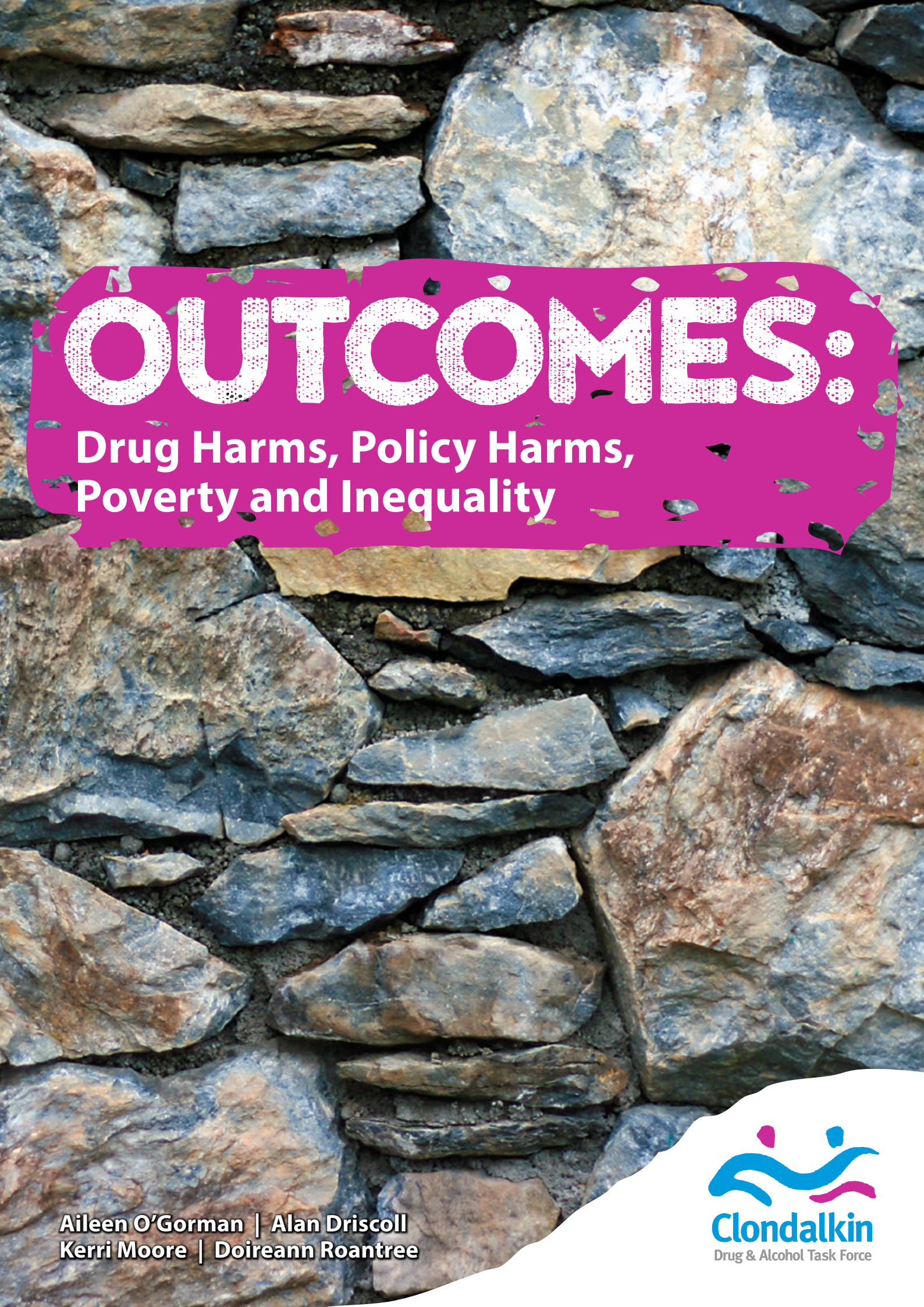

OUTCOMES:

Drug Harms, Policy Harms, Poverty and Inequality

Aileen O'Gorman | Alan Driscoll
Kerri Moore | Doireann Roantree

Clondalkin
Drug & Alcohol Task Force

Final Report to the Clondalkin Drug and Alcohol Task Force

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DISCLAIMER:

The views expressed in this report are those of the authors and do not necessarily represent the views of the Clondalkin Drug and Alcohol Task Force or the University of the West of Scotland.

ABOUT THE AUTHORS:

Dr Aileen O'Gorman is Senior Lecturer in Alcohol and Drug Studies at the University of the West of Scotland. Previously, she was Lecturer and Coordinator of the Diploma in Community Drugs Work at the School of Applied Social Science UCD; senior research officer with the National Advisory Committee on Drugs; a community regeneration researcher at Fatima Mansions; and a research officer with the Drug Misuse Division of the Health Research Board. She was a member of the Rialto Community Drugs Team managing committee from 2005-2015.

Alan Driscoll and Kerri Moore are graduates from the Diploma in Community Drugs Work and the B.Soc.Science in UCD and work respectively as a community fieldworker and a project worker with Merchants Quay Ireland. Doireann Roantree is a BESS graduate from Trinity College and a postgraduate medical student at the University of Limerick.

Clondalkin
Drug & Alcohol Task Force

UNIVERSITY OF THE WEST of SCOTLAND
UWS


Old Ruins in Shancastle, North Clondalkin

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FOREWORD
Chairperson CLDATF

I want to begin by thanking Dr Aileen O'Gorman of the University of the West of Scotland and her colleagues Alan Driscoll, Kerri Moore and Doireann Roantree for carrying out this timely research. The Clondalkin Local Drug & Alcohol Task Force (CDATF) commissioned this research in order to document and achieve an external assessment of what we knew from experience was happening locally in relation to drugs and drug use. Crucially, the research offers the Task Force the opportunity to design a blueprint and direction for future planning and action and confirms our commitment to the next stage of our work.

Overwhelmingly, one thing that is striking about the research findings relates to the current level of poverty existing within the Task Force area. In casting our mind back twenty years to 1996, the Chairperson of the Ministerial Task Force on Measures to Reduce the Demand for Drugs, in his Preface & Executive Summary of the First Ministerial Report, declared unequivocally that drug problems and those using drugs:

> *"...are concentrated in communities that are also characterised by large-scale social and economic deprivation and marginalisation. The physical/environmental conditions in these neighbourhoods are poor, as are the social and recreational infrastructure ... Life in these estates for many has become "nasty, brutish and short." This cannot continue. The drugs problem is now probably the greatest single problem facing the capital. It must be solved . . ."*

It is worth revisiting these words at this time because our research has confirmed that poverty and related drug harms are still major issues twenty years later in 2016. Unemployment, and associated difficulties, in the Clondalkin area is particularly high and well in excess of the national average. The relationship between poverty, inequality and drug use continues to be, as it was twenty years ago, a major issue. Government policies have continued to impact, negatively it appears, on the levels of poverty in Clondalkin and other areas. Dr O'Gorman, in her research, refers to such policy harms by quoting the Economic and Social Research Institute (ESRI) which describes these harms as 'policy induced losses'.

Another feature of Local Drug Task Forces in 1996 was the bottom up approach adopted by them. This model of statutory, voluntary and community participation recognised the experience of those living within the community and used this to great effect. However, the partnership arrangement has come under some strain over time and in 2016 there is a need to revisit those earlier principles and re-establish them in practice.

Of great importance also are the findings about the emerging needs of children, young people and adults within the Clondalkin community. However, once again, the research recognises there is a wealth of knowledge within the area when it comes to dealing with the many complexities facing these young citizens. Any new developments within this area should take this local knowledge and long-time experience into consideration.

It is clear that the primary aim of the Clondalkin Local Drug & Alcohol Task Force is to respond to drug issues in the area and to help in reducing or minimising the demand for and damage caused by drugs. The Task Force also has a role to educate and deter people from using drugs in the first place. Nevertheless, we are faced on a daily basis with the reality that people do take drugs and as such they face risks to their health, safety and wellbeing. We are aware that patterns of

It is clear that the primary aim of the Clondalkin Local Drug & Alcohol Task Force is to respond to drug issues in the area and to help in reducing or minimising the demand for and damage caused by drugs.

drug use change, new methods of administering the many and various types of drugs appear and the landscape changes as new drug preferences emerge. As ever, this and other Task Forces need to be continually vigilant in monitoring drug and drug use trends while at the same time develop ways to communicate with those same drug users about minimising health risks and harms.

The Task Forces have endured significant losses of funds over recent years. We are expected to do more and more with ever decreasing resources. This simply cannot continue. In order to do its work of responding to the various challenges identified in this report, CDATF must have the funding, resources and recognition necessary in order to keep abreast of changes taking place on an ongoing basis.

However returning to the issue of poverty it is a well-used and worn metaphor that all boats should rise with incoming prosperity. It might be aptly suggested that some yachts have risen while we still await with some concern the rise of all the boats. I invite you to read this report that highlights the ongoing existence of poverty, inequality and drug and policy related harms in this community.

Ray Mc Grath
Chairperson, CDATF

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ACKNOWLEDGEMENTS

This research study was commissioned by the Clondalkin Drug and Alcohol Task Force (CDATF) through a Request to Tender advertised in December 2014. I am very grateful to Sandra Mullen the CDATF Coordinator and its Chairperson Ray McGrath who, along with members of the Research Advisory Group: Noreen Byrne, Maria Finn, David Lynch and Rosie McGlone, provided very helpful guidance and support throughout this process. Special thanks also to Jennifer Clancy and Tara Deacy at CDATF for their very helpful support and to Dr Marguerite Woods for her helpful and insightful comments on an earlier draft of this report.

A tremendous thank you to Alan Driscoll, Kerri Moore and Doireann Roantree for their research assistance and input into the fieldwork, data gathering, transcription and data analysis for this study.

A very special thank you to all those who participated in the interviews, focus groups and conversations for this research study including residents across the Clondalkin Drug and Alcohol Task Force area; members of the Clondalkin Drug and Alcohol Task Force and its sub-groups (Treatment and Rehabilitation; Prevention; and the Community Representatives Forum); the members, staff and service users of services and programmes in the CDATF area including: the Addiction Studies Group, Balgaddy Women's Group, Carline, Clondalkin Addiction Support Programme (CASP), Clondalkin Travellers Development Group, Clondalkin Youth Service, Crosscare, Dochas Family Centre, An Garda Siochana, Garda Youth Diversion Projects, HSE Addiction Services, HSE Social Inclusion Services, Neart Le Cheile (Cumas and Cairdeas projects), North Clondalkin Community Development Programme, North Clondalkin Community Safety Forum, Ronanstown Youth Services, School Completion Programme, South West Clondalkin Community Safety Forum, South Dublin County Council, South Dublin County Partnership, and Clondalkin Tus Nua.

Additional thanks to my colleagues at the University of the West of Scotland for their support, in particular Professors Avril Taylor and Bob Pyper; Louise Ryan (Research Office) and Duncan Sloan (Finance Office).

Aileen O'Gorman [1]

[1] Corresponding author: Dr Aileen O'Gorman, School of Media Culture and Society, University of the West of Scotland. Email address: Aileen.O'Gorman@uws.ac.uk

Round Tower Clondalkin Village

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REPORT SUMMARY

INTRODUCTION

In 1997, the government established Local Drug Task Forces (LDTFs) which were later renamed Drug and Alcohol Task Forces (DATFs) as an area-based policy response to the dual concentration of problem drug use (at the time mainly injecting heroin use) and poverty and social exclusion. The Clondalkin Drug and Alcohol Task Force (CDATF) was one of fourteen task forces set up at that time, replicating the model of community-led interagency partnerships that had developed in many areas of the city overwhelmed by epidemic levels of heroin use among its young people.

For almost twenty years the Task Force has worked to reduce drug-related harms to individuals, families and communities by working in partnership with key stakeholders in the community, voluntary and statutory sectors on the coordination and delivery of services. In 2015, mindful of the significant changes in patterns of drug use, deteriorating economic and policy environments, and the impact of austerity policies for people and services in the area, the CDATF commissioned this research study to inform its future strategic planning and discussions on policy and practice.

RESEARCH AIMS AND METHODS

The aim of this research study is to provide an in-depth understanding of current patterns of drug use, drug-related harms and emerging needs of individuals, families and the community in the Clondalkin DATF area. The research also seeks to explore the relationship between poverty, inequality and drug-related harms; and the impact of the changing policy environment on the capacity of drug task forces to coordinate a community-based multiagency partnership response to drug use.

The research study used a community and participatory methodology which included ethnography (street based research) and qualitative methods (in-depth interviews and focus groups) coupled with an analysis of indicators of drug trends and local socio-economic data. This approach helped to reach an in-depth understanding of local drug consumption practices and drug-related harms at the individual and community level. In addition, the study examined the impact of the prevailing social, public and drug policy environments on the lived experience of residents in the area and the work of the Drug and Alcohol Task Force and community-based services.

Overall, ten focus groups were conducted with 80 individual participants. A further sixteen one to one interviews were conducted with current and former drug users, representatives from the statutory, community and voluntary services, and members of the CDATF Board. Further data were collected through individual interviews and conversations with 50 contacts over the course of 100 hours of ethnographic fieldwork.

The report is divided into sections which examine the context of poverty, inequality and policy-related harms; drug trends; groups at risk of drug-related harms; and the policy environment and experience of partnership and interagency working.

