



PREVENTION

Research

Supply Reduction

National Drugs Strategy (*interim*)

2009-2016

Department of Community, Rural and Gaeltacht Affairs

Treatment

Rehabilitation

PN.A7/0508

Department of Community, Rural and Gaeltacht Affairs

An Roinn Gnóthaí Pobail, Tuaithe agus Gaeltachta 2009

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FOREWORD BY AN TAOISEACH

Problem drug use continues to be one of the most significant challenges facing our country. It undermines the potential of the person involved, devastating the lives of families and causing huge problems for local communities.

Much has changed since the first comprehensive National Drugs Strategy was put in place in 2001. At that time the emphasis was on the heroin problem in Dublin and it is heartening that much has been achieved in helping to tackle this problem. However, reflecting the situation generally in EU countries and beyond, problem drug use has spread to other areas and the range of drugs available has increased. The challenge involved is complicated by the fact that drug use can be linked to circumstances of social exclusion as well as to circumstances of economic prosperity.

It is against this background that I welcome this new National Drugs Strategy for 2009 - 2016 prepared by John Curran, T.D., Minister of State, which has been developed in partnership with a wide range of Government Departments, Agencies, Community and Voluntary interests.

Real partnership has been very evident across the initiatives of the National Drugs Strategy both at national level and at local level, especially through the work of the Drugs Task Forces. I pay tribute to the continued efforts of those working in, and supporting, drug projects in local communities and acknowledge the huge contribution made by the community and voluntary sectors in this work. I note that this aspect of the Strategy will be retained and developed over the next eight years.

I look forward to a renewed emphasis on prevention in the Strategy. It is very important that the number of people who decide to experiment with drugs is reduced. Such experimentation can lead to significant problems for many. When people develop problems, we must address their treatment needs effectively, with joined - up inter - agency working and with an emphasis on successful rehabilitative outcomes.

At a time of scarce resources, we all recognise the need to secure the maximum impact from the resources we invest through the National Drugs Strategy. The achievement of best value for money is to the ultimate benefit of individual problem drug users, their families and communities.

Finally, I also welcome the recent decision by Government to develop a National Substance Misuse Strategy that will combine a comprehensive response to alcohol issues with the provisions of the National Drugs Strategy.

Brian Cowen, T.D.

A handwritten signature in black ink, appearing to read 'Brian Cowen', written in a cursive style.

Taoiseach

FOREWORD BY MINISTER OF STATE

On my appointment as Minister of State with responsibility for the National Drugs Strategy in May 2008, I immediately engaged in the consultation process in relation to a new Drugs Strategy. In many ways it was a good time to become directly involved as plans for the next 8 years were being mapped out.

If I needed any confirmation of the extent of the drugs problem, the consultation process provided it. While the progress made under the 2001 - 2008 Strategy was widely praised, and the partnership approach was seen as beneficial, it is clear that the drug problem has changed in the intervening period. The significant contribution made to the Strategy by the community and voluntary sectors is also clear and I intend to build upon this for the future. The original Strategy grew out of the heroin problem in Dublin. We now need a Strategy that is truly national and that is capable of dealing with a variety of drugs, often mixed by polydrug users.

In the new Strategy the successful emphasis on a partnership approach will be renewed. I have decided that we will retain the 5 pillars of the Strategy - supply reduction, prevention, treatment, rehabilitation and research - as these have served us well and still encompass the areas that need to be addressed. This will also facilitate the dovetailing of the Strategy with the provisions of the EU Drugs Action Plan 2009 - 2012.

If we could achieve more in regard to prevention, I believe that the impact on the overall problem would be greatly enhanced. We will continue to bring the prevention message to the general public, especially young people and their parents, while also endeavouring to target those who are at particular risk. Supply reduction measures will incorporate international co-operation, an emphasis on targeting criminal networks and encouraging community involvement. Meanwhile, the aim is to further develop treatment and rehabilitation services, with an emphasis on an appropriate mix of drug-free and harm reduction services, ranging from low key interventions to specialist expertise across the sectors. Drugs research will address the information needs of Government and the provision of information to national and international agencies.

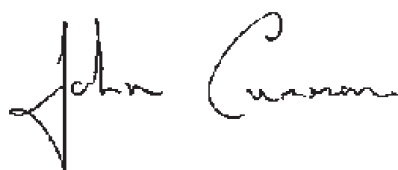
Across all pillars we will maintain the focus on individuals, their families and communities. I feel that it is vital that we support the families of problem drug users and, also, that we encourage their involvement on the rehabilitative effort. In relation to the problem drug users themselves, I think that we must always endeavour to empower people to access the social, economic and cultural benefits of life in line with their needs and aspirations.

I would like to thank all the Government Departments, statutory agencies, sectoral representatives and organisations, focus groups and individuals for their time and effort in putting forward their ideas and views on how best to address the drugs problem in Ireland. Continuation of this partnership approach is vital to achieve the implementation of the actions of the Strategy and I will continue to facilitate this.

I also want to thank the Steering Group, chaired by Ms. Kathleen Stack, who worked tirelessly in developing proposals and making recommendations to me on the new Strategy. The input of the staff of the Drugs Strategy Unit of the Department of Community, Rural and Gaeltacht Affairs, the National Drugs Strategy Team and all Drugs Task Forces across the country is also greatly appreciated.

Tackling the drugs problem in Ireland is an onerous task but I am determined that, working together and building on the progress already achieved, we will make great strides forward over the coming years.

John Curran, T.D.

A handwritten signature in black ink, reading 'John Curran'. The signature is written in a cursive style with a large initial 'J' and a prominent flourish at the end.

Minister of State with responsibility for the National Drugs Strategy

ACKNOWLEDGEMENTS

I want to gratefully acknowledge the input of members of the Steering Group to the production of this Report which would not have been possible without the considerable time, energy and effort that they gave to it over the past 18 months. Members of the Group provided a wide variety of perspectives and insights into a range of complex issues associated with problem drug use, all of which were very important in finalising the proposals in the Report.

I also want to acknowledge the input of the many Departments, organisations and individuals who made submissions during the consultation process in 2008. The work and advice provided by PA Consulting is also acknowledged.

Finally, I would like to sincerely thank the staff of the Drugs Strategy Unit – Michael Conroy, Eddie Arthurs and Marie McBride – who ably supported the work of the Steering Group and ensured that it was well served at all times. A particular word of thanks to our secretary – Linda O'Rourke – for her work, patience and organisational skills over the past year and a half.

Kathleen Stack

Chairperson

June 2009

EXECUTIVE SUMMARY

In late 2007, a review of the National Drugs Strategy 2001–2008 got underway. The overall objective of the review was to examine the progress and impact made under the current Strategy and to make recommendations for the period 2009–2016, which the new Strategy will cover. A Steering Group, chaired by the Department of Community, Rural and Gaeltacht Affairs, managed and oversaw the process.

An extensive consultation process was undertaken as part of the review to give individuals and groups an opportunity to outline their views on the effectiveness of the current policy and what the priorities for the new Strategy should be. An overview of the issues raised under the different areas – which the Steering Group had regard to in their deliberations - is outlined in the various chapters.

A key finding from the review is that the current approach to tackling problem drug use in Ireland – which has developed around the five pillars of supply reduction, prevention, treatment, rehabilitation and research – continues to be relevant and appropriate. The proposals and actions under the new Strategy, therefore, are based around the existing pillar structure.

The Steering Group also had regard to the current nature and scale of the drug problem in Ireland, which has undergone some notable changes over the lifetime of the current Strategy. The primary focus when the current policy was drawn up in 2001 was on the opiate problem, primarily in Dublin. While the prevalence of heroin has ameliorated to an extent in the Dublin area, this has been offset to a degree by its wider dispersal around the country. In addition, there is now widespread public concern regarding the misuse of cocaine, particularly when combined with other illegal substances and alcohol.

Widespread public concern was also expressed during the consultation process about the problem use of alcohol – both as a stand - alone public health issue and in association with illicit drugs. On 31st March 2009, the Government approved the development of a combined National Substance Misuse Strategy to cover both alcohol and drugs. This Report is, therefore, an interim Strategy pending the development of the combined Strategy. This is due to be developed by the end of 2010 and will incorporate the material in this Report, which is the agreed drugs element of it.

As part of its terms of reference, the Steering Group also looked at the effectiveness of the structures and co - ordination mechanisms supporting the current Strategy. To facilitate greater coherence in policy - making and service delivery, the establishment of a dedicated Ministerial Office for Drugs is being recommended, the details of which are outlined in chapter 6.

NATIONAL DRUGS STRATEGY 2009 - 2016

The conclusions and priorities identified by the Steering Group are set out in chapters 1–6 of this Report. In light of this analysis, the Steering Group has identified a series of objectives and key performance indicators across the five pillars of supply reduction, prevention, treatment, rehabilitation and research.

Allied to this, the Steering Group has developed 63 actions that are designed to drive the implementation of the new Strategy. A number of the actions also relate to the co-ordination structures, in particular, to the establishment of an Office of the Minister for Drugs.

The 63 individual actions are set out in detail in chapter 7.

Implementation of the actions will be a matter for the Departments and agencies involved in the delivery of drugs policy. Their implementation will be overseen by the Office of the Minister for Drugs, supported by the Oversight Forum on Drugs, as appropriate.

Departments and agencies will also prepare a report by the end of 2009 detailing how each of their actions will be implemented with indicative timelines.

OVERALL STRATEGIC OBJECTIVE

The *overall strategic objective* for the National Drugs Strategy 2009–2016 is:

To continue to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research.

OVERALL STRATEGIC AIMS

The following are the *overall strategic aims* of the Strategy:

- To create a safer society through the reduction of the supply and availability of drugs for illicit use;
- To minimise problem drug use throughout society;
- To provide appropriate and timely substance treatment and rehabilitation services (including harm reduction services) tailored to individual needs;
- To ensure the availability of accurate, timely, relevant and comparable data on the extent and nature of problem substance use in Ireland; and
- To have in place an efficient and effective framework for implementing the National Substance Misuse Strategy 2009 - 2016.

OBJECTIVES AND KEY PERFORMANCE INDICATORS

SUPPLY REDUCTION

Objectives

- To significantly reduce the volume of illicit drugs available in Ireland;
- To prevent the emergence of new markets and the expansion of existing markets for illicit drugs;
- To disrupt the activities of organised criminal networks involved in the illicit drugs trade in Ireland and internationally and to undermine the structures supporting such networks;
- To target the income generated through illicit drug trafficking and the wealth generated by individuals involved in the illicit drugs trade; and
- To tackle and reduce community drug problems through a co-ordinated, inter-agency approach.

Key Performance Indicators

- Increase of 25% in the number of supply detection cases by 2016, based on 2008 figures;
- Increase of 25% in the volume of drugs seized that are considered to be intended for the Irish market by 2016, based on 2008 figures; and
- Twenty Local Policing Fora established and operating by 2012.

PREVENTION

Objectives

- To develop a greater understanding of the dangers of problem drug/alcohol use among the general population;
- To promote healthier lifestyle choices among society generally; and
- To prioritise prevention interventions on those in communities who are at particular risk of problem drug/alcohol use.

Key Performance Indicators

- Decrease in the number of opiate users in Dublin area and stabilisation of opiate users in rest of country by 2011;
- Stabilisation in recent, and reduction in current prevalence of illicit drugs in 15 - 34 population (Drug Prevalence Survey 2010/2011);
- Reduction in numbers engaged in poly - drug use (Drug Prevalence Survey 2010/2011);
- Reduction of level of drug misuse reported by school students (regular survey results and ESPAD Survey 2011);
- Delaying the age of first use of illicit drugs (ESPAD Survey 2011);
- Delaying the age of first drink and reduction in binge drinking among young people (ESPAD, National Prevalence Survey, HBSC Surveys); and
- Reduction in the Early School Leaving figures from 11.5% (2007) to 10% by 2012, utilising the widely recognised definition of 'early school leaver' used by Eurostat¹.

¹ The proportion of persons aged 18 to 24 years whose highest level of education attained is lower secondary or below, and who did not receive either formal or non - formal education in the previous four weeks.

TREATMENT & REHABILITATION

Objectives

- To develop a national integrated treatment and rehabilitation service that provides drug free and harm reduction approaches for problem substance users; and
- To encourage problem substance users to engage with, and avail of, such services.

Key Performance Indicators

- 100% of problem drugs users accessing treatment within one month of assessment by 2012;
- 100% of problem drugs users aged under - 18 accessing treatment within one week of assessment by 2012;
- 25% increase in residential rehabilitation places by 2012 based on 2008 figures;
- 25% increase in Hepatitis C cases among drug users treated by 2012; and
- Put a drugs interventions programme in place by 2012, incorporating a treatment referral option, for people who come to the attention of An Garda Síochána and the Probation Service due to behaviour caused by substance misuse.

RESEARCH

Objectives

- To ensure the availability of data to accurately inform decisions on initiatives to tackle problem substance use; and
- To provide appropriate research to fulfil the information needs of Government in formulating policies to address problem substance use.

Key Performance Indicators

- EMCDDA indicators developed on the extent and nature of problem drug use in Ireland;
- Comprehensive and timely reporting systems in place for:
 - (i) treatment and rehabilitation; and
 - (ii) progression of offenders with drug - related offences through the criminal justice system
- Completion of identified research programme by the NACD.

CO - ORDINATION

Objectives

- To bring greater coherence to the co - ordination of substance misuse policy in Ireland across all sectors; and
- To maintain and strengthen partnerships with communities to tackle the problems of substance misuse.

Key Performance Indicators

- Establishment of the Office of the Minister for Drugs by mid 2009; and
- Development of an overall performance management framework by end 2010.

INTRODUCTION



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National Drugs Strategy
(interim) 2009 - 2016

Treatment

Rehabilitation

INTRODUCTION

Role of the Steering Group

In late 2007, the then Minister of State with responsibility for the National Drugs Strategy, Pat Carey, T.D. established a Steering Group to develop proposals and make recommendations for a new National Drugs Strategy covering the period 2009–2016. The Group was chaired by the Department of Community, Rural and Gaeltacht Affairs and was made up of representatives of the key Departments and agencies involved in delivering the current NDS, as well as representatives from the community & voluntary sectors. The full membership of the Group is set out in Appendix 1.

The terms of reference of the Steering Group were as follows:

- Examine the progress and impact of the National Drugs Strategy 2001 - 2008 across the five pillars of supply reduction, prevention, treatment, rehabilitation and research in the context of the objectives, key performance indicators and actions set out therein;
- Examine the relevance of the current Strategy in tackling the current nature and extent of problem drug use in Ireland, including emerging trends and cross - cutting issues, and identify any gaps presenting and indicate how they might be addressed;
- Review the operational effectiveness of the structures of the National Drugs Strategy, including co - ordination mechanisms;
- Examine developments in drugs policies, and in dealing with problem drug use generally, at EU and international level;
- In light of the foregoing, to consider how a new Strategy, to cover the period 2009 - 2016, should address problem drug use, including the structures through which this would be done;
- Develop performance indicators to measure the future effectiveness of the new Strategy; and
- Make recommendations for a new Strategy to the Minister of State and, subsequently, the Cabinet Committee on Social Inclusion, Children and Integration by the end of 2008.

The Steering Group was assisted in its work by independent consultants – PA Consulting Group – who reported on the consultation process (see below) and prepared a report for the consideration of the Group to assist it in its deliberations.

Consultation Process

As part of its work in developing a new Strategy, an extensive consultation process was undertaken in early to mid 2008. This included the following elements:

- (i) **written/e-mail submissions**—an advertisement was placed in the national newspapers in late February 2008 inviting interested individuals or organisations to make submissions. Relevant Departments and agencies were also written to inviting them to make submissions. In total, 153 submissions were received – a full list of which are contained in Appendix 2.
- (ii) **public consultation meetings** were held at 15 locations around the country between late April and early June 2008 — five in Dublin, and one in Athlone, Portlaoise, Galway, Sligo, Limerick, Kerry, Cork, Waterford, Gorey and Dundalk (see Appendix 3). Total attendance over all of the meetings was just over 1,200, giving an average of 80 approx. The format for each session was identical in all locations with four key questions being posed:
 - the key concerns surrounding the issue of drug use in the area/region;
 - what is working well within the current Strategy,
 - the main gaps in the current Strategy; and
 - the priorities for the future Strategy.A report on the key conclusions of each meeting was posted on the Department’s website – www.pobail.ie.
- (iii) **meetings with Departments/Statutory Agencies** – in total 18 meetings were held with the relevant Departments and agencies during June and July 2008. The aforementioned questions also formed the basis for these meetings. A full list is contained in Appendix 4.
- (iv) **meetings with sectoral groups, organisations and focus groups**—a full list of the groups and organisations with whom meetings were held is set out in Appendix 5
- (v) **engagement with the Oireachtas** – in September 2008 and in February 2009, Minister of State John Curran T.D. met with the Oireachtas Joint Committee on Arts, Sport, Tourism, Community, Rural & Gaeltacht Affairs to hear the views of Members on priorities for the new Strategy. A Seanad debate was also held in June 2008 and this provided Senators with an opportunity to input into the new Strategy.

Following the completion of the consultation process and the work of the consultants, the Steering Group proceeded to analyse all the views and data presented before reaching the conclusions and recommendations set out in this Report.

Background

The current National Drugs Strategy (NDS)², which was launched in 2001, came to an end at the end of 2008. The Strategy - which was Ireland's first co-ordinated effort to address the issues of problem drug use - was delivered through five inter-connected pillars dealing with:

- Supply reduction;
- Prevention (including education & awareness);
- Treatment;
- Rehabilitation (*added as the fifth pillar after the Mid - Term Review of the Strategy in 2005*); and
- Research.

In keeping with its terms of reference, the Steering Group, in this Report, examined the progress made under the current NDS across the different actions and have identified a number of areas that need to be prioritised in the new Strategy. In developing its proposals, the Steering Group was influenced by a number of factors.

In particular, it was cognisant of the fact that a key finding from the review is that the approach and rationale outlined in the current Strategy continues to be relevant and appropriate. Consequently, the proposals outlined in this Report are based around the existing pillar structure, as identified above.

In meeting the terms of reference, the Group also took account of:

- the various issues raised during the consultation process; and
- new emerging trends such as the increased prevalence of cocaine and the increased prevalence of heroin outside of the eastern region.

² All references to the "current NDS" throughout this document refer to the National Drugs Strategy 2001 - 08.

These are outlined in more detail below.

They also drew on:

- the work of the consultants (PA Consulting Group);
- relevant research findings; and
- the Group's own experiences of working in the drugs field.

Over the lifetime of the Strategy, there have been notable changes in the nature and scale of the drug problem. While in 2001 the Strategy was essentially concerned about problem opiate use, there is now widespread public concern regarding the misuse of cocaine, particularly when combined with other illegal substances, and alcohol, along with increased reports of problem polydrug use. However, heroin remains a significant problem and a matter of serious concern for many communities.

The 2006/07 Prevalence Survey³ is the best estimate of the national prevalence of problem drug use. Overall, the survey found that, while there had been an increase in recent (last year) drug use, current (last month) use had stabilised from the previous survey in 2002/03. It also confirmed:

- that illegal drug use continues to be predominantly a younger adult phenomenon, with those under 35 accounting for the bulk of usage;
- that males are twice as likely to use illegal drugs, although the rate of increase among females was significantly higher than that among males; and
- the emergence of cocaine as a threat, particularly among younger adults.

The recently published 2007 European School Survey Project on Alcohol and other Drugs (ESPAD)⁴ study indicated that lifetime use for cannabis had stabilised (slight decrease from 20% to 19%) and that lifetime use for other illegal drugs, other than cannabis, had reduced (from 10% to 7%). Current use of cannabis had also decreased (halved from 17% to 9%), while use of other illegal drugs had stabilised. Since 2003, lifetime abstinence from all substances has virtually doubled from 6% to 11% in 2007.

³ Drug Use in Ireland and Northern Ireland – 2002/2003 and 2006/2007 – Drug Prevalence Surveys: National Advisory Committee on Drugs & Public Health Information & Research Branch (PHIRB) in Northern Ireland.

⁴ Survey estimates the prevalence of drug use among school-going students in their 16th year. Comparisons are between 2003 and 2007.

Heroin use continues to be concentrated primarily in areas of urban disadvantage in Dublin and in other urban centres, particularly in Leinster and the south of the country. The prevalence of heroin has ameliorated to an extent in the Dublin area with a significant drop in the rate of new entrants identified. However, this has been offset to a degree by its wider dispersal around the country. Overall, the rate of new entrants to treatment had dropped significantly by approximately 20% between 2001/2 and 2006/07.

The use of cocaine continues to grow, albeit from a small base, particularly among younger adults. While it is a countrywide problem, it is most prevalent in Dublin, and in the east and south of the country. The high prevalence of poly - substance use is also a marked feature among those presenting to treatment services.

Over and above the damaging health consequences for problem drug users, hugely damaging effects are caused by drug dealing, drug - related crime and anti - social behaviour which can undermine the stability of individuals, families and communities. Significant concerns were raised during the consultation process about increased levels of intimidation within local communities across the country. The nature and scale of intimidation has increased with families of drug users increasingly regarded as targets. The increase in intimidation is, in part, thought to be due to increased levels of drug - related debts, which are particularly associated with the rise in cocaine use.

During the consultation process, there was also widespread public concern in relation to the problem use of alcohol - both as a stand - alone public health issue and in association with illicit drug use. On 31st March 2009, the Government gave approval for the development of a combined National Substance Misuse Strategy to cover both alcohol and drugs. Chapter 1 deals with these developments and the issues arising therefrom.

In framing its recommendations, the Steering Group also had regard to the EU Action Plan on Drugs 2009–2012. The Action Plan is centred on two key dimensions of drugs policy - demand reduction and supply reduction - complemented by three cross - cutting themes - co - ordination, international co - operation and information, research & evaluation.

The Steering Group also noted that a key strength of the current NDS has been the bringing together of Departments, agencies and the community & voluntary sectors to develop a collective response to tackling the drugs problem. The value and importance of this partnership approach is recognised and it will continue to underpin the implementation of the new Strategy over its lifetime.

Finally, the Group was conscious of the changing economic circumstances in Ireland at present combined with proposals for public sector change and the impact that these developments may have on the extent and pace of implementation of the priorities and actions set out in this Report. While this is outside the control of the Steering Group, keeping focus and maintaining momentum on the priorities identified is considered vital if Ireland is to continue to tackle the major challenge of drug misuse over the next 8 years.

Structure of the Report

The Steering Group's Report is structured as follows:

- Chapter 1 – looks at the development of a National Substance Misuse Strategy to include drugs and alcohol;
- Chapters 2 to 5 of the Report review progress under the existing pillars of the NDS and outline what the priorities for the next Strategy should be;
- Chapter 6 looks at structures and sets out the role and responsibilities of the new Office of the Minister for Drugs; and
- Chapter 7 sets out the strategic aims and objectives of the new Strategy and details the priorities and actions - across the 5 pillars – that will support its implementation.

INCLUSION OF
ALCOHOL INTO
A NATIONAL
SUBSTANCE MISUSE
STRATEGY

Supply Reduction

National Drugs Strategy
(interim) 2009 - 2016

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CHAPTER 1

INCLUSION OF ALCOHOL INTO A NATIONAL SUBSTANCE MISUSE STRATEGY

INTRODUCTION

1.1 As outlined in the Introduction, during the extensive consultation process that was held during 2008, there was widespread public concern in relation to the problem use of alcohol - both as a stand - alone public health issue and in association with illicit drug use.

1.2 Alcohol is frequently associated with many aspects of Irish social and cultural life and its use has become deeply woven into our national identity. For many, alcohol is also seen as a gateway to illicit drug use, particularly for young people, while poly - drug use - which very often includes alcohol - is now the norm among illicit drug users.

1.3 At the end of March 2009, the Government agreed to include alcohol in a National Substance Misuse Strategy, with individual Ministers (*Health & Children and Community, Rural & Gaeltacht Affairs*) being responsible for the aspects relevant to their respective briefs.

1.4 While the Steering Group strongly welcomed this development, it was very conscious that developing a National Substance Misuse Strategy, which encompasses both drugs and alcohol, presents many challenges and will take a considerable period of time, given the nature of the public health and other issues that are involved. In addressing the multiplicity of issues associated with the problem use of alcohol and drugs, it is also acknowledged that a number of complexities will arise as the new Strategy will be addressing both legal and illegal substances.

1.5 At the same time, the Group recognised that a substantial amount of work had been done at that stage (by the end of March 2009) to advance the Drugs Strategy and it felt that it was important that this be allowed to progress to conclusion as quickly as possible.

1.6 Accordingly, to implement the Government decision, the Steering Group adopted the following approach:

- Work on completing the Drugs Strategy continued and the Report was approved by Government in June 2009. In the context of polydrug use and alcohol issues, references within this document reflect the combined

approach that is now Government policy. This Strategy is being published as an “interim” Strategy pending the drafting and finalisation of a National Substance Misuse Strategy (*which will operate until 2016*).

- A new Steering Group will be established in autumn 2009 to develop proposals for an overall National Substance Misuse Strategy that will incorporate the already agreed drugs policy element. Membership of the Group will reflect the appropriate statutory, community/voluntary and other relevant interests. The Group will be jointly chaired by officials from the Department of Health and Children and the Office of the Minister for Drugs (see chapter 7). The secretariat function will be shared between the two bodies. The Group will be asked to report by the end of 2010.

1.7 An action is included in this Report - the new “interim” Drugs Strategy - to give effect to the above approach.

1.8 The remainder of this chapter sets out the context and rationale for the need to address the problems caused by alcohol misuse in society. It is intended to inform and direct the work of the new Steering Group to be established later in 2009 to develop proposals for an overall National Substance Misuse Strategy.

Alcohol – No Ordinary Commodity

1.9 Alcohol is a drug and intoxicant which has significant pharmacological and toxic effects both on the mind and on almost every organ and system in the human body. Alcohol is implicated in numerous premature deaths every year from disease, accidents and violence. It has been shown to be causally related to more than 60 different medical conditions. The negative consequences of alcohol include harm to physical health, psychological well - being and relationships. These consequences impact on all facets of society, from the affected individuals and their families to the medical, social and legal resources of the State. These problems range from a once - off problem (fall, accident, fight, unprotected sex, violence, absence from work) to a recurring problem (poor school/work performance, financial hardship, relationship difficulties), chronic illness (cancer, liver damage) and to a sustained dependence (alcoholic disorder). Homelessness and domestic violence are also among the consequences of alcohol misuse. Some of these problems, especially the acute problems, arise where the light or moderate

drinker drinks to excess on a single drinking occasion, while others result from regular heavy drinking over a longer period of time.

Alcohol Consumption in Ireland

1.10 Alcohol consumption trends and patterns are important from a public policy point of view. Alcohol consumption in Ireland has increased significantly over recent decades. There has been a marked rise in consumption levels from the mid - 1990s which peaked in 2001 at 14.3 litres of pure alcohol per person aged 15 and over. The overall consumption rate decreased to 13.4 litres by 2007 and fell to 12.8 litres (provisional) in 2008⁵. Although there is a decrease in consumption from the peak in 2001, Ireland consumes more alcohol per capita than most of its European counterparts – approximately 30% higher in 2006. Ireland has a higher percentage of abstainers than other countries, implying that those who do drink, consume alcohol in greater quantities when compared to other countries.

1.11 The figures mean that each person aged 15 and over consumes an average of 20 standard drinks of alcohol per week. This is equivalent to 10 pints of beer or 3 bottles of wine or 1 bottle of spirits per week. Since the recommended maximum weekly consumption levels are currently 14 standard drinks for women and 21 for men, this means that a significant number are drinking more than the recommended limits.

Alcohol use in the population

1.12 People in Ireland also engage in drinking patterns that are excessive and problematic, with heavy and binge drinking now the norm for a substantial number of people. The Eurobarometer Survey, published in March 2007, on Attitudes to Alcohol reported that 54% of Irish respondents binge drink at least once weekly, compared to 28% of Europeans.

1.13 The National Health and Lifestyle Survey - SLÁN 2007⁶ – reported more encouraging findings. It found that the percentage of respondents reporting that they had 6 or more standard

drinks at least once per week has fallen from 45% in 2002 to 28% in 2007. This pattern was reflected across gender, age and social class. However, the SLAN 2007 Research Team warn that these findings must be viewed with caution since the survey method has changed over this period (from postal self - report questionnaires in 2002 to face - to - face interviews in 2007) and the willingness to report drinking excessively may differ by survey method.

1.14 The Health Behaviour in School - Aged Children (HBSC)⁷ survey in 2006 found that half of the children aged 15 - 17 reported being current drinkers and just over a third reported having being “really drunk” in the last 30 days.

1.15 Young people's propensity for risk - taking and their relative inexperience with alcohol place them at particular risk for alcohol - related harm. Research from the United States has found that people who begin drinking before the age of 15 are four times more likely to develop alcohol dependence at some time in their lives, compared with those who have their first drink at age 20 or older.

Alcohol - related Health and other problems in Ireland

1.16 In 2002, the World Health Organisation (WHO) identified alcohol as the third highest risk factor (after tobacco and hypertension) for premature death and ill - health in developed countries. Since the early 1990s, there has been a dramatic increase in alcohol - related harm in Ireland, with the increase most pronounced in the period 1995 to 2002. As outlined above, the harm from alcohol is linked to a range of health and social problems such as accidents, injuries, chronic ill - health, premature death, public safety, violence, child neglect, marital problems and lost productivity. Alcohol harm is not confined to the drinker but extends to the family, community and wider society. The negative role of alcohol in family well - being was documented in a number of Irish studies, where alcohol has the potential to contribute to domestic violence, relationship and marriage problems and impact on the most vulnerable of children.

1.17 Both the average per capita alcohol consumption and individual patterns of drinking are important determinants of alcohol - related problems. In general, increases in overall consumption are accompanied by a greater incidence of health and social problems. Evidence of this can be seen from research published by the Health Research Board (HRB) in 2007⁸ which found that:

5 While there was a reduction in alcohol sales in the Republic of Ireland in 2008, this is being largely offset by a rapid increase in the volume of alcohol being purchased more cheaply in Northern Ireland for consumption in the South. The measured consumption data does not take account of the imported alcohol from Northern Ireland so there is a concern that the reduced consumption data reported for 2008 is a false indicator.

6 SLÁN is a national survey, (carried out by the Department of Health & Children), of the lifestyle, attitudes and nutrition of people living in Ireland. The most recent survey was carried out in 2007. It includes questions on alcohol and the use of illicit drugs.

7 Health Behaviour in School aged Children (HBSC) is a World Health Organisation (WHO) collaborative cross national study.

8 Overview 6: Health - related Consequences of Problem Alcohol Use: HRB, 2007.

- Alcohol - related hospital discharges increased by 92% between 1995 and 2004;
- There were large increases in the number of discharges with acute and chronic conditions, but the largest increase was observed among discharges with alcohol - related liver disease, which increased by 147% between 1995 and 2004;
- Alcohol - related mortality also increased during the same time period, with an incidence of 7.1 deaths per 100,000 adult population in 2004, compared to 3.8 in 1995;
- Half of all alcohol - related deaths occurred to people aged between 50 and 70 years;
- Alcohol is also implicated in fatal road traffic accidents. In 2003, alcohol was found to be a contributory factor in 36% of road fatalities; and
- The high level of alcohol consumption has been accompanied by a parallel increase in the incidence of alcohol - related crime among juveniles.

1.18 In recent years, a binge drinking culture has emerged among women and drunkenness has increasingly become socially accepted. The consequences of this change in drinking patterns can be observed in hospital discharges. While women account for just a quarter of all alcohol - related discharges, among those aged 17 or under, the proportion of female discharges is much higher at 47%.

Policy measures to tackle alcohol misuse – work of the new Steering Group

- 1.19** As outlined above, identifying the policy measures and actions required to incorporate alcohol into a National Substance Misuse Strategy will be challenging. Potential synergies have been identified between alcohol and drug treatment and rehabilitation services – and in prevention programmes - and these are set out in the relevant chapters in this Report. However, the new Steering Group will also need to address broader issues around the supply and availability of alcohol, pricing, marketing, promotion and sponsorship etc.
- 1.20** It is noted that there is a developing scientific knowledge of what strategies work to reduce alcohol - related harm. The WHO has highlighted policies and programmes that have been shown to be effective in tackling alcohol misuse⁹.

These include:

- reducing the demand for alcohol through taxation and pricing mechanisms;
- regulating and restricting the availability of alcoholic beverages;
- regulating the marketing of alcoholic beverages (in particular those practices that influence younger people);
- enactment of appropriate drink - driving policies;
- implementing screening programmes and brief interventions against hazardous and harmful use of alcohol (e.g. in primary care and Emergency Departments); and
- providing easily accessible and affordable treatment services for people with alcohol - related disorders.

1.21 A number of Irish reports will help to inform the work of the new Steering Group. These include the reports of:

- the Strategic Task Force on Alcohol (2nd Report 2004);
- the *Sustaining Progress* Partnership Group “Working Together to Reduce the Harms Caused by Alcohol Misuse” (2006); and
- the Government Alcohol Advisory Group (2008).

Research reports, published by the Health Service Executive (HSE) and the Health Research Board (HRB), will also aid the work of the Group.

1.22 It is also noted that in order to tackle the harms caused by alcohol misuse, Government has already taken the initiative via new legislation – the Intoxicating Liquor Act 2008 – and codes of practice on alcohol advertising and sponsorship. Current Government policy is based on the belief that alcohol policies and interventions targeted at vulnerable populations can prevent alcohol - related harm. In addition, policies targeted at the population at large can also have a protective effect on vulnerable populations and reduce the overall level of alcohol problems. Therefore, both population - based strategies and interventions, and those targeting particular groups, such as young people and women, form the basis of current policy development and implementation.

⁹ Second Report of the World Health Organisation (WHO) Expert Committee on Problems Related to Alcohol Consumption, 2007.

SUPPLY REDUCTION PILLAR

PREVENTION

Research

Supply Reduction

National Drugs Strategy
(interim) 2009 - 2016

Treatment

Rehabilitation

CHAPTER 2

SUPPLY REDUCTION PILLAR

INTRODUCTION

2.1 The focus of this chapter is predominantly on illicit drug use rather than alcohol, with the exception of underage drinking, due to the fundamental legal difference involved in their supply. As outlined in chapter 1, issues around controlling and influencing the supply of alcohol will be considered by the new Steering Group which will be set up to develop the new National Substance Misuse Strategy.

2.2 Problem drug use impacts on society as a whole and is a major issue of public concern. For communities, the most damaging effects are those caused by drug dealing, drug - related crime and anti - social behaviour, which can undermine the stability of families and communities. Interventions to address these issues are key elements of supply reduction, one of the five pillars of the current NDS.

2.3 In the current NDS, the main focus of the supply reduction pillar is on reducing the volume of illicit drugs available, while reducing access to all drugs. This chapter provides an overview of the pillar and assesses progress both in achieving the NDS actions, and the impact of those actions by reviewing performance against the Key Performance Indicators (KPIs). It also outlines the key findings from the consultation process, which has helped to inform the priorities for the new NDS.

2.4 Supply reduction accounts for 21 of the 108 actions outlined in the current NDS, as amended by the Mid - Term Review (MTR) in 2005. Law enforcement is a crucial element in the pillar and as a result, many of the actions fall to the following key Departments and agencies to implement:

- Department of Justice, Equality and Law Reform; including An Garda Síochána, the Courts Service, the Irish Prison Service, the Probation Service and the Forensic Science Laboratory;
- Office of the Revenue Commissioners - Customs Service; and
- Local Authorities (as regards anti - social behaviour).

2.5 The Local and Regional Drugs Task Forces¹⁰ - as well as the community and voluntary sectors - also play an important role in complementing the work of the law enforcement agencies, bearing in mind that law enforcement is only part of the overall supply reduction effort.

Table 2.1 – Strategic Aim and Objectives of Supply Reduction Pillar under the current NDS

National Drugs Strategy 2001 - 2008 – Supply Reduction
Strategic Aim: <ul style="list-style-type: none">■ To reduce the availability of illicit drugs.
Strategic Objectives: <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; and■ To significantly reduce access to all drugs, particularly those drugs that cause most harm amongst young people, especially in those areas where misuse is most prevalent.

ASSESSMENT OF PROGRESS DURING THE PERIOD OF THE CURRENT NDS

2.6 The following were identified as being among the key issues over the lifetime of the current NDS:

- number of drug seizures and volume of drugs seized;
- legislative changes in regard to illicit drugs;
- Garda resources in Local Drugs Task Force (LDTF) areas;
- expansion of Community Policing Fora; and
- specialist training for the judiciary on drug related issues.

Legislative changes in regard to the supply of illicit drugs

2.7 Over the lifetime of the Strategy, the Department of Justice, Equality and Law Reform has introduced a number of pieces of legislation that contain elements related to drug trafficking. These include:

- European Arrest Warrant Act 2003;

¹⁰ See Appendix 6 for details of the Local and Regional Drugs Task Forces.

- Criminal Justice (Illicit Traffic by Sea) Act 2003;
- Criminal Justice (Joint Investigation Teams) Act 2004;
- Garda Síochána Act 2005;
- Proceeds of Crime (Amendment) Act 2005;
- Criminal Justice Act 2006;
- Criminal Justice Act 2007; and
- Criminal Justice (Mutual Assistance) Act 2008.

Garda resources in LDTF areas

2.8 Much progress has been made in increasing the level of An Garda Síochána resources in LDTF areas over the lifetime of the current Strategy and, in particular, since the MTR in 2005. Key areas of progress have included:

- An increase in Garda resources in LDTF areas which includes:
 - An increase of 18%¹¹ in general resources (2001 - 2007);
 - An increase of 36% in Community Policing resources (2001 - 2007); and
 - An increase of 35% in Drugs Units resources (2001 - 2007).
- An increase in the personnel numbers in the Garda National Drugs Unit;
- The establishment of a number of additional Drugs Units in both Local and Regional Drugs Task Force areas;
- The establishment of the Organised Crime Unit on a permanent basis to tackle organised crime including drug trafficking;
- An increase in the resources of the Criminal Assets Bureau (CAB), particularly through the recruitment of asset profilers; and
- A series of ongoing special operations.

Expansion of Community Policing Fora¹²

2.9 A key priority of the current NDS was the expansion of Community Policing Fora (CPF) to all LDTF areas and other areas experiencing problems with drug misuse. Progress has been slower than anticipated

¹¹ Overall staffing levels in An Garda Síochána have increased from 11,640 (1,728 civilians) on 31st December 2000 to 13,755 (1,687 civilians) on 31st December 2007. This represents an increase of 18% over that period.

¹² "Community Policing Fora were renamed as "Local Policing Fora" under the Garda Síochána Act, 2005.

in this regard. In 2005, the Garda Síochána Act was enacted and this allowed for the establishment of Joint Policing Committees (JPC) on a statutory basis. This is a forum for members of An Garda Síochána to meet with local representatives to discuss community issues and the JPC guidelines have identified drugs as a priority area for these discussions. In September 2008, the Ministers for Justice, Equality & Law Reform and Environment, Heritage & Local Government, along with the Garda Commissioner, launched the roll - out of JPCs from the pilot phase in 29 local authority areas to all 114 areas. Work on the establishment of these committees by the Local Authorities and An Garda Síochána is ongoing, and at the end of February 2009, 73 such committees were in place. One of the functions of the JPCs is to establish local policing fora, in consultation with An Garda Síochána.

2.10 CPFs only operate in three LDTF areas¹³ at present while Community/Police Partnerships operate in a number of other areas. The delay in establishing CPFs in LDTF areas, and other areas experiencing drugs problems more recently, is related to some extent to the overall development of the JPC initiative and the need to align more locally - based structures with the broader policing partnership framework. Guidelines are currently being drafted for the establishment of CPFs in LDTF areas.

