

REPORT OF THE RAPID EXPERT REVIEW OF THE NATIONAL DRUGS STRATEGY 2009-2016

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1. Introduction

The review exercise

Key Points

- This rapid expert review (RER) does not constitute a formal evaluation of the Irish National Drug Strategy (INDS).
- The purpose of this exercise is to place the INDS in context and provide input for consideration by the group tasked with the development of the next strategy. The RER represents the panel's opinion on what appear to be top level issues or questions that merit attention.
- Although the RER canvassed a broad set of opinions and reviewed documentary evidence to inform their deliberations, there are obvious limitations to what can be accomplished within such a short time period. These limitations should be born in mind when reflecting on the findings presented here.
- Despite the limitations a number of key issues emerged that in the review panel's opinion represent clear areas for consideration in the development of the new strategy. These are presented below and some possible options for addressing these issues are also explored.

This report contains the findings from a rapid review of the Irish National Drug Strategy (INDS). The review is primarily based on site visits and meetings conducted during an intensive week long study visit. During the visit the panel met with over 150 individuals, including governmental officials, statutory and voluntary sector service providers, community members and service users. Although meetings took place only in Dublin and Cork, the panel also met people with responsibility for, or with knowledge of, the situation in other locations. The panel also considered some additional contextual documentary evidence and all those attending interviews were invited to submit additional evidence in written form. These submissions were also taken into consideration in drafting the views expressed in this paper. A list of the organisations that contributed to the review, either through participation in meetings or by providing submissions to the review panel, often both, is provided in Annex A. In many cases we saw several representatives of these organisations with different responsibilities or geographical remits.

The Rapid Expert Review (RER) was designed to provide a top-level overview of the strategy to inform the work of the Steering Group tasked with developing the new strategy. As such, it presents insights useful for framing the ongoing strategy development work, but is not intended as a formal evaluation of the outgoing strategy. The terms of reference for the rapid expert review panel work can be found in Annex B. Put simply, the review is intended to inform the development of the next National Drug Strategy by providing a 'helicopter view' of and capturing some key learning points from the experiences of the National Drugs Strategy 2009-2016. In doing this the panel members hope to provide useful input to facilitate the development of the new strategy whilst recognising that the responsibility and expertise necessary for undertaking that exercise lies elsewhere.

It is important to acknowledge from the start the obvious limitations of such a rapid exercise that has to address a complex policy area, covering numerous actions and actors and that took place over an eight year implementation period. Our analysis is therefore necessarily reductive and top level. We have tried to identify, where this is possible, the important issues around which some level of consensus or discordance exists and to make an informed comment based on the evidence we have reviewed. The panel is indebted to the large number of stakeholders who generously contributed their time to support this process but must also acknowledge that the number of views it is possible to canvas in a one week period is necessarily limited, as was the time it was possible to allocate to those interviewed. To be useful in informing the current drug strategy development process it has

also been necessary to assess the evidence we have received quickly. Only limited opportunities have therefore existed for seeking further clarification, checking discrepancies or identifying additional supporting evidence. Despite these limitations we would hope the analysis presented here will be helpful by focussing attention on some of key issues for elaboration within the next strategy. Our hope is that we have provided some useful signposts to what are the potential fruitful directions of travel for the group tasked with the responsibility of developing the content and form of the future Irish National Drugs Strategy (INDS).

Placing the Irish Drug Strategy in context

Key Points

- The INDS when it was drafted reflected what could be regarded as a well-crafted and comprehensive version of a contemporary EU drug strategy. In terms of content, and to some extent form, it is largely consistent with the EU strategy and the strategies and action plans of many other member states.
- The strategic and action elements of the INDS are combined in one document that covers a relatively long time period, an alternative that is used in some other countries and at the EU level is to have separate strategy documents accompanied by shorter-term action plans.
- In common with many other European strategy documents it is grounded in addressing the issues that were priorities at the time of its creation – with heroin and the need to increase service uptake for those with opioid problems being one central element.
- The INDS is not atypical in its scope in regards to drugs and alcohol but no consistent approach is evident in this regard at EU level and this is an area where no strong consensus exists internationally.
- The INDS and the planned future national drug strategy will exist however in a policy space in which articulation with other existing strategies, both in respect to other substances and other issues, will be crucial if synergies are to be developed and overlaps avoided, which is even more important in the current financial climate.
- In both the supply and demand area a number of new challenges have emerged in recent years that are either absent or underdeveloped in the current strategy.

At the time of its drafting the INDS could be seen to represent what would be generally regarded as a comprehensive and well-drafted example of a modern European national drug strategy. Even though times have changed many of the key issues addressed in the INDS remain relevant and can be found in other national strategy documents. In a general sense then the INDS still reflects many of the key policy concerns found both at the European Union level and in the Member States. These long-term strategic planning tools set out the main priorities, principles, objectives and actions underpinning the national response to drug problems.

Many national documents mirror or have elements in common with the EU drug strategy. The EU drug strategy 2013-2020 and its current action plan 2013-2016 are built around the two pillars of demand and supply reduction and the three cross-cutting themes of coordination, international cooperation, and information, research, monitoring, and evaluation. The INDS's action plan is built around five pillars: supply reduction; prevention; treatment; rehabilitation; and research. It also made a small number of recommendations on coordination issues. Thus it differs somewhat in form from the current EU model and arguably lacks the benefits that may accrue from having cross cutting elements, such as a more elaborated coordination component. That said, arguably it is appropriate to give greater emphasis to cross-cutting issues and co-ordination at the EU level and there is considerable similarity in respect to the detail found within the pillars and cross cutting themes in both documents. A top-level commitment to a balanced approach between supply and demand reduction is present in the INDS, as is the intention to inform actions with evidence. These

are the central tenets of the EU and all European national drug strategy documents, even if they are sometimes given different names or structured differently.

Structurally, the Irish strategy is similar to the strategies of other EU Member States. Like 14 of the 27 countries, Ireland combines its strategy and action plan into one document. The other 13 EU Member States with a strategy and action plan set them out in separate documents. The EU strategy follows this second approach whereby the general principles and approach to drug policy are elaborated in a longer term strategy document, while shorter sequential action plans are used to adapt to new problems. In this way, in the short and medium term, only action plans, rather than a whole strategy, need periodic revision and reorientation.

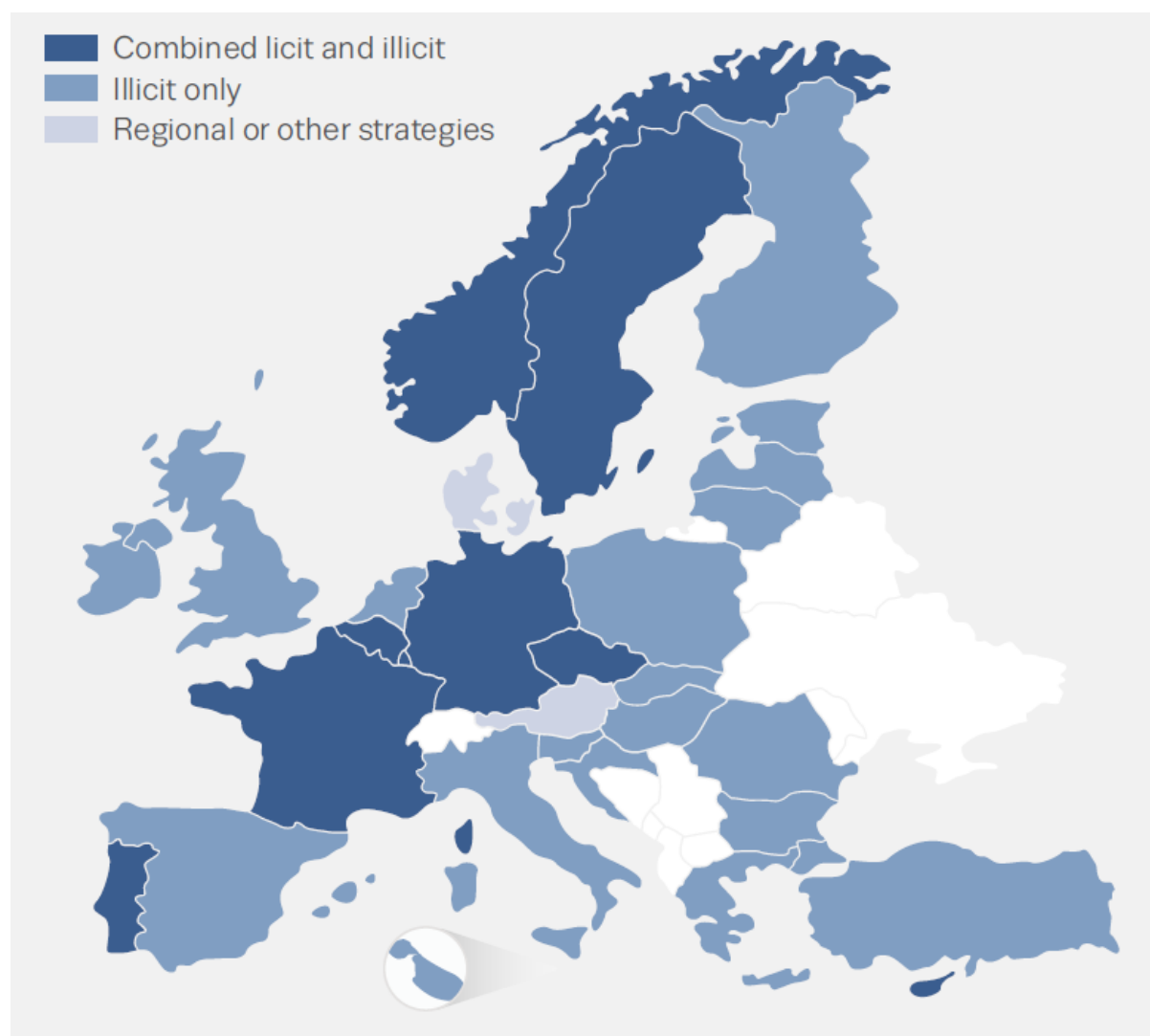
About two thirds of EU strategies address illicit drugs alone, while the remainder also have a significant focus on other substances (such as alcohol, the misuse of medicines etc.), and occasionally also behavioural addictions (see Figure 1). Most countries with a broader strategy are found in Western Europe. Two of Ireland's immediate neighbours, the administrations in Northern Ireland and Wales, have combined illicit drug and alcohol strategies. Given the common issues that exist for addressing drug, alcohol and other substance problems, especially in respect to prevention and treatment, there is current debate in many countries on the benefits of a combined strategy in this area. Conversely some would argue that addressing large commercial markets on the one hand and the licit drug market on the other points to the need to develop separate initiatives. This is not an argument we will elaborate on in detail here other than making the observation that whatever the approach taken there is merit in clarity and having a clear synergy and linkage between strategies that are addressing overlapping and linked policy areas. The current Irish drug strategy (2009-2016), like its predecessor, is mainly focused on illicit drugs, but deals with alcohol in terms of prevention and treatment and the strategy appeared to be framed, initially at least, as an interim approach that would be superseded by an integrated substance misuse strategy. There is also the 2012 Steering Group Report on a National Substance Misuse Strategy, which focused on alcohol as a complement the National Drug Strategy. This 2012 report has a strong focus on regulatory and population health issues related to alcohol sale and consumption and the prevention, treatment and rehabilitation and research sections are aligned with the current drug strategy.

There are also a number of other strategies addressing specific populations, areas, or social issues where drugs are a component issue. Any future Irish national drug strategy, regardless of its scope, will necessarily have to address issues of detail where there is a crossover of strategic objectives that concern both illicit and illicit substances, (such as: early onset, prevention, poly drug use, etc.), or other issues (for example housing, gender equality, youth offending, marginalised communities etc.). Therefore the scope of new national drug strategy and its articulation with other strategies addressing alcohol, other substances, and other issues, will be an important question for the future strategy development process to address. This issue is returned to later in this review.

