Close to Home

A Study on the Misuse of Drugs and Alcohol in the Midland Region

Midland Regional
Drugs Task Force

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Foreword

The Midland Regional Drugs Task Force is very pleased to present the findings of its research study, Close to Home, A Study on the Misuse of Drugs and Alcohol in the Midland Region.

One of the aims of the Midland Regional Drugs Task Force is to identify and address gaps in service provision, having regard to evidence available on the extent and specific locations of illicit drug use in the midland region.

This report explores the perceptions of and responses to 'community drug problems' within the counties of Longford, Westmeath, Laois and Offaly. The report identifies factors contributing to the drug related issues at a community level within the identified areas, details current drug service provision and identifies gaps in service delivery.

On behalf of the Midland Regional Drugs Task Force, I would like to thank the authors of this research study, the Health Research Board, in particular Jean Long, Suzi Lyons and Janet Robinson for their dedication and professionalism in conducting and completing the research study.

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I welcome the opportunity to thank Pat Carey T.D., Minister for Community, Equality and Gaeltacht Affairs for launching this research study and the Department of Community, Equality and Gaeltacht Affairs for funding this research.

Antoinette Kinsella
Co-ordinator
Midland Regional Drugs Task Force

Glossary

Benzodiazepines are a type of psychoactive drug, prescribed for anxiety, insomnia, and some forms of epilepsy. They are only prescribed when the disorder is severe or disabling or subjecting the person to extreme distress. It is recommended that benzodiazepines are prescribed for short periods only as dependence is a significant risk in patients receiving such medication for longer than a month. Street names for benzodiazepines include benzos, Valium, Diazepam, Roche, D5s, and D10s.

Binge drinking is a pattern of heavy drinking that occurs on a single occasion. The Health Promotion Unit defines binge drinking as consuming six or more standard drinks on a single occasion. A standard drink contains 10g of pure alcohol and is the equivalent of one bottle of beer, one pub measure of spirits, one alcopop or one small (100ml) glass of wine.

Drug users: Individuals who have a history of drug dependency or of non-dependent abuse of drugs and/or other substances.

Ecstasy-related substances include Methylenedioxymethamphetamine (MDMA), N-methyl-diethanolamine (MDEA), Brolamfetamine (DOB) and Methylamphetamine.

Legal highs: Psychoactive alternatives to controlled drugs such as LSD, ecstasy, cannabis and opioids, sold through shops, often referred to as 'head shops'.

Non-poisonings: Deaths in individuals with a history of drug dependency or non-dependent abuse of drugs (ascertained from toxicology results, Central Treatment List, medical or coronial records) whether or not the use of the drug was directly implicated in the death.

Solvents or volatile inhalants: Breathable chemical vapours that are intentionally inhaled because of the chemicals' mind altering effects. Includes: fuel, aerosols or gas.

Obstruction has a technical/legal meaning, e.g. the giving of false information to the gardaí or preventing an arrest by hiding a person or disposing or destroying drugs which are the subject of a Garda search.

Opiates: Street names for different opiate-type drugs include Gear, DF118.

Polysubstance is the use of two or more substances (drugs, alcohol, solvents etc). In the NDTRS, they are cases who present for treatment with two or more problem substances and in the NDRDI are cases that have two or more drugs or substances implicated in their death.

Poisonings: Deaths in individuals directly due to the toxic affect of the consumption of a drug and/or other substance.

Abbreviations

AA	Alcoholics Anonymous
CSO	Central Statistics Office
CTL	Central Treatment List
D/CRGA	Department of Community, Rural & Gaeltacht Affairs
D/E&S	Department of Education & Science
D/EHLG	Department of Environment, Heritage and Local Government
D/H&C	Department of Health and Children
E	Ecstasy
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
FAS	National Training and Employment Authority
FETAC	Further Education and Training Awards Council
GP	General practitioner
HBV	Hepatitis B virus
HCV	Hepatitis C virus
HIV	Human Immunodeficiency Virus
HPU	Health Promotion Unit
HSE	Health Service Executive
ICCS	Irish Crime Classification System
JLO	Juvenile Liaison Officer
LSD	Lysergic acid diethylamide
MDA	Misuse of Drugs Acts
MDEA	N-methyl-diethanolamine
MDMA	Methylenedioxymethamphetamine
MRDTF	Midlands Regional Drugs Task Force
NA	Narcotics Anonymous
NDTRS	National Drug Treatment Reporting System
NDRDI	National Drug-Related Deaths Index
NERDTF	North East Regional Drugs Task Force
NIDA	National Institute on Drug Abuse
PULSE	Police Using Leading Systems Effectively
RDTF	Regional Drugs Task Forces
SAPS	Small Area Population Statistics
SPHE	Social, personal and health education

Executive Summary

Background and methods

The MRDTF commissioned this study in order to establish an evidence base for drug-related issues in the Midlands region to inform the development of appropriate strategies and to respond to these issues in four selected communities. A rapid situation assessment technique was used, bringing together information from several different sources as well as interviews and focus groups with key informants in four selected communities. The key findings are presenting in the following paragraphs:

The MRDTF area

The MRDTF area covers four counties with a population of approximately one-quarter of a million people, and has seen a rise in its population and a change of ethnic mix over the past years. Overall it has marginally lower educational levels and housing occupancy than the national levels.

One in five of the population in the MRDTF area has used an illegal drug at least once in their lifetime. Younger adults, especially men used illegal drugs, however it is shown that a proportion of women have used legal drugs. The majority of alcohol and drug use appears to start before the age of 18. The serious impact of this is clear: two out of every five drug-related deaths in the MRDTF area was a person aged 20 to 29 years of age.

Alcohol use is also very prevalent among the population and was the main problem substance treated in the region (2004 – 2007). It was also implicated as an additional substance in many cases treated for polysubstance use. Alcohol (in conjunction with another drug or substance) was implicated in over one-quarter of drug-related deaths in the region.

Cannabis was the most commonly used drug in the general population, but the data indicated that ecstasy, cocaine and heroin was also available in the region, along with a range of other illegal and legal drugs. Cocaine use emerged as a newer trend. An opiate (mainly heroin) was the main problem drug treated in the region. Heroin and other opiates were implicated in over one-third of all deaths due to poisonings reported in the MRDTF area between 1999 and 2005.

While the number of people who sought treatment for benzodiazepine addiction was very small, there was evidence that it was being abused in the MRDTF area and has been implicated in more drug-related deaths in the area than any other substance. Benzodiazepines were used by opiate and alcohol users. Polysubstance use among drug users in the region was evident.

The upward trend in prosecutions for heroin in the two Garda Divisions comprising the MRDTF area indicated that the heroin market has spread to these four counties. Although the number of prosecutions for cocaine was lower it follows a similar upward trend.

