

TACKLING DRUGS **TOGETHER.**

***A MULTI- AGENCY APPROACH TO EDUCATION ON DRUGS,
PREVENTION AND CARE FOR MISUSERS.***

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NORTH EASTERN HEALTH BOARD

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Lib-Our Lady of Lourdes Hosp. Drogheda



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- * **Members of the strategy sub group (Appendix A).**

- * **Members of the Regional Drugs Consultative Committee (Appendix B)**

- * **The organisations, agencies and voluntary groups who helped in the research. (Appendix E)**

- * **To the individuals themselves for providing the information.**

TERMINOLOGY AND LANGUAGE USED.

In this document drugs refer to: illegal substances, prescription drugs and alcohol. This conforms with the 1947 Health Act: Medical preparations (control of sale) regulations, and misuse of drugs acts 1977/1984

The North Eastern Health Board adopts the definition of the Pharmaceutical Society of Ireland (1996):

“ Drugs abuse may be defined as the use of any substance, legal or illegal, which damages the physical or mental health of the user and / or his relationships with friends, family or society in general and/ or damages his vocational functioning either at work, inside or outside the home” (P2).

1.1

Introduction:

Shaping Healthier Future - A strategy for effective health care in the 1990's identifies "the illegal use of drugs to be a problem" It also identifies other addictive substances as priority target areas. This includes: smoking, Alcohol and appropriate use of (prescribed) medicines.

The Health Promotion Strategy - 'making the healthier choice the easier choice , sets clear targets and action plans to address alcohol and substance misuse .

In 1996 the Government established a ministerial task-force (Cabinet Sub Committee on drugs) and a strategy on measures to reduce demand for drugs.

The task force recommended the setting up of regional consultative groups which will advise on local measures to reduce substance misuse.

1.2

Regional Drugs Consultative Committee.

In 1996 North Eastern Health Board formed the regional multi agency committee. The membership of the group is drawn from the following sections and organisations, Health, Justice, Education, Garda Siochana, Youth Services, Fas, Social Welfare and Voluntary Sector (see appendix A).

The terms of reference for the committee were established and agreed at the management meeting (see appendix B). The first recommendation of this committee was the establishment of a sub-group to work on a strategy for tackling drugs.(see appendix C).

1.3

North Eastern Health Board - Drugs Misuse Prevention Group.

In recent years there has been a growing concern within Ireland about the increase of, and problems associated with, drugs misuse. Figures published by the Health Research Board indicated that in 1995 there were 41 clients from the N.E.H.B. region who received treatment. (see table 1 - page 10)

The North Eastern Health Board is not different from any other region in Ireland in its concern about this problem. However, because of this concern it created a small drug misuse prevention group which comprised of the following :-

- The Regional Health Promotion Officer and Regional Drugs Co-ordinator with the overall responsibility to co-ordinate a systematic approach to reduce demand for drugs and the harm resulting from its use/misuse.

- A Specialist in Public Health Medicine to assess the needs, conduct and supervise research and evaluation programmes and their effectiveness.

- Regional Child Health Development Officer - who has responsibility for developing services for protection of children and promote their welfare.

- The group co -opted members of other professionals on an ad-hoc basis.

- This group also created North Eastern Health Boards Drug Workers forum - professionals who are employed by the Board for the purpose of reducing drugs demand.

LITERATURE REVIEW

1.1

Literature search forms an integral part of any planning in the health service. The reasons for doing so are multiple but ultimately to enable the planning of services based on best practice, value for money, effectiveness and inclusivity. Therefore, the literature research concentrated on education about drugs misuse, prevention of its misuse and the harm resulting from it.

This literature research was also informed by similar papers from this country (other Health Boards) UCG Literature search and overseas. The following are some of the results:-

1.2 Drugs misusers are not a homogenetic group and therefore one cannot stereotype them.

1.3 Regular alcohol (mis) use usually precedes experimentation with illegal drugs but for “most young people drugs starts and finishes with experimentation”.
(Centre for Health Promotion - UCG)

1.4 Surveys on adults reveal a lack of understanding of the drug scene and drugs misuse.

1.5 Prevention.

1.5.1 Scare tactics which involved giving the public frightening stories and images “failed at almost every hurdle and sometimes even increased use”.
(see report in 'Drugs - Screw You' Campaign, London)

1.5.2 “Just Say No”, although popular is not very effective.

1.5.3. Impact on behaviour is a long term goal.

1.5.4. Decision making skills and social skills enhancement are two methods which look promising especially when combined with other techniques.

1.5.5. To be effective, programmes must be tailor made to the target group. While accepting that social influences are universal and multi factorial, it is not necessarily applicable to all adolescents who are at varying degrees of maturity and risk.

1.6 Education.

1.6.1 Parental education programmes are showing increasing effectiveness.

1.6.2. Early school leavers are at a higher risk and should be targeted.

1.6.3. Peer Drug Users: This is an innovative approach where drug users become a friendship network for other drug misusers. However it is proving impractical to do so because of the nature of the issue.

1.7 Risk Factors

Most people will acknowledge that knowledge on its own has little impact on actual behaviour. In order to change peoples behaviour programmes should aim to change peoples attitudes and increase their skills in making decisions.

1.7.1 Risk factors associated with drugs misuse (according to Hawkins et al.) are categorised (with adaptations) as follows:

Laws and norms favourable towards behaviour.
Availability
Extreme economic disadvantages
Neighbourhood disorganisation
Psychological factors
Family use and attitudes
Poor and in consistent family management practices
Family conflict
Low bonding to family
Early and persistent problem behaviours
Academic failure
Low degree of commitment to school
Peer rejection in early school years
Association with drug using peers
Alienation and rebelliousness
Early onset of drug use
Favourable attitudes towards drugs use.

Better understanding of these risk factors enable us to target the programmes in an efficient and effective basis.

1.7.2. Risk Protective features like extended support systems, extended positive value systems are crucially important.

- 1.8. Timing of intervention is crucial. Primary prevention should be implemented when there is a weak evidence of problem. When the problem is widespread, the objectives should be to approach as many associated problems for as many people as possible.
- 1.9. Mass media campaigns on its own seems to be ineffective.
- 1.10 The combination of strategies appear to work synergistically with one another.

Section 3

3.1 H.R.B. RESULTS

TABLE 1

ALL TREATMENT CASES IN 1996

COUNTY	NUMBER OF CASES
Louth	15
Meath	24
Cavan	1
Monaghan	1

TABLE 2

PRIMARY DRUGS - IN 1996

COUNTY	OPIATES	CANNABIS	STIMULANTS
	%	%	%
Louth (15 Cases)	20.0 (3)	40.0 (6)	33.3 (5)
Meath (24 Cases)	29.2 (7)	20.8 (5)	50.0 (12)

H.R.B. Comment: These figures are most likely under estimated as the reporting systems are not fully developed.

