



European Monitoring Centre
for Drugs and Drug Addiction



**2005 NATIONAL REPORT (2004 Data)
TO THE EMCDDA
by the Reitox National Focal Point**

IRELAND
**New developments, trends and in-depth
information on selected issues**

REITOX

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Summary

This report, written following EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) guidelines,¹ is divided into two parts. The first part (Part A) provides an overview of new developments and trends in the drugs area in Ireland for 2004 and, in some cases, for the first six months of 2005. These are covered under the following headings:

1. National policies and context
2. Drug use in the population
3. Prevention
4. Problem drug use
5. Drug-related treatment
6. Health correlates and consequences
7. Responses to health correlates and consequences
8. Social correlates and consequences
9. Responses to social correlates and consequences
10. Drug markets

The second part (Part B) examines three specific issues considered to be important at an EU level. The three issues are:

1. Gender differences
2. European drug policies: extended beyond illicit drugs?
3. Developments in drug use within recreational settings

The following new developments and key findings in the drugs area in Ireland occurred or were made available during 2004 and the first six months of 2005:

- The National Drugs Strategy 2001–2008 was the subject of a mid-term review, which was completed in June 2005. The review recommends adjustments to ‘refocus’ and ‘re-energise’ the National Drugs Strategy.
- ‘Refocusing’ of the National Drugs Strategy is recommended in order to meet emerging trends, identified particularly in the treatment area, including an increased prevalence of polydrug use, including cocaine; an increased incidence of hepatitis C as well as the ongoing prevalence of HIV; and the need to strengthen and expand rehabilitation provisions, in light of the significant and ongoing expansion in treatment provision in recent years.
- ‘Re-energising’ of the National Drugs Strategy is recommended under all four pillars (Supply Reduction, Prevention, Treatment and Research), including measures such as the provision of additional resources, extending the reach and availability and accelerating the roll-out of certain programmes, increased training, establishing guidelines and models of best practice, and further monitoring of initiatives.
- Recognising that a measure of the expenditure on drugs is vital in gauging the cost-effectiveness of the different elements in the National Drugs Strategy, the mid-term review proposes that expenditure directly attributable to drugs programmes should be measured. Although this would not capture the overall resources devoted to addressing the direct and indirect costs of drug use, the

¹ A copy of the EMCDDA guidelines is available from the EMCDDA’s website at www.emcdda.eu.int. The guidelines require each Focal Point to write their National Report in a prescribed format using standard headings and covering each topic using a check list of items. This helps to ensure comparability of reporting across the EU.

review suggests that it would give 'an indication as to the overall budget priorities' accorded to the illicit drugs issue.

- In mid-2005 the government issued *Prison Rules, 2005*, which includes specific provision for mandatory drug testing of prisoners. Later in 2005 the Irish Prison Service is expected to commence implementation of a new strategy of mandatory drug testing, addiction counselling and treatment, and to implement extra measures to prevent drug use and provide a more complete system of rehabilitation of prisoners with drug misuse problems.
- To counteract the limitations of drug-related data sources with regard to heroin use in the regions, the National Advisory Committee on Drugs (NACD) is developing a Drug Trend Monitoring System (DTMS). This system will collect primary data as well as analyse secondary data on a range of drug-use indicators in order to identify nationwide trends in drug use, including the spread of heroin use outside of Dublin. A report on the pilot DTMS will be submitted to the Cabinet Committee on Social Inclusion for consideration later in 2005.
- Parliament and civil society have undertaken a number of initiatives which have led to, or influenced, government decisions in the area of drugs policy, including family support services and support for family networks, services for members of vulnerable minorities affected by drugs, the needs of service users, community policing, and the treatment of cocaine addiction.
- The third European School Survey Project on Alcohol and Other Drugs (ESPAD) was published in December 2004. For school-going children aged 15–16 years there was a notable increase in lifetime use of any illicit drug between 1999 (32%) and 2003 (40%), up 8%. This increase followed a drop between 1995 and 1999.
- Ireland ranked joint third after the Czech Republic (44%) and Switzerland (41%) for lifetime experience of any illicit drug in 2003. The average for the 35 ESPAD countries in 2003 was 22%.
- The majority of those who have tried any illicit drug have used cannabis (marijuana or hashish). The lifetime prevalence rates for cannabis use are thus similar to those for use of any illicit drug and reflect the same trend. Lifetime use of inhalants dropped slightly between 1999 (22%) and 2003 (18%) but remains high. The average for the 35 ESPAD countries in 2003 was 10%.
- The results of a national survey of third-level students were published in April 2005. Cannabis was the most common illicit drug used by students, with over one-third (37%) reporting that they had used it in the past 12 months. Ecstasy was the second most used illicit drug, followed by cocaine, magic mushrooms and amphetamines. For all drugs, the levels of use were higher among students than among those of a similar age group (15–24 years) in the general population. The use of solvents (inhalants) was particularly high.
- The mid-term review of the National Drugs Strategy 2001–2008 recommends four new key performance indicators (KPIs) under the prevention pillar: (i) a reduction of 5% by 2007 in estimated prevalence of opiate use based on 2001 data; (ii) a reduction of 5% by 2007 in prevalence rate of recent and current use of illicit drugs in the general population based on the 2002/2003 rate; (iii) substance use policies in place in 100% of schools; and (iv) early school

leaving in local drugs task force areas reduced by 10% based on the 2005/06 rate.

- The mid-term review recommends that a new cross-pillar on Family Support services in drug prevention be included in the National Drugs Strategy.
- The mid-term review recommends that a working group be established to examine the area of prevention programmes in non-school settings, with the aim of developing guidelines on models of best practice to assist in the implementation of non-school setting interventions (selective and indicated prevention).
- A new fund to tackle emerging needs in the local drugs task force areas has been launched and is currently being used to fund the piloting of four interventions aimed at tackling cocaine use in communities.
- The number of treated cases in Ireland reported to the National Drug Treatment Reporting System (NDTRS) has increased steadily, from 6,048 in 1998 to 9,084 in 2003. This increase is explained by a combination of factors: a true increase in drug use, an increase in access to treatment services, and an increase in the number of centres reporting cases to the NDTRS.
- The numbers treated for problem drug use and residing in the Health Service Executive (HSE) Eastern Region (Dublin, Kildare, Wicklow) increased by 23% between 1998 and 2003, while the numbers treated for problem drug use and residing in the seven HSE areas outside the Eastern Region increased by 197% during the same period
- The profile of main problem drugs reported by treated cases differed by place of residence. Overall, 94% of treated cases residing in the HSE Eastern Region reported that an opiate was their main problem drug, while almost 20% of treated cases residing outside the HSE Eastern Region area reported an opiate as their main problem drug. Just under 3% of treated cases residing in the HSE Eastern Region reported that cannabis was their main problem drug, while just over 55% of treated cases residing outside the HSE Eastern Region reported this as their main problem drug.
- Drug use exists among new migrants to Ireland. The majority of problem users have used drugs prior to their arrival but a considerable number commence drug use in Ireland. According to the migrants, drugs are used to help deal with social exclusion and post traumatic stress disorder.
- On 1 January 2005, the ten health boards managing the health services in Ireland were replaced by a single entity, the Health Service Executive (HSE), which will manage Ireland's public health sector.
- In March 2005, the HSE published its National Service Plan (NSP) for 2005. The plan emphasises that responses to the needs of those dependent on drugs or alcohol require a partnership approach across organisational boundaries, together with clear strategies to prevent and reduce levels of drug or alcohol misuse and harm. The management of all addiction services will be under the remit of the Primary, Community and Continuing Care service delivery unit, which will oversee a number of national care groups.

- In 2001, the National Drugs Strategy identified seven key performance indicators to measure progress under the treatment pillar. In 2005, the mid-term review recommended that these be replaced by four new indicators to reflect the diversity of drug types and the number of drugs used by those seeking treatment, and to monitor the availability of harm reduction interventions.
- The total number of drug treatment services available in Ireland increased between 1998 and 2003. The largest increase was in outpatient treatment services and general practitioner services.
- A working group to examine the extent of problem drug use among those aged under 18 years was established in October 2001 and reported in September 2005. The group reviewed the extent of the problem and noted that 'attendances by children account for a substantial proportion of the workload of the addiction services in Ireland'. The group examined the issue of informed consent. The group recommended that: where possible, the family be involved in treatment as this leads to better outcomes; substitution treatment should not be initiated outside a specialist context and a four-tiered model which would ensure that the services provided would be based on the specific needs of the child and their family.
- Smyth *et al.* (2005b) examined the medium-term follow-up outcomes of 109 patients attending an inpatient opiate detoxification programme between July 1995 and December 1996. Of the 109 patients interviewed, 25 (23%) reported neither using opiates nor prescribed methadone recently. After controlling for confounding factors, opiate abstinence was found to be significantly associated with completion of an inpatient treatment programme, persistence with aftercare and the absence of a family history of substance misuse.
- In 2002, the Methadone Prescribing Implementation Committee was requested to review the Methadone Protocol that was introduced in October 1998. There were 19 recommendations in the Methadone Protocol, of which 12 were completely implemented by the end of 2004, four were almost completely implemented and the remaining three required some further work. The three requiring further work related to service provision, including the range of services, the link between treatment services and general practitioners, and pharmacists' contracts.
- In June 2005, the Health Research Board published an overview of drug-related deaths in Ireland. According to data from the General Mortality Register, almost all drug-related deaths between 1991 and 1994 occurred in Dublin. Between 1995 and 2000, there was a substantial increase in drug-related deaths in Dublin, from 39 to 90, and a steady increase outside the Dublin area, from 4 to 29. In 2001, there was a sharp decrease in the number of drug-related deaths in Dublin (to 55) and a continued increase outside Dublin (to 33 in 2001 and 35 in 2002). A National Drug-Related Deaths Index is to be set up in Ireland so as to comply with Action 67 of *'Building on Experience: National Drugs Strategy 2001–2008'*.
- In 2004, there were 365 newly diagnosed cases of HIV infection reported to the Health Protection Surveillance Centre, of which 71 (20%) were infected through injecting drug use. This represents an increase on the numbers of new HIV

cases among injecting drug users in 2002 (50) and 2003 (49). Of the 64 cases for whom place of residence was known, 60 lived in the HSE Eastern Region.

- Two studies estimated the prevalence of blood-borne viruses among treated opiate users. Between 66% and 72% of drug users tested positive for hepatitis C; 17% for hepatitis B core antigen, and 11% to 12% for HIV in two areas of Dublin. These results are in line with results from a study in a similar setting.
- Cullen *et al.* (2005) examined, by means of in-depth interviews, the experiences of heroin users attending general practice with respect to risk practices for hepatitis C. Twenty-two participants said that they had tested positive for hepatitis C, of whom 15 had consumed alcohol in the week prior to the study. Nine consumed more than the recommended amount for their gender. Those respondents who reduced their alcohol intake did so because they were concerned about their health, while those who increased their alcohol intake did so to substitute for heroin.
- Moore *et al.* (2004) at Dublin City University profiled harm-reduction services in Ireland. All service providers in the Eastern Region reported that methadone maintenance and one-for-one needle-exchange facilities were available in their areas. With the exception of filters, all other types of injecting equipment were provided to clients attending these services. Half of the service providers in the Eastern Region area reported that filters were not available at their service. In contrast, service providers outside the ERHA area stated that methadone maintenance was the mainstay of their harm-reduction services and that no injecting equipment was distributed. Pipes were not provided at any service in Ireland.
- In Ireland, hepatitis B vaccine is recommended for several high-risk groups, including prisoners and injecting drug users. Grogan *et al.* (2005) reported that 81% of 316 clients attending methadone treatment in an area of Dublin had commenced a course of this vaccine and 177 (56%) had completed at least three doses of the vaccine. O'Sullivan (2004) reported that 86 per cent of those for whom the vaccine was indicated tested positive for anti-HBs, which indicates in this case a vaccine-induced immunity.
- On 9 August 2005, the Minister of State at the Department of Health and Children introduced a new Statutory Instrument, the 'Medical Products (Prescription and Control of Supply) (Amendment) Regulations 2005'. This permits the supply and administration of a number of medicinal products (including naloxone, for the management of respiratory depression secondary to a known or suspected narcotic overdose) by pre-hospital emergency care providers in specific circumstances.
- A team at Dublin City University explored the management of individuals with a combination of mental illness and substance misuse in Ireland (McGabhann *et al.* 2004). The team reported that there is a need to: formalise referral procedures between the mental health services and the addiction services; reconsider exclusion criteria; use valid assessment tools; develop and expand the small number of evidence-based dual diagnosis services in existence.
- The first drug-prevalence study among the homeless population in Ireland revealed that drug use is a major contributory factor to becoming and remaining homeless.

- The mid-term review of the National Drugs Strategy recommends that a fifth pillar – rehabilitation – be included in the strategy to assist drug users to move towards social reintegration.
- A review of a major state-sponsored vocational training and employment-support scheme reports a conflict between the aims of the scheme according to the sponsors, FÁS (National Training and Employment Authority), and the perceptions of participants. On the one hand, the sponsors aims are to enhance labour market opportunities for stabilised drug users, whereas on the other hand, participants perceive the scheme as assisting them in relapse prevention and rehabilitation, with the option of labour market participation a remote possibility.
- The review of the FÁS scheme also reports that twice as many females (67.7%) as males (32.3%) participated in the scheme. Data from 2002 show that males accounted for 71% of cases living in and treated for problematic drug use in Ireland. This would suggest that males are not well disposed to accessing the FÁS support scheme.
- A model of good practice in inter-agency work has been developed to co-ordinate an approach to providing quality supports and services to drug users. The Blanchardstown EQUAL Inter-agency Initiative contains protocols on confidentiality and lead agency work.
- The total number of drug offences where criminal proceedings commenced decreased by just over 10% in 2003, to 7,150 offences. However, a larger proportion of these (25%) were for drug dealing than in the previous year (19%). In 2003, 67% of the offences where criminal proceedings commenced were for simple possession. In 2002, 76% of offences were for possession.
- In 2003, cannabis-related prosecutions accounted for 57.6% of the total number of drug-related prosecutions. There has been a steady increase in cannabis-related prosecutions since 1996, despite a brief downturn in 1998. Cannabis-related prosecutions decreased in 2003.
- In 2003, heroin-related prosecutions accounted for 10.6% of the total number of prosecutions. Prosecutions related to cannabis, heroin, ecstasy and amphetamines all declined during 2003.
- In late 2003 the Garda Research Unit published a study which examined the link between opiate use and criminal activity in Ireland (Furey and Browne 2003). Among the findings were: of 131 drug users surveyed, 110 had looked for drug treatment and 100 had received it; 64 respondents reported an association between the receipt of treatment and engagement in crime and 49 of these respondents reported doing 'a lot less' crime.
- With regard to drug treatment in prison, a number of positive developments are reported, such as the introduction of evidence-based methadone treatment services that can be accessed by the majority of opiate-dependent prisoners. Attempts have also been made to vaccinate a significant minority of prisoners against hepatitis B, something very few prisons, nor, indeed, community health services, have managed. The employment of registered nurses facilitated the

separation of disciplinary and healthcare roles. There has also been an increase in the availability of drug-free units.

- In 2004 divisional drug policing plans were posted on the Garda website.
- The Garda Síochána Act 2005 provides for the development of joint policing committees at local-authority level and for the establishment of local policing fora in designated areas under the umbrella of such committees. These bodies are to act as fora where matters relating to local issues of policing and crime, including drug-related issues, can be discussed and where strategies and recommendations for dealing with issues locally can be formulated.
- Along with traditional supply-prevention measures, Mountjoy Prison has introduced new visiting arrangements to prevent drug smuggling which involve prior nomination and identification of visitors. The Irish Prison Service has also installed nets over a number of prison yards to prevent drugs being propelled over prison walls.
- An evaluation of a pilot juvenile arrest referral programme in Dublin's north inner city has recommended that the pilot phase of the scheme be extended, with additional resources in terms of staff, programme development and monitoring.
- The Customs Service report that, although the number and quantity of cannabis resin seizures has been showing signs of decline in recent years, indications are that this trend is reversing.
- Following a generally consistent increase in cannabis-related prosecutions in all Garda regions between 1995 and 2002, there was a decrease in such prosecutions in all Garda regions in 2003.
- In 2003, ecstasy-related prosecutions declined in all Garda regions.
- Since 1995, there has been a steady increase in heroin-related prosecutions in the Garda Eastern Region, from zero prosecutions in 1995 to 75 in 2003. While the trends in the other regions are more sporadic, it is clear that, although heroin remains predominantly a Dublin-based phenomenon, it is no longer exclusively based in the capital.
- Although cocaine-related prosecutions in the Dublin Metropolitan Region have continued to rise each year, since 1999, the proportion of the total number of such prosecutions which are not Dublin-based has also continued to grow. While there was a slight decrease in cocaine-related prosecutions in the Southern Region in 2003, there was a 167% increase in such prosecutions in the Eastern Region. Increases were also recorded in the Northern, South Eastern and Western Regions.
- In 2003, supply offences decreased in all Garda regions except for the Dublin Metropolitan and the Eastern regions.
- With regard to perceived availability of certain drugs, Ireland ranks first among the 35 ESPAD countries in the case of inhalants, crack, cocaine and ecstasy. These findings suggest an exaggerated perception of drug availability in Ireland.

- The ESPAD survey found that, of the 40% of students who had used illicit drugs, 19% had received the drug for the first time from a friend or sibling, and 15% had shared it in a group.
- Arising from the mid-term review of the National Drugs Strategy, a new key performance indicator relates to the monitoring of the number, as distinct from the quantity, of seizures.
- The total number of drug seizures recorded in the annual reports of the Garda Síochána decreased by 17.2% between 2000 and 2003, down from 7,706 to 6,377 seizures. Seizures made by customs decreased by approximately 18.7% during this period, down from 961 seizures in 2000 to 781 in 2003.
- Heroin seizures have decreased by just under 18% since 2001, down from 802 in 2001 to 660 in 2003.
- Cocaine seizures increased steadily to a total of 213 in 1999, dropped slightly in 2000, and increased sharply to a total of 566 seizures in 2003.
- Ecstasy is the second most commonly seized drug in Ireland. Following a sharp increase in the number of ecstasy seizures, from 347 in 1997 to 1,864 in 2000, there was a decrease to 1,027 seizures in 2002 and then a slight increase to a total of 1,083 seizures in 2003.
- Cannabis remains the principal drug seized in Ireland, accounting for 58 per cent of total drug seizures in 2003. In 2003, the number of cannabis seizures increased to a total of 3,705.
- The total quantity of cocaine seized in 2003 was 107.5 kg. This represents a 500% increase on the amount seized in 1995.
- The volume of heroin seized has remained relatively consistent over the past few years, while the volume of cocaine seized has increased. This suggests that, contrary to speculation in the media and elsewhere, the increased availability and use of cocaine might not be displacing that of heroin.
- The most recent Garda drug price estimates saw a reduction in the street price of cocaine from approximately €100 to €70 per gram in 2004.
- According to the Forensic Science Laboratory, drug purity levels have remained fairly constant, with heroin purity ranging from 30% to 40% and that of cocaine ranging from 9% to 25%.

Part A: New Developments and Trends

1. National Policies and Context

1.1 Overview

This chapter provides an overview of new developments in the legal and policy areas for 2004 and the first half of 2005. Seven pieces of legislation with implications for the drugs issue were enacted and two further legislative items were initiated. The mid-term review of the National Drugs Strategy 2001–2008 was completed during this period and has led to a 'refocusing' of priorities and a 're-energising' of the roll-out of various actions in the Strategy. Parliament and civil society were active in contributing to the debate and development of drug-related policy.

1.2 Legal framework

This section describes a number of legislative measures enacted or in preparation during the reporting period.

The purpose of the Criminal Justice (Joint Investigations Teams) Act 2004 is to give effect to the EU Council Framework Decision of 13 June 2002 on Joint Investigation Teams. These may be established for a specific purpose and limited period, by mutual agreement of the competent authorities of two or more member states, in order to carry out criminal investigations with a cross-border dimension in one or more of the member states setting up the team. Such investigations may involve investigations into organised crime, which may include drug trafficking.

The Intoxicating Liquor Act 2004 amends the Intoxicating Liquor Act 1988 to provide a clear statutory basis for the holding of alcohol-free events for persons under the age of 18 years in licensed premises (e.g. a nightclub) or a part of licensed premises (e.g. a function room in a hotel) at a time when intoxicating liquor is not being sold, supplied or consumed and any bar counter there is securely closed.

Section 36 of the Road Traffic Act 2004 makes a number of technical amendments to section 36 of the Taxi Regulation Act 2003 (see National Report 2004). Section 36 of the Road Traffic Act, 2004 provides, *inter alia*, that a person convicted summarily, where a penalty other than a term of imprisonment (that the person serves in whole or in part) is imposed by the Court, is disqualified from holding a licence for a period of 12 months and, accordingly, the licence stands suspended for that period.

The Proceeds of Crime (Amendment) Act 2005 makes further provision in relation to the recovery and disposal of proceeds of crime and for that purpose amends the Proceeds of Crime Act 1996, the Criminal Assets Bureau Act 1996, the Criminal Justice Act 1994 and the Prevention of Corruption (Amendment) Act 2001. The Act does not make specific reference to drug legislation. However, proceeds of crime legislation has been directed against those involved in organised crime involving drug trafficking. The Act also allows proof of criminality to include criminality outside the State.

Section 28 of the Maritime Safety Act 2005 introduces prohibitions on the operation of vessels in Irish waters while under the influence of alcohol or drugs to such an extent as to be incapable of properly controlling or operating the vessel. Section 29, *inter alia*, entitles the person in command of a vessel to refuse permission to board a vessel to a person who is under the influence of alcohol or drugs to such an extent that they

misconduct themselves or cause offence or annoyance to persons on the vessel. Section 31 introduces controls and penalties in relation to the consumption of alcohol or drugs on board vessels.

Section 13 of the Safety, Health and Welfare at Work Act 2005 provides for drug testing in the workplace. The legislation obliges the employee to ensure that he or she is not under the influence of an intoxicant to the extent that he or she is in such a state as to endanger his or her own safety, health or welfare at work or that of any other person. Also, if reasonably required by his or her employer, the employee must submit to any appropriate, reasonable and proportionate tests, by or under the supervision of a registered medical practitioner who is a competent person, as may be prescribed. An employer may require an employee to undergo an assessment by a registered medical practitioner, nominated by the employer, of his or her fitness to perform work activities. Regulations have not yet been finalised. The NACD has commissioned research to assist in the preparation of the necessary regulations. This research is to consider such issues as:

- Information on drug impairment in the workplace
- Right to privacy on health issues in the workplace
- Information on substance use in the workplace
- Literature search on drug testing issues in the workplace

The Garda Síochána Act 2005 was passed into law in July 2005. In March 2005, the Joint Oireachtas Committee on Justice, Equality, Defence and Women's Rights conducted a review of community policing in Ireland in light of proposals contained in Chapter 4 of the Garda Síochána Bill 2004 to establish new local policing structures. Many of the recommendations of the Joint Committee have been incorporated into the Act (Oireachtas Joint Committee on Justice Equality Defence and Women's Rights 2005).

An important amendment to the original Bill was the inclusion of the Minister of State at the Department of Community, Rural and Gaeltacht Affairs with responsibility for drugs strategy in the preparation of guidelines concerning the establishment and maintenance of joint policing committees (JPCs) by local authorities and the Garda Commissioner. The Act also provides for the inclusion on the JPCs of 'persons representing local community interests'. Another important tier in the new local policing structures is the establishment of local policing fora. The Act provides for the establishment of such fora by JPCs in consultation with the local Garda superintendent 'as the committee considers necessary'. The steering group which oversaw the mid-term review of the National Drugs Strategy highlighted concerns raised during its consultation process about the pace at which community policing fora were developing in drugs task force areas. In light of these concerns, and developments with regard to the Garda Síochána Act 2005, a new Action has been incorporated into the Strategy: 'Taking into account the provisions of the Garda Síochána Bill 2004 (enacted as of June 2005), Community Policing Fora should be extended to all Local Drugs Task Force areas and to other areas experiencing problems of drug misuse.'

The Irish Medicines Board (Miscellaneous Provisions) Bill 2005 provides for a number of amendments to the Misuse of Drugs Act 1977. These include provisions:

- to extend the powers available to the Minister to give a direction, following a conviction for an offence under the Misuse of Drugs Acts or the Customs Acts, prohibiting bodies corporate involved in the practice of community pharmacy, and their officials, from having such controlled drugs as may be specified;

- to enable the Irish Medicines Board to issue licences and permits in respect of controlled drugs for various purposes;
- to limit the prohibition of the cultivation of poppies to that of poppies cultivated for the production of opium.

A number of amendments to the Criminal Justice Bill 2004 are being proposed by the Minister for Justice, Equality and Law Reform. The Bill is currently being considered by the Joint Oireachtas Committee on Justice, Equality, Defence and Women's Rights. Among the proposed amendments are:

- provisions for creating criminal offences in relation to participation in criminal organisations
- proposals to strengthen the provisions on the imposition of the 10-year mandatory minimum sentence for drug trafficking
- new offences of supplying drugs to prisoners
- provisions in relation to a Drug Offenders Register
- new provisions to deal with anti-social behaviour, such as anti-social behaviour orders
- provisions to raise the age of criminal responsibility to 10 years.

Other legal developments

With regard to cannabis, the NACD recently published *An overview of scientific and other information on cannabis* (Morgan 2004). The report draws on relevant research from Ireland and abroad, with a view to presenting a balanced account of how this illegal but widely used substance affects a range of outcomes. The overview was conducted by authors from four different disciplines. Chapter four of the report examines the criminological and sociological consequences of cannabis use (Connolly 2004a). Many of the negative criminological and sociological consequences related to cannabis have been attributed to its legal status, rather than to any properties of the drug itself. The debate over cannabis law reform remains one of the most contested areas of international drug policy. The legal status of cannabis has come under increased scrutiny in recent years in Ireland. The National Crime Forum, established by the Minister for Justice, Equality and Law Reform in 1998, heard arguments for and against the decriminalisation of cannabis. Chapter four of the NACD report also looks at the effect that drug laws have had on educational and employment prospects, relationships and travel in a number of countries. Although there is clear evidence of violence associated with the drug trade, in the absence of any adequate studies into Irish drug markets it is impossible to state with any clarity the extent to which violence is associated specifically with the trade in cannabis. The chapter concludes by highlighting the need for further research in the drugs–crime area in Ireland. There is a particular need for more data describing the way in which laws are being implemented in the area of drug markets.

Implementation of legislation

In its interpretation of Section 8(2) Criminal Justice (Drug Trafficking) Act 1996 the Court of Criminal Appeal in the case of the *Director of Public Prosecutions v. Peter Byrne* (30 October 2003, Ref 26/2) defined the circumstances in which a search

warrant issued by a Garda superintendent can be utilised (GNDU, personal communication, September 2005). In delivering its judgement the court stated:

It is not the case that An Garda Síochána are free to choose whether they will apply for a search warrant to a Judge or Peace commissioner or to a Superintendent. They must apply to a Judge or Peace Commissioner unless the very limited circumstances which permit them to apply to a Superintendent are present. These circumstances must be demonstrated to be present for the Superintendent's warrant to be valid.

In *Creaven & anor v. Criminal Assets Bureau & ors* [2004] IESC 92, the Supreme Court held that a District Judge cannot sit and hear applications outside the district to which he/she is assigned. Although the case did not concern a drug-related matter, commenting on the decision, the Garda National Drugs Unit (GNDU) stated:

One implication of this decision is that where in the course of conducting an operation gardaí wish to apply for search warrants on an urgent basis, and the premises to be searched relate to a number of District Court Districts, such warrants can only be obtained from district Judges assigned to, and then sitting in, the relevant Districts. (GNDU, personal communication, September 2005)

Action 27 of the National Drugs Strategy obliges the Garda Síochána, the health boards and vintner representative bodies to '*prepare guidelines... for publicans and night-club owners regarding drug dealing on, or in the vicinity of, their premises. These guidelines should set out clearly the actions which the owner of the premises should take in response to drug dealing...*' (Department of Tourism Sport and Recreation 2001: 114). In June 2005 an information booklet, entitled '*Guidelines regarding drug dealing on or in the vicinity of licensed premises*', was launched with the aim of addressing Action 27 (An Garda Síochána and others 2005). The guidelines were drawn up by An Garda Síochána, with the co-operation of the Licensed Vintners Association, the Irish Nightclub Industry Association, the Vintners Federation of Ireland, the Department of Health and Children, and the Irish Hotels Federation. The guidelines cover such matters as the law in relation to drug issues, the legal conditions and appropriate procedures for the conducting of searches of persons entering premises, signs of drug misuse by customers, what to do if drugs are found, first aid, and the monitoring of queues.

In December 2004, the Oireachtas decided to extend sections 2, 3, 4, 5 and 6 of the Criminal Justice (Drug Trafficking) Act 1996 into force until 31 December 2006. These sections relate to police detention powers in suspected drug cases.

Part II of the Criminal Justice Act 1999, as amended, provides in section 5 for mandatory minimum sentences for possession of drugs with a value of €13,000. The Minister for Justice, Equality and Law Reform, Michael McDowell TD, in response to a parliamentary question, informed the Oireachtas that, since the provisions came into force on 26 May 1999 up until May 2004:

a total of 180 persons had been prosecuted, of whom 12 received a sentence of ten years or more. By 29 November of this year, the number of persons prosecuted had risen to 229, with 22 persons receiving a sentence of ten years or more. (McDowell 2004b)

The European Arrest Warrants Act 2003 came into effect on 1 January 2004. The Minister for Justice informed the Oireachtas that this Act:

simplifies extradition and surrender procedures between member states of the EU for offences such as illicit trafficking in narcotic drugs and psychotropic substances. (McDowell 2004a)

Crime statistics

The annual reports of the Garda Síochána are the main source of data on crime in Ireland. However, a number of concerns have been raised as to their reliability. Action 4 of the National Drugs Strategy requires 'the establishment of a framework to monitor numbers of successful prosecutions, arrests and the nature of sentences passed'.

The Expert Group on Crime Statistics, established to consider the compilation and reporting of crime statistics, submitted a number of recommendations to the Minister for Justice, Equality and Law Reform in July 2004. Based on these recommendations, the Minister has approved the establishment of a Central Crime Statistics Unit. However, concerns about existing official data sources remain. A minority report of the Expert Group concluded that lack of clarity regarding the collation of information about crimes reported to and recorded by An Garda Síochána meant that the Group was unable to reach conclusions 'about the quality, reliability and accuracy of Garda data' (Expert Group on Crime Statistics 2004b; Expert Group on Crime Statistics 2004a). The Expert Group has recommended that a special research project be commissioned by the Department of Justice, Equality and Law Reform to address this issue. Other important recommendations include:

- crime statistics to be released promptly and to a rigidly set timetable;
- significant changes in the reporting, categorisation or description of offences to be clearly explained;
- crime reports to contain all relevant information in relation to the methods of compilation, including the main counting rules;
- future changes in crime reports to be implemented after consultation with major stakeholders;
- crime statistics to cover all non-headline offences known or reported;
- annual crime statistics to be provided by county;
- greater access to data throughout the criminal justice system to be provided to researchers.

Another recent development, which should also enhance our understanding of crime as it impacts at a local level, is contained in the Garda Síochána Act 2005. Section 36 of the Act provides for the establishment of joint policing committees. One of the functions of these committees is to keep under review 'the levels and patterns of crime, disorder and anti-social behaviour in that area (including the patterns and levels of misuse of alcohol and drugs)'. It is unclear at this stage how this will be done, whether through the use of local surveys or through the increased availability of official data at a local level.

1.3 Institutional framework, strategies and policies

Since 2001, the National Drugs Strategy 2001–2008 (Department of Tourism, Sport and Recreation 2001) has provided the framework for illicit drugs policy in Ireland. In March 2005 a Progress Report (Department of Community Rural and Gaeltacht Affairs 2004) on the implementation of the National Drugs Strategy was published, followed in June 2005 by a mid-term review of the Strategy (Steering group for the mid-term review of the National Drugs Strategy 2005). As a result of the review process, priorities and actions under the National Drugs Strategy have been adjusted. These adjustments are reported on below.

An update on new initiatives announced in the government's Agreed Programme for Government (Fianna Fáil and the Progressive Democrats 2002), which are in addition to the actions identified in the National Drugs Strategy, are also described in this section.

Co-ordination arrangements

With over 20 statutory agencies involved in delivering the National Drugs Strategy, as well as multiple service providers and community and voluntary groups, a hierarchy of 'interagency mechanisms' is in place to co-ordinate policy and activities in pursuit of the strategic objectives, as summarised below.

Level	Inter-Agency Co-ordinating Mechanism
National	Cabinet Committee on Social Inclusion
	Inter-Departmental Group on Drugs (IDG)
	National Drugs Strategy Team (NDST)
Regional	Regional Drugs Task Forces (RDTFs)
Local	Local Drugs Task Forces (LDTFs)

A dedicated institutional framework – the National Drugs Strategy Unit in the Department of Community, Rural and Gaeltacht Affairs (DCRGA) – co-ordinates the overall implementation of the National Drugs Strategy and interacts closely with all the statutory and non-statutory agencies involved in delivering the Strategy.

The mid-term review makes a number of recommendations to strengthen the co-ordination and integration of activities at national level.

- The Inter-Departmental Group (IDG) is not perceived to have fulfilled the role envisaged for it, as an advisory group to the Cabinet Committee on Social Inclusion. To strengthen its ability to anticipate and respond to implementation issues and/or new trends emerging that may affect the Strategy and its decision-making role, it is recommended that the IDG be reconstituted and its membership expanded to include representatives of additional state agencies and of the community and voluntary sectors. Departmental officials should be given the authority to make decisions on the issues being discussed by the IDG. It is also anticipated that this reconstituted IDG will provide an opportunity for feedback and discussion on issues relating to drug misuse as they arise at EU and international fora.
- The National Drugs Strategy Team (NDST) is considered to be in a unique position to identify service gaps and best practice approaches as well as trends and developments on the ground and bring these to the attention of the IDG and the government. To ensure that it can continue to fulfil this role, membership of the NDST is to be reviewed to ensure adequate representation of the community and voluntary sectors, and a periodic review of resourcing levels is to be instigated to ensure its ongoing effectiveness.
- The role of the National Drugs Strategy Unit in the Department of Community, Rural and Gaeltacht Affairs (DCRGA) is clearly articulated in the mid-term review for the first time. It includes not only co-ordination of and monitoring and reporting on the National Drugs Strategy and advice and support to the Minister of State with responsibility for the Drugs Strategy, but also the operation and management of, or financial accountability for, a range of drug-related funds and state agencies. The Unit also represents Ireland at EU meetings of national drug co-ordinators.

National plan and/or strategies

The mid-term review of the National Drugs Strategy (Steering group for the mid-term review of the National Drugs Strategy 2005) which was based on a wide and thorough public consultation process and analysis of key national and EU data to assess progress and impacts, as well as emerging trends and gaps, recommends adjustments to the Strategy in order to 'refocus' priorities and 're-energise' the roll-out and implementation of various key actions during the remaining period of the Strategy. 'Refocusing' is recommended in order to meet emerging trends, identified particularly in the treatment area, including an increased prevalence of polydrug use, including cocaine; an increased incidence of hepatitis C as well as the ongoing prevalence of HIV; and the need to strengthen and expand rehabilitation provisions, in light of the significant and ongoing expansion in treatment provision in recent years. 'Re-energising' is recommended under all four pillars, including measures such as the provision of additional resources, extending the reach and availability and accelerating the roll-out of certain programmes, more training, establishing guidelines and models of best practice, and further monitoring.

Details of the adjustments and innovations recommended under each of the pillars, including the new, fifth pillar, Rehabilitation, are outlined below. In total, 17 of the 100 actions are replaced or amended, and eight new actions are identified.

Supply Reduction: under this pillar, the review notes progress on most of the 21 actions. Recommendations are made with regard to three key issues.

- The extra Garda (police) resources allocated to local drugs task force (LDTF) areas have not had the expected impact and steps are to be taken to increase resourcing and ensure effectiveness in preventing drug dealing on the ground in LDTF areas.
- Progress in establishing community policing fora in all the LDTF areas has been slow and action is to be taken to accelerate roll-out.
- Options for providing guidance and training for the judiciary in dealing with drug-related issues are to be explored.

Prevention: under this pillar, 11 of the 16 actions are completed or ongoing and some progress has been made with regard to the other five. Recommendations were made in relation to five key issues.

- The introduction of school substance abuse policies has encountered practical problems in a number of schools and a mechanism for monitoring the deployment of such policies is recommended.
- The effectiveness of the SPHE (Social Personal and Health Education) programme, which is part of the post-primary syllabus and includes a dedicated module on preventing substance abuse (including alcohol), has been diminished owing to varying standards of delivery and low prioritisation by schools. The review recommends enhanced training in prevention education for teachers and student teachers, and enhanced support services for schools in LDTF areas in delivering the programme, and greater encouragement to all schools to prioritise the implementation of school-based prevention programmes within existing timetables.
- Gaps and inconsistencies in the delivery of non-school-based programmes by different agencies were found and it is recommended that a working group be formed to develop guidelines and models of best practice for such programmes.
- Confusion was found to exist in how parents and families access information about substance abuse. The review recommends that factual information on prevention should be more easily accessible and also that the mandate and resourcing of the

Home School Community Liaison Service should be strengthened to help in information provision.

Treatment: under this pillar, nine of the 36 actions were considered completed or ongoing, while some progress was noted on a further 24, and little progress on just three. The review noted that a complicating factor in completing actions under the Treatment pillar was the variation in the prevalence of drug misuse across the country, which resulted in uneven rollout of services nationwide. Six key issues are identified.

- Given the increased prevalence of polydrug use, including cocaine, the availability and range of treatment options should continue to be increased.
- Rehabilitation is such an important component in facilitating drug misusers' 'moving on' and ultimately reintegrating them into society that it is recommended as a fifth pillar of the National Drugs Strategy.
- While guidelines for the treatment of under-18-year-olds presenting with serious drug problems have been developed, in compliance with an action in the National Drugs Strategy, it is now essential that these guidelines be fully implemented, with priority given to areas of most need.
- In light of the increase in the incidence of hepatitis C and the ongoing prevalence of HIV, higher priority needs to be given to the actions in the Strategy relating to harm-reduction approaches, including needle-exchange and exchange of other injecting paraphernalia, and ensuring wider geographical availability and availability at evenings and weekends.
- While the review recognises that there have been significant improvements in treatment provision in recent years, in the remaining phase of the Strategy the concentration should be on providing appropriate treatment no later than one month after assessment.
- Difficulties in recruiting new pharmacists and general practitioners into the methadone protocol resulted in recommendations to continue to increase general practitioner and pharmacist participation in the provision of methadone treatment, and to examine the issue of the voluntary and community services employing medical staff directly.

Research: under this pillar, the review noted that just one out of five actions have been completed and varying progress reported on the other four. As well as discussing the need to improve the management of drug-related research, including maintaining the standard of local and regional research, promoting inter-agency co-operation and coherence, ensuring regular reporting, and encouraging information sharing, the review identifies two new key issues.

- There is no mechanism in place to track progress in implementing the recommendations arising from the research reports carried out by the NACD and the review recommends establishing a process to monitor the implementation of the recommendations.
- The Central Methadone Treatment List should be developed by the provision of further information regarding entry and re-entry of clients and the length of time in treatment and this additional information should be made available on an annual basis.

Rehabilitation: with regard to this proposed new pillar, the review recommends that a working group be set up to develop an integrated rehabilitation provision. The group, to be chaired by the Department of Community, Rural and Gaeltacht Affairs, is due to report to the IDG and the Cabinet Committee on Social Inclusion by the end of 2005.

In June 2002 the incoming Fianna Fáil–Progressive Democrat government published an Agreed Programme for Government (Fianna Fáil and the Progressive Democrats

2002), setting out its priorities for 2002–2007. The Agreed Programme broadly endorses the Supply Reduction, Prevention and Treatment pillars of the National Drugs Strategy. It also identifies five new initiatives, designed to contribute to:

- achieving drug-free prisons,
- reducing drug supply, and
- improving information in respect of the drug situation.

The new initiatives and recent progress in relation to them, as outlined in the government's annual progress report for 2005 (Fianna Fáil and the Progressive Democrats 2005), are set out below.

We will provide for compulsory drugs testing of prisoners where appropriate.

In mid-2005 new prison rules were published, including specific provision for mandatory drug testing. Later in 2005 the Irish Prison Service is expected to commence implementation of a new strategy of mandatory drug testing, addiction counselling and treatment, and to implement extra measures to prevent drug use and provide a more complete system of rehabilitation (see also Section 9.3).

Where a person has been found to be involved in the supply of drugs to a prisoner we will introduce a stiffer penalty.

The Criminal Justice Bill 2004 will create a new offence of supplying drugs to prisoners. It is expected that this Bill will be enacted during 2005.

We will require convicted drug dealers to register with the gardaí after leaving prison.

The Criminal Justice Bill 2004 will also provide for the establishment of a drug dealers register. This register will be based on the same principles as the sex offenders register and will enable the movements of convicted drug dealers to be recorded in a similar fashion, covering changes of address and movements in and out of the State.

We will ensure that an early warning system, involving all key agencies, is in place to track the potential spread of heroin into new areas.

To counteract the limitations of drug-related data sources with regard to heroin use in the regions, the NACD is developing a Drug Trend Monitoring System (DTMS). This system will collect primary data as well as analyse secondary data on a range of drug use indicators in order to identify nationwide trends in drug use, including the spread of heroin use outside of Dublin. A report on the pilot DTMS will be submitted to the Cabinet Committee on Social Inclusion for consideration later in 2005.

We will continue to prioritise heroin and cocaine for intervention, and will publish separate national targets for supply reduction for each major type of drug.

In reporting on this initiative, the government refers to a key performance indicator, already included in the National Drugs Strategy, which identifies one aggregate target for the volume of all drugs seized in Ireland: 'A key indicator in the Strategy is to increase the volume of opiates and all other drugs seized by 25% by end of 2004 and by 50% by end 2008, using 2000 seizures as a base.' No breakdown of this target for 'each major type of drug' is provided.

Implementation of policies and strategies

One major structural change has occurred, with implications for the implementation of actions under the Prevention and Treatment pillars of the National Drugs Strategy. On 1 January 2005 the Health Service Executive (HSE) was established to manage

Ireland's public health sector as a single national entity. It replaced the former regional health boards, which had responsibility for 23 actions in the National Drugs Strategy, and joint responsibility for a further 11 actions. Responsibility for these actions has transferred across to the HSE (see Section 5.2).

Impact of policies and strategies

The mid-term review sought to assess the impact and direction of the National Drugs Strategy at the mid-point. As such, it represents a stock-take of progress, when the implementation of some of the actions is still ongoing, and does not seek to assess overall impacts. It concentrates on examining the progress and impact of the Strategy under each of the four pillars in relation to the objectives set for each pillar. It concludes that the Strategy's current aims and objectives are 'fundamentally sound' and that 'progress is being made' across all four pillars. It reports, moreover, that 49% of actions in the National Drugs Strategy have been completed or are ongoing, action is under way on a further 45%, and just 6% require 'considerably more progress'. Finally, it proposes new and revised key performance indicators (KPIs) under each pillar, reflecting both lessons learned in the course of the review and developments in the collection and availability of research and data since the Strategy was first published.

By reprioritising actions for the second phase of the National Drugs Strategy up to 2008 and by proposing new and revised key performance indicators, the mid-term review expresses the belief that the Strategy will better deliver the aims and objectives set out for the period 2001–2008.

1.4 Budget and public expenditure

Up-to-date information on budgetary provisions and public expenditure on the illicit drugs issue in Ireland is not available.

The mid-term review of the National Drugs Strategy, published in June 2005, recognises that 'a measure of the expenditure is vital to gauge the cost effectiveness of the different elements of the Strategy'. The review proposes that only expenditure that is directly attributable to drugs programmes (e.g. drugs services of the Health Services, cost of Garda (police) drug units, drugs-specific training of prison officers) should be measured. Although this would not capture the overall resources devoted to addressing the direct and indirect costs of drug use, the review suggests that it would give 'an indication as to the overall budget priorities' accorded to the illicit drugs issue. The review recommends that the IDG should consider how best this issue should be progressed and that the estimates should be produced on an annual basis. No timeframe is set for implementing this recommendation.