POVERTY, INEQUALITY AND POLICY-RELATED HARMS

Since the Great Recession began in 2008, levels of poverty in Ireland have increased significantly and disproportionately with some social groups experiencing much higher rates of poverty than others. More than half of the people who live in social housing, are unemployed, or who live in lone-parent families experience deprivation and over a third are defined as being 'at risk of poverty' – they live on less than 60% of the average income which amounts to less than €200 per week.

The Clondalkin DATF area is home to a disproportionate number of people experiencing poverty, such as people out of work. The number of people registered as unemployed trebled from over 3,500 to 10,000 (a 179% increase) in the first three years of the recession.

Media and political discourses tend to pathologise people, groups and communities that experience poverty as an outcome of individual or family dysfunction. Little attention is paid to the role government decisions and policies play in shaping negative life outcomes for people.

The political responses to austerity and the decisions taken to restructure and retrench the welfare state have resulted in vulnerable people disproportionately experiencing a series of policy induced harms. The harmful outcomes of policies that have reduced supplementary welfare payments, which provide an important cushion against poverty, and the funding for voluntary and community organisations who provide support for people experiencing poverty are seen as a form of structural violence by the state - defined as the avoidable impairment of fundamental human needs (Farmer, 2006; Galtung, 1990).

The social research evidence is clear - drug use disproportionately harms people who experience challenging lives rooted in poverty and inequality. Where poverty clusters at a neighbourhood level, drug-related harms cluster too. This study identified deep pockets of poverty and inequality within the CDATF area placing its residents at a high risk of experiencing drug-related harms. This level of risk can be traced to policy induced harms and the structural violence of the state rather than individual behaviour.

DRUG TRENDS

Since the Clondalkin Drug and Alcohol Task Force was established, patterns and trends in drug consumption have evolved in response to global and local shifts in drug production and supply, and in fluctuating levels of demand influenced by accessibility, price, quality, and cultural appeal. Currently, the most common drugs taken by young people in the region are alcohol, cannabis, cocaine, ecstasy and new psychoactive substances - rates of 'any illegal drug' use have almost doubled in the previous five years.

Drug use surveys focus on the use of individual drugs whereas drug use in the everyday world is a polydrug activity. In the CDATF area, patterns of polydrug use mainly included combinations of (herbal) cannabis, 'tablets' (various prescription pills such as benzodiazepines and 'Z drugs') and alcohol. Cocaine, new psychoactive substances such as mephedrone, and various ecstasy type substances are widely used in recreational settings. Heroin and crack cocaine continue to be used by a small proportion of habitual drug users with few young people reported to be currently using these drugs.

Though drug trends may come, go and reappear there was a general consensus among our research participants that there was 'no shortage of drugs' in the area and that use had increased with the recession.

RISK GROUPS FOR DRUG-RELATED HARMS

This research study identified four groups at a high risk of drug-related harms; the in-treatment population; family members affected by drug use; the Traveller community; and socially excluded young people engaging in drug risk behaviours and the drugs economy but out of touch with services.

People in drug treatment highlighted the adverse impact of the restructuring of welfare programmes and reductions in welfare benefits; the lack of respite and detoxification options for those wishing to exit treatment; the lack of treatment for problems with benzodiazepine use; and the lack of engagement by HSE drug treatment services with the community and voluntary services and key workers supporting them.

For most people whose drug use has become problematic there is a family member whose life has been affected by their use. Parents, partners and siblings of problem drug users outlined the stresses and strains they experienced with having a family member or living with a relative who is drinking or taking drugs excessively. Family support groups helped build their coping capacity in a non-judgemental atmosphere and reduced the 'helplessness and hopelessness' many experienced.

The experience of children living with, and affected by, parental and family member substance use was identified as a concern by community-based services providers. These services reported the difficulties they experienced in accessing support, psychological and learning assessments for children at risk, particularly since the funding cuts to education and welfare programmes. The newly established Hidden Harm initiative is aimed at addressing these gaps in services but it is doing so in isolation from the knowledge and experience available at the community level.

The Traveller population are a high risk group for drug-related harms due to the level of social exclusion, health inequality, educational disadvantage and discrimination they experience. Interviews with members of the community and service providers noted an increase in the use of prescription drugs, cannabis and cocaine. Drugs remain a divisive and taboo subject within the community and the uptake of generic drug services is low as a result.

For many young people living in the Clondalkin DATF area making the transition from childhood to adulthood in a high risk environment brings an increasing array of challenges, yet there is a decreasing level of resources to address their needs – notably in relation to educational, social development and psychological difficulties. The high level of suicides among young people in the area is of immense concern.

The expansion of the drugs economy during the years of the economic boom had a destabilising effect in parts of Clondalkin. The operation of the drugs economy in the neighbourhood provides one of the few employment and economic opportunities for young people, leastways for a time, to access the status and goods that work provides. However, there is a high level of systemic violence attached to this hidden economy. Without recourse to legal means to settle disputes over drug debts, suspected informants, and stolen or seized consignments of drugs they are liable to be resolved by violent means.

THE POLICY ENVIRONMENT

The economic and policy environments in which the Drug and Alcohol Task Forces operate have changed considerably since they were established in 1997. The Drug Task Forces were established at the cusp of an economic boom with generous government funding and clear policy structures as part of a general programme of support for area-based policy initiatives and partnership models of governance. Since then ideological changes, and government cuts in support and spending on the community and voluntary sector, and on health, education and social welfare programmes have affected the capacity of the Drug and Alcohol Task Forces to respond to the increased needs of those affected by drug related harms.

Over its life time the Drug and Alcohol Task Forces have experienced a host of administrative, governance, strategic, structural and role changes, as well as a disproportionate number of evaluations and reviews.

The changes in the policy environment can be traced to the influence of neo-liberal thinking characterised by the centralisation of power and decision making, the reduction of the activities of the state (for example, the contracting out of public and social services), the individualisation of social problems, and adherence to new public sector management principles. Within the paradigm of neo-liberal ideology there is no scope for civil society input into the decision making process.

The challenges faced by the DATFs are not dissimilar to those faced by others in the community and voluntary sector addressing issues from a community development perspective. These challenges are symptomatic of a policy era that is more hostile than supportive to the community sector; community-based services; and local knowledge and collective approaches to addressing social issues.

PARTNERSHIP AND INTERAGENCY WORKING

A key strength of the DATF model has been its interagency and partnership approach to addressing drug related harms in their communities. Over the years, the DATF model of intersectoral collaboration has been challenged by a lessened input from many of the key partners from the statutory services, seen to be a repercussion of a centralisation process that has been ongoing for some time.

The government's centralisation agenda indicates the conscious shifting of power from the community to the centre and is seen to be exercised in two overlapping ways: 1) the closing down of the spaces for communities and community-based services to input into the decision making process; and 2) the extreme levels of monitoring, reporting requirements, and effectiveness and value for money evaluations.

With centralisation, much of the policy and decision making process influencing the implementation of the National Drugs Strategy is seen to have shifted from an initial community-based bottom-up approach to a hierarchical top-down approach from the Drugs Policy Unit in the Department of Health. Confusingly, and frustratingly for those seeking to maintain the intersectoral partnership approach, the policy rhetoric appears on the surface to have largely unchanged and continues to use the same language of partnership (collaboration and interagency working) even though this no longer translates into the experience on the ground.

The current policy environment increases the challenges DATFs experience in working with a number of the stakeholder statutory agencies. For example, the difficulties the DATF encounters in establishing formal interagency protocols and case management approaches across services exemplified in the implementation of the National Drugs Rehabilitation Framework.

CONCLUSION

Three key issues stand out from this report – the negative outcomes of government policies and reforms on vulnerable individuals, communities and the services and DATFs that support them; the policy shift towards viewing drug use as an individual behavioural issue, rather than a community issue; and the undermining of partnership as a model of intersectoral collaboration on the cross-cutting issue of drug related harms.

Drug policy in Ireland has become more focused on addressing individual drug using behaviour as if these issues were context free. Little attention is paid in policy discourses to the underlying issues of poverty and inequality and even less consideration is given to the harmful outcomes of policy. These include the severe reductions in welfare and social care funding, and an increased emphasis on individual responsibility, centralisation of power, and a public management system focused on measuring outputs, effectiveness and value for money – all utterly disconnected from the needs of people and communities.

The inclusion in the National Drug Strategy review of an evaluation of the outcomes of austerity and reform policies on drug-related harms and the capacity of services and DATFs to respond to increased levels of need would broaden our framework of understanding and responding to drug problems. A rehabilitation of the DATF model of community-based partnership and a revitalisation of their capacity to coordinate local responses along with the addition of a Social Inclusion pillar in the new National Drugs Strategy and future drug and poverty proofing of policies would provide a basis for addressing many of the issues outlined in this report.

Neart LeCheile Children's
Play Therapy Room

SECTION ONE
Background to the Research Study

INTRODUCTION

In the 1980s, the clustering of heroin scenes and drug markets in marginalised urban neighbourhoods in Dublin indicated a strong social and spatial bias to drug-related harms, similar to those reported in other urban areas in the UK and Europe. Since then, patterns and trends in drug consumption have evolved in response to global and local shifts in drug production and supply, and in fluctuating levels of demand influenced by accessibility, price, quality, and cultural appeal.

The consumption of an assortment of licit and illicit substances (and in particular the polydrug use of alcohol, cannabis, stimulants and hallucinogens) has become a regular feature of weekend and festive socialising. The idea that this form of 'illegal leisure' has become normalised overlooks the way social inequalities and marginalisation impact on patterns of drug use and risk behaviour.

This research study seeks to explore drug use and drug-related harms in the context of a risk environment in the Clondalkin Drug and Alcohol Task Force (CDATF) area in Dublin. The CDATF is one of fourteen drug task forces established by the government in 1997 replicating the model of community-led interagency partnerships that had developed in many areas of the city beset by epidemic levels of heroin use among its young people. In the task force areas, residents had disproportionally experienced a history of social and structural exclusion and inequality; multi-generational unemployment and poverty; educational disadvantage; and a large population of young people with few social, economic and recreational opportunities – all risk factors for problem drug use (Higgins, 1998; O'Gorman 2004).

Since then, the Clondalkin Drug and Alcohol Task Force (CDATF) has worked to reduce the harms caused to individuals and the community (including drug users, parents, grandparents, children, siblings and other family members) by the misuse of drugs. To achieve this goal, the CDATF works in collaboration with key stakeholders in the community, voluntary and statutory sectors to develop and improve the coordination and delivery of services through a multiagency partnership approach.

Currently, and despite ongoing funding cuts, fifteen projects are funded through the CDATF. These range from general prevention programmes for young people; targeted prevention programmes for young people at risk or already involved in harmful drug and alcohol use; youth outreach programmes; education and awareness raising programmes for parents and members of the community as well as programmes for children of drug using parents. Adult services include one to one crisis interventions, key working, care planning, and counselling; specific integrated 12 step programmes with an education and training focus; treatment and rehabilitation programmes including needle and syringe exchanges programmes, low threshold programmes, homeless services; stabilisation, rehabilitation and aftercare; family support programmes for parents, partners and siblings of drug users; programmes for those in prison and their families; and capacity building and community development programmes.

In carrying out its work, the CDATF has consistently sought best available evidence to guide its strategic planning. In 2014, mindful of the tumultuous changes in recent times the CDATF commissioned this research study to assess the changes in drug trends and drug related harms; and analyse the changes in the economic and policy environment since the onset of the Great Recession in 2008 and the subsequent introduction of austerity policies.

RESEARCH AIMS AND OBJECTIVES

The overall aim of this research is to provide an in-depth understanding of current patterns of drug use and drug related harms in the Clondalkin area; and the current and emerging needs of individuals, families and members of the broader community. In addition, the research study seeks to develop a new framework for understanding drug use in the current local and national context. It is intended that this analysis will inform debate, policy and practice and the development of a community-based substance misuse strategy which reflects the values of equality, partnership, autonomy and accountability.

In commissioning this research study five key aims were identified by the Clondalkin Drug and Alcohol Task Force, these were to:

1. Identify current patterns of (licit and illicit) drug use in the area.
2. Identify the current and emerging needs of children, young people, adults and families affected by drug use in the area.
3. Explore and identify the relationship between poverty, inequality and drug use.
4. Review the effectiveness of the current partnership approach to the coordination and delivery of community-based responses to drug use in the area.
5. Deliver a comprehensive evidence-based report to inform debate and the development and implementation of the CDATF strategic plan.

COMMUNITY RESEARCH METHODOLOGY

The community and participatory research methodology used for this study has been developed over time by the Principal Investigator (Dr Aileen O'Gorman) for studying drug issues at a neighborhood level. This critical interpretivist methodology is a sociologically grounded mixed-method approach based on the collection and analysis of ethnographic (street research) and qualitative data (in-depth interviews and focus groups) coupled with an analysis of:

i) drug trend indicator data (such as prevalence and drug treatment demand data);

ii) local socio-economic data (on risk factors such as unemployment, educational disadvantage); and

iii) the prevailing social, public and drug policy environments which enable or restrict the lived experience of people in the community and the work of the Drug and Alcohol Task Forces.

This research approach uses induction and triangulation to validate and cross-check data and arrives at an in-depth understanding of drug consumption practices and drug-related harms at the individual and community level. Findings are situated within analyses of the local and national socio-economic and cultural contexts, policy and risk environments, and social theories on drug use.

In carrying out its work, the CDATF has consistently sought best available evidence to guide its strategic planning.

