

South Western Regional Drug and Alcohol Task Force

Strategic Plan 2015 - 2017

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List of acronyms

ACAR	Athy Community Addiction Response
ARAS	Abbey Regional Addiction Services
ASK	Addiction Services Kildare (Users Forum)
CASC	Community Addiction Studies Course
CE	Community Employment
CPF	Community Policing Forum
CPI	College of Psychiatrists of Ireland
C&V	Community & Voluntary
DAG	Drugs Advisory Group (former)
DCYA	Department of Children and Youth Affairs
DEHLG	Department of the Environment, Heritage and Local Government
DEIS	Delivering Equality of opportunity In Schools
DES	Department of Education and Skills (previously Science)
DJE	Department of Justice and Equality
DJEI	Department of Jobs, Enterprise and Innovation
DJELR	Department of Justice Equality and Law Reform (former)
DH	Department of Health
DHC	Department of Health and Children (former)
DPEI	Drug Prevention Education Initiative
DPU	Drugs Policy Unit
DSFA	Department of Social and Family Affairs (former)
DSP	Department of Social Protection
DTTS	Department of Transport, Tourism and Sport
DTF	Drugs Task Force
HALO	Helping Adolescents Learn to Overcome (substance misuse)
HIQA	Health Information and Quality Authority
HRB	Health Research Board
HSE	Health Service Executive

ICGP	Irish College of General Practitioners
ICT	Information and Communications Technology
IDG	Inter Departmental Group (former)
JPC	Joint Policing Committee
KWETB	Kildare Wicklow Education and Training Board
KWWCAS	Kildare West Wicklow Community Addiction Service
KYS	Kildare Youth Services
LCDC	Local Community Development Committee
LD(A)TF	Local Drugs and Alcohol Task Force
NACD(A)	National Advisory Committee on Drugs (and Alcohol)
NCC	National Coordinating Committee
NDRF	National Drugs Rehabilitation Framework
NDRIC	National Drugs Rehabilitation Implementation Committee
NDS(T)	National Drugs Strategy (Team)
NDTRS	National Drug Treatment Reporting System
NSMS	National Substance Misuse Strategy
OFD	Oversight Forum on Drugs
OMCYA	Office for the Minister of Children and Youth Affairs
OMD	Office of the Minister for Drugs (former)
QuADS	Quality in Alcohol and Drugs Services
RAPID	Revitalising Areas by Planning, Investment and Development
RD(A)TF	Regional Drugs (and Alcohol) Task Force
RSA	Road Safety Authority
RWGR	Report of the Working Group on Rehabilitation
SPHE	Social, Personal and Health Education
SPY	Special Projects for Youth
SWRDATAF	South Western Regional Drug and Alcohol Task Force
TF	Task Force

South Western Regional Drug and Alcohol Task Force Strategic Plan 2015 – 2017

Summary

The plan was developed in the period October 2014 – April 2015 under the guidance of a working group. The process for doing so included extensive stakeholder consultation and consideration of relevant written materials.

The full report comprises: an introduction; an overview of need in the region; a relatively detailed description of the current response to that need; an analysis of Task Force (TF) strengths, weaknesses, opportunities and threats; and a consideration of the issues that had to be taken into account when drawing up the strategy. The key components of the plan itself are summarised below.

Mission

Together we will work to reduce the harm caused by alcohol and other drugs to individuals, families and communities in our region.

Aims and objectives

1. To contribute to a reduction in the ready availability of drugs within our region

1.1 To ensure Joint Policing Committees (JPCs) actively incorporate strategies to deal with the supply of illicit drugs and associated drug-related intimidation and with the enforcement of the law on all types of alcohol sales

1.2 To raise awareness amongst relevant stakeholders about key alcohol supply issues, including availability, server training programmes and drink-driving

1.3 To ensure local communities most affected by problem drug use have in place appropriate community-based drugs networks

2. To contribute to the prevention of harm caused by problem drug use in our region

2.1 To ensure that the framework used to deliver drugs prevention and education is adequate and that evidence-based approaches are used in the delivery of Social, Personal and Health Education (SPHE) in primary schools, post-primary schools and Youthreach centres

2.2 To raise awareness about harmful drug use within a range of settings and to a range of at-risk groups using both online and offline methods

2.3 To focus on prevention measures within the family unit

2.4 To ensure standardisation in the screening of alcohol intake

2.5 To assist, where possible, in the development of youth cafés and similar alcohol-free venues, especially in communities with large numbers of at-risk young people

2.6 To integrate drug prevention and intervention initiatives for at-risk young people

3. To contribute to the provision of appropriate treatment and rehabilitation options within our region

3.1 To ensure work on alcohol treatment and rehabilitation within the region is both in line with national developments and supports national developments

3.2 To raise awareness about alcohol treatment and rehabilitation services (including aftercare)

3.3 To increase the range of evidence-based psychosocial interventions in tier 3 and 4 services (including aftercare)

3.4 To increase the range of drugs-related child and adolescent services (including aftercare)

3.5 To support families experiencing dependency problems using evidence-based interventions (including aftercare)

3.6 To formulate and implement agreed protocols for integrated treatment and rehabilitation services, including service level agreements so that there is clarity on the roles and responsibilities of each party

3.7 To enable access to medical support across TF areas (including aftercare)

3.8 To provide increased opportunities for service users and ex-service users to support each other on the journey to recovery, including, where appropriate, into mainstream employment

3.9 To enable recovering drug users to return to their former community or move into a new community

4. To contribute to the alcohol research agenda

4.1 To ensure that high quality relevant alcohol research is undertaken and disseminated to stakeholders

5. To ensure that our TF is fit-for-purpose

5.1 To have TF members who understand and are fully committed to fulfilling their responsibilities for collective action

5.2 To have a fully functioning structure for the TF

5.3 To support the positive involvement of the projects funded by the TF (and others) into the work of the TF

5.4 To secure additional resources to support the work of the TF and initiatives in the region

5.5 To publicise the TF and the full continuum of services in the region, as well as other relevant developments, using the TF website and social media channels

5.6 To maintain a quality administrative function, streamlining as necessary

Reaching the plan's ambitious targets is dependent on proactive implementation by all TF members, all TF staff and a number of community-based service providers.

---SECTION 1---

1. Introduction

1.1 The problem

- 1.1.1 Substance misuse is a complex issue that affects – often gravely – not only the individuals concerned, but also the people around them, as well as the wider community. Previously, much of the attention in this field was focused on halting the spread of certain illegal drugs. However, researchers, policy-makers and practitioners are increasingly giving consideration to the misuse of legally available substances, the broader reasons that explain why people choose to supply and use drugs, the consequences of problematic drug use, and the most effective ways to manage the problem.
- 1.1.2 Prevalence data show that the numbers of people using illegal drugs are relatively small. For example, in 2010/11, 1.5% of 15-64 year olds in Ireland stated that they had used cocaine in the previous year, with only 0.5% saying that they had done so in the preceding month. However, national data also reveal that very high numbers of people take legal drugs, often in combination with other substances (both licit and illicit). The most common combination of drugs is alcohol and tobacco. Ireland has one of the highest per capita alcohol consumption rates in the world, with particularly worrying levels of underage drinking. The tangible costs associated with problem alcohol use in Ireland in 2007 were calculated to be €3.7 billion (comprising health care costs associated with alcohol-related illness, suicides, road accidents, crime, work absence, accidents at work and premature mortality). These figures are undoubtedly underestimates as there are also many less tangible costs.
- 1.1.3 Due to the wide-ranging nature of the problem, by association, the responses for dealing with it also need to be multi-faceted. These range from prevention and early intervention to treatment and aftercare.

1.2 The legal and policy context

- 1.2.1 The principal legislative framework for illicit drugs is laid out in the Misuse of Drugs Acts 1977 and 1984 and the Criminal Justice (Psychoactive Substances) Act 2010, but these are supplemented by many other relevant laws, regulations and bye-laws. Of particular current interest is the Public Health (Alcohol) Bill, which is due to be signed into the Irish Statute Book during 2015.
- 1.2.2 The infrastructure for dealing with Ireland's drug problem is complex and ever-changing. The key player is the Drugs Programmes and Policy Unit (DPU – previously the Office of the Minister for Drugs – OMD), which supports the work of the National Advisory Committee on Drugs and Alcohol (NACDA), the Oversight Forum on Drugs (OFD – previously the Inter Departmental Group – IDG) and the National Coordinating Committee for Drug and Alcohol Task Forces (NCC – previously the Drugs Advisory Group – DAG).

- 1.2.3 The first Local Drugs Task Forces (LDTFs) were set up in 1997. There are now 14 LDTFs and 10 Regional Drugs Task Forces (RDTFs). Their Terms of Reference (updated in 2014) can be found in Appendix 1.
- 1.2.4 The DPU oversees, coordinates and reports on the implementation of the National Drugs Strategy (NDS – interim) 2009-2016, which is the primary policy framework. Its overall strategic objective 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"*. The specific actions that are deemed the responsibility of L/RDTFs are listed in Appendix 2.
- 1.2.5 The National Drugs Rehabilitation Implementation Committee (NDRIC) developed the National Drugs Rehabilitation Framework (NDRF) in 2010. Its aim is to provide: *"A framework through which service providers will ensure that individuals affected by drug misuse are offered a range of integrated options tailored to meet their needs and create for them an individual rehabilitation pathway"*. The specific actions that are deemed the responsibility of L/RDTFs, as outlined in the 2007 Report of the Working Group on Rehabilitation (RWGR), are listed in Appendix 3.
- 1.2.6 In 2014, the L/RDTFs acquired a formal remit for dealing with problem alcohol use, which is gradually resulting in a change of name to Local/Regional Drug and Alcohol Task Forces (L/RDATFs). The NCC has outlined the possible role that L/RDATFs might play in relation to alcohol, although its suggestions are not mandatory at present. These are listed in Appendix 4.
- 1.2.7 It is recommended that all services working in the field adhere to QuADS (Quality standards in Alcohol and Drug Services).

1.3 The South Western Regional Drugs and Alcohol Task Force

- 1.3.1 The South Western Regional Drugs and Alcohol Task Force (SWRDATAF or 'the TF') was established in 2005. It is funded under a Section 39 Service Agreement with the Health Service Executive (HSE). In 2014, it received €139,777 for its operational budget plus an allocation of €20,840 for disbursement to community supports. The SWRDATAF is not a legally constituted organisation in its own right. Rather it is a network of members, including elected, statutory sector, voluntary sector and community representatives. The current membership of the TF is shown in Appendix 5.
- 1.3.2 There is a small team of paid staff, based in the TF offices in Naas. The HSE employs a full-time Coordinator for the TF. The Co. Kildare LEADER Partnership hosts a Development Worker and Administrator (both full-time) and has also seconded a part-time temporary worker to progress work on the implementation of the NDRF within the region (the Rehabilitation Coordinator). Finally, there is a part-time Administrative Assistant working on a Community Employment (CE) scheme.

- 1.3.3 The boundaries of the RDATEFs reflect those of the former Health Boards. The SWRDATEF is part of the HSE Mid-Leinster Region. Appendix 6 shows that the TF encompasses all of Co. Kildare, the western part of Co. Wicklow, all of South Co. Dublin, and the southern and western parts of Dublin City. Appendix 7 shows that within the SWRDATEF boundaries lie six LDATEFs (namely: Ballyfermot, Canal Communities, Clondalkin, Dublin 12, South Inner City and Tallaght). In practice, the SWRDATEF concentrates on those parts of the region that are not covered by the LDATEFs, although naturally, it communicates with them from time to time.
- 1.3.4 Research conducted for the TF's last strategic plan showed that the region covered by the TF had a population of around 203,327 and was growing at a very fast rate. It is without doubt part of the capital's 'commuter belt' and, as such, has significant numbers of young people. The region is very varied both geographically and socio-economically. It includes highly urbanised parts of Dublin, large towns such as Kildare, small towns such as Blessington and extensive rural areas. Pockets of severe deprivation are masked by overall affluence at regional level.

1.4 The strategic planning process

- 1.4.1 This is the TF's third strategic plan. When drawing up the previous two plans, considerable effort was expended on establishing the need within the region and mapping initial responses for meeting that need. As the TF marks a decade of existence, there is less of an imperative to revisit these aspects in detail, although naturally, they are not ignored. More attention is instead paid to the outcomes that are being sought as a result of the TF's work and the means that might be employed to achieve these outcomes.
- 1.4.2 Whitebarn Consulting was contracted in late 2013 to assist the TF in developing an operational plan for 2014. Whitebarn Consulting was subsequently recontracted to help the TF draw up a strategy for the period 2015-2017. A Strategic Planning Working Group was established to guide the consultant in her work. It comprised the TF Coordinator and five TF members and convened on three occasions.
- 1.4.3 The consultant met with the TF Coordinator to undertake a detailed progress review on the 2014 operational plan. A stakeholder mapping exercise was then conducted in order to draw up a consultation strategy for both primary and secondary stakeholders. This resulted in: 23 responses to an online questionnaire; 11 telephone interviews; four group interviews; and one focus group. In total, 57 individuals provided input into the process, including service users and their families, TF funders, TF members, TF staff, representatives from projects funded by the TF, public representatives and other external organisations. Stakeholder engagement data were supplemented by an extensive review of all relevant internal documentation and key external literature (see Bibliography).
- 1.4.4 This document is in two main parts. The first section presents a contextual and organisational analysis. The second section comprises the strategic plan proper.

