A Rapid Assessment Research (RAR) of drug and alcohol related public nuisance in Dublin City Centre.

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Foreword

The issue of substance misuse related anti-social behaviour in Dublin city centre has for a long time been a source of media focus and public concern.

Following the establishment in 2010 of the Dublin City Local Business Policing Forum, this issue became a recurring item of discussion. A number of agencies and organisations were invited to make presentations on the topic. In January 2011, in his capacity as chairman of the Policing Forum, former Lord Mayor of Dublin, Councillor Gerry Breen, called a meeting of representatives of some of Dublin City's key stakeholders. At the meeting it was proposed that a generic Good Neighbour policy which could be localised by any drug service could be developed. As part of the Ana Liffey Drug Project's suite of services, the Progression Routes initiative was tasked with the job of interviewing relevant stakeholders to develop a suitable policy. During this process those involved expressed an interest in establishing a cross city/inter-agency group to address the issues in a co-ordinated manner and this was presented back to the Policing Forum.

Arising from this, the Strategic Response Group (SRG) was formed with the objective of developing ways to build sustainable street-level drug services and address related public nuisance. The inaugural meeting of the SRG took place in the Mansion House on the 3rd of June 2011. The SRG is independently chaired and its membership includes representatives of the following organisations:

Ana Liffey Drug Project; An Garda Síochána; the City Clinic (HSE); Drug Treatment Centre Board; Dublin City Business Improvement District; Dublin City Council; Dublin Simon Community; Merchants Quay Ireland; the North Inner City Local Drugs Task Force; the South Inner City Local Drugs Task Force; the Union for Improved Services, Communication and Education (UISCE).

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At its inaugural meeting the SRG agreed that the issues being confronted were complex and that future responses needed to be guided by a number of core principles. These included the following:

> Responses should be coordinated and partnership-based
> Responses should be evidence-based
> Responses should complement and not duplicate other relevant policies
> Responses should be measurable
> Responses should not make problems worse or simply shift them elsewhere

The following specific guiding aims were also agreed on:

> To reduce public fears and address perceptions of concern associated with clients receiving drug treatment
> To decrease the visibility of substance misuse
> To address street nuisance associated with substance use/misuse, including noise and loud public behaviour
> To address negative perceptions of the city as an unsafe place to be
> To ensure agencies/services related to the issues are working in a coordinated manner
> To identify short, medium and long term solutions to the issues identified
> To promote a balanced perspective on the issues
> To compile all relevant information and data in relation to the issues arising and the responses to them

To assist it in its deliberations on a future strategy the SRG commissioned the current research study, the primary purpose of which was to assemble an evidence base. This involved a Rapid Assessment Research Project. The study was jointly funded by the stakeholders of the SRG. The evidence base was used by the SRG to inform its subsequent discussions and recommendations as to future responses to the issues arising.

The SRG report: ***A better city for all – a partnership approach to address public substance misuse and perceived anti-social behavior in Dublin City Centre*** was launched by the former Lord Mayor of Dublin, Councillor Andrew Montague in the Mansion House in June 2012[1]. The report contains sixty-one short, medium and long-term recommendations in the following areas: Treatment, Rehabilitation, Homelessness, Alcohol Supply, Policing, Urban Planning, Legislation and Regulation. The implementation of these recommendations is currently being progressed by a committee chaired by the Area Manager for Dublin City Council and established under the auspices of the Dublin City Local Business Policing Forum, chaired by the current Lord Mayor of Dublin, Naoise Ó Muirí.

The research and ultimate strategic recommendations are focused on the area between Christchurch and the Irish Financial Services Centre and from Parnell Square to St Stephen's Green (the focus area). On behalf of the SRG I would like to thank the authors, Dr Marie Claire Van Hout and Tim Bingham for completing the research within the extremely limited timeframe made available. I would also like to thank the Garda Síochána Analysis Service for providing the data presented in Chapter 4 which was derived from the Garda Síochána PULSE system. We also wish to thank the services users, members of the business community and transport representatives for their participation in the research.

As this research shows, substance-related anti-social behaviour is an elusive issue to define. It can involve a range of actual activities such as harassment and intimidation and also behaviour such as congregation in groups or shouting that is not intended to offend but can do so. At the same time, the right of people to use and enjoy the civic space must be tempered by the responsibility to use it in a way that does not unduly impinge on the rights and entitlements of others.

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[1] For a copy of the report see: http://www.drugsandalcohol.ie/17769/

The underlying causes of the issues being addressed here must be seen in a historical context. For example, the clustering of drug treatment and homeless supports and services in the city centre should be viewed against a backdrop of the need to provide adequate supports to disadvantaged and marginalised inner-city communities and vulnerable individuals.

Such concentration of services in the centre of Dublin can also be seen against the backdrop of the reluctance of communities and regions surrounding Dublin to tolerate such services in 'their own back yard'.

The recommendations of the SRG are founded on the premise that the issues being addressed are not primarily policing or criminal justice matters. Policing responses can often do little more than displace street-based nuisance elsewhere. The imprisonment of those who commit economically motivated crimes as a consequence of their addiction often amounts to an expensive way of making a bad problem worse. The issue of substance-related anti-social behaviour is primarily a public health issue and any sustainable long-term solution can only be delivered in that context. The SRG recommendations, which are informed by the evidence presented in this study and by the collective experience of its stakeholders who have decades of coalface experience in responding to drug-related problems in the city, are aimed at investigating ways to best deliver people's treatment or accommodation needs in a way that can assure greater public support.

Johnny Connolly
Chairman of Strategic Response Group
December 2012

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Executive summary

Rapid Assessment Research

The research aimed to assemble an evidence base around perceived anti-social behaviour associated with the provision of drug treatment in Dublin's city centre, upon which to build a strategic response incorporating short/medium/long term goals and actions within the area. It will be used to guide discussions on how to reduce visibility of drug related public nuisance, improve public perceptions of safety in the area and provide comprehensive, safe, effective and appropriate treatment services within a series of short, medium and long-term strategies.

Methods employed

The RAR method combined various research methods and data sources in order to construct an overview of the problem by cross-checking and comparing the information from several different sources, which included the following;

1.   A critical review of literature using the following inclusive search terms: anti-social behaviour, public nuisance, open drug scenes, public place injecting, intimidation, drug related litter, situation crime prevention, policing, community activism, urban regeneration and drug mandated treatment from the period 1998 to 2012 and using several electronic databases (Google Scholar, Ebsco Host, Science Direct, PubMed).

2.   PULSE data for the research area was analysed and provided by An Garda Siochana.

3.   A mapping exercise inclusive of an environmental visual assessment using digital photographs to view the geographical distribution of drug and alcohol related public nuisance was undertaken to assess levels of 'hotspots' for public nuisance, anti-social drug and alcohol using congregations, drug related littering, alcohol retail outlets and placement of drug treatment, housing, policing and community services in the area.

4.   Interviews and focus groups were conducted with business and transport stakeholders (n=19), community, voluntary and statutory stakeholders (n=19), and service users (n=23).

5.   Random street intercept surveys were conducted with passers-by (n=25) and with drug users (n=26).

The chosen methodologies are essentially concerned with participant experiences of anti-social behaviour in this research area, types of behaviours recorded and opinions around potential strategic response. Data was collected over a four-week period in November and December 2011 and January 2012 by an experienced Privileged Access Interviewer [PAI].

Ethical Considerations
All potential research participants partook voluntarily and were advised of their right to withdraw from the study at any stage if they so wished. Prior to seeking verbal informed consent, each participant was given a comprehensive information leaflet, and in the case of street intercepting and telephone interviews, were provided verbally with details of the research aim, and were asked for verbal informed consent. All participants were assured of confidentiality and were allocated a code to ensure anonymity.

Data Analysis
The environmental visual assessment was undertaken whilst mapping the area, and yielded a series of maps outlining 'hot spots' for drug littering, outlets selling alcohol, placement of treatment and community services, community policing forums and An Garda Síochána stations. PULSE data assisted in presenting a detailed context relating to law enforcement and crime statistics for the research area. For the purpose of analysing the PULSE data, the research area was divided into seven quadrants. Participant observation techniques, reflexive field accounts, photographic records and detailed memos supported the data analysis of primary and secondary data. The data were analysed to identify trends in attitudes, perceptions and emerging patterns relating to stakeholder, service users, street drug user and passers-by perspectives on anti-social behaviour and drug related public nuisance in the area

Research Limitations

The research is exploratory and limited by a small sample size of participants willing to partake. However, despite the small numbers of participants, the validity and accuracy of the findings are optimised by the use of triangulated data sources from PULSE data relevant to the area, service user perspectives, business and transport, community, voluntary and statutory stakeholder perspectives, passers-by and street problematic drug user perspectives, photographical and environmental mapping analysis.

Key Findings

Definitions and experiences of anti-social behaviour

A continuum of acceptable versus not acceptable forms of public behaviours, and level of impact between anti-social, nuisance and criminal elements of the behaviours was described in the research. A range of definitions of anti-social behaviour were recorded in the interview narratives, with anti-social behaviour deemed to be (typically) illegal, causing interference, visual and physical intimidation, and feeling unsafe, impacting negatively on businesses, services, customers, tourists and individuals accessing the area whether on foot, in private transport or on public transport. Particular anti-social activities mentioned included; visible drinking and drug use, intoxication, aggressive and loud behaviour, youth and child drinking and drug dealing on the streets, phone snatching, graffiti, night time alcohol abuse, mobile phone theft, harassment, street assaults, begging/'tapping' on the street and at Luas ticket machines, car break-ins, pick pocketing and other petty crimes. Pulse Data reflected drug crime detections which correspond closely with typical business hours, peaking between the hours of 10am to 5pm. A clear distinction between specific quadrants is presented in terms of crime profile, which corresponds to the predominant commercial activity of these areas, retail and night-time entertainment respectively. Quadrant 6 is significantly different to all other areas of the study, due to the inclusion of Temple Bar, which has its own specific crime profile. Property crime is associated with the retail areas and public order offences are associated with the night-time entertainment areas.

Perceptions of Threat and Intimidation in the research area

Negative media portrayal of anti-social behaviour in the research area was described. The urban design and poor lighting of certain streets was mentioned in the interviews and focus groups as contributing to perceptions of fear and lack of safety. Tourists and visitors to the area spoken to during 'walkabouts' in the research area had not observed any forms of anti-social behaviour, and reported feeling safe and happy with the Garda presence in the area. However, those working in the area had all observed anti-social behaviour, had felt intimidated, and reported feeling unsafe in the area both during the day, and at night times.

Open drug scenes in the research area

Congregations of drug users and loitering were particularly visible during 'walkabouts' on a number of streets and near specific Luas stops. The greater the footfall on certain streets, the less visible congregations of problematic drug users appeared. There was a noticeable increase in congregating at lunchtime during 'walkabouts' when services closed for lunch. Qualitative narratives observed concern for aggressive and vocal behaviour occurring due to withdrawals and use of prescribed medication and alcohol.

Drug dealing in the research area appeared both transient due to availability of types of drugs for sale (i.e. heroin, cannabis, new psychoactive drugs such as mephedrone, prescribed medication; zopiclone (zimovane), diazepam (valium), crack cocaine, methadone and crystal meth) and also filtering into middle class drug consumption at the weekends. Open drug scenes are mobile with both users and dealers walking and cycling in the research area. Service user interviews described increasing competitiveness with child and youth involvement in drug dealing, greater numbers of individuals dealing, and many mobile by using bicycles. Surveyed drug user street intercepts and service user narratives reported knowledge of 'hotspots' for drug dealing often outside of known treatment centres, occurring in response to drug availability, and transient drug dealing networks in the research area.

Street and Public Place Injecting in the research area

The research found that public place injecting was confined to a small number of drug users who are homeless or rough sleepers. Drug related litter was observed during 'walkabouts' in a number of streets and alleyways in the area. Interviews and focus groups highlighted concerns about unsafe injecting practices, particularly during times when needle exchanges were closed. Photographed deterrents included the use of fluorescent lighting to restrict injecting, and notices placed on service doorways.

Prescription Medication Use in the research area

The issue of prescription medication use by a variety of drug using groups and dealing within visible and transient open drug scenes and identified 'hot spots' (i.e. at Luas stops) in the research area were discussed in interviews and focus groups. Prescription medication use contributed to dis-inhibition and vocal street intimidation of passers-by. Service users described use of prescribed medication as helping to pass the day, 'tapping' and encouraged walking around the research area. Littering of benzodiazepine packaging was observed and photographed during 'walkabouts' in the research area. Garda sanctioning and control of use was viewed as problematic due to lack of powers in relation to prescribed drugs. Market availability of anti-anxiety and sedation medication is sustained by purchase via web based outlets serving Ireland, pharmacy and factory theft. Concerns were also raised with regard to importation of counterfeit medicines, with unidentified contents and potential for user harm. Interviews with service users also identified a need for greater service support systems for those with depression, anxiety and at risk of suicide.

Homelessness in the research area

The research underscored the relationship between homelessness, street based public nuisance and tensions over the civic right for space. The impact of the Housing (Miscellaneous Provisions) Act 1997 was regarded as largely negative and it was deemed inappropriate as a way of dealing with both antisocial individuals and their families, or problematic drug and alcohol use. The legislation was viewed as contributing to increased levels of rough sleeping and uptake of emergency accommodation.

Reported accommodation of surveyed drug user street intercepts ranged from 'living with friend's, to living on the street and in B & B accommodation, and with females reporting living with friends, to a greater extent than males, and with males living on the street more often than females. Interviews described gender restrictions in hostel and B&B accommodation with males required to vacate during daytime hours, and thereby contributing to daytime boredom, endless walking around the research area, loitering and drug activities. The need for more beds, hostels and accommodation options for homeless individuals of both genders, and particularly drug free accommodation provision with 24 hour access, was observed to be fundamental in reducing street based public nuisance, contact with drug users, and opportunity to purchase and use both licit and illicit drugs.

Alcohol Sale and Consumption in the research area

A clustering of outlets selling alcohol in the research area was observed during 'walkabouts', with shops situated in a number of locations. However, instances of street drinking were not visible during 'walkabouts', with consumption of alcohol taking place off the main streets, and often disguised by being poured into soft drink bottles. Interviews and focus groups with stakeholders reported that easy access to retail outlets selling alcohol in the focus area, availability of cheap alcohol, lack of staff responsibility in the sale of alcohol, increased levels of child and youth drinking (with purchase of alcohol by adults), contributed to alcohol and drug related public nuisance (in the form of street violence, harassment, begging and assaults, particularly during the night time economy, and near Luas lines).

Policing in the Research Area

Covert and overt policing operations were deemed effective , but appeared inconsistent across north and south of the focus area, and contributed to displacement of (already transient) open drug scenes within and outside of the area. Drug market responses to increased Garda presence included use of children on bicycles, the Luas and reduced carrying of drugs. PULSE data reflected that suspect offenders for all crimes are predominately male and of Irish nationality, the average age across all quadrants is 30.

Qualitative narratives described satisfaction with policing efforts but highlighted the need for increased vigilance, along with service level policing in deterring congregating, loitering and drug activity outside of services.

Decreased child and youth fear of retribution, alongside poor relations with Gardaí were described, and highlighted the need for improved Garda and community partnership, and family support initiatives designed to target youth crime.

Influx and Transport into the Research Area

Over half of surveyed drug user street intercepts lived in the immediate area, with the remainder accessing the area for services. Key services such as treatment centres are easily accessible via transport hubs (i.e. Luas and buses). A greater number of surveyed drug user street intercepts were male, and the majority were aged over 30 years and of Irish nationality. None of the surveyed drug user intercepts were employed. A majority reported using the bus, Luas and walking in order to access the research area, with none using the DART, train or taxis. A large majority of surveyed drug user-street intercepts reported coming into the research area daily, with friends, and in order to access services in the locality. Just over half of surveyed drug user street intercepts reported that services were satisfactory. Qualitative narratives described the influx of individuals coming into the research area as contributing to open drug scenes, loitering outside treatment centres, and congregations of drug and alcohol users, homeless people and drug dealers in certain 'hot spots', and directly contributing to continued networking between those in treatment and those actively using drugs on the streets. A proportion were described as originating from outside of the research area (Tallaght, Clondalkin, Lucan, Blackrock) and outside of Dublin itself (counties Waterford, Louth, Kilkenny, Kerry, Meath, Kildare and Wexford).

Potential Responses

This RAR presented visual and illustrative data upon which to build future discussions within the SRG and has highlighted a series of key themes for future strategy building. Qualitative narratives discussed potential relocation of services, along with integrated urban, shop and transport planning using CCTV monitoring and policing systems.

Stakeholders observed the need for improved rehabilitative pathways for those on Methadone treatment, greater access to and provision of treatment options across Ireland in order to reduce the levels of influx into in the research area, and to address and reduce user perceptions of the area as a hive of drug dealing activity. The need for integrated and inter agency community, service, business, family, youth, service user and Gardaí using a partnership approach to address anti-social behaviour are important, alongside the potential business community investment in the development of community employment schemes, as part of improved detoxification and treatment pathways for clients accessing services in the research area.

Chapter 1. Introduction and Rationale for the Research

The research was undertaken against a background of heightened public and community concern for local drug related crime, street dealing, antisocial behaviour and public nuisance in inner city Dublin. Several Irish studies have illustrated the interplay between local drug markets and increasing concerns for the extent of related criminal and antisocial drug and alcohol related behaviour (Cox and Lawless, 1998; Connolly, 2001; Cullen, 2001, Murphy-Lawless, 2002; Cox and Lawless, 2003; Connolly 2003a; b; Mahabir et al., 2011). However, according Cox and Lawless in 2003, the extent of drug related public nuisance and antisocial behaviour in Ireland remains unknown.

The relationship between drug use, crime and antisocial behaviour is complex (Cox and Lawless, 2003). Antisocial behaviour although a broad concept, is defined in the Criminal Justice Act 2006 as '*behaviour that causes or, in the circumstances is likely to cause, to one or more persons who are not of the same household as the person; harassment or; significant or persistent alarm, distress, fear or intimidation or significant or persistent impairment of their use or enjoyment of their property',* and with *'public nuisance encompasses crimes, disturbances and antisocial behaviours that disrupt the safety, security, health and tidiness of a community or neighbourhood and which jeopardise the quality and enjoyment of life of the inhabitants of street, a neighbour or a community.'* It encompasses all minor incivilities to criminal behaviour (Fahey, 1998) and may include disorderly conduct; intoxication, threatening, abusive or insulting behaviour in a public place; failure to comply with a member of An Garda Síochána; entering a building with an intent to commit an offence and failure to surrender intoxicating liquor (Institute of Criminology, 2003).

Research underscores the association between mental health issues, special needs, poverty and other disadvantages amongst those engaging in anti social behaviours and problematic drug and alcohol use (Hunter et al., 2000).

The relationships between drug market concentration in certain areas, unemployment, low educational attainment, single unit families, social exclusion and problematic access to suitable housing are evident (Dean et al., 1983; McKeown et al., 1993; O' Higgins and O' Brien, 1995; Cox and Lawless, 1999; Howley, 2000; Mayock and Moran, 2000; Costello & Howley, 2000; Cox and Lawless, 2003; Hickey and Downey, 2003; Corr, 2003; Cleary et al., 2004; O'Loingsigh, 2004; Smyth and O' Brien, 2004; Drug Misuse Research Division, 2004). Indeed, studies in Dublin's north inner city have recorded high instances of resident exposure to drug market activity and concerns around public safety, drug consumption and drug related crime (i.e. burglaries, disturbances and youth loitering) (Connolly, 2001). Widespread drug availability in local Dublin communities serves to compound localised drug related public nuisance in the form of open drug dealing, use of illicit drugs, problematic behaviour resulting from such drug use, drug related litter (i.e. injecting equipment), street harassment, vandalism, graffiti and tenant noise (Keogh 1997; Fahey, 1998; O' Higgins 1999; Connolly, 2002; Connolly, 2003a;b). This issue contributes to community fragmentation, heightened community stress, loss of community space, an influx of non residents into the area, the labeling and stigmatization of certain Dublin estates, resident fears for safety and reduced quality of life (Corcoran, 1998; Morley, 1998; O' Higgins, 1999; Cox and Lawless, 2003). Such behaviours can overtime influence community expectations of what behaviours are acceptable and become normalized (Crawford, 1997; Bland and Read, 2000), with research by Connolly (2003a) in the north inner city observing a familial concern for the negative impression of open drug scenes, public place dealing and drug use on children and youth.

Research shows that housing design and residential situation can interplay with social exclusion, marginalisation, unemployment, crime, intimidation and drug related antisocial behaviour. This is particularly evident in the case of urban clustering or *'problem housing estates'* often containing those with multiple social disadvantage, with drug dealers situating themselves in such areas and with presence of problematic or criminal families increasing levels of antisocial and criminal activity, heightened community tension, levels of intimidation and fear of safety, and with poor community cohesion and police-community

engagement further complicating matters (McCarthy and McCarthy, 1995; Lund, 1996; Morris, 1996; Loughran, 1996; Lee and Murie, 1997; Fahey, 1998; O' Higgins, 1999; Cox and Lawless, 2003; Loughran and McCann, 2006; Department of Community, Rural and Gaeltacht Affairs, 2009; O' Leary, 2009). The Housing (Miscellaneous provisions) Bill was enacted in July 1997 and included a range of measures giving local authorities the power to address drug related antisocial behaviour in the form of drug dealing, intimidation and violence (Loughran, 1999; Silke, 1999). However, this housing legislation, although deemed effective in evicting tenants for antisocial behaviour, has been described as discriminatory (in some instances), using a *'loose definition'* of antisocial behaviour, with concerns for due process and with social housing providers assuming a policing role which is deemed to contribute to movement of the *'drug problem'* to other areas and increased homelessness among drug users, cohabitants and their children (Kelly 1997; Cox and Lawless, 1999; Woods, 2000; Mayock and Moran, 2000; Memery and Kerrins, 2000; Rourke 2001; Murphy-Lawless, 2002; Connolly, 2003b, Mayock and Vekic, 2006; Cassin and O' Mahony, 2006; Pillinger, 2006). Recent media reporting has highlighted concern for funding cuts to homeless services, and difficulties with resettlement policies in fast tracking homeless individuals into private rented accommodation (see Irish Examiner, Wednesday February 22nd 2012). In addition, problem housing estates have the potential to spread beyond original social housing situation (Fahey, 1998). Recent research undertaken in Limerick has advocated for a strategic and coordinated response to criminality, community degeneration and disadvantage, with area regeneration based on intense policing, the targeting of criminal assets (CAB operations), the eviction of tenants engaged in criminal or antisocial behaviour, development of public transport systems and attraction of commercial investment (Fitzgerald, 2007).

In recent times, more participatory approaches to estate management have emerged, which consult tenants in the design, development and refurbishment of these estates (Fahey, 1998; O'Gorman, 2000).

Dublin Corporation established a successful estate management policy in 1998 to address anti-social behaviour which included local representation and involvement, multi-agency participation, maintenance and service provision (Memery and Kerrins, 2000). Efforts from a community perspective have also included *'The Good Neighbour Policy'* which aimed to respond to community needs in relation to problematic drug and alcohol use, housing and social exclusion. Resident involvement in community anti-drug initiatives (i.e. public meetings and street vigils, community policing, anti-drug marches and vigilante type behaviours) has historically attempted to improve quality of life in estates experiencing drug related activity and antisocial behaviour (Bennett 1988; Dublin Corporation, 1997; O'Mahony 1997; Connolly 1998; McAuliffe and Fahey 1999; Loughran, 1999; Butler, 2002; Murphy-Lawless 2002; Connolly, 2003c; Cox and Lawless, 2003). Community activism in Ireland has contributed to both increased public awareness and governmental response, community control and yet also (in some instances) internal community tensions and conflict (Cullen, 1989; O'Mahony 1997; Murphy-Lawless 2002; Connolly, 2003c). The National Drug Strategy Steering Group 2009-2016 (see Action 5 National Drug Strategy 2009-2016, Department of Community, Rural and Gaeltacht Affairs, 2009) noted an increase in fear, violence and intimidation relating to drug related debts and anti-social behaviours (i.e. threats, damage to property and physical violence, all of which often unreported) within communities across Ireland, and has expressed concern with regard to the negative consequences for community participation. Research has highlighted the need for dedication of resources for consultative mechanisms to operate, alongside codes of practice and training for those involved, and most particularly in areas experiencing high levels of intimidation and fear, and where police and community relations are strained (Mulcahy and O' Mahoney, 2004; O Leary, 2009; City Wide Drugs Crisis Campaign, 2010).

Positive developments in providing a coordinated response across four pillars (supply, treatment, education and research) to drug dealing and drug related public nuisance in certain areas have included the establishment of local drugs task forces which facilitated exchange of information between Dublin Corporation and the Garda Síochána, joint policing with the Garda Síochána and local community policing fora (CPF) in LDTF areas

(Dublin Corporation 1997; Loughran, 1999; Garda Síochána Act, 2005; Connolly, 2002; Connolly, 2004; Department of Justice, Equality and Law Reform, 2006). However, policing remains restricted by the lack of common definition of anti-social behaviour, and ambiguities regarding agency remit, with forces needing to consider the available resources, tactics and strategies available to deal with these behaviours in a coordinated manner (Crawford , 1997; Bland and Read, 2000). The recent City Wide Drugs Crisis conference also advocated integrated, specific, contextualised and proportionate partnership approaches to improve local response to drug related intimidation, and which included; development of consistent, secure and protective systems for reporting, a *'Dial to Stop Intimidation'* service; effective Joint Policing Committee, fast-tracking within the court systems, and community based mediation (Connolly, 2011a;b).

Methadone MaintenanceTreatment

Methadone maintenance treatment (MMT) has been available in Ireland since 1992, with initial provision of treatment in Dublin. The Report of the Expert Group on the Establishment of a Protocol for the Prescribing of Methadone was undertaken in 1993. A small number of the large MMT clinics were established in the 1990s, along with several satellite clinics with smaller case loads. The health professionals involved include clinic doctors, (with or without general practitioner training,) and consultant psychiatrists. In 1998, the *Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations* was introduced, with specific administrative structures implemented in order to monitor treatment delivery and patient trends (Central Treatment List or CTL). The Methadone Treatment Protocol was then devised by the Irish College of General Practitioners (ICGP) in 1998 in order to support MMT delivery across Ireland (and not limited to the initial Dublin context), GP training, increase the number of clients on MMT within a community based primary care context, assist in audits and presented systematic protocols for methadone prescription and patient management (Butler, 2002). An internal review was conducted in 2005 by the Methadone Prescribing Implementation Committee (2005). Currently there are three types MMT service provision in Ireland namley; clinics, level 2 and level 1 GPs.

The system is based on Level 1 trained GP's (foundation level restricted to 15 patients, where stabilisation occurs in a health board treatment centre or with a Level 2 trained GP) and Level 2 trained GP's (qualified to initiate treatment, stabilize doses and provide ongoing maintenance treatment (Delargy, 2008). Most recent data indicates that in 2008, 259 general practitioners (GP's) worked with the Methadone Treatment Protocol, with 2/3 of MMT clients treated in specialized clinics and 1/3 treated in the community (Health Service Executive, 2011).   8,551 Irish patients (of which 5,352 were in clinics) were receiving MMT by the end of December 2009 compared with 5,965 (of which 3,849 were in clinics) at the end of December 2002. At the end of December 2009 1,525 patients were recorded with level 1 GPs compared to 807 in 2002; with 1,674 patients recorded with level 2 GPs in 2009 compared to 1,309 at end of 2002. The number of level 1 GPs has increased grown from 151 in 2002 to 218 in 2009. However, less than 5% of patients in level 2 practice were transferred to level 1 GPs per year over the period 2002 to 2009.

The first external review of the Methadone Treatment Protocol was undertaken in 2010 so as to maximize treatment provision, assess clinical governance and audit, referral pathways, GP enrollment, training (Level 1 and 2) and coordination, appropriateness and efficacy of urine testing, data collection and analysis and engagement with the Department of Justice on methadone prescribing in Garda stations was published in December 2010 (Farrell and Barry, 2010). The review commented on improved prescribing and quality of independent practitioner practice, and advised the need to maximize treatment provision and referral pathways with requests for detoxification reviewed as part of a service audit process and with a timely response (see *'National Drugs Rehabilitation Framework'* Working group on drugs rehabilitation, 2007). Indeed, the need for an increase in the number of community and residential detoxification services in Ireland has been articulated at national and local level (Mannix, 2006; Dept. Community, Rural and Gaeltacht Affairs, 2007; Corrigan and O'Gorman, 2008; Doyle and Ivanovic, 2010; McDonnell and Van Hout, 2010; McDonnell and Van Hout, 2011).

A report from the statutory Working Group on Rehabilitation states that, "*clients often feel that they are not given adequate options regarding their treatment and care-plans.......this is particularly evident to detoxification*" (Dept. Community, Rural and Gaeltacht Affairs, 2007:35). This has had direct implications for levels of drug related public nuisance. Indeed, debates centre around treatment and NSP centre location as contributor to increased levels of street based public nuisance. Recent new rules have also been introduced by the Railway Procurement (RPA) agency in 2012, in order to tackle increasing anti social behaviour on the Luas [tram system], with 970 individuals convicted of public order offences and 128 threats to railway inspectors recorded in 2011.

Several protocols have been developed to outline the minimum medical and psycho-social supports necessary for individuals engaging in interagency community detoxification (see the National Drug Rehabilitation Framework; Doyle and Ivanovic, 2010; Regional Drug Coordination Unit HSE Mid-West, 2010), with particular focus on the use of benzodiazepines (Department of Health and Children, 2002; Progression Routes Initiative, 2011a) and methadone (Progression Routes Initiative, 2011b). However, the review by Farrell and Barry underscores the need to provide a broader range of treatment options in Ireland with inclusion of buprenorphine and naloxone treatment modalities, and to revise the title to "*The Opioid Treatment Protocol*". It also calls for rural service development, improved integration between and among services with development of care planning using electronic records, improved clinical governance and audit (see '*Achieving Excellence in Clinical Governance: towards a culture of accountability,* 2010), a need to review benzodiazepine prescribing (see '*Report of the Benzodiazepine Committee*' Department of Health and Children 2002), delivery of treatment to prisoners within community based services, Garda medical assessment of individuals in custody and prescribing of methadone in stations, and expansion of the number of Level 2 GP's with greater emphasis on moving patients from Level 1 to Level 2 GPs.

These recommendations are particularly useful when considering the interplay between drug users and those in treatment with levels of drug related public nuisance and emphasizes the need for improved inter agency and multidisciplinary working using Treatment Outcome Profiles, and with consideration of family, community and user groups.

Rationale and Context for the Research

Cassin and O' Mahony (2006) have debated how over reliance on legislation and criminal justice in dealing with Ireland's illicit drug trade has generated its own problems, with criminal laws targeting the disadvantaged drug user, rather than drug suppliers, and with increased anti-drug user public perceptions fueling the already marginalised and criminalised drug using groups. Research has shown that problem drug use is more likely to occur in certain Dublin communities (Keegan, 1996; Cullen, 1997), with higher levels of antisocial behaviour in inner city and metropolitan areas (Hunter et al., 2000). In 2011, the first *'Your Dublin Your Voice'* survey reported that over one third of respondents (total sample of n=2200) felt that antisocial behaviour, drugs and begging were the worst thing about residing in the city, and nearly half disagreed or strongly disagreed with the statement *"I feel safe when I am in the city at night-time"* (see www.yourdublinyourvoice.ie). Discussions emerging from this survey relate to the following;

- The impact of such alcohol and drug related antisocial behaviour on tourists, visitors and businesses in the city along the quays, boardwalks and transport hubs, and around the IFSC (Amiens and Talbot Street),

- The negative effect of antisocial behaviour and the concentration of social services (drug treatment clinics) and minimum pricing alcohol retail outlets on business trade in the city centre,

- The lack of legislative control on prescription pills, homelessness, street loitering,

- The need for greater Gardaí supports alongside community partnership, and the development of a Local Policing Business Forum as partnership between the Dublin City Business Association (DCCBA), Business Improvement Districts (BIDS), Dublin Tourism, Temple Bar Traders, DCC and An Garda Síochána.

The Strategic Response Group (SRG) was formed in response to concerns about perceived anti-social behaviour associated with the provision of drug treatment in Dublin's city centre. Members of the SRG include representatives of Ana Liffey, City Clinic, Merchants Quay Ireland drug treatment centres and the Drug Treatment Centre Board, the business community representative body BID, An Garda Síochána, Dublin City Council, the North Inner City Local Drugs Task Force and the South Inner City Local Drugs Task Force, Dublin Simon Community and the Union for Improved Services, Communication and Education (UISCE). A series of consultative meetings were held in 2011 (see Appendix 1) in order to discuss the level of public nuisance and drug related antisocial behaviour in Dublin's inner city, with an emergent and identified need for a Rapid Assessment Research (RAR) and a mapping exercise to estimate levels of drug and alcohol related public nuisance during business and out of hours in the area between Christchurch and the IFSC and Parnell Square to St Stephens Green.

