



House of Commons
Northern Ireland Affairs
Committee

The Illegal Drugs Trade and Drug Culture in Northern Ireland

Eighth Report of Session 2002–2003

Volume I



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The Northern Ireland Affairs Committee

The Northern Ireland Affairs Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Northern Ireland Office (but excluding individual cases and advice given by the Crown Solicitor); and other matters within the responsibilities of the Secretary of State for Northern Ireland (but excluding the expenditure, administration and policy of the Office of the Director of Public Prosecutions, Northern Ireland and the drafting of legislation by the Office of the Legislative Counsel).

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Summary

Throughout much of the second half of the twentieth century Northern Ireland successfully resisted the drugs trade. But since the early 1990s class A drugs such as ecstasy, cocaine and heroin have become more readily available. The 'opening up' of Northern Ireland to external influences, and the increased economic and social confidence of many individuals, particularly the young, have fostered a climate in which the recreational use of drugs such as ecstasy and cannabis is widely tolerated.

The population of problem drug users in Northern Ireland has not yet reached critical mass, but it is growing. Following the paramilitary ceasefires, the criminal networks established to support and finance terrorism have been turned over to organised crime, including the drugs trade. There is some evidence to suggest that their efforts to cultivate a market in drugs such as ecstasy and cocaine are proving successful; the highly addictive drug crack cocaine may also be more widely used than has previously been thought.

One consequence of the delayed infiltration of the trade into Northern Ireland has been deferred investment in the infrastructure needed—primarily in health and social services but also in education, enforcement and the criminal justice system—to tackle the problems arising from the drugs trade and drug culture. In recent years Northern Ireland has seen some very promising initiatives tackling problem drug use, through collaboration between the criminal justice and health services, and the voluntary sector. Yet these continue to struggle for financial support. Strategies for substitute prescribing and needle exchange schemes, which are essential to prevent the spread of blood-borne viruses (HIV, Hepatitis C) amongst an injecting population, remain at an early stage of development.

There is a real danger that the Government will find itself unprepared to deal with the health, social and economic consequences of a rapid increase in drug use in Northern Ireland. Such an increase may be as little as three years away.

1 Introduction

1. Cannabis, ecstasy, amphetamines, heroin, cocaine and crack cocaine all feature in the drug culture in Northern Ireland. To this extent the situation in Northern Ireland, and the problems arising from it, are similar to those in Great Britain. But there are other respects in which Northern Ireland's experience stands apart.

2. The nature of Northern Ireland's communities—both their cohesion, and the divisions between them which gave rise to conflict—contributed to resistance to the drugs trade throughout much of the second half of the twentieth century. But since the early 1990s class A drugs such as ecstasy, cocaine and heroin have become more readily accessible. Following the paramilitary ceasefires, the criminal networks originally established to support and finance terrorism have been turned over to organised crime including the drugs trade. While those exploiting Northern Ireland's new openness to the world are substantially motivated by the opportunities for illicit profit, the drugs trade in Northern Ireland remains enmeshed with those who are, or have been, paramilitaries. Not all of the terrorist organisations are on ceasefire and, for those that are, the pursuit of power through violence remains a recent memory.

3. In contrast to many parts of Great Britain, and to some extent the Republic of Ireland, the population of problem drug users in Northern Ireland has not yet reached critical mass. One consequence of the delayed infiltration of the drugs trade into Northern Ireland has been deferred investment in the infrastructure needed—primarily in health and social services but also in education, enforcement and the criminal justice system—to tackle the problems arising from the drugs trade and drug culture. This Committee warned in 1996 that the authorities could no longer take for granted Northern Ireland's comparatively "drug-free" status. Eight years on a strategy is in place, but it is still in the early stages of implementation. Meanwhile the nature of the drugs trade and drug culture in Northern Ireland has shifted considerably.

4. When we announced our inquiry in August 2002 we intended to focus primarily on Government strategy in tackling the supply of illegal drugs to the Northern Ireland market, and on the problem of drug-related crime. Following the suspension of the Assembly in October 2002, it seemed appropriate to extend our inquiry to cover the other important strategic elements of drugs education, treatment and rehabilitation. In this report we make recommendations on these aspects of policy, while hoping that they will be issues the Assembly itself will pursue further in the future.

5. Since January we have taken evidence, either formally or informally, from a wide range of individuals and organisations. We have visited facilities in Belfast, Antrim, Ballymena and the North-West of England, and have also been to the Republic of Ireland and to the Netherlands to explore policy in those jurisdictions. We are unable to report all our discussions, as some have inevitably touched upon intelligence. Nonetheless we are grateful to all those who have helped us in our work. In particular, we wish to thank our Specialist Adviser, Angus McIntosh, and Hugh Farren of the staff of the Northern Ireland Assembly for their valuable support and

assistance. We would also like to thank Karen McElrath of Queen's University Belfast for her help in the early stages of the inquiry and for making papers available to us.

6. Following recommendations from the Advisory Council for the Misuse of Drugs (ACMD) and the Home Affairs Committee, the Government announced in July 2002 that cannabis would be reclassified under the Misuse of Drugs Act 1971 from Class B to Class C.¹ In view of this statement, we published in May an interim report examining the possible consequences of this change for Northern Ireland, together with the evidence we had received to date.² We received, and published, the Government response to that report in July.³ These papers are referred to in this report, although the arguments are not substantially repeated.

2 Demand: Northern Ireland's drug culture

The history of drug use in Northern Ireland

7. Northern Ireland was not perceived to have a definable drug culture until the 1990s. This Committee's earlier report on illicit drug use recorded that Government's official policy in Northern Ireland throughout the 1980s and the early 1990s was to take a low profile approach to drug education and prevention, for fear that high-profile action would stimulate an otherwise low level of interest in drugs.⁴ Prior to the early 1990s, the most commonly used drugs were cannabis, sulphates and LSD⁵, although other drugs available in Great Britain were in circulation: recent research found that the earliest reported initiation into heroin use in Northern Ireland occurred in 1981.⁶

8. A change, both in Northern Ireland's interest in illegal drugs, and in Government policy towards drug use, appears to have taken place with the arrival of ecstasy in Northern Ireland in about 1992–93.⁷ Surveys of self-reported drug use, together with drug seizure data for the period 1991–1995, indicate that there were sharp rises both in the popularity of ecstasy and in its availability. Seizures of cannabis and LSD also increased over the period. These factors led to the formulation of a new Government policy, with clear priorities for action on education, treatment, enforcement, research and evaluation, which was adopted in 1995.⁸

1 The Government Reply to the Third Report from the Home Affairs Committee Session 2001–02, *The Government's Drugs Policy: Is It Working?*, Cm 5573 p3

2 *The illegal drugs trade and drug culture in Northern Ireland: interim report on cannabis*, Sixth Report of Session 2002–03, HC 353-I and -II.

3 Sixth Special Report of Session 2002–03, HC 935

4 *Illicit drug use in Northern Ireland*, First Report of 1996–97, HC 52 para 3.

5 *Illicit drug use in Northern Ireland*, First Report of 1996–97, HC 52 para 17.

6 *Heroin use in Northern Ireland: a qualitative study into heroin users' lifestyles, experiences and risk behaviours (1997–1999)*, Karen McElrath PhD p9

7 Q5. Question numbers Q1–Q346 may be found in the second volume of the Committee's Sixth Report, HC353-II. Question numbers Q347–Q604 may be found in the second volume of this report, HC 1217-II.

8 *Illicit drug use in Northern Ireland*, First Report of 1996–97, HC 52 paras 18–20, 5.

Why did ecstasy increase in popularity?

9. During the early 1990s Northern Ireland was moving towards the beginning of the peace process. While we sought to explore the extent to which young people may have turned to drugs such as ecstasy to escape the continuing stress and tension of the conflict, we were told that the hypothesis had never been the subject of substantial research.⁹ Although we have been told anecdotally that individuals under stress—for example, in prison—may turn to drugs as a means of temporary escape from their problems, it appears far more likely that young people in Northern Ireland, as elsewhere, generally made a positive choice to experiment with ecstasy and cannabis as part of their lifestyle.

10. For all its potential harmfulness ecstasy, like cannabis, has been widely perceived as a recreational drug. This perception has been bolstered by its association, from the early 1990s, with club culture, parties and raves. The association with a generation-specific cultural activity may have helped ecstasy's establishment in Northern Ireland, as elsewhere, as a relatively mainstream choice amongst the community of young drug takers.

The role of the conflict

11. The political changes in Northern Ireland in the 1990s did impact upon the drug culture in other ways. We have heard on a number of occasions the suggestion that the strong and active presence of the police and army in Northern Ireland prior to the ceasefires proved a deterrent to drug traffickers, as the risk of detection while transporting or dealing drugs was high. Consequently, the scaling-down of this presence may have made it easier for traffickers to establish and maintain a market. The involvement of paramilitaries in organised crime increased as the ceasefires left them with time on their hands. The ceasefires also made individuals more confident in going out at night, enabling social centres such as pubs and clubs to flourish.

Attitudinal change

12. Individual and community attitudes have been key to the nature of the drug culture in Northern Ireland. Historically, Northern Ireland's close-knit communities may have acted as a protection for the young people within them, and made it difficult for the young to participate in illicit activity without being observed. Widespread strong adherence to religious tenets and observances may also have played a role; this is still cited as a factor influencing young people's attitudes to drugs in Northern Ireland today.¹⁰

13. Cannabis and ecstasy may have flourished in recent years as drugs of choice because they are generally perceived by users and many non-users to be relatively harmless to the individual and to society. Neither is perceived to be expensive or strongly addictive, giving rise to drug-related crime; neither requires the user to inject, creating the risk of infection with HIV or

9 HC 353-II, Ev 11

10 HC 1217-II Ev 76

Hepatitis from shared or discarded equipment. Both have more positive associations than drugs such as heroin and crack cocaine: ecstasy, as previously described, is closely linked to the club scene; cannabis is associated with hippie culture. By contrast, some evidence suggests that heroin use is perceived very differently. A 1999 survey of ecstasy users in Northern Ireland encountered very negative responses to heroin, which was described to researchers as having “a scummy kind of air around it”.¹¹

14. Even with rising tolerance of certain drugs, illicit drug use in Northern Ireland remains a minority activity. Rob Phipps of the Health Promotion Agency pointed out that while it was possible to argue from current statistics that a quarter of 16-year-olds were using drugs, it was equally valid to look at the statistics and conclude that three-quarters of 16-year-olds were not taking drugs. The perspective adopted could be important in communicating to young people what constitutes ‘normal’ behaviour.¹² This is particularly important if, as we have been told, society in general has become more tolerant of drug-taking, and a “supportive environment” for drug use has been established. Rob Phipps also told us:

“...there is a culture, in terms of the music, in terms of the media. So what you do get in young people are what we call ‘expectancies’, an understanding that drug-taking is there, it has become normal ... they [do] not see it as a big issue the way that adults and parents do. That is not to say they all take them, but the kind of “Oh and aren’t they evil”, they do not say that ... Also you have, over the last 10 or 15 years, what some people would argue is a more hedonistic view about life anyway, ... they do want their enjoyment now, they do want ... their short quick fix.”¹³

Other factors

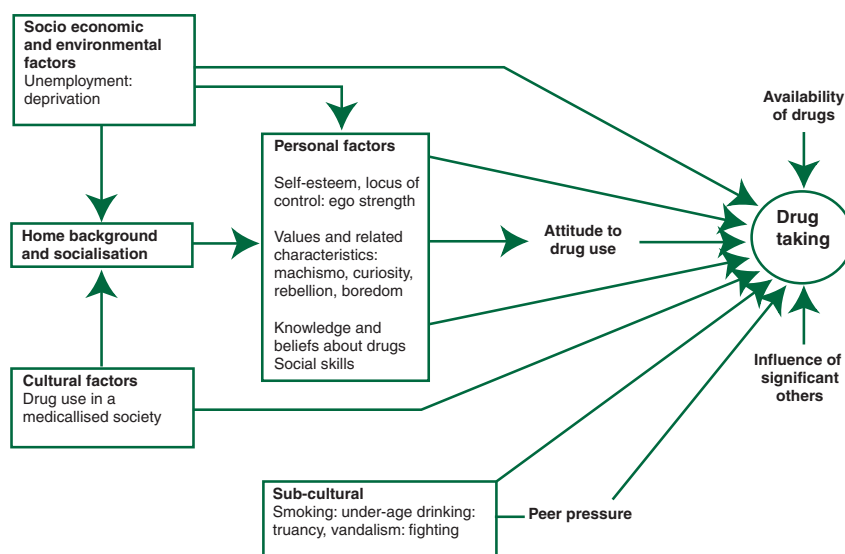
15. On an individual basis other factors may carry far more weight than public perception in determining drug use choices. The Probation Board of Northern Ireland reminded us that “the liability of young people to become involved in drug use cannot be separated from issues of family support, poverty, educational opportunities, employment and social cohesion”; the role of the family was also raised by the Police Service of Northern Ireland.¹⁴ The Health Promotion Agency identified a wide array of issues which operated as “push and pull” factors in the complex pattern of young people’s drug use. These are set out in the diagram below:

11 *Ecstasy use in Northern Ireland: a qualitative study* K McElrath/K McEvoy, Queen’s University of Belfast, May 1999

12 HC 353-II Q9

13 HC 353-II Q5

14 HC 353-II Ev 139; Ev 45



Data source: Health Promotion Agency

Is all drug use the same?

16. Even as certain drugs appear to have become more widely tolerated, it appears that individual routes through drug taking are becoming more varied and sophisticated. Various surveys have indicated that curiosity and the desire to experiment are key motivating factors for individual drug users. Many do not progress beyond experimentation, while others will continue to take drugs on a recreational or intermittent basis. Nor do such users necessarily stick to one drug. The Health Promotion Agency informed us:

“In the past people have looked at drug use by an individual of moving along a continuum going from experimentation, through recreational use to problem and/or dependent use. However researchers are now beginning to note that there are different ‘pathways’ in respect of drug use, and that some individuals simply take cannabis (which they don’t perceive as an ‘illicit drug’) and nothing else. Others move between alcohol, cannabis, ecstasy and amphetamines depending on social circumstances and personal choice... Others ... do find themselves in a far more chaotic drug-taking lifestyle, with many associated problems in respect of relationships, the law, work and personal health.”¹⁵

17. The increased prevalence of poly-drug use was raised by a number of witnesses, who perceived drug users to be increasingly selective in their consumption, making decisions based both on drug availability and on the outcomes they wished to achieve through drug use. The Police Service of Northern Ireland (PSNI) told us that young people, in particular, would consume ecstasy “to give them the ability to ‘party’ or dance all night long” and take cannabis to help them relax.¹⁶ A community worker from Kilcooley Community Forum told us that packets of mixed drugs including ecstasy and benzodiazepines, known as “party packs”, were

¹⁵ HC 353-II Ev 3

¹⁶ HC 353-II Ev 28

for sale in clubs in Bangor.¹⁷ Andrew Rooke of the Probation Board Northern Ireland told us that:

“...offenders who are habitually using what we could call mind-altering substances ... are likely to switch between the two or to choose to mix the two or to use one when the other is not available and so on ... If the opportunity comes along to use another substance they would. If they felt that the effect of one substance was amplified by the use of another substance then they would.”¹⁸

Research into ecstasy use in Northern Ireland has also indicated that individuals using ecstasy are likely to consume alcohol at the same time.¹⁹

18. While recognising that the pathways into drug use are changing, it may still be valid to divide the community of drug users into three groups:

- Experimental;
- Recreational; and
- Problem users.

While all use of drugs, even experimentally, poses the risk of harm to the user—as illustrated by the death of Leah Betts in 1995—it is problem users who are most at risk personally from their drug use and, in certain cases, who lay the greatest costs on society.²⁰ Problem use has been formally defined as “drug use with serious negative consequences of a physical, psychological, social and interpersonal, financial or legal nature for users and those around them.”²¹ Much of our report focuses on strategy specifically in relation to problem drug users, because of these personal and social costs.

19. Nonetheless, experimental and recreational drug use cannot be ignored. It has the potential to harm, and to lead the individual into addiction. It profits organised criminals just as much as the purchase of apparently harmless counterfeit goods such as designer clothes and counterfeit CDs. The difficulty for government in tackling such use is, as it has always been, to do so in a way which neither stimulates curiosity nor over-dramatises the risks involved. The Health Promotion Agency warned us that both experimental and recreational users:

17 HC 353–II Ev 48

18 HC 1217–II Q352

19 *Ecstasy use in Northern Ireland: a qualitative study* K McElrath/K McEvoy, Queen’s University of Belfast, May 1999 pV

20 Another example is provided by the case of three West Belfast men who died after swallowing high-strength morphine tablets they had found by chance in a stolen car, having previously consumed a combination of ecstasy, diazepam, cannabis and alcohol, *Victims ‘killed by powerful tablets’*, Irish News 13 June 2003

21 *Hidden Harm: responding to the needs of children of problem drug users*, ACMD June 2003

“...would argue that their style of drug taking is recreational and controlled, and may even resent a drug campaign which seemed to see them as addicts and a threat to themselves and society.”²²

The strategy adopted by Government for educating young people about drug use is discussed in chapter 7 below.

Indicators of demand: surveys and statistics

20. It is inevitably difficult to get a full and accurate picture of illicit activity such as drug use. Officials depend upon a variety of data sources for statistical evidence, including independent research, police records and health service returns. All of these are important sources, but are limited to some degree.

Surveys of self-reported use

21. The most comprehensive surveys of Northern Ireland drug use currently available are the Young People’s Behaviour and Attitude (YPBA) Survey, which covers 12-16 year olds, and the Omnibus Survey, which explores use by 16-25 year olds. Both were carried out in 2000 and provide a ‘snapshot’ of the nature and frequency of individuals’ drug use within these age groups at the time. In considering this data, it should be noted that returns are based on individual claims of drug use rather than on evidence, and may have been influenced by the individual’s trust in the interviewer, peer pressure and other factors. The sample size for the Omnibus survey (840) was significantly smaller than the sample for the YPBA survey, and its statistical significance may therefore be lower.

22. Key conclusions from the two surveys were as follows:

- One quarter of 12-16 year olds reported ever having used drugs (including solvents);
- About one in six respondents to the same survey (17%) reported using drugs at the time of the survey, while 7% reported frequent use;
- Lifetime use (reporting use of drugs at least once over the course of life to date) increased with age, from 13% at the age of 12 to 40% for 16 year olds and 54%—just over half—by the age of 25;
- Current and frequent use peaked at about the age of 21;
- Drug use was generally higher among males than females in both surveys, and the discrepancy was most marked amongst reported frequent users;
- Use was found to be generally higher amongst secondary school students than among grammar school students, and among those entitled to free school meals than among those not entitled to free school meals;

- Cannabis was the most common drug currently in use by both groups, although more 12-16 year olds had experimented with solvents than cannabis; and
- Cannabis and ecstasy were most frequently perceived to be very or fairly easy to obtain by both groups (although the basis for the individual's assessment in each case was not explored).

23. Since drug use in Northern Ireland is a relatively recent phenomenon, there is little comparable historical data from which to assess trends. Nonetheless the Northern Ireland Executive told us that “it is clear that the data point in one direction: more young people are using drugs”.²³

Drug prevalence across time, 1992–00, HBSC and YIPBA surveys

Survey	Year	Drugs Included	% ever used	% using now
HBSC 1992	1992	Drugs and solvents	15.8	5.6
HBSC 1994	1994	Drugs and solvents	25.9	18.0
HBSC 1998	1998	Drugs only	27.7	18.1
YPBA Fifth formers	2000	Drugs only	33.0	24.7
YPBA Fifth formers	2000	Drugs and solvents	38.9	27.2

Data Source: HBSC and YPBA Surveys

The HBSC (Health Behaviour of School Children) Surveys are of fifth formers

Comparisons with Great Britain and the Republic of Ireland

24. Similarly, there is limited evidence to compare with rates of use in other places. The Northern Ireland Executive drew our attention to the European School Survey Project on Alcohol and Other Drugs (ESPAD) which compared rates of smoking, drinking and drug use among young people in various European countries in 1995 and 1999. This reported that illicit drug use among girls was slightly less prevalent in Northern Ireland than in Great Britain, and amongst boys was similar to use in England and Wales but lower than use in Scotland. In the four years between the two surveys the proportion of girls in Northern Ireland who used drugs rose markedly: experimentation with cannabis had increased by 14%, to approach levels of use in Great Britain. In the same period the abuse of volatile substances (solvents) by both boys and girls in Northern Ireland had fallen, but remained slightly higher than in other parts of the UK.²⁴

25. A general drugs prevalence survey throughout the island of Ireland has recently published its initial findings. This survey, commissioned jointly with the National Advisory Committee on Drugs in the Republic of Ireland, is a welcome development. It not only provides valuable information on the prevalence of a range of drugs in Northern Ireland, but also for the first time provides a comparison with the Republic of Ireland. The survey found that the proportion of respondents who reported ever taking an illegal drug was similar in Northern

23 HC 353-II Ev 114

24 HC 353-II Ev 114–116

Ireland (20%) and the Republic of Ireland (19%). Cannabis was the most commonly used illegal drug, with a similar lifetime prevalence rate in both jurisdictions. However, current rates of use of cannabis among young adults aged 15-34 were higher in Northern Ireland (5.4%) than in the Republic of Ireland (4.4%).

