

SOUTHERN REGIONAL DRUGS TASK FORCE

STRATEGIC PLAN
2005 – 2008

ACTION PLAN
2005 – 2007

PRESENTED TO THE
NATIONAL DRUGS STRATEGY TEAM

FEBRUARY 2005

FOREWORD

The Strategic Plan of the Southern Regional Drugs Task Force is the result of a significant amount of discussion and consultation with a wide variety of individuals and organisations throughout Cork and Kerry. It is important for us to acknowledge the efforts made and time given by members of the public, organisation volunteers, representatives of Voluntary and Community organisations, without whose input this report would not be possible.

The aim of the Consultation Process was to determine the nature and extent of the problem of alcohol and substance misuse within Cork and Kerry. The Task Force with the assistance of the County and City Development Boards sent out 1800 letters to organisations requesting information on their work relating to alcohol and drug issues. Where the response indicated activity a further comprehensive and detailed document was forwarded. We wish to thank all those organisations who helped us in this task.

In order to gain accurate insight to the issues the Task Force engaged a highly experienced researcher Mr. Peadar King to carry out a number of focused and public consultations. Mr. King undertook this study throughout November 2004 to February 2005 meeting with particular groups in the area of Education and Youth, Treatment and Rehabilitation, Law Enforcement and Research. Public Consultations were held in five locations throughout the region. All contributions were recorded and are documented within the Plan.

The Research process was supported on an ongoing basis by a sub group of the Task Force consisting of the Sub Group Chairs the Interim Co-ordinator and the Task Force Chairman. I want to particularly thank the efforts of the Sub Group Chairs: Michael J. Harte, (Supply Reduction) David Lane, (Education & Prevention) Mick Devine, (Treatment & Rehabilitation) John O'Connor, (Research).

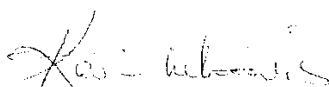
The Administration of this entire process is the excellent work of Ms. Marwin Jagoe A/Staff Officer, Health Services Executive. We wish to particularly thank her and here assistants for the cooperation and help to the Task Force and the development of the Strategic Plan.

We offer our thanks and appreciation for the expertise and guidance offered and time given by Dr. Tim Jackson, Specialist in Public Health Medicine, Department of Public Health, Health Services Executive Southern Area.

We have truly committed Task Force members in this region. Members while representing their own particular interest group are always thinking within the bigger picture with the greater good for the entire community in mind. We want to thank each member for their dedication time and commitment to the Task Force and particularly the development of this Plan.

We present this plan to the National Drug Strategy Team for consideration.

Signed:



Kevin Davis, Chairman

Signed:



Willie Collins, Interim Coordinator

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STRUCTURE OF SOUTHERN REGIONAL DRUGS TASK FORCE

Current Structure:

Chairman – Mr. Kevin Davis -Voluntary

Sub Groups

- **Supply Reduction** - Chairman – Mr. Michael John Harte – Community Rep.
- **Education & Prevention** - Chairman – Mr. David Lane – LDTF Rep.
- **Treatment & Rehabilitation** - Chairman – Mr. Mick Divine – Voluntary Rep.
- **Research** - Chairman – Mr. John O’Connor – Voluntary Rep.

Task Force Members -

- **Voluntary**
- **Community**
- **Political**
- **Statutory**

Support Structure -

- **Interim Co-ordinator - Mr. Willie Collins – Health Service Executive**
- **Administrative Support – Ms. Marwin Jagoe - Health Service Executive**

Office Accommodation – Health Service Executive

Meetings – Bi-monthly

Location – Health Centre, Macroom, Co. Cork.

MEMBER OF SOUTHERN REGIONAL DRUGS TASK FORCE

Mr. Kevin Davis, Voluntary, (Chairman)
Mr. Eamonn O'Reilly, Area Based Partnerships
Ms. Margaret Casey, Community Sector
Mr. Teddy O'Sullivan, Community Sector
Mr. John Fuller, Community Sector
Mr. Michael John Harte, Community Sector
Mr. T.J. Hourihan, Community Sector
Ms. Nora O'Donovan, Community Sector
Mr. Dominic Sullivan, Department of Education & Science
Insp. Charles Barry, Garda Siochana
Mr. Willie Collins, Southern Health Board
Mr. Pat Crowley, Social Inclusion Measures Group
Ald. Con O'Connell, Public Representative
Cllr. Kevin O'Keeffe, Public Representative
Cllr. Dan Kiely, Public Representative
Cllr. Tom Fleming, Public Representatives
Mr. Dermot O'Connell, Probation & Welfare Services
Mr. Paddy O'Sullivan, Revenue Commissioners (Customs & Excise Division)
Mr. Tom Daly, V.E.C.
Mr. Con Cremin, Voluntary Sector
Mr. Mick Devine, Voluntary Sector
Mr. John O'Connor, Voluntary Sector
Mr. Dan Cottrell, Voluntary Sector
Mr. Denis O'Brien, Voluntary Sector
Fr. Ger Godley, Voluntary Sector
Mr. David Lane, Cork Local Drugs Task Force
Mr. Colm O'Herlihy, Prison Services
Supt. Barry O'Brien, National Drugs Strategy Team

PROFILE OF RESEARCHER

PEADAR KING works as a freelance research consultant and documentary maker. In 2004 he produced *Chasing the Rainbow* – an hour-long celebration of ten years of democracy in South Africa and *What in the World?* – a five part series on globalisation and poverty. He is author of *The Politics of Drugs – from production to consumption* (2003) published by The Liffey Press; *Relying on the Few? A Study of Voluntary and Community Participation in County Clare* (2004) published by Rural Resource Development and co-author of *Gender and Learning A Study of the learning styles of women and men and their implications for further education and training* (2002) and published by AONTAS.

RESEARCHER'S ACKNOWLEDGEMENTS

I wish to thank the following people for their contribution to this report.

- Kevin Davis, Chairperson SRDTF
- Willie Collins, Interim Co-ordinator SRDTF
- David Lane, Chairperson of Sub-committee on Education and Prevention
- John O'Connor, Chairperson of Sub-committee on Research
- Michael Devine, Chairperson Sub-committee on Treatment and Rehabilitation
- Michael John Harte, Chairperson on Sub-committee on Supply Reduction
- Marwin Jagoe, Administrator.
- and all members of the SRDTF.

This report has benefited enormously from the generous and much valued comments of Dr. Tim Jackson, Specialist in Public Health Medicine (HSE) and of his colleague Heather Hegarty, Acting Senior Research Officer (HSE) for advice on sourcing and presentation of demographic data. I am indebted to them both.

Finally, I would very much like to thank all those I met during the consultative process of this study. Their comments and insights provided a wealth of information that has shaped this study.

I trust what follows does justice to all those who gave of their time and effort.

Peadar King
Februray 2005

Chapter 1 Introduction

Introduction

In 2002, the government decided to extend the Local Drugs Task Force model to all parts of the country. Prior to the establishment of the Regional Drugs Task Forces (RDTF), there were fourteen Local Drugs Task Forces – twelve in Dublin and one each in Dun Laoghaire and Cork City. The success of this model involving a partnership of voluntary and statutory bodies, prompted the government to extend the concept nationwide. Ten new RDTFs were established and these were co-terminus with the former Health Board areas.

The Southern Regional Drugs Task Force (SRDTF) was established in 2003 by the National Drugs Strategy Team (NDST). The Strategy Team reports to the Interdepartmental Group (IDG) chaired by Minister Noel Ahern T.D., Minister for State at the Department of Community, Rural, and Gaeltacht Affairs. The IDG reports to the cabinet sub-committee on Social Inclusion chaired by An Taoiseach Bertie Ahern T.D.

The Role of the RDTF

The government outlined the role of the RDTFs in its Guideline document (May 2002). According to the guidelines the role of the RDTF is:

To research, develop, implement and monitor a co-ordinated response to illicit drug use at regional level, based on best evidence of what is effective. This will be done through a partnership approach involving the statutory, voluntary and community sectors.

(Source: National Drugs Strategy Team, 2002, p.6)

Illicit drug use is the primary concern of the RDTF. However, the RDTF acknowledges that excess alcohol consumption and the over-reliance or misuse of prescribed drugs often accompanies illicit drug use and these need to be factored in to a holistic response. The Guidelines set down six objectives or terms of reference and they are as follows:

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

(Source: National Drugs Strategy Team, 2002, p.6)

The government recommended that RDTFs might wish to progress their work with reference to the four pillars that underpin the National Drugs Strategy. They are:

- Prevention (including awareness and education);
- Treatment (including rehabilitation and harm reduction);
- Research (including the dissemination of information on drugs and drug related issues);
- Supply Control.

(Source: National Drugs Strategy Team, 2002, p.16)

These four pillars as well as the nine grounds outlined in the Equal Status Act 2000 will frame both the context and content of this study.

Drug and Alcohol Consumption

All the evidence indicates that only a minority but an increasing minority of people consume illicit drugs (National Drugs Strategy, 2001 –2009, National Drug Treatment Reporting System, 2003. Jackson, 1997. King, 2003 Morgan, 2004). By contrast alcohol consumption is widespread. The profile of the “typical drug user” remains fairly constant. Jackson (1997) describes the typical drug user as follows:

The drug user in this survey tends to be young, male from urban areas, is also a smoker or drinker and has smoked or drunk from an early age (more) than non-drug users. Part-time employment, high frequency of pub and disco attendance and low frequency of attendance of church are all associated with increased drug use. Recent and Current drug use are highest at younger ages, and fall almost to nil over age thirty-five.

(Jackson, 1997, p.6)

Indications are, however, that consumption patterns are becoming more and more normalised and more mainstream. Noel Gallagher’s (of the rock band Oasis) prediction in an interview in *New Musical Express* in 1997 that taking drugs or more precisely cannabis, was “like getting up and having a cup of tea in the morning” (Shiner and Newburn, 1999, p. 123) is very much reflected in many of the interviews conducted as part of this study. He was not alone in this assertion. Former Health Minister John O’Connell went further. Not only did he agree with the normalisation theory but he also downplayed the seriousness of cannabis consumption. He argued in the Dáil that cannabis was “no more dangerous than a glass of beer” (Butler, 2002, p. 128). It would appear that a sizeable number of people agree.

Notwithstanding such debates, illicit drug use and excessive alcohol use pose serious challenges for society. Both are potentially addictive and illicit drugs by their nature bring people into either direct or indirect contact with drug trafficking and illegal activity. Both are potentially disruptive of individual, familial and community life. As a consequence, both require a societal response. The question is how ought that response be framed. Attempting to answer that question is the work of this study.

Speaking in 1999 at a gender mainstreaming conference in Cavan, An Taoiseach Bertie Ahern stated that new interventions “requires us to rethink established norms and behaviours and to adjust our perceptions, attitudes and behaviour” (Ahern, 1999). The challenge for the Southern Regional Drugs Task Force in setting forth its four-

year strategy is to ensure that the agreed policy and its implementation will meet people's needs and positively impact on their lives. To achieve that requires the rethinking of established norms. This challenge to rethink established norms was further underscored by the Department of Justice, Equality and Law Reform.

When mainstreaming a policy, policy makers can ask, at all stages of policy development — when we make a policy, are we accidentally contributing to some inequalities? If we change our decisions in some manner, can we help to address inequalities? Instead of solving problems later, it is possible to be pro-active the whole way through the policy making process. This helps to avoid accidentally creating or compounding inequalities. (Department of Justice, Equality and Law Reform, 2000, p. 7)

The Equal Status Act (2000) identified nine grounds on which it is illegal to discriminate and they are: gender, marital status, family status, sexual orientation, religion, age, disability, race and membership of the Travelling community. While it is not mandatory to proof every policy under these nine grounds, it is regarded as good practice to do so. Such proofing allows policy makers to double check if their interventions are meeting the target or in a worst case scenario are not making a difficult situation worse. Further to the nine grounds outlined in the Equal Status Act 2000, the Equality Authority has asked the Department of Justice, Equality and Law Reform to consider four additional grounds and they are: criminal conviction, trade union membership, political opinion and socio-economic status.

More and more it has come to be accepted that the “one size fits all” policy framework does not work and in its place what is required is a more targeted, focused approach.

In determining policy while policy makers are required to consider the nine grounds it is not mandatory that every initiative must have application to each of the nine grounds. Rather policy makers need to reflect on which constituent groups are more likely to be affected by a legislative change and has cognisance been taken of their particular needs.

For the purposes of this report and on the basis of a review of the international literature some grounds have a more direct relevance for drug and alcohol policies than have others. Of the nine grounds this study will concentrate on gender, sexual orientation, family status, age, disability, race, and membership of the Travelling Community. Of the four proposed grounds, this report will take cognisance of criminal convictions and socio-economic status. The issue of homelessness is also a key variable in responding to drug and alcohol consumption and while that is not part of the nine or proposed four grounds, this report will make reference to this issue and will also make reference to literacy levels.

Structure of this Report

This report is in six chapters including this, the introductory chapter.

Chapter Two provides a detailed profile of the Southern Regional Drug Task Force area i.e. Counties Cork and Kerry including Cork City.

Chapter Three will identify key alcohol and drug-related services in the Cork-Kerry area.

Chapter Four describes the research methodology and will detail the consultative process undertaken in preparation of this report.

Chapter Five will detail the views and perspectives of those who participated in the consultative process.

Chapter Six will conclude the study and detail key recommendations for the Southern Regional Drugs Task Force.

Chapter 2

Drug and Alcohol Consumption in Cork and Kerry – Some Contextual Issues

Introduction

A pre-requisite for the framing of any area-based policy initiative is some knowledge of the people who may be affected by the policy development. Policies need to reflect the needs of a population and to that end this chapter will profile Counties Cork (including Cork City) and Kerry. In undertaking this task, The Equal Status Act 2000 will be central to the analysis, as will recent demographic trends. Specifically, this Chapter will profile the Southern Regional Drugs Task Force area under the following headings: demography, socio-economic status, gender, family status, membership of the Travelling community, disability, sexual orientation, ethnicity, criminal conviction grounds, homelessness, and literacy levels. Finally, the chapter will note some significant health-status trends of the people of Cork and Kerry.

Demographic Trends

Spatially, County Cork (7,454 sq. kilometres) is the largest county in Ireland (69,825.16 sq. kilometres) and County Kerry (4,700-sq. kilometre) is the fifth largest. Galway, Mayo and Donegal, are the second, third and fourth largest counties respectively. The 2002 census revealed that the population of the County Cork, including Cork City, was 447,829 and the population of County Kerry was 132,527 (CSO, 2002). The total population of the Southern Health Board area is 580,356, an increase of just over six per cent (6.2%) from the 1996 census.

While nationally the population increased by eight per cent between 1996 and 2002, the population of Cork City declined by just over three per cent, Cork Suburbs increased by almost twenty per cent, County Cork increased by almost eleven per cent and County Kerry by just over five per cent. County Cork, excluding the City but including the Suburbs, recorded the biggest increase in population in Munster (10.7%) and the biggest increase of all the western seaboard counties, excluding Galway City. The Cork County Development Board predicts that the population of the County will increase by between 12% (35,170) and 18% (52,100) between 1996 and 2011 (Cork County Development Board, 2002, p. 27). Table 1 details the above information.

Table 1
Population Growth 1996-2002 in Cork and Kerry

Area	1996	2002			Change in Population 1996-2002	
		Persons	Males	Females	Actual	Percentage
Cork City	127,187	123,062	59,263	63,799	-4,125	-3.2
Cork Suburbs ¹	52,767	63,177	31,085	32,092	10,410	19.7
Cork County	293,323	324,767	163,054	161,713	31,444	10.7
Kerry County	126,130	132,527	66,572	65,955	6,397	5.1

¹ In the CSO figures for 2002, Cork suburbs are included in Cork County data. This column is included here purely for illustrative purposes.

SHB	546,640	580,356	288,889	291,467	33,716	6.1
Ireland	3,626,087	3,917,336	1,945,187	1,972,149	291,249	8.0

(Source: CSO 2002 and SHB, 2003, p. 5)

Cork City too experienced a decline of three per cent but Cork suburbs increased by 19.7%. It should be noted, however, that the fastest growing suburbs of Cork such as Douglas, (+10%) and Riverstown in the Glanmire region (+64%) are enumerated in Cork Suburbs and County giving a somewhat skewed representation of the decline of Cork City. Table 2 gives a sense of the growth of some of these areas close to Cork City.

Table 2
Growth in Selected Cork Suburbs by Census 2002

Area	1996	2002			Change in Population 1996-2002	
		Persons	Males	Females	Actual	Percentage
Ballincollig	13,288	14,591	7,535	7,751	1,303	9.5
Carrigaline	7,827	11,191	5,525	5,666	3,364	43.0
Douglas	13,906	15,286	7,535	7,751	1,380	9.5
Riverstown	2,138	3,506	1,751	1,755	1,469	64.0

(Source: CSO 2002)

Growth in County Cork was uneven with areas in the north and northwest experiencing population decline. Streamhill, a divisional electoral district (DED) in the Mallow rural area lost over twenty-three per cent of its population and four DEDs in the Kanturk rural area lost more than ten per cent of their population. There were also significant losses in the Macroom rural area as there were in towns like Boherbue (-15.2%), Newmarket (-8.3%), Buttevant (-7.8%), Castletownbere (-5.5%) and Kanturk (-0.9),

The 2002 census also reports a fall in the 20-30 age group in rural areas and pronounced internal migration into the larger towns and the city. In keeping with other western counties (Clare, Galway, Leitrim, Mayo and Donegal), both Counties Cork (excluding Cork City) and Kerry have slightly more males than females reflecting historically higher levels of female out-migration. There is a very high level of unmarried males in some rural areas in both counties.

These losses were off-set with significant growth elsewhere. Towns like Tower (+64.7%), Clonakilty (26.0%), Middleton (16.3) Macroom (15.4%) and Passage West (15.0%), all reported the high levels of growth. Table 3 has the details.

Table 3
Population of Towns in County Cork by Census 2002

Area	1996	2002			Change in Population 1996-2002	
		Persons	Males	Females	Actual	Percentage
Bandon ²	1,697	1,578	767	811	-199	-7
Bantry	2,936	3,150	1,505	1,645	214	7.3
Blarney	1,963	2,146	1,068	1,078	183	9.3
Buttevant	1,070	987	467	520	-83	-7.8
Castletownbere	926	875	425	450	-51	-5.5
Charleville	2,667	2,685	1,321	1,364	18	0.7

² These figures exclude Bandon Environs where the population increased by 529 (17.3%) from 3,054.

Clonakilty ³	2,724	3,432	1,627	1,805	708	26.0
Cobh ⁴	6,468	6,767	3,372	3,395	299	4.6
Crosshaven	1,312	1,373	668	705	61	4.6
Dunmanway	1,427	1,532	762	770	105	7.4
Fermoy ⁵	2,310	2,270	1,092	1,178	-40	-1.7
Kanturk	1,666	1,651	786	865	-15	-0.9
Kinsale ⁶	2,007	2,257	1,137	1,120	250	12.5
Macroom ⁷	2,457	2,836	1,377	1,459	379	15.4
Mallow ⁸	6,434	7,091	3,394	3,697	657	10.2
Mitchelstown	3,123	3,300	1,634	1,666	177	5.7
Midleton ⁹	3,266	3,798	1,821	1,977	532	16.3
Newmarket	1,150	1,055	521	534	-95	-8.3
Passage West ¹⁰	3,638	4,184	2,074	2,110	546	15.0
Skibbereen	1,926	2,000	945	1,055	74	3.8
Schull	595	693	331	362	98	16.5
Tower	1,841	3,032	1,498	1,534	1,191	64.7
Youghal ¹¹	5,630	6,203	3,070	3,133	573	10.2

(Source: CSO, 2002)

Notwithstanding a growth of five per cent between 1996 and 2002, the population of Kerry is ageing as it is in the whole of the Southern Health Board area. County Kerry's population is significantly older than the national average. Just over eleven per cent of the population of the State are over the age of sixty-five whereas over eighteen per cent of the population of County Kerry is over that age. There was a twenty-five per cent reduction in primary school pupils in the county between 1988 and 2000 (Kerry County Development Board 2002, p. 20). In contrast, both Cork City (12.8%) and Cork County's (10.8%) over sixty-five population is very close to the national average (11.1%).

Population growth in the County Kerry is as uneven as in County Cork. High growth rates are recorded in the urban centres and loss of population in rural areas. Knocknagashel lost 3.4% in its population, Beale in North Kerry almost fifteen per cent and Sneem rural area in South Kerry lost almost twelve per cent. Other noticeable population losses occurred in Ballylongford (-18.8%), Ballybunion (-9.6%), Ballyheige (-7.8%), Tarbert (-9.4%) and all located in the north of the county. In the east of the county, population losses were experienced in Brosna (-18.1%), in the south of the county Kilgarvan (-10.9%) and Knightstown (-9.9%). Population details of towns in Co. Kerry are provided in Table 4.

³ These figures exclude Clonakilty Environs, where the population increased by 40 (17.7%) from 226.

⁴ These figures exclude Cobh Environs where the population increased by 1,053 (52.9%) from 1,991.

⁵ These figures exclude Fermoy Environs where the population increased by 375 (17.4%) from 2,159.

⁶ These figures exclude Kinsale Environs where the population increased by 240 (22.7%) from 1,057.

⁷ These figures exclude Macroom Environs where the population grew by 32 ((27.45) from 117.

⁸ These figures exclude Mallow Environs where the population increased by 512 (38.4%) from 1,334.

⁹ These figures exclude Midleton Environs where the population grew by 1,216 (41.3%) from 2,943.

¹⁰ These figures exclude Passage West Environs where the population grew by 127 (44.7% from 284.

¹¹ These figures exclude Youghal Environs where the population grew by 81 (25.9%) from 313.

Table 4
Population of Towns and hinterlands in County Kerry by Census 2002

Area	1996	2002			Change in Population 1996-2002	
		Persons	Males	Females	Actual	Percentage
Ballybunion	1,470	1,329	643	686	-141	-9.6
Caherciveen	1,250	1,272	626	646	22	1.8
Castleisland	2,233	2,162	1,034	1,128	-71	-3.2
Dingle	1,536	1,828	865	963	292	19.0
Kenmare	1,420	1,844	864	980	424	29.2
Killarney	8,809	12,087	5,781	6,306	3,287	37.3
Killorglin	1,278	1,359	649	710	81	6.3
Listowel ¹²	3,393	3,589	1,699	1,890	196	5.8
Tralee ¹³	19,056	20,375	9,686	10,689	1,319	6.9

(Source CSO, 2002)

Social, Economic and Geographical Profile

While counties Cork and Kerry have benefited enormously from the relatively recent upturn in the Irish economy, many rural areas in both counties have been largely unaffected by the economic changes that have taken place. Poverty in general tends to be invisible and rural poverty is particularly so. Equally, poverty tends to be concentrated in public sector housing estates and on the fringes of small towns and villages. Nolan *et al* in their 1998 study of poor households argue that

...rural areas unlike some urban areas do not present homogenous areas of advantage and disadvantage. Rural areas are more diverse and the experience is often individual and dispersed (my emphasis) over a greater geographic area...concentrations of poverty (also) exist in public housing estates on the fringes of small towns and villages...high risks of poverty (are) associated with living in small towns and villages.

(Nolan *et al*, 1998, XXVII)

In its Strategy document for 2002 –2011, the Cork County Development Board, too expressed concern about the plight of rural areas, villages and small towns, albeit from a somewhat different perspective. The 1996 Census reported a sharp fall in the 20-30 age group as people migrated from the county after finishing school. This was particularly the case among women in this age group. Consequently, the number of young women in the countryside is relatively low and the number of unmarried males is quite high in some areas. The report concluded: "a need has been identified to upgrade the infrastructure supporting towns and villages in the County and conserve the attractiveness of towns and rural villages and the quality of the rural environment". (2001, p. 23). The evidence would indicate that a similar problem exists in Co. Kerry.

Both Cork and Kerry between them have over 2,000 km of coastline (itself an issue for illicit drug supply reduction). Off this coastline are twenty-two inhabited islands on which live 1,677 people 0.3% of the SHB region (Jackson, 2004, p. 16). While this population is small, equity demands equal access to all services.

¹² These figures exclude Listowel Environs where the population grew by 147 (55.9%) from 263.

¹³ These figures exclude Tralee Environs where the population grew by 718 (80.3%) from 894.

Fishing is an important economic activity in County Cork, but less so in Kerry. County Cork accounts for 15.6% of the national catch in value terms in 1998. Agriculture remains an important employer in the county accounting for over twenty-five per cent of income in the north and west. However, prospects for the sector are not good. Farms of less than 100 acres are in decline and if current trends of ownership and restructuring in favour of bigger holdings continue, it is expected that there will be a drastic reduction in the number of small farms in the County.

County Cork A Profile

The Cork County Development Board reports that manufacturing industry has performed well in recent years but that there is too much reliance on both the food and pharmaceutical industry. However, it warns that the pharmaceutical industry is poorly integrated with few spin-off industries and could be facing a period of considerable change (2002, p.32)

On tourism, the Cork County Development Board reports that there are signs of environmental pressure in the county and a trend away from domestic visitors in favour of high-spending overseas visitors. Business in Cork Airport is booming with a five-year twenty per cent increase and projections for increased traffic into the future.