ETHICS

Ethical approval for this study was obtained from the Ethics Committee of the School of Media, Culture and Society at the University of the West of Scotland. The ethos underpinning this community research methodology seeks to minimize the traditional power imbalance between the researchers and the researched; to maximize our understanding from the perspective of the affected communities; and to ensure that dignity and respect underpin the social relations of the research process. This ethical approach is informed by the following values and actions:

- Informed Consent – people are provided with sufficient appropriate information about the nature of the research being undertaken so that they can make an informed judgement about whether they wish to participate or not. Permission is sought to record interviews where this is being done.
- Sensitivity – time is taken to build trust and rapport between the researcher and the participants and care and sensitivity are taken especially when asking questions about illicit and risk behaviours.
- Value free – researchers maintain a listening ear and an open mind and take a non-judgemental and value-free approach in their interactions with the participants.
- Confidentiality and anonymity – the details of the people participating in this research are confidential. Care is taken to ensure participants and their input is anonymised; interview and other data are stored in a safe and secure location and codes used to anonymise data; caution is taken to avoid (further) stigmatising vulnerable groups or places.

RESEARCH PROCESS

Contextual quantitative data were collected and analysed on key indicators of drug use (data on drug treatment, drug prevalence surveys), and socio-economic data from the Census Small Area Population Statistics (SAPS).

Primary data was collected through a series of research interviews, conversations and focus groups with people living and working in drug-related fields in the Clondalkin area. Interview schedules were designed and pilot tested and where possible interviews and focus groups were recorded and transcribed. Data were analysed for emerging themes on patterns of drug use, drug related harms, and policy related issues in the local drug and alcohol task force areas. Overall, ten focus groups with a total of eighty individual participants and a further sixteen one to one interviews were conducted with key stakeholders in the statutory, community and voluntary services, current and former drug users, and members of the CDATF Board.

Further data were collected through individual interviews and conversations during the ethnographic fieldwork period. Drug users by virtue of the criminalised and stigmatised nature of their activities are a largely hidden and 'hard to reach' population. Consequently, in order to access drug-using groups in their natural locations, the principal investigator and privileged access fieldworker conducted over one hundred hours of ethnographic fieldwork in Clondalkin during which time over fifty contacts were made with drug users and residents. Fieldwork sessions took place in different areas, at different times and days to try and capture a broad as possible sense of drug use in the area with each session lasting approximately two hours. Fieldworkers took notes during (where possible) and after each session and this information was synthesised, thematically coded and analysed in a series of feedback sessions and triangulated with other data to cross-check and validate.

Ten focus groups with a total of eighty individual participants and a further sixteen one to one interviews were conducted with key stakeholders in the statutory, community and voluntary services, current and former drug users, and members of the CDATF Board.

The research fieldwork began in February 2015, with the bulk of the fieldwork conducted between May and July - the findings reflect the local drugs situation and policy environment at that time.

The drug users we located during the ethnographic fieldwork were those that had a public presence in the communities at the time of the research. All of the people we interviewed were Irish and a small number were members of the Traveller community. Two-thirds of the drug users we encountered were male, reflecting the gendered pattern of public space.

Throughout the research process the Principal Investigator liaised with the Clondalkin Drug and Alcohol Task Force Coordinator and reported to a Research Working Group set up by the CDATF. Meetings were held on a six weekly basis to discuss progress, present preliminary findings and receive feedback.

LAYOUT OF THE REPORT

Section Two of this report examines the context of poverty and inequality in the Clondalkin Drug and Alcohol Task Force area and the impact of the risk environment on drug use and drug related harms. Section Three explores current drug trends in the area. Section Four examines the experience of groups at risk of drug-related harms. Section Five explores the changing policy environment in which Drug and Alcohol Task Forces operate and the impact of this on partnership and interagency working. Section Six concludes with a consideration of the key issues raised in this report.

Clondalkin Tus Nua

SECTION TWO
Poverty, Inequality and Policy Related Harms

INTRODUCTION

Research studies over the years have established strong links between problem drug use (as distinct from drug use) and a host of socio-economic conditions - such as poverty, unemployment, educational disadvantage, social exclusion and housing problems (ACMD, 1998; Buchanan, 2006; Foster, 2000; O'Gorman, 2000; Seddon 2005; Shaw, Egan & Gillespie, 2007). Further research studies have identified risk groups who are vulnerable to problematic drug use or to having their drug use problematized (Moore, 2012). These include young people out of education, work or training; young offenders; young people who are homeless; have been in care; or have parents with a drug or alcohol problem (Health Advisory Service, 2001; Lloyd, 1998). The spatial clustering of these risk factors and risk groups in marginalised urban neighbourhoods is often constructed in policy and media discourses as a function of individual, family or community pathology: this ignores the structural underpinnings of this association. In this respect, the concept of the 'risk environment' (Rhodes, 2002) provides a useful framework for analysing how the socio-spatial clustering of drug-related harms are shaped by adverse political, economic and social policies (O'Gorman, 2004).

Local Drug Task Forces were established in 1997 as a policy response to these twin issues – the concentration of problem drug use (at the time mainly heroin use) and poverty in marginalised urban areas. Since then, as discussed in the subsequent sections of this report, both drug trends and policy support for the Drug Task Force model have changed. By beginning this study with an analysis of the nature of poverty and inequality in Clondalkin, the intention is to highlight the level of risk environment inhabited by many residents in the area, particularly since the beginning of the 'Great Recession' in 2008.

POVERTY IN THE CLONDALKIN DRUG AND ALCOHOL TASK FORCE AREA

Poverty may seem like an alien concept in the Western world in the 21st century but it is a concept based on the notion of relativity – the experience of individuals, families and communities compared with others in the same society. The government Office for Social Inclusion defines the experience of poverty as:

> *People are living in poverty if their income and resources (material, cultural and social) are so inadequate as to preclude them from having a standard of living, which is regarded as acceptable by Irish society generally. As a result of inadequate income and resources, people may be excluded and marginalised from participating in activities, which are considered the norm for other people in society.*[2]

Following this definition, the state uses three measurements of poverty in Ireland:

1. Deprivation (being unable to afford two or more items from the list below[3]) – this affects almost one third of the population (31%) in Ireland.
2. At risk of poverty (living below 60% of the average income, equivalent to €10,425 a year, or €200 a week in 2013) – this affects 15% of the population.
3. Consistent poverty (a combination of both of the above: deprivation plus 60% of the average income) – this affects 8% of the population).

[1] http://www.socialinclusion.ie/poverty.html

[2] Experiencing two or more types of enforced deprivation from the deprivation indicators: Two pairs of strong shoes; A warm waterproof overcoat; Buy new not second hand clothes; Eat meat, chicken, fish or a vegetarian equivalent every second day; Have a roast joint or its equivalent once a week; Had to go without heating during the last year through lack of money; Keep the home adequately warm; Buy presents for family or friends at least once a yea; Replace any worn out furniture; Have family or friends for a drink or meal once a month; Have a morning, afternoon or evening out in the last fortnight for entertainment.

Table 1: Poverty rates in Ireland and among social groups

Measurement of Poverty	National	Social Housing Residents	Lone Parent Households	Unemployed (male)	Educationally Disadvantaged
Deprivation	31%	57%	63%	55%	36%
Social Groups	15%	35%	32%	37%	20%
Consistent Poverty	8%	23%	23%	24%	11%

Source: SILC, 2013

Table 2: Population by Electoral Divisions in CDATF area

Electoral Divisions in the CDATF area	Population (N)	Population (%) of CDATF	% in area aged 15-34
Clondalkin-Cappaghmore (Foxdene, Burgh an Ri, Meile an Ri, Tor an Ri)	2,605	3.2	30.7
Clondalkin-Dunawley (Bawnogue, Deansrath, Kilcronan, Oldcastle)	10,877	13.5	34.4
Clondalkin-Monastery (Fox and Geese, Knockmitten, Yellowmeadows)	10,904	13.5	35.3
Clondalkin-Moorfield (Collinstown, Harelawn, Moorfield)	6,251	7.8	35.0
Clondalkin-Rowlagh (Neilstown, Ronanstown, Rowlagh, St Marks)	4,058	5.0	35.2
Clondalkin Village (Commons, Fairview)	8,492	10.5	31.6
Lucan-Esker (Foxborough, Ballyowen, Esker South)	29,820	37.0	30.0
Palmerston West (Greenfort, Irishtown, Shancastle)	7,593	9.4	33.9
Total	**80,600**	**100.0**	**32.5**

These levels of poverty have increased significantly since the Great Recession began in 2008. For example, the rate of people experiencing deprivation in 2013 (31%) has almost trebled since 2007 (12%)[4]. However, similar to the clustering of drug-related harms among risk groups and in marginalised areas, poverty is unevenly distributed throughout the population. Social groups such as those who are unemployed have low levels of education, live in lone parent households or in social housing all experience disproportionately higher rates of these different levels of poverty (See Table 1 above). For example, twice as many people in lone parent households experience deprivation than the national average (63% compared to 31%) and three times as many people living in social housing experience consistent poverty than the national average (23% compared to 8%).

THE CLONDALKIN DRUG AND ALCOHOL TASK FORCE AREA

The Clondalkin Drug and Alcohol Task Force area covers a large geographic area (Clondalkin, Palmerstown, Lucan and Newcastle) spanning a wide range of socio-economic realities from the established and new middle-class estates of South Clondalkin, Lucan and Palmerstown to the mass social housing estates developed in the 1980s (such as Neilstown, Bawnogue and Ronanstown) and the newer developments in Balgaddy.

Data for this section of the report is drawn from the Small Area Population Statistics (SAPS) of the most recent Census data available from 2011 (CSO.ie). These statistics are based on the Electoral Divisions (EDs) within the CDATF area (see Table 2).

[4] Poverty in Ireland is measured using data from the Survey on Income and Living Conditions (SILC), the latest of which relates to 2013. http://www.cso.ie/en/releasesandpublications/er/silc/surveyonincomeandlivingconditions2013/

POPULATION STRUCTURE

Housing and planning policies have led to a substantial population increase within the Clondalkin area since the Drug Task Force was established in 1997 – from approximately 55,000 people to 80,600 (a 45% increase). The bulk of this increase has been in the Lucan area where the population has almost quadrupled over this time (from 7,550 to 30,000). There are now 26,000 households in the area, a large population dispersed over a wide catchment area.

This population increase has implications in terms of the resources and service provision required to meet the needs of the population, needs which have increased with the recession. In addition, levels of rapid population change can significantly influence the degree and dynamic of social change in a community which in turn, can impact on the level of risk for problem drug use in a neighbourhood. For example, one-third of the CDATF population is aged between 15-34 years (n=26,200) – the age group with the highest level of drug use. If, as is suggested by the national population study on drug use, 46% of the age group in this region have ever used an illegal drug, and 93% have used alcohol, then the CDATF is dealing with at minimum a potential client population of 12,000 illegal drug users and 24,500 alcohol users.

Of course not all drug and alcohol users will develop problems related to their drug and alcohol use. By and large, this will depend on other aspects of their lives such as the level of poverty and inequality they experience and their employment, education and housing opportunities.

HOUSING

Housing is a key issue impacting on people's lives which is shaped by policy decisions made at central and local authority level. In Ireland, the spatial segregation of people with a high risk of poverty due to their long term exclusion from the labour market and consequent reliance on social welfare is an outcome of housing policy. Since the 1980s, the policies facilitating the sale of local authority housing to residents under tenant purchase schemes, and the lack of new build and renovation of empty properties has resulted in a drastic reduction in the stock of social housing. As a result, only those with the most acute needs (such as the long term unemployed and lone parent households) can access social housing and consequently there is a direct correlation between living in social housing and living in poverty in Ireland.

In the CDATF area, the most recent census figures (2011) show that there is a substantially higher than average concentration of social housing in the areas of Cappaghmore (65%), Rowlagh (36%), Moorfield (27%) and Dunawley (25%) compared to the proportion of social housing at the national level (9%) (See Table 3 for all area based figures). More than half (57%) of the people living in accommodation that was rented at below the market rate or rent free (synonymous with being a social housing tenant) experience deprivation. Over one-third (35% up 5 percentage points from 30% in 2008) of this group are 'at risk' of poverty (SILC, 2013). These figures do not include people renting privately through rent supplement (RAS) who are unable to meet the cost of housing, and who are placed at a high risk of poverty by sharply increasing rents and caps on RAS (ESRC, 2014:66).

The clusters of poverty situated within social housing estates are also found within the accommodation available for the Traveller community, refugee and asylum seekers, and homelessness people in the area. Shortages of social housing in the general population have affected the Traveller community also and currently there are 22 families and 70 children living in inadequate accommodation in Palmerstown Lodge where they are provided with Bed and Breakfast but are without cooking or clothes washing facilities[5]. One of the largest accommodation centres used by the Reception and Integration Agency (RIA) for direct provision for refugees and asylum seekers is based in the CDATF area in the former Towers Hotel[6]. The Centre currently houses 204 people – a group identified as experiencing a high level of social exclusion and risk for problem drug use (Fountain, 2006).

GENDER AND LONE-PARENT HOUSEHOLDS

Gender is a poverty issue also and the feminisation of poverty is evident in the extent to which a disproportionate number of female headed households are housed in social housing reflecting the high level of need of this social group.

There is a very strong correlation between living in a lone-parent household and living in poverty. Almost two in three people (63%) living in households with one adult and one or more children (mainly lone female parents) experience deprivation – twice that of the national rate (30%). Almost one in four of this group experience consistent poverty (23%) – three times higher than the national average (8%).

Housing policies at national and South Dublin County Council level have led to a disproportionate number of lone-parents housed in the CDATF area - two-thirds of the population in Cappaghmore (64%) and almost half of the population in Moorfield (46%) and Dunawley (42%) compared to the national average of 27 per cent. These figures suggest a high level of poverty in these areas.