Small group surveys

26. We also received data from several surveys of particular communities or groups. The Northern Ireland Prison Service requests all new committals to report drug dependence on arrival. In the period January-April 2003 these included: cannabis (20%); ecstasy (10%); amphetamines (4%) and heroin and cocaine (5% combined).²⁵ The Lisburn Community Safety Audit 2002 recorded figures which were slightly lower than, but broadly in line with, those in the YPBA survey for use among school children (in this instance aged 11-18). 15.6% of those in the group had used drugs, and usage increased above the age of 15. Among the users cannabis was very strongly the drug of preference (77.6%), followed by ecstasy.²⁶

27. A Community Audit carried out by the Falls Community Council in October 2002 provides interesting data not only on the reported facts of drug use, but also on the reasons for use. The survey found that 83% of respondents had been offered drugs, and almost half (43%) had first experimented with them because of curiosity. Over one third (36%) took them because friends were using them and nearly all (97%) were with friends when they took drugs. Nearly all had tried cannabis (91%), with solvents the next most frequently cited substance at 26%.

28. Fewer than half the respondents to this survey (41%) might be classified as 'experimental' users, having taken drugs less than 5 times. Of the remainder, 38% had taken drugs more than ten times and 35% claimed to be using drugs at least once a fortnight. Respondents were asked why they took drugs: the most popular answers were: to celebrate (41%); because they enjoyed them (34%) and because the drugs helped them relax (32%). These responses were very similar to the reported reasons for taking alcohol: to celebrate (48%); for enjoyment (32%) and to get drunk (32%). The respondents to the survey were predominantly 14-17 years old (79%) and still at school (80%). Sixty per cent of them were male.²⁷

Statistics from health and social care provision

29. Within health and social care there are currently two main sources of information on drug use: the addicts index, and the drug misuse database. The addicts index is a long-term data set, which records numbers of individuals formally registered by physicians as addicts. While it used to be a UK-wide index, the set for England, Wales and Scotland was closed in 1997; the index for Northern Ireland was maintained.²⁸ In 2000 there were 304 addicts on the Northern

25 HC 1217-II, Q376

26 HC 353-II, Ev 141

27 Falls Community Audit Community Drugs Project *Final Report* 25 October 2002

28 *Prevalence of problem heroin use in Northern Ireland*, Karen McElrath PhD, Queen's University Belfast March 2002 p6

Ireland index, 77 of whom were newly notified in that year. Just over a third (35%) of those on the index in 2000 had injected at some stage, while 17% did not inject. The intravenous drug use status of the remainder was not reported.²⁹

30. The drug misuse database was set up in Northern Ireland in the late 1990s, and provided its first full year statistics from 1 April 2001–31 March 2002. Both statutory and non-statutory agencies contribute to it. While the coverage provided by the database is not fully comprehensive—some agencies, for a variety of reasons, do not contribute to it—it contains data relating to a wider sample of drug users with a variety of drug-related health problems.

31. The Government's statistical analysis of the first year's results reveals that 969 individuals were reported to have accessed treatment, of whom three quarters were male. The mean (average) age of these individuals was 27, and over half were either in their 20s or under the age of 20. The age profile for females was slightly older than for males. For these individuals accessing treatment the main drug of misuse was, again, cannabis but the next most common main drug of misuse was heroin (21%), followed by other opiates (14%) and then ecstasy (9%). Where heroin was used, it was predominantly recorded as the main problem drug, rather than as a 'subsidiary' drug; ecstasy was frequently recorded as a subsidiary drug.

Geographical variation

32. Northern Ireland has four regional health and social services boards, and data returns can be analysed on this regional basis. The Government's analysis indicates that just under half of the users recorded on the database (44%) were treated in the Eastern Board area whilst only 9% were treated in the Southern Board area. The Eastern Board area covers over 40% of the population and includes Belfast, and many of these users presented to non-statutory agencies. The incidence of treatment per 100,000 population was highest in the Western and Eastern Board areas, although those in the Northern Board area were both more likely to report heroin as the main problem drug than users in other areas, and were more likely to report having injected.³⁰

33. As with the YPBA and Omnibus surveys, the data presented by these databases must be treated with a degree of caution. They cover only those drug users who found it necessary to present for treatment, and were then willing to have information about their drug use recorded. Thus, they are likely to present only a small part of the overall picture. A widely-regarded survey by Karen McElrath of the prevalence of problem heroin use in Northern Ireland in 2000 calculated that, while the official number of registered heroin addicts was 233, the actual number of problem heroin users was in the range 695-2100.³¹ This conclusion illustrates the extent to which such problems may be hidden from official view.³²

29 HC 353-II Ev 64

30 Statistics from the Northern Ireland Drug Misuse Database 1 April 2002–31 March 2003, DHSSPS October 2003

31 *Prevalence of problem heroin use in Northern Ireland*, Karen McElrath PhD, Queen's University Belfast, March 2002

32 For further data on the use of heroin in Northern Ireland see paragraph 200 below.

34. Nonetheless, by combining the information presented by the surveys, it is possible to present certain fairly general hypotheses about current drug use in Northern Ireland:

- Drug use in Northern Ireland is predominantly by men, although use by women is significant and increasing;
- More young people than previously are taking drugs;
- Drug use is most likely to take place in the late teenage years and 20s; while the peak age of incidence is 21, it is those who continue to take drugs beyond this age who are then more likely to seek treatment;
- Curiosity and the desire to experiment are important elements in the pattern of drug taking in Northern Ireland;
- Cannabis is the main drug of choice. Ecstasy is widely used either as a main or subsidiary drug;
- Users of heroin as their main drug of choice are more likely to seek access to treatment than main users of ecstasy; and
- Proportionately more users in urban parts of Northern Ireland have accessed treatment than users in predominantly rural areas (although this may be equally a question of the availability of drugs in these areas, and of the availability of services, as it was learned some received treatment in the Republic).

Police data

35. The statistics above focus primarily on use. The availability of drugs on the market is another important factor and is equally difficult to establish. The Police Service of Northern Ireland told us that in assessing trends in drug supply they drew upon historical data relating to seizures, and upon information relating to the street price of drugs in Northern Ireland and Great Britain.

Seizures

36. Data provided by the PSNI for seizures in the period 2000–2003 are set out below. We have previously reproduced data for 1997–2001 with our interim report.³³ The data suggests the following:

- Seizures of ecstasy were significant and showed a general upwards trend over the period;
- Seizures of cannabis remained at roughly the same level over the period, and were significant;

- Until 2001–02 seizures of cannabis remained at roughly the same level, and were significant, with a marked increase in resin seizures in 2002–03;
- Seizures of cocaine over the period were comparatively low, although increasing; and
- Seizures of LSD diminished substantially over the period.

Drugs Seized	2000/01		2001/02		2002/03	
	No. of Seizures	Amount Seized	No. of Seizures	Amount Seized	No. of Seizures	Amount Seized
Class A						
Cocaine: Powder (gms)	27	1,701.40	28	3,399.90	44	3,023.87
Wraps	0	0	4	4	3	12
'Crack' (gms)	2	43.1	4	66.5	1	50
Ecstasy: Tablets	346	410,671	262	127,368	258	605,188
Powder (gms)	6	498	8	232.81	2	1
Capsules	4	11	1	2	5	25
LSD: Doses	9	117	3	122	1	4
Microdots	2	201	0	0	2	1
Opiates: Powder (gms)	61	3,131.60	46	102.11	21	346.01
Tablets	7	1,670	4	51	1	41
Ampoules	4	203	1	4	1	1
Mls	6	121	8	366	14	428.52
Wraps	10	16	42	69	1	1
All Class A	455	-	385	-	335	-
Class B						
Cannabis: Resin (kgs)	1,320	384.4	1,126	417.2	1,366	709.5
Herbal (kgs)	45	21.6	65	49	78	27.7
Plants	11	210	14	141	29	202
Oil (gms)	0	0	0	0	0	0
Joints	131	253	119	273	104	169
Amphetamine: Powder (kgs)	51	3.9	70	8.8	83	27.6
Wraps	8	16	8	26	9	24
Tablets	8	458	3	118	4	11
Barbiturates: Tablets	0	-	0	-	0	-
All Class B	1,458	-	1,259	-	1,534	-
Total Seizure Incidents*	1,750		1,533		1,781	
*As seizure incidents can involve more than one drug type, seizure figures for individual drugs cannot be added together to produce totals						
Arrests	1,266		990		1,295	
Street Value' of Drugs Seized'	£9,994,769		£6,559,700		£11,082,910	

Data Source: PSNI

37. The PSNI assessment of street prices is also shown below. These show generally that the street prices for drugs were higher over the period 1999–2003 than in Great Britain, perhaps suggesting lower levels of availability. However, all prices dropped over the period and PSNI warned that the prices for cannabis, cocaine and ecstasy, in particular, had decreased “noticeably”.³⁴

Street Prices 1999–2003

May 1999	Speed/gm	Cannabis/oz	Cocaine/gm	Heroin/gm	Ecstasy/tab	LSD/dose
UK average	£10	£100	£75	£65	£11	£3.85
London	£10–15	£100–120	£60–120	£60–80	£10–£15	£5
Manchester	£5–10	£70–90	£45	£45	£8–20	£2–3
Belfast	£10–15	£120	£100	£120	£10–15	£3–5
May 2000	Speed/gm	Cannabis/oz	Cocaine/gm	Heroin/gm	Ecstasy/tab	LSD/dose
UK average	£10	£96	£65	£71	£9	£3.59
London	£10–15	£100–120	£50–80	£60–80	£15–25	£4–8
Manchester	£3–5	£75–80	£60	£50	£5–8	£3
Belfast	£10	£120	£100–120	£100–120	£12.50	£3–5
April 2001	Speed/gm	Cannabis/oz	Cocaine/gm	Heroin/gm	Ecstasy/tab	LSD/dose
UK average	£9	£83	£64	£66	£8	£3.46
London	n/a	n/a	£45–65	£40–70	£7–10	n/a
Manchester	£5–10	£60–80	£60–80	£45–60	£8–10	£3
Belfast	£10	£150	£100–120	£100–120	£10	£3–5
April 2002	Speed/gm	Cannabis/oz	Cocaine/gm	Heroin/gm	Ecstasy/tab	LSD/dose
UK average	£9	£73	£60	£60	£8	£3.26
London	£16	£50	£50	£20–25	£2.50	n/a
Manchester	n/a	£60–80	£45–60	£48	£5–10	£3
Belfast	£6–10	£60–70	£100	£60–80	£7–10	£3–5
April 2003	Speed/gm	Cannabis/oz	Cocaine/gm	Heroin/gm	Ecstasy/tab	LSD/dose
UK average	£9	£76	£56	£61	£6	£3.10
London	£15	£60	£35–40	£80	£2	n/a
Manchester	£5–10	£45–70	£40–60	£40–50	£8–10	n/a
Belfast	£6–10	£80	£60–80	£80–100	£5–10	£3–5

Data Source: NCIS, Synthetic Drugs Unit

In the remainder of this section we describe the evidence we have received in relation to the availability of, and demand for, specific drugs.

Cannabis and ecstasy

38. All of the data available indicates that cannabis has consistently been a widely used drug. We have reported previously our conclusions in relation to the Government's proposal to reclassify cannabis from Class B to Class C, on the grounds of its relative harmfulness to the user.³⁵

39. Since that report, new medical research has been published into the links between cannabis use and mental health problems. We discuss this at paragraphs 78–79 below. Following the evidence we previously reported of confusion arising from the Government's announcement

35 *The illegal drugs trade and drug culture in Northern Ireland: interim report on cannabis*. Sixth Report 2002–03 HC 353–I

on cannabis, we have received further evidence of changes in young people's attitudes to cannabis. This arises from a project run with schools by the Council for Education in World Citizenship Northern Ireland. We were told that:

“In 1997 cannabis was viewed by the pupils as an illegal drug and they were reluctant to discuss the problems openly. It was perceived then that approximately one third of the participants had had experience of cannabis consumption. By 2003, it was assumed that most pupils had been offered cannabis and the pupils were willing to discuss openly matters relating to the demand and supply of cannabis. In 2003 participants displayed confusion relating to the re-classification of cannabis – some now believing that its consumption was on a level with under-age drinking, something not quite legal but not punishable by law.

It was evident that pupils were split on the seriousness of consumption. Those of an evangelical leaning viewed cannabis like alcohol, something never to be taken, while others linked it to ecstasy, tobacco and alcohol consumption – things that all young people tried. ... the pupils initially were not aware of the health hazards associated with cannabis, particularly to mental health.”³⁶

40. While cannabis is the most widely-used drug, ecstasy is the most popular Class A drug in Northern Ireland. The Northern Ireland Office described it to us as “a ‘social’ drug, popular among young people who frequent bars, clubs and pubs”.³⁷ While cannabis consumption is believed to have remained relatively stable in the period 1997–2001, seizure data suggests a steady increase of ecstasy consumption up to the year 2000. The figure for 2001, while lower than for the previous year, remained higher than those for 1997, 1998 and 1999. Generally, ‘lifetime’ use of ecstasy was estimated to be marginally greater in Northern Ireland than in Great Britain.³⁸ The 2002/2003 All-Ireland Drug Prevalence Survey found that lifetime use of ecstasy was significantly higher in Northern Ireland (6%) than in the Republic of Ireland (4%).

41. Research into ecstasy use in Northern Ireland suggests that the patterns of consumption of ecstasy are rather different from cannabis. Responses to a 1999 study suggested that ecstasy was generally taken infrequently fitting the pattern of experimental or recreational use: 50% of respondents had used it less than once a month in the six months prior to the study, and only 5% had used it at least twice a week. By comparison, a third of respondents claimed to use cannabis daily and 60% claimed to smoke at least 20 tobacco cigarettes a day.³⁹ That the pattern of use continues to change may be reflected in the fact that the 1999 survey found the average age of first ecstasy use to be 21; statistics from the Drug Misuse Database for 2001–2002 found the average age of first use to be 18.⁴⁰

36 HC 1217–II Ev 76

37 HC 353–II Ev 96

38 HC 353–II Ev 96; 31. ‘Lifetime’ use is use at least once over the course of the respondent’s life.

39 *Ecstasy use in Northern Ireland: a qualitative study*, K McElrath/K McEvoy, Queen’s University Belfast May 1999

40 McElrath/McEvoy; Statistics from the Northern Ireland Drug Misuse Database April 1 2001–31 March 2002

Amphetamines, prescription drugs and nubain

42. While the use of LSD is believed to have fallen over recent years (see paragraph 36 above) amphetamines and prescription drugs continue to be abused by a minority. The Organised Crime Task Force threat assessment for 2003 notes that amphetamines accounted for 6% of drug seizures in 2002, including the largest ever single seizure of amphetamines—8 kilogrammes—in Belfast in October 2002. The most commonly abused prescription drugs were reported to be diazepam and temazepam.⁴¹

43. Northern Ireland also has a small but significant community, based in the Western Board area, of drug users abusing a drug called nubain. This is an opiate-based painkiller generally used by body-builders, which may be purchased over the internet.⁴² As an opiate it is related to heroin, methadone and morphine.⁴³ We were told that over a period of about five years the problem has changed both in its size and seriousness: while previously the typical user would be in employment and living a “reasonably healthy lifestyle”, more recently the typical user would be unemployed and frequently turning to crime to finance their use.⁴⁴ While the Northern Ireland Office estimated that there were between 120 and 140 nubain users,⁴⁵ the Department of Health, Social Services and Public Safety (DHSSPS) subsequently estimated that there were more than 150 users, while a local doctor told us that there were “between 100 and 200 at the very least”.⁴⁶

44. Nubain may only be administered intravenously through injection, and thereby gives rise to specific concerns about infection with Hepatitis B or C, or HIV. As it is a short-acting drug, users have to administer it more often than heroin: where heroin users might inject two or three times a day, we were told that nubain users might have to inject between 6 and 12 times a day. The risk of infection by blood-borne viruses is therefore very high. Harm minimisation is discussed in chapter 7 below.

Heroin, cocaine and crack cocaine

45. The presence in Northern Ireland of a small but significant population of heroin users, primarily based in and around the town of Ballymena in Co. Antrim, has been recognised for some time. Recently it has begun to spread, to South Belfast, North Down and Omagh,⁴⁷ although the nature of the abuse in the separate communities is different: we were told that while injecting users were prevalent in Ballymena, in South Belfast the drug tended to be smoked.⁴⁸

41 *The Organised Crime Task Force Threat Assessment 2003*, Northern Ireland Office June 2003

42 *The Organised Crime Task Force Threat Assessment 2003*, Northern Ireland Office June 2003

43 HC 353–II, Q333

44 HC 353–II Ev 100

45 HC 353–II Ev 100

46 HC 1217–II, Q512; HC 353–II, Q333

47 HC 353–II Ev 31

48 HC 353–II Ev 138

46. Officials told us that the estimated number of problem heroin users was far smaller than in other parts of the UK or in Dublin, and was not “out of control”.⁴⁹ Where heroin was detected and seized by police, it tended to be in small quantities, which supported the view that the overall market continued to be small. The Police Service of Northern Ireland took the view, based on experience elsewhere, that growth in a heroin market tended to follow a pattern of fairly predictable incremental steps: compared to this model, Northern Ireland was still “at an early stage” of growth. While significant, it was suggested to us that an explosion in heroin use, as had been witnessed in earlier years in Dublin and Edinburgh, was not perceived to be an immediate threat.⁵⁰

47. Similarly we were told by the PSNI and government officials that crack cocaine “has hardly made an appearance at all in Northern Ireland.”⁵¹ Since a consignment was first detected in 1997, there had been very few further seizures, each consisting of only a few grammes. These seizures had for the most part been in the heroin-using areas of Ballymena and Belfast, and in several cases had been associated with seizures of heroin.⁵²

48. Concern was, however, expressed about the possible growth in the market for cocaine. While there is little substantial evidence of a change, the Organised Crime Task Force Threat Assessment 2003 warns that “intelligence and evidence point towards an increasing cocaine market in Northern Ireland”.⁵³ The PSNI told us that purity levels and falling street prices for the drug supported the theory of a growing market.⁵⁴ Research conducted on behalf of the Northern Ireland Prison Service also supported the theory: the number of admissions to the service who self-reported cocaine use rose from 3% in September 2000 to 29% in February 2003.⁵⁵

49. Not only was this evidence worrying, but we were concerned to discover a significant discrepancy between the reports of the police and Government on the availability and use of drugs, and reports from community and outreach workers. This was particularly the case in relation to crack. While Jane Kennedy MP, the Security Minister, told us that there was “little evidence” of crack being used, community workers told us that crack was available in certain places and at certain times, and that as many as “two out of three of the heroin users centrally located would access crack cocaine regularly when they can afford it”. One worker suggested that crack was rarely seized by police because, being a highly prized commodity in the drug-using community, it tended to be consumed rapidly as it became available; another recorded

49 HC 353-II Ev 96; Q32

50 HC 353-II Ev 31

51 HC 353-II Q136; see also Q32

52 HC 353-II Ev 31

53 *The Organised Crime Task Force Threat Assessment 2003*, Northern Ireland Office June 2003

54 HC 353-II Ev 31

55 HC 353-II Ev 131

that females, in particular, appeared to be using crack, and users were manufacturing it for themselves out of cocaine rather than attempting to purchase it on the market.⁵⁶

50. We have discovered that one of the difficulties in assessing the availability of cocaine and crack cocaine is that within many data sets statistics for the two drugs are combined. **In view of the apparent rise in the availability and consumption of cocaine and crack cocaine, data on seizures and the use of cocaine and crack cocaine should be recorded separately, so that trends in the use of each drug may be assessed more accurately.**

Alcohol and solvents

51. Although alcohol is a legal, rather than illegal, drug it is important to acknowledge its role in the pattern of drug usage. We were reminded that alcohol dependency and alcohol-related anti-social behaviour cause far more damage to individuals and to society than drugs. Up to 40% of young male admissions to medical and surgical wards in Northern Ireland's hospitals arise from alcohol-related problems.⁵⁷ Similarly, the Probation Board of Northern Ireland told us that between 30–40% of pre-sentence reports involved alcohol-related offences. Alcohol use is also sometimes combined with the use of illegal drugs: the 1999 survey of ecstasy use found that “most users consumed alcohol, often in large quantities, when taking ecstasy”;⁵⁸ a doctor described a typical problem user who might seek medical support as one who is:

“... smoking 15, 20 joints of cannabis per day and then at weekends in addition to that [is] taking between 6, 8 and 10 ecstasy tablets per night, usually Thursday through till Sunday night, all washed down by large quantities of beer.”⁵⁹

52. Solvent abuse is also a significant problem. We were told that solvents, which are comparatively easy to obtain, are “often the substance of first choice” for the youngest experimenters with drugs at the age of 11 or 12.⁶⁰ While not so prevalent as use of cannabis or ecstasy, evidence from research and other statistics suggests that a fifth of all school children have been offered solvents on at least one occasion and 15.5% of all drug users have tried solvents.⁶¹ Concern has been expressed that solvent use is generally on the increase, and is also migrating from the juvenile to the adult age group.⁶²

56 HC 353-II QQ250–256

57 HC 353-II Q331

58 *Ecstasy use in Northern Ireland: a qualitative study* K McElrath/K McEvoy, Queen's University of Belfast, May 1999

59 HC 353-II Q297

60 HC 353-II Q19

61 HC 353-II Ev 90; *Illicit drug use in Northern Ireland – a summary*, DrugsPrevention.net

62 HC 353-II Ev 138

3 Supply: the illegal drugs trade

*“The motivating factor behind the drugs trade is now, as it has always been, money”.*⁶³

53. Where there is a demand, there will be those who will seek to profit through supply; the rarer the commodity, the higher the price the supplier can exact through the market. For these reasons individuals and organised gangs have always participated in the illegal drugs trade. Northern Ireland itself, other than exceptionally, is not a producer of the illegal drugs described in the previous chapter.⁶⁴ The vast majority of drugs consumed in Northern Ireland therefore have to be imported.

