National Drugs Strategy 2001-2008
Rehabilitation

Department of Community, Rural and Gaeltacht Affairs

Report of the Working Group on Drugs Rehabilitation, May 2007

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Department of Community, Rural and Gaeltacht Affairs

An Roinn Gnóthaí Pobail, Tuaithe agus Gaeltachta 2007

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Minister of State's Foreword

The development of a comprehensive policy for drugs rehabilitation represents a further deepening of the National Drugs Strategy. During the comprehensive consultation phase of the Mid-term Review of the National Drugs Strategy in 2005, rehabilitation emerged as a key issue. The main message was that, with the significant and ongoing expansion in treatment provision, there was a need to focus more closely and comprehensively on rehabilitation as the next step in the process.

Subsequently the report of the Mid-term Review recommended that rehabilitation should become the fifth pillar of the National Drugs Strategy and that a Working Group should be set up to develop an integrated rehabilitation provision. This report represents the culmination of the work of that Working Group on Drugs Rehabilitation.

I welcome the holistic interpretation of rehabilitation taken by the Working Group. Rehabilitation is not just about becoming drug-free, rather it is more about people regaining the capacity for daily life from the impact of drug use. The broad definition of rehabilitation utilised by the Working Group encompasses a structured development process focused on individuals, involving a continuum of care and aimed at maximising their quality of life and enabling their re-integration into communities.

The increased focus on rehabilitation again emphasises Government's commitment to addressing problem drug use in Ireland in a flexible way and in a spirit of consultation and partnership. I am convinced that the increased emphasis being given to rehabilitation as a pillar of the National Drugs Strategy will lead to significant advances in that area and will enhance the overall comprehensive strategy. Already some progress has been made in regard to rehabilitation, but the implementation of the recommendations of the Working Group will greatly accelerate this. At the same time, I know that the implementation of the recommendations will throw up challenges and present problems but, with all involved working together with a shared commitment to problem drug users, these can be overcome.

I would like to thank all involved in the production of this report, across Government Departments, Agencies and the Community and Voluntary Sectors. In particular, I thank the members of the Working Group on Drugs Rehabilitation.

Noel Ahern T.D.
Minister of State with responsibility for the National Drugs Strategy

Acknowledgements

I would like to thank all who contributed in so many ways to the production of this report. Numerous Government Departments, organisations and individuals made presentations, submissions and other inputs to the process and I am most grateful for their contributions.

In particular I thank the members of the Working Group on Drugs Rehabilitation for all their work. The members brought a variety of experiences to the table and their commitment to achieving a quality, comprehensive and achievable outcome in regard to rehabilitation for problem drug users lead to much robust, but amicable, debate. I hope that the implementation of the drugs rehabilitation structures and measures arising from this report will benefit from the participative approach adopted in the formulation of the recommendations.

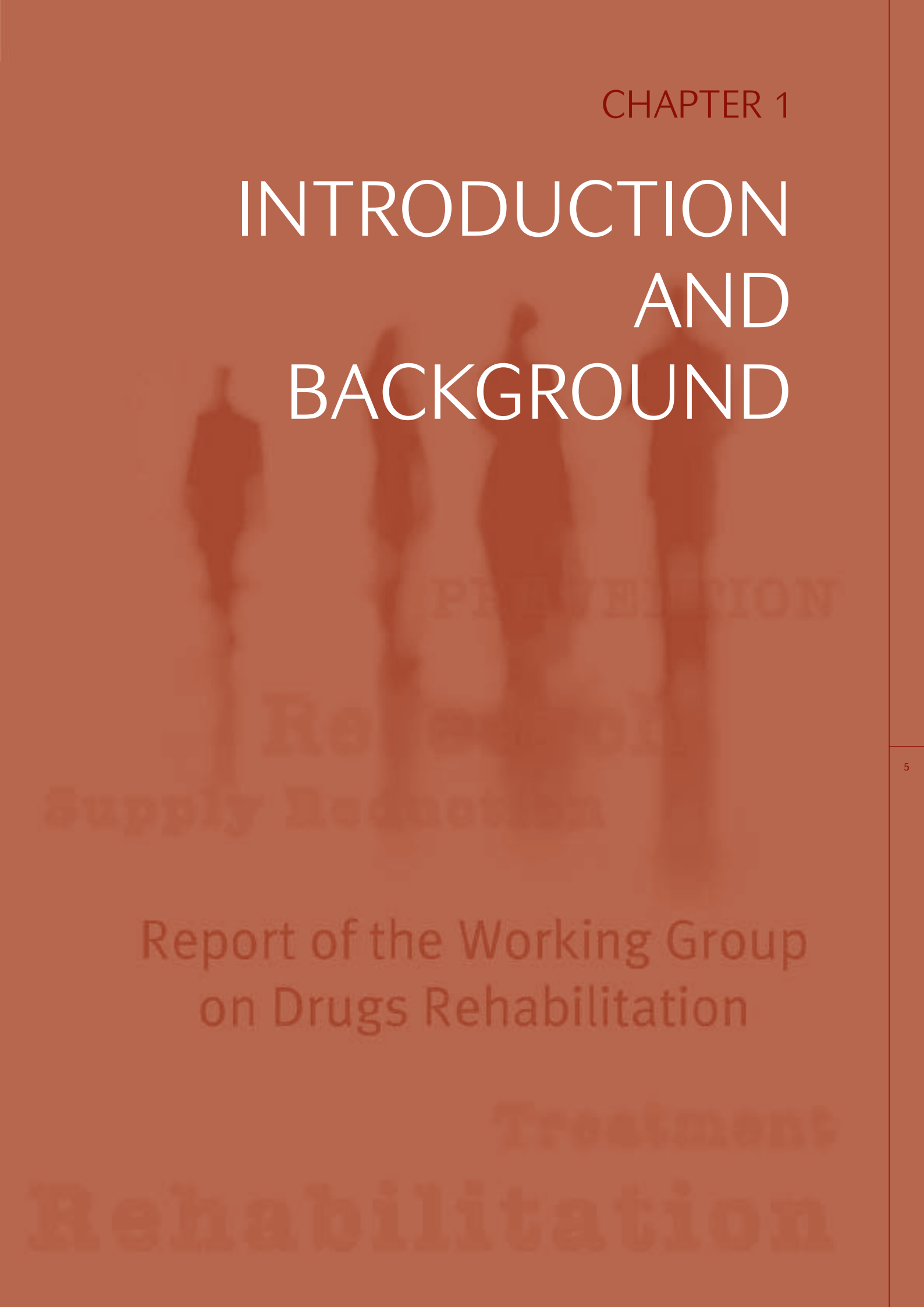
I also thank everybody in the Drugs Strategy Unit of the Department of Community, Rural & Gaeltacht Affairs for their help in the production of the report.

Michael Conroy
Chairperson

May 2007

CHAPTER 1

INTRODUCTION AND BACKGROUND



1 Introduction and Background

1.1 The Working Group on Drugs Rehabilitation arose from a recommendation in the Mid-Term Review of the National Drugs Strategy, which was published in June 2005. Extensive public consultations were conducted as part of the Mid-Term Review. Although it found that the current aims and objectives of the Drugs Strategy are fundamentally sound, the Review highlighted the need to re-focus priorities and accelerate the rollout of some of the Strategy's actions and a number of new actions and amendments were included. In this context, rehabilitation was identified by the Steering Group as an area that needed to be developed, particularly in light of the significant and ongoing expansion in treatment provision in recent years. In particular, the Steering Group stated in the Report that:

> *"…..The need for a rehabilitation element to the overall Strategy was a recurring theme during the consultations and was seen as essential in ensuring that drug users are not kept on methadone indefinitely. A clear definition of what rehabilitation is, and an identification of the agencies and groups that should be involved in providing such services, was called for throughout the consultation process. The emphasis throughout was that rehabilitation services need to be tailored to meet the client's needs and to flow seamlessly from treatment, as part of the continuum of care.*
>
> *Aftercare was seen as a key gap in terms of access to employment, sheltered and appropriate housing and relapse prevention and to break the cycle of drug dependence. The special Community Employment (CE) schemes for problem drug users and other FÁS schemes were mentioned in the consultation process as a very important element in the rehabilitation of problem drug users. However, there was a strong message throughout the consultation phase that there is a need for more rehabilitation services focussing on general life skills, as well as vocational opportunities[1] …."*

1.2 In this regard, a new action[2] was agreed which calls for rehabilitation to become the fifth pillar of the Strategy. The action recommended that a Working Group be set up to develop a strategy for the provision of integrated drugs rehabilitation services and to report to the Inter-Departmental Group on Drugs and to the Cabinet Committee on Social Inclusion on the appropriate policy and actions to be implemented. Accordingly, this Working Group was established in September 2005 and was chaired by the Department of Community, Rural and Gaeltacht Affairs. The Group consisted of representatives from relevant Departments and Agencies as well as representatives from the Community and Voluntary Sectors.[3]

1.3 The terms of reference of the Working Group on Rehabilitation were as follows:

On the basis of an agreed definition of drug rehabilitation and bearing in mind the recommendations of the Mid-Term Review and the existing provisions in the Strategy, the Group shall

- *examine the existing provision of rehabilitation services in Ireland;*
- *identify best practice;*
- *identify gaps; and*
- *recommend actions, including timeframes, to develop an integrated rehabilitation service.*

Members of the Group shall be representatives of their sectors and shall be in a position to obtain the commitment of their sectors to the actions agreed by the Group.

1.4. The National Drugs Strategy (2001-2008) was developed within the broader social inclusion context, and set within the broad policy frameworks of the National Development Plan, the National Action Plan against Poverty & Social Exclusion and the Social Partnership Agreements. In turn, the rehabilitation pillar of the Strategy is being developed within this broader context to support the social inclusion of recovering drug users through facilitating and supporting individuals to reintegrate into society, with significant benefits to families and communities. It will support the achievement of key strategies with respect to vulnerable groups generally, across such areas as health, education, employment and social affairs.

PROCESS

1.5 In order to assist and inform the Working Group, the National Advisory Committee on Drugs (NACD) prepared a paper based on a series of discussions within the NACD's Treatment/Rehabilitation Sub-Committee and the NACD main Committee. The paper addressed issues such as defining rehabilitation, the importance of rehabilitation, best

1 Mid-Term Review of the National Drugs Strategy 2001-2008, Report of the Steering Group, June 2005

2 Action 105 of the National Drugs Strategy

3 For a full list of Members of the Group see Appendix 1

practice in relation to rehabilitation and challenges to the implementation of rehabilitation strategies. The NACD also prepared a review of the literature evidence as to what constitutes best practice in drug rehabilitation. This work fed into the discussions of the Working Group.

1.6 The Working Group was conscious that the Mid-Term Review Report involved an extensive public consultation process. Over 120 written submissions were received. Presentations from over 25 Departments, agencies and community groups involved in delivering the Strategy were made to the Steering Group. In addition, five regional public seminars were held in Galway, Limerick, Waterford, Carrick-on-Shannon and Dublin. Rehabilitation featured strongly throughout this process. In this context, the Working Group on Rehabilitation decided to draw on the outcomes of this process rather than conduct a separate exercise.

1.7 However, to assist them, the Working Group decided to hold focussed meetings with various service providers, service users and their families, and experts in the field of rehabilitation. A list of those who attended these meetings can be found in Appendix 2. The issues raised were varied and wide-ranging and the Working Group focused, in particular, on a number of key issues of common concern.

DEFINITION OF REHABILITATION

1.8 The discussion paper produced by the NACD was used by the Working Group as a basis for its deliberations in relation to the definition of rehabilitation.

1.9 Due to the complex needs of drug users and the variety of possible approaches to treatment, a concise definition of rehabilitation is difficult. Some organisations view it as a distinct phase separate from treatment, while others view it as an integral part of the treatment process. It is also important to bear in mind that problem drug use exacerbates, and is exacerbated by, other difficulties in a person's life such as ill-health, poverty, unemployment, educational disadvantage, housing problems, fractured family and community relationships, criminal justice problems, etc. Consequently, treating drug misuse constitutes only part of the rehabilitation process.

1.10 Problem drug use is a chronic, often recurring, condition. As a result, rehabilitation is best understood as a process that supports and encourages drug users at each stage of their drug use (from those whose drug problem is severe and chaotic, to those who have stabilised, recovered or relapsed), and at each stage of their cycle of behavioural change – pre-contemplation, contemplation, action, maintenance, and relapse.

1.11 Rehabilitation can take place prior to, during, or after treatment and would therefore be accessible to current, stabilised and former drug users. At each stage of this process, it was agreed that all services should be client-centred and respond to the needs of drug users. The Working Group further agreed that there was no one treatment or rehabilitation programme which will be effective for everyone. This was particularly emphasised throughout the meetings with service providers and experts in the field of rehabilitation. The Working Group takes the view that the rehabilitation process should ideally begin from the first time the client accesses a service for problem drug use.

1.12 The Working Group discussed the issues surrounding the definition of rehabilitation in-depth and it was agreed that for the purposes of this work, rehabilitation is defined as:

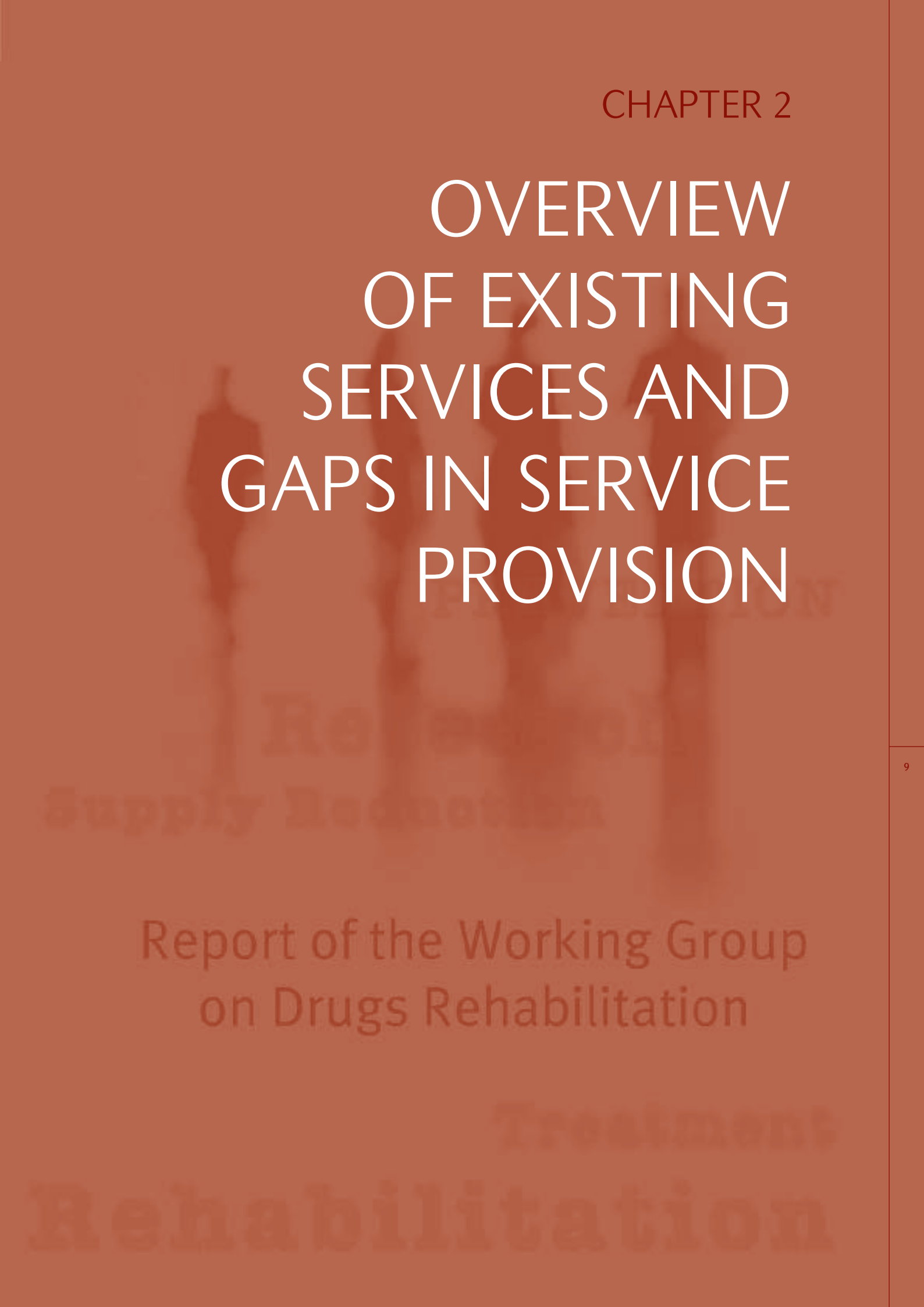
- *A structured developmental process whereby individuals are facilitated to become fully involved in the process of regaining their capacity for daily life from the impact of problem drug use;*
- *Providing a 'continuum of care' to problem drug users enabling them to address their needs, as most appropriate for them (these needs may include health, social, housing, employment, educational and/or vocational);*
- *Being aimed at maximising their quality of life, and that of their families and communities; and*
- *Enabling their re-integration into their community.*

The aim of this holistic process is to empower people so that they can access the social, economic and cultural benefits of life in line with their needs and aspirations. Drug rehabilitation, therefore, encompasses interventions aimed at stopping, stabilising and/or reducing the harm associated with a person's drug use as well as addressing a person's broader health and social needs.

1.13 Chapter 2 of the report provides on overview of existing service provision and gaps in this regard. Best practices in relation to rehabilitation are identified in Chapter 3 along with an outline of a proposed model of integrated service delivery and the role of Department and agencies involved in its delivery. Chapter 4 details the recommendations of the Working Group for the development of an integrated rehabilitation service.

CHAPTER 2

OVERVIEW OF EXISTING SERVICES AND GAPS IN SERVICE PROVISION



2 Overview of Existing Services and Gaps in Service Provision

INTRODUCTION

2.1. While in broad terms, activities such as methadone dispensing services, stabilisation programmes, one-to-one counselling, group therapy, holistic therapies and needle exchanges can be viewed as treatment and harm reduction services, they also form part of the rehabilitation process. Outreach support, assessment and referral, pre-induction programmes, drop-in services, attendance at programmes at local level and prison support are encompassed in the rehabilitation process as well. Given the importance of the problem drug user actively engaging in the rehabilitation process and being prepared and motivated to fulfil their role therein, a key aspect of the process revolves around facilitating him or her to develop his/her employability including through CE employment schemes, vocational training or engaging/returning to education at an appropriate level. However to enable recovering problem drug users to maximise their chances of successful rehabilitation, their societal and family needs must also be addressed.