The 2002 Census reported that there are 5,864 people in Cork City who were unemployed or looking for their first regular job, and 8,044 in the County. Within the City, people in the 25-34 age group are more likely to be unemployed (1,640) followed by those in the 35-44 age group (1,174). The same trend can be found in the County with 2,147 unemployed in the 25-34 age-group and 1,726 unemployed in the 35-44 age-group. There are 1,343 people unemployed in Cork City in the 15-24 age-group and 1,542 unemployed in the County in the same age-group.

Social class provides a useful indicator of health status and life expectancy. Excluding social class 7 (all others gainfully occupied and occupations unknown) Cork City and County has a lower proportion in the higher social classes and a greater concentration of people in the middle to lower social classes than has Dublin City and Dublin City and County. There is a higher proportion of unskilled and semi-skilled people in Cork City than there are in Dublin. Table 5 has the details.

Table 5
Social Class Profile of Cork City and Cork County compared to Dublin City and County

Area	Social Class 1	Social Class 2	Social Class 3	Social Class 4	Social Class 5	Social Class 6	Social Class 7
Cork City	6.3	19.3	14.9	16.0	12.0	6.5	24.6
Dublin City	6.8	22.4	15.9	14.4	9.8	5.3	25.0
Cork County	6.9	27.6	16.8	17.8	11.5	5.0	14.2
Dublin City & County	7.8	27.8	17.0	14.5	8.8	4.1	19.6

(Source CSO, 2002)

Cork has two thriving third level institutions. During the decade of the nineties, the number of third-level students studying in Cork Institute of Technology (CIT) and University College Cork (UCC) rose by a whopping 84.4%. Current enrolment in CIT is in the region of 11,300. Of these, 6,300 are full-time students and 5,000 are part-time. UCC has a student population of approximately 14,500 and no breakdown was available for the number of occasional students. About 3,000 fulltime first year students enrolled in 2004. The Institute of Technology in Tralee (ITT) has a student population in the region of 3,500 and of these 1,000 are part-time (Sources CIT, UCC and ITT).

County Kerry

County Kerry has the second highest deprivation levels in Munster (based on the 1996 Census of population) after County Clare. The Haase study (1999) reported that Kerry, Clare and parts of West Cork do not share the general affluent situation of the Province. In County Kerry the share of occupations accounted for by small farming are twice the provincial and national averages (2.6% compared to 1.3% and 1.2% respectively). These Kerry farms generate relatively low incomes. (Haase, 1999).

The 2002 Census reported that there are 4,639 people in Co. Kerry unemployed or looking for their first regular job. Unemployment is quite evenly spread across the 25-54 age group. Over five hundred of those aged 20-24 and over two hundred of those in the 15-19 age groups are unemployed.

While as outlined above, Cork has a larger concentration of its population in the middle to lower classes compared to Dublin, so too has County Kerry in comparison with County Cork. There is a lower proportion in Social classes 1,2 and 3 in Kerry than there are in Cork. Table 6 has the details.

Table 6
Social Class Profile of County Kerry compared to Cork City and Cork County

Area	Social Class 1	Social Class 2	Social Class 3	Social Class 4	Social Class 5	Social Class 6	Social Class 7
County Kerry	4.7	23.2	16.3	18.0	12.0	6.5	18.9
County Cork	6.9	27.6	16.8	17.8	11.5	5.0	14.2

(Source: CSO, 2002)

Class status has direct relevance for health status. Admission rates to psychiatric hospitals in the Cork/Kerry Region are highest for unskilled occupations and lowest for employer/managerial categories. (SHB, 2003, 52) While the relationship between occupation and mental illness is a complex one “those in lower socio-economic groups suffer the burden of the more debilitating conditions notably schizophrenia, alcohol disorders and depression (SHB, 2003, p.52).

Within the region in percentage terms, Co. Kerry has the highest number of people over 45 years living in one-person households. Ten per cent (10,621) compared to a national average of seven per cent of people in Co. Kerry live on their own.

Both Cork and Kerry have Gaeltacht areas even if the English language is beginning to impact more and more. Gaeltacht Chorca Dhuibhne is located on the Dingle

peninsula and Gaeltacht Uibhrathaigh is situated on the Iveragh Peninsula. In Cork, there are Gaeltacht areas in Muscraí and in Olean Cléire. The 1996 Census of population indicated high use of Gaelige in the suburbs of Cork City possibly indicating population flows from Gaeltacht areas. The growth of Gael scoileanna may very well have contributed to the high use of Gaelige in these suburbs.

Socio-Economic Profile: A Summary

The increase in employment, while bringing obvious and much needed benefits to the people of the region, was not evenly spread and did not bring equal benefits to everyone. While unemployment has dropped significantly, unemployment and underemployment continues to be a reality for many. The Director of Public Health in the Southern Health Board region in her annual report (2003) described unemployment as “a major risk to health...as it has significant adverse effects on both physical and mental health” (2003. p.34). This applies equally to both women and men. However not all health indicators are gender neutral. Gender differences in health status have been well documented.

Gender Issues

Men have higher rates of early mortality and women are generally regarded as having greater levels of morbidity and the former is frequently attributed to unhealthy behaviours. Men tend to smoke more, drink more and drive more carelessly than do women. Underlining these behaviours is the way in which men construct their identity. All the evidence on the social construction of masculinity indicates that men tend to have an exaggerated belief in their own invincibility and that this is particularly so in younger men.

Studies in the United States suggest that white, robust, self-assured, middle class, able-bodied, sports-orientated, young to early middle aged, settled, heterosexual men set the standard against which the rest of men are measured and more often than not found wanting. (Sailsbury and Jackson, 1996 p.7). The situation in this country would appear to be no different. Many boys and men feel they do not measure up to the standard expectation and consequently experience fear, isolation, rejection and loneliness.

In research carried out in Irish post primary schools, (Lodge and Lynch, 1999) found that the peer group values of boys have changed little, in terms of how they define masculinity, since previous research ten years earlier. Lynch, (1999, p. 143) also reports that ongoing self-esteem difficulties for girls and that girls have a lower academic self-image than boys and many commentators believe that this continues on into adult life. These low levels of self-esteem would appear to co-exist even with high levels of academic achievement. Conversely boy's self esteem would appear to be unaffected by low academic performance. Rather, masculinity was strongly equated by the boys in the study, with various forms of physical prowess. Such constructs result in greater risk taking – over a quarter of males in Cork and Kerry consume more than the recommended weekly limits for alcohol at least monthly, for example, - and more reluctance to recognise physical health and emotional distress and to seek help.

To what extent that is a cause of suicide is highly contested. What can be definitely stated is that the suicide rate in Cork and Kerry is higher than the national average and

that the gap is widening (SHB, 2003, p. 49). Dr. Tim Jackson (1997) has reported that males use cannabis twice as much as females and Mark Morgan (2004) reports that “there is consistent evidence that young people attempting suicide are more likely to have a history of heavy cannabis use than are others”(Morgan 2004 p. 15).

While much of the focus on drug consumption is on men’s behaviour and more particularly men’s problematic behaviour, increasingly it would appear that women are consuming more and more. The effect of this increased consumption is the subject of much debate (King, 2003, pp 90-97). One school of thought argues that this is further evidence of women asserting themselves and current drug use by young women is just one part of buying into a pleasure-centred lifestyle. Others take a less benign view and counter-argue that women’s increased drug consumption is yet another indicator of the way in which women are becoming trapped in the legitimate and the illegitimate consumerist snare.

The SHB Plan for Women’s Health 200-2002 identified the dearth of information and the difficulty in accessing information as one of the greatest disadvantages women encounter in accessing health care.

Difficulties in accessing information which was appropriate, relevant and timely was identified by women as the factor which caused the greatest disadvantage in accessing health care. This inability to access information was identified as limiting their decision-making power and reducing their options when considering health issues. This problem permeated all levels of the service.

(Women’s Health Advisory Committee, 1999, p.2)

With regard to alcohol and drugs the report states that women have special needs in this area and therefore require specific responses at the levels of research, education/prevention and treatment. These will be detailed at a later stage in the report. Furthermore, the National Drugs Strategy 2001 – 2008 highlighted women sex workers as a high-risk group who may be susceptible to serious and sustained drug and alcohol consumption (National Drugs Strategy 2001, p. 34).

Family Status

In the *Foreword to Families and Family Life in Ireland: Challenges for the Future (2004)*, the broadcaster and journalist Olivia O’Leary argued “that too often government policy is not family proofed” (Daly *et al* 2004, p.11). The report commissioned by the Department of Social Community and Family Affairs outlined the myriad changes that have come to affect and shape family life in Ireland. While the constitutional understanding of family as consisting of children who live with their married parents and in a family situation where the mother is based at home remains the official definition of the family, the *de facto* situation has changed enormously since 1937 when the constitution was enacted.

Not only has the family structure changed in Ireland but so too has it changed and continues to change globally. According to the United Nations that change is unprecedented in human history - “the family, as a living evolving institution faces what may be the most difficult challenge in the history of the human species” (Daly *et al* 2004, p.2). The UN goes on to state that the rate of change is so great that it is a major factor of stress for families.

The then Minister for Social Community and Family Affairs, Mary Coughlan T.D. identified growing female participation in the labour force, increasing separation and divorce, declining births rates, more cohabiting couples, lone parents, migrant families and older people living alone as the root cause of much of that change. The past ten years has, for example, seen a thirty-two per cent increase in births outside marriage.

In addition to the above, the rise in individualism was identified in the report as having a major impact on families. Another consistent finding in the report was the pressure felt by parents and the confusion around the most appropriate way to raise their children. Furthermore, many parents feel that they are easily scapegoated by society when things go wrong in their families – “there seems a new readiness to blame the parents if things go wrong” (Daly *et al* 2004, p.31).

The report acknowledges that alcohol and drug consumption can play a part in things going wrong. “Alcohol addiction is seen to play a critical role in many cases of relationship breakdown. So also are other addictions (such as drugs and gambling) major causal factors in placing family relationships in jeopardy” (Daly *et al* 2004, p. 46).

Concerns with alcohol consumption would appear to be well founded. According to the Strategic Task Force on Alcohol “adults in Ireland had the highest reported consumption per drinker and the highest level of binge drinking in comparison to adults in other European countries” (2004, p. 8). While it has been well established that illicit drug consumption is higher and more serious in poor deprived areas and amongst younger people, there would not appear to be any evidence to suggest that it is more serious among particular types of families. This is not to imply that drug and alcohol policies ought not to be family-proofed.

Membership of the Travelling Community

It has been very well established that drug use is believed to be fairly prevalent among some socially and economically marginalised ethnic groups who are even more cut-off from service provision due to language and cultural reasons. For obvious reasons, the precise level of drug use is difficult to establish. “Minority ethnic groups’ caution around mainstream authority figures, the fear of being scapegoated, nomadism, language barriers, all combine to make drug use estimates more difficult” (King, 2003, p. 99).

Members of the Travelling Community were also identified by the National Drugs Strategy as a high-risk group (National Drugs Strategy 2001, p. 34). A study conducted for Pavee Point (Hurley, 1999) highlights some significant differences between drug use within the Traveller community and the settled community. The research indicated that “while the age of commencement was higher than the settled population at around 16/17, substance use persisted into early adulthood” (Hurley, 1999, p. 16). Cannabis was the main illicit drug among members of the Travelling Community with some evidence suggesting that women consumed significant amounts of prescribed drugs. As in the settled community, it is the very disadvantaged Travellers who are most at risk from heroin use. The evidence suggests that all Travellers' drug use is linked to their overall marginalised status in society.

While no specific reference is made in the Strategic Task Force on Alcohol to members of the Travelling community, there is much anecdotal and recorded evidence both from members of the Travelling and settled communities that alcohol consumption is very high particularly amongst men. Alcohol consumption is complicated for members of the Travelling community because of the difficulty they have in gaining access to pubs and clubs notwithstanding the specific legislative protections afforded them. As a result, it would appear that much of the alcohol is consumed at home.

A 2003 study conducted by the Mid-Western Health Board reported “striking differences in the alcohol consumption patterns of Traveller women and men” (MWHB, 2003, p.35). Men were nearly five-times more likely to consume alcohol than were women. Furthermore, male alcohol consumption is high from an early age – eighty-six per cent of young Traveller men in the 15-19 age-group consume alcohol while no consumption was recorded for young women (MWHB, 2003, p.36). It would appear that young Traveller women do not begin to consume alcohol until they are in their twenties and then in much smaller numbers (100% Male, 21% Female). Alcohol consumption for both women and men peaks in later mid-life (45-54) and declined thereafter.

Evidence both from the Western Health Board and the Southern Health Board areas (Callanan *et al*, 2002 and Jackson *et al* 2001) indicate that members of the Travelling community are disinclined to access preventative services and that Traveller “male gender culture” (Callanan *et al*, 2002, p. 44) is a barrier to access primary health care. Very often Traveller women have to attend the GPs to get a prescription for their menfolk. Jackson concludes that there is a silence about Traveller access to psychiatric care as this is a major taboo topic and the Callanan study reported that this silence is particularly pronounced among men but less so amongst women. .

There are relatively few members of the Travelling Community living in Co. Cork – 851 (2.6%). About the same number live in Cork City (7%). Cork has significantly fewer members of the Travelling Community (5.6 per 1,000 population) than has Galway City (16.0 per 1,000 population) but slightly more than the Greater Dublin area (5.2) and Limerick City (4.7).

In percentage terms, there are even fewer members of the Travelling Community living in County Kerry than there are in Co. Cork Less than one per cent of the population (860) of the County are members of the Travelling Community. There is a relatively high concentration of members of the Travelling Community in Tralee (23.3 per 1,000 population) Killarney (22.6) and Listowel (21.3).

Disability Issues

Published in the mid-nineties, the *Report on the Commission on the Status of People with Disabilities* (undated) states at the outset that “people with disabilities¹⁴ are the neglected citizens of Ireland” (undated, p.5). The report further states that people with disabilities are justifiably angry and their anger was evident in their submissions to

¹⁴ There are three pillars to disability (1) psychiatric illnesses, (2) physical sensory disability (3) intellectual disability

the Commission that was established to advise the government on practical measures to ensure that people with disabilities can fully exercise their right to participate in all aspects of society. The Commission reported that Irish society excludes people with disabilities from almost every aspect of economic, social, political and cultural life. Since its publication some improvements have been made not least because of significantly increased financial allocation in the budget of 2004.

The Director of Public Health in the Southern Regional Health Board, Elizabeth Keane, argues in her 2004 Health Status Report that “the spectrum (of disability) is broad and the impact on the individual extremely varied”. (Keane, 2004, p.28). These spectrum of disorders range from impairment (any loss of structure or function in the body) to disability (the lack of an ability to perform an activity) to handicap (the disadvantage that a person has in society)

For the first time the 2002 census recorded information on the disability status¹⁵ of the population. However, no comprehensive surveys of people with disabilities have been undertaken to date in the state. There are a total of 323,707 (8.2% of the total population) people with disabilities in the State.

According to the CSO (2002), Cork City has 13,791 people with a disability (11.2%), higher than the national average (8.2%). By contrast, Cork County has a significantly lower rate than Cork City with 24,098 people (7.4%) with a disability. Co. Kerry has 11,497 people with a disability (8.6%) similar to that of the national average but higher rate than has Co. Cork. Overall, the percentage of the population in both counties is close to the national average.

Of those with a disability, in the Southern Health Board area (49,386) over a half had a physical disability, about a third had an intellectual disability and about a quarter had a sensory i.e. visual or hearing disability (Keane, 2004 p, 29)

With regard to admission for psychiatric illnesses, males in the Southern Health Board area had a higher rate of admission than females and this trend is in keeping with national trends. What is noteworthy is that the Southern Health Board area has higher admission rates in the 20-34 age group and lower admission rates in older age groups compared to national admissions. The Southern Health Board area has over 600 admissions for the 20-24 age group and over 800 for the 25-34 age group. However, the largest number of people admitted was in the 45–54 age group. (Keane, 2004, p. 36).

Single people account for over half of all first admissions to Irish psychiatric hospitals in 2002 and single males are more likely to be admitted than are females. (Daly *et al*, 2002, p. 14). Divorced persons had the highest rate of admissions in the Southern Health Board area (Daly *et al*, 2002, p.40) People in lower socio-economic groups have higher admissions and this is also the case within the Southern Health Board

¹⁵ The CSO uses six categories of disability and they are (1) blindness, deafness, or severe vision or hearing impairment, (2) a condition that substantially limits one or more basic physical activities, (3) difficulty in learning, remembering or concentrating (4) difficulty in dressing, bathing, or getting around inside the home (5) difficulty in going outside the home alone (6) difficulty in working at a job or business.

area. The Southern Health Board had the highest rate of all health boards for schizophrenia and also had the highest rate of non-voluntary admissions, closely followed by the Western Health Board and there was an increase in the rate of non-voluntary admissions between 2001 and 2002 in the SHB area.

Depression was a key factor in admissions but alcohol, accounted for thirteen per cent of admissions in the Southern Health Board area. Comparisons, according to Keane, for alcohol-related admissions with other health boards is difficult as admission practices vary widely. Nationally men are twice as likely to be admitted for alcohol-related disorders compared to women. There is a general increase in the level of admission for alcohol-related psychiatric disorders in the Southern Health Board area between 1999 and 2001 and this applies to both women and men.

The composite picture that emerges from admission trends is that males either in their twenties to middle ages, single or divorced from lower socio-economic backgrounds with a tendency to depression and alcoholism are more likely to be admitted to psychiatric care.

Sexual Orientation Issues

Since the decision of the European Court of Human Rights on the Senator Norris case in 1998, which ruled that Ireland was in breach of the European Convention on Human Rights in that it had criminalised private homosexual acts between consenting men – homosexual acts between women was never a criminal act - and the subsequent decriminalisation of such acts in 1993, Irish society has experienced a sea-change in attitudes to homosexual people. Commenting on the European Court ruling and the subsequent decriminalisation, the Church of Ireland Gazette at the time asserted the rights of gay and lesbian as follows:

What the European Court has done is to force us to recognise that there is a gay community in Ireland and that this community is composed of Irish people who have the same rights and responsibilities as the rest of us.

(Source: Kearon, 1994, p.10)

A Raphael Gallagher, a Roman Catholic Priest, expressed a similar view.

The persistence of myths about homosexuality is a sign of prejudice and intolerance; because many people never give themselves the chance to understand homosexuals the stereotyped images remain. We must learn to accept that somehow, in God's providence, some people are homosexual. Homosexual emotions are real for these people; the social climate for all of us would improve if we could accept the fact that among our friends and neighbours, relatives and colleagues, there are some people who happen, among other aspects of their personality, to be homosexual.

Their personal suffering can be bitter, their struggle agonising, their sense of loneliness and exclusion intense. They need respect

(Source: Gallagher, 1985, 11 – 13)

Like all discrete populations, it would appear that there are specific drug and alcohol-related issues relevant to the gay and lesbian community. Sexual orientation is also regarded as a strong predictor of drug use and this applies in particular to gay men. An Anglo-American market research company reported that “gay men are almost five

times more likely to abuse substances than their straight counterparts — gay men, perhaps more than any other group in British society, are polydrug users” (Tierney, 2002, p. 41).

Irish gay men are equally more likely to use drugs than are their straight counterparts. In a study of 1,269 gay men published in June 2002 (Carroll *et al.*), 55 per cent of those surveyed had consumed an illicit drug other than alcohol, Viagra or steroids. Ecstasy is also a drug of choice amongst the gay community with just over 25 per cent of the gay men surveyed stating that they used it. Gay men are, however, more likely to use cannabis (32.5 per cent) than ecstasy. Cocaine and speed (amphetamines), drugs that speed up the way your body works — hence its name — are consumed by 14 per cent and over 12 per cent respectively.

No comparative study was found for lesbian women, although anecdotal evidence would suggest that there is a higher incidence of alcohol use/misuse among lesbians than there is among their heterosexual counterparts. Anecdotally, it would also appear that alcohol consumption is high amongst the gay community and this is linked to both the reliance on clubs and bars for social interaction and the reliance on alcohol by some gay and lesbian people who have difficulty in coming to terms with their sexuality.

The 2002 census reports that there were 2,580 same-sex couples resident in the same households - 1,682 male and 898 female couples. No breakdown exists per county. Notwithstanding the above pleas for a more tolerant and inclusive attitude, in general a censorious attitude by the many members of the public towards public declarations of homosexuality prevails. Consequently, the CSO statistics in this respect is regarded as an understatement of the number of gay, lesbian and bi-sexual people in the State. According to the Cork City Development Board (CCDB) “it is now accepted that *at least* (my emphasis) ten per cent of the population is lesbian, gay or bi-sexual (LGB)” (CCDB, 2001, p. 6). That would then suggest that at a conservative estimate the LGB population of Cork City is 12,718. If one were to apply the same percentage to the population of County Cork it would suggest that the LGB population is 29,332.

If one applies the ten per cent off the population if gay, lesbian or bi-sexual yardstick, then one can conclude that the LGB population of County Kerry is 12,613.

Gallagher (1985) estimates the lesbian and gay percentage of the overall population as “the same as in most other countries between two-and-a-half and five per cent”. If one were to take four per cent as a mid-point then one could estimate the LGB population of Cork is 4,993, County Cork is 12,993 and Co. Kerry is 5,296. Gallagher’s estimation discounts bi-sexual people.

Ethnic/Immigrant Issues

There is a general misconception that only recently has this country begun to take its first tentative if faltering step towards becoming a multicultural / multiracial / multiethnic society. Yet, historical evidence indicates that Irish society has experienced wave after wave of immigration and that each wave of immigrants has integrated into Irish society even becoming “more Irish than the Irish themselves” over time. ÓDonnabháin (2002) challenges the notion that the experience of multiculturalism and multi-ethnicity is new to Ireland. Rather, he asserts that it dates

back to the tenth, eleventh and twelfth centuries. While we may have historically constructed an homogeneous identity for ourselves, the reality is that we are a hybrid people and that hybridisation is likely to continue as travel and transport becomes easier and as political borders become more porous.

Certainly in the last ten years, Ireland has experienced a new wave of immigration bringing a new round of linguistic, social and cultural diversity in its wake. There is a perception that when cultures meet that two or more readily defined ways of living come together cheek by jowl and that invariably tensions ensue. Demarcation, it would appear, is central to those who like to think that culture is permanent and frozen in time and place, that culture clearly differ and divide. The renowned critic of literature and culture the Palestinian Edward Said, dismisses such rigid demarcations, counter-arguing that cultures are in fact

very permeable though their dominant representation and ontology are often presented as exclusive.

(Kahn, 1995, p. 15)

No culture exists in absolute isolation according to Said and their “contiguous” existence facilitates synchronisation and attachment rather than clear differentiation.

Such debates may appear somewhat abstract if not tiresome yet, they have a clear relevance for all service providers who seek to work for and with newly-arrived residents of this State. Aware of such reticence to engage with broader debates Secombe (1999) argues that the best-designed programmes put in place by well-intentioned people, are on their own, inadequate to the task.

Anecdotally, it would appear that many of those who have recently arrived in this country are shocked at the level of alcohol consumption. Currently, there are 19,147 (CSO, 2002) Muslims in the country and while they vary, in the same way as Christians do, in degree of adherence to their faith, the culture from which they come is strong in its antipathy to alcohol and drug consumption. According to the Koran intoxicants of all sorts are the work of Shaytan (Satan). This antipathy is shared by many African and Asian people.

However, alcohol consumption in countries from the former Soviet Union bloc is very high and it was this extraordinarily high level that Mikhail Gorbachev targeted in his 1986 perestroika campaign. It is worth noting in the context of East European consumption patterns that with the exception of Hungary, many East European and Baltic State countries have increased prevalence of general consumption (Ireland is second to Denmark in this league) and binge drinking (Keane, 2004. p.42). To what extent that has relevance for people from the Baltic States and other former Warsaw pact countries now working in Ireland is unclear.

Reflecting on the interplay between ethnicity, race and drug consumption, Khan (2000) challenges popular stereotypical images of ethnic minorities as habitual drug users. While acknowledging that very little is known at EU level about social exclusion, drugs and minorities, what data there is does not support such a view, she contends. Despite this, Khan claims that “minorities are over-represented amongst drug-law offenders reported to the judicial system” (Khan, 2000, p. 9). Khan also

asserts that national, regional and local drug policies are generally silent on the issue of drugs and minorities.

No one dedicated source of information for the thirty-six categories of immigrants in the State exists, so the task of establishing the number of Non-Irish-Nationals is very difficult. Between 1 January and 31 October 2004, 3,842 work permits were granted or renewed by the Department of Enterprise, Trade and Employment to Non-Irish-Nationals working in County Cork (Source: Department of Enterprise, Trade, and Employment). No further breakdown on that population is available. However, nationally, almost 7,000 work permits were granted to people from The Philippines (the largest number to any one country), and about three-and-a-half thousand to people from the Ukraine, South Africa and Romania.

