taskforce
DUN LAOGHAIRE RATHDOWN
DRUG AND ALCOHOL TASK FORCE

Submission
to Citizen's Assembly
on
Drug Use 2023

June 2023

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Introduction

The document is the submission to the Citizen's Assembly on Drug use from Dún Laoghaire Rathdown Drugs and Alcohol Task Force (DLRDATF). The submission is structured as follows:

1. Profile of DLR
2. Findings from our consultation and experience
3. Response to question set out by the Citizen's Assembly

By means of background, DLRDATF was established in 1997 as one of the initial 12 Local Drugs Task Forces set up following the publication of the "Rabitte Report" in 1996.[1] DLRDATF coordinate a community response to drug problems (alcohol problems were added in 2013). It is made up of representatives from community, voluntary and statutory bodies, public representatives and independent members.

Dún Laoghaire Rathdown Drug and Alcohol Task Force

The DATF is a forum for assessing needs and leading out on debates, analysis on drug and alcohol issues in DLR, and more widely as appropriate. Since its inception, the Task Force has guided the services for drug and alcohol services in the Dún-Laoghaire Rathdown local authority area through regular programmes including research, strategic planning and output monitoring. DLRDATF provide and support services and interventions under the following four priorities:[2]

1. Prevention
   The DATF will develop, support and coordinate preventive activities and projects, thereby protecting young people and children from harms arising from and associated with problem drug and alcohol use, with particular attention to increasing resilience, strengthening life-skills and healthy life choices, across a variety of school, community and family settings.

2. Treatment, Health Diversion and Interagency
   DLRDATF support and collaborate with HSE clinical leads in their inter-agency work, their various efforts to respond to people with complex needs, arising from homelessness, injecting drug use and dual diagnosis, and also in assisting the roll-out of health-diversion when this commences. DLR Task Force funded project, Community Addiction Team (CAT), and the HSE funded project DROP (Dun Laoghaire Rathdown Outreach Project) are leaders in developing a comprehensive, community service in this field.

[1] Government of Ireland (1996) First Report of the Ministerial Task Force on Measures to reduce the demand for Drugs.
[2] strategic_plan_2023-2025.pdf (dlrdatf.ie)

3. Disadvantaged Communities
   DLRDATF recognises that vulnerable communities present particular challenges for tackling drug problems. The DATF is aware that when there is a lack of attention to underlying social issues that some communities become even more vulnerable. They are at-risk of further community alienation, potentially leading to criminality and anti-social behaviour associated with the drug trade. The DATF seeks to play a role in disadvantaged communities and groups particularly through developing a local presence and in ensuring funded services have outreach capabilities and also through making direct linkages with other relevant services and bodies in order to support this work.
4. Horizontal themes
   The DLRDATF undertakes ongoing review and monitoring, and the need to constantly improve structures, activities and programmes through capacity-building, training, research and ongoing consultation. Actions here include those around: structures and governance; Research and data; "hidden harms" in practice community; training; and, service user involvement.

Profile of Dun Laoghaire Rathdown (DLR)

The socio-economic and demographic profile of DLR is unique in the State. DLR has the largest concentration of affluence when compared to the State as a whole or with other counties. However, this affluence serves to mask disadvantage in DLR.[3]

Figure 1: Map of Dún Laoghaire Rathdown

Overall, the Pobal HP Deprivation Index[4] ranks DLR as in the "Marginally above average" band, with nevertheless the highest score in the State. However, of the 69 Electoral Divisions (EDs) that the makeup up DLR, 38 are *affluent*, 25 are *marginally above average* and just 6 are *marginally below average*. In population terms, this equates to 61% of DLR (133,234) in 2016 living in *affluent* EDs, 31% (67,597) in 2016 resident in EDs categorised as *marginally below average* and just 8% (17,408 in 2016) living in EDs deemed *marginally below average*. In other words, no EDs in DLR in 2016 was categorised as *disadvantaged*.

In 2009 and 2010, work undertaken for Southside Partnership DLR, before the introduction of the Pobal HP Small Area level deprivation index[5], undertook extensive research on a social exclusion profile of DLR. One of the motivations here was anecdotal evidence that there existed pockets of deprivation in DLR that was enveloped by significant, nationally, relative affluence.

