CONTENTS

CONTENTS

FOREWORD

The first meeting of the Dublin North-East Task Force was held in March 1997 and the Task Force produced its first Interim Report in June of that year. Tremendous progress has been achieved over the last ten years through a combination of community and statutory efforts, especially when viewed against the backdrop of the bleak years that preceded 1997.

I would like to express my deep gratitude to all of the people who down through the years contributed as members of the Task Force committee, sub-committees and project management committees. Equally I would like to recognise the often heroic efforts of people who work or have worked in the Task Force and as service providers in projects or in statutory provision. I also acknowledge the suffering and the efforts of families affected by drugs and those of individual drug users trying to rebuild their lives. We have all tried to engage as members of a bigger movement, each valued and each making its own unique contribution.

None of this would be possible without the continued support of Government at a political level and the work of key Government Departments and agencies, especially the NDST. In this context the support for the development of Strategic Plans is welcome and in particular their endorsement as outlined in the National Development Plan 2007-2013 i.e. "Strategic plans, developed by the Drugs Task Forces and based on the identified needs of the areas involved, will continue to be central to the effort to counteract the problems of drug misuse". I strongly believe this evidence based approach is vital in the critical evaluation of existing structures, programmes and services and their pro-active development and restructuring to meet the rapidly changing and ever growing threats posed by illicit and licit drugs.

Finally, I would like to thank Niall Watters of Unique Perspectives, the author of this excellent report; our Task Force Co-ordinator Tom O'Brien who was the driving force in getting the whole process to this stage; and dedicated strategy steering group members Judith Leech and Matthias Borscheid.

I commend this report to readers in both policy and action arenas. It is comprehensive, informative, thought provoking and exhorts all concerned to new ways of thinking and new approaches to one of society's most insidious and intransigent problems.

George Ryan
Chairperson
Dublin North East Drugs Task Force

summary analysis & conclusions

SUMMARY, ANALYSIS & CONCLUSIONS

1 INTRODUCTION

This chapter provides an overview and summary of the report, its findings, and outlines the main conclusions that can be drawn. It also provides a framework, in terms suggestions and recommendations, for the future content and direction of the strategy of Dublin North East Drugs Task Force. The broad future strategy is presented in the following chapter.

As a starting point, it is worth reflecting on the aims and approach of the research. The broad aims of the research were to investigate the current position of the Task Force in order to develop a strategy. Therein the objectives of the research were to:

- *identify gaps in services of the task force so as to address current issues in a planned, strategic manner*
- *provide available valid data on the extent of drug misuse in the catchment*
- *provide efficient and effective framework to implement a local strategy*

The methodology for the research emphasised balancing systematic data, such as statistics and prevalence figures, with qualitative perceptions based on the experiences of well placed stakeholders, and also those with drug related problems.

This method allowed both elements to complement each other and give a comprehensive picture of prevalence and service needs. From here, the research approach sought to develop dialogue with the task force over the draft strategy so as to arrive at an understood and owned strategic approach.

2 CONTEXT OF THE TASK FORCE'S WORK

The second chapter outlines the policy context of the work of the task force and provided an overview of drug prevalence at national level.

Herein, it underlined that the broad policy context of the DNEDTF is the NDS. The NDS has a wide set of aims and is structured by five, pillars under which integrated cluster of actions are implemented: reduction, prevention, treatment, rehabilitation and research. The recent mid term review of the NDS outlined a number of additional focus areas which include: increased presence in and interaction by Garda with communities; substance use policies in schools and non school settings; information for prevented for parents and families; engaging with families and family support; focusing on polydrug use; working with those under 18 years, and; employment of medical staff in community based drug services. One of the implications for the present research is to tie in with the varied structure, approach and actions of the NDS.

In respect of the national picture of drug prevalence, the report revealed that 19% of people surveyed had used drugs at some point in their life. The use of drugs is not on the whole large nationally. The prevalence of drug is however higher in younger age groups than in

older cohorts. The highest prevalence is seen in the 25-34 age range although drugs such as cocaine have higher prevalence rates in the 15-24 age range. This suggests a shift in the drugs being used by different age groups. Men are twice as likely to use drugs as women. At the regional level, drug use is much higher in the eastern parts of the country than the elsewhere. This is evidenced by the finding that 30% of people reports use of drugs in their lifetime in the wider Dublin north city and county area.

Opiate use is higher in the Dublin region then elsewhere around the country. There has been an increase since 2000 in the numbers receiving methadone. The majority of opiate users seeking treatment are aged between 20 and 34.

In contrast to heroin use, there is no apparent association between cocaine and cannabis and socio-economic background. If anything, those in work and renting were more likely to cite use of these drugs than those in lower relative positions. This biography of both cocaine and cannabis is widespread among the population and not related to one group more than others. This suggests that the nature of all drug use in any one operational area – such as the catchment of the task force - will go across and between socio-economic boundaries and, where it applies, geographic areas regardless of clustering of affluence, deprivation etc.

Garda national statistics suggest that cannabis resin is the most common drug type making up drug offences over the past 15 years, although the number of such offences is increasing it has decreased as proportion of all drug offences from over 90% in 1990 to just over 60% in 2005. The statistics on drug offences suggest that, bar ecstasy, the number of offences relating to all drugs is on the increase. However, the date presented suggests that there has been significant in crease in offences for cocaine, the number have increased by a multiple of four over the last five years. Overall, the move towards cocaine and relative stabilisation of the number of heroin offences suggests a shift in drug use patterns, which is echoed in most recent research.

3 SOCIO-ECONOMIC PROFILE OF TF CATCHMENT

Dublin north east area, the catchment of the task force, is a large geographic area and is not homogenous in social and demographic terms. The area can be considered a mixed one, with pockets of disadvantage, normally characterised by social housing, alongside relatively affluent areas.

The sub catchment areas in which where there is a relative concentration of affluence, relative educational attainment, private housing, more affluent social classes are - including those adjacent to them - Raheny, Clontarf, Howth and Sutton. The areas characterised by concentrations of attributes of disadvantage such as social housing, deprivation, low educational attainment, membership of less affluent social classes are Darndale, Belcamp and Priorswood, areas to the east of Malahide Road on Collins Avenue; Edenmore; Donaghmede; Kilmore and Coolock; Bonnybrook.

The size of the catchment and its mix of affluence and deprivation are the key features of the profile of the task force. It is undoubtedly a large geographical area comprising varied communities and community

types. The implication of this, especially with the changing nature of problem drug use and the groupings associated with problem use, suggests that multiple methods and approaches are required. Regardless of the dynamics of drugs use, the catchment is itself varied socially, demographically and geographically and this needs therefore to be factored in to the approach and thinking of the task force in its future operations and responses.

4 PREVALENCE OF DRUG PROBLEMS IN DUBLIN NORTH EAST

The findings under this heading show that the most common drug involved in addiction of those presenting were opiates. Notwithstanding this, the total number of cases reporting cocaine as their main problem drug increased by 30% between 1998 and 2002. The number reporting cannabis use as a problem and the number presenting for treatment for cannabis use was significant. This may imply that drug treatment services may need to respond to a wider range of substances in addition to their present focus on opiate treatment solely. The relative increase of prevalence of cocaine is a key consideration and is heavily supported by anecdotal evidence provided in the consultations with stakeholders and drug users.

In keeping with the overall trend above, the incidence of treated drug problems in the Northside Partnership area decreased from 119.2 per 100,000 in 2000 to 77.7 in 2002. Most of those presenting for treatment among these numbers were doing so in respect of opiate use.

In total, there were 2,340 persons treated for drug addiction between 1998 and 2003 in Dublin North East. 21% of this number was at that time new, previously untreated cases. At ED level, the areas with some of the highest numbers of those presenting were in Edenmore, Kilmore C & D, and Priorswood B, C and D. As is evident from the socio-economic profile section of the report, these are also the areas with the highest relative concentrations and indicators of deprivation. This seems to warrant a continued targeting of these areas. It is evident that areas with high indicators of social deprivation in tandem with relative affluence, namely Kilbarrack and conterminous areas, also record high numbers presenting for drug treatment. This underlines the need to be cautious in targeting responses and interventions solely toward disadvantaged areas and thus taking an approach which casts a wide net in terms of supports. The 'across the board' nature of cocaine and cannabis use also warrants this type of approach.

A large majority (88%) of those presenting for treatment did so at local health and social service centres. Up to 2003, less than 1% of those presenting did so at their GP.

The majority of those presenting as new cases over the 1998 to 2003 period are in the 20 to 29 age range (56%). The next largest proportion (30%) is the 10 to 19 age range while almost 14% of those who present for treatment are over 30 years but under 40. Thus, those aged between 16 and 29 are those most likely to present for treatment. This relates of course in the main to opiate addiction. The majority of those that presented for treatment in the Task Force area, over half, were unemployed. The next biggest proportion, one

quarter, were 'in employment'. 61% of those presenting had ceased full time education at 16 years of age while just 2% had gone to third level education.

Half of those presenting for treatment were referred to the centres through family and friends. The importance of regular social relationships in accessing services would seem therefore to be an important conduit of referral. This emphasises the importance of disseminating information on treatment and other drug related supports generally as well as in a targeted way. In contrast, about one in ten of clients of drug treatment services were referred by a GP or other treatment centre.

Of those that presented to treatment centres, 80% had a problem related to opiate use and 12.5% were in treatment for cannabis use. This suggests that these are the two main problem drugs in the area, however, as noted above, this is also a reflection of the nature of the services and type of drug and drug user profile that they cater for. It does not tell us the extent of latent problem drug use particularly in respect of cocaine and alcohol.

Of the total number of new cases presenting for treatment over the time period, 66% suggested that they were polydrug users. The main subsequent drugs used were cannabis (35%), benzodiazepine (19%), cocaine (13%), ecstasy (13%) and opiates (10%).

The drugs related death incidence rate in the TF area is 6.6 per 1,000 15-64 year olds. This rate is twice that of areas with not-designated as a LDTF one. The analysis of drugs related deaths reveals that two thirds of opiate users who died also tested positive for three or more drugs, while only 11% tested positive for one. This underlines the reality of polydrug use and the relationship between drugs such as heroin, benzodiazepine, methadone and to a certain extent alcohol also.

NACD drug prevalence estimate from 2001 for the Northside Partnership area/DNEDTF is 731. This is a rate per 1000 of 10.6. Individuals in the 25-34 age range were those with drug problems. However, the figures are made up overwhelmingly of males, notwithstanding this the numbers of females included is still significant in the 25-34 age range. The numbers overall demonstrates that the opiate phenomenon is something that has happened in the last two generations paralleling the 1980s and 1990s. However, in 2001 there were remained significant numbers in the 15-24 age range. However, the overall rates refer to a very wide catchment and one that is not as concentrated in terms of social housing and disadvantage as some of the other task forces. It may the case for instance, and as seems reasonable, that the rates for distinct areas taken alone may be much higher and in keeping with some of the other LDTFs with similar socio-economic profiles to these areas. As noted earlier, it also calls into questions, what are the numbers of those who have drug problems and who have not presented for treatment.

The Garda statistics reveal some interesting and worrying trends. These suggest that drug offences dipped in the early years of this millennium but have resurged in 2005. Heroin has decreased and stabilised over the 1999 to 2005 period. Ecstasy and other dance culture oriented drugs have nearly disappeared in drug offence terms. Cannabis remains the most significant drug in terms of offences. This has increase to some 65% of all offences in 2005

encompassing 674 offences in the Dublin North Garda Division. The starkest trend is the manifold increase in cocaine, both in the number of offences and its proportion of all offences. This increased each year up to 2003 to 20% of all offences from just 3% in 1999. This is a six fold increase over this time period and underlines the prevalence of cocaine and justifies anecdotal evidence.

The NACD funded Kilbarrack Coast Community Project research is of value in that it gives a frame to understand teenager's view and experiences of drugs. This research suggests that prevalence increases with age with alcohol (84%) and cannabis (43%) being particularly stark findings in the 16 to 18 year age group. The research also suggests that young people who have left school are more likely to be current users of cannabis, cocaine and ecstasy.

5 CONSULTATION WITH STAKEHOLDERS & FUNDED PROJECTS

The main findings coming from the qualitative consultations with the stakeholders add value and depth to the statistical data on prevention, socio-economic profile and the policy context of the task force area. These consultations suggest that the extent of the drug problem in Dublin North East is still significant but its nature has changed over the years.

The main drugs causing difficulties are heroin, cocaine, alcohol, cannabis, and benzodiazepines. The responses demonstrate that polydrug use is commonplace which is supported by the prevalence findings. It is worth noting that the prevalence of Cocaine was a particular feature of the responses.

In terms of the location of blackspots of drug problems the research suggest that there are distinct geographic locations of problem drug use, areas with high concentration of social housing and open areas/certain public meeting points. This validates and is supported by the prevalence and socio-economic data.

These finding emphasise the interrelated or overlapping nature/complex and socialised nature of drug use in the areas. For instance, although heroin use is still prevalent, it seems to have stabilised. This again reflects and is supported by the earlier quantitative data. The most prevalent drugs seem to be cocaine and alcohol. A clear finding is that use of cannabis and to a slightly lesser extent, cocaine has become normalised. The challenged this poses is that many users may not see these drugs as dangerous, addictive and do not therefore lead to problems. This is what is referred to as a shared and passed-on knowledge about drugs and drug problems. Problems with legal drugs refer in the main part to alcohol, there is also suggestions that other legal drugs are misused, namely, benzodiazepines which has also led to what is termed 'prescription leakage'.

The findings suggest that there is a distinct economy that surrounds drugs and that, for some, the income from direct and indirect supply of drugs is seen as nearly a realistic form of income in the absence of other alternatives. This highlights the wider social and economic context of drug problems and its relationship to social exclusion and organised criminality at the local level.

The impact of the TF is considered to have been good particularly in the early days since 1997 to 2001. However, this impact has lessoned over time. As such it is felt that the TF has lost

some direction, vibrancy and relevance to current drug problems.

The current response of the task force is not universal, not all projects and initiatives are considered on an equal standing in their efficacy. In other words, some projects are viewed as better than others, some areas are better catered for, some problems are being addressed while others are not, resources are insufficient, the conceptualisation of the causes and consequences of problem drug use are too narrow, and some group's needs are not included.

The areas suggested for the TF to focus on in the future to overcome problems broadly include adoption of a strategic approach; adoption a continuum of care model for the drug user; putting polydrug use at the core of the approach; responding in particular within this to cocaine and alcohol; providing ancillary, support and technical inputs to initiatives, projects and activities in the community and between relevant organisations; adopting a broad family support approach; capacity building for community interests and increasing and then maintaining meaningful community input; focusing on young people especially those under 18; promoting the work, message and services/supports of the TF; undertaking advocacy and lobbying work; and also increasing a practical and supporting focus on community policing.

There seems also from the feedback to be a need to put in place new structures for operating and undertaking the activities of the TF. The main ones cited in the feedback are: local area committees; community representative structures; and in tandem with these new protocols and system.

Part of this restructuring seems to point toward a reassessment of mainstreamed projects. The general conclusion here is that the work of the mainstream projects, current and future ones, if possible should be brought under the strategic remit of the TF. This is to improve the work of the TF and also that of respective mainstreamed projects.

6 CONSULTATION WITH DRUG USERS

The consultations with drug users significantly added a realistic and valuable depth to the overall research. The finding from this part of the research suggests that the communities in the TF's catchment are interconnected in terms of drug use.

There is an implication in the responses that the prevalence of heroine has stayed static at least or perhaps even decreased. This is a feature of each section of the report findings.

From the responses, it is evident that most problem drug users started their drug use in their early teens and this drug use has gone on until the present time. This suggests that some of those with serious drug problems have been involved with drugs for almost all, or large parts, of their adult life.

A number of combinations of drugs are most regularly seen. They differ depending on the individual and also their peers. For instance, unlike older drug takers, younger generations may be more likely to use a combination of

cocaine and alcohol. It is also the case that through out all polydrug use, alcohol and/or cannabis act as a background canvass of sorts. In short, they are always present in the background.

There is a strong belief among those with drug problems that some people can use drugs, not get into difficulty and live normal and often successful lives. This serves as a powerful for some people in their drug taking.

A new generation, socially diverse, of drug users has developed and their main drug of choice appears to be cocaine. This tallies with earlier findings and the increase prevalence of cocaine across all groups but especially younger age cohorts.

The main factors that are seen as contributing to drug use are: Peer and socialisation processes; Personal and family history; Widespread availability and prevalence of drugs; Enjoyment and pleasure; Social escape and anaesthesia; and, Low self-esteem and education deficiency. Overall, these areas are interrelated and some or all of the factors may have worked together in their personal biography of problematic drugs users.

Many of those who recognised that they had problems did not know where to seek help initially. Many of those did not finding out about services in a formal way through referral. The main way that people learned about services was through word of mouth. This is echoed in earlier findings which show that about half of all referrals were through family and friends.

Those who attended both community based projects and treatment in Trinity Court though their GP prefer and local based and relative personal approach of the community-based projects.

The main areas noted to improve existing services were

- *improved contact with key workers, counsellors and other ancillary professionals*
- *outreach*
- *better, and more realistic ,education of both medical and social support staff*
- *progression routes and paths in care*
- *integrated services, where they work together as a one stop shop*
- *more information and supports around cocaine and related problems*
- *focus more on polydrug use rather than just heroin*
- *provide a choice of counsellors, social workers and doctors*
- *aftercare services*
- *There was a call for a greater variety in the existing projects in terms of activities, areas, supports and progression.*

The main additional support that drug users would like to see available are:

- *continuum of care*
- *Family support,*
- *Better premises*
- *realistic, concrete alternative activities for young people*

7 CONCLUSIONS AND SUGGESTIONS FOR STRATEGY

There is a trend in drug use nationally away from older conceptions of problem opiate use mostly associated with areas of disadvantage. While it is important to recognise that this problem has not worsened and if

anything has stabilised, there are wider drug problems and drugs characterising problem drug use in modern Ireland, Dublin and therefore in Dublin North East. However, the challenge to the Task Force seems to be to response to a new and dynamic problem drug use reality. This seems to require new ways of working, new ways of thinking and the ability to respond flexibly and in a joined up integrated way. It is also recognises that many of the problems that the Task Force looks to deal with are not in its capacity alone to address, this opens up the need to work at regional and national level, through partnership, networking or lobbying, with appropriate bodies and agencies.

As such, the following are the main areas of focus, based on the findings of the research that the Task Force will focus on, tackle and/or operate under in the next number of years. In short, the following are the key themes that will inform its strategy.

1. The Task Force should adopt a more strategic approach which will contain objectives, actions and goals.
2. The strategy should make specific suggestions for its sub committees that dovetail with the pillars of the NDS: prevention, treatment and rehabilitation, and supply and control. In addition, it could look to develop a new sub committee looking at 'support services'.
3. The approach adopted in all task force funded projects should be one of progression along a continuum of care. This will require systems of referral and new projects and services alongside existing ones, including the reintegration of previously mainstreamed projects.
4. Local area committees: made up of projects, community representatives, ancillary services etc., could be put in place to decide on projects and their implementation and overall better respond to
   Areas:
   - Bayside, Howth, Sutton, and Baldoyle
   - Darndale, Coolock, Belcamp and Kilmore
   - Donaghmede, Ayrfield, Kilbarrack and Edenmore
   - Artane, Donnycarney, Beaumont
   - Raheny, Killester, Clontarf
5. Projects and supports should be initiated in areas with no coverage through outreach and animation.
6. The TF's focus should move beyond heroine to include cocaine, alcohol and polydrug use.
7. There is a need for special and focused initiatives on cocaine.
8. There is a need to develop models for integrated/joined up/interagency responses based on the needs of the clients.
9. There is also a requirement to put the concept of a continuum of care at the heart of the approach. This will thus focus on progression/aftercare as well as prevention, harm reduction, stabilisation and treatment.
10. There is a need to progress staffing and premises issues including professionalisation of staff in projects as they progress.
11. Young people, including those under 18, should become a key target group of the task force.
12. There is a need for a revitalisation of the TF, including promotion and increasing visibility.

13. The research suggests the creation of a policy development, technical and support services role within the TF for projects and new initiatives.

14. The approach to family support should be adopted. The definition of family support should be a broad one such as that adopted by the NACD in its report on family support published in 2004[1] which sees family support encompassing therapeutic work, childhood development and education interventions, youth work, community development, parent education, and, home-based parent and family supports.

15. There is a need to increase community participation. This involves getting 'new blood' in, and setting up area based/coherent neighbourhood/community representative fora. This will provide community representation over the course of the next number of years.

16. As part of a strategy mechanisms and the principle of review, monitoring and accountability should be introduced.

17. The TF should focus on the relationship of drug problems to social exclusion and local economy

18. The TF should increase information dissemination and supports around cocaine, other drugs and related problems in a targeted, general and multiple methods manner.

19. There should be annual planning for sub committees as advisory expert groups on prevention, treatment and rehabilitation, supply and control, and, support services.

20. Part of the role of the TF will be to undertake advocacy, lobbying and networking about its work, the issues presenting themselves in communities, barriers to work, research findings and generally areas that impact on drug problems but are not in the capacity of the task force to tackle successfully in isolation.

[1] Watters, N. et al, 2004

strategy vision & principles

STRATEGY

VISION & PRINCIPLES

The research (as outlined in the main body of the report) has gone some way toward identifying the areas in which the Task Force needs to focus on as part of its future operations and activities. This chapter outlines the overall strategy for the Task Force for the coming number of years. The Strategy is structured into an overall vision. This is in turn followed by a range of objectives, each of which contains actions and a number of goals that are planned to achieve each objective and ultimately the vision. The strategy is informed by the findings and suggestions arising out of the report which can also be consulted to flesh out the detail of some of the objectives, goals and actions.

The suggested vision for Dublin North East Task Force is:

> **The vision of the Task Force is to create and sustain a system of supports, services and empowerment for individuals, families and communities through which existing and future problem drug use in Dublin North East is prevented, reduced and managed.**

The principles under which the Task Force will implement its strategy and inform its actions centre on the following:

- current services will be enhanced in order to maintain existing supports
- provision of new additional supports and services which have a continuum of care model at its heart
- focus on polydrug drug use which encompasses both illicit and licit drugs, including alcohol
- work on an integrated basis - across community, voluntary, private and statutory services
- taking account of the causes and effects of problem drug use at the level of the individual, family and community through to its social and economic context and origins.
- client-led services will be integrated and envelope the client based on her/his/their needs
- flexible and responsive to emerging needs
- planning for the future
- advocacy and lobbying
- emphasising community input
- improving co-ordination, co-operation and policy learning
- promoting active citizenship and social capital

Objective 1: REFOCUSING THE TASK FORCE

Goal 1: **Role of the Task Force**

Action:

The Task Force will move toward a focus on making policy in respect of the overall task force and its various sub focus areas and sub committees. This will include developing the ground for new initiatives in line with the strategy, making decisions, monitoring etc., which in turn will inform actions and objectives. Ultimately, the Task Force will be responsible for the implementation of the strategy and the corporate governance of the Task Force. It will set down a range of policies and protocols by which the various sub committees and projects will proceed under. With the likely turnover in representation in the Task Force, in the light of the new community representative structures and local area committees (see goal 2 below), a system of induction training should take place for new members, this would also include statutory member that are new to the Task Force. As part of the overall strategy, the various objectives and goals, it is expected that thematic annual work plans will be developed which set out activities, expected outcome, processes etc for each year. These will be developed at the appropriate level within the task force and will be assessed and ultimately approved by the task force following their assessment of the work plans in respect of the strategy

Goal 2: **Local Area Committees**

Action:

In each of a number of coherent community areas, namely 1. Bayside, Howth, Sutton, and Baldoyle, 2. Darndale, Coolock, Belcamp and Kilmore, 3. Donaghmede, Ayrfield, Kilbarrack and Edenmore, 4. Artane, Donnycarney and Beaumount, and 5. Raheny, Killester and Clontarf, a Local Area Committee (LAC) committee will be established. Each of the communities has similarities in terms of the type of localities they encompass and also the nature of problem drug use they contain. The LACs will focus on developing a series of local actions and measures linking in with new and existing projects that focus on problem drug use. They will contain members from ground based statutory workers, voluntary organisations, advocacy groups (youth, Travellers etc as appropriate to the area), community based groups and community representatives. The community representatives will be drawn from a formal community representative fora. The LAC's remit will be to ensure that services in terms of prevention, rehabilitation and treatment, supply and control and support services, are based on an integrated approach. It will look to develop systems of referral and co-operation. Overall, it will respond to the needs of areas and their residents while implementing the policies and objectives of the task force. Ground level or area based services would include ancillary ones such as in therapeutic work, education, accommodation, health, personal development, counselling, family support, youth work, training, mentoring, community development etc. Each LAC will undertake a work plan for each year and this will be

assessed and approved by the Task Force. The expert advisory sub committees will feed into the LAC in terms of best practice and appropriate models with respect to their individual focus areas. It is possible for the LACs to also discuss and focus on areas outside of problem drug use directly but which impact or otherwise affect indirectly problems relating to drug use. In short, the LACs will operate as micro version of the Task Force but with a community based focus to their areas. The LACs will be formally represented on the Task Force by its elected community representative(s).

Goal 3: **Community Representative Structures**

Action: In order to enhance and make community input to the task force sustainable and at the core of its activities, the community representatives will be elected through the new local areas sub structures. They will have a term of two years and will be replaced after that time. They will however have an option after one year to step down should they so wish. They will be elected by a community fora structure that will build on and dovetail with that developed by the Northside Partnership. The aim of this action is to ensure communities are at the heart of the Task Force while also providing a transparent and accountable system of representation. The other aim of the action is to reinvigorate community representation in order to involve younger people and ensure that the community representation is representative of changing circumstances and trends in each of the five sub areas. The elected community representative(s) will also be responsible for feeding back information and decisions to the their communities while also taking issues, activities and concerns to the Task Force proper on behalf of their community

Goal 4: **TF sub-committees**

Action: As part of the overall strategy, the existing committees of the TF will take on an expert or advisory role in their respective areas of focus. They will effectively advise the Task Force and Local Area Committees on the best practice and models of work in their respective areas. Each will be asked to develop a work plan based on the overall Strategy each year. In addition, a new sub committee will be formed replacing and absorbing the existing childcare committee. It will look at and be entitled the support services sub committee and will have responsibility for exploring areas that act as support and integral services to those who work with those, or are affected by, drug misuse. The focus will include childcare, family support, youth services, community development, social inclusion, etc and how these can benefit and add value to the work of LACs, the task force, and funded and mainstreamed project. The work plan for the various sub committees is set down below under the respective headings for each objective.

Objective 2: TRANSFORMING EXISTING & INITIATING NEW PROJECTS

Goal 1:	**New Geographic Areas**
Action:	To date the Task Force has not had community based projects and other services available in each of the areas. In order to overcome this, and as part of development work leading to LACs in these areas, the Task Force will undertake animation work in these areas so as to develop community based projects and supports for problem drug users. The challenge will be to consult, undertake capacity building with newly animated groups, and network with others to develop a consensus around the establishment of projects. The areas of note here include Donaghmede, Bayside, Baldoyle and Artane/Beaumount etc. As noted above, these projects will have a focus on polydrug use including alcohol.
Goal 2:	**Moving to counter Polydrug Use**
Action:	The task force will look to enhance existing projects to provide supports and interventions for a wider range of drug problems and drug types. This will look to respond to poly drug use including alcohol. This will require a shift in existing projects that have to date mainly focused on opiate related problems. The shift will absorb existing project's work on opiate addiction to widen so as to include cocaine, cannabis other drugs and alcohol. This will require re-skilling, training, application of new models and resources (including premises) for this approach. This will require additional resourcing of existing projects in line with the other elements of the strategic framework set down here.
Goal 3:	**Alternative project approaches**
Action:	Although existing projects will be transformed to cater not only for opiate problems but also for polydrug use and alcohol, the evidence presented in the research leading to this strategy points to a new client group with drug related problems that may be less likely to seek assistance through existing projects. They might for instance associate these projects with heroin users alone and as such believe that they do not have a similar need for support etc. It may also be the case that individuals and their families from some areas may not be keen to be seen to enter established project settings or mix with groups that they consider to have more severe drug problems, regardless of the ethics of this perspective, it is incumbent on the task force to provide supports and services in a manner that will be effective and practical. For this reason, such supports and services should aim to meet with the lifestyle and view point of those with drug problems. As such, outreach and part drop in services should be provided in various areas. These will be part time initially, and will aim to be inconspicuous. These supports will focus therefore particularly on those with cocaine and alcohol related problems.