Drug trafficking routes

54. Drug trafficking is a global trade. Traffickers move drugs from their place of origin (for example South America, Afghanistan) to the market using a variety of routes and methods ranging from the straightforward to the highly complex and subtle. Yet while specific routes and methods are constantly changing it is possible to draw some general conclusions about the predominant characteristics of the trade into Great Britain and Northern Ireland.

55. Countries which were commonly referred to by our witnesses, and which have also featured in recent news reports of drugs seizures, as transit points for illegal drugs were the Netherlands and Spain.⁶⁵ A recent very successful joint operation by HM Customs & Excise and the Dutch Police led to the dismantling of an organised crime group and the seizure of 400kg of heroin which was being imported from Turkey to the UK via the Netherlands.⁶⁶ An operation in the Republic of Ireland early in 2003 saw the arrest by Gardai of individuals from the UK, Ireland and Spain in connection with the seizure of €2million of heroin.⁶⁷ One reason why the Netherlands and Spain in particular may be used by traffickers may rest in the historic links which both have with other countries, the subsequent commonality of language and the long-established (legitimate) trading routes between them.

56. Having reached continental Europe, it was suggested that many drugs consignments followed broadly the same routes into the UK itself. Although the nature of demand in Northern Ireland is different from that in Great Britain, the two are treated as a single market by many drug traffickers. Therefore, the routes by which drugs enter the UK generally apply equally to the Northern Ireland market. Mike Wells of HM Customs & Excise told us that:

“our principal belief is that the primary route of Class A drugs trafficking is essentially east to west across the British Isles ... the vast majority of Class A drugs enter the United

63 HC 353–II Ev 28

64 A recent news story reported the detection and closure of a “sophisticated cannabis growing facility” in the Sydenham area of Belfast, *60 cannabis plants found*, Irish News 16 July 2003

65 See for example HC 353–II Ev 33

66 HC 353–II Ev 26

67 *Heroin worth €2 million seized in Dublin*, Irish Times 13 February 2003

Kingdom in what I would term the South East quadrant; the ports and airports bounded by a line from probably the Wash to Southampton, primarily of course, Felixstowe, Dover, the Channel Tunnel, the London airports and to some extent, Southampton as well ... From there drugs are moved to a variety of secondary points of distribution within the UK and then moved on, as the case may be, into Scotland, Northern Ireland, the Republic of Ireland and so on.”⁶⁸

Higher street prices in Northern Ireland also tended to support the theory that it was considered a secondary market within the UK, rather than an immediate destination.⁶⁹

57. Nonetheless, there are indications of growing interest in the potential of the Northern Ireland market. The Police Service Northern Ireland told us that they were aware of “several” individuals from Northern Ireland who had moved to other parts of the UK or to continental Europe with the intent to establish drug networks to Northern Ireland.⁷⁰

The UK and the Republic of Ireland

58. An obvious question to consider in relation to Northern Ireland is the extent and nature of the drug trade between Northern Ireland and the Republic of Ireland. The markets in each case are rather different: the heroin-using community in Dublin is significantly larger than the equivalent community in Northern Ireland. Recent press reports have tended to suggest that heroin is taken predominantly from the UK into the Republic of Ireland, rather than the other way; similarly, HMCE told us that a large seizure of ecstasy and cannabis made at Holyhead in December 2002 was on the point of crossing to Dublin, although it was not possible to determine whether the Republic of Ireland was the intended final destination.⁷¹

59. While information about drug trafficking routes is drawn from police activity and drugs seizures, there will always be a difficulty in gathering definitive evidence from intercepted goods as to the final destination of the drugs concerned. Intelligence activity is therefore crucial: we shall discuss this further in paragraphs 114–123 below.

Methods of drug trafficking

60. Drugs are transported by all possible methods to reach the market. The method chosen by the trafficker is likely to depend upon a number of factors including intelligence about the activity of the enforcement authorities, and the physical size and weight of the consignment: for example, herbal cannabis is a relatively low-priced and bulky product which in a

68 HC 353–II QQ41–42

69 HC 353–II Ev 14

70 HC 353–II Ev 33; *Huge ecstasy haul*, Irish News 20 June 2003

71 *Woman jailed for smuggling heroin*, Irish Times 1 May 2003 recorded the conviction of an English woman for smuggling heroin from King’s Cross in London to Dublin; *Heroin worth €2m seized in Dublin* Irish Times 13 February 2003 recorded a seizure at Dublin port which was said by Gardai to be “a set-back to traffickers in Liverpool, Manchester and Dublin”; Q85

‘commercial’ quantity may be better suited to transportation in a motor vehicle than concealed in a courier’s clothing.

61. Recent news reports indicate that concealments in motor vehicles have been used for transporting drugs consignments of considerable quantity and value: the largest ever seizure of ecstasy destined for Northern Ireland—with a potential street value of £4.5 million—was intercepted from a heavy goods vehicle at Dover on 19 June 2003.⁷² Nonetheless, for the highest value drugs such as heroin and cocaine much smaller consignments are viable for the drug trafficker: for these, traditional and widely-recognised methods of transport such as carriage on the person continue to be practised.

62. One common feature of most methods of carriage is the degree of control which the trafficker retains over the goods during their route to the market. We were reminded that the trade is predominantly concerned with profit and the trafficker, like a legitimate trader, will be concerned to secure a full return on his investment. Intimidation of drug couriers, through threats of violence against the individual or his or her family members, is not uncommon. Routes which deny traffickers control of their consignments, such as the postal system, while they may be used, are therefore less attractive.

63. In considering the trade, and the activity of the enforcement authorities in relation to the trade, it is important to acknowledge how very sophisticated drug smuggling can be. To take a recent example, it has been reported that Gardai in the Republic of Ireland arrested individuals in relation to a cocaine smuggling operation which involved spraying clothing with a cocaine solution, transporting the clothing and then laundering the cocaine out at the destination.⁷³ **During visits to police and Customs offices we have been shown an astonishing variety of drug concealments—all of which had been detected by officers through a mixture of intelligence, persistence, and intuition. Their continuing success in often difficult circumstances is very much to their, and to the authorities’, credit.**

The drugs trade and organised crime

64. The growth of organised crime in Northern Ireland in recent years poses a significant threat to the region’s stability.⁷⁴ Crimes such as oils and tobacco fraud undermine the legitimate economy, and the illegal trade in controlled drugs damages individuals and the communities in which they live. During our inquiry into the financing of terrorism we were introduced to the concept of the ‘criminal entrepreneur’, who will engage in any activity, anywhere, and in any company, if the profit to be made is sufficiently high.⁷⁵ As has been widely recognised, the drugs trade—crossing international boundaries, and highly lucrative—is precisely the kind of activity to attract such individuals. We have been told that serious

72 *Huge ecstasy haul*, Irish News 20 June 2003

73 *Cocaine operation smashed*, Belfast Telegraph 18 July 2003

74 *The financing of terrorism in Northern Ireland*, Fourth Report 2001–02 HC978–I; *Impact in Northern Ireland of cross-border road fuel price differentials: three years on*, First Report 2002–03 HC 105–I

75 *The financing of terrorism in Northern Ireland*, Fourth Report 2001–02 HC 978–I

criminals increasingly view controlled drugs as a commodity like any other, and will combine drug smuggling with both other legal and illegal trades. The official definition of an organised criminal network is of one comprising three or more individuals.⁷⁶ The Organised Crime Task Force Threat Assessment for 2003 estimates that around 690 individuals are involved in serious and organised criminal activities in Northern Ireland.⁷⁷ While in 2002 there were estimated to be 78 organised crime groups in Northern Ireland, it has recently been suggested that fragmentation of existing groups has seen this figure increase in 2003 to around 110.⁷⁸

65. The particularly pressing concern for Northern Ireland in the growth of organised crime is the links which have developed between its criminal networks and current and former paramilitaries. The relationship between them has been described as a ‘continuum’, in which it is difficult to see where one begins and the other ends. The implications of this relationship are self-evident: paramilitaries bring to criminal operations their connections, and skills developed over many years in evading detection;⁷⁹ they draw from criminality new means to exercise power over others, and the resources to fund lavish lifestyles or—should it seem expedient to do so—to conduct new campaigns of terror.

66. The relationship between the paramilitary organisations and the drugs trade is an ambivalent one. Historically, organisations from both Northern Ireland’s main traditions have distanced themselves from illegal drugs, recognising them to be unpopular with the majority of residents in the communities they purported to represent. Through its cover organisation, Direct Action Against Drugs, the Provisional IRA claimed responsibility for the murders of 8 individuals allegedly involved in the trade.⁸⁰ Punishment attacks against alleged dealers have been repeatedly carried out by both republican and loyalist organisations and fulfil a dual purpose: to deliver a public relations message that the organisations are ‘defenders of the community’ whilst also asserting each organisation’s control over the area in which the attack took place.

67. At the same time organisations—or at least, individuals within them—have recognised the profit to be made from exploiting the demand for drugs. The Police Service of Northern Ireland told us:

“The loyalist paramilitaries, particularly elements within the UDA and LVF, will involve themselves at all levels of drug dealing, from supply and importation to distribution and street level dealing... Elements within the republican paramilitaries have involved themselves in the importation and supply of controlled drugs throughout Northern Ireland. Others will tacitly approve drug dealing in their areas on receipt of payment. It is not fully understood whether these individuals are operating on behalf of their parent organisation or whether all the profits are for individual gain. ... Of those persons

76 Organised Crime Task Force, Threat Assessment 2002 p3.

77 Organised Crime Task Force, Strategic Response 2003–04 p18

78 *Sudden wealth could prove costly in Ulster*, Financial Times 5 August 2003

79 HC 353–II Ev 97

80 HC 353–II Ev 33

currently subject to Drug Squad investigation, 30% have links to loyalist paramilitary organisations, 15% have links to republican organisations and 11% have links to both ...⁸¹

When a large consignment of ecstasy was seized at Belfast docks in February we were told that the police believed the drugs to be destined for “a gangster who chooses to wrap himself up in the union jack rather than the tricolour.”⁸² We were also told that the drugs trade in certain parts of Belfast appeared to be more organised and controlled than in other parts of Northern Ireland,⁸³ and that some drugs were more closely associated with paramilitary organisations than others. Loyalist organisations were said to be linked to amphetamines and ecstasy, while cannabis and the illegal trade in prescription drugs were more prevalent in republican areas.⁸⁴

68. The drugs trade may be increasingly attractive to the paramilitary organisations for two reasons: firstly, because greater community tolerance of certain drugs (cannabis and, to a degree, ecstasy) makes it possible for organisations to exploit the market in those goods while maintaining a ‘high moral stance’ on the undesirability of other substances. Secondly, controlling the supply of drugs to a particular individual or group potentially gives an organisation power over that individual or group at a time when, through the peace process, their influence is otherwise diminishing. Peter Leonard of the Northern Ireland Prison Service told us that “as [paramilitary] power wanes in one particular area they will seek to actually push hard in other areas to re-assert themselves”.⁸⁵ The Probation Board Northern Ireland had encountered instances where paramilitary organisations became indirectly involved in the trade through purchasing users’ debts: these were then used to exert control over users, with the threat of punishment beatings and/or exclusion from the community held over individuals who failed to repay what they owed.⁸⁶

69. The drugs trade is not exclusively operated by organised networks. We were told that in Ballymena an informal supply network existed below the level of the major drug suppliers, with individuals “often trading drugs to support their own dependency.”⁸⁷ But the extended criminal networks which are engaged in the trade and facilitate the movement of large quantities of drugs are both a major concern and, quite possibly, the key to tackling the problem. We shall discuss the work of Government in tackling the trade in detail later in this Report.

70. We have heard fears that organised criminals will use the profits from the trade in ecstasy and cannabis to develop a market in Northern Ireland for more highly addictive

81 HC 353-II Ev 33

82 HC 353-II Q145

83 HC 353-II Ev 102

84 HC 353-II Ev 138

85 HC 1217-II Q418

86 HC 353-II Ev 102

87 HC 353-II Ev 138

and damaging drugs such as heroin and crack cocaine. This must not be allowed to happen.

The problem of forecasting

71. How likely is it that this will happen? While forecasting is always an imprecise science, **we have been concerned at certain discrepancies of perception as to the availability of drugs which we have identified between the views of officials in the Northern Ireland Office and those of workers in community or health services who are in closer contact with the drug-using community.** As we have previously noted, government officials assured us there was little evidence of the presence and/or manufacture of crack cocaine in Northern Ireland, while others not only testified to its availability but were able to suggest particular sectors of the community who would tend to use it. Similarly, the Police Service of Northern Ireland told us that the street price of ecstasy was £5–10 a tablet, while the Probation Board Northern Ireland told us that ecstasy cost about £1 a tablet.⁸⁸

72. Research has previously pointed out that official data such as the addicts index and police seizure statistics, which are used as the foundation for Government policy, are “lagged” indicators: their data is historical and consequently significant trends may not be revealed until several months after they have developed.⁸⁹ In a situation which may escalate rapidly—as happened with the expansion of the heroin-using community in Dublin in the 1980s and 1990s—a **government relying on historical data could find itself massively unprepared to deal with the problems which follow in the wake of drug use, whether increased crime or rapidly spreading infection with HIV and Hepatitis B and C. We urge the Government to review the role and weighting given to historical data in the development and implementation of Northern Ireland’s drugs policy.** Rather than having an essentially reactive approach to Northern Ireland’s drugs culture, Government should be alert for early indications of changing trends by encouraging official bodies to notify apparent changes at the earliest opportunity. It should seek to be more proactive and should explore further the potential value of forecasting in future strategy development.

73. In the course of our inquiry **we have also discussed other issues in relation to the supply of illegal drugs which it would be inappropriate to place in the public domain. We intend to write directly to the Minister, Jane Kennedy MP, with recommendations on these issues. We shall expect the Northern Ireland Office to consider them and respond as if they had formed part of this Report.**

88 HC 53-II Ev 138; see table at paragraph 37 previously

89 *The prevalence of heroin use in Northern Ireland*, Karen McElrath, Queen’s University Belfast, March 2002

4 The consequences for society

Health Effects

74. All controlled drugs are harmful to health and carry physical and/or psychological risks for the individual. The health effects can vary in severity depending on the type of drug and in a number of cases can result in death. Intravenous drug users are also exposed to risks of contracting blood borne viruses through the sharing of injecting equipment. The purity and strength of the drugs can also have a significant impact on the effect.

Fatalities

75. It has been suggested that the incidence of drug related deaths may be higher than recorded in the official figures. The Registrar General recorded 14 opiate and related narcotic deaths and one amphetamine related death in Northern Ireland in 1998–2002.⁹⁰ There had also been 7 ecstasy-related deaths in Northern Ireland in the same period.⁹¹ Mark Gordon of Kilcooley Community Forum claimed there had been 13 heroin/opiate related deaths over a two-year period while only six of these were recorded. He suggested that some of these deaths may have been recorded as death by misadventure or accidental death.⁹²

“Mortality rates among heroin users are high. In a 33-year follow-up study of 581 male heroin “addicts” who were required to undergo drug treatment between 1962 and 1964 in California, the mortality rate among male heroin addicts was estimated to be 50 to 100 times the rate of the general male population of the same age group.”⁹³

During a visit to Ballymena we were advised that in the past 6 years there had been 12 drug related deaths and a further two suicides directly linked to heroin use in Ballymena. We were also told that 5 of the heroin-related deaths had taken place within a quarter mile radius in an estate in the town.

Infection by blood-borne viruses

76. There is an absence of firm data on the incidence of drug users in Northern Ireland with blood-borne viral infections such as Hepatitis A and C and HIV. The risk of acquiring blood-borne infections is associated with injection behaviours such as the sharing of needles or other paraphernalia. The United Kingdom Harm Reduction Alliance warned that a potentially dangerous situation is now present where HIV transmission through injecting drug use could

90 HC 353–11 Ev 64

91 Data provided by GRO

92 HC 353–II Ev 48; QQ 244–245

93 *Review of Research on Substitute Prescribing for Opiate Dependence and Implications for Northern Ireland*, K McElrath, Queen’s University of Belfast, January 2003

rapidly escalate. There may already be some evidence of this.⁹⁴ The UKHRA also pointed out that “Hepatitis B remains endemic among injectors, .. and there is a major epidemic of Hepatitis C infection amongst UK drug users”.⁹⁵ Nicky Kwok, an outreach worker from Belfast, claimed that Northern Ireland already has an epidemic of Hepatitis C and blood-borne viruses.⁹⁶ The Chief Medical Officer in her evidence was unable to confirm or deny the existence of such an epidemic and pointed to an anonymised UK-wide survey of saliva tests due to report ‘during the summer’ to provide an answer. We also raised with the Minister the absence of a register of drug users who may have Hepatitis C.⁹⁷

77. The Northern Ireland Office of the Royal College of Physicians has stated that 35% of Hepatitis C patients gave a history of intravenous drug abuse in the past⁹⁸ while Dr Cassidy stated that 74 (28%) of the 265 reports of HCV infection recorded by the Communicable Diseases Surveillance Centre (NI) since 1994 reported a history of intravenous drug use.⁹⁹ We comment further on the development of a Hepatitis C strategy at paragraphs 195–197 below.

Cannabis

78. In our interim report we discussed the arguments about the relative harmfulness of cannabis. In the Northern Ireland context cannabis is by far the main drug of misuse among those presenting for addiction-related health services comprising almost half (47%) of the total.¹⁰⁰ Cannabis psychosis, a severe mental illness similar to schizophrenia, is increasingly being recognised as a major problem among cannabis users, particularly younger males.¹⁰¹ Dr Don MacFarlane reported that he had a number of cases with this type of condition. He said they were the worst problems that he had and were “very difficult to treat.”¹⁰² Dr Dominic Connolly spoke of typical patients who were quite heavily dependent on cannabis, who suffered from depression and paranoia.¹⁰³ Mark Gordon also expressed concerns about the health effects of cannabis. He said :

“... if anybody carried out research into the number of acute admissions of young people in particular under the age of 18 who were either admitted to the mental institutions or psychiatric wards or have had to be assessed by a consultant psychiatrist, I

94 See for example, *HIV cases on the rise in the North*, Irish Independent, 14 June 2003, which reports 24 new cases of HIV up to June, double the number for the same period in 2002

95 HC 353–II Ev 47

96 Q278. An epidemic of hepatitis C, a contagious viral disease that can lie dormant for years before progressing to chronic liver disease, would result in permanent liver damage or death for many individuals and would present a major public health challenge. The disease is spread through infected blood and the sharing of needles by intravenous drug users is a major cause of transmission.

