

SHARED SOLUTIONS

**First Strategic Plan of the
Western Region Drugs Task Force**



SHARED SOLUTIONS

First Strategic Plan of the Western Region Drugs Task Force

Produced April 2005 by
Fiona Walsh (Interim Coordinator)
&
Simon Comer (Researcher)
in consultation with the Cathaoirleach and Members
of the Western Region Drugs Task Force

Published 2006 by the Western Region Drugs Task Force
The Arcade, Main Street, Castlebar, Co. Mayo.
Tel. 094 9020 428
westernrdtf@eircom.net

TABLE OF CONTENTS

FOREWORD	1
1 BACKGROUND & CONTEXT	3
1.1 Consultation process	3
1.2 Tackling the fundamental issues	4
1.2.1 Inclusion of alcohol	5
1.3 Shared solutions	5
1.3.1 Co-ordination	5
1.3.2 Shared values	5
1.3.3 Interagency co-operation	6
2 RESEARCH	7
2.1 Demography of the region	7
2.1.1 Population increase	8
2.1.2 Galway demographics	10
2.1.3 Mayo demographics	10
2.1.4 Roscommon demographics	10
2.1.5 Urban, rural and isolated populations	11
2.1.6 Age structure	12
2.2 Nature & extent of alcohol & illicit drug use	14
2.2.1 Alcohol	15
2.2.2 Tobacco	20
2.2.3 Prescription drugs and other medications	22
2.2.4 Cannabis	23
2.2.5 Ecstasy	25
2.2.6 Cocaine	26
2.2.7 Heroin and other opiates	26
2.2.8 Other drugs	27
3 PREVENTION & EDUCATION	28
3.1 What is prevention?	28
3.1.1 Who should prevention be targeted at?	28
3.2 Types of Prevention Programmes	29
3.2.1 Universal prevention programmes	29
Information	29
Parent support programmes	29
Generic youth work initiatives	29
Substance use prevention & education in schools	31
Positive alternatives	33
Peer education	33
Mentoring/Buddy schemes	33
3.2.2 Targeted programmes for at risk groups	34
Assertive outreach programmes	34
Child development support	34
Family support	34

<i>Community mobilisation</i>	35
<i>Diversionary interventions</i>	36
4 SOCIAL INCLUSION	37
4.1 The significance of rurality and underdevelopment	38
4.2 Tackling social disadvantage	40
4.2.1 Revitalising disadvantaged areas	40
4.2.2 Social Inclusion Measures Working Groups	41
4.2.3 Travellers	43
4.2.4 Homelessness	43
4.2.5 Prisoners	45
5 TREATMENT	47
5.1 Treatment services in the region	47
5.1.1 Gaps in service provision identified in the consultation process	49
5.1.2 Questions of priority	50
5.2 Towards integrated care	50
5.2.1 The goals of integrated care	50
5.3 Issues to be considered	51
<i>Benzodiazepine misuse</i>	51
<i>Therapeutic alternatives</i>	51
<i>Suicide and substance misuse</i>	51
<i>Dual diagnosis: substance use and mental disorders</i>	51
<i>Evidence-based practice</i>	51
<i>Screening</i>	52
<i>Brief interventions</i>	52
<i>Access to treatment services</i>	52
<i>Community-based detoxification</i>	52
<i>Inpatient detoxification</i>	52
<i>Rehabilitation</i>	53
6 SUPPLY REDUCTION	54
6.1 Gárda Síochána	54
6.2 Customs & Excise	56
6.3 Partnership in crime prevention	57
6.3.1 Working with rural communities	57
7 SHARED SOLUTIONS	59
7.1 Issues to be addressed	59
7.1.1 Protective factors	59
7.1.2 Early intervention and treatment	61
7.1.3 Rehabilitation and relapse prevention	61
7.1.4 Relevance and need	62
7.1.5 Monitoring and evaluation	62
7.1.6 Value for money	62
7.2 Outline of proposed developments and indicative costs	63
Notes on development proposals	65
1: Community Liaison Workers	65
2: Education Support Workers	65

3: Community Alcohol Detoxification Workers	65
4: Pilot Project: Community Substance Misuse Worker for Homelessness	65
5: Pharmacy Liaison Worker	65
6: Community Substance Misuse Workers (Third Level Colleges)	66
7: Inpatient detoxification beds	66
8: Regional inpatient drug & alcohol treatment unit	66
9: Rehabilitation Beds	66
10: Residential support service for homeless	66
REFERENCES	67
ANNEX 1: TASK FORCE MEMBERS	75
ANNEX 2: LIST OF AGENCIES ATTENDING OPEN SPACE CONSULTATION	76
ANNEX 3: MAPS OF CLÁR & RAPID AREAS	79
ANNEX 4: LIST OF ABBREVIATIONS	83
LIST OF TABLES AND FIGURES	
Figure 1: Population percentage changes in Galway, Mayo & Roscommon 1996-2002	8
Table 1: Population changes 1996-2002 in County Galway towns	9
Table 2: Population changes 1996-2002 in County Mayo towns	10
Table 3: Population changes 1996-2002 in County Roscommon towns	11
Figure 3: Proportion of population living in rural and urban areas 1996-2002*	12
Figure 4: Percentage population by county & age group in 2002	13
Table 4: Population in 2002 of towns with ≥1500 inhabitants by age group	13
Table 5: Regular alcohol consumption by health board, gender & age	18
Table 6: Self-reported alcohol use in school-children aged 10-17, by health board	19
Table 7: Trends in alcohol use among 16-year-old Irish school students 1995-2003	19
Table 8: Cannabis use by age group	25



One of the key recommendations of the National Drugs Strategy 2001-2008 was the establishment of Regional Drugs Task Forces throughout Ireland, based on the geographical boundaries of the former health boards. The function of each Task Force is to research, develop and implement, using a partnership approach, a coordinated, regionally-appropriate response to substance misuse. The Western Region Drugs Task Force (WRDTF) was duly set up to cover the counties of Galway, Mayo and Roscommon and the first meeting was held in May 2003. In addition to the Chair and Coordinator, members of the WRDTF include representatives from a range of statutory, local authority, voluntary, community, non-profit and other non-governmental organisations across the region.

Each Task Force was required to produce a regional strategic plan based on identified problems, resources and gaps in services. *Shared Solutions*, the WRDTF Strategic Plan, is the culmination of a lengthy series of discussions within the Task Force, as well as a consultation process with invited organisations conducted in late 2004. It also takes cognisance of a range of different regional and national policy documents, research reports and other literature. Therefore, we hope, it reflects the collective thinking of a large number of people. It was submitted to the National Drug Strategy Team in late April 2005 and approved in late September.

The structure of *Shared Solutions* follows guidelines issued by the National Drugs Strategy Team, and takes as its main themes the 'four pillars' of the National Drug Strategy: Research, Prevention & Education, Treatment, and Supply Reduction. It also looks at important cross-cutting issues relating to social inclusion. Although at Government level the national alcohol and drugs strategies are managed separately, a policy decision was taken early on by the WRDTF to include alcohol in its deliberations. This decision reflects the reality that alcohol is the main problem drug nationally and regionally, and that the nature of substance misuse in our society does not necessarily follow lines neatly drawn by political, legal, social or institutional definitions. *Shared Solutions* implies 'joined-up' thinking, mutual values, complementary ways of working and collective actions.

This document sets out a broad framework for integrated action, and highlights a wide range of inter-related issues to be addressed in the short, medium and long term. The appointment of a full-time Coordinator and other core staff, expected in early 2006, as well as the provision of appropriate funds, will allow the preparation and implementation of an Operational Plan based on the present strategy. The practical work of the Task Force is only just beginning. Concerted effort and commitment will be needed, not just to directly address problems relating to substance misuse, but also to develop and strengthen the inter-agency partnerships needed to make real progress.

Finally, I would like to express my appreciation to the members of the Task Force for their dedication, continued participation and valuable input over the past two years. I wish to thank Interim Coordinator Fiona Walsh for managing the development of the Task Force and this Strategic Plan, Simon Comer for his research contributions to the production of the strategy, and Mary Rowland for her excellent administrative work. Thanks also to all the many people who participated in the Open Space consultations in 2004.

Padraig Hughes

Cathaoirleach

Western Region Drugs Task Force

December, 2005

1 BACKGROUND & CONTEXT

This report is the response of the Western Region Drugs Task Force to the *National Drugs Strategy*. It is a regional approach to drug and alcohol misuse that prioritises local needs and sets out local development proposals for the next three years. The overall aim of the *National Drugs Strategy* 2001-2008 is “to significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research”²⁵. These last four themes are the “four pillars” of the *National Drugs Strategy*. This report will address drug issues regionally within that framework. It looks at the nature and extent of the alcohol and drug problem in the region, assesses the level of local service provision and identifies gaps in these services, and prioritises those areas most in need of development. The report also outlines how we intend to monitor and evaluate programmes and services.

The aims of the Task Force are

- To develop an integrated and well-managed response to drug and alcohol problems across the region
- To propose a range of solutions and service interventions based on the four pillars of the National Drugs Strategy
- To ensure that responses are monitored and evaluated according to best practice and value for money principles.

1.1 CONSULTATION PROCESS

This report incorporates the experience and opinions of Task Force members, who have participated in general and sub-group meetings over the past eighteen months, including discussions of various drafts, and as such it is a collaborative effort. In addition, to reflect local views, two ‘Open Space’ consultation events were held in November 2004, inviting over 300 participants from a variety of statutory and voluntary agencies, community networks and associations. The first event was held in Castlebar, County Mayo with the participants coming from Mayo and Roscommon; the second event took place in Galway City, involving participants from both the city and the county (see Annex for list of participants). The Open Space format provides a forum

in which contributors can decide and discuss whatever topics are of particular interest to them, within the overall theme of the event. Their comments and proposals were recorded and have informed the development of this strategy document.

Throughout the Open Space consultation events there was a general feeling expressed of frustration and disillusionment at the lack of any committed response to tackling the complex issues around alcohol and drug misuse. The consultation process that informed this report was critical of many of the policies to date. Some of the comments made about gaps in services were:

"Money has been ring-fenced for drugs – no one is listening to Alcohol Services"

"Alcohol services lack funding & resources"

"There is a lack of co-ordinated services"

"We need multi-disciplinary teams"

"There is poor communication between service providers & agencies"

"There must be more effective use of funding & other resources"

"We need a more inclusive approach"

"What about parents' knowledge & responsibility?"

"No accurate local data collection regarding drug-related harm"

"So many gaps!"

More work is required in the coming year to identify the exact nature and extent of these gaps in service provision and their relevance to local needs, and to determine appropriate service responses.

1.2 TACKLING THE FUNDAMENTAL ISSUES

Drug and alcohol misuse is not a new issue. However, it is imperative that it is taken seriously and dealt with effectively at both policy level and at the level of service delivery if we are to make any real impact on reducing the problems that affect our communities. It is important to be aware of what we know about how drug problems develop and the harm they can cause in a community. We must strengthen and build up the protective factors now that will assist communities, families and individuals to deal with substance use in the future. If we know, for example, that poor socioeconomic status is associated with substance misuse, then it is necessary to ensure that we employ proactive social policies that redress economic

inequities, improve access to education, provide employment, enable access to good quality housing and support the overall improvement of people's quality of life, as these are known protective factors that can reduce the incidence of alcohol and drug misuse. We must also be mindful of rural deprivation and isolation which can be less visible but equally as damaging.

1.2.1 Inclusion of alcohol

Alcohol is a pervasive, complex issue of major public health and social significance. Unfortunately, government and society do not yet seem ready or willing to comprehensively tackle alcohol misuse despite the overwhelming evidence of the harm it can cause.

The recently published second report of the Strategic Task Force on Alcohol made very clear recommendations on reducing the impact of alcohol-related harm. However, in our Open Space consultation process people felt that there is little political will to address the alcohol misuse issue and to implement the STFA recommendations. The members of the Western Region Drugs Task Force feel strongly that it is necessary to include alcohol in our deliberations and recommendations regarding service developments, given that it is by far the most commonly used substance in the region.

1.3 SHARED SOLUTIONS

No one agency can tackle all drug-related problems on its own, but working together we can employ joint planning and forward thinking to achieve *shared solutions* and integrated service planning that will address the drug and alcohol problem early and hopefully reduce the harmful impact of drug and alcohol misuse. For this approach to work, a number of guiding principles must be adopted.

1.3.1 Co-ordination

For the Task Force to operate successfully a dedicated core team of people is required to drive the development of projects, to monitor and evaluate initiatives, and to provide administrative support.

1.3.2 Shared values

Task Force members, and the agencies they represent, need to agree on shared values, commit to common principles and agree a joint work programme that complements the plans of individual agencies. It would be beneficial for Task Force members to sign up to a Memorandum of Understanding, or Interagency Agreement, that agrees common targets and goals.

1.3.3 Interagency co-operation

The multi-agency process is essential for successful joint development of projects. The Task Force programme should complement and support the work of the existing agencies and services. It is not meant as a replacement or an alternative. Ideally the finance made available could be best used to match or joint fund prioritised developments. True inter-agency co-operation will require, at minimum, an open policy of sharing information and working together to identify new solutions and new initiatives.

2 RESEARCH

In 1996, the Centre for Health Promotion Studies (CHPS) at NUI Galway published a research report, *Substance Misuse in the Western Health Board: Prevalence, Practice and Proposals*⁷⁵. In addition to reporting the findings of the surveys of alcohol and illicit drug use that had been conducted up to that date, the CHPS study also gathered information and opinions from a wide range of service providers and other interested parties in the region. The indications at the time, in relation to substance misuse prevalence, were that

- Alcohol misuse was the biggest problem, and had a significant impact on services
- Underage drinking was common, and alcohol problems were occurring earlier
- Use of illegal drugs was widespread
- Complacency, inaction and “the drink culture” were to blame for continuing alcohol problems
- Boredom and social alienation among young people were major risk factors for substance abuse.

Since that time, Ireland has experienced significant social changes, including large population growth in some areas, net immigration and an overall dramatic increase in affluence. It is not intended in this report to attempt a detailed analysis, in the context of these socio-demographic developments, of any changes that may have occurred in the nature and extent of alcohol and drug misuse. In order to provide a demographic perspective for considering relevant regional and national prevalence data on substance misuse, CSO census data on population changes are presented first, followed by summaries of available alcohol and drug data.

2.1 DEMOGRAPHY OF THE REGION

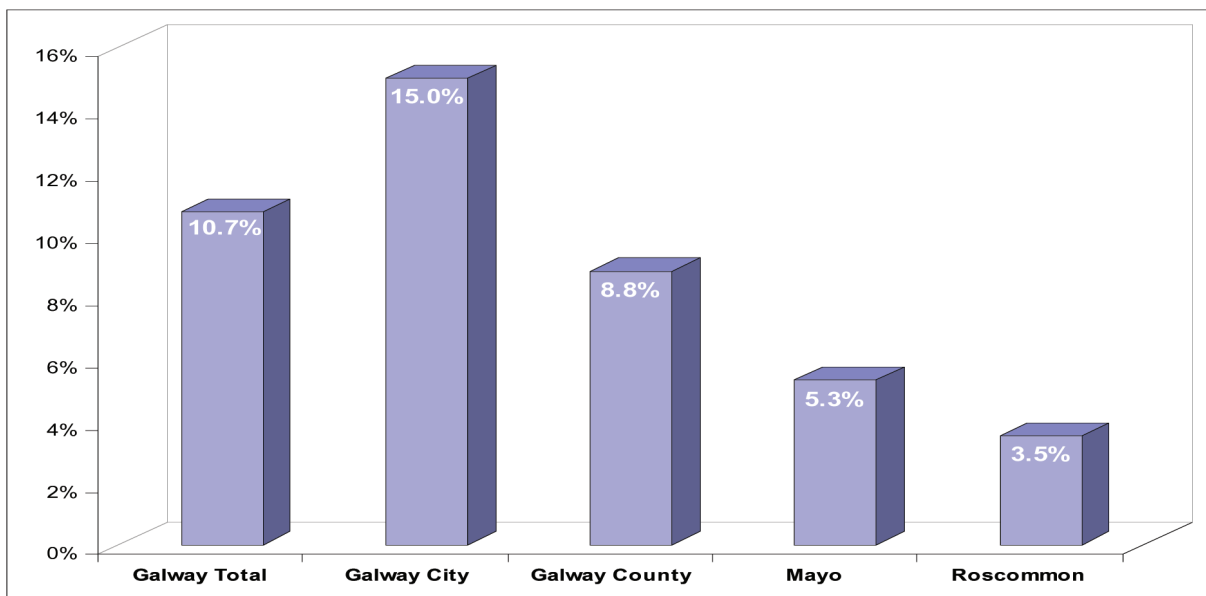
For well-known historical reasons, Ireland has one of the lowest population densities in the enlarged EU, with the exception of the Nordic countries and some states formerly in the Soviet Union. Since most of Ireland’s population is concentrated in the East, the average density in counties Galway, Mayo and Roscommon (GMR) is even lower, and is similar to that of Sweden: c. 21/km². The GMR area comprises one fifth of the land mass of Ireland, but has only one tenth

of the population. If the region had the same population density as the EU average, the population would be approximately 2 million, double that again if the density was the same as that of the UK, and around 7 million if that of Holland. The total area of the three counties is around 14000 km², roughly half the size of Belgium (population 10 million). The actual number of GMR inhabitants recorded in the 2002 census was just over 0.38 million.

2.1.1 Population increase

Though the socioeconomic impact of historical mass emigration is still being felt in some areas of the country, net immigration is now the norm, albeit on a much smaller scale. While starting from a low base, the recent growth in population in some areas has been dramatic, and it needs to be considered whether service provision has kept pace. Census data from 1996 and 2002, and ongoing CSO monitoring of births and immigration, show that the population of Ireland has risen to its highest level since 1871¹⁰. This trend is of course evident in the GMR region, where the overall population has increased by 8% since 1996. Central Statistics Office projections for the area suggest that the population will rise to 400,000 or more by 2011 if current trends continue. However, as might be expected, growth to date has not been uniformly distributed (see Figure 1) and the higher levels are seen in the larger urban areas and their neighbouring towns.

Figure 1: Population percentage changes in Galway, Mayo & Roscommon 1996-2002



As shown in Tables 1-3, some localities have experienced very large percentage increases in population, although in many cases the populations were small to begin with.

Nevertheless, it is not inconceivable that large relative increases in small populations may give rise to local problems or concerns depending on local circumstances. Also, it is necessary to consider a town’s catchment area: for example, while CSO census data gives the population for specific towns, there may be a much larger number of people dispersed in surrounding areas who rely on those towns for services and amenities. It is also possible that a small town may have more resources, services or community development activity than a larger one.

For these reasons, it may be necessary going forward to consider each locality (in each county) case-by-case. Using the Electoral Division (ED) as the basic unit of analysis, in conjunction with local knowledge and as wide a range of data sets as possible, may be advantageous in this regard. Such analyses are beyond the scope of the present report. The feasibility and potential value of using Geographical Information Systems for more detailed and multidimensional analyses could be considered in the future, bearing in mind research needs and the cost and complexity of accessing the technology.

Table 1: Population changes 1996-2002 in County Galway villages and towns with over 400 inhabitants, in order of population size

Town	1996	2002	% change
Galway	57241	65832	15.0%
Ballinasloe	5654	6101	7.9%
Tuam	5627	5947	5.7%
Loughrea	3335	4004	20.1%
Athenry	1614	2154	33.5%
Gort	1182	1776	50.3%
Oranmore	1410	1692	20.0%
Clifden	920	1355	47.3%
Portumna	984	1235	25.5%
Oughterard	751	1209	61.0%
Moycullen	601	883	46.9%
Headford	574	703	22.5%
Mountbellew	547	667	21.9%
Ballygar	546	642	17.6%
Carraroe	242	629	159.9%
Dunmore	445	594	33.5%
Glenamaddy	394	457	16.0%
Kinvara	432	447	3.5%
Total population towns >400 pop.	82499	96327	16.8%
Total other population	106355	112750	6.0%
Total area population	188854	209077	10.7%

2.1.2 Galway demographics

Galway has seen rapid growth in the last decade or so. An increase of 15% on the largest population base in the region translates into a sizeable absolute increase in numbers, with potential implications for service demand and provision. Elsewhere in the county, double or even triple digit percentage increases in local populations (see Table 1) are not necessarily as noteworthy if the absolute numbers are low.