2. Identifying the need

2.1 Difficulties associated with needs identification

- 2.1.1 As stated in section 1.4.1, the preparation for this strategic plan did not seek to include a detailed analysis of need. Even if it had done so, needs identification is a difficult process, especially in a region that is as large as that covered by the SWRDATAF and that crosses several county boundaries. Official data sets are limited in scope and there is often a considerable time lag between data collection and public availability of those data. It is known that much problem drug use is hidden, which means that official figures do not fully reflect need. Many people fail to recognise their problematic drug misuse, or if they do, they do not necessarily seek help for it. Anecdotal evidence suggests that waiting list figures for support services can be artificially low, as providers are reluctant to widely advertise their services and then unable to cope with the resultant demand for those services.
- 2.1.2 Despite these obvious limitations, the TF would be well advised to adopt, in the long-term, a much more data-driven approach to needs analysis.
- 2.1.3 The profile provided here takes as its starting point the information gathered as part of the previous strategic planning process, and complements this with the most recently available quantitative data and the qualitative information provided by consultees. The view was strongly expressed that the drugs/alcohol problem in the SWRDATAF region was large and serious, but not significantly different to that anywhere else in the country.

2.2 Geography

- 2.2.1 Drugs misuse in the region may previously have been associated with disadvantaged parts of specific towns, especially those on direct public transport routes into Dublin. This is no longer the case. Drugs are readily available, and being used – in the words of a consultee – *"in every town and village ... there's always a supplier"*. However, the drugs problem may be less hidden in deprived areas than elsewhere. Also, the negative consequences of drugs misuse may have a greater impact in very small communities.
- 2.2.2 Notwithstanding the above, certain places were singled out for description within the consultation process. For example, Athy, on the south-western fringe of the region, was previously designated as a RAPID (Revitalising Areas by Planning, Investment and Development) area and is known to have an ongoing drugs problem. Maynooth, on the northern fringe, has a high student population and, as such, a high level of demand for certain drugs. There is anecdotal evidence of significant alcohol misuse in the Curragh Camp, which is an army base and military college located in the western part of the region. From time to time, certain places flare up as 'hot spots'. Both Celbridge in the northern part of the region and the West Wicklow towns of Blessington, Baltinglass and Dunlavin were mentioned in this context.

2.3 Substances

2.3.1 In line with national trends, the most pervasive problem drug within the region appears to be alcohol. Polydrug use and the misuse of both over-the-counter and prescription drugs are common. Impure and high-strength drugs can be especially problematic.

2.3.2 Health Research Board (HRB) data from the National Drug Treatment Reporting System (NDTRS) show that out of 959 referrals in 2013, there were 782 new treatment episodes within the SWRDATAF area. Individuals were treated in either statutory or non-statutory services, including residential centres, community-based addiction services, general practitioner (GP) surgeries and prisons. The problem substances identified were:

Alcohol	385
Opiates	220
Cannabis	127
Cocaine	25
Benzodiazepines	18
Others	5
Ecstasy	<5
Volatile inhalants	0
Other stimulants	0

The data also showed that at least 149 people had injected drugs at some point in their lives, with 40 having done so in the month prior to seeking treatment, and 66 having at some stage shared injecting equipment.

2.3.3 Central Treatment List data for 2013 show that there were 487 clients from the SWRDATAF region who were undergoing methadone treatment. This represents 4.4% of the national total, which can be considered as average. The breakdown for treatment services was:

GPs	266
Clinics	127
National Drug Treatment Centre (Trinity Court, Dublin 2)	57
Prison	<43

As shown in section 3.2.10, there is no clinic providing methadone treatment within the SWRDATAF area (excluding the LDATF areas). In addition to those receiving treatment in Trinity Court, it is therefore reasonable to infer that the substantial figure of 127 clients receiving such services in 'clinics' (more than a quarter of the total) is also travelling to Dublin-based facilities.

2.4 Population

2.4.1 Due to the widespread nature of the problem, the issue of alcohol and other drugs has the potential to affect everyone, although clearly it affects some more than others.

- 2.4.2 Whilst there is a cohort of 'seasoned' (poly)drug users – primarily unemployed Irish men aged from their mid-twenties to late thirties – drugs misuse is evident across socio-economic classes, nationalities, genders and the age spectrum. NDTRS data show that at least 640 males and 280 females were referred in the TF area in 2013, ranging in age from 17 years and younger, to 50 years and over. 84% were living in stable accommodation and 78% had gone to school until at least age 15 (or were still in school). Central Treatment List data for the same year show that 341 men and 146 women availed of methadone treatment.
- 2.4.3 A body of anecdotal evidence suggests that the age at which young people in the region are starting to use drugs is lowering. For example, consultees relayed incidents of children, some only of primary school age, bringing decanted spirits into schools and/or smoking cannabis on the way to and from school; sometimes even on school premises. The Transition Year was highlighted as a particularly vulnerable time during which 15-16 year-olds might engage in drugs misuse, although it was also pointed out that there were many "*gangs of roaming young lads*" in the 12-15 year age bracket who were engaging in anti-social behaviour, including minor drug and alcohol use. The problem can be an intergenerational one, in which children, their parents and other family members all misuse a variety of substances.
- 2.4.4 Arguably those who experience the most difficulty are those who do not only engage in substance misuse but also have another problem, such as a mental illness or an intellectual disability. This is not only because their needs are complex by themselves, but also because services tend to be structured in such a way that does not readily deal with those who have a dual/multiple diagnosis. Those for whom English is not their first language may also have very real problems accessing services.

2.5 Consequences

- 2.5.1 The consequences of problem drug use can range from the minimal to the devastating.
- 2.5.2 Overdoses are common. The HRB's National Drugs Related Deaths Index shows that in 2012, there were 18 deaths in the SWRDATF area resulting from poisoning by alcohol and/or other drugs (this is the annual average for each of the years since 2004 when these data were first collected; it is also the average for each of the L/RDATF areas). The total number of poisoning deaths for Ireland in that year was 350. In addition, there were 283 non-poisoning deaths, which are deaths amongst drug users that are indirectly attributed to their drug use, such as suicide or accidents caused by impaired judgement (these figures are not broken down by L/RDATF area).
- 2.5.3 The effects of drugs misuse can be long-term. For example, drug-induced psychosis can lead to a lifetime in mental health services. Even if people recover fully, stigmatisation can continue forever.
- 2.5.4 Furthermore, the effects of drugs misuse are not limited to the individual engaging in the drug use. They can also be felt by those in their immediate vicinity (families/friends, etc) and beyond. It can lead to anti-social behaviour and crime, both directly and indirectly. For example, it was reported that within the region, a staggering 90% of calls to An Garda Síochána at weekends involve alcohol (estimate).

- 2.5.5 Drugs misuse should not be considered in isolation. It is part of a complex web that is closely associated with other issues of concern, such as exclusion from school, unemployment, family breakdown, homelessness, gambling, eating disorders, deliberate self-harm, underage and/or high risk sexual activity, violence, etc.
- 2.5.6 For most people, the best chances of avoiding, managing or exiting drug misuse will come as a result of engagement with appropriate services. Appropriateness will vary according to the individuals in question. It is clear that there is a high demand for services and that, for various reasons, need is only being partially met at present (see section 3).
- 2.5.7 2013 NDTRS data for the SWRDATAF region show that the largest group of people self-refers (41%). They also highlight that the most common treatments are: individual counselling (29%); medication-free therapy (21%); alcohol detoxification (16%); and brief interventions (11%). Although significant numbers successfully complete their treatment (38%), large numbers disengage from treatment (often whilst unstable) or are transferred elsewhere. Uptake of vaccination and viral screening for HIV and Hepatitis B/C is minimal. Numbers engaging in aftercare are small.

3. Responding to the need

3.1 Exploring the landscape for service delivery

- 3.1.1 Service users have diverse and multiple needs. It follows, therefore, that more than one agency is necessary to meet these needs and that services must be plentiful, accessible and appropriately coordinated.
- 3.1.2 As stated in section 1.4.1, the process for developing this plan did not seek to include a full mapping exercise of the services currently available within the SWRDATAF area. Notwithstanding, in order to recognise the status quo and plan for the future, it is necessary to have an understanding of the individuals/organisations that have a role to play within the region in terms of responding to current and emerging need. The listing below, which was drawn up through the consultation process and limited desk research, does not claim to be a comprehensive inventory of services available within the region, however.
- 3.1.3 It is strongly recommended that efforts are made, in the short- to medium-term, to create a detailed services directory that is publicly available (online) and that is updated on an ongoing basis. The recent secondment to the TF of a member of staff to oversee the implementation of the NDRF (the Rehabilitation Coordinator), which will include a mapping exercise of regional treatment and rehabilitation responses, is an excellent opportunity to commence this process.
- 3.1.4 In line with the advice to adopt a data-driven approach to needs analysis (see section 2.1.2), likewise it is recommended that such an approach gradually be used to analyse service provision, in order to limit service gaps and/or duplications.
- 3.1.5 One of many recognised challenges faced by the TF is the fact that its boundaries are in many cases different from those of the other stakeholders it works with (such as county councils and An Garda Síochána).

3.2 Statutory services

Local authorities

- 3.2.1 Local authorities have a role in providing housing, managing anti-social behaviour, promoting community development, etc. As stated in section 1.3.3, the SWRDATAF boundary extends across four local authority areas. In practice, the TF interacts mainly with Kildare Co. Council. Contact with Dublin City Council, South Dublin Co. Council and Wicklow Co. Council is minimal.
- 3.2.2 Elected representatives clearly have a role to play in this context, because they are charged with representing the views of their constituents, making policy decisions and allocating resources. In late 2014, the NCC confirmed that up to five seats of a L/RDATAF should be reserved for elected representatives (two for members of the Oireachtas and three for local authority members). To date, no members of the Oireachtas have been represented on the SWRDATAF, but three councillors are represented. A total of seven councillors chose to participate in the consultation process for this strategic planning process.

Revenue

- 3.2.3 The Customs section of Revenue plays a role in terms of supply reduction. A representative sits on the SWRDATF.

An Garda Síochána

- 3.2.4 An Garda Síochána is represented on the membership of the TF. The role of Gardaí is to deal with potential and actual offences in which alcohol and other drugs are implicated, with an emphasis on reducing the supply of illegal drugs. In this context, the SWRDATF actively promotes the multi-stakeholder Crimestoppers/Dial to Stop Drug Dealing campaign and the Drug Related Intimidation Reporting Programme.
- 3.2.5 Where possible, young people who are found to be involved with drugs will be cautioned under the Garda Diversion Programme and may be referred to a community-based Garda Youth Diversion Project. This is an effective route for some young people, but certainly not all; consultees highlighted a lack of respect for the police force as a significant problem.

Probation Service

- 3.2.6 The Probation Service is also represented on the TF. The service supports offenders to avoid re-entering crime. As such, it builds relationships with a broad range of statutory agencies and non-statutory service providers, in order to meet the needs of its clients (and in so doing, reduce crime levels within society).

Department of Social Protection

- 3.2.7 Many of the TF's beneficiaries are entitled to some form of payment from the Department of Social Protection (DSP), which is therefore potentially a key player. Although nominally listed as a member, the DSP is not represented at SWRDATF meetings.

Department of Health and the HSE

- 3.2.8 The Department of Health (DH) provides funding for the Drug Prevention and Education Initiative (DPEI – see section 3.3.10). It is not represented on the SWRDATF, however.
- 3.2.9 The HSE is the main funder of the SWRDATF. Furthermore, its Primary Care and Addiction Services divisions are represented on the TF. The latter includes an Addiction Counsellor based in Newbridge Health Centre and an outreach needle exchange service. There are other arms of the HSE that are relevant in terms of dealing with the region's drugs/alcohol problem, including but not limited to: Naas General Hospital, the Chief Pharmacist, children and family services and mental health services. Service users and family members who took part in the consultation process reported inconsistency in the way that different HSE employees interact with those who are drug dependent, with some being highly sensitive to their specific needs and challenges, but others far less so.