[5] Clondalkin Traveller Development Group

[6] http://www.ria.gov.ie/en/RIA/RIA%20Monthly%20Report%204-2015.pdf/Files/RIA%20Monthly%20Report%204-2015.pdf

Table 3: Proportion of People in Social Groups Nationally and Locally

Social groups	National	Cappaghmore	Dunawley	Moorfield	Rowlagh
Social Housing	9%	65%	25%	27%	36%
Lone Parent Households	27%	64%	42%	46%	56%
Educationally disadvantaged	n/a	54%	45%	53%	64%
Unemployed (male)	22%	44%	35%	36%	45%

Source: SAPS Census 2011

EDUCATION

Levels of educational disadvantage in the CDATF area are significantly higher than average with multiple negative consequences. Education is one of the key determinants of the trajectory of people's lives, and early school leaving and /or a lack of educational qualifications impacts on the health and wealth of current and future generations. There is a high correlation between educational disadvantage and poverty as people's capacity to earn a decent income and maintain employment throughout their working lives is severely constrained by a lack of educational qualifications. Educational disadvantage is also one of the highest risk factors for problem drug use.

Nationally, almost one in four people with Lower Secondary education (23% in 2013, up from 17% in 2008) are 'at risk of poverty' that is living on below €200 per week. Fourteen per cent of people with Lower Secondary education live in consistent poverty - almost three times the rate (5%) in 2008.

In the CDATF area, a disproportionally high number of people finished school at lower secondary level - almost two in three people in Rowlagh (64%); and almost half of the adult residents in Cappaghmore (54%), Moorfield (53%), Palmerstown West (46%) and Dunawley (45%). These figures suggest a high level of poverty in these areas.

EMPLOYMENT

Employment has an important function for individuals, families and communities not just economically but socially. Our social class, status, health and education are all linked to the nature of our employment, or lack of it, as is the level of poverty we experience.

In Ireland, people who are unemployed experience the highest levels of poverty. Nationally, more than half of the people who are unemployed (55%) experience deprivation; over one in three (37% - up from 23% in 2008) are at risk of poverty - more than double the national average rate (15%).

One in four people out of work live in consistent poverty (24% - up from 10% in 2008) again the highest rate among all social groups and three times the national average (8%).

In the CDATF area, the extent of unemployment and joblessness, particularly among men, as a result of the recession is phenomenal. In some areas, male unemployment rates have doubled since 2006 such as in Rowlagh (45% up from 22%) and Cappaghmore (44% up from 21%). The rapid increase in the number of people signing on the Live Register at the Clondalkin Social Welfare Office (that is, the number of people receiving Jobseekers Benefit and Allowance and part time workers) shows the dramatic change in people's circumstances as the recession took hold. The numbers of people registering on the Clondalkin SWO Live Register almost trebled from 3,694 in 2007 to 10,318 in 2010 (a 179% increase). Though numbers have fallen since this peak in 2010, the number of people currently registered for unemployment are still double what they were in 2007 (n=6,694).

POVERTY, INEQUALITY AND THE POLITICS OF AUSTERITY

As demonstrated above, there is an uneven distribution of poverty throughout society and some social groups and areas experience poverty disproportionately. In this analysis of the CDATF area, some electoral division areas – Cappaghmore, Dunawley, Moorfield and Rowlagh – experienced disproportionately higher levels of a range of poverty indicators (social housing, educational disadvantage and unemployment). Within these electoral division areas, smaller areas with pockets of extreme deprivation were identified (in the smaller Enumeration Areas of the Census data) in parts of Deansrath, Foxdene, Greenfort, Harelawn, Kilcronan, Lindisfarne, Liscarne, Meile An Rí, Neilstown, Rowlagh, Shancastle, St Marks, and Tor an Rí.

Media and political discourses tend to pathologise people, groups and areas that experience poverty by presenting poverty and associated social problems such as unemployment,

[7] In this case, measured by the proportion of people aged 15 years and over who have either no formal education, or whose highest educational level attained was primary education or lower secondary education.

educational disadvantage and drug dependency as an outcome of individual or family dysfunction. These discourses also focus on the cost of people's joblessness to the state, in terms of the welfare benefits they receive, rather than examine the impact of poverty on the lives of individuals, families and communities. Little attention is paid to the role government decisions and policies play in facilitating these negative outcomes for people. Shining a spotlight on the outcomes of policy harms (what the Economic and Social Research Institute (ESRI) term 'policy induced losses' see Keane et al. 2014) is one way of counteracting these dominant stigmatising views on poverty.

The role of government policy in producing and reproducing poverty is exemplified by the consistent decision to set the level of welfare payments under the poverty line. This decision results in the high level of poverty among welfare recipients. For example, the Jobseeker Allowance, the Jobseeker Benefit, and the Disability Allowance are currently set at €188 weekly, and the Supplementary Welfare Allowance at €186, whereas the poverty line in 2015 is €202 per week.

The politics of austerity and the decisions taken to restructure and retrench the welfare state during the Great Recession by the government and the European Troika (the European Commission, European Central Bank, and the International Monetary Fund) resulted in a series of policy harms that disproportionally affected the more vulnerable and less well off in Irish society (Caritas, 2014). These decisions are seen as a form of structural violence by the state - defined as the avoidable impairment of fundamental human needs (Farmer, 2006; Galtung, 1990). For example, though the government publicly claimed it was maintaining core social security rates, they introduced radical reductions in supplementary payments that provide an important cushion against poverty. Policy decisions since 2008 have resulted in a net reduction in welfare supports for Child Benefit, unemployment benefits for young people[8] [most in lower socio-economic groups], the 'Christmas bonus', fuel allowance, the respite care grant, rent supplements, back to education allowance, one-parent family payments, and back to school clothing and footwear allowances. The lowest income groups were among those most severely impacted by these policy-induced losses (Callan et al., 2014).

In addition to these direct losses, people placed at risk of poverty by the state were affected by the cuts in funding to community, voluntary and statutory organisations that provide a range of support services to them. Harvey (2015) estimates that the voluntary and community sector experienced a disproportionate reduction in funding of between 35-45% in the period 2008-2015 compared to an overall reduction in government spending of 4%. Interim funding for the CDATF was reduced by 22% (from €1.8m in 2008 to €1.4m in 2015) and mainstream funding by 15% (from €1.3m to €1m in 2015) with additional cuts in FAS / Department of Social Protection funding and funding for universal education and training initiatives in the area.

At a community level, the experience of living in a poor area exacerbates poverty and affects people living in the area who are not poor but who are disadvantaged in their experiences and command over resources (Spicker, 2001). Consequently, poverty in a community is a problem for the collective and results in an array of needs including a restricted access to power over the decisions that affect their lives:

> *It is not simply that poor material circumstances are harmful to health; the social meaning of being poor, unemployed, socially excluded or otherwise marginalised also matters ... we become more prone to depression, drug use, anxiety, hostility and feelings of hopelessness.* (Wilkinson and Marmot 2003:9)

CONCLUSION

The social science drugs literature has consistently highlighted that drug use disproportionately harms people who experience challenging lives rooted in poverty and inequality. Where poverty clusters at a neighbourhood level, drug-related harms cluster too. This study identified deep pockets of poverty and inequality within the CDATF area placing its residents at a high risk of experiencing drug-related harms. This level of risk can be traced to policy induced harms and the structural violence of the state rather than individual behaviour.

The numbers of people registering on the Clondalkin SWO Live Register almost trebled from 3,694 in 2007 to 10,318 in 2010 (a 179% increase).

[8] Reduced to €100 for 18-24s, and €144 for 25 year olds

Children's playground Balgaddy

SECTION THREE
Drug Trends

INTRODUCTION

Research studies of drug use illustrate a distinct socio-spatial concentration of drug-related problems in marginalised communities where residents experience an unequal burden of multiple and interconnected deprivations such as poverty, unemployment, early school leaving, homelessness, poor housing, and social exclusion (O'Gorman, 2004; Buchanan, 2006). The disproportionally high levels of poverty and disadvantage experienced by residents in Clondalkin, outlined in the previous section of this report, demonstrate the high level risk environment for drug-related harms they inhabit.

Since the Clondalkin Drug and Alcohol Task Force was established, patterns and trends in drug consumption have evolved in response to global and local shifts in drug production and supply, and in fluctuating levels of demand influenced by accessibility, price, quality, and cultural appeal (Agar, 2003; EMCDDA, 2013; UNODC, 2013). The consumption of an assortment of licit and illicit substances (and in particular the combined use of alcohol, cannabis and stimulants), has become a regular feature of weekend and festive socialising among young people. In the 1990s, research evidence contended that this form of 'illegal leisure' had become normalised and accommodated into the social and cultural practices of different social groups (Measham et al., 1994; Parker et al., 1998). However, this view overlooked the differentiated patterns of drug consumption and risk behaviour among groups such as young people living in marginalised neighbourhoods (MacDonald & Marsh, 2001; Shildrick 2002).

In Ireland, estimates of drug use and drug use indicators (such as drug related arrests and drug seizures) are rarely available at a local level so we have to rely on data from national and regional studies to build a picture of what is happening at a local level.

DRUG TRENDS

The National Drug Prevalence Survey has been conducted every four years since 2001. However, data is only made available at Regional Drug and Alcohol Task Force (RDATF) levels. Of these, the South West RDATF covers the area of South and West Dublin, West Wicklow and Kildare and includes the Clondalkin DATF area. In this region, lifetime use of any illegal drug increased from 26% in 2006/7 to 36% in 2010/11 (up 10 percentage points). Statistically significant increases in the rates of drug use were noted among men (up 16 percentage points from 31% to 47%) and younger adults (up 15 percentage points from 31% to 46%). (NACDA, 2013:84).

Rates of recent and current drug use also increased substantially in the region since the 2006/7 survey. These increases were particularly evident among young adults (aged 15-34 years) whose rates of recent use (in the past year) of any illegal drug almost doubled (from 10% to 19%) and rates of current use (in the past month) more than quadrupled (from 2% to 9%) suggesting a considerable increase in drug use in the CDATF area during this period. These increased rates related mostly to cannabis use (recent use increased from 9% to 15%); cocaine use (there was a fivefold increase in the rate for recent use from 1% to 5%); and an upsurge in the use of New Psychoactive Substances (NPS) with one in ten young adults (10%) reporting recent use. Much smaller levels of use were noted for heroin and crack cocaine with less than one in a hundred people (0.03%) reporting use of these drugs, though population surveys tend not to capture clusters of problematic drug use such as these.

The most recent national data on drug use among children and teenagers[9] report high levels of alcohol use, drunkenness and illicit drug use among young people. Half (50%) of young

[9] Captured at a national level through the Health Behaviour in School-aged Children (HBSC) 2010 survey, Kelly et al. (2012) and the European Schools Survey Project on Alcohol and Other Drugs (ESPAD) study, Hibbell et al. (2011).

teenagers (15-16 year olds) reported current alcohol use (in the last month). Almost one quarter (23%) had been drunk in the last month, and two out of five (40%) young people had engaged in heavy episodic drinking (five or more drinks) in the last 30 days. Almost one in five young people reported ever using cannabis (18%) with more boys reporting use (22%) than girls (15%).

THE MEANING OF NEIGHBOURHOOD DRUG TRENDS

Drug trends suggested by these surveys present drug use as an atomised and individualised undertaking and do not capture the reality of polydrug use where people use a combination of drugs for different affects. Nor do these studies capture the availability of drugs within peer networks and drug markets at a local level which influence drug choices. The ethnographic fieldwork, focus group and interview data collected for this study with drug users, affected family members, service providers and residents, provides a more in-depth and contextualised understanding of drug use than drug prevalence data and is presented later in this section of the report.

Knowledge, attitudes and beliefs about drug use varied widely among those we interviewed and many were influenced by media stories focusing on issues such the role of peer pressure within youth groups to use drugs, or stories of drug sellers preying on young people to buy drugs. Social research aimed at understanding the context of people's drug use provides a useful counterpoint to the many myths and urban legends about drugs and their effects. Research evidence notes that the crucial issue is not so much about peer pressure but the circulation of drugs within friendship networks with shared attitudes about drug use (Oetting and Beauvais, 1988; Pearson, 1990). These drug-using networks play an important role in how the effects of drugs are interpreted (ACMD, 1998). Contrary to much popular opinion, the effects of drugs are 'learned behaviour' and constructed through group processes rather than an automatic outcome of taking a drug (Becker, 1963). These processes are framed by a combination of the drug (the pharmacological action of the substance itself); the set (the attitude, personality and mind-set of the user at the time); and the setting (the influence of the physical and social setting within which the use occurs) (Zinberg 1984).

People's reasons for taking drugs vary. Many people take drugs because they are curious and wish to experiment and their experience of substances is often pleasurable rather than negative and damaging (Hunt et al., 2007). For some people, their use can help to create and validate an experience of collective community (Room, 2013). Some people use drugs to relax, to stay awake, or to enhance an activity (Boys et al., 2001). Drug use by people living in risk environments with an experience of inequality and multiple deprivations – such as in parts of the CDATF area (see Section 2) – is seen to be linked to the stress and strain of everyday life and the higher levels of anxiety and depression that occur where inequality is greater (Singer, 2008; Wilkinson & Pickett, 2009). In these situations, drug use provides young people with a status and an alternative identity to that of low paid work and low cost consumption (Bourgois, 1998; Sandberg & Pedersen, 2009).