The Reception and Integration Agency of the Department of Justice, Equality and Law Reform indicates that there are eight centres in Cork providing direct provision to refugees and asylum seekers. These have ninety per cent occupancy. The centres and their capacity is as follows:

Cobh (43), Glounthaune (108), Clonakilty (95), Kinsale Road Cork (304), Wellington Road Cork (104), Millstreet (145), Pope's Quay Cork (274), Bantry (36)

(Source: The Reception and Integration Agency)

Given a ninety per cent occupancy rate, the total number of people in direct provision is in the region of a thousand people. Nigerians (28%) constitute the largest national group. A slight majority of people in direct provision are male (52%) and sixty per cent are between the ages of nineteen and fifty-five. The vast majority (78%) of those in direct provision is there for more than six months with thirteen per cent (13%) there for more than two years.

Between 1 January and 31 October 2004, 1,259 work permits were granted or renewed by the Department of Enterprise, Trade and Employment to Non-Irish-Nationals working in County Kerry (Source: Department of Enterprise, Trade, and Employment).

County Kerry has nine centres of direct provision for refugees and asylum seekers, four in Tralee and two in Killarney. They are:

Kenmare (56), Killarney (94), Killarney (58), Tralee (100), Tralee (120), Tralee (112), Tralee (34) Glenbeigh (17).

(Source: The Reception and Integration Agency)

Like Cork, they too have an occupancy rate of ninety per cent so the current number of people in direct provision in County Kerry is 532 approximately.

The reality is that we know very little about the 160 different nationalities (Daly *et al* 2004, p. 25) who now comprise more than seven per cent of the population (Fanning, *et al* 2004, p.3) that have recently arrived into the country not least their drug or alcohol consumption patterns. A study of approximately 200 immigrants conducted in the Cork/Kerry area in 2002 (Foley Nolan *et al*, 2004, p. 19) reported male only consumption of cannabis and that only one per cent had consumed cannabis in the previous twelve months. Coincidentally, this is also the figure presenting for

treatment. There were ninety admissions to psychiatric hospital (1% of the total number of admissions) listed as Non-Irish-Nationals in 2002 and just over a quarter of those (26%) had a diagnosis of alcoholic disorder. Nearly one-fifth had a diagnosis for depression (Daly *et al* 2002, p.42). In the Cork/Kerry study, twenty-seven per cent of the respondents stated that they drank alcohol and of those the vast majority (91%) were male. Both the number of those who consume alcohol and the volume of consumption is lower than that of the rest of the population of the country. (Foley Nolan *et al* 2004, p. 33).

A spokesperson for the Customs and Excise has informed this study that a number of cannabis seizures destined for Non-Irish-Nationals have been made in the last year. To what extent these were for consumption by Non-Irish-Nationals or consumption by the general population is unclear.

Notwithstanding that this country has not yet ratified the UN Convention on the Protection of all Migrant Workers and Members of the Families (IHRC and NCCRI, 2004 p. 25) the rights of Non-Irish-Nationals to health care and treatment should that arise is underwritten in international law to which the Irish government is committed. C188 of the International Labour Organisation guarantees medical care to migrant workers. The Convention on the Rights of the Child, guarantees to every child the highest attainable standards of health care and this includes the rights of Non-Irish-Nationals in this country.

Prisoners (Punishment and Crime)

Ireland has one of the lowest crime rates in Western Europe and yet it has one of the highest incarceration rates (Irish Penal Reform Trust 2004, p.1). A survey conducted for the Council of Europe in 2002 (Aebi, 2002) reported that Ireland has a committal rate of 312.5 per 100,000 population far in excess of countries like France (110.3 per 100,000), Finland (131.5), Italy (139.7) and Belgium (140.1). During the period, 1991-2001, there was an average increase of forty-three per cent in the prison population in Ireland. In the six-year period, between 1995 and 2001 the prison population increased by 1,000 (Barclay and Tavers, 2003).

Paul O'Mahony reported that in 1997, this country imprisoned a greater proportion of its citizens than any other country in Europe. In that year, Ireland sent to prison 328 people per 100,000 – four times more people than did Greece or Turkey. It would appear that the trend towards imprisonment is set to continue. The Minister for Justice Equality and Law Reform announced in 2004 that he plans to increase prison spaces by twenty-five per cent.

Reflecting on prison policy in Ireland, the Governor of Mountjoy prison, John Lonergan, told a recent Céifin conference in Ennis that imprisonment on its own is not the solution to society's social problems. "Prison is not capable of undoing in a short period the damage inflicted over a lifetime" (1999, p.60) he asserted. Highlighting the strong relationship between drug misuse and crime, he called for "a national planned approach and huge resources...and not stand idly by as we watch as thousands of our young people are destroyed by drug and alcohol abuse" (1999, p. 60).

Nationally, women constitute less than three per cent (2.6%) of the prison population. About one-third (34%) of the prison population is between the ages of seventeen and twenty-four. Nearly half (46%) are between the age of twenty-five and forty. The remainder (20%) are over forty. The Irish Penal Reform Trust, a non-governmental organisation for the rights of people in prison and reform of Irish penal policy, estimate that it costs €85,000 to accommodate each prisoner every year.

For Garda statistical purposes, the Southern Region (there are six regions in total) consists of Cork City, Cork North, Cork West, Kerry and Limerick. In 2003, this region had the second highest number of prosecutions (1,276, 23%) in the State after the Dublin Metropolitan Region for offences involving cannabis. It had the fourth highest for ecstasy (137, 14.2%). There were twenty (2.7%) heroin offences but seventeen of these were in Limerick and three (0.4%) were in Cork City (Garda Síochána, 2003, p.77 – 80).

Of the 1,276 prosecutions that were initiated in 2003, 1,243 have been completed. Of these, the majority (35.8%) was in Cork City followed by Cork West (17.7%), Co. Kerry (14.0%) and Cork North (8.4%). The remainder was in Limerick. While prosecutions fell from the previous year, the Southern Region had the second largest number of prosecution per 100,000 population in the State. (Garda Síochána, 2003, p.77 – 80).

The vast majority (92%) of those prosecuted were male. Of the total number prosecuted, fifty-two (5.5%) in Cork and Kerry were under the age of seventeen, 321 (34.5%) were between the age of 17-21 and 559 were over the age of twenty-one. The Southern Region had the second highest number of cautions issued to children aged between seven and eighteen. Of these the highest number was in Cork City (533, 39.6%) followed by Cork West (226, 16.0%), Cork North (172, 12.2%) and Co. Kerry (156, 11.0%). The remainder was in Limerick. (306, 21.2%). The Southern Region had the third highest number of child offenders cautioned per 1,000 of population. The Dublin Metropolitan area had the highest

Despite the way in which racial stereotypes are often evoked in profiling drug dealers (King, 2003), the evidence from the 2003 Garda Report would indicate that ninety-eight per cent of prosecutions were of Irish people. British people were the next biggest national group. Only sixteen (0.2%) Africans, ten (0.1%) East Europeans/Middle Eastern people were prosecuted and two Asian people.

While the Garda report concentrates on drugs, the Commissioner does point out in his *Foreword* that the misuse of alcohol plays a very significant role in public order offences.

Homelessness

The United Nations Centre for Human Settlement, Habitat, defines homelessness as inadequate shelter, privacy, space and security (King *et al* 2000). In this country homelessness is defined in Section Two of the Housing Act, 1988, as a person, who, in the opinion of the local authority concerned

(a) has no accommodation available which he or any other person who normally resides with him, or might reasonably be expected to reside with him, can reasonably occupy or remain in occupation of,

(b) is living in a hospital, county home, night shelter or other such institution because he does not have accommodation of the kind referred to in (a) and is unable to provide accommodation from his own resources.

(Source: Government of Ireland. 1988)

Like all other social classifications in society, homeless people are not an homogenous group. There are a variety of routes in and out of homelessness. Age, gender, health status, sexual orientation, alcohol and drug use, family violence, refugee asylum seeker, and family history i.e. whether or not childhood/adulthood or part of was spent in care, prison, psychiatric hospital, have experienced emigration, separation or divorce are all inter-linked and contributory factors of homelessness. Nor are homeless people single units. Families can also become homeless or indeed family units can be established while homeless. While the public face of homelessness is street homelessness, it is not its sole expression. People can be out of home in a range of temporary accommodation from bed and breakfast accommodation, squats, the homes of other family members or friends.

In a survey (2001) of twenty-eight young homeless people in Cork aged between 18-26, seventy-one per cent consume alcohol forty-one percent reported the use of illegal unprescribed tranquillisers (2), cocaine (2), unprescribed sleeping tablets (1), drugs. The choice of drugs consumed was quite wide – cannabis (9), ecstasy (5), crack, (1), solvents (1) and heroin (1) (Frost *et al* 2001, p.10)

The report highlighted the bi-directional relationship between homeless and drug and alcohol consumption. Drugs and alcohol contribute to homelessness and are a refuge, however unsatisfactory, from homelessness. Many of the young people in the survey reported both physical and emotional health problems and also felt that the health services were not responding adequately to their health needs. Emotional health problems include depression, panic disorder and suicide threat.

The placing of young people in psychiatric wards was one such inappropriate response cited by the homeless young people. Instead of these wards being the first port of call, many of the young people felt that access to a pre-treatment centre in a safe appropriate environment would be more appropriate.

O'Meachair's study (2004) reports that there are seventy-two homeless people in North Cork of which eleven are women and oldest is aged ninety-six. Of the seventy-two homeless people, forty-two are single, nineteen married, ten separated, three widowed and one divorced. In eight of the eleven cases where women are homeless, domestic violence was cited by eight. Many of the men have a history of addiction.

In West Cork, there are five homeless beds in a hotel in Dunmanway to cater for Adult Homeless Persons in the West Cork Area. Presently, none of these beds are occupied.

There were 380 people homeless in Cork City in 2002 and approximately twenty-five homeless in Co. Kerry in 2005.

Literacy

It is not an exaggeration to say that the findings of the Morgan *et al* study (1997) on adult literacy in Ireland sent shock waves throughout not only the educational system but also society in general. The results indicated that the much-trumpeted educational system was found wanting and seriously wanting. The study found that a quarter of Irish adults had problems with even the most simple literacy task (Literacy Level 1) - the figure for Sweden was six per cent and the Netherlands is ten per cent. Furthermore, thirty-two per cent were at Level 2. Over half of the Irish population were at Literacy Levels 1 and 2.

In the Literacy Level 1 the reader knows the alphabet but has difficulty reading. One of the tasks at Level 1 respondents are asked is to look at the directions on a bottle of aspirin to find out the maximum number of days a person should take this medicine (Morgan *et al* 1997, p. 22). People at Level 2 can read but have difficulty with writing, spelling or grammar. At Level 2 respondents were given directions about the general care of a plant and the reader is asked what happens when the plant is exposed to temperatures of fourteen degrees centigrade or lower (Morgan p. 23).

The above report did not go unnoticed. The White Paper on adult education *Learning for Life* committed the Department of Education and Science to (among other priorities) prioritising those with lowest literacy levels (Department and Education and Science 2000, pp. 88-90).

The relevance of these findings for this study rest with the strong co-relation between literacy levels and deprivation status. Morgan and Kett (2003) claim that there is a quite strong relationship between reading failure and anti-social behaviour – “it is an important link in the interacting causal chain” (2003, p. 24).

Poor literacy diminishes life chances, reduces the possibility of engagement not only in economic activities but also in social and cultural life – “much more remarkable is the finding that frequency of involvement in literacy activities is also related to participation in sport and even an enhancement and enrichment of people’s lives so that they are more likely to have a broad range of interests in film, sport and community” (Morgan and Kett, 2003, p. 14).

Over half of those in Irish prisons are at Level 1, a figure Morgan and Kett find “particularly alarming given the age profile of the prison population (2003, p. 55). Levels of literacy are also relevant to further understanding those who seriously misuse drugs. The indications are that people who seriously consume drugs are more likely to have serious literacy problems. This has serious implications for at least one of the pillars of the national drug strategy, namely education and prevention.

Prescribed Drug Misuse

While the issue of the misuse of prescribed drugs is outside the terms of reference of this study, concern about the misuse of prescribed drugs was raised again and again in the consultative process. Concern about the misuse of prescribed drugs is not just a regional issue. A former inspector of Mental hospitals, Dr. Dermot Walsh has gone public (Irish Times December 14 2004) on his concern that doctors are over prescribing anti-depressants with little evidence of any public health benefit. Arguing that the rise in suicide “mirrors almost exactly the increased use of

antidepressants...along with the length of stay in psychiatric hospitals (2004) he declared that it is time “for more talk and less tablets”. Walsh’s view has international support.

The British National Institute for Clinical Excellence has urged doctors not to use on anti depressants as a first port of call in treating people with mild depression. Minister of State Tim O’ Malley T.D. of the Department of Health and Children at the launch of a survey of patients in long-stay mental health facilities agreed that there had been an overuse of medication in the treatment of mental health in the past (Donnellan, 2004). That over-reliance was the subject of much discussion as will be outlined in Chapter Five of this study.

Summary

In summary, Counties Cork and Kerry, like other parts of the country, has experienced recent substantial socio-economic and cultural change in the last half century. Equally, like other parts of the country, the overall economic transformation of both counties masks serious underlying problems. While the overall population has grown, parts of rural Cork and Kerry is experiencing serious decline. The decline in Cork City has more to do with boundaries and population shifts in the city rather than any serious change. Concern has been expressed by the age profile in parts of both counties. There is an overrepresentation of older single men in some rural areas and an absence of younger women skewing the population balance. Places like Carrigaline in County Cork and Killarney in County Kerry have benefited from this rural decline.

While the economy of both counties has benefited enormously from recent economic upswings, concern has been expressed at the over reliance on some industries and the low level of linkage between foreign-owned and indigenous industry. Prospects for the agriculture sector are not good. The traditional family farm is in decline and there is greater consolidation of farms. County Kerry has the highest deprivation level in Munster and unemployment is still very much a reality for many people.

The suicide rate in Cork and Kerry is higher than the national average and that gap is widening. It is particularly high for young men underscoring yet again the degree to which many men struggle with day to day living. Nor are women immune to such struggles but their coping mechanisms would appear to be somewhat different.

Other groups too have their own struggles. For the most part, members of the Travelling community are estranged from mainstream society as mainstream society is from them. The social cleavage is reinforced by social and economic practices that put barriers in the way of Travellers access to educational and work opportunities.

Estrangement is also a feeling that many people with disabilities and gay, lesbian and bi-sexual people feel, notwithstanding recent budgetary changes and the huge legislative protections that have been put in place in recent years. They are not alone. Newly arrived migrants, be they in the workplace or barred from the workplace can feel adrift cut off by linguistic and social barriers. Metal bars cut people in prison off from mainstream society and very often these bars do not come down on release. People who are homeless are confronted with an altogether different dilemma. Getting in to accommodation as opposed to getting out of accommodation is their challenge.

And for those who do not have the basics of literacy getting anywhere is a real problem.

As well as being issues of national concern, all of these issues impact locally albeit sometimes in quite different ways. This Chapter has attempted to provide an overview of these different ways in Cork and Kerry. In doing so, it has sought to highlight some of the fault lines within which the seeds of alcohol and drug consumption root and grow. In the view of this report, it is against this background that the Southern Regional Drugs Strategy must begin the next phase of its work. It is from this starting point that in the words of the Taoiseach we are required to rethink established norms and behaviours and to adjust our perceptions and attitudes.

Chapter 3 Drug, Alcohol and Related Services in the SRDTF Region.

Introduction

This Chapter will detail current drug and alcohol services in the region and current uptake of these services. Jackson's (1997) study recommended that a number of key services should be developed both in the areas of Prevention and Treatment. The Prevention services he recommended were as follows:

- Comprehensive Substance Use Prevention Policies and programmes must be available and implemented;
- Priority should be given to high prevalence areas;
- Youth services in the community must be developed and supported, especially for early school-leavers;
- Recreation and sports facilities should be available in all areas, especially in high drug prevalence areas;

With regard to treatment, Jackson (1997) recommended:

- The integration of all available services e.g. Southern Health Board, Local Authority, Community, Education, Justice at all levels, rather than in isolation;
- Satellite and Outreach clinics should be developed;
- Existing Alcohol and Drug treatment centres should be expanded. General Practitioners, Nurses and other professionals may need further training in handling of alcohol and drug problems especially at key early stages;
- Residential care for specialised intervention needs.

Drug and Alcohol Services Counties Cork and Kerry

Data for accesses to treatment centres has been standardised since 1999. Since then, the number of people attending treatment services has expanded greatly by about 300% for both drugs and alcohol. The following tables detail current service provision in the area. There are three residential service treatment centres with thirty-six bed capacity. Table 7 provides the details.

**Table 7
Voluntary Treatment Services
Residential Treatment Centres in Cork and Kerry**

Treatment Centre	Services Provided
Tabor Lodge, Ballindeasig, Belgooly, Co. Cork	18 bed Residential Centre for alcohol and drug misuse. This service is for adults only.
Talbot Grove, Scartaglin Road, Castleisland, Co. Kerry	12 bed Residential Centre for alcohol and drug misuse. This services is for adults only.
Cara Lodge Adolescent Centre, Ahiohill, Enniskeane Co. Cork	6 bed Residential Centre for Adolescent Boys

In addition to the above services within the region people of Cork and Kerry can also access services in Limerick, Kildare and Kilkenny. Table 8 has the details.

Table 8
Residential Treatment Services provided outside of Cork and Kerry Region

Treatment Centre	Services Provided
Cuan Mhuire, Bruree, Co. Limerick	125 bed Residential Centre for alcohol and drug misuse. This service is for adults only.
Cuan Mhuire, Athy, Co. Kildare.	Specialised Residential Drug Unit for the treatment of Opiate Misuse.
Aislinn Adolescent Treatment Centre, Ballyragget, Co. Kilkenny.	12 bed Residential Centre for drug and alcohol misuse. This service is for young people 14 – 18 years of age.

There are two half-way houses in the region with a total capacity of twenty beds. Table 9 has the details.

Table 9
Continuing Care – Residential Half-Way Houses in Cork and Kerry

Fellowship House, Doughcloyne, Spur Hill, Togher, Cork.	10 bed Continuing Care Programme for men only
Renewal Centre, Shanakiel, Blarney Road, Cork	10 bed Continuing Care Programme for women only

There is one non-residential treatment service in the area located in Mallow, Co. Cork. Table 10 has the details.

Table 10
Non-Residential Treatment Centres in Cork and Kerry

Name	Services Provided
Anchor Treatment Centre, Spa Glen, Mallow, Co. Cork.	This is an outpatient rehabilitation programme for alcohol and drug abuse.

The Health Service Executive provides two out patient programmes in Arbour House Treatment Centre. Table 11 has the details.

Table 11
Statutory Treatment Services

Name	Services Provided
Health Service Executive, Arbour House Treatment Centre, St. Finbarr's Hospital, Douglas Road, Cork.	Arbour House consists of two outpatient programmes for adults and young people. It provides a range of services depending on the individual needs of the client.

The Health Service Executive also has thirteen community and counselling and advisory services throughout the region. Table 12 has the details.

Table 12
Community Counselling and Advisory Services

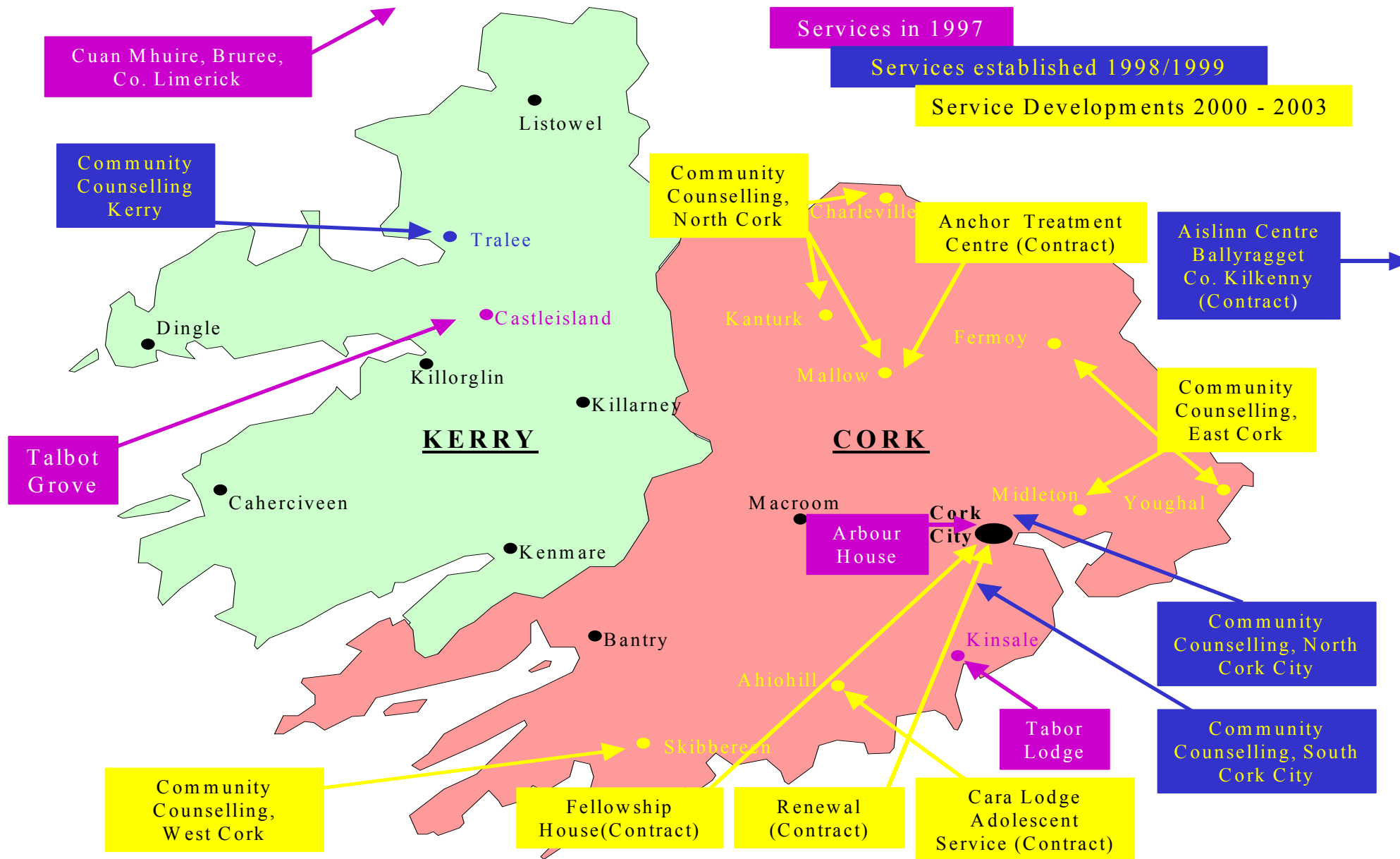
<p>Health Services Executive Community Counselling and Advisory Services</p> <p>North Cork City, 10, Church Street</p> <p>South Lee, Togher, Mahon</p> <p>East Cork Midleton, Youghal</p> <p>North Cork, Mallow, Charleville, Kanturk and Fermoy</p> <p>West Cork Skibbereen - Medical Centre, Market Street</p> <p>Kerry Tralee, 38, Ashe Street, Killarney, Kenmare, Killorglin, and Caherciveen</p>	<p>The Community Counselling and Advisory Services offer Assessment and Referral to individuals and families concerned about alcohol and drug misuse. Clients are seen on individual basis for counselling at locations close to their place of residence.</p>
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A range of additional supports are also available to the people in the region and these are detailed in Table 13.

Table 13
Additional Support Services

<p>St. Helen's Convent Missionary Charities Blarney</p>	<p>Is a Residential Centre for homeless persons. Counselling is provided to the residents who may have concerns about alcohol and drug misuse. This service is for adults only.</p>
<p>The Bridge Co-op, Cork City</p>	<p>Support services for individuals with alcohol and drug problems. This group also organise work schemes.</p>
<p>Matt Talbot Adolescent Services, Douglas, Cork</p>	<p>The Matt Talbot Adolescent Service provide support services for adolescents and their families who are experiencing difficulties relating to alcohol and drug misuse.</p>
<p>Alcoholics Anonymous (AA) (021) 4500481</p>	<p>Self help support for people with alcohol related problems.</p>
<p>Al Anon / Al Ateen (021) 4311899</p>	<p>Self-help support group for family and friends of people with alcohol related problems.</p>
<p>Gamblers Anonymous (021) 4279701 / (086) 8749799</p>	<p>Provides 24-hour telephone support from fellowship of people who help each other recover from gambling addiction.</p>
<p>Gam Anon (021) 4279701 / (086) 8749799</p>	<p>Provides support for families and friends of people who are addicted to gambling.</p>
<p>Narcotics Anonymous (NA) (021) 4278411</p>	<p>Self-help support group for people who are addicted to substances.</p>
<p>Nar Anon, St. Augustine's Priory, Washington Street, Cork. (01) 8748431</p>	<p>Self-help support group for families and friends for people who are addicted to narcotics.</p>

HEALTH SERVICE EXECUTIVE SOUTHERN AREA- DEVELOPMENT OF DRUG AND ALCOHOL TREATMENT SERVICES 1997 - 2003



Treated Drug Misuse Database

The Southern Health Board's Department of Public Health has established a comprehensive reporting system of "Treated Drug Misuse". This database was developed to work closely with national reporting systems and to assist in the correlation of European statistics. The service's database has been developed to include information fields on treatment and discharge status of clients, which allows for greater profiling of clients and for obtaining useful information on treatment outcomes.

