of drug use according to treatment demand (NDTRS) was 50.1 for every 100,000 persons.

It was also shown how the incidence of opiate use recorded in the region in the 1996 to 2000 period was 5 per 100,000 and that this rose dramatically in all four counties in the period 1998 to 2002. This was part of a wide trend seen in the east/north east of the country and ranged in the region at its highest rates per 100,000 of population in Cavan (10), Louth (10.3) and Meath (11.5).

When this same analysis is applied to the use of cannabis, this showed a dramatic increase in use between the five year periods of 1996-2000 and 1998-2002. At the county level, the highest measures for cannabis use are seen in Meath, (34/100,000 population) and Louth (42.5). Moreover, although the rate in Cavan was lower than the former counties, it registered a 157% increase in cannabis use between the two periods in question.

More contemporary raw figures supplied by the Central Treatment List show that there were, at the time of carrying out the research in 2007, 7 GPs and 52 pharmacies participating in the methadone maintenance scheme in the region. In mid 2007, they were treating between 144 and 154 patients. These patients are those whose main drug problem relates to opiate use and does not therefore include non opiate users, who as we have seen make up the majority of drug users.

In recognition of the limitations of treatment data, the research looked at the most recent prevalence survey which includes data on the North East for 2006/7. This survey showed that almost one in four people in the North East had used illicit drug at some point in their life. This is most acute in the 15-34 age group where the prevalence of lifetime drug use is one in three. 25% of those in this age group reported using cannabis at some point in their life, use of heroin is less than 1% overall and in the 15-34 age range; use of cocaine is 5.6% overall for the region 10% in the 15-34 age group. There was a 466% increase in the prevalence of cocaine use between 2002/3 and 2006/7. Cocaine use is the starkest finding in the previous data. In the context of factoring in poly drug use, it was revealed also that 9 out of 10 people in the region had consumed alcohol and that there was little difference in the trends for alcohol over age ranges.

What this prevalence data shows, when placed alongside the treatment data, is that the vast majority of drug users do not present for treatment. It implies at any time that there are multiples of drug users in the community for every drug user who seeks treatment.

Another source, Garda statistics on drug offences from 1999 to 2005 show that cannabis offences accounted for 78% of all drug offences in the region in 2005. This data also showed a general decrease in the number of ecstasy and other 'dance culture' drugs. Along with the upward trend in cannabis there was also a less obvious increasing trend in the number of cocaine related offences, highlighting the change over from ecstasy use to cocaine over the last number of years. Although this level of drug crime data is not available from 2006 on, the most recent national data from the CSO suggests that drug offences in general have increased with 2007 being one of the highest on record. This underlines again the general upward increase in drug use nationally, and in all likelihood, in the North East also.

This is the quantitative data and issues of prevalence were also put to stakeholders, drug users and affected family members as part of the research. These findings reveal that drug use and drug use problems are felt to have exasperated in recent years. It is also evident from the responses that the trend is one of increase which is also evident or least indicated in the hard prevalence data outlined above.

It is viewed as particularly acute in relative terms in areas of clustering of social housing in some of the region's larger towns. In terms of heroin, the suggestions coming out of the interviews point to ongoing problems that, while not at the same scale, drew parallels with the nature of heroin problems in Dublin in the past.

In terms of nature of problem drug use, the findings reveal that the main drugs used in the region is cocaine, cannabis, alcohol, heroin and prescription drugs - with a particular emphasis on the first three of these. In addition, the findings showed that in the use of cannabis has been 'normalised' in that it is considered a substance in the same manner as alcohol; heroin is mostly associated with more deprived areas and specific rural areas; cocaine is the recreational drug of choice with the widest user group in terms of social class, education and employment and is closely associated with consumption of alcohol; alcohol consumption is growing with worrying trends in use among under 18s; and finally, the nature of drug use is according to the findings one of poly drug use. In other words, many of the illicit drugs noted above are routinely taken in conjunction with the use of one or more other/secondary drugs.

The findings suggest that cocaine is particularly prevalent in the region and mirror the earlier findings that cocaine users are a socially diverse and wide group and this is supported by the most recent prevalence data. Cocaine is generally viewed as more prevalent in towns. Polydrug use is a feature of drug use and normally includes alcohol, cannabis and

cocaine. In some case, heroin can be added to this mix. Heroin is seen as increasing but mainly in social deprived urban areas, there is some evidence that heroin is more widely used in the rural and western part of the region in recent years. The findings again acknowledge the increasing use of alcohol among adolescents. One of the key findings is the impact of what might be termed the 'Dublin effect'. This is where areas close to Dublin or which have had large numbers of migration from Dublin have developed a social network of sorts with Dublin. This has resulted in greater use and availability of drugs in these areas of the region than those without this 'Dublin effect'.