The GNDU reports that 'work will commence shortly on highlighting expenditure by An Garda Síochána specifically on drug law enforcement' (GNDU, personal communication, September 2005).

1.5 Social and cultural context

Public opinions of drug issues

Public opinion in Ireland views drug trafficking as an issue in need of urgent action. *Eurobarometer 63*, for which the field work was conducted in May/June 2005, reported that, when asked to select the three actions that the EU should follow, in order of

priority, from a list of 16 possible actions, respondents in Ireland ranked 'fighting organised crime and drug trafficking' second, after 'fighting poverty and social exclusion' (European Commission 2005a). *Eurobarometer 62*, for which the field work was conducted in October/November 2004, reported that on that occasion respondents in Ireland reversed the ranking, with 'fighting organised crime and drug trafficking' as the top priority for action, just ahead of 'fighting poverty and social exclusion' (European Commission 2005b).

Initiatives in parliament and civil society

Parliamentary committees, comprising elected representatives from all parties in the Oireachtas (Houses of Parliament), and a range of community and voluntary bodies have been active in researching drug-related issues and making recommendations to improve performance. A notable initiative during the period covered by this National Report was the publication of the first four reports funded under the Community/Voluntary Sector Research Grant Scheme, administered by the NACD. This research fund was established to promote a better understanding of drug-related issues in communities; boost the research capacity of the community/voluntary sector and, consequently, their capacity to influence policy and the planning of services; and facilitate liaison between community/ voluntary organisations, service planners and service providers.

A selection of initiatives taken by parliament and civil society that have contributed to the development of drug policy during the period covered by this National Report is provided below.

Family support

The public consultation process carried out as part of the mid-term review of the National Drugs Strategy highlighted the need to develop supports and guidance for parents, as well as children at risk. During the consultation process, the community-based CityWide Family Support Network, representing local family support groups, independent family members and those working directly with families of drug users, published a report *Supporting grandparents. . . supporting children* (CityWide Family Support Network 2004), based on consultation with a number of carers involved in family support groups, and campaigned for 'Family Support' to be identified as the fifth pillar of the National Drugs Strategy.

Although not established as a new 'pillar' of the drugs strategy, family support is identified as a cross-cutting issue in the mid-term review of the National Drugs Strategy (see Section 3.2). The review adopts the recommendations made in a study commissioned by the NACD on the role of family support services in drug prevention (Watters and Byrne 2004).

Service users

In 2001 the National Drugs Strategy included an action requiring public drug treatment service providers to draft service-user charters. The mid-term review of the Strategy calls for service users to be consulted in the drafting or revision of these charters. During the life of the National Drugs Strategy there has been a growing awareness and recognition of the needs of drug-service users. In 2002 the Irish College of General Practitioners published a model service charter for use by general practitioners, and in 2003 UISCE (a group comprising drug users, ex-users and professionals who seek to ensure the voice of the drug user informs drug policy) published a report on service users' experiences and perceptions of methadone substitution treatment service provision (UISCE 2003). During 2005 a collaborative piece of community-based action research expanded the scope of these discussions, seeking to identify and address

issues confronted by drug users in relation not only to drug treatment services but also to health services in general (O'Reilly *et al.* 2005).

Community policing

The National Drugs Strategy includes an action to extend the Community Policing Fora (CPF) initiative to all local drugs task force areas. The mid-term review of the Strategy found that, although CPFs are being piloted in a number of areas, progress in extending them has been slow. The review recommends that, taking into account the provisions in the Garda Síochána Bill 2004 (see Section 1.2), CPFs should be extended to all local drugs task force areas and to other areas experiencing drug misuse problems.

During the period covered by this report, several initiatives in civil society and parliament contributed to thinking on community policing. In Dublin, the Blanchardstown Local Drugs Task Force published a report (Connolly 2004b) which made a number of recommendations with regard to the structure and process of a local community policing forum. A public consultation on crime and policing in Dublin City (Lord Mayor's Commission 2005) argued strongly that reducing crime, disorder and anti-social behaviour cannot be the sole responsibility of the gardaí and the Courts, and that local bodies and communities should share the responsibility. In March 2005, the Joint Oireachtas Committee on Justice, Equality, Defence and Women's Rights (2005) conducted a review of community policing in Ireland in light of the proposals contained in the Garda Síochána Bill 2004.

Cocaine

The mid-term review of the National Drugs Strategy noted the increased prominence of cocaine, both in terms of supply and the prevalence of cocaine misuse. Early in 2005 a series of pilot treatment projects were launched and the mid-term review called for the lessons learned from the evaluations of these projects to be implemented in LDTF areas. It was in the context of the pilot treatment projects that an Oireachtas Committee undertook to investigate the treatment of cocaine addiction, with particular reference to the Irish experience (Oireachtas Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs 2005).

2. Drug Use in the Population

2.1 Overview

This section provides an overview of the new developments and trends in drug use in the population in Ireland for 2004 and early 2005.

Drug prevalence surveys in the general population are important in that they can shed light on the patterns of drug use, both demographically and geographically and, if repeated, can track changes over time. They help to increase our understanding of drug use, and to formulate and evaluate drug policies. They also enable informed international comparisons, provided countries conduct surveys in a comparable manner.

2.2 Drug use in the general population

No new surveys of drug use in the general population were carried out or published in the current reporting period.

In 2005, the NACD published revised prevalence estimates from their national survey of drug use in the general population 2002/2003 (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005). According to the NACD, the revisions were necessary due to anomalies discovered in the original survey data.

Full details of the revised estimates can be found in the on-line version of Standard Table 1. Key findings for Ireland are described below. One in five (18.5%) adults reported using an illegal drug in their lifetime (see Table 2.2.1). For young adults (aged 15–34 years) this rose to one in four (26.0%) people. Twice as many men as women reported the use of an illegal drug during the last month or the last year.

Table 2.2.1 Lifetime, last-year and last-month prevalence of illegal drugs in Ireland, 2002/2003

Ever used an illegal drug*	Adults 15–64 years %	Males 15–64 years %	Females 15–64 years %	Young adults 15–34 years %
During lifetime	18.5	24.0	13.1	26.0
During last year	5.6	7.8	3.4	9.7
During last month	3.0	4.1	1.7	5.2

* illegal drugs refer to any use of amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005)

Cannabis was the most commonly used illegal drug. One in six adults had used cannabis in their lifetime and this increased to one in four for young adults (see Table 2.2.2).

Table 2.2.2 Lifetime, last-year and last-month prevalence of cannabis in Ireland, 2002/2003

Ever used cannabis	Adults 15–64 years %	Males 15–64 years %	Females 15–64 years %	Young adults 15–34 years %
During lifetime	17.4	22.4	12.3	24.0
During last year	5.0	7.2	2.9	8.6
During last month	2.6	3.4	1.7	4.3

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005)

Prevalence of other illegal drugs was lower and confined largely to the younger age group. One in fourteen (7.1%) young adults claimed to have tried ecstasy at least once in their lifetime (see Table 2.2.3).

Table 2.2.3 Lifetime, last-year and last-month prevalence of ecstasy in Ireland, 2002/2003

Ever used ecstasy	Adults 15–64 years %	Males 15–64 years %	Females 15–64 years %	Young adults 15–34 years %
During lifetime	3.7	4.9	2.6	7.1
During last year	1.1	1.7	0.5	2.0
During last month	0.3	0.7	-	0.6

- no respondents in this category

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005)

Cocaine use (including crack) was much higher in men than women for lifetime, current and recent use (see Table 2.2.4).

Table 2.2.4 Lifetime, last-year and last-month prevalence of cocaine (including crack) in Ireland, 2002/2003

Ever used cocaine (including crack)	Adults 15–64 years %	Males 15–64 years %	Females 15–64 years %	Young adults 15–34 years %
During lifetime	3.0	4.3	1.6	4.7
During last year	1.1	1.7	0.5	2.0
During last month	0.3	0.7	-	0.7

- no respondents in this category

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005)

2.3 Drug use in the school and youth population

On 14 December 2004 the Minister of State at the Department of Health and Children, Mr Sean Power, announced the publication of the third European School Survey Project on Alcohol and Other Drugs (ESPAD) (Hibell *et al.* 2004). The third ESPAD survey was conducted in 35 European countries during 2003 and collected information on young people's alcohol and illicit drug use. The target population was school-going children born in 1987. Thus, those surveyed were aged either 15 or 16 years at the time of the survey. As in the earlier ESPAD surveys, the 2003 survey was conducted with a standardised methodology and a common questionnaire to provide comparable European data.

The publication of the results for the 2003 Irish ESPAD survey allows comparisons with the previous Irish ESPAD surveys conducted in 1999 (Hibell *et al.* 2000) and 1995 (Hibell *et al.* 1997). Trends in some of the main indicators of drug use over the last eight years are reported in Table 2.3.1. There was a notable increase in lifetime use of any illicit drug between 1999 (32%) and 2003 (40%), up 8%. This increase followed a drop between 1995 and 1999. Ireland ranked joint third after the Czech Republic (44%) and Switzerland (41%) for lifetime experience of any illicit drug in 2003. The average for the 35 ESPAD countries in 2003 was 22%.

Table 2.3.1 Changes in the proportion of school-going children (15–16 years) in Ireland using drugs in the ESPAD surveys of 1995, 1999 and 2003

Drug use	1995 survey %	1999 survey %	2003 survey %
Lifetime use of any illicit drug*	37	32	40
Lifetime use of cannabis	37	32	39
Lifetime use of inhalants	NA	22	18

*includes cannabis, amphetamines, LSD or other hallucinogens, crack, cocaine, heroin and ecstasy

NA = Not Available

Source: (Hibell *et al.* 1997; Hibell *et al.* 2000; Hibell *et al.* 2004)

The majority of those who have tried any illicit drug have used cannabis (marijuana or hashish). The lifetime prevalence rates for cannabis use are thus similar to those for use of any illicit drug and reflect the same trend. The rate of lifetime use of inhalants dropped slightly between 1999 (22%) and 2003 (18%) but remains high. The average for the 35 ESPAD countries in 2003 was 10%.

The Irish 2003 ESPAD survey was managed by Dr Mark Morgan, St Patrick's College, Dublin, and funded by the Department of Health and Children. The sampling strategy involved a two-step process. All secondary schools were divided into three strata (single-sex secondary, mixed secondary, and vocational and community schools). In the first sampling step, schools were selected within each strata proportionate to the number of schools in the sampling frame. A total of 120 schools were selected in this manner. In the second sampling step, two grade-five classes were randomly selected from these schools. Out of the 120 selected schools, 108 agreed to participate and, out of the 216 classes chosen from these schools, 196 participated. Students in these classes who were born in 1987 were asked to complete a questionnaire administered by a teacher in the school. A special room in each school was provided for this purpose. Data collection was carried out during April. A total of 2,407 students participated in the survey. The response rate (participating students in participating classes) was 96%. No information was available on the students in non-participating schools or classes. As indicated above, the desired target population in the ESPAD survey was students born in 1987. However, the ESPAD report notes that in Ireland grade five accommodates only about 67% of all students born in 1987. Consequently, the Irish results cannot be generalised to 1987-born students in other grades.

On 25 April 2005 the Minister of State at the Department of Health and Children, Mr Sean Power TD, announced the publication of *The Health of Irish Students* report (Health Promotion Unit 2005a). The report incorporated the results of the College Lifestyle and Attitudinal National (CLAN) survey and a qualitative evaluation of the College Alcohol Policy Initiative. The aim of the CLAN survey was to establish a national student profile of lifestyle habits, including living conditions, general health, mental health, dietary habits, exercise habits, accidents and injuries, sexual health and substance use – tobacco, alcohol and illicit drugs (Hope *et al.* 2005). This information will be used in planning for student needs and as a baseline in monitoring trends over time.

With regard to alcohol use, three out of every four drinking occasions were binge drinking occasions for male students, compared to three out of every five for female students. Binge drinking is a term used to describe a single occasion of excessive or high-risk drinking, defined in this survey as drinking at least four pints of beer or a bottle of wine or equivalent at one drinking occasion. These figures indicate that this pattern of high-risk drinking is the norm among college students, with more male than female binge drinkers.

The likelihood of students experiencing adverse consequences from their own drinking increased with more frequent binge drinking episodes. Students who were regular binge drinkers, defined as binge drinking at least weekly, were three times more likely to have experienced money problems (32% vs. 10%), fights (22% vs. 6%), accidents (13% vs. 4%) and unprotected sex (19% vs. 6%) than were students who were binge drinking less frequently, or were not binge drinkers. Regular binge drinkers were also twice as likely as other student drinkers to be current smokers (38% vs. 18%) and recent cannabis users (54% vs. 25%). Regular binge drinking can also interfere with academic performance. For example, regular binge drinkers were twice as likely to miss classes due to alcohol (61% vs. 27%) and to report that their studies were affected (39% vs. 19%).

With regard to drug use, cannabis was the most common illicit drug used by students, with over one-third (37%) reporting that they had used it in the past 12 months (Table 2.3.2). Ecstasy was the second most used illicit drug, followed by cocaine, magic mushrooms and amphetamines. For all drugs, the levels of use were higher among students than among those of a similar age group (15–24 years) in the general population. The use of solvents (inhalants) was particularly high. Male students were more likely to use illicit drugs than were female students. Significant differences ($p < 0.01$) between genders were observed for cannabis, ecstasy, cocaine, magic mushrooms and solvents.

Table 2.3.2 Illicit drug use in past 12 months by undergraduate full-time students (CLAN survey) compared to those aged 15–24 years in the general population, 2002/2003

Used in last 12 months	CLAN survey	General population*
	%	(15–24 years) %
Cannabis	37.3	11.0
Ecstasy	8.0	2.8
Cocaine	5.8	2.7
Magic mushrooms	4.9	1.1
Amphetamines	4.5	1.2
Solvents	2.2	0.2
LSD	1.7	0.2
Heroin	0.4	0.2

* National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005) *Drug use in Ireland & Northern Ireland. Bulletin 1. First results (revised) from the 2002/2003 drug prevalence survey*. Dublin: National Advisory Committee on Drugs.
Source: (Hope *et al.* 2005)

The report recommends ten actions required to ensure that the college environment is more conducive to the positive health and well-being of all students. Acknowledging that alcohol-related harm was particularly high and of major concern, the report recommends the implementation of all five elements of the college alcohol policy framework (Health Promotion Unit 2001). In addition, the report recommends that a programme of ongoing research should be agreed to allow for monitoring of trends and evaluation of programmes and interventions.

The CLAN survey was carried out among undergraduate full-time students in 21 third-level colleges in Ireland during the academic year 2002/2003. The colleges included seven universities, twelve institutes of technology and two colleges of education. A national sample size was calculated using a 3% precision and a 95% degree of confidence, with a breakdown for the colleges based on each college population. Each participating college generated a random sample from its computerised enrolment list of full-time undergraduate students, distributed the self-completed survey questionnaire by mail to selected students and collected the completed questionnaires by mail or by using drop-off points on campus.

A total of 3,259 students responded to the survey, giving a reported response rate of 50%. No information is given in the report about those who did not respond, so it is not possible to tell if they differed in any way from those who did respond. Of those who did respond, 38% were male and 62% were female. Based on Department of Education and Science figures, the gender breakdown for persons receiving full-time education in the academic year 2002/2003 was 46% male and 54% female (Department of Education and Science 2004). Thus, there would appear to be a slight over-representation of female students in the CLAN survey.

2.4 Drug use among specific groups

Lawless and Corr (2005) at Merchants Quay Ireland assessed the nature, extent and experience of alcohol and drug use among people who were homeless in four cities in Ireland, namely: Cork, Dublin, Galway and Limerick. The report was prepared for the NACD and launched in April 2005. 'Homelessness' was defined as living in a hostel or shelter, a bed and breakfast, or a squat, or living temporarily with family or relatives. In Cork, Galway and Limerick the definition was extended to include transitional housing or long-term supported housing.

In Dublin, the sample was selected using a quota sampling based on gender, age and primary accommodation type, while in Cork, Galway and Limerick the quota sample was based on primary accommodation. The majority (247, 70%) of the sample was recruited in Dublin and the remainder (108, 30%) in the other three cities. The 355 participants were recruited from among those in contact with homeless services in the four cities. Drug treatment centres and needle-exchange facilities were excluded from the list of services so as to avoid over-estimating the prevalence of drug use.

Between June and October 2003, nine field workers interviewed the participants using a semi-structured questionnaire, which:

- Elicited information regarding basic identifiers, personal characteristics, accommodation types, experiences of homelessness, income, health, alcohol and drug use, risk behaviours, contact with services and current needs;
- Measured problem alcohol use using a validated tool known as the Alcohol Use Disorders Identification Test Screening Instrument (AUDIT);
- Assessed drug use through three approaches, which included:
 - European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) standard questions on lifetime, recent and current use of various drug classifications;
 - A 10-point version of the Drug Abuse Screening Test (DAST) to identify problematic drug use;
 - Severity of Dependence Scale to measure the degree of dependence on a variety of drugs.

Each person interviewed was allocated a unique identifier (initials, gender and date of birth) and these identifiers were shared between the fieldworkers so as to avoid respondents participating more than once.

The prevalence of drug use among the homeless is presented below.

- Of the 355 participants,
 - 74% reported illicit drug use at some point in their life, 64% reported illicit drug use in the year preceding the study and 52% reported illicit drug use in the month preceding the study (Table 2.4.1);
 - Cannabis was the most common illicit drug used, with 69% using it at some point in their life, followed by heroin (42%), ecstasy (42%), cocaine powder (41%), amphetamines (35%), hallucinogens (28%), crack cocaine (19%) and solvents (16%);
 - Cannabis was the most common (43%) illicit drug used in the last month, followed by heroin (22%), cocaine powder (17%), ecstasy (12%), crack cocaine (3%) amphetamines (2%), hallucinogens (1%), and solvents (1%);
 - 45% were using more than one drug at the time of the study and this represents 72% of current drug users;
- Using the DAST screening instrument, 36% of the 355 participants were classified as problem drug users and 65% of the 183 current drug users were problem drug users;

- Using the Severity of Dependence Scale, 43% of the scores of the 183 current drug users indicated a high level of psychological dependence.

Table 2.4.1 Prevalence of illicit* drug use in the homeless population in Ireland in 2003

Illicit drug use	Total (n=355)	Dublin (n=245)	Cork (n=36)	Limerick (n=36)	Galway (n=36)
	%	%	%	%	%
During lifetime	74	80	72	42	64
During last year	64	72	53	28	50
During last month	52	59	42	25	36

*Illicit drugs defined as cannabis, ecstasy, amphetamines, cocaine powder, crack cocaine, heroin, hallucinogens, and solvents

Source (Lawless and Corr 2005)

As expected, drug use is much more common among the homeless population than among the general population. The profile of drug use reported by the homeless population in 2003 is similar to that reported by the prison population in 1999 (Centre for Health Promotion Studies 2000), indicating the high-risk substance use among these two populations and, possibly, considerable overlap between the prison and the homeless population.

Of the 352 participants for whom frequency of alcohol use was known, 105 (30%) were not drinking alcohol at the time of the survey, while 83 (23%) consumed alcohol on four or more days per week. Of those reporting alcohol use at the time of the survey and who were screened for problem alcohol use (n=247), 73% had an alcohol problem and 49% of these had a high-level alcohol problem

3. Prevention

3.1 Overview

In June 2005 the mid-term review of the National Drugs Strategy was published (Steering group for the mid-term review of the National Drugs Strategy 2005). The review considered both the actions and key performance indicators under the Prevention pillar of the Strategy. The National Drugs Strategy (Department of Tourism Sport and Recreation 2001) set out nine key performance indicators (KPIs) to measure progress under the prevention pillar. The mid-term review of the Strategy recommends replacing these with four new KPIs:

- The 3 Source Capture-Recapture study estimate of opiate misusers, due to be released in 2007, to show a stabilisation in terms of overall numbers and to show a reduction of 5% of the prevalence rate based on 2001 figures (published in 2003)
- The NACD Drug Prevalence Survey, due to be released in 2007, to show a reduction of 5% in the prevalence rate of recent and current use of illicit drugs in the overall population based on 2002/03 rate
- Substance use policies in place in 100% of schools; and
- Early school leaving in LDTF areas reduced by 10% based on 2005/06 rate.

The capture-recapture study and the NACD drug-prevalence study have replaced the European School Survey Project on Alcohol and Other Drugs (ESPAD) surveys as data sources to assess progress in reducing demand for drugs among the target populations under the prevention pillar. However, both studies contain limitations for measuring a reduction or otherwise in substance use among 15–16-year-olds in the school-going population, whereas ESPAD provided a precise measurement for this age band. The capture-recapture study estimates the prevalence of opiate use among 15–64-year-olds. The NACD drug-prevalence survey estimates the prevalence of different illicit drugs in the general population. The sample estimates in both studies would need to be much larger to provide robust estimates for this two-year age band to be capable of being used to measure a reduction in demand for illicit substances among this target group. Both studies would also need to establish who among the respondents in the 15–16-year age band were attending school. Indeed, the research team behind the NACD drug-prevalence study concedes that estimates produced in the 2003 study can be treated more robustly for the general population than those for sub-groups of the population, such as different age groups (National Advisory Committee on Drugs & Drugs and Alcohol Information and Research Unit 2003). This is because the sample size was calculated to provide a total population estimate.

It is important to assess the demand for illicit substances among the 15–16-year-old school-going population as half of the 16 actions under the prevention pillar target school-going young people through interventions designed to address educational disadvantage and prevention of substance misuse. The replacement of ESPAD represents a missed opportunity to capture data specific to the school-going population.

The remaining two KPIs have a strong association in that they can both assess progress on actions designed to address educational disadvantage. Consistent monitoring and implementation of substance use policies in all schools can create a

climate where students with substance misuse issues can be supported rather than disciplined. This concern was raised during the consultation process of the mid-term review of the National Drugs Strategy. An over-emphasis on disciplinary sanctions through suspension and expulsion can contribute to early school leaving. In addition, all schools now have a legal obligation to report absences and expulsions to the National Educational Welfare Board (NEWB), which in turn has been entrusted with prioritising LDTF areas in the course of its work. Early identification of substance-related absenteeism and expulsions in LDTF schools through this process requires the early intervention of educational welfare officers (EWOs) in conjunction with teachers, parents and specialised substance-misuse counsellors. This process can contribute to supporting the young person to remain in mainstream education. Failure to intervene at this stage will almost certainly add to the numbers of early school leavers and lead to an experience of alienation and marginalisation on the part of the young person.

The mid-term review of the National Drugs Strategy contains an overview of progress on 16 actions under the prevention pillar. Half of the actions relate to school-based prevention programmes that can be broadly categorised into (i) programmes to tackle educational disadvantage and (ii) programmes to develop personal skills and make students more aware of drug-related issues. Eleven actions are listed as either completed or ongoing over the lifetime of the strategy. On the remaining five actions, while some progress has been made, further work is necessary or under way in order to complete their implementation. The review also contains a number of recommendations on actions to be replaced, amended and new actions to be included (see Section 1.3).

3.2 Universal prevention

School

Implementation of substance use policies in schools

The Steering Group notes that returns to the Department of Education and Science indicate that over 50% of all schools had adopted substance use policies by mid-2004. The Group recommends setting a new target date for policies to be implemented in schools in high-risk areas, the development of a national monitoring system in schools and annual reporting of substance misuse policy implementation. The Group recommends replacing Action 43 of the National Drugs Strategy with the following new actions:

- Substance use policies should be developed and implemented in all Local Drugs Task Force (LDTF) schools by the end of 2005/06 academic year. (New Action)
- A mechanism to monitor the development of substance use policies in all schools should be put in place and should report annually. (New Action)

Implementation of Social, Personal and Health Education (SPHE) in schools

Social, Personal and Health Education (SPHE) is a curriculum subject in both primary and secondary schools up to Junior Certificate. At both levels, SPHE includes dedicated modules focusing on substance use prevention. However, the review noted that the practice of implementing SPHE varied between schools. As SPHE is not an exam subject, it was found to be lacking in priority as a regular timetable subject. The Steering Group believes that consistency in the delivery of SPHE modules is vital to their successful implementation. In this context, the Group considers that ongoing training and support in prevention education should be made available for teachers

and, furthermore, that it should be part of the curriculum for student teachers. The group recommends amendments to three existing actions in the Drugs Strategy and the inclusion of one new action:

- Appropriate and ongoing training and support services should be put in place on a nationwide basis for teachers to deliver the SPHE. (Action 31 amended)
- The supports provided to LDTF area schools through the Walk Tall support service should be extended to other areas of disadvantage. (Action 32 amended)
- Schools at primary and post-primary levels should further prioritise the implementation of school-based prevention programmes within existing timetables. (Action 33 amended)
- Prevention education should be part of the curriculum for student teachers. (New Action)

Understanding Substances and Substance Use – A Handbook For Teachers

A handbook to assist teachers to deliver substance use education in both primary and post-primary schools was launched by the Addiction Services and Health Promotions Department of the South Western Area Health Board (SWAHB) and Walk Tall: the Substance Misuse Prevention programme at the end of 2004 (Keane *et al.* 2004). The handbook contains basic information on how to mainstream drug terminology and the use of slang terms in youth culture; a theoretical model from which to understand the different stages of drug use; factual information on administration routes; effects of use, risks of short- and long-term use and legal status are given for both licit and illicit drugs. In addition, the handbook outlines some of the main factors that can contribute to drug use and on the other hand looks at some of the protective factors that can reduce the risks of engaging with drugs.

The handbook contains a useful exploration of what is termed the 'epidemiological triangle of drug use', considering the interaction of different factors that influence the effects of a drug. The section is grounded in the theoretical proposition of Zinberg (1984). According to Zinberg, there are three key factors in play when drugs are being used: the make up and compound of the drug itself (drug), the psychology of the person (set) and the social environment (setting). Reference to the framework provides for the removal of the temptation to demonise the properties of drugs as solitary effect producers, without considering the psychological condition and social context of the user. The drug, set and setting framework can be a useful basis of discussion for teachers, particularly in secondary-school drug education, as it has the capacity to enable teachers to neither deny nor demonise the effects that drugs can produce but instead understand such effects through the interaction between users, the drug and the environment.

The handbook also addresses the signs and symptoms of drug use and the issue of home drug testing. The section highlights the need for teachers and parents to be aware that signs and symptoms that may traditionally be linked to drug use, such as erratic mood swings, changes in appearance and loss of interest in school, are also normative aspects of the experience of adolescence.

Family

Support for parents and families

The Steering Group for the mid-term review of the National Drugs Strategy noted that a number of interventions in LDTF areas targeted parents of at-risk young people and families of drug users, but also highlighted the continuing gap in support services for parents and families outside LDTF areas. It noted that phase two of the National Drugs Awareness Campaign had attempted to bridge this gap by focusing on parents by means of information on the campaign website and leaflet distribution. The approach adopted in this second phase is as follows:

	Target group	Actions	Rationale
Second phase of the National Drugs Awareness Campaign	Parents	'Parent orientated' TV and radio ads; parents' information booklet; a roadshow inviting parents nationwide to Q&A sessions locally	To encourage more open communication between parents and children

However, the Steering Group concluded that, despite the availability of this material, confusion existed among parents and families as to how best to access information regarding drugs. The group recommended the replacement of Action 35 and the inclusion of a new action to support parents and families:

- Factual preventative information for parents and families in dealing with substance misuse should be more easily accessible in appropriate locations such as Garda Stations, Libraries, Health Centres and other public offices (Action 35 replaced).
- The role of the Home School Community Liaison Scheme (HSCL)² should be further strengthened through the provision of additional resources; in particular, there is a need to expand the engagement of HSCL with families dealing with drug misuse (New action).

The creation of a cross-pillar on Family Support Services in drug prevention is also proposed as a new action in the review. The review supports the implementation of recommendations contained in the 2004 NACD report, *The Role of Family Support Services in Drug Prevention* (Watters and Byrne 2004). The recommendations are:

- increase the capacity of services to respond through an appropriate level of resources and training for staff in services
- strengthen inter-agency links and networks by building knowledge of local community issues and attitudes thus improving communication
- develop relevant monitoring and evaluation tools to measure effectiveness of services.

The National Drugs Strategy Team (NDST) is given primary responsibility for encouraging the local and regional drugs task forces to prioritise the provision of family support services in their areas and action plans.

² The Home School Community Liaison scheme (HSCL) focuses on primary and post-primary schools that have been designated as disadvantaged

Community

Prevention programmes in non-school settings

The Steering Group for the mid-term review of the National Drugs Strategy notes that, while there has been progress in developing non-school-based programmes in recent years, there are gaps and a lack of consistency in the way the programmes are delivered by the different agencies. The group recommends an amendment to Action 37 to address these gaps:

- A working group should be established under the aegis of the Department of Education and Science to examine this area, to identify ongoing gaps and to develop guidelines and models of best practice for the implementation of substance-use programmes in non-school settings. The group should report by January 2006 (Action 37 amended).

A new fund to tackle emerging needs in the LDTF areas has been announced by the Department of Community, Rural and Gaeltacht Affairs. This fund is currently being used to finance the piloting of interventions to address cocaine use in some communities. These interventions include training of frontline staff in both the community and statutory sectors dealing with cocaine users; the production of educational material outlining the dangers associated with cocaine use; and four pilot treatment interventions for specific groups such as intravenous cocaine users, problematic intranasal cocaine users and problematic female cocaine users.

3.3 Selective/indicated prevention

In the areas of selective and indicated prevention, the Steering Group highlights a number of interventions that require further development. For example, the group notes the importance of *youth work* in engaging with young people in a non-school setting, particularly those most at risk. In this context, the group highlights *alternatives to drug misuse* for young people and the need to prioritise high-risk areas within LDTFs through the Young People's Facilities and Services Fund (YPFSF) and the Sports Capital Programme (SCP). The YPFSF aims to divert at-risk young people (aged 10–21) in disadvantaged areas from engaging in substance misuse through targeted funding of services and facilities. The SCP provides similar funding and support to sporting interventions in designated disadvantaged areas.

The Steering Group acknowledges that approximately €85 million has been allocated, primarily to the 14 LDTF areas, to support over 450 services and facilities projects. The group states that access by the target group to these facilities, particularly to the larger youth and community facilities being put in place through the YPFSF, is a key issue and one that is being actively monitored by the Fund's National Assessment Committee. The group recommends that expansion of the Fund to other areas of similar need, outside of the LDTFs, needs to be actively progressed; it notes that ongoing work by the NDST regarding the identification of future task force areas is relevant in this regard. Also, the group believes that targeting potentially high-risk groups, such as foreign national young people, should be a priority area for the Fund in the future.

The Steering Group welcomes the recent circular from the Department of Education and Science encouraging schools to allow community access to their premises outside of school hours. The group also notes that this issue is being considered at present by the National Assessment Committee (NAC) and that the Committee will be developing proposals in this regard which will be brought to the IDG for consideration as soon as possible.

4. Problem Drug Use

4.1 Overview

This section provides an overview of new developments and trends in the prevalence and characteristics of problem drug use in Ireland for 2004 and early 2005.

The EMCDDA defines problem drug use as 'injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines' (EMCDDA 2004: 50). However, this section, written following EMCDDA guidelines, requires clients in treatment to be covered. It should be stressed that not all clients in treatment fit the above EMCDDA definition of problem drug use.

4.2 Prevalence and incidence estimates

No new prevalence and incidence studies have been carried out or published in the current reporting period.

The last national prevalence estimate for problem drug use was for opiate users. The research – the first national study of its type – was commissioned by the NACD and conducted by a team from Trinity College Dublin (Kelly *et al.* 2003). A three-source capture-recapture methodology was applied following guidelines recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA 2002b). Three national data sources were used for both 2000 and 2001: clients in methadone substitution treatment, individuals known to be opiate users by An Garda Síochána (Irish police), and patients discharged from acute hospitals with an International Classification of Diseases code corresponding to drug dependence.

While the estimated number of opiate users increased slightly between 2000 and 2001, the rate per 1,000 population aged 15–64 years remained remarkably stable at 5.6. For both years, rates were higher for men than women in all age categories.

Opiate use is still predominately a Dublin phenomenon, which was reflected in the finding that the rate of opiate use in Dublin in 2001 was 15.9 per 1,000 population aged 15–64 years and outside Dublin the rate was just under 1.2 per 1,000 population aged 15–64 years.

4.3 Profile of clients in treatment

Substances used

Drug treatment data are viewed as an indicator of drug misuse as well as a direct indicator of demand for treatment services. The National Drug Treatment Reporting System (NDTRS) is an epidemiological database on treated problem drug use in Ireland. The NDTRS is co-ordinated by staff at the Drug Misuse Research Division of the Health Research Board on behalf of the Department of Health and Children. For the purpose of the NDTRS, treatment is broadly defined as 'any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their drug problems.'

Numbers treated by place of residence

The number of treated cases in Ireland reported to the NDTRS has increased steadily, from 6,048 in 1998 to 9,084 in 2003 (Table 4.3.1). This increase is explained by a combination of factors: a true increase in drug use, an increase in access to treatment services, and an increase in the number of centres reporting cases to the NDTRS.

Table 4.3.1 Number (%) of cases treated for problem drug use, by treatment status, in Ireland, 1998–2003

Treatment status	1998	1999	2000	2001	2002	2003
	Number (%)					
All cases	6048	6206	6933	7900	8596	9084
Previously treated cases	4194 (63.9)	4421 (71.2)	4877 (70.3)	5664 (71.7)	6259 (72.8)	6772 (74.5)
New cases	1626 (26.9)	1673 (27.0)	1941 (28.0)	2073 (26.2)	2098 (24.4)	2198 (24.2)
Status unknown	228 (3.8)	112 (1.8)	115 (1.7)	163 (2.1)	239 (2.8)	114 (1.3)

Source: unpublished analysis from the NDTRS

The numbers treated for problem drug use and residing in the Health Service Executive (HSE) Eastern Region (Dublin, Kildare, Wicklow) increased by 23% between 1998 and 2003, while the numbers treated for problem drug use and residing in the seven health board areas outside the HSE Eastern Region increased by 197% during the same period (Table 4.3.2). The numbers treated for problem drug use and residing in the HSE Eastern Region are substantially higher than numbers treated for problem drug use residing outside the HSE Eastern Region. Of note, as a proportion of all treated problem drug users, the proportion living outside the HSE Eastern Region increased from 15% in 1998 to 29% in 2003; this suggests that drug misuse is becoming a problem outside this region.

Table 4.3.2 Number (%) of cases treated for problem drug use, by HSE area of residence, 1998–2003*

Area of residence	1998	1999	2000	2001	2002	2003
	Number (%)					
All cases	6048	6206	6933	7900	8596	9084
HSE Eastern Region	5083 (84.0)	5152 (83.0)	5323 (76.8)	5868 (74.3)	6248 (72.7)	6405 (70.5)
Seven HSE areas outside the HSE Eastern Region *	886 (14.6)	1031 (16.6)	1596 (23.0)	2024 (25.6)	2328 (27.1)	2629 (28.9)
Non-resident	10 (0.2)	12 (0.2)	9 (0.1)	7 (0.1)	9 (0.1)	3 (0.0)
Address unknown	69 (1.1)	11 (0.2)	5 (0.1)	1 (0.0)	11 (0.1)	46 (0.5)

*The seven HSE areas are the: Midland, Mid-Western, North Eastern, North Western, Southern, South Eastern and Western.

Source: unpublished analysis from the NDTRS

Main problem drug

The profile of main problem drugs reported by treated cases differed by place of residence (Table 4.3.3). Overall, 94% of treated cases residing in the HSE Eastern Region reported an opiate as their main problem drug, while almost 20% of treated cases residing outside the HSE Eastern Region area reported an opiate as their main problem drug. Just under 3% of treated cases residing in the HSE Eastern Region reported cannabis as their main problem drug, while just over 55% of treated cases residing outside the HSE Eastern Region reported this as their main problem drug. In both areas, the numbers reporting cocaine as their main problem drug increased but the increase is greater outside the HSE Eastern Region. It is important to note that cocaine is mainly reported as a second, third or fourth problem drug. The reason that cocaine was reported as an additional problem drug in 2003 is that 84% of cases

reporting cocaine use are attending opiate treatment services and service providers reported opiates as the treated drug user's main problem drug.

Table 4.3.3 Main problem drug reported by cases treated for problem drug use, by HSE area of residence, 1998–2003

Main problem drug	1998	1999	2000	2001	2002	2003
Number (%)						
HSE Eastern Region	5070	5152	5323	5868	6248	6405
Opiates	4652 (91.8)	4840 (93.9)	5031 (94.5)	5631 (96.0)	5921 (94.8)	6020 (94.0)
Cannabis	206 (4.1)	168 (3.3)	137 (2.6)	95 (1.6)	177 (2.8)	165 (2.6)
Benzodiazepines	57 (1.1)	27 (0.5)	56 (1.1)	57 (1.0)	42 (0.7)	63 (1.0)
Cocaine	56 (1.1)	32 (0.6)	47 (0.9)	43 (0.7)	73 (1.2)	134 (2.1)
Ecstasy	46 (0.9)	50 (1.0)	32 (0.6)	30 (0.5)	18 (0.3)	11 (0.2)
Amphetamines	24 (0.5)	18 (0.3)	2 (0.0)	4 (0.1)	1 (0.0)	2 (0.0)
Volatile inhalants	18 (0.4)	8 (0.2)	11 (0.2)	3 (0.1)	3 (0.0)	6 (0.0)
Other substances	11 (0.2)	9 (0.2)	7 (0.1)	5 (0.1)	13 (0.2)	4 (0.1)
Seven HSE areas outside the HSE Eastern Region	886	1031	1596	2024	2328	2629
Cannabis	419 (47.3)	553 (53.6)	933 (58.5)	1146 (56.6)	1334 (57.3)	1424 (54.2)
Opiates	160 (18.1)	181 (17.6)	241 (15.1)	397 (19.6)	490 (21.0)	637 (24.2)
Ecstasy	148 (16.7)	164 (15.9)	257 (16.1)	271 (13.4)	245 (10.5)	248 (9.4)
Amphetamines	48 (5.4)	42 (4.1)	28 (1.8)	17 (0.8)	29 (1.2)	34 (1.3)
Benzodiazepines	37 (4.2)	23 (2.2)	42 (2.6)	52 (2.6)	64 (2.7)	57 (2.2)
Cocaine	27 (3.0)	24 (2.3)	31 (1.9)	52 (2.6)	79 (3.4)	174 (6.6)
Volatile inhalants	17 (1.9)	24 (2.3)	30 (1.9)	37 (1.8)	43 (1.8)	23 (0.9)
Other substances	30 (3.4)	20 (1.9)	34 (2.1)	52 (2.6)	44 (1.9)	32 (1.2)

Source: unpublished analysis from the NDTRS

Substance use among young treated drug users

In Europe, adolescent substance misuse increased during the 1990s. Ireland has among the highest rates of substance misuse among schoolchildren in Europe. Smyth and O'Brien (2004) sought to describe the socio-demographic and drug-misuse profile of children presenting to addiction treatment services in Dublin during the 1990s. Of the 9,874 individuals who sought addiction treatment, 1,953 (20%) were aged less than 18 years. There was a sharp increase in the number of children seeking treatment after 1993. The main drug of abuse was an opiate in 48% of cases. Compared to adults, the children were more likely to be female and less likely to inject. As the decade progressed, the proportion of girls increased, injecting was reported more frequently and there was a dramatic rise in heroin misuse. Child heroin users were more likely to be female and to be homeless, compared to their adult counterparts. This study highlights the need for a dedicated service for child drug users in Dublin.

4.4 Main characteristics and patterns of use from non-treatment sources

Drug use among new communities in Ireland: An exploratory study

Corr (2004) carried out research to develop an understanding of problematic drug use among new communities in Ireland.

Three members from new communities (a Russian, a Romanian and a Nigerian) were recruited and trained in ethnographic fieldwork techniques. The recruits then carried

out 280 hours of fieldwork. The fieldwork included observing drug users in their own social setting and recording informal discussions with drug users and key informants; the data collected was recorded in a daily diary. In addition, 10 individuals from new communities who described themselves as problematic drug users participated in semi-structured in-depth interviews. Six of these interviewees were from Africa, three from the former USSR and one from Central/Eastern Europe. Also, the staff at Merchants Quay research unit organised two focus groups: one with individuals working with new communities in Ireland and one with drug service providers.

Of the 10 problem drug users who were interviewed, seven reported heroin and three reported cocaine as their respective drugs of choice. Five interviewees reported injecting heroin. In general, there were reports of drug injecting taking place among individuals from Russia, Estonia and Pakistan. As a rule, heroin users from Africa reported smoking heroin rather than injecting it. Some members of the Somali community were reported to be using Khat, a chewable green leaf stimulant, while some members of the Russian community were reported to make a special porridge called Kasha, which is laced with cannabis. None of the 10 were in treatment.

With respect to accommodation, seven were staying in emergency hostels; two were staying with friends and one lived in rented accommodation. Eight interviewees were unemployed and two in full-time employment. With respect to legal status, four were seeking asylum, four were undocumented immigrants, one was documented as a labour migrant and one had refugee status.

Issues of social exclusion were particularly prominent among the interviewees. Both interviewees and drug users encountered during the fieldwork cited escape from their current situation as a reason for continuing or initiating drug use. Their current experiences included feeling excluded, isolated and fearful of state authorities. Some reported using drugs to escape episodes of post-traumatic stress disorder arising from their experiences of war and torture prior to arriving in Ireland. Four interviewees had no history of problematic drug use prior to arriving in Ireland, while one had ceased using drugs for 10 years and had restarted in Ireland. Younger members of new communities were reported to use drugs as a means of mixing with and gaining acceptance from Irish peer groups, mainly in recreational settings such as clubs.

5. Drug-Related Treatment

5.1 Overview

This section presents new data on the treatment system and provides updated information on medically assisted treatment. The definitions used are presented where necessary in the relevant sections.

5.2 Treatment system

On 1 January 2005, the ten health boards managing the health services in Ireland were replaced by a single entity, the Health Service Executive (HSE), which will manage Ireland's public health sector (Health Act 2004). The Chief Executive Officer of the HSE is directly accountable to the Oireachtas for the performance and management of the HSE and the Department of Health and Children is responsible for legislation and policy. The former health boards were responsible for health care provision to populations in specific geographical areas. In the interest of continuity of care, the HSE has maintained these ten areas for an interim period and called them HSE areas. When the HSE has established itself and redeployed staff, health care will be provided through four HSE regions and 32 local health offices. This process commenced on 1 September 2005. The local health offices are based on the geographical boundaries of the existing community care areas. Table 5.2.1 presents the past health board structure, the present interim structure and the proposed future regional structure of the public health services in Ireland.

Table 5.2.1 The past health board structure, present interim structure and the proposed future regional structure of the public health services in Ireland

Regional Health Authority	Health boards	HSE areas	HSE regions	Local health offices/community care areas
Not applicable	North Eastern Health Board	HSE North Eastern Area	HSE	Cavan/Monaghan
Eastern Regional Health Authority (ERHA*)	Northern Area Health Board	HSE Northern Area	Dublin/North East Region	Louth Meath Dublin community care areas 6–8
Eastern Regional Health Authority (ERHA)	East Coast Area Health Board	HSE East Coast Area	HSE	Dublin community care areas 1–5
Eastern Regional Health Authority (ERHA)	South Western Area Health Board	HSE South Western Area	Dublin/Mid-Leinster Region	Wicklow Kildare
Not applicable	Midland Health Board	HSE Midland Area		Laois/Offaly Longford/Westmeath
Not applicable	South Eastern Health Board	HSE South Eastern Area	HSE Southern Region	Carlow/Kilkenny Wexford
Not applicable	Southern Health Board	HSE Southern Area		Waterford South Tipperary Four community care areas of Cork (North Lee, South Lee, North Cork, West Cork) Kerry
Not applicable	Mid-Western Health Board	HSE North Western Area	HSE Western Region	Donegal Sligo/Leitrim
Not applicable	North Western Health Board	HSE Western Area		Galway Mayo
Not applicable	Western Health Board	HSE Mid-Western Area		Roscommon Clare Limerick (part of) North Tipperary/East Limerick

*The ERHA is known as the HSE Eastern Region for the interim period

The Inter-Departmental Group (IDG) overseeing the implementation of the National Drugs Strategy expanded to include senior-level representation from the HSE. The mid-term review of the Strategy (Steering group for the mid-term review of the National Drugs Strategy 2005) also recommends that both the Department of Health and Children and the HSE be represented on the National Drugs Strategy Team (NDST).