The current strategy can be seen as building on and extending the approach found in its predecessor (the 2001-2008 strategy) and, as noted already, in content reflected well the policy priorities that were current at the time of its conception. However, it covered a relatively long period of time and so it is perhaps unavoidable that, in both the supply and demand areas, a number of new challenges have emerged in recent years that are either absent or underdeveloped in the current strategy. This is again not an issue that is unique to Ireland and in some respects the current INDS appears quite forward-looking at the time of its drafting; for instance, it noted growing concerns about cocaine use and the diffusion of opioid problems outside of the Dublin area. Nonetheless there are clearly a number of issues that are now impacting on EU member states and will need to be addressed in any future drug strategy. At the European level, the need to formulate a more robust response to New Psychoactive Substances has, for example, been a central issue in recent policy discussions. Ireland

has been a prominent country in recognising the problems these products can cause and introduced policies in this area but these developments post-date the current strategy document.

Figure 1: National drug strategies and action plans: availability and scope



(Source: European Drug Report 2016, EMCDDA)

It is not possible to review here all of the new challenges that European drug policies are now facing. We can only make some very general observations with the note that some of the policy priorities in different member states are likely to differ reflecting different national contexts. Overall most European countries still face the need to provide effective and sufficient services to address heroin use and related injecting drug problems and this cohort is generally ageing because, by historical standards, there are low levels of new recruitment into these behaviours. Chronic poly-drug using problems have become more apparent, however, with stimulants, medicinal products, cannabis and synthetic opioids all now contributing to a more complex drug problem. The need to address drug-related HIV infections was a major policy driver for European responses throughout the last two decades. This topic remains important but there are now growing new concerns about stimulant use and associated high risk sexual and drug taking behaviours. In respect to injecting, HCV treatment and prevention has become a greater policy priority in the context of the continuing high prevalence and potential high costs accruing from this disease with new therapeutic opportunities now available. For some countries where a large, long-established opioid treatment cohort exists there is

also growing interest in exploring the possible longer-term therapeutic goals that may be appropriate to recovery among this group.

Reflecting the demand situation, on the supply side law enforcement is increasingly faced by a more joined up and globalised drug market where drugs are simply one of the illicit areas in which crime groups are active. Drug trafficking groups increasingly exploit the opportunities that this presents, which include the growth in container traffic and parcel delivery services. Organised crime groups also appear increasingly able to establish operational links between countries, or to operate on a transnational basis, resulting in a greater need for both operational and strategic cooperation and coordination activities at the European and international level. The increasing number of NPS and the growth in online markets for drugs also represent a new and potentially growing challenge, as do changes in synthetic drug and cannabis production. Demographic changes in Europe also mean that crime organisations can exploit the existence of new migrant communities resulting in the need for law enforcement to identify and target new organisations becoming active on their territories. Overall the greater importance of synthetic substances and greater diversity in the drug market also increases the importance of having adequate access to forensic and toxicological services, an area in which capacity in many countries is underdeveloped.

The need to retool drug strategies and actions to address changing needs is not unique to Ireland and can be seen at the EU level, within other EU countries and internationally. Nor are we suggesting that Ireland has not addressed many of these issues under the framework provided by the current strategy; as illustrated by the considerable investment in policy development around the NPS issue. That said, the development of a new strategy and implementation framework will provide the opportunity to explore ways to address some of these, and other emerging issues, more directly. It will also allow the impact of broader social changes to be taken into account. Developments in information technology and changes in the way young people communicate, for example, are likely to have implications for any strategy in which engagement with this group is a key part. In Ireland, as elsewhere, social migration has changed the demographic composition of many communities and this is also likely to have important implications for the future.

2. Broad issues concerning the current INDS identified in the review

Key Points

- There was a consensus that the INDS had served as a valuable instrument, both in respect to the structures and coordination mechanism it established, and in respect to its content which allowed priorities to be identified and targeted.
- The existence of the strategy was widely seen as playing a useful role in facilitating multiagency working, encouraging stakeholder buy-in, and galvanising political support for drug issues.
- At the point of its inception it provided an appropriate and sufficient framework for the prioritisation of investment and for coordination of activities. The pillar structure within the strategy appeared to have been useful in respect to encouraging joined up working within some areas but was also at times seen as unhelpful in respect to impeding cross pillar coordination.
- The focus in the strategy on rehabilitation and improving services for those with opioid problems reflected the priority issues of the day.
- The impact of the global economic recession was an important disruptive factor.
- The long time period of the strategy, together with the large number of embedded actions, meant that it was not reactive to change and this led to a decline in relevance and momentum.
- Over time some of the advantages delivered by the strategy in its initial phase became less apparent. Changing needs, stakeholder participation, sustaining appropriate coordination mechanisms, and follow up and continuing relevance of actions, were all identified as areas that became more problematic over time.
- In respect to sustainability over time there appeared to be geographical differences in the extent to which the strategy had positively impacted on local structures, services and practice.
- The commitment to measuring progress over time is a positive aspect of the INDS. However the appropriateness of the KPIs to the strategic goals is not always clear, the necessary data for their measurement was not always available, and in some cases their usefulness as measures of change over time is questionable. As the strategy progressed investment in monitoring KPI performance appeared to decline.
- The commitment to research, monitoring and evidence based interventions was another identified strength of the INDS. However, some problems with coordination and structural issues were raised during discussions as were problems of standardisation and data linkage between strategically important information held at different levels within the system (national, local, regional). Also an overall lack of capacity for interpreting the information available was reported. Resource issues also meant that opportunities for commissioning research were limited; these issues appeared to be particularly important in some areas, such as forensic science capacity, and had impacted negatively on the availability of data.
- The policy and operational space in which the INDS has to operate appears to have become increasingly complex over time and this appears to have resulted in the development of potentially overlapping structures, and some corresponding lack of clarity on the purpose and role of different structures or actors working in the area.
- The importance of alcohol in terms of: the high prevalence of alcohol problems; the interactions that exist between alcohol and drug problems; and the position of alcohol within the current, and future, drug strategy; was an issue raised repeatedly during the review.

The issues facing drug policies in other EU member states described in the previous section were also highlighted as current issues in Ireland. Discussions repeatedly turned to substantive issues such as: the challenges posed by an aging opiate cohort; the availability of new psychoactive substances;

and increased concern about cannabis related problems including the availability of high potency products. The policy issue of how to avoid the possible unintended negative consequences of criminalising users, especially young cannabis users, was also raised by a number of those giving evidence. This question is also a concern in other EU countries, and was flagged up in the current strategy but remains an issue.

There were also some topics which, although relevant to other countries, appeared to be given particular emphasis in discussions and therefore may be regarded as having greater importance within an Irish context. These included concerns about problems related to prescription drug use and the diffusion of opiate use and other drug problems to rural communities. The inclusion within the INDS of measures to respond to drug related intimidation was also given emphasis, and this issue appears to remain important. In virtually all countries, homelessness, and housing insecurity, have historically been among the social problems most commonly associated with substance misuse disorders. It was therefore not surprising that this issue was raised repeatedly during the review process. It is of note however that this topic seemed to be particularly important and generally regarded as a priority area within the Irish context.

Overall opinions of the strategy

In respect to the more specific question of attitudes to the INDS itself, it is important to start by acknowledging the general consensus expressed that it had delivered value. This appeared to be true both in respect to the establishment of the supporting structural elements and coordination mechanisms and in respect to the content. Overall progress was reported to have been made on many of the priority areas that were identified when the document was conceived. For example, services for problem opioid users have developed considerably under the current strategy and this is widely acknowledged to have been one of the key areas that required addressing when the document was drawn up. There was also a general recognition that, with the passing of time, the strategy had become less appropriate to contemporary needs and in some areas problems had emerged. Despite this however, it is also possible to identify many examples of good work that have and continue to be implemented under the current framework.

Overall the panel's impression was that both on a coordination and service level Ireland had made significant progress during the course of the strategy and in many areas the country would stand in a positive light in respect to appropriate European and international comparisons. The panel observed during their visit many examples of what appeared to be well-coordinated and high quality activities, including some that might be considered exemplary. A relatively strong consensus emerged in our meetings that the strategy had helped facilitate multiagency working, encouraged stakeholder buy-in, and helped galvanise political support for drug issues. It was also noted by some respondents that political interest and support for the strategy in its early years, had been particularly helpful in generating a momentum for action. The view was also expressed that the strategy had been useful in targeting resources on key areas – in particular, and as noted above, an expansion of treatment and rehabilitation services for problem opioid users.

The adoption of a pillar structure within the strategy appeared to bring with it both advantages and disadvantages. Many respondents reported that the pillars have been useful to coordination and priority setting; the grouping of activities in common related areas being seen as providing a point of focus and facilitating joined up working across the topic areas within each pillar. It was also noted, however, that they could be unhelpful in areas in which cross pillar coordination of activities was required. There was also a risk that actions that fell across pillars could lack ownership and therefore be neglected especially at times in which resources were being reduced. At worst the pillar structure was seen by some as encouraging a silo mentality and thus undermining collective engagement with the strategy objective as a whole. However, overall, most comments appeared to acknowledge that the benefits outweighed the costs of this structural approach. To some extent the

views expressed varied by pillar, so for example in the area of supply reduction, opinions were generally favourable suggesting it provided coherence and was useful for priority setting. Nevertheless, it is of note that some of the problems identified in implementing the strategy in this area concerned cross pillar articulation (e.g. assessment and referral of those with drug problems from the criminal justice system).

More generally the topic areas associated with the pillars themselves appear well chosen in the sense that they encompassed all the main elements that we would expect to find in a modern balanced drug strategy. Given the views expressed overall on this issue the Panel would note that consideration might usefully be given to how the structural architecture of the future strategy can be designed in such a way as to maintain the clarity that comes from the grouping of similar areas together whilst at the same time encouraging cross-area working and collective engagement with the overall objectives of the strategy. Drug strategy documents from other countries in Europe and elsewhere may provide useful points of contrast in this respect and we discuss some possible alternative approaches to structuring the strategy later in this review.

External disruptors

An implicit or explicit recurring issue raised throughout the study visit was the disrupting impact that the global economic recession had on the implementation of the strategy. This is an obvious point to make but it is also one of central importance to a top-level understanding of the issues that impacted on the strategy across its implementation period. The shock to public finances and resulting knock-on effect on resource availability clearly impeded the possibility to pursue some objectives and led to a contraction in others. This is a factor external to the strategy itself and to some extent the existence of the strategy and its implementation framework appeared to be seen as providing some level of resilience and supported the provision of some core services during clearly what was a difficult period. There was a suggestion made that the lack of resources had been an incentive for some services to find more creative ways to work together.

Overall, however, the views expressed to the panel strongly indicated that the knock-on effects of the financial crisis were a major disruptive factor. The negative impact of which included: lack of resources for existing or new activities; less political engagement; and weakening of coordination mechanisms, in part because the necessary key staff were not in place and in part because the activities possible became more limited. A tendency for some important partners (housing and education, for example) to disengage with the strategy as they necessarily became more focused on maintaining their core business areas was also noted and as a result opportunities for developing or sustaining cross-sector partnerships became more limited. More positively, whilst public finances remain under pressure and ensuring value for money rightly remains a central concern for those responsible for commissioning services, the panel's impression was that there was now a positive attitude to the likely future opportunities for supporting activities in the drugs area.

