DRUGS IN DUBLIN

WORKING TOGETHER WE CAN MAKE DIFFERENCE

CONFERENCE:

DUBLIN CASTLE

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SPEECH BY
MS. LIZ MCMANUS, T.D.,
MINISTER FOR HOUSING
AND URBAN RENEWAL
AT THE
DUBLIN CORPORATION FORUM
"DRUGS IN DUBLIN - WORKING TOGETHER
WE CAN MAKE A DIFFERENCE"
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Importance of the Drugs Forum

I would like to thank Dublin Corporation for affording me the opportunity to address this important Forum.

To effectively tackle the drug problem, to rebuild communities, to improve them in terms of their physical and social infrastructures, and revitalise them economically we need to create a new dynamic between statutory agencies and local communities. That is why events such as this Conference are so important and I was delighted to have been able to financially assist this project.

The Problem in Dublin

The **Ministerial Task Force on Measures to Reduce the Demand for Drugs**, of which I am a member, found conclusively that heroin abuse is overwhelmingly a Dublin problem, and Dublin's opiates problem is the main national drugs problem.

In fact, 10 of the 11 priority areas identified by the Task Force are in Dublin - the other is in North Cork City.

Coming to grips with the problem is made difficult by the lack of hard data on the extent of drug misuse in the capital. This of course in part reflects the illegal nature of the problem.

Data recently published by the **Health Research Board for 1995** give an indication of the scale of drug abuse. The data confirms that in Greater Dublin the total number of cases presenting for treatment in 1995 was **3,593 - 21 per cent up on 1994**.

While the provision of better treatment services may account to some extent for the growth in numbers presenting for treatment, the numbers actually misusing drugs is certainly greatly in excess of this figure. The report also concluded that the profile of the drug misuser in treatment in Greater Dublin is that of a young, unemployed male who has left school early and is misusing an opiate, most likely heroin, possibly injecting it.

Health Boards are now in the process of setting up information databases in their areas of operation. In its Report, the Task Force recommended that these databases be established as quickly as possible and that information be exchanged between Health Boards.

The link between large-scale drug addiction and social and economic disadvantage and deprivation is clearly established. What is required is an integrated, multi-dimensional response which addresses issues of **supply** and **demand**, and the **economic and social factors** which aggravate the problem.

These issues have been targeted for action by the Government and our recommendations in the areas of **treatment, education/prevention and rehabilitation** are now in the process of being implemented. Consultation was an important feature of the work of the Task Force which received submissions from many organisations and individuals. As a member of the Task Force, I would like to personally thank them for making submissions and to assure them that their views were fully considered in the preparation of the first report.

The demand for heroin in Dublin is a reflection of the underlying pattern of disadvantage and social exclusion. Many of the submissions received underpinned this point.

However it is important to make clear that the majority of families and young people living in, even the worst affected areas, are not drug abusers. What they want is to improve the quality of their lives and their children's lives and to ensure a future for themselves and their communities.

New Structures - A Partnership Approach

New structures have been put in place to ensure that the drugs problem is tackled in a coherent and integrated manner. It is essential that those involved in combating the drugs problem at local level have a say in determining policy. Therefore, a three tier approach has been adopted.

The commitment to overcome drugs extends to the highest political level. It is for this reason that a **Cabinet Drugs Committee**, chaired by the Taoiseach, has been established to give overall political leadership in the fight against drugs. This committee also comprises the Ministers for Health, Environment, Education, Justice and the Minister of State to the Government.

At a second level, we have established a **National Drugs Strategy Team** comprising officials from relevant Government Departments, the Eastern Health Board, the Gardai and members with experience of working in the voluntary and community sectors. Their primary objective is to ensure that the Government's drug strategy is implemented effectively.

The Strategy Team will also ensure effective co-ordination between agencies and oversee the establishment of the third layer in the strategy to provide an effective response to the drugs crisis - that is the Local Drugs Task Forces. The Strategy Team will work closely with these Task Forces, ensuring that the problems and priorities of the communities in their areas are continually monitored and addressed at central Government level.

A number of the Local Task Forces are now in place and have begun the important work of drawing up local development plans for their areas. This is an important process which brings the voluntary, community and statutory sectors together in **partnership** to develop strategies to combat the drugs problem at local level.

It acknowledges the central role of community groups but it also puts the onus on all sectors to co-operate fully. It will only succeed if everyone moves outside of their demarcation lines and commits to genuine partnership.

The Government is playing its part. It adopted all of the report's recommendations and immediately set aside **£10 million** this year to support the implementation of development plans which will be drawn up by the Local Task Forces. **A further £3 million** has been provided to enable my Department to introduce an Estate Improvement Programme, to which I will return later.

Reducing the supply of illegal drugs

Measures to tackle the demand for drugs are matched by those designed to shrink their supply. Changes in the law are exposing those who deal in the death and misery of our young people. The Criminal Assets Bureau is a new statutory body, with staff drawn from the gardai, the Revenue Commissioners and Department of Social Welfare. It has the capacity to mount a sustained and focused attack on the illegally acquired assets of criminals involved in serious crime and forms a central part of the Government's anti-crime measures.

In July 1996 the Government announced a further package to deal with crime and drugs. These initiatives will result in increases in Garda numbers, recruitment of further civilians to release Gardai from administrative duties, a review of Garda efficiency and cost-effectiveness, creation of further prison places, the appointment of additional judges and arrangements for extra sittings of the Central Criminal Court and the Circuit Court, a number of law reform measures including the recent referendum on bail and additional staffing resources in the Forensic Science Laboratory where drug seizures are analysed.

A package of tough legislation including measures to seize the assets of the drug barons and tackle their networks head on has recently been passed including

* **The Proceeds of Crime Act, 1996** provides a powerful new mechanism for the freezing and forfeiture of the proceeds of crime.

* **The Criminal Justice Act, 1996** provides for detention for up to 7 days for drug trafficking offenses, allows for the presence of Customs Officers at interviews of suspects, and allows inferences to be drawn by a Court from the failure of an accused to mention particular facts when being questioned by a Garda.

* **The Disclosure of Certain Information for Taxation and Other Purposes Act, 1996** provides for more effective exchange of information between the Gardai and the Revenue.

Taken together, these measures greatly enhance the powers of the State in dealing with the drugs menace.

The Gardai are also playing their part. **Operation Dochas** has been in operation over the past few months in all Dublin Garda Districts and involves more than 500 uniformed and plain clothes Gardai.

Economic Aspects

Efforts to address the problems of supply and demand are not enough. Social and economic conditions, including unemployment are key factors in the high levels of drug addiction in Dublin. Our success as a government in achieving unprecedented job creation levels does not deflect us in any way from a determination to tackle in particular the corrosive nature of long-term unemployment.

Estate Improvement Programme

We know that much of the crime and anti-social behaviour associated with illegal drug dealing is carried on in some local authority housing estates and flat complexes and this presents significant problems for the Corporation. As a Minister with responsibility for housing, this is of particular concern to me.

I was pleased that the Task Force recognised the interdependence of a good physical environment and quality of life for tenants and recommended that the Department of the Environment should introduce an Estate Improvement Programme to assist local authorities in tackling environmental and related problems of severely run-down urban housing estates and flat complexes.

The Programme will focus on enhancing, upgrading and making safe the living environment of communities as well as improving estate management. It is not a question of simply asking local authorities to do more without additional resources. I believe that the allocation of £3m to the Programme over the next two years will have a very real impact in the worst affected housing estates and flat complexes.

I have stressed to the authorities concerned the importance of adopting an integrated approach which actively involves tenants in the drawing up of proposals for projects. I have also asked them to explore what contribution, financial or otherwise, can be made by other statutory agencies, business interests, Partnership Companies and tenants themselves. The implementation of this Programme presents local authorities with a further opportunity to develop partnerships and build bridges with local communities, and I want to see these opportunities availed of to the greatest possible extent.

To date, I have given approval in principle to proposals from Fingal County Council for a project in Blanchardstown and have allocated a grant of £500,000 for this project. I have also approved a grant of £750,000 to South Dublin County Council.

Today, I am pleased to announce a grant of £1.25 million to Dublin Corporation for a programme of works in areas which they have identified for priority action. In each case, the grants will be matched by authorities from their own resources.

Support for Housing Management

Dublin Corporation is adopting a progressive approach to estate management. A welcome feature of this approach is the deployment of some thirty Executive Housing Officers to work closely with local communities. They will be available to meet with tenants each day in estates so that problems can be deal with immediately as they arise. You will hear more of this tomorrow from Vincent Norton. Since taking office, one of my main objectives has been to assist local authorities to improve their estate management performance in view of the crucial importance of the housing service and its effect on the lives of tenants.

To support local authorities in this respect, I have introduced a number of initiatives including a **housing management grants scheme** and the setting up of a Housing Management Group to promote best practice in housing management. Authorities are also being assisted to undertake a programme of training and development for their tenants.

The Housing Management Group has prepared **Best Practice Guidelines** in Housing Management and workshops are currently being held for local authority officials.

Improving communication between the authority and its tenants is a particular priority if the management of the housing service is to be made more responsive to individual needs. One means of achieving this objective is through publication of a **tenant's handbook** which provides a wide range of information on the services provided by the authority and which clearly sets out the respective responsibilities of the authority and its tenants. Earlier this week, the Corporation launched such a handbook and a copy is included with the documentation you have received. This is a very worthwhile initiative by the Corporation and I was pleased to have been able to make a financial contribution towards the cost of compiling the handbook.

