

# Working Notes

facts and analysis of  
social and economic issues

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Jesuit Centre for Faith and Justice  
26 Upper Sherrard Street, Dublin 1

Phone: 01 855 6814  
Email: [info@jcfj.ie](mailto:info@jcfj.ie)  
Web: [www.jcfj.ie](http://www.jcfj.ie)

Editor: Margaret Burns

Production Team: Berna Cunningham  
Lena Jacobs  
Yanira Romero

Printed by: Colorman Ireland  
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# Drug Policy: Need for Radical Change?

*Peter McVerry SJ*

## Introduction

What began as a heroin problem in inner-city Dublin in the 1980s has now spread like a cancer throughout Irish society. A wide variety of drugs, from cannabis to heroin to cocaine and on to crack cocaine, are now available in almost every town and village in Ireland. Crystal meth will probably be the next wave of drugs to hit our shores. While many of us have lived our entire lives without ever seeing an illegal drug, this most certainly cannot be assumed to be the case for the children and young people now growing up in our society.

The monetary value of the illegal drug trade in Ireland probably runs to hundreds of millions of euro per year.<sup>1</sup> This ‘business’ has created about twenty violent drug gangs, who import illegal drugs and control their sale. Despite the successes of the Gardaí in seizing huge quantities of drugs and arresting those who are dealing in this trade, there is no shortage of drugs on our streets. As long as a kilo of cocaine can be bought in South America for €700, and sold on the streets of our cities and towns for €70,000, there will be no shortage of people willing to risk imprisonment – or worse – for this kind of profit. Each new generation of drug dealers is more violent and more alienated from the society around them than those who went before, and the factors which trigger their violence are becoming more and more trivial. Their violence and threats of violence discourage all but the bravest from providing information or evidence to the Gardaí.

How are we to tackle this scourge? There are two basic dimensions to any drug policy:

- Policies to deal with the supply of drugs;
- Policies to deal with the demand for drugs.

## Policies Relating to the Supply of Drugs

The emphasis in current drug policy is on trying to reduce the supply of drugs. Spending related to the ‘war on drugs’ – on, for example, policing, customs controls, courts and prisons – accounts for the vast bulk of what can be considered drug-related public expenditure. By comparison, spending which attempts to deal with the demand for drugs – on

education and drug treatment, for example – is a miniscule part of public expenditure. The imbalance between the levels of expenditure on these two elements of the response to the drug problem is not, in my view, justified.

Any discussion of drug policy must begin with what I consider to be a self-evident statement: *current policy isn't working*. I would suggest that a debate on drug policy should start with the following three questions, which I would address to both politicians and the wider public:

1. *Do you believe that Ireland will ever again become free of illegal drugs?*

If your answer is ‘yes’, where is the evidence for your optimism? Our experience in Ireland, over the past thirty years, suggests that drug availability is likely to continue to be a major problem, despite the successes of the Gardaí. The recession has led to a reduction in the overall demand for drugs and in particular in the demand from recreational drug users.<sup>2</sup> However, the scale of the problem is still enormous and it is possible that the economic hardship associated with the recession will increase use among some groups and will draw into drug-dealing young people who were not previously involved and who would not have become involved were it not for a lack of employment opportunities in the current economic climate.

In this globalised economy, it seems impossible to stop the movement of drugs from country to country, whenever there is a demand for them. Almost every country in the world – including those that execute drug dealers! – has a drug problem.

2. *If illegal drugs are here to stay, who should control the supply of drugs?*

At present, the supply of illegal drugs is obviously controlled by criminal gangs. I doubt if anybody wants the criminal gangs to continue to supply illegal drugs, with all the consequence that follow.