- 3.2.10 The single biggest identifiable gap is the lack of a drug treatment centre (methadone replacement, etc) in the region. As highlighted in section 2.3.3, large numbers of people travel to the National Drug Treatment Centre and other clinics in Dublin, sometimes up to seven days a week. The negative implications of this are enormous. Significant time is lost as a result of the constant travel, leading – for instance – to key working sessions in other services being missed and children who are accompanying their parents not going to school. Although a travel allowance is sometimes provided, this does not cover the full public transport costs of attending a service based in the capital; the almost inevitable fare avoidance can create a downward spiral of fines. The HSE is making concerted efforts to establish a clinic in one of the region’s major towns. Up until now it has experienced problems in sourcing a suitable site, but it feels hopeful that, with the proactive involvement of its partners on the SWRDATF, this long-standing goal can be achieved during 2015.
- 3.2.11 The final key players within the healthcare context are GPs, who interact on a daily basis with those who misuse substances and are thus well-placed to promote harm-reducing behaviour and refer clients to other services. Only GPs who have undergone specialist training are able to treat opiate-dependent people. There are five Level 1 GPs in the region (in Naas, Celbridge, Monastervin, Leixlip and Athy). These GPs are able to treat a maximum of 15 stabilised patients who have been referred from drug treatment centres or Level 2 GPs. Level 2 GPs can initiate treatment of up to 35 patients (50 if in partnership with other doctors in their practice). There is currently one such GP in Naas and one in Leixlip, although there are plans for a further three to be based in Newbridge and Leixlip. Many GPs do not wish to get involved in the treatment of opiate-dependent patients, or even if they do, they would prefer not to do so within the premises in which their surgeries are run. The temporary co-location of a Level 1 GP within ARAS (see sections 3.3.7-3.3.9) during 2014 was reported as having been largely successful, as it integrated medical care with additional supports.

Educational services

- 3.2.12 The Department of Education and Skills (DES) is no longer represented on the TF. This is potentially problematic, given the importance of education in both the prevention of drugs misuse and in the rehabilitation process.
- 3.2.13 The Kildare and Wicklow Education and Training Board (KWETB) is represented on the TF. KWETB is the largest education provider within the region. Its services include Youthreach centres for early school leavers in Athy, Blessington, Leixlip and Naas (plus a fifth centre outside the regional boundaries of the TF), but demand for places at these centres often outstrips supply. The Dublin Dun Laoghaire Education and Training Board is the channel for Department of Health funding to DPEI (see sections 3.2.8 and 3.3.11).
- 3.2.14 There are a large number of other educational establishments in the region, at primary, secondary and tertiary levels. There are at least 10 DEIS (Delivering Equality of opportunity In Schools) schools at primary level and eight DEIS schools at post-primary level.

- 3.2.15 SPHE is a core subject in both the primary and post-primary curricula. There is, unfortunately, no constant proactive relationship between the SPHE Support Service and the TF, or its funded projects, despite attempts at fostering this. The misuse of substances is only one component of SPHE and it has been found that many teachers are insufficiently trained to deal with the drugs/alcohol issue. In response, schools may choose to engage external speakers whose approach is not in line with accepted quality standards for educating about the misuse of drugs.
- 3.2.16 It was reported that many school principals will not accept the size of the drugs problem. It was also reported that so-called 'zero tolerance' policies are leading to even very young teens being excluded from schools. The SWRDATF Coordinator attends quarterly meetings of a number of School Completion Programmes in the region.

3.3 Non-statutory services

Cuan Mhuire

- 3.3.1 Cuan Mhuire was founded in 1966. Its Athy site is one of five in Ireland. This provides a 117-bed alcohol addiction treatment facility and a 22-bed facility for those seeking to deal with dependency on other drugs. In addition to detoxification and treatment/rehabilitation, it also offers family support, aftercare and residential transition. Although Cuan Mhuire has, amongst other things, CHKS and ISO 9001:2008 accreditation, its treatment model has been criticised by some for not being evidence-based. A Cuan Mhuire employee sits on the TF, as a representative of the near-defunct Voluntary Drug Treatment Network.

Kildare Youth Services

- 3.3.2 Kildare Youth Services (KYS) was founded in the early 1970s and provides a range of relevant services. HALO stands for Helping Adolescents Learn to Overcome substance misuse. The HALO Project was established in 2009. It was formerly managed by Kildare West Wicklow Community Addiction Services (see sections 3.3.7-3.3.9), but in mid-2013, KYS adopted the HALO project. This means it is now much more closely integrated with KYS' other services, including youth projects throughout the region (six of which are Special Projects for Youth – SPY), the Naas Child and Family Project, a youth counselling service, a youth information service and two Garda Diversion Projects.
- 3.3.3 HALO has an open referral policy and a relatively short waiting list. In 2013, HALO received 96 new referrals, 82 of which engaged in treatment and 67 of which successfully completed their treatment. On assessment, individualised care plans are drawn up and implemented using primarily one-to-one supports over a number of weeks/months. Occasional group work is also undertaken, for example, on the request of an external partner.
- 3.3.4 The HALO Project is based in Naas. It delivers a satellite service one day per week in Athy and one day per week in Celbridge. It previously provided a half-day per week satellite service in Blessington, but this was discontinued due to a lack of referrals. However, discussions are now taking place about recommencing this service in the youth café in Blessington, in response to expressed need.

- 3.3.5 HALO also provides a substance misuse information and awareness programme for parents (completed by 19 parents in 2013) and supports a peer-led family support group (engaging 12 parents by late 2013), although plans are afoot to combine this to a greater extent with the work of the South Western Family Support Network. HALO is also commencing work in relation to young people's support during 2015. Further information on both these developments is provided in section 3.3.15.
- 3.3.6 The HALO Project is not represented on the TF because of a perceived conflict of interest in terms of its HSE funding. In 2014, its budget allocation was €168,295. It is guided by a steering group that includes, amongst others, the TF Coordinator.

Kildare West Wicklow Community Addiction Services

- 3.3.7 This organisation was established in 2008 and in 2009, it merged with the Abbey Project. It trades as ARAS (Abbey Regional Addiction Services). It provides a range of services to adults, including drop-ins, one-to-one counselling, group therapy and complementary therapies. In 2014, it received 226 new referrals. At any time, its main service in Newbridge has around 70 clients, with a further 30 or so clients at its Celbridge service, and approximately 50 people on its waiting list. ARAS recently piloted the SAOL Project's RecoverMe programme and is currently exploring options for delivering aftercare.
- 3.3.8 ARAS is not represented on the TF because of a perceived conflict of interest in terms of its HSE funding. In 2014, its budget allocation was €368,125. Unlike HALO and DPEI (see sections 3.3.6 and 3.3.11), ARAS does not presently have a mechanism for the TF Coordinator to be involved in its governance structures.
- 3.3.9 The ARAS premises are also used on a part-time basis by the peer-led Addiction Services Kildare (ASK) Users Forum, the peer-led Ellen Family Support Group, Cocaine Anonymous, the Dublin Simon Community, HSE Outreach Workers and the Probation Service.

Foroige

- 3.3.10 Foroige is a long-established national youth work organisation. It runs ten youth clubs within the region and one Garda Youth Diversion Project. Most significantly, it hosts the DPEI, which was established in 2006 and which is based in Naas. DPEI's primary focus is on training staff and volunteers who work with young people and on educating parents. It is also available to work with schools and other education providers in the development of their substance misuse policies, but to date, few have availed of this service. In recent years, DPEI has coordinated the Strengthening Families Programme (see section 3.4.2). This programme has been delivered in Athy, Newbridge and Kildare. DPEI is exploring work in relation to young people's support during 2015 (see section 3.3.16).
- 3.3.11 DPEI is not represented on the TF because of a perceived conflict of interest in terms of its Department of Health funding. In 2014, its budget allocation was €102,280. It is guided by a steering group that includes, amongst others, the TF Coordinator.

Athy Community Addiction Response

3.3.12 ACAR is a new community-based initiative that supports both individuals and their families who are dealing with substance misuse within the Athy area. It is not represented on the TF's membership. ACAR has close links with the peer-led Athy Family Support Group.

Local Development Companies

3.3.13 Co. Kildare LEADER Partnership delivers a range of rural, enterprise, social inclusion and community development initiatives throughout the county. As indicated in section 1.3.2, the Partnership is the employer of all TF staff, except the Coordinator, who is employed by the HSE. Since late 2013, it has also hosted the 24-place Kildare Addiction Services CE Scheme, which has seven places ring-fenced for people in recovery and which allows for a higher supervisor to participant ratio than 'ordinary' CE schemes. CE participants are undertaking a range of roles in Athy, Kill, Naas and Newbridge, including the provision of family support, peer support, administration and social media. A Partnership representative is a member of the TF and the SWRDATF Coordinator is a member of the Partnership's Social Inclusion Subcommittee.

3.3.14 The SWRDATF has no active contact with the Co. Wicklow Partnership.

Anonymous support groups

3.3.15 Various organisations offer '12-step programmes', often supported by information and helplines. Alcoholics Anonymous hosts meetings in more than 30 locations in the region. Al-Anon/Alateen hosts meetings at a further three locations. Cocaine Anonymous meets in Newbridge (ARAS). Narcotics Anonymous meets in Athy.

Family support services

3.3.16 There are two Family Resources Centres in the region – one in Newbridge and one in The Curragh. Additionally, Kildare has the Teach Dara Community and Family Centre. The South Western Family Support Network is a TF initiative that works out of a former Garda station in Kill and that comprises representatives from the Ellen Family Support Group, (former) HALO Family Support Group and Athy Family Support Group. The network is facilitated and supported by the SWRDATF Development Worker and two CE participants. The feasibility of establishing a further family support group in the Blessington area is currently being assessed. The National Family Support Network's Young People's Support Programme pilot is presently being explored by DPEI and HALO.

Other non-statutory services

3.3.17 The Blessington and District Forum is a community body for West Wicklow. The newly established Blessington Youth Project is another key player in this locality. A number of voluntary organisations operate homeless services in the region, including the Dublin Simon Community (Naas, Newbridge and Celbridge), Focus Ireland and the Peter McVerry Trust (Newbridge). Church-based short-term homeless shelter is provided in Newbridge and Athy. The SWRDATF Coordinator sits on the board of directors of the Athy Alternative Project, which is an ex-offenders initiative, because it has been found that increasing numbers of the project's clients are presenting with substance misuse problems. The SWRDATF Development Worker sits on the board of directors of The Hive youth café in Kildare. A range of other social inclusion and community development initiatives exist within the region.

3.4 Other services and stakeholders

3.4.1 The Co. Kildare Local Community Development Committee (LCDC) is a recently established multi-stakeholder group comprising statutory and non-statutory members, which is currently drawing up a six-year socio-economic plan for the county. SWRDATF is represented on this; indeed, it is the only L/RDATF in the country to have successfully secured a seat on an LCDC. Whilst the TF is not represented on the Co. Wicklow equivalent, it is envisaged that possibilities will arise to play an active part in the development of relevant plans (for example, through the emerging Public Participation Networks). The Integrated Services Programmes are also significant in this context.

3.4.2 The Co. Kildare Children and Young People's Services Committee is a multi-agency initiative to secure better developmental outcomes for the county's children and young people. The SWRDATF Coordinator is also represented on this committee. Contact has been made with the coordinator of the Co. Wicklow equivalent, but there appear to be no responses that are specific to West Wicklow.

3.4.3 JPCs comprise representatives from various sectors. The SWRDATF is only represented on the Co. Kildare JPC. The JPCs are currently undergoing structural changes.

3.4.4 The private sector should not be forgotten when discussing alcohol and other drugs. There are key roles for publicans, retailers, the legal profession, the media, etc.

3.5 Service gaps

3.5.1 Consultees consistently pointed to the inadequacy of current service provision. Some service gaps have already been identified above. A number of other gaps also became apparent and these are outlined below.

3.5.2 There is a considerable lack of awareness of the services that do exist.

- 3.5.3 Available services are concentrated in a limited number of urban areas. This is particularly problematic for those in rural areas and/or those who do not have ready access to private transport options, such as young people and people who are economically disadvantaged.
- 3.5.4 There is a particular lack of drug-specific services in West Wicklow, despite a demonstrable need in this area, especially in terms of young teenagers engaging in drugs misuse and anti-social behaviour. This part of the region continues to be neglected, as demonstrated by the TF's lack of engagement with the decision-making structures in Co. Wicklow.
- 3.5.5 There are insufficient: women-specific services; drop-in facilities; after-hours services (for both drug users and their families); abstinence-based treatments that are not embedded in a religious ethos; aftercare facilities; and community engagement options for those leaving prison and rehabilitation services. Some parents also lamented the fact that their substance-using children could not be forced to engage in treatment, although it should be noted that research shows that client motivation is central to successful outcomes.
- 3.5.6 Referral pathways between services are inadequate, which can lead to people 'falling between the cracks'. The view was expressed by some that this was especially problematic in the transition between youth and adult services. Improved coordination, including further protocols, are necessary.
- 3.5.7 Services that are available outside the region may not be accessible due to distance, cost and waiting lists.
- 3.5.8 Conversely, some services are under-utilised. This is not necessarily indicative of a lack of demand; it may instead be that the service model is unsuitable for the current needs of potential clients.

4. SWOT analysis

4.1 An introduction to SWOT

- 4.1.1 SWOT stands for Strengths, Weaknesses, Opportunities and Threats. It is a classic model to represent the current status of an organisation and the context in which it operates, thereby providing the springboard for informed future action. Strengths and weaknesses are *internal* aspects of an organisation; an organisation should strive to build on its strengths and overcome its weaknesses. Opportunities and threats relate to the *external* environment; an organisation has far less control over these, but it should do everything it can to seize arising opportunities and mitigate against the risks associated with potential threats.