An innovative research methodology, pre the onset of "Small Area" data in 2018, was used combining Census enumerator data, anonymous data on social welfare from the Department of Social Protection and anonymous data on social housing from DLR County Council. This resulted in the identification of 21 pockets of disadvantage

[3] Microsoft Word - The 2016 Pobal HP Deprivation Index - Introduction 07.doc (trutzhaase.eu)
[4] Pobal HP Deprivation Index
[5] The Pobal HP Deprivation Index was available for Electoral Division level only until 2018.

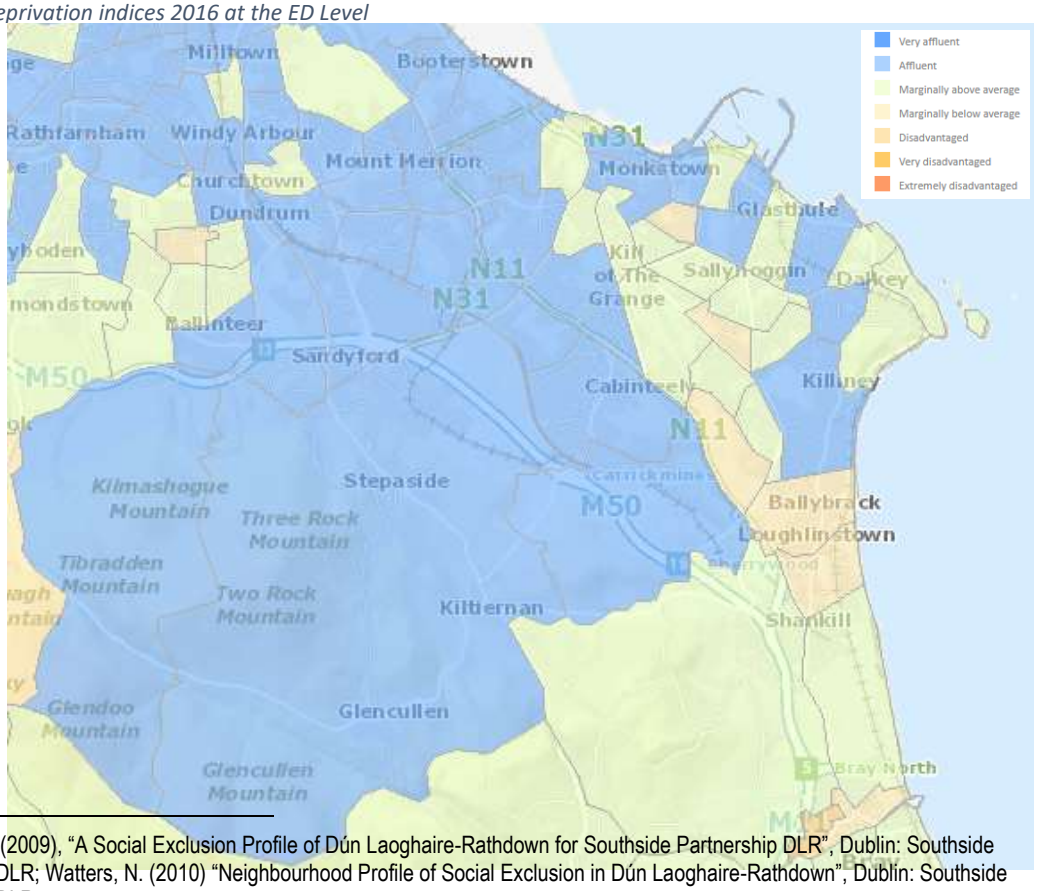
that, for the overwhelming majority, was not evident at the Electoral Division level. In other words, officially deprivation did not exist in such areas under the official deprivation measure.

Southside Partnership DLR's 2009 and 2010 reports concluded, among other things, the following:[6]

> "This comparative analysis reveals that in many EDs across DLR the absolute numbers of persons occupying social inclusion categories is as great and often times greater than in areas [outside of DLR] with much higher proportions of social inclusion categories relative to the size of the catchment. The implication of this finding is such that areas officially considered more disadvantaged, and in some cases considerably more deprived, than DLR exhibit smaller numbers of persons falling into one or more social inclusion indicators than seen in DLR. In other words, the numbers in DLR may be larger and the proportion much lower than in such areas. This finding suggests that there is a greater 'on the ground' need in DLR than such areas."

The reality of deprivation in DLR, that is surrounded by significant relative affluence, became evident following the use of Small Area data, below the ED level, for the analysis of 2016 Census data.[7] Figure 3 below shows affluence and disadvantage, across a gradient from very affluent to extremely disadvantaged, at the ED level from Census 2016. This shows large swathes of blue (representing affluence), green (representing marginally below average) and then light orange (representing areas categorised as marginally below average). This depiction shows NO areas of disadvantage in DLR.