Specialist training for judiciary on drug related issues

2.11 The Judicial Studies Institute was established by the judiciary in 1996. In this context, the Steering Group notes that, due to the constitutional independence of the judiciary, the role of the Department of Justice, Equality & Law Reform is limited to funding the Institute on an annual basis. The Institute produces a journal periodically and organises conferences, seminars and lectures for judges with the objective of enhancing their knowledge and understanding of the law and legal principles, with particular regard to new developments.

Other areas of progress

2.12 The Steering Group also recognises that progress has been made in a number of other areas:

- a co - ordinating framework has been established to manage drugs policy in each

¹³ The three LDTFs are: (i) Finglas/Cabra LDTF, (ii) North Inner City LDTF and (iii) Blanchardstown LDTF.

Garda District, with Policing Plans now being produced in each District. Furthermore, drugs are now a priority in all Policing Plans, both local and national;

- there has been a 56% increase in the strength (resources) of Drugs Units, across National, Divisional and District Drugs Units. Furthermore, processes are in place that support daily contact between the National and Local Drugs Units; and
 - the Criminal Assets Bureau (CAB) has focused its efforts more on middle and lower ranking criminals involved in drug dealing. CAB uses the services of more than 100 Criminal Asset Profilers, who are in place in each Garda division throughout the country. The allocation of Divisional Profilers continues to be monitored and reviewed on an ongoing basis. In addition, the Revenue Commissioners have a number of asset profilers in place.
- 2.13** An Garda Síochána and Revenue's Customs Services (along with the Naval Service) make up the Drugs Joint Task Force and all three agencies continue to develop co - operation - both nationally and internationally - with relevant law enforcement and intelligence agencies with the aim of reducing the amount of drugs coming into Ireland. An agreed Memorandum of Understanding has been central in facilitating this co - operation. In particular, the Steering Group notes:
- the establishment of a Maritime Analysis Operations Centre – Narcotics (MAOC - N) in Lisbon which is an initiative of seven Western European countries (Ireland, Spain, Portugal, France, Italy, UK & Netherlands) specifically focused on reducing the threat of cocaine trafficking into the EU. This initiative is funded by the Department of Justice, Equality and Law Reform and is being operated by An Garda Síochána, Revenue's Customs Service and the Naval Service;
 - the measures that have been implemented to address Action 15 of the current NDS focusing on coastal watch and other ports of entry to restrict the importation of illicit drugs. Coastal Watch Programmes have been in place since the 1990s. In addition, the Customs Service has re - launched the Drugswatch Programme, which seeks to enlist the help of the maritime community and other strategically placed persons in the fight against drug smuggling. Confidential reporting arrangements and a 24/7 freephone service are in place and these have facilitated a number of significant detections.
 - various initiatives aimed at reducing the supply of drugs, such as the "Dial to Stop Drugs" scheme which, have been undertaken by the Local and Regional Drugs Task Forces.
- 2.14** Notwithstanding the progress outlined above, the Steering Group also notes that there has been less advances in other areas. Some of these are outlined in the following paragraphs.
- 2.15** The availability of drugs in prisons continues to be a key challenge for the NDS, although progress has been made on counteracting this as well as on the expansion of treatment services in prisons. The Group acknowledges the progress achieved in recent years to address this issue through:
- increased security arrangements that have been put in place with a focus on supply elimination;
 - the establishment of Operational Support Units in each prison dedicated to (and currently developing expertise in) searching and intelligence gathering;
 - the enforcement of more stringent procedures regarding all contraband;
 - the provision of security screening of all persons entering prisons; and
 - the further development of the drug detection dog service.
- 2.16** The Operational Support Units, using advanced searching techniques, are in addition to the normal prison staff and they can target specific problem areas relating to the trafficking of contraband, including drugs, into prisons.
- 2.17** Mandatory drug testing is now established in a number of prisons and it is proposed to introduce it on an incremental basis to other prisons from 2009 onwards.
- 2.18** In order to address concerns at the use of mobile phones and how such use has contributed to the increasing levels of the controlling of illegal drug activity from within prisons, the Irish Prison Service (IPS) installed a pilot scheme of technology to prevent their use. This pilot, which began at the Midlands/Portlaoise Prison Complex in April 2007, was completed in early 2009. Following the evaluation of the inhibition system, which proved very positive, the IPS, in 2009, installed the technology in Portlaoise Prison. In addition, trials of alternative systems of mobile phone blocking technology commenced in 2009 in Limerick Prison, Mountjoy Prison Medical Unit and Cloverhill Prison.

2.19 The Steering Group notes that the IPS Drug Detection Dog Service has now been established. This will ultimately involve about 30 dog handling teams, 10 of which are currently in operation. The searching is concentrated on visitors to prisons, but searches within the prison are also undertaken. Initial indications suggest that these teams have had a significant interception and deterrent effect.

2.20 Overall, while welcoming the increased security arrangements that have been put in place, the Group considers that there is a need to monitor these arrangements. Thus, it welcomes the establishment of the External Oversight Group on IPS Drug Policy, a Monitoring Group that will focus on problem drug use in prisons, from both a security and a treatment & rehabilitation perspective. Furthermore, the Steering Group considers that the development of a comprehensive treatment and rehabilitation programme in prisons is a critical element in counteracting problem drug use in our society. This is dealt with further in chapter 4.

2.21 The Steering Group notes that community engagement has become more difficult in some areas, due to the increased incidence of intimidation. Although An Garda Síochána continue to develop their intelligence - led approach with co - operation from communities, there is a need for widespread community engagement to support the conviction of known drug offenders. This engagement is thought to be at risk in areas where communities are fearful of increasing intimidation. Community engagement was a key focus of Action 8 of the current NDS which recommended multi - agency participation (including the community) in targeting drug dealing through local Drug Policing Plans. The issue of intimidation is dealt with in more detail later in this chapter.

KEY FINDINGS FROM THE CONSULTATION PROCESS

2.22 While recognition was given during the consultation process to the significant increases in drug seizures over recent years, the impact of those seizures on reducing the overall supply of drugs was questioned. Consequently, despite the successes of law enforcement agencies in seizing drugs, a key theme to emerge during the consultation process was the perception that illicit drugs are more readily available across the country in recent years.

2.23 Other issues highlighted during the process include the following:

- There was support for the continued development of community policing, with the establishment of Local Policing Fora (LPFs - formerly CPFs – see paragraphs 2.9 and 2.10 above) being widely regarded as important to the success of supply reduction measures. This requires effective links between An Garda Síochána and the community to enable an effective response to local drug issues. However, these links are currently not as effective as they should be, partly because of the increased fear of intimidation;
- Significant concerns were raised about increased levels of intimidation within local communities across the country. The increase in intimidation is, in part, thought to be due to increased levels of drug - related debts, which are particularly associated with the rise in cocaine use. In many cases, families are faced with demands to cover the debts of a family member (with various issues around the circumstances of such debt and the calculation of the sum alleged to be involved), with threats of violent consequences for non co - operation;
- While overall visibility of An Garda Síochána on the ground has improved - partly due to the increase in police numbers in recent years - further visibility in the most at risk areas is still considered a priority;
- The perceived widespread availability of drugs in prisons across the country was highlighted and the concern that current policies are ineffective in dealing with the problem. In this regard, some suggested that the number of drug detection dogs in prisons be increased;
- There is a perceived lack of consistency in the criminal justice system in dealing with drug - related offences, in particular the perceived reluctance of the judiciary to impose mandatory sentences. The sentencing of drug - related offences is seen to vary dramatically, depending on the individual's location. People convicted in more rural areas are often perceived as receiving stiffer sentences than those in Dublin and other cities. Overall, the level of sentencing and the fear of imprisonment are not seen as sufficient disincentives for those dealing in drugs in local communities. There is also a sense of frustration at the perceived 'wasted' efforts of An Garda Síochána to bring an individual to court, where a minimal sentence can be imposed;

- There is recognition of the success of the CAB, in particular for the new focus on middle and lower ranking criminals. There is a perception that the majority of funds seized by the CAB are directly drug - related, and as such should be invested back into local communities which have been affected by drugs. The Steering Group recognises, however, that much of the funds seized represent the recoupment of social welfare payments and unpaid taxes, and are, therefore, monies owed to the Exchequer. Notwithstanding this, there were calls for the successes of the CAB at local level to be further highlighted, particularly those in relation to the middle and lower ranking criminals, which can provide a morale boost in the communities;
- The issue of underage drinking was consistently raised by many, both as a problem in its own right and as a gateway to the use of illicit drugs;
- Concerns were raised regarding the development of new illicit synthetic drugs, both within and outside the EU, where legitimate chemicals are being diverted to manufacture such illicit synthetic drugs (paragraph 2.47 also refers). In this regard, the Steering Group notes that the Revenue's Customs Service has dedicated Precursor Liaison Officers located at key areas around the country and that there is a commitment to continue to develop the Precursor Programme under the new NDS. Reference was also made to the 2008 seizure of methamphetamine in a joint operation between An Garda Síochána and the Revenue's Customs Service - the first significant seizure of this drug in Ireland;
- The delays experienced in testing of cases by the Forensic Science Laboratory to support prosecutions was raised. For the most part, this was as a result of the significantly increased levels of seizures by An Garda Síochána and Revenue's Customs Service. While the Laboratory achieved an impressive 66% increase in the number of drugs reports they produced between 2006 and 2008, the number of cases submitted to them also increased by 70% over the same period. This negated their efforts to reduce delays in the criminal justice system. A shorter turnaround time of cases submitted to the Laboratory is required to ensure the more efficient investigation of drug offences;
- There was some reference to the concept of Drug Courts. While many agreed with the concept of such a Court, there was little awareness or understanding of the

effectiveness of the model. Consequently, there was uncertainty as to whether the model should be expanded, given the level of resources involved. The Steering Group notes that a review of the Drug Court model is ongoing in the Department of Justice, Equality & Law Reform; and

- The issue of the legislative framework governing illicit substances was raised on a number of occasions, with some requesting a review of that framework. Some people were of the opinion that consideration should be given to potentially legalising, decriminalising or changing/redefining the legal status of certain illicit drugs (particularly cannabis) and the associated penalties for possession.

PROGRESS AGAINST CURRENT KEY PERFORMANCE INDICATORS (KPIs)

- 2.24** The KPIs for the supply reduction pillar were revised in the MTR and relate primarily to increases in the volume and number of seizures, as well as increases in supply detections. The latest data highlights that each of the supply reduction KPIs have been achieved. Table 2.2 provides a summary of the KPIs and progress to date against each.

Table 2.2 - Progress against KPIs

	Target	Progress
1	Volume of drugs seized increased by 50% based on 2000 figures.	The volume of drugs seized overall, exceeds 50% based on 2000 figures, in particular for cocaine, heroin and cannabis resin. See Table 2.3 below.
2	Number of seizures increased by 20% based on the 2004 figures.	The overall number of seizures increased on average by 59% over the 2004 figures.
3	Number of supply detections increased by 20% by end 2008 based on 2004 figures.	The number of detections believed to be for supply increased by 125% over the numbers recorded for 2004.

Source: An Garda Síochána and the Revenue's Customs Service

Seizures

- 2.25** Both the volume and value of seizures has increased significantly in Ireland since 2000. Table 2.3 highlights the increases in the volume of drug seized across the various categories of drugs.

Table 2.3 – Drug Seizures 2000 – 2007

Type of Drug	2000	2001	2002	2003	2004	2005	2006	2007
Heroin (kg)	23.9	30.31	16.7	27.046	26.5	32.28	128.41	129.84
Cocaine ¹⁴ (kg)	18	5.3	31.7	107.4	167.3	229.38	190.19	1,718
Cannabis Resin (kg)	401	567	3,333	5,349	3,226.5	6259.8	6,951.8	1,167
Cannabis Herb (kg)	208	13,208	6,105	219	303	180	305	1,782.62
Ecstasy (tablets & capsules)	557,357	469,914	117,076	1,292,296	1,099,413	327,424	147,306	119,972
Amphetamines (tabs)	149	N/A	12,728	1,019	91	19,452	6,399	10,395
Amphetamines (kg)	5.92	17.93	16.4	96.82	92.4	10.5	38.24	55.13

Source: Garda Annual Reports, Revenue's Customs Service & Forensic Science Laboratory.

2.26 In relation to the revised KPIs, the Steering Group notes that:

- the volume of drugs seized has increased across almost all major drug categories, in particular cocaine and cannabis resin. While heroin seizures between 2000 and 2005 were relatively stable, there has been a significant increase in the volume seized in 2006 and 2007; and
- as well as the volume of seizures, the number of seizures conducted has increased by 59% on 2000 figures, highlighting that the increased volumes are associated with an increase in the number of seizures and are not solely attributed to a low number of large seizures.

2.27 The increases in seizures represent important operational successes for the law enforcement agencies, mainly due to the ongoing co-operation between An Garda Síochána, Revenue's Customs Service and the intelligence-led approach being used. However, the Steering Group notes that the impact of increased seizures on the overall supply of illicit drugs is difficult to determine. Due to the problems associated with estimating the size of the illegal drug market in Ireland, it is difficult to conclude whether increased seizures are actually resulting in a reduction in overall supply - or whether the overall supply of drugs has increased and the percentage of seizures has remained relatively even. Meanwhile, it is acknowledged that the figures often quoted in relation to drugs seizures as a percentage of the total drugs market in Ireland are speculative and currently, have no proven basis. Other factors around supply and demand, such as the numbers presenting for treatment and the price of drugs on the street, also need to be considered.

2.28 By May 2007, there was a 125% increase in the number of supply detections compared to the 2004 figures, against a 20% target for the end of 2008. This can be compared with a doubling of total drug detections over the same period.

2.29 There were some concerns amongst the Steering Group about the time being allocated by An Garda Síochána to what is perceived as less serious drug-related crime, such as the possession of cannabis for personal use. The Gardaí advise that about 20% of drugs crime relates to supply offences and 80% to possession. Supply offences generally involve much more time and resources. Furthermore, Gardaí cannot foretell the outcome of their operations in advance.

2.30 The overall conclusion is that all of the KPIs were achieved before the end of 2008. However, while the Steering Group accept that drugs seizures are recognised internationally as one of the key indicators for monitoring trends in supply, they are also of the view that there are limitations in only measuring seizures as an indicator of reducing supply. In terms of the new strategy, it is important to consider whether these KPIs remain the most appropriate and relevant measurable to indicate whether the overall objective of the supply pillar has been achieved, i.e. to reduce the availability of illicit drugs.

CONCLUSIONS AND PRIORITIES FOR THE FUTURE DRUGS STRATEGY

2.31 The Steering Group acknowledges that significant progress has been evident under the supply reduction pillar since 2001 – both in relation to the actions and KPIs. The revised KPIs have been exceeded, and many of the actions outlined in the current NDS have either been completed, are ongoing

¹⁴ The 2007 cocaine figure includes the 1,500 kg approx of cocaine seized off the Cork coast in July 2007. A find of this size may distort the figures for comparative purposes. It is thought that the cocaine was en route to a destination other than Ireland.

tasks, or considerable progress has been made and they are well advanced. Progress is also evident in relation to the priorities identified in the MTR, although some of that progress continues to be slow. Despite this, it is accepted that drugs continue to be available on an on - going basis in many communities.

2.32 While the progress made in relation to the establishment of the JPCs and LPFs is acknowledged, the issue of community policing continues to be a key priority going forward.

2.33 As outlined in paragraph 2.9 above, following a pilot phase, JPCs are now to be rolled out to the 114 Local Authority areas. The JPCs cover all aspects of policing (the drugs problem would only constitute a small part of this) and they facilitate a more co - ordinated approach to policing through greater co - operation and liaison between Local Authorities and An Garda Síochána. The Committees are comprised of members of the Local Authority, representatives of members of the Oireachtas, senior Gardaí, the community and voluntary sectors and Local Authority officials. Their meetings are held on a periodic basis and, as a rule, they are open to the press and to the public.

2.34 LPFs deal with drugs and associated issues such as estate management and anti - social behaviour. They involve a much smaller geographical area (e.g. Dublin's North Inner City) and seek to build up a more direct bond between An Garda Síochána and local communities. This helps to create conditions of trust in which the drugs problems can be addressed in a proactive and concerted way. The 3 existing LPFs are provided with full - time administrative support and, while this greatly facilitates their work, the Steering Group notes that the costs involved are a factor in expanding LPFs to more areas.

2.35 The expansion of JPCs is welcome, and should be of help in the overall fight against drugs. However, the Steering Group believes that progress in this regard should not be a reason to ease off on the programme of expansion of LPFs. The latter bodies have proven most beneficial where established and the Group see it as vital that they are set up in further areas on an incremental basis, ensuring the optimum level of local community engagement, An Garda Síochána focus and disruption to the drugs trade.

2.36 The Steering Group notes that the increasing fear and incidence of intimidation has emerged as a key concern within communities. The nature and scale of intimidation is reported to have increased in recent years and is seen as having the potential to affect the participation of communities in the NDS. The families, friends and associates of drug users, as well as the drug users themselves, are increasingly the targets of intimidation and violence. In many cases families are faced with demands to cover the debts of a family member. These debts primarily arise as a result of drug usage or drug supply whereby the individual is held financially liable for drugs used, or seized by the authorities, either in their possession or under their control. Apart from the huge impact on the families directly affected, the increased levels of violence have significant negative consequences for the wider communities.

2.37 The Steering Group note that intimidation can take many forms including damage to property, threats and physical violence. Furthermore, many of the incidents which may have their origins in acts of intimidation may not be recognised or reported as such. This potentially leads to low levels of reporting and feelings of helplessness among victims and families.

2.38 The Steering Group acknowledges the severe consequences that this is having in the communities affected and is also aware that there is no easy remedy. The Department of Justice, Equality and Law Reform and An Garda Síochána are fully aware of public concerns in relation to this issue and all of the drug - related aspects of crime. An Garda Síochána continues to prioritise the tackling of serious organised crime in all its facets in the Annual Policing Plan. As outlined above, the JPCs and LPFs will provide a forum whereby issues that arise at community level can be brought to the attention of An Garda Síochána. However, those directly affected by intimidation will be unlikely to speak at these meetings. Furthermore, given the nature of the offence, victims may be less likely to report incidents directly to the authorities or to pursue a prosecution through the court system. The Steering Group recommends that An Garda Síochána, in conjunction with relevant partners, develop an initiative that will allow for communication, either directly between the victims and An Garda Síochána, or via the Family Support Network or other agencies.

- 2.39** The establishment of an information system to enable the tracking of drug - related offences is considered to be a key element in assessing the success of enforcement activities. While it is recognised that this action will have significant technical and resource implications, the presence of an integrated information system will support the development and implementation of policy responses in an efficient and timely manner.
- 2.40** The independence of the judiciary is recognised as a fundamental principle of our criminal justice system. However, the perceived lack of consistency in the sanctioning of drug - related offences is an on - going concern, as it relates directly to the confidence of the public in the success of the NDS.
- 2.41** The Steering Group notes that the Revenue's Customs Service successfully use dogs to uncover drugs. Since the first detector dog team was deployed in 1984, the resource has been increased incrementally and currently stands at 13. Further expansion of drug dog teams is recommended. In addition, while it is noted that the Customs Service has one mobile x - ray scanner that is capable of screening vehicles and containers it is felt that this is inadequate to meet the threats posed by the drugs trade. Furthermore, the fact that it is generally known that only one such scanner is available facilitates avoidance of detection due to the choice of access routes available. It is noted that, in May 2009, Revenue were completing the tendering process for a second X - Ray scanner.
- 2.42** The issue of young children (some under the legal age of culpability) being used by those involved in the drugs trade to "run" drugs is also a major concern. These children are particularly sought by drug dealers to avoid detection as it is known that many will not be subject to legal penalty. At the same time, apart from the dangers involved, the young people gain financially and are more likely to be led into a life involving drugs and the drugs trade.
- 2.43** The Steering Group is of the view that renewed efforts need to be made to address the issue of underage drinking which is often perceived as the direct cause, or the underlying cause, of many of the problems encountered by individuals and communities. They acknowledge the benefits of the enactment of the Intoxicating Liquor Act 2008, which tackles the increased visibility

and availability of alcohol through retail outlets with off - licences, while tightening the conditions under which premises with on - licences qualify for special exemption orders permitting them to remain open beyond normal licensing hours. The Act strengthens public order provisions and provides for improved enforcement and increased penalties. However, the Steering Group also feel that the impact of the measures therein, and the situation generally, should continue to be monitored to ensure that alcohol is not being supplied to under - 18s. In this context, it is noted that, as outlined in paragraph 2.1 above, the issues around controlling and influencing the supply of alcohol will be considered by the new Steering Group who will be developing the National Substance Misuse Strategy.

- 2.44** It is an offence under the Road Traffic Acts to drive under the influence of intoxicants. The Steering Group is of the opinion that procedures need to be developed to provide for the equivalence of treatment between driving under the influence of alcohol and driving under the influence of drugs. To this end, the Steering Group considers that the following issues need to be addressed:
- road side drug testing should be implemented when feasible¹⁵;
 - random testing should be implemented from the introduction of road side drug testing;
 - legislation on the issue of driving under the influence of intoxicants should be reviewed and appropriate enforcement options should be considered;
 - the forensic analysis programme of the Medical Bureau of Road Safety should be expanded to deal with drug driving;
 - relevant training should be provided for Gardaí, doctors and nurses; and
 - there should be detailed examination of the toxicology reports of all drivers involved in fatal road traffic accidents to ascertain the level of drug use involved.
- 2.45** The Steering Group acknowledges that the resourcing levels of the Forensic Science Laboratory have been reviewed and increased recently. The Group feels that the situation should continue to be monitored to ensure that appropriate resources are in place to facilitate timely prosecution of offenders.

¹⁵ There is as yet no reliable system of preliminary roadside testing for drugs, but the Medical Bureau of Road Safety is keeping abreast of developments in this area.

Such timely prosecution would be assisted by the introduction of a presumptive testing regime in appropriate cases, similar to that which has been in operation in U.K. police forces for a number of years.

- 2.46** In the wider context of supply reduction, it is considered that the Forensic Science Laboratory is the most appropriate agency to undertake purity/potency testing on seized drugs as a long - term data collection project. This would ensure better intelligence in regard to emerging trends in the drugs market.
- 2.47** The Steering Group has concerns about the sale of psychoactive substances (often referred to as “legal highs”), often in headshops prominently located in our cities and towns. This concern centres on the dangers of such psychoactive substances as well as them being a gateway to illicit drug use. The Group feel that every effort should be made to monitor the activities of these businesses on an ongoing basis, with the objective of ensuring that no illegal activity is undertaken and that steps are taken speedily for changes in legislation where it is deemed to be appropriate.
- 2.48** Furthermore, it is considered that the Department of Health & Children should keep drug - related legislation under review, with a particular focus on new synthetic substances, new or changed uses of psychoactive substances and drugs precursors.
- 2.49** The Steering Group considered the legislative framework governing illicit substances. Most were not in favour of legalising, decriminalising or changing/redefining the legal status of certain illicit drugs (cannabis was the focus of most discussion in this context). In these discussions, it was pointed out that findings from the Drug Prevalence Surveys of 2002/03 and 2006/07¹⁶ indicated that approximately 70% of those surveyed were of the opinion that recreational use of cannabis should not be permitted (support for the medicinal use of cannabis was about 70% over the two surveys).

PRIORITIES

- 2.50** In light of the above, the Steering Group has identified the following priorities in relation to supply reduction under the new NDS:
- the continued disruption of the supply of illicit drugs;
 - the ongoing monitoring of legislative and regulatory frameworks with a view to pursuing changes where necessary;
 - the continued roll - out of LPFs to all LDTF areas and other areas experiencing serious and concentrated problems of drug misuse;
 - the inclusion of drugs issues in a more central way in the work of JPCs to ensure that there is a concerted effort against drugs, including through Drugs Task Force involvement, in the Local Authority areas involved;
 - renewed efforts to address the issue of underage drinking which is often perceived as the direct cause, or the underlying cause, of many of the problems encountered by individuals and communities;
 - the development of an integrated system to track the progression of offenders with drug - related offences through the criminal justice system;
 - the continued implementation of increased security procedures and arrangements to reduce and eliminate the supply of drugs in prisons; and
 - the continued promotion of greater integration and co - operation at EU and international level, focusing on the global dimensions of drugs supply. This would include a focus on precursors for diversion to the manufacture of illicit synthetic drugs.
- 2.51** These issues are returned to in Chapter 7 where actions in relation to the new Strategy are identified.

¹⁶ Drug Use in Ireland and Northern Ireland 2002/2003 and 2006/2007 Drug Prevalence Surveys – National Advisory Committee on Drugs and Public Health Information & Research Branch (PHIRB) in Northern Ireland.

PREVENTION PILLAR

PREVENTION

Research

Supply Reduction

National Drugs Strategy
(interim) 2009 - 2016

Treatment

Rehabilitation

CHAPTER 3

PREVENTION PILLAR

INTRODUCTION

- 3.1** As outlined in the Introduction, the primary focus of this Report is on illicit drug use. However, alcohol is also referenced in this chapter in the context of developing a broader prevention strategy to tackle substance misuse, particularly in relation to under 18 year olds.
- 3.2** Prevention of problem drug use, in a broad sense, seeks to prevent the taking of illegal drugs, the prevention of harm where drug taking has initiated and the prevention of relapse where drug treatment has started. It also seeks to increase the awareness and understanding of people of the consequences of problem drug use and to delay the onset of first use. Prevention as a concept, is therefore, highly complex.
- 3.3** Research has identified risk and protective factors¹⁷ and these show that effective drug prevention must not rely solely on giving information on the harmfulness of drugs, but must also build self - efficacy through the development of social and personal skills. These skills are only as effective as their implementation within a wider context of complementary policy development relating to such issues as educational achievement; provision of family support; reducing marginalisation and poverty; reducing involvement in crime; rehabilitation of offenders; provision of youth supports/ services; and interruption of supply and availability of drugs.
- 3.4** Problem drug use by an individual, or by a group of people, is rarely caused by a single factor. Instead, the interplay between multiple conditions and factors that put an individual at risk of using or developing problems with drugs influences the experience or outcome. These complex and interlinked factors will vary between communities and individuals. For instance, the type of drug used will depend on the availability, price and accessibility of particular drugs.

¹⁷ **Risk factors** are: early school leaving or poor educational attainment; history of unemployment; poverty; poor mental health; family conflict/breakdown; anti - social behaviour; involvement in crime; family history of addiction (including alcohol); ethnicity and marginalisation and drug - taking in social networks. **Protective factors** are: family factors; educational factors; individual characteristics; personal and social competence.

- 3.5** Under the current NDS, the focus of the prevention chapter is on promoting a greater awareness and understanding of the dangers of problem drug use throughout society. At the outset, this chapter looks at the progress achieved across the various actions and key performance indicators. It also examines the key findings from the consultation process and outlines what the priorities for the new NDS should be in relation to this area. The risk factors referred to above also help to inform the development of future priorities and actions.

Table 3.1. – Strategic Aim and Objectives of the Prevention Pillar under the current National Drugs Strategy

<i>National Drugs Strategy 2001 - 2008 – Prevention</i>	
Strategic Aim	
■ To promote throughout society a greater awareness, understanding and clarity of the dangers of drug misuse.	
Strategic Objectives	
■ To develop a greater understanding of the dangers of problem drug use among the general population; and	
■ To promote healthier lifestyle choices among young people and other vulnerable groups at risk of problem drug use, through personal development, life - skills and harm reduction approaches.	

ASSESSMENT OF PROGRESS UNDER CURRENT NDS

- 3.6** The actions of the prevention pillar of the current NDS can be separated into four areas:
- Early school leaving;
 - Education programmes in school - setting;
 - Education programmes in non school - settings, including diversionary programmes primarily developed in LDTF areas; and
 - Awareness campaigns.

Early School Leaving (ESL)

3.7 The NDS includes four actions targeting ESL¹⁸.

- The Government's DEIS Action Plan [Delivering Equality of Opportunity in Schools] is aimed at identifying and tackling levels of disadvantage and it provides the basis for school supports to, among others, schools in LDTF areas (action 29). The initiatives under DEIS are being rolled out on a phased basis to 873 schools between 2005 and 2010. It incorporates the School Completion Programme which targets children most at risk of leaving school early. The Department of Education & Science has also developed a Traveller Education Strategy, one objective of which is to address the problem of ESL in this community. A Traveller Implementation Group has been established to co-ordinate education policies for Travellers based on integration, inclusion, and age-appropriate placement. While the number of Traveller students attending primary and post-primary schools has increased significantly in recent years, absenteeism and retention rates remain as major challenges.
- The National Educational Welfare Board (NEWB) was set up in 2002 to address issues of attendance and to encourage young people to stay in school or training, as appropriate. LDTF areas (action 30) were prioritised in the roll-out of NEWB services across the country. In accordance with available resources, Educational Welfare Officers (EWOs) provide an intensive service in these areas and work with other agencies and services that are engaged with "at risk" families. While the Board publishes research on school participation, including data on attendance and the number of children with whom EWOs are engaged on a national and regional basis, this data is not broken down by LDTF area. The NEWB is also working with schools to support them in developing school attendance policies (action 36) and has issued guidelines for schools on developing Codes of Behaviour. It is also developing guidelines on attendance strategies for schools.

¹⁸ The Education (Welfare) Act, 2000, provides that the minimum school-leaving age is 16 years or the completion of three years post-primary education, whichever is the later. A widely recognised definition of "early school leaver" is that used by Eurostat: *the proportion of persons aged 18 to 24 years whose highest level of education attained is lower secondary or below and who did not receive either formal or non-formal education in the previous four weeks*. The relevant figure for Ireland in 2006 was 12.3% as compared to an EU average of 15.2%. The source of data that Eurostat use to create this indicator is the European Labour Force Survey, which in the Irish case, is the Quarterly National Household Survey (QNHS).

- The Department of Education & Science also has a number of other programmes which, while not specifically included in the NDS, are designed to identify and provide supports to children at risk. These include the National Educational Psychological Service (NEPS) and Youth Encounter Project Schools.

- One of the new actions arising from the MTR of the current Strategy was to provide additional resources for the Home School Community Liaison Scheme (HSCL) which was designed to involve parents in their children's education. It is regarded by the Department of Education & Science as a critical intervention in improving outcomes of children from disadvantaged areas. The HSCL has been expanded to include all DEIS schools.

3.8 In summary, three of the four actions relating to ESL are ongoing and one (action 103) has been completed. Those that are ongoing are being addressed primarily through the broader social inclusion agenda.

3.9 There is a strong correlation between ESL and all its aspects - poor school attendance, lack of engagement in school, disruption, poor results etc - and early alcohol/drug use. The socio-economic factors that drive the former are primarily the same as those that influence the latter behaviour. These predominantly relate, in varying degrees, to the level of individual, family and community dysfunction experienced and to the level of other negative social influences involved, particularly negative peer relationships and media influences. In this context, ESL has been identified as a critical event in experimentation with drugs and, consequently, measures to promote successful school completion rates also impact on potential problem drug/alcohol use.

3.10 Projects to address successful school completion rates were a central feature of the initial LDTF plans. Many of the initial projects have since been mainstreamed, with a further tranche of projects currently under consideration for mainstreaming. More recently, school completion initiatives have figured less prominently in LDTF plans and they were not prioritised to any significant extent in the RDTF plans. School completion actions have, however, been a strong feature of services developed under the Young Peoples Facilities and Services Fund (YPSF)¹⁹.

¹⁹ Responsibility for the Young Peoples Facilities & Services Fund transferred to the Office of the Minister for Children & Youth Affairs from the Department of Community, Rural & Gaeltacht Affairs on 1st January 2009.

- 3.11** Meanwhile, addressing ESL and maximising successful school completion rates is a central pillar of the Government's social inclusion policy. A number of mainstream actions such as Youthreach and Senior Traveller Training Centres (STTCs) were developed by the Department of Education & Science under the National Development Plan 2001 - 2006 and are to be further developed under *Towards 2016*. This focus is also central to the activities of Community Training Centres administered by FÁS.
- 3.12** From a community perspective, Area Based Partnership Companies also have a role in educational development through Community - Based Youth Initiatives and Services for the Unemployed, the two sub - measures of the Local Development Social Inclusion Programme. The RAPID Education Programme, which was implemented in 2008, uses RAPID Area Implementation Teams (AITs) to develop, from a community perspective, suitable educational projects aimed at fostering successful school completion.
- 3.13** Addressing ESL and all its aspects has, therefore, been the subject of increased focus and attention in recent years, particularly since the development of the current NDS. Given those developments, the Steering Group considers that the role of the new NDS in relation to addressing this problem lies within the context of complementing existing programmes. This complementarity can be best achieved through the further development of youth services, particularly as they relate to the future educational engagement of youth at risk. Any services developed should be based on deepening engagement with young people and their families in the non - school setting and complementing the services being developed through the existing programmes.

Education and awareness programmes in school settings

- 3.14** The two main dimensions of these actions were to develop substance misuse policies in schools in LDTF areas²⁰ and to strengthen drugs education and awareness programmes in school settings through a variety of measures. These related to subject prioritisation, parental engagement, support to teachers and trainee teachers and research & evaluation of programmes²¹.

Substance Misuse Policies

- 3.15** The Department of Education & Science provides guidance to schools in developing substance misuse policies, but the primary responsibility for developing and implementing such policies rests with individual schools. The Regional Office Service of that Department monitors compliance with this action and, in this regard, it conducted a sample survey of schools in December 2005. Overall, 72% of schools responded to the survey and, of these, 71% of primary schools and 75% of post - primary had policies in place, while a further 18% and 19% respectively were developing policies. SPHE (Social and Personal Health Education) support personnel (para. 3.23 also refers) also offer guidance and advice on developing school policies but this is only available when the school involved seeks such support.
- 3.16** While it is not possible to determine whether substance misuse policies exist in all of the schools in LDTF areas based on published data, it is generally accepted that progress in relation to this action is substantially completed. However, there is a lack of clarity as to the quality of these policies and the degree to which they are actively implemented and subject to review.

Prevention and awareness programmes in schools

- 3.17** Prevention and awareness programmes in schools are a key element of the overall prevention pillar. The Social Personal Health Education (SPHE) Programme is the foundation for developing awareness of drugs and alcohol issues in schools. It is a mandatory part of the curriculum at primary and junior cycle in second level.
- 3.18** SPHE is designed to build the esteem and confidence of young people through developing their life skills, and substance misuse is an integral part of the curriculum. As part of the programme, the Department of Education & Science has developed a number of supports for teachers and parents through the SPHE Support Services (para.3.23 also refers). Drug prevention education is part of the pre - service training for primary teachers, while it is an elective in the Higher Diploma for second - level student teachers. A dedicated SPHE inspectorate is also in place. The Department of Education & Science is currently developing a senior cycle SPHE Programme through the National Council for Curriculum and Assessment and is working on a framework for this with a small number of schools.

²⁰ Action 43.

²¹ Actions 31, 32, 33, 34, 35, 42 and 102.

3.19 However, a key question has arisen as to the effectiveness of SPHE in preventing or delaying problem substance use. In this context, the SPHE curriculum was reviewed and it was found that, in concept and design, it is in line with international best practice. However, its effectiveness at second level was consistently questioned during the NDS consultation process, in particular by school - goers themselves.

3.20 One of the key concerns raised during the consultation process was the commitment given to SPHE by individual schools and the support that teachers receive to deliver the programme. The findings from the consultations suggest that, while a framework is in place, there are still key questions to be addressed about its delivery in terms of its overall effectiveness.

3.21 The Walk Tall Programme and On My Own Two Feet are integral parts of the Social, Personal and Health Education (SPHE) curricula at primary and post - primary level respectively.

The Walk Tall Support Service has, since February 2002, supported all primary schools in LDTF areas to implement the *Walk Tall Programme* in the context of SPHE. Since September 2007, all DEIS schools have been offered similar support.

The Post - Primary SPHE Support Service provides support to schools in relation to all aspects of the SPHE curriculum, including the *On My Own Two Feet* component.

3.22 Recognising the limitations of the previous SPHE evaluation, which did not include the views of parents and students, the SPHE Management Committee²² commissioned a further evaluation by NUIG²³, based on a sample of 12 post - primary schools. This evaluation found that, while SPHE is regarded as challenging, valuable and contributing to students' attitudes to health, the programme has a number of limitations:

- support services for the delivery of SPHE are crucial in developing the competence of teachers and schools that find it difficult to implement SPHE. Available support services should be targeted at such teachers and schools. Whole School Evaluations should help to identify such schools. Support for

SPHE should be provided in the context of in - service training;

- there is little engagement with parents in the planning and development of SPHE; and
- curriculum overload, timetabling pressures and lack of status for SPHE affect its provision in schools.

The evaluation also noted that the development of whole school planning is fundamental to the creation of a supportive whole school approach and this process should include assigning SPHE the same level of importance as any other subject area.

3.23 The Steering Group notes that full-time supports have been in place since the inception of SPHE to provide professional development for teachers, as well as school visits, a website and a resource directory. However, the evaluation has highlighted difficulties relating to second - level schools continually assigning responsibility for the subject to different teachers, thereby diluting the impact of the investment in professional development for teachers. The lack of a pre - service qualification in this area is also a problem. However, the programme is being delivered in all schools and the general feedback is that the curriculum support services are viewed very positively. The Department of Education & Science will continue to work with those services to strengthen implementation in this important area.

3.24 The Steering Group also believes that more should be done to incorporate the self - esteem, personal development, health and well - being and substance prevention message - that is at the core of the SPHE and other prevention/ awareness programmes in schools - into the broader school curriculum and environment. The Group feel that improvements to the programme could be made by delivering it in a manner more appropriate to the lifestyle of the students, with more focused efforts being made to integrate the SPHE message into other areas of school work (e.g. science subjects) and, indeed, across whole school activity, including sport and recreational activities.

²² Membership of the Committee includes representatives of the Department of Education & Science, HSE and the National Council for Curriculum and Assessment.

²³ The Implementation of SPHE at Post Primary Level: A Case Study Approach, NUIG, May 2008.

Education and awareness programmes in non - school settings and development of diversionary programmes

3.25 The two key dimensions of these actions related to the development of diversionary alternatives particularly in LDTF areas²⁴ and the application of SPHE - type prevention programmes in non - school settings, facilitated through the establishment of a working group²⁵.

3.26 The YPFSF has been the main funding mechanism for providing alternative activities for young people under the current NDS. Between 2002 - 2007, funding of €127.5m was provided to approximately 500 services and facilities in LDTF areas and four other designated urban centres - Limerick, Waterford, Carlow and Galway. Drugs Task Forces have also been involved in developing prevention/awareness programmes. In 2008, some 289 projects, with a value of €18.95m, across both Local and Regional Drugs Task Forces had either an exclusive education/prevention focus or included prevention/education as part of the project remit. These figures include LDTF activities in both school and non - school settings, with many aimed towards at risk populations. Others focus on raising broader community awareness.

3.27 Non - school projects that focused on at risk young people facilitated the development and extension of activities. The 2008 evaluation of LDTF projects²⁶ found that the available evidence suggests that diversion may have a role to play in preventing problem drug use in at risk groups. However, many LDTF - funded projects of this type concentrated on creating diversionary opportunities, rather than on specific prevention interventions, indicating a need for further training among those running such projects. It also concluded that more generic programmes to address risk factors may be more appropriate for funding through mainstream provision. In this context, a particular challenge for these education and prevention projects is to improve links with other services and to identify appropriate referral routes.

3.28 In addition to the YPFSF, a number of funding streams positively impact on young people who are subject to various risks. These include:

- Special projects to assist disadvantaged youth (SPY) (operated through the Department of Education & Science);
- HSE - funded initiatives in relation to education and prevention; and
- Garda Juvenile Diversion Programme (operated by Juvenile Liaison Officers) and Garda Youth Diversion Projects (funded by the Irish Youth Justice Service).

The more general Youth Service Grant Scheme/Local Youth Club Grants (operated through the VECs) is also worth noting in this regard.