Numbers of People Availing of Services

In the five-year period from 1999-2003, 6,734 people have availed of treatment services. Table 14 has the details.

Table 14

Numbers availing of Community-based Treatment Services in Cork and Kerry 1999-2003

Place	Year Treated					Total
	1999	2000	2001	2002	2003	
Tabor Lodge	209	212	213	452	359	1,445
Arbour House	295	449	552	555	540	2,391
Talbot Grove	98	182	179	257	243	959
Anchor Centre	0	61	70	101	143	375
N. Lee	0	108	122	181	118	529
N. Cork CCS	0	0	18	34	51	103
E. Cork CCS	0	0	53	75	91	219
W. Cork CCS	0	0	30	0	0	30
Kerry CCS	0	73	173	204	212	662
GPs	0	0	0	0	21	21
Total	602	1,085	1,410	1,859	1,778	6,734

(Source: Department of Public Health, SHB, 2004)

Almost two-thirds of all those seeking treatment in 1999 did so for alcohol-related difficulties and one-third for drug-related reasons, since then the number seeking help because of their drug consumption has increased from 34% to 40%. Table 15 has the details.

Table 15

Numbers presenting for Treatment for Alcohol/Drug Consumption

Drug	Year Treated					Total
	1999	2000	2001	2002	2003	
Alcohol	397	720	852	1,161	1,059	4,189
Drugs	205	365	558	698	719	2,545
Total	602	1,085	1,410	1,859	1,778	6,734

(Source: Department of Public Health, SHB, 2004)

In addition to the above, Keane (2004, p. 37) reports an increase in admissions to acute general hospitals for alcohol-related disorders.

Profile of those Presenting for Treatment for Drug and Alcohol in the Southern Health Board Region

In a study of 613 people who presented for treatment in 2003, 327 (53%) had never been treated previously and 285 (47%) were previously treated (National Drug Treatment Reporting System, 2004).

Fewer women were treated in 2003 compared to the previous three years. From 1998-2001 just over a quarter of all people presenting for treatment were women (27%, 27%, 26% and 27% respectively) and that declined to less than a quarter in 2002 and 2003 (23%).

Exactly half of those who went for treatment in 2003 lived with parents/family. Just over eleven per cent (11.2%) lived alone. Only a minority (16%) of those who presented for treatment was living with a drug misuser.

The vast majority (93%) were Irish. The vast majority (87%) had some experience of secondary school, while six per cent had primary only schooling and seven percent had third level. The average age of first time in treatment was twenty-four and the average age of those previously treated was twenty-nine. Sixteen was the average age for first drug use. The age profile of those treated is detailed in Table 16.

Table 16
People Presenting for Treatment in the SHB Region in 2003 by Age N = 633

Age	Never Treated	Previously Treated	Not Known	Total
10-14	10	2	0	12 (1.9%)
15-19	116	49	0	165 (26.2%)
20-24	78	70	0	148 (23.3%)
25-29	52	55	1	108 (17.1%)
30-34	36	48	0	84 (13.3%)
35-39	23	30	0	53 (8.48)
40-44	14	20	0	34 (5.47%)
45-49	5	6	0	11 (1.7%)
50-88	4	13	0	17 (2.7%)
Missing	0	1	0	1 (0.1%)
Total	338	294	1	633 (100%)

(Source: National Drug Treatment Reporting System)

Of those who presented for treatment, cannabis was by far the most frequently consumed drug followed by ecstasy (and other mdma), cocaine and heroin. There has been a slight increase in the number presenting for heroin treatment from 1998 to 2003 with the number of cases ranging from five to a high of sixteen in 2002. Table 17 has the details

Table 17
Main Type of Drug Used by those presenting for Treatment in 2003
in the SHB Region (2003)

Type of Drug	Never Treated	Previously Treated	Not Known	Total
Cannabis	224	166	1	391 (61.9%)
Ecstasy (and other mdma)	34	30	0	64 (10.2%)
Cocaine	31	19	0	50 (8.0%)
Heroin	15	33	0	48 (7.6%)
Benzodiazepines	16	14	0	30 (4.7%)
Other opiates	6	20	0	26 (4.2%)
Hypnotic and sedatives excluding benzodiazepines	2	6	0	8 (1.3%)
Amphetamines	4	3	0	7 (1.1%)
Voilatile inhalants	3	1	0	4 (0.6%)
Unspecified drug	2	1	0	3 (0.4%)
Hallucinogens	0	0	0	0
Opiate Substitutes	0	0	0	0
Total	338	294	1	633 (100%)

(Source: National Drug Treatment Reporting System)

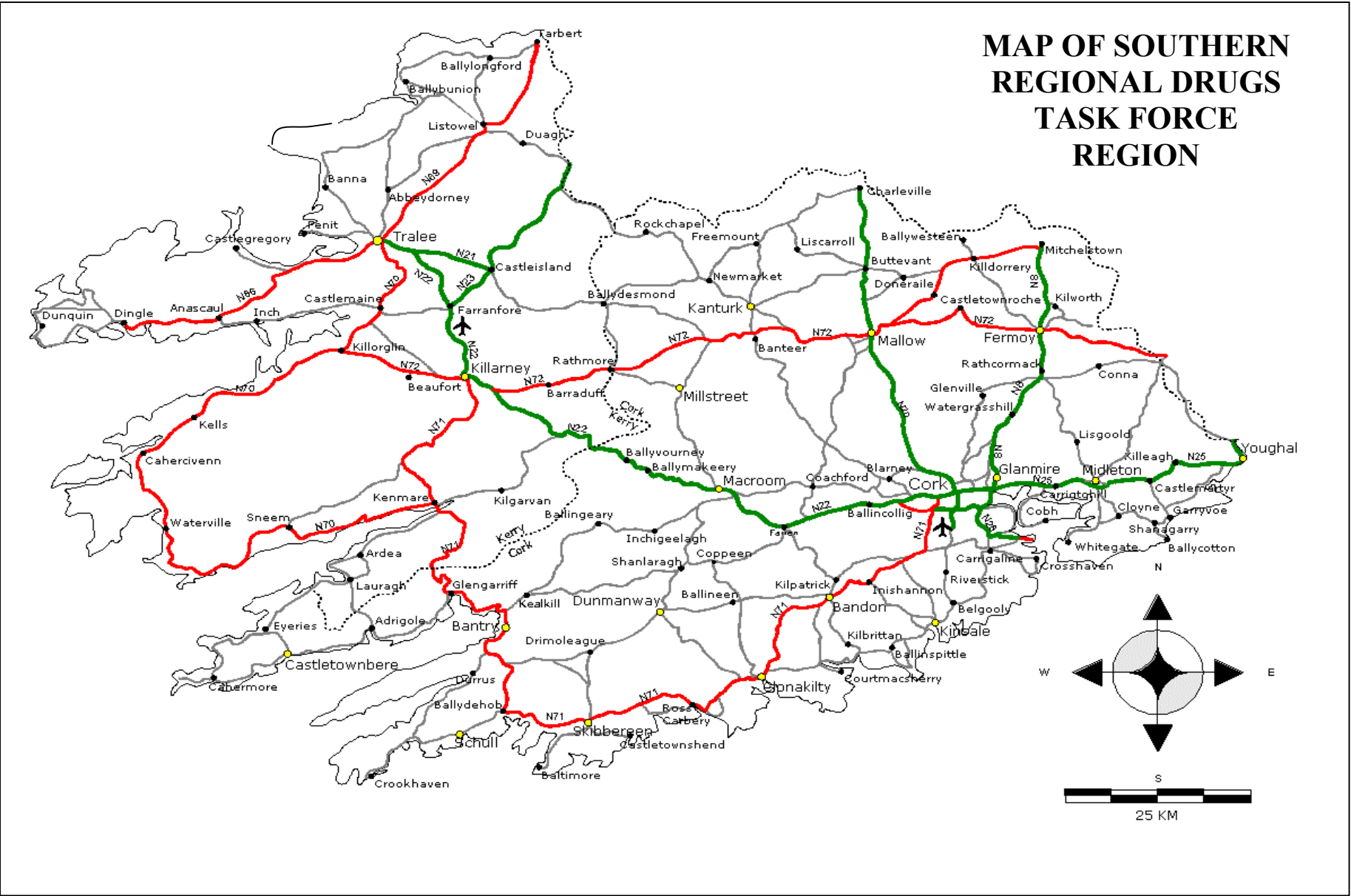
Community and Voluntary Organisations Involved in Alcohol and Drug-related Work

In parallel with this study, the SRDTF undertook a “scoping exercise” to establish the number of community and voluntary organisations in the region that were providing specific drug initiatives, at risk initiatives or general initiatives that might impact on drug and alcohol consumption patterns in the region. A total of 134 organisations stated that they provided at least some drug/alcohol-related services as part of their work. Of these, sixty (46%) were returned from Cork City, fifty-three (40%) from Cork County and nineteen (14%) from County Kerry. Two came from outside the area. Table 18 summarises the above.

Table 18
Community and Voluntary Organisations with some Drug/Alcohol-related Activities in Cork and Kerry

Type of Initiative	Number
Drug Specific Initiatives	32 (23.9%)
At Risk Initiatives	35 (26.1%)
General Initiatives	67 (50.0%)
Total	134

MAP OF SOUTHERN REGIONAL DRUGS TASK FORCE REGION



The organisations involved in Drug-Specific work are detailed in Table 19.

Table 19
Organisations Involved in the Initiatives

Drug Specific Initiatives
Alliance Sexual Health Centre,
Anchor Treatment Centre,
B.A.Y. Project,
Churchfield Community Trust,
Club Cork Initiative,
Cork Youth Information Centre,
Cuan Mhuire Bruree,
Customs & Excise,
F.A.C.T. Ballincollig Family Resource Centre,
Fellowship House,
Fermoy Young Mothers Group,
Glanmire Community Drugs Initiative,
Irish Friends of the Suicide Bereaved,
Irish Society for the Prevention of Cruelty to Children,
Knocknaheeny Youth Project,
Mahon Drugs Task Force Initiative,
Midleton Community Youth Project,
No Name Clubs,
Post Release Services Project,
Prison & Probation Addiction Counselling Service,
School Support Programme,
SHB, D & A Services, Adult Programm,
SHB, D & A Services, East Cork,
SHB, D & A Services, Kerry,
SHB, D & A Services, North Cork,
SHB, D & A Services, North Cork City,
SHB, D & A Services, West Cork,
SHB, D & A Services, Youth Programme,
SHEP Support Service,
South Kerry Life Education Mobile Ltd.,
Tabor Lodge Treatment Centre,
Togher Link UP

Thirty-five organisations were involved in “At Risk” Initiatives and these are detailed in Table 20

Table 20
Organisations involved in “At Risk” Initiatives

“At Risk” Initiatives
Avondhu Development Group,
B.A.Y. Project,
Bandon Youth Project – Foroige,
Banteer Underage Soccer Club,
Bantry & Dunmanway School Completion Programme,
Beara Youth Development Project – Foroige,
Carrigaline Youth Initiative – Foroige,
Cork Simon Community,
Cork YMCA,

Dublin Hill/Ballyvolane Initiative for Youth,
Farranree Alcohol Awareness Project,
Glen & District Youth Project,
Glen Action Project,
Glen Young Adult Project – Foroige,
Greenmount Youth Initiative,
Gurrabraher / Churchfield Outreach Project,
Hillgrove Outreach,
KDYS – Community Based Youth Projects - Tralee, Killarney, Listowel,
KDYS – Early School Leavers Holistic Development Programme - Killarney & Tralee,
KDYS – Outreach Centres - Caherciveen, Killorglin, Kenmare, Castleisland, Listowel, Tralee,
KDYS – Youth Café & Games area / Performance area / Exhibition area – Killarney,
KDYS – Youth Crime Diversion Project - Tralee & Killarney,
KDYS – Youth Information Service – Tralee,
KDYS – Youthreach Leaving Cert Applied – Tralee,
Knocknaheeney Youth Project,
Le Cheile School,
M.A.Y. Project – Foroige,
Mahon Youth Development Project –Foroige,
Mallow School Completion Programme,
Mayfield Youth 2000 – Phase 1,
Mayfield Youth 2000 – Phase 2,
North Kerry School Completion Programme,
Partnership Tra Li,
SKY Youth Project – Foroige,
Youghal Youth Project – Foroige.

Sixty-seven organisations were involved in “general initiatives and these are detailed in Table 21

Table 21
Organisations Involved in “General Initiatives”

General Initiatives
Adrigole Foroige Club
Alliance Sexual Health Centre
Allihies / Garnish Foroige Club
Aughadown Foroige Club
Ballinascarthy Foroige Club
Ballydehob Foroige Club
Ballyhooley Foroige Club
Ballyvolane / Dublin Hill School Completion Programme
Baltimore Foroige Club
Banchara Womens Network
Bandon Foroige Club
Banteer Underage Soccer Club
Barryroe Foroige Club
Bera Island Foroige Club
Castlemanger Foroige Club
Castletownbere Foroige Club
Charleville Community Child Care Ltd.
Comharchumann Chleire Teo
Cork Association for the Deaf
Cork Community Drug Prevention Training Project
Cork Education Support Centre
Department of Education & Science – National Education Psychological Service
Department of Education & Science – National Educational Welfare Board

Department of Education & Science – SHEP Support Service
Department of Education & Science – Southern Regional Office
Department of Education & Science - Visiting Teacher for Travellers
Department of Education and Science – Office of the Inspectorate, Assistant Chief Inspector
Department of Education and Science – Social Inclusion Unit
Drinagh Foroige Club
Duagh Family Centre
Dunmanway Foroige Club
Eyeries Foroige Club
Foroige Area Manager
Glen Youthreach
Graffiti Theatre Co.
Home School Community Liaison, North Presentation Primary School
Irish Countrywomens Association
Irish Friends of the Suicide Bereaved
Irish Girl Guides
Kanturk Foroige Club
Kealkill Foroige Club
Kerry County Community & Voluntary Forum
Kilcrohane Foroige Club
Kildorrery Foroige Club
Kilmichael Foroige Club
Le Cheile Family Resource Centre
Liscarroll Foroige Club
Mallow Youthreach Training Centre
MFG Comhar Dhuibhne
Midleton Community Forum Limited
National Training and Development Institute
Newmarket Teachers Group
Newtownshandrum Foroige Club
No Name Club – Killarney
North Kerry School Completion Programme
O.S.S.
Rosscarbery Foroige Club
Rylane Foroige Club
Scoil Iosagain Boys Primary School
Shalom Montessori Pre-School
Shanballymore Foroige Club
Skibbereen Foroige Club
Social and Health Education Project
Southern Gay Men’s Health Project
Timoleague Foroige Club
Union Hall Foroige Club
West Cork Education Centre

Cork Local Drugs Task Force

In 1997, the government established Local Drugs Task Forces (LDTF). Initially, eleven were established – ten in Dublin and one in Cork. Subsequently, three others were established in Bray, Dublin and Dun Laoghaire/Rathdown. Each LDTF was mandated to develop a locally-based integrated response to the drug problem and prepare an Action Plan. The Cork LDTF Plan, submitted its plan in July 2000, focused on both adults and young people as well as on the wider community. The Cork LDTF Projects are as follows:

**Table 22
Cork Local Drugs Task Force Projects**

<i>Name of Project</i>	Primary Schools	Secondary Schools	Street Work	One to one Support / Counselling	Youth/ Group Work	Work with Parents/ Community	
(B.A.Y.) Ballyphehane Action for Youth Project			√	√	√	√	
Ballincollig Youth Initiative	√	√	√	√	√	√	
Carrigaline Youth Initiative	√	√	√		√		
Dublin Hill Initiative for Youth	√	√		√	√	√	
Farranree Alcohol and Drugs Awareness Project	√	√		√	√	√	
Glanmire Community Drug Initiative	√	√		√	√	√	
Glen Neighbourhood Youth Project	√	√	√	√	√	√	
Greenmount Youth Project	√	√	√				
Gurrabraher / Churchfield Outreach Project	√	√			√	√	
DAYS Project, Douglas	√	√	√	√	√	√	
Hillgrove Outreach	√	√		√	√	√	
Knocknaheeny / Hollyhill Youth Centre	√	√	√	√	√	√	
M.A.Y. Project	√	√	√	√	√		
Mayfield Youth 2000 – Phase 1	√	√	√	√	√	√	
Mayfield Youth 2000 – Phase 2	√	√	√	√	√	√	
Togher Link-Up Ltd.	√	√		√	√	√	
Citywide Parents Support Group						√	
Club Cork	Educate night club staff off licence owners and staff, door people and managers to take an active role in dealing with substance abuse on their premises						
Community Counseling and Advisory Service					√	√	
Community Outreach Drug Awareness Project,	Information Library. Provides support and training to groups, organises seminars and organises the Cert. and Diploma in Community Based Guidance and Support UCC.					√	√

Community Policing / JLO Initiative	Has a budget for events etc					
Cork Simon Street Outreach Project			√	√		
Cork Youth Information Centre	Produces "No You Are Not Alone" a guide of useful addresses, including drugs services for young people.					
Cork YMCA Free Counselling Service				√		
Dion Project	Equips out of home young people with the skills for independent living to prevent them from getting involved in drugs and prostitution			√	√	
Halfway House for Men				√		
Peer Education Programme		√		√	√	√
Post Release Service	Support Services for prisoners on release			√		
Rehabilitation Programme for Ex-prisoners (Probation and Welfare Services)				√		
School Support Programme	√	√				
Stop Drugs Now				√		

Further to the above services, a range of statutory bodies provide a combination of drug-specific initiatives, initiatives aimed at risk people or general initiatives that may impact on drug/alcohol services. These include:

- Area-Based Partnerships;
- County and City Development Boards;
- Community Development Programmes;
- Department of Education and Science;
- Department of Justice, Equality and Law Reform;
- Department of the Community, Rural and Gaeltacht Affairs;
- Department of Social Community and Family Affairs;
- Dormant Accounts Programme;
- Estate Management;
- FÁS;
- Garda Síochána;
- Health Services Executive;
- Local Authorities;
- Prison Services;
- Probation and Welfare Services;
- RAPID (Revitalising Areas through Planning Investment and Development) Programme;
- Revenue Commissioners (Customs & Excise Division);
- Social Inclusion Measures Group;
- Vocational Education Committees;

Summary

This Chapter has detailed some of the responses of statutory, community and voluntary service providers to the growing level of alcohol and drug consumption in Cork and Kerry. As outlined above, there has been an exponential growth (about 300%) in the number accessing treatment since 1999. As the level of growth continues to increase it would appear that the level of provision will also have to increase. This and other issues will be dealt with in greater detail in the next and final Chapter.

Chapter 4 Research Methods

Introduction

The Southern Regional Drugs Task Force commissioned this study. The objective of the study was to prepare a four-year development plan to respond to regional drug issues in the Cork-Kerry area. The SRDTF undertook a consultative process to enable it prepare its four-year strategy. This chapter details how that consultative process was conducted.

The Research Method

A qualitative approach to the collection of data was adopted in this study. Qualitative research operates on the principle that the people involved in an activity should be heard and their voice should be influential in shaping the direction of the enterprise in which they are involved. The role of the researcher is, according to Rubin and Rubin (1995), “to listen to people as they describe how they understand the world in which they live and work” (1995: p.3).

Thirteen consultative meetings were organised with a cross-section of interested parties, four of which, were public meetings. Details of these meetings are outlined in Table 1 below. The objective of these meetings was to:

- Map drug and alcohol consumption in the Cork Kerry region;
- Identify any gaps in service provision and, if so, where those gaps are;
- Identify what needs to be done to address perceived gaps in service.

Qualitative research involves the interviewer and the interviewee becoming conversational partners with scope for personal biographies, motivations, experiences, understandings, values, and preferences. The interview also provides opportunities to identify intervention success and failures, form explanations and theories, and offer opinions on possible outcomes. Flexibility is the key to the qualitative approach. In many respects, interviews are similar to ordinary conversations that one may have at any time. However, the *raison d'être* of the research conversation is very different. It is to increase all the conversational participants' understanding, knowledge and insights.

Framing these conversations is somewhat problematic. It has to be done in a way that would trigger thoughts and reactions yet these triggers must not steer the conversation in any particular direction. At each of these consultative meetings the same conversational triggers were used.

Prior to the initiation of these conversations, the Interim Co-ordinator of the SRDTF, Willie Collins outlined the institutional background to the establishment of the ten regional drugs task forces. This was followed by a short presentation from Peadar King. In his presentation he drew heavily on the work (1997) of Dr Tim Jackson specialist in public health medicine and also made reference to more contemporary work (2004). He began by describing Jackson's “typical drug user”.

The drug user in this survey tends to be young, male from urban areas, is also a smoker or drinker and has smoked or drunk from an early age (more) than non-drug users. Part-time employment, high frequency of pub and disco

attendance and low frequency of attendance of church are all associated with increased drug use. Recent and Current drug use are highest at younger ages, and fall almost to nil over age thirty-five.

(Jackson, 1997, p.6)

This was followed by Cork Kerry users' drug of choice in 1997.

- Cannabis (lifetime 16.5%, recent, 7% and current 4%).
- Hallucinogens - LSD and Magic Mushrooms. Lifetime 6%, recent 2% and current less than 0.5%. (p.35)
- Stimulants - Amphetamines, Ecstasy, Cocaine. Lifetime 5%, recent 2% and current 1%. (p.37)
- Solvents – glue, Tipp-ex. Lifetime 1% recent less than 0.1% and current less than 0.1%. (p.42)
- Opiates – Methadone, Heroin Lifetime 1%, recent less than 0.5% and no current use detected. (p.41)
- Sedatives – Barbiturates, Sleeping tablets, Tranquillisers Lifetime 2%, current 2% and recent 0.5%. (p.39)

(Jackson, 1997)

The presentation also made reference to locational, gender, employment status, age and other issues.

Following on from this presentation, the conversation began between the participants on what, if anything has changed since 1997 and gradually people began to map current consumption patterns. In attempting to describe current consumption reference was made to the nine grounds listed in the Equal Status Act 2000 as well as reference to location, prisons, literacy and social class. The conversational triggers used are detailed in Appendix 1.

The qualitative approach makes a number of demands on the researcher. Foremost of these is the obligation to honour confidentiality and to report honestly to those who commissioned the research on what people had to say about drug and alcohol consumption patterns in the region. Conscious of these obligations, each participant was given a protocol. Details of the protocol are given in Appendix 2.

The Participants

A total number 113 people attended the thirteen meetings. Public meetings were advertised in the following newspapers; Avondhu Press, Imokilly People, Southern Star and Vale Star. News items were carried in The Evening Echo, Kerry's Eye, The Examiner and Radio Stations 103 FM County Sound and Kerry Radio. The bulk of those that attended were in their middle years or older. There were approximately an equal number of women and men. Details of those who attended the consultative process are outlined in Table 22

Table 22 Details of Consultative process undertaken by the SRDTF

Location	Type of Meeting	Number Present	Organisations Represented
Midleton 13 December 2004	Public	2	Anchor Treatment FAS
Skibbereen 8 December 2004	Public	10	Ballydehob counsellor Cork County Council Southern Health Board
Mallow 14 December 2004	Public	10	Catholic Clergy Cloyne Diocesan Youth Services Community Work Department, SHB (3) Davis College Le Cheile Family Resource Centre Town Mayor Patrician Academy Rapid
Tralee 6 December 2004	Public	15	Coláiste Ide counsellor Department of Education and Science Listowel Family Centre Kerry's Eye Revenue Commissioners (Customs & Excise Division) School Completion Programme South Kerry Life Education South Kerry Partnership Tralee Partnership
Macroon	Public	5	Catholic Clergy Mercy Sisters
Cork City 3 November 2004	Education & Prevention	11	Cork Education Centre Department of Education (2) National Educational Psychological Service (NEPS) School Completion Programme (3) SPHE Support Service Southern Health Board West Cork Education Centre Youthreach
Cork City 5 November 2004	Education & Prevention	9	Ballincollig Youth Initiative Beara Youth Worker Cloyne Diocesan Youth Centre Cobh Family Resource Centre Cork City Partnership Foroige Linc (2) YMCA
Cork City 17 November 2004	Treatment & Rehabilitation (1)	23	Anchor Treatment Centre Arbour House Treatment Centre (2) Carrigaline Youth Initiative Community Counselling Services, Southern Health Board Cork Prison Addiction Services (2) Cork Prison Post-release Services Cork Prison Medical Services Cuan Mhuire, Bruree Emergency Department South Infirmary/Victoria Hospital Matt Talbot Services – Cara Lodge Renewal Treatment Centre (2) Southern Health Board (2) Tabor Lodge Treatment Centre (3) Talbot Grove Treatment and Addiction Centre (3) Probation and Welfare Service
Cork City 17 November 2004	Treatment & Rehabilitation (2)	9	Cork Prison (2) Cork University Hospital A + E Department (2) Cuan Mhuire Treatment Centre FAS Fellowship House (2) Renewal Centre
Cork City 8 December 2004	Sport & Recreation	3	Community Alert, Southern Region North Cork Civil Defence Sports Development Officer, Cork City Council
Tralee 6 December 2004	Sport & Recreation	1	GAA

Tralee 10 November 2004	Education & Prevention (1)	11	Garda Siochána Kerry Counselling Centre Kerry Diocesan Youth Service Kerry Rape and Sexual Abuse Centre Meitheal Forbartha na Gaeltachta, Comhar Dhuibene Partnership Tralee (2) St. Vincent de Paul (3)
Tralee 11 November 2004	Education Prevention (2)	9	Department of Education (2) Kerry Diocesan Youth Service National Educational Psychological Service (NEPS) South Kerry Development Partnership

In addition to the above, each meeting was attended by at least one member of the SRDTF. Each members of the SRDTF is only counted once in the above list. Some people attended two meetings but they are only included in one meeting. A one-off meeting was held with two representatives of the Travelling community.