In March 2005, the HSE published its National Service Plan for 2005, outlining how the HSE intends to deliver its drug treatment services (Health Service Executive 2005). The management of all addiction services will be under the remit of the Primary, Community and Continuing Care service delivery unit, which will oversee a number of national care groups. The national care group with specific responsibility for addiction services is Social Inclusion Services, but the management of methadone treatment services also appears under the remit of Primary Care Services and the management of detoxification also appears under the remit of Mental Health Services. Therefore, it is not clear who is responsible for which aspects of the addiction services at present. The HSE National Service Plan (NSP) for 2005 emphasises that responses to the needs of those dependent on drugs or alcohol require a partnership approach across organisational boundaries (including drugs task forces) together with clear strategies to prevent and reduce levels of drug or alcohol misuse and harm. The plan also endorses a needs-based approach to the delivery of services that minimises disadvantage.

A clear alignment with the National Drugs Strategy is established through the commitment made in the national service plan for 2005 to Action 22 of the national health strategy, *Quality and Fairness*, which states that all relevant actions in the National Drugs Strategy will be implemented by 2008 (Department of Health and Children 2001). Moreover, the national service plan for 2005 commits Addiction Services, within Social Inclusion Services, to providing six-monthly reports to the Department of Community Rural and Gaeltacht Affairs on the implementation of the National Drugs Strategy, supporting the Health Research Board (specifically the National Drug Treatment Reporting System), and implementing the research recommendations of the NACD. The NSP states that the HSE's Addiction Services will monitor the two key performance indicators that relate to timeliness of access to treatment services. The NSP was published prior to the mid-term review of the National Drugs Strategy and will be tailored in 2006 in light of the review findings.

The National Drugs Strategy identified seven key performance indicators to measure progress under the treatment pillar (Department of Tourism Sport and Recreation 2001). The mid-term review recommends that these be replaced by four new key performance indicators (Steering group for the mid-term review of the National Drugs Strategy 2005). The current key performance indicators monitor progress in relation to the provision of treatment places, prison-based treatment services, service user charters and rehabilitation. The number of treatment places for opiate addiction increased from 6,000 places by end 2001 to 7,390 places by end March 2005; this key performance indicator has been achieved. According to the mid-term review, a number of services have drafted service-user charters and this process will be completed by the HSE. Although the mid-term review recognised that more needs to be done, the prison services have developed an infrastructure for the delivery of methadone treatment and set up a number of drug-free units since 2001. The introduction of counselling services and the development of post-release arrangements for those requiring treatment or harm reduction services will be required in the future; this key performance indicator has been discontinued and the rationale for the removal of this indicator is not stated.

The key performance indicators on treatment have been revised to reflect the diversity of drug types and number of drugs used by those seeking treatment and requires that:

- 100% of problematic drug users will access appropriate treatment within one month after assessment.

A set of guidelines has been developed and agreed (published in September 2005) to guide the treatment of problem drug users aged under 18 years and the KPI has been replaced with a new indicator:

- 100% of problematic drug users aged under 18 will access treatment within one month after assessment

The two KPIs relating to treatment will be measured through the HSE's Addiction Services and the HRB's National Drug Treatment Reporting System.

The mid-term review of the National Drugs Strategy specified a number of actions for the HSE:

- an audit of the current availability of treatment options, including an assessment of treatment needs and methods of tracking ongoing developments, to be completed by mid-2006;
- increase the availability and range of drug-related treatment options, including detoxification;
- expand the provision of needle-exchange and harm-reduction services to ensure wider geographic availability and availability at evenings and weekends;
- increase the numbers of GPs and pharmacies participating in the methadone protocol.

Treatment is provided through a network of statutory and non-statutory agencies. There are two broad philosophies through which treatment services are provided, namely: medication-free therapy and medically assisted treatment. There is a small degree of overlap between the two. Medication-free therapy uses models such as therapeutic communities and the Minnesota Model, though some services have adapted these models to suit their particular clients' needs. Medication-assisted treatment includes opiate detoxification and substitution therapies, alcohol and benzodiazepine detoxification, and psychiatric treatment. Various types of counselling are provided through both philosophies of treatment and independent of either type of treatment. Alternative therapies, such as aquapuncture, are provided through some community projects in Dublin.

The total number of drug treatment services available in Ireland and participating in the NDTRS increased between 1998 and 2003 (Table 5.2.2). The largest increase was in outpatient treatment services. In the HSE Eastern Region, counsellors employed by statutory services did not consistently return information on cases who received counselling only, therefore there is an under-representation of cases in this region treated for use of drugs other than opiates. There was a small decrease in the number of residential treatment services. Though only 31 (10%) general practitioners provided returns to the NDTRS in 2003, there were 205 general practitioners prescribing methadone treatment in Ireland during December 2003. The prison service does not participate in the NDTRS, although it does provide drug treatment services.

Table 5.2.2 Number and type of services providing treatment for problem drug use and number of cases treated (in brackets) in Ireland and reported to the NDTRS, 1998 to 2003

Drug services	1998	1999	2000	2001	2002	2003
Outpatient	83 (4566)	86 (4497)	105 (5583)	120 (6688)	124 (7270)	135 (7576)
Residential	17 (1272)	16 (1005)	18 (796)	16 (725)	21 (798)	17 (911)
Low-threshold*	3 (182)	4 (284)	2 (280)	2 (216)	2 (149)	3 (259)
General practitioner	1 (24)	42 (413)	29 (274)	32 (271)	28 (371)	31 (323)
Treatment in prison	2 (4)	2 (7)	0 (0)	0 (0)	0 (0)	1 (11)
Not known	0 (0)	0 (0)	0 (0)	0 (0)	1 (8)	0 (0)

*Low-threshold services are services that provide low-dose methadone or drop-in facilities only.
Source: unpublished data from the NDTRS.

Action 49 of the National Drugs Strategy 2001–2008 identified the need to develop a protocol for treating under-18-year-olds presenting with serious drug problems (Department of Tourism Sport and Recreation 2001). A working group established in October 2001 published its report in September 2005 (Working Group on treatment of under 18 year olds 2005). The working group reviewed the extent of the problem and noted that ‘attendances by children account for a substantial proportion of the workload of the addiction services in Ireland’. The group considered the legal and ethical issues surrounding the treatment of persons under 18 years old presenting with serious drug misuse problems. The group acknowledged the difficulties experienced by service providers, particularly in relation to consent and family involvement. They noted that the current legislation allowed persons aged 16 to 17 years to consent on their own behalf to certain treatments. However, there appeared to be some doubt as to whether the courts would accept that such consent would apply to drug treatment. In this context, it was felt that the concept of Gillick competence, whereby professionals could assess whether a young person was competent to give informed consent, could play an important role. The working group recommended that, where possible, the family be involved in treatment as this leads to better outcomes. The group stated that substitution treatment should not be initiated outside a specialist context. The working group believed that the four-tiered model developed by the Health Advisory Service in the UK, adapted as necessary to an Irish context, would best deliver effective services to young people presenting with problem drug use. This approach would ensure that the services provided would be based on the specific needs of the child and their family; provide a full range of drug-related education, prevention and treatment interventions; and be competent to deal with the complex ethical and legal issues surrounding such interventions. The four tiers were:

- Tier 1 Generic services provided by teachers, social services, gardaí (police), general practitioners, community and family groups for those at risk of drug use. Generic services would include advice and referral.
- Tier 2 Services with specialist expertise in either adolescent mental health or addiction, such as juvenile liaison officers, local drugs task forces, home–school liaison, youthreach and drug treatment centres. The types of service delivered at this level would include brief intervention, counselling and harm reduction.
- Tier 3 Services with specialist expertise in both adolescent mental health or addiction and the capacity to deliver a combination of treatments through a multi-disciplinary team.
- Tier 4 Services with specialist expertise in both adolescent mental health and addiction and the capacity to deliver a brief, but very intensive intervention through an inpatient or day hospital.

The working group agreed that the services would be adolescent-specific, local and accessible, have a combination of disciplines on site, and offer assessment, treatment

and aftercare. In addition to the extra resources required to address the needs of these young people, it was suggested that greater co-ordination could maximise the impact of existing services.

5.3 Drug-free treatment

There is no new published information on drug-free treatment.

5.4 Medically assisted treatment

Approximately one-quarter of those who ever use heroin will develop dependence. In Ireland, opiate dependence is classified using the *International Classification of Diseases and Related Health Disorders, Tenth Revision* (WHO 1992). The Code F11.2 describes an opiate-dependent client as one with 'a strong desire to take opiates, difficulties in controlling their use, persistence in their use despite harmful consequences, a higher priority given to opiate use than to other activities and obligations, increased tolerance and physical withdrawals'. Medically assisted treatment is also used to manage persons with alcohol or benzodiazepine dependence and similar definitions apply.

Detoxification

Three inpatient units and a number of outpatient treatment centres provide detoxification for problem opiate and benzodiazepine users in Ireland. Inpatient treatment centres generally provide detoxification and early rehabilitation on a short-term basis (2 to 12 weeks). Methadone is the most commonly used drug for opiate detoxification; in recent years buprenorphine and lofexidine have also been used to detoxify opiate users in treatment centres in this country. Subutex® has been authorised for use in opiate dependence in Ireland since late 2002, but there is no combination of buprenorphine and naloxone treatment currently authorised. On completion of inpatient and outpatient detoxification, a number of clients go on to residential or non-residential after-care programmes. Of the 9,084 cases reported to the NDTRS in 2003, 803 (9%) attended an opiate or benzodiazepine detoxification service.

Smyth *et al.* examined the medium-term follow-up outcomes of 109 patients attending an inpatient opiate detoxification programme between July 1995 and December 1996; five patients died following discharge and 109 (76%) of the remaining 144 admissions were interviewed (Smyth *et al.* 2005b). The outcomes were ascertained through one interview (at between 18 and 42 months) following discharge from the inpatient opiate detoxification programme. The interview determined recent opiate use and asked about pre-treatment and treatment adherence characteristics. Of the 109 patients interviewed, 25 (23%) reported using neither opiates nor prescribed methadone recently. After controlling for confounding factors, opiate abstinence was found to be significantly associated with completion of an inpatient treatment programme (Odds ratio 4.1, 95% CI 1.4–11.9), persistence with aftercare (Odds ratio 7.6, 95% CI 2.3–25.3) and the absence of a family history of substance misuse (Odds ratio 3.3, 95% CI 1.1–9.9).

Opiate substitution

Methadone maintenance involves the daily administration of methadone (an oral opioid agonist) as a treatment for opiate dependence. In Ireland, methadone is the opiate substitute of choice for maintenance therapy (Methadone Treatment Services Review

Group 1998). The aim of methadone maintenance therapy is to replace illicit opiate use with a licit oral medication in order to provide the individual with a stable lifestyle and reduce the harms associated with problem opiate use. Methadone is taken once per day because its long duration eliminates withdrawal symptoms for between 24 and 36 hours. Given in high doses it reduces the craving for heroin and blocks the euphoric effects of heroin if the two drugs are taken together.

Policy and protocols

In 2002, the Department of Health and Children requested the Methadone Prescribing Implementation Committee to review the Methadone Protocol that was introduced in October 1998. The published review was released in June 2005 (Methadone Prescribing Implementation Committee 2005).

According to the review, there were 6,883 people receiving methadone treatment in Ireland at the end of December 2003.

As part of the review, submissions were invited from interested parties and 46 submissions were received in September 2002. The submissions were analysed to identify themes and recommendations were made to address the themes identified.

The themes identified through the submissions were:

- **Breadth of representation on the Methadone Prescribing Implementation Committee**

A number of submissions identified the need to invite onto the committee representatives from the community, service users, the voluntary sector, the Drug Treatment Centre Board, the former area health boards and the Irish Psychiatric Association. The committee will invite representatives of the Drug Treatment Centre Board, the former area health boards and the Irish Psychiatric Association to sit on the committee.

- **Revising aspects of the regulations**

Several submissions requested revisions to the prescribing of methadone. None of these suggestions were taken on board as it would mean re-writing the regulations.

- **Clients' experiences of methadone treatment services**

Clients attending methadone treatment programmes requested that all clients should participate in their treatment plan, stable clients should not need to attend weekly, individual appointment times should be given to clients, clients continuing to use drugs chaotically should be treated separately from more stable clients, and the issue of privacy with respect to urinalysis should be addressed. The committee recommended that it would be more appropriate to address these issues through the service users' charter in each HSE area.

- **Issues pertaining to general practitioners**

A number of submissions stated that there is a need to take a co-ordinated approach to methadone treatment outside the HSE Eastern Region and to increase the recruitment of level 1 and level 2 general practitioners throughout the country. The committee will review the role of the National General Practitioner Co-ordinator to ensure greater support to the areas outside the Eastern Region. A small number of general practitioners requested an increase in the number of clients that a practitioner is permitted to treat. The committee will deal with such requests on an individual basis. It was suggested that training on treating opiate misuse be included in undergraduate and postgraduate medical training. In addition, it was suggested that specialist

methadone training should continue and that completion of such training should be one of the criteria for General Medical Service posts in deprived areas. These ideas were welcomed by the committee and will be recommended to the relevant authorities. It was also suggested that general practitioners be given the resources to comply with the requirements of the NDTRS. Such compliance is a condition of the general practitioners' contract negotiated in 2003.

- **Issues pertaining to pharmacists**

Pharmacists requested joint training with other health professionals, which the committee considered a useful suggestion. The need to increase the recruitment of pharmacists was raised. The committee recommended the employment of a liaison pharmacist for the HSE areas outside the Eastern Region. Some pharmacists requested routine hepatitis B vaccination; this is available free from the HSE to all participating pharmacists and their staff. Pharmacists and clients raised the issue of security and privacy in pharmacies. The committee reported that these issues were outside their remit as they had resource implications, and noted that grants were available through the HSE for upgrading premises. Some pharmacists reported that a regular client might present to a pharmacy without a prescription, giving rise to a dilemma for the pharmacist: to follow the regulations, or to fulfil the duty of care to the client. The committee took a pragmatic view, stating that the pharmacist should provide the previously prescribed treatment, document the experience and ensure the client sought an up-dated prescription as soon as possible. Actions should be taken to prevent its occurrence if this practice is repeated on a regular basis.

- **Co-ordination between services and continuity of care for clients**

According to the text of the submissions, the lack both of co-ordination between psychiatric services and drug treatment services and of continuity of care between prison services and drug treatment services needed to be addressed. The committee agreed with these statements and welcomed the establishment of a national committee to develop protocols for transfer of clients between the prison services and the HSE. The committee stated that structures should be developed to ensure that clients on methadone treatment who require psychiatric treatment are not at a disadvantage.

- **Guidelines for the management of young drug users**

Guidelines for the management of opiate users aged under 18 years were requested; these were published by the Department of Health and Children's working group in September 2005 (see Section 5.2).

There were 19 recommendations in the review of the Methadone Treatment Protocol, of which 12 were completely implemented by the end of 2004, four were almost completely implemented and the remaining three required some further work. The three requiring further work related to service provision, including the range of services, the link between treatment services and general practitioners, and pharmacists' contracts.

In addition, a review of counselling services in Counties Dublin, Kildare and Wicklow was completed in 2004. This has not been released to date.

6. Health Correlates and Consequences

6.1 Overview

This section presents new data on the incidence of drug-related mortality, and on the incidence and prevalence of blood-borne viruses. The definitions used are presented where necessary in the relevant sections.

6.2 Drug-related deaths and mortality of drug users

In June 2005, the Health Research Board published an overview of drug-related deaths in Ireland (Long *et al.* 2005a). The data presented in this publication describe what is known about drug-related deaths and deaths among drug users in Ireland between 1990 and 2002. The analysis presented is based on data reported to the General Mortality Register, and on ad hoc studies that extracted data from the coroners' records, the Central Treatment List, and the HIV/AIDS surveillance system, and on an epidemic investigation.

In Ireland, the Central Statistics Office (CSO) collates data on drug-related deaths extracted from the General Mortality Register (GMR). The Registrar of Births, Deaths and Marriages formally records all notified deaths in each jurisdiction. Depending on the circumstances, deaths are notified by the Coroner Service, hospitals or general practitioners. In addition, if the gardaí are investigating a death on behalf of the Coroner Service, they provide supplementary information related to the death to the CSO. Using data from the GMR, the CSO then categorises the cause of each death using the World Health Organization (WHO) diagnostic coding manual on the international classification of diseases (known as ICD categories) (WHO 1977). The ninth revision of the ICD manual continues to be used in this country. To date, in Ireland, the annual number of drug-related deaths is taken to be the aggregate total number of deaths recorded under the ICD-9 category 304, which relates to 'a death by drug dependence', plus those recorded under ICD 9 code 965.0, which refers to 'poisoning by opiates and related narcotics'. Using these definitions, the CSO extracts the numbers of drug-related deaths (along with demographic information) and provides them to the DMRD at the HRB. At the European level, the EMCDDA has developed a standardised method for extracting drug-related deaths from the GMRs in all member states (EMCDDA 2002a). This standardised method selects certain drug-related death categories and is known as 'Selection B'. The broad diagnostic categories and codes included in 'Selection B' are: drug psychoses (292), drug dependence (304.0, 304.2-9), non-dependent drug abuse (305.2-3, 305.5-7, 305.9), accidental poisoning (E850.0, E850.8-9, E854.1-2, E855.2, E855.9, E853.2, E851, E852, and E858.8-9), suicide and self-inflicted poisoning (E950.0-5), and poisoning with intent undetermined (E980.0-5). The substances causing death must be specified. For GMRs using ICD-9, the number of poisoning deaths (E-codes) must be extracted in combination with nature of injury codes (N-codes). The national definition from 2005 onwards will be the EMCDDA's selection B.

The main findings are:

- Between 1990 and 1994, there was a small but steady increase in the number of drug-related deaths, from 7 to 19, reported by the GMR in Ireland (Figure 6.2.1). Between 1995 and 2000, there was a substantial increase, from 43 to 119, and in 2001 there was a considerable decline (to 88) in the number of drug-related deaths. In 2002, the number of drug-related deaths increased

marginally (to 91) when compared to 2001. The data trend follows the curve of the opiate epidemic in Ireland. Detailed data are presented in Standard Tables 5 and 6.

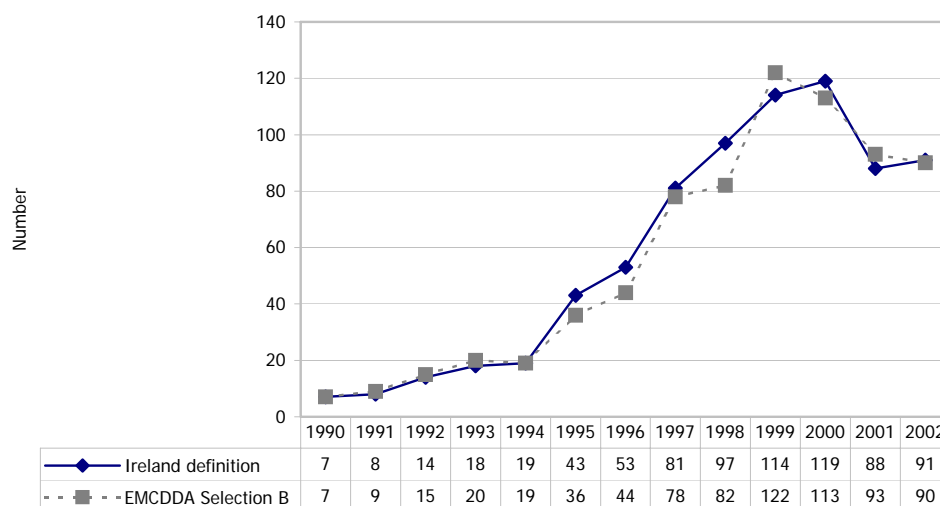


Figure 6.2.1 Number of direct drug-related deaths in Ireland, by national and by European definition, reported by the CSO, 1990 to 2002 (unpublished data from the vital statistics)

- According to data from the GMR, almost all drug-related deaths between 1991 and 1994 occurred in Dublin (Figure 6.2.2). Between 1995 and 2000, there was a substantial increase in drug-related deaths in Dublin, from 39 to 90, and a steady increase outside the Dublin area, from 4 to 29. In 2001, there was a sharp decrease in the number of drug-related deaths in Dublin (to 55) and a continued increase outside Dublin (to 33 in 2001 and 35 in 2002). These data follow trends in treated problem opiate use in Dublin and outside Dublin.

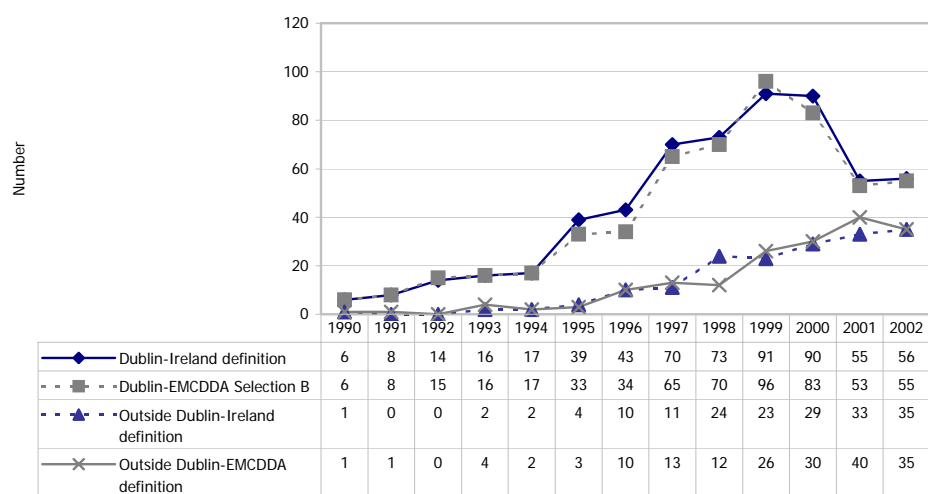


Figure 6.2.2 Number of direct drug-related deaths in Ireland, by national and by European definition and by place of death, reported by the CSO, 1990 to 2002 (unpublished data from the vital statistics)

- From 1998 to 2001, the annual numbers of opiate-related deaths extracted by Byrne (2002) from the Dublin coroners' records were consistently higher than those reported by the GMR. These variations may be related to differences in the definition of opiate-related deaths applied in each case. The GMR considers opiate-related deaths to be those occurring as a direct result of opiate use, while Byrne investigated all the coroners' cases that tested positive for opiate use and so included a broader range of opiate-related deaths.
- Opiate-related deaths account for the largest proportion of deaths among drug users in Ireland. The review of coroners' cases found that polysubstance use was common among drug users who had died.
- According to both the GMR and Byrne's review of coroners' data (Byrne 2001, 2002) those who died as a result of drug use were older than their counterparts in treatment, indicating an increased risk with age. As expected, more men than women died.
- Following a review of the Dublin coroners' cases, Byrne reported that 13% of drug-related deaths were associated with imprisonment or recent release from prison.
- Injecting drug use is associated with infection and subsequent mortality.
- Deaths as an indirect result of drug use are not systematically documented and have been assessed only in small-scale studies in Dublin. The findings of these studies indicate an underestimate in opiate-related deaths but provide little information on other drug-related deaths. A system is required to document drug-related deaths and deaths among drug users.

6.3 Drug-related infectious diseases

In 2004 and 2005, there have been a number of publications, which update or advance our knowledge of blood-borne viruses among drug users in Ireland.

Important changes to infectious disease legislation were introduced in Ireland on 1 January 2004. The Infectious Disease Regulations 1981 were amended to establish a revised list of notifiable diseases and, for the first time, their causative pathogen (Statutory Instrument No. 707 of 2003 2003). As part of the revised legislation, laboratory directors as well as clinicians are required to report the named notifiable diseases. The changes to the list of notifiable diseases are consistent with a European Commission Decision on communicable diseases (European Commission Decision 2000/96/EC 2000). Hepatitis B was already classified as a notifiable disease but the inclusion of laboratory directors as a source of notification will increase the number of notifications. There are no data by risk factor status. Hepatitis C occurs mainly in two populations in Ireland: cohorts of individuals who became infected through infected blood and blood products, and injecting drug users. As part of the revised legislation on 1 January 2004, hepatitis C is now specified as a notifiable disease. The inclusion of hepatitis C as a notifiable disease (from 2004 onwards) will provide important data on new cases of hepatitis C in the general population but will not specify risk populations (such as injecting drug users).

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1985. By the end of 2004 there were 3,764 diagnosed HIV cases in Ireland, of which 1,203

(32%) were probably infected through injecting drug use (Health Protection Surveillance Centre 2005). In 2004, there were 365 newly diagnosed cases reported to the Health Protection Surveillance Centre, of which 71 (20%) were infected through injecting drug use (Figure 6.3.1). This represents an increase on the numbers of new HIV cases among injecting drug users in 2002 (50) and 2003 (49). Of the 71 new HIV cases, 44 were male and 27 were female and the average age was 30.1 years. Of the 64 cases for whom place of residence was known, 60 lived in the HSE Eastern Region. The authors of the report highlighted the need to continue to promote the use of harm-reduction measures among injecting drug users.

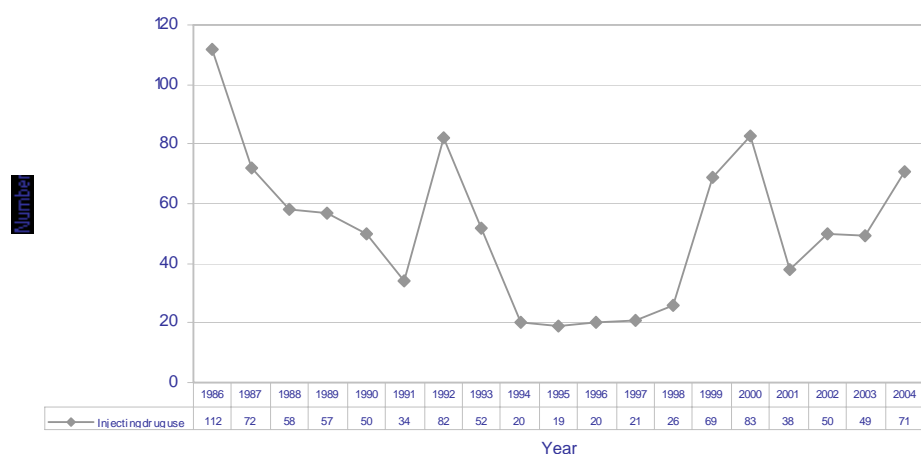


Figure 6.3.1 Number of new cases of HIV among injecting drug users by year of diagnosis reported in Ireland, 1986 to 2004 (adapted from Kelly and Clarke 2000; National Disease Surveillance Centre 2002, 2003, 2004; Health Protection Surveillance Centre 2005)

Grogan *et al.* (2005) assessed the uptake of screening for blood-borne viruses and hepatitis B vaccine among 358 heroin users attending 21 drug treatment clinics in the HSE South Western Area up to December 2001. In addition, the authors estimated the prevalence and incidence of blood-borne viruses in this cohort. A one-in-four systematic sample of clients prescribed methadone in the 21 drug treatment clinics in the HSE South Western Area in December 2001 was selected from the Central Treatment List. The data were collected from the clinical records and Table 6.3.1 presents a summary of the findings: of note, 66% tested positive for hepatitis C, 17% for hepatitis B core antigen, 2% for hepatitis B surface antigen and 11% for HIV. These results are in line with results from a study in a similar setting. The authors point out that the results were ascertained from clinical records and pertain only to those documented in the clinical records examined, the tests were collected over an extended time period and those testing negative at their first test may have subsequently sero-converted and not have had a repeat test. In addition, injector status was not ascertained and the authors acknowledge that the proportion of injectors testing positive for each virus would be much higher.

Using a cross-sectional survey method, O’Sullivan (2004) assessed the prevalence of blood-borne viruses among a cohort of 90 injecting drug users attending an opiate substitution programme at the Drug Treatment Centre Board. The sample size was estimated using a wide 10% level of precision and 95% level of confidence. He obtained adequate blood samples from 65 of the 90 clients interviewed. The main findings were: 72% tested positive for hepatitis C, 17% tested positive for hepatitis B, no respondent tested positive for hepatitis B surface antigen and 12% tested positive for HIV. These results are in line with results from a study in a similar setting.

Table 6.3.1 Uptake of blood-borne viral screening and prevalence and incidence of such infections in treated heroin users (n=358) in the HSE South Western Area up to the end of 2001

Blood-borne viruses	Tests for	Purpose of test	Number (%) screened	Number (%) tested positive at end of period	Number tested negative at first test	Number re-tested	Number (%) re-tested that acquired infection since first test	Incidence rate in person years (95% CI)
Hepatitis C	Antibodies to the hepatitis C viruses	Appears 3–6 months after initial infection and indicates previous or current infection	316 (88%)	207 (66%)	120	27	11	24.5 (12.2-43.8)
Hepatitis B	Antibodies to hepatitis B core antigen (Anti-HBc IgG)	Appears 1–2 months after initial infection and indicates a naturally acquired infection with the hepatitis B virus	244 (68%)	42 (17%)	205	18	3	9.0 (1.9-26.3)
	Hepatitis B surface antigen (Anti-HbsAg)	Appears 1 months following exposure and a continued presence for six months or more indicates a carrier status	299 (84%)	6 (2%)				
	Anti-HBs	Indicates a vaccine induced immunity or a full recovery from infection	Of the 177 clients who completed a course of hepatitis vaccine, 134 (76%) were tested	114 were denoted as having a vaccine induced immunity				
HIV	Antibodies to HIV	Ever been infected with HIV	307 (86%)	33 (11%)	278	59	4	3.4 (0.9-8.7)

In another published study, Keating *et al.* (2005) estimated the proportion of hepatitis C positive individuals with each genotype in an intravenous drug-using cohort, and then estimated the proportion that spontaneously cleared the hepatitis C virus. The study followed the progress of 496 hepatitis C antibody positive individuals attending five drug treatment centres in Dublin. None of this cohort had tested positive for hepatitis B or HIV.

Of the 299 PCR positive samples that had their genotype determined, genotype 1 and 3 were the most common (Table 6.3.2). The PCR test detects whether the virus is still in the blood and will show if a person has an ongoing infection.

Table 6.3.2 Number of PCR-positive samples by genotype of selected hepatitis C antibody positive individuals attending five drug treatment centres in Dublin

Genotype	Number (%)
	Total =299
1	146 (48.8%)
2	6 (2.0%)
3	145 (48.5%)
4	2 (0.7%)
5	0 (0.0%)
6	0 (0.0%)

Of the 496 hepatitis C positive participants in the sample, 191 (38.5%) were shown to be HCV RNA negative when re-tested, indicating that they had spontaneously cleared the virus. A higher proportion of women (47.4%) than men (34.5%), $p < 0.01$, cleared the virus spontaneously. A higher proportion of those with a history of jaundice (12.0%) than those who reported no history of jaundice (7.9%), $p < 0.01$, cleared the virus spontaneously. Age and duration of injecting drug use was not associated with spontaneous hepatitis C virus clearance. The rate of spontaneous viral clearance was higher than previously reported.

Smyth *et al.* (2005a) examined the contribution to infection with hepatitis C of unsafe injecting practices and the social context of injecting in Dublin. Of the 242 participants who completed the questionnaire, 159 had a test for hepatitis C. The analysis was based on the 159 that were tested for hepatitis C. Of those tested, 61% tested positive for hepatitis C. After controlling for other factors, the authors found that an increased number of lifetime injections increased the risk of hepatitis C. For example, those who had injected more than 1,000 times were almost nine times more likely to test positive for hepatitis C than those who injected less than 100 times. In relation to the social context, individuals who injected in the home of another injecting drug user were almost five times more likely to test positive for hepatitis C than those who injected in their own home or another place. Those individuals who injected in the company of close friends and family members were around three times more likely to test positive for hepatitis C than those who injected with acquaintances.

Cullen *et al.* (2005) examined the experience of heroin users attending general practice with respect to risk practices for, investigation of, and treatment for hepatitis C through in-depth interviews. The questionnaire had a mix of closed and open questions. At the time of the study, 38 former or current heroin users were registered with the practice. Of these, 25 (66%) agreed to be interviewed. Those interviewed were more likely to be female and older than the other heroin users attending the practice. At the time of the study, 23 of the 25 participants were receiving methadone maintenance (14 at the practice and nine at specialised drug treatment centres). Twenty-two participants said that they had tested positive for hepatitis C, of whom 15 had consumed alcohol in the week prior to the study. Nine consumed more than the recommended amount for their gender. Of note, eight reported neither drinking excessively nor using heroin in the previous six months and were therefore suitable for investigation. Only four of the eight suitable clients were referred for further investigations and one had commenced treatment. The respondents identified 'not sharing needles', 'adopting safe sexual practices' and 'not using drugs' as ways to avoid hepatitis C transmission. Those respondents who reduced their alcohol intake did so because they were concerned about their health, while those who increased their alcohol intake did so to substitute for heroin. Some respondents had a negative perception of liver biopsy, though those who had undergone this investigation reported that the procedure was not as difficult to tolerate as expected. Many respondents had negative perceptions of antiviral treatment. The experience of treatment by medical and nursing personnel at secondary treatment services was mixed, with some having very positive experiences while others reported that the service providers were impersonal and withheld

information. The authors concluded that there were a number of barriers to hepatitis C treatment for injecting drug users and these need to be addressed so as to encourage uptake of treatment.

There are three main, naturally occurring, epidemiological types of botulism: food-borne, intestinal colonisation (infant botulism) and wound botulism. The neurological signs and symptoms are the same for all three types and may include respiratory paralysis. Wound botulism is caused by growth of cells and release of toxin *in vivo*, is associated with traumatic wounds and abscesses and has been reported in drug users, such as those injecting heroin or sniffing cocaine. Up to the end of 1999 there were no confirmed cases of wound botulism in the UK (Brett *et al.* 2004). Between January 2000 and the end of December 2002, there were 33 clinically diagnosed cases of wound botulism in the UK and Ireland. All cases had injected heroin into muscle or by 'skin popping'. The clinical diagnosis was confirmed by laboratory tests in 20 of these cases. Eighteen cases were caused by type-A toxin and two by type-B toxin.

6.4 Psychiatric co-morbidity

Figure 6.4.1 presents the rate of first admissions among those aged 16 years or over to inpatient psychiatric services with a diagnosis of drug dependence, per 100,000 of the population in Ireland between 1990 and 2003. It is notable that the rate increased steadily over the reporting period and was almost four times higher in 2001 than it was in 1990, with a subsequent fall in 2002 and 2003. The analysis presented in the National Psychiatric In-Patient Reporting System (NPIRS) does not comment on the possible explanations for this trend but indicates that more of those with drug dependence are treated through the addiction services (Daly *et al.* 2004).

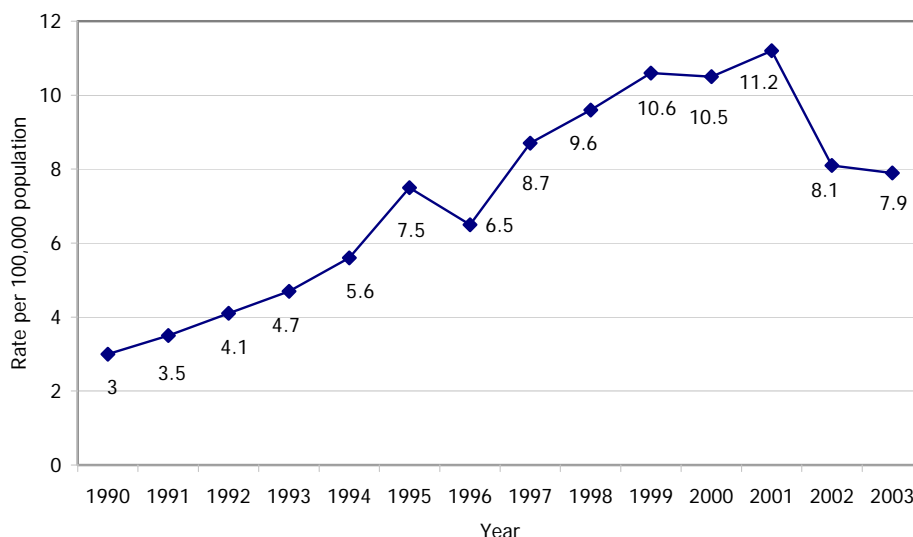


Figure 6.4.1 Rate of psychiatric first admissions aged 16 years or over with a diagnosis of drug-dependence (using the ICD-10 three character categories) per 100,000 of the population in Ireland and reported to the NPIRS, 1990 to 2003

There were no new data published on numbers with psychiatric and addiction co-morbidity.

6.4 Other drug-related health correlates and consequences

There are no new data published in this area in 2004 and the first half of 2005.

7. Responses to Health Correlates and Consequences

7.1 Overview

This section presents new data on responses to drug-related mortality, blood-borne viruses and psychiatric co-morbidity. The definitions used are presented where necessary in the relevant sections.

7.2 Prevention of drug-related deaths

Overview of harm-reduction approaches in Ireland

The NACD commissioned Moore and colleagues at Dublin City University to review the international evidence for harm-reduction approaches and the availability of such approaches in Ireland (Moore *et al.* 2004). This section will concentrate on the part of that review that profiled harm-reduction services in Ireland. For the purpose of the review, a harm-reduction approach was defined as one 'that focuses on reducing the harm that substance misusers do to themselves and their families.' The aim of such approaches was 'to reduce the transmission of HIV, hepatitis and other infectious diseases and to maximise service users' health'. The harm-reduction approaches asked about in the study were needle exchange (including types of injecting equipment distributed), methadone maintenance, replacement drugs, smoking or snorting pipes, and provision of information on safer injecting. Methods to prevent or manage overdose were not specifically examined in the study, nor was the availability or uptake of hepatitis B vaccine.

With assistance from the regional drug co-ordinators and area operations managers, a purposeful sample of services and key informants (n=16) was chosen to take part in a thirty-minute telephone interview. The telephone interview was administered using a pre-tested questionnaire containing a combination of open and closed questions. Of the 16 service providers interviewed, nine worked in the Eastern Regional Health Authority (ERHA) area and one from each of the remaining seven health boards. Three informants from outside the ERHA reported that their work did not include harm reduction with drug users who used paraphernalia to administer drugs and these interviews were discontinued at that stage. It was unusual that three participants selected in a purposeful sample had no experience of working with injecting drug users, since such drug users live and are treated in each health board area. This limited the researchers' ability to provide a national picture.

The nine service providers working in the ERHA area reported working with injecting drug users, mainly opiate users. In addition, three service providers worked with cocaine users. Some service providers also reported treating cases reporting problem benzodiazepine use. According to service providers outside the ERHA area, the main problem substances were alcohol, cannabis and ecstasy.

All services providers in the ERHA area reported that methadone maintenance and one-for-one needle-exchange facilities were available in their area. With the exception of filters, all other types of injecting equipment were provided to clients attending these services. Half of the service providers in the ERHA area reported that filters were not available at their service. In contrast, service providers outside the ERHA area stated that methadone maintenance was the mainstay of their harm reduction services and no injecting equipment was distributed. Pipes were not provided at any service in Ireland.

All service providers in the ERHA area and a tiny minority outside the area reported providing information on specific injecting techniques and care of an injection site. The service providers in the ERHA area also advised clients on safer smoking and polydrug use.

With respect to health promotion practices, the majority of service providers in the ERHA area said that their services provided information and demonstrations on safer injecting practices in line with current evidence. The authors do not report whether such information was provided by services outside the ERHA area.

On a national basis, the vast majority of service providers reported that the main purpose of harm-reduction approaches was to reduce the harm that drug users did to themselves. Some service providers reported that harm-reduction services reduced the transmission of infectious diseases. Two services providers mentioned that harm-reduction services were a pathway to other health care services. Half of the health service providers in the ERHA area reported that these services promoted safer injecting practices.

All service providers reported similar vulnerable groups, such as women, children and homeless clients. In addition, service providers reported that priority groups included polydrug users, those with mental illness, and those testing positive for HIV. It is interesting to note that those testing positive for hepatitis C were not regarded as a priority or vulnerable group. Yet, it is accepted that hepatitis C is common among injecting drug users, that co-infection between hepatitis C and HIV leads to more aggressive liver disease, and that individuals with co-infection have a poorer prognosis than those with a single blood-borne viral infection.

All of the service providers in the ERHA area and half of those outside it reported that specific issues, such as blood-borne viruses, localised bacterial infections at injection sites and sexual health, were addressed in their programmes. It is not clear from the research the extent to which these issues were addressed.

According to the service providers both in and outside the ERHA area, services were normally available without appointment and were mainly provided during office hours, with a small number opening in the evenings (in the ERHA) and at weekends (methadone services outside the ERHA). The service providers said that the main means of advertising was by word of mouth. Services were also advertised through published directories and posters in clinics.

All service providers reported either formal or informal links with other health and social care services. Many reported working closely with persons from the criminal justice system. The service providers in the ERHA area reported links with self-help groups.

In general, service providers in the ERHA area reported that policy did translate into practice, although the majority stated that there were occasions when they had to 'bend the rules' to facilitate patient care. In contrast, the majority of service providers outside the ERHA area reported that policy did not translate into practice, and unofficial practices occurred at one service, in that needles, syringes and condoms were distributed.

The service providers in the ERHA suggested a number of developments to improve the current service, such as:

- expansion of outreach work
- greater access to low threshold services
- increased variety of needle-exchange outlets

- adaptation of current services to deal with cocaine
- provision of respite houses
- greater inter-agency collaboration.

The service providers outside the ERHA area requested:

- an increase in resources
- clear policies and structures with respect to needle exchange and methadone maintenance
- evidence-based practice in relation to harm reduction interventions
- strategies to reduce waiting lists for treatment
- community-focused outreach services.

National Drug-Related Deaths Index

A National Drug-Related Deaths Index is to be set up in Ireland in order to comply with Action 67 of the National Drugs Strategy (Department of Tourism Sport and Recreation 2001). The Drug Misuse Research Division of the Health Research Board was requested to set up this index by the Department of Health and Children and the Department of Justice, Equality and Law Reform in February/March 2005. The index will be a census of drug-related deaths and deaths among drug users in Ireland. The number of drug-related deaths and deaths among drug users is one of the EMCDDA's key indicators to measure the consequences of the drug situation. The protocol for the data collection, validation and analysis is the *EMCDDA Scientific Report: The DRD Standard Version 3* (EMCDDA 2002a). This was developed and validated by European experts. In order to ensure a complete and accurate index it is necessary to use data from several sources. The data sources are: the Coroner Service, the General Mortality Register, the General Registrar's Office, the Central Treatment List and the Hospital In-Patient Enquiry Scheme. Since June 2005, the Health Research Board has employed two researchers to work on the register.

Emergency services can administer naloxone

On 9 August 2005, the Minister of State at the Department of Health and Children introduced a new Statutory Instrument, the Medical Products (Prescription and Control of Supply) (Amendment) Regulations 2005 (Statutory Instrument No. 510 of 2005 2005). This permits the supply of a number of medicinal products (including naloxone, for the management of respiratory depression secondary to a known or suspected narcotic overdose) to pre-hospital emergency care providers. This medication can be administered by advanced paramedics in accordance with clinical procedure guidelines or following a medical practitioner instruction. In addition, emergency technicians may administer naloxone in accordance with a medical practitioner instruction. This will improve the speed of response to narcotic overdoses.

7.3 Prevention and treatment of drug-related infectious diseases

Mid-term review of the National Drugs Strategy

For the first time in Ireland specific performance indicators on harm reduction have been introduced. These are:

- Harm-reduction facilities available, including needle exchange where necessary, open during the day, and at evenings and weekends, according to need, in every local health office area; and

- Incidence of HIV in drug users stabilized, based on 2004 figures.