I am also very impressed with the resource pack which has been provided to each Corporation household and which aims at advising people, and parents in particular, what help is available if someone they know is using drugs.

The Corporation deserve credit for their approach to developing housing management and other initiatives. This has required a cultural change and new thinking which will ultimately benefit the authority and its tenants.

Housing (Miscellaneous Provisions) Bill, 1996

The initiatives we have introduced to support local authority housing management cannot, on their own, succeed in tackling crime and anti-social behaviour in local authority estates. The Housing (Miscellaneous Provisions) Bill, 1996, published in December, is designed to give local authorities improved legal powers to deal with problems arising on their estates from drug dealing and serious anti-social behaviour.

I want to make clear that anti-social behaviour is carefully defined for the purposes of the Bill in relation to drug dealing and other related serious activities such as personal intimidation or violence.

One of the most important provisions of the Bill is for a new "excluding order" procedure against those occupants of a local authority house who are directly involved in anti-social behaviour. This will allow a more targeted response than is currently available. Up to now, the only action a local authority could take in cases of serious anti-social behaviour was to seek to have the entire household evicted with, as it were, both the innocent and the guilty subject to the same legal sanction.

Local authorities are also being given power in the Bill to refuse to house an applicant whom they are aware is engaged in drug dealing or related activity. They will also have the right to refuse, on the same grounds, to sell a dwelling under a tenant purchase scheme or to consent to resale of a tenant purchase dwelling.

In order to help avoid problems with build up of rent arrears there will be a new procedure under the Bill enabling local authority rents to be deducted from social welfare incomes in cases of serious arrears.

There are a number of other provisions in the Bill to improve the speed and effectiveness of various procedures such as the issuing and service of summonses; evidence by Gardai, local authority and health board officials in Court cases where witnesses would be intimidated; exchange of information between relevant authorities; and measures against intimidation of local authority or health board staff and witnesses. It also gives health boards discretion to refuse or withdraw supplementary welfare assistance as well as dealing with the problem of squatting where anti-social behaviour is involved.

The Bill reflects a number of new approaches, designed to meet serious problems that have arisen in some cases. Their use will be exceptional but it is important that they're available where needed to protect communities from the ravages of drug dealers.

Conclusion

As we approach the millenium the drugs problem is one of the most serious challenges facing this city. The Government has demonstrated that is committed to fighting the problem of drug misuse. We have recognised its seriousness and have put considerable resources at the disposal of the relevant authorities. We have put new structures in place to ensure that the marginalised communities will no longer be ignored nor abandoned.

Our approach is based on an understanding of the drugs crisis. It is also based on the understanding that here in this room and beyond in the wider community we share a common resolve to face this challenge.

In conclusion, I want to commend Dublin Corporation for hosting this event, and to congratulate, particularly, the Lord Mayor Brendan Lynch and the members of the Corporation's Prevention of Crime Committee for initiating the idea. The range of speakers on the programme, and the participative nature of the workshop format, reflects the degree of commitment which all of you have to tackling perhaps the most serious issues confronting our society as the twentieth century draws to a close.

Thank you very much.

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CONFERENCE: "DRUGS IN DUBLIN -

WORKING TOGETHER WILL MAKE A DIFFERENCE"

ADDRESS BY JOHN FITZGERALD, CITY MANAGER,

7TH FEBRUARY, 1997

A LOCAL AUTHORITY PERSPECTIVE

INTRODUCTION

Misuse of drugs and related problems constitute a serious threat to stability of social and economic life in certain areas. This Conference is an expression of our concern at the implications for the City as a whole.

In this context our primary role is that of landlord and Housing Authority with direct responsibility for 24,000 homes which provide accommodation for 70,000 people.

However, as Local Authority, our responsibilities extend far beyond the role of landlord and housing provider. We have an interest in, and are concerned with, every issue that effects community life in and around the city.

Problems of social deprivation are concentrated - though not exclusively so - in local authority housing estates. We are not unique in that regard - it is a feature of all cities of similar size as is the linkage between drug abuse and other social problems which has been clearly established.

Housing Refurbishment

Most of our housing areas are in good condition, are stable and compare favourably with good quality private housing conditions. Other areas are, however, seriously run-down and require extensive refurbishment.

The background is well documented - serious imbalance in social mix: dependence on welfare: more than two-thirds of principal earners unemployed: long term unemployment which crosses generations: isolation and vulnerability of a growing number of single parent families: lack of stability due to absence of family support network in newer communities and so on. There is little evidence to suggest that the situation has improved over recent years; in fact there is growing evidence to the contrary.

The existing housing refurbishment programme - though extremely successful to the extent to which it has been implemented - is not capable of dealing with problems of this magnitude. If nothing else happens, the situation will get worse, not better. We are trying therefore, along with the Department of the Environment, to put together a refurbishment programme which can do what needs to be done within a reasonable period of time. The economic climate now lends itself towards packaging a programme which can make the necessary impact. Indeed, one of the most frustrating aspects of economic life in the city at this time is the extent to which certain parts remain stubbornly excluded from the benefits of the economic boom that goes on around them.

I am satisfied that we can organise our resources - under direction of the City Architect and his Department - to take on a major refurbishment programme with capacity to transform those areas which are seriously run-down; Additional investment is required though not at levels which cannot be met.

Estate Management

In addition to refurbishment projects we are extensively involved in estate management initiatives; our objective is to have a number of estate management agreements with tenant groups in selected estates before the end of this year. We have deployed 20 staff to work full-time on estate management and will deploy more over the next 12 months. These new Estate Managers will create the linkages necessary to build better communities through which local issues, particularly incidents of anti-social behaviour, can be addressed. This policy is clearly explained in our tenants handbook and explanatory leaflet on estate management, a copy of which is in your Conference Pack. Each of our tenants will already have received copies of these as part of a Resource Pack which was posted to all Corporation homes at the end of January. The Resource Pack contains several other items including laminated “helpline” sheets and educational material prepared by the Health Promotion Unit of the Department of Health.

We have a very strong Community department engaged in development of community facilities at local level. This year we are carrying out a refurbishment programme to upgrade all our playcentres which, in the longer run, will become community resource facilities to meet the needs of young people.

We are currently carrying out a survey of 400 of our tenants to elicit their views on our housing service. To assist this process we have prepared a "Right to Replay" comment sheet which is available in the Housing Department - a sample of this is in your Conference Pack.

I believe that effective tenant participation and community building is a pre-condition to housing estate regeneration. Local community involvement at refurbishment stage and afterwards is a vital ingredient without which - as we have experienced in the past - the outcome will not be successful.

Conclusion

In summary, given necessary resources, we will commit ourselves to comprehensive refurbishment programme which will have capacity to revive those part of the city where such action is warranted. If we can do so, and I have no doubt about our ability, the impact in those areas and throughout the city will be significant in terms of creating an environment in which long-term solutions to social problems can be considers.

This should not be regarded as a “Housing” solution in isolation from other matters - there are obvious social, economic and environmental benefits for the city as a whole.

Community participation is an essential pre-requisite; We will support this concept in every way we can through close collaboration with other agencies, particularly the Gardai and the Eastern Health Board. Local Community Associations and Area Partnership Boards are essential players in this regard. Working arrangements with the Gardai are extremely good in all areas in which we have common interface - and these are extensive. There is great determination on both sides to make things happen on the ground. We work closely with the Eastern Health Board to the extent that we are now considering provision of public offices which can provide jointly for Corporation and Health Board requirements, also possibly including the presence of other state agencies in a cluster which, in effect, becomes a one stop shop for primary local services. Provision of public infrastructure of this kind is surely more necessary in, or adjacent to, socially deprived areas than outside these areas.

A permanent solution to structural long term employment must involve investment, public and private, in all its forms. Private investment could be encouraged by means of selective local designations to encourage provision of necessary services including provision of low cost industrial units.

This longer term approach, - housing refurbishment and environmental upgrading along with community building, is an essential if we aspire to resolve rather than contain the problems which underlie the need for this conference.

The conference is not an end in itself; it is part of a process which has already begun and is gaining momentum. The deliberations and outcomes of the Conference are important learning opportunities for all of us. It is important also in terms of generating the chemistry and energy which will, I believe, lead to joint effort which can make a real contribution to the lives and living conditions of those inside and outside areas of social deprivation.

Though the approach outlined might be aspirational, it is possible and can be done; the economic climate might not be as favourable again. The scourge of social deprivation is a serious threat to the economic and social fabric of the city at the present time. To do nothing is not an option; there are solutions and, together, we can make them happen.

DISPELLING DRUG MYTHS

THE PRESENTATION TO BE MADE BY

DR DESMOND CORRIGAN

DEPARTMENT OF PHARMACOGNOSY
SCHOOL OF PHARMACY
TCD

AT THE “DRUGS IN DUBLIN” CONFERENCE
DUBLIN CASTLE FEB 7TH, 1997

DISPELLING DRUG MYTHS

It is perhaps surprising that myths should arise about the chemicals that we call drugs. One might expect that modern science with all its expertise, equipment and knowledge would be able to predict and describe exactly what will happen when a given chemical enters that human body. Indeed we do know what happens with most drugs when they are tested under scientific conditions.

