Building on Experience

National Drugs Strategy 2001 – 2008

Department of Tourism, Sport & Recreation.

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Eoin Ryan T.D.
Minister of State with special responsibility for the National Drugs Strategy.

FOREWORD

Drug misuse is one of the great social ills of our time. It affects individuals, families and whole communities. That is why this review of our current drugs policy is so important. It is the most comprehensive analysis and assessment of the drugs problem ever conducted in Ireland and outlines the policy framework through which all those involved in addressing this problem can work for the next seven years.

A striking feature of the consultations conducted as part of the review, particularly outside of Dublin, was the serious concern expressed about the widespread abuse of alcohol by young people and the perception that such abuse may be a gateway to illicit drug misuse. I have made these views known to my colleague, the Minister for Health and Children, Michál Martin T.D., and the recent launch of an Alcohol Awareness Campaign, aimed particularly at young people, is clearly both timely and critical. In addition, the new strategy contains recommendations designed to ensure close liaison between the implementation of the Drugs and Alcohol Strategies.

Many Government Departments and agencies, community and voluntary organisations and individuals provided information and assistance and made submissions during the course of the review. Their help was greatly appreciated, particularly for the many insights into this complex problem which they presented from a variety of perspectives. In particular, I wish to express my thanks to the members of the Review Group who gave so generously of their time and oversaw the work of the review. I would also like to thank Farrell Grant Sparks/Dr Michael Farrell/Nexus Research Co-operative Consultants for the assistance they provided. In addition, I would like to thank the staff of my Department whose commitment and dedication was so instrumental in maintaining the pace and scope of the review and, ultimately, the production of this Report.

While the review has been taking place, progress has also been made in enhancing the current strategy and a number of landmark initiatives have taken place. These include the publication of the Steering Group Report on Prison-Based Drug Treatment Services in June 2000; the establishment of the National Advisory Committee on Drugs in July 2000; the establishment of the pilot Drug Court in the North Inner City of Dublin in January 2001; and the substantial increase in the number of treatment places available (from 4,332 at the end of 1999 to 5,032 at the end of 2000). Meanwhile, preparation of new Action Plans by the Local Drugs Task Forces has continued and the Cabinet Committee on Social Inclusion has, in the past few months, approved over £5.5m in funding for nine updated plans covering a wide variety of initiatives in the areas of treatment, rehabilitation, awareness, prevention and education.

I believe that with the implementation of the recommendations set out in this Report and the active involvement and hard work of all those engaged in tackling drug misuse, we can turn the tide on one of the greatest threats facing our young people and society today.

EXECUTIVE SUMMARY

In April 2000, the Cabinet Committee on Social Inclusion requested that a review of the current national drugs strategy be undertaken. The overall objective of the review was to identify any gaps or deficiencies in the existing strategy and to develop revised strategies and, if necessary, new arrangements through which to deliver them. A sub-group of the Inter-Departmental Group on Drugs and the National Drugs Strategy Team – known as the Review Group – managed and oversaw the process.

As part of the review, a study of the latest available data on the extent and nature of drug misuse in Ireland was undertaken. This revealed that the most commonly used drug in Ireland is cannabis, followed by ecstasy. However, in terms of harm to the individual and the community, heroin has the greatest impact. Both treatment data and data from An Garda Síochána indicate that heroin misuse remains, almost exclusively, a Dublin phenomenon. Research shows that the majority of those presenting for treatment are male, are under 30 years of age and are unemployed while over half had already left school by the age of 15. An overview of drug misuse in Ireland is outlined in Chapter 2.

Ireland's current approach to tackling the drug problem has developed around the four pillars of supply reduction, prevention, treatment and research. Central to the approach has been the bringing together of key agencies – both statutory and community/voluntary – in a planned and co-ordinated manner, to develop a range of appropriate responses to tackle drug misuse, not just in relation to the supply of drugs but also in providing treatment and rehabilitation for those who are addicted, as well as developing appropriate preventative strategies. The various elements of the current national drugs strategy are outlined in Chapter 3.

As part of the review, the drug strategies of a number of other countries were examined. The approach to dealing with drug misuse in those countries shared common twin characteristics – a focus on the needs of the drug misuser, coupled with attempts through various enforcement measures and agencies to cut off the supply of drugs, with the degree of emphasis varying according to the country's fundamental philosophy on tackling the drugs issue. An overview of the international approaches is set out in Chapter 4.

An extensive public consultation process was undertaken as part of the review to give individuals and groups an opportunity to outline their views on the effectiveness of the current strategy and how it might be improved/adapted. Approximately 190 written submissions were received, 34 different groups made oral presentations and a series of eight consultation fora were held throughout the country at which over 600 people attended. An overview of the issues that emerged during the consultation process is set out in Chapter 5.

NATIONAL DRUGS STRATEGY 2001-2008

In developing a new strategy for the next seven years, the Review Group recognised that while much remains to be done, there are encouraging signs of progress in recent years which suggests that the current approach to tackling the drug problem is proving to be effective. The Group believes, therefore, that the present approach provides a ***solid foundation*** from which all those involved in trying to tackle the problem should work for the future. Consequently, it is recommended that the new strategy should ***endorse*** the existing approach and should expand on and strengthen the pillars and principles which underpin it.

The conclusions of the Review Group in relation to the individual pillars that constitute the current strategy are set out in Chapter 6. In light of these conclusions and the ***overall strategic objective*** and ***strategic aims*** set for the Strategy, the Review Group has developed ***100 individual actions*** which are designed to build on the existing approach and drive the new strategy forward.

Implementation of the actions will be a matter for the Departments and agencies involved in the delivery of drugs policy. Their implemenation will be overseen by the Inter-Departmental Group on Drugs, in consultation with the National Drugs Strategy Team. Six monthly progress reports will be made to be Cabinet Committee on Social Inclusion.

The 100 individual actions are set out in detail in Chapter 6.

FRAMEWORK FOR THE NATIONAL DRUGS STRATEGY 2001 – 2008

Overall Strategic Objective

The ***overall strategic objective*** for the National Drugs Strategy 2001 – 2008 is :

to significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research

Overall Strategic Aims

The following are the ***overall strategic aims*** of the Strategy :

- **to reduce the availability of illicit drugs;**
- **to promote throughout society a greater awareness, understanding and clarity of the dangers of drug misuse;**
- **to enable people with drug misuse problems to access treatment and other supports in order to re-integrate into society;**
- **to reduce the risk behaviour associated with drug misuse;**
- **to reduce the harm caused by drug misuse to individuals, families and communities;**
- **to have valid, timely and comparable data on the extent and nature of drug misuse in Ireland; and**
- **to strengthen existing partnerships in and with communities and build new partnerships to tackle the problems of drug misuse.**

Objectives and Key Performance Indicators

Supply Reduction

Objectives

- To significantly reduce the volume of illicit drugs available in Ireland, to arrest the dynamic of existing markets and to curtail new markets as they are identified; and
- To significantly reduce access to all drugs, particularly those drugs that cause most harm, amongst young people especially in those areas where misuse is most prevalent.

Key Performance Indicators

- Increase the volume of opiates and all other drugs seized by 25% by end 2004 and by 50% by end 2008 (using 2000 seizures as a base);
- Establish a co-ordinating framework in relation to drugs policy in each Garda District by end 2001; and
- Increase the level of Garda resources in Local Drugs Task Force areas by end 2001, building on lessons emanating from the Community Policing Forum model;
- Strengthen and consolidate existing coastal watch and other ports of entry measures designed to restrict the importation of illicit drugs;
- Co-operate and collaborate fully, at every level, with law enforcement and intelligence agencies, in Europe and internationally, in reducing the amount of drugs coming into Ireland.

Prevention

Objective

- To create greater societal awareness about the dangers and prevalence of drug misuse; and
- To equip young people and other vulnerable groups with the skills and supports necessary to make informed choices about their health, personal lives and social development.

Key Performance Indicators

- Bring drug misuse by schools-goers to below the EU average and, as a first step, reduce the level of substance misuse reported to ESPAD by school-goers by 15% by 2003 and by 25% by 2007 (based on 1999 ESPAD levels as reported in 2001);
- Develop and launch an ongoing National Awareness Campaign highlighting the dangers of drugs, the first stage to commence by end 2001;
- Develop formal links at local, regional and national levels with the National Alcohol Policy, by end 2001 and ensure complementarity between the different measures being undertaken;
- Publish and implement a policy statement specifically relating to education supports for Local Drugs Task Force areas, including an audit of the level of current supports, by end 2001;
- Nominate an official from the Department of Education and Science to serve as a member of each of the Local Drugs Task Forces by end 2001;

- Prioritise Local Drugs Task Force areas during the establishment and expansion of the services of the National Educational Welfare Board;
- Have comprehensive substance misuse prevention programmes in all schools and, as a first step, implement the "Walk Tall" and "On My Own Two Feet" Programmes in all schools in the Local Drugs Task Force areas during the academic year 2001/02;
- Complete the evaluation of the "Walk Tall" and "On My Own Two Feet" Programmes by end 2002; and
- Deliver the SPHE Programme (Social, Personal & Health Education) in all second level schools nation-wide by September 2003.

Treatment

Objectives

- To encourage and enable those dependent on drugs to avail of treatment with the aim of reducing dependency and improving overall health and social well-being, with the ultimate aim of leading a drug-free lifestyle; and
- To minimise the harm to those who continue to engage in drug-taking activities that put them at risk.

Key Performance Indicators

- Have immediate access for drug misusers to professional assessment and counselling by health board services, followed by commencement of treatment as deemed appropriate, not later than one month after assessment;
- Have access for under-18s to treatment following the development of an appropriate protocol for dealing with this age group;
- Increase the number of treatment places to 6,000 places by end 2001 and to a minimum of 6,500 places by end 2002;
- Continue to implement the recommendations of the Steering Group on Prison-Based Drug Treatment Services as a priority and implement proposals designed to end heroin use in prisons during the period of the Strategy;
- Have in place, in each Health Board area, a service user charter by end 2002;
- Have in place, in each Health Board area, a range of treatment and rehabilitation options as part of a planned programme of progression for each drug misuser, by end 2002; and
- Provide stabilised drug misusers with training and employment opportunities and, as a first step, increase the number of such opportunities by 30% by end 2004.

Research

Objectives

- To have available valid, timely and comparable data on the extent of drug misuse amongst the Irish population and specifically amongst all marginalised groups; and
- To gain a greater understanding of the factors which contribute to Irish people, particularly young people, misusing drugs.

Key Performance Indicators

- Eliminate all major research gaps in drug research by end 2003; and
- Publish an annual report on the nature and extent of the drug problem in Ireland and on progress being made in achieving the objectives set out in the Strategy.

Co-ordination

Objective

- To have in place an efficient and effective framework for implementing the National Drugs Strategy.

Key Performance Indicators

- Establish an effective regional framework to support the measures outlined in the Report by end 2001;
- Complete an independent evaluation the effectiveness of the overall framework by end 2004.
- Each agency to prepare and publish a critical implementation path for each of the actions relevant to their remit by end 2001; and
- Review the membership, work-load and supports required by the National Drugs Strategy Team to carry out its terms of reference, by end September 2001.

Part I

Review of the Current Strategy

Chapter 1

1.1 TERMS OF REFERENCE

1.1.1 The Cabinet Committee on Social Inclusion, in line with the commitment to review the current drugs strategy contained in the Review of the Government Programme and in the Programme for Prosperity and Fairness,[1] requested in April 2000 a review to:

- identify the latest available data on the extent and nature of problem drug use in the country as a whole, any emerging trends in drug misuse and the areas with the greatest level of problem drug use;
- outline the current National Drugs Strategy, including the role of the statutory agencies and the community and voluntary sectors, in terms of :
  - supply reduction;
  - education, prevention and awareness;
  - risk reduction, treatment and rehabilitation;
  - inter-agency co-ordination and integration; and
  - community/voluntary sector participation in the design and delivery of the strategies.
- examine the impact of the current National Drugs Strategy across the headings listed in the context of the objectives set for it and the resources allocated to date;
- identify any major gaps and deficiencies presenting across these headings;
- examine international trends, developments and best practice models; and
- in the light of the foregoing, consider how the current National Drugs Strategy, including the structures involved in its development and delivery, can be revised or modified to meet the gaps and deficiencies identified.

1.1.2 The Cabinet Committee on Social Inclusion was established in 1997. The Committee has, inter alia, responsibility for reviewing trends in the area of problem drug use, assessing progress in implementing national drugs strategy and resolving policy or organisational difficulties which may inhibit effective responses to the problem. It is chaired by the Taoiseach and comprises the Tánaiste and the following Ministers – Tourism, Sport & Recreation; Education & Science; Environment & Local Government; Health & Children; Finance; Justice, Equality & Law Reform; Social, Community & Family Affairs; the Minister for Housing and Urban Renewal at the Department of the Environment and Local Government; the Minister of State for Local Development (with special responsibility for the National Drugs Strategy) the Minister of State for Children; the Minister of State for Rural Development and the Attorney General.

[1] Action Programme for the Millennium Review, November 1999 and the Programme for Prosperity and Fairness, 2000.

1.2 REVIEW PROCESS

1.2.1 Responsibility for conducting of the review rested with the Inter-Departmental Group (IDG), which reports to the Cabinet Committee and oversees progress on the implementation of the drugs strategy and overall policy. The following Departments are represented on the IDG: Tourism, Sport & Recreation (Chair); Taoiseach; Finance; Education & Science; Enterprise, Trade & Employment; Environment & Local Government; Health & Children and Justice, Equality & Law Reform. The IDG established a sub-group, known as the "Review Group" to manage the process. The Group comprised representatives of key departments and the National Drugs Strategy Team (NDST) including a representative of the community and voluntary sectors. A full list of the members of the IDG and the Review Group is contained in Appendix I. The Secretariat to the Review was supplied by the Drugs Strategy Unit of the Department of Tourism, Sport and Recreation.

1.2.2 The review included an extensive consultation process, research of international examples of best practice and an examination of various relevant evaluation reports and other literature. The Review Group was assisted in its work by independent consultants (Farrell Grant Sparks, Dr Michael Farrell and NEXUS Research Co-operative) who reported on the consultation process and prepared draft documents for consideration by the Review Group.

1.2.3 Advertisements were placed in the national newspapers in April 2000 inviting any interested individuals or organisations to make submissions. State Agencies such as Health Boards, the Gardaí, VECs, the Prisons Service, Local Authorities etc. were written to separately, inviting them to make a submission with a view to assisting the Review Group to identify any gaps or deficiencies in the Strategy, develop revised strategies and, if necessary, new arrangements through which to deliver them. In total, 189 submissions[2] were received and each submission was analysed in light of the terms of reference. A small number of submissions, which related to specific project proposals or issues which fell outside the remit of the review, were referred to relevant agencies for appropriate consideration.

1.2.4 Public invitations were subsequently inserted prominently in all of the national newspapers inviting interested parties and members of the public to attend one of eight regional fora around the country. The first of these took place in Cork on Friday 10th June, followed by Kilkenny on Monday 12th June; Galway on the 15th; Limerick on the 16th; Dublin on the 19th; Athlone on the 22nd; Sligo on the 23rd and Dublin, again, on the 26th. Some 600 people in all participated in the fora.

1.2.5 The format of the fora was identical irrespective of location and facilitated wide-ranging debate in relation to the drugs strategy. An overview of current strategy was presented by the Minister of State followed by presentations by each of the various interests i.e. the Health Boards, the Gardaí, the Department of Education and Science and the voluntary and community sectors. Following these presentations, questions were taken from the floor. Each session was then broken up into 4 workshops, each with a separate theme, (a) existing risk reduction, treatment and rehabilitation methods; (b) existing supply reduction measures; (c) existing education, prevention and awareness strategies and (d) other issues, including emerging trends in drug misuse, drugs in prisons and gaps in existing strategies to deal with these issues.

[2] A full list of submissions is contained in Appendix 3.

1.2.6 Analysis of the attendance sheets indicates that a broad spectrum of people attended, including representatives from the Health Boards, An Garda Síochána, Local Authorities, Customs and Excise, youth workers, treatment services, schools, individual treatment and rehabilitation centres, community and voluntary sectors, drug-user groups and members of the general public. Response sheets were also provided to all attendees at each forum, providing them with a further opportunity to express opinions in relation to current drugs strategy. Sixty-six response sheets were returned.

1.2.7 During July and August 2000, following the fora, a total of 34 different groups[3] representing Government Departments, Agencies, service providers and other interested parties were invited to meet with and make presentations to the Minister of State, members of the Review Group and the consultants, on their respective contributions to overcoming the drugs problem and to explore how they might address issues emerging from the fora. The consultants also met separately with the NDST to discuss a range of issues, in particular the Team's current responsibilities, both in relation to Local Drugs Task Forces (LDTFs) and the broader strategy.

1.2.8 A debate in Seanad Eireann, in June 2000, provided an opportunity for Senators to make an input to the review. In addition, towards the end of the review process, the Minister of State and officials visited Sweden, Australia and Switzerland to discuss their experiences and to look at the range of treatment and rehabilitation facilities operating in those countries.

1.2.9 A detailed review of available epidemiological data was conducted by the consultants in order to identify, using the best available information, the extent and nature of problem drug use in the country as a whole, any emerging trends in drug misuse and the areas with the greatest levels of drug misuse. Epidemiological data was also sourced for groups identified as engaging in drug misuse. In order to examine international trends and developments and to identify models of good practice, the drugs strategies of Australia, the Netherlands, Portugal, Spain, Scotland, Sweden, Switzerland and England were analysed in detail. The Embassies of the relevant countries were a key source of information in this regard.

[3] A full list of those who made presentations is contained in Appendix 3.

1.3 THE REPORT

1.3.1 Once the consultation process was completed, the Review Group proceeded to analyse all the views and data presented, before reaching the conclusions and recommended actions outlined in Part 2 of the Report. The Report was adopted by the Government in April 2001.

Chapter 2

2.1 NATIONAL DATA COLLECTION

2.1.1 According to the Health Research Board (HRB), the term drug use "refers to any aspect of the drug taking process"; however, drug misuse or problem drug use refers to drug use which causes "social, psychological, physical or legal difficulties as a result of an excessive compulsion to continue taking drugs". Indirect methods encompassing the use of numbers of known drug misusers in the country *i.e* those registered for treatment, drug-related arrests and deaths *etc.* are currently used to approximate the numbers of drug misusers within the Irish population.

2.1.2 The Drug Misuse Research Division (DMRD) of the HRB was established in 1989 and is responsible for operating the National Drug Treatment Reporting System (NDTRS) which is the main source of information on drug misuse in Ireland. The NDTRS is an epidemiological database, which provides data on people who avail of treatment services for problem drug use, on a nationwide basis. This provides information on the current patterns and trends of treated drug misuse and drug addiction in Ireland. Data are provided to the NDTRS through centres or service locations where drug misuse is treated.

2.1.3 From 1990 to 1994, NDTRS data were collected in relation to the Greater Dublin area only. In 1995, the data collected by the NDTRS was extended to the whole country in response both to domestic demand for national data on treated drug misuse and, following the establishment of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) in 1993, when the provision of national information became a requirement for each Member State. At present, the NDTRS is the country's most developed epidemiological database and one of the key indicators of drug misuse.

2.1.4 Drug treatment data collected by the NDTRS provides a synopsis of the number of drug misusers availing of drug treatment services within the country in a particular year. Although recorded as the number of cases presenting for treatment rather than total the number of individuals,[4] analysing data on drug misusers receiving treatment for the first time can allow conclusions to be drawn from changes in the patterns and trends of problem drug use over time. The DMRD publishes an annual report, the most recent being the Statistical Bulletin 1997 and 1998, with a more up-to-date data set to be published in mid-2001. The DMRD and the Irish College of General Practitioners are now co-operating in collecting data from GPs working under the Methadone Treatment Protocol.[5] They are also examining the possibility of the inclusion of prison treatment services as part of their on-going efforts to promote more comprehensive data collection systems.

[4] The NDTRS records the number of total treatment contacts *i.e.* all cases receiving treatment at any time during the calender year. The term **cases** rather than individuals is applied, as there is a possibility of double counting of individual patients who may have been treated more than once.

[5] Department of Health (1993). *Report of the Expert Group on the Establishment of a Protocol for the Prescribing of Methadone.* Dublin: Department of Health.

2.1.5 Other sources of information on drug misuse in Ireland which the Review Group drew on include:

- Department of Health and Children – statistics on infectious diseases;
- Central Statistics Office (CSO) – Report on Vital Statistics (Regional Registrars of Births and Deaths);
- Garda Síochána – annual reports on drug-related arrests and offences; and
- Forensic Science Laboratory at Garda HQ – drug seizure data.

As well as these sources of information, of which the DMRD and the Garda Síochána are the most developed, many individual reports and studies carried out on both a local and national scale by Health Boards, LDTFs, academic institutions and by individual organisations/authors were referred to.

2.2 DATA COLLECTION AT EUROPEAN LEVEL

2.2.1 In addition to the operation of the NDTRS, the DMRD is the designated Irish Focal Point for the EMCDDA's REITOX Network. In 1993, the EMCDDA was set up, by the European Commission,[6] in response to the escalating drug problem in Europe. With 16 Focal Points operating within the REITOX Network, one in each Member State and the European Commission, the main responsibility of the EMCDDA is to provide valid, comparable and objective information, which accurately reflects the rapidly changing drug patterns and trends in Europe. In the context of epidemiology, the EMCDDA has identified 5 key indicators[7] of drug misuse in Europe. These indicators, which are listed below, will be implemented in each Member State and over time will provide information on trends and patterns of drug misuse. The first two are direct indicators of drug use/misuse in a population, while the remainder give an indirect indication of drug misuse.

- Extent and pattern of drug use in the general population;
- Prevalence of problem drug use;
- Demand for treatment by drug users;
- Drug-related deaths and mortality of drug users; and
- Drug-related infectious diseases (HIV, hepatitis).

With data based on the above indicators, the EMCDDA publishes an annual report. The most recent report, published in 2000, is the fifth annual report the Centre has produced on the state of the drugs problem in the EU. The EMCDDA is working closely with the DMRD in Ireland in an attempt to harmonise data collection across the EU. By synchronising data among Member States, comparisons can be made about emerging trends across the EU.

[6] Council Regulation (EEC) no. 302/93.

[7] *Extended Annual Report on the State of the Drugs Problem in the European Union, 2000.* EMCDDA.

2.3 DRUG MISUSE IN IRELAND

2.3.1 The DMRD acknowledges the limitations of current prevalence estimation methods and the need for on-going investigation of data availability in order to carry out accurate prevalence estimation work. As mentioned in paragraph 2.1.2 above, figures from the NDTRS relate only to the persons who present themselves for treatment nationwide and, may not include private hospitals and clinics, as all information submitted to the HRB is done on a voluntary basis. Drug misuse outside of treatment is, therefore, not accounted for in their figures. Accordingly, it should be noted that numbers presenting for treatment for problem drug use do not represent the total number of drug users in the country. In fact, they may not even represent all those experiencing problems with their drug use.

2.3.2 A number of attempts have been made to estimate the number of opiate users in Ireland. Dr Catherine Comiskey estimated the prevalence figures based on three 1996 data sets – the methadone treatment list, acute hospital discharges and Garda data.[8] This exercise was confined to residents in the Dublin region. Her results suggested a rough estimate of the number of opiate users, in Dublin in 1996, was 13,460, a prevalence of over 21 per 1,000, aged 15 – 54 years (or 2.1 *per cent* of the population). **However, concerns have been expressed about the method used ("capture/re-capture" model), which state that this figure could be significantly lower or higher.**[9] The *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* (1996) also attempted to estimate the number of opiate users by extrapolating from the treatment numbers and arrived at an estimate of approximately 8,000 heroin misusers in the Greater Dublin area.

2.3.3 The number of heroin users on methadone maintenance programmes at December 2000 was 5,032 compared to 4,332 at the end of 1999. A further 469 users, in the Eastern Regional Health Authority (ERHA) area, were on the waiting lists to receive treatment.

[8] Comiskey, C. (1998). *Prevalence Estimate of Opiate Use in Dublin, Ireland during 1996.* Dublin: Institute of Technology Tallaght, 28.

[9] Uhl states that "one has to warn seriously against regarding capture-recapture estimates as reliable scientifically based estimates. As we could demonstrate: the true value may easily be 50% less or 100% more than estimated", "The Prevalence of Problematic Opiate Use in Austria Based on a Capture-Recapture Estimation", Uhl, Dr Alfred, Ludwig-Boltzmann Institute for Addiction Research at the Anton-Proksch Institute, Vienna, 2000.

2.4 NATIONAL AND REGIONAL TRENDS

2.4.1 Surveys carried out on schools and young people and reports by An Garda Síochána show clear differences particularly, between the Greater Dublin area and the rest of the country, as regards the misuse of drugs and drug types. This disparity in the pattern of drug misuse throughout the country is also indicated in the NDTRS. Of the clients receiving treatment in 1998, 85 *per cent* were resident within the ERHA area, while 4 *per cent* were treated in the Southern Health Board (SHB) area. The small numbers remaining received treatment in the other 6 Health Board areas (Table 2.1). Details of the treatment provided, which includes a range of medical approaches (including detoxification, methadone substitution and drug-free programmes) and non-medical therapies (such as addiction counselling, group therapy and psychotherapy), is broken down by the main drug of misuse in each Health Board area and is given in Table 2.2.

Table 2.1 – Clients (by residence) receiving treatment for drug misuse by Health Board Area in 1998*

Treated in	Number	%
Eastern Health Board	5,076	85%
Southern Health Board	303	5.1%
North Western Health Board	48	0.8%
Midland Health Board	96	1.6%
Western Health Board	14	0.2%
Mid Western Health Board	96	1.6%
North Eastern Health Board	128	2.1%
South Eastern Health Board	201	3.4%
Total (includes residence not known)	6,043	100%

* NDTRS Statistical Bulletin 1997 and 1998.[10]

Of clients who received treatment in 1998, the main drug of misuse was heroin in almost 70 *per cent* of cases. These were mainly confined to the Dublin area.

Table 2.2 – Treatment by main drugs of misuse in Regional Health Board areas in 1998*

Data	Total No.	Heroin		Cannabis		Ecstasy		Cocaine		LSD		Others**	
National	6,043	4,297	71.1%	642	10.6%	196	3.3%	88	1.5%	14	0.2%	806	13.3%
EHB	5,076	4,121	81%	211	4.2%	45	0.9%	58	1.1%	4	0.1%	637	12.7%
SHB	303	14	4.6%	120	39.6%	89	29.4%	12	4%	4	1.3%	64	21.1%
NWHB	48	10	20.8%	21	43.8%	10	20.8%	0	0%	1	2.1%	6	12.5%
MHB	96	23	24%	51	53.1%	5	5.2%	0	0%	2	2.1%	15	15.6%
WHB	14	6	42.9%	2	14.3%	1	7.1%	1	7.1%	0	0%	4	28.6%
MWHB	96	7	7.3%	57	59.4%	11	11.5%	3	3.1%	1	1.0%	17	17.7%
NEHB	128	32	25%	52	40.6%	15	11.7%	2	1.6%	2	1.6%	26	19.5%
SEHB	201	22	10.9%	119	59.2%	19	9.5%	9	4.5%	0	0%	32	15.9%

* NDTRS Statistical Bulletin 1997 and 1998 (Note – National total contains those clients of no fixed abode and from outside Ireland).

** Others include morphine sulphate tablets, medical and non-medical methadone and other opiates, amphetamines, benzodiazepines, hypnotics, inhalants and sedatives and non-LSD hallucinogens.

[10] Information from the NDTRS is presented according to the Health Board area in which the client is resident. This may be in contrast to the Health Board where the treatment was received. In most cases, the Health Board of residence and that of treatment are the same.

2.4.2 Socio-demographic information, compiled by the NDTRS and profiles of drug misusers reporting for drug treatment indicate that the majority of drug misusers are male (70 *per cent*) and in the 20 – 24 year age bracket (36 *per cent*). Over three quarters of the drug misusers reporting for treatment left school by the age of 16 years and over 70 *per cent* were unemployed. As regards drug misuse behaviours, over half of the clients reported injecting their main drug, while 34 *per cent* smoke their main drug. Almost three quarters of those receiving treatment for drug misuse were under 19 years of age when they first tried their main drug and over 30 *per cent* were regularly using their main drug for between 2 to 3 years.

2.4.3 In January, 2000 an external review of the drug services for the Eastern Health Board was published.[11] As regards the provision of services for drug misusers, urine tests were carried out for opiates, benzodiazepines and tricyclics in five ERHA addiction centres. Overall results are presented in Table 2.3. Although the positivity rates for both opiates and tricyclics were low, the high rates of benzodiazepine positivity indicate a growing problem of poly-drug misuse.

Table 2.3 – Poly-Drug Misuse – Urinalysis results from 5 ERHA Addiction Centres*

Drug Type	Aggregate Clinic Total % Positive
Opiates	30
Benzodiazepines	65
Tricyclics	14

* Farrell *et al.*, 2000

2.4.4 Data from An Garda Síochána Annual Reports relating to drug possession offences and seizures are one indicator of the use of non-opiate drugs, such as cannabis *etc.*, throughout the country. Table 2.4 demonstrates the regional breakdown of drug possession offences in Ireland. However, it should be noted that seizures may not necessarily be related to usage in that locality as the drugs may have been in transit. Table 2.5 shows the number of possession offences by region and drug type in 1999.

Table 2.4 – An Garda Síochána Regional breakdown of drug possession offences*

Region	Number & percentage of offences							
	1996		1997		1998		1999	
Eastern	149	5%	340	9%	416	7%	874	12%
Dublin	1,243	43%	1,839	44%	2,941	53%	2,719	38%
Northern	99	3%	170	4%	195	4%	275	4%
South Eastern	215	8%	368	9%	468	8%	652	9%
Southern	883	31%	1,169	28%	1,289	22%	1,770	25%
Western	296	10%	262	6%	322	6%	847	12%
Total	2,885	100%	4,156	100%	5,631	100%	7,137	100%

* An Garda Síochána Annual Reports 1996, 1997, 1998 and 1999.

Of the number of people prosecuted for drugs offences in 1999, the Southern region accounted for 25 *per cent*, the next highest after Dublin which had decreased significantly to 38 *per cent*. In all regions the majority of persons prosecuted for drugs offences were male and over 21 years.[12]

[11] Farrell, M., Gerada, C., Marsden, J. (2000). *External Review of Drug Services for The Eastern Health Board.* National Addiction Centre, Institute of Psychiatry, London.

[12] An Garda Síochána Annual Report 1999.

