Second Report

of the

Ministerial Task Force

on

Measures to Reduce

the Demand for Drugs

May, 1997

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Chairman's Introduction

Politics is about people. People not simply reduced to individuals left to their own devices, atomised, without society, and with only a minimal State. Politics therefore is about people in society.

Politics is about government, which is to say that it is about the appropriate relationship between the State and civil society. The idea of counterpoising the interests of people on the one hand to the political process and political institutions in our democracy on the other is a nonsense. The democratic State empowers people, which is to say it enables society. It enables social and mutual endeavour. It also empowers through interventions in its own right. It seeks to ensure - through institutions of State, through fiscal policy, public spending programmes, education, social policy and so on - equality of opportunity and also that degree of equality of outcomes without which society as such would cease to exist.

Politics in a democracy must be responsive to public needs. Yet for far too long our State paid little attention to the rising drugs phenomenon, its causes, impact and consequences.

For a decade and more, this State failed to tackle effectively the spread in the illicit trafficking and pushing of opiates, the destruction of the lives of individuals, the havoc

wrought in communities. It neglected adequately to address also the underlying forces at work in such communities that fed from within the drug phenomenon - their marginalisation within the formal economy; the geographical marginalisation that re-informed economic marginalisation; misguided approaches to public housing policy. Deficiencies in education and social policies also, for example, compounded the other forces at work. Work itself was made scarce in these communities. The result was a spiral of decline.

The State also attended insufficiently to developments within youth culture. It did not meet the needs of our youth and it did not adequately address the concerns of young people and parents, particularly in urbanising Ireland. The State was late in recognising the power of peer pressure and many aspects of youth culture as it developed in the eighties. Parents' need for information and guidance, the need for a harm reduction approach in the broadest sense to public health policy as it relates to youth culture, on all of this the State was slow to act.

The result is to be seen today in the two ways. First of all it is to be seen in a situation that has been likened to a modern day equivalent of a TB epidemic. It is not a bad comparison. In the 1950s the TB epidemic induced strong, coherent, concerted and multifaceted State action. Resources were allocated. Facilities were provided. The harm to individuals and the cost of society was, over a period, reduced to a minimum.

Secondly, the result of neglecting this phenomenon is to be seen in our society as a body politic, in the shape of frustration, cynicism, alienation, fear and disconnection from politics itself. These forces have taken root in the communities in which the heroin phenomenon is lodged. Many ordinary people, parents and otherwise, in these communities are turned off politics, forced into direct action and they are fearful. In the wider society also, there are the same phenomena as they see disorder, poverty and decay manifest.

I am conscious of the fact that parents particularly are frustrated and fearful and, in the deprived "blackspots", grandparents in many instances are having to return to parenting, this time their grandchildren, as a consequence of the havoc wreaked by heroin. We need education and information initiatives by the State at a number of levels - in our schools, in our youth, sport and recreational clubs and organisations and in the community at large. We

need to provide more specialist social, health and welfare services, targeted economic measures and urban and community renewal initiatives.

This Government has moved in a concentrated and concerted fashion to deal with the drugs phenomenon, particularly within the last year. The international dimension to supply side measures has being strengthened. Criminal assets are being seized. And, in the shape of this Ministerial Task Force, there has been a major initiative on the demand side, with two dimensions emerging. We have begun directly to tackle the underlying forces - environmental improvement and so on. But also we have developed a strong philosophy of harm reduction and treatment of the consequences of drug abuse - stabilisation, methadone maintenance, detoxification, rehabilitation and re-integration. Established schemes such as Community Employment and new measures such as the Local Employment Scheme are being adapted to the need of the communities worst affected.

On the non-opiates side, there are also a series of initiatives that overlap with the heroin problem but also go beyond it. Under the direction of the Department of Education, drug misuse programmes have been developed at both primary and second level schools and teachers and indeed parents are being trained to deliver these programmes. There are also the information programmes of the Health Promotion Unit at the Department of Health, aimed directly at young people.

Taking a broader view and going beyond the remit of this Task Force, the Department of Health has produced its own alcohol awareness programme. The main policy objective of this programme is to promote moderation in alcohol consumption, for those who wish to drink, and reduce the prevalence of alcohol-related problems in Ireland, thereby promoting the health of the community.

The strategic plan recently published by the Minister for Sport must also be seen in this general context. It is a plan that locates sport and State support of sport in a context much wider than simply the development and promotion of performance and high performance sport. The Plan embraces health and lifestyle, social, personal development and education dimensions - as well as the development of the high performance dimensions.

Now, in this Report, we advance some further measures for decision by the Government. Key among these is a public/private initiative for the development of youth, recreational and sporting facilities. In ***Chapter 3*** of this Report, which deals with non-opiates and youth culture, the reader will find details of this proposed initiative.

Heroin in the community was very much the focus of our First Report. The initiatives announced in the Report are now having a major impact, as is outlined in ***Chapter 2*** of this Report. There, the reader will find a description of what is happening now in these communities, the impact of the initiatives, how the financial package of the First Report is working on the ground.

There remains however another dimension - drugs in the prisons - which we indicated in our First Report is a special problem, deserving separate examination. Drugs and the prison system are dealt with the ***Chapter 4*** of this Report. In that chapter the reader will find a description of the nature of the problem. It is not generalised within the prison system, it is a phenomenon that grips one institution in particular - Mountjoy. The Task Force discussed the problems at Mountjoy prison at some length. While it is strictly speaking an issue for prison policy generally, there was a strong feeling that there should be a serious examination of the issue of closing down Mountjoy and selling the site for urban development, with the revenues from the sale going into funding of the prison programme. The issue is whether a nineteenth century institution can ever be transformed into a modern, efficient and humane facility.

We have concluded that, for as long as that prison continues to function as it now does, it will continued to be plagued with an internal drugs problem - smuggling and continued abuse within the prison. However, even if this problem were eliminated, there would still be a problem within the prison in that most of its core population of inmates are drug users and there is the question of medical and other treatment services for them, not only within the prison system itself, but as they move between prison and the community. What is needed is an effective inter-action between the services provided on both sides of the prison gate. We are not expert in this area and therefore, we have concluded that the best way forward is to

establish an Expert Group that will examine the situation and make professional recommendations as to how this might best be achieved.

We are convinced as a group that has met virtually weekly since our establishment to examined this acute problem in our society that there is no single answer to the problem - even in relation to the demand side. The immediate need is for stabilisation and direct measures to deal with the background/environmental factors. However, for some, the approach of the therapeutic community will certainly offer an option. The therapeutic communities option is an important one. We deal with their role ***Chapter 5*** of this Report.

Before concluding, we would also remark on the paucity of local research to date into various aspects of the drugs phenomenon in Ireland. It is not a phenomenon that is unique to Ireland, it is a global phenomenon. We were struck by the volume of research, its scope and its detail undertaken elsewhere. Here too, we have some catching up to do. We are glad to report that there has been some movement in recent months. For example, the recommendations of our First Report in respect of databases are being implemented. We have also seen recently the announcement of funding for 26 research projects ranging over social science research, research into detection and analysis and as a third area, biochemistry and pharmacology. These projects are being funded under Measure 4 of the R&D sub-programme of the E.U. Operational Programme for Industry and £1m has been allocated.

I conclude as I began. Politics is about people. We politicians are at the heart of an implicit compact between society on the one hand and on the other, its creation, the State and government. Our job is to facilitate the proper and orderly functioning of society and to respond appropriately to the needs of citizens in society. That is our purpose in government and, in the context of the drugs phenomenon, the object of this Task Force.

Chairman,
Ministerial Task Force on Measures to
Reduced the Demand for Drugs

Summary of Key Recommendations

- the establishment of a Youth Services Development Fund - with contributions from the Exchequer and the corporate sector - to develop youth services in disadvantaged areas where there is a significant drugs problems. We envisage that the contribution from the Exchequer will be of the order of £20 million;

- the preparation of development proposals by relevant bodies to meet the prioritised needs of young people in disadvantaged areas where there is a significant drugs problem;

- the according of a high priority in the allocation of the "demographic dividend" in education to the provision of staff to lead the development of the youth services in disadvantaged areas;

- the training and employment of youth leaders from disadvantaged communities under Community Employment and other social economy measures;

- the development and implementation of a substance abuse prevention programme specifically for the non-formal education (youth work) sector, to be introduced with an accredited "Training for Trainees" programme;

- the employment of a training team to develop, co-ordinate and implement this education strategy throughout the Youth Service.

- The development of specialised outreach programmes to reach those not in contact with any services or organisations, i.e. those who are often most at risk;

- the development and implementation of information strategies designed specifically to target young people with low literacy skills;

- the establishment of pilot projects in urban areas, where locally-appointed Sports Development Officers will work in partnership with Local Authorities, Vocational Education Committees, Health Boards, sports clubs, sports centres and community groups to attract isolated young people into sport and physical recreation;

- the establishment of Local Sports Development Forums to co-ordinate local activities and bring local clubs and groups together;

- the continued development of education/awareness initiatives, including the expansion of the programmes of substance misuse prevention/education in primary and second level schools;

- the development of information/media campaigns in relation to drugs such as ecstasy, which replicate the approach being taken in some other countries, like Britain;

- 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;

- 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.

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Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs

Chapter 1

Introduction

On 9 July, 1996, the Government set up a Ministerial Task Force to review the present arrangements for a co-ordinated approach to drugs demand reduction and, in the light of that review, to identify for Governmental action any changes or additional measures necessary to provide a more effective response. The terms of reference of the Task Force are set out at **Appendix 1**. The membership of the Task Force comprises:

Mr. Pat Rabbitte, T.D.	Minister to Government (Chairman)
Mr. Brian O'Shea, T.D.	Minister of State at the Department of Health
Mr. Gay Mitchell, T.D.	Minister of State at the Department of the Taoiseach and Foreign Affairs
Ms. Liz McManus, T.D.	Minister of State at the Department of the Environment
Mr. Bernard Allen, T.D.	Minister of State at the Departments of Education and the Environment
Mr. Austin Currie, T.D.	Minister of State at the Departments of Health, Education and Justice
Mr. Bernard Durkan, T.D.	Minister of State at the Department of Social Welfare.

First Report

On 11 October, 1996 we published our First Report. In it, we concentrated on the nature and extent of drug misuse in Ireland, its underlying causes, the effectiveness of the current response by the statutory authorities and the structural arrangements for delivering that response.

We concluded that heroin abuse is by far the most pressing aspect of the drugs problem at this time. Heroin abuse appears to be primarily a Dublin phenomenon - confined almost exclusively to the areas experiencing the greatest levels of economic and social disadvantage. We focused on dealing with this phenomenon through a strategic, locally-based, integrated response in the areas where the problem is most severe. Our proposals - all of which were subsequently adopted by the Government - included:

- the establishment of a Cabinet Drugs Committee, chaired by the Taoiseach, to give overall policy direction in the fight against drugs:
- the establishment of a ***National Drugs Strategy Team***, to advise on and implement that policy;
- the setting up of ***Local Drugs Task Forces*** in the worst affected areas and mandating them to develop comprehensive anti-drugs strategies for those areas;
- the introduction of a range of measures in relation to the ***treatment*** of heroin abusers, including a proposal to eliminate the waiting lists for methadone maintenance by the end of the current years;
- proposals to enhance the ***rehabilitation*** opportunities available to heroin misusers who have stabilised;
- a series of drugs ***education***/***awareness*** measures to complement and build on existing prevention strategies; and

- an ***Estate Improvement Programme***, to assist local authorities in tackling environmental and related problems in severely run-down housing estates and flat complexes where the drugs problem is particularly severe.

A report on the steps taken and the progress achieved to date in implementing these strategies is contained in ***Chapter 2***.

Issues addressed in this Report

Since the publication of our First Report, in conjunction with overseeing the implementation of the strategies recommended in it, we have also been examining other aspects of the drugs problem.

We looked at the misuse of non-opiate drugs. Whereas opiate abuse is confined almost exclusively to marginalised communities, the misuse of so-called "soft drugs", such as cannabis and ecstasy, is a nation-wide phenomenon. These drugs are available in every town and village in Ireland, although the actual incidence of their misuse is unknown. In ***Chapter 3*** we examine the nature and extent of the problem, which is to a high degree associated with youth culture and we recommend a series of proposals - mainly preventative - to address it.

In ***Chapter 4*** we look at the issue of drug abuse in our prisons and examine the effectiveness of the current treatment services available to prisoners who misuse drugs. Given the fact that a large proportion of heroin abusers are most likely to experience a period of imprisonment and the concentration of the heroin problem in Dublin, it is to be expected that Mountjoy plays a crucial role in the fight against opiate abuse in our capital city. Recognising that one of the critical factors which leads to heroin abuse is social and economic deprivation and, as a result, the causes of drug misuse do not begin or end in Mountjoy, we examine how the prison's drug treatment services interact with those operating on the outside and how they might be better integrated.

In ***Chapter 5*** we look at the role of the therapeutic communities in the treatment and rehabilitation of drug misusers. These communities - along with other treatment methods -

are an integral part of the overall range of services available to drug misusers. We consider how best to address the need to evaluate different models of treatment, aware that new approaches are proposed on a regular basis.

Submissions from the Public

As with our First Report, we invited the public to make submissions in relation to the issues under review in this Report. In all, 72 organisations or individuals responded - see ***Appendix 2***. A summary and analysis of these submission is at ***Appendix 3***.