3.29 In recent years, there have been significant increases in the Garda Juvenile Diversion Programme and the Garda Youth Diversion Projects, with over 100 projects working with young people at risk of engaging in crime and substance misuse in targeted locations around the country. However, progress has been modest in monitoring the effectiveness of such schemes - e.g the Arrest Referral Scheme (action 13 of the current NDS refers). Under its National Strategy 2008 - 2010, the Irish Youth Justice Service, in partnership with An Garda Síochána, intends undertaking a programme aimed at improving the effectiveness of projects.

3.30 The Garda Youth Diversion Projects are regarded as being broadly successful in diverting large numbers of young people from the formal criminal justice system²⁷, with the onward referral of young people identified as being at risk. Consequently, the Steering Group considers that such programmes should continue to be part of the broader NDS, with any expansion being subject to robust measuring and evaluation of the impact of existing projects.

²⁴ Action 3.

²⁵ Action 37 (Implementing Actions 31 - 35 in non - school settings).

²⁶ National Drugs Strategy Team: Evaluation of LDTF Projects: Horwath Consulting Ireland Ltd, January 2008. The aim of the evaluation was to assess the contribution of projects to LDTF plans and the implementation of the National Drugs Strategy 2001 - 2008. The evaluation examined the structures, effectiveness, efficiency and value for money components of the projects.

²⁷ Publications in respect of the Garda Diversion Projects and Special Projects: Study on the "Impact and Effectiveness of the Garda Special Projects": Matt Bowden & Louise Higgins, May 2000 Annual Report of the Committee Appointed to Monitor the Effectiveness of the Diversion Programme, 2005.

3.31 Furthermore, the Steering Group believes that greater links are necessary between the various agencies with responsibility for the wider needs of young people. In particular, there should be closer co-operation between An Garda Síochána, the Office for the Minister of Children and Youth Affairs (OMCYA), the HSE and the voluntary and community sectors (particularly youth organisations), all of whom play a role in this area. This is encompassed by the National Youth Justice Strategy 2008 - 2010.

3.32 Overall, as with the YPFSF, the Steering Group believes that the focus under such programmes on “at risk” young people is critical and must continue into the future. This is essential to ensure that additional services are provided that complement those already provided.

Future Youth Service Provision

3.33 Generally, there are two key dimensions to youth services provided through community and youth organisations:

- provision of professional youth services, aimed primarily at youth at risk; and
- voluntary based youth and sports activities, which have a mainly recreational focus, aimed at facilitating the engagement of the youth population in activities and pursuits. This is primarily volunteer-driven where people come together to engage in a common interest (e.g. youth theatre, environmental issues), to run a youth club or to pursue a sporting activity.

Provision of professional youth services aimed primarily at youth at risk

3.34 There is a wide range of youth services operating that are aimed at the at risk youth population. These have been developed under a range of agencies with a health, justice, education or drugs focus to address a variety of issues from child protection through to promoting health awareness. In essence, these services try to address broadly similar risk factors associated with the individuals involved, their families, their peers and their communities and it is generally accepted that there is a need for greater integration and co-operation between agencies.

3.35 Bringing all youth services under the OMCYA aims to facilitate the integration of youth services at a national level. Co-ordination

between the services and provisions for young people is aimed at ensuring better efficiency and effectiveness. In this regard, it is noted that elements of the Youth Work Act 2001 (particularly the county planning mechanism) could promote a more coherent approach to the provision of youth work services across the country. In terms of the NDS, it is critical that the drugs issue remains central to the ongoing development of youth services and, in particular, to educational/recreational activities for young people who are most at risk.

3.36 The fact that a working group (action 37) was not established to facilitate the implementation of actions 31 - 35 in non-school settings has, the Steering Group believes, contributed to preventative initiatives remaining largely unco-ordinated at a national level. This, in turn, has led to significant potential for inconsistent approaches to drug education by different groups and organisations. In order to develop a uniform approach to drugs education in school, youth and community settings throughout the country, the Drug Education Workers Forum (DEWF) developed a quality standards framework and also provided seminars for people working in drugs education. Funding was provided from the Department of Community, Rural and Gaeltacht Affairs to print the training manual and to roll out a 3-year training programme on the quality standards. The aim is to bring more consistency in approaches utilised and the Steering Group believes that the DEWF framework should be used as the standards, or the basis for the standards, to be applied in respect of drugs education across all youth services. A lead agency is required to drive this formal recognition of a set of national standards and the Steering Group feels that the OMCYA is best placed to take on this role. The standards agreed (subject to amendments over time) should also be applied to future preventative and awareness messages aimed at voluntary-based youth and sport activities.

3.37 As outlined above, the YPFSF has been the key mechanism for developing youth facilities under the current NDS. In regard to facilities, the Steering Group considers that a number of issues need to continue to be pursued in regard to accessing new and existing community, sports and schools buildings. These include:

- ensuring that appropriate supervision and support is in place;

- guaranteed access for the most at risk young people; and
- late night and weekend access.

3.38 The Steering Group understands that the OMCYA is currently examining the issue of youth café development. During the consultation phase for the new Strategy, the need to ensure late night and weekend opening of such facilities was highlighted, as was the need to put in place structures that promote preventative measures to the youth who use them. In this regard, international evidence suggests that activities on their own are not sufficient to prevent substance misuse – there is also a need to have complementary structured programmes of supports. These could include brief interventions, referral to other services, as appropriate, and educational activities. This is not only relevant to youth cafes, but also to all diversionary activities aimed at both youth at risk and the general youth population.

Voluntary - based Youth and Sport Activities

3.39 Internationally, it is accepted that it is vital to promote drug prevention messages to the general youth population, as well as putting particular focus on youth at risk. The Drug Prevalence Survey 2006/7²⁸ confirms the availability of drugs across the country and given the mix of drugs involved, all youth are clearly at risk of becoming involved. Furthermore, the fact that at any particular time certain drugs are seen as “fashionable”, along with their association with general recreation, dance etc, can increase the risk for some young people.

3.40 Many youth initiatives in Ireland are aimed at the general youth population (which includes youth at particular risk). These are managed and developed in the main by the various youth organisations and sports clubs, often with Government supports under various schemes. These settings afford an opportunity to promote substance awareness and prevention messages. They also afford a significant opportunity to promote peer - led approaches to the dissemination of prevention messages.

3.41 Under the YPFSS, funding for the employment of drugs education officers was provided to a number of youth organisations to develop and implement drugs education programmes for the young people involved. The Steering Group believes that there is scope for developing such drugs education programmes further.

Awareness Campaigns - National, Regional and Local Level

3.42 These actions involved a national awareness campaign²⁹, community - based initiatives to promote awareness including involvement of user groups³⁰ and the role of the media in developing understanding of substance misuse³¹.

3.43 A national awareness campaign which was conducted between 2003 and 2005 incorporated a number of elements aimed at raising:

- drug awareness among the general population;
- drug awareness among parents;
- awareness about cocaine primarily among younger adults; and
- awareness about cannabis among the 15/16 age group.

3.44 The evaluation of the campaign subsequently commissioned by the NACD³² found that it was difficult to demonstrate whether the campaign had been effective in achieving its objectives. The review highlighted tensions in the co - ordinating structures, as well as an inadequate level of funding, that contributed to limiting the effectiveness of the campaign.

3.45 The Steering Group notes that the evidence of the general effectiveness of awareness campaigns - as stand - alone activities - has not been proven in terms of success in changing behaviours. The NACD evaluation concluded that stand - alone mass media campaigns are less effective than multi - component, multi - level interventions that reflect the complex nature of drug prevention and harm reduction. The evaluation also called for greater inter - agency working to maximise the impact of campaigns and that national and local campaigns should be closely linked.

²⁸ Drug Use in Ireland and Northern Ireland – 2002/2003 and 2006/2007 – Drug Prevalence Surveys: National Advisory Committee on Drugs and Public Health Information & Research Branch (PHIRB) in Northern Ireland.

²⁹ Action 38.

³⁰ Actions 95, 96 and 97.

³¹ Action 73.

³² A Process Evaluation of the National Drug Awareness Campaign 2003 - 2005: NACD, January 2008.

3.46 The 2008 national drugs awareness campaign (focusing on cocaine) which was led by the HSE utilised multi - media approaches appropriate to the target audience. Local cocaine campaigns which linked in with the aims and objectives of the national campaign were implemented in late 2008. In developing these and future campaigns, there is a need to focus on ensuring that local, regional and national campaigns complement each other. The Steering Group considers that specific segments could also be aimed at third - level institutions, workplaces and recreational venues.

3.47 A national website funded by the HSE and run by Crosscare (www.drugs.ie) and a number of project - based websites that promote awareness and provide information and points of contact, have also been developed under the NDS. However, the use of the internet and modern technologies is underdeveloped and the Steering Group believes that these should be a focus for development under the new Strategy, with a view to providing comprehensive information on issues involved and services available.

3.48 With regard to the new Strategy, the Steering Group considers that a series of awareness campaigns should be developed that would:

- ensure that local and regional campaigns complement and add value to national campaigns;
- optimise the use of ICT in drugs awareness initiatives (e.g. through internet search engines and social network websites);
- ensure a co - ordinated approach by all key players to the development and implementation of a designated drug awareness week/day with agreed themes and methodologies; and
- through the engagement with services users, representatives or services working with the following communities, target:
 - third level educational institutions, workplaces and recreational venues;
 - at risk groups (Travellers, new communities, lesbian, gay, bi - sexual, transgender community (LGBTs), homeless people, prisoners and sex workers); and
 - education/awareness among drug users to minimise the levels of usage and to promote harm reduction measures.

3.49 In general, it is felt that the media, in their broadest context, play a significant role in

society's understanding and perception of problem alcohol and drug use. In relation to alcohol, advertising and sponsorships (especially in the sporting context) are seen as particular problems, especially as they are often targeted at the young and impressionable. In this context, it is noted that strengthened codes on advertising and sponsorship, which were developed between the Department of Health & Children and representatives of the Irish drinks and advertising industries, came into effect on 1st July 2008. Under these codes, the Irish alcohol industry may not sponsor any sporting competitions, leagues, events or competitors where such events are designated specifically for participants under 18 years of age. In this context, the Department of Health & Children established a Working Group to engage with relevant stakeholders and the sporting bodies to examine the extent of sport sponsorship by alcohol companies and to consider how the health - related concerns might be further addressed. The Working Group is expected to report in Autumn 2009. The Steering Group welcomes these developments.

3.50 While much media coverage is responsible and informed, the view was expressed during the consultation process that the media does, in many ways, contribute to the glamourisation of drugs - rather than creating an understanding of the dangers of substance misuse. It clearly can have both negative and positive effects ranging from benign reporting on drug use among celebrities - with fears that this promotes drug use - to the factual exposition of the consequences of problem drug use - be it for individuals and their families or for communities.

KEY FINDINGS FROM THE CONSULTATION PROCESS - QUALITATIVE ASSESSMENT

3.51 One of the key themes to emerge from the consultation process is the perception that drug and alcohol use is more widespread and that the age profile of those involved is getting younger. Measures to prevent and/or delay drug and alcohol use - especially amongst young people - are, therefore, particularly important and urgent.

3.52 While it is possible to demonstrate clear progress in implementing the current NDS actions in relation to prevention, the consultation process found that prevention measures are not seen to be making sufficient impact.

3.53 The key themes to emerge from the consultation were:

- school - based education programmes, on which the NDS places particular emphasis, were considered to be very uneven in their delivery and, therefore, in their overall impact. The impact fundamentally depends on the commitment of individual schools and the confidence and competence of individual teachers. Young people consulted were highly critical of their experiences of the delivery of SPHE. The recent evaluation of SPHE has also identified areas to prioritise in order to achieve improvements in the effectiveness of school programmes, in particular, support for teachers and schools and significantly better engagement with parents.

- access to recreational and other facilities for young people was considered to be important in preventing them from misusing drugs and alcohol. While numerous examples of worthwhile youth clubs, and other out - of - school facilities that provide alternatives for young people were highlighted throughout the consultation process, the lack of such facilities and appropriate supporting structures across the country emerged as a key gap. Such facilities are particularly important for young people who leave school early. In this regard, the Steering Group believes that the scope to provide access to school facilities outside of school hours is an issue that should be progressed as a matter of urgency.

PROGRESS AGAINST CURRENT KPIS

3.54 This assessment of impact is based on the revised KPIS agreed during the MTR of the current NDS, which was carried out in 2005:

Key Performance Indicator	Outcome
<i>The 3 source Capture - Recapture study estimate of opiate misusers to show a stabilisation in terms of overall numbers and to show a reduction of 5% of the prevalence rate based on 2001 figures published in 2003</i>	The latest 3 source capture - recapture study had not been completed by the time the Steering Group finalised this Report. However, it is noted that heroin use continues to be concentrated primarily in areas of urban disadvantage in Dublin and in other urban centres, particularly in Leinster and the south of the country. The prevalence of heroin has ameliorated to an extent in the Dublin area with a significant drop in the rate of new entrants identified. However, this has been offset to a degree by its wider dispersal around the country. Overall, the rate of new entrants to treatment had dropped significantly by approximately 20% between 2001/02 and 2006/07. Heroin remains a significant problem and a matter of serious concern for many communities, however.
<i>The NACD Drug Prevalence 2006/07 Survey to show a reduction of 5% of the prevalence rate of recent and current use of illicit drugs in the overall population based on the 2002/03 rate</i>	Prevalence of recent drug use (use in last year) increased from 5.6% in 2002/03 to 7.2% in 2006/07 among all adults aged 15 - 64. The trend for overall current drug use (use in last month) remained stable at 2.9%, though, for the younger adults group (15 - 34), it decreased from 5.2% to 4.8%.
<i>Substance use policies in place in 100% of schools</i>	A Department of Education & Science study in 2005 indicated that substance misuse policies were in place in between 89% and 94% of primary and post - primary schools that made returns (72% of schools made returns).
<i>Early school leaving in LDTF areas reduced by 10% based on 2005/06 rate</i>	Data specific to LDTF areas is not available. Current data on early school leaving is available through: <ul style="list-style-type: none"> I. School retention rates of pupils; II. Eurostat; and III. Quarterly National Household Survey (QNHS). <p>While it is not possible to definitively conclude that ESL has reduced by 10% in LDTF areas, both Eurostat and the QNHS suggest that the number of early school leavers is reducing. Eurostat data shows that the percentage of people aged 18 - 24 who have, at most, lower secondary education has decreased from 14.7% in 2002 to 12.3% in 2006. While the QNHS survey shows that 16.1% of people had not attained a Leaving Certificate in 2001, this had reduced to 14.37% in 2006.</p> <p>Thus, the figures show a downward trend in early school leavers. Together with feedback from the LDTFs, it is reasonable to contend that this indicator is, at least, going in the right direction.</p>

3.55 The Steering Group notes that while the increase in levels of last year drug use is a cause for concern, the stabilisation of current drug use is welcome and is broadly similar to what is happening in the rest of the EU.

CONCLUSIONS AND PRIORITIES FOR THE FUTURE DRUGS STRATEGY

3.56 Overall, the Steering Group believes that a tiered or graduated approach to prevention and education measures in relation to drugs and alcohol should be developed with a view to providing a framework for the future design and development of interventions. This would involve varying degrees of intervention involving a “light touch” for the general population who are less at risk, up to a more concerted effort at a younger age for those most at risk. It would necessitate well - developed inter - agency working, with all involved needing to be clear of their own roles and knowledgeable on the roles of others. In assessing the level of risk involved, the overall environment incorporating individual development, parents, peers, school and community would all be factors.

3.57 Interventions could be seen to fall under the following broad headings:

(i) Universal (primary) prevention programmes:

- Aimed at reaching the general population such as students in schools, to promote overall health of the population and to prevent the onset of drug and alcohol misuse. Measures often associated with this type of programme include awareness campaigns, school drug/alcohol education programmes and multi - component community initiatives.

(ii) Selected (secondary) prevention programmes:

- Aimed at groups at risk, as well as subsets of the general population including children of drug users, early school leavers and those involved in anti - social behaviour. These programmes aim to reduce the effect of risk factors present in these subgroups by building on strengths and developing resilience and protective factors.

(iii) Targeted (tertiary) prevention programmes:

- Targeted at people who have already started using drugs/alcohol, or who are likely/vulnerable to engage in problematic drug/alcohol use (but may not necessarily be drug/alcohol dependent), or to prevent relapse. These require individual or small group programmes aimed at addressing specific needs.

3.58 As outlined above, prevention is a particularly complex pillar with intricate connections between skills and understanding of the consequences of problem drug/alcohol use, exposure to risk factors and early drug/alcohol experimentation. The focus of prevention measures in the current NDS has, to a large extent, been on the provision of education services in school - settings for the school - going population. While conceptually these programmes are sound, and in line with evidence - based practice on prevention, the Steering Group notes that their application and delivery limit their effectiveness.

3.59 Provision of education in non - school settings remains fragmented and unco - ordinated, in part due to the failure to set up a working group (action 37) to co - ordinate the application of school - type programmes in non - school settings. The provision of alternative recreational facilities for young people is also underdeveloped. In addition, despite significant expenditure on recreational activities, many young people do not have access to such facilities in out - of - school settings. There is considerable scope to streamline funding mechanisms to provide a comprehensive range of structured, out - of - school alternatives. However, in order to be most effective, they will need to be targeted at young people who are most at risk and be developed as part of overall prevention programmes. The Steering Group believes that the enhanced role of the OMCYA offers the potential to bring more coherence in this area.

3.60 The Steering Group is of the view that there is a need to further develop and promote prevention strategies in a number of other key areas – third - level institutions, workplaces, sports and other community and voluntary organisations. Much work has been done in these areas to date:

- All universities have alcohol policies in place;
- IBEC promotes a policy on intoxicants among its membership;
- Trade unions have consistently been involved with the issue, both in the workplace and the wider community; and
- Many sports and youth organisations have substance misuse policies in place or in development.

The Steering Group considers that there is a need to further promote the development of substance misuse policies in these settings, along with the development of a brief interventions approach, where appropriate.

- 3.61** As outlined in chapter 1, the considerable negative impact that problem drug and alcohol use has on families is well known. The effects include deteriorating relationships and making the family dysfunctional, psychological and social problems, increased stress, depression and behavioural disorders, and financial difficulties – all of which can contribute to family breakdown and negative impacts on adults and, particularly, on children in families. The latter are likely to be at high risk due to the prevalence of drug/alcohol misuse within their families, peers and communities and are at risk of becoming problem drug users in later life. Accordingly, the Steering Group recommends that actions to support the families of drug users should be developed as part of the new NDS.
- 3.62** In the context of this pillar, the potential role that an overdose prevention policy could play is also noted. This issue is developed in more detail in chapter 4.
- 3.63** A key feature of *Towards 2016* is the identification of improved educational outcomes as an important priority. Measures to address key risk factors to delay/prevent people from using substances are fundamentally connected to the wider Government policy of improved educational outcomes. A key future priority is a more concerted approach to prevention, in particular to address the risk and prevention factors that can affect early experimentation with drugs and alcohol.
- 3.64** Evidence suggests that the nature of the drugs problem is changing and becoming more complex. Drugs are generally more widely accessible to young people. These trends require a more concerted approach to prevention, with a strong emphasis on co-ordinating the actions of the different agencies involved in delivering programmes, as well as funding diversionary programmes such as the YPFSF.
- 3.65** The Steering Group acknowledges social capital as a critical component in building resilience in communities, as was pointed out in the NACD Community Drug Study³³. High levels of social capital (encompassing engagement in the community, volunteering, working together and overall positive community spirit and identity) act as a buffer against the dangers of problem drug and/or alcohol use. On the other hand, the lack of social capital in a community can act as an early warning in regard to the presence

of problems relating to drugs and/or anti-social behaviour. Accordingly, supporting community development to enable the building of capacity to avoid, or respond to and cope with, drug problems, is important in terms of substance misuse prevention. Such capacity can also facilitate more effective local level activity around drug and alcohol prevention and awareness initiatives.

- 3.66** The important role which Civil Society plays in drugs prevention is now being more recognised at EU level. It is considered important that the experiences of people in their communities contribute to the debate and thus inform public policy. The Steering Group notes that Ireland has a strong history in this regard and can contribute to developments at EU level.

PRIORITIES

- 3.67** In light of the above, the Steering Group has identified the following priorities in relation to prevention under the new NDS:
- the further development of a tiered or graduated approach to prevention and education measures in relation to drugs and alcohol. This approach would provide a framework for the future design of targeted prevention and education interventions;
 - improved delivery of SPHE in primary and post-primary schools, encompassing the implementation of the recommendations of the SPHE evaluation in post primary schools and the development of a whole school approach to substance use education in the context of SPHE;
 - the co-ordination of the activities and funding of youth interventions in out-of-school settings to optimise their impacts;
 - a continued focus on orienting educational and youth services towards early interventions for people and communities that are most at risk;
 - the promotion of healthier lifestyle choices among young people in regard to the dangers of alcohol, with particular reference to misuse and binge drinking; and
 - the development of timely awareness campaigns targeted in a way that take individual, social and environmental conditions into account.
- 3.68** These issues are returned to in Chapter 7 where actions in relation to the new Strategy are identified.

³³ A Community Drugs Case Study – Developing Community Indicators for Problem Drug Use: NACD, 2006.

INDIVIDUAL

Prevention:
Treatment
& Rehabilitation

Targets people
who have already used
drugs/alcohol
or who are
likely/vulnerable
to do so.

**Tertiary
Prevention**
indicative
programmes
Targets
drug users

**Selected (Secondary) Prevention
programmes:**

target those with increased risk
such as early school leavers, young offenders,
children of drug and/or alcohol dependent
parents and disadvantaged communities.

Universal (Primary) Prevention programmes:

target the general population with school programmes and
workplace initiatives, population health, awareness campaigns,
multi - component community initiatives including supply reduction,
thereby creating an environment conducive to health and well - being supporting
engagement of people in community life.

POPULATION

TREATMENT AND REHABILITATION

PREVENTION

Research

Supply Reduction

National Drugs Strategy
(interim) 2009 - 2016

Treatment

Rehabilitation

CHAPTER 4

TREATMENT AND REHABILITATION

INTRODUCTION

4.1 The Treatment and rehabilitation pillar of the current NDS focused on developing services to address the health and social consequences of problem drug use by individuals, particularly those misusing opiates. The primary aim was to put in place services to cater for opiate misusers with a strong focus on the original LDTF areas (primarily in Dublin) where the problem was most concentrated. More recently, the focus has broadened to re - engineering services to develop a comprehensive substance treatment service capable of dealing with all substances, particularly given the increasing geographic dispersal of problem drug use (including opiates), the increased prevalence of polydrug use and cocaine use, the increasing strength of cannabis, as well as the pervasive misuse of alcohol and the level of misuse of prescription drugs in society.

4.2 In developing this chapter, and in line with the Government decision to develop a National Substance Misuse Strategy, the Steering Group was conscious of the need to bring greater coherence and co - ordination to alcohol and drug issues at a policy, planning and operational level. In this context, the Group strongly endorses the approach of the HSE involving the re - orientation of its addiction services towards polydrug issues (including alcohol), using a 4 - tiered model

approach³⁴ as a national framework through which to deliver services. The integration of treatment services within the context of the NDS relates to the integration of addiction services and the development of appropriate pathways to and from general health service provision.

ASSESSMENT OF PROGRESS DURING THE PERIOD OF THE CURRENT NDS

4.3 The strategic aim of the pillar is set out in Table 4.1. below. Treatment and rehabilitation accounted for nearly 40% of the actions in the current Strategy. Given the health focus involved, the HSE³⁵ was responsible for delivering/leading on many of the actions, but there were important roles for a number of other Departments/Agencies including:

- Department of Health & Children;
- Department of Community Rural & Gaeltacht Affairs;
- NDST/Drugs Task Forces;
- FÁS;

³⁴ Four tiers of service delivery are used to denote different levels of service provision. These are: **Tier 1:** Generic services which would include drug - related information and advice, screening and referral and would be aimed at those who might consider, or who are at the early stages of, experimentation with drugs or alcohol. Service providers might include An Garda Síochána, General Practitioners or community and family. **Tier 2:** Services with specialist expertise in either mental health or addiction, such as juvenile liaison officers, local drugs task forces, home - school liaison, Youthreach, General Practitioners specialising in addiction and drug treatment centres. The types of service delivered at this level would include drug - related prevention, brief intervention, counselling and harm reduction and would be suitable for those encountering problems as a result of drug or alcohol use. Tier 2 interventions are delivered through outreach, primary care, pharmacies, emergency departments, liver units, antenatal clinics or in social care, education or criminal settings (An Garda Síochána, the Probation Service, the Courts Service, Irish Prison Service). **Tier 3:** Services with specialist expertise in both mental health and addiction. These services would have the capacity to deliver comprehensive treatments through a multi - disciplinary team. Such a team would provide medical treatment for addiction, psychiatric treatment, outreach, psychological assessment and interventions, and family therapy. Tier 3 interventions are mainly delivered in specialised structured community addiction services but can also be sited in primary care settings such as level 1 and 2 GPs, pharmacies, prisons and probation services. **Tier 4:** Services with specialist expertise in both mental health and addiction and the capacity to deliver a brief, but very intensive, intervention through an inpatient or day hospital. These types of service would be suitable for those encountering severe problems as a result of drugs or alcohol.

³⁵ HSE, when it was established, took over delivery of services from the relevant Health Boards.

- Irish Prison Service;
- Department of Education & Science; and
- Department of Environment, Heritage & Local Government.

4.4 In addition, the voluntary sector have historically played a significant role in the development and delivery of treatment and rehabilitation services nationally. The Probation Service and the Homeless Agency³⁶ have also had important roles in facilitating the development of services. Overall, this has resulted in a significant increase in the range of services being delivered by the statutory, community and voluntary sectors.

Table 4.1. – Strategic Aims and Objectives of the Treatment Pillar under the current National Drugs Strategy

National Drugs Strategy 2001 - 2008 – Treatment	
Strategic Aims	
■	To enable people with drug misuse problems to access treatment and other supports and to re-integrate into society;
■	To reduce the risk behaviour associated with drug misuse; and
■	To reduce the harm caused by drug misuse to individuals, families and communities.
Strategic Objectives	
■	To encourage and enable those dependent on drugs to avail of treatment with the aim of reducing dependency and improving overall health and social well-being, with the ultimate aim of leading a drug-free lifestyle; and
■	To minimise the harm to those who continue to engage in drug-taking activities that put them at risk.

4.5 With respect to treatment, the following were identified as being the key issues over the lifetime of the current NDS:

- Access for drug misusers to treatment within one month;

- Development of a range of treatment options, including harm reduction approaches;
- Access for under-18s to treatment following the development of an appropriate protocol; and
- Development of prison-based drug treatment services.

Access for drug misusers to treatment within one month

4.6 Over the period 2001 - 07, opiates were the main problem drug treated (on average, opiates accounted for 63% of all cases entering treatment annually over the period), followed by cannabis (23%), and cocaine (7%). The main change has been the increase in the numbers reporting cocaine as their main problem drug, which has increased from approximately 2% in 2001 to 13.5% in 2007.

4.7 A central feature of those entering into treatment has been the poly-substance nature of their misuse. Each year between 2001 and 2007, between 70% and 75% of people entering treatment services (includes new cases and previously treated cases) had problem use of more than one drug³⁷.

4.8 An early and urgent priority of the NDS was to increase the availability of treatment for opiate users, in particular, through developing access to methadone treatment. The NDS set a target of 6,500 treatment places by 2002. This has been surpassed with the number of individuals on methadone treatment increasing from 4,963 in 2001 to 8,794 by end March 2009 - an increase of 77%. This has resulted in the condition of many users stabilising, leading to a much improved quality of life for them. The above figures do not reflect the full number of people who receive treatment in a full year. In 2007, for example, 9,756 received methadone treatment during the course of the year, while approximately 8,500 were in receipt of treatment in any particular week.

4.9 The HSE indicates that people who present for treatment are generally assessed within 1 week and offered treatment within 8 to 10 weeks. Notwithstanding this, and the significantly increased numbers in methadone treatment, there are a number of places where services, particularly methadone services, are not provided within one month, as envisaged under the current Strategy. Waiting times

³⁶ The Probation Service, working both in prisons and the community, provides a significant level of resources and services for problematic substance misusers on Probation Orders, Community Service Orders, in prison or on Post Release Supervision. The Homeless Agency was established in 2001 and has sought to co-ordinate the development of services for homeless people in the Dublin area, as outlined in their strategies, most recently, "A Key to the Door 2007 - 2010".

³⁷ HRB Trends Series 2, Trends in treated problem drug use in Ireland, 2001 to 2006, Health Research Board, 2008. Figures for 2007 from the NDTRS, ADRU, HRB, March 2009.

vary around the country. Analysis at the end of 2008 indicates that:

- 17 of the 26 clinic areas throughout the country have waiting times of 3 months or less (less than one month in 8 areas); and
 - the remaining 9 areas currently have waiting times in excess of 3 months (with 4 of these areas reporting waiting times of a year or more).
- 4.10** Recent data³⁸ from the HSE indicates that there were approximately 550 people waiting for methadone treatment across the country - with 71% of these relating to 7 treatment centres. These centres are in the midlands, the south east, the south and in Dublin.
- 4.11** The Steering Group notes that the main reason for the waiting lists outside of Dublin is the lack of level 2 GPs³⁹ (this is looked at in more detail later in the chapter). With respect to Dublin, a primary cause of waiting lists in one of the centres relates to the complex nature of the cases being dealt with, resulting in longer turnover times being experienced and the lack of appropriate services for onward referral. Overall, the Steering Group notes that an underlying problem has been the lack of adequate additional resources for the development of treatment services within the HSE addiction services.
- 4.12** The HSE is currently considering the adoption of a standard definition and national protocol concerning waiting times for opiate treatment. This is with a view to ensuring that a comprehensive data system is in place to monitor the progress of opiate treatment service provision.
- 4.13** As the primary focus under the current Strategy has been on timely provision of opiate services, no register of the treatment for other drugs such as cocaine and cannabis has been developed. However, on the basis of the cases reported to the National Drug Treatment Reporting System (NDTRS) in 2007, it is noted that treatment for non - opiate addiction was provided in almost all cases within the target one month waiting period.

- 4.14** The expansion of methadone treatment has been possible across the country through the expansion and development of HSE clinics, many of which are in community and voluntary sector premises, and the increase in the number of GPs and pharmacies participating in the Methadone Protocol.

Table 4.2: Participation in the Methadone Protocol

	2001	2007	% increase
No. of participating pharmacies	268	471	76%
No. of participating GPs	195	256	31%
No. of trained Level 1 GPs	N/A	562	
No. of trained Level 2 GPs	N/A	33	

Source: HSE

- 4.15** Table 4.2 illustrates that there has been a substantial increase in the number of participating pharmacies and that a basic national coverage has been achieved, notwithstanding concerns about the availability of services out - of - hours and at weekends.
- 4.16** The process of getting problem drug users to access and remain in treatment has been enhanced as a result of services developed through the Drugs Task Forces, with its focus on developing Community Drug Teams and the development of local treatment and rehabilitation services. These include family support interventions that complement the work being done through the statutory sector. These services have been primarily at tiers 1 and 2.
- 4.17** While there has been an increase in overall GP numbers, their level of recruitment and involvement remains a critical constraint in eliminating waiting lists and in the further expansion of substitute treatment services. Both the Irish College of General Practitioners (who, in late 2008, developed an on - line training module covering level 1 training that can be accessed by all GPs), and the HSE, through the work of the GP Co - ordinators for service delivery and training, have made significant efforts to recruit GPs. Despite these efforts, the recruitment of GPs to undertake level 2 training, which enables doctors to initiate treatment, remains difficult. This is an enduring problem for the NDS and was also highlighted during the MTR in 2005.
- 4.18** In this context, the Steering Group notes the factors that are contributing to the slow growth of participation can include a perceived lack of supports for participating GPs and lack of access by GPs to sufficient

³⁸ Figures supplied to the Inter Departmental Group on Drugs (IDG) in December 2008.

³⁹ Level 2 GPs can initiate treatment.

local addiction centres and specialist services. Other factors may include limitations on the community and voluntary sectors from employing medical staff, clinical governance issues, concerns about the appropriateness of methadone as a treatment, the lack of referral pathways and a lack of focus at graduate level on addiction services. Protocols and clinical governance guidelines should be developed further in this area.

4.19 Problem drug and alcohol use among the homeless population is a serious concern with a significant number of homeless people requiring access to treatment and rehabilitation services. There have been significant developments, both at the strategic level⁴⁰ and in relation to the level of services available, with respect to the homeless. In the Dublin area, a report in 2008 by the Homeless Agency⁴¹ indicates that expenditure on homeless services has increased by 22% from €51m in 2005 to €62.5m in 2008. The majority of this increase relates to accommodation for the homeless. There has been a 14% increase in expenditure on support services generally, with the increase in respect of health/detox/rehab/outreach being 10%. However, the Steering Group recognises that gaps in the provision of services persist, particularly in regard to attracting (and retaining) drug users with complex needs into treatment. These comments also apply to other hard to reach groups involved in problem substance use.

4.20 It is clear that methadone treatment has had significant beneficial effects⁴², with approximately 2,900 completing their treatment in the period 2000 to 2007. As highlighted in Table 4.3, 6,872 entered treatment for the first time in the same period, with the number of new entrants towards the end of the current Strategy period being approximately 80% of the rate of new entrants at the beginning.

40 See "The Way Home: Strategy to Address Adult Homelessness in Ireland 2008 - 2013" Department of Environment, Heritage & Local Government, 2008 and "A Key to the Door 2007 - 2010", The Homeless Agency, 2007.

41 Review of Finances and Expenditure for Homeless Services in Dublin: Homeless Agency, 2008.

42 Results of NACD ROSIE studies which show significant and sustained improvements for both the individuals involved, in terms of health and wellbeing, and for society, particularly in terms of reduced criminal activity.

43 It is not possible to determine whether those who have successfully completed treatment programmes remain drug free. No follow - up system is in place, as it would be overly intrusive given that most will want to move on with their lives.

Table 4.3: New entrants and completion in 2000 - 2007 period

2 - Year Period	Summary per 2 - year period of numbers coming on the Central Treatment List (CTL) for the first time.	Numbers of Persons who successfully completed treatment ⁴³ .
2000/01	2,107	637
2002/03	1,598	718
2004/05	1,511	742
2006/07	1,656	831
Total 2000/07	6,872	2,928

Source: HSE

4.21 While methadone treatment has made an important contribution to retaining people in treatment, data is not available on the length of time people are remaining on methadone. In this regard, it is noted that the HSE is currently reviewing the issue of data collection and analysis with a view to developing a more comprehensive data system for management and research purposes.

4.22 Methadone is the principal substitute treatment provided in Ireland with alternatives not generally made available. However, the Steering Group notes that a feasibility study to examine the use of a buprenorphine - based product in both clinical and community settings is being undertaken in 2009.

4.23 While it is clear that there has been significant success in attracting problem drug users into services and retaining them there, it is acknowledged that if they lapse from treatment, it can be difficult to get them to re - engage. Also, it is noted that some people are reluctant to seek treatment as they do not feel they are ready for, or necessarily need, it. There is no reliable estimate of the size of this cohort.

4.24 With respect to both cocaine and cannabis, for which psycho/social treatments are the most effective, services have been developed under the NDS both directly by the HSE and through the Drugs Task Forces. The HSE has provided cocaine services in Dublin South West, Cork and Galway and in 2008 the Drug Treatment Centre Board commenced a service in Dublin's north inner city. The Drugs Task Force projects include those funded through the Emerging Needs Fund (2005/2006) and the Cocaine/Rehab Initiative (2008). In addition, a number of mainstreamed and interim Drugs Task Force projects have adapted their services to respond to cocaine use in their areas. Overall, the services seek to provide for a range of treatments, both medical and non - medical, to be available

and the HSE is moving towards the provision of an integrated treatment service for all substance users. A key element in addressing the challenges faced in meeting emerging drug needs is the appropriate skilling of staff.

- 4.25** Arising from work done by the National Drugs Strategy Team (see chapter 6) in 2004, training was provided through Merchants Quay Ireland (MQI) to upskill front line staff and volunteers to respond to cocaine use. In addition, the HSE's National Addiction Training Programme, on its inception in 2007, concentrated on providing training to staff around emerging cocaine use. Training in cognitive behavioural coping skills was also provided for qualified counsellors through Leeds University, in partnership with the HSE. Community, voluntary and statutory service providers participated in this training. The broader voluntary and community sectors also provide a wide range of courses to address the educational needs of staff.

Residential Services/Abstinence

- 4.26** While there has been a significant expansion of treatment services in clinical and community settings since 2001, detoxification and residential services have not progressed to the same extent.
- 4.27** Between 2001 and 2006, 68,754 cases were treated for substance misuse and 54% of these received methadone treatment⁴⁴. In the same period, 7% (4,985 cases reported by the NDTRS) accessed residential services.
- 4.28** As Table 4.4. illustrates, there was a small increase in the number of residential cases over the period, with 20% more cases reported in 2005/06 compared to 2001/02. The development of residential services needs to be considered in the context of the four - tier model and the target of dealing with clients at the lowest appropriate tier. All reports point to a need for more residential places but this needs to be addressed within the context of services being developed in communities also.

Table 4.4 Residential Treatment Cases 2001 - 2006

Period	Number of Cases
2001/02	1,525
2003/04	1,639
2005/06	1,821

Source: Health Research Board

- 4.29** The further development of residential and aftercare services is a central element of providing alternative drug - free approaches to problem drug users, particularly opiate users. The Steering Group notes that this approach is resource intensive and there can be heightened risks involved in the event of relapse. It is critical, therefore, to ensure that the individuals involved have access to follow - on structured supports in the community and a continuum of care model to maximise their potential for success.
- 4.30** The Steering Group also notes that a key issue is the lack of detox facilities. The Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Abuse)⁴⁵ identified the additional residential services, including detox facilities, that need to be developed to ensure that an adequate minimum residential infrastructure is in place. It also sets out a possible framework for the development of an appropriately monitored quality set of standards (see para 4.65 also).
- 4.31** Concerns were also expressed about the "Vision for Change" Report of the Expert Group on Mental Health Policy⁴⁶. The full implementation of the Report would have a significant negative impact on the availability of detox places for problem substance users. Such implementation of the Report would require the realignment of funding in the HSE, with the necessity to transfer the relevant mental health services resources to its addiction services.

Harm Reduction approaches

- 4.32** The current NDS included 3 actions to reduce harm arising from substance misuse which relate to the expansion of needle exchanges and the reduction of drug - related deaths. Among the aims of these actions is to reduce the prevalence of Blood Borne Viruses (BBVs) among intravenous drug users (IDUs).

⁴⁴ HRB Trends Series 2: Trends in treated problem drug use in Ireland, 2001 to 2006: Health Research Board 2008. This analyses data from the National Drug Treatment Reporting System (NDTRS) and the Central Treatment List (CTL). It should be noted that the trends refer to cases – not individuals – and therefore, does not give a true picture of the number of people being treated for substance misuse.

⁴⁵ The Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Abuse): Health Service Executive, 2008.

⁴⁶ Vision for Change: Report of the Expert Group on Mental Health Policy: Department of Health & Children, 2006.

4.33 A key intervention in reducing the prevalence of BBVs is the **provision of Needle Exchange Programmes (NEPs)**. Needle exchanges have been expanded but are still only available in 5 of the 10 RDTF areas and in 13 of the 14 LDTF areas (coverage provided in the greater Dublin area, the midlands and the mid - west). A combination of fixed and outreach services are involved and it is noted that a service will be commissioned in the remaining LDTF area in 2009. While needle exchange services are in place in areas that traditionally experienced high levels of substance misuse, it is acknowledged that there are significant gaps in the availability of such services around the country. The Steering Group believes that NEPs are required across the country and, in areas that are already covered, out - of - hours and week - end provision is needed. A particular gap is the lack of development of needle exchange in community pharmacy settings. In this regard, the HSE and the Irish Pharmacy Union have agreed a plan to roll out Needle Exchange services through Community Pharmacies in 65 prioritised new locations. This will commence in the second half of 2009 and the Steering Group greatly appreciate the support of the Elton John AIDS Foundation with this project.