The four communities

Community A - County Offaly

Community A is a small community in Co Offaly which had several indicators of deprivation, including rising unemployment. There was no consensus on what was the most problematic substance in the community, with both alcohol and drug misuse considered the cause of major problems in the community. However there was agreement that the situation was getting worse.

Many different types of drugs appeared to be easily available in the community. This was seen in the reports of the apparent normalisation of cannabis use among young people, perceptions that cocaine use was tolerated as a weekend party-drug and evidence of injecting heroin use in the community. The harm associated with this problematic substance use for the individual, their family and the community were graphically illustrated by participants. These harms ranged from the impact on both physical and mental health, emotional well-being and financial security, the breakdown of relationships, abuse and violence, and propagation of intergenerational problem drug use.

Particular issues were identified around young people. These included the apparent ease of access and apparent normalisation of alcohol and drug use, especially cannabis, among teenagers. The need for viable alternative activities for young people was highlighted.

All participants highlighted the lack of addiction treatment services in the community, especially lack of residential beds, detoxification facilities, methadone maintenance treatment and services for under 18s. Families reported struggles to access services to get help for their relatives. This was expressed in the need for a broad ranging addiction service, located in the community for problem substance users and their families. Transport difficulties in the community hampered access to services, which appeared to be compounded by the dearth of general practitioners providing addiction services. It was evident that many individuals are polysubstance users and that the services needed to refocus to deal with this situation. Aftercare and family support were other services which were identified as services essential for the community.

The penetration of the local drugs market, with easy availability of a range of different drugs is facilitating the initiation and continued use of drugs in the community. The existence of, and visibility of, a local drugs market is perceived to have created an atmosphere of fear and intimidation for some of the local community. The need for alternatives to imprisonment was highlighted for problem drug users.

Community B - County Laois

Community B is a medium sized town in Co Laois. Although the population has good levels of educational attainment it has seen a rise in unemployment in recent times.

There were different opinions on whether drugs or alcohol was the most problematic substance in the community, it was felt that the community had experienced a drug problem for some time and the situation was getting worse.

Alcohol, illicit and licit drugs were reported as being misused in the community. However excessive problematic alcohol consumption appeared to be accepted as normal within the community, both among teenagers and adults. Teenagers and young people appeared to be able to access both alcohol and drugs relatively easily, often through friends and their social circle. The harmful consequences of problematic substance use were reported by the participants: physical and mental health problems, emotional distress, financial problems, the breakdown of family relationships, crime, violence and drug-related deaths.

Participants felt that there was an increase in heroin use in the community, along with reports of sharing needles. The waiting list for the existing methadone clinic was reported to be excessively long by all participants and indeed it was acknowledged that opiate users had even stopped presenting to the service because of this. This can partially explain the decrease in the numbers of cases assessed or treated for problem substance use at county level between 2004 and 2007. Some participants reported that being committed to prison was the only way to access methadone maintenance.

The need to improve and expand the existing addiction services was identified by all participants as they could not cope with the level of the current problems or spectrum of drugs available. The lack of general practitioners providing services was highlighted as an issue. In particular, improved access to residential treatment, including detoxification facilities with adequate provision of aftercare were deemed important. The lack of services for under 18s was also identified. Polysubstance use was common.

There appeared to be a very busy and visible local drug market in certain areas in the community, with a range of licit and illicit drugs available. This had created an atmosphere of fear and intimidation among some of the local people, as well as frustration, as the perception was that nothing was being done about the problem. However, most participants felt that the gardaí themselves were doing their best, but their resources were too limited. As imprisonment was felt to exacerbate or even to be instrumental in initiation of problem drug use, the need for alternatives to custodial sentences was raised.

Community C – County Longford

This small town has several indicators of socio-economic deprivation. According to most participants, alcohol and drug consumption was relatively widespread in the community across all social classes, although there was no consensus as to which was the more serious problem. However, alcohol treatment presented the most considerable burden on the treatment services and was linked to progression to drug use.

The detrimental effects of problem substance use were seen in this community too; these included health, psychological well-being, relationship problems, stress for families and wider consequences for society. The influence of peers was seen as pivotal in many areas of alcohol and drug use, including: initiation, access, normalisation, continuation of substance use or relapse after a period of abstinence.

The reported ease of access to a wide range of drugs, both licit and illicit, was a factor in the development, normalisation of use and propagation of the drugs problem in this community. Heroin was seen as a significant problem, with the number of cases entering treatment increasing considerably over a four year period.

For young people, participants felt that the use of alcohol and drugs, especially cannabis, was common even from a relatively early age. Many of those in treatment started alcohol and drug use before the age of 18 years and the lack of services for adolescents was highlighted as was the need for improved drug awareness education.

Overall, participants agreed that there were very limited services for people and their families, with alcohol and drug problems in Community C. Many of the services were not available in the community and people had to travel to access them. Access was further hampered by lengthy waiting lists. The services required included assessment, methadone treatment, counselling, aftercare support, family support, improved social reintegration services, residential treatment and detoxification. The services also need to re-orientate to address the polysubstance addiction problems.

There was a perception that drug use is associated with public disorder and criminal behaviour, fuelled by the visibility of the local drugs market. This had created no-go areas and an atmosphere of fear for some of the local population.

Community D - County Westmeath

Community D is a medium sized town in Co Westmeath. There was no agreement on what was the most problematic substance in the community, with both alcohol and drug misuse considered the cause of major problems in the community. However, there was agreement that the situation was getting worse.

The relatively easy local access to licit and illicit drugs was reported as one of the most important factors contributing to the spread of the problem. This was seen in the reports of the apparent normalisation of alcohol and drug use among young people and, in relation to problem drug use, the influence of peers as a factor in relapse after a period of abstinence or even treatment. The physical and mental health consequences of alcohol and drug use for the individual user were reported. The harm associated with problem substance use and experienced by family members included emotional turmoil, a disruption to, and the breakdown of the family unit.

All participants highlighted the lack of addiction services in the community, in particular the need to increase the number of general practitioners involved in opiate treatment, expansion of methadone treatment, detoxification beds and services for under 18s. According to the participants, the focus of the current addiction services was on the provision of opiate treatment, despite the evidence of polysubstance use in the community. In relation to problem alcohol use, the need for early intervention was reported. Participants mentioned the need to expand the existing drop-in centre, which is for adult men, to provide services for women and young people. In addition, the need for counselling and/or detoxification services to facilitate admission to residential treatment and improved support services to aid the recovery from problem substance use including education, accommodation and employment opportunities was also reported.

Reports of drug-related crime in the community, some of it violent, and the visibility of drug dealing appeared to have created an atmosphere of intimidation in certain sectors of the community.

Summary of key findings and recommendations

The issues that were common to all communities are presented along with examples of best practice or existing strategies and national recommendations for the problems identified. The findings may in part be generalised to the whole of MRDTF area. The findings should also be considered in the context that service providers in the MRDTF strive to do their best for service users, with limited resources and increasing demand. The consistency of the findings with other Irish and international research means that at the time of data collection, it did provide an authentic picture of the substance misuse problems in the four communities. The main development since data collection is the increase in availability of legal highs through head shops and this may require investigation in the future.