Chapter 2. Methodology

Research Aim:

The research aimed to assemble an evidence base around perceived anti-social behaviour associated with the provision of drug treatment in Dublin's city centre, upon which to build a strategic response incorporating short/medium/long term goals and actions within the area between Christchurch and the IFSC and Parnell Square to St Stephens Green. It will be used to guide discussions on how to reduce visibility of drug related public nuisance, improve public perceptions of safety in the area and provide comprehensive, safe, effective and appropriate treatment services within a series of short, medium and long-term strategies (see Appendix 1). The scale and impact of anti-social behaviour can only be estimated by gauging the perceptions of those whose lives are affected by such behaviour. The RAR method combined various research methods and data sources in order to construct a research overview of the problem by cross-checking and comparing the information from several different sources (UNODC, 1999, EMCDDA, 2000). This approach has been used successfully in drug research (Stimson et al., 2001; Fitch and Stimson, 2003; Connolly et al., 2008a).

For the purposes of this research the following definition of drug related anti social behaviour or public nuisance guided the research design; *'Anti-social behaviour is a behaviour that lacks consideration for others and that is likely to cause harassment, alarm or distress, whether intentionally or through negligence.'* (Berger, 2003, Fingal County Council, 2011; Your Dublin Your Voice, 2011), and included;

- Drug dealing
- Drinking alcohol on the streets
- Begging
- Prostitution related activity such as curb crawling and loitering
- General drunken behaviour (which is rowdy or inconsiderate)
- Drug related litter
- Intimidation or harassment

- Assault;

- Vandalism;

- Noisy Behaviour

- Verbal abuse

- Rough sleeping

The chosen RAR method represents mixed forms of data in the form of research mapping, photographical records of the area, narratives from consultations, focus groups and interviews, and descriptive data from random passers-by and drug using street intercepts. The objectives were as follows;

1. To undertake a critical review of literature using the following inclusive search terms: anti social behaviour, public nuisance, open drug scenes, public place injecting, intimidation, drug related litter, situation crime prevention, policing, community activism, urban regeneration and drug mandated treatment from the period 1998 to 2012 and using several electronic databases (Google Scholar, Ebsco Host, Science Direct, PubMed).

2. To incorporate detailed PULSE data from An Garda Siochana relevant to the research area.

3. To undertake a mapping exercise inclusive of an environmental visual assessment using digital photographs to view the geographical distribution of drug related public nuisance (see Small et al., 2007; Parkin and Coomber 2009b) in order to assess levels of '*hotspots'* for public nuisance, anti-social drug and alcohol using congregations, drug related littering, alcohol retail outlets and placement of drug treatment, housing, policing and community services.

4. To collect qualitative data in semi structured interviews and focus groups conducted with community, voluntary and statutory agencies (n=19), business and transport stakeholders (n=19) and with service users (n=23) (for Qualitative Guides, see Appendix 3), and during local *'walk about'* tours.

5. To conduct random street intercepting of street drug users (n=26) with support from outreach workers in the area (for Street Intercept Surveys, see Appendix 4).

6. To conduct random street intercepting using a brief field survey with every tenth passerby (n=25) was conducted at several points and varied timeframes in the research area (for Passerby Street Intercept Surveys, see Appendix 5).

The chosen methodologies are essentially concerned with participant experiences of anti social behaviour in this research area, types of behaviours recorded and opinions around potential strategic response. The consultative phase with the SRG assisted in defining recruitment procedures, finalising the brief street surveys, deciding key themes for interviews and focus groups, and exploring issues relating to access and gate keeping.

Data was collected over a four-week period in November and December 2011 and January 2012 by an experienced Privileged Access Interviewer [PAI]. There is a growing body of research that has relied on PAI's to gain access to and collect data from samples of people who use illicit drugs (Griffiths et al., 1993, Kuebler and Hausser, 1997). Research has also demonstrated that PAIs can access large numbers of respondents within relatively brief periods of time (Griffiths et al., 1993, Kuebler and Hausser, 1997) which compliments the chosen RAR methodology. Participants were recruited with assistance from the Research Advisory Group representing the SRG, and with assistance from drug treatment and other services.

Research mapping of the area was undertaken over a period of 7 days whilst conducting random street intercepts with passersby and drug users. Observational data in the form of detailed field notes, digital memos and digital photographs assisted in providing a picture of the situation relating to drug related public nuisance in the research map[2].

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[2] Although this data was used to inform the SRG discussions, it has been removed from the report so as to ensure the anonymity of specific locations and to prevent any of the sites from developing or consolidating a reputation as a drug market

The passerby and drug user street intercept surveys consisted of questions relating to passerby demographics, uptake of public transport into the area, frequency of presence in the research map, uptake and experiences of community and drug services accessed, types of substances used, perspectives and experiences of injecting drug use, drug and alcohol use, and street begging, experiences of street based harassment and intimidation, and observations around current policing levels.

Business and transport, community, voluntary and statutory stakeholder interview themes consisted of the following; public and business perceptions on drug related public nuisance, visibility of alcohol and /or drug use, drug markets and drug related litter, issues affecting local business, impacts on public transport systems, interplay between homelessness or rough sleeping, off licenses and current drug treatment uptake, alternatives to current treatment provision, policing and CCTV, perspectives on a coordinated response to drug related public nuisance. Focus group themes for service users related to drug user views on day and evening services in the research area, service related needs provision, access to and uptake of services, levels of homelessness, issues relating to housing and public transport, methadone maintenance treatment, prison discharge and rehabilitation, perspectives on drug related public nuisance in the form of harassment, assault, intimidation, open drug markets in the area, impact of current policing levels and drug courts.

Ethical Considerations

All potential research participants partook voluntarily and were advised of their right to withdraw from the study at any stage if they so wished (EMCDDA, 2000). Prior to seeking verbal informed consent, each participant was given a comprehensive information leaflet, and in the case of street intercepting and telephone interviews, were provided verbally with details of the research aim, and were asked for verbal informed consent (see Appendix 6). All participants were assured of confidentiality and were allocated a code to ensure anonymity.

Data Analysis

The environmental visual assessment was undertaken whilst mapping the area, and yielded a series of maps outlining *'hot spots'* for drug littering, outlets selling alcohol, placement of treatment and community services, community policing fora and An Garda Síochána stations. PULSE data assisted in presenting a detailed context relating to law enforcement and crime statistics for the research area. Participant observation techniques, reflexive field accounts, photographic records and detailed memos supported the data analysis of primary and secondary data. The data were analysed to identify trends in attitudes, perceptions and emerging patterns relating to stakeholder, service users, street drug user and passers-by perspectives on anti social behaviour and drug related public nuisance in the area. The content analysis of transcripts, field notes and memos was assisted by NVIVO software, which is designed to manage non-numerical unstructured data, and aid in the development of a coding scheme. Several reviews of transcripts, field notes, photographs and memos were undertaken, with the field researcher assisting in the interpretation of ambiguities and data outliers. Codes were assigned to identify key constructs, which were then allocated into categories. The street surveys for random passers-by and street drug users were analysed descriptively using SPSS.

Research Limitations

The research is exploratory and limited by small convenience sample sizes of participants willing to partake. However, despite the small numbers of participants and missing data in the case of drug user street surveys, and due to the nature of this RAR, validity and accuracy of the findings are optimised by the use of triangulated data sources from PULSE data relevant to the area, service user perspectives, business and transport, community, voluntary and statutory stakeholder perspectives, passersby and street drug user perspectives, photographical and environmental mapping analysis. In addition, a variety of research methodologies were employed which compliment and support the findings.

Chapter 3. Literature Review

Introduction

In May 2003 the Eurobarometer survey on public safety, exposure to drug related problems and crime in the European Union (EU) was published by the European Commission (European Commission 2003). Irish trends relating to public frequency of exposure (*often'* and *'from time to time'*) to drug related problems increased between 2000 and 2002, with data for *'often'* remaining constant over time, and with a reduction in *'from time to time'* in 2002. These trends in public exposure to drug related problems may be due to increased law enforcement efforts, a large proportion of Irish individuals answering *'don't know'*, increased efforts at community regeneration and equally a moderation in public perceptions of Ireland's drug issue in that time frame (Drug Misuse Research Division, 2004). In addition, according to the Drug Misuse Research Division's report (2004) drug markets and its related problems tend to be concentrated in certain areas, and may shift in location in response to policing and community efforts. Dublin based drugs and crime surveys (Connolly, 2001; 2003a;b) and City Wide Drugs Crisis Campaign (2004) have indicated high rates of public awareness of drug dealing visibility, commonly sold in stairwells, in private homes, bars and discos or on the street, with heroin, cannabis, ecstasy, cocaine and benzodiazepines easily available. Concerns also remain in Ireland with systemic aspects of the drug trade evidenced by increasing drug related gangland murders and shootings (Connolly, 2006a;c). The debate continues with regard to prohibition (Seddon, 2000), with Stevens et al. (2005a:10) arguing; *'that prohibition leads to more economic-compulsive and systemic crime by forcing up the price of drugs and leaving distribution in the hands of criminals.'* Others argue that deregulation of drug markets could contribute to increased drug using rates and thereby increased crime rates (Inciardi 1999).

The relationship between drug use and crime remains complex (Seddon, 2000; da Agra, 2002). Several explanatory causal models have been proposed, which include the psycho-pharmacological model (describing the drug-crime links relating to intoxication); economic-compulsive model (describing the drug users need to secure illicit income to support a drug habit), the systemic model (describing drug related crime arising from contact with the illicit drug market), and common-cause model which proposes there is no direct causal link between crime and drugs, but related to other factors such as socio-economic deprivation (Goldstein, 1985; Nurco, 1987; Harrison and Gfroerer, 1992; Parker and Bottomley, 1996; Byqvist and Olsson, 1998; Hough et al. , 2000; Pudney, 2002). Associated harms are presented as socio-cultural and economic structural outcomes, with lower socio-economic status (SES) indicators including inequality, deprivation, neighbourhood disadvantage, unemployment and low educational attainment (McBride and McCoy, 1993; Wilkinson, 1996; Strathdee *et al.,* 1997; Baron, 1999; Buchanan and Young, 2000; Vitellone, 2004; Jarrin *et al.,* 2007). However, criminal activity can heighten drug use by provision of a source of funds to support a drug habit, and may mutually reinforce each other, thereby prolonging the drug using and criminal career (Burr, 1987; Farabee *et al.,* 2001; Hough, 2002; McSweeney and Hough, 2005). Studies have also found that drug dependency is associated with low self-esteem and sense of shame, feelings which are compounded by funding a drug habit through prostitution, begging or petty crime (Skretting, 2007).

Violence and property crime are strongly associated with socio economic deprivation, with intimidation in public areas and public order offences particularly characteristic of excessive alcohol use (Speer *et al.,* 1998; Magennis *et al.,* 1998; Scott *et al.,* 1999; Home Office, 2000a;b; Bromley and Nelson*,* 2002; Martin *et al.,* 2004; Alcohol Action Ireland, 2011), with drug use less common in public order offences, and poly drug use further compounding the issue of public nuisance (Institute of Criminology 2003; Drug Misuse Research Division, 2004). Whichever the route of causality or reinforcement, some policy responses remain focused on drug related crime rates (Deitch *et al.,* 2000; Rolles *et al.,* 2004) with research also suggesting that overall problematic drug using rates are not related to overall crime victimization rates (Van Kesteren *et al.,* 2000; EMCDDA, 2004a).

Here follows a series of drug related crime statistics used to create a picture of the Irish illicit drug market relating to consumption, distribution and displacement patterns from a recent Drugnet publication (Connolly, 2011c).

Drug Crime Rates in Ireland

The criminal legislative framework as it applies to drugs in Ireland is outlined in Misuse of Drugs Acts (MDA) 1977 and 1984, and the Misuse of Drugs Regulations 1988, and includes the importation, manufacture, trade in and the possession (other than by prescription) of the psychoactive substances (Connolly, 2006c). In 2006, crime reporting statistics became responsibility of the Central Statistics Office (CSO). Most Irish drug users receiving imprisonment sentencing do so for the consequence of their crime (i.e. theft, burglary, prostitution, larceny), and not for drug offences (Connolly, 2006c). Research shows that drug possession offences (particularly in the case of cannabis) account for the majority of drug offences recorded, with reductions recorded in different time frames related to increased employment of drug users, availability of treatment and methadone maintenance options (Connolly, 2006c).

Please note that data presented in the following graphs may be inaccurate due to not all drugs seized undergoing analysis at the Forensic Science Laboratory (FSL). Of note is the significant reduction in cocaine, heroin and ecstasy type drug seizures since 2007. However, other research in that timeframe has indicated an increase in forging of prescriptions, and use of street benzodiazepines (D'Arcy 2000, An Garda Síochána 2004).

Drug offences

Figure 1 shows an increase in criminal proceedings for the possession of drugs for personal use from 2003 to 2008. Possession offences represented almost 75% of the 14,374 drug offences in 2008. The increase in total drug offences since 2003 is accounted for by the increase in simple possession offences. Proceedings for drug supply increased marginally, from 2,654 in 2007 to 2,967 in 2008.

Figure 1 Trends in relevant legal proceedings for drug offences, 2003-2008
Source: Central Statistics Office
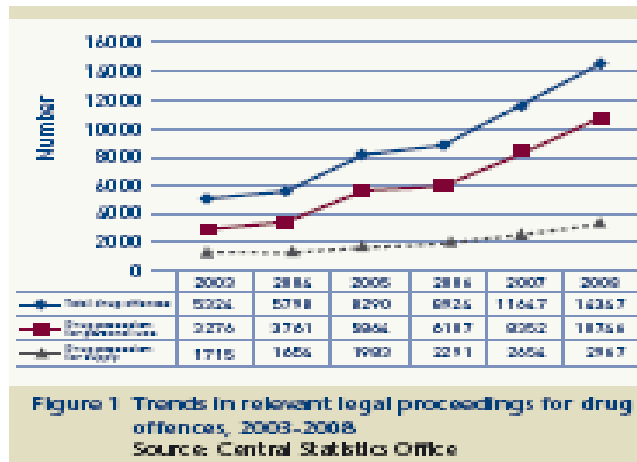
Connolly, J (2011c) Drugs and crime data. Drugnet Ireland, Issue 39, Autumn 2011. pp. 21-23.

Figure 2 indicates that proceedings for the offence of obstructing the lawful exercise of a power (i.e. resisting arrest, or disposal of drugs to evade detection) decreased in 2008, following a steady rise since 2003. In 2008 an increase in the number of proceedings for drug importation cultivation or manufacture of drugs and forging of prescriptions were recorded, with findings complicated by increased law enforcement efforts during that timeframe.

Figure 2 Trends in relevant legal proceedings for selected drug offences, 2003-2008
Source: Central Statistics Office
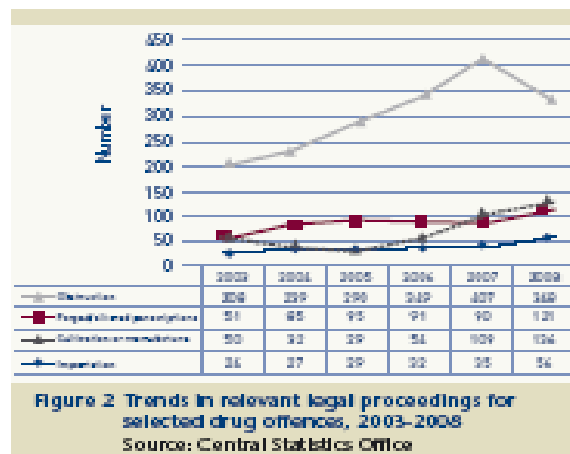
Connolly, J (2011c) Drugs and crime data. Drugnet Ireland, Issue 39, Autumn 2011. pp. 21-23.

Drug seizures

Figure 3 presents trends in cannabis-related seizures which show that cannabis seizures accounted for the largest proportion of all drugs seized between 2003 and 2009. The total number of drug seizures increased in the timeframe 2005 and 2007 and decreased in consecutive years, which can be partly due to the decrease in cannabis and cocaine seizures in that timeframe. Findings may be complicated that potential for reduced use of cannabis and intensified law enforcement efforts.

	2005	2006	2007	2008	2009
All seizures	6362	8417	10444	9991	5494
Cannabis-type substances	3555	4243	5176	5652	2314

Figure 3   Trends in the total number of drug seizures and cannabis seizures, 2005–2009
Source: Compiled by the Forensic Science Laboratory drug section and reported by the Central Statistics Office
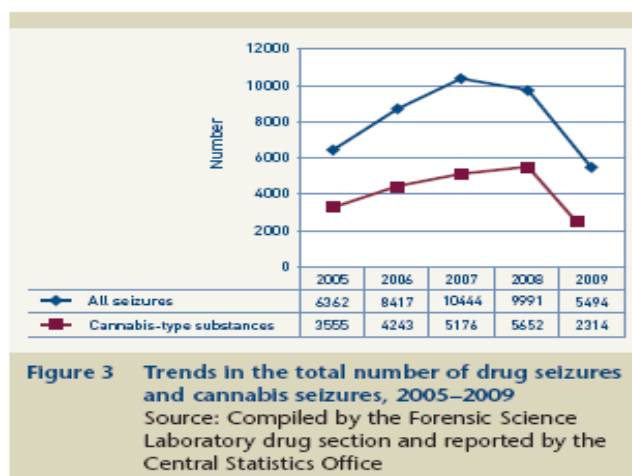
Connolly, J (2011c) Drugs and crime data. Drugnet Ireland, Issue 39, Autumn 2011. pp. 21-23.

Figure 4 presents data relating to trends in seizures for drugs, excluding cannabis, between 2003 and 2009, with a significant decline recorded in cocaine, heroin and ecstasy type substances seized since 2007.

Figure 4 Trends in the number of seizures of selected drugs excluding cannabis, 2003-2008
Source: Central Statistics Office
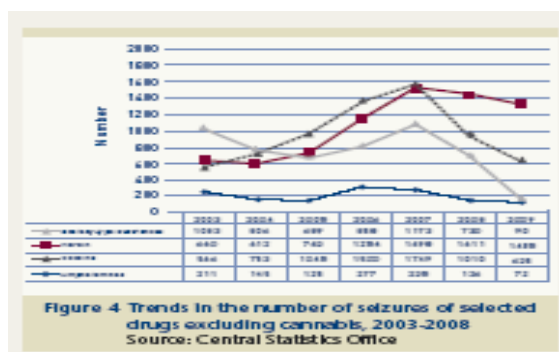
Connolly, J (2011c) Drugs and crime data. Drugnet Ireland, Issue 39, Autumn 2011. pp. 21-23.

Open Drug Scenes, Violence and Drug related Public Nuisance

According to the EMCDDA (2005a:9) in their special issue report entitled *'Drug-related public nuisance — trends in policy and preventive measures';* drug-related public nuisance cannot be reduced to simply drug related crime and *'is a catch-all concept, an eclectic mix of elements differing in nature, substance and extent: in this respect, it can include situations, behaviours or activities.'* Such activities can range from minor to causing extreme distress, and in certain instances (i.e. a harm reduction or treatment facilities) can be viewed as both causing public nuisance or responding to it, with its effect not strictly proportional to levels of criminality, deviance, vandalism and presence in public areas, individual drug user harms, and may also reflect social tolerances in that country (Waal, 2004). Drug related public nuisance policies can be integrated into national drug policies as is the case in Belgium, Ireland, Luxembourg, the Netherlands and the United Kingdom, (EMCDDA, 2005a) and as component of specific measures (i.e. the Irish Housing (Miscellaneous Provisions) Act 1997). The remainder EU countries (i.e. Hungary, Czech Republic, France, Germany, Greece, Italy, Slovenia) do not report public nuisance policies contained within their national drug strategy, and instead utilise their public order and safety policies, and *'ad hoc'* interventions to address drug related public nuisance. General legislation concerning public order and non drug related public nuisance, legislation focusing on drug specific public nuisance (i.e. the Anti Social Behaviour Act in the United Kingdom), and drug laws concerning drug use, possession, transportation, and dealing can also be utilised (EMCDDA, 2005b). However, the EMCDDA (2005a;b) raises concerns with regard to finding a balance between community rights for safety and respect for human rights.

Researching drug markets is the *'new vogue'* (Coomber, 2004), with varied sociological, economic, psycho-behavioural and criminological approaches to understanding this phenomenon (Ritter, 2006). Drug markets can be *'open'* or *'closed'* in terms of visibility and barriers to access (May *et al.,* 2000). Causes of drug related public nuisance comprise of three overlapping cohorts which include poly drug users, problematic drug users and those with underlying mental health issues, and with settings situated in *'open drug scenes'* , in *'small meeting points'* and in *'hot zones'* for drug trafficking (EMCDDA, 2005a).

Indeed, the term *'open drug scene'* defines a *'meeting point where drugs are sold and places where users gather and meet each other'* with public nuisance policies encompassing a range of objectives and substances (alcohol and/or drugs) (EMCDDA, 2005a:10). Dalton and Rowe (2004) presented an insight into drug markets as economic activity, with three groups identified which include, users who obtain access to a reliable source, middlemen who benefit by taking a slice of the profit from each deal, and dealers who profit from sales and cover provided by middlemen. Other ethnographic research on local level drug dealing as part of community economic activity has described less distinctions between users and dealers (Fitzgerald, 2009). However, the phenomenon of such public drug markets is associated with problems in the form of identifiable *'no go'* areas for local residents, visible drug consumption, injecting and intoxication in public areas, poly drug use, drug related mortality, street violence between users, presence of organised crime groups and gang wars, street sex work, drug related petty crime, homelessness, the littering of drug paraphernalia, drug tourism, noise, traffic interference and houses (i.e. *'informal sorting houses'*) where drugs are sold/used (Broadhead *et al.,* 2002; Connolly, 2006a; Cusick, 2007). Indeed, research has underscored the relationship between the drug trade and rates of urban violence (Johnson *et al.,* 2000; Ousey and Lee, 2004; Martin *et al.,* 2009; Werb *et al.,* 2011), which are compounded by environmental factors such as homelessness, drug related factors such as drug induced psychosis, financial involvement, drug related debts and attempts to attain status within local drug markets (Decker, 2003; Marshall *et al.,* 2008; Brownstein *et al.,* 2000; Castle, 2009; Agren, 2010). Connolly (2006a) has also observed how such *'open drug scenes'* can make it problematic for drug users to commit or seek treatment.

Potential strategies for response to *'open drug scenes'* have been much debated in national and international arenas (Drug Misuse Research Division, 2004; International Narcotics Control Board (INCB), 2004; EMCDDA, 2005a;b). A balance of demand reduction, supply reduction and harm reduction is advised (Aitken *et al.,* (2002).

Dalton and Rowe (2004:242) highlighted the need for policy makers to select one of two choices; '*they can either 'renovate the existing social arrangement' through measures such as security enhancement and community participation that could push the selling and use of drugs off the estate but to somewhere else, or (a much more radical proposal) seek to regulate drug markets, i.e. accept the illegality of the trade but tolerate its operation.'* The EMCDDA report in 2005 identified a trend in the EU which de-emphasises criminal sanctions for simple possession for personal use. Research shows that drug law enforcement has little if no effect on drug pricing, availability and demand, with some research reporting increased crime rates if drug prices increase, and open drug markets quickly becoming closed, and operating via use of sophisticated technologies and intermediaries, runners and lookouts (Reuter and Kleiman, 1986; Best *et al.,* 2001; May and Hough, 2001; Maher and Dixon, 2001; Aitken *et al.,* 2002). Dealers exit an *'open drug scene',* with street dealing becoming more opportunistic with higher risk, more volatile and with greater numbers of violent disputes leading to murders and non-fatal shootings (Rasmussen *et al.,* 1993; Maher and Dixon, 1999; 2001; Resignato, 2000; Levitt and Venkatesh, 2000; Benson *et al.,* 2001; Shepard and Blackley, 2005; UNODC, 2008; Werb *et al.,* 2011).

However, governments generally address drug market violence and intimidation via drug law enforcement efforts aimed at reducing the sale and supply of illicit drugs (i.e. targeted crackdowns of known street drug markets, military interventions and legal sanctions against drug users, dealers and producers (May and Hough, 2001; Drucker, 2002; Aitken *et al.,* 2002; Veillette, 2005; Werb *et al.,* 2011). An urgent need to address drug related violence using alternative regulatory models has been advised, alongside specific structural and gender specific initiatives where levels of violence and intimidation in public places, communities, among young and old are targeted by specific initiatives focusing on type of drug related violence, victims, offenders, social contexts and location (Marshall *et al.,* 2008; Werb *et al.,* 2011). Research also shows that drug law enforcement does not incur significant reductions in supply and use where drug demand is high (Degenhardt *et al.,* 2008) with some experts calling for the regulation of certain drugs (Rolles, 2009).

Of interest is that, Portugal's drug decriminalisation policy which prioritises public health, harm reduction and treatment responses for drug users, alongside prevention tactics has resulted in a reduction of both illicit drug use and associated harms (Hughes and Stevens, 2007; Greenwald, 2009).

The EMCDDA reports and discussions (Wall, 2004) have proposed a movement away from repressive law enforcement in the form of '*zero tolerance*', and toward that '*conditional tolerance*' within a multi-faceted combination of '*repression*' and *tolerance*' in law enforcement, social and health services, and community partnership (Connolly, 2006a). Countries in the EMCDDA report '*Drug-related public nuisance — trends in policy and preventive measures*' agreed that although very large open drug scenes cannot be permitted to develop due to large scale public intimidation and generalised perception that drug use is acceptable, smaller, more containable drug scenes are easier to manage so as to preserve citizen rights to congregate in public areas, facilitate the provision of low threshold services, avoid displacement of drug scenes to other areas or underground, and facilitate police monitoring of the issue (Fitzgerald, 1999; Berzi, 2004; Wall, 2004; Herzig, 2004; Rasmussen and Sorensen, 2004; Fossum, 2005; Holman, 2005; Connolly, 2006a). In order to address '*drug tourism*' where an influx of drug users from outside the area occurs, initiatives to encourage users to return to their own localities can include voluntary inducements, arrests, physical transportation to their homes and diversion to drug treatment centres (Wall, 2004; Fauske, 2005). However, such '*neighbourhood renewal*' and '*weed and seed*' initiatives whilst operating as partial and full displacement policies do not necessarily reduce harm, and instead act as dispersal mechanism (Wall, 2004; Brindenball and Jesilow, 2005). According to Aitken *et al.,* (2002), by temporarily reducing the visible aspects of open drug scenes, drug markets will speedily adapt to new conditions, and may incur unwanted negative consequences such as public health harms in the form of displacement of drug markets into suburban areas, reduced safe injecting and needle disposal, and greater instances of violence and fraudulent behaviours. Research has described the potential for normalisation of injecting drug use among vulnerable youth in areas previously with no IDU (Miller *et al.,* 2002; Roy *et al.,* 2003).

The displacement of drug scenes can increase mortality rates, negatively affect health of drug users and uptake of harm reduction and treatment services, as well as lending itself to underground drug market adaptation supported by mobile phone use (which is difficult for police to penetrate), the emergence of closed markets located in houses, and crime displacement from drug dealing to property crime (Fitzgerald 1999; Maher and Dixon, 1999; Connolly, 2006a).

Policing

Police visibility in areas experiencing antisocial behaviour increases resident confidence in authorities in dealing with crime and public nuisance in their community (Moon *et al.,* 2011). Loxley *et al.,* (2004) argue that mixed evidence exists with regard to effectiveness of police crackdowns, and particularly due to localised conditions and drug user adaptability. Area characteristics affect public perceptions of crime rates (Flatley *et al.,* 2010; Quinton, 2011), with residents in highest crime areas are most likely to say that local crime is *'about average'* (Moon *et al.,* 2009), and with victims of crime most likely to indicate a crime rate increase (Flatley, *et al.,* 2010). In particular, intense policing and *'spillover'* into another area can result in an increase in '*bunking*' (i.e. the sale of low quality drugs) (Aitken *et al.,* 2002) which contributes to increased violence to resolve drug debts and disagreements, and maintain losses of territory (Erickson, 2001; Taylor and Brownstein, 2003). According to Nordt and Stohler (2009), in their Zurich experience, they did not find a relationship between levels of police activity, incidence rates of problematic heroin use and street heroin pricing. Policing tactics often include deployment of officers within a defined area for short periods of time, undercover officers acting as drug dealers or users (i.e. buy and busts or test purchasing), surveillance using CCTV, body searches, street chases and physical restraints (Kersten, 2000). Such attempts focus on disruption of drug markets, interrupting supply channels, increasing time spent sourcing drugs for users and dealers, and ultimately aim to stimulate users to seek treatment.

Responses to police activity carry the potential to create social harms and impact negatively on health of drug users (especially injecting drug users) in the form of rushed injecting, reduced user carrying of syringes for fear of confiscation, with potential for injecting whilst in withdrawal using un-sterile equipment, and with a shift toward nasal and oral storage of drugs with risk for contamination, accidental overdose and viral transmission (Maher and Dixon, 1999; Bastos and Strathdee, 2000; Kerr *et al.,* 2005; Lister *et al.,* 2008).

Policing strategies typically incorporate frontline strategies, monitoring and regulations strategies and partnership strategies (Fleming, 2008). A detailed spatial and temporal knowledge of alcohol and drug related crime and disorder in identified *'hot spots'* is vital to policing (Bromley and Nelson, 2002). Jacobs *et al.,* (2007) advocated that within a recognition of awareness of structural factors which aggravate drug related problems (i.e. fragmented communities, family breakdown, poverty, increased mobility), policing methods need to assume a greater civil or community focused approach known as '*problem orientated policing'*, and which ultimately aims to increased levels of social capital, social cohesiveness and civic engagement (White, 2002; Loxley *et al.,* 2004). Ritter (2006) described such *'Problem Oriented Guides for Police'* produced by Community Oriented Policing Services in the US, and which strive to assist police in understanding and responding to local community crime and disorder issues. This manual has a guide number 13 entitled *'Drug dealing in open-air markets'* which offers a useful guide to police response to this issue (Harocopos and Hough, 2005). James and Sutton (1998) comment that successful harm minimisation may necessitate the police to subordinate the interests (or '*self interests'*) of local groups which support traditional law enforcement policies and practices. A discretionary approach is also advised with police officers via cautioning of drug users, avoiding interaction whilst injecting, providing referral to appropriate health and social services (before or after arrest) and with police maintaining distance from health services (Kerr *et al.,* 2003).

Inter-Agency working and Partnership Initiatives

According to Jacobs *et al.,* (2007) inter agency collaboration within the public sector can be utilised successfully to address social problems such as illicit drug activity and associated anti social behaviours. Partnership initiatives can operate to disperse an '*open drug scene'* and prevent development of a new one via intense policing and law enforcement against drug dealers and users, the introduction of civil or criminal legal powers (i.e. Antisocial Behaviour Orders (ASBOs), administrative measures (i.e. fines), court orders to prevent public nuisance related to drugs, harm reduction (i.e. needle and syringe exchanges, drug consumption rooms) and low threshold treatment, social and housing supports, employment assistance, community mediation and community groups, information campaigns and medical provision (Herzig , 2004; Walker , 2004; Wall, 2004; Van der Meer 2004; Holman, 2005; EMCDDA, 2004b; 2005a;b). Other initiatives include the closure of '*crack houses'* , eviction from local authority housing and more severe sentencing for repeat offenders (Woudstra, 2004; Burgess, 2004; Jongeneel, 2005; Barron, 2005, EMCDDA, 2005a).

For example, in the United Kingdom, Drug and Alcohol Action teams (DATs) and Crime Reduction Partnerships work together in partnership to address drug related crime and public nuisance (Burgess, 2004; Hanrahan, 2005) under guidance from the Crime and Disorder Act, 1998. These DATs involve partnerships between police, social and health services, with training provided in referrals and harm reduction philosophies (Smith *et al.,* 2000). Similarly, Holand (2004) and Fossum (2005) described a similar police and agency cooperation in Norway, and political and street coordination, with weekly meetings between stakeholders in Germany (Weimar, 2005), Austria (David, 2005), Switzerland (Feller, 2005), France and Luxembourg (Carpentier, 2005) and Sweden (Holman, 2005).

In Dublin (Ireland) regular meetings between stakeholders occur at local and senior public levels, so as to provide a forum for local residents to raise issues relating to concerns (Connolly, 2005; Metcalfe, 2005; Barron, 2005; Keane, 2005).