However when drugs are used on the 'street' they are taken in ways, in quantities and in combinations which differ enormously from normal medical use, by individuals who differ in age, gender as well as physical and psychological make up from one another. This complexity makes it difficult to establish exactly what is happening in and to the human body leading the development of a large number of myths concerning different drugs.

The myths I wish to examine are

1. the myth that 'drugs don't jump up and bite you'
2. the myth of accidental addiction
3. the myth of safe heroin
4. the myth of impurities in ecstasy
5. the myth that water makes ecstasy safe

MYTH 1: DRUGS DON'T JUMP UP AND BITE YOU.

Unfortunately drugs do jump and bite you! By definition drugs cause huge changes in brain structure and chemistry as well as physical changes affecting other organs in the body. As a result drug users run the risk of a whole range of drug related problems i.e. problems which are a direct result of the interaction between the drug and the human body.

Drug-Related Problems
Sometimes there is a tendency to view the risks of drug taking in very narrow terms. There is an emphasis on addiction, overdoses and more recently on HIV and AIDS. Such an emphasis could be misleading, both in terms of evaluating the harmfulness of a particular drug and also in relation to attempts to respond constructively to problem drug taking. It is necessary therefore to take a very broad view of what constitutes a drug-related problem and to include under this heading, not just the obvious addiction etc., but also the concepts of drug related disease, drug-related crime, drugs in pregnancy, the effect of drugs on learning and work, on accidents and on behaviour.

Addiction
Addiction, or to give its jargon term, drug dependence, is the compulsive use of a drug on a regular basis in order to experience its psychoactive effects or to avoid the discomfort of its absence. There are different types of dependence, i.e. dependence of the opiate type, dependence of the alcohol type and so on. Many drugs result in compulsive use after repeated exposure to them. Examples include heroin and other opiates, alcohol, tranquillisers, nicotine,

cocaine. Sometimes the dependence in physical, sometimes it is psychological. The latter is the most difficult to deal with.

Addictive use is the most serious problem a drug user can face because it often means daily exposure to the drug. However some drugs are not particularly addictive, e.g. LSD, but that does not make LSD at 'safe' drug. Equally, it is possible to use an addictive drug on a regular basis but not be addicted to it. Alcohol is a good example where most alcohol users are not addicts but still are at risk from a host of medical, legal, social and other problems.

Overdoses and Sudden Death
Another classical way of assessing a drug is to ask does it result in death if you overdose on it. Some drugs, e.g. heroin, cocaine, alcohol, are lethal in overdose. Others can cause sudden death, for example, solvents in glues, aerosols and gas canisters, and above all MDMA or 'Ecstasy'. On the other hand there are drugs such as cannabis and LSD which have never killed anyone in overdose.

Drug-Related Disease
The well-recognised link between drug abuse and HIV transmission is just one facet of drugs and disease. It is an aspect of what is called Technique-Specific Disease, i.e. disease related to the way the drug is used rather than a particular drug. Specifically it is due to the injection of drugs using shared contaminated needles, syringes, mixing bowls - what addicts call the 'works'. It does not matter what drug is injected - it could be heroin, it could be amphetamines, it could even be anabolic steroids by body builder - as long as there is sharing of equipment, there is the risk of sharing not just HIV but also all of the Hepatitis virus (B, C and D), blood poisoning, abscesses, gangrene and so on.

A second aspect of drug-related disease is one that is often neglected, namely, Substance-Specific Disease. That is disease caused by the direct toxic effect of the chemicals on different parts of the body. Examples include:-

Brain and liver damage	-	Alcohol
Lung and heart disease	-	Tobacco and Cannabis
Strokes and heart attacks	-	Cocaine
Heat-stroke and liver damage	-	Ecstasy

In addition we should take into account the acute psychoses which can be triggered by cannabis, the depression due to chronic ecstasy use and the more prolonged mental illness which can be precipitated by LSD.

Drug and Pregnancy
If a pregnant woman is using drugs, the foetus in her womb will also be exposed to the drug at key and vulnerable stages of its psychical and mental development. The results can include babies born addicted to opiates, physical abnormalities related to cocaine and alcohol, retarded intrauterine growth and development due to exposure to alcohol, tobacco and cannabis.

Drug and Learning
One of the most consistently reported effects of the use of any of the cannabis group of drugs, i.e. herbal marijuana, resinous hash or the distilled hash oil, is a damaging effect on short-term memory and learning ability. Evidence has accumulated from laboratory studies where cannabis disrupts all tests of learning ability, from surveys of young

cannabis users who are still impaired six weeks after becoming drug-free and from surveys of adult daily users who overwhelmingly report memory and concentration difficulties.

Drugs and Accidents
The major culprit in this category has to be alcohol and the recognised scale of the problem needs little further comment from me. In addition, other drugs can cause accidents, including tranquillisers and in particular cannabis. In many countries cannabis use is now recognised as a major cause of injuries and deaths in car truck and rail crashes. In one U.S. study of fatal truck crashes, younger drivers tended to have detectable levels of cannabis in their blood while alcohol was predominant in older drivers. It is perhaps surprising that cannabis and alcohol appear at the same percentage frequency in such accident victims.

Drug and Behaviour
For many drug users, it is the changed behaviour under the influence of the drug which can be the most damaging aspect of their drug use. A good example of this is the violence associated with alcohol. The confused drunken behaviour associated with solvent is often the major risk for most youngsters involved in solvent abuse. Particularly worrying is the delusional behaviour resulting from LSD use given the increased popularity of this drug in 'Rave' setting. With cannabis the development of an apathetic negative outlook and attitude can be particularly destructive for many young people.

Drug and Crime
There is a widespread perception that drug use is associated with both violent and acquisitive crime. There is no clear-cut explanation for this perception because it is clear that no drug is inherently criminogenic Most people associate the expression 'drug-related crime' with acquisitive crimes carried out by opiate addicts to obtain money for their next 'fix', Street heroin is expensive and addicts do commit robberies to obtain money for drugs. Violence and threats of violence are used in the course of robberies but generally speaking heroin and other opiates tend to reduce aggressive violence tendencies rather than create or release the. The link between opiate abuse and crimes against property may not be totally valid according to the findings of research studies. There is no doubt that the high cost of street opiates is a major factor in the criminal careers of many addicts. However Inciardi and McBride have reviewed much of the American literature and noted that among the majority of street users who are involved in crime, their criminal careers were well established prior to the onset of drug use. The MSRB study of heroin users in Dun Laoghaire (1984) stated that 61% of the heroin users in that area had been arrested for crimes before they began to use the drug.

More recently, Ramsay, writing in the magazine DrugLink (July / August 1994) about the situation in Britain, noted 'that there are few grounds for linking the growth in recreational drug use with increasing property crime'. Other U.K. researchers in this area have said that 'most crime is not committed by drug user at all' and that acquisitive crime is only

one of a variety of funding sources available to an addict. The most up-to-date study on the cost of heroin-related crime was performed by a group led by Baker from the Institute for the Study of Drug Dependence in London. A summary of their findings was published in DragLink in November 1994. In this report the authors challenged the calculation that half of acquisitive crime in England and Wales was committed by opiate or cocaine addicts. They found that heroin users in England and Wales raised between £58 million and £864 million from acquisitive crime in order to purchase heroin. This estimate amounts to between 1 and 21 percent of the total cost of acquisitive crime in England Wales. They point out that the data are very poor leading to a wide variation. However it is striking that large though the figures undoubtedly area, that vast majority of property crimes in the U.K. are not committed by heroin users! Information from the Netherlands and from Norway shows that welfare payments and drug dealing are more significant than robbery as sources of money for drug users in these countries. We urgently need accurate information about the life styles of Irish drug users to understand how they finance their drug use. Inaccurate information about the levels of drug related crime could wrongly increase the concern of local communities about the risk of local treatment facilities bringing, what they wrongly perceive to be drug-crazed criminal into their areas.

Drugs and Violent Crime

One of the U.K. reports on drugs and crime also noted the strong link between smokeable cocaine (‘Crack’) and violent crime. This is probably due to the paranoia which results from the prolonged use of stimulants such as cocaine and the amphetamine-type drugs thus triggering extreme violence. At the present time, given the use levels of such drugs, these are potential risks as are the risks of violence resulting from the disinhibiting effects of some tranquillisers, e.g. temazepam and flunitrazepam prescribed for some opiate users.

Alcohol and Violence

A much more real risk of violence is associated with a more mundane drug, namely alcohol, the Royal College of Psychiatrists in the U.K. estimated that alcohol was involved in up to 50% of murders and up to 70% of assaults. In an analysis of more than 9,000 violent crimes reported from 11 different counties, Murdoch and co-workers found that nearly two-thirds of violent offenders were drinking at the time of the crime. They report that it is now widely accepted that alcohol has a direct and dose-related effect on aggression in humans with a particularly strong relationship between alcohol consumption and martial violence.

MYTH 2: ACCIDENTAL ADDICTION

One of the questions I am most frequently asked by parents concern the risk that their children could be given a drug in a sweet, in a drink or in the from of the transfer to be applied to the skin. They are frightened that the child will then become hooked for life.

I believe that this is unlikely for a number of reasons. Many drugs e.g. heroin are not particularly effective when taken by mouth. Part of the attractiveness of heroin is the speed at which the euphoric effects (the 'hit', 'buzz', 'rush') start when the drug is injected or smoked. Taken in a sweet or drink the effects would be much slower and less powerful so that there would be less incentive to repeat the experience.