Expand and improve existing services

The existing addiction services need to expand and improve to cope with the increasing numbers requiring treatment, for both alcohol and drug misuse, alone or in combination. Addiction treatment services in two areas need to re-orientate their focus from, not only on opiates, but also other drugs as well as towards a more integrated approach to the management of drug and alcohol use. This improvement should include an out-of-hours face-to-face service. Improved communication between service users and services and between statutory and voluntary services is also required. Some of these may be achieved though individual care plans and the appointment of a key worker to each client, as per the recommendations of the Report of the Working Group on Drugs Rehabilitation. Improved support and services for the family of problem substance users is also a requirement.

Improve and increase access to services

Access to services, in terms of reducing waiting lists and providing timely and adequate levels of and diverse types of services is required. Geographical distances were both a barrier and a burden to service users and their families accessing services and need to be addressed when locating or expanding services. Ideally services should be provided as close to the persons home as possible and this means that a decentralised approach to the provision of all addiction services should be considered.

Harm reduction

Harm reduction programmes, including needle exchange, need to be introduced or expanded as appropriate in the region.

Access to methadone treatment

There appears to be a chronic problem in accessing methadone maintenance treatment in the MRDTF area, with lengthy and intractable waiting lists. Possible solutions include increasing the number of general practitioners providing treatment in the community, expanding and improving existing services and providing alternative treatment options for those with problem opiate use or who are currently on methadone. It appears to be difficult to increase the number of general practitioners to provide services for opiate users stable on methadone. In the UK and Australia, nurse specialists, under the supervision of an addiction psychiatrist, have been used to provide such treatment and the evidence indicates that the treatment provided is as good as and in some cases better than that provided by general practitioners.

Access to detoxification, rehabilitation services and aftercare

There are no residential detoxification or residential treatment facilities in the MRDTF region and this lack of places in general, compounded by waiting periods and distances involved for other facilities outside the region were identified as a significant problem in the region. The recommendations around the provision of these services from the Report of the HSE Working Group on Residential Treatment and Rehabilitation should be implemented and the use of community detoxification programmes considered.

Problem alcohol use

Problem alcohol use on its own or in combination with other drugs, was highlighted as a major problem in the region and placed considerable burden on communities and the addiction services. In addition to adequate treatment facilities, strategies which reduce alcohol-related harms include increased taxation and regulation of the availability of alcohol. Education in schools, public service announcements and voluntary regulation by the alcohol industry are not effective in their own right as a preventative measure, but only as part of a comprehensive strategy.

Services for under-18s

Access to and availability of appropriate services for under-18s with problem substance use was highlighted as a major issue in the MRDTF area. The importance of providing local, accessible and adolescent-specific services has already been identified as a priority by the Department of Health and Children. Ideally services should have a combination of disciplines on site: assessment, treatment, aftercare and social reintegration.

Improved drug awareness education

Prevention of early drug use is important as many of those in treatment commenced their substance use before the age of 18. Successful strategies include: targeting at-risk young people, behavioural life skills development, interpersonal and communication skills and family-based programmes.

Drug related deaths

Strategies to reduce drug related deaths include rapid access to treatment, education of drug users, their family, friends and the community in the risks of overdose, dangers of polysubstance use (for example cocaine and alcohol) and basic life support skills.

Social reintegration

A need for improved and additional services addressing accommodation, education and employment issues in order to reintegrate former problem drug users to society. Young people who leave education early would particularly benefit from this approach.

Drug crime

There is evidence that illicit drug markets are operating in each county and these markets need to be disrupted to reduce drug-related harms to the individuals and the communities. There is growing evidence that partnership between all stakeholders offers the most sustainable method of responding to street level markets. This would require a multi-level response with the justice system, police, health authorities and communities working together to deal with the problem.

1 INTRODUCTION

1.1 Background

The National Drugs Strategy 2001–2008 set out an overall strategic objective to significantly reduce the harm caused to individuals and society by drug misuse.[1] Under the Strategy's action plan, ten regional drugs task forces (RDTFs) were set up across the country to deliver a more co-ordinated response to the problem. Each RDTF is responsible for putting in place a strategy to tackle drug use in their region. Their role is to research, develop and implement a co-ordinated response to drug use through a partnership approach. The task forces are made up of representatives from statutory, voluntary and community agencies, public representatives and other key interest groups.

The Midland Regional Drugs Task Force (MRDTF) was established in 2003; it comprises the counties Laois, Offaly, Longford and Westmeath. Under its terms of reference, the MRDTF commissioned this study of substance use in four communities, one in each county of the region.

1.2 Research aims and objectives

The aim of this study was to establish an evidence base for drug-related issues in the Midlands region to inform the development of appropriate strategies to respond to these issues.

The study objectives were to:

- collate available indicator data to assist in developing a profile of community drug problems in the identified areas;
- explore the perception of and response to community drugs problems within the identified areas;
- identify factors contributing to the drug-related issues at a community level within the identified areas;
- describe the current drug service provision (and identify gaps in service delivery) in the identified areas; and
- employ the research findings to inform the establishment of a local drug network in each major town in the Midland region, and assist each network in developing action plans based on the issues relevant to their geographical area.

1.3 Methods

Using a rapid situation assessment technique,[2] this research was conducted over an six month period in 2008 and 2009, and gathered information from multiple sources. It drew together existing quantitative data, supplemented by qualitative primary research. This approach has been used successfully in drug research nationally and internationally.[3-5] The majority of the quantitative information relevant to the four communities studied was available only at regional or county level. A descriptive analysis of relevant variables was carried out using SPSS, version 15. SPSS is a computerised statistical package used to analyse numeric data. The communities and layout of the report were chosen by the MRDTF before the study commenced.

The qualitative primary research was conducted in each community by means of key informant interviews and focus groups.[2] This research explored the factors contributing to drug issues, the perceptions of and responses to the drug problem, perceived gaps in service delivery, and proposed solutions. A purposeful sample was taken of the following stakeholders in each community:

- drug users (both problematic and recreational)
- families affected by drug use
- non-drugs users

- service providers from HSE and social services, such as medical staff, social workers, counsellors, gardaí
- service providers from non-governmental organisations and the voluntary sector
- community project workers and co-ordinators
- youth groups and services

Local drug awareness and network groups were instrumental in identifying potential participants. Participants were chosen because they had particular experiences relevant to the research objectives.[6] Community groups and service providers assisted in identifying problem and recreational drug users, and snowball sampling was used to recruit additional participants.[6] Young people aged 16–17 years were invited to participate in the study. Participants from the community were given a €20 voucher to cover costs incurred.

Focus groups and in-depth interviews were conducted between June and October 2008, and in July 2009. A total of 96 people were interviewed with approximately equal numbers of representative participants in each community.