Implications of the timeframe for the strategy

In addition to problems associated with the impact of the recession, the issue of other changes over the time period covered by the strategy was frequently raised. Overall the opinions expressed to the panel can be simply summarised as: the strategy was a valuable instrument and many of the approaches it supported continue to provide value but, nonetheless, over time the usefulness and appropriateness of the instrument declined. In particular, the relevance and value of some of the coordination structures have become less clear, stakeholders engagement has declined in some important areas, and the strategy is no longer seen as appropriately formulated for driving innovation, service development and necessary change, for example in the appropriateness of KPIs. To a large part this was seen as reflecting the fact that the drug situation and resulting needs had changed considerably since the drafting of original document. In particular, there is now a more diverse drug problem both in respect to the substances used and the geographical, and possibly

social, location of those with needs. The current INDS was seen as, to some extent, geared towards addressing a localised problem of primary heroin use. Agreement now appeared to exist that, whilst this issue remains important, opioid related problems had diffused geographically and needs in this area had evolved. In addition, it is also now necessary to give greater attention to the consumption of other substances and problems related to poly-substance consumption.

The panel's view is that these opinions should not be taken as a criticism of the INDS but rather as highlighting the need for any strategy to be able to adapt to the inevitable changes that will occur during its implementation period. It is natural that at the end of its life the strategy document will be less well configured to contemporary needs. However, it is important to note in this context that many of the original issues that the INDS targeted still remain important. So for example, it can be acknowledged that there is a need for the new strategy to target a broader range of drug taking behaviours but at the same time recognised that opioid use remains a major cause of drug related morbidity and mortality and services for this group, including the provision of substitution treatment, will need to remain a priority issue. Similarly, whilst there is evidence that drug problems have become more geographically diffused the capital remains relatively important for many drug problems, with some inner city and other disadvantaged areas particularly affected.

Geographical inequity in provision

Another recurring theme throughout the review was the geographical variation in the extent to which the strategy had influenced local structures, services and practice. Factors which appear to have played a part in this imbalance include: changes in the location of needs since the drafting of the last strategy; the difficulty of reconfiguring delivery structures in response to these changes; and practical and resource issues related to developing service models suitable for areas where the target population is more geographically dispersed. It appeared that both service provision and coordination mechanisms were regarded as strongest in those areas with longer established problems. Not surprisingly this issue was particularly noted as a concern for those working outside of the Dublin area.

Specialist drug services in most countries have tended to be concentrated in inner city areas where drug problems have historically been most pronounced. Ireland is also not unique in facing a growing need to increase drug service provision in smaller towns and rural areas, as this appears to be a growing issue in a number of countries. There are some obvious challenges in providing access to specialist services in rural areas and these appeared to be well understood. Some good examples of activity in this area (e.g. SASSY (Substance Abuse Service Specific to Youth, Dublin 1) were also presented to the panel, which if positively evaluated might be used as models to be built upon more widely. Responding to drug problems outside inner city areas, and ensuring there were referral pathways between services based in different geographical areas, were highlighted as an on-going challenge. This topic is therefore likely to be an important one for development within the new drugs strategy framework. It was suggested that one of the barriers to extending treatment service provision was simply the availability of specialist staff outside of inner city areas. This issue, in the specific context of medical staff and the supervision of drug-substituted treatment, is discussed in more detail below.

Linking local to national

One of the key features of the Irish context is the strong role of community organisations in both strategy development and delivery. This can be seen in the local and regional task force structures that underpin delivery and provide a forum for input from stakeholders at different levels, including community representation. Many of those interviewed expressed the view that for various reasons the coordination between local, regional and the national level had become less effective in some areas over time. A number of factors appear to explain this. Firstly, the recession resulted in organisational changes and recruitment freezes; second there appeared to be a growth in structures

focusing on specific issues that overlapped to some extent; and thirdly the initial political drive and engagement with what was seen at the time as a crisis issue reduced (as has been the case in other countries). This led over time to a loss of clarity over roles and responsibilities at different levels with the value of some bodies becoming less apparent and lines of communications blurred.

Another area in which good articulation between structures at the local and national levels is important is in the identification and adoption of effective interventions. The panel heard evidence of how efforts were being made to identify and encourage the adoption of evidence-based practices, for example in the drug prevention area, but there was still considerable work to do in this respect. Even in the short period of the review exercise we saw a number of examples of well-developed and documented programmes that appeared to represent possible examples of good practice with potential for application at the national level, but we were told that such roll out could be difficult to achieve in practice. This suggests a need for a clear mechanism for identifying good practice, supporting programme evaluation, and encouraging wider implementation where this is appropriate.

The need for effective engagement with local communities, needs based service provision, and mechanisms to ensure the quality of services delivered across locations, came up repeatedly during discussion on the current strategy. It is important that the local task forces or equivalent structures conduct local needs assessments but there were concerns raised that a bottom up approach to service development, if it is not supported by appropriate structures, can result in a pressure to locate services where the voices are loudest rather than where needs are greatest. Innovation at local level can also be important for developing and testing new approaches. At the national level, it is important to provide the structures necessary for prioritisation and the mechanisms necessary for: quality assurance; the dissemination of good practice; and to ensure evidence based programmes are adopted.

In summary, it is clear that there is a need to ensure that provision of services reflects identified needs, that resources are invested in those services that have been shown to be effective and that there is effective and multi-directional coordination and communication between actors at national, regional and local level. These all appear to be areas in which the new drug strategy may play a valuable role.

Addressing the needs of minority groups

The panel also heard evidence calling for recognition of the needs of, or including more participation of, some specific sections of the community. These included the Traveller and Roma communities, the LGBT community, and new migrants. A key issue for some minority groups (e.g. Travellers and Roma) is that they may require different referral pathways to access treatment or other services. A view was also expressed that better representation on, and engagement with, coordination structures was also needed. More generally the need to ensure gender sensitive services, develop services for young people and do more for the families of those affected by drug problems was also repeatedly mentioned, including the phenomenon of intergenerational transmission of drug problems. The issue of representation of drug users, families and others affected by drug problems at all stages of service development and the encouragement of peer involvement in service provision was also raised. In such a short study visit it is difficult for us to comment with any authority on the relative needs of different sections of the community or the extent to which they are being met. We would note however there are good reasons and widespread support for reflecting on how all sections of the community are served in the next drug strategy.

Measuring performance

The commitment to measuring progress over time is a positive aspect of the INDS. However the appropriateness of the KPIs chosen to the strategic goals was not always entirely clear. In some

cases their relevance for identifying progress over time appeared questionable or they were seen as overly ambitious in the context of available resources and capacities. It was also pointed out that the data necessary for monitoring some of the targets chosen was not easily available. Reflecting these issues, it was also not clear the extent to which some of the key performance indicators were still being used, or considered useful as a tool to monitor and drive performance. Taken together both interview and documentary evidence would suggest it would be a useful to inform the selection of the KPIs to be included in the new drug strategy with a reflection of the lessons learnt in respect to the selection and performance of the KPIs adopted in the current strategy.

Some more specific comments were made about use of performance measurement indicators in the drugs area that raise additional issues we feel are important. KPIs based on estimates of the extent of particular drug using behaviours (initiation, use in last year etc.), although potentially attractive, need to be carefully interpreted simply because of the large number of possible factors influencing drug trends. The appropriateness and implications of selecting a base year and accompanying annual targets expressed as a percentage increase also needs to be carefully considered. In the supply reduction area, for example, the KPIs adopted were for a 25% increase in the number and volume seizures by 2016 compared to 2008. However, it was questioned whether the approach was helpful given the potential impact of a small number of large seizures on any annual total and changes that occur in drug trafficking practices. In addition there is no clear or simple relationship between drug seizures and availability, a reduction in which was one of the drug strategy objectives. While large seizures may disrupt the activities of organised criminal networks (another objective), most drug seizures are small seizures from users or street dealers and have little direct impact on organised crime. The only other supply reduction objective that had any KPI associated with it related to tackling and reducing community drug problems. The KPI for this was simply the process measure of establishing 20 Local Policing Fora by 2012 with no accompanying outcome measure included.

The importance of matching the KPI to the objective and actions proposed was also illustrated by the treatment and rehabilitation KPI and action (number 38) on establishing a drug interventions programme, incorporating a referral option from the criminal justice system to treatment services. This was again essentially a process target but was nevertheless perceived as an unrealistic objective given a lack of police capacity to make assessments and capacity in the health system to receive them; especially as the referral opportunity generally occurred outside of normal working hours. This also raised the issue of who has responsibility or ownership for such cross-cutting areas and their ability to mobilise the necessary resources for delivery from essential partners. However, without any outcome or output targets the KPI may be considered met if a referral protocol or framework is established, even if it is rarely activated.

Ambitious performance targets were also set in the treatment area in respect to referral times for both for adults and young people with treatment needs. In some areas, achieving this level of performance was clearly challenging and it was not clear to the panel if this was still being systematically monitored or what implications and follow-up would arise from a failure to meet the performance targets set. It is clearly important that monitoring of KPIs is followed by analysis of any problems and appropriate remedial action taken where necessary. This links back to the issue of clarity with respect to roles and responsibilities at different levels in the system and the need to ensure sufficient capacity exists for the accurate monitoring performance.

Research and monitoring

The commitment to research, monitoring and evidence based interventions was another identified strength of the INDS. Nevertheless, some problematic coordination and structural issues were raised during discussions. One key aspect of these concerned a lack of standardisation and linkage of routine data and a lack of capacity and a mechanism for the analysis and collation of strategically

important information held at different levels in the system (national, regional, local). At a structural level the value of having an advisory structure with a direct link to policy (National Advisory Committee on Drugs and Alcohol (NACDA)) was raised but resourcing issues meant that the amount of dedicated research it was possible to pursue in this context was limited. In the discussions and in submissions to the panel, the problem of limited resources available for research and how best to maximise the value of the research capacity that exists within the system were recurring topics. Some suggestions were made that pointed to the need to review existing roles and responsibilities. We were unable to explore this issue in detail but this may be an area merits further consideration.

An additional important point raised was the need to distinguish between research and routine monitoring activities. In regard to routine monitoring, from an EMCDDA perspective Ireland is regarded as having a capable Focal Point and performing quite well in respect to agreed European reporting commitments. In respect of epidemiological information, the adoption of the European standard measures was apparent and these appeared to work relatively well in comparison with other countries. However, during discussions, issues were raised about the structural location of the work collating indicators and how this needed to compete with dedicated research funding with possibly undesirable consequences. Outside of the epidemiological area there appeared to be a need for to identify, standardise and collate other important data sources that were seen as having a potential for both strategic and operational purposes. The panel was told of difficulties in exploiting data available at local level for example where information is available but sometimes not used, because of a lack of capacity or because standardised measures had not been adopted. The limitations of available information technology resources, and again standardised approaches, for monitoring and sharing information on those accessing drug treatment and social support service was also raised in some discussions. Resource and coordination issues also meant that in some important areas, and notably in respect to forensic science capacity, there appeared to be a clear issue in respect to ensuring data availability. This may in part reflect the fact that the emergence of NPS and greater use of synthetic and novel substances has increased the need for this kind of information. The resources within Forensic Science Ireland currently struggle to deal with the level of confirmatory testing for required for legal purposes so only limited resources are available for surveillance or research activities to provide wider intelligence to support both operational actions and a strategic understanding of changes in the drug markets (see below).

The importance of policy and strategy connectivity

The policy and operational space in which the INDS has to operate appears to have become increasingly complex over time and this appears to have resulted in potentially overlapping constructions, and some corresponding lack of clarity on the purpose and/or role of different structures or actors working in the area. The number of relevant strategies and frameworks that have been developed is remarkable. This provides both opportunities and challenges. There is the potential for efficiency savings from cross-strategy co-ordination and this may also enhance inter-departmental co-operation. On the other hand there is the danger of duplication and a lack of clarity with respect to areas of responsibility. Additionally, a number of people suggested the need for a greater focus on implementation and delivery and the need for support to local areas in this regard.

One such area is alcohol. The importance of alcohol in terms of: the high prevalence of alcohol problems; the interactions that exist between alcohol and drug problems; and the position of alcohol within the current, and future, drug strategy; were issues raised repeatedly during the review. There are different models across Europe as highlighted above and whatever option is taken the important point is to ensure that areas such as prevention and treatment, where a cross-substance approach is essential are adequately supported.

