



European Monitoring Centre
for Drugs and Drug Addiction



**2009 NATIONAL REPORT (2008 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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Dr Jean Long
Head of Unit

This report was written by:

Johnny Connolly	Jean Long	Deirdre Mongan
Anne Marie Donovan	Ena Lynn	Brigid Pike
Martin Keane	Suzi Lyons	

This report was edited by Joan Moore with the assistance of Brigid Pike and was compiled by Mairea Nelson

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Summary of each chapter

This report, written following European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) guidelines,¹ is divided into two parts. Part A is an overview of new developments and trends in the drugs area in Ireland for 2008 and, in some cases, for the first six months of 2009. These are covered under the following headings:

1. Drug policy: legislation, strategies and economic analysis
2. Drug use in the general population and specific sub-groups
3. Prevention
4. Problem drug use
5. Drug-related treatment: treatment demand and treatment availability
6. Health correlates and consequences
7. Responses to health correlates and consequences
8. Social correlates and social reintegration
9. Drug-related crime, prevention of drug-related crime and prison
10. Drug Markets

Part B examines two specific issues considered important at an EU level. The Selected Issues are:

1. Cannabis markets and production
2. Treatment for older drug users

Main points from Part A

1. Drug policy: legislation, strategies and economic analysis
 - The Criminal Justice (Surveillance) Act 2009 provides for the first time a legal framework to allow covert surveillance material to be used in criminal trials.
 - The Criminal Justice (Amendment) Act 2009 provides for all organised crime offences to be declared scheduled offences for the purpose of trial in the Special Criminal Court unless the Director of Public Prosecutions directs otherwise. The Special Criminal Court operates with three judges and without a jury. The Act has led to a number of criticisms from lawyers and human rights groups.
 - The Criminal Justice (Miscellaneous Provisions) Act 2009 provides a statutory framework for controlling firearms and seeks to halt the emergence of a gun culture in Ireland.
 - The Community, Rural and Gaeltacht Affairs (Miscellaneous Provisions) Act 2007 provides a statutory mandate for the functions and responsibilities of the Minister for Community, Rural and Gaeltacht Affairs, including the co-ordination of the implementation of the National Drugs Strategy.
 - In March 2009, Minister for Health and Children, Mary Harney TD, announced that 1-benzylpiperazine (BZP) is now a controlled drug within the terms of the Misuse of Drugs Act, 1977
 - The Criminal Justice (Mutual Assistance) Act 2008 commenced in August 2008. This defines the competent authorities, the Revenue Commissioners and the Garda Síochána, in relation to controlled deliveries of drugs and confirms current procedures adopted in relation to controlled deliveries of drugs. The Attorney-General's advice regarding interpretation of certain provisions in the Act is currently awaited.
 - In its opening debate of the 2008 academic year, the Trinity College Historical Society debated the motion 'That the sale of cannabis should be legalised'. Opposing the motion Pat Carey TD, former Minister of State for the national

¹ A copy of the EMCDDA guidelines is available from the EMCDDA website at www.emcdda.eu.int
The guidelines require each Focal Point to write its 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.

drugs strategy, set out in detail not generally provided the government's position on this controversial issue.

- In September 2009 a new national drugs strategy, covering the period 2009–2016, was published. It continues to be based on five pillars – Supply Reduction, Prevention, Treatment, Rehabilitation, and Research.
- Under the supply reduction pillar, the primary aim of reducing the availability of drugs remains. However, there is a greater note of realism, for example in the way in which the impact of drug supply reduction activities is determined.
- Having reviewed progress under the NDS 2001–2008, the Steering Group concluded that 'a tiered or graduated approach to prevention and education measures in relation to drugs and alcohol should be developed with a view to providing a framework for the future design and development of interventions'.
- The Steering Group stated that this pillar, which combines the treatment and rehabilitation pillars, had a wider focus than in the NDS 2001–2008. It aimed to develop a more comprehensive treatment service capable of dealing with all problem substances nationally, rather than focusing mainly on opiate misuse in Dublin.
- The NDS 2009–2016 intends to collect information and complete research projects in order to inform policy formulation and to develop or enhance responses to the drug situation, while the NDS 2001–2008 intended to measure the extent of drug use by person, place and time, and describe the characteristics of drug users, but did not state how the new information would be used.
- The Government has approved the development of a combined substance misuse policy to include both alcohol and drugs. A new steering group is to be established in the autumn of 2009 to develop proposals for the overall substance misuse strategy. It will incorporate the already agreed drugs policy element. The group will be asked to report by the end of 2010.
- While there was no formal evaluation of the national drugs strategy, two independent studies identified opportunities for enhancing the management of the drugs strategy.
- A review of the strategic management processes and governance arrangements underpinning the national drugs strategy between 2001 and 2007 highlighted four underlying tensions, with regard to performance management, research and analysis, co-ordination and strategic control that might have influenced the achievement of outcomes.
- A value-for-money study of drug treatment and rehabilitation services called for improvements in the monitoring and evaluation of measures through establishing service levels and monitoring not only outputs but also outcomes and costs.
- Following the introduction in 2007 of the life-cycle approach to the framing of social inclusion policy, including illicit drug policy, a systematic review of the broader literature on the concept has been undertaken, and consideration given to how it should be translated into specific forms of policy prescription and evaluation.
- In the new national drugs strategy the co-ordination mechanisms have been completely revised and streamlined.
- An Office of the Minister for Drugs (OMD) is to be established, incorporating both the former Drugs Strategy Unit in the Department of Community, Rural and Gaeltacht Affairs (DCRGA) and the National Drugs Strategy Team. The OMD will report directly to the Cabinet Committee on Social Inclusion, Children and Integration.
- The Interdepartmental Group on Drugs (IDG) is to be re-constituted as the Oversight Forum on Drugs (OFD). Its primary role will be the high-level monitoring of progress being achieved across the strategy and agreeing appropriate ways forward where issues are blocked or progress is being impeded.

- Local and regional drugs task forces will continue to play a strong role in addressing the drug problem in Ireland. The participation in and commitment by all sectors to the drugs task force process will be strengthened, and more active engagement by service users and services working with specific at-risk groups in the design and planning of interventions under the new strategy will be promoted.
- It is estimated that approximately €264 million was spent on core services for problem drug users in 2008, an increase of 13 per cent over spending in 2007. A similar level of spending was initially approved for 2009 but, on foot of the continuing decline of the Irish economy and the need to achieve a 'prudent fiscal outturn' for 2009, expenditures across all government bodies were reduced. Details of the spending cuts are not yet available but a reduction of 15 to 20 per cent has been mentioned in relation to the drugs task forces.
- The new strategy states that the OMD should oversee the development of a performance management framework, including mechanisms whereby government departments, agencies and drugs task forces report regularly to the OMD on expenditures and outputs and outcomes.
- On 1 January 2009 the Young People's Facilities and Services Fund (YPFSF) was transferred from the DCRGA, where it was administered by the Drugs Strategy Unit, to the Office of the Minister for Children and Youth Affairs (OMCYA).
- In recent years the role of families in tackling the drugs problem has become increasingly recognised and funding has followed.
- No studies of the social cost of drug use have been undertaken. However, in the past decade or so, there have been significant advances in the collection of data relating to the drug problem in Ireland, which may be expected to yield data relevant to such a study. Several one-off studies have also been undertaken, which may, in the absence of system-level data, help in the estimation of economic values.

2. Drug use in the general population and specific sub-groups

- On 25 January 2008, the National Advisory Committee on Drugs (NACD) and the Drug and Alcohol Information and Research Unit (DAIRU) in Northern Ireland published jointly the results of the second all-Ireland general population drug prevalence survey. The proportion of adults (aged 15–64 years) who reported using an illegal drug in their lifetime increased by five percentage points, from 19% in 2002/3 to 24% in 2006/7. The proportion of adults who reported using an illegal drug in the last year increased marginally, from 6% in 2002/3 to 7% in 2006/7.
- Cannabis was the most commonly used illegal drug in Ireland. The proportion of adults who reported using cannabis at some point in their life increased from 17% in 2002/3 to 22% in 2006/7. Nine per cent of young adults claimed to have tried ecstasy at least once in their lifetime in 2006/7.
- Cocaine use increased in 2006/7 compared to 2002/3. The proportion of adults who reported using cocaine (including crack) at some point in their lives increased from 3% in 2002/3 to 5% in 2006/7. The proportion of adults who reported using cocaine in the last year increased from 1% in 2002/3 to 2% in 2006/7.
- The proportion of adults who reported using a sedative or tranquilliser at some point in their lives was almost 11%. The proportion of young adults was 6%, while the proportion of older adults was higher at just under 15%. More women (13%) than men (8%) reported using a sedative or tranquilliser in their lifetime.
- The proportion of adults who reported using an anti-depressant at some point in their lives was just over 9%. The proportion of young adults was 7% while the proportion of older adults was higher at just under 11%. More women (13%) than men (6%) reported using an anti-depressant in their lifetime.
- On 29 April 2008, the Department of Health and Children published the third SLÁN Survey of Lifestyle, Attitudes and Nutrition in Ireland. The survey involved

10,364 face-to-face interviews with adults resident in Ireland, which represented a 62% response rate. In the 2007 survey, respondents were asked about their use of illegal drugs in the last year. Six per cent reported that they had used an illegal drug in the year prior to the survey; the reported use of such drugs was higher for men (9%) than for women (4%). As expected, cannabis was the most commonly-used drug. The percentage of those who used cocaine in the last year was surprisingly low at 1%. In general, these data are not comparable to the results of the 2006/7 general population survey by the NACD as the SLÁN survey excluded those aged between 15 and 17 and included those over 65 years.

- The fourth ESPAD survey was conducted in 35 European countries during 2007 and collected information on alcohol and illicit drug use among 15–16-year-olds. In terms of drug use, the Irish data showed a marked decrease in lifetime use of any illicit drug between 2003 (40%) and 2007 (22%), a fall of 18 percentage points. As the majority of those who have tried any illicit drug have used cannabis (marijuana or hashish), the decrease in illicit drug use was influenced by the considerable decrease in the number of students who had tried cannabis at some point in their lives, from 39% in 2003 to 20% in 2007 (European average 19%). Lifetime use of solvents/inhalants decreased from 18% in 2003 to 15% in 2007, but remained higher than the European average (9%). In the case of both amphetamines and cocaine powder, the proportions reporting lifetime use increased marginally above the European average of 3%. In 2007, one in ten of the survey participants reported that they had taken prescribed tranquillisers or sedatives at some point in their lives; the use of such drugs had decreased marginally since 1999.

3. Prevention

- Secondary school students in Ireland were perceived to have poorer levels of social bonding with the educational system compared to the OECD average.
- The effectiveness of the Social, Personal and Health Education (SPHE) programme, which is the main vehicle through which substance use prevention interventions are implemented in secondary schools, was consistently questioned during the recent review of the national drugs strategy, in particular by students themselves.
- In the National Drugs Strategy (interim) 2009–2016 (para. 3.67) the steering group calls for improved delivery of SPHE in primary and post-primary schools, encompassing the implementation of the recommendations of the recent SPHE evaluation in post-primary schools and the development of a 'whole of school' approach to substance use education in the context of SPHE.
- Crosscare published and disseminated an evidence-based booklet to support families to discuss and address substance use problems within the family unit.
- In late 2008, to dovetail with the national awareness campaign on cocaine use, 'The Party's Over' funding was allocated from DCRGA for cocaine awareness campaigns at local and regional level, to be delivered through the local and regional drugs task forces.
- A recent report on educational disadvantage identified the strengths and weaknesses of the Delivering Equality of Opportunity in Schools (DEIS) programme, which targets a number of schools in disadvantaged areas throughout the country.
- Headstrong, the National Centre for Youth Mental Health, promised a 'new direction' based on evidence for tackling the mental health needs of young people growing up in Ireland.
- Recent research undertaken by Headstrong showed that
 - young people are not engaging with services;
 - supports and services are inaccessible;
 - services are inappropriate to the needs of young people.
- Young marginalised people did benefit from interventions to improve their involvement in youth participation structures.

4. Problem drug use

- Dr Alan Kelly and colleagues estimated the prevalence of problem opiate use in Ireland using a three-source capture-recapture method. The three data sources employed to generate the estimate were the Central (methadone) Treatment List, Hospital In-Patient Enquiry Scheme and Garda PULSE data. The three sources of data indicated that there were 11,807 opiate users known to services in Ireland in 2006 and indicated that there were an estimated 8,943 users not known to the services (hidden population). The estimate indicated that there were between 18,136 and 23,576 problem opiate users in Ireland in 2006; the point estimate was 20,790. The authors reported that the estimate is likely to be inflated because the population is not closed, that is, it continues to recruit people into treatment and police custody. In addition and critical to the size of the estimate, the overlap between the three populations sources is small.
- Drug overdose was the most common form of deliberate self-harm, representing 72% of all such episodes reported in 2008. Forty-one per cent of all drug overdoses involved a minor tranquilliser, 23% involved paracetamol-containing medicines and 22% involved anti-depressants/mood stabilisers. There was evidence of alcohol consumption in 42% of all episodes of deliberate self-harm emphasising the strong association between alcohol consumption and suicidal behaviour. Illicit drugs such as cocaine and heroin were involved in 3.8% of all overdose acts. The biggest rise in deliberate self harm was observed in men, an increase of 11% from 2007, resulting in the highest rate since the Registry was established in 2002.

5. Drug-related treatment: treatment demand and treatment availability

- The HSE's *National Service Plan (NSP)* contains the agency's plans in the drug and alcohol areas during 2009. The HSE's Addiction Services, including both illicit drugs and alcohol, are located within through Social Inclusion Services, which are part of the Primary, Community and Continuing Care (PCCC) directorate. Nationally, the level of *activity* in the addiction services area increased in 2008 and should be maintained in 2009, but the level of *performance* is expected to remain static at 2007 levels. In 2008, 7,636 clients were in methadone treatment and the HSE expects to reach this level of activity again in 2009. Eighty-four per cent of substance misusers should commence treatment within one calendar month. Eighty-eight per cent of substance misusers under the age of 18 should commence suitable treatment within a calendar month.
- A needs assessment study was carried out in NERDTF to examine the number and profile of drug-users, assess in-patient and out-patient drug treatment services, explore needs of drug treatment service users and their families; identify gaps in service provision, and make recommendations. This study found that drug use in the region had increased in recent years. The main problem drugs identified were cocaine, cannabis, alcohol, heroin and prescription drugs. One of the issues raised was the normalisation of cannabis use to the point where it was considered equivalent to consuming alcohol. The recommendations included more residential detoxification treatment, out-of-hours treatment, crisis and early intervention, and treatment for under-18s, better information, wider scope of treatment options and more focus on polydrug treatment including alcohol.
- The Comptroller and Auditor General (CAG) published a report examining drug treatment services (mainly cannabis, cocaine, ecstasy and heroin addiction). For problem opiate treatment some of the issues identified were that although there had been an increase in provision, gaps in needle exchange services still existed. The CAG report found that compared to the numbers of opiate users who received methadone, the numbers who received detoxification or attended follow-on rehabilitation were very low.
- In the area of treatment for problem drug use (excluding opiates) the CAG report found that although there was an increase in the prevalence of cannabis use there had not been a commensurate increase in the number of cases

treated over the same time period. The report noted that changes in the pattern of drug misuse in both urban and rural areas posed a difficult challenge for services. The report suggested that there were two separate client groups: 1) a largely opiate-based polydrug addiction problem concentrated in certain marginalised sectors of society, and 2) those with problem use of drugs such as cannabis, cocaine and ecstasy, spread more widely across social groups and geographic areas.

- While the CAG report noted that accurate information about the level of demand for problem drug treatment is very important for service planning purposes, the current national drug treatment database (NDTRS) is not able to track the progression of an individual from one service provider to another. The report recommended improved methods of recording individual information in the NDTRS should be sought.
- Looking at access to treatment, the CAG report noted that the current database may underestimate the extent of waiting for assessment. Additionally, some service providers also operate 'informal' waiting lists, and call those on the informal list only when an assessment appointment becomes available. The report called for improvement in the recording this type of information so the true extent of waiting for treatment may be gauged. The data showed that while a high proportion of individuals commenced treatment within the one-month target, approximately 460 people were recorded as waiting for methadone treatment in April 2008. The average waiting time for those on the lists in some areas was over a year.
- The CAG report recommended that the effectiveness of treatment for problem use of drugs other than opiates needs to be evaluated.
- A summary of opiate treatment outcomes in Ireland at one year and at three years after entry to treatment showed that of the 404 users recruited, 289 individuals completed all three interviews. Results found an overall sustained reduction in the use and amount of drug use. The numbers of those who reported using heroin in the 90 days preceding data collection fell from 81% at intake to 47% at one year and remained at that level at three years. The proportion who reported use of more than one drug decreased from 78% at intake to 50% one year later and to 45% three years after intake. There were also sustained improvements in other areas with the largest achievements between one and three years in housing, training and employment. There was also a sustained decrease in acquisitive crime from 31% at intake to 14% at one year and this level was sustained at three years. Of those for whom treatment status at three years was reported, 201 (70%) were still in treatment, of whom 173 were in methadone treatment.
- A survey was conducted with GPs who had undergone training in the management of methadone clients, of which 35% responded to the questionnaire. Of these, two of every three practices were in an urban area. Just over two-fifths said that illicit drugs were a major problem in their area. Seventy-two per cent were providing patients with methadone treatment at the time of the survey. The vast majority of GPs thought that the MTP was beneficial to patients. Some of the issues highlighted with the training were the difficulty of managing complications of drug use, managing patients who continue to use drugs, managing patients with alcohol or benzodiazepine problems. These could be dealt with in future training programmes. The additional services most desired by GPs were addiction counselling, in-patient detoxification and rehabilitation beds, and employment schemes.
- Figures from the two national registers for recording drug treatment data in Ireland, the National Drug Treatment Reporting System (NDTRS) and the Central Treatment List (CTL), show that the total number of cases receiving methadone treatment increased by 32% between 2002 and 2007. The number receiving treatment in private general practice increased by 36% during the same period. In each of the six years, at least 30% of cases who received methadone treatment were treated in private general practice.

- A study conducted with young people in Dublin accessing opiate treatment found that, despite strict controls, they reported that illicit methadone was easy to obtain. More than half of participants reported the use of illicit methadone both prior to and during treatment, frequently to counteract opiate withdrawal symptoms. During treatment, failure to attend the clinic was the most common reason for withdrawal symptoms. Two-fifths obtained illicit methadone in order to do their own detox or maintenance while one-third reported using methadone for hedonic effects prior to commencing treatment. Participants reporting the misuse of benzodiazepines were more likely to report use of illicit methadone.
- The Council of Europe's Pompidou Group commissioned a survey of quasi-compulsory treatment (QCT) in Europe. The primary form QCT available in Ireland is that offered by the Irish Drug Treatment Court (DTC). The DTC deals with offenders who have either pleaded guilty or been convicted of minor crimes committed as a consequence of drug abuse. Anecdotal reports from the DTC suggest that despite low graduation numbers the programme is successful in Ireland and is due to be expanded.
- The Ana Liffey Drug Project (ALDP) continues to develop its assertive street-based outreach work in which staff seek to engage people who are based on the streets of Dublin's inner city and who may experience problem drug use and/ or homelessness. In November 2008 it launched peer-led outreach, disseminating information about keeping safe on the streets. In March 2009 the Dublin City Business Improvement District (DBID) announced a long-term partnership with the ALDP, and as the first step, announced its contribution towards the purchase of an eight-seater van to support the ALDP outreach programme. In June 2009 the ALDP established an SMS text messaging service for its service users.
- In July 2009, a feasibility study to look at providing buprenorphine/naloxone treatment as an alternative to methadone commenced. The aim is to enrol up to 80 problem opiate users who agree to treatment and are suitable (40 in specialist centres and 40 in the community). The study is to be reviewed after eight months with a view to deciding if it will be offered to all drug treatment clients. The evaluation of the study will be conducted according to agreed evaluation criteria and using a recognised audit tool.
- The annual number of treated cocaine cases increased from 954 in 2002 to 2,643 in 2007. Almost four out of five cases who reported cocaine as their main problem drug used more than one drug. However, there are two different profiles: those who use opiates alongside cocaine and those who use combinations of alcohol, cannabis and/or ecstasy alongside cocaine. Half of the treated cocaine cases were under 27 years old and the majority were male.
- The number of cases who reported an opiate as a problem drug increased from 8,804 in 2002 to 11,392 in 2007. The rate of increase in new opiate cases was highest outside Dublin. Cannabis, benzodiazepines and, in more recent years, cocaine were the most common additional problem drugs used alongside opiates. Overall, 40% of problem heroin users injected the drug, but the proportion doing so decreased between 2003 and 2007 and was linked to a corresponding increase in smoking opiates, indicating the success of harm reduction messages.
- Between 2001 and 2007 there was a decrease in the number of cases presenting for treatment and reporting cannabis as their main problem substance, from 1,384 in 2003 to 958 in 2007. Nearly three-quarters used one or more additional drugs. The number of cases reporting cannabis as an additional problem drug increased from 1,383 in 2001 to 1,630 in 2007. The drugs associated with cannabis use were alcohol, ecstasy, amphetamines and cocaine. Frequency of cannabis use among treated cases was considerably higher than that among the general population. Half had commenced cannabis use before they were 14 years old, and the majority were men.
- Between 2001 to 2007, the annual number of treated cases reporting sedatives or tranquillisers as a main problem drug ranged between 78 and 171. Of these, 87% reported a benzodiazepine as their main problem drug, while three

quarters used one or more additional drugs. The number of cases reporting sedatives or tranquillisers as an additional problem drug exceeded 1,000 per year between 2001 and 2007. The main drugs associated with sedative or tranquilliser use by new cases entering treatment were cannabis, alcohol, stimulants, cocaine and opiates.

- Between 2001 to 2007, only 10 treated cases reported anti-depressants as a main problem drug, of whom half used one or more additional drugs. Fifty-six cases reported anti-depressants as an additional problem drug. The drugs associated with anti-depressant use were opiates and sedatives.
- In 2007, 5,977 cases entered treatment in Ireland. The majority of cases attended outpatient services. Heroin was the most common main problem drug and over two-thirds reported polysubstance use. Many problem drug users in treatment were young and male.
- In 2008, 6,247 cases entered treatment, the majority for problem heroin use. Of those who entered treatment, the majority attended outpatient services.

6. Health correlates and consequences

- Between 2001 and 2008 there was an overall decline in the number of new injector HIV cases (38, 50, 49, 71, 66, 57 54 and 36 respectively) when compared to 2000. Of the 36 new HIV cases among injecting drug users reported to the HPSC in 2008, 27 were male and nine were female and the average age was 33 years. Twenty-two of the 34 cases with a known address lived in the HSE Eastern Region (Dublin, Kildare and Wicklow).
- The HPSC reported that there were 1,537 cases of hepatitis C reported in 2008, compared to 1,128 cases in 2004, and 85 cases of hepatitis 'type unspecified' in 2003. In 2008, 38% of newly-reported hepatitis C cases had risk factor status reported. As expected, the majority of these cases (76.9%) reported injecting drug use as the main risk factor. Just over 4% of cases said that they were recipients of blood or blood products at some time in the past and according to the HPSC were late reports to the system. Of the 447 cases who reported injecting drug use as their main risk factor, 85% were notified by services in Dublin, Kildare and Wicklow and the remainder by services in HSE areas outside these counties. Seventy-one per cent were male and 62% were under 35 years old.
- The HPSC was informed of four cases of wound botulism – all affecting injecting drug users – in late November 2008 by.
- Data from the Hospital In-Patient Enquiry (HIPE) scheme show that there were a total of 14,770 not-fatal overdose cases recorded in the period 2005–2007. The age group at risk of non-fatal overdoses is the 15–24-year age group and non-fatal overdose cases are more common among females than among males. Over two thirds (69.5%, 10,259) of all overdose cases involved nonopioid analgesics. Narcotic or hallucinogen drugs were involved in 11.1% (1,647) of cases. More than one quarter (27.5%, 453) of males overdosed using narcotic or hallucinogen-type drugs.
- According to the sixth annual report from the National Registry of Deliberate Self Harm for the period 2006–2007 (2008) drug overdose was the most common form of deliberate self-harm, representing 74% of all such episodes reported in 2006–2007. The national rate of deliberate self-harm in both 2006 and 2007 was higher among females than among males and largely confined to the younger age groups. For the six-year period 2002–2007, the rate of presentation of deliberate self-harm is relatively stable.
- Patients attending for methadone treatment were significantly more likely to have a chronic illness, to be prescribed recurrent medications and to attend a general practice than their matched counterparts who are not prescribed methadone.
- A recent study has estimated that 35% (95% CI = 28–41%) of current or former heroin users attending primary care for methadone treatment were classified as problem alcohol users and 14% were classified as dependent users. According to data for the National Drug Treatment Reporting System, 24% of opiate users

entering opiate treatment reported alcohol as an additional problem drug which is lower than the estimate presented in this recent study.

- In 2007, the total number of admissions to psychiatric inpatient care in Ireland has continued to fall. In 2006, 724 cases were admitted to psychiatric facilities with a drug disorder, of whom 265 were treated for the first time. The report does not present data on co-morbidity, so it is not possible to determine whether or not these admissions were appropriate.
- Between 2003 and 2007, the number of poisonings recorded in Ireland (as per Selection D) has risen from 108 to 185.
- In the last two years for which data are available, 2006–2007, over three-quarters of cases have been male (287, 78.4%), and the majority of cases (258, 70.5%) have been aged between 20 and 40 years. This is a very similar profile to poisoning deaths reported in Ireland in previous years.
- Of the 366 cases of poisoning recorded in 2006 and 2007, heroin and unspecified opiates accounted for 84 (23.0%) of these deaths while methadone alone accounted for 20 (5.5%) deaths. Almost half of all deaths owing to poisoning (180, 49.2%) were attributable to polysubstances including an opiate.
- The first national report on non-poisoning deaths among drug users in Ireland between 1998 and 2005 showed that 476 (63.8%) were due to trauma and 270 (36.2%) were due to medical causes.
- Half of trauma deaths were in young men aged between 20 and 29 years and the most common causes of death were hanging (174, 36.5%) and road traffic collisions (95, 20.0%).
- A positive toxicology report was available in 412 (86.5%) cases of death owing to trauma. In many cases more than one substance was present. Alcohol and cannabis were most frequently present.
- The annual number of deaths owing to medical causes increased from 11 in 1998 to 63 in 2005. The majority (180, 66.7%) of drug users who died of medical causes had a history of opiate use. The majority were aged between 30 and 44 years. The most common medical causes of death were cardiac events (67, 24.8%), followed by respiratory infections (48, 17.8%) and liver disease (31, 11.5%).
- The correlation of toxicology and drug-use history with the type of death recorded supports the argument that drug use is contributing to the premature death of drug users in Ireland. The continuing upward trend in drug-related deaths reflects the increasing numbers in the population who are consuming drugs and taking risks and who have acquired infections or developed medical conditions associated with drug use.

7. Responses to health correlates and consequences

- The National Immunisation Advisory Committee and the Department of Health and Children are recommending significant changes to Ireland's national childhood immunisation programme in 2008 (National Immunisation Advisory Committee 2008). These changes, which were published in the revised *Immunisation guidelines for Ireland* in August 2008, include the addition of hepatitis B vaccine, to the routine childhood programme. The 5-in-1 childhood vaccine will be replaced with a 6-in-1 vaccine which includes hepatitis B vaccine.
- Needle and syringe exchange services were first provided in Ireland in 1989, when five exchanges were established (Robinson *et al.* 2008). There are now 34 exchanges in the country, operating three models of service: fixed-site exchanges, home visit exchanges, and exchanges in public locations. Peer-based, pharmacy, prison-based or vending machine exchange services are not available in Ireland.
- Relatively few patients infected with the hepatitis C virus through intravenous drug abuse receive effective antiviral therapy. A pilot study of supervised antiviral treatment in a community non-residential drug treatment facility was conducted. Thirteen patients infected with hepatitis C virus genotype 2 or 3

were identified in a drug treatment clinic. Six patients agreed to treatment. Full treatment course was administered in all six, with sustained viral response in 5/6. This study demonstrates that effective treatment penetration can be improved for this patient group by shared care with drug treatment services, without the need for significant increases in resources.

8. Social correlates and social reintegration

- Data from the final report of the ROSIE study showed that at least 10% of opiate users in drug treatment were likely to experience frequent episodes of homelessness.
- Recent research on sex work, risk and drug use revealed that the majority of study participants grew up in inner-city, working-class poverty-stricken communities, where a well-established heroin market exposed them to a range of substances from an early age. Peers and social networks were the dominant route into sex work; economic necessity to cater for their opiate habits the main reason. Involvement in sex work often led to an escalation in drug use, which was paid for with the extra cash. Heroin, cocaine and crack cocaine use was prevalent in the daily lives of these sex workers.
- The latest findings from a longitudinal study investigating the lives of young homeless people in Dublin found that there are pathways out of homelessness for young people whose contact with their families had remained strong; they received support in accessing treatment for their substance use and in making the transition to supported living conditions. The research also showed that there are young people who remain trapped in homelessness and substance use through repeated exposure to unstable accommodation and the street 'drug scene'.
- The recent review of drug treatment and rehabilitation services by the Comptroller and Auditor General recommended the development of 'step-down' accommodation facilities to support individuals coming from residential drug treatment who want to put distance between themselves and their 'old lifestyle'.
- The Steering Group that drafted the new National Drugs Strategy highlighted the need to provide the provision of appropriate housing if treatment and rehabilitation services were to achieve sustained successful outcomes.
- The Homeless Agency recommended a shift in policy towards an evidence-based 'housing first' strategy to meet the needs of homeless people in Dublin, including homeless drug users and those at-risk of becoming homeless.
- Homeless people, surveyed by the Homeless Agency, highlighted relationship breakdown, mental health issues and alcohol and drug use as key factors contributing to their becoming homeless.
- Homeless people identified lack of information about services, difficulty in accessing private rented accommodation, addiction to alcohol or drugs and the stigma of being homeless as obstacles preventing them from exiting homelessness.
- Homeless people highlighted the problem of open drug use in homeless services, and service providers highlighted the lack of detox beds and rehabilitation support available to homeless people with alcohol or drug addiction.
- The ROSIE study of treatment outcomes found significant increases at one year and at three years in the number of participants undertaking vocational training courses.
- The ROSIE study also revealed that the number of people currently employed increased significantly between intake and three-year follow-up, with figures rising from 16% (64) to 29% (102). The number of participants deemed 'not working' decreased substantially.
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9. Drug-related crime, prevention of drug-related crime and prison

- In 2007, of the total drug offences (n = 11,647), almost 72% were for simple possession. Obstruction offences, which often involve an alleged offender

resisting a drug search or an arrest or attempting to dispose of drugs to evade detection, increased from 208 offences in 2003 to 407 in 2007, an increase of 96%. Since 2005, drug cultivation or manufacture offences have more than trebled, increasing from 29 offences in 2005 to 109 in 2007.

- In every year between 2003 and 2007, except 2006, cannabis-related proceedings represented more than 50% of the total of all drug types. In 2006, cocaine-related proceedings bypassed heroin-related proceedings for the first time. In 2007, heroin-related proceedings have again overtaken cocaine-related proceedings but only marginally, with both continuing their upward trend since 2003. Ecstasy-related proceedings have also continued to rise since 2005, following a slight decline since 2003.
- In 2007, there was an increase of almost 60% in Driving Under the Influence of Drugs (DUID) prosecutions.
- In early 2009, the Family Support Network (FSN) published the findings of research into the issue of intimidation of the families of drug users by those involved in drug dealing. Nearly all family support services indicated that their clients, mostly family members of drug users, had experienced debt-related intimidation. The burden of intimidation fell primarily on the mothers of users, but siblings, fathers, grand-parents, children and partners of users were also affected. About 35% of the cases of intimidation related to debts of between €100 and €500.
- In October 2008 the Limerick Regeneration Agencies launched their regeneration plan to implement the recommendations of the Fitzgerald report, which was published in 2007. This report had been tasked with addressing social exclusion, crime and disorder issues (including illicit drugs) in certain communities and disadvantaged areas in Limerick city.
- In September 2008 a Dial to Stop Drug Dealing campaign was officially launched. Individuals and communities affected by drug dealing are being urged to pass on information relating to drug dealing in their local communities by dialling a confidential telephone number. By June 2009, the campaign had been launched across the country and was considered to be 'very successful'; there had been in excess of 3,300 calls that generated over 920 information reports to the Gardaí.
- Operation Resolute is a joint Customs and Garda Síochána project aimed at building up intelligence on organised crime groups. Following a highly successful pilot phase, Revenue plan to extend the operation nationwide.
- A recent report has highlighted the low number of offenders progressing through the Drug Treatment Court (DTC). The Department of Justice, Equality and Law Reform is currently seeking to determine the reasons behind the relatively low numbers being dealt with in the DTC and to consider if measures can be taken to improve its operation. This review will determine whether a further expansion of the DTC will take place.
- The Joint Policing Committee (JPC) pilot was evaluated in early 2008 and final guidelines were issued to enable the establishment of JPCs in all local authority areas. Further guidelines are due to be published in the latter half of 2009 enabling the establishment of Local Policing Fora (LPFs) in local drug task force areas.
- The Irish Prison Service (IPS) annual report for 2007 detailed developments in drug supply reduction measures in Irish prisons, including the seizure of mobile phones from prisoners, new prison visiting arrangements, enhanced perimeter security and the introduction of drug detection dogs.
- The IPS annual report for 2007 also described developments in rehabilitation and treatment services for prisoners during 2007. Measures advanced during 2007 to enhance drug rehabilitation included the provision of addiction counsellor services and the allocation of additional nurse officers and prison officers to dedicated drug treatment teams. Nine prisons provided methadone substitution treatment to 1,840 prisoners in 2007, of whom 185 were receiving methadone for the first time.

- The first detailed study into prison recidivism was conducted by the Institute of Criminology at University College Dublin. Although the study was focused not only on drug-related offenders, some of its findings highlighted the links between problematic drug use, crime and recidivism.

10. Drug markets

- In the all-Ireland general population drug prevalence survey in 2006/7, the majority (62%) of recent cannabis users considered it 'very easy' or 'fairly easy' to obtain the drug within a 24-hour period, and almost two-thirds of recent cocaine powder users said that cocaine powder was easy to obtain within a 24-hour period.
- A study of illicit methadone use and abuse in young people accessing treatment for opiate dependence in Ireland found that, despite strict controls, 73% of participants reported that illicit methadone was easy to obtain.
- The fourth ESPAD study, undertaken in 2007, found that 43% of Irish students said marijuana or hashish would be 'fairly easy' or 'very easy' to obtain, 25% said the same for amphetamine and 31% for ecstasy.
- According to Customs Drug Law Enforcement (CDLE) South Africa continues to be the main source for herbal cannabis with Amsterdam and Belgium being the main transit hubs for the majority of seizures during 2008. Over the past 18 months, CDLE reports that there has been a 'noticeable increase in detections of sapling cannabis plants and seeds'.
- CDLE also reports the seizure of a significant supply of Methamphetamine in July 2008. This is the first significant detection of Methamphetamine (also known as Meth or Crystal Meth or Ice) in the history of the State.
- The number of drug supply offences in the Dublin Metropolitan Region (DMR) has increased steadily from 846 in 2004 to 1,477 in 2007. This represents just over 55 % of the total number of supply offences throughout the State in 2007.
- During 2007 prosecutions for drug supply increased in the southern region by 60% and by 40% in the south-eastern region, by 44% in the eastern region and 70% in the western region. They decreased slightly in the northern region.
- Research commissioned by the Clondalkin Local Drugs Task Force in west Dublin, found that a greater amount and variety of illegal drugs has become available in recent years. Drug dealing has become more open, frequently being conducted in public places, and is seen as an attractive and lucrative 'career option' for a proportion of young people living in Clondalkin.
- In October 2008, the Alcohol and Drug Research Unit of the Health Research Board (HRB) launched *Crack cocaine in the Dublin region: an evidence base for a crack cocaine strategy*. The north Dublin inner city remains the primary crack market in Dublin. Non-Irish national dealers who import small amounts of cocaine via couriers dominate the market. However, a growing number of Irish dealers are reported to be involved in the distribution of crack throughout the Dublin region, and prepared crack has been available throughout the city since 2006. Findings indicate that the crack market is a closed market, meaning that dealers do not sell to strangers, exchanges are generally arranged using mobile phones, and buyers are directed to exchange points outside the inner city.
- Drug seizures have continued to increase since 2005. Of the 10,444 reported drug seizures in 2007, 5,176 (49.6%) were cannabis-related. There has been a continuous steady rise in cocaine and heroin seizures since 2005. In 2007, there were 1,749 cocaine seizures and 1,698 heroin seizures. The number of seizures of ecstasy-type substances has also continued to rise, following a decline from 2003 to 2005.

Main points from Part B

11. Cannabis markets and production
 - Drug seizure data, survey findings and law enforcement operations in recent years (2006–2008) suggest that commercial domestic cannabis production is gaining momentum in Ireland.
 - There is limited evidence available to ascertain the size and growth of domestic cannabis production.
 - There has been an increase in ‘grow shops’ nationwide since 2000. Grow shops are generally referred to as ‘head shops’ in Ireland. Information on the extent of the head shop industry is not reliable as there is no official register of head shops in Ireland.
 - According to media reports, the first head shop in Ireland opened in 2000 and by 2007 there were at least 24 head shops operating nationwide.
 - Two recent all-Ireland general population drug prevalence surveys (2002/3 and 2006/7) highlight cannabis use patterns in the adult Irish population. The majority (60%) of current cannabis users reported using a form of cannabis resin. Almost two-in-five (38%) reported using a form of herbal cannabis.
 - No research studies have been conducted in Ireland on the nature of the Irish drug market. Research currently being completed by the Health Research Board will look at the organisation and structure of Irish illicit drug markets. A number of books have been written by investigative journalists about specific criminals or organised crime groups involved in the trade in illicit drugs including cannabis.
 - Wholesale prices for cannabis are not currently available in Ireland.
 - As part of ‘Operation Vacuum’, the Garda Síochána targeted domestic production of cannabis in 2008. Several large scale ‘cannabis factories’ were uncovered nationwide. Many were located indoors, both in private residences and commercial premises. The largest production facility successfully targeted by police in January 2009, had 1,200 cannabis plants, using the water based hydroponic system of cultivation.
 - Morocco is the major producing country of cannabis resin, the principal form of the drug used in Ireland. According to Customs Drug Law Enforcement ‘South Africa continues to be the main source for herbal cannabis with Amsterdam and Belgium being the main transit hubs for the majority of seizures during 2008.
 - Drug seizure data highlight increasing numbers of both cannabis plants and herbal cannabis seizures. Although drug seizures are seen as an indirect indicator of drug availability, it is important to remember that they can also merely reflect changes in police emphasis or priorities. There has been a sharp increase in cannabis herb seizures, from 609 seizures in 2006 to 1,910 in 2007. The number of cannabis plants seized more than doubled from 47 seizures in 2006 to 100 seizures in 2007.
 - Trend data for proceedings for possession of herbal cannabis in the Dublin Metropolitan Region (DMR) and Nationally from 2003 to 2007 show that there has been a steady upward trend in proceedings in the DMR since 2004. The steep upward trend in such proceedings nationally since 2006 in particular, is due to the upward trend in all garda regions since 2004 and a sharp rise in the South Eastern region during 2007 where proceedings for the possession of herbal cannabis increased from 218 in 2006 to 472 the following year.
12. Treatment for older drug users
 - The proportion of drug users aged 40 and over in treatment has increased from 3.1% of the total in 1998 to 9.4% of the total in 2008.
 - The biggest increase was observed in the age group 40–49, increasing from 2.7% in 1998 to 8.0% in 2008.
 - The proportion of treated clients aged over 60 is very low and remained almost constant for all years between 1998 to 2008.

- Between 1998 and 2007, one-fifth (22%) of the total deaths due to poisonings recorded in Ireland (as per Selection D) were among individuals aged 40 and over.
- The number of deaths in the older age groups increased steadily from 18 cases in 1998 to 28 cases in 2004, after which there was a jump in the number of deaths to 45. Since 2005, the number of deaths in this age group has fallen slightly.
- In the older age groups, the majority of deaths due to poisonings occurred among those aged 40 to 49. The majority of older drug-related deaths were male.
- Nearly two thirds of poisonings among older drug users were due to more than one substance. Of these, almost all included an opiate-type drug.
- The proportion of drug users aged 40 and over in methadone maintenance treatment has increased from 4% in 1994 to 19% in 2008.
- Only a very small proportion (less than 0.5%) of treated clients started their drug use after the age of 40. The proportion did not change over the 10 years under review.
- Overall, heroin is the main problem drug reported by all older drug users.
- Only a small proportion of older drug users reported cocaine as their main problem drug. Very few drug users aged over 50 years reported cocaine as their main problem drug.
- The small number of drug users aged 50 and over makes inferences about these older groups more difficult.
- In 2008, almost one in ten clients entering drug treatment were aged 40 years or older. The majority of these older users were aged between 40 and 49.
- In 2008, the majority of older drug users reported using heroin. Lower proportions of older drug users reported cocaine as their main problem drug compared to younger users.
- In 2008, benzodiazepines and other opiates were the main problem drugs for clients aged 60 or over. However, the small numbers make inferences difficult.
- Older drug users have not been identified as a vulnerable or high-risk group in Ireland who need dedicated services. No specific research has been done on this group, but as the cohort ages this may need to be re-evaluated.

Part A: New Developments and Trends

1. Drug policy: legislation, strategies and economic analysis

1.1 Introduction

The classification of drugs and precursors in Ireland is made in accordance with the three United Nations conventions of 1961, 1971 and 1988. Irish legislation defines as criminal offences the importation, manufacture, trade in and possession, other than by prescription, of most psychoactive substances. The principal criminal legislative framework is laid out in the Misuse of Drugs Acts (MDA) 1977 and 1984, and the Misuse of Drugs Regulations 1988. The offences of drug possession (s.3 MDA) and possession for the purpose of supply (s.15 MDA) are the principal forms of criminal charge used in the prosecution of drug offences in Ireland. The Misuse of Drugs Regulations 1988 list under five schedules the various substances to which the laws apply.

The National Drugs Strategy 2009–2016 provides the implementation framework for illicit drugs policy in Ireland. The Strategy has an overall strategic objective, ‘To continue to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research’.

Implementation is based on a ‘partnership’ approach, whereby over 20 statutory agencies, multiple service providers and community and voluntary groups work together in a nationwide network of regional and local drugs task forces (DTFs) to deliver the Strategy, with the statutory agencies critical in terms of core service provision. Two central entities provide national oversight. The Office of the Minister for Drugs (OMD) develops policy, co-ordinates the implementation of the Strategy, and supports the work of the DTFs and the community and voluntary sectors in relation to the Strategy. It reports to the Cabinet Committee on Social Inclusion, Children and Integration. An Oversight Forum on Drugs (OFD), comprising senior representatives of the various statutory agencies involved in delivering on the Strategy, and representatives from the community and voluntary sectors, provides high-level monitoring of progress against the Strategy and agrees ways forward where issues are blocked or progress is being impeded. It reports to the OMD.

With regard to funding, priorities for public expenditure on the drugs issue are set out in the National Drugs Strategy and the National Development Plan. Public funds are allocated by way of the annual parliamentary Estimates process, which allocates funds to departmental Votes. Funding for regional or local initiatives may be either directly from government agencies, or funds such as the Young People’s Facilities and Services Fund (YPFSF), administered by the Office of the Minister for Children and youth Affairs, or via the regional and local DTFs. The funding mechanism via DTFs proceeds from ‘initial’ to ‘mainstreamed’ funding as follows:

- *Initial funding*: DTF projects are initially set up as *pilot projects* with funding provided through the Drugs Initiative, administered by the Department of Community, Rural and Gaeltacht Affairs (DCRGA). The government department or agency most closely associated with the nature of the project acts as the *channel of funding* to the project during this pilot phase.
- *Mainstreamed funding*: after the pilot phase, each project is evaluated and a decision taken with regard to *mainstreaming* it in the appropriate government department or agency. Once a project is mainstreamed, the responsibility for the funding of the project transfers to that department or agency and DCRGA is no longer involved. DTFs continue to have a monitoring role in relation to mainstreamed projects.

Other public funding mechanisms include the Dormant Accounts Fund and the national lottery. The statutorily-based Dormant Accounts Fund contains unclaimed monies transferred by credit institutions and insurance undertakings. The Dormant Accounts legislation provides that these funds may be allocated to projects and programmes designed to alleviate poverty and social deprivation.

1.2 Legal framework

1.2.1 Laws, regulations, directives or guidelines

This section lists firstly criminal justice and secondly other legislation, introduced or enacted during the past year, which may impact directly or indirectly on the illicit drugs situation.

The **Criminal Justice (Surveillance) Act 2009** provides for the first time a legal framework to allow covert surveillance material to be used in criminal trials. The Garda Síochána, the Defence Forces and the Revenue Commissioners will have a statutory framework for the operation of secret electronic surveillance to combat serious crime as well as subversive and terrorist threats against the security of the State. The legislation also builds in safeguards with regard to its authorisation, duration and operation.

The Act provides that secret surveillance can be used as evidence either to support other direct evidence on criminal charges, or as a basis on its own for a charge of conspiracy. Some of the specific provisions of the Act include:

- Carrying out of surveillance on foot of an authorisation granted by a District Court Judge under strict conditions for a period of up to three months, or in urgent situations by authorisation from a senior officer for a period of no longer than 72 hours.
- Imposition of strict rules governing approval, administrative procedures and the keeping of records in all cases.
- Provision of safeguards regarding the retention and disclosure of information concerning the operation of the act including criminal sanctions for breach of confidentiality.
- A complaints procedure whereby a person may complain to a Complaints Referee.
- A system of judicial oversight of the operation of the Act by a Judge of the High Court, designated by the Government.
- The admissibility as evidence of information obtained as a result of surveillance in criminal proceedings.
- Rules regarding disclosure of information surrounding authorised surveillance in proceedings.

The **Criminal Justice (Amendment) Act 2009** makes provisions to enable all organised crime offences to be declared scheduled offences for the purpose of trial in the Special Criminal Court unless the Director of Public Prosecutions directs otherwise. The Special Criminal Court operates with three judges and without a jury. In this legislation, an organised crime group is within the meaning of part seven of the Criminal Justice Act 2006. In that Act, 'a criminal organisation means a structured group, however organised, that:

- is composed of 3 or more persons acting in concert,
- is established over a period of time,
- has as its main purpose or main activity the commission or facilitation of one or more serious offences in order to obtain, directly or indirectly, a financial or material benefit'.

In relation to bail, organised crime offences will be scheduled as 'serious offences' within the meaning of the Bail Act 1997, thereby providing for circumstances where bail may be refused by the courts. Moreover, as of 1 May 2009, the Director of Public

Prosecutions can appeal to the High Court against a decision of the District Court to grant bail. An appeal can also be taken against conditions attached by the District Court to bail. This is intended to ensure tighter conditions where bail is granted.

The Act has led to a number of criticisms from lawyers and human rights groups. Some 300 lawyers wrote a letter to *The Irish Times* challenging its constitutionality. The Irish Human Rights Commission (IHRC), which is Ireland's national human rights institution and which is mandated to make recommendations to the Government in relation to the protection and promotion of human rights in the State, opposed a number of measures in the Criminal Justice (Amendment) Bill 2009. With regard to restrictions on the Irish constitutional right to trial by jury the IHRC stated: 'the IHRC is cognisant that organised crime is a problem in Ireland and that it has the potential to cause great harm in Irish society. However, the IHRC considers that the exigencies of the situation in Ireland do not justify the restriction of the Constitutional right to trial by jury' (Irish Human Rights Commission 2009).

With regard to the justification that the measures introduced in the Bill are a response to the risk of jury intimidation, the IHRC stated 'the risk of jury intimidation is one means by which the normal administration of justice can be undermined. However, in the absence of supporting data the IHRC queries a blanket assumption about the actual or potential level of jury intimidation in Ireland'. The IHRC suggested that a number of other measures could be adopted to address this potential problem including having an anonymous jury, screening the jury from public view, protecting the jury during the trial, or locating the jury in a different place from where the trial is being held with communication by video link. The IHRC also made a number of recommendations in relation to other aspects of the Act, including provisions to restrict the right to silence and provisions relating to 'organised crime'. With regard to the latter, the IHRC was concerned that the seriousness of the penalty proposed under section 5 of the Act relating to the offence of 'directing' a criminal organisation, with the potential for life imprisonment, might give rise to arbitrary or disproportionate sentences for an accused who is proved to have played a minor role in a criminal organisation. The IHRC recommended that 'the proposed penalty under section 5 of the 2009 Act should be qualified and revised downwards to take account of the level at which the accused directs a criminal organisation' (p12).

The Irish Council for Civil Liberties (ICCL) also strongly condemned provisions allowing the role of the Special Criminal Court to be expanded. According to Mark Kelly, director of the human rights watchdog:

In a matter of weeks, the United Nations' top human rights experts will call upon the Minister's senior officials to justify the continued existence of the Special Criminal Court. In these circumstances, for Dermot Ahern (the Minister) to moot the expansion of the Court shows a flagrant disregard for Ireland's international human rights obligations. ...If we are to effectively tackle gangland crime, the Gardaí must be placed in a position to fully enforce existing criminal laws, especially in cases where attempts are made to intimidate key witnesses. The emphasis should be upon intelligence-led and community-based policing coupled with improved witness protection, rather than on undermining the rule of law by expanding the Special Criminal Court.

In July 2009, the President of Ireland, as provided for in the Irish Constitution, *Bunreacht na hÉireann*, following consultation with the Council of State as to whether she should refer the Criminal Justice (Amendment) Bill 2009 to the Supreme Court for a test as to its compatibility with the Irish Constitution, decided not to take this course of action and, on 23 July, she signed the Bill into law.

The Criminal Justice (Miscellaneous Provisions) Act 2009 provides a statutory framework for controlling firearms and seeks to halt the emergence of a gun culture in Ireland.

The **Community, Rural and Gaeltacht Affairs (Miscellaneous Provisions) Act 2007** provides a statutory mandate for the functions and responsibilities of the Minister for Community, Rural and Gaeltacht Affairs, including:

Co-ordinate the implementation of the National Drugs Strategy (including matters relating to the allocation of services and facilities to counter drug misuse in areas of the State where such misuse is significantly higher than in other areas of the State). (Section 2 (1) (d))

Section 2 (2–4) of the Act provides the Minister with the power to develop, implement, maintain or expand any scheme that in her or his opinion supports or promotes the functions for which he or she is responsible, including the co-ordination of the National Drugs Strategy. It also allows the Minister to terminate any such scheme.

The **Spent Convictions Bill 2007** was introduced in Dáil Éireann for its second reading. The Bill is intended to apply where a prison sentence not exceeding six months or a fine or penalty have been imposed, and then only after a certain number of years have elapsed without a further conviction. The purpose of the Bill is to help rehabilitate convicted persons through facilitating their reintegration into the workforce and allowing them to build new careers. Following a debate, the Bill was referred to the Select Committee on Justice, Equality, Defence and Women's Rights.

The **Criminal Procedure Bill 2009** makes provisions for a modification of the rule against double jeopardy in order to allow a person who has been acquitted of an offence to be re-tried in circumstances where new and compelling evidence emerges or where the acquittal is tainted due, for example, to corruption or intimidation of witnesses or jurors or perjury. The rule against double jeopardy provides that no person may be put at risk of being punished twice for the same offence. The legislation applies to a number of drug-related offences.

The **Housing (Miscellaneous Provisions) Bill 2008** was introduced into Dáil Éireann for its second reading. Section 35 of the Bill requires each local housing authority to adopt a strategy for the prevention and reduction of anti-social behaviour in its housing stock. The Bill also amends the definition of anti-social behaviour in the Housing (Miscellaneous Provisions) Act 1997, extending it to include damage to property, graffiti and significant impairment of the use or enjoyment of a person's home.

The **Communications (Retention of Data) Bill 2009 (No 52 of 2009)** requires service providers, those engaged in the provision of a publicly electronic communication service or a public communication network by means of fixed line or mobiles or the internet to retain data relating to fixed and mobile telephony, for 1 year, and data relating to internet access, internet email and internet telephony for 2 years, and provides for disclosure in relation to the investigation of specified offences including Customs offences.

The **Health (Miscellaneous Provisions) Bill 2009** makes arrangements for progressing the integration of health service agencies in line with Government policy on the rationalisation of public sector agencies. Part 5 of the bill provides for the dissolution of the Drug Treatment Centre Board and the transfer of its rights, liabilities, land and any other assets to the Health Service Executive.

1.2.2 Laws implementation

In March 2009, Minister for Health and Children, Mary Harney TD, announced that 1-benzylpiperazine (BZP) is now a controlled drug through statutory instruments (121 and 122 of 2009) amending the Misuse of Drugs Act 1977, and that its possession or sale is now a criminal offence. The new statutory instruments will ensure that BZP is no longer available for sale in 'head shops' around the country or on the streets.

BZP is a relatively new synthetic psychotropic (mood altering) substance which has been sold as ecstasy under the street names 'Legal E', 'Legal X' 'XTC', 'A2', 'piperazine', or 'party pills'. In Ireland, party pills containing BZP have been widely sold in head shops. The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) conducted a risk assessment of BZP in 2007 and found that its use can lead to various medical problems, though the long-term effects of the substance are still unknown (Europol-EMCDDA 2007). The risk assessment report concluded that due to its stimulant properties, risk to health and the lack of medical benefits there was a need to control BZP. Against this background, the Council of the European Union decided in July 2007 that BZP should be defined as a new psychoactive substance and to be made subject to control measures and criminal provisions.

The **Criminal Justice (Mutual Assistance) Act 2008** commenced in August 2008. It defines the competent authorities, the Revenue Commissioners and the Garda Síochána, in relation to controlled deliveries of drugs and confirms current procedures adopted in relation to controlled deliveries of drugs. A memorandum of understanding and operational protocol in relation to these procedures have been placed in the library of the Oireachtas. With regard to the provisions contained in the Act, the Garda Síochána have recently taken the view that the Garda Commissioner is the only competent authority in the State to accept controlled deliveries of drugs from foreign law enforcement authorities, that is police and customs. Revenue believes that this view is at variance with the legislation. The advice of the Attorney General is awaited on this issue.

Minister's contribution to Trinity cannabis debate

In its opening debate of the 2008 academic year, the Trinity College Historical Society debated the motion 'That the sale of cannabis should be legalised'. In opposing the motion Pat Carey TD, at the time Minister of State for the national drugs strategy, set out in detail not generally provided the government's position on this controversial issue. With regard to the health effects of cannabis use, the Minister argued that cannabis cigarettes produce 'three times more carcinogenic "tars" than tobacco and five times more poisonous carbon monoxide' and that this put users at risk 'of bronchitis and double(d) the risk of certain types of cancer, including lung and throat cancer'. Referring to the association between cannabis use and mental illness, the Minister stated that long-term cannabis use could, in some cases, 'trigger mental illness such as schizophrenia and depression – two sicknesses that cannot afford to be promoted considering this country's intolerable suicide rates'.

The Minister stated that the 'vast majority' of young people who have used a variety of illegal substances initiated their illicit drug consumption with cannabis. Consequently, 'they become involved and immersed in the drug culture', come to know drug dealers and 'more often than not' come into contact with users of drugs of a more serious nature. With regard to the potency of cannabis, the Minister suggested that, while previously most cannabis contained approximately 2% of the active substance THC, newer 'specially cultivated strains of cannabis can be up to 16% THC'. He acknowledged, however, that these 'newer strains' are not the most commonly used types of cannabis in Ireland. The Minister, who is a former schoolteacher, highlighted research which, he said, pointed to a connection between cannabis use and early school leaving. While cannabis use is, Minister Carey stated, 'far from the only factor stopping teenagers and young adults reaching their educational potential, it seems somewhat ridiculous to me that we would risk further exacerbating the already existing difficulties by legalising cannabis.'

With regard to the reclassification of cannabis to a Class C drug in the UK,² the Minister stated that equivalent penalties continue to be much higher than those currently in force in this country. The changes in the UK appear to allow greater

² Cannabis in the UK has subsequently been reclassified again, to class B.

discretion in dealing with people found to be in possession of cannabis. Under Irish law, the gardaí and the Courts already have a very high degree of discretion in dealing with these cases.

Referring to developments in the Netherlands, the Minister said that the Mayor of Rotterdam had recently announced that 27 of the city's 62 coffee shops must close as of 1 January 2009, because these shops were located too close to secondary and vocational schools. This was part of a rowing back by Holland at both national and at local level of its existing perceived 'liberal' policy.

The Minister argued that, although the level of acceptance of cannabis use is growing, 'the majority of people in Ireland ... are against the legalisation of cannabis. This is a fundamental reason in a democracy as to why you wouldn't legalise a drug.' Finally, the Minister questioned the assertion that legalisation would result in the elimination of criminal activity surrounding cannabis. 'It may', he argued, 'only result in a transfer from drug-related criminal activity to other forms of criminal activity.' Even if cannabis were legalised, he suggested, 'it is difficult to envisage that its provision would be anything other than heavily regulated. This would provide continued opportunities for criminals to continue their involvement in the illegal supply of cannabis.' The motion was defeated by a narrow majority.

1.3 National action plan, strategy, evaluation and co-ordination

1.3.1 Implementation and evaluation of national action plan and/or strategy

On 10 September 2009 a new national drugs strategy, the National Drugs Strategy (interim), 2009–2016, (NDS 2009–2016) was launched by the Irish government (Department of Community Rural and Gaeltacht Affairs 2009). The document was prepared by a Steering Group, chaired by DCRGA and comprising representatives of the key departments and agencies involved in delivering the current drugs strategy, as well as representatives from the community and voluntary sectors. The Steering Group examined the progress and impact of the previous strategy and its relevance to the current nature and extent of drug-related problems in Ireland, reviewed the operational effectiveness of the structures for implementing the strategy, and examined developments in drug policies, and responses to the problem, at EU and international level. In light of this information, and following extensive public consultations, the Steering Group drew up a new strategy, which was approved by the government.

During the consultation process for the NDS 2009–2016, there was widespread public concern in relation to the problem use of alcohol, both as a stand-alone public health issue and in association with illicit drug use. On 31 March 2009, the Government approved the development of a National Substance Misuse Strategy to cover both alcohol and drugs.

The contents of the new strategy, and the arrangements being made to manage the inclusion of alcohol in a 'national substance misuse strategy', are described below, following a summary of the Steering Group's assessment of the progress made during the lifetime of the previous national drugs strategy (NDS 2001–2008).

No formal process or output/outcome evaluation of the NDS 2001–2008 was undertaken. However, two independent studies published earlier in 2009 reviewed aspects of the previous drugs strategy. The contents of these two studies are outlined at the end of this section.

National Drugs Strategy 2001–2008 (NDS 2001–2008) – Steering Group’s assessment

The Steering Group that managed the preparation of the NDS 2009–2016 assessed progress against the key performance indicators (KPIs) under each of the pillars in the previous strategy.³

Supply reduction

All KPIs under this pillar were achieved. The targets of a 50% increase in volume of drugs seized based on 2000 figures and a 20% increase in the number of seizures based on 2004 figures were both exceeded. The 125% increase in supply detections between 2004 and 2008 significantly exceeded the target of 20%. While acknowledging the operational success which this represented for law enforcement, the Steering Group noted that, without a reliable estimate of the size of the illegal drug market in Ireland, the impact of increased seizures on the overall supply could not be measured.

Other areas of progress included increases in Garda Síochána resources in LDTF areas and various initiatives aimed at reducing the supply of drugs, such as the ‘Dial to Stop Drug Dealing’ scheme, undertaken by local and regional DTFs. Less progress was achieved in expanding Community Policing Fora (CPF) and reducing the availability of drugs in prisons.