2.1.3 Mayo demographics

Overall, Mayo’s population increased by 5.3% between 1996 and 2002. The number of people living in villages and towns with over 400 inhabitants increased by nearly a fifth, while the population living outside these areas decreased slightly. Castlebar grew by a third, Westport and Ballinrobe by a quarter, and Ballina by a fifth in this period. However, five Mayo towns registered a decrease in population, according to CSO census data (see Table 2).

Table 2: Population changes 1996-2002 in County Mayo villages and towns with over 400 inhabitants, in order of population size

	1996	2002	% change
Castlebar	8532	11371	33.3%
Ballina	8006	9647	20.5%
Westport	4520	5634	24.6%
Claremorris	1914	2101	9.8%
Ballinrobe	1309	1626	24.2%
Swinford	1386	1497	8.0%
Ballyhaunis	1287	1381	7.3%
Kiltimagh	917	1000	9.1%
Belmullet	954	952	-0.2%
Crossmolina	1103	935	-15.2%
Foxford	944	878	-7.0%
Charlestown	597	675	13.1%
Killala	657	650	-1.1%
Knock	575	595	3.5%
Keel-Dooagh	518	541	4.4%
Newport	567	527	-7.1%
Total population towns >400	33786	40010	18.4%
Total other population	77738	77436	-0.4%
Total area population	111524	117446	5.3%

2.1.4 Roscommon demographics

The overall population increase in County Roscommon (3.5%) was the lowest of the three counties. Table 3 shows the population changes in six Roscommon villages/towns with over

400 inhabitants, plus the Environs of Athlone (the term the CSO uses to refer to that part of the Athlone population officially listed under Roscommon).

Table 3: Population changes 1996-2002 in County Roscommon towns with over 400 inhabitants, in order of population size, plus the Environs of Athlone

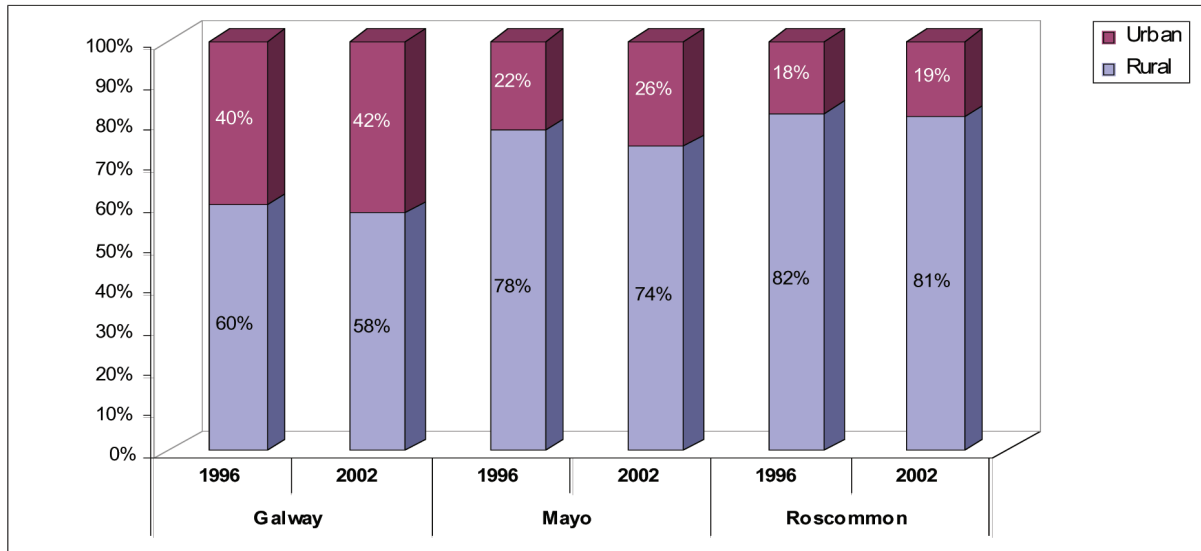
Town	1996	2002	% change
Roscommon	3915	4489	14.7%
Boyle	2222	2205	0.8%
Castlerea	1790	1788	-0.1%
Ballaghaderreen	1248	1416	13.5%
Strokestown	572	631	10.3%
Elphin	545	527	-3.3%
Environs of Athlone	1214	1626	33.9%
Total population towns >400	11506	12682	10.2%
Total other population	40469	41092	1.5%
Total area population	51975	53774	3.5%

2.1.5 Urban, rural and isolated populations

Approximately 60 per cent of the total Irish population are living in urban areas (defined by the CSO as towns with a population of 1500 or more). The situation in the GMR region is quite the reverse. Despite the phenomenon of larger relative increases in town populations, rural dwelling continues to be a very important feature of settlement patterns in the region. As Figure 2 shows, while the overall trend since 1996 has been a slight shift to urban areas, the majority of GMR inhabitants (66% overall) continue to live in small towns, villages and the countryside. More than half of the citizens of County Galway reside in rural areas, three quarters of those in County Mayo, and 8 out of 10 of those in County Roscommon. (Of course, apart from lifestyle choices, many people living in rural areas do so because they cannot afford to buy houses in urban areas; this may be a more significant phenomenon in Co. Galway.)

“Villages with populations less than 500 are under threat of losing their services and becoming less viable [and] it is crucially important that these villages be strengthened so that they can continue to serve their rural hinterlands”³⁶. There are also the Gaeltacht areas and several inhabited islands off the coasts of Galway and Mayo, and the needs of their communities must be met also. The significance of the rurality of the region is discussed in Chapter 4.

Figure 2: Proportion of GMR population living in rural and urban areas 1996-2002*



* Environs of Athlone included in the figures for Roscommon urban areas

2.1.6 Age structure

As well as population distribution, population composition must also be considered. For a variety of reasons, Ireland still has one of the youngest populations in Europe (although gradually ageing, in keeping with international trends). Because of the mass emigration in the first half of the 20th century there are very few old people around in Ireland today. However, the traditionally high birth rate began to decline in the 1980s. Thus there are now a relatively high number of 15 to 25 year olds compared to other age cohorts. Dramatic economic growth in the last decade (itself due in part to the large numbers of employable young people), and the ensuing high level of immigration, has also had an impact on the demographic profile.

Figure 3 illustrates the youthful age composition of the population (using the CSO's 5-year intervals from Census 2002), and shows a 'bulge' around the 15-24 age group. The very high proportion of people in their 20s from all areas drawn to Galway City is to a major extent due to the existence in Galway of two third level educational institutions. The presence of several major employers and the city's reputation as the arts and entertainment capital of the West have had a major effect also.

A third of the GMR population lives in towns with more than 1500 inhabitants. Table 4 shows both the actual numbers (CSO figures, Census 2002¹⁰) and proportions for five different age groups in each of these towns.

Figure 3: Percentage population by county & age group in 2002

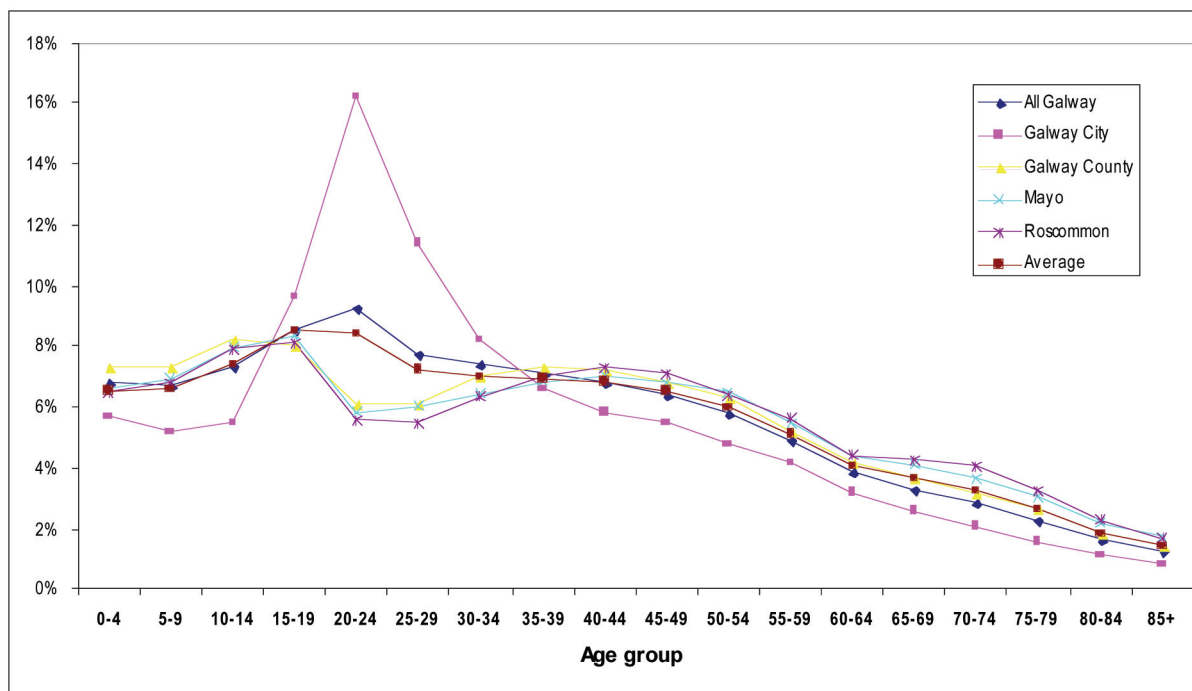


Table 4: Population in 2002 of towns with ≥1500 inhabitants, in order of size, by age

	Age group										
	Total	0-14		15-24		25-44		45-64		65+	
	No.	No.	%	No.	%	No.	%	No.	%	No.	%
Galway City	66163	10829	16.4%	17088	25.8%	21215	32.1%	11629	17.6%	5402	8.2%
Castlebar	11371	2406	21.2%	1906	16.8%	3813	33.5%	2018	17.7%	1228	10.8%
Ballina	9647	2186	22.7%	1504	15.6%	2831	29.3%	2036	21.1%	1090	11.3%
Ballinasloe	6219	1329	21.4%	881	14.2%	1688	27.1%	1317	21.2%	1004	16.1%
Tuam	5947	1293	21.7%	885	14.9%	1677	28.2%	1315	22.1%	777	13.1%
Westport	5634	961	17.1%	774	13.7%	1712	30.4%	1268	22.5%	919	16.3%
Roscommon	4489	912	20.3%	631	14.1%	1299	28.9%	935	20.8%	712	15.9%
Loughrea	4004	821	20.5%	552	13.8%	1175	29.3%	789	19.7%	667	16.7%
Boyle	2205	415	18.8%	326	14.8%	510	23.1%	551	25.0%	403	18.3%
Athenry	2154	531	24.7%	295	13.7%	725	33.7%	388	18.0%	215	10.0%
Claremorris	2101	419	19.9%	319	15.2%	600	28.6%	420	20.0%	343	16.3%
Castlerea	1788	324	18.1%	223	12.5%	402	22.5%	461	25.8%	378	21.1%
Gort	1776	340	19.1%	256	14.4%	575	32.4%	354	19.9%	251	14.1%
Oranmore	1692	379	22.4%	253	15.0%	531	31.4%	416	24.6%	113	6.7%
Ballinrobe	1626	348	21.4%	226	13.9%	516	31.7%	343	21.1%	193	11.9%
Total	126816	23493	18.5%	26119	20.6%	39269	31.0%	24240	19.1%	13695	10.8%

2.2 NATURE & EXTENT OF ALCOHOL & ILLICIT DRUG USE

In 2000, the Health Research Board published the results of a nation-wide survey of the public's knowledge, attitudes and beliefs in relation to alcohol and illicit drugs⁸. There was a high level of concern among respondents regarding the extent of the problem generally: 75% believed that the drug situation was "out of control", while almost 95% thought that drug-related crime was a major problem. Despite this, over half of respondents considered that alcohol abuse caused more problems in society than drug abuse and just under half believed that drugs were "not really a problem" in their own neighbourhood. Almost 95% were also of the opinion that illegal drugs were a great threat to young people, while over 50% believed that "it is normal that young people will try drugs at least once" and that "most young people try out cannabis". When asked whether they personally knew someone with a "drugs problem", a quarter of all respondents said they did, with younger people living in urban areas being more likely to have experienced this.

A mid-term review of the National Drugs Strategy was conducted in 2004*. Written submissions were received from a wide range of statutory and voluntary organisations around the country, including current perceptions and concerns regarding trends in alcohol and drug misuse. Among the preliminary findings from that review were the following observations:

- Alcohol continues to be the major problem drug in most areas and is very often used along with illicit drugs.
- The supply of alcohol to under-age young people is particularly problematic and is reported to have escalated, resulting in children as young as 12 having to be pumped out.
- There is widespread misuse of prescription drugs (benzodiazepines in particular), due to inadequate control of supply and illicit street sales.
- There has been a reduction in the age at which young people are being offered and are starting to use cannabis, with children as young as 12 being seen smoking hash.
- The availability and problematic use of cocaine is increasing, particularly among young people. Cocaine is now regarded as a major issue, some regarding it as a growing epidemic that will have a serious impact on services.
- There has been an increase in polydrug use: heroin, cocaine, cannabis, alcohol and benzodiazepines are all taken together in some cases.

* *Mid-term Review of the National Drugs Strategy 2001-2008*. Published mid-2005 by the Dept. of Community, Rural & Gaeltacht Affairs.

- Solvent abuse, mainly by very young people, still occurs and should not be forgotten.

While some of these problems may be local in nature (e.g. specific off-licences consistently breaking the law, or the presence of major drug dealers in certain communities) and are not necessarily typical of the GMR region, no area can be immune and any of these problems could potentially occur if they are not occurring already.

Do these responses reflect the experiences and perceptions of people living in the GMR area, and do they tally with the available data on the region? There have been no region-specific studies of drug and alcohol use since the mid-1990s, and therefore the data from these older studies cannot be taken as reliable guides at this time (although they are useful as reference points). However, there is currently no evidence that, all other things being equal, the GMR region differs substantially from the rest of Ireland (excluding the greater Dublin area) in terms of alcohol and drug use. This is not to say that future research will not reveal local problems or situations meriting particular attention. In the meantime, providing due regard is given to their limitations*, national surveys (and their regional breakdowns where available) can be used as indicators of the current regional situation. The population surveys considered in this report are the *European School Survey Project on Alcohol and other Drugs*^{43,44}, the *Survey of Lifestyles, Attitudes and Nutrition* and the *Health Behaviour in School-aged Children* survey¹², and the 2002/2003 all-Ireland *Drug Prevalence Survey*⁶⁷. Drug-specific surveys referred to here include Ramstedt & Hope's 2002 study of the Irish drinking culture⁸⁰ and the national study of the prevalence of opiate use published by the National Advisory Committee on Drugs in 2003⁶⁶.

2.2.1 Alcohol

The substance used by most people (around 75%) living in the GMR area is alcohol. For many years, its legality, availability, familiarity and ubiquity have allowed alcohol to be portrayed as "essentially benign"⁹. However, because of its widespread use and its inherent potential to cause harm, alcohol must be regarded as being "no ordinary commodity"³.

When considering alcohol consumption in a population, two important points must be understood first:

Total alcohol consumption in a population is an important indicator of the number of individuals who are exposed to high amounts of alcohol. Adult per capita alcohol consumption is, to a considerable extent, related to the

* For example, the size and nature of the sample used, random sample variations, the data collection method, the relatively low occurrence of illegal drug use in the population compared to use of legal drugs, the illicit nature of drug use, and other factors may all have a bearing on the reliability of prevalence estimates.

prevalence of heavy use, which in turn is associated with the occurrence of negative effects.

The relationship between total alcohol consumption and harm is modified by the number of drinkers in a population and by the way in which alcohol is consumed.³

International research has shown that when alcohol consumption levels increase in society generally, there tends to be an increase in the prevalence of heavy drinkers, in terms of annual intake³. Because heavy drinkers account for a significant proportion of total consumption, it is unlikely that the total consumption level would increase without an increase in their drinking. Also of importance is the fact that most drinking is social in nature: people tend to influence each other's drinking behaviour, which implies that "heavier drinkers, along with other drinkers, tend to drink more when [overall] consumption increases"³. An environment where low alcohol consumption is the norm will tend to encourage lighter drinking, whereas an environment in which alcohol is readily available and affordable, and drinking is socially sanctioned or promoted, will tend to encourage heavier drinking⁵⁵. This correlation between 'average' drinking and 'problem' drinking has important implications for the implementation of measures aimed at tackling alcohol-related harm in our communities, and supports the adoption of a public health approach that addresses the total drinking population as well as targeting high-risk groups and individual drinkers.^{45,85,90}

The Strategic Task Force on Alcohol (STFA) has collated and analysed national data on alcohol consumption, drinking patterns and trends, and alcohol-related harm⁹⁰. Although the figures are for the whole country, there is no reason to believe that the GMR area differs substantially from these. Among the STFA's findings are:

- Ireland continues to have one of the highest levels of per capita alcohol consumption in the world.
- Per capita consumption has increased by nearly 50% since the early 1990s.
- Ireland also has a relatively high number of abstainers, which implies that many drinkers are consuming at risky levels.
- High-risk drinking (bingeing, intoxication, regular heavy drinking) is common, especially among men.
- 30% of male drinkers (22% female) consume more than the recommended upper weekly limit, this figure being substantially higher among young men with lower levels of educational attainment.

- Alcohol-related harm is evident throughout Ireland – in the courts, hospitals, workplaces, schools and homes – and the vast majority of it occurs among the adult population rather than among underage drinkers.
- Rates of alcohol-related diseases and deaths have increased in the last decade or so, in parallel with the increase in alcohol consumption.
- Alcohol is a major cause of Accident & Emergency and Psychiatric admissions, and is involved in 40% of road deaths and 30% of all road accidents.
- Public order offences – especially public intoxication and abusive behaviour – have greatly increased in the last decade.

It is clear that Ireland has “an alcohol problem of world-class proportions”, and it is time that this State committed the necessary resources to provide a world-class response to the problem⁵⁰. The cost of alcohol-related problems in Ireland – in terms of healthcare, road accidents, crime, absenteeism and other consequences – was conservatively estimated at €2.65 billion in 2003⁹⁰. In 2003, the total consumer spending on alcohol in Ireland was €6 billion, an increase of 60% over 1997 levels. This level of expenditure was 10% greater than the total spent on professional services (including medical goods and services), 13% more than on food (excluding eating out), 27% more than on personal transport (including cars and fuel), and 87% more than on clothing and footwear¹¹. In the same year the State collected €989 million net in VAT and Excise on alcohol⁸¹.

Given the well-established correlation between the level of alcohol consumption and the hazards referred to above, it can be inferred that the GMR region experiences its fair share of alcohol-related harm. Regional data derived from national surveys suggest that alcohol consumption in the region is not substantially different from the high levels occurring in other parts of Ireland, except for the greater Dublin area where substance use generally tends to be higher.

In 2003 the Centre for Health Promotion Studies at NUI Galway published regional figures, based on a national sample, from the National Health and Lifestyle Surveys of 2002. As the report points out, the aim of the survey was to establish patterns in health and lifestyle at a national level. Therefore the significance of the reported regional figures is to identify potential variations that may merit further investigation¹².

Table 5 shows that the prevalence of regular (at least once a week) alcohol consumption among adults in the Western Health Board/GMR area is comparable to all other regions outside the greater Dublin area¹². Consumption of alcohol on five or more days in a typical week was also similar to other areas: males 15%, females 10%. The proportion of regular

drinkers consuming more than the recommended weekly limit was 28% for males (which was close to the average) and 12% for females (below average).