4.34 While some can be successfully treated for Hepatitis C, and a treatment is available and provided through the HSE, the trends in relation to the disease are a particular concern. While the trends are difficult to gauge, due in part to the initial asymptomatic nature of the disease, the Health Protection Surveillance Centre (HPSC), which has been charged with monitoring its incidence since it became a notifiable disease in January 2004, have identified approximately 6,885 cases (approximately two thirds male) to the end of 2008⁴⁷. Of these cases, 77% have been in the HSE Eastern Region. While there is no definite measure of the number of IDU cases involved, it is generally accepted that the majority of cases (approx. 70%) are drug - related⁴⁸. In response to these concerns the HSE established a Working Group on Hepatitis C and their report is now being considered by the HSE.

47 Data from HPSC Annual and Quarterly Reports to end 2008.

48 Data from Blood - borne viral infections among IDUs in Ireland, 1995 to 2005: HRB Drug Misuse Research Division, 2006 estimated that 70% of IDUs attending treatment tested positive for the Hepatitis C virus. More recent data from the HPSC for the 2nd and 3rd quarters of 2008 indicate that 74% of the cases, where risk factors were reported (approx 33%) were IDU cases.

Drug Related Deaths

4.35 In November 2008, the HRB published a National Drug - Related Deaths Index⁴⁹ covering the period 1998 - 2005. It covers deaths arising not only from illegal drugs, but also from legal substances ranging from prescription drugs to volatile inhalants. It is the first comprehensive report of its kind in Ireland and shows an increasing rate of deaths from drug misuse. Table 4.5 sets out the overall figures for the period.

Table 4.5 Poisonings and non - poisonings by year of death, 1998 to 2005

	1998	1999	2000	2001	2002	2003	2004	2005	Total
Poisonings*	178	187	182	175	210	184	205	232	1,553
Non -	64	84	79	101	126	112	155	168	889
Total	242	271	261	276	336	296	360	400	2,442

* 54% of poisoning deaths were aged between 20 and 40 years and males accounted for 67% of poisoning deaths. Poisonings are defined as deaths directly due to the toxic affect of the consumption of a drug(s) and/or other substances. Non - poisoning are defined as deaths in people with a history of drug dependency or non - dependent abuse of drugs, whether or not the drug use was directly implicated in their deaths.

4.36 The Report indicates that, while heroin and other opiates, including methadone and opiate analgesia, continue to be mainly responsible for deaths by poisoning, poly - substance use (of both illicit and licit drugs) is a significant factor and has been a consistent feature over the period 1998 to 2005. Prescription and over - the - counter medication is implicated in many poisoning deaths. Specifically, it is noted that benzodiazepines, often in conjunction with an illicit substance, have been implicated in more deaths than any other drug. The number of deaths due to cocaine - either alone or in conjunction with another drug - has increased significantly in 2004 and 2005. Overall, alcohol (in conjunction with one or more other drugs or substances) was implicated in a quarter of deaths by poisoning. This represents an underestimation of the total number of alcohol - related deaths because deaths due to alcohol alone were not included in the analysis. The number of deaths as a result of poisoning illustrates the need for a National Overdose Prevention Strategy and it is noted that work on developing such a Strategy has commenced through the HSE.

49 HRB Trends Series 4: Trends in Drug - Related Deaths and Deaths among Drug Users in Ireland 1998 - 2005: Health Research Board, 2008.

- 4.37** The Steering Group notes that progress has been slow in implementing the recommendations of the Report of the Benzodiazepine Committee⁵⁰ Specific concerns, as highlighted by the conclusions of the report, relate to their overuse by those on methadone, as well as to their overuse generally in the population. Among the factors influencing this misuse is their perceived over-prescription, and the levels of access through the internet and through illegal procurement, whether locally or through importation. In this context, it is noted that a number of issues need to be addressed, including a review of the regulatory framework covering their availability and increased monitoring and application of sanctions already in place. While the monitoring of prescribing to patients under the GMS scheme has been improved, the monitoring of private prescribing has proved more problematic and needs to be addressed.
- 4.38** While issues surrounding the oversupply and overuse of benzodiazepines need to be addressed in the National Overdose Prevention Strategy, as referred to above, the Steering Group also believes that there is an urgent need for the Irish Medicines Board to review the current regulatory controls and the implementation of clinical guidelines.
- 4.39** As Table 4.5 illustrates, there has been a sharp increase in non-poisoning deaths (deaths indirectly due to drugs) over the 1998 - 2005 period. While they represented 24% of deaths in 1998, by 2005 they accounted for 42% of drug-related deaths. Of the deaths, 84% were male and, overall, 64% were in Dublin with the median age being in the early 30s. The highest increases occurred in the NDRDTF and the SWRDTF areas⁵¹ with a doubling in the rate in the former area and an increase of just over 50% in the latter area. The Steering Group notes that this is an important area for further research, with a view to developing an appropriate public health policy response.

⁵⁰ Report of the Benzodiazepine Committee: Department of Health & Children, 2002.

⁵¹ HRB identifies these areas as NDRDTF – North Dublin City and Council Regional Drugs Task Force – consisting of North Dublin City and County, including the 5 LDTF areas within these boundaries, and SWRDTF – South Western Regional Drugs Task Force – consisting of south west Dublin, west Wicklow and Kildare including the 6 LDTF areas within these boundaries.

Treatment of Under - 18s

- 4.40** There were three specific actions in the current NDS relating to provision of treatment services for young people:
- Access to counselling services;
 - Treatment to include family therapy; and
 - Implementation of the guidelines agreed for treatment of under - 18s.
- 4.41** Counselling and family therapy services are both recognised as being important components in the treatment of under - 18s. While counselling and family services have been developed under the current NDS, particularly in LDTF areas and in the under - 18s service provided in the south west area of the HSE (Dublin and Mid Leinster), accessing services by some in this cohort is problematic. This reflects the fact that the level of services in some areas is not sufficiently developed to ensure access to them within an acceptable timeframe. The Steering Group notes, however, that no under - 18s are waiting for access to a HSE methadone programme.
- 4.42** Services for under - 18s have been developed through both the HSE and Drugs Task Force projects over the course of the current Strategy. The HSE has taken a number of measures to implement the Guidelines for Treatment of Under - 18s⁵², (developed under the aegis of the Department of Health and Children), including hosting a national workshop in 2006. The national workshop highlighted a number of key enduring issues relating to services for young people including:
- inter-agency collaboration to implement the 4 tier model for services;
 - the lack of tier 3 and 4 services outside of Dublin; and
 - the need for family intervention support models.

The outcomes from the national workshop and the Guidelines for the Treatment of under - 18s are now being utilised to develop HSE - led under - 18s services in the HSE Regions, both in Dublin and beyond. These will complement the under - 18s service in place in the south west area of the HSE, referred to above.

⁵² Report of the Working Group on Treatment of Under 18 year olds Presenting for Treatment to Services with Serious Drug Problems: Department of Health & Children and Health Service Executive, 2005.

Treatment in prison settings

- 4.43** There are 4 actions in the current NDS relating to treatment in prisons (actions 21 - 24) and they are primarily aimed at expanding treatment and rehabilitation programmes, involving the community and voluntary sectors and conducting an independent evaluation of the Irish Prison Service (IPS) Strategy in regard to drugs.
- 4.44** The IPS adopted its Drugs Policy and Strategy in 2006⁵³ and it is aimed at reducing availability and expanding treatment services within prisons. The former is referred to in chapter 2 while the focus in this chapter is on developing the level of treatment and rehabilitation services in prison and maintaining the continuity of such services for prisoners on their release.
- 4.45** The IPS, in partnership with statutory and voluntary agencies, seeks to provide people in its custody with programmes to assist in the prevention, treatment, rehabilitation and aftercare so as to minimise the harmful effects of substance misuse and to prevent the spread of HIV, Hepatitis B & C, as well as other infections. It seeks to provide clinical services for the assessment, treatment and care of patients, comparable to those available in the community and appropriate to the prison setting. Treatment programmes provided within the prison environment are patient - focused, with the objectives of harm reduction, stabilisation of the patient's addiction and with a longer - term aim of assisting the return of the patient to a drug - free lifestyle.
- 4.46** The IPS Drugs Policy and Strategy has witnessed active IPS investment in responding to people with drug problems in the prison system. Phase 1 of the policy has commenced the process of putting in place the necessary staffing levels to provide a quality service to prisoners. Phase 2 will seek to further focus on providing prisoners with access to the range of drug treatment options, consistent with the objective of achieving a standard of care which is equivalent to that available in the community. This will, in part, be achieved by augmenting current staffing levels, and also by strengthening community links. It is noted that the number of prisoners treated between 2006 and 2007 increased by approximately 17% and this attests to the high level of need for services amongst the prison population.

- 4.47** Working to fulfill the commitments contained in their Policy and Strategy involves the implementation of stringent measures to prevent drugs from getting into prisons while, at the same time, continuing to invest in services within prisons to reduce the demand for illicit drugs in the prisoner population. It also involves meeting prisoners' treatment and rehabilitative needs.

It is noted that specific developments to date include:

- Addiction Counselling Service – this consists of 24 counsellors and, in conjunction with other developments, is delivering approximately 1,000 hours per month of prisoner access to addiction counselling;
- Funding under the Dormant Accounts Fund to community groups to provide addiction counselling and support to prisoners while in prison and on release in the community;
- Additional specialist sessions in addiction psychiatry at the Mountjoy complex and Cloverhill/Wheatfield. These are significantly improving the quality, co - ordination and availability of drug treatment;
- In Mountjoy, the treatment services comprise (i) a dedicated pharmacy service responsible for the management of all medicines (mainly methadone) used as substitution treatment in the management of addiction. Drug treatment is provided to all those availing of services in Mountjoy on an equivalent basis to that available in the community, while meeting all legal and professional requirements, (ii) six specialist nurses who have a distinct role with regard to addiction assessment, treatment planning and delivery and evaluation of care and (iii) a clinical addiction team involving all of the disciplines engaged in drug treatment services; and
- The IPS is seeking to enhance specialist input, similar to Mountjoy, at all prisons, but particularly at Cloverhill/Wheatfield and other prisons where demand for drug treatment services is high.

⁵³ Keeping Drugs Out of Prisons: IPS Drugs Policy and Strategy – Irish Prison Service, 2006.

4.48 While substitute treatment services are being provided in the majority of prisons, the Steering Group notes that this is not the case in all prisons and this constitutes a key gap. In relation to harm reduction in a prison setting and arising from a recommendation of the joint NACD/NDST report⁵⁴, a small expert group has been convened to consider the issues of providing needle exchange in prisons and they are due to report in 2009.

4.49 In recognition of the high risk of overdose or relapse immediately following release from custody, a critical priority and a key enduring concern for all parties involved is the development of an effective and co-ordinated interagency approach to ensure the seamless transition from prison back into the community. This requires the availability of, and timely access to, a range of supports including suitable accommodation, treatment/counselling services, training/education/employment options and personal supports. These were identified in the Report of the Working Group on Drugs Rehabilitation⁵⁵ and the Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Abuse)⁵⁶. Expanded use of Integrated Sentence Management within the prisons will also help to underpin the development and implementation of prisoners' case management plans. These plans, based on a full assessment of needs, seek to ensure timely effective interventions, using a multi-agency approach. It is noted that clarity is required around who will deliver these services, including planned release and post-release arrangements, is essential in this regard.

4.50 The provision of substitute treatment services, and planning for continuity of those services on release, for remand prisoners in particular, needs to be addressed. However, the Steering Group notes that the IPS does not have authority in regard to overseeing a prisoner's release from remand, as that is a matter for the Courts. However, as far as possible, they should endeavour to plan for continuity of treatment service.

4.51 The Steering Group also notes that the IPS treatment services can only initiate substitute treatment services if the individual has a treatment place in the community.

4.52 The Group welcomes the setting up of the External Oversight Group on IPS Drugs Policy, which will focus on problem drug use in prisons from both a security and a treatment & rehabilitation perspective.

REHABILITATION

4.53 Rehabilitation measures were included originally under the treatment pillar of the NDS. However, a key recommendation of the MTR in 2005 was to prioritise rehabilitation by developing it as a separate pillar of the Strategy. This led to the establishment of the Working Group on Drugs Rehabilitation that reported in 2007 with a comprehensive range of recommendations addressing rehabilitation. (See Appendix 7 for full list of recommendations).

4.54 The Report provides a broad definition of rehabilitation and sees it as a structured development process focusing on individuals, involving a continuum of care and aimed at maximising their quality of life and enabling their social and economic reintegration into communities. A key aim of the overall process is the empowering of recovering problem drug users so that they can re-engage with society in a manner consistent with their needs and expectations. It stresses the importance that clients be activated and prepared to fulfill their role on the path towards rehabilitation. In this context, the level of motivation of clients is critical to the degree of likelihood of achieving a successful outcome.

4.55 Many Departments and agencies are providing an array of services in this regard, including:

- health - based services;
- educational services;
- training and employment services;
- community development services;
- family support services;
- probation services;
- Garda services; and
- housing services.

⁵⁴ Needle Exchange Provision in Ireland: National Advisory Committee on Drugs & National Drugs Strategy Team, 2008.

⁵⁵ Report of the Working Group on Drugs Rehabilitation: Department of Community, Rural & Gaeltacht Affairs, 2007.

⁵⁶ Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Abuse): Health Service Executive, 2008.

4.56 It recognises that all or some of these services can play a role in the rehabilitation of a problem drug user. However, the Report recognises that there is a need to build on these existing services and improve their co-ordination while promoting a more integrated and client-centred approach to the process of rehabilitation.

4.57 One of the key recommendations relates to the establishment of a National Drug Rehabilitation Implementation Committee (NDRIC), chaired by the HSE, as part of their lead role in rehabilitation. The Steering Group notes that this Committee was set up in late 2008, along with the assignment of the Senior Rehabilitation Co-ordinator who chairs and leads the work of the group. The Committee has also agreed its terms of reference for addressing the rehabilitation needs of people in treatment.

4.58 Among the issues identified in the Report that will need to continue to be addressed are the development of:

- protocols for inter-agency working;
- Service level agreements between parties;
- case management and care plans;
- case managers and key workers; and
- Quality Standards Frameworks.

4.59 The recommendations in the Working Group Report also cover a number of other areas:

Medical support

The expansion and integration of treatment options for recovering drug users is recommended, particularly counselling and therapeutic services and the further development of detox and residential services (these latter elements are more fully dealt with by the HSE Residential Rehabilitation Report),

Role of families in rehabilitation

The active encouragement of family participation is recommended, subject to the agreement of the individual, and the reconciliation of problem drug users with estranged family members should be pursued. Families should be seen as service users in their own right and information, support and advice, including advice on guardianship options, where applicable, should be made available to parents (and others as appropriate) who are coping with a family member's problem drug use.

Childcare

The need for additional childcare facilities be addressed and the better integration of these services with treatment and rehabilitation services is recommended. The services need to have a stronger focus on child development. The provision of parenting programmes also needs to be addressed.

In this context, the Steering Group believes that the NDRIC and OMCYA should work together within the context of existing policies and services to:

- Facilitate closer engagement between child, outreach and drug services at a local level;
- Consider ways to address the needs of the children of problem drug users through flexible provision under any successor programme to the Community Childcare Subvention Scheme 2008 - 2010; and
- Establish and disseminate best practice.

Community Employment/Employment/Access to education and training

The impact of Community Employment on rehabilitation should be strengthened by complementary support and involvement from the HSE, the Department of Education & Science and relevant agencies to ensure that the health and educational needs of participants are being properly addressed, not only during, but also before and after their participation.

In this context, the Steering Group considers that there is also a need for targeted employment support mechanisms given that recovering problem drug users are likely to be particularly vulnerable in the current labour market.

Housing

The provision of appropriate housing and developing inter-agency procedures are recommended to facilitate recovering drug users in accessing appropriate accommodation and the services necessary to ensure that tenancies can be maintained.

Rehabilitation of offenders

The provision of treatment and rehabilitation services in prison are recommended, as well as the need to ensure continuity of care in the community on release.

4.60 The Steering Group recognise that many people using drugs can acquire criminal convictions as a consequence of their drug use. Such convictions can often act as a significant barrier in terms of successful rehabilitation and reintegration in terms of access to employment and travel for people in the longer - term. In this regard, the Steering Group recommends that consideration be given to developing a legislative framework whereby certain convictions could be considered spent after an appropriate period of time.

4.61 As mentioned at 4.14, the Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Abuse) was published in early 2008. It identified the number of detox and rehabilitation beds needed to provide a minimum adequate level of coverage (see Appendix 8 for the full list of recommendations). It also addressed the issue of the development and monitoring of standards in residential care. This report, and the Report of the Working Group on Drugs Rehabilitation (May 2007) have a significant degree of commonality and the Steering Group believes that they should be actioned and progressed with this in mind.

Training and Skills Development of Staff and Volunteers

4.62 The training and re - skilling of staff in a range of existing and emerging addiction issues is seen as a key component in the continuing development of a comprehensive and responsive addiction service. To this end, the statutory, voluntary and community sectors have all played important roles in providing training and support to staff around addiction and alcohol issues - and related issues such as health & safety and risk management. While much of this has been done within the National Qualifications Framework, thus enhancing the opportunities available to people working in the field, some courses have been provided outside that framework. Initiatives include:

- the voluntary and community sectors provide a wide range of certified and accredited courses and modules for staff, both in their own services and in the statutory services;
- the Local and Regional Drugs Task Forces provide a programme of courses and seminars;
- the National Addiction Training Programme (NATP), which commenced in 2007, provides a comprehensive suite of training to staff in the HSE and in partner agencies. During

the first 6 months of 2008, almost 400 staff attended a broad range of continuing professional education programmes. The Programme, which is reviewed and amended on an ongoing basis, is provided in liaison with Waterford Institute of Technology and was independently evaluated after 12 months of operation. Within this context, the HSE Addiction Training Unit (ATU) in Dublin has been to the forefront of the continued development of the Cognitive Training Coping Skills Programme for addiction counsellors⁵⁷. A follow - on programme was subsequently provided by the HSE ATU, while a third programme is scheduled for 2009 as a result of funding made available via a cross Task Force Initiative involving representatives of the RDTFs, the ATU and the NATP; and

- graduate courses in addiction studies, counselling, and related fields, provided through 3rd level institutions.

4.63 The Steering Group considers that these initiatives have established a solid basis for moving forward on this vital issue. However, despite these developments, it is accepted that there still is significant work to be done in rolling out national training standards for addiction services, including accreditation standards (aligned to the National Qualifications Framework) for workers in the addiction field. All future course provision should be developed and provided within the Framework.

4.64 In addition, the Group believes that it is important that the training programmes outlined above, and those provided by link partners such as the Homeless Agency and others, take cognisance of each other's work so as to avoid overlap and to ensure value for money.

Quality and Standards for Addiction Services

4.65 The provision of quality assurance of the care received by service users of drug treatment services is key to the outcomes that are achieved in terms of treatment and rehabilitation. In addition, such quality assurance has been shown to be critical to patient safety. Quality and standards for addiction services need to be developed within a clinical and organisational governance framework that is based on adopting a systematic approach to assuring the quality of patient care. It is a framework through which the addiction services will be accountable for

⁵⁷ Originated from the recommendations of the Cocaine Subgroup of the NDST in 2004.

continually improving the quality of service and for safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish. Clinical and organisational governance needs to promote clinical and organisational leadership and accountability with clear protocols for the delivery of care.

4.66 A Report⁵⁸ into the issue of clinical governance identified key features to be addressed to ensure patient safety. The aim is to have well - informed patients receiving safe and effective care from skilled professionals, in appropriate environments, with assessed outcomes. A similar commission in the UK in the 1990s identified the following seven pillars of clinical governance:

- Risk Management;
- Clinical Effectiveness;
- Education, Training and Continuous Personal and Professional Development;
- Use of Information;
- Staffing and Staff Management;
- Clinical Audit; and
- Service User involvement.

4.67 The HSE recognises that there is a need for the appointment of clinical directors at regional level who will work with managers appointed at a similar level to ensure organisational competence in the delivery of drug treatment services. Such a goal ties in neatly with the plan to ensure that sufficient tier 3 and 4 resources are available to support both the community and primary care sector, as well as the voluntary sector, in working with problem substance users. This organisational framework and clinical governance system needs to apply to all outpatient settings, as well as to residential and medical inpatient units.

4.68 Specific standards of care and clinical competence are required in order to evaluate and continually improve services. Such standards have been developed within the UK drug treatment field, where the quality of drug and alcohol services is evaluated using an instrument specifically designed for the purpose - the Quality in Alcohol and Drug Services (QuADs) system.

4.69 In addition to clinical standards, providing quality patient care must also include the organisational capacity to recruit competent professionals, with key skills, to perform the tasks and jobs required – in this case to treat and rehabilitate patients. With this in mind, it is envisaged that the new NDS will adopt a clinical and organisational governance structure working to standard protocols such as those laid out by the QuADs, or equivalent systems. This ensures an equivalent standard in the delivery of care between the statutory sector and the voluntary sector. Professional competence standards also need to be addressed to ensure quality of care. In the UK, the Drug and Alcohol National Occupational Standards (DANOS) have been agreed at a national level. While an informal system has grown up in Ireland, this will need to be developed further in order to meet a formal national standard which would provide transparency and clear guidelines for employing organisations.

4.70 In terms of development of standards in the Irish context, a pilot project was developed under the HSE's National Drug and Alcohol Working Group. This was spearheaded by the former Dublin East Coast area, which tested the QuADS system. The HSE established a Working Group in early 2008 to examine the issue of introducing benchmarked quality and standards to addiction services. The Report of the Working Group⁵⁹ was adopted by the HSE as policy in January 2009. The first phase involves the introduction of the QuADs quality standard or equivalent to all addiction services. The voluntary sector have also been working on the development and implementation of quality standards and has some good working examples that can feed into agreed national standards. It is planned that, within the timeframe of the new Strategy, this will roll - out to all services with the establishment of national standards and clinical and operational governance to ensure that these standards are met. The aim is that clinical and organisational governance will be established throughout the drug treatment services thereby ensuring organisational and clinical capacity to deliver a high standard of safe care to patients.

⁵⁸ Report of the Commission on Patient Safety and Quality Assurance: Department of Health & Children, 2008.

⁵⁹ The Report of the Working Group Examining Quality and Standards for Addiction Services: Health Service Executive, 2008.

Counselling

4.71 At present, neither counselling nor psychotherapy are statutorily regulated within Ireland. However, both professions have been progressing voluntary regulation, and standards have been set for the training of counsellors and psychotherapists. More recently, a joint forum convened by the Minister of State for Equality, Disability and Mental Health at the Department of Health and Children encouraged dialogue between all of the professional bodies involved under the title “Psychological Therapies Forum”. This Forum provided a report⁶⁰ on training standards and professional accreditation in order to progress statutory regulation. The report recommended that counsellors be trained to Higher Diploma level and psychotherapists to Masters level.

4.72 Despite moves towards a national framework and areas of good practice, the Steering Group notes that there has been no formalisation of professional training standards and competencies across the voluntary and statutory sectors. There is, therefore, a need for this to be formally addressed. For many years, the HSE has required higher diploma level training and accreditation with the Irish Association for Counselling and Psychotherapy (IACP), Irish Association of Alcohol and Addiction Counsellors (IAAAC) or Irish Council for Psychotherapy (ICP). Higher Diploma level training is considered appropriate as the area of addiction is complex. The Steering Group considers that staff working as counsellors within the Irish health system need to have considerable training in order to handle the complex needs of this client group.

4.73 Counselling services are appropriately placed to treat, or be part of a treatment response for those who have become dependent on substances. There is clear evidence from international literature⁶¹ that counselling and other psychosocial interventions enhance and improve the outcomes in conjunction with substitute prescribing for those who are opiate dependent. It has, therefore, been the policy of the HSE to provide counselling and psychosocial interventions alongside substitute prescribing. The Steering Group believes that counselling, under clinical supervision, should be an integral part of these programmes.

4.74 In relation to problem alcohol, cocaine and stimulant use, there is good evidence⁶² to support the use of Motivational Interviewing and Cognitive Behavioural Coping Skills (CBCS) training. Although many counsellors in the addiction services are trained in skills - based Motivational Interviewing and approximately 50 have been trained in Cognitive Behavioural approaches, between the voluntary and statutory sector (mainly in the east coast), there is a need for further up - skilling of staff in all relevant sectors. It is recommended that an audit of skills of counselling staff be undertaken to identify the training need of this professional group. The delivery of such training falls under the remit of the NATP (see para. 4.62) and other agencies, as appropriate.

4.75 The current Strategy envisages the development of a more robust rehabilitation pillar to help the progression of problem drug users into further community integration. Evidence - based approaches such as the Community Reinforcement Approach (CRA)⁶³ and Social Behavioural Networking Therapy⁶⁴ should be used as adjunctive to these services.

4.76 The Steering Group notes that the general hospital setting (Emergency Departments in particular) is a key area to deliver interventions designed to address both psychological and social harms associated with problem substance use. The training of trainers within the general hospital setting, particularly addiction counsellors and nurses, is necessary in order to provide adequate screening and brief interventions for all substances of abuse including nicotine, alcohol and drugs.

⁶² Project Match – multisite clinical trial designed to test a series of priority hypotheses on how patient - treatment interactions relate to outcome (alcohol): University of Connecticut Health Centre, supported by the US National Institute on Alcohol Abuse and Alcoholism (NIAAA).

⁶³ The Community Reinforcement Approach (CRA) is a comprehensive behavioural programme for treating substance misuse problems. It is based on the belief that environmental contingencies can play a powerful role in encouraging or discouraging drinking or drug use. Consequently, it utilises social, recreational, familial and vocational reinforcers to assist in the recovery process.

⁶⁴ Social Behaviour and Network Therapy (SBNT) is an intervention package developed by integrating strategies found to be effective in other substance misuse treatment approaches. It is built upon the premise that social network support for change is central to the resolution of addictive behaviour. The core principle of SBNT is that positive change is promoted by support from a close network of family members and/or friends (referred to as “network members”) who provide a person who wishes to abstain from, or reduce substance use, with positive social support for change.

⁶⁰ Submission by the Psychological Therapies Forum to the Department of Health & Children regarding Statutory Registration of Counsellors and Psychotherapists in Ireland, September 2008.

⁶¹ Ball & Ross, 1991 and McLelland, 1996

Service User – Information and Engagement

- 4.77** Providing information on available services emerged as an important theme from the consultation process. The current NDS included actions to provide information on the availability of services.
- 4.78** In this context, it is noted that the HSE has completed a mapping process of local services. Local Health Offices have compiled directories of all services (including addiction services) in their areas and these are posted on the HSE's website www.hse.ie. Several Drugs Task Forces have (i) produced directories in booklet form, (ii) listed drug services in their area on their websites and (iii) provided input to the national service directory at www.drugs.ie. The Steering Group believes that it is vital that information/directories provided by the HSE, Local and Regional DTFs and the community and voluntary sectors are readily accessible, consistent in format, relevant and regularly updated, as well as being understandable to their target audience.
- 4.79** The National Strategy for Service User Involvement in the Irish Health Service - "Your Service Your Say" - was published by the Department of Health & Children and the HSE in consultation with the Health Services National Partnership Forum in May 2008. This Strategy provides a template for engagement with socially excluded groups, including drug users. In addition, a number of fora have been established to facilitate user group engagement with Drugs Task Forces, principally through the Drug Users Forum. Despite these developments, there is a continuing need to further develop service user engagement – both as an essential part of clinical governance procedures and service planning.

Family support

- 4.80** The MTR in 2005 identified the need to strengthen support for families. There were 3 main dimensions to the actions on families under the current NDS:
- Prioritise the provision of family supports by Drugs Task Forces: In this context, it is noted that a significant number of DTF projects (61%) include a family dimension. In addition, €1.7m was secured under the Dormant Accounts Fund for family support projects in DTFs, with several running the Strengthening Families Programme;
 - Development of family support networks: There has been tangible progress in the development of family support networks over

recent years. The umbrella organisation, the Family Support Network, has received funding from both the Department of Community Rural & Gaeltacht Affairs and the Family Support Agency to develop its capacity to support networks across the country. In addition, there is evidence that family support networks are being established more broadly across the country; and

- Implementation of the NACD report on families⁶⁵ which proposed increasing the capacity of services, strengthening interagency links and networks, and developing relevant monitoring and evaluation tools: While there are growing inter - agency linkages, which are beginning to strengthen services, the role of Family Resource Centres and the Family Support Agency needs to be more explicitly linked in with Drugs Task Forces and family support networks so as to enhance service provision.
- 4.81** In recent years, the HSE has significantly developed its family support services. Family support programmes are provided by a range of professionals including family workers, social workers, child - care workers, youth and community workers, public health nurses. Examples of these programmes include services provided by the Community Mothers, Family Support Workers, Teen Parents Support Projects, and Spring Board Projects and may encompass a range of general parenting programmes and supports. The HSE indicates that expenditure on family support services has increased by 80% over the period 2003 - 2007 (from €46m to €82m).
- 4.82** In this context, the Steering Group notes the reference in the Report of the Working Group on Drugs Rehabilitation⁶⁶ (see para. 4.53) that families of problem drug users have the potential to be key to the rehabilitation effort. That report made five recommendations in regard to the role of families in the rehabilitation process, varying across supports for families to their more central involvement in the rehabilitative process. The establishment of the NDRIC, as outlined in para.4.57 above, will provide a forum (with formal links to the family support network) where the implementation of these recommendations can be examined in more detail and progressed.

⁶⁵ Report on The Role of Family Services in Drug Prevention: National Advisory Committee on Drugs, 2004.

⁶⁶ National Drugs Strategy 2001 - 2008 – Rehabilitation: Report of the Working Group on Drugs Rehabilitation: Department of Community, Rural & Gaeltacht Affairs, 2007.

Emergency Services and Ambulance Services

4.83 While the current NDS did not include emergency services under its remit, it is clear from the experience of such services over the lifetime of the Strategy that problem substance use (predominantly alcohol), particularly on week - end nights, needs to be addressed. The Steering Group considers that training for Emergency Service personnel, as well as for paramedics in the ambulance service, is necessary to ensure that they are familiar with drugs issues and alternative care pathways.

4.84 This is being developed at present under the NATP (see para. 4.62), as evidenced by the specific programme recently undertaken with the Emergency Department of Waterford Regional Hospital. The Population Health Pillar of the HSE is also leading out on the training of emergency service staff in selected acute hospitals in the use of brief intervention programmes. This includes screening and appropriate referral for clients presenting with alcohol and drug issues.

4.85 While some screening⁶⁷ and brief interventions are carried out in general hospital settings, there is a need to further develop these with a view to putting in place a comprehensive screening programme for those who present with problems that are related to problem substance use. At the same time, the capacity of hospital personnel to deliver appropriate brief interventions needs to be developed further.

4.86 It is envisaged that the development of a National Overdose Prevention Strategy, as outlined earlier in this chapter, by the HSE, will result in the further development and co - ordination of the overall approach in these areas. A key issue in this regard is the provision of training (including training in the administration of naloxone in particular) for all paramedics to deal with overdose incidents.

ALCOHOL

4.87 As outlined in chapter 1, the health consequences of problem alcohol use manifest themselves in a number of ways, ranging from alcohol - related mortality to alcohol - related road fatalities, to the role of alcohol in suicides and self - harm⁶⁸. The extent of the health consequences of problem alcohol use can be illustrated through examining alcohol - related discharges from acute hospital services. Table 4.6 outlines those discharges during the course of the NDS.

Table 4.6: No. of alcohol - related discharges by year 2001 - 2007⁶⁹

	2001	2002	2003	2004	2005	2006	2007
Male	11,805	13,234	13,018	13,050	10,852	12,629	13,340
Female	4,018	4,523	4,523	4,328	4,073	4,424	4,677
Total	15,823	17,757	17,541	17,378	14,925	17,053	18,017

Source: Hospital In - Patient Enquiry system, which relates to data from 60 hospitals

It should be noted that alcohol - related discharges increased significantly from the mid 1990s, when, between 1995 and 2002, the number of annual alcohol - related discharges virtually doubled (92% increase). Since then, the number of discharges has been relatively stable.

4.88 With respect to the age profile of those discharged, an analysis of data for the period 1995 to 2004⁷⁰ by the HRB showed significant differences between males and females as illustrated in Table 4.7:

68 Reach Out: National Strategy for Action on Suicide Prevention, 2005 - 2014: Health Service Executive National Suicide Review Group and Department of Health & Children, 2005.

69 There was a substantial decrease in the number of alcohol - related discharges in 2005. However, coding in the HIPE changed from ICD 9 to ICD 10 in that year. This may account for the variation, as the overall consumption did not change from 2004 to 2005. The figures for 2007 are provisional.

70 Between 1995 and 2004 there were 139,692 alcohol - related discharges, of which 75% were male and 25% were female.

67 ASSIST – Screening and Brief Interventions programmes delivered in some hospitals.

Table 4.7: No of alcohol - related discharges by gender between 1995 - 2004

Age	Less than 30	30 to 49	50 or more
Male	17%	31%	52%
Female	25%	33%	42%

Source: Department of Health and Children

While males accounted for approximately 75% of discharges annually over the period, an underlying trend is the significant increase in alcohol consumption and binge drinking among young women in recent years, with women under 30 comprising 25% of females being treated. This is further emphasised by the fact that 47% of discharges of those under 18 years were women.

4.89 The analysis also showed that of the approximately 140,000 cases treated in the period, 48% were treated for acute conditions, 43% were treated for chronic conditions and 9% were treated for liver conditions. However, over the period, the severity of the condition for which people were treated increased. Data shows, that by 2004 the number of acute condition cases increased by 75%, the number of chronic condition cases and liver condition cases increased by 92% and 175% respectively. The analysis further indicated that 12% of the cases had an additional drug - related diagnosis.

Treatment for Alcohol use

4.90 Treatment data for problem alcohol use is recorded through two systems, the National Psychiatric In - patient Reporting System and the National Drug Treatment Reporting System (NDTRS). While the former has been in place since 1965, the latter was only introduced in 2004. It is noted that the extent of overlap between the two systems is unknown.

4.91 While the number of alcohol disorders cases reported through the National Psychiatric In - patient Reporting System have approximately halved since 1995, they were stable over the 2006/07 period. This change relates primarily to the enhanced community - based approach introduced in regard to mental health. Data for 2007 indicates that 2,699 were treated for alcohol disorders as their primary diagnosis, with a further 724 diagnosed with other drug disorders as their primary diagnosis. At the same time, the problem of people with alcohol disorders not seeking to access treatment persists. In addition, the Steering Group notes that many in society suffer harmful consequences of the use of alcohol, while not at the level of addiction.

4.92 Table 4.8 sets out data from the NDTRS⁷¹ on people treated for alcohol disorders in the period 2004 - 2007.

Table 4.8: People treated for alcohol disorders

	2004	2005	2006	2007
Previously treated cases	2,177	2,230	2,345	3,110
New cases	2,827	3,228	3,432	3,736
Unknown	140	68	99	466
All Cases	5,144	5,526	5,876	7,312

Source: Health Research Board

The cases reported cover those treated in outpatient and residential settings only and so do not include those treated in primary care settings. HRB analysis shows that in the case of problem drug users entering treatment between 2001 and 2006, 70% to 75% had problem use of more than one drug. In contrast, only about 20% of those entering treatment for alcohol (new cases and previously treated cases) had problem use of a second drug.

4.93 It is not possible to quantify the number of problem alcohol users that require addiction treatment. However, the significant difference between the number of cases reported in the hospital system for treatment for the consequences of alcohol use and the number of cases reported through the treatment system for alcohol addiction indicates that there is a considerable cohort of problem alcohol users that could benefit from engagement with addiction treatment services.

4.94 Early interventions are targeted at hazardous and harmful use of alcohol and are designed to reduce alcohol consumption before dependence develops. There is strong evidence⁷² that brief interventions provided within various healthcare contexts are effective in reducing hazardous and harmful use. These contexts, in particular, include primary care, general hospital wards, mental health services and Emergency Departments. The Steering Group believes that training in brief interventions needs to be rolled out across the healthcare service to maximise the impact of this cost-effective approach.

⁷¹ Data covering the period 2004 - 2006 was sourced from the HRB Trends Series, Trends in treated problem drug use in Ireland, 2001 to 2006, HRB 2008. Figures for 2007 from the NDTRS, ADRU, HRB, March 2009

⁷² Cochrane Review: Cochrane collaboration is a global network of volunteers dedicated to improving healthcare decision - making globally, through systematic reviews of the effects of healthcare interventions.

ASSESSMENT OF IMPACT

Progress against KPIs - quantitative assessment of impact

100% of problematic drug users accessing treatment within one month after assessment.	<p>The primary focus of the current Strategy has been on putting substitute treatment services in place for opiate users. In this regard, while there has been continuing growth in the number of treatment places provided, and while access to treatment within one month after assessment for methadone services is available in many areas, the provision of such services in some areas continues to be problematic for the reasons outlined in this chapter.</p> <p>On the basis of the cases reported to the NDTRS in 2007, treatment for non - opiate addiction was provided in almost all cases within the target one month waiting period.</p>
100% of problematic drug users aged under - 18 accessing treatment within one month after assessment.	<p>Under - 18s are a priority group for drug treatment and none have been waiting for more than a month for initial treatment (methadone). However, the availability of appropriate residential and community support services is problematic and needs to be addressed.</p>
Harm reduction facilities available, including needle exchange where necessary, open during the day, and at evenings and weekends, according to need, in every local health office area.	<p>Facilities are available in limited areas, primarily in the Dublin area, the Midlands and the Mid - West, through a mixture of fixed site and outreach services. Progress in implementing these harm reduction measures present ongoing challenges.</p>
Incidence of HIV in drugs users stabilised, based on 2004 figures.	<p>Data available from the Health Protection Surveillance Centre indicates a drop in the number of HIV cases among IDUs although the actual number of cases reported each year is relatively small. There has been a gradual and consistent drop from 71 in 2004 to 36 in 2008⁷³. The incidence of blood borne viruses (BBV), particularly Hepatitis C, among IDUs is a continuing cause of concern</p>

4.95 The MTR included four new KPIs to measure performance in achieving objectives. Performance under the new KPIs can be summarised as above.

KEY FINDINGS FROM THE CONSULTATION PROCESS

The findings presented here arise from the consultation process outlined in the Introduction.

4.96 The overall increases in funding and the expanded range of treatment services in place since the publication of the current NDS were acknowledged. The consultation process also highlighted the willingness to test new approaches and pilot initiatives as a positive aspect in the response to drugs. It was recognised that there is significant potential for shared learning across the country with regard to best practice and successful initiatives.