4.2 Strengths

Good staff team

- 4.2.1 Consultees were highly complimentary of the SWRDATF staff team. Their experience, professionalism, commitment, approachability and sensitivity were consistently pointed out. The staff members were considered to be very good at building relationships and sustaining positive interagency links, as well as balancing competing priorities. The phrase "*finger on the pulse*" was also used to describe the staff's dynamism, responsiveness and flexibility. There is also a very positive working relationship between the team members themselves.

TF members

- 4.2.2 Certain aspects of the SWRDATF membership, and the way it operates, can be commended. Members were described as "*good, pleasant people*", representing a cross-section of opinions and on-the-ground experience. At a fundamental level, staff described feeling supported by the TF and explained that most members would willingly cooperate if staff made a direct request for help with a particular issue. Specific individuals were picked out as being especially strong and genuinely interested.

Administration

- 4.2.3 Administrative processes appear to run relatively smoothly. The TF has regular, professionally administered meetings, attendance at which is improving. It has also developed a comprehensive induction pack for TF members and a number of important policies and procedures. Whilst this is positive, it should be noted that the continuous updating of any such documents must not be neglected.

Innovation

4.2.4 Creative approaches that use 'outside the box' thinking have been shown to be increasingly important in the context of shrinking state funding. The TF, especially its staff team, has shown strengths in instigating and developing new initiatives. The three primary projects that are funded through the TF (HALO, ARAS and DPEI) are the clearest demonstration of success in this regard. However, there are many other examples also, including: the ShelfHelp initiative in partnership with library services; a stress control project; the proactive initiation and support of service user involvement within the region; and the acquisition of the former Garda station in Kill as premises for the South Western Family Support Network (with support from the Office of Public Works).

4.3 Weaknesses

Less than effective TF

- 4.3.1 The TF equals its members, but unfortunately, it is rarely perceived as such. When people refer to the TF, they invariably mean its staff team, whose role is to *support* the work of the TF. During the consultation process, TF members consistently talked of 'they/them' and never of 'we/us'. This is not just a problem of language. It signifies an issue that is of greater concern, namely, that people do not understand what their role on the TF is, or could be. It reflects a lack of shared understanding about the concept of effective representation and of how the multi-stakeholder TF model has the potential to create positive collective impact. The fact that one-third of TF members chose simply not to participate in the consultation process for the development of this plan highlights that there is not full 'buy-in' to the model. Whilst this is a definite weakness, it can also be argued that this is a direct consequence of a situation in which membership of the TF is often only a very small part of members' jobs/lives. This is in contrast to the staff team, who perform their roles on a full-time basis.
- 4.3.2 A culture has been allowed to develop in which TF members do not feel able or willing to take the initiative to drive change. Clearly, a vehicle such as the TF requires that meetings be held, but meetings of and by themselves do not effect change. Although well attended and administered (see section 4.2.3), TF meetings do not tend to be productive. Remarkably, TF members have never formally proposed an agenda item for discussion. There is a general reluctance to raise issues within the group setting, with a preference for having private conversations before and/or after meetings – this is the antithesis of collaborative working. A previous request that each TF member reports at meetings about relevant developments within their own organisation/field was refused. Useful information does sometimes get shared at meetings, but not in a proactive or consistent manner. Meetings are passive; there is an over-reliance on the Coordinator verbally recounting written reports and there is far too much focus on financial oversight, as opposed to driving strategy and actively seeking solutions to identified problems. On a number of occasions, consultees spoke of "*tip-toeing around issues*", "*talking shops*" and "*going round in circles*". There appears to be a lack of willingness to engage in constructive discussion and to make decisions. This is compounded by insufficient action by TF members in between meetings.

- 4.3.3 Turnover in some of the slots on the TF is rapid (for example, HSE), whereas other slots have been occupied by the same representatives for periods that are far longer than those recommended by statutory guidelines (for example, An Garda Síochána). The terms of office are three years for all members, including the chairperson, but excluding elected representatives. Members may be appointed for two consecutive terms. Other slots, such as those for a DES representative or a representative dealing with Travellers' issues, remain open. Despite attempts to improve the induction process, a number of consultees expressed the view that they still do not really understand what their role on the TF is. Possible explanations for this include: lack of 'buy-in'; lack of training in how to be an effective TF member; insufficiently senior staff who are not entitled to make decisions; lack of trust between different stakeholders; ineffectual facilitation of meetings; and overdependence on the Coordinator.
- 4.3.4 During 2014, it was decided to abolish the TF's non-functioning subgroups and theme groups (with the exception of the Finance Subgroup), and replace these, as necessary, with more time-limited working groups dealing with specific issues, such as the Strategic Planning Working Group that is guiding the process of developing this plan. The present structures are still far from ideal, however. Some people still believe that the standing subgroups and theme groups exist. Even though there is a Finance Subgroup, its Terms of Reference are out-of-date and the issues that it is responsible for are also being discussed in detail at full meetings of the TF, which is a waste of precious time. A new NDRF Working Group has been set up and, after some time, a chairperson has been found and Rehabilitation Coordinator appointed. However, concerns remain about the lack of a small and easily definable goal for this group and the size of the group, which is arguably too large to be workable.

Insufficient resourcing

- 4.3.5 Along with every other social purpose organisation in the country, the SWRDATAF does not have at its disposal all the money it requires to meet expressed need. As such, it has to target its available resources – both financial and non-financial – as effectively as possible, as well as leverage as many additional resources as it is able to. The TF staff team has already shown that it is able to be creative about finding and stretching sources (see, for example, sections 1.3.2 and 4.2.4). Its ability to do more of this is hampered by a number of factors, however.
- 4.3.6 Organisations in the region are fiercely protective of the limited funds that they each have available. This can foster a culture of secrecy and competition, instead of partnership, and this makes it less likely that they will willingly pool resources.
- 4.3.7 The TF is a 'go-between' for its statutory funders (especially its primary funder; the HSE) and the projects that are supported by these funds. Even if it wishes to do so, it has very limited scope/flexibility to make meaningful changes in the way these funds are allocated and used.
- 4.3.8 As highlighted in section 2.1, it is difficult to quantify what the needs in the region are, which makes it difficult to prove to funders that more resources are needed. It was also argued that the TF is "*not sufficiently political*" and therefore insufficiently assertive in terms of lobbying for more support from its statutory funders.

Tensions between the TF and funded projects

- 4.3.9 There is an undeniable 'them and us' atmosphere between the TF and the three main funded projects (DPEI, HALO and ARAS). This can be explained in part by a palpable frustration that the projects are only "*scratching the surface*" in terms of meeting demand within the region. However, it is largely as a result of the financial issues described in sections 4.3.6-4.3.8 above. The nature of service level agreements with statutory partners is not conducive to savings being made in one area being reallocated to other areas, or being shifted into different spending periods. Being wholly, or almost wholly, funded by one agency severely limits a project's autonomy. Although theoretically independent, in reality, one party has more power than the other, which can result in unhealthy and unproductive relationships. In this case, it is leading to micro-management of projects with excessive reporting requirements. Accountability is crucial, but the methods to achieve it must be proportionate. Arguably, more efforts should be expended on evaluating the relative impact of the services.
- 4.3.10 This situation is exacerbated by the fact that the three projects do not have a seat at the TF table. As referenced in section 3.3, a decision was made in this respect in order to avoid conflicts of interest (though it should be noted that it is not uncommon in other L/RDATFs for projects that receive TF funding to also be members of the TF). The advantages and drawbacks of this decision can be debated. What cannot be denied is that it has led to the relative isolation of a group of stakeholders who are some of the most engaged with the region's drugs issue. There is, at present, insufficient two-way communication between the TF and the projects that is frank and that openly recognises the constraints under which all parties are operating.

Ineffectual ways of working

- 4.3.11 There are myriad networks, committees, advisory groups and similar structures operating within the region, as shown in section 3. Each of these meets, often on a frequent basis. Many of the same individuals are represented at these meetings. The SWRDATF Coordinator in particular attends a huge number of meetings. The short-term positive effects of attendance at these meetings can be negligible, although, over time, a constant presence and the consistent raising of the TF agenda can reap rewards. These longer-term benefits have to be balanced against the time that could have been spent concentrating on other priorities. It is advised that staff members are even more discerning about the meetings at which TF attendance is essential. Spreading the load amongst TF members may also be possible.
- 4.3.12 The state has specified which stakeholders should lead on/participate in the implementation of national drugs policy (see Appendices 2-4). However, at regional level, this is not automatically translated into practice. Some consultees defined very clear boundaries in terms of what they perceived their own responsibilities to be, sometimes without credible explanation (in the eyes of the consultant). It follows, therefore, that they consider other responsibilities to be within the remit of other agencies, who, in turn, may not agree. This has the potential to lead to 'stand-offs', work not being done, work being done by an inappropriate body, etc.

4.3.13 Whilst being outcomes-focused is an approach that is relatively well established in terms of working with individual service users, the concept is less well understood within an organisational context, let alone a multi-stakeholder environment that stretches across an entire region. As a result, few clear outcomes have been defined and few achievable targets have been set. The result is a lack of agreed priorities and an overly reactive way of working.

Communications concerns

4.3.14 The TF's public face is the Coordinator (see section 4.3.11). The Development Worker also plays a role in this regard and the Administrator and her Assistant are the first point of contact for those who call or email the office. There is, however, no visible figurehead from within the TF membership.

4.3.15 The SWRDATF website is very poor and outdated. It neither describes the size and nature of the problem that the TF is trying to tackle, nor what/who the TF is and does. A previous attempt was made at an online directory of services specific to the region, but this is hopelessly inadequate and out-of-date. The automatic feed of national news is good, but there is no information about previous/current developments in the region. A new website is due to come on stream soon.

Service gaps

4.3.16 These were previously outlined (see section 3.5). They indicate a deep and broad range of unmet needs.

4.4 Opportunities

Legislative and policy changes

4.4.1 The SWRDATF does not operate in a vacuum. It is affected directly and indirectly by changes in legislation and public policy. It is sometimes able to have an effect on such developments, again either directly or indirectly. It is at a far remove from many laws and policies, such as the European Union Drugs Strategy 2013-2020. However, it is able to influence policy-making closer to home, due to its involvement on relevant structures. The most significant of these will be a new national drugs strategy, which is due to be published in 2016. At a more localised level, the new LCDC planning process in particular (see section 3.4.1), provides an opportunity to raise the prominence of the alcohol/drugs issue within Co. Kildare.

4.4.2 In many instances, it is not possible to predict what the effect of potential changes in law and policy will be, but the TF should consider the different scenarios and plan for its own likely response. Relevant examples include possible legislative changes regarding medical injection centres and the introduction of naloxone, and the possible extension of the community mobilisation on alcohol pilot, which is currently being tested in five areas.

Funding

- 4.4.3 The deep economic recession of recent years led to budgets being slashed across the board. The current uplift in the economy will, hopefully, lead to improved public finances over the course of the plan. In any case, RDATFs are entitled to apply for a Small Grants Fund to cover unanticipated circumstances or seed funding of community and voluntary sector initiatives in their area. It is also likely that grants of up to €50,000 will become available during this year for disbursement by L/RDATFs towards alcohol projects.
- 4.4.4 There are further resourcing opportunities elsewhere. For example, European Union funding is available towards social innovation projects in the drugs field. Further research could potentially uncover many other avenues for bringing in more money. This would be a rather new departure for the TF and could require skills and time that may not presently be available.
- 4.4.5 It is also possible that certain initiatives tested by the TF may be mainstreamed if they prove successful, as was done with the Strengthening Families Programme (see section 3.3.10). It is hoped that the pilot to deliver young people's support (see section 3.3.16) will similarly be incorporated into the plans of the Co. Kildare Children and Young People's Services Committee.

Availability of non-monetary resources outside the region

- 4.4.6 Nationally, the drugs/alcohol field is quite well developed and there are numerous resources available outside of the region that can be availed of without having to 'reinvent the wheel'. For example, Community Awareness of Drugs provides up-to-date drugs training and the Quality Standards Supports Project offers an online module for quality champions. Agencies such as the HRB provide solid research evidence as to what type of interventions do and do not work. Furthermore, the TF can make use of national health promotion and similar campaigns in order to highlight these regionally (dissemination of literature, etc).

Underexploited regional sources

- 4.4.7 The TF already has experience of a number of successful initiatives and ways of working that could readily be expanded upon. For example, it could: run even more Community Addiction Studies Courses (CASCs); work more closely with neighbouring L/RDATFs; make better use of its CE scheme to develop day services; and support the roll-out of the Text Alert System in communities that do not already have this. It could also explore further options for 'piggy-backing' on to other services.
- 4.4.8 There are almost certainly other non-monetary resources that the TF has not availed of up until now. These include the seeking of pro bono support, the involvement of interns/volunteers to support the staff team, and capitalising on the opportunities offered by social media. It could also be helpful to hold TF meetings at different venues throughout the region (provided as appropriate by TF members and funded projects), so that TF staff and members gain a fuller understanding of the environments in which their counterparts operate. (However, it may be difficult to find venues that are of a sufficient size to host full TF meetings.)