Table 2.5 – An Garda Síochána Regional breakdown of possession offences by drug type in 1999*

Region	Number of Offences/Percentage of Total																
	Cannabis		Cannabis Resin		Heroin		LSD		Ecstasy		Amphets		Cocaine		Other**		Total
Eastern	98	11%	445	51%	19	2%	3	<1%	200	23%	83	10%	9	1%	17	2%	874
Dublin	471	17%	737	27%	852	32%	2	<1%	211	8%	70	2%	126	5%	250	9%	2,719
Northern	87	32%	100	37%	0	0	1	<1%	60	22%	16	6%	4	1%	7	2%	275
South Eastern	86	13%	351	54%	1	<1%	11	2%	81	12%	92	14%	6	1%	24	4%	652
Southern	80	5%	1,147	65%	12	1%	5	<1%	368	21%	108	6%	10	<1%	40	2%	1,770
Western	82	10%	501	60%	3	<1%	4	<1%	103	12%	95	11%	14	2%	45	5%	847
Total	904	13%	3,281	46%	887	13%	25	<1%	1,023	14%	464	7%	169	2%	383	5%	7,136

* An Garda Síochána Annual Report 1999.

** Others include morphine sulphate tablets, medical and non-medical methadone and other opiates, amphetamines, benzodiazepines, hypnotics and sedatives and non-LSD hallucinogens as well as possession of forged prescriptions.

2.5 TYPES OF DRUGS MISUSED

2.5.1 A number of surveys suggest that the most commonly used illegal drug in Ireland is cannabis.[13/14/15] Table 2.6 deals with possession offences and this also indicates that cannabis is the illicit drug most commonly used throughout the country, with little change occurring in recent years. Heroin represents approximately 13 *per cent* of all drug-possession offences, almost all (96 *per cent*) of which are recorded in the Dublin region. Table 2.7 shows the seizures of selected drugs by year. However, it should again be pointed out that seizures might not necessarily be related to usage in Ireland as the drugs may have been in transit.

2.5.2 Table 2.6 shows that ecstasy is the second most commonly cited drug in possession offences accounting for 14 *per cent* of drug-possession offences in 1999, one percentage point ahead of heroin possession. Ecstasy is the third most commonly misused drug after heroin and cannabis for which individuals receive treatment.

Table 2.6 – Number of possession offences and percentage of total by year and drug type*

Drug Type	1996		1997		1998		1999	
Cannabis (inc.plants)	355	12%	546	13%	441	8%	904	13%
Cannabis resin	1,441	51%	2,096	50%	1,749	31%	3,281	46%
Heroin	432	15%	564	14%	789	14%	887	13%
LSD	24	1%	39	1%	13	<1%	25	<1%
Ecstasy	340	12%	475	11%	439	8%	1,023	14%
Amphetamines	152	5%	239	8%	273	5%	464	7%
Cocaine	42	1%	97	2%	88	2%	169	2%
Other**	96	3%	65	2%	1,839	33%	383	5%
Morphine			6	<1%				
Total	2,885	100%	4,156	100%	5,631	100%	7,136	100%

* An Garda Síochána Annual Reports 1996, 1997, 1998 and 1999.

** Others include morphine sulphate tablets, medical and non-medical methadone and other opiates, amphetamines, benzodiazepines, hypnotics and sedatives and non-LSD hallucinogens as well as possession of forged prescriptions.

[13] Gleeson, M., Kelliher, K., Haughton, F., Feeney, A., and Dempsey, H. (1989). *Teenage smoking, drug and alcohol abuse in the Mid West*. Department of Public Health, Mid Western Health Board.

[14] Jackson, T.M.R. (1997). *Smoking, Alcohol and Drug Use in Cork and Kerry.* Southern Health Board, Department of Public Health.

[15] Moran, R., O' Brien, M. and Duff, P. (1997). *Treated Drug Misuse in Ireland.* National Report 1996. Dublin: The Health Research Board.

Table 2.7 – Quantities of drugs seized by year*

Drug Type	1996	1997	1998	1999
Cannabis	2.4kg	34.8kg	44.5kg	66kg
Cannabis resin	1,993kg	1,247kg	2,157kg	2,511kg
Heroin	10.8kg	8.2kg	38.34kg	16.95kg
LSD	5,901 Sqs	1,851 Sqs	798 Sqs	577 Sqs
Ecstasy	19,244 Tabs	17,516 Tabs	604,827 Tabs	229,091 Tabs
Amphetamines	7.6kg	102.9kg + 3,889 Tabs	45.4kg + 4,780 Tabs	13.4kg + 12,051 Tabs
Cocaine	642kg	11kg	331.17kg	85.55kg

* An Garda Síochána Annual Reports 1996, 1997,1998 and 1999.

2.5.3 The increase in the use of cocaine, both nationally and internationally and particularly among young professionals, was one of the emerging trends in drug misuse identified during the public consultation process and by the EMCDDA.[16] A conference held by the Nurses Addiction Network (NAN)[17] in May 2000 identified this trend in Ireland. Garda statistics on the number of possession offences for cocaine as shown in Table 2.5 suggest a significant increase in its usage. At present, attempts are being made by the DMRD to identify data on cocaine use for inclusion in a report to be published this year.

[16] Annual Report on the State of the Drugs Problem in the European Union 2000, EMCDDA 2000.
[17] Conference "*Cocaine, An Emerging Problem*". Clontarf Castle, May 2000, Nurses Addiction Network.

2.6 DRUG MISUSE IN PRISONS

2.6.1 The primary and most up-to-date source of information on current drug misuse within the Irish prison population is the recent report[18] by the Department of Community Health and General Practice, Trinity College Dublin, on the prevalence of use and risk to **committal**[19] prisoners in 1999. This report is, in fact, the second phase of an earlier **census** survey report[20]. **At the time of the census survey, the prison population was approximately 2,700 in 15 prisons and the census survey sampled 1,205 of these in 9 prisons. By conducting a committal survey, the study included everyone who was commited on that exact day, including prisoners who had not yet been charged. In these circumstances, a lot more non-serious offenders are represented in the committal survey than in the census survey. The committal report surveyed 607 prisoners in 7 prisons.** In both the census and committal surveys there was a mix of high and medium risk[21] prisons involved (1 low risk prison was included in the committal survey). It should be noted that prisons in Dublin, where all of the "high risk" prisons are located, have more drug misuse among the prison population and higher rates of infection than other prisons throughout the country.

2.6.2 The data show that the proportion of prisoners reporting drug misuse, both before entering and within prison, was significantly lower in the committal survey than in the census survey. Table 2.8 indicates the numbers of prisoners who reported having smoked heroin in the past year or having ever injected drugs.

Table 2.8 – Proportion of Prison respondents who had smoked heroin or ever injected drugs*

	Census	Committal
Smoked heroin in the last 12 months	46%	31%
Ever injected drugs	43%	29%

* Allwright *et al.*, 1999, Long *et al.*, 2000

Most of those prisoners who reported having smoked heroin in the past year (Table 2.9) had also injected drugs and *vice versa*. Evidence, from both surveys, showed that women prisoners were more likely to smoke heroin and/or ever inject drugs than male prisoners.

Table 2.9 – Gender breakdown of respondents who had smoked heroin or ever injected drugs*

	%Women Census/Committal	%Men Census/Committal
Smoked heroin in the last 12 months	60/65	45/28
Ever injected drugs	60/60	42/26

* Allwright *et al.*, 1999, Long *et al.*, 2000

2.6.3 More than half of the respondents who reported ever injecting drugs said they had commenced injecting before their 18th birthday, 92 *per cent* reported having first injected 3 years ago and over 70 *per cent* had injected in the week prior to committal. In the light of this evidence, the survey suggests that most injectors were current drug misusers (census survey). Although figures are slightly lower as regards the drug misuse behaviours of committal respondents, evidence also suggests that the majority of injectors responding to the committal survey are also current drug misusers.

[18] Long, J., Allwright, S., Barry, J., Reaper-Reynolds, S., Thornton, L., Bradley, F. (2000). *Hepatitis B, Hepatitis C and HIV in Irish Prisoners, Part II :Prevalence and Risk in Committal Prisoners 1999.* Prepared for the Minister for Justice, Equality and Law Reform by the Department of Community Health and General Practice, Trinity College, Dublin.

[19] A committal survey was conducted in order to ensure adequate representation of short-term prisoners, as long-term prisoners are likely to be over-represented in a census survey.

[20] Allwright, S., Barry, J., Bradley, F., Long, J., Thornton, L. (1999). *Hepatitis B, Hepatitis C and HIV in Irish Prisoners: Prevalence and Risk.* Prepared for the Minister for Justice, Equality and Law Reform by the Department of Community Health and General Practice, Trinity College, Dublin.

[21] Prisons were allocated their status of high, medium and low risk according to the estimated prevalence of drug-related infectious diseases and the estimated

2.6.4 Data from both surveys highlighted the level of initiation into injecting drug use and the sharing of drug using equipment within prisons. A similar proportion of injecting drug users reported starting injecting while in prison (Table 2.10). However, there are significant differences in the injecting practices of prisoners between the census and committal surveys, in that a higher proportion in the census population reported not injecting in the month prior to the survey, which may suggest that some injectors may have stopped injecting while in prison. Moreover, the proportion of prisoners that reported sharing injecting equipment, both outside and within prisons, was higher in the census population.

2.6.5 There was a greater representation of young people, *i.e* people younger than 18 years, in the committal survey than in the census survey, as is indicated in Table 2.11.

Table 2.10 – Injecting and equipment-sharing behaviour of drug misusing prisoners*

Drug misuse behaviours	Census%	Committal%
Started injecting in prison	21	17
Injecting in the month prior to the survey	45	72
Sharing injecting equipment in month prior to imprisonment	37	33
Sharing injecting equipment inside prison	58	43

* Allwright *et al.*, 1999, Long *et al.*, 2000

Table 2.11 – Number of Under 18 Years respondents that smoked heroin or ever injected*

	Census	Committal
Respondents Under 18 Years	3%	12%
Under 18 Yrs. who smoked heroin in past year	38%	16%
Under 18 Yrs. who ever injected	25%	16%

* Allwright *et al.*, 1999, Long *et al.*, 2000

A higher percentage of clients, under 18 years, reported smoking heroin in the past year and ever injecting in the census prison population than in the committal prison population.

2.6.6 In 1998, the Probation and Welfare Service (PWS) carried out a survey on the number of problem drug misusers among offenders in contact with their service in the Dublin region.[22] The survey was based on the Probation Officers' assessment of clients' drug usage. It included 54 community-based service personnel on 12 community-based teams. At the time, there were 2,183 offenders in contact/ under supervision with these personnel. Results of the survey indicated that over 56 *per cent* of all surveyed had a known history of problem drug use. Of these, 82 *per cent* had misused drugs in the ten months prior to the survey while only 12 *per cent* were totally drug free at the time of the survey. Of those that had misused drugs in the ten months prior to the survey, the primary drugs of misuse were opiates (over two thirds of cases) and cannabis (18 *per cent*). This high percentage in the number of offenders misusing opiates could be explained by the fact that the survey was conducted in the Dublin region, where the majority of opiate use is located.

[22] "Problem Drug Use among offenders in contact with the Probation and Welfare Service in Dublin", Probation and Welfare Service, 2000, unpublished survey presented to the Review Group by the PWS on 14 July 2000.

2.7 DRUG MISUSE AMONG YOUNG PEOPLE

2.7.1 In recent years, the prevalence of alcohol, tobacco and drug misuse has been growing amongst young people both in Ireland and throughout the European Union. A survey carried out by the National Youth Council of Ireland indicates that 53 *per cent* of young people in Ireland have tried an illegal drug.[23] Prevalence among young people has long been a major concern, not least because of the threat to public health, but also because of the strong relationship between alcohol and drug misuse and antisocial and criminal behaviour. One of the methods used in measuring the alcohol and drug habits of young people is to conduct school surveys, as the school population represents the majority of the age groups of interest and is easily accessible.

2.7.2 The proportion of young people presenting for treatment has decreased.[24] While in 1995, 2% of those presenting for treatment were under 15 years of age; this had dropped to 0.6% in 1998. The proportion of 15 to 19 years olds dropped from 31 % in 1995 to 22% in 1998.

2.7.3 Many organisations, particularly the Health Boards, have carried out a number of local school surveys throughout the country in recent years. In 1999,[25] a survey was conducted on substance misuse in early adolescents among pupils in the Dublin region. The study demonstrated that just under one third reported use of at least one illicit substance. Cannabis was the most commonly used illegal substance followed by the use of inhalants. The reported mean age for first time use of cannabis, amongst the Dublin pupils who had used the drug, was 12.5 years. Results of a survey conducted by the Department of Public Health of the Mid-Western Health Board showed that, other than alcohol, cannabis and inhalants were the main drugs used by the students in this region.[26/27] Almost 30 *per cent* of the students surveyed had tried at least one drug in their lifetime, with over 12 *per cent* using at least one drug at the time of the study. The lifetime[28] and current use of all drugs (except inhalants) were found to increase systematically with age. The rates for both lifetime and current drug misuse were higher in urban areas.

Table 2.12 – Age Category of Clients who presented for Treatment for Problem Drug Misuse*

Age Category	1995		1996		1997		1998	
Under 15 Years	84	1.9%	43	0.9%	36	0.7%	39	0.6%
15 to 19 Years	1,361	31%	1,446	29.8%	1,269	26.0%	1,327	22.0%

* National Drug Treatment Reporting System, Health Research Board.

[23] National Youth Council of Ireland, 1998.
[24] National Drug Treatment Reporting System, (NDTRS) Health Research Board.
[25] Brinkley, Fitzgerald & Green (1999). *Substance use in early adolescents. A study of the rates and patterns of substance use among pupils in Dublin.*
[26] Gleeson *et al. ibid.*
[27] Kiernan, R. (1995). Thesis on substance use among adolescents in the Western Health Board Area. Unpublished Thesis. Faculty of Public Health Medicine, Royal College of Physicians of Ireland.
[28] Lifetime use refers to substance ever taken. Current use refers to substance use within the past month.

1999 ESPAD Report

2.7.4 Within the EU, the majority of countries have conducted national school surveys over recent years, mainly as part of the European School Survey Project on Alcohol and Other Drugs (ESPAD).[29] The most recent ESPAD Report was conducted in 1999 (Report published in 2001). The main feature of the ESPAD study is the prevalence of drug use, both legal and illegal, among 16 year-old school goers. The study describes the substance use behaviours, as well as related beliefs and attitudes, among over 80,000 15-16 year olds in 30 European countries.[30] The methodology involved the use of an identical questionnaire in each of the participating countries, which was then collected, using the same methods to allow for the collation of a comprehensive and comparable dataset.

2.7.5 In Ireland, the study involved 2,277 students (the majority born in 1979 and in 5th year) from 98 schools that were randomly selected nationwide. The main results of the study are outlined in Table 2.13. Results indicate that the percentage of Irish students who had experimented with each of the substances was higher than that of the EU average, particularly in relation to the use of cannabis although it has declined from the 1995 figure. However, further studies need to be conducted that ensure sample representativeness, before any firm conclusions on comparative data are drawn. Figure 2.1 shows the Irish position vis-a-vis other ESPAD countries in the EU and the United States in 1995 and 1999 as regards the use of cannabis and ecstasy by 15-16 year olds.

Table 2.13 –Proportion of 15-16 year old students using drugs, alcohol and tobacco compared to the ESPAD average*

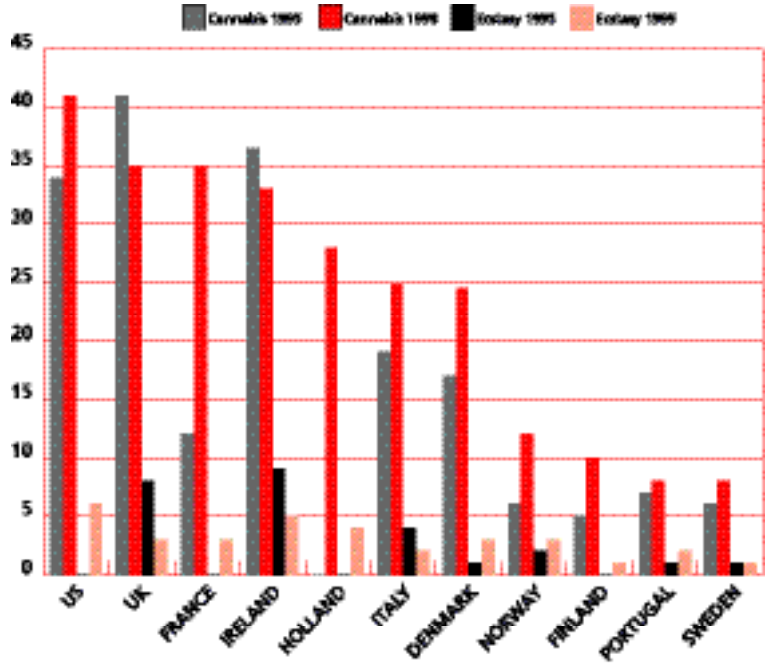
Proportion of Irish students that	Irish 1995 %	Irish 1999 %	ESPAD countries avg % 1995	ESPAD countries avg % 1999
Had any alcohol in last 12 months	86	89	80	83
Were drunk in the last 12 months	66	69	48	52
Ever smoked	74	73	67	69
Smoked in last 30 days	41	37	32	37
Used cannabis	37	32	12	16
Used any drug but cannabis	16	9	4	6
Used tranquillisers/sedatives	8	5	7	7
Used Solvents	n/a	22	n/a	9

* Data taken from the 1995 and 1999 ESPAD Reports.

[29] Hibell *et al.*, (2001). *The 1999 ESPAD Report: Alcohol and Other Drug Use Among Students in 30 European Countries.*

[30] *The ESPAD Study: Implications for Prevention.* Drugs: Education, Prevention and Policy, Vol. 6, No. 2, 1999.

Figure 2.1 – Percentage of 15-16 year olds have used Cannabis and Ecstasy in selected ESPAD countries and the United States in 1995 & 1999



Alcohol and Tobacco Use

2.7.6 Throughout the consultation process, alcohol misuse was identified as a major problem within Irish society, particularly among young people. The National Health and Lifestyle Surveys published in 1999 took account of the consumption of alcohol and tobacco in the population. The surveys are separated into two studies – SLÁN (Survey of Lifestyles, Attitudes and Nutrition) represents adults aged 18 years and above and the HBSC (Health Behaviour in School-Aged Children), which represents school-going children aged 9–17 years.

2.7.7 Research relating to the consumption of alcohol and tobacco is contained in the HBSC/SLÁN[31] report published in February, 1999. The report states that the pattern of drinking behaviour among adults in Ireland has changed. Data from the report indicate that a higher percentage of males than females, across all ages, consume alcohol regularly. Consumption is becoming more regular within younger age groups. Another report[32] suggests that 59 *per cent* of school children drink occasionally and 16 *per cent* drink regularly. As well as drinking more regularly, the SLÁN report indicates that 27 *per cent* of males and 21 *per cent* of females consume **more** than the recommended weekly limits of "sensible" alcohol consumption.[33]

[31] Friel, S., Nic Gabhainn, S. and Kelliher C. (1999) *National Health & Lifestyle Surveys.*

[32] Brinkley *et al* 1999. op cit.

[33] Sensible alcohol consumption is regarded as 21 units for males and 14 units for females per week.

Table 2.14 – Percentage of Males/Females Consuming more than the Recommended Limits of Alcohol*

Age Category	SC 1-2[34]	SC 3-4	SC 5-6
	% Males/Females	% Males/Females	% Males/Females
18 – 34 Years	34/27	32/34	40/22
34 –54 Years	23/11	30/16	21/8
55 + Years	23/8	24/15	25/21

* The National Health and Lifestyle Surveys, SLÁN Report.

The results indicate that consumption in excess of the sensible limit of alcohol is greatest among males in the 18 – 34 year age bracket, among semi-skilled (SC5) and unskilled (SC6) individuals.

2.7.8 The HBSC survey, conducted in 1998, indicates that 32 *per cent* of school respondents reported ever having had a drink. Overall 29 *per cent* admitted to having a drink in the past month. Of these, boys were more likely to report current drinking than girls, 34 *per cent* compared to 24 *per cent* respectively. A similar trend applied to the number of respondents who reported having been "really drunk", with a greater number of boys than girls more likely to have consumed amounts of alcohol which made them "really drunk". For both boys and girls, the majority of those who reported currently drinking and ever being "really drunk" were in the 15–17 years age bracket.

2.7.9 The progression of use from tobacco and alcohol to cannabis and, then, to other drugs is a consistent finding in a number of studies conducted on young people. Although it is not inevitable that someone who smokes cigarettes or drinks alcohol will progress to the use of cannabis or other drugs, the risk of using cannabis and other drugs is much higher among individuals who smoke or drink alcohol, than among non-smokers and non-drinkers.[35] The SLÁN survey reports that 31 *per cent* of the Irish adult population smoke, with a marginally higher percentage of male (32 *per cent*) than female (31 *per cent*) smokers. Of the 31 *per cent* who smoke, the majority (39 *per cent*) of smokers are within the 18 – 34 year age group, a trend similar to that of alcohol consumption.

2.7.10 The HBSC report shows that almost half of school-aged children have had a cigarette, which is substantially higher than the percentage who reported having had a drink (32 *per cent*). Overall, 21 *per cent* of the children were current smokers, with the majority in the 15 –17 year age bracket. The data highlighted that, overall, more girls (36 *per cent*) than boys (31 *per cent*) smoked within that age bracket.

[34] Social class distribution of SLÁN – SC1: Professional workers, SC2: managerial and technical, SC3: Non-manual, SC4: Skilled manual, SC5: Semi-skilled, SC6: Unskilled.

[35] Evaluating Drug Prevention in the European Union. EMCDDA Scientific Monograph Series No 2. EMCDDA.

Drug Misuse outside the School System

2.7.11 Although school surveys may represent the majority of the age groups of interest when referring to young people, they do not represent those young people that are most at risk *i.e* who are not in the school system. Treatment data from the NDTRS indicate that, in 1998, just over a quarter of clients (26.8%) had left school before the official school-leaving age of 15 years. Over half (55.4%) had left school before the age of 16 years. Seventy nine *per cent* had left school before the age of 17 years. Records of students entering the second-level school system are collected and maintained by the Department of Education and Science. These records are checked against the number of students taking junior and senior cycle exams each year, so that the retention rates of each of the 26 counties can be ascertained at each cycle. Data from the 1993 retention profiles[36] (began post-primary in 1993) indicate that Dublin South and Dublin County Borough had the highest rates of early school-leaving. For example, of the students who began post-primary education in 1993, in those areas, almost 30 *per cent* had left school without sitting the Leaving Certificate and 10 *per cent* without sitting the Junior Certificate examinations. Throughout the rest of the 25 counties, figures varied from between 14 and 30 *per cent* for the number of individuals that had left school without sitting the Leaving Certificate.

2.7.12 As regards drug abuse, data from the NDTRS Statistical Bulletin 1997 and 1998 indicate the number of clients who presented for treatment for problem drug use during 1997 and 1998 and the age at which these clients had left school (Table 2.15).

Over half (55.4%) had left school before the age of 16 years, whereas 3 *per cent* of the individuals receiving treatment for problem drug use in 1998 were still in school.

Table 2.15 – Treatment Contacts during 1997 & 1998

School Leaving Age	Per cent %	
	1997	1998
Never went to school	0.2	0.1
Under 15 Years	26.9	26.8
15 Years	27.3	28.6
16 Years	22.4	23.1
17 Years	12.0	11.4
18 Years and Over	6.7	7.1
Still at school	4.6	3.0
Total	100	100
Total Number	4,910	6,043

National Drug Treatment Reporting System Statistical Bulletin 1997 & 1998.

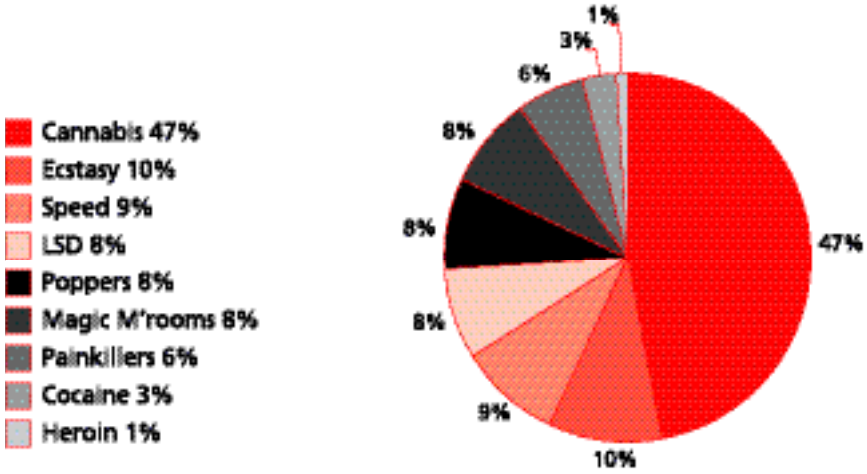
[36] Post-Primary Pupils' Database/Examinations System, Department of Education and Science.

Drug Misuse amongst Third Level Students

2.7.13 Finally, in relation to young people and drug misuse, there are approximately 140,000 full-time and part-time students currently in higher and further education colleges in Ireland. In 1998, the Union of Students in Ireland (USI) published a national drugs survey of third level students.[37] This survey, which was conducted among students, aged between 17-24 years attending higher and further education colleges nationwide, is one of the few sources of information compiled to date on drug misuse among third level students and was based on a sample of 1,000 students.

Results from the survey indicated that 80 *per cent* of third level students in Ireland have taken an illegal drug and over half of these were still taking the same drug at the time of the study. The range of drugs taken by students was very broad and is outlined here in Figure 2.2. Overall, the survey suggests a relatively high level of drug misuse within the current student population, although as Figure 2.2 shows, the drugs involved were overwhelmingly non-opiates.

Figure 2.2 – Drugs first used by third level students



[37] *USI National Drugs Survey of Third Level Colleges 1997/98.* The Union of Students in Ireland (USI), May 1998.

2.8 OTHER AT RISK GROUPS

2.8.1 In 1998, the Combat Poverty Agency commissioned research into the correlation between drug misuse and poverty.[38] The findings indicated that;

- The majority of people being treated for drug misuse are unemployed and have low educational attainment, and the age profile of those in treatment is declining;
- Opiates and, heroin in particular, were found to be drugs most likely to be associated with deprived areas, although there is a marked contrast between the level of heroin misuse in Dublin and in the rest of the country; and
- Poverty and deprivation are more likely to encourage, rather than discourage, drug misuse.

The key findings of this research remain valid in the context of current epidemiological trends.

The public consultation highlighted a number of other at risk groups, amongst whom there is a perceived high prevalence of drug misuse *e.g.* the homeless, the Traveller Community and those involved in prostitution. The Review Group looked at available evidence in relation to these three groups.

The Homeless Population

2.8.2 The prevalence of drug misuse among homeless people in Ireland is a particular problem and is extremely difficult to quantify. The latest assessment carried out by the Department of the Environment and Local Government in March 1999 estimates that there are some 5,234 homeless people nationwide. Although the exact percentage of drug misusers among this population is unknown, a survey carried out by Focus Ireland, in June 1999, found that 36 *per cent* of the 762 homeless people interviewed were misusing drugs.

2.8.3 In 1999, the Merchants Quay Project conducted a study of homeless people availing of treatment for drug misuse. It found that drug-taking practices increased in risk among homeless drug misusers, particularly with regard to sharing needles and public usage. The report[39] stated that:

- 56 *per cent* of the respondents reported an increase in their drug misuse as a result of being homeless;
- 92 *per cent* of rough-sleeping misusers interviewed reported injecting drugs in public places, compared to 37 per cent of those who were staying with friends; and
- 49 *per cent* reported sharing injecting equipment.

[38] O' Higgins (1998). *Review of Literature and Policy on the links between Poverty and Drug Abuse.* Combat Poverty Agency/ESRI.
[39] Cox, G. and Lawless, M. (1999). *Wherever I Lay My Hat: A Study of Out of Home Drug Users.* Merchants Quay Project: Dublin.

2.8.4 According to Focus Ireland, in 1999 Dublin Corporation evicted 30 tenants, under the Housing Acts and an estimated 90 *per cent* of these evictions were drug-related.[40] However, a recently published study[41] carried out on the impact of the Acts states that they fail to take account of the difficulty of differentiating between drug misuse and drug dealing, although often the drug misuser will engage in small-time dealing to support his/her own habit. That said, it should be noted that the term "anti-social behaviour" is tightly defined in the Housing (Miscellaneous Provisions) Act 1997, which differentiates between drug dealing and drug use.

2.8.5 The Department of the Environment and Local Government reported to the Review Group that Dublin Corporation and other local authorities only carry out evictions in extreme circumstances and only when all other options have been exhausted. The number of evictions must be viewed in the context of a total local authority stock of some 100,000 houses. Furthermore, the eviction of tenants or exclusion of individual family members is contrary to the ethos of local authorities as social housing providers. The Department envisages that the relevant local authorities will develop mechanisms in co-operation with the LDTFs that facilitate early intervention in drug related cases so that such action may be avoided to the greatest extent possible.

The Traveller Community

2.8.6 In general, there is no evidence to suggest that illicit drug use among the Traveller Community is, at present, a major issue, although obviously there is always potential for such a problem to develop in the future. In 1999, Pavee Point Travellers' Resource Centre conducted a survey[42] on drug misuse within the Traveller Community using information collated from treatment centres via questionnaire, focus groups with Travellers and a consultative meeting with Traveller groups. Outcomes from the survey indicate that the nature of drug misuse among the Traveller population is similar to drug misuse trends among young people outside the Dublin region. In general, it would appear that substances most commonly misused are cigarettes, alcohol and cannabis, followed closely by ecstasy, amphetamines and solvent misuse. Heroin misuse within the Traveller Community is still at a relatively low level. Other notable outcomes from the survey were that:

- Of all the Drug Service Providers (21) surveyed, only one third were aware of whether or not travellers were accessing their services; and
- Cannabis appears to be the most commonly used drug, even more so than alcohol, as Travellers have easier access to cannabis than alcohol, because of the difficulties they face in accessing pubs and off-licences. The use of cannabis is "normalised" and is not perceived as being an illegal activity by the majority of the Traveller community.

[40] Focus Ireland's Submission to the Review of the National Drugs Strategy.
[41] Memery, C. and Kerrins, L. (2000). *Estate Management and Anti-Social Behaviour in Dublin. A Study of the Impact of the Housing Act 1997.* Threshold Publication.
[42] Pavee Point Youthstart 1998-9, *Drugs and the Traveller Community Project,* Pavee Point Travellers' Resource Centre, Dublin, August 1999.