CURRENT DRUG TRENDS IN THE CLONDALKIN DRUG AND ALCOHOL TASK FORCE AREA

Drug use surveys tend to focus on the use of individual drugs, however, drug use in the everyday world tends to be a polydrug issue and in the CDATF area is reported to most frequently involve cannabis (herbal) and 'tablets'[10] (various prescription pills such as benzodiazepines and 'Z drugs') mixed with alcohol.

Cocaine, New Psychoactive Substances (NPS) such as mephedrone, and various ecstasy type substances were reported to be widely used in recreational settings. Heroin and crack cocaine continue to be used by a small proportion of habitual users.

Drug trends were reported to fluctuate based on what was available in the local drugs market and what was value for money - particularly drugs used in youth recreational settings such as New Psychoactive Substances (NPS), Ketamine, and various forms of ecstasy. Through trends may come and go and reappear there was a general consensus, voiced by one of the young adult drug users we spoke to:

> *" There's no shortage of drugs. The recession might have hit Ireland but the recession doesn't hit drugs. The recession hits and drugs get worse"* (Research Participant).

CANNABIS USE

Cannabis use, mostly herbal cannabis (grass and weed) than hashish or resin, was reported to be widespread and to be accommodated into the social and recreational practices of many residents in the area across all age groups. As noted in the National Advisory Committee on Drugs and Alcohol (NACDA, 2012) population survey almost half (43%) of young adults in the region have used cannabis and at best estimates this would be a minimum for the CDATF area. Many people spoke about using cannabis as 'a relaxer' and as a way of

[10] The term 'tablets' was used to describe an assortment of medication prescribed largely for the treatment of insomnia and anxiety such as the benzodiazepines alprazolam/xanax®, diazepam/valium®, flurazepam/dalmane®, temazepam/Restoril® etc. and the 'Z drugs' such as zolpidem/stilnox®, zopiclone/zimovane®.

coping with the feelings of depression, anxiety and anger they experienced (see Boys et al., 2001).

Service providers working with young people reported cannabis use to be commonplace among young teenagers (13 and 14 year olds), and in particular by boys. These reports match the high levels of cannabis use found in national surveys of school going youth (HBSC 2010). Workers locally raised concerns about the impact of cannabis use on young people's development and mental health; and their attendance and participation at school and other education programmes.

Cannabis use was reported to be widespread and to be accommodated into the social and recreational practices of many residents in the area across all age groups.

Cannabis use increases the risk of young people coming into contact with the drugs economy and the criminal justice system. Though most young people obtain cannabis through friendship and family networks (Hibbell et al. 2011) with ongoing use they invariably come into contact with the local drugs market. In our fieldwork we encountered a number of young people who had taken up positions as runners and delivery boys for local drug retailers as a means of funding their use and making some additional money, often to pay back drug related debts.

There were many reports of local '*domestic*' cannabis cultivation with people growing for their personal use as well as to sell on for profit. The abundance of 'grow shops' throughout the city selling the paraphernalia needed, enabled "*instead of people who wouldn't grow a pansy in their garden*" to establish grow houses locally. This local trend mirrors similar cultivation enterprises in many European countries (Decorte et al., 2011). Involvement in such enterprises can bring people into direct contact with the drugs economy with all the potential risk this incurs, including the increased risk of coming into contact with the criminal justice system.

TABLETS

Prescription tablets of all kinds are readily available on the streets from the traditional benzodiazepines (such as Diazepam/Valium) to the Z drugs (such as Zimovane and Zoplicone) known locally as "Zocs" and high strength "Super Zocs". Their widespread availability was reported to be due to the resale of prescriptions, to consignments imported from abroad via the internet, and to illicit manufacturing in the inner city and locally.

Aside from their prescribed use for anxiety and insomnia, '*tablets*' were reported to be used by a wide range of people in combination with other drugs such as alcohol, heroin or methadone to enhance their effects; or to relax after a session of cannabis or stimulant use. Their low cost and easy availability was reported to add to their prevalence and popularity.

STIMULANTS AND HALLUCINOGENS

Cocaine was reported to be the second (illicit) drug of choice among people in the CDATF area with its use now widely accepted across age, gender and social class. Cocaine use was reported to be used by young people (though the quality of what they are using was debatable) and by older '*working men*' as a status drug at weekends – this raised concerns about increased levels of cardiac disease and cocaine-related deaths among this age group.

Cocaine was reported to be mainly used in pub and party settings to prolong and enhance the effects of alcohol use and followed by benzodiazepine use to ease the *'come down'* of stimulant use. There were some suggestions of heroin use being used to mitigate the 'come down' from cocaine but this was difficult to verify. The majority of cocaine users we spoke to did not engage with drug services as they did not perceive their use to be problematic.

The young people we spoke to were more attracted to using cheaper New Psychoactive Substances, ecstasy and ketamine and *'party products'* of dubious quality and ever changing content, many sourced from the internet. These young drug users also did not engage with local drug services. They associated these services with injecting heroin users and did not see themselves as having a problem particularly as they were not injecting drugs.

ALCOHOL

Alcohol was reported to be the drug with the most negative impact on the quality of life and the well-being of people living in the CDATF area. The increase in alcohol outlets in shops, pubs and off-licences, and its low cost and the ease of access for all ages (from deliveries by pubs and various illicit *'dial a drink'* services) is seen to have negatively impacted on the area. Its use as a stand-alone drug or underpinning cannabis, stimulant and opiate use is so pervasive that non-drinkers were regarded as an oddity.

DRUGS ASSOCIATED WITH DEPENDENCY

Heroin use in the CDATF area was seen and reported to be ongoing, unlike other areas of the city where heroin use has decreased significantly. Dave, one of the street drug sellers we spoke with was of the view that: *"Heroin has always kinda been here, it's never really gone away".* Similar to other areas, though, there are few young heroin users in the area. The same seller remarked that:

"Nowadays for the younger people growing up, heroin isn't seen as a cool drug … it takes them longer to get into heroin, their late 20s maybe"(Research Participant).

The young people we spoke with were fiercely resistant to the idea of using heroin, crack cocaine, or intravenous drug use. They clearly differentiated themselves from the people they labelled as *'junkies'* - older habitual drug users with a history of intravenous drug use and a preference for *'tablets',* alcohol, methadone, heroin and crack cocaine. Their behaviour was indicative of the stigma associated with heroin use in the community, even from people who are using other drugs. As one of the community workers remarked:

> *"Young people see 'scumbags', 'junkies'… and see themselves as completely different… they'd be off their faces from the weed and tablets and all and they'd still slag off the lad that's on heroin"* (Community Worker).

Workers in the community drug services reported how young people's differentiation of their drug use from heroin and crack use transferred into their attitudes towards drug services, which they regarded, incorrectly, as *'junkie services'.* Consequently, young drug users were reluctant to engage with services despite engaging in high risk drug behaviours.

Our fieldwork noted that it was older people in the 30 plus age group who were smoking *'brown'* (heroin). There was some overlap between this group and crack cocaine users - older, current or former heroin and methadone users – but it was reported that a higher than average proportion of older female users had started using crack cocaine. *'Rocks'* of crack cocaine were readily available at the local street markets.

A survey by O'Heaire (2013) conducted with clients of a local harm reduction service (n=119) reported that almost three-quarters of the clients (71%) availed of crack pipe distribution kits, and three-quarters of these (74%) were male drug users. More than half (52%) of the clients were polydrug users, and 42% were heroin users. A quarter of the clients (25%) also used the needle exchange service. Almost all of the clients (91%) were receiving methadone maintenance treatment. These findings suggest a cohort of heavily dependent users injecting heroin and smoking crack cocaine in high risk conditions in a number of derelict buildings we visited during our fieldwork in the area.

CONCLUSION

Drug use surveys focus on the use of individual drugs. However, drug use in the everyday world in the area is a polydrug activity most frequently involving (herbal) cannabis and *'tablets'* combined with alcohol. Cocaine, and New Psychoactive Substances (NPS) such as mephedrone, and various ecstasy type substances were reported to be widely used in recreational settings. Heroin and crack cocaine continue to be used by a small proportion of habitual users under high risk conditions, though rarely by young people.

Drug trends were reported to fluctuate based on what is available in the local drugs market and what was value for money. Through drug trends may come and go there was a general consensus that there was no shortage of drugs in the area particularly since the recession.

Drug use surveys focus on the use of individual drugs. However, drug use in the everyday world in the area is polydrug activity.

SECTION FOUR
Risk Groups for Drug-Related Harms

INTRODUCTION

The historic concentration of problematic drug use in areas like Clondalkin which have experienced a high level of structural violence by the state has consequences beyond those of the individual drug users. Close knit kinship and peer networks in the community have resulted in many families experiencing multiple drug related harms as family members, friends and neighbours developed drug problems. The quality of life in the community has been further affected by open drug markets attracting users and sellers to trade in the area and the drug-related violence that often accompanies this trade.

In our research, four groups in particular were identified as being at high risk of drug and related harms – the in-treatment population; the families of drug users; the Traveller community; and young people, particularly those engaging with the drugs economy but out of contact from services.

IN TREATMENT POPULATION

A complete picture of the number of people receiving treatment for drug and alcohol use in the CDATF area is difficult to access. Data is available from the Health Research Board's National Drug Treatment Reporting System (NDTRS) but not all services are included in this system, neither are those attending GPs for treatment of a drug and/or alcohol related problem. As a result, NDTRS figures underestimate the level of treatment and drug related need in the area, and the type of treatment services included in the NDTRS influence the profile of those engaged in treatment.

The NDTRS data for 2014 indicate that there were at least 436 people resident in the CDATF in treatment for drug and alcohol problems. An analysis of this in-treatment group show that they were mainly male (67%) and almost two-thirds were over 30 years of age (67%). More than one-third (37%) lived with their parents or family and over a quarter (29%) lived with their children, either alone or with their partner. Over half (55%) were unemployed, over one in ten (12%) had a disability, and nine per cent were on a community employment or state training course. More than half (58%) had not reached leaving certificate level in school. The in-treatment data records the primary drug for which a person is being treated: the largest proportion of people were treated for an opiate related problem (40%); a quarter were treated for alcohol problems (25%); with lesser proportions treated for problems with cocaine use (15%); cannabis use (14%); and benzodiazepine use (4%).

The benefits of methadone maintenance treatment (MMT) for people with the chronic recurring disease of opiate addiction are well evidenced in terms of reducing intravenous and harmful drug use and improving health (Comiskey et al. 2009; McKeganey 2008). Overall, people attending this form of treatment are doing well, as described by project workers in a number of services:

> *"You get a lot of people that are stable on methadone moving on with their lives, some people will have a slip every now and again and other people you know have periods of stability and then periods of instability"* (Project Worker).

> *"You do see the progression; you do see people can change. There is improvement for people's lives, even for people that are in the depths of a crisis"* (Project Worker).

However, a number of concerns were expressed in our interviews and focus groups with service providers and drug users about people being *'stuck'* in long-term methadone treatment, and about the practice of prescribing methadone in isolation from other support services which address the range and high level of needs among this client group:

"You just get the impression that they give up on you … leave them on their benzos and methadone … they're quiet, they're happy, especially if you're a parent" (Current MMT client).

"It seems that the whole view of all the services is a harm reduction view; it's not geared towards recovery… Reduce the crime, reduce everything but it doesn't care much about the person" (Former MMT client).

These views reflect the ongoing tension and debate internationally about long-term methadone treatment and the role of MMT in the rehabilitation and recovery process – issues returned to again in the policy section later in this report. In our interviews with community-based services, the HSE MMT clinics were perceived to be overly tolerant of client behaviour that included ongoing illicit drug use and *'topping up'* with prescribed drugs leading to a commonly held view of an ageing opioid population *'using anything and everything'.* Though the lack of sanctions in the clinics were regarded as partly responsible for these risk behaviours, the restructuring of welfare programmes and cuts to benefits were also seen to have adversely affected this population as described by community workers supporting this group:

"We've had a lot of relapse as well like a lot of people who were clean [from heroin] for a long time and since the recession hit they've relapsed back into drug use" (Community Worker).

"People are selling their methadone on the street to make some money and topping up with benzos to keep their buzz" (Community Worker).

Further concerns were reported in interviews about the lack of options for clients wishing to exit treatment. Among the key issues raised were the lack of respite and detoxification options (both community-based and residential) for drug users; the lack of clinical support for detoxification; the extent of benzodiazepine prescribing and the lack of treatment for their misuse; the lack of engagement by the HSE clinical services with key workers from community and voluntary services - issues dealt with further in Section Five of this report.

In our focus groups with current and former MMT clients, we got a sense of the enormity of the challenges facing those seeking to exit treatment, as one young man described:

"When you become a drug addict you just continue it because it's the only way of life that you know … it's hard to get out of that when all you know is drugs and people on drugs … it's very hard to break away from that … from something that you've put so much effort into. It's very scary coming out of treatment … it's very, very scary coming off the drugs. You're doing everything for the first time. It's a heightened state of anxiety and noticing stuff for the first time" (Research Participant).

For those who had sought to go through a detoxification from methadone treatment, there were additional fears of relapse and of the high risk of overdosing if they relapsed. As one former MMT client, who had undergone a number of unsuccessful detoxifications, described: *'your body might be ready but your head is not'.* The potentially fatal repercussions of a failed detoxification are an ongoing concern for clinicians who must adjudicate between the client's wish for detoxification and the likelihood of a relapse. Differing views about treatment were the cause of much tension between the HSE clinical team in charge of treatment, their client, his or her family, and their support workers in the community drug services.