The findings therefore establish there is an ongoing increase in drug use in the North East and is particularly stark in respect of cocaine. The key drugs of note are cannabis, cocaine, and alcohol, with stabilisation in the use of heroin/opiates over recent years.

7.2.2 Assessment in-patient and out-patient drug treatment services

There are a number of in-patient and out-patient drug treatment services available for illicit drug users, as opposed, to alcohol in the region. There appears to be some alcohol detoxification capacity in some acute hospitals or mental health facilities notably Monaghan General Hospital and St. Brigid's, Ardee. However, it was suggested that there may be up to two beds dedicated to alcohol and drug treatment in each acute hospital which would cover those located elsewhere in the region including Drogheda and Cavan.

In the research, a wide range of inpatient services were cited and the various links and referral systems to each or the experience of individuals trying to access in patient services was outlined. In the findings, there is a level of confusion about what is meant by inpatient treatment, detoxification, residential treatment and outpatient treatment. Regardless of this, it is clear that at present no inpatient or community based detoxification residential programme is currently available in the North East Region. This was very clear to all of those consulted and is the basis for the complex system of referrals to the above the stakeholders cited.

In terms of the capacity of existing outpatient services and inpatient services, the findings point to a good deal of diversity in the quality standards that can be used across the various treatment services. This relates to professional qualifications, standards of client care and experience in treatment. In addition, the approach of the various services was seen as differing also as to a focus on drug free, abstinence based treatment model, a religious/evangelical-Minnesota 12 step models and a stabilisation/harm reduction model.

The findings suggest that the capacity of the mainstream HSE services was limited by staffing levels, resources and the numbers of level 1 and more critically level II GPs as per the methadone protocol. It was suggested that in some counties – Cavan and Monaghan – a different approach to drug treatment is pursued (focusing on alcohol and illicit drugs) to that seen for instance in Meath and Louth. In the research, it was suggested that this leads to less of a focus on outreach in the former areas than in the latter which are based on community clinic settings. It was also noted that there are differences as to the linkage between HSE services and allied areas in the health service of relevance to addiction across and between different regions and settings.

The areas deemed in the research as positive aspects of treatment services include:

- Outreach services operated by the HSE addiction services
- The holistic approach adopted by organisations such as CDA
- The linkages between mental health and addiction services in Cavan and Monaghan allowing for a focus on dual diagnosis.
- The status of those availing of the methadone maintenance programme alongside psycho-social supports provided by HSE counsellors.

The areas in which treatment services were seen to not have not worked well centred on the underdevelopment of the services when compared with best practice and other areas; the absence of thorough continuum of care policy at the heart of treatment; limited networking and collaboration (formal and informal) between services including in particular community/voluntary and statutory/mainstream services; not having a clear poly drug use focus; and the ongoing waiting lists and the difficulties this causes for the motivation and harm reduction among problem drug users

The reasons put forward for why treatment services were not seen to have worked as well revolved around: lack of leadership; lack of regional thinking; clinical boundaries, agendas and interests including those of GPs; limited integration with alcohol issues in some areas; low priority of addiction services within health services; statutory – community/voluntary mistrust; transport and access; service, and planning and referral interagency formal protocols

The findings also suggest that many felt that they were passed around by agency to group to agency etc., when first looking to access treatment services. The interviews recount some difficulties in finding out about services, where to go and who to contact. The key finding is that agencies and personnel contacted – GPs, Garda, teachers, social workers etc. – did not know where to point those seeking help for drug problems.

The findings highlight an interesting trend: those who are most positive about treatment services in the region are those that have availed of them or are currently doing so, those who were less positive have had great difficulty in getting support and availing of treatment or who see the lack of progression as failure of treatment.

In terms of the impact of current treatment services, the finding suggests that it was difficult to gauge the impact of the services in the absence of data, information about the service and key performance indicators or targets.

7.1.2.3 Needs of drug treatment service users and their families/ Gaps in service provision The research findings suggest that they are one in the same thing from the perspective of services users, their families and other families affected by problem drug use.