Research Analysis

As outlined in the protocol, the discussions were audiotaped and transcribed. In keeping with the commitment detailed in the protocol, only the researcher read the transcripts The data was then analysed according to the categories outlined in the Equal Status Act (2000) and detailed in Chapter One of this study.

Summary

The Southern Regional Drugs Task Force commissioned this study. The objective of the study was to prepare a four-year development plan that will respond to regional drug issues in the Cork Kerry area. A total of thirteen meetings were held as part of the consultative process. Data from these meetings is detailed in the next chapter.

CHAPTER 5 ISSUES AND PERSPECTIVES

“It’s rural and its urban, it’s boys and it’s girls. It is rich families, poor families”.
(Specialised Addiction Counsellor)

Introduction

In the course of the consultation process, a range of issues and perspectives on how the Southern Regional Drugs Task Force should proceed with its work have emerged and these will be detailed in this chapter. In chronicling these issues, this chapter will provide as many different perspectives as possible. While the main issues and perspectives will be the major focus of this chapter minority views and perspectives will also be included. These minority views can often highlight needs and responses that the majority observations might miss.

In reporting these findings, the primary concern is to communicate without comment what was heard over thirteen meetings and almost twenty-five hours of conversations. The findings from the qualitative research were cross-referenced with the preliminary findings from Dr. Tim Jackson’s quantitative study, *Smoking, Alcohol and Drug Use in Cork and Kerry A Repeat Study 2004*. This study focused on people in the 15-45 age-group so some of the findings of this study are outside the terms of reference of the Jackson study. Where both studies intersect there is significant convergence in the findings.

Structurally, this chapter will be divided into four sections. The first will describe people’s overall perceptions of drug and alcohol consumption in Cork and Kerry. Secondly, the chapter will focus on discrete populations as outlined in Chapters Two and Three of this report. Thirdly, the chapter looks at participants perceived gaps in service and finally, this chapter will look at how people think the Southern Health Board ought to proceed over the next three years.

The quotations listed below are credited in a generic way. As detailed in Appendix 2, confidentiality was assured to those that participated. Not everything that was said is reproduced here in this report. The quotes are chosen to highlight particular points of view. Just because one quote is attributed to, for example, an educationalist does not mean that only this one educationalist made that type of comment. Very similar points may have been made by a counsellor or community worker or a member of the public.

In summary the structure is as follows:

- Overall perception of drug and alcohol consumption in Cork and Kerry;
- Effect of drug and alcohol consumption on specific populations;
- Gaps / difficulties in service provision;
- Responding appropriately.

OVERALL PERCEPTION OF DRUG AND ALCOHOL CONSUMPTION IN CORK AND KERRY

Perceived Difference in Drug Consumption Since 1997

The general consensus was that drug and alcohol consumption has significantly increased since the Jackson study of 1997.

I was surprised by the figures presented by Jackson – they were very low then.
(Educationalist)

I would also say that the figures offered are very conservative. I would say cannabis is much higher now than what Jackson said.
(Educationalist)

I presume the situation has deteriorated since 1997. There is certainly a greater amount of drugs around than there used to be.
(Youth Worker)

Alcohol Consumption Patterns: An Overview

The general perception is that alcohol consumption is widespread across all sectors of society.

For people under thirty, the most abused chemical is alcohol. Cannabis is second and ecstasy third with cocaine really beginning in the last year in particular to make big inroads.
(Specialised Addiction Counsellor)

People don't realise the extent to which they are drinking and that is across all age-groups. Young men who think it is a normal thing to do on a Saturday and Sunday, go down to the pub and watch Sky Sports and carry on fifteen or sixteen pints later and do the same thing on a Sunday. And hopefully get up for work on a Monday. There is a big group of middle-aged women whose favourite drink is vodka. I also see a lot of single men who just go to the pub because they haven't married have no extended families and we also get a lot of young ladies from eighteen and upwards drinking quite heavily. It goes right across the social spectrum. All types and all walks of life. Most people regard themselves as social drinkers.
(Health Care Worker)

...there are difficulties in relation to alcohol and the high level of acceptance of alcohol by the parents. It is totally part of the culture and the parents, even the regular traditional conservative parents for whom alcohol is a huge part of their lives.
(Educationalist)

We are talking about all young people – middle class and working class people – mostly boys and mostly working class boys. They are starting in their mid-teens from the age of fourteen upwards. Many are on the edge of the educational system struggling to stay or even perhaps struggling to get out.
(Youth Work Administrator)

There is a lot of binge drinking and it is problematic as it does lead to violent assault and early sexual experimentation and fighting in the chipper on a Friday night.

(Youth Worker)

If we could eliminate the overindulgence of drink, we'd have most of the problems solved.

(Health Care Worker)

A number of people expressed the view that some of the drinking is a response to the emotional stress many young people experience.

What we found is that many of those who started drinking did so because of situations that were intolerable for young people to have to deal with emotionally. It is one way of blotting that out. My guess that happens still for a percentage of young people who are drinking today. It is very difficult if they are in a home situation that they can't deal with. They feel that one way – a very unhealthy way – of dulling the pain and numbing themselves out. I don't know how much support you can give a young person if that is still what they have to go home to. Alcohol is the most common way for these children. Certainly drugs would be involved as well. More males than females. Alcohol seems to be a way of coping but it is hugely destructive.

(Specialised Addiction Counsellor)

Many young people are blocking out the hardships of their young lives with alcohol. There are issues they can't cope with. emotional, financial.

(Family Support Worker)

It was suggested that sport is both effected by high alcohol consumption and contributes to it.

There is a fair degree of drink culture after matches. There is no question about that. The minute the match is over, they all go to the pub, even at minor level. There's no mystery to it. We don't have time to address this problem. It would be great if we did.

(Voluntary Sports Administrator)

I am very involved in the GAA and I have seen clubs failing to field teams on a Sunday morning because some of them couldn't get up because they are drunk. It is right across the social spectrum. Alcohol is a huge factor in contributing to problems in the home, the school and the community. There is a huge problem with underage drinking.

(Educationalist)

Not everybody was concerned about the current level of alcohol or drug consumption least of all the consumers.

I think there can be a bit of unnecessary panic about this generation's alcohol and drug consumption. I'm not too sure that they are drinking more than we did in my time. I think they will emerge with a better education than we did and will emerge in time as well functioning members of society. They will have better education and better employment prospects.

(Educationalist)

The vast majority of young people are OK. People might be coming in on Monday dragging a bit but that's about it.

(Educationalist)

One person argued that unless we address the source of that misery, consumption will continue.

For most people the threat of going to prison is a problem. Most don't see their drug use or alcohol use as a problem – being unemployed is as big a problem as their drug use. Without their drink and drugs they would have a miserable existence altogether – it's their drink and drugs that is cushioning the blow somewhat.

(Specialised Addiction Counsellor)

Illicit Drug Consumption: An Overview

There was also broad agreement that illicit drug consumption is on the increase.

I am totally astounded by the level of drug use. Every day there is dealing going on. It is a real issue for me and it is something that I am quite shocked by.

(Educationalist)

I don't think we can underestimate the number of drugs that are being used. I think we have a problem bigger than what we are estimating it to be.

(Community Worker)

People don't perceive illicit drug use as wrong; they perceive it as totally normal. It has become normalised behaviour. I don't think young people are aware of the dangers of consumption. They look at the high rather than what it is made of. It is the same with cannabis use. It is just a way of relaxing. I would say of those around the eighteen mark, that 30-40% are using drugs of some sort on a semi-regular basis.

(Public Representative)

Young people also see themselves as immortal. They don't think they can be harmed by drugs.

(Community Worker)

The findings from the Jackson (2004) study support the above assertions. Recent drug consumption (in the last twelve months) has increased significantly from just over seven per cent (7.1%) in 1996 to under fifteen per cent (14.7%) in 2004. There was a significant increase in Cork City from 11.2% in 1996 to 18.3 in 2004; an almost identical increase in Cork County from 11.2% in 1996 to 18.4% and there was also a significant increase in drug consumption in Co. Kerry from 6.8% in 1996 to 14.3% in 2004.

Cannabis

Cannabis is the most commonly consumed illicit drug.

One of the biggest problems in our area is cannabis smoking by the parents and the families. Is just so common and so acceptable. That it is creating a lot

of problems for us. It is creating a big cultural divide in what is acceptable and what is not acceptable. I would go even further and say that a lot of young people are experimenting a lot younger even than eleven years of age.

(Educationalist)

For young people particularly in largest towns and Cork City cannabis is no longer considered a drug. It's normalised in that sense. So, if you ask people about drugs they will talk about the hard end stuff that they may not be using anyway – cocaine and heroin. Cannabis is very often what they see around them including their parents smoking.

(Youth Work Administrator)

Cannabis is socially acceptable now. They smoke it like cigarettes; they don't look at it like a drug.

(Youth Worker)

Jackson (2004) also found highly significant recent increases in cannabis consumption between 1996 (6.6%) and 2004 (13.8%).

Ecstasy

Ecstasy would appear to be the second most commonly consumed illicit drug.

What we found was that the three most common drugs were alcohol, cannabis and ecstasy. Ecstasy came right down the line. Alcohol experimentation was beginning from the age of eleven plus. At fifteen, sixteen people start experimenting with cannabis and after that ecstasy.

(Youth Worker)

Ecstasy is very big over in Kerry. It would be the number one drug for the under 25s. Yes cocaine but money is probably a problem so they don't get the cocaine. They all start off with alcohol. It is the biggest one. Everyone drinks. That's normal. It's normal for under thirties.

(Specialised Addiction Counsellor)

Jackson also found a highly significant recent increase in stimulant (including ecstasy and cocaine) consumption between 1996 (1.7%) and 2004 (4.2%).

Cocaine

This study also found increased consumption of cocaine.

With high-income earners, I think cocaine is certainly used. Cocaine is more used in Cork City and that people using coke cope quite well by and large.

(Educationalist)

With regard to cocaine use, we would have a high incidence of under 35s who would represent with chest pains or positive for cocaine. No gender pattern. Surprisingly enough we find mid-to-higher class but we also get more working class young people. These are the affluent generation.

(Health Care Worker)

Around the county, there are similar patterns to what is happening in the city (Cork); there's a significant increase in the use of cocaine.

(Educationalist)

The perceived increase in cocaine consumption was corroborated in the Jackson (2004) study. There has been a highly significant increase in cocaine consumption – albeit from a very low base – from 0.1% in 1996 to 2.1% in 2004.

Heroin

There would appear to be an increase in the use of heroin albeit from a very very low base.

I presume that the situation has deteriorated since 1997. It would appear to me to be so anyway. I think there is a lot more heroin than there used to be. Smoking heroin.

(Educationalist)

There's been a significant increase in the use of cocaine and a noticeable increase in the use of heroin.

(Specialised Addiction Counsellor)

There would traditionally have been a quite a serious drug problem in West Cork. We are talking also about port towns where there is easy access to a lot of drugs and heroin is becoming quite a problem. There is injecting use of heroin in one of those port towns.

(Member of Public)

The above finding was verified in Jackson's (2004) study who found that opiate (including heroin) had significantly increased – albeit from a low base - from 1996 1.0% to 2.2% in 2004.

Solvents

Participants reported some localised use of solvents.

Solvents seems to be a phase or part of very early substance misuse.

(Specialised Addiction Counsellor)

The feeling is solvents at thirteen – fourteenish. A very small minority. Male and female.

(Educationalist)

In 1994, one young person died from inhaling a solvent. We were aware of some of our students experimenting with solvent use. Late teens. I think the summer time is a problem in a lot of areas.

(Educationalist)

This low-level of consumption is also reflected in Jackson's (2004) study. Jackson found that an increase from 0.1% in 1996 to 0.4% in 2004, which he regards as a non-significant increase.

Hallucinogens

No reference was made during the whole course of the consultative process to hallucinogens.

Jackson (2004) reported that there was no significant increase in hallucinogen consumption from 1996 (2.5%) to 2004 (3.6%).

Prescribed Drugs

Misuse of prescribed drugs was a feature of the discussions and this misuse was most common amongst women.

We have an enormous problem with street use of prescribed drugs. There are huge amounts being bought and sold on the streets. Benzodiazepine seems to be the one. The other would be prescription opiates.

(Specialised Addiction Counsellor)

There is nearly always a certain amount of prescribed drugs involved

(Specialised Addiction Counsellor)

Abuse of prescribed medication would be a very big problem. Also things like "Solpadine" can be abused. We are talking right across the whole social spectrum. People who have left school at primary level at secondary at third level. We also get people with food addiction many of those who would come to us would have had a parent using alcohol or have had treatment themselves.

(Specialised Addiction Counsellor)

Another group I would like to mention and this is those taking sleeping tablets or barbiturates. I would have quite a few people who would be elderly, particularly women sixties seventies age-group who are self-administering those type of relaxants, sleeping tablets, calmers. They would be taking these prescriptions but with quite a laxity. My personal view is that they are over-used. People take a half, one, two, they up and down them. I would feel that it is too casual. They would want it challenged. It is comfortable.

(Alternative Health Practitioner)

For some, particularly those in prison, there is not just one drug of choice.

Most of the guys that I'm working with don't have a drug of choice – they have several drugs of choice. It's whatever they can get their hands on really.

(Specialised Addiction Counsellor)

While Jackson (2004) did not look specifically at prescribed drugs, he did examine trends in sedatives (including sleeping tablets and tranquillisers). He found a not significant increase from 0.4 in 1996 to 0.9 in 2004.

Profiling the user

A number of different profiles emerged of the "typical user".

Mainly male, crafts people, trades people, relatively high earners, earning four or five hundred a week, under thirty and in employment – possibly starting at eighteen or nineteen and the patterns persisting into the mid-twenties.

(Specialised Addiction Counsellor)

Their patterns of abuse would be very similar. They would use alcohol at weekends. They would use ecstasy or cocaine once a week and they would use

cannabis during the week. The reason for that is that cannabis is much cheaper than any of the other drugs. They tend to buy their cannabis on payday and that does them for the week.

(Specialised Addiction Counsellor)

Our population would be lower social class. We would have very few qualified apprentices, very very few professional people. Most of our clientele would be in the unskilled area and I suppose we would be talking 20% - 30% unemployed. We would have three males to one female. In the last year, we have seen ten Non-Irish-Nationals.

(Specialised Addiction Counsellor)

Some participants emphasised that drug consumption is a symptom of a deeper malaise or crisis in society and felt that the underlying causes of drug consumption need to be addressed.

The drug misuse problem is as much a symptom as a problem in itself. It is the tip of the iceberg. It is a symptom and not a cause. It is important that we are not all the time crisis led. We need to go beyond the quick fix. Maybe there is something about space and dialogue and listening and conversation and the need to think in terms of the long term and not be lurching from one scheme to another. That isn't particularly helpful. Something about slowing the whole thing down as well. There needs to be a longer slower approach. We need to give young people some quality, the quality of being listened to.

(Specialised Addiction Counsellor)

Drug use is a symptom of problems in society and the issue of drug use will never be addressed unless we look at these broader and deeper issues.

(Educationalist)

One participant expressed concern at the level of debt young people are experiencing because of their drug consumption although the most commonly held belief was that it is affluence that is one of the significant driving forces of drug and alcohol consumption.

Debt is a major issue for many young people. One girl owed €800 and she did not have the ability to pay. Her father had to borrow the money and his son is also on the run because they don't have the money. He is nineteen. For the parents the pressure is unreal. That is just one incident. I have come across at least ten in the last six months.

(Youth Worker)

One person suggested that many young people have as much as €300-€400 disposable income per week.

Quite a number of young people when they are intoxicated are in possession of €300-€400 at any one time. They have been given this by the parents for personal use. It is quite common for young people to have a lot of disposal money.

(Specialised Addiction Counsellor)

EFFECT OF DRUG AND ALCOHOL CONSUMPTION ON SPECIFIC POPULATIONS

Socio-economic status

While there was general consensus that alcohol and drug consumption transcends social class, specific concerns were expressed about people from disadvantaged backgrounds.

Many of the young people we are working with are from more disadvantaged backgrounds, both economically and socially.

(Educationalist)

Poor educational outcomes, early school leavers, these are the people we get. Early school-leavers tend to abuse alcohol earlier.

(Specialised Addiction Counsellor)

Middle class people are not immune from the effects of over indulgence in alcohol.

There is also a difficulty with people who are well educated and have good jobs. It might be just at weekend or on a Saturday night. There is definitely abuse at weekend and considerable damage.

(Educationalist)

Rural Urban consumption patterns

Many of the participants were of the view that rural consumption is on the increase and that the traditional divide between rural and urban lifestyles has become blurred.

I would very much like to disabuse people of the notion that there is much difference between the city and the county any more. In my generation, there was where the country lagged behind but not any more.

(Educationalist)

The misuse of alcohol by under eighteens is far and away the biggest issue followed a good way behind by cannabis. The misuse of alcohol is strong in small towns and in rural areas.

(Youth Worker)

A number of participants reported high consumption of alcohol in fishing villages and expressed concern about the consequent danger to life

Coming from a small fishing village, the drinking that goes on there is you go to the pub at six o'clock in the morning during the summer especially in the salmon fishing going on, there is a lot of drinking. A lot of danger involved with youngsters going out in boats. Coming out of pubs and going into punts. Not being able to walk or stand and they are going out in punts and into boats. Putting their life in danger. Around the village children are on the beach at night, would be on the pier and again very very dangerous. Very young kids at that.

(Member of the Public)

Trafficking through ports also came up for discussion.

There is a number of packages that are been brought in at the ports and are been dropped off by boats. They are finding their way around. That would certainly be well known around the area. It is long established going back twenty years that you can get drugs in West Cork.

(Member of the Public)

However, it was felt that there was a reluctance to name this as it might be detrimental to the image of these places and would negatively impact on their tourist potential.

But we can't portray that there is a drug problem on West Cork because it is a tourist centre. It is not seen as politics because you then won't have people coming, bring their children and letting their youngsters out around. It is like nothing happens. There is a reluctance to recognise that.

(Member of the Public)

The above perception that drug consumption had increased across urban and rural settings is confirmed in Jackson's (2004) study with the exception of towns of less than 5,000 people. There was a highly significant recent (in the previous twelve months) increase in drug consumption in towns of more than 10,000 people from 7.4% in 1996 to 22.6% in 2004. In towns of less than 5,000 there was hardly any change from 9.5% in 1996 to 10.1% in 2004 but a highly significant increase in rural areas from 4.5% in 1996 to 9.8% in 2004.

Age

Many recent studies have reported significant levels of underage drinking and the evidence from the consultation process would appear to support that. Jackson (1996) reported that illicit drug consumption petered out after the age of thirty-five and it would appear that this is no longer the case.

Alcohol is the number one drug across all the age-groups. As a drug, it tends to be ignored and downplayed.

(Specialised Addiction Counsellor)

The level of youth drinking is at an alarmingly high rate and it is posing problems across all sectors of society.

(Educationalist)

We haven't come across a situation (in a treatment centre) where alcohol wasn't a problem. Many would have started at a very early age in their thirteens and fourteens.

(Specialised Addiction Counsellor)

Both alcohol and cannabis consumption are posing serious challenges to schools and centres of learning.

There is a concern about the impact of alcohol on school discipline and absenteeism on the Monday morning. They talk about unpleasant incidents at the deb's ball and things happening on the busses.

(Educationalist)

There is often a drug-related issue to suspensions and expulsions in schools. There are some issues that they are either using drugs or bringing drugs into school. I suspect that it is only the lost and the careless that are being caught.

The more efficient and organised are just not being noticed by the system. They are keeping their heads under the radar. The figures that we have are lower than the use would indicate mostly cannabis; Es over weekend and that is evident on Monday morning. Absenteeism and illness - that kind of thing. Cannabis both male and female. Es again both but a lot among girls.

(Educationalist)

The staff are used to it and are turning a blind eye to it because of fear. Most of the staff are from (the local area) and are afraid of disputes spilling out from the Centre and are therefore reluctant to confront the young people. Even within the centre there is dealing going on. You are nearly relieved if they are absent because if they come in with a hangover you spend the day trying to cajole them and trying to keep them happy. So it is actually a relief if they are not in on Monday. Sometimes Tuesday is not any better.

(Educationalist)

Concern was also expressed about the transition from primary to post-primary education and with the level of pressure many young people are under, not all of it school related.

I agree that there are problems related to the transition from primary to secondary level.

(Educationalist)

Young people live highly pressurised lives from the points system and the Leaving Certificate or trying to be the next pop star.

(Educationalist)

One person discounted the view that children in primary schools are drinking.

The principals and teachers that I would work with would say that there isn't really a problem with alcohol at primary level. Experimentation with tobacco might be the same thing. At post-primary level it is alcohol. It is mostly 15, 16 and 17 year olds that are out drinking,

(Educationalist)

Like adults, peer pressure is also an issue for young people.

Youth peer pressure is the big problem. Everybody drinks. Adult peer pressure is just as significant. Alcohol is the big problem. From 15 upwards, they are all drinking. We have a culture of drinking, the parents drink, the young people drink.

(Specialised Addiction Counsellor)

The focus on youth consumption during the consultative process is well placed. According to the Jackson study (2004) in the last twelve months the following number of people have taken drugs: 17.6% of 15-19 year olds, up from ...18.0% of 20-24% up from ...13.0% of 25-34 up from 5.4% and 5.5% of 35-44 year olds up from 1.6%, all highly significant.

Gender

Increased alcohol consumption by girls and young women was reported. Concern was also expressed about the level of consent to sexual activity in situations of high alcohol consumption.

Female drinking is very much on the increase. Young girls are becoming more sexually active as a result of binge drinking. Young women's sexual health is becoming a huge issue.

(Youth Worker)

Young people get into sexual situations and activities that they wouldn't do if they hadn't taken alcohol. I think it is important to say to young people that sexual desire is increased if you drink alcohol so you are more likely to get involved and do something that you otherwise would not do. Alcohol dims your awareness and you are less likely to see danger signs.

(Specialised Addiction Counsellor)

Boy's single sex schools were also singled out for special mention.

I think there is a problem within single sex boys' schools. The issue is not being addressed, is not being talked about. This is particularly so in middle class schools. There is a denial at the level of alcohol consumption and to a lesser extent on drug consumption that is happening.

(Educationalist)

Young men who are not either in college or at work or in uncertain relationships were also seen as particularly vulnerable.

Young men aged 18-26 who are not in college or in fulltime work who are not in relationships are most at risk Men who are separating or separated are often very vulnerable.

(Specialised Addiction Counsellor)

It was also felt that a lot of young men do not want to take on family responsibility

A lot of young men do not want to take family responsibility. Young guys get married and they have been having the gas until they are 28 or 29. The misses has a baby and now he has to be responsible. He doesn't no more want to take responsibility for this. She can but he doesn't do this.

(Specialised Addiction Counsellor)

Attention was also drawn to the specific needs of middle-aged women and older single men.

I would like to highlight the needs of adult women. From 40-45 up, there's nothing for them. They may have come from broken homes, they may have been thrown out, their kids don't want them, their families don't want them and they have absolutely no where to go. There's no support for them. These are women that are halfway through their lives.

(Specialised Addiction Counsellor)

Men particularly, single, older men, very high dependent on alcohol in our area. Men aged forty, fifty,

(Specialised Addiction Counsellor)

I come from a women's half-way house. And all the people would have had primary treatment. The age group we would cover would be 18 and upwards and always you will find alcohol. Women in the 40+ age group we will always find abuse of prescribed medication. and that could apply to some of the younger people too. Sexual abuse is very common with the people that we deal with – nearly 50% of them.

(Specialised Addiction Counsellor)

Alcohol consumption was strongly linked to sexual abuse by one of the participants.

I come across issues of alcohol abuse and sexual abuse where alcohol abuse follows child sexual abuse. Alcohol is used as a way of coping. We have a lot more presenting now because of the climate. It might be easier now to talk about that.

(Specialised Addiction Counsellor)

Denial around the way in which alcohol and drugs contribute to the high suicide level particularly amongst young men would appear to be prevalent according to the participants in the consultative process.

I think we also need to be aware of the close relationship between alcohol and suicide. We have a huge amount of depression out there amongst young people. There is a minority with depressions that use substances, to deal with that.

(Specialised Addiction Counsellor)

There are a very high number of suicides, which are seriously drug and alcohol related. We need to respond to this.

(Community Worker)

The need to respond to alcohol-related road deaths also came up for discussion.

We also need to look at the issue of safe driving. There are young fellas that are killed across the country every weekend because they sit into a car with a drunk driver, people they would not sit in with if they were sober. The message needs to be got out to young people not to drop their guard or be sucked into situations that may cause difficulty for them.