Table 5: Regular alcohol consumption by health board, gender & age (SLÁN 2002)

Health Board	Total (%)	Male (%)	Female (%)	18-34 (%)	35-54 (%)	55+ (%)
North Eastern	74	80	68	84	78	54
Midland	73	82	65	81	79	54
South Eastern	74	78	70	83	82	52
Southern	76	80	72	84	79	60
Mid Western	73	81	68	86	75	52
Western (GMR)	74	76	72	85	76	58
North Western	73	82	65	83	74	56
South West Area	84	87	81	93	86	67
East Coast Area	86	86	85	92	92	68
Northern Area	83	86	81	91	87	69

In the all-Ireland Drug Prevalence Survey⁶⁷, 89% of all respondents aged 15-64 in the GMR area reported that they had consumed alcohol at least once in their lifetime, 78% in the previous 12 months, and 68% in the previous 30 days⁶⁷. Assuming these figures can be applied to the general GMR population, this means that around 220,000 people consumed alcohol at least once in their lifetime, 195,000 in the last year, and 170,000 in the last month.

Ramstedt and Hope’s national study of drinking habits showed that around two thirds of all men and around a half of all women aged 18-64 go drinking at least once a week. In this study, “binge drinking” was defined as “at least one bottle of wine, 25 centilitres of spirits or 4 pints of beer, or more, during one drinking occasion”⁸⁰. Nearly half of all men in the study, and 16% of women, reported that they go drinking in this fashion at least once a week. These rates were higher in the younger age groups: 59% of men and 26% of women aged 18-29.

In 2002, the second Health Behaviour in School-aged Children study (HBSC)¹² surveyed the self-reported health behaviours of a national sample of Irish school-goers aged 10-17 years. Regional figures were also published¹². The HBSC data in Table 6 were standardised by age and sex to allow for comparisons between health boards, and show that the rates in the GMR region for this group are close to the average. In general, boys tended to be more likely than girls to report having ever taken alcohol or having been drunk.

Table 6: Self-reported alcohol use in school-children aged 10-17, by health board (HBSC 2002)

	NEHB	MHB	SEHB	SHB	MWHB	WHB	NWHB	SWAHB	ECAHB	NAHB	All
% Have <u>never</u> taken alcohol	40	40	36	45	36	43	44	36	41	39	40
% Drank alcohol in past month	24	25	31	24	31	25	22	29	23	27	26
% Have ever been drunk	27	28	35	28	35	28	29	35	33	35	31
% Drunk more than 10 times	6	8	6	6	7	6	5	8	8	8	7

The European School Survey Project on Alcohol and Other Drugs^{43,44} was first conducted in 1995 and covered 26 countries including Ireland. The second ESPAD survey was in 1999 (30 countries) and the third in 2003 (35 countries). The survey uses a standardised method and a common questionnaire for direct comparability, and only students who reach 16 years of age during the survey year are eligible to participate.

Table 7 shows the figures from all three ESPAD surveys for five selected variables^{43,44}. For most categories there was a noticeable increase in prevalence between 1995 and 1999, with relatively little change between 1999 and 2003. Lifetime prevalence of having been drunk twenty times or more has escalated since 1995, however, rising ten points for boys (a 45% relative increase) and fourteen points for girls (a 93% relative increase). The prevalence of binge drinking (defined in this study as five or more drinks in a row) has also markedly risen, especially among girls. Girls were five points behind boys in 1995, but in 2003 had gone two points ahead, a relative increase of 65%.

Table 7: Trends in alcohol use among 16-year-old Irish schoolgoers 1995-2003 (ESPAD)

	Boys (%)			Girls (%)			All (%)		
	1995	1999	2003	1995	1999	2003	1995	1999	2003
Lifetime use any alcoholic beverage 40 times or more	37	41	42	31	39	36	34	40	39
Any alcoholic beverage 10 times or more in past month	14	18	17	9	16	14	12	16	16
Drunk lifetime 20 times or more	22	28	32	15	18	29	19	25	30
Drunk 3 times or more in past month	17	27	27	14	23	25	15	24	26
Binge* drinking past month 3 times or more	25	32	31	20	32	33	23	31	32

* Binge drinking defined as 5 drinks or more in a row.

This phenomenon of both a high prevalence and gender parity in heavy alcohol use is only seen in a small number of countries in the ESPAD survey, mainly Ireland, the UK and the Nordic countries. Ireland is consistently at the top of the scale for binge drinking, and is one of only three countries where the prevalence of this variable is higher for girls than for boys (the other

two countries being the Isle of Man and the UK). This trend merits closer attention and further investigation. While risky drinking in any population group is a matter of serious concern, it is important to remember the physiological reality that, given similar levels of alcohol consumption, a majority of females will get drunk faster and will be more vulnerable to alcohol-related problems than males¹⁷.

Heavy and hazardous drinking is also occurring to a notable degree among third level students. The College Lifestyles and Attitudes Survey, which involved a nationally representative sample of 3250 students in 21 third level institutions, found that binge drinking rates are higher in this cohort than in the general population, particularly among females⁴⁷. There is a large student population in the GMR area (20,000+ including full-time and part-time students) and so a high prevalence of risky or problem drinking in this group is a cause for concern.

2.2.2 Tobacco

Although fewer people smoke tobacco than drink alcohol, the impact of tobacco in terms of disease and death is far higher. Tobacco kills more people than the combined total attributable to alcohol, cocaine, heroin, homicide, suicide, car accidents, fire and AIDS⁹².

An important aspect of tobacco use, in the context of drug misuse generally, is its role as a 'gateway drug' and its prominent role in the common phenomenon of polydrug use. Research has shown that, for example, adolescent users of tobacco are much more likely to progress to use of illicit drugs than are nonusers of tobacco. Clearly, not all adolescent cigarette smokers progress to using illicit drugs, but tobacco has proved a strong and consistent predictor of subsequent illegal drug use. Learned smoking behaviours facilitate progression to other drugs that are self-administered by the same method, while smoking as a social activity normalises substance use⁶⁰. Smoking provides "exposure opportunities" where young smokers are more likely to encounter and use other substances⁹⁶.

There is a very strong association between tobacco and alcohol use: up to 95% of alcoholics smoke cigarettes and approximately 70% of alcoholics are classified as heavy smokers, while adolescents who begin smoking are three times more likely to begin using alcohol⁹². In addition to the psychological and social processes involved, there is also evidence from pharmacological studies that nicotine alters brain chemistry in a way that enhances the influence of other drugs, an effect that may be reciprocal. For example, alcohol use seems to promote continued smoking and smoking promotes continued drinking¹. In a major scientific review, the US Surgeon-General concluded that the pharmacologic and behavioural processes that determine tobacco addiction are similar to those that determine addiction to drugs such as heroin and cocaine⁹¹. Of all drugs,

whether used together or individually, tobacco is one of the most addictive. In the US National Comorbidity Survey, the estimated proportion of recent tobacco users who had developed clinical syndromes of drug dependence was 32%, compared to 9% for cannabis, 15% for alcohol, 17% for cocaine and 23% for heroin¹.

In the 2002 SLÁN survey¹², the prevalence of regular/occasional smoking among adults aged 18+ in the Western Health Board/GMR region was 28% for men and 22% for women. Males also smoked more cigarettes than females. In the all-Ireland Drug Prevalence Survey⁶⁷, 62% of respondents in the GMR area reported ever smoking tobacco, 36% in the previous year and 31% in the previous month. Rates among young adults were lower than the corresponding national figures: 32% vs 37%. The prevalence rate for current tobacco use among females (33%) was higher than that for males (30%), a difference which was not seen in the national figures. In the HBSC survey¹², 33% of boys and 35% of girls aged 10-17 in the WHB/GMR region reported ever smoking, while 19% of boys and 16% of girls reported that they were current smokers; these rates did not differ markedly from other health boards outside the Eastern region. The 2003 ESPAD survey⁴⁴ showed a continued decrease since 1995 in the 30-day prevalence of smoking among both boys and girls, although girls' rates remain higher than boys'. The boys' rate was 28% in 2003 (down from 37% in 1995), while the girls' rate was 37% (45% in 1995).

The workplace smoking ban introduced in 2004 was widely supported, even among smokers, and led to a drop of 18% in cigarette consumption (and a decline in tax revenue of €128 million) in six months. This legislation was a good example of an effective public health policy, and future research can be expected to reveal its benefits. Nonetheless, it may be the case that committed smokers are also adapting in ways other than by reducing their smoking or by continuing to go to pubs and smoking outside. While tobacco sales have decreased, and around 8% of smokers have quit since the ban, off-licence sales of alcohol for home consumption have increased. Although a move towards home drinking had already been occurring, the smoking ban may have accelerated the trend. Research into the effects of the smoking ban on consumption patterns of both tobacco and alcohol, as well as health outcomes, will be a useful line of enquiry.

Although it is anticipated that smoking prevalence will decline following the smoking ban, smoking rates will remain relatively high in disadvantaged groups without more targeted interventions. In Ireland, as in other countries, there is a marked difference in the prevalence of smoking between social classes and according to level of educational attainment, with manual workers being more than twice as likely to smoke as those in the professional or managerial classes⁵⁸. Smoking rates are higher among people living in council housing⁷⁶ and there is also some evidence that the prevalence could be much higher among Travellers than in the general although population⁶³ targeted health research in this community has been relatively sparse to date.

2.2.3 Prescription drugs and other medications

A key factor in the misuse of any drug is availability. For this reason, among others, "it is difficult not to agree with the suggestion that most Irish people have more to fear from legal drugs and medicines than from illegal drugs"¹⁷. The Pharmaceutical Society of Ireland has stated that misuse of over-the-counter (OTC) medicines seems to be "a widespread and intractable problem"⁵⁹. Products suspected of being misused include drugs with potential sedative or stimulant properties, such as analgesics (particularly those containing codeine), antihistamines, sleeping aids, cough mixtures and laxatives. OTC medicine abuse has been under-researched and regarded as a low priority.

Commonly abused prescription medicines include sedatives and tranquillisers, particularly the benzodiazepines. Benzodiazepines are broadly divided into anxiolytics (anti-anxiety drugs) and hypnotics (sleep-inducing agents) and are among the most frequently prescribed and widely used of all medicines. It is already known that misuse of benzodiazepines (street diversion) is common among opiate and polydrug users⁶. However, the relatively low number of such users in the GMR area suggests that if there is a benzodiazepine misuse problem of any notable size it is more likely to be found in the general population. According to the Benzodiazepine Committee, "it has been recognised for a considerable period of time that benzodiazepine anxiolytics and hypnotics can cause drug dependence when taken on a long-term basis, even in prescribed therapeutic doses"⁶. Tolerance to their effects – one aspect of addiction – may develop within 3 to 14 days of continuous use. Analyses by the Benzodiazepine Committee of prescribing patterns in the General Medical Services (or medical card) Scheme, which covers about a third of the Irish population, have indicated that in this group about 1 in 10 people overall, rising to about 1 in 5 in the over-60s, are prescribed benzodiazepines. Prescribing rates tend to be higher for women. In the Eastern Regional Health Authority area, around 6% of GPs were found to be prescribing at a rate at least 50% higher than that of their colleagues, while up to 70% of GMS patients in this area receiving such prescriptions "would appear to be taking benzodiazepines on an ongoing basis"⁶.

Recent research conducted in Ballymun found that benzodiazepine misuse was very prominent among habitual users of other drugs, that there was a clear gender bias in prescribing, with women receiving almost two thirds of prescriptions, and that "a considerable proportion of patients who are initiated on benzodiazepines continue to take them for many years"⁴. An audit of dispensing patterns in community pharmacies showed that 90% of prescriptions were issued on the GMS scheme, while 77% of prescription items came from just four doctors.

Although Ballymun is in many ways a very different environment to the West of Ireland, this study is a very informative and useful account of why and how benzodiazepine misuse occurs.

The Drug Prevalence Survey⁶⁷ reported that 3.7% of all respondents aged 15-64 in the GMR area had used sedatives, tranquillisers or anti-depressants in the previous month, with females being more likely to have used these drugs (5.1% vs 2.4%) as were the older adults (4.6% vs 2.8%). Last year prevalence in this study was 5.5% overall, with the rates for females and the older age group being higher: males 4.5%, females 6.5%, young adults 3.2%, older adults 7.4%. All of these rates were similar to those for the country as a whole. In the SLÁN survey¹², 1.2% of women and 0.4% of men in the GMR area had used tranquillisers or sedatives without a doctor's prescription in the previous twelve months – a question on prescribed use was not included in the survey.

Benzodiazepines, opiates and cannabis are, in similar proportions, the three most frequently reported secondary problem drugs among users attending treatment for addiction²⁷. The reported experiences of addiction counsellors indicate that, in the treatment of drug addiction, benzodiazepine dependence alone or concurrently with other drugs typically requires a more extended detoxification process. The availability of benzodiazepines, the prevalence of their use and misuse, and the likelihood and severity of dependence, suggest that closer attention should be paid to the possibility that there could potentially be a benzodiazepine problem in the GMR area.

2.2.4 Cannabis

The most commonly used illicit drug in the GMR area, as elsewhere, is cannabis. The trend internationally has been towards significantly increasing use, particularly among adolescents and young adults. Despite the high prevalence of cannabis use, uncertainty persists about its physical and psychological consequences⁷⁸. Consequently, it is also one of the most widely researched and debated of controlled substances. As a comprehensive and wide-ranging review of the literature on cannabis for the National Advisory Committee on Drugs states, "the vast body of research on the consequences of cannabis use does not lend itself to simple and easy conclusions"¹⁴. A particularly important issue – one with potentially serious public health implications – is the association of cannabis use, especially among adolescents and young adults, with the later onset of mental disorders, including depression, anxiety and psychosis. Does cannabis cause these conditions, or do people who already have a predisposition for these disorders tend to use cannabis more, perhaps as a form of self-medication?

The lack of irrefutable, conclusive evidence of significant harm to public health, in the context of widespread and persistent use of the drug, has sustained scientific and political debate for many years, allowing scope for the pragmatic (though contentious) easing of restrictions on cannabis use in some jurisdictions. Cannabis use, among young people especially, remains a controversial area, and absence of good data has hindered the development of rational and consistent public health policies⁷⁸. Holland has long been perhaps the best-known example of a low-restriction regime, while the UK, following a recommendation from the Advisory Council on the Misuse of Drugs and with the full backing of the Association of Chief Police Officers, reclassified cannabis from Class B to Class C in 2004. Converging evidence from well-designed and carefully controlled epidemiological studies of cannabis use as a potential cause of psychiatric illness, published before and since the reclassification decision was made, has however led the UK government to initiate a reassessment of its position⁴⁶. Holland has also recently 'de-liberalised' its policy.

A prospective four-year study that followed the progress of over 2400 young people in Germany aged 14 to 24 with and without a diagnosed predisposition for psychosis at baseline, concluded that "cannabis use moderately increases the risk of psychotic symptoms in young people but has a much stronger effect in those with evidence of predisposition to psychosis"⁴¹. While cannabis use accounted for 6% of psychosis outcomes in the total study population and 14% in the predisposed group, psychosis predisposition did not predict cannabis use, thus countering the self-medication hypothesis. These findings support previous prospective (follow-up) studies that indicated a causal association between cannabis use and certain psychiatric symptoms. A three-year follow-up study of 4000 persons in the Netherlands⁹⁴ reported that 50% of the psychosis diagnoses identified could be attributed to cannabis use and concluded that "cannabis use increases the risk of both the incidence of psychosis in psychosis-free persons and a poor prognosis for those with an established vulnerability to psychotic disorder". An Australian study of 1600 adolescents followed for seven years⁷⁸ found a strong association between daily use of cannabis and depression and anxiety among young women; in contrast, depression and anxiety in teenagers did not predict higher cannabis use. These and other similar studies strengthen the argument that use of cannabis increases the risk of psychiatric illness⁸². Given that this risk rises with level of use, and that nowadays cannabis often contains more of the main active constituent (THC) than ever before, the public health impact of widespread, frequent and increasing use could be considerable⁴². Since adolescence and early adulthood is the peak period for both cannabis use and incidence of psychosis, preventing harmful exposure in this high-risk age group is an important public health goal⁹⁵.

Last year prevalence of cannabis use in the 2002 SLÁN survey¹² was 5% for adults aged 18 and over in the Western Health Board region; this rate was the lowest of all health boards and was significantly lower than those for the Dublin area. Male prevalence rates were consistently higher than those for females in all health board areas, and in the GMR region the male rate was three times higher: 9% vs 3%.

In the all-Ireland Drug Prevalence Survey⁶⁷, self-reported use of cannabis in the last 30 days among all respondents aged 15-64 in the Western Health Board/GMR region was 1.3%, compared to 2.6% for the country as a whole. Last month prevalence was similar for males and females, but higher among older respondents (see Table 8). Males had higher rates than females for both last year and lifetime prevalence: 2.7% vs 1.3% and 16.5% vs 9.7% respectively. These rates were all lower than those for the country as a whole.

Table 8: Cannabis use by age group (NACD 2004)

	Prevalence of cannabis use (WHB area)		
	Lifetime	Last year	Last month
All respondents 15-64	13.2%	2.0%	1.3%
Young adults 15-34	17.1%	1.5%	0.6%
Older adults 35-64	9.9%	2.4%	1.9%

In the HBSC survey¹², 10% of boys and 4% of girls aged 10-17 in the Western Health Board region reported using cannabis in the previous year. Rates were similar for lifetime use. These were among the lower rates in the country and were significantly lower than those in the Eastern Regional Health Authority. The 2003 ESPAD survey⁴⁴ reported that the lifetime and 30-day prevalence rates for 16-year-old Irish school students were 39% and 17% respectively, on a par with the UK and in the top five of all countries surveyed. Rates were equal for boys and girls. In the 1999 ESPAD survey⁴³, 59% of Irish respondents perceived cannabis as being “fairly easy” or “very easy” to obtain, which was the highest percentage of all the European countries in the study.

2.2.5 Ecstasy

The 2002 SLÁN survey¹² noted an increase in the national 12 month prevalence rate of Ecstasy use among adults aged 18+ compared to the 1998 survey: from 2.9% to 3.9% in men and from 1.5% to 2.4% in women. The 18-34 age group had the highest rate: 6.4% in 2002. The regional (WHB) SLÁN figure for all adults was less than 0.5%, one of the lower rates among the former health boards. Last month prevalence in the Drug Prevalence Survey⁶⁷ was 0.3% nationally for

all adults aged 15-64 and twice this rate for males and the younger age group (15-34). Last month and lifetime prevalence were 1.1% and 3.8% respectively, and in each case rates were higher for males and the younger age cohort. Figures for the GMR area in this survey were lower (2% lifetime prevalence overall) and the same pattern in age and gender was evident. Lifetime use of Ecstasy was 5% overall in the 2003 ESPAD survey⁴⁴. There was little difference between boys and girls or between 1999 and 2003.

2.2.6 Cocaine

There has been growing concern in recent years over the increasing availability and use of cocaine in Ireland. According to the National Advisory Committee on Drugs, "anecdotal reports suggest that the increase in cocaine use has been across the general population, not just among existing problem drug users or confined to certain urban areas"⁶⁶. Although research on the scale of the potential problem regionally or nationally has been sparse so far, data from the criminal justice system, drug treatment centres and small research studies indicate that cocaine use is having an increasing impact on services though its prevalence is still small compared to other drugs⁶⁶. Drug treatment data are an indirect indicator of drug misuse, and an increased reporting of problem cocaine use has been noted across a number of health boards outside the Dublin region: "though small, the numbers reporting cocaine use increased consistently, indicating the early years of an epidemic"²⁸. Small-scale qualitative studies conducted in the Dublin area have reported an increased visibility of cocaine in pubs and clubs and have identified a phenomenon of users injecting the drug⁶⁶.

The Drug Prevalence Survey⁶⁷ indicated that 3% of the general adult population in Ireland have ever used cocaine and less than one per cent have used crack. Lifetime prevalence was highest among 15-34 year olds at 5%. Last month and last year prevalence rates in the GMR area were less than 1% and tended to be higher in younger males. The 2002 SLÁN survey¹² reported a national increase in last year prevalence among males from 1.8% in 1998 to 3% in 2002 and among females from 0.6% to 1.9%. The corresponding rate for the GMR area was around 1% overall. Rates were generally higher in the 18-24 age group. In the 1998 HBSC¹² and 1999 ESPAD⁴³ surveys, around 2% of respondents reported that they had ever used cocaine.