AFFECTED FAMILY MEMBERS

For most individuals whose drug use has become problematic there is a family member whose life has been affected by this development. Our interviews and conversations with parents, partners and siblings of problem drug users highlighted the immense strain placed on families, and the feelings of stigma and shame they experienced, as one mother described:

"When I first found out me sons were on drugs I was more petrified. What am I gonna do? How do I stop this? Where do I go? Who do I go to? … I was left there feeling like hopeless, you know the way like, and from there on I just think it festered until today where it's beyond control, madness, mayhem, everything you can think of. It's crazy and I just can't cope with it anymore" (Family Support Member).

In Ireland, the nature of close-knit families, the lack of resources and the shortage of affordable accommodation have resulted in many problem drug users continuing to live in their parental home long into adulthood. Having a family member who is drinking or taking drugs to excess can result in a series of negative outcomes for the whole family. In our focus groups with family members, we identified a number of recurring themes in their accounts of the impact on their families, these included:

- recurring arguments and disagreements within the family;
- conflict over missing money and possessions, and pressure to give or lend money;
- anxiety and uncertainty about the person's movements and moods;
- family occasions marked by the person's poor behaviour;
- concerns about the person's health and safety;
- drug use and drug-using paraphernalia within the home; and
- contact with the criminal justice system – police, probation, and sometimes court attendances and prison visits.

Family members also reported instances of intimidation and retaliation against parents and the family homes over unpaid drug bills. These reports of families living in fear are similar to those documented in a number of research studies in Dublin (O'Leary, 2009; Connolly & Buckley 2016). As one mother we interviewed described:

> *"Before a fella come up to your door with a baseball bat and threatened you and your family whereas now he'll come up with a knife or a shotgun… The debts are following the family. Even if the person has taken their own life it doesn't matter you still owe… if the Guards come and raid your house you still owe the dealer two grand for whatever has been taken out of the house so that debt never dies unless it's paid."* (Family Support Member).

> *"People are too afraid to stand up against them. They are taking out credit union loans and maxing out credit cards in order to pay off debts."* (Family Support Worker).

Elderly parents reported the difficulties they experienced caring for their ageing drug dependent son or daughter with numerous health issues. Grandparents related their experience of taking on the parental role with their grandchildren. They reported shortcomings with the support they received from statutory health and social workers as well as being faced with additional financial costs they incurred and the difficulties they experienced accessing carers and children's allowance (see also Woods, 2002; O'Leary and Butler, 2015).

Members of the family support groups we attended recounted the impact on their mental and physical health and the help they received at these meetings to build their coping capacity and reduce the *"helplessness and hopelessness"* they felt, described by one mother as feeling like:

> *"He used to suck me dry. I used to think he was breathing my air he used to be that bad."* (Family Support Member).

> The stress-strain coping support (SSCS) model (outlined by Orford et al. 2010a, 2010b) acknowledges the stressful life circumstances of having a close relative with a substance misuse problem and advocates a structured programme of good quality non-judgemental social and emotional support along with good information and material support to help coping efforts and contribute positively to family members' health.

IMPACT OF PARENTAL DRUG USE WITHIN THE FAMILY

In addition to families being affected by other member's drug use, families themselves may also be a source of drug related harm. This can take a number of forms. In interviews conducted for this research study, services working with young people described their difficulty in challenging young people's drug using behaviour when their parents are using drugs in the home and are ambivalent about their children's drug use. Other service providers raised concerns about poor parenting skills and the lack of boundaries between parent and child in families with parental drug use, though these families were reported to be in the minority:

"We've kids coming in [to school] from these households and they're late to school, their parents are hungover … there's no food in the house, there's no clothes washed… there isn't that parental support. It's often that our kids are parenting the parents - they become young carers and then they often become young parents too because they're used to that role, they feel that 'I'm competent at this, it's something I'm really good at doing." (Service Provider)

The experience of children living with, and affected by, parental substance use has become the subject of a new policy initiative called the National Hidden Harm Project[11] which is in the process of being rolled out by TUSLA the Child and Family Agency. The initiative notes that though not all parents who use substances experience difficulties with parenting, and not all children exposed to parental substance misuse are affected adversely, there are concerns that children affected by parental substance use may suffer harm in a number of ways through physical and emotional neglect, including exposure to harm and poor parenting.

Community and voluntary services in the Clondalkin and other drug and alcohol task force areas have been supporting children affected by drug use and their parents since the LDATFs were established and they have amassed a wealth of knowledge and experience dealing with the issues facing children and families. In our interviews with these services, they described the ongoing difficulties in accessing supports, and psychological and learning assessments, for children at risk either through their own drug use, or that of a parent or other family member, particularly with the funding cuts to a wide range of support and social care services that have been implemented under the austerity programme. There is a concern that the Hidden Harm initiative will side-line the ongoing work in communities with children and families and will seek to address children's needs in isolation from their environment rather than ensuring sufficient appropriate resources are available locally for maximum sustainable impact.

[11] Established in 2014 by HSE Social Inclusion and TUSLA the Child and Family Agency.

TRAVELLER COMMUNITY

The Clondalkin Drug and Alcohol Task Force area is home to a large Traveller community who are a high risk group for developing problematic levels of drug use due to the high level of social exclusion, health inequality, educational disadvantage, and the discrimination they experience in their everyday lives (Fountain, 2006).

Interviews with members of the community, and the service providers working with them, reported an increase in the use of prescription drugs, cannabis, and cocaine in the community. For women, the use of prescription drugs, intravenous Melanotan use (as a tanning aid), and the sharing of injecting equipment within their family group were regarded with concern as they run the risk of infections and blood-borne diseases such as HIV and hepatitis. For men, concerns were raised about the use of steroids and performance enhancing drugs to prepare for fighting bouts, and the use of cocaine to *'come up'* for fighting bouts.

The Traveller community who are a high risk group for developing problematic levels of drug use due to the high level of social exclusion, health inequality, educational disadvantage, and the discrimination they experience in their everyday lives.

Heroin use was reported to be low-key and very hidden as its use is deeply stigmatised within the community. Cases were reported of families being *"burnt out of their homes"* because of a family member's use. Support groups reported large increases in recent years of Travellers doing *'home-detoxes'* with methadone without letting anybody else know:

> *"Travellers won't go in [to drug services] because they are a private group and they don't want other Travellers to know"* (Community Worker).

Unlike the settled community, drug use was not reported to be normalised within the Traveller community. Despite the reported increase in drug use, drugs remain a divisive and taboo subject within the community:

> *"Within the Traveller community, drugs and drugs issues for a long time was a taboo subject. Nobody spoke about it even though everybody was aware it was happening, but they felt like if they didn't name it … Families used to deal with it themselves or say you know 'he's not well, he's sick' and they'd kind of move away from other families (Community worker)."*

Though the social context of drug use within the Traveller community was unique in a number of ways, the community shared some similar experiences with the settled community. For example, the use of cocaine as the drug of choice for festive occasions such as weddings and christenings was a trend within the wider CDATF areas; so too were the links between drug use, poor mental health and suicide and the lack of services to deal with these interrelated problems; as was the experience, particularly of women, of intimidation by people owed *'drug money'* by their son or daughter:

"Mothers end up paying for the drugs; they are intimidated by the dealers in the area. They have experienced windows being broken and homes vandalized. There are some people on the emergency transfer housing list as the result of a threat on their lives and their families' lives" (Community Worker).

YOUNG PEOPLE ON THE MARGINS

Many young people living in the CDATF area where there are high levels of poverty, inequality and social exclusion (see Section 2 of this report) are at a high risk of developing problematic levels of drug use. Making the transition from childhood to adulthood in high risk environments brings an array of challenges, yet in the current financial and ideological environment the state makes decreasing levels of resources available to address these.

Children and young people in the area were identified as having a wide range of unmet needs such as educational support needs; social development needs; psychological needs; and problems with numeracy and literacy leading to poor attendance at schools and early school leaving, or leaving school without a qualification. These needs of young people were reported to have increased since the recession while the availability of support services had shrunk.

For many young people, the level of unemployment in the city and the CDATF area meant that career choices were bleak. One young person we interviewed reported that there were:

> *"Lots of the girls working, menial work, in services, and in shops in the Liffey Valley Shopping centre. No one was going after to have a career or anything. Most of the boys are on 'the scratcher' [jobseekers allowance]."* (Research Participant)

Research studies internationally have demonstrated how marginalised young people with aspirations for status and financial success but with little opportunity to achieve these through the formal economy are drawn to working in the drugs economy (Bourgois, 2004; Nightingale 1993). The operation of the drugs economy in the neighbourhood is intricately linked to the drug trends and policy harms flagged earlier in the report - the increase in drug use in the general population; the extent of joblessness; and the cuts in welfare

supports. Physically as well as socially marginalised housing estates provide the space and the supply of labour for the organisation of the drugs economy to bag, store and distribute drugs and money (O'Gorman, 2014).

As drug use has become part of *'everyday'* life (South, 1999) in the area, drug retail transactions have become part of the everyday experience of most drug users (Coomber, 2004; Chatwin & Potter 2014). The traditional distinction between a drug user and a drug dealer has never translated easily into everyday life. Many drug users engage in *'social supply'* that is *"non-commercial drug transactions among non-strangers"* as part of the rituals of sharing drugs in recreational settings (Chatwin & Potter 2014: 525) where one or two people buys the product to share for little or no profit. For most drug users, the ideal is to sell sufficient drugs to cover the cost of their own use, as Johnno described:

> *"I was involved selling bits and bobs, like for myself I was never making money; I was just making my own supply. Like you'd make a few bob, small bits, but I wouldn't be flashing, I'd keep the odd thing in the house but most of it would be parked off in hiding spots or you'd be doing favours and you'd be going from one place to another place with stuff and you'd get enough to keep yourself ticking over"* (Research Participant).

However, the expansion of the drugs economy, and particularly the cocaine-based drugs economy during the years of the economic boom, was reported to have a destabilising effect in parts of the CDATF area where larger scale distributors live or have family connections. The relatively high number of drug-related shootings and murders in the area can be seen to stem from the systemic violence associated with the organisation of the drugs economy locally (see Goldstein, 1985; Reuter, 2009). In this hidden economy, without recourse to a legal means to regulate its business, disputes over sales territory, suspected informants, and stolen or seized consignments of drugs are liable to be resolved by violent means (Hammersley, 2008).

The building up of drug-related debts was reported as one of the main causes of drug-related violence in the area, in contrast to the popular view that the violence is an outcome of the effect of a drug. Young people we interviewed told us how they could quickly build up a debt through overuse. If the debt was small, they sought to repay it from their earnings, if working, or their social welfare payment, as Tommy described:

> *"You have to hand over your social card when you get a lay on [credit], then the morning you get your labour [jobseekers allowance] you give him a ring and he comes up and meets you and gives you the labour card, you get your few quid, give him his few quid "* (Research Participant).

Young people also reported how being in debt could bring you into closer involvement with the drugs trade by being asked to hold or distribute drugs around the area. The alternative, people reported, were harsh punishments including severe beatings and shootings, as Mark related:

> *"The young fellas are really just full of fear running around, it's sad. Like on the outside its 'scumbag coke dealers' but they're just afraid scared little boys out there trying to make a name for themselves fuelled up by fear"* (Research Participant).

Others who were involved in small-scale selling related how they found themselves in trouble when they had used most of the drugs they had bought to sell and were placed under pressure to repay their debts, as Damien's experience demonstrated:

> *"With cocaine, you're getting it on tick and generally the fella that's giving it is doing it himself so we are all in the same predicament, we're all getting a bit to sell but you're doing it yourself and losing it and you're getting into debt and the next fella is ringing you up and saying 'where's your money'. So say you'd get an ounce of coke there would be a fella ringing you in a week saying look I want the money, I need the money - pressure, pressure, pressure"* (Research Participant).

The stress and strain many young people describe in owing money, and getting involved and out of their depth in the drugs trade, had an additional impact on the community in terms of the high rates of mental health problems and suicide which were seen to be related to these experiences. Community-based services reported the increasing constraints placed on them by their funders and being directed to focus on work targeted on securing educational outcomes rather than the social development work that would support these young people with high levels of need.

CONCLUSION

In this research study, four groups were identified as being at a high risk of drug and related harms – the in-treatment population; the families of drug users; the Traveller community; and young people, particularly those out of touch with services and engaging with the drugs economy. The drug-related harms experienced by these risk groups can be traced to broader social and economic conditions, and the experience of relative poverty and inequality, as well as the harmful outcomes of policy.


Family
like branches on a tree,
we will grow in different
directions yet our roots
remain as one.

SECTION FIVE
The Policy Environment and Partnership

INTRODUCTION

Previous sections of this report have outlined the nature of drug-related harms at the individual, family and community level, and described how these harms are situated within the context of a risk environment exacerbated by the politics and policies of austerity. Drug and Alcohol Task Forces also operate in this context within an environment which has changed significantly since they were first established. This section of the report examines the changing policy environment for DATFs over the past twenty years and the impact this has had on its operations and its capacity to respond to the needs of those affected by drug use in the CDATF area.

ENABLING POLICY ENVIRONMENT

In 1997 the government had established Local Drug Task Forces in response to a decade of civil society campaigns calling for state support for marginalised areas overwhelmed by epidemic levels of heroin use. In Clondalkin, as in many of the other communities affected, a prototype multi-agency task force was already in existence led by local groups seeking to address drug-related harms in the community. These arrangements were formalised under the LDTF policy initiative as a community-based partnership of the community, voluntary and statutory sectors and were initially granted generous government funding and underpinned by robust institutional structures.