3. Implications for the future NDS

Possible key focus and principles for the strategy

The review has highlighted a number of key issues which have implications for both the structure and content of the next strategy. Firstly, there are a number of core themes that emerge, relating to focus and principles, that we suggest need to underpin any new strategy. These are summarised below and then expanded on briefly in the following sections.

We suggest that the strategy should:

- focus on achieving **equity of access** to...
- ... **appropriate quality services**, i.e. evidenced based and adhering to quality standards;
- be **responsive to changing needs** – new drugs, new patterns of use, new groups of users;
- **address different levels of harm** (individuals, families and communities);
- have the perspective and engagement of those affected integral to the process;
- provide **continuity and coherence** (for individuals, services, strategies).

Equity of access

The variable nature of provision, whether in respect to geography, particular population groups (based on age, gender or ethnicity), or type of problem (different substance types or way in which you are affected), came up repeatedly during our meetings. We also saw many examples of excellent practice in local areas but mainstreaming these appeared to be a problem, with some appearing to be stuck as ‘pilots’ with associated uncertainties around funding etc. A similar issue was described around the implementation of some national frameworks or programmes; some areas were able to make more progress than others while there was sometimes duplication of effort in developing the tools necessary for such implementation. This suggests that a focus on ironing out these disparities and also identifying and spreading best practice might usefully be central to the next strategy.

Appropriate quality services

The commitment to evidence-based practice was widely supported and seen as essential. This requires the use of programmes that have been shown to work adapted to the Irish context and monitored for fidelity and effectiveness in practice. Evaluating innovative practice developed at the local level and then, if effective, making these widely available could lead to the development of a suite of approved programmes nationally from which local areas could choose suitable programmes to meet the needs they identify.

Responsive to changing needs

Building on the strong community focus in the previous strategy, responsiveness could be achieved through regular needs assessments at the local level that are analysed at the national level to identify emerging issues to allow reprioritisation, the development of new initiatives or the adjustment of current ones.

Address different levels of harm

Recognising the needs and incorporating actions to address harms to users, families and communities explicitly across all pillars will help address some of the inequity highlighted above.

Engage with those affected by the drug problems at all stages

This will enhance the effectiveness of the strategy. In other European countries peer-led services have been developed that make an important contribution to drug programmes and reduce barriers to service uptake.

Continuity and coherence

... is important both across strategies and over time. For such a strategy to be delivered, a supportive environment and a number of other features will be necessary.

To be successful the new strategy will need to:

- have political and public support
- provide clarity of objectives and responsibility
- foster working together
 - o Interconnected structures
 - o Inter-agency working
- be evidence infused
 - o Information systems / Performance measurement (revised KPIs)

Possible directions of travel / what might such a strategy look like

There is no such thing as a perfect strategy and there are many alternative approaches which all have pros and cons. It is important to consider both the structures and the content to ensure that both aspects are aligned with the overall vision and objectives. It is also essential that both structures and content are reflective of local needs and circumstances, so it would be neither appropriate nor realistic for the rapid external review team to specify these. However, the following provides some suggestions as to approaches that might be considered.

Strategies and action plans

On the one hand, strategies need to provide a long term vision and some stability in order to achieve changes in entrenched problems. However, on the other there is a need for some flexibility to allow for changing needs and situations or to make corrections in response to evidence that the approach being taken is not working or is having unintended consequences. The current strategy, which was essentially an eight year action plan, did not provide that flexibility and lost momentum over time as it was to some extent overtaken by events.

An alternative approach, which we would recommend adopting, would be to have a **longer term strategy document to provide the vision, objectives and structure alongside shorter (eg 3 year) action plans for achieving the objectives**. The process of refreshing action plans may provide an opportunity to review progress and change focus if appropriate and also to re-energise those involved in delivery.

Annual implementation progress reports are also valuable for facilitating effective monitoring and evaluation of the strategy and supporting action plans.

Vision, goals, objectives and actions

A common critique of the current drug strategy is that the objectives, actions and performance indicators were not clearly linked together and also were rather static. For example, there were some that just called for continuing activity or encompassed a host of other actions and were always 'on-going' (e.g. INDS action 32 regarding treatment and rehabilitation is 'overloaded'), while others were achieved immediately or became redundant. There also appeared to be little attention given to sequencing of actions or timeframes for delivery or whether targets were in fact achievable; it is

important to try and balance aspiration with achievability (stretching but not impossible objectives). Having an action plan that is regularly refreshed will address some of these issues by focussing on the immediate steps needed to move towards the longer term strategic objective. However, more important is to have a strategy which has clear links and a flow from the overarching vision, through the goals and objectives prioritised, to the actions and finally the indicators selected for monitoring progress and evaluating success. The use of logic models or theories of change might help the development process.

The starting point should be a **broad overarching vision** to frame the strategy and provide general direction. The vision, although broad, should highlight what sort of change or endpoint is expected and be aspirational in order to direct activity and motivate people to participate. The current Drug Strategy has as its overarching objective “To continue to tackle the harms caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars...” and hence is process rather than outcome orientated. In contrast, the vision for Healthy Ireland is “A Healthy Ireland, where everyone can enjoy physical and mental health and wellbeing to their full potential, where wellbeing is valued and supported at every level of society and is everyone’s responsibility”. Having a similar type of vision for the new drug strategy, which links to that for Healthy Ireland, would be worth considering. For example it might look something like: “An Ireland in which the damage done by substance use and the associated harms experienced by individuals, families and communities are minimised and wellbeing is maximised, and where all those who experience problems associated with substance use can access high quality services and support irrespective of where they live or who they are.”

Underneath and flowing from the vision should be a **few key goals underpinned by more specific objectives which should be directly linked to top level indicators of success**. These can be considered to form the pillars or themes for the strategy. For each of these, the action plan identifies the steps to be taken over the period of the plan to deliver the objectives. This allows the identification of some process and intermediate outcome indicators to demonstrate progress and be diagnostic of problems in delivery that might need addressing.

Examples of the sort of key goals that might be considered are:

1. Reduce the harms associated with drug markets and supply.
2. Provide the opportunity for all those experiencing problems with substance use to access treatment and other services and to make progress towards full participation in society.
3. Provide an environment that promotes well-being and supports people to make sensible choices about substance use.

These are similar to pillars of supply reduction, treatment and rehabilitation, and prevention but more clearly focused on the outcome sought. They are still very broad so any such goals would also need to be underpinned by more specific objectives. These obviously need to be based on the priorities identified for the new strategy but some examples of the sort of things that might be considered are illustrated in the following table.

The **action plan** would then identify the specific actions to be undertaken over the period of the plan to make progress towards achieving these objectives, **linked to shorter term process and output measures**.

Overarching goals – underpinned by more specific objectives		
Reduce the harms associated with drug markets and supply	Provide the opportunity for all those experiencing problems with substance use to access treatment & other services & to make progress towards full participation in society.	Provide an environment that promotes well-being & supports people to make sensible choices about substance use.
<p>1 (a) Reduce negative impact on users, families and communities of drug markets.</p> <p>1 (b) Increase the focus of law enforcement activity on most harmful dealers/ OCGs.</p> <p>1 (c) Shift the focus of drug law enforcement and the criminal justice system away from possession and promote a therapeutic approach to those with substance use problems throughout the CJS.</p> <p>1 (d) Reduce the availability of medicinal products on the market.</p>	<p>2(a) Provide an appropriate range of recovery-oriented treatment services to meet assessed needs in all geographical areas.</p> <p>2(b) Implement the rehabilitation framework and improve access to rehabilitative support, including employment and housing support.</p> <p>2(c) Reduce drug-related deaths.</p>	<p>3(a) Support parents and families. Implement evidence-based programmes to improve parenting skills and provide support to families affected by drug misuse in their own right.</p> <p>3(b) Earlier intervention and prevention. Expand the provision of evidence based universal programmes (SPHE - Social Personal and Health Education) in schools, targeted youth programmes building life skills as well as indicated interventions for young people developing substance misuse problems.</p> <p>3(c) Provide harm reduction interventions for young people who are experimenting with substances.</p>

Making it happen: Delivery structures etc.

In addition to the objectives and actions to achieve these, there are a range of cross-cutting themes that need to be addressed in order to deliver the strategy. These were issues that came up frequently in the review as discussed earlier. How they should be addressed is a matter for the steering committee to decide, but we would suggest there are some key qualities or features that should be aimed for. Our focus here, therefore, is on the different functions needed to support the strategy rather than on the specific bodies that are currently, or might in the future, be tasked with these roles.

The importance of **leadership** to provide drive, direction/prioritisation and to ensure resources are made available is obvious. A number of those interviewed suggested that having the lead in the office of the Taoiseach gave much greater weight to the strategy but that, at a minimum, it is important to have a minister with designated responsibility for the strategy in place. The hiatus when there was no minister was seen as a time when momentum was lost, while conversely the appointment of Aodhán Ó Ríordáin, T.D. as Minister with responsibility for the Drug Strategy was seen as having a very positive impact. In addition to a ministerial lead there will be a need for some committee or forum to support this role.

The necessarily multi-sectoral nature of the drug strategy makes good **coordination** of central importance at both national and local level. During the current strategy some changes had been made to the coordination structures associated with the strategy. These changes were seen in a fairly negative light by many of those we interviewed for a range of reasons. What came through in

these discussions was the importance of national and local structures having clearly defined roles and responsibilities. For example, the local areas might be responsible for needs assessment for their area, while at the national level analysis of information from all geographical areas would be undertaken to inform prioritisation and appropriate allocation of resources. Similarly the local bodies would need to develop local implementation plans which would be monitored nationally and support provided as needed. For this to operate effectively would require two-way communication flows as well as representation of the key stakeholders at both levels.

Another key issue is the **mobilisation of resources**, both in terms of finances and personnel. The multi-sectoral nature of action to address drug problems means that these will not always be 'labelled' resources and there will be a need to involve a lot of people for whom drugs are not the primary focus of their work. Therefore support and direction at the national level will be needed to ensure that at the local level staff from all relevant departments are engaged and that drug-related initiatives are able to access broader funding pots, such as funding for youth programmes.

In addition to coordination, **quality assurance and clinical governance** will be important to the successful implementation of the strategy. This was raised in a number of different ways in our interviews and is of particular importance when resources are tight. The national bodies would have a key role in this respect but would need to work with the local areas to identify and evaluate innovative approaches as well as ensuring standards are maintained. As suggested above, consideration should be given to establishing suites of approved interventions that have been shown to be effective and from which local areas would be expected to select to meet relevant needs they identify. For example, in the area of prevention there are international programmes that have been shown to be effective, such as the Strengthening Families Programme, which, if effectively adapted for the Irish context (as is being done in Cork), might be one such approved intervention. Locally developed programmes, if shown to be effective, should also be included in any such list.

Monitoring and evaluation of progress towards the goals in order to spread good practice and identify problem areas will be essential. The selection of appropriate performance indicators is critical in this respect and was seen as a weakness of the current strategy. There is a need to measure quantity, quality and impact of interventions. The identification of overall KPIs clearly linked to the specific objectives is important but they will often be quite long term. Accompanying them with interim input and output measures based on logic models will allow progress in the short-term to be monitored. However, it is important that the data collected is analysed and action taken to address any problems identified. This needs to be done from the perspective of a learning organisation rather than 'naming and shaming', using performance monitoring as a tool for identifying models of good practice and providing support to those underperforming.

A positive feature of the last strategy was the inclusion of a **research** pillar. Research can help understand the nature of the problem being addressed, how it is changing and what can be done to tackle it. However, our interviews suggested that the research function became somewhat disconnected from implementation of the current strategy, so developing a structure that ensures that research is integrated within the strategy implementation process is important.

The monitoring of performance and conducting research is not enough on its own and there is a need for analysis and drawing out of the implications of the findings for policy and practice. For example, to highlight areas that are underperforming and require support, identify emerging challenges that require a different response, etc. The **analysis and advice** arising from this then needs to be fed into the discussions around direction and prioritisation at the national level so that decisions can be made about the actions needed.