- 4.4.9 An additional venture known as the Abbey Community Project, may be providing services to drug users in Celbridge. The TF has sought to make contact with this project but it is presently unclear if it is functional.

4.5 Threats

The enormity of the issue

- 4.5.1 There is a danger that the deep-rooted, complex and substantial nature of the problem can lead to a certain kind of inertia. This is especially true since alcohol was formally included into the agendas of L/RDATFs, without any associated increase in funding to tackle this enormous issue, and the potential dilution of impact of any initiatives that are undertaken. The lack of real-time data and the persistent use of interventions that are not evidence-based are additional obstacles.

Difficulties in predicting trends

- 4.5.2 Certain developments are easier to predict than others. For example, the homelessness problem, which is strongly correlated with the drugs/alcohol issue, is getting worse and will have to be taken into account when considering the likely numbers of people who will require treatment. However, it is far more difficult to predict what 'fads' might spread quickly (for example, NEK nominations) or what new substances might appear on the scene (for example, crystal meth). So-called 'headshop' products are not causing major concerns at present, but this situation requires constant vigilance.

Uncertainty about the political context

- 4.5.3 During the lifetime of the plan, there will be a general election, which could potentially result in a change of government and a change in drugs policy. There is uncertainty over the future role and boundaries of L/RDATFs generally and without a guarantee of sustainable funding, planning for the future is difficult.
- 4.5.4 Furthermore, there are ongoing structural changes within the HSE. Of particular relevance is the fact that the HSE has indicated that it will not act as the regional lead on the implementation of NDRF, which is a significant challenge (it has agreed to assist in the roll-out, however). Also, the service level agreements that were previously in place between the TF and ARAS and HALO will from here in be directly between the HSE and these two projects. The governance structures for managing this new relationship are currently being worked out. At worst, it will result in a situation in which the TF retains an administrative burden but has no say in the way the projects conduct their work. At best, it will release some of the time and energy that is currently spent by TF staff on assuring the projects' accountability.

5. Towards a strategic plan

5.1 Freedom versus constraints

- 5.1.1 The development of a new strategic plan provides, to some extent, the opportunity for 'a fresh start' for the SWRDATF. Indeed, the very process of developing the plan obligates the TF to refocus and to consider new ways of doing things, because it was agreed that maintaining the status quo was not an option. However, the TF cannot take a 'blank page' approach either, because it is constrained both by centrally dictated requirements (see section 1.2) and by the reality of the situation in which it presently finds itself (see section 4).

5.2 Essential requirements

- 5.2.1 The Strategic Planning Working Group agreed a number of fundamental criteria that must underpin the plan. These include the need for: clarity; realism; a document that would be seen as 'our strategy'; clearly defined responsibilities for everyone involved with the TF; a practical plan; the inclusion of alcohol as well as other drugs; an outcomes focus; measurable targets; and appropriate reporting mechanisms.
- 5.2.2 The guiding principles for the operation of L/RDTFs, as outlined by the DAG in 2011, are: propriety; responsiveness; transparency; accountability; efficiency and effectiveness; and partnership. Consultees articulated a number of additional values that they believed should drive the TF. These include: putting the beneficiaries front and centre of the TF agenda (ahead of any individual or organisational interests), equality of access to services and the use of appropriate language to describe drugs use/dependency.

5.3 Making choices

- 5.3.1 It is far easier to generate long lists of activities that the TF might undertake than it is to decide which of these are most strategic in terms of reaching defined goals. The TF must resist the temptation to try and be 'all things to all people'. To this end, it was clarified what the TF would definitely not do over the coming three years, namely: become a frontline service provider; act as a grant-giver to individuals; or develop into an agency that undertakes generic health promotion (that is, not specific to drugs). It was also accepted that it would neither be possible nor desirable to incorporate all of the suggestions made by consultees (often because they fall outside the scope of the TF). Furthermore, it was acknowledged that certain activities that are presently taking place might need to be halted in preference of those that are likely to have a bigger impact. A full list of actual and potential activities that have been discarded for the foreseeable future is provided in Appendix 8.

- 5.3.2 A number of options were explored before choosing what approach would be adopted by the TF when formulating the strategy. Ideas to significantly change the service model, to adopt a purely data-driven model, or to focus on specific geographical areas within the region, were rejected in favour of a 'back to basics' approach, in which the TF would strive to successfully deliver some initiatives under all relevant headings of the NDS, the RWGR (NDRIC) and the 2014 discussion paper on alcohol and L/RDATFs (see Appendices 2-4). As statutory documentation has been used to structure the plan, both the language used and the priorities adopted reflect these central directives.
- 5.3.3 It was also accepted that the SWRDATAF is not a LDATF, and as such, its approach to tackling the drugs misuse problem will be different than if it were operating in a more locally based setting.
- 5.3.4 When deciding priorities, there is a tension between targeting prevention (which, if done well, will reap hard-to-measure, but long-term benefits) and concentrating on services for those already affected by substance misuse (with more readily measurable, short- to medium-term results). It was agreed that the identification of acute gaps in treatment and aftercare (see section 3.5) mean that considerably more efforts need to be directed here over the coming three years. This will inevitably mean prevention measures receive somewhat less attention than might be desirable if resources were more plentiful.
- 5.3.5 The ultimate success of the TF depends to a large extent on its effective functioning. It is important, therefore, that there are explicit objectives to improve the way that the TF is structured and operated over the coming years. This involves consideration of the membership and the way that the members interact. It is important that, at a minimum, the three main community/voluntary sector drugs projects are involved to a far greater extent in joint strategic discussions. The TF has to decide whether it is possible to do this as full TF members. If a decision is made that this is not possible, due to conflict of interest concerns, alternative ways will have to be found to seek their views.

---SECTION 2---

SWRDATAF strategic plan 2015-2017

Mission

Together we will work to reduce the harm caused by alcohol and other drugs to individuals, families and communities in our region.

Aims

1. To contribute to a reduction in the ready availability of drugs within our region
2. To contribute to the prevention of harm caused by problem drug use in our region
3. To contribute to the provision of appropriate treatment and rehabilitation options within our region
4. To contribute to the alcohol research agenda
5. To ensure that our TF is fit-for-purpose

A NOTE ON OBJECTIVES AND TARGETS:

For each aim, a table has been drawn up, which includes a number of objectives, linked to specific statutory guidelines. Each objective is associated with one or more targets.

Targets that can be proactively achieved by the TF are written in normal font.

Targets that are more reliant on a reactive approach to external developments are *italicised*.

A NOTE ON RESPONSIBILITIES:

In the tables below, **TF staff** are only listed where they have primary responsibility for ensuring targets are reached. Whilst TF staff will naturally be involved in progressing all of the aims and associated objectives – particularly in terms of facilitating interagency working – it is important that **TF members** play an active role in driving work on those targets for which they have direct responsibility. Those **stakeholders who are neither TF staff nor current TF members**, but who must nonetheless play a pivotal role in terms of achieving the strategy, have been marked in orange.

AIM 1: To contribute to a reduction in the ready availability of drugs within our region

INTENDED OUTCOMES: REDUCED SALES OF ALCOHOL AND ILLICIT DRUGS; REDUCED LEVELS OF DRUG-RELATED INTIMIDATION; INCREASED AWARENESS ABOUT ALCOHOL SUPPLY ISSUES; INCREASED CAPACITY OF LOCAL COMMUNITIES TO RESPOND TO LOCAL DRUGS ISSUES

Statutory guideline	TF objective	TF target	TF responsibility
NDS action 3 & alcohol paper supply actions 3, 6, 7, 9, 10	1.1 To ensure JPCs actively incorporate strategies to deal with the supply of illicit drugs and associated drug-related intimidation and with the enforcement of the law on all types of alcohol sales	Establishment of clear systems to ensure active TF communication with all JPCs: 2015: Co. Kildare 2016: Co. Wicklow 2017: Dublin	<ul style="list-style-type: none"> • An Garda Síochána • Kildare Co. Council • Revenue
Alcohol paper supply actions 5, 8, 11	1.2 To raise awareness amongst relevant stakeholders about key alcohol supply issues, including availability, server training programmes and drink-driving	<p><i>Roll-out, throughout region, of all national alcohol supply initiatives as they come on stream</i></p> <p><i>Advice to national stakeholders, on an ongoing basis and using available fora, of relevant alcohol supply issues arising within the region</i></p>	<ul style="list-style-type: none"> • An Garda Síochána • DPEI • Other TF members
NDS action 4	1.3 To ensure local communities most affected by problem drug use have in place appropriate community-based drugs networks (for example, encompassing community champions, education and training, recovery coaches, peer support – it may be possible to develop a support package for use by local communities)	<p>At least 1 CASC run each year</p> <p>Three actively supported local drugs networks: 2015: self-sufficiency of drugs network in Athy 2016: establishment of drugs network in West Wicklow 2017: self-sufficiency of drugs network in West Wicklow and establishment of drugs network in one other community of need within the region</p>	<ul style="list-style-type: none"> • ACAR • Blessington & District Forum • Elected representatives • Kildare CVF • Kildare LEADER Partnership

AIM 2: To contribute to the prevention of harm caused by problem drug use in our region

INTENDED OUTCOMES: INCREASED AWARENESS ABOUT THE POSSIBLE HARM OF ALCOHOL AND OTHER DRUGS; DELAYED AGE AT WHICH ALCOHOL AND OTHER DRUGS ARE FIRST USED; REDUCED NUMBERS OF PEOPLE CONSUMING ALCOHOL AND OTHER DRUGS; REDUCED INTAKE OF ALCOHOL AND OTHER DRUGS; LESS DANGEROUS (COMBINATIONS OF) DRUGS BEING TAKEN

Statutory guideline	TF objective	TF target	TF responsibility
NDS action 19 & alcohol paper prevention action 4	2.1 To ensure that the framework used to deliver drugs prevention and education is adequate and that evidence-based approaches are used in the delivery of SPHE in primary schools, post-primary schools and Youthreach centres	Establishment of systems to ensure ongoing proactive communication between the key stakeholders for prevention and education	<ul style="list-style-type: none"> • DPEI • HSE • KWETB
NDS actions 28, 30 & alcohol paper prevention action 1	2.2 To raise awareness about harmful drug use (including: illicit drugs; underage drinking; excessive/binge drinking; drink-related anti-social behaviour/public order offences; drinking and pregnancy), within a range of settings and to a range of at-risk groups using both online and offline methods	<p><i>Roll-out, throughout region, of all national alcohol/drugs awareness programmes as they come on stream</i></p> <p><i>Advice to national stakeholders, on an ongoing basis and using available fora, of relevant alcohol/drugs awareness issues arising within the region</i></p>	<ul style="list-style-type: none"> • DPEI • HSE • KWETB • Other TF members
NDS action 29 & alcohol paper prevention action 6	2.3 To focus on prevention measures within the family unit (to include drugs misuse by parents and children)	<p>Roll-out of Strengthening Families programme (minimum one per annum) and Positive Parenting for Prevention courses (parents and train-the-trainer)</p> <p>2015: completion of National Family Support Network Young People's Support programme</p>	<ul style="list-style-type: none"> • DPEI • Family Support Network • HALO • HSE

Alcohol paper prevention action 3	2.4 To ensure standardisation in the screening of alcohol intake	By 2017: all those undertaking screening and brief interventions in the region to be making use of the online HSE alcohol self-assessment tool	<ul style="list-style-type: none"> • ARAS • HALO • HSE
Alcohol paper prevention action 5	2.5 To assist, where possible, in the development of youth cafés and similar alcohol-free venues, especially in communities with large numbers of at-risk young people	2015: Functional youth café in Kildare (The Hive)	<ul style="list-style-type: none"> • TF staff • DPEI
Alcohol paper prevention action 7	2.6 To integrate drug prevention and intervention initiatives for at-risk young people	By 2017: written referral protocols in places for all relevant services	<ul style="list-style-type: none"> • An Garda Síochána • DPEI • HALO • HSE • KWETB

AIM 3: To contribute to the provision of appropriate treatment and rehabilitation options within our region

INTENDED OUTCOMES: IMPROVED INFORMATION FLOWS; INCREASED AWARENESS ABOUT AVAILABLE SERVICES; INCREASE IN NUMBER OF AVAILABLE SERVICES; IMPROVED PATHWAYS BETWEEN SERVICES; INCREASED NUMBERS OF PEOPLE AVAILING OF SERVICES; INCREASED OPPORTUNITIES FOR SERVICE USER VOICES TO BE HEARD; ENHANCED OPPORTUNITIES FOR THOSE AT THE END OF THE RECOVERY JOURNEY