2.2. "Ancillary supports" which address the societal and family needs of a problem drug user can make an important contribution to the overall rehabilitation process and may significantly increase the prospects for a successful outcome. Therefore, it is important that these supports, ranging from addressing housing needs and child-care issues to initiatives such as the provision of information and advice, family counselling and networks, be continued, improved and developed as required.

2.3. This Chapter seeks to give an overview of the numbers presenting for treatment, the existing level of rehabilitation service provision and the gaps in this provision.

NUMBERS PRESENTING FOR TREATMENT

2.4. The total number of cases treated for problem drug use in the 2001/2005 period are set out in Table 2.1. The number of cases treated increased considerably, from 7,900 in 2001 to 12,400 in 2005. This is due to a combination of factors including an increase in the number of treatment places, an increase in reporting to the National Drug Treatment Reporting System (NDTRS) and an increase in drug use.

Table 2.1 Numbers of cases treated for problem drug use in Ireland, 2001 to 2005[4].

Treatment status	2001	2002	2003	2004	2005	2006
Continuous care	3023	3446	3834	6883[5]	7301	7795
New cases	2073	2098	2198	1850	2043	N/A
Previously treated	2642	2820	2938	2723	2906	N/A
Status unknown	162	232	114	177	150	N/A
Total	7900	8596	9084	11,633	12,400	N/A

2.5. Of the 12,400 problem drug users who were treated in 2005, 5,099 entered or returned to treatment in that year. Of these 5,099 cases, 2,790 (55%) were living in Dublin. 2,118 (76%) of these Dublin residents had been previously treated and 2,520 (90%) of them reported an opiate[6] as their main problem drug was. Of the 2,309 (45%) cases residing outside Dublin, 780 (34%) had been previously treated and the most common main problem drugs reported were cannabis (981, 43%) and opiates (748, 33%)[7].

2.6. Overall, the main problem drug reported by cases entering or returning to treatment in 2005 were opiates (3277, 64%), cannabis (1058, 21%), cocaine (482, 9.5%), ecstasy (125, 2.5%), benzodiazepine (77, 1.5%), other stimulants (37, 0.7%) and volatile inhalants (27, 0.5%). More than one drug (polydrug use) is involved in 3,585 (70%) of these cases.

2.7. In relation to opiate misuse, it is estimated that there are currently around 14,500 problem opiate users in Ireland, with approximately 12,000 of these based in the greater Dublin area[8]. Of the 14,500 problem opiate users, 8,005 were on methadone maintenance programmes at 31 October 2006, with 5,195 of these being treated in clinics and 2,810 by General Practitioners (GPs)[9].Over 6,500 of those participating in methadone maintenance

4 Source: Unpublished data from the NDTRS and Central Treatment List

5 Number of clients on the Central Treatment List on the 31 December 2003, 2004 and 2005 and carried over to 1 January for the respective year

6 Of the cases who reside in Dublin and entered or returned to treatment in 2005, the profile shows that just 69% were male, just under 20% were less than 25 years and 45% were living with their parents/family. In addition, 52% did not complete second level education and only 14% were in regular employment.

7 Of the cases who live outside Dublin and entered or returned to treatment in 2005, almost 80% were male and 56% were less than 25 years old, and well over half were living with their parents/family. In relation to education and employment, 47% did not complete second level education and only 28% were in regular employment.

8 "A 3-Source Capture Recapture Study of the Prevalence of Opiate Use in Ireland 2000 to 2001" National Advisory Committee on Drugs; May 2003.

9 Unpublished data from the Central Treatment List

programmes are based in the Dublin area. While the number of problem drug users on waiting lists for methadone treatment varies between regions, the total figure at the end of August 2006 was 294.

2.8. The overall number of those using methadone as a treatment has grown from 5,032 at end of 2000 to 8,005 at 31 October 2006, representing an increase of 59%. Table 2.2 below sets out a summary of new entrants and the number of those who have successfully completed treatment per two-year period since 2000 as recorded on the Central Treatment List.

Table 2.2: New entrants and completion in 2000-2005 period[10]

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

This data reflects a downward trend in the number of new entrants presenting for methadone treatment. The rate of this decrease has slowed over that period from 24% between 2000/01 and 2002/03 to 5% between 2002/3 and 2004/5. A heartening feature is the steady increase in the numbers successfully completing treatment in that period.

2.9. In Dublin the number of new opiate users entering treatment has decreased from 889 in 1998 to 438 in 2005. While the total numbers are smaller outside of Dublin, there has been an increase from 71 in 1998 to 413 in 2005. The numbers in treatment outside the main population centres can present major challenges in relation to meeting both treatment and rehabilitation needs where numbers are low and those involved are dispersed across large geographic catchment areas.

2.10. The capacity of current systems to identify the progress of clients through treatment is limited. The National Drug Treatment Reporting System (NDTRS) is the key mechanism currently available in that regard but this has limited capacity. There is a need to develop enhanced tracking and monitoring of problem drug users as they progress through treatment and rehabilitation. This presents significant challenges given the range of agencies and service providers involved in delivering services.

OVERVIEW OF EXISTING REHABILITATION SERVICES

2.11. The level of current service provision available for the rehabilitation of problem drug users is not easily determined given the broad nature of the definition the Working Group has adopted, the difficulty in distinguishing between what constitutes treatment and what constitutes rehabilitation and the scope for problem drug users in rehabilitation to avail of what can be considered as mainstream services, many of which have been expanded over the last number of years. While some services that link elements of their programmes directly to the rehabilitation of problem drug users can be identified and quantified (some LDTF programmes, FÁS CE Schemes and projects funded by the Probation Service), others cannot be readily quantified (e.g. some services provided by the HSE, and through the Department of Education & Science).

2.12. LDTF, FÁS and Probation Service expenditure that is specifically aimed at the rehabilitation of problem drug users is estimated to be €28.73m for 2005. Table 2.3 below breaks this figure down between the current LDTF programmes[11], the FÁS Special CE schemes and projects funded by the Probation Service.

Table 2.3: Identifiable direct expenditure on rehabilitation

Agency	Amount € million
LDTF Programme (Rehab element)	11.93
FÁS	14.50
Probation Service	2.30
Total	28.73

With respect to the LDTF element, approx. €8.74m (73%) of this funding is channelled to projects through the HSE, with €1.18m (10%) channelled through FÁS. The balance of funding is primarily for education or prison link services.

2.13. The HSE, as the main provider of addiction services in the country, provide a range of services from education and prevention, through treatment, harm reduction, stabilisation, rehabilitation[12] and aftercare for problem drug users. The HSE estimate that their expenditure in 2005 was €92.71m[13] at a minimum, up 12% on the corresponding 2003 figure. Table 2.4 below sets out the main components of this provision:

10 Figures supplied by the HSE

11 The actions identified in the initial plans of the LDTFs were mainstreamed from 2001. The current cost of those projects transferred to the HSE is identified in Table 2.4

12 Of particular interest in the context of this report is the work of the Rehabilitation Integration Service set up in 2000 in the former Northern Area Health Board to develop a co-ordinated and integrated response to individuals seeking to develop progression pathways out of problem drug use. The service involves intensive person-centred rehabilitation assessment, guidance, planning and referral/ brokerage with aftercare support.

13 Drug and alcohol services are treated differently in compiling the figures. With respect to what was the Eastern Regional Health Authority, only expenditure incurred on Drug services are included in the expenditure whereas with respect to the remainder of the country Drug and Alcohol services are included in the figures as they cannot be distinguished.

Table 2.4: HSE provision for addiction services in 2005	
HSE Services	Amount € million
Mainstream Services	65.02
Drug Treatment Centre Board	9.48
Section 65 Funding[14] (Community)	9.98
LDTF Mainstreamed	8.02
YPFSF Mainstreamed[15]	0.21
Total	92.71

2.14. The mainstream services and the services provided through the Drug Treatment Centre Board consist of a combination of treatment and rehabilitation services provided through the HSE. Included here are services ranging from those provided by GPs, pharmacists, and psychiatrists through to counsellors/therapists, outreach workers and education officers. While the Drug Treatment Centre Board service is a national service, approximately 80% of the mainstream services are provided inside the former ERHA region and would be concentrated on LDTF areas.

2.15. However, there is a range of other services provided by the HSE for the general public, which can be accessed by problem drug users. These include services provided through

- Primary Community and Continuing Care (PCCC) - such as the range of initiatives around children and families (e.g. High Support Units, Springboard Initiative, Resource Centres), mental health and social inclusion (e.g. homelessness initiatives);
- the National Hospitals Office and Population Health (or NGO services via Section 65 etc.); and
- the Hospital Directorate.

Each of these services encounter, with varying intensities, issues related to addiction and it is not feasible to disaggregate the elements therein nor to estimate the cost involved.

2.16. Similarly, other Departments/Agencies provide services that can be availed of by problem drug users in rehabilitation but those services and their associated costs cannot be disaggregated. The key Departments/Agencies involved are:

- Department of Education & Science/VECs (Adult/Community Education including literacy services, Social Inclusion Initiatives, Youth Affairs)
- FÁS (Employment Services)
- Partnerships (e.g. Back To Education Initiatives, Local Employment Services)
- Community Development Projects (varies significantly but many projects have developed community based services, such as childcare and community/adult education, with funding provided by relevant Departments/Agencies)
- Department of Social & Family Affairs (Information Offices and Employment Support Services, Family Support Agency, Money Advice and Budgeting Services)
- Probation Service (Prison Link services and support services through a range of community and voluntary based projects)
- Gardaí (Juvenile Liaison Schemes and Garda Diversion Programmes)
- Local Authorities (Housing primarily)
- Homeless Agency (housing and other issues around homelessness)

Further information on the roles of Departments and Agencies are set out in Chapter 3.

2.17. As the above brief overview indicates, significant levels of services are available for access by those in rehabilitation. As regards gaps in these services, it is felt that problems can arise at the point when clients move from one service to another, or where a client is availing of multiple services without the necessary co-ordination between the service providers being in place. It is acknowledged by the Rehabilitation Working Group that assistance for those in recovery, through the mechanism of enhanced case management, is a key need not only to enable those in rehabilitation to access these services as required but to ensure that appropriate support is available at crisis times in their rehabilitation. The issue of case management is addressed in Chapter 3.

TREATMENT AND REHABILITATION ISSUES

2.18. Treatment and rehabilitation complement each other in very significant ways. The view from research, and the consensus of those who inputted to the work of the Working Group, is that a seamless continuum of care for recovering problem drug users is desirable. The 4 Tier service delivery model, which is to be used in tackling the addiction problems of under-18 year olds, represents one possible framework for rehabilitation services.

2.19. Treatment options can include medication (substitution programmes, methadone reduction, detoxification) and/or therapeutic services such as

14 Section 65 relates to Section 65 of the Health Act, 1953. These projects are funded by the HSE but are provided by the community/voluntary sector.

15 Young People's Facilities and Services Fund (YPFSF) mainstreaming relates to Waterford where 4 projects were mainstreamed from 2004.

addiction counselling, group therapy, psychotherapy and/or life skills training. Views in respect of treatment range from abstinence to harm reduction, both of which are considered as valid approaches. This duality of approach must continue to be catered for and be reflected in the services provided for treatment and rehabilitation.

2.20. In line with the above, some see the continued use of methadone (or other substitution programmes) as a successful outcome for those problem drug users whose aim is harm reduction while others see methadone use as a transitional measure in the treatment/rehabilitation process rather than as a successful long-term solution.

2.21. Many existing treatment and rehabilitation services focus on the treatment of opiate users. In the past few years cocaine use, the misuse of alcohol and prescribed medication in conjunction with illicit drug use and polydrug use generally have posed challenges to the delivery of services. In the future, new drugs and new drug trends will undoubtedly arise and it is important that services are adaptable to meet the diverse needs of a range of problem drug use.

2.22. It is clear that significant variations will arise in the type of rehabilitation needed by, and appropriate for, various clients in the target population. For example, residential rehabilitation may be an effective option for chronic problem drug users, while community detoxification, with the assistance of a local GP, may be more appropriate for other problem drug users who may have strong family or community based support. A key issue to be addressed is the balance to be achieved between the provision of rehabilitation in (i) residential and (ii) community settings. Some service users have expressed the view that there is scope for service providers to improve the level of communication with them in regard to their care-plans.

2.23. The treatment and rehabilitation services available on a residential and community basis are set out below.

A. RESIDENTIAL DETOXIFICATION AND REHABILITATION SERVICES

2.24. A breakdown of the number of residential places currently available from service providers in Ireland is attached at Appendix 3. This information, which has not been audited, was compiled from a self-assessment exercise that the HSE undertook with the services involved in mid 2006[16]. A total of 794 beds are documented, of which 405 are potentially available to problem drug users. However, the number of dedicated beds for problem drug users could not be established and the number that are occupied by these at any given time can vary. Some service providers observed that some of those being treated for alcohol addiction can also be involved in polydrug misuse.

The residential services provided can be separated into three categories as follows:

(i) Specialist Residential Detoxification Treatment;

(ii) Community Based Detoxification Programmes with Residential Support;

(iii) Abstinence Based Residential Rehabilitation Programmes.

(i) SPECIALIST RESIDENTIAL DETOXIFICATION TREATMENT

2.25. These services are aimed at individuals presenting with a high level of presenting need, complex patterns of problem drug use and associated physiological problems (e.g. Hep C). They involve inpatient drug/alcohol detoxification or stabilisation services. These services are under the direction of a Medical Director/Consultant Psychiatrist with specialist skills in the area of substance misuse and involve multi-disciplinary teams covering Psychiatry, GP, Nursing and Counselling/Therapy. Twenty-three beds are provided under this category by the statutory sector.

(ii) COMMUNITY BASED DETOXIFICATION PROGRAMMES WITH RESIDENTIAL SUPPORT

2.26. These services are aimed at problem drug users who have been assessed by a GP as appropriate for community based detoxification but who require a high level of support, in terms of their environmental/psycho-social needs, in a residential setting. Clients in this category usually have less intense medical needs that do not require in-patient medical care. Providers offer significant psycho-social/therapeutic support and/or skills based training to those in treatment. There is a close liaison between the provider and the designated community based GP in relation to the detoxification element of care plans. Nineteen beds are provided within this category through the voluntary sector.

RESIDENTIAL DETOXIFICATION SUMMARY

2.27. In Britain, the National Treatment Agency for Substance Misuse briefing on Tier 4 services (2003), citing Matrix 2003, estimated that one inpatient detox bed is needed per 48,000 of population. Given a population of approx. 4.25 million[17] this would suggest a detox bed requirement of 89 beds

16 The Working Group on Drugs Rehabilitation recognises that the Working Group on Residential Treatment/Rehabilitation, set up by the HSE in September 2006, is undertaking a comprehensive review of residential rehabilitation provision and the figures used here should be taken as indicative.

17 June 2006 CSO Population Report.

for Ireland. While consideration of the adequacy of the level of residential services provided is to be pursued further by a Working Group established by the HSE in September 2006, there is a clear consensus in the Working Group on Drugs Rehabilitation that there is an urgent need for an increase in the number of detoxification beds available in the country. The group recognise that a range of issues need to be considered before a final figure on the number of beds required is determined, involving the respective roles of both statutory and non-statutory providers, but feel that steps should be taken now to implement an interim increase of 25 detoxification beds[18].

(iii) ABSTINENCE BASED RESIDENTIAL REHABILITATION PROGRAMMES:

2.28. These programmes cater for clients who are drug and alcohol free. The programmes are abstinence-oriented and the emphasis is on understanding and maintaining a drug or substance free lifestyle. The ethos underlying the programmes varies in orientation, ranging from the 12-step model to the therapeutic community approach to the systemic/psychotherapeutic model. All services are therapeutic by nature and, to varying degrees, emphasise skills enhancement, vocational skills training and personal responsibility. Most programmes are connected with HSE addiction service treatment providers in terms of treatment support/consultation. A total of 546 beds are provided under these programmes, of which 363 can cater for problem drug users, though the number occupied by problem drug users at a given time varies and can be quite small.

2.29. Many of these service providers, who are predominantly from the voluntary sector, provide community based day services as well. They also offer aftercare and reintegration programmes after completion of the residential programmes. These give support and guidance during this key phase of recovery as people move towards full reintegration.

B. COMMUNITY BASED TREATMENT AND REHABILITATION SERVICE

2.30. A key element of both treatment and rehabilitation services is the service provided by both local GPs and pharmacies involved in the dispensing of methadone. With respect to the provision of treatment services, 226[19] GPs are involved in methadone maintenance programmes nationwide (183 of these are based in the Dublin area, with 43 elsewhere). A total of 375[20] pharmacies dispense methadone to recovering problem drug users (226 of these are based in the Dublin area, with 149 elsewhere). The level of service provision is not uniform throughout the country and current efforts need to be maintained to address this, as recommended by the Mid-term Review of the National Drug Strategy 2005.

2.31. Non-residential community based rehabilitation services for problem drug users is most advanced in Local Drug Task Force (LDTF) areas, with a less developed service provided in RDTF areas across the rest of the country (See 2.32 and 2.33). In RDTF areas some rehabilitation services have been developed primarily funded through the HSE under Section 65 of the Health Act, 1953.

2.32. Figures (supplied by the HSE) for Addiction Services provided outside what was formerly the Eastern Region Health Authority (ERHA) area are outlined in Table 2.5 below. Appendix 4 breaks down these figures by region.

Table 2.5 : Addiction Services provided outside the former ERHA area in 2005

HSE Services[21]	Amount
€ million	
Mainstream Services	13.25
Section 65 Funding	2.64
LDTF Mainstream[22]	0.30
YPFSF Mainstream[23]	0.21
Total	16.22

The development of community-based responses is most developed in the Eastern half of the country with little drug specific support provided towards the Western seaboard.

2.33. With the establishment of the 10 RDTFs, full Task Force coverage of the country has been achieved and this is now facilitating a more co-ordinated response to problem drug use. Their Action Plans have been agreed and funding has been provided for implementation. A key challenge to be faced by RDTFs is the development of services for large catchment areas within which there are small dispersed numbers of problem drug users.