The second of the two new harm reduction indicators is based on an increased number of HIV cases among drug users in 2004 (see section 6.3).

Hepatitis B vaccine

In Ireland hepatitis B vaccine is recommended for several high-risk groups; prisoners and injecting drug users are two of the high-risk groups named in the guidelines (National Immunisation Advisory Committee 2002).

Hepatitis B vaccine is free to all injecting drug users attending drug treatment centres, but is not necessarily free to all injecting drug users attending general practice. The vaccine has become easily available at drug treatment centres but is more difficult to access at general practice. In general, doctors caring for injecting drug users in the general practice setting must order an individual dose of vaccine for each injecting drug user they intend to vaccinate. Those injecting drug users without a medical card must pay for the vaccine. This militates against opportunistic vaccination, which is considered an important strategy to achieve a high level of immunisation in a vulnerable group. The coverage of hepatitis B vaccination for injecting drug users is not monitored on a continuous basis; the coverage estimates presented in this section were taken from *ad hoc* studies at treatment centres. Grogan *et al.* (2005) reported that 81% of 316 clients for whom the hepatitis B vaccine was indicated had commenced a course of this vaccine and 177 (56%) had completed at least three doses. O'Sullivan (2004) reported that 86% of those for whom the vaccine was indicated tested positive for anti HBs which indicates in this case a vaccine induced immunity. The uptake and completion rates of hepatitis B vaccine are much higher in these cohorts than those reported in prisoners or at general practice in Ireland between 1998 and 2001.

Consensus guidelines on managing persons at risk of or infected with hepatitis C

The Dublin Area Hepatitis C Initiative Group developed consensus guidelines on the management of hepatitis C in general practices located in the Eastern Region (Dublin Area Hepatitis C Initiative Group 2004). The guidelines were produced in five stages: identification of key stakeholders; development of evidence-based draft guidelines; discussion of content; reaching consensus using the Delphi method; and review of guidelines by a sample of general practitioner users. The guidelines are presented in a logical format by key aspects of care and include:

- General aspects of care cover the means of transmission and actions to protect yourself and others;
- Prevention or care of other blood-borne or other hepatotoxic viruses, which include hepatitis A and B vaccination;
- Screening for and presentation of hepatitis C test results, which include pre-test counselling, post-test counselling and explaining hepatitis results;
- Initial management of patients infected with hepatitis C, which includes means of transmission, alcohol and drug use, nutrition, vaccination and weight reduction (where necessary);
- Subsequent management of patients with hepatitis C, referral to a hepatology service, conditions for treatment and information required by the hepatology service.

Consultation towards developing a regional hepatitis C strategy

The findings of a consultation event held in June 2004 involving service users, service planners and a wide range of health and social care professionals and organised to assess the health and social care requirements for those with or at risk of acquiring hepatitis C were released in December 2004 (Hepatitis C Scientific Advisory Subgroup of the Blood Borne Virus Forum and the Eastern Regional Health Authority 2004). The method used in the consultative process was 'open space technology'. 'Open space' is a qualitative methodology used to enable a large and diverse group of people to explore complicated issues in a limited time by presenting participants with central themes. Organic and self-organising, the participants set a detailed agenda and subsequently facilitate qualitative discussion at impromptu workshops. The contents of the discussions are simultaneously documented. The central themes, presented in the invitation to this event, were: 'What are the significant issues in formulating a region-wide policy on hepatitis C' and 'What are the optimum approaches to these issues?'

Over 70 people attended the event, among them service planners, health and social care professionals and service users. With respect to the first of the central themes, the participants identified the issues they would like on the agenda on the morning of the event.

The participants identified 16 significant issues and a workshop was organised for each issue. A small group discussion took place on each topic and a workshop facilitator recorded the issues raised during the discussion. These data were subsequently analysed using qualitative methods.

Four common themes emerged from the 16 workshops:

- Health promotion

There is a need to develop a set of consistent messages on modes of transmission, pathways to treatment and success of treatment, with such messages delivered through a variety of media.

- Role of the media

Another need was to ensure that the mass media provides accurate information to the general public and high-risk groups. It was suggested that the media use an approach that allays fears and reduces the stigma associated with the infection.

- Service provision

It was noted that access to and availability of services to prevent or treat hepatitis C should not be associated with mode of transmission. There is a need for equivalence of care between several groups, for example, those who acquired their infection through blood products *versus* injecting drug users; those who live in Dublin *versus* outside Dublin; and those in prison *versus* those in the community. The information about, criteria for and pathways to treatment should be transparent and easily accessed. Expansion of nursing and psychology services to support those testing positive for hepatitis C is required.

- Research, policy and planning

In general, the participants emphasised the importance of an extended surveillance system to ascertain the extent of the problem but stressed that such a system must protect the identity of the individual. Participants also wanted research to develop best-practice protocols (including medical and complementary therapies) to manage this infection.

In the afternoon session, the process was repeated to explore optimum approaches to the themes identified in the morning. Eight actions were identified and a workshop was organised to deal with each action. A number of common themes emerged from the second set of workshops:

- **Peer support and prevention**
The importance of using peer groups in planning and developing prevention, harm reduction and treatment interventions was stressed. Peer-group insight and experience were considered very useful in ensuring that new approaches would be appropriate. It was also suggested that indicators would be developed to monitor and evaluate prevention and harm reduction interventions.
- **Education and training**
The actions suggested were in line with the health promotion actions identified in the morning session.
- **Liaison, key workers, co-ordination and collaboration**
A number of suggestions were made, including appointment of key workers (such as liaison nurses); development of transparent communication policies and procedures; improvement in access to services through multi-agency collaboration; and introduction of a core monitoring group to ensure client-centred services.
- **Accessing services**
Developments to make services more accessible and user-friendly were identified as a priority.
- **Psychological and complementary therapies**
Respondents thought that psychological support and complementary therapies, in conjunction with medication, would be very beneficial to a client's quality of life.

The event represented an ongoing collaboration between two groups – the Hepatitis C Scientific Advisory Subgroup of the Blood Borne Virus Forum (a group of health and social care professionals with an interest in hepatitis C and related issues) and the HSE Eastern Region. At the launch of the report in December 2004, the ERHA presented its response to the findings and its plans for the future. The findings of the open space event are being used to help inform the forthcoming HSE Eastern Region's hepatitis C strategy. It was indicated that a group convened to formulate a regional strategy on hepatitis C intends to audit the health services available to those with hepatitis C and actively to provide information on service availability and identify models of best practice both nationally and internationally. This strategy will be published in late 2005 or early 2006.

7.4 Interventions related to psychiatric co-morbidity

Management of individuals with psychiatric and addiction co-morbidity

In 2002, the NACD commissioned a team at Dublin City University to explore the management of individuals with a combination of mental illness and substance misuse in Ireland. The definition of dual diagnosis used for this study was 'the co-existence of both mental health and substance misuse problems for an individual'. Two distinct groups of service providers treat patients with combinations of such illnesses, the mental health services and the addiction services.

The report by MacGabhann *et al.* (2004) was launched on 1 November 2004. In order to review the management of dual diagnosis in Ireland, the researchers:

- Reviewed relevant national and international literature to identify the most appropriate methods of assessment, treatment and management of such illnesses.
- Organised an open forum in one geographical area with a representative group of stakeholders (n=58/60, 97%). This included service users, mental health and addiction service providers, social service providers and representatives from the police. Participants considered the findings of the literature review in the context of their personal experience of dual diagnosis. The proceedings were documented and the transcriptions were analysed and themes were identified.
- Carried out a national postal survey in order to provide a national overview of service provision for dual diagnosis in Ireland. This survey also ascertained attitudes towards and opinions about the place of dual diagnosis in Irish health services. A stratified sample by occupation and county of employment was selected. The participants were managers, clinicians and other service providers (n=141/191, 74%). The questionnaire consisted of 35 questions.
- Completed face-to-face semi-structured interviews with 10% of the respondents to the national survey (n=14) to explore the key findings. The responses were taped and transcribed.

A number of key themes were identified during the open forum:

- Respondents found it difficult to conceptualise, define and assess the severity of dual diagnosis.
- Policy development to date did not recognise dual diagnosis.
- The general practitioner was the first point of contact and the main service provider.
- Clients experienced stigmatisation, discrimination and marginalisation at addiction and mental health services.
- Services were not always client centred, sometimes normal practices overrode client needs.
- It was difficult for clients to access services.
- Few formal structures and protocols were provided to guide staff.
- Application of evidence-based practice varied.
- There was inadequate communication and liaison between services.
- Clients were lost in the gaps between the addiction and mental health services.
- Professionals working in addiction services were educated separately to those working in mental health services.
- Differences in the professional cultures of the two services led to conflicting beliefs and practices.
- There were difficulties in respecting professional care and treatment provided by the 'other' service.
- Multi-disciplinary approaches were more effective than single-discipline approaches.
- A variety of service models exist, mainly serial, sometimes parallel and occasionally integrated.

These themes were used to develop the questionnaire for the national survey.

The main findings of the national survey were:

Over one-fifth of service providers reported that policies to address dual diagnosis were available in their area. The examples cited by respondents indicated that these policies address aspects of dual diagnosis rather than dual diagnosis itself. None of the plans or service reviews submitted to the researchers addressed the specific issue of dual diagnosis. Over two-fifths of service providers reported that formal and informal structures existed in their area, with more in addiction services (56%) than in mental health services (33%). In theory, one-fifth of respondents thought refusing treatment to people with dual diagnosis was justified. In practice, a large proportion of providers in the addiction (58%) and the mental health (43%) services reported that exclusion criteria applied to people with a dual diagnosis. The source of referral differed between the mental health services and addiction services. The mental health services accepted referral through general practitioners only, while the addiction services accepted referrals from a wide variety of sources (including self-referrals).

In relation to assessment, 93% of respondents thought routine screening should be in place and 66% reported that they always assessed clients for dual diagnosis. Sixty-three per cent of respondents agreed with the statement, 'Clinical staff in my service are adequately trained to assess dual illnesses', and 71% strongly agreed with the statement, 'Our service identifies clients with dual diagnosis'. According to the service providers, dual diagnosis is recorded for 37% of cases. No respondent used a validated tool to assess dual diagnosis.

There is some ambiguity in relation to the recognition and treatment of dual diagnosis, evidenced by the lack of service structures and the extent of exclusion criteria. For example, 92% of respondents from mental health services reported that they treat people with substance misuse problems, yet 43% of respondents reported exclusion criteria applied to people with a dual diagnosis. Seventy-one per cent of respondents reported that they do not follow recommended models of treatment and 39% of respondents agreed with the statement, 'Clinical staff in my service are adequately trained to treat dual diagnosis'.

Overall, the responses indicated that there was little systematic co-ordination of care for people with dual diagnosis evident in any health board area; only 18% of services offered a specific service. There were at least three models of service provision in operation: a parallel model (52%), an integrated model (29%) and a serial model (16%), although three-quarters of survey respondents agreed with the statement, 'A fully integrated service is the best way to help people with dual diagnosis'.

Respondents reported that 76% of services had formal communication links with other services, while 54% had informal communication links. Respondents were generally content with the level of communication between addiction and mental health services, though this was strongly influenced by those who had responsibilities across both service areas. According to the authors, a higher proportion of respondents from the addiction services disagreed with the statement, 'Communication between addiction and mental health services is adequate to treat dual diagnosis' than the proportion of their counterparts in the mental health services, ($p < 0.03$).

There was consensus throughout the study that GPs should be involved in the management of people with dual diagnosis.

It is clear that a published national strategy is required to deal with individuals who have both drug addiction and psychiatric illness. In practice, there is a need to:

- formalise referral procedures between the mental health services and the addiction services;
- reconsider exclusion criteria;
- use valid assessment tools;
- develop and expand the small number of evidence-based dual diagnosis services in existence;
- provide appropriate treatment for psychiatric illness and problem drug use, regardless of the treatment provider or setting.

In order to improve responses, further research is required to estimate the prevalence of dual diagnosis, to ascertain the needs of persons with dual diagnosis and to define the role of primary care professionals in the management of these combined conditions.

7.5 Interventions related to other health correlates and consequences

There are no new publications in this area in 2004 and the first half of 2005.

8. Social Correlates and Consequences

8.1 Overview

This section highlights the association between social exclusion and problematic drug use by reporting on research among the homeless population, a small group of homeless heroin users, a small group of women with experience of prostitution and members from new communities in Ireland. In relation to drug-related crime, this section will report data on drug offences where criminal proceedings commenced and also on trends in such offences by offence drug type. We also report on new research in relation to cocaine and a major new study by An Garda Síochána on the relation between drugs and crime. No new information is available in relation to drug use in prison.

8.2 Social exclusion

Research among the homeless and a small group of homeless heroin users revealed that drug use is a major contributory factor to becoming and remaining homeless. In addition, it would seem that experiences of homelessness contribute to changes in drug-using patterns, with an escalation in problematic drug use and episodes of risk-taking around sharing injecting paraphernalia being reported. Such practices can exacerbate the experience of being homeless and create further obstacles between individuals and services. Similarly, the women with experiences of prostitution highlight the risks involved in using drugs while engaging in sex work, and the exclusionary nature of some drug treatment policies against the women. Members of new communities report using drugs to cope with experiences of isolation and exclusion, including unemployment and living in emergency accommodation. This section will include a brief sketch of the four research reports, looking at the research aims, methods and key findings.

Homelessness

Research carried out on behalf of the Tallaght Homeless Advice Unit (2004) explored the issues, policies and practices faced by homeless heroin users from Tallaght that contributed to their becoming and remaining homeless. Tallaght is a large Dublin suburb with an estimated population of 150,000. Data-collection methods included interviews with 17 service users of the Tallaght Homeless Advice Unit (Female = 8; Male = 9).

The profile of interviewees reveals a pronounced experience of social exclusion and social problems. Eleven were experiencing homelessness at time of interview,³ while 15 were on a methadone-maintenance programme. The eight women interviewees had 17 children between them; the nine men had fathered 10 children between them. Sixteen children were aged 4 years or under; seven were aged between 4 and 8 years; and four were aged between 8 and 11 years. Key findings of the research were:

- All respondents had experience of intravenous drug use, with heroin and cocaine the main drugs being injected.
- A majority reported that their drug use contributed to their initial homeless experience. Over half reported that their families were unable to cope with their

³ Homelessness at time of interview included accommodation in B&B (3), hostel (2), relatives/friends (1), rough sleeping (3), transitional housing (3) and family home (1)

drug use, while evictions under anti-social behaviour legislation and relationship breakdown were cited as additional factors leading to homelessness.

- Most agreed that their drug use helped to sustain their experience of homelessness and created a barrier to moving out of homelessness, e.g. all but one reported being evicted from hostels and B&Bs because of drug-related incidents.
- Some reported that becoming homeless greatly exacerbated their drug use. For example, the transition to using heroin intravenously was strongly associated with moving into the homeless scene, particularly when frequenting emergency hostels and sleeping rough.
- Repeatedly, interviewees identified the lack of accommodation for homeless people in Tallaght as a factor in exacerbating their drug use, as travelling into the city centre to access emergency accommodation increased the likelihood of involvement in the 'drug scene'.
- Some interviewees reported that residing in the same B&B premises for more than a three-month period enabled them to stabilise their drug use and ensure their children attended school
- Emergency hostels were clearly identified by all as the primary risk accommodation associated with chaotic use of drugs. All repeatedly stated that their drug use escalated in hostels, and most associated emergency hostels with their most chaotic periods in terms of drug use.
- Almost a quarter reported suicide thoughts while using drugs; five reported heroin overdose resulting in hospitalisation. Injecting heroin was associated with feelings of being out of control around drugs.

Lawless and Corr (2005) carried out the first drug prevalence study among the homeless population in Ireland on behalf of the NACD. A total of 355 individuals experiencing homelessness were surveyed using quota sampling, a non-probability technique aimed at producing a representative sample without a random selection of cases. Sample characteristics included: 69% (n=244) male and 31% (n=111) female, with a mean age of 35 years. Hostel (50%), B&B (19%) and rough sleeping (16%) were reported as the most common homeless accommodation types. The majority of the respondents were dependent on government benefits. The research revealed some important insights into the lives of homeless drug users under a number of headings.

Prevalence of drug use

- Seventy-four per cent reported lifetime use of an illicit drug, with cannabis the most frequently reported lifetime drug (69%).
- Forty-three per cent reported cannabis as the primary illicit drug of current use, with 22% currently using heroin.
- Seventy-two per cent of current drug users reported use of more than one drug, and 26% of rough sleepers reported the use of five drugs or more.
- Higher rates of current heroin use (34%), current cocaine use (25%) and current use of crack (7%) were reported among those sleeping rough, than among hostel dwellers and B&B occupants.
- Eighteen per cent reported current use of methadone; 28% of this group had not been prescribed methadone.

Risk behaviour associated with drug use

- Changes in drug-using patterns as a result of becoming homeless were reported by 77% of current users. For example, initiation into drug use (for a minority), changes in primary drug and routes of administration, increased frequency/quantity, and associated lifestyle behaviour changes were cited.

- Thirty-five per cent of the total study population reported having injected drugs; 19% reported injecting heroin in the last month. 52% of current heroin users were daily users.
- Fifty-four per cent of current injectors were street injectors, with males more likely to report injecting in public places.
- Forty-six per cent of respondents reported that they usually injected alone, with males significantly more likely to report this behaviour.
- Only 26% of current injectors reported not experiencing an injecting-related difficulty in the three months prior to interview, with males significantly more likely to report no difficulty. On the other hand, 71% of current injectors reported scarring and bruising of an injecting site, 32% reported abscesses or infections of site, while 20% reported accidental overdose in the three months prior to interview.
- Fifty-three per cent of current injectors reported sharing injecting paraphernalia in the previous four weeks with 23% reporting lending injecting equipment and 17% reporting borrowing.

Physical and psychiatric health

- Fifty-one per cent of problematic drug users were hepatitis C positive, compared to 23% of the total study population.
- Problematic drug users reported higher rates for the majority of physical health complaints than was found among the total study population.
- Problematic drug users were proportionally less likely to report having a medical card compared to the total study population
- Problematic drug users were proportionally more likely to report psychiatric health concerns than their non-problematic drug-using counterparts.

Service provision for homeless drug users

- Almost a third of current drug users staying in emergency accommodation reported difficulties accessing such services due to their drug use
- Few of the homeless services interviewed have official policies on illicit drug use or possession and dealing.
- The general perception among service providers was that homeless services do not adequately meet the needs of homeless drug users. Service providers highlighted the lack of move-on options from emergency accommodation for homeless drug users.
- The results would indicate that problematic drug users were more likely to experience problems accessing homeless services and more likely to be refused access to homeless services compared to the total homeless population.

Personal drug use (n=67; 19%) was cited as the second most common reason for becoming homeless. Eighty-seven per cent of those experiencing homelessness first used drugs before becoming homeless.

School drop out (early school leavers)

Long *et al.* (2005b) report that 25.3% of all cases reported to the NDTRS in 2002 were early school leavers (left school before the age 15 years). This showed a slight reduction from 27.4% in 2001 and 28.2% in 2000. Regarding new treated cases, 18.2% reported leaving school before the age of 15, again showing a reduction from 21.1% in 2001 and 20.1% in 2000.

Drug use among sex workers

TSA Consultancy, on behalf of Ruhama a voluntary organisation working with women in prostitution, conducted research in Dublin over a 14-month period between 2003 and 2004 with 19 women with experience of working in prostitution (TSA Consultancy 2005). The aim of the research was to develop a model of intervention to support women involved in prostitution to access the social economy, community education or local employment. The research was based on the participatory research model. Fourteen of the women participated in more than one interview, with the majority of the women interviewed five times.

Most of the women had engaged with the services of Ruhama for a number years and were keen to explore ways of taking further steps away from their experience of prostitution. For some of the women, this experience included additional problems of alcohol and drug use. For example, when engaged in active prostitution, some of the women reported being 'out every night' to support a drug habit and a pimp. The women were also aware of the dangers of not being fully alert due to the effects of alcohol and drugs and the inherent risks involved with prostitution.

The research identified drug and alcohol use as primarily a survival mechanism for some of the women. For example, they would habitually get drunk or stoned or use prescription drugs in order to work, and then use drugs and alcohol 'to numb the pain' of prostitution. The authors report that for women working in prostitution, the need to maintain strict boundaries between their private and public selves is an extremely important psychological tool for survival. However, for some of the women in this research, the use of drugs acted against this separation and 'mixed it all up'. In addition, when some of the women tried to access drug treatment services, their experience was that the existing policies that services had in place was a major barrier to moving on.

Drug use among new communities in Ireland

Merchants Quay Ireland (MQI) carried out exploratory research with the aim of developing an in-depth understanding of problematic drug use among new communities (Corr 2004). The research highlighted the association between social exclusion and problematic drug use among some members of new communities in Ireland,

Three members from new communities - Russian, Romanian and Nigerian - were recruited and trained in ethnographic fieldwork techniques. Fieldwork included semi-structured in-depth interviews with 10 individuals from new communities who identified themselves as problematic drug users. Four of the 10 reported no history of problematic drug use prior to arriving in Ireland, while one had ceased drug use for 10 years and had restarted in Ireland. Six interviewees were from Africa, three from the former USSR and one from Central/Eastern Europe.

Seven interviewees reported heroin and three reported cocaine as their respective drugs of choice. Five reported injecting heroin and indicated that the sharing of injecting equipment was prevalent. There were also reports of injecting drug use among individuals from Russia, Estonia and Pakistan. It was reported that injecting practices tended to be minimal among individuals from Africa, who tended to smoke heroin. Members of the Somali community were reported to be using Khat, a chewable green leaf stimulant, while members from the Russian community were reported to make a special porridge called Kasha, laced with cannabis.

Interviewees and other drug users met during fieldwork cited escapism from their current situation as a reason for continuing their drug use. Their current experiences included feeling excluded, isolated and fearful. Some reported using drugs to escape episodes of post-traumatic stress disorder that resulted from experiences of war and torture prior to arriving in Ireland. It was reported that younger members of new communities used drugs as a means of mixing with and gaining acceptance from Irish peer groups, mainly in recreational settings such as clubs.

Seven interviewees were staying in hostels, two were staying with friends and one in private rented accommodation. Eight were unemployed and two in full-time employment. Four were seeking asylum, four were undocumented immigrants, one was documented as a labour migrant and one had refugee status. The majority expressed an interest in accessing treatment for their drug use but highlighted a number of barriers that prevented their engaging with services. For example:

- There was scant knowledge of methadone-maintenance programmes, and some were persuaded by their Irish peers to treat methadone with skepticism as it was perceived to be as addictive as heroin.
- Those with knowledge of methadone maintenance reported waiting lists and the assessment procedure as barriers to uptake.
- Many associated treatment with abstinence and were unaware of harm-reduction approaches (only two used a needle exchange).
- Promotional material on treatment services is rarely available in languages other than English.
- Some felt uncomfortable with the idea of 'group therapy' where the majority of participants were Irish;
- Treatment options were poor, and few addressed cocaine problems.
- Fear of being stigmatised by drug workers and fear of services reporting clients' drug use to the state authorities were reported as significant barriers.

8.3 Drug-related crime

Drug offences

Data are routinely published in the Garda annual reports for both 'headline' and 'non-headline' offences, on the number of cases in which criminal proceedings commenced. The terms 'headline' and 'non-headline' in relation to drug offences were first used in the Garda report for 2000 and replaced the previously used terms 'indictable' and 'summary'. An offence is termed indictable or summary by the statute that creates it. In general, a summary offence is less serious than an indictable one. Summary offences are heard in the District Court by a judge without a jury. Indictable offences are tried in front of a jury. Using the Garda report for 2003, the most recent year for which data are available, we will now consider the outcome of specific drug offences where criminal proceedings commenced (An Garda Síochána 2004).

Table 8.3.1 Headline drug offences which became known to the gardaí in 2003

Headline Offences 2003	Cultivation or manufacture of drugs	Importation	Obstruction under Drugs Act	Possession of drugs for sale or supply	Totals	
Offences reported or known to the gardaí	74	35	304	2302	2715	
Offences detected	74	31	288	2302	2695	
Offences in which criminal proceedings commenced	56	10	172	1406	1644	
Results of proceedings in cases dealt with on indictment	Convictions	0	2	1	32	35
	Acquittals	0	0	0	5	5
	<i>Nolle prosequi</i> entered	0	1	0	5	6
	Committed for trial and still awaiting trial	0	7	1	30	38
Results of proceedings in cases dealt with summarily	Convictions	8	2	32	156	198
	Dismissals	3	0	21	69	93
	Charge proved and order made without conviction	0	0	0	4	4
	Still pending in District Court	2	9	67	481	559

Source: Annual Report of An Garda Síochána 2004

Table 8.3.1 presents the outcomes for the headline offences which became known to the gardaí in 2003. A total of 2,715 headline offences were reported to, or became known to, the gardaí in 2003. The figure in 2002 was 2,979.

Of the 1,644 headline drug offences for which criminal proceedings commenced in 2002, 46 were dealt with on indictment with a further 38 are still awaiting trial. A total of 295 were dealt with summarily, with a further 559 still pending in the District Court. In 2003, of those cases dealt with on indictment, 35 resulted in a conviction and 5 in an acquittal. Of the cases dealt with summarily, 198 resulted in a conviction and 93 were dismissed. The data presented in Table 8.3.1 does not provide information on the outcome for 706 of the 1,644 offences where criminal proceedings commenced in 2003.

The vast majority of drug offences that come before the courts are dealt with summarily in the District Court. Table 8.3.2 presents the non-headline offences where proceedings commenced as reported in the annual Garda report for 2003.

Table 8.3.2 Non-headline drug offences where proceedings commenced in 2003

Non-headline offences 2003	Proceedings commenced	Convictions	Dismissed/withdrawn	Pending
Unlawful possession, Section 3 MDA	4805	775	192	1051
Forging or altering a prescription	80	6	0	49
Other	36	1	5	7
Totals	4921	782	197	1107

Source: Annual Report of An Garda Síochána 2004

The majority of non-headline drug offences where proceedings commenced in 2003 are for possession or 'simple possession' (s3, Misuse of Drugs Act 1977). Of the 7,150 drug offences, both headline and non-headline, reported in the Garda annual report and in which proceedings commenced in 2003, 67% were for Section 3 offences.⁴ It can also be noted from the two above tables that, of the total number of drug offences in which proceedings commenced, both headline and non-headline, the vast majority (98.7 %) were disposed of summarily, with only 84 cases being dealt with on indictment. Also, of the 4,921 non-headline drug offences where criminal proceedings commenced in 2002, whereas there were 782 convictions, 197 were dismissed or withdrawn and 1,107 are still pending, the data are silent on the outcome of the remaining 2,835 cases in which proceedings commenced.

The vast majority of drug offences reported in the annual Garda reports come under Section 3 MDA 1977, which prohibits possession of any controlled drug without due authorisation (simple possession), Section 15(1) MDA 1977 concerns the possession of a controlled drug for the purpose of unlawful sale or supply (possession for sale or supply) and Section 21 MDA, 1977 deals with obstruction. Other offences regularly reported on relate to the unlawful importation into the State of controlled drugs contrary to Section 21(2) of the MDA 1977; permitting one's premises to be used for drug supply or use contrary to Section 19(1) of the MDA; the use of forged prescriptions; and the cultivation of cannabis plants.

The use *per se* of drugs, excluding opium, is not a criminal offence in Ireland. The distinction between use and possession can lead to confusion in this area. Drug consumption or use refers to the mere use of illicit substances, and is separate from illicit acts such as possession, cultivation, transportation or supply. Although, in practice, it would be impossible to use a substance without possessing it, some legal systems make this distinction, prohibiting drug use as a specific offence. Figure 8.3.1 shows trends in possession, supply and total drug offences since 1993.

⁴ Data on drug offences are presented both in a statistical table and in a specific chapter on drug offences. However, there is a discrepancy in the total number of offences as presented in different sections. When we look at the tables above, the total headline and non-headline offences in which proceedings commenced is 6,565. However, the figure presented on page 79 of the report is 7,150.

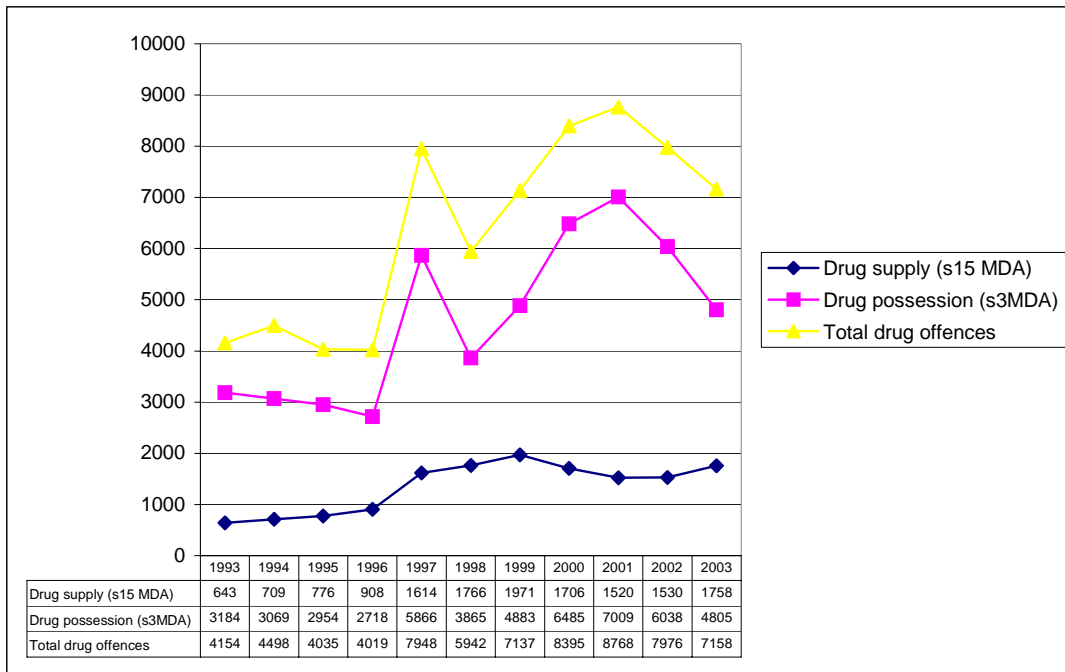


Figure 8.3.1 Trends in possession (s3MDA), supply (s15 MDA) and total recorded drug offences 1993–2003 (from annual reports of An Garda Síochána 1993–2003)

Following a slight decline in the number of drug offences prosecuted between 1994 and 1996, there was a sharp increase in such prosecutions in 1997. This is explained by a 116 % increase in simple possession offences during 1996. In 1998, such offences decreased again sharply.⁵ From 1998 to 2001 the number of simple possession offences prosecutions again increased sharply, from a total of 3,865 such offences in 1998 to 7,009 in 2001. Drug supply offences increased steadily from 1993 until 1999. Between 1999 and 2001 supply offences decreased slightly. Since 2001, the number of prosecutions for drug supply has been on an upward trend. This is in contrast to simple possession offences which have decreased by 31.5% since 2001.

It is unlikely that the increase in prosecutions for possession during 1997 is due to an increase in the incidence of such offences relative to other years. There are a number of possible explanations for the dramatic increase in the number of drug offence prosecutions during 1997. Firstly, it can be seen from Figure 8.3.2, which shows trends in other drug offence prosecutions, that there was also a sharp rise in the number of obstruction-related prosecutions (s21 MDA) in that year. Trends in the prosecution of drug offences other than possession and supply do not show any particular pattern. (O'Mahony 2004) suggests, in relation to obstruction offences, that 'the fluctuating number of charges for obstruction suggests that this represents an approach to law enforcement that tends to go in and out of fashion amongst the Garda'.

⁵ Before 1998, the data in the Garda reports relating to offence type presented the number of persons prosecuted in respect of each offence rather than the number of offences. As the same person can be charged with a number of offences in the same year, it can be assumed that the total offences should generally be a larger figure. However, a primary counting rule used in the compilation of statistics is the primary offence rule, which states that 'where two or more criminal offences are disclosed in a single episode it is the primary offence which is recorded'. For an explanation see Garda Síochána (2002) *Annual Report* p.142.

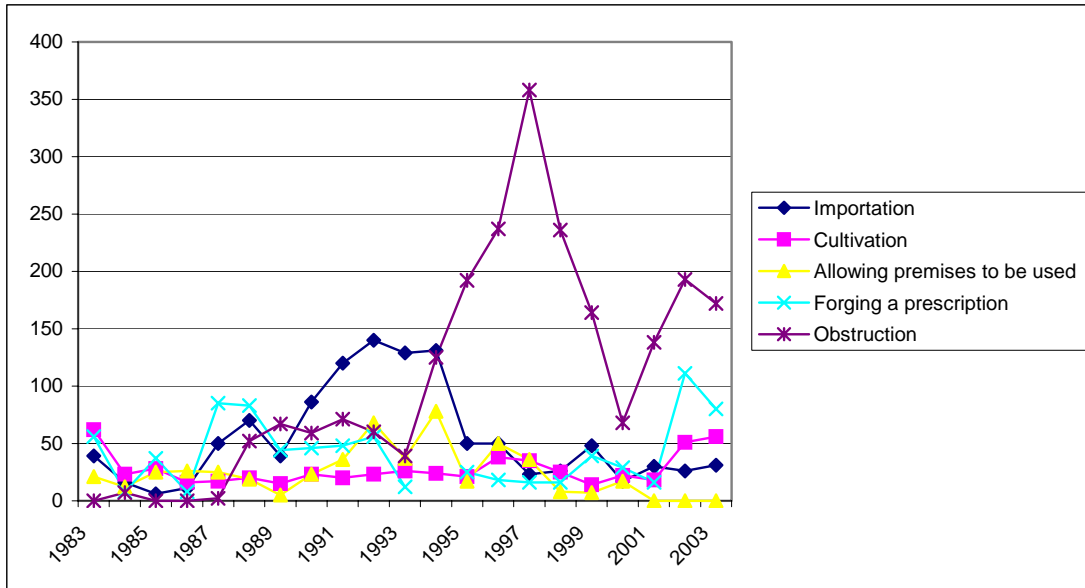


Figure 8.3.2 Selected MDA drug offences where proceedings commenced, 1983–2003 (possession s3 and supply s15 offences excluded) (from annual reports of An Garda Síochána, 1983–2003)

Secondly, the GNDU was established in 1995 and this concentration of dedicated Garda resources to drug law enforcement is likely to have had a fairly immediate impact on crime figures. Thirdly, the upsurge in anti-drug community activity in the mid-1990s following a number of drug-related deaths in inner city Dublin is likely to have led to pressure on the gardaí to respond proactively (Lyder 2005). Fourthly, the increase may also be related to pressure brought about to enforce cannabis laws following the murder of journalist Veronica Guerin in July 1996 by a gang which featured prominently in the importation of cannabis.

The total number of drug offences where criminal proceedings commenced decreased by just over 10% in 2003. However, a larger proportion of these (25%) were for drug dealing (s15 MDA) than in the previous year (19%). In 2003, 67% of the offences where criminal proceedings commenced were for simple possession (s3 MDA). In 2002, 76% of offences were for possession.

Figure 8.3.3 shows trends in drug offences where criminal proceedings commenced, by drug type, between 1995 and 2003. It can be seen that the majority of drug offence prosecutions are cannabis related. In 2003, cannabis-related prosecutions accounted for 57.6% of the total number of drug-related prosecutions. There has been a steady increase in cannabis-related prosecutions since 1996, despite a brief downturn in 1998. Cannabis related prosecutions decreased in 2003.

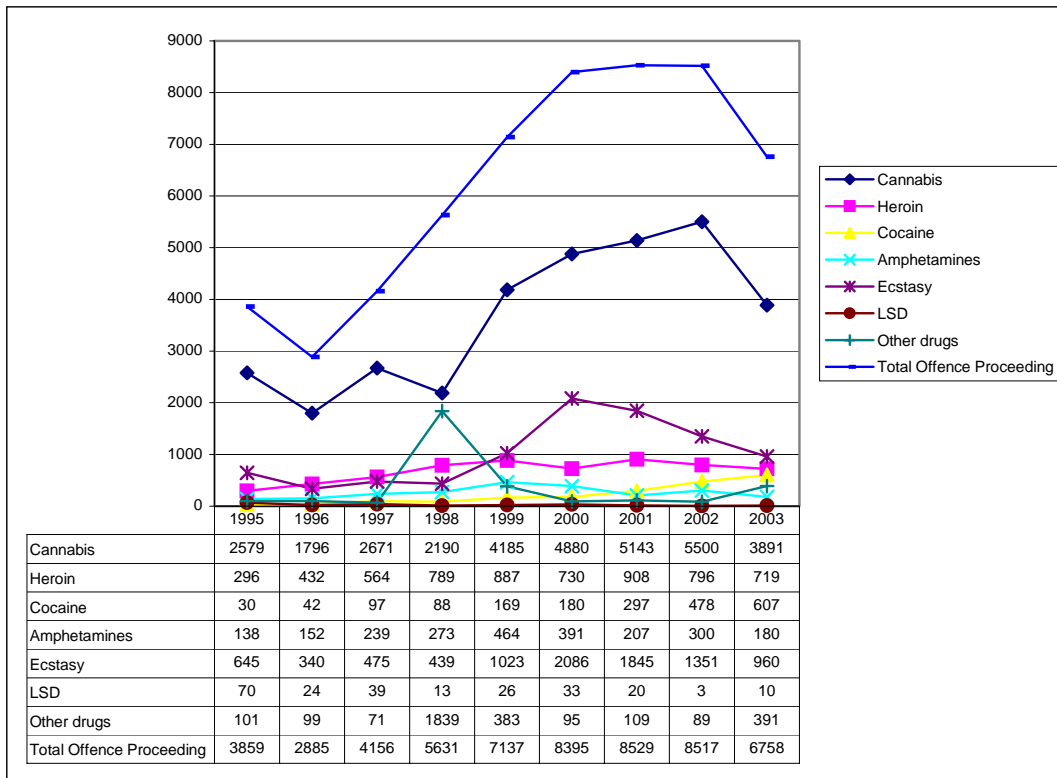


Figure 8.3.3 Recorded drug offences where criminal proceedings commenced, by drug type, 1995–2003 (from annual reports of An Garda Síochána 1995–2003)

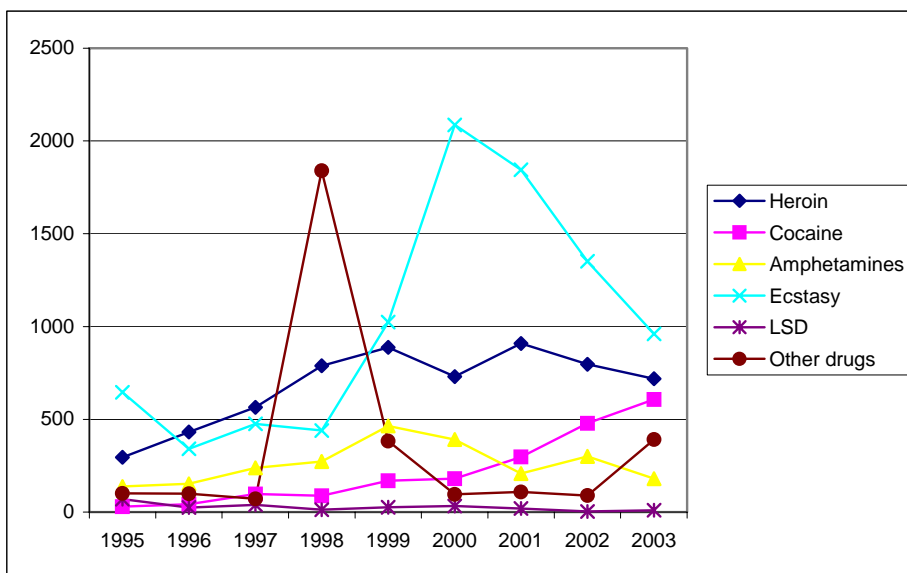


Figure 8.3.4 Trends in drug-related prosecutions for a selection of drugs, excluding cannabis, 1995–2003 (from annual reports of An Garda Síochána, 1995–2003)

Figure 8.3.4 highlights the dramatic increase in the category ‘other drug’ prosecutions in 1998. Offences in the ‘other drug’ category jump from 65 in 1997, to 1,839 in 1998, to 383 in 1999, and then back down to 95 in 2000. It is unclear from the annual report

why this increase occurs in 1998 but it is likely to be a recording error. We can see a large increase in ecstasy-related offences between 1998 and 2000, followed by a steady decline up to 2003.

Heroin-related prosecutions have declined slightly in recent years, following a steady increase from 1995 to 1999. In 2003, heroin-related prosecutions accounted for 10.6% of the total number of prosecutions by drug type. Prosecutions related to cannabis, heroin, ecstasy and amphetamines all declined during 2003.

There has been a steady increase in cocaine-related offences in Ireland since 1998. In 2003, cocaine-related prosecutions accounted for just under 9% of the total prosecutions by drug type. Several seizures of cocaine processing equipment such as presses and vacuum packing equipment were also made (GNDU, personal communication, September 2005).

Other drug-related crime

In March 2004, the CityWide Drugs Crisis Campaign (2004) published a report entitled *Cocaine in local communities: survey of community drug projects*. This survey was carried out in response to the growing concern expressed by community groups across Dublin in relation to the emerging cocaine problem in many parts of the city. The authors surveyed community drug projects to establish whether cocaine users were being treated by local services and, if so, what services were offered to them and what additional services needed to be developed.

Questionnaires were sent to 59 community drug projects requesting information about cocaine use among clients of services and within communities. Although the response rate was low (46%), the projects that participated in the study represented each task force area within Greater Dublin and that of Dun Laoghaire–Rathdown. The non-respondents may manage drug projects where cocaine use is not a problem, and therefore did not complete the questionnaire, leading to a reporting bias.

The report outlines the implications cocaine has for the users and their families and for the wider community.

- Individuals
 - Fifty-two per cent of the project workers reported that cocaine use caused clients to become aggressive and agitated, resulting in difficulties for staff.
 - Almost two-fifths of the respondents reported that the 'high' from cocaine does not last very long; clients therefore use cocaine more frequently, which has cost implications.
 - Fifteen per cent of project workers reported that clients were becoming involved in crime in order to cover the costs of their cocaine use.
 - Twenty-two per cent of the participants reported that clients presented with mental health problems.
 - A number of project workers, particularly those in the south inner city and Ballyfermot, reported that clients injecting cocaine combined with heroin were developing deep vein thrombosis (DVT) and abscesses.
- Families
 - Almost half of the participants stated that cocaine was responsible for domestic rows.
 - Thirty per cent claimed that parents of cocaine users were extremely worried and unsure of how to deal with the problem.
 - Project respondents in Dublin 8 claimed that families had no option but to leave the area because of cocaine-related debt or anti-social behaviour.

- Some project workers reported an increase in the number of young people forced to leave home because of their cocaine use.
- Respondents reported that cocaine can also have a negative impact on the children of users: for example, in the Dublin 8 area a small number of children had been put into care because of their parents' excessive cocaine use.
- Communities
 - Fifty-eight per cent of project workers reported increases in petty crime, dealing and other anti-social behaviour within their community,
 - Eight per cent of project staff cited recreational cocaine use as causing work-related problems for a number of people living in the area.

A major study by the Garda Research Unit was published in 2003 (Furey and Browne 2003). The study sought to establish the link between opiate use and criminal activity in Ireland for the years 2000/2001. An earlier study by Keogh (1997) focused on the drug-crime relationship in Dublin in 1996.

Both studies combined the use of official police statistics and interviews with drug users. The purpose of the Keogh study was to provide reliable information on the relationship between illicit drugs and the commission of crime in the Dublin Metropolitan Area (DMA). The study by Furey and Browne extended the analysis to the other Garda Síochána regions throughout the State. Another difference between the two studies is that Furey and Browne examined the use of opiate-based drugs only, while Keogh included some individuals who used only non-opiates such as ecstasy, cocaine and amphetamines. However, the majority (93%) of the subjects in Keogh's report were opiate users.