Statutory guideline	TF objective	TF target	TF responsibility
Alcohol paper treatment & rehabilitation actions 1, 2, 5, 8, 13, 15, 16, 17, 19	<p>3.1 To ensure work on alcohol treatment and rehabilitation within the region is both in line with national developments and supports national developments</p> <p>[This objective relates to: Clinical Directorate; early intervention guidelines; regulatory standards development; specialist detoxification; Hidden Harm; intervention programme for young people who have come to attention of An Garda Síochána/Probation Service; alcohol dependent prisoners; use of alcohol amongst specified groups within the population; National Addiction Training Programme]</p>	<p><i>Support of national leads by informing them of relevant alcohol treatment and rehabilitation issues arising within the region, on an ongoing basis and using available fora</i></p> <p><i>Dissemination of relevant national information at local level</i></p>	<ul style="list-style-type: none"> • All TF members • ARAS • HALO
Alcohol paper treatment & rehabilitation action 20	<p>3.2 To raise awareness about alcohol treatment and rehabilitation services (including aftercare)</p>	<p>2015: research completed and publicised on available services and gaps in region 2016: strategy drawn up for increasing range of services (including outreach) 2017: identification of early successes</p>	<ul style="list-style-type: none"> • ARAS • Cuan Mhuire • Other TF members • Rehabilitation Coordinator
Alcohol paper treatment & rehabilitation action 6	<p>3.3 To increase the range of evidence-based psychosocial interventions in tier 3 and 4 services (including aftercare)</p>	<p>2015: research completed and publicised on available services and gaps in region 2016: strategy drawn up for increasing range of services (including outreach) 2017: identification of early successes</p>	<ul style="list-style-type: none"> • Cuan Mhuire • HSE • Probation Service

Alcohol paper treatment & rehabilitation action 7	<p>3.4 To increase the range of drugs-related child and adolescent services (including aftercare)</p> <p>[This objective relates to the roll-out of Tusla and Meitheal]</p>	<p>2015: research completed and publicised on available services and gaps in region</p> <p>2016: strategy drawn up for increasing range of services (including outreach)</p> <p>2017: identification of early successes</p>	<ul style="list-style-type: none"> • HALO • HSE
Alcohol paper treatment & rehabilitation action 12, 14 & NDS action 41	<p>3.5 To support families experiencing dependency problems using evidence-based interventions (including aftercare)</p> <p>[Also see objective 2.3]</p>	<p>Delivery of HALO substance misuse information and awareness programme</p> <p>2015: research completed and publicised on available services and gaps in region</p> <p>2016: strategy drawn up for increasing range of family support services</p> <p>2017: identification of early successes</p>	<ul style="list-style-type: none"> • ARAS • DPEI • Family Support Network • HALO • HSE
Alcohol paper treatment & rehabilitation action 11 & RWGR integrated rehabilitation service action 2, 3, 14	<p>3.6 To formulate and implement agreed protocols for integrated treatment and rehabilitation services, including service level agreements so that there is clarity on the roles and responsibilities of each party</p>	<p>2015: clarity achieved on National Rehabilitation Framework Working Group/Treatment & Rehabilitation Subgroup, Rehabilitation Coordinator appointed and mapping exercise completed</p> <p>2016: protocols drawn up in line with national protocols</p> <p>2017: service level agreements drawn up in line with protocols</p>	<ul style="list-style-type: none"> • ARAS • HSE • Other TF members • Rehabilitation Coordinator
RWGR medical support action 7	<p>3.7 To enable access to medical support across TF areas (including aftercare)</p>	<p>By 2017: to have explored all options for developing medical support access across all neighbouring L/RDATFs</p>	<ul style="list-style-type: none"> • ARAS • HSE • Rehabilitation Coordinator
RWGR employment action 6 & NDS action 42	<p>3.8 To provide increased opportunities for service users and ex-service users to support each other on the journey to recovery, including, where appropriate, into mainstream employment</p>	<p>2015/6: ASK Users Forum and Kildare Addiction Services CE scheme operating sustainably</p> <p>2016/7: additional (ex-)service user initiatives developed as appropriate</p>	<ul style="list-style-type: none"> • ARAS • ASK Users Forum • Kildare LEADER Partnership

<p>RWGR housing actions 6, 7</p>	<p>3.9 To enable recovering drug users to return to their former community or move into a new community (this requires a contact point in local authorities to whom matters arising in relation to tenancy issues for people in rehabilitation may be directed)</p>	<p>Local authority contact points established: 2015: Co. Kildare 2016: Co. Wicklow 2017: Dublin</p>	<ul style="list-style-type: none"> • Kildare Co. Council • Elected representatives
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AIM 4: To contribute to the alcohol research agenda

INTENDED OUTCOMES: INCREASED KNOWLEDGE ABOUT ALCOHOL MISUSE; IMPROVED UNDERSTANDING ABOUT ALCOHOL MISUSE; IMPROVED PRACTICE FOR DEALING WITH ALCOHOL MISUSE

Statutory guideline	TF objective	TF target	TF responsibility
Alcohol paper research actions 1, 3	4.1 To ensure that high quality relevant alcohol research is undertaken and disseminated to stakeholders	<i>Participation as required in national and other research</i> <i>Dissemination of research information at regional level as it becomes available</i>	<ul style="list-style-type: none"> All TF members

AIM 5: To ensure that our TF is fit-for-purpose

INTENDED OUTCOMES: INCREASED CLARITY ABOUT ROLES AND RESPONSIBILITIES; IMPROVED COMMUNICATION; HIGHER LEVEL OF AWARENESS OF SWRDATAF; GREATER ABILITY TO ACHIEVE OTHER AIMS

Statutory guideline	TF objective	TF target	TF responsibility
All	<p>5.1 To have TF members who understand and are fully committed to fulfilling their responsibilities for collective action</p>	<p>Formal commitment made by each TF member to implement strategic plan</p> <p>Succession plans in place and all TF vacancies filled</p> <p>No TF members to remain in place beyond their recommended terms of office</p> <p>Minimum 75% TF meeting attendance rate</p> <p>Induction and other training provided as necessary</p>	<ul style="list-style-type: none"> All TF members
	<p>5.2 To have a fully functioning structure for the TF (to include: monthly meetings of the TF with strategy implementation as the primary focus; monthly meetings of the Finance Subgroup; regular meetings of any time-limited working groups established by the TF)</p>	<p>2015: Finance Subgroup terms of reference reviewed and implemented and TF meetings agenda reconfigured (see Appendix 9)</p>	<ul style="list-style-type: none"> Finance Subgroup
	<p>5.3 To support the positive involvement of the projects funded by the TF (and others) into the work of the TF</p>	<p>2015: decision made about inviting funded projects to become members of TF or setting up of alternative communication structures</p> <p>Ongoing support and monitoring of funded projects</p>	<ul style="list-style-type: none"> All TF members <ul style="list-style-type: none"> ACAR ARAS DPEI HALO

	<p>5.4 To secure additional resources to support the work of the TF and initiatives in the region (to include further statutory funding, non-statutory funding and non-financial resources)</p>	<p>Significant additional resources secured for West Wicklow Funding sourced for the position of Rehabilitation Coordinator post-2015</p>	<ul style="list-style-type: none"> • All TF members
	<p>5.5 To publicise the TF and the full continuum of services in the region, as well as other relevant developments, using the TF website and social media channels</p>	<p>2015: basic interim website put in place and strategy developed for a new website and social media presence 2016: new website launched 2017: use of appropriate social media to support new website</p>	<ul style="list-style-type: none"> • TF staff
	<p>5.6 To maintain a quality administrative function, streamlining as necessary</p>	<p>2015: audit undertaken of administrative processes/time spent 2016: time-saving recommendations implemented 2017: review of new processes completed</p>	<ul style="list-style-type: none"> • TF staff

A NOTE ON RISKS:

The ultimate success, or otherwise, of this strategy is dependent on whether it is in fact implemented. It must not be allowed to gather dust on a shelf and should be publicised widely. The TF must build on its strengths and seize arising opportunities, as well as overcome its weaknesses and manage any threats (see section 4). Not doing so would not only leave it highly exposed to external forces, but would also mean that the outcomes that are being sought would not be realised. It is vital that aim 5, which is essentially an internal goal, is attended to at the earliest opportunity, because the TF must be structured, led and operated in a way that allows it to flourish, in order that it may have a chance of achieving aims 1-4. None of this can be done without resources. The multi-stakeholder model of the TF, and the uncertainty of statutory funding levels for the TF, mean that the plan has not been costed; this in itself is a risk that must be managed carefully throughout the lifetime of the strategic plan.

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Appendix 1: Revised Terms of Reference for L/RDATFs 2014

- To coordinate the implementation of the NDS in the context of the needs of the region/local area
- To implement the actions in the NDS where TFs have been assigned a role
- To promote the implementation of evidence-based local/regional drug and alcohol strategies and to exchange best practice
- To support and strengthen community based responses to drug and alcohol misuse
- To maintain an up-to-date overview on the nature and extent of drug and alcohol misuse in the area/region
- To identify and report on emerging issues and advocate for the development of policies or actions needed to address them
- To monitor, evaluate and assess the impact of the funded projects and their continued relevance to the L/RDTF strategy and to recommend changes in the funding allocations as deemed necessary

Appendix 2: Role of L/RDATFs as laid out in the NDS (interim) 2009-2016

Supply reduction

Action 3: 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.

(other players: DEHLG (lead); DJELR; Local Authorities; An Garda Síochána)

Action 4: Foster community engagement in areas most affected by the drug problem through the establishment and support of appropriate drug networks.

(other players: OMD; C&V sectors)

Prevention

Action 19: 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.

(other players: OMD (lead); HSE; DES; OMCYA; An Garda Síochána; Service Providers)

Action 28: Develop a sustained range of awareness campaigns that:

- 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 coordinated approach by all key players to the development and implementation of a designated drug/alcohol awareness week/day with agreed themes and methodologies;
 - Target:
 - o 3rd level educational institutions, workplaces and recreational venues;
 - o at risk groups (Travellers, new communities, LGBTs, homeless people, prisoners, sex workers);
 - o education/awareness among drug users to minimise the levels of usage and to promote harm reduction measures
- (other players: HSE (lead); other relevant agencies)*

Action 29: Develop a series of prevention measures that focus on the family under the following programme headings:

- Supports for families experiencing difficulties due to drug/alcohol use;
- Parenting skills;
- Targeted measures focusing on the children of problem drug and/or alcohol users aimed at breaking the cycle and safeguarding the next generation

(other players: HSE and DESS (joint leads); OMCYA; DSFA; Service Providers)

Action 30: Develop selective prevention measures aimed at reducing underage and binge drinking.

(other players: HSE (lead); DHC; Service Providers)

Treatment & rehabilitation

Action 41: Support families trying to cope with substance-related problems, in line with the recommendations of the Report of the Working Group on Drugs Rehabilitation.

(other players: HSE (lead); FSA; Depts and Agencies; FSN; C&V sectors)

Action 42: Continue to develop and expand: (i) Service User Fora; and (ii) Drug User Fora in line with the recommendations of the Report of the Working Group on Drugs Rehabilitation.

(other players: (i) HSE (lead); (ii) OMD; C&V sectors)

Appendix 3: Role of L/RDATFs as laid out in the Report of the Working Group on Rehabilitation 2007

Integrated rehabilitation service

Action 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.

Responsibility: Rehabilitation Co-ordinators in conjunction the Treatment and Rehabilitation Sub-Groups of the Drugs Task Forces (lead on drawing up), NDRIC (lead on approval).

Action 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.

Responsibility: Rehabilitation Coordinators in conjunction with (i) NDRIC (lead on drawing up national level/ approval local level), (ii) the Treatment and Rehabilitation Sub-Groups of the Drugs Task Forces (lead on drawing up local), IDG (lead on approval national level).

Action 14: As Treatment and Rehabilitation Sub-groups of Drugs 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.

Responsibility: NDST (lead), Drugs Task Forces.

Medical support

Action 7: The possibility of developing cross Drugs Task Force facilities should be explored.

Responsibility: Rehabilitation Co-ordinators (lead), Drugs Task Forces, NDST.

Employment

Action 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.

Responsibility: Drugs Task Forces (lead), Rehabilitation Co-ordinators.

Housing

Action 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.

Responsibility: DEHLG (lead), Drugs Tasks Forces.

Action 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.

Responsibility: DEHLG (lead), Drugs Task Forces.

Appendix 4: Possible role of L/RDATFs in relation to alcohol as identified by the NCC 2014

Supply

Action 3: With respect to Section 16 of the Intoxicating Liquor Act 2008 (sale, supply and consumption of alcohol),

- develop and implement an enforcement mechanism; and
- make regulations under Section 16 (1), (b) and (c) of that Act.

Lead agency: DH, DJE

Outside the scope of DATFs. However, through the mechanisms of JPCs, CPFs and Supply Control sub-committees DATFs can play a role in gathering information in relation to enforcement of legislation on alcohol sales and supply and in providing information to Gardaí for enforcement purposes. DATFs may also wish to advocate in this area.