Persons involved in Prostitution

2.8.7 Little information is available as to the exact extent of drug misuse among persons working in prostitution. However, estimates are available from projects that have close contact with this group. Figures by outreach workers coming in contact with women involved in prostitution show that, since 1997, the numbers have increased significantly (Table 2.16). In 1999, the Women's Health Project of the Eastern Health Board, conducted research on drug-using women working in prostitution. Over 84 *per cent* of the women reported injecting heroin in the month prior to the study[43] and most women reported taking more than one drug at the time of the research, highlighting a trend of poly-drug use amongst this group. Results also indicated that the main reason 83 *per cent* of the women were working in prostitution was financial, in most cases to "make money for drugs". Similarly, the outreach manager of the Ruhama Women's Project reports[44] that since 1998, some 90 *per cent*[45] of their contacts are involved in prostitution to fund either their own, or their partners' drug habit. The most up to date information, relating to the outreach work, indicates an increase in the number of contacts[46] with women involved in prostitution over the past 3 – 4 years. The Project estimates that there were 402 women working in prostitution at the end of 2000, an increase of 139 on the previous year.

Table 2.16 – Total Contacts from 1997 – 2000*

Year	No of contacts with women working in prostitution	No of nights worked by the Project
1997	619	46
1998	1,087	82
1999	1,932	99
2000	2,012	126

* Ruhama Women's Project.

2.8.8 According to the Gay Men's Health Project's 1997 pilot study report on Males in Prostitution, drug misuse is also prevalent amongst this group. Twenty seven men involved in prostitution were interviewed and the drugs they had used included cannabis (76%), poppers (72%), speed (56%), ecstasy (52%), cocaine (44%) and heroin (20%).[47]

[43] *Drug Using Women Working In Prostitution.* The Women's Health Project, Eastern Health Board, Dublin, Ireland and European Intervention Project, AIDS Prevention for Prostitutes Supported by the EU DGV under its Programme "Europe against AIDS", 1999.
[44] The Ruhama Women's Project is a national voluntary organisation working with women in prostitution.
[45] Based on personal communication between Ruhama Women's Project and contacts of the Project.
[46] The number of contacts represents the number of women the Project comes in contact with while working on the streets at night.
[47] *Report on Men in Prostitution*, Eastern Health Board/Gay Men's Health Project, 1997.

2.9 HEROIN MISUSERS IN TREATMENT

2.9.1 The Central Treatment List, which is compiled by ERHA, is the only register of patients receiving methadone maintenance within Ireland at present. As a result of the Methadone Treatment Protocol, this list now also includes those patients receiving methadone maintenance from GPs working under the Protocol. According to the Central Treatment List, at December 2000, there were 5,032 patients availing of methadone maintenance treatment throughout Ireland. Table 2.17 shows the breakdown of patients on the Central Methadone Treatment List for 1995-2000. This list only covered the Eastern Health Board area up to and including 1998.

Table 2.17 – Central Methadone Treatment List*

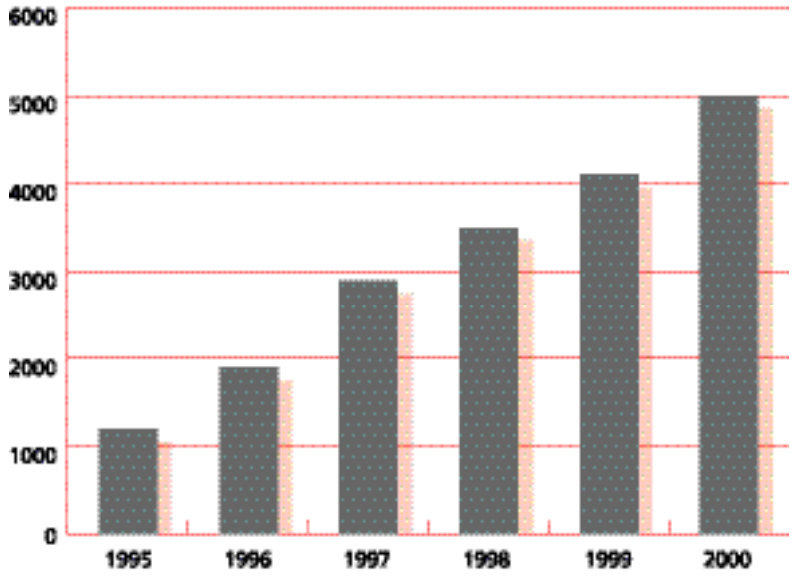
Breakdown of Patients	Dec 1995	Dec 1996	Dec 1997	Dec 1998	Dec 1999	Dec 2000
ERHA Clinics	424	616	1,182	1,939	2,502	2,849
Provincial Clinics	N/A	N/A	N/A	N/A	N/A	41
Trinity Court	305	260	207	504	515	513
Attending General Practitioners within ERHA area	629	985	1,470	1,167	1,252	1,574
Attending General Practitioners outside ERHA area	N/A	N/A	N/A	N/A	63	55
Total number of patients	1,358	1,861	2,859	3,610	4,332	5,032

* Data taken from the Central Treatment List, Eastern Regional Health Authority.

2.9.2 At the end of 2000, over 56 *per cent* of patients were receiving treatment in 49 ERHA clinics and almost one-third from GPs in the ERHA area. Over 10 *per cent* are receiving treatment in Trinity Court, which is a Dublin-based treatment centre. The remaining patients, which account for just under 2 *per cent* are availing of treatment in four Provincial Clinics – Athlone, Carlow, Portlaoise and Waterford or from GPs outside the ERHA area. This highlights the fact that opiate/ heroin misuse remains largely confined to the ERHA area, particularly Dublin.

2.9.3 Figure 2.3 shows the marked increase in the numbers of drug misusers accessing treatment; from 1,358 in 1995 to 5,032 at the end of 2000. This increase is all the more significant when account is taken of the strong local opposition to the provision of treatment centres. This is the case even in some of the areas worst affected by the drugs problem. The ERHA is continuing to work in these areas and with those communities where, at present, there are still significant gaps in treatment service provision.

Figure 2.3 – Methadone Treatment Numbers at end year 1995-2000 from the Central Treatment List



2.9.4 There has been a 16 *per cent* increase in the number of patients availing of methadone treatment nationwide from December 1999 to December 2000. The 2000 data set also includes data from Provincial Clinics which now offer methadone maintenance treatment, where previously such treatment was unavailable. Although the figures show that there has been an increase in the number of individuals in treatment, this is more than likely a reflection of the development of treatment service provision available for drug misusers throughout Ireland[48] which is encouraging more users to come forward and to avail of these services.

2.9.5 Table 2.18 shows the number of participating GPs and pharmacies, both in and outside the ERHA area, for 1998, 1999 and 2000.

Table 2.18 – Area Breakdown of Participating Pharmacies and GPs*

Area breakdown of Participating Pharmacies	1998	1999	2000
Pharmacies within ERHA area	145	154	158
Pharmacies outside ERHA area	30	49	58
Total	175	203	216
Area breakdown of Participating GPs			
No. of GPs participating within ERHA area	97	122	130
No. of GPs participating outside ERHA area	28	32	27
Total	125	154	157

* Central Treatment List, Eastern Regional Health Authority.

2.9.6 As of December 2000, according to the the Methadone Waiting List, there were 469 clients currently waiting to avail of methadone treatment in Ireland. Of this number, over three quarters were male clients of which almost 45 *per cent* were in the 20 – 24 year age bracket. Almost 60 *per cent* of the female clients were in the 20 – 24 year age bracket. Table 2.19 compares waiting list figures in June 1998 and in December 2000.

Table 2.19 – Gender breakdown of the Methadone Treatment Waiting List as in June 1998 & December 2000*

Gender	June 1998	December 2000
Females	113	113
Males	143	356
Total	256	469

* East Coast Area Health Board.

2.9.7 There has been a significant increase in the number of individuals waiting to avail of methadone maintenance treatment between June 1998 and December 2000. This has been matched by an increase in the number of treatment places as demonstrated in Figure 2.3. The most significant increase occurred in the number of male clients waiting to avail of treatment. However, it must be stated that the increase in the waiting list may again reflect growth in the provision of methadone treatment services throughout the country which, in turn, encourages more people to come forward and seek treatment.

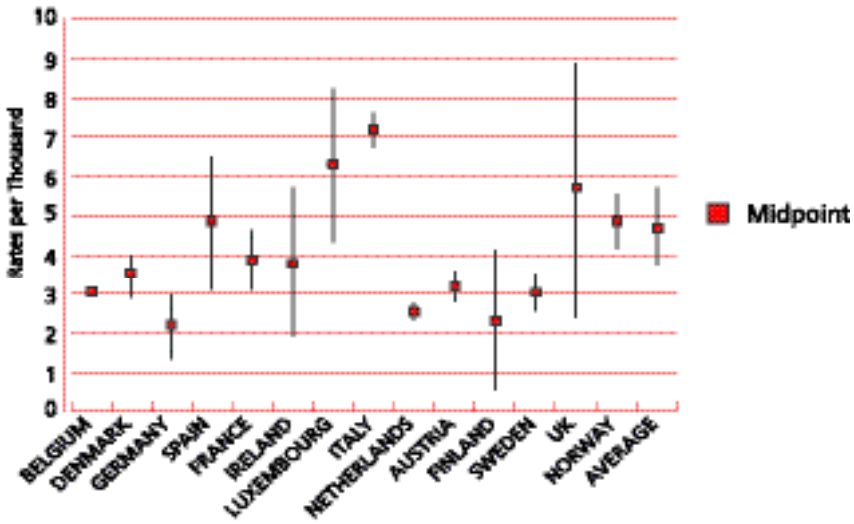
[48] O' Higgins, K. (1996). *Treated drug misuse in the Greater Dublin area. A review of five years 1990 – 1994.* The Health Research Board, Baggot St. Dublin, Ireland.

2.10 PREVALENCE COMPARISONS WITH OTHER COUNTRIES

2.10.1 National prevalence figures for EU countries are often difficult to obtain and, therefore, difficult to compare. The EMCDDA Annual Report on the state of the drugs problem in the European Union is based on the collation of data and national reports provided by each of the National Focal Points operating within the REITOX Network. The DMRD is the designated Focal Point within Ireland. Part of each EMCDDA Annual Report demonstrates the prevalence, patterns and consequences of drug misuse and provides updated information on indicators of the prevalence of drug misuse, health consequences, law enforcement and illicit drug markets within the EU. **The EMCDDA has, over recent years, compiled information from national population surveys on drug misuse in 11 Member States, including Ireland, although, prevalence figures, such as those given below in Figure 2.4 should be interpreted as crude estimates only.** At present, there are an estimated 1 to 1.5 million problem drug users (mainly heroin) in the EU.[49]

2.10.2 The evidence from Figure 2.4 highlights the wide-ranging scale within which prevalence estimates must be calculated. The figure refers to the number of problem drug users, as defined by the EMCDDA, per thousand in the 15-64 year old age group. Luxembourg and Italy have the highest rates, taking into account both the lowest and highest range of estimates. As regards Ireland, the mid point between these two estimates is 3.8, putting it just above the EMCDDA country average of 3.68. Heroin has been identified as the main substance of problem drug use within the EU. The overall prevalence of problem drug use, particularly heroin, appears not to have increased in most EU Member States over recent years.[50]

Figure 2.4 High, mid and low points of the estimates (rates per thousand population) of national problem drug prevalence in the EU and Norway*



[49] Total EU population of 375 million.

[50] *Annual Report on the State of the Drugs Problem in the European Union,* EMCDDA, 2000.

Drug-Related Deaths

2.10.3 In many countries throughout the EU, the number of drug-related deaths began to stabilise and even decrease in some cases, in the late 1980s and early 1990s. However, a number of countries are still experiencing increases, particularly Ireland. The scale of the number of deaths varies dramatically between each country, as can be seen in Figure 2.5.

However, in the absence of harmonised definitions and methodologies across Europe, direct comparisons of drug-related death statistics between countries can be misleading. Data for Ireland show that the number of drug-related deaths rose from 7 in 1990 to 90 in 1998. The increase between 1994 and 1998, however, may be mainly due to improved recording practices as the use of restrictive, or more inclusive definitions, of drug-related deaths can lead to very different estimates.

Figure 2.5 – Number of Acute Drug-Related Deaths Recorded 1990-98

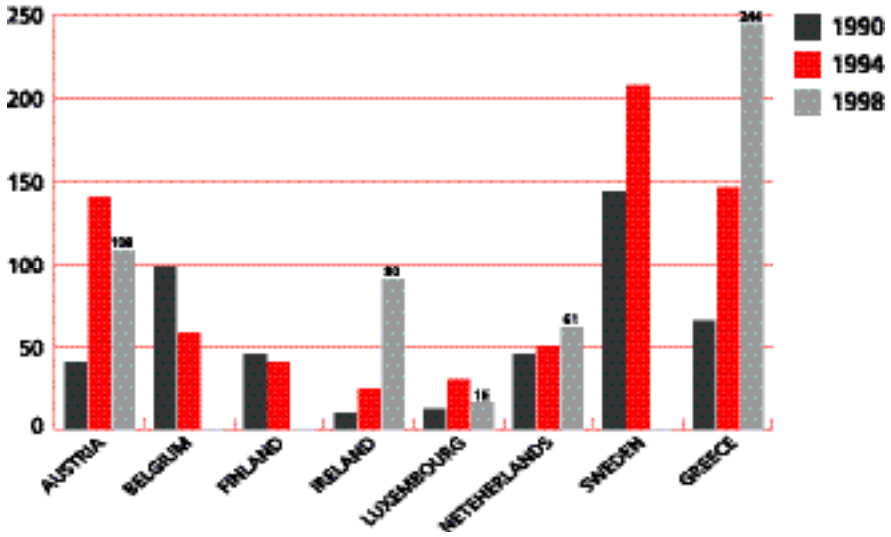
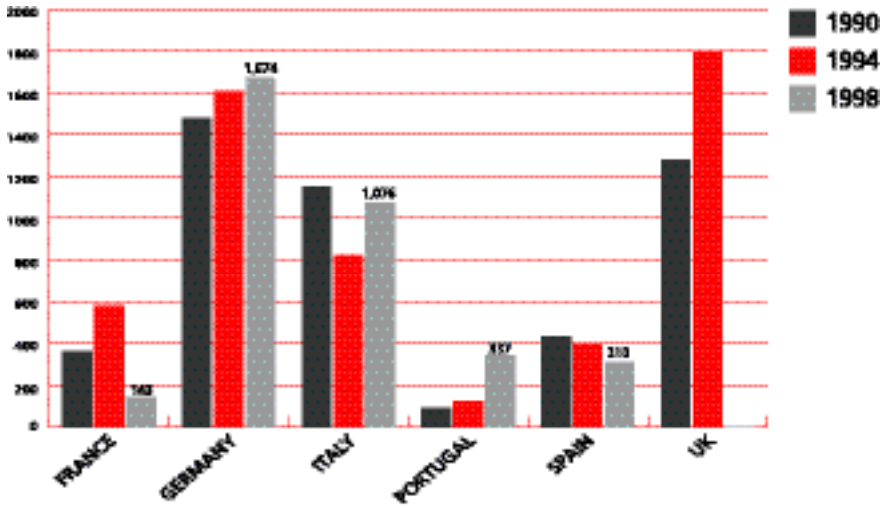


Figure 2.5 (contd) – Number of Acute Drug-Related Deaths Recorded 1990-98



2.11 ADDRESSING GAPS IN PREVALENCE DATA

2.11.1 Recognising that research and information gaps exist about the nature and extent of the drug problem in Ireland, the Government, through the Cabinet Committee on Social Inclusion, established the Interim Advisory Committee on Drugs in 1999. As part of its subsequent report,[51] the Interim Committee set out priority policy information needs and recommended a 3 year programme of research, which would be overseen by a National Advisory Committee on Drugs (NACD).

2.11.2 The Interim Committee also identified a range of research and information gaps under the headings of prevalence, prevention, treatment and consequences. It concluded that a more focused and integrated approach was required in the collection and assimilation of data and this could be achieved through establishing a central database on problem drug use in Ireland. This database should contain all research and information relating to problem drug use and addiction and be easily accessible to all the relevant organisations and policy-makers involved in drug-related issues.

2.11.3 On foot of the Interim Committee's recommendations, the National Advisory Committee on Drugs was established by Government in July 2000. The Committee is overseeing the delivery of a three year research programme aimed at addressing the priority information gaps and deficiencies in the area of drug misuse. This programme includes compiling a comprehensive inventory of existing research relating to the prevalence, prevention, treatment/rehabilitation and consequences of problem drug use in Ireland. The Committee is also looking at how best to determine the size and nature of the drug problem in Ireland, the effectiveness of existing models and programmes in the area of prevention, treatment and rehabilitation and the cost to society of the drug problem. In view of the large amount of research and information which is currently being produced by various agencies and groups, the Government also designated the HRB as a central point to which all such information should be channelled.

[51] *Report of the Interim Advisory Committee on Drugs,* Department of Tourism, Sport and Recreation, February 2000.

2.12 SUMMARY

The main points made in this overview of drug misuse are:

- the most commonly used illegal drug in Ireland is cannabis, followed by ecstasy;
- in terms of harm to the individual and the community, heroin has the greatest impact;
- heroin misuse remains, almost exclusively, a Dublin phenomenon;
- cocaine is seen as an emerging drug of misuse though the numbers presenting for treatment so far remain quite small;
- the majority of those presenting for treatment are male, under 30 years of age and unemployed;
- over half those presenting for treatment inject their main drug while a third smoke it;
- over half of those presenting for treatment had left school by the age of 16;
- in 1999, the highest number of drug possession offences were in the Dublin region, followed by the Southern region;
- there is clear evidence of a significant level of drug use occurring within Irish prisons. Overall, surveys estimate that two fifths of the Irish prison population have a history of injecting drug use, nearly half of whom continued to inject while in prison;
- the proportion of young people (under 19 years of age) presenting for treatment has decreased;
- in 1999, the percentage of Irish students who experimented with drugs, alcohol and tobacco was higher than the EU average, particularly in relation to the use of cannabis, although it had declined since the 1995 ESPAD survey;
- over 5,000 people are currently receiving methadone maintenance treatment, the majority in the ERHA area;
- there are less than 470 people currently awaiting treatment, the majority of whom are male;
- there is a serious problem of poly-drug use, including heroin, among men and women involved in prostitution;
- heroin is the main substance of problem drug use in the EU;
- there are an estimated 1m – 1.5m problem drug users (mainly heroin) in the EU;
- the overall prevalence of problem drug use, particularly heroin, appears not to have increased in most EU countries in recent years;
- using the mid-point of national prevalence estimates for problem drug use, Ireland is marginally above the EU average;
- while the number of drug-related deaths in Ireland is amongst the lowest in the EU, the rate of increase is significantly higher than in any other EU country – though this may be mainly due to improved recording methods.

Chapter 3

3.1 INTRODUCTION

Evolution of Current Response

3.1.1 During the 1960s and 1970s, the use of amphetamines and LSD appeared to be the main drug problem in Ireland. Policy responses included the formation of the Garda Drug Squad, the establishment of the National Advisory and Treatment Centre for Drug Abuse and the enactment of the Misuse of Drugs Act in 1977. However, the early 1980s witnessed a growth in heroin use in inner city areas and other deprived communities in Dublin. A number of Government Committees were established, which recommended the introduction of a series of legislative provisions. In addition, a number of educational, structural, community and youth services and treatment changes were recommended, including the setting up of the National Co-ordinating Committee on Drug Abuse in 1985 and the subsequent strengthening of the co-operation between the enforcement agencies, in particular, An Garda Síochána, Customs and Excise and the Naval Services. Notwithstanding these developments, however, the drug problem continued to increase in scale and scope, especially in deprived communities.

3.1.2 In order to ensure that services were co-ordinated at the highest level, the National Co-ordinating Committee was re-constituted and strengthened in 1990 under the aegis of the Department of Health. In response to recommendations from the Committee and others to tackle drug misuse and trafficking, a Strategy was put in place based on four pillars of supply reduction; demand reduction; manpower training and development and international co-operation. Measures designed to implement the Strategy included (i) better co-ordination between statutory and voluntary agencies in the provision of services; (ii) involvement by general practitioners; (iii) increased powers for enforcement agencies;(iv) the development of a Drug Education Programme for schools and colleges; (v) in-service training for teachers; (vi) the establishment of Community Drug Teams under the auspices of the Health Boards and (vii) the creation of links between the educational, treatment and community services and the prisons.

First Ministerial Task Force Report

3.1.3 Despite these measures, by the mid 1990s, the drug problem, particularly in Dublin, was still growing. The Government responded to widespread public disquiet by setting up a *Ministerial Task Force on Measures to Reduce the Demand for Drugs* in 1996, to deliver an "integrated range of services covering the areas of treatment, rehabilitation and education/prevention".

3.1.4 The *First Report of the Task Force*, which focused on heroin misuse, concluded that social and economic disadvantage, unemployment and poor living conditions were predictors of drug misuse. It also concluded that such misuse had consequences which included a severe localised effect, a life of crime and associated prison records, ill-health, poor employment prospects, deterioration in the quality of life, low educational attainment, high levels of family breakdown and the prevalence of communicable diseases. The Report extrapolated from the treatment statistics to establish heroin addiction trends and suggested that there were approximately 8,000 heroin addicts in the greater Dublin area at that time.

3.1.5 The First Report emphasised education and prevention as long-term solutions to the drugs problem. The Report also envisaged circumstances where "everyone who so wishes should be afforded access to treatment and rehabilitation services". Achieving this would address, *inter alia*, the waiting lists for methadone treatment. Critically, the First Report proposed administrative structures to ensure strategic delivery of the drugs policy in a coherent, integrated, cost effective manner in areas of the most severe drug misuse. The structures proposed included (i) a Cabinet Committee to confer political leadership on the policy and to resolve inter-organisational barriers to effective responses and (ii) an Inter-Departmental Group (IDG), representing the Assistant Secretaries at those Departments serving on the Cabinet Committee, to address policy issues and review progress. It also proposed a National Drugs Strategy Team (NDST) to (i) operate on a cross-departmental basis and ensure effective co-ordination, (ii) identify and consider policy issues before referring them to the IDG and (iii) co-operate with and oversee the work of the Local Drugs Task Forces (LDTFs) who were to co-ordinate delivery of the projects in the areas of highest heroin use.

Local Drugs Task Forces

3.1.6 The LDTFs were set up in areas identified as having the highest levels of drug misuse. Originally, 12 LDTFs were established in the Greater Dublin area: North Inner City, South Inner City, Ballymun, Ballyfermot, Finglas/Cabra, Dublin 12 (Crumlin, Drimnagh, Kimmage and Walkinstown), Dublin North East, Canal Communities (Bluebell, Inchicore and Rialto), Blanchardstown, Clondalkin, Tallaght and Dun Laoghaire-Rathdown. An LDTF was also set up in North Cork City, where the emphasis is primarily on prevention. Following a review of the LDTFs in 1999, Bray was designated as a Task Force area.

3.1.7 The LDTFs each have a chairperson and employ a co-ordinator who helps prepare local action plans which include a range of measures in relation to treatment, rehabilitation, education, prevention and curbing local supply. In addition, the LDTFs provide a mechanism for the co-ordination of services in these areas, while at the same time allowing local communities and voluntary organisations to participate in the planning, design and delivery of those services. The Government originally allocated £10 million to support the implementation of 234 separate measures contained in the plans. In July 1999, the Cabinet Committee on Social Inclusion approved further funding of £15 million per annum to enable the LDTFs to update their drug action plans. The focus of these plans is on the development of community-based initiatives to link in with and add value to the programmes and services already being delivered or planned by the statutory agencies in the LDTF areas. Currently, the LDTFs are updating their plans for the next three years. A sum of £122 million has been provided in the National Development Plan to support the work of the LDTFs up to 2006.

Second Ministerial Task Force Report

3.1.8 In 1997, the *Second Report of the Ministerial Task Force* commented on the progress made since the First Report was published. It also focused on the nationwide use of drugs other than heroin, such as cannabis and ecstasy, drug misuse in prisons and the need for authoratitive research to inform the Government's policy on drugs. Its recommendations included:

- the establishment of a Youth Services Development Fund with a contribution from the Exchequer of £20m, to develop youth services in disadvantaged areas, where a significant drug problem exists or has the potential to develop;
- the training and employment of youth leaders from disadvantaged communities under the FÁS Community Employment Programme and other social economy measures;
- the continued development of education/awareness initiatives, including the expansion of substance misuse prevention/education programmes in primary and second level schools;
- the development of properly supervised treatment programmes for "low risk" offenders who misuse drugs and are convicted of petty crimes, as an alternative to prison;
- the continued development of security measures in Mountjoy to prevent the smuggling of drugs into the prison;
- the establishment of an Advisory Body to conduct research into the causes, effects, trends *etc.* of drug misuse and to evaluate the effectiveness of different models of treatment; and
- the establishment of an independent Expert Group – containing international expertise – to assess how treatment services inside and outside prison interact and to make recommendations for the improved co-ordination/integration of those services for drug misusers coming into contact with the criminal justice system.

Minister of State

3.1.9 In 1997, the Government appointed a Minister of State for Local Development at the newly created Department of Tourism, Sport and Recreation, with special responsibility for co-ordination of the National Drugs Strategy.

Evaluation of the LDTFs

3.1.10 An external evaluation of the LDTF Initiative was completed in June, 1998 by PA Consulting. The consultants recognised that, given the need for an urgent response to the drugs problem, there had been considerable "learning on the job" with some Task Forces being overly project driven. Nevertheless, the Task Forces had provided local communities with a focus for their efforts and had improved inter-agency working relationships as well as those between agencies and local communities. Notwithstanding these positive developments, PA Consulting took the view that there was a need for some Departments and agencies to show a stronger commitment and to make a more effective contribution to the initiative. It was also felt that the effectiveness of representation at local level could be improved. Specific recommendations included:

- the continuation of the LDTFs for two further years with updated plans;
- a greater level of guidance for LDTFs, particularly for planning and evaluation; and
- a clear project-monitoring and evaluation framework.

In response, the NDST established working groups to examine Task Force aims and objectives, roles and responsibilities, the preparation of new plans and monitoring. This led to the publication of a handbook, *Local Drugs Task Forces, A Local Response to the Drug Problem*, in 2000. The handbook specifically addresses many of the operational recommendations arising in the PA Consulting Report and provides guidelines which are being overseen by the NDST, in co-operation with a facilitator dedicated to work with the Task Forces. Arising from a review of the membership of the LDTFs, local elected representatives were invited to participate in their work. Other key recommendations, such as the formalisation of links between the Task Forces and Local Area Partnerships and the roles of the Departments of Education and Science and Social, Community and Family Affairs are the subject of on-going negotiations.

Young People's Facilities and Services Fund

3.1.11 The Young People's Facilities and Services Fund (YPFSF) was established in 1998 to support the development of youth facilities, including sport and recreational facilities, and services in disadvantaged areas where a significant drug problem exists or has the potential to develop. The overall aim of the Fund is to attract young people in disadvantaged areas – at risk of becoming involved in problem drug use – into more healthy and productive pursuits. The target group for the Fund is youth aged 10 to 21 years who traditionally have found themselves outside the scope of mainstream youth activities because of their family background, their involvement in crime or drug misuse or their lack of education.

Four Pillars of the Government's Response

3.1.13 The main elements of the Government's response to the drug problem have continued to evolve, over the past three years, around four distinct but inter-linked pillars which, in the process, have been refined into:

- **supply reduction;**
- **prevention (including education and awareness);**
- **treatment (including rehabilitation and risk reduction); and**
- **research**

Furthermore, the pillars are now underpinned by improved inter-agency co-operation and co-ordination. The location of principal responsibility for each of these areas lies amongst the State agencies, as outlined in Table 3.1. The Department of Tourism, Sport and Recreation is responsible for the overall co-ordination of the National Drugs Strategy.

3.1.14 There is, of course, a necessary sharing of responsibility. For example, An Garda Síochána have an important role in primary prevention and the Prisons Service in rehabilitation, in addition to their more high profile roles in supply control. The allocation of responsibility across functional categories is made more diffuse and, arguably more effective, by the role in Ireland and elsewhere, of the community and voluntary sectors across the four pillars of the drug strategy.

Table 3.1

Pillar	Lead Department/Agency	Other Key Actors
Supply Reduction	Dept. of Justice, Equality & Law Reform An Garda Síochána Customs & Excise Service in the Office of the Revenue Commissioners Prisons Service Naval Service	Dept. of the Environment & Local Government Local Authorities Community & Voluntary Sectors
Prevention	Dept. of Education & Science Dept. of Health & Children Regional Health Boards	An Garda Síochána Community & Voluntary Sectors
Treatment	Dept. of Health and Children Regional Health Boards FÁS	Prisons Service Probation & Welfare Service Community & Voluntary Sectors
Research	Health Research Board National Advisory Committee on Drugs	

3.2 SUPPLY REDUCTION PILLAR

Department of Justice, Equality and Law Reform

3.2.1 The main focus of supply reduction strategy over the past five years has been on:

- updating legislation to reflect the modern reality of drug trafficking;
- greater specialisation by enforcement agencies; and
- a new emphasis on co-ordination and co-operation amongst the main enforcement agencies.

The Department of Justice, Equality and Law Reform has administrative responsibility for the Courts, Prisons and Probation and Welfare Services and for An Garda Síochána and also has responsibility for policy on the reduction of the supply of drugs. In recent years, several legislative and criminal justice measures have been put in place, under the aegis of the Department, to inhibit the supply of drugs, as summarised in Table 3.2 below.

Table 3.2 – Legislative and Criminal Justice Measures

Act	Enforcement	Year
Criminal Justice Act	Seizure & confiscation of assets derived from the proceeds of drug trafficking Money laundering International mutual assistance in criminal matters	1994
Criminal Justice (Drug Trafficking) Act	Detention of persons suspected of drug trafficking for up to 7 days	1996
Criminal Assets Bureau Act	The establishment of the Criminal Assets Bureau	1996
Proceeds of Crime Act	The freezing and forfeiture of the proceeds of crime	1996
Disclosure of Certain Information for Taxation & Other Purposes Act	Exchange of information between the Revenue Commissioners & the Gardaí	1996
Bail Act	Allows for the refusal of bail to a person who has been charged with a “serious offence”	1997
Criminal Justice (Drug Trafficking) Act	Mandatory minimum 10 year sentences for drug trafficking	1999

An Garda Síochána

3.2.2 An Garda Síochána are responsible for the enforcement of drug laws and are an important component of the national drugs strategy. A number of specialist Garda Units have been created with the objective of putting greater focus on certain key tasks in stemming the supply of illicit drugs and building up expertise in these areas. In addition, their Policing Plan 2000 sets requirements for each Garda District and Sub-District to establish its own Drug Policing Plan, which would include multi-agency participation in targeting drug dealing at local level.