3.2 Illicit drug use in the North Eastern Health Board

QUANTITATIVE RESEARCH

2.1 Introduction

To inform the health promotion strategy of the NEHB a programme of research was initiated by the Department of Public Health which aimed to assess and document the prevalence and patterns of drug use by adolescents. The research approach used both quantitative and qualitative methodologies aimed at covering a broad range of complementary issues. The following section will delineate a brief summary of a larger report resulting from this investigation.

2.2 Methodology

To assess the prevalence of drug usage in the NEHB, 1,516 adolescents from 21 schools (stratified for school type) in the four counties were randomly distributed a confidential questionnaire.

2.3 Results

Table 1 presents the breakdown of county representations within the sample. Adolescents were grouped into age categories of 13 years or younger, 14, 15, 16 and 17 years or over.

Table 1: Percentage breakdown of number of adolescents sampled from each county

County	Total sample (N)	% of sample
Meath	336	22%
Louth	517	34%
Cavan	372	25%
Monaghan	291	19%
Total	1,516	100%

2.4 Smoking

Lifetime prevalence rates (i.e. percentage of adolescents who had ever smoked at least one whole cigarette) ranged between 39% at age 13 years or younger and 64% at age 16 years. The percentage of adolescents smoking at least 1 cigarette a day (i.e. regularly smoking) was high ranging between 20% at age 13 years, 37% at age 16 years and overall 31%. Males had slightly higher rates of regularly smoking except at age 17 years where prevalence of females smoking was higher than males. Overall, regular smoking prevalence rates were substantially higher in the NEHB compared to 1993 national rates for both male and female adolescents. At age 16 years, 40% and 34% of NEHB males and females were regular smokers compared to 26% and 23% nationally, respectively.

2.4 Alcohol

Lifetime prevalence rates for alcohol ranged between 44% at age 13 years or younger, 91% at age 17 years or older and 73% for all ages. Regular consumption of alcohol (i.e. one or more drinks per week) varied between 26% at age 13 years, 81% at age 17 years and 57% overall. Patterns of male and female consumption were very similar. Adolescents tended to have binge drinking patterns with most alcohol being consumed on a Friday or Saturday night.

2.6 Illicit Drug Use

Table 2 presents the percentage drug use across all age groups for each non-user / user category. Adolescents were categorised as; never having taken a drug; adolescents having used the drug on only one occasion; sporadic users (adolescents who had used the drug on a number of occasions but not regularly); and regular (adolescents using a drugs on a monthly or weekly basis). A false drug named norenol (nickname buzz) was also included.

This drug was intended to assess over reporting rates. Across all ages, 1.6% of adolescents report having taken this drug at some point.

Table X: Percentage illicit drug use across all age groups for each user category

Drug type	Never	Once	Sporadic	Regular
Glue or solvents	80.7	7.7	9.6	2.0
Cannabis	75.1	5.2	10.2	9.5
Ecstasy	94.7	2.4	1.3	1.6
L.S.D.	94.3	2.8	2.1	0.8
Speed	94.2	2.4	2.0	1.4
Psilocybin*	92.5	2.9	3.8	0.8
Heroin (smoked)	98.1	1.2	0.4	0.4
Heroin (injected)	99.7	0.2	0.0	0.1
Cocaine	98.4	0.9	0.3	0.4
Barbiturates	98.8	0.5	0.4	0.3
Cough syrup	95.4	2.0	2.0	0.7
Other	96.2	1.0	2.1	0.7

* magic mushrooms

Overall, solvent and cannabis use tended to be the most popular drugs used with psilocybin, speed and ecstasy used to a slightly lesser extent. Most adolescents reporting using illicit drugs were using 1-2 types of drugs. Overall, 41%, 23% and 21% of adolescents reported being offered cannabis, ecstasy and solvents, respectively. After age 16 years, adolescents tended to be offered cannabis, ecstasy, LSD, speed and psilocybin. Across all drug types, adolescents who were regular smokers or drinkers were offered drugs at a far higher rate than adolescents who were not. Adolescents offered drugs were primarily first offered drugs between 12-15 years of age. Adolescents reported being offered drugs primarily at discos (28%), on the street (22%) and at house parties (18%). These adolescents were primarily offered drugs by a best or very good friend (29%) or someone their friend knew (29%).

At age 13 years, 6%, 7% and 3% of adolescent had used solvents once, sporadically and regularly, respectively with males using solvents at a slightly higher rate than females. At age 17 years, the comparable rates for once, sporadic and regular solvent use were 7%, 8% and 1%.

At age 13 years, 4% of adolescents had used cannabis once, 2% sporadically and 1% regularly. At 17 years, 5%, 19% and 17% of adolescents had used cannabis once, sporadically and regularly. At age 13 and 17 years, 1% and 5% of adolescents had used ecstasy once, 0% and 3% sporadically, and 0.3% and 3% regularly, respectively. Across the NEHB counties, Louth demonstrated the highest prevalence rates of solvent and cannabis use with Meath showing the highest level of ecstasy use.

In summary, this research has shown that smoking and alcohol lifetime prevalence and regular usage rates are high, especially when compared to national figures (1993). Patterns of illicit drug use are low with usage tending to be concentrated on solvent and cannabis use. Ecstasy, psilocybin and speed were the second major category of illicit drug used. although their percentage use was low. Usage of drugs such as cocaine, heroin or barbiturates were reported being used by less than 1% of adolescents. Adolescents reported being offered drugs between the ages of 12-15 years of age and typically by their friends or at least someone their friends knew. Adolescents who were smokers or drinkers were offered drugs at a substantially high level than equivalent non-smokers or non-drinkers.

3.3 Drugs in Adolescent Worlds 'Telling it as it really is'

A Qualitative study into drug misuse among adolescents in the North Eastern Health Board .

'While quantitative research surveys the field qualitative research mines it'

3.1 Introduction :

In order to develop effective future strategies to deal with adolescent drug misuse in the North East it was felt that in addition to exploring the prevalence of drug misuse a qualitative approach which explores why, where, when & how young people use drugs was also necessary . In this instance both research methods work not in opposition but in tandem with each other ensuring the validity of the over all findings .

3.2 Aims :

- To gain an understanding of the views, experiences and knowledge of young people in relation to illicit drug use in the North East .
- To explore the level of convergence between the adult world and adolescent worlds by listening to the views of adults who through their work and leisure intermittently bisect adolescent worlds .
- To use this knowledge in association with the quantitative findings to develop a multi agency approach to reduce adolescent drug misuse in the North East Region .

3.3 Methodology :

18 Focus Groups were held in total, the average group size being 8. Eleven of these were with adolescents and 8 with adults referred to as Concerned Agents. Focus group methodology does not provide data which is generalisable because a random sample is not selected. Rather the sample is selected to provide the most meaningful information in terms of the study objectives. In this instance the focus groups aimed to explore diversity rather than to establish any kind of 'representativeness'.