(Justice Support Service)

While men tend to outconsume women, the assertion that women's drug consumption is on the increase is borne out in the Jackson study (2004). There has been a highly significant increase in female consumption from 4.1% in 1996 to 11.4% in 2004 and an equally highly significant male increase from 10.0% in 1996 to 18.0% in 2004.

Family Status

People living in fluid family situations were seen as more likely to consume illicit drugs.

The majority of the parents would be in the thirties. They would be single parents, high levels of poverty, a lot of them would be living with their extended family rather than in houses of their own. There would be multiple fathers and no father at the same time. Unemployed, parents in their thirties, living in fluid family situations. These people are very serious consumers. It (has) becomes the norm.

(Educationalist)

We are seeing a lot of males under 25 (in a treatment centre). A lot of young men are coming to us with a history of suicide attempts, A lot are unemployed, have one or more partners, with young children, that they won't have any contact with. For us the problem is the client in front of us but also the family of that client. Many are coming from a family where there is alcohol and drug problems. They have lived with it all of their lives. We are dealing with second-generation problems. The norm for them is drinking and drug using. And they are polydrug users. Alcohol, cannabis, cocaine benzodiazepine and it is like that they don't count that about that.

(Specialised Addiction Counsellor)

One person identified the home as a major site of influence.

There is evidence of drug and alcohol in the home and it has a radical impact on the lives of young people

(Educationalist)

One person reported that second and third generations within the same family are often affected by drug and alcohol addiction.

People are often second or third generation attending of services. It is in the home, the family. There is unquestioned use of alcohol as a way of coping. The family context needs to be taken into account.

(Specialised Addiction Counsellor)

Time and again the degree to which family occasions are marked or celebrated in pubs came up for discussion and the consequent dangers were alluded to.

When a child is baptised, they go into the pub. When the child makes their Holy Communion, the same thing happens and the same for confirmation. and funerals. Because children are not supposed to be in pubs after nine o'clock they roam around the village unsupervised while the parents remain on drinking.

(Member of the Public)

Two diametrically opposed views were expressed about parental attitude to the consumption patterns of their children. The first tended to blame the parents for their children's drug and alcohol consumption.

Parent disinterest is a problem. There are young parents that are very disconnected from their children.

(Educationalist)

Parents are not taking responsibility. I think the parents give them a lot of money and graze them off for the weekend.

(Specialised Addiction Counsellor)

I think there are three things missing from their home. There's a very poor work ethic in the home. There is a very poor school ethic in the home. There is a big acceptance of anti-social behaviour. The parents will defend them on anti-social behaviour.

(Specialised Addiction Counsellor)

A lot of young people feel that their parents are not there for them and I think it is very sad.

(Specialised Addiction Counsellor)

The second opinion was in the minority but took a much more conciliatory approach...

...there is a tendency to blame the parents. We have to remember that children have been barraged and marketed by rampant capitalism. Entirely unregulated capitalism. That doesn't care on what the impact of that is in terms of early sexual activity or whatever. We don't judge the unregulated rampant capitalism, we judge the parents. It is the state that has abdicated its responsibility around the whole society.

(Community worker)

I think that each generation has specific problems and that one of the problems of this generation is that we target young people as consumers. Children are seen as a lucrative market by the legal and illegal markets.

(Educationalist)

The standard message nowadays to children is that 'you are an autonomous individual and if you want to go out on your own then you go'. So parents are being sidelined and the more marginalised they become the more disconnected they become.

(Community Worker)

Parents are human too and doing their best even though teenagers may not see it like that at the time. The current level of drinking is also taking its toll on parents. I think parents have a very tough job. I think parents need support, advice and information.

(Community Worker)

Jackson's (2004) study reports higher consumption among single people followed by living as married/cohabiting followed by divorced separated married.

Mental Health Issues

It would appear that people with mental health problems are particularly vulnerable and their needs are difficult to meet particularly when there are additional addiction problems.

There is a huge hole in the net when it comes to people with addiction and with psychiatric difficulties. It seems that nobody wants to take on these and are not equipped or resourced to do so. A lot of the guys that we see do have a fair amount of psychiatric problems in addition to their addiction.

(Specialised Addiction Counsellor)

Men with mental health problems are also another real difficulty. The men coming in who have huge alcohol problems and then we have the break-down of relationships and the barring orders and there is a specific problem with people with arson – trying to get them into anywhere is a nightmare.

(Specialised Addiction Counsellor)

Nearly all (who present for treatment) would have particular psychiatric disorders.

(Specialised Addiction Counsellor)

One participant felt that there was no co-relation between drug consumption and disability.

I have no evidence to suggest that there is any co-relation between the existence of intellectual disability and increased drug use either legal or prescribed.

(Educationalist)

Prisoners and Ex-prisoners and their Families

Re-integrating people back into society remains a difficult task and very often the first few days after release are crucial.

The first few days of release from prison, people are very vulnerable and if you don't see them during this period, if there is not high support especially in terms of accommodation there are constantly coming back in again. What we need is integration of services, and that there is a crucial two-to-three days for support and intervention.

(Justice Support Service)

Particular concern was expressed about the needs of wives and partners of those in prison.

There is a cohort of people out there – women who are attached to prisoners or people who are in the judicial system and they live a kind of hidden life with a culture of drugs, alcohol and deprivation and they don't access services.

(Specialised Addiction Counsellor)

Members of the Travelling Community

While people might differ on the causes of high levels of alcohol consumption within the Travelling Community most were agreed that high levels of consumption is a reality.

There is certainly a problem with alcohol among the Travelling community but there's always a danger in saying that because you are never sure how that is going to be perceived (a) by the Travelling community itself and (b) by others outside it. But there is a difficulty and that has to be acknowledged.

(Community Worker)

Depression and redundancy were cited as one of the reasons for heavy drinking

But what I am seeing now is a whole lot of depression and a level of suicide and suicide, which is probably linked to drugs.

(Community Worker)

Traditional work for men has been cut-off particularly in the scrap area. The introduction of EU laws on working in landfill sites has cost Travellers a lot in terms of the kind of work they can now do. Travellers were the real recyclers. Now these skills are redundant.

(Community Worker)

Young men featured quite highly in the consumption stakes but increasingly it would appear that young women are drinking as well.

There is a problem with young Travellers, particularly the boys and men. There are an awful lot of fellas in jail for drug-related or alcohol-related crimes. A lot of the problems start for boys after confirmation. They're in a poverty trap and they're supposed to be men. But they're no work for them. A lot of them just go bushing. The amount of women and alcohol I would have seen...is quite frightening.

(Community Worker)

Alcohol and drug consumption is seen amongst the Travellers as quite corrosive to the general wellbeing of the community, partly because the community is quite small and the behaviour of one can quickly impact on the lives of others.

Drinking in families has a huge effect. If you have a crack in a family it has huge effects. We are a small community, so if something happens like drug or alcohol abuse it has huge affect on the whole community.

(Community Worker)

Partly because of the smoking ban but also because of the negative attitude many Travellers experience when they go into pubs, home drinking is on the increase.

Because of the difficulty of getting served in bars home drinking is an issue. I have often heard people say "you'd be better off going down and getting a carry-out" rather than having the hassle of going to a pub. There is a tendency for a lot more home drinking to happen. Also not been able to smoke in the pubs as well.

(Community Worker)

It was also reported that the misuse of prescribed drugs by Traveller women is an issue.

Yes, there is an issue around Traveller women taking prescribed drugs. It is not a widespread issue. There is a sharing of prescription drugs. That's very worrying. There are a number of women that I would know that are constantly out of it. You'd see them walking down the street and they wouldn't know day from night.

(Community Worker)

It would appear that members of the Travelling community are reluctant, for whatever reason, to access treatment centres.

Listening to Sr. Veronica in Kilkenny I have heard her say that in over twenty years only three Travellers have come through her doors.

(Specialised Addiction Counsellor)

Travellers do not access treatment centres because it is very hidden in the community to have a problem like that. It is very taboo. Nor are Travellers accessing counselling for bereavement or for mental health issues. These are big issues for Travellers.

(Community Worker)

With regard to drug consumption it would appear that hash and cocaine is on the increase.

Here in Cork and I have to say I have very limited knowledge in terms of what people are consuming it would seem to be a lot of hash and tablets. I hear more and more people talking about cocaine. The white powder. But the white powder could be anything. It's snorted. More and more we're hearing about that.

(Community Worker)

Ethnicity

One person reported that drug traffickers are targeting Non-Irish-Nationals.

We have evidence that herbal cannabis is being directed at Non-Irish-Nationals and there is a trade in respect of this drug in existence.

(Justice Support Service)

One member of the public asserted that Non-Irish-Nationals simply do not have the financial resources to buy drugs or alcohol in any great amount and what they earn they repatriate.

With regard to refugees and asylum seekers, the priority of Eastern Europeans in the main is to make money to send home. The drinking they engage in is exclusively through the off-licences. They haven't come in to the pub culture. We don't have any problem with their alcohol consumption.

(Member of the Public)

People were generally of the view that there is a low level of alcohol and drug consumption amongst newly arrived people from abroad.

One of the things I heard from people who have just arrived into the country is how shocking they find our acceptance of alcohol.

(Member of the Public)

One person took a very different view:

Non-Irish-Nationals. They are going out with the local people and they are getting to know them. And they are using drugs. Where they are getting them from is another story. They all know each other.

(Member of the Public)

Another minority view highlighted the culture of toleration amongst English people living in West Cork.

When families are casual about cannabis, their children are casual about it. I would notice that English people who have lived here quite a while would be more casual and comfortable with cannabis use than other groups. I would notice that their children would have similar comfort. For local people who discover that their children have been taking cannabis or whatever there is shock. There wouldn't be a shock among another group. It wouldn't even be an issue. It would not be regarded as an issue. It is just taken for granted.

(Alternative Health Practitioner)

In response to these expressed views, one participant warned against the dangers of xenophobia.

We should be very careful about what we say and that can very easily end up in a belief that all Non-Irish-Nationals in the locality (are consuming drugs) Just to be careful about making statements like that. I certainly have never heard of any Non-Irish-National been convicted for drug offences whether it be using or supplying.

(Member of the Public)

Sexual Orientation

One participant reported relatively high levels of drug and alcohol consumption within the gay, lesbian and bi-sexual community.

We know from international studies that the gay and bi-sexual community misuse or over use drugs and alcohol more than their heterosexual counterparts. There is then the culture itself so, for example, the gay men's community and the culture of clubs it is all very conducive to recreational drug taking. But we have no idea at all of what the problem in Ireland is for Irish gay and lesbian people. Everything we know is based on our own experience, anecdotal evidence and international evidence.

(Community Worker)

There would seem to be an increase certainly within the lesbian community but again we have no evidence to back that up. What we suspect is in terms of prescription medication, we suspect that there is much more prescription medication being used than we are aware of. How many gay men and lesbians are medicated? We don't know that and we also see a link between self-medication because they won't go to the doctor. If they are suffering from depression they don't wish to disclose their sexual orientation.

(Community Worker)

Within the gay men community viagra is heavily used in North America so we would suspect that this would be replicated here. Within the women's community it is more likely to be Prozac and that would be anecdotally. When drugs are not available alcohol is used particularly in rural areas. So, when you have lesbians and gay men in rural areas you would have particularly high levels of alcohol misuse. That kind of level of drinking is normalised in the community.

(Community Worker)

Homelessness

Homelessness as a result of alcoholism figured quite high in some of the discussion groups.

A big percentage of the people who came to us last year (for treatment) would have been homeless.

(Specialised Addiction Counsellor)

Male homelessness was seen by some as a particular problem.

I think there is a big issue around homelessness and men. Men who are out of the family home for all kinds of reasons maybe alcohol abuse, maybe depression. I think that is something we haven't addressed in relation to subsistence abuse and suicide.

(Specialised Addiction Counsellor)

There are definitely an awful lot of people who find it very difficult to go back home because they have too much damage done. When they come out of treatment, their family doesn't want them and they're really good people genuinely nice people but they have fallen by the wayside and women too. There isn't a home for them to go.

(Member of the Public)

When they leave treatment the insecurity comes back into the lives again. If they can find a place that gives them a bit of security. When I came out Johnny (not real name) found me a place only for that I would be sleeping again in the back of the car, which I ended up in and I can understand people like that going back.

(Member of the Public)

Familial supports that were once in place can no longer be taken for granted according to one person.

The social supports that were there twenty-thirty years ago where mother took someone home even though the guy was married and separated – he went home to his mother. That does not happen in anything like the same degree. Broader family supports are not there so we have to look at something like half-way houses, three-quarter way houses, and independent living situations.

(Specialised Addiction Counsellor)

Two people made very brief reference to the issue of literacy and consumption.

People come in (for treatment) with major literacy problems

(Specialised Addiction Counsellor)

I think it is in the poorer areas and there is a lot of alcohol abuse. There is poor literacy.

(Educationalist)

GAPS / DIFFICULTIES IN SERVICE PROVISION

The culture of normalisation around alcohol and cannabis consumption is posing serious problems for those working in the area of education and prevention.

It makes our work very difficult in having to go into classes and try and promote prevention when a lot of children in classes who don't actually realise that hash smoking is illegal because it is so common at home.

(Educationalist)

One person working in the education sector felt that there was very little support for them in addressing drug and alcohol issues and that they are left floundering.

You are kind of left in a no man's land with no direction. There is very little support unless you go to other co-ordinators that are also looking for the same thing. There does not appear to be a strategy or a policy when it comes to Youthreach Centres. Some have policies that they make themselves but are not supported by anyone. The differences between Centres are huge in terms of tolerance levels.

(Educationalist)

As well as those working in centres of learning having difficulties coming to terms with drug and alcohol consumption, so too it would seem that parents are having similar difficulty.

I think parents need support. I think parents need skills in talking to their children about drugs.

(Educationalist)

Repeatedly, the lack of out-of-school services was highlighted.

Outside of school hours, there is a serious lack of alternatives. There is nothing to do – especially for those who do not play sport, but even for those that do they might have a match at weekends and some training once a week and that's it.

(Educationalist)

We did a consultation and the constant message that came up was the lack of facilities for youth, the lack of alternative to the pub. People then get into the habit of going to the pub because it is the only place. We need drop-in centres, people to work with young people.

(Youth Worker)

The lack of control over the sale of alcohol off-licences and the late opening of public houses was also repeated over and over again.

There is very little control of off-licences and kids can be seen leaving at the weekend with all kinds of things.

(Justice Support Service)

Every supermarket, off-licence in the country is thriving. Last year two or three people stopped me in the street and asked me to get drink for them – 14, 15, and 16. They are having parties in fields. That is an awful worry.

(Educationalist)

They are sending older boys to buy drink. The big problem is off-licence. I am completely against off-licences. There's seems to be no limit to what they can buy. I have seen during the Kerry festival people coming out with crates of beer. That's ludicrous.

(Educationalist)

The later the pubs are open the bigger the problems that are there. Around ten or eleven normal tiredness is setting in. With alcohol, that is postponed. At three o'clock in the morning tiredness really kicks in. Tolerance levels at that hour of the morning are very low. In every town and village on a Saturday night, guards are run off their feet. The fallout for casualty departments is enormous. It is a fire brigade service when discos close at three in the morning.

(Justice Support Service)

Glamorised advertising of alcoholic products has contributed to the excess consumption it was alleged.

What amazes me is the amount of advertising by drink companies on TV and radio. They stopped advertising smoking and they let people know the dangers

of smoking but they never let people know the dangers of drink. The dangers of drink are for me are a lot more dangerous than the dangers of smoking. I think advertising is completely immoral.

(Member of the Public)

Pre-service and inservice teacher education came in for a good deal of criticism.

I think we need to look seriously at teacher training both preservice and inservice. Teachers see themselves as subject specifics and do not see the bigger picture.

(Educationalist)

There is a need for teacher training colleges to change the way they do things. The number of teachers who want to get involved in SHPE type activities is very small.

(Educationalist)

There is huge need for pre-service training for teachers.

(Educationalist)

There is a lot of resistance to change within schools and what we need is to support those teachers that are seeking change.

(Educationalist)

There was also a widely held view that service provision is very disconnected and there is a lot of wastage due to lack of coordination.

I also think there is duplication of service. All existing services should be put side by side and we need to ask if scarce resources are being best utilised.

(Educationalist)

I feel that there is not enough collaboration between these interventions to provide service at the time people need. People are protective of their own organisation and more particularly of their own ethos. Each values their own approach. There needs to be a way to safeguard that without hindering the possibility of collective and collaborative action. There needs to be some very creative way of utilising the resources that are there.

(Educationalist)

There are a variety of groups visiting schools with no coherent plan.

(Justice Support Service)

There is no liaison between AA, NA GA or OA. And I would even go so far as to say that AA even look at NA, GA and OA as stealing their programme and piggybacking on it. Something needs to be done in that sphere.

(Justice Support Service)

There were very specific observations made about the lack of integration between state and voluntary services and also between state provided community and psychiatric services.

Community services developed and also statutory services developed and we have developed them in parallel rather than as a single service. That is a big problem.

(Specialised Addiction Counsellor)

We need to connect services with services. There is very little connection between for example A+E services and a detox centre and a connection on to a counselling service. When we look at treatment services getting about 6% of their referrals from doctors, which should be about 90%. People don't seem to treat the underlying causes. They will treat the broken leg but will not address the alcohol that caused the broken leg.

(Specialised Addiction Counsellor)

Lack of access to services, particularly for rural people were identified as an issue.

Many services are located in urban areas and that does not suit rural communities. We rarely liaise.

(Specialised Addiction Counsellor)

Distances are huge in Cork and Kerry. If you are down in Waterville, the nearest counselling place is Tralee or Castleisland. We have to take into account in any plan the geographical spread.

(Specialised Addiction Counsellor)

The other big gap is the number of referrals. In twenty-nine months we have maximum five referrals from the SHB in Tralee.

(Specialised Addiction Counsellor)

Lack of access to services for ex-prisoners with psychiatric disorders was also identified as an issue that needs to be addressed.

The vast majority of people that we work with (prison service) would have some disabilities. Some would be psychiatric patients. My problem is that when you try and place these people in treatment nobody really wants them. It is a real problem with prisoners. Many are institutionalised, have intellectual handicaps. They end up in no man's land and nobody wants to know them.

(Justice Support Service)

I agree. I think a lot of people with psychiatric needs fall between the services. Intellectual disabilities more than anything else and then more dual disorders.

(Specialised Addiction Counsellor)

Lack of detoxification services was also raised.

Supports need to be put in place that will keep a person stable in a pre-treatment plan. Connected with the area of pre-treatment is the issue of detoxification, so that people can be safely detox from chaotic use of chemicals prior to admission to a facility. The pre-treatment issue does raise issues as to how services are co-ordinated. There's a whole service that needs to be developed there.

(Specialised Addiction Counsellor)

The gap is detox and when someone has relapsed. And they are on their own and where do they go? That is a real problem.

(Specialised Addiction Counsellor)

Modes of assessment came in for particular criticism.

We lack a common assessment tool, common values or recommendations. So that everybody who turns up at the door of treatment centre gets an assessment and then may be referred as an out-patient, or to a community service. If we had that common approach.

(Specialised Addiction Counsellor)

The way funding from government departments is disbursed also came in for criticism.

We also need to look at the source of funding. Some projects receive money from the Department of Education and Science, some from the Department of Community and Family Affairs, from the Department of Justice, Trade and Enterprise. A lot of time people are trying to twist to fit the funders, whatever their thing happens to be. In order to fit the criteria the funder has, you provide X and for another funder you provide Y while you may need to be providing AB and C.

(Youth Worker)

We are now in a position that there is a huge amount of auditing of funding and rightly so. It is public money. Maybe in the past people had a little wriggle room. You better not wriggle out of the specific contract to which you signed up to because as sure as eggs you will have the EU auditor at your door. That rigidity creates gaps.

(Youth Worker)

The need for continuous funding was a common theme.

Solutions will never happen without funding and that is important.

(Specialised Addiction Counsellor)

Funding for research where there is a specific knowledge deficit was also mentioned during the consultative process.

There is a knowledge deficit. There is a fear amongst parents. They don't know where to go what to do. If there is a problem it should be dealt with it locally and parents should have that local access and support. These are the gaps that are there.

(Specialised Addiction Counsellor)

We do very little work on this issue with the gay and lesbian community because we do not have the resources, nor are any of the agencies doing anything with us. So, there is no work at all being done on the ground – certainly in the lesbian community. There is a small bit of work being done in the gay community with the Gay Men's Health project but again very little resources.

(Community Worker)

We need resources. We need to acknowledge that gay, lesbian and bi-sexual people do misuse drugs and alcohol. First of all we need to find out the extent of the problem, there's need for a baseline research done and then the agencies responsible need to make sure that they target this community.

(Community Worker)

Responding Appropriately

Overview

One person argued that each county should be regionalised and that an integrated approach should be adapted.

I'd like someone to spearhead the whole thing even if it was to divide the two counties into four regions each and then have an interagency approach.

Everyone would be able to bring some of their experiences like we did today.

(Specialised Addiction Counsellor)

Treatment

From the time people begin to seek help, they need to be supported particularly when treatment places are not available. This and the need for support in the event of relapse were identified during the consultation process.

What we need to develop is the pre-treatment area. People have nothing to sustain them in that time. Pre-treatment time is crucial. To keep that person supported in that crucial time. What we need to look at is a continuum of care that treatment starts at assessment. The other area that people are struggling with is the relapse area. We need to look at the whole package.

(Specialised Addiction Counsellor)

There is a real need for a place where people can detox prior to treatment.

(Specialised Addiction Counsellor)

The need for half-way, three-quarter houses was mentioned again and again particularly in rural areas.

Something that is very important is that we are not talking about individuals with problems, we need to be responding to families with problems or to geographical locations with problems. To treat the individual in isolation and to return them to families or locations is to undo the treatment. So, we need to look at half-way houses.

(Specialised Addiction Counsellor)

Most people leaving treatment are facing court cases when they come out. There's nobody there. They are sitting inside in a flat. They might have a television, they might have a radio, they might have a heater, they might have a fire, they might not. The drink is in the background, they are facing a court case and it is running around inside in their head and it is getting bigger and bigger. There's no one to speak to but if they were in a three-quarter house, they could speak to Joe Soap and they'd get it sorted out some way. But if you are on your own like I was...the day before the court case, I drank. If you are on your own and facing a court case, it is not a pretty sight at all.

(Member of the Public)

People in the hinterland of Cork City have access to a whole lot of services and are absolutely not there in the rural areas. There is a need for more dedicated areas for people who need to re-structure their lives.

(Specialised Addiction Counsellor)

We have nothing like the half-way house or three-quarter-way houses. I'm not saying that these are the only option. But we need these kinds of services.

(Specialised Addiction Counsellor)

A dedicated unit for treating young people was also needed.

We need a residential facility for treating young people in the Cork area. Young people under eighteen, are currently going to Belgium, Germany and Scotland from the juvenile courts for treatment. Six went overseas in 2004.

Ninety per cent of those coming before the juvenile courts will have alcohol/drug issues and this must be dealt with.

(Justice Support Service)

Specific supports for young women were called for.

When some of the younger women leave us, they tend to gather in a particular coffee shop with other young women that they would have met in different treatment centres. I don't think it is healthy. You are talking about all these addicts in early recovery and they are released together and it is not good. I think what they need is something more structured. I would see that as a huge need. For the younger people leaving early recovery.

(Specialised Addiction Counsellor)

As well as physical half and three-quarter way houses, there may also be a need for support in the pre-abstinence stage.

Nearly all the treatment that is being offered is abstinence-based treatment. For many people abstinence may not be an option at a particular time. We need to be able to work with people who may not be able to establish abstinence immediately and hold these people in some kind of service until maybe they can make a commitment to abstinence.

(Specialised Addiction Counsellor)

It was also agreed that people living in rural areas had particular needs.

We need a greater spread of services in throughout both counties – like a first access point for people. We are meeting people from rural areas that we would have never met before. There's a huge secrecy in rural areas as well. The way we deliver services in rural areas is very important. It needs to be further developed so that we can intervene earlier. What we need is a first access centre.

(Specialised Addiction Counsellor)

An out-of-hours service is also required.

We need to be able to access treatment outside of office hours i.e. evening time treatment.

(Specialised Addiction Counsellor)

Cost of Treatment

Treatment is provided free to those in the state services with medical cards but not to those in the voluntary sector. This perceived anomaly ought to be addressed in the view of a number of participants

I think it is necessary for people with medical cards to have the full cost of treatment paid for. It is accepted in the state-run services but not in the voluntary sector.

(Specialised Addiction Counsellor)

Co-ordination of Treatment

This was a key issue for many of the participants.

We need to look at increased co-operation between the voluntary and the state sector, between the psychiatric services and ourselves in addiction services and also from general hospitals. We get very little referrals from hospitals and we need to think more broadly on our customer base, so to speak.

(Specialised Addiction Counsellor)

I think we are all basically saying the same thing. More integration of services is needed – mental health services and general hospital services.

Co-ordination and people working in the interests of their clients and not in their own interests.

(Specialised Addiction Counsellor)

I'd really like to see less of pass the parcel from one to another. Continuity is important.