3.2.3 The Criminal Assets Bureau (CAB) was set up in 1996 specifically as a cross-agency response, including An Garda Síochána, the Revenue Commissioners and the Department of Social, Community and Family Affairs, to target the proceeds of crime, in particular, drug trafficking. The success of the Bureau is recognised both nationally and internationally. The Garda National Drugs Unit was established in 1995 with specific responsibility for targeting national and international drug trafficking. The National Crime Council has also been established to inform public policy on crime, including drug-related crime and drug prevention. In addition, Community Policing Fora (CPF) have been introduced on foot of co-operation between the Gardaí and the LDTFs in order to deal with the drug problem at a local level. At present, CPF operate in some of the LDTF areas on a pilot basis. Once evaluated, it is the intention that best practice will be identified for the future development of CPF in other LDTF areas on a needs basis.

3.2.4 As well as the CAB and the Garda National Drugs Unit, other specialist Garda units include the Garda Bureau of Fraud Investigation, the National Bureau of Criminal Investigation and the local Garda Drugs Units. Moreover, various initiatives have been, or are being, taken to target drug-related crimes, such as those described in Table 3.3 below.

Table 3.3 – Initiatives of An Garda Síochána

Operation	Description
Dóchas	Focused patrolling in areas where drug dealing is prevalent
Cleanstreet	Undercover Gardaí targeting suspected dealers in areas where drugs are known to be available
Mainstreet	Targets drug dealing and use in and around the O'Connell Street area
Nightcap	Targets venues such as nightclubs where drugs are being sold

Customs and Excise Service

3.2.3 The Customs and Excise Service in the Office of the Revenue Commissioners has primary responsibility for the prevention, detection, interception and seizure of controlled drugs, which are smuggled either at importation or exportation. A Memorandum of Understanding concerning the relationship between the Customs and Excise Service and An Garda Síochána, with respect to drugs law enforcement, was endorsed jointly by the Ministers of Finance and Justice in 1996. Other initiatives to combat the supply of drugs have included agreements with trade associations and individual companies in the matter of detection of illegal drug smuggling and the Customs Drugs Watch Programme which enlists the help of coastal communities and maritime personnel (fishermen and pleasure craft owners) in reporting suspicious activities.

3.2.4 Following the agreement of the Memorandum of Understanding between the Customs and Excise Service and the Gardaí, a number of operational and liaison structures have been developed. These include:

- a joint task force comprising Customs, Garda and the Naval Services;
- personnel exchange between the respective organisations at Head Office level;
- liaison between nominated Customs and Garda officers at local level; and
- an ad-hoc group, comprising a Deputy Commissioner of An Garda Síochána, the Assistant Secretary of the Revenue Commissioners with responsibility for Customs and the Flag Officer of the Naval Service.

The Customs and Excise Service is also represented on the Multi-disciplinary Group on Organised Crime which was established at national level in 1997. This Group feeds into a similar structure at European level which co-ordinates the fight against organised crime. In addition, there is on-going liaison with the Garda National Drugs Unit and the CAB. In response to the challenge presented by the EU Single Market, the Customs National Drugs Team was set up by the Revenue Commissioners and targets the illegal importation of drugs into Ireland.

3.2.5 At international level, the Customs Services in all EU Member States are linked electronically to facilitate quick and effective exchanges of information on the suspicious movement of people and goods. In addition, a Customs and Fiscal Attaché has been assigned to the Irish Embassy in London with particular responsibility for liaising with the UK intelligence services and the Drugs Liaison Officer Network. Appointments are also being made to Europol in The Hague.

Prisons Service

3.2.6 The Prisons Service has responsibility for the provision and maintenance of a secure, efficient and progressive system of containment and rehabilitation for offenders committed to custody. This role is undertaken in a co-operative and co-ordinated way with prisoners, their families, the community, other Government Departments and statutory agencies. However, serious capacity problems have, in the past, led to overcrowding, particularly in Mountjoy prison, which was, until recently, the main committal prison in the State. This severely undermined the development of prison-based treatment services in the past. However, the current prison building programme will alleviate this situation and will, accordingly, facilitate the on-going development of these services. In the past year, two new prisons have come on stream, Cloverhill Prison in Clondalkin and the Midlands Prison in Portlaoise. In addition, extensive redevelopment work is planned for Cork, Limerick and Mountjoy prisons. In this regard, approx. 1,000 extra prison places have been provided and 1,000 more are planned.

Department of the Environment and Local Government

3.2.7 Under the 1997 Housing Act, the Department of the Environment and Local Government provides financial support to local authorities for housing management activities and other initiatives, on local authority estates, which are associated with problems of drug-related crime and anti-social behaviour.

3.3 PREVENTION PILLAR

3.3.1 There are a number of Government Departments and Agencies involved in a range of education, prevention and awareness measures which aim to reduce demand for drugs in Irish society.

Department of Education & Science

3.3.2 The Department of Education and Science has a number of initiatives to combat drugs, all of which are closely linked with the package of measures it has to combat educational disadvantage *e.g.* early intervention with pupils at risk under programmes such as the *Disadvantaged Area Scheme,* the *Stay in School Retention Initiative* and the *Home-School Liaison Scheme*. The Department operates two initiatives in the context of preventative actions – the Substance Misuse Prevention Programme (SMPP), "Walk Tall", for primary schools and the Substance Abuse Prevention Project (SAPP), "On My Own Two Feet", aimed at second level school pupils. The Department is also co-operating with the Department of Health and Children in delivering health promotion programmes in primary and second level schools. As part of its effort to increase awareness amongst young people of drugs and drug-related issues, the Department works closely with FÁS on joint-funded initiatives such as Youthreach and in the running of workshops aimed at increasing drug awareness in areas where acute drug problems are apparent.

3.3.3 The "Walk Tall" Programme – which was launched in 1996 – has three main aspects:

- a substance misuse awareness programme for students, parents and teachers;
- the development of education resource materials and in-service training for teachers; and
- targeting schools where there is a noticeable incidence of substance abuse, particularly heroin.

The main aims of the Programme are to give students the confidence, skills and knowledge to make healthy choices, to seek to avert or delay experimentation and to reduce the demand for legal and illegal drugs. The Programme has established links with the Gardaí, Health Boards, LDTFs, parents groups and education centres. Approximately 2,400 schools have participated in the day seminars of the "Walk Tall" Programme to date.

3.3.4 The post-primary programme, "On My Own Two Feet", was developed in co-operation with the Department of Health and Children and the Mater Dei Counselling Centre and was introduced in 1995. The Programme consists of a number of resource materials and in-service training and the approach taken is to enable post-primary pupils to take control over their own health and welfare. The introduction of the new Social, Personal and Health Education (SPHE) Programme in second level schools, from September 2000, will ensure that Substance Misuse Prevention, which is a part of SPHE, will become an integral part of the school curriculum for junior cycle students.

Department of Health and Children

3.3.5 The Department of Health and Children also places considerable emphasis on the need for education and prevention. The National Health Promotion Strategy, approved by the Government in 2000, has a strategic aim "to endeavour to reduce the numbers engaging in drug misuse". The Health Promotion Unit (HPU) promotes a multi-faceted approach to drug awareness, education and prevention. A range of activities are supported, for example:

- the "Substance Abuse Prevention Programme (SAPP)";
- life-skills programmes;
- award programmes for schools;
- initiatives in the youth service;
- the dissemination of resource material; and
- local campaigns in ERHA areas.

3.3.6 The HPU also formulates preventative policies. However, the implementation of these policies on the ground is very much a matter for the regional Health Boards, as the Department's role – at the policy level – has been to monitor and oversee implementation and to provide resources. The Department situates its policy responses in the context of UN efforts to combat drugs through establishing targets to be achieved by 2008.

An Garda Síochána

3.3.7 The Gardaí also have a role under this pillar. High priority has been accorded to engaging with young people involved, or at risk of becoming involved in drugs and crime. The Garda Youth Diversionary Projects are operated by multi-agency Management/Advisory Committees, which encompass the Gardaí, Probation and Welfare Service personnel, youth organisations, local clergy and representatives of local statutory and community and voluntary groups. As of April 2001, there are 51 projects in operation. The concept of introducing a specific drug prevention element to these projects is currently under review. Other community based Garda initiatives include the Drug Awareness Programme for communities; Garda Schools Programmes; Garda Mobile Anti-Drugs Unit and the Juvenile Diversion Programme. Moreover, Garda Juvenile Liaison Officers also serve throughout the country.

Young People's Facilities and Services Fund

3.3.8 In 1998, the YPFSF was set up to develop youth facilities, including sport and recreational facilities, and services in disadvantaged areas where a significant drug problem exists or has the potential to develop. The primary focus of the Fund is on LDTF areas and selected urban areas (*i.e.* Galway, Limerick, South Cork City, Waterford and Carlow) where a serious drug problem exists or has the potential to develop. A sum of £102 million has been provided under the National Development Plan (2000 – 2006) to support measures under the Fund, of which approx. £46 million has been allocated to date in the first round of funding.

3.3.9 In establishing the Fund, the Cabinet Committee set up a National Assessment Committee to (i) prepare guidelines for the development of integrated plans in the target areas, which meet the overall aims and objectives of the Fund; (ii) facilitate the establishment of the local structures charged with developing plans; (iii) assess the plans emanating from each of the target areas and (iv) make recommendations on funding to the Cabinet Committee on Social Inclusion. The National Assessment Committee is responsible for monitoring on-going progress in implementing the plans and strategies approved and addressing any difficulties or issues arising. It is also overseeing an external evaluation of the Fund, in conjunction with the Department of Education and Science, which will provide a comprehensive and independent assessment of the Fund, taking account of its overall aims and objectives. The evaluation of the Fund commenced in April 2001.

Local Drugs Task Forces

3.3.10 The LDTFs, in the context of implementing their Action Plans, are delivering a range of measures in the education, prevention and awareness areas. Initiatives include community-based drug awareness programmes in schools, youth clubs and other places where young people congregate; drug awareness programmes for parents, teachers etc; peer education programmes and projects to prevent early school-leaving.

3.4 TREATMENT PILLAR

Department of Health and Children

3.4.1 The Department of Health and Children has overall policy and legislative responsibility for health, social services and child welfare in Ireland, as well as various responsibilities for aspects of drug policy, principally treatment and rehabilitation services. In developing its policy on drug misuse, the Department has adopted a health promotion approach. The Department's national policy on the treatment of alcohol and drug misuse stresses the need for community based interventions rather than specialist in-patient approaches. These services include family support and community medical and social services.

3.4.2 Responsibility for the provision of treatment and rehabilitation services for drug misusers is vested with the ten Regional Health Boards. The Health Boards also provide support and training for community groups which are involved in drug-related prevention or rehabilitation activities, as both the community and voluntary sectors play a significant part in the provision of drug related services, especially in the LDTF areas. The Health Boards have appointed Regional Drug Co-ordinators and many have also established Regional Drug Co-ordinating Committees comprising representatives of the relevant Health Board, An Garda Síochána, Education Services and the community and voluntary sectors. There is regular contact between the NDST and the Regional Drug Co-ordinators.

3.4.3 Growth in drug-related problems throughout the country has resulted in the need for many of the Health Boards to formulate a specific drug strategy for their region. This is especially the case in the area of development of services, which are local and tailored to the needs of particular communities. The majority of these strategies are being developed at present in accordance with emerging trends which are specific to the individual regions. Perhaps not surprisingly, the emphasis in many Health Boards outside of the Eastern region has been on education and prevention initiatives. However, because of the nature of the drug problem in the Eastern catchment area, the Eastern Regional Health Authority (ERHA) has been involved in a significant degree of activity and expansion of treatment services within its area.[52] The expansion of services in the ERHA area has been a priority in order to protect the health of misusers themselves, to prevent the spread of infectious diseases and to reduce the effect of chaotic behaviour on certain neighbourhoods.

3.4.4 Although waiting lists remain a problem in the successful treatment and rehabilitation of drug misusers in the Eastern region, there has, nonetheless been an extensive development of treatment facilities especially in the Greater Dublin area. For example, at the end of 1997 there were 21 treatment locations in the Eastern Health Board area, while there are now 55. Due to difficulties associated with estimation and resistance amongst some users to treatment, service planners do not always have the opportunity to plan services around accurate prevalence figures. Nevertheless, it is envisaged that over the next 2-3 years, supply will approach actual demand for treatment and rehabilitation.

[52] Farrell *et al.*, 2000 op cit.

Prisons Service

3.4.5 In October 2000, the Government approved in principle the implementation of the recommendations contained in the Report on Prison-Based Drug Treatment Services which was produced by a Steering Group, established by the Director General of the Prison Service.[53] These proposals will result in a major overhaul of prison-based drug treatment services and should make a major contribution to breaking the cycle of drug dependency, crime and imprisonment which are inextricably linked at present. Perhaps the main conclusion of the report is that the Prisons Service must replicate in prison, the level of medical and other supports available in the community for drug dependent people, to the maximum extent possible.

3.4.6 In addition, the report proposes a multi-disciplinary approach to the drug problem in prisons and the appointment of a senior figure from the ERHA to co-ordinate the overall treatment service in the Dublin prisons, as well as drugs counsellors and extra nurses, psychologists and probation service staff. All staff in the relevant institutions will receive training in drugs-related issues and refresher courses every year thereafter. Links are also being established with local community and voluntary groups, through liaison committees, to enhance the throughcare and aftercare arrangements for prisoners in receipt of drug treatments in custody. Implementation of the recommendations of the report are progressing at present.

3.4.7 The Probation and Welfare Service, although not a primary drug treatment agency, co-ordinates a range of drug treatment initiatives, in co-operation with a number of rehabilitation agencies and the community.

Drug Court

3.4.8 A Drug Court was established in January 2001 in the North Inner City of Dublin. It has as its primary aim "the reduction of crime through rehabilitation of the offender but not excluding punishment should the circumstances so warrant".[54] Rehabilitation and structured supervision will be used to help participants to escape the cycle of offending with the ultimate objective of ending all criminal activity. It is hoped that best practice will be identified to allow for expansion, as appropriate.

FÁS

3.4.9 FÁS works closely with the voluntary, community and state sectors on projects aimed at prevention, treatment and rehabilitation. Specific drug-related programmes, operated by FÁS, include the Special Drugs Community Employment Programme, on which 1,000 places have been set aside for recovering drug misusers.[55] Employment Service Offices, which are based throughout the country, provide trained staff to work with stabilised drug misusers to assist them to secure employment or further training. Similarly, a number of "advocates", located in severely disadvantaged areas, provide a mentoring service to young people experiencing drug problems.

Department of the Environment and Local Government

3.4.10 Special high support hostel accommodation is necessary for homeless people with drug dependence problems. Under the Homeless Strategy, funding has been provided by the Government for the provision of two high support hostels in Dublin for people with drug and alcohol dependence problems. In view of the number of people with such problems in Dublin, Dublin Corporation and the ERHA are taking the lead role in drawing up and implementing suitable proposals.

[53] *First Report of the Steering Group on Prison-Based Drug Treatment Services*, July 2000, The Prisons Service.
[54] *First Report of the Drug Court Planning Committee, Pilot Project*, August 1999, Dublin; The Stationery Office.
[55] 800 places were taken up on the FÁS programme at end April 2001.

Voluntary Drug Treatment Network

3.4.11 The Voluntary Drug Treatment Network [56] provides a framework for a number of voluntary drug groups working in the area of treatment to meet, share issues of concern and develop more comprehensive responses to the prevention and treatment of problem drug use. The Network is an umbrella group that aims to challenge drug misuse and related issues in a creative, caring and motivational way. It provides a comprehensive range of drug treatment methods that range from harm reduction intervention through to long-term residential drug-free programmes. There are two core strands to the composition of the Network. These are localised community-based treatment responses, that have emerged from local residents and individuals seeking to respond to issues in their areas and regional responses that provide treatment at national and, occasionally, at EU level.

3.4.12 The Network has representatives on the National Aids Strategy Committee, the NDST and the National Advisory Committee on Drugs (NACD). They are also members of the Community Platform that forms part of the Community and Voluntary Pillar of the Social Partnership. However, the Network itself does not have a national remit to represent all the voluntary drug treatment organisations in the country. It is primarily for the Dublin based organisations which deal with drug misuse but some of its members do have a national focus in terms of treatment and training. The Network engages with various Government Departments and Regional Health Boards who assist in the funding of its services.

3.5 RESEARCH PILLAR

Drug Misuse Research Division of the Health Research Board

3.5.1 As set out in Chapter 2, the Drug Misuse Research Division (DMRD) of the Health Research Board was established in 1989 and is responsible for operating the National Drug Treatment Reporting System (NDTRS) which is the main source of information on drug misuse in Ireland. The NDTRS is an epidemiological database, which provides data on people who avail of treatment services for problem drug use, on a nationwide basis. This provides information on the current patterns and trends of treated drug use and drug addiction in Ireland. Data is provided to the NDTRS through centres or service locations where drug misuse is treated.

3.5.2 The Government has designated the DMRD as the central point to which all research data and information should be channelled. In order to deliver on the role assigned to it, the DMRD is developing a National Documentation Centre which policy-makers and other interested parties can use to access all relevant and up-to-date information and research in the field of drug misuse in Ireland and internationally. In addition to existing data, all future research and information will be channelled or, as appropriate, its existence notified and recorded in a way which facilitates ease of retrieval by policy-makers and other interested parties. The Documentation Centre will build on the existing resources of the DMRD and will capitalise on its position as the National Focal Point for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA).

[56] The Voluntary Drug Treatment Network is comprised of Addiction Response Crumlin, Ana Liffey, CASP, Coolmine Therapeutic Community, Fettercairn DP, Killinarden ARP, Mater Dei Counselling, Merchants Quay Project, Saol Womens Project, Ballymun YAP.

National Advisory Committee on Drugs (NACD)

3.5.3 The NACD was established in July 2000 to advise the Government in relation to the prevalence, prevention, treatment and consequences of problem drug use in Ireland, based on the Committee's analysis and interpretation of research findings and information available to it. The Committee is overseeing the delivery of a three year prioritised programme of research and evaluation on the extent, nature, causes and effects of drug misuse in Ireland, identifying the contribution which can be made by all the relevant interests. Its membership reflects statutory, community, voluntary, academic and research interests as well as representation from the relevant Government Departments. The Committee operates under the aegis of the Department of Tourism, Sport and Recreation.

Health Promotion Unit (HPU) of the Department of Health and Children

3.5.4 The HPU of the Department of Health and Children is also involved in the publication and dissemination of information and literature which promotes the avoidance of drug misuse. In this regard, the National Health Promotion Strategy sets clear aims and objectives to support best practice models which promote the non-use of drugs and, where they are used, the minimisation of the harm done by them.

3.6 CO-ORDINATION ACROSS THE PILLARS

Cabinet Committee on Social Inclusion

3.6.1 The Cabinet Committee on Social Inclusion gives overall political direction to the Government's social inclusion policies, including the national drugs strategy. It has, *inter alia*, responsibility for reviewing trends in the area of drug misuse, assessing progress in implementing the national drugs strategy and resolving policy or organisational difficulties which may inhibit effective responses to the problem.

Department of Tourism, Sport and Recreation

3.6.2 The Department of Tourism, Sport and Recreation is responsible for the overall co-ordination of national policy to tackle drug misuse with a Minister of State who reports to the Cabinet Committee on Social Inclusion. The Department chairs and provides the secretariat to the IDG and funds both the NDST and the NACD.

Inter-Departmental Group on Drugs (IDG)

3.6.3 The IDG oversees progress on the implementation of the national drugs strategy and reviews Government policy on issues which may arise, including submissions from the NDST and the National Assessment Committee for the YPFSF. It meets on a monthly basis and is chaired, at Assistant Secretary level, by the Department of Tourism, Sport and Recreation which also provides the secretariat to the Group. The following Departments are represented, at Senior Official level, on the IDG: Taoiseach; Finance; Education & Science; Enterprise, Trade & Employment; Environment & Local Government; Health & Children and Justice, Equality & Law Reform. The Chair of the NDST is also a member of the IDG.

National Drugs Strategy Team (NDST)

3.6.4 The NDST, which has joint monthly meetings with the IDG, is a cross-departmental team comprised of personnel from a number of Departments and Agencies. Members have direct access to their respective Ministers and the heads of the relevant Departments on matters relating to the effective implementation of the various programmes and initiatives operating under their aegis, particularly in so far as they relate to the 14 LDTF areas. Their time is divided evenly between their parent Department/Agency and the Team. The community and voluntary sectors each have a representative on the NDST and, as such, the Team is a partnership between the statutory, community and voluntary sectors.

3.6.5 The NDST is chaired, at Principal Officer level, by the Department of Health and Children. Full-time secretarial and administrative support for the NDST is provided by staff seconded from the Department of the Taoiseach and the ERHA. The NDST ensures that there is effective co-ordination between Departments and Agencies, oversees the work of the LDTFs, identifies and considers policy issues and, through joint meetings with the IDG, ensures that policy is informed by the work of and lessons from the LDTFs. Each member of the NDST acts as a liaison person for one or more LDTFs. The NDST also meets on a regular basis with the chairs and co-ordinators of the LDTFs to review progress and identify issues to be addressed.

Local Drugs Task Forces (LDTFs)

3.6.6 Membership of the LDTFs include representatives of all the relevant agencies such as the Health Board, the Gardaí, the Probation and Welfare Service, the relevant Local Authority, elected public representatives, the Youth Service and FÁS. Moreover, LDTFs also include representation from voluntary agencies, community representatives, a chairperson nominated by the local Area Partnership and a co-ordinator provided by the relevant Health Board.

3.7 PUBLIC EXPENDITURE ON THE CURRENT DRUGS STRATEGY

3.7.1 The cost of drug misuse at a societal level is extremely difficult to quantify[57] as it encompasses areas like the public health costs of disease associated with drug dependence, the cost of acquisitive crime and associated losses and insurance costs which are borne by both business and individuals. The level of State spending on drugs-related issues is also difficult to estimate and is complicated by the fact that expenditure is spread across a number of Departments, Local Authorities, Agencies and other statutory organisations. Even within Departments and Agencies, it is difficult to arrive at an accurate estimate of costs associated specifically with drug misuse as services such as An Garda Síochána, the Prisons, the Courts and Probation and Welfare Services and the various health agencies deal with drugs issues as part of their wider daily services.

3.7.2 Bearing these limiting factors in mind and using the information supplied to the Review Group, it is estimated that the development, co-ordination and delivery of the four pillars that make up the current National Drugs Strategy approximated to £144 million in 2000. This is broken down by Departments and Agencies in Table 3.4.

[57] The EMCCDA, in consultation with the Pompidou Group, is currently researching improved mechanisms for the establishment of costs to society of drug misuse.

Table 3.4 – Direct Expenditure in 2000

Department/Agency	Expenditure £
Dept. of Justice, Equality & Law Reform	97.0 ml
Dept. of Health & Children	25.2 ml
Dept. of Enterprise, Trade & Employment	4.7 ml
Dept. of Education & Science	5.9 ml
Dept. of Tourism, Sport & Recreation	9.1 ml
Revenue Commissioners (Customs and Excise)	1.5 ml
State Laboratory	0.4 ml
TOTAL	143.8 ml

* Rounded to one decimal place.

Notes: The expenditure for the Department of Education and Science includes the YPFSF. The expenditure for the Department of Tourism, Sport and Recreation is mainly for the implementation of the LDTF action plans and is paid through the implementing Departments and Agencies. The expenditure figure for the Department of Enterprise, Trade and Employment represents funding for the Special Drugs Community Employment Programme run by FÁS for recovering drug misusers. Expenditure for the Department of Health and Children comprises the additional funding granted to Health Boards from 1996 to 2000 plus the 2000 funding allocated (from other sources as well as the Department of Health and Children) to the DMRD.

Chapter 4

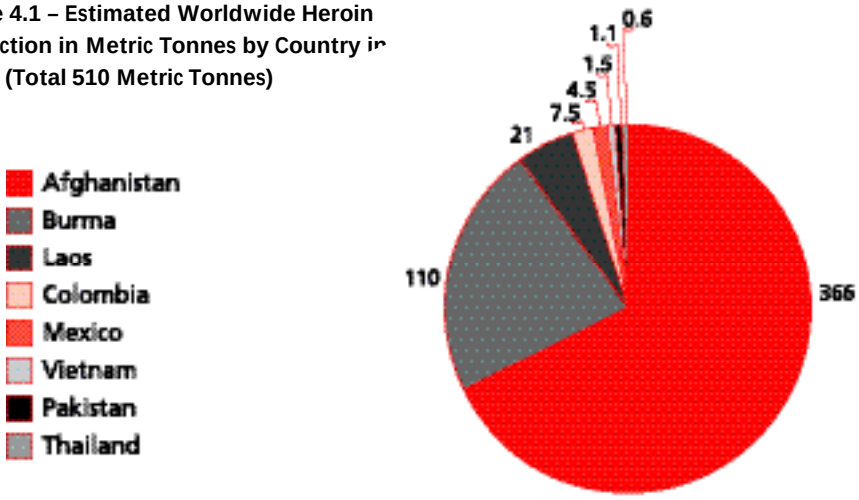
4.1 THE INTERNATIONAL TRADE IN DRUGS

4.1.1 Drugs are an international problem and the trade in drugs is worth many billions of pounds annually. A 1997 report by the United Nations Drug Control Programme (UNDCP) estimated that the trade in drugs amounted to 8% of total international trade, that is roughly the same as textiles, oil, gas or world tourism. There is a marked difference between the price of drugs sold in Ireland, in the source country and while in transit. Prices can vary for a number of reasons, *e.g.* size of the crop, number of seizures, demand *etc.* but as an example, a kilo of heroin is sold in Afghanistan for IR£1,000, in Turkey for IR£8,750, in the Netherlands for IR£19,000 and in Ireland for IR£80,000. It can then realise up to four times this figure on the streets, depending on the number of exchanges and the level of purity.

4.1.2 While narcotic crops are cultivated worldwide and cannabis products, in particular, are produced in a number of regions, three areas of the world account for the vast majority of cocaine (coca) and heroin (opium) production. Cocaine production is concentrated in South America (primarily Colombia but both Peru & Bolivia also produce significant amounts – see figure 4.2). Heroin is primarily produced in South West Asia (overwhelmingly in Afghanistan) and to a lesser degree in South East Asia (the Golden Triangle which straddles Burma, Laos, Thailand and Vietnam – see figure 4.1). Colombia and Mexico have also developed significant potential heroin production capability. By 2000, they accounted for approx. 2.4% of world heroin production which is targeted mainly at the U.S. Although there is some limited domestic production of cannabis and some synthetic drugs (mainly ecstasy), Ireland is primarily an importer of drugs and is also sometimes used as a transit point for other European destinations. The main routes for these drugs into the country are as follows:

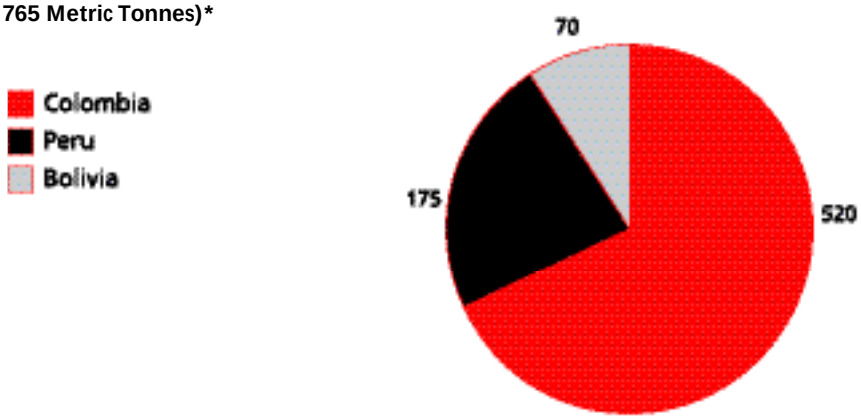
- Heroin – Heroin mainly originates in Asia and comes through Turkey and the Balkans and arrives in Ireland primarily through the UK or the Netherlands. Amounts are generally quite small and are for the home market. Due to the size of the quantities, they can be transported in a number of different ways and can be difficult to detect.
- Cocaine – Cocaine is shipped in much larger amounts from South America, in many cases through the Caribbean, arriving in Ireland in most cases through other EU countries, in particular the UK.
- Cannabis – Cannabis can be produced anywhere but the bulk of cannabis sold in Ireland comes from North Africa, mostly Morocco, via sea-going yachts as well as articulated trucks using cross-channel ferries. In general, the shipments are quite large in size.
- Ecstasy – Ecstasy and other synthetic drugs can also be produced anywhere although most of the ecstasy that is sold in Ireland is believed to be sourced in the Netherlands and Belgium, but increasingly drugs are being sourced from Eastern Europe.

Figure 4.1 – Estimated Worldwide Heroin Production in Metric Tonnes by Country in 2000* (Total 510 Metric Tonnes)



* "Southwest Asia – Opium Cultivation and Production Estimates 2000", publication of the United States Office for National Drug Control Policy, 2000.

Figure 4.2 – Estimated World Cocaine Production in Metric Tonnes by Country 1999 (Total 765 Metric Tonnes)*



* "Major Coca & Opium Producing Nations – Cultivation and Production Estimates, 1995-1999", publication of the United States Office for National Drug Control Policy, 1999.

4.2 EUROPEAN UNION

4.2.1 The EU Member States have been adopting common measures for combating drug addiction since the mid-1980s. In 1990, the Rome European Council adopted the first European Plan to Combat Drugs, which was then revised and updated by the Edinburgh European Council in 1992. The 1995-1999 EU Action Plan stressed the need for a multi-disciplinary and integrated response, centred around demand reduction, supply reduction, the fight against illicit trafficking and international co-operation and co-ordination at national and EU level. The more recent EU Action Plan 2000 – 2004 is based upon the conclusions of the Cardiff and Vienna European Councils. The Strasbourg based Council of Europe also plays a key role in a pan-European response to the drugs problem, particularly through the Pompidou Group which is currently chaired by Ireland.

4.2.2 The EU Action Plan to Combat Drugs (2000-2004) emphasises the continuing threat to society posed by illicit drugs. The Plan outlines the need for a balanced approach between demand and supply reduction. The main aims and objectives of the 2000-2004 Plan are:

- to ensure that the issue of the fight against drugs is kept as a major priority for EU internal and external action;
- to continue the EU integrated and balanced approach to the fight against drugs, in which supply and demand reduction are seen as mutually reinforcing elements;
- to ensure collection, analysis and dissemination of objective, reliable and comparable data on the drugs phenomenon in the EU with the support of European Monitoring Committee on Drugs and Drug Addiction (EMCDDA) and Europol;
- to promote international co-operation, integration of drug control into EU development co-operation and to support the efforts of the UN and of the United Nations Drug Control Programme (UNCDP), in particular, to develop international co-operation, based on the principles adopted at United Nations General Assembly Special Session on Drugs (UNGASS); and
- to emphasise that, while not bidding for new resources, the successful implementation of the strategy and actions mentioned in this Action Plan will necessitate appropriate resources.