Objective 3: WAYS OF WORKING, PROCEDURES AND PROCESSES

Goal 1:	**Continuum of Care**
Action:	As part of the overall strategy of the task force, a core part of the future work will be to move to a model of care that emphasis progress and continuity of support. This is often referred to as the 'continuum of care'. In this sense, it is expected that clients will pass through a range of supports, over time in a manner that suits their recovery needs, ultimately toward a drug free status. This will require that each support or project accessed has a range of options for clients to move to the next stage beyond the project itself. The key aspect is that there is a progression path which is available as the client passes through a range of phases toward hopefully a drug free status. The packages of supports available should revolve around stabilisation, treatment, rehabilitation and aftercare. In practical terms, this will require the development of projects and services at each of these levels or indeed the existence of the range of support within one broader project. This will also necessitate the introduction of some form of tracking to monitor the progression and movement of clients in order to monitor and improve a continuum of care model.
Goal 2:	**Task Force Protocols and Polices**
Action:	Under the overall strategy, the Task Force will have responsibility for laying down operational policies for its various activities. These will, in consultation with the funding projects (existing and future ones), set down the TF aims for the policy area and what is expected of the sub TF actors and what the outcomes should be. These will also set down criteria under which task force work will be undertaken. It is expected that the various actors working in partnership with Task Force will ensure that their work is in keeping with the policy. Policies will be developed in terms of accountability, monitoring and evaluation; annual planning; co-operation and networking; promotion and information dissemination; professionalisation and training; management; relationships with sub committees and local areas committees; two way reporting on progress (task force and communities); standards etc.

Objective 4: PREVENTION

Goal 1: **Widening the Definition of Prevention**

Action:

As part of the approach to prevention, issues of wider significance than educational efforts alone will become the centre of the task force's understanding of prevention. These will include looking at individual, community and family risk as well as protective factors in respect of problem drug use as drug prevention. It will look to define its work in terms of specific and non specific risk factors. This understanding will therefore tie in with the membership of the local area committees and the general approach to prevention work under the strategy. This emphasises expanding prevention work toward countering risk factors for drug use and thus strengthening protective factors in the context of the individual, their family and also their community. Prevention education is only one element of this approach. The refocusing of prevention work will look therefore also at socialisation processes, peer processes, family support (broadly defined) and community development. It will be a multiple methods approach on each of the three levels: individual, family and community.

Goal 2: **Prevention Tools & Messages**

Action:

The content of prevention work in formal settings and in the media will be candid and realistic. In this sense, the short term benefits and attractions of drugs and drug culture should be openly acknowledged along with the outcomes of addiction. This emphasises providing a message about drugs that is in keeping with the lived experience of those who are at most risk of problem use. The prevention tools – informal and formal – will use valid examples and provide young people in particular with the information to assess the risks of drug use. This is not to say that the dangers of drugs will not also be emphasised, however, this approach will not only do this but try to engage with young people and others on their terms in respect of initial recreational, socialised and peer etc., motivations for drug taking. This will be supported by real life case studies of former addicts to draw out the realities and hardships of addiction and to give a true picture of the dangers of drugs. In addition, prevention efforts will be diverse, using multiple methods, to account for the varied biographies of drug users, and also focus on different age groups. This will therefore involve the use of formal, informal, multiple mediums to articulate its message and various services available for prevention work and education on drug problems.

Goal 3: **Outreach**

Action: Related to the earlier goals, the task force will develop an outreach service which will work with those at risk or in the early stages of drug taking. Again the aim here is to engage with groups that have not previously come in contact with prevention work, and who are arguably those most at risk of falling into problematic drug use. This will require additional resource and retraining to ensure that outreach workers can be deployed in the areas where the other facets of the prevention work is not seen as being effective.

Goal 4: **Formal and Informal Settings**

Action: The educational side of prevention work will not only be delivered in the formal setting of schools with young people but also in the informal setting of youth clubs and other settings including 'on street' work with young people. This will be a key mechanism of engaging with young people and will draw on and overlap with the outreach goal above.

Goal 5: **Active Citizenship & Social Capital**

Action: The approach to prevention will also emphasis active citizenship and the development and enhancement of social capital. In short, this means drawing those at risk of problems use and those in the early stages of drug use into their communities and wider society. This will be a programme of supports aimed at different ages, especially those under 35 and then also young people. The development of stakeholding by those at risk in active citizenship, voluntarism and thus their local community will develop a sense of purpose and inclusion. Again, the integration of this action with other goals under the strategy will be an important aspect of the overarching task force approach.

Objective 5: TREATMENT & REHABILITATION

Goal 1: **Menu of Treatment & Rehabilitation Options**

Action: At the outset, the initiatives in treatment and rehabilitation will follow a polydrug use and continuum of care approach. This is in keeping with tenets of the strategy. Choice, customer focus and differing needs, suggests that at the stages of stabilisation, treatment and rehabilitation, a range or menu of options should be available to the client based on their personal and family needs. This will require gathering information, negotiating with options in and outside of the catchment, developing protocols for transfer and tracking, and comprehensive referral processes.

Goal 2: **Pilot Medical/Social Project**

Action: In keeping with the NDS, the task force will explore with community, statutory and medical groups the establishment of a community based project that effectively integrates medical and social treatment options. This will act as a seamless service for the drug user. It will cater for polydrug use. The aim is to implement this type of approach and develop a case study of learning which will inform the roll out of this type of project. The need for the integration in this realm of both medical and social aspects of treatment and rehabilitation are clear needs expressed in the research. Due to professional, funding and organisation constraints, the development of this approach although clearly necessitated from the individual's point of view, has proved difficult. The task force is committed to seeking solutions to these problems and to pass on learning in order to improve the all round service for problems drug users.

Goal 3: **Improving Existing Services**

Action: In the research, a range of stakeholders and drug users acknowledged that there may be a skills deficit in some projects and this highlights the need for ongoing skills development and training for those who work with problematic drug users. This action therefore firstly will set down minimum requirements for new staff and in turn develop quality standards and good practice models to inform work. This will be done in consultations and with the agreement of funding and other relevant agencies. The second part of this action will source the provision of training and skills development to those currently working in projects of this nature over a number of steps. The professionalisation of the various services is an important step up in quality provision in the catchment. The services will also benefit from efforts to improve their premises and therefore increase the possibility of the provision of treatment places at the local level.

Goal 4: **Drug User's Forum**

Action: The task force will support and encourage the full establishment of drug user's forum in the catchment. This is in keeping with the client led principle underpinning the strategy. The forum will be structured flexibly and provided with administration and organisational support in order to meaningfully input to the development and running of services. Over time the forum can be delegated to sub areas within the catchment. The forum will be broadly representative, as far as practicable, of the range of problem users in the catchment. The forum will be supported to develop an independent voice for those availing of services. It is hoped to facilitate representatives of the forum to also play a role in the structures of the task force

Objective 6: SUPPLY & CONTROL

Goal 1: **Community Policing**

Action: The task force will work with and tie in with the community policing fora. It will also look to expand the role of community policing by discussion and dialogue with various stakeholders. The aim of this is to develop a better relationship between police and communities. A key part of this action responding to a central need identified in the research and consultations is the need to significantly enhance the visibility of police in communities. Part of this will involve interaction between local area committees and the community police. This will necessitate developing relationships through the task force with the various police divisions comprising Dublin North East to enhance the interaction between the various communities in each of the divisions as opposed to task force catchment level alone.

Goal 2: **Toxic Substance Protocol**

Action: In the case of that information on the circulation of immediately life threatening, tainted and toxic drug substances comes to light, this should be addressed in the short term as a priority in supply and control terms to reduce potential fatalities. A protocol will be discussed and developed by the task force to alert police and health authorities where such information comes to light. The response and feedback of the authorities should also be included as part of this system.

Goal 3:	**Information Line**
Action:	A range of models will be discussed and amended to choose one in which information on broad drug illicit activity can be passed on to the police in a confidential fashion. This may include phone lines, text messages, online sources etc.
Goal 4:	**Countering Drug Related Criminal Economic Activity**
Action:	The relationship between low income, disadvantage and drug related criminal activities will be explored in conjunction with local development, social inclusion and probation services. This will look at the reasons why individuals became involved, whether through addiction or financial rationale alone, to understand the points in the biography of individuals in which interventions could be made. The aim is to develop a project/programme/set of guidelines which looks to disincentivise economically the involvement in drug related criminality in lieu of other incomes and opportunities. It is intended to pass the findings of this action on through lobbying activities.
Goal 5:	**Inter-agency Co-operation**
Action:	The group should look to increase co-operation with the Customs and Excise and other actors across the various communities that make up the task force. The aim is to develop better working co-operation between such agencies at the local level. This will focus on the geography unique to Dublin North East.
Goal 6:	**Social Planning in New and Existing Areas**
Action:	The architectural and planning layout of communities, especially new and planned ones, will become a focus of the task force in order to improve these in terms of the supply and circulation of drugs and anti social behaviour, and ongoing and more developed street, local area presence by the Police. This will involve an agreement with planners, the other elements in the process including developers along with police, communities and task force personnel. At the outset, this will require some exploration to develop a workable system to progress such interactions toward effective outcomes. The Local Area Committee structure will play an important role in this action. This will therefore involve local communities in this process as well as statutory service providers such as the HSE in the physical development and design of new and existing communities.

Objective 7: SUPPORT SERVICES

Goal 1: **Family Support**

Action:

Family support is an area that not only has loomed large in the findings of the research leading to this strategy but is also an area that has been flagged in the review of the NDS. It concerns not only group, family work of a therapeutic and support nature, but also community development, youth work, parent education, home based parent and family support and child development and education interventions. These will be a focus not only of prevention work but also harm reduction, treatment and ultimately rehabilitation and social reintegration. Each of the types of family support noted can play a role in countering exposure of children to drug use, countering negative role models of using drugs as a coping mechanism, family based difficulties, relationship conflict etc. They should thus aim to bolster the caring role of the family, provide emotional support, set realistic development expectation on family members, supporting goals and structures in family life, and maintaining strong family networks. This is where the task force will aim to concentrate its efforts to bring family support into its activities. With the varied areas noted here, the local area committees will play an important role in the implementation of this work. It follows that their membership will reflect some of these areas also. The role of the advisory sub groups/committees in this regard will be to outline how this family support approach can be implemented through new ways of working, linking and processes.

Goal 2: **Childcare**

Action:

Childcare remains an area of need nationally. This is particularly acute for those who need to take up employment opportunities, training and education. In terms of those with drug problems and their families, there is a need to have in place childcare places that are subsidised, depending on need, so that such persons can attend supports, treatment and training etc. this requires the task force to have in place and maintain a system of contacts and arrangements for childcare places in conjunction with such supports. This is done through the childcare bureau. This type of activity will be expanded as part of this strategy and additional efforts will be made with the partners and relevant bodies to increase the availability of childcare places for those accessing supports for problem drug use. A further area of focus will be long term childcare salutation for those who are able to take up residential treatment opportunities.

Goal 3: **Social Inclusion**

Action:

The relationship between social exclusion and drug problems is clear from this research and others. This suggests that a multifaceted approach is required to respond to drug problems which are by their nature similarly multidimensional. Developing a more co-ordinated approach between the task force and those bodies

focused on social inclusion is an important part of the strategy. This will initially involve a dialogue on how the task force's work and that of the agencies can dovetail. It is hoped to put in place pilot programmes where new and existing projects of both types of interventions can work closer together for the benefit and needs of the clients.

Goal 4: **Education, Training & Employment**

Action:

An important part of the overcoming drug problems following treatment is around rehabilitation and social reintegration. As the research has shown and the strategy has adopted, the notion of a continuum of care is important in this process. This requires that once a drug user has passed through treatment that they are supported, sometimes referred to as aftercare, further in terms of coping with being drug free and being placed back into the social and economic context in which they may have first become involved in problem drug use. It is at this point that considerable supports are required which focus on bring recovering/ed addicts back into a stable social structure. Key to this is employment, and prior to this is undertaking – in view of the current labour market –education or training to be in position for employment. The focus of this action will therefore be to develop programmes of support for those who have successfully been treated for drug problems and who are ready to undertake rehabilitation and social integration. These programmes will include a range of supports around education, training, social skills, counselling etc. The programmes are part of the continuum of care or progression approach which will be central to the strategic approach of the task force in the coming year.

OBJECTIVE 8: INFORMATION & COMMUNICATION

Goal 1: **Promotion**

Action:

The research suggests that to date there is a level of ignorance in the communities that comprise the task force catchment about what the task force is, what it does, what this involves etc. This action comprises a set of promotional campaigns by the task force. The aim is two fold, firstly to promote the work of the task force and secondly to get information and messages to the public and agencies/services about drug related problems. Key elements of this will be to ensure all funded projects acknowledge the role and funding of the task force. In addition, newsletters, advertisements, flyers, emails, website links, information brochures, signage etc., will be apart of this process. Information on new initiatives, drug

problems and solutions will be circulated by the task force to various agencies, community bodies, and statutory services and the media on an ongoing basis.

Goal 2: **Internal Communication**

Action: To date the task force has evolved its information circulation in respect of drug issues, administrative issues, new funding etc. As part of the strategy and particularly information and communication, the task force will ensure a structured stream of information is provided to all member bodies and projects. This will include all models, areas of best practice, policy information, administrative information, funding opportunities, development elsewhere in the catchment, local area committee information etc. This will by email and through the recently developed task force website. Log in options for information discussion will also be explored through the website. This information will take the a two way format with the task force being the fulcrum for passing on information from one area, project, on issue etc., throughout the task force. It is hoped initially to develop structured weekly emails at the outset of this process.

Objective 9: YOUNG PEOPLE

Goal 1: **Services for Under 18s**

Action: The research suggests that problem drug use does not isolate itself to those over 18. Indeed, the anecdotal evidence and survey research presented here reveals that young people consume alcohol and cannabis and that those who have left school are more likely to involved with these and other drugs. Research has continually shown that early intervention is an important factor in successful interventions. Young people who use drugs and develop addiction problems do not come under the remit of the task force and responsibility for providing supports to this group rests with the HSE. In view of the lack of addiction services for this group, the task force will set about developing services in the catchment for this age cohort. This will be done in conjunction with the relevant statutory authorities and in keeping also with guidelines cited for work with young people in the NDS. This will also take account of the treatment protocols developed by the HSE and others in respect of working with under 18s. Elsewhere in the strategy, work with young people includes that in respect of prevention and outreach. This action will look to put in place a pilot project for this age cohort which, following review, will inform what effective actions can be taken and adopted by policy and ultimately rolled out as a comprehensive service for those

with drug problems in this age cohort. It will involve a range of key community, voluntary and statutory actors including the HSE, Probation and Welfare Service, education interests and youth bodies etc.

Goal 2: **Increasing Diversionary Activities**

Action:

The lack of activities and recreation pursuits for young people was a theme coming out of the research. This together with the relative prevalence and culture of drug taking in some areas acts to place many young people in proximity to drugs leading to drug use. Although there are diversionary activities for young people, there appears to be a need for more. As such the task force will look to see how it can add to existing activities and develop new ones for young people. This will include looking successful models such running in other parts of the country. The important aspect of this action however is that this approach will look at what young people would like to see and do. This is therefore trying to provide alternative activities for young people, which is in keeping with their perceived reality, socialisation norms and processes, especially some of the young people who are most of risk of drug use. This will also take account of the various groupings and trends of young people so that one grouping is not alienated etc. This may eventually take the form of a fund for new activities and/or joint initiatives.

OBJECTIVE 10: TECHNICAL SUPPORT UNIT

Goal 1: **Support Unit**

Action:

As indicated in the body of the research leading to this strategy, there is a need for the task force to have in place a unit which will provide technical support to the funded projects and services in respect of areas intrinsically related to their work but of a specialist, or technical nature and overly cumbersome for projects to adopt without appropriate support in practical and/or time terms. This might be integrating the latest research in the drugs area, development of new models within their work, developing and implementing organisational and management structures, funding applications, financial management, guides on consultation, networking, representation, collaborative work, evaluation, planning etc. the role of the unit will therefore be to develop this work and present it in a practical form so that the projects and services can easily access latest developments, best practice and information and absorb these into their practices. The unit will be staffed and will draw on existing staffing resources also. It will have a research, policy, technical focus as well as some of the other areas noted above.

Goal 2:	**On Site Visits & Dialogue**
Action:	In addition to the development of documentary guides and the provision of advice centrally, the technical support unit will also work on the ground, one to one with projects as the needs to dictate. This will essentially be consulting, facilitative service provided by the task force on an individual and therefore tailored basis to projects.

Objective 11: ADVOCACY & LOBBYING

Goal 1:	**Advocacy**
Action:	The task force will through its structures gather information on issues and factors that act as barriers to the work and progress with the clients of the services supported. In the course of this work, the various supported projects will be encourages to adopt a advocacy role which looks to voice the concerns, experiences and expectations of the client group in respect of countering problem drug use. This will emphasise highlighting issues, gaining access to decision makers, putting the case of clients across (on their behalf or as a support to the client), looking for solutions and improvements in services. The task force will develop a system to develop the skills of those associated with it in advocacy work. This action will include a significant input of the drug user's forum and local area committees.
Goal 2:	**Lobbying**
Action:	In recognition of the fact that many of the factors that affect problem drug sue are outside of the capacity, and often the remit, of the task force, it will adopt a policy of gathering evidence, research, experiences and insights. These will be explored and analysed to produce key findings and policy implication documents. These will form the basis of lobbying role that the task force will take in informing and suggesting policy and service changes to the National Drug Strategy Team, the Department of Community, Rural and Gaeltacht Affairs, other government departments, elected representatives, statutory service providers and the media. Areas that may be themes of such lobbying and policy work include capacity issues, ancillary and support services, integration, drugs policy, premises and facilities, emerging issues and trends at community level etc. The aim of this goal is to stimulate changes and improvements in policies and services in the context of problem drug use. This action will include a significant input of the drug user's forum and local area committees.

chapter 1
introduction

CHAPTER 1

INTRODUCTION

BACKGROUND TO THE REPORT & STRATEGY

Dublin North East Drugs Task Force (DNEDTF) was established, along with the other Local Drugs Task Forces (LDTF), in 1997. Since that time, DNEDTF has provided significant support, direction and funding to a range of projects in Dublin North East.

It now boasts funding of over 20 projects across its catchment dealing with a range of issues related directly an indirectly to drug problems. In addition, there are four projects initiated by the Task Force that are now mainstreamed under established state agencies.

The work of the Task Force is in keeping with the National Drugs Strategy 2001-2008. However, locally the work is organised into a number of key themes, namely: rehabilitation and treatment; education and prevention; supply and control; and, childcare.

The catchment of the Task Force covers a wide area of Dublin North East, stretching from the Swords Road, Collins Avenue Junction north to the M50 and east, including new developments in Donaghmede and Baldoyle, and east to the Howth Road, the sea including the Howth Peninsula.

According to the last Census (2002), this catchment had a population of 108,748. The 2006 Census preliminary report puts the population of the catchment at 105,057.

At this point in time, the Task Force is looking to appraise and review its work to date and current position with a view to identifying gaps in its service. The outcome of this research is hoped to act as the basis for the Task Force to arrive at a point form where to outline its strategy for the coming years. This is the broad setting for the research.

OVERALL AIMS OF THE RESEARCH

In summary, this research process has a number of aims as follows:

- To explore the current position of the Task Force
- Identify gaps in the service
- To respond in a planned and strategic manner
- Provide valid data on the extent of drug misuse in the area
- Provide an efficient framework for implementing local strategy

This report outlines some of the key issues emerging for the Task Force to address and looks at how these issues will be responded to strategically over the coming years.

REPORT STRUCTURE

Following this opening chapter, the next chapter (2) outlines the context of the Task Force's work in terms of the extent of the drug problems nationally and the policy responses made by the Government. The third chapter provides a social and economic profile of the Dublin North East Area. The following chapter explores the extent of the drug problems in the task force area. Chapter 5 provides the feedback on the views and insights of a range of stakeholders in the Task Force, these include members of the Task Force, stakeholders, funded local projects. The

following chapter recounts the views of drug users and those affected by drug use in the area. The earlier sections of report presented the main findings made in the report and through analysis, reaches a range of conclusions and also set out a range of options for future actions of the Task Force based on the research culminating in a strategy for the future work of the Task Force.

METHODOLOGY

The methodology for the research involved 5 phases. The overall approach to the research and strategy development was to balance systematic data, such as statistics and prevalence figures, with qualitative perceptions based on the experiences of well placed stakeholders, and also those with drug related problems. This method allows both elements to complement each other and give a comprehensive picture of prevalence and service needs The method used in the research is sometimes referred to as 'triangulation' whereby the views of key position stakeholders on the issue were sought and their collective view and perspectives offers a rich view of the main aims of the research process. This yields valuable information that also complements the statistical data uncovered in the earlier phases of the research. From here, the research approach sought to develop dialogue with the task force over the draft strategy so as to arrive at an understood and owned strategic approach.

The main phases of the research, in chronological order, are as follows:

1. The initial phase discussed the project in detail with the Task Force's Steering Group, identified and clarified the key issues to be addressed during the research process and the relevant stakeholders to be consulted.
2. The second phase of the research reviewed literature, studies and statistical data relevant to the research. This included details of the prevalence of drug use in the Task Force Catchment, socio-economic data on the area, the policy context and the development of the Task Force. This allowed for all background and context information to be collected and digested in order to inform the overall research, its research tools, implementation and also its findings. This phase also developed the interview schedule which guided the consultations with stakeholders and finalised the sample of groups and individuals to be consulted.

The third and fourth, and substantive, phases of the process were the field consultations.

3. Phase three involved consultations with stakeholders and funded projects. In all some 30 interviews were held. These included members of the Task Force and other relevant projects, interests and services in the catchment. This group were chosen due to their knowledge and work with drug problems in the catchment, and/or with groups at risk of drug use. Each of the interviews was guided by an open ended interview schedule. Thus the main topics guiding the interviews were as follows: profile of respondent; their perspective on/or role in DNEDTF; views on

the extent of drug use in the catchment; impact of TF/its projects in responding to drug problems; the extent to which the TF meets local needs; gaps in services or the approach to drug problems; response of the TF to gaps; services/policies and activities put in place by the TF; structures for information and coordination; criteria for projects; suggestions on a future strategy; mainstreaming; and, emerging priority issues.

4. The fourth phase consulted with persons affected by problem drug use. Interviews and three focus groups were held with past and present clients of a number of drug projects. This group were identified and approached by existing projects. 22 individuals took part in these consultations, the majority of which were one to one interviews. The participants agreed to take part in the interview; again confidentiality and the independence of the researchers were stressed in the course of these consultations. Both the interviews and focus groups were guided by an interview schedule

5. Phase five involved the development of strategy. Following the previous stages, a draft report was prepared which not only contained the main findings of the research but also outlined ideas for a strategy. With this information, meetings were convened with key stakeholders in order flesh out priorities, amend and add to objectives and actions for the future. This phase was not designed to depreciate or prioritise the findings and suggestions coming out of the consultations but rather to fine-tune a strategy in terms of its suggested implementation and to gain support for it from key actors in statutory agencies and most importantly on the ground in communities. This phase was important to strengthening the validity and reliability of the consultations process especially in terms of developing ownership over, understanding of, and responsibility for a strategy for the future for Dublin North East Drugs Task Force.

chapter 2
context

CHAPTER 2
CONTEXT

INTRODUCTION

Dublin North East Task Forces is one of 14 LDTFs in the state. The LDTFs were initiated on foot of the reports of the Ministerial Drugs Task Force on Measures to Reduce Demand for Drugs in 1996 and into 1997. LDTFs were established in the areas identified as having the highest levels of drug use, in particularly opiates such as heroin. This chapter presents an overview of the social and policy context in which the task force works. It firstly looks at the National Drugs Strategy, secondly at the role of the task forces, thirdly, at some specific information about DNEDTF and finally, at national prevalence measures of drug misuse. The overall aim of this chapter is to set the context for the research findings and the resulting strategy.

NATIONAL DRUGS STRATEGY

The overriding policy framework for LDTFs is the National Drugs Strategy (NDS). The strategy was initially launched in 2001, hence its time frame: 2001-2008. It built on the Ministerial Report on Drug Misuse produced in 1996 and 1997. The main aim of the NDS is:

"To significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and rehabilitation and research".

The Strategy was initially delivered through what it terms pillars. The pillars are interconnected clusters of actions around the following themes:

- supply reduction
- prevention (through education & awareness)
- treatment (including rehabilitation & risk reduction)
- research

The objectives of each of the pillars are as follows:

Pillar of NDS	Objectives
Supply reduction	- To significantly reduce the volume of illicit drugs available in Ireland, to arrest the dynamic of existing markets and to curtail new markets as they are identified - To significantly reduce access to all drugs that cause most harm amongst young people, especially in those areas where misuse is most prevalent
Prevention	- To create societal awareness about the dangers and prevalence of drug misuse - To equip young people and other vulnerable groups with the skills and supports necessary to make informed choices about their health, personal lives and social development.
Treatment & Rehabilitation	- To encourage and enable those dependent on drugs to avail of treatment with the aim of reducing dependency and improving overall health and social well being, with the ultimate aim of leading a drug-free lifestyle - To minimise the harm to those who continue to engage in drug-taking activities that put them at risk.
Research	- To have available valid, timely and comparable data on the extent of drug misuse amongst the Irish population and specifically amongst all marginalised groups - To gain greater understanding of the factors which contribute to Irish people, particularly young people, misusing drugs.

Pillar of NDS	Lead & Key Agencies
Supply reduction	- Department of Justice, Equality & Law Reform, - An Garda Siochana - Revenue Customs & Excise Service - Prisons Services - Department of the Environment & Local Govt. - Local Authorities - Community and Voluntary Services
Prevention	- Department of Education & Science - Department of Health & Children - Health Services Executive (HSE)
Treatment & Rehabilitation	- Department of Health & Children - HSE - FAS
Research	- National Advisory Committee on Drugs (NACD) - Health Research Board (HRB)

Under each of the pillars, a range of actions and responsibilities are set down. Central to this approach is the bringing together of key agencies, both statutory and community/ voluntary, in the implementation of the strategy.

The implementation structures for the NDS and its various activities and responsibilities are set out in the document. There are a number of lead agencies for each of the strategy's pillars indicated above.

In addition to the lead agencies, there are a range of other bodies that play a role in the overall implementation of the NDS. These include government committees, interdepartmental groups and the overall lead Department (Community, Rural and Gaeltacht Affairs) and a dedicated National Drugs Strategy Team (NDST).

The NDST is a cross-departmental Team from Departments and Agencies involved in the drugs field. It also contains one representative each from the community and voluntary sectors. Its purpose is to oversee the work of the Local and Regional Drugs Task Forces; address and make recommendations on issues arising, and to report on progress in this area.

In addition, there are assessment committees for the Young Peoples Services and Facilities Fund as well as local development groups for this fund in the various communities. At the local and regional level, there are the LDTFs and the recently established Regional Drugs Task Forces respectively.