4.97 While examples of good practice were acknowledged, the key gap is that treatment services are not consistently available across the country. More specifically, the consultation process highlighted the following:

- The commitment to a continuum of care approach, with a comprehensive service

from engagement, through detox and on to aftercare, was a strong theme throughout the consultations. This requires greater coordination and integration of services and the development of formal care plans (including a focus on aftercare) to place the individual's needs at the centre of any response. It also implied an approach that would offer both drug - free and harm reduction options. This view was most prevalent in relation to the treatment of heroin addiction through methadone programmes, where there was strong support for abstinence - based options to also be put in place;

- The lack of residential detox services around the country was consistently raised. Access to such services is seen as being difficult. The 'drug - free' requirement to access many residential rehabilitation services was also identified as a problem, given this lack of detox services;
- Access to methadone services is an issue, particularly outside Dublin as prevalence increases geographically. The number of GPs who can initiate and prescribe methadone varies significantly between areas;
- At the same time, there was concern about the long - term effects of methadone on individuals, as well as the inappropriate location of some treatment centres. While research has been carried out on long - term treatment effects, these are not evident to

⁷³ Newly diagnosed HIV infections in Ireland – Quarters 3 & 4 of 2007, 2007 & 2008 Annual Summaries: Health Protection Surveillance Centre (HPSC)

the general public. At the same time, it was acknowledged that access to a methadone programme had allowed a significant number of people to return to, and maintain, a stable work and social/family life. The lack of alternative options to methadone treatment was also highlighted as a key development priority;

- The implications of the “Vision for Change” Mental Health Strategy, (referred to in para 4.31, above) was consistently raised. The implementation of this strategy has raised significant concerns about access to appropriate treatment for individuals. While alcohol and drug addiction are classified internationally as a mental health disorder, this is no longer the case in Ireland, leading to concerns that people may not get the treatment they require.
- The specific issues of dealing with problems of drug use in prisons were identified, with perceived high levels of addiction among those leaving this setting. The perception is that drugs are freely available in prisons and that current programmes are inadequate;
- There was strong support for further investment in most types of intervention including clinics, counselling, stabilisation programmes and rehabilitation services;
- The need to implement the recommendations of the Reports of the Working Group on Drugs Rehabilitation and the Working Group on Residential Treatment & Rehabilitation (Substance Abuse) was highlighted. The need for the development of co - ordinated inter - agency working was also raised;
- Priorities differed from area to area with an overall focus on ensuring a consistent level of provision across all areas of the country. A further gap was the absence of out - of - hours services and services operating at weekends;
- Strengthening family support services also emerged as a priority from the consultation process. Gaps remain in services for families across the country, with the focus still predominantly on the drug user. Services required for families include respite, counselling, alternative therapies, mediation and marriage/relationship guidance. In addition, family support groups have identified specific issues in relation to guardianship, men's issues and siblings as key future priorities in development of services;
- The role of FÁS Community Employment schemes in helping recovering drug users to

develop their personal and employment skills and find a pathway back to work is strongly valued. In this context, the implementation of the Individual Learner Plan was highlighted. This identifies participant's needs and records progression towards labour market reintegration. The development of targeted programmes by FÁS was seen to be essential and should be an integral part of the new NDS, with a commitment to ensuring that such initiatives are available to recovering drug users in all parts of the country; and

- Most people felt that there is a need to combine treatment and rehabilitation services for drugs and alcohol, given the growing evidence of polydrug use and the role of alcohol as a potential 'gateway' drug. Overall, across the consultation process, there was strong support for combining alcohol and drugs in a single Strategy. Where concerns were expressed about this approach, the reservations primarily related to the danger that the drugs issue could be lost in the context of dealing with alcohol, particularly if adequate additional resources were not provided.

Needs of specific groups

4.98 A key theme that emerged throughout all elements of the consultation process was the requirement to focus the NDS on the needs of specific communities in accessing services. In general, it was felt that the current NDS does not sufficiently differentiate the needs of specific groups and tailor services accordingly. Along with the needs of prisoners, the key constituencies with specific needs highlighted during the consultation process are set out below. In addition, the work that has been ongoing in targeting drug misuse amongst these groups is highlighted, as is research on the current levels of prevalence, where it is available.

New communities

The Steering Group notes that there is a lack of information on the prevalence of drug taking among new communities so it is not possible to accurately determine the extent of any problem that may exist. Drug treatment data suggests that the number of non - Irish national cases treated for drug misuse grew from 135 in 2001 to 195 in 2006, constituting 2.8% and 3.8% respectively of total cases treated⁷⁴. The number of new cases has almost doubled from 47 to 93 over the same period (or 2.3% and 4.2% of total new cases).

⁷⁴ HRB Trends Series 2: Trends in Treated Problem Drug Use in Ireland, 2001 to 2006, Health Research Board, 2008.

Data from MQI indicate that approx 30% of their clients in 2008 (comprising 35 nationalities) were non - Irish. Of these, 90% were from Europe - with 47% of those coming from new EU Member States (30%) or non - EU states (17%). Use of cocaine, cannabis and heroin is evident, as well as a range of other drugs. A specific problem for new communities is a lack of information about the support services available. Representative bodies of new communities have also found it difficult to engage with NDS structures, including Drugs Task Forces, due to lack of knowledge on how to do so.

The HSE, in consultation with key partners, including NGOs representing new communities, in part response to their Intercultural Health Strategy report⁷⁵, have sought to address this concern. These efforts included engagement through focus groups with members of new communities to ascertain their views and an independent report of these engagements has been prepared. As much information is spread to new communities through informal channels, a key priority for the new NDS is to build on this engagement with representative organisations. In doing this, their channels of communication can best be utilised to target information so as to raise awareness about treatment and rehabilitation services.

Travellers

Data is not available to indicate the number of Travellers who present for treatment as, heretofore, they have not been recorded as a distinct group under the NDTRS. However, the NACD found that the prevalence pattern broadly mirrors that of the general population, with cannabis, sedatives and tranquilisers most commonly used, followed by cocaine, ecstasy and, lastly, heroin⁷⁶. The issues experienced by Travellers in relation to drugs are entwined with issues of inequality and marginalisation. This means that Travellers are more likely to be exposed to the risk factors that lead to problem drug use. It also implies that response mechanisms to address the associated problems need to factor in these issues. There are heightened concerns within that community about the growth in problem drug use. This is also acknowledged by the HSE as a key and growing concern. The NACD report found that, while there are some good models of service provision, Travellers experience specific problems relating to access to services arising from a lack of awareness of the existence and nature of drug services, lack of formal education, stigma and embarrassment and lack of culturally appropriate services.

In the context of an overall Traveller Health Strategy⁷⁷,

75 National Intercultural Health Strategy 2007 -12, Health Service Executive, 2008.

76 An Overview of the Nature and Extent of Illicit Drug Use amongst the Traveller Community: An Exploratory Study, National Advisory Committee on Drugs, 2006.

77 Traveller Health: A National Strategy 2002 - 2005, Health Service Executive, 2002.

the HSE has a Regional Traveller Health Unit in place in each former Health Board area. These Units work with, and advise, the HSE on the health and social care needs of Travellers. In addition, in areas where there are significant numbers, the HSE has engaged members of that community as peer primary carers working to link Travellers to services. The All - Ireland Traveller Health Status Study, undertaken by the HSE, commenced in 2008, will report on the broad spectrum of health and social care needs of Travellers.

It is also noted that current models of good practice in relation to Traveller - specific drugs work can be drawn on to develop guidelines for best practice in relation to such work. In this context, the Steering Group noted the completion, in May 2009, of a framework document in respect of the implementation of the recommendations of the NACD Report on the nature and extent of illicit drug use amongst the Traveller Community. The Steering Group is of the view that the implementation of this framework should be considered in the context of developments of drugs policies over the lifetime of the new NDS.

Lesbian, Gay, Bisexual and Transgender (LGBT) Community

While there is no comprehensive data on prevalence within the LGBT community, research indicates that young LGBT people are more likely to take drugs, in particular "recreational"⁷⁸ drugs, than in the general population. The use of poppers⁷⁹ was highlighted as a particular concern. The research also found that 21% have systematically used drugs (i.e. on more than 60 occasions) and that 60% had taken drugs over the 12 months preceding the survey. Unlike the general population where current illegal drug use tends to decline significantly among the older population, the perception and concern in this community is that current drug use is sustained to an older age.

People presenting with dual diagnosis

People who experience both mental health and substance misuse problems experience specific difficulties in accessing treatment. Research by the NACD⁸⁰ found that there was no systematic provision of care services for this group of people and that many services operated exclusion criteria (58% for addiction services and 43% for mental health services). As outlined earlier in this chapter, the Steering Group has concerns that difficulties in accessing services

78 Data from Drug Use amongst Lesbian, Gay, Bisexual & Transgender Young Adults in Ireland: BeLong To, 2007. Other surveys (Gay Men's Health project 2000; LGBT 2008) in the LGBT community confirm that rates of "recreational" drug use among that cohort are much higher than in the general population.

79 Poppers" is the popular name for various alkyl nitrites - the effects include a "rush" sensation and relaxation of muscles that facilitate sexual intercourse.

80 Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland: National Advisory Committee on Drugs, 2004.

for people presenting with both mental health and substance misuse could be exacerbated by the implementation of the “Vision for Change” Mental Health Strategy. While the prevalence of dual diagnosis is not known, as it is not recorded by service providers, the NACD study reported previous research in Ireland that indicated it could be relatively high. In addition, the NACD found that homeless people are more likely than the general population to experience both mental health and substance misuse problems due to environmental factors, particularly the lack of supported housing.

Homeless people

NDTRS drug treatment data shows that the number of homeless cases, relative to total cases treated, increased from 153 to 265 between 2001 and 2006 (3.2% and 5.1% respectively of total cases)⁸¹. The needs of homeless people are particularly complex and highlight key gaps in inter - agency working, particularly at local level.

The NACD study of homeless people⁸² highlighted that:

- 50% had been in prison at some time;
- 30% had received some treatment for psychiatric illness;
- Polydrug use was reported by 72% of current drug users (52%⁸³);
- 51% were problem alcohol users while 36% were problem drug users⁸⁴;
- 50% of problem drug users reported contact with methadone treatment services in the last month; and
- 50% of problem drug users were positive for Hepatitis C.

This profile highlights the specific problems facing people who are homeless with substance misuse problems. At present, the Drug Treatment Centre Board provides a significant level of treatment services for homeless people. Key issues that arise include:

- accessing social housing – need for secure and stable environment;
- elimination of waiting lists for access to treatment;
- localising treatment provision;
- the possible provision of methadone in hostels;
- lack of safe places for people to inject drugs; and
- provision of outreach services to where homeless people reside.

The Steering Group notes that the provision of appropriate housing is seen as the critical need that must be addressed if treatment and rehabilitation services are to deliver sustained successful outcomes with this cohort.

Sex Workers

A small number of agencies in the statutory, community and voluntary sectors are seeking to provide support services for sex workers. As with the homeless, the key requirement is for a holistic approach to the needs of those working in prostitution and inter - agency co - operation is the key to providing these services. While some funding for interventions has been provided through the Drugs Task Forces, insufficient support services have been developed to date. In addition, concerns about the growth in sexually transmitted infections (STIs) among this cohort emphasises the need for improved harm reduction services - including access to needle exchange and condoms - which should be provided on an outreach basis. The Steering Group is of the view that there should be better integration between infectious disease services, addiction services and general hospital services. In this context, the Steering Group also notes that an NACD Report⁸⁵ on drug use and sex workers was published in May 2009.

4.99 Overall, the specific needs of these groups, outlined above, highlight important issues for the new NDS around the provision of treatment and information, in particular the capacity to identify and address their needs. The capacity of professionals working in treatment is also critical and specific training is required. It also underlines the need to ensure that they have the opportunity within the NDS framework to engage with key agencies. However, it is important to acknowledge that the fundamental problems of these groups relate to social and economic disadvantage and addressing these wider social inclusion issues is critical.

81 HRB Trends Series 2: Trends in Treated Problem Drug Use in Ireland, 2001 to 2006, Health Research Board, 2008.

82 Drug Use Among the Homeless Population in Ireland: National Advisory Committee on Drugs, 2005. While the Study provided an assessment on the nature and context of drug misuse among people who are homeless in 4 locations – Dublin, Cork, Galway and Limerick - it did not estimate prevalence. The figures are indicative of the extent and type of problems faced by homeless people.

83 In contrast to 2.9% in overall population.

84 As defined by Alcohol USE Disorders Identification Test (AUDIT) and Drug Abuse Screening Test (DAST) respectively.

85 Drug Use, Sex Work and the Risk Environment in Dublin: National Advisory Committee on Drugs, 2009.

CONCLUSIONS AND PRIORITIES FOR THE FUTURE DRUGS STRATEGY

4.100 There has been a significant expansion of treatment services, particularly in relation to methadone treatment, which has dominated the development of treatment over the lifetime of the current NDS. However, there have been significant changes in the patterns of drug use, involving a greater range of drugs, increased use of cocaine, poly - substance use (including alcohol) and a greater geographical spread of problem drug use. Overall, the Steering Group is of the view that future treatment and rehabilitation services need to be integrated and responsive to changing trends. This is essential to deal with the range of problems caused by drugs and alcohol across the country.

4.101 In terms of the new NDS, the Steering Group believes that there are two broad contexts within which services should be developed:

- opiate use, and polydrug use that involves opiates. This continues to be concentrated in socially disadvantaged areas, among marginalised communities and primarily in urban communities across the country; and
- other drug use, and polydrug use generally not involving opiates, spread across the general community.

4.102 It is the view of the Steering Group that, while methadone substitution treatment must continue to be a cornerstone of opiate treatment services, it should be augmented by other approved substitution treatments, as appropriate. With respect to continuing to improve timely access to, and exit from treatment, the Steering Group considers that, along with the continuing recruitment of level 2 GPs, the Methadone Protocol should be reviewed with respect to expanding the options through which the service is provided. This would include:

- Increasing the upper limit on the number of drug users that more experienced GPs can work with;
- Examining ways of supporting level 1 & 2 GPs to take a full complement of clients;
- Considering whether future GP training should include addiction issues to allow GPs operate at level 1 & 2;

- Consideration of the development and use of an Advanced Nurse Practitioner or Clinical Nurse Specialist⁸⁶ role;

- Considering the case for voluntary organisations to recruit doctors in relation to drug treatment, particularly in the case where such organisations have a significant history in dealing with individuals with complex social needs;

- Facilitating the use of mobile units; and

- Monitoring and reviewing the progress of clients with a view to creating appropriate opportunities for clients to successfully complete their treatment and exit the programme drug - free.

4.103 The Steering Group endorses the view of the Working Group on Alcohol and Drug Synergies that there is a clear need to bring greater coherence and co - ordination to alcohol and drug issues at a policy, planning and operational level. With respect to treatment and rehabilitation, the Steering Group sees the re - orientation of all addiction services towards dealing with problem substance use as a key feature of the new Strategy. This will necessitate the use of the 4 - tiered model approach, (outlined in paragraph 4.2) involving the statutory, community and voluntary sectors, within a national clinical and governance framework through which to develop and deliver these services. The focus of the new Strategy will be on the development of addiction services and pathways between these and other elements of the health and social services that deal with the consequences of problem substance use.

4.104 Future development of treatment and rehabilitation services must also take place within the context of the HSE's current reconfiguration of services and the move towards an integrated care model. It must also reflect the development of Primary Care Teams and Social Care networks to deliver community - based health services. The realignment of the mental health services will be a significant element of this and will have a direct relevance to clients with addiction issues.

⁸⁶ The nurse specialist is a nurse who is qualified beyond the level of a nurse generalist and is authorised to practice as a specialist in a branch of the nursing field. Titles for the nurse specialists include the designation nurse modified by the name of the speciality. There are clinical/advanced nurse specialists in a variety of areas e.g. emergency, hospice home care, older adults, stroke care.

- 4.105** The model of treatment and rehabilitation services is based on the development of an inter - agency approach based on a continuum of care, key worker and the availability of a range of treatment options to meet individual needs. These are widely accepted as core principles underpinning treatment and rehabilitation. The continued development of psychosocial services, including brief interventions, is central to the development of such a service. In addition, the Group believes that comprehensive treatment facilities for problem drug users should be available in all areas where a problem exists or arises.
- 4.106** The Steering Group is of the view that tier 3 and 4 services are underdeveloped and their further development must be a priority if a comprehensive treatment and rehabilitation service is to be achieved. In this regard, the Steering Group acknowledges the current financial constraints that face the public service, but see this objective as an achievable goal over the lifetime of the new NDS. Particular opportunities in this regard might arise through the ongoing restructuring of the HSE and the reconfiguration of the mental health services.
- 4.107** The implementation of the recommendations of the Report of the Working Group on Drugs Rehabilitation and the HSE Working Group on Residential Treatment & Rehabilitation (Substance Abuse) will provide a basis through which the rehabilitation needs of people presenting for treatment can be delivered. As outlined earlier in this chapter, the recommendations cover a wide range of issues and supports.
- 4.108** The Steering Group is also of the view that the development of needle exchange facilities and other harm reduction approaches is vital if the risk from BBVs is to be lessened, and consequent deaths reduced. To this end, the incidence of Hepatitis C among IDUs needs to be tackled in a comprehensive way. In this context, the Group believes that the forthcoming HSE report on Hepatitis C, subject to it being considered and agreed, should be implemented as a priority.
- 4.109** The increase in drug - related deaths, as identified through the National Drug - Related Death Index 1998 - 2005, shows the clear need for a National Overdose Prevention Strategy. This is currently being developed by the HSE. Addressing concerns about the availability and use of prescription drugs in general, but of benzodiazepines in particular, along with providing training in the use of naloxone for Emergency and Ambulance staff should be fundamental elements of this policy.
- 4.110** It is noted that there has been a significant increase in non - poisoning deaths (those indirectly related to drugs). The Steering Group considers that further research is needed to identify the factors contributing to these deaths, with a view to developing a co - ordinated health policy response to address such issues.
- 4.111** It is critical that adequate and appropriate treatment services are available for under - 18s, focused in particular on youth most at risk (including homeless, those at risk of homelessness and those coming out of care at 18) that come to the attention of social, justice and youth services. Many of these young people may still be at the early stages of problem substance use and most will have underlying personal problems that need to be addressed. Early intervention is a critical factor in minimising the chances of them developing more severe problem substance use. For those with more severe personal problems, additional residential services will be necessary. Putting in place a formalised referral service, governed by protocols, is central to these services being developed. Support services for families, including family therapy services, need to be further developed in this context.
- 4.112** The Steering Group is of the view that a drugs interventions programme, incorporating a treatment referral option for those for whom it is appropriate, should be developed for people, primarily youth and young adults, who come to the attention of the Gardaí due to behaviour caused by substance misuse. The key services involved in developing such a co - ordinated referral option would be An Garda Síochána, the Department of Justice, Equality & Law Reform, the HSE treatment services, the Irish Youth Justice Service, the Probation Service and voluntary and community youth services. In this context, the Group feel that many of the required services are already in place for this, but that inter - agency co - operation needs to be more developed.
- 4.113** While the IPS has significantly expanded its treatment services in a number of prisons in recent years, there needs to be a continuation of this expansion with a view to developing a comprehensive treatment and rehabilitation service for problem substance users in all prisons. It is also critically important that a

managed release programme continues to be developed that connects those released from prison with follow - on treatment and rehabilitation services.

- 4.114** With respect to the specific groups outlined in paragraph 4.98, there is a need to further develop outreach services (in a multiplicity of languages as far as feasible) that will facilitate timely access to treatment, allied to the need to develop appropriate residential rehabilitation options.
- 4.115** The Steering Group believes that the expansion of harm reduction approaches, based on an evidence - based approach covering developments internationally requires further consideration. It is envisaged that research in this area will be undertaken by the NACD and this is addressed in chapter 5.
- 4.116** As outlined above, among the most difficult cohort to engage with are those experiencing both substance misuse and mental health issues. Many of these also have other problems, such as being homeless. The development of a comprehensive service to deal with the needs of dual diagnosis clients is an essential component of an integrated treatment and rehabilitation service.
- 4.117** Treatment and rehabilitation services intermittently encounter challenges in managing clients' behaviours. This can range from the general anti - social behaviour of some clients to more serious cases related to threatening behaviour (often related to gang feuds) and can undermine the provision of treatment. The Steering Group, while fully acknowledging these difficulties, considers there is no ready solution to this problem but is of the view that when such situations do arise, that the safety of staff and clients is paramount. It is recommended that protocols be developed to facilitate the better handling of these situations.
- 4.118** The consequences of problem substance use (including alcohol) often have a significant and disproportionate impact on Emergency services, particularly at week - ends. While there are good examples where training (e.g. brief intervention training) has been of benefit to staff, it is accepted that training (in the administration of naloxone in particular) for staff needs to be developed over the coming years. The Steering Group is of the view that there is a need to put protocols in place that facilitate acute hospitals to provide an early intervention service for people with

substance misuse and related issues who present to Emergency services.

- 4.119** An appropriate educational model for paramedic (ambulance service), nurse and midwife training should be developed to ensure that they are familiar with relevant drug treatment issues and alternative care pathways.
- 4.120** While training is now available for GPs, there is a need to develop training for undergraduate doctors in regard to substance misuse and its treatment.
- 4.121** There is also a need to:
- continue to develop service user fora to engage with problem drug users; and
 - continue to develop, review and update directories of services currently available, and to explore innovative and accessible ways of disseminating information on services.
- 4.122** Progress has been made across statutory, voluntary and community services in introducing benchmarked standards for services, including accreditation for staff and competency frameworks. However, it is accepted that this is an issue that requires to be further developed to ensure national coverage to an acceptable standard across the range of services provided. The Steering Group is of the view that a quality and standards framework, based on the Report of the Working Group Examining Quality & Standards for Addiction Services and on the clinical and organisational framework developed by the HSE, should be introduced building on the initiatives in the HSE, voluntary and community sectors among others.
- 4.123** The Steering Group believes that the feasibility of cross - border initiatives on drugs and alcohol (e.g. needle exchange and residential services) within the all island health agenda should also be explored. This should be done in line with HSE cross - border arrangements for other health and social services.

PRIORITIES

4.124 The Steering Group has identified the following priorities in relation to treatment and rehabilitation under the new NDS:

4.125 These issues are returned to in chapter 7 where actions in relation to the new Strategy are identified.

Development of General Problem Substance Use Services

- Develop an integrated national treatment and rehabilitation service for all substances, using a 4 - tier model approach, underpinned by an appropriate clinical and organisational governance regime;
- Maximise operational synergies between Drug Addiction Services, Alcohol Treatment & Rehabilitation Services, General Hospital Services and Mental Health Services;
- Expand the availability of detox facilities, opiate substitution services, under - 18 services and needle exchange services where required;
- Implement the recommendations of the:
 - (i) Report of the Working Group on Drugs Rehabilitation; and
 - (ii) Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Abuse);
- establish a drugs interventions programme, incorporating a treatment referral option, for those who come to the attention of the Gardaí due to behaviour caused by substance misuse.

Specific Groups

- Further develop engagement with, and the provision of services for, specific groups: Prisoners, Homeless, Travellers, New Communities, LGBTs and Sex Workers.

Quality and Standards Framework

- Develop a clinical and organisational governance framework for all treatment and rehabilitation services.

Training and Skills Development

- Develop national training standards for all those involved in the provision of substance misuse services, and co - ordinate training provision within a single national substance misuse framework.

RESEARCH AND INFORMATION

PREVENTION

Research

Supply Reduction

National Drugs Strategy
(interim) 2009 - 2016

Treatment

Rehabilitation

CHAPTER 5

RESEARCH AND INFORMATION

INTRODUCTION

5.1 The current NDS set out to develop data sources and research on the extent and nature of drug misuse in Ireland with a view to having an informed, evidence - based approach to the on - going development of the Strategy. The pillar has been crucial in deepening our understanding of the drugs situation in Ireland and placing it within an international context.

5.2 The EU Action Plan on Drugs 2009 - 2012 views the understanding of the drug problem in society as a priority and identifies research and information as a cross - cutting theme. In this context, information flows need to be put in place with a view to ensuring a uniform approach to data collection across Europe. This will facilitate the development of an overall European perspective on problem substance use and will allow for comparability of data between different jurisdictions. From an Irish perspective, information flows need to be further improved so as to have comprehensive and more timely data available. This will facilitate improved planning and management of services with a view to ensuring quicker responses to problems as they arise. This is particularly relevant with respect to treatment and rehabilitation services. It will also improve the evidence - base for future research.

RESEARCH PILLAR - KEY FEATURES

5.3 The strategic aim of the research pillar in the current NDS is set out in Table 5.1. below. Two groups are tasked with providing health and social information to inform the approach to tackling drug - related issues - the National Advisory Committee on Drugs (NACD), and the Alcohol and Drug Research Unit (ADRU) of the Health Research Board (HRB). The NACD was set up to conduct, commission and analyse research on issues relating to drugs and to advise Government on policy development in the area. The ADRU of the HRB manages drug - related information systems and collates and synthesises all information and research for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA)⁸⁷.

5.4 A number of other Government Departments and agencies have contributed to developing data collection processes and commissioning or conducting research. The resultant information has increased our understanding of the drugs problem in Ireland. They included:

- Department of Health & Children;
- The HSE;
- Drug Treatment Centre Board;
- Health Surveillance Protection Centre (HSPC);
- National Drugs Strategy Team (NDST) - including Drugs Task Forces;
- Department of Justice, Equality & Law Reform;
- An Garda Síochána;
- Forensic Science Laboratory;
- Irish Prison Service;
- Irish Courts Service;
- Central Statistics Office;
- FÁS;
- Department of Environment, Heritage & Local Government;
- Department of Social & Family Affairs;
- Department of Education & Science;
- 3rd Level Institutions;
- Joint Oireachtas Committee on Arts, Sport, Tourism, Community, Rural & Gaeltacht Affairs; and
- Community and voluntary sectors.

Table 5.1 – Strategic Aim and Objectives of Research Pillar under the current NDS

National Drugs Strategy 2001 - 2008
– Research
Strategic Aim:

- To have valid, timely and comparable data on the extent and nature of drug misuse in Ireland.

Strategic Objectives:

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

⁸⁷ The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) was established in 1993 and is based in Lisbon. The Centre through its collection, analysis and dissemination of objective, reliable and comparable information on drugs and drug addiction, provides an evidence - based picture of the drug trends at European level.

ASSESSMENT OF PROGRESS UNDER CURRENT NATIONAL DRUGS STRATEGY

5.5 There were two main streams of work under this pillar:

Information Collection (4 actions – 4, 65, 67, 107)

These actions focused on:

- the collation of data on the progression of offenders with drug - related offences through the criminal justice system (arrests, prosecutions etc.);
- securing the co - operation of treatment providers in returning NDTRS information; and
- developing an accurate mechanism to record drug - related deaths and further developing the Central Treatment List (CTL)⁸⁸, coupled with the development of treatment waiting lists on a regional basis.

Research (4 actions - 98, 99, 100, 106)

These actions concentrated on the following research studies:

- estimating the prevalence of drug use among the general population;
- estimating the number of opiate users;
- exploring the experience of drug use among specific vulnerable populations;
- documenting opiate treatment outcomes; and
- examining the effects of sharing drug - using equipment.

Action 106 dealt with the monitoring of NACD recommendations, as set out in the different reports.

Information collection

5.6 The EMCDDA has developed five epidemiological indicators (see Table 5.2) that monitor the changing nature of problem drug use across Europe. The indicators provide a framework through which to examine problem drug use in our society and to place it within a European context. There has been considerable improvement in the quality of data collated on these indicators, though some gaps remain.

Table 5.2: Progress on development of Indicators

Indicator	Progress
Prevalence and patterns of drug use among the general population	<p>The NACD, in conjunction with their colleagues in Northern Ireland, have undertaken two all - island Drug Prevalence Surveys (2002/03 and 2006/07). These have established the national prevalence of drug use among the general population, given insights on the spread of drug use by region, and provided more detailed information on the use of particular drugs in the general population.</p> <p>The ESPAD⁸⁹ survey undertaken every 4 years (2007 report was released in March 2009) estimates the prevalence of drug use among school - going students in their 16th year.</p> <p>The HBSC⁹⁰ cross - national research study also gives some insight into alcohol and cannabis use of the youth population (age group 11 - 17).</p> <p>The survey of lifestyle, attitudes and nutrition in Ireland, SLÁN⁹¹, published by the Department of Health and Children, also gives some insight into the population's alcohol and drug use (age group 18 and over).</p>
Prevalence and patterns of problem drug use	<p>The NACD undertook a 3 - source Capture Recapture Study to estimate the prevalence of problematic opiate use throughout Ireland in 2001. This built on a similar 1996 study that covered the Dublin area only. A further study to estimate the 2006 prevalence is currently underway.</p> <p>The Research Outcome Study in Ireland (<i>ROSIE</i>), and the information provided through the NDTRS provide significant insights into the patterns of problem drug use.</p> <p>The issue of estimating the prevalence of problematic drug use, other than opiate use, has been considered but the current lack of a unique identifier (see para 5.7 below) in data sources does not facilitate this. At this point, the Drug Prevalence Surveys provide the best available prevalence estimates for cocaine, cannabis and other problem drug use.</p>
Demand for drug treatment (statistics from drug treatment centres on clients starting treatment)	<p>Drug treatment data has also improved substantially through the NDTRS (which records treatment for problem drug and alcohol use), and the CTL (which records methadone treatment). However, there are limitations on the information available. The NDTRS records episodes of drug treatment and does not reflect the number of individuals who received treatment. In addition, it is still not fully automated and, critically, does not include outcome/exit data for all areas.</p> <p>Data on waiting lists is being collected by the HSE. They report regularly to the Inter - Departmental Group on Drugs (see chapter 4) on this issue.</p>
Drug - related infectious diseases	<p>The HPSC has introduced a surveillance system for Hepatitis B and C (notifiable diseases) and HIV. While risk factors for HIV are reported for the vast majority of cases, risk factors for Hepatitis B and C are reported on a minority of cases. There is no national prevalence estimate of BBVs among the drug using population.</p>
Drug - related deaths and mortality of drug users	<p>THE HRB has developed a National Drug - Related Deaths Index (NDRDI) and has published data for the period 1998 - 2005, (see chapter 4). This data collection mechanism complies with the requirements of the EMCDDA.</p>

88 Central Treatment List (CTL) fulfils its core statutory (SI 225/1998) function – to be a complete register of all patients receiving methadone (as treatment for problem opiate use) in Ireland. Once on the list, the current treatment status of the majority of clients can be tracked by means of transfer and exit records.

89 European School survey Project on Alcohol and other Drugs (ESPAD): The survey is carried out every 4 years in 40 European countries.

90 Health Behaviour in School aged Children (HBSC): A World Health Organisation (WHO) collaborative cross national study.

91 SLÁN is a national survey (carried out by the Department of Health & Children) of the lifestyle, attitudes and nutrition of people living in Ireland. The most recent survey was carried out in 2007. It includes questions on alcohol and the use of licit and illicit drugs.

- 5.7** Substantial progress is, therefore, evident in developing data. A key constraint in enhancing current data collection is the lack of a unique identifier that, with a patient's consent, would allow the system to track individual histories and permit the calculation of numbers treated for specific drugs in the population. Issues around data protection legislation constitute a major difficulty in overcoming this problem.
- 5.8** Data gaps have also been identified under the prevention and rehabilitation pillars, as well as in regard to harm reduction (which include needle exchange and social care services). In relation to the latter, the Dublin Addiction Information System has been collecting data on needle exchange in the northern and east coast HSE areas. In this context, it is recognised that there is a need to develop a national harm reduction database that can be maintained alongside the NDTRS, and the HSE is considering how best to progress this matter.
- 5.9** The primary focus of the current NDS has been on developing data in relation to prevalence, treatment and drug - related deaths. Much work has also been undertaken in the justice area in the development of information systems. Examples of this include the development of Pulse (Garda information system), the role of the Central Statistics Office (CSO) in reporting crime statistics and Irish Youth Justice and Irish Prison Services' information systems.
- 5.10** Some exploratory work has been conducted by the lead agencies to progress action 4 of the current NDS relating to the collation of data on the progression of offenders with drug - related offences through the criminal justice system (arrests, prosecutions etc.). However, significant technical and resource issues continue to prevent the compilation of such information. The Steering Group considers that the availability of such a system to track offenders with drug - related offences is a critical element of designing and establishing policy in the area of law enforcement as it relates to supply reduction. (See 2.39)
- 5.11** There are significant levels of prevention activity across the statutory, community and voluntary sectors, ranging from school - based actions to actions and activities through community and voluntary organisations (particularly among youth and sporting organisations). However, it is noted that the reporting of outcomes, and the establishment of the impacts of initiatives undertaken is under - developed. The Steering Group

considers that the recent consolidation of youth affairs within the OMCYA and the evaluation of DEIS initiatives, affords an opportunity to develop reporting systems and to look holistically at prevention strategies aimed at both the general youth population and youth most at risk.

Research

- 5.12** The NACD has published 70 reports⁹² since it was established and has substantially completed the actions identified in the NDS:
- It has published, or is about to publish, reports on at risk groups identified in the NDS - the homeless, Travellers, sex workers and early school leavers;
 - It also commissioned a longitudinal study on treatment outcomes (Research Outcomes Study in Ireland - *ROSIE*) under which it has published seven reports on outcomes to date; and
 - it has published a report on Harm Reduction Approaches in Ireland, incorporating international evidence (action 100 refers).
- 5.13** The 2005 MTR of the current NDS identified an additional action relating to the monitoring of the implementation of NACD recommendations. To date, no formalised procedure has been put in place to monitor implementation but the progress of NACD reports are routinely discussed at IDG meetings.
- 5.14** The ADRU of the HRB, has undertaken and disseminated research in relation to drugs through its trend paper series (NDTRS and NDRDI), overview series, research publications and its quarterly newsletter - Drugnet Ireland. The ADRU also manages the National Documentation Centre on behalf of the Department of Community, Rural and Gaeltacht Affairs. This is a significant information resource for researchers, policy - makers and people working in the areas of drug or alcohol use and addiction, or related fields.
- 5.15** Research has also been undertaken independently or jointly by a number of Departments and agencies. The joint NACD and NDST reports on Cocaine and on Needle Exchange⁹³, which were based on data and/

⁹² Details of publications by the National Committee on Drugs can be found on www.nacd.ie.

⁹³ An Overview of Cocaine Use in Ireland II: National Advisory Committee on Drugs & National Drugs Strategy Team, 2007. Needle Exchange Provision in Ireland: National Advisory Committee on Drugs & National Drugs Strategy Team, 2008.

or research produced by the HSE, ADRU, ESRI, An Garda Síochána and the Irish Prison Service, are good examples of this. A report on crack cocaine⁹⁴, undertaken by ADRU, was jointly financed by the Department of Justice, Equality & Law Reform and the HSE. A promising feature of this research has been the level of inter - agency and inter - departmental engagement on mutually beneficial initiatives.

5.16 Drugs Task Forces have sought to develop local data sources to facilitate needs analysis and planning, and they have also undertaken a number of research projects over the lifetime of the current Strategy. Drugs Task Forces also tap into any information that is available through their statutory representatives. Analysis of the LDTF strategic planning process, undertaken in 2008, found that, while the LDTFs presented a comprehensive picture of drug prevalence using data from a number of different sources, there is an issue of a lack of consistent reliable local data in a useable form. The difficulty in developing local data sources was also highlighted in the NACD's Community Indicators Study which explored the development of a Community Indicator for Problem Drug Use⁹⁵.

5.17 Three systematic reviews⁹⁶, funded by the NACD, have been completed by the National Medicines Information Centre on the use of naloxone, lofexidine and buprenorphine in the management of problem opiate users. The Department of Health & Children published a review of benzodiazepine use⁹⁷, in 2002, as well as good practice guidelines for clinicians to ensure more appropriate prescribing of these drugs. These publications were developed under the aegis of the NDS and, along with other NACD and HRB publications, were disseminated to a wide audience including policy makers.

94 Crack Cocaine in the Dublin Region, An Evidence Base for Crack Cocaine Study: HRB Research Series 6, Health Research Board, 2008.

95 A Community Drugs Study: Developing Community Indicators for Problem Drug Use, National Advisory Committee on Drugs, 2006.

96 The Use of Naloxone in the Management of Opiate Dependence Syndrome, National Committee on Drugs, 2003. The Use of Lofexidine in the Management of Opiate Dependence Syndrome, National Committee on Drugs, 2003. Report on the Use of Buprenorphine as an Intervention in the Treatment of Opiate Dependence Syndrome, National Committee on Drugs, 2002.

97 Report of the Benzodiazepine Committee, Department of Health & Children, 2002.

5.18 With respect to research developed outside the remit of the NDS, an internal analysis which was undertaken by the HRB identified 69 peer - reviewed drug - related publications produced in 2001/2002 and 2005/2006 (i.e 69 publications over a total of 4 years). These were classified into three main categories:

- the nature and extent of drug use and its consequences (most common);
- clinical publications on aspects of problem drug use; and
- a small number of harm reduction reports.

5.19 Overall, it is clear that a significant amount of research has been undertaken and that the results of this research have been widely disseminated. It is noted that this would have influenced policy formulation at least informally.

ASSESSMENT OF IMPACT PROGRESS AGAINST KPIS - QUANTITATIVE ASSESSMENT OF IMPACT

5.20 The KPIS identify 3 important outputs in relation to the research pillar:

- Eliminate all identified gaps in drugs research by mid - 2008;
- Publish an annual report on the nature and extent of the drug problem in Ireland, drawing on available data; and
- Publish a report on progress being made in achieving the objective and aims set out in the Strategy every two years.

In relation to the first indicator, there has been a significant increase in the knowledge of the drug problem in Ireland arising from commissioned research and data improvements. Given the evolving nature of the drug problem, however, it is unrealistic to expect that commissioned research has bridged all research gaps as these become evident over time.

On the second indicator, an annual report is prepared by the ADRU, as the Reitox National Focal Point, for the EMCDDA. This is a substantive report on the drugs situation in Ireland, and our responses to it. This National Report has been available to the public since 2005.

The third indicator, which was added in the MTR of the Strategy, has not been progressed in a formal way.

5.21 The current KPIs do not seek to outline how effective the data and research has been in influencing and shaping the development of policy and practice on a routine basis at national, regional and local level. It is clear, however, that research has provided much important information which has influenced decision - making.

5.22 There is strong evidence that NACD and HRB (ADRU) reports and bulletins are widely disseminated and have an impact. They contribute to creating a climate for change in the NDS, examples include a number of NACD reports, below:

- Drug Use Prevention – Overview of Research (November 2001) was routinely referred to by practitioners;
- The Use of Buprenorphine as an Intervention in the Treatment of Opiate Dependence Syndrome (October 2002) was well - received internationally and has helped to inform the Department of Health & Children’s response and discussion at local level with GPs;
- Drug Use among the Homeless Population (April 2005) has added credibility to the work of the homeless agencies and was specifically used to develop the case for drug workers in this field;
- An Overview of the Nature and Extent of Illicit Drug Use amongst the Traveller Community – an Exploratory Study (October 2006) has also given credibility to their needs;
- Needle Exchange Provision in Ireland (December 2008) reinforced the need for access to services; and
- The Role of Family Services in Drug Prevention (November 2004) helped to bolster the efforts of the Family Support Network.

5.23 On the other hand, the “Vision for Change” (Mental Health Strategy – see chapter 4) excluded addiction services from mental health services, contrary to the views documented in the dual diagnosis report⁹⁸ and contrary to general international practice.

KEY FINDINGS FROM THE CONSULTATION PROCESS

5.24 While research did not figure prominently in the public consultations, the need for better information systems and more research was included in some submissions. It was also captured and articulated in the submissions from the organisations that are more centrally involved in this area. The conclusions and priorities for the future NDS outlined below take on board the findings from the overall consultation process.

CONCLUSIONS AND PRIORITIES FOR THE FUTURE DRUGS STRATEGY

Information

5.25 Much more is now known about the drugs situation in Ireland than was the case in 2001, with significant progress made in regard to 4 of the 5 key epidemiological indicators identified by the EMCDDA:

- prevalence and patterns of drug use among the general population;
- prevalence and patterns of problem drug use;
- demand for drug treatment; and
- drug - related deaths and mortality of drug users.

Limited progress has been made in respect of the drug - related infectious diseases indicator.