In any event, instant addiction is rare to non-existent. Addiction is a chronic relapsing condition which takes time, money and repeated exposure to the drug in order to develop. Few, if any addicts become addicted without an awareness that they are progressing from experimentation though occasional use into that they are progressing from experimentation through occasional use into compulsive addictive use. Some drugs are difficult to dissolve and disguise because of their taste and other e.g. LSD or 'acid' would have such frightening mental effects if taken unknowingly, that nobody would ever wish to repeat the experience.

MYTH 3: 'SAFE' HEROIN

It is believed that there has been a large increase in heroin smoking in the past year or so, a characteristic we share with Belgium, Denmark and Sweden. It appears that some young people have been fooled into using heroin to smooth out the high from MDMA and they have also been told (it would appear) that if they don't use a needle that there will be no problem. Firstly heroin is not a particularly useful 'downer', and secondly, as many heroin smokers have discovered the hard way, you don't have to inject heroin to end up with a heroin problem. Heroin is heroin whether you inject it, swallow it, smoke it or snort it. It is a highly addictive poison and will always be highly addictive poison even if it were 100 percent pure. In addiction one must express concern over the possible effects on the lung of chemicals from heroin smoke as well as worrying about the heroin itself.

MYTH 4: IS THE IMPURITIES IN ECSTASY WHICH ARE DANGEROUS

Much of the discussion about the health effects of MDMA and the related drugs MDEA and MDA sold as 'E' or 'Ecstasy' has centred on the role of impurities in the toxicity of these drugs. This is a dangerous myth because it suggests to young ecstasy users that if the drug were pure it would be safe. The reality is that the drug itself is the problem because it can kill through causing heat-stroke or through an effect on water balance leading to water intoxication. We are beginning to learn that some people are at risk from the short term effects of the drug because they are slow metabolisers i.e. they break the drug down slowly. Others are fast metabolisers who appear to be at risk of damage to the liver and heart and of degeneration of certain key nerve cells in the brain leading to depression.

No amount of purification of the drug will minimise or eliminate those effects. In any event, no evidence of ground glass, rat poison, or heroin has been found in samples from Ireland, U.K., U.S.A. and South Africa. Substitutes such as ephedrine, ketamine and

amphetamine are sold as rip-offs but by and large what is sold is one of the three genuine drugs.

The related myth that half a tablet is safe can also have tragic consequences apart from the fact that taking an ineffective half dose of a drug can give no guarantees about the safety of a full dose.

MYTH 5: DRINK PLENTY OF WATER WITH AN ‘E’

Much attention has focused on deaths from heat-stoke after MDMA, even though people have died for other reasons, e.g. as a result of delusional behaviour, from heart attacks and from asthmatic attacks. The combination of the direct effect of the drug on body temperature and the heat generated by rave dancing can be lethal.

In attempting to reduce the level of such deaths, MDMA users were advised to drink as much water as possible. This advice has had disastrous consequences because deaths from water poisoning have occurred due to the way the drug causes the brain to release a hormone which shuts down the kidneys even though there is plenty of liquid in the body. This effect known as SIADH (Syndrome of Inappropriate Anti Diuretic Hormone) is also known to occur with other drugs including the antidepressants. Because the kidneys shut down, the excess water in the body is absorbed by brain cells which lose vital sodium and also swell in the process. This swelling leads to coma and death.

As a result the harm reduction message has had to be changed to tell users to sip no more than 1 pint of water every hour, or better still to drink fruit juice or an isotonic sport drink which would replace the salt as well or better still don’t used the drug at all. It may not be fashionable to say it but if you don’t want a drug problem don’t take the drug!

While these are many drug myths the BIGGEST MYTH OF ALL is that drug use is inevitable and that we as a community are powerless to deal with it.

We are not powerless. As many in this audience have shown, it is possible to reduce the supply of drugs and it is possible to reduce the demand for drugs in our city.

Chemical intoxication is neither safe, normal nor acceptable no matter what the chemical or what the age group. That is the message which I will continue to deliver wherever and whenever I can.

Eastern Health Board

1997 Service Plan

Pat McLoughlin
PROGRAMME MANAGER,
AIDS/DRUGS SERVICE.
7th February, 1997.

The Eastern Health Board is responsible for the provision of health and personal social services to the peoples of Countries Dublin, Wicklow and Kildare, a total population of 1.3 million which represents 35.7% of the total population of the State. The Board is responsible for providing, co-ordinating and funding treatment programmes for drug misusers in its area. The exception is the Drug Treatment Centre. Trinity Court, which is funded directly by the Department of Health.

Our Boards strategy is to promote a drug free lifestyle, develop outreach contact with the greatest possible numbers of drug users, decide on the appropriate treatment and encourage all drug users to move to a more normal drug free lifestyle. Our treatment programmes have as their objective in the short-term, control of the drug misusers addiction within the context of the long-term aim of a return of the drug misuser to a drug free lifestyle.

It is our Boards philosophy to provide addiction centres and associated satellite clinics where clients can access quality services on the basis of need in their local area. Addiction centres are day centres where the following services are provided: Information, education and HIV prevention services, primary care, addiction counselling, community welfare services, urine screening, methadone dispensing and aftercare and rehabilitation.

Satellite clinics are operated by general practitioners who have been specially trained in drug misuse. These general practitioners have access to the specialist medical and counselling staff at the treatment centres and prescribe methadone at the clinics which is dispensed by retail pharmacists. Urine screening and counselling are an essential part of this programme. It is this local development of services which has created the greatest challenge to the Board in 1996 and will continue to do so in 1997. The scale of the problem requires more localised addiction centres and satellite clinics supported by a much greater involvement of general practitioners and retail pharmacist’s in the

community. Despite a major increase in resources being spent by the Eastern Health Board, from £lm in 1992 to £9m in 1996, there remains to be put in place an infrastructure capable of treating those who present at present for services and those who require treatment and have not yet presented. Our Board approved a development plan in April 1996 which has led to significant developments in providing a comprehensive response to drug misuse in its area.

A review of 1996 shows that 1,300 additional clients came on to treatment programmes. The number of general practitioners prescribing methadone has increased from 15 at the beginning of the year to 58 by the years end and the number of community pharmacists dispensing methadone has increased from 3 at the beginning of the year to 39 at the end of 1996. The enlightened approach taken by both the Irish College of General Practitioners and the Pharmaceutical Society of Ireland is of even greater strategic importance to our Board as we continue to develop the role of the general practitioner and retail pharmacist as the comer stone of our services for the future.

A new addiction centre was opened in Ballymun during 1996. This brings the number of Health Board managed addiction centres to 4. This centre which treats 100 at present will be developed to its capacity of approximately 140 in early 1997. 6 new satellite clinics in the South Inner City, Tallaght and Kilbarrack were opened in 1996 bringing the total number of satellite clinics to 8.

A mobile clinic commenced in 1996 in two inner city locations. This services reaches more chaotic drug users who are injecting their drugs and incapable of stabilising on methadone maintenance or unable to access such programmes. The primary focus of this service is HIV prevention. This service will be fully operational during early 1997 and servicing at least two more sites and will be the subject of an on-going evaluation to determine if it is achieving its objectives.

The dispensing of methadone on a seven day basis commenced in 1996 at the addiction centres. This provides further control on the supervision of methadone and ensures that methadone is not available for sale by clients who are attending the addiction centres. This service commenced at 3 of the Boards 4 addiction centres during 1996. It is clear that there is now emerging a major problem in the city of young persons smoking heroin. Programmes for young heroin smokers commenced in 1996 and treated 77 clients. A skills programme for employment for 10 young adolescents who are drug free commenced in 1996 and will continue for 1997. Our Board recognises that the provision of treatment alone is not sufficient to bring people towards a drug free lifestyle. Aftercare and rehabilitation is critical as an integral part of a treatment programme. During 1996 264 clients received such aftercare and rehabilitation. It is critically important that other agencies become involved in aftercare and rehabilitation. The Health Board alone cannot provide the training and rehabilitation needed to ensure that clients can access further education, training or employment.

Our Board increased the number of in-patient detoxification beds from 10 to 12 in 1996 and through a contractual arrangement with the Merchant's Quay Project who have a further 12 downstream detoxification beds. This has allowed 167 clients to be detoxed in 1996. The provision of downstream beds ensures an efficient use of the specialist detoxification unit at Cuan Dara.

A new management structure was put in place comprising a Programme Manager with three Area Operations Managers covering the Eastern Health Board area. The Board is in the process of selecting Local Area Co-ordinators who will have as their remit the implementation of the Health Board service plan locally, ensuring a more localised management structure. Two new Consultant Psychiatrists with a special interest in substance misuse were appointed. These psychiatrists provide a consultant service to the prisons. Five Education Officers were selected who will be specifically dedicated to

working on education and prevention programmes in the field of drug misuse. The Board believes that there is now in place an organisational structure at clinical and managerial level capable of dealing with the problem of drug misuse. An external review of our services was carried out during 1996. The review stated that we had achieved an impressive range of goals with the establishment of a network of services and a rapid growth in its overall size of service provision. The review recommended further expansion to treat the number of persons requiring a methadone maintenance service.

The provision of services by 30 voluntary organisations over a broad spectrum from education, information, various treatment initiatives including therapeutic communities, aftercare and rehabilitation was supported by way of grants of £1.5m by our Board in 1996. The extent of voluntary and community interest in drug misuse is evident by the fact that the Boards staff had been liaising with 100 groups in its area who were concerned with drug misuse. The Government have now set our Board the target of eliminating waiting lists during 1997. We are determined to achieve this target and with the resources which are already available to the Board are now putting in place the following developments.