2.2.7 Heroin and other opiates

Because of the illegal nature of many drugs, it is difficult to precisely establish the number of users. Possession carries the risk of acquiring a criminal record as well as incurring public disapproval or notoriety. Users of illicit drugs are therefore generally hidden populations and their activities tend to be covert or inconspicuous (notwithstanding occasional reports of open

drug dealing). Heroin use, above all intravenous use, is regarded as especially deviant and is associated with crime, infectious diseases and social disorder. Heroin users are often feared and stigmatised even when they are actively seeking treatment for their addiction⁵. The number of opiate users in a community is therefore not just difficult to determine accurately but may also be an issue arousing considerable concern or controversy.

In the all-Ireland Drug Prevalence Survey no respondent in the GMR area reported use of heroin. However, as the survey report states, this “does not mean that there was no use of that drug in the area, although it is indicative of low levels of use”⁶⁷. Rates for the country as a whole were low, with 0.5% of all respondents having ever used the drug. Use of Methadone and other opiates was also infrequent. In the SLÁN survey¹², regional prevalence of heroin use was similarly low.

In 2002/2003, researchers at Trinity College Dublin conducted a Capture Recapture study of opiate use in Ireland⁵³. This was a statistical analysis using three separate data sources: the Central Drug Treatment List, the national Gárda Study on Drugs, Crime and Related Criminal Activity, and the Hospital In-Patient Enquiry (HIPE) database. The statistical model used in this study produced an estimated prevalence of opiate use expressed as the rate per 100,000 persons aged 15-64 for the years 2000 and 2001. The rates for the GMR area were 12.7 in 2000 and 17.9 in 2001, which were among the lower rates in the country.

2.2.8 Other drugs

This category includes LSD, amphetamines, inhalants and mushrooms. Overall, lifetime and last year prevalence of all of these drugs are less than 1% in the GMR area. Lifetime prevalence is about 2% regionally and 3-4% nationally, being higher in the younger age groups.

Inhalant or solvent abuse is regarded as being primarily an adolescent phenomenon although it is known to occur among young children and occasionally among adults¹⁷. Volatile substances that can be abused are numerous and many are widely available, and their potential harmful effects can be serious and unpredictable. It is therefore a matter of some concern that young people may be continuing to abuse these substances. In the 2003 ESPAD survey⁴⁴, 21% of Irish 16-year-old girls and 14% of boys reported that they had ever used inhalants. These were among the highest rates in the 35 countries surveyed.

3 PREVENTION & EDUCATION

Prevention and education are two of the protective factors that help to ensure that individuals and communities can reduce the impact of drug and alcohol related harm. Alcohol and drug misuse is already occurring, however, as surveys have shown. Therefore it is necessary to respond to the situation that impacts upon us today and to try to delay or avoid the onset of drug use and reduce the potential for harm.

The National Drugs Strategy prevention and education objectives are

To create greater societal awareness about the dangers and prevalence of drug misuse.

To equip young people and other vulnerable groups with the skills and supports necessary to make informed choices about their health, personal lives and social development.

3.1 WHAT IS PREVENTION?

The NACD report on drug use prevention⁶⁵ identified three types of prevention: primary, secondary and tertiary. Primary prevention is to prevent the onset of a substance-related problem. Secondary prevention is to intervene if a problem is likely to occur. Tertiary prevention involves harm reduction in those who already manifest the problem and also preventing further problems occurring once they have been treated (relapse prevention).

3.1.1 Who should prevention be targeted at?

The focus of drug and alcohol campaigns is often on young people and their risk-taking behaviours, yet it is also important to look at the range of people and age groups who may develop problems. Whilst it may be true to say that very few older people develop heroin problems, they may experience difficulties with alcohol, tranquillisers, sleeping tablets or painkillers. It is important to recognise that people may be experiencing dependence difficulties with over-the-counter medications.

3.2 TYPES OF PREVENTION PROGRAMMES

In planning the development of prevention initiatives we must remember that there are a range of issues that require targeted intervention. There are two broad categories of prevention programmes: universal and targeted.

3.2.1 Universal prevention programmes

Universal programmes aim to reach the general population or smaller defined groups. These can be run in various settings, including schools, youth services and family services and can take a number of forms.

Information

Increased knowledge and understanding of any problem helps us to deal with it at a personal level and at a community level. It is necessary that we understand the nature of the local drug situation, the facts about the drugs that are available and are being used locally, and the consequences of substance misuse. In order to help prevent problems and reduce harm, it is of primary importance that people know what is effective in prevention. It is essential that when agencies are intending to run education, information, or training programmes that they know of what is already being done and that they get advice on targeting and using the most effective model available.

Parent support programmes

Parents are a crucial influence in the behaviour of their children. Most parents recognise the growing number of issues that can impact on the wellbeing of young people today, including binge drinking, smoking, illicit drug use, antisocial behaviour, bullying, suicide, eating disorders, road safety and others. Parents need to be knowledgeable about how to tackle these issues, and should be encouraged to seek help early if problems are suspected or identified. There are a growing number of parenting programmes and education programmes available that can assist parents to address such problems. These are not as successful if done in an ad hoc fashion, however. Parent support is essential in prevention efforts: "the benefits of parent education have been shown to be effective [and] parent education is therefore one of a range of family support interventions"⁹⁷. It is also important that parent support programmes link in a cohesive way with education and prevention efforts in schools.

Generic youth work initiatives

It is advisable to provide universal Youth Work programmes in all localities to offer a safe and respectful space for young people to socialise. Many youth clubs already exist thanks to the tireless work of volunteers and parents. These initiatives should be supported, and helped to

access or develop appropriate local facilities. The National Development Plan²³ contains a number of important measures relating to youth, including the Youth Service Grant Scheme, Youth Information Centres, and Community-based Youth Initiatives. Other measures directed towards at-risk youth include Special Projects for Disadvantaged Youth, the Young People's Facilities and Services Fund and the Gárda Youth Diversion Programme. Because these measures are spread across a number of government departments, efforts to ensure coherence are particularly important⁶⁹.

It is very important with such youth interventions, and social inclusion measures generally, that there is a strong commitment to proper resourcing and to the effective use of those resources through coordination, integration and elimination of duplication. Social inclusion and the importance of service coordination are discussed in Chapter 4.

The Young People's Facilities & Services Fund (YPF SF) has been administered since January 2003 by the Department of Community, Rural & Gaeltacht Affairs (CRAGA) and routed through the VECs. The Fund targets disadvantaged young people aged 10-21, including those who are at risk of drug use. At present there are a small number of projects in the GMR area that have been funded by the YPF SF, all of which are in Galway: Bohermore Teenage Development Project, Ballybane Adventure Programme, Circles, the Peer Education Programme and the Le Chéile Ragoon Youth Project. Projects of this type should be set up where needed throughout the GMR region, drawing on the funding available through the YPF SF and other sources. The location of the YPF SF in CRAGA offers opportunities for links to other activities such as local and community development, RAPID, CLÁR and the Regional Drugs Task Force. A mid-term evaluation of the Border, Midland and West Regional Operational Plan³² found that spending in the YPF SF up to that time was substantially below target – due to “lack of demand” and “poor promotion” of the measure – and recommended a 60% reduction in the budget for 2004-2006. However, the Task Force expects that spending will significantly increase as initiatives to address gaps in services for young people, as identified in this Strategy, are developed and implemented.

The National Youth Council has called for a number of measures to address the lack of services for young people (long-term funding, co-ordinated service provision, accessible information, and “one stop youth shops” incorporating health workers, youth workers and counsellors) and for policy and practice to be “rural proofed to ensure parity of esteem for rural youth” in keeping with the terms of the 1999 White Paper on Rural Development⁷⁴.

Substance use prevention & education in schools

This is an area of recurring concern for many people. Given the prevalence of substance misuse among school-goers, and their reported ease of access to alcohol and other drugs, it is very important that substance misuse education is comprehensively dealt with in schools. Research shows that drug and alcohol education is best delivered in the context of lifeskills programmes that are appropriate to the developmental stage of young people. Programmes such as these help to equip young people with the facts about drugs and the consequences of substance use, as well as empowering them to develop the confidence, attitudes and personal skills conducive to responsible decision-making.

The Social, Personal and Health Education (SPHE) programme, and the resources *Walk Tall and On My Own Two Feet*, have been developed with such aims in mind and with the broad objectives of promoting physical, mental, and emotional wellbeing within the framework of the school curriculum. SPHE is now part of the curriculum for all students in primary schools and in the junior cycle of post-primary schools, and is being developed for the post-primary senior cycle. Support for post-primary schools (including assistance with developing school substance use policies) is provided by the SPHE Support Service*. The national office for this service is in Dublin and the regional support workers are based in the Western Region Health Service Executive. Support for primary schools is provided by the Primary Curriculum Support Programme; there is no dedicated SPHE support service for these schools at present.

Although SPHE can be implemented as a stand-alone subject, an integrated “whole school” approach and supportive school environment are regarded as important foundations for the programme²¹. Substance Use is one of the ten modules in the junior cycle SPHE curriculum. The Department, expressly acknowledging “concerns about the behaviour of young people in relation to alcohol, smoking ... and the use of illegal substances”, states that “all second level schools must timetable SPHE as part of the Junior Cycle core curriculum”²².

A national survey of post-primary schools, carried out before SPHE became a required part of the curriculum, found that the implementation of the programme was quite variable³⁸. Among Secondary Schools (comprising three quarters of the survey response) the percentage offering SPHE ranged from 79% of girls’ schools, to 64% of mixed schools, to 57% of boys’ schools. Furthermore, the survey reported that, although the SPHE has “ten key themes for each of the Junior Cycle years, which are revisited on a year-by-year basis”, the proportion of schools offering the programme decreased from 70% for First Years, to 57% for Second Years, to 46% for Third

* The SPHE Support Service is a partnership between the Dept. of Education & Science, the Dept. of Health & Children and the Health Service Executive, in association with the Marino Institute of Education, with funding from the National Development Plan.

Years. The main obstacles to implementing the programme, as reported in this survey, were curriculum overload (identified by 90% of principals), lack of time for coordinating and planning (66%), and inadequate training for teachers (45%). Respondents' comments in this survey (which included the views of principals, SPHE coordinators and teachers) characterised SPHE as a qualitatively different subject in terms of both content and methodology, that had to compete for space and acceptance in a very busy exam-oriented curriculum, in circumstances where many teachers felt they would be operating outside their capabilities, class sizes were often too large for the SPHE delivery format, and opportunities for proper training were lacking. One third of principals in schools implementing SPHE reported that the topic of Substance Use was given strong emphasis in their programme, while 90% of SPHE teachers/coordinators in the survey identified Substance Use (along with Relationships and Sexuality) as being very relevant to the lives of pupils.

Since SPHE became a required part of the curriculum in September 2003, the number of schools implementing the programme has risen dramatically. There are 83 post-primary schools in the GMR region, and 80 of these have reported that they are offering the programme⁸⁸. A survey of schools in the region, conducted by the SPHE Support Service in March 2004, indicated that 99% of schools were offering SPHE in 1st Year, 64% in 2nd Year and 41% in 3rd Year. It may be expected that these levels will rise, since many schools not previously offering SPHE may have decided to introduce the programme incrementally, starting with 1st Year classes in 2003. A gender breakdown of these figures is not currently available⁸⁸.

The Task Force recognises SPHE as an excellent and comprehensive programme, and recommends that it should be adequately resourced and ideally implemented in its entirety in every school. It is important that the programme is delivered as developmentally appropriate throughout the school cycle, that the delivery methods follow best practice, and that all students (boys and girls) benefit from it. To ensure that the Substance Use module in particular is adequately delivered in all schools, we have identified the need for Alcohol and Drug Education Support Workers to work with the SPHE Support Service in their efforts to have the SPHE programme fully implemented in all schools in the region. Within the framework of a whole school approach, these workers would provide practical, specialist training and support for teachers and schools in relation to substance use education and policy development. This would include linking with Post Primary Support Services, Home School Liaison Officers, the VECs' Adult Education and Community Education facilitators, parent support programmes, and other relevant services and personnel.

Programmes such as SPHE, however well-implemented, cannot achieve lasting change on their own. Principals, teachers and other personnel need the support of school management boards, schools need the support of parents and governors, and all need the support of the local community. Dealing with substance abuse involves all sectors of society. Referring to alcohol in particular, Minister for Education & Science Mary Hanafin has said that the drinks industry, retailers, parents and the community as a whole must acknowledge their responsibilities and “need to reflect on the general attitude to alcohol use”¹⁹. Accordingly, we must explore how the community working together can support changes that make for a safer and healthier environment. Drugs awareness education is essential as it allows us to understand the nature of the problem and how to begin to tackle drug-related harm. However, education in its broadest sense is not just the responsibility of schools. Education must be all inclusive, and it is important that we recognise the influence of peers, adults, families and the culture that exists in our community.

Positive alternatives

Primary prevention is not simply a matter of “zero tolerance”. It is also about providing positive alternatives to drug using which can delay the onset of substance use or avoid its occurrence at all. A health-promoting society provides positive initiatives that are attractive alternatives to a diverse audience, through music, arts, sport, drama, cinema, and so on. These can be done through youth services, pastoral projects, sports organisations, community centres and volunteer programmes.

A project such as “the Gaf” Health Advice Café in Galway is an example of a primary prevention initiative targeting 14-18 year olds, offering a positive space within the context of a health promotion ethos and an active learning environment. Young people are encouraged to take classes or programmes that deal with health or social issues that are age specific. The Gaf combines peer education programmes, mentoring initiatives and lifeskills training with social activities. Other positive youth development initiatives include Roscommon Youth Service and the forthcoming Open Space project in Castlebar.

Peer education

Peer education trains people of a similar age and back ground to convey information and resistance training approaches to others in there own community. This can be adults or young people. More research is required to assess the value of such interventions.

Mentoring/Buddy schemes

Mentoring is about matching the social and support needs of people with a positive/safe volunteer.

These are valuable for all age groups. The Big Brother Big Sister programme is an example of a successful youth mentoring programme. But the value is there for older people as well, and it is particularly important to support such programmes in rural communities.

3.2.2 Targeted programmes for at risk groups

Assertive outreach programmes

These programmes target those who are hardest to reach working at street level to engage with groups offering brief interventions around harm reduction, personal safety, sexual health and homelessness. The objective is to encourage contacts to engage with existing services.

Child development support

The Task Force recognises the need for child development and educational interventions, particularly for children who live in disadvantaged circumstances. Such interventions include crèches, nurseries, playgroups, homework clubs, after school clubs, home/school/community liaison and related types of services⁹⁷.

Family support

“The family is generally considered one of the most important locations of socialisation, and therefore of influences, for its members and especially children”⁹⁷. It is therefore essential to target support at families, particularly those that are vulnerable to or have an increased exposure to substance misuse. It is important that parents are aware of their children’s risk of exposure to drugs, that they know the impact drugs can have and that they are sufficiently knowledgeable about the consequences of drug misuse and how to deal with a drug problem.

In addition to these external risks, difficulties involving family management, parenting skills and levels of caring in families have all been strongly linked to substance misuse and related activities among young people. Deprivation and other pressures on family life result in increasing numbers of at-risk children, and the family thus becomes a risk factor for drug problems at societal level. Support programmes work by “diminishing family risk factors for drug problems through strengthening families”⁹⁷. Properly-implemented, evidence-based support programmes for parents can, for example, help to prevent the development of antisocial behaviour in their children⁹⁸. Family support programmes are multi-faceted and cover a wide array of service types and interventions, including therapeutic interventions, parent education, child development and education, home based parent and family support programmes, youth work and community development⁹⁷.

The Child Care Act 1991 obliges the Health Services to provide child care and family support services. Given its broad remit in respect of promoting overall child welfare, the HSE therefore provides a wide range of family support services and programmes throughout the region that target children, adolescents, parents and families collectively. All of these programmes are part of international best practice initiatives, are evidence-based, and are reviewed and evaluated on an ongoing basis. These services are also strongly involved in and committed to helping children and families through difficult situations such as violence or problems with alcohol or drug misuse. Under the umbrella term of Family Support a diverse range of intervention types are provided, including therapeutic interventions, parent education programmes, home-based parent and family support programmes, child development and education interventions, youth work, and community development programmes. Programmes in operation throughout the GMR region deliver some or all of these interventions. These include pre and post school services, Children Act Services, community-based adolescent services (e.g. Neighbourhood Youth Projects, adolescent support projects, mentoring programmes, Teenage Health Initiative), Springboard projects and community development family support projects. Where the delivery of these services involves working directly with young people and parents experiencing difficulties in relation to substance misuse, Family Support services work in partnership with the range of substance misuse services in the area. They would play an important role in the identification of people experiencing substance misuse problems and in referring them to appropriate agencies while continuing to support the service user with other issues.

Community mobilisation

Community involvement and engagement are essential if the Task Force is to truly reflect local needs. The community development process works to engage people in developing local initiatives. The first step in any community development initiative is acknowledging that there is a problem that needs to be dealt with or addressed. Our consultation process confirmed that people are concerned about many aspects of substance misuse. People said that they “can see the problems locally but they need help to know how to tackle them”.

Drug and alcohol problems impact on all generations, so the focus should not be exclusively on the behaviour of young people. Prevention efforts should benefit all citizens, and therefore community initiatives should offer a broad range of supports and explore the needs of all age groups.

The Task Force has identified a role for community liaison workers, who would cross-link with the relevant statutory and voluntary agencies in the region. This approach would help to raise

awareness of substance misuse issues, identify the local impact of substance misuse, assess local service development needs, and forge interagency collaboration and joint initiatives to tackle local problems.

Diversionary interventions

Diversion projects are community-based interventions which aim to engage drug users already involved in petty theft and other crime and link them into mainstream services as an alternative to the formalised route of the criminal justice system.

4 SOCIAL INCLUSION

Poverty and deprivation are more likely to encourage than discourage drug use¹⁵, and substance misuse can be both a cause and an effect of social exclusion. Problematic use of alcohol, tobacco, prescription medicines and illegal drugs has serious consequences for public health, and it is already known that lower socio-economic groups have a lower health status overall. A health promotion perspective on substance misuse must take into account existing social and health inequities⁷⁹:

It is clear some people turn to addictive substances when living in difficult circumstances and without the supports, incentives and opportunities available to them to live a healthy life. There is a social gradient to most aspects of substance use, with people from lower socio-economic groups using more tobacco and illegal drugs, and having lower rates of successfully quitting.

Low level of educational attainment is associated with problem drug use, and educational disadvantage sustains and exacerbates social exclusion: “some school communities ... are characterised by high levels of unemployment, single-parent families, low levels of parental education, lack of pre-school facilities, substance abuse, poor diet, absenteeism and a lack of parental involvement”, yet such schools are often seriously under-resourced³³. Failure to tackle the root causes of such problems in a coherent way at an early stage ends up costing society much more in the long run. The ongoing and ultimate costs of childhood antisocial behaviour, juvenile offending and consequent social exclusion, for example, are very high and fall on many different agencies; proper resources, deployed in a rational and coordinated manner, could therefore result in large cost savings⁸⁶.

It is essential therefore to recognise the needs of groups that are often marginalised in society and target them for priority inclusion. Given the opportunities and imperatives provided by national and regional development strategies, the Task Force must play its part in concerted efforts to tackle social exclusion, as “the importance of achieving coordination and integration of social inclusion measures under the National Development Plan cannot be overstated”⁶⁹. If these opportunities are not grasped, “social exclusion will continue and ... street violence, crime, drug and alcohol abuse will increase”³⁵. It is important that efforts are made to tailor service

developments to fit the needs of groups that are marginalised, disadvantaged or isolated. For example, assertive outreach initiatives can be an essential service provision for some populations.

4.1 THE SIGNIFICANCE OF RURALITY AND UNDERDEVELOPMENT

The GMR area is a “double peripheral area” within the Border Midlands West (BMW) region, hence the particular designation of the three counties of the West as an area eligible for continuing aid from EU Structural Funds⁸⁹. The historical depopulation of large tracts of marginal land has resulted in the “desertification” of many areas in the GMR region, a phenomenon characterised by weakening of demographic structures, loss of funding and investment, increasing marginalisation, and closure or absence of rural services and facilities³⁹.