The interviews were audio taped and transcribed verbatim. The data were entered into NVivo (an analytic software package designed specially for qualitative or text data) for analysis. A coding scheme was developed based on the topic guide and all transcripts were coded and new codes added as new issues emerged. Key themes were identified within each community. The data were examined for similarities and differences within the identified themes. In order to assess their validity, findings were compared with other national and international study findings. Contributions from participants are quoted to emphasise particular themes. In exchanges with the interviewer, the speakers are indicated as 'P' for participant and 'I' for interviewer.

Confidentiality

While the confidentiality of informants was assured, many of the participants were concerned about being identified from the study. Therefore, the descriptions of the communities are general, not specific. Additionally, any individual who provided a service, either statutory, community or voluntary, is identified only as a 'service provider', with an assigned participant number. Also, the precise number and type of participants interviewed in each study site is not specified to preserve anonymity within these small communities. Identifiers such as name, gender, family relationship or area of residence have been removed or modified in some quotations to ensure confidentiality. Where necessary, quotations have been abbreviated or condensed to facilitate anonymity and legibility.

Ethical procedures

Ethical approval was received from the Drug Treatment Centre Board. Child protection guidelines were consulted and adapted for the study. Informed, signed consent was obtained from all adult participants, while signed parental consent was given for participants aged 16–17 years.

1.4 Data sources

Central Statistics Office (CSO) census data

Data from the CSO 2006 census, and Small Area Population Statistics (SAPS) compiled by the CSO were used for the population-based analysis in this report. SAPS data are available for a variety of geographical areas for 2006. The denominators used were based on the population in the legally defined boundaries of a town, and, where appropriate, population figures of suburbs and environs. Specific descriptive variables were chosen as proxies for indicators of deprivation and poverty in the communities studied: housing

occupancy, educational level, and composition of household unit. It should be noted that the data used is from the 2006 census, therefore the demographic profile of the region may have changed since that time.

Prevalence surveys

This study includes information on substance use in Ireland from the following surveys:

- The all-Ireland drug prevalence surveys of 2002/3 and 2006/7.[7] [8] This is based on individuals aged 15–64 years in the general population living in private households on the island of Ireland. Results for Ireland were reported by regional drugs task force area.
- The 2007 European School Survey Project on Alcohol and Other Drugs (ESPAD).[9] ESPAD collects standardised information on substance use in European students who reach the age of 16 years during the calendar year of data collection. The aim of the survey is to have a national representative sample of young people to allow comparisons across Europe.

General population surveys have a number of limitations as indicators of drug trends. People who do not live in private households, such as the homeless and those living in institutions, are not included in such surveys. In addition, problem drug users are under-represented, as their chaotic lifestyles often hamper their recruitment to such surveys. Therefore, the findings of the prevalence survey in relation to heroin and crack cocaine use are likely to be underestimated. Similarly, surveys of school-going children, such as ESPAD, do not include children who have left school early and who are typically more vulnerable to drug use.

National Drug Treatment Reporting System (NDTRS)

The NDTRS is an epidemiological database of treated problem drug and alcohol use in Ireland. The system records data in relation to episodes of treatment, rather than in relation to individual clients. This means that a person can appear more than once in the database if they attend more than one service in a given year. The main definitions used in the NDTRS analysis are:

All cases treated – people who receive treatment for drug or alcohol misuse at each treatment centre in a calendar year, including:

- *Previously treated cases* – people who were treated previously for drug or alcohol misuse at any treatment centre and have returned to treatment;
- *New cases treated* – people who have never been previously treated for drug or alcohol misuse;
- *Assessed only* – describes individuals who were assessed but who did not progress to treatment;
- *Status unknown* – people whose status with respect to previous treatment for drug or alcohol misuse is not known.

NDTRS data on cases living in the MRDTF area who were assessed or treated for problem drug or alcohol use in the four-year period 2004–2007 were analysed for this study. The variables used included socio-demographic information, main problem substance, additional problem substance(s) used and risk behaviour, including age of initiation to drug use.

National Drug-Related Deaths Index (NDRDI)

The NDRDI is an epidemiological database of drug-related deaths and deaths among drug users in Ireland. The number of these deaths in an area is an indicator of the consequences of problem drug use. Accurate recording of such can provide an estimate of the total burden of mortality related to drug use in Ireland.10

There are two types of death recorded in the NDRDI:

- Directly drug-related deaths (poisonings) are deaths that are directly due to the toxic effect of

the presence of a drug and/or other substance in the body. Other terms used to describe this type of death are poisoning, overdose, and drug-induced death.

- Indirectly drug-related deaths (non-poisonings) are deaths in individuals with a history of drug dependency or non-dependent abuse of drugs that are not caused directly by poisoning, such as deaths from an AIDS-related disease resulting from infection through sharing of injecting equipment.

NDRDI data on deaths in the MRDTF area between 1999 and 2005 were analysed for this study. The variables presented in this study included age, gender, type of death and drugs implicated in the death.

Drug-crime data

Data on drug-related crime can be used as indirect indicators of the supply and availability of drugs. Drug-related crime includes offences committed in contravention of the Misuse of Drugs Acts (MDA) 1977 and 1984, and offences such as acquisitive crimes committed by problematic drug users to support their drug habit. The vast majority of drug offences reported by the CSO come under three sections of the Misuse of Drugs Act 1977: Section 3 (simple possession), Section 15 (possession for sale or supply), and Section 21 (obstruction).

This study used data reported by the CSO to show trends in drug offences in the Midland region for the years 2003 to 2006. These data are primarily a reflection of the activities and effectiveness of the gardaí, rather than the availability of drugs or the incidence of drug-related crime, and are influenced by a number of factors: willingness of the public to report crime to the gardaí; Garda recording practices; law enforcement activities and priorities; and effectiveness of the gardaí in detecting drugs and drug offences.[11 12] The data are presented for the relevant Garda divisions of Laois/Offaly and Longford/Westmeath.

1.5 Format of the report

This report is divided into eight chapters. This chapter outlined the research aims, objectives, data sources and methodology. Chapter 2 brings together all the available quantitative data at regional level. Chapters 3, 4, 5 and 6 present the qualitative data from the four communities, along with supporting data from the NDTRS where appropriate. Each of these chapters begin with a brief overview of the community and concludes with a summary of key findings. The final chapter presents key issues and recommendations based on data from the region and the four communities.

2 THE MIDLAND REGIONAL DRUGS TASK FORCE AREA

2.1 Overview

This chapter gives an overview of the MRDTF area based on quantitative data from the national drug prevalence survey, two national drug-related databases and demographic and crime statistics from the CSO. Where possible, data from the different sources are presented together to give a multi-dimensional view of some relevant variables. The first section presents a brief demographic overview of the region, followed by a description of drug use by gender, age and drug type. The final sections provide an overview of trends in drug offences, treated drug use and drug-related deaths.