The Plan emphasises the need to evaluate experience and identify best practice to ensure continuity and consistency in order to build upon the previous Action Plan. It identifies many new challenges and re-affirms the Union's commitments to the relevant UN Conventions.[58] Furthermore, it sets targets under its six key headings: co-ordination; information and evaluation; reduction of demand; prevention of drug misuse and of drug-related crime; supply reduction and international co-operation.

[58] The 1961 Single Convention of Narcotic Drugs, the 1971 Convention on Psychotropic Substances and the 1988 Convention against Traffic in Narcotic Drugs and Psychotropic Substances. Under these Conventions, the parties are obliged to apply specified measures to substances listed in the Conventions and to any substance subsequently brought within the scope of the Convention by the United Nations Commission on Narcotic Drugs.

4.2.3 The following are key features of the EU Action Plan:

- it provides for the European Commission to organise appropriate evaluations at mid-term and on completion of the EU Drugs Strategy (2000 – 2008). Each Member State will have to account for the actions they have taken in accordance with the relevant sections of the Action Plan;
- including in the EU Annual Report on Drugs an overview of measures taken as follow-up to the Action Plan;
- completion of a study into the definitions, penalties and practical implementation of laws by the Courts and law enforcement agencies for drug trafficking within the Member States;
- completion of work on the five key epidemiological indicators and the development of indicators on drugs related crime, the availability of illicit drugs and drug-related social exclusion;
- launch of a study on attitudes to drugs throughout the EU;
- establishment of measurable targets so that assessments can be made on progress in achieving objectives in the Action Plan; and
- evaluation of the co-ordination arrangements that are in place.

4.2.4 The EU has also prioritised the fight against drugs in its external relations. In this regard, it has applied two categories of action. First, is the active support for global policy-making, the strengthening of strategy settings by UN institutions and the effective functioning of informal bodies. Second, is the need for bilateral and regional actions in the area of trade policy, technical assistance and political dialogue. It is envisaged that the Union will use the full range of measures at its disposal in the field of external relations, including enhancement of common foreign and security policy. In addition, co-operation agreements with third countries regularly feature drugs clauses.

4.3 OVERVIEW OF SELECTED NATIONAL DRUG POLICIES

4.3.1 The Review Group also looked at national drugs policies in the Netherlands, Portugal, England, Scotland, Spain, Sweden, Australia and Switzerland as broadly representative of the spectrum of recent national strategic responses. The approach to dealing with drug misuse across all these States shared common twin emphases – a focus on the needs of the drug misuser, coupled with attempts through various enforcement measures and agencies to cut off the supply of drugs, with the degree of emphasis varying according to the country's fundamental philosophy on tackling the drugs issue.

4.4 AUSTRALIA

4.4.1 The Australian Drug Strategy is based on the principle of harm reduction. Harm includes levels of illness and disease, criminal offences and personal and social disruption from drug misuse. It recognises explicitly that there is a heavy commitment outside of the Strategy to the treatment of disease and trauma caused by misuse of drugs and to law enforcement to restrict the supply of drugs. In these circumstances, the Strategy, in its own right, is intended to be a catalyst for change and innovation. It supports a diverse range of drug and alcohol services in the areas of treatment, prevention, supply control and education and training. The specific initiatives embraced by the Australian Strategy include partnerships between various governmental and non-governmental agencies, media campaigns and the production of core educational resources.

4.5 THE NETHERLANDS

4.5.1 The main aim of drugs policy in the Netherlands, as in Australia, is to reduce the risks experienced by drug misusers, those in their immediate environment and Dutch society in general. For misusers, the central goal is the protection of their health which is achieved through prevention and care measures. Such measures are buttressed by the activities of the police and other enforcement agencies. Dutch policy is also formulated on the premises that:

- there is a distinction to be made between "hard" drug and "soft" drug misuse;
- processing of misusers through the criminal justice system is more damaging to the misuser than the use of drugs; and
- every effort should be made to inhibit drug misusers from ending up in an illegal environment where outreach can be difficult.

Prevention interventions are carried out by local or regional organisations in the fields of education, health, drugs, youth and social work. Information and education campaigns can be generic or targeted at specific high-risk groups. In the health sector, the objective includes the prevention through harm reduction policies of further deterioration. The actions designed to achieve this include syringe exchange and methadone maintenance programmes and the provision of food and shelter to misusers.

4.5.2 An experiment involving the prescription of heroin under strict medical supervision has also been in place in the Netherlands since 1998. It involves a group of 750 serious misusers whom it is considered can no longer be helped by the regular care system. The experiment involves the comparison of two different treatments – treatment with methadone and treatment with methadone in combination with heroin. The aim of the study is to examine whether the prescription of heroin has a beneficial effect on the physical or mental health and social functioning of drug misusers. Amsterdam and Rotterdam were chosen for the first phase of the experiment and 50 misusers in each area are being prescribed heroin, in addition to methadone. An evaluation of the experiment has not yet been carried out.

4.4.3 Overall, Dutch policy attempts to provide differentiated care which, insofar as is possible, is attuned to the wide range of needs of the individual drug misuser.

4.6 PORTUGAL

4.6.1 The basic principles underpinning the Portuguese Strategy embrace:

- prevention to minimise demand for drugs through appropriate education and information programmes;
- recognition of the human dignity of misusers and the complexity of the issue of drug misuse;
- an openness to innovative and evidence-based responses to the drugs problem;
- co-ordination between various governmental and non-governmental agencies; and
- community mobilisation.

4.6.2 The objectives of Portuguese Strategy include effective international co-operation; the provision of good quality information about drug misuse to the Portuguese population; information on the use of drugs by young people and the securing of the necessary resources for the treatment and social re-integration of drug misusers.

4.6.3 Portugal aims to deliver a broad range of strategic actions, consistent with the harm reduction policies and humanistic philosophies adopted in other countries.

4.7 ENGLAND

4.7.1 The UK Drugs Strategy "Tackling Drugs to Build a Better Britain" was launched in 1998. Scotland, Wales and Northern Ireland have since developed their own drug strategies which are aligned with and reflect the key elements of the UK Strategy. The key aim of the 10-year Strategy is to create a healthy and confident society, increasingly free from the harm caused by the misuse of drugs. There are four main elements:

- Young People – to help young people resist drug misuse in order to achieve their full potential in society;
- Communities – to protect communities from drug-related anti-social and criminal behaviour;
- Treatment – to enable people with drug problems to overcome them and live healthy and crime-free lives; and
- Availability – to stifle the availability of illegal drugs on the streets.

4.7.2 **Young people:** the Strategy seeks to prepare young people both to resist drugs and, as necessary, to handle drug-related problems. This is achieved through the provision of information, skills and support especially to at risk groups. The main mode of delivery is through the education system starting with the teaching of broad life-skills at primary school.

Communities: the Strategy seeks to protect communities from drug-related crime and anti-social behaviour by identifying drug misusing offenders at key points in the criminal justice system and encouraging them to take up appropriate treatment or other effective programmes of help. The evaluations of the "Arrest Referral Scheme" and the "Drug Treatment" and "Testing Order" pilot schemes indicate significant reductions in drug use and crime committed by offenders whilst on the schemes. These schemes are now being rolled-out nationally.

Treatment: the Strategy seeks to improve the provision of drug treatment to enable all problem drug misusers to have proper access to support from appropriate services, including primary care, when needed, which will have a positive impact on health and crime.

Availability: the Strategy seeks to stifle the availability of illegal drugs on UK streets by focusing on disrupting and dismantling the trafficking groups who are responsible for the bulk of illegal drugs supplied to and distributed within the UK.

4.7.4 The structures put in place to deliver the strategy is headed by the Ministerial Steering Group on Drug Misuse (MSGD). The UK Anti-Drugs Co-ordinator and his deputy, along with the UK Anti-Drugs Co-ordination Unit (UKADCU), have a key role in co-ordinating the Strategy and assessing and driving forward progress against key targets. Strategic co-ordination of the strategy in England is driven forward by the Strategic Planning Board (SPB) which takes ownership of the strategy targets, agrees business plans for each aim of the Strategy and advises MSGD accordingly. Drug Action Teams (DATs) are responsible for co-ordinating the local delivery of the drugs strategy. Representation on DATs is from the core agencies of education, social services, health, police, prisons, local housing authority and probation service.

4.8 SCOTLAND

4.8.1 Four key pillars underpin the Scottish Strategy. They are social inclusion, partnership, co-ordinated action and evidence-based responses and accountability.

4.8.2 Effective drug education for all young people lies at the heart of policy on prevention in Scotland. The emphasis is on health education, including drug education, within a comprehensive programme of personal and social development aimed at providing young people with the necessary knowledge and skills to choose a healthy lifestyle. The actions taken to reduce drugs within communities in Scotland include (i) the tackling of drug misuse within a wider social programme; (ii) reducing drug-related crime through substitute prescribing regimes; (iii) implementing and evaluating Drug Action Teams; (iv) promoting initiatives to cut drug crime through arrest referral and diversion and (v) education programmes for parents.

4.8.3 Treatment in Scotland is designed to improve the general health of misusers. Aims include stemming the spread of infections, the induction of abstinence through detoxification and residential care programmes. Pharmacy needle exchanges, together with specialist drug service needle exchanges, have been developed throughout Scotland and methadone prescription is a major part of treatment strategy.

4.8.4 The police and other enforcement agencies accord a high priority to drug enforcement in Scotland. The Scottish Prisons Service has mandatory drug testing, a feature which has led to a substantial increase in the number of prisoners seeking support for their drug misuse problems.

4.9 SPAIN

4.9.1 The main goals of Spanish policy on drugs include the prioritisation of prevention, demand and harm reduction; the fostering of programmes which promote the re-integration of drug dependent persons into Spanish society; and the reduction of supply through concerted action against drug trafficking, money laundering and other related crimes.

4.92 Prevention, which is primarily aimed at young people, is considered to be the most important strategy for dealing with the drug problem in Spain. Prevention is structured around certain principles, priorities and objectives. These principles include (i) the co-ordination of actions by the State agencies; (ii) the active participation of communities and (iii) the promotion of "education for health", measures aimed at preventing the spread of disease and a reduction in illness and associated infectious conditions. The priorities for intervention are schools, families, the workplace, communities and the media. The objectives of the Spanish Strategy buttress these priorities.

4.9.3 Harm reduction in Spain aims to reduce the harm caused by drugs consumption as regards the wider society as well as the individual user's health. Harm reduction covers, amongst other things, syringe exchange and methadone maintenance programmes. Integration of drug misusers into Spanish society operates on the premises of equitable treatment for users throughout the country, the co-ordination of the actions of relevant intervention agencies and the provision of quality controlled, differentiated, evidence-based and localised programmes.

4.9.4 Another element of Spain's harm reduction programme is the recent provision of injecting rooms for misusers in the Autonomous Region of Madrid. Although not officially in accordance with Spain's national strategy on drugs, the injecting rooms opened in Madrid in June 2000 and approximately 1,200 misusers availed of the service in the first 3 months.[59] The Madrid region has a population roughly the size of Ireland and has between 14,000 – 15,000 heroin misusers. Services are divided into two levels of care – primary care which includes a needle exchange programme (2 million needles exchanged last year), methadone maintenance (in 1999, over 8,000 drug misusers received methadone of which over 3,500 were new to the programme), as well as psychiatric and emergency care. The injecting rooms are aimed at those intravenous drug takers who are the highest risk group, are frequently homeless and the least likely to come within any of the normal social services. No evaluation of the effectiveness of the Madrid programme has been carried out to date.

4.9.5 The Strategy on supply control in Spain involves co-operation with security services across Europe including Europol, combating the internal distribution of drugs through the actions of specialised investigation units and reducing street supply and dealing.

[59] Personal communication from Cabrera Formeiro (head of the Autonomous Region of Madrid's Anti-Drug Agency).

4.10 SWEDEN

4.10.1 The overriding aim of Swedish policy is a "drug free" society. Consequently, the problem of drug misuse is treated primarily as a matter for the criminal justice system as distinct from the social services. The aim is that drugs should never become an integral part of Swedish society and that drug misuse should be regarded as unacceptable behaviour and as a marginal phenomenon.

4.10.2 In Sweden, the overriding aim of the drugs policy crystallises into three sub-goals:

- reducing the number of new drug misusers;
- inducing more misusers to abstain; and
- reducing the supply of drugs.

Sweden takes the view that the essential pre-requisite of a successful drugs policy is for people of all ages to disassociate themselves from drugs and drug misuse. With this objective in mind, the main purpose of information provision in Sweden is to re-enforce public hostility to drug misuse. In this context, school programmes have a crucial role to play and the school curriculum requires every school to draw up a special action plan for alcohol, narcotic drugs and tobacco instruction. School programmes are re-enforced by generic or targeted information campaigns.

4.10.3 In Sweden, all non-medical usage of drugs is unacceptable. As a result, Sweden takes a restrictive position on methadone maintenance treatment and needle exchange programmes. For example, methadone maintenance is strictly controlled under rules defined by the National Board of Health and Welfare and the number of patients may not exceed 600.[60] By international standards, however, Sweden has an unusually small proportion of heroin misusers, as heavy drug misuse is generally dominated by stimulants such as amphetamines. The 2000 EMCDDA Report indicates that Sweden has one of the lowest national prevalence estimates for problem drug use in the EU. More specifically, the percentage of clients admitted for treatment for opiate use in Sweden is also among the lowest in the EU.[61]

4.10.4 Persistent drug misusers, who are likely to harm themselves seriously, can be admitted into care against their wishes as a form of compulsory restraint. Therapeutic approaches in Sweden cover the range of psychotherapeutic and sociotherapeutic interventions in residential and outpatient environments. As Swedish drug policy is primarily concerned with preventing the spread of drug misuse, supply is looked upon as a grievous offence. Over the years the list of offences and penalties has been expanded and augmented.

[60] A Preventive Strategy – Swedish Drug Policy in the 1990's, The Swedish National Institute for Public Health 1998:21 & Fact Sheet No.4 March 1999, Ministry of Health and Social Affairs, Sweden.

[61] European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2000) Annual Report on the State of the Drug Problem in the European Union, 2000.

4.11 SWITZERLAND

4.11.1 Swiss drugs policy is predicated on a four pillars model: prevention; therapy and re-integration; harm reduction and repression and control. Complementary measures such as information dissemination, research and evaluation, epidemiology and co-ordination and co-operation between differing agents support these pillars. The goals of Swiss drugs policy are:

- to decrease initial drug misuse and avoid evolution towards addiction;
- to help misusers overcome addiction;
- to improve the living and social conditions and health of drug misusers; and
- to inhibit trafficking and supply.

4.11.2 The concept of prevention in Switzerland is very broad and encompasses both primary and secondary prevention. As such, it recognises the linkages between prevention and treatment and between the consumption of legal and illegal drugs and considers community participation in prevention activities to be vital. The Swiss framework for prevention includes schools, local authorities, sports facilities and organisations and youth associations. The exercise of prevention activities is, as a rule, delegated to local agencies.

4.11.3 Swiss drug policy, in the fields of therapy and treatment, aims to promote abstinence where possible and to foster the social and psychological health of those who remain dependent. Therapies are differentiated and attuned to individual needs and are carried out in residential settings, outpatient facilities and prisons. Outpatient treatments include methadone substitution programmes and the prescription of heroin under medical supervision. Harm reduction covers activities to improve the medical and social conditions of those most heavily addicted. Actions taken to uphold this aim include social support, involving the provision of employment and housing; health care, where needle exchange programmes and sterile injecting environments play a part and prison projects.

4.11.4 In relation to heroin prescription in Switzerland, evaluations have been mixed. The results ascribed to this programme include: (i) better retention and compliance rates when compared to injectable morphine and methadone; (ii) improvements in physical health; (iii) diminished use of illicit heroin and cocaine; (iv) better housing and fitness for work; (v) decline in contact with drug misusers and the drug scene and (vi) a decrease in income from illegal and semi legal activities.[62] A study of the Swiss programme urged the continuation of heroin-assisted treatment provided it was confined to and directed at, an appropriate target group and was delivered in suitably equipped and supervised outpatient clinics.

4.11.5 However, the report of an external evaluation[63] on the Swiss study was more sceptical. The Report of the External Panel concluded that:

- it was medically feasible to provide an intravenous heroin treatment programme under highly controlled conditions where the prescribed drug is injected on site, in a manner that is safe, clinically responsible and acceptable to the community; and
- participants reported improvements in health and social functioning and a decrease in criminal behaviour and in reported use of illicit heroin.

Nevertheless, the External Panel felt there was a need for continued scepticism about the specific benefits of one short acting opioid over others and that there was a need for further studies to establish objectively the differences in the effect of these different opioids. This scepticism was predicated on the view that the Swiss studies were not able to determine whether improvements in health status or social functioning in the individuals treated were causally related to heroin prescription per se or a result of the impact of the overall treatment programme.

[62] Uchtenhagen, A., et al. (1999) *Prescription of Narcotics for Heroin Addicts: Main Results of the Swiss National Cohort Study.*

[63] Ali, R. *et al* (1999) Report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts, Executive Summary, p. 1.

4.12 SUBSTITUTION TREATMENTS IN THE EUROPEAN UNION

4.12.1 While methadone remains the dominant treatment type in many European countries, including Ireland, Table 4.1 indicates the range of alternative treatment types that are now being employed across Europe :

Table 4.1 – Substitution Treatments in the EU*

Country	Methadone Treatment Introduced	Introduction of other substitution substances (a)
Belgium	1994	Occasional use of buprenorphine(b), dihydrocodeine
Denmark	1970	Buprenorphine (b,c) and LAAM (both 1998) (c)
Germany	1992	Dihydrocodeine (1985), heroin (1999)(c), LAAM (1999), buprenorphine (2000) (b)
Greece	1993	No other substance prescribed
Spain	1983	LAAM (1997)
France	1995	Buprenorphine (1996) (b)
Ireland	1970	No other substance prescribed (e)
Italy	1975	Buprenorphine (1999) (b,c)
Luxembourg	1989	Dihydrocodeine (1994) (c), Mephenon® (d)
Netherlands	1968	Heroin (1997) (c)
Austria	1987	Slow-release morphine (1997), buprenorphine (1997) (b,c)
Portugal	1977	LAAM (1994) (c)
Finland	1974	Buprenorphine (1997) (b)
Sweden	1967	No other substance prescribed
UK	1968	Buprenorphine (1999) (b)

Notes: Methadone remains the dominant treatment type in most European countries.

(a) Dates refer to the year the political decision was taken to prescribe the substance.

(b) Buprenorphine is in the form of Subutex® and not Temgesic® as this only contains small amounts of the substance.

(c) Trial only.

(d) Date not known.

(e) Consultant Psychiatrists who are responsible for the clinical management of drug misuse services in the ERHA, where the majority of opiate misusers reside, are examining the potential of alternative products for use in the treatment of drug misusers, bearing in mind the possible side effects of these products.

*Source: EMCDDA 2000 Annual Report on the State of the Drugs Problem in the European Union.

4.13 OVERALL COMMENTS

4.13.1 Strategies in the countries reviewed for dealing with drugs issues fall, broadly speaking, into two camps: Firstly, those that focus on the needs of the drug misuser as a citizen in society with rights, entitlements and responsibilities – the so-called humanistic approach – and, secondly, those that place the primary, but not exclusive emphasis, on the criminality associated with drug importation, trafficking, supply and, in certain circumstances, use. While international debate has, to some extent, tended to be polarised around those respective extremes, it would be wrong to conclude that they are absolutes. Countries with a humanistic perspective have vigorous policies to combat drug supply at all levels, while those with a more restrictive approach have, in varying degrees, education, prevention and treatment and rehabilitation programmes as components of their national policies. In both approaches there is, therefore, a range of interventions employed to tackle the problem.

4.13.2 One of the most controversial interventions in the harm reduction field that arose in the study of the strategies reviewed was the provision of heroin prescription and/or injecting rooms as described in Switzerland, the Netherlands and Spain. As outlined in this chapter, the evaluations of these experimental treatments have either not yet taken place (Netherlands and Spain) or are mixed (Switzerland) and, therefore, there is a need for further evaluation and continued research to establish objectively the benefits of such treatments. In this context, the Review Group is also cognisant of the opposition of the International Narcotics Control Board (INCB) – who is responsible for overseeing and monitoring international policy in relation to international drug controls – to such forms of treatment. The INCB is responsible for overseeing and monitoring international policy in relation to international drug controls.

4.13.3 Given Ireland's international obligations in this regard, the Review Group does not consider that the introduction of such forms of treatment is warranted at this time. However, the situation should be kept under review and the results of research, both national and international, should be monitored.

[62] INCBReport 1999, Pgs 26, 27 & 60.

Chapter 5

overview of issues emerging from the public consultation process

5.1 INTRODUCTION

One of the most striking features of the extensive public consultation process carried out by the Review Group, was the mature and deep level of understanding of the nature of the current drug problem and the burden it places on individuals, their families, communities and society. However, this should not be confused with any broader acceptance of drug misuse. The consultation process was, by and large, free of moral or ethical discussions on the rights and wrongs of drug misuse or associated issues about freedom of choice. Both the public fora and the submissions made by state agencies, the voluntary and community sectors, individuals, user groups, families of drug misusers and professionals working in the areas of prevention, treatment and rehabilitation and enforcement, made it very clear that drug misuse is a societal ill because it causes harm, which permeates throughout all levels of society. Discussions throughout the public consultation process were very wide-ranging and the main issues emerging in the context of the terms of reference for the Review are outlined in this Chapter under the headings of:

(i) supply reduction;

(ii) prevention (including education and awareness);

(iii) treatment (including rehabilitation, and risk reduction); and

(iv) co-ordination.

5.2 SUPPLY REDUCTION

The main issues raised regarding supply reduction fell under the broad headings of:

- Legislative and judicial Issues;
- Garda Role; and
- Prisons.

Legislative and Judicial Issues

5.2.1 The vast majority of submissions were supportive of the current legislative framework, but there was a perceived leniency in relation to the sentencing of drug traffickers. In addition, it was felt that An Garda Síochána may need to devote additional resources to targeting medium and larger dealers.

5.2.2 There was strong support for the concept of a Drug Court and for its potential extension depending on the outcome of the initial pilot phase. There was commentary on community and voluntary sector involvement in the new structures and on the dangers of the Drug Court being perceived as a “fast track” to methadone treatment.

5.2.3 Throughout the consultation process, there was consistent recognition of the success of the CAB and a recurrent suggestion that consideration be given to introducing more localised CABs. It was also suggested that assets seized by the CAB should be dedicated to the provision of prevention and rehabilitation programmes in the communities in the areas most affected by the drugs problem.

5.2.4 There was a widespread feeling that those aged under 18 should not be prosecuted for drug possession offences, rather they should be referred to the relevant support agency. There were also concerns that, at present, the sentencing regime is inconsistent. At the opposite end of the spectrum, there were a small number of submissions which advocated a "zero tolerance" approach to all drugs and who argued that the perceived primary focus on methadone maintenance within current policy was an expression of the State's tacit acceptance of drug misuse.

5.2.5 Finally, a small number of submissions debated the potential impact of decriminalisation for possession of small amounts of cannabis or the use of discretion by the Gardaí in arrest procedures. Decriminalisation of the possession of heroin for personal use was also mentioned as a measure that might enable resources currently allocated to imprisonment to be spent on treatment and rehabilitation. There were also a small number of submissions which referred to heroin prescription and the provision of heroin injecting rooms.

An Garda Síochána

5.2.6 There was general consensus that those involved in illicit drug dealing should be the main focus of Gardaí activities and, in this regard, it was suggested that known dealers should be targeted. Furthermore, while there was considerable support for the Gardaí and recognition of their successes to date in reducing the supply of drugs, there was also concern that drug dealing was still occurring openly on the streets, particularly in disadvantaged areas. The need to increase the resources devoted to supply control was emphasised. The success of Community Policing Fora (CPF), where they are in existence, was commended and there was a strong view that this form of co-operation should be extended. In areas where there is an emergent drugs problem, it was suggested that there should be dedicated Garda Drug Units in order to target dealers. In this context, information sharing between the Gardaí, Local Authorities and relevant agencies in different areas was regarded as essential to prevent the movement of dealers throughout the country and the consequent establishment of markets for drugs previously unavailable, or not widely used, in areas outside of Dublin.

5.2.7 The Garda Youth Diversionary Projects were regarded as being generally successful. The view was expressed that these projects create positive links between young people potentially at risk and the Gardaí, which might eventually facilitate a reduction in supply, crime and misuse of drugs. The view was also expressed that the enforcement agencies should work more closely with local communities on collaborative supply control projects.

Prisons Service

5.2.8 The role of the Prisons Service as regards supply control was highlighted throughout the consultation process. While prison clearly impacts on supply control by providing a sanction against drug misuse and drug dealing, it was the perceived under-utilisation of the prison system in the rehabilitation of drug misusers which was the main focus of comment. There was considerable concern that drugs are so widely available within prisons that some prisoners who formerly had not used drugs may come into contact with and start to use drugs for the first time while in prison. Similarly, there were concerns that, while in prison, young offenders come into contact with hardened drug dealers and gain an "education" in drug-related crime which they may use upon release. Both of these factors were regarded as subverting the prisons role in supply control.

5.2.9 There was widespread concern that the prison system is failing to realise its potential, not only in addressing the needs of those who are addicted to drugs through the provision of suitable treatment, but also in the provision of the kinds of counselling, education and training which would impact on the offender's behaviour after release. A related factor was the perceived widespread availability of drugs in prisons and the sense that, if prisoners can maintain drug habits while in prison, there is neither the opportunity nor the incentive to engage in rehabilitation programmes.

5.2.10 The issue of more community and voluntary involvement in prison structures in order to ensure that there is a continuity of care within the community for the offender post-release also arose. However, there was also acknowledgement of the possible operational implications of such involvement.

5.3 PREVENTION

Education

5.3.1 Consolidation of measures to counter early school-leaving, especially in the LDTF areas, was regarded as a priority issue. Similarly, the need to provide pre-school supports for children who are at risk and who may well drop out of the school system before they can fully benefit from the existing programmes was identified. The imperative to involve parents in school drugs education programmes was also identified, not withstanding the difficulty of engaging the parents of children who are most at risk.

5.3.2 Overall, there was general support for "Walk Tall" and "On My Own Two Feet" Programmes in schools. However, there was some concern that the material used may need to be reviewed to ensure that it is still culturally relevant, age appropriate and it was suggested that they should, perhaps, incorporate a spiritual dimension. The need to implement these programmes immediately, particularly, in all schools in the Task Force areas was highlighted in a number of submissions, as was the need to provide drug prevention materials for third level students.

5.3.3 It was suggested that the Department of Education and Science should have a role in drafting guidelines to assist schools in developing a school drugs policy.

Prevention

5.3.4 There was widespread recognition of the link between disadvantage and problematic drug misuse and consequent support for measures designed to counter disadvantage. The need for these policy measures to be targeted – in a concerted manner – at those communities where both disadvantage and drug misuse are most prevalent, through mechanisms such as the Integrated Services Process (ISP), was also highlighted.

5.3.5 A recurring theme was the role of the family in prevention. Parental attitudes and behaviours to alcohol and drugs were regarded as having a significant impact on their children's attitude to drug taking. Indeed, there were strong concerns expressed at many of the fora, particularly those held outside of Dublin, in relation to the amount of alcohol being consumed by young people and the potential that such drinking has to lead young people into drug misuse. Reference was also made to the wider difficulties experienced by parents who may not have the necessary time to devote to the supervision of their children or who do not have the necessary knowledge and skills to address drug-related issues. Provision of parenting skills, particularly for at risk families and of drug prevention education for children were identified as mechanisms for overcoming these difficulties.

5.3.6 There was significant recognition of the role of sport and recreation in drug prevention and there was quite widespread support for the YPFSF. The continued need for a wide range of recreational activities to be made available was highlighted. There was a need to provide funding for activities which will appeal particularly to young people who would not typically become involved in mainstream sporting activities. Key target groups identified included Traveller children, early school-leavers and homeless youth.

Awareness

5.3.7 There was strong support for a national media awareness campaign, but a degree of scepticism about the use of shock or scare tactics in such campaigns. As an alternative, the potential for using popular culture and key media figures to endorse an anti-drugs message was highlighted. It was suggested that, prior to the initiation of an advertising campaign, young people, especially within the communities where drug misuse is most prevalent, should be consulted about possible content. Moreover, a review of the campaigns, which have been "rolled out" in other countries, should be conducted. The need for corresponding ancillary campaigns – using a variety of media and targeted at specific groups, including existing drug misusers and other at risk groups – was also expressed.

5.3.8 There was a strong sense that alcohol and drug misuse were related in Irish society. The view was expressed that there needs to be greater awareness, particularly amongst parents and young people of the association between these types of abuse.

5.3.9 At a general level, there was support for the generation of an easily accessible data source of all local and national support services available to those who are either using or "experimenting" with drugs. Communities which are currently relatively unaffected should have access to such a data source which would help identify a drugs problem as it emerges.

5.3.10 There was considerable concern expressed about the way in which drugs issues are presented in the national media. To address this, it was suggested that there should be a source of accurate, unbiased information available to the media and that there should be greater journalistic responsibility in the reporting of drugs issues. The stigmatisation of drug misusers in some sections of the national press was regarded as being unhelpful to the goals of generating community support for the provision of treatment and rehabilitation services.

5.3.11 It was felt that there was very limited involvement of the corporate sector in the consultation process. However, this sector was identified as having a role to play in the sponsorship of awareness activities. There was also a suggestion that the corporate sector may need to become more aware of drug misuse amongst employees and, particularly, amongst young professionals.

5.4 TREATMENT

The importance of treatment and rehabilitation, including risk reduction, in the context of a National Drugs Strategy, was widely acknowledged in the consultation process.

Treatment

5.4.1 The need for the provision of a comprehensive range of drug treatment options was a critical component in a number of submissions relating to treatment. Throughout the consultation process, the need to expand the treatment options available was highlighted strongly, as was the need to endorse holistic patient care to include a wide range of services for the drug misuser. The continuum of care philosophy was identified as an important approach, whereby drug misusers could eventually attain a drug-free lifestyle. Moreover, providing an adequate treatment service to all drug misusers, within an acceptable time period, was a consistent demand.

5.4.2 Where the current strategy has focused on the development of a range of responses to the heroin problem in the eastern region of the country, a number of submissions suggested that there is a need to consolidate and further develop treatment options aimed at a range of addictions and types of drug misuse. The need to expand the current response to include all illicit drugs, as well as alcohol and prescribed medication, emerged repeatedly throughout the consultation process.