The focus groups with young people included males and females aged between 13-19 yr. drawn from a variety of social, geographical, and educational backgrounds. A particular effort was made to include young people not attending main stream schools as these had previously been included in the quantitative study. The adult focus groups, 8 in total, were drawn from sectors of the adult population who through their work are closely involved with young people. These included Juvenile Liaison Officers, Home School Liaison Officers, various strands of Youth Workers, from Foroige, to Out Reach Workers , members of a Drug Awareness Group etc. (Full listing in Appendix). In addition to the above focus groups 7 in-depth interviews were held with young people who are still abusing or have abused in the past. This dimension facilitated greater exploration of issues that arose at the level of the focus groups in addition it allowed the researcher to explore in greater depth the social biography of the drug user .

Side effects:

'The only thing addictive in the hash is the nicotine, it is the tobacco. A lot of people who are getting addicted to it they think it is the joint but it is the nicotine.'

Social Setting influencing effect of drug :**Effects of E**

'Well it depends again on the atmosphere, you take it and the type of people you hang around with, if you are with friends it doesn't really matter but if you are with people you don't know well then you are in trouble'.

Pharmacological make up of Drugs .

'You see there is heroin in E.' (Past regular user of E.)

3.4.2. Availability :

While knowledge gaps existed in relation to the specifics of illicit drugs, this same gap was not replicated when exploring the availability of illicit drugs. In all youth groups, both users and non users were *'au fait'* with where drugs could be purchased locally. Most people agreed that cannabis, ecstasy and acid were easily available, while a few said that although it was not at all as easy to get hold of heroin if you **really** wanted it you could get it .

While the non users knew generally where to get drugs if they wished, the nuances of actual drug procurement was however confined to the user.

3.4.3. Drug Procurement & Distribution network.

Unlike the adult world of drug dealing where the distribution system of drugs revolves around large quantities of money, is fed on a value system of greed and sustained by an elaborate crime network, the adolescent world for the most part revolves around concepts of *friendship, reciprocity, sharing*.

Q: Do you think drugs could be related to crime?

A: I'm sure some if it is, but that's because they are like that anyway. If they are smoking dope it doesn't cause you to go out and rob for it... you buy drugs if you have the money and if you have none you don't really buy them.

Q: Where do you get the money for the hash?

A: You just don't drink, you just sacrifice something else for the week

'I paid once and my friend paid the other time'.

'Everyone puts their money together to get it (hash)'.

As the above quotes suggest illicit drug use does not always involve crime. In this instance for the most part, resources were pooled and drugs were shared among friends. It was friendship and not large profits that lay at the heart of the drug procurement process.

While friends use drugs together it is also friends who are the suppliers of drugs. Few transactions are anonymous. Adolescents buy from another adolescent or they will approach a middle man who get drugs on their behalf, but they always know who they are buying from. This is important not always for health reasons but for economic reasons. Knowing the person they believe ensures that they will get good value for money this is particularly true with hash.

'I wouldn't take nothing from a stranger, I wouldn't give my money to a stranger...they might try to rip you off or something. Yes put it in the microwave or something it goes big but there is nothing in it. '

With E health reasons are given greater priority, in that they believe that friends will not sell them something contaminated that might damage or injure them .

'Well if you were really good friends with them they wouldn't do that. You would be more convinced that they wouldn't do anything to harm you, you would be safer like.

If adolescents for the most part get drugs for one another and from one another how relevant is the stereotypical image of the *Drug Pusher*?

Drug Pushing / Drug Seeking .

The term drug pushing is often used to describe the drug distribution network in operation in the adolescent world .

However in reality *drug pushing* it would seem is no longer an apt description of what is happening in the adolescent world. Pushing depicts passive adolescents who are coerced into taking drugs against their will, this of course is not their reality. They describe being *offered* drugs or seeking them out for themselves .

3.4.4. Why do young people try drugs?

While insights into the knowledge base adolescents have on illicit drugs and the distribution network they use is important, the constant question on most adults lips and in particular health professionals is *Why do young people try drugs ?*. Like previous studies this study found that the reasons for drug use are variable and in most cases multiple. The following are the reasons most commonly given by the users themselves .

1. Boredom

2. Personal Problems almost always involving family problems.

3. Experimentation *'Just for the craic', out of curiosity' 'Just to see what the buzz was like, just to see what would happen'*

4 Enjoyment & Sociability: In addition all users in discussing their own drug use however emphasise that they take drugs primarily because they enjoy their effect and sociability, this despite the fact that their induction into the drug scene was often unpleasant. For some their unpleasant experience acted as a barrier to further use to others it was deemed a rite of passage.

5. Peer Influence

As the above quote suggests, peers do influence other peers to take drugs, however the stereotypical view of Peer Pressure as that of '*a negative social force that results in unwilled behaviour and involvement in proscribed behaviours*' (Glassner & Loughlin 1989) is no longer an apt description of what is happening in adolescent worlds as it does not recognise

- The positive influence peers have on one another
- That young people are individuals with a capacity to choose. They choose which peer groups to join, which peer groups to leave, and which new peer combinations to associate with .

Peers as Protectors

'I was offered some it was the white powdery stuff, I think it was speed or something like that.

Q: Why did you decide not to take it ?

A 'cause like I don't know, my friend was sitting down beside me and she doesn't do anything like that .

Peers as Healers

Q: Who was the mates you hung around with ?

A: There was a fella I hung around with and he wouldn't touch it so I gave it up with him , he didn't touch it so after a while I said fuck it and I gave it up .

New Peer Groups as Rehabiliators .

Users seek out new peer groups as they try to quit or as a long term barrier to further use .

I don't hang around with anyone from that group. Yes sure I know I can't hang around with the lads and that's just it you know what I mean ...you have to stop hanging around with the people you were with and stop going to the places you were going'

It would seem from the above findings that friends choose friends to correspond with their own usage patterns rather than changing drug taking to respond to friends pressure .

3.4.5. Why do some quit ? Barriers to further use .

Not every one who starts taking drugs continues to take them so it was also necessary to explore why some young people give up. In this instance barriers to further use revolved around 4 main findings .

1. Being caught by the Gardai .

Fear of being caught by the Gardai did not deter young people from **taking drugs** in the first instance because they ... *'don't think of 'the later on' now'*.

However it did act as a **barrier** to further use (this finding was not confined to any social class).

'I got into trouble with the Gardai and then I just said that's it, enough is enough'
(Youth reach trainee)

'I am very very afraid of anything to do with drugs at the moment and I think I will be for a long way to come. I mean I came close to going to jail .' (3rd level student .)

2. Fear of damage to their health

For some the effects on their health either real or anticipated did provoke them into giving up the drugs they were using .

'Because you know it is bad for you, it is just like anything you know your brain is in mush basically and you are talking like an idiot, people just say like I'm not taking it anymore and they just stop '

I only took that (E) about 5 times. I never took it that often. When I seen how dangerous it was and all that we stopped taking it altogether '

3. Bad experience either experienced themselves or witnessed in a best friend .

Bad experience in this context refers more to *near death experience* than a bad trip.