A large land area, historical depopulation, significant pockets of deprivation and poor social and physical infrastructure may have implications for patterns of substance misuse and for service responses to such patterns. For example, a chronic lack of social and civic amenities, along with inadequate public transport, has led to a situation where in many localities the rural pub functions as a community centre. This is not without risk: for instance, 70% of fatal traffic accidents occur on rural roads (those in non-built-up areas with higher speed limits, including national routes) and alcohol is involved in 30-40% of such accidents^{72,73}.

A decade ago, the prevalence of alcohol and illicit drug use was higher in urban areas of the GMR, especially Galway City, than in rural areas⁵⁴. In recent years there has been a “growing recognition that illegal drugs, particularly cannabis and ecstasy, are readily accessible in towns and rural areas throughout [Ireland] and, along with alcohol, are becoming an increasing aspect of recreational activity amongst categories of youth in particular”⁶⁴. However, little or no data are available in Ireland or elsewhere to systematically compare the current nature and extent of substance use in urban and rural areas. Nonetheless, it appears that while variations in the geographical distribution of drug use are known to occur (heroin being the most obvious example), other differences are not as great as might be hoped for, although problem drug use is in general more likely to occur in deprived urban areas³⁴.

In this context, it is important to acknowledge that whilst disadvantage occurs in both urban and rural areas, it is necessary to distinguish between the two: “special emphasis must be placed on the causes of disadvantage in rural areas ... [taking] careful recognition of the need to have decentralised mechanisms that reach out into the heart of rural areas and which are specifically targeted at those who need them the most”⁶².

Although many people expect and enjoy a good quality of life in the countryside, rurality and isolation are not intrinsically protective, and a lack of diversionary leisure and recreational facilities could increase the vulnerability of rural young people to the misuse of alcohol and illegal drugs¹⁸. The problems of boredom, nothing to do and lack of positive alternatives also occur in towns, but may be particularly acute in rural areas: “young people who find themselves living in rural areas have fundamentally the same needs as young people living anywhere else. It is the variability of access to provision to meet those needs which creates disadvantage”⁴⁰.

Where drug dependence and associated difficulties do occur, lack of treatment facilities, or lack of access to such services, increases the prevalence of problems in the community⁴⁹. Research conducted in the UK and other countries has demonstrated the extra costs and barriers associated with rurality and remoteness². Problems include: economies of scale; additional travel costs and high levels of unproductive time; additional communications costs; poorer access to training, consultancy and other support services; difficulties of networking; and the slow pace of development work. Distance from services has a direct negative impact on utilisation rates and health-seeking behaviour (the ‘distance-decay effect’). Social features of rurality also affect service utilisation rates. For example, a culture of self-reliance and a fear of stigma have been cited as key factors in the low utilisation of mental health services. In Ireland, the counties with the highest suicide rates are predominantly rural, with the rates in all areas being much higher among males, who are less likely to access health services⁵². There are also inequities in the geographical distribution of health services, including primary care and mental health services, which typically have been developed in areas of greatest affluence rather than greatest need⁷⁹. All of these barriers point to the need for “rural proofing” of service provision⁶².

Unfortunately, many disadvantaged areas have been caught in a “Catch 22” situation: without development there has been a lack of infrastructure, while the deficiencies in infrastructure have impeded development⁸³. Development efforts over the years by a range of local, regional and national organisations, both statutory and voluntary, have sought to address these and other deficits. More recently, under the terms of the National Development Plan, prioritised state investment programmes such as CLÁR and RAPID have been introduced with the aim of revitalising disadvantaged rural and urban areas in a coherent, targeted and accelerated way.

It is essential that these programmes and related initiatives are fully resourced and continued as long as is necessary in order to resolve the significant deficiencies in social, community and service infrastructure and investment that exist in the region^{7,99}. It is a matter of considerable

concern that, as Minister for Finance Brian Cowen has stated, "investment in the BMW region at mid-2004 in the key area of economic and social infrastructure was some €660 million below the target set" while Exchequer spending on regional development was a further "€240 million below profile"⁸⁷.

4.2 TACKLING SOCIAL DISADVANTAGE

Ireland has become a very prosperous country in the last decade, and the benefits of this prosperity are evident. The number of people employed in is now around 45 per cent of the population, a record level in recent history. Some areas of the West, particularly Galway, have experienced rapid jobs growth. Jobs mean disposable income of course, and it needs to be considered what effect this may have on patterns of alcohol and illicit drug use. Despite the enormous progress made, significant pockets of unemployment, socio-economic disadvantage, deprivation and infrastructural deficit still remain (whether in terms of geography or social groups) and these must be given due consideration also. The key risk factors for poverty and social exclusion are many and varied, with substance misuse often playing a role as both origin and outcome²⁹:

[Factors] include discrimination, poor quality public services, unemployment (especially long-term), low income, low quality employment, poor health, low qualifications, disability, old age, migration, family break-up, drug addiction and alcohol abuse, as well as living in disadvantaged areas. These social risk factors often interact and accumulate over time.

The Programme for Prosperity and Fairness committed the Government to providing, under the National Development Plan, targeted investment in disadvantaged areas. Initiatives include the Local Development Social Inclusion Programme operated by the Area-Based Partnerships, and the Community Development Programme. In 2001 the CLÁR and RAPID programmes were introduced for rural and urban areas respectively. Both programmes are coordinated by the Department of Community, Rural and Gaeltacht Affairs (a relatively new ministry that was established in 2002 and which now also has responsibility for the National Drugs Strategy). The principle of "additionality" is central to both CLÁR and RAPID, which means that approved projects are meant to obtain matching funding from other Government departments, state agencies and Local Authorities. Public/Private Partnerships are also encouraged. The measures covered by the programmes include "physical, social and community infrastructure", which obviously gives scope for a wide range of initiatives broadly or specifically relevant to alcohol and drug issues.

4.2.1 Revitalising disadvantaged areas

CLÁR areas (Ceantair Laga Árd-Riachtanais) were selected on the basis of population decline between 1926 and 1996, and the programme is intended to combat the negative effects of this depopulation, such as withdrawal of services and loss of development funding. Following an analysis of the 2002 Census data, the CLÁR areas were reviewed and extended (see Annex 3 for maps). Substantial sections of the GMR region are now included: North-West, North-East and South-East County Galway, most of County Mayo, and the Northern half of County Roscommon (plus a strip adjoining the North-East Galway CLÁR).

RAPID (*Revitalising Areas by Planning, Investment and Development*) is a focused Government initiative targeting the most concentrated urban areas of disadvantage in the country. Strand 1 was confined to the major urban areas, and Strand 2 focuses on certain provincial towns. There are several RAPID areas within the GMR region: in Galway City the neighbourhoods of Ballybane, Ballinfoile, Bohermore, New Mervue and Westside, and in County Galway the towns of Ballinasloe and Tuam (see Annex 3 for maps). Although each RAPID area may have its own particular concerns, the broad priorities typically include health, education, childcare, community facilities, sport & recreation, youth development, substance misuse and community policing. Problems such as lack of recreational and diversionary activities for youth, sale of alcohol to minors, underage and “bush” drinking, illicit drug use, antisocial behaviour, vandalism, crime and lack of community policing are recurring themes in RAPID areas, and are being addressed in the Local Action Plans of the Area Implementation Teams²⁶. The Task Force needs to work in close collaboration with these initiatives going forward.

4.2.2 Social Inclusion Measures Working Groups

The Social Inclusion Measures Working Groups of the County Development Boards “have proved successful in providing a networking forum where social inclusion stakeholders can meet, discuss issues and share information [and have] increased awareness of social inclusion issues and assisted in breaking down traditional organisational barriers”⁶⁹. Nevertheless, given that the SIM Groups’ function is to coordinate at local level the delivery of the social inclusion measures of the National Development Plan, much greater progress needs to be made in terms of collaboration not just between all the relevant services but also between the relevant government departments. The NDP/CSF Evaluation Unit, evaluating the social inclusion coordination mechanisms, found that the coordination process has faced major constraints at national as well as at local level⁶⁹. These included

- The vertical nature of departmental organisational cultures
- Lack of flexibility to adjust spending programmes to local circumstances
- Lack of authority underpinning the local coordination function

- Absence of incentives to encourage organisations to eliminate duplication
- A general lack of priority attached to the objectives and work of SIM Groups by government departments and local delivery agencies.

At national level, “no cross-departmental framework agreements have been drawn up setting out clear principles for inter-departmental cooperation ... nor has any specific department been appointed to lead on [this]”⁶⁹. At local level, representatives on the SIMS groups reported that “no guidance from their parent departments and agencies had been received nor had any formal mandate or direction been provided”.

Partnerships have improved the ways society collectively solves its problems and meets its needs⁷⁷. Local partnerships contribute positively to both the processes and the outcomes of social inclusion initiatives. Their potential benefits include better policy coordination and integration, as well as cost-effective, innovative and multi-dimensional approaches to social inclusion²⁹. However, these potential benefits will not be realised through purely local effort⁷⁷:

Governments have created networks of partnerships and given them goals to achieve, but without ensuring that the prospective partners could take an active and consistent part in the activities to reach these goals. Public services have rarely been required to integrate in their mission the policy objectives assigned to the partnerships in which they were expected to participate.

It would appear therefore that authorities and agencies at national level have experienced the same coordination difficulties that local partnerships are expected to overcome. The Western Region Drugs Task Force will suffer from the same problems if these fundamental issues are not dealt with. Many of the Social Inclusion Measures and Target Groups are highly relevant to Task Force objectives. It is important therefore that the work of the Task Force closely interconnects with the implementation of SIMs and other programmes, and that the necessary steps (including and especially those relating to resource allocation) are taken at appropriate level in government departments as well as in the various stakeholder organisations to ensure that strategies and operations are coherent, coordinated and complementary.

Social exclusion in the region involves multiple disadvantages which can only be addressed in an integrated way³¹. One route to tackling coordination problems at local level would be to focus on outcomes for socially excluded target groups and to work towards a problem-solving agenda where a common problem is identified and a strategy to address this jointly agreed⁶⁹.

4.2.3 Travellers

The national Traveller Health Strategy²⁴ states that not enough is known about the pattern and use of drugs and alcohol in the Traveller community and recommends that more research be conducted in this area. This lack of information applies to Travellers themselves as well as to service providers. However, drinking, smoking and related illnesses were among the most common issues identified by Travellers when consulted on their health needs¹⁰⁰.

The national Traveller Health Strategy seeks to promote awareness among the Regional Drugs Task Forces of the issues for Travellers in relation to drug use and to ensure that there is recognition and inclusion of Travellers in the development of strategies and plans.

The Traveller Health Strategy²⁴ proposed a number of actions including the following:

- Any research into Traveller health and lifestyles to include research into the pattern of use of alcohol and drugs.
- Service providers in the area of substance misuse to be made aware of the results of research and of the importance of including Travellers in the planning and delivery of services.
- Ensure access to services is improved.
- Travellers will be involved in the design of targeted substance misuse prevention.
- Training of Traveller Community Health Workers around education and prevention approaches to substance misuse.

The Task Force has identified a need for research into substance use and related issues in the Traveller community, and recognises the importance of assertive outreach in meeting the service needs of this client group. Substance misuse initiatives in the Traveller community should be culturally appropriate and peer-led, "to enable Travellers to respond to misuse issues on their own terms"¹⁰⁰.

4.2.4 Homelessness

A study of the health status of homeless people in the West⁴⁸ found that homeless people experience significant inequalities in health and are in particular need of health promotion interventions. Referring to substance use in this population group, the report stated that

“addiction makes it difficult for those affected to break the cycle of homelessness”. The main pathways to homelessness were a range of inter-related factors including addictions, mental health problems, relationship difficulties and poverty. 80% of the study participants were current smokers and 60% were current drinkers. Over half of current drinkers scored 2 or more on the CAGE alcoholism screening instrument, indicating alcohol problems. A quarter of those who used drugs had drug problems warranting further investigation, as indicated by the Drug Abuse Screening Test, while over a third had substantial problems requiring intensive assessment. The report recommended that “alcohol counselling and treatment services, including outreach facilities, should be reviewed with a view to increasing the uptake of services by homeless people”.

A comprehensive study of substance use and homelessness in the country’s four main urban centres (including Galway) was carried out in 2003, the first of its kind in Ireland⁵⁷. The prevalence of substance misuse in the homeless population was substantially higher than in the general population. 70% of the study participants were drinkers, and half of this group had a high level of alcohol problems. 52% overall had used an illegal drug (mainly cannabis) in the last month, and of these almost two thirds were assessed as having a drug dependence problem. Nearly one in five of the total study population were engaged in concurrent problematic alcohol and drug use. Substance misuse was cited as both a significant cause of first becoming homeless and as a major factor in remaining homeless. 30% overall had ever been admitted to a psychiatric hospital and over half had been imprisoned. Although the prevalence of heroin use in the West was very much lower than in the Dublin area, its impact was still felt by homeless services. A need was identified by homeless service workers for low threshold facilities with a harm reduction orientation, including needle disposal and exchange facilities, that would help to engage and retain the more chaotic and high-risk drug users in the services generally.

These and other related issues are under active consideration by the Homeless Forum in Galway, who are at present assessing the needs of homeless persons with substance misuse problems and the possible services responses. Options being considered include a ‘wet house’ (where alcohol is permitted in the building) or ‘low threshold facility’ (where there is a greater tolerance of people staying in the building having consumed alcohol or drugs). There is no ‘dry’ hostel at this time, nor is there any street outreach. Meanwhile, there are few places available in community treatment programmes, and waiting lists are lengthy. Homeless services have called for a more client-centred approach to service provision that facilitates access and responds to the particular needs of homeless people with drug and alcohol problems. To respond to these issues, the Task Force has identified a need for a Community Substance Misuse Worker to provide

specialist services for the homeless agencies. The Task Force also now has a representative on the Homeless Forum and will therefore be closely involved in future developments.

4.2.5 Prisoners

There is one prison in the GMR area, Castlerea, which caters for male offenders aged 17 and over. The prison's committal region comprises all of Connacht, plus the counties of Longford, Donegal, Cavan and Monaghan, but prisoners may also be transferred to Castlerea from other prisons around the country. The total number of committals (convicted and remand) to the prison during 2003 was 1431, the daily average number in custody being 195, or 102% of bed capacity⁵¹. In 2004, 54% of prisoners were from within the GMR area – 35% from County Galway (84% of these from Galway City), 15% from Mayo, and 4% from Roscommon – and 75% of prisoners were unemployed⁸⁴.

The Task Force must be cognisant of issues relating to prisoners' drug and alcohol problems that may become apparent not just during their incarceration in Castlerea but also pre-sentencing and post-release. Anecdotal reports from service providers familiar with the prison suggest that substance misuse is very prevalent. "There is little doubt but that much crime leading to imprisonment results from substance (including alcohol) misuse", therefore tackling drug addiction should be "a central part of any crime prevention strategy and measures to tackle [drug and alcohol] addiction in the prison system should be intensified and given greater priority"⁷⁰.

A wide range of individual and group programmes is provided by Castlerea Prison to assist prisoners with addiction and other problems. Harristown House, situated beside the prison, was established in 1998 and is funded by the Department of Justice, Equality & Law Reform through the Probation & Welfare Service⁷⁰. It offers a six-week residential programme providing addiction treatment for up to 12 men at a time. This is followed by a two-year aftercare support programme, involving the participants and their families. An addiction counsellor from the HSE Western Area Drugs Service attends the prison one day per week. Voluntary agencies, such as Alcoholics Anonymous, also visit the prison and "engage with a large number of prisoners"⁵¹. A new initiative, the You Are Equal project, is working on developing the employability of former prisoners⁸⁴. This project is a network of statutory bodies and community/voluntary groups that work with serving and former prisoners, and focuses on both securing and maintaining employment by addressing issues such as homelessness, addiction and personal development.

It is evident, however, that need outweighs the services currently available and that more and better coordinated services are required within the prison. There is also a need for well-coordinated

follow-up services to assist prisoners and their families in resettlement and re-integration and to prevent relapse and re-offending. Waiting lists are too long, and sometimes this may result in a prisoner being transferred to another institution before receiving treatment or counselling, only to end up back at the end of another waiting list elsewhere. Protocols regulating access to treatment may vary from one prison, agency or administrative region to another, which complicates referrals both within the prison system and after release. Barriers such as these only serve to obstruct and discourage prisoners who are trying to seek help.

In addition to the need for a comprehensive response to problems with treatment service provision, significant institutional reform is also required. The National Economic & Social Forum recommended that, with prisoner re-integration as a key goal, "all prisoners under sentence should have a comprehensive Sentence Management Plan developed on committal by a multi-disciplinary team with the cooperation of the prisoner and in consultation with other stakeholders"⁷⁰. Prisoners' addiction treatment needs should be put in place as part of their Sentence Management Plan, and the health services should ensure that all prisoners on treatment programmes in custody have their treatment continued on release. However, two years later the NESF, while acknowledging the positive developments that have taken place in the Prison Service, stated that it was "concerned at the pace of change in some instances, such as the system of Positive Sentence Management which has not yet come on stream"⁷¹. Difficulties with implementing cost-cutting measures initiated by the Department of Justice, Equality & Law Reform are also having a detrimental effect on some promising and effective rehabilitative programmes for prisoners⁵⁶. It is important that Castlerea prison should not be adversely affected by these difficulties and that existing programmes and initiatives are supported and strengthened.

5 TREATMENT

Treatment is a vital part of reducing drug and alcohol related harm to individuals, families and communities. The National Drug Treatment Reporting System (NDTRS) defines treatment as “any activity targeted at people who have problems with substance use (excluding tobacco), and which aims to improve the psychological, medical and social state of individuals who seek help for their problem”²⁷.

The National Drugs Strategy treatment objectives are:

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

The growing evidence for the cost effectiveness of addiction treatments must be acknowledged and acted upon. If properly resourced, comprehensive treatment services were provided, Irish taxpayers could expect a ten-fold return on their investment, in terms of lower utilisation of other health services, reduced criminal activity, decreased dependence on social welfare and increased work productivity⁵⁰.

5.1 TREATMENT SERVICES IN THE REGION

The current statutory and non-statutory/voluntary treatment and rehabilitation service provision includes:

- Western HSE Addiction Counselling Services
- HSE Western Area Drugs Service
- Hope House, Foxford, Co. Mayo
- Harristown House, Co. Roscommon
- Cuan Mhuire, Athenry, Co Galway

The Task Force recognises and values the work of the existing staff in the statutory health services

and the voluntary sector. We need to draw on the strengths and expertise of those currently working in the field. The Task Force hopes to forge links and relationships with all the main agencies to enhance service provision and create integrated care pathways.

In order to increase the uptake of service provision, it is essential to have a range of direct access treatment services easily available. The services need to accommodate people who experience drug problems at all levels, from experimentation to dependence. The range of service provision should include local provision of both community and inpatient detoxification, access to residential rehabilitation programmes as well as aftercare relapse prevention and support programmes.

Treatment services should enable access by people from all user groups. Services need to identify and remove any barriers that limit access and explore new ways of working that are flexible to the needs of clients, in order to increase uptake. Homeless clients or clients from many marginalised groups may require assertive outreach and community programmes that will provide for them in more appropriate setting.

To improve any individual's overall health and help them to achieve a drug-free lifestyle, service delivery should focus on contributory factors that impact on personal health status such as mental health, diet and nutrition, stress management, employment status and living conditions.

Drugs and alcohol impact not only on the individual drug user but also on partners and families. It is important therefore that support services are aware of the negative impact of drug misuse on significant others. Programmes should be made available that offer people support to deal with a problem drug user in the family, through education or by offering practical support and intervention to protect vulnerable family members from potential drug-related harm.

It must be recognised that not every drug or alcohol misuser is going to want or be able to achieve a drug/alcohol free lifestyle. Treatment service provision needs to accommodate those who continue to engage in drug/alcohol taking activities that put them at risk and work to engage them in treatment programmes. Treatment programmes need to be flexible and meet the clients needs. They need to follow best practice guidelines and be subject to regular monitoring and evaluation.