Prevention

The KPIs under this pillar related to levels of problem drug use, prevalence, substance use policies in schools and rates of early school leaving. Heroin use stabilised in the Dublin area with a significant drop in new entrants. However, heroin use outside Dublin rose substantially. Drug prevalence targets were not achieved and the 2006/07 drug prevalence survey reported increases in recent and current use. The target of having substance use policies in all schools was near completion at the time of a Department of Education and Science survey in 2005. A number of data sources were used to estimate the levels of early school leaving and, while precise figures were not available, it appeared that early school leaving had decreased during the period of the NDS 2001–2008.

While many of the actions relating to implementation of prevention programmes were completed or near completion, the Steering Group questioned the effectiveness of a number of the programmes. Despite the high number of schools which reported that they had implemented substance misuse policies, the quality of these policies had not been assessed and there was a need to determine how actively they were being implemented. The Social Personal Health Education (SPHE) programme, the foundation for developing awareness of drugs and alcohol issues in schools, is a mandatory part of the curriculum but its effectiveness as a drug prevention measure was constantly questioned during the consultation process.

Treatment and rehabilitation

Three of the KPIs under the treatment and rehabilitation pillar specified increased availability of treatment and harm reduction services and one sought a reduction in the incidence of HIV. The target of a maximum waiting period of one month for treatment for problem drug use had been achieved for almost all non-opiate addiction cases. However, there were still difficulties in providing access to treatment within one month after assessment for methadone services in many areas. No person under 18 years of

³ The KPIs used to measure progress under the pillars in the NDS 2001–2008 were revised by the Steering Group that undertook the mid-term review of the drugs strategy Steering Group for the Mid-Term Review of the National Drugs Strategy (2005). [Mid-term review of the National Drugs Strategy 2001-2008](#). Department of Community, Rural and Gaeltacht Affairs, Dublin..

age had had to wait longer than a month to initiate treatment following assessment, but there were still not enough residential places or community supports. There was limited progress in providing harm-reduction services, but the incidence of HIV among IDUs had seen a consistent reduction. The incidence of hepatitis C continued to cause concern.

While rehabilitation was covered under the treatment pillar in the NDS 2001–2008, the mid-term review of the NDS 2001–2008 (Department of Community Rural and Gaeltacht Affairs 2005) recommended that a separate pillar be established. Following a recommendation in the report of the Working Group on Drugs Rehabilitation (Working Group on Drugs Rehabilitation 2007), a National Drug Rehabilitation Implementation Committee (NDRIC), chaired by the HSE, was set up.

The Steering Group found there had been progress in several areas related to the mid-term review's recommendation to strengthen support for families and the HSE had significantly developed its family support services.

Research

The KPIs under this pillar dealt with information on prevalence in the general population, problem drug use, demand for drug treatment, drug-related deaths and drug-related infectious diseases. In 2005 the National Advisory Committee on Drugs (NACD) published the findings of a drug prevalence survey carried out in Ireland and Northern Ireland in 2002/03. This survey was repeated in 2006/07 and the results published in 2008. The NACD also commissioned studies on drug prevalence among vulnerable groups, including the homeless, new communities in Ireland and Travellers. Other studies had given some insight into alcohol and cannabis use among the youth and school-going populations. While work on the second 3-source capture-recapture study, to estimate the prevalence of problematic opiate use, has yet to be completed, the Research Outcome Study in Ireland (ROSIE), and the information provided through the National Drug Treatment Reporting System (NDTRS), had provided significant insights into the patterns of problem drug use.

Improvements in the reporting of problem drug use to the Health Research Board's Drug Misuse Research Division (renamed Alcohol and Drug Research Unit (ADRU) in 2007) increased the efficiency of the flow of the data on drug treatment demand and the quality of the information. In 2005 the Health Research Board (HRB) developed a National Drug-Related Deaths Index (NDRDI), which subsequently published data for the period 1998–2005 (Lyons, Suzi *et al.* 2008). The Health Protection Surveillance Centre (HPSC) introduced an extended surveillance system for hepatitis B in 2004 and for hepatitis C in 2007. The Steering Group noted that there had been no concerted effort to monitor the incidence and prevalence of hepatitis B, hepatitis C or HIV among drug users since the NDS 2001–2008 was launched.

National Drugs Strategy 2009–2016 (NDS 2009–2016)

In his foreword to the NDS 2009–2016, the Taoiseach, Brian Cowen TD, observed that the previous drugs strategy had been successful in tackling the heroin problem in Dublin but that the situation had now changed: 'problem drug use has spread to other areas and the range of drugs available has increased. The challenge involved is complicated by the fact that drug use can be linked to circumstances of social exclusion as well as to circumstances of economic prosperity.'

In their forewords to the new strategy, both the Taoiseach and the Minister of State with responsibility for the Drugs Strategy, John Curran TD, emphasised that partnership both at national and local level, including the drugs task forces, would continue to form the basis of the government's approach to tackling the problem. Deputy Curran confirmed that the government would also continue to base its approach on the five pillars – supply reduction, prevention, treatment, rehabilitation and

research, ‘as these have served us well and still encompass the areas that need to be addressed. This will also facilitate the dovetailing of the Strategy with the provisions of the EU Drugs Action Plan 2009–2013.

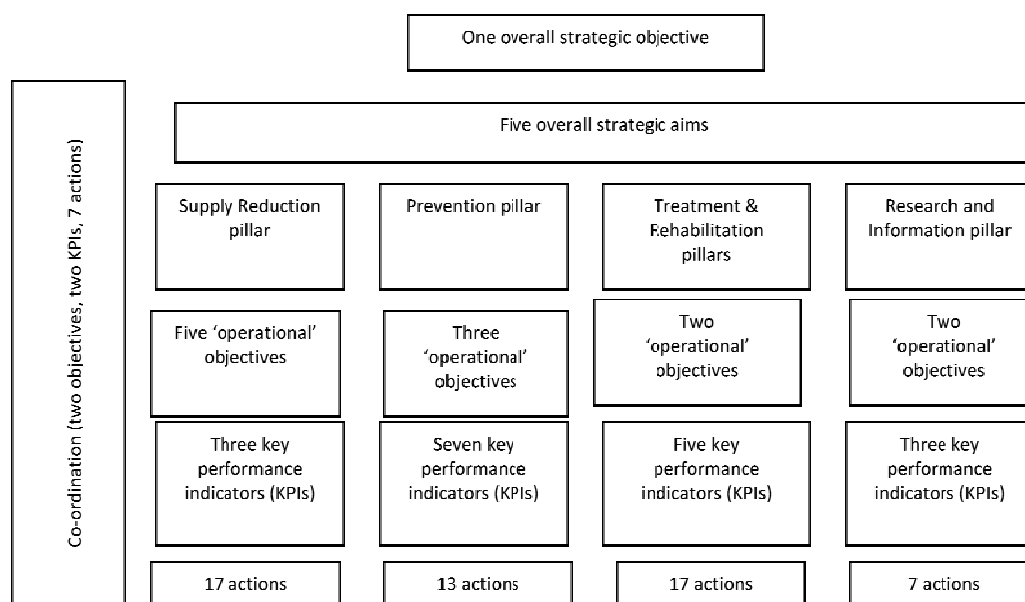


Figure 1.3.1 Strategic framework adopted in the NDS 2009–2016

The NDS 2009–2016 uses the same framework as before, constructed around a hierarchy of aims, objectives, key performance indicators (KPIs) and actions (Figure 1.3.1). The expectation is that the high-level aspirations will provide an over-arching logic uniting the whole, while, simultaneously, the underpinning actions will drive the new strategy forward. The overall strategic objective remains the same as before except that a fifth pillar, rehabilitation, has been included and the aim of ‘significantly reducing’ harm has been replaced by an aim of ‘continuing to tackle’ harm (Table 1.3.1).

Table 1.3.1 Strategic objectives, NDS 2001–2008 and NDS 2009–2016

Strategic objective, NDS 2001–2008	Strategic objective, 2009–2016
To significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research	To continue to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research

While the overall strategic approach and framework are broadly the same as before, the contents of the pillars in the NDS 2009–2016 reveal some shifts in emphasis – reflecting either the changing nature of the situation and the problem being faced, the experience gained through implementing the previous drugs strategy, or the insights acquired through the new research and information accumulated during the past seven years. The new priorities and actions identified by the Steering Group under each pillar are outlined in the following paragraphs.

Supply reduction

Under the supply reduction pillar, the primary aim of reducing the availability of drugs remains. However, there is a greater note of realism, for example in the way in which the impact of drug supply reduction activities is determined.

Acknowledging the significant increase in drug seizures in recent years, the Steering Group stated that during the consultation phase ‘the impact of those seizures on

reducing the overall supply of drugs was questioned' (para.2.22). The Steering Group stated, 'Due to the problems associated with estimating the size of the illegal drug market in Ireland, it is difficult to conclude whether increased seizures are actually resulting in a reduction in overall supply – or whether the overall supply of drugs has increased and the percentage of seizures has remained relatively even' (para. 2.27). The Steering Group further acknowledged that 'the figures often quoted in relation to drugs seizures as a percentage of the total drugs market in Ireland are speculative and currently, have no proven basis' (para. 2.27). Consequently, the Steering Group concluded that there is a need to develop other measurements to determine the effectiveness of supply reduction activities rather than just relying on drug seizures.

An issue highlighted during the consultation phase was the possibility of decriminalising or changing the legal status for the simple possession of certain drugs such as cannabis, owing to the garda resources involved in prosecuting such cases. The Steering Group reported that, according to the gardaí, 'about 20% of drugs crime relates to supply offences and 80% to possession' (para. 2.29). Despite this, most of the Steering Group were not in favour of 'legalising, decriminalising, or changing/redefining the legal status of certain illicit drugs (cannabis was the focus of most discussion in this context' (para. 2.49). The Steering Group noted that the findings of the nationwide drug prevalence surveys conducted in 2002/03 and 2006/07 indicated that approximately 70% of respondents did not think recreational cannabis use should be permitted (support for the medicinal use of cannabis was about 70%). The Steering Group did, however, agree to prioritise the ongoing monitoring of legislative and regulatory frameworks with a view to pursuing changes where necessary.

Other priorities identified by the Steering Group included developing local partnership approaches through the Joint Policing Committees and Local Policing Fora provided for in the Garda Síochána Act 2005; tackling underage drinking and drug-related intimidation; the development of an integrated system to track the progression of offenders with drug-related offences through the criminal justice system; the continued implementation of measures to curtail the supply of drugs in Irish prisons; and a renewed focus on addressing the use of precursors in the manufacture of illicit synthetic drugs. The last priority calls for increased collaboration with international bodies such as the EMCDDA and Pompidou Group of the Council of Europe.

Prevention

In their forewords to the NDS 2009–2016 both the Taoiseach and the Minister for Drugs emphasised the importance of prevention. Minister Curran stated: 'If we could achieve more in regard to prevention, I believe that the impact on the overall problem would be greatly enhanced.'

Having reviewed progress under the NDS 2001–2008, the Steering Group concluded that 'a tiered or graduated approach to prevention and education measures in relation to drugs and alcohol should be developed with a view to providing a framework for the future design and development of interventions' (para. 3.56). The Steering Group identified three levels in this framework, which are outlined below. In naming the three levels, the Group combined the current prevention classification framework – universal, selected and indicative – with the old classificatory framework of primary, secondary and tertiary.

Universal (primary) prevention programmes

Aimed at reaching the general population, such as students in schools, to promote overall health of the population and to prevent the onset of drug and alcohol misuse. Measures often associated with this type of programme include awareness campaigns, school drug/alcohol education programmes and multi-component community initiatives.

Selected (secondary) prevention programmes

Aimed at groups at risk, as well as subsets of the general population including children of drug users, early school leavers and those involved in anti-social behaviour. These programmes aim to reduce the effect of risk factors present in these subgroups by building on strengths and developing resilience and protective factors.

Indicative (tertiary) prevention programmes

Targeted at people who have already started using drugs/alcohol, or who are likely/vulnerable to engage in problematic drug/alcohol use (but may not necessarily be drug/alcohol dependent), or to prevent relapse. These require individual or small group programmes aimed at addressing specific needs.

With regard to specific interventions, the Steering Group identified the following priorities:

- *improved delivery of SPHE in primary and post-primary schools* – the Steering Group acknowledged that while the focus of prevention measures in the NDS 2001–2008 had been on the provision of education services in school settings for the school-going population, their application and delivery had limited their effectiveness.
- *the co-ordination of the activities and funding of youth interventions in out-of-school settings to optimise their impacts* – under the NDS 2001–2008 the provision of education in non-school settings had been fragmented, the provision of alternative recreational facilities for young people had been under-developed, and many young people had not had access to recreational facilities in out-of-school settings.
- *a continued focus on orienting educational and youth services towards early interventions for people and communities most at risk* – the Steering Group recommended that actions be developed to further support the families of drugs users, and it acknowledged community development as an important step in building the capacity of local communities to avoid, or respond to and cope with, drug problems.
- *the development of timely awareness campaigns targeted in a way that takes individual social and environmental conditions into account* – the Steering Group saw the need to further develop and promote prevention strategies in a number of key areas such as third-level institutions, workplaces, sports and other community and voluntary organisations.

Treatment and rehabilitation

The Steering Group stated that this pillar, which combines the treatment and rehabilitation pillars, had a wider focus than in the NDS 2001–2008. It aimed to develop a more comprehensive treatment service capable of dealing with all problem substances nationally, rather than focusing mainly on opiate misuse in Dublin. The Steering Group identified a number of priorities grouped under four main themes.

1. Development of general problem substance use services – develop an integrated national treatment and rehabilitation service for all substances, using a four-tier model approach, underpinned by an appropriate clinical governance regime.

The Steering Group supported the HSE's reorientation of addiction services towards polydrug use using a four-tier model. The focus of the strategy will be on the development of addiction services, and of pathways between them and other relevant health and social services.

The treatment of drug users with hepatitis C is specifically mentioned for the first time in the NDS 2009–2016. The Steering Group noted that there has been a gradual and consistent decrease in the number of HIV cases reported, while the incidence of hepatitis C among IDUs is a cause of concern. The KPI on the monitoring of the incidence of HIV has been dropped and, for the first time, a KPI for the treatment of hepatitis C in drug users has been included.

Data from the National Drug-Related Deaths Index (NDRDI), set up in line with Action 67 in the NDS 2001–2008, has shown an increase in drug-related deaths since 1998 (Lyons, Suzi *et al.* 2008), and a new action in the NDS 2009–2016 calls for the development of a National Overdose Prevention Strategy, and also for a response to the increasing numbers of indirectly drug-related deaths.

The Steering Group prioritised the expansion of the availability of detox facilities, opiate substitution services, under-18 services and needle-exchange services where required. The KPI relating to service provision for under-18s remains the same as in the NDS 2001–2008, but with a new target of 100% access to treatment within one week (as opposed to one month) of assessment by 2012. While the document states that methadone substitution is the cornerstone of opiate treatment and looks for continued recruitment of Level 2 GPs,⁴ a new action calls for the review of the Methadone Treatment Protocol to maximise the provision of treatment and to facilitate appropriate progression pathways. Additionally, the action calls for alternative opiate substitution services.

Noting that there had only been a small increase in the number of residential places between 2001 and 2006, the Steering Group called for the development of residential care in the context of the four-tier model. Along with appropriate aftercare services, the Steering Group saw residential care as central to the provision of alternative, drug-free treatment for problem drug users. The NDS 2009–2016 includes a new KPI relating to residential places, which states that there should be a 25% increase in residential rehabilitation places by 2012 based on 2008 figures.

The Steering Group called for the establishment of a drugs intervention programme, incorporating a treatment referral option, for those who come to the attention of the Garda Síochána because of behaviour caused by substance misuse. It stated that this programme would be aimed at young people and young adults. While many of the services needed for this programme are already in place, the Steering Group noted that interagency co-ordination needs to be developed. A new KPI specifies that this programme should be in place by 2012.

2. Specific groups – further develop engagement with, and the provision of services for, specific groups: prisoners, homeless, Travellers, new communities, the lesbian, gay, bisexual and transgender (LGBT) community and sex workers.

These specific groups are listed separately in the NDS 2009–2016. Those with a dual diagnosis (both mental health and substance misuse problems) are also mentioned specifically. These groups have been highlighted in order to differentiate their specific needs and to tailor services for them. New issues for prisoners have also been identified. These include the recognition of the high risk of overdose or relapse immediately following release from custody and the need for the development of an effective and co-ordinated interagency approach to ensure a seamless transition from prison back into the community. The Steering Group noted that not all prisons provided substitution treatment, and identified this issue as a key gap.

3. Quality and standards framework - develop a clinical and organisational governance framework for all treatment and rehabilitation services.

The Steering Group stated that while progress had been made in introducing standards in treatment and rehabilitation services, further measures were necessary. For example, currently neither counselling nor psychotherapy services are statutorily regulated. New actions are identified in relation to developing a clinical and organisational governance framework for addiction services and developing a regulatory framework on a statutory basis for the provision of counselling.

⁴ Under the Methadone Treatment protocol, a level 2 GP is authorised to take up to 35 clients on methadone maintenance, and can take on clients without their having to be referred by a treatment clinic.

4. Training and skills development – develop national training standards for all those involved in the provision of substance misuse services, and co-ordinate training provision within a single national substance misuse framework.

The actions relating to training and skills development are more specific in the new strategy, as they are seen as a key component in the development of a comprehensive addiction service. The new actions call for the development of national training standards, including accreditation, for addiction services (both statutory and voluntary). The need for staff training in the use of naloxone in order to prevent fatal overdose is specifically mentioned.

Research and information

The NDS 2009–2016 intends to collect information and complete research projects in order to inform policy formulation and to develop or enhance responses to the drug situation, while the NDS 2001–2008 intended to measure the extent of drug use by person, place and time, and describe the characteristics of drug users, but did not state how the new information would be used (Table 1.3.2).

Table 1.3.2 Research objectives and KPIs, NDS 2001–2008, and Research and information objectives and KPIs, NDS 2009–2016

2001– 2008	2009–2016
Have valid, timely and comparable data on the extent of drug misuse amongst the Irish population and specifically amongst all marginalised groups	Ensure the availability of data to accurately inform decisions on initiatives to tackle problem substance use
Gain a greater understanding of the factors which contribute to Irish people, particularly young people, misusing drugs	Provide appropriate research to fulfil the information needs of Government in formulating policies to address problem substance use
Eliminate all major research gaps in drug research by end 2003	EMCDDA indicators developed on the extent and nature of problem drug use in Ireland
Publish an annual report on the nature and extent of the drug problem in Ireland and on progress being made in achieving the objectives set out in the Strategy	Comprehensive and timely reporting systems in place for: treatment, rehabilitation; and on the progression of offenders (with drug-related offences) through the criminal justice system
	Completion of identified research programme each year by the NACD

The NDS 2001–2008 was based on a low level of information and the information that existed was not collated in a single place or easy to access. The NDS 2001–2008 intended to eliminate all research gaps and funded an extensive programme of research about the drug situation and the responses to it. The NACD was established to co-ordinate the programme of research and advise the Government on its findings. The information available on the drug situation has increased dramatically since 2001; for example, the NACD published 70 research reports between 2001 and 2008 while the HRB published 35 reports during the same period. All research publications are located in a single web-based library known as the National Documentation Centre on Drug Use (NDC).

At the time the NDS 2001–2008 was developed, it was not widely understood by those working in the drugs area that the EMCDDA required all countries to complete a national report on the current drug situation and responses to it each year. Since 2004, the national reports to the EMCDDA have been made available on the NDC website and these annual reports are used by policy makers to keep abreast of progress. The challenge now is to sustain this level of knowledge and to identify the most efficient ways of updating our knowledge. With this in mind, the title of the research pillar has been changed to the research and information pillar.

In the new strategy NDS 2009–2016, the emphasis, and investment, will be on the development of a single information system that will consist of existing data sources (such as the CTL, NDTRS, NDRDI, and HPSC) and these information sources will be linked using a unique identifier. This will enable us to document the exact number of known problem drug users, and trace their treatment and rehabilitation pathways and outcomes. Consent and data protection procedures would be put in place to protect individuals' identities.

The EMCDDA indicators will guide the continuous and periodic data collection process. Examples of continuous data collection processes are the CTL, HPSC drug-related infectious diseases, NDTRS, NDRDI and PULSE. Examples of periodic data collection processes are the survey measuring the prevalence of problem drug use among the general population and the estimation of the numbers of problem drug users. The annual programme of research will include projects that could not be achieved through routine data collection mechanisms, for example exploring new issues, testing new interventions or measuring long-term impact. The development of an annual rather than an eight-year research programme will allow for sudden changes in the situation and prioritising of projects in line with available resources.

The seven research-related actions in the NDS 2001–2008 were substantially completed. In the NDS 2009–2016 four priorities have been identified, which closely link to the KPIs (Table 1.3.3). These priorities have been translated into eight associated actions, which identify the agency with lead responsibility for implementation together with all other contributing agencies.

Table 1.3.3 Research and information priorities, NDS 2009–2016

-
1. Continue to develop indicators and reporting systems on the extent and nature of problem substance use in Ireland (seeking to remove barriers to the development of these reporting systems and indicators)
 2. Develop a prioritised research programme, to be reviewed annually
 3. Continue the Drug Prevalence and the ESPAD surveys
 4. Develop a research management framework and disseminate research findings and models of best practice.
-

The critical success factors for Ireland in delivering on the new strategic objectives are to ensure that capacity to complete drug-related research is developed further, that there is no duplication of research projects or information systems, and that projects and interventions are planned using the best practice available within Ireland or in other countries.

Inclusion of alcohol in new substance misuse strategy

Announcing the decision to develop a 'substance misuse' strategy, including both illicit drugs and alcohol, Minister of State with responsibility for the Drugs Strategy, John Curran TD, said: 'A combined strategy will facilitate a more coherent approach to the issues and consequences of alcohol and illicit drug use including addictive behaviours. We cannot continue to look at these problems in isolation.' (Curran 2009) A new steering group will be established in autumn 2009 to develop proposals for a strategy that will incorporate the already-agreed drugs policy element. Membership of the new steering group will reflect the appropriate statutory, community/voluntary and other relevant interests. The group will be jointly chaired by officials from the Department of Health and Children and the Office of the Minister for Drugs and will be asked to report by the end of 2010.

The interim drugs strategy contains a number of proposals relating to alcohol. These are summarised below.

Supply reduction

During the public consultation process, the issue of underage drinking was consistently raised, both as a problem in its own right and as a gateway to the use of illicit drugs. However, owing to the fundamental legal difference involved in their supply, the focus in the interim drugs strategy is on illicit drugs rather than on alcohol, with the exception of underage drinking.

Prevention

Alcohol is referenced under this pillar with regard to developing a prevention strategy to tackle substance misuse, particularly in relation to under-18-year-olds. One of the key themes to emerge from the consultation process was the perception that drug and alcohol use are becoming more widespread and that the age profile of those involved is getting younger. Measures to prevent and/or delay drug and alcohol use – especially among young people – are, therefore, particularly important and urgent.

Treatment and rehabilitation

The Steering Group endorsed the view of the Working Group on Alcohol and Drug Synergies that greater coherence and co-ordination of alcohol and drug issues at policy, planning and operational levels are needed. With respect to treatment and rehabilitation, the Steering Group saw the re-orientation of all addiction services towards dealing with problem substance use as a key feature of the new strategy.

The Steering Group acknowledged that it was not possible to quantify the number of problem alcohol users requiring treatment. However, the significant difference between the number of alcohol-related hospital discharges and the number of reported cases receiving treatment for alcohol addiction indicated that there was a considerable cohort of problem alcohol users who could benefit from engagement with addiction treatment services.

Research and information

The Steering Group recommended the development of a research management framework in relation to problem substance use in Ireland. In relation to alcohol, it specifically recommended:

- the development of appropriate epidemiological indicators of problem alcohol use, and building on existing monitoring systems and prevalence surveys;
- measuring the impact of alcohol and drugs on the Irish health and justice systems; and
- monitoring problem substance use (including alcohol) among those presenting to hospital emergency departments.

Independent reviews of the NDS 2001–2008

In January 2009 the Health Research Board published an overview entitled ***Development of Ireland's drug strategy 2000–2007*** (Pike 2008). The objectives of the overview were to gain insights into how the underpinning strategic management processes and governance arrangements had supported implementation and might have influenced the outcomes, and to explore options for the effective management of these elements. Using Henry Mintzberg's (Mintzberg 2007) (Mintzberg 1994) five 'strategic forms' as the analytical framework, the overview highlighted four underlying tensions.

First, in setting direction, it was apparent that there was an ongoing disconnect between the strategic objective and goals, which expressed an aspiration to reduce the harm to individuals, families and society from illicit drugs, and the operational objectives and key performance indicators, some of which directed effort towards the

prohibition of the illicit drug market and the achievement of a drug-free society. Two activities were proposed to help ensure effective management of this ambiguity – the formulation of a more rigorous system of performance measurement, for example a drug harm index, and more integrated performance through focusing on the measurement and evaluation of outputs and outcomes, rather than inputs and processes.

Second, with regard to the making of strategic choices, the overview identified two broad information types – scientifically derived, or evidence-based, information, and public opinion. These two streams of information reflect the rational and the non-rational aspects of the decision-making process. The overview outlined how considerable effort has gone into building up the evidence base, but little comprehensive, systematic, scientific investigation of the nature of public opinion and the role of the media, has been undertaken. Furthermore, while there have been significant strides in building the evidence base, there have been gaps in the use of overt analytical, modelling or evaluative methods in policy development.

Third, an exploration of the co-ordination of the NDS 2001–2008, and the allocation of responsibilities to individual entities for implementation, had highlighted complex governance issues. The recent OECD review of the Irish public service (Organisation for Economic Co-Operation and Development 2008) suggested ways of overcoming such tensions, for example through adopting networked organisational forms and integrated performance management systems.

Fourth, during the lifetime of the NDS 2001–2008, changes in the external environment had been amenable to control through means such as project planning, the mid-term review of the NDS, and the creation of the Emerging Needs Fund. Other changes, however, usually in the wider public policy environment, had had a more oblique connection to the NDS. It was not clear whether or how the intention behind initiatives, such as shifts in social inclusion policy or the introduction of drug testing in various contexts, had been compared with, or assessed against, the intentions behind the NDS. The overview canvassed steps to develop a system of strategic control that would encompass both emerging and intended strategies.

In conclusion, it was argued that it was essential to recognise that no amount of strategic planning and strategic control can eliminate uncertainty entirely. In order to realise a strategy as intended, the strategic manager needs to see strategy development as a continuous process, based on ‘real-time learning-formation’ rather than on ‘prior formulation’. To capture and work with this tendency to complexity and instability, it was deemed important that the strategic manager (1) recognise the tensions and conflicts inherent in strategy and work with these, rather than seek to reduce the instability by focusing on what is amenable to control, and (2) foster and encourage continuous and inclusive debate and deliberation on the direction and contents of strategy as a means of discovering new options and resolving critical strategic tensions.

In March 2009 the Comptroller and Auditor-General published a report ***Drug addiction treatment and rehabilitation*** (Comptroller and Auditor General and Department of Community Rural and Gaeltacht Affairs 2009). The objective of the study was to review the value-for-money (VFM) of drug treatment and rehabilitation services. It looked at all the main publicly-funded treatment and rehabilitation services provided for persons with addiction to illicit drugs. The findings are discussed later in this report (see section 5.3.1).

With regard to monitoring of and reporting on the NDS 2001–2009, the report found that focus had been on the extent to which various actions outlined in the strategy had been implemented, rather than on the extent to which planned outputs and outcomes had been delivered. It acknowledged that the National Advisory Committee on Drugs (NACD) had undertaken research into aspects of drug misuse such as homelessness

or family support. However, while this type of study provided benchmarks and context measures for performance monitoring and reporting, the authors argued that it did not represent a substitute for routine reporting on achievement of outputs and outcomes. The authors made several recommendations with regard to monitoring and evaluation:

Service levels established: all treatment and rehabilitation projects should be governed by service level agreements that specify the services to be provided and the standards to be met.

Outcomes monitored: while a focus on implementing actions is necessary, it needs to be supplemented with programme achievement information so that the effect of those actions can be gauged.

Costs monitored: there is a need for greater transparency on the cost of treatment and rehabilitation services. Performance in terms of both targets achievement, and budgetary outcomes, should be reported regularly.

1.3.2 Other drug policy developments e.g. government declaration, civil society initiatives

In 2007 a life-cycle approach to the framing of social inclusion policy was adopted in Ireland. Illicit drug misuse fitted into the new life cycle approach under the childhood, youth and people of working age stages, and under the additional heading 'Communities' (for full account of change, see Section 1.3.2 of the 2007 National Report (Alcohol and Drug Research Unit 2007). In October 2008 Ireland's Economic and Social Research Institute (ESRI) hosted an international seminar on the life cycle approach to social inclusion. The seminar marked the publication of the ESRI's research into the role that life cycle factors play in shaping patterns of poverty and social exclusion in contemporary Irish society (Whelan and Maître 2008b).

Observing that the life cycle approach had been introduced without any systematic effort to link its use to the broader literature on the concept, or any detailed consideration of how it should be operationalised, the authors explained (Whelan and Maître 2008a) how the life cycle approach to social inclusion marked a shift in perceptions of the nature of risk. Traditionally, social policy interventions had focused on risks associated with unemployment, disability, and insufficient resources in childhood and old age, and had tended to redistribute resources across the life cycle, from working age groups to children and to older people. More recently, social policy interventions within the life cycle approach had begun to focus on risks faced by specific sub-groups at particular stages in their lives, for example risks associated with entering the labour market, remaining in the labour market, or managing care responsibilities.

The authors commented that while the life cycle approach offers a set of lenses through which to focus on the issues, it does not offer a ready-made set of prescriptions: a 'general analytic framework that accounts for the dynamics and the links between events and the appropriate analytic tools' is needed. To fully understand the nature of the dynamic inter-related risks require the mapping of social exclusion patterns across the life cycle, and an understanding of the manner in which they combine with other socio-economic characteristics. To this end, the authors called for longitudinal studies, which would support research into the consequences of various policies and interventions for life cycle outcomes, and would play a critical role in translating the life cycle perspective into specific forms of policy evaluation and prescription.

1.3.3 Co-ordination

Compared to the co-ordination arrangements in place for the NDS 2001–2008, those to support the implementation of the NDS 2009–2016 are greatly simplified and streamlined (see Figure 1.3.2). A new Office of the Minister for Drugs (OMD) will

incorporate the work and functions of both the Drugs Strategy Unit (DSU) in DCRGA and the National Drugs Strategy Team (NDST) and will report directly to the Cabinet Committee on Social Inclusion, Children and Integration (CCSICI). The direct reporting line to the CCSICI and use of a 'networked organisational' structure in the OMD will preclude the need for an Interdepartmental Group on Drugs (IDG), which will be reconstituted as an Oversight Forum on Drugs (OFD).

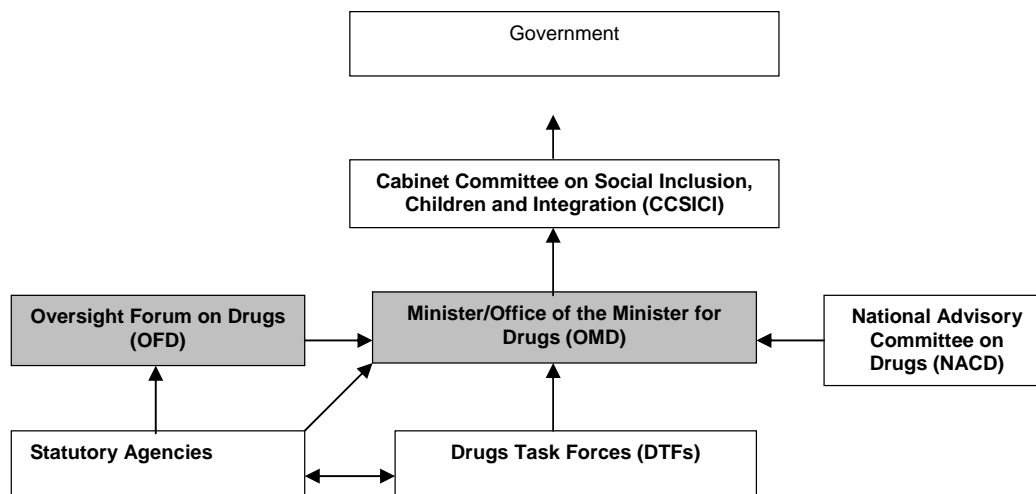


Figure 1.3.2 Co-ordination arrangements for the NDS 2009–2016 (after (Department of Community Rural and Gaeltacht Affairs 2009): Table 6.14)

Assessing progress under the NDS 2001–2008, the Steering Group that drafted the new NDS found that 20 out of 22 actions to support co-ordination had been implemented, the key performance indicators relating to co-ordination reached, and the co-ordination arrangements had 'stimulated and promoted inter-agency working in a difficult cross-cutting policy and service area' (para. 6.7). However, the Steering Group also found that there were 'capacity and structural limitations', which were limiting ability to meet the new challenges including:

- accounting for expenditure;
- governance;
- mainstreaming;
- capacity of services to meet client needs; and
- monitoring/evaluation.

The need was identified to establish a structure which would:

- support and drive the ongoing implementation of the NDS, while respecting the various lead roles and statutory responsibilities of the departments/agencies involved;
- provide a more cohesive and integrated framework that promotes closer co-operation and accountability between the different players, as well as greater transparency for expenditure; and
- provide a clear hierarchy and a greater transparency of the roles from the Government and Cabinet Committee on Social Inclusion, Children and Integration to the local project level.

Table 1.3.4 Key design features of the new Office of the Minister for Drugs (OMD)

Responsibilities	Operating Principles	Resourcing
<ul style="list-style-type: none"> ◦ national co-ordination ◦ policy development ◦ supporting the work of the NACD ◦ supporting the community and voluntary sectors 	<ul style="list-style-type: none"> ◦ local responses to local need based on local planning and decision making ◦ community representation and involvement 	<p>The OMD will be staffed by the current staff of the DSU and the NDST. Some 12 officers at Assistant Principal level from the various government departments and state agencies with</p>

Responsibilities	Operating Principles	Resourcing
<ul style="list-style-type: none"> ◦ co-ordinating Irelands input to the EU, UN and other international for a regarding the rug issues 	<ul style="list-style-type: none"> ◦ partnership between community, voluntary and statutory sectors ◦ direct linkages between local and national structures ◦ direct linkages between local and national policy 	<p>responsibilities under the NDS will also be assigned on a half time basis for a minimum of three years. These staff will work with the OMD, and protocols to reflect their ongoing roles will be drawn up. These staff will also continue to work within their parent Departments and agencies to seek to positively influence policy, programme activity and resource allocation in regard to drug issues.</p>

The design of the OMD (Table 1.3.4) resembles the networking model promoted in a recent OECD review of the Irish public sector (Organisation for Economic Co-Operation and Development 2008). The OECD review described the Office of the Minister for Children and Youth Affairs (OMCYA), established in 2005, where staff from different government departments (including Health, Education and Justice) had been brought together in one location (the Department of Health and Children) to work in a networked way on issues of strategic national importance with regard to children. The review's observations on the OMCYA may be applied equally to the new OMD:

Policies that cut across the function responsibility of a number of departments can lead to difficulties in determining who is the overarching 'owner' accountable for the service provided. The work to date by the OMC has demonstrated that there is value in ensuring that units, such as the Irish Youth Justice Services, remain connected to their parent department (Department of Justice, Equality and Law Reform). This ensures that they have ongoing interaction with, and input to the development of policies targeted at children while also ensuring that accountability for the services they deliver remains within the remit of their Minister. This guarantees that historical mismatches between children's policy and youth justice policy can be addressed. (pp. 241–242)

To support integration, the Steering Group recommended an Oversight Forum on Drugs (OFD) to replace the Interdepartmental Group on Drugs (IDG). Comprising the same membership, its primary role will be the high-level monitoring of progress being achieved across the strategy and agreeing appropriate ways forward where issues are blocked or progress is being impeded. It will also provide a forum for discussion and feedback on issues relating to problem drug use that arise in EU and international arenas. The Steering Group proposed two additional mechanisms to support the new integrative role of the OMD: (1) an Advisory Group of the OMD, comprising representatives of the statutory, voluntary and community sectors, to advise the Minister on operational and policy matters relating to the NDS; and (2) twice-yearly bilateral meetings between the Minister for Drugs and the Director of the OMD, on the one hand and key stakeholders on the other hand. The Steering Group believed these meetings would help to keep a focus on drug-related issues and the broader implementation of the NDS.

The National Advisory Committee on Drugs (NACD) is to be co-located with the OMD and the Director of the NACD is to become a member of the senior management team in the OMD. While acknowledging the need for the NACD to be 'independent' in regard to research, the Steering Group stated that the closer alignment with the OMD will 'better address the issue of linkages between policy development and research'. Local and regional drugs task forces (DTFs) will now report to the OMD for all activities, outputs and expenditures. Priorities for the new OMD with regard to the DTFs will include:

- considering reporting and accountability arrangements for DTF projects with a view to simplifying the system;

- examining the feasibility of achieving the optimum structure for the employment arrangements of DTF personnel;
- reviewing and renewing the commitment and participation of all members of DTFs, including the position of chairperson; and
- updating the handbook for the operation of DTFs to take account of the new structural arrangements and include guidelines on mainstreaming.

The NDS notes that the National Drugs Rehabilitation Implementation Committee will also be 'closely linked' to the OMD.

1.4 Economic analysis

1.4.1 Public expenditures

The most recent information available on public expenditure on drugs in Ireland is for the year ended 31 December 2008 (Table 1.4.1). It relates to labelled, that is directly drug-related, public expenditure. It represents a 13 % increase over 2007 labelled public expenditure, which, in turn, represents an 8 % increase over 2006 spending.

Table 1.4.1 Public funding directly attributable to drugs programmes, 2006–2008

Department/Agency	Allocation 2006 (€million)*	Allocation 2007 (€million)**	Allocation 2008 (€million)***
Dept of Community, Rural and Gaeltacht Affairs	43.000	51.518	65.207
Department of Health and Children	0.978	0.984	1.033
Health Service Executive	85.053	83.177	101.867
FÁS (National Training Agency)	18.600	18.700	18.800
Department of Education and Science	12.140	12.270	12.386
Dept of Environment, Heritage and Local Govt	0.461	0.481	0.496
Dept of Justice, Equality and Law Reform	9.530	12.890	8.790
Irish Probation Service	n.a.	n.a.	2.897
Irish Prison Service	5.000 est.	5.000 est.	5.000
Garda Síochána	33.400	38.800	38.800
Revenue's Customs Service	6.525	8.581	9.000
Department of Foreign Affairs****	1.140	1.400	n.a.
Total	214.687	232.401	264.276

n.a. = not available

* Source: (Alcohol and Drug Research Unit 2007) This total excludes expenditure by the Department of Foreign Affairs.

** Source: (Curran 2008, 3 December)⁵ This total excludes expenditure by the Department of Foreign Affairs.

*** Source: *National Drugs Strategy 2009–2016*: Table 6.3 (Department of Community Rural and Gaeltacht Affairs 2009). This total excludes expenditure by the Department of Foreign Affairs.

**** Source: (Martin 2009, 26 May)⁶

Preliminary estimates for 2009 indicated that spending across all departments would be maintained at the 2008 level (Moloney 2009, 5 March). However, on 6 April 2009, in response to the continuing decline of the Irish economy and the need to achieve a 'prudent fiscal outturn' for 2009, the government introduced an emergency budget. This reduced expenditures across all government departments and state agencies. Details of reductions in drug-related spending across government departments and agencies in 2009 are not yet available except in respect of the Drugs Initiative administered by the Department of Community, Rural and Gaeltacht Affairs (DCRGA). DCRGA's drug-related budget dropped from €65.207 million in 2008 to €40.611 million in 2009; this was attributed in part to the transfer of funding for the Young People's Facilities and Services Fund (YPFSF) to the Office of the Minister for Children and Youth Affairs (OMYCA) (Curran 2009, 26 May).

⁵ In presenting the figures, Minister of State with responsibility for the Drugs Strategy, John Curran TD, explained Curran, J. (2008, 3 December) *Parliamentary Debates Dáil Éireann Official Report: Unrevised*. Vol. 669, No. 3, p. 675, PDF version. Available at www.gov.ie/oireachtas/frame.htm '...there are a number of Departments and agencies involved in the implementation of the National Drugs Strategy. However, the level of State funding on drug-related issues can be difficult to estimate as the costs associated with services provided by An Garda Síochána, the Prison Service, the HSE [Health Service Executive] and others deal with drug misuse as part of their wider daily services.'

⁶ This funding represents Ireland's voluntary contribution to support the work of the United Nations Office on Drugs and Crime (UNODC).

The UN's statistical framework COFOG and Peter Reuter's (Reuter 2004) 'effects of interventions' framework, first applied to Ireland's **labelled drug-related public expenditure** for 2005, as reported in the Selected Issue 'Public expenditure on drugs' (Alcohol and Drug Research Unit 2007), has not been applied to the 2006–2008 data. Although it is believed that it would reveal a similar pattern of drug-related public expenditure, the analysis has not been repeated as there were significant gaps in the original data that have not yet been filled. Recent evidence suggests, however, that such gaps can be addressed. Specifically:

Budgeting and financial reporting systems: The Selected Issue on public expenditure on drugs in Ireland in 2005 (Alcohol and Drug Research Unit 2007) commented that many government departments and agencies did not capture and report the necessary data. However, the recent VFM study by the Comptroller and Auditor-General (Comptroller and Auditor General and Department of Community Rural and Gaeltacht Affairs 2009) demonstrated that it is possible to break down drug-related public expenditure by service provider and/or function (Table 1.4.2).

Table 1.4.2 Estimated funding of drug addiction treatment and rehabilitation services, 2007*

Department/Agency	€m	€m
HSE/hospital clinic treatment services		58
Drug Treatment Centre Board services		10
Primary care-based methadone treatment		14
Community and voluntary sector treatment and rehabilitation services		
Section 65 funding — HSE	12	
Mainstreamed drug task force projects — HSE	8	
Interim drug task force projects — DCRGA/HSE/FAS/Probation Service	16	
Probation service grants	3	39
Prison drug treatment and rehabilitation		3
FÁS Community Employment schemes		16
Total expenditure on drug treatment and rehabilitation		140

* Source: (Comptroller and Auditor General and Department of Community Rural and Gaeltacht Affairs 2009): Table 8.4

Non-governmental functions: The Selected Issue on drug-related public expenditure (Alcohol and Drug Research Unit 2007) noted that, while a large tranche of public money (€33.962 million) was voted for the central government function of 'community development', this same money was then disbursed for expenditure on a range of regional or local programmes or projects that would be more accurately coded as health-related or education-related functions. The need to define the nature of these disbursements was noted. The Comptroller and Auditor General's report again revealed that it is possible to obtain this type of detail. Thus, with regard to interim-funded LDTF projects in 2007 administered by DCRGA (€27.2 million), €15.6 million was spent on treatment and rehabilitation, and €1.6 million on education, drug prevention etc. The Comptroller and Auditor General's report did not provide a breakdown of mainstreamed LDTF projects but responses to recent Parliamentary Questions show that individual government departments, which administer the 'mainstreamed' projects, can account for these projects. For example, in 2007 the Department of the Environment, Heritage and Local Government funded five mainstreamed LDTF projects worth €0.481 million (Finneran 2009, 26 May), while the Department of Education and Science funded 38 projects worth €3.621 million (O'Keeffe, B. 2009, 26 May).

In addition to labelled expenditure, there is an unquantified level of **unlabelled expenditure on the illicit drugs issue** in Ireland, that is through programmes not specifically targeted at the illicit drugs issue. The Selected Issue on public expenditure on drugs in 2005 (Alcohol and Drug Research Unit 2007) did not attempt to estimate non-labelled drug-related public expenditure. However, responses to a recent series of Parliamentary Questions seeking information on departmental expenditure on tackling problematic alcohol and illicit drug use in the past three years yielded information on non-labelled drug-related public expenditure over and above the health and criminal justice systems. Again, this data demonstrates that the capacity exists to identify unlabelled expenditure.

- Department of Arts, Sport and Tourism (DAST): Various funding schemes and programmes in the sports and arts sectors are believed to assist in tackling the illicit drugs problem by encouraging healthy lifestyles through sport and recreation and promoting personal and social development. For example, the Code of Ethics and Good Practice for Children's Sport, which has been disseminated to sports clubs and in respect of which the Irish Sports Council has organised training courses, discourages the use of drugs, alcohol and tobacco. However, it is not deemed practicable to estimate the portion of the funding which achieves positive substance misuse outcomes (Cullen, M. 2009, 26 May).
- Department of Education and Science (DES): Its substance misuse prevention education contributes to the overall aim of Government policy in relation to drugs. At primary level, the Substance Misuse Prevention Programme (SMPP or 'Walk Tall' Programme) is a national programme, which provides in-service to teachers in primary schools in the area of legal and illegal substances. The programme teaching and resource materials focus on both alcohol and drugs in an age appropriate manner. The programme has an integrated approach to drug education and is a key strategy in drug abuse prevention education. Teaching and resource materials developed by the 'Walk Tall' Programme are made available to all primary and special schools nationally. In 2007, it had a budget of €420,557. In addition, substance misuse prevention education is implemented as part of SPHE in all primary and post-primary schools and is a mandatory part of the curriculum at primary and junior cycle in second level. The overall cost of SPHE in 2007 was €202,000. It received matching funding from the Health Service Executive/Department of Health and Children (O'Keeffe, B. 2009, 26 May).
- Department of Foreign Affairs (DFA): Under the Emigrant Support Service, the government has over the past three years allocated funding totalling over €41 million to support Irish communities overseas, including €15.183 million in 2008. The focus of this funding is on supporting voluntary sector organisations engaged in the delivery of key frontline welfare services to Irish communities abroad. These services target the most vulnerable including the elderly, the homeless and those suffering addiction. The Minister commented: 'Many of our most vulnerable emigrants experience a range of interlinked challenges, requiring the Government funded organisations to provide broad outreach services, which can include responses to alcohol or drug abuse. It is not possible, however, to provide specific figures on this programme's annual spend on alcohol and illegal drug use.' (Martin 2009, 26 May)
- Department of Social and Family Affairs (DSFA): The Family and Community Services Resource Centre Programme operated by the Family Support Agency, which is under the auspices of the DSFA, supports over 100 Family Resource Centres (FRCs) nationwide. The 2009 budget for this budget is over €18 million. While the FRCs do not have a specific remit to tackle problematic alcohol or drug use, providing support to families experiencing such problems is one of the services provided (Hanafin 2009, 26 May).

The Steering Group that drafted the NDS 2009–2016 called for a **planning and reporting system**, incorporating both statutory and community and voluntary bodies, that will, when implemented, go a long way towards providing the desired detail on Ireland's public expenditure on drugs (para. 6.61):

- an overall performance management framework to be developed by the OMD, in consultation with relevant Departments and agencies, to assess and monitor progress across the NDS;
- a mechanism to be put in place whereby relevant departments and agencies outline their proposed budgets for drug-related initiatives to the Minister of State, in the context of the annual Estimates process;
- departments and agencies to report to the OMD on their expenditure, outputs and outcomes twice a year, in an agreed format;
- departments and agencies to incorporate their envisaged contribution to the work of the National Drugs Strategy in their Statements of Strategy and Business Plans and to report on the associated outputs and outcomes in their annual reports;

- DTFs to report to the OMD for expenditure and activity relating to their projects twice a year, and to produce an annual statement, in an agreed format, giving an assessment of the work and outputs of their projects – and their broader strategic and co-ordinating work – in the previous 12 months;
- the OMD to establish on-going liaison with DTF projects in regard to their overall work and activities, as well as their channels of funding; and
- the OMD to produce an annual report of progress of the services and structures under its direct influence, and a report of the progress of the overall strategy every two years.

1.4.2 Budget

The structure of funding arrangements to address the issue of illicit drugs remains the same as in previous years and the proportionate levels of allocation are also similar. However, there have been several small adjustments that reflect strategic shifts in the approach to tackling the drugs issue, specifically among young people and in the way that families are supported.

On 1 January 2009 the **Young People's Facilities and Services Fund (YPFSF)** was transferred from DCRGA, where it was administered by the Drugs Strategy Unit, to the OMCYA. The object of the transfer is to assist in ensuring the most strategic use of this fund and other youth programmes under the remit of the OMCYA and to provide a cohesive and comprehensive response to the needs of all young people, including those at risk of drug misuse. The direction, purpose, objectives etc of the fund and the administration arrangements remain the same.

At national level, a National Assessment Committee (NAC), currently chaired by the Office of the Minister for Children and Youth Affairs, monitors the fund in line with the criteria that would apply in relation to approving applications for funding at the level of local plans and projects. The current composition of the NAC includes representatives of the departments of Community, Rural and Gaeltacht Affairs, of Justice, Equality and Law Reform, and of Environment, Heritage and Local Government; community and voluntary representatives; and a representative from Dublin City Council and from City of Dublin Youth Services Board (CDYSB).

In recent years **the role of families** in tackling the drugs problem has become increasingly recognised and funding has followed. The mid-term review of the NDS 2001–2008 (Steering Group for the Mid-Term Review of the National Drugs Strategy 2005) called for the development of family support services and support for family support networks in the areas of information provision and assistance to local family support groups. Budget provisions have been made as follows:

- In 2007 the Family Support Network (FSN), established in 2000 under the auspices of Citywide Drugs Crisis Campaign, gained recognition as an autonomous national organisation. Its aim is to improve the situation of families coping with drug use by developing, supporting and reinforcing the work of family support groups and regional family support networks, by working for positive change in policy and practice and by raising public awareness about the problem of drugs for families and communities. It is funded through the Drugs Strategy Unit of the DCRGA and the Family Support Agency of the Department of Social and Family Affairs.
- As noted above (Section 1.4.1), over 100 Family Resource Centres (FRCs) throughout the country, also funded by the Family Support Agency (€18 million in 2009), while not having a specific remit to tackle problematic alcohol or drug use, provide support to families experiencing such problems (Hanafin 2009, 26 May).
- In late April 2009, following the emergency budget in early April, the government announced the allocation of €1.56 million through the Dormant Accounts Fund for substance misuse projects, specifically to support 80 projects intended to expand the provision of family support services (Ó Cuív 2009).

1.4.3 Social costs

No studies of the social cost of drug use have been undertaken in Ireland. However, in the past decade or so, there have been significant advances in the collection of data relating to the drug problem in Ireland, which would yield data relevant to such a study. Several one-off studies have also been undertaken, which, in the absence of system-level data, would help in the estimation of economic values.

Data collection relevant to the social and economic costs of the use of illicit drugs in Ireland is most developed in the health sector, with data available on both directly drug-related treatment and also on comorbidity and trauma associated with drug misuse. In recent years initiatives have been taken to collect data on premature mortality and morbidity attributable to drug misuse and these data are relevant to estimating the economic impacts of illicit drug use on employment and productivity. In relation to drug-related crime, in 2006 the Central Statistics Office assumed responsibility for the compilation of statistics on law enforcement and criminal justice, including drug-related offences. However, gaps still exist in these areas.

2. Drug Use in the General Population and Specific Targeted Groups

2.1 Introduction

Drug prevalence surveys of the general and school-child population are important sources of information on the patterns of drug use, both demographically and geographically and, when repeated, can track changes over time. In Ireland such surveys are conducted every three to four years. These surveys 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. The four main data collection tools are listed below.

An **All Ireland Drug Prevalence Survey** was initiated in 2002 by the National Advisory Committee on Drugs (NACD) in Ireland and the Public Health Information and Research Branch (PHIRB), formerly known as the Drug and Alcohol Information and Research Unit (DAIRU), within the Department of Health, Social Services and Public Safety (DHSSPS) in Northern Ireland. The main focus of the survey is to obtain prevalence rates for key illegal drugs, such as cannabis, ecstasy, cocaine and heroin, on a lifetime (ever used), last year (recent use), and last month (current use) basis. Similar prevalence questions are also asked of alcohol, tobacco, and other drugs such as sedatives, tranquillisers and anti-depressants. Attitudinal and demographic information is also sought from respondents.

The questionnaire and methodology for this drug prevalence survey are based on best-practice guidelines drawn up by the EMCDDA. The questionnaires are administered through face-to-face interviews with respondents aged between 15 and 64 normally resident in households in Ireland and Northern Ireland. Thus persons outside these age ranges, or who do not normally reside in private households, have not been included in the survey. This approach is commonly used throughout the EU and because of the exclusion of those living in institutions (for example, prisons, hostels) this type of prevalence survey is usually known as a general population survey.

The first iteration of this general population drug prevalence survey was undertaken in 2002/3, and a second iteration in 2006/7. A series of bulletins reporting the findings of the 2002/3 iteration have been published, and a second series of bulletins reporting the findings of the 2006/7 iteration have also been published. As with other European surveys, people over the age of 64 are excluded from this survey, as they grew up in an era when both the use and availability of illegal drugs were very limited. Therefore surveys with older people have, to date, shown very low rates of use even on a lifetime basis. This situation will change over time as the younger population grows older. Hence lifetime prevalence rates are likely to increase for a considerable period of time. When examining the data and comparing results over time, last-year use is the best reflection of changes as it refers to recent use. Last-month use is equally valuable as it refers to current use.

This chapter presents a summary of the survey findings estimating the prevalence of drug use among the general population in 2006/7 and compares these findings with those of the 2002/3 survey. One in four people in Ireland used an illicit drug at some point in their life in 2006/7 and one in five used cannabis. Cocaine use increased in 2006/7 compared to 2002/3. The proportion of adults who reported using cocaine (including crack) at some point in their lives increased from 3% in 2002/3 to 5% in 2006/7.

The **Survey of Lifestyles, Attitudes and Nutrition (SLÁN)** is a national survey of the lifestyles, attitudes and nutrition of people living in Ireland. To date surveys have been carried out in 1998, 2002 and 2007. Adults aged 18 years and older living in private households have been included. SLÁN 1998 and SLÁN 2002 were postal surveys, based on samples from the Electoral Register, involving 6,539 respondents in 1998

(62% response rate) and 5,992 in 2002 (53% response rate). SLÁN 2007 involved 10,364 respondents in face-to-face interviews at home addresses, based on samples from the GeoDirectory (62% response rate). All three SLÁN surveys have covered themes of health and social status, and related health service use. In April 2008 the Department of Health and Children published the report on SLÁN 2007. In general, these data are not comparable with the result of the 2006/7 general population drug prevalence survey as the SLÁN survey excludes those aged between 15 and 17 years and includes those aged over 65 years.

The **Health Behaviour in School-aged Children (HBSC)** is a cross-national research study conducted in collaboration with the WHO Regional Office for Europe. The study aims to gain insights into, and increase our understanding of, young people's health and well-being, health behaviours and their social context. HBSC was initiated in 1982 and is conducted every 4 years. It is a school-based survey with data collected through self-completion questionnaires administered by teachers in the classroom.

The Health Promotion Research Centre, National University of Ireland, Galway was invited to join the HBSC network in 1994 and conducted the first survey of Irish schoolchildren in 1998; the survey has been repeated in Ireland in 2002 and 2006. HBSC Ireland surveys school-going children aged 10-18 years. To obtain the Irish HBSC participant sample, lists of primary and post primary schools are obtained from the Department of Education and Science, and schools across the country are randomly selected and invited to participate. The HBSC survey instrument is a standard questionnaire developed by the international research network and used by all participating countries. Each survey questionnaire contains a core set of questions looking at background factors, individual and social resources, health behaviours and health outcomes. Questions about smoking, alcohol use and cannabis use are asked under the heading of health behaviours.

The 2006 HBSC survey found that, 16% of children reported using cannabis during their lifetime, compared with 12% in 2002. Cannabis use was highest among those aged 15–17, with about one in five in this age group using cannabis in the previous 12 months.

The **European School Survey Project on Alcohol and Other Drugs (ESPAD)** is a collaborative effort of independent research teams in about 40 European countries. Data has been collected every four years since 1995, using a standardised method and a common questionnaire. The fourth data collection was carried out in 35 countries during the spring of 2007 and the results were published in March 2009. The Swedish Council for Information on Alcohol and Other Drugs (CAN) initiated the project in 1993. Support has been provided by the Pompidou Group at the Council of Europe, the Swedish Ministry of Health and Social Affairs, the Swedish National Institute of Public Health and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The data collections in the individual countries are funded by national sources. The rationale for the survey is that school students are easily accessible and are at an age when onset of substance use is likely to occur. (By definition, early school leavers, a group known to be vulnerable to alcohol and drug use, are not represented.)

The fourth survey was conducted in 35 European countries during 2007 and collected information on alcohol and illicit drug use among 15-16-year-olds; 2,249 students from 94 randomly-selected schools participated, which represents a response rate of 78%. Fewer schools and students participated in 2007 than in 2003.

On 26 March 2009, the findings of the fourth European School Survey Project on Alcohol and Other Drugs (ESPAD) were published. In terms of drug use, the Irish data show a marked decrease in lifetime use of any illicit drug between 2003 (40%) and 2007 (22%). As the majority of those who have tried any illicit drug have used cannabis (marijuana or hashish), the decrease in illicit drug use was influenced by the

considerable decrease in the number of students who had tried cannabis at some point in their lives, from 39% in 2003 to 20% in 2007 (European average 19%).

2.2 Drug use in the general population

2.2.1 Drug use in the general population, 2006/7: repeat survey

On 25 January 2008, the National Advisory Committee on Drugs (NACD) and the Drug and Alcohol Information and Research Unit (DAIRU) in Northern Ireland published jointly the results of the second all-Ireland general population drug prevalence survey (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008a).

The Irish survey followed best practice guidelines recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The questionnaire, based on the 'European Model Questionnaire', was administered in face-to-face interviews with respondents aged between 15 and 64 years normally resident in households in Ireland and Northern Ireland. With the exception of two questions and two show cards, the questionnaire employed for the 2006/7 survey was the same as that used in 2002/3. Fieldwork was carried out by MORI MRC during late 2006 and early 2007. The final achieved sample was 4,967 in Ireland. This represented a response rate of 65%. The sample was weighted by gender, age and region to ensure that it was representative of the general population. The main measures of use were lifetime (ever used), use in the last year (recent use) and use in the last month (current use). The detailed methodological background to the general population survey on drug use and the results are presented in Standard Table 1.

The proportion of adults (aged 15–64 years) who reported using an illegal drug in their lifetime increased by five percentage points, from 19% in 2002/3 to 24% in 2006/7 (Table 2.2.1). The proportion of young adults (aged 15–34 years) who reported using an illegal drug in their lifetime also increased by five percentage points, from 26% in 2002/3 to 31% in 2006/7. As expected, more men reported using an illegal drug in their lifetime than women.

The proportion of adults who reported using an illegal drug in the last year increased marginally, from 6% in 2002/3 to 7% in 2006/7 (Table 2.2.1). The proportion of young adults who reported using an illegal drug in the last year increased from 10% in 2002/3 to 12% in 2006/7. The proportion of adults who reported using an illegal drug in the last month remained stable. The findings with regard to cocaine and cannabis are discussed in sections 2.2.3 and 2.2.4 below.

Table 2.2.1 Lifetime, last-year and last-month prevalence of illegal drug use in Ireland, 2002/3 and 2006/7

Illegal drug use*	Adults		Males		Females		Young adults	
	15–64 years		15–64 years		15–64 years		15–34 years	
	%		%		%		%	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
Lifetime	18.5	24.0	24.0	29.4	13.1	18.5	26.0	31.4
Last year	5.6	7.2	7.8	9.6	3.4	4.7	9.7	12.1
Last month	3.0	2.9	4.1	4.3	1.7	1.4	5.2	4.8

* Illegal drugs in this context are 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 2005c) (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008a)

Nine per cent of young adults claimed to have tried ecstasy at least once in their lifetime in 2006/7 (Table 2.2.2).