In order for such community and governmental partnerships involving police, social, health, criminal justice, homeless, drug and alcohol teams/task forces, pharmacists, public transport providers, youth and religious services and community representatives to be successful, adequate resources, regular meetings with motivated stakeholders at both local and strategic level, provision of meeting places, a well defined media strategy, access to current local and site specific prevalence data, outreach with drug users alongside with clear guidelines for the interagency exchange of information, agreed measures to reduce public fear and visibility of drug related anti social behaviours, and performance protocols for proposed interventions must be considered (Van der Meer , 2004; Burgess, 2004; Ahven , 2005; Weimar, 2005; Metcalfe, 2005; Jongeneel, 2005; Hanrahan, 2005; Holman, 2007). A commitment for senior stakeholders, enthusiasm, a clear rationale and effective leadership from key stakeholders is vital, with positive outcomes dependent on resources and commitment of partners involved, levels of local resident involvement and media roles (Herzig, 2004; Weimar, 2005) (see Appendix 2). Jacobs *et al.,* (2007) observed the impact of bureaucratic barriers, unrealistic targets, high participant turnover, inadequate resources, and contradicting philosophies between police (sanction oriented) and social (welfare oriented) departments as undermining effective collaboration. Consultation with residents and local community groups, and with drug users themselves with an analysis of local drug scenes is an important part of such partnership responses (Fauske, 2005; Woudstra, 2004; Judd *et al.,* 2005; Holman, 2005).

Research by Randall (2011) has commented on the lack of a specific interface between research and drug policy making structures. The partnership working must also consider contentious public attitudes toward the placement of drug treatment facilities near residential and public areas. Process and outcome evaluations of such partnership initiatives must be undertaken, with improvements measurable, and which can include opinion polls, surveys and ethnographic studies exploring the extent of the drug problem in the location, the initiatives effect on the users themselves, the *'collaborative climate'* for all stakeholders and number of meetings/attendance rates, impacts on levels of crime and

nuisance (Burgess, 2004; Holman, 2005; Kraalj, 2005; Connolly, 2005; Connolly and Donovan , 2008).

Research shows that the monitoring of partnership and sustainable approaches can improve interagency relations, mutual understanding of the issue, improved service provision, positive visitor reports of the area, reduced petty crime (Weimar, 2005; Connolly, 2005, Metcalfe, 2005; Holman, 2005).

Public Injecting Interventions

Community and business concerns with regard to public place drug injecting remain, as it isare seen to negatively impact on community cohesiveness and perceptions of resident safety, restricted public amenity (i.e. needle stick injuries (NSI) in children) and quality of life (Wood *et al.,* 2003a; McKeganey et al, 2004; O'Somachain, 2004; Nyiri *et al.,* 2004; Taylor et al, 2006a; b; Blake Stevenson, 2010). Rhodes *et al.,* (2007a) describe public injecting as related to homelessness, drug dependence and opportunity, with the fast preparation and injection of drugs in public places away from the *'public gaze'* conducive to avoid public and police interruption (Fitzgerald, 2005). SES is associated with increased rates of unsafe injecting practices, violent and property crime and risk behaviours (Kang and DeLeon, 1993; Strathdee *et al.,* 1997; Galea *et al.,* 2004; Australian Institute of Health and Welfare, 2005). Research has estimated that rates of injecting drug use in public places are reportedly more common in deprived areas and among homeless or those in hostel accommodation (Cox and Lawless, 1999; European Monitoring Centre for Drugs and Drug Addiction, 2002; Scottish Executive, 2004; Judd et al, 2005; Diggins, 2005; Kemp et al, 2006; Wood et al, 2006a; b; Hunt, 2006; Newcombe, 2007; Neale et al, 2008; Blake Stevenson, 2010). There is a heightened risk of health complications, environmental contamination, high risk injecting practices (i.e. groin injecting, direct and indirect sharing of equipment) associated with public injecting (Smyth *et al.,* 2004; Scottish Executive, 2004; Wright *et al.,* 2005; Hunt, 2006; Atkinson, 2006).

Public place injecting is associated with poly drug use, fatal and non fatal overdose, cerebral hypoxia, vascular damage, blood borne virus transmission, femoral or neck injecting, peer injecting and related injury, sharing, use of discarded needles and contamination (*'dirty hits'*) (Fry, 2002; Navarro and Leonard, 2004; Hunt et al.,2007; McKnight etal.,2007; Rhodes et al.,2008; De Beck et al., 2009; Parkin, 2009; Parkin and Coomber, 2010; Marshall et al.,2010).

Interventions seeking to disperse and displace public injecting scenes include intense policing (i.e. *'crackdowns'*), physical removal of injecting sites by legitimate force, displacement tactics involving blocking, fencing, surveillance, fluorescent lighting in public toilets and motion detector alarm systems (O'Somachain, 2004; Cooper *et al.,* 2005; Parkin, 2009; Parkin and Coomber, 2010).

Research shows that for many outdoor injectors and *rough sleepers'*, heroin is administered to assist the user in sleeping, dealing with cold weather and as distraction (Scottish Government, 2008). In-depth research on public injecting in Scotland found that for '*rough sleepers'* and homeless with hostel accommodation, there was no alternative to public or street injecting (Blake Stevenson, 2010). Areas most conducive to public injecting are most likely to be quiet, secluded and where the general public does not frequent (Keep Wales Tidy, 2007; ENCAMS, 2005). Indeed, Parkin (2009) described a continuum of public place safety and hygiene for injecting drug users, which ranged from controlled safe areas (i.e. public toilets with visits pre planned); semi controlled areas (i.e. street, alleyways and wasteland); uncontrolled (i.e. rooftops, parks and doorways most commonly used by homeless individuals or *'rough sleepers'*). Research suggests that public injecting is characterized by a sense of urgency and user shame, due to fear of public or police interruption (Rhodes *et al.,* 2007a). Both Parkin and Coomber (2009a) and Newcomb (2007) describe the presence and frequent use of *'informal sorter houses'* or *'shooting galleries'* (i.e. rooms, derelict buildings, dealer houses, under bridges) where addicts meet to inject, and highlighted the association with less safe disposal of sharps.

Blake Stevenson (2010) reported that many pubic place injectors described their preference to inject somewhere clean, safe and private, and without police or public harassment. According to Hunt *et al.,* (2007) and Wood et al., (2004a) the majority of public injectors in the United Kingdom would be willing to use a drug consumption room if available, with researchers suggesting that if such services were located close to *'open drug scenes'*, it would be possible to engage with vulnerable injecting drug users such as youth and homeless individuals, and reduce unsafe street disposal of drug injecting equipment.

In some countries, supervised injecting centres (SICs) or drug consumption rooms have had some success (International Narcotics Control Board (INCB), 2004; Hedrich, 2004; EMCDDA, 2004b; Carpentier, 2005; Weimar, 2005; Fauske, 2005) and have greatest potential impact when both individual and public health objectives are consulted, and an acceptable level of public order and community safety is sustained (Wood *et al.,* 2001; Fischer *et al.,* 2004; Navarro and Leonard, 2004). Such facilities reduce levels of *'rushed'* injection, overdoses and unsafe disposal of sharps , promote safer injecting practices, and provide a monitoring systems of its attendees (Strike *et al.,* 2004; Wood et al., 2004a;b; Kerr et al.,2006; Cusick and Kimber, 2007; Salmon et al.,2009; Haemmig and Van Beek,2005; Parkin and Coomber, 2011a; b). However, SICs are often not equipped to deal with assisted injectors who are at higher risk of HIV infection (Kerr *et al.,* 2003; Wright and Tompkins, 2004; O'Connell *et al.,* 2005; Petrar *et al.,* 2006; Small *et al.,* 2006). Longitudinal research assessing community perceptions of SICs indicate a decrease in businesses and residents witnessing public place injecting and publicly discarding injecting paraphernalia, with significant change in street visibility of proportions of drug related debris, and times offered drugs for purchasing (Wood *et al.,* 2004a;b;c; Kerr *et al.,* 2005; Salmon *et al.,* 2007). Research in Ireland has highlighted injecting drug users willingness to use SIF's, even though mixed opinions were evident among key stakeholders and policy makers (O Shea, 2007).

Future '*ecological or environmental approaches*' need to target individual or micro drug injecting environments, ensure policing levels do not compromise injectors health, improve emergency responses and address structural factors such as SICs and provision of public toilets, housing, education and community rehabilitation (Des Jarlais, 2000; Butler and Robson, 2001; Fitzgerald, *et al.,* 2004; Blankenship *et al.,* 2006; Small *et al.,* 2007). The development of integrated SICs and low threshold housing (i.e. '*Housing First*'), alongside supported employment options for street drug users can reduce potential involvement in drug markets and street disorder in open drug scenes, reduce overdose instances and provide drug using individuals with a sense of private space (Krusi *et al.,* 2009; Larimer *et al.,* 2009; Lyotier, 2010; Richardson *et al.,* 2010; De Beck *et al.,* 2011).

Other developments include the provision of holistic services incorporating needle exchange and mobile outreach syringe distribution, syringe vending machines, blood borne virus (BBV) testing, immunization, health and social information provision, social, medical, housing, employment and educational agency referral, and coordinated pharmacy exchange networks with open access (Rhodes *et al.,* 2006a; Atkinson, 2006; Lister *et al.,* 2008; Parkin and Coomber, 2010; Islam and Conigrave, 2007; Parkin and Coomber; 2011a; Inman, 2011). However, barriers to uptake remain with regard to age, gender, ethnicity and housing status (Neale, 2006; Shaw *et al.,* 2007; Diggins, 2005). Lastly, public concern for drug related litter (DRL) in community settings and shared social space (i.e. play areas, public toilets and parking areas) remains despite research showing that viral sero-conversion and infection relating needle stick injuries (NSI) are not common (Russell and Nash,2002; Blenkharn, 2008) and has highlighted the need for '*drug related litter bins*' in community settings (Darke et al.,2001; Fitzgerald, 2005; Taylor *et al.,* 2006a;b; Devaney and Berends,2008; De Beck *et al.,* 2009; de Montigney *et al.,* 2011; Parkin and Coomber, 2011b). O'Somachain (2004) also underscored the need for official procedures, staff training and provision of safety equipment (i.e. gloves, tongs and bins) to safely remove drug litter.

Situational Crime Prevention

It must be noted that urban regeneration whilst addressing urban decay, does not address individual social problems (Cusick and Kimber, 2007). However, urban regeneration and renewal initiatives combined with policing and community activism are useful to highlight public drug and alcohol use as social problems (Cusick, 2007; Rhodes *et al.,* 2007b). Situational crime prevention (SCP) efforts to prevent the development of '*new drug scenes'* include the design and management streets to deter emergence of drug using and dealing. This includes closed circuit television (CCTV) which offers some deterrent to theft but is less effective in the case of violent crime (Welsh and Farrington, 2002; Gill and Spriggs, 2005) and the *'designing out of crime'* in public spaces (Bromley and Nelson, 2002), with examples including *'defensible space'* in the remodeling of housing with limited casual access, lighting, high quality window and door locks, installing motion detector alarms and optimization of natural surveillance

(i.e. removal of foliage) (Newman, 1972; Armitage, 2000; Tilley, and Laycock, 2002; Pease, 2002; Cox and Lawless, 2003; Walker, 2004; Ahven, 2005; Holman, 2005; EMCDDA, 2005a; Parkin and Coomber (2009a). However, such research shows that the benefits of SCP may be short-lived and result in displacement of crime and poor sustainability, with offenders moving to areas with lower levels of SCP (Fitzgerald, 1999). Other critiques include the creation of a "*fortress society*" which serves to reinforce social exclusion, lack of trust and reduced quality of life experienced by communities experiencing drug related crime (Davis, 1990). Conflicts may also exist between interventions aiming to reduce drug related harm with localities experiencing drug related disorders, the stigmatization of placement of drug services, and broader regeneration efforts to develop businesses (Punch, 2005; Cusick and Kimber, 2007).

Court-mandated treatment

Research shows that participation in drug treatment such as abstinence based, methadone maintenance and heroin assisted treatment contributes to reduced levels of criminal activity, with economic benefits outweighing treatment costs (Uchtenhagen *et al.,* 1997; Rydell and Everingham, 1994; Hough *et al.* 2000; Prendergast *et al.,* 2002; van den Brink *et al.,* 2003; Godfrey *et al.,* 2004). However, positive treatment outcomes remain tempered by variance between treatment sites, levels of poly drug use, co-morbidity and relapse rates, and additionally by question of scale with small, closely monitored programmes proving difficult to replicate on national levels (Gossop, 2004). The knowledge around the incurred benefits of drug treatment has led to efforts to utilise treatment as alternative to imprisonment.

A Drug Treatment Court (DTC) is defined as *"Treatment Orientated Court where the judge dispenses justice with the help of an integrated team of professionals who provide treatment to the defendant"* (5th Report of Working Group on a courts Commission on Drug Courts). DTCs provide a unique forum for therapeutic jurisprudence (Senjo and Liep, 2001), with race, gender, education, age and motivation to cease drug use identified as importance predictors of success (Newman 1983; Scott and Terry, 1997).

Although present research has been tainted by methodological issues (Stevens *et al.,* 2005b), estimations of effect suggest that DTCs reduce levels of re arrest and recidivism (Lind *et al.,* 2002; Lipsey, 2003; National Center on Addiction and Substance Abuse, 2003; General Accountability Office, 2005; Stevens *et al.,* 2005; Latimer *et al.,* 2006; Wilson *et al.,* 2006; Shaffer, 2011), with studies in the UK and Scotland recording poor results, with high rates of reoffending and reconvictions (Spicer and Glicksman, 2004; McIvor, 2004).

A pilot DTC was established in 2001 in Dublin's north inner city (Farrell, 2002), with an evaluation of the scheme in 2002 recommending expansion of the scheme, with positive findings in relation to reduced recidivism and illicit drug use, and channeling participants onto training and employment (Farrell, 2002). Difficulties were observed to relate to the provision of full and timely treatment services.

The Department of Justice, Equality and Law Reform (2010) evaluation also highlighted the low number of participants entering and successfully completing the DTC programme, even though positive effects were recorded for all participants, completed or dropout. Researchers have speculated that volunteers seeking treatment may be crowded out of the system and that court ordered treatment may harm staff and peer relationships with the offender (Hunt and Stevens, 2004). Quality of the chosen treatment modality itself remains of paramount importance (Millar *et al.,* 2004).

Chapter 4. PULSE Data

Provided by An Garda Siochana.

Total Research Area

A total of 6,663 crime incidents were extracted over the 14 month period (Dec'10 to Jan'12) being examined. The suspect offenders associated with each of these incidents were also extracted.

The dispersion of crime incidents across each of the quadrants is not uniform nor is the profile of crime incidents within each quadrant. Figure Int-1 presents a mosaic plot that illustrates the varying sizes of the crime incidents in each quadrant and each crime category. From the diagram, Quadrant 1 has the largest number of crime incidents, and Quadrant 5 has the smallest number of crime incidents. A clear distinction of the profile of crime incidents can be made between Quadrants 1-4 and Quadrants 5-7. In Quadrants 1-4, Property Crime (PC) has the highest proportional frequency compared to other crime categories. In Quadrants 5-7, Public Order (PO) incidents have the highest proportional frequency.

Figure Int-1
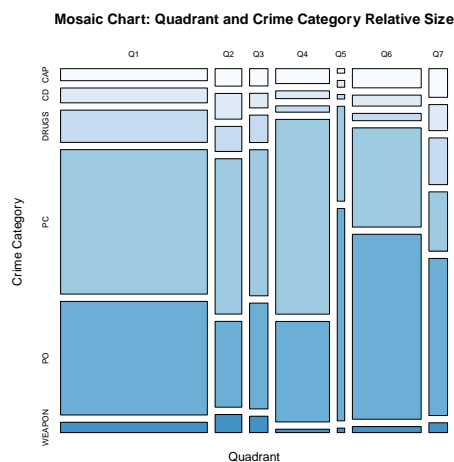
A temporal analysis of each of the crime categories is presented in Figures Int-2 on the next page.

Figure Int-2

Temporal Analysis:Crime Category
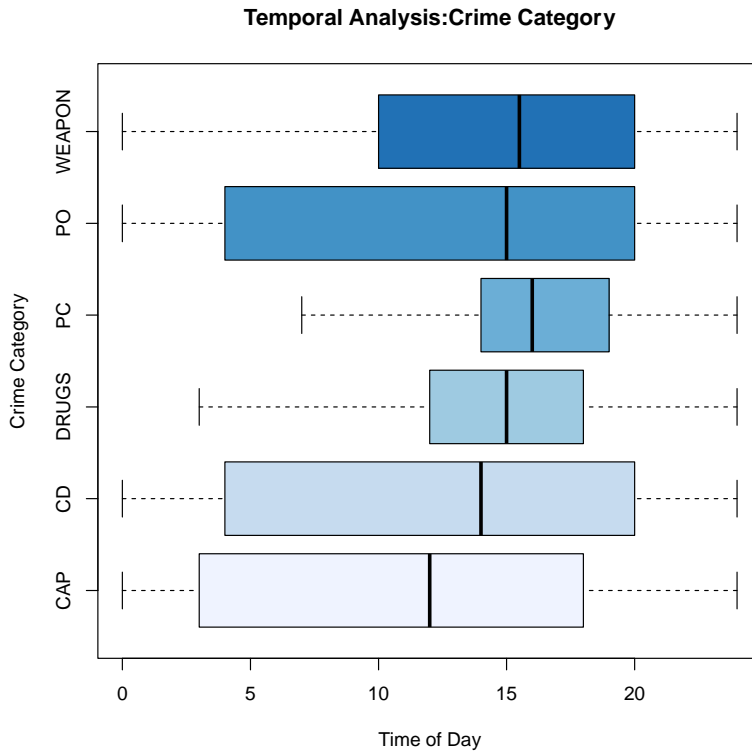
From this the most significant factor is the concentration of the Drug Crime around a short time frame (11am-5pm), much more so than the other crime categories listed. This may be interpreted that drug seizures are occurring predominately during core working hours in the city centre.

A total of 7,731 suspect offenders were returned for the period under analysis. 72% were male and 73% were Irish. The average age of a suspect offender was 30 years of age, with no significant differences between gender and nationality.

A number of fields associated with a Suspect Offender are filled in at the discretion of a Garda. These fields are reported in the Summary stage, but are not commented upon in the individual quadrants. Table Int-1 on the next page presents the field "Contributing Factor". 25% of Incidents which had a suspect offender had a value associated with this field.

Table Int-1

Contributing Factor	Count
Blank	4994
Committed to Feed Alcohol Habit	36
Committed To Feed Drug Habit	94
Garda Believes Alcohol Consumed	1457
Garda Believes Drugs Consumed	66
Offender Admits Consuming Alcohol	13
Offender Admits Consuming Drugs	2
Witness Believes Alcohol Consumed	1
Total	**6663**

Of those records that are filled in 87% (1,457 incidents) are recorded as "Garda Believe Alcohol Consumed." Public Order offences made up 32% of all extracted crimes.

Table Int-2

Quadrant	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Grand Total
1312 - Public order offences	820	94	99	264	78	648	145	2148

Table Int-3 presents the results from the "Home Circumstances" Field. The majority of suspects were recorded as "Living with parents"

Table Int-3

Home Circumstances	CAP	CD	DRUGS	PC	PO	WEAPON	Grand Total
(blank)	141	126	144	1111	1193	62	2777
Alien			1	1	1		3
Hostel	6	5	12	68	81	4	176
Living Alone	1	1	11	60	35	4	112
Living with Others/Lodging	9	9	23	120	108	12	281
Living with Parents	61	87	171	618	538	68	1543
Living with Partner	2	4	12	108	77	10	213
Living with Relatives	2	5	15	57	47	3	129
Living with Spouse		2	1	32	28	5	68
No Fixed Abode	8	6	13	63	107	6	203
Non-resident				1	5		6
Other	3	10	19	94	70	5	201
Traveller	2	1	11	34	47	2	97
Grand Total	**235**	**256**	**433**	**2367**	**2337**	**181**	**5809**

Methodology of Search

Crime Incidents and Search Incidents occurring in the two Garda Divisions, DMR North Central (Bridewell, Fitzgibbon Street, Store Street stations) and the DMR South Central (Donnybrook, Kevin Street, Pearse Street stations), over a period of 14 months (December 2011 – January 2012), were extracted.

The returned results were limited to only those incidents that had been marked *"Detected"* or *"Resulted in Proceedings"*, indicating that there was a Suspect Offender associated with a crime incident. This has implications for interpreting that data as discussed in the next section *'Background to Reading the Data'*. The returned results were further limited to only those Crime Types of interest to the research group, as detailed in Table:Int-4 below.

Table Int-4

ICCS: Crime Types of Interest
0321 - Assaults causing harm
0323 - Assault or obstruction of Garda/official, resisting arrest
0324 - Minor assault
0611 - Robbery of an establishment or institution
0613 - Robbery from the person
0711 - Aggravated burglary
0712 - Burglary (not aggravated)
0713 - Possession of an article (with intent to burgle, steal, demand)
0811 - Theft/Unauthorised taking of vehicle
0812 - Interfering with vehicle (with intent to steal item or vehicle)
0821 - Theft from person
0822 - Theft from shop
0823 - Theft from vehicle
0824 - Theft/Unauthorised taking of a pedal cycle
0826 - Theft of other property
0831 - Handling or possession of stolen property
1012 - Cultivation or manufacture of drugs
1021 - Possession of drugs for sale or supply
1022 - Possession of drugs for personal use
1031 - Forged or altered prescription offences
1032 - Obstruction under the Drugs Act
1122 - Possession of a firearm
1131 - Possession of offensive weapons (not firearms)
1141 - Fireworks offences (for sale, igniting etc.)
1212 - Criminal damage (not arson)
1312 - Public order offences
1313 - Drunkenness offences
1322 - Trepass on lands or enclosed areas
1354 - Permit/Licence offences for casual/street trading
1363 - Allowing a child (under 16 years) to beg
1365 - Begging

This resulted in a total of 21,388 crime incidents being returned. The address location of where each of the crime incidents occurred was then extracted. This resulted in 9,759 different addresses being extracted. Many of the addresses are generic and used multiple times (e.g. O'Connell Street).

The address data was then cleaned to obtain only those streets that were of interest to the research group. The list of streets of interest is detailed at the beginning of the analysis of each quadrant. This yielded a total of 1,025 separate addresses. The crime incidents dataset was then further refined to only those crimes that occurred in locations of interest which reduced the total crime incident dataset to 6,663 incidents.

The suspect offenders associated with each of those incidents was then extracted yielding a total of 7,731 persons. Some persons may be associated with multiple crimes and some incidents may have multiple suspect offenders associated with them. 75% of crime incidents had only one suspect offender associated with them.

A number of new variables were calculated for each crime incident, including the age of the suspect offender associated to the crime incident and the geographic origin of the suspect offender. Where there was >1 suspect offender the average age of all suspect offenders was calculated. Where there were mixed nationalities associated with a crime incident the nationality was recorded as "Mixed". In the case where all suspect offenders were of the same nationality, (i.e. 3 Irish SOs) a value of Irish was associated with the crime incident.

Background to Reading the Data

The crime incident dataset (6,663 incidents) only includes incidents that have been marked "Detected" or "Resulted in Proceedings". This is due to the fact that the research group are interested in profiling the suspect offenders and therefore it did not make sense to include crime incidents that were undetected. This has implications for interpreting the data. The crime incidents were grouped into 6 crime categories. The groupings and the detection rates are shown in Table Int-5 on the next page.

Table Int-5

Crime Category	Crime Types Included	Typical Detection Rates
CAP (Crime Against Person)	0321 - Assaults causing harm 0323 - Assault or obstruction of Garda/official, resisting arrest 0324 - Minor assault	approx. 45%
CD (Criminal Damage)	1212 - Criminal damage (not arson)	approx. 20%
DRUGS (Drug Crime)	1021 - Possession of drugs for sale or supply 1022 - Possession of drugs for personal use 1031 - Forged or altered prescription offences 1032 - Obstruction under the Drugs Act	approx. 99%
PC (Property Crime)	0611 - Robbery of an establishment or institution 0613 - Robbery from the person 0711 - Aggravated burglary 0712 - Burglary (not aggravated) 0713 - Possession of an article (with intent to burgle, steal, demand) 0811 - Theft/Unauthorised taking of vehicle 0812 - Interfering with vehicle (with intent to steal item or vehicle) 0821 - Theft from person 0822 - Theft from shop 0823 - Theft from vehicle 0824 - Theft/Unauthorised taking of a pedal cycle 0826 - Theft of other property 0831 - Handling or possession of stolen property	approx. 30%
PO (Public Order Offences)	1312 - Public order offences 1313 - Drunkenness offences 1322 - Trepass on lands or enclosed areas 1354 - Permit/Licence offences for casual/street trading 1363 - Allowing a child (under 16 years) to beg 1365 - Begging	approx. 95%
WEAPON (Weapons and Explosive Offences	1122 - Possession of a firearm 1131 - Possession of offensive weapons (not firearms) 1141 - Fireworks offences (for sale, igniting etc.)	approx. 99%

When reducing the crime dataset to those incidents with suspect offenders, the DRUGS crime incidents will remain the same as almost 100% of drug incidents have a suspect offender (nearly all drug incidents are Garda driven and are detected through enforcement activities and searches). For Crimes against a person (CAP) however the number of crimes will reduce by 55%, as only 45% have a suspect offender associated. It is important therefore to note that the figures here do not represent the true level of crime, however they are a representative sample of solved crime incidents. This may have introduced bias into the data.

Quadrant Analysis

The research area was divided into 7 Quadrants. These quadrants do not reflect Garda boundaries, therefore the data was manually coded.

Quadrant 1:

Quadrant 1 contains the following streets; Jervis Street, Old Abbey Street, Abbey Street, Eden Quay, Custom House Quay, Marlborough Street, Talbot Street, Lower Gardiner Street, Amien Street, Foley Street, Sean McDermott Street, O'Connell Street, Liffey Street.

Quadrant 1
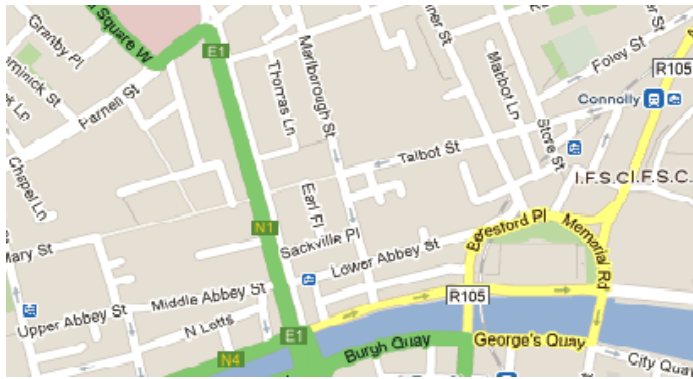
Crime Incidents and Search Incidents that occurred in Quadrant 1 were extracted. Table Q1-1 below details the month count broken down by crime type.

Table Q1-1

	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Grand Total
CAP (Crime Against Person)	**6**	**7**	**8**	**13**	**11**	**8**	**14**	**6**	**8**	**5**	**5**	**5**	**5**	**5**	**106**
0321 - Assaults causing harm	2	2	2	4	4	3	2	1	2				1	1	2	26
0323 - Assault or obstruction of Garda/official, resisting arrest					1		1						1		3
0324 - Minor assault	4	5	6	9	6	5	11	5	6	5	5	4	3	3	77
CD (Criminal Damage)	**7**	**12**	**20**	**6**	**6**	**11**	**5**	**10**	**7**	**7**	**7**	**7**	**12**	**13**	**130**
1212 - Criminal damage (not arson)	7	12	20	6	6	11	5	10	7	7	7	7	12	13	130
DRUGS	**14**	**20**	**19**	**22**	**18**	**21**	**28**	**12**	**23**	**19**	**27**	**21**	**18**	**21**	**283**
1021 - Possession of drugs for sale or supply	8	6	7	10	7	12	9	4	12	9	10	8	10	11	123
1022 - Possession of drugs for personal use	2	10	12	12	10	7	15	8	8	9	10	12	7	7	129
1031 - Forged or altered prescription offences											1				1
1032 - Obstruction under the Drugs Act	4	4			1	2	4		3	1	6	1	1	3	30
PC (Property Crime)	**118**	**86**	**89**	**117**	**75**	**68**	**60**	**78**	**104**	**103**	**86**	**88**	**102**	**92**	**1266**
0611 - Robbery of an establishment or institution	6	4	2	2		2	2	1	1	3		1	1	1	26
0613 - Robbery from the person		7	2	4	10	1	2	5	3	5	5	1		4	49
0711 - Aggravated burglary	1														1
0712 - Burglary (not aggravated)	4	1	2	4		2	2	3	5	2	3	3	2	3	36
0713 - Possession of an article (with intent to burgle, steal, dem	1			2	1	1					1	1	1	1	9
0811 - Theft/Unauthorised taking of vehicle		1				1			1	1			1		5
0812 - Interfering with vehicle (with intent to steal item or vehi	3	3				1	1		1	3		2	1	1	16
0821 - Theft from person	2	4	4	12	3	5	2	3	5	8	13	6	3	1	71
0822 - Theft from shop	88	47	49	77	48	46	41	46	69	51	47	58	82	65	814
0823 - Theft from vehicle	1	4	7	3		1	2	2	2	5	2	1	1		31
0824 - Theft/Unauthorised taking of a pedal cycle		2	5	1	1		2	2	2	8		2	4	1	28
0826 - Theft of other property	8	6	7	7	4	4	3	9	4	15	3	4	7	6	87
0831 - Handling or possession of stolen property	4	7	11	5	8	4	3	7	5	10	10	7	3	9	93
PO (Public Order Offences)	**53**	**82**	**69**	**101**	**81**	**89**	**65**	**64**	**64**	**45**	**74**	**88**	**66**	**55**	**996**
1312 - Public order offences	49	73	58	85	71	78	59	58	56	39	64	53	32	45	820
1313 - Drunkenness offences	4	7	8	8	8	8	5	5	7	3	8	7	4	4	86
1322 - Trepass on lands or enclosed areas		1	2	6	2	2	1	1		2	1	3	2	2	25
1354 - Permit/Licence offences for casual/street trading		1	1	2		1						2	1		8
1363 - Allowing a child (under 16 years) to beg									1	1					2
1365 - Begging											1	23	27	4	55
WEAPON (Weapons and Explosive Offences	**2**	**8**	**8**	**6**	**4**	**13**	**5**	**8**	**10**	**8**	**4**	**8**	**4**	**3**	**91**
1122 - Possession of a firearm				1							1				2
1131 - Possession of offensive weapons (not firearms)	2	8	8	5	4	13	5	8	10	7	3	8	4	3	88
1141 - Fireworks offences (for sale, igniting etc.)											1				1
Grand Total	**200**	**215**	**213**	**265**	**195**	**210**	**177**	**178**	**216**	**187**	**203**	**217**	**207**	**189**	**2872**

A total of 2,872 crime incidents occurred over the 14 month period in quadrant one. Quadrant one is the largest quadrant out of the seven. Figure Q1-1a and Q1-1b presents a bar chart of the number of crime incidents over the 14 month period grouped by crime category and months. The most common crime category is Property Crime (PC). Specifically in this category "Theft from shop" has the highest frequency, with 814 incidents. The streets contained in this quadrant could typically be described as retail use, and therefore the high occurrence of this type of crime is unsurprising.

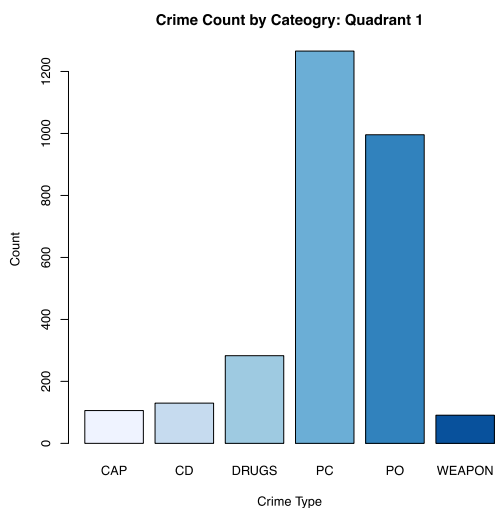From Figure Q1-1b the number of incidents is uniform across the 18 month period.

Figure Q1-1a   **Figure Q1-1b**
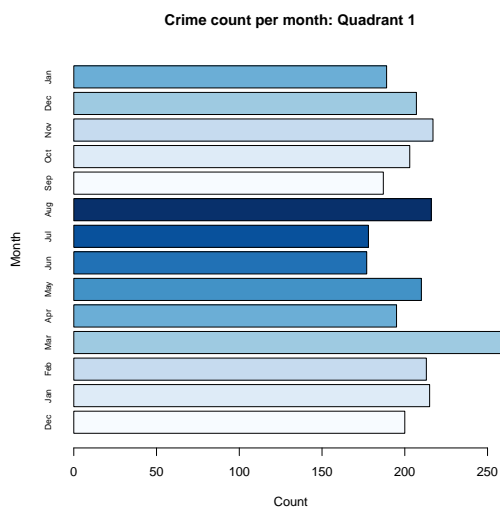
The time period for the 2,872 crime incidents was analysed by day of week and hour of the day. The "Time Reported" associated with each crime incident was rounded to the nearest hour and a heatmap based on the density of crime incidents for each hour was created. The results are shown in Fig Q1-2a.