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Chapter 2

Progress on Implementation of the Recommendations in our First Report

Focus of First Report

In our First Report, we focused on the following issues:

- *identifying the nature and extent of drug misuse in Ireland;*
- *examining the underlying causes of the phenomenon, in particular the reasons why it is more prevalent in certain areas/communities;*
- *improving the effectiveness of the current response by the statutory agencies involved in tackling the problem;* and
- *improving the structural arrangements for delivering that response.*

We concluded that heroin abuse was by far the most serious aspect of the drugs problem confronting not only the statutory authorities, but Irish society in general, at this time. We developed a response which focused on the following issues: the concentration of heroin abuse in the areas of greatest social and economic disadvantage; the need for effective co-ordination between statutory and other agencies in delivering their anti-drugs programmes in these areas; and the need for the involvement by the local communities in the development and implementation of these programmes. We proposed a range of measures to tackle these issues. Details of the steps taken and the progress achieved to date in implementing our proposals - which were subsequently adopted by Government - are outlined below.

In adopting our proposals, the Government set aside additional funding of £14 million in the current year to implement them, as follows:

- £10 million to support the implementation of anti-drugs strategies to be developed by Local Drugs Task Forces in the worst affected areas;

- £1 million to assist Health Boards in developing anti-drugs strategies in other areas; and

- £3 million over 1997/98 towards an Estate Improvement Programme, to assist local authorities in tackling environmental and related problems in severely run-down housing estates and flat complexes.

Structures

Perhaps the most significant recommendations in our First Report were the proposals in relation to structures. We proposed the introduction of new structural arrangements to ensure more effective co-ordination between all relevant agencies at both central and local levels. Arising from this, the following have been established:

- a ***Cabinet Drugs Committee;***
- a ***National Drugs Strategy Team***; and
- ***13 Local Drugs Task Forces***

Cabinet Drugs Committee

The membership of this Committee comprises:

Mr. John Burton T.D.	Taoiseach (chairman)
Mr. Michael Noonan T.D.	Minister for Health
Mr. Nora Owen T.D.	Minister for Justice
Mr. Brendan Howlin T.D.	Minister for Environment
Mr. Niamh Bhreathnach T.D.	Minister for Education
Mr. Pat Rabbittee T.D.	Minister to the Government

This Committee gives overall political leadership in the fight against drugs, reviews all trends in the drugs problem, assesses progress in the strategy to deal with both the supply and demand aspects, and resolves any policy or organisational difficulties which may inhibit an effective response to the problem.

National Drugs Strategy Team

The National Drugs Strategy Team was set up at two levels - ***policy and operational***.

The ***Policy Team*** comprises Assistant Secretaries from the Departments which are represented on the Cabinet Drugs Committee and from the Office of the Tánaiste. Its remit is to review progress in the implementation of the Government's anti-drugs strategy (including the recommendations in our First Report); address any policy issues which might arise from its implementation; and report to the Cabinet Drugs Committee on a regular basis and bring to its attention any issues requiring political direction or decision.

The ***Operational Team*** also comprises representatives from the same Departments as those represented on the Cabinet Drugs Committee. In addition, it contains a representative each from the Garda Siochana, the Eastern Health Board and FAS, along with two persons with extensive experience in voluntary/community work in the drugs sector - Fr. Sean Cassin and Mr. Fergus McCabe. The Operational Team's objectives are:

- to ensure that there is effective co-ordination between Departments/statutory agencies in implementing the Government's anti-drugs strategy;
- in relation to the Local Drugs Task Forces:
    - to oversee their establishment and assist them in their work on an ongoing basis;
    - to draw up guidelines to assist them in the preparation of their anti-drug strategies;
    - to evaluate their strategies, when submitted, and make recommendations to Government regarding the allocation of resources to support their implementation;
- to monitor developments at local level, ensuring that the problems and priorities of communities are being addressed by central government; and
- to identify and consider policy issues before referring them to the Policy Team. The policy and operational elements of the Team may meet in joint session to discuss these issues and any other matters relevant to their remit.

Local Drugs Task Forces

To ensure effective co-ordination of programmes and services at local level, to involve communities in the development and delivery of locally-based anti-drugs strategies, and to focus our actions on tackling the drugs problem in the communities where it is most severe, Local Drugs Task Forces were set up in the following areas:

- Dublin North Inner City
- Dublin South Inner City
- Ballymun
- Finglas/Cabra
- North East Dublin
- Blanchardstown
- the Canal Communities (Rialto/Inchicore/Bluebell)
- Ballyfermot
- Kimmage/Walkinstown/Crumlin/Drimnagh
- Tallaght
- Clondalkin
- Dun Loaoghaire/Rathdown (parts of)
- North Cork City (where the emphasis is being placed on preventive measures)

While the worst affected areas were identified in our First Report on an electoral wards/DEDs basis, the areas in which the Task Forces actually operate are broadly similar to the Partnership areas designated under the Local Development Programme 1994-1999. In Dublin Inner City, however, Task Forces have been established on both sides of the Liffey, while in Cork the Task Force area covers the North City only.

The membership of the Task Forces comprises a representative each from the relevant Health Board, the Garda Siochana, the Probation and Welfare Service, the relevant Local Authority, the Education/Youth Service and FAS, along with a chairperson and six community representatives nominated by the local Partnership company. Voluntary agencies delivering a

drugs service in the area were also invited to participate, while the relevant Health Board was requested to provide a co-ordinator to each Task Force.

The Task forces were established to provide a strategic, locally based response by the statutory, voluntary and community sectors to the drugs problem in the areas worst affected by the drugs scourge. Specifically, they have been mandated to:

- compile a profile of all existing or planned services and resources available in their area to combat the drugs problem;
- prepare a development strategy to deal with the local drugs problem, which:
    - establishes the extent, pattern and dynamic of the problem in the area,
    - maximises the use of existing resources,
    - ensure effective co-ordination of the services and agencies concerned,
    - identifies strategic priorities for the achievement of the objectives of the strategy,
    - ensures that the strategy is consistent with other programmes and services which facilitate a reduction of the drugs demand in the area e.g. the Area Action Plan of the local Partnership;
    - includes proposals for the commitment of such development funds as may be provided,
    - provides for the monitoring and evaluation of the implementation of the strategy;
- oversee the implementation of the local drugs strategy; and
- provide such information, reports and proposals to the National Drugs Strategy Team as may be appropriate from time to time.

Funding of anti-Drug Strategies

As already mentioned, the Government approved funding of £10 million in 1997 to support the implementation of the non-mainstream elements of the anti-drugs strategies, following their evaluation by the National Drugs Strategy Team and approval by Government. The mainstream elements of the plans will be funded from the available resources of Government

Departments and their supporting agencies. The Strategy Team issued guidelines to assist the Task Forces in preparing their plans. A copy of these guidelines, which also set out the criteria to be used in assessing the plans and arrangements for disbursing funding to implement them, is at ***Appendix 4***.

The Task Forces were requested to submit their plans as quickly as possible, having regard to the need to maintain the momentum - and indeed sense of hope in communities - which has been built up since the publication of our First Report and the subsequent establishment of the Task Forces. In this regard, many of the Task Forces - in advance of developing their detailed plans - are initially identifying proposals which need to be introduced in their areas on a priority basis and are submitting these to the National Drugs Strategy Team for approval.

We are also aware that the Task Forces, in preparing their proposals, are engaging in as wide a consultative process as possible. In many areas, this has involved the establishment of working groups on the different elements of the plans (i.e. treatment, rehabilitation, prevention, etc.) and has also involved public consultation meetings. We understand that the response to this process has been very positive, particularly from community and voluntary groups. This, in turn, has led to a substantially greater amount of work for the Task Forces than was perhaps originally envisaged. While this has to some degree slowed down the process of developing the strategies, we view it as a positive development, as it confirms our earlier belief that communities have a willingness to engage in developing local anti-drugs strategies and indeed a major contribution to make to the process.

Other Recommendations in our First Report

In additional to the new structures which have now been put in place, we also made a number of other recommendations in our First Report, which have been, or are in the process of being, implemented. The following is an update on these initiatives:

Information/research

Health Boards are engaged in various types of research in order to ascertain the extent and nature of drug misuse. The Department of Health, in conjunction with the Health Research

Board, is working with Health Boards to ensure that the information which they produce is valid, reliable and comparable and in keeping with guidelines produced by the European Monitoring Centre on Drugs and Drug Addiction.

The Eastern Health Board has commenced a major research project in the Dublin area, aimed at establishing the prevalence of hard drug misuse.

Treatment

The Eastern Health Board has approved its drugs and AIDS service plan for 1997, which sets out recommendations for the expansion of all of its services for drug misusers. The proposals in the plan are being considered by the Local Drugs Task Forces - insofar as they relate to their areas - in the context of preparing their anti-drugs strategies.

young drug misusers:

programmes for young people who are, in the majority, heroin smokers have been established or are being supported in Clondalkin, Ringsend, Irishtown, Ballyfermot and the North and South Inner City areas. Other programmes are commencing in Baggot Street, the City Clinic in Amiens Street, the Aisling Clinic in Ballyfermot and Ballymun. The programmes (each of which lasts for about 2-3 months and which involve detoxification, counselling, family and group therapy) will deal with approximately 300 young people during 1997.

waiting lists:

the Eastern Health Board continues to expand its services to meet the target of eliminating its waiting lists for methadone maintenance by end 1997.

consultation with local communities:

the Eastern Health Board invited community groups and voluntary agencies with which it has an involvement to a workshop in January, 1997 to agree on what these organisations' priorities were regarding education/prevention and treatment. 57 different organisations were represented at this meeting.

Consultation continues with community groups and voluntary agencies on the establishment of Health Board services. The Board continues to work closely with the Local Drugs Task Forces to ensure that there is agreement on all developments and that services are developed in accordance with the identified needs and priorities of each area.

mobile clinic:

the mobile clinic continues to operate in the North and South Inner City and further sites are being investigated at Inchicore, Ballymun and Bluebell. It is expected that these additional sites will be operational shortly.

involvement of general practitioners and pharmacists:

the Eastern Health Board continues to recruit general practitioners and pharmacists into the treatment of drug misusers. Around 60 general practitioners and 42 pharmacists are currently involved. Over 1,900 people are receiving methadone maintenance, from either Health Board treatment clinics or general practitioners. The Department of Health Group, which has been established to review the involvement of general practitioners and pharmacists in the treatment of drug misuse, continues to meet and expects to provide the Minister for Health with a report on the issue in the near future.

telephone helpline:

training will shortly be provided to staff who have been selected to operate the helpline and it is expected that the service will be ready to commence in the near future.

Rehabilitation

FAS is implementing the following initiatives arising from recommendations in our First Report:

- it is prioritising all Community Employment (CE) applications which offer work experience/training for recovering drug misusers;

- priority is also being given to CE applications offering work experience/training for former drug misusers who are employment ready;

- FAS is working closely with the Local Employment Service with a view to establishing special links with sponsors of CE projects providing opportunities to former drug misers who are employment ready;

- in some instances, following local consultation with the Partnership, FAS has designated CE projects involved in the above area as "innovative". This allows for a more flexible delivery of CE; and

- there is a FAS representative on each Local Drugs Task Force and on the National Drugs Strategy Team.

The Eastern Health Board is working on the expansion of successful rehabilitation schemes such as the Saol and Soilse projects. These projects had been identified in our First Report as being particularly beneficial models of intervention.

Education/prevention

In our First Report, we recommended a range of measures in relation to education/prevention. The following is an update on progress in implementing these recommendations and other developments in this area:

Primary Schools:

There are three main strands to the programme of substance misuse prevention/education being developed at primary school level:

- awareness and information initiatives;

- the preparation and dissemination of educational resource materials for schools;

- a particular focus on areas where drugs, especially heroin, are known to be seriously misused.

- Two information booklets have been prepared - one for schools and the other for parents. Awareness and information seminars for teachers and parents are being organised, associated with the development of resource materials for schools. The information booklets will be available n schools in the areas where seminars are being held.

- Educational resource materials have been prepared for all primary school class levels and are being pilot-tested in 26 schools. The introduction of these resource materials to schools in the priority areas identified in our First Report will begin shortly. A programme of in-service training for teachers has been organised for schools participating in the pilot-testing. An extension of this training for teachers in other schools will accompany the introduction of the resource materials to those schools.

- Liaison has begun with local community groups in the areas where the resource materials are being pilot-tested. Training for teacher-counsellors and home-school liaison teachers in the priority areas is also being planned.

- There is a Steering Committee for the entire primary school programme. In addition, a full-time Project Officer has been appointed.

Second-Level Schools:

In-service training for teachers on the use of the programme *"On My Own Two Feet"* continues. To date over 1,000 second-level teachers have received this training, which has been offered to all second-level schools at this stage. The resource materials used in the programme are being revised at present, in the light of experience of their use.

An annual summer school for teachers, dealing with a range of health related issues (including drugs), will be organised by the Departments of Education and Health with the Mater Dei Counselling Centre.

Youthreach:

"On My Own Two Feet" has been disseminated to Youthreach centres throughout the country. Three training programmes, exclusively for Youthreach centre staff, are being organised during the current school year.

The Health Promoting School Network:

This network has been expanded from ten to forty schools during the current school year. There are twenty primary schools and twenty second-level schools in the network. Prevention of substance misuse receives special emphasis in the programmes of the network.