Figure 2: Deprivation indices 2016 at the ED Level



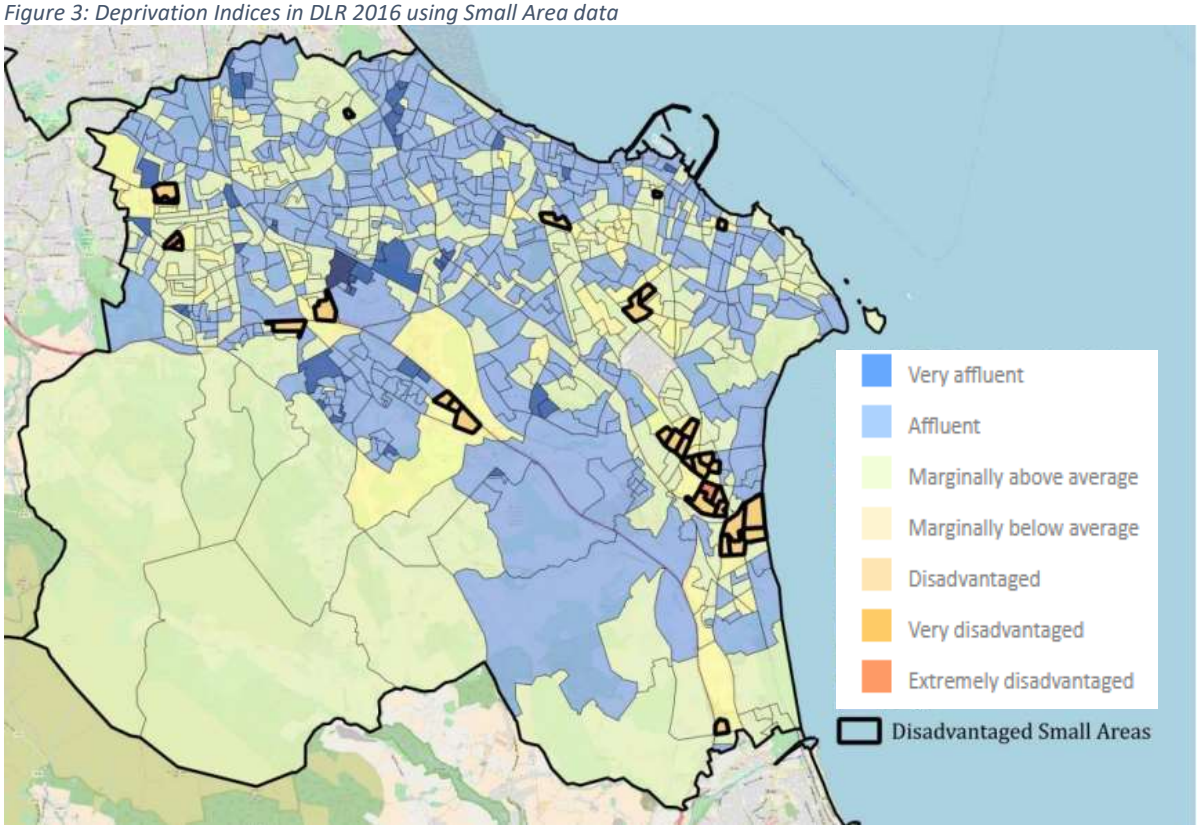
[6] Watters, N (2009), "A Social Exclusion Profile of Dún Laoghaire-Rathdown for Southside Partnership DLR", Dublin: Southside Partnership DLR; Watters, N. (2010) "Neighbourhood Profile of Social Exclusion in Dún Laoghaire-Rathdown", Dublin: Southside Partnership DLR.

[7] Small Areas, of which there are over 18,400 in the State as opposed to 3,409 Electoral Divisions, are comprised typically of 150 households.

Source: Deprivation Indices (pobal.ie)

Figure 3 below contrasts with Figure 2 and shows the map of DLR at the Small Area level. This again shows concentrations of blue, representing affluent small areas, but this time there a number of darker shades of orange, representing disadvantaged areas which were not visible at the ED level.

