Services on a shoestring-

Time for investment to aid recovery.

Local Drugs and Alcohol Task Forces

Pre-Budget Submission 2024

<u>**June 2023**</u>

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Local Drug and Alcohol Task Forces - important actors in the delivery of our national drug and alcohol strategy

This is a collective Pre Budget-Submission of behalf of the 14 Local Drug and Alcohol Task Forces (LDATFs). LDATFs were set up in the late 1990s to address the drug crisis and play a central role in addressing current and emerging drug and alcohol challenges and trends in communities.

The Chairs of the Local Drug and Alcohol Task Forces have come together to seek an immediate increase in the funding allocation of €3 million for our Local Drug and Alcohol Task Forces (LDATFs) in Budget 2024.

LDATFs play a key role in the identification of emerging drug and alcohol trends within the local community and are responsible for developing and implementing a local strategy in line with the national strategy Reducing Harm, Supporting Recovery (2017-2025).[1]

We are very concerned that in the period in question, 2012 to 2022, there has been a lack of investment in community-based services supported and coordinated by the LDATFs while at the same time the populations in the LDATF catchment areas have exploded alongside increases in drug and alcohol problem use. During this period public expenditure in general, and the health envelope and HSE budgets, have seen significant and ongoing increases.

Rationale for our demand for an increase in funding

The requested increase for an increase of €3 million in funding is required because the demands and needs in our communities for drug and alcohol services and supports has risen significantly at a time when public expenditure and health spend has seen significant and sustained increases.

As detailed below, demand for treatment services in our areas has increased substantially in the period 2012 to 2022 while there has been no corresponding increase in funding. This lack of an increase in funding is unsustainable given the rise in demand, increased populations in the Task Force catchment areas and in recent years double digit inflation. We set out below the reasons for our demand for an increase in funding.

Significant increase in demand for treatment services in LDATF areas

There has been a significant increase in demand for treatment and support services in our areas since 2012 as evidenced by the data from the National Drug Treatment Reporting System (NTDRS). An analysis of the NDTRS figures show both the total number of cases and the total of new cases for the LDATF areas for the period 2011 to 2021.[2]

[1] http://www.drugs.ie/downloadDocs/2017/ReducingHarmSupportingRecovery2017_2025.pdf

[2] The Chairs of the LDATFs are grateful to staff in the Health Research Board who provided the data used here.

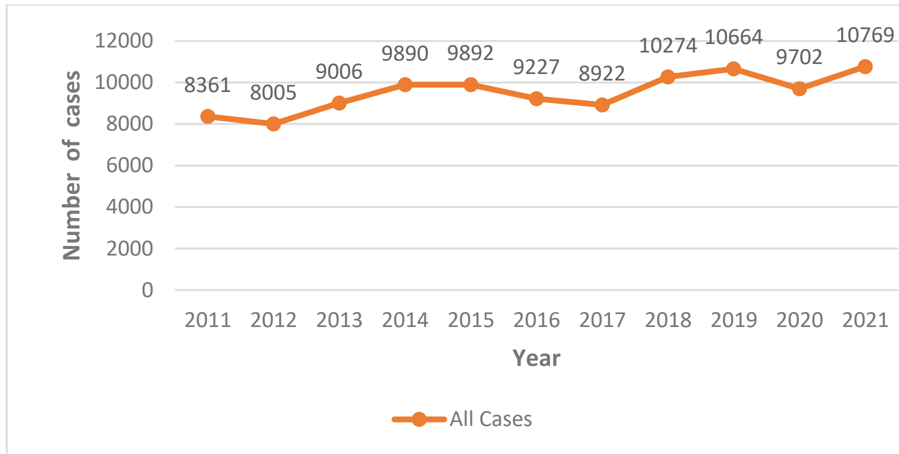


Figure 1 total number of drug cases treated in the LDATFs in the period 2011 to 2021[3]