Department of Health:

The Department of Health continues to co-operate and consult with the Department of Education on the development of the substance abuse prevention programme for primary schools and on the implementation of the programme in second level schools. Health Board staff are assisting in the provision of in-service training.

The Health Promotion Unit produced an educational video entitled *"My Best Friend"* and this has been distributed to all second level schools and other relevant agencies. The principal aim of the video is to be a supportive resource for drugs education. It seeks to be a trigger for discussion and to give an insight into the way in which drug misuse impacts on relationships and lives, using the example of a teenager's first experience of drugs - in this case ecstasy - and her eventual addiction to heroin.

Training in the community-based programme *"Drugs Questions - Local Answers"* for health and education professionals, Gardai, youth workers and others interested in drug-related problems are ongoing and available on a national basis through the Health Promotion Unit or the relevant Health Board.

The *"Leadership Training Programme for Primary Prevention of Drug Misuse"* (a Crosscare initiative, supported by the Health Promotion Unit and the European Commission) is a pilot project which aims to develop and implement a flexible process to facilitate targeted communities in tackling their own drug prevention issues.

In the Eastern Health Board area, four Health Education Officers have taken up duty, while a further five Officers will be recruited during the current year.

In general, Health Boards around the country are playing an active role in local initiatives. In approving the recommendations in our First Report, the Government set aside additional funding of £1 million in 1997 to assist Health Boards in devising anti-drugs strategies in their areas. In addition, Regional Co-ordinating Committees have been established in each Health Board area and their remit includes making recommendations and monitoring education/prevention measures. Each Health Board has launched or is launching information and awareness campaigns in its own area, telling young people and their parents about the dangers of drug misuse.

Role of Parents and Voluntary/Community Organisations

At this point, we would like to comment on the role of parents and voluntary/community organisations in developing and delivering anti-drug strategies.

As may be evidenced from the education/prevention programmes which are being developed or assisted by the Departments of Health and Education, these Departments, along with their supporting agencies, fully recognise that parents have a key role to play in reducing the numbers of drug-taking young people. Parents are more likely to spot tell-tale signs of a developing drug habit, such as behavioural changes. We would encourage their continued involvement in devising and implementing programmes to tackle the drugs problem.

Voluntary and community organisations also play a key part in the development and delivery of appropriate models of prevention and treatment for specific groups, and their services continue to be crucial to the success of interventions by the statutory agencies. In our First Report, we identified a key role for these agencies in tackling the drugs problem in the areas worst affected by the heroin problem. We recommend their continued involvement in developing and implementing future anti-drugs strategies, along with continued support by the State for their work.

Estate management

As mentioned earlier, arising from a recommendation in our First Report, the Government set aside £3 mission over 1997/98 to support the implementation of an Estate Improvement Programme. This programme has been introduced by the Department of the Environment on a pilot basis and deals with priority areas in Dublin City, South County Dublin, Fingal and Cork and Limerick cities. The purpose of the programme is to assist local authorities in tackling environmental and related problems in severely run-down local authority housing estates and flat complexes in certain disadvantaged urban areas, thereby enhancing the living environment for tenants.

The £3 million of Exchequer funding made available over the period 1997/98 will be, at least, matched by local authorities from their own resources. Work to the value of more than £6 million will, therefore, be carried out under the programme and will have a significant beneficial effect on he areas in question.

Allocations were approved under the programme in respect of the following local authorities:

Dublin Corporation	£1.25m
South Dublin County Council	£0.75m
Fingal County Council	£0.25m
Cork Corporation	£0.25m
Limerick Corporation	£0.25m

Local authorities were required to adopt an integrated approach involving tenants, Partnership companies, business interests, community groups and statutory agencies in the planning and implementation of projects. Consultation and partnership, therefore, are strong features of the Estate Improvement Programme.

Community policing

In our First Report, we recommended that a comprehensive policing strategy should be developed in the areas experiencing the worst effects of the drugs scourge.

Late last year, the Garda Commissioner launched a major initiative in respect of misuse of drugs, and the consequences attached thereto, in the Dublin Metropolitan Area. This initiative - *Operation Dochas* - is an integral part of the entire community policing concept.

Neighbourhood (community) policing, as a specific policing strategy, was introduced in urban areas in 1987 and the total number of Gardai specifically allocated to communities under this initiative stood at 193 pre-*Dochas*.

Operation Dochas was established on two principal pillars: the need to increase the uniformed Garda presence on the streets in specific community areas; and the need to support this community policing presence with specialist units - both covert and overt.

The aims and objective of *Operation Dochas* are:

- to re-inforce Garda commitment to the community at local level;
- to address the drugs problem in Dublin at community level;
- to establish a more personalised policing service at local community level;
- to prioritise the Garda focus on the drugs problem in Dublin; and
- to ensure that the only policing of these communities is performed by the Gardai, with the co-operation of local people.

The continued expansion of Community Policing and the implementation of *Operation Dochas* should be seen as a conscious and deliberate choice made by Garda management in favour of a philosophy of having a uniformed presence within the community areas in greatest need of a significant policing effort against drugs and related incidents. This philosophy is supported in many practical ways, including increasing Garda resources allocated to such duties. Since the implementation of *Operation Dochas* the uniformed Garda community policing presence has increased by a factor of 235%, from 193 to 455 members.

Policing involves a partnership, not only between the community and the police service, but also all those agencies who provide services for that community. In this regard, the Gardai are fully committed to and engaged in the multi-agency approach.

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Chapter 3

Misuse of Non-Opiate Drugs

Introduction

In this Chapter, we consider the situation in respect of certain non-opiate drugs, such as cannabis, and psychoactive drugs, such as ecstasy, LSD and "speed". Some of these drugs - like cannabis, which has been widely available since the 1960s - are long established. The arrival of others, most particularly ecstasy, is a more recent phenomenon. All of these drugs are associated to a high degree with *youth culture*. They also feature as part of the heroin scene, in the shape of the phenomenon known as poly-usage. However, the problem of heroin, on which we focused in our First Report, is markedly different from the *youth culture* drugs scene.

Extent of drug misuse

As mentioned in our earlier Report, definitive information on the prevalence and nature of drug misuse in this country is not available, reflecting the fact that the activity itself is illegal.

In the absence of reliable data, we are obliged to rely on:

- *indicators of drug misuse*, e.g. data on treatment, arrests, seizures, hospital admissions and drug-related deaths; and
- anecdotal evidence - from drug misusers who are receiving treatment or from those who are in contact with drug users.

However, both these sources have their shortcomings. With regard to treatment data, the information may well reflect factors other than levels of drug misuse, for example:

- the type of services that are available;
- the number of treatment places available;

- the services which return data to the Health Research Board's reporting system (this is done on a voluntary basis and not al treatment services partake); and
- the manner in which the data is presented.

Similar qualifications apply to the other indicators, such as data on seizures and arrests. Statistics in these cases may well reflect the level of Garda activity in different areas rather than the actual level of drug misuse. Also, the seizures may occur in areas other than that of the intended destination for the drugs. With regard to the second source of knowledge - informed anecdotal evidence - the lack of systematic collection of such data requires that it be treated with caution.

Research

We previously highlighted the need to address the lack of reliable data on the extent of drug misuse. We pointed out that there was a need for accurate research to assist in the longer term targeting of the drug services and to ensure that an appropriate mix of services was provided, based on the evidence for their need and effectiveness. Databases are currently being established in each Health Board area. When these are in place, they will contribute greatly to the collection and analysis of accurate information and will also assist in identifying new trends. This, in turn, will assist in the effective targeting of programmes and services and for this reason it is essential that comparable data be complied in each Health Board area. In ***Chapter 5*** of this Report we make additional recommendations in this area.

Nature of the drug problem

Despite the lack of data, the information which is available does provide us with a qualitative awareness of the nature of the problem which - even if accurate prevalence statistics existed - is also crucial to our understanding of the complexities involved in illicit drug use. For example, those who engage in this activity usually do so on a wide range of levels, which include:

- once-off experimentation;
- occasional and controlled drug use;
- regular but controlled drug use; and

- problematic use, where an individual's drug habit becomes the primary factor in his or her life.

Without acknowledging and considering this range of "drug using careers" when implementing strategies to tackle the problem, we run the risk of alienating drug misusers from the very strategies with which we seek to help them.

Range of the problem

Drug misuse occurs when any drug (legal or illegal) is harmful, or potentially harmful, to the physical, mental or social well-being of an individual, group or society. Despite the lack of definitive data, we do know that drug misuse is widespread in Ireland and that it takes two forms:

- ***heroin abuse*****,** which is confined mainly to Greater Dublin; and
- ***the misuse of other drugs, including so-called "soft" drugs such as cannabis and ecstasy***, which is a nation-wide phenomenon. Included also in this group would be amphetamines, tranquillisers, LSD., inhalants/solvents and magic mushrooms.

Alcohol

We note the views expressed in a number of submissions that alcohol should be considered in the context of any report on substance abuse. In particular, we are aware of the concern of many individuals and groups at the increasing attractiveness of alcoholic "fruit" drinks, especially among younger people.

We do not propose to deal specifically with alcohol abuse in this Report as we were only mandated to look at the abuse of *illicit* substances. In addition, the Minister for Health has produced separately a national strategy on alcohol. The main policy objective of this strategy is to promote moderation is alcohol consumption, for those who wish to drink, and reduce the prevalence of alcohol-related problems in Ireland, thereby promoting the health of the community. Nevertheless, it should be pointed out that the preventative strategies, which we

will outline later in this Chapter, are as relevant to tackling the problem of alcohol abuse as they are to the prevention of the misuse of drugs.

Heroin abuse

As already mentioned, we dealt with heroin abuse in our First Report. It was no coincidence that the areas where the problem is most severe are also those experiencing the highest levels of social and economic disadvantage. The link between heroin abuse and social and economic deprivation has been well established - not least in our earlier Report.

From the evidence which is available, it can also be stated with a reasonable degree of certainty that heroin abuse is never separate from the use of other drugs, such as cannabis, ecstasy, tranquillisers, sleeping tablets, barbiturates, alcohol etc. Opiate users often begin their drug using practices on other substances, although it is acknowledged that many non-opiate users do not progress to hard drug abuse.

As detailed in ***chapter 2***, we have already proposed and are currently overseeing the implementation of a range of initiatives to tackle the drugs problems in the heroin *"blackspots"* in a strategic, integrated fashion.

"Soft Drugs"

The use of so-called "soft drugs" such as ecstasy and cannabis is now widespread throughout the country and it is generally accepted that these drugs are available in every town and village in Ireland, although the actual incidence of their misuse is unknown. Cannabis is usually smoked and ecstasy is taken in tablet form. Ecstasy became popular in the United States in the 1980's in association with "house" music and is now popular at "rave" parties or dancing, while cannabis became popular in the 1960s as a recreational drug.

The Health Promotion Unit's publication *"Facts about Drug Abuse in Ireland"*, compiled by Dr. Des Corrigan of the School of Pharmacy, TCD, lists in some detail the known long term and short term effects of cannabis and ecstasy.

Effects of Cannabis

Cannabis is not usually considered to produce physical dependence, although tolerance to the effects occurs and physical withdrawal symptoms have been noted after cessation of heavy use. Psychological dependence has been noted in some users. Cannabis increases the workload of the heart and people who suffer heart disease, angina and blood pressure are particularly vulnerable to the adverse effects of cannabis. Another high risk group are those with pre-existing mental illness, particularly schizophrenia and depression, because cannabis may trigger off a relapse or make symptoms worse. There has been a steep increase in the number of patients admitted to Swedish psychiatric hospitals with a diagnosis of acute anxiety, delirium, schizophrenia and psychosis attributed to cannabis use.

On the basis of the evidence to date, it can be stated with reasonable certainty that some of the effects of cannabis are harmful to human health, but the extent of the risk is unknown. An authoritative American study of cannabis concluded that little is known for certain about the effects of marijuana on human health, but what is suspected about these effects justifies serious concern.

History of Ecstasy

The drug 3,4 Methylenedioxymethamphetamine (or MDMA or ecstasy or E) has become highly controversial in recent years. The drug was first developed in the early years of the century. It was patented by the German pharmaceutical company Merck in 1913. At that stage it would appear MDMA was marketed as a slimming pill. However, it then seems to have disappeared from use until the early 1950s, when it was tested by the U.S. armed forces for possible military application.

Modern day usage of the drug is usually traced to its “re-discovery” by an American biochemist, Alexander Shulgin, who worked as a research chemist with the Dow chemical company. During the late 1970s, Shulgin became a proponent of the use of MDMA for therapeutic purposes in psychotherapy. The drug was then still legal. However, between the late seventies and the mid eighties, the use of ecstasy for recreational purposes spread in the United States. At this point - in 1987 - the drug became controversial and was banned by the Drug Enforcement Agency (DEA). A series of court cases followed but by 1988 the DEA

ban was confirmed, although the ban is still being contested on grounds of its constitutionality by advocates of the drug in the U.S. The drug went underground.

It was in the late 1980s that the drug "arrived" in Europe (where in fact it had originally been developed). It was quickly adopted by elements of British youth culture in particular. It became closely associated with "house" music and the dance and "rave" scenes. It is now estimated that up to one million tablets are consumed in Britain every week and that up to three-quarters of a million people have taken ecstasy, with well over a hundred thousand regular users. The British estimates are based on the bi-annual British Crime Survey carried out by the Home Office.