In more recent times, the strategy has been reviewed and assessed. The mid-term review of the NDS was published in mid 2005. It recommends a number of additions and amendments to the 2001 NDS. The review saw no need to change the overall aims and

Pillar of NDS	Recommendations
Supply reduction:	- Garda resources in LDTF areas to be increased including additional resources to community policing. - community policing fora to be put in place in all LDTF areas
Prevention:	- substance use policies in schools in LDTF areas - ongoing training and supports to teachers to deliver Social Personal & Health Education (SPHE) - Prioritise SPHE - prevention education to be included in curriculum - investigate substance use programmes in non-school settings - factual and easily accessible preventative information for parents and families on substance use - Home School Community Liaison Scheme to be expanded to engage with families affected by drug problems
Treatment:	- auditing treatment availability and assessing treatment needs - responding to polydrug use by increasing availability of treatment options - rehabilitation to become the 'fifth pillar' of the NDS - implementation of guidelines on working with under 18s - wider time and geographic availability of harm reduction services such as needle exchange - consideration of employment of medical staff by voluntary and community based drug services
Co-ordinating structures:	- exploration of alcohol and drugs and the potential for better co-ordination
Cross-pillar:	- implement the recommendations of the NACD Family Support Report [2]

objectives of the strategy. The success of the strategy varies across the various pillars. The review recommended the addition of eight new actions, replacement of ten actions and the amendment of seven. One of the main changes is that rehabilitation becomes a stand alone and new fifth pillar in the overall strategy.

Of particular note in the context of this research, the review recommended the following amendments, additions to update the 2001 NDS (see above).

What is interesting about the recommendations is that they provide national perspectives on some of the areas that were seen as missing form the NDS. They also serve therefore as a wider context to some of the findings outline as part of this research.

LOCAL DRUGS TASK FORCES

There are 14 LDTFs of which Dublin North East is one. Most were established in 1997 and in this sense they predate the NDS and have been at the forefront of local and national efforts to tackle drug problems in communities. Their overall role, as envisaged by the NDS, is to prepare and implement action plans which identify existing and emerging gaps in services in relation to education/prevention, treatment, rehabilitation and curbing local supply.

Due to their membership (community, voluntary, statutory and elected interests) the LDTFs also provide a mechanism for the co-ordination of mainstream services in their areas while also providing a forum which facilitates local community and voluntary organisations to participate in the planning, design and delivery of local services and responses.

[2] Watters, N. et al, 2004

In addition to this, the Task Forces work to aid the development of community based initiatives and to link in with, and add value to, the programmes and services already being delivered or planned by statutory agencies. This is seen in part to be done on the basis of their membership. As noted, the make-up of the task forces includes representatives from all the relevant agencies such as the HSE, the Gardai, the Probation and Welfare Service, the Department of Education and Science, the Local Authority, Youth Services and FAS. The Task Forces have to date drawn up two actions plans based on intensive consultations (1998 and 2001), the plans represent a consensus on the priority issues to be addressed in the community in terms of problematic drug use. Each plan included a range of measures in terms of treatment, rehabilitation, education and prevention, and curbing the local supply of drugs.

DUBLIN NORTH EAST DRUGS TASK FORCE

The key objectives of the Dublin North East Drugs Task Force are:

- To promote a greater awareness, understanding and clarity of the dangers of drug misuse in the area.
- To enable those with drug problems access to treatment and other supports which will allow the individual re-integrate into society.
- To reduce harm caused by drug misuse to individuals, families and communities.
- To strengthen existing partnerships in and with communities and build new partnerships to tackle drug misuse.
- Have available data to examine the extent of drug misuse in the Dublin North East area.

In Dublin North East to date, the Task Force has initiated and supported 24 projects. Eight of which have been mainstreamed.

Current projects and their areas of focus are detailed below:

Drug Awareness Project, Artane.
This project works with children and young people in and out of the school setting in the general Artane area. The activities of the project include: after school groups, drama groups, drop in for teenagers, drug awareness through personal development. The group also provides counselling and one to one support for local people and runs personal development course for the parents of the young people who use the centre.

Kilmore Youth Project
This project provides arts, drop in clubs, sports, swimming lessons, indoor football, young women's groups, social and personal education, drama and drug awareness. The project is for young people who reside in Kilmore.

Ana Wim Kilmore
This is a drug awareness group in Kilmore. It aims to identify and work with substance misusers through family support. The project does this through active listening, providing information and support services such as advocacy.

Bonnybrook Drug Awareness and Parent Support Group
This group is based in Brookhaven Rehabilitation Centre. The group looks to work with drugs users and their families. It provides one to one counselling, family support, outreach, treatment and rehabilitation referrals, personal development, reflexology, spiritual healing, family cope programme, arts

and crafts, addiction management, narcotics anonymous, prison linkage work, and beautician drug education programmes.

EDIT
EDIT is a community based drug project based in Edenmore. Its target group is stabilised drug users. It provides counselling, awareness group meetings, acupuncture, therapy, computer skills, holistic group, narcotics anonymous meetings and social activities.

Donnycarney Youth Project
This project is based in the purpose built 'Le Cheile' facility. It works with young people aged between ten and 21 years of age. Included in the activities provided by the club are sports, arts, computers, sexual health, alcohol and drug awareness, drama, film-making, stained glass, jewellery making, sewing, a jobs club and the training of youth volunteers.

Donnycarney Special CE Scheme
The target group of this scheme is people recovering from substance abuse whose objective is to renter the active workplace. The activities of the project cover literacy skills, self development, counselling, and FETAC accredited courses in holistic therapies and computers etc.

Donnycarney Drug Project
The target group for the project is those residing in the Donnycarney area. The activities provided by the project centre on a drop in clinic, methadone maintenance, counselling, key working and outreach work.

Kilbarrack Coast Community Project (KCCP)
The target group of this project are problematic drug users. The activities include desktop publishing, magazine production, creative writing, arts and crafts, individual training, forklift driving, welding, and nail sculpture. KCCP also funds a parent support group.

Youth Matters (youth project of KCCP)
This group works with young people aged eight to 18 years of age. The group works with local schools and the activities include after school clubs, life skills training, arts and crafts, cooking, budgeting, drug awareness, drama, personal development, photography and desktop publishing.

Howth Peninsula Drug Awareness Group
The target group of this group is young people, drug users and their families in the Howth, Sutton and Baldoyle areas as well at Irish and immigrant fishermen. The activities provided by the project include drop-in, referral, education classes, homeless project, harm reduction, methadone clinic, family support and youth work.

Darndale/Belcamp Drug Awareness Group
The target group of the group are people from Darndale, Belcamp and Moatview. The activities of the group include referrals, one to one support, family support, liaise with community agencies, prison visits, complementary therapies, drop in and drug free time.

Rehabilitation and Support Programme
This project provides structured rehabilitation for persons stable on methadone and coming from the general Dublin 17 area.

DRUG USE PREVALENCE & TRENDS

In the following chapter, drug prevalence data for Dublin North East is presented. However, and in order to create a context for the work of the TF, the national trends in drug prevalence are briefly outlined in this section. A wide range of sources are used below to give a sense of the nature and extent of drug misuse nationally.

National Prevalence Survey

The national survey of prevalence rates for illegal drugs was commissioned by the National Advisory Committee on Drugs (NACD) and Drug Alcohol Information and Research Unit (DAIRU) of Northern Ireland in 2002/3. The revised bulletin of results was published in mid 2005.

This survey found that one in every five people has used drugs (19%) in their life time[3].In the last year, one in eighteen - or just under 6% - reported ever using illicit drugs and 3% stated they were current users. This suggests that in the context of the population as a whole show illegal drug use is limited. This does not take account of regional differences which are addressed below.

From this survey, it is apparent that cannabis is the most used illegal drug, used by 17.4% in their lifetime. 5% had used cannabis in the previous year and 2.6% state they are current users.

This survey found that one in every five people has used drugs (19%) in their life time

The prevalence of other drugs however were considerably lower and seen mostly in younger age ranges. Lifetime prevalence of drugs included: magic mushrooms (3.9%), ecstasy (3.7%), amphetamines (3%), cocaine and LSD (2.9%). Half of one percent reported using heroin in their lifetime.

In age band terms, the highest life time prevalence is seen in the 25-34 age group. The exception to this is for drugs such as cocaine, ecstasy, poppers and solvents which are highest in the 15-24 age group. Furthermore, the use of sedatives and anti-depressants is most prevalent in the 55-64 age range.
In respect of gender, this survey suggests that men use illegal drugs twice as much as women.

The regional dimensions of the national prevalence survey demonstrates that rates of use are much higher in east of the country, the so called greater Dublin area, than elsewhere. Using the former health board areas, the survey

Table 2.1: NACD National Prevalence Survey, NAHB and Ireland.

Area	Lifetime 15-64 yrs	Lifetime 15-34 yrs	Lifetime 35-64 yrs	Recent 15-64 yrs	Recent 15-34 yrs	Recent 35-64 yrs	Current 15-64 yrs	Current 15-34 yrs	Current 35-64 yrs
Ireland	19%	26.4%	12.3%	5.6%	9.7%	1.9%	3%	5.2%	1%
NAHB	29.5%	38.6%	20.7%	8.5%	14.3%	2.9%	5.4%	9.2%	1.7%

Source: Dept. of Community, Rural and Gaeltacht Affairs, 2004: 13.

[3] This survey refers to prevalence in terms of lifetime use, recent use (< 12 months) and current use (< 1 month)

reveals that in the Northern Area Health Board catchment nearly 30% of people have used illegal drugs in their lifetime. Across all measures, this region demonstrates significantly higher prevalence rates in respect of age bands also. Prevalence rates for all measures of prevalence were higher in the east of the country than elsewhere.

Again the value of this study is that it will allow for an analysis of trends and changes in drug use over time which will better inform responses, supports and new approaches. In terms of specific drugs, the following are some of the relevant findings coming out of the bulletins released under the prevalence survey (opiate use is dealt with separately below)

Cocaine

- 3% of 15-64 year olds reported taking cocaine at some point in their lives. Only 1.1% used these drugs in the last year and .3% in the last month.
- On average, prevalence rates were higher for young people: 4.7% in the 15-34 age group. Prevalence rates in Ireland are highest in the former Dublin health board areas. For instance, the former Northern Area Health Board demonstrates prevalence rate of 5.2%.
- There is no apparent association between cocaine use and any one socio-economic grouping, although slighter higher lifetime use rates were seen in lower socio-economic groups. Respondents who rent accommodation fro a private landlord were more likely to use cocaine, those who own their property were least likely to use cocaine.
- Those who attained higher education levels reported higher prevalence rates, lifetime and last year, than those with lower levels of educational attainment. This suggests that the biography of cocaine users goes across the board.

Source: NACD/DAIRU, 2005.

Cannabis

- 17% of 15-64 reported taking cannabis at some point in their lives. One in 20 or 5% used cannabis in the last year and the corresponding figure for use in the last month was 3%.
- Prevalence is highest among those in the 15-34 age group (24%). 11% of those ages 35 to 64 reported use.
- Cannabis is widely used across all socio-economic groups and is not higher in lower income groupings. Those at work are more likely to use cannabis.
- Respondents who rented their accommodation from a private landlord and/or local authority had higher prevalence rates than those that owned their own home.
- Those who left education aged 20 or over have higher life time prevalence rates.

Source: NACD/DAIRU, 2005.

Opiate Use

Research carried out on the number of opiate uses (NACD, 2003) reveals in 2001 there were 14,452 opiate users nationally and of those 12,446 were in Dublin. This survey reveals national prevalence rates of 5.6 per thousand in the 15-64 age group and 16 per thousand in this age group in Dublin. Comparing 1996 and 2001, this survey shows that the prevalence in 2001 at 18.2 compared to 21 per thousand in 1996. The opiate prevalence data presented suggests that there is an aging of the opiate using population nationally and thus points to reduced take up of opiate use in the lower age groups.

Treatment Statistics

The Central Treatment List deals with a register of individuals receiving methadone. The following table provides a breakdown of 2000, 2003 with this the 2006 figure culminating at the end of September 2006 that is for a period

Central Treatment List ERHA, 2000-part 2006

Area	2000	2003	2006(9 mths)	NAHB
Former ERHA Clinics	2,849	3543	4039	1839
National Clinics	41	123	195	
Trinity Court	513	501	526	
Prisons	-	402	406	
GPs Former ERHA	1574	2160	2539	810
GPs National	55	154	261	
Total	5032	6883	7560	-

Source: Drug Treatment Centre Board October 2006, Dept. of Community, Rural and Gaeltacht Affairs, 2004: 15.

of nine as opposed to 12 months. Included in this list also are some figures for the former NAHB.

The number receiving methadone has increased over the years. There has been an increase in the number of treatment centres outside the former ERHA area which has led to an increase in the numbers using the services listed outside the eastern region. It has been noted that the increase in the availability of places leads to more users coming forward for treatment.

The lion's share of clients is aged in the main between 20 and 34 years of age and after that in the 35-44 age range. There appears to be very opiate users under the age of 20. This may be because of a time lag in seeking treatment or more optimistically, a reduction in the number of new users in this age group as opposed to older age ranges.

For the most part there has been an increase in the number of opiate cases seeking treatment in both the eastern region and elsewhere in the state. The number in the eastern region is higher although parts of the country have seen very large proportionate in creases. This may be due to better reporting, more treatment places as well as an increase in prevalence. It is worth noting, that at any given time there are a number of people on the waiting lists for services

Currently in the former NAHB area – in which DNEDTF is located - there are a total of 50 GPs working with 810 clients under the methadone protocol. There are currently 78 pharmacies working with the overall total of 1493 clients in residing in the area.

Garda Síochána National Statistics

The figures in the table and chart below detail the offences detected by the Garda according to their annualised statistics over the last 15 years nationally. These show the overall number of offences for each drug type and also the proportion of all offences that a drug type makes up.

The percentages of each drug type each year are telling. They suggest for instance that although cannabis resin is by far the main drug

Currently there are a total of 50 GPs working with 810 clients under the methadone protocol

type under which offences occur (some 5,133 in 2005), this has decreased in proportion from over 90% in 1990 to close to 60% in 2005.

Of course, as the figures suggest the number of offences for all drugs, except ecstasy, is however on the increase and this is a trend that needs to be monitored.

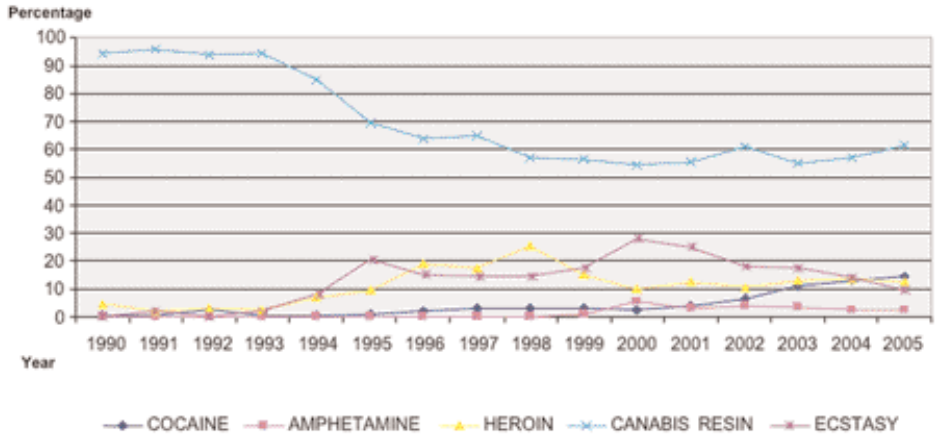
The data in the table below shows a substantial increase in offences for cocaine over the period. This increase has stark in the last number of years, the number of cocaine offences has quadrupled over the last four to five years. This is evidenced that for the first time since data was captured, that Cocaine offences were higher than heroin offences in 2005. Indeed, heroin offences have stabilised up to 2005 when it saw an increase, it still is a lesser drug in offence terms than cocaine. Ecstasy, although still not insignificant, is declining in numerical and proportionate terms. Overall, the move toward cocaine is perhaps the most important aspect of the data and suggests a shift in drug use patterns, notwithstanding cannabis, away from heroin and ecstasy and toward cocaine.

Table 2.3: Number and Annualised Percentage of Misuse of Drugs Act Offences by Drug Type

YEAR	COCAINE	%	AMPHETAMINE	%	HEROIN	%	CANABIS RESIN	%	ECSTASY	%
1990	11	0.74	n/a	0	71	4.75	1413	94.52	-	0
1991	7	0.29	n/a	0	45	1.84	2354	96.04	45	1.84
1992	77	2.74	n/a	0	91	3.23	2643	93.92	3	0.11
1993	15	0.49	n/a	0	81	2.65	2895	94.70	66	2.16
1994	15	0.45	n/a	0	230	6.86	2848	84.91	261	7.78
1995	30	0.94	n/a	0	296	9.31	2209	69.47	645	20.28
1996	42	1.86	n/a	0	432	19.16	1441	63.90	340	15.08
1997	97	3.00	n/a	0	564	17.45	2096	64.85	475	14.70
1998	88	2.87	n/a	0	789	25.74	1749	57.06	439	14.32
1999	169	2.90	464	1.22	887	15.23	3281	56.34	1023	17.57
2000	180	2.43	391	5.27	730	9.84	4031	54.34	2086	28.12
2001	297	4.06	207	2.83	908	12.42	4053	55.44	1845	25.24
2002	478	6.36	300	3.99	796	10.59	4595	61.10	1351	17.97
2003	607	11.10	180	3.29	719	13.15	3003	54.91	960	17.55
2004	764	13.06	160	2.74	778	13.30	3335	57.01	813	13.90
2005	1224	14.68	191	2.29	1022	12.26	5113	61.33	787	9.44

Source: Garda Síochána Statistics

Percent of Misuse of Drugs Act Offences by Drug Type 1990-2005



Source: Garda Síochána Statistics

SUMMARY & CONCLUSION

This chapter has provided an overview of the wider context in which the Dublin North East Drug Task Force is situated. The main areas covered in the chapter were the policy context of the LDTFs provided by the NDS, secondly the background and function of the LDTFs themselves and finally drug misuse overview in Ireland.

The main points coming out of this chapter are outlined below:

- The policy context of the DNEDTF and all task forces is the NDS. This has a wide set of aims and is structured by five (before the NDS review, four) pillars under which integrated cluster of actions are implemented. The five pillars are supply reduction, prevention, treatment, rehabilitation and research.
- The review of the NDS outlines a number of additional focus areas which include: increased presence in and interaction by Garda with communities; substance use policies in schools and non school settings; information on prevention for parents and families; engaging with families and family support; focusing on polydrug use; working with those under 18 years, and; employment of medical staff in community based drug services.
- There are currently 14 LDTFs of which DNEDTF is one. The role of the LDTFs is to prepare and implement actions plans which identify existing and emerging gaps in respect of the pillars of the NDS. LDTFs also provide a mechanism for the co-ordination of mainstream services in their respective catchments, whilst also allowing local

communities and voluntary bodies to participate in the planning, design and delivery of services.

- DNEDTF has initiated and support 24 projects. It aims to promote greater awareness of drug misuse; access to treatment; reduce harm; strengthen existing and build new partnerships; and, have available data to examine drug misuse in Dublin North East.

- 19% of people surveyed had used drugs at some point in their life. The use of drugs is not on the whole large nationally. The prevalence of drug use is however higher in younger age groups. The highest prevalence is in the 25-34 age range although drugs such as cocaine have higher prevalence rates in the 15-24 age range. Men are twice as likely to use drugs as women.

- Regionally, drug use is much higher in the eastern parts of the country than the average, for instance 30% of people report use of drugs in their lifetime in the wider Dublin north city and county area.

- In contrast to heroin use, there is no apparent association between cocaine and cannabis and socio-economic background. If anything, those in work and renting were more likely to cite use of these drugs than those in lower relative positions. This biography of both cocaine and cannabis is widespread among the population and not related to one group more than others.

- Opiate use is higher in the Dublin region then elsewhere around the country. There has been an increase since 2000 in the numbers receiving methadone. The majority of opiate users seeking treatment are aged between 20 and 34.

- Garda national statistics suggest that cannabis resin is the most common drug type making up drug offences over the past 15 years, although the number of such offences is increasing it has decreased as proportion of all drug offences from over 90% in 1990 to just over 60% in 2005. The statistics on drug offences suggest that, bar ecstasy, the number of offences relating to all drugs is on the increase. However, the data presented suggests that there has been a significant increase in offences for cocaine: the number of cocaine offences have increased by a multiple of four over the last five years. Overall, the move towards cocaine and relative stabilisation of the number of heroin offences suggests a shift in drug use patterns.

chapter 3

profile of task force area

CHAPTER 3
PROFILE OF TASK FORCE AREA

INTRODUCTION
This chapter presents a profile of the main social, economic and demographic characteristics of the task force catchment area. The chapter provides an overview of the area and its make up, population, household structure, education, social class, employment and deprivation. The final part of the chapter summarises the main issues brought out in the chapter and provides some conclusions. The overall aim of this chapter is to provide a socio-economic picture of the context in which the task forces operates.

AREA MAKEUP & POPULATION
The first thing that should be said about the catchment area of the Task Force is that it was originally moulded on the operational area of the Northside Partnership, which was initially established in 1992. As such, along with a range of electoral divisions (EDs) in the north east of Dublin City (Dublin City Council's administrative area) it also encompasses three EDs in Fingal. The rationale for this is ostensibly that the overall catchment area is socially as well as geographically linked to the urban areas on the north east of the city. Figure 3.1 below depicts the various EDs that comprise the Dublin North East Drugs Task Force.

Like most of the established areas in Dublin City, there has not been a great degree of population growth since the last but one, Census 2002.

Figure 3.1: Electoral Divisions comprising the DNEDTF catchment area
Source: Area Development Management/Gamma, 2004.

Table 3.1: Task Force Population 1996-2006

Electoral Divisions	Pop. 1996	Pop. 2002	Pop. 2006	% Change 1996-2006	% Change 2002-2006
Dublin City EDs					
Ayrfield	5,335	5,426	5,330	0	-1.8
Beaumount A	3,059	2,667	2,626	-14	-1.5
Beaumount B	4,591	5,173	5,054	10	-2.3
Beaumount C	3,487	3,050	3,071	-11.9	-0.7
Clontarf East A	3,399	3,279	3,236	-4.8	-1.3
Clontarf West A	3,347	3,487	3,456	3.3	-0.9
Clontarf West B	2,705	2,602	2,403	-11.2	-7.6
Edenmore	3,159	2,890	2,760	-12.6	-4.5
Grange A	5,322	7,301	7,062	32.7	-3.3
Grange B	2,329	2,138	2,871	23.3	34.3
Grange C	4,301	3,673	3,321	-22.3	-4.6
Grange D	4,918	4,330	4,162	-15.4	-3.9
Grange E	3,327	2,930	2,635	-20.8	-10.1
Harmonstown A	3,388	3,070	2,821	-16.7	-8.1
Harmonstown B	2,776	2,585	2,636	-5	2
Kilmore A	2,726	2,943	3,532	30	20
Kilmore B	3,260	3,006	2,807	-13.9	-6.6
Kilmore C	1,779	1,676	1,453	-18.3	-13.3
Kilmore D	2,611	2,337	2,259	-13.5	-3.3
Priorswood A	1,615	1,564	1,581	-2	1.1
Priorswood B	3,353	3,298	2,882	-14	-12.6
Priorswood C	3,790	3,633	3,574	-6	-1.6
Priorswood D	3,026	2,846	2,748	-9.2	-3.4
Priorswood E	3,126	2,883	2,714	-13.2	-5.9
Raheny-Foxfield	3,000	2,712	2,442	-18.6	-10
Raheny-Greendale	2,497	2,478	2,297	-8	-7.3
Raheny-St. Assams	3,770	3,488	3,293	-12.7	-5.6
Fingal EDs					
Sutton	6,510	6,203	5,905	-9.3	-4.8
Howth	9,008	8,706	8,186	-9.1	-6
Baldoyle	6,739	6,374	5,940	-11.9	-6.8
TOTAL DNEDTF	**112,2563**	**108,748**	**105,057**	**-6.4**	**-3.4**
Dublin City	481,854	495,781	505,739	5	2
Dublin City & County	1,058,264	1,122,821	1,186,159	12	5.6
Ireland	3,626,087	3,917,203	4,234,925	16.8	8.9

Source: Census 1996, 2002 & Preliminary Report 2006

Figure 3.2: Map of the operation area of Northside Partnership, recent and future developments

Source: Northside Partnership, Annual Report 2005.

Figure 3.2: Map of the operation area of Northside Partnership, recent and future developments

Source: Northside Partnership, Annual Report 2005.

Over the 1996 to 2002 period, the Dublin North East Task Force had a population decrease of 6.4% while the city had a population increase of 5%, 12% in all of Dublin and just under 17% nationally. The population decreased also between 2002 and 2006. However, the surrounding city showed a population increase of 2% during this period and 5.6% in the county. This suggests that the TF area is on the whole a settled and ageing one. In Census 2002, the only EDs with a significant increase on the previous Census was 'Grange A' and 'Grange B', this is the area around the road between Clarehall and Donaghmede. There was also population increases in 'Kilmore A' and 'Beaumount A', which is areas adjacent to Beaumont hospital. In Census 2006, 'Grange A' and 'Kilmore A' were the only EDs registering population increases in the catchment of 34.3 % and 20% respectively.

There has been much development in parts of the catchment subsequent to Census 2002 and 2006. There is currently and likely to be much development of housing and social and economic infrastructure in the 'Northern Fringe' of the catchment. This includes new industrial and housing development along the N32 and then also and to a greater extent above Clarehall, Donaghmede and Baldoyle on greenfield sites. Indeed, the Northside Partnership estimate, as reflected in the map above, that there maybe an additional 15,000 housing units on the northern fringe of the Dublin North East accounting for up to 40,000 additional residents. There has also been development around the Beaumont Hospital area which has added to the population in these areas. As the table demonstrates, the likely population growth is not yet noticeable in the

Table 3.2: Task Force Population 1996-2006

Electoral Divisions	Pop. 2002 aged 15-44 (Nos)	Pop. 2002 aged 15-44 (%)
Dublin City EDs		
Ayrfield	2,683	49.4
Beaumount A	1,064	39.8
Beaumount B	2,698	52.1
Beaumount C	3,942	40.8
Clontarf East A	1,254	38.2
Clontarf West A	1,630	46.7
Clontarf West B	1,230	47.3
Edenmore	1,152	39.8
Grange A	4,089	56.1
Grange B	1,115	52.1
Grange C	1,700	46.3
Grange D	2,123	49.0
Grange E	1,344	45.5
Harmonstown A	1,286	41.9
Harmonstown B	1,041	40.2
Kilmore A	1,598	54.3
Kilmore B	1,353	45.0
Kilmore C	752	44.9
Kilmore D	1,012	43.3
Priorswood A	813	65.2
Priorswood B	1,620	49.2
Priorswood C	1,647	45.3
Priorswood D	1,853	48.5
Priorswood E	1,488	51.7
Raheny-Foxfield	1,194	44.0
Raheny-Greendale	1,071	40.4
Raheny-St. Assams	1,408	40.4
Fingal EDs		
Sutton	2,774	42.6
Howth	3,518	39.0
Baldoyle	2,896	43.0
TOTAL DNEDTF	**53,348**	**49.1**
Dublin City		51.9
Dublin City & County		53
Ireland		51

Source: Census 2002.

Dublin North East has a higher overall proportion of lone parent households than elsewhere.

population totals from Census 2006. However, it is likely to be a feature of the next Census in 2011. The implication of this is that needs of the developing areas have to be considered by the task force over the coming years as the various developments are completed. Overall, in 2006 there were 105,057 people residing in the catchment of the task force.

As noted in the previous section, most of those affected by problem drug use are in the age range of 15-44 years, have low educational attainment and limited employment experience.

With this in mind, it is worth noting the areas in the Task Force area which most match this profile and where special attention should be paid in terms of the location of services and responses for the future. However, data on these categories are only available from Census 2002 and therefore should be treated with some caution. Overall, the proportion of persons in the State in this age range in 2002 was 51% while in Dublin City the number is just under 52%. The overall figure for the Task Force Area is 49.1%. The measure for the task force is in keeping with the comparative aging and settled nature of the various EDs that make up the area. However the following areas show higher than average – catchment and city/national measures - concentrations of persons in that age range: Beaumount B (52%); Grange A (56.1%); Grange B (52%); Kilmore A (54.3%); Priorswood A (65.2%); and Priorswood E (51.7%).

