Mid-Term Review of the National Drugs Strategy

Submission from
CityWide Drugs Crisis Campaign

September 2004

Introduction.

The anger of local communities and the campaigns that grew out of that anger played a major role in finally making the drugs crisis a political priority in 1996. At that time, we saw the recommendations of the Ministerial Task Force on Drugs being implemented without delay and budgets being put in place to facilitate prompt delivery of plans. For the next few years, it seemed that the political will was there to tackle the drugs crisis and many projects and programmes came into being, offering hope for a better future for our drug users and their communities.

A significant number of people in local communities are directly involved both in the delivery of services to drug users, which have expanded in a major way since 1996 and many are also involved in local structures like the LDTFs. They are clearly aware of and have been directly involved in much of the progress that has been made, in partnership with a range of state agencies. Communities are now involved in structures, where there were no structures for them in 1995.

Yet, the overall impression at this time of the Mid-term Review is of communities that are tired, disillusioned and worried.

> Communities are tired, (they) feel shafted, feel disempowered, feel blamed.
> (There is a) wider acceptance among people of drug use.
> Communities are tired. There is a tolerance of the situation and communities feel shafted.
> People are throwing in the towel. The hope of leadership and tackling it (the drugs crisis) has gone
> Communities feel ground down, there is a "reluctant acceptance" of the drugs issue.
> People are no longer approaching their politicians for help, Councillors are no longer approached by the community about drugs issues.
> Communities are demoralised and need to be re-motivated.
> The heart has gone out of communities in relation to the issue, communities are drained of energy.

Why do communities feel like this after eight years of the Drugs Strategy, when the progress and achievements since 1996 are both clearly recognised and acknowledged? In this submission, three main reasons are identified.

1) **The structures that were put in place to deliver a community-led, partnership approach have been undermined and, as a result, the role of local communities has been diminished.**
2) **Local community projects have experienced cutbacks in their budgets for delivering services to drug users, despite commitments to ringfencing of drug strategy monies.**
3) **While it is the clear view of local communities that they are continuing to live with a serious drugs crisis, there has been a general failure to deliver on the actions outlined in the National Drugs Strategy.**

Section 1) Structures for delivery – LDTFs, NDST, RDTFs.

The Local Drug Task Forces.

The model for the Local Drug Task Forces came from within the community, when ICON set up the Inter-Agency Drugs Project in the North Inner City. Communities recognised the need for community-led, partnership structures to tackle the drugs crisis and welcomed the setting up of the LDTFs as a means of developing this community-led, partnership approach. In the early years of the Task Forces it appeared to communities that the state was committed to making the model work and to giving a real role to communities in the response to the drugs crisis.

However, it is the view of the LDTF community representatives and community organisations that the role of the Task Forces has been undermined during the last two to three years and that this represents an undermining of the role of local communities. There is a whole range of indicators of this:

- The IDG began to intervene more actively in questioning local plans that had been approved by the NDST.

- This led to delays in the implementation of projects in the second plans and some were never implemented.
- A previous commitment to provide additional staff for LDTFs was withdrawn.
- Many of the recommendations of the Burtenshaw report were not implemented.
- No commitment was given to the future life of the Task Forces at the end of the second plans in 2002.
- No additional budgets have been allocated to Task Forces in the last three years.
- The strategic role outlined for Task Forces under the second plans has not been implemented and the Task Forces have been sidelined in relation to policy issues.
- Despite the emergence of a significant and worrying trend in the use of cocaine in LDTF areas, the Task Forces have been given no mandate to respond to the problem.
- The Health Boards have bypassed the Task Forces in their implementation of the mainstreaming process, resulting in significant problems for services.
- A year has been wasted in a meaningless consultation process on rationalisation, the outcome of which is to add an additional layer of bureaucracy to the Task Force process and further diminish local community involvement.

Priorities for Action.