Whilst there is general recognition of the work done by the existing counselling services, the consultation process highlighted the considerable gaps that remain in service provision. In particular there was significant anger expressed that a valuable inpatient service was

closed down in Ballinasloe without consultation or forward planning to accommodate clients' treatment needs in the community.

5.1.1 Gaps in service provision identified in the consultation process

- Lack of a consistent primary health care screening programme
- Insufficient dedicated detoxification beds for alcohol in the region
- No dedicated detoxification beds for drug users in the region
- No clear treatment pathway for people requiring inpatient stabilisation
- No clear treatment protocol in Accident & Emergency departments
- No standardised referral process for rehabilitation
- Inadequate funding of rehabilitation
- No community-based alcohol detoxification programmes
- No specialist substance misuse consultant
- Inadequate treatment for drug users with concurrent mental disorder
- No standardised relapse prevention programmes
- No residential services to accommodate street drinkers
- No needle exchange programme for injecting drug users
- Very few user support groups
- Very few workplace Employee Assistance Programmes
- No targeted back-to-work rehabilitation programmes
- No consistent access to family therapy or long term psychotherapy
- No counsellors targeted at homeless drinkers or drug users
- No protocol for drug screening
- No recording of drug and alcohol related harm data
- No clear treatment protocol for under 18s
- No supportive accommodation for homeless people undergoing community treatment programmes.
- Lack of anger management interventions

5.1.2 Questions of priority

This long list of gaps raises questions of priority in health service policy and provision:

- Where do drug and alcohol issues fit in the new health service structures?
- Why has drug misuse been prioritised when alcohol misuse is a far bigger problem?
- How do we square the circle of 'deregulation' of the sale of alcohol with the lack of funding or priority for treatment service provision?
- How do we deal with the impact of drugs and alcohol on public order offences, personal safety, domestic violence, drink driving, suicide, work-related accidents, and sexually transmitted diseases?

There are many more negative impacts of drug and alcohol misuse: increased reporting of drug-related mental health problems, drugs as a conduit to criminal activity, drug-associated behavioural problems, ever-earlier experimentation and, for some, subsequent problem drug misuse. It is essential that the Task Force addresses these and other important issues in the coming years.

5.2 TOWARDS INTEGRATED CARE

The Task Force is seeking to set up a working group involving the Health Services Executive and other local service providers to plan the development of treatment service provision and integrated care pathways.

5.2.1 The goals of integrated care

There are a number of different treatment philosophies and approaches used in the drugs and alcohol field. Their overall aims are to:

- Reduce illicit drug use and drug related harm
- Reduce the harm caused by alcohol misuse
- Improve all aspects of health
- Reduce involvement in criminal activity
- Improve personal, social and family functioning
- Improve education and employment prospects
- Improve stability of housing and accommodation.

5.3 ISSUES TO BE CONSIDERED

Benzodiazepine misuse

Society has developed an over-reliance on medication such as tranquillisers, sleeping tablets, painkillers and over-the counter medicines. In 2002 the Department of Health and Children published a report on benzodiazepine misuse which stated that “concerns have been raised over many years about the potential for misuse of benzodiazepines amongst a range of users”, in particular illicit drug misusers and the elderly⁶.

Therapeutic alternatives

It is timely therefore that we explore the appropriateness of having a range of therapies readily available. The talk therapies such as counselling, psychotherapy and family therapy are well recognised as successful interventions and support mechanisms for people with dependence problems. It would also be helpful to consider the value of other safe and effective complementary therapies as supportive options for those experiencing substance misuse problems.

Suicide and substance misuse

Careful consideration must be given to the apparent link between substance misuse and suicide. Since little is known about the real nature of the association, it is very important to research this issue further and to explore interagency developments that can reduce the incidence of suicide.

Dual diagnosis: substance use and mental disorders

Comorbidity or dual diagnosis (simultaneous drug problems and mental illness in the same person) is often underestimated and underdiagnosed. Research has shown that many problem drug users also suffer from mental illness, and a significant proportion of people diagnosed with a psychiatric illness have a history of substance misuse³⁰. Concurrent problems of this nature place individuals at high risk, but services are not there to meet the need. For example, a recent study of drug use among the homeless found that one third of problem drug users had been diagnosed with a psychiatric illness, yet providers of services for the homeless reported that there was “no service which was prepared to deal with drug use and mental health problems simultaneously”⁵⁷. In Ireland, as in many other European countries, “health and social policy is still in its infancy in terms of recognising and planning for service provision in this field”⁶¹. Much work needs to be done to develop an understanding of the nature and extent of comorbidity in Ireland and the GMR region, and to create a framework for an integrated service response to this complex issue.

Evidence-based practice

The Task Force is anxious to ensure that all treatment services adhere to and demonstrate evidence-based practice. There is a large body of evidence to support the effectiveness of opportunistic screening and brief interventions for alcohol and drug misusers in a wide variety of settings³. Early intervention is essential.

Screening

The use of validated screening tools is invaluable in the early identification of substance misuse problems. For example, the CAGE questionnaire is a simple method of screening to assess the presence of an alcohol problem, and the World Health Organisation AUDIT questionnaire includes questions about alcohol consumption, alcohol related problems and alcohol dependence.

Brief interventions

In patients with minimal alcohol dependence but who are drinking above safe limits, brief interventions have been demonstrated to have lasting beneficial effects. The most effective method of brief intervention is motivational interviewing. A follow up interview can help to reinforce change or prompt the investigation

Access to treatment services

When a client of a service is assessed as possibly having an alcohol or drug problem, there should be a clear treatment pathway and quick access to a range of services at local level. It is possible currently to get assessment and counselling services, but there is a lack of community-based detoxification programmes and no clear access route to inpatient detoxification or treatment.

Community-based detoxification

It is essential that community-based alcohol detoxification services are developed in the Western region. These programmes can support people in their own community and/or prepare them for rehabilitation.

Inpatient detoxification

Service provision in the region should include access to local beds for people requiring inpatient detoxification for problem alcohol and drug use.

Rehabilitation

There are three inpatient rehabilitation units in the Western region: Hope House, Cuan Mhuire and Harristown House. Funding is required to support these programmes and there is no clear rehabilitation budget from the Health Service.

6 SUPPLY REDUCTION

Supply reduction is the fourth pillar of the National Drugs Strategy. In the context of illicit drugs, it is essential that efforts are continued to prevent the flow of banned substances into and out of the region and to interrupt the local supply of drugs where this occurs. Regarding alcohol, supply reduction mainly involves enforcement of laws regulating the sale of alcohol.

The supply reduction objectives of the National Strategy are:

To significantly reduce the volume of illicit drugs available in Ireland, to arrest the dynamic of existing markets and to curtail new markets as they are identified.

To significantly reduce access to all drugs, particularly those drugs that cause most harm amongst young people, especially in those areas where misuse is most prevalent.

The two main agencies involved in supply reduction efforts are the *Gárda Síochána* and the Revenue Commissioners, both of which are represented on the Task Force. However, other statutory and non-governmental agencies, as well as urban and rural communities in the region, all have their role to play⁶⁸.

6.1 GÁRDA SÍOCHÁNA

The *Gárda Síochána*, as well as working nationally and internationally on the problem of drug trafficking, are also involved in a range of local initiatives. The *Gárda Drug Policy* endorses the partnership approach to tackling drug misuse, and places a high priority on "rigorous enforcement of all drug legislation as a means of reducing the supply of drugs within society"³⁷. Three main priorities were identified in this policy:

- The conducting of intelligence-driven operations against all levels of drug distribution and the support structures that facilitate drug distribution
- The commitment of specific resources at both a national and local level commensurate with the threat posed by drug distribution

. . . supply reduction

- Working in partnership with other groups and agencies including local communities, Customs, the Naval service, and both voluntary and statutory services.

In addition to enforcing legislation dealing with drug and alcohol issues (including the *Misuse of Drugs Act*, *Criminal Justice (Public Order) Act* and *Intoxicating Liquor Act*) the *Gárda Síochána* also operate within the framework of policies including the *National Drugs Strategy*, the *Gárda Youth Advisory Group Report*, the *Uniform Approach to Licensing Law Enforcement Report* and the *National Report on Drugs-Crime Linkage*. The goals of the *Gárda Síochána* nationally are:

- To enforce the law relating to sale and supply of drugs
- Deal with underage drinking on the streets
- Tackle the sale of alcohol to those underage
- Deal with underage drinking in pubs
- Supervise licensed premises.

Each *Gárda* division in the GMR area (Galway West, Mayo and Roscommon/Galway East) also produced its own Divisional Policing Plan in 2004. Specific actions included in these plans are aimed at tackling alcohol and drug misuse issues through a combination of detection, enforcement, prevention and education.

Actions aimed at tackling alcohol misuse in the region include

- Strict enforcement of legislation and consistent application of *Gárda* policy in relation to alcohol sales
- Identification and prosecution of establishments that supply alcohol to minors
- Promotion of Age Cards for young people
- Maintaining a register of inspections of premises in each district
- Strict enforcement of legislation regarding street drinking
- Identification and targeting of public order flashpoints
- Contact to be maintained with members of the licensed trade regarding their roles and responsibilities
- Continuation of the *Gárda* Schools Programme
- Continued *Gárda* support for and involvement in the 'No Name' Clubs throughout the region.

Actions aimed at tackling illegal drugs include

- Each district to compile a District Drugs Policing Plan
- Inter-divisional sharing of intelligence and personnel to combat the supply and sale of illegal drugs
- Liaison with other agencies involved in combating illegal drugs
- Monitoring, identification and targeting of local drug suppliers
- Liaising with Criminal Assets Bureau regarding confiscation of the assets of drug dealers
- Liaising with nightclub security staff with a view to preventing drug supply and use
- All major music events to be policed
- Liaising with schools to increase awareness of the dangers of drug abuse.

It is anticipated that, within the framework of the Gárda Establishment Redistribution Model (a tool for the rational deployment of Gárda resources), increased resources will be deployed where needed in the GMR area. The assets of criminals involved in drug dealing are being targeted, and an application has been made for the services of the Gárda National Drugs Unit to carry out Operation Cleanstreet (an undercover operation targeting drug dealers that has been successfully conducted in other parts of the country) in Galway and other larger towns in the region. The employment of civilian staff to release Gárda officers from administrative duties, and the setting up of a dedicated Traffic Corps, would provide more Gárdaí for much-needed community policing²⁶.

6.2 CUSTOMS & EXCISE

Customs Officers work closely with other agencies and are involved in a joint task force with the Gárda Síochána and the Naval Service. These bodies cooperate at a local level to prevent drug trafficking. The Customs National Drugs Team (CNDT) concentrates solely on combating the importation of illegal drugs into Ireland. In addition to its strategically-placed Intelligence, Operational, Maritime and Dog Units, all of which are mobile, the CNDT is also supported by outfield officials working in the GMR area who are responsible for the detection and prevention of drug smuggling as part of their normal duties. The CNDT operates a Drugs Watch programme aimed at alerting the public to drug trafficking and securing their cooperation in tackling the importation of illegal drugs. In the GMR area, the main bases for Drugs Watch officers are Galway and Castlebar. The CNDT also provides a confidential freephone number.

6.3 PARTNERSHIP IN CRIME PREVENTION

Supply of illegal drugs, and illegal supply of legal drugs, are perhaps inevitably associated with a range of other law-breaking or antisocial behaviours, many of which impinge directly on communities. For example, alcohol is involved in a large proportion of Public Order offences involving juveniles, the prevalence of which has greatly increased in recent years¹³. There is likely to be considerable overlap between supply reduction efforts and crime prevention generally. Although such endeavours are primarily the responsibility of the *Gárdaí*, the support and participation of all sectors of the community are also essential⁶⁸.

Recognising this, the National Crime Council has proposed a Crime Prevention Model based on a partnership approach designed to integrate with existing structures⁶⁸. Operating within the Social Inclusion Measures Working Groups of the City and County Development Boards, this initiative would seek to identify the underlying causes of local crime problems and develop targeted interventions aimed at confronting current crime and preventing new occurrences. The Crime Prevention Model emphasises the importance of intervention at the earliest possible stage, long-term planning and investment, and inter-sectoral coordination backed by a high level of commitment from management within the various agencies involved. These proposals were intended to be compatible with the work of the Regional Drugs Task Forces, and would therefore offer clear opportunities for ongoing collaboration.

Dealing effectively with the underlying causes of crime and antisocial behaviour will require approaches that have a combined focus on the needs of individuals at risk, building communities, appropriate community policing, and measures to tackle social, economic and educational disadvantage¹⁶. Local policing partnerships, properly resourced, would allow the *Gárda* to adopt a more pro-active approach in law enforcement and community policing²⁶.

6.3.1 Working with rural communities

Participatory Drugs Profiling is a UK police initiative which emerged from research and investigation into rural drug problems²⁰. Utilising the knowledge and skills of the police, in collaboration with voluntary and statutory agencies, and with the involvement of community members (including parents and young people), the scheme aims to establish a shared view of local drugs issues and how they may be tackled. PDP involves drawing up an authentic and locally relevant profile of an aspect of drug taking and uses this as the basis for task-oriented group discussions. The programme was developed for use in rural areas, with the aim of providing for the particular needs and social circumstances of rural communities. Further investigation and consideration of PDP, or similar programmes elsewhere if they exist, would be useful to determine whether

. . . supply reduction

such approaches could have benefits for community policing, supply reduction and crime prevention efforts in the rural West of Ireland.

7 SHARED SOLUTIONS

The job of the Task Force is to take a co-ordinating role in the development of projects that are specifically designed to prevent or tackle drug and alcohol misuse. The Task Force will look to existing service providers and agencies to continue their own development initiatives and ensure the complementarity of service development plans.

The Task Force wants to work with agencies and communities in urban and rural areas to identify their own needs, develop their own plans and prioritise their own developments. Rather than 'reinvent the wheel' it is our intention to seek integration with existing structures such as County Development Boards, Social Inclusion Measures Working Groups, Community Forums and others to support and enhance these development plans.

7.1 ISSUES TO BE ADDRESSED

The consultation process has identified a list of service gaps and other problems, as encountered by the public, local agencies and service providers. Listed below are issues requiring further consideration and analysis going forward. These will be examined in greater detail, and an implementation plan will be prepared, once full-time Task Force staff are appointed.

7.1.1 Protective factors

Planning ahead to reduce exposure to drug and alcohol misuse.

- The major service providers need to apply positive planning principles that foster safer and healthier communities. It is essential to provide positive alternatives and social support structures in the development of new communities. For example: community centres, crèches, schools, generic youth services, health advice cafes, GPs, pharmacists.
- Also important is the provision of good social and transport infrastructure that will allow access to leisure activities, cinemas, swimming pools, sports, recreation facilities and shops.
- In the small town/rural context these facilities are often absent and should be a priority for development.

- For people living in smaller towns or in rural areas, access to services is a significant issue. This needs further exploration and research.
- Increased access to mentoring projects such as Big Brother-Big Sister.
- Increased access to Neighbourhood Youth Projects, Youth Service projects and centres, Youth Advocacy Projects, and specialist support services that offer early intervention programmes.
- Increased Garda resources are needed to provide increased community policing initiatives, particularly in high risk areas.
- Early detection and disruption of drug dealing and supply.
- Introduction of a responsible sale of alcohol programme.
- A ban on alcohol advertising and sponsorship.
- Oppose "Happy Hours" and alcohol promoting events.
- There needs to be rigorous enforcement of the law and existing policies relating to alcohol and drugs use, as per the recommendations of the Strategic Task Force on Alcohol report.
- Health Services need to provide consistent local access to primary health care.
- Early identification of problems through screening and brief intervention programmes in all primary health care settings and in targeted youth projects.
- The Education sector needs to ensure that SPHE is provided and adequately resourced in all schools.
- Funding should be made available to enable communities to provide parenting programmes for raising awareness and helping parents deal with the consequences of drug and alcohol misuse and other related issues.
- Development of a multi-agency local drugs monitoring network to identify changes in substance use trends.
- Development of support services for marginalised groups.
- Targeted adult Peer Education projects, e.g. the Traveller health projects.
- Workplace policies that support early intervention for drug and alcohol users.
- Drug policies in schools and youth services that support early identification and intervention.
- Provision of easily available information on alcohol and drug issues and the services available (e.g. via helpline, advertising in local media).

7.1.2 Early intervention and treatment

Providing early access to help/treatment.

- Work with GPs in primary healthcare setting to improve screening and early intervention.
- Adequate direct access to assessment, counselling and support services for people who are experiencing drug or alcohol related problems.
- Assertive outreach programmes to target groups who are reluctant to access services.
- Community-based detoxification programmes for drugs and alcohol.
- Family support services to help families deal with the impact of drug or alcohol misuse.
- Provision of a range of supported treatment programmes.
- Supported housing for homeless people who require treatment interventions.
- Access to local detox beds for people requiring inpatient stabilisation or treatment.
- Access to specialist medical expertise to support the primary health care initiative with responsibility for the inpatient treatment programme.
- Provide a regional inpatient drug and alcohol treatment unit
- Support the urgent appointment of a medical Consultant post
- Assessment of the need for a needle exchange programme to reduce the harm caused by injecting drug use.
- Targeted diversion projects to engage people in treatment and other services as early as possible.

7.1.3 Rehabilitation and relapse prevention

Maintaining a drug-free lifestyle.

- Providing access to a sufficient number of rehabilitation beds and programmes, including through purchase of beds in existing residential rehabilitation centres.
- Support the further development of community-based relapse prevention programmes.
- Support programmes for users and families.
- FÁS programmes need to target drug and alcohol users.

7.1.4 Relevance and need

Projects must be drug or alcohol related, and should have direct relevance to the objectives and priorities of the Regional and National drug strategies. Project funding will be prioritised in relation to relevance and need, which will be monitored by the Task Force.

7.1.5 Monitoring and evaluation

All projects will be subject to monitoring and evaluation criteria. This will involve exploring the outcomes and the impact of the project in a systematic and rigorous manner.

7.1.6 Value for money

It is essential that projects or initiatives demonstrate value for money. Accounts and expenditure will be subject to audit as part of the evaluation process.

7.2 Outline of proposed developments and indicative costs

	Detail	Cost year1	Cost Year 2	Cost Year 3
Task Force staffing and setup				
Task Force Coordinator		60,000	60,000	60,000
Project Worker (Grade 5)		25,000	50,000	50,000
Administrator (Grade 4)		20,000	40,000	40,000
Training budget		5,000	25,000	25,000
Website development	Initial setup	5,000	N/A	N/A
Accommodation	Rent	10,000	20,000	20,000
	Insurance	3,000	5,000	5,000
	Start up costs	10,000	N/A	N/A
	Office supplies	5,000	10,000	10,000
Measures to address gaps in services				
4 Community Liaison posts (see Note 1 over)	Salaries	60,000	240,000	240,000
	Project costs	5,000	20,000	20,000
	Rent	6,000	20,000	20,000
	Office equipment	20,000	20,000	20,000
3 Education Support Workers (see Note 2)			180,000	180,000
3 Community Alcohol Detox posts (see Note 3)	Salary		180,000	180,000
	Project costs		20,000	20,000
	GP support	Cost to be determined by HSE/Dept. of Health ^s		
Substance Misuse worker for homeless (Note 4)	Salary	20,000	60,000	60,000
Pharmacy Liaison Worker (Note 5)	Salary		50,000	50,000
	Project costs		5,000	5,000
	Pharmacy support	Cost to be determined by HSE/Dept. of Health ^s		
3 Community Substance Misuse Brief Intervention Counsellors NUIG and GMIT (Note 6)		60,000	180,000	180,000
Substance Misuse Consultant post	HSE	Cost to be determined by HSE/Dept. of Health ^s		
Local inpatient detoxification beds (Note 7)	HSE	Cost to be determined by HSE/Dept. of Health ^s		
Regional inpatient drug & alcohol treatment unit (Note 8)	HSE	Cost to be determined by HSE/Dept. of Health ^s		
Rehabilitation beds (Note 9)		200,000	200,000	200,000
Residential support service for homeless people (Note 10)			1,100,000	1,100,000

Table continued on next page

Continuation: Outline of proposed developments and indicative costs

Grants				
Grants to community-based projects		N/A	200,000	200,000
Grants for education, information and support for families affected by addiction		N/A	100,000	100,000
Grants for primary prevention initiatives for young people		N/A	200,000	200,000
Research				
Substance misuse in the Traveller community			30,000	
Misuse of benzodiazepines and other medicines			30,000	
Service delivery for marginalised groups				50,000
Evaluation of Task Force Implementation Plan				30,000
	Total	514,000*	3,045,000*	3,065,000*

* Additional funding to be added for uncosted proposals marked § in table above.