3. *If drugs are here to stay, and if we do not want the criminal drug gangs to control their supply then who should do so?*

That is a question that we continue to avoid. Politicians run scared of it. But it is a fundamental question. In my view, the State should take control of the supply of drugs – what is commonly referred to as ‘legalising drugs’. The term ‘legalising drugs’ is not one that I am comfortable with, as most people will, rightly, associate it with that other legalised drug, alcohol, and nobody in their right mind would want heroin or cannabis to become as readily available as alcohol. But ‘controlling the supply of drugs’ differs from the situation regarding alcohol in two ways:

Firstly, alcohol is widely available in every supermarket, corner store and petrol station. Indeed, Government decisions over the past decade have allowed a considerable expansion in the range of outlets licensed to sell alcohol. No-one suggests that drugs should be available in such a manner.

Secondly, hundreds of millions of euro are spent every year on the promotion of alcohol. No-one is suggesting that drugs should be advertised and promoted.

A better model for the ‘legalisation’ of drugs is the provision of methadone. Methadone is a highly dangerous, very addictive, drug which is available, free of charge, to those who want it – basically heroin users. The supply of methadone is tightly controlled by the State. The result is that it is very difficult to obtain on the streets. Criminal gangs see no point in trying to deal in methadone since it can be obtained through legal channels.

If we are to effectively deal with the supply of drugs, then a public discussion on alternative policies that are evidence-based needs to begin immediately. Of course, any change in drug policy would require considerable education of parents and the broader public. Much of the discussion of drug policy takes place in a context of fear: parents are scared to death of discovering that their son or daughter is a drug user – understandably so. Parents need to be reassured that the ‘legalisation’ of drugs will actually make it *more* difficult for their children to access drugs.

### **Global Commission on Drugs Policy**

Such discussion may be timely. Globally, the traditional ‘war on drugs’, has come under scrutiny. In January 2011, the Global Commission on Drug Policy was launched. The Commission’s international membership included former Presidents of three Latin American countries

(Colombia, Mexico and Brazil) – statesmen who had enthusiastically embraced the ‘war on drugs’ in their respective countries, a ‘war’ supported by billions of dollars from the United States. The Commission also included Kofi Annan, former Secretary General of the United Nations; Javier Solana, former European Union High Representative for the Common Foreign and Security Policy; George P. Shultz, former U.S. Secretary of State, and George Papandreou, Prime Minister of Greece.

The Commission issued its report in June 2011 and set out a number of principles and recommendations to guide national and international drug policies and strategies. These were summarised by the Commission as follows:

- *End the criminalization, marginalization and stigmatization of people who use drugs but who do no harm to others.*
- *Encourage experimentation by governments with models of legal regulation of drugs to undermine the power of organized crime and safeguard the health and security of their citizens.*
- *Offer health and treatment services to those in need. Ensure that a variety of treatment modalities are available, including ... the heroin-assisted treatment programs that have proven successful in many European countries and Canada. Implement syringe access and other harm reduction measures that have proven effective in reducing transmission of HIV and other blood-borne infections as well as fatal overdoses.*
- *Apply much the same principles and policies stated above to people involved in the lower ends of illegal drug markets, such as farmers, couriers and petty sellers. Many are themselves victims of violence and intimidation or are drug dependent ... Drug control resources are better directed elsewhere.*
- *Invest in activities that can both prevent young people from taking drugs in the first place and also prevent those who do use drugs from developing more serious problems ... The most successful prevention efforts may be those targeted at specific at-risk groups. Focus repressive actions on violent criminal organizations, but do so in ways that undermine their power and reach while prioritizing the reduction of violence and intimidation.<sup>3</sup>*

The Commission supports the arguments it puts forward by drawing on the experience in Switzerland of policies and programmes based on public health considerations rather than criminalisation. It referred to a study on the heroin substitution programme adopted, which indicated that:

- *[The programme] substantially reduced the consumption amongst the heaviest users and this reduction in demand affected the viability of the market. (For example, the number of new addicts registered in Zurich in 1990 was 850; by 2005, the number had fallen to 150.)*
- *It reduced levels of other criminal activity associated with the (drug) market. (For example, there was a 90% reduction in property crimes committed by participants in the program.)*
- *[The removal of] local addicts and dealers [meant that] Swiss casual users found it difficult to make contact with sellers.<sup>4</sup>*