(Justice Support Service)

The Key Worker

The concept of the key worker emerged again and again. One participant described the function of the key worker as follows:

One of the real identifiable needs in the national strategy was the idea of key worker. It addresses a lot of the issues that have been raised about people falling through the gaps and not being able to access psychiatry and not being able to access half way house or whatever. Somebody shouldn't be coming out of prison and that week or that day panicking about where are we going to get them in. There should be a plan that somebody should be working on that for three months or six months beforehand. Everybody should have a key worker and s/he should be able to deal with a good number of clients so it shouldn't be such an onerous task. The funding has never been put in place to provide key worker. People are working with the panic button or the crisis button pressed all the time and everybody is overloaded. Therefore the services cannot properly develop in any sort of meaningful way. At present, it is depending very much on goodwill and on people stretching themselves that bit extra, people working outside their own remit.

(Specialised Addiction Counsellor)

If a key worker was appointed, I think that would address the services are not as well co-ordinated in this area as they could be.

(Specialised Addiction Counsellor)

Education and Prevention

A good deal of criticism was directed at GPs and the way in which they respond to drug and alcohol difficulties and in particular the ease in which they prescribe medicines. It was felt that GPs need to be educated in this area.

There is a need for GPs to be educated on the use of the prescription of benzodiazepine and its use as a long-term treatment of anxiety disorders. It would seem to be the case that they are too easily prescribed. Middle-aged women we would occasionally get into treatment for alcoholism and then it would emerge that there is a very strong dependency on benzodiazepine and it is a bit of a shock to the system because in good faith they have taken the benzos as prescribed and then to be told that you need to come off them as it sabotages treatment.

(Specialised Addiction Counsellor)

I think there is something very wrong when guys can get a month supply three times in one week from the same GP. This happens. There are particular GPs

that guys would know about and word gets around and they go and get a month's supply, they go back the next day and say they lost them and they get another one and then they go back two days later and the dog is after eating them and they get more. No questions asked.

(Specialised Addiction Counsellor)

Middle-aged women themselves need education on the effect of benzodiazepines.

One of the subtle gaps coming back to the middle-aged women is education. There is a very high use of benzo abuse and alcohol abuse with middle-aged women. Some of the women, while they might be very aware of the alcohol are not really aware the benzo are a drug that can be abused because it is a prescribed drug. There is a need for education around that for middle-aged women.

(Specialised Addiction Counsellor)

There was a general consensus that education needs to start in the primary schools.

Maybe in terms of awareness we go into Transition years and fourth years, maybe we need to bring it right down, down to the first years and maybe primary school.

(Educationalist)

Some people, it would appear are not even in the education loop according to one source.

Young Travellers are completely outside the loop when it comes to drug and alcohol education. There is no prevention work been done. We need a community development approach to drug and alcohol awareness for Travellers. We need specific and targeted work with Travellers, which would include the expertise of Travellers.

(Community Worker)

There was also the view that whole family response at both the level of treatment and education is required if the issue of drug and alcohol excess is to be tackled.

The family context needs to be taken into account.

(Specialised Addiction Counsellor)

Pre-natal classes for mothers and fathers were identified by one respondent as an opportunity to raise awareness about drugs and alcohol.

I think part of pre-natal class should look at lifestyle issue and the opportunity costs of having a baby. We need to look at what are your own feeling as a new father. You might be seventeen and you need to look differently at things. We need men's groups facilitating men in their roles as fathers and community leaders. Just more support for them.

(Specialised Addiction Counsellor)

One person was of the view that people working in the catering industry need to be aware of the needs of their customers and be pro-active in tackling excessive drinking.

We need to teach bartenders and GPs and frontline people that may notice this person's drinking is problematic or is causing some difficulties in their life. The intervention does not necessarily have to come from the workplace.

(Specialised Addiction Counsellor)

One participant was of the view that members of the judiciary tend to operate unilaterally and without recourse to other professionals in the area of addiction. They too need education on collaboration with other professionals and on how addiction or high level consumption affects people.

One of the difficulties I see in Cork is some kind of liaison with the judges. They seem to act separately from recommendations from psychiatrists and doctors and treatment centres and so on. I think it is unhelpful to say the least to operate in this unilateral way.

(Specialised Addiction Counsellor)

There was also the view that people working in the area of drug and alcohol services need continuous education and very often those working in the area do not have all the skills that are required to respond effectively.

As a resource centre, we need to be educated as well. Staff need to be educated. Particularly those working on the frontline. That requires resources and we don't have resources. We need better co-ordination between the agencies to give us that education. Drugs are a community issue but they are also a family issue. We do not have the skills to respond to that other than to refer people on. We need more skills more education and more training. There is a knowledge deficit there.

(Specialised Addiction Counsellor)

We would have more confidence in dealing with the situation if we knew more about the situation ourselves. We need to be educated. We don't know what young people are thinking or doing.

(Educationalist)

This was also an issue for people involved in sporting organisations. One person felt the SRDTF should work in collaboration with all the sports bodies who in turn would then work with the clubs.

There is one subcommittee within the GAA, Comhairle. We are all volunteers and we get training from Croke Park and we then deliver programmes within the club structure. At present no formal sessions are conducted on lifestyle issues like drink and drugs and I think there is room for that. In Kerry alone there are seventy clubs so in that way you would reach an awful lot of young people. I think the GAA would be interested in looking at ideas where we would look at alcohol and drugs. Other organisations might also be interested.

(Sport Administrator)

Research

Three areas of research were briefly alluded to and they related to consumption amongst members of the Travelling and LGB communities. It was also suggested that research is needed to establish why some services are reluctant to refer people onto community-based treatment and counselling services.

We don't know the level (of consumption within the Travelling community) because it hasn't been researched. It needs to be but it needs to be done in a way that is acceptable to Travellers.

(Community Worker)

While there would seem to be an increase certainly within the lesbian community but again we have no evidence to back that up. We need that evidence.

(Community Worker)

One of the things I would be concerned with is that you would have a number of strands within the Health Board from the general hospitals and very few people come from the general hospitals to our (community-based) services. They end up in psychiatry, which may be an inappropriate place for a lot of people. We get very few referrals from psychiatry to the community services afterwards. I think we need to know why.

(Specialised Addiction Counsellor)

Supply Reduction

No specific proposals emerged on this issue except some generic comments on ports and the fishing industry that have been outlined above.

Finally, one person concluded:

I think we should prepare for the long haul.

(Educationalist)

Chapter 6

Conclusions and Recommendations

The drug misuse problem is as much a symptom as a problem in itself. It is the tip of the iceberg. It is a symptom and not a cause. It is important that we are not all the time crisis led. We need to go beyond the quick fix. Maybe there is something about space and dialogue and listening and conversation and the need to think in terms of the long term and not be lurching from one scheme to another. That isn't particularly helpful. Something about slowing the whole thing down as well. There needs to be a longer slower approach. We need to give people some quality, the quality of being listened to.

(Voice heard during the consultation process)

Introduction

Consumption of alcohol and illicit drugs in counties Cork and Kerry including Cork City was the main focus of this study, commissioned by the Southern Regional Drugs Task Force. Chapter One of this report outlined the background to the study, Chapter Two profiled the Southern Regional Drugs Task Force area and reviewed both national and international literature relevant to drug and alcohol consumption. Chapter Three detailed drug and alcohol services in the Region. Chapter Four outlined the research method employed in this study. Chapter Five presented the details of the consultative process undertaken in the region. This Chapter will detail the conclusions reached and makes a series of recommendations for a course of action over the four-year period from 2005 – 2008.

The conclusions and recommendations in this report are framed by the four pillars of the National Drugs Strategy 2001-2008 – Supply Reduction, Prevention, Treatment and Research. The recommendations are informed by the consultative meetings undertaken in preparation of this study and outlined in Chapter Four and the literature review outlined in Chapter Two.

Dr. Tim Jackson, a specialist in public health medicine, conducted a major study in 1996 on *Smoking, Alcohol and Drug Use in Cork and Kerry* (Jackson, 1997). This study was repeated in 2004. For comparative purposes, the findings of the repeat study *Smoking, Alcohol and Drug Use in Cork and Kerry (2004)* are used in this report. During the qualitative research, participants in the consultative process were first asked to what extent, if at all, drug and alcohol consumption patterns have changed since Jackson's first study in 1997 and from that opening the conversations ensued.

Conclusions

Consumption by Type of Drug

Between 1996 and 2004, there has been an increase in alcohol and drug consumption across all types of drugs in Cork and Kerry.

- Alcohol consumption increased significantly across all ages.
- Cannabis consumption has significantly increased and is the most popular illicit drug of choice.

- Ecstasy has significantly increased but from a much lower base.
- Cocaine has significantly increased but this too is from a very low base.
- Heroin has significantly increased but again from a very low base.
- Solvent misuse has remained the same or increased somewhat but this increase is not significant.
- Hallucinogenic drug misuse has increased but this too from a low base and the increase is not significant
- The misuse of prescribed drugs would appear to have increased but it is not possible to quantify this precise increase.

Summary Findings

There has been a perceived increase in overall drug consumption in Cork and Kerry between 1996 and 2004 and this increase has been corroborated by Jackson's (2004) study. The following table sums up the above findings by drug type.

Table 23
Increase in Drug Consumption by type of Drug in Cork and Kerry from 1996 – 2004

Findings from the Consultative Process cross-referenced with Jackson 2004

Drug Type	Increase	Decrease	Same	Findings Corroborated by Jackson (2004)		
				Highly Significant	Significant	Not Significant
Overall	•			•		
Cannabis	•			•		
Ecstasy	•			•		
Cocaine	•			•		
Opiates	•					•
Solvent			•			•
Hallucinogens						•

Consumption by Population Type

It was possible to identify particular population groups where there is a higher propensity towards consumption.

- Illicit drug consumption has increased significantly and this increase is most pronounced in the 15-19 and 20-24 age-groups. There is a highly significant decline after the age of twenty-five with less than four per cent consuming in their forties.
- There was a highly significant increase in male consumption in the 1996-2004 period and a highly significant increase in female consumption. Male consumption still outstrips female consumption but the gap is closing.
- Single people and people in fluid family situations are more likely to consume illicit drugs.

- People with mental health problems are particularly vulnerable and their needs are difficult to meet when they are complicated with illicit drug use.
- Addiction, often multiple addictions, are a feature of many prisoners' and ex-prisoners' lives and that of their immediate families.
- High male alcohol consumption, particularly among young men and increasing among young women is a feature of many Travellers' lives. Cocaine is beginning to make its presence felt in the Traveller community reflecting general trends in society.
- There is conflicting evidence on drug consumption trends among newly arrived Non-Irish-Nationals. One study suggests very low levels of consumption while the consultative process highlighted specific illicit drug-trade aimed directly at Non-Irish-Nationals.
- Indications are that consumption level of illicit drugs is high in the gay community and alcohol and misuse of prescribed drugs is high in the lesbian community.
- Drug and alcohol consumption is high among homeless people.
- While drug consumption is still highest in Cork City, the increase in large towns and rural areas is highly significant.

Summary Findings

With regard to discrete populations, both the consultative process and Jackson (2004) reported increased across a range of populations. Table 2 has the details.

Table 24
Increase in Drug Consumption by Population Type in Cork and Kerry from
1996 – 2004
Findings from the Consultative Process cross-referenced with Jackson 2004

Population Type	Increase	Decrease	Same	Don't Know	Findings Corroborated by Jackson (2004)		
					Highly Significant	Significant	Not Significant
Cork City	•				•		
Cork County	•				•		
Kerry County	•				•		
Urban (10,000+)	•				•		
Large Towns (5,000-9,999)	•				•		
Small Towns (1,500-4,999)	•						•
Rural	•				•		
Young People	•				•		
Middle-aged People	•				•		
Women	•				•		
Men	•				•		
Married				•			
Single	•						
Separated/Divorced	•						
People with Mental Health Illnesses	•						
Travellers	•						
Non-Irish-Nationals				•			
People with Mental Illness	•						
(Ex)Prisoners	•						
Gay/Lesbian/Bisexual				•			
Homeless	•						
Working class	•				•		
Middle class	•				•		

General Conclusion

Drug and alcohol consumption are inextricably linked. Interventions under all four pillars should reflect that reality.

Alcohol-specific conclusions

- Societal tolerance of high alcohol consumption, most particularly among the young, has increased significantly;
- Glamorised advertising is seriously contributing to the consumption of alcohol;
- The easy availability of alcohol in off-licences and supermarkets is seriously contributing to alcohol problems in society.

Illicit drug-specific conclusions

- The culture has changed and tolerance of consumption of illicit drugs, most notably, cannabis has significantly increased.

Prevention and Education Issues

- The general high level of tolerance of alcohol and cannabis consumption has significantly increased the difficulty of frontline staff i.e. youth workers, educators, community workers and health promotion workers, in communicating a moderation message for alcohol consumption and an abstinence message for illicit drug consumption;
- The difficulty that many of these frontline workers are having is shared by many parents, notwithstanding the high tolerance of many parents and the general community towards high levels of alcohol consumption and illicit drug consumption, particularly cannabis consumption;
- Many families were perceived to be under pressure and while parents were scapegoated for many of their children's ills, there was a perception that care and support is more appropriate than blame and scorn;
- There were calls for increased drug and alcohol awareness in pre-service and in-service of teacher education;
- There was a view that single-sex boys' schools receive less life skill education than do other schools;
- Alcohol and drug-related discipline has become a serious issue and poor school/education centre attendance is becoming a serious issues of concern;
- There is a perception that there is a knowledge gap among service providers in this area and that there is an increased need for training and up-skilling people working in the education/prevention area;
- Repeatedly, participants at the consultative process stated that there is a dearth of out-of-school services for young people.

Treatment

- There was a general belief that state and voluntary sector service provision could be better integrated. In particular, the level of integration between general practitioners and community-based services needs to be enhanced.
- Service provision needs to take into account the degree to which the population is dispersed throughout the region.
- People within the GMS system (medical card holders) do not have adequate access to treatment facilities within the voluntary sector.
- Pre-treatment and detoxification services were seen as inadequate despite significant increases in personnel and uptake.
- The *Key/Link Worker* approach offers greater flexibility for treatment, and rehabilitation. No such resource currently exists in the region.
- Varieties of assessment were identified in the course of the consultation process.
- Inconsistencies in sentencing policy were identified without the full exploration of alternative strategies, treatments and supports;
- Currently young people coming before the Courts cannot be mandated to give a urine sample.

Supply Reduction

- A lot of concern was expressed about the ease with which young people have access to alcohol in off-licences and supermarkets;
- Particular concern was expressed about coastal communities and the trafficking in drugs that is happening there;

- Currently the issue of supply reduction is generally perceived to be the preserve of the Gardaí and Customs and Excise services. Local communities, individuals and organisations do not see themselves as centrally involved in this role;
- The manner in which funding is granted by government departments and the lack of local discretion in spending the funding received was criticised.

Research

- There is an ongoing need to fund research;
- Crime statistics tend to hide the extent of drug and alcohol consumption. While not the presenting issue, much of juvenile crime is caused by alcohol and drug consumption. The precise extent to which drug and alcohol consumption contributes to juvenile crime needs to be established;
- The impact of the *Walk Tall* programme in schools needs to be constantly reviewed and where appropriate extended;
- There is a need for ongoing coordination between all the various agencies involved in school-based drug and alcohol work;
- There is a need for greater information about the consumption patterns amongst minority populations e.g. Non-Irish-Nationals and the gay and lesbian community.

Recommendations

The following recommendations are made on the basis of the above conclusions.

Education and Prevention

- That all young people and their parents irrespective of their location should have access to balanced and well-grounded information on drugs and alcohol;
- That the SRDTF liaise with Department of Education and Science Inspectors, the National Education Welfare Board, the Schools Completion Programme, The Home-School Liaison Programme, The Health Promoting Schools Initiative and the Second Level Support Service and the Whole School Review programme;
- That a consultative process be undertaken by the SRDTF with a selection of schools on drug and alcohol-related difficulties and that a submission be made to the recent review announced by the Minister for Education and Science on school discipline;
- To support the provision of SPHE in schools and in particular to support the provision within single sex boys' schools in the region;
- There is need for some consistency of approach on the part of the community voluntary and statutory sector in work undertaken in schools and centres of education;
- To develop a series of educational outreach post-formal education programmes in conjunction with the trade union movement, professional and industrial bodies where there is a strong youth presence in the workforce e.g. FÁS, the Construction Industry Federation and SIPTU;
- To work in collaboration with service providers in the Rapid (Strand 2) designated towns and with the Clár Programme;
- To support peer education programmes for young people that tackle the issue of drug and alcohol misuse;

- To engage with the third-level sector, i.e. the Students' Union, the chaplain services and counselling services in providing a comprehensive alcohol and drug education programme;
- To develop targeted educational programmes with adult voluntary and community groups, e.g. the St. Vincent de Paul Society and voluntary groups e.g. the Irish Countrywomen's Association;
- To develop pilot educational programmes with Sports Partnerships, sports administrators, coaches and other personnel within sporting organisations in the region e.g. Comhairle within the GAA;
- To designate staff with educational, counselling and developmental skills who will work with minority groups like members of the Travelling community, ex-prisoners, gay, lesbian and bi-sexual people, Non-Irish-Nationals, and homeless people;
- That a process of reflection and engagement with professional service providers e.g. general practitioners, members of the judiciary and other members of the legal profession, social workers, probation and welfare workers, addiction counsellors on ways in which the needs of those who come to their attention can be met;
- That family support and education should be an integral part of the work of the SRDTF;
- That all staff/volunteers working in education and prevention should have regular access to on-going inservice courses and if they wish to have opportunities to have these courses credited. Discussions of accreditation should be undertaken with FETAC;
- To support a programme of community-based drug and alcohol-free events for teenagers;
- To tackle the issue of rural isolation by supporting the delivery of youth services at local level;
- Mandatory alcohol awareness programmes should be made available to all those who have been convicted of driving with excess alcohol.

Treatment

- Clear pathways of referral for all those involved in frontline education and prevention work need to be put in place;
- To develop co-operation and collaboration between those working in the psychiatric sector and those working in the voluntary sector in the provision of treatment to people in the region;
- To develop partnership between the state sector and voluntary sector in the provision of treatment to people in the region who need to avail of services for alcohol and drug misuse, it is time that the state sector secures ongoing funding to increase financial viability of the voluntary treatment services operating in the region;
- It is now opportune to develop the role of "key/link worker" to ensure a transition between each different phase of treatment. This role can assist in supporting people on waiting lists, during treatment and with on-going rehabilitation needs as they arise;
- The needs of families impacted by problematic alcohol and drug consumption must be addressed so that rehabilitation can take place for the family unit. Each treatment facility should provide a family treatment dimension to its programme, the development of which gives rise to funding, training and plant requirements;

- To ensure salaries in the voluntary sector keep pace with salaries of the state sector;
- Specific after care residential centres – half-way and three-quarter way houses – are required, specifically for adolescents;
- Provision of in-patient facility for safe detoxification. Training and support is necessary for the provision of out-patient detoxification;
- Ensure that the level of treatment service provision keeps pace with the increase in the level of consumption;
- Implement recommendations of the Benzodiazepine Working Group, with particular reference to Recommendations 3, 5 and 14 on the use of repeat prescription for benzodiazepines and their misuse and Recommendation 11 regarding to hospital and other healthcare providers prescribing practice;
- Ensure that the planning of any new treatment services take account of the dispersed nature of the population;
- Recognise that there is a role for alternative therapies and counselling and that drug-based remedies are not always necessary;
- That those involved in treatment are given regular opportunities to attend courses including evening courses, and have access to the latest information and models of treating those with drug or alcohol problems. A number of seminars should be organised for all treatment providers on a wide range of issues including, for example, the cultural needs of Non-Irish-Nationals;
- Promote and compliment the medical and the specialised counselling services.
- While abstinence remains the preferred treatment option, the SRDTF should consider if there are intermediary options (specific harm reduction strategies) that need to be put in place;
- With due recognition of the rights of every citizen before the Courts, urine samples should be sought from young people in this situation and evidence of illegal drugs in the system should be taken into account in deciding how best to respond to the needs of that person.

Supply Reduction

- That work should be undertaken with coastal communities on how they can best contribute to the reduction in the trafficking of illicit drugs;
- That communities should be encouraged to work in tandem with the Gardaí and the Customs and Excise Services.
- More regulation of off-licences and supermarkets with a view to curbing the level of access of young people to alcohol.

Research

- That peer-led research should be undertaken on the consumption patterns, of minority groups in particular Non-Irish-Nationals, members of the Travelling community and bisexual, gay and lesbian people along with the identification of appropriate educational and treatment models;
- That there should be a commitment to formative evaluation and that this form of evaluation should accompany any development work that the SRDTF should undertake;
- To conduct some research on the use and misuse of benzodiazepines in the region and to set targets for the reduction of their misuse.

Funding and Other Issues.

- The degree of funding offered for all of the above pillars was perceived to be less than adequate;
- There is a cross-over between the role of the Southern Regional Drugs Task Force and a range of voluntary, community and statutory agencies that will require a great deal of co-ordination;
- Imaginative and successful initiatives have been undertaken by the Cork City Local Drugs Task Force that may be appropriate models of engagement for the SRDTF.

Appendix 1 The Conversational Agenda

- OK that was Jackson in 1997. At the outset, I'm wondering if anything has changed, **what** is the situation locally? How would you characterise local drug and alcohol consumption in your own area?
- I suppose one of the things we are always conscious of is to try and differentiate between perceived and real consumption patterns. So, I'd like to explore this in a bit more detail. **What** kind of tangible evidence you have come across of consumption patterns in your local area?
- When we are talking about consumption patterns, I think it is important that we are all clear about **what** we are talking about. So, can we list the type of drug and alcohol choices that people are making at present?
- That is helpful in terms of establishing or mapping what is happening on the ground. I'm also interested in trying to get a fix on **who** is consuming. So, if we were to profile the users who do you think we would be talking about?
- Inevitably, when we are talking about consumption patterns, we talk about problematic consumption. I am curious to know **what** do you regard as problematic use?
- Let's take this a step further. **How** many or what percentage of young people do you believe to be at risk from drug consumption?
- In our discussion so far, we have talked a good deal about mapping. A key aspect of any mapping exercise is to try and geographically locate the discussion. So, in your experience **where** are, if I can use the term, the consumption hotspots?
- I think a lot of attention is focused on urban centres but there is some evidence to suggest, for example, in Nolan, *et al's* 1998 study *Where Are Poor Households? The Spatial Distribution of Poverty and Deprivation in Ireland*. They argue that there are concentrations of poverty in public housing estates on the fringes of small towns and village and that there are high risks of poverty attached to living not only in these places but also in rural areas and these are often not picked up by service providers. What do you make of that?

I want now to turn our attention to very specific issues and try and get a more detailed picture of consumption patterns.

- **What** about ethnicity. Is this an issue? Have recent demographic / migratory trends impacted on drug consumption in the region?
- **What** about women and men? Is it the case that men's consumption gets more attention than that of women's?
- **What** about Social Class? The general perception is that drug consumption amongst working class people is subject to greater surveillance than drug

consumption of middle class people. Is this a fair representation and if so is this as it ought to be?

- **What** about Age? The evidence would suggest that younger people's drug consumption patterns get much greater attention than does older people and in particular older people's improper use of prescription drugs does not get the attention it deserves. Is that the case and is that a cause for concern?
- **What** about Disability? Are there specific issue that we ought to be addressing?
- **What** about Sexual Orientation? Again international evidence suggests that there is much higher levels of drug consumption amongst the gay and lesbian community than in the rest of the population. Should the strategy address this?
- **What** about Family Status? Is there any evidence to suggest higher levels of consumption among certain types of families?
- OK, I think we have enough of mapping done. Can I now turn to the question of **why**? Why do you think consumption patterns are the way they are?
- I want to move on to the question of response. The first question to ask is: are we aware of the services that are available to the public? So, for example if someone was to say to you I am worried about my daughter / son, **how** would you respond to them?
- Are there clearly recognisable gaps in the current response and if so **what** are they?
- **What** do we need to do to address those gaps? First of all, I'd like to get a general overview of how you think we ought to be bridging the gaps? Specifically, I'd like to establish if you think that there ought to / needs be a specific response to take account of:
 - Gender
 - Social class
 - Rural – urban
 - Ethnicity
 - Age
 - Disability
 - Sexual orientation
 - Family statusand what ought that response be in terms of Supply Reduction, Education/Prevention, Treatment and Research?
- **What**, if anything do you think we ought to be doing to protect those who are not consuming illegal drugs or who are not problematic drinkers?

- Finally, is there anything that you think we have neglected to cover in our discussion today that you think we need to include or make reference to in the report?

Not all of these questions were asked rather this was used as a checklist by the researcher. As indicated above, the participants very often dictated the pace and content of the discussions.

Appendix 2

The Consultation Protocol

The following was circulated to everyone who attended the consultative meetings.