Table 2.2.2 Lifetime, last-year and last-month prevalence of ecstasy use in Ireland, 2002/3 and 2006/7

Ecstasy use	Adults		Males		Females		Young adults	
	15–64 years		15–64 years		15–64 years		15–34 years	
	%		%		%		%	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
Lifetime	3.7	5.4	4.9	7.2	2.6	3.6	7.1	9.0
Last year	1.1	1.2	1.7	1.8	0.5	0.6	2.0	2.4
Last month	0.3	0.3	0.7	0.5	0.0	0.2	0.6	0.6

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005c) (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008a)

The considerable increase in the proportions using any illegal drug at some point in their lives was influenced by the facts that drug use in Ireland is a recent phenomenon and that the population of lifetime and recent drug users in Ireland is relatively young. Drug use is measured among adults aged 15–64, and those leaving this age group over the next fifteen to twenty years are less likely to have been exposed to drug use than those entering the measurement cohort.

When compared to the 19 other countries that completed a general population survey on drug use using the European model questionnaire, Ireland ranks seventh highest for lifetime use of cannabis, fourth for lifetime use of amphetamines, fourth for use of cocaine, third for ecstasy and third for LSD.

2.2.2 Drug use among the general population in regional drugs task force areas

On 25 June 2008, the NACD published (National Advisory Committee on Drugs 2008) a bulletin outlining drug prevalence data for 2006/7 by Regional Drug Task Force (RDTF) area. As expected, the use of illegal drugs was lowest in the north-west and highest in the east of the country (Table 2.2.3).

With regard to lifetime use, the following findings are notable:

- Cannabis was the most commonly reported illegal drug in each of the RDTF areas, with proportions ranging between 13% in the North West and 36% in the East Coast areas (Table 2.2.4).
- Ecstasy was among the four most commonly reported drugs in each of the RDTF areas, with proportions ranging between 2% in the North West and 11% in North Dublin (Table 2.2.5).
- Cocaine was among the top four drugs ever used by the survey respondents in all areas except the North West (Table 2.2.6). Lifetime cocaine use was highest in the North Dublin and East Coast areas. Though the proportions were small, there was a significant increase in lifetime use of cocaine in five RDTF areas in 2006/7 when compared to 2002/3 (Table 2.2.6).
- Poppers were among the four most commonly used drugs in the North West while amphetamines were among the four most commonly used drugs in the South East.

Table 2.2.3 Proportion of respondents who reported lifetime, last-year and last-month use of illegal drugs, by regional drugs task force area of residence

RDTF area of residence	Percentage that used any illegal drugs*					
	Ever in lifetime		In year prior to survey		In month prior to survey	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
East Coast	25.9	38.4 [†]	6.3	12.4 [†]	4.1	5.3
North Dublin City & County	29.5	32.2	8.4	12.8	5.3	8.2
South West (Dublin)	24.0	25.6	7.5	7.4	4.3	2.0
South East	18.5	25.4	6.9	7.9	3.1	3.6
North Eastern	18.9	22.9	6.4	5.7	2.4	1.1
Midland	11.0	19.6 [†]	2.8	4.4	1.0	1.7
Mid West	12.0	18.0	3.2	5.8	1.6	1.4
Southern	12.1	16.3	4.7	4.9	2.1	2.0
Western	12.5	23.3 [†]	2.9	4.7	1.9	1.6
North West	10.6	14.5	2.6	2.9	0.2	0.3

*Illegal drugs in this context are amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

[†]Significant changes in proportion for the two survey periods

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005a) (National Advisory Committee on Drugs 2008)

Table 2.2.4 Proportion of respondents who reported lifetime, last-year and last-month use of cannabis, by regional drugs task force area of residence

RDTF area of residence	Percentage that used cannabis					
	Ever in lifetime		In year prior to survey		In month prior to survey	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
East Coast	24.5	35.9 [†]	6.1	11.3 [†]	3.8	4.2
North Dublin City & County	26.9	28.8	7.7	11.9	4.5	7.9
South West (Dublin)	23.2	24.0	7.3	6.7	3.9	1.8
South East	16.8	23.3	5.8	5.1	2.1	2.8
North Eastern	17.8	19.5	5.2	4.6	1.9	0.8
Midland	10.7	17.0	2.8	4.1	1.1	1.1
Mid West	10.9	17.0	3.0	4.7	1.6	1.4
Southern	11.6	15.0	4.4	4.6	2.1	2.0
Western	12.0	21.0 [†]	2.0	4.3	1.3	1.6
North West	9.3	12.8	2.2	2.9	0.2	0.3

[†]Significant changes in proportion for the two survey periods

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (Bulletins 2, 2005 & 2008) (National Advisory Committee on Drugs 2008)

Table 2.2.5 Proportion of respondents who reported lifetime, last-year and last-month use of ecstasy, by regional drugs task force area of residence

RDTF area of residence	Percentage that used ecstasy					
	Ever in lifetime		In year prior to survey		In month prior to survey	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
East Coast	5.4	7.6	2.5	2.3	0.9	0.5
North Dublin City & County	6.5	11.2	1.6	2.9	0.3	1.0
South West (Dublin)	5.9	4.1	1.3	0.5	0.0	0.0
South East	4.3	6.5	1.3	1.9	1.3	0.3
North Eastern	2.6	5.4	0.5	0.9	0.0	0.0
Midland	2.0	5.8 [†]	0.9	0.9	0.0	0.3
Mid West	1.7	2.9	0.6	0.8	0.0	0.3
Southern	2.8	3.5	0.9	0.6	0.2	0.2
Western	1.8	4.4	0.3	0.9	0.3	0.3
North West	0.3	2.2 [†]	0.0	0.3	0.0	0.3

[†]Significant changes in proportion for the two survey periods

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005a) (National Advisory Committee on Drugs 2008)

Table 2.2.6 Proportion of respondents who reported lifetime, last-year and last-month use of cocaine, by regional drugs task force area of residence

RDTF area of residence	Percentage that used cocaine*					
	Ever in lifetime		In year prior to survey		In month prior to survey	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
East Coast	6.3	9.1	2.3	3.1	0.5	0.8
North Dublin City & County	5.2	11.0 [†]	1.7	3.3	0.8	1.4
South West (Dublin)	5.0	3.8	1.5	0.8	0.6	0.3
South East	2.5	6.7 [†]	1.7	2.4	0.0	0.9 [†]
North Eastern	1.2	5.6 [†]	0.0	1.5	0.0	0.0
Midland	1.3	4.4 [†]	0.3	1.7	0.3	0.9
Mid West	1.1	2.9	0.6	1.0	0.0	0.0
Southern	1.9	3.1	0.7	1.1	0.4	0.2
Western	1.6	3.5	0.7	1.5	0.4	0.4
North West	0.0	1.6 [†]	0.0	0.3	0.0	0.3

*Cocaine in this context is cocaine powder and crack.

[†]Significant changes in proportion for the two survey periods

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005a) (National Advisory Committee on Drugs 2008)

2.2.3 Cannabis use in Ireland

The third bulletin of results from the 2006/7 all-Ireland general population drug prevalence survey focused on cannabis use in the adult population (15–64 years) and patterns of cannabis use (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008c).

Cannabis use increased over the four years since the previous survey in 2002/3 (Table 2.2.7). The proportion of adults who reported using cannabis at some point in their life (ever used) increased from 17% in 2002/3 to 22% in 2006/7. The proportion of young adults who reported using cannabis in their lifetime also increased, from 24% in 2002/3 to 29% in 2006/7.

The proportion of adults who reported using cannabis in the last year (recent use) increased from 5% in 2002/3 to 6% in 2006/7. The proportion of young adults who reported using cannabis in the last year increased from 9% in 2002/3 to 10% in 2006/7.

The proportion of adults who reported using cannabis in the last month (current use) remained stable at 3%.

Table 2.2.7 Lifetime, last-year and last-month prevalence of cannabis use in Ireland, 2002/3 and 2006/7

Cannabis use	Adults 15–64 years		Males 15–64 years		Females 15–64 years		Young adults 15–34 years	
	%		%		%		%	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
Lifetime (ever used)	17.4	21.9	22.4	27.0	12.3	16.6	24.0	28.6
Last year (recent use)	5.0	6.3	7.2	8.5	2.9	3.9	8.6	10.4
Last month (current use)	2.6	2.6	3.4	4.0	1.7	1.1	4.3	4.2

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005b) (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008c).

Half of all cannabis users had first used the drug before they were 18 years old. The lifetime prevalence rate was higher for men (27%) than for women (17%).

Over one-quarter (26%) of respondents who had ever taken cannabis reported using (or having used) it regularly. The lag time between first use and regular use was two years. Of those who were or had been regular users, two-thirds (66%) said that they had stopped taking cannabis, 10% said that they had tried to stop but failed and almost one-quarter (24%) had never tried to stop. Of those who had stopped, approximately one-third (32%) said they had done so because they no longer wanted to take the drug, 19% said they had health concerns and 17% said it was no longer part of their social life.

The majority (62%) of recent cannabis users considered it ‘very easy’ or ‘fairly easy’ to obtain the drug within a 24-hour period. Over half (57%) reported obtaining the cannabis they had last used at the house of friends, 12% obtained it in the street/park, 8% in a disco/bar/club and 5% ordered it by phone. The majority (44%) got the cannabis they had last used from a family member or friend, 28% had shared it among friends and 22% had bought it.

The majority (60%) of current cannabis users reported using a form of cannabis resin. Almost two-in-five (38%) reported using a form of herbal cannabis. Approximately 24% used the drug daily in the month prior to the survey, a further 10% used it several times a week, 28% used it at least once a week and 37% used it less than once a week. Men were more frequent users than women. Almost all smoked it, as a joint (93%), in a pipe (4%) or in a bong (3%); less than 1% ate the drug.

2.2.4 Cocaine use in Ireland

The fourth bulletin of results from the 2006/7 all-Ireland general population drug prevalence survey (a follow-on from the first such survey in 2002/3) focused on cocaine use in the adult population (15–64 years) and patterns of cocaine use (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008b).

Cocaine use increased in 2006/7 compared to 2002/3. The proportion of adults who reported using cocaine (including crack) at some point in their lives increased from 3% in 2002/3 to 5% in 2006/7 (Table 2.2.8). The proportion of young adults who reported using cocaine in their lifetime also increased, from 5% in 2002/3 to 8% in 2006/7. As expected, more men reported using cocaine in their lifetime than women, 7% compared to 3.5%.

The proportion of adults who reported using cocaine in the last year (recent use) increased from 1% in 2002/3 to 2% in 2006/7 (Table 2.2.8). The proportion of young adults who reported using cocaine in the last year increased from 2% in 2002/3 to 3% in 2006/7.

The proportion of adults who reported using cocaine in the last month (current use) remained stable at under 1%.

Table 2.2.8 Lifetime, last-year and last-month prevalence of cocaine use (including crack) in Ireland, 2002/3 and 2006/7

Cocaine use	Adults 15–64 years		Males 15–64 years		Females 15–64 years		Young adults 15–34 years	
	%		%		%		%	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
Lifetime	3.0	5.3	4.3	7.0	1.6	3.5	4.7	8.2
Last year	1.1	1.7	1.7	2.3	0.5	1.0	2.0	3.1
Last month	0.3	0.5	0.7	0.8	0.0	0.2	0.7	1.0

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2006) (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008b).

Of the 4,967 survey respondents, 5% had used cocaine powder; crack cocaine use was rarely reported (0.6%). Half of all cocaine powder users commenced cocaine use before they were 22 years old, while half of all crack users commenced use before they were 20 years old.

Of the 25 current cocaine powder users, just over 68% used cocaine less than once per week, while 25% used it at least once per week. All of the current cocaine powder users reported snorting the drug.

Of the 79 recent cocaine powder users, only 9% obtained their cocaine from a person who was not known to them. Cocaine powder was most commonly obtained at the home of a friend (43%) or at a disco, bar or club (36%). Almost two-thirds of recent cocaine powder users said that cocaine powder was easy to obtain within a 24-hour period.

Of the 35 self-defined ‘regular’ cocaine powder users, almost 82% had successfully stopped taking cocaine. The most common reasons for discontinuing were: concerns about its health effects (28%), could no longer afford it (17%), impact on employment, family and friends (11%), did not enjoy it any more (8.7%), attended a rehabilitation programme (8.2%) or did not want to continue using it (8.2%).

The findings of this survey should be interpreted with care in view of the small number of responses used to describe the patterns of cocaine use. The socially-excluded population is unlikely to be represented in a general population survey of this kind; its members may not live at fixed addresses or, if listed, may be difficult to locate for interview.

2.2.5 Sedative, tranquilliser and anti-depressant use in Ireland

The sixth bulletin of results from the 2006/7 all-Ireland general population drug prevalence survey focused on sedative or tranquilliser and anti-depressant use in the adult population (15–64 years) (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2009b) see section 2.2.6.

The proportion of adults who reported using a sedative or tranquilliser at some point in their lives was 11% (Table 2.2.9). The proportion of young adults was 6%, while the proportion of older adults was higher at 15%. More women (13%) than men (8%) reported using a sedative or tranquilliser in their lifetime.

The proportion of adults who reported using a sedative or tranquilliser in the last year was 5%, and of older adults 7% (Table 2.2.9).

The proportion of adults who reported using a sedative or tranquilliser in the last month was 3%, and of older adults 4% (Table 2.2.9).

Table 2.2.9 Prevalence of sedative and tranquilliser use in Ireland, 2006/7

	Adults	Males	Females	Young adults	Older adults	
	15–64 years	15–64 years	15–64 years	15–34 years	35–64 years	
	%		%		%	
Lifetime (ever used)	10.5	8.0	13.2	5.9	14.6	
Last year (recent use)	4.7	3.7	5.7	2.5	6.5	
Last month (current use)	3.0	2.4	3.5	1.3	4.4	

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2009b).

The proportion of adults who reported using an anti-depressant at some point in their lives was 9% (Table 2.2.10). The proportion of young adults was 7% while the proportion of older adults was higher at 11%. More women (13%) than men (6%) reported using an anti-depressant in their lifetime.

The proportion of adults who reported using an anti-depressant in the last year was just over 4%, and of older adults 5% (Table 2.2.10).

The proportion of adults who reported using an anti-depressant in the last month was 3%, and of older adults 4% (Table 2.2.10).

Table 2.2.10 Prevalence of anti-depressant use in Ireland, 2006/7

	Adults 15–64 years %	Males 15–64 years %	Females 15–64 years %	Young adults 15–34 years %	Older adults 35–64 years %
Lifetime (ever used)	9.2	5.9	12.5	7.1	10.9
Last year (recent use)	4.3	3.0	5.6	3.2	5.2
Last month (current use)	3.1	2.3	3.9	2.2	3.9

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2009b).

The average age (among all users) at first use of sedatives or tranquillisers was 29 years for males and 31 for females. The average age at first use of anti-depressants was 34 years for males and 30 years for females.

More than half (57%) of current users of sedatives or tranquillisers, and 91% of current users of anti-depressants, took them daily or almost daily. Most current users got their sedatives or tranquillisers (89%) or anti-depressants (100%) on prescription. However, 11% of sedative or tranquilliser users reported that they had either got them from a friend or another source or bought them without a prescription in a pharmacy.

Sedative or tranquilliser and anti-depressant use was more likely among those who were dependent on the state long-term, were not in paid employment, had lower levels of educational attainment and had left education before the age of 15 years.

Respondents who were separated, divorced or widowed reported higher prevalence rates of sedative or tranquilliser and anti-depressant use compared to those who were single (never married), co-habiting or married.

2.2.6 New information on polydrug use in Ireland

The fifth bulletin of results from the 2006/7 all-Ireland general population drug prevalence survey focused on polydrug use in the adult population (15–64 years) and patterns of polydrug use (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2009a)

For the purpose of Bulletin 5, polydrug use was defined as the use in the last month of two or more of the following substances: alcohol, tobacco, any illegal drug or any other legal drug (sedatives, tranquillisers or anti-depressants).

Just under one-fifth (19.6%) of the 4,967 survey respondents in Ireland reported that they had not used any substance in the last month. Among those who had used drugs in the last month, the most common substance combinations were:

1. 26.5% had used alcohol and tobacco
2. 3.3% had used alcohol, sedatives or tranquillisers, and anti-depressants
3. 2.6% had used alcohol and at least one illegal drug
4. 2.4% had used tobacco and at least one illegal drug
5. 2.3% had used tobacco, sedatives or tranquillisers, and anti-depressants
6. 2.2% had used alcohol, tobacco and at least one illegal drug
7. 1.9% alcohol and sedatives or tranquillisers
8. 1.9% alcohol and anti-depressants
9. 1.6% had used alcohol, tobacco, sedatives or tranquillisers, and anti-depressants
10. 1.5% had used tobacco and anti-depressants

The combination of alcohol, tobacco and any illegal drug was more commonly reported by men (3.4%) than by women (0.9%). Thirty-one per cent of young adults (15–34 years) reported that they had used alcohol and tobacco, compared to 23% of older adults (35–64 years). The same relationship was observed among users of alcohol, tobacco and at least one illegal drug, with 3.8% of young adults and 0.8% of older adults reporting this combination.

The results of the polydrug use survey reflected substance use in recreational situations, rather than problematic substance use in socially-deprived areas or among treated problem drug users.

2.3 Drug use in the school and youth population

2.3.1 Drug data from third SLÁN survey

On 29 April 2008, the Department of Health and Children published the third SLÁN Survey of Lifestyle, Attitudes and Nutrition in Ireland. This survey was completed by Morgan and colleagues (Morgan *et al.* 2008) at the Royal College of Surgeons in Ireland.

The survey involved 10,364 face-to-face interviews with adults resident in Ireland, which represented a 62% response rate. The sample was drawn from the GeoDirectory, using a multi-stage probability procedure, and was stratified by townland, urban–rural location, age and social class.

Respondents were asked a number of questions about their drug use. The responses were weighted for age, gender, marital status, country of birth and ethnicity. The authors noted that the findings must be interpreted with caution because of the change in sample selection and data-collection methods in 2007 compared to those used in 2002 and 1998, as shown in Table 2.3.1.

Table 2.3.1 Summary of SLÁN methods, 1998, 2002 and 2007

	SLÁN 1998	SLÁN 2002	SLÁN 2007
Population	Adults aged 18+	Adults aged 18+	Adults aged 18+
Sampling frame	Electoral register	Electoral register	GeoDirectory
Sample	Multi-stage sample, drawn by electoral division	Multi-stage sample, drawn by electoral division	Multi-stage probability sample
Stratification	Percentage distribution across each of 26 counties, locality and gender	Percentage distribution across each of 26 counties, locality and gender	Percentage distribution across townlands, age groups, social classes and urban–rural location
Methods	Self-completion questionnaire and self-completion of Food Frequency Questionnaire	Self-completion questionnaire and self-completion of Food Frequency Questionnaire	Face-to-face interview and self-completion of Food Frequency Questionnaire
Obtained sample	6539	5992	10364
Response rate	62%	53%	62%

Source: (Morgan *et al.* 2008)

In the 2007 survey, respondents were asked about their use of illegal drugs in the last year (Table 2.3.2). Six per cent reported that they had used an illegal drug in the year prior to the survey; the reported use of such drugs was higher for men (9%) than for women (4%). As expected, cannabis was the most commonly-used drug. The percentage of those who used cocaine in the last year was surprisingly low at 1%.

Table 2.3.2 Last-year prevalence of illegal drug use in Ireland

	Adults 18 years or over %	Males 18 years or over %	Females 18 years or over %
Illegal drug use*	6.0	9.0	4.0
Cannabis	5.0	8.0	3.0
Ecstasy	1.0	1.0	<1.0
Cocaine	1.0	2.0	<1.0

* Illegal drugs in this context are amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

Source: (Morgan *et al.* 2008)

In general, these data are not comparable to the results of the 2006/7 general population survey by the NACD as the SLÁN survey excluded those aged between 15 and 17 and included those over 65 years. In addition, the use of confidence intervals would allow commentators to rule out sampling variation when comparing the SLÁN surveys, both over time and with other surveys completed at the same time.

2.3.2 Fourth ESPAD survey on substance use among young people

On 26 March 2009, the fourth European School Survey Project on Alcohol and Other Drugs (ESPAD) was published (Hibell, B *et al.* 2009).

ESPAD surveys have been conducted every four years since 1995, using a standardised method and a common questionnaire. The rationale for these surveys is that school students are easily accessible and are at an age when onset of substance use is likely to occur. (By definition, early school leavers, a group known to be vulnerable to alcohol and drug use, are not represented.) ESPAD survey information is valuable in planning prevention initiatives.

The fourth survey was conducted in 35 European countries during 2007 and collected information on alcohol and illicit drug use among 15–16-year-olds; 2,249 students from 94 randomly-selected schools participated, which represents a response rate of 78%. Fewer schools and students participated in 2007 than in 2003.

In terms of drug use, the Irish data showed a marked decrease in lifetime use of any illicit drug between 2003 (40%) and 2007 (22%), a fall of 18 percentage points (Table 2.3.3). As the majority of those who have tried any illicit drug have used cannabis (marijuana or hashish), the decrease in illicit drug use was influenced by the considerable decrease in the number of students who had tried cannabis at some point in their lives, from 39% in 2003 to 20% in 2007 (European average 19%). Lifetime use of solvents/inhalants decreased from 18% in 2003 to 15% in 2007, but remained higher than the European average (9%). In the case of both amphetamines and cocaine powder, the proportions reporting lifetime use increased marginally above the European average of 3%. In 2007, one in ten of the survey participants reported that they had taken prescribed tranquillisers or sedatives at some point in their lives; the use of such drugs had decreased marginally since 1999.

Table 2.3.3 Proportions of school-going children (15–16 years) in Ireland who reported lifetime use of drugs in the ESPAD surveys of 1995, 1999, 2003 and 2007

	1995 %	1999 %	2003 %	2007 %
Lifetime use				
Any illicit drug*	37	32	40	22
Cannabis	37	32	39	20
Inhalants (solvents)	n.a.	22	18	15
Ecstasy	9	5	5	4
Cocaine powder	2	2	3	4
Amphetamines	3	3	1	3
Prescribed tranquilisers or sedatives	n.a.	11	10	10
Non-prescribed tranquilisers or sedatives	7	5	2	3

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

n.a. = not available

Sources: (Hibell, B. *et al.* 1997) (Hibell, Björn *et al.* 2000) (Hibell, Björn *et al.* 2004) (Hibell, B *et al.* 2009)

In another national study, the HBSC (Health Behaviour in School-aged Children) survey, lifetime cannabis use among 15–17-year-olds was 29% in 2006 compared to 26% in 2002 and 25% in 1998 (S Nic Gabhainn, personal communication, 2008). The HBSC survey shows a steady marginal increase in cannabis use between 1998 and 2007, whereas the ESPAD survey shows a large increase between 1999 and 2003 and a larger, unexpected decrease between 2003 and 2007 (Figure 2.3.1). It is important that in the future the reasons for the change in cannabis use reported in the ESPAD surveys be investigated; it could represent a genuine decrease in the use of cannabis or a change in the sample chosen or the way the questionnaire was administered.

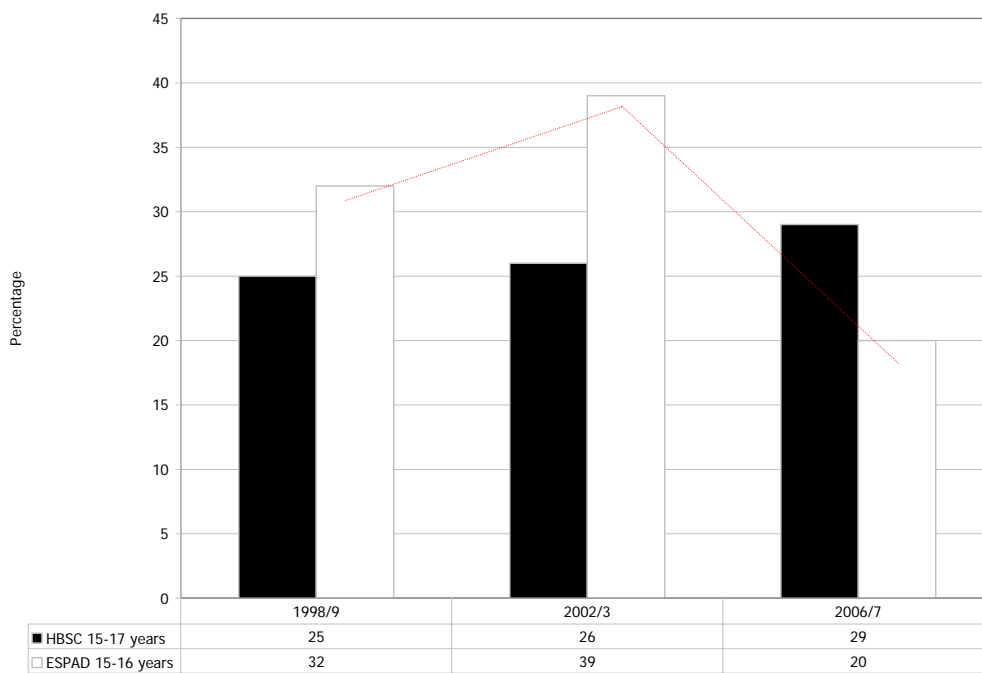


Figure 2.3.1 Trends in lifetime cannabis use, as reported by the ESPAD and HBSC surveys at three time points

Drug and solvent use among national school children in mid-western Ireland

In 1997, the Mid-Western Health Board undertook a baseline study to examine health status and behaviours of adolescents in the region i.e. counties Clare, Limerick, North Tipperary and Limerick City, and completed a follow-up study in 2002. The latter study found that a minority of children aged 13 years or under reported regular substance use. The present study (Houghton *et al.* 2008) was completed in 2004 to examine the current extent of tobacco, alcohol and drug use among national (primary) school children aged 11 to 14 years in Limerick City, Limerick County, Clare and North Tipperary (the Mid-West Region).

The survey questions about drug and glue/solvent misuse were drawn from the Health Behaviour in School-aged Children (HBSC) survey. The study population was selected from fifth and sixth class pupils (years seven and eight) attending national schools in the region. Fifty schools were randomly selected from a geographically stratified sample, with a quarter of the schools selected from each area. A total of 43 schools participated in the survey. The response rate, calculated inclusive of children in the non-participating schools, was 76.2%.

Of the 1,254 questionnaires analysed, 573 were from males and 681 from females. Participants ranged in age from 10 to 14 years (although only two were aged 14), with 47% (588) coming from fifth class and the remainder from sixth class. The mean age of the participants was 11.5 years (SD = 0.73).

Of the respondents, 1% (n = 12) reported that they had used cannabis at least once in their life, of whom eight were male and four were female. Only two children reported having used cannabis three or more times.

A total of 1.3% (n = 16) of respondents reported having ever taken 'any other drug'. Thirteen of these had done so 'once or twice' and the remaining three had done so three or more times. Of the children who had ever taken 'any other drug', 13 were male and three were female.

Fifty-three (4.2%) children had used glue/solvents at least 'once or twice' in their lives. Forty-four out of the 53 replied that they had only ever done this 'once or twice'. Thirty-three were male and 20 were female.

This survey indicates that use of cannabis and of solvents starts at a young age in Ireland.

Drug and alcohol-related knowledge, attitudes and behaviours of early school leavers aged 15–20 years in the west of Ireland.

Redmond (Redmond 2008) explored the drug and alcohol-related attitudes, knowledge and behaviours of early school leavers in the west of Ireland.

The data were collected using three methods: questionnaires, focus groups and PhotoVoice. The participants included 47 males and 59 females, aged 15–20 years, who answered the questionnaires; 22 young people (14 males and 8 females; average age 16 years) in three focus groups, one per county (Galway, Mayo and Roscommon); and five males (aged 15–16 years) who participated in a PhotoVoice project.

The use of most substances was higher among early school leavers compared to their school-going contemporaries. Early school leavers were more likely to use cannabis, cocaine, ecstasy and speed. Solvents were used by both groups. Alcohol use was widespread and accepted, with knowledge of the harms from alcohol coming from lived experience. Parental attitudes were identified as an important influence on a young person's respect for alcohol. A lack of understanding of the link between drugs and addiction was evident. It was particularly common for respondents to link cocaine use and addiction. Dissatisfaction with current drugs education, or lack of it, was apparent and the knowledge level varied considerably among participants.

The author concluded that consistent and appropriate means must be used to challenge young people's attitudes to substance use, to enhance knowledge, to positively impact behaviour and to utilise normative education. A link must be made to parenting practices, as parents have significant influence in developing resilience, self-esteem, and motivation to be involved in non-substance-using activities. Emphasis must also be placed on providing a range of youth services to meet the needs and diversity of young people, and the education system as it stands requires a creative approach to become more holistic in achieving better mental, social and emotional health.

Drug and alcohol use among adolescents in south-eastern Ireland

Van Hout (Van Hout 2009b) completed semi-structured interviews with a random sample of 220 15–17-year-old students from schools and youth training centres in the south-east of Ireland.

Just under one-quarter of the respondents reported ever using an illicit drug, and the majority who had tried drugs were boys. Almost all respondents said that they had been offered drugs and that drugs were easily available in urban areas. The majority of respondents believed that drug use would increase in the future in the area. They said that the police or schools did not take action to stop dealing or drug use in public. Drugs were purchased over the phone and could even be delivered to the schoolyard. Cannabis was the most common illicit drug used and was the first drug used. A small number reported that ecstasy or amphetamine was their first drug. Alcohol was usually consumed alongside illicit drugs. Cannabis was perceived as a safe drug, while cocaine, heroin and speed were perceived as dangerous drugs. Most respondents took drugs because they were curious, bored or their friends were taking them. Some respondents said that drugs helped them to relax or gave them a buzz. Respondents said that on the first occasion they had not planned to take drugs, but that the opportunity arose. Just under half felt ill after taking the drug but this did not deter them from further drug taking. The majority were aged between 10 and 15 years when they

took their first drug, and the drug was usually given by a friend or older sibling. A small number reported that they clubbed together with friends to buy drugs. Some respondents reported that they controlled their drug use to prevent addiction, overdose, or other physical symptoms. Some of the older drug-using respondents reported that they had ceased illicit drug use because drugs had lost their appeal, they had experienced negative effects or they preferred alcohol. Very few drug-using respondents were worried about the legal consequences of illicit drug use.

The respondents who had never taken drugs gave the following reasons as to why they were not interested in drugs: drugs were dangerous, they had observed the side effects of drugs, or drug use was difficult to control. Some respondents were afraid of their parents' reaction if they found out.

The author concluded that the attitudes towards drug use of both adolescent users and abstainers have become more liberal and 'normalised' and this is against the backdrop of rising drug use in the community.

Volatile inhalant use among young people in south-eastern Ireland

Van Hout and O'Connor (Van Hout and Connor 2008) explored practices, social dynamics and effects of solvent or volatile inhalant use and suggested methods to deter or stop use among young people. This inquiry was part of a much larger study on drug use. The authors interviewed 20 young people (average age 13.2 years) living in the south-east of Ireland using a semi-structured questionnaire. Eleven males and nine females participated in this aspect of the study. The first time the child used a solvent was opportunistic and in the company of peers. The average age of first solvent use was 10.3 years and most stopped using solvents by the age of 13 years. Most children reported that they 'fainted' or felt 'sick' the first time they used these substances. The frequency of subsequent solvent use was sporadic and opportunistic. Subsequent use of solvents was in a more controlled fashion to reduce side effects. Half of the solvent users also smoked cigarettes despite the obvious danger. Solvent use was followed by initiation into alcohol use (average age of first use 12.5 years) and subsequently a small number experimented with cannabis. Most used solvents outdoors with their peer group and during the long summer holidays. There were some reports of solvent use during school breaks. The type of solvent used was determined by cost, access and place of residence. Children who lived in rural areas used a limited number of products, namely, wood glue, diesel and petrol, whereas children in urban areas used a wide variety of products including Pritt Stick, methylated spirits, hairspray, deodorant, chrome paint, butane, nitrous oxide and Vick's nasal inhalant. Some products were inhaled using a plastic bag, others by placing the spray nozzle in their mouth or nostril, and others by pouring the product on a damp cloth and placing it over the face. The participants reported a variety of reasons for continuing to use solvents, such as be part of the peer group, relieve boredom, experience a high, deal with stress or escape from reality. They reported a variety of physical effects such as fainting, vomiting, inflamed nostrils or headache. Following use, some participants reported taking actions that they would not normally do, such as having sex, being involved in vandalism or completing dares. All respondents knew someone who had died as a result of solvent use. In general, the children reported that teachers were uncomfortable delivering information about drug use.

Service providers' views of youth alcohol and drug use in south-eastern Ireland

Van Hout (Van Hout 2009a) explored the views of 78 service providers based in the south-east of Ireland on youth substance use and current service provision. The service providers worked in one of the following services: youth, community, addiction, education or health.

The service providers believed that illicit drugs and drug use had become a normal aspect of society in the area. They said that illicit drug use had increased because the

availability of drugs had increased, young people had more disposable income, they had greater freedom and parental monitoring was lacking. According to the service providers, young people had a positive attitude to alcohol use and a facilitating attitude to drug use and this encouraged experimentation. In addition, children had better knowledge about the effects of individual drugs and the effects of mixing them. They said that teachers were trying to control drug dealing and use in the schoolyard.

The respondents reported that children are introduced to alcohol at a young age and observe their parents and siblings drinking to excess. They cited poor parental monitoring and unstructured leisure time as contributing factors. Young people were observed purchasing and sharing drugs among close peers or best friends. Drug and alcohol use occurred in fields, on the streets or at friends' houses. The service providers reported that drug use could start as young as 10 years of age and that boys were more likely than girls to experiment. Young people had developed an informal hierarchy of drugs, according to the perceived level of harm, with heroin at the top of the scale and cannabis at the bottom. Young people thought that heroin was safe if smoked and that cannabis was as safe as cigarettes.

The service providers said that most children experimented with drug use and matured out of it, but that children experiencing family problems and disruption were more likely to develop problem drug or alcohol use. Drug use included use of solvents and inappropriate use of prescription medication.

According to the service providers, adolescent diagnostics and services are based on adult models. The author suggested that adolescent services should be developed using age- and situation-appropriate models of care.

Parents' views of youth alcohol and drug use in south-eastern Ireland

Van Hout (Van Hout 2009b) provided an exploratory account of rural parents' views on alcohol and illicit drug use among youth in the south-east of Ireland.

Facilitated by school completion officers, convenience sample of parents (34 mothers and 21 fathers) with adolescent children was selected at a parent–teacher evening at three rural schools. Semi-structured interviews were conducted, which included questions relating to the parents' perceptions of youth drug and alcohol use (both in terms of recreational and problematic use in their communities), drug availability, perceptions of risk, types of settings for adolescent substance use, service provision and drug information. The parents were not questioned about their own children but about youth in general. Following transcription of the interviews, a content and thematic analysis was conducted.

The results suggested parental concern with regard to increased exposure to drugs among youth in local rural communities. The majority of parents were aware of youth alcohol use, they were concerned about all drugs, they were not aware of specific differences in drug-related risk and had difficulty comprehending harm-reduction principles. Most parents recognised the need for greater parental monitoring through improving accountability for free time, improving parent–child interaction, and visibility of services.

The author observed that life in contemporary rural Ireland is influenced by dominant social changes in terms of seeing the normalisation of alcohol and drug use in youth subcultures. This is facilitated by increasing fragmentation of traditional rural family norms and values, emerging acceptability of alcohol and drug use in recreation time and the increasing availability of alcohol and drugs. The author suggested there is a need to provide drug education, service visibility and family support for those experiencing problem substance use.

2.4 Drug use among targeted groups/settings at national and local level (university students and conscript surveys, migrants, music venues, gay clubs, gyms)

Substance use among Irish women expecting their first baby

Between April 2003 and May 2004, Donnelly and colleagues (Donnelly *et al.* 2008) interviewed 1,011 Caucasian women attending a maternity hospital in Dublin's city centre to determine their use of illegal drugs, tobacco and alcohol. The definition of illegal drugs used in the survey was not given in the paper. The study participants were expecting their first baby, were less than 20 weeks pregnant and were aged between 16 and 40 years. Women were interviewed at private, semi-private and public antenatal clinics. The study response rate was very high at 95%.

Of the 1,011 women interviewed, 235 (23.5%) respondents reported that they had taken an illegal drug at some point prior to this pregnancy. As expected, cannabis was the most commonly-used illegal drug, with 214 (21.2%) respondents reporting that they had used this drug at some point prior to this pregnancy. Seventy (6.9%) respondents had used ecstasy at some point prior to this pregnancy while 64 (5.8%) had used cocaine. Ninety women (8.9%) had used more than one illegal drug. Eleven women (1.1%) had used an illegal drug during this pregnancy.

In relation to tobacco use, 574 (56.7%) of the women interviewed reported that they had smoked cigarettes at some point in their lives; 282 (28.8%) reported that they were current smokers, of whom 87 (30.8%) smoked more than 10 cigarettes a day.

In relation to alcohol use, 545 women (53.9%) said that they had drunk alcohol on at least one occasion since their first positive pregnancy test, and, of these, 500 (91.7%) had drunk between one and four units, 33 (5.1%) between five and 10 units and 12 (2.2%) more than 10 units.

Alcohol consumption and cigarette smoking were associated with illegal drug use: smokers were 2.8 times more likely to use illegal drugs than non-smokers, while women who drank alcohol were 1.8 times more likely use illegal drugs than non-drinkers. The type of clinic attended or the level of education achieved were not found to be associated with the use of illegal drugs. High levels of alcohol use among pregnant women in Ireland has been reported elsewhere.

This survey does not report confidence intervals so it is not possible to estimate the use among the population of primigravid women.

Substance use in the Traveller community in the WRDTF area

The Western Region Drugs Task Force (WRDTF) has published a report on the nature and extent of substance use, and use of services, by members of the Traveller community in the west of Ireland (Van Hout 2009a). This is the second in a series of three reports on substance use in the region commissioned by the WRDTF.

Data were collected from 57 focus groups that included both adult and younger members of the Traveller community. Interviews and consultations were held with 45 service providers, including services dealing specifically with substance use among Travellers. The fieldwork was complemented by prior consultation with stakeholders, desktop research and a literature review.

Service providers reported a marked increase in problematic drug and alcohol use among Travellers in the last 10 years in the west of Ireland. Substance use was mainly seen as an escape from depression, poor health, difficulties with employment and strained relationships with the settled community. In terms of risk, older Travellers

reported a fear of drugs and potential overdose, with younger Travellers indicating an acceptance of the use of drugs such as cannabis and ecstasy as relatively normal.

Alcohol

According to service providers, alcohol remains the substance of most concern in this community, and increasing levels of use were reported among Traveller men and more recently among single Traveller women. Some Travellers were aware of 'drink problems' in their community, and reported that such problems were usually dealt with within the family. Service providers felt that because Travellers are discriminated against in certain pubs, they buy cheap alcohol from supermarkets, which contributes to high levels of consumption in the home and at halting sites. They reported that high levels of alcohol use can contribute to violence in the home and when a family break-up occurs and 'the head of the house' (usually the male) leaves the family home, the women often resort to alcohol and prescribed medication.

Drugs

Travellers commented that there have been visibly 'more drugs' in urban areas in the west in the past two years, and that drugs are increasingly available in the region as a whole in comparison to the situation 10–15 years ago. Ecstasy, speed, hash and cocaine are the drugs most commonly used. Polysubstance use is common, most often in the following combinations: alcohol and hash/cannabis; alcohol and benzodiazepines; benzodiazepines and Solpadeine; Solpadeine and alcohol; cocaine and alcohol; Red Bull and Anadin; Zamadol and Coca-Cola; Anadin and Coca-Cola and painkillers and alcohol. According to service providers, Traveller males use hash, cocaine and ecstasy and Traveller women tend to use prescription medication. Despite some anecdotal reports of heroin (smoking), crack cocaine and cocaine use, the majority of service providers reported little direct evidence to suggest that these substances were widely used.

Levels of illicit drug use among young Traveller women were perceived to be lower than those reported by young women in the general population. This was often attributed to the degree of monitoring, parental control and restriction of income of young women in Traveller communities. However, there were reports that young Traveller women use night sedation medication and benzodiazepines.

Drug dealing

Mixed views existed on the nature and extent of drug dealing in the Traveller community. The general consensus was that it exists but is not widespread and that users tend to obtain their drugs through their own families and have little contact with dealers in the settled community. Some Travellers were concerned that both Traveller and settled drug dealers were recruiting young Travellers to act as 'runners' and were therefore also providing them with an introduction to drugs and a context for use.

Drug awareness and information

Travellers felt the level of drug awareness within their community was quite low. Older Travellers viewed illicit drugs as a sensitive and 'taboo' topic. The majority of Travellers who had participated in drug awareness training felt that it was not suitable for a Traveller group, as it was not based on their values and beliefs. The most pervasive theme was the importance of involving the Travellers in drug education and prevention, and taking into consideration their norms and cultural values in the delivery of such services and educational materials. It was remarked that Travellers 'would prefer information from Travellers'.

This research is welcome and builds on what is already known about substance use in the Traveller community. The main findings are similar to those of a 2006 study (Fountain 2006), and show that levels of illicit drug use among Travellers are low compared to those in the general population, particularly in the case of Class A drugs such as heroin and cocaine. This research shows the influence of the informal 'social controls' that pertain in some Traveller communities. These informal mechanisms are

often credited with reducing the use of illicit drugs among young Traveller women, but appear to be less effective in reducing the use of prescription and over-the-counter drugs by young women.

Substance use in new communities in the WRDTF area

A report commissioned by the Western Region Drugs Task Force (WRDTF) explored substance use among new communities in the west of Ireland and identified barriers to effective use of services (Kelly, C. *et al.* 2009). New communities included migrant workers, refugees, asylum seekers, and migrants who had been granted citizenship. At the time of the 2006 census, there were 48,387 non-nationals living in the west of Ireland.

The authors stated that members of new communities in Ireland came from countries where the rates of substance use among adults were generally lower than in this country. They noted that Irish research and informal reports from service providers suggested that migrant workers and refugees and asylum seekers were not accessing health services in Ireland because of the high cost of these services, lack of insurance, unfamiliarity with the health system and poor English language skills.

The authors reported that risk factors for substance use in new communities were generally the same as those in other communities, and included mental health issues, social isolation, poor education levels and unemployment. For some members of new communities, post-traumatic stress disorder could interact with experiences of discrimination and social exclusion to increase the risk of substance use. Other factors included the strain of being undocumented, having illegal status, and anxiety about being discovered. Having limited access to medical services except in the case of an emergency could impede access to frontline services such as GPs where substance use might be identified as a problem and treated early.

According to this report, adolescents in new communities could experience isolation owing to low levels of supportive peer relationships in school. Additional strain could occur for these young people when they learned a new language and cultural practices reflecting the norms of the indigenous population. This might result in a clash with the value system and cultural practices of their family. Taken together, these factors could increase the risk of substance use among young people as they tried to fit in with the indigenous culture and deal with social isolation.

The authors interviewed by phone 18 statutory and voluntary groups involved in the support of new communities or the provision of substance use services, to explore their views on substance use in these communities. Almost all those contacted had no specific or specialist information on the issue, nor did their organisations have policies or strategies to address the issue.

This research included an analysis of regional press coverage of substance use issues in the west, and particularly in new communities, between 8 and 14 December 2008. The results suggested that there was more media interest in alcohol-related issues than in other drug issues and that there was more ambivalence about alcohol (which is presented as both potentially dangerous and positive and worthy of promotion) than other drugs (which are presented entirely negatively). In relation to the issue at hand, only five articles were identified where members of new communities and alcohol or other drugs were explicitly linked, and just three of those cases concerned drug possession or public drunkenness.

This report mentioned a small number of studies on appropriate responses to substance use in new communities. These were highlighted as potential 'starting points' for communication among service providers and, according to the authors, were 'in a sense pragmatic and in some cases "best guesstimates" of what could work'.

The authors uncovered little evidence of substance use as a substantial problem, or one that required immediate action, among new communities in the west of Ireland. However, the reluctance of members of new communities to access health services, as acknowledged in this report, suggests that the views of service providers as to the extent of substance use may not reflect the true situation in the communities. Alternative methods of collecting primary data, such as training people from new communities to undertake in-depth fieldwork, including interviews and observation, may yield a different picture to that conveyed here. A 2004 study using these methods found that heroin and cocaine use were becoming a problem among some sections of new communities in Ireland (Corr 2004).

3. Prevention

3.1 Introduction

Drug prevention has been a key pillar in Ireland's National Drugs Strategy 2001–2008 and the new National Drugs Strategy (interim), 2009–2016 will continue to focus on developing drug prevention policy and practice (Department of Community Rural and Gaeltacht Affairs 2009). Drug prevention is delivered in schools through the Walk Tall (primary schools) and the Social, Personal and Health Education (post-primary schools) programmes. Drug prevention interventions are also provided in the community in different settings, including youth clubs and youth cafés, and by means of a number of diversion activities provided by the statutory, voluntary and community sectors. Young people and their families are the main target groups for drug prevention activities, which consist mainly of universal and selective prevention, with little focus on indicated prevention.

3.2 Universal prevention

3.2.1 School

Environment in secondary schools in Ireland compared to other OECD countries

Fostering a positive, safe and supportive school environment can be an important protective factor against substance use (Meyer and Cahill 2004). Data from the latest OECD Teaching and Learning International Survey (TALIS) show some interesting findings regarding the nature of the school climate in Ireland and its possible impact on teachers and students (Organisation for Economic Co-Operation and Development 2009). Irish secondary school students are more likely to arrive late for school, be absent from school, engage in intimidation or verbal abuse of other students and teachers, and use/possess alcohol and/or drugs compared to the OECD average (Table 3.2.1). In addition, Ireland has quite a high level of teacher absenteeism (43%) compared to the OECD average of 25.8%. These data reflect the challenges that pertain in schools and which adversely impact on pedagogical instruction and the personal and social development of students.

Table 3.2.1 Percentage of teachers of lower secondary education whose school principal considered the following student behaviours to hinder instruction 'a lot' or 'to some extent' in their school, Ireland and OECD average

Student factor	Ireland	OECD average
	%	%
Arriving late for school	57.7	39.4
Absenteeism	70.9	45.8
Classroom disturbance	53.6	60.2
Cheating	2.9	20.9
Profanity/Swearing	21.6	36.5
Vandalism	10.6	27.1
Theft	4.7	15.3
Intimidation or verbal abuse of other students	36.6	34.6
Physical injury to other students	4.3	15.9
Intimidation or verbal abuse of teachers or staff	17.9	16.8
Use and/or possession of alcohol and/or drugs	15.0	10.7

Source: Adapted from (Organisation for Economic Co-Operation and Development 2009)

The findings from the TALIS study suggest that there is a strong perception among principals and teachers in Ireland that students are engaged in a number of activities that may compromise their educational development and threaten their bonding with the educational system. Poor levels of bonding with social institutions is considered a

risk factor for early school leaving and poor academic performance and can lead to substance use and related behaviours in students. The provision of substance prevention programmes in schools and their potential impact on reducing demand for alcohol and drugs among students are likely to be compromised in settings where the school climate is less than supportive to both staff and students.

The views of secondary school students on substance use education

The Social, Personal and Health Education (SPHE) programme is the main vehicle through which substance use prevention interventions are implemented in secondary schools. The programme aims to improve social and personal competencies in students so they can understand and counter the many social influences that are seen as contributing to their use of drugs and alcohol.

The curriculum for Social, Personal and Health Education (SPHE) in the junior cycle of secondary school is presented in ten modules, each of which appears in each year of the three-year cycle.

- Belonging and integrating
- Self-management: a sense of purpose
- Communication skills
- Physical health
- Friendship
- Relationships and sexuality
- Emotional health
- Influences and decisions
- Substance use
- Personal safety

Nic Gabhainn *et al.* (Nic Gabhainn *et al.* 2008) examined the contribution of the SPHE curriculum to the experience of junior cycle students and to the junior cycle curriculum. A random sample of 12 schools was drawn representing different combinations of school characteristics, including school type (secondary, community comprehensive, vocational), size, location, status (disadvantaged or not) and pupil gender.

Data collection

- 49 members of staff in the 12 schools were interviewed.
- 57 parents participated in the nine focus groups.
- 713 students participated in workshops representing three classes from each school.
- 686 of the workshop students returned self-completed questionnaires.
- 911 parents completed and returned questionnaires.

Findings from a thematic analysis

Quality and value of SPHE provision

- SPHE is challenging and worthwhile.
- Quality teaching is essential for the successful delivery of SPHE.
- Insufficient time is given to SPHE.
- Sufficient and relevant resources are essential for the delivery of a high-quality SPHE programme.
- Many parents lack sufficient knowledge and commitment.
- SPHE is regarded as valuable and helpful.
- SPHE suffers from timetabling pressures and there are difficulties with curriculum overload that influence SPHE provision.
- SPHE has a lack of status in comparison to examination subjects.

The contribution of SPHE to health attitudes, health behaviours and educational experience of junior cycle students

- SPHE contributes positively to students' attitudes to health, especially in their future lives.

- SPHE helps students to think about and discuss health issues relevant to their age group.
- SPHE provides opportunities for the development of personal and social skills among students.
- It is difficult for staff to evaluate the influence of SPHE on health behaviours among students.
- There is agreement that SPHE has the potential to improve the health behaviours of students.
- Most parents and students are satisfied with the support SPHE offers in relation to keeping healthy.
- There is consensus that SPHE enhances the educational experiences of students. All groups are enthusiastic about the educational potential of the subject.
- Students are more ambivalent than their parents about the influence SPHE has on their education.
- Students express the view that SPHE is helpful to them in dealing with difficult situations.

Implementation of SPHE

- SPHE staff, particularly those who choose to teach it and have been trained, enjoy the experience.
- The majority of the students enjoy learning during SPHE classes.
- The importance of continuity in relation to teaching SPHE to the same class over a period of years is stressed by teachers.
- Support and training for the teachers are regarded as essential for success of SPHE.
- SPHE is included in the planning process in fewer than half the schools.
- Schools are keen to include SPHE in whole-school planning.
- Almost all schools have policies and structures that support the running of the SPHE programme.
- The role of the SPHE co-ordinator is seen as pivotal to success.
- Members of the SPHE team who feel valued and supported express a strong sense of satisfaction in their work.
- More than half of parents think that schools need more support in their delivery of a successful SPHE programme.

Stakeholder involvement

- There is little engagement with parents in the planning and development of SPHE.
- Parents who do comment are enthusiastic and encouraging about the SPHE programme.
- Many parents feel unable to comment due to their lack of knowledge of SPHE.
- Some of the parents' comments indicate that they would like to know more about the SPHE programme and to feel more involved in this aspect of their child's education.

Ten of the twelve schools in this study were in favour of the continuation of SPHE into the senior cycle. However, a minority of parents and students did not support this view.

During the recent review of the National Drugs Strategy 2001–2008, (Department of Community Rural and Gaeltacht Affairs 2009) the effectiveness of SPHE at second level was consistently questioned in particular by students themselves. The commitment given to SPHE by individual schools, and the support teachers receive to deliver the programme, were also mentioned as key concerns during the consultation. These concerns had already been raised during the mid-term review of the National Drugs Strategy (Steering Group for the Mid-Term Review of the National Drugs Strategy 2005).

Although it is widely accepted that substance prevention programmes in secondary schools in Ireland are well designed and follow best practice guidelines, i.e. they adopt a social influence approach in combination with competence enhancement, the emerging consensus from the latest drugs strategy review suggests that the SPHE

programme is unevenly delivered across and within schools. The uneven delivery has been attributed in the past to an overcrowded curriculum, lack of positive status for SPHE and limited engagement with parents (Geary and McNamara 2003). In the National Drugs Strategy (interim) 2009–2016 (para. 3.67) the steering group calls for improved delivery of SPHE in primary and post-primary schools, encompassing the implementation of the recommendations of the recent SPHE evaluation in post-primary schools (Nic Gabhainn *et al.* 2008) and the development of a 'whole of school' approach to substance use education in the context of SPHE.

Kerry Life Education project: an evaluation

The Kerry Life Education (KLE) project is delivered from a fleet of mobile buses called 'Life Education' classrooms that visit primary schools in Co Kerry in the south west of Ireland. The project includes a mix of health promotion and information and covers diet, self-esteem, peer dynamics, bullying, and alcohol and substance use. It has been visiting schools since 2004 and is estimated to reach between 5,000 and 7,000 students per year. An evaluation of the KLE project has recently been published and the methods used and key findings are summarised below (Jackson *et al.* 2008).

Methods of evaluation

This was a process evaluation aimed at uncovering the perspectives of schools, parents and professionals on the operation and relevance of the KLE project. A survey questionnaire was sent to 68 schools that had participated in the project; the response rate was 84%. The principal of each school was asked to complete the questionnaire using a consensus view between principal, teachers and parent representatives. A different survey questionnaire was sent to eight key professionals in the fields of health promotion and education; six responded. In addition, data from the Health Behaviour in School-aged Children (HBSC) dataset for 2006 were analysed and comparisons on a number of variables were made between students in KLE schools and students from comparison schools in County Kerry.

The perspective of schools

The majority of schools (89%) reported the teaching, content and presentation of KLE to be excellent and appropriate for children, and 95% wanted the project to continue. Ninety per cent reported that KLE was good or excellent at supporting individual components of the SPHE programme, including learning about the body, making decisions and relating to others. Ninety-three per cent reported having a substance use policy, with 94% reporting that KLE provided either good or excellent support to the development of substance use policies. Only 46% reported that parents had received input from the KLE project. Ninety-six per cent perceived the impact of the project on students to be good or excellent, with the same figure anticipating the potential impact over time to be good or excellent.

The perspective of key professionals

Three of the six professionals who responded were not familiar with the work of KLE prior to being surveyed. When they did learn of the project, respondents reported mixed views. Public health professionals expressed cautious optimism that KLE could provide consistent information on substance use, contribute to a holistic approach to health promotion and increase the number of health promotion sites available to young people. In contrast to the view of the majority of schools, the two education professionals expressed concern that KLE was short-term and did not reinforce the consistent approach taken in SPHE that seeks to develop life skills during school-going years.

Comparison of KLE student data with HBSC data

The evaluators compared data for Fifth and Sixth Class students who participated in the KLE project with HBSC 2006 data from comparison schools in Kerry. Lifetime consumption of alcohol was lower among Fifth Class KLE students than among students in comparison schools. Differences favouring KLE students were noted on a

number of other variables, including being satisfied with life, taking more frequent exercise, consuming fewer soft drinks, snacks and chips and being less likely to be involved in bullying.

When interpreting these favourable results for KLE students it is important to note that the sample was small and was 75% female. In addition, the differences observed between KLE students and students not receiving the intervention cannot be attributed solely to the intervention of KLE, as any number of factors may explain these changes. Further research under more controlled conditions is needed before any substantive conclusions can be reached. Nonetheless, the KLE project is popular among school personnel and parents in Kerry. Evidence shows that short-term interventions delivered on a once-off basis are not very useful in making drug education effective in young people's lives (McGrath *et al.* 2006). However, when used in conjunction with a comprehensive programme such as SPHE, they can enhance understanding of the issues being addressed and contribute to a perception in the community that potential substance use among young people is being tackled. Such a perception can undermine the belief among young people that substance use is 'normalised' and tolerated by the community.

3.2.2 Family

Crosscare, a social care agency working in Dublin, has produced a useful booklet that aims to support parents and guardians in dealing with drug and alcohol issues in the family. The booklet, *Don't lose the head*, contains 64 pages and uses cartoon characters and speech bubbles to convey important messages about drugs (Crosscare 2008). The booklet is based on an extensive review of the literature undertaken by an independent researcher (Clerkin 2008). The review examined the most cited international studies in the field of drug prevention and abstracted key information on 'what works' and 'how it works'. This evidence was then transferred into a 'family-friendly' format in the shape of the booklet and was complemented by extensive consultations with national representatives from the voluntary and community sectors who brought their expertise to the process. Consultations were also undertaken with parents and young people on their information needs and appropriate ways of disseminating this information in a useable format for all stakeholders. The process also drew on the experience of staff at Crosscare who provide the Drugs and Alcohol Programme (DAP) and the Teen Counselling intervention.

The booklet contains chapters on talking to children about drugs, dealing with drugs in the family, factual information about drugs and a list of services to support families. It draws on the social influence model to discuss the key influences on human behaviour, i.e. parents, peers and the media. Families are encouraged to develop skills in communication and decision-making to help them understand and respond to the influences of the media and the peer network. The focus on peers is important in this regard; research has shown that young people tend to be introduced to drugs by peers and, in some cases, come to see drug-using behaviour as 'normal' and assume that the majority of young people are using drugs (Mayock, Paula 2000).

By advocating a social influence model to understand the factors leading to drug use and the development of social skills to address these factors, the booklet highlights the key components of the current evidence base on drug prevention. It aims to help families discuss drugs in a reasoned manner, without using scare tactics, and this approach can be useful in 'blowing the myth' that drug use is a normal activity among peers. The booklet also includes a number of quizzes that families can use to generate discussion about drugs; this is a useful technique based on evidence that interactive discussion is more effective than instructional delivery in drug prevention.

One of the few large-scale studies of parents' support needs in Ireland was based on a survey of 1,000 parents (Riordan 2001). In that survey, the most frequently identified sources of parenting information or knowledge were the family, natural instinct and books, magazines and newspapers, which suggests that parents use a number of

information sources to improve their parenting skills and that the Crosscare booklet is appropriate to their needs. Respondents identified the three main concerns they had in relation to their children as: (i) exposure to drugs, (ii) negative influence of media, and (iii) the ability to maintain good relationships with their children. The contents, layout and theoretical approach of the Crosscare booklet can address these concerns and help parents to develop positive parenting skills.

3.2.3 Community

Since the emergence of the local drugs task forces (LDTFs) in the 1990s, and more recently the regional drugs task forces (RDTFs), as mechanisms for co-ordinating service provision to individuals, families and communities affected by drugs, the role of the community in helping to reduce demand for drugs has grown. The community and voluntary sector, in partnership with the statutory sector, has developed and implemented a number of prevention interventions in both school and non-school settings. The active role of the community sector has been particularly helpful in addressing local concerns about the impact of locating services in communities.

In late 2008, to dovetail with the national awareness campaign on cocaine use, 'The Party's Over' (for an account of this campaign, see Section 3.3.1 of last year's National Report (Alcohol and Drug Research Unit 2008), funding of €500,000 was allocated from DCRGA for cocaine awareness campaigns at local and regional level, to be delivered through the local and regional drugs task forces.

In outlining this extension of the national campaign, Minister for Drugs John Curran TD observed: 'The Task Forces, through their interaction with communities and groups on the ground, are considered best placed to deliver meaningful, appropriate and focussed campaigns. A workshop was also held with the Drugs Task Forces to share learning and information and to assist them in planning their individual campaigns. In addition, many of the Drugs Task Forces already have in place a number of valuable initiatives, including events such as "Awareness Weeks". Such initiatives have proven to be effective as many of them focus on the issues particular to their own localities' (Curran 2009, 4 March).

3.3 Selective prevention in at-risk groups and settings

3.3.1 At-risk groups

Strategies to reduce early school leaving in disadvantaged communities

The NDS 2001–2008 included four actions targeting early school leaving. Action 29 referred to the embedding of the government's DEIS Action Plan (Delivering Equality of Opportunity in Schools), which is aimed at identifying and tackling levels of disadvantage and provides the basis for school supports, in schools in LDTF areas. DEIS incorporates the School Completion Programme, which targets children most at risk of early school leaving, and the Department of Education and Science (DES) has developed a strategy to tackle educational disadvantage and early school leaving in the Traveller community.

There is a lack of information regarding the effectiveness of DEIS in reducing early school leaving in disadvantaged areas, especially in local and regional drugs task force areas (Department of Community Rural and Gaeltacht Affairs 2009). However, recent research by the Economic and Social Research Institute (ESRI) on behalf of Barnardos provide a snapshot of the operation of DEIS and assess the views of stakeholders on its likely effectiveness (Smyth and McCoy 2009). The research was based on interviews with parents, children and principals from DEIS schools, and with key professionals working in the area, and a national postal survey of school principals.

School principals responding to the postal survey highlighted their concerns that the current economic uncertainty is having a direct impact on the children of disadvantaged families by adding to the stress already experienced. This was seen as potentially contributing to higher levels of drug use, and in the long term, unemployment and drug use would lead to higher levels crime.