At that time there had been a very clear political and policy focus, at European and national level, on responding to social issues through targeted area-based initiatives and community-based partnership approaches. The Drug Task Force model represented an innovative policy response to a spatially situated social problem and a model of participatory democracy unique in the extent to which affected communities were involved in developing and implementing policy at a local level, and influencing policy at a national level.

In the late 1990s community drug problems were a highly politicised and prioritised social issue and Drug Task Forces regarded as a key mechanism for the delivery of drug policy. Within the first ten years of this policy initiative an estimated €125 million had been allocated to the 14 LDTF areas, leading to the establishment of over 400 community-based projects employing more than 300 staff (Ahern, 2006). In addition, a series of funding programmes were targeted at LDTF areas such as the Young People's Facilities and Services Fund (YPFSF), the Premises Initiative (2000), the Emerging Needs Fund (2005), and Dormant Accounts (2001). However, government support for area-based initiatives waned from the beginning of the 2000s (Norris, 2014). Since then, community drug problems have been deprioritised and the Drug Task Force model has faced an increasing number of challenges to its function and remit.

CHANGING POLICY ENVIRONMENT

Since their establishment, the policy environment Drug and Alcohol Task Forces operate within has changed substantially and they have experienced a host of challenging administrative, governance, strategic and structural changes as well as being subject to extensive reviews and evaluations. For example, they have experienced changes in:

i) Departmental Administration - four government departments have had responsibility for the governance of the Task Forces and the National Drug Strategy. From its initial power base in the Department of An Taoiseach, the Drugs Strategy has been moved to the Department of Tourism, Sport and Recreation; the Department of Community, Rural and Gaeltacht Affairs (later renamed the Department of Community, Equality and Gaeltacht Affairs); to its current base in the Department of Health.

ii) Institutional structures – there have been a series of changes to the components of the institutional framework

in which the DATFs operate. These include the demise of the National Drug Strategy Team, the Inter-Departmental Group, the Drug Strategy Unit, the Office for the Minister of Drugs, and the Drugs Advisory Group; currently they include the Oversight Forum on Drugs, the National Co-ordinating Committee on Drug and Alcohol Task Forces, and the Drugs Programme Unit. These structures have reported variously to Cabinet Committees and Sub-committees on Social Inclusion, Children and Integration, and Social Policy and Public Service Reform.

iii) Government Ministers – eight Ministers (of State) to date have had responsibility for the National Drugs Strategy - Eoin Ryan, Noel Ahern, John Curran, Pat Carey, Róisín Shorthall, Alex White, Leo Varadkar and Aodhán Ó Ríordáin – including a period when there was no Minister with the portfolio.

iv) Drug Strategies – Eight major drug strategy /policy documents have been published: The Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996), The Ministerial Task Force on Measures to Reduce the Demand for Drugs. (1997), the National Drugs Strategy 2001-2008 (2001), the NDS Critical Implementation Path (2004), the Mid-Term Review of the National Drugs Strategy 2001-2008 (2005), the Report of the Working Group on Drugs Rehabilitation (2007), the National Drugs Strategy (Interim) 2009-2016 (2009), and the Report of the Steering Group on a National Substance Misuse Strategy (2012).

v) Terms of Reference - the original terms of reference for the LDTFs set out their role as assessing the extent and nature of the drug problem in their areas and developing coordinated strategies to respond to the problems identified; these Terms of Reference have been changed twice since. The most recent change in 2012[12] emphasises the DATFs role in reporting, monitoring, evaluating and impact assessment. In addition, there is ongoing ambivalence as to whether alcohol is, or is not, integrated within its brief.

vi) Evaluations and Reviews – there have been eight evaluations and reviews covering the work of the Drug Task Forces since they were established: PA Consulting Group (1998), Comptroller and Auditor General (2000), Ruddle et al./National College of Ireland (2000), PA Consulting (2001), National Drugs Strategy Team (2002), Goodbody Economic Consultants (2006), Horwath/ Matrix (2008), and the Department of Health (2012).

vii) Resources and terms of engagement – DATF budgets have been reduced year on year since the recession. Less funding available for allocation to local services has reduced their capacity to respond to increased levels of need in the area. In addition, more onerous contractual arrangements, via a shift from grant aid funding to service level agreements, have constrained human resource capacity for strategic planning and front line service delivery.

The cumulative impact of these changes has resulted in an increasingly difficult and disabling policy environment for the DATFs, and the services they support, to carry out their work.

DISABLING POLICY ENVIRONMENT

The changes in the policy environment can be traced to the influence of neo-liberal thinking characterised by the centralisation of power and decision making, the reduction of the activities of the state (for example, the contracting out of public and social services), the individualisation of social problems, and adherence to new public sector management principles.

This new policy environment was clearly evident in the (current) National Drugs Strategy 2009-2016, when it was launched in 2009 with an emphasis on:

- centralising structures and co-ordination mechanisms to facilitate 'greater coherence in policy-making and service delivery' (p. 5);
- public sector management principles of measuring outcomes, outputs, effectiveness and value for money with the linking of each of the Strategy's objectives to a set of SMART (specific, measurable, and targeted) key performance indicators;
- framing the drug problem as an individualised phenomenon rather than one situated within the context of poverty, inequality and social exclusion – poverty gets one mention in a footnote of the strategy document; and
- the criminalisation of drugs policy where drugs are prioritised as a policy issue because of their perceived propensity to cause crime and disorder rather than as a social problem meriting attention in itself.

Within the paradigm of neo-liberal ideology there is no scope for civil society input into the decision making process. As described by a local community worker:

[12] Terms of Reference of the Drug Task Forces were amended by the Department of Health (2012). Currently, the terms of reference of task forces are to: (i) support and strengthen community-based responses to drug misuse through drawing up and implementing a local drug and alcohol strategy; (ii) identify and report on emerging issues and local responses; (iii) monitor, evaluate and assess the impact of funded projects and their continuing relevance to the local task force strategy; and (iv) recommend changes to the central funding allocations as deemed necessary.

"It is an ideological shift, it is about centralised control, it is a lack of trust in the ability of local communities to make decisions about themselves; it's a lack of faith and a distrust in local autonomy and local knowledge and the skill base in communities "(Community Worker).

Consequently, the DATF model has faced ongoing and increasing challenges to its ethos, function and remit. For example, the extensive reviews and evaluations conducted on DATFs and community-based projects are, as noted by Norris (2014), significantly more than those conducted on mainstream public spending programmes even though the findings of each review have been largely supportive of the DATF model.

This critical focus on the DATF initiative is disproportionate in terms of its cost to the exchequer within the overall drugs strategy. Though it is difficult to fully disaggregate expenditure on the drugs strategy within government department budgets, overall government expenditure on drugs-related issues was estimated to be €240m million in 2014 (ADRU, 2015:29). Almost three-quarters of public expenditure on drug programmes is spent on HSE Addiction Services (38%) and supply reduction and criminal justice services (34%); approximately 10 per cent of the overall budget is allocated for drug task force projects.

The Report on the Review of Drug Task Forces and the National Structures under which they Operate (Department of Health, 2012) is seen by some to toll the death knell of the DATF model. The Review set out to examine the DATFs role, composition and structures; streamline its funding; and overhaul accountability and reporting arrangements. The Review acknowledges the expertise of the DATFs:

'Drug Task Forces are very well placed to develop proposals to respond to emerging local needs as they have local area knowledge, community support and cross-sector expertise (p.5).'

However, the language and tone of the Review is forthrightly critical and heavily loaded with suggestions of poor practice in its instruction to the DATFs to:

'… exercise their oversight and decision making role in an independent, credible and transparent manner … develop a governance framework which will provide greater management and control of expenditure … contain the necessary safeguards to ensure that DTFs carry out their functions in a way which will stand up to external scrutiny … provide the Department with a better level of assurance that public funds are being adequately accounted for and subject to the appropriate level of financial control. (p.5)'

The challenges faced by the DATFs are not dissimilar to those faced by others in the community /voluntary sector addressing issues from a community development perspective such as the Community Development Projects (CDPs); the Family Resource Centres; and the Local Development Partnerships. These challenges are symptomatic of a policy era that is more hostile than supportive to the community sector; community-based services; and local knowledge and collective approaches to addressing social issues (see CWC, 2015). There is a shared view in the sector, described by one CDATF member, as:

'Something more generally going on that goes beyond financial and governance concerns … very reflective of the way government is thinking at the moment and I do believe very much that some sort of agenda is being implemented certainly at senior civil service level and with the agreement of the politicians in power so you can see similarities right across the board ' (CDATF Member).

EXPERIENCE OF CENTRALISATION

A key outcome of the neo-liberal policy agenda is the centralisation of power (and allied realignment process) which has reversed the trend for devolved decision-making in area- and community-based policy initiatives favoured in the 1990s and shifted any vestiges of power disseminated to communities back to the centre.

With centralisation, the community led bottom-up policy and decision-making process that shaped the development and implementation of the first National Drugs Strategy has shifted to a hierarchical top-down approach emanating from the Drugs Policy Unit in the Department of Health. At the heart of this recentralisation project (noted by MacGregor and Thickett, 2011: 489) lies a tension between the desire for control and bureaucratic standardisation and the *'diversity and dynamism on the ground in the real world.'* From the accounts of CDATF members interviewed for this research, this was experienced in two key, albeit overlapping, ways:

The community led bottom-up process that shaped the development and implementation of the first National Drugs Strategy has shifted to a hierarchical top-down approach.

1. The closing down of the spaces for communities and community-based services to input into the decision making process.
2. Extreme levels of monitoring, reporting requirements and effectiveness and value for money evaluations.

The impact of this on the ground was described by one CDATF member as being:

> *"About centralised control it's about administratively trying to put everything into particular boxes that make things clean within the administrative function - but the local control is going out of things more generally … priorities are being set for local level at national level in terms of the kind of work we are expected to be doing"* (CDATF Member).

The Drugs Policy Unit's fervent focus on monitoring and evaluation impacted on the capacity of the DATFs and local services and was reported to be soaking up the time and energy of the DATFs to the detriment of other aspects of their work:

> *"Much more micro managing and trying to drive the DATF into a kind of an arm of the state where your function becomes not about developing strategies … but about monitoring and scrutinising at a local level … incredibly dispiriting and disempowering for the local organisations"* (CDATF member).

CDATF members reported their frustration with the highly dysfunctional administrative and financial reporting systems that projects and services have to comply with. Yet, rather than addressing these faulty systems, the DPU have increased levels of monitoring even further and this does not reflect the type of work conducted at the local level:

> *"The way programmes are monitored, evaluated - very more output focussed more than outcome focussed … the flexibility of what you are allowed to do at local level is very restricted in terms of the quality outcomes you used to be able to achieve sometimes these were maybe not immediate outcomes but they were things that had longer term impacts - there doesn't seem to be a way of measuring those there doesn't seem to be a desire to develop systems that might measure those kind of impacts as well"* (CDATF member).

Proposals for a new performance monitoring system for 'evidencing the effectiveness of individual Task Forces' based on a theory of change model and using a logic model framework are currently being developed through the National Co-ordinating Committee of Drug and Alcohol Task Forces in preparation for the new National Drugs Strategy due in 2017.

IMPACT ON PARTNERSHIP

The centralisation process is the antithesis of the DATF community-based partnership model. This partnership model was based initially on the collaborative and coordinated working relationship of community, voluntary and statutory organisations involved in service provision for drug users, young people, and families. These included representatives of statutory agencies such as the health service, local government and development bodies, the police and probation services and the state training agency (FÁS) as well as representatives from a number of government ministries, namely education, health and justice. However, over the years membership and attendance at the DATF's has tailed off particularly from representatives of the statutory agencies:

> *"The agencies come and go, and when they consider there is a need to attend they attend, but that's not really attendance "* (CDATF member).

The less active engagement of senior decision makers from the public and statutory sector and the less frequent attendance of these representatives at the DATF Board meetings (with the exception of the Gardaí and the local authority) is in part attributed to the restructuring, reduced resources, and staff shortages within these sectors. However, this issue is also seen to be a repercussion of the centralisation process and the statutory agencies' perception that the locus of power has shifted away from community-based partnerships back to the centre:

> *"The agencies have fewer resources and don't see the DATF as somewhere that decisions can be made about things that matter "* (CDATF member).

Changes in administrative structures were also identified as reasons for lessened interagency work. Originally, DATF projects were set up under a tripartite arrangement between the DATF, the project promoter (which was providing the service) and the state agency which was the channel of funding. In theory, the three agencies were to act as partners in the delivery of the service in the local area. Over time, this approach which was seen as the fundamental to the relationship in the DATF model has been diminished with little integration achieved.

CHALLENGING RELATIONSHIPS

The changing nature of the social relationships within the DATF have led to difficulties in working in partnership with the statutory services, including the HSE and in particular the DSP who do not attend CDATF Board meetings.

A key concern expressed by Board members was of the changing relationship between the DATF and the HSE and the perceived erosion of the independence and autonomy of the DATFs. Part of this was seen to stem from the fact that many DATF co-ordinators (though not in the case of Clondalkin) are employed by, or seconded from, the HSE. With the HSE taking over responsibility for DATF interim projects there is a sense that the HSE now regard the DATFs, and the community based projects funded by them, as essentially public services carrying out their function.

The case of the HSE communications to the DATFs in 2013 seeking the implementation of the Haddington Road Agreement (in the form of four additional hours per worker per week in the services funded by them) as if community-based workers were public sector employees with the salary scales, employment conditions and security of tenure attached to their posts, is seen as a moot example of the HSE disregard for the DATFs independent role as a partner in addressing drug related harm in the area.