Action 5: Develop proposals for an all-island initiative in relation to alcohol issues including alcohol availability, treatment and health promotion.

Lead agency: DH, DJE

DATFs can play a role in supporting and informing the national lead where appropriate, and disseminating information at local level.

Action 6: Introduce a statutory code of practice on the sale of alcohol in the off-licence sector.

Lead agency: DH

Outside the scope of DATFs. However, DATFs can through the JPCs, CPFs and Supply Control sub-committees monitor compliance with legislation on alcohol sales and provide information to Gardaí for enforcement purposes. DATFs may also wish to advocate in this area.

Action 7: Provide that the HSE may object to the granting of a court certificate for a new licence and to renewal of licences.

Lead agency: DJE

Outside the scope of DATFs. However, DATFs can play a role in statutory actions through the mechanisms of JPCs, CPFs and Supply Control sub-committees in gathering information in relation to enforcement of legislation on alcohol sales and supply and in providing information to Gardaí for enforcement purposes. DATFs may also wish to advocate in this area. For example, DATFs can provide information to the general public on the methods and grounds for objecting to the granting or renewal of licences in the local area. DATFs may wish to keep the HSE informed via their HSE rep.

Action 8: Establish standards for server training programmes in the on-trade and the off trade. Provide that participation by licensees and staff in such programmes is a condition of the licensing process.

Lead agency: DH, DJE

DATFs can play a role in supporting and informing the national lead where appropriate, and disseminating information at local level. In this instance, the HSE will develop national standards for safe serving training, and DATFs may wish to deliver or support such programmes in their area.

Action 9: Develop a system to monitor the enforcement of the provisions of the intoxicating liquor legislation:

- to ensure consistency of application across all Garda regions; and
- concerning the sale, supply or delivery of alcohol to minors, with particular emphasis on age verification.

Lead agency: Garda Síochána

Outside the scope of DATFs. However, DTFs can play a supporting role through the mechanisms of JPCs, CPFs and Supply Control sub-committees in gathering information in relation to enforcement of legislation on alcohol sales and supply and in providing information to Gardaí for enforcement purposes. DATFs may also wish to advocate in this area.

Action 10: Consider, having regard to enforcement constraints, the possible need to strengthen the legislative controls on distance sales.

Lead agency: DJE (lead), Garda Síochána

Outside the scope. However, DATFs can play a role in statutory actions through the mechanisms of JPCs, CPFs and Supply Control sub-committees in gathering information in relation to enforcement of legislation on alcohol sales and supply and in providing information to Gardaí for enforcement purposes. DATFs may also wish to advocate in this area.

Action 11: Introduce the following measures to further counter drink-driving:

- introduce appropriate hospital procedures to provide alcohol testing of drivers who are taken to hospital following fatal/injury collisions;
- introduce driver rehabilitation programmes for repeat drink-driving offenders and those at high risk of re-offending;
- provide for the use of alcohol ignition interlocks as a sentencing option for those convicted of repeat drink driving offences; and
- monitor and regularly publish the volume of driver alcohol testing, including mandatory alcohol testing, undertaken by An Garda Síochána on a county and national basis.

Lead agency: DTTS (lead), RSA, HSE (Lead on Bullet Point 1), Garda Síochána

Outside the scope of DATFs - however, DATFs may wish to play an awareness-raising role at local level.

Prevention

Action 1: Seek greater co-ordination of prevention activities at both national and local levels. Such activities should, where feasible, utilise ICT and consider a social marketing approach, to target:

- underage drinking;
- drink-related anti-social behaviour/public order offences;
- excessive drinking generally;
- those who are pregnant or likely to become pregnant; and
- other specific at-risk groups.

Lead agency: HSE (lead), Depts and agencies, voluntary, community and commercial sectors

DATFs can play a role in supporting and informing the national lead where appropriate, and disseminating information at local level. In this instance, the HSE will develop a national branded campaign, and DATFs may wish to inform and support the campaign in their area, through community mobilisation.

Action 2: Further develop a co-ordinated approach to prevention and education interventions in relation to alcohol and drugs as a co-operative effort between all stakeholders in:

- educational institutions (including third level);
- sporting organisations;
- community services;
- youth organisations and services; and
- workplaces.

Lead agency: HSE and DCYA (Co-leads), An Garda Síochána, DTFs

(i) DES

(ii) DTTS (iii) DCYA (iv) DJEI

DATFs have a major role to play in community engagement and endorsement of all the actions of the NSMS, and specifically in the Prevention Education area. It is envisaged that DH, HSE and DATFs will work closely in this area to support community mobilisation activities. Some DATFs will have existing experience in cross-cutting prevention actions and their experience will be valuable.

Action 3: The alcohol screening tools used by health professionals should reflect the Irish standard drink (10 grams). The low-risk weekly guidelines for women should be to consume less than 112 grams of pure alcohol per week (11 standard drinks per week) and for men to consume less than 168 grams per week (17 standard drinks per week). Develop and implement more detailed clinical guidelines for health professionals relating to the management of at-risk patients.

Labels on alcohol products sold in Ireland should include the number of grams of alcohol per container, along with calorific content and health warnings in relation to consuming alcohol in pregnancy.

Lead agency: DH, (lead) HSE, professional bodies

DATF can play a role in supporting and informing the national lead where appropriate, and disseminating information at local level. In this instance, the HSE have developed an online alcohol self-assessment tool that DATFs may wish to support and encourage the use of in screening and brief interventions

Action 4: Continue the development and monitoring of SPHE in schools and Youthreach centres for education programmes through:

- implementing the recommendations of (i) Inspectors' reports in relation to all schools and Youthreach centres for education and (ii) the SPHE evaluation (National University of Ireland Galway 2007) in post-primary schools;
- rolling-out a senior cycle school programme; and
- introducing (i) national guidelines for educational materials and (ii) national standards for teacher training, in relation to SPHE.

Lead agency: DES (lead)

While the DES has lead responsibility for this action, DTFs can utilise existing structures to monitor and support evidence based approaches to delivery of SPHE in schools

Action 5: Encourage the provision of alcohol-free venues for young people, with an emphasis on those most at risk (e.g. youth cafés, alcohol-free music and dance venues and sports venues), with:

- the young people being centrally involved in the development and management of the programmes and venues;
- late night and weekend opening; and
- increased access to school facilities in out-of-school hours.

Lead agency: DCYA (lead), DES

DATFs have been actively involved in developing youth cafés and facilities and can continue to identify gaps, advocate and lobby for further provision

Action 6: Further develop prevention measures aimed at families in relation to alcohol misuse (including prevention measures in relation to parental alcohol problems and the effect of this on children):

- at a broad level for all families; and
- aimed at families deemed to be at risk.

Lead agency: HSE (lead), DCYA, DES

DATFs should continue their information dissemination and advocacy role at local level in support of the national roll out of this action. In this instance, the HSE and Tusla Hidden Harm project has been established and DATFs in the relevant areas may wish to support the project and the development of a Hidden Harm protocol.

Action 7: Develop and incorporate a drugs/alcohol intervention programme, with referral to specialist services where required, into schemes aimed at youth at risk, including the SPY, the Garda Juvenile Diversion Programme and the Garda Youth Diversion Projects.

Lead agency: An Garda Síochána (lead), DCYA, HSE, community and voluntary youth services

DATFs and the projects they support can continue their interagency coordination and referral work in this area

Treatment & rehabilitation

Action 1: Establish a Clinical Directorate to develop the clinical and organisational governance framework that will underpin treatment and rehabilitation services. The Directorate will also build the necessary infrastructure required to improve access to appropriate interventions and treatment and rehabilitation services for clients with alcohol/substance use disorders.

Lead agency: HSE Directorate (lead), ICGP, CPI, voluntary and community sectors

DATFs currently promote best practice, quality assurance and good governance and it is envisaged that this role will continue in support of the HSE as lead agency

Action 2: Develop early intervention guidelines for alcohol and substance use across all relevant sectors of the health and social care system. This will include a national screening and brief intervention protocol for early identification of problem alcohol use.

Lead agency: HSE Directorate (lead), voluntary and community sectors

DATFs may continue their information dissemination and advocacy role at local level in support of the national roll out of this action. DATFs can also play a role in supporting the roll-out of the HSE SAOR screening and brief intervention training at local level.

Action 5: Develop regulatory standards for all tier 3 and tier 4 services with regard to substance misuse.

Lead agency: HIQA (lead)

Outside the scope of DATFs, but they could play a role in supporting and informing the national lead where appropriate, and disseminating information at local level, in particular via the Grant Aid Agreement monitoring & evaluation process

Action 6: Develop and broaden the range of evidence-based psychosocial interventions in tier 3 and tier 4 services.

Lead agency: HSE Directorate (lead), voluntary and community sectors

DATFs can identify gaps and build capacity of services in their operational areas to develop and broaden range of evidence based interventions, linking with the HSE National Addiction Training programme. To be monitored via Grant Aid Agreement.

Action 7: Using the recommendations of the 'Report of the Working Group on Treatment of Under-18 year olds Presenting to Treatment Services with Serious Drug Problems' (2005) as a template:

- identify and address gaps in child and adolescent service provision;
- develop multi-disciplinary child and adolescent teams; and
- develop better interagency co-operation between addiction and child and family services.

Lead agency: HSE (lead)

Key role for DATFS in supporting the implementation of this recommendation and engaging in local/regional rollouts of Tusla and Meitheal

Action 8: Develop a specialist detoxification service that:

- promotes the expansion of nurse prescribing in alcohol detoxification;
- provides a number of clinical detox in-patient beds for clients with complex needs; and
- provides community detox for those with alcohol dependency problems.

Lead agency: HSE Directorate (lead), voluntary and community sectors

Outside the scope of DATFs, but they can play a role in supporting and informing the national lead where appropriate, and disseminating information at local level

Action 11: Establish a forum of stakeholders to progress the recommendations in A Vision for Change in relation to establishing clear linkages between the addiction services, primary care services, community mental health teams and specialist mental health teams to facilitate the required development of an integrated approach to service development, including:

- developing detoxification services;
- ensuring availability of, and access to, community- based, appropriate treatment and rehabilitation services through the development of care pathways; and
- ensuring access to community mental health teams where there is a co-existing mental health condition.

Lead agency: HSE Directorate (lead)

DATF can play a role, as stakeholder, in the implementation of this action, specifically at Treatment and Rehabilitation Sub-committee level, within the context of the Rehabilitation Framework

Action 12: Develop a comprehensive outcomes and evidence- based approach to addressing the needs of children and families experiencing alcohol dependency problems. This would involve a whole-family approach, including the provision of supports and services directly to children where necessary. This approach should be guided by and coordinated with all existing strategies relating to parenting, children and families and in accordance with edicts from the Office for the Minister for Children and the Child and Family Support agency.

Lead agency: HSE Directorate (lead), DCYA, voluntary and community sectors, Family Support Network

DATFs may play a role in supporting the national lead (possibly Tusla) where appropriate, in the implementation of this action through promoting outcomes and evidence-based approaches to work with children and families experiencing alcohol dependency problems.

Action 13: Explore the extent of parental problem substance use through the development of a strategy, along the lines of the Hidden Harm Report in Northern Ireland, and respond to the needs of children of problem substance use by bringing together all concerned organisations and services. This could be developed through links with Cooperation and Working Together, dedicated to health gain and social wellbeing in border areas.

Lead agency: HSE Directorate (lead), DCYA, voluntary and community sectors, Family Support Network

DATFs may play a role in supporting and informing the national lead (possibly Tusla) where appropriate, and disseminating information at local level. In this instance, the HSE and Tusla Hidden Harm project has been established and DATFs in the relevant areas may wish to support the project and the development of a Hidden Harm strategy.

Action 14: Develop family support services, including:

- access to information about addiction and the recovery process for family members;
- peer-led family support groups to help families cope with problematic drinking;
- evidence-based family and parenting skills programmes;
- the reconciliation of problem drinkers with estranged family members where possible; and
- the development of a short-stay respite programme for families of problem drinkers.

Lead agency: HSE Directorate (lead), DCYA, voluntary and community sectors, Family Support Network

DATFs may play a role in supporting and informing the national lead (possibly Tusla) where appropriate, and disseminating information at local level

Action 15: Develop a drugs/alcohol intervention 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.

Lead agency: DJE (lead), Probation Service, An Garda Síochána

DATFs can continue their information dissemination and advocacy role at local level in support of the national roll out of this action, which is similar to Action 38 of the NDS. Roll out via the DATF mechanism is a possibility.

Action 16: Continue the expansion of treatment and rehabilitation services in prisons to include treatment for prisoners who have alcohol dependency. Develop protocols for the seamless provision of treatment and rehabilitation services for people with alcohol problems as they move between prison and the community.

Lead agency: Irish Prison Service (lead); Probation Service; HSE Directorate

Outside the scope of DATFs, but they may play a role in supporting and informing the national lead where appropriate, and disseminating information at local level

Action 17: Address the treatment and rehabilitation needs of the following specified groups in relation to the use of alcohol: members of the Traveller community; members of the lesbian, gay, bisexual and transgender community; new communities; and sex workers. This should be facilitated by engagement with representatives of these communities, and/or services working with the communities, as appropriate.