When looking at needs of users and then gaps in treatment services, the first thing that is evident from the findings is that many of the issues cannot be viewed a mutual exclusive or stand alone. The nature of the findings were such that many of the issues raised as gaps or needs in respect treatment services in the region are interrelated, which in turn suggest filling those gaps requires an equally integrated response.

Two gaps featured significantly in the findings. The first can be referred to as the continuum of care. This normally means that each service users is assessed based on their situation and needs and are placed on a tailored care path plan which responds to the nature of their individual drug problems and related factors. This form of care, the continuum, requires a system of progression from engagement, assessment, treatment, through to rehabilitation, social integration and aftercare. Of course, the lines between these phases are not always evident but this gives a sense of the phases suggested as a continuum of care. It could also be added here that a perceived gap in treatment is the lack of service user input to treatment regimes and for some, a perception that problem drug users are not well treated and respected in some current treatment settings in the region.

The second central finding here was the gap around inpatient or residential treatment and detoxification availability in the region. This requires regionally based detoxification/residential treatment beds and related step down facilities in the community such as ‘halfway houses’ etc. Again, such facilities would be part of a continuum of care for individual service users based on their respective needs.

Harm reduction approaches were also seen as a gap. This takes into account needle exchange, the provision of information, education on safe drug use, health promotion and easy access to low threshold treatment should a particular user be motivated to access treatment. There was also a gap evident in respect of outreach work with drug users, home visits and ‘on street’ engagement. However, there was a perceived polarisation between harm reduction and abstinence based approaches to drug treatment.

In keeping with the notion of the continuum of care and tailored care planning in drug treatment, it was also evident from the findings that an accompanying gap in services is the availability of what can be termed as ancillary or parallel supports. This refers to the supports and interventions which are available alongside each phase of progression along the continuum. This might include personal development, literacy, education/training, accommodation, family support interventions, mediation, employment etc.

The findings also suggest there are gaps in the integration of services among agencies for drug users. This is most apparent in the case of formal collaboration arrangements and multiagency working. However, related to this was the need for understandings and respect between statutory services, specifically HSE and community and voluntary services. There is a sense of confusion on each side about what it is that the others do, what the nature of the relationship should be and what role the Task Force might or should play therein.

There was also a gap in services raised in respect of GPs. Here respondents felt firstly that there were not enough level II GPs in the region, that support for the current GPs was not at the level it ought to be and that GPs, paradoxically, should be vetted to ensure they have the interests of drug users in mind. An issue was also raised about the 'power' that GPs and clinical specialists wield in treatment services.

This in turn led therefore into needs in respect of the medical and psycho-social treatment modalities. The findings suggest that treatment options available and supported for the most part focus on the medical aspect of treatment associated with methadone maintenance. The suggestion coming from the research is that there ought to be more options in drug treatment which incorporated medical, therapeutic, social, and alternative modalities rather than focus on medical means alone.

Another gap/need identified was around treatment services for those under 18, and then those under 16 in the form of early interventions along psycho-social and medical lines. The findings also note the need for specialist treatment regimes for cocaine in view of the increase in use of this drug and the unlikelihood that users of this drug, given their social composition and stereotypes associated with existing drug treatment as opiate treatment solely, would access existing treatment services as currently structured and located.

The final major gap/need noted was the need to focus on a wider definition of problem drug use viewing addiction in broader terms than drugs problems which in turn looks at polydrug use rather than is as the present and the legacy case focusing on opiates alone.

7.3 RECOMMENDATIONS

This final part of the report outlines a number of areas for recommended future actions and attentions in order to respond to the findings of the needs analysis of treatment services in the North East. While the recommendations are set out as distinct entities, they should however be viewed as an integrated set of components all of which contribute to improvement in treatment services/responses in the region in keeping with the findings of this needs analysis. For example, while one recommendation refers to the need for treatment of drug problems to be part of a wider continuum of care, it follows that key elements of this would be the putting in place of a holistic approach, addressing ancillary or related issues such as accommodation, personal issues etc., and having some system of tracking of progress along a continuum of care for individual clients of treatment services. These latter elements are set down below as separate recommendations but are clearly related elements of the introduction of a continuum of care approach. They are set out separately below for emphasises purposes and to draw out different tasks which arise out of the research toward enhancing drug treatment in the region.