'He just got into such a bad state, it frightened the life out of me when I saw the mad red eyes in Mark (from sniffing) and I was there. Jesus if he looks that bad I said to myself what do I look like I must have been in a right state so it kind of frightened the life out of me and I wouldn't really go near it again.

4. Changing Peer Group Also acts as a barrier to further use as discussed earlier.

3.4.6. What drugs are they using?

Similar to the quantitative study the drugs that are most frequently used revolved around Solvents (particularly in the younger end of the adolescent spectrum 13-14yr) Hash, E, Acid and LSD, of this quintet hash was perceived as the least harmful. Some argued that the risks from taking cannabis were less than consuming alcohol or smoking cigarettes. In addition it relaxed you and therefore reduced the possibility of violence often associated with too much alcohol. E, on the other hand was perceived as more risky than hash and alcohol, particularly by non users in that one E could bring immediate death .

'Like Leah Betts she only took half a tablet and she died'.

'I am saying now that I probably won't take drugs but I have a feeling that sometime I will (14yr. Female). Bearing this in mind barriers to initial use were in many ways more difficult to refine than motivating factors. It seemed that non users think very differently about illicit drugs than their using counter parts as reflected in the following quotes .

Barriers to initial use revolved around 3 main findings .

1. Fear as a barrier :

'But you could die on just one E

I wouldn't take drugs or anything it's stupid, Life is too short to take it for me anyway'

2. Parents as barrier

'My dad kind of trusts me not to take them, I told them I would never take them'.(14 female)

'I smoke and I drink , but I would never take drugs because it would break my parents heart and I could never do that'. (3 rd level female)

Concept of guilt, shame, 'letting them down' destroying trust ' this finding was more prevalent in the middle class female groups

3. Positive peer association also acts as a barrier to initial use as mentioned earlier.

3.4.9. Views on current Drug Education & Health Promotion Initiatives .

The current 'ad hoc' system of one off lectures on drugs was not well received .The lecture format was particularly criticised .

'It's a one way kind of education. They talk at you, they don't listen, they give you facts, they don't give you opinions, they don't like give you examples and they are talking really structured language it's all like they are reading from a book and it had absolutely no meaning for us at all'.

Some did mention that of all the health promotion leaflets they received on drugs that one that made some impact on them was the one on E with *'all the colours'*, however for the most part Health Promotion literature and strategies are not their main sources of information, but rather magazines, movies, in particular *'Trainspotting'*, T/V advertisements particularly the one with the *'rotten apple'*.

'And that video 'say no ' that is a load of ...it is so stupid...the best one is Bliss magazine and you can see the place and you can see what's going on and that's brilliant because I look at it for ages and it just explained everything to you ...you don't have to read anything.'

3.4.10. Recommendations for the future as the adolescents see them

- More amenities for young people
- Drop in social centre, run by young people under the mentorship of adults (similar to *Nucleus* in the Northern Ireland)
- *'Get young people like us to help with the advertising'*
- Holistic approach to education in Primary school
- Harm reduction.

Strategies involving a harm reduction stance arose in every focus group .

'I think the leaflets should be more brought out to make sure that everyone knows the story if someone is on E and how to handle it'.

'You see the government are all saying bad , bad , and people are going I want to see the other side and they don't tell people OK if you take it this will happen to you and you do this'.

3.5 Concerned Agents

3.5.1. Findings :

There was convergence for the most part between the two worlds particularly between youth workers **and** those who work with the young people in their natural setting .While the main focus of the research was on illicit drugs similar to the young people the concerned agents felt that under age drinking was a far more serious problem than illicit drugs , some even suggested that the analytic lens was tilted in the wrong direction .

'The problem is you see political wise and all that is, it is a great problem to shout about drugs and all that and what you are going to do about drugs and what you are setting up but there is still a major alcohol problem' (Adult Male)

'But drugs because everyone is making a big deal out of it, you are aware of it but drink yes everyone is doing it ...there is more chance of you becoming an alcoholic than a junkie' (Female Adolescent) .

3.5.2. Further Recommendations for the future as outlined by the concerned agents .

- Continuum of responses.
- Community response ,was suggested even though most were unfamiliar with D.Q.L.A.
(Drugs Questions - Local Answers)
- More amenities, *'Natural buzz to replace artificial buzz.*
- Peer Education . (While Dundalk & Drogheda had programmes organised and awaiting funding, other areas were not familiar with the concept)
- Harm reduction. *'Irresponsible if you do and irresponsible if you don't' .*

This was an ideological response that gave rise to some discussion. Some participants felt that ignoring this as part of an over all response is an inadequate response as it ignores the well being and health of those young people already using drugs. Other felt that adopting this stance would condone the use of illicit drugs and in that sense it was irresponsible .

- Social Drop in centre : again this provoked discussion.
- Suggestions for Drug Counselling, Drug Treatment Centres ,& a Urine testing centre' arose in only two of the group discussions and when they arose they were met with resistance by some of the members

R: In the area of counselling do you think we actually need a treatment centre , like Coolmine here with a whole infrastructure?

A: Yes, I feel yesI deal with parents every Thursday night at our Resource Group and these are parents of children that are addicted .(Hash , Speed LSD).(Speaker 1)

A: No no we do not need a treatment centre .(Speaker 2.)

*A: I think a treatment centre of the Coolmine type could use up a lot of finances you wouldn't want to see that happening, I mean like what **** is saying there are not hard facts around the level of usage { getting those would be helpful } (Speaker 3).*

- **Parental Education**

There was consensus however around the need for some education of Parents .but avoiding the term *Parenting Courses* in the packaging of these as this carried a stigma and adversely affects attendance. Areas mentioned for attention were, Parental Communication, Parental Monitoring

- 'Reality Checking' by Health Promotion in the development of their new initiatives by including both young people and Youth workers
- Outcome measurement by Health Promotion Unit of its strategies

Given that the full report will contain a more rigorous discussion section. The following is just a resume of the main findings:-

3.5.3. Resume of Qualitative Research Findings .

- Adolescents are not a homogenous group in that not all young people are using drugs and those who do so in varying degrees
- The popular belief that young people are well informed about illicit drugs is not consistent with these research findings .
- Illicit drugs and crime are not always mutually related. Different drug worlds have different mores and values. Light users, moderate users, and heavy users often participate in different social worlds .
- Stereotypical images of *Peer Pressure*, and *Drug Pushing* need to be refined as they no longer aptly describe illicit drug use in adolescent worlds
- Control and illicit drugs are not usually recognised as concepts that sit easy together , yet adolescents do exercise control over their drug use.
- The multi-dimensional aspect of adolescent illicit drug use must involve a variety of new creative responses some of which may be counter to those advocated in the past. The possibility of including Harm Reduction, Peer Education, & Reality Checking approaches as part of these strategies should be carefully considered.