COMMUNITY BASED REHABILITATION SERVICES IN LDTF AREAS

2.34. LDTFs operate in areas experiencing the highest levels of drug misuse. Twelve of the 14 LDTFs are located in Dublin, with the others in

18 The Department of Health and Children and the Health Service Executive are reserving their position on this issue pending the completion of the report of the Working Group on Residential Treatment / Rehabilitation.

19 as of 31 October 2006 (Drug Treatment Centre Board).

20 as of 31 October 2006 (Drug Treatment Centre Board).

21 The Drug Treatment Centre Board provides a National Service and is excluded.

22 Relates to Cork City projects mainstreamed in 2001 under Round 1 of LDTF Programme.

23 Relates to Waterford City projects mainstreamed in 2004 under YPFSF.

Bray and Cork. LDTFs provide a mechanism for the co-ordination of mainstream services in these areas (see 2.12 above), while facilitating the participation of local communities and voluntary organisations in the planning, design and delivery of those services.

2.35. Rehabilitation of problem drug users has been a key element of all LDTF plans. Working from the definition of rehabilitation, service provision has evolved around four themes:

(a) Community Drug Teams – engagement (including re-engagement), referral and negotiation/ provision of support to problem drug users.

(b) Provision of therapeutic support.

(c) Employment access, training and education.

(d) Ancillary supports (family, childcare, housing, welfare).

In addition to the above, a number of projects were specifically aimed at high-risk groups such as the homeless, ex-prisoners, Travellers and those people involved in prostitution.

2.36. Some community supports have also been provided. These revolve around helping communities to become more informed, and to accepting the rehabilitation of problem drug users within their own community.

2.37. Each LDTF area has, to varying degrees of intensity, services that cater for each of the above four themes developed under the LDTF umbrella with funding provided by the Department of Community, Rural & Gaeltacht Affairs, and by the relevant State Agencies involved. Appendix 5 sets out the service providers, number of projects and channel of funding for each LDTF area. In total there are 109 providers involved, with an average of approx. eight providers in each LDTF area - ranging from 5 to fifteen per area.

2.38. Services have been developed under two rounds of the LDTF programmes (with some capital provision through the Premises Initiative) and the Emerging Needs Fund, which the Department of Community, Rural and Gaeltacht Affairs have funded. The outcome of the forthcoming evaluation of most of the projects under the LDTF programme should inform the rehabilitation framework going forward. Also, a number of projects under the Emerging Needs Fund target newer aspects of the drug problem (in particular the emergence of cocaine and polydrug use and the need for rehabilitation services).

(a) Community Drug Teams

2.39. Eleven LDTF Community Drug Teams (CDTs) have been supported under the Drugs Strategy since 1997. Many of these were developed through local residents involvement from the outset to address their concerns regarding drug problems in their areas. Services are developed in partnership with voluntary and statutory sectors assisting the local communities. CDTs focus on a specific geographic community. Along with treating individuals and families, they see the wider community as a client of the service. The range of service reflects local needs and can include treatment, counselling and support for individual and families affected by drugs misuse, promoting drug awareness in the community, outreach to families and specific target groups such as prisoners. In addition, the CDTs provide a focal point for other state services to access and support clients.

(b) Provision of Therapeutic support

2.40. A number of counselling and other therapeutic services are provided under the LDTF programmes. The CDTs are involved in some of these services. Those involved in education, training and employment may also avail of these services.

(c) Education, Training & Employment

2.41. Services have been developed in each LDTF area aimed at assisting recovering problem drug users to access opportunities relating to existing education, training and employment services. These latter services are catered for predominately through mainstream providers and an issue for the Working Group was to consider how best to cater for rehabilitating problem drug users to re-engage with this mainstream provision. As indicated earlier, problem drug users, depending on a variety of factors, will have different needs with respect to these services. For a minority, only some assistance towards re-engagement with work may be required while others will require more intense levels of support. For those who are almost ready to return to work, or to take up employment for the first time, mainstream service provision should be sufficient. Others will need more intense help through education, community employment, community services provision and day programmes[24].

(c.1) Education

2.42. To date low levels of formal education predominate among people who present for treatment and consequently there is a need to facilitate the re-engagement of problem drug users in rehabilitation with the education process, whether through mainstream provision, the informal

24 An example of a response is the Bridge to Workplace Initiative developed by the Health Service Executive Rehabilitation/Integration Service, FÁS, the Local Employment Service Networks (and Area Based Partnerships) of Finglas/Cabra, Blanchardstown, Dublin North East, Ballymun and the North Inner City and which was funded in part by the Finglas/Cabra LDTF (Dept CRGA). This initiative sought to expand the progression potential of 40 people with addiction problems, through the establishment of a work experience stimulation programme. The aim of the intervention is twofold:

- to provide a quality work experience opportunity and the skills and support framework to access and maintain participation; and
- to create a forum whereby the partners involved can work together to holistically meet the needs of people with drug misuse issues.

youth education sector or adult/community based provision. Significant changes have occurred, and are ongoing, within both the adult and the informal youth education sectors, with respect to the level of resources made available to these sectors over recent years. However, it is clear from the consultation process that there is a need to build upon the efforts already made to enable a fuller re-engagement by problem drug users with both the formal and informal education sectors.

2.43. A number of significant reports pointing the way forward with respect to addressing educational disadvantage have been published, including the report of the Minister for Education & Science's appointed Educational Disadvantage Committee in 2005, and the implementation of the recommendations of this report should enable the needs of problem drug users to be more adequately addressed.

2.44. With respect to young recovering problem drug users, initiatives such as Youthreach and VTOS (Vocational Training Opportunities Scheme) are available to those not immediately able to return to mainstream education for whatever reason. For adult recovering problem drug users, literacy and numeracy courses are often a key initial step on their educational pathway.

2.45. When recovering problem drug users move beyond literacy and numeracy, they may wish to access further education, whether through community education or mainstream provision. Supports, such as the Back To Education Initiatives (BTEI) or community support will generally be required to varying degrees to achieve such transition.

2.46. There can also be difficulties in moving forward to mainstream education when literacy/numeracy work and community education has been achieved. While this gap is being partially addressed through the development of accredited courses within the community education sector (including in drugs work), some support issues persist, with few progression paths (particularly to third level education).

2.47. Issues such as childcare costs, transport cost, fees etc. need to be taken into consideration when assessing whether the supply of courses is adequate in meeting demand, as such issues can affect the take up of the available options.

2.48. Overall, it is felt that there is a need for closer contact between education providers, in particular local VECs, and the services involved in the rehabilitation process. VECs, building on the efforts already made, need to become more proactively involved in meeting the needs of problem drug users in rehabilitation.

(c.2) Community Employment Provision

2.49. Community Employment is provided by FÁS and there are currently 1,000 places available on the scheme across 65 projects (see appendix 6 for list of projects). The Review of the National Drugs Strategy refers to FÁS CE Programmes as a very important element in the rehabilitation of problem drug users (outlined in Action 74 of the National Drug Strategy).

2.50. Projects have developed wide-ranging programmes to meet the individual needs of their clients, both at a personal and vocational level. A wide range of both skills-based and personal development training is being provided. Projects also provide personal support services, including one-to–one counselling, family support and referral to therapies. Advocacy work on behalf of clients forms a key element of the work of projects and deals with a range of issues such as housing, social welfare issues, legal issues etc.

2.51. A major evaluation (Bruce Report[25]) of CE Special Drug Projects was undertaken in 2004, the main findings of which are set out below. (The North East LDTF also evaluated the Special CE Drug Projects in its area and this evaluation reached similar conclusions to the Bruce report).

The main findings of the Bruce Report were:

- participants surveyed as part of the evaluation generally find the schemes beneficial in meeting their therapeutic and rehabilitative needs.
- the challenge of using a labour market mechanism as a rehabilitative tool, and the difficulty in balancing the rehabilitative and employment-oriented dimension of the scheme to meet individual needs, was highlighted.
- while international evidence shows integration on a training scheme and a focus on employment have tangible benefits, the timing of these schemes during the rehabilitation process has a major impact on the likelihood of a successful outcome.
- progression to employment was not seen as a realistic option for many participants, partially because it would take longer than three years (5 to 7 years was mentioned) and also because of the importance of socio-economic background issues (e.g. education, housing). The Bruce Report states that from monitoring progression in Cork CE schemes it can be seen that 10% of scheme participants have secured, and remained in, employment. Figures are not available for the Dublin schemes.

25 "Report of the Review of the Drugs Task Force Project Activity for FÁS Community Employment Participants" Dr Alan Bruce; 2004.

- The conclusions of the evaluations highlighted fundamental challenges, which needed to be faced to strengthen the approach. Gaps identified included the following:
    - need for greater inter-agency co-operation;
    - the overall management of an interconnected service;
    - the provision of additional person–centred and family supports;
    - the primary role that the Health Boards need to play in relation to rehabilitation;
    - CE only makes sense if delivered as part of a coherent and interlinked programme of rehabilitation and support for the client group.

(c.3) Community Services Programme

2.52. Currently none of the projects run under this programme (formerly the Social Economy Programme and now the responsibility of the Department of Community, Rural & Gaeltacht Affairs) specifically target recovering problem drug users. This programme is project driven, which means that specific projects will need to be identified and developed that could cater for the target group. The 2006 call for expressions of interest for the 2007-2009 programme, however, does include projects which support and employ stabilised and recovering problem drug users in the categories of projects eligible for consideration. Also existing projects can be approached to see if they could accommodate problem drug users at an appropriate stage in their recovery (as has happened on some projects in the past).

(c.4) Employment

2.53. The aim of progressing problem drug users into employment is a key target of any rehabilitation strategy. While drug specific Community Employment schemes allow participants to gain work experience and to develop a working routine, these schemes are not an end in themselves and there is a need to build in progression routes to mainstream employment.

2.54. As identified in the Bruce report with respect to CE, recovering problem drug users have difficulty in moving on to secure, and remain in, employment. This area should to be researched in greater depth with increased engagement at both a national and local level, with employer and trade union organisations, to identify initiatives that might be implemented to achieve greater reintegration of rehabilitated problem drug users in the workforce.

(d) Ancillary supports

2.55. Ancillary services relate to services provided to facilitate access to treatment and rehabilitation and to provide family support to problem drug users and their families. With respect to this latter element, the services developed in LDTF areas involve the provision of information and advice, one-to-one or group counselling, discussion groups, residential respite breaks, childcare services and drop-in services.

2.56. In addition, and notwithstanding the recognition of the need for family support structures in all LDTF programmes developed, a view was expressed that the families of problem drug users should be facilitated in becoming more involved in the process of rehabilitation and that more information and support should be made available to these families.

2.57. Access to childcare was highlighted as a key issue in relation to rehabilitation. The availability of childcare facilities for the children of clients wishing to access treatment/rehabilitation is a significant factor influencing their participation in programmes.

2.58. Female problem drug users tend to present later for treatment and can have significant concerns about the implications for their children of presenting for treatment. Partly as a result of later presentation, they tend to have multiple health problems, and they experience particular health problems in relation to pregnancy. They are often economically dependent on illicit drug-using partners and can have experience of abusive relationships. All of these factors need to be taken into account in providing rehabilitation programmes for women.

SPECIFIC RISK GROUPS

(a) Homeless

2.59. Lack of suitable housing is one of the main barriers to rehabilitation. Also, this is one of the factors, which if not addressed adequately, increases the likelihood of relapse following rehabilitation. The benefits gained from a residential rehabilitation programme, with an emphasis on routine and structure were seen to be short-lived unless follow-up and post release support was made available, and accommodation needs were met. This issue can often arise also in the case of those leaving prison.

(b) Ex-Prisoners

2.60. Both those in prison and those coming out of prison are high-risk groups with respect to problem drug use. While problems are still being experienced in prison settings, treatment and rehabilitation provision within prisons has improved significantly in recent years. The Working Group welcomes the Irish Prison Service Drugs Policy and Strategy published in May 2006 which recognises

the importance of continuity with respect to the provision of treatment, care and support services post-release and their commitment to achieving this objective.

2.61. The Review Group would reiterate the need to ensure the expansion and involvement of the community and voluntary sectors in prison drug policy in line with Action 24 of the National Drug Strategy.

2.62. Many drug users receive a criminal conviction that impacts on their access to employment and this can prove a serious impediment to rehabilitation and make successful re-integration into mainstream society more difficult. The development of rehabilitation of offenders legislation, which would allow for certain categories of criminal convictions to effectively become 'spent' after a specified period of time, was identified by the Steering Group who compiled the Mid-Term Review of the National Drugs Strategy as an issue which should be considered. The Rehabilitation Working Group is advised that the Law Reform Commission is examining the concept of expunging the sentences of recovering problem drug users after a period.

(c) Children of drug using parents

2.63. While the impact of the drug use of parents on their children, in terms of personal, social and educational development, has not been studied in any comprehensive way, it is accepted that such children constitute a particular at risk group.

(d) Prostitution

2.64. People involved in prostitution are a high-risk group in relation to problem drug use. While a number of projects are targeted specifically at this group, it is particularly difficult to engage this group in treatment and rehabilitation. They tend to have multiple issues besides problem drug use that also need to be addressed.

(e) Travellers

2.65. While historically under the National Drugs Strategy, Travellers were considered to be less at risk from illicit drug misuse[26], there is evidence of increasing levels of drug misuse within that community. The recommendations of the recent NACD report examining the nature and extent of illicit drug use among the Traveller Community[27] need to be considered in the context of rehabilitation, with particular focus on culturally appropriate accessible services.

(f) Mental Health

2.66. A significant number of people have co-existent mental health and substance misuse problems (commonly referred to as dual diagnosis). Research carried out by the National Advisory Committee on Drugs in 2004[28] found that a lack of systematic co-ordination of care is evident in relation to dual diagnosis clients.

(g) New Communities

2.67. As mandated under the National Action Plan against Racism, the HSE is currently developing an intercultural strategy that will take into account the diverse needs of new communities in respect of addiction issues. The pattern research carried out to date in this area is a 2004 exploratory study undertaken by Merchants Quay Ireland on drug use in new communities[29] that found that drugs services needed to develop in an accessible and culturally appropriate way.

SUMMARY

2.68. It is clear that a range of services are already in place to support the rehabilitation of problem drug users. The challenge is to implement measures to adapt and build on this in a co-ordinated and client-centred way.

26 See National Drug Strategy 2001-2008. See pg. 35.

27 "An overview of the nature and extent of illicit drug use amongst the Traveller Community: an exploratory study" National Advisory Committee on Drugs; October 2006.

28 "Mental Health and Addiction Services and the Management of Dual Diagnosis in Ireland" National Advisory Committee on Drugs; November 2004.

29 "Drug Use Among New Communities in Ireland. An Exploratory Study" funded and published by the National Advisory Committee on Drugs; October 2004.

CHAPTER 3

STRUCTURES FOR THE DELIVERY OF REHABILITATION SERVICES

3 Structures for the Delivery of Rehabilitation Services

INTRODUCTION

3.1 The focus of this chapter is on the development of structures for the delivery of rehabilitation services that will facilitate an effective management of clients through the system, ensuring that they receive an appropriate level of service and that their progress can be adequately monitored. Among the key factors involved are (i) the need for increased co-ordination of services, (ii) the development of a quality standards framework and (iii) identifying and addressing the staff training needs to achieve these standards. The chapter also covers the role of Departments/Agencies involved in the delivery of rehabilitation services.

3.2 Problem drug users need a range of assistance and services when engaging in rehabilitation from their problem drug use and its consequences. They can face many obstacles and some problem drug users, such as people who are homeless, ex-prisoners or people who have been diagnosed for co-existing drug and mental health problems (dual diagnosis), may have particular needs.

3.3 The National Advisory Committee on Drugs recently reviewed a range of rehabilitation programmes. This review identified some key components, which, in conjunction with drug treatment, would form the basis of an integrated rehabilitation programme:

- Drug specific interventions
  (e.g. help in understanding addiction, motivational interviewing, peer advice to develop strategies for avoiding drug use, drug-related harm and relapse, one-to-one counselling, group therapy, methadone dispensing services, and holistic therapies)
- Health promotion
  (e.g. general well-being, diet, harm reduction, safe sex information, dental treatment, information and advice)
- Personal development
  (e.g. general life skills, social skills, communication skills, family support, community support, parenting skills)
- Education
  (e.g. adult education to encourage social analysis and esteem raising, as well as literacy, numeracy, art, and vocational training, re-engaging with mainstream education provision, group education, early school leaver programmes, peer drug education initiatives)
- Employment
  (e.g. Community Employment, employment preparation, job search and interview skills, job preparation and placement)
- Support and advocacy
  (e.g. dealing with housing/resettlement, social welfare and criminal justice issues)
- Social and recreational activities
  (aimed at providing an alternative to a drug using lifestyle and boosting morale and confidence)

3.4 A large number of organisations are involved in the provision of these services as no single agency has the range of competencies and expertise to cater for all the requirements. Thus, a problem drug user will most likely not just access one rehabilitation service - rather he or she will need a range of services provided by a number of organisations.

3.5 Some of the difficulties with the current situation can arise from issues such as:

- problem drug users attending different services for their different needs where there is a lack of co-ordination;
- reluctance of agencies to share information and/or responsibility for the client;
- differing views on which agency should take the 'lead' with a shared client;
- steps towards rehabilitation potentially giving rise to ineligibility for current supports (or fears in that regard);
- divergence between the views of clients and their medical practitioners on facilitating staged withdrawal from individual's methadone maintenance programmes.

BEST PRACTICE IN REHABILITATION

3.6 The Working Group considers that it is neither feasible nor desirable to develop a standard model of rehabilitation as one model does not fit all. Socio-demographic data on clients in treatment for problem drug use provided by the National Drug Treatment Reporting System (NDTRS) indicates that different drug users have different drug using histories, different life experiences, and consequently, different rehabilitation needs. However, across all rehabilitation modalities, a number of factors associated with positive outcomes remain relatively constant. These include the following:

- **Preparation for and rapid access to rehabilitation**
  It is important that those presenting for rehabilitation should undergo a thorough assessment of needs (both initially and at regular intervals during the programme), should be given full and accurate information and should have a

menu of options based on this information. The client should be central to the process and it is important that he/she feels involved in this. At all stages the client should be informed as to the process and any practical issues that need to be addressed before admission. Ideally, once a decision has been reached it is important that steps towards implementation are taken quickly.

- Social and environmental factors
  Whether in a residential or community setting, environmental factors should be taken into account at all stages, from assessment to treatment/rehabilitation to aftercare. This applies irrespective of the setting or type of treatment/ rehabilitation service. This means that when clients are engaged in rehabilitation there is a need to address housing, family, education, social life and employment (or engagement in meaningful activities). Timely plans in relation to these aspects should be in place. When a client moves on, there should be a range of options in terms of aftercare.