Figure 3: Deprivation Indices in DLR 2016 using Small Area data



Source: Southside-Partnership-DLR-Strategic-Plan-2020-2023-Website.pdf (southsidepartnership.ie)

Table 1 (below) shows a summary of key socio-economic indicators for DLR with comparatives for the State and for Dublin city and county.

Table 1: Selected Socio-economic Indicators for Dún Laoghaire Rathdown (2016 Census)

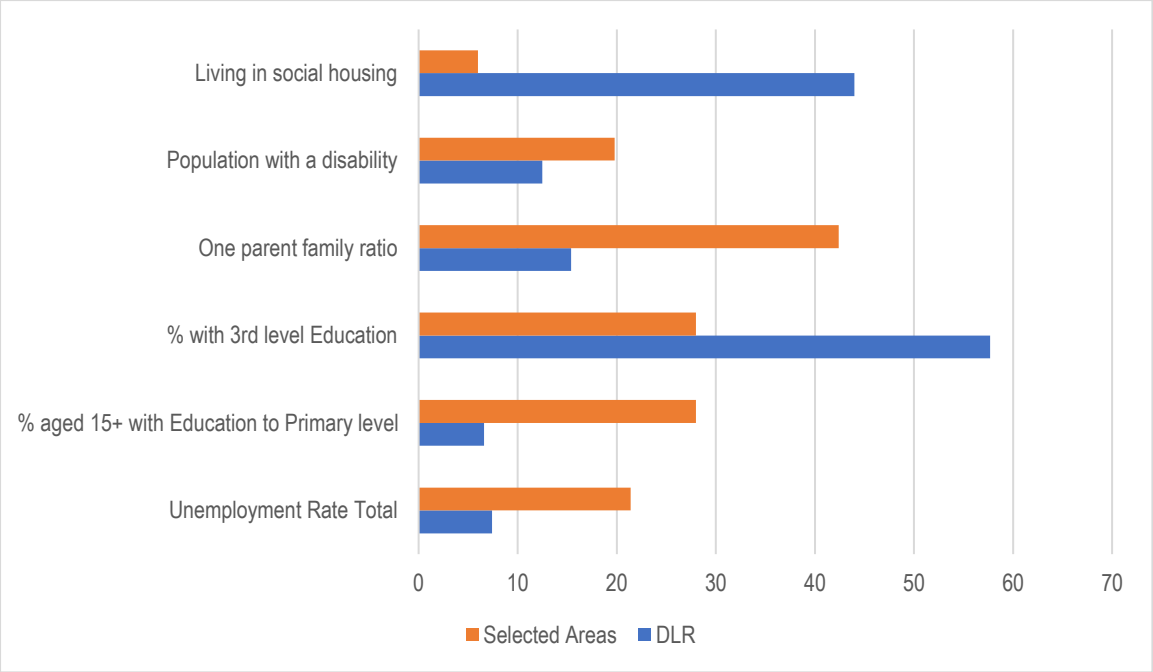
Indicator	DLR	Dublin	State
Population at work	95,925	614,776	2,006,641
Labour Force Participation Rate	58%	64%	61%
Unemployment Rate	7.4%	11.6%	12.9%
% of Population aged 15+ with Education to Primary Level only	6.6%	11.5%	13.3%
% of Population aged 15+ with Education to Upper Secondary	32.4%	42.6%	48.6%
% of Population aged 15+ with Education to Third Level	57.7%	40.7%	33.4%
One Parent Family Ratio	15.4%	23.5%	20.0%
% Local Authority Housing 2016	5.9%	9.3%	8.4%
% of population from the Traveller Community	0.2%	0.4%	0.7%
% of population from New Communities	11.6%	15.1%	11.6%

% of Population with a Disability	12.5%	13.1%	13.5%

Source: CSO Census 2016

In Figure 4 (below), we can see a comparison between some key indicators for DLR and some selected areas in the county that illustrates very well this contrast.

Figure 4: Comparison of socio-economic indicators between DLR county average and selected areas experiencing inequality (2016 Census)



Source: CSO Census 2016

The Small Area population data (2016 Census) identified that 12.1% of the DLRLDATF population was categorised as 'disadvantaged', accounting for 26,419 persons. This cohort of people are located in 89 of the 760 Small Areas the comprise the DLRLDATF area despite the high level data (at the Electoral Division level as opposed to the Small Area) reflecting an overwhelmingly affluent profile.