The two studies incorporated three principal phases. Phase One involved an estimation of the total number of opiate users known to the gardaí at the time of the study. In the Keogh study, 3,817 opiate users were identified in the DMA in 1996, while Furey and Browne recorded a figure of 4,706 opiate users in the DMA in 2000/2001. However, a valid comparison cannot be made between these figures. Firstly, Furey and Browne's figure is based on data for two years, while Keogh's figure is based on data for a single year. Secondly, as Furey and Browne point out, the DMA is now larger than it was at the time of the Keogh study, incorporating an extra Garda division.

Phase Two involved a survey of a sample of the drug users identified in Phase One. The surveys sought to elicit data about the drug users themselves, their drug-taking environment and their criminality.

Phase Three involved an examination of national crime figures in order to estimate the relationship between opiate use and crime. Keogh estimated that drug users were responsible for 66% of detected indictable crime, while Furey and Browne concluded that drug users were responsible for just 28% of detected crime. While this difference is quite striking, it can be partly explained by some of the survey findings from Phase Two. A number of these findings are given in the table below.

Table 8.3.3 Comparative Garda Síochána studies on drug–crime linkages, 1997 and 2003

Variable	Keogh study	Furey and Browne study
Crime as main source of income	59%	13%
Unemployment rate among drug users	84%	55%
Most common age of first taking drugs	15 years	15 years
Drug first used – cannabis	51%	55%
Drug first used – heroin	32 %	27%
First introduced to drugs by friend	81%	86%
Estimated daily expenditure on drugs*	€51	€75
Percentage who sourced drugs from local drug dealer	46%	76%
Crime came before drugs	51%	33%
Drugs came before crime	30%	56%
Drug use and crime started together	19%	11%
Percentage who had been in prison	81%	66%

* Keogh estimated that the cost of one gram of heroin in 1997 was €100 (Keogh, 1997: 40). Furey and Browne do not provide a figure. However, the current cost of one gram of heroin is approximately €190.

In the Keogh study 59% cited crime as their main source of income, while the figure in the Furey and Browne study was 13%. It is also noteworthy that the Keogh study reported an unemployment rate of 84% among the sample, while Furey and Browne reported an unemployment rate of 55%. This latter finding supports the economic motivation theory by suggesting a lesser dependence on the proceeds of crime in a context of available employment. It also indicates an ability among opiate users to maintain employment despite their addiction. A factor that may have contributed to this is the increased availability of drug treatment in the time between the two studies. Indeed, Furey and Browne found that 75% of respondents claimed that their receipt of drug treatment had in fact decreased their criminal activity.

A worrying finding of the Furey and Browne study relates to the apparent stabilisation of local drug markets over time and the ease of drug availability. The study records an increase from 46% to 76% in the number stating that they sourced their drugs from a local dealer. This has serious implications for local policing and other supply control initiatives.

Another significant difference between the two studies relates to the relationship between respondents' initiation into drug use and their criminal activity. While the Keogh study found that 51% of respondents had committed crime before beginning to use drugs, a finding which is broadly consistent with the international literature, Furey and Browne recorded a figure of 33%.

The survey findings of the Furey and Browne study must be treated with a degree of caution, however, because of the poor survey response rate. The response rate in the Furey and Browne survey was just 27% (131 out of 486) compared to 78% (351 out of 450) in the Keogh study. Furey and Browne compared the respondents and non-respondents in their survey according to two available variables, gender and possession of a criminal record, and found little difference between the two groups. This provides some evidence to suggest that the sample might not be totally unrepresentative of the total number of drug users known to the police. Furey and Browne highlight the difficulties they encountered in contacting potential respondents and point to a 123% increase in homelessness between 1996 and 2004.

The difficulties encountered in accessing respondents for interview in this study show the obvious limitations of studies of this nature, where the police seek information about criminal behaviour from subjects they have arrested or known. This relates to a possible perception among respondents that by self-reporting criminal behaviour they risk exposing themselves to possible incrimination. Keogh, for example, encountered difficulties in acquiring specific information from respondents, particularly concerning their participation in violent criminal behaviour. Furey and Browne suggest that a possible reason for the reluctance among drug users to participate in their survey may have been related to a perceived deterioration in relations between the gardaí and drug users since 1997, which, the authors contend, may have occurred as a consequence of a number of policing operations targeted at drug users.

Another methodological issue relates to the use of Garda-recorded crime statistics. In order to assist them in identifying known drug users and to establish the relationship between opiate use and crime, the two studies relied on different data sources. Keogh relied on manual data and an earlier Garda computer system while Furey and Browne used the new Garda Síochána PULSE system. The recent minority report of the Expert Group on Crime Statistics has highlighted major concerns in relation to the operation of this data system and also about earlier crime-recording practices (Expert Group on Crime Statistics 2004b).

Despite these shortcomings, the Furey and Browne study provides useful and recent information about a hard-to-reach population.

Of the 131 drug users surveyed by Furey and Browne (2003), 110 had looked for treatment and 100 had received it. Sixty-four respondents reported an association between the receipt of treatment and engagement in crime. Forty-nine of those respondents reported doing 'a lot less' crime (p. 34). It is unclear whether this is actually the case, however. A follow-up study of the progress of those respondents who reported a decline in their offending behaviour as a result of drug treatment would be instructive.

Furey and Browne found that opiate users are responsible for less than one-quarter of larceny offences (23%) and just over one-third of burglaries (37%). The lowest percentage (4%) of detected crime accredited to opiate users is for assault. The study found that 49% of respondents had been convicted of robbery, which was the highest crime category recorded. The authors point out that robberies represent only a very small percentage of headline crimes annually. Nevertheless, robbery is defined and experienced as a violent crime.

Furey and Browne found that drug users are almost twice as likely to be caught offending as non-drug-users. They make the important point, however, that they are discussing 'detected' crime and they highlight the possibility that differences in crime committal ratios between drug users and non-drug-users may be due to the fact that, 'the attendant consequences of their drug use may have rendered them less likely than non-users to evade detection' (p. 20).

8.4 Drug use in prison

No new information available.

8.5 Social costs

No new information available.

9. Responses to Social Correlates and Consequences

9.1 Overview

This section will highlight the proposal for a new pillar on rehabilitation to be added to the National Drugs Strategy. Also covered are the legislative obstacles facing drug users who have been evicted from local authority housing for anti-social behaviour, when they try to access rental supports to live in the private sector. The relatively small provision of transitional housing options and dedicated emergency accommodation options is also highlighted. On a more positive note, the provision of education and vocational training supports appears to be receiving increased attention and a recent review of the main education and training programme dedicated to drug users provides valuable learning opportunities for enhancing the relevance and quality of this service in the future. The section also reports on a cocaine study which considered services' responses to Ireland's developing cocaine problem. We also report on a number of positive developments in prison-based drug treatment. The publication of policing plans and progress towards the establishment of local policing structures are also reported. With regard to drugs in prison, new supply-control measures including the introduction of mandatory drug testing are significant developments, as is the publication of an evaluation of an arrest referral scheme in Dublin.

9.2 Social reintegration

The mid-term review of the National Drugs Strategy, completed in 2005, recommends that rehabilitation becomes the fifth pillar of the Strategy as it was seen as a critical issue and recurring theme throughout the consultation process during the review. The rationale for developing a fifth pillar on rehabilitation is based on the belief that drug users should not be kept on methadone indefinitely but assisted in 'moving on' towards social reintegration. The steering group notes the many different views and interpretations of what constitutes rehabilitation, ranging from therapeutic approaches on the one hand to training and social re-integration on the other. However, the group agrees that, in general, rehabilitation includes personal development, training, community integration, access to housing and employment. It is recommended that a working group be established under the aegis of the Department of Community, Rural and Gaeltacht Affairs to examine this area comprehensively and to develop an integrated rehabilitation provision, and report by the end of 2005 on the appropriate actions to be implemented.

Housing

Current legislation would seem to suggest that drug users evicted from local authority housing could be prohibited from securing supplementary rent allowance that would support them in securing accommodation in the private rental sector. Section 16 of the Housing (Miscellaneous Provisions) Act 1997 gives discretion to the Health Service Executive to refuse or withdraw Supplementary Welfare Allowance, rent or mortgage supplementation for private housing in the case of persons evicted, excluded or removed from, or refused, housing on the grounds of anti-social behaviour.

The exclusionary nature of this legislation has recently been acknowledged by the Homeless Persons Unit (HPU), which has the responsibility for allocating homeless status to individuals and which is the main referral agency to accommodation services in Dublin. The HPU states:

If the person is evicted for anti-social reasons, according to the Housing (Miscellaneous Provisions) Act, 1997, rent allowance 'may be restricted'. In practice the HPU says that people are excluded from rent allowance and are placed into emergency accommodation instead. (Bergin *et al.* 2005: 13)

In addition, recent changes to the provision of rent supplements mean that new applicants must now pay their own rent for six months before becoming eligible for rent supplement. This can have adverse implications for people being released from residential drug treatment or prison, or those evicted from local authority housing and dependent on social welfare payments. Interestingly, only one organisation that works directly with drug users, Merchants Quay Ireland, has been invited to participate in the Rent Supplement Coalition that has been set up to campaign for changes in the current situation.

Transitional housing

A small number of specific transitional housing interventions target drug users, mostly provided by the voluntary sector, with some financial assistance from the statutory sector. Merchants Quay Ireland provides a transitional housing intervention dedicated to former drug users who experience homelessness following completion of residential drug treatment. According to the Merchants Quay Annual Review 2004 (2005), accommodation is provided for a period of up to 24 weeks and during 2004 there were 12 residents in the house. The Arrupe Society, also a voluntary organisation working with homeless drug users, provides transitional accommodation through the Avoca project. Residents include individuals who have completed residential treatment. The intervention encourages residents to maintain a drug-free lifestyle (Fr Peter McVerry, personal communication, 2004). The Sisters of Mercy in Cork provide transitional housing to men and women who have completed residential drug treatment, through the Fellowship House and Renewal Programme respectively (Sr Cait O'Leary, personal communication, 2005). In the statutory sector, the Health Service Executive Northern Area Rehabilitation/Integration Service (RIS), with Focus Ireland and Keltoi, is providing assisted housing units in George's Hill for people coming out of Keltoi and working towards reintegration. Currently, seven housing units are being prepared. The programme includes the following components: individual work, group work, home management/lifeskills training, and community-based training, education and employment opportunities (C Morgan, personal communication, 2005).

Emergency accommodation

Similarly, a small number of emergency accommodation options specifically target individuals engaged in problematic drug use. DePaul Trust Ireland provides a low-threshold, harm-reduction hostel for young rough sleepers, many of whom are intravenous drug users. Facilities include 16 beds in seven twin and two single rooms. The Caretakers Hostel operated by Focus Ireland targets out-of-home young people aged 16–21 years who are misusing drugs. Accommodation includes nine beds, five for males and four for females. According to a recent annual report, 40 young people used the service during the period May to December 2003, (Focus Ireland 2003). Haven House provides 24 beds in 10 rooms for single homeless women with children, including women with alcohol or drug problems. The Health Service Executive Northern Area operates the 'Out Of Hours Service' in Lefroy House, providing an emergency social work service to young people aged 12–18 years who present as out-of-home outside office hours.

Education and training

Vocational training and employment support interventions are provided by FÁS, the National Training and Employment Authority, to individual drug users through dedicated LDTF projects and through mainstream community employment (CE)

schemes. A recent review of the special FÁS CE scheme for drug users (Bruce 2004) reports that, as of 30 January 2004, there were 812 participants. However, this number represents a shortfall as FÁS has 'ring-fenced' approximately 1,000 CE places to provide training to drug users across the LDTF areas.

The review highlights a number of key issues that require explanation. For example, twice as many females (67.7%) as males (32.3%) were participating on the scheme. However, recent data from the NDTRS for 2002 (Long *et al.* 2005b) shows that males represented 71% of cases living and treated in Ireland for problematic drug use. This suggests that male problematic drug users are not well disposed to accessing vocational training and employment support interventions.

In addition, the review notes the difference between the providers of the FÁS scheme and the participants in their understanding of the primary goals of the CE scheme. On the one hand, FÁS aims to provide vocational training aimed at enhancing the labour market prospects of clients, while on the other hand Bruce (2004: 59–60) observes that:

The most common theme for participant respondents was that, for them, CE was rehabilitative rather than job oriented. Many saw employment as a worthy but essentially remote aspiration. Most were focused on staying stable – with others aiming to become drug free as soon as possible. This would appear to stem from the immediacy of medical and personal needs rather than any rejection of employment outcomes per se.

The review provides insights into the strengths and weaknesses of the special FÁS CE scheme according to supervisors, project workers, FÁS personnel and participants. For example:

- Some supervisors experienced role confusion where, on the one hand, many operated in strong personal support and advocacy roles for participants. Others saw their roles sometimes tending towards addiction recovery support, while others viewed their role as partly therapeutic or as one of advocacy. Many supervisors, dealing on a daily basis with the many complex personal issues of participants, found difficulty in articulating a vocational employment perspective in any realistic sense. Most project workers expressed the view that meaningful progression to the labour market was not an option for the majority of participants or that, if it were, it could take substantially longer than three years.
- Many acknowledged a lack of training and resources.
- Background issues regarding poverty and social deprivation were widely reported as complicating progress towards a labour market orientation. In this regard, a strong emphasis was placed on the role of education as the key lever of change for the individual (and the community). The achievement of certification was frequently mentioned as providing both the best impetus to work and a strong reinforcement of therapeutic aspects. Strong opinions were expressed about the HSE's lack of consistency or strategic involvement in the area.
- A general concern expressed was the lack of standardisation and practice. Projects varied greatly not only in terms of outcomes (which were felt to be inadequately monitored anyway) but also in terms of process and operation. Particular concerns were expressed by most respondents around assessment criteria, identification of needs and the structure of activities to meet these needs. There was a concern that FÁS was called on to meet a range of social,

personal and economic needs for which it had neither the expertise nor resources.

- The high value placed by all respondents on education and the recognition of certification attained shows that longer-term perspectives on community and vocational reintegration are not absent. The range of problems expressed was notable. It included issues around money and allowances, homelessness, a very poor standard of general health and inadequate diet. Many respondents expressed concern about their ability to stay clean and avoid relapse. One of the most consistently valued elements of CE participation was the growth in self-esteem and self-confidence.

The HSE Northern Area Rehabilitation/Integration Service (RIS) has been involved in developing a number of innovative initiatives to support current and former drug users in accessing vocational training and employment options (C Morgan, personal communication, 2005). For example:

- Bridge to the Workplace is a one-year pilot 'work experience' initiative aimed at stimulating change and progression for those with a history of problematic drug use. This intervention seeks to expand the progression potential of 40 people with addiction through the establishment of a workplace, work experience stimulation programme for up to 26 weeks, as part of a planned progression route. It is a multi-agency collaborative effort involving the HSE, FÁS, Blanchardstown Local Employment Service (LES), Finglas/Cabra LES, Northside LES, Ballymun Job Centre, and Dublin Inner City Partnership. The main target groups are clients of addiction services and LES networks.
- KeySkill is a rehabilitation/reintegration and counselling service initiative. It ran for a total of nine sessions, each session lasting two hours. Six clients were assessed as suitable for the pilot; five commenced; and four completed the programme, achieving the 'Certificate of Achievement' and 'Letter of Competence'. Attendance was excellent and punctuality rated as very good. Four clients continue to link in with RIS for the duration of pilot.

The Blanchardstown EQUAL Inter-agency Initiative was developed to establish a co-ordinated approach to providing quality supports and services to former and current drug users in the Blanchardstown area of Dublin. The key objective was to bring together statutory and voluntary agencies working with current and former drug users in order to establish clear inter-agency protocols and good working relationships. The primary aim is to enhance opportunities for the target group to progress towards employment opportunities. Developments to date include a protocol on lead agency working, which provides a definition of the term and establishes the responsibilities of the lead agency. According to the protocol, a lead agency assumes the most significant role in providing and co-ordinating services to a client, including the provision of a key worker. Responsibilities include carrying out a needs assessment, holding and managing the overall care plan and tracking and following up on a client to prevent 'a fall through the cracks'. In addition, a protocol on confidentiality has been developed and adopted by all eight participating agencies, covering areas such as the limits of confidentiality, sharing client information, working with under-18s and accommodating clients' access to files containing information on them. From February to April 2004 the protocols were piloted among the agencies. Preliminary evaluation results show that co-operation between agencies is improving, particularly on the challenging issues of three-way meetings and lead agency referrals. A three-way meeting is one between the lead agency, the agency the client has agreed to be referred to, and the client. The Blanchardstown EQUAL Initiative evaluation noted that three-way meetings were consistently reported as being positive both for introducing clients to new agencies and

for resolving issues arising for clients between agencies (Blanchardstown EQUAL Initiative 2004). The lead agency approach is seen by most agencies as having clarified the roles of other services and allowed the interventions to be client-focused. Following the pilot phase, all eight agencies agreed to mainstream the use of the protocols in their work programmes. However, lead agencies recognise that these new approaches will take time to develop, to embed and to implement. As part of the evaluation of the pilot phase, a facilitated focus group session was held with eight clients in early September 2004. All the clients had been through the inter-agency initiative and found it to be a better way of working. According to the evaluator, they questioned why it was not used everywhere when it had so many advantages for service users.

Responding to cocaine use

The lack of services available to cocaine users was of particular concern to those who participated in the cocaine study conducted by the CityWide Drugs Crisis Campaign (2004). According to the report, almost one in five of the community drugs projects that participated in the study said that they had no services for cocaine users; however, the majority of projects did provide some services. These included: acupuncture, yoga, reiki, relaxation methods, Indian massage, and home detoxification through acupuncture and acupressure. Almost 60% of the projects provided counselling, while 45% provided harm-reduction services specifically for cocaine users. Fourteen per cent provided practical support, such as laundry, bathing facilities and nursing care. Half of the project workers claimed that they were not aware of any other service treating cocaine use in their area. Project workers stated that they would be interested in providing:

- alternative therapies specifically for cocaine users
- cocaine-specific education programmes
- respite for cocaine users
- detoxification programmes.

However, in order for such services to be developed, project workers felt that they would need additional training and an increase in staffing and funding, and evidence of political will to tackle the issue. The findings of this study support the findings reported by the NACD (2003) in its overview of cocaine use in Ireland.

Drug treatment in prison

Following a number of studies which showed high levels of drug use and drug-related infectious diseases among the Irish prisoner population (Allwright *et al.* 2000; Dillon 2001; Hannon *et al.* 2000; Long *et al.* 2001; Long *et al.* 2003; Long *et al.* 2004a), during 2000 and 2001 the Irish Prison Service, along with other agencies, developed both drug treatment service plans and healthcare plans for Irish prisoners (Group to Review the Structure and Organisation of Prison Health Care 2001; Irish Prison Service 2000; Irish Prison Service 2003). By the end of 2002, the Prison Service was at an advanced stage of drafting an Irish Prison Drug Service Policy that would be in line with Ireland's National Drugs Strategy and with the World Health Organization's *Health in Prisons Project: Prisons, Drugs and Society* (WHO (Europe) Health in Prisons Project and the Pompidou Group of the Council of Europe 2001). This policy is awaiting approval from the Minister for Justice, Equality and Law Reform.

A number of positive developments have occurred, such as the introduction of evidence-based methadone treatment services that can be accessed by the majority of opiate-dependent prisoners. Attempts have also been made to vaccinate a significant minority of prisoners against hepatitis B, something very few prisons, nor, indeed, community health services, have managed. The employment of registered nurses facilitated the separation of disciplinary and healthcare roles. There has also been an increase in the availability of drug-free units (Long *et al.* 2004a).

In 2004, a consultant psychiatrist in addiction was appointed by the HSE Northern Area to provide a service to prisoners in Mountjoy Prison in Dublin. The number of prisoners in receipt of methadone maintenance has also increased – from 184 in December 2000 to 290 at the end of July 2004 (Department of Community Rural and Gaeltacht Affairs 2004).

9.3 Prevention of drug-related crime

Policing

In 2004 Divisional Drug Policing Plans were posted on the Garda website at www.garda.ie. A co-ordinating framework has been established under an Assistant Garda Commissioner. It assigns responsibility for co-ordinating the Garda Drugs Strategy at a regional, divisional and district level.

A programme of education for Garda Divisional Search Teams has been developed and is currently being implemented to advise best practice in relation to the discovery and safe investigation of clandestine drug laboratories where there is a danger of volatile substances being encountered which might constitute a danger to the public or members of An Garda Síochána carrying out a search.

A Garda initiative called 'Operation Anvil', aimed at targeting organised crime and other serious criminal activity (including drugs), was initiated in 2005. The GNDU reports that the operation, which focuses on the Dublin Metropolitan Region, 'has yielded significant results to date, including many drug seizures and the seizure of in excess of 100 firearms'. (GNDU, personal communication, September 2005).

The Garda Síochána Act 2005 provides for the development of Joint Policing Committees at local-authority level and for the establishment of local policing fora in designated areas under the umbrella of such committees. These bodies are to act as fora where matters relating to local issues of policing and crime, including drug-related issues, can be discussed and where strategies and recommendations for dealing with issues locally can be formulated (see section 1.2). The guidelines for this legislation are currently being formulated. There are currently three Community Policing Fora, in the North Inner City, Finglas/Cabra and the South Inner City, with another one agreed for the Blanchardstown drugs task force area of west Dublin (Connolly 2004b; Oireachtas Joint Committee on Justice, Equality, Defence and Women's Rights 2005).

Customs

A Customs cutter (RCC *Suirbhéir*) was commissioned in 2004. The boat will patrol the coastline with the purpose of intercepting vessels suspected of drug smuggling.

Drugs in prisons

Along with traditional supply prevention methods, new visiting arrangements which involve prior nomination and identification of visitors have been introduced in Mountjoy Prison to prevent drug smuggling. The Irish Prison Service has also installed nets over a number of prison yards to prevent drugs being propelled over prison walls.

The Minister for Justice, Equality and Law Reform, Mr Michael McDowell TD, announced the publication of new draft prison rules in June 2005. The rules deal with all aspects of prison life, including accommodation, visiting rights, discipline, health and education. The existing prison rules date back to 1947. The new rules make provision for the introduction of compulsory or mandatory drug testing (MDT) of prisoners, a commitment in the Agreed Programme for Government between Fianna Fáil and the Progressive Democrats (Fianna Fáil and the Progressive Democrats 2002).

Section 28 (5) (a) of the new Prison Rules provides: 'In the interest of good order, safety, health and security and in accordance with directions set down by the minister, a prisoner ... shall, for the purpose of detecting the presence or use of an intoxicating liquor or any controlled drug ... provide all or any of the following samples, namely – urine, saliva, oral buccal transudate, hair.' The announcement comes at a time of increased debate as to the merits of MDT. The Irish Penal Reform Trust (IPRT) has consistently opposed the introduction of MDT. Speaking to *Drugnet Ireland*, Rick Lines, executive director of the IPRT, said:

... such testing increases heroin use among prisoners, increases injecting and the risk of HIV and hepatitis C transmission through shared syringes, reduces the uptake of voluntary drug treatment by prisoners, and wastes money that could be better spent on more effective drug programmes. (Connolly 2005a)

Arrest referral

Action 13 of the National Drugs Strategy 2001–2008 obliges An Garda Síochána 'To monitor the efficacy of the existing arrest referral schemes and expand them, as appropriate'. Action 19 promotes such early intervention approaches to problem drug use: 'Incidences of early use of alcohol or drugs by young people coming to Garda attention to be followed up by the Community Police and/or the health and social services, in order that problem drug misuse may be diagnosed/halted early on through appropriate early intervention'. The main aim of arrest referral schemes is to provide information to arrestees about appropriate services and to facilitate referral to treatment at the primary points of entry into the criminal justice system, usually the police station. Arrest referral is an early intervention aimed at people who have been arrested and whose offence may be linked to drug use. Such policies are premised on the idea that treatment will lead to a reduction or cessation of illicit drug use and will thus reduce or negate further drug-related offending by the drug user.

Pilot arrest referral procedures have been put in place in Cork, Dún Laoghaire and Ballymun. In addition, a further pilot arrest referral scheme is in operation in the North Inner City Drugs Task Force area. This has recently been evaluated and a summary report published (Connolly 2005b).

Juvenile arrest referral schemes are consistent with the principles outlined in the Children Act 2001, which emphasise prevention and the diversion of young offenders from prosecution (see Ireland National Report 2004). The summary report published by the North Inner City Drugs Task Force (2005) and funded by the Department of Justice, Equality and Law Reform on a pilot arrest referral scheme in Dublin's north inner city was launched in April 2005 by Noel Ahern TD, Minister of State with responsibility for the National Drugs Strategy.

The report considers best practice approaches in the UK, where significant progress has been achieved in introducing arrest referral schemes. The report also considers an arrest referral scheme in operation at Gransha Hospital in Derry, the Derry Arrest Referral Team (DART) Alcohol/Drugs Service, and outlines three different arrest referral intervention models. The information-giving model provides information such as leaflets on treatment, but there is no advice, counselling or follow-up; the incentive or coercive model involves cautioning an arrestee to seek advice from a drugs worker or postponing a cautioning decision pending attendance by the arrestee at a drug service; and the proactive model involves specialist arrest referral workers based in the police stations or on call.

The north inner city pilot scheme involves co-operation between the outreach services of the HSE Northern Area, An Garda Síochána North Central Division and the local drugs task force. Participation in the scheme is completely voluntary for arrestees and does not interfere with the normal operation of the criminal justice system. The initial take-up of the scheme has been low. The report provides data for juveniles arrested in the North Central Division stations of Store Street, Mountjoy, Bridewell and Fitzgibbon Street between May and September 2003. Of the 214 arrestees, 167 were male. Only 14 (6.5%) of these arrests were made under the Misuse of Drugs Act MDA 1977.

The take-up rate for the scheme is reported as 'quite low', with only a small number of individuals referred to the health services. The report acknowledges that many young arrestees will not see their drug use as problematic but rather as 'dabbling' or 'recreational' and will therefore not seek help. Also, the low number of MDA-related arrests leads the authors to question whether the scheme should be broadened to all juvenile arrestees, 'regardless of their offence within appropriate qualifications'. The low take-up rate of the scheme is consistent with data provided by the NDTRS. Table 9.3.1 shows the number and percentage of cases reported to the NDTRS by court, probation or police. As can be seen, the proportion of cases referred from these criminal justice agencies is low and has remained relatively unchanged between 1998 and 2002.

Table 9.3.1 The number (%) of cases reported to the National Drug Treatment Reporting System who were referred by police, probation or court, 1998–2002

	1998	1999	2000	2001	2002
Police, probation, court	518 (8.8)	427 (7.1)	439 (6.5)	480 (6.4)	598 (7.4)
Total cases ¹	5862	5993	6754	7532	8116

¹ Cases in which the referral source was recorded.

Source: Unpublished data from the National Drug Treatment Reporting System, Health Research Board

The low take-up rate in the Dublin scheme is consistent with findings from other such schemes in their early stages. Referrals in the Derry scheme increased from 85 in 2001 to 249 in 2003. Similarly, as the pilot becomes increasingly established in the north inner city, the gardaí report that the number of referrals is also growing. The primary recommendation of the report is that the pilot phase of the scheme should be extended, with additional resources in terms of staff, programme development and monitoring.

10. Drug Markets

10.1 Overview

Following feedback on Ireland's 2004 national report, in this section we consider available police data on drug offence prosecutions by Garda region in order to identify trends in drug distribution at middle market level throughout the country. We also report on the European School Survey Project on Alcohol and other Drugs (ESPAD) in relation to drug availability and sources. Data on drug seizures and trends are also presented and analysed. Available data on drug prices and purity, although limited, are also reported.

10.2 Availability and supply

No studies have been conducted on Irish drug markets. With regard to the international drug market, the original sources of supply vary according to the type of drug.

When drugs are seized, Irish law enforcement personnel, including the gardaí and Customs, seek to determine the destination of the drugs by considering a number of factors associated with the particular seizure: the size of the seizure, the geographical location of the seizure, whether for example weather conditions inadvertently caused a diversion into Irish waters of a particular shipment, or the circumstances of the individuals apprehended along with the drugs (CDLE, personal communication, June 2004). The figures presented below in relation to drug destinations should therefore be regarded as 'guesstimates'.

With regard to the importation and internal distribution of drugs, the 'middle market', a possible indicator of distribution patterns is drug-related prosecutions by drug-type and by Garda division. While this data, which is presented in the Garda annual reports, primarily reflects law enforcement activities and the relative ease of detection of different drugs, it may also provide an indicator of national drug distribution trends and whether, for example, we can see a concentration of prosecutions along trafficking routes. Also, with regard to heroin, which has always been a predominantly Dublin-based phenomenon, a comparative analysis of heroin-related prosecutions by Garda division can indicate whether the heroin market is spreading outwards from Dublin. This law enforcement data can also be considered along with other data sources such as the NDTRS to identify common patterns.

Cannabis resin

The major producing country of cannabis resin, the principal form of the drug used in Ireland, is Morocco (EMCDDA 2004). The main supply route for cannabis resin is from Morocco via Spain, the Netherlands or the UK to Ireland. The bulk of cannabis resin seized by Customs in 2003 was concealed in freight consignments from North Africa. Large quantities of cannabis resin has also been seized along the south coast of Ireland being smuggled by yachts, small craft or converted fishing vessels (CDLE, personal communication, July 2005)

A strong decrease in the trafficking trend for cannabis resin was detected in 2001 by Customs at Dublin Port. The reason for this decrease has not been identified. Of the cannabis resin seized in 2002, 10% was transported by air and 90% by sea (Garda National Drugs Unit 2003). Reporting on possible reasons for a decrease in cannabis trafficking into Ireland for that year, the GNDU states: 'The major decrease in trafficking in cannabis in Ireland can probably be attributed to the fact that four major shipments

were intercepted during 2001, which were destined for the UK market thereby causing traffickers to stop trying to use Ireland as a transit country' (Garda National Drugs Unit 2003: 8). Customs report that, although the number and quantity of cannabis seizures has been showing signs of decline in recent years, indications are that this trend is reversing (CDLE, personal communication, December 2003).

Cannabis herb

The cannabis herb seized in Ireland originates primarily in South Africa and Thailand. It arrives in Ireland via different countries, including France, Germany, the UK, the Netherlands and Belgium. In 2001 there was a large increase in the amount of cannabis herb seized in Ireland. This was reported as being due to Ireland being targeted as a transit country for supplying cannabis herb to the UK market (CDLE, personal communication, December 2003)

Customs seized over 19 tonnes of cannabis herb in the years 2001/2 and the vast bulk of this was detected in a small number of very large seizures in maritime freight (18 tonnes), the bulk of the balance being detected in passenger baggage at the airports: 'The majority of these [seizures] have been seized from freight consignments originating in Spain, South Africa and Thailand. One significant consignment which was seized during 2002 involved the smuggling of nearly 6 tonnes of herbal cannabis, nearly €25 million worth, concealed within concrete garden furniture which had originally been shipped from Thailand' (CDLE, personal communication, December 2003). It is believed that this consignment was destined for the UK market.

The largest proportions of cannabis related prosecutions take place in the Dublin Metropolitan and Southern regions, Figure 10.2.1. The large concentration of such prosecutions in the Southern Region may be partially explained by the importance of the south coast as an importation point for cannabis resin coming from North Africa. It is also noteworthy that, following a generally consistent increase in cannabis-related prosecutions in all regions between 1995 and 2002, in 2003, there was a decrease in such prosecutions in all Garda regions. This is likely to reflect a change in Garda enforcement strategy rather than a decline in cannabis availability or use.

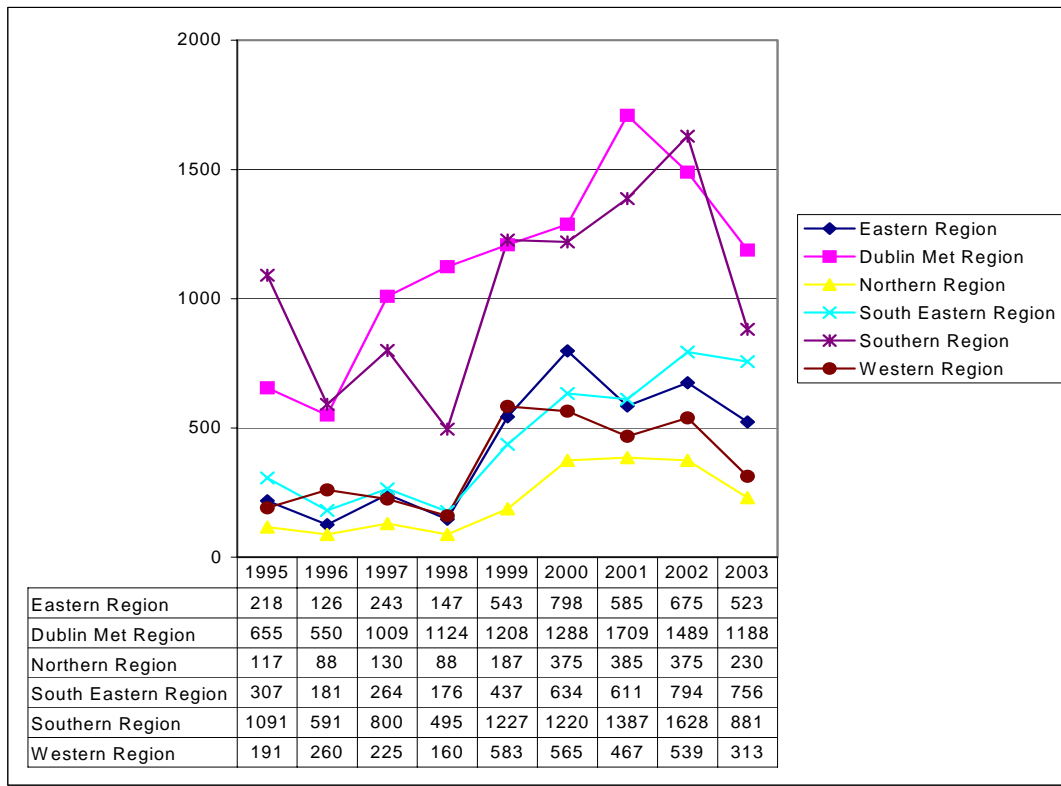


Figure 10.2.1 Trends in cannabis-related prosecutions by Garda region, 1995–2003 (from annual reports of An Garda Síochána 1995-2003)

Key to Garda regions: **Eastern Region:** Carlow/Kildare; Laois/Offaly; Longford/Westmeath; Louth/Meath **Dublin Metropolitan Region:** Eastern; North Central; Northern; South Central; Southern; Western **Northern Region:** Cavan/Monaghan; Donegal; Sligo/Leitrim **South Eastern region:** Tipperary; Waterford/Kilkenny; Wexford/Wicklow **Southern Region:** Cork City; Cork; Cork West; Kerry; Limerick **Western Region:** Clare; Galway West; Mayo; Roscommon/ Galway East

Synthetic drugs

Synthetic drugs such as ecstasy and amphetamines are produced in numerous locations throughout the EU but there is a concentration of such production in the Netherlands and, to a lesser extent, in Belgium, the UK, Spain and Germany (Europol 2001). Central and Eastern Europe have also emerged as producers of synthetic drugs, with illicit laboratories discovered in Poland, Bulgaria, Hungary and the Baltic states. The UK, the Netherlands and Germany report the highest number of illicit amphetamine laboratories, while the Netherlands and Belgium produce 80% of the MDMA (ecstasy) consumed worldwide. The main place of origin for ecstasy in Ireland is the Netherlands and, to a lesser extent, Belgium (Moran *et al.* 2001).

The UK is the main transit country for the ecstasy arriving in Ireland. The GNDU reported that in 2001 all of the amphetamine seized in Ireland was transported by mail, and that 50% of the ecstasy was transported by air and 50% by mail (Garda National Drugs Unit 2003). Amphetamine trafficking trends were regarded as stable in 2001, while ecstasy showed a strong decrease. In 2002, the GNDU reported that 5% of the amphetamine seized in Ireland was transported by air and 95% by sea. Trafficking trends were regarded as stable. This suggests the possibility of a significant change from year to year in the transportation methods used for amphetamines.

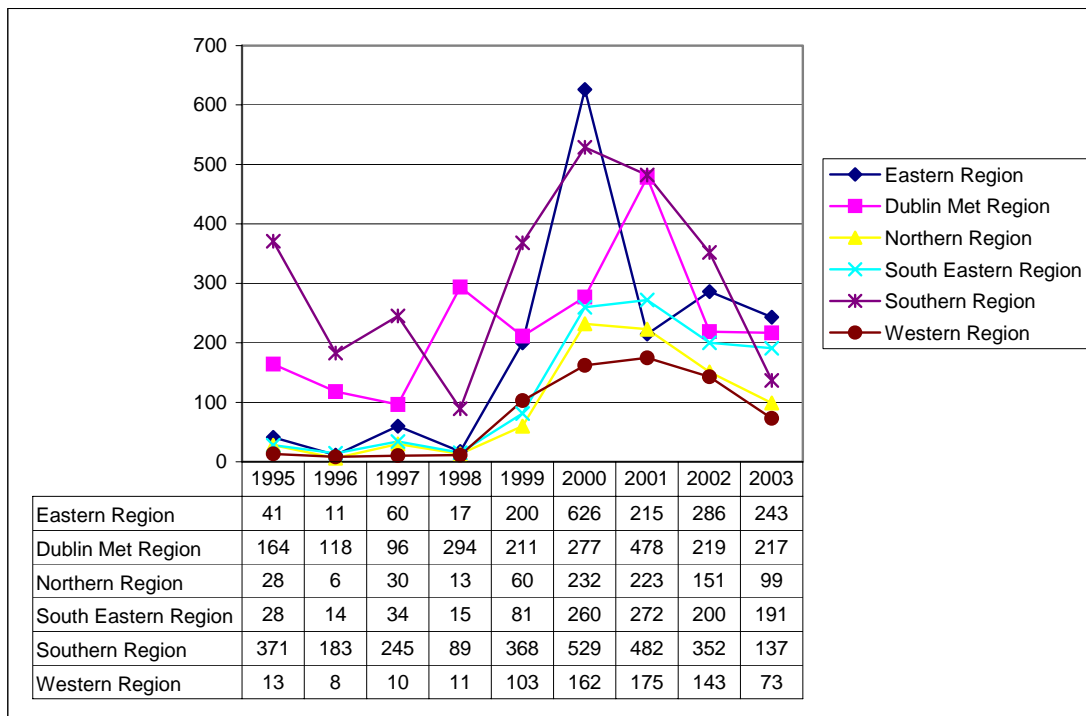


Figure 10.2.2 Trends in ecstasy-related prosecutions by Garda region, 1995–2003 (from annual reports of An Garda Síochána 1995–2003)

Despite the concentration of population in the Dublin Metropolitan Region, ecstasy-related prosecutions appear to be dispersed quite widely throughout the state. If prosecutions can be regarded as an indicator of availability, then the ecstasy drug market can be regarded as quite diffuse. Ecstasy-related prosecutions peaked in 2000 in the Eastern, Southern and Northern regions and in 2001 in the Dublin Metropolitan, South Eastern and Western regions. In 2003, ecstasy-related prosecutions declined in all Garda regions. It is unclear whether this reflects a change in Garda enforcement practice or a decline in the availability and use of ecstasy.

According to the GNDU, ‘During the reporting period there were indications that Ireland is likely to become a producer of synthetic drugs. This suspicion is based on a number of unusual and significant seizures’ (GNDU, personal communication, September 2005). These seizures were of Benzylmethylketone (BMK) and Piperonylmethylketone (PMK) in Dublin, precursors used in the manufacture of ecstasy and amphetamine and also of amphetamine processing equipment in Tipperary. The GNDU also reports a ‘noticeable increase in the availability of regulated pharmaceutical products at street level within the city centre of Dublin’ (GNDU, personal communication, September 2005).

Heroin

Most of the heroin arrives into Ireland by sea and a small percentage by mail. Trafficking trends appear stable. According to the GNDU, ‘most trafficking of heroin into Ireland is organised by Irish nationals, based in Ireland or the UK. The drugs are imported mainly hidden in vehicle parts or personal baggage’ (Department of Health and Children 2002). There has been a steady decline since 1999 in the number of new cases of problematic opiate use in Dublin, as reported to the NDTRS (Kelly *et al.* 2005). This is an indirect indicator of new recruitment into opiate use.

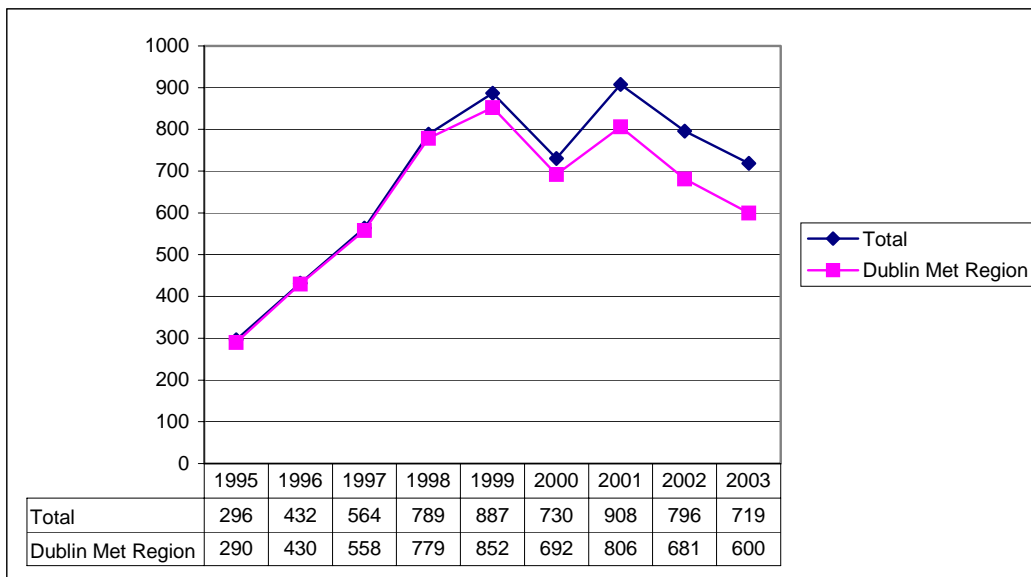


Figure 10.2.3 Trends in heroin-related prosecutions in the Dublin Metropolitan Region, 1995–2003 (from annual reports of An Garda Síochána 1995–2003)

Figure 10.2.3 shows the trends in heroin-related prosecutions in the DMR as a percentage of all such prosecutions. It can be seen that the vast majority of heroin-related prosecutions occur in Dublin.