From Fig Q1-2 on the next page it is evident that most crime incidents occurred between the hours of midday and 11 pm during the week. There is also a small grouping of incidents occurring in the early hours of Sunday, associated with night-time crime occurring over the weekend.

Fig. Q1-2a

Heatmap of Crime Incident: Quadrant 1
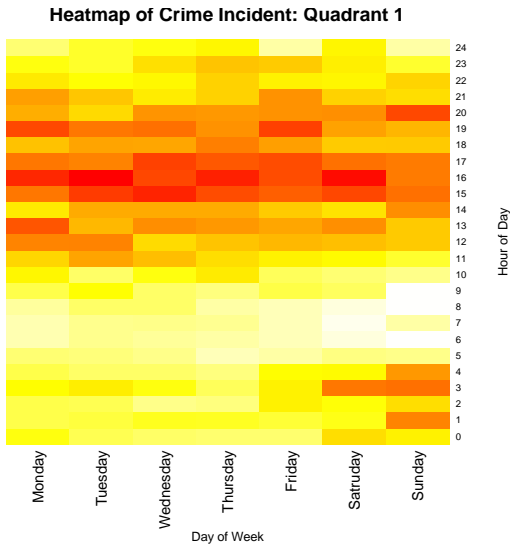
A profile of the suspect offenders associated with each of the crime incidents was created. There were a total of 3,308 suspect offenders associated with 2,873 incidents. The 3,308 suspect offenders is not exclusive, in that the same suspect may be associated with more than one crime incident. The gender split is around one-third female and two thirds male. The average age of suspect offender was 29 years (and this was the same for both men and women). Figure Q1-3a displays a histogram of the age profile. The geographic location of the suspect offenders is shown in Fig Q1-3b. 78% of suspect offenders were from Ireland. The next largest group was classified as European (excluding UK residents) at 14.3%. European suspect offenders tend to be typically older by a small amount.
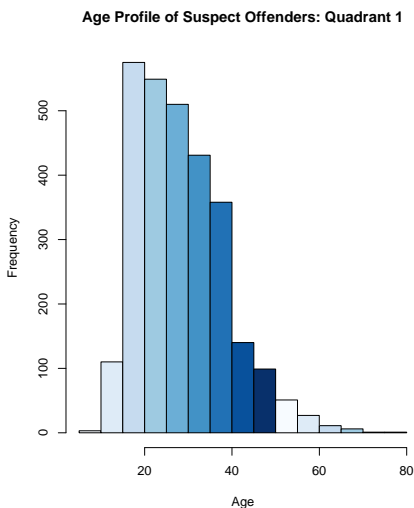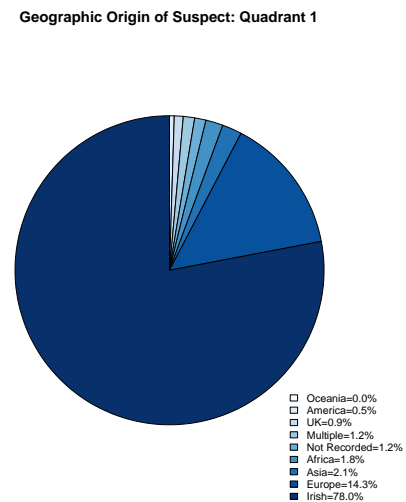
Fig Q1-3a

Fig Q1-3b

Age Profile of Suspect Offenders: Quadrant 1

Geographic Origin of Suspect: Quadrant 1

Quadrant 1 presents a typical pattern of crime associated with a retail area. Due to the high footfall in the area and the wide geography of the streets in this quadrant, the crime counts are quite large.

Quadrant 2:

Quadrant 2 contains the following streets; Parnell Square, Parnell Street, Thomas Lane, Loftus Lane, Mountjoy Square, Frederick Street.
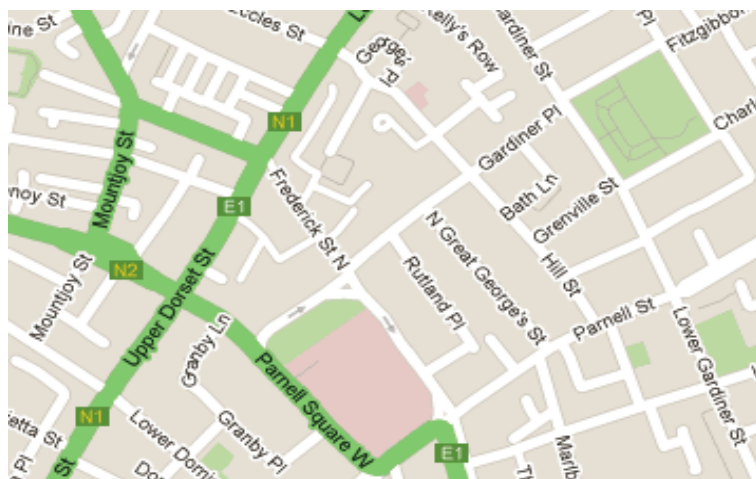
A total of 523 crime incidents were extracted over the 14 month period, Dec-10 to Jan-12. These are presented in Table Q2-1

Table Q2-1

Quadrant 2:	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Grand Total
CAP (Crime Against Person)	**3**	**4**	**3**	**2**	**1**		**2**	**5**	**1**	**1**	**3**	**2**	**1**		**28**
0321 - Assaults causing harm	1	4	1		1		1	3			1		1		13
0323 - Assault or obstruction of Garda/official, resisting arrest												1			1
0324 - Minor assault	2		2	2			1	2	1	1	2	1			14
CD (Criminal Damage)	**11**	**2**	**5**	**8**	**1**	**3**	**3**	**1**	**1**			**1**		**5**	**41**
1212 - Criminal damage (not arson)	11	2	5	8	1	3	3	1	1			1		5	41
DRUGS	**4**	**4**	**6**		**1**	**5**	**3**	**4**	**4**	**3**		**3**	**1**	**2**	**40**
1021 - Possession of drugs for sale or supply		2	4			2		1	1	2		2	1		15
1022 - Possession of drugs for personal use	4	2	1		1	3	3	3	3	1		1		1	23
1032 - Obstruction under the Drugs Act			1											1	2
PC (Property Crime)	**19**	**15**	**17**	**28**	**12**	**19**	**14**	**11**	**28**	**16**	**27**	**17**	**12**	**13**	**248**
0611 - Robbery of an establishment or institution										1					1
0613 - Robbery from the person		1		1		1	2		2		1	3		1	12
0712 - Burglary (not aggravated)			1	5					2				2	2	12
0713 - Possession of an article (with intent to burgle, steal, demand)		2	2			1			2			1			8
0811 - Theft/Unauthorised taking of vehicle						1		1							2
0812 - Interfering with vehicle (with intent to steal item or vehi	1				1		3		2					1	8
0821 - Theft from person	1	2	2	1					4	1	4	2	1	1	19
0822 - Theft from shop	8	7	8	8	9	8	4	4	10	7	9	7	5	3	97
0823 - Theft from vehicle	3						3	3	2		4	1			21
0824 - Theft/Unauthorised taking of a pedal cycle		1	1	3	1	1			1	3	1				12
0826 - Theft of other property		2	1	2		3	2		2	2	5	2	1	1	23
0831 - Handling or possession of stolen property	6		2	4		4		3	1	2	3	1	3	4	33
PO (Public Order Offences)	**9**	**11**	**15**	**13**	**9**	**14**	**6**	**8**	**10**	**15**	**11**	**2**	**6**	**8**	**137**
1312 - Public order offences	7	9	10	8	4	11	4	6	8	10	9		3	5	94
1313 - Drunkenness offences	2	1	1			2	1			1	1		3		12
1322 - Trepass on lands or enclosed areas		1	4	4	5		1	2	2	4	1	2		2	28
1354 - Permit/Licence offences for casual/street trading						1									1
1363 - Allowing a child (under 16 years) to beg				1											1
1365 - Begging														1	1
WEAPON (Weapons and Explosive Offences)	**3**	**2**	**1**	**2**	**2**	**2**	**2**	**4**	**3**	**1**	**4**	**1**		**2**	**29**
1131 - Possession of offensive weapons (not firearms)	3	2	1	2	2	2	2	4	3	1	4	1		2	29
Grand Total	**49**	**38**	**47**	**53**	**26**	**43**	**30**	**33**	**47**	**36**	**45**	**26**	**20**	**30**	**523**

Similar to Quadrant 1, Property Crime (PC) is the highest volume crime in this quadrant. It is worth noting that Property Crime (PC) would be even higher if non-detected incidents were included in the extraction process.

Figure Q2-1a shows a breakdown of the volumes of crime incidents by category over the 14 month period. Within Property Crime, "Theft from shop" is the highest crime type. Figure Q2-2a shows the breakdown of crimes over the 14-month period. There appears to have been a significant increase in the number of detected incidents in May-11 preceded and followed by lower months. This may have been a result of Garda Operations surrounding the state visit of Queen Elizabeth II, which was heavily focused in this quadrant.
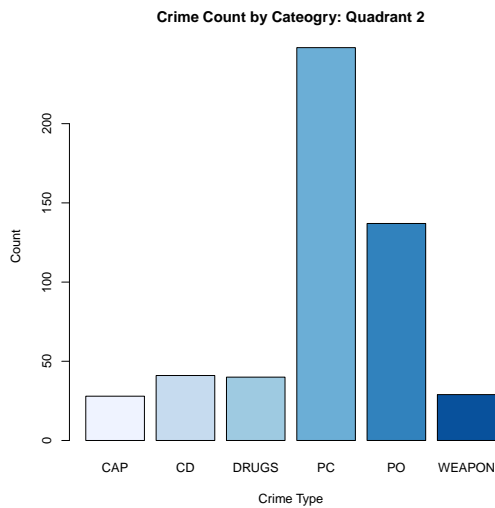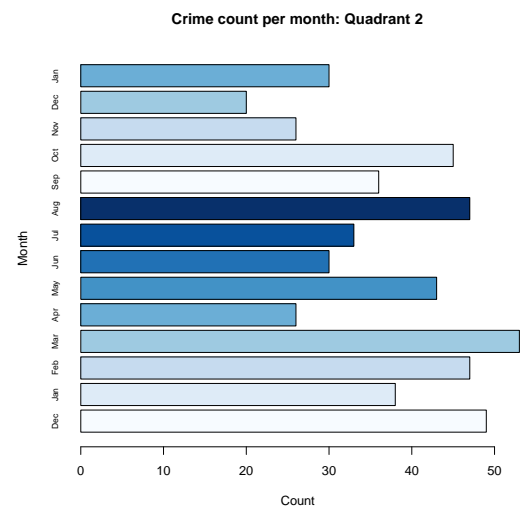
Fig Q2-1a

Fig Q2-1b

Crime Count by Cateogry: Quadrant 2

Crime count per month: Quadrant 2

A heatmap of time of day for the number of Crime Incidents and Garda led searches was created. A similar pattern as seen in Quadrant 1 emerges with the majority of incidents occurring between the hours of midday and 11pm. As there is less crime here the patterns (colours) are less dense than in Quadrant 1.

Fig Q2-2 See next page

Fig Q2-2

Heatmap of Crime Incident: Quadrant 2
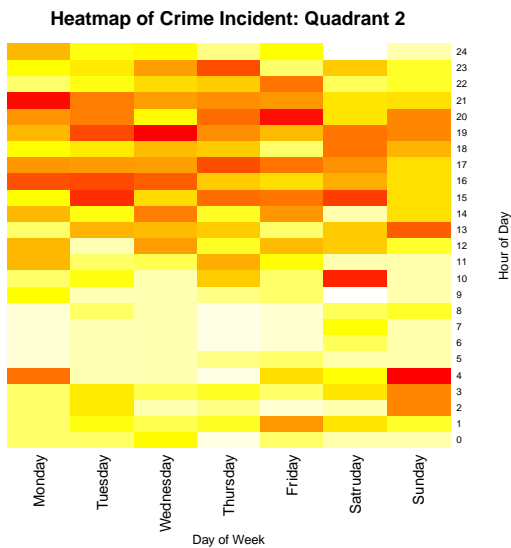
The profile of suspect offenders is presented in Fig Q2-3a and Fig Q2-3b. A total of 608 suspects were recorded. Only 13% of suspect offenders were female, with an average age of 31 years. The average age of male suspect offenders was 31.

In Quadrant 2, 71% of the suspect offenders were Irish, followed by Europeans (excluding the UK) at 18% and 4% for Asian.
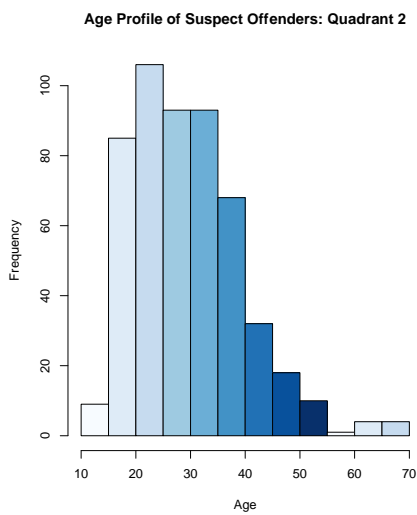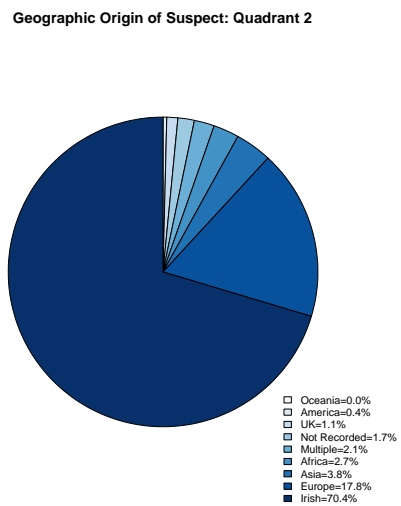
Fig Q2-3a

Age Profile of Suspect Offenders: Quadrant 2

Fig Q2-3b

Geographic Origin of Suspect: Quadrant 2

Oceania=0.0%
America=0.4%
UK=1.1%
Not Recorded=1.7%
Multiple=2.1%
Africa=2.7%
Asia=3.8%
Europe=17.8%
Irish=70.4%

Quadrant 3:

Quadrant 3 consisted of the following streets; Thomas Street, Lord Edward Street, Ushers Quay, Cork Street, Oliver Bond Street, John Street, Island Street, Lower Bridge Street, Usher Street, St. Augustine Street, Castle Street, Fishamble Street.

Table Q3-1 presents the crime incidents broken down by type and month.

Table Q3-1

Quadrant 3:	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Grand Total
CAP (Crime Against Person)		5	1	4	1	1	1	1			1	1	3		19
0321 - Assaults causing harm		2		4				1				1	1		9
0323 - Assault or obstruction of Garda/official, resisting arrest						1					1				2
0324 - Minor assault		3	1		1		1						2		8
CD (Criminal Damage)	1	2	1	2		3	3	1	1		1	1			16
1212 - Criminal damage (not arson)	1	2	1	2		3	3	1	1		1	1			16
DRUGS		2	3	1	4	2	2	1		2	5	1	4	3	30
1012 - Cultivation or manufacture of drugs		1													1
1021 - Possession of drugs for sale or supply			1	1	3	1	2			1	4		3	1	17
1022 - Possession of drugs for personal use		2	1		1	1		1			1	1	1	2	11
1032 - Obstruction under the Drugs Act										1					1
PC (Property Crime)	3	11	7	12	6	11	10	15	14	12	25	13	10	11	160
0611 - Robbery of an establishment or institution								1		1					2
0613 - Robbery from the person				2		1	1	1			1		1		7
0712 - Burglary (not aggravated)		1	1	3	1	2	1		1				3	1	14
0713 - Possession of an article (with intent to burgle, steal, demand)						2				1	1	1			5
0811 - Theft/Unauthorised taking of vehicle	1				2							1			4
0821 - Theft from person											1				1
0822 - Theft from shop	2	8	5	6	3	6	8	11	11	9	19	11	5	10	114
0823 - Theft from vehicle			1												1
0824 - Theft/Unauthorised taking of a pedal cycle				1						1	1				3
0826 - Theft of other property		2						1	1		1		1		6
0831 - Handling or possession of stolen property								1	1		1				3
PO (Public Order Offences)	8	15	11	9	15	8	7	10	8	2	9	8	4	2	116
1312 - Public order offences	8	14	8	9	12	7	7	9	7	1	7	6	2	2	99
1313 - Drunkenness offences			3		1	1		1	1	1	1		2		11
1322 - Trespass on lands or enclosed areas					1						1	2			4
1363 - Allowing a child (under 16 years) to beg		1			1										2
WEAPON (Weapons and Explosive Offences)	1			3	1	2	1	2	2	1	1	1	1	2	18
1122 - Possession of a firearm				1		1					1				3
1131 - Possession of offensive weapons (not firearms)	1			2	1	1	1	2	2	1		1	1	2	15
Grand Total	13	35	23	31	27	27	24	30	25	17	42	25	22	18	359

A total of 359 incidents were extracted from PULSE for the 14 month time period. As with Quadrants 1&2, Property Crime (PC) offences had the highest frequency of crime category, although significantly Public Order Offences are relatively high also.

This is probably unsurprising as quadrant 3 contains less retail activity and is on the fringes of a major area for nighttime entertainment, Templebar. (The Templebar area is detailed in Quadrant 6).

Figures Q3-1a and Q3-1b display the crime categories and the number of crime incidents by month. There appears to be a large increase in the number of incidents in October 211. This is associated with an increase in the number of "Theft from shops" incidents. While there may be significance to this increase, it should be noted that as the quadrant has a small overall total, 359 incidents, a small increase in the number of incidents can appear large on the charts.
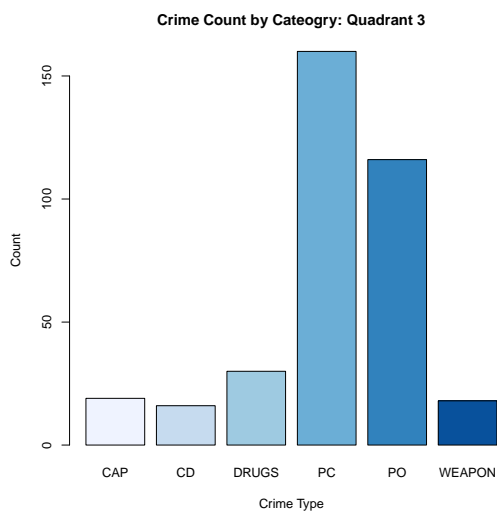
Fig Q3-1a

Crime Count by Cateogry: Quadrant 3

Fig Q3-2a

Crime count per month: Quadrant 3
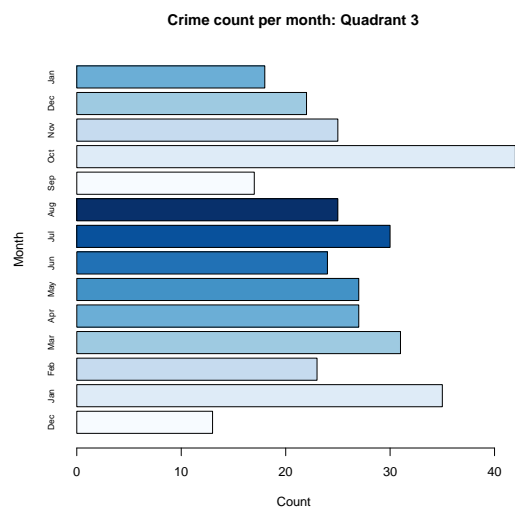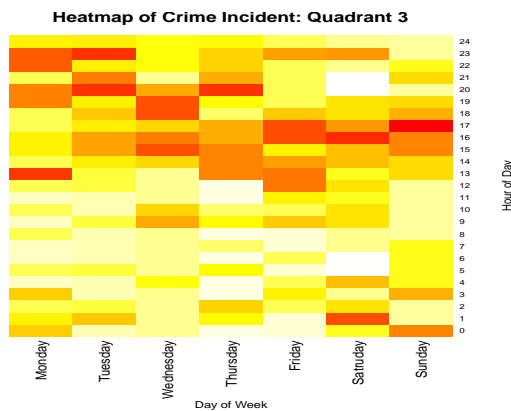
Fig Q3-2

Heatmap of Crime Incident: Quadrant 3

A heatmap of Incidents was created and are displayed in Figure Q3-2. The distribution for Incidents remains broadly similar to Quadrant 1 and Quadrant 2, albeit with less dense areas.

The profile of suspect offenders is presented in Fig Q3-3a and Fig Q3-3b. A total of 409 suspects were recorded. 13% of suspect offenders were female, with an average age of 34 years. The average age of male suspect offenders was 33. Figure Q3-3a indicates that there is significant group of suspect offenders between the ages of 15-20 and 35-40 which was not apparent in the previous two quadrants. 78% of the suspect offenders were Irish.
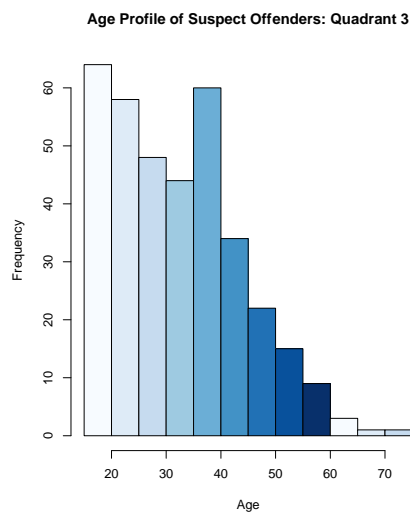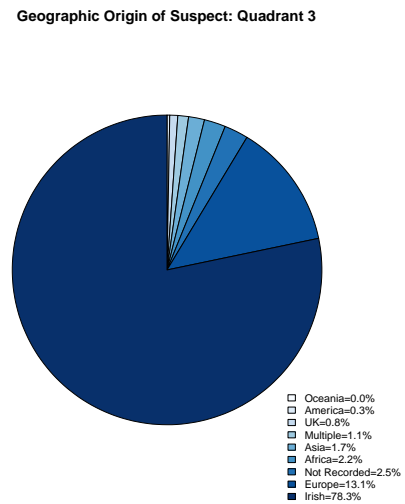
Fig Q3-3a

Age Profile of Suspect Offenders: Quadrant 3

Fig Q3-3b

Geographic Origin of Suspect: Quadrant 3

Oceania=0.0%
America=0.3%
UK=0.8%
Multiple=1.1%
Asia=1.7%
Africa=2.2%
Not Recorded=2.5%
Europe=13.1%
Irish=78.3%

Quadrant 4:

Quadrant 4 consisted of the following streets; Aungier Street, Stephens Green Shopping Centre, Grafton Street, York Street, Drury Street, Upper Mercier Street, William Street.

A total of 1053 crime incidents were extracted over the 14 month period, Dec-10 to Jan-12. These are presented in Table Q4-1

Table Q4-1

Quadrant 4:	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Grand Total
CAP (Crime Against Person)	**7**	**4**	**2**	**3**	**6**	**3**	**2**	**3**	**7**	**4**	**4**	**1**	**2**		**48**
0321 - Assaults causing harm	1	4		1	1	1	1	1	2	1	2	1	1		17
0323 - Assault or obstruction of Garda/official, resisting arrest	1										1				2
0324 - Minor assault	5		2	2	5	2	1	2	5	3	1		1		29
CD (Criminal Damage)	**4**	**5**	**3**	**1**	**3**	**1**	**3**	**1**			**2**	**1**	**1**		**25**
1212 - Criminal damage (not arson)	4	5	3	1	3	1	3	1			2	1	1		25
DRUGS	**1**		**2**				**1**	**1**	**4**	**5**	**2**	**1**	**2**	**1**	**20**
1021 - Possession of drugs for sale or supply							1	1	3	5			2		12
1022 - Possession of drugs for personal use			2						1		2	1		1	7
1032 - Obstruction under the Drugs Act	1														1
PC (Property Crime)	**39**	**45**	**54**	**47**	**61**	**37**	**40**	**55**	**30**	**43**	**33**	**49**	**65**	**28**	**626**
0611 - Robbery of an establishment or institution		1		1	1			1						1	5
0613 - Robbery from the person		2		1	1	1	1								6
0712 - Burglary (not aggravated)	3	3	3			3		1	1	1	1				16
0713 - Possession of an article (with intent to burgle, steal, demand)		1	2	1			3	3	1		1	4	3	1	20
0821 - Theft from person		1	2	7	7			2	3		2	4	6	4	39
0822 - Theft from shop	34	36	38	34	48	28	31	39	22	33	23	36	48	23	473
0823 - Theft from vehicle						1					1	1			3
0824 - Theft/Unauthorised taking of a pedal cycle			2					1							3
0826 - Theft of other property	2	2	7	1	2	2	1	3	4	3	2	2	6		37
0831 - Handling or possession of stolen property		1	1	1	2	2	2	4	2	3	1	1	4	2	24
PO (Public Order Offences)	**23**	**24**	**35**	**21**	**19**	**14**	**18**	**34**	**30**	**24**	**24**	**15**	**25**	**17**	**323**
1312 - Public order offences	20	20	28	17	18	13	18	30	26	22	21	11	10	10	264
1313 - Drunkenness offences	3	2	4	4		1		3	4	1	2	4	5	2	35
1322 - Trepass on lands or enclosed areas			2							1	1				4
1354 - Permit/Licence offences for casual/street trading		1			1			1							3
1363 - Allowing a child (under 16 years) to beg		1	1										1		3
1365 - Begging													9	5	14
WEAPON (Weapons and Explosive Offences)	**1**		**2**				**2**	**2**			**2**	**1**		**1**	**11**
1131 - Possession of offensive weapons (not firearms)	1		2				2	2			2	1		1	11
Grand Total	**75**	**78**	**98**	**72**	**89**	**55**	**66**	**96**	**71**	**76**	**67**	**68**	**95**	**47**	**1053**

As with Quadrants 1, 2 & 3, Property Crime (PC) is the largest crime category in Quadrant 4 followed by Public Order (PO). Within Property Crime, "Theft from shop" is the largest crime type. This is unsurprising given the inclusion Stephens Green Shopping Centre in the quadrant.

Figures Q4-1a and Q4-1b display the crime categories and the number of crime incidents by month. From Q4-1b it appears that there are months with significant increases in the number of Crime Incidents.

This increase is driven by "Theft from shop" and may be linked to typical season sales, Christmas time and school breaks. A deeper analysis of the data would yield more insight into this.
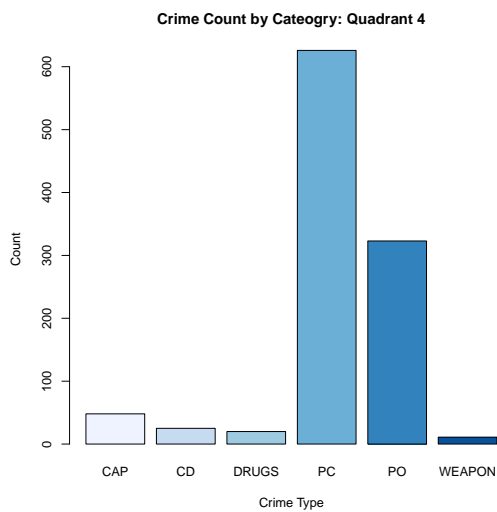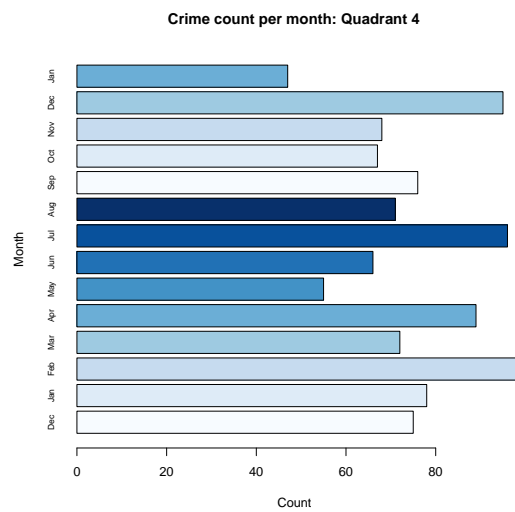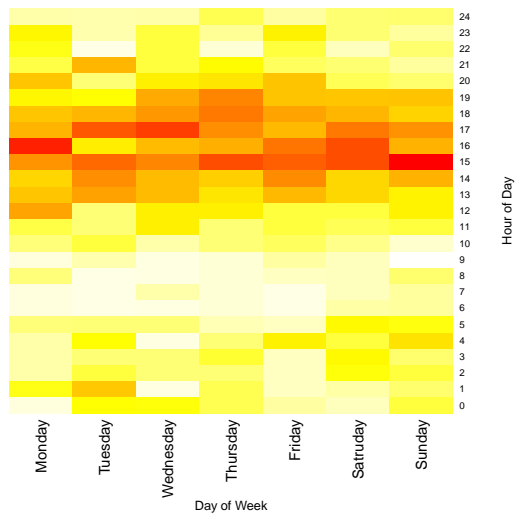
Fig Q4-1a   **Fig Q4-1b**

A heatmap of the distribution of crime incidents is shown in Figure Q4-2. The most evident pattern from this is the shorter time span of crime incidents in this quadrant which typically occur between 12 midday and 8pm in the evening, compared to other quadrants.

Fig Q4-2

Heatmap of Crime Incident: Quadrant 4

The profile of suspect offenders is presented in Fig Q4-3a and Fig Q4-3b. A total of 1,195 suspects were recorded. The profile is very similar to Quadrant 1, which is also a retail district, in that 32% of suspect offenders were female, however the average age is significantly older at 35 years. The average age of male suspect offenders was 31.

64% of the suspect offenders were Irish, followed by 22% of European origin (excluding the UK) and 4% of Asian origin.
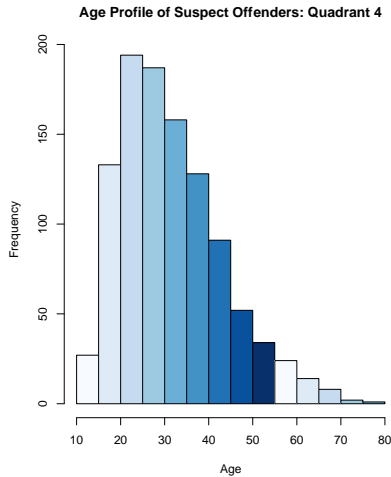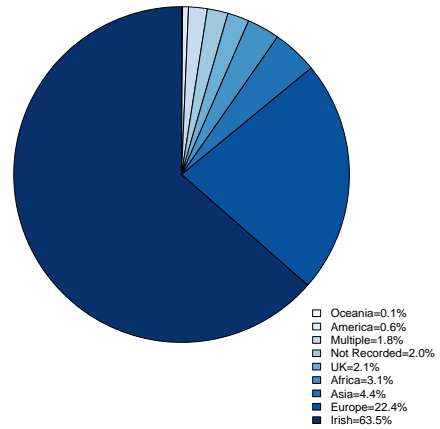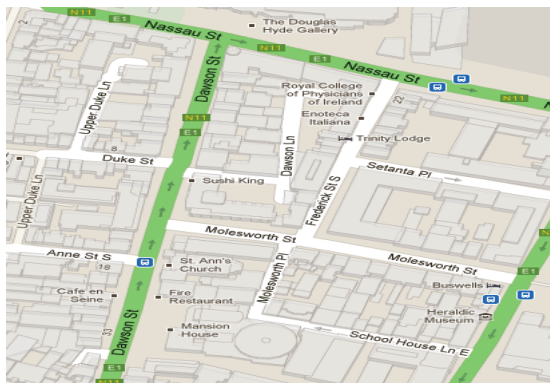
Fig Q4-3a

Fig Q4-3b

Geographic Origin of Suspect: Quadrant 4

Age Profile of Suspect Offenders: Quadrant 4

- Oceania=0.1%
- America=0.6%
- Multiple=1.8%
- Not Recorded=2.0%
- UK=2.1%
- Africa=3.1%
- Asia=4.4%
- Europe=22.4%
- Irish=63.5%

Quadrant 5

Quadrant 5 consisted of the following streets; Molesworth Street, Dawson Street, Frederick Street, Dawson Lane, Nassau Street.