5.26 The Steering Group considers that the continuation of the All - Island National Prevalence Survey in 2010/2011 and 2014/15 is a prerequisite for monitoring the prevalence of problem drug use in our society. The Group considers that alcohol use also needs to be monitored in a more comprehensive way and is of the view that the Prevalence Survey should be amended to include survey questions on alcohol. This would allow for a deeper understanding of the changing prevalence and patterns of alcohol use in the general population. While it is agreed that the ESPAD Survey should continue to be the primary estimator of substance misuse among those under 18, it is also acknowledged that as a school - based survey it will not fully capture the level of misuse among the youth population most at risk. Consideration needs to be given, therefore, as to how to effectively monitor changes in the prevalence of substance misuse among this cohort. The Steering Group believes

⁹⁸ The Management of Dual Diagnosis in Mental Health and Addiction Services in Ireland: National Advisory Committee on Drugs, 2004.

that the development of such a monitoring system should be informed by the research currently being completed by the NACD on early school leaving and substance misuse

- 5.27** While the information provided through reporting systems, such as the NDTRS and the CTL, and through research projects such as *ROSIE*, provide significant insights into the patterns of problem drug use and into those engaged in treatment, the issue of estimating the prevalence of heroin, cocaine and emerging trends in new drugs is much more problematical. There is a need to develop our data sources to estimate the overall prevalence of problem drug use. Critical in this regard is the putting in place of a unique identifier, as outlined in paragraph 5.7 above. Without such an identifier, it is unlikely that further significant progress can be made. It is also important that an ethnic identifier, where appropriate, is further developed, particularly in the area of treatment and rehabilitation.
- 5.28** The system of monitoring changing trends needs to be further developed with a view to ensuring full participation in the EU Early Warning System⁹⁹. In this regard, the recommendations of the NACD's Report¹⁰⁰ on the role of laboratory stakeholders might be considered further.
- 5.29** A system for monitoring cases of problem substance use (including alcohol) presenting to hospital Emergency Departments should be introduced and this is discussed in chapter 4. This could be done through the inclusion by hospitals of a small number of questions on alcohol and drug abuse in their generic data collection systems.
- 5.30** The Steering Group considers that the introduction of a Drugs Trend Monitoring System should be considered by the Office of the Minister for Drugs (see chapter 7), in its first year of operation, in the light of developments regarding research and information under the new NDS.
- 5.31** While there have been improvements in the development of information systems in the justice area, their use is under - developed within the context of the NDS. For example, PULSE data is not routinely available to the ADRU for reporting purposes to the EMCDDA.
- 5.32** The development of a real time National Substance Reporting System (NSRS) that is timely and monitors treatment and rehabilitation outcomes is considered to be crucial. This would integrate the NDTRS, CTL, DAIS and HPSC (in respect of BBVs) information relating to IDUs and related reporting systems (e.g. prison treatment services, homeless treatment services, National Psychiatric In - patient Reporting System and the Hospital In - Patient Enquiry (HIPE) System, NDRDI and general mortality register) into a single reporting framework to monitor the outcomes of treatment and rehabilitation services. Essential to this is the need to develop a unique identifier that while, respecting the privacy of individuals, facilitates the tracking of treatment outcomes. A unique identifier would allow the NDTRS to track individuals through treatment and social re - integration and to identify factors associated with positive and negative treatment outcomes.
- 5.33** The Steering Group believes that there is also a need to further improve information in relation to a number of at risk groups including the following:
- BBVs: no national estimate of prevalence of BBVs, particularly Hepatitis C, among the drug - using population is available. Risk factor data should be provided by all relevant organisations as an automatic element of the data to be notified to the HPSC;
 - the prevalence of psychiatric co - morbidity among drug and alcohol users is unknown; and
 - problem drug/alcohol use among the prison and homeless populations – a repeat of earlier research should be considered.
- 5.34** The continued development of the National Drugs - Related Death Index is an important aspect of the development of our data sources. There is a need for this information to be available in a more timely manner but this is dependent on the implementation of the recommendations of the Coroners Report¹⁰¹. It is noted that an implementation team has been established in the Department of Justice, Equality & Law Reform in this regard.

⁹⁹ EU Early Warning System as established by EU Council Decision 2005/387/JHA.

¹⁰⁰ Report on the Role of the Laboratory Stakeholders on the Early Warning and emerging Trends Committee, this was an internal report carried out by the National Committee on Drugs and was submitted to the IDG for their consideration in December 2007.

¹⁰¹ Report of the Working Group on the Review of the Coroner Service: Department of Justice, Equality & Law Reform, 2000.

5.35 The EMCDDA has identified three areas - harm reduction, drugs & crime and public expenditure - where they consider new indicators at EU level should be developed. The Steering Group notes that the work on these is still at an early stage. While it is acknowledged that the development of these indicators present significant challenges, the Group is of the view that they would provide further useful insights into the drugs issue and that Ireland should be at the forefront of the development of some, or all, of them.

RESEARCH

5.36 A number of important research initiatives with respect to treatment and rehabilitation have been identified in chapter 4. These relate to:

- the factors influencing indirect drug deaths;
- harm reduction approaches, based on an evidence - based approach covering developments internationally; and
- the effect of alcohol and drugs on the Irish health and justice systems.

It is noted that research recommendations were also made in the Report of the Working Group on Drugs Rehabilitation, as outlined in chapter 4.

Such research proposals should be assessed and reviewed annually to facilitate implementation, as appropriate, over a phased period.

5.37 The Steering Group believes that clinical research is underdeveloped in Ireland. The Group is of the view that the programme of research, to be developed, should include research into the following, on a priority basis subject to annual review:

- the psychosocial adjustment and quality of life of patients on long - term methadone maintenance treatment;
- the evidence of the effectiveness of the progression of clients from substitute maintenance treatments to abstinence;
- the misuse and prolonged use of psychotropic drugs; and
- new developments in treatments for drugs.

5.38 The Group also considers that research into the impact of prevention programmes aimed at youth at risk should be undertaken to establish the outcomes being achieved. This should include examination of the range of youth services being provided, such as those through YPFSF, SPY and the Garda Youth Diversion programmes.

5.39 With respect to research broadly, the Steering Group considers an annual research programme should be agreed by the Minister, the Office of the Minister for Drugs (see chapter 7) and the NACD, as early as is feasible after the commencement of the new Strategy. The development of this work programme should take cognisance of the need to develop reporting systems and indicators on the extent and nature of problem drug use in Ireland as discussed above. In this context, the Steering Group considers that the following areas, among others, should be considered in the finalisation of the programme:

- Research recommended in the Report of the Working Group on Drugs Rehabilitation;
- Harm reduction approaches, founded on an evidence - based methodology covering international developments;
- The evidence of the effectiveness of the progression of clients from substitute maintenance treatments to abstinence;
- Psychosocial adjustment, and quality of life, of patients on long - term methadone maintenance treatment;
- The misuse and prolonged use of psychotropic drugs;
- Factors influencing deaths that are indirectly related to drugs;
- New developments in treatments for drugs;
- The impact of alcohol and drugs on the Irish health and justice systems;
- Further research on psychiatric co - morbidity among drug users;
- Prevalence patterns of problem substance use among prisoners and homeless people; and
- Exploration of the feasibility of developing an indicator to monitor changes in the prevalence of substance misuse among youth at risk.

5.40 The Steering Group considers that the NACD should seek to develop a framework through which it can influence research carried out into problem substance use in Ireland, whether at a national (including 3rd level institutions), regional or local level, and whether within or outside the NDS organisational framework. The aim would be to influence the areas in which research is carried out, to promote the improvement of research standards in the substance misuse area, to increase interest and expertise in such research and to strengthen links with other research bodies.

5.41 It is noted that a significant body of knowledge on evidence - based best practice in relation to dealing with problem drug use has been built up. However, a key challenge is to disseminate best practice among service providers to ensure that it is applied. The increased collaboration between Drugs Task Forces, the NACD and the HRB has been helpful in this regard, as has the development of the NATP by the HSE, as outlined in chapter 4. The National Documentation Centre of the HRB can play an important role also. An important aspect of this will be the strengthening of links between research and training provision at national and local level.

PRIORITIES

5.42 The Steering Group has identified the following priorities in relation to research and information under the new NDS:

- Continue to develop indicators and reporting systems on the extent and nature of problem substance use in Ireland (seeking to remove barriers to the development of these reporting systems and indicators);
- Develop a prioritised research programme, to be reviewed annually;
- Continue the Drug Prevalence and the ESPAD Surveys; and
- Develop a research management framework and disseminate research findings and models of best practice.

5.43 These issues are returned to in chapter 7 where actions in relation to the new strategy are identified.

INSTITUTIONAL STRUCTURES

PREVENTION

Research

Supply Reduction

National Drugs Strategy
(interim) 2009 - 2016

Treatment

Rehabilitation

CHAPTER 6

INSTITUTIONAL STRUCTURES

INTRODUCTION

6.1 A wide range of statutory, community and voluntary sector organisations are currently involved in delivering the NDS at national, regional and local levels. As a cross - cutting area of public policy and service delivery, the implementation of the NDS represents, therefore, a significant institutional challenge. Ultimately, its overall effectiveness is closely linked to how well the institutional and co - ordination arrangements work.

6.2 This chapter provides an overview of the key elements of the co - ordination framework. It assesses progress in achieving NDS actions, as revised by the MTR in 2005, examines the effectiveness of the overall framework and makes recommendations for the new NDS.

Co - ordination framework - key features

6.3 Table 6.1 - Key strategic aim and objective of the co - ordination framework.

**National Drugs Strategy 2001 - 2008
– Co - ordination framework**

Strategic Aim

- To strengthen existing partnerships in and with communities and build new partnerships to tackle the problems of drug misuse

Strategic Objective

- To have in place an efficient and effective framework for implementing the National Drugs Strategy

6.4 The institutional arrangements that support cross - agency working are an important element in the success of the implementation of the NDS. The MTR acknowledged that the effective implementation of the NDS as a whole was closely linked to the working of these arrangements.

6.5 The key co - ordination mechanisms in the current NDS include:

- Department of Community, Rural and Gaeltacht Affairs (Drugs Strategy Unit - DSU);
- The National Drugs Strategy Team (NDST);

- The Inter - Departmental Group on Drugs (IDG);
- Local and Regional Drugs Task Forces; and
- Cabinet Committee on Social Inclusion, Children & Integration.

6.6 Arising from the First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs, the NDST was established as a cross - departmental team on the lines envisaged in the Strategic Management Initiative in the Public Service. The core mandate of the Team was threefold (i) to effectively oversee the operation of the Local and Regional Drugs Task Forces (ii) to ensure effective co - ordination between Departments and agencies and (iii) to identify and consider policy issues and ensure that policy is informed by the work and lessons from the Task Forces, through joint meetings with the IDG.

6.7 An important achievement of the NDST - and the other NDS co - ordination structures - is that they have stimulated and promoted inter - agency working in a difficult cross - cutting policy and service area. Relevant Departments and statutory agencies – as well as representatives of the community and voluntary sectors - are represented on the NDST, the IDG and the Task Forces.

ASSESSMENT OF PROGRESS UNDER THE CURRENT NDS

6.8 The MTR found that most of the 22 co - ordination actions in the Strategy had been implemented, with only 2 requiring “considerably more progress”. Arising from the MTR, 5 of the 22 co - ordination actions were replaced or amended with no new actions being recommended.

6.9 The MTR identified three priorities in relation to the co - ordination pillar, which the adjusted/ replaced actions were designed to address in particular:

- Addressing the membership and operation of the NDST (action 83) - *these have been substantially progressed;*
- Strengthening the operation of the IDG and specifying its modus operandi and membership (action 79) - *actions progressed;* and
- Engagement with the Oireachtas Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs (action 77) – *action on - going.*

6.10 The actions under the co - ordination pillar of the current Strategy can be separated into a couple of areas. In the main, they relate to the work of the (i) the DSU (ii) the NDST and (iii) the IDG.

(i) The actions relating to the DSU were primarily concerned with co - ordinating the overall implementation of the Strategy in partnership with other Departments and agencies, as well as working through the IDG to establish the cost effectiveness of the various elements of each pillar of the NDS.

(ii) The actions relating to the NDST were, in the main, focused on their work in relation to the Local and Regional Drugs Task Forces and disseminating models of best practice arising from that work. The NDST also had a role, through engagement with relevant interested partners, in capacity building within communities, particularly in developing community representation, and in disseminating good practice.

(iii) In relation to the IDG, it was tasked with addressing operational difficulties in relation to the on - going implementation of the NDS. Other actions related to its membership, joint meetings with the NDST and reporting by Departments, Agencies and other relevant organisations, as required.

All of these actions have, in the main, either been completed or are ongoing tasks.

6.11 Overall, the achievements made through the NDST and Drugs Task Forces since the 1990s have been considerable. The structures put in place, responding initially in the main to an opiate problem in Dublin, were innovative and broadly effective. Among the areas of achievement under the stewardship of the NDST were the following:

- a real focus on the drugs problem;
- the establishment of Local and Regional Drugs Task Forces throughout the country;
- prominent placing of the drugs problem in the social inclusion sphere;
- a targeted response to drugs issues as they affected people on the ground;
- structures that engaged communities and fostered commitment;

- encouragement of ownership of issues and voluntary involvement;
- upskilling and empowerment of people on the ground;
- training initiatives and promulgation of a standards and accreditation framework;
- dissemination of models of good practice;
- co - operation between the statutory, community & voluntary sectors; and
- structures that encouraged inter - agency working at NDST and Drugs Task Force level.

6.12 The focus for the new NDS is, therefore, to build on the achievements to date and put structures in place that will best facilitate tackling problem substance misuse nationwide over the coming seven years.

PROGRESS AGAINST THE CURRENT KPIS

6.13 The current NDS identified 4 KPIS to assess the efficiency and effectiveness of the framework for implementing the NDS:

Table 6.2 KPIS and summary of progress

KPI	Progress
Establish an effective regional framework to support the measures outlined in the Report by end 2001.	RDTFs now established in 10 regions throughout the country (and with LDTFs provide full national coverage).
Complete an independent evaluation of the effectiveness of the overall framework by end 2004.	This was an integral part of the MTR of the NDS which was completed in 2005.
Each agency to prepare and publish a Critical Implementation Path (CIP) for each of the actions relevant to their remit by end 2001.	CIP was completed and updated in 2005.
Review the membership, work - load and supports required by the NDST to carry out its terms of reference by end September 2001.	Additional resources secured for NDST.

6.14 Significant progress has been made in developing the actions and in reaching the agreed KPIS. The Steering Group considers, however, that more meaningful indicators are required in the new NDS to assess the efficiency and effectiveness of the overall co - ordination framework over the coming years. The development of a performance

management framework is also relevant in this context and this issue is examined later in this chapter.

CAPACITY TO DEVELOP AND IMPLEMENT STRATEGY

6.15 Despite the progress made, the Steering Group believes that there are a number of areas where the current NDS could be improved to better tackle problem substance use over the period until 2016 and ultimately, to better enhance the overall capacity to develop and implement strategy. These areas include:

- influencing the prioritisation and provision of mainstream services;
- accounting for expenditure;
- governance;
- the roles and responsibilities of the DSU and the NDST;
- mainstreaming;
- capacity of services to meet clients needs; and
- monitoring/evaluation.

These areas are addressed in detail below.

Influencing priorities and mainstream service provision

6.16 One of the key challenges for the NDS is its ability to influence the priorities of key agencies who are involved in delivering relevant services at national, regional and local level. While considerable progress has been made in implementing the actions in the NDS, this tended to be most successful where one Department, agency or Drugs Task Force was involved in implementing an initiative, rather than where a number of agencies were involved, with the potential for organisational problems and inconsistent levels of commitment. In this context, it is noted that co-ordinating structures depend on their ability to influence - rather than their authority to secure implementation of the NDS.

6.17 The level of capacity to influence mainstream service provision can make it particularly challenging for the Minister of State with responsibility for the NDS to ensure that services are delivered in line with the strategic priorities of the Strategy. This is particularly so given the often competing social inclusion (and other) priorities of Departments and agencies.

6.18 In this context, it is noted that problem drug use may not be sufficiently high on other Departments/agencies agendas when considered purely from the perspective of their own responsibilities and concerns. However, it may warrant a more prominent role when viewed from a broader societal angle.

6.19 As identified in chapter 4, another structural concern within the health sector is the need to factor in the implications of the roll - out of the "Vision for Change" mental health services for the development of HSE addiction services. This primarily relates to the need to realign those elements of mental health services, currently dealing with drug and alcohol issues, to its addiction services.

6.20 The challenge, therefore, is to put a structure in place that optimises the chances to influence policy formulation and programme implementation across the various agencies involved.

6.21 The Group also notes that the Cabinet Committee on Social Inclusion, Children and Integration deals with a wide range of social inclusion policy areas, of which drugs is one issue. While the scope for routine debate on drugs is limited, therefore, the Group acknowledges that addressing the broader social inclusion agenda ensures that the drugs issue is taken into consideration, as it is an integral aspect of many of the social inclusion priorities. The fact that the proposed National Substance Misuse Policy (drugs and alcohol) is to be developed, regular engagement by the Cabinet Committee in this area is considered vital and it is the view of the Steering Group that substance misuse should be a formal agenda item at meetings at least twice a year.

Accounting for expenditure

6.22 While it is not difficult to identify annual expenditure across Departments and agencies in relation to the provision of core services for problem drug users, identifying monies expended on generic services provided for the general public remains a difficulty. While it is estimated that approx €276m was spent on these services in 2008 – see *table 6.3 below* - this figure excludes the cost of some generic services, as indicated above, and so understates total expenditure. While bringing more clarity to NDS expenditure across all departments and agencies presents significant challenges, efforts to improve on the financial information available will continue and, accordingly, help to track trends in this regard more effectively.

Table 6.3 - 2008 expenditure by Departments and agencies that is directly attributable to drugs programmes

Department/Agency	2008 Expenditure (€m)
Department of Community, Rural and Gaeltacht Affairs	€65.207
Department of Health and Children	€1.033
Health Service Executive	€101.867
FÁS	€18.8
Department of Education and Science	€12.386
Department of Environment, Heritage and Local Government	€0.496
Department of Justice, Equality and Law Reform	€8.79
The Probation Service	€2.897
Irish Prison Service	€5.00
An Garda Síochána	€44.4
Revenue's Customs Service	€14.9
Total	€275. 776

Source – Department of Community, Rural and Gaeltacht Affairs 2009

6.23 The Steering Group notes that the EMCDDA also recognises the importance of more clarity in public expenditure in the drugs area and that they are developing guidelines to support the development of an indicator in this regard.

Organisational Governance

6.24 The current co - ordination framework, which was designed to encourage effective inter - agency working relationships, is complex. It is felt that further development is needed in the area of organisational governance and in particular, it is noted that:

- The Minister of State has overall political responsibility for the NDS but his authority to ensure implementation of NDS actions across all pillars is considerably constrained. The key pillar organisations involved in service delivery are accountable to the Accounting Officer of their respective Departments/agencies and to their respective Ministers for all expenditure, priorities and actions;
- The Secretary General of the Department of Community, Rural and Gaeltacht Affairs is ultimately accountable to the Public Accounts Committee for all expenditure incurred by his Department, including that incurred in respect of services funded by his Department through the Drugs Task Force process. However, this is not underpinned by sufficiently robust reporting arrangements from these organisations to the Department;

- Drugs Task Force Co - ordinators are employed by the HSE, while development workers and administration staff are employed mainly by Area Partnerships Companies, in the case of the RDTFs, and through various hosting agencies in the case of the LDTFs. This has led to inconsistency in reporting arrangements in Drugs Task Forces between chairpersons, co - ordinators and other personnel;
- There are some concerns about the adequacy of the monitoring arrangements of interim - funded projects, though it is acknowledged that the NDST has played a significant role in supporting the Drugs Task Forces through the introduction of agreed monitoring and evaluation processes; and
- The development and implementation of agreed standards of clinical governance at national level is a priority within the HSE. This is a complex and challenging task, involving the harnessing of the expertise, knowledge and resources to commission the mix of services that incorporate best practice and meet evidenced - based need. The development of such a structure for treatment and rehabilitation services will be of significant assistance to Drugs Task Forces in regard to their roles in commissioning, promoting, providing and delivering services to respond to the needs of their populations.

Drugs Strategy Unit (DSU) & National Drugs Strategy Team (NDST)

Roles & responsibilities

6.25 The Steering Group found that both the DSU and the NDST have co - ordination, policy and strategy roles. The NDST was originally established in 1996/97 under Department of the Taoiseach and subsequently moved to the Department of Tourism, Sport and Recreation, where the DSU was put in place in 1998/9. Responsibility for the drugs area moved again in June 2002 to the newly established Department of Community, Rural & Gaeltacht Affairs. The operational and managerial role of the NDST has increased in recent times due to the increase in the number of Drugs Task Forces and the increase in the number of projects at Drugs Task Force level. As outlined in para 6.6 above, the NDST has also had a policy role, which was informed by the work of the Drugs Task Forces.

- 6.26** The core role of the DSU is to co - ordinate the work of agencies, to provide resources to channels of funding, Drugs Task Forces and others, and to manage the development of policy. However, its focus has predominantly been on co - ordination and managing funding, with its policy role being under - developed.
- 6.27** Overall, this has led to some confusion for Drugs Task Forces and a perception has emerged of a double layer of administration, and a lack of clarity around the role and responsibilities of the NDST vis - à - vis that of the DSU.
- 6.28** There is also a perception in the Drugs Task Forces and the NDST that more incremental funding processes have been put in place since the last area - based plans were developed (in 2002 for LDTFs and 2005 for RDTFs). This arises from funding having been made available to address more nationally identified needs, such as cocaine and rehabilitation. While these funding streams were welcomed, concerns have been expressed that they were not based on the principle of priorities being directed only from a local level, involving the development of projects exclusively identified by, and specific to, local needs. The latter process was also seen to foster local ownership of both strategic plans and action - based responses.
- 6.29** While there has been a focus on planning from the local level upwards, it is recognised that there is also a need for a national perspective in regard to the development of policy and services. Furthermore, the national perspective sits within an EU, and a wider international, perspective on the overall global drugs problem.
- 6.30** The Steering Group notes that both cocaine and rehabilitation were identified as national concerns after extensive consultation. The former came into clear focus as a result of a joint NACD and NDST Report on cocaine¹⁰², which was based on data from the HSE, the HRB, the Gardaí, Revenue's Customs Service and international evidence. The latter was highlighted during the 2005 MTR of the NDS, which identified the under - developed response to rehabilitation as a key gap in the Strategy. These examples illustrate the advantages of "marrying" the national and local perspectives, and, indeed, the international perspectives in developing policy.

- 6.31** In the future, the Steering Group considers that the combination of local, national and international perspectives should be utilised, as appropriate, in the planning and development of initiatives and in the allocation of resources. For example, in the area of treatment and rehabilitation where a 4 - tier model is to be utilised, the development of tier 3 and tier 4 initiatives should normally be best taken from a national perspective but informed by local input and international trends. Similarly, addressing the needs of specific groups (new communities, homeless people and others (as outlined in chapter 4) would usually involve an integrated national approach.

Mainstreaming

- 6.32** A key achievement under the NDS has been the development of a range of established services in LDTF areas and of newer services in RDTF areas. The original principle was to mainstream projects after evaluation to the appropriate Department/agency and this occurred in respect of the first tranche of projects in 2001.
- 6.33** Mainstreaming of a second tranche of projects is currently being progressed following the evaluation carried out in 2007/08. It is noted that difficulties have arisen in completing the transition to mainstreaming, which include establishing "best fit", and concerns about the lack of clarity regarding roles, responsibilities and funding for mainstreamed projects.
- 6.34** The large number of interim projects that are currently operating under the Task Force structure can also have the effect of diverting Task Forces from their broader strategic and co - ordinating role in relation to drugs issues in their areas of operation.
- 6.35** The Steering Group considers it to be important to ensure that appropriate agreed clinical and organisational governance is put in place from the outset with respect to the further development of treatment and rehabilitation services. Also, future prevention should generally be integrated within the broader framework of prevention initiatives applying at a particular time.
- 6.36** Drugs Task Forces, while generally performing well, are of the view that they face a number of difficulties in optimising their input. The areas of difficulty include:
- continuing to improve data for needs analysis to provide a better evidence base;

¹⁰² An Overview of Cocaine Use in Ireland II: National Advisory Committee on Drugs & National Drugs Strategy Team, 2007.

- inconsistency of responses by Departments and statutory agencies;
- achieving greater engagement by local elected representatives in some areas; and
- Drugs Task Force boundary issues (e.g. the mix of DTFs, Local and Regional in Dublin; and the geographical area covered by some RDTFs).

Capacity to deliver services to meet client needs

6.37 A wide range of statutory, voluntary sector and community sector organisations are involved in delivering the NDS at national, regional and local level, with the statutory agencies critical in terms of core service provision. While the structures are designed to promote inter - agency working, and have been largely successful, this continues to be a key challenge for the NDS. Primary agencies responsible for mainstream pillar services have developed their individual capacity to deliver services using the partnership approach with evident progress (as outlined in chapters 2–5). However, there is still room for improvement. For example, in regard to treatment and rehabilitation, a key aim is to provide a seamless continuum of care based on the needs of an individual. In this regard, the Steering Group notes that it is important that the NDS continues to progress from a service - led model to a client centred model of care (incorporating the needs of families and communities) over the lifetime of the new Strategy.

Monitoring and evaluation

- 6.38** Evidence shows that monitoring and performance frameworks can be an important lever in stimulating implementation of policies by putting a sharper focus on performance. While the collection of data has advanced considerably in recent years, thus providing many of the core elements for such frameworks, this work is not sufficiently co - ordinated and timely to facilitate the effective assessment and monitoring of progress. A performance management framework could also be an important lever in influencing progress. Given the range of agencies involved in implementing the NDS, the Steering Group believes that a developed performance management framework would be an important tool to aid the focus on implementation.
- 6.39** In this context, the Group also notes that under the EU Action Plan on Drugs 2009–2012, one of the five priority areas

identified is “Information, Research and Evaluation”. Within this priority, the need to further develop instruments to monitor the effectiveness of responses to problem drug use has been identified as an objective that Member States must progress. The need to ensure the ongoing evaluation of national drugs policies using improved indicators and reporting mechanisms is also highlighted.

6.40 The Steering Group notes that the majority of evaluations carried out to date have tended to be around processes and outputs achieved by individual elements and projects of the NDS, rather than assessments of overall outcomes being achieved in tackling the drug problem. While the former will continue to be an important part of the evaluation approach into the future, the Steering Group believes that there is a need to evaluate services in a more comprehensive way that assesses not only services being developed and provided under the NDS framework, but also closely related services provided in the broader social inclusion context.

6.41 Overall, therefore, the Steering Group believes that the significant progress to date needs to be built upon by strengthening the capacity of the current co - ordination structures to effectively support the delivery of the new NDS.

CONCLUSIONS AND PRIORITIES FOR THE NEW NDS

6.42 As outlined earlier in the chapter, an important achievement of the current NDS co - ordination structures is that they have stimulated and promoted inter - agency working in a difficult cross - cutting policy and service area. While recognising the importance of maintaining and building on this under the new NDS, the Steering Group also found that there are capacity and structural limitations that are affecting their ability to support the implementation of the NDS.

6.43 As a result, the Group believes that a new structure will need to:

- continue to address the existing and emerging needs of problem substance users, their families and their communities through measurable outputs and outcomes;
- facilitate the Minister of State who is given responsibility by Government for the NDS to effectively fulfill that role;

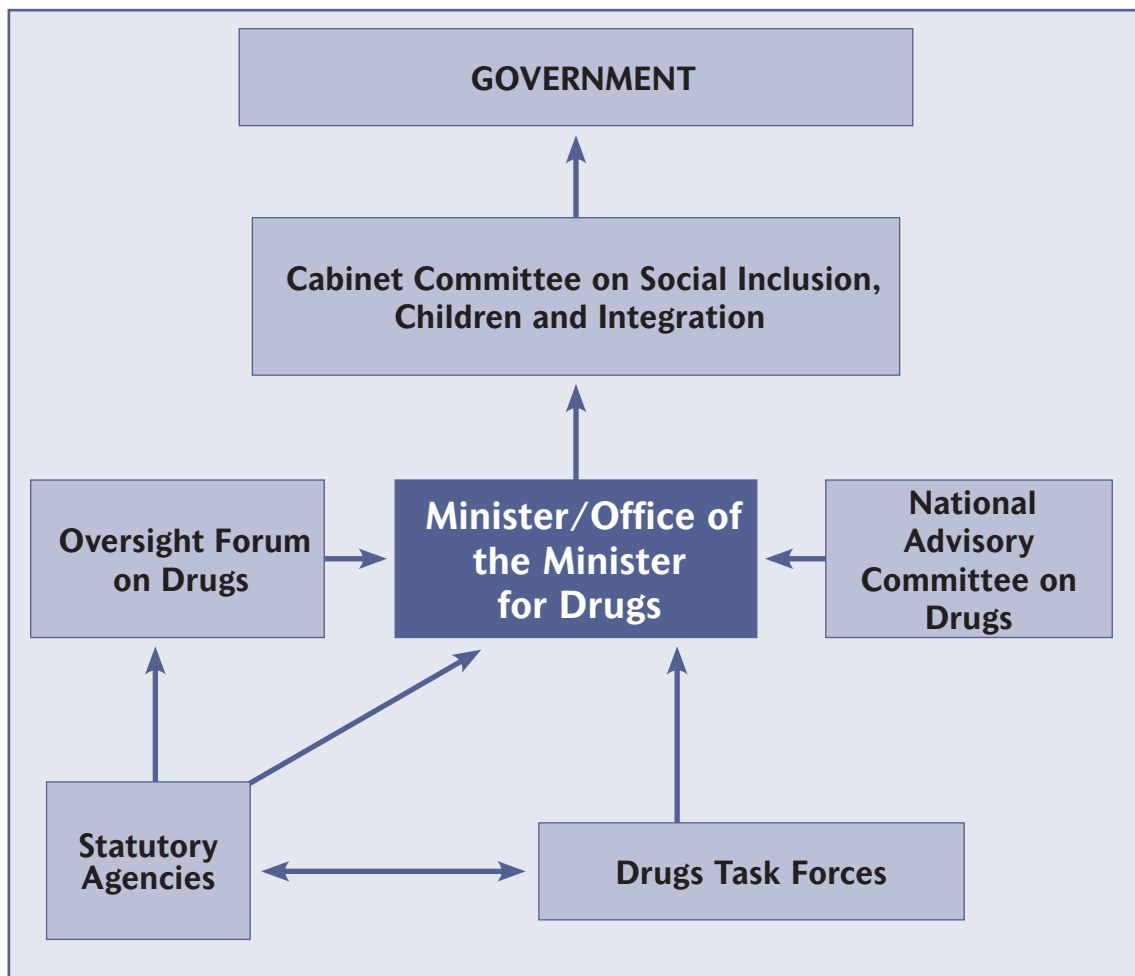
- provide the necessary assurances to the Secretary General of the Department of Community, Rural & Gaeltacht Affairs, and his counterparts in other Departments, in regard to their roles as Accounting Officers;
- streamline administration;
- reflect problem substance use as a global issue that must be tackled on a world - wide, EU, national and regional/local basis;
- facilitate co - ordination across statutory, community and voluntary sectors;
- build upon the partnership process that is already in place; and
- marry the bottom - up approach to a top - down perspective to achieve and deliver a comprehensive and effective response to problem substance use.

6.44 Accordingly, the Steering Group recommends¹⁰³ that an **Office of the Minister for Drugs** (OMD) be established to facilitate greater coherence in policy - making and service delivery.

6.45 The new OMD will incorporate the work and functions which, under the structures of the current NDS was carried out by the DSU and the NDST and it will also impact on the role of the IDG. Critically, it will support and drive the ongoing implementation of the NDS, while respecting the various lead roles and statutory responsibilities of the Departments/agencies involved. Overall, the Steering Group believes that the OMD, by building on the significant achievements to date, will provide a more cohesive and integrated framework that promotes closer co - operation and accountability between the different players, as well as greater transparency for expenditure.

6.46 The new Office, and the simplification of the overall structural framework, will also provide a clear hierarchy and a greater transparency of the roles from the Government and Cabinet Committee on Social Inclusion, Children & Integration to the local project level – see Table 6.4 below.

Table 6.4 - National Drugs Strategy 2009 - 2016 Organisational Structure



*[Note: the work of the National Drugs Rehabilitation Implementation Committee will also be closely linked to the OMD]

103 Community sector representatives do not endorse this recommendation.

6.47 The new Office will continue to reflect the following principles:

- Local responses to local need, based on local planning and decision making;
- Community representation and involvement;
- Partnership between community, voluntary and statutory sectors;
- Direct linkages between local and national structures; and
- Direct linkages between local and national policy.

KEY FEATURES OF THE NEW OFFICE

(i) Roles & responsibilities

6.48 The Steering Group recommends that the OMD should have the following key roles and responsibilities:

(a) National co - ordination

- to advise and support the Minister of State in the OMD;
- to co - ordinate the overall implementation of the NDS at local, regional and national levels;
- to ensure effective co - ordination between Departments and agencies;
- to provide an over - arching cross - sectoral framework to address policy development and operational issues in relation to the Strategy, while respecting the various lead roles and statutory responsibilities of Departments/agencies involved; and
- to ensure the timely and effective input of relevant Departments and agencies into operational and policy developments, as appropriate.

(b) Policy Development

- to identify and progress policy issues that impact on the implementation of the NDS, in the context of the drugs problem being a major national challenge, using a partnership approach;
- to ensure that policy is informed by the work of the Local and Regional Drugs Task Forces, the NACD and the NDRIC;
- to take on board key reports and plans identified by partner agencies;
- to advise the Cabinet Committee on Social Inclusion, Children & Integration on critical

matters of a public policy nature relating to the NDS; and

- to identify appropriate matters for consideration by the Minister of State for submission to Government for decision or information, as appropriate.

(c) Supporting the work of Drugs Task Forces

- to oversee the work of the Local and Regional Drugs Task Forces;
- to act in a liaison role with the Drugs Task Forces and to assist their ongoing work by:
 - drawing up guidelines for the development of local/regional action plans;
 - evaluating local/regional plans and making recommendations regarding funding of the plans;
 - monitoring developments at local/regional level to ensure that problems and priorities of communities are addressed at national level;
 - contributing to the development of government policy on drugs; and
 - developing the capacity of Drugs Task Force projects.
- to ensure effective co - ordination between statutory representatives and the community & voluntary sectors in the OMD in delivering on the objectives of the Task Forces;
- to be accountable for the expenditure and activities of the projects funded by the Department of Community, Rural and Gaeltacht Affairs through the Drugs Task Force network; and
- to promote and support the process of mainstreaming projects to Departments and agencies.

(d) Supporting the work of the NACD

- to support the work of the NACD in the on - going implementation of its agreed work programme;
- to be accountable for expenditure arising from that work; and
- to widely disseminate information on drugs issues and on best practice models.

(e) **Supporting the community and voluntary Sector**

- To facilitate and support the engagement of the community & voluntary sectors in their roles in the NDS.

(f) **International Links**

- To co - ordinate Ireland's input to the EU, the UN and other international fora regarding drugs issues.

(ii) **Staffing**

6.49 The new Office will be headed by a Director and staffed by the Department of Community, Rural and Gaeltacht Affairs. The allocation of staff to different areas of work will reflect the ongoing role, responsibilities and priorities of the new Office that will be developed as part of its work programme. The Steering Group recommends that the Director's post should be filled by open competition.

6.50 The Steering Group acknowledges the concerns of some members and of the Drugs Task Forces regarding the loss of knowledge and experience associated with the closure of the NDST. However, it is also noted that detailed transitional arrangements to facilitate the smooth transfer of functions to the new Office have been drawn up by the Department of Community, Rural and Gaeltacht Affairs and will be rolled out. These cover a broad range of issues covering financial matters, role of the interim Advisory Group, liaison with the Drugs Task Forces, role of the statutory and community & voluntary representatives, progression of "live" issues in the NDST workplan, as well as day - to - day administrative issues.

(iii) **Cross - Departmental/Agency and Community & Voluntary input**

6.51 Involvement of the statutory sector in co - ordination structures has been a key feature of the current NDS and reflects their critical role in delivering services. To retain and deepen the cross - Departmental input, the Steering Group recommends that, as currently operates, an officer at AP level (or equivalent) should be assigned to the OMD on a half - time basis, for a minimum of 3 years at the outset (subject to the exigencies of the Public Service), from:

- An Garda Síochána;
- Department of Justice, Equality & Law Reform;
- Department of Health & Children;

- HSE;
- Department of Education & Science;
- FÁS;
- Department of Environment, Heritage & Local Government; and
- Department of the Taoiseach.

It is noted that all of these organisations were represented on the NDST.

6.52 In addition, the Steering Group recommends that the following organisations should be represented in the new Office on a similar basis:

- Customs Service of the Office of the Revenue Commissioners;
- Department of Social & Family Affairs, through the Family Support Agency;
- Irish Prison Service; and
- The Probation Service.

6.53 As part of their role within the OMD, the statutory sector representatives will have responsibility for driving the implementation of the new Strategy, primarily at local and regional levels. They will work with the Director and staff of the OMD and protocols to reflect their on - going roles will be drawn up. In addition, they will continue to work within their parent Departments and agencies to seek to positively influence policy, programme activity and resource allocation in regard to drugs issues.

6.54 At a more national level - particularly in terms of influencing policy and budgets - the Steering Group recognises that the representatives will need to be strongly supported by their more senior Department/agency personnel who will be represented on the Oversight Forum on Drugs (see paragraphs 6.65 - 6.70). The Steering Group considers that the OFD will have an important influencing role with regard to the ongoing implementation of the NDS.

6.55 The community and voluntary sectors have played a key role in the current NDS. The Group believes that it is vital that the input, expertise and participation of these sectors be maintained under the new co - ordination arrangements. Accordingly, it is recommended that funding at current levels be provided by the OMD to support the active participation of the two sectors in the work of the Office for an initial period of three years. Protocols will be developed in this regard. The Steering

Group notes that support along broadly similar lines is provided to community & voluntary pillar organisations by the Department of Community, Rural and Gaeltacht Affairs to support their participation in the *Towards 2016* process.

6.56 To secure collective commitment for the implementation of the NDS, the Steering Group recommends that an Advisory Group of the OMD, comprising representatives of the statutory (including D/CRGA) and community & voluntary sectors – as set out above - should be established. The function of the Group will be to advise the Minister on operational and policy matters relating to the NDS. In this way it is intended that progress in advancing the Strategy will be supported, and issues and/or blockages arising will be identified and addressed. Upon appointment, the Director will chair the Group. In the interim period, the Minister of State will chair the Group which will meet regularly. As happens at present, the Minister of State will ultimately be the final decision maker.

6.57 The Steering Group recommends that the OMD should consider how best to promote service user involvement in the new NDS. They further recommend that protocols be developed in an appropriate and timely manner to support such engagement.

(iv) **OMD Budget**

6.58 While recognising the importance of the independence of the new Office, the Steering Group recommends that the budget, including the allocations to support the work of the Drugs Task Forces, should remain, for the time being at least, within the Vote of the Department of Community, Rural & Gaeltacht Affairs, where it would have a separate subhead.

(v) **Other key features**

6.59 In order to strengthen and consolidate the role of the new Office - particularly in the areas of governance and accountability - the Steering Group recommends that:

- an overall performance management framework should be developed by the OMD, in consultation with relevant Departments and agencies to assess and monitor progress across the NDS;
- a mechanism should be put in place whereby relevant Departments and agencies outline their proposed budgets for drug - related initiatives to the Minister of State, in the context of the annual Estimates process.

This should be done with a view to ensuring that there is appropriate and adequate focus on addressing the key priorities in regard to problem substance use - as outlined in this Strategy - across relevant Departments and agencies.

- Departments and agencies should report to the OMD on their expenditure, outputs and outcomes twice a year, in an agreed format;
- Departments and agencies should incorporate their envisaged contribution to the work of the NDS in their Statements of Strategy and Business Plans and should report on the associated outputs and outcomes in their Annual Reports;
- Drugs Task Forces should report to the OMD for expenditure and activity relating to their projects twice a year. In addition, they should produce an annual statement, in an agreed format, giving an assessment of the work and outputs of their projects – and their broader strategic and co - ordinating work - in the previous 12 months;
- The OMD should establish on - going liaison with Drugs Task Force projects in regard to their overall work and activities, as well as their channels of funding; and
- The OMD should produce (i) an annual report of progress of the services and structures under its direct influence and (ii) a report of the progress of the overall Strategy every two years.