SECTION FOUR

Recommendations

4.1 Key Recommendations:

1. Alcohol is a major problem. As a matter of urgency there should be a policy.
2. A strategy for reduction of smoking prevalence is needed.

4.2 Introduction:

In the light of our research, better understanding and knowledge of drugs and the drugs scene, coupled with our aims to reduce demand, supply of drugs, its' misuse and harm resulting, the Regional Drugs Consultative Group recommends that the North Eastern Health Board adopt the following:

1. The following set of principles.

- 1.1 The strategy must be comprehensive and should address: education, prevention treatment and care issues.
- 1.2 There are two element in drugs prevention.
 - 1.1 Demand Reduction - *see item 4.3*
 - 1.2 Supply Reduction - *see item 4.4*
- 1.3 The scarce resources available must be targeted on the basis of:
 - 3.1 Size of the problem
 - 3.2 Successful intervention methodology (evidence based)
 - 3.3 Needs
 - 3.4 Long term planned action.
- 1.4 The role of schools is crucial. Guidelines for schools should be agreed using a consultative approach.

1.5 The general approach should be on the basis of:

- 5.1 Multi agency work e.g. Health Boards, Schools, Gardai, local Authorities, local Communities etc.
- 5.2 Multi disciplinary approach e.g. Doctors, Teachers, Youth Workers, Nurses and so on.
- 5.3 Collaboration and co-ordinated work.

1.6 The overall approach should achieve:

- 6.1 Raising awareness of the issues.
- 6.2 Increase knowledge about drugs.
- 6.3 Change peoples attitudes.
- 6.4 Influence young peoples behaviour
- 6.5 Better treatment and access to treatment for Drug Misusers and their families.
- 6.6 Monitor and review the situation on regular basis.

4.3 SPECIFIC MEASURES TO REDUCE DEMAND

4.3.1 Information, Education and Training

It is recommended that integrated health promotion programmes be implemented across the whole of the North East. These programmes should have the following:-

- * Whole Community Education, Promotion and Empowerment
- * Health Promoting Schools and Colleges which will enhance peoples lifeskills, decision making skills and create a health conducive environment. There should be some emphasis on those at risk of leaving school early.
A schools drugs policy is strongly recommended to all schools in the North East. (see appendix D for proposal)
- * Parent Education and Support Programmes should continue. Emphasis should be on accurate information and data, leadership skills, drug questions - local answers approach and support to parents who suspect or know that their child misuse drugs.
- * Special attention must be placed on mass communication systems. (e.g. newspapers and radio). These systems should be encouraged to take a more positive role but especially in relation to mass information and education initiatives.
- * There is an urgent need to investigate the feasibility of educational programmes in the music industry e.g. disco's, nightclubs etc.
- * A co-ordinated continued update to all professionals in the field.

4.3.2 Assessment, Counselling and Treatment

It is recommended that an integrated service for drugs misusers (and their families) be implemented wherever is necessary.

This service should include:

- * Outreach workers to work with the relevant statutory and community based organisations, establishing links with young people at risk of drug misuse.
- * To develop local initiatives on an individual and on a group work basis including community projects for young people at risk of drug misuse.
- * To establish s comprehensive counselling and treatment services for drug misusers.
- * The role of the General Practitioner is very important. Clear service plans would advance that role.
- * To develop shared care protocols with community and voluntary organisations who have a role in the counselling and treatment of drug misusers.
- * To develop clear guidelines for referral and treatment (emergency and assessments) to all those who care for drug-misusers.
- * The role of the Mental Health Services in treatment of drugs misusers is crucial. Clear linkage to other services in Dublin (and elsewhere) should be established.

4.4 Measures to Reduce Supply

It is recommended that the Health Board should endorse and support Garda Siochana and Customs and Excise in their tireless effort to control local production of synthetic and other illegal drugs, the importation and distribution of drugs and the other law enforcement initiatives.

It is also recommended that there should be a programme targeted at the community to empower all, to reduce the level of supply of drugs. Such programmes could include these specific measures:

- * Training of interested individuals on Community Leadership e.g. community education, prevention of drugs and alcohol misuse, Killenarden drugs primary prevention programme (a group of parents for parents) and so on.
- * Publicise the Garda Confidential phone line.
- * Provision of more parenting and community Mothers courses
- * Increase the profile of juvenile liaison officers, the Gardai in the community and the probation services.
- * Special services should be devised for young offenders connected with drug misuse.
- * More social amenities (including drop-in centres) should be established for young people in general.

4.5 Research and Development

It is recommended that the Health Board continues to investigate drug misuse on a long term basis.

The research is needed not only to establish the extent of current and future drug misuse but also the impact of current work undertaken. This would be necessary for the development of services on an ongoing basis.

It is also envisaged that such a function will monitor, on a regular basis the service's and service provision.

SECTION 5

Actions and Plans

The North Eastern Health Board accepts the findings of the research. It also welcomes the recommendations and set of principles outlined by the Regional Drugs Consultative Committee. In response to these, the Board is undertaking the following actions :-

1. SMOKING

Smoking is the biggest killer in our country. In the NEHB every year more than 535 people die as a direct result of smoking. Therefore, smoking prevention and reduction is one of the top priorities. The Board re-affirms its commitment to the policy of no smoking in all health facilities and premises. The Board will also undertake the following specific action plans with the aim of getting a smoke-free environment as the norm.

- * A more comprehensive health promotion approach will be offered to the twenty nine post-primary schools currently participating in the Health Schools project. A further five school will be included in 1998 bringing the total number of children benefiting from the project to 19,5444 (65% of the total students). By the year 1999 all post primary schools who wish to participate in the region will be included.
- * A health promotion approach will be offered to 100 primary schools, covering 14,700 (30% of the total pupils) children on a phased basis across the region during 1998. this programme will focus on the needs of this age group using appropriate materials and teaching methods. By the year 2000, all of the primary schools in the region who wish to participate will be included.
- * A feasibility study will be carried out to establish the needs of weak ability students who may not be able to avail of the current health promotion programmes in post-primary schools.
- * The Board cannot tolerate violation of the law on sale of tobacco to minors. To that end Health Promotion, in conjunction with the Environmental Officers, will embark on a comprehensive programme targeted at point of sale, education to parents and other members of the community and children themselves.
- * The appointment of three Oral Health Educators will significantly impact on smoking prevention and the inclusion of schools who wish to participate in the healthy schools project.

- * GP's will be trained in Brief Intervention techniques. Research indicates smoking reduction rate of 5 - 17% annually.
- * Further relevant intervention and approaches will be developed throughout the year with the Youth services on smoke prevention. These will include peer-led education, development of resources and material by young people for young people and major media (written, visual and verbal) programmes will be planned.