1. The provision of residential detoxification facilities

One of the clearest findings in the research is the lack of detoxification facilities, services for drug users in the North East region. The research points to a complicated web of referrals to a range of different facilities, waiting lists, different methodologies etc, for those wishing to avail of drug detoxification treatment. The research has clearly demonstrated the expressed need for such facilities to be located in the North East region.

However, as noted in the body of the report, the provision of detoxification facilities is by no means straightforward. There are obviously economic problems with such provision in terms of operational funding, staff resources, capital funding etc. There are perhaps also issues in respect of clinical governance, admissions policies, and suitability protocols

and so forth. All of these issues would ideally need to be addressed. Furthermore, in practicable terms, it is not perhaps realistic for such a facility to be provided in a specifically developed location in terms of a new build given current funding challenges. However, the decisions on how, where, who etc., have to be assessed in terms of feasibility to arrive at the practicable solution.

Nonetheless, the research clearly points to the need for such drug treatment detoxification facilities and this is therefore a key recommendation arising from the treatment needs analysis research.

2. Information and promotion of services

The research establishes that there is a degree of confusion, misinformation and in some case, no information on what treatment options are available. This opens up therefore the need for a significant communication exercise to be undertaken across the region with a view to outlining the options and details of the treatment.

In this sense, it will be important to identify a range of key information nodes which are critical to information provision on treatment services. In other words, information about treatment should not only be made available through services to the public but to the range of services and agencies that come in contact indirectly and directly with those with drug problems. This includes all doctors, nurses, social workers, gardai etc. Thus it will be important to use both formal methods but also informal methods such as word of mouth.

In addition, important elements of this will be newsletters, advertisements, flyers, emails, website links, information brochures, signage, seminars, training of staff and professionals, development of information sharing, public and organisational campaigns etc.

3. Continuum of care and tailored case management

Based on the findings of this research, it is recommended that a core part of the future treatment work will be to move to a model of care that emphasises progress and continuity of support. This is often referred to as the 'continuum of care'. In this sense, it is expected that clients will pass through a range of supports, over time, in a manner that suits their recovery needs, and ultimately if appropriate toward a drug free status. This will require that each support or project accessed has a range of options for clients to move to the next stage beyond the project/support itself. The key aspect is that there is a progression path which is available as the client passes through a range of phases toward hopefully a drug free status. The packages of supports available should revolve around stabilisation, treatment, rehabilitation and aftercare. In practical terms, this will require the development of projects and/or services at each of these levels or indeed the existence of the range of supports within one broader treatment system. This will also necessitate the introduction of some form of tracking to monitor the progression and movement of clients in order to monitor and improve a continuum of care model.

Beyond the development of a continuum of care, it is recognised from the research that alongside this approach it is necessary to have a case management approach, whereby clients have a contact point or key worker who they can work with over the course of their progression. This is to avoid the moving of clients from service, to agency, to service etc., and to move the focus of treatment over the course of the continuum away from the interests of the service provider toward the interests of the client.

4. Collaboration, multiagency responses including open dialogue and consultation between statutory and community/voluntary services

The effective collaboration of the statutory, community and other interests is an essential part of responding to the expressed treatment needs of those with drug problems. This is also true based on the findings in the North East. As is obvious, many of these issues are outside of the direct control of the task force, individual organisations etc., but they have served to hinder effective collective responses. For this reason, it is recommended that formal efforts are made to

develop lines of communication and networking between the various bodies - community, voluntary and statutory – involved in the treatment of those with drug problems in the region.

It is suggested therefore that dialogues be facilitated whereby key agencies might develop frameworks and protocols around collaboration, sharing and interagency working. This of particular need in the context of the continuum of care and case management models of work. It might also allow for greater synergies to be developed with the HSE in the context of the imminent roll out of primary care teams and networks under the transformation programme for primary continuing and community care.

5. Integrated, holistic treatment options and services

This is less so a practical recommendation than a suggestion on a principal of working when it comes to treatment services. The findings show how there is a need for treatment services to respond to the whole life circumstances of clients and their drug problems. In other words, this requires treatment to account for the direct and indirect circumstances of drug problems for individuals. For instance, the research has show how there is a need to widen the definition and understanding of treatment beyond what could be called the medical modality. This recommendation should logically involve a greater integration of psycho/social and medical facets of treatment. This will necessitate therefore the development of interagency protocols around the various services and supports the clients come into contact with. Again, this is in keeping with the notion of a continuum of care.