HOUSEHOLD STRUCTURE

Household structure refers to the broad make up of households in the catchment area of the task force. It refers to the ownership of households, type of households, and persons (adults and children) in each household as noted in Census 2002. The total number of households in Dublin North East according to Census 2002 was 38,818 in 2002. Of this 5,768 were headed by lone parents. This represents 16% of households. The corresponding proportions in Dublin city in 2002 was 13.3%, in Dublin City and County 12.7% and nationally 11.9%. Thus Dublin North East has a higher overall proportion of lone parent households than elsewhere.

Looking in more detail at lone parent households, the number of households headed by a lone parent with all children under 15, that is, children who are fully dependent on the lone parent and not able to participate in the labour market, was 1,625 or 4.7% of the total number of households. This was similar to the city measure but larger than the county and national proportions.

The number of lone parent households with at least one child 15 years of age or younger was 2,210 at the last released Census, 2002. This equated to 6.4% of all households and was only marginally larger than the proportion seen across the city, but larger than the county and national proportions.

Looking at the ED level there are some notable trends underlying the collective figures. These are noted in the table below and demonstrate the particular EDs with overall numbers of lone parents, numbers of such households with all children or just one child 15 years of age or under respectively which are significantly greater than the corresponding measures seen in Dublin city, county and also nationally.

Table 3.3: Lone parent households

Electoral Divisions	Total Households	Lone Parent Households (% of all family units)	Lone Parent Households all children < 15 (% of all family units)	Lone Parent Households at least one child < 15 (% of all family units)
Dublin City EDs				
Ayrfield	1,552	11.3	3	4.8
Beaumount A	995	10.1	0.9	1.1
Beaumount B	1,488	8	1.9	2.4
Beaumount C	1,137	10.6	1.8	2.3
Clontarf East A	1,263	11.3	1.7	2.2
Clontarf West A	1,366	11.9	3.4	4
Clontarf West B	983	16.4	3.9	5.5
Edenmore	947	19.9	6.2	8.3
Grange A	2,143	11.1	4.7	6.1
Grange B	581	14.5	4.6	6
Grange C	1,073	18.5	5.1	7.6
Grange D	1,373	14.7	3.9	5.2
Grange E	955	14.5	3.7	5.3
Harmonstown A	1,063	14.4	2.7	3.7
Harmonstown B	926	17.9	3.5	5.3
Kilmore A	895	13.5	4.8	6
Kilmore B	978	30.9	9.9	13.9
Kilmore C	556	33.8	17.8	19.8
Kilmore D	756	15.6	3.4	4.6
Priorswood A	425	14.6	3.8	6.6
Priorswood B	748	34.9	13.4	23.8
Priorswood C	915	45.8	25	34.3
Priorswood D	880	23.9	7	11.3
Priorswood E	845	18.5	5.6	7.6
Raheny-Foxfield	800	14.9	2.4	3.6
Raheny-Greendale	787	18.4	5.7	8.3
Raheny-St. Assams	1,286	10.3	1.6	2.4
Fingal EDs				
Sutton	2,136	9	1.5	1
Howth	2,880	9.7	1.9	1.2
Baldoyle	1,990	12.1	2.4	1.6
TOTAL DNEDTF	**34,722**	**16**	**4.7**	**6.4**
Dublin City		13.3	4.7	6.3
Dublin City & County		12.7	4.3	5.5
Ireland		11.9	3.9	5.3

Source: Census 2002

Table 3.4: Lone parent households at the ED level

Electoral Divisions	Lone Parent Households (% of all family units)	Lone Parent Households all children< 15 (% of all family units)	Lone Parent Households at least one child < 15 (% of all family units)
Clontarf West B	•		
Edenmore	•	•	•
Grange B	•	•	
Grange C	•	•	•
Grange D	•		
Grange E	•		
Harmonstown A	•		
Harmonstown B	•		
Kilmore A		•	
Kilmore B	•	•	•
Kilmore C	•	•	•
Kilmore D	•		
Priorswood A	•		•
Priorswood B	•	•	•
Priorswood C	•	•	•
Priorswood D	•	•	•
Priorswood E	•	•	•
Raheny-Foxfield	•		
Raheny-Greendale	•	•	•

These are the areas with higher concentration therefore of lone parent households including those with children under 15. These are areas in which support services, particularly family support, could be targeted to both act as prevention and harm reduction in the case of problem drug use. The relationship between lone parenthood and disadvantage has been long established also which underlines the important of dovetailing social inclusion activities with those concerning problematic drug use.

Looking at housing tenure also allows for an insight into possible areas of disadvantage in which there is a higher probability, or more precisely visibility in the absence of privately funded treatment options, of problematic drug use. It is evident from a raft of research that there is a relationship between housing tenure and social disadvantage in most cases, this relates to social housing rented from the local authority.

The table below details the number of number of households owner occupied with and without a mortgage and also those rented or being purchased from a local authority and finally those rented in the private rental sector.

Looking at this data, it is evident that the Dublin North East area is not homogenous in social terms. That is, it is not solely characterised by social housing and related disadvantage. In Dublin North East area, 78% of households are owner occupied. This is larger than the measure seen in the city, the county and nationally. Nearly two thirds of the EDs reveal owner occupier rates greater than the national average. This suggests that there is relative affluence in the catchment. In some cases, over 90% of the dwellings are owner occupied.

However, 13.4% of all households are rented in some form from the local authority responsible. This is less than the city wide measure but is above that for the county and the state. On closer examination, a number of EDs reveal significantly greater comparative proportions of their make up is social housing. In some cases, these are multiples of the catchment and wider figures: Kilmore B, Kilmore C, Priorswood B, Priorswood C. Again these areas, together with others with large concentrations of social housing, are obvious areas for concerted interventions by virtue of the close correlation between social housing, disadvantage/social exclusion and the risk of problematic drug use.

Table 3.5: Household tenure

Electoral Divisions	Owner Occupied (%)[4]	Purchased or rented from Local Authority (%)[5]	Rented in Private Rented Sector[6]
Dublin City EDs			
Ayrfield	89.9	3.1	3.1
Beaumount A	91.5	1	5.4
Beaumount B	77.1	2	17.9
Beaumount C	86.4	4.5	6.5
Clontarf East A	82	10.7	5
Clontarf West A	80.2	5.3	12.5
Clontarf West B	67.8	24.2	5.5
Edenmore	67.8	22.1	6.3
Grange A	90.3	2	5.8
Grange B	62.3	11.3	3.1
Grange C	82.5	11.6	2.1
Grange D	81.1	10.5	5.7
Grange E	73.2	18.7	5.8
Harmonstown A	79.8	12.9	3.8
Harmonstown B	74.3	18.1	3.3
Kilmore A	73.3	16.6	6.3
Kilmore B	43.3	50.4	2.7
Kilmore C	39	55.2	1.7
Kilmore D	65.1	11.2	4.1
Priorswood A	88.4	6.8	1.7
Priorswood B	26.5	62.1	1
Priorswood C	13.5	79.1	3
Priorswood D	46.4	41	3.2
Priorswood E	75.7	13.3	2.2
Raheny-Foxfield	84.9	10.1	2.4
Raheny-Greendale	63.3	27.2	4.1
Raheny-St. Assams	87.3	2.7	7.3
Fingal EDs			
Sutton	90.9	0.5	8.5
Howth	89	4	7.1
Baldoyle	87.5	6	5
TOTAL DNEDTF	**77.7**	**13.4**	**5.4**
Dublin City	55.7	16.8	21
Dublin City & County	67.5	13.1	14.5
Ireland	73.9	10.4	11

Source: Census 2002

Although, there are clearly clusters of such areas, there are also more affluent areas alongside these areas that together make up the whole of the task forces catchment. The implication of this is the challenge that this poses in terms of targeting resources and ensuring that supports are appropriate and available to those with drug problems across all of the catchment.

EDUCATION

Education attainment data demonstrates differences in levels of education in different parts of the area and lends some evidence to targeting of resource in areas in which educational attainment, thus skill levels, employment and ultimately income prospects, is low with a corresponding higher risk of concentration of problem drug use. By the same token, it also allows for differences in approach, if needed, in areas where educational profiles are more advanced etc. Generally, it contributes to the overall understanding of the profile of the catchment.

In this regard, the table below outlines the data available from Census 2002 on each of the EDs and also for the wider areas in terms of a number of key junctures in individual biographies of when education ceased. Overall, it is important to note that that those who had no formal education are those who are statistically most likely to experience difficulties in terms of employment and income and thus risk of social exclusion etc. This is also the case for those who left school before completion of the junior cycle of second level (15 or under also known as an early school leaver). While those who have attained completion of second level or higher are less likely to be at risk of disadvantage.

[4] Includes those who are owner occupiers with, and with no, mortgage.

[5] Includes those currently renting, and in the process of purchasing a property, from a local authority.

[6] Encompassing those renting furnished and unfurnished dwellings.

Table 3.6: Level of cessation of education

Electoral Divisions	No formal or primary education (%)	Junior secondary ed. Only(5)	Senior secondary education (5)	3rd level education (%)
Dublin City EDs				
Ayrfield	19.8	28.8	34.9	16.5
Beaumount A	26.6	21	32.8	19.6
Beaumount B	19.4	19.2	30.8	31.6
Beaumount C	28.1	19.9	33.2	18.8
Clontarf East A	23.1	20.6	30.5	25.9
Clontarf West A	17.8	19.5	31.9	30.9
Clontarf West B	38.3	23.1	21.2	17.4
Edenmore	37.3	27.8	23.7	11.2
Grange A	14.2	27.9	36.6	21.3
Grange B	20.3	30.9	35.1	13.7
Grange C	32.5	28	29.2	10.3
Grange D	20.7	23.5	31.8	24.1
Grange E	26.8	24.1	31	18.1
Harmonstown A	28.1	25.5	29.5	17
Harmonstown B	30	27.3	28.4	14.4
Kilmore A	22.3	28.1	31.3	18.2
Kilmore B	43	32.8	19.5	4.8
Kilmore C	41	34.4	19.4	5.3
Kilmore D	33.8	21.8	31.2	13.1
Priorswood A	23.1	34.4	31.9	10.5
Priorswood B	41.1	35.2	19	4.7
Priorswood C	35	43.6	16.3	5.2
Priorswood D	40.7	29.8	21.7	7.8
Priorswood E	30.2	31.7	28.8	9.3
Raheny-Foxfield	17.1	21	34.6	27.3
Raheny-Greendale	30.5	25.8	25.9	17.8
Raheny-St. Assams	11	17.6	35.7	35.7
Fingal EDs				
Sutton	20.6	15	35.6	39
Howth	10.4	13.7	30	45.8
Baldoyle	21.6	21	34.9	22.5
TOTAL DNEDTF	**23**	**22.4**	**31.2**	**23.2**
Dublin City	23.6	19.2	25.1	32.1
Dublin City & County	20.4	22.3	29.5	27.7
Ireland	22.2	22.7	29.1	26

Source: Census 2002

The task force catchment area shows a similar rate to the city of those who left school with primary or no formal educational qualification. This rate (23%) is marginally more than the respective county and national total. However, at the ED level there is a good deal of diversity. Some of the EDs reveal rates of those falling into this category at over 30% and in the case of Kilmore B & D, Priorswood B & D, over 40%. This contrasts with measures of less than 15% in EDs such as Clontarf West B, Raheny-St. Assams and Howth.

Looking at those whose education ceased at junior level secondary education only (typically to Intermediate, Group or Junior Certificate levels), the measure for the task force as a whole is similar to the county and national figures but greater than the city measure. Again at ED level, there are differences ranging from 43.6% in Priorswood C to 15% in Sutton. The areas around Kilmore, Priorswood and areas bordering them show a trend that is above each of the catchment, citywide and national averages. This indicates a lower level of educational attainment among residents in these areas in 2002. It is of note also that many of the areas with higher rates of ceasing education on or before the completion of the junior cycle at second level are also those areas with high comparative levels of persons who had no formal educational attainment or completed primary education category only.

Turning to secondary education completion, 31.2% of task force catchment's population has completed their education at this level as of 2002. This is above the measures for both the city and county and also nationally. About half of the EDs were above the task force measure.

Finally, just under a quarter (23.2%) of the catchment resident who finished education did so at third level. This is notably lower than the similar measure for the city, the surrounding county and nationally. However, a number of EDs (Howth, Sutton, Raheny-St. Assams) display proportions of their population whose education cases at third level above both city and national proportions. In a trend seen above, there are also lower proportions attaining third level education in a number of clustered EDs. These areas are Raheny-Greendale (Kilbarrack), all of the Priorswood and Kilmore EDs, Harmonstown, most of the Grange EDs, Edenmore, and Ayrfield. The lowest measures, suggesting educational disadvantage, are to be found in the Priorswood area that encompasses Darndale, Clonshaugh, Bonnybrook and Priorswood.

SOCIAL CLASS

Although social class is a contested issue in terms of where one starts and finishes and its relationship to income and poverty, it does provide a valuable overview of what categories of social class are most evident in the various communities that make up the task force catchment. For the purposes of description, the seven social classes enumerated as part of the Census are collapsed in the table below into:

1. Professional workers, managerial and technical occupations,
2. Non-manual and skilled manual workers and,
3. Semi/unskilled workers and others gainfully occupied such as those who have not been in paid employment or in who live in households where no one is in paid employment.

The proportion of the catchment falling into the professional, managerial and technical occupations, social class 1 and 2, is 29.6. This is similar to the corresponding proportion seen in

Table 3.7: Social class

Electoral Divisions	Prof. workers, Man. & Technical (Soc. Class 1 & 2)	Non-manual & skill manual (Soc. Class 3 & 4)	Semi/ unskilled (Soc. Class 5,6 & 7)
Dublin City EDs			
Ayrfield	24.1	46.6	29.3
Beaumount A	31.8	42.4	25.8
Beaumount B	30.9	37.7	31.4
Beaumount C	29.8	42.3	28
Clontarf East A	39.9	36.1	24.1
Clontarf West A	38	38.8	23.3
Clontarf West B	20.5	38.9	40.7
Edenmore	16.4	36.8	46.8
Grange A	32.1	45.8	25.9
Grange B	21.2	47.1	31.8
Grange C	15	46.4	38.5
Grange D	32	40.8	27.3
Grange E	24.3	41.9	33.8
Harmonstown A	21.9	42.7	35.4
Harmonstown B	23	40.9	36.2
Kilmore A	26.4	41.1	32.5
Kilmore B	8.2	38.2	53.7
Kilmore C	7.4	35.3	57.4
Kilmore D	20.5	42.4	37.2
Priorswood A	16.6	48.7	34.6
Priorswood B	6.7	28.2	64
Priorswood C	5.4	28.6	66
Priorswood D	8.3	35.7	55.9
Priorswood E	17.8	44	38.2
Raheny-Foxfield	38	36.8	25.2
Raheny-Greendale	21.2	36.7	42.1
Raheny-St. Assams	50	31.8	18.2
Fingal EDs			
Sutton	40	44.9	15.1
Howth	57.5	22.3	20.2
Baldoyle	31.8	40.2	28
TOTAL DNEDTF	**29.6**	**38.6**	**40.3**
Dublin City	29.4	30.4	40.2
Dublin City & County	35.7	31.7	32.7
Ireland	31.6	33.7	34.7

Source: Census 2002

Dublin city but is less than Dublin County (35.7) and Ireland (31.6). In a number of EDs, the proportion falling into these social classes is well above the task force average and also therefore city, county and nationally. These include Sutton, Howth, Raheny, Clontarf, and Grange A. This is in keeping with the trend seen above and suggest that these areas are concentrations of those in higher social classes, with less social housing, higher educational attainment etc. In contrast, a number of EDs notably in Kilmore, Priorswood, and Grange C are well below both the Task Force measure and the wider measures. These areas, as seen above, are also those that exhibit lower educational attainment, concentration of lone parents and social housing.

The number of residents in the task force assigned in Census 2002 to social class three and four was 38.6%. This is significantly above the corresponding proportions seen in the Dublin and at national level. 16 of the 30 EDs comprising the Task Force area have over 40% falling into these social classes. Generally, the proportions falling into these social classes – non manual and skilled manual workers – is less varied and more homogenous at the ED level than that elsewhere.

40.3% of the catchment's population are characterised as belonging to social class six and seven. As outlined these classes encompass semi-skilled, unskilled and those without occupation. The 4 out of every 10 score for the catchment is in line with the corresponding figure for the City, but it is someway above that for Dublin County (32.7%) and also the state (34.7%). Thus suggests that there is a large concentration unskilled and low skilled in the population of the catchment. At

the ED level, this is more acute.

Taking the national and countywide proportions, 12 EDs are below these figures and a further ten are marginally above them. Three EDs (Clontarf West B, Edenmore and Raheny-Greendale) reveal a measure of over 40% falling into social classes five to seven, a further three EDs include over 50% in these social classes (Priorswood D, Kilmore B & C) and finally, Priorswood B and C have over 60% of their residents categorised as belonging to social classes five, six and seven.

EMPLOYMENT

Unemployment is less acute in Ireland than it was in past decades. However, along with the other measures noted in this chapter, it still goes some way toward giving a more comprehensive picture of the socio-economic and demographic profile of the catchment.

Overall what is most evident is the rate of employment has increased and the rate of unemployment has decreased over the years. This is keeping with picture elsewhere in the state. The table below illustrates the unemployment rate for the Task Force area and also the labour force participation rate.

The unemployment rate in the Dublin North East Drugs Task Force area was 7.6% in 2002. This is considerably less than the corresponding measure for Dublin City (10.4%) and is less also than that for County Dublin and Ireland. This is due to the large number of EDs which have unemployment rates less than the Task Force average and also therefore county and national rates.

However, as is the case throughout the profile of the catchment, there are a number of EDs with unemployment rates in excess of the both

Table 3.8: Unemployment and Labour Force Participation Rate

Electoral Divisions	Unemployment Rate	Labour Force Participation Rate
Dublin City EDs		
Ayrfield	7.5	65.6
Beaumount A	4.4	50.9
Beaumount B	5	65.6
Beaumount C	6.2	52.5
Clontarf East A	5	48.3
Clontarf West A	5.1	58.3
Clontarf West B	12.2	57.7
Edenmore	14.1	50.5
Grange A	6.3	71.5
Grange B	6.9	67.5
Grange C	11.3	62.9
Grange D	7.6	66.5
Grange E	10.1	61.6
Harmonstown A	7	55
Harmonstown B	10.2	51.8
Kilmore A	8.1	68.2
Kilmore B	16.1	53.6
Kilmore C	19.5	51
Kilmore D	6.7	56.1
Priorswood A	8.4	70.7
Priorswood B	25.4	65.3
Priorswood C	24.9	61.1
Priorswood D	16.5	60.5
Priorswood E	9.5	64.3
Raheny-Foxfield	8.3	57.3
Raheny-Greendale	10.8	56.9
Raheny-St. Assams	5	50.4
Fingal EDs		
Sutton	4.9	49.4
Howth	6.2	49.1
Baldoyle	7.1	50.1
TOTAL DNEDTF	**7.6**	**53.7**
Dublin City	10.4	60.2
Dublin City & County	8.5	61.2
Ireland	8.8	58.3

Source: Census 2002

the Task Force average and those seen in the surrounding city and at national level. The main ones of note are Clontarf West B, Edenmore, Grange C, Kilmore B & C, and Priorswood B, C and D.

The Labour Force Participation Rate (LFP) is the percentage of a population over 15 years who are active in the labour market that is who are at work, seeking a first job or unemployed. For the Task Force, the LFP rate was 53.7 in 2002. This was less than the city, county and national totals. The anomaly in the trend may be accounted for by the fact that a number of EDs have relatively low rates and that many of these are the more affluent areas suggesting an ageing population and higher rates of retirees, high levels of students, and those categorised as working on home duties etc. It is noticeable also that many of the EDs exhibit LFP rates which are considerably higher than the comparative averages. These areas include those that relatively high levels of unemployment, which suggests that such areas may also contain paradoxically high levels of employment also, but in less skilled occupations according to the social class data.

Another helpful tool in understanding the importance of employment in given areas is the economic dependency rate (EDR)[7]. The EDR is the proportion of the population in a given area who are not in the labour force relative to those who are. The implication of the EDR is that those in the labour force and at work are the economic providers for the former groups. As such, the higher the EDR the greater the resource and services needs in such areas for those in the labour force and also social and other service providers.

The table on the right provides the EDR for the

Table 3.9: Economic Dependency Rate

EDs	EDR
Dublin City EDs	
Ayrfield	1.1
Beaumount A	1.3
Beaumount B	0.8
Beaumount C	1.3
Clontarf East A	1.6
Clontarf West A	1.1
Clontarf West B	1.3
Edenmore	1.8
Grange A	1.0
Grange B	1.0
Grange C	1.2
Grange D	1.0
Grange E	1.1
Harmonstown A	1.3
Harmonstown B	1.6
Kilmore A	1.2
Kilmore B	1.8
Kilmore C	2.2
Kilmore D	1.3
Priorswood A	1.0
Priorswood B	2.0
Priorswood C	2.6
Priorswood D	1.5
Priorswood E	1.2
Raheny-Foxfield	1.3
Raheny-Greendale	1.5
Raheny-St. Assams	1.5
Fingal EDs	
Sutton	1.1
Howth	1.2
Baldoyle	1.1
TOTAL DNEDTF	**1.2**
Dublin City	1.2
Dublin City & County	1.2
Ireland	1.4

Source: Census 2002

[7] The EDR is the rations of the inactive population in terms of the labour market (children under 14, unemployed, 1st time job seekers, home duties, retired, students and those unable to work) to those at work.

Table 3.10: Relative deprivation at ED level.

EDs	Relative Deprivation
Ayrfield	Marginally Above Average
Beaumount A	Marginally Above Average
Beaumount B	Marginally Above Average
Beaumount C	Marginally Above Average
Clontarf East A	Marginally Above Average
Clontarf West A	Affluent
Clontarf West B	**Disadvantaged**
Edenmore	**Disadvantaged**
Grange A	Marginally Above Average
Grange B	Marginally Above Average
Grange C	**Disadvantaged**
Grange D	Marginally Above Average
Grange E	Marginally Below Average
Harmonstown A	Marginally Below Average
Harmonstown B	Marginally Below Average
Kilmore A	Marginally Above Average
Kilmore B	**Disadvantaged**
Kilmore C	**Disadvantaged**
Kilmore D	Marginally Below Average
Priorswood A	Marginally Below Average
Priorswood B	**Extremely Disadvantaged**
Priorswood C	**Disadvantaged**
Priorswood D	**Disadvantaged**
Priorswood E	Marginally Below Average
Raheny-Foxfield	Marginally Above Average
Raheny-Greendale	Marginally Below Average
Raheny- St. Assams	Affluent
Sutton	Affluent
Howth	Affluent
Baldoyle	Marginally Above Average

Source: Haase and Pratschke 2005: 36.

Task Force as a whole and also for each of the EDs as well as comparative figures for the City, County and State. The EDR for the Task Force area is 1.2 which is identical to that for the City and County of Dublin. It is less than the national measure (1.4) At the ED level, there is some variance. The measures range from 2.6 in Priorswood C to 0.8 in Beaumount B. The areas with the highest EDR in 2002 were (above 1.6) were Clontarf West A, Edenmore, Harmonstown B, Kilmore B & C, and Priorswood B & C.

DEPRIVATION

Many of the measures have in some way made a contribution to the calculation of derivation. Deprivation has been measured in the last number of Censuses using the Haase index. This brings a number of measures together to develop one measurement of deprivation in given areas whether that is respect to just one ED or collection of EDs making up the catchment of in this case the Task Force. This approach uses similar measures over the course of a range of Censuses so that deprivation can be measured over time and between areas. The underlying dimensions of deprivation such as social class, demographic and labour market deprivation are factored into the score. It is worth noting that measures of deprivation are not as indicative as they once were in light of the overall improvement in the generalised affluence of Irish society over the past decade. Thus, use of relative measures, EDs compared with each other, is a better means to allow deprivation indicators have more descriptive and analytical value. In the table below, outlined is the relative position of each ED in respect of each other. As such the scale for describing each of the EDs range over the following:

- *Very Affluent*
- *Affluent-Marginally Above Average*
- *Marginally Below Average*
- *Disadvantaged*
- *Very Disadvantaged*
- *Extremely Disadvantaged*

This suggests therefore that the area of Darndale, Belcamp and Priorswood are the most deprived in the catchment of the Task Force. These areas are also among some of the most deprived in the state. These therefore require extra and more intensive targeting than other area or at least a different type of approach. Following this, the areas categorised as disadvantaged are:

- *Areas to the east of Malahide road on Collins Avenue;*
- *Edenmore;*
- *Donaghmede;*
- *areas around the Oscar Traynor road and Northside shopping centre in Kilmore and Coolock;*
- *Priorswood and Bonnybrook.*

It is important to note that areas adjacent to these, but in another ED, that are by and large more affluent, may also be considered as an extension of disadvantage. One example here would be Kilbarrack which borders Donaghmede but is in Raheny-Greendale, which as we have seen does exhibit some indicators of significant disadvantage but is also the situation of relative affluence which skews the overall deprivation score for this ED.

As well as these areas, there are a number of affluent areas that are seen in the trends outlined throughout this section. These again may have drug problems but ones that are of a less visible character due to perhaps greater resources and/or clusters of prevalence.

SUMMARY & CONCLUSION

On the whole, the data presented in this chapter suggests that the Dublin north east area, the catchment of the task force, is firstly significant in geographic size and secondly is not homogenous in social and demographic terms. This demonstrates that the area is a mixed one with pockets of disadvantage, normally characterised by social housing, alongside relatively affluent areas. The area goes over local authority administrative borders whereby most of the catchment is in Dublin city, a significant area is also situated in Fingal. The areas where there is a relative concentration of affluence, higher levels of relative educational attainment, private housing, concentrations of social classes one to 4 etc., are obvious (the areas of and adjacent to Raheny, Clontarf, Howth and Sutton) as too are those areas with a concentrations of contrasting area attributes such as social housing, deprivation, low educational attainment, membership of social classes five, six and seven etc (Darndale, Belcamp and Priorswood, areas to the east of Malahide road on Collins Avenue; Edenmore; Donaghmede; Kilmore and Coolock; Bonnybrook.). This is a key feature of the profile of the task force. It is undoubtedly a large geographical area, made up of varied communities and community types; as such this suggests that multiple methods and approaches are required. In other words, one size does not fit all.

chapter 4

prevalence of drug problems in dublin north east

CHAPTER 4
PREVALENCE OF DRUG PROBLEMS IN DUBLIN NORTH EAST

INTRODUCTION

This chapter provides a summary of the main information and data available on the prevalence of drug use and drug related problems in Dublin North East. The understanding of prevalence here is based on that used by the National Advisory Committee on Drugs[8]:
'prevalence is a measure of how many drug users there are in a community…and how they are distributed across the population e.g. by age, gender, geographical location of type of drug use.'

The aim here is provide an overview of the number of drug users and the type of drugs being used in the catchment. However, it is important to outline the limitations of this approach at the outset. As is officially accepted, drug users are often a hidden grouping due to the nature of drug use and the consequences of addiction. In addition, there is no 'census of drug use' and drug users. As such, the ideal way to gather information on drug use in a given geographic area is to conduct a full-scale primary research survey. In view of the problems logistically and in resource terms to carry out such surveys, estimations of prevalence of drugs use in a given area are derived from a number of sources which while individually are partial, collectively provide a best available overview of drug prevalence in the catchment.

The two mains sources of data can be referred to as routine and non-routine data sources (ibid, 2003:4).