5.4.3 Methadone maintenance received a mixed response in the submissions, as well as among the participants at the consultation fora. Those submissions in favour of methadone as a means of treatment acknowledged its effectiveness in reducing drug misuse, drug-related disease and drug-related crime *etc.* However, the need to clarify the role of GPs in the provision of drug treatment was highlighted, particularly as regards the perceived slow growth in GP involvement since the introduction of the Methadone Treatment Protocol. Reducing the current waiting lists to increase the accessibility of methadone maintenance emerged as a key issue. On the other hand, a number of submissions were opposed to the concept of methadone maintenance as a means of treatment. The point was made that methadone maintenance was keeping misusers within the user environment, with little focus on attaining a drug-free lifestyle. In this context, treatment as a medical response and not a behavioural response, was questioned. Broadly speaking, there was a perception expressed at the fora that there was a general lack of understanding about the objectives of methadone maintenance.

5.4.4 Throughout the submissions, reference was made to the Methadone Treatment Protocol which was implemented in 1998, as well as the need now for a protocol on the prescription of benzodiazipienes. The perceived emergence of poly-drug use was a cause for concern in a number of submissions, as was the risk of methadone becoming a "street" drug.

5.4.5 Throughout the consultation process there was consistent agreement about the need for treatment services which were aimed specifically at young people, *i.e* those under 18 years. This was considered to be an important priority for the new Strategy. The overall perspective envisaged a comprehensive range of geographically accessible treatments targeted directly at young people. The importance of addressing the needs of young drug misusers, in the context of the family, was also highlighted.

Rehabilitation

5.4.6 Local, community-based support systems were identified as an integral aspect of rehabilitation, particularly, the role of the FÁS Community Employment Programme for recovering drug misusers. The general lack of residential care facilities was also highlighted in the context of providing a managed environment of care. The need for increased funding for existing facilities, as well as the provision of additional aftercare facilities, in the form of half-way houses was outlined in a number of submissions. The potential to engage Prison Officers in the delivery of counselling and rehabilitation programmes was identified, as was the need to adequately resource the Probation and Welfare Service, both within the Prisons Service and in the broader community.

5.4.7 The development of comprehensive rehabilitation services within prisons was identified in the submissions as an opportunity that should be further utilised in order to restore misusers to a drug-free lifestyle. The point was made that, in order to provide such services, an expansion of staff, particularly medical and counselling staff, was a necessary condition.

Risk Reduction

5.4.8 The submissions and participants in the consultation fora expressed repeated concern about the need for harm reduction measures in the overall provision of drug treatment services. Although it was acknowledged that the spread of drug-related diseases has been controlled somewhat in Ireland, the need to minimise the spread of such diseases, in particular Hepatitis C, through the increased use of needle exchange facilities was identified in a number of submissions. However, the absence of a proper national system for needle and syringe exchange emerged as a perceived gap in the treatment services, the overall perception being that a properly planned and co-ordinated needle exchange service would have a positive effect on drug taking practices. Concern about reducing the proportion of injecting drug misusers also emerged in the submissions.

5.5 CO-ORDINATION

Co-ordination

5.5.1 The need for greater co-ordination within and between agencies was, perhaps, the most common theme throughout the consultation process. There was a perceived lack of clarity about the structures charged with the delivery of national drugs policy. In this context, there was significant support for the need to adopt a more co-ordinated approach at Departmental level. There was also a recurrent suggestion that the Department of Social, Community and Family Affairs should be represented on the IDG and the NDST.

5.5.2 The appropriateness of vesting responsibility for overall co-ordination of the National Drugs Strategy in the Department of Tourism, Sport and Recreation was questioned. The view was expressed in a small number of submissions that responsibility for the Strategy should be vested elsewhere *e.g.* the Department of the Taoiseach or the Department of Health and Children.

5.5.3 As regards mechanisms to improve interagency co-ordination, it was suggested that an ISP style approach should be used to facilitate greater co-ordination between agencies, even though increased co-ordination would require additional time, training of staff and expenditure on the necessary information technology. There was some concern that statutory representatives were not receiving the necessary support from their parent Departments or Agencies to enable them to deal with the additional workload required to ensure co-ordination in the day-to-day delivery of responses.

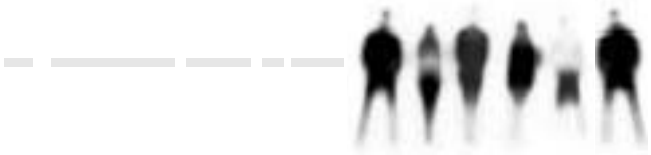
5.5.4 There was widespread support for the role of the community and voluntary sectors in the delivery of the current Strategy based on experience in the LDTF areas and for structures which harness the activities of these sectors to national and strategic goals. Most commentary on the community and voluntary sectors related to the role of these sectors in the LDTF areas. A key concern was the need to ensure that community and voluntary sectors representatives on LDTFs remain truly representative of their constituencies. In this context, it was suggested that community representatives should be elected on to Task Forces by the local community and should serve for a defined period. The need to establish mechanisms through which community opinion can be channelled on a regular basis to the community representative was highlighted. However, the potential intimidation of individuals who are seen to be involved in efforts to curtail drug dealing was also identified.

5.5.5 During the consultation fora, there was some discussion about the merits of the various approaches which had been adopted by the community and voluntary sectors outside the Task Force areas. Notwithstanding this, there was concern that community and voluntary sectors projects outside of the LDTF areas are operating in a policy vacuum and, as such, are responding to perceived local needs, rather than complying with the overall goals of a national policy. As a result, there was some concern about duplication of effort at local level and some more serious anxieties about the quality of project delivery. It was suggested that criteria for the delivery of treatment, rehabilitation, education and awareness projects be established and that all projects – while being responsive to local needs – should also demonstrate compatibility with these criteria prior to receipt of funding. There was also the related concern that such criteria should be developed in co-operation with the community and voluntary sectors to ensure that they have the necessary flexibility to enable an appropriate response to be delivered locally. It was suggested that, as a quality control mechanism, all projects should be subject to external evaluation after a pre-determined interval.

5.5.6 Finally, many community and voluntary project promoters felt that they were dedicating disproportionate resources to researching and accessing funding sources. It was also felt that the duration of funding cycles should be lengthened in order to give projects a realistic opportunity to achieve their objectives.

Part II

Towards a New Strategy 2001 – 2008



Chapter 6

6.1 INTRODUCTION

6.1.1 Following the foregoing review of national and international drug strategies, the Review Group has reached a number of conclusions which are set out in this chapter.

6.1.2 Despite on-going efforts by Governments around the world to deal with problem drug use, no single universally acceptable effective response model has emerged. In Ireland, the Government's approach to tackling the drug problem has developed around the four pillars of supply, prevention (including education and awareness), treatment (including rehabilitation and risk reduction) and research. This approach incorporates, more or less, the full range of activities which are the hallmarks of modern drugs strategies in other jurisdictions studied by the Group. Central to the Irish approach has been the bringing together of key agencies, in a planned and co-ordinated manner, to develop a range of appropriate responses to tackle drug misuse, not just in relation to the supply of drugs but also in providing treatment and rehabilitation for those who are addicted, as well as developing appropriate preventative strategies. The current strategy has been further enhanced by the growing involvement of the community and voluntary sectors and by the ever increasing effectiveness of international co-operation in areas such as supply control and research.

6.1.3 An important element of the overall response has been the work carried out by the 14 Local Drugs Task Forces in the areas worst affected by problem drug use. The principal strength of the Task Forces is that they allow local community and voluntary groups to work hand in hand with the State agencies in responding to the drug problem in their areas. The Task Forces provide a range of drug programmes and services in the areas of treatment, rehabilitation, awareness, prevention and education and they are currently updating their local action plans for the next three years. The setting up of the Local Drugs Task Forces has been a positive development and is generally regarded as an effective mechanism for tackling the drug problem.

6.1.4 While the Review Group recognises that much remains to be done, there are encouraging signs of progress in recent years, which suggests that the current approach to tackling the drug problem is proving to be effective. Huge strides have been made in providing treatment for those who are dependent on drugs. In particular, there has been a very significant degree of activity and expansion in the services provided by the ERHA over the past five years – where the majority of heroin users reside – resulting in "probably one of the most innovative community drug service programmes in Europe."[65] This has resulted in a major expansion in the numbers on methadone maintenance – from under 1,400 in 1995 to over 5,000 at the end of 2000. The number of treatment locations has risen from 21 at the end of 1997 to 55 at present, a very significant achievement given the strong community opposition to the location of these centres in many areas. There is also a relatively high level of provision of in-patient and residential rehabilitation services in Dublin.

[65] Farrell *et al.*, op cit.

In addition, there have been significant developments in the delivery of services to drug misusers through GP and pharmacy-based services in the past five years. Currently, there are 216 pharmacies and 157 GPs participating in the methadone protocol, the highest number since its introduction in 1998.

6.1.5 The importance of moving drug misusers currently in treatment towards full rehabilitation and re-integration into society is widely recognised. In this context, over 800 stabilised drug misusers are currently participating in a specially designed FÁS Community Employment Programme which offers them counselling, training and other necessary supports. It is also very encouraging to note the number of drug misusers on methadone maintenance who are finding employment. In 2000, a study found that a number of clinics informally reported that around 40% of those on methadone programmes were returning to work. In this context, it is worth noting that rates of 30% are considered remarkable by international standards.[66]

6.1.6 There have also been a number of other significant achievements in recent years :

- over 120 of the original LDTF projects have now been mainstreamed and the Task Forces are currently updating their plans for the next three years;
- the NACD, which was established in July 2000, is overseeing a three year prioritised programme of research and evaluation on the extent, nature, causes and effects of drug misuse in Ireland;
- over 340 projects are being developed as part of the YPFSF, in recognition of the important role that diversionary activities, such as involvement in sport and recreation, can have on young people at risk of drug misuse;
- a joint policy on prison-based drug treatment services has been agreed between the Prisons Service and the ERHA and is being implemented at present; and
- a pilot Drug Court has been set up in the North Inner City of Dublin which will provide opportunities to divert people away from the criminal justice system into alternative and more effective treatment and rehabilitation programmes.

6.1.7 Given the complex nature of drug misuse, the Review Group recognises that it will take time for many of these measures to make a significant impact on the problem. However, the Review Group believes that the present approach provides a ***solid foundation*** from which all those involved in trying to tackle the problem should work for the future. The new Strategy should, therefore, ***endorse*** the existing approach and should expand and strengthen the pillars and principles which underpin it.

[66] Farrell *et al.*, op cit.

6.1.8 The Group believes that the current Drugs Strategy would be further strengthened if all the State Agencies involved in its delivery specify annual targets in terms of outputs and desired outcomes for their respective programmes and initiatives. This should be agreed with the IDG, in consultation with the NDST, and used as a benchmark for performance review on an annual basis by the Cabinet Committee on Social Inclusion. Such a development would sharpen the focus of the Strategy and bring further clarity to its aims and objectives for service providers, drug misusers and the public at large.

6.1.9 The Group welcomes the Government's positioning of the National Drugs Strategy within the wider social inclusion policy and the strong commitment to areas of disadvantage in the National Development Plan 2000-2006. The Group fully recognises that, notwithstanding the obvious benefits for communities affected by the drugs problem of having a specific drugs strategy, the best prospects for these communities, in the longer term, rest with a social inclusion strategy which delivers much improved living standards to areas of disadvantage throughout the country.

6.1.10 Set out below are the Group's conclusions from its review of the individual pillars that constitute the current strategy. Out of these conclusions, the Group have developed ***100 individual actions*** which are designed to build on the existing approach and drive the new strategy forward.

6.2 SUPPLY

6.2.1 Law enforcement and interdiction are crucial elements of the national drugs strategy. The Review Group considers that law enforcement resources should continue to be targeted at disrupting the activities of organised crime groups as there is ample evidence that the same organisational networks involved in drug trafficking also engage in other forms of illegal activity. Consequently, interventions that reduce several forms of crime are more likely to be cost-effective.

6.2.2 The Review Group found that international co-operation in measures to reduce supply is important particularly for the following reasons:

- as drug dealers are increasingly mobile and drug dealing takes place within an international context, co-operative efforts are critical to the effective detection and prosecution of major dealers;
- it reflects society's interest in curtailing drug misuse within national boundaries and also signifies a willingness to assist other countries in their efforts to reduce supply; and
- parties to international agreements can benefit from working with each other to control supply.

6.2.3 Ultimately, individuals involved in the trafficking of illegal drugs should be aware that there are effective national and international sanctions against such action and that the Irish enforcement agencies have both the full support of their international partners and the appropriate resources to detect and prosecute drug traffickers. Ireland should continue to work proactively towards the consolidation and enrichment of existing international co-operation mechanisms, with particular emphasis on co-operative actions with Ireland's EU partners, in particular through the new European Crime Prevention Network.

6.2.4 As regards legal issues, the Review Group noted that substantial progress has been made in recent years in terms of legislation dealing with drug-related crime. In fact, the success of the Criminal Assets Bureau (CAB), in tackling the twin menaces of drugs and organised crime, has been recognised at a national and international level and this was highlighted repeatedly through the public consultation process. That said, the point was made consistently during the course of the review that no matter how good the legislation, it must continue to be implemented if it is to be effective.

6.2.5 A principal role of the law enforcement agencies is to dissipate the influence of criminal groups. The Review Group considers that community oriented policing strategies can play a vital role in this regard. The criminal justice system contributes to a reduction of crime, not only by reactive policies of detection and punishment of offenders, but also by preventative policing policies in partnership with community groups. The Review Group also noted that local information is an essential component of the drug control activities conducted by the enforcement agencies. The strengthening of relationships between the community and law enforcement agencies and the development of mechanisms for sharing information are core elements of supply reduction. Over recent years, successive Garda operations, as well as the development of programmes of estate management, have inhibited open drug-dealing. The Review Group concluded that these developments must be sustained and safe mechanisms for individuals and communities to actively co-operate with the enforcement agencies must be developed in order to reduce supply radically. Individuals, families, communities and a range of statutory and non-statutory agencies each have a role in curtailing the amount of illicit drugs in circulation.

6.2.6 The Prisons Service is another critical element of the supply reduction "pillar". The threat of imprisonment is both a sanction against and a punishment for, involvement in supply activity. The imprisonment of drug dealers is critical to the disruption and eventual destruction of established drug markets. Prison can also play an important role in the rehabilitation of offenders, however, the Irish Prisons Service has suffered capacity constraints which have inhibited the development of an integrated drugs policy within the Service. This is being addressed by the Department of Justice, Equality and Law Reform, which in addition to the 1,000 additional places provided in recent years has plans for 1,000 more.

6.2.7 The Review Group welcomes the Report of the Steering Group for Prison-Based Drug Treatment Services, which has been approved in principle by Government and is now being implemented. Prisons should aim to equip prisoners with the necessary social and vocational skills to reject drug dealing post-release. Clearly, the success of such initiatives is contingent on the provision of ancillary supports in the form of housing, social welfare supports and employment opportunities when the offender returns to his or her community. In addition, the Group welcomes the involvement of the community and voluntary sectors in liaison meetings with the Prisons Service and feel that this role should be expanded.

6.2.8 In common with all elements of the National Drugs Strategy, the activities under the supply reduction pillar should be subject to regular evaluation.

6.3 PREVENTION

6.3.1 Reducing the demand for drugs is central to Irish drugs policy and it is clear that such demand reduction activities must be continued and reinforced. In this regard, most recent literature points to the need for comprehensive demand reduction strategies which include programmes that:

- seek to strengthen resilience amongst young people in or out of school by fostering positive stable relationships with family or key community figures especially in the early years, thereby, enhancing their sense of belonging to family or social group or locality and increasing their educational and training opportunities and employment prospects;
- are cognisant of the complexity of youth culture and which can effectively influence young people's choices in relation to drug misuse;
- seek to increase the community's understanding of the antecedents of drug misuse and effective interventions to reduce harm;
- link drug-specific interventions with interventions in related areas such as youth crime prevention and mental health promotion strategies, employment, education and training initiatives; and
- maximise the effectiveness of school-based programmes through efforts to keep young people engaged in school and the identification and provision of supports for at-risk children, management of drug-related incidents and a broad-based curriculum which supports all aspects of the child's development.

6.3.2 A considerable component of Irish drug policy has evolved as a direct response to the on-going heroin problem. The opportunity afforded by the Task Force process to address this problem has facilitated the implementation of a more proactive Strategy, of which prevention is a key component. That said, there is considerable debate on the efficacy of different preventative approaches and, undoubtedly, current responses will need to be augmented as a greater understanding of the circumstances in which people become involved in drug misuse emerges, particularly the strong correlation between early school leaving and drug misuse.[67]

6.3.3 As well as effective drug specific prevention strategies, tackling poverty, better housing, access to educational opportunities, supportive environments for parents and employment prospects, all have a role to play in prevention and management of drug misuse and drug-related harm. In this regard, the efficient and effective implementation of the YPFSF and other targeted local development initiatives will be critical to the future success of the National Drugs Strategy. There is a need to develop an inclusive approach which aims to ensure that young people are afforded opportunities for well-structured leisure activities and that these activities have good levels of appropriate adult supervision included within them.

6.3.4 As regards awareness, while the Review Group's research analysis indicates that problematic drug misuse is more closely associated with certain groups and communities than others, evidence of growth in drug misuse nation-wide, in particular amongst young people, indicates that throughout Irish society, children, professionals, families, employers and a range of high-risk groups are increasingly exposed to drug misuse and drug-related harms. As drug education programmes have only been delivered in schools by the Department of Education and Science since 1995, there still is a large section of the population who have never received any formal education about drugs.

[67] Data in Chapter 2 show that over half of those presenting for treatment for problem drug use had already left school by the age of 15 years. Over three quarters of the clients presenting for treatment left school by the time they were 16 years old.

6.3.5 Misinformation, or a lack of information, undermine investment in harm reduction measures and can also contribute to the stigmatisation of the individual drug misuser and his or her family. It is, therefore, imperative that Irish people become more aware of the risks associated with drug taking, the nature of drug misuse and the supports and services which must exist to minimise harm.

6.3.6 A National Awareness Campaign to highlight the facts about drug misuse should be put in place, which would aim to facilitate informed, open and constructive discussion on approaches to drug prevention. A multi-media approach that will raise visibility of drug misuse among young people and other vulnerable groups is advocated. The approach should take account of previous campaigns which suggest that young people do not respond positively to a simplistic "Don't Take Drugs" message. Experience in other countries would also suggest that awareness campaigns around drug misuse need to be sustained over a prolonged period in order to have the maximum impact on the target audience. Other elements of international campaigns have included targeting the drugs of first use as a key to longer-term prevention and demand reduction strategies, information and help for parents, teachers, sports coaches *etc.* and the maintenance of a consistent message through the co-ordination of media efforts with other initiatives in schools and communities.

6.3.7 While there is considerable debate evident in the international literature about the efficacy of school programmes,[68] there was strong support throughout the consultation process for the need to implement school-based programmes as "a first line of defence" as individuals are experimenting with and becoming addicted to drugs at an earlier age. Initial evaluations of such programmes are favourable but comprehensive longitudinal studies are required. Notwithstanding that, it is essential that current programmes are supported fully and implemented effectively in all schools.

6.3.8 The Review Group acknowledges that issues involved in the design of schools drug policies are complex. On the one hand, schools must minimise the dangers caused to children by drug misuse and drug misusers within schools and on the other, neither parents nor students should be afraid to ask schools for help in addressing drug misuse. Nevertheless, the Group feels that such policies should be developed and that there should be a range of measures available in cases where students are misusing drugs. It is noted that the ultimate sanction of expulsion can have the effect of alienating a student from mainstream sources of help and may result in the student becoming more involved in the culture of drug misuse.

6.3.9 Finally, there is also a requirement to ensure that drug education and awareness programmes are integrated into broader community-based approaches and are reinforced by mass media responses. Although not a central part of the implementation of the National Drugs Strategy, it is felt the media can help foster a broader awareness, which, in particular, can help generate parental understanding of and engagement with, their children about approaches to reducing the risk of drug involvement.

[68] *Handbook on Drug Abuse Prevention: A Comprehensive Strategy to Prevent the Abuse of Alcohol and Other Drugs*, Robert H Coombs and Douglas Ziedonis (eds) 1995.

6.4 TREATMENT

Treatment

6.4.1 The need to progress towards a more fully integrated and holistic treatment service also emerged as a critical element of the consultation process. There are two related components to the attainment of this goal;

- the expansion of the range of available treatment types; and
- the provision of additional treatment places.

Similar to other countries, methadone is the dominant mode of treatment as the current strategic response developed largely as a reaction to the heroin problem. Moreover, links between the treatment and criminal justice fields (including both the courts and prisons) are key priorities to ensure the most effective utilisation of existing resources and the maximum impact of treatment on drug-related crime.

6.4.2 The provision of a comprehensive range of drug treatments has been a critical component of national drug policy over the past decade. Much of this focused on the development of a broad range of responses to the heroin problem in the eastern region of the country and was accompanied by a high commitment to investing in treatment. By the standards of other countries, there is a relatively high level of provision in Ireland,[69] but at present, demand for treatment is still outstripping supply. However, the ERHA is confident that with 6,000 treatment places it could manage the demands on services and significantly reduce or eliminate waiting lists (at the end of December 2000 there were 469 people waiting for treatment in the Greater Dublin area). In this regard, it should be noted that the number of people in treatment is a moving population. At any given time people will be moving to different phases of treatment and rehabilitation, some becoming drug-free. The provision of, say, 6,000 places will cater for a number of patients well in excess of that number. For example a detoxification programme takes around 6 weeks. Therefore 1 detoxification bed will cater for around 8 patients per year. Others can be detoxed on methadone treatment. A proportion of these people will continue to remain drug-free and no longer require a place within treatment services. Some may relapse, however and may need to re-enter the system.

6.4.3 It is important that the level of GP and pharmacy involvement in the provision of treatment programmes is increased. By providing a service in the community in which the drug misuser lives, the GP and pharmacist can aid the stabilisation and rehabilitation of the misuser. In this regard, pharmacists need to be more involved in the overall treatment programme for the recovering misuser as they are in a unique position to identify early on any problems the misuser is experiencing. In addition, increased capacity at the primary care level will have the effect of alleviating the pressure on the secondary care services which are currently over-subscribed.

6.4.4 There is also a need for the continuation of treatments which are proven to be effective and for the broader provision of treatment, particularly in prisons, where, mainly due to capacity constraints, such provision was not previously available. There is also now a need to consolidate and further develop treatment approaches which recognise international evidence-based responses to drug misuse and drug dependency. In particular, the provision of treatment for young people who have begun to experiment with drugs is a matter of urgency. There is also a need to ensure that any further development of services is tailored to demand and that resources are appropriately allocated to the most efficient and effective of these services, based on pre-defined performance indicators.

[69] *Review of Drug Services in the Eastern Health Board Area*, Farrell, Dr M., Buning, E., 1996 states that "The range and pattern of service provision is consistent with most and further advanced than many other European Union member states".

6.4.5 When evaluated by a range of criteria, including outcomes in health, social well-being, economic prosperity and levels of crime, drug treatment proves to be cost-effective. Furthermore, experience has shown that treatment over the longer-term is more cost effective than detention in prison. Accordingly, people with drug problems should be encouraged at every opportunity to enter drug treatment, given the benefits that can accrue to them as individuals, as well as to the general community. For the future, every effort must be made to ensure that treatment is attractive and accessible to all who need and can benefit from it. More attention should also be given to ensuring an assertive follow-up of known users who do not avail of treatment and to supporting the development and operation of mutual self-aid or self-help organisations and services. In these circumstances, all efforts to divert individuals from the criminal justice system into treatment should be explored and further developed. The development of a Drug Court system and the evaluation of this intervention should provide further information on the cost effectiveness and social impact of this particular approach.

6.4.6 In the consultation process it was represented that the use of methadone may be inhibiting the use of alternative treatment types. However, it must be acknowledged that methadone is internationally accepted as one of the most beneficial substitute drugs in the treatment of heroin addiction and is the most evaluated type of treatment.[70] As part of an overall continuum of care for people who are addicted to heroin, methadone has been widely used in Ireland and in most other countries. However, as alternative medical and non-medical treatment types gain ground and as new forms of addiction emerge, there may be a need to expand the range of treatment types available to the drug misuser. In this regard, the Consultant Psychiatrists who are responsible for the clinical management of drug misuse services in the ERHA area, where the majority of opiate misusers reside, are currently examining the potential of alternative products for use in the treatment of drug misusers, while also bearing in mind the possible side effects of these products.

6.4.7 Throughout the consultation process, the most commonly cited substitutes, recommended for use as alternative treatment options, included Lofexidine, LAAM (L- Alpha Methadol Hydrochloride) and buprenorphine. Lofexidine is a non-opioid and can be used to detoxify people who are dependent on opiates. It may be particularly useful in treating young people who are at an early stage in addiction. LAAM is a substitute drug similar to methadone in composition and pharmacological effects. It has a much longer duration of action than methadone (up to 72 hours). However, it should be noted that the European Agency for the Evaluation of Medicinal Products (EMEA) have expressed concerns about possible side effects from its use and are currently advising prescribers not to introduce any new patients to this therapy. Buprenorphine is a semi synthetic opiate and is another form of treatment for heroin and other opiate addiction. It produces less euphoria than heroin. As with all substitute treatments, their applicability to the treatment of heroin misuse in an Irish context should be rigorously evaluated and closely monitored.

6.4.8 Detoxification programmes followed by drug-free residential programmes have been used with varying degrees of success in the treatment of opiate and other forms of addiction. However, to date they have been somewhat overshadowed by the demand-led requirement to eliminate waiting lists for methadone treatment. Expansion of both types of facilities go hand in hand as

[70] Marsch, L.A. (1998) *The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behaviour and criminality: A meta-analysis,* Addiction 93, 515-532.

many residential drug-free facilities require clients to be drug-free on admission. The expansion of residential provision requires a corresponding increase in detox capacity. Delays in accessing detox programmes impact negatively on motivation and the drug misuser may no longer be willing to detoxify when a detox placement becomes available. In this context, there is a clear requirement for increased provision of both residential and detox places, although again it should be noted that by European standards, Ireland has a quite high level of provision. There is also a need to incorporate innovative non-medical approaches to the treatment of a range of addictions[71] where they are found to be appropriate.

6.4.9 The apparent younger age of initiation into drug misuse and dependent drug misuse[72] has created a corresponding need for the development of treatment types catering specifically for the needs of young people under 18 years of age. Furthermore, as part of the National Children's Strategy "Our Children – Their Lives", it is proposed that specialist drug treatment services for the under – 18s will be expanded. Planning of such services should be closely linked to the national profile of drug misuse amongst young people in order to make them relevant to the needs of the young drug misuser. To enable family involvement in the treatment process, ideally, most services should be located in the areas where the drug misuse is occurring and is most prevalent.

6.4.10 While services for young people and adolescents should be linked to existing services, there are strong arguments against services which enable close contact between habitual and younger/newer drug misusers. There were also strong arguments presented in the public consultations against the use of methadone in the treatment of young people. It is important to point out that the treatment of under – 18 years old presents serious legal and other dilemmas for professionals working in the area. Family involvement is regarded as a critical component of the treatment of young people and, consequently, treatment should also include family therapy and community integration phases.

Rehabilitation

6.4.11 Rehabilitation involves the provision of the necessary supports to enable a recovering misuser to attain an acceptable quality of life. Given that patterns of drug misuse and addiction are far from homogenous, there is a need to develop a wide variety of rehabilitation supports, appropriate to each stage of recovery and to the particular needs of the client.

6.4.12 To achieve successful reintegration of the user into his or her community, it is also essential that service providers recognise and attempt to address community concerns about the on-going management of treatment centres and that local communities accept responsibility for ensuring that adequate treatment facilities are provided for drug misusers in their own locality.

6.4.13 The need for half-way houses for recovering drug misusers, who are not already being treated in the community, was highlighted repeatedly during the public consultations and in the submissions to the review. An increased rate of relapse was associated with an immediate return to a drug-taking environment and, in this context, consideration should be given to establishing a network of half-way houses throughout the country.

[71] Transcendental Meditation and Electro-Neuro Therapy, as well as a variety of religious based approaches, were amongst the treatment types highlighted in the consultations.

[72] NDTRS, 1996-1998, Health Research Board.

6.4.14 There is also a need to ensure that recovering misusers have access to housing, training and employment opportunities. Drug misusers are sometimes forced to leave the family home, or otherwise become homeless, through drug misuse. The effectiveness of treatment and the goals of rehabilitation are often undermined by the failure to ensure that recovering misusers have access to accommodation. It is particularly important to ensure that the accommodation needs of misusers availing of residential treatment types are met when the residential phase of the programme is complete. There may need to be closer liaison between treatment providers, counsellors, probation and welfare officers and the relevant local authorities in this regard.

6.4.15 For many drug misusers, the return to employment is a critical stage in the rehabilitation process. However, the often negative stereotyping of former drug misusers can be an impediment to their employment. Consequently, it is considered that FÁS should initiate worthwhile contacts with employers on behalf of drug misusers. Employer organisations, trade unions and key Government Departments and Agencies should work in partnership to develop mechanisms, which would increase employment opportunities for former misusers.

6.4.16 The Labour Inclusion Programme, which is currently being piloted in the Dublin North East Task Force area, is designed to assist recovering drug misusers in obtaining and holding down employment. The Programme is supported by employers and trade unions, as well as statutory, voluntary and community organisations working in the drugs area and provides a range of supports to former drug misusers at a particularly difficult stage in their recovery. It is proposed to evaluate the Programme and, if it is successful, to replicate it in other areas.

6.4.17 Rehabilitation may involve the restoration of important relationships, with family and friends or reintegration to the work or training environment. At an ideological level, the successful rehabilitation of a recovering drug misuser is also contingent on societal attitudes towards drug misusers. Mechanisms that work towards societal and community acceptance of the recovering drug misuser should be developed.

6.4.18 It is difficult to quantify the level of expansion required in current rehabilitation provision, as much depends on the nature of the client's drug misuse and individual circumstances. Notwithstanding this, it seems likely that investment in rehabilitation will make existing treatment regimes more attractive to users and will reduce incidences of relapse.

Risk Reduction

6.4.19 Traditionally, the dominant trend in policy has been towards the achievement of a reduction in drug misuse and the ultimate attainment of a drug–free society.[73] However, the recognised link between drug misuse and the spread of disease has resulted in the need to adopt strategies that reduce the risks posed by such behaviour both to the individual misuser and the wider community. The importance of improving existing mechanisms to reduce drug-related harm emerged as a distinctive theme both throughout the consultation process and in the review of international strategies. In all of the countries surveyed, harm reduction is a considerable component of national strategies. The need to develop and expand existing harm reduction measures and to investigate scientifically-based innovative responses, appropriate to Irish circumstances and consistent with our obligations under international conventions while also taking account of international best practice, is vital for the protection of drug misusers, those they live with and the wider community.