Regarding the operation and effectiveness of DEIS, respondents had a number of positive remarks to make about the programme. These included the view that by providing additional funding to subsidise a range of measures, including reducing class sizes, emphasising literacy, providing healthy school meals and offering vocational alternatives, the School Completion Programme could yield significant benefits to children and their families in the long run. However, a separate report published by Barnardos, which integrated the findings of the ESRI report, made the point that children attending DEIS schools were already disadvantaged relative to their peers when starting school and that DEIS was not capable of solving all the problems that shaped this disadvantage (Barnardos 2009).

The ESRI report made a useful distinction between DEIS and non-DEIS schools, and in doing so highlights some of the more acute problems that shape and contribute to the socio-economic disadvantage of pupils in DEIS schools. As well as catering for students from disadvantaged backgrounds, DEIS schools have disproportionate numbers of groups of students requiring extra support, including newcomers, Travellers and children with learning disabilities.

This report has been a useful addition to the debate on how to respond to the educational and developmental needs of children in disadvantaged communities. On the one side, as the authors pointed out, the DEIS programme has the advantage of being a targeted intervention delivered in communities that have been identified as having higher than average scores on a number of indices used to assess the extent of disadvantage. This targeted approach can in theory deal with problems more directly than the universal approach.

On the other hand, the evidence in the ESRI report indicated that the problems faced by children attending DEIS schools were so great in number and intensity that the number of families that might benefit from the DEIS programme could be quite small. The authors made the point that concentrating children from socio-economically deprived communities who also have acute learning and behavioural needs in selected schools may lead to an increasing ghettoisation of these schools. Future evaluations of the DEIS programme need to consider both sides of this debate.

A new direction for tackling the mental health needs of young people in Ireland

Headstrong, the National Centre for Youth Mental Health in Ireland, is a non-governmental organisation (NGO) that commenced work in 2006 against a background of national concern about increasing youth suicide rates, youth drug and alcohol abuse, and media coverage of anti-social and high-risk behaviour among youth, which led some to believe that the mental health needs of young people were being neglected. Headstrong commenced a programme of work that included extensive data-collection exercises with youth, service providers and community leaders over a two-year period to understand the nature and scope of the mental health challenges facing young people in Ireland. In addition, a review of national and international research and policy was undertaken to ascertain best practice in working to improve young people's mental health. From this work Headstrong has drawn a number of key conclusions, which are included in its recent report and paraphrased below (Bates *et al.* 2009).

- Every young person has coping capacity and can make their community a better place.
- Young people are assets in a community and should not be viewed in problematic terms.

- The developmental needs of young people in Ireland have been historically and are currently neglected.
- Communities have substantial untapped resources which can be developed without great cost.
- Young people need to be involved in the planning and implementation of policy and practice in all sectors pertaining to their development.
- Communities need assistance to become more scientific and systematic in developing, implementing and monitoring their local plans and strategies around community development.
- The absence of mental illness is not mental health; the absence of problems does not always indicate you are prepared for challenges.
- All young people have mental health needs, not just those in distress or at risk.

Based on these conclusions, Headstrong has developed an innovative support service model called Jigsaw. Headstrong's vision is that Jigsaw will provide a framework of systemic change that will lead to young people being connected to their communities and having the resilience to meet the challenges of their own mental health development. Jigsaw has been formulated using ecological systems theory which considers the ecology of human development and the developing person in relation to the social environment. Thus, Jigsaw is about re-engineering systems of services and supports. The challenge for Headstrong in designing Jigsaw was not just to consider an expansion of current services and supports, but rather to think differently about how to address the unique needs of young people in Ireland. The objective of Jigsaw is systems transformation.

The Headstrong research revealed a clear picture of the core needs that young people must satisfy in order to experience a quality of mental health that will enable them to withstand the social changes that envelop their lives at an apparently increasing rate. These needs are summarised below:

- personal and social development assets, e.g. personal talents, role models and family support;
- capacity to form secure bonds with others;
- social, emotional, cognitive and moral competencies;
- self-determination and self-efficacy;
- positive sense of identity; and
- social and community values and contributions to others.

The research also revealed that young people are not engaging with services; supports and services are inaccessible; and services are inappropriate to the needs of young people.

According to the authors, one of the reasons for the mismatch between the types of services available and what young people want is that there is an almost exclusive focus on specialist services, rather than on the broader range of community-based services and supports that is required. Headstrong's experience has been that many of the resources required to accomplish a more balanced and responsive system already exist in the community. These need to be identified, enhanced, and integrated. Headstrong believes that it is critical to involve young people in the planning process. Young people want respect, confidentiality and a safe, accessible and supportive environment appropriate to their age and needs.

As part of its research programme, Headstrong recently undertook a national baseline survey of adolescent mental health with 1,070 adolescents aged 12–18 years. It plans to extend the scope of its survey to include around 10,000 young people aged 12–25. A preliminary analysis of the data already collected reveals that:

- one in five reported having no one to talk to about their problems, with over 25% reporting that if they had problems with depression, they had no one to turn to;

- nearly one in ten reported having serious problems but did not seek professional help;
- only 64% had an adult they could trust always available to them; this percentage was lower for males (56%) than for females (70%);
- one in five had been in trouble with the police authority. Levels of personal risk behaviour was high in the 14–16-year age category, with one in five drinking weekly (up to 50% monthly), and over one in 10 bingeing weekly (nearly one in three monthly).
- only 40% felt they could cope well with their problems, and over one in three felt they were generally not happy.

Evaluation of work with marginalised youth

The Office of the Minister for Children and Youth Affairs (OMCYA) established an Inclusion Programme in December 2007 aimed at engaging marginalised young people in ‘youth participation structures and processes’. Seven organisations were allocated funding to support such involvement by the young people they represented. An independent evaluation of the first year of the Inclusion Programme has now been published (McEvoy 2009).

The seven participating organisations and the number of participants from each organisation involved in the Inclusion Programme and other youth participation projects are shown in Table 3.3.1. Grants were offered to these organisations so that they could help young people become involved in structures such as the Children and Young People’s Forum (CYPF) and Comhairle na nÓg. These structures provide a mechanism whereby the views of young people can be gathered on issues relevant to them, such as recreation policy and youth cafés.

Table 3.3.1 Number of young people involved in the Inclusion Programme and other youth participation structures, by participating organisation

	Inclusion Programme	Other participation structures	Total
Barnardos	2	0	2
BeLonG To Youth Service (an organisation for lesbian, gay, bisexual and transgendered (LGBT) young people)	1	2	3
Ferns Diocesan Youth Service (FDYS)	37	10	47
Inclusion Ireland (National Association for people with an intellectual disability)	2	0	2
Irish Association of Young People in Care (IAYPIC)	4	0	4
Irish Wheelchair Association (IWA)	12	1	13
Pavee Point (Traveller organisation)	10	5	15
Total	68	18	86

Source: (McEvoy 2009)

Site visits were made to six of the organisations and the evaluator conducted face-to-face interviews and a number of telephone interviews with key stakeholders in all seven organisations, including 21 young people, and 11 adults who were youth leaders, project leaders, steering committee representatives or directors of the organisations. Each organisation submitted two progress reports during the first year of operation.

Sixty-eight young people were involved in projects specifically relating to the Inclusion Programme and a further 18 were involved in other youth participation structures. More than half of the total number is accounted for by the high numbers attending the Ferns Diocesan Youth Service in Wexford. The evaluator stated that the numbers involved were a ‘simple and important criterion’ of success; however, it must be noted that in most cases the numbers were small. This may reflect the ‘bedding down’ time it takes to initiate this type of intervention and to attract marginalised young people.

The young people interviewed identified the benefits of participation in the Inclusion Programme and other youth participation projects in terms of opportunities – to get involved; to have a voice; to make new friends and understand different points of view; to improve personal skills, such as communication, confidence and team working; and to feel a sense of achievement. The evaluation noted that the personal stories of the young people were testament to a programme that was well organised, well supported and meaningful and the ultimate benefit was that young people felt empowered and valued in the projects, as reflected in comments such as: ‘you are not judged on your background’ and ‘people don’t treat you differently’.

The evaluator stated that the achievements of this programme represented progress in a short space of time. However, continued commitment and drive were required from the OMCYA and participating organisations to ensure that young marginalised people continued to benefit from engaging in youth participation structures, and that such structures benefit from integrating the views of young people on issues affecting their lives.

3.3.2 At-risk families

See National Report 2008 for most recent information (Alcohol and Drug Research Unit 2008).

3.3.3 Recreational settings

See National Report 2008 for most recent information (Alcohol and Drug Research Unit 2008).

3.4 Indicated prevention

3.4.1 Children at risk (e.g. children with AD(H)D, children with externalising or internalising disorders)

No new information available

3.5 National and local media campaigns

The Steering Group that drafted the National Drugs Strategy (interim), 2009–2016 (Department of Community Rural and Gaeltacht Affairs 2009) noted the evidence from the evaluation of the national drug awareness campaign mounted between 2003 and 2005 (Sixsmith and Nic Gabhainn 2007), which concluded that stand-alone mass media campaigns were less effective than multi-component, multi-level interventions that reflect the complex nature of drug prevention and harm reduction.

The Steering Group considered that a series of awareness campaigns should be developed that would (para. 3.48):

- ensure that local and regional campaigns complement and add value to national campaigns;
- optimise the use of ICT in drugs awareness initiatives (e.g. through internet search engines and social network websites);
- ensure a co-ordinated approach by all key players to the development and implementation of a designated drug awareness week/day with agreed themes and methodologies; and
- through the engagement with services users, representatives or services working with the following communities, target third-level educational institutions, workplaces and recreational venues; at-risk groups (Travellers, new communities, lesbian, gay, bi-sexual, transgender community (LGBTs), homeless people, prisoners and sex workers); and education/awareness among drug users to minimise the levels of usage and to promote harm reduction measures.

4. Problem Drug Use (PDU)

4.1 Introduction

This chapter provides an overview of developments and trends in the prevalence and characteristics of problem drug use in Ireland ranging from data for 2006 relating to the prevalence and incidence estimates of PDUs, to more recent studies relating to data on problem drug users from non-treatment sources and on varieties of problematic drug use.

It is not possible to estimate the number of injecting drug users or problem cocaine users in Ireland as the National Drug Treatment Reporting System (NDTRS) does not have a unique identifier and this is the most reliable source of such data. This issue has been raised in a number of strategy submissions and it is hoped that this issue will be addressed in the forthcoming health information bill. A national 3-source capture-recapture study, to provide statistically valid estimates on the prevalence of opiate drug use in the national population during 2006, was commissioned by the National Advisory Committee on Drugs (NACD). The three data sources used in the study were the Central (methadone) Treatment List (CTL), the Hospital In-Patient Enquiry (HIPE) database and Garda PULSE data. The findings were published in 2009 (Kelly, A. *et al.* 2009); they update a similar study for 2000–2001 (Kelly *et al.* 2003), which, in turn, update a Dublin-only study for the year 1996 (Comiskey, C.M. 1998). The new study indicates that use has increased since the previous survey.

The National Registry of Deliberate Self Harm is a national system of population monitoring for the occurrence of deliberate self harm. It was established, at the request of the Department of Health and Children, by the National Suicide Research Foundation. Reported on Section 6.3.1 below is the sixth annual report from the National Registry of Deliberate Self Harm, based on data collected on persons presenting to hospital emergency departments as a result of deliberate self harm in 2006 and 2007 in the Republic of Ireland. The Registry had near complete coverage of the country's hospitals for the period 2002-2005. In 2006-2007, for the first time, all general hospital and paediatric hospital emergency departments in the Republic of Ireland contributed data to the Registry. Thus, for 2006-2007 the Registry achieved complete national coverage of hospital-treated deliberate self harm.

The Registry defines deliberate self harm as: 'an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences'. All methods of deliberate self harm are recorded in the Registry, including drug overdoses and alcohol overdoses, where it is clear that the self harm was intentionally inflicted. All individuals who are alive on admission to hospital following a deliberate self harm act are included. Not considered to be cases of deliberate self harm are, among other things, accidental overdoses, e.g. an individual who takes additional medication in the case of illness, without any intention to self harm; alcohol overdoses alone where the intention was not to self harm; accidental overdoses of street drugs, i.e. drugs used for recreational purposes, without the intention to self harm; and individuals who are dead on arrival at hospital as a result of suicide.

The EMCDDA (2004) defines PDU as 'injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines'.

4.2 Prevalence and incidence estimates of PDU

4.2.1 Indirect estimates of PDU

Estimation of the numbers of problem opiate user in Ireland using capture-recapture

In 2006 Dr Alan Kelly and colleagues in Trinity College Dublin (TCD), on behalf of the National Advisory Committee on Drugs (NACD), repeated the three-source capture-recapture study undertaken in 2000–2001 (Kelly *et al.* 2003) (Kelly, A. *et al.* 2009). The three data sources employed to generate the estimate were the Central (methadone) Treatment List (CTL), Hospital In-Patient Enquiry (HIPE) Scheme and Garda PULSE data.

The three sources of data indicated that there were 11,807 opiate users aged 15–64 years known to services in Ireland in 2006 and an estimated 8,943 users not known to the services (hidden population) (Table 4.2.1). The estimate indicated that there were between 18,136 and 23,576 problem opiate users in Ireland in 2006; the point estimate was 20,790 (Table 4.2.2). Twenty-eight per cent (5,886) resided outside Dublin and 72% (14,904) resided in Dublin (Table 4.2.3). The authors reported that the estimate was likely to be inflated because the population was not closed, that is, it continued to recruit people into treatment (in Dublin and outside Dublin) and police custody (outside Dublin). In addition, the overlap between the three population sources was small. These two factors are known to inflate estimates obtained through the capture-recapture method. The respective population rates for Dublin and the Rest of Ireland are 17.6 per 1,000 and 2.9 per 1,000.

The point estimate for Ireland has increased by 44%, from 14,452 in 2001 to 20,790 in 2006. The point estimate for Dublin increased by 21% while the point estimate for the rest of Ireland (excluding Dublin) increased by 164%; of note, the estimate of opiate users living outside Dublin was relatively small in 2001. In Dublin, the rate of opiate use per 1,000 of the 15–24 year old population decreased by 62%, from 18.7 in 2001 to 7.2 in 2006 and this indicates that the number of younger people commencing opiate use has decreased. The rate of opiate use per 1,000 of the 15–64 year old population residing outside Dublin increased from 0.5 in 2001 to 1.5 in 2006 and this indicates that opiate use has increased outside Dublin. In an unpublished study, Kelly and colleagues report that retaining opiate users in treatment reduces their likelihood of being in contact with the gardaí (Dr A. Kelly, personal communication, 2009). For example, only 12% of males aged 25–34 years who were attending treatment services between 2001 and 2006 and known to the gardaí in 2001 continued committing crime in 2006. This is in line with findings from the ROSIE study and indicates that methadone treatment reduces the incidence of crime. The detailed results are presented in Standard Table 7.

Table 4.2.1 Number of known opiate users, estimated hidden number, prevalence estimate and population rate in Ireland, in Dublin and in the Rest of Ireland, 2006

	Age group	Known number	Estimated hidden number	Estimated prevalence	Rate/1,000 population
Ireland	15–64	11807	8983	20790	7.2
Dublin	15–64	9442	5462	14904	17.6
Rest of Ireland	15–64	2365	3521	5886	2.9

Source: Unpublished data from Kelly *et al.* 2009, TCD.

Table 4.2.2 Estimated prevalence of opiate use in Ireland, in Dublin, and in the rest of Ireland, 2001 and 2006

	2001				2006			
	Estimate	Lower bound	Upper bound	Rate/1000 population	Estimate	Lower bound	Upper bound	Rate/1000 population
Ireland	14493	13453	16336	5.6	20790	18136	23576	7.2
Dublin	12268	11519	13711	15.9	14904	13737	16450	17.6
Rest of Ireland	2225	1934	2625	1.2	5886	4399	7126	2.9

Source: (Kelly *et al.* 2003) and unpublished data from Kelly *et al.* 2009, TCD. Numbers using the summative method

In 2006, 28% (5,886) resided outside Dublin and 72% (14,904) resided in Dublin (Table 4.2.3). Seventy-one per cent were male. One in five was between 15 and 24 years old and half were between 25 and 34 years old.

Table 4.2.3 Prevalence estimate of opiate users by age, gender and place of residence, 2006

Gender	Age group	Ireland	Dublin	Rest of Ireland
All	15–64	20790	14904	5886
Males	15–64	14787	10395	4392
	15–24	3150	1892	1258
	25–34	7238	5172	2066
	35–64	4399	3331	1068
Females	15–64	6003	4509	1494
	15–24	1159	701	458
	25–34	3298	2605	693
	35–64	1546	1203	343

Source: Unpublished data from Kelly et al. 2009, TCD.

The prevalence rate for men 15 to 24 years old in Ireland was relatively stable in 2006 compared to 2001 while the prevalence rates for older men increased (Table 4.2.4). This indicates that the rate of entry by men to opiate use may have stabilised though the overall rate of opiate use has increased. It is important to note that opiate dependence is a chronic condition.

Table 4.2.4 Prevalence estimates and rates of opiate users for males by age, 2001 and 2006

Region	Age band	Prevalence estimates		Rate/1,000 population	
		2001	2006	2001	2006
Ireland	15–24	3194	3150	9.5	9.8
	25–34	4376	7238	14.7	19.7
	35–64	2228	4399	3.3	5.6
Dublin	15–24	2735	1892	29.3	19.9
	25–34	3740	5172	36.3	43.0
	35–64	1803	3331	9.9	16.3
Rest of Ireland ^a	15–24	N/A	1258	N/A	5.6
	25–34	N/A	2066	N/A	8.4
	35–64	N/A	1068	N/A	1.8
	15–64	1688	4392	1.8	4.2

^a In 2001 there were insufficient numbers outside of Dublin to provide reliable estimates by individual age bands. Source: (Kelly et al. 2003) unpublished data from Kelly et al. 2009, TCD.

The prevalence rate for women 15 to 24 years old in Ireland decreased in 2006 compared to 2001 while the prevalence rates for the older women increased. This indicates that the rate of entry by women to opiate use may have decreased (Table 4.2.5).

Table 4.2.5 Prevalence estimates and rates of opiate users for females by age, 2001 and 2006

Region	Age band	Prevalence estimates		Rate/1000 population	
		2001	2006	2001	2006
Ireland	15–24	1999	1159	6.2	3.7
	25–34	1941	3298	6.6	9.3
	35–64	714	1546	1.1	2.0
Dublin	15–24	1766	701	18.7	7.2
	25–34	1784	2605	16.2	21.9
	35–64	628	1203	3.2	5.7
Rest of Ireland ^a	15–24	N/A	458	N/A	2.1
	25–34	N/A	693	N/A	2.9
	35–64	N/A	343	N/A	0.6
	15–64	537	1494	0.6	1.5

^a In 2001 there was insufficient numbers outside of Dublin to provide reliable estimates by individual age bands. Source: (Kelly et al. 2003) and unpublished data from Kelly et al. 2009, TCD.

4.2.2 Estimates of incidence of problem drug use

There are no estimates of the incidence of problem drug use in Ireland.

4.3 Data on PDU from non-treatment sources (police, emergency, needle exchange)

4.3.1 Description of clients attending harm reduction

There is up-to-date national data on drug users attending needle exchanges (Robinson *et al.* 2008). This is presented in standard table 10 and structured questionnaire 23. Overall, between 10% and 30% of clients attending needle exchanges were female in 2007. The youngest clients were aged between 16 and 20 years. Twenty-five services were open to any person aged over 18; five of these also dealt with 16–18-year-olds. Two services catered for women and sex workers; two served residents only; and two operated specific services for ethnic minorities. Twenty-nine services reported that a significant minority of their clients were homeless.

Twenty-nine services reported heroin as the drug most commonly used by clients; 18 services reported cocaine as the most common. As expected, injecting was the most common route of administration (reported by 19 services). Benzodiazepine injecting was reported as a common practice by 11 services. Nineteen services reported that clients attending their service injected steroids.

4.3.2 National Registry of Deliberate Self-Harm annual report 2008

The seventh annual report from the National Registry of Deliberate Self Harm was published in July 2009 (National Registry of Deliberate Self Harm Ireland 2009). According to the report there were 11,700 presentations of deliberate self-harm, involving 9,218 individuals, to hospital A&E departments in 2008. Reviewing data collected by the Registry for the six-year period 2002–2007, the report indicated that the rate of presentation of deliberate self-harm was relatively stable. However, a 6% increase was noted in the national person-based rate of deliberate self-harm, from 188 per 100,000 in 2007 to 200 per 100,000 in 2008.

The biggest rise in deliberate self-harm was observed in men, an increase of 11% from 2007, resulting in the highest rate since the Registry was established in 2002. Men represented 45% of deliberate self-harm episodes in 2008 and women accounted for 55%.

Concordant with previous reports, deliberate self-harm was largely confined to the younger age groups. Almost half of all presentations (46.5%) were by people aged less than 30 years. The peak age range for females and males presenting was the same as previous reports at 15–19 years for females and 20–24 years for males. The report showed an increase in the number of persons presenting with deliberate self-harm aged 10–14 years.

Rates were higher in urban settings, with the highest rate (17%) in Dublin North East Hospital Group. The number of deliberate self-harm presentations was highest on Mondays and Sundays, accounting for one in three of all presentations. Over 40% of the total number of presentations were made between the hours of 8pm and 3am.

Repetition of deliberate self-harm accounted more than one in five (21%) of all presentations in 2008 and the highest proportion of repeated acts was among the 30–40 years age group.

Drug overdose was the most common form of deliberate self-harm, representing 72% of all such episodes reported in 2008. Overdose rates were higher among females (79%) than among males (64%). On average, at least 31 tablets were taken in episodes of drug overdose. The total number of tablets taken was known in 74% of cases. Forty-one per cent of all drug overdoses involved a minor tranquilliser, 23% involved paracetamol-containing medicines and 22% involved anti-depressants/mood stabilisers. According to the report, although the analgesic, distalgesic, was withdrawn

from the Irish market in January 2005, distalgesic was involved in 29 cases of deliberate self-harm in 2008, this compared to approximately 400 cases reported annually between 2002 and 2005.

There was evidence of alcohol consumption in 42% of all episodes of deliberate self-harm, emphasising the strong association between alcohol consumption and suicidal behaviour. Illicit drugs such as cocaine and heroin were involved in 3.8% of all overdose acts.

Attempted hanging was more often used as a method of deliberate self-harm in 2008 than in previous years, accounting for 16% of all self-harm acts in the 10–14 years age group. Self-cutting was the only other method of deliberate self-harm, representing 21% of all episodes, and was more common among males (25%) than among females (18%).

The emergency department was the only treatment setting for more than half (57%) of all deliberate self-harm patients, that is, they did not proceed to further treatment.

The report recommended the following measures to reduce the incidence of deliberate self-harm:

- continued support for the national mental health awareness campaign and evidence-based mental health promotion initiatives and implementation of more intensified prevention and intervention programmes at national level;
- development and implementation of initiatives to increase awareness of mental health issues among the general public and service providers supporting the unemployed or people experiencing financial difficulties;
- development of a system to enable deliberate self-harm data to be linked with suicide mortality data to improve the understanding of risk factors associated with suicide;
- prioritisation of evidence-based mental health programmes for children and adolescents in addition to specialist mental health services;
- development of more uniform assessment procedures and evidence-based interventions targeting people who repeatedly self-harm;
- restriction or withdrawal from the market of highly lethal drugs; and
- confirmation of the effectiveness of interventions such as cognitive behavioural and problem-solving treatments among men presenting with deliberate self-harm.

4.4 Intensive, frequent, long-term and other problematic forms of use

4.4.1 Description of the forms of use falling outside the EMCDDA's PDU definition (in vulnerable groups)

Drug-using sex workers

A large-scale qualitative study has highlighted the need for adequately-resourced support structures to reduce the risk of harm to drug-using sex workers in Ireland. The first of its kind, this study by the NACD (Cox and Whitaker 2009) explored the local risk environment within which drug-using sex workers in Dublin live and work. The authors concluded that wider social and situational factors, such as poverty, housing, health, educational needs and employment prospects are as fundamental to reducing risk of harm in this vulnerable group as addressing drug use.

In-depth interviews were conducted with 35 drug users currently or formerly engaged in sex work, and biographical, drug use and offending behaviour data were collected by means of brief questionnaires. In addition, interviews were held with 40 professionals across community, voluntary and statutory sectors whose work either directly or indirectly impacted on drug-using sex workers. This intensive, qualitative approach

revealed that there was a range of behaviours associated with drug use and its accompanying lifestyle which placed individuals at particular risk of harm.

For the most part, participants in the study grew up in communities associated with social and economic marginalisation and high levels of unemployment. They moved more or less continuously through drug and alcohol services, homeless hostels, the judicial system and other social care agencies. Participants used a range of strategies to reduce danger, yet their perception of risk was relative to their situation, thus leading them to treat some risks as acceptable or necessary. Current harm reduction interventions tend to focus on individual risk behaviour, often overlooking the wider social contexts in which members of this group live and work.

Arising from analysis of the research, the NACD recommended:

- continued and adequate funding of existing services that deal with this client group; expansion of outreach services (particularly out of hours) to target existing and developing street sex markets, and development of peer outreach to areas of the city with known networks of drug-using sex workers;
- continued funding of programmes (such as specialist Community Employment (CE) schemes for drug users) aimed at getting drug users back to work;
- provision of flexible hostel accommodation for drug-using sex workers who are homeless, ranging from low-threshold facilities to accommodation that assists recovery and rehabilitation;
- recognition of the role of drug services in identifying male and female clients involved in sex work and in providing advice on safer sex practices in order to reduce sexual risk in personal intimate relationships and commercial sex transactions.

In terms of policy, the authors recommended that 'harm reduction be explicitly stated as a guiding principle of the new National Drugs Strategy' (p.26), and that the strategy must also outline a continuum of harm-reduction activities, a 'model package' of interventions, minimum standards for services and optimal levels of service coverage.

Drug tests in Irish prisons

Information on drug testing in prisons in 2008 was obtained from the Irish Prison Service. These data indicated that more than 20,000 voluntary tests were carried out to monitor drug use and responses to treatment. These tests included those carried out on committals (new entries) as well as those carried out on existing inmates. It may be assumed therefore that some of the positive test results related to drugs or alcohol consumed outside the prison. Between one-third and one-half of those screened tested positive for at least one drug. The common metabolites detected indicated use of cannabis, benzodiazepines and opiates (Table 4.4.1). It is not clear whether the numbers of positive cases excluded prisoners who were prescribed benzodiazepines; if they do not, these figures overstate the extent of unregulated use of benzodiazepine in prisons. Cocaine and alcohol were detected in a small number of tests. The profile of positive opiate and benzodiazepine tests indicated moderate use of such drugs among prisoners tested in Mountjoy, Wheatfield, Limerick, Midland and Cloverhill prisons. The proportion of positive tests was low in St Patrick's Institution and in Castlerea and Cork prisons. It would be useful if the test results of prisoners who were tested at committal interview could be removed from this analysis, as this would provide a more accurate assessment of drug use in Irish prisons.

proportion of intravenous users made a transition from injecting powder cocaine to smoking crack cocaine because of the physical harms of injecting. Frequency of use ranged from daily to weekly and was largely dependent on financial resources.

The north inner city was the primary crack market in Dublin; the market was dominated by non-Irish national dealers who imported small amounts of cocaine via couriers. However, a growing number of Irish dealers were reported to be involved in the distribution of crack throughout the Dublin region, and prepared crack had been available throughout the city since 2006. Findings indicated that the crack market was a closed market, meaning dealers did not sell to strangers, exchanges were arranged using mobile phones, and buyers were directed to exchange points outside the inner city. The price of crack was relatively stable and uniform, with prepared quantities or 'rocks' being sold for €50 or €100. Crack houses were reported as locations where crack was used and in some cases prepared in exchange for free crack; they were not reported as venues for crack dealing or as sites for sex work.

A high proportion of crack users were homeless, unemployed and did not have formal educational qualifications. According to data from treatment services, the majority of crack users were male and half were aged between 20 and 29 years. However, females involved in sex work and single mothers were reported to develop the most chaotic addiction. Common physical side-effects of crack use are breathing problems, heart problems and rapid weight loss, and the most common psychological consequences are paranoia, aggressiveness and depression. Compulsive crack users reported neglecting their children, often diverting their financial resources towards buying crack. Shoplifting, burglary and robbery were reported as means of supporting the crack cocaine habit. Service providers reported an increase in the numbers of women returning to or beginning sex work to fund their crack use.

Identifying new drugs and new drug trends with the help of drug helplines

In July 2009 the European Foundation of Drug Helplines (FESAT) published the results from the 15th (Evenepoel 2009b) and 16th data collections for its monitoring project (Evenepoel 2009a). Since the beginning of 2001 FESAT has been collecting information every six months on the types of person contacting helplines, the content of these calls and how this has changed compared to the previous six months. According to the author, the main objective of this monitoring is to identify the emergence of new drugs and new drug trends; the data cannot quantify the size of any such changes.

Of the 34 relevant FESAT helplines, 14 helplines in 11 countries, including Ireland, participated in the project in the first half of 2008. This article outlines some of the main changes reported for the first half of 2008 when compared to the second half of 2007, and presents some unpublished information from the Drugs/HIV Helpline in Ireland.

The smallest of the 14 participating helplines in Europe answered less than one call per day, and the largest, more than 60 calls per day. Seven helplines answered 10 calls or fewer per day; six helplines answered 11 to 30 calls; one helpline answered 31 to 60 calls and one helpline answered 61 or more calls. Half of the helplines answered 13 or more calls per day. The Drugs/HIV Helpline in Ireland answered an average of 14 calls per working day, though this figure included calls about sexual health. There were 1,805 calls between January and June 2008, which represented an 8% decrease when compared to the preceding six-month period. This decrease was expected owing to the fact that there was an increase in the number of calls during the pharmacy strike in October 2007 (Aileen Dooley, personal communication, 2009).

The FESAT report noted a decline in the numbers of helplines reporting calls about crack (9 helplines), heroin (6 helplines), ecstasy (6 helplines), cocaine (4 helplines) and hash (4 helplines) across Europe in the first half of 2008 when compared to the second half of 2007, and an increase in the number of helplines reporting calls about alcohol (10 helplines), medications (other than opiates and benzodiazepines) (7 helplines) and

benzodiazepines (4 helplines). There were mixed reports about cocaine and cannabis across Europe, with some helplines reporting increases and some reporting decreases.

In Ireland, there were large decreases in the number of calls to the Drugs/HIV Helpline about hashish and painkillers containing opiates in the first half of 2008 when compared to the second half of 2007. There were large increases in the number of calls about alcohol, cocaine, ecstasy and smoking heroin (Aileen Dooley, personal communication, 2009).

During the first half of 2008, a number of helplines in Europe received calls about drugs that had not been reported to them before. Helplines in Belgium and in Germany reported calls about the 'spice' products which are used to induce the same effect as cannabis. A helpline in Belgium received calls about 'space shuttles', which are in the form of mushrooms or herbs. A helpline in Norway received its first call about mescaline, a hallucinogenic drug.

5. Drug-related Treatment: treatment demand and treatment availability

5.1 Introduction

Two broad philosophies underlie the approaches to treatment: medication-free therapy and medication-assisted treatment. 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 acupuncture, are provided through some community projects.

On 1 January 2005, the 10 health boards managing the health services in Ireland were replaced by a single entity, the Health Service Executive (HSE), which manages Ireland's public health sector. The HSE's Addiction Services, including both illicit drugs and alcohol, are delivered through Social Inclusion Services, which is part of the Primary, Community and Continuing Care (PCCC) directorate. Treatment is provided through a network of statutory and non-statutory agencies.

In 1998, the same year as the CTL was established, a Methadone Treatment Protocol (MTP) was introduced. Prior to the introduction of the MTP only a small number of GPs were prescribing methadone. This resulted in a large number of drug misusers travelling long distances from all parts of Dublin in search of methadone. This affected the communities in which the prescribing GPs practised. There was also anecdotal evidence that a large quantity of methadone and physeptone was available for sale on the black market. The MTP was to ensure that treatment for opiate misuse could be provided wherever the demand existed. Locally-based methadone treatment for opiate misusers is now provided through drug treatment clinics, satellite clinics or through general practitioners in the community.

Under the MTP general practitioners are contracted to provide methadone treatment at one of two levels – Level 1 or Level 2. Level 1 qualification under the programme allows GPs to maintain methadone treatment for misusers who have previously been stabilised on a methadone maintenance programme. Each GP qualified at this level is permitted to treat a maximum of 15 stabilised misusers. Level 2 qualification allows GPs both to initiate and maintain methadone treatment. Each GP qualified at this level may treat up to a maximum of 35 misusers. Practices where two qualified level 2 GPs are practicing are permitted under the protocol to treat a maximum of 50 misusers.

Under the Community Pharmacy Contractor Agreement the HSE can agree with individual pharmacies to dispense methadone mixture DTF1mg/ml to opiate dependent persons in their local areas on a special methadone prescription form. The involvement of the community pharmacists in the dispensing of methadone also ensures that a large number of opiate dependent persons may be treated in their own local area.

National data collection tools

The National Drug Treatment Reporting System (NDTRS) is a national epidemiological database which provides data on treated drug and alcohol misuse in Ireland. The NDTRS collects data from both public and private outpatient services, inpatient specialised residential centres and low-threshold services. For the purposes 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 substance misuse problems'. The NDTRS is a case-based, anonymised database. The NDTRS is co-ordinated by staff at the Alcohol and Drug Research Unit (ADRU) of the Health

Research Board (HRB) on behalf of the Department of Health and Children. Significant improvements in the NDTRS's data collection processes and procedures mean that the HRB is now able to report on the information collected from treatment centres on a more regular basis. The number of drug treatment services participating in the NDTRS continues to increase (Standard Table TDI 34). Although treatment is provided within the Irish Prison Service, it was only in 2009 that counsellors working in the prison service began to return information to the NDTRS.

The Central Treatment List (CTL) was established under Statutory Instrument No 225 following the *Report of the Methadone Treatment Services Review Group 1998* (Methadone Treatment Services Review Group 1998). This list is administered by the Drug Treatment Centre Board on behalf of the HSE and is a complete register of all patients receiving methadone (for treatment of opiate misuse) in Ireland and provides all data on methadone treatment nationally.

The Research Outcome Study in Ireland (ROSIE) was the first prospective study of treatment outcomes for opiate users to be conducted in Ireland. The objective was to evaluate the effectiveness of treatment and other intervention strategies for opiate use. The study recruited 404 opiate users entering treatment between September 2003 and June 2004. Three treatment modalities, provided through both inpatient and outpatient settings, were the focus of attention – methadone maintenance, structured detoxification, and abstinence-based treatment programmes. In addition, a sub-sample of individuals was recruited from needle exchange interventions. Participants were interviewed at treatment intake, or as soon as possible thereafter, and again at 6 months, 12 months and 3 years after the baseline interview. Data were collected by means of a structured interview. The interview instrument contained a comprehensive set of outcome measures detailing the social and psychological characteristics of the cohort, and a range of treatment process factors in relation to treatment outcomes. Between September 2006 and October 2008 seven papers in the ROSIE Findings series, concentrating on particular aspects of the study, were published; in June 2009 a report on outcomes at 1-year and 3 years for the whole population and the 'per protocol' population, i.e. participants who completed all three interviews, was published (Comiskey, Catherine M *et al.* 2009).

5.2 Strategy/policy

5.2.1 Plans for drug and alcohol services in Ireland in 2009

The Health Service Executive's National Service Plan 2009 (NSP) contains the agency's plans in the drugs and alcohol area during 2009 (Health Service Executive 2008). Table 5.2.1 summarises the key result areas for 2009 together with the outputs delivered in 2008 and the deliverables for 2009.

'Key result areas' are a new element in the HSE's annual service plan. They have resulted in a rationalisation and reduction in the number of action lines in the addiction services area. Just three key result areas are identified: enhancement of addiction services, development of the new National Drugs Strategy, and the and supporting the drugs task forces model.

Table 5.2.1 Addiction Services in 2009

Key result area	Output 2008	Deliverable 2009
Enhancement of addiction services (Progress implementation of the recommendations of the 2007 report of the Working Group on Drugs Rehabilitation)	Regional addiction plans developed	Further development of multi-disciplinary teams for provision of services to under-18 year-olds. This will facilitate the further development of harm reduction services, including needle exchange and methadone services.
	Recruitment of Rehabilitation Co-ordinator under way	
	Development of National Rehabilitation Implementation Committee under way	Implementation of the Rehabilitation Strategy (to include appointment of co-ordinator) Addiction services training programme

Key result area	Output 2008	Deliverable 2009
Development of new National Drugs Strategy (NDS)	HSE / Department of Health and Children submission to NDS review.	Planning undertaken for implementation of HSE components of the new National Drugs Strategy 2009 – 2013
National Drugs Task Force	Mainstreaming process agreed with the Departments of Community, Rural and Gaeltacht Affairs and Health and Children	Progression of mainstreaming of 169 local drugs task forces (LDTFs) as appropriate, starting from April onwards.

Source: (Health Service Executive 2008)

The performance information framework used in the HSE has also been refined. In the addiction services area, one measure of ‘activity’ and two indicators of ‘performance’ have been identified. The figures indicate that, nationally, the level of activity in the addiction services area increased in 2008 and this new level is due to be maintained in 2009, but the level of performance is expected to remain static at 2007 levels. The 2009 performance target for treatment of substance misusers aged under 18 is based on baseline data collected in 2008.

Activity – the average number of clients in methadone treatment per month per area: In 2008 the national target was to maintain throughput at the 2007 level of 7,000 clients. In the event, throughput in 2008 reached 7,636 and the HSE expects to reach this level of activity again in 2009.

Performance – the number and percentage of substance misusers for whom treatment, as deemed appropriate, commenced within one calendar month: In 2008 the national target was to exceed the 84% (n=1,406) performance level achieved in 2007. In the event, the 2007 level was attained but not exceeded, and this same level of 84% has been set as the target for 2009.

Performance – the number of substance misusers under 18 years of age for whom treatment, as deemed appropriate, commenced within one calendar month: No target was set for this indicator in 2008 as the staff to develop services for under-18s were only appointed during 2008. However, data collected in 2008 showed that 88% (n=106) of substance misusers under the age of 18 commenced suitable treatment within a calendar month. This performance level has been set as the target for 2009.

The breakdown of performance by HSE region, also published in the plan, reveals variations, with the regions around Dublin performing below par. Regarding commencement of treatment for substance misusers in 2008, the Southern Region exceeded the national target by over 10% at 96% (n=547), while the combined Dublin/North East and Dublin/Mid-Leinster regions only achieved a performance level of 64% (n=510). Regarding commencement of treatment for under-18s, the target timeframe of one calendar month was achieved 100% by both the Southern (n=53) and Western (n=30) regions, but the combined Dublin/North East and Dublin/Mid-Leinster regions only achieved a level of 62% (n=23). These regional performance targets have been rolled over for 2009.

Under the heading of ‘Improving our infrastructure’, the service plan lists two capital works in the Dublin/Mid-Leinster Region, which, it states, are to be commissioned and in place before the end of 2009 and which can be funded within the HSE’s 2009 allocation:

- Clondalkin: new purpose-built addiction centre providing psychiatry, GP, counselling, pharmacy, nursing, psychology and family therapy services; and
- Pearse Street: refurbishment and upgrade of the Drug Treatment Centre.

5.2.2 RDTF strategies and treatment

An assessment of treatment needs in the North Eastern Regional Drugs Task Force Area

The North Eastern Regional Drugs Task Force (NERDTF) commissioned a needs assessment study in order to:

- assess the number and profile of drug-users;
- assess in-patient and out-patient drug treatment services;
- explore needs of drug treatment service users and their families;
- identify gaps in service provision; and
- make recommendations for future service development and resources required.

The study examined available quantitative data and also carried out qualitative interviews with a wide range of stakeholders, including staff working in addiction services, community and voluntary groups, drug users and family support groups (Watters 2008). The NERDTF covers the counties of Louth, Meath, Cavan and Monaghan. The main results are summarised below.

The study found that drug use in the region had increased in recent years. National prevalence data showed that almost one in four people in the region reported using an illicit drug at some point in their life, and one in three in the 15–34-year age group.

The report did not include all data available at the time from the NDTRS; Table 5.2.2 presents the complete figures for 2001 to 2006, showing a 27% increase in the total number of cases over the six years. This was mainly due to the increase in new cases seeking treatment.

Table 5.2.2 Number (%) of cases entering treatment in the former North Eastern Health Board area, 2001–2006

	2001	2002	2003	2004	2005	2006
All cases	370	306	387	374	365	471
Previously treated cases	125 (33.8)	99 (32.4)	146 (37.7)	130 (34.8)	125 (34.2)	149 (31.6)
New cases	221 (59.7)	186 (60.1)	229 (59.2)	236 (63.1)	224 (61.4)	303 (64.3)
Treatment status unknown	24 (6.5)	21 (6.9)	12 (3.1)	8 (2.1)	16 (4.4)	19 (4.0)

Source: (Reynolds *et al.* 2008)

According to the NDTRS, the incidence of treated drug use in the region for 2001–2006 was 91.3 per 100,000, an increase on the 1998–2002 rate of 50.1 per 100,000.

The main problem drugs identified by the study were cocaine, cannabis, alcohol, heroin and prescription drugs. The main problem drugs among those entering treatment between 2001 and 2006 were cannabis (54%), opiates (27%) and cocaine (10%).

Most of the respondents interviewed felt that drug use was a growing problem in the region. Other issues raised included the normalisation of cannabis use to the point where it was considered equivalent to consuming alcohol. Heroin use was associated with social deprivation and rural areas, while cocaine was perceived as being used by all social classes, with use starting in the late teens. Increased polydrug use was also commented on. Increased consumption of alcohol by teenagers was reported.

The report noted that services varied in type, quality and availability throughout the region. There was a range of outpatient services, but no dedicated inpatient facility for drug treatment and detoxification. Underdevelopment of the services was suggested as a factor in some of the weaknesses in service provision. Other issues raised included insufficient staff resources in HSE Addiction Services, limited collaboration between statutory and voluntary services, lack of a clear focus on polydrug use and lengthy waiting lists.

Recommendations of the report are summarised below:

- provide services for residential detoxification, out-of-hours treatment, crisis and early intervention, and treatment for under-18s;
- provide clear access pathways and accessible information on the types of service and treatment available;
- move to a continuity of care model, with a case management approach, and systems to monitor progress and outcomes;
- widen the scope of treatment services to cover holistic care for the client and their family, and improve the support services;
- develop a set of standards/guidelines to improve the appropriateness/location of services;
- adjust treatment approaches to respond to polydrug use, including alcohol, and increase harm reduction approaches, including needle exchange, health education and easy access to low-threshold treatment;
- improve collaboration and communication between statutory and community services.

Launch of Dublin 12 Local Drugs Task Force strategic plan

The Minister of State with responsibility for drugs strategy, John Curran TD, launched the Dublin 12 Local Drugs Task Force Strategic Plan 2009–2013 on 12 May 2009 (Dublin 12 Local Drugs Task Force 2009). The launch was followed by workshops on a number of themes, including the availability of treatment, rehabilitation, education and prevention initiatives, and families dealing with drug issues. The plan was the product of extensive consultation with stakeholders in the catchment areas of Crumlin, Drimnagh, Kimmage and Walkinstown. Specific aims and objectives in the new strategy include:

- Treatment – continue to develop the cross-task force harm reduction/needle exchange service and increase collaboration between drug treatment and alcohol services.
- Rehabilitation – lobby for a rehabilitation/integration service (RIS) and increased rehabilitation options, and develop forums and networks such as the D12 Service Users Forum.
- Education – consolidate and develop interventions aimed at young people at risk, develop links with schools and provide accredited addiction studies courses locally.
- Supply control – work towards implementing initiatives such as the Joint Policing Committees and the Dial to Stop Drug Dealing campaign, and develop the Community Safety Partnership with the gardaí and other community stakeholders.
- Research – strengthen data collection systems, commission local research to inform service planning, and participate in national-level studies.
- Family support – re-establish family support groups and support the development of childcare facilities for drug-using families.
- Alcohol – develop a plan to address alcohol misuse, identify local alcohol services and form stronger relationships with them.

5.3 Treatment systems

5.3.1 Organisation and quality assurance

Audit of drug treatment in Ireland

The Comptroller and Auditor General (CAG) published a report entitled Drug treatment and rehabilitation on 6 June 2009 (Comptroller and Auditor General and Department of Community Rural and Gaeltacht Affairs 2009). The drug treatment services examined in this report were those caring for people with addiction to illegal drugs (mainly cannabis, cocaine, ecstasy and heroin). The report reviewed:

- the extent to which the demand for drug treatment and rehabilitation services was being met;
- the timeliness of access to drug treatment;

- the extent to which the effectiveness of drug treatment and rehabilitation services was evaluated; and
- the effectiveness of the arrangements for co-ordination of drug treatment and rehabilitation at an individual case level, and nationally.

Treatment for problem opiate use

It has been estimated that there were between 12,884 and 15,883 problem opiate (mainly heroin) users in Ireland in 2001. Up to 2000, opiate use was concentrated in the greater Dublin area, but at the time of this report there was evidence that it had spread throughout the country. Methadone substitution treatment is the main form of treatment for opiate addiction in Ireland. At the end of 2007, just over 8,000 people were receiving methadone treatment. Around one-third of those receiving methadone treatment were cared for by private general practitioners. Needle-exchange services were provided in some areas, with the aim of reducing the risks associated with the sharing of injecting equipment. According to this report, there was some increase in the provision of needle-exchange services between 2001 and 2009, but gaps in service provision remained. The authors reported that in the period under review the numbers of opiate users who received detoxification treatment and the numbers who attended follow-on rehabilitation treatment were very low when compared with the numbers who received methadone treatment. They estimated that the extent of detoxification treatment provision was in the region of 100 courses of treatment per year. While the authors acknowledged that long-term methadone maintenance is likely to be the best outcome that can be achieved for a significant proportion of opiate users, they suggested that the HSE set targets for rates of progression through the various forms of treatment.

Treatment for problem drug use (excluding opiates)

The prevalence of cannabis and cocaine use among the general population increased between 2002/3 and 2006/7. The authors assumed that the habitual use of a number of other drugs was also on the increase between the two surveys. The authors reported that, despite this, there did not appear to have been a commensurate increase in the number of cases treated for problem use of cannabis over the life of the National Drugs Strategy 2001–2008. The findings of the review indicated that changes in the pattern of drug misuse (e.g. heroin addiction outside of Dublin and cocaine addiction in Dublin) created a challenge that service providers and planners found difficult to address. The review noted that many clients reported multiple addictions. The current pattern of drug use suggested that there were, in effect, two separate client groups for whom drug treatment needed to be provided:

- those with a largely opiate-based addiction problem, with more than three in five reporting multiple drug use, and concentrated in certain marginalised and poor sectors of society; and
- those with problem use of drugs such as cannabis, cocaine or ecstasy, spread more widely across social groups and geographic areas.

Although the prevalence of illegal drugs such as cannabis and cocaine was higher in Dublin than in the rest of the country, the rate at which users of these drugs entered treatment appeared to be significantly lower in Dublin than elsewhere. The authors noted that there was a risk that the uptake of addiction treatment reflected the available services in a geographical area rather than the needs of the people living in the area.

Demand for treatment

Accurate information about the level of demand for treatment for problem drug use is very important for service planning purposes. The National Drug Treatment Reporting System (NDTRS), relies on treatment service providers to collect details on each individual who presents for treatment. The information is transmitted to the HRB, without personal identification details (e.g. name or address) of the individuals receiving treatment. The result is that while the number of courses of treatment delivered can be identified, it is not possible to track the progression of an individual from one service provider to another. The review noted that ‘the NDTRS has the

potential to generate better estimates of demand for treatment, but greater compliance by service providers with the NDTRS data input rules would be required if this is to be achieved.' The review recommended that ways of recording treatments being sought and provided be on an individual basis and in a manner that ensures security of the information.

Access to treatment

This review reported that the NDTRS data may underestimate the extent of waiting for assessment. In some areas recording of information for NDTRS purposes starts only at the time of assessment, rather than at the time of initial presentation or referral. Some service providers also operate 'informal' waiting lists, and call those on the informal list only when an assessment appointment becomes available. In addition, where drug users are aware of long waiting times for access to local services, they may be deterred from presenting for assessment. The HRB provides a protocol defining the terms referral, assessment and treatment, but needs to put more emphasis on ensuring that all service providers record information completely and accurately so that the true extent of waiting for treatment may be gauged. Subject to these limitations, analysis of NDTRS data indicated an estimated 82% of those beginning methadone treatment in 2007 commenced treatment within the one-month target following assessment. In almost all cases treated for cannabis, cocaine or other stimulants, treatment was provided within the one-month target.

While a high proportion of individuals commenced treatment within the one-month target, approximately 460 people were recorded as waiting for methadone treatment in April 2008. The average waiting time for those on the lists in some areas was over a year.

A target of carrying out an assessment within three days of presentation (or referral) for treatment has been set. Of the opiate cases recorded by the NDTRS for 2007, an estimated 61% were reported to have been assessed within three days of presentation. Almost one in eight of those assessed was reported to have waited more than a month for their assessment. For persons presenting for assessment for problem cocaine use in 2007, 56% were recorded as having been assessed within the three-day target. Of those presenting for assessment for cannabis or stimulant use, less than 40% were assessed within the target time.

Effectiveness of treatment

Observing that evaluation of treatment effectiveness is complex, the report described the ROSIE (Research Outcome Study in Ireland) as sound and informative work in relation to treatment of opiate addiction in Ireland. It commented that the effectiveness of treatment for problem use of drugs other than opiates needs to be evaluated.

ROSIE – opiate treatment outcomes

On 9 October 2008, the NACD published a summary of opiate treatment outcomes in Ireland at one year and at three years after entry to treatment (Comiskey, C. *et al.* 2008).

At baseline, the 404 opiate users recruited to the study were entering treatment for the first time, or were returning to treatment after a period of absence, at any one of 54 services nationwide. Of these, 289 individuals completed all three interviews – at baseline (2003/4), at one year (2004/5) and at three years (2006/7). These individuals (the per-protocol population) were asked the same questions at the three time points. The interview schedule examined key outcome measures, including:

- drug use in the 90 days preceding the interview – specifically type, frequency, quantity and cost;
- harmful practices and consequences;
- health status, using a self-rated physical and psycho-social health assessment;

- social functioning, including accommodation, employment, and involvement in crime; and
- mortality, using information obtained from the participants' contacts and the General Mortality Register. (Six of those who entered treatment died during the three-year period.)

The proportion of participants who reported using heroin in the 90 days preceding data collection fell from 81% at intake to 47% at one year, and was sustained at 47% at three years. The average frequency of heroin use in a 90-day period reduced from 42 out of 90 days at intake to 15 out of 90 days at one year, but increased to 20 out of 90 days at three years. The average quantity of heroin consumed each day over a 90-day period decreased from 0.9 grams at intake to 0.3 grams at one year, and this lower consumption rate was sustained at three years. There was a corresponding reduction in the average amount spent on heroin on a typical day, from €75 at intake to €24 at one year; the average spend at three years was not reported.

There were reductions in the proportions of participants who reported use of non-prescribed methadone, cocaine powder, crack cocaine, cannabis, alcohol and non-prescribed benzodiazepines at one year compared to the baseline interview. The reduced levels were maintained between one-year and three-year follow-up for all drugs except benzodiazepines.

The proportion of participants who reported use of more than one drug decreased from 78% at intake to 50% one year later and to 45% three years after intake.

The proportion of participants who reported injecting drug use in the 90 days preceding data collection decreased from 46% at intake to 29% at one year and 27% at three years. There was a small overall decrease in the proportion reporting an overdose, from 7% at intake to 4% at one year, to 5% at three years.

In relation to mental health symptoms experienced in the three months prior to each interview, there was no reduction at three years in the proportion who reported symptoms of anxiety but some reduction in the proportion who reported three of five symptoms of depression.

The proportion of participants living in unstable accommodation decreased from 25% at intake to 21% at one year and 18% at three years. The proportion attending training courses in the six months prior to interview increased from 15% at intake to 29% at one year and 33% at three years. The proportion currently employed increased from 15% at intake to 20% at one year and 31% at three years. The most progress between one and three years was in the areas of housing, training and employment.

The proportion of participants who reported involvement in acquisitive crime decreased from 31% at intake to 14% at one year and this decrease was sustained at three years. In addition, the proportion who reported selling or supplying drugs reduced from 31% at intake to 11% at one year and this decrease was sustained at three years.

At the time of entry to treatment, 7% of the 289 participants were not using drugs; the proportion had improved to 29% at one year and was sustained at 29% at three years. Of those for whom treatment status at three years was reported, 201 (70%) were still in treatment, of whom 173 were in methadone treatment.

GPs' attitudes to the Methadone Treatment Protocol

Almost one-third (32%) of opiate users prescribed methadone substitution are cared for in private general practice in Ireland. In light of this information, the Irish College of General Practitioners (ICGP) conducted a postal survey in 2006 to determine the attitudes of Irish GPs to the Methadone Treatment Protocol (MTP) (Delargy 2008).

A questionnaire was sent to 600 GPs who were recorded on the ICGP's drug misuse database as having received training in the management of methadone clients. Just under 35% (207) responded. It is notable that 247 GPs had patients on the Central Treatment List at the time of the study.

Almost half of the GPs who responded were aged between 46 and 60 years and 29% were female. Two out of every three practices were situated in an urban area. Just over two-fifths of the GPs said that illicit drugs were a major problem in their practice area; the majority of these GPs practised in an urban location. Ninety-two per cent confirmed that they had attended special training in methadone treatment.

Of the 207 GPs who completed the questionnaire, 72% were providing patients with methadone treatment at the time of the survey. Over half had 10 or fewer patients. Only 35 prescribing doctors or their staff did not want any more patients. Forty-six GPs were willing to take more patients, which suggests that there is capacity to support the transfer of suitable clients to a normal health care environment.

The vast majority of GPs thought that the MTP was beneficial to patients, though some said that methadone was addictive and difficult to get off (Figure 5.3.1). It was also noted that patients who attended daily might be unable to take up employment.

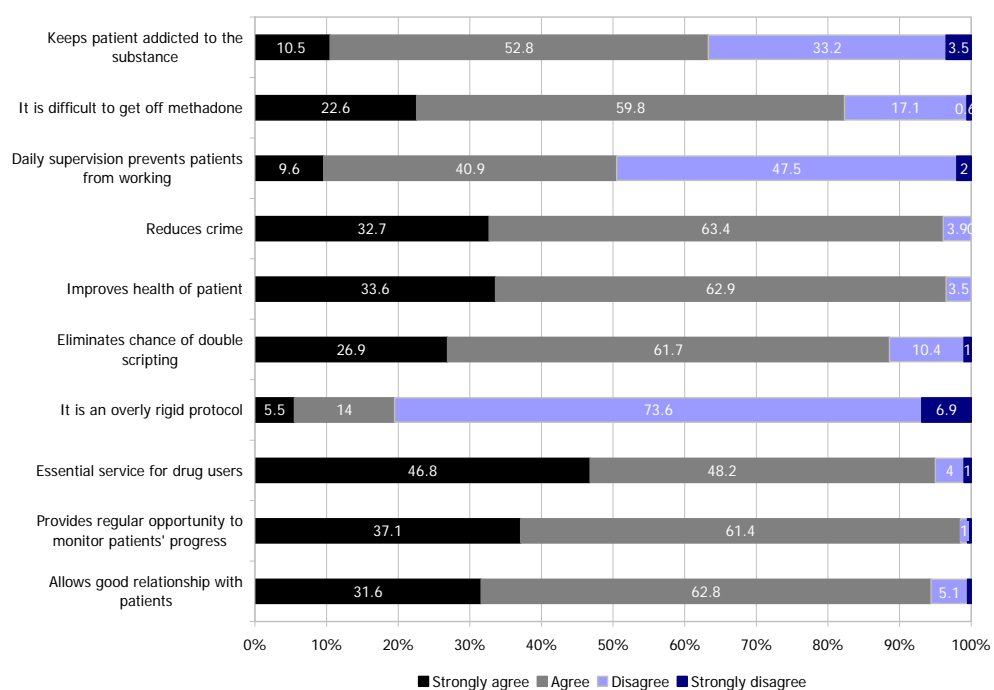


Figure 5.3.1 General practitioners' attitudes to methadone treatment, 2006 (Source (Delargy 2008))

Only 3% of GPs reported that their training was not sufficient to stabilise patients receiving methadone substitution. One-third reported that their training was not sufficient to manage the complications of drug use. Over two-fifths reported that their training was not sufficient to manage patients who continued to use illicit drugs. Just under two-thirds reported that their training was not sufficient to manage patients with alcohol problems, while over half reported that their training was not sufficient to manage patients with benzodiazepine problems.

The types of training that GPs considered most useful to them were small locally based continuing education networks, individual mentoring, and distance learning.

The additional services most desired by GPs were addiction counselling, in-patient detoxification and rehabilitation beds, and employment schemes.

GPs' role in methadone treatment

According to the NDTRS and the CTL the total number of cases receiving methadone treatment increased by 32% between 2002 and 2007 (Table 5.3.1). The number receiving treatment in private general practice increased by 36% during the same period. In each of the six years, at least 30% of cases who received methadone treatment were treated in private general practice.

Table 5.3.1 Total cases in methadone treatment, and number, treatment status and percentage of cases treated in private general practice, 2002–2007

Cases in methadone treatment	2002	2003	2004	2005	2006	2007
Total cases	7419	7736	8800	9354	9675	9769
Cases treated in general practice	2323	2494	2699	2827	2890	3161
Cases continuing in treatment in general practice from the previous year*	1875	2113	2292	2488	2642	2872
Cases entering treatment in general practice during the reporting year†	448	381	407	339	248	289
Cases treated in general practice as a percentage of total cases	31%	32%	31%	30%	30%	32%

*Numbers obtained from the Central Treatment List

†Numbers obtained from the National Drug Treatment Reporting System

The proportion of cases continuing in methadone treatment each year was higher among those attending private general practice than among those attending other treatment providers (Table 5.3.2). The cases attending general practice were older than those attending other treatment providers. There was no difference in the gender profile.

Table 5.3.2 Proportion of cases in methadone treatment in Ireland, by treatment status, gender and age group, 2002–2007

	Treatment service	
	General practice	Other
	%	%
Cases continuing in treatment from the previous year	87	75
Cases entering treatment (either new or returning)	13	25
Male	69	67
Female	31	32
Age group		
10–14 years	0	0
15–19 years	1	2
20–24 years	13	18
25–29 years	31	32
30–34 years	24	24
35–39 years	15	13
40–44 years	9	7
45–49 years	5	3
50–54 years	2	1
55–59 years	1	0
60–64 years	0	0
65 years or over	0	0

Illicit methadone use among young people

A paper was published in 2008 on illicit methadone use and abuse among young people accessing treatment for opiate dependence in Ireland (Roche, A. *et al.* 2008). At the time of publication, no research into methadone diversion had been conducted in Ireland. This study examined illicit use of methadone in a group of clients aged 25 and under attending a treatment programme for opiate dependence in the Drug Treatment Centre Board clinic in central Dublin in May 2005.

Data were obtained through a structured interview covering demographic information, family background, treatment history, current and prior drug use, current and prior

reasons for illicit methadone use, details of methadone supply, and experiences of selling methadone.

Of the 81 people interviewed, the average age was 22 years, and 51% were female. The average age of first drug use was 13 years, and 70% of participants reported cannabis as the first illicit drug used.

More than half of the participants (51%) reported that other family members had also used heroin. Thirty-one per cent of participants were homeless or living in a hostel.

The average age of first use of heroin was 15; one participant reported never having used heroin. The majority (91%) reported smoking as the first route of administration of heroin, while the remaining 9% reported injecting as their first route of administration. Almost four-fifths (79%) reported having injected heroin at some point in their lives.

The average prescribed daily methadone dose reported by participants was 66mg. Almost one-third (31%) reported that this dose did not control the symptoms of heroin withdrawal.