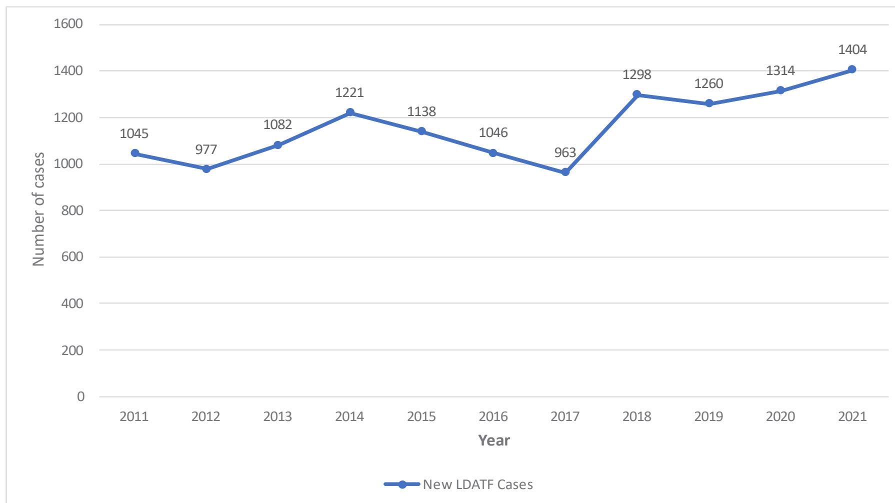
Appear 

Figure 2 new drug cases for LDATFs treated in the period 2011 to 2021.

In 2012, there were 5,166 people in drug and alcohol treatment services in our LDATF areas, by 2021 this had risen to 7,223[4] or by almost 40%. On further analysis, it becomes clear that while the numbers in receipt of treatment for alcohol addiction has increased marginally by 5%, there has been a very significant 60% increase in those undertaking treatment for drugs in our fourteen LDATF areas. While there has been an increase nationally in the overall numbers in treatment services, the increase here has been much more modest at 6.4%. This data reflects the huge pressures which services and supports on the ground in our areas have experienced in the last decade and demonstrates the urgent need for additional resources.

[3] People can appear more than once in the figures if they attend different treatment centres.
[4] National Drug Treatment Reporting System (NDTRS), Health Research Board, https://www.drugsandalcohol.ie/tables/

Profile	2012	2021	% increase/decrease
National Treatment	16,614	17,678	6.4%
LDATF Treatment-Drugs & Alcohol	5,166	7,223	39.8%
LDATF-Treatment Drugs Only	3,252	5,210	60.2%
LDATF-Treatment Alcohol Only	1,914	2,013	5.1%
Cocaine-Treatment	377	1,610	427%

Table 1 treatment cases nationally and in the LDATF catchment areas

Further analysis of the NTDRS data illustrates the impact of specific drugs in all LDATF areas. In 2012, there were 377 people in treatment, where cocaine was the primary drug addiction. By 2021 this had increased to 1,610 or by 427%. Cocaine and crack cocaine is having a devastating impact on individuals, families and communities. According to a 2021 HRB[5] report, there has been a threefold increase in the number of cases treated for problem cocaine use in 2020 compared to 2014. The increase in the misuse of crack cocaine has placed huge demands on community drugs services in recent years and has wreaked havoc in the lives of many in our LDATF areas.

Flatlining LDATF budgets while health spending increases

While we welcome and support the increased public investment in health services we regret and cannot understand why successive Governments have failed to value and invest in our community drug prevention, treatment and recovery services.

In 2012, overall Government expenditure was €67.6bn, by 2022 this figure increased by 43% to 97.6bn[6]. During this period the overall health budget increased by 56% from €14.2bn to €22.2bn.

In 2010 the LDATF allocation was €20,945,601. In 2022 this figure was €19,089,425. While there was a one off increase to counter inflation in 2022 of 3.5% based on current allocation, this does not address the ongoing and long term erosion of LDATF inadequate resourcing and did not increase our core funding The reduced allocation for LDATFs does not consider the increased and changing needs in the communities we work with, and the increased costs associated with enhanced governance and compliance. While we note some dormant accounts and other funding has been provided during this period, it has largely been of a once-off nature and does not provide the security and sustainability required to deliver meaningful services to service users, families and communities. In some cases, we are forced to refuse service provision to vulnerable people whose needs we cannot meet due to insufficient funding. The lack of investment seriously

[5] Health Research Board, 2014 – 2020 Drug Treatment Data, July 2021, https://www.hrb.ie/news/press-releases/single-press-release/article/hrb-reports-rise-in-cocaine-and-crack-cocaine-treatment/

[6] Where my Money Goes https://whereyourmoneygoes.gov.ie/en/2022/

hampers our ability to fulfil our objectives, support the needs of our communities and contribute to the implementation of stated national policy.

Key Statistics	2012	2021	Percentage +/-
Overall Government Expenditure	€67.6bn	€97.6bn	+43%
Health Expenditure	€14.2bn	€22.2bn	+56%
LDATFs Budget	€20m	€19.09m	-4.5%

Table 2 Analysis of Government expenditure, health spend and LDATF allocation

Soaring inflation impacting on LDATFs ability to deliver services.