Routine Data Sources	*Garda and Justice Data* *Drug Treatment Data* *Drug-related Mortality Data* *Data on Drug-related illness*
Non-routine data sources	*Relevant local surveys* *Focus group/area surveys* *Local network or qualitative information*

For the most part, the research has looked to access, using this model, what data is available with regard to the catchment of the DNEDTF. However, that data is outlined below comes with something of a 'health warning'. The reasons are as follows:

- *What data is available is not specific to the area of the task force. It does not refer to the EDs that comprise the catchment of the TF. It may relate to the operational areas of another entity such as the HSE, Garda district, local authority or be county wide etc.*
- *The data is not necessarily comparative, that is that sources of data may use different definitions and understanding of one drug, addiction, a problem drug user or may have been taken at different times etc.*

Overall what data can be presented is the best statistical picture available on the prevalence of drug use in the catchment. It is for this reason (and for the purposes of getting a qualitative or human and organisational view) that we complement the data presented here with findings from in-depth consultations with stakeholders and drug users.

This chapter is structured as follows: Drug Treatment; Drug Related Deaths; NACD Prevalence Estimate; Local Surveys; and the

[8] Cox, 2003:1

final section of the chapter provides a summary of the findings and draws a number of conclusions.

DRUG TREATMENT

The National Drug Treatment Reporting System (NDTRS) is referred to as an 'epidemiological database' on treated problem drug use in the state. In the NDTRS, treatment is defined as 'any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for tier drug problems' (HRB 2005:5). The NDTRS is comprised of information collected for each person who receives treatment for problem drug use at treatment centres in a given year. This information is compiled at national level by the DMRD of the HRB"[9].

In the NDTRS, drug treatment data is viewed as an indirect indicator of drug misuse as well as a direct indicator of demand for treatment services. This data is used at national and European levels to provide information on the characteristics of clients entering treatment, and on patterns of drug misuse, such as types of drug used and consumption behaviours. In 1996 NDTRS data was used to identify a number of local areas with problematic heroin use[10]. These areas were later designated as Local Drugs Task Force Areas and are continuing to provide strategic responses to drug misuse in their communities[11].

According to the NDTRS, there were 44,767 cases treated in Ireland between 1998 and 2003. The most recent report, 2005, summarising drug prevalence data from 1998 to 2002, has a number of findings about the HSE Northern Area in which DNEDTF is situated.

Each of the figures below related to incidence rates per 100,000 of population aged 15 to 54:

- *There was an increase of 6% of persons treated for drug misuse between 1998 and 2001 and a decrease of 11% in 2002 (617 persons).*
- *The incidence of those treated for problem drug use aged between 15 and 64 almost halved between 1998 and 2002.*
- *The incidence of treated problem drug use in the HSE area across 1998 to 2002 was 103 cases per 100,000.*
- *Between 1998 and 2002, opiates were the most common single drug problem reported by new and previously reported cases. The number reported problems related to cannabis use decreased by 14% of this period in the HSE eastern region. This could be related to under reporting and lack of treatment places for cannabis.*
- *The total number of cases reporting cocaine as their main problem drug increased by 30% between 1998 ad 2002 in the HSE eastern region*
- *In the eastern region, the difference between the numbers reporting cannabis use in the population and numbers seeking treatment for problem cannabis use was greater than that in any other of the seven HSE areas. According to the HRB, 'this indicates that treatment services in this area may need to cater for a number of licit and illicit drugs used rather than focusing on opiate treatment'*

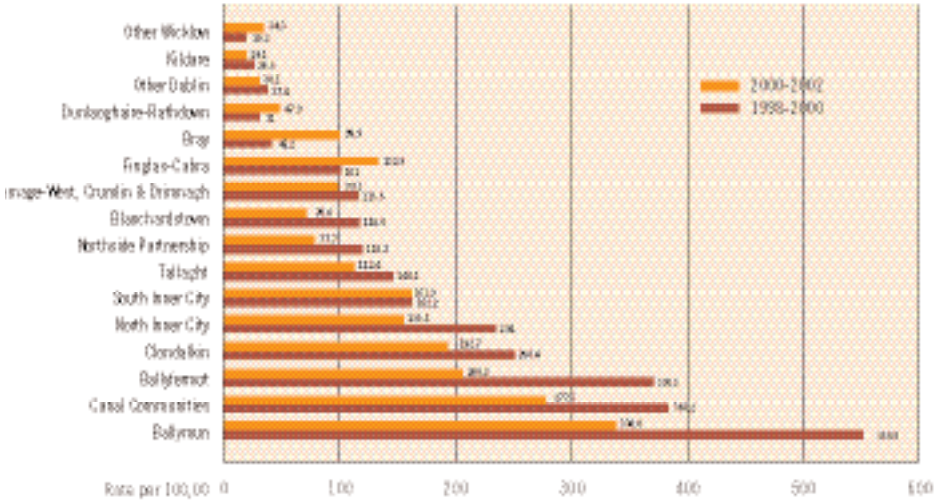
The incidence of treated problem drug use in the 15 to 64 age group for the LDTF areas was calculated in the periods 1998 to 2000, and 2000 to 2002. It increased in three and decreased in 9 of the task force areas over the period.

[9] For the purpose of the NDTRS, Clients who attend needle-exchange services are not included in this reporting system. Up to 2004, clients who reported alcohol as their main problem drug were not included in this reporting system. Treatment options include one or more of the following: medication (detoxification, methadone reduction and substitution programmes), addiction counselling, group therapy, psychotherapy and/or life skills training. Treatment is provided in both residential and non-residential settings. In Ireland, data returns to the NDTRS for clients attending treatment services during 2003 were provided by 187 treatment services: 170 non-residential and 17 residential

[10] Ministerial Task Force, 1996

[11] The monitoring role of the NDTRS is recognised by the Government in its document Building on Experience: National Drugs Strategy 2001–2008. Data collection for the NDTRS is one of the actions identified and agreed by Government for implementation by the former health boards: 'All treatment providers should co-operate in returning information on problem drug use to the DMRD of the HRB (Department of Tourism, Sport and Recreation 2001: 118)

Table 4.1: Incidence of treated drug problem use for persons aged 15-64 in LDTF and non-LDTF areas, 1998 & 2002[12].



Source: Kelly, F. Long, J & Lynn, E. Trends in treated problem drug use in the HSE Eastern Region, 1998-2002: 11.

In the Northside Partnership area, equating in part to the DNEDTF, the rate in the 1998-2000 period was 119.2 and this decreased in the 2000-2002 period to 77.7. In short, this suggests that number presenting for drug treatment is decreasing in the DNEDTF area.

This table also illustrates the comparisons between the Northside Partnership/Task Force area and the other LDTF areas.

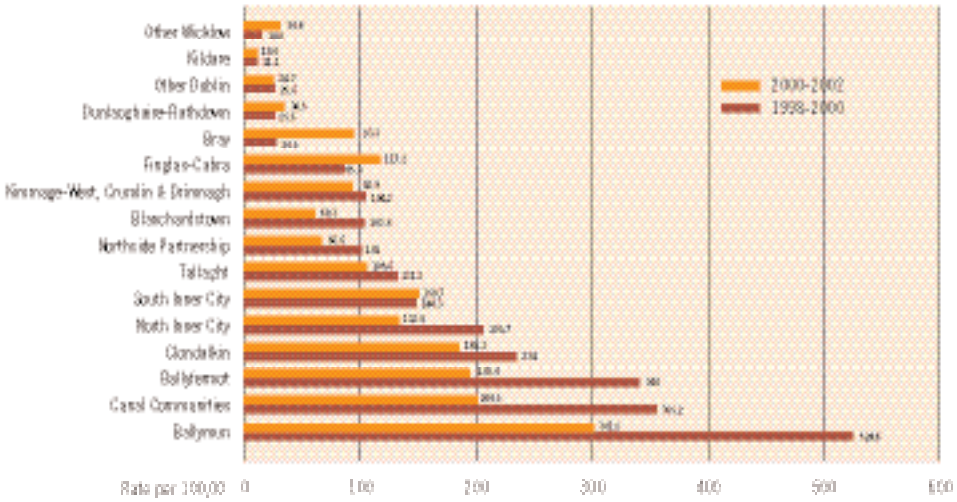
The second table in this section, 4.2, looks at the incidence of treated opiate use among those aged between 15 and 64 over this period in each of the task forces areas. The incidence increased in some of the LTDFs. In the Northside Partnership area, the measure in the 1998-2000 period was 101 and this dropped per 100,000 to 66.6 in the 2000-2002 period. However, it should be noted that given the propensity for drug treatment centres to date - and at that time - to focus on opiate use mainly, it is reasonable to assume the rate of those presenting for other drug problems may not have been recorded.

Table 4.3 on the next page looks at the incidence of treated non opiate use among persons aged 15-64 in the LDTFs over the two periods outlined above. In the catchment of DNEDTF, the incidence decreased from 18.2 to 11.2 per 100,000 persons.

As noted in the previous chapter, due to the heterogeneous social profile of the TF catchment, the comparison with other areas is difficult in respect of the variations therefore in the profile of the respective areas. However, the evidence seems to make clear that opiate use and other drug use which leads to treatment has decreased in recent years. This is perhaps a reflection on the one hand of the existence of treatment centres and on the other that new cases which are not opiate related are not presenting.

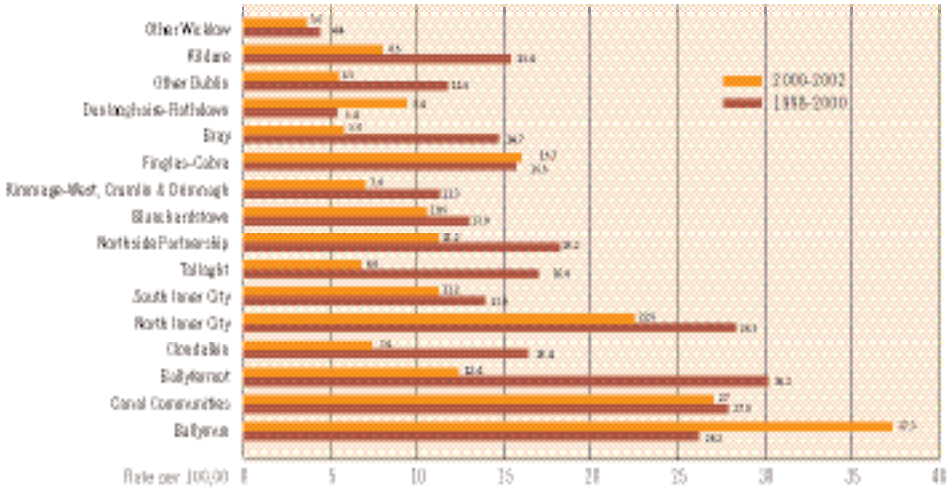
[12]This table is in the context of every 100,000 persons as per Central Statistics Office, 2003

Table 4.2: Incidence of treated OPIATE use for persons aged 15-64 in LDTF and non-LDTF areas, 1998-2000 & 2000-2002



Source: Kelly, f. Long, J & Lynn, E. Trends in treated problem drug use in the HSE Eastern Region, 1998-2002: 10.

Table 4.3: Incidence of treated NON-OPIATE use problem use for persons aged 16-64 in LDTF and non-LDTF areas, 1998 & 2002.



Source: Kelly, f. Long, J & Lynn, E. Trends in treated problem drug use in the HSE Eastern Region, 1998-2002: 12.

It is clear also that one way or the other the prevalence rates in the Northside Partnership/ Dublin North East area remain over twice that seen in areas not designated as a LDTF area.

Looking in more depth at data from the NDTRS for Dublin North East, specific data was provided on trends in treated problem drug use, 1998 to 2003, in the catchment of the DNEDTF.

The following tables are inclusive of new and previously treated cases[13].

According to the NDTRS therefore, there were 2,340 persons treated for drug addiction between 1998 and 2003. Of this number, 21% were new cases or previous treatment was not known.

Table 4.4: Area of residence: Ever previously treated for problem drug use, 1998-2003[14]

ED	Never treated (New cases)	Previously treated	Not known	Total
Ayrfield	20	64	2	86
Beaumont A	1	9	0	10
Beaumont B	16	29	2	47
Beaumont C	4	17	1	22
Clontarf East E	3	4	1	8
Clontarf West A	5	21	1	27
Clontarf West B	12	33	0	45
Edenmore	17	110	5	132
Grange A	16	34	3	53
Grange B	5	10	0	15
Grange C	12	35	2	49
Grange D	14	98	2	114
Grange E	12	38	4	54
Harmonstown A	13	39	1	53
Harmonstown B	7	20	3	30
Kilmore A	7	31	0	38
Kilmore B	14	85	3	102
Kilmore C	16	91	2	109
Kilmore D	8	16	2	26
Priorswood A	13	33	1	47
Priorswood B	61	308	4	373
Priorswood C	34	168	4	206
Priorswood D	40	154	5	199
Priorswood E	16	97	5	118
Raheny-Foxfield	13	73	0	86
Raheny-Greendale	12	104	6	122
Raheny-St Assam	4	8	1	13
Raheny unspecified	9	22	0	31
Dublin 17, Artane unspecified	6	8	0	14
Baldoyle	14	65	1	80
Sutton	7	23	1	31
Total	431	1847	62	2340

[13] The main elements of the reporting system are defined as follows: in the case of the data for 'previously treated cases' there is a possibility of duplication in the database; for example, where a person receives treatment at more than one centre. For those receiving methadone maintenance or detoxification, this possibility is considered to be small since the introduction of the Misuse of Drugs Regulations in 1998, whereby precautions are taken to ensure that methadone treatment is available from one source only.

[14] As is evident from the table, Howth was not included in the NDTRS due to this area not being included in the catchment of the Northside Partnership which is presumed to be an identical catchment to the Dublin North East Drugs Task Force.

What is perhaps most striking about the table is the convergence between areas with a high number of treated persons and the areas indicated in the previous chapter as being disadvantaged or extremely disadvantaged. The areas of note here are Edenmore, Kilmore C & D, and Priorswood B, C & D. It is also evident that areas that contain indicators of disadvantage such as significant number of lone parent households, unemployed, lower social class designations etc, yet which also contain more affluent pockets and as such are not deemed to be disadvantaged on the deprivation scores alone, have high numbers of individuals who presented for addiction treatment. The most obvious ones here are Raheny-Greendale and Grange D both of which comprise parts of Kilbarrack. Again, this is feature of the DNEDTF catchment area.

The following table indicates the type of centre in which individuals in the task force area received treatment over the years 1998 to 2003.

These figures show that there is an under-representation of treatment episodes for GP's[15].

The vast majority of those receiving treatment did so through local health care or social service centres.

Analysis on new cases presenting (table 4.6) for treatment between 1998 and 2003 suggests that there was a peak seeking services in 1999. The numbers have decreased since that year and 2000 and remained static and similar for 2001 through to 2003. A question here seems to be about capacity of services provided and whether these are the numbers the can begin treatment. In relation to the peak years, there is also a question concerning whether this year when most of the treatment services were first available to those residing in the Dublin North East.

Table 4.6: Number of new cases each year

Year	Frequency	%
1998	85	19.7
1999	122	28.3
2000	70	16.2
2001	53	12.3
2002	48	11.1
2003	53	12.3
Total	**431**	

Table 4.5: Type of centre & year treated

Type of Centre	1998	1999	2000	2001	2002	2003	Total	%
Hospital inpatient unit	3	8	5	0	0	0	16	< 1
Therapeutic community	36	22	7	11	6	16	98	4
Other specialised residential treatment centre	5	5	9	15	15	12	61	3
Day centre or day hospital	2	1	2	0	0	0	5	< 1
Local health care/ social service centre	310	344	330	344	341	379	2048	88
Low threshold/drop in/s street Agency/mobile clinic	0	3	2	1	2	2	10	< 1
Other specialised non residential centre	6	11	9	18	17	16	77	4
General practitioner	0	15	2	1	4	1	23	1
Drug treatment in Prison	1	1	0	0	0	0	2	< 1
Total	**363**	**410**	**366**	**390**	**385**	**426**	**2340**	

[15] The NDTRS are currently collecting data from 2001-2004 on persons treated by GP's for drug misuse.

The table below indicates the type of centres in which new cases of those with drug problems sought treatment. This again emphasis the predominance of local health and social service centres as the main centre for treatment. There is however some notable increase in those presenting to therapeutic communities and to a lesser extent other specialised not residential centres.

Table 4.7: Type of centre where new cases sought treatment

	Frequency	Percent
Therapeutic community	42	9.7
Other specialised residential treatment centres	25	5.8
Day centre or day hospital	4	.9
Local health care/ social service centre	319	74.0
Low threshold/drop in/ street Agency/mobile clinic	6	1.4
Other specialised non residential centre	34	7.9
General practitioner	1	.2
Total	431	100

Of the new cases, 70% were male which is in keeping with earlier findings. There was no discernible trend of a larger proportion of females presenting for drug treatment over the 1998-2003 periods.

In the table below, the age range of those presenting for treatment between 1998 and 2003 is presented. This suggests that the majority of those presenting are in the 20 to 29 age range (56%). The next largest proportion (30%) is the 10 to 19 age range and almost 14% present for treatment who are over 30 years but under 40. From this, it is reasonable to assume – in keeping with earlier data trends presented in the report – that those aged between 16 and 29 are those most likely to present for treatment. This relates in the main to opiate addiction.

Table 4.8: Age range of those presenting for treatment

Age Range	Total (5)	Percent
10-19	128	30
20-29	241	56
30-39	58	13.5
40+	3	< 1
Not known	1	< 1
Total	**431**	**100**

Table 4.9 demonstrates that majority of those that presented for treatment in the Task Force area were unemployed. The employment status of the next biggest proportion, one quarter, was 'in employment'. The emphasis on unemployment is interesting and seems to be in keeping with the characteristics of those with drug problems and the areas where they are most prevalent within the catchment. The fact that one quarter are in employment is also an interesting finding.

Table 4.9: Employment status

Employment Status	Total	Percent
In paid employment	109	25.3
Unemployed	236	54.8
FAS or other training course	17	3.9
Student	46	10.7
Housewife or husband	5	1
Retired or unable to Work	3	<1
Other	3	<1
Not known	12	2.8
Total	**431**	**100**

The table below provides a breakdown of the highest level of education reached by those presenting for treatment (new cases). The vast majority ceased their education at second level. One in ten were still in full time education while

less than 2% had gone to third level education. Looking at some of this data in more detail suggests that 43% of those in treatment completed their education at age 15. At 16 this proportion rises to 61%. This implies that the lions share of those who are in treatment left full time education early.

Table 4.10: Education, highest level reached

Level of cessation of education	Total	%
Primary level	31	7
Secondary level	311	72.2
Third level	8	1.9
Never went to school	1	<1
Still in fulltime education	< 46	10.7
Not known	34	7.8
Total	431	100

4.11: Source of referral

Source	Total	%
Self	109	25.3
Family & friends	106	24.6
Other drug treatment centre	42	9.7
General practitioner	42	9.7
Hospital/medical agency	20	4.6
Social services	18	4.2
Court/ probation/police	28	6.5
Other	55	12.8
Not known	11	2.6
Total	431	100

Of this group of clients, the NDTRS data suggest that about half were referred to the treatment centre through the individual problem user or their family/friends. The importance of regular social relationships in accessing services would seem therefore to be an important conduit of referral. This emphasises the importance in the majority of cases of dissemination of information on treatment and other drug related supports both generally as well as in a targeted way. In contrast, about one in ten of clients of drug treatment services were referred by a GP or other treatment centre.

The main other findings arising out of the NDTRS with respect to Dublin North East Drugs Task Force was the following:

- Of those that presented to treatment centres, 80% had a problem related to opiate use and 12.5% were in treatment for cannabis use. This suggests that these are the two main problem drugs in the area, however it is also a reflection of the nature of the services and type of drug and drug user profile that they cater for.
- Of the total number of new cases presenting for treatment over the time period, 66% suggested that they were polydrug users. The main subsequent drugs (second, third and fourth drugs) used by those presenting for treatment between 1998 and 2003 were as follows: cannabis (35%), benzodiazepine (19%), cocaine (13%), ecstasy (13%) and opiates (10%). 48% of those who have used drugs injected. Thus a majority did not use drugs intravenously.
- The following is the type of treatments (and possibly more than one simultaneously) that client presenting for treatment first availed of:
- 22% of those who present for drug treatment over this time period availed of detoxification/short term reduction.
- 39% of those availing of a treatment for this

90% of those who died of drug related deaths between 1998 and 2001 resided in LDTF areas

availed of long term substitution/ maintenance treatment such as methadone.

- 7% availed of psycho social therapies and medicament free.
- 58% undertook advice, counselling and related types of support.
- 2% took part in activities focusing on social integration.

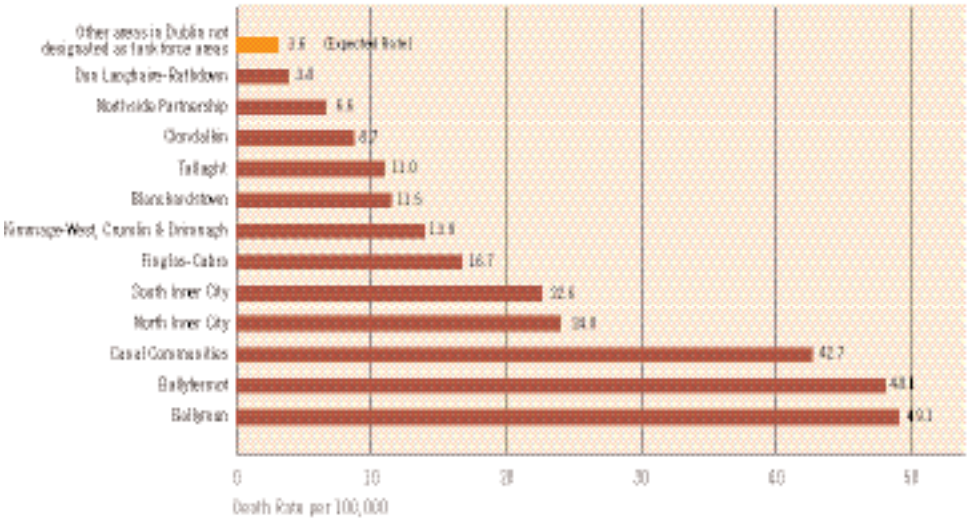
DRUG RELATED DEATHS

This information is provided by the Drug Misuse Research Division (DMRD) of the HRB[16]. It is gathered from the General Mortality Register and studies that took data from the records of the Coroner, Central Drug Treatment List, the Aids Surveillance System and from epidemic research. The overall findings are based on data relating to the period between 1990 and 2002. The general trend suggests a rise in drug related deaths in Dublin between 1995 and 2000 compared to the 1991 to 1994 period[17].

Between 1998 and 2001, the Dublin city and county coroners' office investigates 332 opiate-related deaths. (Indirect deaths from drug use are not therefore recorded) The analysis of this data reveals that 65% of those who died were between the age of 15 and 34, and 87% were male. Half of those that died did so in their homes, 16% in public spaces, 13% died in prison or soon after their release.

Of note here, 90% of those that died resided in LDTF areas. The incidence (rate per 1000 15-64 yr olds population based on Census 2002) of drug related death was explored for each of the task forces. The incidence in the Dublin area not covered by LDTFs was 3.1. The lowest rated for LDTF areas was seen in Dun Laoghaire at 3.8 and the highest in Ballymun at 49.1. As can be seen the areas referred to as the Northside Partnership area has an incidence rate of 6.6 which is the second lowest among the TFs. This is not surprising given the relatively mixed housing tenure in the catchment and its

4.12: Drug related deaths in LDTF and non-LDTF designated areas in Dublin.

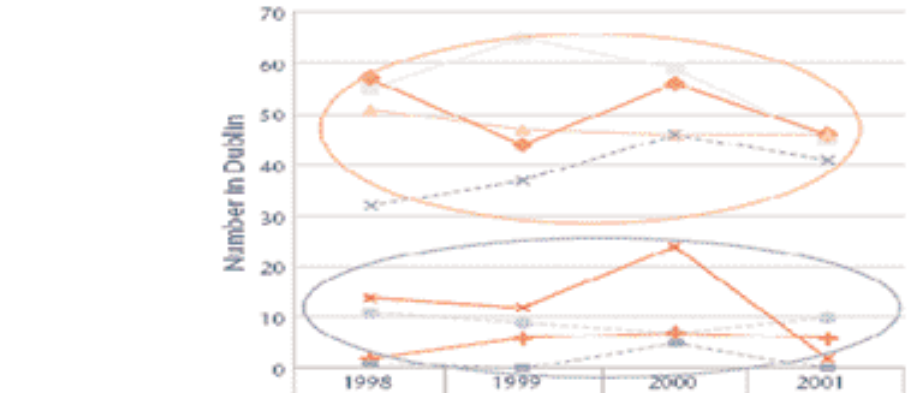


Source: Long J, Lynn E and Keating J (2005:43) Drug-related deaths in Ireland, 1990-2002. Overview 1. Dublin: Health Research Board.

[16] Long et al, 2005

[17] On the general Mortality register from the Coroner's records, only direct deaths resulting from drug use are systematically recorded

4.13: Drugs present in drug related deaths.



	1998	1999	2000	2001
Heroin	57	44	56	48
Benzodiazepines	55	65	59	45
Methadone	51	47	46	46
Alcohol	32	37	46	41
Cannabis	14	12	24	0
Antidepressants	11	9	7	10
Cocaine	2	6	7	6
Ecstasy	1	0	5	2

Source: Ibid 2005:44.

relationship to opiate use etc. The rate is however twice that of areas with no LTDF.

This source also looked at what drugs were present in opiate related deaths (see below). This analysis of this data by Byrne (2001) suggested that two thirds of opiate users who died tested positive for three or more drugs, while only 11% tested positive for one. This seems to underline polydrug use. This also seems to show the relationship between drugs such as heroin, benzodiazepine, methadone and to a certain extent alcohol also.

NACD PREVALENCE ESTIMATES 2001

The figures were supplied to DNEDTF by the NACD in April 2006. The data is based on the two source Capture Recapture Methodology Study[18]. This study collected data in 2000 and 2001 on those seeking treatment for opiate use from the following sources[19]:

- *Garda Study on Drugs, Crime and Related Criminal Activity*
- *Central Drug Treatment List*

This study also notes that there were discrepancies between the LDTFs view of their catchments and that of the Department of Community, Rural and Gaeltacht affairs. The document states that 'it was agreed between the NACD and the Department of Community, Rural and Gaeltacht Affairs that the Partnership boundaries comprising the Area Partnerships be used to denote the LDTF boundary as this was the intention set out in the First Ministerial Report on Measures to Reduce

[18] Kelly et al, 2003

[19] Hospital In-Patient Enquiry (HIPE) is a part of the overall methodology but data is not available on the ED in which patients reside

In 2001 there remained significant numbers in the 15-24 age range

the Demand for Drugs in 1996.

Thus the figures below do not include parts of the Fingal administrative area, namely the EDs of Baldoyle, Sutton and Howth which are operationally part of the catchment of the DNEDTF. In addition, the population refers to Census 1996.

The breakdown from this study of prevalence for the Northside Partnership catchment is as follows:

4.14: NACD drug prevalence estimates for TF catchment.

Sex	Age	Prevalence	Population	Rate/1000
F	15-24	68	8,450	8
F	25-34	99	8,408	11.8
F	35-64	12	18,464	0.6
M	15-24	168	8,724	19.3
M	25-34	306	8,078	37.9
M	35-64	64	16,503	3.9
TOTAL	**15-64**	**731**	**68627**	**10.6**

This suggests, given the limitations of the data, that those in the 25-34 age range in 2001 were those seeking treatment. Although the figures are made up overwhelmingly of males, the numbers of females included is still significant. The numbers over 35 demonstrates that the opiate phenomenon is something that has happened in the last two generations paralleling the 1980s and 1990s. However, in 2001 there remained significant numbers in the 15-24 age range.