- An immediate commitment should be made to the future of the LDTFs and budgets allocated to enable them to respond to the changing local drug problem.
- This would include a particular focus on addressing the developing cocaine problem, where this is relevant.
- The Task Force process should be publicly relaunched, in order to restore the confidence of local communities and of community representatives and to restore local communities to a lead role in the strategy.

The National Drug Strategy Team.

Another innovative feature of the Task Force model was the direct relationship between the LDTFs and National Drug Strategy Team. This link between the national and local structures meant that communities had direct contact with the people who were making decisions about their local strategy. However, from the community perspective, this relationship has been less effective in the last few years for a number of reasons

- The IDG has cut across the NDST role in approving local plans and affected the delivery of integrated plans at local level.
- The NDST has not been able to resolve the difficulties that have arisen at local level, in particular between local project promoters and the Health Boards.
- The NDST has not been supported in developing its overall strategic role in relation to the drugs issue.
- The NDST has been sidelined in the consultation process around rationalisation and the proposal to give a role to the CDBs will further diminish its role.

Priorities for action.

- Priority should be given to addressing how the NDST can be supported by the IDG and Cabinet sub-committee in developing its strategic role around the drugs issue.
- The direct relationship between the NDST and LDTFs should be maintained and the Task Force process should remain independent of the CDBs or other bureaucratic structures.
- The community sector has been represented on the NDST in an exceptional manner by Fergus McCabe. However, the workload is impossible for one representative and means that there is a huge imbalance in the sectoral representation on the NDST. A minimum of two new community representatives should be added to the NDST, one selected by the LDTF community representatives and the second by the RDTF community representatives.

The Regional Drug Task Forces.

The Citywide policy document **in 1999** stated "There is a need for the National Drugs Strategy to become genuinely national. It would be absolutely inexcusable for any other city or town in Ireland to experience a heroin epidemic similar to Dublin. Yet this will happen unless preventative strategies are put in place before heroin has taken hold in other cities or towns. Waiting until there is a heroin problem is leaving it too late." What is the situation five years on?

The recent paper from the DMRD says about the regions "The incidence of treated problem opiate use increased sharply, from 2.0 in 1998 to 8.3 in 2002. The increase in new problem opiate users at treatment services indicates a spread of heroin use in the seven health board areas."

There has been considerable delay in the setting up of the Regional Drug Task Forces and now that they are finally in place, there are serious concerns amongst community representatives and community organisations about how they are working. It is the view of the RDTF community representatives that the current provision of part-time co-ordinators is totally inadequate and indicates a lack of serious commitment to making the Task Forces work. There is also concern amongst the community representatives that the current Health Board run structure is compromising the independence of the RDTFs, in effect they are being seen as health board structures rather than partnership structures in which the Health Boards participate.

The use of the CDB fora to select community representatives has proven problematic in some areas, and this role for the CDBs was intended to be an interim measure while the development of local community networks was supported. The development of these networks has not in fact been supported. There are also particular challenges in carrying out the role of the community representative on the RDTFs, given the size of the regions and the range of drug related issues that are present. The representatives are clear about their need for more support at local level and more networking at national level.

Priorities for action.

- Full-time co-ordinators must be employed as a matter of urgency.
- It is essential that, once fulltime co-ordinators are put in place, there is a formalised induction process for all of the agencies involved in the RDTFs, so that the independence of RDTF structures from the Health Boards is clear.
- The development and support of the community networks needs to be a priority for each Task Force and resources need to be made available for this.

- Resources need to be available both at regional and national level to provide for support and networking of RDTF community representatives.
- Citywide participated in a national meeting in September 2001 to encourage community organisations to become involved in RDTFs. Since then, most of the commitments given to those communities have been broken. It is essential that budget allocations for the RDTFs are announced immediately to restore the faith of local communities in the process.

Finally, there is one more important point that needs to be made in relation to the structures. From 1996 to 2002, there was a Junior Minister with dedicated responsibility for the Drugs Strategy and other Local Development issues. Since 2002, this has in effect been reduced to half a junior ministry, as the current portfolio has been expanded to include responsibility for housing within the Dept. of the Environment. This change was seen by communities as a clear signal of the declining importance of the drugs issue to government and it needs to be reversed without delay.