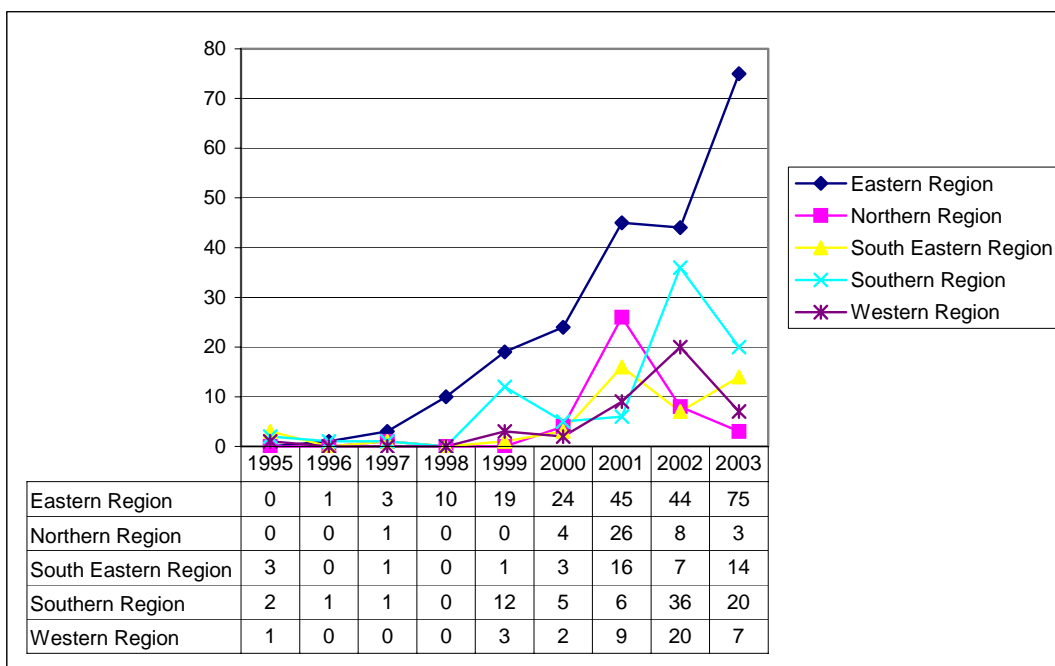


Figure 10.2.4 Trends in heroin-related prosecutions by Garda region outside the Dublin Metropolitan Region, 1995–2003 (from annual reports of An Garda Síochána 1995–2003)

However, as can be seen from Figure 10.2.4, which shows heroin-related prosecutions outside the Dublin Metropolitan Region since 1995, there has been a steady increase in heroin-related prosecutions in the Eastern Region, from 0 prosecutions in 1995 to 75 in 2003. While the trends in the other regions are more sporadic, it is clear that, although heroin remains predominantly a Dublin-based phenomenon, it is no longer

exclusively based in the capital. It would require further research to determine whether this represents a shift or displacement in the heroin market outside the capital city. However, it is apparent that, while heroin-related prosecutions have decreased in the Dublin Metropolitan Region since 2001, they have increased in the areas immediately surrounding Dublin. Furthermore, these findings are consistent with findings from the National Drug Treatment Reporting System with regard to trends in treated problem drug use in the Eastern Region (Kelly *et al.* 2005; Long *et al.* 2005b)

Cocaine / crack

The available indicators suggest a significant increase in cocaine trafficking in Ireland in recent years. The cocaine which arrives in Ireland comes primarily via the UK and the Netherlands (Garda National Drugs Unit 2003).

The GNDU estimated that all of the cocaine seized in Ireland in 2001 was destined for the Irish market. It is estimated that 50% of cocaine seized arrived by air and 50% by mail. A slight decrease in trafficking trends in cocaine was identified in 2001. However, reporting on an increase in cocaine trafficking for 2002, the GNDU states that it 'is probably attributable to the fact that use has become more mainstream and the drug is more widely sold at street level' (Garda National Drugs Unit 2003: 8). Customs also report that the number and quantity of cocaine seizures increased significantly after 2001, stating that 'cocaine is being smuggled into Europe by means of impregnation of clothing and in concealments in polystyrene packaging, shoes, picture frames and cosmetics and also as a consequence of its being swallowed and concealed internally' (CDLE, personal communication, May 2004).

A recent survey conducted by the CityWide Drugs Crisis Campaign, which was carried out in response to an increased concern among community groups about an emerging cocaine problem, found evidence of increased trafficking of cocaine at retail level (CityWide Drugs Crisis Campaign 2004). Figure 10.2.5 shows trends in cocaine-related prosecutions in the Dublin Metropolitan Region as a proportion of the total number of such prosecutions. From 1995 until 1999, only a small number of cocaine-related prosecutions took place outside the Dublin Metropolitan Region. However, although cocaine prosecutions in the Dublin Metropolitan Region have continued to rise each year since 1999, the proportion of the total number of cocaine-related prosecutions which are not Dublin-based has also continued to grow.

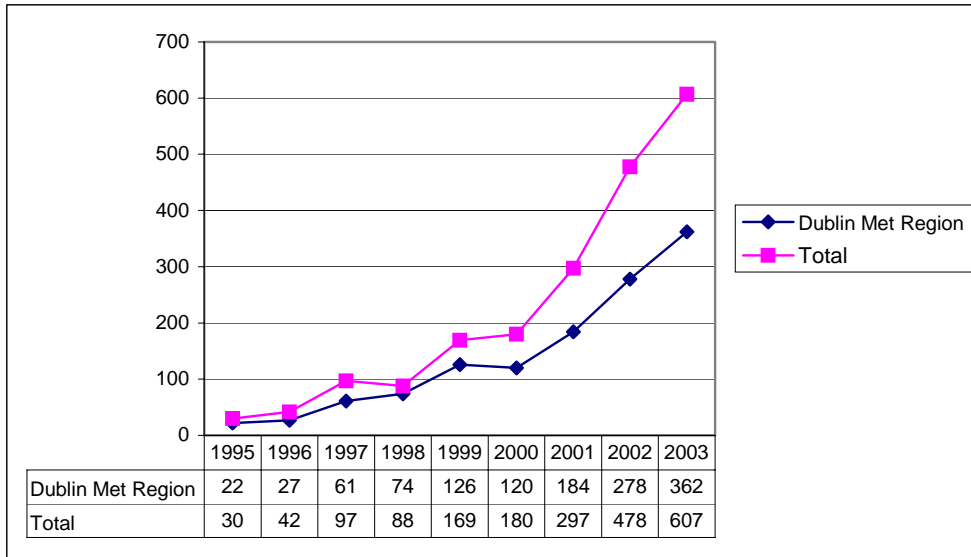


Figure 10.2.5 Trends in cocaine-related prosecutions in Dublin Metropolitan Region, 1995–2003 (from annual reports of An Garda Síochána 1995–2003)

As can be seen from Figure 10.2.6, there has been a sharp increase in cocaine-related prosecutions in the Southern Region since 1999, rising from 10 prosecutions in 1999 to 136 in 2002. Although there was a slight decrease in such prosecutions in the Southern Region in 2003, there was a 167% increase in cocaine-related prosecutions in the Eastern Region. Increases were also recorded in the Northern, South Eastern and Western regions.

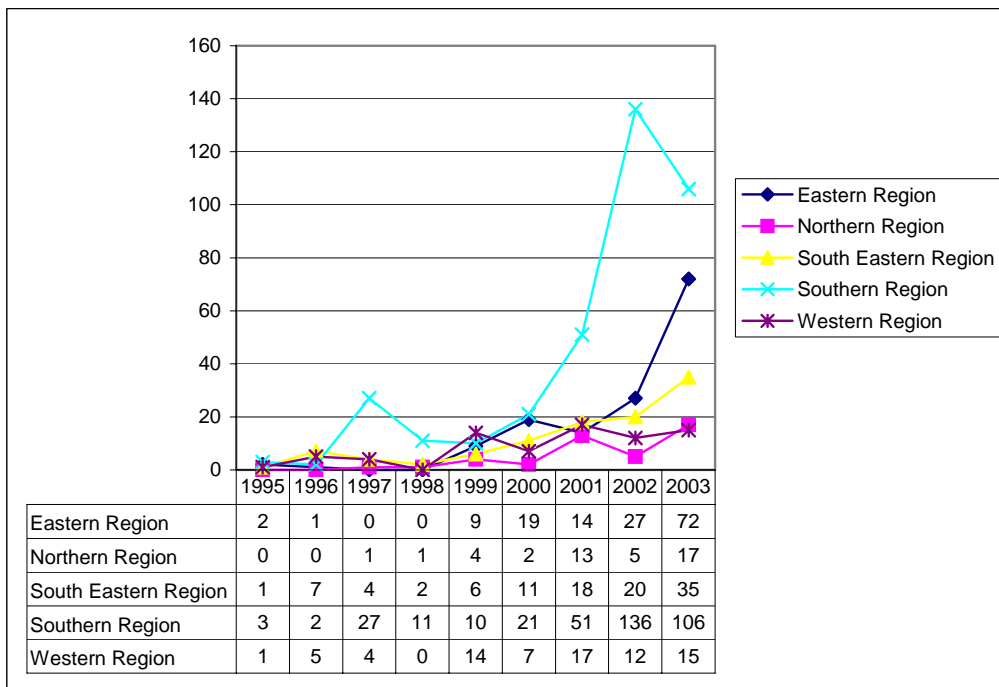


Figure 10.2.6 Trends in cocaine-related prosecutions outside the Dublin Metropolitan Region, 1995–2003 (from annual reports of An Garda Síochána 1995–2003)

In the Garda annual reports, drug-related charges are broken down into various categories. Of particular interest with regard to drug trafficking in Ireland is the category 'drug supply' (s15 Misuse of Drugs Act 1977/84). As can be seen from Figure 10.2.7 most supply offences occur in the Dublin Metropolitan Region. Figure 10.2.8 shows trends in supply offences in the other Garda regions throughout the state. Offences by drug type are not presented in the annual reports.

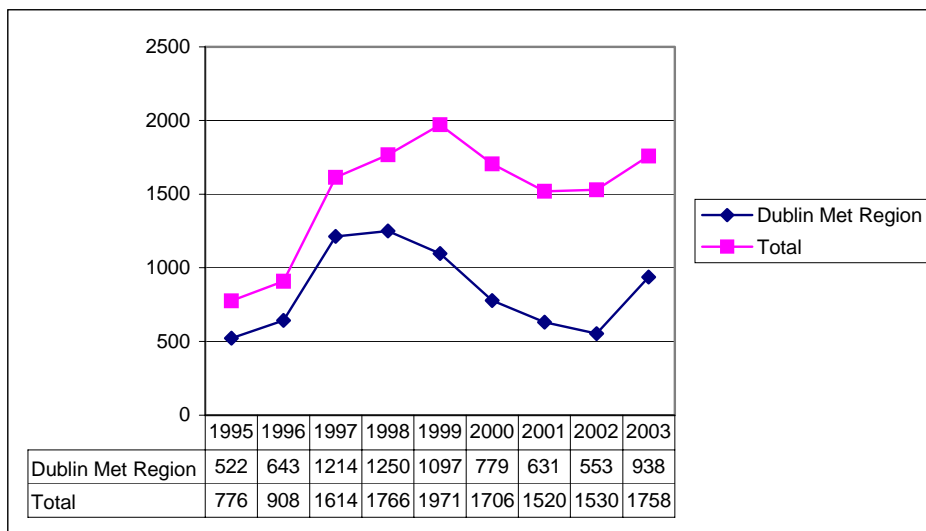


Figure 10.2.7 Trends in supply offences in Dublin Metropolitan Region, 1995–2003 (from annual reports of An Garda Síochána 1995–2003)

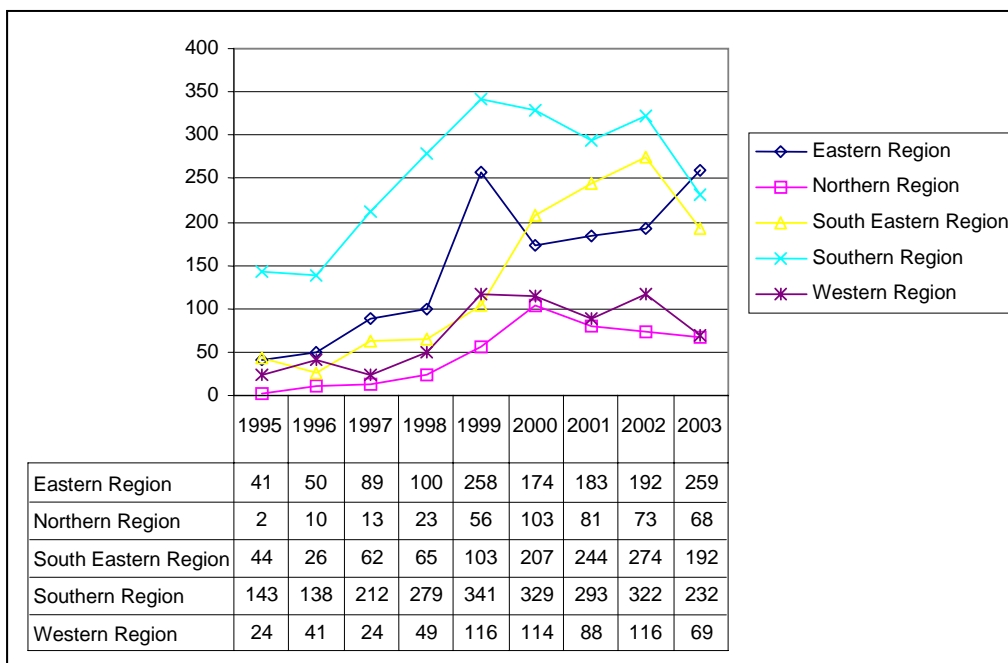


Figure 10.2.8 Trends in supply offences outside Dublin Metropolitan Region, 1995–2003 (from annual reports of An Garda Síochána 1995–2003)

When we compare Figures 10.2.7 and 10.2.8, we can see that from 1995 to 1997 drug supply offences increased in all Garda regions, except for the Southern and South

Eastern regions during 1996 when such offences declined slightly. In 1998, supply offences increased in all regions, with the largest increase in the Southern Region. From 1998 to 2002, supply offences decreased each year in the Dublin Metropolitan Region, down from a total of 1,214 offences in 1997 to 553 in 2002. However, the total number of offences increased up to its highest recorded point of 1,971 offences in 1999. This came about primarily as a result of a 158% increase in such offences in the Eastern Region and a 136% increase in the Western Region. Increases were also recorded in the Northern, South Eastern and Southern regions in 1999. In 2002, supply offences increased in all Garda regions except for the Dublin Metropolitan and Northern regions. It is unclear whether this reflects a real decrease in such offences in the Dublin and Northern regions, alterations in drug market patterns or a change in enforcement activities and resource deployment. In 2003, supply offences decreased in all Garda regions except for the Dublin Metropolitan and Eastern regions.

The ESPAD surveys (Hibell *et al.* 2000; Hibell *et al.* 1997; Hibell *et al.* 2004) also consider the question of drug availability. Table 10.2.1 provides figures from the most recent ESPAD survey (2003) on the perceived availability of substances (Hibell *et al.* 2004). The survey was conducted in 35 countries. The figures relate to those who answered 'very easy' or 'fairly easy' to the question, 'How difficult do you think it would be for you to get each of the following?' Among the 35 ESPAD countries, Ireland ranks first for perceived availability among respondents of inhalants, crack, cocaine and ecstasy. This appears remarkably high. For example, with regard to crack, Ireland is ranked joint first with the UK. However, the crack market in Ireland is not developed to anywhere near the same extent as in the UK. Also, with regard to ecstasy, 34% of Irish students perceive it as 'very easy' or 'fairly easy' to obtain. In the Netherlands and Belgium, the principal producing countries of the drug, the figures are 16% and 20% respectively. These findings suggest an exaggerated perception of drug availability in Ireland.

Table 10.2.1 Perceived availability of substances: Percentages among Irish students answering 'Very easy' or 'Fairly easy' in ESPAD Survey, average percentage among all ESPAD countries, and Ireland's ranking against other ESPAD countries, 2003

	Inhalants	Anabolic steroids	Marijuana	Amphetamine	LSD	Crack	Cocaine	Ecstasy	Heroin	Magic Mushrooms
Ireland	77	12	60	17	16	18	22	34	17	25
ESPAD Average	41	11	35	13	12	10	12	17	11	13
Ireland's Ranking in terms of Perceived Availability of Substances	1	14	2	10	7	1	1	1	2	3

Source: Hibbell B *et al.* (2004)

In the 2003 ESPAD study, 73% of Irish students knew of some place they could easily buy cannabis; the European average was 55%. Thirty per cent of Irish students reported that cannabis was easily available in school, which was just under twice the EU average. Table 10.2.2 compares the findings from Ireland with the average for the other 35 ESPAD countries.

Table 10.2.2 Places where marijuana or hashish can be easily bought: percentages among Irish students in ESPAD Survey, and average percentage among all ESPAD countries, 2003

	Don't know any place	Street, park	School	Disco, bar	House of a dealer	Other
Ireland	27	36	30	31	27	9
ESPAD Average	45	23	16	27	21	13

Source: Hibell *et al.* (2004)

Drug dealers and individual drug sources

There is some empirical evidence in Ireland on the proportion of drug users who also sell drugs (Furey and Browne 2003; Keogh 1997; O'Mahony 1997). Furey and Browne (2003) conducted a survey of 131 drug users. Respondents for whom crime was a source of income in the last month were asked to indicate the types of crime committed. Of the 47 who answered, the following types of crime were the ones most engaged in on a frequent basis: shoplifting (n=29), burglary (n=18), robbery (n=17), selling drugs (n=15) and stealing from cars (n=14).

The ESPAD survey (Hibell *et al.* 2004) found that, of the 40% of students who had used illicit drugs, 19% had received the drug for the first time from a friend or sibling, and 15% had shared it in a group.

10.3 Seizures

A key performance indicator (KPI) in the National Drugs Strategy is to increase the volume of opiates and all other drugs seized by 25% by the end of 2004 and by 50% by the end of 2008, using the volume of seizures in the year 2000 as a base. However, as the quantities of drugs seized can vary significantly from year to year, with a few very large seizures in one year distorting the overall picture, the number of separate seizures is generally regarded as a more useful indicator. The mid-term review of the Strategy recommended a new KPI to monitor the number as distinct from the quantity of seizures. The new KPI under the Supply Reduction pillar of the Strategy stipulates that by 2008 'the number of seizures' must have increased by 20% based on 2004 figures' (Steering group for the mid-term review of the National Drugs Strategy 2005).

There is also evidence to suggest that Ireland is occasionally used as a transit country for drug supplies to the UK market and elsewhere in Europe (Garda National Drugs Unit 2003). For example, the Customs Service seized over 19 tonnes of herbal cannabis in the period 2001/2002. From the intelligence available to it, Customs has concluded that the bulk of this product was for the UK market and elsewhere (CDLE, personal communication, July 2005). Therefore, the number of drug seizures should not be regarded as necessarily reflecting drug use at a national level. Either way, one can assume that relatively stable prices and drug supply would indicate that the amount seized is a small fraction of the whole.

The majority of seizures, whether made by Customs or gardaí, are recorded in the annual reports of the Garda Síochána. The seizure statistics published in the annual reports of the Revenue Commissioners include only those seizures made by Customs officers. However, seizures also result from joint Garda–Customs operations and investigations. Although the seizure figures in the Garda annual reports include most Customs seizures, we will present the figures provided by Customs in recent years

separately, so as to enhance the overall picture of enforcement activities at different stages of the drugs market. Seizures made by Customs will usually occur at points of access into the country such as sea- and airports, land frontiers, postal centres and approved Customs premises. Table 10.3.1 shows the number of drug seizures as reported in the annual reports of the Garda Síochána,⁶ and Table 10.3.2 shows those presented in the annual reports of the Revenue Commissioners.

Table 10.3.1 Number of seizures of specific drugs recorded in annual reports of Garda Síochána, 1995–2003

	1995	1996	1997	1998	1999	2000	2001	2002	2003
Cannabis resin	3031	3233	3753	4264	4322	4401	5960	2746	3366
Cannabis herb	148	179	294	213	188	219	253	242	309
Cannabis plants	26	36	55	36	28	21	20	36	30
Heroin	209	664	599	884	767	598	802	714	660
Cocaine	42	93	157	151	213	206	300	429	566
Ecstasy-type substances *	571	405	347	466	1064	1864	1485	1027	1083
Amphetamines	89	217	475	680	467	169	162	243	211
LSD	62	42	48	19	29	31	6	0	5
Other	0	375	454	317	240	197	181	166	147
Total	4178	5244	6182	7030	7318	7706	9169	5603	6377

* Ecstasy-type substances include MDA, MDMA and MDEA.

Source: Annual reports of An Garda Síochána 1995–2003

Table 10.3.2: Number of seizures of specific drugs recorded in annual reports of the Revenue Commissioners, 2000–2003

Drug seized	2000	2001	2002	2003
Heroin	6	7	2	4
Cocaine	12	3	22	27
Ecstasy	12	13	7	8
Amphetamines	7	7	2	4
Cannabis resin	160	211	115	244
Herbal cannabis	764	957	491	494
Seizure totals	961	1198	641	781

Source: Annual reports of the Revenue Commissioners 2000–2003

When we compare Table 10.3.1 and Table 10.3.2 for the years 2000 to 2003, we can see that, in the case of heroin, cocaine, ecstasy and amphetamines, seizures made by Customs represent only a small proportion of the total number of seizures recorded in the Garda annual reports. However, Customs appear to have made a large number of seizures of herbal cannabis between 2000 and 2003. Also, many of these seizures do not appear to have been included in the Garda annual reports.

The total number of cannabis seizures reported in the Garda Annual Report for 2003 was 3,705. Cannabis seizures are classified under three headings: herbal cannabis, cannabis resin and cannabis plants. The vast majority of cannabis seizures made in Ireland are of cannabis resin. However, most of the seizures of herbal cannabis made by Customs between 2000 and 2002 do not appear to have been reported as such in the Garda annual reports. Customs reported 764 seizures of herbal cannabis in 2000; the Garda report presents a figure of 219 for that year. In 2001, Customs reported 957 seizures of herbal cannabis, while only 253 are recorded in the Garda report. In 2002, Customs reported 493 herbal cannabis seizures; only 242 appear in the Garda report

⁶ The number of seizures for each drug was not reported in the Garda Reports prior to 1995. Only the quantity and the total number of seizures was reported.

for that year. In 2003, Customs reported 494 herbal cannabis seizures while 309 seizures appear in the Garda report.

This can partly be explained by the fact that many of these seizures by Customs, particularly of small amounts, might not result in a prosecution or conviction. This might occur in cases where there is an absence of sufficient supporting evidence, for example, where the drugs came through the mail. However, all seizures will still be accounted for and reported as such by Customs (CDLE, personal communication, June 2004).

The total number of drug seizures recorded in the annual reports of the Garda Síochána decreased by 17.2% between 2000 and 2003, down from 7706 to 6377 seizures. Seizures made by Customs decreased by approximately 18.7% during this period, down from 961 seizures in 2000 to 781 in 2003.

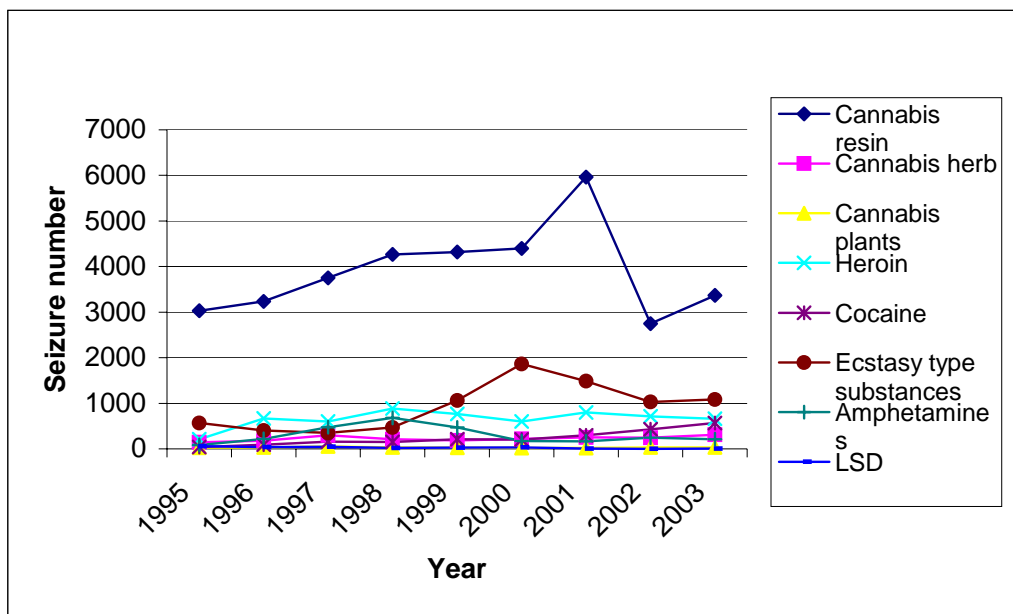


Figure 10.3.1 Trends in the number of drug seizures for selected drugs 1995–2003 (from annual reports of An Garda Síochána 1995–2003)

Figure 10.3.1 shows the trends in the number of seizures of specific drugs between 1995 and 2003, the most recent year for which statistics are available. The total number of drug seizures more than doubled between 1995 and 2001, increasing from 4,178 in 1995 to 9,169 in 2001. In 2002 there was a significant decrease of 39% in the total number of drug seizures. As can be seen, however, this decrease appears to have been caused by a 51% decrease in cannabis resin seizures and a 31% drop in ecstasy seizures. In 2003 the total number of seizures increased from 5,603 in 2002 to 6,377 seizures in 2003. Figure 10.3.2 excludes cannabis seizure trends and shows trends in the other main drugs seized.

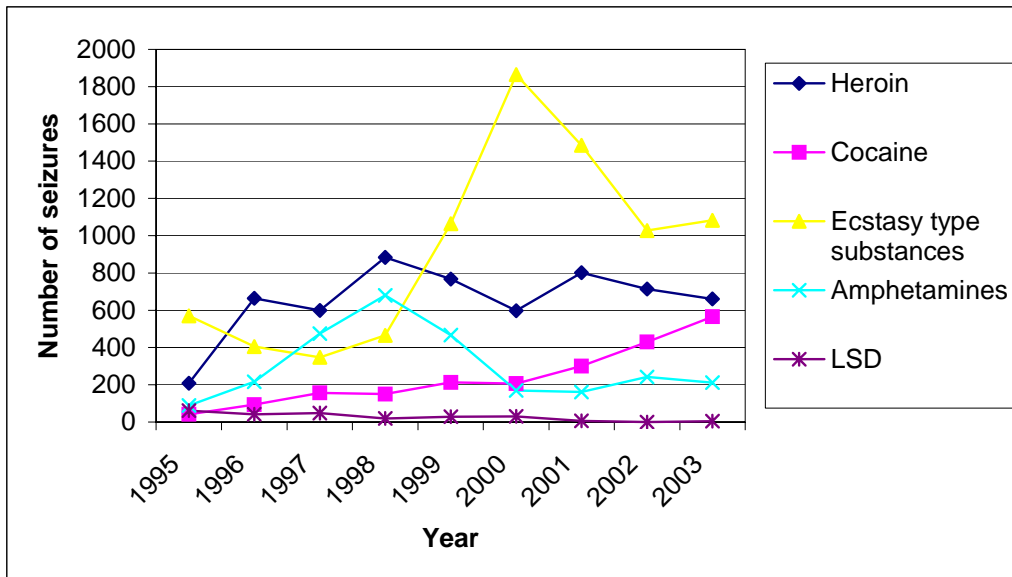


Figure 10.3.2 Trends in the number of heroin, cocaine, ecstasy, amphetamines and LSD seizures 1995–2003 (from annual reports of An Garda Síochána 1995–2003)

As can be seen from Figure 10.3.2, heroin seizures appear to have peaked at 884 in 1998, followed by a decline to 598 seizures in 2000. In 2001, the number of heroin seizures rose to 802. Heroin seizures have decreased by just under 18% since 2001, down from 802 in 2001 to 660 in 2003.

In Ireland, cocaine seizures increased steadily to a total of 213 in 1999, dropped slightly in 2000, and increased sharply to a total of 566 seizures in 2003. Customs report that the biggest single trend observed in the last two years was the increase in the number of cocaine seizures and also in the volume of cocaine seized. Twenty-two seizures totalling 19,473 kg of cocaine, with a reported value of €2,000,000, were made in 2002 (Revenue Commissioners 2003).

Ecstasy is the second most commonly seized drug in Ireland. Following a sharp increase in the number of ecstasy seizures, from 347 in 1997 to 1,864 in 2000, there was a decrease to 1,027 seizures in 2002 and then a slight increase to a total of 1,083 seizures in 2003.

Amphetamines seizures increased from 89 in 1995 to 680 in 1998, followed by a continuous decline to a total of 162 in 2001. In 2003 there was 211 amphetamine seizures.

Cannabis remains the principal drug seized in Ireland, accounting for 58% of total drug seizures in 2003. There has been a steady increase in cannabis seizures since 1995, with a significant increase from 4,641 seizures in 2000 to 6,233 in 2001. However, in 2002 there was a 51% decrease, with the number of cannabis seizures down to 3,024. In 2003, cannabis seizures increased to a total of 3,705 seizures.

Seizure quantities

Owing to the fluctuations in quantities of drugs seized from year to year, the number of seizures is regarded as a more useful indicator of drug availability and supply than quantities. For example, quantities may fluctuate widely from one year to the next, as in one year, there may be a few very large seizures. However, identifying the quantities of drugs seized can be a useful indicator of enforcement activities. Also, as mentioned above, increasing the volume of drugs seized is a commitment within the National Drugs Strategy 2001–2008 (Department of Tourism Sport and Recreation 2001). Quantities of drugs seized are reported in the annual reports of the Garda Síochána and in the annual reports of the Revenue Commissioners, which record the drug seizures in which the Customs Service is involved.

In 2003 both the volume of cannabis resin seized and the number of seizures increased. The total quantity of cocaine seized in 2003 was 107.5 kg. This represents a 500% increase on the amount seized in 1995. The volume of heroin seized has remained relatively consistent over the past few years, while the volume of cocaine seized has increased significantly. This suggests that, contrary to speculation in the media and elsewhere, the increase in the availability and use of cocaine might not be displacing heroin, with heroin volumes remaining consistent.

10.4 Price/purity

Price

Street drug prices as used by An Garda Síochána are set out in a Garda Headquarters Directive. Street prices for each drug are calculated on the basis of a special survey conducted among:

- Garda personnel involved in combating drug possession and supply at street level
- the Forensic Science Laboratory
- the Garda National Drugs Unit
- anecdotal evidence.

The most recent survey (2004) saw a reduction in the street price of cocaine from approximately €100 per gram to €70 (GNDU, personal communication, September 2005).

Purity

According to the Forensic Science Laboratory, drug purity levels have remained fairly constant, with heroin ranging from 30% to 40% and cocaine ranging from 9% to 25% (FSL, personal communication, September 2005).

Part B – Selected Issues

Summary

11. Gender differences

11.1 Interpretation of gender data on:

a. Consumption in the general population and young people

Gender differences in drug use in the general population and in young people in Ireland can be ascertained from a number of national surveys and, where such surveys have been repeated using the same methodology, trends in drugs use by gender can also be examined.

Gender differences in the general population

The first national drug prevalence survey in the general population was carried out by the NACD between October 2002 and April 2003 (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005). The survey followed best practice guidelines recommended by the EMCDDA (2002b). The questionnaire, based on the 'European Model Questionnaire', was administered through face-to-face interviews with respondents aged between 15 and 64 years normally resident in households in Ireland. The final achieved sample was 4,918, representing a response rate of 70%. The sample was weighted by gender, age and health board area to maximise its representativeness of the general population. The main results, in terms of gender differences, from this survey are discussed below.

Gender differences in lifetime, last year and last month prevalence (%) for selected drugs among adults (15–64 years) in Ireland for the years 2002 and 2003 are shown in Table 11.1.1. In terms of lifetime prevalence, almost twice as many men (24%) as women (13%) reported ever using an illegal drug. The level of use reported for cocaine, LSD, magic mushrooms and poppers was more than twice as high among men. However the lack of confidence intervals around these estimates makes it difficult to determine if these differences are statistically significant. Women reported higher lifetime prevalence rates for sedatives, tranquillisers and anti-depressants than men (15% compared to 9%) and for other opiates (4% compared to 2%). In both cases these drugs could have been obtained either with or without a prescription. Information on sedative, tranquilliser and anti-depressant use and other opiate use without a prescription has not yet been published separately.

In terms of last-year prevalence, men reported a rate of illegal drug use over twice as high as women. The greatest gender differences were seen in the rates for magic mushrooms (six times greater) and for amphetamines and cocaine use (over three times greater). In contrast, almost twice as many women as men (7% compared to 4%) reported the use of sedatives, tranquillisers and anti-depressants (with or without a prescription) in the last year. Overall, twice as many men (4%) as women (2%) reported the use of an illegal drug in the previous month. There was a similar gender difference in the levels of cannabis use during this period, with twice as many men

(3.4%) as women (1.7%) reporting use in the previous month. Again, the lack of confidence intervals around these estimates makes it difficult to determine if these differences are statistically significant.

Table 11.1.1 Gender differences in lifetime, last year and last month prevalence (%) for selected drugs among adult males and females (15–64 years) in 2002/2003

Drug	Lifetime prevalence		Last-year prevalence		Last-month prevalence	
	Males %	Females %	Males %	Females %	Males %	Females %
Any illegal drugs ¹	24.0	13.1	7.8	3.4	4.1	1.7
Cannabis	22.4	12.3	7.2	2.9	3.4	1.7
Heroin	0.7	0.3	0.1	0.1	0.1	0.1
Methadone ²	0.4	0.3	0.2	0.2	0.1	0.2
Other opiates ^{2,3}	2.0	4.0	0.4	0.5	0.2	0.1
Cocaine powder	4.1	1.6	1.7	0.5	0.7	-
Crack	0.5	0.1	0.1	0.1	-	-
Amphetamines	4.0	1.9	0.7	0.2	0.2	0.1
Ecstasy	4.9	2.6	1.5	0.6	0.6	*
LSD	4.4	1.4	0.2	-	*	-
Magic Mushrooms	5.7	2.0	0.6	0.1	0.1	-
Solvents	2.2	1.1	*	0.1	*	-
Poppers	3.9	1.3	0.4	0.4	0.1	*
Sedatives, Tranquillisers, Anti-depressants ²	9.3	15.0	4.2	7.3	3.0	4.9

1. Any illegal drugs include amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

2. With or without a prescription.

3. Other opiates include opium, Temgensic®, buprenorphine, Diconal, napps, MSTs®, pethadine, DF118® (dihydrocodiene), and morphine.

- no respondents in this category

* less than half of 0.1% (<0.05)

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005

In April 2003 the results of the second national Survey of Lifestyle, Attitudes and Nutrition (SLÁN) were published (Kelleher *et al.* 2003). The SLÁN survey was first undertaken in 1998 (Friel *et al.* 1999) and repeated again in the summer of 2002. In both surveys a small number of questions on drug use were asked, allowing drug use patterns to be examined. As in 1998, the sampling frame was the electoral register, the target population thus being adults aged 18 years and over. A proportionate random sampling design was used to select the survey sample. The questionnaires were posted to respondents and were self-administered. A total of 5,992 questionnaires were returned from a valid sample of 11,212 sent out, giving a response rate of 53.4%. This compares with a response rate of 62.2% in the 1998 survey. The report notes that the 2002 survey had fewer young males (18–34-year-olds) than the earlier survey and than occur in the general population as a whole.

The published SLÁN results provide only a limited analysis of the drug-use questions. Prevalence figures for males and females are reported separately. While the first SLÁN report did not report any drug prevalence data, the second SLÁN report provides data from both the 1998 and 2002 surveys, thus allowing gender comparisons over time. These comparisons are discussed below.

Lifetime, last-year and last-month prevalence of cannabis use for adult males and females (18+ years) in 1998 and 2002 are shown in Table 11.1.2. Prevalence rates are higher for males than females and this gender difference has remained over time. For both genders, there has been an increase in the proportion of people claiming to have ever used cannabis or to have used the drug in the last year or in the last month. The largest increase occurred in 'lifetime' use and may reflect a growing willingness to experiment with cannabis. It should be stressed however that no confidence intervals were provided around these estimates so that the differences between the two surveys could be due to sampling variation.

Table 11.1.2 Trends in lifetime, last-year and last-month prevalence of cannabis use for adult males and females (18+ years) between 1998 and 2002

Cannabis use	Adult males	Adult males	Adult females	Adult females
	1998 %	2002 %	1998 %	2002 %
During lifetime	21.9	26.2	13.8	19.1
During last year	11.0	12.1	6.2	6.7
During last month	6.7	7.8	2.8	3.0

Source: Kelleher *et al.* 2003

Apart from the cannabis figures the SLÁN report also provides last-year prevalence rates by gender for amphetamines, cocaine, ecstasy, heroin, LSD, magic mushrooms, solvents, and tranquillisers or sedatives (without a doctor's prescription), see Table 11.1.3. For most drugs, men had higher use in the last year than women and this gender difference remained over time. Again, the lack of confidence intervals makes it difficult to determine if these differences are statistically significant. The fact that the gender differences in the use of tranquillisers or sedatives (without a doctor's prescription) are not as marked as the gender differences observed in NACD's drug prevalence survey (described above) strongly suggests the need to provide separate data on the use of these drugs with and without a prescription.

Table 11.1.3 Trends in last-year prevalence of amphetamines, cocaine, ecstasy, heroin, LSD, magic mushrooms, and solvent use for adult males and females (18+ years) between 1998 and 2002

Used in last year	Adult males	Adult males	Adult females	Adult females
	1998 %	2002 %	1998 %	2002 %
Amphetamines	3.6	2.4	1.3	0.6
Cocaine	1.8	3.0	0.6	1.9
Ecstasy	2.9	3.9	1.5	2.4
Heroin	0.5	0.4	0.3	0.5
LSD	1.9	1.6	0.8	0.8
Magic Mushrooms	2.2	2.3	0.6	0.6
Solvents	0.5	0.7	0.3	0.6
Tranquillisers or sedatives ¹	1.3	1.4	1.3	1.0

1. Without a doctor's prescription

Source: Kelleher *et al.* 2003

Gender differences in young people

Also in April 2003, the results of the second national Health Behaviour in School-aged Children (HBSC) survey carried out in Ireland were published (Kelleher *et al.* 2003). The HBSC survey is a cross-national research study conducted in collaboration with the World Health Organization (WHO) Regional Office for Europe. Its aim is to gain new insight into, and increase our understanding of, young people's health and well-being, health behaviour and their social context. A total of six HBSC surveys have been conducted across Europe since the early 1980s. The first HBSC survey conducted in Ireland was carried out in 1998 (Friel *et al.* 1999) and repeated again in 2002. In both surveys a small number of questions on drug use were asked, allowing drug use patterns to be examined. The sampling procedures followed those used in 1998. Individual schools within health boards were first randomly selected and classes within schools were subsequently randomly selected for participation. The objective was to achieve a nationally representative sample of school-going children. The survey was carried out between April and June 2002 and covered children aged 10–17 years present in school on the day of the survey. A total of 176 schools out of a valid sample of 347 participated in the survey, giving a school response rate of 50.7%. However, only 5,712 questionnaires from 93 schools received by the end of the summer term

were included in the second HBSC report to maintain seasonal comparability with the first HBSC report.

The published HBSC results provide only a limited analysis of the drug-use questions. Prevalence figures for males and females are reported separately for lifetime and last-year use of cannabis and lifetime use of glue or solvents. While the first HBSC report did not report any drug prevalence data, the second HBSC report provides data from both the 1998 and 2002 surveys, thus allowing comparisons over time. These comparisons are discussed below.

For school-going boys there was a small drop in both lifetime and last-year prevalence of cannabis use between 1998 and 2002, Table 11.1.4. School-going girls on the other hand experienced an increase in cannabis use. Again, the lack of confidence intervals around these estimates makes it difficult to determine if these differences are statistically significant. In both surveys, boys had higher rates of cannabis use than girls, though this difference was not as marked in the 2003 survey.

Table 11.1.4 Trends in lifetime and last-year prevalence of cannabis use for school-going boys and girls (10–17 years) between 1998 and 2002

Cannabis use	Boys 1998 %	Boys 2002 %	Girls 1998 %	Girls 2002 %
During lifetime	16.2	14.2	8.6	11.7
During last year	14.0	13.4	6.7	9.5

Source: Kelleher *et al.* 2003

Lifetime prevalence of glue or solvent (inhalants) use increased slightly between the two surveys for both genders, Table 11.1.5. Again, boys had higher rates of inhalant use than girls in both surveys.

Table 11.1.5 Trends in lifetime prevalence of glue or solvent use for school-going boys and girls (10–17 years) between 1998 and 2002

Glue or solvent use	Boys 1998 %	Boys 2002 %	Girls 1998 %	Girls 2002 %
During lifetime	6.0	7.7	3.7	4.9

Source: Kelleher *et al.* 2003

As discussed in Section 2.3 the third European School Survey Project on Alcohol and Other Drugs (ESPAD) was published in December 2004 (Hibell *et al.* 2004). The third ESPAD survey was conducted in 35 European countries during 2003 and collected information on young people's alcohol and illicit drug use. The target population was school-going children born in 1987. Thus, those surveyed were aged either 15 or 16 years at the time of the survey. As in the earlier ESPAD surveys, the 2003 survey was conducted with a standardised methodology and a common questionnaire to provide comparable European data over time. Gender differences in drug use in the 2003 Irish ESPAD survey compared with a previous Irish ESPAD survey conducted in 1999 (Hibell *et al.* 2000) are discussed below.

For school-going boys there was a small increase in lifetime prevalence of cannabis use between 1999 and 2003 (Table 11.1.6). School-going girls, on the other hand, experienced a much larger increase in lifetime use of cannabis, up 10% from 29% in 1999 to 39% in 2003. While last-year prevalence remained the same for boys between the two survey periods, it again increased by 10% for girls (22% in 1999, 32% in 2003). While last-month prevalence (current use) dropped for boys between 1999 and 2003, it increased for girls from 11% to 17%. This increasing trend in cannabis use by school-going girls is similar to that found by the HBSC surveys, though direct comparisons are made difficult because of the different age groups. While the prevalence of cannabis

use was higher for boys than girls in the 1999 survey, this gender difference was reversed in the 2003 survey. Again, the lack of confidence intervals around these estimates makes it difficult to determine if these differences are statistically significant.

Table 11.1.6 Trends in lifetime, last-year and last-month prevalence of cannabis use for school-going boys and girls (15–16 years) between 1999 and 2003

Cannabis use	Boys 1999 %	Boys 2003 %	Girls 1999 %	Girls 2003 %
During lifetime	35	38	29	39
During last year	31	31	22	32
During last month	18	16	11	17

Source: Hibell *et al.* 2004; Hibell *et al.* 2000

While lifetime, last year and last month prevalence of inhalant use dropped for boys between 1999 and 2003, it remained stable or increased slightly for girls (Table 11.1.7). While boys had slightly higher rates of inhalant use than girls in the 1999 survey, this gender difference was reversed in the 2003 survey, a pattern similar to that observed for cannabis use.

Table 11.1.7 Trends in lifetime, last-year and last-month prevalence of inhalant use for school-going boys and girls (15–16 years) between 1999 and 2003

Inhalant use	Boys 1999 %	Boys 2003 %	Girls 1999 %	Girls 2003 %
During lifetime	22	14	21	21
During last year	12	7	10	11
During last month	5	2	3	4

Source: (Hibell *et al.* 2004 and Hibell *et al.* 2000)

b. Mortality and drug-related deaths

In June 2005, the Health Research Board published an overview of drug-related deaths in Ireland (Long *et al.* 2005a). The data presented in this publication describe what is known about drug-related deaths and deaths among drug users in Ireland between 1990 and 2002. According to the authors, the Central Statistics Office (CSO) in Ireland collates data on drug-related deaths extracted from the General Mortality Register (GMR). The Registrar of Births, Deaths and Marriages formally records all notified deaths in each jurisdiction. Depending on the circumstances, deaths are notified by the Coroner Service, hospitals or general practitioners. In addition, if the gardaí are investigating a death on behalf of the Coroner Service, they provide supplementary information related to the death to the CSO. Using data from the GMR, the CSO then categorises the cause of each death using the World Health Organization (WHO) diagnostic coding manual on the international classification of diseases (known as ICD categories). The ninth revision of the ICD manual continues to be used in this country. At the European level, the EMCDDA (2002a) has developed a standardised method for extracting drug-related deaths from the GMRs in all member states. This standardised method selects certain drug-related death categories and is known as 'Selection B'. The broad diagnostic categories and codes included in 'Selection B' are presented in EMCDDA guidelines. The substances causing death must be specified. For GMRs using ICD-9, the number of poisoning deaths (E-codes) must be extracted in combination with nature of injury codes (N-codes). Using this definition, the CSO extracts the numbers of drug-related deaths (along with demographic information) and provides them to the DMRD at the HRB.

Figure 11.1.1 presents the number of direct drug-related deaths, by gender, reported from 1990 to 2002 using the European definition known as Selection B. The vast majority of drug-related deaths occur among men, which is not surprising since the vast

majority of drug users are men. Of note, there was a steady increase in the number of drug-related deaths among women between 1994 and 2000 and a levelling off in 2001 and 2002. The number of drug-related deaths in males increased steadily between 1990 and 1993, and more dramatically between 1994 and 1999; and between 2000 and 2001 there was a sharp decrease in the number of men who died.