Notwithstanding this, the prevalence rates refer to a very wide catchment and one that is not as concentrated in terms of social housing and disadvantage as some of the other task forces. It may the case for instance, and which seems reasonable, that the rates for distinct areas within the catchment taken alone may be much higher and may thus be in keeping with some of the other LDTFs with similar socio-economic profiles to these distinct areas. As noted earlier, it also calls into question the numbers of those who have drug problems and who have not presented for treatment.
The trends for the other task forces areas were as follows:

4.15: NACD drug prevalence estimates for all TFs

LDTF 2001	Prevalence	Population	Rate/1000
Ballyfermot	810	13417	60.4
Ballymun	723	9841	73.5
Blanchardstown	416	34858	11.9
Bray	209	20113	10.4
Canal Comms.	376	8648	43.5
Clondalkin	1012	49308	20.5
Dublin 12	656	338040	17.2
Dun Laoghaire/Rathdown	706	130,854	5.4
Finglas-Cabra	653	36131	18.1
North Inner City	1530	39979	38.3
South Inner City	1297	41584	31.2
Tallaght	1244	53662	23.2

GARDA STATISTICS

In the earlier chapters, national Garda statistics were reported in respect of drug offences. In this chapter, statistics relating to Dublin North East are assessed. In the main, the statistics related to the Northern Division of the Dublin Metropolitan Region of the Garda Síochána. This is the smallest unit for which detailed data is available. This region contains the catchment of DNEDTF but is somewhat larger. The Garda districts in the Northern Division are: Ballymun, Clontarf, Coolock, Dublin Airport, Howth, Malahide, Raheny, Santry, Swords and Whitehall. The station districts that cover part of the catchment of the task force are Clontarf, Coolock, Howth and Raheny. As such, the data

4.16: Garda Statistics on Drug Offences (no. & %) for Northern Division of Dublin Metropolitan Region.

Drug Offence	1999		2000		2001		2002		2003		2004		2005	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Cannabis	349	43%	456	58%	622	61%	449	66%	293	58%	346	66%	674	65%
Heroin	247	30%	184	23%	166	16%	90	13%	43	9%	57	11%	104	10%
LSD	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%	2	<1%
Ecstasy	61	7%	102	13%	156	15%	46	7%	36	7%	19	4%	24	2%
Amphetamine	27	3%	23	3%	11	1%	8	1%	6	1%	2	<1%	7	<1%
Cocaine	25	3%	22	3%	64	6%	89	13%	101	20%	100	19%	210	20%
Other	105	14%	0	0%	6	1%	2	<1%	26	5%	2	<1%	18	2%
Total	814		787		1025		684		505		526		1039	

Source: Garda Síochána Annual Reports, 1999-2005.

presented may not relate to the task force alone, it does however (in view of the relationship between drug problems and its supply between conterminous task force areas) give some idea of the trends in the supply and detection of drugs at local level.

This data has mixed news. It suggests that drug offences dipped in the early years of this millennium but have resurged in 2005. Heroin has decreased and stabilised over the 1999 to 2005 period. Ecstasy and other dance culture oriented drugs have nearly disappeared in drug offence terms. Cannabis remains the most significant drug in terms of offences. This has increase to some 65% of offences in 2005 encompassing 674 offences in the Dublin North Garda Division. The starkest trend is the manifold increase in cocaine, both in the number of offences and its proportion of all offences. This increased each year up to 2003 to 20% of all offences from just 3% in 1999. This is a six fold increase over this time period and underlines the prevalence of cocaine and justifies anecdotal evidence.

LOCAL SURVEYS

Under the grant programme for community and voluntary sector groups provided by the NACD, Kilbarrack Coast Community Project undertook a sizeable research process into their local area[20]. The Kilbarrack area is situated in the Task Force catchment the project has been mainstreamed from its origination under the Task Force by the HSE in 2001.

The survey is the most in-depth of its kind available and gives a good insight into some trends of drugs use and knowledge among young people. This is not to say that the study is applicable elsewhere in the catchment, its does however provide a frame with which to make judgements about trends in other areas of the catchment.

The survey sampled young people who were attending and had left school in the Kilbarrack area. The research also conducted interviews with a range of stakeholders. The area is comprised of both local authority and private housing. The area comprises a mix of pockets of

[20]Farrington et al, 2004

significant disadvantage alongside relative affluence. 285 young people were interviewed, 36% were aged between 10 and 12, 38% between 13 and 15, and 26% between 16 and 18 years of age.

The main findings of this survey were as follows:

- *Alcohol was the main drug used with over 75% of the respondents citing this. Over half of the young people were current users of alcohol.*
- *Cannabis was the most widely used illicit drug. Over 20% of the young people stated they were current cannabis users. Over 40% of young people had used cannabis at some point. Cannabis was given to young people the first time by friends in three quarters of cases.*
- *16% of young people surveyed had used inhalants. 4% of young people described themselves as current users.*
- *6% of young people had used cocaine. This figure rises to 18.3% in the 16-18 year age group. One quarter of males in this age group had used Cocaine. Most of those that had used cocaine, nearly 77% had used on less than five occasions.*
- *Less than one percent of those interviewed had used heroin.*
- *LSD, amphetamine and 'magic mushrooms' were not widely used by young people.*
- *4% of young people reported ever using ecstasy*

This research suggests that prevalence increases with age with alcohol (84%) and cannabis (43%) being particularly stark findings in the 16 to 18 year age group. The research also suggests that young people who have left school are more likely to be current users of cannabis, cocaine and ecstasy.

The important point about these findings as stated is they give a good systematic view of one area and allow us to make certain judgements about risks in other areas as a means of undertaking work at prevention and support/networking levels.

SUMMARY & CONCLUSION

This chapter has presented a range of data on the prevalence of drug use in and around the Dublin North East area. At the outset, what is evident is that although this data is important in its own right, it is hard to place it in a systematic and comparative context. This is because of overall deficiencies with the data, what it relates to, when it is collected, what areas each source covers, which drugs are included etc. Indeed, the main deficiency is that much of the data seems to refer to past assessments.

That aside the research used a number of different sources of data that shed light on the prevalence of drug use in Dublin North East. The main findings are:

- At the outset, HSE data reported in 2005 for the north Dublin city and county area indicates a decrease in the numbers presenting for drug misuse treatment. The most common drug involved in addiction of those presenting were opiates. Notwithstanding this, the total number of cases reporting cocaine as their main problem drug increased by 30% between 1998 and 2002. The number reporting cannabis use as a problem and the number presenting for treatment for cannabis use was significant.

This may imply that drug treatment services may need to respond to a wider range of substances in addition to their present focus on opiate treatment solely.

- According to the NDTRS, and in keeping with the overall data above, the incidence of treated drug problems in the Northside Partnership area decreased from 119.2 per 100,000 in 2000 to 77.7 in 2002. Most of those presenting for treatment among these numbers were doing so in respect of opiate use (101 per 100,000 in 2000 and 66.6 in 2002). The corresponding incidence for non opiate treated drugs was 18.2 and 11.2.

- The NDTRS reports that there were 2340 persons treated for drug addiction between 1998 and 2003 in Dublin North East. Of this number, 21% were new previously untreated cases. In terms of sub catchment EDs, the areas with some of the highest numbers of those presenting were in Edenmore, Kilmore C &D, and Priorswood B, C and & D. These areas are those that are also the most deprived. It is evident that areas with high indicators of social deprivation in tandem with relative affluence, also record high numbers presenting for drug treatment. This underlines the need to be cautious in targeting responses and interventions and also casting a wide net in terms of supports.

- A large majority (88%) of those presenting for treatment did so at local health and social service centres. Up to 2003, less than 1% of those presenting did so at their GPs.

- The majority of those presenting as new cases over the 1998 to 2003 period are in the 20 to 29 age range (56%). The next largest proportion is 30% and this is the 10 to 19 age range and almost 14% present for treatment that are between 30 and 40. Thus, those aged between 16 and 29 are those most likely to present for treatment. This relates of course in the main to opiate addiction. The majority of those that presented for treatment in the Task Force area, over half, were unemployed. The employment status of the next biggest proportion, one quarter, was 'in employment'. 61% of the presenting had ceased full time education at 16 years of age while just 2% had gone to third level education.

- Half of those presenting for treatment learnt of the centres through family and friends. This emphasises the importance in the majority of cases for the dissemination of information on treatment and other drug related supports generally as well as in a targeted way. The importance of regular social relationships in accessing services would seem therefore to be an important conduit of referral. IN contrast, about one in ten of clients of drug treatment services were referred by a GP or other treatment centre.

- Of those that presented to treatment centres, 80% had a problem related to opiate use and 12.5% were in treatment for cannabis use. This suggests that these are the two main problem drugs in the area, however, as noted above, this is also a reflection of the nature of the services and type of drug and drug user profile that they cater for. It does not tell us the extent of latent problem drug use particularly in respect of cocaine and alcohol which is on the increase in prevalence terms as we have seen.

- 66% of those presenting for treatment suggested that they were polydrug users. The main subsequent drugs used were: cannabis (35%), benzodiazepine (19%), cocaine (13%), ecstasy (13%) and opiates (10%).

- The drugs related death incidence rate in the TF area is 6.6 per 1,000 15-64 year olds. This rate is twice that of areas with not-designated as LDTF one. The analysis of drugs related deaths suggested shows that two thirds of opiate users who died also tested positive for three or more drugs, while only 11% tested positive for one. This once more underlines the reality of polydrug use and the relationship between drugs such as heroin, benzodiazepine, methadone and to a certain extent alcohol also.

- NACD drug prevalence estimate from 2001 for the Northside Partnership area/DNEDTF is 731. This is a rate per 1000 of 10.6. Individuals in the 25-34 age range were those with drug problems. The numbers overall demonstrates that the opiate phenomenon is something that has happened in the last two generations paralleling the 1980s and 1990s. However, in 2001 there remained significant numbers in the 15-24 age range. However, the overall rates refer to a very wide catchment and one that is not as concentrated in terms of social housing and disadvantage as some of the other task forces. It may the case for instance that the rates for distinct areas taken alone may be much higher and in keeping with some of the other LDTFs with similar socio-economic profiles to these areas. As noted earlier, it also calls into questions, what are the numbers of those who have drug problems and who have not presented for treatment.

- The Garda statistics reveal some interesting and worrying trends. These suggest that drug offences dipped in the early years of this millennium but have resurged in 2005. Heroin has decreased and stabilised over the 1999 to 2005 period. Ecstasy and other dance culture oriented drugs have nearly disappeared in drug offence terms. Cannabis remains the most significant drug in terms of offences. This has increase to some 65% of all offences in 2005 encompassing 674 offences in the Dublin North Garda Division. The starkest trend is the manifold increase in cocaine, both in the number of offences and its proportion of all offences. This increased each year up to 2003 to 20% of all offences from just 3% in 1999. This is a six fold increase over this time period and underlines the prevalence of cocaine and justifies anecdotal evidence.

- The NACD funded Kilbarrack Coast Community Project research is of value in that it gives a frame to understand teenager's view and experiences of drugs. This research suggests that prevalence increases with age with alcohol (84%) and cannabis (43%) being particularly stark findings in the 16 to 18 year age group. The research also suggests that young people who have left school are more likely to be current users of cannabis, cocaine and ecstasy.

chapter 5

consultations with task force stakeholders & funded projects

CHAPTER 5

CONSULTATIONS WITH TASK FORCE STAKEHOLDERS & FUNDED PROJECTS

INTRODUCTION

This section of the report looks at the views, insights and experiences of a range of stakeholders on the main themes of the research. The emphasis of the chapter is therefore on the perceptions of key stakeholders (statutory and voluntary) in respect of needs, gaps, activities etc, of DNEDTF and also in respect of drug problems in Dublin North East.

The chapter is broken down into a number of sections that by and large keep with the theme of each of the questions asked in the interviews or consultation. In all, some 32 interviews took place during this part of the research.

The main sections of the chapter are as follows:

- Profile of Respondents
- Perspective on/role in DNEDTF
- Extent of drug use
- Impact of TF/its projects in responding to drug problems
- Meeting local needs
- Gaps in services/approach
- Responding to gaps
- Services/policies/activities to be put in place
- Structures/information & Co-ordination
- Key learning
- Criteria for projects
- Suggestions on Strategy
- Mainstreaming
- Emerging priority issues
- Future organisation and implementation

The chapter closes with a summary of the main findings.

PROFILE OF RESPONDENTS

The purpose of this question was to develop a profile of, and/or type of activities that the interviewed groups were engaged in.

The groups/stakeholders consulted can be categorised into the following:

- DNEDTF staff
- National Drugs Strategy Team
- Community based interim project
- Community based Mainstream funded project
- Youth project/group
- Local development organisation
- Elected representative
- TF board members
- Statutory agencies
- Local services providers
- Community and voluntary groups

Although this is by no means a definitive range of the various community based groups and other services in the Dublin North East area, the groups consulted represent a wide range of communities, interests and services that are involved in drug issues and work at the local level[21].

PERSPECTIVE/ROLE IN DNEDTF

In order to draw out the context of the interviewees, each were asked to outline what perspective they brought to DNEDTF or in respect of the wider drug problems in the catchment.

The main perspectives noted are best depicted around the following concepts:

Community

This included both community development perspectives and bringing information from within the communities in the catchment to the task force. In other words, both representatives in local communities who experience and live

[21] It should be noted that some of the organisations and personnel interviewed would fall into a number of categories above, one example is that of state agencies that might also be a TF board member.

Statutory services and organisations play an important part in the TF.

with drug problems and their implications as well as those in involved in community development work in local communities are included here. These perspectives included talking about the changing nature of drug problems in communities, related issues such as crime and the local drug economy. The role of the community perspective was to bring this vital and 'lived' experience to the centre of the deliberations of the task force.

Family

The perspectives noted here are twofold, the first was from an individual view and the second from a service viewpoint, both focusing on families of those with or at risk of drug problems. Under this heading, the respondents referred to supporting families through counselling, home help, group work etc. It is also referred to working with those with drug problems in the context of the family and communities they live in and the wider interaction with the consequences of drug use. The family support view can also be taken to include prevention and harm reduction efforts.

Social inclusion

This perspective saw drug problems as an issue which is interlinked with wider issues of social exclusion and socio-economic disadvantage. This view suggests that social inclusion efforts would also have some impact on countering problem drug use. Of course, it follows that the opposite relationship, drug work leading toward inclusion, also holds true in this logic.

Projects

Some of those contributing to the feedback in this section saw themselves as representing the view of the existing mainstream and interim projects initiated or overseen by the task force.

Policy

A number of stakeholders saw their perspective policy terms. These including some area based groups and also some representatives of larger, and in some cases statutory, bodies. The policy perspective encompasses learning and having a focus on what the work of the TF means relative to existing and future policy. It is also seen as giving the TF a remit as a local policy maker for interventions in communities. This is conceived as setting down key aims and principles, based on needs analysis, to respond to these problems. These principles etc., would then inform the work that was carried out at the local level.

Elected Representatives

This perspective brings a representative democratic voice to the TF in addition to the participative one reflected by the community perspective noted above.

Supply & Control

One view represented is that of examining and responding to the physical availability of drugs and their circulation. This is a legal role in terms the control of the illicit supply of drugs.

Housing & Accommodation

This is wide standpoint which is concerned with housing and accommodation for families and individuals affected by problem drug use. It also takes into consideration anti social behaviour and its affect on housing areas in respect of the supply and preparation of drugs and the use of accommodation for this purpose.

State Services

Statutory services and organisations play an important part in the TF. This point of view not only emphasised how a state agency might participate and therefore endorse the work of the TF, but also how it could contribute to these

activities and also make suggestions to the TF and the parent agency in order to better respond to drug problems in a more integrated and cohesive way.

Young People
The representation of the views, experiences of, and work with young people was another prominent viewpoint which some brought to the task force.

Organisation
The organisational view is one which takes in the overall management and running of the TF internally and by implication, how this feeds and informs the external work of the TF. This included the executive and board activities of the TF represented by its coordinator, staff and chairperson.

Customer/Client
Finally, throughout the responses, the importance of responding to the real and complex needs of drug users was highlighted. These emphasise the importance of the client led rather than a service led perspective.

EXTENT OF DRUG PROBLEMS IN DUBLIN NORTH EAST

In Chapter 4, the systematic evidence on the extent of drug use in the Dublin North East area was explored. This suggested an increase in Cocaine use and some stabilisation in Heroin. In this chapter, it was noted there that much of the information about the actual extent of drug use was - in the absence of full Census like research, which is unlikely – limited, partial and inconsistent in purely statistical terms. It is therefore hard to come to a definitive measure of the extent of drug use with any certainty. The information simply put is not available to come

there is as yet no community based systematic response to newer drugs

to such a conclusion. In the absence of such data, the best model at the local level to get a sense of the extent of drug problems is to balance what systematic data is available with anecdotal information from reliable sources in the various communities as well as relevant service providers.

Thus, each of the stakeholders was asked to outline what, from their experience, is the extent of drug use in the catchment[22].

The responses were varied, as one would expect. They emphasised different quantifications of the problem emphasised different groups, different areas and different drugs. However, the general consensus was that the prevalence of drug use, problematic or not, remained significant in the catchment. It was variably described as 'rampant', 'serious', and generally no better than in the past. However, the key point emerging here is that the problem is not necessarily worse, but has changed and widened from what was been seen before. From the feedback, its seem reasonable to conclude that the extent of drug use and related problems has exacerbated in the context that there is no as yet community based systematic response to newer drugs, much of it is going unseen, and new users whose characteristics are not the same as in the past. This at the outset is the immediate challenge for the TF.

The main drugs noted are heroin, cocaine, alcohol, cannabis, and benzodiazepines. The responses demonstrate that polydrug use is commonplace. The prevalence of cocaine was noted in particular. In this respect, recreational

[22]Drug users are asked the same question in the following chapter.

cocaine use is seen to be widespread. To many, its use was similar in acceptance to the use (misuse) of alcohol. The use of the two drugs simultaneously was also noted. The very widespread use of alcohol among all age groups, including large numbers of those under 18, was also prominent in the responses.

In response to the questions of which areas in the catchment had the highest prevalence of drug problems, there were three main categories of answers. The first was to suggest distinct areas: those noted are Darndale, Coolock, Priorswood, Howth, Baldoyle, Edenmore, Bayside, Kilbarrack and Donaghmede. The second type of response emphasised the type of housing tenure, social housing (low income) areas were generally seen as the areas with the highest prevalence in the experiences of the stakeholders. The third set of responses highlighted location-related rationale and specific locations. Included here were the following:

- shopping centres
- open spaces
- areas with no drug projects or services (Howth, Baldoyle, Donaghmede, Artane and Bayside)
- train stations
- derelict buildings
- along bus routes, notably the 17A
- problems were more visible in social housing than in private housing areas, however, in latter areas the problem exists but is hidden
- finally, there was the view that the type of drug indicated different areas. In this sense, drug problems were prevalent throughout the catchment.

What is probably likely is that there is a degree of truth and value in each of the three categories. Taken together therefore they are probably an accurate description of the geographic prevalence of drug use in Dublin North East and are generally supported by earlier quantitative evidence.

TRENDS IN PROBLEM DRUG USE

Following the discussion of what stakeholders saw as the prevalence of drug problems, this was followed by discussions around what trends are evident. The importance of this is that it gives as insight into details about what responses are required going forward.

The responses here were substantial and merited a dedicated section in the findings report.

What is particularly striking about the responses is the close and overlapping relationship between many of the trends. This underlines the complex and socialised nature of drug use in the areas.

The trends can best be explained in terms of the range of themes or elements they can be clustered under. They are in no order of importance or prevalence:

Drug Types

Although heroin use is still prevalent, the belief expressed is that as a problem it is stable and there is some supports in place (although this is only the case in some communities) However, the drugs mentioned as being most prevalent, on the illicit side, are cocaine and, on the legal side, Alcohol. These were mentioned repeatedly throughout the research. The cocaine problem is also a clear trend throughout the responses here. The nature of the Cocaine problem and its illicit dealing supply, debt implications has worryingly prompted some respondents to draw parallels between this and the early signs

of the ensuing heroin problem some years back.

Normalisation

From the responses, a clear finding is that use of cannabis and to a slightly lesser extent, cocaine has become normalised. Cannabis is very widely used and by numbers much greater than those that use stronger drugs such as cocaine. Some of those consulted felt that a higher number of young people may consume cannabis than alcohol. For those that use cocaine, it is again considered normal, socially acceptable and recreational. In this sense, cocaine use as a recreational drug has parallels with how wider society might view the consumption of alcohol. This is of course not the case for everyone. It is however the way these drugs are used and viewed by those who take them regularly. The fact that use of these drugs is not as visible and in the case of cocaine, not as quick to lead to obvious signs of deterioration in the person in a manner seen with heroin, all add to 'recreational' use of these drugs. The challenge this poses is that many users may not see these drugs as dangerous, addictive etc. In other words, they are part of normal social practices for those concerned and do not in the short term lead necessarily to problems in social or working life for users.

Polydrug Use

As touched on earlier, the feedback makes clear that polydrug use is the norm as opposed to the exception. The drugs noted include alcohol, cannabis, cocaine, heroin, benzodiazepines, Ecstasy, and amphetamines. There was more limited mention of meth-amphetamine or 'crystal-meth' and 'crack cocaine'. Once more, the presence of alcohol, cannabis and cocaine were also considered to be 'normal' by those who use these drugs. The most common combinations of drugs suggested in the responses, and depending on the person, are as follows:

alcohol & cannabis
alcohol, cannabis & cocaine
alcohol & cocaine (with some consumption of Cannabis)
ecstasy & cocaine (with some consumption of Alcohol and Cannabis)
cocaine & Heroin (with some consumption of Alcohol and Cannabis)
heroin & Benzodiazepine (with some consumption of Alcohol and Cannabis)

It was also pointed out that those in methadone treatment may also consume cannabis, cocaine, heroin and benzodiazepine.

Shared knowledge & Beliefs

Related to the points made above there are a number of common, or shared beliefs prevalent in communities. This information can be 'accepted' knowledge among young people and those in their twenties, in certain areas and within particular groups etc. The main point is that much of the information has no basis in fact and points to a lack of education. The main sets of beliefs noted:

- Cannabis does not lead to the use of other drugs
- There is no relationship between recreational drugs - in this case cannabis, cocaine and also alcohol - and mental health difficulties
- Cocaine is not addictive and is a healthy alternative to 'addictive' drugs such as heroin
- People can use cocaine over a long term and continue to have successful and unimpaired social and working lives
- There is no toxicity problem caused to the body following the consumption of large quantities of alcohol and cocaine together etc.

Income derived from direct and indirect supply of drugs is seen as nearly a legitimate form of income

Prescription Drugs

Some of the respondents suggested that there was widespread use on benzodiazepines. This was particularly acute for those taking part in methadone maintenance. Respondents felt that the there was an over prescription of benzodiazepines for those on such programmes. Consequently, many noted that there was 'prescription leakage' whereby there was a black market for benzodiazepines which are sold on 'the street'.

Crime/local economies

The findings suggest that there is a distinct economy that surrounds the supply and sale of illicit drugs. In this sense, the research suggests that in disadvantaged areas the income derived from direct and indirect supply of drugs is seen as nearly a legitimate form of income, or at least one which is welcomed in the absence of other alternatives. This is a very important point and links the wider drug problem to social exclusion and relative poverty. In other words, along with the relationship between disadvantage and problem drug use, disadvantaged areas are ripe for the criminal economy of drug supply.

This issue is complicated by the sale of drugs by those with drug problems as a means to pay for their addiction. At the top of the chain of supply are criminal elements which for want of a better characterisation, behave like businesses which focus on their 'bottom line'. The research suggests that the criminal organisation around drugs is significant and this is related to the vast profits to be earned, despite the risk of detection and prosecution. The local economies and its control of drug supply is multi layered and complex.

Finally, the local economy that is developed around the supply and sale of drugs is coupled with what many see as increasing violence. Due to the profits to be made, the material respect drug dealers are held in - due to some of their material possessions (cars etc) – dealers are easily replaced by others when they are detected by the judicial system or removed by rival dealers. The violence surrounding the criminal gangs involved in dealing, in terms of their competition and rivalry, punishments for unpaid debt, is in the view of those consulted here increasing. One view for instance states that they are aware of cases where an unpaid drug debt of €200 warrants a non fatal shooting. Overall, the availability and use of guns by those involved in drug dealing leads to increased and often indiscriminate shootings. This group of people see drugs in business terms and operate a gang code mentality not dissimilar to the dramatic portrayals such as the 'Sopranos'.

However, on a positive note, it is also suggested that prior to the onset of Cocaine, crime related to drug problems decreased due to the methadone maintenance programmes. In some areas of the overall catchment, this is particularly evident.

Social structuring of drugs

The findings also refer to the socio-cultural acceptance of drug use and related problems in a number of communities making up the TF catchment. This is seen as a result of social and economic exclusion and is anchored in apathy and powerlessness in those communities. In addition, limited job prospects, unemployment and low self esteem all contribute to sense of fatalism in some communities. The implication

of this is that it is hard for such communities to come together and counter the causes and prevalence of drug problems and circumstances which make them. This is obviously a target for community development activities.

Wider impact

In line with the thrust of the much of these trends, the responses point to the wider impact that drug problems have. This goes beyond the individual drug user to include their children, partners, extended family, friends, and local community. There is a view prevalent also that the wider impact is intergenerational in its affects on not only the user but often their parents and children. The issues at play here include families with difficulties, problems with children, youth problems, financial debt, violence, illness, institutionalisation (prison and hospital), and death. Many more elements of the wider impact of drugs problems can also be added to this list.

User profile

The profile of people who are or are becoming problem drug users was a common theme in the discussions. These suggested that the stereotypical profile of the heroin addict is no longer applicable and the profile of drug users is changing. The age ranges from 15 to 34. The user can be considered affluent, relatively well educated, as well as in lower income communities with lower educational attainment. The spread is according to one respondent, 'across the board'. The number of young people involved is significant. Many of those who make up drug users now see and view heroin addicts as 'pariahs' and do not share the same characteristics. However, it should be noted this is not to say that those who have problems with heroin are not in need of a range

The profile of drug users is changing. The age ranges from 15 to 34. The user can be considered affluent, relatively well educated, as well as in lower income communities with lower educational attainment.

of continued and additional supports. If anything, it expands the profile of the drug user.

What much of the above seems to imply is that many of these concepts and themes are, on examination, interrelated and mutually reinforcing. The variegated nature of drug problems at local level is clearly an issue that demands and equally multifaceted response. Overall, one of the key points that these issues imply is that there exists very little formal responses to many of these problems. This is perhaps a good direction of where future work might be pointed.

IMPACT OF DNEDTF

The research asked those consulted to assess the impact of DNEDTF. The general view is that the TF has worked well. It has been particularly good for those who availed of the projects and services it has provided/supported. This has resulted in saved and improved lives, not to mention prevention of further or additional problems. Nevertheless, there is a view that while the impact has been good this was particularly in

the early days since 1997 to 2001 and that the impact has lessoned over time. As such it is felt that the TF has lost some direction, vibrancy and relevance to current drug problems. While the work of the TF is and has been valuable, the nature of the drug problem has moved requiring new responses. This is of course a realisation on the part of DNEDTF and is the motivation for the present research and strategy.

The following are the areas where the TF has worked well:

- bringing a multi-agency approach to drug problems in Dublin North East
- facilitating services at local or ground level
- the local project model
- reduction in drug related crime
- funding premises and facilities
- harm reduction for heroin users
- funding
- involving communities

In contrast, the feedback suggests the following are the areas in which the Task Force has not worked as well:

- providing development and technical support to local communities and projects
- flexibility and the ability to change and respond to change
- accountability of funded initiatives, reporting and monitoring
- learning from what has not worked well
- research, evaluation and policy issues
- networking,
- lobbying and advocacy
- visibility and input at ground/community level
- prioritising one project or area over others
- over association with funding and administration
- image, lack of visibility and presence with community groups and in communities
- planned and strategic response
- weak and disappointing input of state agencies
- lack of effective representation and structures of representation for communities
- focus on families and communities
- over focus on response to heroin and not to other drugs
- governance of projects, particularly mainstream projects
- co-operative, collaborative work across catchment
- stagnancy at Board level
- confusing and weak structures
- lack of emphasis on professionalism
- progression of clients from methadone maintenance
- community policing

It is evident that some issues noted have been simultaneously a success and not a success. It is of course not unique for the gaps, or less successful areas to be identified rather than the successes in assessments. Like with all social policy interventions, the TFs work is an ongoing one which is parallel to the problems that it faces which are, as noted, complex.