6.60 In addition, in order to keep a focus on drug - related issues and the broader implementation of the NDS, the Group recommends that twice a year:

- The Minister of State with responsibility for the OMD should meet bilaterally with the Ministers for Justice, Equality & Law Reform, Education & Science, and Health & Children;
- The Minister of State and the OMD Director should also meet with:
 - the Garda Commissioner;
 - the Secretary Generals of the Departments of (i) Justice, Equality & Law Reform, (ii) Health & Children, (iii) Education & Science,
 - the Chairman of the Revenue Commissioners;
 - the relevant senior official in the HSE;
 - the Director General of the Irish Prison Service, the Director General of FÁS, the Directors of the Probation Service and the OMCYA.

- Given the on - going key role of the Drugs Task Forces under the new Strategy, it is also recommended that the Minister of State and the OMD Director should meet with the chairs and co - ordinators of the Local & Regional Drugs Task Forces at least twice a year;

- Given the key role that rehabilitation will play in the new Strategy, the OMD will have close and formal links with the work of the Senior Rehabilitation Co - ordinator (SRC), and will be represented on the National Drug Rehabilitation Implementation Committee (NDRIC). Accordingly, two meetings a year should take place between the Minister of State, the OMD Director and the SRC.

- The Minister of State and the OMD Director should also meet twice a year with:

- the Chairperson and Director of the NACD; and
- representatives of the Family Support Network.

6.61 Members of the OMD Advisory Group (as outlined above) could also be invited to attend these meetings, as appropriate.

6.62 In addition, the Steering Group recommends that:

- Drugs should be an agenda item on the Cabinet Committee for Social Inclusion, Children & Integration at least twice a year – following on from the meetings between the Minister of State and the relevant Ministers;

- The OMD and the Minister should report directly to the Cabinet Committee on Social Inclusion, Children & Integration as appropriate, and to Government through the Minister for Community, Rural & Gaeltacht Affairs;

- The OMD Director should have the right to attend MAC meetings in the Departments of Justice, Equality & Law Reform, Health & Children and Education & Science, when agenda items in relation to drugs issues are being discussed; and

- The Director of the OMD should be a member of the Senior Officials Group on Social Inclusion, Children & Integration.

6.63 The Steering Group believes that liaison and interface with the OMCYA is key with regard to the development of services for young people involved or at risk of becoming involved in substance abuse. This is with a view to ensuring that the OMCYA continues to address these young people as a priority.

6.64 Furthermore, it is felt that the OMD should address the needs of specific at risk communities and groups (as identified in chapter 4), working with their representative fora and/or other services addressing their needs and with local/regional input, as appropriate.

ROLE OF THE IDG IN THE NEW OFFICE

6.65 The Inter - Departmental Group on Drugs (IDG) has played an important role in the formal NDS co - ordination structures in securing effective inter - agency working. It is currently chaired by the Minister of State and the Department of Community, Rural & Gaeltacht Affairs provides the secretariat. While representation on the Group was pitched at Assistant Secretary level, by and large this did not happen. While the Steering Group notes that this is a capacity issue common to many co - ordinating structures, it may have undermined the effectiveness of the Group in some NDS areas.

6.66 One of its main roles is to resolve emerging operational difficulties in implementing the NDS. Its role and composition were strengthened arising from the MTR and, in this context, the Steering Group believes that it has become more valuable in terms of monitoring progress of mainline services.

6.67 Overall, it is considered that there is merit in retaining a group that has an oversight role in monitoring the implementation and roll - out of the Strategy. Equally, a group that has the power to influence and free up blockages in the system is also considered very important to the effective functioning of the new Office. Accordingly, it is recommended that the IDG be re - constituted as the Oversight Forum on Drugs (OFD). The new Forum should meet quarterly and its primary role should be the high - level monitoring of progress being achieved across the Strategy and to agree on the appropriate way forward where issues are blocked or progress is being impeded. It is recommended that the OFD should also provide a forum for discussion and feedback on issues relating to problem drug use that arise in EU and international arenas (see paragraphs 6.92 - 6.100).

6.68 The Minister of State will continue to chair the OFD and the OMD will provide the secretariat. The aim of having representation on the OFD at Assistant Secretary, or equivalent, level will continue, particularly with a view to maximising the influencing role of the group. Again, the community

and voluntary sectors will each be given the opportunity to nominate a representative to the OFD. The chairperson of the NACD should also be a member of the Forum.

6.69 Accordingly, the Steering Group recommends that the OFD should have the following terms of reference:

- To examine the progress of the NDS 2009 - 2016 across the five pillars of supply reduction, prevention, treatment, rehabilitation and research in the context of the aims, priorities, actions and key performance indicators set out therein;
- To address operational difficulties and blockages in implementing the NDS and agree on appropriate ways forward to overcome these difficulties;
- To monitor progress on associated mainline services with a view to influencing outcomes;
- To provide any reports on existing actions and details/rationale of future plans sought by the Minister of State, as chairperson of the Forum;
- To consider developments in drugs policies, and in dealing with problem drug use generally, at EU and international level; and
- To discuss and agree, as far as possible, on the approach to drugs issues at the Cabinet Committee on Social Inclusion, Children and Integration.

6.70 The Steering Group also recommends that the terms of reference for the OFD should be reviewed in the context of the development of a National Substance Misuse Policy.

ROLE OF THE NACD IN THE NEW OFFICE

6.71 As outlined in Chapter 5, the NACD is the research arm of the NDS and representatives of all the relevant Departments, agencies and sectors relating to problem drug use sit on the Committee. Its main function is to advise the Government in relation to the prevalence, prevention, treatment and consequences of problem drug use in Ireland. The Steering Group notes that since early February 2009, the NACD Director post has been filled on secondment by a Principal Officer from the Department of Community, Rural & Gaeltacht Affairs. The Group recommends, however, that the post should be filled through open competition, as soon as possible.

6.72 While the NACD does not play a direct role in co-ordinating the implementation of the NDS, it is a critical element of the overall drugs policy in Ireland and research will continue to be a pillar in the new NDS.

6.73 In these circumstances, the Steering Group recommends that Director of the NACD should be a member of the senior management team of the new OMD and should, ultimately, report to the Director of the OMD. Independence in regard to the research work of the NACD will be fully maintained.

6.74 While again recognising and stressing this independence of the NACD, it is also recommended that the Director and staff of the NACD should be located in the same building as the new OMD. Having the NACD as part of the new Office should also help to better address the issue of linkages between policy development and research.

6.75 The Steering Group notes that the decision to have a National Substance Misuse Strategy may have implications for the membership and work programme of the NACD. This is an issue that will need to be considered by the new Steering Group tasked with developing that Strategy. In the meantime, the Group recommends that the NACD should continue to progress the work programme recommended in this Report.

THE OMD AND THE DRUGS TASK FORCES

6.76 The Steering Group recognises the key role that the Local and Regional Drugs Task Forces have played in addressing the drug problem in Ireland in recent years. The Group believes that the Drugs Task Forces will continue to play a strong role in the coming years in addressing the drug problem in Ireland and they should continue to have a focus on:

- monitoring the implementation of projects and evaluation with a view to mainstreaming;
- preparing updated action plans;
- identifying emerging strategic issues and developing proposals on policies or actions needed to address them; and
- providing for the implementation of a local/regional drugs strategy.

6.77 As outlined above, the OMD will continue to support the work of the Drugs Task Forces and their projects through regular liaison and contact, as provided heretofore by the

NDST. In line with the over-arching role envisaged for the OMD, the Steering Group recommends that Drugs Task Forces should report to the Office for the activities, outputs and expenditure of projects under their remit – as well as for their broader strategic and co-ordinating work – on an on-going basis, in an agreed manner. Conditions of the funding of projects should be such as to ensure co-operation from projects in this regard.

6.78 The Drugs Task Force Co-ordinator will have a key role to play in this regard and will be the principal point of contact with the OMD.

6.79 The Steering Group also notes that approximately 600 projects are currently in place through the Drugs Task Forces. The project approach was designed to deliver speedy and relevant services to Drugs Task Force communities in response to needs at a point in time. At this stage, the multiplicity of projects has added a layer of reporting complexity that needs to be further addressed. The Group recommends that the reporting and accountability arrangements for projects be considered by the OMD as a matter of priority, with a view to simplification of the reporting arrangements.

6.80 As outlined earlier in this chapter, difficulties exist in the arrangements that are currently in place regarding the employment and management of Task Force staff. These difficulties impact on governance and on the overall effectiveness of the Task Forces. In this context, the Steering Group considered a number of options, including:

- setting up of Drugs Task Forces as limited companies to employ all members of staff;
- development of a single agency - under the direction of the OMD – to act as the employer for the staff involved;
- where co-ordinator vacancies arise, they would be employed in line with other Drugs Task Force staff i.e. employed directly by the Task Force or by a hosting agency.

6.81 Overall, the Steering Group has not reached a clear consensus on the best way forward to address the complex human resource, and other, issues involved. Accordingly, the Group recommends that the feasibility of achieving the optimum structure for the employment arrangements of the Drugs Task Force personnel be examined by the OMD once it becomes operational over the coming months. This examination should feed into the development of the new National Substance Misuse Strategy and the consideration of the

appropriate structures for its delivery. In the interim, the Steering Group recommends that current employment arrangements should remain in place.

6.82 The Steering Group is also of the view that the commitment and participation of members of Drugs Task Forces needs to be reviewed and renewed given the perceived inconsistency of responses by Departments and statutory agencies and to achieve greater engagement by local elected representatives in some areas.

6.83 The Steering Group believes that greater engagement by Departments/agencies would be achieved by:

- providing suitable inductions for local staff to effectively contribute to the work of the Drugs Task Forces;
- ensuring representatives have appropriate decision making authority;
- bringing relevant information regarding developments at local, regional and national levels within their organisations that impact on progressing actions in the NDS; and
- activating their monitoring role regarding Drugs Task Force projects.

6.84 Equally, representatives need to ensure that their parent organisations are kept informed of developments at Drugs Task Force level and how these might impact on their agencies. In order to reinforce the principles of partnership working and the sharing of good practice, the OMD reps from various statutory bodies should convene meetings of their RDTF and LDTF reps twice annually.

6.85 With respect to elected representatives, particularly in RDTF areas, the Steering Group considers that these reps should come from across the local authority spectrum i.e. city and county councils as well as local municipal authorities.

6.86 The Steering Group also notes that a handbook for the operation of LDTFs was developed in 2000 and that work on updating it for RDTFs is being progressed. The handbook outlines the roles and responsibilities of all members of the Drugs Task Force process, including their membership and operational workings. It is recommended that the handbook should be updated to take account of the new structural arrangements proposed in this Report. The Steering Group also recommends that guidelines on mainstreaming should be included in the handbook.

6.87 In addition, the Group believes that, in the interests of bringing fresh ideas and approaches to the work of Drugs Task Forces, the position of chairperson should be reviewed every 3 years.

DEDICATED TREATMENT AGENCY

6.88 Treatment and rehabilitation are two of the key pillars of the NDS and as well as the statutory sector, there are a wide range of voluntary and community organisations providing services in this area. This is reflected in the substantial funding that is being provided annually across all the sectors to support the provision of such services.

6.89 From the perspective of achieving better co-ordination and value for money across such services, the Steering Group considers that the question of the need for/desirability of a dedicated treatment agency, along the lines of the National Treatment Agency (NTA) model used in England and Wales should be explored. Under the NTA, all addiction services (excluding those related to prisons - although there is strong interaction) are funded through the NTA who are charged with overseeing and monitoring performance. In the main, services continue to be provided by the NHS, but with a significant role for community & voluntary sectors. A key strategic consideration in the setting up of the NTA was the fact that treatment of those with problem drug use was not sufficiently high on the agenda when considered from a purely health perspective, whereas it was seen as more important when viewed from a broader societal perspective. The NTA has a dedicated budget for the provision of services throughout England and Wales.

6.90 Given current financial and other constraints, the Steering Group recognises that setting up a dedicated treatment agency is not likely to be feasible at present. However, the Group recommends that this issue should be examined by the OMD within the context of the development of the National Substance Misuse Strategy. Such an examination should also have regard to other examples of international best practice, in addition to the NTA model.

6.91 The Steering Group also notes the Report of the Office of the Comptroller & Auditor General in relation to drug treatment and rehabilitation in Ireland, which was published in June 2009. This examination looked at all of the main publicly - funded treatment and rehabilitation services provided for persons

with drug problems. It is focused, in the main, on service provision in the period 2001 to 2007 and looked at the contribution to treatment and rehabilitation services by all of the agencies involved, e.g. HSE, Drugs Task Forces, the IPS, FÁS and the community & voluntary sectors.

ROLE OF THE OMD IN RELATION TO INTERNATIONAL CO - OPERATION

6.92 Drug misuse is an international problem and the Steering Group notes that it is vital that the national and international aspects of it are tackled in a co - ordinated way. In this context, the nature of the problem calls for regional, international, bilateral and multilateral approaches.

6.93 By virtue of its membership of the European Union and institutions such as the United Nations, Ireland has a number of international obligations that must be supported and serviced. Participation in international fora should be seen as an opportunity. On the one hand, we have a duty to share our experience with our international partners, while on the other, Ireland can learn from the experiences of many countries, especially those with much experience in dealing with drugs problems over many years. Properly co - ordinated international co - operation can, and will, add value to the new NDS.

6.94 International co - operation activities in which Ireland are engaged aims to:

- help the overall efforts to address the drugs problem, particularly in the EU, but also globally;
- achieve a high level of public safety by tackling international drug trafficking;
- access information on the initiatives taken in other countries with the aim of applying potentially effective ideas to our problems at home;
- share our experiences and the outcome of our efforts with others for their benefit; and
- establish contacts and relationships to the mutual benefit of different jurisdictions.

6.95 The Steering Group notes that officials from various Departments represent Ireland at a number of fora. Table 6.5 (below) sets out the key groups in this regard:

6.96 As well as the working groups mentioned above, Ireland co - operates internationally in many other ways. A good example of multilateral co - operation is the Maritime Analysis and Operations Centre - Narcotics – MAOC - N. An Garda Síochána, the Customs Service of the Revenue Commissioners, the Naval Service and the Department of Justice, Equality & Law Reform worked closely with 6 other countries on its establishment in 2007. Currently, a Garda and a Customs Liaison Officer are working at the Centre in Lisbon, sharing and receiving intelligence and other information primarily regarding cocaine being shipped into the European Union. Also, An Garda Síochána and the Customs Service have a number of Liaison Officers working in a number of European cities, as well as at Europol and Interpol.

6.97 Revenue's Customs Service also attend first Pillar Precursor related Conferences/ Workshops and various other meetings dealing with drugs topics, with representation being decided on a case by case basis (e.g. meetings dealing with controlled deliveries, or with Europol).

6.98 Ireland fulfils its role in all of these fora in an active manner. However, a lot of the activity takes place within the area of work of a given Department, with little focus on communicating information on the activities of various committees, the Irish input being made and the outcomes of the deliberations. Overall, the Steering Group believes that there is much to be gained from better co - ordination of the overall Irish effort, more sharing of Irish positions on issues and an inter - departmental input into strategies for important areas. Departments and agencies need to co - ordinate more effectively and develop national positions in a more timely manner on issues arising at the various international institutions.

6.99 In the context of a lead agency for each relevant international forum, actual participation at individual meetings should also relate to the issues being discussed, as well as to the Departmental ownership of the particular group involved.

6.100 The Steering Group recommends that the OMD should take on the lead role in this co - ordinating process. The more hands - on co - ordination role of the OMD would not affect the primary responsibility of the other Departments (and Ministers) in regard to their lead areas. Given that virtually all the

Table 6.5 - EU and Other Groups & Committees and Irish Representation

Group/Committee	Attended by:
Horizontal Working Party on Drugs (HDG – EU Group)	Department of Community, Rural & Gaeltacht Affairs Department of Justice, Equality & Law Reform Department of Foreign Affairs Department of Health & Children
Commission on Narcotic Drugs (CND - United Nations)	Department of Foreign Affairs Department of Justice, Equality & Law Reform Department of Health & Children Department of Community, Rural & Gaeltacht Affairs
European Monitoring Centre for Drugs and Drug Addiction (EMCDDA – EU Institution based in Lisbon)	Department of Health & Children (Board Meetings) EMCDDA National Focal Point: HRB (Alcohol and Drug Research Unit)
The Pompidou Group (and associated Platform Groups) (Council of Europe Co - operation Group to combat drug abuse and drug trafficking)	Department of Health & Children Health Research Board Revenue's Customs Service Drug Treatment Centre Board
EU National Drugs Coordinators Network	Department of Community, Rural & Gaeltacht Affairs
British - Irish Council Intersectoral Group on Drugs (Chaired by Ireland, this is one of 8 intersectoral groups under the East - West dimension of the Good Friday Agreement)	Department of Community, Rural & Gaeltacht Affairs Other Departments and agencies as appropriate
Civil Society Forum on Drugs (Set up in 2007 to facilitate the involvement of civil society in the implementation and development of the EU Drug Strategy and Action Plan.)	Community & Voluntary Sectors
Multidisciplinary Group (MDG) on Organised Crime (Council of Europe)	Department of Justice, Equality & Law Reform, An Garda Síochána, Revenue's Customs Service

relevant Departments will be represented in the new Office, such co - ordination should be easier to achieve and should become an on - going feature of their work. As well as this on - going interaction, the new arrangements should include:

- circulation among relevant Government Departments of draft speeches and briefings to be presented internationally (for observations);
- quarterly meetings involving key officials from the relevant Departments (or as needs arise);
- an annual meeting chaired by the Minister of State to plan our broad approach across the various issues and fora; and
- more regular up - dates at OFD level (6 monthly or a needs arising basis).

PRIORITIES

6.101 As outlined above, the following key priorities have been identified by the Steering Group:

- The establishment of an Office of the Minister for Drugs to co - ordinate, support and drive the on - going implementation of the NDS 2009 – 2016;
- The re-constitution of the Inter - Departmental Group on Drugs as the Oversight Forum on Drugs with revised terms of reference;
- The development of an overall performance management framework across all relevant Departments and agencies to facilitate the effective assessment and monitoring of progress;
- The renewal of the participation and commitment by all sectors to the Drugs Task Force process to ensure more effective and consistent engagement;
- The promotion of more active engagement by service users and services working with specific identified at risk groups in the design and planning of interventions under the NDS;
- Building on existing work, the establishment of a more co - ordinated approach to fulfilling Ireland's international role and responsibilities with respect to problem substance use.

6.102 These issues are returned to in Chapter 7 where actions in relation to the new Strategy are identified.

NATIONAL DRUGS STRATEGY 2009 – 2016

PREVENTION

Research

Supply Reduction

National Drugs Strategy
(interim) 2009 - 2016

Treatment

Rehabilitation

7. NATIONAL DRUGS STRATEGY 2009 – 2016

- 7.1 In light of the analysis, conclusions and priorities identified in chapters 1 – 6 above, the Steering Group recommends that the Government adopts the following, objectives, key performance indicators and actions across the five pillars of supply reduction, prevention, treatment, rehabilitation and research. A number of recommendations are also made in relation to the co - ordination structures, in particular, relating to the establishment of a dedicated Office of the Minister for Drugs. In total, 63 actions are recommended and these are set out below.
- 7.2 As outlined in chapter 1, this Report is an interim Strategy pending the development of a National Substance Misuse Strategy. This is due to be developed by the end of 2010 and will incorporate this Report.
- 7.3 Departments and agencies will be asked to prepare a report by the end of 2009 detailing how each of their actions will be implemented with indicative timelines.

OVERALL STRATEGIC OBJECTIVE

- 7.4 The overall strategic objective for the National Drugs Strategy 2009 – 2016 is:
- ***To continue to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research.***

OVERALL STRATEGIC AIMS

- 7.5 The following are the overall strategic aims of the Strategy:
- To create a safer society through the reduction of the supply and availability of drugs for illicit use;
 - To minimise problem drug use throughout society;
 - To provide appropriate and timely substance treatment and rehabilitation services (including harm reduction services) tailored to individual needs;
 - To ensure the availability of accurate, timely, relevant and comparable data on the extent and nature of problem substance use in Ireland; and

- To have in place an efficient and effective framework for implementing the National Drugs Strategy 2009 – 2016.

- 7.6 Across the 5 pillars, the following objectives and key performance indicators are recommended:

SUPPLY REDUCTION

Objectives

- To significantly reduce the volume of illicit drugs available in Ireland;
- To prevent the emergence of new markets and the expansion of existing markets for illicit drugs;
- To disrupt the activities of organised criminal networks involved in the illicit drugs trade in Ireland and internationally and to undermine the structures supporting such networks;
- To target the income generated through illicit drug trafficking and the wealth generated by individuals involved in the illicit drugs trade; and
- To tackle and reduce community drug problems through a co - ordinated, inter - agency approach.

Key Performance Indicators

- Increase of 25% in the number of supply detection cases by 2016, based on 2008 figures;
- Increase of 25% in the volume of drugs seized that are considered to be intended for the Irish market by 2016, based on 2008 figures; and
- Twenty Local Policing Fora established and operating by 2012.

PREVENTION

Objectives

- To develop a greater understanding of the dangers of problem drug/alcohol use among the general population;
- To promote healthier lifestyle choices among society generally; and
- To prioritise prevention interventions on those in communities who are at particular risk of problem drug/alcohol use.

Key Performance Indicators

- Decrease in the number of opiate users in the Dublin area and stabilisation of opiate users in the rest of the country by 2011¹⁰⁴;
- Stabilisation in recent, and reduction in the current, prevalence of illicit drugs in 15 - 34 year old population (Drug Prevalence Survey 2010/2011);
- Reduction in numbers engaged in poly - drug use (Drug Prevalence Survey 2010/2011);
- Reduction of the level of drug misuse reported by school students (regular survey results and ESPAD Survey 2011);
- Delaying the age of first use of illicit drugs (ESPAD Survey 2011);
- Delaying the age of first drink and reduction in binge drinking among young people (ESPAD, National Prevalence Survey, HBSC Surveys); and
- Reduction in ESL figures from 11.5% (2007) to 10% by 2012, utilising the widely recognised definition of 'early school leaver' used by Eurostat¹⁰⁵.

TREATMENT & REHABILITATION

Objectives

- To develop a national integrated treatment and rehabilitation service that provides drug free and harm reduction approaches for problem substance users; and
- To encourage problem substance users to engage with, and avail of, such services.

Key Performance Indicators

- 100% of problem drugs users accessing treatment within one month of assessment by 2012;
- 100% of problem drugs users aged under - 18 accessing treatment within one week of assessment by 2012;
- 25% increase in residential rehabilitation places by 2012, based on 2008 figures;
- 25% increase in Hepatitis C cases among drug users treated by 2012; and

104 The variation in Dublin/rest of country targets arises from the point of development of drug prevalence in the country now, the increasingly dispersed nature of more recent usage and the scale and location of treatment & rehabilitation responses developed to date.

105 The proportion of persons age 18 to 24 whose highest level of education attained is lower secondary or below, and who did not receive either formal or non - formal education in the previous four weeks.

- Put a drugs interventions programme in place by 2012, incorporating a treatment referral option, for people who come to the attention of the Gardaí and the Probation Service due to behaviour caused by substance misuse.

RESEARCH

Objectives

- To ensure the availability of data to accurately inform decisions on initiatives to counteract problem substance use; and
- To provide appropriate research to fulfil the information needs of Government in formulating policies to address problem substance use.

Key Performance Indicators

- EMCDDA indicators developed on the extent and nature of problem drug use in Ireland;
- Comprehensive and timely reporting systems in place for:
 - treatment and rehabilitation; and
 - progression of offenders with drug - related offences through the criminal justice system
- Completion of identified research programme by the NACD.

CO - ORDINATION

Objectives

- To bring greater coherence to the co - ordination of substance misuse policy in Ireland across all sectors; and
- To maintain and strengthen partnerships with communities to tackle the problems of substance misuse.

Key Performance Indicators

- The Office of the Minister for Drugs established by mid 2009; and
- Development of an overall performance management framework by end 2010.

ACTION PLAN

- 7.7 The Steering Group recommends a series of actions to be taken across the full range of Departments and agencies involved in delivering drugs policy to ensure that the aims and objectives outlined above are met. These actions are listed below and their implementation will be overseen by the Office of the Minister for Drugs, supported by the Oversight Forum on Drugs, as appropriate.

No	Area/Pillar	ACTION	Agency
1	National Substance Misuse Strategy	Establish a Steering Group in autumn 2009 to develop proposals for an overall Substance Misuse Strategy, incorporating the already agreed interim National Drugs Strategy	D/H&C and OMD (joint chairs)
SUPPLY REDUCTION			
2	Supply Reduction	Establish LPFs in all LDTF areas and other areas experiencing serious and concentrated problems of drug misuse	D/JELR D/EHLG; An Garda Síochána (all 3 sharing lead)
3	Supply Reduction	Include drugs issues in a central way in the work of JPCs to ensure that there is a concerted effort against drugs in the areas involved. The issue of drug - related intimidation from the lower level to the most serious should be raised at both the JPCs and the LPFs with a view to devising appropriate and sustainable local responses to the issue.	D/EHLG (lead); D/JELR; Local Authorities; An Garda Síochána; DTFs
4	Supply Reduction	Foster community engagement in areas most affected by the drug problem through the establishment and support of appropriate drug networks.	DTFs; OMD; C&V sectors
5	Supply Reduction	Develop a framework to provide an appropriate response to the issue of drug - related intimidation in the community.	An Garda Síochána (lead); Family Support Network; D/JELR
6	Supply Reduction	Put in place an integrated system to track the progression of offenders with drug - related offences through the criminal justice system	D/JELR (lead); An Garda Síochána; The Courts Service; Irish Prison Service
7	Supply Reduction	Develop an initiative to target adults involved in the drugs trade who are using young children (some under the legal age of culpability) to engage in illegal activities associated with the drug trade.	An Garda Síochána
8	Supply Reduction	Continue to implement increased security procedures in prisons, including the development of the drug detection dog service.	Irish Prison Service
9	Supply Reduction	In relation to drugs and driving: <ul style="list-style-type: none"> ■ implement random road side drug testing as soon as this is technically and legally possible; ■ review legislation on the issue of driving under the influence of drugs and consider appropriate enforcement options; ■ expand the forensic analysis programme of the Medical Bureau of Road Safety to deal with drug driving; ■ train Gardaí, doctors and nurses in all relevant issues around drugs/driving; and ■ introduce detailed examination of full toxicology reports of all drivers involved in fatal road traffic accidents to ascertain the level of drug use involved. 	D/Transport (lead); Road Safety Authority; An Garda Síochána; HSE; Medical Bureau of Road Safety
10	Supply Reduction	Engage in appropriate enforcement strategies to ensure compliance with the prohibition of the sale of alcohol to persons under 18 years of age. Further reforms to the licensing laws to combat the sale or supply of alcohol to persons under 18 years of age should be considered where they are justified by reference to an evidence - based approach.	An Garda Síochána D/JELR
11	Supply Reduction	Continue to monitor the resources of the Forensic Science Laboratory, to ensure that appropriate levels are in place to facilitate timely prosecution of offenders, as well as purity/potency testing on seized drugs.	D/JELR
12	Supply Reduction	Contribute to the timely prosecution of drug - related offences by the introduction of a presumptive testing regime, in appropriate circumstances.	D/JELR (lead); An Garda Síochána; FSL
13	Supply Reduction	Review the current operation and effectiveness of the Drug Court, including the exploration of other international models.	D/JELR
14	Supply Reduction	Monitor the activities of headshops, and all businesses involved in the sale of psychoactive substances, with the objective of ensuring that no illegal activity is undertaken. Ensure that steps are taken to reform legislation in this respect where it is deemed to be appropriate.	D/H&C (lead); An Garda Síochána; D/JELR; Irish Medicines Board; D/EHLG; Revenue's Custom Services
15	Supply Reduction	Keep drugs - related legislation under continuous review, with particular focus on new synthetic substances, new or changed uses of psychoactive substances, and against the background of EU and broader international experience and best practice.	D/H&C (lead); An Garda Síochána; D/JELR; Revenue's Customs Service; Irish Medicines Board; OMD; C&V sectors
16	Supply Reduction	Keep legislation under continuous review to deal with the evolving situation in regard to drug precursors, against the background of EU and broader international experience and best practice.	D/H&C (lead); Revenue's Customs Service; Irish Medicines Board; OMD; C&V sectors

No	Area/Pillar	ACTION	Agency
17	Supply Reduction	Continue to work with partners at EU and other international levels to intercept drugs, and precursors for diversion to the manufacture of drugs, being trafficked to Ireland.	An Garda Síochána; Revenue's Customs Service (joint leads); D/JELR; D/FA; OMD
18	Supply Reduction	Monitor the volume of drugs seized in the Irish jurisdiction on an annual basis as a percentage of total European seizures, based on EMCDDA figures.	An Garda Síochána (lead); Revenue's Customs Service; D/H&C; HRB
PREVENTION			
19	Prevention	Develop a framework for the future design of targeted prevention and education interventions in relation to drugs and alcohol, using a tiered or graduated approach.	OMD (lead); HSE; D/E&S; OMCYA; An Garda Síochána; DTFs and Service Providers
20	Prevention	Improve the delivery of SPHE in primary and post - primary schools through: <ul style="list-style-type: none"> ■ the implementation of the recommendations of the SPHE evaluation in post - primary schools; and ■ the development of a whole school approach to substance use education in the context of SPHE. 	D/E&S (lead); D/H&C; HSE
21	Prevention	Ensure that substance use policies are in place in all schools and are implemented. Monitor the effectiveness of the implementation of substance use policies in schools through the whole - school evaluation process and the inspectorate system and ensure that best practice is disseminated to all schools.	D/E&S
22	Prevention	Promote the putting in place of substance misuse policies and the development of a brief interventions approach, where appropriate, in: <ul style="list-style-type: none"> ■ informal education sector; ■ training centres; ■ 3rd level institutions; ■ workplaces; and ■ youth, sport and community organisations. 	OMD and all other relevant Departments/ Agencies
23	Prevention	Implement SPHE in Youthreach Centres of Education and in Youth Encounter Projects and ensure that substance misuse policies are in place in these recognised Centres for Education. Implement age appropriate substance prevention/awareness programmes in training settings, including VTOS and Community Training facilities. Introduce monitoring and follow - up procedures in relation to substance prevention activity in the above settings.	D/E&S (lead); FÁS
24	Prevention	Co - ordinate the activities and funding of youth interventions in out - of - school settings (including the non - formal youth sector) to optimise their impact through targeting risk factors, while developing protective factors for youth at risk.	OMCYA
25	Prevention	Continue to develop facilities for both the general youth population and those most at risk through: <ul style="list-style-type: none"> ■ increased access to community, sports and school facilities in out of school hours; and ■ the development of youth cafés. 	OMCYA (lead); D/E&S
26	Prevention	Implement a uniform set of drugs and alcohol education standards, using the DEWF framework being implemented by Drugs Task Forces at present.	OMCYA (lead); D/E&S; HSE
27	Prevention	Further develop a national website to provide fully integrated information and access to a National Helpline.	HSE (lead) & relevant agencies

No	Area/Pillar	ACTION	Agency
28	Prevention	<p>Develop a sustained range of awareness campaigns that:</p> <ul style="list-style-type: none"> ■ ensure that local and regional campaigns complement and add value to national campaigns; ■ optimise the use of ICT in drugs and alcohol awareness initiatives (e.g. through internet search engines and social network websites); ■ consider a co - ordinated approach by all key players to the development and implementation of a designated drug/alcohol awareness week/day with agreed themes and methodologies; ■ target: <ul style="list-style-type: none"> □ 3rd level educational institutions, workplaces and recreational venues; □ at risk groups (Travellers, new communities, LGBTs, homeless people, prisoners and, sex workers); and □ education/awareness among drug users to minimise the levels of usage and to promote harm reduction measures 	HSE (lead); DTFs and other relevant agencies
29	Prevention	<p>Develop a series of prevention measures that focus on the family under the following programme headings:</p> <ul style="list-style-type: none"> ■ supports for families experiencing difficulties due to drug/alcohol use; ■ parenting skills; and ■ targeted measures focusing on the children of problem drug and/or alcohol users aimed at breaking the cycle and safeguarding the next generation 	HSE and D/E&S (joint leads); OMCYA; D/SFA; DTFs and Service Providers
30	Prevention	Develop selective prevention measures aimed at reducing underage and binge drinking.	HSE (lead); D/H&C; DTFs and Service Providers
31	Prevention	<p>Maintain the focus of existing programmes targeting ESL and the retention of students in schools.</p> <p>Improve the measurement of the outcomes of such programmes in order to target and expand them in areas of greatest need.</p>	D/E&S
TREATMENT & REHABILITATION - Development of General Problem Substance Use Services			
32	Treatment & Rehabilitation	<p>Develop a comprehensive integrated national treatment and rehabilitation service for all substance users using a 4 - tier model approach. This will incorporate:</p> <ul style="list-style-type: none"> ■ the ongoing development of the spread and range of treatment services; ■ the recommendations of the Report of the Working Group on Drugs Rehabilitation; ■ the recommendations of the Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Abuse); and ■ the provision of access to substance misuse treatment within one month of assessment. 	HSE ¹⁰⁶ (lead); Depts and Agencies; C&V sectors
33	Treatment & Rehabilitation	Maximise operational synergies between Drug Addiction Services, Alcohol Treatment & Rehabilitation Services, General and Emergency Hospital Services and Mental Health Services. Within this context, there should be a focus on addressing the needs of dual diagnosis clients.	HSE (lead); Voluntary sector
34	Treatment & Rehabilitation	<p>Expand the availability of, and access to:</p> <ul style="list-style-type: none"> ■ detox facilities; ■ methadone services; ■ under - 18 services; and ■ needle exchange services where required. 	HSE (lead); C&V sectors.
35	Treatment & Rehabilitation	<p>Review the Methadone Treatment Protocol to maximise the provision of treatment, to facilitate appropriate progression pathways (including exit from methadone treatment where appropriate) and to encourage engagement with services. The review will include engagement with the community and voluntary sectors.</p> <p>Examine and implement as appropriate, alternative substitute opiate treatment services.</p>	HSE (lead); D/H&C D/H&C

¹⁰⁶ The National Drug Rehabilitation Implementation Committee (NDRIC), chaired by the HSE, has a key role to play in the delivery of the recommendations of the two reports referred to in action 32.