6.4.20 It is important that a significant reduction in the reported level of injecting drug misuse and the rates of sharing injecting equipment is achieved. These are essential elements of containing the spread of HIV and Hepatitis C *etc.* among injecting drug misusers and should also contribute to a decline in the prevalence of these diseases amongst the non-using population. These aims would also be consistent with the objectives set out in the National AIDS Strategy published by the Department of Health and Children in June 2000. Such a reduction will be contingent on continued efforts to enhance harm reduction measures such as needle exchange facilities.

6.5 RESEARCH

6.5.1 An important element of any strategy is the knowledge upon which it is based. The provision of good quality information on the extent and nature of the problem in Ireland should underpin the National Drugs Strategy. In doing so, it would support and inform policy-makers and service providers in drug-related sectors. The issue of research on drug-related issues is one that needs to be strengthened in terms of acquiring comprehensive and comparable data. Indeed, the need for improved research in each of the main themes – supply reduction, education, prevention and awareness and treatment and rehabilitation, including risk reduction – was a persistent theme of the consultation process. Research is essential to enable the dissemination of models of best practice in line with EU and Government policy.

6.5.2 The NACD will play an important role in this regard. The Committee's primary function is to advise the Government in relation to the prevalence, prevention, treatment and consequences of problem drug use in Ireland, based on its analysis of research and information available to it.

6.5.3 The Committee is overseeing the delivery of a three year research programme aimed at addressing the priority information gaps and deficiencies in the area of drug misuse. This programme includes compiling a comprehensive inventory of existing research and information relating to the prevalence, prevention, treatment/rehabilitation and consequences of problem drug use in Ireland. The Committee is also looking at how best to determine the size and nature of the drug problem in Ireland, the effectiveness of existing models and

[73] Peter Reuter and Johnathon P. Culkins American Journal of Public Health (1995;851059-1063) *Redefining the Goals of National Drug Policy.* Recommendations from a Working Group.

programmes in the area of prevention, treatment and rehabilitation and the cost to society of the drug problem. It is essential that the findings of the research, commissioned by the Committee, are disseminated widely in a format which is accessible to all bodies and agencies with an interest in the drugs issue and to the wider community.

6.5.4 The National Drug Treatment Reporting System (NDTRS), which is run by the Drug Misuse Research Division (DMRD) of the Health Research Board (HRB), is the key source of information and research in relation to drugs issues. However, to improve the efficiency and quality of this flow of information, there is a need for all treatment providers to report problem drug use to the DMRD. Within treatment facilities, this will involve the designation of a staff member with specific responsibility for ensuring that all relevant data is returned to the NDTRS. Responsibility for NDTRS data returns should be incorporated into the contracts of medical practitioners working in treatment centres, in general practices and in prisons.

6.5.5 There is also a need to develop an accurate mechanism for recording the number of drug-related deaths in Ireland. At present, drug-related deaths are recorded by the General Mortality Register (GMR) of the Central Statistics Office, based on the ICD code system.[74] Other countries have developed dedicated systems for recording drug-related deaths and it is important, for the purposes of comparative analysis, that the Irish system is capable of generating an equivalent level of information. In the short term, however, there should be a focus on improving the data collection process leading up to the recording of a drug-related death.

6.6 CO-ORDINATION

6.6.1 The public consultation process indicated a lack of clarity in relation to structures and the respective roles involved in the development and implementation of our national drugs policy. Chapter three of this Report outlines the current structures and a number of actions are recommended, particularly in relation to individual remits, that would provide greater clarity across structures for service providers and the wider public alike.

6.6.2 Some of the submissions raised, as a matter of some concern, the location of lead responsibility for co-ordination of the National Drugs Strategy in the Department of Tourism, Sport and Recreation. The Review Group found that in the countries surveyed, the co-ordination of their drugs strategies fell under the remit of either the Prime Minister's Department or the Department of Health. Clearly, from a strategic perspective, both of these Departments in Ireland, because of either political authority or budget size, wield considerable influence which could be used to further the Strategy. However, in the case of the Department of Health and Children – as it is a service provider – if it were to be accorded overall responsibility, its ability to drive issues surrounding supply control and education and awareness issues would be limited. The Department of Tourism, Sport and Recreation can, however, be objective in relation to all the thematic areas covered by the national policy. In addition, the Department has overall responsibility for local development and for co-ordination of a number of different programmes to promote social inclusion. Given the correlation between drug misuse and social exclusion, it is considered that the Department is strategically well placed to take the lead role in the co-ordination of the National Drugs Strategy. On balance, therefore, it is proposed that responsibility for the co-ordination of the Strategy be retained by the Department of Tourism, Sport and Recreation.

[74] International Classification of Diseases (9th Revision) as set out by the World Health Organisation (WHO). This includes drug dependency and poisoning.

6.6.3 The creation of a post of National Anti-Drugs Co-ordinator, along the lines of the "Drugs Tsar" in the UK and USA, was suggested in some of the submissions. However, in Ireland, the Minister of State at the Department of Tourism, Sport and Recreation is responsible for co-ordinating the National Drugs Strategy. In addition, the Department chairs and provides the Secretariat to the IDG. Furthermore, through his Department's role in the IDG, the National Assessment Committee for the YPFSF and the NACD, the Minister of State is in a good position to promote a cross-sectoral approach, which has been an important objective of the drugs strategy to date.

6.6.4 A common theme in the consultations was the need for the creation of a structure which has the capacity to reflect and respond to the drug problem on a national basis. The LDTFs are a specific response to the scale of the drugs problem in specific disadvantaged urban areas. There was no conclusive evidence available to the Review Group that any other urban area is currently experiencing a drugs problem comparable to that experienced within the LDTF areas. Consequently, the Review Group considers that it is not appropriate at this time to create Task Forces of this kind in any other large cities/towns. However, this is not to suggest that drug-related problems do not exist throughout the country and, consequently, the situation should be kept under review.

6.6.5 The Review Group examined what structures might be appropriate to tackle drug misuse outside the LDTF areas. It was noted that Regional Drug Co-ordinating Committees already exist in many of the Regional Health Board areas and the Review Group examined how these Committees might be aligned to any new structures. In this regard, it was felt that new Regional Drugs Task Forces (RDTFs) should be developed which would incorporate and expand the work of the current Regional Drug Co-ordinating Committees. The secretariat to the RDTFs should be provided by the relevant Health Boards. Each RDTF would be responsible for putting a strategy in place specifically for their region and should have a budget to develop and support the implementation of their action plans. The Review Group recognised that the geographical remit of these Task Forces will make it difficult for all the various statutory and non-statutory sectors to have representatives. However, it is considered that every effort should be made to ensure that there is an equitable regional spread of members which also take account of differing levels and natures of drug misuse within any given region.

6.6.6 The Review Group acknowledged that in relation to the ERHA and SHB (Southern Health Board) areas, the existence of LDTFs raises certain issues for the proposed Regional Drugs Task Forces. It concluded, however, that while working within overall regional plans in order to maximise resources and minimise overlap or duplication, every effort should be made not to disrupt the work of the LDTFs at this time, given their experience and their concentrated focus on areas of high opiate abuse. The current framework should be built on and, as natural linkages develop, the LDTFs should feed into regional plans.

6.6.7 The LDTFs are currently updating their existing strategies and the Cabinet Committee on Social Inclusion has approved many of these plans and has allocated funding for them. A review of the operations of the Task Forces has been commissioned by the NDST and its recommendations should be relevant to the establishment of the proposed RDTFs.

6.6.8 The Department of Education and Science has a key role to play in any National Drugs Strategy and, particularly, in regard to the LDTFs. However, as currently structured, the Department is not in a position to provide representation on each of the 14 Task Forces. Much attention has focused on the lack of a direct link between communities and the Department. The recent Cromien report on the operations, systems and staffing needs of the Department reflects the difficulties faced by it in delivering quality services in a highly challenging environment. A high-level Task Force within the Department is preparing a blue print for the implementation of recommendations contained in the report. The Department will be submitting proposals for significant structure and service delivery reforms, including the establishment of local offices, to Government in the near future. In this context, the Department's representation on the LDTFs, which has been an issue since the establishment of the Task Forces, will be addressed.

6.6.9 There is also a perceived need to strengthen and improve the level of community representation on Task Forces in order to ensure their effective engagement. While this is necessary and should be resourced, the need for greater integration must be weighed against the threat that such "formalisation" may alienate community groups themselves from their constituencies. The NDST should commission research to examine the training and support needs of groups in order to equip them to participate fully in the process at national, regional and local levels.

6.6.10 It is essential to the continued credibility of the LDTF projects and, any new projects which may emerge via the proposed RDTFs, that they are able to attract suitably qualified staff. Project organisers must be able to offer opportunities for professional development and reasonable security of tenure must be set out clearly in contracts.

6.6.11 The level of seniority of statutory representatives on the LDTFs was highlighted as a matter of concern in the consultations. Similar anxieties might arise in due course with regard to agency representatives on the RDTFs. However, there is a danger that insistence on seniority may preclude individuals with a particular understanding of, and enthusiasm for the work, being nominated to, Drugs Task Forces at local or regional level.

6.7 FRAMEWORK FOR THE NATIONAL DRUGS STRATEGY 2001 -2008

Overall Strategic Objective

The overall strategic objective for the National Drugs Strategy 2001 – 2008 is :

To significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research.

Overall Strategic Aims

The following are the overall strategic aims of the Strategy :

- **to reduce the availability of illicit drugs;**
- **to promote throughout society, a greater awareness, understanding and clarity of the dangers of drug misuse;**
- **to enable people with drug misuse problems to access treatment and other supports and to re-integrate into society;**
- **to reduce the risk behaviour associated with drug misuse;**
- **to reduce the harm caused by drug misuse to individuals, families and communities;**
- **to have valid, timely and comparable data on the extent and nature of drug misuse in Ireland; and**
- **to strengthen existing partnerships in and with communities and build new partnerships to tackle the problems of drug misuse.**

6.7.1 OBJECTIVES AND KEY PERFORMANCE INDICATORS

In light of the analysis in Part 1, the conclusions set out at the beginning of this Chapter and the overall strategic objective and aims set for the National Drugs Strategy 2001 – 2008 as set out across, the Review Group recommends that the Government adopts the following **objectives** and **key performance indicators** (KPIs) under the four pillars of supply reduction, prevention (including education and awareness), treatment (including rehabilitation and risk reduction) and research. A number of recommendations in relation to co-ordination are also made.

In line with the EU Drugs Strategy, the new Strategy will run from 2001 to 2008. The objectives and KPIs will be reviewed at the mid-term stage of the Strategy and following this review, the KPIs may need to be amended. These objectives and key performance indicators should be incorporated into the Statements of Strategy of the relevant Departments and Agencies.

Supply Reduction

Objectives

- **To significantly reduce the volume of illicit drugs available in Ireland, to arrest the dynamic of existing markets and to curtail new markets as they are identified; and**
- **To significantly reduce access to all drugs, particularly those drugs that cause most harm, amongst young people especially in those areas where misuse is most prevalent.**

Key Performance Indicators

- **Increase the volume of opiates and all other drugs seized by 25% by end 2004 and by 50% by end 2008 (using 2000 seizures as a base);**
- **Increase the level of Garda resources in LDTF areas by end 2001, building on lessons emanating from the Community Policing Forum model;**
- **Strengthen and consolidate existing coastal watch and other ports of entry measures designed to restrict the importation of illicit drugs;**
- **Establish a co-ordinating framework in relation to drugs policy in each Garda District by end 2001; and**
- **Co-operate and collaborate fully, at every level, with law enforcement and intelligence agencies, in Europe and internationally, in reducing the amount of drugs coming into Ireland.**

Prevention

Objective

- **To create greater societal awareness about the dangers and prevalence of drug misuse; and**
- **To equip young people and other vulnerable groups with the skills and supports necessary to make informed choices about their health, personal lives and social development.**

Key Performance Indicators

- **Bring drug misuse by schools-goers to below the EU average and, as a first step, reduce the level of substance misuse reported to ESPAD by school-goers by 15% by 2003 and by 25% by 2007 (based on 1999 ESPAD levels as reported in 2001);**
- **Develop and launch an ongoing National Awareness Campaign highlighting the dangers of drugs, the first stage to commence by end 2001;**
- **Develop formal links at local, regional and national levels with the National Alcohol Policy, by end 2001 and ensure complementarity between the different measures being undertaken;**
- **Publish and implement a policy statement specifically relating to education supports for LDTF areas, including an audit of the level of current supports, by end 2001;**
- **Nominate an official from the Department of Education and Science to serve as a member of each of the LDTFs by end 2001;**

- Prioritise LDTF areas during the establishment and expansion of the services of the National Educational Welfare Board;
- Have comprehensive substance misuse prevention programmes in all schools and, as a first step, implement the "Walk Tall" and "On My Own Two Feet" Programmes in all schools in the LDTF areas during the academic year 2001/02;
- Complete the evaluation of the "Walk Tall" and "On My Own Two Feet" Programmes by end 2002; and
- Deliver the SPHE Programme (Social, Personal & Health Education) in all second level schools nation-wide by September 2003.

Treatment

Objectives

- To encourage and enable those dependent on drugs to avail of treatment with the aim of reducing dependency and improving overall health and social well-being, with the ultimate aim of leading a drug-free lifestyle; and
- To minimise the harm to those who continue to engage in drug-taking activities that put them at risk.

Key Performance Indicators

- Have immediate access for drug misusers to professional assessment and counselling by health board services, followed by commencement of treatment as deemed appropriate, not later than one month after assessment;
- Have access for under-18s to treatment following the development of an appropriate protocol for dealing with this age group;
- Increase the number of treatment places to 6,000 places by end 2001 and to a minimum of 6,500 places by end 2002;
- Continue to implement the recommendations of the Steering Group on Prison-Based Drug Treatment Services as a priority and implement proposals designed to end heroin use in prisons during the period of the Strategy;
- Have in place, in each Health Board area, a service user charter by end 2002;
- Have in place, in each Health Board area, a range of treatment and rehabilitation options as part of a planned programme of progression for each drug misuser, by end 2002; and
- Provide stabilised drug misusers with training and employment opportunities and, as a first step, increase the number of such opportunities by 30% by end 2004.

Research

Objectives

- **To have available valid, timely and comparable data on the extent of drug misuse amongst the Irish population and specifically amongst all marginalised groups; and**
- **To gain a greater understanding of the factors which contribute to Irish people, particularly young people, misusing drugs.**

Key Performance Indicators

- **Eliminate all major research gaps in drug research by end 2003; and**
- **Publish an annual report on the nature and extent of the drug problem in Ireland and on progress being made in achieving the objectives set out in the Strategy.**

Co-ordination

Objective

- **To have in place an efficient and effective framework for implementing the National Drugs Strategy.**

Key Performance Indicators

- **Establish an effective regional framework to support the measures outlined in the Report by end 2001;**
- **Complete an independent evaluation the effectiveness of the overall framework by end 2004.**
- **Each agency to prepare and publish a critical implementation path for each of the actions relevant to their remit by end 2001; and**
- **Review the membership, work-load and supports required by the National Drugs Strategy Team to carry out its terms of reference, by end September 2001.**

6.8 ACTION PLAN

6.8.1 The Review Group recommends a series of actions to be taken across the full range of Departments and Agencies involved in the delivery of drugs policy, to address specific gaps in the current strategy, to strengthen each of the four pillars which underpin it and to ensure that the foregoing objectives are met. These actions are listed below and their implementation should be overseen by the IDG, which in consultation with the NDST, should report on progress to the Cabinet Committee every six months.

Department of Tourism, Sport and Recreation

1 The Department, through the IDG and the NDST, to co-ordinate the implementation of the National Drugs Strategy in partnership with Government Departments, State Agencies and the community and voluntary sectors and to bring to the attention of the Cabinet Committee on Social Inclusion any identified issues which have a detrimental effect on the implementation of policy.

2 The IDG, in conjunction with the NDST, to establish an evaluation framework for the Strategy, incorporating the performance indicators against which progress under the four pillars will be assessed. Annual reports and mid-term evaluations would facilitate progression towards key strategic goals. The cost effectiveness of the various elements of each pillar of the new Strategy should be established to enable priorities to be established and a re-focusing, if necessary, of strategic objectives from the mid-term evaluation stage at 2004.

3 Continued provision of accessible, positive alternatives to drug misuse in areas where such misuse is most prevalent through the YPFSF and, more generally, through arts and culture youth programmes, the schemes run by the Irish Sports Council and the facilities provided through funding under the Sports Capital Programme. These should be accessible and attractive to those most at risk of drug misuse and those from socially, educationally and culturally diverse backgrounds. In this regard, the LDTF areas should be prioritised. Specific efforts should also be made to ensure that the groups who are most at risk of drug misuse are actively engaged in recreational activities at local level.

Department of Justice, Equality and Law Reform

4 To oversee the establishment of a framework to monitor numbers of successful prosecutions, arrests and the nature of the sentences passed.

5 To establish, in consultation with the Gardaí and the community sector, best practice guidelines and approaches for community involvement in supply control activities with the law enforcement agencies.

6 To review the ongoing effectiveness of crime legislation, in tackling drug-related activity.

Garda Síochána

7 To increase the level of Garda resources in LDTF areas by end 2001, building on lessons emanating from the Community Policing Forum model.

8 To establish a co-ordinating framework for drugs policy in each Garda District, to liaise with the community on drug-related matters and act as a source of information for parents and members of the public. Each Garda District and Sub-District be required to produce a Drug Policing Plan to include multi-agency participation in targeting drug dealers.

9 To target the assets of middle-ranking criminals involved in drug dealing.

10 To continue to target dealers at local level by making additional resources available to existing drugs units and for the establishment of similar units in areas where they do not currently exist.

11 To extend the Community Policing Fora (CPF) initiative to all LDTF areas, if the evaluation of the pilot proves positive. The proposed RDTFs should be consulted in assessing whether CPFs should be established in regional areas of particular need. Where CPFs do not exist, CPF methods should be adopted as best practice for mainstream policing policy.

12 To ensure that operations similar to ***Dóchas, Nightcap*** and ***Cleanstreet*** are implemented in urban centres throughout Ireland, where drug dealing is on-going.

13 To monitor the efficacy of the existing arrest referral schemes and expand them, as appropriate.

Garda Síochána and Customs and Excise

14 To continue to work more closely together in accordance with the principles of their Memorandum of Understanding. They should also co-operate and collaborate fully with law enforcement and intelligence agencies in Europe and internationally in reducing the amount of drugs coming into Ireland.

15 To strengthen and consolidate existing coastal watch and other ports of entry measures designed to restrict the importation of illicit drugs by end 2002

16 To develop benchmarks against which seizures of heroin and other drugs can be evaluated under the *EU Action Plan* in order to establish progress on a yearly basis.

17 To ensure greater integration of Customs and Excise within a European context, an Officer of the Customs and Excise Division should be appointed to the Europol National Unit.

18 To have available to the enforcement agencies detection dogs and other resources to restrict the importation of illicit drugs.

Garda Síochána and Health Boards

19 Incidences of early use of alcohol or drugs by young people coming to Garda attention to be followed up by the Community Police and/or the health and social services, in order that problem drug misuse may be diagnosed/halted early on through appropriate early intervention.

Courts Service

20 To have in all LDTF areas an early intervention system, based on the Drug Court model, if the evaluation of the pilot in the North Inner City of Dublin is positive. This should be accompanied by appropriate familiarisation for the judiciary on the role of the Drug Court.

Prison Service

21 To continue to implement the recommendations of the Steering Group on Prison-Based Drug Treatment Services as a priority and to implement proposals designed to end heroin use in prisons during the period of the Strategy.

22 To expand prison-based programmes with the aim of having treatment and rehabilitation services available to those who need them including drug treatment programmes, which specifically deal with the reintegration of the drug using offender into the family/community.

23 To commission and carry out an independent evaluation of the overall effectiveness of the Prison Strategy by mid 2004. The review should cover all aspects of drug services in prisons including research on levels and routes of supply of drugs in prisons.

24 To expand the involvement of the community and voluntary sectors in prison drug policy via the on-going development of Local Prison Liaison Groups and the formal meetings between the sectors and the Steering Group on Prison-Based Drug Treatment Services.

Department of the Environment and Local Government

25 To commission an external evaluation of the impact of enforcement activity under the Housing Acts (evictions, excluding orders) on homelessness by end 2001.

26 To monitor and evaluate homelessness initiatives in relation to drugs issues in the context of the Homeless Strategy and, particularly, in relation to the Dublin Action Plan.

Garda Síochána, the Health Boards and Vintner Representative Bodies

27 Representative bodies including the Vintners Federation of Ireland (VFI), the Licensed Vintner's Association (LVA) and the Irish Hotel Federation (IHF) to prepare guidelines, in association with the Garda authorities and the Health Boards, for publicans and night-club owners regarding drug dealing on, or in the vicinity of, their premises. These guidelines should set out clearly the actions which the owner of the premises should take in response to drug dealing *e.g.* co-operation with the Gardaí *etc.*

28 Gardaí to object to the renewal of licences for publicans and night-club owners where there has been a history of drug dealing on the premises.

Department of Education and Science

29 To publish and implement a policy statement on education supports in LDTFs, including an audit of the level of current supports by end 2001 and nominate an official to serve as a member of each Task Force. The Department's representatives on the Task Forces will meet to discuss crosscutting issues, chaired by a senior official. This will be done in the context of structure and service delivery reforms which will be considered by Government.

30 To prioritise LDTF areas during the establishment and expansion of the services of the National Educational Welfare Board.

31 To put in place by end 2001 mechanisms which will support, enhance and ensure the delivery of school-based education and prevention programmes in all schools nation-wide over the next three years. The ultimate aim of these programmes should be to ensure that every child has the necessary knowledge and life-skills to resist drugs or make informed choices about their health, personal lives and social development.

32 To implement "Walk Tall" and "On My Own Two Feet" Programmes in all schools in the LDTF areas, in the context of the SPHE Programme during the academic year 2001/02.

33 To deliver the SPHE Programme in all second-level schools by September 2003.

34 To complete the evaluation of the "Walk Tall" and "On My Own Two Feet" Programmes by end 2002 and to continue to evaluate the programmes in order to establish whether they need to be augmented or whether there is a need for alternative programmes to address key gaps. Furthermore, schools should encourage the participation of parents in such programmes, where appropriate. In particular, mechanisms for engaging the parents of at-risk children in programmes should be examined with a view to establishing models of best practice.

35 To ensure parents have access to factual preventative materials which also encourage them to discuss the issues of coping with drugs and drug misuse with their children.

36 To ensure that every second-level school has an active programme to counter early school-leaving with particular focus on areas with high levels of drug misuse.

37 Recommendations 31-35 to apply equally to the non-school education sector e.g VTOS, Youthreach and Community Training Workshops operated by FÁS. Such sectors often deal with young people from more disadvantaged backgrounds who are more at risk of drug misuse. For this reason, incorporating a drug element to the education provided, as outlined earlier, is important.

(The Health Promotion Unit of the Department of Health and Children and the Health Boards are partners in the implementation of actions 31-35 and 37).

Department of Health and Children

38 To develop and launch an on-going National Awareness Campaign highlighting the dangers of drugs, based on the considerations outlined in the conclusions. The campaign should promote greater awareness and understanding of the causes and consequences of drug misuse, not only to the individual but also to his/her family and society in general. The first stage should commence before the end of 2001.

39 To ensure that adequate training for health care and other professionals engaged in the management of drug dependency is available, including, if necessary, arrangements with third level institutions and professional bodies.

40 To consult all treatment and rehabilitation providers in order to ensure that performance indicators, used in the evaluation of services, accurately and consistently reflect the needs of specific areas *i.e* performance indicators should reflect the reality of the drug problem locally.

41 To oversee implementation of the recommendations of the Benzodiazepine Working Group, which is due to complete its work by end June 2001, as part of the overall strategy of quality improvement of current services.

Departments of Education and Science and Health and Children

42 To ensure that the design and delivery of all preventative programmes is informed by on-going research into the factors contributing to drug misuse by particular groups. The programmes should also include the development of initiatives aimed at equipping parents of at risk children with the skills to assist their children to resist drug use or make informed choices about their health, personal lives and social development.

43 To develop guidelines, in co-operation with the Health Boards, to assist schools in the formation of a drugs policy and ensure that all schools have policies in place by September 2002.

Health Boards

44 To have immediate access for drug misusers to professional assessment and counselling by health board services, followed by commencement of treatment as deemed appropriate, not later than one month after assessment.

45 To increase the number of treatment places for opiate addiction to 6,000 by the end of 2001 and to a minimum of 6,500 by end 2002.

46 To develop and put in place by end 2002 a service-user charter specific to treatment and rehabilitation facilities which would lead to a greater balance in the relationship between the service user and the service provider. Such a charter would be helpful to drug misusers presenting for treatment with low levels of educational attainment and/or low levels of self-esteem.

47 To base plans for treatment services on a "continuum of care" model and a "key worker" approach to provide a seamless transition between each different phase of treatment. This approach will enhance movement through various treatment and aftercare forms. In addition, the "key worker" can act a central person for primary care providers (GPs and Pharmacists) to contact in connection with the drug misuser in their care.

48 To have in place, in each Health Board area, a range of treatment and rehabilitation options as part of a planned programme of progression for each drug misuser, by end 2002. This approach will provide a series of options for the drug misuser, appropriate to his/her needs and circumstances and should assist in their re-integration back into society.

49 To develop a protocol, where appropriate, for the treatment of under 18 year olds presenting with serious drug problems especially in light of the legal and other dilemmas which are posed for professionals involved in the area. In this context, a Working Group should be established to develop the protocol. The Group should also look at issues such as availability of appropriate residential and day treatment programmes, education and training rehabilitative measures and harm reduction responses for young people. The Group should report by mid 2002.

50 To develop, in consultation with the NACD, criteria to ensure that all State-funded treatment and rehabilitation programmes accord with quality standards as set out by the Health Boards.

51 To have a clearly co-ordinated and well publicised plan in place for each Health Board area by end 2002 for the provision of a comprehensive and locally accessible range of treatments for drug misusers, particularly for young people, the planning of such services to be linked to the national profile of drug misuse amongst young people and to the areas where usage is most prevalent. These plans to be implemented by end 2004.

52 To produce and widely distribute a well publicised, short, easily read guide to the drug treatment services available in each Health Board area with contact numbers for further information and assistance.

53 To require from 2002 that all Health Boards, in considering the location and establishment of treatment and rehabilitation facilities, develop a management plan in consultation with local communities. Existing examples whereby Health Boards have established monitoring committees with the local community to oversee the operation of the treatment services have proven successful and should be replicated, where appropriate.

54 To consider, as a matter of priority, how best to integrate child-care facilities with treatment and rehabilitation centres and how childcare can best be provided in a residential treatment setting. This should be done in conjunction with the Department of Justice, Equality and Law Reform.

55 To explore immediately the scope for introducing greater provision of alternative medical and non-medical treatment types, which allow greater flexibility and choice. This may increase the number of drug misusers presenting for treatment as it is evident that a "one size fits all" approach is not appropriate to the characteristics of Irish drug misuse.

56 To consider as a matter of priority, how to increase the level of GP and pharmacy involvement in the provision of treatment programmes. Increased capacity at the primary care level will have the effect of alleviating the pressure on the secondary care services which are currently over-subscribed.

57 To oversee the development of comprehensive residential treatment models incorporating detoxification, intervention, pre-treatment counselling, motivational work, therapeutic treatment and high quality rehabilitation for misusers who wish to become drug-free. Resources should continue to be targeted at the most efficient and effective of these services.

58 To report to the NACD on the efficacy of different forms of treatment and detox facilities and residential–drug free regimes on an on-going basis.

59 To secure easy access to counselling services for young people seeking assistance with drug-related problems, especially given the correlation between suicide and drug misuse and the growing incidence of suicide amongst young people.

60 To ensure that treatment for young people includes family therapy and community integration phases, in order to encourage family involvement which is a crucial component in the treatment of young people.

61 To consider developing drop-in centres, respite facilities and half-way houses, where a clear need has been identified, as such facilities have been found to be useful in the prevention of relapse.

62 To review the existing network of needle-exchange facilities with a view to ensuring access for all injecting drug misusers to sterile injecting equipment.

63 To pursue with the relevant agencies, as a matter of priority, the setting up of a Pilot Community Pharmacy Needle and Syringe Exchange Programme in the ERHA area and in the event of a successful evaluation, the programme to be extended where required.

64 To continue to develop good-practice outreach models, including mechanisms to outreach drug misusers who are not in contact with mainstream treatment or support agencies. A reduction in the level of drug-related deaths, particularly from opiate abuse through targeted information, educational and prevention campaigns must be a key aspect of the Strategy.

65 All treatment providers should co-operate in returning information on problem drug use to the DMRD of the HRB.

66 To consider the feasibility of new suitably trained peer-support groups in the context of expanded provision. Peer-support groups are a component of the existing strategy and are regarded as an effective rehabilitative support.

Coroners' Service and the Central Statistics Office

67 To develop an accurate mechanism for recording the number of drug-related deaths in Ireland.

Local Authorities and Health Boards

68 To achieve close liaison between treatment providers, social workers, probation and welfare officers and the relevant local authorities as well as family supports, so as to ensure that recovering misusers should have access to housing. This is very important in ensuring that the effectiveness of treatment and the goals of rehabilitation are not undermined.

69 To develop and implement proposals for the collection and safe disposal of injecting equipment, in order to ensure that the wider community is not exposed to the dangers associated with unsafe disposal.

70 To consider how the design of housing estates can contribute to the prevention of drug dealing in the context of on-going reviews of the Social Housing Design Guidelines for Local Authority Estates. In this regard, the lessons from the ISP may be relevant.

City and County Development Boards

71 To consider the needs of those areas experiencing high levels of drug misuse when drawing up city/countywide strategies for economic, social and cultural development.

Professional Bodies and Training Institutes

72 To make available to individuals interacting with groups most at risk of drug misuse, such as youth workers, teachers, student welfare officers, GPs, pharmacists, nurses, counsellors, child care workers, law enforcement agents, members of the judiciary *etc.* specialist drug prevention training as part of their initial vocational training. The relevant professional body or employer should ensure that training, or up-skilling is available on an on-going basis to ensure that the approach taken reflects changing attitudes and patterns of drug misuse.

Public Media

73 To encourage the media to play a larger role in creating a greater understanding of drug misuse throughout society. Informed coverage and analysis and debate of drugs issues on an on-going basis within the public sphere will contribute to the successful implementation of the Strategy. In this regard, the role of the Department of Tourism, Sport and Recreation, as the co-ordinator of the National Drugs Strategy, as a possible central source of information should be considered.