However in terms of the apparent contradictory views, this may not be as surprising as it first seems since perceptions on a particular issue depend on the location of the viewpoint relative to the TF in time, engagement and current experience of drug problems. In other words, it may be that what worked once is not appropriate to changing needs now. Thus existing work may need to be concreted while simultaneously being added to, altered and revitalised to respond to changing and future needs.

MEETING LOCAL NEEDS

This line of investigation looked into whether the Task Force and/or its funded projects – interim and those mainstreamed – are meeting current needs. The research generally referred to a broad conception of what needs are in respect of problematic drug use and its related issues. This was also left up to the respondents to articulate based on their insights and experiences.

The findings are at once encouraging but also reflect the difficulty of the work and the complexity of the issue that is being dealt with.

The main response, about half of all replies, suggests that TF and its projects are meeting needs 'partially' and/or to 'a certain extent'. This is followed, in similar proportions respectively, by a view that needs are either emphatically, or are not, being met. A minority of respondents felt that that it is hard to tell one way or the other in the absence of systematic data as to what the needs are or how effective the responses have been. Perhaps the responses can be summed in the words of one interviewee, 'the work of the TF is answering a need, but not all needs'.

Looking at the responses in more detail, in the case of 'partially meeting a need', the responses varied along the following lines:

- some projects are meeting needs while others are not
- some geographic areas are better served than others
- needs are being met in relation to certain drugs such as heroin but not others, notably cocaine and alcohol
- some of the needs are outside the capacity or remit of the TF and its projects and require lobbying and advocacy to other agencies, the NDST and ultimately the state
- the response is partial due to constraints on resources including professionally qualified staff
- the response does not go far enough and doe not take account of wider social, economic and community issues related to both the causes and effects of problematic drug use
- only pars of the continuum of care are being addressed by projects to the detriment of others
- the true extent of needs is not visible
- and certain groupings, such as young people and families, have needs that are currently not met.

The following explanations from those that believed that needs were not being met can be added to the list above. These included the following:

- some elements of the task force, both statutory bodies and community residents and interests, acted as a barrier to meeting needs
- wider problems of security, crime, drug economies, lack of community involvement all suggest need is not being met
- the needs that are being met are an out of date assessment of need

Overall, the responses go some way to identify the types of needs not being met and some of the areas where future work can be targeted.

GAPS IN SERVICES/APPROACH

As part of the dialogue with stakeholders, the needs that are not being addressed was explored in terms of what in the view of interviewees and their experiences were the gaps in responses and services of the TF.

From analysis it is possible to identify the following themes[23]:

Strategic approach

Under this heading, the respondents talked about the lack of a clear strategy from the TF in terms of its activities and funding projects. This view went further to emphasis the importance of having a greater coordination and cohesion between projects and the various initiatives of the TF. This included more appropriate and effective structures through to greater systems of protocols and procedures that are in keeping with an overall strategic approach. This included moving from what some saw as a crisis driven approach to planning to one that emphasised being proactive, one also that included greater ability for learning from good and bad work with better monitoring and review. This approach would also see problematic drug users as customers and place their experiences and needs of their total drug problems as a key starting point of the work of the TF.

Continuum of care

This theme covered a set of responses that saw gaps in terms of a lack of projects throughout the onset of problem drug use through to stabilisation, treatment, rehabilitation and aftercare. This therefore required ancillary and complementary services and areas such as counselling, psychotherapy, social work, accommodation, education and training, mentoring etc. One important aspect of this was the need to have much clearer links between medical services and social supports received through projects and the ancillary services mentioned here.

Polydrug use

Many of the existing projects of the TF and much of its legacy are the emphasis on heroin. This part emphasised the drugs are not taken in isolation from other drugs, whether illicit or prescription. In other words, polydrug use was seen and experienced as the norm rather than the exception. More information is provided to back this up in the following chapter that outlines the feedback coming from clients and problem drug users in the TF catchment. Along with heroin, the drugs noted here were benzodiazepines, a range of opiate-based pain killers, less so Ecstasy and Amphetamines but there was an overwhelming emphasis on alcohol.

Cocaine

Although polydrug use was mentioned above, there is a need to emphasis the gaps in services in responding to cocaine problems. This is by and far one of the clearest findings in the research and consultation, namely, that cocaine is very widely used and available. Some of the respondents suggested that what they have come to see and learn about cocaine and related problems draws parallels with the way in which the heroin problem originated in the 1980s and 1990s. The key point made here is none, if any, of the projects have in place services and other responses to deal with cocaine. It is a different drug with different responses to heroin.

Alcohol

Again, in a similar manner with cocaine, the TF and its constituents saw alcohol as a very significant problem that is not being dealt with.

Support services

Generally these gaps referred to the need to have in place services and supports from the TF or in the TF area that deal with the technical, analysis, research, management, advice and lobby needs of projects and services set up to deal with drug problems in the catchment of the TF.

[23] Although it should be noted that many of the themes have much in common and to an extent overlap, this is in general a finding seen across the findings in this section of the report.

Family support
This gap relates to the wide range of services that are required for those families of problematic drugs users. This can play a role in harm reduction, relapse prevention, treatment and also in prevention. Typically family support services refer to counselling/therapeutic work, child developmental and educational initiatives, youth work, community development, parent education and finally, home based parent and family support programmes. Each of these is seen to have role in working at different levels of families, individuals and communities with or at risk of problem drugs use and its implications.

Community input
Many of the respondents saw an increasing lack of community and resident input to both the core TF and the local projects. One concern outlined here was the gap in terms of engaging those who have drug problems but who are some way off from presenting to services. This is particularly in respect of the less visible cocaine problem use.

Capacity problems
Some of the responses underlined that the demand for appropriate supports and services in the TF areas for problem drug users is somewhat beyond the resources capacity of the TF and the allied projects at community level.

Facilities
This gap referred to inappropriate premises for existing projects, and thus those in the future. It also referred to the need for sheltered accommodation for those with certain drug problems such as alcohol, while also encompassing locally based respite and treatment facilities. Another element of this perceived gap related to the lack of open facilities at evening and weekend when needs are still present. Part of this related to late night recreation and leisure for young people as well as some services for those with drug use problems.

Young people
From across a diverse range of respondents the problems of underage (<18) drug use was noted. The obvious gap here is that no services exist for this group or indeed to recognise that a problem of addiction and drug use exists among this group in the first place. Many noted that this problem is often relatively hardened when services are in an official position to provide supports to this grouping.

Promotion
It is seen by many that the TF has not promoted its activities and its role sufficiently in communities. This is also seen to be true among other services providers whether statutory, community and voluntary. This would be about promoting all aspects of the TFs work including getting better feedback and using its position to raise important issues.

Advocacy & Lobbying
It is acknowledged that many issues are not in the control of the capacity of the task force to deal with. That is many contributory factors and issues are of a structural or policy nature etc. Thus in order to bring the issues which impact on drug problems to the notice of policy makers, the NDST, other LDTFs, and other statutory services provider, the work of the TF should include lobbying and advocacy on these learning points and suggestion for future action and changes.

Policing
This perceived gap related to the lack of visible policing presence in communities. This also went on to emphasis the lack of community policy structures and a working relationship between

police authorities and local communities around drug problems and solutions.

RESPONDING TO GAPS

To add more depth and insight to the discussion of gaps in the past work of the TF, additional questions were put to the stakeholders. In the main, these questions centred on the extent that the work of the TF could respond to new and emerging gaps and, following this, what would help it to respond to such gaps in the future?

Looking at the first question part of the question, the overwhelming view expressed was that the TF responds to gaps in a partial manner. This is not to say that the work of the TF is haphazard or limited but, as noted above, it was set up to respond to drug problems at a different time and in a different way. Today, its projects are seen as too specialised, overly focused on heroin etc. In addition, its catchment area is seen by some as being too large and varied for it to have one overarching approach. Linked to this also is the fact that the resources of the TF - including its staff - are not at a level that would allow it to respond to the nature of drug problems in the area in a mode in keeping with the nature of the problem is it is currently manifested at ground level.

The resources of the TF - including its staff - are not at a level that would allow it to respond to the nature of drug problems in the area in a mode in keeping with the nature of the problem is it is currently manifested at ground level.

Stakeholders outlined what the TF should do to respond to gaps. In particular, these responses looked at the services, policies and/or activities that the TF, or projects and initiatives under its remit, should put in place to respond appropriately to the gaps.

There was a broad array of responses. These are distilled below into a number of themed areas: strategic and proactive planning; aftercare; additional resources; professionalism; lobbying, networking and advocacy work; interagency work; more involvement with 'mainstreamed' projects; consultation practices; review, monitoring and evaluation; community based supports areas not yet established; formal and informal approach to preventative education; induction and training: extension of TF to include family and community aspects: development of a core technical, support and planning unit; increase in ground level and community focus; promotion of the work and achievement and value of the TF; turnover in representatives from communities; focus on the needs of problematic users; a central focus of the on polydrug use, including alcohol; community policing, children and young people; and, intercommunity access to local services and clinics

The first thing that the above suggests is that the responses are multifaceted. The crossover and this related to the nature of the problem that drugs manifest at the local level. This is of course recognised in the make up of the task

forces at any rate. It is also evident that many of the suggestions made here overlap considerably with responding to the current gaps noted in the earlier question. This is of value as it indicates a clear path for the future of DNEDTF.

STRUCTURES/INFORMATION & CO-ORDINATION

Some of the information presented above shows some of the wider areas for where the TF might look to make amendments and introduce new activities in the future. Given some of these suggestions, the research also looked at the experiences of the current structures, information dissemination and general communication practices of the TF and by implication, what changes might be required to improve the work of the TF going forward.

The results yield a number of contrasting positions. Firstly, some of the stakeholders feel that the present structures and information systems of the TF are satisfactory.

Secondly, a number of the responses focused on problems of the structures as they see them, namely: they are not clear, do not involve other needed parties, may not be appropriate to enhance transparency and accountability, focus perhaps too much on the passion and experiences of community representatives while not also introducing an objective and expert view, do not rely on or use research and, finally, do not inform stakeholders about what the TF, its projects, staff etc., are achieving/doing in a given time period.

Thirdly, in response to some of the problems noted in respect of the TFs structures, information and overall co-ordination, the following general solutions were proposed:

Local area committees

These would include local projects, local community representatives, advocacy groups, state services, voluntary bodies, family support workers and community development personnel. In as far as feasible such committees would function as 'mini task forces'. The key point is that this would allow for the holistic approach mentioned through out the findings to date to be factored into the work of the TF at the local level and would involve a range of wider bodies looking at the individual, family and community aspects of drug problems.

Community input

It is felt across many of the stakeholders that the extent and quality of the input from communities to the work of the TF has waned in recent years. As such, the revitalisation of this input at the local level was seen as an important element in improving structures, information and co-ordination.

Representative structures

In line with the need for a greater input from community members to the TF, the responses suggests that to a large degree the current representative structures of the TF need to be overhauled. Suggestions include limiting the time that one representative can serve, to have clear terms of reference, a reporting structure and clear responsibilities in their role. Notwithstanding this, the role of statutory bodies and their representatives was also questioned. It is felt that clearer input are required from statutory bodies on the TF, at local areas and that clear system of protocol and interagency work need to be put in place to make the most of the involvement of the statutory bodies their representative personnel.

Balance of input

The research suggests the importance of the enhancing community input is a key need for the TF. However, in addition, it is noted that it is important not to over emphasise having community input for the sake of it or more precisely for the sake of being seen to do so. This highlighted above where community representation is questioned as to its actual representatives of the community experiences and interests and the systems in place to feed information back into the communities. To date, there is a feeling the representation from communities has tended to be tokenistic, emphasising issues, but not systematic and tailored responses. Thus some of the views noted the need to have better more functional community representation which at once does not limit but enhances the passion and experiences in communities but also allows for a balancing expert input. This means that along with greater community input an increase of expert input on specific drugs, or related areas such as the family, counselling etc., should be facilitated at local area committee level for instance or indeed at sub group level dealing with the pillars of the NDS.

Protocols & systems

There is a need, in the view of many of the respondents, for the introduction of protocols and policies across the TF to cover what information is available, how it should be disseminated and to whom. This would include to members, local services and agencies, the NDST, and the local community. The principles here are to inform, to educate, to pass on learning, to advance discussion and dialogue and generally to improve transparency, accountability and knowledge about and from the TFs work.

Along with these major points, other factors noted in this relation were an increase in dialogue with the police at local community level, induction and training for new TF members etc. These of course can be included under one ore more of the suggestions above.

KEY LEARNING

Throughout the feedback from stakeholders, there have been a number of areas that have been touched on repeatedly. Much of this can be said to been based on learning from experiences and insights and also taking it consideration the diverse perspectives that the stakeholders bring to this chapter. To crystallise the learning, the stakeholders were asked to outline the key point of learning from their experiences to date. Without overly repeating points made earlier, the areas of consensus were the following:

- -Strategic approach, avoid result and funding chasing
- Reinvigorate community participation
- Professionals services responses
- Put the client at the heart of the response
- Improve co-ordination and co-operation
- Ensure greater flows of information
- ßEnhance the input of statutory bodies and their 'buy in' to the work of the TF.

CRITERIA FOR PROJECTS

The starting point here is the expressed perception in the TF and beyond that the relationship between funded projects and goals and objectives of the TF is not clear. This is also the case in respect of the how projects, and indeed other activities, of the TF respond to expressed needs on the ground, that is how they address gaps and account for their impact and effectiveness. With this mind, the research

looked to address how, in the development of a strategy for the TF, the relationship between activities at the local level might be strategic, keep with the overall strategy and therefore respond to the needs of problematic drug users. In short, the research looked to see what criteria, if any, should be put in place.

The findings suggest that the main factors or criteria in the assessment of activities and projects funded or initiated by the TF should include the following:

- *clear linkage to the agreed aims, objectives, structures, and protocols of the TF as contained in its Strategy. It is also important to emphasise here that this would also allow for a degree of flexibility so as to innovate and respond to changing needs over time and enhance responses.*
- *Related to the point above, it was also suggested that beyond using funding forms and applications, the TF would engage in dialogue with prospective projects and personnel at local level and involve other parties to arrive at responses. These would be developed into a project plan which is in keeping with strategy*
- *There should be evidence of planning and analysis of needs and response options for a particular actions or course of events*
- *Each activity should arrive at a plan that cites aims, processes, partners, co-ordination, outcome, measurables, review and evaluation, and reporting.*
- *There ought to be a link between activities and the work plans of local areas committees and cross TF catchment issues as suggested.*
- *Professional capacity and inputs should be factored in.*

SUGGESTIONS ON STRATEGY

Under the TF, there are a number of sub groups or committees which have responsibility for areas which are generally in keeping with one or more pillars of the NDS. In the research for this report, each of these areas were discussed with the respondents to assess how they might contribute to the work of the TF as part of a strategic plan. Each one is dealt with briefly below.

Before looking at each individually the suggestion common to all sub groups centred on the following:

- **Each would develop a work plan annually that would be in keeping with the overall TF strategy.**
- **Terms of reference would be developed also.**
- **The role of the sub groups would be to work at a focused and expert level to discuss policy issues and innovation. As such it should include the addition of experts in the various fields in as far as possible. Generally its role would be to give expert structure to the implementation of the Task Force ideas.**
- **It would where appropriate make recommendations to the TF.**
- **Review latest developments in policy and research with relevance to their specific area**
- **Initiatives undertaken should be tracked to measure their effectiveness or failures for learning an future development**
- **In as far as feasible, it is also suggested that the various sub groups should include members of the users sub group with appropriate induction and training. If this is not possible, a structured process of consultation should be initiated to get the views of users and those affected by drug use.**

Prevention & Education

There were a range of views on the work of this group. The suggestion was to look at the role of sub groups and its relationship to what goes on at local level and at TF board level also. The main areas around which the stakeholders suggested that the prevention sub group should focus are:

- *That the groups would look at issues of wider significance than educational efforts alone. These would include preventative work that looks at individual, community and family risk as well as protective factors in drug prevention.*
- *It should look define its work in prevention from primary to tertiary prevention.*
- *It should focus on developing prevention interventions on the socialisation and peer process, especially with young people, and the role this plays in the development of drug problems*
- *The development of stakeholding by young people in active citizenship, voluntarism and thus their local community and sense of purpose and giving for prevention and community development benefits.*
- *The content of prevention work in formal settings and in the media used by the sub group ought to be hard-hitting and realistic. In this sense, it was felt that the short term benefits and attractions of drugs and drug culture should be openly acknowledged with the outcomes of addiction.*
- *The sub group should used formal, informal, multiple mediums to articulate its message and various services available for prevention work and education on drug problems*
- *The educational side of prevention work should not only be delivered in t he formal setting of schools with young people but also in the informal setting of youth clubs and other setting including 'on street' work with young people.*
- *There should, depending on needs, be targeting of some areas from time to time.*

Treatment & Rehabilitation

The suggestions made in the research for this group are:

- *The work of the group should have at its focus polydrug use and dual diagnosis*
- *Menu of treatment and rehabilitation option should be developed to direct referrals and clients on appropriate paths*
- *The group should look to establish initiatives along what has been described as a 'continuum of care.' This would include appropriate content and actions for chaotic/active users, stabilised users, those who are drug free and those also aftercare and social (and economic) reintegration and inclusion.*
- *It is hoped that the group would look to establish pilot initiatives to link the work of community based supports with formal medical services represented by GPs and Clinics*
- *The group would develop quality standards and good practice models*
- *Lobbying and advocacy for the families and carers of family members to appropriate agencies to assist and progress treatment and rehabilitation. This is in keeping with inclusion of issues not traditionally seen as purely treatment and rehabilitation but which impact on the success or otherwise of them.*

Supply & Control

The main suggestions made for this group are:

- *A focus should be placed on the concept of*

community policing. This in not only to tie in with the development of these structures but also to allow greater dialogue and trust between policing services and local communities. One of the aims here is to assist the police in their work.

- *The work of this group should acknowledge difficulties in the work of the police in respect of drugs, legal issues and the courts. Put simply, the work of the Gardai is to collect evidence for the legal process.*
- *It is also suggested that the work of the police is structured very differently to the catchment of the TF. In this sense, three station areas – Coolock, Raheny and Howth – in part of whole make up the catchment of the TF. This creates difficulties and is added to by the fact that parts of the catchment are outside of the city area and under the administration of Fingal County Council when it comes to Community Policing Fora.*
- *Efforts should be made to bring local area community representatives, with a clear representative responsibility and structure, to the group to better link the work of the group to communities.*
- *Where information of the circulation of immediately life threatening tainted and toxic drug substances comes to light, this should take priority in supply and control terms to reduce potential fatalities.*
- *Innovative means of getting information from communities and the public, such as confidential lines etc., should be explored.*
- *The group should explore the relationship between drugs and local economies and look to put in place barriers and alternatives.*
- *The group should look to increase co-operation with the Coast Guard and the Probation and Welfare services.*
- *The architectural and planning layout of communities, especially new and planned ones, should become a focus of the groups to improve these in terms of the supply and circulation of drugs and anti social behaviour*

Childcare

The suggestions emanating from the research for this group are:

- *The groups should change its name to reflect a wider focus. Instead of childcare, it should deal with a range of ancillary and support services. As such it should be renamed the support services sub group.*
- *Its role should be to address the areas that relate to drug problems such as family support, counselling, accommodation, social inclusion, education, training, employment, community development, early intervention and child development, the social economy etc. Its role will be develop the supports and links between support services and the community response to clients*
- *This group should look to develop what are termed aftercare responses for those who availed of treatment and maintenance as well as ancillary services for those with drug problems and finally, supports to prevention work.*

What this suggests overall is that the first of these three areas are still of relevance to the TF and perhaps lets the TF keep in line with the NDS. However, as it shows it is not clear how the work of these relate to the work in the communities and in projects. There is a need for them to have their work plans and to be an important policy discussion forum for the TF in that area. However, their roles vis-à-vis the TF and the local communities on the other hand need to be clarified.

MAINSTREAMING

An ongoing debate in the LDTFs is the role or lack of role as the case may be in respect of projects which are now 'mainstreamed'. This is an issue of importance to the work of the DNEDTF as well as other task forces going forward in their work to counter drug problems in their respective catchments. With this in mind this research explored mainstreaming and mainstreamed projects in the context of the development of strategy for the TF.

There are two main trends in the responses, one addressed the positive aspect and the other the more negative aspects to the mainstreaming.

The positive aspects noted include:

- *continuity in the project is assured, staff are more secure in positions etc*
- *the projects are able to plan ahead due to the security of funding*
- *services for clients are available,*
- *relationships with medical service providers can be developed and enhanced*
- *staff are able to improve their training and qualifications*

However, along with the positive aspects, the main negative issues noted, some contradictory, are:

- *mainstream projects are stagnant and isolated. They are locked in time in responding to one aspect of drug problems namely heroin.*
- *mainstream projects were seen as working to a certain extent on their own without links to the TF, its staff, other work and projects.*
- *Mainstream projects because of how they are funded and linked to their mainstream agency, funding relationship channel for the most part, and lack of contact with TF were seen to loose innovation*
- *Some of the respondents felt that mainstreamed projects were not sufficiently accountable and it was hard to gauge the effectiveness of their work. In this respect, it was felt that the task force was not able to offer support to mainstream projects that were going through difficulties.*
- *Some questioned also the relationship between the mainstream projects and their respective local communities, in terms of representation and responsiveness etc.*

The general conclusion here is that the work of the mainstream projects, current and future ones, if possible should be brought under the strategic remit of the TF. This is to improve the work of the TF and also that of respective mainstreamed projects.

EMERGING PRIORITY ISSUES

The research was concerned not only with past and current work but with how the TF might set about dealing with emerging issues in relation to drug problems. From the feedback, a number of areas were apparent for the TF to concern itself in the development of its future strategy.

Some of these have been explained elsewhere in this chapter, nevertheless the one emanating as broad priorities are:

Cocaine, Alcohol and Polydrug Use:
Staffing and premises
Young People
Revitalisation of the TF:
Policy development and support services:
Family Support
Integration and co-ordination at the local level
Community participation
Lack of progression and continuum of care

Relationship of drug problems to social exclusion and local economy
Non coverage of certain geographic locations
Role of the NDST

SUMMARY AND CONCLUSION

This chapter has set out the main findings from research among the stakeholders, community, voluntary and statutory, on the work of the TF in the present and what it could be like into the future. Against this background, it is evident that there is a good deal of overlap and repetition in some of the responses. This is of importance as it underlines the areas of clear agreement first on the work of DNEDTF to date also what changes are needed going into the futures in response to changing needs and unmet gaps.

The main findings are outlined in bullet point from below.

- The extent of the drug problem in Dublin North East is still significant but its nature has changed over the years. As such, it is seen as broader involving more people, more types of drugs and more diverse. Overall, and for this reason, the extent of drug use and related problems has exacerbated in the context that there are no response in place for how the drug problem has evolved. This is the immediate challenge for the TF.
- The main drugs causing difficulties are heroin, cocaine, alcohol, cannabis, and benzodiazepines. The responses demonstrate that polydrug use is commonplace. The prevalence of cocaine was a particular feature of the findings. The widespread use of Alcohol among all age groups, including large numbers of those under 18, was also prominent in the responses.
- In terms of the location of blackspots of drug problems. There were three categories used to identify such locations: distinct geographic locations, areas with high concentration of social housing and open areas/certain public meeting points. The logic of the responses suggests that each of these characteristics, taken together, therefore they are probably an accurate description of the geographic prevalence of drug use in Dublin North East.
- The findings point to some additional and/or related trends in drug use. The most striking of these their interrelated or overlapping nature. This underlines the complex and socialised nature of drug use in the areas. For instance, although heroin use is still prevalent, it seems to have stabilised. The most prevalent drugs seem to be cocaine and alcohol. A clear finding is that use of cannabis and to a slightly lesser extent, cocaine has become normalised. The challenge this poses is that many users may not see these drugs as dangerous, addictive and do not in the lead to problems. This is what is referred to above as shared and passed knowledge, false, about drugs and drug problems. As noted above, it follows that polydrug use is very widespread. Problems with legal drugs refer in the main part to Alcohol, there is also suggestions that other legal drugs are misused, namely, benzodiazepines which has also led to what is termed 'prescription leakage'. The findings suggest that there is a distinct economy that surrounds drugs and that for some, the income from direct and indirect supply of

drugs is seen as nearly a realistic form of income in the absence of other alternatives. Related to this is the perception that in some communities, there is a socio-cultural acceptance of drug use and related problems. This is seen as related to social exclusion a sense therefore of powerlessness and fatalism in those communities. In line with this depiction of some communities, it follows that impact of drug problems, both in the path to addiction and its consequences goes beyond the individual drug user to include the family and local community. The profile or biography of those who are problem, or likely to become problem, drug users has changed from the stereotype of the Heroin addict to one that is affluent, educated, as well as in lower income communities with lower educational attainment. The implications of this finding for the task forces is that a multifaceted response is required and at present the services and approach initiated by the task force is not responding to the present nature of problem drug use in Dublin North East.

- The general view is that the TF has worked well to date – for instance it has been particularly good for those who availed of the projects and services it has provided. However there is a view that while the impact has been good this was particularly in the early days since 1997 to 2001 and that the impact has lessoned over time. As such it is felt that the TF has lost some direction, vibrancy and relevance to current drug problems. This is in keeping with the earlier findings. The feedback also outlines a range of areas where the task force can look to put in place new ways of working and new types of responses. However, new work aside, there is still a need to at least maintain existing services. However, it may need to be altered and revitalised to respond to changing and future needs.
- The current response of the task force however is not universal, that is not all projects and initiatives are considered to be on an equal standing in respect of their efficacy. In other words, some projects are viewed as better than others, some areas are better catered for, some problems are being addressed while others are not, resources are insufficient, the conceptualisation of the causes and consequences of problem drug use are too narrow, some group's needs are not included etc. The reasons for this are sometimes viewed as being beyond the capacity of the task forces: some are internal to the task forces; some are related to legacy issues with projects and so on. Overall, the findings go some way to identify the types of needs not currently being met and some of the areas where future work can be targeted.
- Although covered in more detail in the body of the chapter, main or general themes for the TF to focus on in the future to overcome problems, past assessments etc broadly include adoption a strategic approach; adoption a continuum of care model for the drug user; putting polydrug use at the core of the approach; responding in particular within this to Cocaine and Alcohol; providing ancillary, support and technical inputs to initiatives, projects and activities in the community and between relevant organisations; adopting a broad family support approach; capacity building for community interests and increasing and then

maintained meaningful community input; focusing on young people especially those under 18; promoting the work, message and services/supports of the TF; undertaking advocacy and lobbying work; and also increasing a practical and supporting focus on community policing.

- There seems also from the feedback here to be a need to put in place new structures for operating and undertaking the activities of the TF. The main ones cited in the feedback are: local area committees; community representative structures; and in tandem with these new protocols and system. Key principles for the work of the task force going forward include the following:

- being strategic
- being professional in approach and in its (funded) staff
- being client led
- improving co-ordination and co-operation
- Enhance the input of statutory bodies and their 'buy in' to the work of the TF.

- The findings also outline a range of areas of how the working and structures of the task forces could be managed and operated including in relation to the pillars of the NDS and its integration with local needs and current sub committee structures.
- Part of this seems to point toward a reassessment of mainstreamed projects. The general conclusion here is that the work of the mainstream projects, current and future ones if possible should be brought under the strategic remit of the TF. This is to improve the work of the TF and also that of respective mainstreamed projects.
- Overall, therefore many of the suggestion for going forward centre on the following:

Strategic planning

- Cocaine, Alcohol and Polydrug Use:
- Staffing and premises
- Young People
- Revitalisation of the TF, Promotion and visibility
- Policy development and support services:
- Family Support
- Integration and co-ordination at the local level
- Community participation
- Lack of progression and continuum of care
- Review, monitoring and accountability
- Relationship of drug problems to social exclusion and local economy
- Non coverage of certain geographic locations
- Professional standard and qualifications
- The need for a more structured NDST in which it is given more power and staffing to advise and assist local and regional task forces or the establishment of a new co-ordinating structure with sole responsibility for drug issues.

chapter 6

consultations with drug users

CHAPTER 6
CONSULTATIONS WITH DRUG USERS

INTRODUCTION

One of the main phases of the research was to consult with drug users and those involved in support services for addiction. The aim of this was to get the views and experiences of this group on the reality of drug use. This looked to assess the gaps in services as experienced by the group and the limitations on existing services. It also explored that nature of past and current drug problems, their availability, related problems and the implications of this for the activities the TF should look to put in place.