Effects of ecstasy

Deaths among ecstasy users have been reported from the United States, Britain and Ireland. In the U.S. deaths have been due mainly to delusional behaviour under the influence of the drug (e.g. climbing electricity pylons), or to pre-existing heart or asthmatic disease. In Ireland some of the deaths which have occurred are believed to have involved massive overdoses related to the presence of huge quantities of tablets being smuggled into the country in body cavities. Many of the deaths in Britain have resulted from heatstroke. The drug causes a serious rise in body temperature (up to 41 degrees centigrade). The hyperthermia is worsened by the steamy atmosphere at the "rave" and the body heat generated by prolonged frenetic dancing. Death subsequently occurs due to muscle breakdown, clotting of blood inside the body and kidney failure.

A recent unexpected problem from the drug is that of hepatitis or jaundice. In some cases the liver damage was sufficiently severe to warrant liver transplantation and deaths due to the liver damage have occurred. The cause is as yet unknown. Experts suggest that the liver damage could have resulted from hyperthermia or that it could be due to direct toxic effects of the drug itself, of one of its breakdown products, of a contaminant produced by mistake during the synthesis, or of an additive used to *"cut"* the pure drug. Other serious complications include cases of convulsions, stroke and severe chest pains.

Because ecstasy has never been officially used as a medicine and because its frequent widespread use by large numbers of young people is so recent, there is little reliable information on the long term effects of the drug. The general belief is that MDMA is not a drug of addiction but it is premature to make a definitive statement about its dependence potential. Firstly, it is an amphetamine derivative and other amphetamines have the potential to cause psychological dependence. Secondly, a number of users in other countries have developed tolerance to the effects of the drug, having to increase the dosage up to five times normal to obtain the same effect. The tolerance may take some weeks to disappear and is an indicator that, with prolonged use, dependence could be a possible problem.

Marketing of "soft drugs"

Many of the submissions to the Task Force expressed concerned that drugs such as ecstasy and cannabis are marketed as being *"cheap and safe"*. The general impression among users of cannabis - which is perhaps the most widely abused drug - is that it is harmless. Some submissions commented on the potential long-term psychological and physiological effects of these drugs.

An area of particular concern in submissions was the marketing of the so-called ***"party packs"***. In addition to an ecstasy tablet, these packs contain a small quantity of heroin, to allow the users to "come down" from the effects of E. The attraction of these packs for young people is obvious, particularly in the context of keeping knowledge of their ecstasy-taking from their parents. One submission even suggested that methadone is being used for this purpose.

There is also widespread concern in relation to the additives which are being used to *"cut"* the pure ecstasy drug. It has been suggested that a variety of substances are being used for this purpose, including rat poison. Furthermore, as the drug is not produced under laboratory conditions, to strict medical standards, the amount of pure ecstasy can very from tablet to tablet.

"Soft drugs" and youth culture

Given that experimentation is a part of adolescence, it is not unreasonable to expect that in some instances drug use may form part of that experimentation. In its submission, the *National Youth Federation* described the close association between the use of drugs such as alcohol, cannabis and ecstasy and *youth culture*. Drugs have been associated with music and youth culture for many decades, the most consistent and abiding drug choices for young people being alcohol and tobacco. Illicit drugs and other stimulants change according to fashions, fads and availability. Evidence suggests that alcohol, ecstasy and cannabis are the most common drugs experimented with by young people today. Unlike heroin abuse, the use of ecstasy and cannabis is not linked to any particular social or economic class.

The attitude of young people to drugs has been the subject of various surveys. During 1996, Ireland participated in a European School Survey Project on Alcohol and Drugs, which was conducted among a random sample of 16 years olds, averaging about 2000 students in each country. The survey was carried out under the aegis of the Swedish National Council for Information on Alcohol and Other Drugs and the Pompidou Group.

It emerged in this study that the 16 year olds of the UK and Ireland who were surveyed tended to report somewhat higher levels of illicit drug use than other countries in the study. However, it should be stressed that the majority of young people (about two-thirds) never tried any illicit substance on even a single occasion.

The results of this survey has not yet been finally collated, but preliminary reports for Ireland show that a high proportion of young people who had experimented with illicit drugs had tried cannabis. Of those who had ever tried any illegal substance in Ireland (37%), all had tried cannabis and just under half of these (16%) had tried substances other than marijuana. It is interesting to note that for the overwhelming majority of people who had tried illegal substances, cannabis was the substance with which they began.

With regard to perceived risk, occasional use of cannabis was considered to be less dangerous than heavy smoking. However, many more were of the view that regular cannabis use was more dangerous than was the case with occasional use. In the case of ecstasy, the

majority of respondents were of the view that occasional use was not risky. This is remarkable given the highly publicised tragedies associated with its use.

Another interesting point to emerge from the survey was that the vast majority of those who had used an illegal substance said that the illegal drug which they first used was either obtained from a friend or shared in a group. Only a very small number said they had bought the drug from a stranger. The inference from this would appear to be that when it comes to starting to use drugs, the influence of friends and peers can be a key factor.

Despite the reservations which we mentioned about placing too much emphasis on treatment statistics, the Health Research Board's 1995 Report on Treated Drug Misuse in Ireland also provides relevant information on drug misuse among young people. That Report indicated that around 90% of those receiving treatment for ecstasy abuse were between 15 and 24 years old. The Report also showed that 35% of the total treatment group nationally had first used any drug when they were less than 15 years old and a further 56% in the Greater Dublin Area and 53% in other Health Board areas were aged between 15 and 19 years when they first used any drug.

Tackling the problem

While treatment is provided by the psychiatric services to those who seek it in overcoming an addiction for the misuse of non-opiate drugs, such as cannabis and ecstasy, the numbers who do so are small relative to the number of users. We believe that to tackle the problem we should concentrate our efforts on primary rather than secondary prevention. This entails developing preventative strategies beforehand rather than relying on treatment and rehabilitation afterwards. We believe that a successful strategy to deal with the abuse of non-opiate drugs entails:

- **education/awareness** measures to discourage people, especially young people, from becoming involved with these drugs in the first place;
- **information** for those who are already using or are likely to use such drugs; and
- the **development of youth and sport** as a preventative strategy in the fight against drugs.

Education/awareness

In ***chapter 2*** we outlined the progress which has been achieved to date in implementing the recommendations in our earlier Report in relation to education/prevention, along with other developments in this area. As education/awareness relates to creating the conditions to stop people abusing drugs in the first place, these measures are as relevant to the strategy to combat the misuse of non-opiates as they were to the strategies outlined in our First Report. We believe that these measures represent a comprehensive programme of action in this area and we recommend that they continue to be expanded and built on in the context of not only alerting our young people to the dangers of substance abuse but giving them the life and social skills to withstand peer pressure to take drugs.

Information

The second component in our prevention strategy is in the area of information on drugs and drug abuse.

Last year, the Government spent £500,000 on drugs awareness campaigns. A mass media drug misuse prevention campaign was launched by the Health Promotion Unit in June, 1996. The aim of this campaign is to alert, remind and warn people about the dangers of drug misuse. There are two distinct target audiences for the campaign:

- **15-24 years olds** who are experimenting with drugs or are at risk of becoming drug misusers; and

- **parents of young people**, many of whom have huge concerns about the subject of drugs.

The message of the campaign is *"drugs destroy lives, not just of the users but people close to them too"*. The TV campaign is supported by cinema and fly posters and there is a radio campaign which is aimed more specifically at parents, urging them to seek advice if they believe that their children are involved in drugs. The radio campaign element contains specific messages on ecstasy and heroin. The first and second phases of the campaign took place during the Summer and Autumn of 1996 and the third phase is currently running.

Decriminalisation and harm reduction

Many of the submissions to us expressed the view that media campaigns which concentrate entirely on delivering a *"NO"* message are not properly focused and that more emphasis should be placed on *"harm reduction"*. These submissions suggested that a highly educated and sophisticated younger population are not satisfied with a simple *"NO"* message. The evidence received by us would appear to support the view that a significant number of young people do not believe all drugs are dangerous. As mentioned earlier, a European survey of 16 year olds conducted last year revealed that in Ireland occasional sue of cannabis was considered to be less dangerous than heavy smoking and that the occasional use of ecstasy was not considered to be risky. Meanwhile in Britain, it is estimated that up to three quarters of a million people have taken ecstasy, while well over one hundred thousand use it regularly.

While a definitive verdict on the long-term physiological and psychological effects of drugs such as cannabis and ecstasy is not yet available, there is sufficient evidence to justify concern among medical experts regarding the dangers of these drugs. In February, 1996, the Government decided that there should be no move to decriminalise so-called "soft drugs" and that hand in hand with this approach, the main focus of education and prevention campaigns should be to discourage young people from becoming involved with drugs in the first instance. The Task Force is also aware that in accordance with Government policy the ultimate aim of the treatment services is to return drug misusers to a drug-free lifestyle. We believe that this should continue to underpin the Government's approach.

At the same time, it must be recognised that many young people, through peer pressure or otherwise, may be tempted to ignore advice not to take drugs and start using so-called "soft drugs", such as cannabis or ecstasy. In countries like Britain, education and prevention campaigns have adopted a "harm reduction" approach in relation to the use of these drugs. In these countries, advice not to use the drug is supported not only by factual information on its known dangers, but also practical advice on how to reduce its harmful effects for those who will choose to ignore this advice.

Furthermore, a code of practice has been developed in Britain for dance or "rave" venues, where it is believed that ecstasy is widely available. This code deals with issues such as:

* air conditioning and ventilation;
* availability of drinking water;
* additional measures to combat overheating, such as the provision of "rest areas";
* other environmental factors such as access, structural conditions, etc.;
* staff training;
* medical and first aid provision; and
* dissemination of information and advice on drugs.

The Minister for Justice has, of course, recently published legislation to deal with the problem of "underground dances or raves" in this country.

Conclusion/Recommendation

The continued development of information programmes and campaigns will, we are certain, alert many young people to the dangers of drug abuse and will assist them in making the decision not to become involved in this practice. Nevertheless, it has to be acknowledged that there are those who will ignore this advice. We believe that, to assist these people, consideration should be given to developing information/media campaigns here in Ireland which replicate the "harm reduction" approach being adopted in countries like Britain.

Youth and Sport

The third element in our strategy to prevent people, especially young people, from becoming involved in drugs is in the area of youth and sport.

The increased availability of drugs and their accessibility - due to reduced cost and prevailing social attitudes - have resulted in a situation where young people have become the most vulnerable category in terms of the threat that drugs pose to individual communities and society in general.

Youth work is recognised as a planned, systematic educational process, designed to assist and enhance the personal and social development of young people. It is a particularly successful intervention in terms of demand reduction among young people for a number of reasons:

- it aims to develop individual potential, assertiveness, self-esteem and personal and community responsibility;
- it is needs-based and flexible in its content to respond to emerging needs, while at the same time providing a very structured environment for the young people involved;
- it acts as a bridge between the young person and the community and facilitates the re-integration of many marginalised young people back into the community.

Therefore, the Youth Service is particularly well placed to respond to the pressures experienced by young people in relation to drugs, e.g., youth culture, unemployment, isolation, social exclusion and peer pressure.

Sport also plays a key role in reaching out to children and young people who are unattached and isolated from their communities and from the formal education and training services. Active involvement in sport and physical recreation has an important preventative role in relation to drug abuse, anti-social behaviour and crime. Sports clubs - working in co-operation with other youth and community groups, statutory services and formal education - help provide a coherent network of challenging and attractive opportunities for the marginalised, socially detached and economically deprived young person.

Sport

The Department of Education currently funds the provision of local sports and community recreational facilities and seeks to target areas of social and economic disadvantage in the operation of this programme. A new programme has been introduced by the Department whereby training is provided by the local Vocational Education Committee for voluntary community “Sport for All” leaders, so that these leaders can work in their localities in co-ordinating sports activities and in helping to increase participation in sport and physical recreation. However, in order to optimise the usage of local sports facilities, to co-ordinate interaction between sports clubs and other community-based services and to attract isolated

young people into sport and physical recreation, there is a need to employ and train resource persons, leaders and motivators at local, grass roots, community level.

The Irish Sports Strategy Report, published in February, 1997, proposes that a number of pilot projects be established in urban areas with local Sports Development Officers working in partnership with local authorities, vocational education committees, health boards, sports clubs, sport centres and community groups. It also proposes that Local Sports Development Forums be established to co-ordinate local activities and to bring local clubs and groups together. This co-ordinated approach - energised by the work of the local Sports Development Officers - would enhance the activities of existing groups and clubs, would promote increased involvement in sport and physical recreation and, in particular, would reach out to marginalised young people and provide them with alternative opportunities and a healthy, productive involvement in their community.

Recommendation

We believe that these proposals, if implemented, would contribute greatly to strategies to reduce the demand for drugs in disadvantaged areas. We recommend that they receive whatever support and resources are necessary to ensure their implementation.

Youth Service

The Youth Service responds in three principal ways to the problems of drug misuse:

- Primary Prevention: health education and diversion
- Intervention: direct work with drug misusers
- Community Development and Education

There is, therefore, significant potential for drug misuse prevention, intervention and community awareness strategies in the non-formal education (or youth work) sector. Youth work programmes which equip young people with the social skills necessary to make informed choices and decisions for their own lives, which encourage a positive self-image

and build personal autonomy and which promote an awareness of personal responsibilities are fundamental to a positive prevention strategy.