2. ALCOHOL

Alcohol misuse remains one of the most significant health problems in the region with its potential impact on families and relationships, accidents and other injuries. The link with drug and substance misuse by individuals is recognised and an action plan to tackle substance misuse will include.

- * Effective liaison between addiction ^{and alcohol} counsellors across the region to ensure that both a health promotion and a treatment approach is offered;
- * Continued board sponsorship of sport and leisure to provide a no smoking and sensible drinking message;
- * Four health promotion GP practices will be developed to provide exemplar models for other GP's in the region. These practices will actively promote no smoking and sensible drinking messages.

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3. SPECIFIC MEASURE TO REDUCE DEMANDS FOR DRUGS

Outreach Workers:

Three new outreach workers are joining the project in January, two in Meath and one in Louth, bringing the total number to four. During their induction they will also be trained as D.Q.L.A. tutors, as will eight members of the community addiction team in Cavan/Monaghan. The project leaders will help the new worker to get in contact with young people and youth/community organisations.

D.Q.L.A Courses:

During 1998 a minimum of 10 courses will be carried out between Meath and Louth. Each course has an average of 16 participants representing different community/youth organisations. The courses will be held in mainly urban areas and will facilitate a community based response leading to local action to tackle the drug issue. The Outreach workers will provide on-going support to the D.Q.L.A. groups, helping them in further training and areas of work they want to start in their communities.

Community Leadership Skills Courses:

50 hours of training will be provided (from January to June) to groups in Dundalk, Navan and Drogheda. On average 12 tutors will emerge from each course with each tutor facilitating a primary school drug awareness programme between September and December 1998. Some trainees from the courses will also emerge as tutors of the Community Skills Leadership course. The new trainees will be recruited during the Summer and trained from September 1998 to June 1999 in both counties.

Peer Leadership:

15 Peer leaders will be trained in the Spring of 1998 in conjunction with Louth Youth Federation. This group will then run a drug awareness programme with their peers at youth clubs and schools. The outreach workers will provide on going support for these young people in their work.

Newsletter:

The second newsletter will be available in Spring 1998. This newsletter will be written by young people for young people.

Direct Work With Drug Users Including Addiction Counselling:

In 1997 direct referrals to the project from young people and/or families totalled 27 (14 in Meath and 13 in Louth). 90% of the referrals were taken in October, November and December - on average 4 per month. As the profile of the service raises in 1998 the number of referrals will increase to an average of 10 per month per county. The outreach workers will respond to each referral and help people access other services e.g. addiction counsellors etc., where appropriate. They will also be available for after care support using different methodologies where appropriate (e.g. one to one befriending, groupwork etc.).

Health Promoting Schools:

To continue and expand.

Parent Education:

Parent Education and Support Programmes either through schools, Parent/Teacher Associations, National Parents Council or direct.

Counselling will be provided by addiction counsellors. They will be receiving referrals either direct from clients or through other agencies like GPs, social workers, outreach workers, voluntary groups etc. In the main counselling will be on one to one basis.

Communications:

Major initiatives and working with mass communication will be carried out in partnership with the Health Promotion Unit of the Department of Health. This will include campaigns as well as the specific work with the ~~mass media~~ or ~~Employment~~ Drug promotion work.

Entertainment:

An application for a grant from the Department of Health is being considered for working with Disco's, night-clubs and other venues and dancing facilities.

Events:

To hold joint public events with the Juvenile Liaison Officers

Mothers:

To enhance and expand the community mothers programme

Voluntary:

To work with and support the voluntary sector.

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4. RESEARCH AND DEVELOPMENT

- To work with the Health Research Board in Dublin
- To continue to investigate drug misuse on a long term basis.

↘
Offer treatment services
encouraged to be
- GPs will be trained in drug replacement therapy
- ~~GP services~~
The mental health services will continue to provide acute services in relation to drug misuse

Appendix A

Regional Drugs Consultative Committee:-

Dr Nazih Eldin (Chairman)	Regional Drug Co-Ordinator NEHB
Gerry Roddy	SEO, Health Promotion Dept, NEHB
Ray Mitchell	Project Leader, Drogheda NEHB
Eamon Murphy	FAS, Dundalk
Ann Coyle	Community Care Manager, NEHB, Dlk.
Superintendent Oliver Lewis	Garda Siochana, Kells
Pat Donnelly	Child Care Development Officer, NEHB
Dr Declan Bedford	Specialist Public Health Medicine,
Nick Killian	National Parents Association
Ciaran Flynn	Principal, Ashbourne Comm. School
Geraldine Lyster	Psychiatrist, NEHB
Helen Hinfey	Psychologist, NEHB
Austin Waters	Senior Social Worker, NEHB
Myles Fitzgerald	Juvenile Liaison Officer, Meath
Ciaran Clark	Juvenile Liaison Officer, Louth
Siobhan Mc Grory	Nat. Youth Council Representative
Pat Shields	Department of Social Welfare
Con Shanahan	FAS, Dundalk
Marie Dooley	Supint. Public Health Nurse, NEHB
Damien Murray	Psychiatric Nurse, St Davnetts Hospital
Bernard Mc Donald	Health Education Officer, NEHB
Mary Ann McGlynn	Drogheda Partnership
Dr Larry Mc Intee	G.P. Unit Medical Officer
Patsy Fitzsimons	Housing Officer, Louth County Council
Geoff Day	Prog. Manager, Mental Health Services
Dennis Connolly	Juvenile Liaison Officer, Monaghan

APPENDIX B

TERMS OF REFERENCE

The Role of this Committee will be as follows:-

- To Advise the Chief Executive Officer and Senior Health Board Management on the health and health care needs of drugs misusers and drug abuse prevention in the North East.
- Report to the Chief Executive Officer or an officer designated by him.

The Functions of the Committee will be as follows:-

- The Committee shall have access to non-personal information in relation to services provided in the North Eastern Health Board area.
- The Committee shall consult with all Statutory and Voluntary bodies and other agencies providing services and supports for drug misusers in the North Eastern Health Board area.
- The Committee shall report on the health and health care needs of the drug misusers and the provision of services to meet these needs in the North Eastern Health Board area either on its own initiative or when required by the Chief Executive Officer.
- The Committee shall review the needs for drug misusers in the North Eastern Health Board area and identify areas where the provision of services is not adequate.
- The Committee shall review trends and other data in all substance misuse.
- The Committee shall advise the Chief Executive Officer on all substance misuse prevention programmes.
- The Committee shall provide an annual review of all programmes directed at drugs and substance abuse in the North Eastern Health Board region.
- The Committee will meet 3 - 4 times a year.

APPENDIX D

Proposed Schools Drug Policy For The North East Region

A.1 Introduction

A drug can be defined as a chemical which causes changes in the way the human body functions either mentally, physically or emotionally. For the purpose of this policy we are concerned with drugs which have the power to change a previous mood and the way a person think about things and drugs or which the taker may become physically or more often psychologically dependent. In the North East it is generally accepted that alcohol and tobacco are the most widely abused drugs, however, illicit substances such as cannabis, Ecstasy, magic mushrooms and solvents are increasingly becoming a problem in our area.