The diagram below illustrates (in yellow) the functions that, on the basis of our rapid review, appear to be necessary for implementing the strategy successfully. The current structures and

communication flows have evolved over time and appear rather complex and disjointed. We have therefore not named them in the diagram below as we feel it is more important to start by considering what needs to be done and at what level, then allocating responsibilities to specific bodies or reviewing terms of reference for these or new bodies, can be done at a later stage. It is the view of the review panel that simplifying the current arrangements and reconfiguring them around the required functions or roles in the new strategy will be important.

At the local level, key functions are **needs assessment, co-ordination and support for local implementation**, the role undertaken by the Local and Regional Task Forces. This local community perspective is extremely important for a successful strategy and some task force structure will clearly be vital for the new strategy. However, many of the people we interviewed highlighted the fact that the current taskforce boundaries were set a long time ago and that they no longer adequately reflect the pattern of drug problems around the country. As a result, there are gaps in service provision and inequitable allocation of resources. The panel is of the view that the Taskforce boundaries should be reviewed in the light of current needs; the fact that results of both a new general population survey and estimates of problem drug use will be available shortly provides a good basis for such a review.

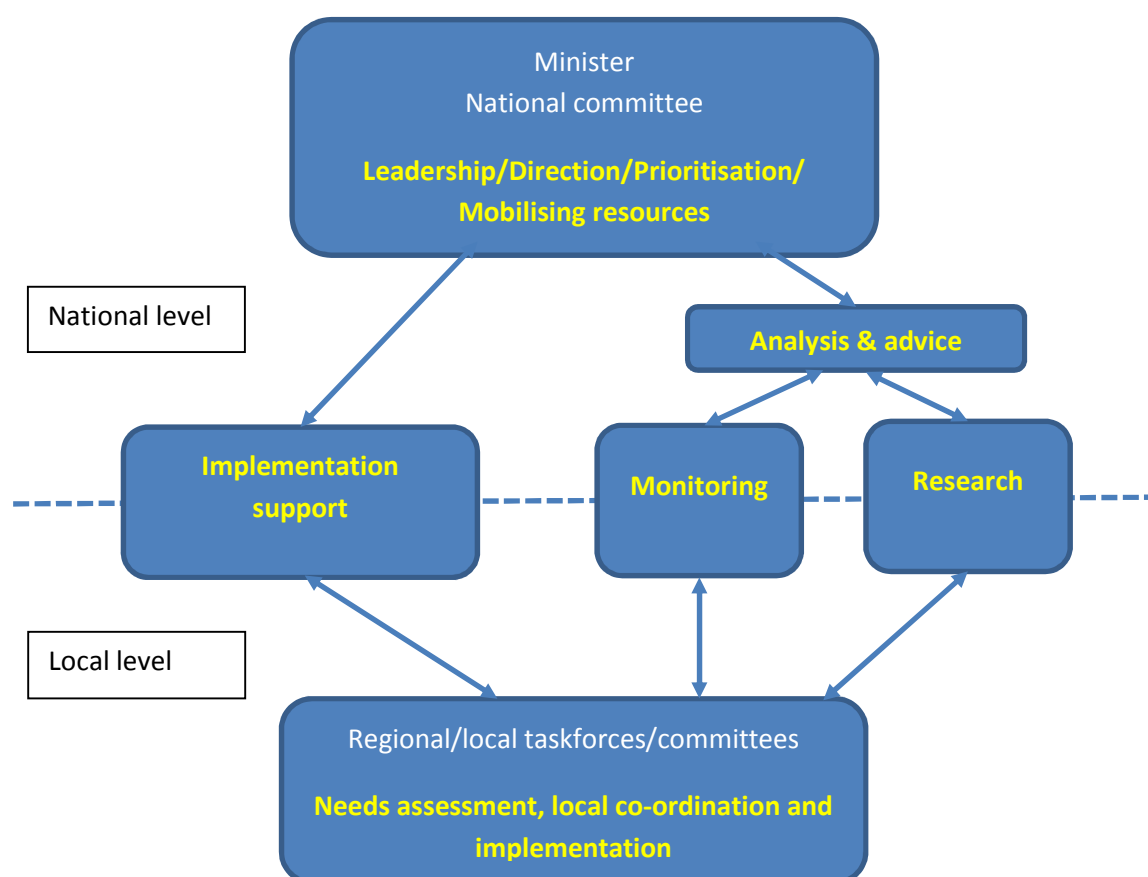


Figure: Functions needed at national and local levels.

Note: these functions are likely to be necessary within any system but their most appropriate location with respect to organisation or structures will vary.

4. Specific issues

The previous section considered the broader issues that were brought to the panel's attention, such as length and format of the strategy, local and national delivery and oversight and key issues affecting delivery, and discussed what we felt were the implications of these for the new strategy. However, in the course of the review a number of more specific issues and opportunities emerged that we feel should be considered for incorporation in the new strategy or action plans and these are outlined below. It is important to note that the nature and speed of the review means that issues identified are not exhaustive but reflect the people and organisations we were able to meet. Also we have not been able to explore them in any detail and in some cases they may be based on a misunderstanding of the current situation on our part. Nevertheless they may be useful in providing ideas for more detailed and informed consideration and development by the Steering Committee and give some pointers to issues that might be addressed in the new strategy.

Synergies with other strategies

The issue of the potential overlaps with other strategies and frameworks was discussed earlier. Making these links explicit by incorporating appropriate objectives or actions from these related areas into the new drug strategy or action plan should help obtain buy-in from the many departmental and organisational stakeholders in the drug strategy.

Some examples of relevant strategy documents and actions are:

- the 2012 Steering Group Report on a National Substance Misuse Strategy, which mainly focused on alcohol – while control measures differ, there are considerable overlaps particularly in the areas of treatment and prevention as well as on harm reduction in nightlife settings;
- Healthy Ireland 2013-2025 provides an overarching governance structure and monitoring mechanisms to support the implementation of relevant strategies with a view to improving health and wellbeing for all people, at all stages of life and in all sections of society. It identifies drug and alcohol problems as key issues.
- Better Outcomes, Brighter Futures, 2014-2020. Young people who develop problems with drug use are unlikely to achieve the outcomes sought in this strategy for children and young people without additional support. It highlights three action areas that are particularly relevant to the new drug strategy: support parents, earlier intervention and prevention, and quality services. These areas will be discussed in more detail below;
- Homeless Strategy National Implementation Plan identifies the need to support people with drug and alcohol problems to avoid homelessness or move out of it.
- Mental Health Strategy. Improving access to treatment for co-morbid mental disorders was highlighted as an important issue for improving outcomes for people with drug problems. Although Vision for Change in 2006 stated that uncomplicated addiction problems were the remit of Addiction services, the importance of improving access to mental health treatment for co-morbid mental health problems was recognised and recommendations for new services made. However, ten years on progress in this area has been limited with new initiatives only recently commenced. A process to review and update A Vision for Change is also underway. This presents an important opportunity to have some joint actions and targets set in order to promote progress in this area.
- Ireland's National Strategy to Reduce Suicide 2015-2020 identifies the risks and links between suicide and alcohol and drug problems.
- The National Sexual Health Strategy 2015-2020 calls for support for children and young people with drug and alcohol problems, as these issues impact on sexual health.

- Ireland's National Action Plan for Social Inclusion 2007-2016 identifies access to healthcare as a key element of avoiding drug and alcohol problems and the funding of community programmes to support healthy lifestyles
- The Joint Irish Prison Service and Probation Service Strategic Plan 2015-2017 recognises that drug and alcohol problems are risk factors in criminal behaviour. The 2011 Irish Prison Service Health Care Standards discusses drug problems and related health issues, such as blood borne viruses.
- An Garda Siochana's 2016 National, Regional and Divisional Policing Plans identify drug related crime as a key issue.

There are several other strategy areas that might warrant consideration if a broader approach to addiction and substance misuse issues is taken in the new strategy. These include Tobacco Free Ireland, the Irish Sports Council's National Anti-Doping Programme, and the work of the Department of Justice on regulating gambling. Other areas for consideration might include screen addiction (aka internet, gaming addiction) and behavioural addiction like eating disorders. Varying mixes of these issues are addressed in some national addiction strategies in the EU, although may be beyond the scope of the new strategy at present.

Treatment and rehabilitation/recovery

Treatment and rehabilitation provision need to go hand in hand; developing skills and gaining employment, having a roof over your head and being integrated into society are important for treatment to be successful in the longer term. Whether or not there should be separate treatment and rehabilitation pillars or themes, is a judgement call. Having them separate may provide a greater focus on non-treatment issues but may also result in separation of the two elements, reducing the impact of both. The same is true about whether the term 'rehabilitation' or 'recovery' is used; both come with associated 'baggage', i.e. entrenched and opposing or differing interpretations of what these terms encompass that may cause conflict or the assumption that it is "someone else's business" or that it is limited to a specific service or approach. A pragmatic approach is required and the main focus should be on trying to ensure that there are clear and simple pathways between the different services so that those engaged in treatment have access to the rehabilitation support they need from the start of treatment and vice versa, with a shared goal of progress towards recovery/social integration.

Treatment service delivery issues

As discussed above, one of the challenges for the future Irish national drug strategy will be to develop models of care appropriate for more complex drug consumption patterns. Problems resulting from the consumption of multiple substances, misused medicines, cannabis and synthetic drugs of all descriptions are posing an increasing challenge for drug services. This sort of drug consumption also has important implications for the burden placed on emergency services. That said, Ireland remains a country with a relatively large opiate problem and even if the characteristics and needs of this group are changing they remain a key target for drug treatment services. Moreover there remain important capacity, access and service provision issues that we would suggest should be addressed in the next drug strategy.

In respect to the treatment of opiate and chronic drug problems, the team was impressed by the considerable work that had been done in identifying appropriate working frameworks in this area. There also appeared to be a good, and to a large extent shared, understanding of the current challenges faced for developing these services further. Whilst it is not possible to review these in detail here, we feel it is important that these are considered in the development of future strategy or any accompanying action plans and we have highlighted a few areas that we think provide important opportunities for improvement. To some extent these more detailed points are exemplars of some of the broader strategic issues discussed earlier in this review - specifically the need to

ensure: geographical equity of care and system responsiveness to changing needs; the identification and national roll out of effective care models; effective inter-service partnerships and appropriate pathways of care for service users; and the development of services that are appropriate for the needs of all sections of the community.

Despite the considerable work that had been done, there still appeared to be considerable **barriers to introducing clinical innovation**; particularly in respect to new pharmacotherapies for substitution treatment. Examples were identified which concerned existing medications for which clinical trials had been conducted and authoritative reviews already produced (e.g. oral naltrexone, OST with slow-release oral morphine, high-intensity supervised injectable heroin maintenance) as well as examples involving new medications (e.g. naltrexone implant and depot; nasal naloxone; depot buprenorphine). As the range of therapeutic options available for drug treatment is likely to expand in the coming years, openness to testing new approaches and, after appropriate review, the capacity to implement them nationally, is likely to be an increasingly important systemic competence. In part it appears that frameworks established to limit inappropriate prescribing and the diversion of medicines may be acting as barriers. There may therefore be a need to review these frameworks to ensure they remain fit for purpose, reflect current evidence standards, and are appropriately forward looking. It is worth adding here that a number of new medications already exist or are in development in the international clinical research arena that are likely to have important implications for future clinical care options in the drug treatment area (some examples were highlighted above). An example of the importance of looking to the future to take advantage of new developments and ensure preparedness can already be seen in the area of HCV treatment for current or former drug users. Here there is a need not only for awareness of the availability of new high-cost, short-term, and highly-effective curative treatments but also make appropriate decisions on how these will be made available given the potential impact on health budgets. One way in which fuller engagement in clinical research and development might be feasible, despite the often high-intensity and high-cost of exploration of potential new treatments, may be through actively promoting the establishment of strategic collaborations with potential partners across Europe and facilitating engagement in future international trials of these new treatments.