An emergency assessment service will commence by April 1997. The objective of this service is to eliminate the waiting list for assessments, provide an emergency response for persons who are referred for assessment and for those who present themselves for assessment. The establishment of this service will assist in establishing the numbers of persons prepared to accept treatment and help identify the locations where treatment initiatives are required.

The Board will increase the number of specialised in-patient detoxification beds from 12 to 15 in 1997. In addition a 20 bed downstream detoxification unit will he commissioned during 1997. This development, together with the liaison with the Merchant's Quay

Project should ensure that the necessary physical infrastructure will be in place to eliminate waiting lists for detoxification. Our Board is establishing programmes for young heroin abusers at each of our addiction centres. The programme aims to provide medical stabilisation and detoxification. Each programme will have the capacity to treat 20 young people at any one time. Since the programmes last for 2-3 months they will have the capacity to treat in excess of 300 young persons in 1997. Individual counselling, group counselling and family therapy will be an integral part of these programmes.

The recruitment of Education Officers will see the development of programmes aimed at increasing the awareness of drug misuse issues and the development of strategies aimed at influencing young people regarding drug misuse. Our Board will engage in discussions with voluntary organisations who we grant aid to ensure a co-ordinated approach to education and prevention.

During 1996 the accommodation and technological infrastructure was put in place to provide a helpline service. Recruitment has now commenced for staff to operate this service which will provide information and support to persons concerned with substance misuse.

The Board from its existing resources will treat approximately 500 additional clients during 1997 through the increase of clients at our existing addiction centres, by the continuing referral of stabilised clients to general practitioners, by the enhancement of the mobile clinic service and through the development of local satellite clinics.

A sexually transmitted disease clinic will be established at our addiction centre in Baggot Street by March 1997.

Our Board recognises the need to constantly evaluate the effectiveness of different service strategies. During 1997 we will evaluate the first 12 months operation of the Cuan Dara detoxification centre, the needle exchange data for 1995 and 1996, the methadone prescribing protocol, the AIDS epidemiology data for 1995 and 1996 and the sexually transmitted disease service.

This range of services will ensure a greater accessibility to treatment based on need. improving the personal health of drug users, reducing further chaotic and anti-social behaviour and a limiting of HIV transmission. The Dept. of Health have now asked the Board for a plan to further deal with the Boards objectives of eliminating waiting lists. This plan is now being prepared within a budget limit of £5m. The plan will be based on the priorities set by our Board at its special meeting on the 13th of November and through the priorities identified by representatives of 59 voluntary and community representatives at a workshop held by the Board on the 27th of January 1997. The developments which are under active consideration at present include:

1. The provision of an in-patient short-stay stabilisation unit.

2. Six new addiction centres and a major expansion of small satellite clinics.

3. The development of aftercare and rehabilitation for clients who have been detoxed or are on maintenance programmes. These will be developed at or near our addiction centres.

4. An information system capable of providing accurate, timely and effective information of existing and future treatment strategies.

5. The provision of key workers in the community to provide support to young heroin abusers, clients on detox and maintenance programmes and abusers who have not yet availed of our services.

6. An information and awareness campaign for parents, youth groups, voluntary organisations, sporting organisations and the public at large regarding drug misuse and the services and supports which are available in the community.

This plan when completed will be presented to our Board for approval and will be implemented in conjunction with the Local Drugs Task Forces recently established as a consequence of the Ministerial Task Force on Drug Misuse. We believe that these task forces have a key role in developing a comprehensive plan relative to the specific needs identified in their own local community. We hope that a local consensus involving statutory bodies, voluntary bodies and community groups will lead to a dynamic response to all aspects of drug misuse.

Our Board will have the capacity to provide an infrastructure capable of treating persons in their own local areas during 1997. It is critical that the Board can achieve consensus in the community to the locations identified for these centres. Community resistance to the establishment of centres and genuine difficulties being experienced by communities in agreeing locations for centres have been a major stumbling block in rapidly expanding our services. It is important that all agencies recognise that delays in providing treatment means that the individual addict cannot access treatment and leaves communities having to continue to endure all the problems associated with drug misuse.

Our Board will continue to engage in consultation with communities to endeavour to get support for its addiction centres and satellite clinics. We promote the idea of liaison

groups representative of the Boards staff and of members of the community in the immediate area of our centres to ensure that services arc provided in an orderly manner.

We are confident that with community acceptance and support we can deliver on our targets of eliminating waiting lists in 1997. Our Board is working in close co-operation with the Gardai and local authorities to tackle the issues which lead to drug misuse. We will continue to play our part in so far as we are statutorily capable in tackling this issue.

Presentation for Conference
Drugs in Dublin, Working Together We can Make a Difference
Dublin Castle, 7th February, 1997. Dublin Corporation.

Introduction.

Towards the end of the 1970s, and the beginning of the 1980s, concern was being expressed in Dublin about the growth in drug misuse in the city, particularly young peoples' drug misuse, and the growth in availability of heroin on the streets. Research studies carried out at the time showed alarming rates of heroin use, particularly among already disadvantaged young people. An account by two journalists, Flynn and Yeates, traced how the supply of heroin had become organised in a way that had not previously been seen in Dublin. Illegal drug use had been discussed since the late 60s, when a series of articles by another journalist had highlighted such activity in the city, and police attention had been drawn to it. (Bushe 1968).

Throughout the 1980s, local communities consistently drew attention to their plight, and to the struggle they were having in trying to control the severe consequences of the drug misuse on their areas. Attempts which were made to engage statutory agencies in a meaningful way in the community proved unsuccessful, and communities set about responding in different ways. In 1981, Ballymun, an area of high unemployment and social deprivation, which was once described as "the most disadvantaged area in the State" by an Eastern Health Board special committee, set up their own response. The Youth Action Project. Those who started it believed that a way forward could be found, and that the community was the best place to develop that way.

In the south inner city area of Dublin, people took action to evict drug pushers from their communities, after major efforts on the part of statutory workers on the ground failed to generate a response from the authorities. This action took on the characteristics of a social movement, involving major participation of people from all over Dublin, and focused on

the supply of heroin in communities. We have seen similar action again in the 90s, and while it is controversial, and open to exploitation, it has at its core “one of the most remarkable expressions of civic responsibility the country has ever seen” (Fintan O’Toole 1996). It has sparked off an involvement in the communities which will develop in other ways. Other groups which were set up include CAD (Community Awareness of Drugs), which has consistently organised awareness programmes for parents throughout the country, and is not concentrated in any one area, and Community Response set up a community led partnership of statutory, voluntary and community, developing ways of responding to drug related problems in the South Inner City.

Problem drug use is a major issue for many of our communities. There is a wealth of support from all over Dublin to “do something” about the problem. A City-Wide campaign was set up. and drew up a strategy for a response which involves health, education and justice issues. People have been organising themselves to play a part in helping. Once again, different actions are taking place in different communities, ranging from parent-to-parent education programmes, to local people engaging doctors and organising structures for the provision of methadone.

The hurt which has been caused to our communities through the downward spiral of problem drug use is extensive. People, already struggling to reach a basic standard of living, coping with unemployment, poor alternatives, overcrowding and lack of facilities, found problem drug use in their areas to be devastating. Theft increased, security became a major issue, people isolated themselves, staying behind their own front doors, local incidents increased, security grills went up, anyone with any resources at all moved out. In many cases, businesses closed, and the media reinforced an image of hopelessness. People felt abandoned by the powers that be, and in some cases dereliction ensued.

Feelings of anger, shame, hatred, fear, hopelessness, guilt, despair, powerlessness, bounced around everywhere; feelings which are usually very hard for us to express and come to terms with. They are usually reacted to, and we have seen some of these reactions

in behaviours which attempt to control, to avoid, which become rigid, judgemental, which are confusing, crisis oriented, and which adopt trial and error techniques.

Collectively, we were ill prepared to deal with the enormity of the spiralling disaster, and we can identify phases we have gone through since drug abuse was first evident. The first was disbelief. People were told this is not happening, it's not that bad, you're exaggerating, etc. Only those who were directly affected in their own families knew how bad it was. Until some research was done. Even then, it was believed that the problem had gone away, that it had levelled off.

Then the search was on to find the reason for this - why is it happening? There are many reasons, and they have all been discussed. They are complex, involving individual, family, community, and society. We know the reasons. But have we worked to change them? Many people believed it was a phase we were going through, that we would grow out of it. But we didn't.

Next we said - let's control this. This reaction still goes on, especially in the minds of those who believe that stronger laws and tougher sentences, more prisons will rid us of this problem.

The problem still grew, and the blame game then went on and on. Every sector blames the other. "It's your fault" is the common cry. The buck is passed, until it can be passed no further. Vulnerable parents, already struggling, are the last dumping ground.

Each section has also tried to find separateness from the problem, like family members who try to get away from it. This is helped by the separateness of our systems, and our departments. It's seen in communities, by people doing things like sending their children out of the area to school, going to shopping centres in other areas, socialising in other areas, etc. We can live in areas without seeming to be part of them. And we have tried to live in spite of it, and get on with our lives. It was not a talking point for a while, it was taken for granted, part of life. It wasn't news! It wasn't on the political agenda.