While inflation remained steady over this ten-year period, it increased dramatically in early 2022 with the outbreak of war in Ukraine which has impacted global energy and food prices, with huge demands placed on European countries to respond to the unfolding humanitarian crises. This has placed additional pressure on the LDATFs to manage their inadequate budgets.

The LDATFs have experienced a double whammy of static funding in the midst of significant inflation alongside a large increase in demand for the services they support at local level.

Figure 3 Irish inflation rate 2012 to 2022 source https://take-profit.org/en/statistics/inflation-rate/ireland/ [7]

Inequitable burden on the most socially excluded communities which LDATFs serve.

The LDATFs operate in many of the most disadvantaged communities in the country, where individuals, families and communities have endured the most hardship from the impact of drug use over many decades. As noted in a recent HRB research report "*Drugs and Alcohol Data-*

[7] https://tradingeconomics.com/ireland/inflation-cpi

analysis by geographical area and deprivation indicators"[8] all areas are impacted by drug use, however not all areas are impacted equally. This report shows the relationship between social exclusion and disadvantage and the prevalence of drug and alcohol treatment episodes. For example, the below table shows that while just 14% of the national population live in areas classified as disadvantaged, very disadvantaged or extremely disadvantaged in the Pobal HP Deprivation Index, 42% of all drug treatment episodes, where opioids were the primary drug use, were reported from these areas. This trend is replicated across all drug and alcohol use types. An analysis of treatment episodes shows that there were 293 cases per 10,000 people in the most disadvantaged areas with just 61 to 66 per 10,000 in more affluent areas.

This report notes that health policy is increasingly being framed in terms of achieving healthy outcomes and improving wellbeing. It concludes that in order to meet the intent of the Sláintecare reform programme, there needs to be a more targeted distribution of resources to ensure services are provided where they are most needed. **In the last decade, the opposite has occurred, with funding for LDATF areas remaining static and in real terms in significant decline, when inflation is taken into account**. **This must be reversed in Budget 2024, with significant increase to the core funding of LDATFs and the services they support.**

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**

Table 3 Distribution of alcohol and drug use and deprivation bands across the population

[8] "Drugs and Alcohol Data-analysis by geographical area and deprivation indicators", Health Research Board, Supplement to the Winter 2023 issue of Drugnet Ireland.

Recruitment and retention challenges eroding our services.

LDATFs and the services we support are highly dependent on, and indebted to, the qualified, professional and dedicated staff provide services in our community-based organisations. However, the failure to invest in LDATFs in the last decade means that we are increasingly unable to attract and retain staff. For example, Task Force projects staff did not receive the public sector pay restoration which is inequitable and needs to be addressed as these workers should be on parity of esteem with their colleagues in larger voluntary and community organisations. We believe this is an equity issue and must be addressed outside the 3 million ask.

This means that we are unable to compete in the labour market, within the public service which can offer better pay and terms and conditions. Also, due to restricted funding some community-based services can only offer part time employment. This disparity in funding and opportunities has created significant difficulties in terms of staff recruitment and retention in community drug and alcohol services with many qualified staff voting to work elsewhere with better terms, conditions and benefits.

A report, commissioned by us and carried out by Adare Human Resource Management earlier this year, analysed the recruitment and retention matters in the LDATFs. It found that that 11 of the 12 LDATFs surveyed had undertaken recruitment in the 12 months, with 50 roles being advertised. Of these roles, only 31 or 62% were filled. The following reasons were given by respondents as to the primary reason for the difficulty in recruiting staff.

- 42% of participants identified uncompetitive salaries as a primary challenge.
- 42% of participants identified the experience/qualifications of candidates as a primary challenge.
- 17% of participants identified issues with the volume of applications received.
- 8% of participants identified that an inability to offer full time hours was a primary challenge in their organisation.

Almost all the reasons can be traced back to the lack of funding and investment in community drug services supported by LDATFs. The posts are not attracting sufficient suitable candidates because of the terms and conditions, some of those who do apply lack the experience and qualifications and the lack of full-time opportunities discourages others from applying.

The report also examined the retention challenges which LDATFs were experiencing and found that:

- 50% of Participants stated that low salary was a primary issue in retaining staff.
- 25% of Participants noted that a lack of promotional opportunity was an issue.
- 8% of Participants advised that a lack of contractual security was an issue.
- 17% of Participants stated that they had not experienced retention challenges.