The Commission also draws attention to the fact that the percentage of people who inject heroin in the Netherlands is the lowest in the EU-15 countries and heroin has lost its appeal to mainstream young people who consider it now to be a ‘dead-end street drug’. The report notes: ‘Medically prescribed heroin has been found in the Netherlands to reduce petty crime and public nuisance, and to have positive effects on the health of people struggling with addiction.’<sup>5</sup>

The last in the list of the Commission’s recommendations is simply: *Act urgently: the war on drugs has failed, and policies need to change now.*<sup>6</sup>

### **Policy Relating to the Demand for Drugs**

The other dimension of a proper drug policy is tackling the demand for drugs. In the first instance, we as a society need to look at the issue of the ‘primary’ demand for drugs: what are the factors that lead people to decide to use drugs in the first place? We know that drug abuse is strongly associated with economic and social deprivation – but we must also acknowledge that Irish society has long since gone past the stage where drug use is confined to a small minority of the population, among whom socially deprived people are disproportionately represented.

Availability, curiosity, and peer pressure may

be among the immediate reasons that a person might experiment with drugs. But we need to look deeper and consider how the ways our society is ordered and the values by which it is shaped may influence the resort to drugs. We need, for example, to consider the relevance of the inequality and insecurity that impact so profoundly on people’s daily existence and to acknowledge the aloneness and the spiritual emptiness that lie behind the consumerist culture that is still pervasive. Are these factors giving rise to a ‘need to escape’, a need which finds expression not just in illegal drug use but in the extremely unhealthy and socially damaging patterns of alcohol consumption that have now become entrenched in Ireland?<sup>7</sup>

If we are to reduce the demand for drugs we need to look hard at what young people growing towards adulthood are offered by our society – not just in material terms but in terms of an overall quality of life, which includes relationships with family, peers and the wider community, as well as the quality of the educational, recreational and cultural opportunities available to a young population that has diverse needs, interests and abilities. Clearly, then, addressing the factors influencing the initial demand for drugs must go further than educational measures and specific prevention programmes – though these are, of course, extremely important.

And what of demand associated with those who have become habitual users or seriously drug dependent? The obvious answer is that we should be doing everything possible to provide treatment – ensuring that there is, in the words of the Global Commission on Drugs Policy, ‘a wide and easily accessible range of options for treatment and care for drug dependence’.<sup>8</sup>

The issues relating to encouraging and enabling people to access services for their drug problems are, of course, complex; even after people have come to acknowledge the seriousness of the impact of their drug use, they may still resist entering treatment. But one thing should surely be clear: where a person with a drug problem expresses a willingness to enter treatment they should be able to access that treatment without undue delay.

In fact, almost all drug users with whom I have worked have wanted to give up drugs at some point in their life. The reality is, however, that the provision of services is very patchy, and too often access depends on which part of the country, or even which part of Dublin, a person lives in.

Even if a place becomes available, a person may have to travel a long distance, on a daily basis, to the nearest treatment programme. There can be delays of months, or years, in gaining access to a methadone treatment programme. These are serious obstacles for drug users wanting to access help.

The window of opportunity that exists when a person is motivated to seek treatment may last only a few weeks, or at most a few months, and if access to treatment is not available during that time, discouragement sets in. One of the recommendations of the inter-agency Steering Group which carried out the *Mid-term Review of the National Drug Strategy 2001–2008* (published 2005) was that access to treatment should be available to drug users within one month of assessment.<sup>9</sup> Six years later, we are a long way from implementing this recommendation.