No	Area/Pillar	ACTION	Agency
36	Treatment & Rehabilitation	Continue to develop and implement across health services the screening/assessment of people presenting with early indicators of drug and alcohol issues, utilising a uniform brief intervention tool, and including referral where appropriate.	HSE (Lead); C&V sectors
37	Treatment & Rehabilitation	Develop and implement a mechanism for early identification, and onward referral where appropriate, of substance misuse among under 18 service users in the wider statutory, community and voluntary sectors.	OMCYA (lead); D/JELR Services (An Garda Síochána; IPS; The Probation Service) D/E&S Services (D/E&S, Schools and 3 rd Level Institutions) C&V sectors
38	Treatment & Rehabilitation	Develop a drugs interventions programme, incorporating a treatment referral option, for people (primarily youth and young adults) who come to the attention of the Gardaí and the Probation Service, due to behaviour caused by substance misuse.	An Garda Síochána (lead); D/JELR (IYJS); HSE; Probation Service; OMCYA; C&V Youth Services; OMD
39	Treatment & Rehabilitation	Maintain and develop treatment services dealing with Blood Borne Viruses (BBVs), with particular emphasis on Hepatitis C treatment services.	HSE
40	Treatment & Rehabilitation	Develop a response to drug - related deaths through: <ul style="list-style-type: none"> ■ A National Overdose Prevention Strategy; ■ A co - ordinated health response to the rise in deaths indirectly related to substance abuse; and ■ A review of the regulatory framework in relation to prescribed drugs. 	HSE (lead); D/H&C D/H&C(lead); Irish Medicines Board
41	Treatment & Rehabilitation	Support families trying to cope with substance - related problems, in line with the recommendations of the Report of the Working Group on Drugs Rehabilitation.	HSE (lead); FSA; Depts and Agencies; FSN; DTFs; C&V sectors.
42	Treatment & Rehabilitation	Continue to develop and expand: <ul style="list-style-type: none"> (i) Service User Fora; and (ii) Drug User Fora in line with the recommendations of the Report of the Working Group on Drugs Rehabilitation.	(i) HSE (lead); (ii)OMD; DTFs; C&V sectors.
TREATMENT & REHABILITATION - Specific Groups			
43	Treatment & Rehabilitation	Continue the expansion of treatment, rehabilitation and other health and social services in prisons. Develop an agreed protocol for the seamless provision of treatment services as a person moves between prison (including prisoners on remand) and the community.	IPS (lead); The Probation Service; HSE; C&V sectors.
44	Treatment & Rehabilitation	Address the treatment and rehabilitation needs of: <ul style="list-style-type: none"> ■ Travellers; ■ New Communities; ■ LGBTs; ■ Homeless; and ■ Sex Workers This should be facilitated by engagement with representatives of those communities and/or services working with those groups as appropriate.	HSE (lead); C&V sectors.
TREATMENT & REHABILITATION - Quality and Standards Framework			
45	Treatment & Rehabilitation	Develop a clinical and organisational governance framework for all treatment and rehabilitation services, in line with the Report of the Working Group Examining Quality & Standards for Addiction Services, and subject to a timeframe for compliance given the resource implications involved.	HSE (lead); Voluntary sector
46	Treatment & Rehabilitation	Develop a regulatory framework on a statutory basis for the provision of counselling within substance misuse services.	D/H&C (lead); HSE

No	Area/Pillar	ACTION	Agency
56	Research/ Information	Develop a research management framework in regard to problem substance use in Ireland. Disseminate research findings and models of best practice.	NACD (Lead); HRB; OMD
CO - ORDINATION			
57	Co - ordination	Establish an Office of the Minister for Drugs with the roles and responsibilities outlined in chapter 6.	D/CRGA
58	Co - ordination	Establish the Oversight Forum on Drugs (OFD) with the terms of reference set out in chapter 6.	D/CRGA
59	Co - ordination	Develop an overall performance management framework for the NDS across all Departments and Agencies to assess and monitor progress.	OMD
60	Co - ordination	Continue to develop engagement with specifically identified at risk groups, including: <ul style="list-style-type: none"> ■ Travellers; ■ New Communities; ■ LGBTs; ■ Homeless; and ■ Sex Workers at the appropriate national/regional/local level in the design and planning of interventions under the NDS.	OMD (lead); other relevant Departments and Agencies
61	Co - ordination	Develop protocols between relevant Departments and agencies to ensure that a more co - ordinated approach is put in place to support Ireland's international role and responsibilities in relation to problem drug use.	OMD (lead); Other relevant Departments and Agencies
62	Co - ordination	Review and renew the participation and commitment of members of the Drugs Task Forces. Revise the Drugs Task Force Handbook to take account of the new structural arrangements. Review Drugs Task Force boundaries. Examine the optimum structure for the employment arrangements of Drugs Task Force personnel.	OMD (lead); other relevant Departments and Agencies
63	Co - ordination	Consider the need for/desirability of a dedicated treatment agency, looking at UK and international best practice models.	OMD (lead); other relevant Departments and Agencies

APPENDICES



PREVENTION

Research

Supply Reduction

National Drugs Strategy
(interim) 2009 - 2016

Treatment

Rehabilitation

GLOSSARY OF TERMS	
Addiction Training Unit	ATU
Alcohol and Drug Research Unit	ADRU
Assistant Principal	AP
Blood Borne Virus	BBV
Central Statistics Office	CSO
Central Treatment List	CTL
Cognitive Behavioural Coping Skills	CBCS
Community & Voluntary (Sectors)	C&V
Community Childcare Subvention Scheme	CCSS
Community Employment	CE
Community Policing Fora	CPF
Criminal Assets Bureau	CAB
Delivering Equality of Opportunity In Schools	DEIS
Department of Community, Rural & Gaeltacht Affairs	D/CRGA
Department of Education & Science	D/E&S
Department of Environment, Heritage & Local Government	D/EHLG
Department of Health & Children	D/H&C
Department of Justice, Equality & Law Reform	D/JELR
Department of Social & Family Affairs	D/SFA
Department of Transport	D/TRANSPORT
Drug and Alcohol National Occupational Standards	DANOS
Drug Education Workers Forum	DEWF
Drugs Strategy Unit	DSU
Drugs Task Force	DTF
Early School Leaving	ESL
Economic and Social Research Institute	ESRI
Educational Welfare Officer	EWO
European Monitoring Centre for Drugs & Drug Addiction	EMCDDA
European School Survey Project on Alcohol and other Drugs	ESPAD
European Union	EU
Foras Áiseanna Saothair	FÁS
Forensic Science Laboratory	FSL
General Medical Services (Scheme)	GMS
General Practitioner	GP
Health Behaviour in School - Aged Children survey	HBSC
Health Protection Surveillance Centre	HPSC
Health Research Board	HRB
Health Service Executive	HSE
Home School Community Liaison Scheme	HSCL
Hospital In - Patient Enquiry	HIPE
Human Immunodeficiency Virus	HIV
Information and Communications Technology	ICT
Intravenous Drug User	IDU
Inter - Departmental Group on Drugs	IDG
Irish Association of Alcohol and Addiction Counsellors	IAAAC
Irish Association of Counselling and Psychotherapy	IACP
Irish Business and Employers Confederation	IBEC

GLOSSARY OF TERMS	
Irish College of General Practitioners	ICGP
Irish Council for Psychotherapy	ICP
Irish Pharmacy Union	IPU
Irish Prison Service	IPS
Irish Youth Justice Service	IYJS
Joint Policing Committees	JPC
Key Performance Indicator	KPI
Lesbian, Gay, Bisexual, Transgender	LGBT
Local Drugs Task Forces	LDTFs
Local Policing Fora	LPF
Management Advisory Committee	MAC
Maritime Analysis Operations Centre – Narcotics	MAOC - N
Mid - Term Review	MTR
National Addiction Training Programme	NATP
National Advisory Committee on Drugs	NACD
National Drugs Rehabilitation Implementation Committee	NDRIC
National Drugs Strategy	NDS
National Drugs Strategy Team	NDST
National Drug - Related Deaths Index	NDRDI
National Drug Treatment Reporting System	NDTRS
National Educational Psychological Service	NEPS
National Educational Welfare Board	NEWB
National Health Service	NHS
National Treatment Agency	NTA
National University of Ireland, Galway	NUIG
Needle Exchange Programme	NEP
Non - Government Organisation	NGO
Office of the Minister for Children and Youth Affairs	OMCYA
Office of the Minister for Drugs	OMD
Oversight Forum on Drugs	OFD
Police Using Leading Systems Effectively	PULSE
Quality in Alcohol and Drugs Services	QuADS
Quarterly National Household Survey	QNHS
Regional Drugs Task Forces	RDTFs
Research Outcome Study in Ireland	ROSIE
Revitalising Areas by Planning Investment and Development	RAPID
School Completion Programme	SCP
National Health and Lifestyle Survey	SLÁN
Senior Rehabilitation Co - ordinator	SRC
Sexually Transmitted Infection	STI
Special Projects to assist disadvantaged Youth	SPY
Social Personal Health Education	SPHE
United Nations	UN
Vocational Education Committee	VEC
World Health Organisation	WHO
Young Peoples Facilities and Services Fund	YPFSE

APPENDIX 1

MEMBERSHIP OF STEERING GROUP

Name	Organisation
Kathleen Stack (Chair) Michael Conroy Eddie Arthurs Marie Mc Bride	Department of Community, Rural & Gaeltacht Affairs
Patricia O'Connor (Replaced during process by Aoife Davey)	National Drugs Strategy Team
Mairéad Lyons (Replaced during process by Dr Eamon Keenan)	National Advisory Committee on Drugs
Fergus McCabe Martin Hayes Meetings also attended by: ■ Anna Quigley	Community Sector
Tony Geoghegan Feidhlim Ó Seasnáin (Replaced during process by Brendan Murphy)	Voluntary Sector
John Garry Meetings also attended by: ■ Niall Cullen ■ Paula Cooney	Department of Justice, Equality & Law Reform Irish Probation Service
Eamon Corcoran Meetings also attended by: ■ Anna - May Harkin	Department of Health & Children
Andrew Duggins (Replaced during process by Liam Hughes) Meetings also attended by: ■ John Moloney	Department of Education & Science
Theresa Donohue (Replaced during process by Colin Hehir)	Department of Environment, Heritage & Local Government
Gretta Crowley Eddie Matthews Dr Brion Sweeney Meetings also attended by: ■ Liam Keane ■ Joe Doyle ■ Alice O'Flynn	Health Service Executive
Barry O'Brien Colette Quinn Meetings also attended by: ■ Joseph O'Connor ■ Pat Byrne	An Garda Síochána
Michael Colgan	Revenue's Customs Service
Gerard Gasparro Meetings also attended by: ■ Miriam Conway ■ Eamon Carey	FÁS
Pat Murray (replaced during the process by Donal Landers) Meetings also attended by: ■ Frances Nangle - Connor	Irish Prison Service
Sheila Heffernan	Drug Treatment Centre Board
Eddie Darcy	Youth Council of Ireland
Cathal Morgan	Homeless Agency
Jean Long (attended for Research Pillar)	Health Research Board
Linda O'Rourke (Secretary)	Department of Community, Rural & Gaeltacht Affairs

APPENDIX 2

WRITTEN SUBMISSIONS RECEIVED

Personal Submissions	
Claire Bissett	Patrick Morgan
Alan Carmody	Pat Mulcahy
John Corr	Denis Murray
John Coonan	Eamonn Murray
Con Doherty	Dolores Nally
Maurice Fitzgerald	Kenneth O'Brien
Michael Fox	Liam O'Brien
Gary Gomringer	Paul O'Brien
C.F. Holohan	Seán Ó Rallaghaigh
Karen Kelly	Darren J. Prior
Sean Lynch	Marie Claire Van Hout
Dr Duncan J Martin	Monica Sharpley
David Mc Cabe	Helen Stone
Dr Ian McCabe	Silvano Taddei
David McCarron	Anonymous
Dan McCarthy	Mary
May McGilloway	Stuart
Mark McGuire	Mary Mc Hugh
John Moloney	

ORGANISATIONS

Addiction Response Crumlin
Alcohol and Drug Research Unit - Health Research Board
Aisling Group
Aislinn Adolescent Addiction Treatment Centre
Alcohol Action Ireland
Ana Liffey Drug Project
Association For Health Promotion Ireland
Ballyfermot Voluntary Drugs and Alcohol Network
Ballymun LDTF (including Thematic Submission - Dual Diagnosis)
Ballyphehane Action For Youth Committee
Barnardos
Beaumont Hospital
Bray Partnership
Canal Communities LDTF
Catholic Youth Care (CYC)
Children Acts Advisory Board (CAAB)
Church of Scientology
Clondalkin Addiction Support Programme (CASP)
Clondalkin Drug Task Force
Cobh Community Concern Group
Combat Poverty Agency
Community Awareness of Drugs
Community Sector Submission - Citywide
Health Service Executive - Consultant Psychiatry Group
Coolmine Therapeutic Community
Cornmarket Project, Wexford
County Wexford Community Based Drug initiative
County Wexford Drugs Outreach Services
Crisis Pregnancy Agency
Crosscare Drug & Alcohol
Department of Arts, Sport and Tourism
Department of Defence
Department of Education & Science
Department of Foreign Affairs
Department of Health & Children and HSE - Joint Submission
Department of Public Health and Primary Care in Trinity College
Donegal Local Development Company Ltd
Drug Education Workers Forum
Drug Policy Action Group
Drug Treatment Centre Board
Drug Treatment Court
Dublin Aids Alliance

ORGANISATIONS

Dublin Simon Community
Dublin West Sinn Fein
Dun Laoghaire Rathdown Community Addiction Team (Geraldine Fitzpatrick)
Dun Laoghaire Rathdown County Council (Chris Furlong)
Dun Laoghaire Rathdown County Council (Angela Sweeney)
ECO - UNESCO
Edendery Addressing Substance Misuse (EASA)
Eolach
Exchange House
Family Support Agency
Family Support Network
Fatima Regeneration Board
FDYS Youth Work Ireland
Finglas Cabra LDTF
Foroige
Galway Traveller Movement Ltd
Greater Blanchardstown Response to Drugs
Hadd Family Support Group
Harm Reduction Services Group (HRSRG)
Headstrong: National Youth Mental Health Foundation
Homeless Agency
Hope House Foxford Co. Mayo
Horizon House
HSE Addiction Services (Maura Maye & Caitrona White)
HSE Addiction Services (Dermot O'Regan)
HSE Addiction Services - GP Co - ordinator Group
HSE Addiction Services Dublin North East
HSE Education Officers Drugs Strategy
Inchicore Community Drug Team
Irish Association of Alcohol & Addiction Counsellors
Irish Bishops' Drugs Initiative
Irish Pharmacy Union
Irish Prison Service
Irish Rural Link
Jim O'Dwyer - LDTF
Drug Treatment Services (Prisons) HSE (Julian Pugh - Co - ordinator)
Kilbarrack Coast Community Drug Programme
Kildare Youth Services
Lesbian, Gay, Bisexual and Transgender Community
Maigue Cluster
Meath Primary Health Care Project for Travellers
Mid West Drug Education Workers Forum

ORGANISATIONS

Midlands RDTF

National Advisory Committee on Drugs

National Drugs Strategy Team

North East Regional Drugs Task Force

North East Voluntary Addiction Service

North Inner City Local Drugs Task Force

NUI Maynooth - Students of Addiction Studies Course

NWRDTF & North West Alcohol Forum

Office of the Revenue Commissioners

Primary Care Safetynet for Homeless People

Progression Routes Initiative

Regional Co - ordinators and Development Workers Network

Rosebud Counselling

South Kerry Community Youth Based Initiatives

South Kerry Development Partnership

Students of University of Limerick & HSE Addiction Studies:

Carl O'Rourke & Anne Hanney

Pauline Walsh, Edward O'Shaughnessy & Jerry Scanlan

Eimear Gilchrist

Diarmuid Breatnach

Sandra Heelan & Seamus Nolan

SWAN Family Support

Tallaght LDTF

Teen Challenge

Traveller Organisations

Traveller Visibility Group

UISCE

Voluntary Drug Treatment Network

Walkinstown Greenhills Resource Centre

West Regional Authority

Wicklow Travellers Group

You're Equal - Cork Network Group

APPENDIX 3

DETAILS OF PUBLIC CONSULTATION MEETINGS

22 nd April 2008	Royal Marine Hotel, Dún Laoghaire
24 th April 2008	Hodson Bay Hotel, Athlone
29 th April 2008	Hilton Dublin Airport Hotel, Malahide Road, Dublin 17
1 st May 2008	Ardilaun Hotel, Salthill, Galway
6 th May 2008	Ashdown Park Hotel, Gorey
8 th May 2008	Plaza Hotel, Tallaght
12 th May 2008	Clarion Hotel, Sligo
13 th May 2008	Hilton Dublin City Hotel, Charlemont Place, Dublin 2
15 th May 2008	Heritage Hotel, Portlaoise
19 th May 2008	Greenhills Hotel, Limerick
20 th May 2008	Fels Point Hotel, Tralee
21 st May 2008	Silver Springs Hotel, Cork
22 nd May 2008	Woodlands Hotel, Waterford
29 th May 2008	Fairways Hotel, Dundalk
3 rd June 2008	Croke Park

APPENDIX 4

CONSULTATION MEETINGS WITH GOVERNMENT DEPARTMENTS AND STATUTORY AGENCIES

Meetings took place with the following key Government Departments and Statutory Agencies. These meetings were attended by members of the Steering Group and representatives of PA Consulting Group. The meetings were broadly based upon the same four questions which were asked at the public consultation meetings.

- An Garda Síochána
- Association of County and City Councils
- Association of Municipal Authorities of Ireland
- Department of Education & Science
- Department of Enterprise, Trade Employment & FÁS
- Department of Environment, Heritage & Local Government
- Department of Health & Children and the Health Service Executive
- Department of Justice, Equality & Law Reform
- Department of Social & Family Affairs / Office of Social Inclusion
- Health Research Board
- Health Service Executive - Consultant Psychiatrist Group
- Irish Prison Service
- The Probation Service
- National Advisory Committee on Drugs
- National Drugs Strategy Team
- Office for the Minister of Children and Youth Affairs
- Office of the Revenue Commissioners, Customs Division and Drugs Law Enforcement Branch
- The Courts Service

APPENDIX 5

CONSULTATION MEETINGS WITH SECTORAL GROUPS, ORGANISATIONS AND FOCUS GROUPS

Meetings took place with the following Sectoral Groups, Organisations and Focus Groups. These meetings were attended by members of the Steering Group and representatives of PA Consulting Group. The meetings were broadly based upon the same four questions which were asked at the public consultation meetings.

- Alcohol Action Ireland
- Chairs of Local Drugs Task Forces
- Chairs of Regional Drugs Task Forces
- Citywide, Community Sector Nationwide
- Coordinators of Local Drugs Task Forces
- Coordinators of Regional Drugs Task Forces
- Drug Action Policy Group
- Drug Education Workers Forum
- Drug Treatment Centre Board
- Ethnic Minority Groups representatives
- EATA
- Family Support Network
- Irish Association of Alcohol and Addiction Counsellors
- Irish College of General Practitioners
- Irish Pharmacy Union
- Irish Traveller Movement/Pavee Point
- Lesbian Gay Bisexual Transgender (LGBT) community (GLEN and Belongto)
- National Voluntary Drug Sector & Voluntary Drug Treatment Network
- National Youth Council of Ireland
- National Homeless Agencies
- Prisoner Groups
- Ruhama and Chrysalis
- Union for Improved Services Communication and Education (UISCE)
- Walk Tall and SPHE

FOCUS GROUPS:

- Participants in CE schemes – Kilbarrack
- Homeless agencies
- Residents in Cuan Mhuire
- Young people focus group - Neilstown

APPENDIX 6

DETAILS OF LOCAL AND REGIONAL DRUGS TASK FORCES

Local Drugs Task Forces

Ballyfermot Local Drugs Task Force

Addiction Services
Bridge House
Cherry Orchard Hospital
Ballyfermot
Dublin 10
Tel: 6206488
Fax: 6206401

Ballymun Local Drugs Task Force

Axis Centre
Main Street
Ballymun
Dublin 9
Tel: 8832142
Fax: 8832144

Blanchardstown Local Drugs Task Force

22a Main Street
Blanchardstown
Dublin 5
Tel: 8604845
Fax: 8604848

Bray Local Drugs Task Force

Unit 2, First Floor
24 Florence Road
Bray
Co. Wicklow
Tel: 2762975
Fax: 2762941

Canal Communities Local Drugs Task Force

Addiction Services
Bridge House
Cherry Orchard Hospital
Ballyfermot
Dublin 10
Tel: 6206413
Fax: 6206401

Clondalkin Local Drugs Task Force

Unit 5
Oakfield
Clondalkin
Dublin 22
Tel: 4579445
Fax: 4579422

Cork Local Drugs Task Force

Community Care Offices
St Finbarrs Hospital
Douglas Road, Cork
Tel: 021 4923132
Fax: 021 4923137

Dublin North East Local Drugs Task Force

Le Chéile
Collins Avenue East,
Donnycarney
Dublin 5
Tel: 8465074
Fax: 8465071

Dublin 12 Local Drugs Task Force

Addiction Services
Bridge House
Cherry Orchard Hospital
Ballyfermot
Dublin 10
Tel: 6206422
Fax: 6206401

Dun Laoghaire/ Rathdown Local Drugs Task Force

Centenary House
35 York Road
Dun Laoghaire
Co. Dublin
Tel: 2803335
Fax: 2300690

Finglas/Cabra Local Drugs Task Force

Tolka Clinic
121 Broombridge Close
Ballyboggan Road
Dublin 11
Tel: 8307440
Fax: 8820330

North Inner City Local Drugs Task Force

22 Lower Buckingham St.
Dublin 1
Tel: 8366592
Fax: 8366286

South Inner City Local Drugs Task Force

Addiction Services
Bridge House
Cherry Orchard Hospital, Ballyfermot
Dublin 10
Tel: 6206438
Fax: 6206401

Tallaght Local Drugs Task Force

c/o Dodder Valley Partnership
Killinarden Enterprise Centre
Tallaght
Dublin 24
Tel: 4664243
Fax: 4664288

Regional Drugs Task Forces:

East Coast Regional Drugs Task Force

(covering Dun Loaghaire, Rathdown and Wicklow)

1st Floor Office
Morton's Lane
Wicklow Town
Co Wicklow
Tel: 0404 20014
Fax: 0404 20024

Midland Regional Drugs Task Force

(covering Laois, Longford, Offaly and Westmeath)

c/o HSE Midland
Unit 4 Central Business Park
Clonminch
Tullamore
Co Offaly
Tel: 057 935 7818
Fax: 057 935 7823

Mid Western Regional Drugs Task Force

(covering Clare, Limerick and Tipperary NR)

Unit 5
Steamboat Quay
Dock Road
Limerick
Work: 061 445 392
www.mwrtdf.ie

North Eastern Regional Drugs Task Force

(covering East Cavan, Louth, Meath and Monaghan)

1 Castle Street
Kells
Co Meath
Tel: 046 924 8642
Fax: 046 924 8203

North West Regional Drugs Task Force

(covering Donegal, Leitrim, Sligo and West Cavan)

c/o Health Promotion Department
Main Street
Ballyshannon
Donegal
Tel: 071 985 2000
Fax: 071 985 1287
www.nwdrugstaskforce.ie

Southern Regional Drugs Task Force

(covering Cork and Kerry)

c/o Drugs and Alcohol Services
Southern HSE
St Finbarrs Hospital
Douglas Road
Cork
Tel: 021 4923135
Fax: 021 4923137

South East Regional Drugs Task Force

(covering Carlow, Kilkenny, Tipperary SR, Waterford and Wexford)

Farronshoneen Youth & Community Centre
Upper Grange
Waterford
Tel: 051 841 144

Western Regional Drugs Task Force

(covering Galway, Mayo and Roscommon)

Unit 6 Galway Technology Park
Parkmore
Galway
Tel: 091 480 051
www.wrtdf.ie

North Dublin City & County Regional Drugs Task Force

(covering North Dublin City and Fingal)

Estuary House
Swords Business Park
Swords
Tel: 813 5583
www.ndublinrdtf.ie

South West Regional Drugs Task Force

(covering South Dublin City, South Dublin, Kildare and West Wicklow)

Block A
Maudlins Hall
Dublin Road
Naas
Co. Kildare
Tel: 045 848538
Fax: 045 848585
www.swrtdf.ie

APPENDIX 7

RECOMMENDATIONS FROM THE REPORT OF THE WORKING GROUP ON DRUGS REHABILITATION

KEY RECOMMENDATIONS

1. Rehabilitation can only be delivered effectively through an inter - agency approach based on a continuum of care that operates within the context of enhanced case management and a quality standards framework. The development of protocols for interagency working, with service level agreements between agencies and co - ordination by rehabilitation co - ordinators, is required.
2. An adequate level of treatment provision is central to rehabilitation. An expansion of the range of treatment options, including an increase in the number of residential detoxification beds, for recovering drug users is essential. The HSE led Working Group on Residential Treatment/Rehabilitation should consider the issue of treatment provision and make detailed recommendations in this regard.
3. The impact of Community Employment on rehabilitation should be built upon by complementary support and involvement from the HSE, the Department of Education and Science and relevant agencies to ensure that the health and educational needs of participants are being properly addressed during their period of participation, as well as pre and post such participation.
4. The housing, childcare, educational and health needs and the employment opportunities of recovering drug users should be addressed through specific initiatives.

INTEGRATED REHABILITATION SERVICE

RECOMMENDATIONS

1. The development of protocols, at national and local level, to facilitate the level of inter - agency co - operation, integration and information sharing needed to implement shared care plans. The protocols will cover the arrangements for the seamless transition of people as they move from the environment of one agency to that of another as well as issues such as a common understanding of confidentiality, common assessment tools, tracking and monitoring, how disputes between organisations should be settled and so on. The protocols will address the sharing

of information between the agencies, while respecting client confidentiality and privacy.

The broad national protocols will be developed through the National Drugs Rehabilitation Implementation Committee and will be approved through the Inter - departmental Group on Drugs and, at Ministerial level, through the Cabinet Committee on Social Inclusion.

2. The local protocols will be agreed by the organisations involved in the model at local level. The Treatment and Rehabilitation Sub - groups of the Drugs Task Forces, each with a rehabilitation co - ordinator among its membership, will be responsible for drawing up and achieving agreement on these protocols under the framework of the broad national - level protocol. The local protocols will be approved through the National Drugs Rehabilitation Implementation Committee.
3. Service Level Agreements (SLAs) will be developed in line with the protocols, so that there is clarity on the roles and responsibilities of each party. Again this will be done at broad national level as well as at local level. The development of the SLAs will be overseen at a national level by the National Drugs Rehabilitation Implementation Committee and they will be approved through the Inter - departmental Group on Drugs. The national level SLAs will be reflected in local SLAs. The local SLAs will be agreed by relevant organisations directly involved in rehabilitation. The development of these SLAs will be overseen by the Rehabilitation Co - ordinators and they will be agreed by the Treatment and Rehabilitation Sub - groups of the Drugs Task Forces before being referred to the National Drugs Rehabilitation Implementation Committee for final approval.
4. The employment and management of rehabilitation co - ordinators (including a senior rehabilitation co - ordinator) to co - ordinate the overall drugs rehabilitation effort across the country within the parameters outlined above, including the development of protocols governing the referral of clients between services and facilitating the putting in place of SLAs between agencies, monitoring case management arrangements and facilitating the development of a quality standards framework.
5. The establishment of a rehabilitation co - ordinators network to facilitate building on successes and avoiding repetition of failures.

6. The development of criteria to ensure that all State - funded treatment and rehabilitation programmes accord with quality standards which are to be set out by the National Drugs Rehabilitation Implementation Committee in conjunction with the HSE (Action 50 of the National Drugs Strategy refers).
7. The development of national template assessment instruments for problem drug users at different stages (including initial qualification as a problem drug user) of their drug use/rehabilitation.
8. The development of templates for individual rehabilitation care plans.
9. In line with best governance practice, all services involved in drugs rehabilitation should be subject to a periodic external evaluation process. Provision for this should be made in the Service Level Agreements.
10. The nomination of personnel in the HSE to fulfil their lead role in relation to case management whereby that organisation is responsible for ensuring that each person is appropriately supported through the rehabilitation system.
11. The nomination of case managers (who can be located in the HSE or in the community or voluntary sectors) to liaise with all relevant agencies to ensure that appropriate services ranging from comprehensive assessment to appropriate supports are in place for each client. The role of case manager will include ensuring that the client's needs are satisfactorily assessed and that, while under the management of his/her service, the client receives an appropriate range of services commensurate with his/her needs.
12. The development of training structures, building on those existing, with appropriate accreditation, for case managers and key workers in drugs rehabilitation - addressing issues such as assessment, case management, care planning, training for inter - agency working, awareness training in relation to the services provided by other organisations and accountability. All service provider staff should have sufficient training to deliver the aspect of rehabilitation for which they are responsible.
13. The provision of appropriate drug related training for non - drug specific mainstream service personnel who provide rehabilitation programmes to problem drug users.
14. As Treatment and Rehabilitation Sub - groups of Drug Task Forces are a key element in the

rehabilitation effort, every Drug Task Force must ensure that it has an effective Sub - group in place.

15. An on - going Directory of Service Providers for drug treatment and rehabilitation in Ireland should be developed and maintained.
16. The National Drug Treatment Reporting System should be developed to provide enhanced tracking and monitoring of problem drug users as they progress through treatment and rehabilitation.

MEDICAL SUPPORT

RECOMMENDATIONS

1. An appropriate level of treatment services for problem drug users should be made available. Service providers should discuss all treatment options with individual clients, including options around detoxification.
2. The range of treatment options for recovering drug users, particularly counselling and therapeutic services, needs to be expanded and existing drug specific services should be re - orientated with a view to enabling a comprehensive drugs service aimed at all drugs to be provided.
3. Clients should be supervised by medical personnel during detoxification in all settings and should be supported by appropriately qualified service providers.
4. As an interim measure, the number of residential detoxification beds provided should be increased by 25¹⁰⁷ pending the outcome of the work of the Working Group on Residential Treatment/Rehabilitation¹⁰⁸.
5. The role of the voluntary sector in the provision of detox facilities should be reviewed and integrated within an overall strategic detox provision.
6. An increase in the number and geographical spread of residential detox places provided by the non - statutory voluntary and community sectors is required. This would be organised in co - operation with the health services to ensure the appropriate level of involvement of medical personnel. The Working Group on Residential Treatment/Rehabilitation should make detailed recommendations in

¹⁰⁷ From 23 to 48.

¹⁰⁸ The Department of Health & Children and the Health Service Executive are reserving their position on this recommendation pending the completion of the report of the Working Group on Residential Treatment/Rehabilitation in the Context of Addiction.

this regard, including recommending the optimum number and geographical spread of such detox facilities.

7. The possibility of developing cross Drugs Task Force facilities should be explored.
8. The involvement of more local GPs in drug treatment should be pursued. GPs should be encouraged to support clients through a process of detoxification and should facilitate the phased withdrawal from methadone where opiate users aim for total abstinence (Action 56 of the National Drugs Strategy refers)¹⁰⁹.
9. A concerted effort should be made to increase the number of participating pharmacies. By providing services in the community in which the problem drug user lives, the pharmacist can aid the stabilisation and rehabilitation of the problem drug user. Furthermore, their involvement in the overall treatment programme for the recovering problem drug user would facilitate early identification of any problems being encountered (Action 56 of the National Drugs Strategy refers).

COMMUNITY EMPLOYMENT

RECOMMENDATIONS

1. The health requirements of CE participants should be addressed during their period on schemes. This would involve direct involvement of the HSE, working in partnership with the schemes, in all Drugs Task Force CE Schemes, with service level agreements covering such issues as counselling, therapeutic support, mental health support, as well as general health (including dental health) and social services. Such initiatives would support the building of confidence and self esteem.
2. The educational requirements of CE participants should be addressed during their period on schemes. This would involve direct involvement of the VECs, working in partnership with the schemes, in all Drugs Task Force CE Schemes, with service level agreements covering such issues as numeracy and literacy and general educational requirements, leading in some cases to re - entry to formal education. Again such initiatives would support the building of confidence and self esteem.

3. The number of drug - specific CE places should be increased from 1,000 to 1,300 to provide more opportunities in view of the levels of demand and the settling down of Regional Drugs Task Forces (Action 74 of the National Drugs Strategy refers¹¹⁰). It is envisaged that this will be done through an increase in the overall number of CE places with consequential financial implications.
4. Participation on CE Schemes should be viewed as a progressive continuum with the options of the pre - CE initiative (see 6 below), Drugs Task Force CE Schemes and mainstream CE Schemes being available to clients as appropriate. This would extend, as needed, the period of support available.
5. Links to other appropriate training programmes, such as Local Training Initiatives (LTI), should be further developed with the support of Local Employment Services (LES)/Area Based Partnerships to encourage progression from CE.
6. A pre - CE stabilisation initiative, focusing on preparation for participation in CE programmes, should be developed. Issues to be covered will include scope and content. It is envisaged that the duration of any scheme should not exceed three months. Entry into the pre - CE scheme should follow a joint assessment involving HSE treatment services and CE providers.
7. Effective implementation of the Drugs Task Force CE schemes as part of an overall rehabilitation framework is dependent on a clear commitment to the model at both management level and local delivery level within FÁS. It is recommended that consideration be given to assigning a post at appropriate management level within FÁS with the specific responsibility of overseeing and monitoring the effective implementation and delivery of the Drugs Task Force CE schemes.
8. With respect to the Community Service Programme for 2007, the issue of provision of counselling, educational and back - up services should be addressed through engagement with the HSE and VECs at a local level as projects are developed, or as recovering drug users are included in projects.

¹⁰⁹ Action 56 as revised by the Mid - Term Review of the National Drugs Strategy calls for the continuation of the increase in the numbers of GPs (particularly level II GPs) and pharmacists participating in the methadone protocol, particularly in the areas of most need.

¹¹⁰ Action 74 of the National Drugs Strategy calls for an increase in the number of training and employment opportunities for problem drug users by 30%.

EMPLOYMENT

RECOMMENDATIONS

1. Access to ongoing support (through the national employment services [LES/FÁS] personnel in conjunction with relevant case managers) should be available to employers of former and stabilised drugs users, as well as to other employees of the firm/organisation. These services would also act as mediator in cases where difficulties arise.
2. The case manager should act as a support for the recovering drug user in employment, addressing any issues or difficulties that might arise.
3. Awareness training on the issues associated with recovering drug users should be developed and made available to prospective employers.
4. Stronger links with employers, employer organisations and Trade Unions need to be established to facilitate easier access for recovering drug users to the workplace. The Social Partnership Labour Group on Market Issues could be a forum that would facilitate this.
5. The potential benefits, including economic benefits, of fulfilling corporate social responsibility through initiatives, including the employment of rehabilitated drug users, should be emphasised.
6. Networks of recovered drug users who are now in employment should be established to give support to each other and to help, and motivate, those who are contemplating the move to mainstream employment.

ACCESS TO EDUCATION

RECOMMENDATIONS

1. The barriers for recovering drug users to accessing education should be identified and removed, where possible. This would involve both systemic barriers (overly restrictive criteria for accessing schemes) and support barriers to facilitate the availing of schemes (fees, transport, childcare etc.)
2. Linked to 1 above, it is recommended that an “Education Fund for Drugs Rehabilitation” be established. This would (i) allow replacement funds be made available to problem drug users (in prescribed circumstances) in instances where they are not entitled to avail of mainstream schemes/grants relating to education and training and (ii) provide

a “helping hand” to recovering drug users through providing funding (a) to support access to, and continuation with, a variety of courses and (b) to contribute towards reasonable costs involved

3. An Outreach approach should be developed by VECs to identify adult education needs of problem drug users in rehabilitation and to develop responses.

HOUSING

RECOMMENDATIONS

1. The specific issues in relation to the accessing by problem drug users of emergency, transitional and long term accommodation should be examined with a view to putting in place, at local level, the inter - agency procedures necessary to facilitate recovering drug users in accessing appropriate accommodation and the services necessary to ensure that tenancies can be maintained.
2. Local authorities should liaise with the relevant Drugs Task Force with the aim of facilitating those recovering drug users who wish to return, to or move into, a community. Local Authorities should continue to bear in mind the preferences of the applicant in deciding on the locality of housing to be allocated, especially in view of the fact that returning them to their local community may not be the most appropriate option in all cases.
3. Dedicated supported accommodation, staffed appropriately, should be provided to cater for those who have difficulties with an independent living environment. The provision of such accommodation is part of the existing homeless strategies and should be strengthened as part of the new homeless strategy
4. Building on recent initiatives, the provision of transitional/half - way housing for recovering drug users should continue to be increased, (for example, through use of the Department of Environment, Heritage and Local Government Capital Funding Scheme). This involves largely independent living, with fallback and periodic support available, as well as networking with other recovered drug users. The trained care staff required for such housing should be supplied by the HSE and voluntary providers.
5. Tenant Liaison Officers and others involved in tenant management issues should receive training to deal with all aspects of drugs - related tenant issues.

6. The Long - Term Housing needs of problem drug users, who are capable of independent living, should be addressed, for example, through the rental accommodation scheme.
7. Through the Drugs Task Forces, arrangements should be put in place for Local Authorities to nominate a contact point to whom matters arising in relation to tenancy issues pertaining to people in rehabilitation may be directed in the first instance.

REHABILITATION OF OFFENDERS

RECOMMENDATIONS

1. Drug treatment and rehabilitation programmes should be made available to all problem drug users in prison in the context of mandatory drugs testing and drug - free prisons (Action 22¹¹¹ of the National Drugs Strategy and the Irish Prison Service Drugs Policy and Strategy 'Keeping Drugs out of Prison' refer).
2. Arrangements should be put in place to ensure that a continuum of care will be available for all problem drug users when they leave prison. These arrangements should be robust and flexible enough to ensure that those released early, with short notice, or those on temporary release, are adequately followed up.
3. A review of the operation of the Local Prisons Liaison Groups, whose current terms of reference include the co - ordination of prison based drug treatment programmes with services and supports available in outside communities, should take place.

CHILDCARE

RECOMMENDATIONS

1. The HSE, in conjunction with the Office of the Minister for Children, should decide on how best to integrate childcare facilities with treatment and rehabilitation services and subsequently progress the matter (Action 54 of the National Drugs Strategy refers¹¹²).
2. An audit of gaps in existing childcare provision for children of problem drug users should be carried out. Research may be needed to ascertain the number of children with drug misusing parents and best practice in relation to integrating childcare into treatment and rehabilitation services.
3. Childcare services for the children of problem drug users should adopt an approach focused on the development of the children.
4. Parenting programmes for problem drug users should be further developed and implemented taking evidence based best practice into account.

ROLE OF FAMILIES IN THE REHABILITATION PROCESS

RECOMMENDATIONS

1. Service providers should actively encourage family participation and reconciliation of problem drug users with estranged family members (e.g. returning to family home). Structured support services may be needed in some cases to assist the process. In this context, the rights of problem drug users who do not want their family involved in the recovery process should be respected.
2. Service providers should be trained to deal with families who are trying to cope with the drug - related problems of a family member.
3. Families should be seen as service users in their own right, given that they often have a direct role in the recovery process. Information, support and advice should be made available to parents (and others as appropriate) who are coping with a family member's drug misuse. Family members need to be informed in a timely manner about the different stages of the recovery process.

111 Action 22 of the National Drugs Strategy calls for an expansion of prison - based programmes with the aim of having treatment and rehabilitation services available to those who need them including drug treatment programmes, which specifically deal with the re - integration of the drug using offender into the family/community.

112 Action 54 of the National Drugs Strategy calls on the Health Service Executive to consider, as a matter of priority, how best to integrate childcare facilities with treatment and rehabilitation centres and how childcare can best be provided in a residential treatment setting. This action will also be carried out with the Office of the Minister for Children.

4. The potential of the involvement of the family in supporting the recovering drug users should be utilised.
5. A pilot short - stay respite programme for families of problem drug users should be developed. Subsequent expansion of the initiative would depend on the outcome of the evaluation of the pilot.

RESEARCH

RECOMMENDATIONS

1. Future research and future evaluations of service provision should be informed by the emerging trends in drug misuse. Such research should focus primarily on (i) the outcomes of rehabilitation services and (ii) adapting existing services to deal with the consequences of new drug trends.
2. Building on the Research Outcome Study in Ireland (*ROSIE*¹¹³) research should be undertaken to examine the outcomes of those who have completed methadone programmes.
3. In line with the childcare recommendations in this report, research is required to ascertain the number of children with drug misusing parents, the issues this raises and best practice in relation to integrating childcare into treatment and rehabilitation services.
4. Research should be undertaken into progression pathways to employment for recovering drug users.

113 *ROSIE* Findings 1: Summary of 1 - year Outcomes – National Advisory Committee on Drugs, 2006.

APPENDIX 8

KEY ISSUES AND RECOMMENDATIONS OF THE REPORT OF THE HSE WORKING GROUP ON RESIDENTIAL TREATMENT & REHABILITATION (SUBSTANCE ABUSE)

Key Issues and Recommendations regarding the Role of Inpatient Detoxification and Residential Rehabilitation

The concept of the Four Tier Model of Care as the framework for the future organisation of alcohol and drug services in Ireland is endorsed.

All four Tiers of this model need to be fully resourced for the model to be fully effective because one Tier cannot be developed or function in isolation from other Tiers.

While not all problem alcohol or drug users will require Tier 4 (inpatient/residential) services, client outcomes are generally recognised as being superior for inpatient versus outpatient provision for those whose care plan calls for Tier 4 services.

The Four Tier Model of Care implies that clients should be offered the least intensive intervention appropriate to their need when they present for treatment initially. Where this does not succeed, more intensive interventions should be offered.

The Working Group highlights the need for a standardised assessment protocol which allows for the systematic identification of the needs of the client ensuring that they are referred to the most appropriate treatment modality in the most appropriate setting.

The Group recommends that where inpatient detoxification is required, it should be as a rule provided in dedicated units. The use of general hospital or psychiatric beds for detoxification should be the exception since the evidence base indicates better outcomes from specialist units.

Attention is drawn to the fact that detoxification of itself is not an effective treatment and that it must be followed up by post - detoxification psychosocial interventions as part of a client - centred rehabilitation programme.

The Group emphasises that the transition from detoxification from alcohol or any other drug into rehabilitation should be seamless so as to avoid waiting lists and delays which can result in client relapse. It is

recognised that in the case of relapse to opiate use, there is a major risk of fatal overdoses occurring at this time.

Key Issues and Recommendations regarding Existing Service Provision

The Working Group calculated that currently in Ireland there are:

- 23 dedicated beds for medical detoxification and stabilisation;
- 15 beds for community - based residential detoxification;
- 634.5 residential rehabilitation beds, of which, a significant proportion (31%) are for the treatment of alcohol problems only; and
- 155 step - down/halfway house beds most of which (76%) are for men only.

We estimate that currently the equivalent of 13 beds are used for detoxification in general hospital settings and the equivalent of 66 beds in psychiatric facilities; which is not in accordance with best practice.

We recommend that clients with co - morbidity issues who are in residential drug and alcohol services should be provided with adequate support by the mental health services, and that clear pathways into residential mental health services for those requiring them should be agreed, as outlined in the NACD commissioned report on *Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland* (MacGabhann *et al.*, 2004)

We further recommend that there should be flexibility to refer people with co - morbidity across catchment areas where an appropriate psychiatric service is not available in their own catchment area.

The Group recommends that a similar National Working Group be established to estimate the current capacity of community - based services within Tiers 1, 2 and 3 as well as looking at the balance between all four Tiers.

The Working Group recommends that GPs with Level Two training be resourced to work within community - based residential programmes to provide residential detoxification.

The Group also highlights the need to review community based or outpatient detoxification services, including the role of Level 2 GPs in their provision.

The Working Group noted that prison provides an opportunity for both detoxification and rehabilitation and would welcome the extension of the existing programmes within Mountjoy prison as well as the establishment of similar programmes in all other prisons within the State. In this regard there is a particular need to integrate alcohol treatment into overall programmes within Irish prisons.

The provision of step - down or halfway house accommodation for newly-released prisoners who have been detoxified or who have started rehabilitation programmes is particularly important, not least because of the vulnerability of such individuals to relapse and overdose.

A mechanism to track progression from treatment services to rehabilitation is required. This linkage can be achieved by use of a unique identifier which we recommend be used for all contacts with drug services to enable integrated care planning in line with the Rehabilitation Strategy, and so that, with appropriate confidentiality procedures, cross referencing can be carried out.

We recommend that a regularly updated directory of current residential services be made publicly available which would detail the programme approach and type of service provided.

In preparing the analysis and overview of current residential rehabilitation facilities, the Group noted the need for an initiative which would examine in - depth the configuration of existing services available, their programme approach, ethos etc.

Key Issues and Recommendations relating to the Assessment of Need for Inpatient Detoxification, Stabilisation and Residential Rehabilitation

There is a need for more refined data on drug and alcohol - related problems such as accidents at work, absenteeism and drug - related deaths, in order to allow the use of more sophisticated needs assessment models in future.

The Working Group based their estimation of need for inpatient detoxification and stabilisation services on the SCAN Consensus Project (a population - based model); the residential rehabilitation requirement was based on the transition from inpatient and outpatient detoxification to residential treatment; and the numbers of adolescents requiring treatment was based on population surveys and estimates of problematic substance use.