2.2 Socio-demographic profile of the MRDTF area

According to the 2006 census, the combined population of the four counties of the MRDTF area (Laois, Offaly, Longford and Westmeath) was approximately 250,000, a 10% increase on the 2002 census figure.

The proportions of the working population in the skilled manual, semi-skilled and unskilled occupational categories were slightly higher than those at national level (Table 2.1). Overall, the region had lower levels of educational attainment compared to national levels (Table 2.2).

Table 2.1 Workforce by occupational category, MRDTF area and nationally, 2006

	Professional %	Managerial & technical %	Non-manual %	Skilled manual %	Semi-skilled %	Unskilled %	Other* %
MRDTF area	5.0	23.4	19.6	21.9	14.4	5.7	10.1
National	6.9	26.3	20.1	19.4	13.7	4.7	8.8

* All others gainfully occupied, and those of unknown occupation
Source: CSO data 2006, based on those in the labour force

Table 2.2 Education levels in the MRDTF area and nationally, 2006

	Primary level* %	Lower secondary %	Upper secondary %	Third level %
MRDTF area	17.0	19.1	25.5	11.1
National	15.2	17.0	23.8	15.6

* Includes those with no formal education
Source: CSO data 2006, based on those aged 15 years and over whose full-time education had ceased.

Housing

Housing is an important socio-demographic indicator. The percentage of owner-occupied houses in the region was above the national rate, and the percentage of local authority housing was just below the national rate (Table 2.3). The percentage of single-parent families in the region in 2006 was 11.3%, similar to the national rate of 11.6%.

Table 2.3 Type of housing occupancy in the MRDTF area and nationally, 2006

	Owner occupied %	Local authority* %	Privately rented %	Other†/ unknown %
MRDTF area	76.8	11.0	7.2	5.0
National	73.1	12.3	9.9	4.7

* Either rented from or being purchased from local authority
† Occupied rent free
Source: CSO data 2006

2.3 Treatment and drug-related deaths data for the Midlands

2.3.1 Drug treatment data

The treatment information presented in this report is based on data returns to the National Drug Treatment Reporting System (NDTRS) for clients living in the Midlands region and entering treatment services for problem drug or alcohol use in the period 2004–2007. The treatment services providing the data are not necessarily based in the Midlands region. During the period under review, data were provided by 42 treatment services, comprising 22 outpatient services, 16 residential facilities and four general practitioners. In the case of the data for 'previously treated cases', there is a possibility that individuals appear more than once in the database, for example where a person receives treatment at more than one centre.

The analysis of NDTRS data provides a description of problem drug and alcohol use in the region. During the four-year period, 2,572 cases presented for assessment or treatment. Of these, 1,014 (39.4%) lived in Westmeath, 713 (27.7%) lived in Offaly, 513 (19.9%) lived in Laois, and 332 (12.9%) lived in Longford. Of the 2,572 cases who presented, 2,449 were treated.

2.3.2 Drug-related deaths data

The information on drug-related deaths presented in this report is based on data collected by the National Drug-Related Deaths Index (NDRDI). Between 1999 and 2005 there were 76 drug-related deaths in the Midland region. Of these, 35 were reported from Westmeath, 25 from Offaly, nine from Longford and seven from Laois. Small numbers mean that a breakdown of figures for individual counties cannot be presented. Alcohol-only poisonings are not included in this analysis as figures are not available for this period; however cases in which alcohol was implicated in a death in conjunction with another drug or substance are included.

2.4 Profile of substance users in the MRDTF area

2.4.1 Gender

In the 2006/7 general population survey, a higher proportion of males than females in the MRDTF area reported using illegal drugs at some point in their lives, such as cannabis, cocaine, amphetamines, ecstasy, LSD, magic mushrooms or solvents (Table 2.4). In contrast, a higher proportion of females than males reported using legal drugs at some point in their lives, such as opiate-based analgesics, sedatives and anti-depressants.

Males accounted for more than 70% of cases living in the MRDTF area who sought treatment between 2004 and 2007 (Table 2.5). The ratio of men to women was similar over the four-year period. Of the 76 drug-related deaths recorded in MRDTF area between 1999 and 2005, the majority were men (72%, 55).

Table 2.4 Prevalence of drug use in the MRDTF area, by gender, 2006/7

	Percentage that used any illegal drugs*					
	Ever in lifetime		In year prior to survey		In month prior to survey	
	Male	Female	Male	Female	Male	Female
Illegal drugs*	23.9	14.9	6.0	2.7	2.1	1.3
Cannabis	19.7	14.1	5.4	2.7	1.4	0.7
Heroin	0.0	0.4	0.0	0.0	0.0	0.0
Methadone	0.0	0.0	0.0	0.0	0.0	0.0
Other opiates	1.7	8.8	1.2	1.5	0.7	0.8
Crack	0.7	0.0	0.7	0.0	0.7	0.0
Cocaine powder	4.5	3.5	0.8	1.9	0.8	0.4
Amphetamines	4.9	2.1	0.0	0.4	0.0	0.4
Ecstasy	8.7	2.7	0.8	1.0	0.0	0.6
LSD	3.7	1.1	0.0	0.0	0.0	0.0
Magic mushrooms	9.6	1.1	0.7	0.0	0.0	0.0
Solvents	3.7	1.6	0.0	0.0	0.0	0.0
Poppers	2.7	2.5	0.0	0.0	0.0	0.0
Anabolic steroids	0.5	0.8	0.0	0.4	0.0	0.0
Sedatives and tranquillisers	9.2	15.3	2.0	8.4	1.3	5.1
Anti-depressants	6.6	13.7	0.7	6.0	0.7	4.7

*Illegal drugs in this context are amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.
Source: NACD and DAIRU (2008)[7]

Table 2.5 MRDTF cases assessed or treated, by gender, NDTRS 2004–2007

	2004	2005	2006	2007	Total
	Number (%)				
All cases	649	555	625	743	2572
Male	438 (67.5)	411 (74.1)	445 (71.2)	520 (70.0)	1814 (70.5)
Female	201 (31.0)	143 (25.8)	180 (28.8)	223 (30.0)	747 (29.0)
Not recorded	10 (1.5)	1 (0.2)	0 (0.0)	0 (0.0)	11 (0.4)

2.4.2 Age

A higher proportion of young adults than older adults reported using illegal drugs at some point in their life (Table 2.6).

At the national level, the 2007 ESPAD study reported that 20% of Irish students surveyed had ever used cannabis, slightly above the European average.[9] Three percent reported ever using tranquillisers/sedatives, below the European average of 5%. Nearly four-fifths (78%) of 16-year-old Irish students surveyed had taken alcohol in the year prior to the survey, while 56% reported having drunk alcohol the month before.