State Training Agencies

74 To increase the number of training and employment opportunities for drug misusers by 30% by end 2004, in line with the commitment to provide such opportunities in the PPF[75] and taking on board best practice from the special FÁS Community Employment Programme and the pilot Labour Inclusion Programme.

75 To examine the potential to involve recovering drug misusers in Social Economy projects, and in other forms of vocational training. The ring-fencing of places within the FÁS Community Employment Programme has been an important element of the existing approach to rehabilitation.

76 To monitor the participation of recovering drug misusers on such programmes and to review their overall effectiveness. In this context, alternative models should be developed where appropriate.

Oireachtas Committee on Drugs

77 To establish a dedicated drugs sub-committee of the existing Select Committee on Tourism, Sport and Recreation, which would meet at least three times a year.

[75] The commitment in the PPF states that "As the number of drug misusers taking treatment increases, the requirement to provide training and employment opportunities to assist them towards a full recovery will also increase."

Inter-Departmental Group on Drugs (IDG)

78 To be chaired by the Minister of State at the Department of Tourism, Sport and Recreation. This will ensure greater co-ordination between the IDG's constituents in the future and will help to maintain high-level representation and more effective communication between the IDG and the Cabinet Sub-Committee.

79 To consist, in future, of designated officials, at Assistant Secretary level, from the following Departments:

- Tourism, Sport & Recreation;
- Taoiseach;
- Finance;
- Health & Children;
- Education & Science;
- Enterprise, Trade and Employment;
- Environment & Local Government;
- Justice, Equality & Law Reform; and
- Social, Community and Family Affairs.

The Chair of the NDST will also be a member.

As has been the practice, regular joint meetings to continue to be held between the IDG and the NDST to contribute to the effective and efficient development and delivery of the National Drugs Strategy.

80 In conjunction with the NDST and the Department of Health and Children, to develop formal links at local, regional and national levels with the National Alcohol Policy, by end 2001 and ensure complementarity between the different measures being undertaken.

81 To seek reports from key service providers, such as the Assistant Commissioner of An Garda Síochána, the Director General of the Prisons Service, the Chief Executive of the relevant Health Authorities, the Revenue Commissioner with responsibility for Customs and Excise and the County/City Manager of relevant Local Authorities on request and to attend meetings, as appropriate. Representatives from the voluntary, community and professional sectors should also asked to attend, as appropriate.

82 The Terms of Reference of the IDG to include the following:

- advising the Cabinet Committee on critical matters of a public policy nature relating to the National Drugs Strategy;
- ensuring the timely and effective input of relevant Departments and agencies into any emerging operational difficulties or conflicts in relation to implementation of national drugs policy; and
- approving the plans and initiatives of the LDTFs and the proposed RDTFs and monitoring and evaluating the outcomes of their implementation through joint meetings with the NDST.

83 In conjunction with the NDST:

- to review the membership of the Team, immediately and, every two years subsequently, in order to ensure that all relevant interests are represented; and
- to review the workload of the NDST and satisfy itself that the level of support is adequate to carry out its new terms of reference. In particular, to examine, as a priority, the need for a Director to oversee the day to day management of the Office and additional technical support workers. The review should be completed by end September 2001.

84 Departments and Agencies participating on the IDG and the NDST to commit themselves in writing to the process and the level and extent of representation should be specified.

National Drugs Strategy Team

85 The Terms of Reference of the NDST to include :

- ensuring effective co-ordination between officials from Government Departments and State Agencies represented on the Team and members of the community and voluntary sectors in delivering local and regional task force plans;
- reviewing on an on-going basis the need for LDTFs in disadvantaged urban areas, particularly having regard to evidence of localised heroin misuse;
- identifying and considering policy issues and ensuring that policy is informed by the work of and lessons from the LDTFs and the proposed RDTFs, through joint meetings with the IDG;
- overseeing the establishment of RDTFs;
- drawing up guidelines for the operation of Local and Regional Drugs Task Forces and overseeing their work;
- evaluating the Local and Regional Drugs Task Forces Action Plans, when submitted and making recommendations to the IDG regarding the allocation of funding to support their implementation;
- ensuring that monies allocated by the Department of Tourism, Sport and Recreation to projects overseen by the NDST are properly accounted for; and
- preparing an annual report and presenting it to the Department of Tourism, Sport and Recreation.

86 To meet regularly with the co-ordinator of the National Alcohol Policy and, similarly, a member of the Team should be represented on the body charged with the co-ordination of the National Alcohol Policy.

87 To continue to be represented on the YPFSF National Assessment Committee and to ensure that the LDTFs continue to be represented on the Development Groups for the Fund.

88 The NDST to be kept informed by Departments and Agencies of any initiatives being taken which will affect Task Force areas. In addition, membership of NDST and of the Local and Regional Drugs Task Forces to be acknowledged and written into the business plans/work programmes of all relevant Departments and Agencies.

89 To consider funding on a pilot basis, training initiatives to strengthen effective community representation and participation in Regional and Local Drugs Task Forces.

90 To examine and advise the IDG on the feasibility of introducing a standards and accreditation framework for all individuals, groups and agencies engaged in drugs work. Such a framework should address issues such as standards, training, qualifications, *etc.*

91 To continue to identify best practice models arising from the work of the LDTFs and the proposed RDTFs and disseminate them widely.

Regional Drugs Task Forces

92 Regional Drugs Task Forces (RDTFs) to be established in each of the current Regional Health Board areas[76] including each of the three Health Boards[77] that comprise the ERHA, with the following terms of reference:

- to ensure the development of a co-ordinated and integrated response to tackling the drugs problem in their region;
- to create and maintain an up-to-date database on the nature and extent of drug misuse and to provide information on drug-related services and resources in the region;
- to identify and address gaps in service provision having regard to evidence available on the extent and specific location of drug misuse in the region;
- to prepare a development plan to respond to regional drugs issues for assessment by the NDST and approval by the IDG;
- to provide information and regular reports to the NDST in the format and frequency requested by the Team; and
- to develop regionally relevant policy proposals, in consultation with the NDST.

93 To consist of senior representatives so that members are capable of decision making and influencing budgets.

94 To include representation from the following sectors:

- Chair;
- Regional Drug Co-ordinator of the Health Board (providing secretarial/administrative support);
- Local Authority;
- VEC;
- Health Board;
- Department of Education and Science;
- Department of Social, Community and Family Affairs;
- Gardaí;
- Probation and Welfare Service;
- FÁS;
- Revenue Commissioners – Customs and Excise Division;
- Voluntary Sector;[78]
- Community Sector;
- Public Representatives (nominated by Local Authority in accordance with normal procedures); and
- Area Based Partnership.

[76] Midland Regional Health Board, Mid-Western Regional Health Board, Southern Health Board, South-Eastern Health Board, Eastern Regional Health Authority, North Eastern Regional Health Board, North Western Regional Health Board, Western Regional Health Board.

[77] East Coast Area Health Board, South Western Area Health Board, Northern Area Health Board.

[78] The Voluntary and Community Sector representatives could be nominees of the Community Development Fora of the relevant City and County Development Boards. However, they should meet the criteria specified in the NDST Handbook for LDTFs and be representative of areas where there are problems of emerging drug misuse.

Local and Regional Drugs Task Forces

95 RDTFs to consider the development and implementation of community-based initiatives to raise awareness. The goal of such initiatives would be to develop best practice models which send a clear and consistent message and which are capable of being mainstreamed. In the communities where drug misuse is most prevalent and where there is considerable knowledge about all aspects of the drugs issue, schools could tap into and use this knowledge as a beneficial aspect of their programmes. By contrast, there are communities that have a very limited knowledge of the nature or manifestations of drug misuse. In these areas, the school, the health promotion officer, GPs, pharmacists, the Gardaí and others must take the lead in creating a greater awareness of drug misuse.

96 To enable user groups in Task Force areas to play a role in the generation of a greater societal understanding of drug misusers and drug misuse issues. For those misusers who may not be in contact with mainstream agencies, these groups can help foster awareness about support services available *e.g.* treatment options, needle exchanges *etc.*

97 To include local publicity about the nature of their work and the type of measures/initiatives being put in place by them as a key element of the work of Task Forces and as part of their action plans. This information should be disseminated as widely as possible.

National Advisory Committee on Drugs

To examine their current three year research programme to establish if the following actions could be accommodated within it:

98 To carry out studies on drug misuse amongst the at-risk groups identified in this Report *e.g.* Travellers, prostitutes, the homeless, early school leavers *etc.* including de-segregation of data on these groups. It is essential that the individuals and groups most affected by drug misuse and those involved in working to reduce, treat and prevent drug misuse have immediate access to relevant statistical information.

99 To commission further outcome studies within the Irish setting to establish the current impact of methadone treatment on both individual health and on offending behaviour. Such studies should be an important tool in determining the long-term value of this treatment.

100 To conduct research into the effectiveness of new mechanisms to minimise the sharing of equipment *e.g.* non-reusable syringes, mobile syringe exchange facilities *etc.* to establish the potential application of new options within particular cohorts of the drug using population *i.e* amongst younger drug misusers, within prisons *etc.*

Part III

Appendices

GLOSSARY

CDP	Community Development Programme
CE	Community Employment
CNDT	Customs National Drug Team
CPF	Community Policing Forum
DLO	Drugs Liaison Officer
DMRD	Drug Misuse Research Division
EMCDDA	European Monitoring Centre on Drugs and Drug Addiction
ERHA	Eastern Regional Health Authority
ESPAD	European Schools Survey Project on Alcohol and other Drugs
EU	European Union
FÁS	Foras Áiseanna Saothairi
HBSC	Health Behaviour in Schools Aged Children Survey
HRB	Health Research Board
HPU	Health Promotion Unit
IDG	Inter-Departmental Group on Drugs
INCB	International Narcotics Control Board
ISP	Integrated Services Process
IV	Intravenous
LAAM	L-Alpha Acetyl Methadol
LDTF	Local Drugs Task Force
LSD	Lysergic Acid Diethylamide
NACD	National Advisory Committee on Drugs
NAPS	National Anti Poverty Strategy
NDP	National Development Plan
NDS	National Drugs Strategy
NDST	National Drugs Strategy Team
NDTRS	National Drug Treatment Reporting System
RDTF	Regional Drugs Task Force
SMI	Strategic Management Initiative
SAPP	Substance Abuse Prevention Programme
SMPP	Substance Misuse Prevention Programme
UN	United Nations
UNDCP	United Nations Drug Control Programme
UNGASS	United Nations General Assembly Special Session on Drugs
USI	Union of Students in Ireland
VEC	Vocational Educational Committee
VFM	Value for Money
YPFSF	Young Peoples Facilities & Services Fund

APPENDIX 1 – KEY STRUCTURES OF THE NATIONAL DRUGS STRATEGY

Membership of Inter-Departmental Committee on Drugs (IDG)

The review was conducted under the auspices of the Inter-departmental Committee on Drugs (IDG) which consists of high level representatives of key Government departments with a role to play in addressing issues related to illicit drug use. Membership of the IDG at the time of publication is:-

Mr. Con Haugh *(Chairperson)*	Department of Tourism, Sport & Recreation
Mr. Eddie Arthurs (Secretary)	Department of Tourism, Sport & Recreation
Ms Eileen Kehoe	Department of the Taoiseach
Mr. Tom Corcoran	Department of Environment & Local Government
Mr. Jimmy Duggan	Chair – National Drugs Strategy Team / Department of Health & Children
Mr. John Fitzpatrick	Department of Finance
Mr. Tom Mooney	Department of Health & Children
Vacancy	Department of Education & Science
Mr. Seamus O'Moráin	Department of Enterprise & Employment
Mr. Brian Purcell	Department of Justice, Equality & Law Reform
Ms. Kathleen Stack	Chair – YPFSF National Assessment Committee/ Department of Tourism, Sport & Recreation
Mr. John Kelly	Department of Tourism, Sport & Recreation

Membership of the National Drugs Strategy Team (NDST)

Membership of the NDST at the time of publication is:-

Mr. Jimmy Duggan *(Chairperson)*	Department of Health and Children
Mr. Ray Henry	Department of the Taoiseach
Ms. Eileen Hughes	Department of Environment & Local Government
Superintendent Barry O'Brien	Garda National Drugs Unit
Mr. John Harkin	FÁS
Ms. Mary O'Sullivan	Department of Social, Community and Family Affairs
Mr. Stephen Falvey	Department of Education & Science
Ms. Lylia Crossan	Department of Justice, Equality & Law Reform
Fr. Sean Cassin	Voluntary Representative
Mr. Fergus Mc Cabe	Community Representative
Dr. Derval Howley	ERHA
Dr Joe Barry	ERHA

National Drugs Strategy Review Sub-Group

The IDG were assisted in the preparation of the review by a sub-group, comprised of representatives from Government Departments and the National Drugs Strategy Team (NDST) consisting of the following members;

■ Mr Con Haugh *(Chairperson)*	Assistant Secretary Chair of the IDG	Department of Tourism, Sport & Recreation
■ Ms Kathleen Stack	Principal Officer – Drugs Strategy Unit,	Department of Tourism Sport & Recreation
■ Mr. Stephen Falvey	Assistant Principal Officer – Social Inclusion Unit	Department of Education & Science
■ Mr. Brian Purcell	Principal Officer – Crime Division	Department of Justice, Equality & Law Reform
■ Superintendent Barry O'Brien	An Garda Síochána	NDST Member
■ Mr. Jimmy Duggan	Principal Officer – Chairperson of the NDST	Department of Health & Children
■ Mr. Fergus McCabe	Community Worker	NDST Member
■ Mr. John Kelly	Secretary to the National Drugs Strategy Review	Department of Tourism, Sport & Recreation

The Secretariat to the review was supplied by the staff of the Drugs Strategy Unit of the Department of Tourism, Sport & Recreation and consisted of Mr. John Kelly (Secretary); Mr Caoimhín Ó Ciaruáin, Ms. Sharon Gleeson; Ms. Patricia Kenna and Mr. Anthony McCarthy. Mr. John Kelly succeeded Mr. Tony Bass as Secretary to the review in November 2000.

APPENDIX 2 – RESPONSES TO THE DRUG PROBLEM IN IRELAND

Time Period	Developments
1966-1979	Working Party on Drug Abuse established December 1968 Report of Working Party completed in 1971 Committee on Drug Education established in 1972 Report of the Committee on Drug Education in 1974 Health Education Bureau established in 1974 Health Education Bureau established in 1974 Misuse of Drugs Act 1977
1980-1985	Prevalence study conducted by Medico Social Research Board in 1983 Inter-Ministerial Task Force established in 1983 Report of the Inter-Ministerial Task Force in 1983 Misuse of Drugs Act 1984 National Coordinating Committee on Drug Abuse 1985
1986-1991	Health Research Board established in 1986 Health Promotion Unit established in 1987 National Coordinating Committee on Drug Abuse reconstituted in 1990 Government Strategy to Prevent Drug Misuse 1991
1992-Present Time	Criminal Justice Act 1994 Criminal Justice (Drug Trafficking) Act 1996 Criminal Assets Bureau Act 1996 Proceeds of Crime Act 1996 Disclosure of Certain Information for Taxation and Other Purposes Act 1996 Bail Act 1997 Housing Act 1997 Ministerial Task Force on Measures to Reduce the Demand for Drugs established in 1996 First Report of the Ministerial Task Force 1996 Establishment of National Drugs Strategy Team 1996 Second Report of the Ministerial Task Force 1997 Establishment of Cabinet Drugs Committee Establishment of Local Drugs Task Forces 1997 Cabinet Drugs Committee reconstituted into wider Committee on Social Inclusion and Drugs 1997 Young People's Facilities and Services Fund 1998 Criminal Justice (Drug Trafficking) Act 1999 National Advisory Committee on Drugs 2000

APPENDIX 3 – SUBMISSIONS RECEIVED

Individuals

- Mr. Max Brohan
- Dr. Gerard Bury
- Dr. Fergus O'Kelly
- Mr. Adrian Carolan
- Cllr. Sheila Casey
- Fr. Sean Cassin
- Prof. Paul Connon
- Mr. Con Doherty
- Dr. Pat Fanning
- Dr. Michael Ffrench-O'Carroll
- Mr. John Fitzgibbon
- Mr. Michael Fox
- Mr. Hugh Greaves
- Mr. Paul Gregory
- Ms. Roslyn Hurley
- Mrs. R. Leech
- Mr. Fergus McCabe
- Ms. Maria McCully
- Ms. Nancy O'Flynn
- Ms. Siobhan O'Donnell
- Mr. Richard Parker
- Mr. Lorne Patterson
- Mr. Ciaran Perry
- Dep. Pat RabbitteT.D.
- Mr. Paul Sheehan
- Mr. C. Skelton
- Mr. Eamonn White

Organisations

Addiction Resource Centre, Rooskey

ADHD – The Irish National Council of Supports Groups

AISÉIRÍ

AISLING – Group Cavan Branch

Aisling Group

AISLINN – Adolescent Addiction Treatment Centre Limited

An Garda Síochána

Area Development Management (ADM) Ltd

Association of Secondary Teachers in Ireland (ASTI)

Athlone Drug Awareness Group

Balbriggan Awareness of Drugs

Ballyfermot Local Drugs Task Force

Ballymun Youth Action Project (BYAP)

Barnardos – Southern Region

Beg Borrow and Steal Theatre Company

CAIRDE

Campaign against Bullying (CAB)

Canal Communities Local Drugs Task Force

Carlow Regional Youth Service

Carlow Urban District Council

Catholic Primary School Managers' Association

Catholic Youth Council (CYC)

Cavan County Council

Clonmel Community Based Drugs Initiative

Wexford Community Based Drug Initiative

COAIM

Coalition of Communities Against Drugs (COCAD)

Combat Poverty Agency

Combined Tallaght Community Treatment Programmes

Community Awareness of Drugs (CAD)

Coolmine House

Cork Local Drugs Task Force

County Kilkenny VEC

County Louth VEC

CPAD

CREW Network

Cross Border Anti-Drugs Initiative Committee

CRSA

Cuan Mhuire

Cumann Lúthchleas Gael

Darndale/Belcamp Resource Centre

Department of Education and Science

Department of Health & Children

Department of Justice, Equality & Law Reform

Department of the Environment and Local Government

Drug Prevention Alliance

Drug Treatment Centre Board

Drugs Education Workers Forum

Dublin City University

Dublin City Wide Drugs Crisis Campaign

Dublin Corporation

Dún Laoghaire Business Association

Dún Laoghaire/Rathdown Local Drugs Task Force

East Coast Area Health Board

East Wall Drugs Committee

Eastern Regional Health Authority (ERHA) (formerly Eastern Health Board)

EURAD

FÁS

Fatima Young Person Project Focus Ireland

FORÓIGE – National Youth Development Organisation

General Practitioners Specialising in Substance Abuse (GPSSA)

Haddington Clinic

Health Research Board (HRB)

Institute of Technology Tralee

Irish Association of Univeristy and College Counsellors

Irish Bishops' Drugs Initiative

Irish College of General Practitioners

Irish Congress of Trade Unions (ICTU)

Irish Medical Organisation (IMO)

Irish Prison Service

Irish Sports Council

Kerry County Council

Kerry Diocesan Youth Service

Kilkenny Drugs Initiative

Killarney Urban District Council

Labour Party

Lake Isle Relaxation Centre

Leisure Point

LINKS

Local Bishops Network Committee

Local Drugs Task Forces Representatives

Marist Rehabilitation Centre

Mater Dei Counselling Centre

Matt Talbot Community Trust

Mayo County Council

Meath County Council

Merchants Quay Project

Mid Western Health Board

Midland Health Board

Midland Regional Youth Service

Mountview/Blakestown Community Drug Team

National Adult Literacy Agency (NALA)

National Council for Curriculum and Assessment (NCCA)

National Parents Council – Post Primary

National Parents Council – Primary

National Youth Council of Ireland

Natural Law Party

North Clondalkin Community Development Association

North Eastern Health Board

North Inner City Drugs Task Force

North Western Health Board

Northern Area Health Board

Nurses Addiction Network

Office of the Revenue Commissioners

One Parent Exchange and Network

PACE

Pavee Point Travellers Centre

Pharmaceutical Society of Ireland

Portarlington Drug Awareness Group

Prevention Project Group, Department of Education, NUI Maynooth

Prison Officers' Association (POA)

Probation and Welfare Service (PWS)

Ranelagh, Rathmines Drug Awareness Project

Rathmines Drug Awareness Group

Rialto Community Drugs Team

Ringsend Action Project Limited

Ringsend and District Response to Drugs

Rinn Development Initiative Limited

Rutland Centre Limited

SAOL Project

Secretariat of Secondary Schools

Sligo County Council

Sligo Northside Community Resource Centre

South East Regional Drug Helpline

South Eastern Health Board

South Inner City Community Development Association

South Kerry Development Partnership

Southern Health Board

Southhill Community Development Project

Southill Young Men's Project

St. Michael's CBS

Tallaght Community Drug Team

Teachers Union of Ireland

Teen Challenge Ireland

Thomas Mullins and Company

Tipperary S.R. Vocational Education Committee

TRUST

UISCE

Union of Students in Ireland (USI)

University of Limerick

URRUS

Vincentian Partnership for Justice

Waterford Community Drugs Network

Western Health Board

Wexford Area Partnership

Wicklow County Council

Oral Hearings

During July and August 2000, the Minister of State, the Chairperson of the IDG, members of the Review Group, representatives of the consultants and the Secretary to the review met the following 34 groups. Each session consisted of a short presentation by the group concerned and then a lengthy discussion around issues raised.

ADM Ltd.

An Garda Síochána

Citywide

COCAD

Combat Poverty Agency

County & City Managers Association

Custom and Excise Division, Revenue Commissioners

Dept. of Education & Science

Dept. of Enterprise, Trade & Employment

Dept. of Health & Children

Dept. of Justice, Equality & Law Reform

Dept. of Social, Community & Family Affairs

Dept. of the Environment & Local Government

Dept. of the Taoiseach

Eastern Regional Health Authority

FÁS

Health Research Board (Drug Misuse Research Division)

Irish Bishops Conference on Drugs

Irish College of General Practitioners

Irish Courts Service

Irish Prisons Service

LDTF Reps

Merchant Quay Project

National Council for Curriculum & Assessment

National Parents Council (Post-primary)

National Youth Council of Ireland

Pharmaceutical Society of Ireland

Policy Research Centre, National College of Ireland

Prison Officers Association

Probation & Welfare Service

Regional Drugs Co-ordinators (excl. ERHA)

UISCE

Union of Students in Ireland

Voluntary Drug Treatment Network

APPENDIX 4 – DRUG TREATMENT TYPES

The following is a sample of drug treatment types, some of which are mentioned throughout the Report.

Needle/Syringe Exchange Schemes

Needle/syringe exchange schemes provide injectors with clean injecting equipment to prevent them from using needles more than once or sharing with other people. Moreover, they facilitate the safe disposal of injecting equipment reducing the harm associated with unsafe drug using behaviour. The overall concept of needle/syringe exchange facilities is to reduce needle sharing and unhygienic practices so that the threat of transmission of disease, in particular hepatitis and HIV, is reduced. Exchange schemes may make contact with injectors who are not in contact with other services and the international literature consistently reports evidence of reduced sharing frequency amongst those attending exchange schemes. Although it is argued that the presence of such a service encourages injecting, research indicates lower HIV rates among drug injectors, where there are good services available. Needle/syringe facilities are now recognised internationally as a central part of a harm reduction strategy.

Detoxification Programmes

The aim of detoxification is to eliminate opiate and other drugs from the body. Detoxification is carried out for a range of drugs, particularly opiate drugs or substitutes to opiate drugs (opioids) and is conducted by either gradually reducing the dosage or abruptly stopping the dosage until the individual is drug free. Treatment generally continues until all withdrawal symptoms have subsided. Detox programmes can be accessed in hospitals (in-patient) or on a community basis.

Methadone Reduction Programmes

Methadone maintenance programmes apply to individuals who are using prescribed methadone as a means of reducing withdrawal symptoms from coming off opiate drugs. The aim is to prescribe a gradually tapering dose over time, with the ultimate aim of the individual achieving abstinence in the medium term. The time in which abstinence is reached can vary significantly between different individuals. Such interventions provide immediate benefit in reducing in drug misuse and injecting behaviour.

Methadone Maintenance Programmes

The aim of methadone maintenance programmes is to stabilise the user by prescribing methadone as a substitute for heroin and other opiate drugs. Methadone maintenance is the most evaluated form of treatment in the treatment of heroin addiction and is the most common substitute of choice for those treating opiate addiction. In some cases, individuals can be prescribed methadone for a number of years. International evidence surrounding methadone indicates that methadone maintenance significantly reduces heroin use, drug related crime and the spread of drug-related diseases through injecting drug misuse

Heroin Prescription

Experiments involving the prescription of heroin, under strict medical supervision are in place in the Netherlands and Switzerland. Only those serious misusers whom it is considered can no longer be helped by the regular care system are allowed participate in the experiments. The INCB opposes such experiments.

In-Patient Treatment Services

In-patient treatment services generally provide detoxification and early rehabilitation, on a short-term basis (2 –12 weeks). On completion of in-patient detoxification a significant number of patients generally go on to residential rehabilitation facilities.

Residential Services

Residential treatment services provide a managed environment for heavily dependent drug misusers who are trying to become drug-free. Internationally, residential treatment programmes are generally divided into three broad categories:

1. Therapeutic Communities, where residents attend intense therapy sessions.
2. Twelve step models based on Alcoholics/Narcotics Anonymous. The aim is for long-term abstinence and the approach is based on spiritual, as well as practical guidance.
3. More general houses, some of which have a religious-based philosophy. The approach used is based on group and individual therapy.

Rehabilitation

Rehabilitation involves assisting a drug misuser in achieving a drug-free lifestyle, as well as enabling the individual to cope with all aspects of daily life. Individuals availing of rehabilitation can either be stabilised on medication, detoxing or already drug free.

Counselling

Counselling plays a central role in drug treatment therapy and can include psychological therapy, group therapy, as well as advice on how to deal with issues such as housing and social problems, criminal justice problems and health problems *etc.*

Alternative Forms of Treatment

Self-Help Networks

Narcotics Anonymous (NA), which is an international self-help organisation, co-ordinates local support groups for drug misusers and is similar to Alcoholics Anonymous. Similar groups are run which place specific emphasis on the family of the drug misuser (Family Anonymous). Both groups are based on the 12-step abstinence model.

NeuroElectric Therapy (NET)[79]

NET is a form of electro-medicine used in detoxification. Special adhesive electrodes are placed behind the ear and continuous stimulation is applied for between 6 to 10 days (significantly less for nicotine addiction). NET is used for both drug and alcohol addiction. It utilises minute amounts of electricity transcranially to re-establish or stabilise the natural levels of neuropeptides intractably disrupted by chronic substance use and misuse.

Transcendental Meditation (TM)

Transcendental Meditation is a simple form of meditation which has documented benefits for health and well being.[80] It is taught using a short programme based on a standard seven-step course and is practiced for 15-20 minutes twice daily. Transcendental Meditation settles mental activity while maintaining (and enhancing) alertness. The health and personal benefits arising from this practice has been researched worldwide, in over 27 countries.

[79] Patterson *et al.* (1996) Electrostimulation: Addiction Treatment for the Coming Millennium. *The Journal of Alternative and Complementary Medicine,* Volume 2, No. 4.

[80] *Transcendental Meditation, Introduction and Overview of Research* – January 1998. Scientific Research on Maharishi's Vedic Approach to Health: Part 1.

APPENDIX 5–DRUG TYPES

Types of Drugs

The following is a sample of drug types mentioned throughout the course of this Report.

There are four main categories of drugs:

- **Depressants**, such as alcohol and cannabis, depress or slow down mental and physical activity.
- **Stimulants**, such as amphetamine and cocaine, stimulate mental and physical activity.
- **Hallucinogens**, such as LSD and magic mushrooms, create hallucinations and delusions and may alter sense of smell, taste, time etc
- **Opiates**, such as heroin and methadone, have pain killing properties and produce feelings of well-being. Opiates are derived from the opium poppy. Opium is the dried milk of the opium poppy and it contains morphine and codeine, which are both effective pain-killers.

Amphetamines are stimulant drugs, also called speed, whiz or base. They come in the form of a white powder, and can be snorted up the nose, mixed in drink or prepared for injection.

Benzodiazepines are synthetic drugs manufactured for medical use and are a form of tranquilliser. Benzodiazepines can be used in the same way as street drugs.

Buprenorphine is a semi synthetic opiate possessing both narcotic agonist and antagonist activity, which is being studied as another alternative form of medication as a treatment for heroin and other opiate addiction. Buprenorphine produces less euphoria than morphine and heroin.

Cannabis is usually smoked when rolled into a cigarette or joint, often with tobacco, or can also be smoked using a pipe. Other common names for cannabis include hash, weed, dope, *etc.* Smoking cannabis generally has a number of physical effects, including decreased blood pressure, bloodshot eyes, increased appetite and occasional dizziness.

Cocaine is made from the leaves of the coca shrub and is a white crystalline powder in its most common form. It is generally sniffed up the nose, but it can also be made into a solution and injected.

Crack is a smokeable form of cocaine made into small lumps or "rocks". It is usually smoked. Crack can also be prepared for injection.

Ecstasy often known as E is both a stimulant and an hallucinogen. Sold in tablet or capsule form, it can be any shape or colour. Tablets are often referred to after the image printed on it, for *e.g.* doves, apples *etc.*

Heroin is an opiate drug from the opium poppy. It is made from morphine and is a white powder in its pure form. Heroin is a sedative drug which depresses the nervous system.

LAAM (L-Alpha Acetyl Methadol Hydrochloride) is a substitute drug similar to methadone in composition and pharmacological effects. It has a much longer duration of action than methadone (up to 72 hours).

Lofexidine is a non-opioid and can be used to detoxify people who are dependent on opiates. It may be particularly useful in treating young people who are at an early stage in addiction.

LSD (Lysergic Acid Diethylamide) is a powerful hallucinogenic drug also known as acid, trips or tabs. It comes on small squares of coloured blotting paper or tiny pills ('microdots'). A tiny dose produces a non-stop 'trip' which can last 8-12 hours.

Methadone is one of a number of synthetic opiates (called opioids) which is manufactured for medical use and has a similar effect to heroin. It is mostly prescribed as a substitute drug in the treatment of heroin addiction.

Morphine is an opiate drug derived from the opium poppy. It is one of the most powerful analgesics known and it acts as an anesthetic without decreasing consciousness.

Tricyclics, otherwise known as antidepressants, are generally used in the treatment of depression and depressive conditions.

APPENDIX 6–REFERENCES

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