For several years, DLR has been recognised as one of the most affluent counties in Ireland. However, this prosperity is not shared equally by all the population and what we see is that specific areas of DLR continue to be more vulnerable to higher unemployment levels, lower incomes, and economic contractions, resulting in a risk of continuing pockets of increased deprivation levels within some communities.

Drug use and deprivation in Dún Laoghaire Rathdown

The above sections highlighted the nature of marginalised disadvantaged communities in DLR, surrounded as they are by significant relative affluence, making such disadvantage hidden for some programmes and policies.

Along with this hidden nature of disadvantage, although it is evident through Small Area data analysis, there has long been a correlation between disadvantage and drug problems. The reasons for this are many but all revolve in one way or another around deprivation and exclusion. Recently, the Health Research Board, administrators of the National Drug Treatment Reporting System (NDTRS), and Pobal, administrators of the Pobal HP Deprivation Indices, undertook a collaborative research project to investigate the correlation between both data sets.

This analysis found, among other things, treatment episodes for all drugs had a relatively linear relationship with deprivation, that is, higher in more deprived areas. In this regard, (visualised below) when calculated as a measure of treatment episodes per 10,000 population, the relationship between disadvantage and drug and alcohol treatment is evident, with 293 treatments per 10,000 in very and extremely disadvantaged areas, while the rate ranged from 61 to 66 in all areas of above average affluence.[8]

For instance from this research, Table 2 below shows the percentage of drug and alcohol treatment episodes by deprivation band compared with the percentage breakdown of the Pobal HP Deprivation Index in the overall population. For example, while 2.8% of the population live in SAs classified as 'very disadvantaged,' 8.6% of all drug and alcohol treatment episodes are reported from these areas. This is even more pronounced when looking at drugs. Some 11.03% of all opioid treatment episodes are reported from very disadvantaged areas, but only 2.8% of the population live in these areas.

Table 2: NDTRS treatment episodes, by percentage drug type and general population, and Pobal HP Deprivation Index band, 2019–2021

Deprivation band	Population (%)	All drugs types (%)	Alcohol (%)	Cannabis (%)	Cocaine (%)	Opioids (%)	Other drugs (%)
Extremely disadvantaged	0.09	0.18	0.11	0.18	0.24	0.13	0.57
Very disadvantaged	2.81	8.57	6.53	7.77	10.17	11.03	10.66
Disadvantaged	11.45	26.52	22.23	26.80	30.33	31.22	28.22
Marginally below average	31.52	29.87	33.19	30.80	28.23	25.58	25.92
Marginally above average	37.10	24.02	26.80	25.08	21.75	20.34	22.22
Affluent	15.24	9.61	10.13	8.53	7.93	9.91	11.24
Very affluent	1.75	1.21	0.99	0.84	1.35	1.79	1.17
Extremely affluent	0.05	0.01	0.03	0.00	0.00	0.00	0.00
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**

Source: https://www.drugsandalcohol.ie/38474/

Table 3 below demonstrates the relationship between Deprivation Index score and the rate of treatment episodes per 10,000 population.

Table 3: NDTRS treatment episodes per 10,000 population, by Pobal HP Deprivation Index band, 2019–2021

Deprivation band	Treatment episodes (per 10,000 population)
Very and extremely disadvantaged	293
Disadvantaged	225
Marginally below average	92
Marginally above average	63
Affluent	61
Very and extremely affluent	66

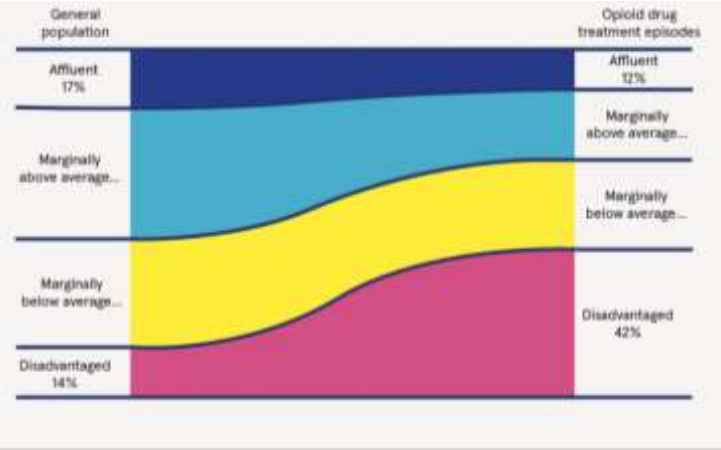
Source: https://www.drugsandalcohol.ie/38474/