People stopped talking about it, trusted no one, and went about their business. But the pain spread. It deepened. We couldn't hide it anymore. It has burst open, like a festered wound, and is gaping for all to see.

The community action born out of this agony has once again made drug abuse a media, and political, issue. Because it didn't go away. It never disappeared. Now communities are facing their problems, and accepting ownership of their areas. But this time, the demand is for the involvement of everyone, all of the key players. Now we see a developmental process, with a demand for more say, leading to change that makes a difference. The collective community voice is saying that enough is enough, and that serious action needs to take place, in both supply and demand strategies.

In YAP we believe that, whatever the variables which affect the onset, the responses we make are crucial in determining if someone remains addicted.

During the 1980s, strategies were developed to move from centralised to community services.

However, "community" can be interpreted in different ways.

Models of community response.

Community as a setting. This is seen as a positive alternative to residential care. Services are more accessible, and the person can stay in their own environment. The people living in the area are seen as the receivers of the services, the patients. Community as a resource for central agencies. This approach goes a step further and uses local structures and resources. For example, local people might be trained to deliver certain services. These people are usually volunteers, and can be very effective in reaching people. Other groups, agencies in the area are also used to further the aims of the central agency. Decisions are made centrally, allocations made, and priorities set. Local people and resources assist the central agency to implement their plans.

Community Development Approach. The basic principles of a community development approach are participation, equity and intersectoral collaboration (Jones and Macdonald

1993). It is an approach which encompasses a commitment to a holistic approach to health and recognises the central importance of social support and social networks. It is a way of working which attempts to facilitate individual and collective action around common needs and concerns which are identified by the community itself, rather than being imposed from outside. (Smithies & Adams 1990). The potential benefits of community participation in primary care include improvement in the design of services, increased effectiveness and efficiency, strengthening monitoring and evaluation of services, improving mobilisation of community resources and progressive assumption of responsibility for health care by the community, with technical and administrative assistance from the health authorities. (Quirke et al 1994).

This is a more radical approach, and sees the role of the community as not only supporting and helping operate services, but more importantly as determining priorities and being involved in the allocation of resources.

What do we mean by participation? While this is also open to interpretation, it has been defined as having essential elements:

- participation must be active; mere receiving of services does not constitute participation;
- participation involves choice;
- choice must have the possibility of being effective. (Rifkin, Muller & Bichmann 1988).

It is striking to note the central, fundamental role which is outlined in the literature for communities. It is claimed that this is the major way to achieve health for all, through the identification of needs, the decisions taken to meet those needs, the planning and implementation of responses. Some of the agencies, like the Family Centre Lower Hutt, New Zealand, go so far as to say "Therapy that does not address cultural meaning webs in informal ways simply continues the process of alienation." In Ireland, Tobin has said that "....not only do such programmes (health and education) have a greater capacity to tackle

social exclusion and inequity but the way in which they operate can actually contribute to exclusion and alienation."

John Hubley (Community Development and Health Education. 1980) observed: "It would seem that current health educational programmes are actually widening social class difference!"

In the drug and alcohol field, the principle of participating in the resolution of serious problems is not new. The fellowship of Alcoholics Anonymous is now 60 years old, and in that time the same principles have been used by family members, people with drug related problems, people with gambling problems, eating disorders, etc. These fellowships were founded to find a way where none existed, and have been attributed with considerable success by many of those who use them.

The Therapeutic Community model of care for those with drug problems has been to the fore, as one of the earliest responses, in responding to the need for help. This model uses as its core, a self-help regime, where everyone who is part of the "community" contributes to the organisation and daily running of the house. Community participation, while it does not just happen, has the potential to improve the quality and scope of drug services. It does not happen quickly, and there is no blue print. This can be very frustrating, especially in an urgent situation. However, many of the basic principles for successful involvement outlined by Quirke et al (1994), are present in our communities in their concern and efforts to protect their children from drug related harm. This can be marched by the health board, and other care providers, by accepting that communities are entitled to participate in service planning; by formally identifying workers who will provide support and technical back up, with approved role legitimacy and adequacy for development work; by accepting that shared care means shared control, and by treating communities as equals in the process of dialogue.

> **"The people have the right and duty to participate individually and collectively in the planning and implementation of their health care."**

(Declaration of Alma-Ata)

The idea of community becoming directly involved in their own health care gathered momentum during the 70s, and into the 80s, as the non-governmental organisations (NGOs) built on community development ideas and related them to health. Health became part of an integrated package that would conquer underdevelopment. 1978 saw the WHO produce the

Declaration of Alma-Ata, which clearly identified community involvement in their own health as the major plank in the strategy to achieve 'Health for All' by the year 2000. Primary Health Care "addresses the main health problems in the community, providing promotive preventive, curative and rehabilitative services accordingly;"

In promoting community involvement in health so forcefully in this declaration, WHO was endorsing the approach which had become popular as a development strategy, and which saw health, not as an isolated variable in people's lives, but as intrinsically linked to many other factors, social & economic, which affected the health status of the community.

> *"involves, in addition to the health sector, all related sectors and aspects of national and community development, ...and demands the co-ordinated efforts of all those sectors;"*

Conclusion:

In seeking to find effective ways to respond to the hurt and pain of our communities, value needs to be placed on the evidence of communities' desperation to have their children treated effectively, of their efforts to make their areas safer for their children, and of their sophistication in employing community development strategies in response to many serious issues facing them.

In taking up the challenges of a community development approach to drug misuse, we can be congruent with Primary Health Care as outlined by WHO, and creative and co-ordinated in our activities.

Previous claims of consensus and intersectoral collaboration in Irish policy making have been "superficial having been achieved and maintained by ignoring many real policy dilemmas...." (Butler 1991 p 230).

The effectiveness of structures at local and national level depend on the debate going beyond superficial levels, on the real dilemmas being faced, and on the required analysis and study being undertaken.

The crisis which drug misuse has presented for our society could yet be the foundation on which to build comprehensive community care. Ignoring the difficulties and challenges runs the risk of deepening the hurt and abandonment even further.

Communities are passing through the nightmares and are coming to see a new hope. How do we respond to that courage? Perhaps this time we can turn and face in their direction. That direction is giving hope, and is finding ways forward, if we are willing to make the changes necessary.

Through this, our ‘‘ability to respond" can be increased, healing can happen.

What does this mean for community services?

1) community are prime movers;

2) leadership is developed from within, not imported.

3) plans are developed locally, not centrally.

4) local structures have a say in the allocation of resources, and determination of priorities.

5) services are community centered.

6) no one agency has all the responsibility.

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Seasamhacht* Ábaltacht* Obair* Léann
S.A.O.L.® PROJECT LIMITED
58 Amiens Street
Dublin 1
Ph: 8553391/8553393
Fax: 8553395

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WOMEN AND DRUGS – THE EXPERIENCE OF THE SAOL PROJECT

This paper has been written as a result of the experiences of the SAOL Project over a 14 month period. It includes a description of the context in which SAOL operates and the type of things we do on a day to day basis as well as its contributions to the lives of women who are drug users in the North Inner City of Dublin.

What is the SAOL Project?

The SAOL Project is a two year pilot programme for former and stable women drug users whose purpose is to move through development work and capacity building from addiction and dependency to self direction and self reliance, it operates on the basis of social justice, adult education and community development principles, and focuses on re-integration into the community.

All of the women who are on the programme were on a methadone maintenance programme through the City Clinic in Amines Street. The project is the first of its kind in Ireland specifically targeting women drug users and came about largely as a result of a research project carried out under the aegis of the Eastern Health Board.[1] This research identified a critical unmet need in the area of drug stabilisation, i.e. intensive support, development, education and rehabilitation programmes.

SAOL was established in mid 1995 and had its first intake of women in October 1995.

Who funds SAOL?

The Project currently operates on an annual grant from the Eastern Health Board, funding from FAS, the State Training Authority in the form a Special Community Employment Scheme and some private contributions and donations (notably from Poetry Ireland Ltd). In addition the project successfully applied for European funding under the Social Exclusion Budget for 1996 to enhance the base programme of work. The budget for 1997, to complete the pilot phase of the programme, will be met by funding from the Eastern Health Board and FAS.

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[1] Female Drug Users and Service Provision, Carmel Dunne, Dissertation. MSc Community Health, TCD, Dublin September 1994.

Project Management

The project is managed as a partnership between the Eastern Health Board, the local Inner City Community, a local voluntary drugs services agency and FAS. We presently employ four full time staff, i.e. Manager, Administrator and two Development Workers. In addition we contract in a number of sessional workers for specific expert pieces of work.

What does the SAOL Project do?

On a day to day basis it gives fifteen women the opportunity to explore their own potential over a two year period through a participative style of adult learning that involves vocational as well as practical skills training[2].

Participants are encouraged to have a sense of ownership around the project and are also encouraged to become involved in regular reviews of course design, delivery and management. The project is designed to be flexible enough to meet the changing needs of the women and structured enough to ensure that the training doest not become unfocused.

Project Development

Training takes place from Monday to Friday from 10.00 am until 2.00 pm. An initial needs assessment with the women selected allowed us to develop a framework of activities covering training, education and development, the aim of these particular training modules is to enhance existing skills, to expose these women to new experiences and educational opportunities and to enable them to make informed choices about their own lives.