Lead agency: HSE Directorate (lead)

DATFs can continue their information dissemination and advocacy role at local level in support of the national roll out of this action

Action 19: Co-ordinate the provision of training within a single national substance misuse framework, i.e. National Addiction Training Programme.

Lead agency: HSE Directorate (lead)

Outside the scope of DATFs - DATFs may link with the National Addiction Training Programme in this regard re their training needs

Action 20: Collate, develop and promote greater awareness of information on alcohol treatment and rehabilitation services.

Lead agency: HSE Directorate (lead)

Participation of DATFs will be key - local coordination of the national aspect

Research

Action 1: Continue to implement and develop, as appropriate, epidemiological indicators and the associated data collection systems, to identify:

- prevalence and patterns of alcohol use and misuse among the general population;
- prevalence and patterns of alcohol use among specific sub-groups;
- demand for alcohol treatment;
- alcohol-related deaths and mortality of alcohol users; • public expenditure; and
- harm reduction.

Lead agency: HRB & NACD (joint leads)

DATFs can carry out local research and participate in national work as required

Action 3: Disseminate alcohol research findings and models of good practice to all relevant statutory, community and voluntary sector organisations.

Lead agency: HRB & NACD

Outside the scope of DATFs, but they may play a role in disseminating information at local level

Appendix 5: SWRDATAF members March 2015

Chairperson

Tommy Skehan (independent)

Elected representatives

CLlr Mick Duff, South Dublin Co. Council (Tallaght Central)
CLlr Teresa Murray, Kildare Co Council (Maynooth)
CLlr Gerry O'Neill, Wicklow Co. Council (Baltinglass)

Statutory sector representatives

Jerry Keohane, An Garda Síochána
Esther Wolfe, HSE (Addiction Services)
Justin Parkes, HSE (Primary Care)
Lorraine O'Sullivan, Kildare and Wicklow Education and Training Board
George Perry, Kildare Co. Council (Housing Department)
Deirdre Matthews, Probation Service
Brian Mullaly, Revenue (Customs)

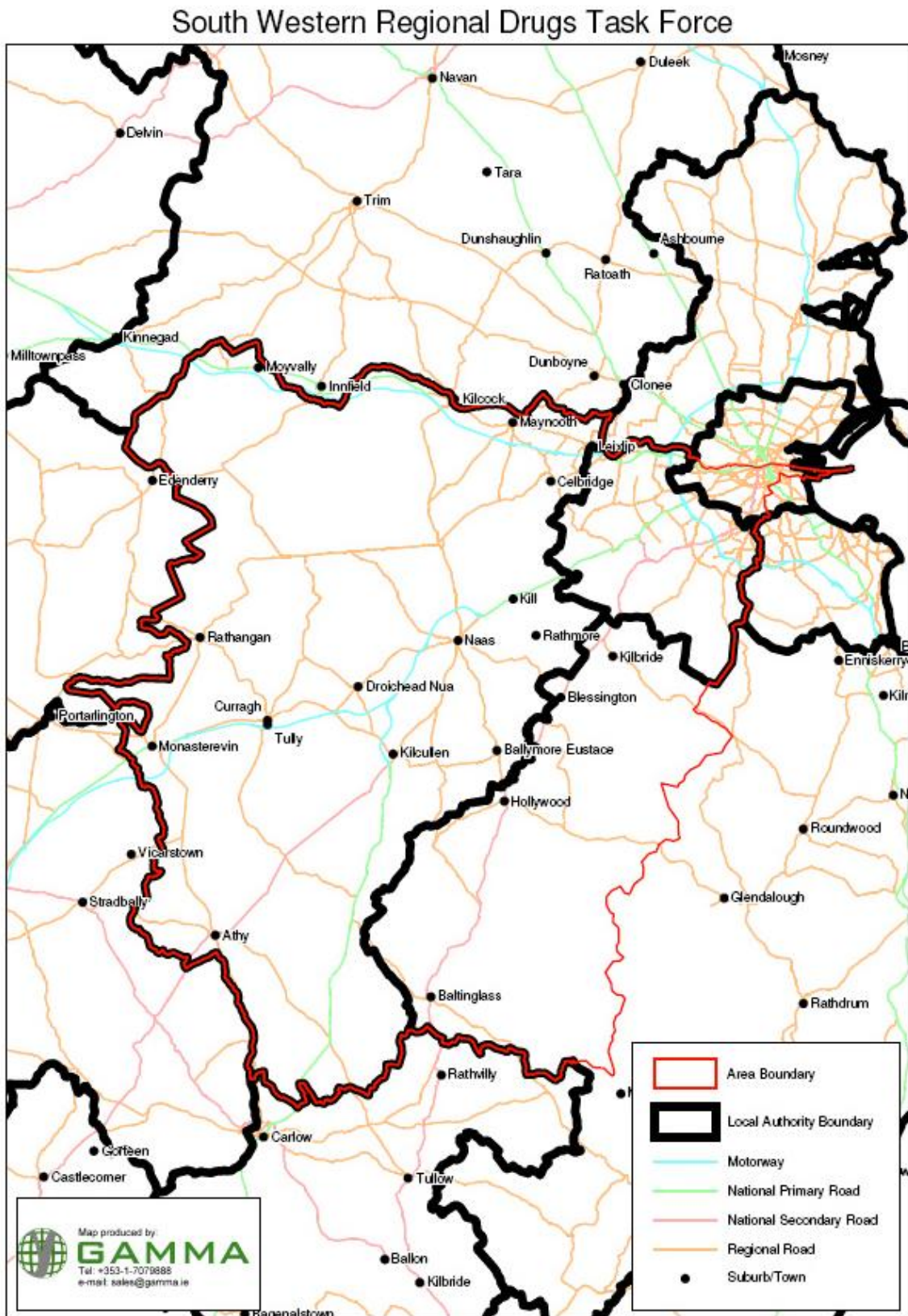
Voluntary sector representatives

Mick McTague, Voluntary Drug Treatment Network (Cuan Mhuire)
Pat Leogue, Co. Kildare LEADER Partnership

Community sector representatives

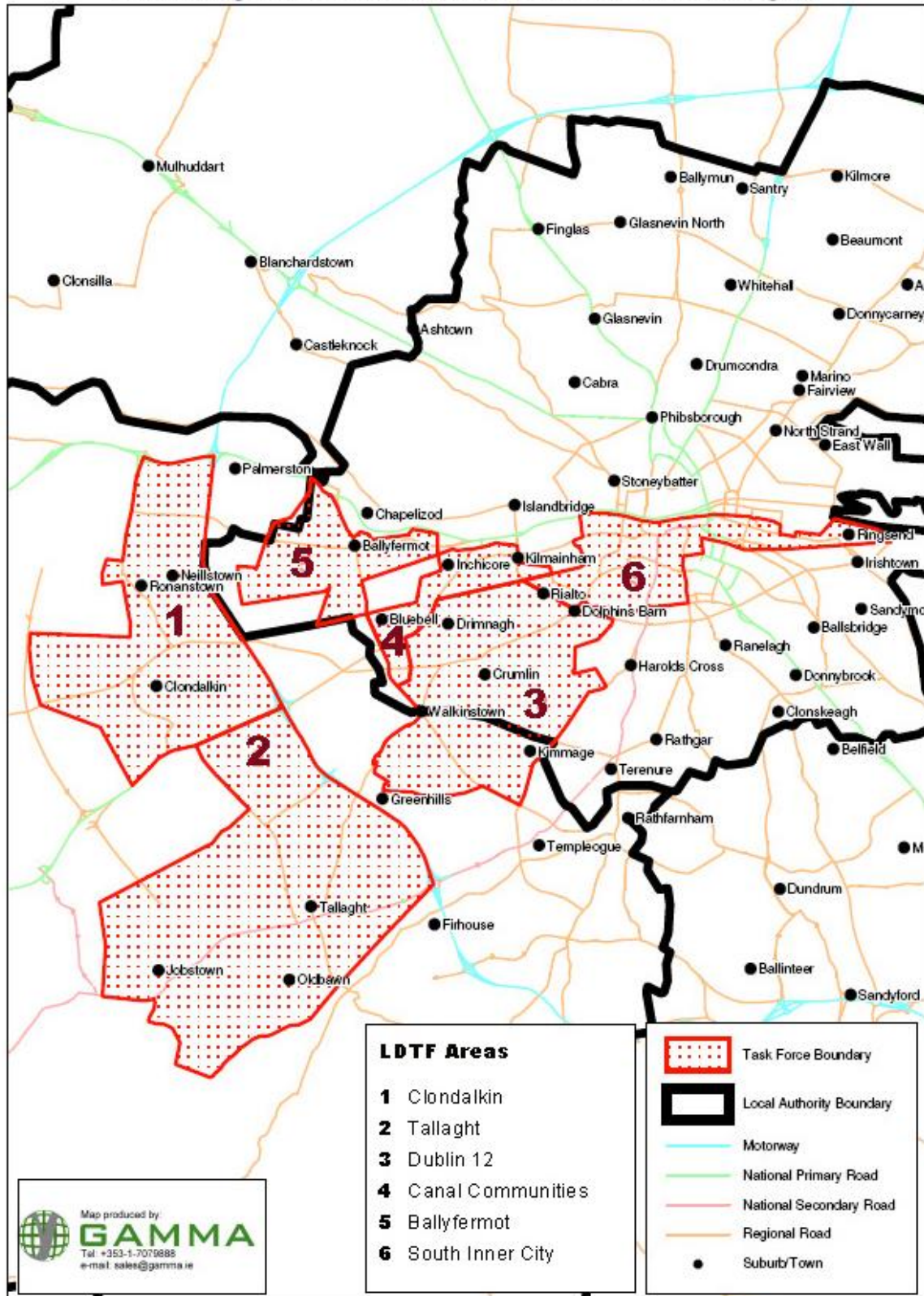
Mark Corkish, ASK Users Forum
Carmel Cashin, Blessington and District Forum
Stella McAuliffe, Family Support Network (Ellen Family Support Group)
PJ Fagan, Kildare Community and Voluntary Forum

Appendix 6: SWRDATF catchment area



Appendix 7: LDTFs within the SWRDATF boundary

Local drug task forces within the south western region



Appendix 8: Activities not included in plan

This listing of consultee suggestions is included for completeness. The activities below all have merit and may at some point be incorporated into the work of the TF or adopted by a more appropriate stakeholder. However, they are not deemed a priority at this point in time. TF staff members are additionally advised to reconsider the full range of meetings that they attend on a regular basis.

- Enforce bye-laws about drinking alcohol in public places (An Garda Síochána responsibility)
- Secure a site for the HSE treatment centre (HSE responsibility)
- Active lobbying of policy makers and the judiciary
- Using meaningful role models like Katie Taylor to divert young people away from the temptation of alcohol and other drugs
- Involving celebrities who are recovered drug users into the TF's work
- Funding youth workers
- Enabling greater links between Youthreach and other agencies working with the same age group
- Develop initiatives to destigmatise those who seek support for their problem substance use
- Training teachers, nurses, pharmacists, church leaders and Gardaí in how to interact with those who are drug-dependent
- Making attendance at a drugs awareness course compulsory for parents with children in sixth class of primary school
- Develop practical supports (for example, home help) for families in distress due to drugs misuse
- Establish a Family Support Subgroup of the TF
- Employ a Family Support Coordinator for the region
- Develop service level agreements with family support groups, ensuring linkages between funded and peer-led groups
- Expand Text Alert throughout the region
- Making presentations to Wicklow County Council

Appendix 9: Suggested revised agenda for TF meetings

- 1 Welcome
- 2 Present and apologies (*running tally of TF members' attendance to be kept alongside information about members' terms of office and affiliation*)
- 3 Approval of minutes of previous meeting (*written and previously circulated*)
- 4 Matters arising not covered elsewhere on the agenda (*with a specific focus on agreed action points from previous meetings*)
- 5 Correspondence
- 6 Approval of Finance Subgroup report (*written and previously circulated*)
- 7 Progress on Strategic Plan 2015-2017:

Aim 1: To contribute to a reduction in the ready availability of drugs within our region

Aim 2: To contribute to the prevention of harm caused by problem drug use in our region

Aim 3: To contribute to the provision of appropriate treatment and rehabilitation options within our region

Aim 4: To contribute to the alcohol research agenda

Aim 5: To ensure that our TF is fit-for-purpose

(Staff report to be written under the headings of the above 5 aims and previously circulated. All information in staff reports to be noted, unless being queried at meeting. Discussion time reserved for additional updates by TF members and for planning next steps. Agreed action points to be recorded in minutes.)

- 8 Additional substantive agenda item (*agreed at previous meeting or subsequently proposed by chairperson – aim to limit to one per meeting*)
- 9 Any other urgent business
- 10 Close (*to include confirmation of next meeting*)