These findings show that LDATFs are struggling to retain experienced and qualified staff due in large part to the lack of funding to be able to match terms and conditions in roles in other

organisations, within the HSE. Comments from the one-to-one interviews with LDATF staff offer insights into the challenges:

> *"Salaries are all funding dependent and are poor, there are no additional benefits provided."*
>
> *"Conditions are not usually attractive; we don't offer a pension."*
>
> *"The HSE is on a huge recruitment campaign and the pay rates are so much better."*
>
> *"The experience and qualifications we are getting is not at the same level as a few years ago."*

While we accept that we will never be able to match the terms and conditions available in the HSE or public sector more generally, we need additional funding now to at least allow us to remain competitive and be able to attract and retain sufficient staff in the community drug sector to meet current and emerging need and demand.

High dependence on Community Employment staff to provide services.

Another issue of concern is the high dependence on Community Employment part time workers to provide some of essential services provided by the community drug and alcohol projects. This has arisen because community drugs services want to respond to the need they witness in their communities but lack the resources to employ staff. While the commitment and hard work of these dedicated CE workers is fully recognised, we question the acceptance of this model of service provision as an adequate response to this increasingly complex and demanding area of need. We do not understand why Government finds it acceptable to depend on this group of workers to provide critical services to vulnerable people. We are unaware of other areas in the health and social care sector where Community Employment workers are relied on to fill gaps created by inadequate funding.

Increase in people with Dual Diagnosis leading to unmet need.

The complexity and multi-faceted nature of how dual diagnosis affects our service users requires more innovative and responsive service delivery methods. While we welcome the Dual Diagnosis Model of Care just launched[9] by the HSE and note that it recommends integrated delivery of services by collaborating stakeholders relevant to the service user, we also know that due to the lack of funding, our services may not be able to contribute as responsively as they would wish to this new approach to support this vulnerable cohort.

We are aware how prevalent dual diagnosis is and its impact on vulnerable people with substance misuse issues. Our LDATFs are ideally placed within the community to play an important role in providing services for people who are experiencing both substance misuse and mental ill-health but need an increase in funding to make this practicable.

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[9] https://www.hse.ie/eng/services/news/media/pressrel/hse-launches-new-model-of-care-for-dual-diagnosis.html

Inadequate funding limits responsive service design and delivery

Inadequate funding means that the LDATFS are simply unable to design more effective ways of reaching new service users. We simply do not have the funds to develop more innovative and responsive approaches to expand our reach and scope of service delivery. This results in vulnerable service users' needs going unmet. This is frustrating as we have the local knowledge, expertise and motivated staff but cannot optimise these elements to deliver the services we know are needed. We are very aware that this vulnerable group face considerably greater challenges in gaining and maintaining recovery. We wish to play our part in providing services to meet their needs but are mindful that to date the overly narrow focus on drug addiction and psychiatric problems in isolation from each other has resulted in this group's needs not being met in a holistic way. We note that this separation of access to care is very detrimental to better outcomes for this group.

Inadequate funding hinders inter-agency work and better outcomes.

While our LDATFs are ideally placed to develop responsive and value-added services to complement the statutory mental health and addiction services we do not have the resources to invest in this strand of work. The result is that many of our service users, who are also HSE Addiction and Mental Health service users, continue to rotate between the three services receiving piece-meal and non-integrated services and supports. They are not receiving joined up care. This lack of inter-agency working is ineffective and inefficient. Our LDATFs require additional funding to allow us to develop more robust and sustainable inter-agency and partnership working practices with our statutory colleagues. We cannot do this without additional funding. We know that if the LDATFs were adequately resourced the services they co-ordinate and support could play a more value-adding and robust role in securing better outcomes for service users.

Conclusion and our Budget ask.

We have outlined how our funding from either central Government via the Department of Health, or via the HSE, has declined in the last decade. This actual decrease in year-on-year funding has happened in a period when populations have increased in our catchment areas alongside a steady uptick in problematic alcohol and drug use. We provide data showing the increase in drug and alcohol misuse and numbers of cases treated. We have shown that:

- Our core funding has not kept paced with the reality of providing sufficient services and recent inflationary pressures have hollowed out our ability to provide services to the level we wish.
- A recent report shows how pay terms and conditions in the sector cannot compete with others, particularly the public sector which results in difficulties in recruiting and keeping staff.