The findings of this chapter are intended to complement the findings for the research in the previous chapter from among what we have termed stakeholders, that is projects and other services that are of relevant in drug prevention and treatment work at a broad level.

This feedback making up this chapter is structured around the following themes:

Location and socialisation
Drug use (including Polydrug use)
Factors contribution to drug use
Polydrug use
Experience of support services
Improving support services
Additional support required locally
Suggestions for improvement and additional services

LOCATION

This question explored the areas in which clients/drug users live and the areas in which they socialise. The responses suggest that most clients lived in the community in which the project was located. However, a number lived elsewhere but had family in the area or previously lived in the area.

In response to the areas in which clients socialise, it is clear that clients do not stay in their area as one would expect. The research also showed that the neighbourhoods in the task force catchment area that the respondents frequented straddled each other and went over a number of miles.

For instance, clients may attend a project and clinic in one location but could quite feasibly attend them in other areas also. The areas that they went to usually coincided with where they might go, in the past or presently, to 'score'. The availability of drugs was an important consideration in visiting various areas. They key point here is that the various communities are interconnected in terms of drug use. It is normal according to this research for clients to frequent up to four distinct communities, understood locally, at any one time. In this case, Kilbarrack, Donaghmede, Ayrfield, Edenmore, Darndale and Coolock can all quite feasibly be the neighbourhoods that one person socialises in. This seems to call into question that nature of area based project and the extent, or not as the case may be, of contact with other projects and other areas. The integrated approach, geographically, seems to be warranted based on these responses.

DRUG USE

There were a number of questions which comprised this theme. The first looked at the age of the first drug use among the clients interviewed or those taking part in the three focus groups. The average age of those interviewed was 32/33. They ranged in age from 24 to 37. This suggests that, for one reason or

another, that those in their teens and twenties are by and large not attending projects and clinics as part of methadone maintenance. There may be many reasons for this as we will see, but it does suggest that heroin may not be as acute in that age range as it is for those who are older. By implication, this also suggests that the prevalence of heroine has stayed static at least or perhaps even decreased.

The average age that the clients interviewed started taking drugs was 13/14 years of age. The age range when people first started to use drug of various types was 9 to 17 years of age. The average time that those who were interviewed have been using drugs this was 19 years. This suggests that for the most part those with drug problems started their drug use in their early teens and this drug use has gone on until the present time. This relates in the main to heroin, however as we have seen earlier, polydrug use is very common. This is an important trend. It suggests that some of those with serious drug problems have been involved with drugs for almost all, or large parts, of their adult life. The implication of this is that from a support point of view it is extremely difficult to overcome this trend in the life of the individual. The treatment, support and aftercare etc., would more than likely be intensive and over a long period. In addition, overcoming drug problems would seem to be more than overcoming the biological addiction but looking at the wider societal environment that those with drugs come in contact with.

This point is clearer when we look at the responses to questions of what drugs clients of these projects first used and why. There is a trend evident in the way those interviewed first came to use drugs. There is a path or scale of

The average age that clients interviewed started taking drugs was 13/14 years.

sorts along which clients were likely to begin their use. Some would start at the beginning and some further on along this hypothetical scale. As we have seen most started at roughly similar ages, that is the early teens. A broad outline of the path or scale of drug use is sketched below:

1. *The drug scale normally starts at the lowest level with glue and other solvents.*
2. *This is followed by cannabis and alcohol. In the early nineties for instance, this was followed by LSD and/or ecstasy. Sometimes there was amphetamines and cocaine use following these or in conjunction with these drugs.*
3. *At this point in the biographies of individuals, polydrug use is normal such that a person is likely to be consuming cannabis, alcohol, amphetamines, ecstasy and/or cocaine. Although there is a sense that cocaine has replaced ecstasy and 'speed' as time went on.*
4. *Heroin use usually follows on from ecstasy and 'speed'/amphetamine use. The rational given, and widely known, is to come down from the 'highs' of stimulant drugs.*
5. *In latter times, those that use heroin, may also use cocaine and various types of benzodiazepine. All the drugs mentioned here are illicitly used and not therefore prescribed.*

In respect of the last point, it became obvious during the research that a significant cohort of people that the respondents knew, and who also used drugs, had an identical drug taking

biography, with the exception of continuous heroin use, to the respondents who became problematic drug users. The important point here is that this other group for one reason or another did not go on to develop the drug problems that many of those interviewed did. There are a number of important implications of this. Firstly, this seems to feed a belief that some people can use drugs and not get into difficulty and live normal and often successful lives. This is undoubtedly a reality but it serves as a powerful justification for some people in their drug taking. It is something that ought to be addressed going forward. Secondly, what is also clear from the above is that individuals with more affluent backgrounds and thus with perhaps more access to private treatment, steadier family circumstances, socialised or peer conventions in which addiction is highly unacceptable, and who shared the same initial drug taking biography of those interviewed here do not fall into addiction. In effect, this is almost a systematic control study of two groups. Although there is no way without in depth research to be sure about this process, it is 'real' in the minds of the respondents here as such it brings the socialisation aspects of addiction to the fore and underlines the social aspects of prevention also.

The clients were also asked what drugs they are currently using. This as expected showed that all of the clients are on methadone maintenance programmes. It also however showed that many of them, practically all, are also using prescribed benzodiazepines. In addition, many of the clients also use illicit drug alongside prescription ones, the main ones noted here are cannabis and cocaine. It is evident also that those that inject heroin are also more likely to inject cocaine, if they use this drug. It is of note that some of the clients suggested that the group of people that use cocaine is in general a different one, according to them, than those that use heroin. This supports earlier findings that a new generation, socially diverse, of drug users has developed and their main drug of choice appears to be cocaine. Finally, a number of the clients were also on prescribed anti-depressant medication. This shows the unfortunate reality of dual diagnosis and the relationship between depression and addiction.

FACTORS CONTRIBUTING TO DRUG USE

This issue was touched on above in the responses on the reasons why people first used drugs. This section goes into more detail in this important matter which took up a good deal of the interview times.

The main points of consensus in the responses were the following:

Peer and socialisation processes

This heading is perhaps one of the most commonly ones used and understood. A large proportion of the client responses suggest that their drug taking was closely related to the effects of peer pressure. In this regard, they could be said to be socialised into drug taking. In a similar manner that persons adopt various views, language, dress even accents etc., drug taking was something that one did or one adopted as part of the normal social processes within their peer group. In this sense, it was viewed as the 'normal' thing to do. It was something everyone else was doing etc. This is not to say that each and every person is influenced to take drugs by their peers and social systems but that for those who develop

problems with addiction this process is an important one in first taking drugs, the type of drugs and the continuation of drug taking to include 'harder' drugs such as heroin. The implication of this, which is not something new, is that prevention and harm reduction efforts must look at the subjective socialisation processes that influence people and lead to problem drug use. A final point is worth making here. The clients cited many friends and associates from the past who had identical drug biographies to them. That is they took the same drugs and at the same time, but somehow never managed to end up as 'junkies'. This is a very strong image in the minds of those interviewed as it seemed to suggest that not all people who took drugs ran into difficulty with addition and drug related problems. So as part of the peer process, even where people were aware of drug addiction, they felt that they would not be the one to become the addict. This stereotype is a strong one and it is probably true. It is again one that needs attention at the prevention level.

Personal and family history

This is a wide-ranging issue brought up in a surprising number of the responses. This suggests that family back ground, normally abusive and difficult family circumstances, is viewed as one factor in the reasons why persons became involved in drugs. There is a sense that some of responses may have come to the fore as a result of counselling or in this sense as a 'typical' response as to the causes of the drug use. However, many of the respondents suggest that home life, abusive family relationships and parental conflict made the taking of drugs, harboured by peer processes, one way of dealing with such problems. This factor also went as far as family members and partners being involved in drug use which in turn led to the problems of addiction for the client. This is related therefore also to the peer type process. The significant minority of clients who suggested this as a factor in their problematic drug use is therefore one linked area of prevention and harm reduction need.

Widespread availability and prevalence of drugs

Throughout the responses, it is evident that many of the casual factors are interrelated. Indeed this finding is seen throughout the research. This causal factor was where the prevalence of drugs and drug use in and around the social groups people find themselves in makes drug use a much easier and an acceptable choice. This is particularly a feature of more disadvantaged areas as opposed to more affluent ones, where drug use may not be visible or as prevalent across the social interactions including in the family setting.

Enjoyment and pleasure

This is a key and often overlooked element in drug addiction. It is both logical and obvious that many of the clients, along with its availability and social acceptance, enjoy and get a 'buzz' from using drugs. It is not that unlike the more widespread view of drinking alcohol. It is one of the areas that needs to be responded to. In short, many of those who have drug problems got involved with drugs initially as they are enjoyable and pleasurable and 'good fun'. This is despite the medium and longer term negative effects of drug use.

Social escape and anaesthesia

This was mentioned in another form above in the section on personal and family history. Some of the respondents partially took drugs to 'get away' from the more negative aspects of their life, whether this was domestic abuse,

Drugs were taken as self medication in order to 'anaesthetise' them from their personal and social realities.

financial problems, relationship problems or borderline depression etc. In this sense, drugs were taken as self medication in order to 'anaesthetise' them from their personal and social realities.

Low self-esteem and education deficiency
A lack of education coupled with low self esteem was a cause of drug use for a number of the respondents here. It is felt that one might either take drugs or be unable to say no to subjective peer pressure in the taking of drugs for this reason.

Taken as a whole, these areas are not intended to be definitive and each is moulded so as to be broad. Nonetheless, they are clearly interrelated and thus among the clients interviewed, some or all of the factors may have worked together in their personal biography of problematic drugs use.

POLYDRUG USE

The overwhelming finding here, mirroring that seen in the previous chapters, is that polydrug use is not the exception but the norm. For all of the clients interviewed, polydrug was typical of their use.

There are some important viewpoints evident here. The first is that generally those who take drugs tend to mix 'uppers with uppers' and 'downers with downers'. This is important as it shows if someone is using ecstasy they might also use 'speed', those who - even following the use of 'uppers – use heroin may also use benzodiazepines.

The drugs mentioned included one or more of the following:
Cannabis and alcohol
Cannabis, alcohol and ecstasy
Cannabis alcohol ecstasy and speed
Cannabis alcohol cocaine,
Cannabis, alcohol, heroine
Cannabis, alcohol, heroin
Cannabis, alcohol, heroin and benzodiazepines
Alcohol, heroine
Alcohol and cocaine
Alcohol, speed, ecstasy, heroin, benzodiazepines
Cocaine and Heroin

What this suggests is that there are a number of combinations of drugs that are most regularly seen. They differ depending on the individual and also their peers. For instance, unlike older drug takers, younger generations may be more likely to use a combination of cocaine and alcohol. It is also the case that through out all polydrug use alcohol and/or cannabis act as a canvass of supports. In short, they are always there in the background.

SERVICES AND SUPPORTS

This question looked at what services or supports clients has used and those that they have sought as part of their drug problems. The responses are quite stark in that they show that many of those who recognised that they had problems did not know where to seek help initially. Looking first at the accessibility of the services, many of those did not finding out about services in a formal way through referral. The main way that people learned about services was through word of mouth. This can be through others who have developed drug problems and also family members. With these responses to the fore, the clients were asked to suggest, from

their experience, areas that would improve the accessibility of existing and future services and supports for problem drug uses. The main points made in the responses are: shorter waiting time and lists; increased out of hour's services (syringe exchanges etc); outreach; and, proactive information dissemination.

The feedback suggests that often the first point of contact for many of those seeking help is through their family and close friends. This invariably leads to contacts with GPs. This is fine in itself but a number of those coming into contact with GPs feel that GP, if not involved with addiction regularly, are not always in position to help them or make appropriate referrals. One aspect of this is that many of the clients will eventually be referred to Trinity Court in the case of Methadone in the GP is not included in the protocol. This points to gaps in terms of the numbers of GPs involved in the Methadone protocol, GPs overall knowledge of addiction and the lack of community-based supports in some areas where addicts reside in the catchment.

In the case of those that do not have a community based project in their local areas to support those with addiction problems, there were some disparaging views made about Trinity Court. Some see it as similar to a 'factory where one size fits all'. Some suggest it is threatening and makes one feel insecure. Unfortunately for many this is tantamount to coming into contact with a wider range of people with drug problems which many feel is not where they would like to be and they would prefer more tailored support. In contrast, the relative personal approach of the community-based projects was viewed as of great benefit to those who were interviewed here.

Other areas of note here is that many felt that it was hard to stay at home or in accommodation with family members of others whom either did not understand drug problems, or were themselves drug users, when the respondent was looking at treatment and undergoing methadone maintenance.

One of the concerns noted also, especially for mothers, was where the supports that they would need for their children and the carers would come from when they went to get help. Again, this is part of the need for wider integrated approaches to drug problems taking into consideration the needs of the individual clients rather that just that of the organisation and support services.

Overall, there is an information gap between services, how they operate and the understanding and knowledge of those who have drug problems. This calls for better information dispersal, outreach and giving this information out generally and as part of the prevention efforts.

IMPROVING EXISTING SERVICE

Following on from the previous questions, clients also outlined their views on what would improve existing services. The responses in general revolved around the following issues:

- *improved contact with key workers, counsellors and other ancillary professionals*
- *better, and more realistic ,education of both medical and social support staff* [24]
- *progression routes and paths in care*
- *integrated services, where they work together as a one stop shop*
- *more information and supports around cocaine and related problems*

[24] There is a distinct view that these people tend to view those with drug problems from their own social and professional lens and not through the lived experience of the drug user. Thus some of the support and approaches are seen as inadequate and doomed to fail.

- *focus more on polydrug use rather than just heroin*
- *choice of counsellors, social workers and doctors*
- *aftercare services*[25]
- *There was a call for a greater variety in the existing projects in terms of activities, areas, supports and progression.*

It is worth paraphrasing one of the interviewees who suggested the current approach of projects allied to Community Employment is, although clearly welcome and improvement on non community based responses, is akin without follow up for many to 'snakes and ladders'.

ADDITIONAL SUPPORTS REQUIRED LOCALLY

As part of the discussion with the various clients and drug users, they were asked to outline what supports they would like to see at the local level for problematic drug users. The following areas were most evident in the responses:

- *The overriding suggestion is the need for a flexible continuum of care approach to drug supports. This is one in which progression is possible and where 'aftercare' is provided. In effect, this means having supports in place at prevention level but then also when drug users area chaotic, stable and then on to rehabilitation toward a 'drug free' status. This in seen to be a long term process and is in keeping with realities of problem drug use and the wider environment according to the drug user's perspective.*
- *Family support, understood here in its widest sense taking in the individual's family, their siblings and extended family and their wider environment was seen as critical for drug users in overcoming and initially coping with drug use in a positive and constructive manner. This is linking the drug user in with their family and vice versa on the part of the focus of the support services.*
- *Better and more appropriate premises for drug projects and places where supports for problematic drug users are provided.*
- *Provision of more realistic, concrete alternative activities for young people especially those in their teens. This view suggested that supports for young people should be in keeping with their worldview. The implication here is that socialisation processes are very strong in terms of inducting young people to drug use. As such, the provision of support must take cognisance of this. There is a sense that drug use is often a rite of passage for young people and that there is little tailored for adolescents in the way of services. The view here is that often this group of young people on the fast track to adulthood and in terms of services are in limbo area between children and adults. It is this vacuum where more alternatives to drug use need to put in place.*

These are the main areas coming out of the responses, each are quite broad. Other issues relate to these and noted in this context also are:

- *Improvements in residential treatment places at the local level*
- *Integrated support provisions with less organisational and geographic boundaries*
- *Professional staff, together with ex-addicts, employed in service organisations*
- *Education and training*
- *Addressing the local economy of drugs*
- *Project and services response to cocaine*

[25] Respondents felt that for the most part there is no support for recovering addicts as they complete project cycles of 3 years. This is seen to effectively put them back to stage one and in the relapse situation. The need for a continuum of care is underlined in the responses and viewed as important therefore to help those to progress through to rehabilitation.

The following suggestions were made specifically in respect of the following areas, which is in keeping with the structure of the DNEDTF and indeed the NDS.

Prevention

Under this heading, the respondents interviewed had a significant amount of comments, views and experiences. At the outset, it was suggested that information about the dangers of drug use alone does not work as a prevention mechanism. The respondents called for a new approach to prevention work and one that goes well beyond prevention education in formal school settings solely. They suggest for instance that efforts should be made on 'street' with young people, in other informal settings as well as in formal ones such as youth clubs, sports settings and schools. This requires therefore an outreach element to the work of the task force and its funded projects and services. In this regard also the responses suggest the message that 'drugs are dangerous' does not work. The considered view of the clients is that a more appropriate message to communicate with those who are more likely to become involved in problem drugs use is to accept and emphasise the drugs are initially 'fun' and 'enjoyable' for some people.

The responses also call for better all round information. At the same time, ex addicts, particularly those who have had negative and difficult experiences due to drug use, should be used as the medium to transmit prevention education messages to young people and those at risk of, or, dabbling in drugs.

The findings here highlight that there is often very little in reality, relative to the social environment that young people find themselves in, to divert this group from drug taking.

Although it is recognised that not all young people are involved in drug taking, a lot of those consulted here believed that existing diversions, recreation and leisure pursuits for this group are limited and more is needed to account and respond to the needs of young people between the ages of 14/15 through to adulthood.

This feedback also emphasised the different and varied biographies of today's drug users. As such, it was suggested that prevention efforts have to be similarly diverse to account for this dynamic.

Finally, it follows that some of the views suggested that prevention efforts not only should be diverse, using multiple methods, to account for the varied biographies of drug users, but should also focus on different age groups. This means not only adults, their families etc., but also adolescents and, crucially, children in the formative years. The implication is that prevention work should be ongoing not just a once off.

Treatment & Rehabilitation

The suggestions made under this heading were touched on in the some of the earlier sections in this chapter, to summarise they are: to professionalise this area of drug response/support work; have better premises in which to undertake this work; involve the experience and benefits of recovered addicts; provision of treatment places at the community/local level.

Supply & Control

The main suggestions made under this heading in the experience of clients revolved around the following themes:

- *ongoing and more developed street, local area presence by the Police. This includes an*

increase in 'raids' in addition to the greater 'street' visibility of the police.

- *respond to the local economic problems which make the supply of drugs very lucrative in the absence of other economic and income opportunities*
- *consider the decriminalisation of minor drugs such as Cannabis which act as gateway drugs and more importantly bring users into contact wit the suppliers of harder drugs such as Cocaine and Heroin.*

Other supports

There were a range of response made under this general heading, there was consensus however around the following areas:

- *greater provision of family support for both those with drug problems, along a continuum of care from chaotic use toward rehabilitation, and in terms of prevention work. This includes the broadest definitions of what 'family support' is. This implies work with children, on parenting, in counselling and other therapeutic approaches and in terms of community development etc.*
- *better integration and collaboration of exiting services for the benefits of the individual and their families rather than for the organisations or service structure*
- *improved and ongoing information dissemination about drug problems and also the various services available*

SUMMARY & CONCLUSIONS

In this chapter, experiences and perception of those with drug problems or recovering from drug problems were brought to bear on the research and therefore the future of the task force. The importance of the responses is clear not only because they refer to the clients and individual on the ground in the catchments but that they also complement the feedback from the stakeholders and the statistical data on prevalence and related issues in the catchment. In other words, the findings here make the overall validity of the findings of the research, and therefore the resulting strategy all the more comprehensive.

The main findings from research among drug users in Dublin North East are as follows:

- Communities in the TF catchment are interconnected in terms of drug use. This seems to call into question that nature of stand alone area based project and the extent, or not as the case may be, of contact with other projects and other areas. A more integrated approach, geographically, seems to be warranted based on these responses.
- The age of those interviewed, who are for the most part heroin users, suggests that those in their teens and twenties are not using Heroin to the same extent of those a generation ahead. This implies that the prevalence of heroine has stayed static at least or perhaps even decreased.
- However, the research suggests that most problem drug users started their drug use in their early teens and this drug use has gone on until the present time. Although this is a characteristic of those with addiction to heroin, it suggests that some of those with serious drug problems have been involved with drugs for almost all, or large parts, of their adult life. The implication of this is that from a support point of view it is extremely difficult to overcome this trend in the life of

the individual. This is made more complex by the reality that nearly all of those with drug problems use a range of drugs simultaneously. In other words, non poly drug use, using only one drug at a given time, is relatively rare.

- What this suggests is that there are a number of combinations of drugs that are most regularly seen. They differ depending on the individual and also their peers. For instance, unlike older drug takers, younger generations may be more likely to use a combination of cocaine and alcohol. It is also the case that through out all polydrug use alcohol and/or cannabis act as a canvass of supports. In short, they are always there in the background.
- There is a strong belief among those with drug problems that some people can use drugs, not get into difficulty and live normal and often successful lives. This serves as a powerful justification for some people in their drug taking. The research suggests also that individuals with more affluent backgrounds, functional family circumstances, negative socialised or peer conventions toward addiction but who share the same initial drug taking biography of problematic here do not fall into addiction.
- Many of the clients use illicit drug alongside prescription ones and those that inject heroine are also more likely to inject cocaine.
- It is of note that some of the clients suggested that the group of people that use cocaine is in general a different one than those that use heroin. This supports earlier findings that a new generation, socially diverse, of drug users has developed and their main drug of choice appears to be cocaine.
- The main factors that are seen as contributing to drug use are: Peer and socialisation processes; Personal and family history; Widespread availability and prevalence of drugs; Enjoyment and pleasure; Social escape and anaesthesia; and, Low self-esteem and education deficiency. Overall, these areas are interrelated and some or all of the factors may have worked together in their personal biography of problematic drugs users.
- The research shows that many of those who recognised that they had problems did not know where to seek help initially. many of those did not finding out about services in a formal way through referral. The main way that people learned about services was through word of mouth. The feedback suggests that often the first point of contact for many of those seeking help is through their family and close friends. This invariably leads to contacts with GPs.
- Those who attended both community based projects and treatment in Trinity court though their GP prefer and local based and relative personal approach of the community-based projects.
- Overall, there is an information gap between services, how they operated and the understanding and knowledge of those who have drug problems. This calls for better information dispersal, outreach and giving this information out generally and as part of the prevention efforts.
- The main areas noted to improve existing services were
  - improved contact with key workers,

counsellors and other ancillary professionals
- better, and more realistic ,education of both medical and social support staff [26]
- progression routes and paths in care
- integrated services, where they work together as a one stop shop
- more information and supports around cocaine and related problems
- focus more on polydrug use rather than just heroin
- choice of counsellors, social workers and doctors
- aftercare services[27]
- There was a call for a greater variety in the existing projects in terms of activities, areas, supports and progression.

- The main additional support that drug users would like to see available are
  - continuum of care
  - Family support,
  - Better premises
  - realistic, concrete alternative activities for young people

- In addition professional staff, local based treatment, integrates services and service locations, socio-economic developments in jobs, training, response to changing drug cultures such as in the case cocaine.

- In terms of the sub committees of the TF and the pillars of the NDS, those consulted here emphasised the following:

  For prevention, more focus should be made at informal settings with young people alongside the more formal ones such as in schools. This emphasises trying to make interventions in the social and peer systems that young people – and others at risk – find themselves in. This suggests outreach work and a message that drugs are initially 'fun and pleasurable' and not a scare mongering message alone. This should be supported by real live stories of former addicts to draw out the realities and hardships of addiction to give a true picture of the dangers of drugs. In addition, prevention efforts not only should be diverse, using multiple methods, to account for the varied biographies of drug users, but should also focus on different age groups.

  Regarding treatment and rehabilitation, the main suggestions are the services should be professionalised, in staff and facilities, be more client needs and experience led and be based at the most local level.

  The main suggestions in terms of supply and control of drugs revolved around a greater policing presence, tackling the underlying economics of drugs and decriminalising 'gateway' drugs.

  There should also be range of 'other supports' in addition to childcare. These refer to broader services and supports to the family, in the community, collaboration between services and existing supports and better information.

[27] Respondents felt that for the most part there is no support for recovering addicts as they complete project cycles of 3 years. This is seen to effectively put them back to stage one and into a relapse situation. The need for a continuum of care is underlined in the responses and viewed as important therefore to help those to progress through to rehabilitation.

References

An Garda Síochána (1999-2005) Annual Report of the An Garda Síochána. Dublin: Garda Headquarters.

Area Development Management/GAMMA (2004) Dublin City, Baseline Data Report. Dublin: Area Development Management.

Byrne, R. (2001) Opiate-related Deaths Investigated by Dublin City and County Coroners 1998 to 2002. Dublin: University of Dublin Addiction Research Centre.

Central Statistics Office (2004) Small Area Population Statistics Series, Census 2002. Dublin: CSO

Central Statistics Office (2006) Preliminary Report of Census 2006. Dublin: CSO.

Cox, G. (2003) Approaches to Estimating Drug Prevalence in Ireland. Dublin: Government Publications (National Advisory Committee on Drugs)

Department of Community, Rural & Gaeltacht Affairs (2005) Mid Term Review of the National Drugs Strategy 2001-2008, Report of the Steering Group. Dublin: Government Publications.

Department of Community, Rural & Gaeltacht Affairs (2005) National Drugs Strategy, Progress Report 2001-2004. Dublin: Government Publications.

Drug Treatment Centre Board (2006) Central Drug Treatment List, Regional Figures. Correspondence, Autumn 2006.

Farrington, D., Connor, A., and Kilbarrack Coast Community Project (2004) A Prevalence Study of Drug Use by Young People in a Mixed Suburban Area. Dublin: Government Publications (National Advisory Committee on Drugs & Kilbarrack Coast Community Project)

Government of Ireland (1996) First Report of the Ministerial Task Force to Reduce the Demand for Drugs. Dublin: Stationery Office.

Government of Ireland (1997) Second Report of the Ministerial Task Force to Reduce the Demand for Drugs. Dublin: Stationery Office.

Government of Ireland (2001) Building on Experience, National Drugs Strategy 2001-2008. Dublin: Government Publications.

Haase, T., and Pratschke (2005) Deprivation and its Spatial Articulation in the Republic of Ireland, New Measures of Deprivation based on the Census of Population, 1991, 1996 and 2002. Dublin: Pobal.

Health Research Board, Drugs Misuse Research Division (2006) National Drug Treatment Reporting System, Specific Report for Dublin North East Drugs Task Force. HRB: Correspondence.

Kelly, F. Long, J & Lynn, E. (2005) Trends in treated problem drug use in the HSE Eastern Region, 1998-2002.

Kelly. A., Carvalho, M, & Teljeur. C., (2004) Prevalence of Opiate Use in Ireland 2000-2001, A 3 Source Capture-recapture Study. Dublin: Government Publications (National Advisory Committee on Drugs)

Long, J., Lynn, E. and Keating J (2005) Drug-related deaths in Ireland, 1990-2002. Overview 1. Dublin: Health Research Board.

NACD & DAIRU (2005) Drug Use in Ireland and Northern Ireland, First Results (Revised) from the 2002/3 Drugs Prevalence Survey Bulletin 1. Dublin: Government Publications (National Advisory Committee on Drugs and the Drug)

NACD (2006) Drug Prevalence Estimates for LDTF Areas, Data from the 2 Source Capture-recapture Structured Methodology. NACD: Correspondence to TFs.

Northside Partnership (2005) Turning Points, Annual Report 2004. Dublin: Northside Partnership.

Watters, N., & Byrne, D (2004) The Role of Family Support Services in Drug Prevention, Dublin: Government Publications (National Advisory Committee on Drugs)