- Retention in a residential programme where appropriate
  In relation to residential programmes, some research has indicated that positive outcomes are associated with the retention of the client in residential treatment/ rehabilitation for a period of three months[30]. 'Treatment dose', 'therapeutic relationship' and 'treatment engagement' have been identified as important factors in influencing a successful outcome[31]. If rehabilitation is to produce improved outcomes, clients should stay for long enough to be exposed to, and to participate in, rehabilitation of sufficient quality and intensity to bring about change[32]. In order to retain clients, it is important that they are treated with dignity and respect, that workers in service providers instil confidence in clients, that these workers are capable and knowledgeable and that there is consistency in the delivery of services. These factors are also important in relation to successful completion of community-based rehabilitation programmes. With respect to residential treatment programmes, ideally clients should have quality accommodation, access to their family and an appropriate balance between 'work, rest and play'.

3.7 The evidence suggests that timing and sequencing within the recovery process is a key element in rehabilitation. Therefore, client-centred care plans - i.e. plans that are appropriate for each individual and based on an assessment of their needs- comprise an optimum strategy. These plans should have goals that are negotiated and agreed between the key worker and the client as well as a clear progression path, which should be revised and updated as necessary. This does not necessarily imply a large number of different options, but rather that a different mix of options could be appropriate for the various clients.

3.8 Rehabilitation care plans must address the needs of the person, including measures to address drug use along with personal and social development, health, adult education, housing and social supports, work placement and integration etc. In this way, care plans need to draw upon a range of different services in different settings, e.g. health care may be provided by a GP in a primary health care setting, educational training by a community college etc. The aim should be to maximise the quality of life, re-engagement in independent living and employability of the recovering problem drug user, in line with their aspirations.

3.9 It is important that clients be activated and prepared to fulfil their role in the push towards rehabilitation. Service providers should seek to empower clients to fully engage with them in facilitating the client's own development. The level of motivation of clients is critical to the degree of likelihood of achieving a successful outcome.

MODEL OF INTER-AGENCY WORKING

3.10 A number of challenges relating to existing structures need to be confronted in order to promote the conditions conducive to encouraging best practices. These relate to improvements with respect to the cohesion of organisational structures, the development of a quality standard framework and enhanced case management.

3.11 In order to develop a comprehensive integrated rehabilitation service, the Working Group believes that the development of a practical model of inter-agency working is required[33]. It is felt that such a co-ordinated way of working is a prerequisite for the delivery of a continuum of care for problem drug users.

30 Dr. Petra Meier "A national survey of retention in residential rehabilitation services" National Treatment Agency for Substance Misuse; Research Briefings 10; June 2005

31 Professor Michael Gossop "Treatment Outcomes: what we know and what we need to know"; NHS National Treatment Agency for Substance Misuse; Treatment Effectiveness 2; January 2005

32 idem

33 The Progression Routes Initiative, managed by the SAOL CE project, is an example of work being undertaken in relation to addressing the barriers to effective case management for rehabilitation services. HSE, FÁS, Dublin City Council, the Homeless Agency, the Probation and Welfare Service, the NDST, An Garda Síochána and a number of voluntary and community organisations are all involved in steering the project. The primary focus of this initiative is the development of practical inter-agency working systems that support effective case management. The project is also facilitating the roll-out of inter-agency protocols and identifying channels through which the results can feed into service planning and policy formulation. While the project is currently working with case managers from a small number of services within a specific geographical area (10 in the North Inner City LDTF area), projects like this have potential to contribute to informing the way forward.

3.12 Generally it is regarded as good practice for rehabilitation programmes to have ongoing evaluation and standards review built in, with client involvement seen to be part of best practice. Clearly identified aims and objectives, including appropriate performance indicators, are required from services delivering rehabilitation projects, as is a shared vision among staff of the type of programme being delivered. Plans need to be reviewed and updated frequently as many projects evolve and develop in response to client needs and to what is found to work best.

3.13 Training, including managerial training and training in programme development, is also seen to be an important element that must be addressed.

3.14 It is the view of the Working Group that, to achieve best practice in the rehabilitation strategy proposed, a number of issues relating to service cohesion, a quality framework and case management need to be addressed. These include:

i) development of protocols to facilitate the level of inter-agency co-operation and information sharing needed to implement shared care plans;

ii) development of service level agreements in line with the protocols;

iii) recruitment of rehabilitation co-ordinators to oversee the process;

iv) development and monitoring of standards in services;

v) development of template assessment instruments for problem drug users at different stages of their progression;

vi) development of templates for individual rehabilitation care plans; and

vii) further training for rehabilitation service providers.

These issues should be addressed within an overall structure that respects and reflects the needs and aspirations of clients, the role of service providers in delivering services and the role of Agencies in funding, co-ordinating, overseeing and reviewing the delivery of these services.

3.15 In considering how such a system might work, the Working Group tried, as far as possible, to take the vantage point of the client. The Working Group believes that the overall model should be client-centred, seeking to match needs with appropriate services. Accordingly, at an early stage, the client's needs should be assessed as fully as possible. This should be conducted in the drugs service with which the client makes first contact with a view to developing an appropriate care plan. The delivery of this care plan, in effect the client's rehabilitation path, is the main focus of the proposed model.[34] The overall model of integrated service delivery was considered in the light of the NACD paper "Key issues relating to best practice in drug rehabilitation" and the four-tier approach.

PROPOSED STRUCTURE

3.16 An outline of the proposed structure for rehabilitation is set out in Table 3.1. – Rehabilitation Reporting Structure. A key proposed addition to existing structures is the establishment of a National Drug Rehabilitation Implementation Committee (NDRIC). As part of fulfilling the lead role in rehabilitation, the HSE will chair this Committee. However, the Working Group stresses that this in no way dilutes the responsibility of individual agencies for the delivery of the services for which they are responsible.

3.17 The NDRIC will have responsibility for:

- overseeing and monitoring the implementation of the recommendations in this report;
- the development of agreed protocols and service level agreements;
- the development of a quality standards framework, building on existing standards;
- overseeing case management and care planning processes; and
- identifying core competencies and training needs and ensuring that such needs are met.

3.18 The Senior Rehabilitation Co-ordinator, who will be employed by the HSE and will be fully part of their structure, will chair the NDRIC. The Committee will have a professional focus, with a strategic and quality emphasis, primarily involving those directly engaged in rehabilitation. The Committee will comprise of representatives of the HSE and the NDST, representatives of the Departments, agencies and community and voluntary sectors reflecting NDST membership (it is envisaged that the individuals would generally not be the same as those on the NDST but would have a more direct involvement in the rehabilitation area), the NACD, rehabilitation and healthcare professionals (e.g. psychiatrist, counsellor, general practitioner, pharmacist), a representative of problem drug users and a representative of families of problem drug users. Representatives should be at a level of authority in their organisations that would facilitate signing off any issues agreed.

34 The Group has noted the model adopted by the Equal project in Blanchardstown and has based some of its approach on that. The Equal project, which was subject to two evaluations, developed a model of inter-agency co-operation designed to bring Agencies (both state and voluntary) together to establish a "co-ordinated" approach to providing quality supports and services for former/current problem drug users. In particular, they developed protocols on confidentiality and lead agency working and these should prove useful with respect to protocol development.

3.19 The Senior Rehabilitation Co-ordinator will report to the Inter-departmental Group on Drugs (IDG) on behalf of the NDRIC. This report would reflect the views, issues arising and progress updates in respect of the implementation of the rehabilitation report and in respect of rehabilitation generally. Rehabilitation would be a standing item on the IDG Agenda, at least for the first year of the implementation of the recommendations of the rehabilitation report.

PROTOCOLS

3.20 It is the view of the Working Group that protocols, which in some instances may exist on an informal basis, should be formally developed to facilitate inter-agency working. The protocols should cover the arrangements for smooth handover of problem drug users as they move from the environment of one agency to that of another. They would cover issues such as a common understanding of confidentiality, common assessment tools, how the referral process would work and how disputes between organisations should be settled. They would be developed at two levels, (i) broad guidelines agreed at national level and (ii) local protocols, covering in some detail the involvement of the local branch of various organisations and agencies.

3.21 The broad national protocols, developed by the National Drugs Rehabilitation Implementation Committee, would be approved through the Inter-Departmental Group on Drugs and the Cabinet Committee on Social Inclusion. These national protocols would then form the basis for the development of local protocols which would be agreed by the relevant organisations directly involved in the delivery of rehabilitation at local level, i.e. agreed central processes but allowing a degree of local flexibility. The local protocols would then be referred to the Treatment & Rehabilitation Sub-Group of the relevant Drugs Task Force(s) and, in turn, the Rehabilitation Co-ordinator for the area would refer them to the National Drugs Rehabilitation Implementation Committee for final agreement. (see 3.17)

SERVICE LEVEL AGREEMENTS (SLAs):

3.22 SLAs will need to be developed in line with the protocols, so that there is clarity on the roles of each party. Again this would be done at broad national level as well as at local level. The development of these SLAs, as with the protocols, will be overseen at a national level by the NDRIC and the same procedures as outlined above for protocols will be used in their development. The broad national SLAs would then be approved through the Inter-Departmental Group on Drugs and must be reflected in local SLAs. Such SLAs would include co-operative interagency working as a responsibility and would require Agencies to make specific commitments regarding the services they will deliver. Furthermore, there may also be scope to tie levels of funding available for organisations to the levels and quality of inter-agency working that they undertake.

3.23 It is proposed that the implementation of protocols and SLAs would be monitored on an on-going basis through the Treatment and Rehabilitation Sub-Group of the Task Forces (see 3.38 and 3.39). The Rehabilitation Co-ordinators would report on matters arising to the NDRIC. The quarterly NDRIC reports, prepared by the Senior Rehabilitation Co-ordinator, for submission to the IDG would outline progress achieved in regard to SLAs and any difficulties requiring decisions or interventions.

CASE MANAGEMENT AND CARE PLANS

3.24 The HSE has the lead role in relation to case management and tracking the progression of service users as they move through the continuum of care. The HSE is responsible for the case management function and for ensuring that function is carried out either by the HSE itself or by a delegated agency. Within the overall model, there needs to be case management of clients through the development of individual care plans. The Working Group accepted that client-centred care plans - i.e. plans which are appropriate for the individuals and based on an assessment of their needs; which have negotiated and agreed goals, revised and updated as necessary; and which are supported by case managers – represent an appropriate strategy. Standard drug rehabilitation assessment forms, for use at different stages in a person's drug use, should form the basis for the development of care plans. These rehabilitation care plans should address the needs of the whole person, from measures to address drug use to personal and social development, education and so on. In this way, care plans need to draw upon different services in different settings, e.g. health care might be provided by a GP in a primary health care setting and educational training by a community college. Care plans would be dynamic so that they would adapt to take account of the progress/setbacks experienced by the client.

3.25 The process of drug rehabilitation should begin at the first point of help-seeking contact a drug user makes to a drug-related service. Each drug service should have at least one drug worker who is trained to conduct rehabilitation assessments and should have a referral system in place.

CASE MANAGER AND KEY WORKER:

3.26 The HSE is the organisation with the lead role in relation to case management in that they are responsible for ensuring that each person is appropriately supported through the rehabilitation system. The HSE will have responsibility for tracking the client's progress from first entry to a service to their final completion of the rehabilitation process, brokering services on behalf of the client where necessary.

The case manager, who can be located in the HSE or in the community or voluntary sector, will liaise with all relevant Agencies to ensure that appropriate services ranging from comprehensive assessment to appropriate supports are in place for each client. The role of case manager will include ensuring that the client's needs are satisfactorily assessed and that, while under the management of his/her service, the client receives an appropriate range of services commensurate with their needs. The case manager will liaise with any Key Worker who is dealing directly with the client in the delivery of the service involved. A client will have a different person as case manger at different times, changing at significant points in their progression (typically as they move to avail of the services of a different agency).

3.27 The emphasis will be on ensuring that clients do not fall between gaps in service provision. In doing this, the case manager would seek to address any blocks and concerns that may hamper the delivery of the care plan at any point in the process (in some instances this may entail involving the Rehabilitation Co-ordinator or having the matter raised at the Treatment and Rehabilitation Sub-Group of the relevant Drug Task Force or, where warranted in exceptional circumstances, through the NDRIC).

3.28 As indicated previously with respect to the need for protocols and SLAs, it will be necessary to ensure that the HSE and the Community & Voluntary services have a strong relationship in terms of reporting client access to services, progress made and referrals. This would result in treatment/ rehabilitation professionals (in whatever setting) working closely together and avoiding duplication, or interventions that might not fit with the overall care plan.

QUALITY STANDARDS FRAMEWORK

3.29 A quality standards framework should be developed for service providers, with enhanced case management procedures, aimed at ensuring the provision of a consistently high quality level of service and a more co-ordinated response to the needs of problem drug users as well as facilitating improved monitoring procedures with respect to the progress of users through the rehabilitation process. The broad framework, building on existing standards, would be set out by the NDRIC, following similar procedures to those involved with the development of protocols and SLAs (approval through the Inter-Departmental Group on Drugs would not be involved). Implementation of quality standards is the responsibility of the service providers, and they would complete a specific quality standards document that would be monitored by the local rehabilitation co-ordinator.

3.30 Stemming from the development of a quality standards framework, the core competencies required to deliver rehabilitation programmes must be determined and any additional training needs of service providers should be identified and addressed.

REHABILITATION CO-ORDINATORS

3.31 A new role of rehabilitation co-ordinator is recommended. They will be responsible for:

- chairing the National Drugs Rehabilitation Implementation Committee (Senior Co-ordinator) and participating as members of the Treatment/ Rehabilitation Sub-Groups of the Drug Task Forces (where they will take the lead with respect to the recommendations of this report);
- co-ordinating the overall drugs rehabilitation effort across the country;
- facilitating the development of protocols for inter-agency working;
- facilitating the putting in place of Service Level Agreements between agencies;
- broadly monitoring case management arrangements;
- facilitating the development of a quality standards framework; and
- identifying the training needed by rehabilitation service providers to ensure the attainment of these standards.

3.32 It is envisaged that one senior rehabilitation co-ordinator will be appointed along with a number of rehabilitation co-ordinators (10 is suggested) and appropriate levels of support staff. The Senior Rehabilitation Co-ordinator will oversee the implementation of the rehabilitation effort and liaise with the other co-ordinators in regard to operations in their individual areas to ensure consistency and high quality in rehabilitation standards.

3.33 The Rehabilitation Co-ordinators will be located in the HSE, who hold the lead role in relation to case management and tracking the progression of service users as they move through the continuum of care and who are responsible for

ensuring that Actions 47 (continuum of care), 48 (range of treatment/rehabilitation options) and 50 (quality standards) of the National Drugs Strategy are implemented. This may involve an increase in the ceiling figure for HSE personnel, unless posts can be filled from within existing structures.

3.34 The areas of operation of the co-ordinators would correspond (as far as is practical - some variation might arise in the Dublin area in particular) with the boundaries of Drugs Task Force areas (i.e. each rehabilitation co-ordinator would be likely to cover the geographical area of more than one Drugs Task Force).

3.35 The Rehabilitation Co-ordinators will be responsible for ensuring that the local protocols are developed in the geographical areas of operation of the individual co-ordinators. These local protocols would be referred to the Treatment and Rehabilitation Sub-Group of the relevant Drugs Task Force(s) and the Rehabilitation Co-ordinator for the area would subsequently refer them on to the National Drugs Rehabilitation Implementation Committee, through the Senior Rehabilitation Co-ordinator, for final agreement. The Co-ordinators will also ensure that the client referrals process is being overseen and seek to address any difficulties/ obstacles arising therein. They would also ensure that quality up-dated standards are in place in rehabilitation services and that case management is being adequately monitored.

3.36 The Rehabilitation Co-ordinators will also have a role, in conjunction with the service providers (and HSE Case Managers as appropriate), in the development of SLAs as outlined above, drafting and achieving agreement on standard drug rehabilitation assessment forms and ensuring that each drug service has the capacity to conduct rehabilitation assessments.

3.37 Should issues arise where difficulties or disputes could not be resolved by the agencies involved or through the involvement of the Rehabilitation Co-ordinators, the Treatment and Rehabilitation Sub-Groups of the Task Force or the NDRIC, they will be presented at IDG level for decision. Ultimately substantive policy issues not resolved in this way will be referred for decision to the Cabinet Sub-Committee on Social Inclusion – such referrals being seen as very much the exception.

TREATMENT AND REHABILITATION SUB-GROUPS OF DRUGS TASK FORCES

3.38 The Drug Task Forces through their Treatment and Rehabilitation Sub-Groups will be responsible for signing off the local protocols for rehabilitation co-ordination developed, under the framework of the broad national-level protocol, by the relevant organisations directly involved in the delivery of rehabilitation at local level. These local protocols will then be referred to the National Drug Rehabilitation Implementation Committee for final agreement. Subsequently the Treatment and Rehabilitation Sub-Groups of Drug Task Forces would monitor the implementation of the protocols on an on-going basis.

The Working Group acknowledges that many of the Local Drugs Task Forces have had Treatment & Rehabilitation Sub-Groups in place for some years and that these have done valuable work. However, the Working Group considers that rehabilitation needs to be more fully supported and prioritised for the foreseeable future if we are to achieve the model of inter-agency working, with agreed protocols and SLAs, outlined in this report. Therefore we are recommending that each Treatment and Rehabilitation Sub-Group will include a Rehabilitation Co-ordinator as a member and that person will take the lead on the Sub-Group with regard to the implementation of the recommendations of this report. The Rehabilitation Co-ordinators will be supported in this regard by the chairpersons of the Sub-Groups and any necessary changes to the guidelines for such Sub-Groups will be made to facilitate these arrangements.

3.39 The Sub-Groups will also be responsible for ensuring that Service Level Agreements between Agencies at local level are put in place and operated and that there is adherence to agreed quality frameworks.

3.40 The Drugs Task Forces will continue their current role and relationship with the NDST in respect of the assessment/recommendation of actions submitted under the Drugs Task Force process.