Referral pathways generally, but in opiate treatment services in particular, also appeared a problematic issue. This appeared to be true both in terms of individuals moving between levels of specialism as their needs changed and in terms of a lack of specialist options in some geographical areas. Both practical and structural barriers appeared to exist that could restrict individuals being appropriately referred between different geographical locations. This problem seemed to be compounded for the homeless drug users, as the existence of a home address appeared to be necessary for accessing some services. General practitioners, when appropriately trained and supported, can increase the capacity of treatment systems to offer substitution care and may be of particular value in areas with a widely dispersed population. The model in Ireland of having two levels of GP qualification with oversight from specialists in addiction therefore seems appropriate. However, to work properly this requires the capacity within the system to move stabilised or less problematic cases downwards towards care at the general practice level. It also requires that general practice can access specialist support and referral options upwards towards more specialists care providers for more problematic cases.

There appeared to be a number of interrelated issues that required review here. For example, despite progress made in **general practitioners being trained to a level 1 standard**, many appeared **reluctant or unable to take on drug substitution clients**. It was suggested here that an important window of opportunity now exists with respect to current negotiations on GP contracts of employment, which could be modified to include this provision of care as a normal requirement, requiring GPs to opt-out rather than opt-in. Clearly, there may be other options for increasing the involvement of GPs and it is important to undertake some assessment of possible alternatives and

their likely impact. Nevertheless, in a range of other areas it has been shown that changing systems to require opting out instead of opting in increases participation and, given that the remuneration for those undertaking substitution care is already substantial, it is not clear what additional incentives would improve participation. The **number and locations of specialist (level two) GPs also appeared problematic**. Sufficient coverage did not appear to exist in all areas and a more general issue of onward referral was reported. The upward referral opportunities for more difficult clients appeared to be sometimes limited whilst some less problematic clients, who potentially could be managed at the general practice level, remained within and absorbed capacity in specialist provision. It was not possible in the short time available for the review team to judge the extent of problems in this area, however there was sufficient evidence available to suggest that a reflection on the organisation and availability of specialist care in respect to both geographical needs and how to facilitate appropriate upward and downward needs based referrals within the system is needed. The current re-negotiations about the GP contract may possibly offer an opportunity to re-visit the relationship between Level 1 and Level 2, the differentiation and the relationship between the two, and the associated levels of financial support provided.

A point that repeatedly reoccurred during the review discussions was the extent to which services, and treatment services in particular, were configured for **meeting the needs of different communities**. It was suggested, and appears reasonable, that working effectively with some communities will require different operational partnerships, care models and staff skills sets. A non-exhaustive list of communities where this issue was discussed as relevant include: the Roma and traveller communities, new migrants and the LGBT community. In addition, the need for services specific to women and young people, who may have different needs to the male opiate users who have generally been dominant treatment services, was highlighted. The review group visited a number of services which appear to provide examples that should be considered for replication or expansion. For example, the SASSY¹ model of satellite provision for young people with counsellors based in the community providing psychological therapies has had positive evaluations and with the added potential for using videoconferencing for clinical supervision appears to have promise for extending service coverage into rural communities. Similarly SAOL² has developed programmes for supporting women with drug problems that could be considered for replication. On a related point there was discussion and concerns raised about the extent to which current approaches to service user involvement were adequate for **ensuring service users have a voice** within drug treatment and other services. Again this is a difficult issue for us to make informed comment on here but note it as a topic worthy of consideration and relates to the issue raised below about peer support.

Mental health provision

The problem of access to mental health services was raised time and again during the review. As highlighted above there is an a need to take the **opportunity of the update of the Mental Health strategy** to recognise the importance of addiction and mental health services jointly addressing the needs of people with co-occurring addiction and other mental health problems. We would suggest that consideration be given to including the establishment of referral protocols as a goal in both new strategies as well as increasing the availability of psychological therapies within addiction services. When established, it will also be important to monitor actual utilisation of these services.

Rehabilitation / Recovery

The panel considered **the Rehabilitation Framework** to a good structure and would suggest that the implementation of this should be a key component of the new drug strategy. It would seem from the discussions we had during our visit that having a Rehabilitation Co-ordinator in place to provide

¹ Substance Abuse Service Specific to Youth, Dublin 1

² SAOL Project, Dublin 1 (<http://www.saolproject.ie/>)

impetus was pivotal to progress in implementation. This may be a short term requirement to overcome barriers to collaboration between services or identify opportunities for new ways of working. However, there is an opportunity to speed up the process by spreading the learning from areas such as Cork and the Southern Region where implementation has progressed further and protocols for inter-agency working have already been developed.

The international evidence highlights access to **employment** as a key component of long-term recovery. As in other areas, there appeared to be some examples of good practice but also some evidence of patchy provision. The panel was not able to consider this area in any detail but the transfer of the Community Employment Programme to the Department of Social Protection appears to provide an opportunity to re-energise and promote the CE Social Inclusion Drug Rehabilitation Scheme within the new drug strategy. As was highlighted in the Bruce Review³, integration of the employment programme with other treatment and rehabilitation provision is key to success but we heard from a number of people that under the current strategy co-operation at the local level was often poor, which was probably exacerbated by the different organisational boundaries meaning that people co-ordinating CE provision might be covering several DATF areas. This might be an issue for consideration if Task Force boundaries are reviewed. The new *Programme Framework for CE Drug Rehabilitation Schemes* seems to be taking a sound approach in positioning the schemes under social inclusion rather than the activation scheme, allowing greater flexibility in provision and outcomes sought, and the recognition of the need for integrated working with other agencies. It also addresses a number of key issues, such as aftercare, dealing with relapses and the need to engage with employers. Incorporating support to the implementation of this and identifying and sharing good practice could make a valuable contribution to the new drug strategy. In implementing it, key issues will be ensuring movement through and out of the scheme (to free up spaces for others) and ensuring that eligibility criteria are established that ensure that those who need it most are able to access the programme. One issue raised with the panel was the need for similar provision for young people with drug problems, who may have differing needs to the aging cohort of people with opiate addiction problems. The age of entry requirement for the current programme has been reduced to 18 years but it would be worth investigating (perhaps as part of an evaluation of current provision) whether (or not) young people have different needs that might be better met in a slightly separate programme with some dedicated provision.

Homelessness or living in unstable housing situations, such as sofa-surfing and temporary accommodation, is recognised as a major barrier to recovery and was raised on many occasions during the review. The analysis of Pathway Accommodation and Support System (PASS) data by the Dublin Regional Homeless Executive (DHRE) highlights the fact that approximately one fifth of their clients have complex needs, including drug and alcohol problems, which makes them harder to help and leads to them taking up disproportionate resources. They have successfully piloted a Housing First programme for this group, which is now being delivered, and consideration might be given to whether there are other areas that might benefit from similar provision. However they, and other providers of services to this group, also highlighted the barriers to treatment for this group (e.g. the issue of not having an address highlighted earlier) and the need to improve pathways between services, which we suggest should be a priority for the new strategy. The development of joint referral and discharge policies and protocols and shared use of the PASS system across treatment (including mental health) and rehabilitation services could facilitate joint working as well as provide information to evaluate programmes and to underpin performance monitoring.

³ Bruce, Alan (2004) Drugs Task Force Project Activity for FAS Community Employment and Job Initiative Participants: A Review. Universal Learning Systems.

An area where there appears to be potential for considerable development that could be supported in the new strategy is that of **peer support and peer-led services**. This is an area which has seen considerable expansion in several European countries in recent years. This goes beyond simple service user engagement to include peer mentors and volunteers working in treatment and aftercare as well as organisations set up and run by individuals with a history of substance use that, for example, manage coffee shops or run market gardens that provide activities, skills development and support alongside signposting to services and advocacy provision. The panel heard about some such provision in Ireland and CE Framework appears to provide some opportunity for incorporating this sort of provision but the Steering Committee might wish to consider more explicit support for the development of these sorts of programmes. Although considered here in respect to treatment and rehabilitation, peer involvement (rather than simply consultation) has the potential to add value to many aspects of drug policy and delivery as discussed earlier when suggesting key principles for any new strategy.

Families

As mentioned earlier in this review, families and significant others affected by a loved one's substance use problems are another key group requiring consideration in the strategy from several different perspectives: there is a need to consider provision for family support to safeguard the children of people with substance use problems; family members of people with drug and alcohol problems suffer significant harms, such as mental distress and intimidation, and require support in their own right; and the international evidence shows the value of families in supporting treatment and recovery. The new drug strategy will need to take account of these different aspects of family involvement.

A number of different individuals mentioned the concerns about **provision for the children of people with substance misuse**. This is a complex area as assessing the risks associated with alternative scenarios is challenging and mistakes can have serious negative consequences. At the same time fear of having children removed from them may stop women seeking help for their drug problems thus increasing risks. Treatment services may also often not be configured to adequately take account of child care needs. Ireland may have some resources to draw on here, for example the SAOL project -visited by the panel appeared to be a model worth learning from and could potentially be extended to other areas. There is also evidence from elsewhere that could be useful. For example, the Family Drug and Alcohol Court (London, UK) provides extensive structured support to parents rather than necessarily removing the child and this approach may have positive outcomes for both children and parents. Alternatively, kinship carers can provide both continuity and stability, although ensuring adequate support and recognition of the costs they incur are important but can be problematic issues. Whatever mix of approaches is adopted coordination with Tusla in this area will be essential.

The strategy will also need to consider the **family members of people with drug and alcohol problems** and others, such as close friends. These individuals may be important in supporting their family member with substance misuse problems engage with treatment and maintain recovery. Services therefore need to consider how they can be involved in an appropriate way in the treatment and recovery process. Family members and others providing social support may also need support in their own right as they can suffer a range of harms and may often fail to recognise their own care needs. Primary care providers need to be alert to the needs of family members and equipped to provide evidence-based programmes. Peer support networks such as the Family Support Network also have considerable potential to provide valuable support, signpost people to services, and help support programme implementation.

Tackling drug supply & related harms

The current drug strategy had a large number of actions under the drug supply reduction pillar but, as discussed earlier, it was not always clear how they related to the objectives under this pillar and had no clear measures of success associated with them. They also mainly relate to processes to be undertaken or developed with no output or outcome targets. Some of these reflect ‘business as usual’ and should continue in the next strategy but we would suggest they would benefit by having a clearer focus and linked to some measure of change. For example, in taking action against those engaged in drug supply prioritising the most harmful markets and OCGs, might be demonstrated by a shift in drug law offences towards supply offences attracting longer sentences and a corresponding relative reduction in the number of possession offences in the courts.

The current drug strategy includes an objective to target the **income generated by drug markets** and also to undermine the structures supporting such networks and we are of the view that targeting such ‘enablers’ of supply is important. However, the current strategy appears to have no actions or indicators relating to these. Incorporating measures of assets seized, with a focus on larger asset recovery to continue the prioritisation of higher level criminals, might encourage a greater focus on this area. Partnerships with the finance sector and professional bodies to tackle their involvement in money laundering might also be considered.

Intimidation and debt associated with drug markets seems to be a particular problem with the way drug markets operate in Ireland and tackling this is an objective in the current strategy that it is clear needs to be continued in any new strategy. Local Police Fora and a “Drug-Related Intimidation Programme” have been established and these seemed to be generally well regarded by those people who raised this topic during the review. However, we also heard evidence that drug debt and intimidation remains a major problem in a number of areas and we have not been given any concrete evidence concerning the impact of these initiatives. This suggests that an action for the next strategy might be to establish an evaluation of the programmes followed by the sharing of good practice identified alongside on-going monitoring of activity and impact. Community involvement in the development of innovative measures of the impact on the community, e.g. surveys of experience of intimidation, drug litter counts, use of local parks that had previously been ‘no-go’ areas because of drug use or dealing, etc., might be considered as part of this.