Finally, in this regard, Figure 5 below shows a visual representation of the relationship for those in opioid treatment in terms of living in disadvantaged or affluent, communities (as measured by Small Areas). It shows

[8] Analysis of the relationship between addiction treatment data and geographic deprivation in Ireland. - Drugs and Alcohol

that while 14% of the population are from all areas of disadvantage, 42% of all opioid treatments are reported from these areas.[9]

Figure 5: People living in disadvantaged communities are far more likely to access drug treatment for opioids than those living in affluent areas



Source: https://www.drugsandalcohol.ie/38474/

To underline the nature of this overlap in DLR, Table 4 below presents specially selected data from the NDTRS for DLR for the years 2004 to 2021 looking across distinct drugs and key indicators of disadvantage available from the NDTRS – educational attainment, accommodation and employment status. This shows larger proportions of those treated in DLR for a number of drugs, including heroin, with low relative educational attainment. It also shows a higher proportion living unstable accommodation for those that have used or use heroin. In respect of employment, while there are significant numbers who retain employment during treatment, larger numbers (especially in the case of heroin) are unemployed or are unable to work for various reasons.

Finally, the last part of the Table shows that reality of polydrug use, while one drug maybe the primary focus of presenting treatment, it is often used alongside other drugs.

Table 4: NDTRS for DLR for the years 2004 to 2021 (Education, accommodation & employment)

Drug	Amphetamine	Benzodiazepine	Cannabis	Cocaine	Ecstasy (Mdma)	Heroin	Other Opioid	Volatile Inhalant	Other
Education									
Never went to school or completed primary school	0	12	10	6	0	82	8	<5	<5
Completed primary education	<5	46	59	47	0	475	37	<5	10
Completed Junior Certificate	<5	88	204	184	<5	653	67	<5	17
Completed Leaving Certificate	<5	39	109	187	<5	279	32	0	21
Completed Third Level Education	<5	21	39	71	<5	78	36	0	6
Not known	<5	42	123	74	<5	242	41	<5	6

[9] It should be noted that while it is demonstrable that there is a clear relationship between area-based disadvantage and treatment uptake, it is not correct to say that drug and alcohol treatment is provided only to those from disadvantaged areas. Almost one-third of all treatment episodes are reported from areas of above average affluence, although this figure varies greatly by drug type. Source: Analysis of the relationship between addiction treatment data and geographic deprivation in Ireland. - Drugs and Alcohol

Accommodation									
Stable accommodation	10	181	482	500	7	1376	198	0	46
Homeless	0	22	19	23	<5	135	6	<5	7
Other unstable accommodation	0	15	9	11	0	49	6	0	<5
Institution (residential care, prison, halfway house)	<5	27	28	31	<5	177	7	<5	<5
Not known	0	<5	6	<5	0	72	<5	0	<5
Employment									
Regular employment	<5	18	94	205	<5	209	52	0	7
Student	<5	<5	129	23	<5	12	<5	0	<5
Retired / unable to work / at home	<5	29	22	31	0	197	28	<5	<5
Unemployed	<5	183	237	277	<5	1285	125	<5	46
Other	0	<5	43	8	<5	35	<5	<5	<5
Not known	0	10	19	25	0	71	6	<5	0
More than one drug									
One	<5	85	287	235	<5	886	109	<5	22
Two	<5	78	117	151	<5	432	61	0	22
Three	<5	46	82	111	<5	321	32	<5	10
Four	0	35	52	61	<5	164	18	<5	6
Five	0	<5	6	11	0	6	<5	0	<5

Source: HRB National Drug Treatment Reporting system, analysis for DLR.

In view of the above in this section, one of the things to keep in mind is that with the release of the Small Area Population Statistics from Census 2022, (on September 21st, 2023) DLRDATF expects that regardless of the overall changes in affluence and deprivation from one Census period to the next (that is 2016 to 2022), the relativities in the county between deprivation and affluence unique to DLR will remain. Given the evidence of the correlation between people with problems with drugs and disadvantage, we expect the extent of need to increase along with increases in drug use, albeit different drugs and polydrug use.

Findings from our consultation and experience

The following is a summary of the key themes that have emerged through DLRDATF's consultations with our service users, our communities and with stakeholders, agencies and their staff – including one consultation convened in June 2023. They summarise the key strategic needs that DLRDATF seeks to respond to under our remit and many have resonance also outside of DLR in respect of problems associated with drugs and therefore related issues:[10]

Normalisation of drug use

We have found that there is now a normalisation around drug use, in particular young people's use of cannabis and cocaine, and early alcohol misuse. These arose as primary issues of concern, and as potentially having far-reaching consequences, in terms of the design and implementation of *all* prevention, harm reduction and treatment interventions into the future.