A total 145 crime incidents were extracted from PULSE for the 14 month period, making Quadrant 5 the smallest of all the 7 quadrants.

Table 5-1

Quadrant 5:	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Grand Total
CAP (Crime Against Person)		1		1											**2**
0324 - Minor assault		1		1											2
CD (Criminal Damage)						1						1	1		**3**
1212 - Criminal damage (not arson)						1						1	1		3
DRUGS						1	1								**2**
1022 - Possession of drugs for personal use						1	1								2
PC (Property Crime)	5	2	2	5	1	4	1	2	2	3	4	5	2	4	**42**
0611 - Robbery of an establishment or institution	1														1
0613 - Robbery from the person	2														2
0712 - Burglary (not aggravated)	1			1		2				1	1	1		1	8
0713 - Possession of an article (with intent to burgle, steal, demand)						1								1	2
0821 - Theft from person		1								1		2			4
0822 - Theft from shop	1	1		1					2			2	1	2	10
0824 - Theft/Unauthorised taking of a pedal cycle										1			1		2
0826 - Theft of other property			2	3	1	1	1			1	1				10
0831 - Handling or possession of stolen property											3				3
PO (Public Order Offences)	6	5	8	6	6	2	3	15	19	4	7	4	9		**94**
1312 - Public order offences	6	5	7	5	5	2	2	13	17	4	6	3	3		78
1313 - Drunkenness offences								1			1				2
1322 - Trepass on lands or enclosed areas				1			1		2			1			5
1363 - Allowing a child (under 16 years) to beg			1		1			1					1		4
1365 - Begging													5		5
WEAPON (Weapons and Explosive Offences)						1								1	**2**
1131 - Possession of offensive weapons (not firearms)						1								1	2
Grand Total	11	8	10	12	7	9	5	17	21	7	11	10	12	5	145

The breakdown by crime category and monthly totals for Quadrant 5 is displayed in Figures Q5-1a and Q5-1b respectively. Most significant in this quadrant is that Public Order (PO) offences are the most dominant type of crime committed. It is not possible to comment on the changes in the monthly total as the overall number of crime incidents is quite low.
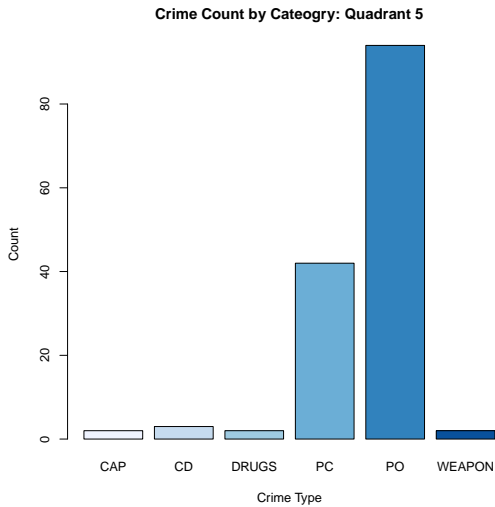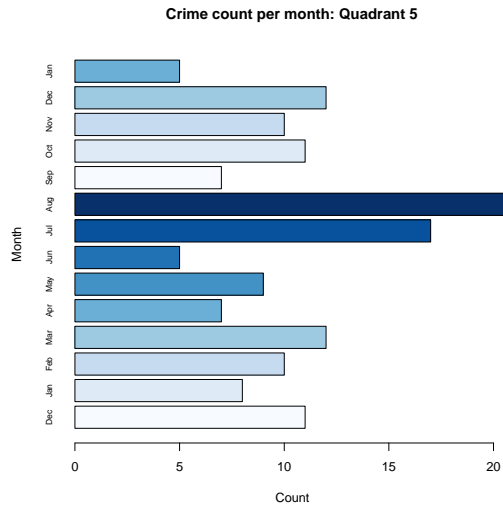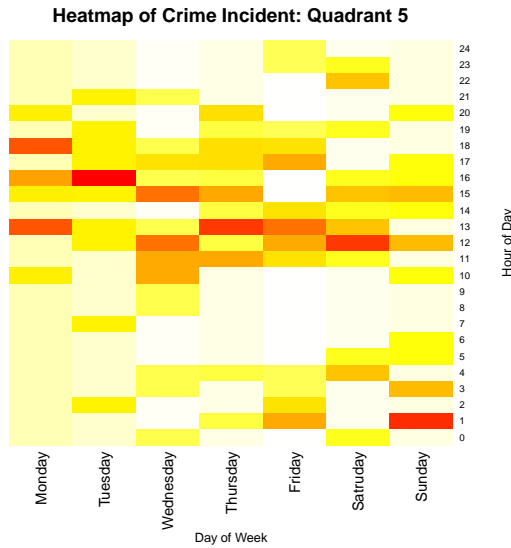
Fig Q5-1a

Crime Count by Cateogry: Quadrant 5

Fig Q5-1b

Crime count per month: Quadrant 5

A heatmap of crimes for Quadrant 5 is created below. The data is relatively sparse to establish a definitive pattern although Fig Q5-2 indicates that the temporal distribution of the crimes is similar to that of other areas.

Fig Q5-2

Heatmap of Crime Incident: Quadrant 5

68% of suspect offenders in Quadrant 5 were males, with an average age of 33 years. The average age for female suspect offenders was 35. The distribution of ages is presented in Figure Q5-3a. Figure Q5-3b displays the breakdown of the geographic origin of suspect offenders. Quadrant 5 had the lowest percentage of Irish suspect offenders at 57%. Suspect offenders of European origin (excluding the UK) account for 32% of suspect offenders.
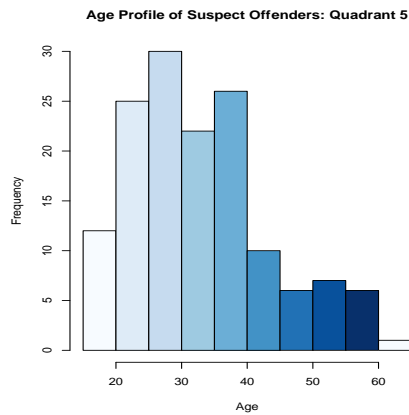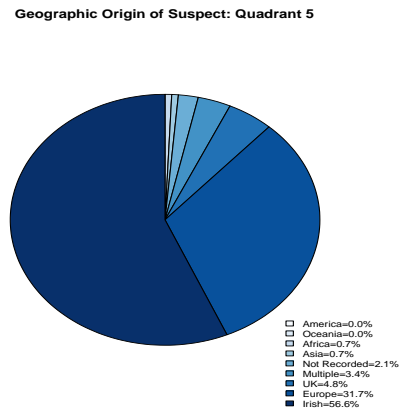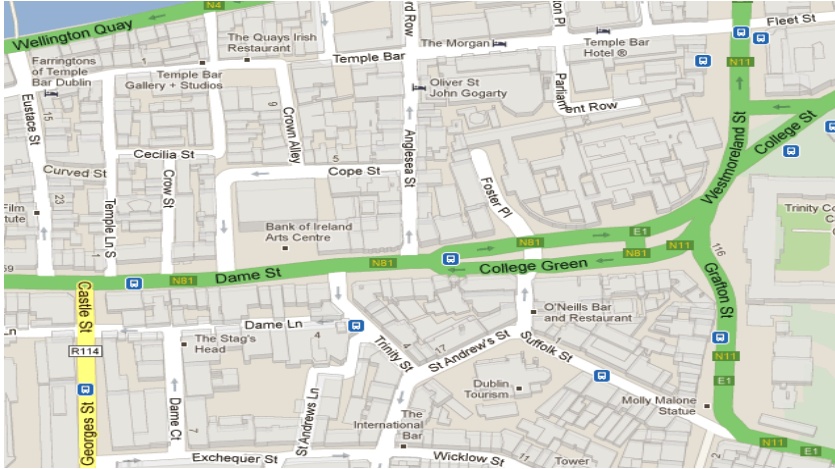
Fig Q5-3a

Fig Q5-3b

Age Profile of Suspect Offenders: Quadrant 5

Geographic Origin of Suspect: Quadrant 5

America=0.0%
Oceania=0.0%
Africa=0.7%
Asia=0.7%
Not Recorded=2.1%
Multiple=3.4%
UK=4.8%
Europe=31.7%
Irish=56.6%

Quadrant 6

Quadrant 6 contains the following streets. Exchequer Street, Wicklow Street, College Green, Dame Street, Westmoreland Street, Temple Bar, Fleet Street.


The detected crime incidents in Quadrant 6 over the 14 month period was extracted. Table Q6-1 displays the results.

Table Q6-1

Quadrant 6:	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Grand Total
CAP (Crime Against Person)	4	5	3	6	7	5	2	13	3	5	8	5	7	6	79
0321 - Assaults causing harm	3	3	1	3	2	4	1	5	1	2	4	4	4	3	40
0323 - Assault or obstruction of Garda/official, resisting arrest			1						4						5
0324 - Minor assault	1	2	1	3	5	1	1	4	2	3	4	1	3	3	34
CD (Criminal Damage)		1	4	4	8	4	4	6	2	3	2	1	2	4	45
1212 - Criminal damage (not arson)		1	4	4	8	4	4	6	2	3	2	1	2	4	45
DRUGS	4		1	3	4	2	1	2	3	2	2	2	2	2	30
1021 - Possession of drugs for sale or supply					2	2		1	1			1	1		8
1022 - Possession of drugs for personal use	3		1	2	2		1	1	1	2	1	1	1	2	18
1032 - Obstruction under the Drugs Act	1			1					1		1				4
PC (Property Crime)	27	22	29	38	22	26	31	36	39	22	29	35	26	25	407
0611 - Robbery of an establishment or institution	3	1	3									1	1	2	11
0613 - Robbery from the person		2	1	1		1	3		2	1	1				12
0712 - Burglary (not aggravated)	3	1	1	1	1	3	1	2	3	5	5	4	1	3	34
0713 - Possession of an article (with intent to burgle, steal, demand)			1			2	1	2	3	1	2	2	3	1	18
0811 - Theft/Unauthorised taking of vehicle					2										2
0812 - Interfering with vehicle (with intent to steal item or vehi	1	1										1			3
0821 - Theft from person	2	2		10	5	3	3	9	9	3	7	6	3	4	66
0822 - Theft from shop	8	5	11	13	7	7	16	15	13	6	5	8	10	8	132
0823 - Theft from vehicle	1					1							1		3
0824 - Theft/Unauthorised taking of a pedal cycle			1	1			1	1	1		2	2		1	10
0826 - Theft of other property	7	7	7	9	4	7	5	5	2	2	3	7	6	4	75
0831 - Handling or possession of stolen property	2	3	4	3	3	2	1	2	6	4	3	4	2	2	41
PO (Public Order Offences)	47	68	58	67	54	47	49	50	81	34	56	50	46	53	760
1312 - Public order offences	43	62	51	60	45	39	44	47	72	29	51	37	30	38	648
1313 - Drunkenness offences	3	6	5	7	8	6	5	2	8	5	5	6	5	4	75
1322 - Trepass on lands or enclosed areas	1		1				1					3	7	5	18
1354 - Permit/Licence offences for casual/street trading							1						1	1	3
1363 - Allowing a child (under 16 years) to beg			1						1	1					4
1365 - Begging												4	3	5	12
WEAPON (Weapons and Explosive Offences)	1	4	3	1	2	1	1		3	3	1	1		4	25
1131 - Possession of offensive weapons (not firearms)	1	4	3	1	2	1	1		3	3	1	1		4	25
Grand Total	83	100	98	119	97	85	88	107	131	69	98	94	83	94	1346

Quadrant 6 is the second largest quadrant with 1,346 crime incidents extracted. Figures Q6-1a and Q6-1b display the breakdown of crime incidents by crime category and monthly totals. Similar to Quadrant 5 Public Order (PO) incidents is the largest crime category. This is due to the inclusion of the area "Temple Bar" which incorporates a large geography of streets. There are significant peaks in March associated with St. Patricks Day and in August.
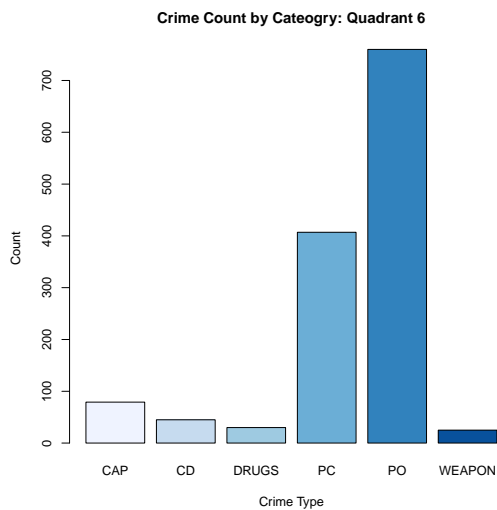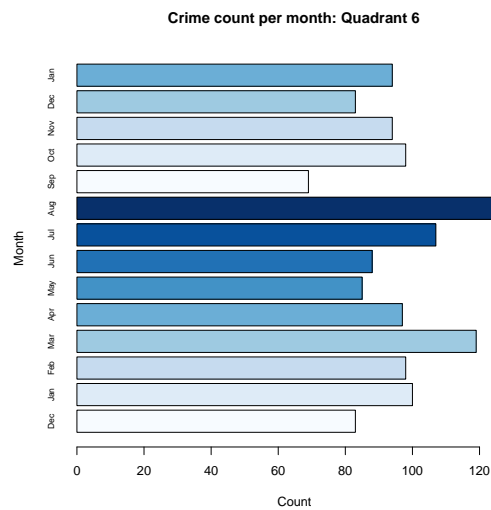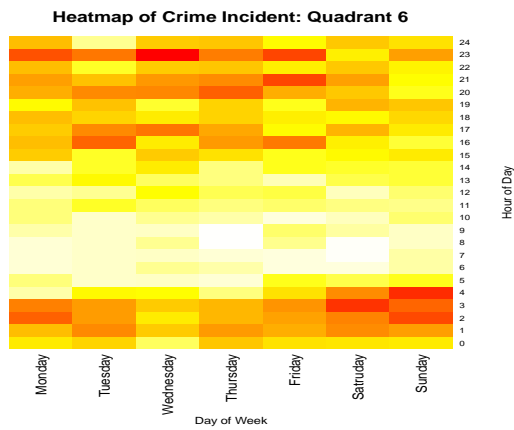
Figures Q6-1a   **Q6-1b.**

Figure Q6-2 displays the temporal distribution of crime incidents. The density shows that compared to other quadrants the highest number of crime incidents are associated with the nighttime economy between the hours of 4pm and 3am.

Fig Q6-2

Heatmap of Crime Incident: Quadrant 6

80% of Suspect offenders were male with an average age of 31. The average age of suspect offenders for females was 29 years. 76% of suspect offenders were Irish.
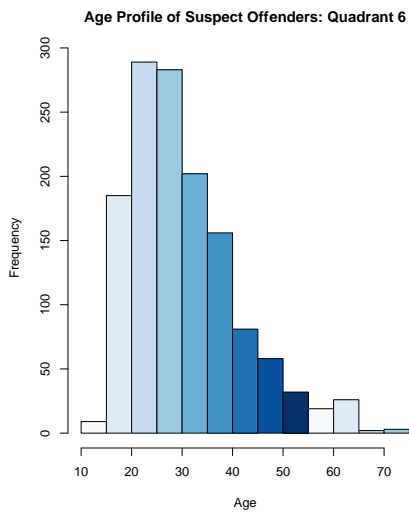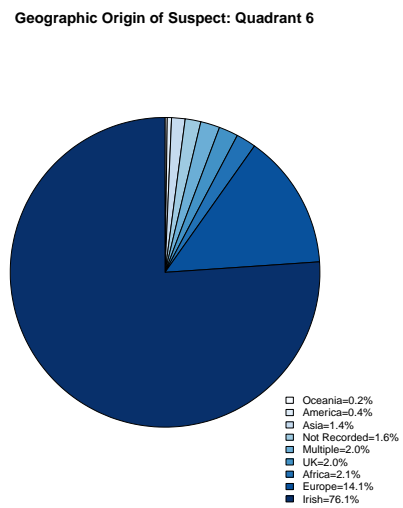
Figures Q6-3a

Age Profile of Suspect Offenders: Quadrant 6

Fig Q6-3b

Geographic Origin of Suspect: Quadrant 6

Oceania=0.2%
America=0.4%
Asia=1.4%
Not Recorded=1.6%
Multiple=2.0%
UK=2.0%
Africa=2.1%
Europe=14.1%
Irish=76.1%

Quadrant 7:

Quadrant 7 consisted of the following streets; Pearse Street, Townsend Street, Tara Street, D'Olier Street, Georges Quay, Moss Street, Poolbeg Street, Cards Lane, Hawkins Street, Custom House Quay.
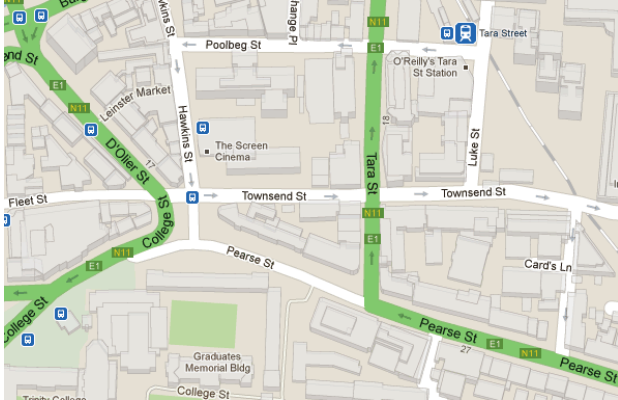
A total of 365 detected crime incidents were extracted for Quadrant 7. Table Q7-1 on the next page displays a breakdown by crime type and month.

Table Q7-1

Quadrant 7:	Dec-10	Jan-11	Feb-11	Mar-11	Apr-11	May-11	Jun-11	Jul-11	Aug-11	Sep-11	Oct-11	Nov-11	Dec-11	Jan-12	Grand Total
CAP (Crime Against Person)	**4**			**1**	**1**	**7**	**2**	**3**	**1**		**2**	**4**	**4**	**3**	**32**
0321 - Assaults causing harm	2				1	4	1	2	1		1	4	1	1	18
0323 - Assault or obstruction of Garda/official, resisting arrest											1				1
0324 - Minor assault	2			1		3	1	1					3	2	13
CD (Criminal Damage)	**2**	**1**		**6**	**2**		**1**	**5**	**1**	**2**	**3**	**5**		**1**	**29**
1212 - Criminal damage (not arson)	2	1		6	2		1	5	1	2	3	5		1	29
DRUGS	**2**	**2**	**3**	**5**	**5**	**1**	**1**	**3**	**4**	**1**	**3**	**12**	**4**	**6**	**52**
1021 - Possession of drugs for sale or supply	2	2	2	3	4		1	3	3	1	1	7	3	4	36
1022 - Possession of drugs for personal use				1	1	1			1		2	4	1	2	13
1032 - Obstruction under the Drugs Act			1	1								1			3
PC (Property Crime)		**2**	**5**	**3**	**26**	**4**	**4**	**9**	**4**	**2**	**3**	**2**		**2**	**66**
0611 - Robbery of an establishment or institution										1			1		2
0613 - Robbery from the person								1							1
0712 - Burglary (not aggravated)						2			2						4
0713 - Possession of an article (with intent to burgle, steal, demand)					1			1							2
0811 - Theft/Unauthorised taking of vehicle							1	1							2
0812 - Interfering with vehicle (with intent to steal item or vehicle)								1							1
0821 - Theft from person					1			1							2
0822 - Theft from shop			2		1							1			4
0823 - Theft from vehicle			1		1	1	1	1							5
0824 - Theft/Unauthorised taking of a pedal cycle				1			1	2							4
0826 - Theft of other property		2	2		20		1	1	1		2				29
0831 - Handling or possession of stolen property				2	2	1			1	1	1	1		1	10
PO (Public Order Offences)	**12**	**21**	**12**	**9**	**8**	**15**	**8**	**7**	**14**	**14**	**17**	**12**	**13**	**13**	**175**
1312 - Public order offences	10	18	10	6	7	12	6	5	14	12	12	10	11	12	145
1313 - Drunkenness offences	2	2	2	3	1	3	2	2		2	2	1	2	1	25
1322 - Trespass on lands or enclosed areas		1									3	1			5
WEAPON (Weapons and Explosive Offences)	**1**			**1**	**2**		**2**	**1**	**1**		**2**	**1**			**11**
1131 - Possession of offensive weapons (not firearms)	1			1	2		2	1	1		2	1			11
Grand Total	**21**	**26**	**20**	**25**	**44**	**27**	**18**	**28**	**25**	**19**	**30**	**36**	**21**	**25**	**365**

Public Order (PO) crime incidents have the highest frequency in Quadrant 7, similar to quadrants 5 & 6. Figures Q7-1a and Q7-1b display a breakdown of crime incidents by category and monthly total. There is a peak in the number of incidents in April 2011. This is driven by a large increase in crime type "Theft of Other Property". It is unclear as to the causes of this peak.
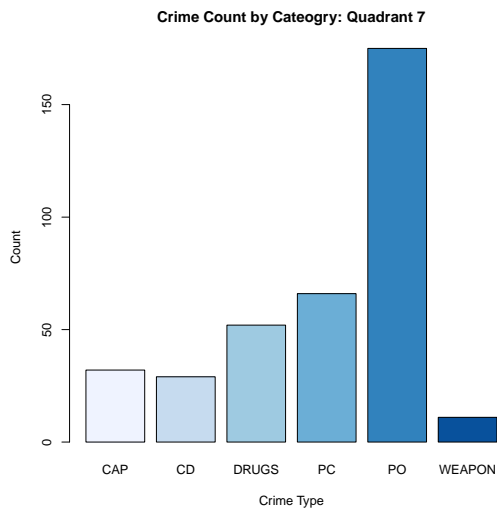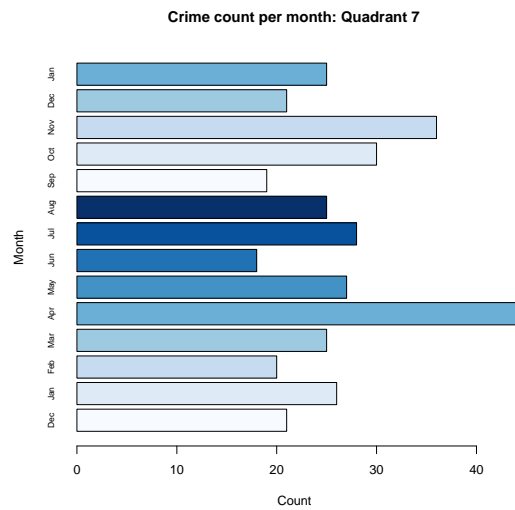
Fig Q7-1a

Fig Q7-1b

The temporal distribution of crimes is shown in Fig Q7-2. The pattern here appears different than all other quadrants, with a significant number of crimes happening in the early hours of the morning time, which is more pronounced at the weekend. This may be due to the presence of Dublin Bus Nightlink services in this area.

Fig Q7-2

Heatmap of Crime Incident: Quadrant 7
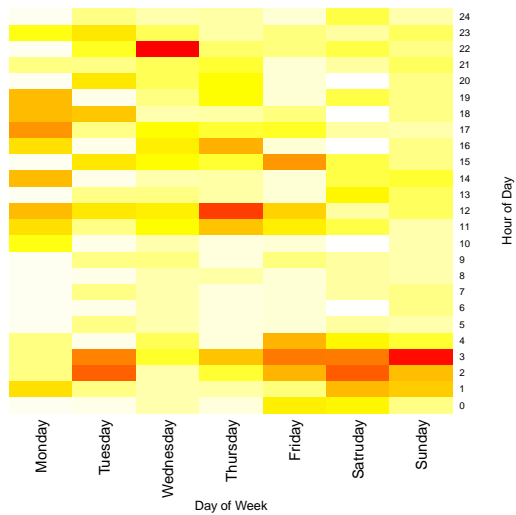
83% of suspect offenders were male in Quadrant 7 with an average age of 31 years compared to 28 years for females.

Fig Q7-3a
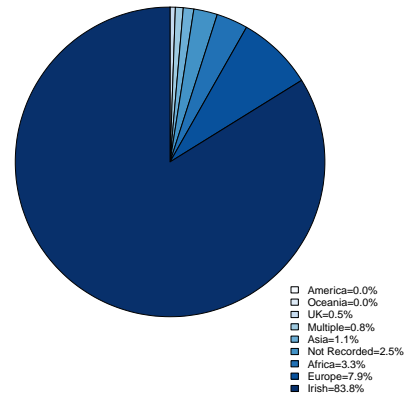
Age Profile of Suspect Offenders: Quadrant 7
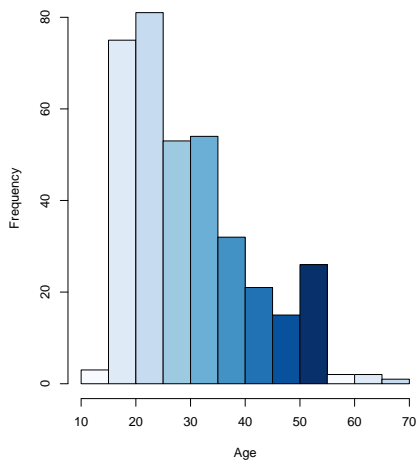
Fig Q7-3b

Geographic Origin of Suspect: Quadrant 7

America=0.0%
Oceania=0.0%
UK=0.5%
Multiple=0.8%
Asia=1.1%
Not Recorded=2.5%
Africa=3.3%
Europe=7.9%
Irish=83.8%

Summary of Key Findings

- A clear distinction between Quadrants 1-4 and Quadrants 5-7 in terms of crime profile, corresponds to the predominant commercial activity of the these areas, retail and nighttime entertainment respectively. Property crime is associated with the retail areas and public order offences are associated with the nightime entertainment areas.

- Drug crime detections correspond closely with typical business hours, peaking between the hours of 10am to 5pm.

- Suspect offenders for all crimes are predominately male and of Irish nationality, the average age across all quadrants is 30.

- There are no significant monthly fluctuations evident in the data.

- Quadrant 6 is significantly different to all other areas of the study, due to the inclusion of Temple Bar, which has its own specific crime profile.

Chapter 5. Mapping of the Research Area

Mapping is a research tool used to support the analysis and triangulation of data from varied sources. In this research, the mapping exercise was used to locate services, outlets selling alcohol, and the distribution of drug related litter (DRL)[3]. In this manner, it is possible to identify and monitor places where alcohol is sold and drug related public nuisance occurred, alongside a visual representation of service locations. By cross referencing with other data in this RAR, perceptions as they relate to this area have the potential to be supported or '*toned down*' in relation to the reality of anti social behaviour in the map confines. The mapping exercise can also be utilised to assist in the future identification of agency and partner specific actions to be undertaken in these places on the map.

Research underscores the contribution that visual methods make to qualitative and ethnographic drugs research, as adjunct means to record data and individual or environmental representations, and particularly when contextualising the structural, economic, sensory and situational influences relating to drug risk environments and social realities of anti social behaviour, homelessness and injecting drug use (Becker, 1998; Evans and Hall, 1999; Fitzgerald, 2002; Rhodes et al., 2006b; Ranard; 2002; Pink, 2004; Malins *et al.*, 2006; Harper, 2006; Rhodes and Fitzgerald, 2006; Fitzgerald, 2009; Bourgois and Schonberg, 2009). In this RAR, the chosen visual methods contributed to the field based '*documentary*', with the digital photographs used to interpret and illustrate the research mapping, and also in order to '*visualise*' the verbal accounts of participant experiences and perspectives (Henley, 1998; Dovey *et al.*, 2001; Ranard; 2002; Malins *et al.*, 2006; Bourgois and Schonberg, 2009; Parkin and Coomber, 2009). This alternative method contributes to a wider understanding of the inter relationships between policy, practice and enforcement, drug users and specific drug scenes in the research area (Parkin and Coomber, 2009).

---

[3] Although this data was used to inform the SRG discussions, it has been removed from the report so as to ensure the anonymity of specific locations and to prevent any of the sites from developing or consolidating a reputation as a drug market

Pink (2007a;b) also emphasized that the applied nature of visual research contributes to qualitative and ethnographic work by contributing to pragmatic social change via participatory, collaborative research with research participants.

Initial phases of research involved *'walkabout tours'* with outreach workers, in order to facilitate the mapping exercise, as existing knowledge on levels of antisocial behaviour in the area was based on assumption and anecdotal hearsay (Rhodes and Fitzgerald, 2006; Pink, 2007b). During these street based walkabouts, photographs of DRL and injecting places were taken, so as to confirm that such sites were used for street injecting, provide the PAI with an awareness and geographic knowledge base of environmental circumstances in these areas, used to guide service user focus groups and brief street intercept surveys, and also provide opportunity for the SRG to revisit these sites at a later date. A database of 40 photographs was compiled, and were coded using NVIVO. Key categories emerged which included; *'Injecting Sites'*; *'Littering of Drug Injecting Paraphernalia'* and *'Deterrents'*. This visual data contributed to both consolidate the interview and focus group data, and provide a socio-spatial context. Although qualitative findings may be influenced by *'interviewer effect'*, the resultant triangulation of data from these varied sources boost research validity (Parkin and Coomber, 2009).

Although this data was used to inform the SRG discussions, it has been removed from the report so as to ensure the anonymity of specific locations and to prevent any of the sites from developing or consolidating a reputation as a drug market. The narrative accompanying the photograps and maps is included below.

Key Observation: Service Placement in the area

The fieldworker noted that key services such as treatment centres are easily accessible via transport hubs (i.e. Luas and buses). Drug services identifiable are situated both within inner city communities, and in city centre locations. Although a wide range of services are situated in the research area, there appears to be a lack of education and training outlets.

Key Observation: Sale of alcohol in the area

The fieldworker observed that clustering of outlets selling alcohol is evident in the research area. map. Convenience stores selling alcohol were observed to attract congregations of individuals, which was particularly evident after 2pm and up until 6/7pm.

Key Observation: Street Injecting in the area

Drug related litter in the form of needles, syringes, spoons, foil, citric packages and other drug paraphernalia was observed and photographed by the fieldworker during walkabouts in a number of streets and alleyways. Street injecting was observed to take place in cars, streets and alley ways.

Parked cars in certain alley ways and pallets discarded for use in fires to keep people warm were observed and photographed by the fieldworker. In some instances, streets and alleyways appeared restricted by use of double yellow lines to deter parking of vehicles for injecting purposes. The fieldworker observed that injecting drug users prepared heroin by 'cooking up' and drawing up in different areas with injecting in another area. Evidence of drug preparation was photographed. Drug preparation and injecting sites were observed by the fieldworker to take place behind bins.

The fieldworker also observed that alley ways chosen for IDU tended to be unlit and hidden out of sight from the public walk ways. The fieldworker observed that some IDU drug users snapped the needle off but left the discarded syringe. The fieldworker observed and photographed evidence that IDU drug users were using the storm drains to dispose of their needles and syringes.

The use of additional drugs in the form of littering of benzodiazepine packaging was observed and photographed by the fieldworker. A variety of deterrents for both injecting drug use and anti-social behaviour were observed by the fieldworker, and included the use of fluorescent lighting to restrict injecting, and notices placed on service doorways.

Key Fieldworker Visual Observations when walking in the research area

Congregations of drug users and loitering were particularly evident on streets The fieldworker observed less visible Garda presence in certain areas, and recorded several instances of visible open drug dealing and sale of contraband cigarettes in this area. It appeared that the easy access to certain streets from the Luas stop (Specific location) facilitated influx of drug users into the area. Greater levels of footfall on certain streets appeared to conceal congregations and small groups of drug users. The fieldworker observed that the greater the footfall on certain street, the less visible congregations of drug users appeared.

Although clustering of outlets selling alcohol was evident in the research area, the fieldworker did not observe many instances of street drinking, with consumption of alcohol taking place off the main streets, and often disguised by being poured into Coke bottles.

Chapter 6 Street Intercept Data

Please note that the following data is compromised by small numbers of participants answering the street survey, and secondly by missing data where questions were not completed.

1. Drug User Sample (n=26)

Demographics

Table 1: Gender.

Male	Female
16 (61.5%)	10 (38.5%)

Note: 61.5% were male drug users (n=16), 38.5% were female drug users (n=10).

Table 2: Age.

18 - 20	20 - 24	24 - 30	30 +
3 (11.5%)	4 (15.4%)	8 (30.7%)	11 (42.4%)

Note: 11.5% were aged between 18 and 20 years (n=3), 15.4% were aged between 20 and 24 years (n=4), 30.7% were aged between 24 and 30 years (n=8), 42.4% were aged over 30 years (n=11). The average male and female ages were in the 24 to 30 year category.

Table 3: Nationality.