It is my intention to promote a fair and respectful relationship with everybody involved in this study. My aim is to produce an honest and informative report that will help to promote a greater understanding of how the SRDTF can effectively work over the next three years. The following will apply:

1. *Permission to audio-tape all interviews will be sought.*
2. *All interview data will be treated in strict confidence and will only be used to prepare the report.*
3. *All information collected by me will not be shown to any third party and will be stored securely at all times. Nobody's name will be used in the final report.*
4. *Unless stated otherwise, it is assumed that all conversations between us are on record.*
5. *All interviewees will receive a copy of this protocol before any interviewee takes place.*

Peadar King
October 2004

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**SOUTHERN
REGIONAL DRUGS TASK FORCE**

ACTION PLAN

2005 - 2007

SOUTHERN REGIONAL DRUGS TASK FORCE ACTION PLAN 2005 - 2007

This Action Plan is the considered priorities for the Southern Region (Cork / Kerry) of the Southern Regional Drugs Task Force following a comprehensive study carried out in November 2004 – February 2005.

The Task Force took into account the time span of the National Drug Strategy “Building on Experience 2001 – 2008” and thus have developed priorities for each year.

Where possible the Task Force are anxious to commence processes and projects at an early stage. Conscious of the need to only create realistic expectations in the community we will request detailed proposals from communities when the Action Plan is approved in principal by the National Drugs Strategy Team.

In a number of proposed developments it has been possible to produce details and costings these are included in the appendices of the Action Plan.

Supply Reduction

1. Development of Club Kerry & Club Cork County – a programme for Clubs, Pubs and Off-licences which trains staff in developing appropriate response to alcohol and drug misuse:

2005

1 Post – Kerry

1 Post – Cork County

Action Plan Appendix 1

Cost Annual - €100,000

2. The SRDTF supports the Customs Drugwatch Programme and the Garda Drug Programme as important initiatives in engaging with the community.

Cost - Nil

3. The SRDTF supports the recent initiative of the Revenue Commissioners in the provision of the Customs Cutter “Suirbheir” as an effective first step in the patrolling of the South West coast line. We recommend further additions to the fleet to effectively patrol the coast as a major deterrent to drug smuggling.

Cost - Nil

Education & Prevention

4. The consultation process identified seventeen areas in Cork and Kerry in need of special Community Projects. Taking into account existing youth, community and statutory services and the RAPID and Clar area the following have been identified as priorities for 2005.

Development of Community Drugs Project in five areas:

2005 – 5 Projects – towns and their environs identified with a population of 6,000+

East Cork	-	1 - Youghal / Middleton / Cobh
North Cork	-	1 - Charleville / Kanturk
West Cork	-	1 - Bantry / Skibbereen / Clonakilty
North Kerry	-	1 - Tralee
South Kerry	-	1 - Killarney

The consultation process identified seventeen areas in Cork and Kerry in need of special community projects. Taking into account existing youth, community and statutory services and the RAPID and Clar area the following have been identified as priorities for 2006.

Development of Community Drugs Project in five areas:

2006 – 6 Projects – towns and their environs identified with a population of 3,000 to 6,000

The consultation process identified seventeen areas in Cork and Kerry in need of special community projects. Taking into account existing youth, community and statutory services and the RAPID and Clar area the following have been identified as priorities for 2007.

Development of Community Drugs Project in five areas:

2007 – 6 Projects – towns and their environs identified with a population of 1,500 to 3,000 including rural areas

The development of these projects takes cognisance of existing projects. They will be modelled on successful initiatives which have taken place within the Cork Local Drugs Task Force as outlined in Action Plan Appendix 2

While these projects are being promoted under the Education and Prevention Pillar they have also been discussed at length by the Treatment and Rehabilitation Sub Group and it is understood that the projects would also have a counselling and referral to treatment dimension to their work.

Action Plan Appendix 2

Cost 2005 - €325,000

Cost 2006 - €390,000

Cost 2007 - €390,000

5. The SRDTF develop seminars on Best Practice on Drugs Education in order to develop consistency in approach by the community, voluntary and statutory sector when working with schools and centres of education.

Cost Annual - €10,000

6. The SRDTF examine models of best practice with the Department of Education and Science and other relevant professionals relating to education and information on drug and alcohol so that all young people and their parents irrespective of their location should have access to balanced and well-grounded information. Exploring models which have been developed within the region taking into account the geographical nature of Cork and Kerry i.e. Kerry Life Education Mobile.

Cost – Nil

7. That the SRDTF consult with a selection of schools on difficulties experienced relating to drug and alcohol misuse and make a submission to the review announced by the Minister for Education and Science on school discipline.
Cost - Nil

8. The SRDTF in conjunction with the relevant groups would examine the needs of minority groups i.e. Traveller community, ex prisoners, gay/lesbian/bi-sexual people, non-Irish nationals and homeless people.
Cost – Nil

9. To support the provision of a schools policy and SPHE by the Department of Education and Science in schools and in particular to support the provision within single sex boys’ schools in the region.
Cost – Nil

10. To support the development of a series of educational outreach post-formal education programmes in conjunction with the trade union movement, professional and industrial bodies where there is a strong youth presence in the workforce e.g. FÁS, the Construction Industry Federation and SIPTU.
Action Plan Appendix 3 **Cost Annual - €10,000**

11. To support peer education programmes for young people that tackle the issue of drug and alcohol misuse.
Action Plan Appendix 4 **Cost 2007 - €25,000**

12. To meet with the third-level sector, i.e. the Students’ Union, the chaplain services and counselling services in providing a comprehensive alcohol and drug education programme.
Cost Annual – €5,000

13. To support the development of targeted educational programmes with adult voluntary and community groups, e.g. the St. Vincent de Paul Society, and voluntary groups e.g. the Irish Countrywomen’s Association;
Action Plan Appendix 5 **Cost Annual - €5,000**

14. To support the development of pilot educational programmes with Sports Partnerships, sports administrators, coaches and other personnel within sporting organisations in the region e.g. Comhairle within the GAA;
Action Plan Appendix 6 **Cost Annual - €5,000**

15. The SRDTF develop a process of reflection and engagement with professional service providers e.g. general practitioners, members of the judiciary and other members of the legal profession, social workers, probation and welfare workers, addiction counsellors on ways in which the needs of those who come to their attention can be met. Further consultations with Pharmacists and General Practitioners together with counselling services will be undertaken relating to the issue of misuse of codeine and other pharmaceutical products.
Action Plan Appendix 7 **Cost - Nil**

16. That the SRDTF would ensure that staff/volunteers working in education and prevention should have regular access to on-going in-service courses and provide opportunities to have these courses accredited. Discussions of accreditation should be undertaken with FETAC;

Action Plan Appendix 8

Cost Annual - €3,000

17. To support a programme of community-based drug and alcohol-free events for teenagers;

Action Plan Appendix 9

Cost Annual - €5,000

18. The SRDTF review the issue of rural isolation by supporting the delivery of youth services at local level;

Action Plan Appendix 10

Cost - Nil

19. Mandatory alcohol awareness programmes should be made available through the Courts to all those who have been convicted of driving with excess alcohol or substances

Action Plan Appendix 11

Cost - Nil

Treatment & Rehabilitation

20. The development of a Key / Link Worker service within the region. It is now opportune to develop the role of “key / link worker” to ensure a transition between each different phase of treatment and rehabilitation. This role can assist in supporting people on waiting lists, during treatment and with on-going rehabilitation needs as they arise;

2005 - 2 - Key / Link Workers

2006 - 2 – Additional Key / Link Workers

Action Plan Appendix 12

Cost 2005 - €100,000

Cost 2006 - €100,000

21. The provision of additional resources within the Treatment Centres to address the needs of particular minority groups.

Action Plan Appendix 13

Cost 2005 – Nil

Cost Annual 2006 - €200,000

22. That the SRDTF would support the establishment of After Care Residential Centres – Half-way and Three-quarter Way Houses.

Action Plan Appendix 14

Cost Annual 2005 – Nil

Cost Annual 2006 - €300,000

23. That the SRDTF would develop a Working Group to review the range of services available for adolescents and the requirements for After Care and Halfway Houses

Cost – Nil

24. Clear pathways of referral for all those involved in frontline education and prevention work need to be put in place;

The SRDTF to develop a Working Group in order to develop co-operation and collaboration between those working in the psychiatric sector and those working

in the community services and voluntary sector in the provision of treatment to people in the region;

Cost - Nil

25. The SRDTF recommends the development of partnership between the state sector and voluntary sector in the provision of treatment to people in the region who need to avail of services for alcohol and drug misuse, it is necessary that funding is made available by the Health Services to ensure ongoing funding and to increase financial support to secure financial viability of the voluntary treatment services operating in the region. This support will ensure salaries in the voluntary sector keep pace with salaries of the state sector.

HSE Funding

SRDTF Cost – Nil

26. The needs of families impacted by problematic alcohol and drug consumption must be addressed so that rehabilitation can take place for the family unit. Each treatment facility should provide a family treatment dimension to its programme, the development of which gives rise to funding, training and plant requirements.

HSE Funding

SRDTF Cost – Nil

27. The SRDTF recommend the implementation of the conclusions and recommendations of the study on Detoxification Services recently completed by Health Service Executive, Southern Area.

HSE Funding

SRDTF Cost - Nil

28. Ensure that the level of treatment service provision keeps pace with the increase in the level of consumption;

Cost – Nil

29. Support the recommendations of the Benzodiazepine Working Group, with particular reference to Recommendations 3, 5 and 14 on the use of repeat prescription for Benzodiazepines and their misuse and Recommendation 11 regarding to hospital and other healthcare providers prescribing practice.

Cost – Nil

30. Ensure that the planning of any new treatment services within the region take account of the dispersed nature of the population.

Cost - Nil

31. Recognise there is a role for a variety of approaches to drug and alcohol, alternative therapies and counselling.

Cost - Nil

32. That staff involved in treatment are given regular opportunities to attend courses including evening courses, and have access to the latest information and models of treating those with drug or alcohol problems. A number of seminars should be organised for all treatment providers on a wide range of issues including, for example, the cultural needs of non-Irish-nationals and changing trends;

Cost Annual - €10,000

33. When the courts require urinalysis as an indicator for determining compliance it is recommended that contractual arrangements be put in place with independent agencies to perform and provide this service.

Cost - Nil

Research

34. Project to evaluate all treatment models in the area, involving both treatment providers and treatment users.

Cost 2006 - €50,000

Cost 2007 - €50,000

35. Formative evaluation must be put in place for all projects funded under the SRDTF.

Cost - Nil

36. Research into establishing the nature, type and volume of alcohol and drug consumption in the region.

Cost 2007 - €5,000

37. The SRDTF in consultation with community groups are aware of emerging issues from time to time.

In this regard it is important that the Task Force are in a position to consider the needs through a Small Grant Scheme. The requirement for this initiative for 2006 is €50,000

Cost 2006 - €50,000

38. Proposed Development:

2 Development Workers/Executives

Reporting to the Coordinator

Role:

- To provide support to the Task Force Members in developing strategic responses to issues arising, particularly the Community and Voluntary Sectors.
- To work with Communities in developing specific proposals for the implementation of the Strategy.
- To work with approved projects in developing and implementing the plans.
- To organise information seminars for communities relating to Drug & Alcohol issues.
- To assist the coordinator in the effective operation of the Task Force Strategy.

Requirement 2005 2 Posts €120,000

ACTION PLAN APPENDICES

Development of Club Kerry & Club Cork County – a programme for Clubs, Pubs and Off-licences which trains staff in developing appropriate response to alcohol & drug misuse:

Action Plan - Appendix 1

The project description below can be applied to both project one serving County Kerry and the other serving County Cork.

Project Title – Project A - Club Kerry

Project Title – Project B - Club County Cork

Project Promoter - Health Promotion Unit, Health Service Executive

Project Priority – 2005

General Description - This project will inform and educate nightclub staff, doormen and managers to enable them to take an active role in dealing with substance misuse within nightclubs in Co Kerry. It was also recommended by the Task Force that this project work with Off Licence owners and staff. This project will be targeted at all nightclubs in the county and at some Off Licences. Local communities and the Gardai will be involved in prioritising the Off Licences that will be invited to participate in this project.

Target Group - Nightclub and Off Licence staff, doormen and managers.

Geographical area covered – Project A – County Kerry

Project B – County Cork

The aims and objectives of project.

The aim of this project is to inform and educate nightclub staff, doormen and managers to enable them to take an active role in dealing with substance misuse within nightclubs in County Kerry. In relation to Off Licences, it is recommended that the project develop a campaign that would inform and educate Off Licence staff on underage drinking, the use of middlemen for alcohol purchasing, and develop strategies to reduce the supply of alcohol to young people. It is envisaged that protocol regarding off licence sales would be developed. A Health Education Officer will be recruited to work on this initiative. This work will be done in four phases:

Phase 1 – Planning – to set up a Steering Committee with representation from the Gardai, the Irish Nightclub Owners Association, Medical Professional and the Health Education Officer.

Phase 2 – Consultation – to target all nightclubs in the area to identify training needs.

Phase 3 – Training – delivery of training to include drug awareness, emergency first aid, legal issues, managing a drug related incident, requirements for a safer nightclub environments.

Phase 4 – Evaluation of Training and the production of materials.

We will request that the project promoters develop a similar implementation plan in relation to Off Licences.

Evidence of the need for this project.

The need for this initiative was highlighted through the gaps identified through the Southern Regional Drugs Task Force Consultation Day and evidence of good practice from the “Safer Dance Initiative” of the Eastern Health Board and the Cork Local Drugs Task Force. This project will address a Level One need as identified through the Drugs Task Force consultation process.

Details of the operation / management structure of the project.

The Health Promotion Unit of the Health Service Executive will have overall responsibility for the project. The project work will be carried out by Health Education Officers in liaison with the Drug and Alcohol Services Co-ordinator for the Health Service Executive. The Project will establish a committee and actively consult with the target group to the delivery of training. A representative from the target group will be requested to participate on the committee’s Steering Group.

Details of how the project will complement other initiatives and avoid unnecessary overlap or duplication?

It is recommended that this project should link in with and complement the Garda Training for door staff in Anglesea Street and also with the Alliance Peer Education Project. There are no services available for the training of nightclub owners and staff in relation to drug prevention and education.

How will this project address the drug problem?

This project will contribute to raising awareness and providing information to nightclub and Off Licence owners and staff. It will specifically address the drug problem by highlighting the need for education and prevention in areas where young recreational drug users are located and providing adequate services and responses for these drug users.

Specify performance indicators against which the success of the project can be evaluated.

- Numbers of individuals trained.
- Numbers of Nightclubs or Off Licences involved.
- Evaluation of the effectiveness of the programme e.g.: evidence of incidents dealt with etc.

Proposed Funding Requirements:

Southern Regional Drugs Task Force	-	€50,000 – Club Kerry
	-	€50,000 – Club Cork County
Total	-	€100,000

Health Service Executive - Administration and all additional costs.

Expected Outputs:

- Models of good practice developed for Off Licence and Nightclub staff.
- Incidents managed in a supportive and effective way.
- Increased awareness amongst staff.
- Increase in information available for staff.

Targets to be achieved:

- A Steering Committee will be established.
- Consultation with all groups will take place.
- The project will have worked with 10 nightclubs.
- The project will have worked with 10 Off Licences.
- At least two training courses will be organised and implemented.
- Training will be evaluated and material will be produced.

Have the Promoters demonstrated the capacity to deliver the proposed project?

Yes. The Health Promotion Unit has already acted as project promoter for the Club Cork 2000 Project and this has been very successful. Support exists for staff, and the Unit has also delivered training on a number of other themes.

Proposed Funding Requirements €100,000

Development of Community Drugs Project in five areas
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Action Plan – Appendix 2**Project Title - Community Drug Initiative.**

The following description is an outline of the proposed Community Drugs Projects throughout the region.

Project Promoter – Community Group

Project Priority – 2005

General Description - The project aims to develop a community-based response to an emerging drug and alcohol problem in the area.

Target Group - 13-23 year olds engaged in regular drinking in the community and a group of teenagers using cannabis and other illegal substances.

Geographical Area Covered – County Cork and County Kerry

The aims and objectives of project.

- The particular focus of the project will be on young people who are not already engaging with structured activities within the area and who are misusing alcohol or drugs.
- The aim of the project is to also enable a community based response to come into place in relation to the drug and alcohol problem in the area and to act as a resource supportive to young people and their families struggling with current abuses of alcohol and other drugs.
- The worker will involve themselves with the target group through recreational, educational and social development programmes.
- The project will focus on the family unit, which is of particular importance in a community.
- Primary and Secondary schools in the area will be targeted and work will be carried out informally in a co-ordinated way with school personnel.

Evidence for the need of this project.

- This project will address a need as identified through the Drugs Task Force consultation process.
- School principals and teachers have identified that behavioural problems associated with alcohol and drug abuse are becoming more evident in the school setting.
- The local residents associations have particularly identified these target groups as requiring an urgent and prioritised response.
- The Health Service and the Probation and Welfare Service are identifying a support gap for young people currently going through the courts system from these areas.

Details of the operation / management structure of the project.

A management advisory committee made up of representatives of local community, statutory and voluntary organisations will be set up if not already in existence. The projects will be administered and managed by professional organisations or committee. The project worker will become an employee of a registered employer and will work directly with the project committee.

Proposed Funding Requirements:

Annual

2005 - 5 Projects	East Cork	-	1 Post - €65,000
	North Cork	-	1 Post - €65,000
	West Cork	-	1 Post - €65,000
	North Kerry	-	1 Post - €65,000
	South Kerry	-	1 Post - €65,000
	Total		€325,000
2006 - 6 Projects	Projected Total		€390,000
2007 - 6 Projects	Projected Total		€390,000

To support the development of a series of educational outreach post-formal education programmes in conjunction with the trade union movement, professional and industrial bodies where there is a strong youth presence in the workforce e.g. FÁS, the Construction Industry Federation and SIPTU.

Action Plan – Appendix 3

The Task Force have identified through consultations the need for focused educational and training programmes for trade union movement, professional and industrial bodies where there is a strong youth presence in the workforce e.g. FÁS, the Construction Industry Federation and SIPTU. In this regard it is proposed that the Task Force would sponsor the development of focused educational and training programmes, ensuring the target groups outlined above are sufficiently informed and equipped to address the prevailing drug and alcohol problems.

Project Promoter – Local Area Partnerships
Project Priority – 2005 and ongoing through 2008
Geographical Area Covered – County Cork and County Kerry

Proposed Funding Requirement

Southern Regional Drugs Task Force annual: €10,000

To support peer education programmes for young people that tackle the issue of drug and alcohol misuse.

Action Plan – Appendix 4

This action is in response to an identified need within communities. The model developed by Alliance in Cork City providing support to community projects in training peer educators is seen to be a way forward. In this regard we propose to set aside a sum of €25,000 in order to support community projects develop this valuable training.

Proposed Funding Requirements: €25,000

To support the development of targeted educational programmes with adult voluntary and community groups, e.g. the St. Vincent de Paul Society, and voluntary groups e.g. the Irish Countrywomen's Association;

Action Plan - Appendix 5

Educational programmes targeted at those Voluntary & Community groups who are involved with families have been identified as a need. This training will be provided by Partnership Groups and Cork Social and Health Organisation who have vast experience in this field.

A sum of €5,000 annually will be required for this purpose.

Proposed Funding Requirements: € 5,000

To support the development of pilot educational programmes with Sports Partnerships, sports administrators, coaches and other personnel within sporting organisations in the region e.g. Comhairle within the GAA:

Action Plan - Appendix 6

The Sports partnership encompasses all sporting organisations in the region. The Task Force will initiate a forum in which to develop a pilot educational programme with sports administrators, coaches etc in order to reduce the misuse of alcohol and drugs and to create greater levels of understanding of drug and alcohol issues.

Proposed Funding Requirement - €5,000

The SRDTF develop a process of reflection and engagement with professional service providers e.g. general practitioners, members of the judiciary and other members of the legal profession, social workers, probation and welfare workers, addiction counsellors on ways in which the needs of those who come to their attention can be met. Further consultations with Pharmacists and General Practitioners together with counselling services will be undertaken relating to the issue of misuse of codeine and other pharmaceutical products.

Action Plan - Appendix 7

The Task Force will create a forum to engage with a broad range of service providers in order to increase levels of understanding of the respective roles and to develop greater levels of cooperation for the benefit of the individual and society.

No Funding Requirements

That the SRDTF would ensure that staff/volunteers working in education and prevention should have regular access to on-going in-service courses and provide opportunities to have these courses accredited. Discussions of accreditation should be undertaken with FETAC

Action Plan - Appendix 8

The SRDTF will require projects to demonstrate their commitment to continuing education and development for their workers. All projects will be expected to support the employee to attend Task Force training programmes.

No Funding requirement

To support a programme of community-based drug and alcohol-free events for teenagers;

Action Plan - Appendix 9

The Task Force are aware of the benefits of promoting alcohol and drug free events for teenagers. Communities indicated a lack of suitable events for young people. In this regard the Task Force wishes to set aside a sum of €5,000 euro to assist particular initiatives throughout the region.

Proposed Funding Requirement – Annual: €5,000

The SRDTF review the issue of rural isolation by supporting the delivery of youth services at local level;

Action Plan - Appendix 10

The Consultations and the Study carried out by the HSE, Southern Area, has indicated a significant increase in drug use in rural areas. In response to this, the SRDTF will

engage with Youth Groups to determine the issues and difficulties particularly relating to the delivery of services in rural areas.

No Financial Requirement

Mandatory alcohol awareness programmes should be made available through the Courts to all those who have been convicted of driving with excess alcohol or substances

Action Plan - Appendix 11

The SRDTF recommends the Department of Justice, Equality and Law Reform Courts Service provide mandatory alcohol & drug awareness programmes for persons convicted of driving while under the influence of alcohol or other substances

No Financial Requirement

The development of a Key / Link Worker service within the region. It is now opportune to develop the role of “key / link worker” to ensure a transition between each different phase of treatment and rehabilitation.

Action Plan - Appendix 12

The concept of Key / Link Worker has been recommended in the National Drug Strategy 2001-2008.

The SRDTF consider this Key / Link Worker the most effective way to reduce the incidence of relapse following primary treatment and the loss of individuals who access Detox or A & E Departments without following through to a treatment programme.

In this regard the Task Force recommend the establishment of a Link Worker service in the region. This will create links for the individual who presents for services and needs assistance in progressing to each subsequent phase of treatment and rehabilitation.

The Link Worker will engage with the client by assisting him/her access appropriate assessment, primary treatment, social welfare support, aftercare options, educational opportunities and training courses.

The Link Worker will be available to support the client throughout the duration of his/her rehabilitation programme.

The Link Workers will be employed by the HSE or other suitable agencies.

They will report to the Regional Co-ordinator

Required for 2005 – 2 Posts – 1 County Kerry and 1 County Cork

Proposed Funding Requirement:

Southern Regional Drugs Task Force	-	€50,000 County Kerry
	-	€50,000 County Cork
Total	-	€100,000

Health Service Executive - Administration and all additional costs.

The provision of additional resources within the Treatment Centres to address the needs of particular minority groups.

Action Plan - Appendix 13

The Task Force in its consultations have identified the need to address the low attendance of minority groups at treatment services. In this regard the Task Force have identified a need to support treatment services in developing specific initiatives to address the needs of individuals within minority groups i.e. Travellers, Non Irish Nationals, gay/lesbian/bi-sexual, ex-prisoners, homeless persons, and those with physical and sensory disabilities.

Resource requirements will vary from centre to centre. The requirements will be more clearly defined following the consultation process as outlined in Action No. 8

No requirement 2005
Estimated Funding Requirements from 2006 - €200,000 annual on going

That the SRDTF would support the establishment of After Care Residential Centres – Half-way and Three-quarter Way Houses.

Action Plan - Appendix 14

The Regional Drugs Task Force are aware through their consultations of the need for continuing support of people who have completed primary treatment programme. Together with Key / Link Worker accommodation needs are identified as a priority. In this regard the establishment of a Half-way and Three-quarter Way House in appropriate locations within the region is a necessity. The Task Force wish to support the establishment of two such centres in the region during 2006.

People who require this type of support may also be categorised as homeless. Initiatives currently being put in place by the Integrated Homeless Strategy will be supported by the Regional Drugs Task Force in providing counselling and support within these facilities.

This model has already been established in Cork City with the assistance of the Cork Local Drugs Task Force.

Project Priority: 2006-2 Centres 1 in Kerry and 1 in Cork County

Proposed Funding Requirement – 2006:
Southern Regional Drugs Task Force - €300,000 Annual ongoing

SUMMARY OF SOUTHERN REGIONAL DRUGS TASK FORCE
FUNDING REQUIREMENTS FOR ACTION PLAN

	2005	New 2006	New 2007
Club County Cork	€50,000		
Club Kerry	€50,000		
Community Drugs Projects	€325,000	€390,000	€390,000
Seminars & Education:			
Best Practice	€10,000		
Trade Union	€10,000		
Peer Education			€25,000
Third Level	€5,000		
Voluntary Groups	€5,000		
Sport Organisation	€5,000		
Staff Accreditation	€3,000		
Alcohol Free Events	€5,000		
Key / Link Worker	€100,000	€100,000	
Minority Group Services	Nil	€200,000	
Half Way Facilities	Nil	€300,000	
Staff Training	€10,000		
Research – Models	Nil	€50,000	€50,000
Research Use Trends	Nil	Nil	€5,000
Small Grants Scheme		€50,000	
TOTAL	€578,000	€1,090,000	€470,000
Co-ordination and Administration			
Existing Funding	€50,000		
2 Development Workers	€120,000		
TOTAL	€748,000	€1,090,000	€470,000