NOTES ON DEVELOPMENT PROPOSALS

1: Community Liaison Workers

To appoint four Community Liaison Workers in Galway City and County, Mayo and Roscommon to link to the local Social Inclusion Measures Working Group of each County Development Board. These workers will

- Forge interagency collaboration and joint initiatives to tackle local problems.
- Help drive initiatives and co-ordinate developments in line with national and regional drug policies.
- Identify the local impact of substance misuse and local service needs.
- Help groups prioritise needs and developments.
- Raise awareness of substance misuse issues among agencies and community organisations.

2: Education Support Workers

Three posts, to support the implementation and the ongoing delivery of the SPHE programmes and other community based education programmes around substance misuse issues. Their role could also include linking with Post Primary Support Services, Home School Liaison Officers, the VECs' Adult Education and Community Education facilitators, parent support programmes, and other relevant services and personnel.

3: Community Drug & Alcohol Detoxification Workers

Three community-based nurses (one for each county)

- To support people on home detoxification programme.
- To liaise with GPs regarding care plan and treatment programme.

4: Pilot Project: Community Substance Misuse Worker for Homelessness

One Community Substance Misuse Worker to engage with homeless people in the hostels and support projects, to offer direct counselling, group work, support of treatment programmes and relapse prevention. This post can be split according to workload between COPE and Galway Simon Community, liaising with other relevant organisations as needed.

5: Pharmacy Liaison Worker

- To work with pharmacists, GPs and relevant agencies on the issue of misuse of benzodiazepines and other medicines.

- To work with pharmacies on addressing the need for and development of a needle exchange programme
- To offer training and support to pharmacists.

6: Community Substance Misuse Workers (Third Level Colleges)

These three posts will target the 18-24-year-old student population in National University of Ireland, Galway and the Galway & Mayo Institute of Technology. They will offer direct access brief intervention, assessment and counselling for substance misuse.

7: Inpatient detoxification beds

To provide local specialist inpatient alcohol and drug detoxification.

8: Regional inpatient drug & alcohol treatment unit

To replace the addiction treatment unit closed down in 2003, and to address a significant gap in services identified in Open Space consultations and by Task Force members.

9: Rehabilitation Beds

Funding to purchase rehabilitation beds/places for drug and alcohol clients in existing programmes.

10: Residential support service for homeless

- For people who are homeless, or at risk of becoming homeless, who are in need of a “dry” and drug-free environment.
- Start up costs and running costs.

REFERENCES

- 1 Anthony J, Wagner F (2000) Epidemiologic analysis of alcohol and tobacco use. *Alcohol Research & Health*, 24(4): 201-208.
- 2 Asthana S, Gibson A, Moon G, Brigham P (2003) Allocating resources for health and social care: the significance of rurality. *Health and Social Care in the Community* 11(6): 486-493.
- 3 Babor T, Caetano R, Casswell S *et al.* (2003) *Alcohol: no ordinary commodity*. Oxford: Oxford University Press.
- 4 Ballymun Youth Action Project (2004) *Benzodiazepines: whose little helper?* Dublin: National Advisory Committee on Drugs.
- 5 Bell J, Dru A, Fischer B, Levit S, Sarfraz M (2002) Substitution therapy for heroin addiction. *Substance Use & Misuse* 37(8-10): 1149-1178.
- 6 Benzodiazepine Committee (2002) *Report of the Benzodiazepine Committee*. Dublin: Department of Health & Children.
- 7 Border, Midlands & West Regional Assembly (2004) *BMW Regional Operational Programme progress report*. Accessed March 2005 at www.bmwassembly.ie
- 8 Bryan A, Moran R, Farrell E, O'Brien M (2000) *Drug-related knowledge, attitudes and beliefs in Ireland: report of a nation-wide survey*. Dublin: Drug Misuse Research Division, Health Research Board.
- 9 Butler S (2002) *Alcohol, drugs and health promotion in modern Ireland*. Dublin: Institute of Public Administration.
- 10 Central Statistics Office (2003) *Census 2002: principal demographic results*. Dublin: Stationery Office.
- 11 Central Statistics Office (2004) *National Income and Expenditure 2003*. Dublin: Stationery Office.
- 12 Centre for Health Promotion Studies (2003) *The National Health and Lifestyle Surveys: SLÁN (Survey of Lifestyle, Attitudes & Nutrition) and HBSC (Health Behaviour in School-aged Children)*. Galway: CHPS.

- 13 Clare E, Digney A (2003) *Public Order Offences in Ireland*. Dublin: National Crime Council.
- 14 Collins C, Connolly J, Crowley D, Morgan M (2004) *An overview of scientific and other information on cannabis*. Dublin: National Advisory Committee on Drugs.
- 15 Combat Poverty Agency (2001) *Tackling drugs at local level: a policy perspective*. Dublin: CPA.
- 16 Combat Poverty Agency (2002) *Submission to the National Crime Council on the consultation paper 'Tackling the Underlying Causes of Crime: A Partnership Approach'*. Dublin: CPA.
- 17 Corrigan, D (2003) *Facts about drug misuse in Ireland*. Dublin: Health Promotion Unit.
- 18 Countryside Agency (2004) *Young people in rural areas*. Accessed February 2005 at www.countryside.gov.uk
- 19 Dáil Éireann (2005) *Parliamentary Debates Official Report*, Volume 599, No. 3, March 9. Accessed April 2005 at www.oireachtas.ie
- 20 Davidson N, Sturgeon-Adams L, Burrows C (1997) *Tackling rural drugs problems: a participatory approach [Crime Detection and Prevention Series Paper 81]*. London: Home Office Police Research Group.
- 21 Department of Education & Science (2000) *Junior Cycle Social, Personal and Health Education*. Dublin: Dept. of Education & Science.
- 22 Department of Education & Science (2003) *Circular M11/03: Social, Personal and Health Education in all schools by September 2003*. Dublin: Dept. of Education & Science.
- 23 Department of Finance (1999) *National Development Plan 2000-2006*. Dublin: Stationery Office.
- 24 Department of Health & Children (2002) *Traveller health: a national strategy 2002-2005*. Dublin: DH&C.
- 25 Department of Tourism, Sport & Recreation (2001) *Building on experience: National Drugs Strategy 2001-2008*. Dublin: Stationery Office.
- 26 Doherty D (2003) *Galway City RAPID Strategic Plan*. Galway: Community & Enterprise Dept., Galway City Council.

- 27 Drug Misuse Research Division (2003) *Trends in treated drug misuse in the Republic of Ireland, 1996 to 2000 [Occasional Paper No. 9]*. Dublin: Health Research Board.
- 28 Drug Misuse Research Division (2004) *Treatment demand in the seven health board areas outside the Eastern Regional Health Authority, 1998 to 2002 [Occasional Paper No. 11]*. Dublin: Health Research Board.
- 29 European Foundation for the Improvement of Living and Working Conditions (2003) *Social inclusion: local partnerships with civil society*. Luxembourg: Office for Official Publications of the European Communities.
- 30 European Monitoring Centre for Drugs & Drug Addiction (2004) *Co-morbidity: drug use and mental disorders [Drugs in Focus 14]*. Lisbon: EMCDDA.
- 31 Fitzpatrick Associates (1999) *Border, Midlands and Western NUTS II Region Development Strategy 2000-2006*. Accessed February 2005 at www.fitzpatrick-associates.com
- 32 Fitzpatrick Associates (2003) *Mid-term evaluation of the Border, Midland and Western Regional Operational Programme*. Accessed March 2005 at www.fitzpatrick-associates.com
- 33 Flynn S (2005) Literacy and numeracy crisis in disadvantaged schools. *Irish Times*, March 28.
- 34 Forsyth A, Barnard M (1999) Contrasting levels of adolescent drug use between adjacent urban and rural communities in Scotland. *Addiction* 94(11): 1707-1718.
- 35 Galway City Development Board (2002) *Gaillimh Beo agus Briomhar: Strategy for Economic, Social and Cultural Development 2002-2012*. Galway: GCityDB.
- 36 Galway County Development Board (2002) *Working Together, Shaping Our Future: Galway County Strategy for Economic, Social & Cultural Development 2002-2012*. Galway: GCoDB.
- 37 Gárda Síochána (2001) *An Gárda Síochána Drug Policy*. Accessed November 2004 at www.garda.ie/angarda/pub/drugpolicy.html.
- 38 Geary T, Mannix McNamara P (2002) *Implementation of Social, Personal & Health Education at Junior Cycle: national survey report*. Limerick: University of Limerick.
- 39 Heanue K (2002) *The missing people: a strategic approach to rural repopulation*. Dublin: Area Development Management Ltd.
- 40 Henderson S (1998) *Drugs prevention in rural areas: an evaluation report*. London: Home Office Drugs Prevention Initiative.

- 41 Henquet C, Krabbendam L, Spauwen J *et al.* (2005) Prospective cohort study of cannabis use, predisposition for psychosis, and psychotic symptoms in young people. *British Medical Journal* 330(7481): 11-15.
- 42 Henry J, Oldfield W, Kon O (2003) Comparing cannabis with tobacco. *British Medical Journal* 326: 942-943.
- 43 Hibell B, Andersson B, Ahlström S *et al.* (2000) *The 1999 ESPAD Report: alcohol and other drug use among students in 30 European countries*. Stockholm: Swedish Council for Information on Alcohol and Other Drugs/Pompidou Group of the Council of Europe.
- 44 Hibell B, Andersson B, Bjarnason T *et al.* (2004) *The ESPAD Report 2003: alcohol and other drug use among students in 35 European countries*. Stockholm: Swedish Council for Information on Alcohol and Other Drugs/Pompidou Group of the Council of Europe.
- 45 Holder H (2003) Population drinking and alcohol harm: what these Canadian analyses tell us [Editorial]. *Addiction* 98: 865-866.
- 46 Home Office (2005) *Classification of cannabis* [press release]. Accessed March 2005 at www.homeoffice.gov.uk
- 47 Hope A, Dring C, Dring J (2005) *College Lifestyle and Attitudinal National Survey*. Dublin: Department of Health & Children.
- 48 Hourigan S, Evans D (2003) *A picture of health: a study of the health status and health promotion needs of homeless people in the West*. Galway: Health Promotion Services, Western Health Board.
- 49 Hutchinson L, Blakely C (2003) *Substance abuse trends in rural areas: a literature review*. In Gamm L *et al.* (eds.) *Rural Healthy People 2010*. Texas: School of Rural Public Health, Texas A&M University System Health Science Center.
- 50 Irish College of Psychiatrists (2005) *Developing and delivering world-class alcohol treatment services in Ireland: a response to the Strategic Task Force on Alcohol Second Report*. Accessed March 2005 at www.irishpsychiatry.com
- 51 Irish Prison Service (2004) *Annual Report 2003*. Accessed April 2005 at www.irishprisons.ie
- 52 Kelleher M, Keeley H, Corcoran P (1997) The service implications of regional differences in suicide rates in the Republic of Ireland. *Irish Medical Journal* 90(7): 262-264.

- 53 Kelly A, Carvalho M, Teljeur C (2003) *Prevalence of opiate use in Ireland 2000-2001: a 3-source Capture Recapture study*. Dublin: National Advisory Committee on Drugs.
- 54 Kiernan R (1995) *Report on substance use among adolescents in the Western Health Board*. Accessed November 2004 at www.ndc.hrb.ie
- 55 Kypri K, Langley J, McGee R, Saunders J, Williams S (2002) High prevalence, persistent hazardous drinking among New Zealand tertiary students. *Alcohol and Alcoholism* 37(5): 457-464.
- 56 Lally C (2005) Throwing away the key? *Irish Times [Weekend Review]*, April 30.
- 57 Lawless M & Corr C (2005) *Drug use among the homeless population in Ireland*. Dublin: National Advisory Committee on Drugs.
- 58 Layte R, Whelan C (2004) *Explaining social class differentials in smoking: the role of education [Working Paper no. 12]*. Dublin: Economic & Social Research Institute.
- 59 Ledwidge M (2005) *Discussion document on the problem of OTC medicine and codeine product misuse and abuse*. Dublin: Pharmaceutical Society of Ireland.
- 60 Lindsay G, Rainey J (1997) Psychosocial and pharmacologic explanations of nicotine's 'gateway drug' function. *Journal of School Health*, 67(4): 123-126.
- 61 MacGabhann L, Scheele A, Dunne T *et al.* (2004) *Mental health and addiction services and the management of dual diagnosis in Ireland*. Dublin: National Advisory Committee on Drugs.
- 62 Mayo County Development Board (2002) *Maigh Eo le chéile le neart: integrated strategy for the economic, social & cultural development of County Mayo*. Castlebar: Mayo CDB.
- 63 Mid-Western Health Board (2002) *Traveller health strategy statement and action plan*. Limerick: MWHB.
- 64 Moran R, O'Brien M, Dillon, L, Farrell E, Mayock P (2000) *National report on drug issues Ireland 2000*. Dublin: Health Research Board.
- 65 Morgan M (2001) *Drug use prevention: overview of research*. Dublin: National Advisory Committee on Drugs
- 66 National Advisory Committee on Drugs (2003) *An overview of cocaine use in Ireland*. Dublin: NACD.

- 67 National Advisory Committee on Drugs (2004) *Drug use in Ireland and Northern Ireland: Bulletin 2*. Dublin: NACD.
- 68 National Crime Council (2003) *A crime prevention strategy for Ireland: tackling the concerns of local communities*. Dublin: Stationery Office.
- 69 National Development Plan/Community Support Framework Evaluation Unit (2003) *Evaluation of Social Inclusion Coordination Mechanisms*. Accessed January 2005 at www.ndp.ie/evaluation
- 70 National Economic & Social Forum (2002) *Re-integration of prisoners [Report no. 22]*. Dublin: NESF.
- 71 National Economic & Social Forum (2004) *Fourth periodic report on the work of the NESF [Report no. 30]*. Dublin: NESF.
- 72 National Roads Authority (2002). *Road Accident Facts*. Dublin: NRA.
- 73 National Safety Council (2004) *Alcohol a factor in 4 out of 10 road deaths*. Accessed December 2004 at www.nsc.ie
- 74 National Youth Council of Ireland (2002) *Submission to the National Crime Council's publication 'Tackling the Underlying Causes of Crime'*. Accessed January 2005 at www.youth.ie
- 75 Nic Gabhainn S, Comer S (1996) *Substance misuse in the Western Health Board: prevalence, practice and proposals*. Galway: Centre for Health Promotion Studies, National University of Ireland, Galway.
- 76 Office of Tobacco Control (2004) *Ireland: trends in tobacco consumption*. Accessed December 2004 at www.otc.ie
- 77 Organisation for Economic Cooperation and Development (2001) *Local partnerships for better governance*. Paris: OECD Publications Service.
- 78 Patton G, Coffey C, Carlin J *et al.* (2002) Cannabis use and mental health in young people: cohort study. *British Medical Journal* 325: 1195-1198.
- 79 Public Health Alliance Ireland (2004) *Health in Ireland: an unequal state*. Accessed November 2004 at www.publichealthallianceireland.org
- 80 Ramstedt M, Hope A (2003) *The Irish drinking culture: drinking and drink-related harm, a European comparison*. Dublin: Department of Health & Children.

- 81 Revenue Commissioners (2004) *Annual Report 2003*. Dublin: Revenue Commissioners.
- 82 Rey J, Tennant C (2002) Cannabis and mental health. *British Medical Journal* 325: 1183-1184.
- 83 Roscommon County Development Board (2002) *Common Vision: Strategy for the Economic, Social & Cultural Development of County Roscommon*. Roscommon: CDB.
- 84 Roscommon Partnership (2005) Email communication, April 29.
- 85 Rose G, Day S (1990) The population mean predicts the number of deviant individuals. *British Medical Journal* 301: 1031-1034.
- 86 Scott S, Knapp M, Henderson J, Maughan B (2001) Financial cost of social exclusion: follow up study of antisocial children into adulthood. *British Medical Journal* 323: 1-5.
- 87 Seanad Éireann (2005) *Parliamentary Debates Official Report*, Vol. 179, No. 8, February 16. Accessed March 2005 at www.oireachtas.ie
- 88 SPHE Support Service (2005) Email communication, April 19.
- 89 Sprenger B (2004) *The forgotten 'West' of Ireland: diversification and rural development*. Paper presented at the international conference "EU at the margins: EU Regional policy, rurality and peripherality" in Angers, France, 15-16 April 2004. Accessed January 2005 at www.regional-studies-assoc.ac.uk/events/150404papers.asp
- 90 Strategic Task Force on Alcohol (2004) *Second Report*. Dublin: Health Promotion Unit, Department of Health & Children.
- 91 US Department of Health and Human Services (1988) *The health consequences of smoking and nicotine addiction*. A report of the Surgeon-General, US Department of Health and Human Services, Publication No. (CDC) 88-8406. Washington: DHHS.
- 92 US National Institute on Alcohol Abuse and Alcoholism (1998) *Alcohol and tobacco (Alcohol Alert no. 39)*. Accessed January 2005 at www.niaaa.nih.gov
- 93 US National Institute on Drug Abuse (2001) *Nicotine addiction [Research Report no. 01-4342]*. Accessed January 2005 at www.drugabuse.gov
- 94 Van Os J, Bak M, Hanssen M *et al.* (2002) Cannabis use and psychosis: a longitudinal population-based study. *American Journal of Epidemiology* 156(4): 319-327.
- 95 Verdoux H, Gindre C, Sorbara F *et al.* (2003) Effects of cannabis and psychosis vulnerability in daily life: an experience sampling test study. *Psychological Medicine* 33: 23-32.

- 96 Wagner F, Anthony J (2002) Into the world of illegal drug use: exposure opportunity and other mechanisms linking the use of alcohol, tobacco, marijuana and cocaine. *American Journal of Epidemiology*, 155(10): 918-925.
- 97 Watters N, Byrne D (2004) *The role of family support services in drug prevention*. Dublin: National Advisory Committee on Drugs.
- 98 Webster-Stratton C (2001) Nipping conduct problems in the bud [Commentary]. *British Medical Journal* 323: 7.
- 99 Western Development Commission (2003) *Annual report 2003*. Accessed March 2005 at www.wdc.ie
- 100 Western Health Board (2003) *Plan for Travellers' Health*. Galway: WHB.