97 HC 1217–II QQ575–576

98 Ev not printed

99 HC 353–II Ev 64

100 NISRA “*Statistics from the Northern Ireland Drug Misuse Database: 1 April 2001 – 31 March 2002*”

101 HC 353– II QQ291–296

102 HC 353– II Q293

103 HC 353– II Q277

think you will find that the numbers of those have increased phenomenally and that is specifically with the drug induced psychosis caused by cannabis alone”.¹⁰⁴

79. Following the publication of our interim report further medical evidence on the links between cannabis use and mental health problems was published by the Institute of Psychiatry. Professor Robin Murray, Professor of Psychiatry, has been reported in the press as saying that

“... in the last 18 months, there has been increasing evidence that cannabis use causes serious mental illness. In particular, a Dutch study of 4,000 people from the general population found that those taking large amounts of cannabis were almost seven times more likely to have psychotic symptoms three years later”.¹⁰⁵

For some of our witnesses the use of cannabis was not seen as the cause of a significant level of harm while for others, as well as the incidence of psychosis, there were also claims of carcinogenic and other effects.¹⁰⁶

Solvents

80. Solvents, often the substances of first choice for abuse by 11 and 12 year olds,¹⁰⁷ carry significant health risks, the most serious of which is sudden sniffing death. Death can occur for first time users as well as regular users, while longer-term use can result in kidney, liver or bone marrow problems. The Health Promotion Agency booklet “Volatile Substance Abuse” states that in Great Britain such abuse “is, for certain ages, a bigger killer than leukaemia, pneumonia and drowning combined, and ... for certain ages, it constitutes a significant proportion of all deaths”.¹⁰⁸ The incidence of solvent abuse is cyclical and geographical and this appears to be reflected in the number of solvent deaths in Northern Ireland: in 2002, the latest year for which figures are available, there were four deaths; in 2000 there were three deaths; while in 1991 there were 10.¹⁰⁹

Impact of drug-related crime

81. The Probation Board Northern Ireland (PBNI) highlighted the complex relationship between drug use and offending behaviour.¹¹⁰ Drug-related crime is not restricted to specific drug offences, such as possession or trafficking, but encompasses acquisitive crime— theft, burglary, deception—to fund a drug habit, as well as offences such as assaults, vandalism or drug-driving committed while under the influence of illegal drugs. The direct effects of drugs or disputes over debts or territories can lead to incidents of violence ranging from street brawls

104 HC 353– II Q201

105 *Cannabis link to psychosis*, The Guardian July 3, 2003

106 HC 353–II Ev 91

107 HC 353– II Q19

108 HC 353– II Q25

109 HC 353– II Q19; data provided by GRO

110 HC 353–II Ev 137

to the murder of rival gang members.¹¹¹ PBNI also found that pressure on individuals with drug-related debts, whether from paramilitary groups or other organised gangs, has led them uncharacteristically to commit violent crimes.¹¹²

82. We were reminded by PSNI that the motivating factor behind the drugs trade is the huge sums of money to be accrued from dealing in drugs and also that “all drugs involvement is a crime and quite often this crime will be familial, stealing property from the family home to buy drugs, even prostitution to obtain money to buy drugs...”.¹¹³ However, much of the information on the extent of drug-related crime is anecdotal or based on small localised surveys. **The need for further information on the links between drugs and crime is recognised, and we welcome the proposal by the Northern Ireland Office and the DHSSPS Drug and Alcohol Information and Research Unit to carry out research in this area.**¹¹⁴

Drug Arrest Referral Scheme

83. The rationale behind the introduction of Northern Ireland’s first drug arrest referral scheme (DARS) in Londonderry is set out in paragraphs 140-146 below. The early experience of the scheme has suggested that more crime may be drug-related than had previously been thought. While it is generally believed that the problem of acquisitive crime being carried out to fund addictive drug habits is less acute in Northern Ireland than in other parts of the UK, and while research in the UK to date would indicate that cannabis and ecstasy use are not generally linked to acquisitive crime,¹¹⁵ early results from DARS would cast doubt on this latter conclusion. Workers on the scheme point to the fact that many of the individuals who have reported through the scheme are chronic cannabis users or involved in social drug taking rather than consuming drugs such as heroin or cocaine,¹¹⁶ and have been arrested for acquisitive crimes such as theft, burglary and taking and driving away a motor vehicle. **Further research is needed into the extent of links between acquisitive crime and chronic use of cannabis or other ‘recreational’ drugs.**

Experience in Ballymena

84. Ballymena is regarded as a heroin hotspot unique in Northern Ireland terms. A recent study by PSNI in the Ballymena area, in relation to acquisitive crime associated particularly with the misuse of heroin, confirmed the view from elsewhere that where heroin is present a problem with acquisitive crime follows.¹¹⁷ During the six-week period 26 November 2001–6 January 2002 43 people were arrested for acquisitive crime of whom nearly half were heroin

111 HC 353–II Ev 138

112 HC 353– II Q355

113 HC 353–II Ev 35

114 HC 353–II Ev 104

115 HC 353–II Ev 100

116 HC 353–II Ev 104

117 HC 353–II Ev 101

users. A total of 113 offences were cleared up, of which 86 were heroin related. Heroin users were most likely to ask for further offences to be taken into account and it was suggested that the level of offenders with previous convictions indicates that those involved in the drugs trade are serial or recidivist offenders.¹¹⁸

85. Another study compared the value of acquisitive crime in Ballymena with Omagh, a similar sized provincial town with a perceived low level drug problem.¹¹⁹ This study in January to May 2002 found that the value of acquisitive crime in Ballymena was estimated at double that of Omagh—£261,000 compared to £135,000. During our visit to Ballymena we were advised informally that shoplifting in the town was down by nearly a quarter this year. This was attributed to a number of factors including the introduction of CCTV, radio links between shops and the fact that most persistent shoplifters were now well known to the business community in the town.

Trafficking and possession

86. Belfast City Council's All-Party Working Group on Drugs Misuse told us that the number of arrests for drug offences has almost doubled over the last 5 years.¹²⁰ For Northern Ireland as a whole the pattern of arrests for trafficking or possession (non-trafficking) offences has fluctuated significantly over recent years. The number decreased from a high of 1,505 arrests in 1995 to 909 in 1997, increasing to 1,480 in 1999–2000 before falling again to 990 in 2001–2002.¹²¹

87. The number of convictions for trafficking and non-trafficking offences also fluctuated over the period 1995–1999. During this period convictions for trafficking offences peaked at 262 in 1996 before falling to 146 by 1999. There were 478 convictions for non-trafficking offences in 1995. This fell to 316 convictions in 1997 but rose again to 431 by 1999. Custodial sentences have fallen steadily since 1996 but community supervision orders have risen since 1997.¹²²

Pharmacy break-ins

88. A particular phenomenon of drug related crime in Northern Ireland was a five-fold increase over a three-year period in attacks on dispensing chemists to obtain prescription drugs.¹²³ Break-ins had been prevalent in the late 1980s and early 1990s but the introduction of steel shutters and other measures reduced the incidence significantly. Mr Hannawin, of the

118 HC 353–II Ev 101; Ev 35

119 HC 353–II Ev 101; Ev 137

120 HC 353–II Ev 90

121 HC 353–II Ev 101

122 HC 353–II Ev 101

123 HC 353–II Ev 99; Ev 141

Pharmaceutical Contractors Committee,¹²⁴ stated that the more recent attacks were armed violent attacks on community pharmacies during daylight hours:

“We had something like 80 of those in the Greater Belfast area in the period of about six months forcing the closure, in some cases, of pharmacies and resulting in pharmacists being hospitalised, staff traumatised and having to be treated in hospital and people were becoming very, very frightened indeed.”

The object of these attacks was to obtain cash or prescription drugs such as diazepam and dihydrocodeine, which were exported to Scotland for sale in the illicit drugs trade.

89. **We are pleased to note that the introduction of time-delay safes in almost all community pharmacies, with funding provided by DHSSPS and NIO, has been very successful in stemming the spate of attacks on pharmacies.**¹²⁵ A report indicates that although there have been a number of attempted robberies there have not been any successful robberies in the Greater Belfast area in the first half of 2003.¹²⁶

90. Stolen or fraudulent prescription forms have also been used to obtain prescription drugs. The extent of this problem is not known but some steps are being taken to reduce it.¹²⁷ DHSSPS has advised that:

“... the illegal use of medicines is not simply confined to popular perceptions of the drug culture in that, for example, there is a body building fraternity who procure medicines through illegal means to assist physical development. On the wider front, pharmaceutical crime is a growing international problem concerned with counterfeit medicines, illegal internet sales, illegal advertising of Prescription Only Medicines, adulteration of herbal medicines and diversion of medicines from within the human and veterinary supply chains.”¹²⁸

91. The Organised Crime Task Force Threat Assessment for 2003 warns that the misuse of prescription drugs, particularly Diazepam and Temazepam, is increasing in Northern Ireland.¹²⁹ The UK Threat Assessment produced by NCIS notes also that the trade in pharmaceutical products is highly profitable, and likely to grow. **Further research should be carried out to determine the extent of misuse of prescription drugs in Northern Ireland, and the measures needed to address the problem.**

124 HC 1217-II Q464

125 HC 1217-II Q467; Ev 73

126 HC 1217-II Q468

127 HC 1217-II Q470

128 HC 1217-II Ev 88

129 *Threat Assessment 2003: Serious and Organised Crime in Northern Ireland*, OCTF June 2003

Drug-driving

92. In our interim report¹³⁰ we drew attention to the links between the use of drugs (mainly cannabis) and driving offences.¹³¹ **We welcome the proposal outlined in the Government’s response to our interim report on cannabis,¹³² to give the PSNI new powers to undertake tests of impairment on motorists suspected of committing driving offences while under the influence of drugs.**

Community attitudes to drug-related crime

93. Community Attitudes Surveys show that drug-related crime is perceived to be a major problem in Northern Ireland as a whole but less of a problem at a local level. The survey in 2001 found that illegal drug abuse was perceived to be the fourth most common crime (19% of respondents) in Northern Ireland. It was considered the issue that the police should pay most attention to in Northern Ireland at a regional level (37%) while a much smaller percentage (11%) asked that illegal drug abuse should receive the most attention from local police.¹³³ There were similar findings in the 2002 survey with illegal drug abuse still the issue that most people (33%) thought the police should pay attention to in Northern Ireland as a whole.¹³⁴

94. A survey of anti-social behaviour by the Northern Ireland Housing Executive (NIHE) in October 2000¹³⁵ suggested that drug abuse and alcohol abuse were not seen as major problems on Housing Executive estates. Drug and alcohol abuse was perceived as more of a problem in estates in the north-eastern part of Northern Ireland and lowest in the southern area; alcohol was a more highly perceived problem in Belfast. However, actual experience of anti-social behaviour suggests that there are behaviours, such as theft and burglary, which could be linked to drug use, but are not defined as caused by drug use. The experience of the NIHE has been that “within those estates where drug use and supply have been identified as a major issue, the resultant criminality and anti-social behaviour has had an adverse impact upon the stability of the local community and the physical environment”.¹³⁶

95. Lisburn City Council¹³⁷ expressed concern that “the illegal drugs trade appears, in many instances, to be controlled by paramilitary organisations and there is a general perception that the PSNI are unable to deal with the situation and the problem is spiralling out of control”. The Council stated that drugs are widely available, and within some public housing areas in

130 Northern Ireland Affairs Committee, *The illegal drugs trade and drug culture in Northern Ireland: interim report on cannabis* Sixth Report 2002–03, HC353–I paras 26–28

131 An example of the link is provided by a case of two teenagers who died following a road accident on the outskirts of Belfast last year. It emerged during an inquest that the driver of one of the vehicles had traces of cannabis in his blood – *Coroner warns of ‘drug-driving’ dangers*, Irish News 2 July 03

132 Northern Ireland Affairs Committee Sixth Special Report 2002–03, HC 935

133 HC 353–II Ev 102

134 NISRA Community Attitudes Survey Bulletin 2002

135 HC 353–II Ev 132; Ev 103

136 HC 353–II Ev 132

137 HC 353–II Ev 141

particular there is strong evidence of active drug dealing. The Council pointed to a recent survey in a designated Targeting Social Need (TSN) housing area of the city in which 84.6% of adults felt that drug misuse was a major problem in the area and 88.7% felt drug pushing was a major problem. Ballymena Borough Council, on the other hand, while recognising that the heroin problem has impacted on the level of crime in its borough, praised “the outstanding work of the Drug Squad and police in detecting, seizing illegal drugs and taking dealers to court”.¹³⁸

5 Government Strategy

“The threat ... to our society is not an enforcement issue alone, rather it is a community issue and requires a collective responsibility in our efforts to tackle the issue of drugs misuse.”¹³⁹

96. As indicated earlier it was considered by Government that Northern Ireland had a relatively limited drugs problem up until the early 1990s. The official response to the issue prior to that was also fairly limited. The Government’s first policy statement was issued in 1986 and, because of the low profile approach adopted, elements of the public information in use at the time in Great Britain were not used in Northern Ireland.¹⁴⁰ A Northern Ireland Committee on Drug Misuse comprising health professionals, civil servants and the voluntary sector monitored the extent of the problem and recommended preventative measures.

97. In response to a significant increase in drug misuse a Drugs Policy Statement was issued in 1995:

“For the first time in Northern Ireland, a clear Statement of Purpose for tackling drug misuse was identified, priorities and objectives were outlined and the roles and responsibilities of various organisations were clarified.”¹⁴¹

In addition a Drugs Campaign was launched in 1996 led by the then Department of Health and Social Services. This campaign featured a public information campaign; drug education training for teachers and other professionals; drug education material; specialist material for drug professionals; a research and information strategy; and the creation of drug co-ordination teams. The Northern Ireland Affairs Committee published a report on illicit drug use in Northern Ireland in December that year.¹⁴²

98. By the late 1990s it was recognised that the nature of the drugs problem in Northern Ireland had shifted. In 1998 a review of the campaign concluded that there was a need for a new strategy to take account of changes in the drug culture in Northern Ireland and also to

138 HC 353–II Ev 136

139 HC 353–II Ev 28

140 HC 353–II Ev 92

141 HC 353–II Ev 93

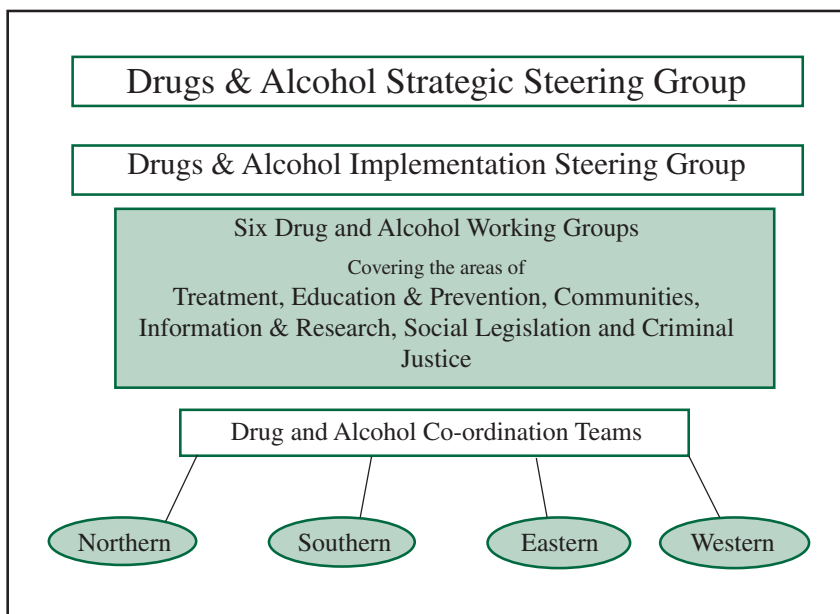
142 Northern Ireland Affairs Committee, *Illicit drug use in Northern Ireland*, First Report 1996–97 HC52

complement the UK-wide strategy, “Tackling Drugs to Build a Better Britain” which had been published in May 1998. The new Northern Ireland Drug Strategy was published in August 1999 and comprised four main aims:

- To reduce the level of drug related harm;
- To protect young people from the harm resulting from illicit drug use;
- To protect communities from drug related anti-social and criminal behaviour; and
- To enable people with drug problems to overcome them and have healthy and crime free lives and reduce the availability of drugs in communities.

Implementation of the 1999 Drug Strategy

99. In May 2001 a joint implementation model was endorsed by the Northern Ireland Executive effectively combining the Drug Strategy and the Strategy for Reducing Alcohol Related Harm and setting up revised implementation structures. The Joint Implementation Model is set out in the diagram below:



Data Source: DHSSPS

100. The implementation structure involves over 100 people representing 36 key agencies. The aim of the strategy is to ensure that all Departments, key organisations and communities are adequately represented and involved. The Northern Ireland Executive had determined that the Department of Health, Social Services and Public Safety should take the lead responsibility for co-ordinating the strategies. In particular the Department chairs the Strategic Steering Group which provides for the involvement of the other relevant Northern Ireland Departments: Education; Employment and Learning; Social Development; Environment; Culture, Arts and Leisure; and Enterprise, Trade and Investment. The NIO Minister responsible for law and

order participated in relevant meetings to ensure co-ordination between the devolved and reserved responsibilities.

101. Six Drug and Alcohol Working Groups, sub-groups of the Steering Group, were formed to cover the main areas of concern, namely: treatment; education and prevention; communities; information and research; and social legislation and criminal justice. The working groups developed a Regional Action Plan based on the key output areas in both the drug and alcohol strategies. The four Drug and Alcohol Co-ordination Teams were charged with translating this Action Plan into local targets with the aim of ensuring a coherent and consistent delivery across Northern Ireland.

102. Following the suspension of the Assembly, the NIO Minister responsible for health and social services became the lead Minister responsible for the strategy. Responsibility for ensuring the effective day to day operation of the structure rested with the regional Drug and Alcohol Strategy Co-ordinator (commonly referred to as “the Drug Tsar”) appointed in February 2001.

103. The Minister told us that implementation of the strategy is still at a relatively early stage and that it is too soon to make a definitive judgement on just how effective it has been.¹⁴³ We recognise that the development of the new strategy and the Joint Implementation Model is a genuine attempt to provide a comprehensive response to the problem and represents a considerable improvement on the previous approach. Many of those who gave evidence to us are direct participants in various elements of the strategy and were fulsome in their praise of it. However, others were less enthusiastic about the current approach and raised a number of concerns.

104. Pharmacists told us that although they participate in implementing elements of the strategy, such as the needle exchange schemes, they were not as involved in the overall development of the strategy as they might have been.¹⁴⁴ **We support the suggestion that a great deal more could still be done through utilising the expertise and experience of pharmacists, to educate and promote awareness of various drugs issues in the community.**

Involvement of drug users

105. The sheer number of working groups and steering committees involved in strategy development has given rise to concerns that the process has become too committee intensive at the expense of practical action. At the same time, it was pointed out that those who are at the receiving end of the services do not have a voice in any of those committees.¹⁴⁵ Des Flanagan, a community worker told us:

“The difficulty I have with it is that any strategy which hopes to impact upon the lives of people involved in drug use ... needs to listen directly to the individuals who are on the

143 HC 1217-II Q590

144 HC 1217-II QQ471-475

145 QQ266-272; QQ345-346; HC 353-II Ev 134

receiving end of the treatment... I am not aware of any individuals who have experience of being a consumer of drug services in Northern Ireland being invited on to any of the working groups.”¹⁴⁶

Outreach worker Nicky Kwok said:

“It is really paramount we actually bring in people who have experience of services on to consultancy forums... You cannot have people designing a programme for a client group they do not understand.”¹⁴⁷

City Bridges, a North/South trade union initiative, told us:

“It is also essential to involve the people most affected by the drug problem in developing solutions to the problem. This means involving drug users and their families and providing support for their involvement through the development of drug users forums and family support groups.”¹⁴⁸

106. It was also suggested that Northern Ireland could learn from the experience of organisations, such as the recently established National Treatment Agency in England, which have successfully involved individuals who have experience of accessing services.¹⁴⁹ **DHSSPS contended that the involvement of community and voluntary representatives on the various working groups and sub-groups constituted user representation.¹⁵⁰ While these groups may, for example, provide support, counselling or other services, it is clear that drug users themselves do not have a direct input to the planning of services.**

Co-ordination of services

107. Co-ordination of services, particularly at the local level, is essential for the success of the strategy. We were concerned to discover that the post of co-ordinator in the Northern Drugs and Alcohol Co-ordination Team had been vacant for over a year. This is particularly worrying in an area that has one of the highest rates of drug misuse in Northern Ireland and includes Ballymena with its acknowledged heroin problems. The post has only recently been advertised, and we have learned that a co-ordinator will take up post shortly. **The Minister, Angela Smith MP, acknowledged that it was unacceptable for the post of NDACT co-ordinator to have remained vacant for so long, and blamed bureaucracy and confusion over who employs co-ordinators for the delay.¹⁵¹ This situation must not be allowed to happen again.**

146 HC 353-II Q267

147 HC 353-II Q271

148 HC 353-II Ev 134

149 HC 353-II Q272

150 HC 353-II Q519

151 HC 1217-II QQ596-597

108. The regional Drug and Alcohol Strategy Co-ordinator appointed in February 2001 to oversee the day-to-day operation of the strategy resigned her post earlier this year. We realise that much of her time during this initial appointment would have been taken up in getting the structures in place. The Minister acknowledged that some lessons have been learned during the initial appointment, in particular, that the co-ordinator needs to have a more strategic policy direction role. **The regional Drug and Alcohol Strategy Co-ordinator post is central to providing drive and momentum to the strategy, as well as to ensuring its smooth running. We are pleased to learn that a new co-ordinator has now been appointed.**

109. We acknowledge that much has been done to integrate the voluntary and community sector into the overall strategy through, for example, the establishment of a working group specifically to promote and support community action. However, **when we met a group of community and voluntary sector representatives they expressed concern that the absence of a devolved Assembly could make it more difficult for them to fulfil their role and to have access to Ministers. The Minister, Angela Smith MP, told us that a Whitehall Minister with responsibility for several Departments will not have as much time available as a local Minister, but that she was nonetheless committed to engaging fully with the voluntary sector.**¹⁵² We welcome this assurance.

110. During a later visit to Northern Ireland we were made aware of a perceived sense of reluctance on the part of some statutory bodies to deal with or acknowledge the services provided by voluntary support groups. **The Steering Group needs to look at ways to ensure that committed people at grass roots level can feel included in the implementation of the drugs strategy and their contribution valued.**

Evaluation

111. A full and independent evaluation of the Drug and Alcohol Strategy was due to commence in September 2003. However, it is already clear that there will be some slippage, as it had not been commissioned by July 2003.¹⁵³ The absence of a regional co-ordinator (the ‘drugs tsar’) has been blamed for this delay. **A thorough evaluation of the drug and alcohol strategy would provide valuable information on how effective it has been to date in achieving its objectives as well as pointing to any changes necessary in planning for the future. We welcome the planned evaluation and urge the Minister to ensure that it is thorough and independent and takes place without further delay.**

6 Enforcement

112. Effective enforcement against the supply of illegal drugs requires that drugs and their traders are cut off from the market. This means not only that drugs on the market are seized, but that supply chains are blocked and broken, and that organised criminal gangs are deprived

¹⁵² HC 1217-II Q588

¹⁵³ HC 1217-II QQ598-604

of the human, financial and other resources which support their activity. The scale of the task facing the enforcement authorities should not be underestimated: it has been suggested that Schiphol airport in the Netherlands, just one of the gateways into Europe, sees 20,000–25,000 drug couriers every year.¹⁵⁴

113. With such a vast international trade, communication and co-operation between different agencies on a national and international basis is vital. Government efforts in Northern Ireland are focused through the Organised Crime Task Force, a multidisciplinary body which oversees strategy, sets targets and facilitates co-operation between agencies on all forms of organised crime. The equivalent body which co-ordinates activity on drugs for the UK as a whole is CIDA (Concerted Inter-agency Drug Action Group).