The use of drugs imposes enormous costs on society, in terms of crime, ill-health and family break-up. In the current recession, drug services have seen their funding cut by as much as 25 per cent; in some cases, services have closed. While this saves money in the short term, the medium and longer term costs to society far outweigh any short-term savings. The recession may well deepen the problems associated with illicit drug use, with inevitable consequences for the well-being and safety of society. Reducing services and increasing waiting lists makes no sense, financial or otherwise. In fact, services ought to be moving in the opposite direction – with a radical expansion in the range of treatment options. The Global Commission on Drugs Policy noted:

*Preventing and treating drug dependence is ... a key responsibility of governments – and a valuable investment, since effective treatment can deliver significant savings in terms of reductions in crime and improvements in health and social functioning.*<sup>10</sup>

While methadone treatment is a useful treatment option it still leaves the person addicted. Methadone is even more addictive than heroin. For those who wish to come off heroin or other drugs and become completely drug-free, the scarcity of residential services presents an enormous problem. Those who live in stable, supportive families may be able to undergo detoxification while remaining at home, but many people – especially those living in families with other family members who continue to use drugs, or who live in areas where drugs

are widely available, or who are homeless – will require residential treatment.

Official reports on drug policy consistently acknowledge the significant gaps in the availability of residential detoxification facilities, including the overall shortfall in places relative to need, geographic disparities in provision and the fact that detoxification beds are provided in general and psychiatric hospitals, rather than being located, in accordance with best practice, in dedicated units.<sup>11</sup> In effect, waiting times for admission can be so lengthy that many give up on their intention to seek treatment. Despite the official recognition of the need for more detoxification places, there is no indication that there is any plan or time line for ensuring an adequate level of provision.

### **Rehabilitation**

After-care and rehabilitation services are an essential aspect of a drug policy that aims to reduce the demand for drugs. When someone manages to become drug-free, there still continues the difficult struggle to remain so. As in the case of treatment services, official documents acknowledge the importance of rehabilitative services – referring to the need for a comprehensive range of services and a ‘continuum of care’.<sup>12</sup> But again, the reality is a serious shortfall in provision.

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*Reducing services and increasing waiting lists makes no sense, financial or otherwise*

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After-care should include the availability of drug-free, supported accommodation for those who do not have a safe or supportive place to live, as well as useful occupation during the day. However, there is virtually no supported, drug-free, after-care accommodation available in the whole country. *The National Drugs Strategy (Interim) 2009–2016* recommended that: ‘Dedicated supported accommodation, staffed appropriately, should be provided to cater for those who have difficulties with an independent living environment.’<sup>13</sup> However, two years after the publication of the Interim Strategy, there is no evidence of any progress in relation to this recommendation.

The biggest barrier to recovery can often be the boredom and meaninglessness of each day’s existence. While on drugs, a person’s day is fully occupied. They have a reason to get up: they

have to get their drugs and they have to find the necessary money; then they have to contact their drug dealer; then they take their drugs. And when the effects wear off, they have to start all over again. The day is full, and has its 'structure', however dysfunctional that may be. But for many people who come off drugs, there is a huge vacuum: there is nothing to get up for, and each day is one long boring hour after boring hour, with nothing to do – except think of what life was like when they were using drugs, when it was anything but boring!

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*The biggest barrier to recovery can often be the boredom and meaninglessness of each day's existence*

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There are Community Employment (CE) schemes, some long-established, which provide places specifically for people who are in recovery. For many former users, such schemes fill the vacuum that arises once they are no longer spending their day seeking the means to meet their habit. In many instances, involvement in such a scheme can make all the difference between staying drug-free and relapsing. The cost of these schemes is very small: an administrative charge plus the incentive of a small increase over and above the welfare payments the person would otherwise receive. However, as is the case with so many other aspects of treatment and after-care, such places are limited relative to the scale of need, and few are available outside Dublin. A guaranteed place for every person who comes off drugs and needs this type of employment support would cost a little money, but save a great deal.