Prevention

[10] For the information of the Citizen's Assembly, DLRDATF would highlight to Members that many of these issues have been present for some time and have been spoken of in previous research, analysis and lived experience. What efforts have been made to mitigate these through National Drug Strategies have not come to fruition in the manner planned or expected. From our vista, we would suggest that this may be related to failures through a mix of lack of implementation, in momentum, will, effective and administratively facilitation of collaboration, the 'silo-ing' of statutory departments and agencies, and not acknowledging the context and thereafter the changes required in social, institutional and structural status quo.

There is a need to put in place a balanced and appropriate mix of universal (population/area-wide) and targeted (selective to at risk groups) prevention measures involving schools, youth and community bodies to reduce to onset of drug and alcohol use by young people. In respect of the final problem, the use of targeted measures is key given that 'one for all' education prevention approaches tend to not interact with those young people most at risk of drug use but rather confirm not using drugs in those least at risk. This needs to approach at risk young people in a manner that speaks to their context and the world as they experience it.

Families

Our consultations and experience have highlighted the negative impact of drug and alcohol use on families, including drug debt and related intimidation and the inability at times to seek help arising from stigma and fears of the criminal justice system, and the need for sensitive and proactive approaches to tackle hidden harms to children arising from parental substance misuse, and to support families in community settings.

Communities

Given the multifactored disadvantage context of the many of the communities in which are service users and potential service users come from and reside in, there is a need for DLRDATF to enhance collaborative structures to address exclusion in our communities. This includes bring together the collective mobilisations of key stakeholder groups including An Garda Síochána, community organisations, family support services as well as addiction services and other relevant localised health and social services. An important part of this is the provision of community policy to interact with communities at risk and in particular with young people.

Access to Treatment

There is a need to connect drug services into community settings and family support networks, to address the provision of an effective network of community-based access routes into harm-reduction, help and treatment and for these to be comprehensively integrated with family support, community services and other systems of care. We particularly note the difficulties, in the context of the above, for women requiring childcare to access treatment and ongoing difficulties with the speed of responsiveness of treatment services to 'windows of opportunity' for those seeking treatment. A related issue here is effective 'aftercare' and transition programmes for those who progress through treatment to live drug free in social settings that in reality will continue to include opportunities for interaction with drug use.

Inter-agency Collaboration

There is a critical need to recommence and mainstream efforts to achieve enhanced integration, alignment and communication across addiction services, mental health services, housing and welfare services, and social integration, particularly for those who are long-term attenders at addiction services.

Support for staff and volunteers

The work that those who work with people with drug problems is difficult, challenging specialised, both for paid staff and volunteers. There is a need to put in place effective supervisions, mentoring and support structures for these groups to avoid 'burn out,' help them optimise their important work and maintain these important services.

Response to specific question set out by the Citizen's Assembly

Based on the substance of this submission, evidence presented in the previous sections, we summarise this information under each of the themes set by the Citizen's Assembly to structure submissions.

- **What are the harmful impacts of drugs use on individuals, families, communities, and wider society?**

Drug use can impact negatively on individuals, their families, in our communities and affects wider society directly (anti-social behaviour, crime), and indirectly (social reproduction of limited life chances). In other words, the division between individuals to society is, in our experience, simplistic and does not recognise the relationships between each part of a whole. In this submission, we have noted that deprivation, disadvantage stands beside comparative advantage and affluence. This leads us to see drug use problems, its prevention and treatment as an issue related to social inequality and social class, evident in spatial terms in differences between communities and neighbourhoods.

In this context, in respect of families, negative impact can include familial trauma, isolation, lack of support, drug debt and related intimidation and the inability at times to seek help arising from stigma and fears of the criminal justice system, and the need for sensitive and proactive approaches to tackle hidden harms to children arising from parental substance misuse, and to support families in community settings.

For communities, again in the context of the opening sentence, drug and alcohol problems add to and are caused by, at the same time and in a reinforcing manner, a multifactored disadvantage context which is a symptom of the social, economic and spatial dislocation of such communities and the lack of effective state policies, services and support to respond to, or improve on, this effectively.