The impact of poor engagement by key stakeholders from the statutory services on interagency collaboration is apparent in the difficulties the DATF encounters in establishing formal interagency protocols and case management approaches across services. This is exemplified in the case of the National Drugs Rehabilitation Framework (2010) one of the cornerstones of the National Drugs Strategy to be rolled out with Local and Regional Drug and Alcohol Task Forces with the aim of providing an *'Integrated Care Pathway'* tailored to meet the treatment and other needs of drug users. However, its implementation has been beset by challenges most notably the difficulty in securing the co-operation of the HSE Addiction Services to work in partnership with non-clinical drugs workers. The roots of this tension appear to lie in the opposition between the social model of addiction represented by the NDRF's '*key working*' model and the medical model of addiction privileged within the HSE:

> *"The HSE [clinical teams] don't operate NDRF in any shape or form … [and] have no interest whatsoever in implementing that except in the community-based projects who are already doing it anyway"* (CDATF member])

> *"A GP might say to you 'I am not talking to those community people' and 'I'm not discussing confidential client info with those community people' and 'I'm not key working I'm a medic' "* (CDATF member)

These tensions are further exacerbated by structural difficulties whereby governance of the NDRF is based in HSE Social Inclusion whereas most of the Rehabilitation / Integration Workers are based in HSE Addiction Services and interagency working between these two branches of the HSE were reported to be not always successful. In addition, a National Addiction Advisory Governance Group was established by HSE Social Inclusion to implement the National Rehabilitation Framework but this does not include clinicians and is regarded as being dismissed by the HSE Clinical Governance Group. The absence of some vital social partners such as housing, GP's, Department of Education, Department of Employment and service users are also reported to be contributing to the difficulties in the implementation of the National Rehabilitation Framework.

The difficulty in securing the co-operation of the HSE Addiction Services to work in partnership with non-clinical drugs workers.

SOCIAL DEFICIT MODEL

Further challenging relationships were identified between the Drug and Alcohol Task Forces and the Department of Social Protection, and with the Department of Children and Youth Affairs. Neo-liberal government policies have increasingly employed a social deficit model to address social issues related to inequality. This model focuses on the *'social deficits'* of people who are unemployed, unskilled or educationally disadvantaged rather than tackling the structural issues that bring about these deficits (Monaghan and Wincup, 2013). This approach is particularly visible in the policies and activities of the Department of Social Protection which has responsibility for the special Community Employment schemes ring-fenced for clients of drug projects. These programmes have been adversely affected by austerity politics with a severe reduction in payments to participants and the training allowances available for them, and a cap on the number of years they can participate in the scheme. Service providers interviewed for this research study noted the stress placed on participants by the DSP's focus on progression routes into work. At a time of high unemployment they felt the DSP had unrealistic expectations for this client group and set them up to fail with a potentially negative impact on the drug users' rehabilitation prospects. As one service provider described.

> *"[They are] pushing people into employment and onto job seekers allowance who are unfit for work just to get them off the live register. They are also sent on courses which they are unable to commit to"* (Service Provider).

Despite these difficulties the DSP were reported to have *"have stepped off all the [CDATF] structures and have done so for a long time"* and are reported to have not engaged with the DATF to try resolving these issues.

The social deficit model has also been adopted by the restructured Department of Children and Youth Affairs and TUSLA (the Child and Family Agency) responsible for addressing

young people's needs. In our interviews with those working with vulnerable young people they described the impact of this policy approach. Their work with young people out of school and out of work was now to focus on making them *'job ready'* and the effectiveness of their work was to be measured by the number of young people with FETAC qualifications the services can deliver. As a result, traditional youth work with marginalised young people has been stymied and services are directed away from addressing the fundamental reasons why the young people could not continue on in school to focus on labour activation programmes despite there being: *"so much chaos going on in their lives",* as one youth worker described:

"There is no recognition that there's root causes to this that needs long term support and infrastructure for people in the community cos you're always going to have people that struggle but now it's all short term interventions, a quick fix, do this for 10 weeks and they will come out the other end the shape you want them to be" (Youth Worker).

Additional cuts in funding to the School Completion Programme (SCP) have also impacted on the level of provision and supports to vulnerable young people such as breakfast and homework clubs which have been significantly reduced. Recent restructuring of the funding of services for children and young people to TUSLA will result in the SCP and other youth services having to compete for funding from TUSLA. At a time of increasing need, the impact of the ongoing reduction and restructuring of these services is of concern.

CONCLUSION

The economic and policy environments in which the Drug and Alcohol Task Forces operate have changed considerably since they were established in 1997. Over its life time, the Drug and Alcohol Task Forces have experienced a host of administrative, governance, strategic, structural and remit changes, and a disproportionate number of evaluations, reviews and critical focus while statutory services escape such scrutiny.

The underlying rationale for the shift from an enabling to a disabling policy environment for community-based responses to social problems is ideological. The influence of neo-liberal thinking characterised by the centralisation of power and the individualisation of social problems is the antithesis of the community-based intersectoral partnership model coordinated by the Drug and Alcohol Task Forces. This new policy paradigm has resulted in tensions, challenging relationships and the imposition of new models of working favouring short- term gains over longer term sustainable community-based responses.

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SECTION SIX
Conclusion

Drug consumption patterns and trends evolve over time and place but drug related harms consistently cluster in communities marked by poverty and inequality. The origins of poverty and inequality do not arise from the actions of people or communities, they derive from the politics, policies and structural violence of the state which privilege powerful groups leaving the more vulnerable experiencing a disproportionate level of policy harms.

This research study on drug harms, policy harms, poverty and inequality identifies how drug use and related harms are contextualised and exacerbated by increasing levels of poverty and inequality, and highlights how policy outcomes harm vulnerable individuals and communities, and the community-based services and multiagency partnerships that support them.

In contrast to the lived experience of drug related harms on the ground, drug policy in Ireland has become more focused on addressing individual drug using behaviour and drug related crime - as if these issues were context free. Little attention is paid in drug policy discourses to the underlying issues of poverty and inequality and even less consideration is given to the harmful outcomes of policy.

The austerity policies introduced in the wake of the Great Recession have exacerbated the existing structural deficiencies in our society (such as unemployment, poverty, housing, educational disadvantage and powerlessness) by cutting funding to education, health, housing, and welfare supports and to the Drug and Alcohol Task Forces and community, voluntary and statutory services that support vulnerable groups. The implementation of these cuts on the grounds of our economic crisis belies the underlying shift to a neo-liberal view on the functions of the state. This shift is characterised by the dismantling of much of the institutional infrastructure of the welfare state (even at the low level this existed previously); and transferring the responsibility of the state to meet people's basic needs on to the individual to address their social deficits (such as poverty and /or drug problems) without regard for the policy context that shaped these. The new policy paradigm had led also to the drawing back of power from communities and the recentralisation of power within government administration and a public management system focused on measuring outputs, effectiveness and value for money – all utterly disconnected from the needs of people and communities.

The harmful outcomes of these policies on the capacity of Drug and Alcohol Task Forces have been highlighted in this report. The DATFs were established as an area-based policy initiative building on existing innovative community-led interagency partnerships which sought to address local cross-cutting social issues. As a model of participative democracy, DATFs represent the very antithesis of centralised power and decision making as favoured by neo-liberalism and have faced ongoing and increasing challenges to its ethos, function and remit. In particular, since 2008, the Clondalkin Drugs and Alcohol Task Force has experienced:

- a year on year reduction in mainstream and interim funding;
- a policy shift from one that framed community drug problems within a context of poverty and inequality to one that frames drug-related harms as a problem of individual behaviour;
- extreme levels of bureaucratic monitoring, reporting requirements, and effectiveness and value for money evaluations;
- a closing down of the spaces for communities and community-based services to input into the decision making process;
- an effective withdrawal of key statutory services from engaging in the multiagency partnership approach; and
- the imposition of new service level agreements and funding contracts which prescribe services to deliver short-term outcomes addressing individual's social deficits over longer-term sustainable change.

These harmful outcomes of policy threaten the DATF model of intersectoral collaboration and do not bode well for its future. As the term of the current National Drugs Strategy comes to an end in December 2016, the Cabinet Committee on Social Policy and Public Service Reform has mandated the Department of Health to develop a new National Drugs Strategy and has stipulated that this should involve a fundamental review of all aspects including the role of the Drug and Alcohol Task Forces.

A missing piece in the development process for the new Strategy is a review of the impact of austerity and reform policies on drug-related harms and the capacity of services and DATFs to respond to increased levels of need. Excluding an evaluation of the outcomes of these policies from the

review ensures that policy makers and administrators are placed outside of the sphere of responsibility for limitations in the current strategy.

There is a concern, that rather than the Strategy renewing its commitment to the DATF model of community-based partnership and maintaining the spaces for affected communities to input into the decision making process, that this model will be scapegoated for not conforming to the reform agenda for increased centralisation of power and control.

One of the key issues to be considered in developing the new Strategy is whether drugs policy should continue to be underpinned by the five existing thematic pillars of supply reduction, prevention, treatment, rehabilitation and research. The influential context of poverty and social exclusion in the development of drug-related harms suggests that a new pillar dealing with Social Inclusion would provide a framework for addressing these issues. Drug and poverty proofing public and social policies could also help identify potential policy harms before they are implemented. However, all of these measures would require a significant change in the mind-set that informs current drug and social policy making.

One of the difficulties in challenging the current policy paradigm is that the state's rhetoric on partnership, collaboration, and interagency working appears on the surface to have largely unchanged, though this no longer translates into the experience on the ground.

It is hoped that this report will provide a useful evidence-based tool to challenge this rhetoric and facilitate debates on a sustainable approach to addressing drug-related harms in the community.

Corkagh Park Fishing Lakes

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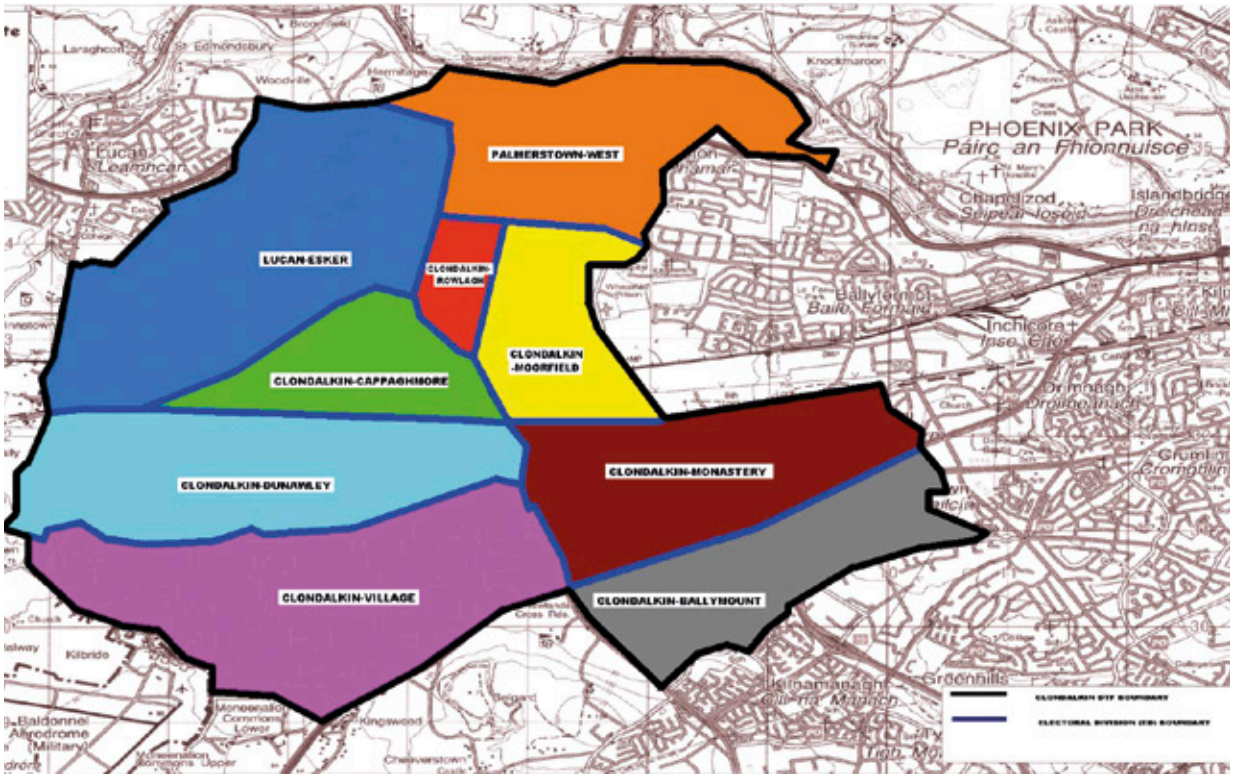
APPENDIX



Adapted from Area Development Management/Gamma, 2004. –Clondalkin Drugs Task Force Strategic plan 2006 p. 22

Clondalkin-Cappaghmore (Foxdene, Burgh an Ri, Meile an Ri, Tor an Ri)

Clondalkin-Dunawley (Bawnogue, Deansrath, Kilcronan, Oldcastle)

Clondalkin-Monastery (Fox and Geese, Knockmitten, Yellowmeadows)

Clondalkin-Moorfield (Harelawn, Collinstown, Harelawn, Moorfield)

Clondalkin-Rowlagh (Neilstown, Ronanstown, Rowlagh, St Marks)

Clondalkin Village (Commons, Fairview)

Lucan-Esker (Foxborough, Ballyowen, Esker South)

Palmerston West (Greenfort, Irishtown, Shancastle)


Clondalkin
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