To begin to address these funding deficits the LDATFs require at least €3 million to be distributed across the fourteen LDATFs to strengthen our ability to provide core services.

We also wish to undertake a follow up piece of research to the Adare report to examine at a more granular level the staffing needs of the community-based drug sector which will be a value adding piece of work for the sector.

This Pre Budget-Submission has been written as a call-out to Government to step up and support the LDATFs and the community-based drug and alcohol projects they work.

It is inequitable and ethically unjust that those closest to the reality of addiction are the least resourced.

It is time that Government shows its intent to stop the corrosive damage to individuals, families and communities struggling to address drug and alcohol problems by allocating an additional €3 million in 2024 to the LDATFs to help us strengthen our capacity to meet current and emerging need.

We are asking Government to right this wrong and support the vital work of our Task Forces.

Background to the Local Drug and Alcohol Task Forces

Local Drugs Task Forces were set up in 1997 to develop a more effective response to the drug crisis that was devastating many communities, especially in areas most affected by poverty and social exclusion. In 2013, alcohol was included in the remit of the Drugs Task Forces. There are 14 Local Drug and Alcohol Task Forces (LDATFs) in Ireland, 12 in the greater Dublin area, one in Bray and one in Cork. LDATFs comprise a partnership between the statutory, voluntary and community sectors. LDATFs develop and implement a local drugs strategy for their areas by co-ordinating all relevant programmes and working to address gaps in services.

What is the Local Drug and Alcohol Task Force Chairs Network?

The primary purpose of the LDATF Chair's Network is to be the representative voice of the Task Forces. It exists to facilitate the Chairs of the Task Forces to exchange information, discuss challenges impacting on LDATFs and where agreed, to develop common policies and positions. The network exists to strengthen the effectiveness and reach of the LDATFs and is not politically aligned. The network has a strong relationship with individual LDATFs and collaborates closely with the LDATF's Coordinator's Network. The LDATFs each has a co-ordinator who is responsible for the delivery of the Task Forces' strategic and operational work plans.

What do Local Drug and Alcohol Task Forces do?

Local Drug and Alcohol Task Forces understand and recognise the impact of problematic substance use on individuals, families, and communities. All LDATFs comprise of representatives from a range of relevant agencies, such as the HSE, the Gardaí, the Probation Service, Education and Training Executives, Local Authorities, Youth Services, as well as elected public

representatives, Voluntary and Community sector representatives and representatives from local residents themselves. LDATFs welcome a health led response to drugs policy, and recognise that health is impacted by poverty, disadvantage and all the social determinants. It is the health-led approach that connect LDATFs closely with integrated responses to meeting need, the Sláintecare Healthy Communities Programme. [10]

What is the policy context for LDATFs?

The current Programme for Government[11] recognises the function and added value of the LDATFs and states *"The Drug and Alcohol Task Forces play a key role in implementing this strategy and increasing access at local level to harm reduction initiatives. We will examine how we can continue to support it in identifying local need in communities, and support targeted initiatives addressing drug and alcohol misuse*." To date there has been very limited progress on this commitment, we are calling on Government to provide DATFs with the resources required to meet the needs at local and community level.

Chairpersons Local Drug and Alcohol Task Forces:

1. **Ballymun Local Drugs Taskforce Andrew Montague**
2. **Ballyfermot Local Drug and Alcohol Task Force Vincent Jackson**
3. **Blanchardstown Local Drug & Alcohol Task Force Ann Losty**
4. **Bray Local Drug and Alcohol Task Force Joe McGuire**
5. **Canal Communities Drug and Alcohol Task Force Lynn Ruane**
6. **Clondalkin Drug and Alcohol Task Force Pat Bennett**
7. **Cork Local Drug & Alcohol Task Force Aaron O Connell**
8. **Dublin 12 Local Drugs & Alcohol Task Force Mary Seery Kearney**
9. **Dublin North East Drugs & Alcohol Task Force John McCusker**
10. **Dun Laoghaire Rathdown Drugs Taskforce Audry Deane**
11. **Finglas/Cabra Local Drug and Alcohol Task force Martin Hoey**
12. **South Inner-City Drugs and Alcohol Task Force Kieran Rose**
13. **Tallaght Drug and Alcohol Task Force James Doorley**

[10] https://www.gov.ie/pdf/?file=https://assets.gov.ie/258377/03714445-85bf-417e-b5fb-237a6c56f57a.pdf#page=null

[11] Programme for Government, P50 https://www.gov.ie/en/publication/7e05d-programme-for-government-our-shared-future/