The Department of Education, through its Youth Services Division, is currently involved in a number of initiatives in the youth work sector. Youth work services are provided primarily by voluntary youth organisations and community groups, involving over 25,000 adult volunteers throughout the country. Professional youth work staff provide support and training for these volunteers across a network of clubs and youth groups and provide for more specialised intensive intervention in special projects for *"at risk"* young people in disadvantaged areas.

The ***National Youth Health Programme*** is a partnership between the Youth Affairs Section of the Department of Education, the National Youth Council of Ireland and the Health Promotion Unit of the Department of Health. It provides, throughout the Youth Service, a broad-based, flexible health education programme for young people incorporating information, training and programme development.

In response to a growing need for guidance and training on drugs issues, the Programme Management Committee developed and launched the *"Youth Work Support Pack for Dealing with the Drugs Issue"* in 1996. The pack aims to facilitate youth organisations in developing a comprehensive drugs strategy which will address the drugs issue at both programme and policy levels. Following on this publication, a drugs training strategy for the Youth Service was introduced in 1997. Ten 4-day regional training events have been organised in order to facilitate as many youth organisations and youth work personnel as possible and will encompass training on the *"On My Own Two Feet"* programme, in additional to the *Youth Work Support Pack.*

A number of special projects for disadvantaged young people, supported by the Department of Education, operate specifically in the drugs education/prevention area. These include the *Ballymun Youth Action Project* and the *Cryptic Project in* Balbriggan, Co. Dublin.

In addition to these specific drugs intervention programmes, almost 200 projects supported under the *Grant Scheme for Special Projects to assist Disadvantaged Youth* are operated by youth organisations and community groups throughout the country and most of these now deal with a range of drug-related issues. The provision of guidelines, resource materials and training for personnel will greatly enhance the effectiveness of these projects in the area of drugs education and prevention.

Recommendations

With emphasis on the educational role of the Youth Service and recognising the fact that it is uniquely positioned to offer positive alternatives to young people in this area, we believe that the following additional strategies would significantly increase the potential of the Youth Service in facilitating demand reduction among young people, particularly those most at risk and least likely to benefit from school-based programmes:

- the development and implementation of a substance abuse prevention programme specifically for the non-formal education sector, to be introduced with an accredited *"Training for Trainers"* programme in order to rapidly maximise the full potential and penetrative effect of the resource material among youth and other organisations and, ultimately, young people. It is envisaged that the multiplier effect of the approach to training would be substantial within youth organisations, resulting in an effective and continuing response to the problem of drug misuse among young people;

- the employment of a training team to develop, co-ordinate and implement this educational strategy throughout the Youth Service;

- the development of specialised outreach programmes to reach those not in contact with any services or organisations - i.e. those who are often most *"at risk"*; and

- the development and implementation of information strategies designed specifically to target young people with low literacy skills.

The submissions received by us - in both this and our previous Report - point to the importance of high quality youth services in areas where there is a high risk of patterns of drugs abuse. By providing after-school activities, development opportunities, the acquisition of social skills, the support of positive role models and such, youth services can play an invaluable role in supporting the successful transition from youth to adulthood.

In areas which are characterised by high unemployment and a poor physical environment, good quality youth facilities can play an important role in an integrated strategy to tackle disadvantage and social exclusion. It is clear that the existing level of provision of youth services - both in terms of personnel and premises - falls significantly short of what is desirable.

Youth Services Development Fund

Given the importance of the preventive dimension of policy in relation to drug misuse, we are of the view that a high priority should be attached to developing youth facilities in areas where the problem of drug abuse is prevalent or where it may be likely to emerge. This requires a balanced approach to the provision of suitable accommodation and personnel.

The objectives to be pursued should be such as to mobilise support across the whole community. The provision of appropriate opportunities for the development of our young people is a matter of interest and concern to the whole community. Those who - by virtue of their family or community background - can have access to opportunities for development, participation and travel are at a distinct advantage relative to those without such benefits. For that reason, we recommend that the provision of improved youth facilities in disadvantaged areas should be regarded as a key objective of our preparations to mark the Millennium.

Accordingly, we recommend that, to meet prioritised needs in disadvantaged communities where drug abuse is a significant problem, development proposals should be prepared by the relevant VECs and local authorities, taking account of the views of local bodies such as the Area Partnership companies. Proposals from the Local Drugs Task Forces should also be

considered in respect of their areas. In the latter case, these would arise from their development plans which are currently being prepared. The allocation of these funds should be determined on the same basis as the £10 million development fund provided for on foot of our First Report. The provision of services should be funded by a mixture of Exchequer and private contributions. We believe that the corporate sector will recognise the strategic importance of preparing the next generation of young people, both in and out of school, to meet the challenges of the world around them. That includes the capacity to resist the drugs menace.

For that reason, we propose the establishment of a Youth Services Development Fund which would aim to provide premises and facilities in disadvantaged areas where there is a significant drugs problem. We propose that the fund should comprise contributions from the Exchequer and the corporate sector. We envisage that an Exchequer contribution of the order of £20 million would enable significant progress to be made in the context of the Millennium in meeting the current needs for premises and facilities.

Youth leaders

The provision of staff to lead the development of Youth Services will also require to be funded. We recommended that this should be accorded a high priority in the allocation of the "demographic dividend" in education, recognising the broad educational role played by those working in the youth service. We also recognise the importance of providing training and employment opportunities for youth leaders from the communities concerned and we recommend that developments within Community Employment and other social economy measures should aim to facilitate the recruitment and deployment of local people to work as youth leaders in their own communities.

Summary of Conclusions/Recommendations

To summarise, whereas heroin abuse is confined almost exclusively to marginalised areas in Dublin, the misuse of non-opiate drugs such as cannabis and ecstasy is a nation-wide phenomenon and is closely associated with *youth culture*. While treatment is provided by the psychiatric services to help those who are addicted to deal with their problem, we believe that

we should concentrate our efforts on developing preventative strategies beforehand rather than on treatment and rehabilitation afterwards. This strategy would entail:

- education/awareness to discourage people, particularly young people, from becoming involved with drugs;
- information/harm reduction messages for those who are already using or are likely to start using so-called “soft drugs”;
- the recruitment of local Sports Development Officers in disadvantaged areas and the establishment of Local Sports Development Forums;
- the development of a substance abuse prevention programme specifically for the non-formal education sector; the employment of a training team to develop, co-ordinate and implement this programme; the development of specialised outreach programmes for “at risk” young people; and the development/implementation of information strategies for young people with low literacy skills; and
- the establishment of a Youth Services Development Fund to provide premises and facilities in disadvantaged communities, based on development proposals to be prepared by relevant statutory agencies, taking account of the views of other relevant local bodies; the provision of staff to lead the development of youth services to be accorded a high priority in the allocation of the “demographic dividend” in education; and the training and employment of youth leaders from disadvantaged communities under Community Employment and other social economy measures.

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Chapter 4

Drug Abuse in Prisons and the Treatment of Prisoners who Misuse Drugs

Introduction

In this chapter we deal with the issues of drug abuse in prisons and the treatment of prisoners who misuse drugs. This follows on from our consideration of the heroin problem in our First Report. Given the fact that many heroin abusers will most likely experience a period of imprisonment, the prison system plays a critical role in the State's battle against drugs.

It is important to remember, however, that the problem does not begin or end in prison. The vast majority of prisoners who misuse opiates come from economically and socially deprived backgrounds. As we pointed out in our First Report, this is perhaps one of the most critical factors in the development of their drug habit. What is required, therefore, is a response which addresses their problems and needs in a holistic manner. This requires an integrated system of supports - both inside and outside the prison system - which can respond to the movement of drug misusers between prison and the community and which seeks primarily to rehabilitate and reintegrate them back into society.

This process may involve not only rehabilitating drug misusers who serve a period of imprisonment but also developing alternatives to prison for low risk offenders who commit petty crime purely to finance their drug habit. These alternatives, which of course would require supervision by the relevant authorities (such as the Probation and Welfare Service) must place their emphasis on treatment and rehabilitation rather than punishment.

Methodology

In undertaking our examination, we:

- visited Mountjoy prison;
- invited and considered submissions from individuals and national, sector and voluntary/community organisation;
- met with the President of the District Court, Judge Peter Smithwick;
- met with the Governor of Mountjoy Prison, Mr. John Lonergan, together with officials from the Department of Justice and the Director of Prison Medical Services; and
- met with the Principle Probation and Welfare Officer, Mr. Martin Tansey, and Ms. Anna Wrynne, Senior Probation and Welfare Officer.

Prison policy generally

It should be stated from the outset that the general question of prison policy was outside the remit of the Task Force. However, an examination of the drugs issue, which does not take account of the fact that many opiate abusers are likely to experience a period of imprisonment, would have been incomplete. It was essential, therefore, that we examined the prison system in the context of how it impacts on the drugs problem, in particular heroin abuse

Issues considered

Given that the opiates problem is mainly concentrated in Dublin and the fact that a huge proportion of heroin abusers committed to prison are sent to Mountjoy, we focused our attention on the drugs problem in that prison and the attempts being made by the authorities to address it. We looked at the following aspects of the problem as it affects Mountjoy;

- the extent of drug misuse in the prison;
- the availability of drugs, including the factors which impact on this;
- the effectiveness of current treatment programmes in the prison, with particular reference to how they integrated with treatment and rehabilitation programmes available on the outside; and

- the question of developing properly supervised alternatives to prison for low risk offenders who misuse drugs

Extent of drug misuse in Mountjoy

A large proportion of prisoners in Mountjoy are drug misusers. The best estimate available suggests that approximately 70% of inmates at any given time have a history of drug misuse. It is considered that approximately half of these have no desire to receive treatment for their addiction. It was also reported to us that the number of prisoners who commence taking drugs in prison is quite small. Contrary to the public perception, most drug takers come in with an already developed habit. With so many chronic drug misusers in the prison, there is obviously a huge demand for drugs. The sheer scale of the demand puts enormous pressure on Mountjoy and aspects of its internal organisation. The evidence available suggests that drugs are being smuggled into Mountjoy despite controls and screening and many misusers continue to feed their habit while in prison. However, it was also contended that the availability of drugs in the prison is falling, due to the current crackdown on the outside.

Measures to tackle the smuggling of drugs into the prison

Measures which have been introduced by the prison authorities to combat the problem include:

- screened visits for prisoners who are caught receiving drugs;
- an increase in the number of prosecutions of those caught smuggling in drugs;
- the introduction, on a pilot basis, of "sniffer" dogs in searches of prisoners' cells; and
- the use of surveillance equipment, with play-back facilities, in monitoring visits.

The severity of the regime required to tackle the problem is of course a matter for local management to determine - having regard to all relevant factors, including the fair and humane treatment of prisoners. We were informed that the following factors inhibit the effectiveness of the authorities in countering the problem in Mountjoy:

- drugs are usually smuggled in in minute quantities and it is impossible to carry out full-proof searches of prisoners, particularly of those who conceal the drugs internally. Factors to be taken into account include bodily integrity of prisoners, the dangers of prison staff contracting HIV/AIDS from needle injuries in searching for syringes, etc;

- the structural state of the prison. Mountjoy was built in Victorian times and was obviously not designed to deal with the modern day phenomenon of drug misuse in prisons. We were informed that, although the prison is in need of extensive renovation, there are no proposals at present to close it - primarily because alternative prison accommodation is not available; and

- the huge throughput of committals. Mountjoy (as the main committal centre in the State) processes in the region of 5,500 to 6,000 inmates per year, many of whom are then distributed throughout the prison system. The huge movement of prisoners between the prison and the courts, etc. contributes greatly to the problem.

The opening of the proposed new remand/assessment centre at Wheatfield in 1998 (with a capacity of 400) will impact on the "throughput" problem at Mountjoy, where the constant movement of prisoners will be greatly reduced. It will also have an effect on overcrowding in the prison. Provided sufficient resources were committed, it would be possible to renovate Mountjoy on a wing by wing basis once the new remand/assessment centre is operational, thereby reducing the tension caused by overcrowding.

Current treatment programmes in Mountjoy

We were advised that the current arrangements in Mountjoy for the treatment of prisoners who misuse drugs are:

- all committals who misuse drugs are offered a 14 day detoxification programme;
- an intensive therapy programme (introduced in the prison in September, 1996) is a multi-agency approach which is co-ordinated by the Senior Probation and Welfare Officer. Each programme deals with 12 offenders and runs for 8 weeks. The therapy programme is a follow-on to the detoxification;

- prison doctors in Mountjoy generally do not favour putting inmates on methadone maintenance programmes unless:

    - they are already on the programme when committed; or

    - are assured of continuing it on leaving Mountjoy;

- a new drug-free unit opened adjacent to Mountjoy in June, 1996, which can accommodate 96 prisoners. This is the former Training Unit of the prison complex. It was indicated to us that there are proposals to extend such units throughout the prison system - in the wings at various prisons and in the open prisons at Loughan House, Shanganagh and Shelton-Abbey.

It was also indicated that there are proposals to introduce a "graduation" system for prisoners who come off drugs, where they can for instance graduate from a closed prison through an open prison, to early release - based on their staying drug free.