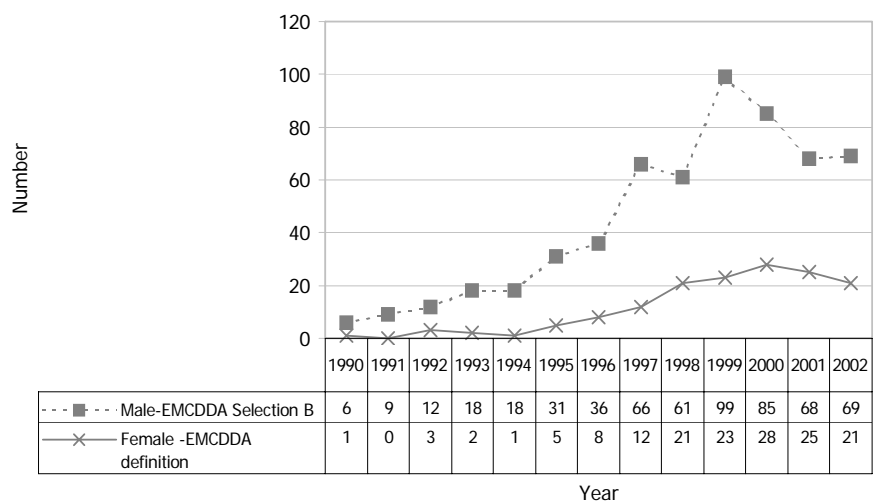


Figure 11.1.1 Gender of direct drug-related deaths in Ireland, by national and by European definition, reported by the CSO, 1990–2002 (unpublished data from the vital statistics)

c. Treatment demand data

Drug treatment data are viewed as an indicator of drug misuse as well as a direct indicator of demand for treatment services. The National Drug Treatment Reporting System (NDTRS) is an epidemiological database on treated problem drug use in Ireland. The NDTRS is co-ordinated by staff at the Drug Misuse Research Division of the Health Research Board on behalf of the Department of Health and Children. For the purpose of the NDTRS, treatment is broadly defined as ‘any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their drug problems.’ Data is collected on both new and previously treated cases. For the purposes of this analysis, the gender profile of new (incident) cases reported to the NDTRS for the period 1998 to 2003 is described below.

The number of new cases treated for problem drug use increased, from 1,626 in 1998 to 2,198 in 2003 (Figure 11.1.2). As expected, more men than women were treated for drug use. The number of both male and female cases treated increased over the period under review; the increase was greater among men than women. Between 1998 and 2003, on average 25% of new cases treated were women, the proportion ranging between 23% and 27%. In the most recent three-year period, there has been a small downward trend in the proportion of new female cases treated, from 26% in 2001 to 23% in 2003.

New cases treated for drug use by gender, 1998-2003

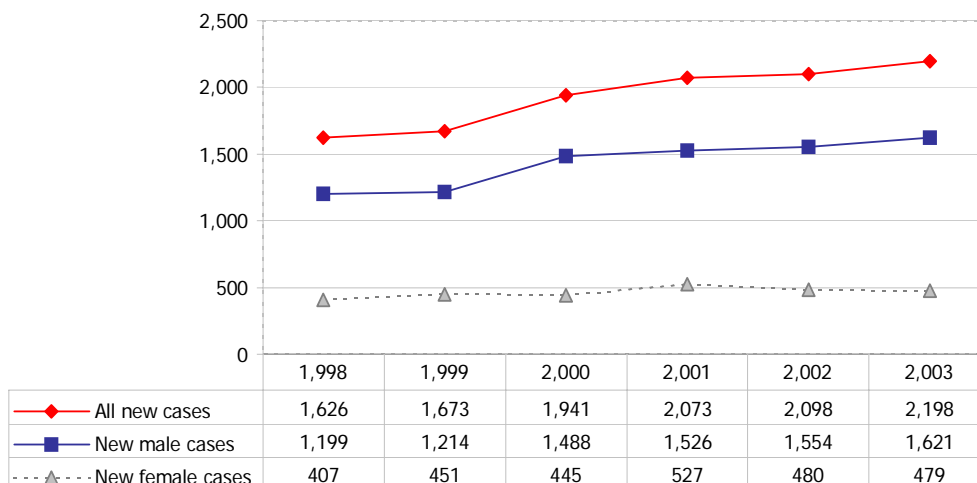


Figure 11.1.2 Number of new cases treated for problem drug use, by gender, 1998–2003

The majority of new cases, both male and female, are treated at outpatient facilities (Figure 11.1.3). A higher proportion of females (79%) than males (72%) are treated at outpatient facilities (Figure 11.1.4). A lower proportion of females (17%) than males are treated in residential facilities; this may be due to the fact that more women (6%) than men (1%) are caring for children on their own. Between 1998 and 2003, there was a large increase in the number of general practitioners providing methadone treatment services in Ireland but, despite this, the number of general practitioners participating in the NDTRS was still very low. During the reporting period, the prison service did not participate in the NDTRS, although it did provide drug treatment services.

Type of service provider attended by new cases by gender, 1998-2003

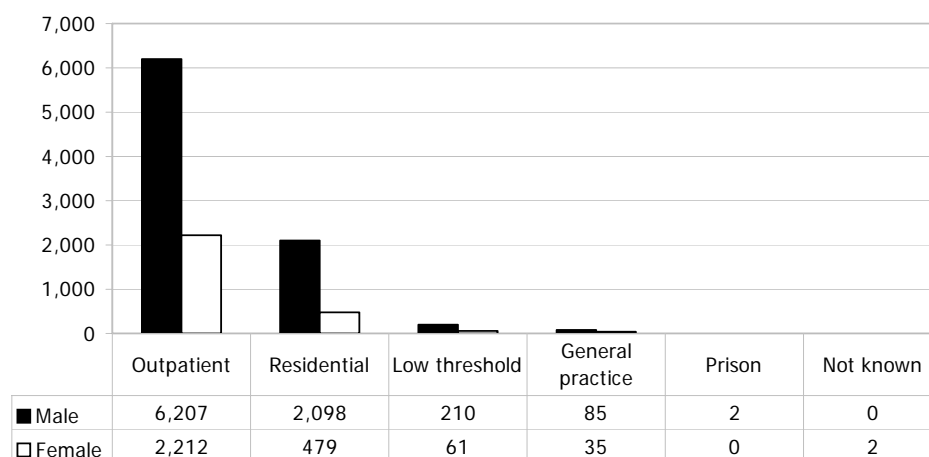


Figure 11.1.3 Number of new cases attending each service provider, by gender, 1998–2003

Type of service provider attended by new cases by gender, 1998-2003

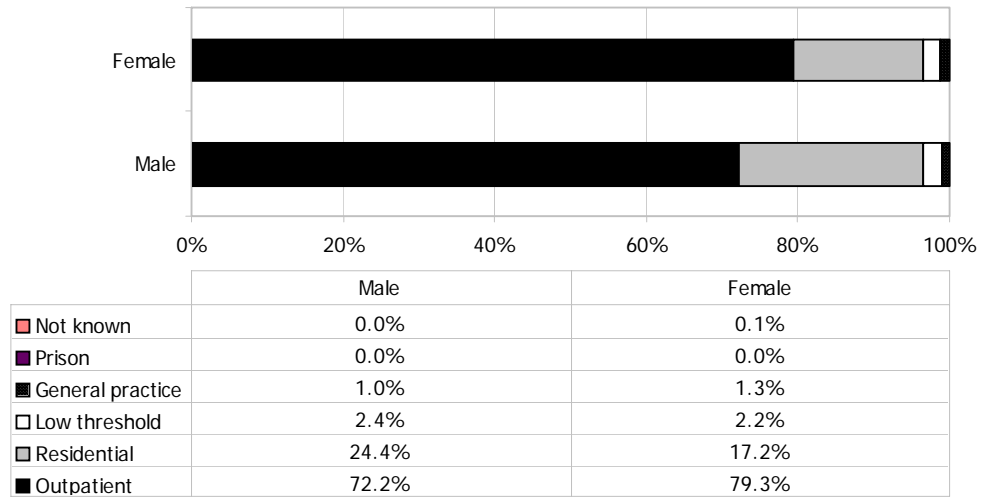


Figure 11.1.4 Proportion of new cases attending each service provider, by gender, 1998–2003

Figures 11.1.5 and 11.1.6 present the numbers and proportions, by source of referral to drug treatment services, for new cases by gender. A higher proportion of females (8%) than males (3%) were referred through the social services. As expected, a lower proportion of females (6%) than males (18%) were referred through the criminal justice system.

New cases source of referral for drug treatment by gender, 1998-2003

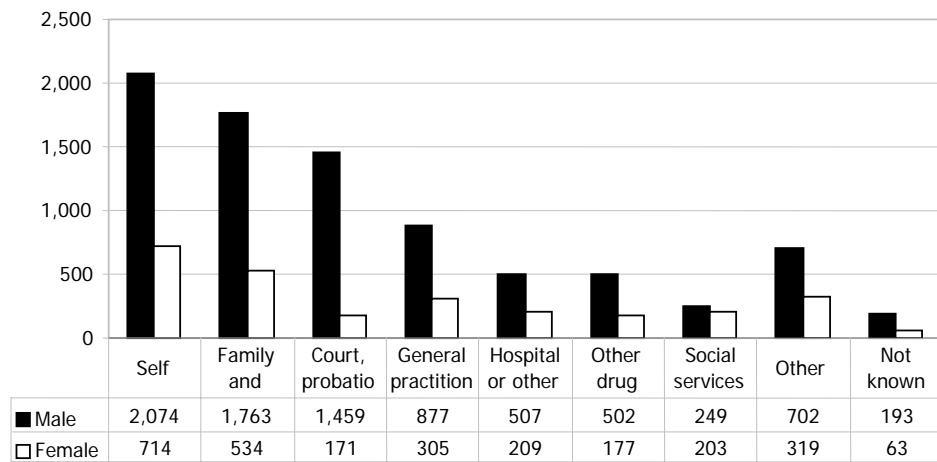


Figure 11.1.5 Number of new cases referred to drug treatment services, by source and gender, 1998–2003

New cases source of referral for drug treatment by gender, 1998 to 2003

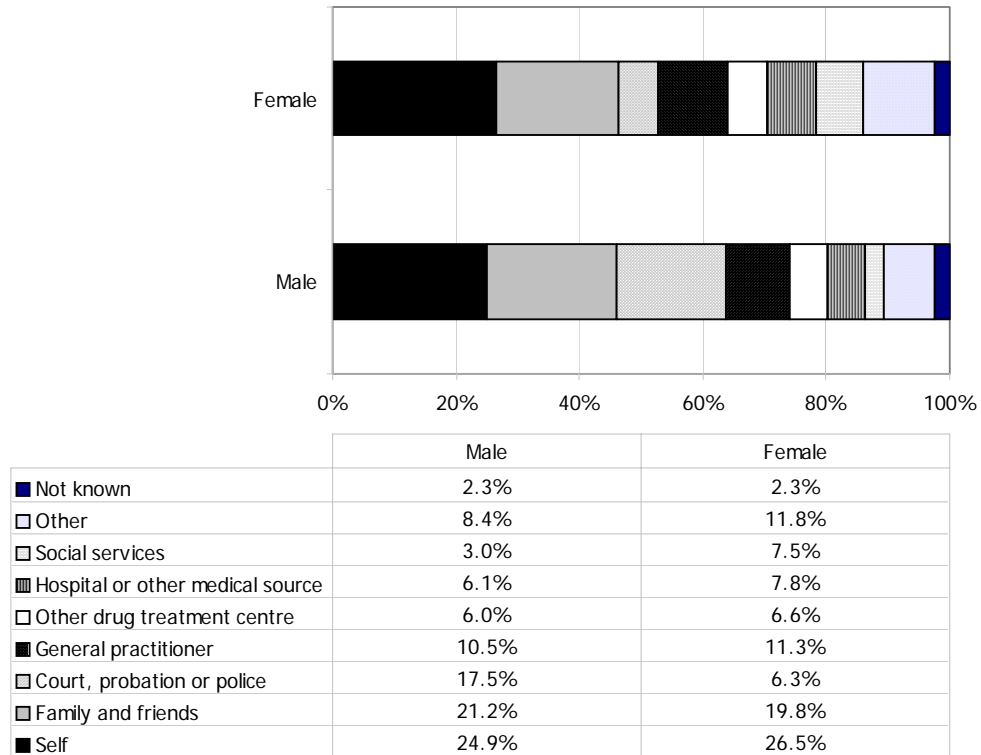


Figure 11.1.6 Proportion of new cases referred to drug treatment services, by source and gender, 1998–2003

With the exception of the youngest age group, the distribution of age at which use of the main problem drug commenced was broadly similar for new cases by gender between 1998 and 2003 (Figure 11.1.7). A slightly higher proportion of men (21%) than women (18%) started using their main problem drug before they were 15 years old. Over 50% of both men and women started to use their main problem drug between 15 and 19 years of age.

The delay in seeking treatment for both newly treated men and women is demonstrated when Figure 11.1.7 and Figure 11.1.8 are compared. For example, only 2% of males and 3% females treated sought treatment before reaching 15 years of age, whereas 21% of men and 18% of women started using their main problem drug before they were 15 years old. The same delay was noted in the 15–19-year-old age group. Of note, a higher proportion of women (73%) than men (66%) sought their first treatment in the under-25-year age groups.

New cases age first used main problem drug by gender, 1998-2003

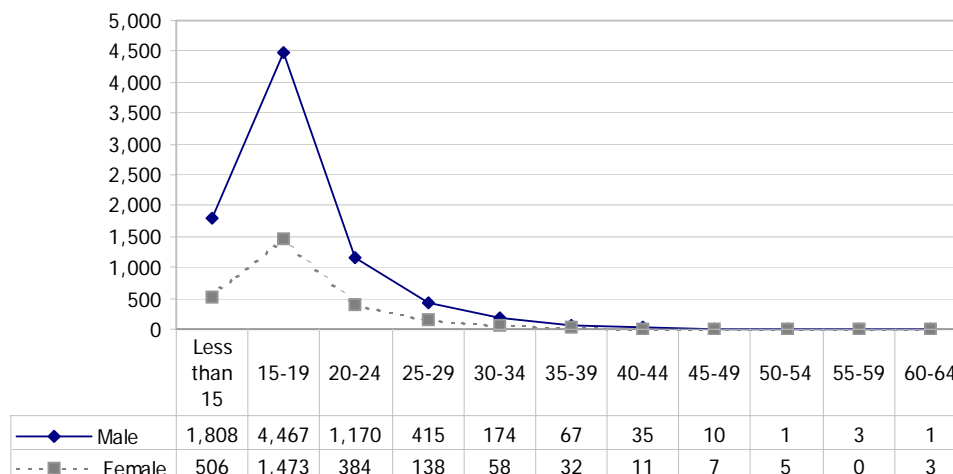


Figure 11.1.7 Age at which new cases commenced using their main problem drug, by gender, 1998–2003

Age of new cases treated for problem drug use by gender, 1998-2003

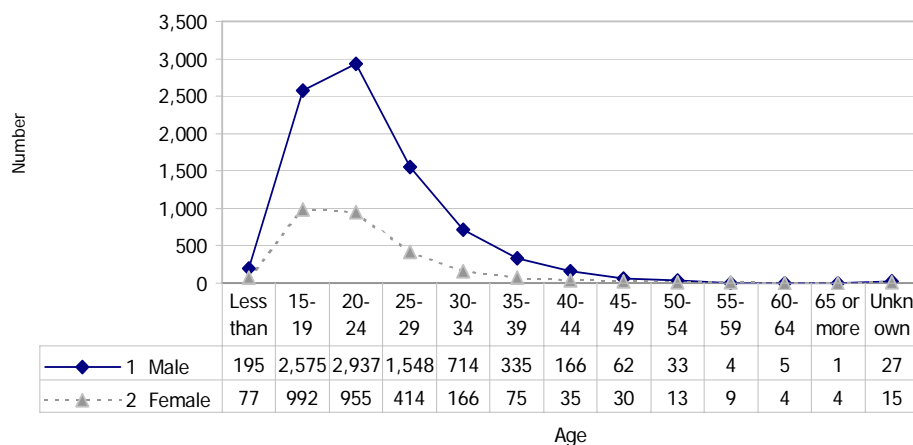


Figure 11.1.8 Age at which new cases were treated for problem drug use, by gender, 1998–2003

Half of both men and women commenced using any drug by the age of 15 years and half of the injectors commenced injecting drug use before they were 19 years old (Table 11.1.8). Half of both men and women had left school before they were 16 years old. Of note, the median age of first treatment was one year lower for women than for men. It is important to note that pregnant women (and their partner if in a stable relationship) are treated on presentation to the services and do not have to go through the normal assessment procedure or on a waiting list; this may influence the median age.

Table 11.1.8 Median age at which new cases treated for problem drug use commenced using drugs, left school, injected and sought treatment, 1998–2003

	Median age (5 and 95 percentile)	
	Male	Female
Age first used any drug	15 (11-21)	15 (12-24)
Age left school	16 (13-18)	16 (13-18)
If injected, age first injected	19 (15-31)	19 (15-29)
Age of first treatment	22 (16-37)	21 (15-37)

Figure 11.1.9 and Figure 11.1.10 present the primary problem drug used by new treated cases, by gender, for the period 1998 to 2003. The numbers and proportions of males treated for stimulants, cocaine and cannabis use were very high compared to those of their female counterparts. The proportion of males treated for opiate use was also higher than that of females but the difference was not as high as for stimulants, cocaine or cannabis use. There was a slightly higher proportion of males than females treated for use of volatile inhalants. A higher proportion of females than males was treated for use of hypnotics and sedatives.

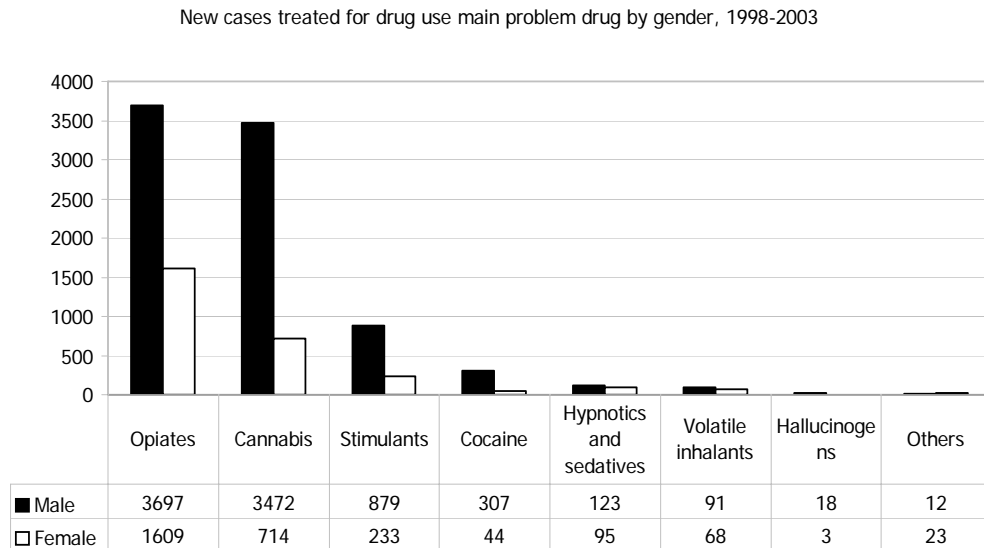


Figure 11.1.9 Number of new cases by main problem drug and gender, 1998–2003

New cases treated problem drug use main problem drug by gender, 1998-2003

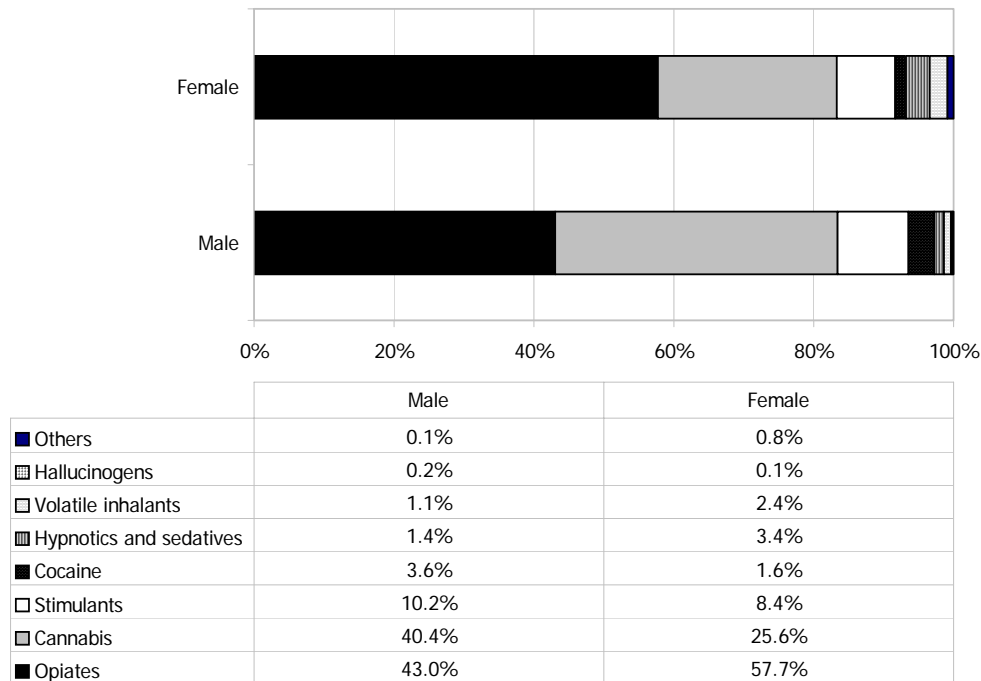


Figure 11.1.10 Proportion of new cases by main problem drug and gender, 1998–2003

A higher number and proportion of males (72%) than females (67%) treated for the first time reported using more than one drug between 1998 and 2003 (Figure 11.1.11 and Figure 11.1.12). This is an indicator that male drug users may be more difficult to treat than female drug users, though factors such as psychiatric co-morbidity may complicate the situation.

New cases treated for drug use reported polydrug use status, by gender, 1998-2003

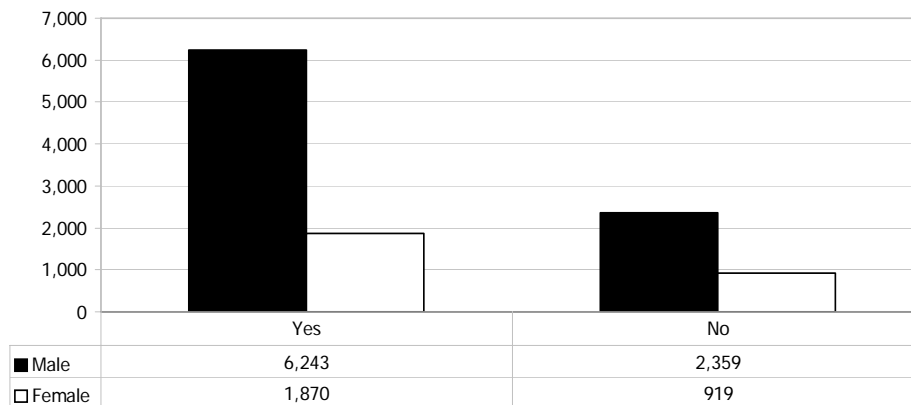


Figure 11.1.11 Number of new cases who used more than one problem drug, by gender, 1998–2003

New cases treated for drug use reported polydrug use status, by gender, 1998-2003

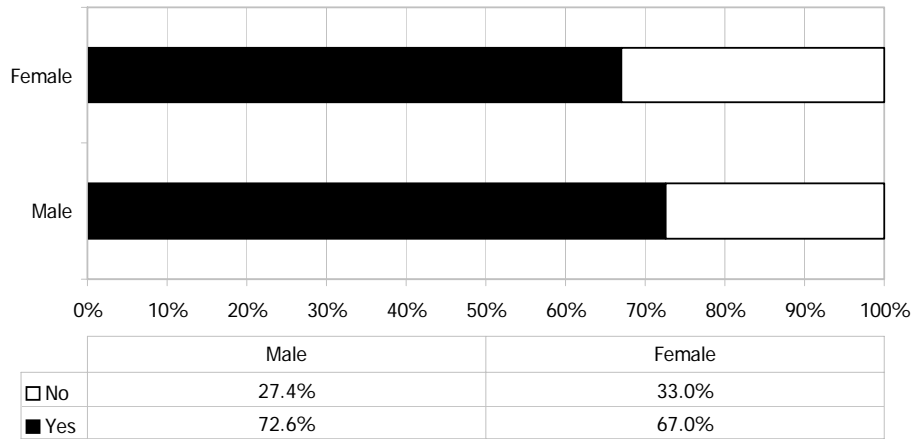


Figure 11.1.12 Proportion of new cases who used more than one problem drug, by gender, 1998–2003

Cannabis, stimulants and alcohol were the most common additional drugs used by new cases (Figure 11.1.13). A higher proportion of males than females used stimulants as an additional problem drug, while a higher proportion of females than males used hypnotics or opiates.

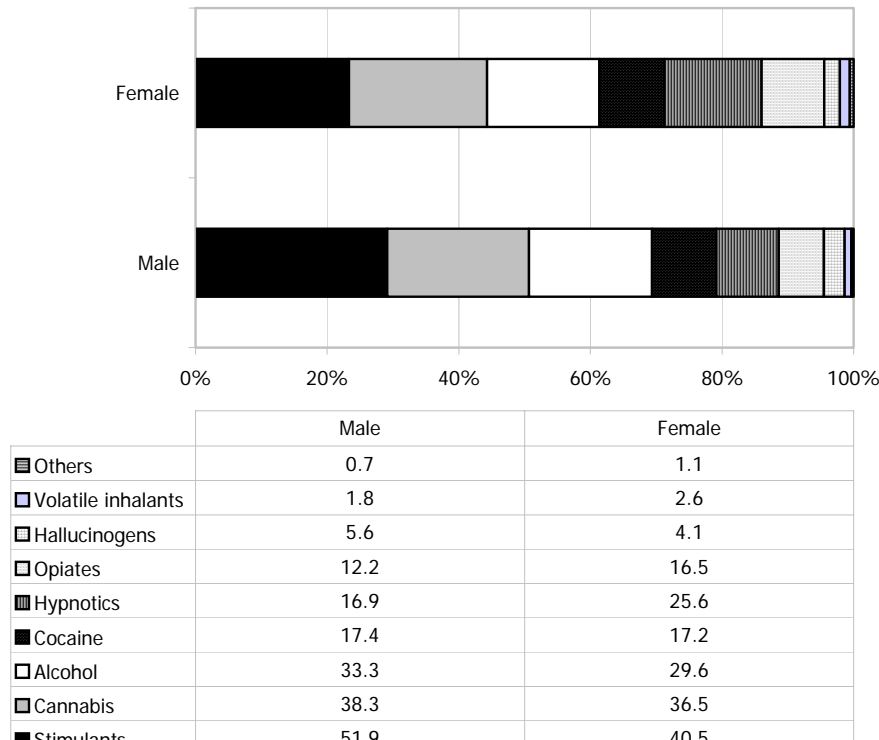


Figure 11.1.13 Proportion reporting additional problem drugs, by drug type and gender, 1998–2003

Between 1998 and 2003, higher numbers of men than women reported injecting drug use at their first treatment (Figure 11.1.14), but a higher proportion of women (34%) than men (28%) reported injecting drug use (Figure 11.1.15). This is explained by the higher proportion of opiate users among women (58%) than men (43%). When injecting drug use was examined in opiate users only, 60% of males and 57% of females injected.

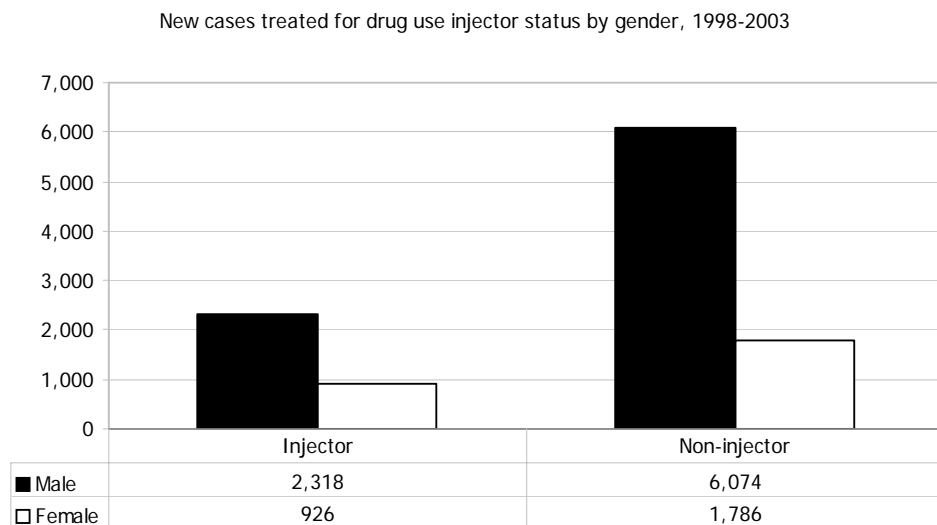


Figure 11.1.14 Number of new cases reported injecting drug use, by gender, 1998–2003

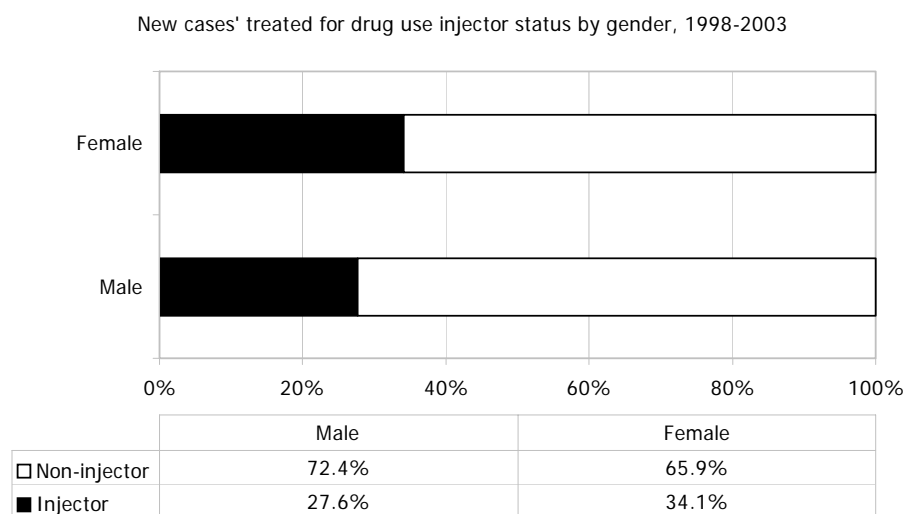


Figure 11.1.15 Proportion of new cases reported injecting drug use, by gender, 1998–2003

A lower proportion of women (59%) than men (69%) lived with their parents or family, a higher proportion of women (19%) than men (13%) lived with their partner, with or without children, and, as expected, a higher proportion of women (6%) than men (1%) lived alone with children (Figure 11.1.16). The type of accommodation did not vary between men and women (Figure 11.1.17).

House companions of new cases treated for drug use by gender, 1998-2003

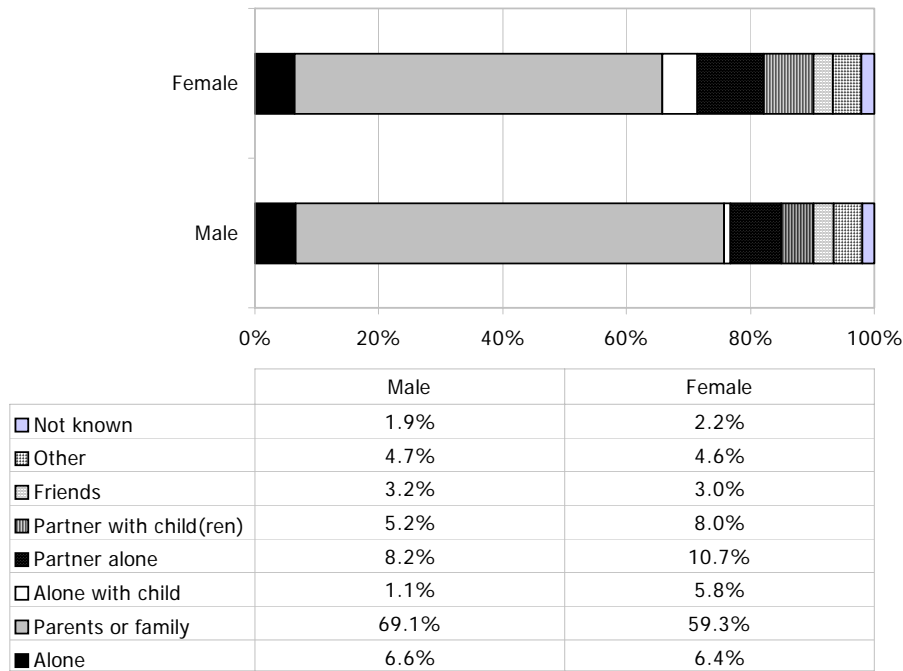


Figure 11.1.16 Proportion of new cases living with each category of house companions, by gender, 1998–2003

New cases treated for drug use reported type of accommodation, by gender, 1998-2003

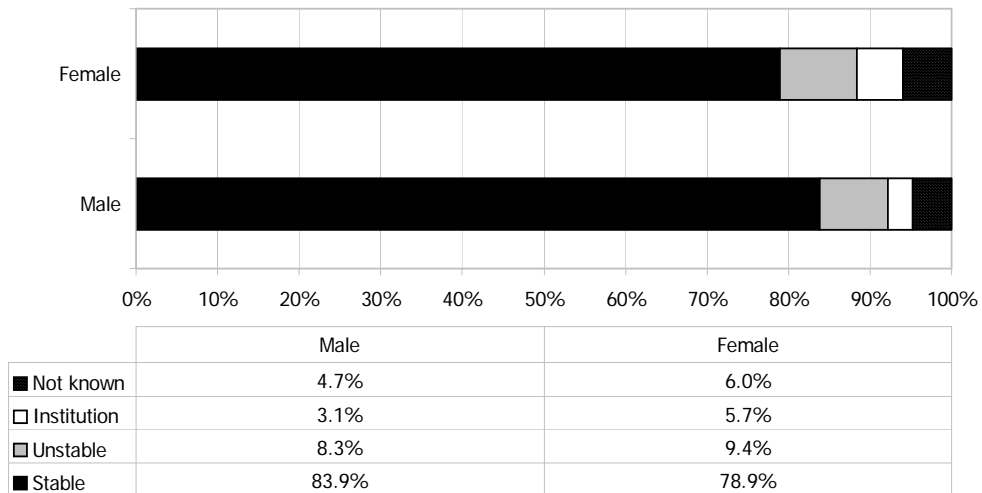


Figure 11.1.17 Proportion of new cases living in each type of accommodation, by gender, 1998–2003

A lower proportion of women (18%) than men (30%) were in regular employment and a higher proportion of women (11%) than men (15%) were students (Figure 11.1.18).

New cases treated for drug use employment status by gender

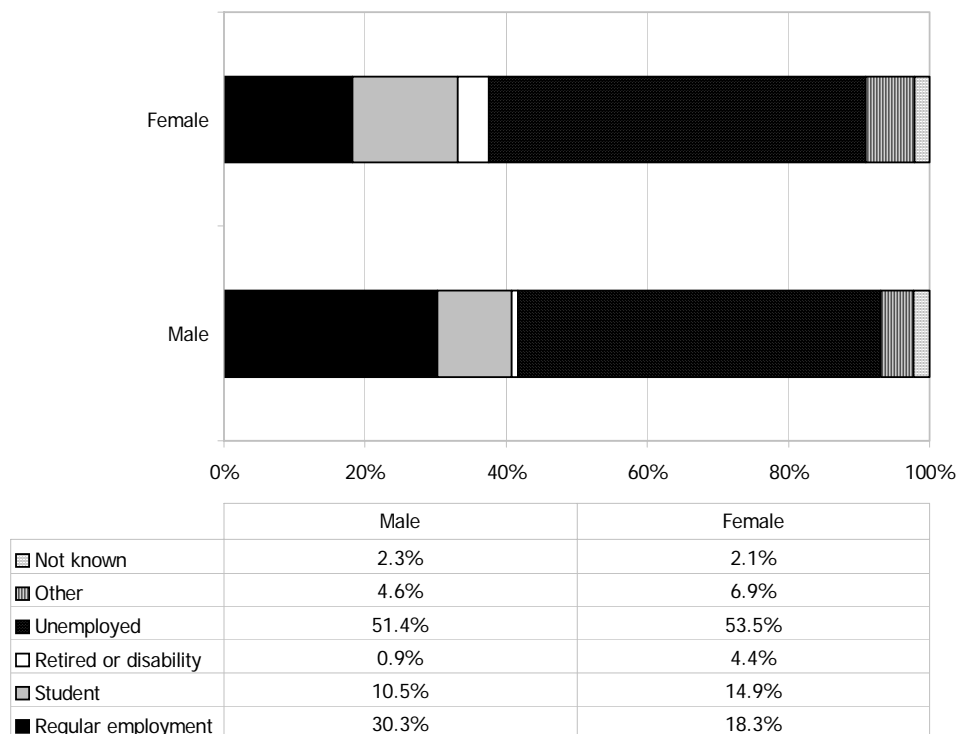


Figure 11.1.18 Proportion of new cases by employment status and gender, 1998–2003

The place of residence in Ireland differed by gender (Figure 11.1.19). A higher proportion of female than male drug users lived in Dublin. The opposite was observed outside Dublin.

New cases place of residence by gender, 1998-2003



Figure 11.1.19 Proportion of new cases by place of residence and gender, 1998–2003

d. Infectious diseases

The number and proportion of new HIV cases among injecting drug users, by gender, from 2000 to 2004 is presented in Table 11.1.9. The majority of cases are male. Over the five-year period, an average of 36% of HIV cases in injecting drug users were female. Between 1998 and 2003, on average 25% of new cases treated for problem drug use were women (Figure 11.1.2), indicating a possible excess risk of HIV among women. The surveillance system for hepatitis does not collect risk factor data.

Table 11.1.9 Number (%) of new HIV cases in injecting drug users in Ireland, by gender, 2000–2004

	2000	2001	2002	2003	2004
	Number (%)				
Male	53 (64)	16 (59)	25 (69)	30 (64)	44 (62)
Female	30 (36)	11 (41)	11 (31)	17 (36)	27 (38)
Total	83	27	36	47	71

Source: National Disease Surveillance Centre 2001–2004; Health Protection Surveillance Centre 2005

The prevalence of HIV or hepatitis B among injecting drug users was not associated with gender in any published prevalence studies. Only two studies, a community-based study and a study of prison entrants, reported a higher prevalence of hepatitis C in women injecting drug users compared to male injecting drug users (Table 11.1.10)

Table 11.1.10 Review of studies identifying risk factors for hepatitis C among drug users in Ireland

Year published and authors	Study design	Study population, sample size and statistical method	Gender associated with testing positive for hepatitis C
1995 Smyth <i>et al.</i>	Old and new attendees registered at Trinity Court Drug Treatment Centre, Dublin, August 1992 to August 1993	272 injectors living in Dublin Bivariate analysis	Yes, 94% of female injectors tested positive for hepatitis C compared to 80% of male injectors.
2001 Long <i>et al.</i>	Cross-sectional survey	Prison entrants Total: 596 Of whom 173 were injectors Multivariate analysis	Yes, women injectors were over three times more likely to test positive for hepatitis C than men, 89% versus 69% respectively.

e. Crimes and arrests

The primary source of information on crime and law enforcement activities in Ireland on a yearly basis is the annual report of the Garda Síochána. The report includes a chapter on drug offences, giving the number of drug offences in which proceedings were taken and the number, age and gender of persons charged as well as the nature of the offence. The Garda annual report is primarily a reflection of the activities and effectiveness of law enforcement organisations, rather than of the prevalence of drugs or the incidence of drug-related crime. The figures are influenced by a number of factors: the willingness of the public to report crime to the gardaí, recording practices, law enforcement activities and effectiveness in detecting drugs and drug-related offences. Effectiveness can, in turn, be influenced by law enforcement strategy, resource availability and deployment and the susceptibility of offenders to being caught. The limitations of official statistics, such as those in the annual report of the Garda Síochána, in terms of describing the overall crime picture, have been highlighted by a number of writers in the area (Connolly 2006).

In 2003, the most recent year for which figures are available, 6,044 persons were prosecuted for drug offences. Of these, 5,548 were male and 496 were female. Figure

11.1.20 shows trends in persons prosecuted for drug offences from 1995 to 2003. Prosecutions of both males and females increased sharply between 1996 and 1997. Following a slight decrease in 1998, prosecutions of males increased from 5,409 in 1998 to 7,352 in 2001, and then declined to 5,548 in 2003. In contrast, the number of females prosecuted declined sharply in 1998 and has remained stable since then.

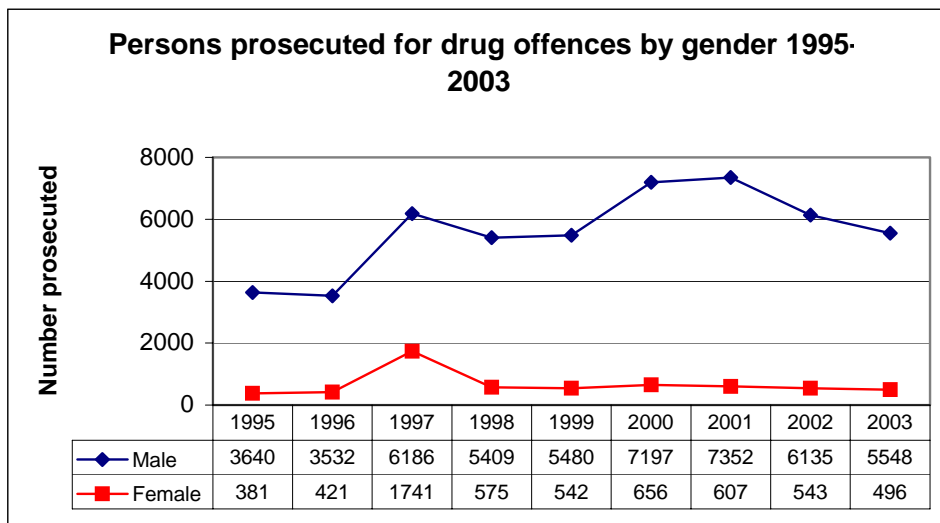


Figure 11.1.20 Persons prosecuted for drug offences, by gender, 1995–2003 (from annual reports of An Garda Síochána 1995–2003)

Figures 11.1.21 to 11.1.23 show prosecutions by gender and age. The sharp rise in prosecutions between 1996 and 1997 occurred among those aged between 17 and 21. This rise is more likely to reflect a change in enforcement practices than any change in drug use. The murder of journalist Veronica Guerin and the emergence of anti-drugs street activity in 1996 most likely contributed to the intensification of law enforcement activities during this period.⁷ The number of prosecutions of males aged over 21 increased between 1999 and 2001 and then decreased, while prosecutions of males between the ages of 17 and 20 increased steadily from 1995 to 2000 and then declined. The number of females aged 17 and over prosecuted has remained low and constant since 1998. The most striking trend is in respect of the prosecution of male children (under-17s). While the number of females prosecuted in this age group has remained low and steady since 1995, the number of young males in this age group prosecuted for drug offences has increased from 127 in 1997 to 426 in 2003.

⁷ See Section 8.3 for a discussion of these developments.