3.41 The Working Group is advised by the National Drugs Strategy Team that the Treatment and Rehabilitation Sub-Groups of the individual Local and Regional Drugs Task Forces are at varying stages of development and effectiveness (in some cases such Sub-Groups have not been established). The NDST secretariat will work with the Task Forces to ensure that they all achieve best practice standards in the short-term. Reflecting the composition of the National Drug Rehabilitation Implementation Committee, these Sub-Groups should have a broad representation of those involved in rehabilitation in the area concerned and representatives should be at an appropriate level of authority in their organisations.

ROLE OF DEPARTMENTS & AGENCIES

The main Departments and Agencies involved (to varying levels of intensity) in the rehabilitation of problem drug users from a policy and/or an operational perspective are as follows:

- **Department of Community, Rural & Gaeltacht Affairs:**
  The Department will continue to develop policy and to co-ordinate the National Drugs Strategy to tackle drugs misuse in Ireland, with particular emphasis on rehabilitation as the fifth pillar of the strategy. The Department also funds (and administers in the case of Community Development Projects) a number of programmes of support for community development so that socially excluded groups and local communities can be active participants in identifying and meeting their own development needs.

- NDST:
  Over and above its key role with respect to supporting the development of action plans to provide area-based responses to the issues surrounding problem drug use, the NDST will:
  - ensure that all Drugs Task Forces have an active Treatment and Rehabilitation Sub-Group;
  - facilitate the development of Cross Task Force treatment and rehabilitation facilities;
  - be represented, as will its constituent Departments, Agencies and organisations, on the National Drugs Rehabilitation Implementation Committee; and
  - continue their current role and relationship with Drugs Task Forces in respect of the assessment/ recommendation of rehabilitation actions submitted under the Drugs Task Force process.

- **Local and Regional Drugs Task Forces:**
  The role of the Drugs Task Forces is to ensure the development of a co-ordinated and integrated response to tackling the drugs problem in their areas. They represent a partnership-based response to drug misuse, involving not only inter-agency but inter-sectoral collaboration, with particular focus on involving the community and voluntary sectors in the planning and delivery of community-based services.

  All Drug Task Forces will have (in some cases these have yet to be established) a Treatment and Rehabilitation Sub-Group to facilitate working with the NDRIC structure on an on-going basis and to plan community-based services in conjunction with the NDST. The role of the Sub-Groups will be reviewed and redefined in the context of this Report by the NDRIC, in conjunction with the NDST and the Rehabilitation Co-ordinators. In the context of this Report, and within the framework of agreed national protocols, their role will include:
  - the continued referral of clients to FÁS special CE schemes;
  - addressing specific issues to meet the needs of clients in areas such as health/ treatment (HSE), accommodation (Local Authorities) and education (VECs);
  - exploring the development of Cross Task Force facilities; and
  - establishing networks of recovered problem drug users who have progressed to employment so that peer support, help, and motivation can be provided to those who are preparing for similar progression.

- **Department ofHealth & Children:**
  The Department of Health & Children is responsible for formulating and monitoring the implementation of policy in respect of health and personal social services. In relation to the National Drugs Strategy, the role of the health services relates primarily to the development of treatment services, to supporting prevention efforts in partnership with other actors such as the Local and Regional Drugs Task Forces and the Department of Education & Science, and to supporting research in partnership with the National Advisory Committee on Drugs and the Department of Community, Rural & Gaeltacht Affairs.

- **Health Services Executive:**
  Under the Health Act 2004, the Health Services Executive is responsible for the management and delivery of health and personal social services in line with national policy.

  In the context of rehabilitation, the health sector plays a key role in providing treatment services for problem drug users. These treatment services enable clients to achieve a level of stabilisation which allows them to benefit from the personal supports, education, training and employment services which are provided by

other agencies and which are key elements of their rehabilitation within society. The HSE also have responsibility for a number of other services which can be used to provide support to those in rehabilitation particularly centered around childcare services, whether they be child protection services or child support services through family support (e.g. Springboard).

The HSE expend about €93m annually on addiction services and they are also the main channel of funding for interim Drugs Task Force projects funded by the Department of Community, Rural & Gaeltacht Affairs. The Rehabilitation Co-ordinators will constitute part of the HSE structure, while having a reporting relationship on rehabilitation matters to the IDG from the National Drugs Rehabilitation Implementation Committee, which will be chaired by the Senior Rehabilitation Co-ordinator.

- Office of the Minister for Children (OMC):
  The recently established Office of the Minister for Children, under the aegis of the Department of Health and Children, focuses on harmonising policy issues that affect children in areas such as early childhood care and education, youth justice, child welfare and protection, children and young people's participation, research on children and young people and cross-cutting initiatives for children. The responsibilities of the OMC include the Equal Opportunities Childcare Programme, programmes and activities of the National Children's Office and policy work on child protection. The OMC also maintains a general strategic oversight of bodies with responsibility for developing and delivering services for children. The Office of the Minister of Children, in association with the Department of Social and Family Affairs and the Central Statistics Office, has responsibility for the governance of the first National Longitudinal Study of children in Ireland entitled "Growing up in Ireland" which is now underway.

- Department of Justice, Equality andLaw Reform:
  The Department provides the policy framework within which the services under its aegis, An Garda Síochána, the Irish Prison Service and the Probation Service operate. It provides strategic direction and guidance to these services and is responsible for monitoring their performance in line with agreed policy objectives. Under its equality remit the Department has responsibility for the co-ordination of actions to support Travellers through the High Level Group on Travellers and also has responsibility for the strategic management and overview of the needs of new communities in Ireland.

- An Garda Síochána:
  The principal elements of Garda services potentially involved with aspects of rehabilitation are the Juvenile Liaison Scheme and the Garda Youth Diversion Programme. They deal with young offenders and those at risk of offending in the 12-18 age bracket, an element of whom are engaged in problem drug use. These projects are primarily preventative in nature but there can be a rehabilitative aspect to their work.

- Irish Prison Service:
  In May 2006 the Irish Prison Service drugs policy and Strategy entitled 'Keeping Drugs out of Prison' was published. In addition to providing a co-ordinated national approach to eliminating drug supply in prisons, the strategy aims to ensure that appropriate treatment is available to prisoners to help them overcome their drug problem. The programme to be undertaken has as its objectives:

- the development of a comprehensive, multidisciplinary assessment process which would assist in matching prisoners to the most effective and appropriate treatments and interventions available:

- the development of individualised programme plans for prisoners having due regard to their particular circumstances; and

- the provision for continuity of post-release treatment, care and support services.

- Probation Service:
  The Probation Service, through its work within prisons and in the community, provides support services to prisoners, ex-prisoners and other offenders, many of whom are problem drug users. The Service currently provides funding to 66 community-based voluntary bodies nationwide that provide a range of services to offenders in local communities, e.g. pre-industrial training and education, offender management programmes, residential accommodation, drug and alcohol abuse treatment/ intervention/awareness programmes, work with offenders in custody and post release, as well as providing a vital ingredient of a focussed programme for those found guilty of criminal offences by the courts and placed on supervision to the Probation

Service. These community projects work closely with Probation Service staff (who refer offenders to them) in the community and in prisons to enhance the re-integration and resettlement experiences of offenders. Approximately €21m, representing over 40% of the total Probation Service budget (€50 million in 2006) is dedicated to funding and supporting these projects.

Specifically in relation to drugs rehabilitation, the Department of Justice, Equality and Law Reform, through the Probation Service, provide annual grants for 18 projects aimed at recovering problem drug users, with the 2006 approved grants amounting to over €2.3m. Other projects provide services that, while not being specifically aimed at recovering problem drug users, can be availed of by them.

- Department of Education & Science / Vocational Education Committees (VECs):
  While the Department of Education & Science does not run any programmes or schemes designed specifically around drug rehabilitation, it does provide a range of educational services, through various agencies, which may be accessed by problem drug users as part of a rehabilitation process. It funds a number of programmes and schemes, both directly and indirectly, that target marginalized/ disadvantaged communities and that are accessible to the target group. The programmes involved relate primarily to Adult/Community Education, Social Inclusion Initiatives and Youth Affairs. The Department also has overall responsibility for accreditation, which is administered by the National Qualifications Authority, the Further Education Training Awards Council and the Higher Education Training Awards Council.

  VECs develop and deliver vocational education and training to meet the needs of early school leavers and adults requiring second chance education and to address the skills needs of entrants and re-entrants to the labour market. Among the support services that are provided by VECs are the adult education guidance service, back to education initiative, community education facilitators, drugs court initiative, education service to prisons, Youthreach, VTOS (Vocational Training Opportunities Scheme) and projects with the homeless service. They will continue to be instrumental in delivering proactive engagement with the relevant elements of the Community and Voluntary sector on adult education themes, similar to those already in place within the Youth Services framework.

  The Department, and in particular the VECs, will continue to develop these services in an increasingly pro-active way. They will be involved in particular with the development of pre-CE projects aimed at those in the early stages of rehabilitation.

- FÁS:
  FÁS, as Ireland's national training and employment authority, provides a range of training and work experience supports to assist those who wish to enter, or return to, the labour market or to upskill themselves in their current employment. As a specific support for people recovering from drug misuse, FÁS provides Drugs Task Force Community Employment Schemes (special CE schemes) that aim to assist recovering problem drug users to enter, or return to, the world of work and gain economic independence. These programmes are a very important element in the rehabilitation process. There are 1,000 ring-fenced special CE places for recovering problem drug users across 65 projects. The main focus of the schemes is to provide training and other supports to assist in the process of rehabilitation. FÁS will support the development of the pre-CE projects for those in the early stages of rehabilitation.

- Department of Social & Family Affairs:
  The Department of Social & Family Affairs, over and above its primary role with respect to income support, has in place a number of services, whether offered directly or through Agencies under its aegis, that provide supports to problem drug users. These services include their Information Offices, Employment Support Services, the Money Advice & Budgeting Service (MABS), the Family Support Agency and their network of Family Resource Centres. The latter two are Agencies under the aegis of the Department.

  MABS was established by the Department to address the problems of money lending and indebtedness. Funded by the Department, it is now available in a number of centres throughout the country. It is an independent voluntary service for individuals or families, primarily those on low incomes, who need guidance in managing their finances in order to avoid getting into difficulties with creditors and moneylenders.

  Projects under the aegis of the Family Support Agency operate much like Community Development Projects, except they have a specific focus on family issues. The programmes and services are designed to promote local

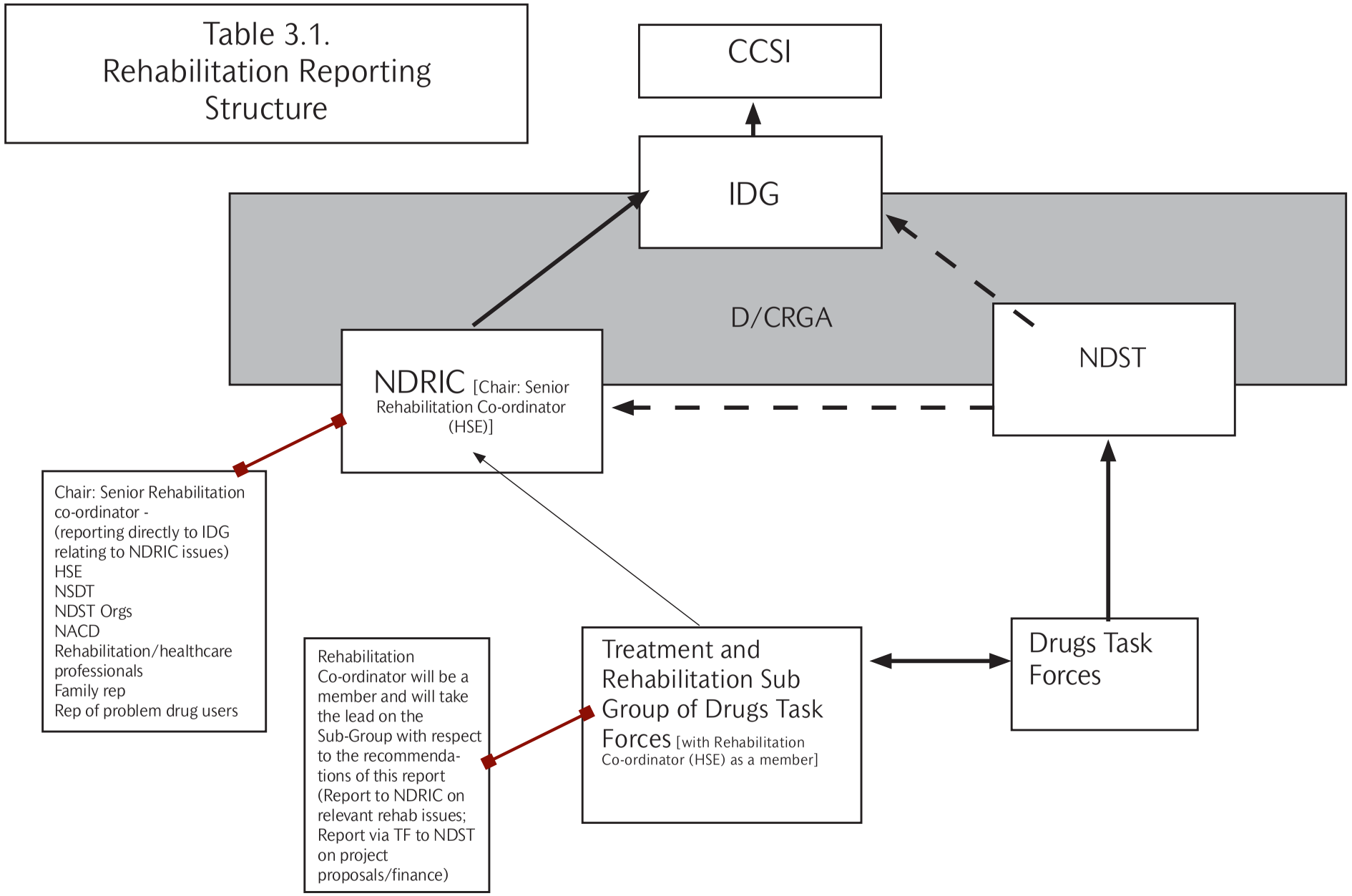
family support, to support ongoing parenting relationships for children and to help prevent marital breakdown. It also has responsibility for the provision of information, and the undertaking of research, on family related matters.

- Department of the Environment,Heritage & Local Government:
  The Department of the Environment, Heritage and Local Government is responsible for the formulation and implementation of policy, and for the preparation of legislation in relation to housing. While the Department does not have a specific strategy in relation to problem drug users, under the new Housing Policy framework specific strategies are being considered to meet the housing requirements of people with special needs, including the homeless population where there is considerable overlap with problem drug use.

- Local Authorities:
  Among the responsibilities of local government is the provision of social and affordable housing in local areas, including Traveller specific accommodation and delivery of accommodation and related services for homeless people. Local Authorities are also responsible for the management and maintenance of housing estates. A number of legislative measures have been put in place to assist Local Authorities in addressing problems arising on their estates in relation to drug dealing and serious anti-social behaviour. Powers available to Local Authorities include the application of excluding orders against individuals who are believed to be engaging in anti-social behaviour and eviction procedures for serious breaches of tenancy agreements. In addition, Local Authorities have expanded their social inclusion and community development role, particularly through the establishment of Community and Enterprise Sections and their lead role on County and City Development Boards (CDBs), who in turn support Social Inclusion Measure Working Groups. As well as this, Social Inclusion Units, established on a pilot basis in 8 Local Authorities in 2002, were placed on a permanent footing in 2006. In line with a commitment in *Towards 2016*, this programme will be extended to 50% of the county/city Local Authorities by the end of 2008 with financial support from the Department of the Environment, Heritage & Local Government.

- Homeless Agency:
  The Homeless Agency is responsible for the management and co-ordination of services to people who are homeless in the four Dublin Local Authority areas, and for the implementation of agreed action plans that aim to eliminate homelessness in the Dublin area by 2010. The Agency is a partnership structure, bringing together the statutory and voluntary agencies responsible for planning, funding and delivering services to people who are homeless.

Table 3.1.
Rehabilitation Reporting Structure



CHAPTER 4

RECOMMENDATIONS

4 Recommendations

INTRODUCTION

4.1 The following section outlines the main issues identified by the Working Group as being important to the rehabilitation process and the recommendations for actions arising therefrom.

KEY RECOMMENDATIONS

1. Rehabilitation can only be delivered effectively through an inter-agency approach based on a continuum of care that operates within the context of enhanced case management and a quality standards framework. The development of protocols for interagency working, with service level agreements between agencies and co-ordination by rehabilitation co-ordinators, is required.

2. An adequate level of treatment provision is central to rehabilitation. An expansion of the range of treatment options, including an increase in the number of residential detoxification beds, for recovering drug users is essential. The HSE led Working Group on Residential Treatment /Rehabilitation should consider the issue of treatment provision and make detailed recommendations in this regard.

3. The impact of Community Employment on rehabilitation should be built upon by complementary support and involvement from the HSE, the Department of Education and Science and relevant agencies to ensure that the health and educational needs of participants are being properly addressed during their period of participation, as well as pre and post such participation.

4. The housing, childcare, educational and health needs and the employment opportunities of recovering drug users should be addressed through specific initiatives.

INTEGRATED REHABILITATION SERVICE

4.2 Throughout the deliberations of the Working Group problems involved in inter-agency working were highlighted as barriers to the progression of clients through different services. Inter-agency links need to be strengthened and services need to be 'client centred', matching their needs at any point in time to the appropriate service. Accordingly, at an early stage the client's needs should be assessed, ideally in the drugs service with which s/he makes first contact, with a view to drawing up a care plan. A decision as to who qualifies as a problem drug user is one for the treatment service provider, based on assessment and need. In order to maximise the resources being invested, internationally accepted best practices and standards, which are subject to an external evaluation process, need to be followed and appropriate performance indicators need to be put in place. A Quality Standards Framework needs to be developed for service providers, with enhanced case management procedures, aimed at ensuring a more co-ordinated response to the needs of problem drug users as well as facilitating improved monitoring procedures with respect to the progress of users through the rehabilitation process. Having established the core competencies required, the training needs of the service provider staff will need to be identified and appropriate training provided. Each organisation involved in services for drugs rehabilitation must set out (and revise and update as necessary) aims, objectives and broad methodology for services delivering rehabilitation programmes. Within the context of the implementation of the recommendations hereunder, it will be necessary to afford time to identified personnel to facilitate the development of relationships and networks between people in the various services. This will be particularly so in the early stages of the implementation of the recommendations.