It appears that the policy in relation to methadone maintenance in Mountjoy is not entirely consistent with that advocated by the Eastern Health Board on the outside. It was pointed out, however, that situation factors in prison over and above those pertaining in the general community - such as prison location, length of sentence, safety in terms of denying access to illicit drugs, etc. - are all relevant in treatment decisions in the prison.

It also seems clear to us that there are no formal structures in place to ensure that the drug treatment services inside and outside the prison are properly co-ordinated, although some efforts are beginning to be made to address this situation. This is particularly important in the context of drug misusers being released from prison. Once a prisoner is released, it is no longer possible for the prison authorities to have responsibility for his or her welfare. In view of this, there is a need for a formal mechanism to ensure that persons being released from prison have access to or can continue this treatment. At present, drug misusers can "drift" in and out of the criminal justice system and treatment programmes without any agency taking primary responsibility for monitoring their welfare on an ongoing basis.

Developing alternatives to prison

We also considered whether it would be more appropriate to intercept certain offenders who misuse drugs at the point of entry into the criminal justice system and divert them towards properly supervised treatment/rehabilitation programmes, as an alternative to prison. While some prisoners are habitual - and their drug taking is merely one aspect of their lifestyle – there are those who commit crime solely to finance their drug habit. We considered whether it would be more effective to divert offenders who commit petty crime purely to feed their habit onto treatment/rehabilitation programmes rather than sending them to prison.

In the United States, a system of Drugs Courts operates in many States. This system was introduced in Dale country, Florida in 1989 as a treatment diversion programme and became known as the Miami Drugs Court. The experiment was subsequently followed in many other States. The Drugs Court is a court-operated rehabilitation programme. It requires a huge support system - embracing public health policy, criminal policy and also, to a degree, education, training and manpower policy. The programme's intake is non-violent defendants arrested on drug possession charges and drug-related offences. The underlying ethos of the programme is that the defendant is retained in the programme until he or she attains set goals or some act diverts them back into the criminal justice system.

It has been proposed that the system might be replicated here - perhaps by designating a certain number of judges to deal exclusively with drug-related cases. This, it is suggested by those who advocate its introduction, would ensure that drug misusers are retained in treatment programmes until they are stabilised/rehabilitated or have committed an act which leaves the authorities no choice but to divert them into the criminal justice system. By designating a set number of judges to deal with such cases, it would allow these judges to develop an expertise in dealing with such offenders and would also facilitate the fast-tracking of drug-related cases.

However, we also heard evidence that such a system was not necessary here. The Drugs Courts are essentially a mechanism which links he processing of certain types of offenders (i.e. drug misusers) into the treatment services. In practice, this is the way in which many of these cases are approached already and there is no great evidence to suggest that the Drugs

Courts would do it any more effectively. Opponents of these courts also say that the judicial system is sufficiently flexible and adaptable to respond appropriately to different types of offender, having regard to the factors which lead them into criminal activity in the first place.

In the context of developing alternatives to prison for low-risk offenders (i.e. those who commit petty crime solely to finance their habit) within the existing courts system, we looked at the following options:

the development of State-run facilities: the building of State-run treatment facilities was first advocated in the Misuse of Drugs Act, 1977. The proposals in that Act - which of course pre-dated the current drugs epidemic - envisaged the institutionalisation of drugs misusers in facilities other than prison e.g. the designation of centres in hospitals. It was pointed out that it would be likely to be held to be unconstitutional and in breach of international conventions to detain persons in custody other than for crimes they have committed. The implication of this is that drug misusers can only be offered the option of treatment as an alternative to prison - they cannot be compelled to receive treatment. On the other hand, it is reasonable to assume that a large proportion of drug misusing offenders would avail of this option, if it existed.

Funding of existing voluntary agencies: the Probation and Welfare Service currently grant-aids appropriate voluntary agencies to whom clients are referred for treatment. The possibility of making additional State funding available to voluntary agencies to allow them to develop their facilities, on the basis that they retain a proportion of places for the referral of clients by the courts, could be considered on the grounds that such developments would reduce pressure for spending in the Prison and Probation Services.

Community involvement: Current policy in relation to the provision of treatment services for drug misusers is to develop these services at local level, with the active involvement of the local community. This policy forms the basis of the Local Drugs Task Forces which have been established in Dublin and North Cork City. The anti-drugs strategies of these Task Forces obviously need to take account of the two-way movement of drug misusers between prison and the community. Consideration could be given to developing ways in which drug

using offenders might be treated within their own communities, as an alternative to prison. It might be possible, for example, for the courts to refer certain low risk offenders for treatment in their own community, provided they are properly supervised to ensure that they are receiving treatment and have ceased their criminal activity. Depending on the offence committed, this might also include community service and may even involve the development of a vocational skill, perhaps through a Community Employment scheme. It would appear that the Local Drugs Task Forces - on which relevant agencies such as the Health Board, FAS, the Gardai and the Probation and Welfare Service are represented - would be the ideal forum to develop proposals of this nature.

Conclusions/recommendations

The problem of drug misuse in Mountjoy does not begin or end in the prison. The vast majority of heroin misusers in the prison came from socially and economically deprived backgrounds. Attempts at their rehabilitation within the prison system - which do not take account of these factors - are of limited potential.

Arising from this, there is a need to develop a response which addresses the needs of these drug misusers in a holistic manner. This requires an integrated system of supports - both inside and outside the prison system. It has been suggested that the system of Drugs Courts which operate in the United States would meet this need. We are not convinced, however, that replicating such a system here in Ireland would necessarily work. We believe that existing arrangements broadly contain the principles which underpin the US system. In our opinion, the key issue to be addressed is the apparent lack of interaction and co-ordination between the various agencies responsible for operating the current arrangements.

We are not convinced that there is sufficient integration of services at present to provide an effective response to the needs of drug misusers who come into contact with the criminal justice system, although there is some evidence that this is beginning to happen. We believe it is imperative that drug misusers do not “slip in and out of the system” as responsibility for their welfare transfers from agency to agency. Properly co-ordinated and planned early releases to allow treatment to continue would be one example of how this might be achieved. It is also important that there be a sufficient degree of consistency in treatment policy

between the treatment services inside and outside prison - although it is recognised that certain operational factors come into play in the prison situation.

Arising from this, we believe that there is a need for an independent assessment - most appropriately, to be carried out with the assistance of international experts - to determine the effectiveness of the current supports available to offenders who misuse drugs and to make appropriate recommendations to integrate them more effectively.

We propose, therefore, that an Expert Group be established to examine these issues and report back within a short timeframe. The membership of this Group should comprise an independent chairperson and two international experts, one on the addiction treatment and the other on prison medical services, along with the Director of Prison Medical Services.

We also need to look at whether certain low risk offenders can be more effectively treated outside of prison, under the supervision of the appropriate authorities. We have suggested three possible models of treatment/rehabilitation in this regard, some of which are already being implemented to some degree. We recommend that these and other effective interventions be explored by the relevant authorities.

Finally, in relation to the smuggling of drugs into Mountjoy, it is our view that the first pre-requisite to any successful treatment programme for drug misusers is that it be carried out in a drug-free environment. We note that prison management has initiated a range of measures to tackle the smuggling of drugs into the prison. We recognise that there are factors - such as the structural state of the prison, the need to treat prisoners humanely, etc. - which have to be taken into account in any operational policy to tackle the problem. We appreciate that many of these problems will be addressed by the opening of the proposed new remand/assessment centre in Wheatfield in 1998.

Nevertheless we fell that, in the interim, prison management should continue to develop and improve strategies to tackle the smuggling of drugs into the prison. These might include more frequent searches of prisoners' cells with the use of "sniffer" dogs, perhaps assisted by the Gardai; the increased use of surveillance equipment (including x-ray photography); and the reporting and prosecution of all persons caught smuggling or receiving drugs.

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Chapter 5

Role of Therapeutic Communities

Methodology

Although in the time available to it, the Task Force did not hear oral evidence in relation to the role of therapeutic communities in the treatment of drug misuse, individual members of the Task Force met separately with various organisations and groups involved in this particular model of treatment. We also sought written submission on the issue in an advertisement which was placed in the national newspapers and a number of magazines last November/December.

Submissions

It is fair to say that this issue did not receive a significant amount of comment in the 72 submissions which the Task Force received from members of the public and national, sectoral and voluntary/community organisations.

The submissions which dealt with the issue were generally supportive of this particular model of treatment. Basically, they contended that the State's response to the treatment of drug misusers concentrated too heavily on one particular model, i.e. methadone maintenance. While some of the submissions argued that abstinence was the only model of treatment capable of long-term success, others suggested that different misusers had different needs at various stages of their addiction and a whole range of responses should be available to meet these needs. These submissions argued that more State funding should be made available to voluntary agencies delivering therapeutic services, both day-care and residential. They also contended that access to these facilities should not be based on one's ability to pay.

One submission suggested that

* an **inter-professional forum** should be established, to facilitate communication between exponents of different treatment models;

* **evaluation** should be a condition of all State funding for projects; and

* we should look at **international experience** in determining the suitability of different models of treatment.

Conclusions

From our examination of the issue, we are of the view that the therapeutic community treatment model should be part of an overall range of treatment and rehabilitation services available for drug misusers. Such information as is available suggests that the success rate for treatment in therapeutic communities is related to the commitment of the individual concerned to return to a drug free lifestyle, as well as the length of time spent in a therapeutic community setting. The development of a more comprehensive range of services, together with greater co-ordination of such services, will, it is believed, allow for access to a bigger number of drug misusers. This in turn will create the conditions to facilitate professionals to work on motivation and greater numbers of drug misusers to opt for a drug free lifestyle

It must be recognised, however, that the decision to stay off drugs is one which must ultimately be made by the drug misusers themselves and that this decision must be made taking into account a range of factors, such as the individual's socio-economic circumstances, pressure from peers, the support available from family members, local communities and statutory and voluntary agencies, as well as the individual's own motivation.

Recommendation

As already mentioned, one of the submissions to us suggested the establishment of a forum to facilitate communication between exponents of different treatment models. It also suggested that we should look at international experience in determining the suitability of different models of treatment. We believe that there is considerable merit in these proposals. We are aware that new approaches to the treatment of drug misusers are proposed on a regular basis. These very often require an in-depth review to establish their merit or otherwise.

It is our view that an advisory body should be established - with appropriate scientific and technical expertise - which would be in a position to conduct such reviews, offer advice and make appropriate recommendations. Such a body could also undertake research into other

aspects of the drugs problem, such as the causes, effects, trends, international developments, etc.

There is a need, however, to ensure that the work of the proposed body is not carried out in isolation of development in relation to research taking place elsewhere. As mentioned earlier, it is essential that we not only conduct more research into the drugs problem but that the research be carried out in a co-ordinated manner, to achieve a maximum return. The advisory group would need to be conscious of other research initiatives which are taking place around the country.

For this reason, it is proposed that the National Drugs Strategy Team should consider how this advisory structure might best be put in place. The Team should be asked to prepare appropriate terms of reference for the new group, along with advising on its proposed membership.

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Appendix 1

Ministerial Task Force On Measures To Reduce the Demand For Drugs

Terms of reference

(a) to report on the measures being taken to promote a reduction in the demand for drugs as follows:

(i) each Minister to prepare a written report on the relevant actions being taken and being prepared, within existing resources, in his/her area of responsibility, as follows:

* *treatment services for addicts* (Minister O'Shea)
* *education programmes in schools* (Minister (Allen)
* *public and community education* (Minister O'Shea)
* *services for children* (Minister Currie)
* *youth, sport and recreational facilities* (Ministers Allen and Currie)
* *employment and training initiatives* (Minister Rabbitte)
* *income maintenance for those undergoing treatment and being released from prison* (Minister Durkan); and
* *local development initiatives and estate management* (Ministers Mitchell and McManus).

(ii) In the light of material supplied by Minister O'Shea, the Committee to confirm the area/communities where the drugs problem is most acute;

(iii) In respect of each area identified under (ii) above, each Minister to indicate

* *the specific services/facilities provided or planned for each area; and*

* *the scope for sharing premises, staffing and information between relevant agencies in each area;*

(b) to identify, in particular, the scope for greater co-ordination with regard to:

(i) educational measures targeting schools, individual communities and the wider public (Ministers O'Shea, Allen and Currie)

(ii) the arrangements for release of prisoners, with particular regard to income maintenance, access to training, etc. (Ministers Rabbitte, Currie and Durkan);

(iii) the extent to which procedures for licensing of public houses and other facilities can contribute to reducing the scope for drug dealing (Ministers O'Shea and Currie);

(iv) to identify measures by which local authorities can ensure, through improved estate management, the reduction in drugs demand and in anti-social behaviour in their estates (Minister McManus); and

(v) to identify how the Area Partnership companies under the Local Development Programme could be supported to be more effective in responding to the drugs problem (Minister Mitchell); and

(c) to report to the Government by the end of September, 1996 on the measures being taken with regard to each of these items, to recommend any changes in policy, legislation or practice to facilitate more effective drugs reduction strategies in light of ongoing progress on the anti-crime package as outlined by the Minister for the Environment and to recommend any structural changes under the Strategic Management Initiative which would facilitate more effective co-ordination.