ANNEX 1: TASK FORCE MEMBERS

WRDTF members in 2005

Name	Organisation	Role on the Western Region Drugs Task Force
Padraig Hughes	Western RDTF	Cathaoirleach
Fiona Walsh	HSE, Galway	Interim Coordinator
John Harkin	FÁS	Representing National Drugs Strategy Team
Cllr. Brian Walsh	Galway City Council	Representing Western Regional Authority
Cllr. Michael Mullins	Galway County Council	Representing Western Regional Authority
Cllr. Dominick Connolly	Roscommon County Council	Representing Western Regional Authority
Cllr. Austin Francis O'Malley	Mayo County Council	Representing Western Regional Authority
Insp. PJ Durkin	Gárda Síochána, Galway	Representing Gárda Síochána
John Kilcommins	Probation Services Roscommon	Representing Probation Services
Dick O'Donovan	Foróige, Galway	Representing Foróige National Youth Development Organisation
Frank Kelly	FÁS, Galway	Representing FÁS
Michael Lovett	Customs and Excise, Galway	Representing Customs & Excise
Maeve Murray	Galway City Partnership	Representing Galway City Partnership
Attracta Canny	Hope House, Foxford	Voluntary Sector Representative
Liam Moroney	Roscommon Youth Services	Voluntary Sector Representative
Orla Nugent	AIDS West, Galway	Voluntary Sector Representative
Anja Branton	Simon Community, Galway	Voluntary Sector Representative
Donna O'Neill	COPE, Galway	Voluntary Sector Representative
Emmet Major	Cuan Mhuire, Galway	Voluntary Sector Representative
Joe O'Neill	Galway City Council	Representing Galway City & County Managers
Stan Sjothun	Galway City Community Forum	Community Representative, Galway City
Noreen Ronaldson	Refugee Council, Ballinasloe	Community Representative, Galway County
Michele Reynolds	Mayo County Community Forum	Community Representative, Mayo
Dolores Duggan	Hope House, Foxford, Co. Mayo	Representing Hope House
Eithne Nic Dhonnchadha	Galway County VEC	Representing Galway County VEC
Davnett McEllin	Galway City VEC	Representing Galway City VEC
John Coll	Mayo County Development Board	Representing Mayo County Development Board

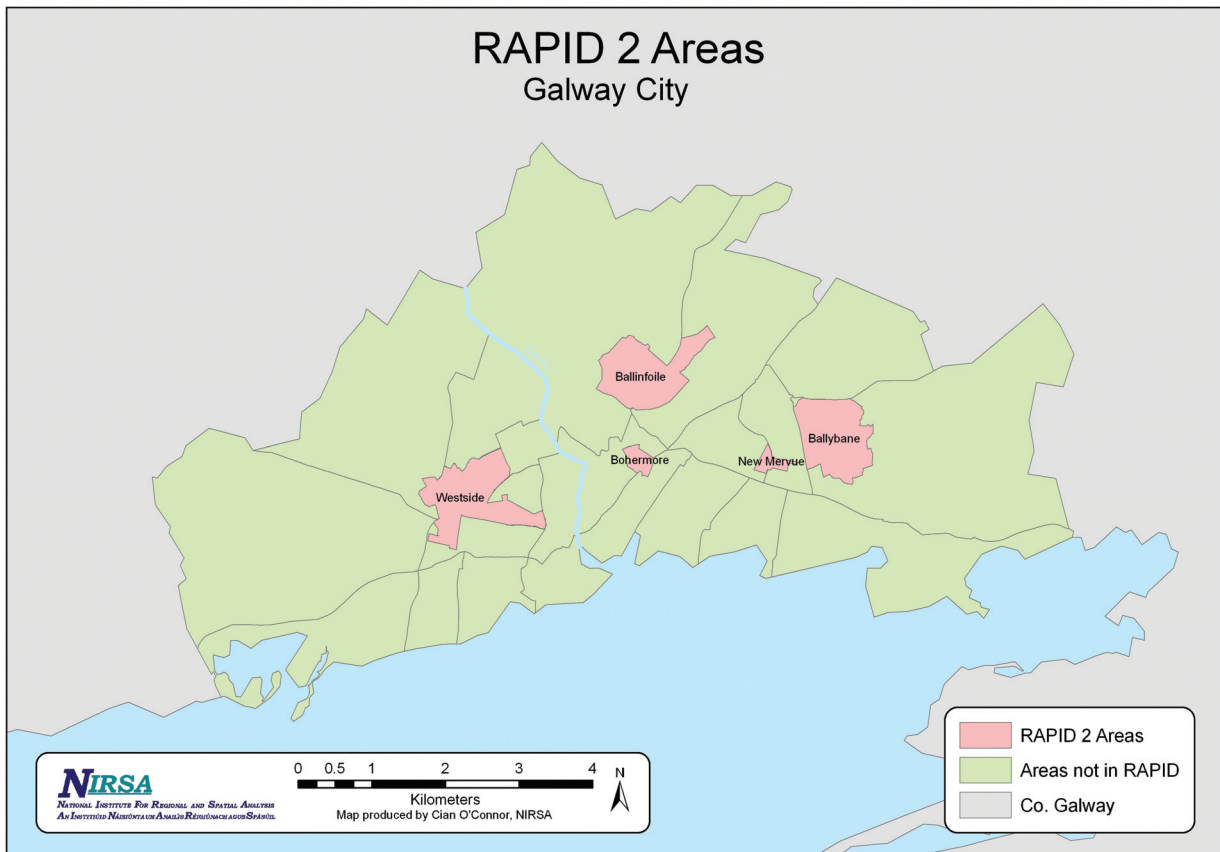
ANNEX 2: LIST OF AGENCIES & ASSOCIATIONS AT OPEN SPACE CONSULTATION NOVEMBER 2004

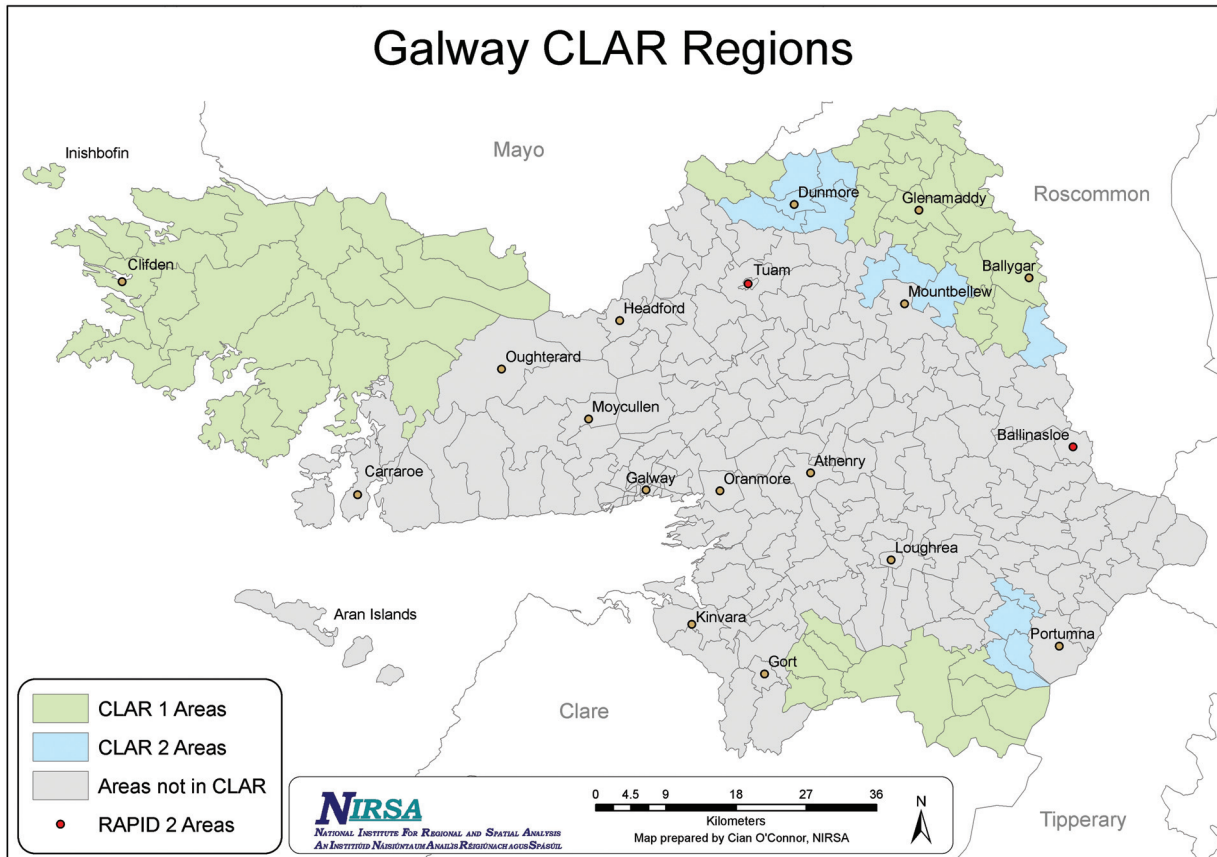
Accident & Emergency Dept., University College Hospital, Galway.
Addiction Counselling Service, Mayo.
Adult Counselling Service, Roscommon.
Aglish House, Castlebar, Co. Mayo.
AIDS West, Galway.
Alcohol Addiction Counselling Service, Merlin Park, Galway.
Athenry Adolescent Support Project, Co. Galway.
Balla Secondary School, Co. Mayo.
Ballina Neighbourhood Youth Project, Co. Mayo.
Ballina Primary Schools, Co. Mayo.
Ballybane Adventure Project, Galway.
Big Brother Big Sister programme, Roscommon.
Boyle Neighbourhood Youth Project, Co. Roscommon.
BRIS Justice Youth Project, Westside, Galway
Castlerea Neighbourhood Youth Project, Co. Roscommon.
Castlerea Prison, Co. Roscommon.
Child & Adolescent Mental Health, Castlebar, Co. Mayo.
Childcare Leader, Ballina, Co. Mayo.
Childcare Services, Roscommon.
Children's Act Services, Castlebar, Co. Mayo.
Community Addiction Counsellor, Tuam, Co. Galway.
Community Care, Roscommon.
Community Development Project's Programme Officer, Co. Mayo.
Community Substance Misuse Counsellor, Galway City.
Community Substance Misuse Counsellor, Loughrea, Co. Galway.
Community Substance Misuse Counsellor, North Galway/South Mayo.
Community Substance Misuse Counsellor, North Mayo.
Community Substance Misuse Counsellor, South Mayo.
Community Welfare Service, Castlebar, Co. Mayo.
COPE, Galway.
Day Care Centre, Athlone, Co. Roscommon.
Department of Psychiatry, University College Hospital, Galway.

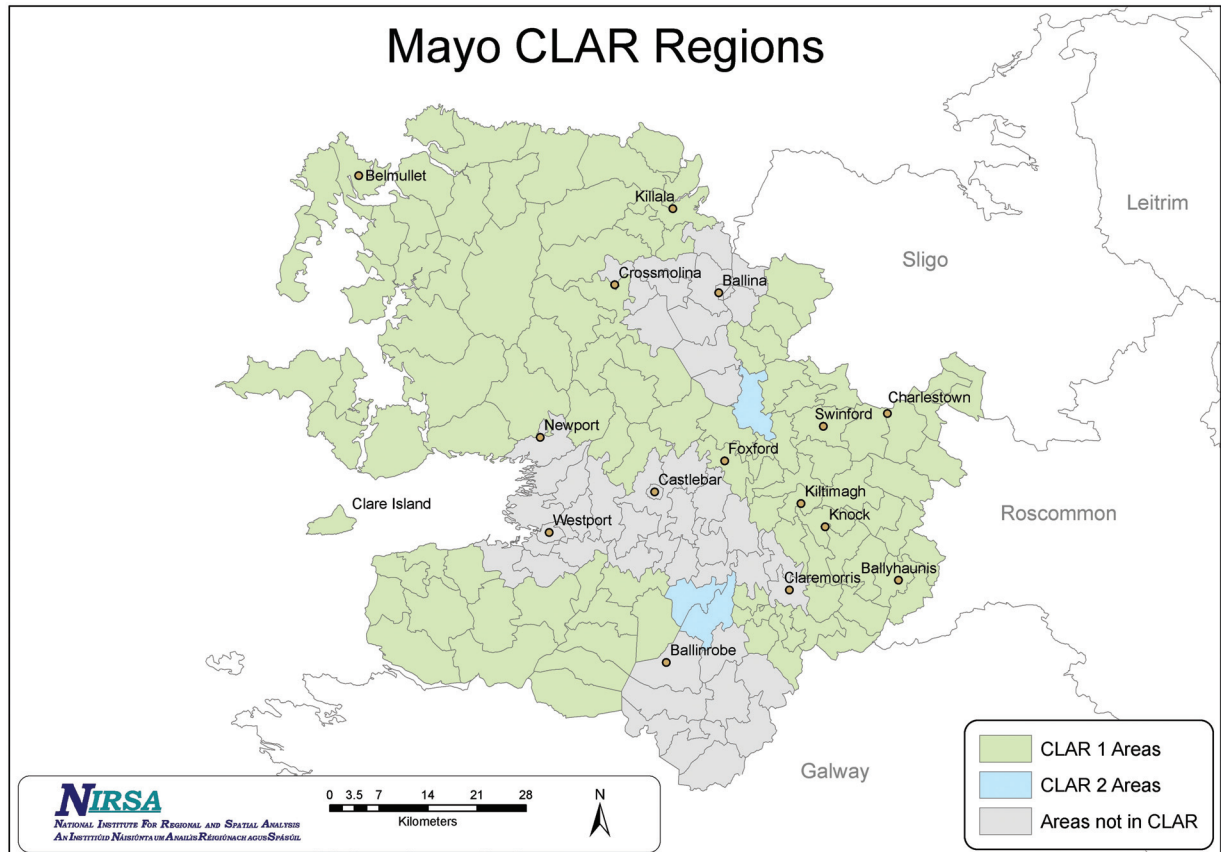
Dóchas don Óige, Galway.
Family Centre, Castlebar, Co. Mayo.
Family Life Centre, Boyle, Co. Roscommon.
Foróige National Youth Development Organisation, Co. Mayo.
Foróige, Galway, Mayo & Roscommon.
Galway City Council.
Galway City Partnership Youth Advocacy Service.
Galway City Partnership.
Galway Diocesan Youth Service.
Galway Refugee Support Group.
Galway Traveller Support Group.
Gárda Síochána JLO, Ballina, Co. Mayo.
Gárda Síochána JLO, Castlebar, Co. Mayo.
Gárda Síochána JLO, Galway.
GMIT Student Health Unit, Galway.
Health Promotion Dept., Castlebar, Co. Mayo.
Health Promotion Dept., Galway.
Home Management Dept., Galway.
Hope House, Foxford, Co. Mayo.
Le Chéile and Ragoon Youth Project, Galway.
Louisburgh Secondary School, Co. Mayo.
Mayo County Council.
Mayo Traveller Support Group, Westport, Co. Mayo.
Mayo Women's Support Services, Castlebar, Co. Mayo.
Moneenageisha Community College, Galway.
NUI Galway Student Services.
Our Lady's Secondary School, Belmullet, Co. Mayo.
Parent, Galway.
Parkside Community Development Project, Ballina, Co. Mayo.
Probation & Welfare, Castlebar, Co. Mayo.
Probation & Welfare, Castlerea, Co. Roscommon
Probation & Welfare, Galway.
Psychiatry Day Hospital, Roscommon.
Renmore Active Retirement Group, Galway.
Revenue Commissioners, Galway.
Sacred Heart Secondary School, Westport, Co. Mayo.
Salthill Active Retirement Group, Galway.

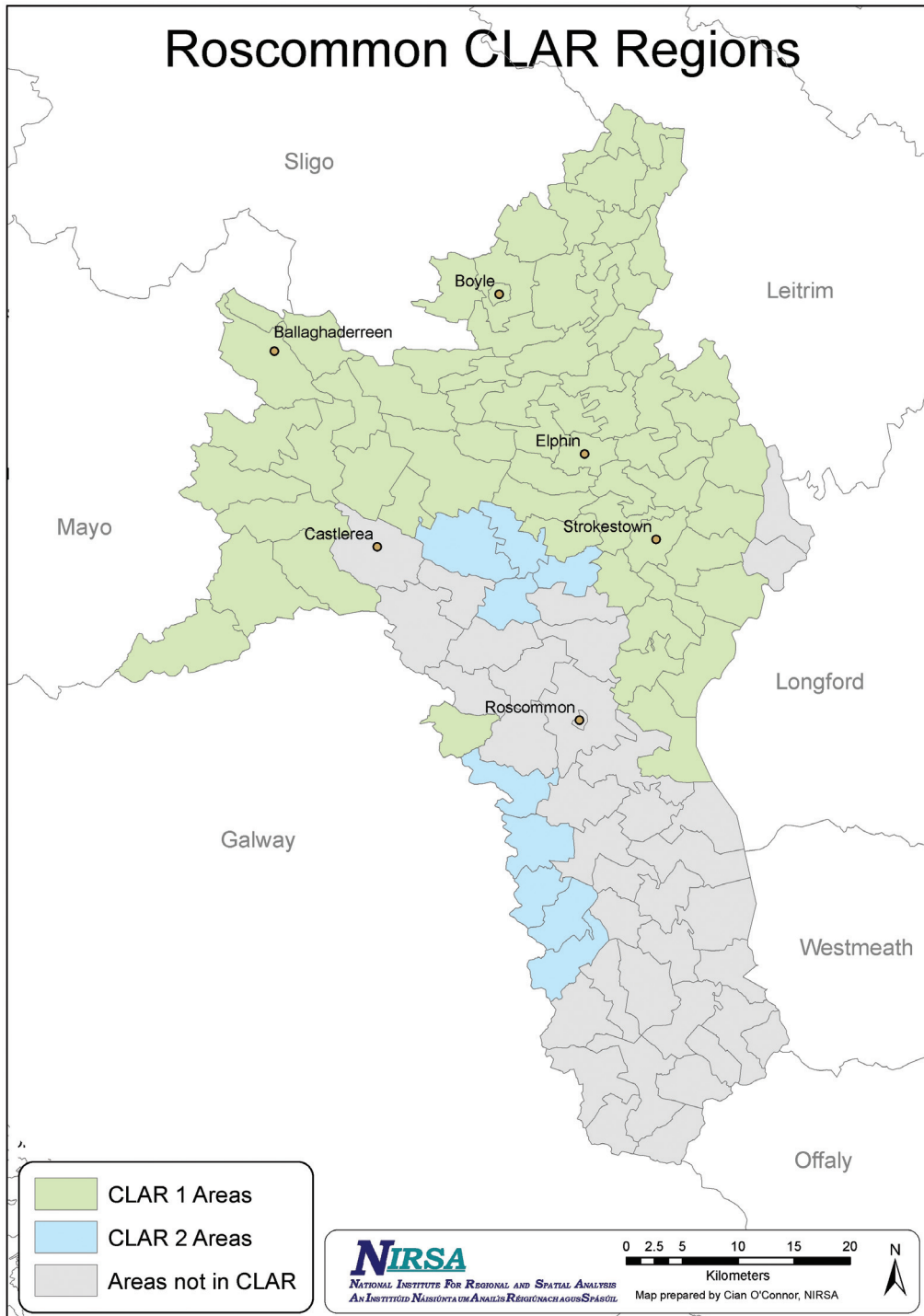
Simon Community, Galway.
SPARK (Support Programme for Adolescent & Refugee Kids), Galway.
SPHE Co-ordinator, Galway.
SPHE Co-ordinator, Mayo.
St. Nathy's College, Ballaghaderreen, Co. Roscommon.
Suicide Resource Officer, Galway.
The Gaf Youth Café, Galway.
VEC Community School, Castlerea, Co. Roscommon.
VEC Moyne College, Ballina, Co. Mayo.
VEC Youthreach, Ballina, Co. Mayo.
VEC, Co. Galway
West Galway Mental Health Service
Westport Family Resource Centre, Co. Mayo.
Westside Neighbourhood Youth Project, Galway.
Youth Action Project, Ballina, Co. Mayo.

ANNEX 3: MAPS OF CLÁR & RAPID AREAS









ANNEX 4: LIST OF ABBREVIATIONS

BMW	Border, Midlands & West Region
CDB	City/County Development Board
CHPS	Centre for Health Promotion Studies
CLÁR	Ceantair Laga Árd-Riachtanais
CNDT	Customs National Drugs Team
CSF	Community Support Framework
CRAGA	Department of Community, Rural & Gaeltacht Affairs
CSO	Central Statistics Office
CPA	Combat Poverty Agency
GMR	Galway, Mayo and Roscommon
HBSC	Health Behaviour in School-aged Children
HSE	Health Service Executive
NACD	National Advisory Committee on Drugs
NESF	National Economic & Social Forum
NDP	National Development Plan
OECD	Organisation for Economic Cooperation and Development
OTC	Over-the-counter
PDP	Participatory Drugs Profiling
RAPID	Revitalising Areas by Planning, Investment & Development
SIM	Social Inclusion Measures
SLÁN	Survey of Lifestyle, Attitudes & Nutrition
STFA	Strategic Task Force on Alcohol
VEC	Vocational Education Committee
WHB	Western Health Board
WRDTF	Western Region Drugs Task Force
YPFSF	Young People's Facilities & Services Fund