### ***Drugs and Penal Policy***

Many drug users end up in prison; some go to prison repeatedly, usually for crimes committed to feed their habit. Hence any drug policy must address the situation of drug users in prison. The scale of the challenge is indicated by studies showing the extent to which people in prison have had a history of using illegal drugs:

- A national study, published in 2000, of a representative sample of prisoners found that 52 per cent had used heroin.<sup>14</sup>
- Another study, carried out in 2003, of five different groups of prisoners found that a very high percentage in all groups had experience of illicit drug use – for example, 56 per cent of

a sample of all males committed to prison in 2003 were current drug users and 48 per cent of females committed in 2003 had a current drug dependence problem.<sup>15</sup>

- In 2009, more than 28,000 voluntary tests were carried out in Ireland's fourteen prisons to monitor drug use and responses to treatment among prisoners. The percentage testing positive varied between different prisons but overall, and excluding methadone, 'between one-tenth and two-fifths of those screened tested positive for at least one drug'.<sup>16</sup>

Despite the efforts of the Irish Prison Service to stem the flow of drugs into prison, many drug users continue to use drugs during the time they are imprisoned. Even more alarming is the fact that some people use drugs for the first time while they are in prison. One factor in this is that because of overcrowding, non-drug users often have to share a cell with others who are using heroin. Over the past decade or so, at least forty people have told me that they had never touched drugs before being imprisoned but had emerged from prison as heroin addicts. Imprisoning non-drug users in such an environment is a disaster, not just for them but for the whole of society. The ready availability of drugs outside of Ireland's main cities may be explained, in some instances, by the fact that non-drug using people from an area have been committed to prison for a relatively minor crime but, while there, have developed a drug habit, which on release they maintain by selling drugs in their home town.

Within many Irish prisons, there has developed a drug culture which successfully perpetuates pro-drug attitudes. While the introduction of drug counsellors into our prisons has been a positive step, it is very difficult for such a service to be effective in an environment where drugs may be 'in your face' and where there is a strong temptation to use drugs to counter the boring, meaningless, existence that is so often prison life. Many prisoners would welcome the opportunity to tackle their addiction while in prison, if the opportunity existed. There are nine detox beds in the whole system for a prison population of around 4,500!

Perhaps the most important addition to drug treatment services would be a custodial drug treatment centre. The Misuse of Drugs Act, 1977 (enacted even before drugs became a serious issue for Irish society) included an enlightened and far-sighted section which allows the court, following

receipt of medical and other assessments, to order that a person convicted of certain drug offences be detained in a custodial drug treatment centre for a period not exceeding one year.<sup>17</sup> The Act further provided that where a person successfully completed the programme in the custodial centre, then a period of probation, or a suspended sentence, would be imposed in lieu of imprisonment. Thirty-four years after this legislation was enacted, no such custodial centre exists. Not only would an option of this kind be far more effective than sending a drug-user to a wasteful existence in a prison where they could still access drugs, but it would help to relieve the chronic overcrowding in our prisons and would ultimately save money.

While the proposed new prison at Thornton Hall, in north County Dublin, has been widely, and rightly, criticised as being too big and too remote, its location would actually be an ideal one for a custodial drug treatment centre. It is disappointing that this option was not considered by the Thornton Hall Review Group in its Report, published at the end of July 2011.<sup>18</sup>

## Conclusion

The failure to tackle adequately the problem of drug abuse when it first began in Dublin's inner city allowed it to grow out of control and expand to other deprived neighbourhoods in the capital. The failure to tackle adequately the emerging drug problem in other cities and towns of Ireland again allowed the problem to expand. More and more drugs became available to more and more people – and to people of all social classes. Unless the political will exists to deal with this threat to the children growing up today, then our society will pay the price in the destruction of more lives, the tearing apart of more families, and increasing demands on our already overstretched health and justice systems.

## Notes

1. There are indicators but no accurate figures regarding the value of the illegal drug trade in Ireland. A *Sunday Business Post* journalist, John Burke, suggested in 2007 that: 'The total value of the illegal drugs market here is almost certainly worth hundreds of millions, or possibly in excess of €1 billion. However, all attempts at calculating the value of the trade come with the caveat that no one can say they are certain their estimate is correct' (see John Burke, 'Boom Time for Dealers', *The Sunday Business Post*, 9 December 2007). Illicit drug seizures by the Gardaí are obviously only a portion of all drugs being brought onto to the Irish market, but what proportion they represent is again an unknown. In 2006, Gardaí seized illicit drugs of the five main drug types to the value of €95 million; figures for seizures of such drugs in 2007 and 2008 were greatly in excess of this (€178 million and €224 million respectively),

but part at least of the increase was attributed to the seizure of large hauls of cocaine destined for Britain. In 2010, Garda seizures had dropped considerably to €30.9 million; see Conor Lally, 'Drug Seizures and Use at Lowest Level Since Before Boom', *The Irish Times*, Monday, 20 June 2011.