4.3 The following recommendations are made in relation to the delivery of an integrated rehabilitation service:

RECOMMENDATIONS

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

   The broad national protocols will be developed through the National Drugs Rehabilitation Implementation Committee and will be approved through the Inter-Departmental Group on Drugs and, at Ministerial level, through the Cabinet Committee on Social Inclusion.
   Responsibility: Rehabilitation Co-ordinators in conjunction with National Drugs Rehabilitation Implementation Committee (lead on drawing up), IDG and Cabinet Committee on Social Inclusion (lead on approval).

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 Coordinators in conjunction the Treatment and Rehabilitation Sub-Groups of the Drugs Task Forces (lead on drawing up), National Drugs Rehabilitation Implementation Committee (lead on approval).

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 Co-ordinators in conjunction with (i) National Drugs Rehabilitation Implementation Committee (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).

4. The employment and management of Rehabilitation Co-ordinators (including a Senior Rehabilitation Co-ordinator) to co-ordinate the overall drugs rehabilitation effort across the country within the parameters outlined above, including the development of protocols governing the referral of clients between services and facilitating the putting in place of SLAs between agencies, monitoring case management arrangements and facilitating the development of a quality standards framework.
   Responsibility: HSE

5. The establishment of a rehabilitation co-ordinators network to facilitate building on successes and avoiding repetition of failures.
   Responsibility: Senior Rehabilitation Co-ordinator.

6. The development of criteria to ensure that all State-funded treatment and rehabilitation programmes accord with quality standards which are to be set out by the National Drugs Rehabilitation Implementation Committee in conjunction with the HSE (Action 50 of the National Drugs Strategy refers).
   Responsibility: NDRIC (lead), HSE, NACD.

7. The development of national template assessment instruments for problem drug users at different stages (including initial qualification as a problem drug user) of their drug use/rehabilitation.
Responsibility: Rehabilitation Co-ordinators (lead), NDRIC.

8. The development of templates for individual rehabilitation care plans.
Responsibility: Rehabilitation Co-ordinators (lead), NDRIC, Service Providers.

9. In line with best governance practice, all services involved in drugs rehabilitation should be subject to a periodic external evaluation process. Provision for this should be made in the Service Level Agreements.
Responsibility: HSE (lead) and other Service Providers.

10. The nomination of personnel in the HSE to fulfil their lead role in relation to case management whereby that organisation is responsible for ensuring that each person is appropriately supported through the rehabilitation system.
Responsibility: HSE

11. The nomination of case managers (who can be located in the HSE or in the community or voluntary sectors) to liaise with all relevant agencies to ensure that appropriate services ranging from comprehensive assessment to appropriate supports are in place for each client. The role of case manager will include ensuring that the client's needs are satisfactorily assessed and that, while under the management of his/her service, the client receives an appropriate range of services commensurate with his/her needs.
Responsibility: HSE, Service Providers (joint lead).

12. The development of training structures, building on those existing, with appropriate accreditation, for case managers and key workers in drugs rehabilitation - addressing issues such as assessment, case management, care planning, training for inter-agency working, awareness training in relation to the services provided by other organisations and accountability. All service provider staff should have sufficient training to deliver the aspect of rehabilitation for which they are responsible.
Responsibility: NDRIC (broad framework), HSE/other service providers (in relation to ensuring that their personnel are properly trained), Training & Education providers, Further Education Training Awards Council and Higher Education Training Awards Council (in relation to accreditation).

13. The provision of appropriate drug related training for non-drug specific mainstream service personnel who provide rehabilitation programmes to problem drug users.
Responsibility: Service Providers, various agencies.

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.

15. An on-going Directory of Service Providers for drug treatment and rehabilitation in Ireland should be developed and maintained.
Responsibility: HRB.

16. The National Drug Treatment Reporting System should be developed to provide enhanced tracking and monitoring of problem drug users as they progress through treatment and rehabilitation.
Responsibility: HSE (lead), HRB.

MEDICAL SUPPORT

4.4 From the consultations of the Working Group it is clear that there are two fundamentally different views in relation to the rehabilitation of opiate users - one view is that stabilisation through continued use of methadone (or an alternative) is a successful outcome for those problem drug users whose aim is harm reduction (as opposed to total abstinence). The alternative view contends that, while methadone use can be useful as a transitional measure in the treatment/rehabilitation process, it should not be regarded as a successful long-term solution. Limited availability of structured

progression routes into, and from, detoxification can create tensions with respect to the rate of progression from medical to psycho-social aspects of rehabilitation. Clients often feel that they are not given adequate options regarding their treatment and care-plans and they feel a lack of personal control over the process. This is particularly evident in relation to detoxification.

4.5 While chronic problem drug users may need to avail of the services of residential detox services, a less intense service may be more appropriate for other problem drug users. Particularly for those with strong family/community support, community-based non-residential detoxification may be the more appropriate option. In practice, this involves the problem drug user attending his/her local GP service on a regular basis.

4.6 Some problem drug users cease taking drugs themselves without any treatment or support, with considerable consequent dangers. The Working Group considers this practice to be unsafe.

4.7 The expansion of rehabilitation facilities and detox facilities go hand in hand. As many residential facilities require clients to be drug-free on admission, the expansion of residential rehabilitation provision requires a corresponding increase in detox capacity. It is envisaged that the Working Group on Residential Treatment/Rehabilitation established in September 2006 to advise the HSE on residential treatment will make detailed recommendations regarding a number of issues including the future range, scope, type and method of delivery of residential rehabilitation.

4.8 Many rehabilitation services are focused on opiate misuse. However, in the past few years cocaine use, the misuse of prescribed medication in conjunction with illicit drugs, and polydrug use generally, have posed challenges to the delivery of services. In the future, there needs to be a transition to the provision of non drug specific services to meet evolving needs in a better and more flexible way. It is also important that the HSE explore the scope for introducing greater provision of evaluated alternative medical and non-medical treatments, which would facilitate greater flexibility and choice as set out in Action 55[35] of the National Drugs Strategy.

35 Action 55 calls on the HSE to explore immediately the scope for introducing greater provision of evaluated alternative medical and non-medical treatment types, which allow greater flexibility and choice.

36 From 23 to 48

37 The Department of Health and Children and the Health Service Executive are reserving their position on this recommendation pending the completion of the report of the Working Group on Residential Treatment / Rehabilitation in the context of addiction.

RECOMMENDATIONS

1. An appropriate level of treatment services for problem drug users should be made available. Service providers should discuss all treatment options with individual clients, including options around detoxification.**Responsibility: HSE (lead), Service Providers / GPs.**

2. The range of treatment options for recovering drug users, particularly counselling and therapeutic services, needs to be expanded and existing drug specific services should be re-orientated with a view to enabling a comprehensive drugs service aimed at all drugs to be provided.
Responsibility: HSE (lead), Service Providers.

3. Clients should be supervised by medical personnel during detoxification in all settings and should be supported by appropriately qualified service providers.
Responsibility: Service Providers (lead), HSE. (D/H&C reserve position)

4. As an interim measure, the number of residential detoxification beds provided should be increased by 25[36] pending the outcome of the work of the Working Group on Residential Treatment/ Rehabilitation[37].
Responsibility: HSE.

5. The role of the voluntary sector in the provision of detox facilities should be reviewed and integrated within an overall strategic detox provision.
Responsibility: Working Group on Residential Treatment/Rehabilitation (lead), HSE.

6. An increase in the number and geographical spread of residential detox places provided by the non-statutory voluntary and community sectors is required. This would be organised in co-operation with the health services to ensure the appropriate level of involvement of medical personnel. The Working Group on Residential Treatment/Rehabilitation should make detailed recommendations in this regard, including recommending the optimum number and geographical spread of such detox facilities.
Responsibility: Working Group on Residential Treatment/Rehabilitation (lead), HSE.

7. The possibility of developing cross Drugs Task Force facilities should be explored. **Responsibility: Rehabilitation co-ordinators (lead), Drugs Task Forces, NDST.**

8. The involvement of more local GPs in drug treatment should be pursued. GPs should be encouraged to support clients through a process of detoxification and should facilitate the phased withdrawal from methadone where opiate users aim for total abstinence (Action 56 of the National Drugs Strategy refers)[38] . **Responsibility: HSE (lead), Irish College of General Practitioners.**

9. A concerted effort should be made to increase the number of participating pharmacies. By providing services in the community in which the problem drug user lives, the pharmacist can aid the stabilisation and rehabilitation of the problem drug user. Furthermore, their involvement in the overall treatment programme for the recovering problem drug user would facilitate early identification of any problems being encountered (Action 56 of the National Drugs Strategy refers). **Responsibility: HSE.**

COMMUNITY EMPLOYMENT

4.9 The Working Group note the contribution being made by the Community Employment (CE) Scheme to the drugs rehabilitation effort and acknowledge the role played by FÁS in this regard. It is recommended that the relative success of Drugs Task Force CE Projects be built upon. CE Drug Projects have been designated as "special" projects in recognition of the fact that they are not operating as a labour market mechanism in the same way as mainstream CE, but rather as a support mechanism through which drug rehabilitation programmes can be delivered. Nine key adjustments have been made which differentiate CE Drug Projects from mainstream CE and these adjustments are based on the needs of the target group of recovering drug users. In future FÁS should liaise with the National Drug Rehabilitation Implementation Committee in regard to any proposals for curriculum development and accreditation of modules relating to these projects.

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

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

4.10 Stabilised and recovering drug users, along with projects that target these groups, have been included in the programme guidelines for the Community Services Programme for 2007.

RECOMMENDATIONS

1. The health requirements of CE participants should be addressed during their period on schemes. This would involve direct involvement of the HSE, working in partnership with the schemes, in all Drugs Task Force CE Schemes, with service level agreements covering such issues as counselling, therapeutic support, mental health support, as well as general health (including dental health) and social services. Such initiatives would support the building of confidence and self esteem. **Responsibility: HSE (lead), FÁS, Service Providers.**

2. The educational requirements of CE participants should be addressed during their period on schemes. This would involve direct involvement of the VECs, working in partnership with the schemes, in all Drugs Task Force CE Schemes, with service level agreements covering such issues as numeracy and literacy and general educational requirements, leading in some cases to re-entry to formal education. Again such initiatives would support the building of confidence and self esteem. **Responsibility: VECs (lead), Department of Education & Science, FÁS, Service Providers.**

3. The number of drug-specific CE places should be increased from 1,000 to 1,300 to provide more opportunities in view of the levels of demand and the settling down of Regional Drugs Task Forces (Action 74 of the National Drugs Strategy refers[39]). It is envisaged that this will be done through an increase in the overall number of CE places with consequential financial implications. **Responsibility: FÁS (lead), Department of Enterprise, Trade & Employement.**

4. Participation on CE Schemes should be viewed as a progressive continuum with the options of the pre-CE initiative (see 6 below), Drugs Task Force CE Schemes and mainstream CE Schemes being available to clients as appropriate. This would extend, as needed, the period of support available.
Responsibility: FÁS (lead), Department of Enterprise, Trade & Employment.

5. Links to other appropriate training programmes, such as Local Training Initiatives (LTI), should be further developed with the support of Local Employment Services (LES)/Area Based Partnerships to encourage progression from CE.
Responsibility: FÁS (lead), Department of Enterprise, Trade & Employment, Area Based Partnerships.

6. A pre-CE stabilisation initiative, focusing on preparation for participation in CE programmes, should be developed. Issues to be covered will include scope and content. It is envisaged that the duration of any scheme should not exceed three months. Entry into the pre-CE scheme should follow a joint assessment involving HSE treatment services and CE providers.
Responsibility: HSE (lead), FÁS, VECs, Service Providers.

7. Effective implementation of the Drugs Task Force CE schemes as part of an overall rehabilitation framework is dependent on a clear commitment to the model at both management level and local delivery level within FÁS. It is recommended that consideration be given to assigning a post at appropriate management level within FÁS with the specific responsibility of overseeing and monitoring the effective implementation and delivery of the Drugs Task Force CE schemes.
Responsibility: FÁS.

8. With respect to the Community Service Programme for 2007, the issue of provision of counselling, educational and back-up services should be addressed through engagement with the HSE and VECs at a local level as projects are developed, or as recovering drug users are included in projects.
Responsibility: Department of Community, Rural and Gaeltacht Affairs (lead), HSE, VEC.

EMPLOYMENT

4.11 Recovering drug users experience difficulties in moving on from assisted employment, and in obtaining mainstream employment generally. Also, while some recovering drug users have no problem with their employers being made aware of their position, others may be of a different view. Employers may have understandable concerns about employing former or stabilised drug users and they need to be supported in this regard by having ready access to advice, models of good practice etc. The employee likewise may need support in settling into a job. Part of the Rehabilitation Co-ordinators function will be strengthening links with employers' organisations and Trade Unions nationally and building up links with individual employers and Partnerships at local and regional level.

4.12 While current tax/PRSI concessions linked to taking on employees generally can be availed of by those employing recovering drug users, and efforts have been made to consolidate such concessions, their adequacy in relation to recovering drug users should be kept under review.

RECOMMENDATIONS

1. Access to ongoing support (through the national employment services [LES/FÁS] personnel in conjunction with relevant case managers) should be available to employers of former and stabilised drug users, as well as to other employees of the firm/organisation. These services would also act as mediator in cases where difficulties arise.
Responsibility: Case managers (lead), LES, FÁS.

2. The case manager should act as a support for the recovering drug user in employment, addressing any issues or difficulties that might arise.
Responsibility: Case managers.

3. Awareness training on the issues associated with recovering drug users should be developed and made available to prospective employers.
Responsibility: Rehabilitation Coordinators (lead), Department of Enterprise, Trade & Employment, IBEC.

4. Stronger links with employers, employer organisations and Trade Unions need to be established to facilitate easier access for recovering drug users to the workplace. The Social Partnership Labour Group on Market Issues could be a forum that would facilitate this.
Responsibility: Department of Enterprise, Trade & Employment (lead), Rehabilitation Co-ordinators, FÁS, ICTU, IBEC.

5. The potential benefits, including economic benefits, of fulfilling corporate social responsibility through initiatives, including the employment of rehabilitated drug users, should be emphasised.
Responsibility : Department of Enterprise, Trade & Employment (lead), Rehabilitation Co-ordinators, FÁS, IBEC.

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.

ACCESS TO EDUCATION

4.13 Accessing education is an essential step in the continuum of care for recovering drug users. Low levels of formal education predominate among people who present with problem opiate misuse. In these cases work on basic numeracy and literacy can be vital to a holistic approach to rehabilitation. Some students can make significant progress very quickly in these areas, once stabilised. Successful educational experiences at this level can be the catalyst to the development of a desire to continue to further their education.

4.14 Rehabilitation should adopt the principles underpinning 'lifelong learning'. Recovering drug users continue to experience difficulties in accessing further education, both at second and third level. Whether this further education is provided through adult education courses, such as community education or drugs-specific courses, or through mainstream education, there is a need for supports in areas such as finance (fees, books, materials and transport) and childcare.

4.15 The relationship between adult education providers and community and voluntary organisations needs to be further developed with a more proactive response by education bodies, in particular VEC's, required to enable problem drug users to be more fully integrated into education provision.

RECOMMENDATIONS

1. The barriers for recovering drug users to accessing education should be identified and removed, where possible. This would involve both systemic barriers (overly restrictive criteria for accessing schemes) and support barriers to facilitate the availing of schemes (fees, transport, childcare etc.)
Responsibility: Department of Education & Science (lead), Case managers, VECs, Department of Social and Family Affairs, Local Authorities and other relevant agencies.

2. Linked to 1 above, it is recommended that an "Education Fund for Drugs Rehabilitation" be established. This would (i) allow replacement funds be made available to problem drug users (in prescribed circumstances) in instances where they are not entitled to avail of mainstream schemes/grants relating to education and training and (ii) provide a "helping hand" to recovering drug users through providing funding (a) to support access to, and continuation with, a variety of courses and (b) to contribute towards reasonable costs involved.
Responsibility: Department of Education & Science

3. An Outreach approach should be developed by VECs to identify adult education needs of problem drug users in rehabilitation and to develop responses.
Responsibility: VECs (lead), Department of Education & Science, Service providers.

HOUSING

4.16 Lack of suitable housing is often one of the main barriers to the rehabilitation of problem drug users. Under the new Housing Policy framework, specific strategies are being considered to meet the housing needs of all those with special needs, such as the homeless[40] (which has a considerable overlap with drugs misuse), Travellers, older people and people with disabilities.

RECOMMENDATIONS

1. The specific issues in relation to the accessing by problem drug users of emergency, transitional and long term accommodation should be examined with a view to putting in place, at local level, the inter-agency procedures necessary to facilitate recovering drug users in accessing appropriate accommodation and the services necessary to ensure that tenancies can be maintained.
   Responsibility: Department of Environment, Heritage & Local Government (lead), NDST.

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: Department of Environment, Heritage & Local Government (lead), Drugs Tasks Forces.

3. Dedicated supported accommodation, staffed appropriately, should be provided to cater for those who have difficulties with an independent living environment. The provision of such accommodation is part of the existing homeless strategies and should be strengthened as part of the new homeless strategy.
   Responsibility: Department of Environment, Heritage & Local Government (Accommodation), HSE (Care Support).

4. Building on recent initiatives, the provision of transitional/half-way housing for recovering drug users should continue to be increased, (for example, through use of the Department of Environment, Heritage and Local Government Capital Funding Scheme). This involves largely independent living, with fallback and periodic support available, as well as networking with other recovered drug users. The trained care staff required for such housing should be supplied by the HSE and voluntary providers.
   Responsibility: Department of Environment, Heritage & Local Government (lead), HSE, Voluntary Providers.

5. Tenant Liaison Officers and others involved in tenant management issues should receive training to deal with all aspects of drugs-related tenant issues.
   Responsibility: Department of Environment, Heritage & Local Government.

6. The long-term housing needs of problem drug users, who are capable of independent living, should be addressed, for example, through the rental accommodation scheme.
   Responsibility: Department of Environment, Heritage & Local Government.

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: Department of Environment, Heritage & Local Government (lead), Drugs Task Forces.

40 One such strategy is the forthcoming Homeless Agency Partnership Action Plan on homelessness in the Dublin area 2007-2010, to be entitled 'A key to the door'.

REHABILITATION OF OFFENDERS

4.17. Many drug users receive criminal convictions. While being arrested can have the positive effect of precipitating problem drug users engagement in drug treatment, at the post treatment level, a criminal conviction can prove a serious impediment to rehabilitation and make successful re-integration into mainstream society more difficult. The development of rehabilitation of offenders legislation, which would allow for certain categories of criminal convictions to effectively become 'spent' after a specified period of time, was identified by the Steering Group who compiled the Mid-Term Review of the National Drugs Strategy as an issue which should be considered. The Rehabilitation Working Group is advised that the Law Reform Commission is examining the concept of expunging the sentences of recovering drug users after a period.