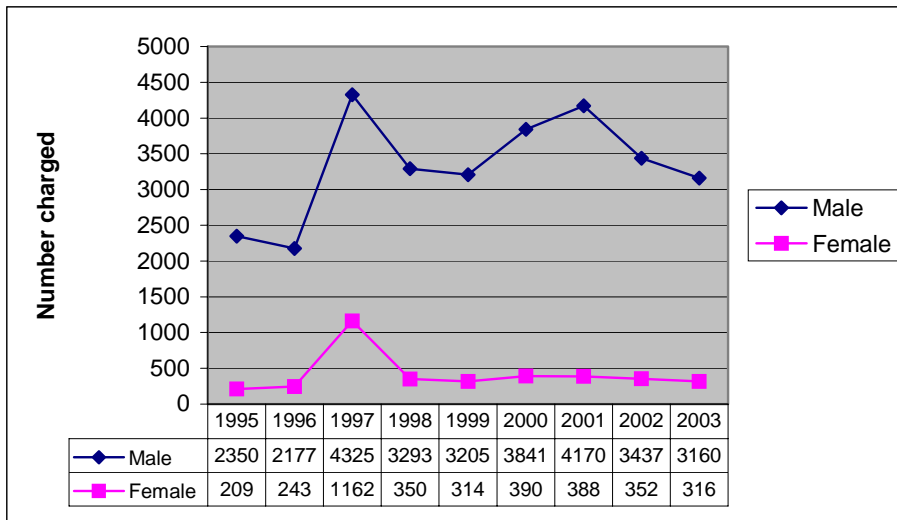


Figure 11.1.21 Number of over-21-year-olds prosecuted for drug offences, by gender, 1995–2003 (from annual reports of An Garda Síochána 1995–2003)

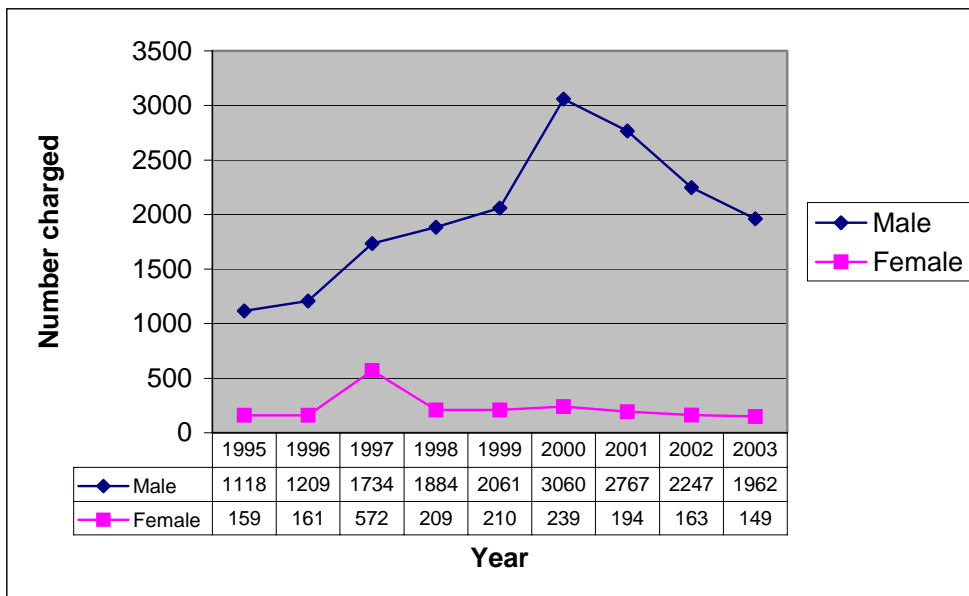


Figure 11.1.22 Number of 17–20-year-olds prosecuted for drug offences, by gender, 1995–2003 (from annual reports of An Garda Síochána 1995–2003)

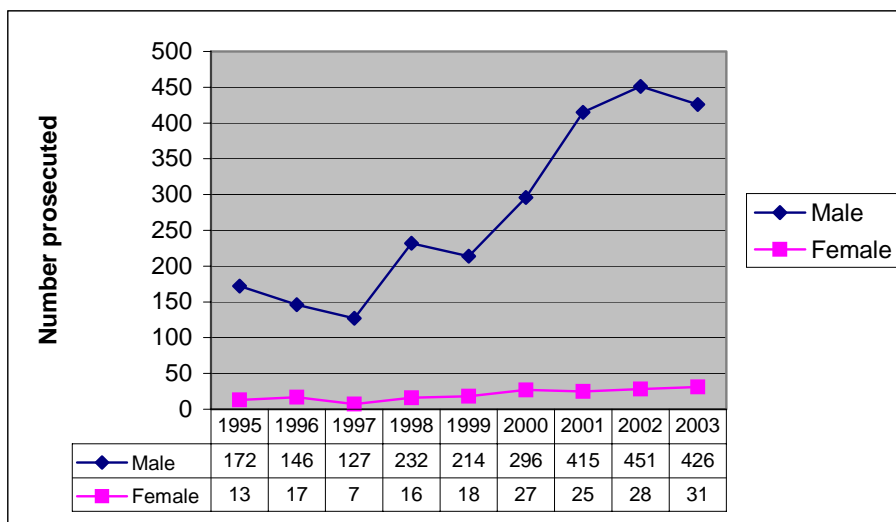


Figure 11.1.23 Number of under-17-year-olds prosecuted for drug offences, by gender, 1995–2003 (from annual reports of An Garda Síochána 1995–2003)

Drug-related crime

International research suggests that women’s drug use and offending are different from men’s. A review of international literature by Willis and Rushforth (2003) found that, for women drug users, the severity of their drug use is more closely related to their criminality than it is for men, particularly for prostitution and property crime activities.

Dillon (2001) found, from a small sample of drug-using prison inmates, that most of the female respondents surveyed were what she termed ‘reluctant criminals’, and that they engaged in crimes which they perceived involved the lowest levels of risk of arrest. Such crimes included prostitution, whereby ‘a move from shoplifting and other forms of larceny to prostitution was seen to offer women a way to earn money while minimising the risk of arrest’ (p. 41). Dillon’s study also found that women were more likely to have become involved in crime after commencing drug use, while men were more likely to have been involved in crime prior to drug use.

The general absence of Irish gender-specific research in this area makes it difficult to identify the local picture or to make comparisons with international research. It is clear from Irish research, however, that a source of income availed of by drug users in Ireland, particularly females, to sustain their drug habit, is prostitution. A survey of 351 drug users by Keogh (1997) found that, of the female respondents (number= 81), 15% stated that they had received some income from prostitution. None of the male users surveyed (number=270) admitted to prostitution or pimping. However, the author suggests that these figures may reflect ‘some under-reporting by the men, amongst whom selling sex may be stigmatised’ (p. 42).

A recent participatory research project conducted with 19 women working in prostitution (TSA Consultancy 2005) found that they reported habitual use of alcohol or drugs to cope with the work and its aftermath (see Section 11.4 for a fuller account).

11.2 Gender-specific responses on children and young people

Prevention programmes in Ireland are not targeted at gender-specific audiences.

11.3 Responses to problem drug use and gender; gender-specific harm reduction responses

In this section the gender-specific responses of two service providers based in Dublin are outlined – the Health Promotion Unit of Merchants Quay, and the Women's Health Project, which promotes the health and well-being of female sex workers.

Geoghegan *et al.* (1999) explored the differences in drug-using characteristics, by gender, in clients attending Merchants Quay Health Promotion Unit. The unit includes a needle exchange as well as a number of other health services. Between May 1997 and April 1998, there were 934 new attendees at the needle exchange. Of these new clients, 24% were female and 76% were male. The new female clients were younger than the male clients, on average 22 versus 24 years respectively. Female clients were nine times more likely to report having a sexual partner who injected drugs than male clients. Female clients were 69% more likely to be living with an injecting drug user than male clients. In addition, the women who participated in this study were almost four times more likely to report sharing injecting equipment with their sexual partner than the men. Women were also 79% more likely to report sharing injecting paraphernalia than men. Of note, the interval between initiating injecting drug use and attending the health promotion unit was shorter for women than for men. A higher proportion of male clients (22%) had received one or more doses of the hepatitis B vaccine than their female counterparts (11%). Furthermore, a higher proportion of clients (30%) who had ever been in prison had received one or more doses of the vaccine than had the proportion that had never been in prison (8%). Since men are more likely to be imprisoned than women, it is likely that most of the clients attending the Merchants Quay Unit had received their hepatitis B vaccination in prison. New female injectors were significantly more likely to suffer from physical and mental health problems than their male counterparts. This was surprising, as new female injectors had shorter injecting careers than new male injectors.

Based on these findings, Merchants Quay Ireland designed a study to examine the health status of female drug users attending the Unit (Lawless 2004). The study employed a mix of quantitative and qualitative methods and was funded by the Health Research Board. The research was conducted over an eight-week period and commenced in November 2001.

The researchers conducted a focus group to ascertain female drug users' interest in the research project and to assist in the design of appropriate data-collection tools. They administered a health information form to establish the participants' socio-demographic details, drug-using history including drug-taking practices, sexual-risk behaviours, current health problems, and prior use of health services. Following completion of the health information interview, participants took part in semi-structured interviews. The data collected during the semi-structured interviews provided insight into each woman's perception of her health status and her past experience of primary care services. Each client had a detailed medical assessment, which included a medical, surgical and gynaecological history. Details of current medication were documented. A physical examination and laboratory tests were completed. Seventeen clients completed the health information form and participated in the semi-structured interviews. Fifteen clients had a medical assessment, though two declined any laboratory tests. Eleven women returned for follow-up interventions.

The main findings of the study were:

Of the 17 women interviewed, the majority were under 30 years of age (14/17), homeless (9/17) and had child-care responsibilities (11/17). Almost half of the women (8/17) reported that their partner was an injecting drug user.

Heroin was the primary drug of choice for all 17 participants. Over three-quarters were polydrug users. All 17 had injected illicit drugs and nine were currently injecting. Of those currently injecting, six had experienced one or more problem at an injection site. Thirteen were currently taking prescribed methadone. Excluding methadone, eight participants were taking other prescribed medications, mainly antidepressants and sleeping tablets.

Over two-fifths (7) of the participants reported that their health status was either bad or very bad. In the three months prior to the study, 16 women reported psychological problems; of these, 11 reported anxiety and 14 reported depression. With respect to sexual risk factors, three women reported ever having a sexually transmitted infection.

Of the 16 clients who had a medical assessment, six reported that they had asthma, while three had epilepsy. Twelve had experienced a gynaecological problem. Nine women were either obese or overweight. Thirteen clients had been admitted to hospital one or more times and, of these, three were admitted as a result of a suicide attempt. In the three months prior to the study, over three-quarters (13/17) had contact with a medical service provider. The most frequent sources of medical consultation were general practitioner, drug worker and accident and emergency services.

Of the 17 women who participated in the interview, 11 had received at least one dose of the hepatitis B vaccine. Thirteen clients requested one or more laboratory tests. Of these, all 13 tested positive for antibodies to hepatitis C and two tested positive for antibodies to hepatitis B.

Overall, the study findings indicate that women who inject opiates have complex health and social problems and do use health services, though the services used in each instance may not be the most appropriate. Polydrug use, depression, anxiety and hepatitis C were common health problems among these women, confirming the need to provide mental health, addiction and infectious disease interventions at drug treatment centre level. The young age profile, level of child care responsibilities and lack of stable housing highlight the importance of, and need for, social services (such as counsellors, family therapists, community welfare officers and social workers) at all similar drug treatment centres.

The Women's Health Project in the HSE East Coast Area promotes the health and well-being of women involved in prostitution. In 1988, an Eastern Health Board (EHB) outreach programme commenced with three outreach workers who were working in public health nursing at the time (O'Neill and O'Connor 1999). The main aim of the outreach team was HIV prevention, with drug users being the main target group, especially those not in contact with other services. A harm-reduction approach was used, promoting safer injecting techniques and safer sex. In 1991, it was decided to commence a specific project for women working in prostitution, the Women's Health Project (WHP). This was motivated by concerns being raised in other countries about the number of women infected with HIV mainly contracted through sexual intercourse. While a small number of drug-using women were working in prostitution at that time, as shown by peer research carried out in 1996, by 1997 the numbers were starting to increase. In 1999, there were approximately 400 female intravenous drug users involved in prostitution in Dublin (estimated Garda figure). The Women's Health Project has had contact with 260 of these. Clients attending the project have access to medical

and addiction services, which employ a harm-reduction approach. This project provides a drop-in service twice a week, on Wednesday afternoon and Thursday night.

11.4 Gender-specific treatment data and approaches – differences in treatment organisation

a. Availability of gender-specific treatment

Ashleigh House

Ashleigh House, part of the Coolmine Therapeutic Community, provides a women's residential programme. It offers a drug-free environment for women wishing to address substance abuse problems in their lives. One of the key principles of this Coolmine programme is the concept of self-help, which encourages residents to play an active role and be responsible for their own rehabilitation and recovery. The programme has three phases:

1. Group therapy and one-to-one counselling allow the individual woman to identify and address any physical and psychological factors associated with her addiction and explore her self-awareness and self-identity.
2. Residents begin to work towards re-establishment in the wider community. All residents are assisted in seeking and securing full-time employment while residing at Ashleigh House. The main focus is on reintegration and resettlement. Individual work continues, through ongoing one-to-one counselling and specialised groups.
3. In the final, aftercare phase, when the two previous phases have been successfully completed, residents are assisted in moving out of Ashleigh House and into their own accommodation. Clients are encouraged to attend a weekly support group at Coolmine.

In addition, child-support workers run parenting skills course on a weekly basis for the women. Other available activities include art, music, drama, weekend passes for swimming, bowling, cinema, yoga, Ki massage, saunas. Ashleigh House has a close liaison with local colleges and schools to assist residents with literacy and/or numeracy problems. Women are encouraged to attend evening classes or clubs of their choice.

Pregnancy and drug use and the establishment of the drug-liaison midwife service in Ireland

In Ireland the need for a specialised intervention service to assist pregnant women with problem drug use has been apparent since the early 1980s (Ryan *et al.* 1981).

Four studies presented data on the socio-demographic profile of respondents in the eighties and early nineties (Ryan *et al.* 1981; Kelly *et al.* 1983; O'Connor 1988; Thornton *et al.* 1990). In general, the respondents were young, single and had low levels of educational attainment. Thornton *et al.* (1990) reported that all 38 cases in their study came from deprived areas in Dublin.

Ryan *et al.* (1981) and Kelly *et al.* (1983) reported that a high proportion of respondents had a history of psychiatric illness. O'Connor *et al.* (1988) and Thornton *et al.* (1990) reported high levels of infectious diseases (such as HIV and hepatitis B) among the drug users. Ryan *et al.* (1981) and Kelly *et al.* (1983) reported that 80% of the respondents used opiates. Infants born to mothers with problem opiate use have a high incidence of low birth weight (Coughlan *et al.* 1999). These infants may also

develop signs and symptoms of opiate withdrawal and subsequently, require admission to a neonatal unit (Thornton *et al.* 1990; Coughlan *et al.* 1999).

Bosio *et al.* (1997) published the estimated prevalence of illicit drug use among antenatal and postnatal attendees at the Rotunda Hospital in Dublin at 2.8% and 5.6% respectively. These data give some idea of the size of the problem at that time.

The first response to the increasing numbers of pregnant opiate addicts was in 1984, when the Drug Treatment Centre Board established a special programme for pregnant women reporting problem opiate use. The programme provided low-dosage methadone maintenance (20mg of Physeptone Linctus) administered daily, a weekly group therapy session and fortnightly attendance at antenatal clinics in the treatment centre. Over the period 1984 to 1986, 45 pregnant heroin addicts availed of this programme. A formal statutory response to the increasing numbers of pregnant women with problem drug use (primarily problem opiate use) and the high levels of morbidity among this group was initiated in 1999 when a specialised drug liaison midwife service was established in the Eastern Regional Health Authority area (Scully *et al.* 2001). This service is provided through a drug-liaison midwife at each of the three Dublin maternity hospitals. These midwives also have links to the community-based addiction centres in the respective health board areas.

Pregnant women and their partners (if active drug users) presenting for assessment of their problem drug use are treated immediately. Staff refer pregnant clients attending drug treatment centres to the midwives and the midwives conduct the initial assessment at the drug treatment centres. The midwife then monitors the client through pregnancy and the six-week postnatal period. S/he offers support and information on pregnancy and drug use. This includes attending the maternity hospital with the women during their antenatal and postnatal visits to liaise with obstetricians in order to ensure a consistent care plan and explain medical issues to the women and explain drug-related issues to the medical staff.

Scully *et al.* (2004) reviewed the referrals to the drug liaison midwife based at the Coombe Hospital from April 1999 to April 2000 through a retrospective review of clinical records. There were 111 referrals to the service. Only 21 women had planned their pregnancy. Eighty-three women were in treatment for substance abuse when referred to the drug liaison midwife. In total, 53 women were assessed as opiate unstable and 21 were benzodiazepine unstable. Fifty-six women attended for five or more visits. Thirteen per cent of women had a caesarean section, which was lower than the proportion of caesarean sections (16%) for all maternity cases at the hospital in 1999. Almost 11% of infants were delivered prematurely, which was higher than the proportion of premature deliveries (6%) for all maternity cases at the hospital in 1999. Just under 43% of infants were admitted to the Special Care Baby Unit, and 29% had a diagnosis of neonatal abstinence syndrome. Of the 85 women taking prescribed methadone, 47% of their infants experienced withdrawals from methadone. Higher methadone dose was associated with an increased risk of withdrawals. There was one neonatal death and no maternal deaths. All infants were discharged to the custody of their mothers. Only 11 women returned for a developmental check, and of these, six had developmental problems.

11.4 Gender-specific social reintegration approaches

Gender-specific social reintegration approaches are not a predominant feature of responses to drug misuse in Ireland. However, there are a small number of interventions specifically targeting women. The SAOL Women's Project located in the

North Inner City of Dublin and the STAR Women's Project located in the Dublin suburb of Ballymun target women who are seeking to stabilise their drug use. Both projects provide a wide mix of family supports, vocational training and employment supports, educational supports, and advice with budgetary and social welfare matters. In addition, both projects provide relapse prevention supports, counselling and social outings. An overview of both projects is provided below.

Two other initiatives are described in this section. The Renewal Women's Residence Programme, based on the Minnesota abstinence model, offers a residential supportive environment for women in the early stages of recovery from addictions and particularly for those emerging from residential treatment. The Next Step Initiative aims to develop a model of intervention to support women involved in prostitution to access the social economy, community education or local employment.

SAOL Women's Project

The SAOL project gets its title from the anglicised acronym of the Gaelic words; Seasamhact, Abaltacht, Obair and Leann, meaning Stability, Ability, Work and Learning. Established in 1995, following research by Dunne (1994) that highlighted the many difficulties women reported in accessing mainstream drug treatment services that did not take account of the different and specific needs of women drug users such as childcare and women's health issues, the SAOL project aims to assist women to achieve and maintain stability in their lives and work towards meaningful social reintegration.

Bowden (1997) conducted an interim evaluation of the project. The evaluator reported that participants were unanimous that the project was a very positive experience in their lives. They reported an improvement in self-esteem and felt their ideas and opinions were valued within the project. An improvement in literacy skills and overall educational development was reported as the most important change to their lives.

Recently released data from the project (J Byrne, personal communication, 2005) show that, from a total of 69 women who had been through the programme up to 2004:

- 13 (27%) left school between the ages of 10 and 13
- 27 (56%) left school between the ages of 14 and 15
- 8 (17%) left school between the ages of 16 and 18
- 37 (77%) never sat the Junior or Group Certificate
- 9 (19%) reached Junior Certificate Level standard
- 2 (4%) achieved Leaving Certificate Level

Of the 69 women who had been through the programme up to 2004, 48 completed the two-year programme; 14 were deemed unsuitable and their contract was terminated; 4 left the project voluntarily and 3 participants died. The outcomes for the 48 who completed the programme were as follows:

- 14 increased their education levels by one (e.g. Junior to Leaving Certificate)
- 8 increased their education levels by two (e.g. pre-Junior to Leaving standard)
- 14 increased their education levels by three (e.g. pre-junior to Third Level)
- 12 remained static at their pre-existing education level
- 24 increased their literacy levels by one grade
- 10 increased their literacy levels by two grades
- 3 increased their literacy levels by three grades
- 11 remained static at their pre-existing literacy levels

A notable achievement by the SAOL project has been the development of meaningful links with external institutions and organisations. For example, over the two-year period 1997 to 1999 the project participated in the New Opportunities for Women (NOW) Community Employment initiative and developed a project called 'Bringing Female Drug Users in from the Margins'. This initiative enabled participants to take part, for the first time, in third-level education. Over this period, 12 participants successfully completed a Women's Studies Certificate Programme at University College Dublin (UCD). In 2002 SAOL participated in a one-year Daphne programme, a European initiative concerned with addressing domestic violence. The SAOL participation examined the links between domestic violence and addiction, by seeking to explain addiction as a survival technique in situations of domestic violence. Subsequently SAOL developed working relations with a number of women's organisations around Ireland, working to address domestic violence and provide services such as women's refuges to female victims. This partnership approach has broadened the profile of SAOL and extended the network of supports available to female participants. As a direct consequence, Women's Aid, a national support organisation for women, now provides a specific support service for women from inner-city Dublin who are experiencing domestic violence.

STAR Women's Project

The STAR Women's Project has developed, since its establishment in 1998 to become an established community employment (CE) intervention for women from the Ballymun area who are working to stabilise their drug use. The project is sponsored by FÁS, the State Training and Employment Authority, and also receives part funding from the HSE Northern Area Addictions Service. It provides two years' intensive training and support to female participants. The project is based on an adult education model, with the emphasis on learning through the group and situating the learning process in the social and cultural life experience of the participants.

The training programme runs for one/two years and employs 16 participants who attend five mornings a week. All participants are taken on for a probationary period of 3–6 months, although this may be increased if an individual is experiencing difficulty meeting the structural demands of the project. Some participants drop out owing to a variety of causes such as relapse into active drug misuse, non-attendance, or irregular attendance. In some cases, domestic violence and lack of childcare facilities can result in irregular attendance. In addition, the project provides an addiction support group, a parenting programme and regular arts and crafts classes.

Updated data provided by the project show that participants were successful in gaining a high level of accreditation through their training. For example, they received the following number of training awards: 30 certificates in 2001, 17 certificates in 2002, 24 certificates in 2003, 28 certificates in 2004. Additional recent data provided by the project on progress of participants when they left the project reveals that for the year 2004, four went on to full employment; eight went on to further community employment; three went on to further vocational training (e.g. FÁS, PACE); two are deceased; and four potential participants did not commence the course.

Renewal Women's Residence Programme

The Renewal Women's Residence Programme was set up by Tabor Lodge, located in the southern area of the country, in response to a need for a residential supportive environment for women in the early stages of recovery from addictions and particularly for those emerging from residential treatment. Renewal has accommodation for 10 women. Length of stay is approximately three months. Residents are encouraged to find part-time or voluntary employment. Family participation is welcomed and encouraged. Residents are expected to attend weekly aftercare sessions. The

programme emphasises personal responsibility, peer support, participation in a twelve-step programme and life-style changes. The programme is based on the Minnesota abstinence model. Group sessions and one-to-one counselling form the therapeutic base of the programme. The FÁS Social Employment Scheme provides an excellent training and work experience programme for those who wish to participate.

Next Step Initiative

The Next Step Initiative (NSI) was developed by the voluntary organisation Ruhama through a participatory action research project. The aim of the NSI was to develop a model of intervention to support women involved in prostitution to access the social economy, community education or local employment. The core objectives of the initiative were:

- to undertake participatory research with a cohort of women who have experienced prostitution in order to identify the range of barriers, internal and external that affect them, and
- to use this learning to develop a model of intervention that could facilitate marginalised women to take the next step in their personal development.

The research engaged with a total of 19 women through the course of 350 hours of fieldwork. Fourteen of the women participated in more than one interview, with only two women engaging for a single one-hour interview. The majority of the women were interviewed five times, for an hour each time, with some women engaging in nine interview sessions. The spacing of interviews allowed the women to revise and reflect on what they had previously discussed. The interviews were not recorded but researchers made notes which were written up when the interview terminated. The women interviewees were then asked to review the notes and approve and make changes and/or additions.

Most of the women were keen to explore ways of taking the next step from their experience of prostitution and additional problems of alcohol and drug use. Some of the women reported that when engaged in active prostitution, they were 'out every night' to support a drug habit and a pimp. The role of drug and alcohol use mostly acted as a survival mechanism as the women would habitually get drunk or stoned or use prescription drugs in order to work and then use drugs and alcohol to numb the pain of prostitution. However, the women did report awareness of the dangers of not being fully alert owing to the effects of alcohol and drugs and the inherent risks involved in prostitution.

The research identified the need for the women to maintain strict boundaries between their private and public selves as an important psychological tool for survival. However, for some of the women the use of drugs acted against this separation and 'mixed it all up'. In addition, when some of the women tried to access drug treatment services, their experience was that existing policies underpinning services was a major barrier to moving on.

The Next Step Initiative has now been developed as a model of support and intervention, targeting women working in prostitution who are keen to access the social economy. The model has been tested for credibility and legitimacy among a number of marginalised women, service providers and specialist services, and the feedback suggests widespread endorsement. The report recommends that policy makers, service providers and specialist services should accept and endorse this model of support as the optimum means of supporting women involved in prostitution to take the next step in their personal development journey.

11.6 Gender-specific aspects in the criminal justice system

a. Responses to petty crime

Petty crime is not defined as such in Ireland. In the annual reports of An Garda Síochána crimes are categorised into 'headline' and 'non-headline' offences. Most drug offence prosecutions are for the simple possession of cannabis (s3 Misuse of Drugs Act. 1977) (Connolly 2006). These are categorised under 'non headline' offences and, as such, can be regarded as less serious. Most drug offences are tried summarily, before a judge and without a jury. A number of schemes exist to divert people away from further involvement in the criminal justice system. Such schemes include arrest referral schemes and the Garda Juvenile Diversion Programme, which has been in existence since 1963 (Ireland National Report 2004). These generally relate to young people who have been apprehended for minor offences and are not targeted in a gender-specific way: the numbers of males or females involved in the schemes reflect offending proportions as seen in Figures 11.1.19–11.1.22.

The Garda Juvenile Diversion Programme has now been placed on a statutory basis with the passage of the Children Act 2001. The programme provides that if certain criteria are met an offender under 18 years of age may be cautioned as an alternative to prosecution. In 2003, drug possession offences accounted for 5.3% of the total number of offences for which juveniles were referred for caution. Drink-related offences made up 20.7% of the total. Referrals by gender for drug offences are not presented in the Garda reports.

b. Gender-specific prison responses

Table 11.1.11 provides data, by age and gender, on the number of persons committed to prison under sentence (i.e not on remand) for drug offences in 2002, the most recent year for which figures are available. Of the 274 persons committed to Irish prisons for drug offences during 2003, 263 were male and 11 were female. It is not clear from the available official data how many people were committed to prison for offences related to their drug use. However, a number of prison studies have shown strong links between drug use, crime and imprisonment.⁸ A survey of 777 prisoners (59 of them women) found that 51% of the male and 69% of the female prisoners reported being under the influence of drugs when they committed the offence for which they were serving a sentence (Hannon *et al.* 2000).

Table 11.1.11 Males and females committed for drug offences under sentence, by age group, 2002

Age group (years)	15–17	17–21	21–25	25–30	30–40	40–50	50+	Total
Males (drug offences)	5	9	52	66	87	42	2	263
Females (drug offences)	1	1	5	2	1	1	0	11
Total committals (all offences)	281	537	1183	1024	1208	987	94	5314

Source: Irish Prison Service (2004)

Table 11.1.12 shows that 8 of the 11 women imprisoned for drug offences in 2003 received sentences of one year or more. In recent years an increasing proportion of Ireland's female prison population has comprised non-nationals convicted for being involved in the importation of drugs or acting as 'drug couriers'. According to Quinlan (2003: 57) 'they have represented up to between 20 to 25% of Ireland's imprisoned women and many of them come from South Africa'. The phenomenon of non-national female drug couriers has changed the profile of Irish female prisoners, not only in terms

⁸ For a review of these studies see Connolly (2006)

of the total numbers imprisoned, but also in terms of the length of their sentences. Quinlan (2003) argues that the introduction of mandatory drug sentences under the 1999 Criminal Justice Act, whereby those found in possession of more than €12,700 worth of drugs must receive a sentence of more than 10 years' imprisonment, has led to a lengthening of the average sentence served by female prisoners. Heretofore, she argues, 'only 3% of the 751 women committed to Mountjoy Prison between September 2000 and September 2001 received prison sentences of one year or over' (p. 59).

Table 11.1.12 Males and females committed to prison for drug offences, by sentence length, 2003

Sentence length	<3 mths	3-6 mths	6mths-1yr	1-2yrs	2-3yrs	3-5yrs	5-10yrs	>10yrs	Life	Ttl
Males	52	32	66	16	25	51	20	1	0	263
Females	0	2	1	3	2	1	2	0	0	11

Source: Irish Prison Service (2004)

The Womens' Prison, The Dóchas Centre, can be described as representing an innovative approach to imprisonment in Ireland. Dóchas is a purpose-built, modern prison, with accommodation for 80 women in seven separate 'houses' within the complex. Two houses are designated as drug free.

12 European drug policies: extended beyond illicit drugs?

12.1 Official endorsement by the National Drugs Strategy

Ireland's '*Building on Experience: National Drugs Strategy 2001–2008*' was developed to deal with the harm caused to individuals and society by the misuse of drugs (Department of Tourism Sport and Recreation 2001). The references and approaches proposed indicate that the actions deal mainly with illicit drugs, in particular, opiate misuse.

As part of the prevention approach, links at national, regional and local level between the National Drugs Strategy and the National Alcohol Policy were called for, 'to ensure complementarity between the different measures being taken'. Treatment services for drug and alcohol use were not officially linked, though, in practice, many of the drug services treat clients for alcohol dependence. As alcohol is a legal substance, it is generally regarded as inappropriate to deal with its availability using the mechanisms for controlling the supply of illicit drugs.

During the consultation process for the mid-term review of the National Drugs Strategy in 2004, participants expressed concerns about alcohol use in Ireland, in particular, binge drinking (Steering group for the mid-term review of the National Drugs Strategy 2005). At that time, participants questioned the rationale for two separate strategies and many felt both substances should be dealt with in a single strategy. The steering group for the mid-term review believed that the question of combining both strategies was beyond its remit. The group recommended that a working group (involving key stakeholders of both the alcohol and drugs areas) be established to explore the potential for better co-ordination between the two areas and how synergies could be improved. The working group will also examine and make recommendations on whether a combined strategy is an appropriate way forward. This working group will report by the end of 2006.

The mid-term review of the National Drugs Strategy published in 2005 recognised the need for an approach to treating problem drug use that could deal with a range of drug dependencies and polydrug use (Steering group for the mid-term review of the National Drugs Strategy 2005). The main emphasis is on developing treatment strategies to manage cocaine and opiate use, but alcohol was mentioned as an important secondary drug.

Tobacco, doping substances in sport, or gambling are not covered in Ireland's current National Drugs Strategy or its subsequent review.

12.2 Genesis and rationale

Alcohol misuse is increasingly being recognised as a major health and social problem. The publication entitled '*Treatment demand for problem alcohol use in the South Eastern and Southern Health Board areas 2000–2002*', which documented treatment demand for problem alcohol use in community settings and special residential services, reported that twice as many are treated for problem alcohol use than drug misuse and one-fifth of those with problem alcohol use also misuse drugs (Long *et al.* 2004b). As mentioned above, people working in the drugs prevention and treatment areas would support an approach that would link alcohol and drugs.

12.3 Responsibility and competences

The Department of Community, Rural and Gaeltacht Affairs in Ireland has responsibility for co-ordinating and overseeing the implementation of the National Drugs Strategy and a number of government departments have responsibility for implementing the actions of the strategy and reporting to the Department of Community, Rural and Gaeltacht Affairs on their progress (Steering group for the mid-term review of the National Drugs Strategy 2005).

The Department of Health and Children is responsible for implementing the National Alcohol Policy, and a number of other departments are responsible for implementing specific actions (Department of Health 1996).

The National Drugs Strategy assigned responsibility for ensuring 'complementarity' between alcohol and drugs measures to the following interagency co-ordinating mechanisms (Department of Tourism Sport and Recreation 2001). The Inter-Departmental Group (for Drugs), in conjunction with the Department of Health and Children and the National Drugs Strategy Team, was to develop formal links at local, regional and national levels with the National Alcohol Policy by the end of 2001. In addition, the National Drugs Strategy Team was tasked with meeting regularly with the co-ordinator of the National Alcohol Policy, and a member of the Team was to sit on the body charged with the co-ordination of the National Alcohol Policy.

13. Developments in drug use within recreational settings

Recreational settings are defined by the EMCDDA for the purposes of this section as clubs, discotheques, bars, parties, restaurants, outdoor events (e.g. festivals) and temporary venues, including the 'run up' and the 'fall out' surroundings.

13.1 New findings about trends in drug use, patterns of consumption and availability within recreational settings

To date there have been no Irish studies which have specifically examined drug use *within* recreational settings.

There is however ad hoc evidence to indicate that drugs are used within recreational settings and that, even in the absence of quantitative information on the nature and extent of this drug use, responses have been developed to tackle the use of drugs within such settings.

According to Murphy *et al.* (1998) ecstasy use in the club scene in Ireland emerged at broadly the same time as elsewhere in Europe, from the mid- to late-1980s, gaining widespread popularity in the early 1990s. One of the first public references to a developing Irish dance culture and the attendant use of ecstasy was a report in the media of a Garda (Irish police) drugs operation in a County Donegal night club in 1992 (O'Mahony 1996). The operation, colloquially known as the 'Rave in the Cave', provided the Irish public with a rare, for its time, glimpse into the 'rave' scene.

A qualitative study in the late 1990s, involving 20 in-depth interviews with ecstasy users aged 17 to 27 years, found that a majority initiated their ecstasy use either in clubs or in other recreational setting, such as parties or pubs (Murphy *et al.* 1998). Taking ecstasy while alone was unusual, but sometimes ecstasy would be taken or continue to be used after clubs in small-group settings. Polydrug use was common. Ecstasy was usually consumed in conjunction with alcohol and other drugs, including amphetamines and/or cannabis.

A decade later, a similar qualitative study, involving 10 in-depth interviews with 'recreational' cocaine users aged 25 to 29 years, found that a majority had initiated their cocaine use in the company of friends in a social setting (Mayock 2001). However, these social settings were more likely to be private than public and most respondents preferred to continue using cocaine in private, rather than public, social settings. While some respondents did use cocaine in dance or club settings, the inconvenience of preparing it made it less conducive to using in a public place. Practically all respondents in the study reported the concurrent use of alcohol and other drugs while using cocaine.

Results from the third European School Survey Project on Alcohol and Other Drugs (ESPAD) show that in 2003 that nearly a third (31%) of school-going children (15–16 years) in Ireland stated that marijuana or hashish could easily be bought in discos, bars, etc. (Hibell *et al.* 2004). However, when compared with the second ESPAD survey, carried out in 1999, this represented a drop from 48% (Hibell *et al.* 2000). In both surveys, more girls than boys indicated that they could easily buy marijuana or hashish in discos, bars, etc. It is not clear from these surveys if the drugs are actually used within these settings.

13.2 An overview of developments in responses, national policies and legal aspects

Developments in responses

The third phase of the National Drugs Awareness Campaign, launched in October 2004, focuses on cocaine (Health Promotion Unit 2004). The campaign is aimed at 18–35-year-olds and is designed to disprove some of the common urban myths surrounding cocaine use. The core message of this phase is that: 'There is no fairytale ending with cocaine' and it used nursery rhyme characters, such as 'Jack and Jill' and 'Georgie Porgie', to illustrate the stark facts about the psychological, physical, sexual and financial problems that can arise from using cocaine as a recreational drug. The campaign features three individual advertisements placed in the restrooms of entertainment venues, such as pubs and clubs, throughout Ireland and is supported by beer mats, free postcards and print advertisements in selected national newspapers and magazines.

In July 2005 the campaign focused on the dangers of mixing cocaine with other drugs, especially alcohol (Health Promotion Unit 2005b). The campaign again includes placing posters in the restrooms of 70 of the largest entertainment venues, such as pubs and clubs, throughout Ireland and is supported by beer mats and print advertisements in selected national newspapers and magazines. Again, the posters use nursery rhyme characters, such as 'Mary' and 'Little Jack Horner'. For example, one poster shows Mary in a collapsed position (Health Promotion Unit 2005c), with the accompanying message:

Mary had a little blow,
As pure and white as snow.

And everywhere that Mary went,
She snorted another row.

Between each line she did some shots,
Which really wasn't cool.

The toxic mix of booze and coke left her
with a permanently damaged heart.

There's no fairytale ending with cocaine.

In addition to the National Drugs Awareness Campaign, a number of local initiatives have focused on recreational settings. Two are described below.

The 'Club Cork' Alcohol & Drugs Awareness Training Programme

This programme was launched in Cork City in March 2004, targeting publicans, security staff and bar staff in the city. The aim is to increase awareness of the negative effects of alcohol and drug misuse and help participants identify possible solutions to deal with such issues. The training programme has been piloted in a number of Cork City bars/clubs. More than 50 staff comprising publicans, bar staff and security staff took part in the two half-day training sessions where training was provided by emergency medical technicians, security personnel, Accident & Emergency consultants and gardaí. Feedback from the pilot programme has been very positive, with

participants and trainers enjoying the interactive and practical nature of the course. Participants report being better informed about the misuse of drugs and alcohol and find it beneficial in terms of their working environment. Many expressed an interest in further training (Southern Health Board, personal communication, June 2004).

The 'Gaf' Health Advice Cafe

The provision of drug and alcohol free entertainment in a health promotional setting has been developed as a key alternative to drug use for young people in Galway City, situated in the West of Ireland. The 'Gaf' provides drug and alcohol free entertainment in a safe environment and on Friday nights local bands play to a packed house until 10.30pm. Latest data from the project shows that an average of 1,000 young people attend the project per month, with 68% in the 15–17-year age group. Slightly more females (53%) than males (47%) attend the project. As part of an evaluation to review and develop the service, a survey was recently carried out among participants assessing their experiences and perceptions of the service. A total of 115 survey questionnaires composed of both open and closed-ended questions were completed. The results show that 55% of those surveyed attend the 'Gaf' once a week, and 77% of respondents perceived the 'Gaf' to be either excellent or good. One of the thematic responses coming from respondents was their reliance on 'peers' for information and support on drug-related and health-related issues. In addition, the responses indicate that the young people surveyed see the 'Gaf' as an acceptable alternative venue to meet friends for socialising purposes (Western Health Board, personal communication, July 2002).

Policy and legal developments

The Licensing (Combating Drug Abuse) Act 1997 provides, *inter alia*, for the disqualification for ever from obtaining an intoxicating liquor, public dancing or public music and singing licence on conviction for a drugs offence. It also provides for the revocation for ever of such licences on conviction for a drugs offence. It further provides for the revocation of such licences for allowing premises to be used for the sale of controlled drugs. In such a case the licence holder will be disqualified for five years from holding such a licence. Section 11 allows the court, when granting a licence, to include conditions to ensure all reasonable arrangements are made to ensure that persons entering the premises are not in possession of any controlled drug and that the premises are not used for the sale or supply of any controlled drug. The Act also contains a number of provisions to prevent the organisation of unlicensed parties, such as so-called 'rave' parties for example. Other sections of the Act provide powers to the gardaí to enter a place where an unlicensed party is taking place and to seize sound equipment and to the courts to forfeit such equipment.

Action 27 of the National Drugs Strategy obliges the Garda Síochána, the Health Boards and vintner representative bodies to '*prepare guidelines... for publicans and night-club owners regarding drug dealing on, or in the vicinity of, their premises. These guidelines should set out clearly the actions which the owner of the premises should take in response to drug dealing...*' (Department of Tourism Sport and Recreation 2001: 114). In June 2005 an information booklet, entitled *Guidelines regarding drug dealing on or in the vicinity of licensed premises*, was launched with the aim of addressing Action 27 (An Garda Síochána and others 2005). The guidelines were drawn up by An Garda Síochána, with the co-operation of the Licensed Vintners Association, the Irish Nightclub Industry Association, the Vintners Federation of Ireland, the Department of Health and Children, and the Irish Hotels Federation. The guidelines cover such matters as the law in relation to drug issues, the legal conditions and appropriate procedures for the conducting of searches of persons entering premises,

signs of drug misuse by customers, what to do if drugs are found, first aid, and the monitoring of queues.

Operation Nightcap was initiated in 1999 to curb drug activity in licensed premises. It involves the strategic deployment of undercover gardaí in licensed premises to apprehend drug dealing and drug use. In 1999, it is reported that drug charges were taken against 87 persons following such operations. Notices were also served on an unspecified number of licensed premises under the provisions of the Licensing (Combating Drug Abuse) Act 1997 (An Garda Síochána 2000). In 2002, Operation Nightcap resulted in 17 premises being targeted following which nine notices were served under the terms of the Act (An Garda Síochána 2003).

Action 12 of the National Drugs Strategy obliges the gardaí to ensure that operations similar to Operation Nightcap are implemented in urban centres throughout Ireland where drug dealing is ongoing. The progress report on the National Drugs Strategy states in relation to Action 12 that, 'A draft document on the future conduct of such operations has been submitted to the Commissioner. This document recommends regional training which is anticipated to commence during 2004' (Department of Community Rural and Gaeltacht Affairs 2004: 42).

Part C

14. Bibliography

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<http://www.taoiseach.ie>
<http://www.pobail.ie>
<http://www.dohc.ie>
<http://www.hrb.ie>
<http://www.ndc.hrb.ie>
<http://www.mqi.ie>
<http://www.nacd.ie>
<http://www.hpsc.ie>
<http://www.ndsc.ie>
<http://www.hse.ie>

14.4 List of databases

- Central Treatment List
- Central Methadone Treatment List
- Drug Trend Monitoring System (DTMS)
- Hospital In-Patient Enquiry scheme (HIPE)
- National Drug Treatment Reporting System (NDTRS)
- National Psychiatric Inpatient Reporting System (NPIRS)

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15.3 List of maps

15.4 List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AUDIT	Alcohol Use Disorder Identification Test Screening Instrument
B&B	Bed and Breakfast (accommodation)
BMK	Benzylmethylketone
CDLE	Customs Drug Law Enforcement
CE	Community Employment
CLAN	College Lifestyle and Attitudinal National (survey)
CPF	Community Policing Forum
CSO	Central Statistics Office
DART	Derry Arrest Referral Team
DAST	Drug Abuse Screening Test
DCRGA	Department of Community, Rural and Gaeltacht Affairs
DMA	Dublin Metropolitan Area
DMRD	Drug Misuse Research Division
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ERHA	Eastern Regional Health Authority
ESPAD	European School Survey Project on Alcohol and Other Drugs
EWO	Educational Welfare Officer
FÁS	Foras Áiseanna Saothair (Training and Employment Authority)
FSL	Forensic Science Laboratory
GMR	General Mortality Register
GNDU	Garda National Drugs Unit
HCV	Hepatitis C Virus
HRB	Health Research Board
HIV	Human Immunodeficiency Virus
HPU	Homeless Persons Unit
HPU	Health Promotion Unit
HSE	Health Service Executive
ICD	International Classification of Diseases
IDG	Inter-Departmental Group on Drugs
IPRT	Irish Penal Reform Trust
JPC	Joint Policing Committee
KPI	Key Performance Indicator
LDTF	Local Drugs Task Force
LES	Local Employment Scheme
MDA 1977	Misuse of Drugs Act 1977
MDA	Methylenedioxyamphetamine
MDEA	Methylenediethanolamine
MDMA	Methylenedioxymethamphetamine
MDT	Mandatory Drugs Testing
MQI	Merchants Quay Ireland
NAC	National Assessment Committee
NACD	National Advisory Committee on Drugs
NDS	National Drugs Strategy
NDST	National Drugs Strategy Team
NDTRS	National Drug Treatment Reporting System
NEWB	National Educational Welfare Board
NPIRS	National Psychiatric Inpatient Reporting System
NSP	National Service Plan
PCR	Polymerase Chain Reaction
PMK	Piperonylmethyltone
RDTF	Regional Drugs Task Force
RIS	Rehabilitation/Integration Service

RNA	Ribonucleic Acid
SPHE	Social, Personal and Health Education
SWAHB	South Western Area Health Board
SCP	Sports Capital Programme
TD	Teachta Dála (Member of Parliament)
UISCE	Union for Improved Services, Communication and Education
WHO	World Health Organization
YPFSF	Young People's Facilities and Services Fund