6. Provision of ancillary or parallel supports

Alongside the continuum of care notion as part of treatment, it is necessary to provide a holistic set of supports and services. The focus of this action will therefore be to develop programmes of support for those and their families who are in treatment under the continuum of care model. At each juncture, it is envisaged that a parallel or ancillary set of supports are provided in order to deal with all aspects of the client's circumstances. These supports will include education, training, social skills, counselling etc., as appropriate to their needs and will warrant the development appropriate protocols around referral and ancillary provision at the time of treatment, rehabilitation and/or aftercare.

7. Overhaul/restructuring of HSE addiction services including increases in resourcing including staffing of HSE services

In the light of the research's consideration of HSE addiction services, and regardless of the legacy issues with the services across the four counties, it is clear that the service is confusing to the clients and does not provide coherent services across the region. Although, it is recognised that changes are afoot in the service, that the HSE is undergoing change, nevertheless, there is a clear need to revisit the overall HSE treatment service from a regional perspective to ensure that the service is optimised in terms of the level and scope of its delivery. This of course is also dependent on the best use of resources provided to the service and this in turn must recognise that the services is under resourced to carry out its present work load not to mention adapt to change and increased demand. The thinking behind this suggested restructuring and overhaul is to ensure that the maximum treatment service, within current limitations, is provided regardless of a client's location in the region and is at times in the interests of the client rather than the service.

8. Monitoring, learning and tracking systems

As a component of the continuum of care model of treatment, it is suggested that there be the introduction of systems that allow the monitoring of progress in terms of case management and thus allow for the drawing out of key learning with a view toward enhancing and improving relevant services and approaches. A key part of this approach is that it not only validates the work that is being done, it also allows for the projects and organisations to identify what works and does not work in their own work. It will provide critical information also for review and forward planning on a regional basis. The development of such systems should not be onerous and should look to successful models in use elsewhere of relevance of responses to problem drug use.

9. User involvement and user led services including the development of complaints procedures

Before looking at this issue, it should be noted there are complaints procedures in place within organisations including the HSE who provide treatment. However, it is not clear to what extent these are client centred, are proactive in communicating rights to clients, cover all service providers including GPs, are accessible and so on. Thus this recommendation is not based on the principle of putting in place complaints procedures but addressing the openness, transparency and accessibility of these services for problem drug users given their life circumstances and personal situation.

Thus the recommendation here is to develop a system or linked systems of complaint procedures for drugs users that are fair, open, easy to access and understand, widely promoted and effective in the region. This system should seek to cover all relevant service providers who are involved in the provision of treatment along the continuum of care and this would obviously include GPs, HSE and community/voluntary providers.

10. Out of hours services

The research points to the need for drug treatment services to be available out of hours. The consultees point out that most of the existing treatment services operate on traditional business hours, Monday to Friday. The research makes clear in expressed needs terms, that drug problems as expected do not necessarily fall easily into the times in which services are open. Thus, and especially in the context of crisis situations, there is a need for there to be some form of around the clock or at least unsocial hours treatment services in the region. This could be organised on a 'round robin' basis following consultations and agreement to protocols between the various treatment service providers. Issues of location and access would also have to be factored into this thinking.

11. Improvement in the location and appropriateness of premises/treatment facilities

The research has shown how staff, other service providers, problem drug users and clients have in significant numbers questioned the appropriateness and/or location of some of the facilities for treatment in the region. This includes around their size, geographic location, privacy etc. On this basis, it is recommended that current facilities are assessed for their appropriateness and a set of guidelines developed to set standards and direct future location and choice of treatment facilities in the region.

12. Incorporating polydrug use to treatment including alcohol

The research confirms that poly drug use is the normal manner in which drugs are used by a large proportion of drug users. In light of this, it is proposed that treatment approaches should look to respond to poly drug use including alcohol. This will require a shift in existing approaches that have to date mainly focused on opiate related problems. The shift will absorb existing work on opiate addiction to widen so as to include cocaine, cannabis other drugs and alcohol. This will require re-skilling, training, application of new models and resources for this approach. It is recognised that current treatment services have begun to focus on more than opiates in response to the needs of this clients. This is a good foundation from which to begin this process and this recommendation is concerned with formalising this approach.