Concern about **internet markets and supply** is an issue of growing importance throughout Europe, in particular with respect to new psychoactive substances (NPS) and misuse of medicines. Given that these are both important issues in Ireland, it would be appropriate for tackling the issue to be included within the new strategy. With respect to NPS, support for the operation of the Early Warning System is important not only for law enforcement but also for those involved in research, forensic and toxicological services, and those providing treatment and other front line responses. Despite the high political priority given to responding to NPS related problems, the networking and coordination activities necessary to support a functioning EWS appeared at times to have been lacking. A particularly problematic issue appeared to be a lack of adequate resources for forensic and toxicological support for EWS activities. The impression given was that to some extent the system was over reliant on the interest and enthusiasm of individuals and lacked structural and institutional support. However, an important caveat here is that it was only possible to gain a superficial impression of activities in this area during the short study visit. Nevertheless, given the increasingly complex and dynamic nature of contemporary drug problems, within the context of the development of the new strategy it would be wise to consider how the capacity to detect and respond in a timely manner to NPS and other emerging problems can be strengthened.

Clandestine darknet markets have generated considerable media interest and are likely to remain important in the future. Consideration will also however need to be given to areas of the surface web, which are likely to become increasingly important for drug supply; these include online

pharmacies, websites, and social media applications. Appropriate action in this area is likely to include partnerships with industry, targeting modes of delivery like fast parcel services and parcel collection points. This is an area where sharing experiences and learning with other European countries is likely to be valuable given the international nature of this problem, the fast pace of change and the need for the development of new approaches.

In addition to the internet the **supply of medicines for misuse** can occur through diversion and 'doctor shopping' which will require different approaches to control. Understanding the relative importance of different sources is an area for investigation to support appropriate action. There is also a role for prevention measures alongside enforcement and regulatory activity. As some unlicensed medicines appear as NPS products, close coordination is required here with both EWS activities and activities in the area of pharmacovigilance.

Criminal Justice System

It was apparent from our interviews that there is concern about the criminalisation of young people caught in possession of drugs and the negative impact this may have on their life chances and a recognition of the potential greater benefit for those with more severe drug problems of receiving treatment rather than punishment. This is also reflected in the current debate in Ireland around decriminalisation of possession offences, possibly along the lines of the Portuguese model. This issue is also more broadly reflected in discourse at an EU level where there is a tendency for a greater priority to be given to targeting drug supply and serious organised crime group activities over measures taken against simple drug possession for personal use. It is worth noting that there appeared to be a widespread consensus expressed during the review that for minor drug offences, especially those related to cannabis possession, the long term costs for both the individual and society of the offence remaining on file in perpetuity were considerable and unjustified. This appears an area in which a number of different approaches could be considered. More generally, and as indicated above, the new strategy could help provide a framework helpful for the prioritising of supply reduction activities in areas that are likely to be of greatest value in respect to their overall impact on the top level objectives chosen for this area. Key performance indicators need to be carefully chosen here as this is an area in which it appears particularly easy to generate perverse incentives: such as the targeting of minor offences to increase overall performance figures.

European research has established that **using the opportunity of contact with the criminal justice system to divert offenders with drug problems into treatment** can be successful in tackling drug problems and reducing crime. The current drug strategy included this in KPIs and actions and there are a range of different programmes now available. However, the review panel has not been able to ascertain how frequently they are used nor how effective they appear to be.

It is important to note that to some extent there are two different groups of drug-users likely to come into contact with the criminal justice system: people who use drugs in a less problematic or dependent way who may be caught in possession of drugs and those who have more severe problems who may be caught in possession of drugs but who are also often charged with acquisitive or minor drug supply offences associated with the need to 'feed' their drug habit. These two groups require different responses but are often grouped together as drug-related offenders. An EMCDDA report "Alternatives to punishment for drug using offenders" published in 2015 highlighted the variety of alternative sanctions available throughout Europe. It found that there were few evaluations of the use of these and that common problems in implementation of them were a lack of support for them due to perceptions of leniency, which meant they were often not utilised and restrictions on their application, such as restricting their use to first time offenders, which meant they could not be applied to those people who might most benefit from them since many dependent users who are not in treatment are frequent offenders. Although we have not reviewed

the different options available in Ireland, the panel has the impression that these same issues may apply to the programmes available.

Serious consideration should be given to having an objective of **increasing diversion from the criminal justice system for those arrested for drug possession** and also diversion into treatment for people with drug problems arrested for low-level non-violent acquisitive crimes committed to obtain drugs. A review of available provision to see if it is targeting the right groups and to what extent it is used would be a good starting point. The current consideration of the potential for a Community Court or Community Justice Intervention which might replace or subsume the current Drug Treatment Court would need to be incorporated within this.

Some specific ideas or issues were raised during our meetings, which we feel are worth giving consideration in the development of the new strategy. For individuals arrested for simple possession offences the impact of a criminal record can be profound and was generally viewed as disproportionate. The Spent Convictions Bill might slightly mitigate this, if passed, but as it will not apply to those with more than one conviction there are likely to be many with a history of drug problems that will not be covered. The Garda Youth Diversion Scheme allows for a young person under 18 years of age to be given a caution instead of prosecution and this may also be accompanied by supervision. However, for adults, no caution option is at present available. However, the Adult Caution Scheme is currently under review and this would be a good opportunity to try and get simple drug possession included in the offences to which an Adult Caution may be given. This would effectively provide a non-criminal option for dealing with drug possession offences. However, if there is appetite to go further along the decriminalisation road then some civil process would need to be established, similar to the Portuguese Dissuasion Commissions. It was suggested that the Restorative Justice Community Based Organisations might be developed to perform this role although additional sanctions or referral options for drug-related offences, such as education programmes or driving licence suspension, would need to be developed alongside treatment referrals and standard restorative justice options.

Under the current strategy, the provision of healthcare to the prison population, both in general and also with regard to OST provision during incarceration, appears to have improved markedly and the panel was impressed by the provision levels described. There also appears to have been progress made with respect to transitions to aftercare. This work needs to be maintained and developed further. In particular it appears that there is a gap in provision for those released without Probation Supervision, which may apply to quite a large section of the prison population likely to have drug problems. These people struggle to obtain accommodation and as a result are very vulnerable to homelessness, relapse and recidivism, undoing the progress made in prison. This is an area for consideration in the new strategy.

Drug related deaths

Drug related overdose and other forms of avoidable mortality associated with drug use has to be a major concern for any future drug strategy as it is in this area that a large share of the health costs associated with drug use are accrued and thus also the area where the greatest potential benefits from intervening effectively may be obtained. After a period of stabilisation, recent data on acute drug related deaths suggest that there have been modest increases in the numbers reported in Ireland, which is clearly a cause for concern. Heroin deaths increased in 2013 for the first time since 2009 and one in five poisoning deaths were heroin-related, in about half of which the user was injecting at the time.

A number of mostly Northern and Western European countries are currently reporting increases in acute opiate related deaths although the reason for this trend is not entirely clear. It has been suggested that, along with changes in reporting practices, poly drug use, including the co-use of medicines, alcohol and stimulants may be important. We note in this respect the concerns about

polydrug use and the misuse of medicines, and benzodiazepines in particular, that were raised during the study visit. It has also been suggested that aging cohorts of opiate users may be becoming more vulnerable to drug overdose or that other risk factors may be increasing vulnerabilities: such as lowered drug tolerances after periods of opiate free incarceration or brief treatment; or the increased availability of high potency synthetic opiates or heroin. Whatever the reasons for changes in this area, it is clear that better understanding of drug related overdoses (both fatal and non-fatal) is important for both informing the development of effective responses and in respect to providing an early warning capacity of potentially new emerging threats, for example the sudden availability of new and toxic NPS products. Good toxicological and contextual information is crucial in this respect and in some parts of Europe local **confidential enquiry schemes** have been established. These schemes establish an expert panel to review each death where drugs are thought to have played a part to ascertain what lessons can be learnt. This sort of analysis can greatly increase the understanding of statistical data in this area and may be worth considering in the Irish context.

There is also a growing evidence base available now to inform strategies to reduce opiate related deaths in particular. The evidence would suggest that a broad set of supporting measures are needed and thus this is an area in which a national and strategic approach is likely to be particularly important. Typical elements of a comprehensive approach to **overdose prevention** are likely to include: targeting known risk periods, such as leaving prison or drug treatment; strengthening regulatory frameworks for dispensing to prevent the leakage or misuse of medicines; the training of those likely to witness or respond to an overdose event; reducing barriers to help seeking; and other harm reduction and prevention approaches.

More recently the evidence base for **naloxone** as an effective intervention has grown significantly, both where the drug is administered by specialist staff, but also when used as a peer, family or first responder delivered intervention. Potentially interesting new formulations and delivery methods are now being developed for this drug, which may facilitate its wider application. In this respect, the proper involvement of family members in training in overdose emergency interim care and the administration of naloxone and making naloxone available to them is important. Staff of hostels for the homeless are another key group for this sort of provision (for fuller consideration, see EMCDDA 'Insights' report on naloxone, 2016). A further recent development that warrants examination is the provision (to the US market only, as of early 2016) of a new nasal naloxone concentrate spray, developed by a Dublin-based pharmaceutical company. This kind of formulation may be potentially valuable, although any opinion on this issue will necessarily need to be informed by future research findings and appropriate regulatory and review procedures.

Another approach in this area, which has been recently debated in Ireland, is the establishment of **supervised injecting facilities**. These programmes appear most appropriate for areas in which there is a high concentration of chaotic, chronic, street drug users, or where other factors, such as high levels of homelessness, result in street drug use. As well as being regarded as having possible benefits to the local community by reducing publicly visible drug use, some evidence suggests that this kind of service may have a role as part of a comprehensive harm reduction strategy and also act as a gateway to other social and health service provision. There is a visible drug scene in Dublin, and possibly elsewhere, that suggests the piloting of such a facility is worthy of consideration. If such a scheme was to be developed, issues to be considered include the appropriate site for the facility (it needs to be readily accessible or it will not be used) and the importance of ensuring that the access rules and criteria are not made so tight that, as was highlighted as a potential issue with CJS interventions, those in most need are not able to make use of it. Attention would also be required to the proper skill-mix of staffing to ensure safety and the ability to manage occasional clinical emergencies, as well as clarity about medico-legal issues and liability etc. (for consideration of these issues, see report on supervised drug consumption rooms by Joseph Rowntree Foundation, UK, 2006; EMCDDA Perspectives on Drugs, 2016, *Drug consumption rooms: an overview of provision and*

evidence). A related issue that may arise in the wider public debate is the consideration of prescribed supply of pharmaceutical drugs to such attendees – this is more usually considered as a high-threshold highly specialist treatment provision appropriate only for a very small fraction of the most entrenched addicted individuals (see EMCDDA ‘Insights’ report *New heroin-assisted treatment*, 2012).

Preventing substance use problems among young people

Programmes aimed at preventing harmful substance use among young people are a core part of all drug strategies and highlighted as important by many of the people we spoke to. Issues around consistency and quality of provision and concerns about co-ordination and linkage between different elements of provision were raised. This area includes programmes to prevent use, delay use and reduce harmful patterns of use and can take place at different stages ranging from early childhood, through school years into young adulthood. They will often address risky behaviours in general and seek to develop life skills and social competencies more broadly rather than being drug-specific.