- **What could the State do to significantly reduce the harmful impacts of illicit drugs on individuals, families, communities and wider society?**

The following are some key themes which, in our view would serve, by way of the State, to significantly respond to problems related to drugs:

- Effective strategic policy, realistic and broadly assessing needs and process, and responding with appropriately resourced, implemented and supporting actions. This would include reassessing illicit drug use in the context of social inequality.
- Proper resourcing of supports and services, taking consideration of inflation and the cost of living.
- Reducing silos in policy and administration to put in place meaningful and effective (interagency) collaborative services, planning and processes - starting with expressed needs of people and communities (rather than starting with existing structures and services).
- Prevention policies that seek to engage with where people they 'are at,' with their 'world view.' This would involve universal or population wide approaches such as those possible in schooling as well as selected or targeted actions for those most excluded, or most at risk of drug use problems.

- **What works, and what does not work, in terms of current legislation, policy and service delivery?**

From the foregoing, what is evident to us in DLRDATF - from our over 25 years providing responses at the community level to problems related to drug use – is not the failure of the strategic policy to respond to drugs, particularly in more recent times with its emphasis on a health led response. We see the limitations in the implementation, resourcing and thus the (political and administrative) 'will' of the strategic policy response. We see here the lack of meaningful, mandated and resourced collaboration to address the social determinants of health. We comment the introduction of the Sláintecare Healthy Communities Programme but note that it is only a drop in the ocean of need but a very welcome one. The communities and the people we seek to serve are more than communities in which there may be drug problems or individuals who may have drug problems. They have multiple needs of which problems related to drugs is just one. This calls for increased joined up, collaborative and interagency work, processes and structures. A key part of this is to properly resource this work and ensure that implementation, as opposed to policy rhetoric, is effective. Involving communities and their residents (social groups and individuals) in service design and monitoring is a key part of ensuring the policy, services and implementation

meet actual needs. We want to see the extension of the place based approach to service delivery incorporating and leverage local authority services to other non health related services.

- **What should be done to reduce supply, demand, and harm?**

The current drug strategy emphasises, in highline policy terms, the importance of a health-led approach and thus harm reduction in respect of drug use problems. This implicitly recognises that these problems are societal by nature and not limited to the moral behaviours of individuals or the clustering of people in some communities. As such, and evidence is particularly strong on this, illicit drug use is related to drug markets, lack of opportunities, social inequality and exclusion. Each feeds the other in the absence of a more effective means to 'level the pitch.'

Responses therefore are multifactorial, with each as intrinsic as the next. They include decreasing demand for drugs and supply through greater inclusion in social and economic life, thus decreasing the 'lure' of drug economies. This requires, among other things, economic policies, education policies, social welfare policies, resourcing of prevention, decreasing the criminalisation of some drugs at particular levels, reducing the economic benefits from drug supply and markets, an effective collaborative continuum of services for individuals (their families and communities) who may develop problems related to drug use, from initial presentation to aftercare and effective 'reintegration.'

- **What should be done to increase resilience, health, and well-being?**

The focus on resilience and well-being is arguably problematic as these terms have a tendency, in some hands, to 'individualise' drug problems and related health issues to a person, a family, a community, a social group etc. In this context, resilience is a relative term, in the sense that its easier to be resilient to similar circumstances where there is greater social, cultural and economic capital to draw on. As such, a focus on resilience and well-being alone does not consider the social life world in which we all live. Some social contexts are more difficult and challenging than others. Deprivation and disadvantage should not be seen therefore as related to low levels of resilience and well-being, but more appropriately should be seen the other way around. In this regard, we note the decades long and intergenerational link between poor health and disadvantage. We suggest therefore a reframing of the manner in which resilience and well-being is spoken of: to one of "what is detrimental to well-being and resilience?"

- **Concluding comments**

DLR DATF continues to be of the urgent view, supported by increasing evidence, that drugs and alcohol problems do not exist in a vacuum, or solely at the level of individuals. They are, more correctly, part of the context (unfortunately) of all communities, but especially for those most disadvantaged. We have already noted the work by the Health Research Board and Pobal showing the correlation with the Pobal HP Deprivation Index and concentrations of areas in which the highest treatment presentations are seen. This reality of deprivation, disadvantage, lack of services, interventions and prevention, not to mention social inequality, is clearly evident in DLR – and in some respects are all the more so given marginalisation and social isolation that emerges for those impacted by addiction who live surrounded by significant affluence.