Irish	Traveller	Eastern European	UK
18 (69.2%)	4 (15.4%)	2 (7.7%)	2 (7.7%)

Note: 69.2% were White Irish nationality (n=18), 15.4% were Irish Traveller (n=4), 7.7% were Eastern European nationality (n=2), and 7.7% were from the United Kingdom (n=2). 2 females were Travellers, 8 were Irish; 2 males were Travellers, 2 were Eastern European, 2 were from the UK and 10 were Irish.

Table 4: Accommodation.

Friends	Family	Street	Hostel	B&B	Other
4 (15.4%)	4 (15.4%)	5 (19.2%)	5 (19.2%)	3 (11.5%)	5 (19.2%)

Male reported accommodation.

Friends	Family	Street	Hostel	Other	B&B
1 (6.25%)	3 (18.75%)	6 (37.50%)	3 (18.75%)	2 (18.75%)	1 (6.25%_

Female reported Accommodation.

Other	Family	Friends	Street	Hostel	B&B
2 (20%)	1 (10%)	4 (40%)	1 (10%)	1 (10%)	2 (20%)

Note: Differences in male and female reported accommodation were evident with females reporting living with friends to a greater extent than males, and with males living on the street more than females

Table 5: Employment Status.

Unemployed	Employed	Student	Disability
16 (61.5%)	0	0	10 (38.5%)

Note: 57.6% reported being unemployed, 0% reported employment, 0% reported being a student and 42.4% reported receiving disability payment.

Accessing the Research Area

Table 6: Accessing the research area.

Luis	Walk	Bus	Taxi	Dart	Train
11 (42.3%)	10 (38.5%)	5 (19.2%)	0	0	0

Note: 19.2% reported travelling into the research area with the Luas (n=11), 38.5% reported walking (n=10), 42.3% reported travelling by bus (n=5). 0% reported using taxis, Dart or the Train.

Table 7: How often do you come into the research area?

Weekends	Once a week	More than once a week	Once a month	Every day
	5 (19.3%)			21 (80.7%)

Note: 80.7% reported coming into the research area everyday (n=21), 19.3% reported coming into the area once a week (n=5).

Table 8: Are you accompanying a friend to a service?

Yes	No
17 (65.3%)	9 (34.7%)

Note: 65.3% reported accompanying a friend to a service in the research area (n=17). 34.7% were unaccompanied (n=9).

Table 9: Are you accessing services in the city?

Yes	No
24 (93.7%)	2 (6.3%)

Note: 24 respondents reported accessing services in the research area. 2 were not accessing services in the research area.

Bar Chart 1 Services accessed in the Research Area (see next page)
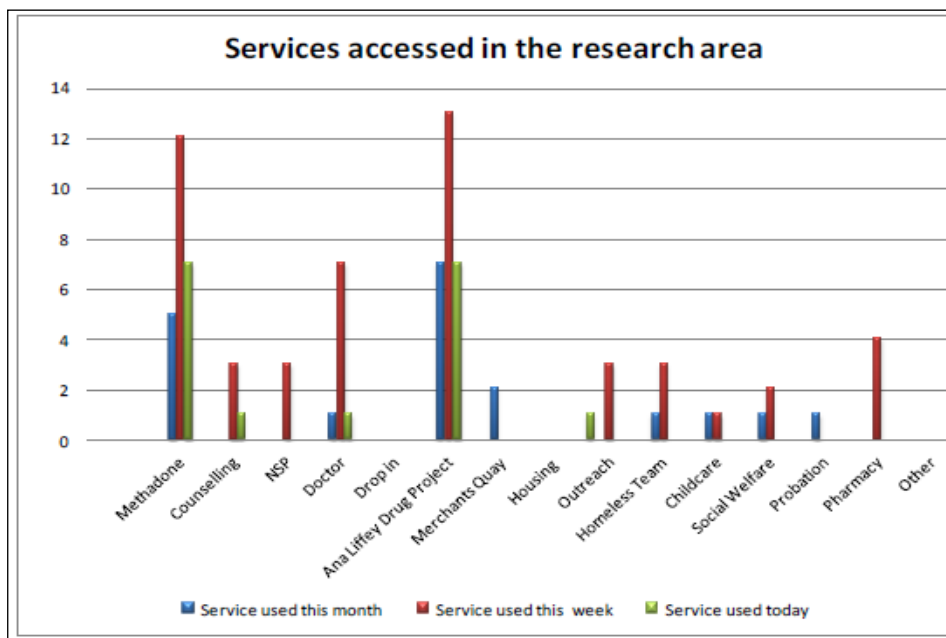
Note: The above bar chart represents the range of services accessed in the research area as per day, week and month timeframes. NSP=Needle Syringe Provision.

Blue represents accessed service this month.

Red represents accessed service this week.

Green represent the service accessed today.

So for example the chart shows that the services most accessed this week and on the day were Methadone Maintenance Treatment and the Ana Liffey Drug Project.

This also highlights that although 16 individuals reported being in the '*homeless status*', less than 5 accessed the homeless team or outreach. This also highlights that the majority of the individuals accessed Ana Liffey Drug project and less than 5 accessed Merchants Quay, this may be due to the location of the research area.

Table 10: Reasons for presence in the research area excluding service uptake.

Accessibility of services in your own area	To remain anonymous	Intimidation from others in your area	Barred from services	To access street drugs/methadone/tablets	Other
				1 (50%)	1 (50%)

Note: Reasons for visiting the research area other than service uptake included the accessing of street drugs.

Table 11: Reason for attendance of service in the research area and out of client residence area.

Don't need a service	Fear of intimidation or violence	Service not meeting my need	No answer.
0	2 (7.5%)	3 (11.5%)	21 (81%)

Note: 21 individuals did not answer the question. Reasons for attending services in the research area and out of the clients residential area included fear of intimidation (n=2), and service not meeting the individuals' needs (n=3).

Table 12: Have you been barred from drugs/homeless service

Yes	No
4 (15.4%)	22 (84.6%)

Note: 84.6% of respondents had never been barred from a drug or homeless service (n=22). 15.4% reported experience of being barred (n=4).

Table 13: Are the drug/homeless services in the research area providing the services you require

Yes	No	No answer
14 (53.8%)	6 (23.5%)	6 (23.5%)

Note: 14 respondents reported that drug and homeless services were satisfactory in the research area. 6 reported these services did not provide the services they required. 6 individuals did not answer this question.

Substances Used

Bar Chart 2: Frequency and Substances Used
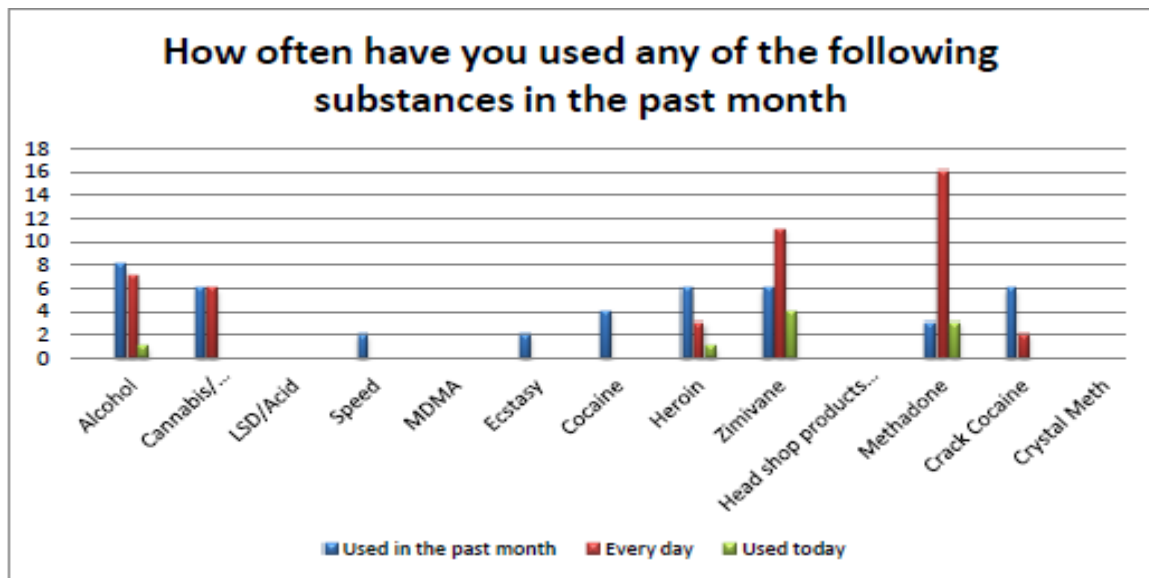
Bar Chart 14 Note: The bar chart represent the range and frequency of substances used in the past month.

Blue represents drug use in the past month.

Red represents daily use.

Green represents use today.

Table 14: Do you use drugs on the street?

Past six months	This month	This week	Today	Everyday	No answer
1 (4%)	2 (7.5%)	6 (24%)	4 (15%)	2 (7.5%)	11 (42%)

Note: 6 individuals reported using drugs on the street this week, 4 individuals reported using drugs on the street *'today'*, 2 individuals reported using drugs on the street *'everyday'* and 2 individuals reported using drugs on the street *'this month'* . 11 did not answer this question. There is no overlap of data i.e. use this week does not imply everyday use or use today. This month represents use this month but not this week or today, or everyday.

Table 15: Do you drink on the street?

Today	Daily	This week	Once a month	This year	No answer
2 (7%)	2 (8%)	4 (15%)	2 (8%)	1 (4%)	15 (58%)

Note: 2 respondents reported drinking on the street *'this month'*, 4 individuals reported drinking on the street *'this week'*. 2 individuals respectively reported drinking on the street *'once a month', 'today' a*nd *'daily'* . 15 individuals did not complete this question.

Table 16: Why do you drink or use on the street?

With friends	Where I scored	Buy alcohol in the off license	No where to go	Other	No answer
5 (19%)	3 (11%)		7 (27%)	2 (8%)	9 (35%)

Note: 7 respondents reported having nowhere to go, 5 respondents reported with friends, and 3 respondents reported scoring. 9 individuals did not complete the question.

Contact with Law Enforcement

Table 17: Have you been arrested or moved on by the Gardai?

Dealing	Assault	Drunk & Disorderly	Shoplifting	Loitering	No answer
2 (8%)	1 (4%)	3 (11%)	5 (19%)	13 (50%)	2 (8%)

Note: 13 respondents reported loitering, 5 respondents reported shoplifting, 3 reported being drunk and disorderly, 2 reported dealing, 1 reported assault. 2 individuals did not complete the question.

Table 18: How many times have you been moved on?

1-3	3-7	7-9	10+	No answer
3 (11%)	1 (5%)		11 (42%)	11 (42%)

Note: 11 respondents reported over 10 occasions of being moved on, 3 respondents reported between 1 and 3 occasions and 1 respondent reported between 3 and 7 occasions. 11 individuals did not complete the question.

Table 19: Why do you return to this location?

Friends	Intimidation	To purchase street drugs	Barred from services	No answer
13 (50%)		8 (31%)		5 (19%)

Note: 13 respondents reported having friends in the area, 8 reported buying drugs and 5 individuals did not complete the question.

Anti Social Behaviour

Table 20: Have you ever been a victim of intimidation, violence, bullying in the research area

Intimidation	Violence	Bullying	No answer
4 (15%)	7 (26%)	8 (31%)	7 (26%)

Note: 8 respondents reported experiences of bullying, 7 reported violence, 4 reported intimidation and 7 individuals did not complete the question.

Table 21: Have you ever had to 'tap' or beg

This year	This month	This week	Today	No answer
1 (3%)	2 (8%)	4 (16%)	2 (8%)	17 (65%)

Note: 4 respondents reported 'tapping' or begging *'this week'*, 2 respondents reported *'this month'* and *'today'*, 1 respondent reported *'this year'* and 17 individuals did not complete the question.

Table 22: How often this year

1-5	5-10	10-15	15+	No answer
1 (4%)		3 (11.5)	5 (19.5%)	17 (65%)

Note: 5 respondents reported over 15 occasions, 3 reported between 10 and 15, 1 reported between 1 and 5 occasions and 17 individuals did not complete the question.

2. Passersby Sample (n=25)

Gender

Male	Female
12 (48%)	13 (52%)

Age

18-20	20-25	25-30	30-40	40+
2 (8%)	8 (32%)	8 (32%)	3 (12%)	4 (16%)

Accessing the research area

Shopping	Passing through	Tourist	Work
4 (16%)	4 (16%)	5 (20%)	12 (48%)

Do you feel safe in the research area?

Yes	
Day time	15 (60%)
Night Time	10 (40%)
No	
Daytime	10 (40%)
Nighttime	15 (60%)

Do you stop accessing the research area at certain times?

Yes	No
13 (52%)	12 (48%)

Have you ever felt intimidated by individuals in the research area?

Yes	No
13 (52%)	12 (48%)

Anti social behaviour observed in the past six months?

Street drinking	16 (64%)
Loitering	15 (60%)
Drug dealing	10 (40%)
Drug using	9 (36%)
Street injecting	2 (8%)
Begging	18 (72%)
Noisy and aggressive behaviours	14 (18%)
Drug related litter	18 (72%)
None	0

Do you feel Garda presence is sufficient in the research area?

Yes	No
15 (60%)	10 (40%)

Open Question: How do you think Dublin city council can address the drug and alcohol related anti social behaviour in this area

Cut down on the amount of 'drinkers' and 'junkies'.

More Gardaí – 'normally just walk by'.

More Gardaí presence, more interaction moving people on.

More education, more influence in the family.

More Gardaí, be more interactive rather than walking on.

Too many clinics close to the area 'put people off' to enter the premises.

Fieldworker Observations

Passersby: Tourists and those passing through had not observed any anti social behaviour. The tourists felt safe and were happy with the Garda presence on the day. One tourist informed the fieldworker that he had been told that this area (named location) was an unsafe area to be at night and that it was safer over the other side (South side).

Those working in the area had all observed anti social behaviour and had been intimidated, and reported to the fieldworker feeling unsafe in the area at night and during the day.

Drug Users:

The fieldworker observed the following;

1. There was a noticeable increase in congregating at lunchtime when services closed for lunch.

2. It was noticeable that those who wanted to 'score' were walking around rather than standing still.

3. Dealing was very mobile.

4. Over half of those interviewed lived in the immediate area.

5. Others reported to come into the area for services.

6. People knew where to come to meet their friends / peers and where to 'score'.

7. Congregating was more evident after Christmas than before Christmas due to reduced foot fall.

8. (Named street) seemed to be a place where they would disperse to on a Saturday.

Chapter 7 Narrative Analysis

A content and thematic analysis of narratives provided by 23 service users aged 23-44 years, 19 business and transport respondents, and 19 community, voluntary and statutory respondents was undertaken. The following key themes emerged from the data; *'Definitions of anti social behaviour'*; *'Contributory factors to anti social behaviour in the research area'*; *'Realities of anti social behaviour in the research area'*; *'Policing Approaches to tackle anti social behaviour in the research area'*; *'Community and Service based Approaches to tackle anti social behaviour in the research area'* and *'Partnership Approaches'*.

Definitions of anti social behaviour'

A range of definitions of anti social behaviour by all respondents were recorded. Service user definitions of anti social behaviour ranged from '*not being able to live in peace'* to behaviours such as youth and child drinking on the streets, phone snatching, night time alcohol abuse, noise in the form of youth shouting and harassment, street assaults, changing drug scenes with children and youth drug dealing, and knife crimes. Service user definitions also appeared grounded in concern for youth and child involvement in anti social behaviours and street nuisance, excessive alcohol consumption and the cyclical nature of street based anti social behaviour within city dynamics.

> *"The kids drinking on the street…it's getting worse they are 12 and 13 drinking, it was bad… it is getting beyond a joke now." (Female service user, aged 33 years)*

Business and transport respondents observed anti social behaviour to be (typically) illegal, causing interference, intimidation, and feeling of unsafe, and impacting negatively on their businesses, the services they provide, their customers, tourists and individuals accessing the area whether on foot, in private transport or on public transport.

"Anything that's considered illegal activity, that would damage our business or foot fall in the area." (Business and Transport respondent 2)

"From the company's point of view, it would be anything that disrupts the normal running of services or interfere with the service we provide to our customers." (Business and Transport respondent 15)

Examples of such behaviours were deemed by business and transport respondents to include visible and abusive forms of drug and alcohol intoxication, congregations of individuals (especially youth and children), begging, tapping and general passerby harassment, visible presence of open drug scenes and dealing networks, graffiti and littering at transport hubs.

"Whatever about the dealing, it's just their presence in the area is intimidating." (Business and Transport respondent 11)

"People that are so drunk that are abusive, gangs of little kids, people that are so wasted that they are lying down in the street…people at the Luas stop begging from people that are trying to buy a ticket." (Business and Transport respondent 2)

Community, voluntary and statutory respondents appeared to hold similar definitions of anti social behaviour to that of business and transport respondents, and described anti social behaviour as any type of behaviour impacting negatively on quality of life, day to day existence, business operations and for those passing through the area.

> *"It is behaviour that directly affects the community that go through the area, drinking and drugs, and anything that affects their day to day life, where they reside or where they conduct their business." (Community, Voluntary and Statutory respondent 1)*

> *"It's any behaviour that not only affects the people in the locality, it affects the people passing through the area, it's a combination of both, its a behaviour that negatively impacts on people and causes their lives to be a misery." (Community, Voluntary and Statutory respondent 13)*

Several comments were made by community, voluntary and statutory respondents with regard to homelessness and its interplay with civic right for space, and public perceptions of anti social behaviour. This appeared at odds with business and transport observations around anti social congregations on the street. Other comments were made with regard to street begging and tapping [walking with passersby asking for money] as way of life for homeless individuals.

> *"I think when anti-social behaviour comes up, particularly around homelessness, it is really an attack on people's right to congregate and business people think that they have a right to own the street and that citizens that don't have a hope are excluded from society. They want to push them out because they think it's bad for business. My own view is that people have a right to congregate on the street, it's a public space… they are citizens as much as anyone else is." (Community, Voluntary and Statutory respondent 9)*

"Behaviour by homeless people? I don't see a lot of it as anti-social behaviour, I see it as behaviour more than anti-social behaviour, there are lots of reasons for that. People would see people that tap or beg, that's a form of anti-social behaviour, I don't see that as part of anti-social behaviour, I see it as a way of living , for some people it's the only way of getting money, to buy food or to book themselves into a hostel, some of the people we would engage with are not entitled to any benefits in any shape or form and sometimes if they have an addiction that they need to support." (Community, Voluntary and Statutory respondent 7)

Community, voluntary and statutory respondent, and several business and transport respondent' discussions were focused on the range of public perceptions of anti social behaviour definitions and how such behaviours have the capacity to intimidate both visually and physically by invading someone's personal and community space.

"For us it would be any behaviour that would intimidate other passengers, [the well behaved normal passengers], that can be from physical violence to even people talking loudly, we even get complaints about people who smell, so it can be a range of things for us." (Business and Transport respondent 16)

"Just the sight of them is enough, for some people they just don't want to see people looking dishevelled in the city centre, and that's anti social enough for them." (Community, Voluntary and Statutory respondent 15)

"A lot of people can feel intimidated by the actual presence of homeless people, or drug users by their appearance, or by the fact that they might speak loudly to one another, or by the fact that they might be drinking alcohol in public. I don't think that's sufficient to warrant that as anti-social behaviour, but where it does invade a person's space, either in terms of aggressive begging or assaulting people, then we are into anti-social behaviour." (Community, Voluntary and Statutory respondent 10)

Several community, voluntary and statutory respondents observed a continuum of acceptable versus not acceptable forms of public behaviours, and level of impact between anti social, nuisance and criminal elements of the behaviours. Law enforcement tactics were observed to be restricted in relation to sanctioning of certain *'general nuisance'* behaviours.

> *"Sometimes anti-social behaviour impacts more than criminal behaviour. Anti-social behaviour is anything that causes a nuisance or affects your quality of life and the majority of it is not classed as criminal behaviour, the Gardaí and the judicial system cannot act on it as much. If you go into flat complexes seeing a child kicking a ball…it can have a terrible effect on you, if that ball is being kicked 24/7 and its against your wall, but that's not anti-social behaviour, anti-social behaviour is when someone sits on your stair well and injects themselves and makes it impossible to enter or leave your home in a safe and secure manner." (Community, Voluntary and Statutory respondent 11)*

> *"The boundaries about what's acceptable and what isn't acceptable can become blurred, they are not often aware they are shouting at times, that can definitely be anti social behaviour in terms of messiness and public disruption." (Community, Voluntary and Statutory respondent 10)*

> *"The consequences of anti-social behaviour go from the guy standing on the street corner and whistling at somebody to somebody losing their home. We are trying to talk about nuisance behaviour, and anti-social behaviour, and criminal behaviour. Nuisance is what all young people all over the world do and there are ways to address it, but that is very different to people going out to purposely annoy or aggravate or intimidate people." (Community, Voluntary and Statutory respondent 12)*

Similar to the business and transport respondents, comments were made by the community, voluntary and statutory respondents regarding intimidation with certain behaviours viewed to exist in group contexts and which included visible drinking and drug use, intoxication, aggressive and loud behaviour, street harassment, assaults, begging on the street and at Luas ticket machines, car break-ins, pick pocketing and other petty crimes;

> *"Open drug selling can be intimidating for people, and then you get the congregation of people that goes with that, people can be hanging around and that can be intimidating and anti-social." (Community, Voluntary and Statutory respondent 10)*

> *"I think that people and staff in the shops are intimidated by them, they are intimidating, they hang around and make demands, we have a porch way so if it rains we try and move them on, they get aggressive." (Business and Transport respondent 2)*

Several community, voluntary and statutory respondents observed how visible drug use and drug dealing, congregations of drug users in *'hot spots'* and *'open drug scenes'*, drug littering, public place injecting and street alcohol use are compounded by the relationship between drug and alcohol use, misuse and dependence, type of drugs involved, potential co morbidity, and homelessness.

> *"A lot of what people consider as anti-social behaviour is often, they mean people that are loud, aggressive in their manner, there maybe instances of violence…and that can be to do with drugs people have taken and also dual diagnosis, mental health issues as well, its symptomatic at where they are at, they are very frustrated and at a very low end of society." (Community, Voluntary and Statutory respondent 15)*

Contributory factors to anti social behaviour in the research area

Service user perspectives on the contributory factors relating to alcohol and drug related public nuisance included issues such as those drug free switching to alcohol, easy access to retail outlets selling alcohol in the research area, availability of cheap alcohol, increased levels of child and youth drinking with purchase of alcohol by adults.

> *"The problem is when they give up drugs, they go on the drink, everybody who is on drugs has an addictive personality, so when they give up drugs, drink is a cheap substitute to drugs." (Male service user, aged 44 years)*

> *"It's too easy to get alcohol in the city and then you get people going in for kids." (Female service user, aged 33 years)*

Several community, voluntary and statutory respondents commented on how alcohol exacerbates street violence, harassment, begging and assaults, particularly during the night time economy, and near Luas lines, and how alcohol use was viewed to contribute to continued public nuisance in the research area;

> *"We find that the anti-social behaviour caused by drugs and alcohol, while they can be very similar they can be very different as well." (Community, Voluntary and Statutory respondent 3)*

> *"Its a city and with a city comes anti social behaviour, you have the late night bars, you have the clubs which brings its own anti social behaviour with it, the clients we deal with actually would take advantage of that situation, so they would base themselves in areas, where they would know that there would be quite a lot of people, maybe drinking or coming out of a nightclub, they know they would benefit from tapping." (Community, Voluntary and Statutory respondent 7)*

> *"There is a huge concentration of blaming all the problems on drugs, where most of the problems in my area are caused by alcohol consumption and the effects of being drunk. Alcohol is now impacting on people getting on and off the Luas at (named street) and people are being attacked." Community, Voluntary and Statutory respondent 11)*

Several community, voluntary and statutory respondents commented on the levels of alcohol retail outlets and cheap pricing of alcohol in the research area, and viewed both the clustering of shops and lack of staff responsibility in alcohol sales and awareness of legislation, as fuelling alcohol and drug related public nuisance in the area;

> *"The main problem are the businesses that sell alcohol, simply if their staff are aware of who they are selling it, they can stop a hell of a lot of problems happening outside their shops, alcohol is not brought into town , it is bought in here , it is sold in here and it is drank in here, and that's what's causing the problems. The places that have liquor licenses should be more responsible, it's not the pubs, it is the off licenses and agents that sell it." (Community, Voluntary and Statutory respondent 1)*

Service users also spoke of individuals coming into the research area from outside the greater Dublin area, contact with other drug users, homelessness and boredom when out of hostel accommodation during the daytime contributed to continued contact with both injecting drug users and poly drug users in MMT, relapse, drug markets (heroin, crack cocaine, tablets), loitering outside treatment centres and increased levels of drug and alcohol related street nuisance. Several service users commented on gender differences in hostel and B&B regulations for accommodation, with males required to vacate during daytime hours. This was also observed by community, voluntary and statutory respondents;

> *"Fellers would be put on the nightbus, and then have to wait until 10 or 11pm to get a B&B, and we are waiting out in the cold and then kicked out at 9am." (Male service user, aged 26 years)*

Several community, voluntary and statutory respondents also commented on the influx of individuals attending clinics in the research area, congregating in known *'hot spots'*, loitering outside of treatment centres, travelling into the research area with the Luas, and with a proportion originating from both outside of the research area (Tallaght, Clondalkin, Lucan, Blackrock) and outside of Dublin itself (counties Waterford, Dundalk, Kilkenny, Kerry, Meath, Kildare and Wexford).

"There are a lot of country people coming up, I have noticed that." Female service user, aged 35 years)

"The Luas is a fantastic service, but for bringing problems into the north inner city has a huge detrimental effect. The dealers don't need to bring cars into town, they have free transport everywhere, it's a transient population and with the volumes of people, it's a comfortable area. Especially with the clinics around they know their customers will always be here." (Community, Voluntary and Statutory respondent 3)

Issues pertaining to transport according to business and transport respondents centred around the civic entitlement to travel for drug users impacting on policing and security on travel routes and with most drug treatment centres located close to tram lines. Issues relating to improved security and policing on Luas lines were described.

"We get the perception that this was not a problem until the Luas arrived, certainly we brought more people and more customers, but we have facilitated some of the movement of anti social behaviour. There used to be a big problem on the board walk and the Gardaí did a great job moving them on, then they moved onto the Luas line, it got bad around 2007 / 2008 and then we put in the new security arrangements." (Business and Transport respondent 18)

"We would like to see Transport police [similar to London] with powers of arrest something that is transport specific. The security company is very good, they look like they mean business with their stab vests on, people like to see them there. We have up dated our laws, whereby you couldn't do anything on the platforms.. we have increased powers." (Business and Transport respondent 18)

Business and transport respondents described how the lack of Garda presence and intensity of presence (at times) both in the research area and on transport networks, coupled with the transient nature of congregations of drug users during the day contributed to the emergence, growth and displacement patterns of street based anti social behaviour and public nuisance. The regulation of different forms of public nuisance was observed to be problematic and ineffective due to lack of sanctioning power, and often leading to displacement into other areas.

> *"It's just not policed at all, I have been there for nearly 15 years and I have seen people selling drugs in the doorway, taking drugs in the doorway, found syringes at the back of the café, even though we are quite vigilant there, there are fights, there are gangs of kids running around, running into the place on a Sunday evening when a staff member is on their own and I just think there is no police presence whatsoever." (Business and Transport respondent 2)*

> *"The resources are made to the Gardaí in fairness, they arrest them and bring them to court, but from there, it is a joke, the judges put them back out and you can see why the Gardaí are fed up with this." (Business and Transport respondent 3)*

Some service users described walking endlessly around the research area in order to fill daytime hours, frequently under the influence of prescribed medication and dealing drugs on different streets;

> *"You have the police stopping you because you are walking around, they stop you asking what you're doing…Look, I am homeless what do you want me to do? It is a catch twenty two position. You sit where the statues are. You are sitting down nothing else to do." (Male service user, aged 26 years)*

The issue of prescription medication use and dealing within visible and transient open drug scenes and identified *'hot spots'* (i.e. Luas stops) in the research area was discussed by both business and transport, and community, voluntary and statutory respondents, and were observed as contributing to continued street based anti social behaviours.

Observations were made with regard to Garda difficulties in sanctioning of use due to lack of classification in the Misuse of Drugs Act in Ireland, and which additionally contributed to very visible sale of these drugs, and a variety of drug users accessing these dealing networks.

> *"When they are dealing the prescription drugs, they have tried numerous ways to deal with that, but it is the legislation that's ultimately standing in their way." (Business and Transport respondent 5)*

> *"People have become much more brazen with the use of tablets.. they seem to know they can't be prosecuted." (Business and Transport respondent 8)*

> *"There are a lot who are seriously addicted to benzo's, and they are prescribed and so they have to maintain that habit, and they have to source the drugs on the black market, it's become almost local knowledge to people, even with people who may not have been associated with the drug scene like pensioners..they know that they can go down there and off load valium to somebody to get money for drink." (Community, Voluntary and Statutory respondent 15)*

Several comments were made about the effect of prescription medication use, along with alcohol, and how street behaviours change and become disinhibited and vocal, thereby contributing to passerby intimidation, harassment, begging and general nuisance.

> *"Alcohol is not a great thing to throw into the mix, when you're talking about anti social behaviour, particularly when there is benzodiazepines and stuff involved. I think the benzo's have a lot to do with people's manner though. It makes people disinhibited, so that people are shouting across the roads to each other." (Community, Voluntary and Statutory respondent 15)*

In contrast, the use of benzodiazepines (oral, injecting) throughout the day was described by services users as lessoning daily boredom, with many service users dealing whilst walking the city;

> *"There are about 80 of us that do laps in that town, we keep walking and smoking joints with each other, people will ring the phone and I will meet them." (Male service user, aged 30 years)*

> *"Taking benzo's on the street it makes you more chatty. It is a warm comfortable feeling, you feel relaxed, some people are goofing off walking around.." (Female service user, aged 33 years)*

Aggressive behaviour due to drug withdrawals was also described by business and transport respondents, as contributing to increased levels of drug dealing and market competitiveness, visible street assaults and begging/tapping across inner city Dublin.

> *"What we are finding is that it is a revenue area as well, so they are collecting more money there, begging more, and they are extremely aggressive as well, when they are begging, a lot of them are coming off the gear and they start to get desperate for more gear and they start shoving coins in your face. We even witnessed last week, they are fighting amongst each other because someone has stolen someone else pitch, and they were knocking the hell out of each other for the pitch, the problem is, it is quite spread out, it is not just one part of the city" (Business and Transport respondent 1)*

Other contributory factors to street based public nuisance in the research area were described by community, voluntary and statutory respondents as including intergenerational dysfunctional family functioning and the socialization of children and youth into normalized anti social cultures involving street nuisance, easy access to alcohol, under age drug and alcohol use, problematic drug and alcohol use, intimidation, graffiti, drug dealing, petty crime and decreased sensitivity toward serious crime.

"It is within the family, it's something that they are used to from a young age, there is no peer support, it's something that is not alien to them, they grow up with it, it is easily accessible from when they grow up, drugs are available to them on their own door step, it's something where they don't see the rights from the wrongs, they don't know the dangers of it, even though they can see the consequences of it, they see the rewards from selling it, and then unfortunately they do use it, they don't realise what addiction is until it is too late, and when they get the alcohol, it is a major part in the city centre, and the accessibility to off licenses and the general availability of alcohol, and the parents themselves and anyone that is looking after a young ones don't see any problem with them drinking at a young age, smoking at a young age, hash seems to be very commonly acceptable, that their kids smoke it to relax them and things like that and then they end up on harder stuff." (Community, Voluntary and Statutory respondent 1)

Several community, voluntary and statutory respondents described how increased intimidation using violence has occurred in recent years within certain families, housing estates and inner city communities;

"The dealers they owe more money, so there is more fear so there is more violence, I think they are a lot more fearful, they know if they screw up the likelihood of them getting shot or their family getting injured is huge, it's a short life span for some of them." (Community, Voluntary and Statutory respondent 1)

Realities of anti social behaviour in the research area

Several business and transport, and community, voluntary and statutory respondents commented on the negative media portrayal of anti social behaviour in the research area, and how in reality it was experienced in a more negative manner by those living, working and passing through the research area;

"People perceive it as an area, where there is constant drug dealing." (Community, Voluntary and Statutory respondent 3)

"They are not reading about it, they are seeing it and that's worse." (Business and Transport respondent 2)

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Business and transport respondent views around needle exchanges, methadone maintenance treatment and general attitudes to drug users were at times negative and derogatory;

> *"I label them all as junkies". (Business and Transport respondent 2)*
>
> *"We have all the needle exchanges in the city centre…that has to be one of the underlying issues here as well. They are coming in from the suburbs for their needle exchange and their methadone, to have those sites located within the city, it's absolutely crazy." (Business and Transport respondent 3)*
>
> *"Age group I would say from late teens to early thirties I presume they die after that. I feel very strongly about it load them into a truck and dump them somewhere else because they do effect trade. If I as a consumer was walking around here and I didn't have to, I would go somewhere else." (Business and Transport respondent 6)*

The main area experiencing public nuisance and street based anti social activity appeared to be around (named locations). Several comments were made by both business and transport, and community, voluntary and statutory respondents around urban design in the research area facilitating anti social behaviour (i.e. poor lighting) and contributing to individual perceptions of fear and threat to safety.