Appendix 2

Submissions from the Public

Organisations and individuals who made submissions

1	Aislinn Adolescent Addiction Treatment Centre (Sr. Veronica Mangan)	32 Willow Park, Clonmel, Co. Tipperary.
2	Newcastle Community Alert Group (Mattie McGrath)	Newcastle P.O., Clonmel, co. Tipperary
3	Mr Greg White	10 Castle Farm, Shankill, Co. Dublin
4	Mr. Patrick Dowling	Kellistown, Rathoe, Co. Carlow.
5	Frederick W. Brennan	83 Glenview Park, Kilpedder, Co. Wicklow
6	Dr. Deirdre Killelea, Clinical Psychologist	Dept. of Child Psychiatry, 90 O'Connell Street, Limerick.
7	Arjen Roolvink	Derrada East, Recess, Co. Galway.
8	Aislinn Project Fund-raising Sub-Committee (Ms. Mary Houlihan)	c/o 32 Willow Park, Clonmel, Co. Tipperary.
9	Cashel Community School (Sr. Claude Meagher)	Dualla Road, Cashel, Co. Tipperary.
10	National Conference of Priests of Ireland, Southern Region (Rev. Padraig O'Byrne)	Priests Road, Tramore, Co. Waterfold
11	Mr. Gordon Ramsey	34, Cartron Bay, Sligo.
12	Friends of Aislinn - Limerick (Mr. Danny Browne)	59 Monaleen Park, Limerick.
13	Council for Addiction Information and Mediation (Mr. Paul Delaney)	Nelson Mandela House, 44 Lower Gardiner Street Dublin 1.
14	Rialto Community Drug Team (Mr. Tony MacCarthaigh)	St. Andrew's Community Centre, 468 South Circular Road, Rialto, Dublin 8.
15	Cllr. Tommy Foley	28 St. John's Park, Tralee, Co. Kerry.
16	Mr. Glenn Perry	89 Glenavon Park, Loughlinstown, Co. Dublin.
17	Mr. Brian J. Ross	28, Eaton Square, Monkstown, Co. Dublin.
18	Ms. Margaret Campion	Dunningstown, Kilkenny.
19	Mr. Con Doherty	57, Esmondale, Naas, Co. Kildare

20	Mr. Patrick Callanan	Carrick-on-Suir Vocational School, Carrick-on-Suir, Co. Tipperary
21	Mercy Social Justice Commission-Southern Province (Bridget O'Keeffe)	St. Joseph's, Greystone Street, Carrick-on-Suir, Co. Tipperary.
22	NARCONON - Drug Rehabilitation & Education Service (E. Kenneth Eckersley)	c/o The Executive Council chairman, Bridge House, 26 Park Crescent, Forest Row, East Sussex Rh18 5ED.
23	Southwest Clondalkin Community Development Project (Peter Keeley - Secretary)	c/o Clondalkin Youth Service, Monastery Road, Clondalkin, Dublin 22.
24	Prison Officer's Association (Mr. Ray Murphy - Ass. Gen. Secretary)	18 Merrion Square, Dublin 2.
25	Ms. Deirdre Cummins	"Ashleigh", Upper Doyle road, Turners Cross, Cork.
26	Aislinn Adolescent Addiction Treatment Centre (Mr. John McDermott)	32 Willow Park, Clonmel, Co. Tipperary.
27	Mr. Brian Dack	13 Watermill Lawn, Raheny, Dublin 5.
28	Ms. Helen Davis	"Ivy Hall", Church Street, Cahir, Co. Tipperary.
29	Athnua House (Sr. Cait O'Leary)	22, Cathal Brugha Street, Waterford.
30	St. Munchin's Action Centre	Enterprise Centre, Kileely Road, Limerick
31	The Line Projects (Mr. Derek Shortall)	Office 7B, 276-288 South Circular Road, Dubline 8
32	LINKS Community Development Group	St. Joseph's, Greystone Street, Carrick-on-Suir, Co. Tipperary.
33	Mr. John Boles	390 South Circular Road, Dublin 8.
34	Congregation of The Sisters of Mercy (Sister Edel Bannon)	Eblana Avenue, Dun Laoghaire, Co. Dublin.
35	Addiction Counsellors Group, Eastern Health Board	Cuan Dara, Navan Road, Dublin 7.
36	Community Addiction Studies Course, Ballymun Youth Action Project (on behalf of course participants)	1a Balcurris Road, Ballymun, Dublin 11.
37	Inter-Agency Drugs Project	108 Amien Street, Dublin 1.

38	Mountjoy Prison Visiting Committee (Mr. Aidan Culhane)	57 Broadford Park, Ballinteer, Dublin 16
39	Community Response	29 Blackpitts, Dublin 8.
40	Kevin & Angela Treacy	Lower South Knock, New Ross, Co. Wexford.
41	Ms. Linda Spain	75 Barton Road Extension, Rathfarnham, Dublin 14.
42	Ballymun Education & Training Forum	c/o Holy Spirits School, Silloge Road, Ballymun, Dublin 11.
43	Mater Dei Counselling Centre (Ms. Kathleen Kelleher)	Mater Dei Institute of Education, Clonliffe Road, Dublin 3.
44	European Association for Treatment of Addiction (Ireland) (Mr. Mike Murphy)	Lislea, Whiteshed, Greystones, Co. Wicklow.
45	Mr. Ian Sheridan	6 The Close, Blackrock, Co. Dublin.
46	North Connacht Youth & Community Service Ltd. (Sean Callagy)	Enterprise Centre, Drumcora, Drumshanbo, Co. Leitrim.
47	Sinn Féin	44 Parnell Square, Dublin 1.
48	National Youth Federation (Fran Bissett)	20 Lower Dominick Street, Dublin 1.
49	Fr. Liam Sheridan	The Community Centre, 11 M. Fatima Mansions, Rialto, Dublin 8.
50	Crosscare (Chris A. Murphy, Director)	The Red House, Clonliffe College, Dublin 3.
51	Probation & Welfare Branch, IMPACT. (Patrick O'Dea)	c/o Smithfield Chambers, Dublin 7.
52	Southside Partnership (Ms. Josephine Fogarty)	45 Upper Georges Street, Dun Laoghaire, Co. Dublin.
53	Communicable Diseases Committee, Wheatfield Place of Detention (Mary Kett)	Education Unit, Place of Detention, Wheatfield, Clondalkin, Dublin 22.
54	Unity Centre - Ballymun	c/o 107 Shangan Avenue, Ballymun, Dublin 9
55	Ballymun Youth Action Project Ltd. (Mary Ellen McCann)	1A Balcurris Road, Ballymun, Dublin 11
56	Combat Poverty Agency (Mr. Hugh Frazer)	Bridgewater Centre, Conyngham Road, Islandbridge, Dublin 8.

57	URRUS - Ireland's Community Addiction Studies Training Centre	Ashly House, Swords Road, Santry, Dublin 9.
58	Ana Liffey Drug Project (Ms. Margaret Woods)	13 Lower Abbey Street, Dublin 1.
59	Coolemine Family Association (Ms. Margaret Brazel)	Coolemine House, 19 Lord Edward Street, Dublin 2.
60	J. Lynam	5 St. Fintan's Terrace, Palmerstown, Dublin 20
61	PACE (Mary O'Flynn, Chairperson)	7 Upper Leeson Street, Dublin 4.
62	The Talbot Centre (Liam Roe)	29 Upper Buckingham Street, Dublin 1.
63	Irish Penal Reform Trust	c/o 4 Merchants Quay, Dublin 8.
64	The Labour Party	17 Ely Place, Dublin 4.
65	Democratic Left.	69 Middle Abbey Street, Dublin. 1.
66	Prison Chaplains (Bishop Eamonn Walsh)	'Naomh Brid', Blessington Road, Tallaght, Dublin 24.
67	Ms. Aileen O'Gorman	Sandymount, Dublin 4.
68	Finglas Youth Service (Mr. Michael Daly)	Unit 1, Main Street, Finglas. Dublin. 11.
69	Dr. John J. O'Connor	The Drug Treatment Centre Board, Trinity Court, 30/31 Pearse Street, Dublin 2.
70	Coolmine House (Mr. James Comberton)	19 Lord Edward Street, Dublin 2.
71	Aisling Drug Information Centre (Marie Byrne)	Church Hill, Navan, Co. Meath.
72	Democratic Left (Cork)	122 Shandon Street, Cork.

Appendix 3

Analysis of submissions from the public

Introduction

The advertisement requesting submissions was placed in the national newspapers and in *Hotpress, the Big Issue* and *In Dublin* magazines in late November/early December, 1996. The deadline for the receipt of submissions was 31 January, 1997 - although this was subsequently extended to end February to facilitate those who were unable to meet the original deadline.

In all, 72 submissions were received. They might be classified as follows:

***Individuals ..... ***	***23***
from Dublin (10)	
rest of the country (13)	
***Organisations..... ***	***49***
national or sectoral (20)	
locally based community or voluntary:	
• from Dublin (17)	
• rest of country (12)	
Total	***72***

Analysis of submissions

The issues raised in the submissions are outlined below. While some concentrated on single issues, a significant number of them dealt with more than one matter, particularly in relation to the treatment of prisoners who misuse drugs and the misuse of non-opiates.

Issues raised in submissions		***Percentage of Submissions***
(1)	**misuse of non-opiates**	29%
(2)	**treatment of prisoners who misuse drugs**	35%
(3)	**therapeutic communities**	10%
(4)	**funding/support for specific projects**.....	35%*
(5)	**other issues…… .....**	22%

* The figure in relation to funding/support for specific projects is perhaps misleading in that 15 of these submissions were exclusively seeking support for one particular project, while a number of others, in addition to making general policy proposals, also sought support for their own projects/organisations/areas.

Misuse of Non-Opiates

The following is a summary of the points raised in submissions in relation to this topic:

nature and extent of problem

A large number of submissions referred to the extent of the problem, commenting that - as in the case of opiate abuse - it was difficult to gauge the prevalence of non-opiate drug abuse. It was suggested that:

* the numbers presenting for treatment are likely to be only a fraction of those abusing "soft drugs", even more so than in the case of opiate abuse;
* many opiate misusers were poly-drug users, mixing the use of heroin with other drugs such as alcohol, cannabis, ecstasy, etc.

There was unanimous agreement in submissions that the abuse of "soft drugs", especially cannabis and ecstasy, is widespread and not just confined to certain marginalised areas or communities.

On submission recommended the setting up of pilot anti-drugs strategies in cities, such as Limerick and Waterford, which were described as being at "pre-heroin" stage.

"party packs"

Numerous submissions referred to the danger of "soft drugs" misusers progressing to harder drugs. Particular mention was made of the so-called "party packs". In addition to an ecstasy tablet, these packs also contain a small quantity of heroin, to allow the user to "come down" from the effects of E before going home. The attraction for young people is obvious. One submission contended that methadone is also being used for this purpose. Many submissions also made reference to the fact that heroin smoking is on the increase, particularly among younger people.

"youth culture"

Another point which emerged was that whereas heroin abuse is confined almost entirely to marginalised communities, the misuse of drugs such as a ecstasy and cannabis is not linked to a particular social or economic class. The assertion by the *National Youth Federation* that the use of soft drugs is closely associated with *youth culture* and *peer pressure* was supported in numerous submissions.

Another area of major concern was that drugs such as ecstasy and cannabis were marketed as being *"safe and cheap"*. Young people in particular are susceptible to this message. Submissions contended that while definitive information on the long term effects of these drugs - particularly ecstasy - is not yet available, there appears to be little doubt as to the psychological dependence which they induce in their users.

"harm reduction"

There was agreement in a substantial number of submissions that media/information campaigns dealing with "soft drugs", particularly ecstasy, should be based on "harm reduction". This is the approach being adopted in countries like Britain, where advice not to use ecstasy is supported by factual information on the known harmful effects of the drug and practical advice on how to reduce these effects. It was also suggested that there should be some attempt to regulate venues at which the drug is available. Measures suggested include:

- ensuring that the water supply is not disconnected;
- the provision of “rest areas”;
- proper supervision of dance halls; training of security staff; and
- distribution of literature on the effects of the drug at these venues.

One submission recommended the initiation of an inclusive forum to discuss and develop policy on cannabis use

targeting of resources

A number of submissions made the point that most existing services and resources were targeted solely towards dealing with opiate abuse. There was a need to develop programmes and services to deal with the misuse of non-opiates. Some of the requirements in this regard, however, would be similar to those being employed to combat opiate abuse:

- more addiction counsellors;
- more residential centres;
- variety of treatment options to cater for different needs, etc.

“legal” drugs

Finally, a number of submissions drew attention to the State’s “tolerance” of legal drugs:

- alcohol (the attractiveness of alcoholic “fruit” drinks for young people was referred to in particular);
- the culture of prescribing pills (one submission referred to excessive prescribing of pills under the medical card scheme).

It was suggested that children are often brought up in a culture where alcohol and “turning to pills” was deemed acceptable. Concern was also expressed about the “black-marketing” of methadone and tranquillisers.

Treatment of prisoners who misuse drugs

The following points emerged in the submissions which dealt with this topic. It should be pointed out that some of the measures suggested are already being implemented, at least to some extent.

nature and extent of drug misuse in prisons

A significant number of submissions:

* referred to the close relationship between heroin abuse and crime; and
* indicated that drug misuse in prisons - particularly Mountjoy - was widespread.