Specific Training Modules

- Personal Development training
- Relaxation and Holistic Therapy
- Art Therapy
- Literacy and Numeracy[3]
- Parenting Skills[4]
- Group Dynamics
- Community Development
- Social Analysis
- Computer/keyboard kills

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[2] See list of specific training modules further in this presentation

[3] The particular target groups have a high level of literacy and numeracy difficulties.

[4] In C. Dunne's report, children are mentioned as the most important reason why women are remaining stable on the methadone programme. The mothers are extremely anxious that their children should have a better future and for this reason the area of parenting and involvement of the children in appropriate activities is seen as crucial to the successful outcome of this project.

- Sewing
- Knitting
- Hairdressing
- Cooking/catering
- Money Advice and Debt Management
- Welfare Rights Information
- Family Planning
- Women's Health & Nutrition
- Social and Recreational visits to theatre, Cinema, etc.
- Outdoor pursuits

WHY DO WE DO WHAT WE DO?

The project operates from a set of values that believe that endemic drug addiction in areas like the North Inner City of Dublin stems from a fundamental in quality in our society. Education attainment standards are poor and opportunities for learning and development are few and far between. The project also believes the social justice is a right for all and as a result we operate from a set of principles which include information and empowerment on basic citizens rights and access to appropriate services in times of need or crisis. This issue of social justice and rights often leads us into an advocacy role and we at times find ourselves being critical of services which are available to these women.

So in practice what does all this mean? Well, on a recruitment level this means that we targeted staff who have all round skills in terms of their work with people at a community based level. Workers with a background in community development who operate from a particular set of principles including respect and equality. People who incorporate an adult education approach to their work, who have a social and political analysis on their work, who operate from a background of their own experiences of disadvantage, who are flexible, skilled in group techniques and who, above all, bring with them an energy and dynamism to the work.

So what does this thing called Community Development and Adult Education really mean?

There are a number of key principles which have to be involved if one is taking a community development approach to their work. These principles must all be in place if one is to truly say that they are taking this approach and not just using the language to explain that a project is based in a community and works with the people in that community.:

Cornerstones of the community development principles

EQUALITY	EMPOWERMENT
WORKING COLLECTIVELY	SOCIAL ANALYSIS

Equality: On a practical level, this means respecting the rights of all people involved in the project as equal and encouraging and respecting critical evaluation of our work.

Empowerment: Empowerment means just exactly what is says. It means giving people the information to allow *them* to become informed about their lifestyle. It means exposing them to a range of choices that may or may not change this lifestyle. It means giving them the confidence to assert themselves - very often in unequal situations. It means allowing them to make their own *informed* choices about their futures.

Working collectively: Community Development can only happen when the processes involved are collective as opposed to individual. Very often, however, this means that work must start with the individual and it is for this reason that personal development is an important focus of our work. However personal development in and of its own is not enough. There is a need to develop the group to take collective responsibility for the actions of the individuals within it.

Social analysis: It is not enough that the treatment of drug addiction focuses only on the individual and the addictive behaviour of that individual. Solutions to drug addiction cannot be found solely within the individual. While addiction therapy is an important component in any rehabilitation programme. An equally important component is providing the tools to analysis the social factors that lead to drug addiction. Very often providing and using these tools can lead to tensions between the medical and social model of drug treatment. Indeed we have been accused of 'rescuing' people from their addiction by allowing them to 'believe' that it is not their fault and that therefore they do not need to do anything about it. This type of simplistic analysis is often unhelpful and needs to be openly and honestly discussed and debated by both disciplines. Social Analysis can provide us with an understanding of drug addiction. It is this understanding, combined with using the other principles, of our work that can often lead to solutions being created.

SO WHAT ARE SOME OF THE PRACTICAL OUTCOMES SO FAR?

SAOL attempts to take a holistic approach to its work. It is not easy. It is very often extremely stressful. But nonetheless, within the limits of its own resources, the project has made a commitment to this process with these women.

The SAOL project has been going now for just over one year and while we are still only halfway through this pilot there are some very real measurable outcomes. The outcomes are both quantitative and qualitative. There are outcomes in terms of educational levels, conceptual levels, self esteem levels, confidence levels, acquired new knowledge, reduction in methadone, etc. etc. it is important to state that the SAOL Project does not operate from an abstinence model - therefore if these women choose to remain stable on methadone, then provided that this choice is an informed one and that the consequences and responsibilities that go with being maintained on a highly addictive substance are accepted, then the work of the Project has been done.

However, the reality of the situation for these women since they came onto our programme are as follows:

- Four of the women could not read or write before they came to this Project. All of the other women, with one exception, had reading and writing difficulties ranging from high grade literacy problems to very low literacy skills. This is a particularly poor indictment on the education system that they were part of for most of their young lives. Five months into the Project they had written poems and short stories and we have had two collections from the project published. President Robinson has requested the opportunity to write a foreword for our next publication. All of the women are studying for examinations in English - ranging from the leaving Certificate to the NCVA levels.

- Several of the women have reduced their methadone intake daily and have also either reduced or ceased using other prescription drugs. Here are some key quotes from the women discussed during review sessions.

  "When I started SAOL I was on 200 mls. (daily) By Christmas (1996) I was down to 6 mls (daily) but I went up to 10 mls (daily) again when my child was sick"

  "When I started SAOL I was on 250 mls (daily). I am now down to 75 mls (daily)"

  "I am on the same dosage since I started."

  " I was on 70 mls (daily) when I started SAOL and I am on 10 mls (daily) now"

  "I was on 90 mls (daily) and I am now on 50 mls (daily)."

  "I was on 100 mls (daily) when I started SAOL and I am on none now."

There are other positive outcomes which are evident to us as staff and management and we hope to have these confirmed as a result of our forthcoming independent evaluation.

COMMENT FROM THE MANAGER ON THE SAOL WOMEN AND DRUG USE

In SAOL the ‘normal’ rules of an education project don’t often apply. The ‘normal’ rules of a development project don’t often apply. The ‘normal’ rules of a training project don’t often apply. The ‘normal’ rules of a group process don’t often apply. One could be forgiven for thinking that the SAOL project is just not ‘normal’! However what it does provide is a normality and a stability that gives voice to those women who have been unheard.

The woman drugs users living in an area like the North Inner City of Dublin does not just have the problems of trying to get money for her daily ‘fix’. She lives in a fractured and severely damaged community. She copes with extreme social isolation and disadvantage. In the experience of SAOL the woman drug user, and in particular those with children, also copes with factors such as:

- poor-housing
- financial worries
- unemployment
- educational disadvantage
- low nutrition
- little social/community support
- extreme levels of stress
- can often suffer domestic abuse
- being in ‘trouble’ with schools because of her children’s behaviour
- often visiting her male partner in prison (and very often having to score drugs for him to enable him cope with life in prison)
- poor medical services
- having to cope with loss and bereavement
- often coping with past sexual abuse
- coping with the ‘maze’ of social services
- frightened to say that she cannot cope because this type of exposure might suggest to the authorities the she is not a capable mother
- being frightened to approach the authorities, particularly for health care, because of ‘judgements’.

One can see that even if you remove the need to get money for the daily ‘fix’ by providing methadone maintenance, you are still left with all of the other factors.

Drug use for women is not simply about coping with trying to get the money for your daily ‘fix’ Drug use for women has layers and layers of complications. Complications that are too difficult to simply label as addictive behaviour and to deal with exclusively in this way. People don’t make healthy choices in a vacuum: they make them in the context of their own environment. These choices are subjects all the pressures and influences that surround them.

A holistic approach is needed in the treatment of women drug users. A holistic approach which recognises that the factors that led to drug abuse and the subsequent chaotic lifestyles are inter-related and must be addressed and supported. In our experiences, these factors are both inside and outside the control of the individual. Until we, as a society, can accept and admit that drug use is not simply an individual's choice but often the result of no other choices, then we will not make any serious impact on the type of endemic drug problem in areas like the North Inner City.

Joan Byrne
Manager
SAOL Project
7th February 1996

Text of Speech to Dublin Corporation "Drugs in Dublin" Conference, Dublin Castle - 07/08 February, 1997.

Assistant Garda Commissioner Thomas C. King

Mr. Chairman, Lord Mayor, Ladies & Gentlemen

In December, 1996, all Heads of Government of the 15 E. U. Counties met in this very room and, as part of an Irish G0overnment initiative, committed themselves to a continuing proactive international co-operative effort against drugs.

I say this, not only by way of acknowledging Government initiatives and its commitment to deal with this drugs issue, but to demonstrate that the issue is an international issue. Heroin finding its way to a Dublin street has its origin in Asia, a fact supported by the European Union Situation Report on Drug Production and Trafficking published in September, 1996.

Any effective action against drugs require An Garda Siochana to ensure that it has an effective network of co-operation with all law enforcement agencies who might be able to assist us in any material way.

The next stage of our interest arises at the point of entry of illegal drugs into the State. In an era of open boarders, free movement of goods and persons, it is a very difficult task to prevent illegal importation. This year, Dublin Port alone will have a movement of approximately 12,000,000 tonnes of goods through the Port. Dublin Airport will have a movement of more than 10,000,000 passengers and when one adds in Dun Laoghaire and the other Ports and Airports in the State, the difficulties for An Garda Siochana and the Customs Authorities become obvious.

It is important to say that in this context of preventing the illegal importation of illicit drugs, there is ongoing co-operation between An Garda Siochana, the Defence Forces (particularly the Naval Service) and the Customs Authorities. Delegates here can be assured that there will be no failure by these State Agencies to co-operate in the most effective way.