Table 2.6 Prevalence of drug use in the MRDTF area, by age group, 2006/7

	Percentage that used any illegal drugs*					
	Ever in lifetime		In year prior to survey		In month prior to survey	
	Young adults 15-34 yr	Older adults 35-64 yr	Young adults 15-34 yr	Older adults 35-64 yr	Young adults 15-34 yr	Older adults 35-64 yr
Illegal drugs*	27.7	12.9	9.2	0.5	3.8	0.0
Cannabis	23.6	11.6	8.5	0.5	2.4	0.0
Heroin	0.0	0.4	0.0	0.0	0.0	0.0
Methadone	0.0	0.0	0.0	0.0	0.0	0.0
Other opiates	1.8	7.8	0.4	2.1	0.0	1.3
Crack	0.7	0.0	0.7	0.0	0.7	0.0
Cocaine powder	6.0	2.4	3.0	0.0	1.3	0.0
Amphetamines	4.7	2.7	0.4	0.0	0.4	0.0
Ecstasy	10.5	2.0	1.9	0.0	0.7	0.0
LSD	3.3	1.8	0.0	0.0	0.0	0.0
Magic mushrooms	10.5	1.4	0.7	0.0	0.0	0.0
Solvents	3.7	1.9	0.0	0.0	0.0	0.0
Poppers	4.2	1.4	0.0	0.0	0.0	0.0
Anabolic steroids	0.0	1.2	0.0	0.3	0.0	0.0
Sedatives and tranquillisers	4.2	18.6	1.4	8.1	0.0	5.7
Anti-depressants	6.5	13.0	3.5	3.0	2.1	3.0

*Illegal drugs in this context are amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.
Source: NACD and DAIRU (2008) [7]

NDTRS data for 2004–2007 show that of 1,834 treated cases who reported alcohol as a problem substance, over half (56.0%) reported their age at first use as under 18 years. One quarter (25.4%) reported their age at first use as 14 years or under. Age of first use was not reported by service providers for 26.5% of these cases. Of 1,418 treated cases who reported problem use of any drug, three out of five (60.8%) reported their age at first use as under 18 years, and 384 (27.1%) at 14 years or under. There was a steady increase in the number of older people presenting for drug treatment over the reporting period. The number of cases aged 50 years or over increased from 77 in 2004 to 122 in 2007 (Table 2.7).

Table 2.7 MRDTF cases assessed or treated, by age group, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	649	555	625	743	2572
17 years or under	33 (5.1)	19 (3.4)	21 (3.4)	20 (2.7)	93 (3.6)
18–19	52 (8.0)	36 (6.5)	39 (6.2)	34 (4.6)	161 (6.3)
20–24	125 (19.3)	104 (18.7)	105 (16.8)	137 (18.4)	471 (18.3)
25–29	111 (17.1)	80 (14.4)	88 (14.1)	123 (16.6)	402 (15.6)
30–34	56 (8.6)	55 (9.9)	79 (12.6)	110 (14.8)	300 (11.7)
35–39	75 (11.6)	61 (11.0)	64 (10.2)	65 (8.7)	265 (10.3)
40–44	70 (10.8)	55 (9.9)	71 (11.4)	69 (9.3)	265 (10.3)
45–49	41 (6.3)	51 (9.2)	46 (7.4)	63 (8.5)	201 (7.8)
50 years or over	77 (11.9)	94 (16.9)	112 (17.9)	122 (16.4)	405 (15.7)
Not recorded	9 (1.4)	0 (0.0)	0 (0.0)	0 (0.0)	9 (0.3)

Of the 76 drug-related deaths in the region between 1999 and 2005, two in five (38%) were in the 20–29-year age group (Figure 2.1). Almost 7% were in the 19 years or under age group. Half of the 76 cases of drug-related deaths or deaths among drug users were under 32 years when they died; half of poisoning cases were under 36 years when they died; and half of the non-poisonings drug deaths were under 29 years when they died.

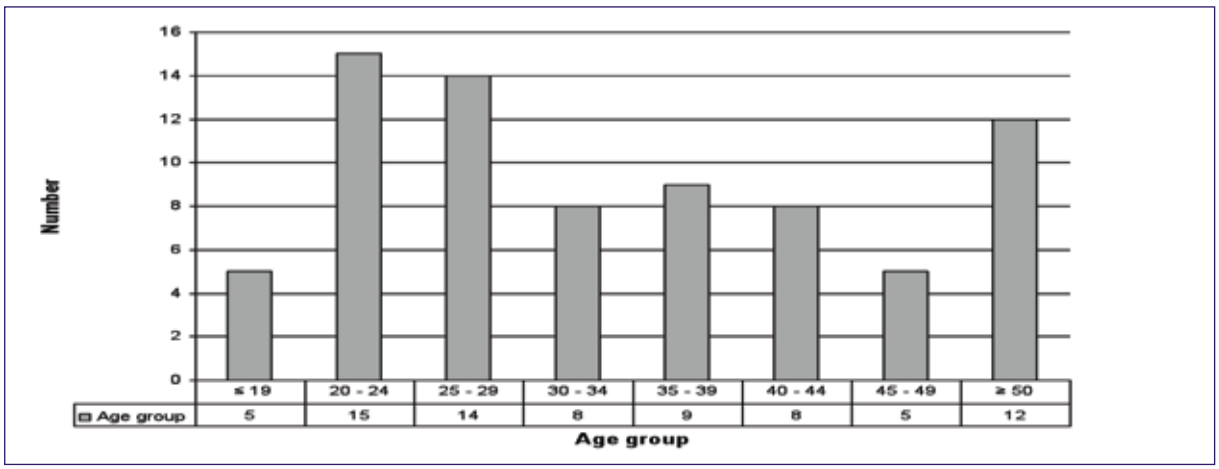


Figure 2.1 Drug-related deaths in the MRDTF area, by age group, NDRDI 1999–2005 (N = 76)

2.5 Types of drugs used in the MRDTF area

This section brings together information on the type of drugs available to or used by people residing in the MRDTF area, using prevalence data, crime statistics, treatment data (NDTRS) and drug-related deaths data (NDRDI).

2.5.1 Substance use among the general population

In 2006/7 one in five of the population in the MRDTF area reported having used an illegal drug at least once in their lifetime (lifetime use) (Table 2.8). The proportion who reported that they had ever used cannabis, ecstasy or cocaine was higher in 2006/7 than in 2002/3. In 2006/7, the most common illegal drugs reported in this context were cannabis (17.0%), ecstasy (5.8%), magic mushrooms (5.5%) and cocaine (4.4%). The proportion of the population of the MRDTF area reporting alcohol use remained the same between 2002/3 (69.0%) and 2006/7 (70.3%).