Co-operation and intelligence

114. International networks are in place to ensure the flow of intelligence through national customs and crime squads, Europol and Interpol. The aim of enforcement activity is to cause the maximum disruption to the trade, and co-operation is extensive. Mike Wells of HMCE told us that such an impact is achieved:

“... where we can take out, typically, bulk supply wherever possible in the largest commodity, which is why we try to undertake a large amount of our effort beyond the boundaries of the UK altogether. We have DLOs [drugs liaison officers] posted around the world and indeed with law enforcement agencies from other countries take out large amounts of Class A drugs bound for the UK before they arrive here.”¹⁵⁵

The PSNI similarly told us that they had established international working relationships and agreements that had enabled the investigation of drugs activity as far afield as Australia.¹⁵⁶ In fact, PSNI Drugs Squad received more intelligence than it could use.¹⁵⁷

Data

115. Following our inquiry into terrorist finance, we were concerned to find out whether the agencies still experienced difficulties in respect of data sharing. Mike Wells of HMCE told us that the procedure was still imperfect from an enforcement perspective, since agencies were inhibited by data protection requirements from providing others with full access. Nonetheless he recognised that a balance between data sharing and data protection had to be struck,¹⁵⁸ and otherwise suggested that close, joint working between different agencies had done much to

154 *Dutch Customs ordered to let drug 'mules' go*, Daily Telegraph, 10 February 2002

155 HC 353–II Q43

156 HC 353–II Ev 35

157 HC 353–II Q159

158 HC 353–II Q81

foster mutual confidence and trust. ACC Albiston from PSNI also confirmed that the different protocols of agencies in other jurisdictions were not a bar to good working relationships.¹⁵⁹

Relations with the Republic of Ireland

116. The extensive land border between Northern Ireland and the Republic of Ireland makes co-operation between the agencies of the two jurisdictions on the island of Ireland particularly important. During our visits to both parts of the island we have been encouraged by the evidence we have seen of such co-operation.

117. The Security Minister, Jane Kennedy MP, recently announced new agreed arrangements for the joint investigation of cross-border organised crime, and raised the possibility of further co-operation on a joint cross-border threat assessment, and a review of existing mechanisms for the exchange of information.¹⁶⁰ **We welcome the very positive approach to joint working shown by the enforcement agencies in both Northern Ireland and the Republic of Ireland. We support the proposal of a joint cross-border threat assessment, and would encourage the Government to consider how information exchanges between the jurisdictions might be improved, so that available intelligence can be exploited to the full.**

Constraints on co-operation

118. If there is any constraint on international and national co-operation it is the availability of resources to tackle the massive and sophisticated illegal drugs trade. While the increased focus on intelligence and mutual co-operation in recent years has greatly increased the effectiveness of enforcement activity, difficult decisions still have to be made on occasion about which piece of intelligence to pursue.

119. In such cases—particularly if a decision has to be made in a hurry—it is logical that co-operating agencies will elect to pursue the case which most clearly matches organisational and governmental priorities. It has been suggested to us that the different performance indicators set for different enforcement bodies can lead them to duplication of effort, omissions, and less effective enforcement.¹⁶¹ It is for these reasons that we raised concerns in our interim report about the impact on enforcement of the decision to reclassify cannabis as a class C drug. Although the proposed change more accurately reflects the harm caused by the drug to the user (relative to the harm caused by other drugs such as heroin) it has the inevitable side-effect of lowering cannabis on the list of enforcement priorities, relative to other concerns such as class A drugs and fuel oil duty evasion.¹⁶²

120. While we were pleased that the Government response to our interim report affirmed cannabis as a priority for enforcement *within* Northern Ireland, **we remain concerned that**

¹⁵⁹ HC 353–II Q160

¹⁶⁰ *Bigger cross-border fight on organised crime urged by NIO*, News Letter, 29 May 2003

¹⁶¹ HC 1217–II Ev 83

¹⁶² Northern Ireland Affairs Committee, *The illegal drugs trade and drug culture in Northern Ireland: interim report on cannabis*, Sixth Report 2002–2003 HC353–I

the Government is underestimating the impact cannabis reclassification may have upon enforcement activity along the routes of supply into Northern Ireland. Although the PSNI have experienced major successes in targeting the cannabis trade, they will continue to need support from external agencies in blocking this source of income for Northern Ireland's organised criminals and paramilitaries. We urge the Government to monitor the situation very carefully in the months following reclassification.

121. Equally, it seems to us that **the tension which can arise where requests for assistance fall outside, or run counter to, an organisation's priorities could be resolved if co-operation was itself made an objective for the major enforcement agencies. We recommend that the Government explore this proposal with the members of the Organised Crime Task Force, and other relevant organisations.**

Resources

122. We have already noted comments by police officers that the PSNI drugs squad has more intelligence than it is able to exploit, and that an increase in resources would enable the squad to pursue more targets.¹⁶³ The Minister, Jane Kennedy MP, was sympathetic to this argument, although she reminded us that the allocation of resources within PSNI is a matter for the Chief Constable rather than for Government. She pointed out that the Chief Constable is looking to restructure the police force so that police officers currently engaged in administration can be released to participate in detection and other police work.¹⁶⁴ **Any steps which can be taken to release skilled police officers for front line policing are welcome. Acknowledging the potential value of more effective enforcement, we believe that the Drugs Squad is a suitable candidate for additional human resources.**

Technology

123. While skilled and experienced officers are the most vital asset of the enforcement agencies, technology is now able to provide valuable support. During our visits to Customs operations across the UK we saw an array of equipment which has significantly enhanced HMCE's ability to detect concealments, both of drugs and of other items such as cigarettes on which it is hoped to avoid paying duty. Although expensive to install, this equipment makes a rapid return on investment through the revenue recovered on cigarettes and alcohol, even before the savings to health and police services from disruption of the drugs trade are calculated. **We have been reminded repeatedly that Customs' primary role is to safeguard the revenue and interests of HM Treasury. We urge the Treasury therefore to consider the benefits which would accrue from enhancing and expanding the technology available to HMCE to assist in the detection of concealed and illicit shipments.** The Minister undertook

163 HC 353-II QQ129-130

164 HC 1217-II Q542

to draw this point to the attention of her colleagues in Government.¹⁶⁵ We trust she has done so.

Assets Recovery

124. One important new aspect of the Government's crime prevention strategy is the increased focus on assets recovery. This is the seizure from criminals of cash or other assets arising from their criminal activity to prevent their use in further crime. While the police and HMCE have for many years had limited powers to seize cash associated with the drugs trade, these powers have been enhanced by the Proceeds of Crime Act 2002. The 2002 Act also established the Assets Recovery Agency, which we discussed at length in our report last year.¹⁶⁶

125. Mike Wells of HMCE told us that the enhanced powers provided by the Proceeds of Crime Act had proved immediately effective: in the first three weeks of operation they had enabled Customs to seize £3.3 million in cash, roughly 20% of the amount seized in the whole of the previous year.¹⁶⁷ While it is not to be expected that the Assets Recovery Agency would have completed any cases since it became fully operational in March 2003, it is already making its presence felt in Northern Ireland: a number of individuals have had their assets frozen pending further investigation, and it has been reported that the Agency's investigators expect almost to double the number of civil recovery cases they take on in their first year, compared to the target set for them by Government. More recently, it has been announced that on 8 September the courts permitted the Agency in Northern Ireland to freeze £1.5 million in assets which are allegedly associated with drug dealing.¹⁶⁸ **We welcome the effectiveness of the assets recovery powers provided by the Proceeds of Crime Act 2002 and we commend the energy and commitment demonstrated by the staff of the new Assets Recovery Agency in its first months of operation.**

126. It has been pointed out to us that the experience of the Assets Recovery Agency is unlikely to follow exactly that of its model, the Criminal Assets Bureau (CAB) in Dublin. Since the CAB was established in 1996 serious and organised criminals have become far more aware of the threat posed to their lifestyles and illicit businesses by assets recovery. Consequently, they have become more sophisticated in concealing or obscuring their financial transactions. The new Assets Recovery Agency, therefore, may have to apply different techniques and to engage in more complex cases before it can achieve the resounding successes enjoyed by the CAB.

127. The Assets Recovery Agency should be a crucial, and powerful, tool in the Government's efforts to disrupt and dismantle organised crime in Northern Ireland. Its early progress has the potential to make or break its reputation as an authority to be feared by the criminal fraternity. We urge the Government to continue in dialogue with the Agency and to consider very carefully any further requests for resources—whether for

165 HC 1217-II Q544

166 Northern Ireland Affairs Committee, *The financing of terrorism in Northern Ireland*, Fourth Report 2001–02 HC978-I

167 HC 353-II QQ92–93

168 *Official Report*, 10 September 2003 c311

trained staff, additional or amended powers, or other provision—which would support the Agency’s work.

Investing recovered assets in communities

128. An important principle in the international practice of assets recovery is to return seized assets to the community which has suffered through criminal activity. When we examined the development of assets recovery policy last year, we were told that “up to half” the Government’s receipts from confiscation, civil recovery and cash forfeiture would be placed in a Recovered Assets Fund by HM Treasury. Organisations involved in crime prevention or community initiatives, including anti-drugs campaigns, would be able to bid for grant funding from the Fund.¹⁶⁹

129. Yet Northern Ireland has not done well out of the Recovered Assets Fund. In 2002 there was only one grant to a Northern Ireland project, to the value of £150,000.¹⁷⁰ This compared with the total value of grants to projects in England and Wales of £14.26 million. The relative paucity of grant to Northern Ireland was explained to us as the consequence of a lack of applications from the region, although there are many important initiatives in Northern Ireland which might have benefited from this type of support.

130. On 2 October 2003 the Home Office announced that the Recovered Assets Fund is being replaced by two new funds: the Recovered Assets Incentivisation Fund, worth £15.5 million a year, and a communities fund worth £7 million a year. We were surprised and dismayed to discover that under the new plans Northern Ireland will have little opportunity to reclaim a share of the assets drained from its economy through organised crime. While the Recovered Assets Incentivisation Fund, like its predecessor, will extend to Northern Ireland the Home Office has made clear that up to 77% (£12 million) of the fund will be ring-fenced in each of the next three years to establish multi-agency recovery teams in England and Wales. The £7 million communities fund will be dedicated to England and Wales alone.¹⁷¹

131. Continued community support for the assets recovery process can best be secured if the community sees actual benefit from it. Yet under the changes announced by the Home Office to the distribution of recovered assets, Northern Ireland’s enforcement agencies will see only a limited return for their efforts, and Northern Ireland’s communities nothing at all.

132. The Home Office previously acted in good faith by establishing an Assistant Directorship for the Assets Recovery Agency in Northern Ireland, and we welcomed that move. But by restricting Northern Ireland’s access to the recovered assets in the new funds it is failing to follow through the assets recovery process to its logical end—converting

169 Fourth Report 2001–02, *The financing of terrorism in Northern Ireland*, HC 978–I para 186

170 The money was given to Forensic Science Northern Ireland for a project analysing the chemical components of ecstasy. The purpose of the analysis is to identify the source of , and confirm links between, different sets of tablets, thus improving intelligence.

171 *Using criminals’ cash to invest in our communities and front-line agencies*, Home Office 2 October 2003

criminal gains into positive outcomes for Northern Ireland’s communities. Many of these communities are in real need and would, by such action, see some point in joining the fight against organised crime.

133. This action by the Home Office is therefore unacceptable and directly counter-productive. There is too much at stake in terms of restoring a stable society and economy, and rooting out serious and organised criminality in Northern Ireland. The Minister must take steps as a matter of urgency to ensure that the assets recovery process in Northern Ireland is not compromised by the Home Office’s decision, and that Northern Ireland has the same rights to access recovered assets as England and Wales.

Border controls

134. Border controls—and the opportunities they provide for surveillance, scrutiny and detection of illicit shipments—have a key role to play in the enforcement effort. Under the Customs & Excise Management Act 1979, HM Customs & Excise (HMCE) have powers to stop, question and search individuals and freight at international borders including, in Northern Ireland, within a 20-mile radius of the land boundary with the Republic of Ireland.¹⁷² Other powers are held by police forces, for example under the Misuse of Drugs Act 1971 and also under the Police and Criminal Evidence Act 1984 and the Anti-Terrorism, Crime and Security Act 2001—although in these acts the powers are not specifically drugs-related.¹⁷³

135. While HMCE expressed themselves largely satisfied with the “ample provision” of their powers,¹⁷⁴ we were alerted to certain sensitivities caused by the screening process for freight at ports. HMCE has powers to stop and search any shipment. As the screening process takes some time, this can lead to certain freight containers being detained in port areas for short periods. Some port authorities impose a charge on detained containers—effectively, ground rent for the duration of the delay, and additional handling charges—which can mean the freight owner experiences not only the inconvenience of the delay but also considerable expense in the course of legitimate business.

136. We were told that some cases had given rise to allegations of discrimination against particular individuals or companies, and were detrimental to the otherwise good, co-operative, working relationships between freight companies and the enforcement authorities. As a consequence, while the authorities would not hesitate to detain a shipment which gave rise to suspicion, they would at times feel under a constraint in terms of carrying out routine checks, or surveillance which might amplify existing intelligence.

137. Port authorities are private companies and are not in this respect subject to Government control. Nonetheless it would be in their interests, as well as the Government’s, to resolve any difficulty which damages co-operation on security-related

172 HC 353–II Q61

173 HC 1217–II QQ547–549

174 HC 353–II Q61

matters. One alternative to the existing case-by-case freight detention charges might be for the port authority to spread the total annual cost of freight detention across all port users as a minimal standing charge. We urge the Minister to discuss solutions to the problem with the port authorities as soon as possible.

7 Intervention

138. Problem drug use can cause health difficulties for the user, and crime and other problems within the user's family and wider community. Both provide reasons for Government to seek to intervene and address the user's lifestyle.

139. The primary principle which must guide any such intervention is that it must seek, wherever possible, to reduce the harm experienced by the user and by the community as a consequence of the drug use. Crucially, the intervention must also be acceptable to the user: a user who is forcibly and rapidly detoxified is more likely to relapse than an individual whose withdrawal from use is voluntary and carefully managed. Therefore, if the aim of intervention is to tackle the individual's problems successfully, there can be no 'one-size-fits-all' policy: a range of options is needed to meet the variety of personal circumstances and personal choices of problem users. In this section we consider options and initiatives available through the criminal justice system and the health service to change users' lifestyles and reduce the harm they experience.

Drug strategy in the criminal justice system

The Drug Arrest Referral Scheme (DARS)

140. In 2002 Northern Ireland received its first Drug Arrest Referral Scheme, established by Sperrin Lakeland Health Trust in conjunction with the Police Service of Northern Ireland. The scheme is based at Strand Road Police Station, Londonderry, and under it, individuals brought into custody by the police may volunteer to meet one of two drug arrest referral workers employed by the Trust.

141. For many, being arrested will represent a crisis in their lives. The event therefore has the potential also to be a turning point for them. Drug arrest referral capitalises on this opportunity for intervention: if an individual in custody volunteers to meet one of the Trust's workers, the worker will seek to establish the exact nature and extent of the individual's drug use problem, and can offer rapid access to medical and other services. This process is entirely separate from any judicial process, and will not be taken into account in any proceedings against the individual. Nonetheless, it provides an opportunity to address the underlying cause of the offence, and reduce the risk of further offending behaviour.

142. While the scheme has yet to be formally evaluated, a number of lessons have already become apparent from it. The collaboration between the police and the local health trust has been fundamental to its effectiveness: while it is the arrest which triggers intervention, it has

been proved that individuals only became willing to talk to the referral workers once they understood they were health practitioners rather than representatives of an authority they did not necessarily trust. The project has had a meaningful impact on a number of clients, some of whom had never had any contact with treatment services previously. The rapidity of access to treatment has also proved important in making the most of the opportunity presented by the arrest to change the individual's behaviour.

143. Data arising from the project is also beginning to yield valuable insights into the problems associated with drug use. It has been calculated that the average client referred to the project spends £140 per week on drugs. To fund this expenditure through criminality, the individual would need to acquire goods of three times that value, or £22,000 per year.¹⁷⁵

144. We understand that these conclusions are in keeping with the results of similar trial schemes carried out in England and Wales. A recent three-year evaluation study found that these schemes resulted in a significant decline in both offending and re-arrests and also produced significant improvements in physical and psychological health. The analysis estimated that the economic and social benefits of arrest referral schemes equated to approximately £4.4 billion over an eight year period.¹⁷⁶

145. A second referral scheme for Northern Ireland has recently been established in Ballymena. **We welcome the success of the experimental Drug Arrest Referral Schemes established in Northern Ireland, and hope this approach will be consolidated and extended to other areas with significant drug-using communities, such as South Belfast.** We also believe that, given the wider prevalence in Northern Ireland society of alcohol abuse, and the association of alcohol with violence, misuse of illegal drugs and other offences, **the potential benefit of extending the remit of such schemes to include those arrested for alcohol-related offences should also be explored.**

146. Funding for DARS and a number of other initiatives is provided through the Criminal Justice Working Group up to March 2004. When we met representatives of the voluntary and community sector back in January 2003 they expressed concern about the lack of clarity on whether support for these projects would continue beyond that date. Unfortunately that uncertainty appears to remain for a number of the projects. We welcome the commitment to continue to fund, for example, the initiative at Hydebank (see paragraph 153 below). However, **we are very concerned that the DARS scheme and, as we understand it, a number of others may be put in jeopardy through a lack of financial commitment. We urge the Minister to provide stable funding for DARS and to make decisions on any other outstanding projects as quickly as possible.**

175 HC 353-II Ev103

176 HC 1217-II Ev 84

The prison and probation services

147. Both the prison and probation services are increasingly aware of drugs as a factor influencing the behaviour of individuals who come within their care. It is not the most significant problem: alcohol dependency and illiteracy were both cited as more widespread difficulties.¹⁷⁷ Nonetheless, both services have taken steps to increase their knowledge of individuals' drug-using habits. The Probation Board now employs a structured assessment document for pre-sentence reports, which probes offenders' lifestyles as well as behaviour immediately and obviously associated with the offence.¹⁷⁸ The Prison Service similarly seeks to ascertain the dependencies of all clients on their first entry into prison.

148. We were told that within Northern Ireland's prison culture cannabis, amphetamines and ecstasy are readily accepted and tolerated. By contrast, heroin and cocaine are not; although for no better reason than because an individual dependent on such a heavily addictive substance will be difficult for other residents to control.¹⁷⁹ There is little intravenous drug misuse, although equipment used for injecting steroids (used in body-building) has been discovered during searches.¹⁸⁰

149. The Prison Service's response to the drugs issue combines enforcement with interventions aimed at challenging drug use. Peter Leonard told us that the service has:

“...to take a hard line with drugs because of the problems that they actually cause, because they are mind-altering substances, because they change behaviour. Sometimes in the very intense human atmosphere of a prison that actually causes enormous problems ... we really have to say that the only acceptable level of illicit drugs in prisons is zero.”¹⁸¹

Enforcement measures adopted by the service include searches, drug testing after periods of leave and the employment of passive drug dogs during prisoner visits.

150. Reducing the prisoner's dependency on drugs can help the prisoner to maintain important family ties which would otherwise be put under strain.¹⁸² While the medical interventions available through prisons are not as wide as in the community—substitute prescribing would only be provided on a short term basis as a continuation of care provided by a GP—¹⁸³ a range of programmes are provided for the individual, giving encouragement, education and, where appropriate, medical or psychological support.