The school sees itself as having a role in the process of enabling students to increase control over and improve their health. We endeavour to promote the well being of students by:-

1. *Providing a safe and healthy environment*
2. *Promoting positive health behaviours*
3. *Increasing knowledge about health*
4. *Promoting the self esteem of students*
5. *Working in partnership with the parents and students*

To this end, in response to the encroaching drug culture in our society we feel the need to implement a comprehensive policy to address the problem of substance misuse in our schools.

The Policy will focus on:-

1. *Strategies for prevention of substance misues problems*
2. *Procedures for dealing with drug incidences in the school*
3. *Guidelines and information for teachers to improve their response to the problem of substance misuse.*

This document should be read with the discipline policy of the school.

A.2 Implementation Of The Policy

The Board of Management, the Principal, Vice Principal, year heads and all Class tutors will be given a copy of the policy. The policy will be available from the Principal to any other member of staff.

Parents and Guardians will be given a copy of the policy on enrolment of their child in school. Enrolment will be on acceptance of this and other school policy documents by them.

Teachers will be briefed on the policy by the Principal and training needs may be identified. Training may be carried out in conjunction with the Health Promotion Department of the North Eastern Health Board.

The policy will be regularly evaluated and updated where necessary.

A.3 Prevention

A.3.1. Education:

It is accepted amongst professionals working within the addiction field that education about alcohol, tobacco and drugs is best carried out by teachers the students know and within the overall context of a healthy living programme. The programme developed by the North Eastern Health Board aims to ensure that:-

- Students have clear information about the effects of the various drugs.
- Students examine their attitudes to alcohol, tobacco and illicit substances in their lives and in the environment in which they live.
- Students are equipped with the skills to make informed and healthy decisions around substance use.

A.3.2. Counselling:

Substance misuse rarely occurs in a vacuum and where a student has been in difficulties because of their use of any drug it is usually discovered they have been using it to help them cope with or avoid some other problem. By enabling the student to identify more positive sources of support when they need it we can help prevent the inappropriate use of substances. This also assists them in developing more long-term skills to cope with traumas or problems they encounter.

A.3.3. Parents:

Regular information evenings will be held at the requests of Parents Associations to help them deal with the problem at home. These evenings will be addressed by the Garda Juvenile Liaison Officer, The Home Youth Liaison Service and the Addiction Counsellor from the North Eastern Health Board.

A.4 Smoking

A.4.1. School Policy:

- The school is a smoke-free area.
- Students are not permitted to smoke or possess cigarettes on the school premises.
- Staff should not permit pupils to smoke on any school trip and should actively discourage smoking in public places.
- Staff may only smoke in the area designated a "smoking zone".
- Visitors will comply with restricted smoking policy.
- Pupils found smoking on school premises will be reported to the year head
- Repeated and blatant offending will result in instigation of the school disciplinary procedure.

A.4.2. Support:

Smoking is an addictive habit, generally acquired in childhood. The school recognises some students may have difficulty stopping smoking. The Addiction Counsellors of the North Eastern Health Board are willing to run smoking cessation groups in schools where demand makes a group feasible and where a designated teacher will co-operate.

A.5 Alcohol

A.5.1. School Policy:

- The School is an alcohol-free area.
- Students will not be allowed to bring alcohol into school or to consume alcohol in school.
- Students will not be allowed to consume alcohol on school trips or tours.
- Alcohol will not be available at Discos or any other after hours activities arranged by the school.
- Where a student comes to school under the influence of alcohol, their parents will be called in to take them home. This will be followed up by the year head at a more appropriate time.
- Students breaking these rules will be dealt with according to the school's disciplinary procedure.

A.6 Illicit Drugs And Solvents

A.6.1. School Policy:

- Students are prohibited from being in possession of, or using illicit drugs or solvents on the school premises.
- Illicit drugs found on school premises should be locked away and the Gardai contacted to dispose of them. Teachers are advised not to transport illicit substances at any time. An investigation by a designated teacher will be made into the origin or illicit drugs found.
- Where the school suspects trafficking of illicit drugs, an investigation will be carried out. Parents of any student involved will be informed. The advice and assistance of the Garda Juvenile Liaison Officer will be sought.
- The school management will expect parents to inform the Principal or Year head if they suspect their child of drug-taking.
- Students suspected of taking drugs or solvents outside school will be monitored and every effort will be made to support them and ensure they get the counselling and help they need.

A.XSCHOOLS POLICY APPENDICES I, II, III

A.X.1 For Teachers:

A.X.1.1. Dealing with the student.

Having observed the behaviours of concern and verified it with others, the class teacher/counsellor or other department teacher talks with the student.

1. Focus on concrete behaviour. Directly telling the student what you have observed and expressing concern for the consequence of this behaviour is the most appropriate response.
2. Don't accuse. It is important to be calm, caring and to create a supportive atmosphere.
3. Listen.
Be aware of lying, deceit and manipulation. A young person who is using alcohol or other drugs is very likely to deny using them or to suggest what was observed was a "once off situation" when in fact this is not the case. This is very common as the student may want to continue using and admitting would make it more difficult. Beware of the trap of confidentiality. Students sometimes ask for confidentiality and then admit to drug use. This is something to be very careful about asking if a student is using drugs. In handling this situation it is important to let the student know that you will help them resolve the situation, you will support them through it and you will let them know when you are going to involve others.
Consult with relevant others and work our strategies using the guidelines set out in the school policy.
4. Attitude - Drug taking stops now. Other issues can be worked out over time.

A.X.2 Dealing with the student under the influence of drugs or whose behaviour indicates potential overdose.

1. Don't leave alone. Comfort, reassure.
2. Attempt to determine drug taken.
 - (i) Student
 - (ii) Friends
 - (iii) Locker/clothing
 - (iv) Odours
3. Contact parents
4. Seek medical Help
5. Postpone discussions until clear of drugs, then implement school policy.

A.X.3. Guidelines for Interview with Parents.

1. Setting up the Meeting
 - Arrange place
 - Make sure there is enough time set aside for the meeting
 - ? who attends

2. Setting parents at ease.
 - Be aware of the fears/anxieties they may have
 - What baggage do they carry?
 - Recognise the responsibility and expertise of parents
 - Build alliance with parents

3. Content of meeting
 - Talk about the specific things you have noticed
 - Share concerns of school
 - Illicit concerns of parents
 - Treat parents supportively. This is a crisis for them
 - Inform them of the support services available to them and their child outside school.

4. Parents discussion with student - at home or at school
 - Necessity for both parents to act together if there are two
 - Necessity for parents to have thought and discussed the problem so as not to be at a disadvantage
 - Concern for the child must be communicated repeatedly

5. Conclusion
 - Decide on an action plan
 - i.e.* setting of limits
 - time to be in
 - access to money
 - rules of the house
 - Arrange follow-up meeting to assess improvements in situation or to discuss further action.