4.18. It is crucial that effective working relationships are established between the various disciplines and Agencies responsible for delivering a comprehensive 'throughcare' component to prison drug treatment. These throughcare processes must be co-ordinated through a multidisciplinary team approach, reflecting the range of services involved with problem drug using prisoners. The Irish Prison Service must form strategic and tactical partnerships, and increase its interaction with community-based agencies, to integrate and co-ordinate the delivery of services to prisoners as they re-enter the community.

RECOMMENDATIONS

1. Drug treatment and rehabilitation programmes should be made available to all problem drug users in prison in the context of mandatory drugs testing and drug-free prisons (Action 22[41] of the National Drugs Strategy and the Irish Prison Service drugs policy and Strategy 'Keeping Drugs out of Prison' refer) **Responsibility: Irish Prison Service (lead), Department of Justice, Equality & Law Reform.**

2. Arrangements should be put in place to ensure that a continuum of care will be available for all problem drug users when they leave prison. These arrangements should be robust and flexible enough to ensure that those released early, with short notice, or those on temporary release, are adequately followed up. **Responsibility: Probation Service (lead), Irish Prison Service, Department of Justice, Equality & Law Reform, Service Providers.**

3. A review of the operation of the Local Prisons Liaison Groups, whose current terms of reference include the co-ordination of prison-based drug treatment programmes with services and supports available in outside communities, should take place. **Responsibility: Irish Prison Service (lead), Department of Justice, Equality & Law Reform.**

CHILDCARE

4.19 Lack of childcare facilities presents a barrier in accessing treatment and rehabilitation options for many, women in particular. Although there was a concern that childcare facilities on the premises of drugs-related services could further stigmatise the children of the problem drug users, the alternative of having children present whilst parents are receiving methadone/therapeutic treatment/counselling was seen as potentially more detrimental. Meanwhile, childcare off-site is inconvenient. The view expressed during the consultations was that drugs-related services, including residential services, should have access to an appropriate level of childcare services and facilities either on-site or elsewhere. This needs to be progressed in the context of identifying gaps in existing service provision.

41 Action 22 of the National Drugs Strategy calls for an expansion of prison-based programmes with the aim of having treatment and rehabilitation services available to those who need them including drug treatment programmes, which specifically deal with the re-integration of the drug using offender into the family / community.

RECOMMENDATIONS

1. The HSE, in conjunction with the Office of the Minister for Children, should decide on how best to integrate childcare facilities with treatment and rehabilitation services and subsequently progress the matter (Action 54 of the National Drugs Strategy refers[42]).
   Responsibility: HSE (lead), Office of the Minister for Children.

2. An audit of gaps in existing childcare provision for children of problem drug users should be carried out. Research may be needed to ascertain the number of children with drug misusing parents and best practice in relation to integrating childcare into treatment and rehabilitation services.
   Responsibility: HSE (lead), Office of the Minister for Children.

3. Childcare services for the children of problem drug users should adopt an approach focused on the development of the children.
   Responsibility: Office of the Minister for Children (lead), HSE.

4. Parenting programmes for problem drug users should be further developed and implemented taking evidence based best practice into account.
   Responsibility: HSE (lead), Family Support Agency, Department of Social & Family Affairs, Office of the Minister for Children, NDST.

ROLE OF FAMILIES IN THE REHABILITATION PROCESS

4.20 Families of problem drug users have the potential to be key to the rehabilitative effort. Sometimes they are not adequately involved in the treatment/rehabilitation of family members. As many problem drug users live in the family home, families should be seen as partners and be centrally involved in the recovery process. Families can also be a valuable resource in terms of childcare.

RECOMMENDATIONS

1. Service providers should actively encourage family participation and reconciliation of problem drug users with estranged family members (e.g. returning to family home). Structured support services may be needed in some cases to assist the process. In this context, the rights of problem drug users who do not want their family involved in the recovery process should be respected.
   Responsibility: Case Managers - HSE (lead), Service Providers, Family Support Agency.

2. Service providers should be trained to deal with families who are trying to cope with the drug-related problems of a family member.
   Responsibility: HSE (lead), Family Support Agency, Department of Social & Family Affairs, NDST, Family Support Network.

3. Families should be seen as service users in their own right, given that they often have a direct role in the recovery process. Information, support and advice should be made available to parents (and others as appropriate) who are coping with a family member's drug misuse. Family members need to be informed in a timely manner about the different stages of the recovery process.
   Responsibility: Service Providers (lead), HSE, Family Support Agency.

4. The potential of the involvement of the family in supporting the recovering drug users should be utilised.
   Responsibility : Service Providers (lead), HSE, Family Support Agency.

5. A pilot short-stay respite programme for families of problem drug users should be developed. Subsequent expansion of the initiative would depend on the outcome of the evaluation of the pilot.
   Responsibility : HSE (lead), Service Providers.

42 Action 54 of the National Drugs Strategy calls on the Health Service Executive to consider, as a matter of priority, how best to integrate childcare facilities with treatment and rehabilitation centres and how childcare can best be provided in a residential treatment setting. This action will also be carried out with the Office of the Minister for Children.

RESEARCH

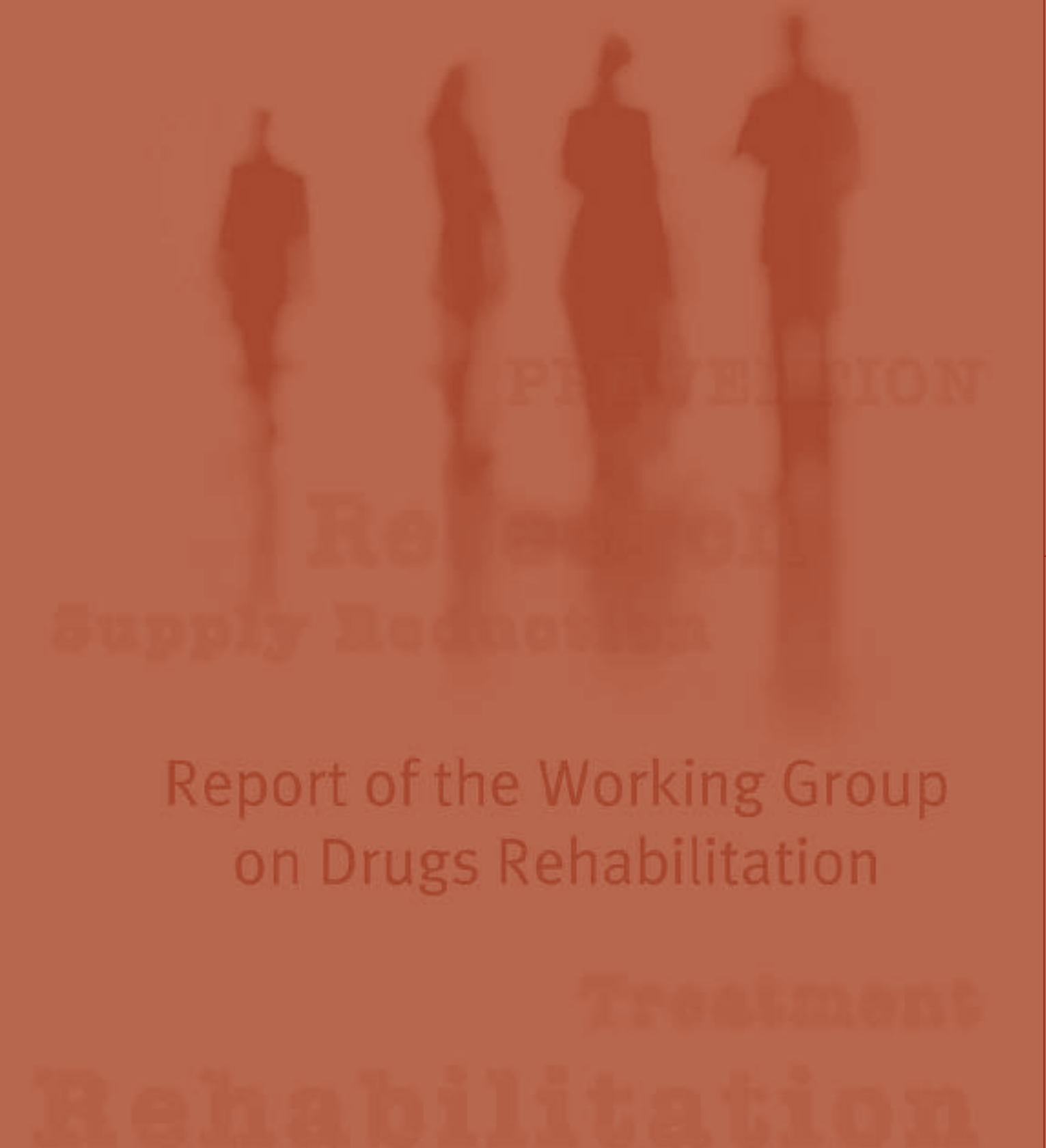
4.21 Sources such as the Research Outcome Study in Ireland (ROSIE), the forthcoming evaluation of LDTF interim funded projects, the 2006/2007 Drug Prevalence Survey and the outcome of the four pilot cocaine treatment projects provide, or will provide, more up to date information on emerging trends in drug use. These should inform policy developments and future actions required regarding the misuse of drugs.

RECOMMENDATIONS

1. Future research and future evaluations of service provision should be informed by the emerging trends in drug misuse. Such research should focus primarily on (i) the outcomes of rehabilitation services and (ii) adapting existing services to deal with the consequences of new drug trends. **Responsibility: NACD (lead), NDST.**
2. Building on the Research Outcome Study in Ireland (ROSIE)[43], research should be undertaken to examine the outcomes of those who have completed methadone programmes. **Responsibility: NACD (lead), HRB.**
3. In line with the childcare recommendations in this report, research is required to ascertain the number of children with drug misusing parents, the issues this raises and best practice in relation to integrating childcare into treatment and rehabilitation services. Responsibility: HSE (lead), Office of the **Minister for Children, NACD.**
4. Research should be undertaken into progression pathways to employment for recovering drug users. **Responsibility: NACD (lead), Department of Enterprise, Trade & Employment.**

43 ROSIE Findings 1: Summary of 1-year outcomes" National Advisory Committee on Drugs: September 2006.

APPENDICES



Appendix 1

MEMBERSHIP OF WORKING GROUP ON DRUGS REHABILITATION

Name	Organisation	*Meetings Attended
Kathleen Stack (Chair) Michael Conroy (Chair)	Dept. of Community Rural & Gaeltacht Affairs	1 21
John Kelly Eddie Arthurs	Dept. of Community Rural & Gaeltacht Affairs	4 13
Patricia O'Connor	National Drugs Strategy Team	18
Mary Ellen McCann	National Advisory Committee on Drugs	19
Anna Quigley	Community Sector	22
Paul Conlon	Voluntary Sector	14
Louise Kenny Nuala O'Reilly Anna-May Harkin	Dept. of Health & Children	1 2 17
Cathal Morgan	Health Service Executive	17
Liam Treacy	FAS	14
Andrew Diggins	Dept. of Education & Science	14
John Laffan Tom Gallagher Theresa Donohoe	Dept. of Environment, Heritage & Local Government	3 4 8
Tony Flynn Brendan Eiffe	Dept. of Justice, Equality & Law Reform	1 2
Sinead Copeland (Secretary) Fidelma Lyons (Secretary) Gabriel Staunton (Secretary)	Dept. of Community, Rural & Gaeltacht Affairs	5 16 1

* 22 Working Group meetings held

Appendix 2

LIST OF GROUPS WHICH PARTICIPATED IN THE PROCESS

Susan Collins	Addiction Response Crumlin, Dublin
Anne Cuffe	Aiséirí Addiction Treatment Centres
Terry McCabe	Blanchardstown Equal Initiative
Rita Burtenshaw	Blanchardstown Equal Initiative
Joe Doyle	Blanchardstown Equal Initiative
Sadie Grace	Citywide Family Support Network
Philip Keegan	Citywide Family Support Network
Niall Cullen	Department of Justice, Equality and Law Reform
Kieran O'Dwyer	Department of Social and Family Affairs
Jim Doherty	Dun Laoghaire/Rathdown Local Drugs Task Force
Siobhan Turner	East Coast Regional Drugs Task Force
Alphonse Franssen	East Flanders Mental Health Care, Belgium; Co-ordinator of Case Management Service at the Provincial Deliberation Platform
John Bennett	Finglas/Cabra Local Drugs Task Force
Wouter Vanderplasschen	Ghent University, Belgium; Researcher at Department of Behaviour Therapy and Psychological Counselling
Martin Keane	Health Research Board
John McGinley	HSE Addiction Services (Northern Area)
Julian Pugh	HSE Drugs Co-ordinator (Prisons)
Dr. Brion Sweeney	HSE, Medical Director / Consultant psychiatrist
David Gilbride	Irish Prison Service
Tony Geoghegan	Merchants Quay Ireland
Cepta Dowling	Northside Partnership, Labour Inclusion Programme
Aileen O'Gorman	NACD
Mairead Lyons	NACD
Lisa Cuthbert	PACE
Joan Byrne	SAOL, Services for women in treatment for drug addiction, Dublin 1
Gerry Mc Allenan	Soilse, Services for Homeless people, Dublin 1
Cyril D'Arcy	South East Regional Drugs Task Force
Con Cremin	Tabor Lodge Treatment Centre, Cork
Maureen Murphy	Tallaght Rehabilitation Project, Dublin 24
Dr. Donal Mc Ananey	UCD, Associate researcher in REHAB
Ruairi MacAuliffe	UISCE
Emily Reaper	UISCE

Appendix 3

RESIDENTIAL TREATMENT / REHABILITATION PROVIDERS IN THE REPUBLIC OF IRELAND

INTRODUCTION

The following aims to provide an analysis of current, reported Residential Treatment Providers in the Republic of Ireland offering services to the following categories:

1. Illicit problem drug users only
2. Poly substance users (including alcohol only)

This information was compiled from a self-reporting exercise which the HSE undertook in mid 2006[44] with the agencies included in the tables below.

The analysis is divided into table A, B, C & D in order to show the type of treatment provided as follows:

TABLE A: SPECIALIST RESIDENTIAL DETOXIFICATION TREATMENT:

Aimed at individuals with a high level of presenting need/ complex patterns of problem drug use and associated physiological problems (e.g. Hep C, etc). Services in this table provide inpatient drug/ alcohol detoxification or stabilisation services. These services are under the direction of a Medical Director/ Consultant Psychiatrist with Specialist Skills in the area of substance misuse and Multi-disciplinary teams including the following disciplines: Psychiatry, GP, Nursing, Counselling/ Therapy.

Provider	Location	Bed Allocation
HSE Cuan Dara	Cherry Orchard Hospital	13 beds
HSE St Michaels Ward	Beaumont Hospital	10 Beds

Total: 23

TABLE B: COMMUNITY BASED DETOXIFICATION PROGRAMMES WITH RESIDENTIAL SUPPORT:

Aimed at service users whom have been assessed by a GP as appropriate for community-based detoxification but who require high support in terms of their environmental/ psycho social needs in a residential setting. Service users in this category usually have less intense medical needs and in-patient medical care may not be necessary. Providers in this table offer significant psycho social/ therapeutic support and/ or skills based training whilst in treatment. There is a close alliance between the provider and the designated community-based GP in terms of the detoxification element to the care plan.

Provider	Location	Bed Allocation
Peter Mc Verry Trust, Lantern	Garristown, Co Dublin.	7 beds (1 of which is for emergency)
Merchants Quay Ireland	High Park, Drumcondra, D1	12 beds

Total: 19

44 The Working Group on Drugs Rehabilitation recognises that the Working Group on Residential Treatment/Rehabilitation, set up by the HSE in September 2006, is undertaking a comprehensive review of residential rehabilitation provision and the figures used here should be taken as indicative.

TABLE C: ABSTINENCE BASED RESIDENTIAL REHABILITATION PROGRAMMES:

Aimed at service users who are drug and alcohol free, i.e. programmes which are abstinence-oriented and where the emphasis is on understanding and maintaining a drug or substance free lifestyle. The ethos underlying the following providers varies in orientation ranging from the 12-step model to the systemic/ psychotherapeutic. All providers are therapeutic by nature and to varying degrees emphasise personal skills enhancement and/or vocational skills training etc. Most providers are connected with HSE addiction service treatment providers in terms of treatment support/ consultation.

Provider	Location	Bed Allocation
St James Camino Network	Camino Residential Centre, Meadowbrook, Cloncurry Cross, Enfield, Co. Meath	Residential Treatment = 12 Transitional housing/ aftercare = 24
Kedron	Edenderry, Co. Meath	12 beds. Little or no presentation of illicit drug use only.
Coolmine House (National Service)	Coolmine, Dublin 15	Phase I beds: Male Residential = 30 Female Residential = 15 Phase II beds: Integration/ Aftercare = 20
The Rutland Centre	Knocklyon, Dublin 16	25 beds in total of which on average 4 beds per month are given over to illicit drug use only. (Note: This provider also specialises in the treatment of other addiction forms such as gambling, etc.)
Aislinn Adolescent Treatment Centre	Ballyragget, Co. Kilkenny	12 beds of which 10 per month are used for illicit drug use only.
Cara Lodge (under the aegis of the Matt Talbot Centre in Cork). Works with Under 18s.	Ahoille, West Cork	6 beds.
Teen Challenge	Rickerstown, Co. Kildare	6 beds.
Aiséirí, Wexford	Co. Wexford	12 beds for which 2 clients with illicit drug use were treated in 2005. (*Note this fluctuates all the time. Both Aiséirí Wexford and Cahir had 323 clients in 2005).
Aiséirí, Cahir	Co. Tipperary	12 beds for which 6 clients with illicit drug use were treated in 2005. (See * above)
Céim Eile (Step Down/ Aftercare)	Waterford	9 beds transitional or step down beds.
Whiteoaks	Derryvane, Co. Donegal	12 beds of which on average 2 beds are used by illicit drug use clients per month. Whiteoaks also note that on average 5 beds per month per year are given over to alcohol and drug use clients.
Bushypark	Ennis, Co. Clare	13 beds of which 4 are used on average per month by illicit drug use only. (Bushypark again note that polydrug use is the primary presentation in their centre).