More than half of participants reported the use of illicit methadone both prior to and during treatment. Counteraction of opiate withdrawal symptoms was the most common reason given. During treatment, failure to attend the clinic was the most common reason for withdrawal symptoms. Forty per cent obtained illicit methadone in order to do their own detox or maintenance. One-third reported using methadone for hedonic effects prior to commencing treatment. Participants reporting the misuse of benzodiazepines were more likely to report use of illicit methadone.

Despite strict controls, 73% of participants reported that illicit methadone was easy to obtain. The most commonly-listed marketplace was outside the treatment clinic, while other locations included the participants' local areas, the quays, and outside city centre train stations.

Of those buying methadone, 42% reported having a regular source. The majority of participants (82%) reported the supplier as someone on a methadone maintenance programme. The vast majority (93%) of participants who had received their methadone prescription as take-aways in the past reported being asked to sell it on; only 6% reported having done so.

Emergency department doctors' and nurses' knowledge and attitudes concerning substance use and substance users

The aim of this study was to determine emergency department doctors' and nurses' knowledge and attitudes regarding problematic substance use and substance users (Kelleher and Cotter 2009).

Data were collected using an adapted survey questionnaire and the Substance Abuse Attitude Survey (SAAS). By means of convenience/opportunistic sampling, all emergency department doctors and nurses (n = 145) working in three university teaching hospitals in Ireland were asked to fill out the knowledge and attitudes questionnaire.

A relatively low response rate of 46% (66) was achieved. Results indicate that participants' current level of knowledge about alcohol and drug misuse in general was satisfactory. Knowledge deficits were noted in relation to drugs such as benzodiazepines and amphetamines, and intervention strategies for alcohol and opiates. The majority of participants had never received any specific training regarding substance use and the authors suggested that substance-using patients might be managed inadequately. The SAAS results indicated that participants exhibited near-optimal attitudes for constructive working with substance-using patients. The majority of

respondents disagreed with the legalisation of drug use but understood that young people might experiment with drugs. The majority of service providers agreed that addiction was a treatable condition and were aware of the factors that facilitated successful treatment. The majority of service providers did not stereotype drug users, but a minority did admit that they were difficult patients to treat.

5.3.2 Availability and diversification of treatment

See section 7.3 for harm reduction responses to prevent drug-related infectious diseases

'Quasi-compulsory' treatment

Quasi-compulsory treatment (QCT) refers to any form of drug treatment that is ordered, motivated or supervised by the criminal justice system. The Council of Europe's Pompidou Group (Criminal Justice Platform) commissioned a survey to ascertain what existing guidelines were employed by various jurisdictions when making QCT orders or recommendations for adult drug-dependent offenders (McSweeney 2008). Of the 35 Council of Europe states requested to participate, 22 countries (including Ireland) provided responses.

The primary form of QCT available in Ireland is that offered by the Irish Drug Treatment Court (DTC). The DTC, established as a permanent court in 2006 after a five-year pilot phase, deals with offenders who have either pleaded guilty or been convicted of minor crimes committed as a consequence of drug abuse. Addressing a European conference on QCT and other alternatives to imprisonment in October 2007, Judge Bridget Reilly of the DTC said: 'Despite the low graduation numbers, the progress and improvement in quality of life for the participants is seen to be very significant by the DTC team, considering the background of low literacy skills, low educational participation, and often difficult social and family history (Connolly 2007). The DTC was due to be expanded to other areas under the National Drugs Strategy 2001–2008, which is currently under review.

Overall, the results of the survey were deemed encouraging but the variety of approaches among member states suggested the need to develop a transnational set of guidelines on QCT practices. It was also concluded that there was scope for legislation in the six responding countries (including Ireland) where legislation was absent. Of these countries, several had prison systems operating at or above capacity.

Drug Treatment clinical policy in the Irish Prison Service

In January 2008, the Irish Prison Service (IPS) produced their comprehensive drug treatment clinical policy document (Irish Prison Service 2008b). It covers a wide range of issues around drug treatment.

There is an extensive section on methadone treatment, outlining the background and rationale for methadone treatment, as well as the clinical management of a prisoner on methadone and the logistics of dispensing. The policy document covers:

- clinical interdisciplinary care planning;
- methadone treatment guidelines;
- assessment – treatment plans and treatment goals (induction, maintenance and detox);
- criteria for treatment priority;
- use of methadone – ordering and dispensing;
- administration and recording of methadone.

The document also outlines in some detail the processes necessary for methadone treatment, whether a prisoner is already on methadone on admission, or treatment is to be initiated in prison, and for planned release of a prisoner on methadone.

Issues around blood-borne viruses, including testing, clinical management and immunisation, are also addressed in the policy.

The document states that the misuse of benzodiazepines is an endemic problem in the Irish prison population and recommends policies and guidelines around assessment of dependence, prescribing and detoxification.

The Lofexidine detoxification and alcohol withdrawal guidelines have been modified from The Maudsley protocols. Guidelines for the use of Naltrexone, as part of an overall programme of addiction treatment along with psycho-social support, are outlined in the document. The guidelines state that Naltrexone should only be prescribed by a medical person experienced in its use. The use of injectable Naltrexone for reversing accidental opiate overdose is not covered.

The document states that an interdisciplinary team will provide treatment for problem cocaine use on an individual basis. There is a range of treatments available including counselling and cognitive behavioural therapy, along with appropriate referrals to medical or psychiatric services as necessary.

It is the policy of the IPS, in accordance with the community standard, to develop a dual diagnosis service for those patients with addiction problems and mental health problems.

Pregnant women are specifically mentioned in the document. The objectives of the care of pregnant women are:

- stabilisation of mother's drug use;
- retention of mother in obstetric and drug treatment service and ensuring adequate support and through care in the community;
- delivery of a full-term baby with healthy birth weight;
- avoidance of in utero exposure to HIV/hepatitis;
- minimisation of the occurrence of neonatal abstinence syndrome;
- promotion and support for positive physical, mental health and social wellbeing throughout and after pregnancy.

Suboxone study

The Department of Health and Children established an expert group to examine the use of buprenorphine/naloxone (suboxone) as a treatment for opiate dependency. The group recommended that a feasibility study on the use of buprenorphine/naloxone treatment as an alternative to methadone be established. The study began in July 2009 and is being conducted at several specialist addiction centres in Dublin and a number of Level II GP practices in Dublin and around the country. The aim is to enrol up to 80 problem opiate users who agree to treatment and are suitable (40 in specialist centres and 40 in the community). The Drug Treatment Centre Board is maintaining electronic records on those taking part in the study. The protocol for prescribing and dispensing buprenorphine/naloxone is similar to that for methadone. If the problem opiate user is pregnant, then she will be prescribed buprenorphine, without naloxone, as the latter drug is contra-indicated in pregnancy. Buprenorphine/naloxone is provided free of charge. The study is to be reviewed after eight months with a view to deciding if it will be offered to all drug treatment clients. The evaluation of the study will be conducted according to agreed evaluation criteria and using a recognised audit tool.

Physical fitness intervention during residential adolescent addiction treatment in the south east

Van Hout (Van Hout 2008) assessed the perception of social context and activity scales of adolescent substance abusers following participation in a physical activity intervention during residential drug treatment. The increase in perception of social context value was measured by increased social interaction, group identification, trust, co-operation and social growth. The increase in perception of activity value was measured by increased enjoyment, self-efficacy, skill acquisition and confidence. The sample (n=47) was assessed on entry to treatment, on completion of treatment; six weeks post residential treatment and six months after treatment using mean, standard deviation, and t-tests.

Sixty-three per cent of the participants were male and the participants were between 12 and 20 years old. In general, the overall mean scores for perception of social context increased from entry to completion of the treatment programme, decreased marginally six weeks after treatment, and returned to baseline levels after six months in aftercare. A small significant positive difference was recorded between entry to treatment and six weeks after treatment ($p = 0.04$). The results relating to perception of activity increased from entry to completion of the treatment programme, increased at six weeks after treatment, and decreased to below the baseline level after six months in aftercare. Positive significant differences were recorded between entry and six weeks post-treatment ($p = 0.02$) and between completion of treatment and six months in aftercare ($p = 0.03$). This research illustrates the positive potential of physical activity as part of an adolescent residential treatment programme and in the six-week follow-up period. The research highlights that it was difficult to maintain the long-term positive benefits and approaches to doing so need to be explored.

5.4 Characteristics of treated clients (TDI data included)

Cases treated for problem cocaine and opiate use, 2002–2007

Two papers, one on problem cocaine use (Bellerose *et al.* 2009) and one on problem opiate use (Carew *et al.* 2009), based on data reported to the NDTRS for the six-year period 2002–2007, were published in 2009. It is important to note that the NDTRS collects data on episodes of treatment, rather than the number of individual people treated each year. This means that individuals may appear more than once if they attend more than one treatment service in a year, and may reappear in subsequent years.

The main findings of the paper on treated problem cocaine use are:

- One-fifth (10,764) of all cases treated for problem drug use between 2002 and 2007 reported cocaine as a problem substance. The annual number of cocaine cases increased by 177%, from 954 in 2002 to 2,643 in 2007. This increase was in line with increases in cocaine seizures, cocaine use among the general population and cocaine-related deaths during the same time period.
- The number of cases who reported cocaine as their main problem drug increased by 502%, from 128 in 2002 to 770 in 2007. The number of cases who reported cocaine as an additional problem drug increased by 128%, from 826 in 2002 to 1,885 in 2007.
- The higher rates of new cases treated for cocaine as their main problem drug were in the north-eastern, south eastern and southern counties. The incidence of treated problem cocaine use was lower than expected in Dublin due to the fact that many problem cocaine users in Dublin also used opiates, and the opiate was categorised as their main problem drug while cocaine was categorised as an additional problem drug.

- Almost four out of five cases who reported cocaine as their main problem drug used more than one drug. Cocaine was used alongside opiates, cannabis, alcohol and ecstasy.
- Cocaine users entering treatment appeared to fit one of two profiles, those who use opiates alongside cocaine and those who use combinations of alcohol, cannabis and/or ecstasy alongside cocaine.
- The majority of cases who reported cocaine as their main problem drug used it on two to six days per week, indicating that cocaine may be used as a week-end drug or during a binge.
- Half of the cases were under 27 years old, 83% were men and 33% were employed. The proportion of treated cocaine cases in employment was higher than the proportion of opiate cases in employment, 35% versus 13%, indicating that treated cocaine users were from a mix of social backgrounds.
- The majority (69%) of cases were treated in outpatient services in 2007.
- There is a wide variety of interventions provided to cocaine cases, though until there is national data on treatment outcomes it is difficult to comment on the effectiveness of these interventions.

The main findings of the paper on treated problem opiate use are:

- The number of cases who reported an opiate (mainly heroin) as a problem drug increased by 29%, from 8,804 in 2002 to 11,392 in 2007. This increase in treatment provision is explained by a combination of factors— an increase in the number of treatment places, an increase in opiate use among the population and an increase in reporting to the NDTRS.
- This increase in treated problem opiate use was in line with increases in heroin seizures in 2005 and 2006, problem opiate use among the population and heroin-related deaths during the same time period.
- The rate of increase in new opiate cases was highest outside Dublin, and in particular in the midland, north eastern, and south eastern counties.
- The proportion of cases treated for opiates as a main problem drug who reported use of more than one drug decreased from 69% in 2002 to 63% in 2007. Between 2002 and 2007, cannabis, benzodiazepines and, in more recent years, cocaine were the most common additional problem drugs used alongside opiates. The use of additional drugs alongside opiates makes it more difficult to treat the addiction successfully.
- Of the 3,575 cases who entered treatment and reported opiates as their main problem drug in 2007, 52% smoked it, 40% injected it, and 4% consumed it orally.
- Between 2003 and 2007 decreasing proportions of cases reported that injecting was their primary route of administration, while correspondingly increasing proportions reported smoking opiates. This indicates that harm reduction messages are being heard and the transmission of blood-borne viruses will be reduced among this cohort.
- The majority of cases who reported an opiate as their main problem drug used it daily, indicating the addictive nature of the drug.
- In 2007, the vast majority (75%) of opiate cases entering treatment were cared for in outpatient services.
- There is a wide variety of interventions provided to opiate cases including counselling, methadone maintenance, brief intervention, and medically assisted opiate detoxification.

Cases entering treatment for cannabis use in Ireland, 2001–2007

Analysis of data from the NDTRS for the seven-year period 2001–2007 (Long 2009a) indicates that the number of treated cases reporting cannabis as a main problem drug decreased from 1,384 in 2003 to 958 in 2007 (Table 5.4.1), of whom 74% used one or more additional drugs. The number of cases reporting cannabis as an additional problem drug increased from 1,383 in 2001 to 1,630 in 2007 (Table 5.4.2). The drugs associated with cannabis use were alcohol, ecstasy, amphetamines and cocaine

(Table 5.4.3). These data indicate that only a small proportion of cannabis users are seen at treatment services, and that the majority of those use more than one drug.

Table 5.4.1 Cases entering treatment for cannabis as a main problem drug, 2001–2007

	2001	2002	2003	2004	2005	2006	2007
	Number (%)						
All cases entering treatment	4797	4948	5054	4506	4877	5191	5684
Cases reporting cannabis as main problem drug	1136 (23.7)	1336 (27.0)	1384 (27.4)	991 (22.0)	1039 (21.3)	1096 (21.1)	958 (16.9)
Of whom:							
New cases	781	924	955	736	794	809	694
Previously treated cases	299	349	401	224	219	260	255
Treatment status not known	56	63	28	31	26	27	9

Source: Unpublished data from the NDTRS

Table 5.4.2 Cases entering treatment who reported cannabis as an additional problem drug, 2001–2007

	2001	2002	2003	2004	2005	2006	2007
	Number (%)						
All cases reporting an additional problem drug	3459	3582	3760	3157	3401	3692	3816
Cases reporting cannabis as an additional problem drug	1383 (40.0)	1362 (38.0)	1445 (38.4)	1239 (39.2)	1417 (41.7)	1579 (42.8)	1630 (45.5)
Of whom:							
New cases	540	511	556	449	527	583	681
Previously treated cases	797	797	842	757	844	925	904
Treatment status not known	46	54	47	33	46	71	45

Source: Unpublished data from the NDTRS

Table 5.4.3 Main problem drug and associated additional drugs used by new cases entering treatment, 2001–2007

New cases	4708	769	1064	99	228	160	4999
	Main problem drug						
	Opiates	Ecstasy	Cocaine	Amphetamines	Benzo-diazepines	Volatile inhalants	Cannabis
Additional problem drug(s) used*	Number (%)						
Opiates	751 (16.0) [†]	16 (2.1)	78 (7.3)	1 (1.0)	36 (15.8)	2 (1.3)	128 (2.6)
Ecstasy	447 (9.5)		394 (37.0)	49 (49.5)	32 (14.0)	11 (6.9)	1897 (37.9)
Cocaine	1029 (21.9)	206 (26.8)	12 (1.1) [†]	25 (25.3)	37 (16.2)	3 (1.9)	865 (17.3)
Amphetamines	89 (1.9)	183 (23.8)	109 (10.2)		4 (1.8)	2 (1.3)	528 (10.6)
Benzodiazepines	1029 (21.9)	20 (2.6)	67 (6.3)	2 (2.0)	9 (3.9) [†]	1 (0.6)	117 (2.3)
Volatile inhalants	17 (0.4)	15 (2.0)	5 (0.5)	1 (1.0)	3 (1.3)	8 (5.0) [†]	118 (2.4)
Cannabis	1866 (39.6)	489 (63.6)	611 (57.4)	60 (60.6)	56 (24.6)	47 (29.4)	6 (0.1) [†]
Alcohol	466 (9.9)	341 (44.3)	497 (46.7)	36 (36.4)	103 (45.2)	57 (35.6)	2389 (47.8)

* By cases reporting use of one, two or three additional drugs

[†] Additional problem drug(s) used may be a form of drug in the same family as the main problem drug.

Source: Unpublished data from the NDTRS

Of the 958 cases treated in 2007 who reported cannabis as their main problem drug, 99% smoked it, and 1% ate it. Use by these 958 cases in the month prior to treatment was reported as follows: 49% used it daily, 22% used it between two and six days per week, 8% used it once per week or less and 19% had not used it. As expected, the frequency of cannabis use among treated cases was considerably higher than among the general population.

Of these 958 cases, half had commenced cannabis use before they were 14 years old, and 86% were men. Of the total number, 109 (11%) lived in Dublin and 849 (89%) lived elsewhere in Ireland. The numbers reflect the greater availability of treatment for

cannabis, cocaine and other non-opiate drugs in Dublin, rather than use among the general population.

Cases presenting for treatment for sedative or tranquilliser use in Ireland, 2001–2007

According to NDTRS data for 2001 to 2007 (Long and Lyons 2009), the annual number of treated cases reporting sedatives or tranquillisers as a main problem drug fluctuated between 78 and 171 (Table 5.4.4). The total for the period was 778 cases, of whom 87% reported a benzodiazepine as their main problem drug. Of the 778 cases, 76% used one or more additional drugs.

Of the 171 cases treated in 2007 who reported sedatives or tranquillisers as their main problem drug, 98% ate them and 0.5% injected them. Use by these cases in the month prior to treatment was reported as follows: 66% used them daily, 12% used them between two and six days per week, 5% used them once per week or less and 11% had not used them. Half had commenced use before they were 19 years old; 66% were men; and 61% lived in Dublin.

Table 5.4.4 Cases entering treatment for sedatives or tranquillisers as a main problem drug, 2001–2007

	2001	2002	2003	2004	2005	2006	2007
	Number (%)						
All cases	4797	4948	5054	4506	4877	5191	5684
Cases reporting sedatives or tranquillisers as main problem drug	115 (2.4)	104 (2.1)	97 (1.9)	108 (2.4)	78 (1.6)	105 (2.0)	171 (3.0)
Of whom:							
New cases	55	39	37	50	44	55	91
Previously treated cases	52	60	60	52	31	44	74
Treatment status not known	8	5	0	6	3	6	6

Source: Unpublished data from the NDTRS

The number of cases reporting sedatives or tranquillisers as an additional problem drug exceeded 1,000 per year between 2001 and 2007 (Table 5.4.5). The main drugs associated with sedative or tranquilliser use by new cases entering treatment were cannabis, alcohol, stimulants, cocaine and opiates (Table 5.4.6).

Table 5.4.5 Cases entering treatment who reported sedatives or tranquillisers as an additional problem drug, 2001–2007

	2001	2002	2003	2004	2005	2006	2007
	Number (%)						
All cases reporting an additional problem drug	3459	3582	3760	3157	3401	3692	3816
Cases reporting sedatives or tranquillisers as an additional problem drug	1107 (32.0)	1155 (32.2)	1050 (28.3)	1009 (32.0)	1110 (32.6)	1200 (32.5)	1155 (30.3)
Of whom:							
New cases	252	264	214	176	206	269	273
Previously treated cases	786	826	791	685	747	771	681
Treatment status not known	32	43	26	31	26	21	14

Source: Unpublished data from the NDTRS

Table 5.4.6 Main problem drug and associated additional drugs used by new cases entering treatment, 2001–2007

New cases	5741	1526	981	371	14	184	5693
	Main problem drug						
	Opiates	Cocaine	Stimulants	Sedatives/ tranquillisers	Hallucinogens	Volatile inhalants	Cannabis
Additional problem drug(s) used*	Number						

New cases	5741	1526	981	371	14	184	5693
	Main problem drug						
	Opiates	Cocaine	Stimulants	Sedatives/ tranquillisers	Hallucinogens	Volatile inhalants	Cannabis
Opiates	848 [†]	102	26	52	2	4	151
Cocaine	1278	14 [†]	272	59	3	3	1056
Stimulants	606	669	257 [†]	62	9	14	2655
Sedatives/ tranquillisers	1267	110	39	27 [†]	0	2	251
Hallucinogens	47	25	37	1	1 [†]	1	165
Volatile inhalants	19	7	16	5	0	9 [†]	127
Alcohol	2209	847	605	109	9	53	10
Cannabis	652	706	422	171	4	62	2719 [†]

* By cases reporting use of one, two or three additional drugs

[†] Additional problem drug(s) used may be a form of drug in the same family as the main problem drug.

Source: Unpublished data from the NDTRS

According to NDTRS data for the years 2001 to 2007, only 10 treated cases reported anti-depressants as a main problem drug, of whom half used one or more additional drugs. In the seven-year period, 56 cases reported anti-depressants as an additional problem drug. The drugs associated with anti-depressant use were opiates and sedatives. Of the 66 cases treated who reported anti-depressants as a problem drug, 53% were men, and 58% lived in Dublin (Figure 5.4.1).

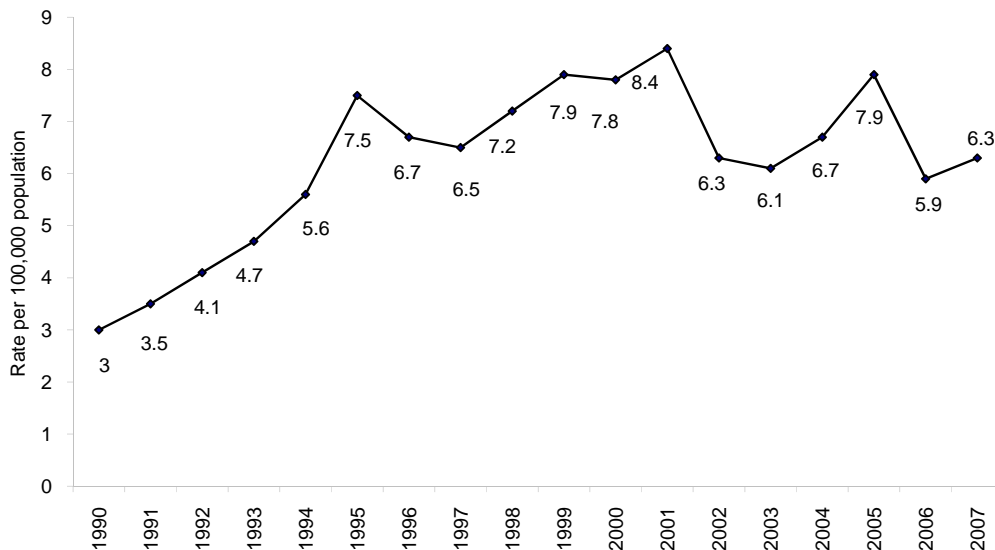


Figure 5.4.1 Rates of psychiatric first admission of cases with a diagnosis of drug disorder (using the ICD-10 three character categories) per 100,000 of the population in Ireland and reported to the National Psychiatric Inpatient Reporting System, 1990–2007 (Daly, Antoinette and Walsh 2003; Daly, A. *et al.* 2005; Daly, A. *et al.* 2007; Daly, A. *et al.* 2008; Daly, Antoinette *et al.* 2004; Daly, Antoinette *et al.* 2006)

5.5 Trends of clients in treatment (incl. numbers)

5.5.1 Drug treatment demand

Figures from the NDTRS for treated problem drug use in Ireland for 2007 show that 13,620 cases were treated in 2007, of which 5,977 entered treatment in that year (Lyons, S 2009). The majority of cases attended outpatient services. An opiate (mainly heroin) was the most common main problem drug reported by cases entering treatment in 2007. The majority of cases treated in 2007 reported problem drug use of more than

one substance (67.1%), which was slightly lower than in 2006 (71.1%). Alcohol was reported as an additional problem substance in 40% of all treated cases. Many problem drug users in treatment were young and male, had low levels of education and were unlikely to be employed. Almost 14% of all new cases treated in 2007 were aged under 18 years of age, a slight increase from 2006. Almost 3% of previously -treated cases were aged under 18 years, similar to 2006.

The prevalence of treated problem drug use among 15–64-year-olds living in Ireland expressed per 100,000 of the population increased by 4%, from 426 in 2006 to 445 in 2007. New cases entering treatment are an indirect indicator of recent trends in problem drug use. The incidence of treated problem drug use among 15–64-year-olds per 100,000 of the population living in Ireland increased from 75 in 2006 to 80 in 2007.

Preliminary analysis of 2008 data shows that 6,247 cases entered treatment, the majority for problem heroin use. Of those who entered treatment, the majority attended outpatient services (4,837, 77.4%). These figures do not include cases who reported alcohol as their main problem drug but used other additional drugs.

6. Health Correlates and Consequences

6.1 Introduction

Problematic drug use can be associated with a number of other health conditions or lead to a range of health consequences, including drug-related infectious diseases, drug-related overdoses, a range of chronic illnesses and acute conditions, and psychiatric comorbidity. Information on these various health correlates and consequences is collected in a variety of information systems.

The Health Protection Surveillance Centre (HPSC) is Ireland's specialist agency for the surveillance of communicable diseases. Part of the Health Service Executive, the HPSC endeavours to protect and improve the health of the Irish population by collating, interpreting and disseminating data to provide the best possible information on infectious disease. The HPSC has recorded new cases among injecting drug users of HIV since 1982, hepatitis B since 2004, and hepatitis C since 2006.

HIPE (Hospital In-Patient Enquiry) is a computer-based health information system, managed by the Economic and Social Research Institute (ESRI) in association with the Department of Health and Children and the Health Service Executive, that collects demographic, medical and administrative data on all admissions, discharges and deaths from acute general hospitals in Ireland. It was started on a pilot basis in 1969 and then expanded and developed as a national database of coded discharge summaries from the 1970s onwards. Each HIPE discharge record represents one episode of care; each discharge of a patient, whether from the same or a different hospital, or with the same or a different diagnosis, gives rise to a separate HIPE record. The scheme, therefore, facilitates analyses of hospital activity rather than of the incidence of disease. HIPE does not record information on individuals who attend accident and emergency units but are not admitted as inpatients. Data relating to 14, 770 cases of non-fatal overdoses for a three-year period, 2005–2007, are analysed in Section 6.3.1 below.

The National Poisons Information Centre (NPIC), located in Beaumont Hospital, provides a national telephone information service on the toxicity, features and management of cases of poisoning. This 24-hour service is offered mainly to doctors and other health care professionals. Queries are dealt with by poisons information officers at the Centre between 8 am and 10 pm, while out-of-hours calls are automatically diverted to the UK National Poisons Information Service (NPIS). Data from this source provide indications of the pattern of human cases of poisoning, including age, gender and agent.

The data collected by the Primary Care Re-imbursment Service (PCRS), previously called the General Medical Services Payments Board and usually referred to as the GMS, is another source of information on the health correlates and consequences of problematic drug use among those who have medical cards, which are means-tested. Medical-card holders receive certain health services, including approved prescribed drugs and medicines, free of charge. Operated by the HSE, the PCRS administers payments to doctors, pharmacists and dentists who provide services under the PCRS scheme. A study, conducted in July 2008, of morbidity among medical-card holders who were opiate users in methadone treatment is reported on in Section 6.3.2 below.

The National Psychiatric In-Patient Reporting System (NPIRS), administered by the HRB, is a national psychiatric database that provides detailed information on all admissions to and discharges from 56 inpatient psychiatric services in Ireland, recording data on cases receiving inpatient treatment for problem drug and alcohol use. NPIRS does not collect data on the prevalence of psychiatric comorbidity in Ireland. Every year the HRB publishes an annual report on the data collected in NPIRS.

Problematic drug use can also lead to premature death. Death can occur as a result of overdose (both intentional and unintentional), actions taken under the influence of drugs, medical consequences or incidental causes. While illicit drugs are involved in many cases of drug-related death, licit (prescribed) drugs are also frequently involved in such deaths (alone or in conjunction with an illicit drug). Alcohol has been reported as the third greatest risk factor for ill health and premature death in Europe. Established in 2005, the National Drug-Related Death Index (NDRD), which is maintained by the HRB, is an epidemiological database which records cases of death by drugs poisoning, and deaths among drug users Ireland, extending back to 1998; the NDRDI has also recorded data on alcohol-related deaths, deaths among alcoholics, and deaths from alcohol-related diseases, extending back to 2004.

The number of deaths as a result of poisoning fluctuated between 1998 and 2003; however, since 2003 the number of cases has risen from 107 cases to 169 cases in 2007. The rise is attributed to cocaine opiates and/or poly-substance use.

6.2 Drug-related infectious diseases

6.2.1 HIV/AIDS and viral hepatitis

HIV surveillance in 2008

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1985. According to the most recent report of the HPSC (O'Donnell, K. *et al.* 2009), at the end of 2008 there were 5,186 diagnosed HIV cases in Ireland, of which 1,417 (27%) were probably infected through injecting drug use.

Figure 6.2.1 presents the number of new cases of HIV among injecting drug users reported in Ireland, by year of diagnosis; data from 1982 to 1985 were excluded from the figure as these four years were combined in the source records. Figure 6.2.1 is based on data reported to the Department of Health and Children, the National Disease Surveillance Centre and its successor, the HPSC. There was a fall in the number of HIV cases among injecting drug users between 1994 and 1998, with about 20 cases per year, compared to about 50 cases each year in the preceding years. There was a sharp increase in the number of cases in 1999 (69 new cases), which continued into 2000 (83 new cases). Between 2001 and 2008 there was an overall decline in the number of new injector cases (38, 50, 49, 71, 66, 57, 54 and 36 respectively) when compared to 2000. It was difficult to interpret the trend owing to the relatively small numbers diagnosed each year, so a smoother curve (grey broken plot line in Figure 6.2.1) was calculated using a rolling centred three-year average. This curve presents a new baseline of between 45 and 65 cases each year.

Of the 36 new HIV cases among injecting drug users reported to the HPSC in 2008, 27 were male and nine were female, and the average age was 33 years. Twenty-two of the 34 cases with a known address lived in the HSE Eastern Region (Dublin, Kildare and Wicklow).

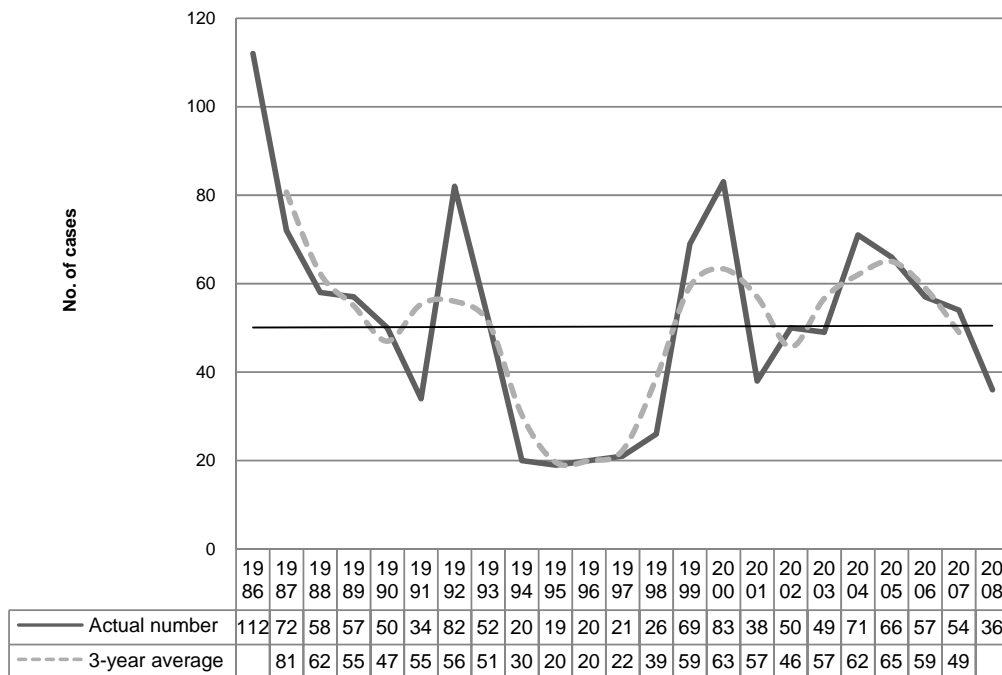


Figure 6.2.1 Actual number and rolling average number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland, 1986–2008. Source: Unpublished data reported to DoHC, National Disease Surveillance Centre and HPSC.

Hepatitis B surveillance in 2008

Hepatitis B is a vaccine-preventable disease which is transmitted through contact with the blood or body fluids of an infected person. The main routes of transmission are mother-to-baby, child-to-child, sexual contact and unsafe injections. The number of cases notified to the HPSC increased each year between 1996 and 2005. In 2006 the number decreased by 7% (to 810) and then increased steadily in 2007 and 2008 (Table 6.2.1). There were 949 cases in 2008, of whom 765 had a chronic infection, 82 had an acute infection and the disease status of 102 cases was unknown. The surveillance system has recorded risk factor data since 2004 and the number of cases notified to the HPSC that include data on risk factors has increased from 30% in 2006 to 59% in 2008. In 2008 59% (557) of all cases had risk factor data reported, of whom seven (1.3%) reported injecting drug use as their main risk factor. The number of such cases remained consistently low between 2005 and 2008, indicating the effectiveness of routine administration of the hepatitis B vaccine.

Table 6.2.1 Number (%) of acute and chronic hepatitis B cases reported to the HPSC, by risk factor status, 2005–2007

Risk factor status	Hepatitis B status								
	2006			2007			2008		
	Acute N (%)	Chronic N (%)	Unknown N (%)	Acute N (%)	Chronic N (%)	Unknown N (%)	Acute N (%)	Chronic N (%)	Unknown N (%)
Total number of cases	93	655	62	52	706	105	82	765	102
% of cases by status	11.5	80.9	7.7	6.0	81.8	12.2	8.6	80.6	10.7
Cases <i>with</i> reported risk factor data	61	177	6	44	315	16	73	428	56
% of cases with risk factor data	65.6	27.0	9.7	84.6	44.6	15.2	89	55.9	54.9
Of which:									
Injecting drug users	0 (0)	3 (1.7)	1 (16.7)	1 (2.3)	4 (1.3)	1 (6.3)	0 (0)	6 (1.4)	1 (1.8)
Cases <i>without</i> reported risk factor data	32	478	56	8	391	89	9	337	46
% of cases without risk factor data	34.4	73.0	90.3	15.4	55.4	84.8	11	44.1	45.1
Total	810			863			949		

Source: Unpublished data from the HPSC

Hepatitis C surveillance in 2008

Hepatitis C is one of the most common blood-borne viral infections among injecting drug users and is transmitted through contact with the blood of an infected person. The main routes of transmission are mother-to-baby, unsafe injections, transfusion of blood and blood products, and unsterile tattooing and skin piercing. The HPSC reported that there were 1,537 cases of hepatitis C reported in 2008 (Table 6.2.2), compared to 1,128 cases in 2004, and 85 cases of hepatitis 'type unspecified' in 2003.

Table 6.2.2 Number of cases and age-standardised notification rates (ASR) per 100,000 population for hepatitis C, 2004–2008

Year	Number of cases	Age standardized rate per 100,000
2004	1128	26.6
2005	1415	33.4
2006	1219	28.8
2007	1556	36.7
2008	1537	36.3

Source: Unpublished data from the HPSC

An enhanced surveillance system for hepatitis C was introduced in Ireland in 2007. Enhanced surveillance is essential to identify risk factors and for planning prevention and treatment strategies. In 2008, 38% of newly-reported hepatitis C cases had risk factor status reported (Table 6.2.3). As expected, the majority of these cases (76.9%) reported injecting drug use as the main risk factor. Four per cent of cases said that they were recipients of blood or blood products at some time in the past and according to the HPSC were late reports to the system (N Murphy, HPSC, personal communication, 2009).

Table 6.2.3 Number (%) of hepatitis C cases reported to the HPSC, by risk factor status, 2007 and 2008

Risk factor status	Hepatitis C 2007	Hepatitis C 2008
Total number of cases	1556	1537
Cases <i>with</i> reported risk factor data	664 (42.7%)	581 (37.8%)
Of which:		
Injecting drug users	503 (75.8%)	447 (76.9%)

	Hepatitis C 2007	Hepatitis C 2008
Risk factor status		
Recipients of blood/blood products	34 (5.1%)	24 (4.1%)
Other risk factors	90 (13.6%)	77 (13.3%)
No known risk factor could be identified by patient or doctor	37 (5.6%)	33 (5.7%)
Cases <i>without</i> reported risk factor data	892 (57.3%)	956 (62.2%)

Source: Unpublished data from the HPSC

In 2007, 85% of cases reporting injecting drug use as their main risk factor were notified by services in Dublin, Kildare and Wicklow and the remainder by services in HSE areas outside these counties (Table 6.2.4). Seventy-one per cent were male and 62% were under 35 years old.

Table 6.2.4 Number (%) of hepatitis C cases who reported injecting drug use as their risk factor by age, gender and place of residence, 2007 and 2008

	Hepatitis C 2007	Hepatitis C 2008
Risk factor status		
Total number of known injector cases	503	447
Gender		
Male	339 (67.4%)	319 (71.4%)
Female	163 (32.4%)	126 (28.2%)
Unknown	1 (0.2%)	2 (0.4%)
Age		
Mean (in years)	32.7	33.3
Median(in years)	31	32
Under 25 years	49 (9.7%)	45 (10.1%)
25 to 34 years	282 (56.1%)	233 (52.1%)
More than 34 years	170 (33.8%)	165 (36.9%)
Unknown	2 (0.4%)	4 (0.9%)
Place of residence		
Dublin, Kildare and Wicklow	445 (88.5%)	379 (84.8%)
Elsewhere in Ireland	58 (11.5%)	68 (15.2%)

Source: Unpublished data from the HPSC

Burden of hepatitis C infection in Ireland

The data provided in this section are abstracted from a paper written by Murphy and Thornton and published in EPI-Insight in July 2008 (Murphy and Thornton 2008).

Central Statistics Office mortality data

For 288 people between 1994 and 2005 the underlying cause of death was reported to be primary liver cancer. According to an international review by staff at the HPSC, approximately one third of primary liver cancer cases are due to hepatitis C.

Hospital In-patient Enquiry (HIPE) Scheme data

Between 1999 and 2004, when HIPE coverage of acute hospitals was 95%, there were 3,060 discharges with a principal diagnosis of '*other specified viral hepatitis without mention of hepatic coma*'. Most of these are likely to have been due to hepatitis C. A further 778 discharges were associated with a principal diagnosis of primary liver cancer.

Liver transplants

The liver unit in St Vincent's University Hospital, Dublin, carried out 311 liver transplants between 2000 and 2006. Twenty-five of these were known to be a consequence of HCV infection and a further 17 were known to be due to hepatitis C plus another indication such as alcoholic liver disease or hepatocellular carcinoma.

6.2.2 STI's and tuberculosis

The surveillance data available in Ireland does not identify drug use as a risk factor for these infections.

6.2.3 Other infectious morbidity (e.g. abscesses, sepsis, endocarditis, wound botulism)

Botulism is a rare but serious illness caused by botulin toxin. The toxin is produced by the bacteria *Clostridium botulinum*. The HPSC was informed of four cases of wound botulism – all affecting injecting drug users – in late November 2008 (Long 2009b). The condition is caused by bacteria that are commonly found as spores in soil or gravel and can be acquired if a wound is contaminated by such material. The bacteria grow in skin abscesses as a result of injecting heroin but the bacteria can also reproduce in the nasal passages as a result of snorting cocaine. Symptoms of botulism usually develop about 12–36 hours after exposure to the toxin and normally begin with blurred vision, difficulty swallowing, difficulty speaking and occasionally breathing problems. Diarrhoea and vomiting can also occur and the disease can progress to paralysis. In recent years this type of botulism has been most commonly reported among chronic drug users, in Ireland and elsewhere. Most people (90–95%) with botulism will recover with treatment.

6.2.4 Behavioural data

There is no new information available.

6.3 Other drug-related health correlates and consequences

6.3.1 Non-fatal overdoses and drug-related emergencies

Data used in the following analysis were extracted from the Hospital In-Patient Enquiry (HIPE) scheme. There were 14,902 overdose cases in the period 2005 to 2007. Of these cases, 132 died in hospital and have been excluded from this analysis. A total of 14,770 cases were included in the following analysis.

Age Group

Figure 6.3.1 shows that the 15–24-year-old age group is at highest risk, with the incidence of overdose decreasing with age. The pattern remains the same for each of the years reported.

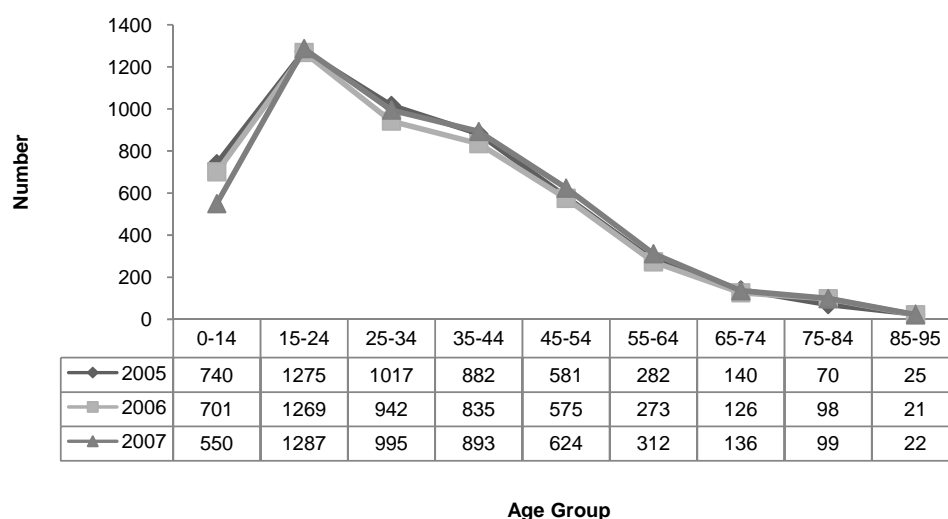


Figure 6.3.1 Incidence of overdose by age group by year, 2005–2007 (n=14,770)
Source: Unpublished data from the HIPE

Area of residence

Figure 6.3.2 shows the number and area of residence of recorded overdose cases between 2005 and 2007. Seventy-nine cases were resident outside of Ireland and 28 cases were recorded as having no fixed abode; these 107 cases were excluded from this analysis of area of residence. From 2005 to 2006 there was an increase (176, 20.4%) in overdose cases among persons resident in Dublin (city and county), followed by a decrease in 2007 (94, 9.1%). The opposite trends were reported for cases resident outside Dublin. Overall, almost one fifth of cases were among persons resident in Dublin.

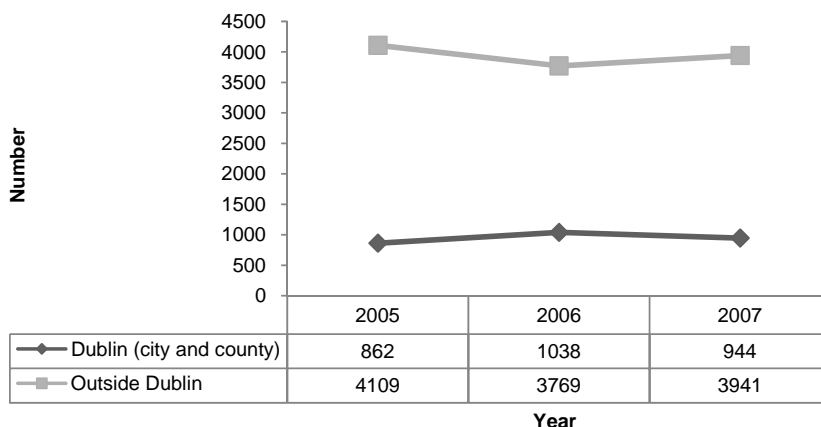


Figure 6.3.2 Area of residence of overdose cases, 2005–2007 (n=14,770)

Source: Unpublished data from the HIPE

Gender

There were more overdose cases among females than among males. There was a slight decrease (189, 6.8%) in the number of females cases in 2006, but this followed by an increase (86, 3.3%) in 2007 (Figure 6.3.3).

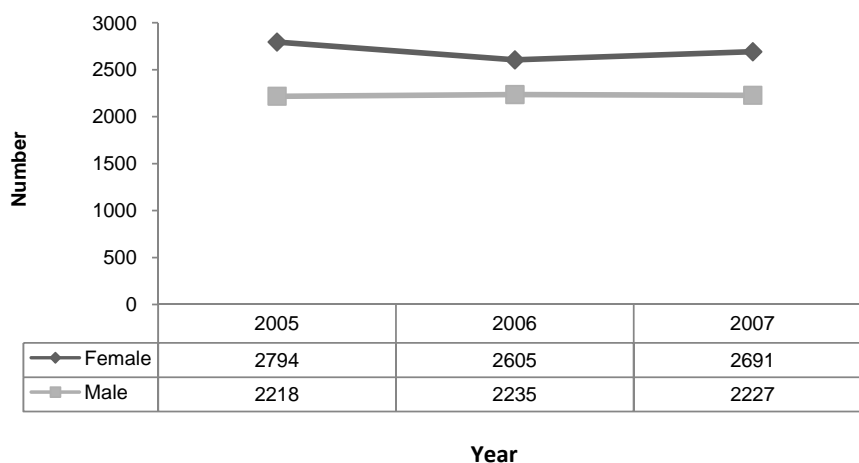


Figure 6.3.3 Incidence of overdose by gender, 2005–2007 (n=14,770)

Source: Unpublished data from the HIPE

Drugs involved

Table 6.3.1 presents all drugs and other substances involved in cases of overdose reported by HIPE from 2005 to 2007. Over two thirds (69.5%, 10,259) of all overdose cases in the reporting period involved nonopioid analgesics, 11.1% (1,647) involved narcotics or hallucinogens and 8.2% (1,207) involved psychotropic medication. There was evidence of alcohol consumption in 13.9% (2,066) of all overdose cases.

Table 6.3.1 Category of drugs involved in overdose cases, 2005–2007 (n=14,770)

Drug category	*Number	%
Nonopioid analgesics	10259	69.5

Drug category	*Number	%
Alcohol	2066	13.9
Narcotics or hallucinogens	1647	11.1
Psychotropic	1207	8.2
Other chemicals and noxious substance	1162	7.9
Benzodiazepines	919	6.2
Antiepileptic/Sedative/Antiparkinson	651	4.4
Autonomic nervous system	384	2.6
Systemic and haematological	216	1.5
Systemic antibiotics	205	1.4
Cardiovascular	188	1.3
Diuretics	162	1.1
Hormones	144	1.0
Gastrointestinal	141	0.9
Other gases and vapours	135	0.9
Muscle and respiratory	56	0.4
Anaesthetics	55	0.4
Topical agents	22	0.2
Antiinfectives/antiparasitics	8	0.0
Other and Unspecified Drugs	2762	18.7

*Total number differs from total number of cases as individual cases may have more than one drug or substance involved in their overdose

Source: Unpublished data from the HIPE

Intent

According to the National Registry of Deliberate Self-Harm Ireland Annual Report 2006–2007 (National Registry of Deliberate Self Harm Ireland 2008), which presents information relating to every presentation of deliberate self-harm to general hospital and paediatric hospital A&E departments in Ireland in 2006 and 2007, drug overdose was the most common form of deliberate self-harm, representing 74% of all such episodes reported in 2006–2007. Intentional overdose accounted for the majority (9,240, 62%) of overdose cases reported through HIPE for the years 2005 to 2007 inclusive (Figure 6.3.4).

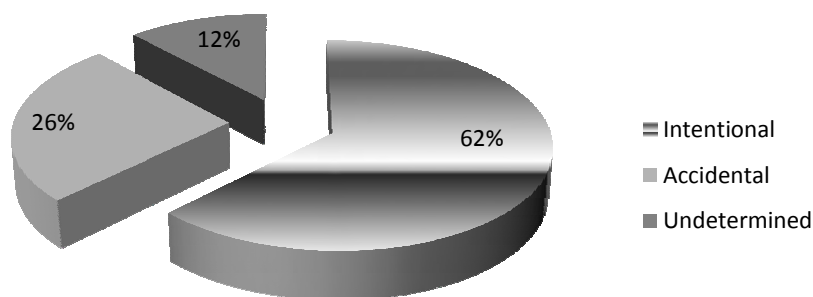


Figure 6.3.4 Intent of overdose, 2005–2007 (n=14,770)

Source: Unpublished data from the HIPE

Table 6.3.2 presents all drugs and other substances involved in cases of intentional overdose reported by HIPE from 2005 to 2007. Three quarters (85.2%, 7,877) of these cases involved nonopioid analgesics, 10.9% (1,007) involved psychotropic medication and 8.8% (810) involved narcotics or hallucinogens. There was evidence of alcohol consumption in 14.7% (1,360) of all intentional overdose cases.

Table 6.3.2 Category of drugs involved in intentional overdose cases, 2005–2007 (n=9,240)

Drug category	*Number	%
Nonopioid analgesics	7877	85.2
Alcohol	1360	14.7
Psychotropic	1007	10.9
Narcotics or hallucinogens	810	8.8
Benzodiazepines	727	7.9
Antiepileptic/Sedative/Antiparkinson	535	5.8
Autonomic nervous system	269	2.9
Systemic and haematological	169	1.8
Systemic antibiotics	161	1.7
Cardiovascular	130	1.4
Gastrointestinal	121	1.3
Other chemicals and noxious substance	121	1.3
Diuretics	108	1.2
Hormones	83	0.9
Muscle and respiratory	43	0.5
Anaesthetics	36	0.4
Other gases and vapours	36	0.4
Topical agents	10	0.1
Antiinfectives/antiparasitics	8	0.1
Other and Unspecified Drugs	1574	17.0

*Total number differs from total number of cases as individual cases may have more than one drug or substance involved in their overdose

Source: Unpublished data from the HIPE

Narcotics or hallucinogens

Narcotic or hallucinogen drugs were involved in 11.1% (1,647) of the total number of overdose cases for the reporting period. The number of overdoses involving narcotic or hallucinogenic drugs decreased by 4.6% (25) from 2005 to 2006, but increased by 13.7% (71) between 2006 and 2007.

The specific drug(s) involved is known for 45.0% (742) of these cases. In 8.5% (63) of cases more than one drug within this category of drugs was used in the overdose, therefore total figures may exceed 100%. Opiates accounted for 60.8% (451); other hallucinogens accounted for 18.3% (136); and cocaine accounted for 16.3% (121) (Figure 6.3.5).

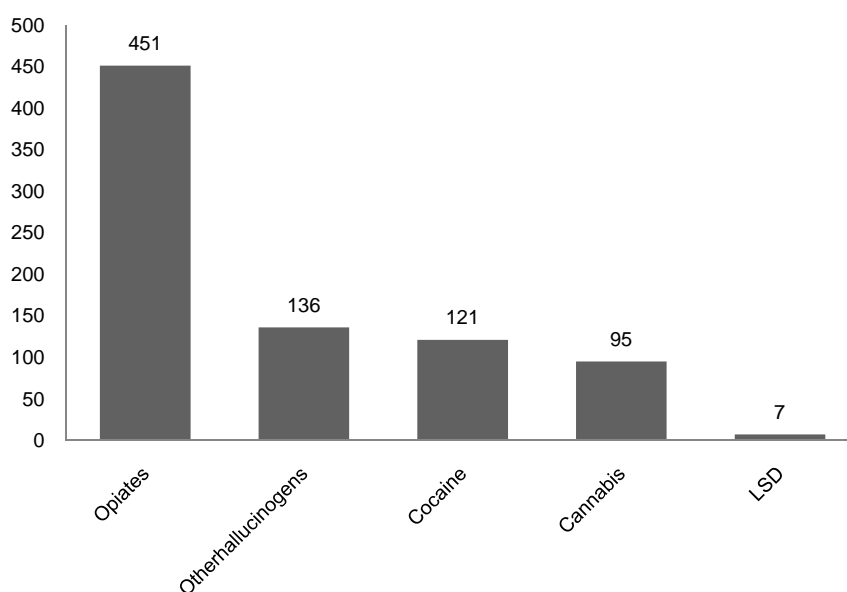


Figure 6.3.5 Drug type within narcotics and hallucinogens drug category, 2005–2007 (n = 742)

Source: Unpublished data from the HIPE

More than one quarter more males than females overdosed using narcotic or hallucinogen-type drugs during the period 2005 to 2007. The majority of cases (39.6%, 653) were in the 15–24-year-old group, and the incidence decreased in successive age groups between 25 and 95 years (Figure 6.3.6). A quarter (25.4%, 419) of overdose cases involving a narcotic or hallucinogen -type drug were resident in the Dublin region (city and county).

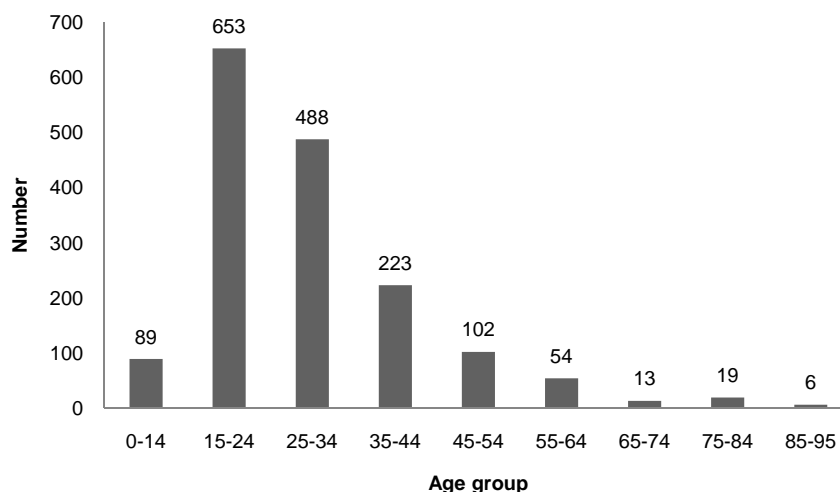


Figure 6.3.6 Age group within narcotics and hallucinogens drug category, 2005–2007 (n = 1647)
Source: Unpublished data from the HPSC

National Poisons Information Centre (NPIC) – 2007 report

According to its annual report (Poisons Information Centre of Ireland 2008), NPIC received 11,011 enquiries in 2007, a decrease of 7.5% on the 2006 figure. Of these, 2,459 were dealt with by NPIS in the UK and are not included in the analysis presented in the report. Of the 8,552 calls answered by NPIC, 8,277 (96.8%) were about human toxicology. The remaining calls concerned poisoning in animals (1.2%) and non-emergency requests for information (2.0%).

Of the 8,552 calls dealt with by NPIC, the highest proportion were from the HSE Eastern Region (28.4%), of which 79.8% were from Dublin city and county.

The most frequent enquiries were from hospitals (35.1%), general practitioners (34.9%) and members of the public (23.0%). The other sources of enquiries were community pharmacists, carers, vets, industry/manufacturers, schools, emergency services, media, and government agencies. The increased use by Irish emergency departments of TOXBASE, the online clinical toxicology database of the UK NPIS, is reflected in a 2.2% drop in the proportion of enquiries from hospitals since last year.

More than half of the enquiries about cases of poisoning in humans concerned children under 10 years of age (Table 6.3.3). The main agents involved in these cases were household products, cosmetics and personal hygiene products, and plants. The majority (88.5%) of all human poisoning incidents occurred in the home.

Table 6.3.3 Age and gender of enquiries about human cases of poisoning, recorded by NPIC, 2007

Age group	Gender			Total	%
	Male	Female	Unknown		
<1	159	152	114	425	5.1
1–4	1921	1588	66	3575	43.2
5–9	208	160	7	375	4.5
10–14	80	109	4	193	2.3

Age group	Gender			Total	%
	Male	Female	Unknown		
15–19	136	241	3	380	4.6
20–49	706	726	9	1441	17.4
50–69	159	206	3	368	4.4
>70	91	112	1	204	2.5
Unknown	434	499	383	1316	15.9
Total	3894	3793	590	8277	

Source: NPIC

The enquiries about human toxicology involved 13,538 agents, mainly drugs, industrial chemicals and household products. The most common enquiry concerned substances containing paracetamol (1,082). Alcohol was next most common (376), and in the majority of cases was ingested with other substances. The third most common agent was ibuprofen (363). Only a small proportion of cases (395, 4.8%) were followed up. Although most recovered completely, 21 cases suffered adverse effects, a further 17 cases died, while the outcome of 68 cases could not be determined.

National Registry of Deliberate Self-Harm – annual report 2008

See section 4.3.2

6.3.2 Other topics of interest

Morbidity among opiate users in methadone treatment

Cullen and colleagues (Cullen, W. *et al.* 2009) completed a study of problem opiate users attending general practice for methadone treatment to estimate the prevalence of chronic illness and examine patterns of health service utilisation among this group compared with matched controls in July 2008. The cases and controls were matched for practice, age, gender and general medical service (GMS) status. Data were collected on a sample of 114 patients attending three general practices: 57 cases attending for methadone treatment (19 per practice) and 57 controls attending for primary care (19 per practice).

Illness among opiate users in methadone treatment

The average age of cases was 37.2 years; 42 (74%) were male; 41 (72%) had GMS cover; all were Irish nationals; and 56 (98%) were documented as living in stable accommodation. Considerable lifetime contact with the practice was observed: 16 patients (28%) had been attending the practice for less than five years, 21 (37%) for between five and 10 years, and 20 (35%) for more than 10 years. There were three reasons for initial contact with the general practice: registration for general medical care (20 patients), treatment of illicit drug use (20 patients), and referral by specialist addiction treatment services for methadone treatment (17 patients). All patients had been prescribed methadone by specialist addiction services prior to attending the general practice for methadone treatment, and 14 (25%) had been referred back to specialist addiction services since commencing methadone treatment at the practice (six in the previous year). The average dose of methadone prescribed (based on the last issued prescription) was 66 mg daily.

Fifty-two patients (91%) had one or more chronic illnesses (in addition to opiate dependence) documented in their clinical record. Hepatitis C (38, 66%), depression (20, 35%), asthma (14, 25%), HIV/AIDS (8, 14%) and DVT/varicose veins/thrombophlebitis (4, 7%) were the most common chronic illnesses recorded. Thirty-nine patients (68%) were on regular prescribed medication in addition to methadone. Thirty-one patients (54%) had had at least one acute condition during the previous three months, of which the most common were: upper respiratory tract infection (10, 18%), insomnia, anxiety or depression (4, 7%), abdominal pain (4, 7%), urinary tract infection

(3, 5%) and ear wax (3, 5%). Tobacco use was noted in the records of 39 patients, of whom 37 were recorded as smokers. Twenty-five patients (44%) had been prescribed at least one time-limited medication (in addition to methadone) for the treatment of an acute illness during the previous three months. In the previous six months, patients had attended their GP for issues other than their addiction care an average of four times, and 27 patients (47%) had either been referred to or attended secondary care.

Comparison with a matched control group

The average age of controls was 37.2 years, 42(74%) were male, 41(72%) had GMS cover, all were Irish nationals and 38 (67%) were documented as living in stable accommodation. Morbidity and health service utilisation rates were high among this group also (Figure 6.3.7). Patients attending for methadone treatment were significantly more likely to have a chronic illness, to be prescribed recurrent medications and to attend a general practice.

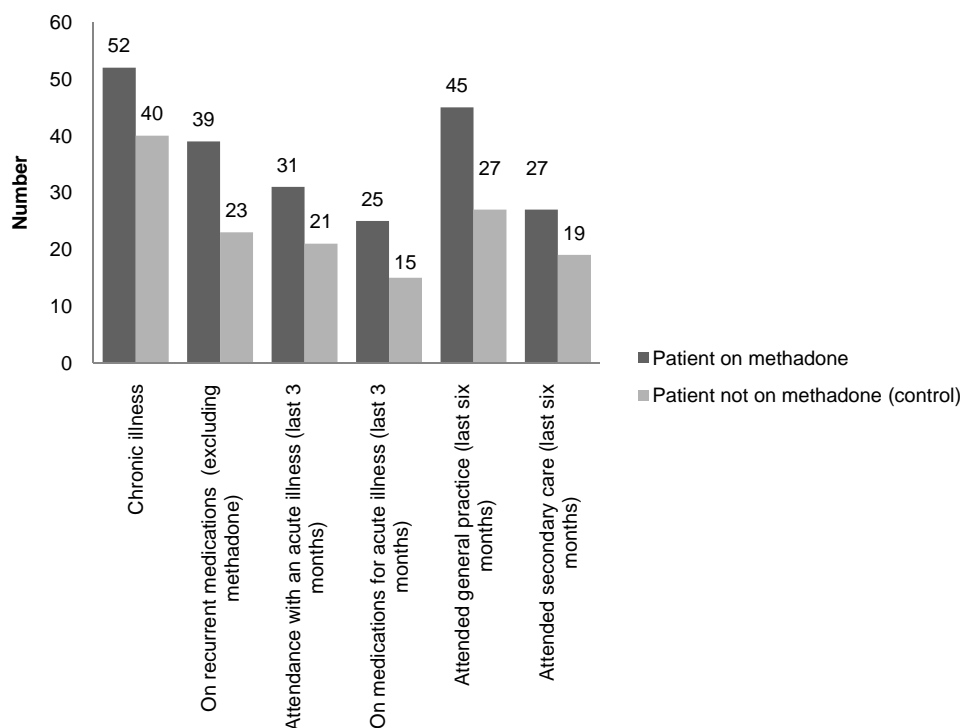


Figure 6.3.7 Comparison of morbidity profile and health service utilisation among patients on methadone and matched controls attending inner city general practices in Dublin, July 2008.