We have already highlighted above some of the links to the children and young people strategy. Youth Services and TUSLA will be key partners in this area as well as Department of Education and Skills. As for other areas of the drug strategy, it will be important to link into on-going programmes. There are a wide range of different types of programmes that need to be considered within this area, at many different levels (universal, targeted, specified) and in a range of settings. However, for all of these quality and use of tested programmes is of major importance – it needs to be remembered that, however well-intentioned, prevention programmes can have the unintended consequence of increasing use and harms. For example, “Just say no” and “scaring straight” approaches have been shown to be ineffective or even harmful, while the most effective programmes are those that are more general ones that seek to build resilience in young people through developing decision-making skills, self-efficacy and engagement in schools and society. Some form of accredited programme list and process for evaluating programmes in Ireland should therefore be considered. The new approach to the funding of targeted Youth Diversion programmes includes this sort of consideration. However, it will also be important to have the flexibility for innovation and the development of new programmes factored into this. As the new programme subsumes the funding for drug-related youth diversion programmes, it will be important that at local level Drug and Alcohol Task Forces liaise with the Children and Young People’s Services Committees (CYPSCs) to ensure coordination and access to funding for youth programmes.

As indicated above, the range of programmes considered for inclusion in this element of the drug strategy needs to reflect different settings. For example, both universal education in schools and provision by youth workers needs to be considered and we would suggest that the new Drug Strategy should link to Healthy Ireland and Better Outcomes, Brighter Futures: the National Policy Framework for Children and Young People here. This latter strategy also includes family support, another important component under this theme. With respect to school-based universal programmes, the new curriculum for 12 to 15 year olds developed as part of Healthy Ireland is potentially valuable, but the extent to which it is implemented and how well this is done will be the key to effectiveness and some mechanism for reviewing this will be needed. Provision outside of schools, both universal and more selective, targeted interventions are also important but need to be aligned with the work in schools, rather than the two working separately, for maximum impact.

Another area to consider for inclusion in the new drug strategy will be harm reduction information/education for users, and social media and new technology may be useful in this regard. Also, in a small number of countries in Europe, drug testing facilities have been developed, (e.g. Wedinos in Wales, DIMS in the Netherlands). These allow drug users to have the substances they have purchased tested anonymously. The rationale for this is that it creates an opportunity to provide harm reduction advice, although this is an area in which the evidence base for judging

impact is limited. These services, along with other approaches, such as amnesty bins (drug collection bins provided in recreational settings) and drug purchasing projects, do allow a better understanding of what drugs are being used at street level, which is valuable given the fast-moving situation in respect to NPS availability and trends in drug use more generally.

Delivery and Performance management

The concerns raised by people we interviewed about the mismatch between some of the KPIs and the objectives in the current strategy and the perception that reviews of performance did not generally appear to lead to action to address problems were highlighted above. However, some potential opportunities associated with developments in this area were also identified.

The work that has been commissioned to develop a **performance measurement framework for Drug and Alcohol Task Forces** is one of these. Although still very much a work in progress, there are a number of ways it can help the new strategy. The resource allocation model being developed, based on the data sources incorporated so far, already clearly illustrates considerable variability between both resource allocation and performance with respect to treatment. While such variation may reflect factors not currently included in the model, such as different recording practices or the presence of particularly challenging populations, critical review of the output and further development of the model may assist in the consideration of the appropriateness of the current Task Force boundaries, as well as resource allocation. The proposal for the Performance Management Framework also specifies the use of theory of change and logic model approaches to underpin the model and inform the selection of performance indicators, as well as highlighting the need for different types of indicator: input, output, result and impact indicators. The review of data sources and the development of logic models being done within the performance measurement framework development need to be reviewed and incorporated into the drug strategy development process.

Another linked issue is the importance of performance management data being linked to action in terms of support and adjustment to activities. This applies both where there are deficits in performance as well as high achievement. Where there is underperformance, support needs to be provided in identifying, diagnosing and addressing underlying problems while high achieving areas can be used as exemplars from which lessons can be learned. This generally supportive rather than punitive approach should reduce the perverse incentives that can accompany a target-driven approach to performance management and encourage a learning culture. It also fits with the already highlighted concern for the identification and sharing of good practice by providing another mechanism for identifying successful programmes. More explicitly adopting a pathfinder approach to introducing new programmes within the new strategy may also be beneficial and help overcome the issue of slow implementation that was noted, for example, with respect to the Rehabilitation Framework. In that case the areas that did employ a rehabilitation coordinator have developed mechanisms for and experiences that can be assessed and rolled out more widely (a national level role).

The challenge for drug strategies is the wide range of sectors involved in delivery and of target groups, which means that data for evaluation and performance management needs to be drawn from many different sources which often do not match with respect to coverage, boundaries, definitions etc. Therefore the issue of **IT system linkage** needs to be considered in the strategy, as this appeared to be problematic under the current strategy. However, our view is that this is likely to be best addressed, through an incremental approach that makes use of proprietary software or systems already in place as far as possible, rather than large, expensive IT projects that all too often fail to deliver. For example, the PASS system has potential for wider application with respect to documenting activity within the Rehabilitation Framework. In Cork they are training all those involved in the Rehabilitation Framework implementation to use the AUDIT and DUDIT screening tools.

5. Final comments

We are mindful of the limitations of such a short review exercise and recognise that the responsibilities for drafting the next Irish National Drug Strategy lie elsewhere. Consequently we have tried not to be over-directive or assertive in the analysis presented here. Nevertheless, we finish this report by reiterating a few of the conclusions we have come to which we see as core to moving forward with a new strategy.

Drug strategies are extremely important. However, it is essential to have realistic expectations and not expect them to solve all the problems inherent in such a complex, multifaceted area in which articulation between social, criminal, and health policy areas is vital. We do think, however, that well-crafted and clear strategy documents can provide the direction and vision to help the progressive development of good services over time and ensure that the different actors in the process are working towards the achievement of common goals. To achieve this, it is important that the top-level priorities are clear and not lost within the accompanying list of details and issues important for implementing the strategy's objectives across its different domains. For this reason, and also to ensure responsiveness to new challenges, we conclude that there is a strong argument for considering a strategy document supported by one or more time-bound action plans.

It is also clear that, given the overlap of concerns in the drugs strategy area, with other areas in which strategies and policy plans are already in place, the issue of synergy and complementarity requires attention. This issue is clearly particularly important in respect to alcohol, which necessarily needs consideration within any new drug strategy, but it is also important to recognise the need to avoid undermining policy advances made elsewhere in addressing market regulation issues.

There are a number of top level issues that recurred across the different pillars of the current drug strategy that we feel the new Irish drug strategy should seek to address. This includes ensuring the equality of access to provision according to need; a concept that applies not only to geographical inequities but also provision for different communities and for different types of drug user. Equity of access also means that high quality interventions, of proven effectiveness, need to be universally available. The strategy could play an important role in promoting structures and processes for the identification and national adoption of quality programmes. This seems to be a clear need and we were presented over the course of the review with many examples of excellent programmes, as well as models, guidelines, and frameworks, for delivering high quality services, but barriers appeared to exist to implementing these at the national level.

Indeed, we found the number of relevant published strategies, frameworks, reviews and protocols in the substance use area striking, and our review echoes many of the recommendations in these. This leads us to suggest that one issue that should be central in the new strategy is implementation and delivery. Important to this, we would argue, is a commitment to monitoring, research and evaluation as cross cutting issues, which is essential in any modern drug strategy. They are necessary for ensuring progress is being made and for the identification and implementation of best practices and new approaches. They also allow the system to be forward-looking and responsive to new threats and challenges as they emerge. Given the pace of change in the drugs area, responsiveness must be regarded as an essential element of any strategic response in this area. However, without a commitment to and a mechanism for taking action on the findings, they will not achieve these outcomes.

Finally, we have tried to outline in the body of this text the structural functions that are likely to be necessary to support the implementation of a strategic approach to the drug problem. We have not tried to map these onto, or comment on how they would fit with, existing structures or the current roles and responsibilities of bodies working in the drugs area. We would conclude however that

clarity of organisational roles and responsibilities is likely to be important for any future strategy. During our visit we were impressed by the obvious passion and enthusiasm of those working in the field. The development of a new strategy therefore represents an important window of opportunity to harness this resource and for reviewing existing structures and ensuring that the system as a whole is coherent and reflects current and, as far as this is possible, future needs.

ANNEX A: List of organisations who contributed to the Review

We are very grateful to the following groups who either met with or provided submissions to the review, often both. In many cases we met with a number of individuals from the same organisation but as we met with so many people we were unable to list everyone individually. This list illustrates the range of people we heard from and who shared their experience and concerns and we hope we have covered everyone but, if not, please accept our apologies.

Organisations who contributed to the review
Addiction Faculty, Royal College of Psychiatry
An Garda Síochána
Ana Liffey Drug Project, Director
Ballyfermot Star
BeLonG To
Bray Community Addiction Team
Chris Luke, Consultant Emergency Medicine, Cork
Community Sector
Cork Education and Training Board, CEO
Cork Local Drugs and Alcohol Task Force Chair
Cork Local Drugs and Alcohol Task Force Co-ordinator
Cork Local Drugs and Alcohol Task Force Development Worker
Cornmarket Project
Courts Service
Department of Children and Youth Affairs
Department of Education and Skills
Department of Health
Department of Justice and Equality
Department of Social Protection
Department of Transport
HSE National Drug Treatment Centre
Dublin City Council
Education and Training Board Sector Representative
Forensic Science Ireland
Foróige
Health Research Board
HSE Addiction Services, General Practitioner Addiction Services
HSE Addiction Services, Chief Addiction Pharmacist

Organisations who contributed to the review, continued
HSE Addiction Services, Consultant Psychiatrist
HSE Drug and Alcohol Services South
HSE National Clinical Lead, Addiction Services
Irish College of General Practitioners
Irish Medical Organisation
Irish Prison Service
Irish Youth Justice Service
Local Drugs and Alcohol Task Force (LDATF) Chairs Network
Local Drugs and Alcohol Task Force (LDATF) Co-ordinators Network
Longford - Westmeath Education and Training Board, Youth Officer
Medical Bureau for Road Safety
Merchants Quay, CEO
Midland GP/Pharmacy Addiction Liaison Nurse
Midland Regional Manager Community Alcohol and Drugs Services
Midland Simon Community, CEO
Midlands Regional Drug and Alcohol Task Force Co-ordinator
Mountjoy Prison, Chief Nursing Officer
Mountjoy Prison, General Practitioner Addiction Specialist
Mountjoy Prison, Senior Addiction Counsellor
National Advisory Committee on Drugs and Alcohol - Chair
National Drugs Rehabilitation Implementation Committee - Chair
National Family Support Network
National Youth Council Ireland
Pavee Point
Regional Drugs and Alcohol Task Force (RDATF) Chairs Network
Regional Drugs and Alcohol Task Force (RDATF) Co-ordinators Network
Revenues' Customs Service
Road Safety Authority
SafetyNet
Southern Region Drugs and Alcohol Task Force Chair
Southern Region Drugs and Alcohol Task Force Co-ordinator
Southern Region Drugs and Alcohol Task Force Development Worker
Spunout
Sr Liz Smyth, School Principal

Organisations who contributed to the review, continued
Students for a Sensible Drugs Policy
TUSLA
UISCE
University College Cork Department of Epidemiology - Lead Researcher Cork & Kerry Alcohol Strategy
Voluntary Sector
Youthreach

Visits

SAOL Project, 58 Amiens Street, Dublin 1
SASSY, 22 Mountjoy Square Dublin 1 Dublin City
Douglas Street Project, Ardagh House, Old Carrigaline Road, Douglas, Cork

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ANNEX B: Terms of Reference of the Rapid Expert Review Panel

- (i) To examine the progress and impact of the National Drugs Strategy 2009-2016 across the five pillars of supply reduction, prevention, treatment, rehabilitation and research in the context of the objectives, key performance indicators and actions set out therein;
- (ii) To identify deficits in the implementation of the strategy;
- (iii) To summarise success factors or barriers to success;
- (iv) To comment on Ireland's evolution in tackling the drug problem in the light of international trends, to include areas such as supply reduction, education and prevention, treatment, rehabilitation and research;
- (v) To identify key learning points arising from the strategy and to highlight areas to consider for development in the new strategy;
- (vi) To provide a report in draft form to the Department; and
- (vii) To submit a final report in writing to the Department.