Provider	Location	Bed Allocation
Peter Mc Verry Trust	Mountjoy Square, D1	- 3 Houses for homeless/ drug users (both drug free and drug users) - Offers on average 17 beds on monthly basis to illicit drug only clients
Tabor Lodge Addiction Treatment Centre	Belgooly, Co. Cork	- 19 beds in total Offers on average 9 beds per month to those with illicit drug use only
Tabor House	Trim, Co. Meath	10 beds, varies between illicit drug use and poly substance use.
Merchants Quay Ireland	St Francis Farm, Carlow	10 beds for Rehabilitation, all illicit drug use and/or poly-substance use.
HSE Keltoi Rehabilitation Unit	c/o St Mary's Hospital, Phoenix Park, D20	10 beds all of which are illicit drug use.
Teach Mhuire	Gardiner Street, D1	25 beds for poly substance use.
Cuan Mhuire	Athy, Co. Kildare	22 beds for illict drug use (also has 125 beds in the alcohol service)
Hope House	Foxford, Co. Mayo	14 beds, poly substance use.
Cenaloco	Knock, Co. Mayo	16 beds, polysubstance use
Fellowship House	Cork City	15 beds, poly substance use
Talbot Grove	Castle Island, Co. Kerry	12 beds, poly substance use
Cuan Mhuire	Bruree, Co. Limerick	135 beds, for poly substance use and 28 detox beds (deals with alcohol, drug dependency- reports 1/3 as having illicit drug use only).

Total: 546 (NOTE: based on self-reporting up to 363 beds can be available for illicit drug treatment)

TABLE D: ALCOHOL ONLY RESIDENTIAL TREATMENT/ REHABILITATION:

Please note that the providers listed below note that clients presenting to their service also have a history of problem drug use.

Provider	Location	Bed Allocation
HSE Barrymore House	217 North Circular Road, D7	9
Cuan Mhuire	Athy, Co. Kildare	125
Cuan Mhuire	Coolarne, Co. Galway	22 Detox beds and 50 Rehab beds

Total: 206

Separate services have evolved to deal with different aspects of rehabilitation needs and, while there may be synergies to be achieved by consolidating aspects of service provision within a single service setting in the future, it is unquestionable that are a number of models available and used by which rehabilitation can be achieved.

Appendix 4

HSE FUNDING OUTSIDE FORMER ERHA REGION IN 2005

	Mainstream €	Section 65 €	LDTF €	YPFSF €	Total – Non-Mainstream €	Total €
South East	2,783,468	473,467	0	21,016	494,483	3,277,951
Southern Area	1,780,063	1,948,697	303,858	0	2,252,555	4,032,618
North East	717,611	15,155	0	0	15,155	732,766
Midlands	5,034,877	0	0	0	0	5,034,877
Mid-Western Area	998,799	205,917	0	0	205,917	1,204,716
Western Area	1,489,683	0	0	0	0	1,489,683
North West Area	445,255	0	0	0	0	445,255
	13,249,756	**2,643,236**	**303,858**	**21,016**	**2,968,110**	**16,217,866**

Appendix 5

LDTF FUNDED SERVICE PROVIDERS

	Channel of Funding	Service Provider	No of Projects
Total number of Service Providers/ Total No of Projects (109/174)			
Ballyfermot (6/11)			
1	**HSE/FÁS**	**BF Advance (CDT)**	**3**
2	**DCC**	**BF Soc Intervent. Init.**	**1**
3	**HSE**	**BF LDTF/Cheshire Comm. Service**	**1**
4	**FÁS/HSE**	**Fusion CPL**	**3**
5	**HSE**	**BF Star***	**2**
6	**HSE**	**BF Urban - Familiscope**	**1**
Ballymun (5/8)			
7	**HSE**	**LDTF**	**1**
8	**HSE**	**Lifestart, Ballymun**	**1**
9	**JELR/FÁS**	**Ballymun Job centre**	**4**
10	**HSE**	**Ballymun YAP**	**1**
11	**HSE**	**Star, Ballymun**	**1**
Blanchardstown (5/11)			
12	**HSE**	**Genesis Psychotherapy**	**1**
13	**HSE**	**LDTF**	**1**
14	**HSE**	**Community Drug Teams (3)**	**7**
15	**HSE**	**Tolka River project**	**1**
16	**HSE**	**Web project**	**1**
Bray (5/6)			
17	**HSE**	**Community Addiction Team**	**2**
18	**HSE**	**Living Life Vol. Counselling Centre**	**1**
19	**VEC**	**Marian Centre**	**1**
20	**HSE**	**Bray P'ship LES N'work**	**1**
21	**VEC**	**Little Bray FRC**	**1**
Canal Communities (7/17)			
22	**HSE**	**Community Drug Teams (2)**	**8**
23	**HSE**	**Bluebell CDP**	**1**
24	**HSE**	**CC P'ship**	**1**
25	**HSE/FÁS**	**Turas**	**2**
26	**HSE/DCC**	**St. Michaels FRC**	**2**
27	**HSE**	**HESED House**	**2**
28	**HSE**	**Fatima Groups United**	**1**

	Channel of Funding	Service Provider	No of Projects
Clondalkin (9/26)			
29	JELR/HSE	CASP	11
30	HSE	CUMAS	3
31	HSE	Bawnogue YPFSF	4
32	HSE	Beacon of Light Counselling Centre	1
33	VEC/HSE	Ronanstown YS	2
34	VEC	Carline Centre for Learning	2
35	HSE	Cairdeas	1
36	HSE	Dublin Simon	1
37	HSE	YSTU	1
Cork (15/15)			
38	HSE	Stop Drugs Now	1
39	VEC	Hillgrove Outreach	1
40	HSE	Parents Support Service	1
41	HSE	Renewal Sheltered Housing	1
42	VEC	Education Unit, Cork Prison	1
43	HSE	Cork Simon	1
44	JELR	Garda - Ballincollig	1
45	JELR	Garda - Dublin Hill	1
46	JELR	Garda - Douglas West/Ogra Chorcaí	1
47	JELR	Garda - Mayfield	1
48	VEC	Foroige - Carrigaline YS	1
49	VEC	Greenmount Youth Action	1
50	VEC	Ballyphehane Action for Youth	1
51	VEC	Glanmire Community drugs Initiative	1
52	HSE	Community Drug Team	1
Dublin 12 (5/5)			
53	HSE	Loreto centre	1
54	VEC	KWCD - Education Bursary	1
55	HSE	CLAY Ltd. - Family Support	1
56	HSE	Walkinstown/Greenhills Resource centre	1
57	HSE	ARC	1
Dublin N/E (5/7)			
58	VEC/FÁS/HSE	Dublin NE LDTF	3
59	HSE	Childcare Bureau	1
60	HSE	Howth Peninsula DA Group	1

	Channel of Funding	Service Provider	No of Projects
Dublin N/E (5/7) contd.			
61	HSE	Artane DA Project	1
62	HSE	Ana Wim Drug Awareness	1
D/L Rathdown (6/8)			
63	HSE	D/L Community Addiction Team	3
64	HSE	Mounttown NYP	1
65	HSE	D/L Rathdown LDTF	1
66	HSE	Gardai D/L - JLO	1
67	FÁS	DROP - D/L Rathdown Outreach	1
68	HSE	SWAN - Community Links	1
Finglas/Cabra (8/15)			
69	P'ship/FÁS/HSE	Finglas Cabra P'ship	3
70	HSE/FAS	Fingal ICTU Centre for Unemployed	4
71	JELR	Finglas YS CYC - Garda Diversion project	1
72	JELR	Cabra Community policing forum	1
73	HSE	HSE Northern Area Addiction Services -CCTV	1
74	HSE/FÁS	Finglas Addiction Support Team (FAST)	2
75	HSE/Ed&Sc	Finglas Cabra LDTF	2
76	HSE	Finglas against Drugs	1
North Inner City (13/22)			
77	Ed &Sc/HSE	FLASC	2
78	HSE	UISCE	2
79	HSE	Ana Liffey	3
80	FÁS	Community After Schools Project	1
81	Ed & Sc	Step by Step	2
82	HSE	HOPE	1
83	FÁS/HSE	NW Inner City Training & Development project	2
84	HSE	OASIS Counselling centre	1
85	FÁS	Gateway Project	1
86	HSE	SAOL	1
87	HSE	Chrysalis	3

	Channel of Funding	Service Provider	No of Projects
North Inner City (13/22) contd.			
88	HSE/DCC	Inter-agency drug Project	2
89	HSE	Snug Counselling service	1
South Inner City (13/15)			
90	HSE	Coolmine House	2
91	HSE	Donore CDT	2
92	HSE	Casadh	1
93	HSE	Mercy Family Centre	1
94	HSE	Exchange House Travellers Centre	1
95	HSE	Community Response SIC	1
96	HSE	Teen Challenge Irl Ltd - Residential treatment	1
97	HSE	SWICN	1
98	HSE	Community Addiction Programme	1
99	D/ELG	Marrowbone Lane Residents Ass.	1
100	D/ELG	Schools St. & Thomas Ct Bawn Family RC	1
101	D/ELG	Michael Malin Res.Assoc	1
102	D/ELG	Marrowbone Lane Tenants Assoc.	1
Tallaght (7/8)			
103	HSE/FÁS	St Dominic's Comm. Res. Centre	2
104	HSE	Brookfield Addiction Response Prog	1
105	HSE	SWAN Tallaght	1
106	HSE	Barnardos	1
107	HSE	Tallaght LDTF	1
108	FÁS	St Aengus	1
109	HSE	Tallaght Partnership	1

*One project jointly with YS

Appendix 6

PROJECTS WHICH RUN DRUG SPECIFIC COMMUNITY EMPLOYMENT SCHEMES

Region	Project Number	Sponsor	Location	Total No
DC	740423312	DOWN TO EARTH THEATRE CO	DUBLIN 8	12
DC	740423347	RADE	DUBLIN 8	20
DC	740423418	NORTH WALL WOMENS CENTRE	DUBLIN 1	2
DC	740423538	RIALTO DEVELOPMENT ASSOCIATION	DUBLIN 8	3
DC	740423549	DOLPHIN HOUSE CE PROJECT	DUBLIN 8	15
DC	740423556	COMMUNITY ADDICTION PROGRAMME	DUBLIN 8	21
DC	740423565	ST JOHN OF GOD CENTRE	DUBLIN 8	2
DC	740423611	COMMUNITY AFTER SCHOOLS PROJECT	DUBLIN 1	6
DC	740423624	LIBERTIES RECYCLING GROUP	DUBLIN 8	49
DC	740523578	ST JOSEPH PENNY DINNER CENTRE	DUBLIN 1	2
DC	740523603	JOBCARE LTD.	DUBLIN 2	17
DC	740523713	BELVEDERE YOUTH CLUB LTD.	DUBLIN 1	8
DC	740523722	THE CAVAN CENTRE	CAVAN CENTRE	15
DC	740523733	CARMICHAEL CENTRE FOR VOL. ORGS.	DUBLIN 7	2
DC	740523797	AFTER CARE RECOVERY GROUP	DUBLIN 11	10
DC	740523813	ST CATHERINE'S COMBINED GROUP	DUBLIN 8	3
DC	740523826	OBLATE	DUBLIN 8	12
DC	740523834	CANAL COMMUNITIES TRAINING PROG.	DUBLIN 8	37
DC	740523854	GATEWAY PROJECT (NWICWN)	DUBLIN 7	17
DC	740523874	CASADH	DUBLIN 8	30
DC	740523897	DUBLIN ADULT LEARNING CENTRE	DUBLIN 1	3
DC	740523908	FRANCISCAN SOCIAL JUSTICE	DUBLIN 8	12
DC	740523913	MERCHANT'S QUAY CONTACT CENTRE	DUBLIN 8	17
DC	740523924	MERCHANT'S QUAY DRAMA PROJECT	DUBLIN 8	19
DC	740523938	MERCHANT QUAY PROJECT	DUBLIN 8	21
DC	740523997	A.S.E.S.P.-AFTER SCHOOL ED.SUP	DUBLIN 1	9
DC	740524008	DUBLIN AIDS ALLIANCE	DUBLIN 1	21
DC	740524023	GEORGES HILL SCHOOL & COMM PRO.	DUBLIN 7	2
DC	740524044	NORTH WEST INNER CITY TRG & DE.	DUBLIN 7	2
DC	740524058	ST MARYS COMMUNITY PROJECT	DUBLIN 7	2
DC	740524081	PAVEE POINT	DUBLIN 1	2
DC	740524128	MERCY FAMILY CENTRE	DUBLIN 8	2
DC	740524162	SAOL	DUBLIN 1	10

Region	Project Number	Sponsor	Location	Total No
DC	740524204	THE COMMUNITY LINKS PROJECT	DUBLIN 8	25
DC	740524229	ENERGY ACTION	DUBLIN 8	3
DC	740524267	ST JAMES RESOURCE CENTRE	DUBLIN 1	17
DC	740524272	COMMUNITY AFTER SCHOOLS PROJECT	DUBLIN 1	5
DC	740524318	CITY OF DUBLIN V.E.C.	DUBLIN1	8
DC	740524328	THRESHOLD LTD.	DUBLIN 7	3
DC	740524354	CENTRE FOR INDEPENDENT LIVING	DUBLIN 7	2
DC	740524554	RINGSEND DIST. RES. TO DRUGS	DUBLIN 4	6
DC	790405547	MATT TALBOT COMMUNITY TRUST	BALLYFERMOT D10	4
DC	790405606	THE ORCHARD COMM. DEV. SCHEME	CHERRYORCHARD	2
DC	790405618	MARKEIVIEZ COMMUNITY CENTRE	BALLYFERMOT	2
DC	790405654	BALLYFERMOT STAR LTD.	BALLYFERMOT	18
DC	790505649	BALLYFERMOT COMMUNITY NETWORK	BALLYFERMOT	2
DC	790505689	BALLYFERMOT RESOURCE CENTRE	B'FERMOT D10	2
DC	790505712	BALLYFERMOT THEATRE WORKSHOP	BALLYFERMOT D10	9
DC	790505722	LONGMEADOWS PITCH & PUTT CO.	BALLYFERMOT D10	2
DC	940600951	FINGLAS CHILDCARE CENTRE	FINGLAS	3
DN	760507757	MILLENNIUM CARVING LTD.	FINGLAS	16
DN	760507848	STAR PROJECT BALLYMUN LTD.	BALLYMUN	16
DN	830404083	TOLKA RIVER PROJECT	MULHUDDART	17
DN	830504131	BLANCH CENTRE FOR IND. LIVING	MULHUDDART	2
DN	830504178	NETWORKING DUBLIN 15	MULHUDDART	8
DN	830504231	COOLMINE LTD.	CLONSILLA	12
DN	900503715	DONNYCARNEY YOUTH PROJECT LTD	DONNYCARNEY	14
DN	900503778	REHABILITATION & SUPPORT PROG.	BELCAMP	22
DN	900503898	THE DEAN SWIFT SPORTS CLUB	CLONSHAUGH	2
DN	900503907	EDENMORE DRUG INTERVENTION TEAM	EDENMORE	15
DN	900503928	KILBARRACK COAST COMM. PROGRAM	KILBARRACK	19
DS	800407555	TALLAGHT REHABILITATION PROJ.	TALLAGHT	5
DS	800507621	ACTION TALLAGHT	BROOKFIELD D24	3
DS	800507644	ST AENGUS COMMUNITY ACTION GROUP	CASTLETYMON GR.	17
DS	800507654	ST DOMINCS COMM RESPONSE PRO.	MILLBROOK	16
DS	810404321	DOLCAIN PROJECT	BAWNOGUE D22	2
DS	810404393	CLONDALKIN CTR FOR THE U/E LTD	CLONDALKIN	2
DS	810504363	THE GET AHEAD CLUB LTD	CLONDALKIN	2
DS	810504382	SOUTH DUBLIN CO. CO. - TALLAGHT	NEILSTOWN	2
DS	810504401	CARLINE CENTRE OF LEARNING	BALGADDY	13
DS	810504414	CLONDALKIN TRAVELLERS ENTERPRISE	CLONDALKIN	3

Region	Project Number	Sponsor	Location	Total No
DS	810504459	CLONDALKIN ADDICTION SUPPORT GROUP	CLONDALKIN D22	9
DS	810504478	NEILSTOWN PARISH SOCIAL ACTION	NEILSTOWN D22	8
DS	810504488	RONANSTOWN COMM CHILDCARE CTR.	NEILSTOWN D22	2
DS	810504497	BAWNOGUE YOUTH & FAMILY SUPPORT	BAWNOGUE D22	3
DS	810504532	CATHOLIC YOUTH CARE	RONANSTOWN D22	20
DS	820503226	ST JOHN OF GOD MENNI ENTERPRISE	BLUEBELL	3
DS	820503236	DRIMNAGH DEVELOPMENT GROUP	DRIMNAGH	2
DS	820503287	ADDICTION RESPONSE CRUMLIN LTD	CRUMLIN D12	19
DS	820503294	ATHRU EDUCATION & TRAINING	CRUMLIN D12	22
DS	820503357	DUBLIN 12 CENTRE FOR UNEMPLOYED	DRIMNAGH D12	2
DS	870523073	SCOUTING IRELAND CSI	TIBRADDEN D16	2
DS	870623178	DUN LAOIRE RATHDOWN OUTREACH	DUN LAOGHAIRE	19
MR	80511698	CUAN MHUIRE MANPOWER	ATHY	5
SW	500432056	CHURCHFIELD YOUTH COMMUNITY TRUST	CORK	11
SW	500432304	CHURCHFIELD YOUTH COMMUNITY TRUST	CORK	14
SW	500532557	GRATTAN PROJECT LTD.	CORK CITY	10
SW	500532717	CHURCHFIELD YOUTH COMMUNITY TRUST	CORK CITY	18
SW	500532827	CHURCHFIELD YOUTH COMMUNITY TRUST	CORK CITY	15
SW	500532838	CHURCHFIELD YOUTH COMMUNITY TRUST	CORK CITY	16
SW	500532848	CHURCHFIELD YOUTH COMMUNITY TRUST	CORK CITY	15
SW	500532859	CHURCHFIELD YOUTH COMMUNITY TRUST	CORK CITY	16
SW	500532978	CORK YMCA	MAHON CORK	14
SW	500533061	NORTHSIDE COMMUNITY ENTERPRISE	CORK CITY	3
			Total	974