2. Conor Lally, *op. cit.* See also Conor Lally, 'Large Increase in Seizures of Heroin over Last Year', *The Irish Times*, Thursday 18 August 2011.
3. *Report of the Global Commission on Drug Policy*, 2011, pp. 2–3 ([www.globalcommissionondrugs.org](http://www.globalcommissionondrugs.org)).
4. *Ibid.*, p. 7.
5. *Ibid.*, p. 7.
6. *Ibid.*, pp. 10–17.
7. For recently published statistics on one dimension of this problem – deaths related to alcohol – see Suzi Lyons, Ena Lynn, Simone Walsh, Marie Sutton and Jean Long, *Alcohol-related Deaths and Deaths among People who were Alcohol Dependent in Ireland, 2004 to 2008*, Dublin: Health Research Board, 2011 (HRB Trends Series, 10). A comprehensive picture of the personal and societal damage of harmful alcohol consumption is provided in Ann Hope, *Alcohol Related Harm in Ireland*, Dublin: Health Service Executive, 2008.
8. *Report of the Global Commission on Drug Policy, op. cit.*, p. 16.
9. Department of Community, Rural and Gaeltacht Affairs, *Mid-term Review of the National Drugs Strategy 2001–2008, Report of the Steering Group*, Dublin: Department of Community, Rural and Gaeltacht Affairs, March 2005, p. 38.
10. *Report of the Global Commission on Drug Policy, op. cit.*, p. 16.
11. See, for example, Department of Community, Rural and Gaeltacht Affairs, *Mid-term Review of the National Drugs Strategy 2001–2008*; Department of Community, Rural and Gaeltacht Affairs, *National Drugs Strategy (Interim) 2009–2016*, Dublin: Department of Community, Rural and Gaeltacht Affairs, 2009; Health Service Executive, *Report of the HSE Working Group on Residential Treatment and Rehabilitation (Substance Users)*, Dublin: HSE, 2007.
12. Department of Community, Rural and Gaeltacht Affairs, *Mid-term Review of the National Drugs Strategy 2001–2008*, p. 58.
13. Department of Community, Rural and Gaeltacht Affairs, *National Drugs Strategy (Interim) 2009–2016*, p. 121.
14. F. Hannon, C. Kelleher and S. Friel, *General Healthcare Study of the Irish Prisoner Population*, Dublin: Stationery Office, 2000.
15. H.G. Kennedy *et al*, *Mental Illness in Irish Prisoners: Psychiatric Morbidity in Sentenced, Remanded and Newly Committed Prisoners*, Dublin: National Forensic Mental Health Service, 2005.
16. Jean Long, 'Drug Tests in Irish Prisons', *Drugnet Ireland*, Issue 35, Autumn 2010, p. 24
17. Section 28.2(b) of the Misuse of Drugs Act, 1977 states: '[T]he court shall, if in its opinion the welfare of the convicted person warrants its so doing, b) order that the person be detained in custody in a designated custodial treatment centre for a period not exceeding the maximum period of imprisonment which the court may impose in respect of the offence to which the conviction relates, or one year, whichever is the shorter.'
18. *Report of the Thornton Hall Project Review Group*, Dublin: Department of Justice and Equality (<http://www.justice.ie/en/JELR/Pages/ThorntonHallReviewRpt>).

**Peter McVerry SJ is a member of the Jesuit Centre for Faith and Justice team and a Director of the Peter McVerry Trust, which provides accommodation and care for homeless young people.**