177 HC 1217-II Q386, 409

178 HC 1217-II Q361

179 HC 1217-II Q415

180 HC 1217-II Q413

181 HC 1217-II Q386

182 HC 1217-II Q386

183 HC 1217-II Q422

151. We were fortunate to be able to see the pioneering work being carried out at the Young Offenders' Centre at HMP Hydebank Wood, Belfast. In a programme run collaboratively with a voluntary agency, Opportunity Youth, residents at the centre who submit to voluntary drug testing live on drug-free corridors and receive privileges such as televisions. Evaluation of the scheme has demonstrated that use of drugs in the centre has reduced from 55% of inmates to 48% in 12 months. Levels of violence on drug-free landings were eight times less than in other parts of the Centre, and participants reported much better relationships with the attendant officers. Recidivism among programme participants has reduced by 7%.¹⁸⁴

152. As has been discovered with the DARS, the involvement of individuals outside the criminal justice system—in this case, the voluntary sector—has significantly enhanced the credibility of the scheme for its potential clients. The scheme has also helped staff shed their “old turnkey” image, and develop a more recognisably modern approach, combining custody with care.¹⁸⁵

153. When we visited Hydebank we were concerned to discover that funding for this excellent initiative was due to run out in March 2004. We were therefore relieved to hear subsequently that, following a guarantee of “fairly substantial” support from the Criminal Justice Working Group, the Prison Service had made a firm commitment to continue the programme. To date it has not been possible to provide a similar scheme for other parts of the Prison Service estate because of concerns that drug-free areas could be manipulated by paramilitaries seeking to achieve segregation.¹⁸⁶ Nonetheless other collaborative projects with the voluntary sector are in place to support individuals in other ways. For example, we were told about a programme called DABBLE, which combines education on drugs with literacy support; other programmes draw on the knowledge and experience of prisoners themselves in peer education.¹⁸⁷

Community attitudes to users and former users

154. One of the key achievements of the Hydebank Wood/Opportunity Youth programme has been the support it has continued to offer to clients on their return to the community, which has contributed to the reduction in the re-offending rate. Release from detention can prove difficult for the individual for a number of reasons:

- The individual may have become institutionalised;
- The individual may be tempted to return to drugs, but may have lost any previously-established resistance to them during the period in prison; and
- The individual who has been convicted of drug use or drug dealing may be rejected by family or community.

184 HC 1217-II Q365

185 HC 1217-II Q409

186 HC 1217-II Q399

187 HC 1217-II Q409

155. Community attitudes to individuals can have a significant role to play in an individual's rehabilitation. But Brian McCaughey of the Probation Board Northern Ireland told us that there can be problems unless the community can be convinced that the individual poses no threat to others.¹⁸⁸ The Northern Ireland Association for the Care and Resettlement of Offenders (NIACRO) told us that 14% of those who contact its Base 2 project are under threat because of alleged involvement in the use of illicit drugs.¹⁸⁹

156. These agencies, together with Lisburn City Council/ASCERT, told us that in order for communities to accept such individuals back an holistic approach to re-integration is required, with the police, probation, health and social services and the education and youth sectors all working together to ensure individuals are given support, accommodation and opportunities for training and employment. Transparency about these interventions is required to increase community confidence in the safeguards being introduced and the nature of the change being wrought in the individual's behaviour.¹⁹⁰

Supervised licences

157. Both the prison and probation services told us that they would find it helpful to have the opportunity to retain individuals sentenced to prison for 12 months or more on a supervised licence, once they are released on parole. A licence could impose certain conditions of behaviour on the individual, such as proven abstinence from drugs, and provide a means to keep the individual in contact with services until the full term of their prison sentence expires. The success of the Hydebank/Opportunity Youth project provides evidence for the effectiveness of continued contact as a means to reduce re-offending, particularly where the custodial sentence itself has been too short to allow rehabilitation.¹⁹¹

158. The Minister, Jane Kennedy MP, told us that a custody probation order of the type described was already available to the courts in connection with sentences of four years or more, but that extending the scheme to sentences of 12 months or more would have considerable resource implications.¹⁹²

159. We separately sought data on the sentences imposed by the courts in cases of both possession and supply of drugs between 1998 and 2002. This data demonstrated that it was exceptional for an individual to be given a sentence of more than 5 years for these offences. Only 1 person was given a sentence of more than 6 years for offences of supply in each of 1999 and 2000; of the remainder, about 50% of the individuals sentenced to custody for possession were sentenced to between one and five years, while the equivalent figure for offences of supply was over 80%. Most of these individuals would not be eligible for a supervised

188 HC 1217-II Q367

189 The Base 2 project seeks to mediate in cases where threats of violence or expulsion are made against a person. HC 353-II Ev 135

190 QQ367, 70, HC 353-II Ev 135

191 HC 1217-II Ev 66 QQ364-365

192 Q559

licence/custody probation order under current provisions, but would be if the scheme were extended, as the agencies suggested, to cover sentences of 12 months or more.¹⁹³

160. Given the proven success of monitoring and post-release support in reducing recidivism, **we believe that investment in the resources necessary to extend the existing supervised licence scheme to sentences of 12 months or more would provide value for money by reducing the risk of ex-prisoners relapsing into problem drug or alcohol misuse, with its health risks and social costs. The Government should discuss the feasibility of the proposal with the prison and probation services, with a view to implementing an extension at the earliest opportunity.**

Joint working

161. While there have clearly been some major successes achieved through co-operation, we were told by both outreach workers and by statutory agencies that progress in joint working was uneven. In part, this reflected cultural difference: voluntary agencies sometimes found the methodical approach and bureaucracy of the statutory sector tiresome. However, we were also told by Brian McCaughey that resource constraints sometimes proved a bar:

“... when you try to draw in the various statutory organisations because of the absence of resources they tend to lean towards their legislative responsibilities, in other words, they will say “That’s not my responsibility, that’s a young person, that’s health and social services. That’s not my responsibility, that’s the education sector” or “the youth sector” and I think if I was looking for anything ... it would be mandating organisations to work together in a co-operative fashion and bending their legislative responsibilities and sometimes stepping outside of them for the good of the young person who needs to be re-integrated.”¹⁹⁴

162. The Minister’s response to these comments was unusually bland: she told us that problems were inevitable “in human organisations”, particularly if some felt they were “not getting their fair slice of the cake”.¹⁹⁵ **All of the evidence indicates that tremendous progress has been made in encouraging and enabling organisations from different sectors to work together. But if organisations are, or believe themselves to be, unable to act consistently in the interests of the client there is still work to be done. The Minister should work with the statutory sector and voluntary agencies to develop protocols or other mechanisms enabling action in cases where statutory responsibility is divided between different services.**

Bail

163. The Police Service of Northern Ireland expressed concern in relation to the provision of bail by the courts in certain cases relating to drugs. ACC Albiston told us that “something in

193 HC 1217-II Ev 62-64

194 HC 1217-II Q368

195 HC 1217-II Q566

the order of 73%” of individuals committing more serious drug offences were being awarded bail. This was problematic as it posed a temptation for offenders, facing the probability of a prison sentence, either to abscond or to enhance their income through further drug trading or other criminal activity while they had the freedom to do so. The police, who have the opportunity to oppose bail at a bail hearing, were finding themselves frequently unable to persuade a judge or magistrate that the risk of absconding or re-offending was a serious one. They were “disappointed” that this was the case, although ACC Albiston acknowledged that the courts were bound by the European Convention on Human Rights to grant bail unless there were very clear reasons not to do so. He added, “Sometimes we know from intelligence that we have a good basis [of evidence] but we are reluctant to have our intelligence tested in an open court.”¹⁹⁶

164. The Northern Ireland Office sent us a detailed and helpful memorandum on the provision of bail in Northern Ireland, which is reprinted in the Minutes of Evidence to our interim report.¹⁹⁷ This notes “that grant of bail in Northern Ireland is governed in the main by the common law rather than statute” and in certain key respects lacks equivalent provision to the law governing bail in England and Wales. For example, in England and Wales a person charged with offences of murder, attempted murder, manslaughter, rape or attempted rape may only be granted bail if the court is satisfied that there are exceptional circumstances which justify it; further, if a court in England and Wales proceeds to grant bail having heard representations for bail to be withheld, it must give its reasons for doing so. Neither provision is currently available in Northern Ireland.

165. The Minister acknowledged that the experience cited by the PSNI, particularly in relation to the difficulty of using intelligence to counter bail applications was “frustrating”. She told us that the question of converting information and intelligence into usable evidence was currently under consideration, as were other issues relating to the bail regime in Northern Ireland. She also confirmed that certain steps to improve the regime had already been taken through the Criminal Justice (Northern Ireland) Order 2003, while others were being pursued through the Criminal Justice Bill.¹⁹⁸

166. We have noted in earlier reports our belief that there are advantages in bringing the law in Northern Ireland as closely into line with the law in England and Wales as is practicable, given the different contexts of the different regions. This is another such case. In particular, **we can see benefits in making available to Northern Ireland provisions which would, as in England and Wales, make the granting of bail exceptional in serious cases including murder, attempted murder and rape. We would like to see drug trafficking added to the list of cases covered by this provision. Similarly, we can see the potential value in Northern Ireland of provisions which would require the court to give reasons for granting bail when representations have been made against it. The Government should consider these**

196 Q167. See, similarly, *Orde's worry over easy access to bail*, Belfast Telegraph 29 August 2003

197 HC 353-II, Ev 110

198 HC 1217-II QQ555-558

suggestions as part of a full consultation on the operation of bail in Northern Ireland, with a view to making further statutory provision at an early stage.

Drug courts and drug treatment and testing orders (DTTOs)

167. Our attention was also drawn to two types of intervention which have been used outside Northern Ireland but are not currently available there. City Bridges described a drug court as one which:

“...allows people who are drug users and who come in front of the courts to be referred to treatment rather than be sent to prison. A significant amount of crime is committed by people who need to feed a drug habit and the aim of the drug court is to prevent future crime by dealing with the drug use.”¹⁹⁹

Staff of drug courts specialise in the work and co-operate closely with health and community services to ensure that the treatment in each case is appropriate and effective for the individual concerned. The approach taken is non-adversarial, and has a therapeutic aspect rather than a purely judicial one. Drug courts have been established in Dublin, Glasgow, Wakefield and further afield, for example in New South Wales.

168. From our discussions here and in other jurisdictions we have learned that there are three factors upon which the success of such an initiative in Northern Ireland would be heavily dependent. Firstly, all involved in providing the service—including police, probation, the judiciary and health practitioners—would have to be fully committed to its therapeutic approach: this could come as something of a culture shock to some. Secondly, those appearing before the court would have to be prepared to accept treatment as a serious alternative to a traditional form of sentence. Thirdly, treatment facilities and options would need to be available to support the court’s decisions.

169. The Minister told us that the possibility of introducing drugs courts had been considered by the Criminal Justice Working Group on Drugs and Alcohol. This had agreed there was not currently sufficient evidence to suggest that the introduction of drugs courts—which she believed to be most effective in tackling heroin and cocaine use—could be justified in Northern Ireland. As a dedicated service, it would have to see a significant number of drug-using offenders to be economically viable.

170. Towards the end of our inquiry we received a helpful submission from the Association of Chief Police Officers (ACPO) about various aspects of the drug strategy in England and Wales. This noted that experimental drug courts had been established, and that the “key advantage” of such courts was the availability of a facility where magistrates and others had a good knowledge of the issues which may surround drug-related offending behaviour. It suggested, however, that such knowledge might be provided to magistrates through a comprehensive

199 HC 353–II Ev 134

drug-briefing programme which, while slower to develop, would lead to a wider recognition of the issues and prove more cost-effective.²⁰⁰

171. We believe that both the options of a drug court and a drug-briefing programme for magistrates merit further exploration, jointly by the Northern Ireland Office and the departments of the Northern Ireland Executive.

172. Andrew Rooke of the Probation Board Northern Ireland noted that drug treatment and testing orders similarly provided an opportunity for the courts to recommend a course of treatment, and to monitor an offender’s compliance. He described this as potentially a “useful option”, which is already available in England and Wales²⁰¹ and is less resource intensive than a drugs court. The NIO told us that the legislative framework to support DTTOs had been put in place through the Criminal Justice (Northern Ireland) Order 1998, but had never been activated because it was believed at the time that the option was not needed. **We believe that there would be advantages in making Drug Treatment and Testing Orders available as an option for use in Northern Ireland. The Government should take whatever further steps are necessary to activate Article 8 of the Criminal Justice Order 1998, and to agree the necessary protocols with the court service and other agencies.**

173. We understand that where DTTOs have been used elsewhere they have been resisted by offenders who perceive the regime as a “harder option” than traditional sentences. It has been suggested that this perception may arise from the heavy emphasis generally placed on the offender’s full compliance with the scheme, regardless of the difficulty for the offender—who may have a severe addiction, and a chaotic lifestyle—in immediately adopting and sustaining high standards of disciplined behaviour. It may be that a pragmatic approach, which could address occasional lapses from the terms of the order without automatically designating the offender as non-compliant, would be more likely to succeed in diverting offenders from custody, and securing long-term behavioural change. **In developing protocols for the use of DTTOs in Northern Ireland, the Government should design a range of sanctions for lapses in compliance which enable the difficulty faced by the offender in meeting the order’s demands to be taken into account.**

Drug Treatment Services

174. The aim of treatment is “to enable people with drug problems to overcome them and lead healthy and crime-free lives”.²⁰² Drug treatment therefore provides benefits not only for the individual drug user but also for the wider community.

175. Investment in treatment services in Northern Ireland, with its relatively limited drugs problem until the early 1990s, has been slow and piecemeal. The same community resistance which helped stifle the spread of the drugs culture in the early days was also resistant to forms

200 HC 1217–II Ev 84

201 HC 1217–II Q364

202 NI Drugs Strategy 1999 (Chapter 7)

of treatment that could perhaps be interpreted as encouraging drug use, such as the introduction of a needle exchange scheme or substitute prescribing.

176. The Chief Medical Officer told us that there was a marked resistance amongst sections of the medical profession to substitute prescribing as a form of treatment and this reflected the views of wider society in Northern Ireland.²⁰³ The same resistance applied to the needle exchange scheme. Dr Cassidy told us:

“My concern was that we were introducing a source of needles and advice about skilled injecting to an injecting-naïve population. The first principle of harm reduction is to move people away from injecting, and then away from heroin, and here we had a situation where we were introducing a readily available source of needles and brochures on how to inject. That gave me considerable cause for concern to the extent that we do not readily advise people where to source needles”.²⁰⁴

Access to services

177. A patient’s first point of contact for any health service is generally through their general practitioner. The same applies to a patient seeking services for drug addiction problems. A GP told us “We deliver 90% of the care to people with drug related problems”.²⁰⁵ As the number of intravenous drug users increases, a greater number of general practitioners are having to deal with the problem. Dr Wilson told us:

“At the minute no one refuses to see them but I would say that there would be a majority of general practitioners who prefer not to see them and would prefer that someone else saw them. They feel that this really is not part of what they see as a family doctor service”.²⁰⁶

178. While many may be reluctant to mix drug treatment services with a family medical service, a few individuals identified a gradual change in perception of drug users and their needs. Dr Magowan, a GP in Ballymena, explained that for most of his career he had not seen any intravenous drug users, but that the number had exploded in the last few years. He said:

“I think we have swung from not wanting to see a single heroin addict through our doors to realising that these are individuals, patients with their own rights and needs and general medical service requirements as well as their drug problem requirements, and they are entitled to proper treatment in general practice the same as every other patient is”.²⁰⁷

203 HC 1217-II QQ477-478

204 HC 353-II Q337

205 HC 353-II Q280

206 HC 353-II Q299

207 HC 353-II Q282

179. The suggestion of a GP practice specialising in dealing with intravenous drug users and providing medical and counselling services in a one-stop shop, as happens in some other parts of the UK, was not considered by the GPs to be practical at present in the context of a relatively small drug-using community.²⁰⁸ Dr Magowan stated that he believed the best place for looking after drug misuse is through the family doctor service.²⁰⁹

180. During our visit to the Railway Street Centre in Ballymena the Homefirst Trust explained how the three units run by the Trust (Railway Street Addiction Service; Community Addiction Service; and Holywell In-patient Addiction Service) form part of a single service and how, for a time, a medical service had been provided from Railway Street by a Senior Clinical Medical Officer from the in-patient unit. That type of one-stop shop had worked well but unfortunately the doctor has now moved on and the Trust is trying to recruit a replacement. We welcome and support this type of development.

181. **We commend the work of community and outreach workers who provide a vital service to people with drug addiction problems at grass roots level, many of whom may not otherwise be in contact with any services.** These workers, by virtue of their direct contact with drug users, are sometimes forced to respond to problems in the absence of an official position. For example, they were the first to provide clean needles before the introduction of an official needle exchange scheme (see paragraph 183 below). Those who gave evidence told us of their difficulties and frustrations in striking a balance between trying to build trust with drug users and often reporting back through a hierarchy.²¹⁰

Needle exchange schemes

182. A limited needle and syringe exchange scheme was established by DHSSPS in the period up to March 2002. It was based in eight community pharmacies throughout Northern Ireland: three of these were sited in the Eastern Board, two in the Northern Board, two in the Western Board and one in the Southern Board. The aim of the scheme is to discourage the sharing of needles by injecting drug users and to help prevent the spread of blood-borne viral infections such as Hepatitis B and C and HIV.

183. Prior to the introduction of the needle exchange schemes we were told that injecting drug users in Ballymena drove to Dublin to pick up needles from a voluntary drug treatment centre there. Later, needles donated free by the gay community in Australia were distributed by a youth worker from the back of his car.²¹¹

184. Official figures would suggest that the scheme has been relatively successful so far in encouraging the exchange of needles, with over 5,200 visits in the first year going up to 6,000 in the second year.²¹² Pharmacists, however, were cautious about claiming that there is yet any

208 HC 353-II QQ300-302

209 HC 353-II Q301

210 HC 353-II QQ179-188

211 HC 353-II QQ227, 217

212 HC 353-II Ev 121; Q438

evidence that it is discouraging high-risk behaviour amongst injecting drug users. They did point out that

“...the introduction of the scheme has certainly proved popular. It has been introduced very smoothly, it is well liked by users and it has attracted relatively little public criticism. From the evidence available and the literature, it should produce a number of benefits both to the clients using the service and to the local community”.²¹³

185. While the introduction of the scheme was generally welcomed, serious concern was expressed to us about the lack of privacy for those availing themselves of it. A major concern was the existence of CCTV in close proximity to needle exchanges, which deterred many individuals from using these services.²¹⁴ We were told of CCTV cameras pointing at the pharmacy buildings in Ballymena and Bangor and about camera surveillance within the main needle exchange scheme in central Belfast. **Although we appreciate the need for security, particularly in view of the prevalence of attacks on pharmacies, a balance needs to be found between the need for measures to deter attacks and the need to provide a discreet and confidential environment for needle exchange.**

186. Inside the pharmacies it seems that little or no privacy is provided in some instances and someone wanting to access needles may have to stand in line with other customers. **In Ballymena we were shocked to learn that individuals seeking to conduct needle exchange transactions in private had to resort to hiding behind the pharmacy sunglasses rack.**²¹⁵ The Minister, Angela Smith MP, agreed that this was unacceptable and told us that “Pharmacies were given £5,000 per pharmacy to make arrangements for people to exchange needles. Most could do better than erecting sunglasses stands to protect people.”²¹⁶ Pharmacists pointed out that they are dealing with buildings that were not purpose built to include a confidential area but that they are using the funding provided by DHSSPS to enhance their premises and provide an area to counsel people or provide a needle exchange.

187. We were told that there is evidence that people as young as 15 or 16 years old can become involved in injecting behaviour and a major aim of the needle exchange must be to prevent them contacting blood-borne viruses. Des Flanagan said:

“With regard to the access to needle exchange there is an issue about when people start to engage in high risk behaviours, particularly when it comes to injecting, we have a responsibility to try and offer them treatment that appropriately meets their needs at an early stage and prevents them at such a young age engaging in high risk behaviours that may lead to them contracting blood-borne viruses and so on. ... when we start to see

213 HC 1217-II Q437

214 HC 353-II Ev 47; QQ217, 219-229

215 HC 353-II QQ223-224

216 HC 1217-II Q582

these young people in five or six years' time and they have Hepatitis C or HIV I think we will have let them down."²¹⁷

188. Mr Flanagan also stated that a further group who have difficulty using the present needle exchange schemes, because of the lack of confidentiality, are individuals within the Ballymena area who may be under threat from paramilitary elements and who tell the paramilitaries that they are no longer injecting heroin.²¹⁸ The Chief Medical Officer acknowledged that there was anecdotal evidence that some people are being intimidated from going into pharmacies to get needles.²¹⁹ We were very concerned to learn from Nicky Kwok, who works mostly with intravenous drug users, many of whom have already contracted viruses, that the majority of them would not use the scheme in Belfast.²²⁰

189. The Chief Medical Officer accepted that the issue of providing needle exchange in locations other than pharmacies needs to be looked at and we welcome her indication that users will be consulted about this process. She also rightly pointed out that "Northern Ireland is still not a safe environment in some of the places where these drug users live" and that the issue of safety as well as access needs to be considered.²²¹

190. The Minister, Angela Smith MP, acknowledged the difficulties with the scheme and indicated that it was still under development. She said:

"One of the things to look at is the consideration of portable back-pack needle and syringe exchanges. They can be used with outreach workers. ... I am not going to give you a commitment that we are going to increase or change the outlets but it is under review. We are still developing the strategy on this but I would not want to mislead you and say yes, that is definitely going to lead to a change in strategy. I do think the issue of portable back-pack needle and syringe exchanges for outreach workers could be particularly significant and that might be a better route than having different outlets".²²²

191. The development of a comprehensive and effective exchange scheme for needles and other paraphernalia is a crucial element in discouraging a culture of sharing among drug users, particularly very young users, and thereby helping to reduce the level of Hepatitis C and other blood-borne viruses in the community. We urge the Minister in her review of the current needle exchange service to ensure that it is made as accessible as possible to all injecting drug users and that it is provided in a discreet and confidential environment. The scheme must not be limited to community pharmacies and the aim must be to discourage high-risk behaviour amongst injecting drug users and provide a gateway to other support and treatment services.