APPENDIX E

Agencies Contacted re. Focus Group Organisation.

* Refers to those who actually participated in the Focus Groups

Navan :

Gardai .

Mr. Eamon Courtney *Superintendent* Garda Station Navan .

*Mr Myles Fitzgerald JLO Navan.

*Sgt Liam Buggy Navan

Social Workers

Mr. Austin Waters *Snr. Social Worker* Navan .

*Mr Tim Hanley .

Probation & Welfare.

Mr Brian Mc Neaney *Head of Probation & Welfare Services* Navan .

*Ms. Caroline Mc Court *Probation & Welfare officer.*

*Ms. Mary McDonald . *Probation & Welfare Officer*

Travellers Groups .

Mr & Mrs Nel MacDonagh *Travellers Workshops* C.Y.W.S. Navan .

Mr Declan Clarke *Course Director with the N.T.T.C. (Navan Travellers Training Centre .)*

Aisling

*Ms. Marie Byrne, & *Ms. Geraldine Smyth, *Ms. Annette Mc Guinness , *Ms. *Jackie Mc Kenna , *Ashling Drugs Awareness Groups , Navan .Address for contact is:*

Together Against Drugs , 19 Lord Edward St Dublin 2.

Youth Groups

*Ms. Bernie Mac Mahon *Meath Youth Federation* St. Anne's Navan .

*Mr Declan Coogan *Youth Worker* .

VEC

*Ms. Catherine Kelly . *Course Co Ordinator Navan VEC .*

*Ms Niamh Lyons, *Trainer with Navan VEC*

ISPCC

*Ms. Catherine Ingoldsely *ISPCC* Navan .

Schools

*Ms Maureen Murray *Home School Liaison Officer Beaufort College* Navan .

*Ms Catherine Kelly *St Joseph's Secondary School* Navan (involved in SAP Programme)

Foroige

Mr Pat O' Meara *Foroige* Ashbourne .

*Ms Marie Daly & *Ms. Christina Carass *Youth Workers* with Foroige.

Dundalk Agencies Contacted:

* Refers to those who actually participated in the Focus Groups

Gardai :

Mr Michael Staunton *Superintendent* Garda Station Dundalk .

Mr Brian Mohan *Detective Garda* Dundalk Garda Station .

*Mr Kieran Clarke *JLO* Dundalk .

Probation & Welfare

*Mr Gerry Hennessey *Probation & Welfare Officer* Earl House Dundalk .

Youth Groups

*Ms Alison Malone *Louth Youth Federation* , Carlton St, Dublin St , Dundalk .

*Mr Kevin Matthews *Muirhevnamore House Project* , 29 Grange Drive Dundalk .

*Mr Michael Stokes *Youth Worker* Muirhevnamore .

Mr Brian Doyle & Ms Clodagh O' Mahony *The House Project* .

16 Oaklands Park Cox's Demense Dundalk .

Ms Marcella Mc Garry *Community Development Worker* Cox's Demense .

Social Workers .

Ms Marie Lynch *Snr . Social Worker Drogheda/Dundalk.*

*Mr Tommy Mc Laren *Social Worker (Cox's Demense)Dundalk.*

Youth Reach

*Ms Margaret Mc Donnell *Youth Reach* Tara Workshops Chapel St, Dundalk .

Mr Aidan Gaughran *Community Training Workshop* Chapel St Dundalk.

Schools

*Mr John Maloney , *Home School Liaison Officer* Redeemer Parish Dundalk .

Third Level

Mr Mark Mc Kenna *Students Union R.T.C.* Dundalk .

Fr . Malacky *Chaplin R.T.C.* Dundalk .

Nurse Breege Rust , *Health Centre RTC* Dundalk .(Dr. David Connolly away) .

Drogheda Agencies Contacted .

* Refers to those who actually participated in the **Focus Groups**.

Gardai

Mr. Fergus Dogett *Superintendent* Garda Station Drogheda .

*Mr Joe Delaney, JLO (& organiser of *No Name Club* Drogheda).

Schools

*Ms. Greta Bohan *Homes School Liaison Officer* St. Olivers Drogheda .

Youth Groups

*Ms. Valerie Everard *Drogheda Youth Development* Narrow West St . Drogheda . * Louise Anne also of Drogheda Youth Development.

Ms. Siobhain O'Brien *Youth Reach* Workspace Unity, Majoralty St Drogheda ..

Mr Brian McGonnigle *Youth Educational Network* , Drogheda Partnership ,12 The Quay Drogheda .

*Mr Nick Reilly , *Drogheda Partnership* , 12 The Quay, Drogheda

Mr Ray Mitchell & his *Youth Workers*, Catherine Doherty & Martin Rafferty . NEHB 104 Chord Rd, Drogheda .

Fas

Mr Sean Murtagh *Fas* Drogheda Community Workshop, Mullaghcrone, Donore Rd, Drogheda

Cavan Agencies Contacted :

*Refers to those who actually participated in the Focus Groups.

Gardai

Mr Jack O' Connor, *Superintendent* Garda Station Cavan .

*Mr Gene Murphy ,JLO,

*Ms Kim Cox Ban Garda with an interest in the drug scene.

Social Workers

Mr Jerry Lowry , *Snr. Social Worker* Cavan / Monaghan .

Community Care

Ms. Janice Mulvey *Community Care* Cavan .

Youth Workers

*Sr. Aine *Youth /Family Worker* Killymooney Activity Centre .

Youth Reach

Mr Diarmuid Wilson *Co -Ordinator of Youth Reach* Cavan

*Ms . Louise Carolan *Youth Officer* Cavan Youth Reach.

Third Level

Ms. Fiona Carolan *Social Studies Course Co -Ordinator* Cavan College of Further Studies,
Main St, Cavan .

Foroige

Fr. John Cooney P.P. Ballyhaise Cavan *(Foroige)* .

Monaghan Agencies Contacted :

* Refers to those who actually participated in the **Focus Groups** .

Gardai

Mr. E Murray , *Superintendent* Garda Station Mohaghan .

*Denis Connolly JLO for Monaghan Based in Carrickmacross .

Social Workers & Community Care

*Ms Janette Cummins *Social Worker* Rooskey, Mohaghan .

*Ms. Jackie Roe , *Community Child Care Worker*, Rooskey, Monaghan .

VEC /Youth Reach .

Mr. Larry Mc Cluskey, CEO., Monaghan VEC , Administration Centre, Beech Hill Monaghan

*Ms Margaret Mc Skane (& *Her Workers .) Head of Knockaconny *Youth Reach* .

*Ms Jane O' Reilly, Ard Scoil Lorgan *VEC*, Castleblaney ,Co. Monaghan .

Youth Federation

Ms Catherine Corrigan , Monaghan Youth Federation (Has now left this position) .

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