> *"I would say (named street) would be one of the worst, its dark, it has got a wall of buses along it, it doesn't feel as if it is going to help you, it hasnt got any escape, you have nowhere to run." Business and Transport respondent 18)*
>
> *"It's like (named street), you know where you are going. but it is the environment outside, even if you try to get to (named locations)…you have to walk down the board walk, that's a perception thing. Dark streets even (named quay), you would not walk down that board walk, however you might walk down the board walk further along, it is the perception of people hanging around… what might happen to you." (Business and Transport respondent 17)*

"The built environment has an impact as well, it's much easier to get away with anti social behaviour in the old flat style complexes, because of the way they were built, bad planning, it is virtually impossible to patrol them, because in order to patrol them, Gardaí have to get out of their cars and walk up the stair wells, something that they rarely do… those who do are usually community Gardaí who know most of the people in the area." (Community, Voluntary and Statutory respondent 11)

"The whole length of (named street), the little lane way, I just walked through it (named flat complex) that area, the whole of (named streets), I know that some of the design of the Luas stops does not help, there is a under croft at (named luas stop) which is dark, we have done certain things to try and lighten up the area." Business and Transport respondent 16)

Service user observations around anti social behaviours also appeared grounded in personal and peer related threat on the street. Feeling unsafe and fearful in the research area was described by both male and female service users.

"I don't go into town much, I normally stay around here (named location) but it is getting to the stage where you are scared of going out." (Female service user, aged 33 years)

"There were 3 guys walking behind me, I just had a strange feeling and hopped into a taxi that was waiting nearby, I would not usually do that, but it's got to the stage where I am getting afraid." (Male service user, aged 33 years)

Concerns were raised by service users for increasing street violence in the form of street intimidation, knifings and muggings.

"My boyfriend was attacked a few months ago for €10 by a guy who had glass in a sock he was hitting him in the face with it, his face was cut over a tenner like." (Female service user, aged 36 years)

"If they see a feller with a few bob on them, they would start a fight with them and rob them." (Female service user, aged 31 years)

"People are being stripped or given a straightener for ripping people, or you can look at somebody in the wrong way, you will get a stripe." (Note: a stripe is a cut across the cheek) (Male service user, aged 31 years)

Several male service users commented on how days spent aimlessly wandering around the research area contributed to increased knife crimes (amongst others) and generalized threat to both drug users, and passers-by;

> *"The ones who are waiting to rip are the ones that hang around all day. They are the lost souls, they are lost, its the be all and end all, that's how they spend their days. My moral is never rip anyone in town, you're always be a marked person and then marked with a stripe, don't talk about anyone behind their backs." (Male service user, aged 30 years)*

Several community, voluntary and statutory respondents described drug user theft of mobile phones as contributing to individual assaults and muggings, and directly facilitated by shops willing to purchase these phones;

> *"The robbery unit went crazy because of snow blow, it was purely because they were robbing the phones to sell for €100 / €200 a time for a phone and go back and spend it all on snow blow or be in credit with these shops that were open at the time. We have seen an increase in particularly I phones, there is a large growth in theft of the person, where they kind of target someone they see as vulnerable, its opportunist, they will take the opportunity and then they are off to sell it, quick enough there are plenty of places around the town that you would be aware of where they are taking these phones and selling them on, or they could get them unlocked and then sell them on themselves." Community, Voluntary and Statutory respondent2)*

Fluctuations in public nuisance in the research area were observed to occur, with greater levels of street congregating and open drug scenes during daytime hours and in some instances on Thursdays. This was observed to impact on business hours in some cases.

> *"We have started closing earlier, we used to be open until 11pm, it is just not worth it because the trouble you get between 9 and 11pm, and staff were too afraid to come and go at that time." (Business and Transport respondent 2)*

The presence of drug activity in certain areas was also observed to be market dependent in the forms of which drugs are available for sale (i.e. heroin, cannabis, tablets, crack cocaine, crystal meth) and appeared to filter into middle class drug consumption at the weekends;

> *"There is a park outside, so there is a lot of dealing and drinking, that would happen in the park, that's a regular thing most days and evenings of the week but on Friday, Saturday and Sunday, there is a lot of activity where quite well dressed people would come and stand at the corner, make a phone call, walk the perimeter of the park, pick up something at some point and off they go, but that only happens around the weekend." (Business and Transport respondent 3)*

Most service users had observed open drug scenes, small meetings and *'hot spots'* for drug dealing in the research area, and commented on both increased competitiveness with greater numbers of street dealers impacting on street trade, and increased youth and child involvement in street dealing. Both service users and some community, voluntary and statutory respondents commented on the use of both bicycles and mobile phones to facilitate mobility of drug dealing hot spots;

> *"Years ago it used to be the likes of older people on the streets and now it is all young fellers, cycling around, asking are you looking for 'gear' are you looking for 'dollies'. You're not even making money, because there are so many of them down there, there are so many kids cycling around and around." (Female service user, aged 24 years)*

> *"This is not something new, there has always been 12 year olds moving hash on their bikes that's been going on for years, but no one seems to pick up on it or there isn't anything anyone can do about it, what can you do, you cannot charge a 12 year old…its easy money." (Community, Voluntary and Statutory respondent 18)*

In contrast, conflicting viewpoints were taken by several community, voluntary and statutory respondent when asked about the operation of drug markets, availability of certain drugs of choice and associations with congregations of drug users on the streets.

"When we hear there is a drought we find that it brings people out of the woodwork and they congregate and they wait in areas, what has been said to us is that when there is a lot of gear around, there is no reason for people to be hanging around, waiting and waiting and looking, whereas when things are tight, people are then talking to each other and grouping and are waiting, that suggests to us that things are tight and people are actively looking for somebody to deal to them." Community, Voluntary and Statutory respondent 5)

"The availability of the drug on the street at the time when it is in, you can tell by the amount of people coming into the area from outside when there is a certain type of drug , it is word of mouth and it is hard to get them out of the area because they know there is a product on the street and its going to go quickly its quite evident. (Community, Voluntary and Statutory respondent 1)

Both service users and community, voluntary and statutory respondents described increased congregations of drug users in certain areas, with levels of '*hot spots'* for drug dealing outside of known treatment centres in the research area. Concerns were raised about residential and service provider interference, and increasing levels of intimidation around methadone diversion. In addition to selling other drugs such as heroin, cannabis, new psychoactive drugs such as mephedrone, prescribed medication (zopiclone, diazepam, zimovaine, valium, D10's and D5's), crack cocaine and crystal meth, several service users reported selling methadone and *'tapping'* in order to make ends meet.

"(Named treatment centre) was very bad at one stage, there is a little cafe just opposite…and the dealers were sitting in there, and they had their little runners outside and they see people coming along and they come over and sell the drugs to them, and when they run out of quarters, they go in and give the dealer the money and get some more." (Male service user, aged 23 years)

"It is like a business they know when the addicts are around, they know the opening times, it is pretty much centred around the clinic. For instance in the morning time when the clinics open, your drug dealers and spotters are around and looking for people that are weak, vulnerable or setting up their other mates through word of mouth… they are comfortable in that area dealing." (Community, Voluntary and Statutory respondent 1)

Community, voluntary and statutory respondents reported seeing increased levels of *'tapping'*, particularly among women, and increased levels of street based sex work. Service users observed the increases in sex work as due to crack cocaine.

"I have noticed more women begging, definitely what I have noticed the areas where people are begging has increased, I have never seen anyone begging on (named street) and now you would see a lot more people. We are engaging with a lot more women working on the streets. What I am amazed at is the amount of money they can earn in a night it was astonishing really. I am noticing a lot of younger males now as well." (Community, Voluntary and Statutory respondent 5)

"I know a few girls that would have gone on the game to get the money to buy crack, and they are lovely girls that's how addictive it is." (Female service user, aged 35 years)

Tablets and new psychoactive drugs such as mephedrone were reported to consist of varied types and forms, often blended with existing street drugs such as cocaine, and available through a variety of sources including internet, pharmacy theft, factory theft, with several community, voluntary and statutory respondents concerned for the importation of counterfeit medicines with unidentified contents and potential for user overdose. Of interest is that several service users also observed purchasing new psychoactive drugs via web based retail outlets serving Ireland.

"You can get them off the internet, you can buy them in bulk over the internet. I go to a dealer to buy my tablets and then sell them on. If I sell them for €2 each and buy them for €1, I am making €1 a tablet, the guys are getting them for 50c some of the guys are going over to Spain or the internet." (Female service user, aged 33 years)

Street injecting according to the community, voluntary and statutory respondents appeared to be confined to a small group of mostly homeless individuals or rough sleepers. Despite this, the interplay between problematic drug and alcohol use, health and social consequences were underscored, with public place injecting viewed as particularly risky in terms of *'rushed'* injecting, environmental contamination, and forms of direct and indirect needle sharing.

> *"In terms of public injecting there are increased levels of harm in terms of poor injecting practice, increased harms in terms of HIV and Hepatitis C, we know there is a high level of Hepatitis C amongst our client group, which is the group that is often associated with perceived anti social behaviour, so the health consequences are huge, these are life and death health consequences, we are talking about when it comes to talking about anti social behaviour, there is the violence that happens when a deal goes wrong, people getting very serious trauma to the head or whatever, there is a very serious level of violence and health consequences. People will worry about what will happen to a child or an adult that will get a needle stick injury, but the real health consequences are actually with the people that are engaged in the practice, so people that are injecting feel the shame and humiliation of having to go down and rushing their hit and damaging their veins and sharing their needles and risk or overdose." (Community, Voluntary and Statutory respondent 10)*

The majority of injecting drug users described how street injecting is unpleasant and unsafe, with users commonly injecting in (named fast food outlets), in cars and in alleyways, and with some reporting groin IDU. A service user spoke about his experiences of rushed injecting when in a public place and said;

> *"I try and go in somewhere, in the toilets or somewhere, I don't do it out on the streets, where any kids are walking past and can see, I wouldn't do that." (Male service user, aged 26 years)*

"Some people go into their groins, bang and that's it one minute job. You can go and cook it up somewhere behind a car or whatever real quick, carry it with you, into a doorway, it takes 30 seconds if you need to go into a vein, you need heat and you get the vein up. Plus if you go into a toilet, there are people outside the toilet door, people are banging on the door and you're trying to get a hit, and that causes stress, whereas if you're on the street and you're going into the groin, it is just bang in and its gone and away with ya… you can go to a secluded spot.."
(Male service user, aged 23 years)

Several service users reported concern for the sharing of used equipment during times when needle exchanges were closed.

"I was asked in town the other day, they were willing to give me €5 for a used barrel and spike, this girl was crying and begging me for, this showed me how desperate people are. I think the exchange was closed, it was lunch hour." *(Female service user, aged 33 years)*

A business and transport respondent also observed how street injecting is facilitated by features in the urban environment and said;

"The areas that are used because they are very discreet, they are used because there are cars or delivery trucks parked, or there are large container bins in the area and they are hidden, shops get delivers and there are pallets left there, these places are hidden, some places are covered and sheltered, they are good hiding places, there is no direct line of sight…more lighting more enforcement of double yellow lines." *(Business and Transport respondent 19)*

Policing Approaches to tackle anti social behaviour in the research area

The majority of observations from the business and transport, and community, voluntary and statutory respondents were positive with regard to the effect of both visible and covert Garda presence and operations in deterring and displacing open drug scenes in the area, and many discussed the outcomes of *'Operation Stilts'*, and the need for a continued proactive, dynamic approach to policing street level anti social behaviour.

"Operation stilts is very useful but it needs to be changed weekly, monthly whatever, we are constantly changing it….thinking of more creative ways of approaching it and moving around and changing , they get used to our particular systems as well, and it's something you're better off to reinvigorate it as well, it's healthy for the Gardaí as well , when you consider it is possibly not the nicest environment for a Garda to work in, I have always acknowledged the people who frequent the area are some of the nicest people in the world. Particularly these people who have their addictions, they are very nice decent people but at the same time , they are not very coherent a lot of the time , it's very hard to have rational conversations and treat these people in a rational sense." (Community, Voluntary and Statutory, respondent 3)

Community, voluntary and statutory respondent comments centred around the effectiveness of high levels of Gardaí visibility, an arrest referral system and a more community based user centred empathic response. Several commented on the usefulness of Antisocial Behaviour Orders (ASBOs).

"I think in the city centre the last two years, especially the last year and a half there has been a massive effort put in [by this station] to combat antisocial behaviour, where as you see high visibility policing, which does deter drug dealing more, so it deters the anti social behaviour drunkenness in the streets and rows have certainly decreased, there are not as many public order instances. I think when there are public order instances it's more drug related to do with dealing and they are more inclined to put it up to the Gardaí. I think that's because the Gardaí are very approachable up town, they are giving people chances, they know these people whereas before they would have been more of a no nonsense approach, they are community Gardaí who know the area and people they are dealing with on a daily basis. We are looking at using ASBO's the decent residents down there.. it is really getting to them, Even if there is a high Garda presence they are very well organised and unfortunately it is a small group that are having a huge effect on the community." (Community, Voluntary and Statutory respondent 1)

"Of course they have a role on the streets in terms of public safety the Gardaí can engage more with the services things like arrest referral schemes are very important to try and keep people out of the criminal justice system, divert people so they don't acquire criminal convictions. The Gardaí have made some progress over here and there is an arrest referral scheme going on in the north inner city." Community, Voluntary and Statutory respondent 10)

However, some business and transport respondents reported concern for inconsistent Garda activity and intensity of activity across the northern and southern aspects of research area, with comments that policing levels are less obvious in the south and restricted to certain '*hotspots*'.

"we had the Gardaí in last week asking why the policing had fallen away, the reason it has fallen away we know it was down to the Queens visit, they restricted the budgets and therefore the presence was curtailed, however I walk down here every morning and there is a Garda presence however its restricted to the actual post office." (Business and Transport respondent 6)

Several community, voluntary and statutory respondents reported that service level policing in conjunction with Gardaí was positive, and deterred levels of loitering and drug user congregations outside services.

"From our perspective, we would have a very, very positive experience of policing activity, we have worked with that from both agencies, policing ourselves and the from the clients perspective, we also make it very well known from posters when clients arrive into the centre and on induction, we tell them into relation to loitering, its written in to the contract, there is a due process from within the contract, if somebody is found to be loitering within the area or causing an issue, we have stages where we go, so the people get due warning and it is not something we take a military approach, to be fair even when the police have stopped our clients, by and large have been very respectful." (Community, Voluntary and Statutory, respondent 17)

The displacement of drug users via covert and overt policing intensity was viewed as important by business and transport, with community, voluntary and statutory respondents observing its limitation in simply moving street level public nuisance, open drug scenes and associated anti-social activity into other areas.

> *"We would have meetings with the Gardaí, it has been an ongoing thing over the years, they put in place an operation to move them on search and arrest them if they find anything. They move on for a while, then the businesses have another meeting with the Gardaí and they want to exact same thing done, so they do the same again and then they arrive back at (named location), so every time it is in a cycle, it is very intimidating for customers. " Business and Transport respondent 15)*

> *"It does not go away, it just gets moved on from one area to another the problem has moved from (named street) into (named street) and into (named park), this is a elderly group, so the older you get the more intimidated you feel, the more they drink during the day, the more the noise level is rising, they are throwing eggs at the windows. The Gardaí are aware and now keep going into the area and moving them on." (Community, Voluntary and Statutory respondent 6)*

One service user commented on Garda displacement of drug scenes from one area to another;

> *"It has gone dead around by (named location), the Gardaí have moved them out and along (named street)." Male service user, aged 31 years)*

Several community, voluntary and statutory respondents observed the drug market responses to heightened Garda presence in certain areas;

> *"People are carrying less and that's the bottom line, that's why you're not going to find those hard drugs up there, because they are afraid, it's easier to lose a line of tablets, than it is too loose a bag of heroin, that's why with the concentration of police up there, you are likely to run into a search at any time and that's what we consistently have to do searching them, checking them out and talking to them." (Community, voluntary and statutory, respondent 3*

Several business and transport, community, voluntary and statutory respondents, and service users observed how the effective networking of groups of children in engaging in drug dealing in certain '*hot spots*' and on the Luas was problematic for Gardaí to counteract.

> *"In the last two weeks I have noticed the accumulation of teenagers being stereotypical, they wear the same clothes everyday, because they can't even afford to be smart enough to change their clothes. They post themselves at each point in the street to let each other know when the Gardaí are coming and when specific ringleaders / leaders are in the area and the others are tipped off by the footmen, they are jumping on the Luas to go down or up the track, they work in teams of two's or three's. I have watched them outside the shop drinking coffee sharing the tablets with each other to take them in public, it is the same individuals all the time, it is more intimidating where ever there is an inlet they hang around. They are growing in numbers and their network is far superior to the Gardaí. The Gardaí are focused on being defensive in this situation based on calls etc but the network is far more advanced and they can't be lifted because they technically are not doing anything." (Business and Transport respondent 13)*

> *"If you're on a bike they think, I won't get arrested, they aren't going to take the bike as well." Male service user, aged 26 years)*

Service users and community, voluntary and statutory respondents observed a lack of fear in children and youth engaging in drug dealing and anti social behaviour, and attributed this to a lack of positive Gardaí relations in certain communities. The need for improved operation of community Gardaí was described to create supportive relations with children and youth at risk, address family and individual intimidation, alongside the targeting and support of high risk families.

> *"To be honest kids don't care about the police, they have no fear, if it's in a child to do something, the police won't stop them. I think the police have got fed up with it all and letting the kids do what they want." Female service user, aged 33 years)*

> *"Young people don't see the Gardaí to protect them, but to make their lives a misery." (Community, voluntary and statutory, respondent 12)*

"I think all we can do at the moment is to work with the families to support them in whatever they decide to do and a lot of the times, they decide to pay up the money through fear, even when they are paying up the money, they don't even know if they are paying the drug baron back because a lot of the times they are using local thugs to collect the money, so you don't even know if the money is reaching the person… there are stories where families are paying up and sometimes they pay up too quickly and come back looking for more or they pay too slow and something happens. The Gardaí label everyone in the family and it might be only one person in the family who uses drugs and got into trouble but the whole family is labelled and families find that with the Gardaí that's what happens and there is a lot of intimidation from Gardaí as well so it's like double intimidation for some families and it's something that needs to be addressed." (Community, Voluntary and Statutory respondent 8)

Community and Service based Approaches to tackle anti social behaviour in the research area

Community, voluntary and statutory respondents commented on the need for improved rehabilitative pathways for those on methadone, greater access to and provision of rural treatment options across Ireland, and a central placement provision service for those rough sleeping in order to reduce the levels of influx into and loitering in the research area, and to address and reduce user perceptions of the area as a hive of drug dealing activity.

"I would suggest a strategic plan needs to be put in place to establish drug services locally, and whilst the city centre will always have a drug issue, we can certainly look after people and then refer them back into services. The thing about Dublin, we are always going to be appealing to people because people will come to the City Centre thinking that's where all the money is, that's where the drugs are, that's where the people are, city centres always attract people, however services need to be local for people. When drug users have to leave their area because of drug use, I think it should be easier for people to be housed outside of their area, there should be some transfer system that that is effective to take people. Not one that takes months and months and years and years." Community, Voluntary and Statutory respondent 6)

Increased vigilance, development of systems and responsibility for dealing with drug activity outside of their service was mentioned by several community, voluntary and statutory respondents.

"We have to recognise that we do draw people to the area, so we do have a responsibility, what happens inside our door and outside, we have a responsibility to engage with our neighbours, the local community and business community" Community, Voluntary and Statutory respondent 10)

"It impacts on businesses and everyday life, if there was a structure in place with a strike system on them, where people can be reprimanded, if they are constantly loitering, after they have received treatment, that could be one way of alleviating a lot of the issues, but then again its where all the groups have to come together, it's not just one persons fault." Community, Voluntary and Statutory respondent 2)

Business and transport, and community, voluntary and statutory respondents commented on the need to remove and relocate treatment centres out of the research area;

"It's a touchy subject, no one wants it on their door step, but our main street to have that level of anti social behaviour every single day of the week, not just people who live within the city centre but people coming in from the suburbs, it just seems absolutely crazy. Relocating the users centres, you have to look at the other side of it as well, we are talking about users here, but I suppose why it's here is because of the transport network brings people in here and there has to be a cost to that we are looking at scratching the surface but there is no financial impact why they are here so we have to look at that first and then decide how to grab hold of it, it's no good saying we will stick it here and that's it, we will get rid of them all, because what we will end up there is no one will be using it and then we have a bigger problem. I agree it needs to be away from the city centre but it needs to be an area noodle point where everything comes in, so an opportunity for those people to go there is viable. If no transport is going there, they won't walk there, it does need to be taken away from the city centre." (Business and Transport respondent 1)

Service users commented on whether treatment centres should be relocated and said;

> *"No I don't believe they should there are not enough, they are only doing that to get rid of the problem , there are more people in Dublin and it is a more populated area, if there was enough in Dublin , they wouldn't need to move any out." Male service user, aged 44years)*
>
> *"If there were more treatment centres, there wouldn't be so many people on drugs." Male service user, aged 23years)*

The need for improved services with harm reduction approaches to include a variety of treatment approaches, needle exchanges and safe injecting facilities, and utilised as gateway into other services and medical supports were discussed by several community, voluntary and statutory respondents, and business and transport respondents with a view to potential reduction in loitering, drug dealing, street injecting and congregations of drug users.

> *"I accept that there is assertive policing that needs to happen at all times not just when drug services are open, we need safe streets by having the appropriate level of policing. I also accept that there is an recovery agenda out there politically, I accept that this needs to be there, but I think that whole issue of the continuum of care where we have Harm Reduction interacting with people and moving them through the continuum because you have a relationship with them is very important so outreach to people, needle exchange, methadone maintenance, other forms of opioid replacement, give people other choices not just methadone not just one but an allowance for where people are gathering because, it would make sense that you would put those services where people are gathering because that is where they are. To make things safer the obvious thing is to give somewhere safe to use drugs the notion of Drug Consumption Rooms or Medically supervised injecting centres, there is evidence that they make a positive impact on the consumption of drugs, they have an impact on getting people into Treatment and Rehabilitation, they have an impact on HIV and Hepatitis C levels within the population. " (Community, voluntary and statutory respondent 6)*
>
> *"If we are not able to provide a centrally based service to actually go and inject in a safe environment, I think we need to make it as safe as possible where they do go and inject." Community, voluntary and statutory respondent 17)*

"There should be somewhere for them to go to take the drugs, some kind of centre where they give them out needles and they give them out methadone, they have nowhere to actually take their drugs. then they spill into people's businesses, try to pick quiet corners in various businesses because they are off the main street and they are out of the public eye , so they think , and that's when it becomes a problem taking on people's premises." (Business and Transport respondent 2)

Service users commented in a similar manner and viewed such centres as reducing injecting related harms.

"They need centres, people are reusing and then throwing the needles onto the street and there are kids in these areas, it is safer for everyone else and its safer for them." Female service user, aged 33 years)

"Having a controlled environment when they can be monitored there would be less people O/Ding, less people getting diseases and less people dying." (Male service user, aged 26 years)

Most service users commented on the need for more beds, hostels and accommodation options for homeless individuals of both genders, and particularly drug free accommodation provision with 24 hour access. This was observed to fundamental in reducing street based public nuisance, contact with drug users, and opportunity to purchase and use both licit and illicit drugs.

"It is bad, I am in a hostel for people that are on drugs, you have to be a drug user on heroin to get into these places, or you have to be a drinker. There are girls on the game who are in the 24 hr access they can come and go as they want, it's crazy." Male service user, aged 30 years)

"There are no drug free hostels in the area and I am off drugs, I have to stay in a few hostels just to get my money, if not they won't pay me, I am on disability if I stay at a friend's house then they will put me onto jobseekers, I am off the gear as well, they are throwing us back to the dogs. I have to get a form from the hostel everyday saying that I stayed there…There is nothing but needles and gear being smoked." Female service user, aged 23 years)

Business and transport respondents also recorded the need for increased housing services to reduce rough sleeping;

"Get drop in centres, shelters I don't know, we are defiantly seeing an increase of rough sleepers, no question about that.. the last couple of years it has got worse , what I am noticing is the quality of the sleeper when you speak to them you can imagine two pay slips ago they could have been working, that's what we are finding, if you look at the clothes, they are quite well dressed but they are sleeping rough, they are the easier ones to move on. They are stereotyped as well, I am sure they are thrown into the same swirl pit as everyone else." (Business and Transport respondent 14)

"Some people sleep during the day because they are afraid to sleep at night." (Business and Transport respondent 3)

Community, voluntary and statutory respondent comments with regard to the effectiveness of the Housing (Miscellaneous Provisions) Act 1997 were largely negative and inappropriate to deal with both antisocial individuals and their families, or problematic drug and alcohol use, and viewed to contribute to increased levels of rough sleeping and uptake of emergency accommodation.

"Under your tenancy with Dublin City Council definition not anti-social behaviour you can lose your home and it is a last resort, people in my area think that Dublin City Council don't act quick enough, and there aren't enough people losing their home." (Community, Voluntary and Statutory respondent 11)

"I know one family in particular that were habitual criminals drug addicts, serious criminals that caused real anti-social behaviour, they were evicted, they went to another suburb of Dublin, but they still come in here, it didn't really solve the problem too much." (Community, Voluntary and Statutory respondent 1)

"If you don't want to see people in the city centre, then don't make them homeless and put them in hostels, find another way, there must be other answers." (Community, Voluntary and Statutory respondent 6)

"Heroin use is a big problem but they don't necessarily have to lose their homes over it and if you do kick them out over heroin use, it's the councils' responsibility to house them again anyway, so they will be put into emergency accommodation, the idea that you do your best to resolve the problem before it becomes a homeless problem, because it's much more expensive to resolve it, if it's a homeless problem because they go through this system and often it can be hard to get out of , if you can keep them in their accommodation and try and prevent the homelessness from happening so if the drug use is causing fights and stuff like that and if you can resolve those problems. (Community, Voluntary and Statutory respondent 9)

Service users described a need for greater service support systems for those homeless, with depression and at risk of suicide, as most services are problematic drug and alcohol oriented.

"Counselors for people who want to get off drugs, and for people that are down and who are only new on the street and to help them cope with it." Male service user, aged 43 years)

The relationship between street injecting and homelessness, and lack of individual social space was reiterated again and again by community, voluntary and statutory respondents.

> *"If there is an issue with public injecting , that's a concern for people's health , if they are injecting in public, it has to be asked why they are injecting in public, it's not the most ideal place to be injecting. Ideally people should be able to take their drugs home and use them at home that's what most people would like to do, but if people don't have a home, I think that is why an underlying cause for injecting in public so there needs to be specialised hostels for people who are injectors." (Community, voluntary and statutory respondent 15)*

Comments by community, voluntary and statutory, and business and transport respondents on use of fluorescent lighting to deter public place injecting were mixed.

> *"It is highlighting that you have a problem…it doesn't reduce the impact just highlights your outlet is a black spot for drug activity." (Business and Transport respondent 2)*
>
> *"If your intention is to stop people finding a vein, then it will do that job, it doesn't really stop skin popping for example, people can still inject and skin pop, they can guess and feel their way through and do more damage, I think the reality is we are better off engaging with them. asking them not to do stuff." Community, voluntary and statutory respondent 6)*

Service users when asked about court mandated treatment commented that readiness to change and cutting ties with former drug using networks was a vital ingredient to success of the programme, and that many found it to be untimely and intensive. Community, voluntary and statutory respondents had mixed views on existing evidence base for this form of intervention.

> *"I have been through it, I wasn't ready for it but it is a great programme, the only thing about it is , they try to run you every day they don't give you a minute to do anything by yourself , it was too much for me , I was there for nearly a year."* Male service user, aged 30 years)

"The last piece of evidence I read was that drug courts don't work and the outcomes are very poor now that might be different now, if it works and its evidence based and the evidence is good then, I would support it because my understanding is that it's trying to re direct people away from prison system, so anything that directs people away from the prisons is a good thing." Community, voluntary and statutory respondent 6)

"I feel like they haven't really delivered , in comparison to the investment that has gone into them there hasn't been a return, it's been too restrictive , I don't see why every court can't just use more community sanctions rather than have a specific drug court, if people are convicted of an offence, I think there should be a good social work report done before any sentencing takes place and then part of their sentence if people have a drug or alcohol problem would be to try and divert them out of custody." Community, voluntary and statutory respondent 10)

Partnership and Urban Design Approaches

The need for integrated and inter agency community, service, business and *Gardaí* partnership approaches were discussed by business and transport, and community, voluntary and statutory respondents. Several community, voluntary and statutory respondents underscored the need for vigilant and proactive policing within a community partnership approach, alongside an empathic and respectful dialogue between law enforcement and service users.

"The police have a vital role to play and I think, things have improved, they find themselves in an unfortunate position that they are expected to be all things to all people, ideally you would like to see the police work in a community way, to develop relationships with the people who live in the area and the people that frequent the area. On one hand the police are asked to be social workers and then on the other had they are asked to be law enforcers and sometimes those roles aren't complimentary. I think they need to engage more with drug services to get an increased understanding of the police.

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The community policing forum in the inner city has worked really, it's ironic that the people who are tarred as anti-social people or drug users are people that live locally in the area, a significant amount are local and there is a community in the inner city as well which people forget about too." (Community, voluntary and statutory, respondent 14)

"It is a partnership approach and I think they need to be talking to people in the area and get to know the people in the area, real people have issues and they need to know that they are dealing with people and that's where the answers are." Community, Voluntary and Statutory respondent 8)

Other community partnership approaches involving local communities, young people and the Gardaí were advocated;

"To gather together as a community, liaise with each other first and foremost as neighbours, neighbourhood support seems to have gone and that could be cause of intimidation from criminals maybe they are too afraid to approach the Gardai. If they come together and voice their opinion through a strong character in the community who is not afraid to stand up against the issues they have and voice their concerns at community forums and things like that." Community, Voluntary and Statutory respondent 1)

"Everybody needs to talk to each other it has to be combined approach from everybody, everybody needs to be dealing with it in the same way, if it's somebody looking at the youth issues and somebody looking at the community issues, unless they talk together, it's not going to work." Community, Voluntary and Statutory respondent 8)

Several comments by both community, voluntary and statutory respondents and business and transport respondents were made with regard to business investment in service provision, recovering addict employment programmes and improved efforts at urban design deterring drug use in the area. Several comments were made with regard to detoxification and treatment pathways incorporating employment as community integration modal and by using input from the business community.

"I think we all have an obligation to try our best to work on that, detox, secure employment, entry level employment and try and give people some quality of life, the worse thing is getting someone into detox and letting them back out onto the street, you are limiting your chances of success, we would do our level best to be part of the solution to that." (Business and Transport respondent, no 19)

"I know that the business community don't want to see any more services in the area, they should have an open mind to what needs to be done, that might mean moving a service to another area, it might mean adapting the existing service to do something like a consumption room, we need an ally in the business community, one that is realistic and with a measured response, at the moment there isn't any money in the economy but in the good times they should consider directing some of their profits towards some of these initiatives that can help solve the issue. I think that then can then ask legitimately if it's being effective." Community, Voluntary and Statutory respondent 6)

"We would invest in a scheme that would clean up the area , they get their dole money but there will get paid a bit more money than the standard dole money, the biggest buzz is that they are changing the area , we would buy into that and sponsor that." Business and Transport respondent 1)

Business and transport respondents described a need to discuss integrated urban, shop and transport planning using CCTV monitoring.

"There is a planning element how shops are developed along these lines, it's an integrated approach to transport planning and land use, if it's going to be a stop you need to consider the land uses around it, because it will attract people to it and that's what you want. We want to bring people to stops, we don't want to push them away." (Business and Transport respondent 14)

"You don't have a problem in (named street) because of the CCTV system, they have got that system in there and they enforce it, if they catch you dealing in drugs or hanging around, they will refuse you." Business and Transport respondent 19)

Several business and transport respondents also observed the need for increased bus networking, advertising on trams and trains in order to boost public perceptions of the research area, and other simple deterrents for drug use on transport systems.