Table 2.8 Prevalence of drug use in the MRDTF area, 2002/3 and 2006/7

	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
Illegal drugs*	11.0	19.6†	2.8	4.4	1.0	1.7
Cannabis	10.7	17.0†	2.8	4.1	1.1	1.1
Sedatives and tranquillisers	n/a	12.1	n/a	5.1	n/a	3.1
Anti-depressants	n/a	10.0	n/a	3.3	n/a	2.6
Ecstasy	2.0	5.8†	0.9	0.9	0.0	0.3
Magic mushrooms	1.8	5.5	0.3	0.3	0.0	0.0
Other opiates‡	1.3	5.1	0.0	1.3	0.0	0.7
Cocaine powder	1.3	4.0†	0.3	1.3	0.3	0.6
Amphetamines	0.6	3.6	0.3	0.2	0.0	0.2
Solvents	1.2	2.7	0.0	0.0	0.0	0.0
Poppers	1.2	2.6	0.0	0.0	0.0	0.0
LSD	1.6	2.4	0.0	0.0	0.0	0.0
Crack	0.3	0.3	0.0	0.3	0.0	0.3
Heroin	0.3	0.2	0.0	0.0	0.0	0.0
Methadone	0.0	0.0	0.0	0.0	0.0	0.0
Anabolic steroids	1.6	0.6	0.0	0.2	0.0	0.0

*Illegal drugs in this context are amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.
†Denotes a significant increase in proportion.
‡The method of counting for this category changed between the two surveys, so proportions are not comparable.
Source: NACD and DAIRU (2005, 2008) [7 8]

At the national level, the 2007 EPSAD survey shows that a slightly higher proportion of Irish students used cannabis, solvents/inhalants and other drugs (apart from sedatives) than their European peers (Figure 2.2).[9] These data are not available by RDTF area or county.

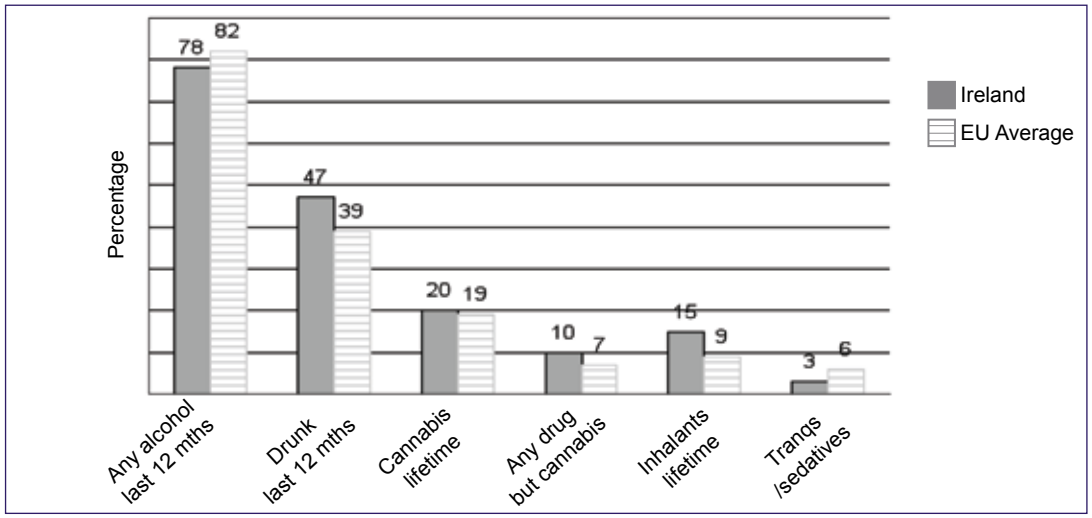


Figure 2.2 Alcohol and drug use by Irish 15–16 year-olds, compared to the EU average, ESPAD 2003

2.5.2 Main problem substance among MRDTF cases treated

Between 2004 and 2007, 2,449 people living in the MRDTF area were treated for problem substance use (Table 2.9). More than 65% of treated cases reported alcohol as their main problem substance; the most

common main problem drug reported was opiates (22.3%), followed by cannabis (6.4%) and cocaine (3.1%). The number of cases reporting opiates as their main problem substance increased over the reporting period. The number reporting alcohol as their main problem substance remained stable over the same period. Although the overall proportion reporting cocaine as their main problem substance was small (3.1%), the number of such cases seeking treatment for cocaine more than doubled over the four-year period. The total number of cases reporting cannabis as their main problem drug decreased over the period.

Table 2.9 MRDTF cases treated, by main problem substance, NDTRS 2004–2007

	2004	2005	2006	2007	Total
Main problem substance			**Number (%)**		
All cases	625	532	587	705	2449
Alcohol	428 (68.5)	356 (66.9)	392 (66.8)	435 (61.7)	1611 (65.8)
Opiates	128 (20.5)	104 (19.5)	125 (21.3)	188 (26.7)	545 (22.3)
Cannabis	45 (7.2)	45 (8.5)	32 (5.5)	35 (5.0)	157 (6.4)
Cocaine	12 (1.9)	12 (2.3)	24 (4.1)	29 (4.1)	77 (3.1)
Ecstasy	5 (0.8)	8 (1.5)	7 (1.2)	4 (0.6)	24 (1.0)
Benzodiazepines	1 (0.2)	6 (1.1)	2 (0.3)	12 (1.7)	21 (0.9)
Amphetamines	2 (0.3)	0 (0.0)	2 (0.3)	1 (0.1)	5 (0.2)
Volatile inhalants	1 (0.2)	1 (0.2)	1 (0.2)	0 (0.0)	3 (0.1)
Other	3 (0.5)	0 (0.0)	2 (0.3)	1 (0.1)	6 (0.2)

Polysubstance use

Of the cases who entered treatment during the period under review, 1,591 (65.0%) reported problem use of one substance only, 384 (15.7%) of two substances, 273 (11.1%) of three substances and 201 (8.2%) of four or more substances.

Table 2.10 presents the additional problem substances used by those reporting problem use of more than one substance, by year treated. Between 2004 and 2007, cannabis, ecstasy, cocaine, alcohol, and benzodiazepines were the most common additional problem substances reported by all cases entering treatment. Cannabis was top of this list in each of the four years, and its use as an additional substance increased over the reporting period. Ecstasy was the second most common additional substance in 2004 and 2005, and was joint second with alcohol in 2006. Ecstasy was replaced by alcohol and cocaine in 2007. The numbers reporting cocaine as an additional problem substance almost doubled, from 46 cases in 2004 to 84 in 2007.