Section 2) Cutbacks in budgets for community drug projects.

The delivery of Task Force plans has seen a significant investment in community drug projects and many of these projects have been to the fore in the development of community treatment services for drug users. Despite this key role, many of the projects have spent the last two to three years struggling with cutbacks and reduced budgets. For many community services, this has meant no increases in budget, which is an effective cutback. Other projects have experienced outright cutbacks in their budgets and this includes community-based projects that have been acknowledged as models of good practice e.g. Saol. These budget cuts have meant that some projects have had to drop the development of the very services that are outlined as actions in the National Drugs Strategy e.g ARC had to drop some of its non-medical treatment options.

Difficulties have also arisen for community projects because of the lack of engagement by the Health Boards in the Task Force process and in a partnership model of working. The Health Boards have made decisions unilaterally about mainstreamed projects and have not engaged in consultation either with the projects concerned or with the Task Forces about the issues arising This is in breach of the agreement that was made with community representatives in the early years of the Strategy about how channel of funding arrangements would work and it should not be acceptable for one party to unilaterally change the rules.

This experience has led community projects to the view that while the need for community led approaches was recognised in the earlier years of the strategy, there is no longterm commitment to maintaining and developing these approaches.

Priorities for action.

- The Health Boards, and any other agencies that act as channels of funding for Drug Task Force monies, should be required to consult with the LDTFs around the development of local drug services and the use of drug strategy funding. The IDG and NDST need to put in place a monitoring system to ensure that this happens.

Section 3) Actions outlined in the National Drugs Strategy.

Treatment.

Update on the situation in local communities.

- Heroin use continues to be a devastating problem, but it is now best described as a problem of poly drug use. People who are using heroin are not using it on its own, they are using a mixture of all sorts of drugs. While poly drug use is not a new phenomenon and has always been there, people believe there is an increase in the scale and extent of it and in the range of drugs being used now.

- This means that it is no longer appropriate to look at or deal with someone's primary drug of use without looking at the other drugs as well. Heroin, cocaine, alcohol, benzos and other drugs are all being taken together.
- Cocaine use has increased significantly in the last couple of years. It is being used with heroin, it is being used by people who have never taken heroin, people who have got clean from heroin are going onto cocaine.
- Crack is not widely available as of yet, but in a small number of specific areas, it is available and being sold in identified locations in the local community.

The National Drugs Strategy clearly acknowledges the need for major developments in the treatment services. The lack of delivery of the actions outlined in the drugs strategy, combined with health board cutbacks in budgets for projects that were supposedly ringfenced as part of the drugs strategy, has generated huge disillusionment in communities around the current state and future development of the treatment services.

Action 45 in the Strategy sets out an increase in the number of treatment places for opiate addiction. This is one of the few actions that has been delivered, with the numbers on the treatment list at 7074 in May 2004.

The following actions have been identified as priorities by communities in relation to treatment.

Action 48

To have in place, in each Health Board area, a range of treatment and rehabilitation options as part of a planned programme of progression for each drug misuser, by end 2002.

Action 51

To have a clearly co-ordinated and well-publicised plan in place for each Health Board area by end 2002 for the provision of a comprehensive and locally accessible range of treatments for drug misusers.

Action 55.

To explore immediately the scope for introducing greater provision of alternative medical and non-medical treatment types, which allow greater flexibility and choice.

Progress to date.

No additional resources have been made available during the last three years to implement these actions. Therefore while numbers in treatment have increased, there is serious concern in communities about the quality and range of services that are currently available. The critical implementation path now says the plan is to "develop services where required depending on resources." This represents a serious weakening of commitment to the development of quality drug treatment services and is not an acceptable position.

Priorities for Action.

- There needs to be an immediate allocation of resources to begin the implementation of these actions.

Action 47 refers to the recruitment of additional staff to develop rehabilitation services.

Progress to date.