Source: (Cullen, W. *et al.* 2009)

An unusual medical complication of heroin abuse, a case report

O'Connor and McMahon (O'Connor and McMahon 2008) reported a case of atraumatic rhabdomyolysis in a 21-year-old man who presented to the emergency department in St James's Hospital by ambulance. He was found collapsed at home by his uncle, complaining of severe pain and swelling in his left lower leg, with reduced sensation to his left foot. He was hepatitis C positive from intravenous drug use, and had used both heroin and cocaine five days previously on his release from prison.

Musculo-skeletal exam showed extensive swelling of his left lower leg, with tense calf compartments. Initial laboratory results showed a raised creatine kinase of more than 155,000 IU/l. Urine toxicology was positive for methadone, heroin and benzodiazepines, whereas urinary dipstick was positive for blood, which subsequent laboratory analysis confirmed to be myoglobin. Atraumatic rhabdomyolysis is a syndrome characterised by injury to skeletal muscle with subsequent release of intracellular contents, that is, myoglobin and creatine kinase. Drugs have direct toxic effects, but may also cause coma-induced rhabdomyolysis, owing to unrelieved

pressure on gravity-dependent body parts. Diagnosis is made with history (i.e. recent heroin or cocaine use), elevated serum CK, plus the possible presence of myoglobinuria.

Aggressive intravenous rehydration remains the mainstay of treatment. If there is any evidence of compartment syndrome, urgent fasciotomy is required. Electrolyte imbalances should be corrected, unless very mildly abnormal. A high index of suspicion and thereby early recognition is crucial to prevent complications in intravenous drug users presenting with unusual symptoms and signs.

Alcohol use among opiate users in methadone treatment in general practice

Ryder and colleagues (Ryder *et al.* 2009) estimated that 35% (95% CI = 28%–41%) of a sample of current or former heroin users attending general practice for methadone treatment were problem alcohol users, and that 14% of the sample were dependent users. According to data from the National Drug Treatment Reporting System, 24% of opiate users entering opiate treatment reported alcohol as an additional problem drug, which is lower than the estimate presented here.

The authors surveyed 196 patients, which represented 8% of those on the Central Treatment List, 31% of those selected in the sample of current or former heroin users attending general practice for methadone treatment, and 71% of those sampled who were invited by their general practitioner to participate. The response rate was lower than desired – an indication of the difficulty that can be associated with doing research among patients attending private general practitioners in Ireland. The authors used a survey questionnaire which included the Alcohol Use Disorders Identification Test (AUDIT) to assess participants' alcohol use, and also collected data on socio-demographic, medical and substance use characteristics.

The median age of the 196 participants was 32 years, 68% were male, 79% said that they had used one or more illicit drugs in the previous month, and 76% had ever injected drugs. Of those who knew their blood-borne viral status, 55% said that they were hepatitis C positive and 5% said that they were HIV positive. Other research indicates that self-reported hepatitis C and HIV status can both over- and underestimate the prevalence of these infections and should be interpreted with caution.

The cases classified as problem alcohol users were significantly more likely to have attended a local emergency department in the previous year and less likely to have attended a hospital clinic in the previous year compared to those who were not problem alcohol users. Among the 107 respondents who reported that they were hepatitis C positive, those who were problem alcohol users were significantly less likely to have attended a specialist hepatology clinic than their counterparts.

The authors concluded that problem alcohol use has a high prevalence among current or former heroin users attending primary care for methadone treatment, and that interventions that address this issue should be explored as a priority.

Trends in drug admissions to psychiatric facilities

Activities of Irish psychiatric units and hospitals 2007, the annual report published by the Mental Health Research Unit of the Health Research Board in December 2008, shows that the total number of admissions to inpatient care has continued to fall (Daly, A *et al.* 2008).

In 2006, 724 cases were admitted to psychiatric facilities with a drug disorder, of whom 265 were treated for the first time (Daly, A *et al.* 2008). The report does not present data on drug use and psychiatric co-morbidity, so it is not possible to determine whether or not these admissions were appropriate. Figure 6.3.8 presents the rates between 1990 and 2007 of first admission of cases with a diagnosis of drug disorder,

per 100,000 of the population. The rate increased steadily between 1991 and 1995, with a dip in 1996 and 1997, and further annual increases between 1998 and 2001. The rate was almost three times higher in 2001 than it was in 1990. Notable dips in the rate occur in the census years 1996 and 2002, and can be partly explained by the increased population figure used as the denominator in calculating the rate for those years.

The overall increase in the rate of drug-related first admissions between 1990 and 2001 reflects the increase in problem drug use in Ireland and its burden on the psychiatric services. The overall decrease in the rate since 2001 possibly reflects an increase in community-based specialised addiction services during this period. The increased rate in 2005 may be accounted for by the use of the 2002 census figure in calculating the rate. The decrease to 5.9 in 2006 reflects the new census figure used as denominator. The rate increased marginally to 6.3 in 2007. Of the 776 discharges with a drug disorder, 51% spent less than one week in hospital and just under 13% spent more than one month in hospital.

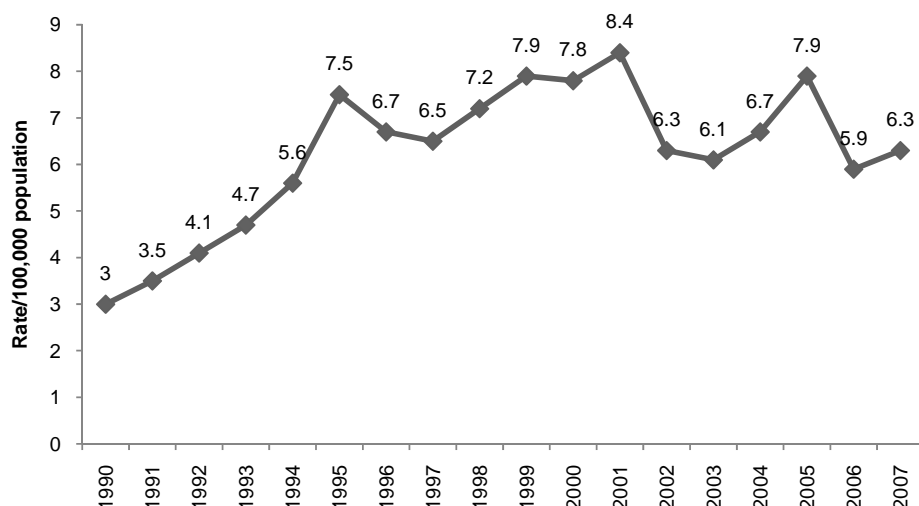


Figure 6.3.8 Rates of psychiatric first admission of cases with a diagnosis of drug disorder (using the ICD-10 three character categories) per 100,000 of the population in Ireland and reported to the National Psychiatric Inpatient Reporting System, 1990–2007

Source: (Daly, Antoinette and Walsh 2003; Daly, A. *et al.* 2005; Daly, A. *et al.* 2007; Daly, A. *et al.* 2008; Daly, Antoinette *et al.* 2004; Daly, Antoinette *et al.* 2006)

6.4 Drug-related deaths and mortality of drug users

The first analysis of data from the NDRDI was published in 2008 (Lyons, Suzi *et al.* 2008). It reported on directly drug-related deaths (poisonings) in Ireland between 1998 and 2005. These data were reported in the 2008 National Report (Alcohol and Drug Research Unit 2008). Data on directly drug-related deaths (poisonings) in 2006 and 2007 have now been collected and analysed and these new data, which have not yet been published in a separate national-level report, are described below in Section 6.4.1.

The first national report on non-poisoning deaths among drug users in Ireland was published in November 2009. It describes trends in non-poisoning deaths (deaths due to traumatic or medical causes) among drug users between 1998 and 2005. These data are described below in Section 6.4.2.

6.4.1 Drug-induced deaths

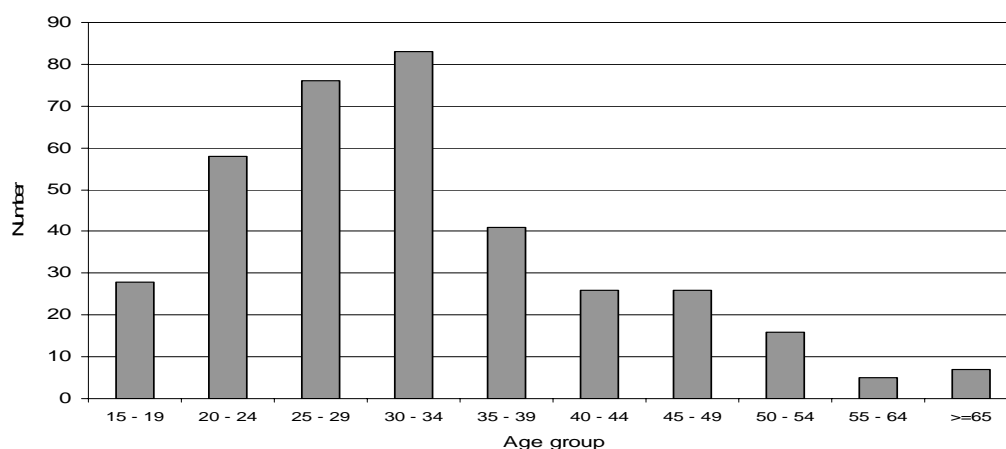
The number of poisonings recorded in Ireland (as per Selection D) has been rising steadily in the last four years, from 108 in 2003 to 181 in 2006 and to 185 in 2007 (Table 6.4.1, also see Standard Table 6).

Table 6.4.1 Poisonings (Selection D) by year, 1998 to 2007 (N=1328)

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Selection D	104	115	113	107	126	108	126	163	181	185

Source: Unpublished data NDRDI

In the last two years for which data have recently become available, 2006–2007, over three-quarters of cases have been male (287, 78.4%). The majority of cases (258, 70.5%) have been aged between 20 and 40 years (Figure 6.4.1) and the median age has been 31 years. Forty-four percent (162) of all poisonings have been aged 30 years or less. This is a very similar profile to that of poisoning deaths reported in Ireland between 1998 and 2005 (Lyons, Suzi *et al.* 2008) and in other countries during the same period (Ghodse *et al.* 2007).

**Figure 6.4.1 Age group of poisonings in Ireland (selection D), 2006 to 2007 (N=366)**

Source: Unpublished data NDRDI

Of the 366 cases of poisoning recorded in 2006 and 2007, heroin and unspecified opiates accounted for 84 (23.0%) cases, while methadone alone accounted for 20 (5.5%). This pattern is similar to that reported for the period 1998 to 2005 (Lyons, Suzi *et al.* 2008). Almost half of all deaths owing to poisoning (180, 49.2%) were attributable to polysubstances including an opiate, which is slightly lower than in previous years (Lyons, Suzi *et al.* 2008).

In 2007, 74.1% of fatal overdoses were associated with opiate use. Deaths as a result of poisoning from cocaine, alone or with another drug, accounted for 28.6% (n=53) of poisoning deaths in 2007.

From a national perspective, alcohol and other drugs, including benzodiazepines, non-benzodiazepine sedatives, antidepressants, other prescription medication and over-the-counter medication contribute significantly to the burden of drug-related deaths in Ireland but are not presented in this national report for the EMCDDA. For further information on the national situation, see the most recent publication at http://www.hrb.ie/uploads/tx_hrbpublications/HRB_Trend_Series_4_01.pdf.

6.4.2 Mortality and causes of deaths among drug users

See Section 6.4.1 and Section 6.4.3

6.4.3 Specific causes of mortality indirectly related to drug use

A total of 885 non-poisoning deaths among drug users were recorded between 1998 and 2005. Of those with a known cause of death (n=746), 476 (63.8%) were due to trauma and 270 (36.2%) were due to medical causes.

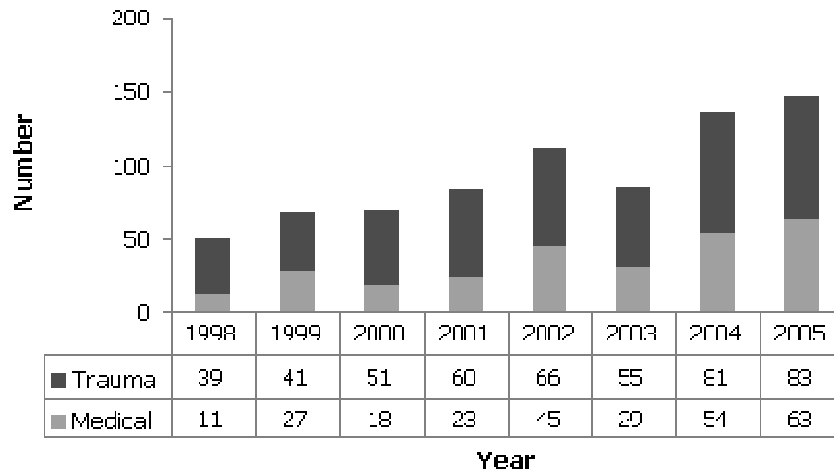


Figure 6.4.2 Non-poisoning deaths among drug users, NDRDI 1998 to 2005 (N=746)
 Source: (Lynn *et al.* In press)

The annual number of deaths owing to trauma increased from 39 in 1998 to 83 in 2005. Half of these deaths were among young men aged between 20 and 29 years. The most common causes of death owing to trauma were hanging (174, 36.5%) and road traffic collisions (95, 20.0%). Almost half of those involved in road traffic collisions were driving the vehicle.

A positive toxicology report was available in 412 (86.5%) cases of death owing to trauma. In many cases more than one substance was present. When these cases were analysed by type of death, the results show that:

- Alcohol was present in nearly three-fifths (241, 58.5%) of deaths.
- Cannabis was the illicit drug most commonly found (227, 55.1%).
- Cannabis (40, 67.8%), opiates (24, 40.7%) and cocaine (18, 30.5%) were found in the greatest proportions in deaths owing to violence (shooting, stabbing or assault).
- MDMA (ecstasy) (26, 28.6%) was found in the greatest proportion among the deaths owing to road traffic collisions.

The annual number of deaths owing to medical causes increased from 11 in 1998 to 63 in 2005. Over three-quarters of these deaths were among males, and the majority were aged between 30 and 44 years. The most common medical causes of death were cardiac events (67, 24.8%), followed by respiratory infections (48, 17.8%) and liver disease (31, 11.5%). When drug-use history is analysed by medical cause of death, the results show that:

- The majority (180, 66.7%) of drug users who died of medical causes had a history of opiate use.
- Two fifths (13, 41.9%) of those who died of liver disease had a history of alcohol dependency.
- The highest number of cocaine users (n=12) and of cannabis users (n=24) was among those who died from a cardiac event.

Of the total number of deaths (including poisoning and non-poisoning deaths) recorded by the NDRDI in the period 1998–2005, 192 (7.9%) cases had a documented history of a blood-borne viral infection. The annual number of these cases increased from nine in 1998 to 41 in 2005. The number of drug users who have acquired a blood-borne viral infection highlights the need for continued and expanded harm reduction programmes, including treatment for problem alcohol use, to reduce the risk of infection and to prevent the long-term health consequences of liver damage.

The number of drug users who have died from hanging or from drowning supports the argument that substance misuse is related to suicide. There is a need for increased awareness and education around this issue, especially for those with a dual diagnosis of mental health and substance misuse problems who are already in treatment and those who present at emergency rooms with non-fatal drug- or alcohol-related injuries.

The number of drug users who were driving at the time of their death and had a positive toxicology is further evidence of the need for more reliable statistics on drink/drug driving. There is a need for expansion of the forensic analysis programme to ascertain the true incidence of driving while under the influence of drugs and/or alcohol. However, there is currently no reliable system of road-side test for the presence of drugs in the body (European Monitoring Centre for Drugs and Drug Addiction 2009).

The correlation of toxicology and drug-use history with the type of death recorded supports the argument that drug use is contributing to the premature death of drug users in Ireland. More effective measures are required to educate drug users about the health consequences of drug use, particularly the cardio-toxic effects of cocaine.

The continuing upward trend in drug-related deaths reflects the increasing numbers in the population who are consuming drugs and taking risks and who have acquired infections or developed medical conditions associated with drug use.

7. Responses to Health Correlates and Consequences

7.1 Introduction

This chapter presents new data on preventing drug-related mortality, the management of blood-borne viral infections, and responses to co-morbidity. The public and voluntary sector institutions that have been engaged in the various initiatives described in the following sections are briefly described here.

In May 2008 the Joint Oireachtas (Parliamentary) Committee on Health and Children formed a sub-committee to consider the high level of suicide in Irish society, and in particular to monitor the implementation of recommendations made in the Joint Oireachtas Committee on Health and Children's 7th Report on The High Rates of Suicide in Irish Society, which had been published in July 2006. The report of this sub-committee, published in June 2009, is described in this chapter. (A joint Oireachtas committee comprises the Select Committees of both Houses of Parliament (Senate and Dáil) sitting and voting together.)

The Health Service Executive (HSE) is responsible for managing and delivering health and personal social services in Ireland. It operates through three areas of service delivery – Primary Community and Continuing Care (PCCC), National Hospitals Office (NHO), and Population Health (PH) – and supports numerous responses to the health correlates and consequences of problematic drug use.

The National Immunisation Advisory Committee (NIAC) is a Standing Committee of the Royal College of Physicians of Ireland (RCPI). It advises the Department of Health and Children in the area of immunisation procedures and related matters. It prepares and maintains the Immunisation Guidelines for Ireland with the assistance of an active committee from associated disciplines in paediatrics, infectious diseases, general practice and public health.

Community Response is a partnership of statutory, voluntary and community interests concerned with issues of problem drug use, drug-related hep C, HIV/AIDS and drug-related crime in the south inner-city area of Dublin. Its aim is to develop and devise practical and effective ways of tracking problem drug use and its effects in Dublin's south inner city, and to work with the local community to determine its own solutions to drug-related issues. Its services include training, education, family support, health promotion, referrals and information-giving. It offers a one-year part-time course leading to a Certificate in Addiction Studies, which is accredited by NUI Maynooth. Its team of community development workers offer a range of workshops which explore such complex issues as Domestic Violence, Drug and Alcohol use, Prejudice and Discrimination.

The Ana Liffey Drug Project (ALDP) is a voluntary organisation offering a low-threshold harm-reduction service in north inner-city Dublin. It works with people experiencing addiction, to minimise the harm that problematic drug use causes them, their families and the wider community. It provides a range of services including a drop-in service, outreach service, family care and case management service, peer-support group and literacy tutoring.

Merchants Quay Ireland (MQI) is a voluntary organisation providing services to people who are homeless and for drug users. Its drug-related services include open access, day support services and settlement and integration services, residential drug treatment, and training, research and policy development services

The Mental Health Commission (MHC) is an independent statutory body established under the Mental Health Act 2001. It is tasked with promoting high standards in the delivery of mental health services in Ireland and ensures the interests of those involuntarily admitted to 'approved centres' are protected.

7.2 Prevention of drug-related emergencies and reduction of drug-related deaths

A Joint Oireachtas sub-committee was established in 2005 to examine in detail the issue of suicide in Irish society; to engage with those who work in suicide prevention; and to hear evidence from those involved in post-suicide counselling and support. According to the World Health Organization, suicide is among the three leading causes of death worldwide among people in the 15–44-year-old age bracket. In 2004, there were 27.1 deaths/100,000 population among men in Ireland, compared to 6.1 in England. For females the rate was 2.9/100,000 population, compared to 1.7 in England. Youth suicide rates in Ireland are the fifth highest in the European Union.

The sub-committee's report, *The high level of suicide in Irish society*, was published in 2006 and accepted for implementation (Joint Committee on Health and Children 2006). It provided detailed information on the extent of suicide in Ireland and made 33 recommendations on how to address the problem. A report by a new sub-committee, published in June 2009, reviewed the extent to which these recommendations had been implemented, and identified the obstacles that had prevented their implementation (Joint Committee on Health and Children 2009) (Table 7.2.1).

Table 7.2.1 Recommendations, and progress on their implementation

Oireachtas report recommendations 2006	Progress
Appoint a suicide prevention officer	Very limited progress
Establish a health and education liaison group	Very limited progress
Appoint a national co-coordinator for the education sector	No significant progress
Set up an evidence-based health promotion programme for transition year students	No significant progress
Develop national training programmes in suicide prevention for teachers, voluntary organisations, primary care teams, hospital staff and mental health service staff	Very limited progress
Organise a consultation with young people	Some progress
Develop anti-stigma and positive mental health promotion media campaign	Some progress
Standardise support and information provided by primary care services to those bereaved by suicide	Some progress
Pilot a fast-track referral system from primary care to mental health services for suicidal individuals	Almost complete
Standardise pre-discharge and transfer planning from or between mental health services	Very limited progress
Develop staff guidelines for people presenting to hospital following self harm	No substantial progress
Conduct study to compare different models of service provision to those presenting to emergency departments with self-harm	Very limited progress
Determine the risk of suicide associated with being in a marginal group, review services and develop new ones as needed	Very limited progress
Develop inpatient units for children with mental health problems and integrate adult and child services administratively	Very limited progress
Implement recommendations from the Inspectorate of Mental Health services within 5 years or Minister or Inspector to resign	No substantial progress
Implement recommendations of alcohol task force; establish screening protocol for intervention of problem alcohol use; establish a range of effective, accessible, appropriate and integrated alcohol treatment services in each HSE area with explicit pathways of care for those seeking treatment for problem alcohol use	Some progress from the Dept. of Justice but very little else
Review and develop a national policy on current alcohol and addiction treatment services	No substantial progress
Evaluate psychological support services for those in prisons	Very limited progress
Provide training for gardaí and prison officers in supporting suicidal individuals	Very limited progress
Review and develop a service plan for bereavement services	Complete
Formally co-ordinate the various voluntary agencies working in the area of suicide bereavement support	No substantial progress
Develop and implement protocols for health service response in the event of suicide clusters	No substantial progress
Facilitate communication between the gardaí, coroners and suicide resource officers so that in the event of a suicide families and others can be provided with information on bereavement support services	Very limited progress
Develop evaluation criteria for a pilot mental health promotion and support initiative for young men	Very limited progress
Evaluate the risk of suicide associated with over-the-counter medications and develop and implement guidelines	No substantial progress
Enable the safe disposal of unused and unwanted medicines	Very limited progress
Examine whether certain Irish places are associated with suicide and implement ways of making these places safer	No substantial progress
Appoint coroner's officers to act as links between the coroner service and the public	Very limited progress
Establish a technical group to link and exchange data between relevant national information systems including the National Drug Treatment Reporting System and the National Drug-related Deaths Index	No substantial progress
Establish a national confidential enquiry into deaths from unnatural causes, including suicide	No substantial progress

Oireachtas report recommendations 2006	Progress
Establish a national ethics committee to oversee suicide-related research	No substantial progress
Agree a national programme of research into self-harm, suicide and suicide prevention	No substantial progress
Publish suicide research guidelines for donors providing funding	No substantial progress

It appears that many of the recommendations outlined in 2006 have not been progressed at all. In addition, the few recommendations that have been completed or mostly completed now need financial resources and political support in order to develop and implement their findings. The report concluded that immediate change is required to properly address the ongoing serious problem of suicide in Ireland. The National Office for Suicide Prevention needs adequate and sustained funding, a higher level of interagency collaboration, and the requisite political support if it is to have any chance of fully implementing the recommendations made in the 2006 Oireachtas report.

7.2.1 Nursing assessment of episodes of deliberate self-harm

In January 2008 a research study *Accident & Emergency Nursing Assessment of Deliberate Self Harm* was released by the HSE South and the National Suicide Research Foundation Ireland (Lamb *et al.* 2008). It reported on a pilot study exploring 'the impact of introducing a suicide education programme and a suicide intent scale into A&E/MAU [Medical Assessment Unit] nursing practice'. The study was based on the concern that inadequate assessment of deliberate self-harm (DSH) patients may result in failure to diagnose treatable underlying conditions such as alcohol and drug dependence. Key findings of the study were that (a) the provision of training was associated with a significant increase in nurses' confidence in dealing with DSH patients and positive changes in their attitudes towards suicidal behaviour and its prevention, and (b) the use of a suicide intent scale is potentially valuable in referring DSH patients presenting at A&E/MAU to the appropriate service.

7.3 Prevention and treatment of drug-related infectious diseases

7.3.1 Strategy to deal with hepatitis C

In January 2007, the HSE established a working group on hepatitis C. The brief of this group is to build on a 2004 unpublished report on hepatitis C carried out by the then Eastern Regional Health Authority. Unlike the 2004 report, the 2007 initiative has a national brief. It is examining how Ireland can best respond to hepatitis C in the areas of surveillance, education and treatment. The working group will comment on how the recommendations of the 2004 report have been progressed. It will bring forward costed and prioritised recommendations. The group has completed its report and is waiting to present it to HSE senior management (J Barry, personal communication, July 2009).

7.3.2 Inclusion of hepatitis B vaccine in the Irish Childhood Immunisation Programme

The National Immunisation Advisory Committee and the Department of Health and Children recommended significant changes to Ireland's national childhood immunisation programme in 2008 (National Immunisation Advisory Committee 2008). These changes, which were published in the revised *Immunisation guidelines for Ireland 2008*, include the addition of hepatitis B vaccine to the routine childhood programme. The 5-in-1 childhood vaccine was to be replaced with a 6-in-1 vaccine which includes hepatitis B vaccine. In the *Immunisation guidelines for Ireland 2002*, hepatitis B vaccine was recommended for several high-risk groups rather than the child population; prisoners and injecting drug users were two of the high-risk groups named (National Immunisation Advisory Committee 2002).

7.3.3 World Hepatitis Day

On 19 May 2008, the Blood Borne Virus Forum marked World Hepatitis Day with an Open Day at Community Response, Carman's Court, Dublin 8. The purpose of the

open day was to raise awareness about hepatitis and in particular about hepatitis C. Attention was drawn to the fact that almost 20,000 Irish people could be infected with hepatitis C and most do not know that they are infected. Information on the symptoms of hepatitis C, its routes of transmission and testing and treatment procedures was provided using educational posters, leaflets and interactive activities.

Two short films were shown - *Hidden I* and *Hidden II* – both of which were produced by Community Response Drama Group and developed through improvisation and role-play. *Hidden I* is an educational drama about drug use, pregnancy and hepatitis C, while *Hidden II* continues the story and educates the viewer about testing and treatment for hepatitis C.

A new hepatitis C awareness board game and DVD were launched at the open day. The board game can be played by up to 10 people and requires players to answer a possible 29 questions about hepatitis C. Postcards which provide information on the risk factors for hepatitis C infection were also launched. The postcards were to be made available in cafés nationwide.

7.3.4 Innovative outreach work

In August 2008, the Ana Liffey Drug Project (ALDP) adopted assertive street-based outreach work in which staff seek to engage people who are based on the streets of Dublin's inner city and who may experience problem drug use and/ or homelessness. According to the project, there are a number of reasons people may not wish to access centre-based services; by conducting outreach they can ensure that these people are not excluded from ALDP and other services. In many ways, the assertive outreach function is an extension of the ALDP's drop-in work – 'we can provide friendly, non-judgmental advice and support on the streets'. Services provided include advocacy, phone calls, referrals to ALDP (and other services) and brief solution-focused interventions.

In November 2008, ALDP launched peer-led outreach, disseminating information about keeping safe on the streets, created by the ALDP peer group - Duck, Dive and Survive. ALDP asked the peer group what they felt was inappropriate and appropriate behaviour on the street. Based on their discussion, the ALDP supported them to create a durable leaflet with a few handy tips for staying safe on the street. The leaflets also promoted the ALDP freephone number.

In March 2009 the Dublin City Business Improvement District (DBID) announced a long-term partnership with the ALDP to help improve the quality of life and conditions of its service users and ultimately assist them in finding greater structure in their lives. Rooted in the 'Continuum of Care' principle, the partnership will operate at both a strategic level and also on the ground where its team of 12 street ambassadors will provide information and refer potential clients to the ALDP. As the first step, the DBID announced its contribution towards the purchase of an eight-seater van to support the ALDP Outreach Programme which includes advocacy, referrals, and interventions on the streets of Dublin City Centre.

In June 2009 the ALDP used a bursary, awarded for coming first in the New Initiatives category of the Crystal Clear MSD Health Literacy Award 2009[1] for its Duck, Dive and Survive series, to establish an SMS text messaging service for its service users. Named 'Survive' SMS Texting Service for people who use drugs, it uses mobile phone technology to communicate with one of Dublin's most marginalised groups. Information provided by SMS includes:

- any change to opening times to key services,
- advice on overdose risks and prevention,
- new trends and dangers relating to illicit drug use, and
- information from service users.

The ALDP work with the Service Users 'Peer Group' to identify key messages to be sent to their peers via this service. An example of a group text message sent to people who attended the ALDP during June 2009 is: 'OVERDOSE: Don't panic. Put them in the recovery position, dial 999, ask for an ambulance and stay with them until the ambulance arrives. Ana Liffey: 1800786828'. Tony Duffin, the ALDP Director, commented: 'There is a high rate of mobile telephone use among the people who use ALDP's services. This innovative approach will reach many people in their day-to-day lives and offer real time information on reducing the risks associated with drug use. During June 2009 over 50 service users signed up to the Duck, Dive and Survive SMS service, and the feedback has been very positive.'

In a separate initiative, also in June 2009, Dublin-based ambient advertising specialists[2] Captive agreed to provide pro bono ambient advertising for Ana Liffey Drug Project. The Duck, Dive and Survive poster that promotes ALDP's freephone was placed in 20 city-centre locations.

7.3.5 Information leaflet on needle-exchange services

In July 2009, the HSE East Coast Area needle-exchange service launched an information leaflet for people who inject drugs (John Craven, personal communication, 2009). The aim of the leaflet is to encourage injectors not to share and never to re-use injecting equipment.

The leaflet includes advice about safer injecting practices and provides guidance on how to look after veins and limit vein damage. It stresses the importance of never sharing drug-taking equipment in order to help prevent the transmission or acquisition of hepatitis and HIV. While the main focus is on injecting drug use, the leaflet states that blood-borne viruses can also be transmitted or acquired by sharing snorting equipment.

Service users are encouraged to seek further advice from needle-exchange services, which are listed in the leaflet, with their opening hours and contact details. Information is also provided on services providing HIV/AIDS prevention, drug treatment and counselling, and the community addiction teams, in the East Coast area. For people seeking treatment and counselling services in other areas, a helpline number is given.

7.3.6 MQI safer injecting guide

On 3 April 2008 Merchants Quay Ireland (MQI) launched the booklet *Safer injecting* at a seminar focused on reducing the harm associated with injecting drug use (Merchants Quay Ireland 2008).

This safer injecting guide was produced for people who inject drugs. The booklet includes advice about safer injecting practices and different types of injecting – into a vein or muscle, or under the skin (skin popping). The importance of washing one's hands prior to injecting to reduce the risk of infection is a simple and important point highlighted in the guide. Advice is provided about how to look after veins and decrease vein damage. Readers are encouraged to seek medical attention if they experience any health issues associated with injecting. A full description of the necessary injecting equipment is provided, along with the important statement that 'single-use syringes are the safest as water and/or bleach will not destroy all viruses'. Overdose prevention techniques and responses are described, along with information on the increased risk of overdose owing to polydrug use. The necessity for protection against the acquisition and transmission of blood-borne viruses is also discussed.

7.3.7 Profile of needle exchange services in Ireland

Needle and syringe exchange services were first provided in Ireland in 1989, when five exchanges were established. There are now 34 exchanges in the country, operating

three models of service: fixed-site exchanges, home visit exchanges, and exchanges in public locations. Peer-based, pharmacy, prison-based or vending machine exchange services are not available in Ireland.

The Health Research Board collated information to profile 31 needle and syringe exchange services operating between November 2007 and February 2008 in Ireland (Robinson *et al.* 2008). A service-inventory questionnaire was used to collect the data. The questionnaire comprised six sections: administrative details, profile of target population, profile of staff and volunteers working in the service, activities, management issues and new phenomena in relation to drug use (Working Group on Data Collection within the Correlation Network 2008). The 31 services provided exchanges at fixed sites (28), on home visits (3) and in public locations (2); two services provided exchanges in two settings.

Of the exchanges surveyed, 17 were operated by government, 11 by a partnership of government and non-government organisations, and 3 by non-government organisations. Two services provided social and medical care; six provided social care only and four provided medical care only. All provided services without charge to the client.

Weekly opening times ranged from 24 and three-quarter hours over five days in one service to one hour on one day in three services. Twenty of the services were open on one day a week for 1–2½ hours. One service was open on seven days a week for one hour each day; this was the only service that operated at weekends. Eight of the services were open after 5 pm on one night a week.

Of the 31 services, 20 provided services in urban locations, 12 in inner city locations and 3 in rural locations; some services operated in more than one location. The majority reported a dispersed open drug scene and/or a hidden scene in their areas.

Seven of the services had no formal data-collection procedures, and two services were not open for all of 2007. A total of 22 services reported 7,069 client attendances in 2007.

Overall, between 10% and 30% of clients were female. The youngest clients were aged between 16 and 20 years. Twenty-five services were open to any person aged over 18; five of these also dealt with 16–18-year-olds. Two services catered for women and sex workers; two served residents only; and two operated specific services for ethnic minorities. Twenty-nine services reported that a significant minority of their clients were homeless.

Twenty-nine services reported heroin as the drug most commonly used by clients; 18 services reported cocaine as the most common. As expected, injecting was the most common route of administration (reported by 19 services). Benzodiazepine injecting was reported as a common practice by 11 services. Nineteen services reported that clients attending their service injected steroids.

Thirty services reported that the outreach workers had an academic (but not a professional) qualification. The remaining service reported that staff did not have formal qualifications. Thirty services were operated by two or more staff during a session; 15 had a general assistant present. Six services provided on-site access to health services, usually provided by a nurse; four provided on-site access to counsellors.

All 31 services reported that staff received training in the assessment of clients' sexual risk practices and injecting practices, and on emergency responses such as overdose prevention techniques. Twenty-six services had a written document about staff training.

A variety of policy and procedural documents have been developed to guide the operation of needle and syringe exchange services in Ireland. A written document for

service providers in relation to health and safety issues was available in all services. A written document in relation to the health and safety of clients was available in 20 services. Thirty services offered staff vaccination against hepatitis A and B, and seven offered staff vaccination against tetanus.

All 31 services completed an assessment when a client accessed the service for the first time. The majority of services recorded clients' drug use, drug history and sexual health practices in the past year. The majority also recorded the blood-borne viral (BBV) infection status of their clients as well as their BBV test and treatment history. The amount of information recorded at the initial visit depended on how comfortable the client was in divulging this information. In some cases, service providers recorded basic client information (such as name, date of birth, drug of choice and mode of administration) at the initial visit and obtained additional details at subsequent visits. No service developed a written care plan for clients. However, 28 services reported reviewing clients' needs after a number of visits – in some services after every two visits and in others after every 10 visits.

The majority of services recorded the following data at each return visit: date, used injecting equipment returned, sterile equipment received, client's sharing of injecting equipment (since last visit), drug(s) used (since last visit), condoms received, and length of visit.

Information was recorded on client assessment forms in 30 services and on a computer system in 19 services; some services recorded the data in both ways. Of the services recording data on computer, 16 used the Drugs/Aids Information System (DAIS), two used Microsoft Excel and one used a specially designed client-information system.

Services provided a range of sterile injecting equipment and materials. All 31 services provided different sizes and types of needle and syringe, as well as alcohol swabs and citric or acetic acid. All services also provided condoms. Thirty services provided stericups or cookers and sterile water; 28 provided non-toxic foil (for smoking heroin); 11 provided syringe identifiers; and seven provided tourniquets. No service provided single-use injecting packs, crack pipes or straws.

All 31 services provided information on safer injecting practices, overdose prevention and blood-borne viruses; 29 provided information on safer sexual health. All services discussed with clients the importance of safely disposing of needles and syringes.

All 31 services reported either providing social care and crisis counselling services on site or referring clients to other services that provided the necessary interventions. Accompanied referrals to either social care or health care services occurred infrequently in the majority of services. However, accompanied referrals to an emergency department were provided if a client presented to the service in a suicidal state.

Some services provided facilities in addition to needle and syringe exchange: 11 had a drop-in club, lounge or open-access service, of which five had tea and coffee making facilities, nine provided meals (a sandwich at minimum), seven had leisure facilities (games, television), nine had telephone facilities and three had internet facilities available to service users.

Day-bed facilities were not provided by any service, though two provided night-bed facilities, with 17 and 20 beds available respectively. Lockers for personal belongings were available in two services. Eight services had personal hygiene facilities available to service users, of which seven had bath or shower facilities, seven had laundry facilities and four had clothes distribution facilities.

7.3.8 Methadone and HCV treatment

Relatively few patients infected with the hepatitis C virus through intravenous drug abuse receive effective antiviral therapy. A study was undertaken to determine if supervised treatment in a drug treatment centre could improve compliance with antiviral therapy (McCormick *et al.* 2008). A pilot study of supervised anti-viral treatment in a community non-residential drug treatment facility was conducted. Thirteen patients infected with hepatitis C virus genotype 2 or 3 were identified in a drug treatment clinic. Six patients agreed to treatment. A full treatment course was administered to all six, with sustained viral response being observed in five of the six. This study demonstrated that effective treatment penetration could be improved for this patient group by shared care with drug treatment services and without significantly increasing the resources needed. The number in the study was small but the findings were in line with other research in this area and supported linking HCV and methadone treatment.

7.3.9 Management of mycotic femoral pseudoaneurysms in intravenous drug abusers

Mycotic aneurysms are caused by microorganisms in the vessel wall. The most commonly-reported cause of mycotic aneurysms today is intravenous drug abuse. The diagnosis should be considered whenever a mass is encountered over a major artery (a blood vessel which carries oxygenated blood) in an intravenous drug abuser. The clinical findings often include a tender, pulsatile mass overlying an artery. The single best diagnostic test is the arteriogram. Mycotic femoral pseudoaneurysms, particularly in the drug-abusing population, pose a difficult problem to the vascular surgeon. The treatment is based on early exploration with debridement of all necrotic and infected tissue, effective drainage, ligation of the artery and appropriate antibiotic coverage.

A study was undertaken reviewing the management of mycotic femoral pseudoaneurysms in intravenous drug abusers presenting to an inner city tertiary referral center in Dublin (Peirce *et al.* 2009). Between 2001 and 2006, nine patients were treated, two patients were treated twice. The average age was 30.7 years with a male-to-female ratio of 1:2. Five patients had a positive viral status for both HIV and hepatitis C, three patients had hepatitis C only and one had HIV only. A combination of groin pain and swelling were the most common symptoms reported when help was sought. Two patients presented with significant bleeding. The diagnosis was confirmed by ultrasound in the majority of cases. Nine cases were managed with arterial ligation and removal of the dead tissue. One case was successfully managed with ultrasound-guided injection to dissolve the clot and another had an arterial puncture closure. On follow-up, one patient required a below-knee amputation following re-injection into the postoperative wound site. Another patient underwent an amputation of his toe due to lack blood supply to it.

The data indicate that ligation and removal of dead tissue are well tolerated in the majority of drug-abusing patients diagnosed with mycotic femoral pseudoaneurysms.

7.4 Responses to other health correlates among drug users

On 14 May 2009 the Mental Health Commission Annual Report 2008 including the report of the inspector of Mental Health Services 2008 (Mental Health Commission 2009) was published. In his national review, the Inspector of Mental Health Services, Dr Patrick Devitt, expressed concern over failure to implement some of the recommendations in *A Vision for Change* (Expert Group on Mental Health Policy 2006), which proposed a framework for mental health service delivery in Ireland. For example, the subsuming of mental health in the Primary and Continuing Community Care directorate of the HSE, rather than in a separate mental health directorate, has resulted in specialist mental health services not having an adequate focus and being regarded

as of secondary importance. The concept of a national network of comprehensive, community-based, multidisciplinary mental health teams is still far from realisation.

With regard to addiction psychiatry, the Inspector wrote: 'Substance abuse or dependence can give rise to certain behaviours mimicking those of mental illness and, in addition, can be a cause of mental illness. Moreover, the use of substances can exacerbate existing mental illnesses and make rehabilitation more difficult. There is a strong need for mental health professionals to become and remain well versed in the problems associated with substance dependence and identify and refer to the addiction services those patients where this is the primary problem. We have not had the opportunity in the past to inspect in detail these services, but look forward to doing so in the future'. The Inspector hopes to be in a position in the future to examine and made recommendations for these services.

8. Social Correlates and Social Reintegration

8.1 Introduction

Social reintegration for drug users is gaining in importance in Ireland, according to recent reviews of policy and practice (Comptroller and Auditor General and Department of Community Rural and Gaeltacht Affairs 2009); (Department of Community Rural and Gaeltacht Affairs 2009); (Working Group on Drugs Rehabilitation 2007). Social reintegration includes providing support with accommodation, education and training and employment, and is aimed at empowering individuals to plan alternative activities to those that they engaged in during their active drug use.

8.2 Social exclusion and drug use

The links between social exclusion and drug use in Ireland have been well established (Keane 2007). Problem drug users in treatment tend to be young and male, have low levels of education and are unlikely to be employed. For a small proportion, around 10%, homelessness and insecure accommodation are persistent problems. In recent times there has been a modest increase in the proportion of other nationalities seeking treatment (Reynolds *et al.* 2008). Research also shows that there are problems with illicit drug use among socially-excluded groups such as sex workers, homeless people and new communities. The research and information presented in this section suggest that services to tackle the needs for accommodation and education, training and employment are as important as services to tackle people's addiction problems and their use of illicit drugs. For example, a recent study on sex work and drug use illustrated that many participants growing up in poverty and disadvantaged communities were exposed to an escalating and changing drug scene where peers shared drugs and introduced others to the sex work industry. These narratives conveyed the corrosive effect of social exclusion on the lives of participants from an early age (Cox and Whitaker 2009).

8.2.1 Social exclusion among drug users

The Research Outcome Study in Ireland (ROSIE) is a national, prospective, longitudinal, multi-site drug treatment outcome study. The study recruited and followed 404 opiate users entering treatment and documented their progress after six months, one year and three years. Recently published results included information on outcomes in terms of social functioning at the three time points (Comiskey, Catherine M *et al.* 2009).

Homelessness and insecure accommodation have been closely linked with problematic drug use and are indicative of social exclusion. The proportion of ROSIE participants who reported being homeless at intake or follow-up interviews, or in the 90 days prior to interview, are shown in Table 8.2.1. These data indicate that at least 10% of opiate users in drug treatment are likely to be experiencing episodes of homelessness on a frequent basis and, despite the gains that might be expected from being in treatment, it appears that moving to secure accommodation is not feasible for them within the current model of treatment. The 'housing first' approach, which seeks to place people in secure accommodation and then deal with their other needs, may be a more effective policy response to this group (see section 8.3.1 on social reintegration for a discussion on this new policy direction).

Table 8.2.1 ROSIE study participants who reported being homeless at or prior to intake and follow-up interviews, or in the 90 days prior to interview

	At intake		At 1-year follow-up		At 3-year follow-up	
	n	%	n	%	n	%
Currently homeless	33	8.3	34	11.3	37	10.4
Homeless within past 90 days	58	14.7	36	11.8	40	11.2

Source: (Comiskey, Catherine M *et al.* 2009)

8.2.2 Drug use among socially excluded groups

This section includes information on the use of drugs and related issues among a number of groups that experience social exclusion, including sex workers, homeless people, Travellers and members of new communities.

For information on substance use in the Traveller community, see section 2.4.1

Drug use and the experience of risk in the lives of sex workers

Recent research on behalf of the NACD aimed to gain an understanding of the local risk environment (i.e. the physical, social, economic and policy environment) within which problem drug-using sex workers in Dublin lived and worked and how they perceived and responded to risk (Cox and Whitaker 2009).

Sampling and recruitment

Accessing eligible study participants proved difficult and sampling and recruitment methods included using key informants to access initial interviewees and then snowball sampling with interviewees to continue the chain referral network. Posters and postcards were placed in sites believed to be frequented by drug-using sex workers and, combined with websites and a magazine, were used to highlight the study and invite potential participants to make contact. Fieldworkers were 'on call' via mobile phones to speak with service providers and/or potential study participants. Despite intense efforts to find problem-drug-using male sex workers, the final number achieved was only four.

Data collection methods

In-depth interviews were carried out with 35 drug-using sex workers (31 female and 4 male); the average age was 32 and the majority were parents. Biographical data and data on recent drug use were collected with a short questionnaire. Interviews were held in service providers' premises, prison, hostels, respondents' cars and coffee shops. Forty professionals who worked either directly or indirectly with drug-using sex workers were interviewed in private rooms in services.

Data analysis

The analysis was undertaken using the constant comparative method to identify the main concepts and themes in the data. This approach facilitated a number of categories and conceptual schema to emerge which provided a basis for establishing the relations within the data that formed the core for middle-ground theoretical development.

Findings and interpretation

Participants grew up in inner-city, working-class poverty-stricken communities, where a well-established heroin market exposed them to a range of substances from an early age. The majority used drugs from an early age, usually in the company of older peers. Peers and social networks were the dominant route into sex work; economic necessity to cater for their opiate habits the main reason. Involvement in sex work often led to an escalation in drug use, which was paid for with the extra cash.

A profile of participants' self-reported use of drugs revealed that two-thirds reported recent heroin use, over a quarter reported recent cocaine use, 15% reported recent crack cocaine use. Overall, rates of self-reported recent drug use were highest among those actively involved in sex work at the time of interview. Eighty-eight per cent were receiving prescribed methadone and one in four was homeless at the time of interview. Among the study participants (and the professionals interviewed), injecting cocaine was considered particularly risky; it was associated with frantic, high-frequency injecting, binge use, extensive vascular and tissue damage and risk of blood-borne viral infection from sharing of used injecting equipment and paraphernalia. While all the participants reported using needle exchanges to access sterile injecting equipment, most also admitted knowingly and/or inadvertently engaging in unsafe injecting

practices in the past. The majority used a range of strategies in an effort to reduce the risk of harm associated with their drug use. The professionals were of the opinion that changes in the local drugs market, most notably the increased availability and use of cocaine, in particular cocaine injecting, had led to an increase in drug-using risk behaviour among this client group.

This research is one of the few in-depth studies undertaken in Ireland to examine the links between drug use and sex work and the risks involved. The findings show that the majority of people grew up in disadvantaged communities where the use of drugs was prevalent. Finding the money to sustain a drug habit was a key reason for entering sex work and often drug use and risky practices around taking drugs occurred when people were engaged in sex work. Heroin, cocaine and crack cocaine use was prevalent in the daily lives of these sex workers.

Drug use among young homeless people

A report on Phase II of a qualitative longitudinal study on homelessness among young people in Dublin city was published in 2008 (Mayock, P *et al.* 2008). The research aimed to generate in-depth understanding of the process of youth homelessness, with particular focus on movement into, through and out of homelessness.

Research methods

Phase II data were collected between September 2005 and August 2006. Information was obtained about the living situations of 37 of the 40 young people (23 males and 17 females) recruited in Phase 1 and follow-up interviews were conducted with 30 (16 males and 14 females) using the life history interview approach.

Findings

In analysing the narratives of the 30 young people re-interviewed at Phase II, the researchers were able to categorise three pathways from homelessness:

- Independent exits from homelessness
- Dependent exits from homelessness
- Continued homelessness

Independent exits

Six of the young people had moved home and one had moved to private rented accommodation. Those who had continued contact with and support from their families throughout the homeless experience made a smoother transition home and were more likely to view their move home in positive terms. Among those for whom drug use was an issue, continued family and parental support was almost always contingent on the young person seeking drug treatment and quitting use. This often involved breaking ties with past friends and associates within both street and drug scenes and establishing new social networks.

Dependent exits

Ten of the young people had either moved to transitional/supported housing (n=7) or to a residential care setting (n=3). They were helped to make this move by support from family members and professional sources, and by participation in education or training. For those who reported drug problems, seeking treatment was a critical enabler in the transition to supported housing. Most felt that it was important to distance themselves from former peer networks and attempted to establish and maintain positive and enabling social relationships. Some experienced financial difficulties as well as problems with everyday household chores and responsibilities. A number reported feelings of loneliness and depression.

Continued homelessness

Thirteen of the young people (11 males and two females) remained homeless, that is, they continued to access emergency hostel accommodation, sleep rough or live in

other temporary or unstable situations. Nine were aged 19 years or under. Most had left school early, reported short-lived attempts at a return to education/training, had limited participation in the labour market and weak family ties. All had a history of drug misuse and two also reported heavy alcohol use; nine reported heroin use.

Housing instability had a discernible impact on these young people's drug-using behaviour. Moving between temporary living places brought them into contact with other drug users and also cultivated an acceptance of the use of 'hard' drugs. Their entry to adult hostels was a point of particular vulnerability owing, in large part, to the sense of despair many experienced at this juncture. Escalating drug consumption impacted on their physical and mental health, and negatively influenced their ability to maintain meaningful ties with society. A number had tried to address the matter of their drug consumption and several had sought treatment at some time.

This research shows that there are pathways out of homelessness for young people whose contact with their families has remained strong; they receive support in accessing treatment for their substance use and in making the transition to supported living conditions. The research also shows that there are young people who remain trapped in homelessness and substance use. They tend to have weak ties with family, poor education skills and problems related to drug and alcohol use. Despite many making efforts to 'get clean', their experience of housing instability and exposure to adult hostels and the street drug scene can elevate the risk of them escalating their substance use and continuing to be homeless.

Drug use in new communities

The third in a series of three research reports commissioned by the Western Region Drugs Task Force (WRDTF) explored substance use among new communities in the west of Ireland and identified barriers to effective use of services (Kelly, C. *et al.* 2009). New communities include migrant workers, refugees, asylum seekers, and migrants who have been granted citizenship. At the time of the 2006 census, there were 48,387 non-nationals living in the west of Ireland.

The authors stated that members of new communities in Ireland came from countries where the rates of substance use among adults were generally lower than in this country. They noted that Irish research and informal reports from service providers suggested that migrant workers and refugees and asylum seekers were not accessing health services in Ireland because of the high cost of these services, lack of insurance, unfamiliarity with the health system and poor English language skills.

The authors reported that risk factors for substance use in new communities were generally the same as those in other communities, and included mental health issues, social isolation, poor education levels and unemployment. For some members of new communities, post-traumatic stress disorder could interact with experiences of discrimination and social exclusion to increase the risk of substance use. Other factors included the strain of being undocumented, having illegal status, and anxiety about being discovered. Having limited access to medical services except in the case of an emergency could impede access to frontline services such as GPs where substance use might be identified as a problem and treated early.

According to this report, adolescents in new communities could experience isolation owing to low levels of supportive peer relationships in school. Additional strain could occur when these young people learned new language and cultural practices reflecting the norms of the indigenous population. This might result in a clash with the value system and cultural practices of their family. Taken together, these factors could increase the risk of substance use among young people as they tried to fit in with the indigenous culture and deal with social isolation.

The authors interviewed by phone 18 statutory and voluntary groups involved in the support of new communities or the provision of substance use services in order to explore their perspective on substance use in these new communities. Almost all those contacted had no specific or specialist information on the issue, nor did their organisations have policies or strategies to address the issue.

This research included an analysis of regional press coverage of substance use issues in the west, and particularly in new communities, between 8 and 14 December 2008. The results suggested that there was more media interest in alcohol-related issues than in other drug issues and that there was more ambivalence about alcohol (which was presented as both potentially dangerous and positive and worthy of promotion) than other drugs (which were presented entirely negatively). Only five articles explicitly linked members of new communities and alcohol or other drugs, and just three of those cases concerned drug possession or public drunkenness.

This report mentioned a small number of studies on appropriate responses to substance use in new communities. These were highlighted as potential 'starting points' for communication among service providers and, according to the authors, were 'in a sense pragmatic and in some cases "best guesstimates" of what could work'.

The authors uncovered little evidence of substance use as a substantial problem, or one that required immediate action, among new communities in the west of Ireland. However, the reluctance of members of new communities to access health services suggested that the views of service providers as to the extent of substance use might not reflect the true situation in the communities. Alternative methods of collecting primary data, such as training people from new communities to undertake in-depth fieldwork, including interviews and observation, may yield a different picture to that conveyed here. A previous study using these methods found that heroin and cocaine use were becoming a problem among some sections of new communities in Ireland (Corr 2004).

The Health Behaviour in School-Aged Children (HBSC) Specific sub-groups

The second report of the 2006 Health Behaviour in School-Aged Children (HBSC) survey was published in 2008 (Molcho *et al.* 2008). The report dealt with four specific sub-groups: Travellers, immigrants, children with a disability/chronic illness and children from schools that had been designated as disadvantaged. The data were collected from a representative sample of primary and post-primary schools in Ireland as part of a cross-national study, in collaboration with the World Health Organization (WHO), to gain new insights and increase understanding of health-related issues in school-going children aged 10–17 years. The first three sub-groups were matched with a sub-group from the general population on socio-demographic characteristics for comparative purposes. The schools that had been designated as disadvantaged were matched with other schools for size, type and location.

Children from the Traveller community

Traveller students were more likely to report that they were current smokers, had drunk alcohol in the last month, had been 'really drunk' at least once in their lives and had used cannabis in the last 12 months (21%) compared to the matched group (12%). However, the number of children from the Traveller community in the total sample was small (n=233, 2%).

Children from schools designated as disadvantaged

Boys in disadvantaged schools were more likely to be current smokers and to have been 'really drunk' than were boys in the matched group. Boys in disadvantaged schools were less likely to report positive perceptions of school: fewer reported that they liked school, that students in their classes enjoyed being together, and that students in their classes were kind and helpful.

8.3 Social reintegration

This section examines recent policy proposals to improve housing and accommodation for homeless people, including drug users, and presents recent information on education and training among people in drug treatment, and employment outcomes from the ROSIE study.

8.3.1 Housing

The Comptroller and Auditor General (CAG) recently undertook an examination of the publicly-funded treatment and rehabilitation services for people with drug addictions (Comptroller and Auditor General and Department of Community Rural and Gaeltacht Affairs 2009). The report looked at the current and future provision of accommodation and related services for drug users within the overall framework of the 2001–2008 national drugs strategy. It noted that responsibility for providing accommodation services for drug users was shared between the local authorities, responsible for providing accommodation, and the Health Service Executive (HSE), which is responsible for providing health and social care services. The report included a recommendation that separate accommodation be provided for drug users in treatment and for those who have completed treatment and wish to pursue a drug-free lifestyle; this would support recovering drug users by reducing the risk of relapse. The report highlighted the role of step-down facilities in this regard and noted that the HSE funded 29 step-down beds for people recovering from drug addiction. It also noted that demand for accommodation places for recovering drug users far exceeded the number of beds available.

An evaluation of one of the HSE step-down projects showed the positive outcomes that can be achieved by recovering drug users (Juniper Consulting 2008). Of 12 former clients who completed the programme, six were living independently, two were living with a family member or a partner and four were living in further transitional housing. Self-reporting by these clients and their key workers suggested that they were no longer abusing drugs and were in education, training and employment. The provision of step-down facilities is clearly beneficial for some recovering drug users. This report highlighted the importance of collecting data on the percentage of people using step-down facilities who progress to independent living. It called for the national monitoring of waiting times for access to transitional or long-term accommodation by those undergoing rehabilitation.

The importance of providing accommodation for homeless people with drug problems was highlighted by the Steering Group established to develop the strategy 2009-2016. The provision of appropriate housing was seen as the critical need that must be addressed if treatment and rehabilitation services were to achieve sustained successful outcomes among this cohort (Department of Community Rural and Gaeltacht Affairs 2009): para. 4.98.

The Steering Group did not discuss the issue of accommodation for drug users in any depth and there is no evidence of building on the work of the CAG's report mentioned above. However, it did list as a priority the implementation of the recommendations of the report of the Working Group on Drugs Rehabilitation (Working Group on Drugs Rehabilitation 2007). One of the recommendations of this Working Group was that local authorities and drug treatment services should work together to identify and provide a range of accommodation supports for recovering drug users

The Steering Group proposed that the recommendations of the Working Group on Rehabilitation be incorporated into a comprehensive integrated national treatment and rehabilitation service using a four-tier model approach similar to that used in the United Kingdom. However, the UK model is a mix of generic and specialist addiction and mental health interventions provided in a range of settings targeting drug users and their families. It does not make explicit how the accommodation needs of drug users can be addressed.

A recurring theme in the reports mentioned above is the need to build on and develop existing examples of inter-agency working to provide a coherent package of services to recovering drug users, including accommodation supports. The Homeless Agency has been identified as a key player in this regard and it has been instrumental in developing a strategic response to tackle the overall problem of homelessness in Dublin. The Department of the Environment, Heritage and Local Government (DEHLG) and the HSE jointly fund the non-statutory Homeless Agency to plan, manage and co-ordinate services to tackle homelessness in the Dublin area. The Agency undertook a comprehensive review of the problem and of responses, and made a detailed submission to government that included a number of recommendations for action within the overall implementation of the new national strategy on homelessness, *The way home* (Department of the Environment Heritage and Local Government 2008). The submission is referred to as 'a new blueprint for change' and is about creating the conditions for change to realise the aim of eliminating long-term homelessness and the need to sleep rough in Dublin; it was included in a recently-published evaluation of homeless services (Brooke and Associates 2008).

As part of the evaluation of homeless services, the Homeless Agency administered a needs survey to homeless people using services in order to assess their long-term accommodation needs. The results showed that, of the 1,531 homeless households that completed the survey, 1,049 (69%) needed mainstream housing with either no support (259, 17%), short-term support (391, 26%), or long-term support (399, 26%); 449 (29%) required residential supported housing with varying degrees of support. According to the Agency, this finding ran counter to the frequently expressed view that most homeless people need long-term high-support residential accommodation. In addition, the Homeless Agency stated that the unit costs of mainstream housing with housing support were considerably lower than the unit costs of supported housing. According to the Agency, the high percentage of households that were assessed as requiring mainstream housing rather than supported housing strongly supported a 'housing first' approach (Brooke and Associates 2008).

The findings from the evaluation of homeless services and a review of the international literature on effective responses to the problem of homelessness form the basis of a reorientation of homeless services towards a 'pathways to housing' approach. This approach, also known as the 'housing first' policy, was designed to end homelessness and improve overall well-being among homeless people with concurrent mental health and addiction needs in New York City. The housing first policy contends that homeless people with high-risk needs are entitled to be accommodated first, without having to meet criteria such as being sober and clean. This runs contrary to the expectations of those who insist on sobriety-contingent and medication-contingent models of housing people. The evaluation report of the Homeless Agency cites a number of studies from the United States which compare the housing first approach with alternative approaches. The housing first approach consistently shows better outcomes for homeless people across a number of social and health variables; they retain accommodation and improve their overall health and social functioning.

However, the Homeless Agency pointed out in its report that the housing first policy did not mean 'housing only': a variety of services were needed to promote housing stability and individual well-being, using means such as the assertive community treatment model or case management. These supports can be delivered to the majority of service users through an adapted 'floating support' model that is aimed at supporting people to retain their accommodation first and then address their other needs. In addition, the Agency stated that the housing first approach only works if affordable housing is available and accessible. One of the principal barriers to the resolution of homelessness in Ireland has been the lack of affordable housing.