13. Focus on harm reduction approaches including outreach

It was revealed in the body of the research that harm reduction approaches were seen as a gap in current treatment services. On this basis, it is suggested therefore that greater emphasis is placed on harm reduction as part of treatment responses across the region. This is based on a wide definition of treatment, outlined in the opening sections of the report, and would therefore take into account needle exchange, the provision of information, education on safe drug use, health promotion and easy access to low threshold treatment, outreach work including home visits and 'on street' engagement. As noted in the findings, it will be important to straddle ideological perspectives on harm reduction to include abstinence based approaches and tapering use harm reduction so as to accommodate to the differing needs of individual problem drug users rather than organisations, as they case may be.

14. The provision of crisis and early interventions

The analysis has shown that there is a need for crisis and early interventions. This relates to providing quick access to treatment (or at least assessment and engagement) for drug users (and their families) where a crisis has occurred or the specific drug user has reached a critical mass point in terms of motivation to seek help. The idea of effective intervention at this point is to reduce the harm caused by this motivation point to be lost and thus the chances of additional harm through ongoing drug use while placed on waiting lists. It is also to limit the anguish and stress caused to family members who have to navigate the complex, often humiliating process of first seeking treatment support for loved ones.

15. Focusing on adolescents

The research suggests that problem drug use does not isolate itself to those over 18. Indeed, the anecdotal evidence and survey research presented here reveals that young people consume alcohol and cannabis. However, it was also shown how there is dearth of treatment services in the region for those under 18 (and in some cases under 16) when it comes to addiction. It is recommended that this area be reviewed and supports be developed so as to respond to this growing area of drug problems in the region. The upshot of this recommendation is therefore to reduce further harm as young people's drug use develops further into their early adulthood and further.

References

- An Garda Síochána (1999-2005)** Annual Report of the An Garda Síochána. Dublin: Garda Headquarters.
- Byrne, R. (2001)** Opiate-related Deaths Investigated by Dublin City and County Coroners 1998 to 2002. Dublin: University of Dublin Addiction Research Centre.
- Central Statistics Office (2004)** Small Area Population Statistics Series, Census 2002. Dublin: CSO
- Central Statistics Office (2007)** Small Area Population Statistics Series, Census 2002. Dublin: CSO.
- Cox, G (2003)** Approaches to Estimating Drug Prevalence in Ireland. Dublin: Government Publications (National Committee on Drugs)
- Commiskey, C. & Cox, G. (2007)** Research Outcome Study in Ireland: Evaluating Drug Treatment Effectiveness 2006-2007 Baseline Data Report. Dublin: NACD
- Contemporary Drug Abuse Treatment** A Review of the Evidence Base 2002
- Department of Community, Rural & Gaeltacht Affairs (2005)** Mid Term Review of the National Drugs Strategy 2001-2008, Report of the Steering Group. Dublin: Government Publications.
- Department of Community, Rural & Gaeltacht Affairs (2005)** National Drugs Strategy, Progress Report 2001-2004. Dublin: Government Publications.
- Drug Treatment Centre Board (2006)** Central Drug Treatment List, Regional Figures. Correspondence, autumn 2006.
- European Monitoring Centre for Drugs and Drug Addiction (2002)** Classifications of drug treatment and social reintegration and their availability in EU Member States plus Norway: FINAL REPORT, Lisbon: EMCDDA
- Government of Ireland (1996)** First Report of the Ministerial Task Force to Reduce the Demand for Drugs. Dublin: Stationery Office.
- Government of Ireland (1997)** Second Report of the Ministerial Task Force to Reduce the Demand for Drugs. Dublin: Stationery Office.
- Government of Ireland (2001)** Building on Experience, National Drugs Strategy 2001-2008. Dublin: Government Publications.
- Haase, T., and Pratschke (2005)** Deprivation and its Spatial Articulation in the Republic of Ireland, New Measures of Deprivation based on the Census of Population, 1991, 1996 and 2002. Dublin: Pobal.
- Kelly, F. Long, J & Lynn, E. (2005)** Trends in treated problem drug use in the HSE Eastern Region, 1998-2002.
- Kelly, A., Carvalho, M, & Teljeur, C., (2004)** Prevalence of Opiate Use in Ireland 2000-2001, A 3 Source Capture-recapture Study. Dublin: Government Publications (National Advisory Committee on Drugs)
- Long, J., Lynn, E. and Keating J (2005)** Drug-related deaths in Ireland, 1990-2002. Overview 1. Dublin: Health Research Board.