217 HC 353-II Q217

218 HC 353-II Q222

219 HC 1217-II Q502

220 HC 353-II Q227

221 HC 1217-II QQ498-499

222 HC 1217-II QQ579, 581

Drug paraphernalia

192. As we note above, injecting drug users make use of a range of paraphernalia including not only syringes and hypodermic needles but also water ampoules, swabs, spoons, bowls, citric acid, filters and tourniquets. The sharing of such items can also be linked to the spread of blood-borne viruses. The DHSSPS Drug Misuse Database records that:

“Information about the sharing of drug paraphernalia is known for 1334 people. Of these, just over one-tenth (11%) reported sharing equipment. Men (12% of whom had shared) were much more likely to have shared equipment than women (7%). Sharing was much more common in the Northern Board area (37% reported sharing) than in other Board areas (eg. Western Board, 11%). This strongly suggests that the equipment being shared was injecting equipment, given the higher rates of injecting in the Northern Board area.”²²³

193. Under Section 9A of the Misuse of Drugs Act 1971 it was until recently an offence to supply any item, except a syringe or needle, where the supplier believed it might be used in the administration of unlawful drugs. The purpose of this provision, which applied throughout the United Kingdom, was:

“to outlaw the supply of cocaine kits (containing articles for facilitating drug use such as razor blades, foil and lemon juice) that were being marketed in the mid 1980s. An exception was made for sterile syringes and needles to permit the supply of clean injecting equipment to drug users in order to reduce the sharing of injecting equipment and prevent the spread of blood borne viruses”.²²⁴

194. This restriction had caused difficulties for outreach workers and others involved in promoting harm reduction,²²⁵ and had put pharmacists in a difficult position. Some pharmacists and others supplied articles of paraphernalia and the Director of Public Prosecutions has taken the view that prosecution would not be in the public interest. We are pleased to note that this anomaly has now been removed with effect from 1 August 2003. The relevant legislation has been changed to enable the supply of items of paraphernalia with the exception of tourniquets.

Hepatitis C strategy

195. The absence of an overall Hepatitis C strategy has been highlighted to us as a serious cause for concern and something which is hampering community and outreach workers in giving advice to clients.

196. It was suggested to us in March 2003 that this strategy had been ‘sitting on the shelf’ for some time: it had been due for release some 10 months earlier but there had been a delay in

223 Statistics from the Northern Ireland Drug Misuse Database: 1 April 2002 – 31 March 2003, DHSSPS October 2003

224 HC 1217-II Ev 72

225 HC 353-II Q273

releasing it.²²⁶ However, when we questioned the Chief Medical Officer about this in June 2003, it transpired that, rather than being ready for release, work on the development of a strategy had only commenced a month earlier and was due to finish in the autumn.²²⁷ When asked about the reason for the delay the Chief Medical Officer told us:

“We have been curtailed a little bit because the same people who are working on that have had to turn their attention to chemical, biological, radiological and nuclear warfare, and also to look at SARS. So we have only a small number of experts in that area in Northern Ireland and they have been somewhat diverted by other issues over recent months.”²²⁸

The Minister, Angela Smith MP, also blamed the SARS outbreak for the delay, saying that “the main doctor dealing with the Hepatitis C strategy had been taken off to deal with SARS”.²²⁹

197. The possible presence already of a Hepatitis C epidemic in Northern Ireland (discussed in paragraph 76 above) highlights the pressing need for a strategy. **It would appear that the Hepatitis C strategy had been planned for issue by early summer 2002 and we are concerned that the spread of the SARS virus, which did not appear until early 2003, may be used as an excuse for a lack of action. We urge the Minister to explore more fully the reasons for the unacceptable delay in developing the strategy and to take steps to ensure that it is produced and implemented as a matter of urgency.**

Substitute prescribing

198. Substitute prescribing is defined as ‘the deliberate prescribing of drugs in a controlled manner in order to reduce the use of illicit drugs or to reduce the harm associated with illicit drug use’.²³⁰

199. One of the major concerns expressed to us in both written and oral evidence by a wide range of organisations was the absence of any formal substitute prescribing programme in Northern Ireland. The UK Harm Reduction Alliance stated:

“There is overwhelming evidence that good quality, accessible treatment with methadone is an effective measure that helps both opiate users and the wider society. It is rarely available in Northern Ireland and often inadequate where it is available. The evidence strongly suggest that oral methadone maintenance attracts opiate dependent people into treatment and helps to improve their health, not least by helping them to avoid or lessen risks of overdose and the contraction of blood-borne viral infections ... It

226 HC 353-II Q271

227 HC 1217-II QQ483-484

228 HC 1217-II Q484

229 HC 1217-II Q574

230 *Review of Research on Substitute Prescribing for Opiate Dependence and Implications for Northern Ireland*, K McElrath, Queen’s University of Belfast, January 2003

reduces the consumption of illicit drugs ... and improves social skills and functioning.”

231

200. During a visit to Holywell Hospital Dr Billy Gregg, Consultant Psychiatrist, told us that, despite the high incidence of heroin use in the Northern Board area, substitute prescribing was only available on a limited basis. It was estimated that there were around 800 injecting drug users in Northern Ireland with 450 of them in Ballymena. In the Northern Board 86% of those presenting for treatment were injecting heroin compared to 13% in the rest of Northern Ireland. As a consequence there was also a higher incidence of needle sharing and it was recognised that for a large number of those injecting, abstinence was not a realistic goal.

201. In 1999, guidelines for formal substitute prescribing programmes known as the ‘Orange Book’ were published by UK Health Departments. No formal programme was introduced in Northern Ireland, because of:

- the relatively low level of heroin misuse compared to other regions in the UK;
- concerns of clinicians over the risks associated with methadone; and
- resistance to substitute prescribing by the wider medical profession.²³²

However, individual doctors could prescribe heroin substitutes.

202. Almost all the consultant psychiatrists and the GPs that we met supported the introduction of substitute prescribing.²³³ Dr MacFarlane, a consultant psychiatrist in the Eastern Board, explained that he had been using substitute prescribing for about three years and he had about three dozen patients on some form of substitute medication. Dr Connolly, a consultant psychiatrist in the Western Board, had been undertaking substitute prescribing for a small number of patients for about a year. Pharmacists told us of their experience of the current *ad hoc* arrangements and their desire to see the introduction of a structured scheme operating on an equitable basis.²³⁴

203. Dr Magowan expressed the frustration of GPs who had joined the Treatment Working Group and were not even allowed to discuss substitute prescribing or to set up a substitute prescribing sub-committee.²³⁵

204. Dr Cassidy, who has concerns about the introduction of substitute prescribing, defended the prevailing policy:

“I think we have to keep in mind that Northern Ireland is unique because of its low prevalence and that these guidelines and principles that apply elsewhere do not apply in

231 HC 353-II Ev 46-47

232 HC 1217-II Q477

233 HC 353-II QQ279-283

234 HC 1217-II QQ460-463

235 HC 353-II Ev 75; Q345

the same way in Northern Ireland because of the unique situation. We are a long way off the justification that they had in England, Glasgow, Dublin and the Netherlands when they made a policy change.”²³⁶

205. The intention to introduce a formal substitute prescribing programme was announced on 25 February 2003 when DHSSPS published a review report on the use of substitute prescribing for heroin dependence. The Department endorsed the central recommendation in that report, which was that it should support the use of methadone as a maintenance treatment for people dependent on heroin, where this is an appropriate treatment option. The Department also indicated its intention to establish an Implementation Group “to oversee the development of structures to support those practitioners dealing with clients for whom substitute therapy is appropriate”.

206. The Implementation Group has been set up²³⁷ but it is evident that it will take some time for it to complete its job and get the necessary structures and resources in place and arrange appropriate training for those involved in prescribing and dispensing. We were told that the issue of substitute prescribing had been considered by the Northern Ireland Council for Drug Misuse in 2000 and again in early 2001 when the advice was to seek research evidence before proceeding.²³⁸ This eventually led to a research report on the prevalence of heroin use in Northern Ireland which was published in March 2002, and a review of research on substitute prescribing which was published in February 2003.²³⁹

207. The Chief Medical Officer in her evidence to us admitted that DHSSPS was “not as far forward as it should be” and blamed a combination of factors, including a shortage of resources, for the delay in putting a service in place.²⁴⁰

208. Northern Ireland has been in the unique position of having advance warning of an impending injecting drug problem. The explosion of heroin users in cities in Great Britain and in Dublin with its consequent problems was there for all to see and it was recognised that sooner or later it would reach Northern Ireland. **While substitute prescribing is not an appropriate form of treatment for every injecting drug user we were very concerned to find that action has not been taken much earlier to plan and introduce this service. We urge the Minister to ensure that an equitable and structured substitute prescribing scheme, with appropriate training, as well as financial and other resources, is put in place across Northern Ireland as a matter of urgency for all appropriate clients.**

236 HC 353-II Q284

237 HC 1217-II Q478

238 HC 1217-II Q479

239 *The prevalence of heroin use in Northern Ireland*, Karen McElrath, Queen's University Belfast, March 2002; *Review of Research on Substitute Prescribing for Opiate Dependence and Implications for Northern Ireland*, K McElrath, Queen's University of Belfast, February 2003

240 HC 1217-II QQ477-481

In-patient treatment

209. In-patient treatment for addictions is provided at six statutory units across Northern Ireland and residential treatment is also available in non-statutory units in Northlands, Londonderry and Carlisle House, Belfast.²⁴¹ These facilities provide for both alcohol and drug addiction. Dr Cassidy outlined the staffing levels and pointed out to us that these services:

“were predominantly developed to treat alcohol addiction and there would be a lack of development of specialist staff to deal with drug problems in the Province overall. It is perhaps worse in some areas than in others in terms of provision, but overall drug treatment services did not develop in Northern Ireland as they did in England and Scotland with the advent of the high prevalence of heroin use and HIV/AIDS, etc.”²⁴²

210. Dr Connolly pointed out that staff numbers available to treat alcohol addiction had remained unchanged for well over 10 years. He expressed concern about growing waiting lists for assessment and treatment for alcohol dependence.²⁴³ The outreach workers expressed similar concerns about bed numbers and waiting lists for those seeking treatment for drug addiction problems. It was claimed that despite a 7% annual increase in referrals to Downshire Hospital the number of beds there had not increased since 1982.²⁴⁴

211. The dedicated in-patient unit at Holywell Hospital, which opened in 2001, has 10 beds but several of them are used for alcohol problems rather than drug related problems. DHSSPS pointed to pressure on resources and the relative merits of providing in-patient services versus services in the community as relevant factors. The Minister, Angela Smith MP, referred to the services at Holywell Hospital and indicated that the waiting time was around two weeks.²⁴⁵ **We are concerned at the absence of a comprehensive range of drug treatment services in Northern Ireland. We have drawn attention to deficiencies in a number of specific areas elsewhere in this report. We urge the Minister to ensure that a proper balance of in-patient and community services, with appropriately trained specialist staff, is developed as a matter of urgency.**

Drug-free therapeutic communities and drug rehabilitation centres.

212. We heard many calls for the provision of a drug-free therapeutic community or drug rehabilitation centre in Northern Ireland.²⁴⁶ A drug-free therapeutic community provides residential treatment through a mixture of therapy and self-help over a lengthy period of time.

241 HC 1217-II Ev 87

242 HC 353-II Q335

243 HC 353-II Q335

244 HC 353-II Q248

245 HC 1217-II QQ507, 584

246 Those calling for such a centre included consultant psychiatrists, outreach workers, community support groups in Ballymena, Dr Paisley MP MEP, NIACRO, and the Probation Board Northern Ireland

A number of these have existed for some time throughout Great Britain and the Republic of Ireland.²⁴⁷

213. Dr Cassidy explained that:

“Residential services, as well as addressing the medical issues and pharmacological issues, address the psychological, mental health, occupational, social and lifestyle issues that many addicts have, and that is very much a longer term process, a process that treatment services alone have great difficulty in managing.”²⁴⁸

NIACRO told us that the “availability of a therapeutic environment, access to ‘time out’ from chaotic offending lifestyles and opportunities for personal development are all required for successful intervention”,²⁴⁹ while the Probation Board believed that “in specific high risk cases, this could be a useful provision which might be established in the Province or made available through agreements with existing projects in other jurisdictions”.²⁵⁰

214. In the absence of a centre in Northern Ireland we were told that statutory community addiction teams refer clients to the Republic of Ireland for treatment ‘where necessary’ and Mark Gordon said “we have referred numerous people over the years to services in Glasgow, London and in the Republic”.²⁵¹ DHSSPS acknowledged that this was happening but said that it had no way of knowing how many people were travelling outside Northern Ireland for this type of service.²⁵²

215. Neither was the provision of a centre seen as a priority by the Department. The Chief Medical Officer said:

“like everything else, it would be a nice thing if we had it. There are many priorities particularly in the drugs area and if you asked me would that be a top priority I would not see it as such at the moment. If the evidence, however, shows us that having an establishment ... would be useful, then we would certainly try to put it on the agenda and try to find the money for it”²⁵³

216. The numbers for whom this type of treatment is suitable are likely to be small but the effectiveness of longer-term rehabilitation is widely accepted. Dr Connolly told us that it would be only a minority of people who would take up an offer of long-term rehabilitation, but

247 An example of this is Coolmine Therapeutic Community in Dublin which has been in operation for 30 years. “The residential treatment programme is a mixture of therapy and self-help engendered through community living. It is divided into two phases. In the first, which lasts nine months, participants are resident in the Coolmine community. The second phase, which lasts four months, is a living-in-and-working-out-phase: participants live in the Coolmine residence, but are allowed to look for work in the wider community.” *Marking 30 years of fight against addiction*, Irish Times, 23 June 2003

248 HC 353-II Q329

249 HC 353-II Ev 135

250 HC 353-II Ev 137

251 HC 353-II QQ246-247

252 HC 1217-II Q505

253 HC 1217-II Q504

“for that minority not only do I believe it would be useful, but there is evidence that that form of rehabilitation—and we are talking about six to 12 months away—is effective, so I would support it.”²⁵⁴

217. The Minister, Angela Smith MP, in her evidence to us gave the first indication that consideration is being given to the provision of such a facility. She said that officials were currently planning a needs assessment for a rehabilitation facility, which she hoped would be completed by March 2004.²⁵⁵

218. The effectiveness of a residential rehabilitation centre or therapeutic community in helping clients confront drug addiction problems is well established and there are clearly a number of people in Northern Ireland who can benefit from this treatment. The Minister should undertake urgent research to establish the level of need and to make appropriate arrangements for the provision of this service.

Services for women and children

219. In providing services for people with drug addiction problems the specific needs of particular groups, such as women and young people under 18 years of age, were raised with us. There appears to be an image of the typical addict as a single white male heroin user and we were told that drug services traditionally in Northern Ireland have not been geared up for women who are experiencing problems with drugs.²⁵⁶ Mark Gordon told us that “if services are inadequate for males they are more so for females”²⁵⁷

220. Des Flanagan told us: “There are more consequences for women when they do access treatment and it is more likely that other services, such as children’s services and statutory social work services, will become involved.”²⁵⁸ He told us that both the numbers of females accessing drug services and the caseload of social workers with children of female drug users were increasing. Karen McElrath, in her report on substitute prescribing, drew attention to research conducted elsewhere which “suggested that problems with childcare may represent a significant barrier to treatment entry, among women in particular”²⁵⁹.

221. Des Flanagan also told us: “There is no established medical service for people under the age of 18 that specifically deals with substance misuse and young people”²⁶⁰ DHSSPS told us about the appointment of youth counsellors in each of the community addiction teams²⁶¹ and

254 HC 353–II Q326

255 HC 1217–II Q584

256 HC 353–II Q213

257 HC 353–II Q214

258 HC 353–II Q213

259 *Review of Research on Substitute Prescribing for Opiate Dependence and Implications for Northern Ireland*, K McElrath, Queen’s University of Belfast, February 2003

260 HC 353–II Q217

261 HC 1217–II Q510

we heard at first hand from some of those counsellors about their work during our visit to Ballymena in April 2003.

222. The Minister, Angela Smith MP, told us that while she had concerns about the need to get services right for both women and young people, “we also have to be mindful that female injecting users in particular are a very small number of those presenting for treatment and services are prioritised in accordance to need and available resources.” However, she did accept that “If mothers present for treatment they need assistance and care for their children”.²⁶²

223. We note and encourage the research currently planned by DHSSPS into the service needs of young vulnerable groups. The Minister should ensure that the specific needs of women, and young people under 18 years, with drug addiction problems are addressed in her evaluation of the drug strategy. In particular, childcare facilities need to be available to enable parents with drug addiction problems to access services.

Education and prevention

224. One of the central aims of the Government Strategy is “to protect young people from the harm resulting from illicit drug use”.²⁶³ The growing drug culture in Northern Ireland makes it more critical than ever that drugs education and awareness programmes, particularly in schools, are geared to meet this challenge. We welcome the emphasis put on this area in the Strategy though the establishment of the Education and Prevention Working Group, with the Department of Education in the lead. We commend, in particular, the wide and diverse range of organisations and interests involved in the Working group. An excellent example of this is the recognition by PSNI that enforcement alone will not solve the problem and the appointment by the Drug Squad of an Education Officer to deliver drug awareness presentations and training to interested parties.²⁶⁴

225. The current “Misuse of Drugs: Guidance for Schools” document was produced and issued by the Department of Education in 1996 and, as we have indicated elsewhere in this report, the nature of the drugs trade and drugs culture in Northern Ireland has shifted considerably since then. However, we are pleased to note that the guidance is being revised and updated and should be issued to schools shortly.²⁶⁵

226. The importance of having preventative education programmes on drugs that are appropriate to the age, experience and development of the young people cannot be over emphasised. Young people themselves have recognised that the drugs education programme needs to start even earlier. A recurring conclusion of the inter-school ‘Drugs and Development

262 HC 1217-II Q587

263 NI Drugs Strategy 1999

264 HC 353-II Ev 35

265 HC 1217-II Ev 71

Youth Parliaments', since their inception in 1997, has been that drugs education should start at primary school level.²⁶⁶

227. It is a statutory requirement for schools to provide drugs education for all pupils during their period of compulsory schooling, i.e. from 4 years of age to 16²⁶⁷ and we recognise that in primary schools this is provided to some extent under the Health Education cross-curricular theme. **We urge the Minister to consider what more can be done to make drug education and prevention programmes a higher priority within primary schools in view of the younger age at which children are experimenting with solvents and illegal drugs.**

228. The increasing prevalence of drugs particularly in post-primary schools was brought to our attention by Mark Gordon²⁶⁸ while the South Eastern Education and Library Board raised concerns about the increasing number of young people who are being expelled from school for experimenting with drugs.²⁶⁹ The Board highlighted the difficulty in providing drugs education programmes for young people who are already using drugs and also the absence of a consistent regional approach on the question of expulsion. The Department of Education has stated:

“While [this issue] is still under review, it is likely that the revised guidance will recommend that schools should develop a repertoire of responses, incorporating both sanctions and counselling, reflecting the different kinds of drug-related offences, such as possession of an illegal drug, individual use and selling or sharing drugs with other pupils.”²⁷⁰

We urge the Minister to consider how a more comprehensive response can be developed to the issue of young people in schools who become involved in drug use. We believe that it should not be a matter for schools alone to provide sanctions or counselling. The provision of appropriate support services at this stage could help to prevent more severe drug addiction problems later.

Conclusion

229. In the introduction to our report, we noted that **this Committee warned of the growth of Northern Ireland’s drug culture eight years ago. While a great deal has been achieved since in the collaborative development of an overarching anti-drugs strategy, as yet the actual provision of resources and facilities for those working on the front line in enforcement, prevention, treatment and rehabilitation has been too slow.**

230. **Although we commend the commitment, ingenuity and hard work of many—including community and voluntary workers, health practitioners, police, customs and prison officers—in tackling the problems associated with the drugs trade, we also believe**

266 HC 1217–II Ev 76

267 HC 1217–II Ev 71

268 HC 353–II QQ190; 202–205

269 HC 1217–II Ev 78

270 HC 1217–II Ev 78

that it is necessary to impress upon officials once again the importance of getting the strategy right, in practice as well as in theory. The drug traffickers will not wait for these facilities to be put in place before they increase the availability of cocaine, crack and heroin: indeed, it seems they are already doing so. There is an urgent need for the Government to be pro-active in minimising the risk to individuals and communities, whether by increased activity against drug traffickers, or by protecting communities from drug-related crime, and individual drug users from the threat of blood-borne viruses.

231. Probably the single most important lesson we learned from our visits to other jurisdictions was the importance of having facilities in place before the problem of drug use reaches critical mass. If that does not happen the suffering of individuals, families and communities will be great, and the task for Government in picking up the pieces will be far harder (and more expensive) than a pre-emptive strategy of the type we advocate. One of our witnesses suggested to us that Northern Ireland has three years to get its drugs strategy right.²⁷¹ This warning must be taken seriously.