As part of the same Homeless Agency evaluation of services, 101 households that had experienced homelessness or were still in accommodation for the homeless were interviewed. The 101 households comprised 85 single people, one couple without

children, and 15 families with children (nine one-parent and six two-parent households). Thirty-five interviews with managers of homeless services in the Dublin area were also undertaken; these comprised seven statutory service workers and 28 working in non-governmental organisations (NGOs). Six focus groups comprising staff from the services being evaluated were also undertaken.

Four factors stood out as contributing to the single people interviewed becoming homeless: relationship and family breakdown (34 respondents), physical and mental health issues (20 respondents), alcohol issues (19 respondents), and drug issues (13 respondents). A number of research studies undertaken in Ireland between 1999 and 2006 had found that the same four factors had contributed to people becoming homeless in the first instance (Keane 2007).

Among the families interviewed, drug issues (five families), relationship breakdown (four families) and having to leave social or private rented accommodation (four families) stood out as the main reasons for initially becoming homeless.

Sixty-six respondents, including nearly everyone who answered the question in the service user interview, said that homeless services staff, especially key workers, had been the main help in moving out of homelessness. This positive view of homeless service providers is complemented by service users' views that friendly and helpful staff are among the best features of homeless services.

In addition, 14 people mentioned their own personal motivation and concern for their dignity as the main driving force in their exiting homelessness, while nine respondents mentioned social workers, GPs and other health staff in this context. These responses were taken as demonstrations of the value of personal support to homeless individuals and families.

Responses to questions about difficulties encountered in getting out of homelessness revealed four issues: lack of information about services (16 respondents), difficulty in accessing private rented accommodation (12 respondents), addiction to alcohol or drugs (11 respondents) and the stigma attached to being homeless (11 respondents). Respondents across the different homeless services (including emergency accommodation, private emergency accommodation, transitional housing and residential supported housing) also highlighted the problem of open drug use in these services. Over half of the 35 managers interviewed cited the lack of detoxification and rehabilitation services for those with either alcohol or drug addiction as the main obstacle to moving out of homelessness. The lack of housing and sustainable move-on options for homeless people and the lack of access to mental health services were also cited by managers as key obstacles to exiting homelessness.

The views expressed by service users and providers in this evaluation of homeless services demonstrated that initial exposure to homelessness was brought about by a combination of personal and social factors that included addiction, mental health issues and the severing of ties with families. Homelessness and exposure to an active 'drug scene' in the vicinity of current services, combined with pre-existing addiction and mental health issues, can effectively trap people in homelessness. The presence of these factors in the lives of homeless people has traditionally been tackled while maintaining them in insecure accommodation. The shift to a housing first policy will help to reintegrate them while also addressing their other problems. This evaluation revealed that service users saw friendly and helpful staff as key motivating agents who can help effect major changes to their accommodation status. The housing first approach uses the skills of experienced and professional staff to implement key actions and, in this regard, the Homeless Agency has been to the forefront in developing a number of training and development programmes for staff working in the sector.

8.3.2 Education, training

The ROSIE study of treatment outcomes found significant increases at one year and at three years in the number of participants undertaking training courses (Comiskey, Catherine M *et al.* 2009). At three years, 11% (40) of the participants were attending some sort of vocational training, 8% (30) were in placements under the community employment (CE) scheme, 8% (29) were attending a personal development and life skills course and 4% (15) were in further education. In many cases, these figures were more than double those reported at intake. Although the numbers are small, the findings demonstrate that engaging in drug treatment can improve opportunities for vocational rehabilitation.

The CE scheme for drug users operates through local projects primarily in LDTF areas and is sponsored by community and voluntary groups. FÁS, the national training and employment authority, provides funding for 1,000 places and the project sponsors are required to sign a service agreement that outlines the work programme and the target outcomes. The primary objective of CE is to prepare participants for entry into the active labour force, although in reality the outcomes outlined by most projects tend to be 'softer' than finding employment. Outcomes include personal development, improved literacy skills and education capital, and supported progression to more specialised training and education. An evaluation of the scheme in 2004 revealed that for the majority of clients on CE placements, moving on to employment was not a realistic outcome; this was in part explained by the lack of focus on vocational development in the projects (Bruce 2004).

Since the introduction of the special CE scheme there has been a constant shortfall in the uptake of places, and the latest figures show a decline in the number of places being used, from 90% in 2004 to 83% in 2007. The reasons for this decline are not clear and, as pointed out by the CAG, the decline 'occurred at a time when the numbers in drug treatment were increasing' (Comptroller and Auditor General and Department of Community Rural and Gaeltacht Affairs 2009). However, as the majority of CE places are available in projects in Dublin and a large part of the increase in the numbers presenting for drug treatment came from outside Dublin (where the number of CE places is much lower), the decline in uptake of places in Dublin remains to be explained.

The recent review of the national drugs strategy 2001–2008 acknowledged the CE scheme for helping recovering drug users to develop their personal and employment skills and find a pathway back to work. The Steering Group that drafted the new national drugs strategy 2009–2016 proposed that the implementation of the Individual Learner Plan (ILP) would help to identify participants' needs and design progression routes towards labour market reintegration. The development of targeted programmes by FÁS was seen to be essential and should be an integral part of the national drugs strategy in the future, with a commitment to ensuring that such initiatives are available to recovering drug users in all parts of the country (Department of Community Rural and Gaeltacht Affairs 2009).

8.3.3 Employment

The Research Outcome Study in Ireland (ROSIE) (Comiskey, Catherine M *et al.* 2009) reported that the number of people currently employed increased significantly between intake and three-year follow-up, with figures rising from 16% (64) to 29% (102). The number of participants deemed 'not working' decreased from 43% (171) at intake to 31% (109) at three years. Regarding main sources of income, the proportion reporting drug dealing and other crime as a main source of income had reduced significantly at one year and at three years in comparison to intake. Income from family/partner had also dropped significantly at one year, and at three years. Furthermore, the proportion of participants who reported social welfare as a main source of income was significantly smaller at three years than at one year. It is interesting to note that the proportion reporting a wage/salary as a main source of income was significantly higher

at three years than at intake and at one year. These figures indicate that participants were becoming more self-sufficient.

9. Drug-related crime, prevention of drug-related crime and prison

9.1 Introduction

Until 2006, the principal source of information on drug offences was the annual reports of the Garda Síochána. In 2006, responsibility for reporting crime statistics was transferred to the Central Statistics Office (CSO). The CSO data are derived from the Garda Síochána computerised PULSE system (Police Using Leading Systems Effectively). The latest data available from the CSO is for 2007 (Central Statistics Office 2008) (Central Statistics Office 2009).

The vast majority of drug offences reported come under one of three sections in the Misuse of Drugs Act (MDA) 1977: section 3 – possession of any controlled drug without due authorisation (simple possession); section 15 – possession of a controlled drug for the purpose of unlawful sale or supply (possession for sale or supply); and section 21 – obstructing the lawful exercise of a power conferred by the Act (obstruction). Other MDA offences regularly recorded relate to the importation of drugs (section 5), cultivation of cannabis plants (section 17) and the use of forged prescriptions (section 18).

Driving under the influence of drugs has been a statutory offence in Ireland since the introduction of the 1961 Road Traffic Act. The principal legislation in this area is contained in the Road Traffic Acts 1961 to 2002. Section 10 of the Road Traffic Act 1994 prohibits driving in a public place while a person is under the influence of an intoxicant to such an extent as to be incapable of having proper control of the vehicle. Intoxicants are defined as alcohol or drugs and any combination of drugs or of drugs and alcohol. Although penalties for driving under the influence of alcohol are graded according to the concentration of alcohol detected, the law does not set prohibited concentrations for drugs. Neither does it distinguish between legal and illegal drugs. Tests to identify the level of impairment can only take place where there is a reasonable suspicion that an offence is being committed.

9.2 Drug-related crime

9.2.1 Drug law offences

Figures 9.2.1 and 9.2.2 show trends in proceedings for drug offences from 2003 to 2007. As can be seen from Figure 9.2.1, criminal proceedings for the possession of drugs for personal use (simple possession) have more than doubled during this period. Proceedings for drug supply have increased marginally, from 1,715 proceedings in 2003 to 2,654 in 2007. The upward trend in total drug offence proceedings during the five-year period is largely accounted for by the increase in simple possession offences. In 2007, of the total drug offences (n = 11,647), almost 72% were for simple possession.

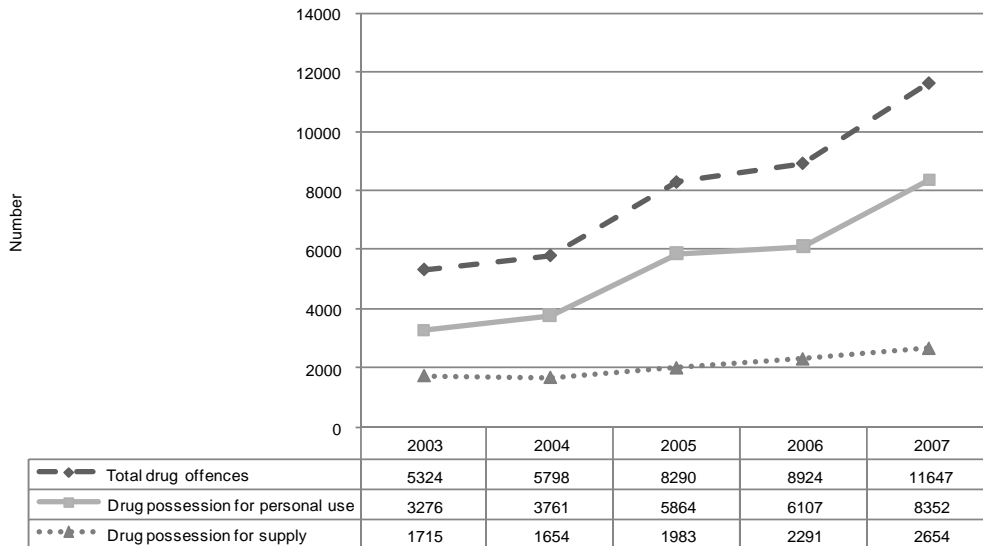


Figure 9.2.1 Trends in relevant legal proceedings for total drug offences, drug possession for personal use and for supply, 2003–2007 (Central Statistics Office 2008) (Central Statistics Office 2009)

Figure 9.2.2 shows trends in legal proceedings for a selection of other drug offences between 2003 and 2007. The offence of obstructing the lawful exercise of a power conferred by the Misuse of Drugs Act (s21) clearly represents the largest category, with obstruction offences totalling more than the other offences combined in every year. Obstruction offences often involve an alleged offender resisting a drug search or an arrest or attempting to dispose of drugs to evade detection. Obstruction offences increased from 208 offences in 2003 to 407 in 2007, an increase of 96%. The number of other offences has remained low, with the offences of forging or altering a prescription and importation remaining relatively stable during the period. Since 2005, however, drug cultivation or manufacture offences have more than trebled, increasing from 29 offences in 2005 to 109 in 2007.

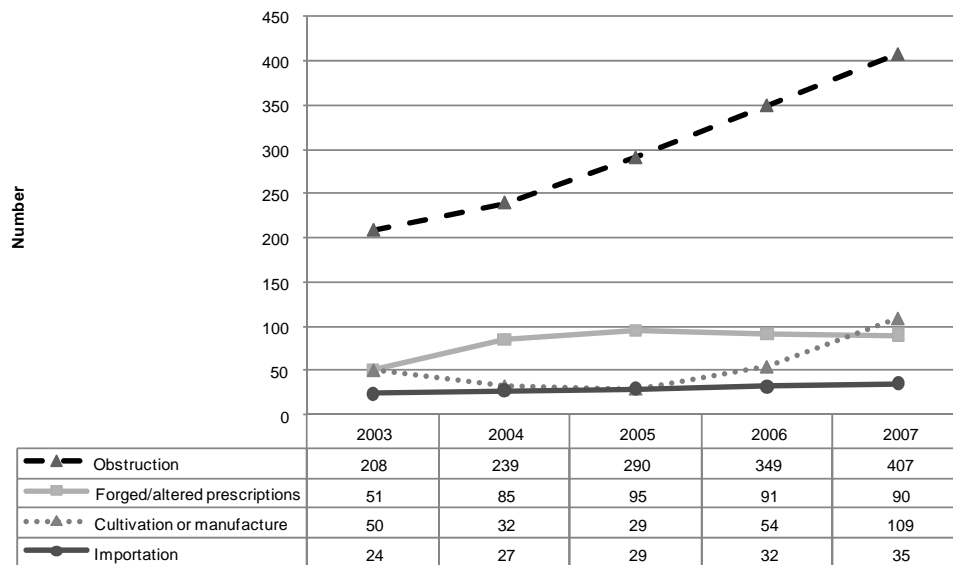


Figure 9.2.2 Trends in relevant legal proceedings for selected drug offences, 2003–2007 (Central Statistics Office 2008) (Central Statistics Office 2009)

Figure 9.2.3 shows trends in proceedings for possession of cannabis-type substances relative to proceedings for possession of all drug types from 2003 to 2007. In every year except 2006, cannabis-related proceedings represented more than 50% of the total of all drug types.

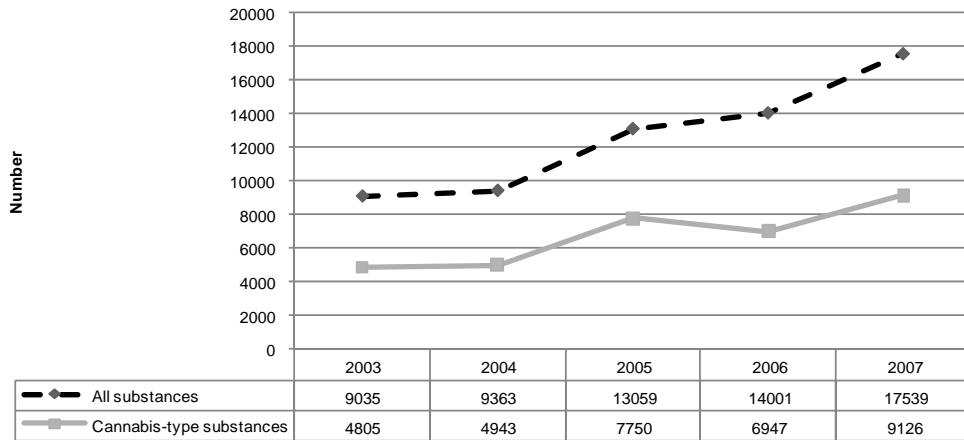


Figure 9.2.3 Trends in proceedings for possession of all drug types and cannabis-type substances, 2003–2007 (Central Statistics Office 2008) (Central Statistics Office 2009)

Figure 9.2.4 shows trends in proceedings for possession by drug type for a selection of drugs excluding cannabis. In 2006, the number of cocaine-related proceedings exceeded heroin-related proceedings for the first time. In 2007, the number of heroin-related proceedings again overtook cocaine-related prosecutions but only marginally. Prosecutions for possession of both heroin and cocaine have continued their upward trend since 2003. Ecstasy-related proceedings have also continued to rise since 2005, following a slight decline since 2003.

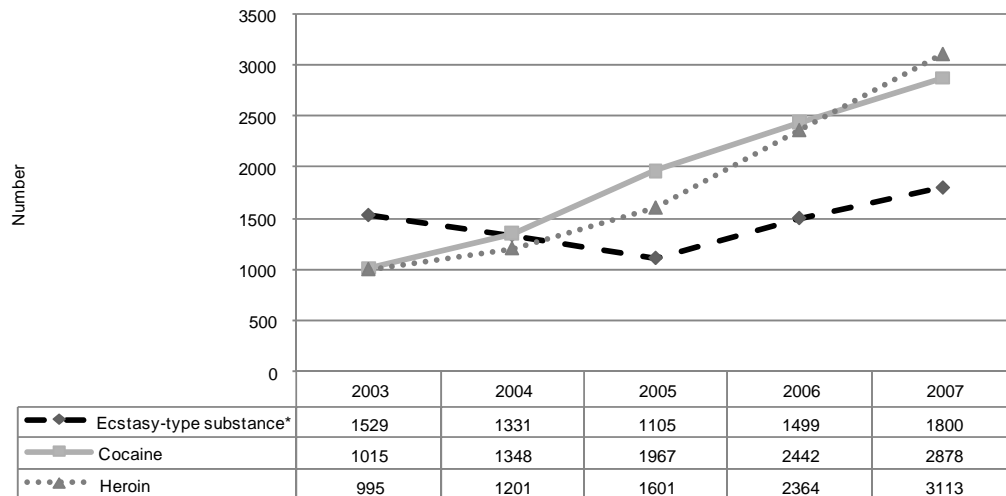


Figure 9.2.4 Trends in proceedings for possession of a selection of drugs, 2003–2007 (Central Statistics Office 2009).

*Also contains MDMA, DMEA, DOB and methylamphetamine

Drugs and driving

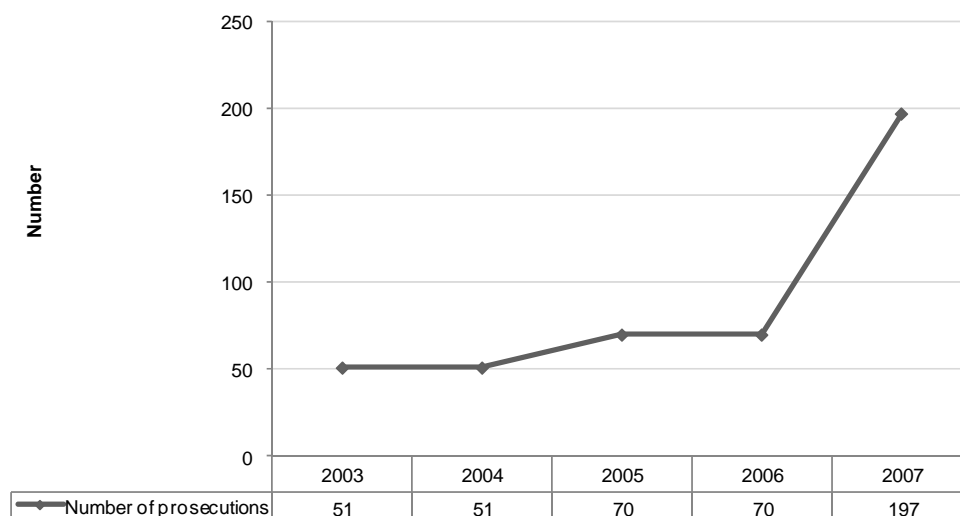


Figure 9.2.5 Trend in prosecutions for driving/in charge of a vehicle while under the influence of drugs, 2003–2007 (Central Statistics Office 2008) (Central Statistics Office 2009)

Figure 9.2.5 shows the trend in prosecutions for driving under the influence of drugs (DUID) between 2003 and 2007. Between 2003 and 2006 the number of prosecutions for DUID increased slightly from 51 in 2003 to 70 in 2006. In the following year there was a marked increase in DUID prosecutions, up to 197 prosecutions, a growth of almost 60%. It is unclear why this increase occurred in 2007. It could possibly reflect an increase in targeted police activity in this area.

9.2.2 Other drug-related crime

Drug-related intimidation of drug users and their families

In early 2009 the Family Support Network (FSN) published the findings of research into the issue of intimidation of the families of drug users by those involved in drug dealing (O'Leary 2009).⁷ Through its work with families the FSN became aware of a large number of families experiencing intimidation by drug dealers as a result of a family member's drug-related debts. The research consisted of a postal survey of 91 family support workers or facilitators. The response rate for the survey was 55%.

A general finding of the research was that no locality or region that responded was untouched by intimidation. Nearly all family support services indicated that their clients, mostly family members of drug users, had experienced debt-related intimidation. About 35% of the cases of intimidation related to debts of between €100 and €500. The largest debts were between €10,000 and €20,000; one case involved €60,000. Many of those in debt belonged to families surviving on very low incomes and families were often only given days to repay the debt. Drug users themselves often resorted to criminal activity to repay debts to dealers. Many agreed to deal drugs themselves or to hide, hold or transport drugs for the dealer to whom they owed money. Others engaged in violent activity, including murder in one case, as a method of repayment. Other violent activity included the holding or concealment of firearms on behalf of the drug dealer. Many female drug users engaged in prostitution to repay their debts.

Respondents were asked to list the types of intimidation experienced by families they encountered. These included verbal threats, physical violence and damage to their home or other property. In seven cases individual family members had experienced sexual violence or threats of such violence. Of 112 cases of intimidation reported, in 35

⁷ The FSN was established in 2000 to support the development of family support groups throughout Ireland. There are currently over 70 family support groups affiliated to the FSN.

cases mothers were the target. The next highest category was the siblings of drug users (23 cases), fathers (21 cases), grandparents and children (17 cases) and partners and others (10 cases).

The report identified a number of issues complicating both the impact of intimidation and the responses available to families. As a person working for the dealer normally collects the debt, it is not always easy for families to know to whom the money is owed or whether the money is being given to the correct person. Whether or not the intimidation stops is an important factor considered by a family when deciding whether or not to pay a debt as 'many families are caught in a recurrent cycle of debt, intimidation, repayment and further debt, (p. 22). Fear often stems from knowledge of the perpetrators and their capacity to follow through on threats. Fifty-one per cent of respondents stated that sometimes threats were carried out, 33% stated that threats were always carried out and 4% said they were never carried out.

Table 9.2.2 shows the various ways that families source money to pay a debt on behalf of a family member. In the case of social welfare payments, including children's allowances and disability payments, in some cases intimidators waited outside social welfare offices on collection days to collect the debt.

Table 9.2.2 Sources of funds used by families to pay a drug debt

Funding sources	No. of cases	%
Salary/wages	25	50
Credit union loan	36	72
Bank loan	9	18
Money lender	21	42
Re-mortgage home	11	22
Selling personal property	17	34
Social welfare payments	22	44
Borrowing from family/friends	33	66
Other	3	6
Not applicable	6	12
Total	183	N/A

Source: (O'Leary 2009) p 23

The study also identified a number of themes through a case study analysis of reported incidents of intimidation. These included the following:

- Threatening behaviour included verbal threats, intimidation at the workplace, harassment, death threats, threats of shooting, beatings or 'knee-capping', and live bullets posted through letter boxes.
- Personal property - houses and cars vandalised and burnt out.
- Physical violence included two drug users murdered, one user carried out a murder because of a debt owed, shootings through doors and windows of family home, hospitalisation due to beatings, burning of a drug user.
- Physical/sexual violence against women included drug users and partners forced into prostitution to protect family from violence, two minors less than 18 years of age forced into prostitution, one dealer threatened to rape daughter of a drug user.
- Fear in the community of reprisal from drug dealers prevented them from raising awareness of the issue.
- Children might be encouraged by dealers to deal to friends or other children so as to create debt and force them into further dealing; they were often present when family members were beaten; and their mothers may be engaged in prostitution in the family home as a means of debt repayment.
- Garda reaction - family members too fearful to approach gardaí in relation to intimidation; many believed gardaí powerless to act; in one case gardaí advised family to pay the debt, while in another they provided protective custody to a family and a drug user.
- Women - perpetrators of intimidation targeted female drug users for debt repayment, and they were also forced, either directly or indirectly, into prostitution; a high proportion of families targeted were headed by a female lone parent; average weekly earnings of females were significantly less than their male counterparts and women were more likely to be out of the workforce; women often

concealed intimidation and payment from their husbands/partners owing to fear that they might not be willing to pay.

- Forced emigration - in many cases drug users had been forced to move or emigrate and were unable to return home.

The report concluded with a series of recommendations. The need to incorporate the issue of intimidation of families in the National Drugs Strategy 2009-2016 was highlighted. The report also called for a pilot initiative to be established whereby the gardaí would identify a member of staff to liaise with families experiencing intimidation. A safe reporting and advice provision procedure for families willing to report the issue was also called for. The report recommended that gardaí needed closer liaison with local family support services. Ways of addressing the fear of reprisal of those willing to pursue the issue of intimidation through the legal system also needed to be put in place. The report concluded that other initiatives that would enable community members to work together to tackle the fear they experience in their locality should also be investigated.

9.3 Prevention of drug-related crime

9.3.1 Addressing crime and anti-social behaviour in Limerick

The Fitzgerald Report submitted to the Cabinet Committee on Social Inclusion addressed social exclusion, crime and disorder issues in the Moyross and Southill communities and other disadvantaged areas in Limerick city (Fitzgerald 2007). The report advocated a strategic response including:

- interventions to address the issue of serious criminality;
- economic and infrastructural regeneration; and
- co-ordination between local authorities, gardaí and community and voluntary sector agencies to tackle entrenched disadvantage.

The report used evidence from a variety of sources which highlighted the decreasing quality of life in these communities. In particular, it pointed to statistics compiled by the CSO indicating that these areas 'are among the most deprived in the country' (p. 5). Additional evidence collected by the author and his team indicated that members of these communities had suffered violent intimidation and damage to personal and council property from so-called 'criminal elements'. Other concerns included the number of young people involved in anti-social behaviour and drug distribution.

The report emphasised that economic and social regeneration could not happen without 'intensive policing arrangements' (p. 8). It stated that 'dealing with the serious (although relatively small in number) criminal elements ... will be fundamental to creating the conditions for real progress to be achieved on all other fronts' (p. 6). This policing initiative should occur in the context of a five-year programme, the objective of which should be to 'normalise and stabilise these areas' (p. 8). Specific recommendations included:

- targeting the assets of criminals by establishing a local Criminal Assets Bureau operation;
- maintaining a highly visible Garda presence in the area, which would involve dedicating up to 100 gardaí to these communities to restore public order and deal with criminal activity;
- empowering Limerick City Council to evict tenants involved in criminal or anti-social behaviour.

It was proposed that two new geographically-defined development agencies (Limerick Southside and Limerick Northside) be established to co-ordinate the delivery of economic and social regeneration. With these structures in place, the report

recommended a number of economic and social initiatives to address disadvantage, including:

- the attraction of commercial investment into these communities via fiscal incentive schemes;
- the development of transport infrastructure and access to these communities;
- the total regeneration of housing stock in these estates, including a mix of social and private housing.

It was recommended that special teams be established to co-ordinate the efforts of existing bodies to provide intensive and targeted interventions to local residents and families. These teams would be multi-disciplinary and include educational welfare officers, family support workers, local drugs taskforce and HSE representatives and community gardaí. Particular emphasis was to be placed on the provision of activities and amenities for young people in the evenings and summer holidays.

In terms of drug abuse, Limerick city currently falls within the remit of the Mid-Western Regional Drugs Task Force. However, the report recommended that Limerick city would benefit from local intervention initiatives including prevention and education initiatives, given that 'the problems of drug abuse in Limerick city are particularly acute' (p. 12).

In October 2008, following a process of consultation with a range of stakeholders, the Limerick Regeneration Agencies launched their regeneration plan to implement the recommendations of the Fitzgerald report (Limerick Regeneration Agencies 2008). The plan identifies three key 'pillars' – social regeneration, economic regeneration and physical regeneration – around which the entire plan will be built.

- Social regeneration is identified as the most important of these pillars. The pillar is broken down into four parts: education, children, youth and family support, health and people and neighbourhoods.
- The economic regeneration pillar seeks to address the serious unemployment levels in the area.
- The physical regeneration element seeks to radically reform the appearance and physical environment of the area.

The regeneration agencies intend to put in place an ongoing assessment of risks relating to the implementation of the plan and incorporate these into an annual report. This will be aligned with an evaluation process which will produce a comprehensive and clear relevant set of benchmarking data. Included in the data for the social objectives will be participation in education, health status and participation in sport. The proposed timeline for the programme is 2009 to 2018.

9.3.2 Drug treatment and crime

Research Outcome Study in Ireland (ROSIE)

In October 2008 the National Advisory Committee on Drugs published a summary of opiate treatment outcomes at one year and at three years after entry to treatment (Comiskey, C. *et al.* 2008). At baseline, the 404 opiate users recruited to the study were entering treatment for the first time, or were returning to treatment after a period of absence, at any one of 54 services nationwide. Of these 404 individuals, 289 completed all three interviews – at baseline (2003/4), at one year (2004/5) and at three years (2006/7). These individuals (the *per-protocol* population) were asked the same questions at the three time points. The interview schedule examined key outcome measures, including:

- drug use in the 90 days preceding the interview – specifically, type, frequency, quantity and cost;
- measures of harmful practices and consequences; and

- social functioning, including accommodation, employment, and involvement in crime.

The proportion of participants who reported using heroin in the 90 days preceding data collection fell from 81% at intake to 47% at one year, and was sustained at 47% at three years. The average frequency of heroin use in a 90-day period reduced from 42 out of 90 days at intake to 15 out of 90 days at one year, but increased to 20 out of 90 days at three years. The average quantity of heroin consumed each day over a 90-day period decreased from 0.9 grams at intake to 0.3 grams at one year, and this lower consumption rate was sustained at three years. There was a corresponding reduction in the average amount spent on heroin on a typical day, from €75 at intake to €24 at one year; the average spend at three years was not reported.

The proportion of participants who reported involvement in acquisitive crime decreased from 31% at intake to 14% at one year and this decrease was sustained at three years. In addition, the proportion who reported selling or supplying drugs reduced from 31% at intake to 11% at one year and this decrease was sustained at three years.

9.4 Interventions in the criminal justice system

Dial to Stop Drug Dealing

In September 2008 the Dial to Stop Drug Dealing campaign was launched. Individuals and communities affected by drug dealing were urged to pass on information relating to drug dealing in their local communities by dialling a confidential telephone number. Individual names or numbers were to be neither requested nor recorded. Calls were to be routed to call centres staffed by non-locals, separate from Garda stations. All information was to be passed on to the Garda Síochána.

The campaign was funded by the Dormant Accounts Fund, the Department of Community, Rural and Gaeltacht Affairs and the Department of Justice at a total cost of €450,000 for a three-phase campaign over nine months. Phase one ran from 1 November 2008 in communities in the areas of Tallaght Local Drugs Task Force (LDTF), Blanchardstown LDTF, South West Regional DTF, North Inner City LDTF, and Dublin North East LDTF. In the second phase, rolled out in January 2009, the initiative was promoted throughout the country. It was strongly emphasised that, though the initiative would be promoted only within the Greater Dublin Area initially, all calls would be answered regardless of location and all information would be passed on to the Garda Síochána.

The project had already reported success in Blanchardstown LDTF where it was launched in 2006 as a part of the Blanchardstown LDTF's supply reduction programme (Connolly, Johnny 2006b). An evaluation of the Blanchardstown pilot initiative revealed that over 296 calls were received over the six-week period, over two-thirds of which were regarded as useful by the Garda Síochána. The website for the initiative can be found at <http://www.dialtostopdrugdealing.ie>

In June 2009, in response to questions in Dáil Éireann, John Curran TD, minister for State with special responsibility for the Drugs Strategy, stated that, owing to financial constraints, the initiative was soon to come to an end. He described the impact the initiative had had:

‘Overall, the campaign has proved to be very successful. To date, there have been in excess of 3,300 calls to the phone-line that have generated over 920 information reports to the Gardaí. It should also be noted that from the outset the Dial-to-Stop Drug Dealing Campaign was to run over a discrete period of time. This was based on the findings from the initial pilot project in

Blanchardstown which found that the vast majority of calls were received early in the campaign following its launch.' (Curran 2009, 17 June)

In September 2009, however, in his speech to launch the National Drug Strategy 2009–2016, Minister Curran stated that the scheme was to be extended. This was, he said, because 'the initiative has proven its worth and has been lauded by many' (Curran 2009, 10 September).

Customs activity

Customs drugs law enforcement reports a range of activities undertaken during the reporting year (CDLE personal communication, July 2009). These include:

- Continued participation in MAOC-N, the maritime analysis and operation centre based in Lisbon
- Acquisition of a second customs cutter in 2009
- Acquisition of an additional scanner for scanning large containers
- One new dog handler and one new detector drug dog to be added to the dog unit during 2009

Operation Resolute is a joint Customs and Garda Síochána project aimed at building up intelligence on organised crime groups. The initial pilot phase of the operation was conducted in selected locations throughout the country. The operation was regarded as highly successful by both agencies. Revenue now plan to extend this operation nationwide.

9.4.1 Alternatives to prison

The Irish Drug Treatment Court (DTC) was established in Dublin in 2001 on a pilot basis. A recent report by the Comptroller and Auditor General has highlighted the low number of offenders progressing through the court (Comptroller and Auditor General and Department of Community Rural and Gaeltacht Affairs 2009). When the DTC was established, it was envisaged that it would handle around 100 cases during the 12-month pilot period. In practice, 37 offenders were admitted to the programme during the pilot. From January 2001 to July 2008, an average of 22 offenders a year were admitted to the programme, just over one fifth of the initial annual target. The Department of Justice, Equality and Law Reform is currently examining the DTC to determine the reasons behind the relatively low numbers of persons being dealt with in the court and to consider if measures can be taken to improve its operation. This review will determine whether a further expansion of the court will take place.

9.4.2 Other interventions in the criminal justice system

Community policing

Pilot Joint Policing Committees (JPCs) have been established under the provisions of the Garda Síochána Act 2005 (Connolly, Johnny 2006a). JPCs bring together public representatives, representatives of local authorities, the Garda Síochána and representatives of the voluntary and community sector to assess levels of crime and anti-social behaviour, including that related to alcohol use and illicit drug use, and to make recommendations as to how to prevent and address such problems. The JPC pilot was evaluated in early 2008 and final guidelines were issued to enable the establishment of JPCs in all local authority areas throughout the state. Further guidelines are due to be published in the latter half of 2009 enabling the establishment of Local Policing Fora in local drug task force areas as provided for in Action 11 of the National Drugs Strategy 2001–2008.

9.5 Drug use and problem drug use in prisons

Supply control

The Irish Prison Service (IPS) annual report for 2007 detailed developments in drug supply reduction measures in Irish prisons (Irish Prison Service 2008a).

Section 36 of the Prisons Act 2007, which came into operation in May 2007, makes it an offence for prisoners to have unauthorised possession or use of mobile phones. Phones are viewed by the prison authorities and the Garda Síochána as contributing to illegal activity outside the prison. It is reported that by the end of 2007 more than 2,124 mobile phones had been seized in Irish prisons.

Other supply reduction measures reported included:

- new prison visiting arrangements whereby only identified and known persons are allowed to visit prisoners, 'reducing the likelihood of visitors attempting to pass drugs, and of prisoners being coerced into receiving visits from persons not known to them to facilitate the passing of drugs' (p.25);
- enhanced perimeter security involving improved netting and closer co-operation with the Garda Síochána to arrest and prosecute persons attempting to convey drugs into prisons;
- improved technology for searching cells and prison property;
- the introduction of drug detection dogs;
- the establishment of an Operational Support Group dedicated to developing expertise in searching and intelligence gathering.

9.6 Responses to drug-related health issues in prisons (and other custodial settings)

According to the IPS annual report for 2007, sentenced committals for drug offences increased by 34%, from 395 (6.5% of total offences) in 2006 to 530 (8.2% of total offences) in 2007. These figures do not include people who were imprisoned for drug-related offences, such as economic acquisitive crimes committed to support a drug habit. Given the clear link between drug use and economically-motivated crime, it may be assumed that many of those imprisoned for property offences were problematic drug users. Of the 530 offenders sentenced for drug offences in 2006, 267 received prison sentences of up to one year, 241 received sentences from one to 10 years and 22 received sentences of more than 10 years

9.6.1 Drug treatment

The IPS annual report for 2007 described developments in rehabilitation and treatment services for prisoners during 2007. Measures advanced during 2007 to enhance drug rehabilitation included the awarding of a contract for the provision of addiction counsellor services, and the allocation of additional nurse officers and prison officers to dedicated drug treatment teams.

The IPS also reported that 'Considerable work was undertaken during the year in consultation with practitioners at local prison level to draft a Drug Treatment Clinical Policy document to provide guidance to practitioners regarding various clinical issues that may arise in treating addiction in a prison context' (p. 26).

As shown in Table 9.6.1, nine prisons provided methadone substitution treatment to 1,840 prisoners in 2007, of whom 185 were receiving methadone for the first time. It is noteworthy that methadone treatment was not provided in two large prisons, namely Cork and Castlerea.

Table 9.6.1 Numbers of individuals receiving methadone treatment* in Irish prisons in 2007

Prison	Total patients during 2007	New patients in 2007	Patients at 31 December 2007
Cloverhill Prison	710	124	176
Dochas Centre	225	26	38
Limerick Prison	10	0	3
Midlands Prison	90	8	30
Mountjoy Main Prison	474	9	112
Mountjoy Prison Medical Unit	120	8	53
Portlaoise Prison	3	1	1
St Patrick's Institution	15	0	6
Wheatfield Prison	193	9	90
Total	1840	185	509

*Methadone treatment in this context is either substitution or detoxification.
Source: (Irish Prison Service 2008a)

9.6.2 Prevention and reduction of drug-related harm

In 2007, the allocation of additional nurse officers and prison officers were allocated to dedicated drug treatment teams.

The IPS also reported that 'Considerable work was undertaken during the year in consultation with practitioners at local prison level to draft a Drug Treatment Clinical Policy document to provide guidance to practitioners regarding various clinical issues that may arise in treating addiction in a prison context' (p. 26).

9.6.3 Prevention, treatment and care of infectious diseases

No new Information available.

9.6.4 Prevention of overdose-risk upon prison release

The IPS annual report for 2007 also stated that funding was provided to community groups to provide addiction counselling and support to prisoners while in prison and on their release in the community.

9.7 Reintegration of drug users after release from prison

Numerous studies in Ireland have shown that problematic drug users tend to have high rates of prison recidivism (Connolly, J. 2006). The first detailed study into prison recidivism was conducted by the Institute of Criminology at University College Dublin (O'Donnell, I. *et al.* 2007). The geographical distribution of prisoners released in 2004 was mapped to set out what is known about the community contexts from which prisoners are drawn and to which they are likely to return. The research was conducted using data from the new IPS computer-based records system, Prison Records Information System (PRIS), to track and map the known addresses of 5,057 prisoners (out of a possible 5,588) who were released in 2004. Although the study focused not only on drug-related offenders, some of its findings highlighted the links between problematic drug use, crime and recidivism.

Method of mapping

The known addresses of released prisoners were coded to the appropriate electoral division (ED) and these divisions were assigned a social deprivation rating according to a deprivation index. This index was computed using census data relating to unemployment, car ownership, overcrowding, local authority housing and social class. A further analytic dimension was provided by the calculation of a standardised prisoner ratio for each ED. This is the ratio of the observed number of prisoners in an ED to the expected number, given the age and gender profile of the ED population.

Findings of the research

More than 25% of offenders are re-incarcerated within 12 months of release and approximately 50% within four years. The most deprived areas in the country had 145.9 prisoners per 10,000 population, compared to 6.3 in the least deprived areas.

The authors stated that 'the magnitude of this difference is startling and demonstrates unequivocally that it is the areas already marked by serious disadvantage that must bear the brunt of social problems that accompany released prisoners' (p. 4). Most prisoners came from city areas – 28.6 per 10,000 population overall, compared to 6.3 from rural areas. Thirty-eight per cent of prisoners released in 2004 had Dublin addresses. The following Dublin suburbs had high standardised prisoner ratios for all crime sub-categories: Finglas, Ballymun and Darndale on the north side of the city; Fettercairn and Jobstown in Tallaght; Cherry Orchard, Rowlagh, Moorfield, Palmerstown and Mulhuddart in the south west; Summerhill, Ballybough and Sherriff Street in the north inner city; and Dolphin's Barn, the Coombe and the Liberties in the south inner city. Deprived suburban areas in Cork, Limerick and Galway also had higher prisoner ratios. However, a number of very deprived areas did not have any prisoners, particularly in Donegal, Kerry, Galway and Mayo.

Drugs and deprivation

This study clearly highlights the link between drugs and poverty: in the most deprived areas there were 57.8 prisoners per 10,000 released after serving a sentence for a drug-related crime, compared to 1.8 in the least deprived areas. In terms of the geographic distribution of drug-related crime, Dublin, followed by the mid-west region (Clare, Limerick and North Tipperary) was more likely to have higher numbers of prisoners convicted for drug-related crimes. While the distribution of violent offenders in Dublin was spread evenly between the suburbs and the inner city, prisoners serving a sentence for drug offences and, to a lesser degree, for property offences were more likely to come from the inner city than the suburbs.

10. Drug Markets

10.1 Introduction

There is no systematic, comprehensive information available on illicit drug markets in Ireland. However, new research relating to Irish drug markets is described in this chapter. Data published by the Central Statistics Office (CSO) also assists us in understanding aspects of the operation of the illicit drug market in Ireland (Central Statistics Office 2008) (Central Statistics Office 2009). This chapter also reports on drug seizures by Customs Drug Law Enforcement and the Garda Síochána.

10.2 Availability and supply

10.2.1 Perceived availability of drugs, exposure and access to drugs

The third bulletin of results from the 2006/7 all-Ireland general population drug prevalence survey (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008c) (a follow-on from the first survey in 2002/3) focused on cannabis use in the adult population (15–64 years) and patterns of cannabis use. The majority (62%) of recent cannabis users considered it ‘very easy’ or ‘fairly easy’ to obtain the drug within a 24-hour period. Over half (57%) reported obtaining the cannabis they had last used at the house of friends, 12% obtained it in the street/park, 8% in a disco/bar/club and 5% ordered it by phone. The majority (44%) got the cannabis they had last used from a family member or friend, 28% had shared it among friends and 22% had bought it.

The fourth bulletin of results from the 2006 all-Ireland general population drug prevalence survey (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008b) focused on cocaine use in the adult population (15–64 years) and patterns of cocaine use. Of the 79 recent cocaine powder users, only 9% obtained their cocaine from a person who was not known to them. Cocaine powder was most commonly obtained at the home of a friend (43%) or at a disco, bar or club (36%). Almost two-thirds of recent cocaine powder users said that cocaine powder was easy to obtain within a 24-hour period.

The latest issue of *European Addiction Research* contains a paper on illicit methadone use and abuse among young people accessing treatment for opiate dependence in Ireland (Roche, A. *et al.* 2008). Despite strict controls, 73% of participants reported that illicit methadone was easy to obtain. The most commonly listed marketplace was outside the treatment clinic, while other locations included the participants’ local areas, the quays, and outside city-centre train stations. Of those buying methadone, 42% reported having a regular source. The majority of participants (82%) reported the supplier as someone on a methadone maintenance programme. The vast majority (93%) of participants who had received their methadone prescription as take-aways in the past reported being asked to sell it on; only 6% reported having done so.

The fourth European School Survey Project on Alcohol and Other Drugs (ESPAD), published on 26 March 2009 (Hibell, B *et al.* 2009), gave some indication of perceived availability of some illicit substances. In response to the question “How difficult do you think it would be for you to get each of the following (cannabis, amphetamine, ecstasy)?”, 43% of Irish students said marijuana or hashish would be ‘fairly easy’ or ‘very easy’ to obtain, 25% said the same for amphetamine (ESPAD average 15%) and 31% for ecstasy (ESPAD average 18%).

10.2.2 Drugs origin: national production versus imported

The origins of drugs vary according to drug type. Although there has been no specific research conducted on trafficking routes into Ireland, its proximity to the UK renders it vulnerable to transit from there, and the proximity of the southern coast of Ireland to

the Iberian peninsula exposes it to the supply of cannabis resin originating in Morocco and cocaine originating in the Andean peninsula. Both cannabis resin and cocaine, according to the UNODC, sometimes enter Western Europe through Ireland. It is widely reported by gardaí and the media that many known Irish drug dealers are resident in Spain, which also facilitates the development of links between suppliers of cannabis and cocaine and drug dealers resident in Ireland (O'Keeffe, C. 2005). Finally, Ireland's long western Atlantic coastline renders it vulnerable to trafficking from the south and central Americas. It is also important to recognise that seizures made in Irish waters are sometimes not destined for the Irish market but are destined for the UK or elsewhere in mainland Europe. In recent years some of the largest cocaine seizures in Europe have been made off the south-western coast of Ireland (Burke 2008).

The following information with regard to individual drugs was supplied by Customs Drugs Law Enforcement (CDLE personal communication, July 2009).

Cannabis

South Africa continues to be the main source for herbal cannabis with Amsterdam and Belgium being the main transit hubs for the majority of seizures during 2008. There have also been a number of eastern European individuals identified transporting herbal cannabis into the state. In all sectors local profiling and national /international intelligence continue to be the dominant triggers.

Customs also reports an increase in domestic cultivation of cannabis. Since the start of 2008 there has been a 'noticeable increase in detections of sapling cannabis plants and seeds'. This has led to a number of joint operations between Customs and the Garda Síochána.

Cocaine

Although South America continues to be the main source for cocaine, there is growing evidence of West African countries, e.g. Benin and Senegal, becoming distribution hubs for the European market. In the case of the airfreight seizure of cocaine from the United States, Canadian/US organised crime groups are suspected of being involved. *In corpore* concealments are still being encountered at the main airports.

Romanian couriers, bringing cocaine through Dublin airport, have been intercepted. A major seizure of over 1.2 tonnes of cocaine was seized in Romania in February 2009 suggesting that it has become a hub for cocaine trafficking.

Heroin

With regard to heroin, the use of both commercial vehicles and groupage loads as concealment methods is reported. Heroin, it is reported, 'continues to be high risk through our ports with a multi kilo seizure in Dublin Port, routing from Holland via the UK and onward to Dublin. The trend of utilising deep concealment methods continues.'

Methamphetamine

A significant supply of Methamphetamine was seized in July 2008. Two separate amounts were discovered over a two-day period from deep concealments. The drugs were loaded in Lithuania and detected as a result of a joint operation between Customs and the Garda National Drugs Unit. This is the first significant detection of Methamphetamine (also known as Meth or Crystal Meth or Ice) in the history of the State.

10.2.3 Trafficking patterns, national and international flows, routes, modi operandi; and organisation of domestic drug markets

Drug offence data published by the CSO can assist in understanding aspects of the operation of the illicit drug market in Ireland (Central Statistics Office 2008) (Central Statistics Office 2009). With regard to the so-called middle market level, which involves the importation and internal distribution of drugs, data on drug supply offence prosecutions by Garda division are a possible indicator of national drug distribution

patterns. While these data primarily reflect law enforcement activities and the relative ease of detection of different drugs, they may also provide an indicator of national drug distribution trends. These data can be compared with other sources such as drug treatment data, for example, to show us trends in market developments throughout the State. Such data can also indicate trafficking patterns by showing whether there is a concentration of prosecutions along specific routes.

The upward trend since 2005 in relevant legal proceedings for drug supply continued until 2007, the latest year for which figures are available (Figures 10.2.1 and 10.2.2). The majority of such proceedings were in the Dublin metropolitan region (DMR). The number of supply offences in the DMR increased steadily from 846 in 2004 to 1,477 in 2007. This represents just over 55 % of the total number of supply offences throughout the State in 2007.

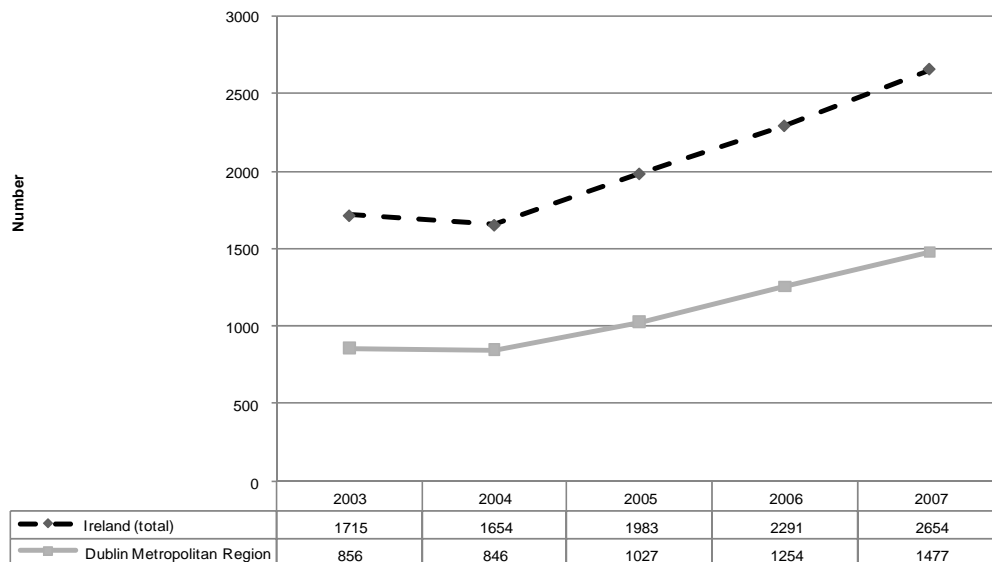


Figure 10.2.1 Trends in relevant legal proceedings for possession of drugs for sale or supply, nationally and in the Dublin Metropolitan Region (DMR), 2003–2007 (Central Statistics Office 2008) (Central Statistics Office 2009)

As Figure 10.2.2 shows, the proportion of the total number of supply offences outside the DMR has increased in most regions since 2005. Relevant legal proceedings for drug supply increased in the southern region by 60% and by 40% in the south-eastern region, 44% in the eastern region and 70% in the western region. Supply offence prosecutions decreased slightly in the northern region during 2007.

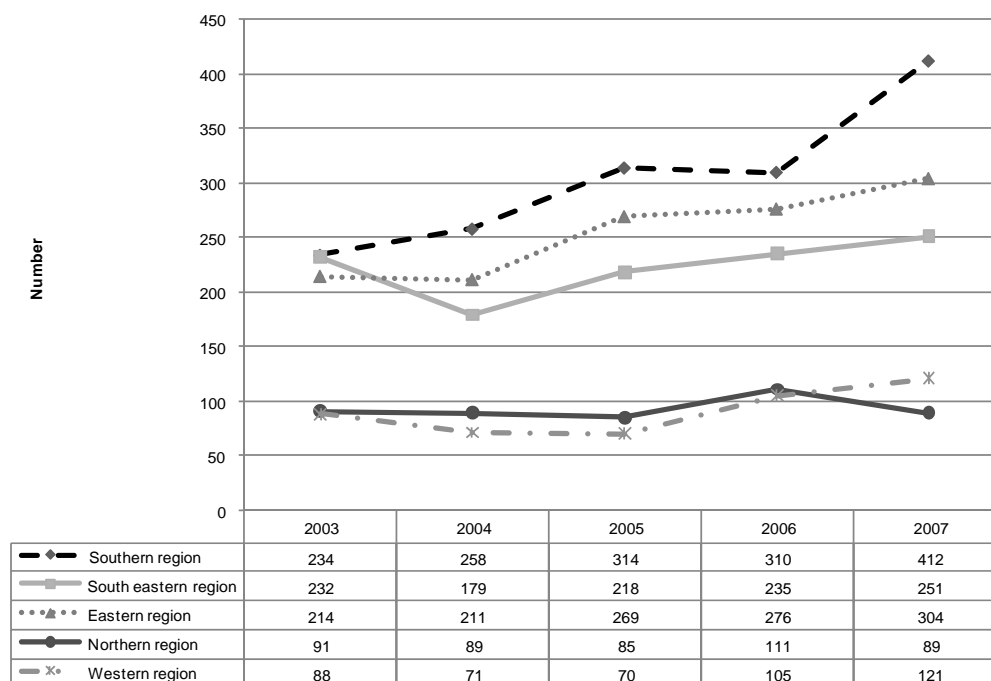


Figure 10.2.2 Trends in relevant legal proceedings for possession of drugs for sale or supply, by region, excluding the DMR, 2003–2007 (Central Statistics Office 2008) (Central Statistics Office 2009).

Drug dealing in Clondalkin, west Dublin

A research report was commissioned by the Clondalkin Local Drugs Task Force (CLDTF) in order to clarify the nature and extent of drug use in the area (Breen 2008).

Both qualitative and quantitative research methods were used, including a survey of 150 drug users by nine peer research assistants, and focus groups with problematic drug users, family members and community members. Available relevant statistics were also collated, such as Garda crime statistics and drug treatment figures. The report covered a wide range of drug-related issues, including information relating to availability, prevalence, profile of users and patterns of use, drug-related health issues and risk behaviours, drug treatment and drug-related crime.

With regard to drug-related crime, the research found that as drug consumption had become less visible, the wider community's concern had centred on drug-related crime and the normalisation of such crime. A greater amount and variety of illegal drugs has become available in recent years. Drug dealing has become more open, frequently being conducted in public places, and is seen as an attractive and lucrative 'career option' for a proportion of young people living in Clondalkin. The report highlighted a belief that law enforcement focuses too much on breaking up high-level drug distribution networks rather than on disrupting the activities of local dealers.

Study on Dublin crack cocaine market

In October 2008 the Alcohol and Drug Research Unit of the Health Research Board (HRB) launched *Crack cocaine in the Dublin region: an evidence base for a crack cocaine strategy* (Connolly *et al.* 2008). The research was commissioned by the Intersectoral Crack Cocaine Strategy Group, which was established by the late Tony Gregory TD, in response to a number of seizures of crack cocaine made by the Garda Síochána in the north inner city.

The report indicated that the number of people using crack in Ireland remained low, with current users representing just 1% of drug users who presented for treatment and 0.1% of the general population. However, the report also made the point that, despite

targeted Garda interventions, crack use had increased and availability had spread throughout the Dublin region. Launching the report, Minister of State John Curran TD said: 'It is good news that the crack cocaine market has not taken hold in Ireland to the extent it has in other countries. However the report highlights the need to remain vigilant to ensure that this remains the case.' The Minister also stated that the report would be central to the development of a timely strategic response through the new National Drugs Strategy.

The HRB conducted the research over a nine-month period beginning in August 2007, using a rapid situation assessment technique developed by the World Health Organization. This involved a multi-method approach which brought together existing research, and drug treatment and criminal justice data, supported by interviews with key informants such as drug users, gardaí, outreach workers and treatment specialists.

The emergence of crack cocaine

A number of factors may explain the rise in crack cocaine use in Dublin. These include the increased availability of powder cocaine; the presence of problematic opiate users who have used crack cocaine in the UK or in Europe and have resumed crack consumption while living in Dublin; and the presence of non-Irish nationals, primarily of West African origin, who have access to cocaine supply routes and experience of preparing crack cocaine.

Drug-using characteristics of crack users

The majority of crack users used more than one drug, with opiates (mainly heroin) being the most common drugs used alongside crack. Smoking was the predominant route of administration. A proportion of intravenous users made a transition from injecting powder cocaine to smoking crack cocaine because of the physical harms of injecting. Frequency of use ranged from daily to weekly and was largely dependent on availability of financial resources.

Dublin crack market

The north inner city was the primary crack market in Dublin; the market was dominated by non-Irish national dealers who were importing small amounts of cocaine via couriers. However, a growing number of Irish dealers were reported to be involved in the distribution of crack throughout the Dublin region, and prepared crack had been available throughout the city since 2006. Findings indicated that the crack market was a closed market, meaning that dealers did not sell to strangers, exchanges were generally arranged using mobile phones, and buyers were directed to exchange points outside the inner city. The price of crack was relatively stable and uniform, with prepared quantities or 'rocks' being sold for €50 or €100. Crack houses were reported as locations where crack was used and in some cases prepared in exchange for free crack; they were not reported as major venues for crack dealing or as sites for sex work.

Social profile of crack users and consequences of crack use

A high proportion of crack users were homeless, unemployed and did not have formal educational qualifications. According to data from treatment services, the majority of crack users were male and half were aged between 20 and 29 years. However, females involved in sex work and single mothers were reported to develop the most chaotic addiction. Common physical side-effects of crack use are breathing problems, heart problems and rapid weight loss, and the most common psychological consequences are paranoia, aggressiveness and depression. Compulsive crack users reported neglecting their children, often diverting their financial resources towards buying crack. Shoplifting, burglary and robbery were reported as common means for users to sustain their crack cocaine habit. Service providers also reported an increase in the numbers of women returning to or beginning sex work to fund their crack use.

Intervention strategies

International evidence indicates that effective intervention strategies are those which combine attempts to disrupt local markets, making them less predictable to buyers and sellers, with attempts to divert drug offenders into treatment services. The most successful approaches to reducing or ceasing crack use are psychosocial interventions such as cognitive behavioural therapy. However, these interventions can only be successful if the user is attracted to and retained in treatment.

Study of Illicit drug market in Ireland

The first comprehensive study of the Irish illicit drug market is currently being carried out by the Health Research Board. The aims of the study are to:

- examine the nature, organisation and structure of Irish drug markets,
- examine the various factors which can influence the development of local drug markets,
- examine the impact of drug dealing and drug markets on local communities, and
- describe and assess interventions in drug markets with a view to identifying what further interventions are needed.

Commissioned by the National Advisory Committee on Drugs, the study employs a range of research methods and is due for publication in 2010.

10.3 Seizures

10.3.1 Quantities and numbers of seizures of all illicit drugs

The number of drug seizures in any given period can be affected by such factors as law enforcement resources, strategies and priorities, and by the vulnerability of traffickers to law enforcement activities. However, drug seizures are considered indirect indicators of the supply and availability of drugs.

Cannabis seizures account for the largest proportion of all drugs seized. Figure 10.3.1 shows trends in cannabis-related seizures and total seizures between 2003 and 2007; drug seizures have continued to increase since 2005. Of the 10,444 reported drug seizures in 2007, 5,176 (49.6%) were cannabis-related.

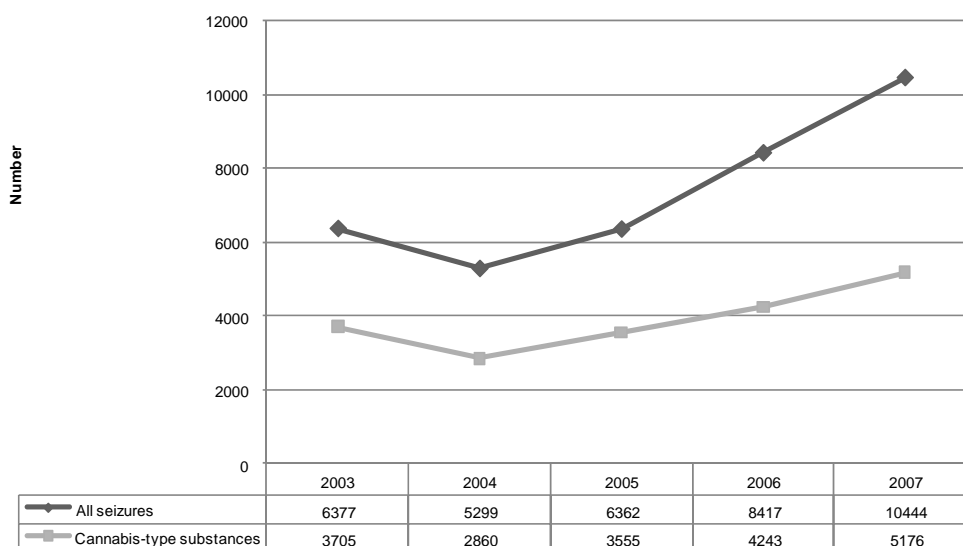


Figure 10.3.1 Trends in the total number of drug seizures and cannabis seizures, 2003–2007 (Central Statistics Office 2008) (Central Statistics Office 2009)

Figure 10.3.2 shows trends in seizures for a selection of drugs, excluding cannabis, between 2003 and 2007. There has been a continuous steady rise in cocaine and

heroin seizures since 2005. In 2007, there were 1,749 cocaine seizures and 1,698 heroin seizures. The number of ecstasy-type substances seized has also continued to rise, following a decline from 2003 to 2005. The number of ecstasy seizures has exceeded the 2003 level.