Where Health Board integration workers are in place, they have no operational budgets and no increase in rehabilitation infrastructure to which to refer people. CE Special Projects continue to be the central plank of rehabilitation services, but the number of places on CE has not increased in line with the increase in numbers on the treatment list. The CE Projects, as well as delivering individualised programmes for their clients, have developed a significant advocacy role in trying to deal with the range of issues that impact on people's rehabilitation. A number of blocks in the social welfare and housing systems have been identified by projects and changes that have been made recently in social welfare provisions, eg. restrictions in rent allowance, are having a negative effect.

Priorities for action.

- The broad range of supports that the CE projects provide needs to be acknowledged through an adequate funding package from both Fas and the Health Boards.
- There is a need to develop additional actions in the Strategy that address the social welfare aspects of rehabilitation
- Action 88 says that government departments should inform NDST of any initiatives that will affect Task Force areas. Is this happening at all? Did Minister Mary Coughlan refer her recent changes in the social welfare codes for consultation about how they might impact on drug users and their rehabilitation? Action 88 needs to be activated.

Action 54 – to consider, as a matter of priority, how best to integrate childcare facilities with treatment and rehabilitation centers.

Progress to date.

Not only has there been no progress on this action, but the reality is that cutbacks in CE and childcare grants have impacted on the availability of existing childcare services in the community. Did these cutbacks come to the NDST for consideration as outlined in Action 88?

Priorities for action.

- The impact of CE and childcare cutbacks on drug projects and drug users should be considered by the NDST under Action 88.

The cocaine issue.

Since the consultation on the Strategy took place, the increase in cocaine use has emerged as an issue of significant concern for local communities and community services. This new trend is placing further pressure on existing services that have largely been developed to address an opiate problem. Citywide research carried out at the end of 2003

showed that out of 29 community drug projects across Dublin that replied, 28 were working with clients who use cocaine, despite having no additional resources.

A subcommittee of the NDST is looking at developing a number of pilot projects around cocaine and, while any initiative to develop services is welcome, this initiative has effectively bypassed the local structures which are in place and will divide out the available resources amongst those who were invited to the table. Where does this leave the community projects in our study who are already attempting to provide some service for cocaine users?

Priorities for action.

- The response to cocaine should be progressed through Local Drug Task Force structures. That's what they are there for, to respond to the changing local drug problem. The LDTFs should be given an immediate mandate to draw up action plans on cocaine that are appropriate for their local area and a budget to deliver on the plans.

Action 86 recognises the need for better co-ordination in relation to alcohol policy. The alcohol issue and how it is to be addressed continues to be a priority for RDTFs. While there may be some links developing at national level, there is a need to look at how co-ordination can be made more effective at a local level.

Supply control.

Update on the situation in local communities.

Despite all of the difficulties, communities are clearly engaged around the treatment issue and have clear ideas about what needs to be done. Around supply issues and related issues of anti-social behaviour, the picture from communities is much bleaker. This is

where many of the most negative feelings arise and where it is hardest for people to see where any progress has been made.

- The whole range of drugs, including prescription drugs such as benzos, are widely and easily available. In many areas, they are very visibly available.
- There are some communities where there seems to be no fear around visible drug dealing and people in those communities feel that it is going on all around them, in public places, on the street. In these communities, far from becoming more sophisticated, drug dealers appear to people to be becoming more blatant and more brutal.
- Public drug dealing seems to have stopped in some areas, but it has been displaced to other nearby areas.
- A media report which was featured on RTE News illustrated this point very well. Previously, drug dealing had been going on very visibly in a particular location in one community. To the reporter, the dealing is no longer visible. But he was brought a short distance up the road to a shooting gallery, hidden under a bridge on a main route into town, where thousands of cars drive over every day, unaware of what is going on underneath the bridge.
- The violence associated with the drugs trade is being experienced by some communities in particular.
- In other communities, dealing is less visible, but this does not seem to mean that there is any less availability. This is attributed in part to an increasing sophistication amongst drug dealers, who have access to more advanced technology, like electronic equipment, and have developed more skilled marketing techniques.
- There was an overwhelming sense of the inevitability of dealing and powerlessness amongst communities to do anything about it. The belief that communities can do something to stop the sale of drugs, as in the mid 90s does not seem to be there anymore.
- This feeling of powerlessness in the face of drug dealing goes across communities. All communities describe a reluctance to get involved in the issue now. However, the context varies considerably across communities, from some