NACD & DAIRU (2005) Drug Use in Ireland and Northern Ireland, First Results (Revised) from the 2002/3 Drugs Prevalence Survey Bulletin 1. Dublin: Government Publications (National Advisory Committee on Drugs and Alcohol Information and Research Unit (NI))

NACD & DAIRU (2008) Drug Use in Ireland and Northern Ireland, First Results from the 2006/7 Drugs Prevalence Survey Bulletin 1. Dublin: Government Publications (National Advisory Committee on Drugs and Alcohol Information and Research Unit (NI))

NACD/NDST (2006) An Overview of Cocaine Use in Ireland II. Dublin: Government Publications

National Treatment Agency for Substance Misuse (UK) (2002) Models of Care, London: NTA

National Drug Treatment Report System (2004) Statistical Bulletin 1997/1998. Dublin: Health Research Board.

Raistrick, D., Heather, N. & Godfrey, C. (2006) Review of the effectiveness of treatment for alcohol problems, London: National Treatment Agency for Substance Misuse

United Nations/European Monitoring Centre for Drugs and Drug Addiction (2006) UN Office on Drug & Crime, New York: United Nations

United Nations Office for Drugs and Crime (1999) Demand Reduction: A Glossary of Terms, New York: UN

United Nations Office for Drugs and Crime (2003) Drug Abuse Treatment and Rehabilitation Planning and Implementation Guide, New York: United Nations.

Watters, N., & Byrne, D (2004) The Role of Family Support Services in Drug Prevention, Dublin: Government Publications (National Advisory Committee on Drugs)

World Health Organisation (1998) Expert Committee on Drug Dependence, Technical Report Series No. 873, Geneva: WHO

www.pobal.ie/live/dep/1002.html

Appendix 1

NORTH EASTERN REGIONAL DRUGS TASK FORCE

Draft theme sheet to guide semi-structured interviews

Families and Drug Users

Preamble: *description and aims of the research, role of the researchers, independence and confidentiality, next stage in the research.*

1. Where do you live and what is your relationship to drugs and/or drug related problems?
2. What in your experience is the nature and extent of (problem) drug use in the areas you are familiar with? What groupings, areas etc, are most affected and why?
3. From your experience, what factors contribute to people taking drugs and what is the impact of drugs in your experience?
4. As far as you know, what services, in patient and out patient, are currently available for treatment of problem drug use? What services do they provide?
5. What services or supports have you/family members used /looked for, to control or overcome drug use? (GP, Counselling, other treatment, community based service examples)
6. How did you find out about these services? What do they do? What would make them more accessible/available?
7. In your opinion, what has the impact of treatment services been, what has worked well and what has not and why?
8. What are the gaps in the treatment services?
9. For those availing of supports/local treatment services, what would improve existing services?
10. What is needed in terms of drug treatment in the region, what additional supports are required locally?
11. Are there further related and indirect needs that should also be considered as part of responding to treatment needs, including related problems such as mental illness, young people and adolescents and social exclusion?

Appendix 2

NORTH EASTERN REGIONAL DRUGS TASK FORCE

Draft theme sheet to guide semi-structured interviews

NERDTF Stakeholder/Addiction Service interviews

Preamble: *description and aims of the research, role of the researchers, independence and confidentiality, next stage in the research.*

12. Please describe your role in the task force, the perspective/viewpoint you bring to it etc?
13. What in your experience is the nature and extent of problem drug use in the catchment of the TF or the areas you are familiar with? What groupings, areas etc, are most affected?
14. What services, in patient and out patient, are currently available for treatment of problem drug use in the catchment? Where are they located, what services do they provide and what is their capacity etc?
15. What has the impact of these services been to date, what has worked well and what has not and why?
16. What are the gaps in the services, broad and specific?
17. What is needed in terms of drug treatment in the region?
18. What are the barriers and enablers for responding to the drug treatment needs of the region in your experience?
19. What suggestions have you for the future of drug treatment in the region?
20. How and where could new treatment options be established and what enhancements could be made to existing services to better respond to the gaps in treatment identified?
21. Are there further related and indirect needs that should also be considered as part of responding to treatment needs, including in respect of dual diagnosis, young people and adolescents and social exclusion?
22. What structures, organisational or administrative changes are required, if any?
23. What suggestions have you for other organisations and people to be consulted as part of this research?