On the relationship between drugs and crime, many submissions suggested that methadone maintenance had a positive effect in reducing crime levels, in that it stabilised misusers who no longer needed to commit crime to feed their habit. A number of submissions, however, made the point that there were many habitual or hardened criminals, whose drug habit was merely one aspect of their lifestyles.

treatment

The following were the comments most frequently made in relation to the treatment of prisoners who misuse drugs:

* there was a need for more detoxification centres, including centres exclusive to women:
* there was a need for more drug free units in prisons/each prison should have its own drug free unit/separate drug free units should be established for women and juveniles (one submission suggested that there should be special prisons to cater for prisoners who misuse drugs, while another suggested that the criteria for admission to drug free units should be relaxed. Another suggested the need to examine models of successful drug-free prisons in other jurisdictions);
* the treatment facilities available in prisons should at least match those available on the outside;
* the policy on methadone maintenance should be the same in prison as that advocated by the Eastern Health Board on the outside;
* there should be community involvement in the rehabilitation of offenders who misuse drugs/Community Drugs Teams should work in prisoners;

* treatment services inside and outside prisons should be co-ordinated (one submission made the point that this might be achieved by placing the Prison Medical Service under the control of the Health Board. Another suggested the establishment of a Working Party of all relevant agencies to address, in a co-ordinated manner, issues such as planned release, treatment, rehabilitation, etc.).

Other comments made in relation to treatment, though not as frequently as those listed above, included:

* the need to increase the number of counsellors and therapists working in prisons/a counsellor should be assigned to each prison;
* post-detoxification facilities were inadequate;
* there should be greater involvement by Narcotics Anonymous in prisons;
* there was a need to instigate needle exchange facilities in prisons;
* the current level of prescribing pills to prisoners was excessive;
* there was a need for prisoners to be able to access different types of treatment (detoxification, methadone maintenance, etc.).

alternatives to prison

There was general agreement that alternatives to prison should be available to offenders whose criminal activity is not of a serious nature and is related solely to their drug habit. Suggestions included:

* more use of community service/work programmes, supported by treatment;
* development of treatment detention centres/local rehabilitation centres/residential therapeutic centres;
* the use of supervision orders in relation to low risk offenders;
* the application by the courts of separate sentencing policy for drug related crimes, including long-term monitoring/suspended sentencing to allow treatment to take place.

One submission suggested that there should be statutory provision for drug treatment facilities for offenders.

Treatment on release from prison

Most of the submissions which dealt with the treatment of prisoners who misuse drugs made the point that the transitional treatment arrangements for misusers being released from prison needed to be improved. These submissions emphasised the importance of ensuring continuity of treatment. Specifically, they stated that:

* prison releases for drug misusers should be properly planned, involving better co-operation/co-ordination between relevant agencies;
* there should be more daytime or temporary releases to allow offenders an opportunity to undergo treatment/rehabilitation;
* *"halfway houses"* should be developed;

Some submissions contended that there was a lack of accommodation/training chances for drug misusers being released from prison.

Security in prisons

This issue did not give rise to the same amount of comment as the matters mentioned above. Two submissions made the point that drug misuse in prison may well be officially tolerated, as it made prisoners more manageable, while another listed a variety of ways in which drugs are being smuggled into Mountjoy. This submission, however, also referred to the difficulties involved in imposing a stricter regime (citing prisoners' rights to bodily integrity, the right of remand prisoners to visits, etc.). It suggested that the development of improved visiting facilities was essential to deal with this problem.

Measures advocated to improve security at prisons included:

- more use of screened visits;
- prosecution of all those caught smuggling drugs into the prison;
- upgrading visiting facilities (the provision of more space and searching facilities);
- use of "sniffer" dogs/regular searches of cells with "sniffer" dogs;
- x-ray equipment to inspect visitors' bags;

- random urine tests of prisoners;

- increased use of security/surveillance cameras, etc.

general

A number of submissions made the following general comments in relation to prisons:

* there was a need for a new/separate remand centre;

* one submission suggested that Mountjoy should be closed down;

* more Probation and Welfare staff were needed/they should receive training (and guidelines) to assist them in dealing with drug misusers;

* there should be more training for prison staff to assist them in dealing with drug misusers;

* an independent Parole Board should be established;

* education materials should be more widely distributed in prisons.

Therapeutic Communities

A relatively small number of submissions dealt with this issue and those which did were generally supportive of this particular model of treatment. Basically, these submissions argued that the State's response to the treatment of drug misusers concentrated too heavily on one particular model, i.e. methadone maintenance. While some of them argued that abstinence was the only treatment model capable of long-term success, others suggested that different misusers had different needs at various stages of their addiction and a whole range of responses should be available to meet these needs.

These submissions also argued that more State funding should be made available to voluntary agencies delivering therapeutic services, both day-care and residential. They also contended that access to these facilities should not be based on one's ability to pay.

One submission suggest that

* an inter-professional forum should be established, to facilitate communication between exponents of different treatment models;

* evaluation should be a condition of all State funding for projects; and

* we should look at international experience in determining the suitability of different models of treatment.

Funding/support for specific projects

In general, these submissions either:

* sought funding or support for the programmes/services which they themselves provide; or

* sought the targeting of funding generally towards their own area of community.

As indicated already, 15 of the submissions in this category (21% of all submissions received) sought support for the development of one particular project. However, a number of other submissions - in addition to seeking support or funding - also made general policy recommendations. These recommendations are dealt with elsewhere in this section, under the appropriate headings.

Other Issues

A range of issues emerged in submissions which were either:

- addressed in our First Report;

  or

- not relevant to the specific issues being dealt with in the Second Report;

  or

- general in nature (e.g. issues which could apply equally to the matters under review in both Reports or indeed to the drugs problem generally).

The following is a summary of these issues. It should be noted that many of the measures suggested are already being implemented.

Structures:

As in the submissions received in respect of the First Report, a number of submissions referred to the need for greater co-operation and co-ordination, both between the statutory agencies themselves and the statutory and voluntary/community sectors. This issue has, of

course, already been addressed by the establishment of the Cabinet Drugs Committee and the National Drugs Strategy Team at national level; the Local Drugs Task Forces in the heroin "blackspots"; and the Regional Co-ordinating Committees in each Health Board region.

Specific proposals which emerged in relation to structures included:

* the appointment of a separate Minister of State with responsibility for the drugs problem, who would chair a National Co-ordinating Committee on Drug Abuse;

* the appointment of a Dublin Drugs Strategy Group.

Treatment:

A significant number of submissions dealt with the current level of treatment available to drug misusers. Suggestions made included:

* the need for more involvement of and support for parents/families of drugs misusers. A significant number of submissions made this point;

* the development of the *"Big Brother"* and *"Big Sister"* schemes which are used in the U.S.;

* the opening of 24 hour/weekend crisis centres;

* the need to cater for the special treatment needs of women (including childminding facilities, etc.);

* the need for multi-disciplinary services for drug misusers/there should be a range of treatment options available.

Other suggestions included:

* More detoxification beds generally/detoxification programmes for users of benzodiazepines;

* The elimination of waiting lists for methadone maintenance, although a few submissions argued against methadone maintenance as an appropriate treatment model.

rehabilitation:

The following recommendations were made:

* more emphasis needs to be placed on training;

* there should be more Soilse-type projects;

* there should be more FAS/CE schemes designed to suit the needs of drug misusers;

* there should be an evaluation of existing training courses.

Education/prevention:

As education/prevention relates to creating the conditions to stop people abusing drugs in the first place, the proposals received in submissions relate to the drugs problem generally and were largely similar to those made in submissions for the First Report. They included:

* the development of drugs awareness programmes in schools/compulsory drugs awareness programmes in schools/extend the "Early Start" programme nation-wide;

* teachers should be involved in delivering drugs programmes;

* additional remedial teachers were required/more counselling support services were needed;

* reduce the teacher/pupil ratio;

* the focus should be on early intervention/after-school programmes should be expanded and supported;

* special measures were needed for early school leavers (one submission made the point that an allowance equal to that paid to early school leavers should also be paid to school attendees in certain areas).

youth services, sport and recreation:

Suggestions included:

* more emphasis on youth services;

* the development of more sports and recreation facilities;

* the appointment of a co-ordinator to each community centre;

* better use of existing community centres.

We have, of course, addressed most of these issue in ***Chapter 3*** of this Report. The rational behind our proposals in this area is to develop youth and sport as a preventative strategy in relation to drug misuse among young people.

research/information:

A significant number of submissions referred to the lack of data on the extent of the drugs problem - both in relation to opiates and non-opiates, as well as on the extent of the problem in prisons. All submissions that touched on this matter referred to the need for more research into the problem. Specific proposals included:

* the establishment of a National Drugs Research and Information Centre to co-ordinate data collection and the dissemination of information;
* the use of voluntary agencies in data collection;
* greater co-ordination between agencies in data collection (Gardai, Health Board, Prison Service, Probation and Welfare Service, CSO, etc.);
* the establishment of a Chair of Addiction Studies in one of our Universities.

A number of submissions also referred to the need for the more effective dissemination of information on drugs. As mentioned previously, many of these submissions dealt with the ecstasy problem and recommended a “harm reduction” approach. Other suggestions included:

* 24 hours telephone helplines;
* the development of a directory of services, covering both the public and private sectors;
* ongoing/more graphic media campaigns.

measures to curb the supply of drugs:

A small number of submissions dealt with measures to curb the supply of drugs. A few of these were critical of the Garda response to the supply issue, in each case suggesting that additional Gardai were needed to tackle the problem. Other recommendations included:

* the establishment of an Organised Crime Unit;

* the fast-tracking of court cases involving drug traffickers;
* tougher sentences for pushers/suppliers
* better patrolling of our coastal waters.

funding:

Apart from the organisations referred to earlier - who sought funding either for their own projects or community - a small number of submissions made proposals in relation to funding generally. These suggested:

* that more use be made of Lottery funds to tackle the drugs problem;
* the setting aside of Government funding, to be totally devoted to tackling the drugs problem;
* the targeting of available resources at priority areas.

crime:

A very small number of submissions sought the categorisation of syringes as a dangerous weapon.

community involvement:

A significant number of submissions made the point that there was a need for strong community involvement in the treatment and care of drug misusers. They recommended

* community based treatment/clinics;
* the establishment of Community Drugs Teams;
* that greater resources be given to communities;
* that more emphasis be placed on community development;
* that community-based employment be pursued to meet the specific needs of an area (estate management, security, etc.);
* that there be greater co-operation between the Gardai and local communities in tackling the supply problem.

miscellaneous:

Proposals/suggestions included:

* more training for health care and other professionals (Gardai, etc.).
* the need for better urban planning, particularly in inner cities

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Appendix 4

Guidelines to assist Local Drugs Task Forces in preparing their anti-drugs strategies

The strategies should accord with the objectives of the Local Drugs Task Forces as outlined in their terms of references.

Each strategy should contain a profile of the area, identifying:

* the nature and extent of drug misuse in the area;
* any underlying processes leading to drug misuse which are endemic to the area;
* the current or planned levels of service provision in the area by statutory, voluntary and community agencies/organisations;

In preparing its strategy, the Task Force should devise a plan to combat the drugs problem in the area. Specifically, the plan should:

* seek to adopt a locally-based approach to service provision;
* maximise the use of resources by ensuring that all programmes/services are integrated and co-ordinated effectively;
* address any gaps in service provision, by identifying what additional programmes/services are needed;
* cost and prioritise proposals for these additional programmes/services, having regard to the overall level of funding available to support the implementation of the plans;
* indicate which agency/organisation will deliver or take the lead in delivering the programmes/services identified in the plan;
* establishment mechanisms for the implementation, monitoring and evaluation of the actions identified in the plan.

In general, each plan should:

* provide an integrated, strategic response to the drugs problem in the area, co-ordinating the delivery of all relevant programmes/services;

* contain proposals relating to treatment, rehabilitation and prevention of drug misuse as appropriate to the specific needs and priorities of the area;

* be consistent with other programmes which facilitate a reduction in drugs demand in the area, e.g. the local Partnership's Action Plan;

* demonstrate a wide consultative process and a wide consensus on the strategies being proposed.

Criteria for evaluating plans

The following criteria will apply in evaluating the plans:

* the current level of service provision in the area;

* whether it has been clearly demonstrated that the additional programmes/services are needed;

* whether the plan integrates with and adds value to existing programmes/services in the area;

* whether elements of the plan are capable of being replicated in other area, following full piloting and evaluation;

* the mechanisms proposed to ensure effective implementation, monitoring and evaluation of the plan

Procedures for appraisal of plans

* each Local Drugs Task Force will submit its plan to the National Drugs Strategy Team, which will evaluate it against the criteria outlined above. The Team may seek clarification, orally or in writing, in relation to any part of the plan;

* the Team will make recommendations to Government, through the Cabinet Drugs Committee, on the merits of the plan and on the level of funding which should be allocated to support its implementation;

* the Government will decide on the amount of funding to be made available to support the implementation of the plan.

Procedure for allocating funding

* a sum of £10 million is being made available over the next twelve months to support the implementation of the non-mainstream elements of the plans;

* the funding will be retained in the Vote of the Department of the Taoiseach initially.

* following a decision by the Government to allocate funding to support the implementation of a plan, the money will be transferred, through the appropriate Department, to the Vote(s) of the statutory agency or agencies delivering or overseeing the delivery of the various programmes/services identified in the plan.

* Each statutory agency will be responsible for complying with normal accountancy procedures in relation to funds allocated to it.

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