"Allow the buses to transverse the city, using it as a network rather than a bus route, a bus route is only good, if you want to go on that bus route." Business and Transport respondent 17)

"We do a lot of advertising for the likes of Grand Canal theatre, people wouldn't think or using the Dart or the Luas to get to a theatre late at night, so we have advertisements on the trams and on the trains." Business and Transport respondent 15)

"We have done a lot of small things not that you would really notice, at the back of (named train station) we have blocked it off it used to be a toilet. We used to have a lot of begging at the ticket vending machines so we removed the seats, it's a very simple thing it just means they cannot sit there all day very subtle changes." Business and Transport respondent 18)

Conclusion

This RAR has presented visual and illustrative data upon which to build future discussions within the SRG and has highlighted a series of key themes for future strategy building. Qualitative narratives discussed potential relocation of services, along with integrated urban, shop and transport planning using CCTV monitoring and policing systems. Stakeholders observed the need for improved rehabilitative pathways for those on MMT, greater access to and provision of rural treatment options across Ireland, and a central placement provision service for those rough sleeping, in order to reduce the levels of influx into in the research area, and to address and reduce user perceptions of the area as a hive of drug dealing activity. The need for integrated and inter agency community, service, business, family, youth, service user and Gardaí partnership approaches using a partnership approach to address anti-social behaviour are important, alongside the potential business community investment in the development of community employment schemes, as part of improved detoxification and treatment pathways for clients accessing services in the research area.

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Appendix 1 - **Key findings and recommendations of Strategic Response Group to build sustainable street-level drug services and address related public nuisance**

Report – A Better City For All: a partnership approach to address public substance misuse and perceived anti-social behaviour in Dublin City Centre. Published by SRG. June 2012.
http://www.drugsandalcohol.ie/17769/

Treatment services

Key findings

It is acknowledged that for a range of historical reasons there is a clustering of treatment services in the inner city. It is also acknowledged by all stakeholders that treatment services are a major part of the solution to the issues being addressed and that the problems would be worse in their absence. Drug-related anti-social behaviour can also undermine the provision of effective treatment. The following recommendations are aimed at minimising any negative impact of such clustering on the city centre while at the same time enhancing the quality of those services and ensuring that vital treatment and drug-related services continue to be made available to those who need them.

Recommendations

Short term actions

- ➤ All treatment and drug-related services should ensure the roll-out of 'good neighbour' protocol and involve service users in the development of best practice approaches in responding to anti-social behaviour.
- ➤ The fact that all main treatment centres close for lunch from 1pm-2pm contributes to the problems being addressed. Treatment and other service providers should review their opening and closing times to address this issue. This could be done through a review of service provision.
- ➤ Design and roll out a peer led campaign on safe disposal of drug paraphernalia to be delivered in each organisation simultaneously.

- Design and roll out a peer led campaign on overdose to be delivered in each organisation simultaneously.
- There should be improved coordination of the available outreach services to optimise service provision.

Medium to long term actions

- There should be greater access to and prompt provision of treatment options nationally.
- People should be treated and provided with support services as close to their home as possible. The treatment provided should be of the level of complexity required to meet their needs. This should ensure that people are only using services that are essential and appropriate to meet their needs and that are local to their place of residence. This should involve a relocation of service provision for some people from the focus area where possible.
- While acknowledging the need for specialised treatment clinics, there needs to be an increase in the proportion of treatment taking place in a primary care setting, and a related reduction in the use of specialised treatment centres. Treatment in primary care involves being prescribed substitution treatment, for example methadone, by a trained GP, and having medication dispensed at a community pharmacy. A greater emphasis on GP prescriptions should ease the pressure on centrally located (i.e. in the focus area) specialised centres. The implementation of the relevant recommendations of the report: *The introduction of the Opioid Treatment protocol* by Professor Michael Farrell and Professor Joe Barry will assist in this respect.
- The continued promotion of a model of individual supported care planning in treatment centres, seeking to increase stabilisation and promote recovery & progression on to GP's and community pharmacies.

- There is a need to engage more GPs, moving from different levels (1-2) of service. The implementation of the relevant recommendations of the report on the Opioid Treatment Protocol by Professor Michael Farrell and Professor Joe Barry will assist in this respect.

- There is a need to make community-based residential crisis stabilisation/detoxification unit(s) available. These should target people with problematic poly-substance use (including alcohol) and multiple needs i.e. public injectors, people with mental health issues and people who are homeless.

- There should be an extension of the current pilot of Regional Pharmacy Needle Exchange across Dublin City and County.

- The provision of pyscho-social support should be expanded for those attending level 1 and level 2 GP's.

- Evidence has shown that many attending drug-related services require mental health interventions & assessments to receive appropriate treatment. There needs to be better integration of drug treatment services and mental health services.

- There needs to be continuing development and implementation of inter-agency protocols towards more effective and responsive *Care and Case Management.*

- Alcohol and drug services tailored to the needs of people who are homeless across the spectrum of service provision should be expanded to include harm reduction, access to substitution treatment[4], detoxification, rehabilitation and aftercare. People who are homeless have been identified as specific 'at risk group' in the National Drugs Strategy.

- There is a group of problematic intravenous drug users who may continue to engage in unsafe injecting practices, possibly in public places, which can contribute to anti-social behaviour, such as the unsafe disposal of needles and drug paraphernalia. International approaches to such problems include:
    - the establishment of medically supervised injecting centres
    - the prescribing of injectables including pharmaceutical opioids.

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[4] This is the procedure of replacing a drug usually heroin with a medically prescribed substitute e.g. methadone or buprenorphine

Such approaches have proven controversial. Research, informed debate and further public consideration is needed in order to establish how best to engage with this group of people in an Irish context. Future approaches may or may not require legislative change.

Rehabilitation

Key findings

There needs to be a greater level of partnership between treatment and rehabilitation services to ensure a seamless package of required supports are made available to the individual.

Recommendations

Short term

➢ Rehabilitation-Integration Service or key workers should be linked in with all treatment centres in the area for the purpose of developing an integrated, inter-agency care plan based on the needs of the service user on assessment.

➢ Rehabilitation work should begin immediately once a person presents for treatment. There should be a focus on integrated rehabilitation, not only for those who are detoxing, but also for those who are stabilising and receiving methadone substitution treatment. The redeployment and up-skilling of existing workers is required in state agencies to fulfil this role.

Medium to Long term

➢ There is a need to develop links between treatment agencies and projects in the voluntary sector with a view to maximising the capacity of existing services. This should be included as part of a partnership approach.

➢ Links should be developed between the business community and treatment centres to encourage employment schemes for stabilised drug users and to encourage

further links with existing services. Business community support in the development of community employment schemes should be provided.

Homelessness

Key findings

It is clear from the research findings and discussions of the SRG that homelessness is a factor that impacts on perceptions of anti-social behaviour. There is a concentration of hostels for people who are homeless or at risk of becoming homeless, and a clustering of homelessness services in or adjacent to the focus area. Hostels are, at best, a short term measure. Hostels are not designed nor are they appropriate for people to live in the long-term. Some hostels have problems with drug use and intimidation which can undermine treatment and rehabilitation efforts. The research findings indicate that some people in hostels must leave hostels (and B&B's) in the morning and are not permitted to return until the evening. Treatment centres and other SRG stakeholders also report evidence of this from their clients. Consequently, such people have little option but to spend their days on the streets. It is acknowledged at a national policy level that access to appropriate long term accommodation/housing is a major block in delaying the implementation of the national Homeless Strategy *The Way Home* and *Delivering the Pathway to Home* – the Framework Homeless Action Plan for Dublin. Some of the issues which arose in the research would be addressed by the full implementation of these policies.

Recommendations

Short term

Emergency provision and Day Time Services

➢ Emergency accommodation should only ever be used in an 'emergency'. This is often not the case, due to a lack of suitable long-term housing options people often spend long periods in emergency accommodation. Private B&B's are a form of emergency provision which are often not fit for purpose and are without regulatory provision.

➢ Street drinking is an issue which arose in this research. To discourage street-drinking, to reduce harm and to offer safer alternatives accommodation models should be provided where people who wish to consume alcohol can do so in their accommodation under regulated conditions. Existing services should be reconfigured to ensure that more 'Wet services' are made available where required, i.e. hostel/temporary accommodation or supported housing that allows the consumption of alcohol on the premises.

➢ Models of emergency provision should be further developed where residents have 24/7 access. This is working effectively in some services.

➢ In addition, effective day time services should be provided to offer support and options for people during the day.

➢ The SRG has been invited to make a formal submission to the Dublin Joint Homeless Consultative Forum to discuss actions required to mitigate and effectively respond to issues associated with problematic drug and alcohol use and abuse.

Medium term

Health and Social Care Supports

➤ Given the high levels of health care needs amongst people who are homeless, on site specialist services are required to work in conjunction with, and complement, mainstream services. Examples of such interventions are the SafetyNet Primary Care Network for Homeless Health Services (Safetynet) and the Mobile Health Bus; run in partnership with Dublin Simon Community, Chrysalis, Safetynet and the Order of Malta which aims to bring primary health care and harm reduction services to people who are homeless and to female street-workers.

➤ Once people are in secure long-term accommodation they should be supported to access mainstream Primary Care Teams and Social Care Networks. Critical to the efficiency of such an approach is the roll-out of the Community Mental Health Teams.

Long term

Access to Appropriate Long Term Accommodation/Housing

➤ There is a need to end the clustering of homelessness services in the city centre. People should be accommodated in the most appropriate setting for their circumstances.

➤ It is critical that a range of appropriate accommodation types are sourced for people who are homeless and that the following provision options are pursued:
  o social housing provision
  o privately rented options
  o properties under the influence of NAMA

➤ In addition, there is potential for appropriate accommodation to be sourced in partnership with homeless services and the business community.

- ➢ Support is needed to help people to move into independent accommodation, appropriate housing support and health and social care support based on need must be provided. In addition, high support housing for those who need more intensive, on-going support must also be an option.
- ➢ Homeless policy in Ireland is working towards a 'Housing led' approach which aims to provide housing, with support as required, as the initial step in addressing all forms of homelessness. This must be pursued as a matter of urgency.

Alcohol supply in the target area

Key findings

Alcohol was identified in the research as a key contributor to public order & property crime within the focus area. There are two dimensions to the alcohol problem. Firstly, the contribution of alcohol misuse in the night-time economy to public disorder. Secondly, problems associated with the impact on public perception of visible street-drinking by a small number of individuals during day-time hours. There is a clustering of off-licenses and mixed products retail outlets in the area. The Dublin Development Plan 2011-2017 has identified the city centre area as being sufficiently supplied with off-licence units. All that is necessary in the case of the District Court ruling is for the Superintendent from the relevant Garda Station to give evidence in objection or for a resident in the local area to give evidence in objection. Objections can also be made to the planning authority for a change of use of a premise to an off-licence.

Recommendations

Short to medium term

> ➤ The SRG endorses the recommendations of the Steering Group on the National Substance Misuse Strategy in relation to the supply of alcohol and the findings of the Oireachtas Committee on the Health report on Alcohol published in Jan 2012.

> ➤ In accordance with the Dublin Development Plan, no new planning permissions should be given for off-sales in the focus area.

> ➤ The relevant Garda Síocháná superintendent should consider the Dublin Development Plan 2011-2017 when considering applications for any further off-licence units in their respective area of responsibility.

> ➤ To ensure that District Court objections to the provision of Off Licences in a certain area can also be made by local businesses, not just by local residents. Local community and city wide Policing Forums should also have a role in this area.

> ➤ Given the concentration of alcohol outlets in the area, the provisions of the Intoxicating Liquor act 2003 relating to the responsible sale of alcohol should be strictly enforced, as should all other relevant regulations including advertising & the promotion of alcohol sales.

> ➤ Reporting on licensing should become a part of the regular agenda of relevant Joint Policing Committee, local & community policing forums.

Policing responses

Key findings

It is acknowledged that this is primarily a public health issue, not a policing or criminal justice one. Covert and overt policing operations were deemed effective but resulted in displacement within and outside of the research area. Qualitative narratives described satisfaction with policing efforts but highlighted the need for increased vigilance, along with service level policing in deterring congregating, loitering and drug activity.

Recommendations

Short to medium term

> ➢ There is a need to build on the positive links that already exist between An Garda Síochána and treatment services through integrated structures. However, there needs to be a further structured engagement at strategic and operational level between local Gardaí and the main treatment and rehabilitation centres. This should happen with a view to providing appropriate behavioural management and enhanced public safety in the vicinity of treatment centres.

> ➢ Policing responses such as Operation Stilts **(**involving surveillance, stop-and-search and regular street patrols**)** have had a positive and lasting effect in certain locations in the research area, by reducing congregations of large groups of people who can be perceived as engaging in anti-social behaviour. These initiatives should be continued, and extended as a short and medium-term strategy. Their overall impact should be monitored and regularly reviewed.

> ➢ Gardaí should continue to maintain a visible presence in the areas prone to anti-social behaviour as this serves to deter disorder and reassure members of the public who reside in, visit or frequent the areas to work.

> ➢ Integrated policing approaches incorporating business, community and other statutory agencies involving 'Problem Orientated Policing' solutions should be maintained and enhanced further to build on current and previous positive outcomes.

- ➤ Police Partnerships with individual stakeholders or stakeholder groups should be maintained and further enhanced to improve positive intervention initiatives such as the recent 'Arrest Referral Pilot' between the Gardaí and the Ana Liffey Drug Project and the weekly reports and joint planning between Dublin City BID and the Gardaí in the target area.
- ➤ As part of the roll-out of the 'Crime Stoppers Dial to Stop Drug Dealing' free phone, a high visibility promotion campaign including retail outlets as well as pubs/clubs & hotels should be undertaken in the city centre area.

Planning and Urban design

Key findings

The built environment including transport infrastructure can have a negative impact on people's enjoyment of public space.

Recommendations

Short term

- ➤ Explore the potential use of audio technology, complimenting CCTV with a public address function.
- ➤ Enhanced public lighting is required to increase public perceptions of safety in particular locations & in general street planning to predict potential use of public spaces.
- ➤ Laneways prone to anti-social behaviour should have double yellow lines and have bins removed. This can also reduce unsafe drug-related behaviour.

Medium term

➢ There is a need for integrated urban, shop and transport planning including the expansion of the use of CCTV monitoring and policing systems to enhance public safety.

➢ Further development, planning and design of future Luas line stops should take place in collaboration with all relevant stakeholders so as to minimise the development of hot-spots for anti-social behaviour

➢ In design planning, there is a need to avoid the development of concealed areas conducive to anti-social behaviour.

➢ There is a need to provide incentives to develop areas and locations prone to anti-social behaviour

Long term

➢ There is a clustering of Pre 1963 Declaration buildings that are capable of being used for hostel emergency accommodation in the city centre, and are being used due to existing demand[5]. This demand needs to be addressed appropriately as identified in the section under the heading "Homelessness". In the meantime it must be ensured that, Pre 63 buildings, that are being used for emergency accommodation or other multi occupied purposes are subject to all appropriate regulations, including health and safety and fire regulations.

Legislation and regulation

Key findings

Sometimes there is a perception that people are dealing illegal drugs when often they are selling legal, albeit possibly non-prescribed drugs, such as benzodiazepines. The street-sale of benzodiazepines and Z-Hypnotics (Zimmovane) has been identified as a major issue.

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[5] A pre 1963 declaration is where an owner of a property which is sub-divided into residential units, makes a declaration that the property was divided and in use prior to the Planning and Development Act, 1963. This allows the property to continue to be used for accommodation without meeting the requirements of the 1963 Act. However, if alterations are made to the property, i.e, extensions, conversions etc., then the requirements of the Act will apply to the property.

Recommendations

Medium to long term

➢ Gardaí need to be given powers to deal with street dealing of non-prescribed drugs so as to initiate prosecutions. The SRG supports the current proposals by Roisin Shorthall TD, Minister of State with special responsibility for the National Drugs Strategy, to update the Misuse of Drugs legislation in relation to Benzodiazepines.

➢ Provisions should also be made for the scheduling of Z-Hypnotics (Zimmovane)

➢ Seek Irish Medicines Board support to include Gardaí authorising officers, which would enable them to enforce IMB regulations. This would allow action within existing legislation on Tablet prosecutions.

➢ The impact of any proposed legislative change needs to be monitored. Specific treatment issues for some individuals and the need for specific treatment supports might arise as a result of this legislation.

Implementing the recommendations through a partnership approach

Key findings

The SRG has been seen by all stakeholders as a very useful initiative. The coming together of all stakeholders is one of the most important outcomes of this process. Any future response to this issue, and the delivery of the recommendations in this report, need to be conducted using a similar partnership approach that includes all relevant stakeholders. An integrated and inter agency, inter disciplinary, voluntary and community, service, business, family, youth, service user and Gardaí partnership approach is required.

Some of the recommendations included here are cross-cutting and consequently their successful implementation will require improved interfaces and 'joined up thinking' between different policy/strategy areas, departments, agencies and services.

They span a range of government departments including the Minister for Primary care within the Department of Health, the Health Service Executive, the Department of the Environment, Community and Local Government and the Dublin Regional Homelessness Executive. They are also relevant to, and are designed to complement, a range of existing or proposed policies such as the National Substance Misuse Strategy, the National Homeless Strategy *The Way Home* and *Delivering the Pathway to Home* – the Framework Homeless Action Plan for Dublin, the Primary care strategy, the Mental Health Strategy *A Vision for Change*, the Dublin Development Plan and existing Garda Síochána Policing Plans, the report on Needle Exchange Provision in Ireland (National Advisory Committee on Drugs/National Drugs Strategy Team 2008), the report of the HSE Working Group on Residential Treatment and Rehabilitation (Substance Users)(2007) and the Report of the Working Group on Drugs Rehabilitation (2007).

It is also difficult to identify any single authority for the city that has the capacity to deliver all the recommendations in this report. Any such body or bodies would need to have sufficient authority to bring agencies and services together when required. Furthermore, many existing state agencies in Dublin have administrative boundaries that are divided by the River Liffey. The problems and issues identified here do not however, recognise such a physical boundary.

Recommendations

The delivery of the recommendations can be facilitated by the following.

> ➢ There is a need to strengthen the links between existing Local Drug Task Forces, particularly in the City Centre area (North Inner City, South Inner City). There is a need to explore a cross North Inner City Local Drugs Task Force and South Inner City Local Drugs Force Partnership Group with a specific focus on implementing the recommendations within this report at a local level.

- There are a number of local & community policing forums in the area concerned. There are also the Joint Policing Committees and the City Central Policing Forum, chaired by the Lord Mayor. These bodies are key structures and have the potential to deliver a comprehensive response at both a policy making level and in terms of implementing actions on the ground. However, the issues arising are not just policing matters and representation on these bodies would need to be enhanced to ensure a fully inclusive approach involving all relevant stakeholders.

- There needs to be better linkages between the regional Homeless Forum (Dublin Regional Homelessness Executive) & relevant Local and Regional Drug Task Forces especially as the Regional Homeless Forum are on statutory footing.

- All future interventions to address this need to be monitored and managed so as to avoid the potential 'dispersal effects' of problems into the surrounding communities, particularly of high visibility public nuisance & street drug dealing. Rather than shifting problems elsewhere, the ultimate goal should be the development of long-term solutions.

Appendix 2 Partnership Principles

Partnership principles (cited directly from Connolly, J (2006:11). Responding to open drug scenes and drug-related crime and public nuisance – towards a partnership approach. Strasbourg: Pompidou Group, Council of Europe).

• Public space is public property. Everybody should behave in a way which is compatible with the needs of other users of the same place.

• What we define as nuisance is a reflection of what we are prepared to tolerate.

• Large 'open drug scenes' are particularly damaging and require intervention of some sort, both for the sake of the community and the safety and health of users.

• There is a need to identify, understand and deeply analyse the problem. The issue becomes primarily about addressing and fixing the problem, not just reacting to a crime.

• Action should be focused on places where crime, deprivation and social exclusion through drugs are most acute, on things that people clearly see.

• Engaging the local community is crucial in tackling local street markets

• There is a need for strategic planning and for agencies to work across disciplines and in partnership in designing responses. No one agency has total responsibility.

• Interventions, in accordance with the circumstances of the problem, must be balanced and should include a combination of law enforcement, social and health services, and environmental action.

• Police must accept and support treatment while social services and voluntary organisations must accept and support the need to diminish public nuisance

• There is a need to provide adequate, and in some cases substantial and long term resources, from all types of services, whatever intervention is taken. Drug treatment must be easily accessible.

• Interventions must be evaluated and improvements must be measurable

• Objectives must be realistic and attainable

• Responses should not further alienate drug users. Focus should be on lessening harms, both to users and society.

Guidelines of good practice (cited directly from Connolly, J (2006:11). Responding to open drug scenes and drug-related crime and public nuisance – towards a partnership approach. Strasbourg: Pompidou Group, Council of Europe).

Problem analysis and planning

• There should be a shared understanding of the problem and agreement on the aims and objectives of the response.

• There needs to be clarity as to how a problem is prioritised and defined and by whom.

• There is a need for accurate and up-to-date data to help explain the problem.

• There is a need for joint strategic planning and for agencies to work across disciplines and in partnership in designing responses.

• Responses should be sustainable in the long term and not just displace the problem elsewhere.

• At planning stage, preparation should consider all possible outcomes from law enforcement and other interventions. For example, spin off effects of arrests for users, other family members.

• Back-up services must be made available prior to intervention.

• Response can be selective and focus on a specific area or group.

• Responses should be monitored and evaluation of effectiveness should be built into any programme of action.

Structure and coordination (cited directly from Connolly, J (2006:12). Responding to open drug scenes and drug-related crime and public nuisance – towards a partnership approach. Strasbourg: Pompidou Group, Council of Europe).

• Specific legislation establishing partnership structures can assist in creating a good climate for partnership development.

• Partnership structures should seek to include all relevant stakeholders.

• Partners should seek to create non-hierarchical structures to facilitate parity of esteem.

• All partners, whether they are from agencies or local communities, should have equal status in decision-making.

• Levels of representation from agencies on partnership committees should ensure that personnel have appropriate seniority for effective decision-making powers at the level at which the partnership meets.

• Cooperation must take place between police and social services at all levels, including the local or street level.

• Effective coordination structures or processes must be established.

Communications (cited directly from Connolly, J (2006:12). Responding to open drug scenes and drug-related crime and public nuisance – towards a partnership approach. Strasbourg: Pompidou Group, Council of Europe).

• Good internal and external communication is a basic requirement for the success of the project.

• There needs to be efficient communication within each agency and also between agencies.

• There is a need to engage with media in a pro-active way.

• Communication systems must be able to address fears which can arise in communities in relation to possible reprisals from drug dealers as a consequence of partnership collaboration.

• Public meetings can be used to keep the community informed and to overcome communication problems.

• The publication of leaflets can be used to communicate information.

• Communications must address issues of confidentiality and individual data protection.

• The establishment of front-line offices can enhance communication between stakeholders.

• Regular meetings are necessary to respond to the ever-changing nature of the problem.

Trust and conflict

• There is a need to overcome issues of distrust.

• Partners should be open to change and to criticism.

• Issues arising from ethnic diversity and cultural differences which might arise in relation to drug use must be addressed.

• There is a need to address issues of abuse of power as this can significantly undermine progress (e.g. police harassment of community members).

• There is a need to avoid agency protectionism and rivalry.

• Regular attendance at meetings is important so as to build up trust and respect.

• Mechanisms of conflict management need to be established.

• Intended change by one partner must be discussed with other partners.

• Partners must respect each other's limitations.

Training and education (cited directly from Connolly, J (2006:13). Responding to open drug scenes and drug-related crime and public nuisance – towards a partnership approach. Strasbourg: Pompidou Group, Council of Europe).

• Training in partnership working should occur within agencies.

• Training should bring partners together and enhance mutual understanding of roles, functions and limitations of different partners.

• Training can occur individually or jointly.

• Training programmes must address issues arising regarding ethnic diversity.

• Learning can also develop through partnership activity and working.

Recruitment and status of partnership (cited directly from Connolly, J (2006:13). Responding to open drug scenes and drug-related crime and public nuisance – towards a partnership approach. Strasbourg: Pompidou Group, Council of Europe).

• Recruitment policies should identify suitable candidates for partnership working.

• The status of partnership approaches should be recognised within agencies through, for example, employee rewards, benefits and flexible working arrangements so as to facilitate meeting attendance etc

• Senior managers should take ownership of partnership initiatives so as to provide leadership and authority.

• Partners must give project implementation top priority within their organisations.

Appendix 3 Qualitative Guides

- What is their definition of anti social behaviour?
- What is their perception of alcohol and drug related public nuisance in the area (show them the map and ask for hotspots)?
- What forms of alcohol and drug related public nuisance have they observed?
- Does this vary per time of day or week?
- Does this stop them accessing the area in their free time or affect feelings of perceived safety? Times?
- What are the contributory factors to alcohol and drug related public nuisance in their opinion?
- What are the social and health outcomes of alcohol and drug related public nuisance in the area?
- Is the Housing (Miscellaneous provisions) Act 1997 which includes a range of measures giving local authorities the power to address drug related antisocial behaviour in the form of drug dealing, intimidation and violence operating in an effective way, or is it contributing to alcohol and drug related public nuisance in the area?
- Have they observed '*open drug scenes*' , '*small meeting points*' and/or '*hot zones*' for drug dealing in the research area?
- Have they observed drug littering?
- Have they observed drug use and injecting?
- What types of drugs are commonly sold/used?
- Have they observed noisy and aggressive behaviours relating to alcohol and drug related public nuisance in the area?
- Have they observed homelessness?
- Have they observed begging?
- Have they observed sex work?
- Have they observed traffic interference relating to alcohol and drug related public nuisance in the area or harassment on public transport in the area?

- Are they aware of any *'informal sorting houses'* used for drug dealing, use and injecting in the research area?

- What are their opinions around policing activity in the area, and what impact does this have on alcohol and drug related public nuisance, in the form of loitering, drug related littering, open drug use and dealing, harassment, intimidation, treatment uptake and retention?

- How can the Gardai deal with underground or closed drug scenes supported by internet and mobile phone technology?

- How can the Gardai deal with violence and intimidation in crime gangs operating in the area?

- How can Gardai deal with displacement of drug markets into other areas following high intensity law enforcement in an area?

- What part do the treatment centres play in addressing alcohol and drug related public nuisance?

- Do they think that alcohol and drug related public nuisance, in the form of loitering, drug related littering, open drug use and dealing, harassment, intimidation makes it difficult for individuals to access and engage in treatment?

- What is the role of the media in worsening or improving levels of alcohol and drug related public nuisance in the area?

- What can be done to address alcohol and drug related public nuisance, in the form of loitering, drug related littering, open drug use and dealing, harassment, intimidation in their opinion?

- What approach is best to address levels of rough sleeping?

- What approach is best to address public place injecting?

- What can be done to address the influx of non resident drug users into the area?

- What approach is best to address drug related intimidation of users and their families?

- What is their opinion of urban renewal and regeneration initiatives?

- What is their opinion of the re-situation of drug treatment centres in the suburbs of Dublin?

- If treatment centres are to be re located, how can they deal with contentious public attitudes toward the placement of these facilities near residential areas?
- What is their opinion of Drug Court Mandated Treatment and its effect on alcohol and drug related public nuisance in the area?
- What is the role of the community in dealing with alcohol and drug related public nuisance in the area?
- What role do businesses play in dealing with alcohol and drug related public nuisance in the area?
- What is their view on agency and community partnership efforts in dealing with alcohol and drug related public nuisance in the area
- Do they favour prohibition or deregulation of Drugs, and how does this view affect levels of alcohol and drug related public nuisance?
- What is their opinion on fluorescent lighting to deter injecting drug use?
- What is their opinion on harm reduction movements for street injectors (i.e SIFs, mobile needle exchange, syringe vending machines etc) operating alongside policing of alcohol and drug related public nuisance in the area?

Appendix 4 Street Intercept (Drug Users) Survey

Gender

Male	Female

Age

18 -20	20-24	24 – 30	30 +

Area of residence by postcode / County _____

Nationality

Irish	Traveller	UK	Eastern European

Accommodation

Friends	Family	Street	Hostel	Squat	B&B	Other

Employment Status

Unemployed	Employed	Student	Disability

How did you travel today

Luas	Walk	Bus	Taxi	Dart	Train	Car

If bus or Luas

Route Taken	Luas	Bus number	Dart	Train

How often do you come into the city

Weekends	Once a week	More than once a week	Once a month	Everyday

Are you accompanying a friend to a service in the City*

Yes	No

Are you accessing a service in the city*

Yes	No

What services do you access in the city

Services accessed	Service used this month	Service used this week	Service used today
Drug Treatment			
• *Methadone*			
• *Counseilling*			
NSP			
Doctor			
Drop in			
• *Ana Liffey*			
• *MQI*			
Housing			
Outreach			
Homeless Team			
Childcare			
Social Welfare			
Probation			
Pharmacy			
Other			

*If no why are you in the city

Accessibility of services in your own area	
To remain anonymous	
Intimidation from others in your own area	
Barred from services	
To access street drugs/methadone / tablets	
Other	

Why aren't you attending a service in your own area

Don't need a service	
Fear on intimidation / violence	
The service is not meeting my need	

Have you ever been barred from a drug /homeless service in the city

Yes	No

Are the drug /homeless services in the city providing the services you require

Yes	No	Don't know

If no what can be improved

Opening hours	Area of the city	Staff attitude	Service provision	Facilities environment

Any comments

_____
_____
_____

Please mark down how often you use any of the following substances in the past six months

Substance	Used in the past month	Every day	Used today
Alcohol			
Cannabis/ Marijuana/Skunk/ Hash			
LSD/Acid			
Speed			
MDMA			
Ecstasy			
Cocaine			
Heroin			
Zimivane			
Head shop products /legal highs			
Methadone			
Crack Cocaine			
Crystal Meth			

Do you use drugs on the street

This year	*This month*	*This week*	*Today*	*Every day*	*No*

Do you drink on the street

This year	*This month*	*This week*	*Today*	*Daily*	*No*

Why did you drink or use on the street

No where to go	With friends	Where I scored	Buy alcohol in the off license	Other	I don't

Have you ever been moved on or arrested by the Gardi from this location

Dealing	Assault	Drunk and disorderly	Shoplifting	Loitering	Not been moved on

How many times have you been moved on from this location in the past twelve months

1-3	3-7	7-10	10 +

Why do you return to this location

Friends	Intimidation	To purchase street drugs	Barred from services

Have you ever been a victim of

Bullying	Intimidation	Violence	No

`

Have you ever had to tap / beg

This year	This month	This week	Today	No

How often this year

1-5	5-10	10-15	15 +

Any other comments

Appendix 5 Street Intercept (Random Passerby) Survey

Male	Female

Age

18 – 20	20 - 25	25 - 30	30 - 40	40 +

For what reason are you in this area?

Work	Shopping	Passing through	Tourist

Do you feel safe in this area?

	Day time	Night time
Yes		
No		

If you have answered 'No', does this stop you accessing this area at certain times?

Yes	No

What time of day?

....

Have you observed any of the following types of anti social behaviour in this area in the past 6 months?

Street drinking	
Loitering / congregation of people	
Drug Dealing	
Drug Using	
Street injecting	
Begging	
Noisy and aggressive behaviours	
Drug related littering	
None	

Have you ever felt intimidated by individuals on the street when visiting this area?

Yes	No

Do you feel Garda presence in sufficient when visiting this area?

Yes	No

How do you think Dublin city can address drug and alcohol related anti social behaviour in this area?

Comments

_____

_____

_____

_____

Appendix 6 Informed Consent and Information Leaflet

Information about the Research and Informed Consent Statement

You are invited to participate in a focus group that seeks to learn more evidence base around perceived anti-social behaviour associated with the provision of drug treatment in Dublin's city centre. This evidence base will be used to assist to build a strategic response incorporating short/medium/long term goals and actions within the area between Christchurch and the IFSC and Parnell Square to St Stephens Green.

 I (Tim Bingham) am the researcher and I will be interviewing people for this study. You will receive a €10 voucher for your participation in the focus group.

The focus group will last about 1 -2 hours. I am <u>not </u>collecting names or other personal identifiers – people's identities will remain anonymous. Your participation in this study is voluntary. You can withdraw from the focus group at any time.

I ask for your consent for us to tape the interview. If you are uncomfortable with having the interview taped, you can say so and we will take notes during the focus group. If names appear in the tape, we will omit this information shortly after the interview. We will transcribe the tapes shortly after an interview is completed and I (Marie Claire Van Hout) am the only person who will have access to the tapes which will be in a locked cabinet. The tapes will be destroyed post transcription. The transcribed narratives will be stored on a password protected computer at Waterford Institute of Technology.

The research will comply with the ethical protocols of the Economic and Social Research Council. If you need any further information on the study, please contact Tim Bingham 0863893530. Thank you.

I consent to participating in an interview and being taped

Sign   Date