Conclusions and recommendations

1. In view of the apparent rise in the availability and consumption of cocaine and crack cocaine, data on seizures and the use of cocaine and crack cocaine should be recorded separately, so that trends in the use of each drug may be assessed more accurately. (Paragraph 50)
2. During visits to police and Customs offices we have been shown an astonishing variety of drug concealments—all of which had been detected by officers through a mixture of intelligence, persistence, and intuition. Their continuing success in often difficult circumstances is very much to their, and to the authorities', credit. (Paragraph 63)
3. We have heard fears that organised criminals will use the profits from the trade in ecstasy and cannabis to develop a market in Northern Ireland for more highly addictive and damaging drugs such as heroin and crack cocaine. This must not be allowed to happen. (Paragraph 70)
4. We have been concerned at certain discrepancies of perception as to the availability of drugs which we have identified between the views of officials in the Northern Ireland Office and those of workers in community or health services who are in closer contact with the drug-using community. (Paragraph 71)
5. A government relying on historical data could find itself massively unprepared to deal with the problems which follow in the wake of drug use, whether increased crime or rapidly spreading infection with HIV and Hepatitis B and C. We urge the Government to review the role and weighting given to historical data in the development and implementation of Northern Ireland's drugs policy. (Paragraph 72)
6. We have also discussed other issues in relation to the supply of illegal drugs which it would be inappropriate to place in the public domain. We intend to write directly to the Minister, Jane Kennedy MP, with recommendations on these issues. We shall expect the Northern Ireland Office to consider them and respond as if they had formed part of this Report. (Paragraph 73)
7. The need for further information on the links between drugs and crime is recognised, and we welcome the proposal by the Northern Ireland Office and the DHSSPS Drug and Alcohol Information and Research Unit to carry out research in this area. (Paragraph 82)
8. Further research is needed into the extent of links between acquisitive crime and chronic use of cannabis or other 'recreational' drugs. (Paragraph 83)
9. We are pleased to note that the introduction of time-delay safes in almost all community pharmacies, with funding provided by DHSSPS and NIO, has been very successful in stemming the spate of attacks on pharmacies. (Paragraph 89)

10. Further research should be carried out to determine the extent of misuse of prescription drugs in Northern Ireland, and the measures needed to address the problem. (Paragraph 91)
11. We welcome the proposal outlined in the Government's response to our interim report on cannabis, to give the PSNI new powers to undertake tests of impairment on motorists suspected of committing driving offences while under the influence of drugs. (Paragraph 92)
12. We support the suggestion that a great deal more could still be done through utilising the expertise and experience of pharmacists, to educate and promote awareness of various drugs issues in the community. (Paragraph 104)
13. DHSSPS contended that the involvement of community and voluntary representatives on the various working groups and sub-groups constituted user representation. While these groups may, for example, provide support, counselling or other services, it is clear that drug users themselves do not have a direct input to the planning of services. (Paragraph 106)
14. The Minister, Angela Smith MP, acknowledged that it was unacceptable for the post of NDACT co-ordinator to have remained vacant for so long, and blamed bureaucracy and confusion over who employs co-ordinators for the delay. This situation must not be allowed to happen again. (Paragraph 107)
15. The regional Drug and Alcohol Strategy Co-ordinator post is central to providing drive and momentum to the strategy, as well as to ensuring its smooth running. We are pleased to learn that a new co-ordinator has now been appointed. (Paragraph 108)
16. When we met a group of community and voluntary sector representatives they expressed concern that the absence of a devolved Assembly could make it more difficult for them to fulfil their role and to have access to Ministers. The Minister, Angela Smith MP, told us that a Whitehall Minister with responsibility for several Departments will not have as much time available as a local Minister, but that she was nonetheless committed to engaging fully with the voluntary sector. We welcome this assurance. (Paragraph 109)
17. The Steering Group needs to look at ways to ensure that committed people at grass roots level can feel included in the implementation of the drugs strategy and their contribution valued. (Paragraph 110)
18. A thorough evaluation of the drug and alcohol strategy would provide valuable information on how effective it has been to date in achieving its objectives as well as pointing to any changes necessary in planning for the future. We welcome the planned evaluation and urge the Minister to ensure that it is thorough and independent and takes place without further delay. (Paragraph 111)

19. We welcome the very positive approach to joint working shown by the enforcement agencies in both Northern Ireland and the Republic of Ireland. We support the proposal of a joint cross-border threat assessment, and would encourage the Government to consider how information exchanges between the jurisdictions might be improved, so that available intelligence can be exploited to the full. (Paragraph 117)
20. We remain concerned that the Government is underestimating the impact cannabis reclassification may have upon enforcement activity along the routes of supply into Northern Ireland. Although the PSNI have experienced major successes in targeting the cannabis trade, they will continue to need support from external agencies in blocking this source of income for Northern Ireland's organised criminals and paramilitaries. We urge the Government to monitor the situation very carefully in the months following reclassification. (Paragraph 120)
21. The tension which can arise where requests for assistance fall outside, or run counter to, an organisation's priorities could be resolved if co-operation was itself made an objective for the major enforcement agencies. We recommend that the Government explore this proposal with the members of the Organised Crime Task Force, and other relevant organisations. (Paragraph 121)
22. Any steps which can be taken to release skilled police officers for front line policing are welcome. Acknowledging the potential value of more effective enforcement, we believe that the Drugs Squad is a suitable candidate for additional human resources. (Paragraph 122)
23. We have been reminded repeatedly that Customs' primary role is to safeguard the revenue and interests of HM Treasury. We urge the Treasury therefore to consider the benefits which would accrue from enhancing and expanding the technology available to HMCE to assist in the detection of concealed and illicit shipments. (Paragraph 123)
24. We welcome the effectiveness of the assets recovery powers provided by the Proceeds of Crime Act 2002 and we commend the energy and commitment demonstrated by the staff of the new Assets Recovery Agency in its first months of operation. (Paragraph 125)
25. The Assets Recovery Agency should be a crucial, and powerful, tool in the Government's efforts to disrupt and dismantle organised crime in Northern Ireland. Its early progress has the potential to make or break its reputation as an authority to be feared by the criminal fraternity. We urge the Government to continue in dialogue with the Agency and to consider very carefully any further requests for resources—whether for trained staff, additional or amended powers, or other provision—which would support the Agency's work. (Paragraph 127)
26. Continued community support for the assets recovery process can best be secured if the community sees actual benefit from it. Yet under the changes announced by the Home Office to the distribution of recovered assets, Northern Ireland's enforcement agencies will see only a limited return for their efforts, and Northern Ireland's communities

nothing at all. The Home Office previously acted in good faith by establishing an Assistant Directorship for the Assets Recovery Agency in Northern Ireland, and we welcomed that move. But by restricting Northern Ireland's access to the recovered assets in the new funds it is failing to follow through the assets recovery process to its logical end—converting criminal gains into positive outcomes for Northern Ireland's communities. Many of these communities are in real need and would, by such action, see some point in joining the fight against organised crime. This action by the Home Office is therefore unacceptable and directly counter-productive. There is too much at stake in terms of restoring a stable society and economy, and rooting out serious and organised criminality in Northern Ireland. The Minister must take steps as a matter of urgency to ensure that the assets recovery process in Northern Ireland is not compromised by the Home Office's decision, and that Northern Ireland has the same rights to access recovered assets as England and Wales. (Paragraphs 131–133)

27. Port authorities are private companies and are not in this respect subject to Government control. Nonetheless it would be in their interests, as well as the Government's, to resolve any difficulty which damages co-operation on security-related matters. One alternative to the existing case-by-case freight detention charges might be for the port authority to spread the total annual cost of freight detention across all port users as a minimal standing charge. We urge the Minister to discuss solutions to the problem with the port authorities as soon as possible. (Paragraph 137)
28. We welcome the success of the experimental Drug Arrest Referral Schemes established in Northern Ireland, and hope this approach will be consolidated and extended to other areas with significant drug-using communities, such as South Belfast. The potential benefit of extending the remit of such schemes to include those arrested for alcohol-related offences should also be explored. (Paragraph 145)
29. We are very concerned that the DARS scheme and, as we understand it, a number of others may be put in jeopardy through a lack of financial commitment. We urge the Minister to provide stable funding for DARS and to make decisions on any other outstanding projects as quickly as possible. (Paragraph 146)
30. We believe that investment in the resources necessary to extend the existing supervised licence scheme to sentences of 12 months or more would provide value for money by reducing the risk of ex-prisoners relapsing into problem drug or alcohol misuse, with its health risks and social costs. The Government should discuss the feasibility of the proposal with the prison and probation services, with a view to implementing an extension at the earliest opportunity. (Paragraph 160)
31. All of the evidence indicates that tremendous progress has been made in encouraging and enabling organisations from different sectors to work together. But if organisations are, or believe themselves to be, unable to act consistently in the interests of the client there is still work to be done. The Minister should work with the statutory sector and voluntary agencies to develop protocols or other mechanisms enabling action in cases where statutory responsibility is divided between different services. (Paragraph 162)

32. We can see benefits in making available to Northern Ireland provisions which would, as in England and Wales, make the granting of bail exceptional in serious cases including murder, attempted murder and rape. We would like to see drug trafficking added to the list of cases covered by this provision. Similarly, we can see the potential value in Northern Ireland of provisions which would require the court to give reasons for granting bail when representations have been made against it. The Government should consider these suggestions as part of a full consultation on the operation of bail in Northern Ireland, with a view to making further statutory provision at an early stage. (Paragraph 166)
33. We believe that both the options of a drug court and a drug-briefing programme for magistrates merit further exploration, jointly by the Northern Ireland Office and the departments of the Northern Ireland Executive. (Paragraph 171)
34. We believe that there would be advantages in making Drug Treatment and Testing Orders available as an option for use in Northern Ireland. The Government should take whatever further steps are necessary to activate Article 8 of the Criminal Justice Order 1998, and to agree the necessary protocols with the court service and other agencies. (Paragraph 172)
35. In developing protocols for the use of DTTOs in Northern Ireland, the Government should design a range of sanctions for lapses in compliance which enable the difficulty faced by the offender in meeting the order's demands to be taken into account. (Paragraph 173)
36. We commend the work of community and outreach workers who provide a vital service to people with drug addiction problems at grass roots level, many of whom may not otherwise be in contact with any services. (Paragraph 181)
37. Although we appreciate the need for security, particularly in view of the prevalence of attacks on pharmacies, a balance needs to be found between the need for measures to deter attacks and the need to provide a discreet and confidential environment for needle exchange. (Paragraph 185)
38. In Ballymena we were shocked to learn that individuals seeking to conduct needle exchange transactions in private had to resort to hiding behind the pharmacy sunglasses rack. (Paragraph 186)
39. The development of a comprehensive and effective exchange scheme for needles and other paraphernalia is a crucial element in discouraging a culture of sharing among drug users, particularly very young users, and thereby helping to reduce the level of Hepatitis C and other blood-borne viruses in the community. We urge the Minister in her review of the current needle exchange service to ensure that it is made as accessible as possible to all injecting drug users and that it is provided in a discreet and confidential environment. The scheme must not be limited to community pharmacies and the aim

must be to discourage high-risk behaviour amongst injecting drug users and provide a gateway to other support and treatment services. (Paragraph 191)

40. It would appear that the Hepatitis C strategy had been planned for issue by early summer 2002 and we are concerned that the spread of the SARS virus, which did not appear until early 2003, may be used as an excuse for a lack of action. We urge the Minister to explore more fully the reasons for the unacceptable delay in developing the strategy and to take steps to ensure that it is produced and implemented as a matter of urgency. (Paragraph 197)
41. Northern Ireland has been in the unique position of having advance warning of an impending injecting drug problem. While substitute prescribing is not an appropriate form of treatment for every injecting drug user we were very concerned to find that action has not been taken much earlier to plan and introduce this service. We urge the Minister to ensure that an equitable and structured substitute prescribing scheme, with appropriate training, as well as financial and other resources, is put in place across Northern Ireland as a matter of urgency for all appropriate clients. (Paragraph 208)
42. We are concerned at the absence of a comprehensive range of drug treatment services in Northern Ireland. We urge the Minister to ensure that a proper balance of in-patient and community services, with appropriately trained specialist staff, is developed as a matter of urgency. (Paragraph 211)
43. The effectiveness of a residential rehabilitation centre or therapeutic community in helping clients confront drug addiction problems is well established and there are clearly a number of people in Northern Ireland who can benefit from this treatment. The Minister should undertake urgent research to establish the level of need and to make appropriate arrangements for the provision of this service. (Paragraph 218)
44. We note and encourage the research currently planned by DHSSPS into the service needs of young vulnerable groups. The Minister should ensure that the specific needs of women, and young people under 18 years, with drug addiction problems are addressed in her evaluation of the drug strategy. In particular, childcare facilities need to be available to enable parents with drug addiction problems to access services. (Paragraph 223)
45. We urge the Minister to consider what more can be done to make drug education and prevention programmes a higher priority within primary schools in view of the younger age at which children are experimenting with solvents and illegal drugs. (Paragraph 227)
46. We urge the Minister to consider how a more comprehensive response can be developed to the issue of young people in schools who become involved in drug use. We believe that it should not be a matter for schools alone to provide sanctions or counselling. The provision of appropriate support services at this stage could help to prevent more severe drug addiction problems later. (Paragraph 228)

47. This Committee warned of the growth of Northern Ireland's drug culture eight years ago. While a great deal has been achieved since in the collaborative development of an overarching anti-drugs strategy, as yet the actual provision of resources and facilities for those working on the front line in enforcement, prevention, treatment and rehabilitation has been too slow. Although we commend the commitment, ingenuity and hard work of many—including community and voluntary workers, health practitioners, police, customs and prison officers—in tackling the problems associated with the drugs trade, we also believe that it is necessary to impress upon officials once again the importance of getting the strategy right, in practice as well as in theory. The drug traffickers will not wait for these facilities to be put in place before they increase the availability of cocaine, crack and heroin: indeed, it seems they are already doing so. There is an urgent need for the Government to be pro-active in minimising the risk to individuals and communities, whether by increased activity against drug traffickers, or by protecting communities from drug-related crime, and individual drug users from the threat of blood-borne viruses. Probably the single most important lesson we learned from our visits to other jurisdictions was the importance of having facilities in place before the problem of drug use reaches critical mass. If that does not happen the suffering of individuals, families and communities will be great, and the task for Government in picking up the pieces will be far harder (and more expensive) than a pre-emptive strategy of the type we advocate. One of our witnesses suggested to us that Northern Ireland has three years to get its drugs strategy right. This warning must be taken seriously. (Paragraphs 229–231)

Formal minutes

Wednesday 22 October 2003

Members present:

Mr Michael Mates, in the Chair

Mr Adrian Bailey

Mr Harry Barnes

Mr Tony Clarke

Mr Eddie McGrady

Mr Steve Pound

Rev Martin Smyth

Mr Bill Tynan

The Committee deliberated.

Draft Report (The Illegal Drugs Trade and Drug Culture in Northern Ireland), proposed by the Chairman, brought up and read.

Ordered, That the Chairman's draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 231 read and agreed to.

Annex agreed to.

Resolved, That the Report be the Eighth Report of the Committee to the House.

Ordered, That the Chairman do make the Report to the House.

Ordered, That the provisions of Standing Order No. 134 (Select Committees (reports)) be applied to the Report.—(*The Chairman.*)

Several Papers were ordered to be appended to the Minutes of Evidence.

Ordered, That the Appendices to the Minutes of Evidence taken before the Committee be reported to the House.—(*The Chairman.*)

[Adjourned till Wednesday 29 October at 3.00pm]

Witnesses

Wednesday 11 June 2003

Page

Mr Peter Leonard and Mr Gary Alcock, **Northern Ireland Prison Service** and Mr Andrew Rooke and Mr Brian McCaughey, **Probation Board for Northern Ireland**

Ev 1

Wednesday 18 June 2003

Mr Terry Hannawin, Ms Andree McCollum, Dr Denis Morrison and Mr Gordon Addy, **Pharmaceutical Society of Northern Ireland**, Dr Henrietta Campbell, Dr Ian McMaster and Mr Dave Rogers, **Department of Health, Social Services and Public Safety**

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Wednesday 9 July 2003

Jane Kennedy, MP, **Minister of State, Northern Ireland Office**, Mr Mark McGuckin and Mr Tom Clarke, **Community Safety Unit, Northern Ireland Office**, Angela Smith, MP, **Parliamentary Under-Secretary of State with Responsibility for Health, Northern Ireland Office** and Martina Campbell, **Department of Health, Social Services and Public Safety**

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List of written evidence

1	Home Office	Ev 43
2	Chief Executive, Pharmaceutical Contractors Committee (NI)	Ev 44
3	Northern Ireland Office	Ev 44
4	HM Customs and Excise	Ev 64
5	Jane Kennedy, Minister of State, Northern Ireland Office	Ev 65
6	Probation Board for Northern Ireland	Ev 66
7	Northern Ireland Office	Ev 71
8	Dr Henrietta Campbell, Chief Medical Officer	Ev 72
9	Northern Ireland Prison Service	Ev 75
10	Council for Education in World Citizenship (NI)	Ev 76
11	South Eastern Education and Library Board	Ev 78
12	Department of Education	Ev 79
13	Northern Ireland Housing Executive	Ev 81
14	Association of Chief Police Officers, Drugs Sub-Committee	Ev 82
15	Department of Health, Social Services and Public Safety	Ev 87
16	Dr Norman Morrow, Department of Health, Social Services and Public Safety	Ev 88

List of unprinted written evidence

Additional papers have been received from the following and have been reported to the House but to save printing costs they have not been printed and copies have been placed in the House of Commons library where they may be inspected by members. Other copies are in the Record Office, House of Lords and are available to the public for inspection. Requests for inspection should be addressed to the Record Office, House of Lords, London SW1 (Tel 020 7219 3074). Hours of inspection are from 9:30am to 5:00pm on Mondays to Fridays.

Strabane Community Drugs and Alcohol Project, Peer Research Report 2002

United Kingdom Harm Reduction Alliance

Northern Ireland Office of the Royal Colleges of Physicians UK

Shiloh Christian Fellowship

Dr T Magowan, Primary Health Care Development Fund, Application for approval

Mr Ian Paisley Jnr

Northern Ireland Unionist Party

Association of Chief Police Officers - paper submitted to the Home Affairs Committee

Homefirst Community Trust

South Wales Police

Reports from the Northern Ireland Affairs Committee since 2001

The following reports have been produced by the Committee since the start of the 2001 Parliament.

Session 2002–03

First Report	The Impact in Northern Ireland of Cross–Border Road Fuel Price Differentials: Three years on	HC 105–I
Second Report	Annual Report 2002	HC 271
Third Report	The Police (Northern Ireland) Bill	HC 233
Fourth Report	The Control of Firearms in Northern Ireland and the draft Firearms (Northern Ireland) Order 2002	HC 67–I
Fifth Report	Forensic Science Northern Ireland	HC 204
Sixth Report	The Illegal Drugs Trade and Drug Culture in Northern Ireland: Interim Report on Cannabis	HC 353–I
Seventh Report	Peace II	HC 653–I
Eighth Report	The Illegal Drugs Trade and Drug Culture in Northern Ireland	HC 1217–I
First Special Report	Government Response to the Committee’s First Report: The Impact in Northern Ireland of Cross–Border Road Fuel Price Differentials: Three Years On	HC 412
Second Special Report	Government Response to the Committee’s Third Report: The Police (Northern Ireland) Bill	HC 555
Third Special Report	Government Response to the Committee’s Second Report: Annual Report 2002	HC 583
Fourth Special Report	Government Response to the Committee’s Fourth Report on the Control of Firearms in Northern Ireland and the Proposed Draft Firearms (Northern Ireland) Order 2002, HC 67–I, Session 2002–03	HC 677
Fifth Special Report	Government Response to the Committee’s Fifth Report on Forensic Science Northern Ireland	HC 722
Sixth Special Report	Government Response to the Committee’s Sixth Report on the Illegal Drugs Trade and Drug Culture in Northern Ireland: Interim Report on Cannabis	HC 935
Seventh Special Report	Government Response to the Committee’s Seventh Report on Peace II	HC 1077

Session 2001–02

First Report	Introduction of the Aggregates Levy in Northern Ireland	HC 333
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Second Report	The Financing of Terrorism in Northern Ireland: Interim Report on the Proceeds of Crime Bill	HC 628
Third Report	Introduction of the Aggregates Levy in Northern Ireland: The Government's Response	HC 713
Fourth Report	The Financing of Terrorism in Northern Ireland. Volume II of this Report (HC 987-II) includes the Government Response to the Second Report, Session 2001-02, The Financing of Terrorism in Northern Ireland: Interim Report on the Proceeds of Crime Bill, HC 628	HC 978-I
First Special Report	Government Response to the Committee's Fifth Report, Miscellaneous Financial Matters, Session 2000-01, and the Government Response to the Committee's Third Report, The Northern Ireland Office 2000 Departmental Report, Session 1999-2000	HC 332
Second Special Report	Government Response to the Committee's Fourth Report, Legal Aid In Northern Ireland, Session 2000-01	HC 400
Third Special Report	Government Response to the Committee's Second Report, The Parades Commission, Session 2000-01	HC 401
Fourth Special Report	Government Response to the Committee's Third Report, Relocation Following Paramilitary Intimidation, Session 2000-01	HC 461
Fifth Special Report	Government Response to the Committee's Third Report, Introduction of the Aggregates Levy in Northern Ireland, Session 2001-02	HC 1118