Against that backdrop, let me come to the subject matter of this Conference, namely, the drugs issue here in out Capital City. I think it is worthwhile to reflect on how we arrived at the current situation.

A review of Garda records and statistics suggest that so called 'Hard Drugs' did not materialise as a problem until the late 1970's. Between 1970 and 1977 seizures were small in number and very few seizures were related to opiate possession or use. At that time, estimates indicated that as much as 90% of illicit supplies were obtained by larcenies from chemist shops.

Heroin appeared on the streets in a significant way between 1980 and 1986. However, only 25% of drugs charges between the period 1978 to 1988 were opium related. What we have observed, therefore, is a gradual process of movement from drugs like L.S.D. to Heroin. We have heard from an eminent speaker at this Conference that there is no such thing as a safe drug, but as communities here in Dublin will testify Heroin misuse has a proven track record of addiction leading, in some cases, to death.

RESEARCH

One of the first requirements for any action programme is to establish first what exactly the problem is, and this can only be done by properly organised and methodical research. I have to say that there has been a failure to undertake such research and I, therefore, welcome recent initiatives where up to 25 separate research projects are being funded. Such research findings can provide a basis for appropriate action by all Agencies and we look forward to these research findings.

An Garda Siochana has initiated a Research Project involving primarily, the Force itself, but with external assistance and professional guidance and direction. I can share some of the preliminary findings with you this morning. This data is based entirely on Garda records and while valid in that perspective, we make no claim or statement that they represent the actuality of the drugs problem overall. They are, however, of sufficient important as to give all of us food for thought and to require us to give careful consideration to their significance for potential action areas in social terms.

In 1996, 3579 persons who had contact with An Garda Siochana, and which contract resulted in a record being created, usually a custody record, were uses of drugs. Of this total 89% were Heroin abuser, 5% Ecstasy abusers and the rest a variety of drugs including Methadone.

The majority of drug abusers are male - 85%. Only 2% of the total number are in employment. 80% of all abuser are in the 15 - 30 year age group. 83% of drug abusers are single with 58% of those residing still in the family home.

In pure statistical terms, the greater numbers of drug abusers are in the major suburbs to the South and West of the City. However, on the basis of percentage of drug abusers relative to the population aged between 15-55, the inner city area has the most severe problem in relative terms.

To put some of theses figures in perspective, the research indicates that young unemployed males are at greatest risk of taking up drug taking leading, in many cases, to serious abuse of hard drugs like Heroin. It further indicates that this becomes a direct family problem, since most still reside in the family home. I think none of this will come as any surprise to many people in this room or to many living in the Community. Nor doest it come as any surprise to professionals in the field and particularly to An Garda Siochana, who have a long history of direct involvement with the Community.

There is no formal research project which has established links between drug abuse and crime. The Garda research, as advised above, is proceeding on a proper research basis to come to some conclusions on the matter. It can be admitted that there is a link and certainly, in some areas, especially the Inner City areas, there is a proven drug it is unwise to jump to uninformed conclusions. For example, a recent analysis of persons charged with syringe attacks, showed that only 12% of such persons were drug abusers. Syringe attacks, therefore, represent opportunist use by criminals of syringes as a weapon to effect their crime.

I will come to Operation 'Dochas' n a moment, but first let me remind all concerned that An Garda Siochana have been active in the fight against drugs since it first manifested itself a problem. There were times when we felt that we were almost alone in combating this problem and it is rewarding to see that that has changed completely.

Through our Community and Neighbourhood Policing strategies and the involvement of the Community in such schemes as Neighbourhood Watch, Pharmacy Watch, Coastal Watch etc. much has been achieved. We have been active in the schools via our schools programme and in many juvenile diversion programmes and have given drugs talks to interested parents and communities for many years.

On the more conventional operational policing side, special priority has been given to anti-drugs operations. The establishment of specialised anti-drug units in each area was a specific response. Paradoxically, this initiative was the basis of criticism, since some people seemed to believe, these units represented the totality of our efforts against drugs. Nothing could be further than the truth, and let it be perfectly understood, that the Garda effort against drugs in a matter of priority for all members and all units.

<u>Operation 'Dochas'</u>

In September of 1996, Senior Garda Management reviewed the then current Garda operations against drugs and their effectiveness. It was decided that any efforts by the Force alone, as a single Agency, could never eliminate the drug problem or, indeed, either drug related crime or crime in general. It was further recognised that whereas we always felt that we had the general passive support of the community, there was a need to revitalise our contact with the community and to create an opportunity for a more proactive community support for the Garda Operations against Drugs in particular.

On 7th October, 1996, the Garda Commissioner announced the start of a new major Garda Operation called ‘Dochas. This is a word which, literally translated, means “Hope”, but in a more traditional Gaelic sense represents a positive image that there will be a successful outcome to the task in hand.

The underlying philosophy underpinning Operation ‘Dochas’ was that close contact and co-operation with the Community was essential to a successful handling of this serious issue of drug abuse and related problems. In addition to that close community contact of uniform officers, task forces spearheaded by the local drugs units were crated to ensure that the issue of drug dealing was directly confronted. And so on 7 October, 1996 An Garda Siochana committed 536 members to a policing practice of close community contact supported by operational drug task units.

Named and identified Garda members were nominated for identified “Community areas” with a mission statement to maintain close personal contact with all concerned in their areas. There were meetings with local organisations, local representatives, other Agencies and Community Groups. This was, in effect, an all out Garda offensive against drug dealing and related criminal activity.

I want to pay tribute here to the local Community, both at the individual and Community Group level. An Garda Siochana respect and acknowledge the part played by the community in the fight against drugs in their areas. We have observed the energy and commitment put into their efforts to get rid of the drug problem and to improve the quality of life for all living in their areas. In a Democracy, like this, policing is not something you do to people, but for them and with them and the success of Operation ‘Dochas’ over the past few months has, in large measure, represented the combined efforts of ordinary decent, hardworking, concerned people and An Garda Siochana.

To those who say that An Garda Siochana is opposed community efforts against drugs I say, quite clearly, that we support and commend community efforts against drugs and other forms of crime. What is not acceptable, is any form of criminal action by anyone in the community, and however worthy the motive may seem, the law is there for the general protection of society and must be observed. Every genuine effort by the community to improve the quality of life in their area will receive only support and encouragement from An Garda Siochana.

What has Operation 'Dochas' achieved?

There has been considerable bonding of community and Garda efforts. The additional uniformed presence has brought about a genuine local improvement in terms of peace and order and quality of life in local community areas, and a recognition that the Police Service is a truly genuine Community service.

In terms of statistics, the following may be of most significance. Since October 7th last

A. Total No. of Drug Searches carried out:	4013
B. Total No. of Vehicular Checkpoints operated:	6393
C. Total No. of Arrests:	2881
D. Total No. of People charged in relation to Operation Dochas:	2325
E. Total No. of Summons applied for:	4272
F. Street Value of Seizures	almost £2m

Two days ago, a significant find of Heroin was made in the North Inner City and charges have been preferred. The street cost of that find is estimated at between £0.5m and £0.75m.

These significant results could not be achieved without public help and assistance and I say thanks to the public for their co-operation.

THE FUTURE

Significant as these figures may be in result terms, I am conscious that they confirm that drug abuse is still a major issue for the community. I can confirm from our point of view that An Garda Siochana remains committed to two policing practices

1. To maintaining a very personalised and community based Policing presence
2. To full engagement in the many inter-agency efforts now underway.

It has long been evident that no Agency, however professional and effective it may be, can resolve this problem on its own. The recent Governmental and local authority initiatives and the additional funding and support for Eastern Health Board operations in respect of treatment will bring results. We intend to play a full proactive part in each of the Drug Strategy Teams, and to the many other schemes which require an inter-agency approach.

An Garda Siochana welcomes the initiatives of the Dublin Corporation in respect of environmental improvement schemes.

The single most important element in a successful anti-drugs effort is the community itself. Without the participation of the community at individual, family and community group levels the work of all the other Agencies is likely to fail, and will certainly not achieve its full effect and advantage.

Urban renewal schemes, while worthy and good in economic terms, tend to be pitched at the level of the infrastructure and buildings. It is time for urban renewal of the social fabric of these areas on the basis of our experience over 75 years now, in these communities, it is evident that community problems have an economic, environmental and social basis. Efforts to resolve, for once and far all, the problems of these areas, will require an inter-agency approach on the State side, business and commercial interest and, above all, help and assistance directed at the social fabric of those societies.

I have personally travelled into these communities and I sense new spirit and a new energy. I believe that there is present in the community now a sense of purpose and a confident expectation that their quality of life can be improved. There is, therefore, in my view, a potent mix of community spirit and genuine efforts by relevant Agencies to focus their efforts on this drugs problem. In the West of Ireland where I grew up, the concept of "Meitheal" was established. This was where the community came together to achieve some specific purpose, which not only got the work done very effectively, but also created a community bonding and renewed everyone's commitment to that community. On the basis of that experience, I welcome the current community efforts and look forward in confidence to joining in those efforts to achieve a level of harmony with the Community to the advantage of all.

In this, the 75th year of Garda service to the community, I wish to place on record that this Force will continue to fully engage in a true sense of partnership with both the Community itself and all other Agencies, included voluntary organisation, in the interest of achieving a drug free, crime free safe city environmental for all citizens and visitors to this wonderful city.