areas where there is a general unease about getting involved to others where there is a very real, definite and identifiable fear. This level of fear is strongly related to the levels of violence and intimidation that are attached to drug dealing in certain communities.

- Drug users are particularly vulnerable to fear and intimidation and drug dealers use violence both against users and against each other. But the entire community is affected whether it is by nuisance, anti-social behaviour, intimidation or violence. Once this is happening in the community, everyone feels unsafe, even if they do not appear to be under direct personal threat.

The following actions in the Strategy were identified as priorities:

Action 7.

To increase the level of Garda resources in LDTF areas by end 2001, building on lessons emanating from the Community Policing Forum model.

Progress to date.

The pilot community policing forum in Rialto, Inchicore and South Inner City has been refused the resources for a co-ordinator and has been struggling even to get funding for basic running costs. This is at a time when the problems around drug dealing in parts of this community are so severe that the local community network has been in contact with the Garda Commissioner about the scale of the problem. The experience of the North Inner City Community Policing Forum confirms the necessity for these fora to be funded if they are to be effective.

Priorities for action.

- If Community Policing Fora are to be established in Task Force areas, then resources must be provided to run them.

Action 8.

To establish a co-ordinating framework for drugs policy in each Garda district , to liaise with the community on drug-related matters and act as a source of information for parents and members of the public. Each Garda district and sub-district be required to produce a Drug Policing Plan to include multi-agency participation in targeting drug dealers.

Progress to date.

There is serious concern around the potential impact of the new Garda Bill, which sets up a formal partnership between the Gardai and local authorities and has no formal role for community representation.

Priorities for action.

- The Garda Bill should be referred to the NDST for consideration of its potential impact on community policing structures, as allowed for in Action 88 of the strategy.

Action 10.

To continue to target dealers at local level by making additional resources available to existing drug units and for the establishment of similar units in areas where they do not currently exist.

Priorities for action.

- It has been announced that hundreds of gardai will be freed up by the privatisation of fine collection and many diverted to traffic control. The IDG and the Cabinet Sub-committee should consider how some of these Gardai can be redeployed to expand the existing Drug Units and to establish new ones where they do not currently exist.
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Action 20 – to have in all LDTF areas an early intervention system, based on the Drug Court model.

Progress to date.

Again the existing drug court has experienced ongoing difficulties with resources and there has been no expansion beyond the North East and North West Inner City. The commitment given at the start of the pilot was that while no new resources would be made available for the pilot itself, once it proved successful then additional resources would be allocated. This has not happened.

Action 4 refers to a framework for monitoring prosecutions, arrests and sentencing.

Priorities for action.

- An issue that receives a lot of public attention is the existence of a ten year minimum sentence for drug dealing on the statute books. This is not being implemented, nor is it appropriate to implement it, so it should be removed.
- The key issue in relation to sentencing is the training which judges receive to enable them to deliver a coherent sentencing policy around drug use and dealing. What training are judges currently receiving in this area?

Action 24 – to expand the involvement of the community and voluntary sectors in prison drug policy via Local Prison Liaison Group and meetings between sectors and Steering Group.

Progress to date.

The Local Liaison Group has developed as a useful means of communication and information exchange between the prisons and the community/voluntary sector and should continue to be supported. The meetings with the Steering Group have not continued as they did not prove effective and the community/voluntary sector continues to maintain that is should be formally represented on the Steering Group as the most effective and efficient means of involvement.

Young people.

Update on the situation in local communities.