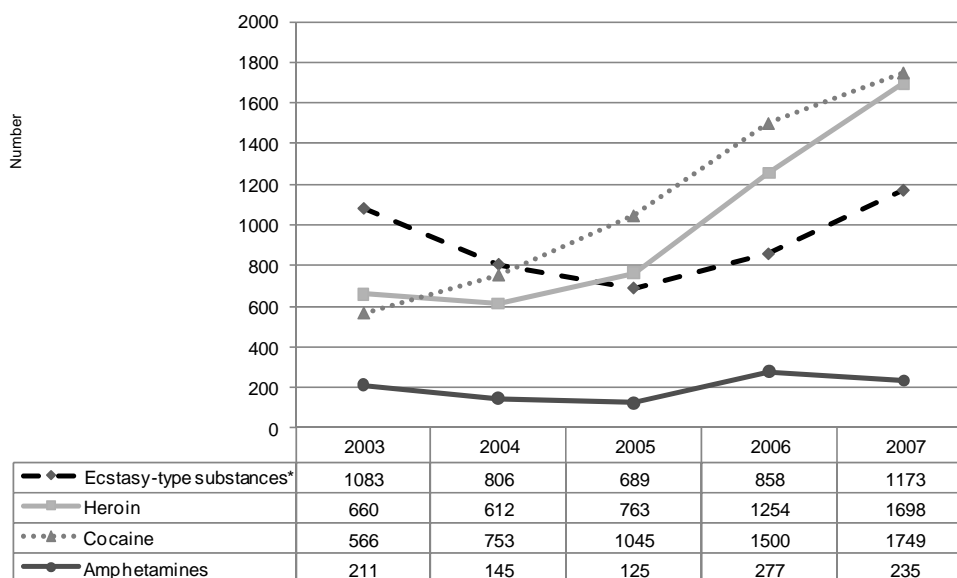


Figure 10.3.2 Trends in the number of seizures of selected drugs, excluding cannabis, 2003–2007 (Central Statistics Office 2008) (Central Statistics Office 2009)
* Includes MDMA, MDEA, and DOB

Table 10.3.1 shows the particulars of all drugs seized in 2007 that were reported by the Forensic Science Laboratory (FSL). Not all drugs seized by law enforcement (the Garda Síochána and Customs Drug Law Enforcement), are necessarily analysed and reported by the FSL. For example, if no individual is identified in relation to the drug seizure, and no prosecution takes place, the drugs may not be sent for analysis and may be destroyed. Alternatively, there may be some large cannabis/cannabis resin cases without a suspect where no analysis was conducted and no quantification (purity determination) was carried out.

Table 10.3.1 Particulars of drugs seized during 2007, and analysed by the Forensic Science Laboratory (Central Statistics Office 2009)

Drug Type	Quantity	Cases
Alprazolam	217 tablets	16
Amphetamine	58,217 grams, 10,471 tablets	235
BZP**	203 tablets, 1.4 grams	43
Cannabis	763,120 grams	1910
Cannabis resin	1,235,352 grams	3166
Cannabis plants*	1,272 plants	100
2 C-B	2 tablets	1
Cocaine	1,751,802grams	1749
CPP***	57,420 tablets	12
Diamorphine (Heroin)	146,586 grams	1698
Diazepam	71,483 tablets, 1,988 gram	166
Dihydrocodeine	358 tablets, 0.2 grams	16
DOB	5 tablets	1
Ecstasy MDMA	204,799 tablets, 13,253 grams	1171
Ecstasy MDEA	7 tablets	2
Ephedrine	695 tablets, 47 capsules, 3.2 grams	11

Drug Type	Quantity	Cases
Flunitrazepam (Rohypnol)	76 tablets	4
Flurazepam	3,608 capsules	24
Ketamine***	52.1 grams 2,082 tablets	28
Khat	Plant samples	2
LSD	140 units	13
Methadone	6,022 millilitres, 900 tablets	21
Methandienone***	4,094 tablets	18
Methylamphetamine	40.9 grams	9
Oxycodone	283 capsules, 263 tablets	2
Temazepam	4 tablets	3
Zopiclone***	2,218 tablets	23

*The number of cannabis plants does not reflect the total number detected as only a sample of the plants are sent for analysis.

** BZP was added to the list of controlled drugs during 2008

*** These drugs are not controlled under the Misuse of Drugs Acts, 1977 & 1984

10.3.2 Quantities and numbers of seizures of precursor chemicals used in the manufacture of illicit drugs

See Section 10.4 of National Report 2008, for most recent information on price and purity.

10.3.3 Number of illicit laboratories and other production sites dismantled; and precise type of illicit drugs manufactured there

See selected issue chapter 11 in relation to cannabis plants. No new information in relation to other drugs.

10.4 Price/purity

See Section 10.4 of National Report 2008, for most recent information on price and purity.

10.4.1 Price of illicit drugs at retail level

No update is available on the information reported in Ireland's National Report 2008 (Alcohol and Drug Research Unit 2008), where it was reported that, 'The Garda Síochána are currently developing a more robust method to ascertain drug prices (GNDU, personal communication, May 2008).'

10.4.2 Price/potency of illicit drugs

In support of the 'Drugs Markets' study currently being conducted in a number of locations in Ireland (Section 10.2.3), the FSL is carrying out a study, analysing drugs samples seized for purity and potency. The FSL has been provided with additional resources to undertake this special initiative. The drugs market study is due to be published in 2010.

10.4.3 Composition of illicit drugs and drug tablets

No update is available on the information reported in Ireland's National Report 2008 (Alcohol and Drug Research Unit 2008), where it was reported that, 'The Forensic Science Laboratory (FSL) reported that the average wholesale purity of heroin in 2007 was 41% while the average retail purity was 40%. The average wholesale purity of cocaine was reported as 27% with the average retail purity 10%. (Forensic Science Laboratory, personal communication, September 2008)

In 2005 Connolly (Connolly 2005) stated: 'Drug purity data are not collated in a systematic way at different market levels in Ireland. The primary function of the Forensic Science Laboratory (FSL) in this area relates to supporting the criminal justice system, and not to research. Only a very small proportion of drugs seized are tested to ascertain the percentage purity. Research should be conducted in the FSL to ascertain the purity levels of different drugs and for different-sized seizures, i.e. both street-level and larger seizures. Such research should be conducted on a national basis. Also, analysis of the various dilutants used to bulk up drugs for street sale could be useful in identifying the health implications for drug users, (pp. 19–20).

Part B: Selected Issues

Summary of selected issues

11. Cannabis markets and production

- Drug seizure data, survey findings and law enforcement operations in recent years (2006–2008) suggest that commercial domestic cannabis production is gaining momentum in Ireland.
- There is limited evidence available to ascertain the size and growth of domestic cannabis production.
- There has been an increase in ‘grow shops’ nationwide since 2000. Grow shops are generally referred to as ‘head shops’ in Ireland. Information on the extent of the head shop industry is not reliable as there is no official register of head shops in Ireland.
- According to media reports, the first head shop in Ireland opened in 2000 and by 2007 there were at least 24 head shops operating nationwide.
- Two recent all-Ireland general population drug prevalence surveys (2002/3 and 2006/7) highlight cannabis use patterns in the adult Irish population. The majority (60%) of current cannabis users reported using a form of cannabis resin. Almost two-in-five (38%) reported using a form of herbal cannabis.
- No research studies have been conducted in Ireland on the nature of the Irish drug market. Research currently being completed by the Health Research Board will look at the organisation and structure of Irish illicit drug markets. A number of books have been written by investigative journalists about specific criminals or organised crime groups involved in the trade in illicit drugs including cannabis.
- Wholesale prices for cannabis are not currently available in Ireland.
- As part of ‘Operation Vacuum’, the Garda Síochána targeted domestic production of cannabis in 2008. Several large scale ‘cannabis factories’ were uncovered nationwide. Many were located indoors, both in private residences and commercial premises. The largest production facility successfully targeted by police in January 2009, had 1,200 cannabis plants, using the water based hydroponic system of cultivation.
- Morocco is the major producing country of cannabis resin, the principal form of the drug used in Ireland. According to Customs Drug Law Enforcement ‘South Africa continues to be the main source for herbal cannabis with Amsterdam and Belgium being the main transit hubs for the majority of seizures during 2008.
- Drug seizure data highlight increasing numbers of both cannabis plants and herbal cannabis seizures. Although drug seizures are seen as an indirect indicator of drug availability, it is important to remember that they can also merely reflect changes in police emphasis or priorities. There has been a sharp increase in cannabis herb seizures, from 609 seizures in 2006 to 1,910 in 2007. The number of cannabis plants seized more than doubled from 47 seizures in 2006 to 100 seizures in 2007.
- Trend data for proceedings for possession of herbal cannabis in the Dublin Metropolitan Region (DMR) and Nationally from 2003 to 2007 show that there has been a steady upward trend in proceedings in the DMR since 2004. The steep upward trend in such proceedings nationally since 2006 in particular, is due to the upward trend in all garda regions since 2004 and a sharp rise in the South Eastern region during 2007 where proceedings for the possession of herbal cannabis increased from 218 in 2006 to 472 the following year.

12. Treatment for older drug users

- The proportion of drug users aged 40 and over in treatment has increased from 3.1% of the total in 1998 to 9.4% of the total in 2008.
- The biggest increase was observed in the age group 40–49, increasing from 2.7% in 1998 to 8.0% in 2008.

- The proportion of treated clients aged over 60 is very low and remained almost constant for all years between 1998 to 2008.
- Between 1998 and 2007, one-fifth (22%) of the total deaths due to poisonings recorded in Ireland (as per Selection D) were among individuals aged 40 and over.
- The number of deaths in the older age groups increased steadily from 18 cases in 1998 to 28 cases in 2004, after which there was a jump in the number of deaths to 45. Since 2005, the number of deaths in this age group has fallen slightly.
- In the older age groups, the majority of deaths due to poisonings occurred among those aged 40 to 49. The majority of older drug-related deaths were male.
- Nearly two thirds of poisonings among older drug users were due to more than one substance. Of these, almost all included an opiate-type drug.
- The proportion of drug users aged 40 and over in methadone maintenance treatment has increased from 4% in 1994 to 19% in 2008.
- Only a very small proportion (less than 0.5%) of treated clients started their drug use after the age of 40. The proportion did not change over the 10 years under review.
- Overall, heroin is the main problem drug reported by all older drug users.
- Only a small proportion of older drug users reported cocaine as their main problem drug. Very few drug users aged over 50 years reported cocaine as their main problem drug.
- The small number of drug users aged 50 and over makes inferences about these older groups more difficult.
- In 2008, almost one in ten clients entering drug treatment were aged 40 years or older. The majority of these older users were aged between 40 and 49.
- In 2008, the majority of older drug users reported using heroin. Lower proportions of older drug users reported cocaine as their main problem drug compared to younger users.
- In 2008, benzodiazepines and other opiates were the main problem drugs for clients aged 60 or over. However, the small numbers make inferences difficult.
- Older drug users have not been identified as a vulnerable or high-risk group in Ireland who need dedicated services. No specific research has been done on this group, but as the cohort ages this may need to be re-evaluated.

11. Cannabis markets and production

11.1 Introduction

Law enforcement data and survey data suggest that there has been a recent growth in domestic cannabis cultivation in Ireland. Several large-scale 'cannabis factories' have been detected as a result of targeted police activity. There has also been an increase in the number of 'grow shops' (also referred to as 'head shops') since 2000. These shops sell paraphernalia associated with the production and use of cannabis products. The majority of cannabis users reported finding it relatively easy to obtain cannabis and many reported originally obtaining cannabis from a family member or friend, indicating a culture of exchange and gifts associated with the use of cannabis.

11.2. Markets

Drug seizure data, survey findings and law enforcement operations in recent years (2006–2008) suggest that commercial domestic cannabis production is gaining momentum in Ireland. Customs also reports an increase in trends in domestic cultivation of cannabis.

11.2.1 Cannabis domestic production

There is limited evidence available to ascertain the size and growth of domestic cannabis production. Survey data from the 2006/7 all Ireland general population drug prevalence study indicates that 16.1% of current herbal cannabis smokers knew that their cannabis was grown in Ireland, 32.7% were not sure and 51.2 % were certain their cannabis was grown outside Ireland (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008c).

There has been an increase in 'grow shops' nationwide since 2000. Grow shops are generally referred to as 'head shops' in Ireland. Information on the extent of the head shop industry is not reliable as there is no official register of head shops. Unlike outlets that sell alcohol, there is no requirement for a special retail licence to open a head shop. According to media reports, the first head shop in Ireland opened in 2000 and by 2007 there were at least 24 head shops operating nationwide (Clarke 2007, 16 December). In addition to selling legal substances such as herbal cigarettes and, until recently, BZP and 'magic mushrooms', many of these head shops sell rolling papers, pipes, grinders, seeds, lights and propagators and other items associated with the cultivation and use of cannabis. The Irish Association of Head Shops represents the interests and concerns of its members to government and the media and monitors the legislative agenda to inform and advise its members of possible ramifications.

11.2.3 Consumer-market share of different cannabis products

Two recent all-Ireland general population drug prevalence surveys (2002/3 and 2006/7) highlight cannabis use patterns in the adult Irish population (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005b) (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008c). The majority (60%) of current cannabis users reported using a form of cannabis resin. However, almost two-in-five (38%) reported using a form of herbal cannabis.

11.2.4 Distribution of cannabis at national level

No research studies have been conducted in Ireland on this subject. Research currently being completed by the Health Research Board will look at the organisation and structure of Irish illicit drug markets.

Investigative journalists have written books about specific criminals or organised crime groups involved in the trade in illicit drugs including cannabis (Mooney 2001) (Williams 2001). No studies have been conducted on middle-market drug distribution in Ireland (Connolly 2005). Research on the middle-market level seeks to describe, for example, how drugs are moved from importation to street level and by whom. The Garda Síochána believe that the distribution of drugs within Ireland is organised by networks of criminal gangs. In some cases these gangs involve members of the same family (Moran *et al.* 2001). Journalist Paul Williams (Williams 2001) who focused on the gang involved in the murder of crime correspondent Veronica Guerin in 1996 suggested the significant involvement of both international and national organised crime networks in the Irish cannabis trade. He also suggested that the same gang was involved in the importation of cannabis, cocaine, firearms and ammunition. The book described regular trips by gang members to Holland to organise cannabis shipments. It suggested that a second level of gang members then sold the drugs to a network of dealers in Ireland, who did not appear to be members of the primary gang, for onward local distribution.

11.2.5 Cannabis wholesale prices, 2004–2008

Wholesale prices for cannabis are not currently available in Ireland. The Garda National Drugs Unit (GNDU), in its report for the government's annual submission to the United Nations Office on Drugs and Crime (UNODC) for 2002, reported that the price of one kilogram (35.27 oz) of cannabis resin at wholesale level in that year was €3,250, with the price per gram at street level ranging from €10 to €15.

11.2.6 Typology of retail outlets for cannabis sale

The 2006/7 all-Ireland general population drug prevalence study examined the availability of cannabis products for users (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008c). The majority (62%) of recent cannabis users considered it 'very easy' or 'fairly easy' to obtain the drug within a 24-hour period. Over half (57%) of recent users reported obtaining the cannabis they had last used at the house of friends, 12% obtained it in the street/park, 8% in a disco/bar/club and 5% ordered it by phone.

11.2.7 Cannabis sources and transactions

A study conducted in 2002 by the Garda Research Unit among second-level students in the Garda divisions of Waterford/Kilkenny and Kerry found that cannabis was the first drug taken by 89% of those who reported having used drugs. In 70% of cases friends had supplied the drugs (Sarma and Ryan 2002). In a study conducted in 2003 Hibell (2004) (Hibell, Björn *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, 15% had shared it in a group. The 2006/7 all-Ireland general population drug prevalence study also examined the sources of cannabis products for users (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008c). Forty-four per cent got the cannabis they had last used from a family member or friend, 28% had obtained it through sharing with friends and 22% had bought it. This suggests a culture of exchange of cannabis as gifts between family and friends.

11.3 Seizures

11.3.1 Supply reduction organisation and activity

Customs Drug Law Enforcement (CDLE) is based within the Revenue Commissioners and is primarily responsible for enforcing the law in relation to the importation of illicit drugs into Ireland via sea and air ports. It is also responsible for intercepting illicit

substances distributed via the Irish postal system. The Garda Síochána is the national police force and has primary responsibility for enforcing and prosecuting offences against Irish drug laws. Over the past 18 months CDLE reports that there has been a 'noticeable increase in detections of sapling cannabis plants and seeds'. This has led to a number of joint operations between Customs and the Garda Síochána⁷.

11.3.2 Seizures of plantations, 2006–2008

As part of 'Operation Vacuum', the Garda Síochána targeted domestic production of cannabis in 2008. Several large-scale 'cannabis factories' were uncovered nationwide. Many were located indoors, both in private residences and commercial premises. The largest production facility successfully targeted by police in January 2009, had 1,200 cannabis plants, using the water-based hydroponic system of cultivation (Roche, B. 2009, 28 January) (McGreevy 2008, 28 July) (Brady 2008)

11.3.3 Origin of cannabis products seized, 2004-2008

The data provided in this section is drawn from an overview completed in 2005 (Connolly 2005), with an update on the origin of herbal cannabis obtained in 2009.

Cannabis resin

Morocco is the major producing country of cannabis resin, the principal form of the drug used in Ireland. 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 have also been seized along the south coast of Ireland, being smuggled by yachts, small craft or converted fishing vessels.

Cannabis herb

The cannabis herb seized in Ireland originates primarily in South Africa and Thailand. It comes to Ireland via different countries, including France, Germany, the UK, the Netherlands and Belgium. In 2001 there was a large increase in cannabis herb seizures. This was reported as being due to Ireland's being targeted as a transit country for supplying cannabis herb to the UK market. In 2001, the Garda National Drugs Unit estimated that 47% of the cannabis herb seized in Ireland was for the Irish market and 53% for the UK market. 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 six tonnes of herbal cannabis, worth nearly €25 million, concealed within concrete garden furniture which had originally been shipped from Thailand'. It is believed that this consignment was destined for the UK market.

According to CDLE 'South Africa continues to be the main source for herbal cannabis with Amsterdam and Belgium being the main transit hubs for the majority of seizures during 2008. In all sectors local profiling and national /international intelligence continue to be the dominant triggers' for detection. (CDLE personal information, July 2009)

11.3.4 Breakdown of cannabis seizures by product and amount seized, 2008

Drug seizure data highlight increasing numbers of both cannabis plants and herbal cannabis seizures. Although drug seizures are seen as an indirect indicator of drug availability, it is important to remember that they can also merely reflect changes in police emphasis or priorities. Data presented in this section relates to the period 2003–2007; data for 2008 is not yet available.

Cannabis resin had represented the bulk of all cannabis seizures from 2003 to 2006 when 85% to 91% of all cannabis seizures consisting of cannabis resin. However, as shown in Figure 11.3.1, this decreased dramatically in 2007 when resin only accounted for 61% of all cannabis seizures. At the same time, there has been a sharp increase in cannabis herb seizures, from 609 seizures in 2006 to 1,910 in 2007. The number of cannabis plants seized more than doubled from 47 seizures in 2006 to 100 seizures in 2007.

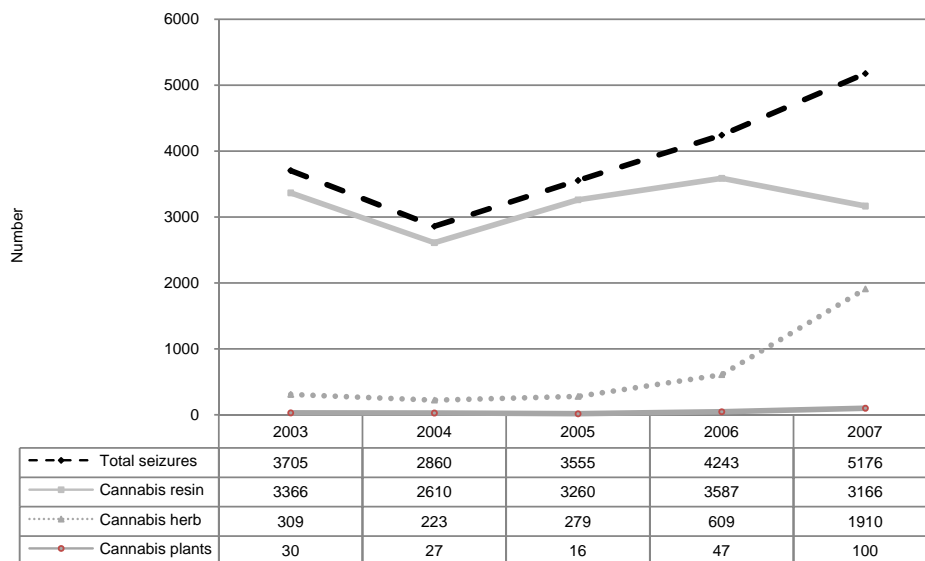


Figure 11.3.1 Trends in the number of seizures of cannabis resin, herbal cannabis and cannabis plants and total cannabis-related seizures, 2003–2007, reported by the CSO (Central Statistics Office 2008) (Central Statistics Office 2009)

The number of individual seizures is a more reliable indicator of trends than the quantity seized as in any one year a very large individual seizure can distort the picture. Although there is generally no clear relationship between the number of seizures and the quantity of the drug seized, Figure 11.3.2 shows that following a sharp increase in the quantity of cannabis resin seized in 2005 and 2006, there was a significant drop in the quantity of cannabis resin seized in 2007. The quantity seized decreased from 6,972kg in 2006 to 1,235 kg in 2007.

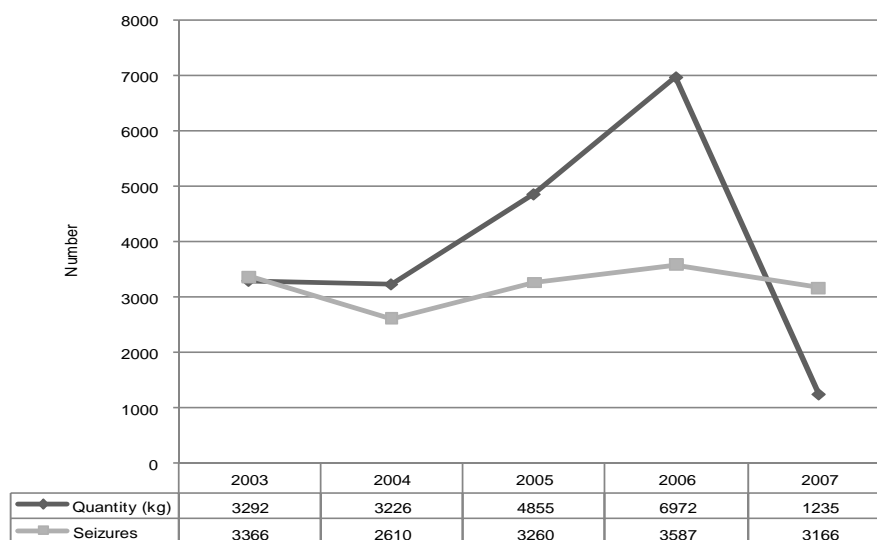


Figure 11.3.2 Trends in the number and quantity of seizures of cannabis resin, 2003–2007, reported by the CSO (Central Statistics Office 2008) (Central Statistics Office 2009)

Figure 11.3.3 shows trends in the number and quantity of herbal cannabis seizures from 2003 to 2007. Both the number and quantity of herbal cannabis seized increased together fairly consistently.

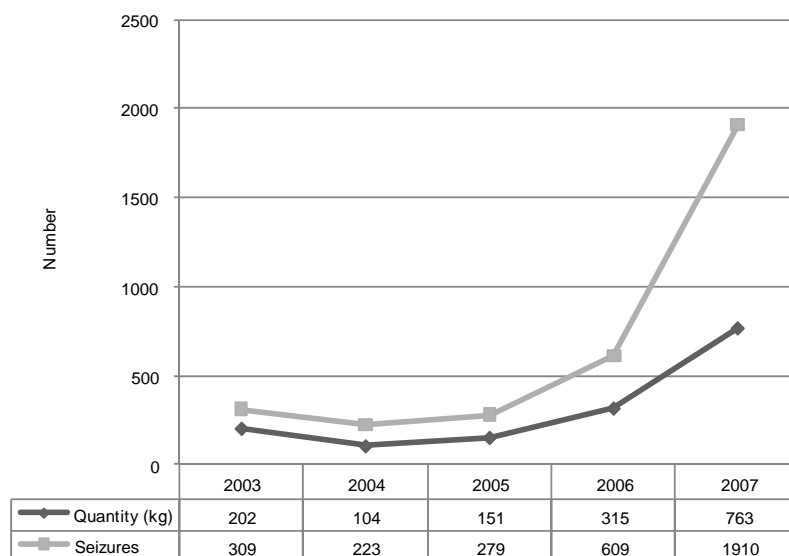


Figure 11.3.3 Trends in the number and quantity of seizures of herbal cannabis, 2003–2007, reported by the CSO (Central Statistics Office 2008) (Central Statistics Office 2009)

With regard to Figure 11.3.4, we can also see a sharp increase in the quantity of cannabis plants seized in 2006 and 2007. As mentioned in section 11.3.2 above, although there has been a doubling in the number of seizures, the large quantity seized may reflect the discovery during this period of a number of cannabis factories producing high yields of cannabis plants.

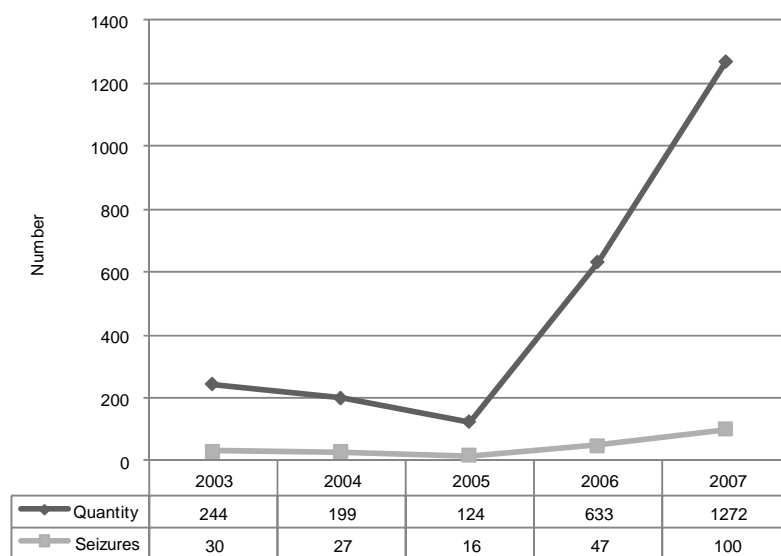


Figure 11.3.4 Trends in the number and quantity of seizures of cannabis plants, 2003–2007, reported by the CSO (Central Statistics Office 2008) (Central Statistics Office 2009)

11.4 Offences - cannabis supply-related offences reported by the police

Data is not available with regard to the type of substances involved in supply offences. The following data is derived from the Garda Síochána PULSE IT system and is reported by the Central Statistics Office (Central Statistics Office 2008) (Central Statistics Office 2009). It provides trends in prosecutions for possession for personal use (s3 Misuse of Drugs Act) by cannabis type.

Figure 11.4.1 shows trends in possession offences for cannabis resin at a national level and in the Dublin Metropolitan Region. A larger number of such proceedings takes place in the Dublin region relative to other garda regions. Generally it can be seen that national trends closely mirror trends in Dublin. In 2007 however, there was an upward trend in the DMR while the national total declined slightly.

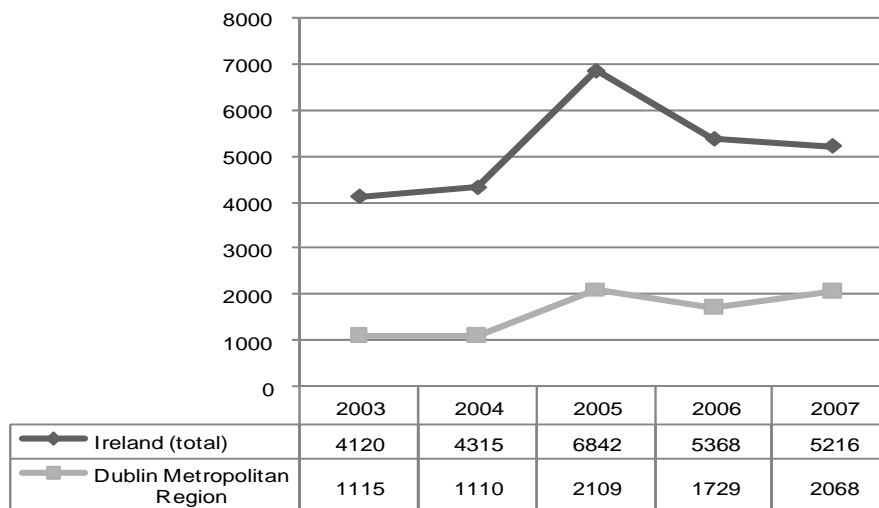


Figure 11.4.1 Trends in proceedings for possession of cannabis resin nationally and in the Dublin Metropolitan Region (DMR), 2003–2007, reported by the CSO (Central Statistics Office 2008) (Central Statistics Office 2009)

Figure 11.4.2 shows trends in possession offences for cannabis resin for the other garda regions throughout the state, from 2003 to 2007. Proceedings for possession of cannabis resin have declined quite significantly in the Southern, Eastern and South Eastern regions since 2005 when they were at their peak. Proceedings for possession in the Northern and Western regions have remained relatively stable.

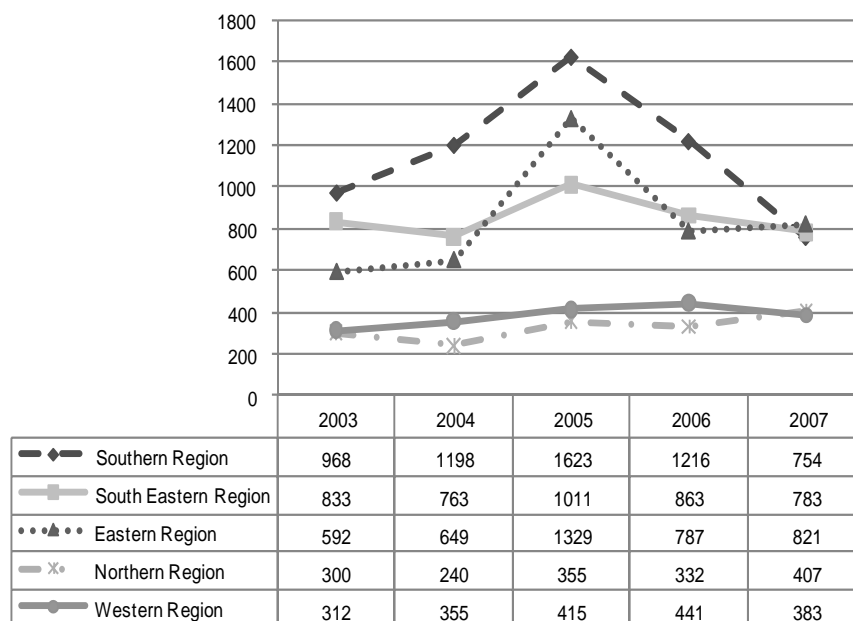


Figure 11.4.2 Trends in proceedings for possession of cannabis resin by region, excluding the DMR, 2003–2007, reported by the CSO (Central Statistics Office 2008) (Central Statistics Office 2009)

Figure 11.4.3 shows trends in proceedings for possession of herbal cannabis in the Dublin Metropolitan Region and nationally from 2003 to 2007. There has been a steady upward trend in prosecutions for the DMR since 2004. As can be seen from Figure 11.4.4, the steep upward trend in such proceedings in nationally since 2006 in particular, is due to the upward trend in all garda regions since 2004 and a sharp rise

in the South Eastern region during 2007 where proceedings in for the possession of herbal cannabis increased from 218 proceedings in 2006 to 472 the following year.

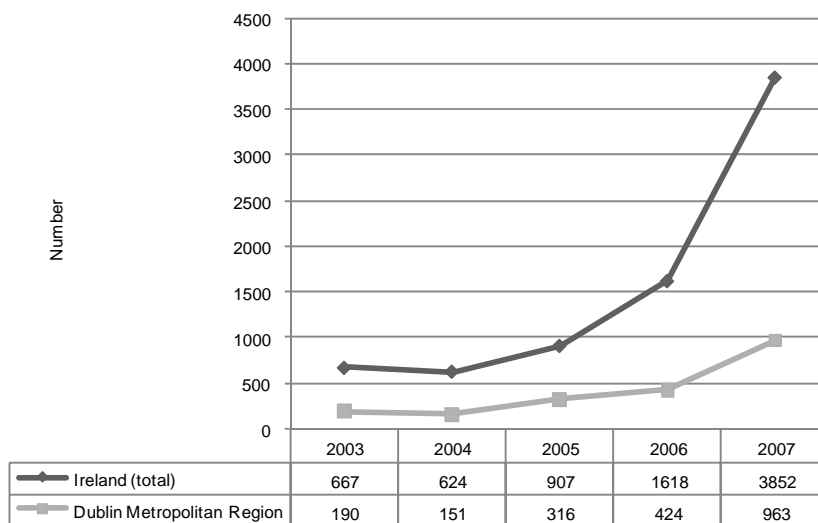


Figure 11.4.3 Trends in proceedings for possession of herbal cannabis nationally and in the Dublin Metropolitan Region (DMR), 2003–2007, reported by the CSO (Central Statistics Office 2008) (Central Statistics Office 2009)

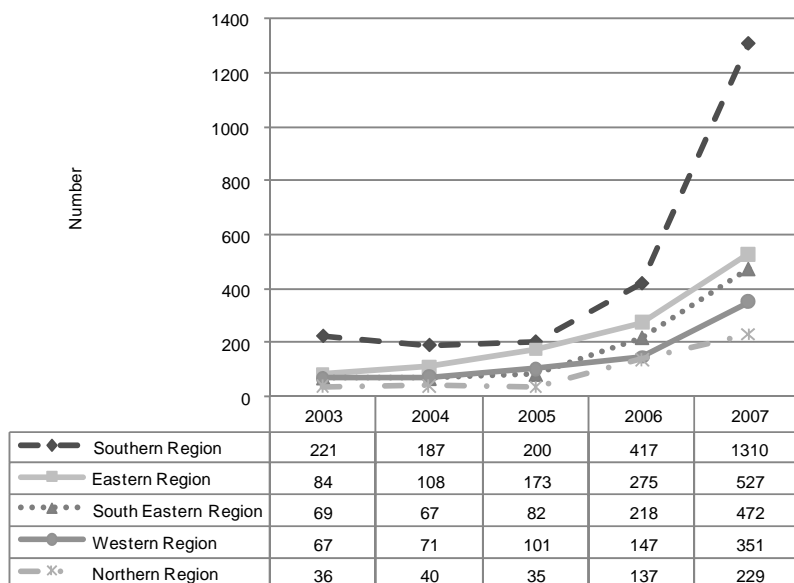


Figure 11.4.4 Trends in proceedings for possession of herbal cannabis by region, excluding the DMR, 2003–2007. Source: (Central Statistics Office 2008) (Central Statistics Office 2009)

The number of proceedings for the possession of cannabis plants was too small to graph by garda region. To include such data may lead to the identification of individual suspects as the number of prosecutions is so low by garda region.

12. Treatment and care for older drug users

12.1 Introduction

Appropriate treatment has been shown to improve the survival of drug users. Additionally, the average age of drug users in Ireland is increasing so the proportion of those aged over 40 in the population is increasing. It is likely that this trend will continue. This will present challenges for the health services, including the drug treatment service. The issue of older drug users has not been examined previously in Ireland.

National data collection tools

This section presents information based on data on older drug users from the following information systems:

The National Drug Treatment Reporting System (NDTRS) is a national epidemiological database which provides data on treated drug and alcohol misuse in Ireland. The NDTRS collects data from both public and private outpatient services, inpatient specialised residential centres and low-threshold services. For the purposes 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 substance misuse problems'. The NDTRS is a case-based, anonymised database.

The Central Treatment List (CTL) was established under Statutory Instrument No 225 following the *Report of the Methadone Treatment Services Review Group 1998* (Methadone Treatment Services Review Group 1998). This list is a register of all patients receiving methadone (for treatment of opiate misuse) in Ireland and provides all data on methadone treatment nationally.

The National Psychiatric In-Patient Reporting System (NPIRS) is a national psychiatric database that provides detailed information on all admissions to and discharges from 56 inpatient psychiatric services in Ireland, recording data on cases receiving inpatient treatment for problem drug and alcohol use.

12.2 Trends of older drug users in treatment

Numbers of older drug users in treatment

In Ireland the proportion of clients aged 40 or over in treatment has risen steadily over the past decade, from 3.1% of the total in 1998 to 9.4% of the total in 2008 (Table 12.2.1, also see Table 1 Selected issue Historical data). Over the period, the biggest rise was observed in clients aged between 40 and 49, increasing from 2.7% in 1998 to 8.0% in 2008. The proportion of treated clients aged over 60 remained almost constant for all years between 1998 to 2008, not more than 0.2% of the total treated clients annually.

Table 12.2.1 Numbers and percentages of clients in treatment in Ireland, by age group, 1998–2008

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total	5090	4394	4744	5135	5455	5560	4724	5039	5285	5775	6247
< 40	4915 (96.6)	4246 (96.6)	4561 (96.1)	4841 (94.3)	5105 (93.6)	5218 (93.8)	4445 (94.1)	4673 (92.7)	4883 (92.4)	5313 (92.0)	5647 (90.4)
40 - 49	135 (2.7)	104 (2.4)	144 (3.0)	221 (4.3)	255 (4.7)	276 (5.0)	233 (4.9)	309 (6.1)	336 (6.4)	383 (6.6)	497 (8.0)
>= 50	23 (0.5)	26 (0.6)	32 (0.7)	45 (0.9)	49 (0.9)	46 (0.8)	40 (0.8)	55 (1.1)	58 (1.1)	67 (1.2)	88 (1.4)
Unknown	17 (0.3)	18 (0.4)	7 (0.1)	28 (0.5)	46 (0.8)	20 (0.4)	6 (0.1)	2 (0.04)	8 (0.2)	12 (0.2)	15 (0.2)

Source: NDTRS

Main problem drug of older drug users

The main problem drug reported varied across different older age groups. Heroin was recorded as the main problem drug among the majority of treated clients aged 40 to 49, rising from 53% in 1998 to 70% in 2006, and dropping slightly to 66.% in 2008 (Table 12.2.2). Although small numbers, the proportion of drug users aged over 50 reporting heroin as their main problem drug also increased over the 10-year period under review, from 26.9% in 1999 to 55.2%% in 2007, again showing a decrease in 2008 to 46.6%.

Only a small proportion of older drug users reported cocaine as their main problem drug. The proportion fluctuated over the 10-year period but peaked in 2007dropping slightly in 2008. Very few drug users aged over 50 years reported cocaine as their main problem drug and small numbers makes inferences difficult.

Only very small proportions of any group of older drug users reported either cannabis or stimulants as a main problem drug.

Other opiates and benzodiazepines were reported as the main problem drug for the majority of those drug users aged 60 years and over.

Table 12.2.2 Percentage of treated older drug users by age group and main problem drug Ireland, 1998–2008

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Total older drug users											
Heroin	48.1	59.2	49.4	54.5	51.6	58.4	63.4	64.8	65.2	65.3	63.5
Other opiates	8.9	10.8	6.3	9.8	4.9	8.1	7.0	7.4	7.1	7.3	9.0
Benzodiazepines	13.9	11.5	11.9	11.3	10.2	6.8	9.2	4.7	5.6	6.2	6.0
Cocaine	3.2	0.8	1.1	1.1	4.3	3.1	4.0	6.0	6.1	7.3	6.5
Methadone	12.0	3.8	8.0	2.6	3.9	2.2	3.7	4.1	3.8	3.6	2.8
Cannabis	5.1	9.2	16.5	15.8	18.1	15.8	9.5	10.7	9.4	8.0	10.5
40 to 49											
Heroin	53.3	67.3	54.9	61.5	57.3	63.4	66.1	66.7	70.2	67.1	66.0
Other opiates	7.4	10.6	4.2	6.8	3.9	6.5	6.0	6.5	3.6	6.0	7.0
Benzodiazepines	11.9	5.8	9.7	8.6	7.1	5.4	7.7	3.2	4.2	5.2	4.4
Cocaine	3.7	~	~	~	4.7	3.3	4.3	6.5	6.8	8.6	7.0
Methadone	11.9	3.8	9.0	3.2	3.9	1.4	3.0	4.2	4.2	4.2	3.0
Cannabis	4.4	8.7	16.7	15.4	18.4	15.2	9.4	11.7	9.2	7.8	10.5
50 to 59											
Heroin	~	26.9	25.0	20.0	22.4	28.3	47.5	54.5	36.2	55.2	46.6
Other opiates	~	~	12.8	15.1	5.3	12.1	10.9	12.3	24.2	12.7	18.4
Benzodiazepines	15.0	20.5	17.9	15.1	13.7	10.6	15.2	12.3	12.1	10.1	11.7
Cocaine	~	~	~	~	~	~	~	~	~	~	~
Methadone	16.7	4.8	3.6	0.0	4.8	7.1	8.6	4.1	2.0	0.0	2.7
Cannabis	~	~	15.6	17.8	16.3	19.6	~	~	10.3	9.0	12.5

Source: NDTRS

~ Numbers less than five are not reported

Initiation of drug use after the age of 40

Another subgroup of older drug users is those who start their drug use *after* the age of 40. However in Ireland, of treated clients with a recorded age of first drug use, only a very small proportion (less than 0.5%) started their drug use after the age of 40. The proportion did not change over the 10 years under review.

Older drug users in methadone maintenance treatment (MMT)

The number of individuals in MMT has increased in Ireland over the past 14 years and the proportion of drug users aged 40 and over in MMT has more than quadrupled in that time from 4.1% in 1994 to 19.2% in 2008 (Figure 12.2.1. and also see Selected Issue Table, historic data).

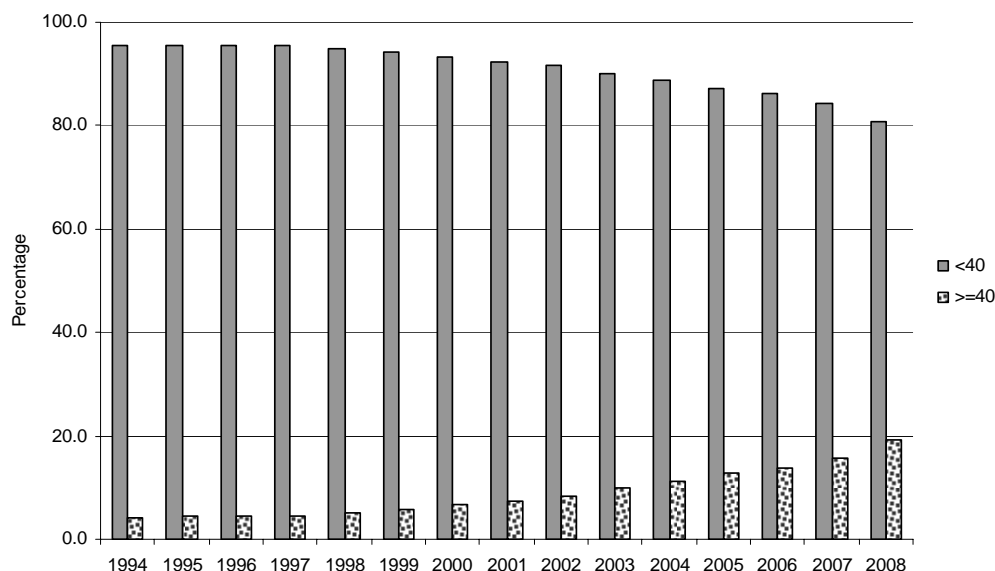


Figure 12.2.1 Proportion of drug users in MMT aged 40 and older, 1994–2008 (Source: CTL)

Discussion

The increase in problem drug users aged 40 to 49 indicates an aging drug user population, either owing to improved survival or longer drug careers. Older problem drug users represent a small but increasing sub-population of users, which is likely to continue to increase over the coming years, but at a steady pace.

The profile of the main problem drug used by the different older age groups did differ, with those aged 40 to 49 more closely resembling the trends among the younger age groups. The profile among those aged 50 to 59 has changed to resemble more closely those aged 40 to 49, perhaps, again, indicating an aging heroin-using population; however, there were greater numbers using opiates other than heroin and benzodiazepines. Although the figures are small, in general drug users aged 60 years and over used mainly other opiates and benzodiazepines.

12.3 Trends in drug-related deaths in older drug users

Of the total deaths owing to poisonings recorded in Ireland (as per Selection D) between 1998 and 2007, 290 (22.0%) were among individuals aged 40 and over (Table 12.3.1). The number of deaths in the older age groups increased steadily from 18 cases in 1998 to 28 cases in 2004, after which there was a jump in the number of deaths to 45 in 2005. Since 2005, the number of deaths in this age group has fallen slightly, to 42 in 2006 and 38 in 2007. Of the total deaths in the older age groups, the majority occurred among those aged 40 to 49 (66.6%). The majority of older drug-related deaths were male (184, 63.4%) see Standard Table 6.

Table 12.3.1 Number of poisoning deaths by age group in Ireland (Selection D), 1998–2007

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Total	104	115	113	106	125	107	126	159	181	185
<40	86	98	90	83	98	78	98	114	139	147
40 to 49	12	12	15	16	22	18	19	27	27	25
50+	6	5	8	7	5	11	9	18	15	13

Source: NDRDI

Types of drugs implicated in deaths among older drug users

The majority of poisonings among older drug users were due to more than one substance (133, 63.3%). Of these, almost all included an opiate-type drug.

Although opiates were implicated in many of the deaths in older drug users, there were differences between the age groups (Table 12.3.2). Heroin or methadone were rarely implicated in those aged 50 or older. Cocaine was only very occasionally implicated in deaths in this older group.

Table 12.3.2 Type of drug implicated in poisonings by age group (Selection D), by year 1998–2005 (n = 210)

		1998	1999	2000	2001	2002	2003	2004	2005	Total
40-49	Total	12	12	15	16	22	18	19	27	141
	Heroin	~	~	~	6	6	4	5	7	33
	Methadone	5	5	5	~	6	~	~	7	36
	Other Opiates	6	~	12	8	13	11	16	12	82
	Benzodiazepines	7	6	6	7	6	3	4	6	45
	Cocaine	~	~	~	~	~	~	~	~	8
	Alcohol	~	~	~	~	10	8	9	8	51
	Other*	3	4	1	2	8	4	3	10	35
50+	Total	6	5	8	7	5	11	9	18	69
	Heroin	~	~	~	~	~	~	~	~	1
	Methadone	~	~	~	~	~	~	~	~	3
	Other Opiates	6	4	8	7	6	11	6	14	62
	Cocaine	~	~	~	~	~	~	~	~	2
	Other	6	3	8	8	4	11	8	11	59

Multi-response table

* Includes Amphetamines, MDMA, hallucinogens, volatile inhalants, non-opiate analgesics, anti-depressants and other prescription medication

~ Numbers less than five are not reported

Discussion

Over the period under review, there was an increase in deaths owing to poisonings among individuals aged 40 and older. The increase in users aged 40 to 49 points to an aging drug user population, as heroin was implicated in many of the deaths in this age group, but rarely in those aged 50 or older. As drug users' survival improves and drug using careers lengthen, it is likely that numbers of deaths in this age group will continue to increase but most likely at a steady pace.

12.4 Characteristics of older Irish drug users in 2008

There were 6,250 clients entering drug treatment in 2008 and recorded in the NDTRS, and of these, 585 (9%) were aged 40 or over (Table 12.2.1). The majority of these older drug users were aged between 40 and 49.

The majority of drug users aged less than 50 reported using heroin (Table 12.4.1). After the age of 40, the proportion reporting cocaine as a main problem drug decreased. Similar proportions of users aged 40 to 49 and aged 50 years and older used cannabis.

Small numbers of drug users aged 60 or over make inferences for this age group difficult, especially as the majority reported other drugs as their main problem. Analyses of this category of other drugs show that they are mainly benzodiazepines and other opiates.

Table 12.4.1 Main problem drug by age group, 2008

	Total	<40	40-49	50+	Not known
Total	6247	5647	497	88	15
Heroin	3753 (60.1)	3372 (59.7)	328 (66.0)	41 (46.6)	12 (80.0)
Cocaine	733 (11.7)	694 (12.3)	35 (7.0)	3 (3.4)	1 (6.7)
Cannabis	1153 (18.5)	1090 (19.3)	52 (10.5)	11 (12.5)	0 (0.0)
Stimulants	140 (2.2)	137 (2.4)	~	~	0 (0.0)
Other	468 (7.5)	354 (6.3)	79 (15.9)	33 (37.5)	2 (13.3)

Source: NDTRS

12.4.1 Older heroin users

Analysis of 2008 data from the NDTRS shows that older heroin users experienced high levels of unemployment; the majority lived in stable accommodation, but unlike younger heroin users, a higher proportion lived alone. While just as many injected heroin compared to younger users, a higher proportion of older drug users first started using drugs later in their life. Only 3.1% of drug users aged under 40 reported starting their first drug use aged 30 years or older, while 40.7% of those heroin users aged over 40 reported their first drug use occurring at 30 years or older.

12.4.2 Older cocaine users

The profile of older cocaine users from 2008 NDTRS data shows that they experienced higher levels of employment compared with younger cocaine users. While similar proportions lived in stable accommodation, a much lower proportion of older cocaine users lived with parents/family (23.7%) compared to those aged less than 40 years (57.3%); they appeared to live either alone or with a partner and/or children. Older cocaine users were more often referred by themselves or by a GP for treatment than younger users.

A much higher proportion of older cocaine users reported that they started using drugs aged 30 years or older (68.4%) compared to only a very small proportion of those aged less than 40 years (3.5%). It should be noted that this variable does have a high proportion of unknown/missing values.

12.4.3 Older cannabis users

The profile of older cannabis users from 2008 NDTRS data shows that while they experienced higher levels of employment than younger users, they had similar levels of unemployment many younger users were still in school or college. This is also reflected in their living status as two thirds of users under 40 (66.9%) reported living with parents or family compared to only one in ten of users aged over 40 (11.3%). A higher proportion of older cannabis users appeared to live either alone or with a partner and/or children.

A much higher proportion of older cannabis users appeared to have referred themselves compared to younger users. A higher proportion of younger users were referred by the courts for treatment compared to a higher proportion of older cannabis users, who were referred by their GPs and hospital/medical services for treatment.

While the highest proportion of all age groups of drug users started using cannabis between the ages of 15 to 19, a higher proportion of older drug users reported first starting drug use aged 30 years or older (17.7%) compared to only a very small number of younger users (0.2%). Again, it should be noted that this variable does have a high proportion of unknown/missing values.

12.4.4 Discussion

Heroin continues to be the main problem drug for most users, regardless of their age. A much higher proportion of drug users aged 40 or over appear to have started their drug use later in life, often after 30 years of age. Drug users aged 60 or over have a different drug use profile. Although the small numbers in this age group make inferences very difficult, it is possible that this age group may either not be accessing treatment services or indeed there may be a very small number of drug users in this age group.

12.5 National policies, strategies and available research in Ireland

All available national strategy documents and related policy documents covering developments at national, regional and local level were examined for any reference to over-40 drug users in treatment. There was no specific mention of this group in any policy document relating to drug treatment and rehabilitation services for drug users.

While there were no documents that referred to the problem use of illicit drugs among older people, one document did refer to the issue of over-use and possible misuse of over-the-counter and prescription medication, especially benzodiazepines, among the Irish population, including older people (Flynn 2009). Excessive and imprudent prescribing practices were one of the factors implicated in this. Treatment data from the NDTRS supports this finding, showing that the highest proportion of clients aged over 60 are treated for other opiates and benzodiazepines (see Table 12.2.2) although the small number of cases involved makes inferences difficult.

In order to ensure that local initiatives for older drug users were not missed, a short one-page questionnaire was designed by the national focal point, asking about the provision or need for specific drug treatment and support services for over 40s. The questionnaire was sent to ten services in August 2009, which were specifically chosen as they are well-established projects providing a range of services for drug users in local drug task forces. Based on their track record of evaluation and innovation it was decided that these projects would be the most likely to develop interventions for over 40s if required. A drug-users forum was included in the ten services selected, as it was felt that they would also know if interventions were either being planned or were operating. The questionnaire was sent by post and followed up a week later by a personal telephone call to the named contact.

Five questionnaires were returned by post and showed that there were no specific interventions operating for drug users. This finding was substantiated by follow-up telephone calls with the remaining projects and these also showed no specific services for this age group. All projects contacted reported that they do not make any age discrimination when providing services and no one spoke of considering separate plans for this age cohort in the future. None of the projects who took part knew of any other project (not included) who offered services specifically to over 40s.

Discussion

To date, older drug users have not been identified as a vulnerable or high risk group in Ireland who need dedicated services at a policy level. There appear to be no specific services offered specifically for users aged over 40 in the addiction services. No specific research has been done on this group however as the cohort ages this may need to be re-evaluated in the near future.

Part C

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13.2 List of relevant databases available on internet

- Central Statistics Office (CSO) interactive tables
- HIPE data 2000–2005

For descriptions of relevant databases not currently available on-line, see introductions to chapters 5, 6, and 7.

13.3 List of relevant internet addresses

<http://aldp.ie>
<http://addictionireland.ie>
<http://www.citywide.ie>
<http://clondalkindrugtaskforce.ie>
<http://corkldtf.ie>
<http://www.cso.ie>
<http://www.courts.ie>
<http://dialtostopdrugdealing.ie>
<http://www.dnedrugtaskforce.ie>
<http://www.dohc.ie>
<http://www.drugs.ie>
<http://drugsandalcohol.ie>
<http://www.drugpolicy.ie>
<http://www.dwec.ie/walktall/index.html>
<http://www.education.ie>
<http://www.esri.ie>
<http://www.fesat.ie>
<http://www.fsn.ie>
<http://www.garda.ie>
<http://www.gov.ie>
<http://www.healthpromotion.ie>
<http://www.hepinfo.ie>
<http://www.hpsc.ie>
<http://www.hrb.ie>
<http://www.hse.ie>
<http://www.iccl.ie>
<http://www.ihrc.ie>
<http://inef.ie>
<http://iprt.ie>
<http://www.irishprisons.ie>
<http://www.iyjs.ie>
<http://www.justice.ie>
<http://www.mhcirl.ie>
<http://www.mrdtf.ie>
<http://www.mqi.ie>
<http://www.mwrdf.ie>
<http://www.nacd.ie>
<http://www.nicdtf.ie>
<http://www.ndublinrdtf.ie>
<http://www.nosp.ie/index.html>
<http://nsrf.ie>
<http://nuigalway.ie/hbsc/>
<http://www.nwdrugtaskforce.ie>
<http://www.omc.gov.ie>
<http://www.oireachtas.ie>

<http://www.pobail.ie>
<http://www.poisons.ie>
<http://www.probation.ie>
<http://www.slan06.ie>
<http://www.swrdtf.ie>
<http://www.tallaghtdtf.ie/index.php>
<http://www.taoiseach.ie>
<http://www.wrdtf.ie>

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- Criminal Justice (Miscellaneous provisions) Act 2009 (No 28 of 2009)
- Criminal Justice (Mutual Assistance) Act 2008 (No 7 of 2008)
- Criminal Justice (Surveillance) Act 2009 (No 16 of 2009)

Misuse of Drugs Act 1977 (No 12 of 1977)
Misuse of Drugs Act 1984 (No 18 of 1984)
Prison Act 2007 (No 10 of 2007)

Bills

Communications (Retention of Data) Bill 2009 (No 52 of 2009)
Criminal Justice (Amendment) Bill 2009 (No 45 of 2009)
Criminal Procedure Bill 2009 (No 31 of 2009)
Health (Miscellaneous Provisions) Bill 2009 (No 67 of 2008)
Housing (Miscellaneous Provisions) Bill 2008 (No 41 of 2008)
Spent Convictions Bill 2007 (No 48 of 2007)

14.5 List of abbreviations

ADRU	Alcohol and Drug Research Unit
AIDS	Acquired Immunodeficiency Syndrome
ALDP	Ana Liffey Drug Project
AUDIT	Alcohol Use Disorders Identification Test
BBV	Blood Borne Viral
BZP	Benzylpiperazine
CAG	Comptroller and Auditor General
CCTV	Closed Circuit Television
CDLE	Customs Drug Law Enforcement
CDVEC	City of Dublin Vocational Educational Committee
CDYSB	City of Dublin Youth Services Board
CE	Community Employment
CES	Community Employment Schemes
CLDTF	Clondalkin Local Drugs Task Force
COFOG	Classification of the Functions of Government
CSO	Central Statistics Office
CTL	Central Treatment List
CYPF	Children and Young Persons Forum
DAIRU	Drugs and Alcohol Information and Research Unit (DHSSPS, NI)
DAIS	Drugs/AIDS Information System
DAP	Drug Awareness Programme
DAST	Department of Arts, Sports and Tourism
DES	Department of Education and Science
DEHLG	Department of the Environment, Heritage and Local Government
DEIS	Delivering Equality of opportunity in Schools
DFA	Department of Foreign Affairs
DMR	Dublin Metropolitan Region
DSFA	Department of Social and Family Affairs
DTC	Drug Treatment Court
DTCB	Drug Treatment Centre Board
DRCGA	Department of Rural, Community and Gaeltacht Affairs
DUID	Driving Under the Influence of Drugs
ED	Electoral Division
EDDRA	Exchange on Drug Demand Reduction Activities
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
FESAT	European Foundation of Drug Helplines
FDYS	Ferns Diocesan Youth Service
FRCs	Family Resource Centres
FSL	Forensic Science Laboratory
FSN	Family Support Network

GMS	General Medical Services Payment Board
GNDU	Garda National Drugs Unit
GP	General Practitioner
HBSC	Health Behaviour in School-aged Children Survey
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HIPE	Hospital In-Patient Enquiry scheme
HPSC	Health Protection Surveillance Centre
HRB	Health Research Board
HSE	Health Service Executive
IAYPC	Irish Association of Young People in Care
ICCL	Irish Council for Civil Liberties
ICD	International Classification of Diseases
ICGP	Irish College of General Practitioners
IHRC	Irish Human Rights Commission
ILP	Individual Learning Plan
IPS	Irish Prison Service
IWA	Irish Wheelchair Association
JPC	Joint Policing Committee
KLE	Kerry Life Education
LDTF	Local Drugs Task Force
MAOC-N	Maritime Analysis and Operational Centre – Narcotics
MAU	Medical Assessment Unit
MDA	Misuse of Drugs Act
MTP	Methadone Treatment Protocol
MQI	Merchants Quay Ireland
NAC	National Assessment Committee
NACD	National Advisory Committee on Drugs
NERDTF	North Eastern Regional Drugs Task Force
NDS	National Drugs Strategy
NDRDI	National Drug-Related Deaths Index
NDST	National Drugs Strategy Team
NDTRS	National Drug Treatment Reporting System
NGO	Non Governmental Organisation
NPIC	National Poisons Information Centre
NPIRS	National Psychiatric Inpatient Reporting System
NPRS	National Perinatal Reporting System
NSP	National Service Plan (of the Health Service Executive)
OECD	Organisation for Economic Co-operation and Development
OMC	Office of the Minister for Children
OMCYA	Office of the Minister for Children and Youth Affairs
OMD	Office of the Minister for Drugs
PBA	Performance Based Accountability
PCCC	Primary, Community and Continuing Care
PCRS	Primary Care Re-imburement Service
PRIS	Prison Records Information System
PTSD	Post Traumatic Stress Disorder
PULSE	Police Using Leading Systems
QCT	Quasi Compulsory Treatment
QNHS	Quarterly National Household Survey
RCSI	Royal College of Surgeons in Ireland
RDTF	Regional Drugs Task Force
RIS	Rehabilitation/Integration Service
ROSIE	Research Outcome Study in Ireland
SAHRU	Small Area Health Research Unit
SLAN	Survey of Lifestyle, Attitudes and Nutrition in Ireland
SMPP	Substance Misuse Prevention Programme
SPHE	Social, Personal and Health Education
TALIS	Teaching and Learning International Survey

TD	Teachta Dála (Member of Parliament)
UNODC	United Nations Office on Drugs and Crime
WHO	World Health Organization
WRDTF	Western Regional Drugs Task Force
YPFSF	Young People's Facilities and Services Fund