- There is a strong culture of acceptance of drug use amongst young people, particularly around alcohol and hash, and this culture is supported by the adult culture around alcohol.
- Drug users are getting younger, are starting to take drugs at a younger age, in particular alcohol and hash. Solvent use is an issue with the younger age group.
- Younger people see cocaine as an attractive drug and believe that it is clean and safe in comparison to heroin.
- There is a multi generational problem with drug use in some communities. Not only are two generations affected in some families, but we are also seeing drugs affecting three, if not four, generations.
- The services are not available in local communities to deal specifically with young peoples drug use. Probably of even greater concern, is the lack of any adequate social care services for young people.
- Where drug use is prevalent in the community, it affects the lives of all children in that community, not just the young people who are using drugs. Childhood is being ruined for many children, because their parents don't feel that its safe to let them go out, they don't feel its alright to let them play around their own area because of fears related to drugs and the wide availability of drugs in the community.
- As they become teenagers, young people are now seen as problems within their own communities, they are seen as "problems" to be dealt with or if that fails to be moved out. Their normal behaviour –"hanging around" – is seen by parents and the community as risky behaviour, both for the young people themselves and for others in the community.

The following actions were identified as priorities.

Action 49.

To develop a protocol, where appropriate, for the treatment of under 18year old presenting with serious drug problems. In this context, a Working Group should be established to develop this protocol. The Group should report by mid 2002.

Action 59.

To secure easy access to counselling services for young people seeking assistance with drug related problems, especially given the correlation between suicide and drug misuse and the growing incidence of suicide amongst young people.

Action 51.

To have a clearly co-ordinated and well-publicised plan in place for each Health Board area by end 2002 for the provision of a comprehensive and locally accessible range of treatment for drug misusers, particularly for young people. These plans to be implemented by end 2004.

Progress to date.

According to the critical implementation path, the Working Group's report was drafted by early 2004 and plans are to be implemented during 2004/2005.

Priorities for action.

- There is an immediate need to set out clear priorities for action based on the conclusions of the report. The actions need to be specific, costed and implementation should begin without further delay.

The Young Peoples Facilities and Services Fund.

Progress to date.

A significant level of resources has been delivered through the YPFSF. However, there is concern amongst some communities about the extent to which the YPFSF has failed to develop the kind of services needed for the young people who are most at risk e.g how many of the services are open in the day time and early evening but not at night time? How many of the services engage in a targeted way with the young people who are excluded, or exclude themselves, from mainstream youth services? The YPFSF is a key

initiative on the prevention side of the drugs strategy and it is essential that it is targeted effectively at the young people most at risk.

Priorities for action.

- To strengthen the role of the YPFSF as part of the drugs strategy, the local assessment committees should now be absorbed into the Task Force structure and should work as sub committees of the Task Force at local level. Similarly at national level, the NAC should be absorbed into the NDST

Involvement of drug users.

Citywide supports the active involvement of drug users and service users in the National Drugs Strategy and continues to work in partnership with UISCE and other user groups. Action 46 commits the Health Boards to the development of a service-user charter specific to treatment and rehabilitation facilities. However, a charter is only of use if there are procedures to monitor how it is being implemented. It is essential that the development of drug users fora is supported and resourced in each Task Force area, so that drug users can participate both in the monitoring of services and in the wider debate on the drugs issue.

Family Support.

Citywide continues to support and facilitate the work of the Family Support Network and supports the submission of the Network in relation to inclusion of families and family issues in the Strategy.

Travellers.

Citywide continues to work in partnership with Pavee Point in relation to Travellers and the drugs issue and in developing links between local community groups and Traveller groups. Citywide supports the Pavee Point submission to the review.

New communities.

Many local communities are now home to a considerable number of non-nationals from a range of different countries. In the Canal communities area, work is being done locally to make contact with these new communities in relation to the issue of drug use.

Research that has been carried out by Merchants Quay and the NACD has also tried to make links with new communities. All of this work indicates the difficulties that face us in making contact with new communities around the drugs issue, but it needs to happen. This should now be identified in the Strategy as an issue for further development.