Table 2.10 MRDTF cases treated, by additional problem substances used, NDTRS 2004–2007

Additional problem drug(s) used*	2004	2005	2006	2007	Total
	Number (%)				
All cases	625	532	587	705	2449
Cannabis	129 (20.6)	117 (21.9)	139 (23.6)	148 (20.9)	533 (21.7)
Ecstasy	81 (12.9)	53 (9.9)	58 (9.8)	53 (7.5)	245 (10.0)
Cocaine	46 (7.3)	52 (9.7)	58 (9.8)	84 (11.9)	240 (9.7)
Alcohol	50 (8.0)	35 (6.5)	54 (9.1)	84 (11.9)	223 (9.1)
Benzodiazepines	24 (3.8)	22 (4.1)	27 (4.5)	32 (4.5)	105 (4.2)
Opiates	23 (3.6)	27 (5.0)	14 (2.3)	19 (2.6)	83 (3.3)
Amphetamines	25 (4.0)	20 (3.7)	23 (3.9)	6 (0.8)	74 (3.0)
Others	3 (0.4)	3 (0.5)	5 (0.8)	3 (0.4)	14 (0.5)
Volatile inhalants	0 (0.0)	2 (0.3)	2 (0.3)	2 (0.2)	6 (0.2)

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

The association between main problem substance and additional substances among new cases entering treatment was examined for the period 2004 to 2007 (Table 2.11). Though the numbers were very small, the pattern of additional substances used was linked to the main problem substance. For example, where an opiate was the main problem substance the most common additional problem substances were cannabis (47.7%), followed by alcohol (16.9%) and cocaine (16.5%). Where cannabis was the main problem substance the most common additional substances were alcohol (44.6%), followed by ecstasy (33.9%) and cocaine (25.0%). Where cocaine was the main problem substance, the most common additional problem substances were alcohol (63.3%), cannabis (61.2%) and ecstasy (38.8%). Information about the combinations of substances used is important in terms of individual clients' care plans, and policy initiatives. The proportion of new cases reporting alcohol as an additional problem substance was relatively high (between 33.3% and 63.3%) except in cases reporting an opiate or amphetamines as their main problem substance. These data indicate a link between alcohol and illicit drug use.

Table 2.11 New MRDTF cases treated, by main problem substance and additional substances used, NDTRS 2004–2007

	Opiates	Ecstasy	Cocaine	Amphet-amines	Benzo-diaze-pines	Volatile inhalants	Cann-abis	Alcohol	Other
New cases	**266**	**18**	**49**	**4**	**12**	**2**	**112**	**899**	**4**
Additional problem drug(s) used*		**Number (%)**							
Opiates	4 (1.5)†		3 (6.1)		4 (33.3)		6 (5.4)	17 (1.9)	1 (25.0)
Ecstasy	33 (12.4)		19 (38.8)	2 (50.0)	2 (16.7)		38 (33.9)	73 (8.1)	
Cocaine	44 (16.5)	11 (61.1)		4 (100.1)	1 (8.3)		28 (25.0)	63 (7.0)	1 (25.0)
Amphetamines	4 (1.5)	6 (33.3)	4 (8.2)				11 (9.8)	23 (2.6)	1 (25.0)
Benzodia-epines	29 (10.9)		2 (4.1)				2 (1.8)	12 (1.3)	
Volatile inhalants							1 (0.9)	2 (0.2)	
Cannabis	127 (47.7)	8 (44.4)	30 (61.2)	2 (50.0)	5 (41.7)	1 (50.0)	1 (0.9)†	139 (15.5)	1 (25.0)
Alcohol	45 (16.9)	8 (44.4)	31 (63.3)	1 (25.0)	4 (33.3)		50 (44.6)		
Others	3 (1.1)	2 (11.1)	1 (2.0)		1 (8.3)		1 (0.9)	2 (0.2)	

*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 substance.

2.5.3 Deaths by poisoning in the MRDTF area

Between 1999 and 2005 there were 55 deaths by poisoning in the MRDTF area. The annual number of deaths increased over the reporting period, from six in 1999 to ten in 2005. Of the total number of poisoning deaths in the seven-year period, over half (28, 50.9%) involved just one substance (not including alcohol). Of these single-substance deaths, nine were due to opiates.

The remaining 27 deaths by poisoning involved two or more substances; 11 involved an opiate (mainly heroin and/or methadone) and a further five involved other opiate-based analgesics.

Table 2.12 presents the substances involved in cases of death by poisoning (both single and polysubstance). Benzodiazepines were involved in 35% of deaths, mainly in conjunction with another substance. Alcohol was involved in over one-quarter of all deaths by poisoning. This proportion is likely to be an underestimate, as deaths due to poisoning by alcohol alone were not included in this analysis.

Table 2.12 Type of drug involved in MRDTF cases of death by poisoning, NDRDI 1999–2005

	Poisoning deaths*
Type of drug	Number (%)
Other opiates†	14 (25.5)
Heroin	9 (16.4)
Methadone	6 (10.9)
Cocaine	2 (3.6)
MDMA	2 (3.6)
Benzodiazepines	19 (34.5)
Other prescription medication	16 (29.1)
Alcohol‡	15 (27.3)
Antidepressants	10 (18.2)
Non-opiate analgesics	6 (10.9)
Volatile inhalants/chemicals, fumes and other	5 (9.1)

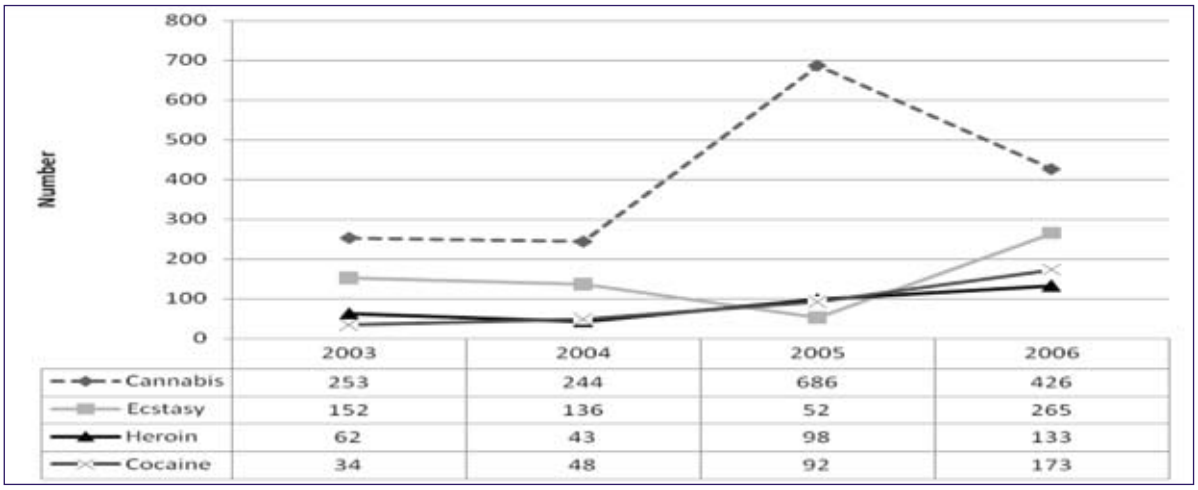
* Percentage total exceeds 100% as more than one drug can be involved in deaths by poisoning.
† Other opiates include unspecified opiates and analgesics containing an opiate compound.
‡ Alcohol is recorded only in the case of polysubstance deaths.

2.6 Drug offences in the MRDTF area

This section presents data on proceedings for drug offences for two Garda Divisions, Laois/Offaly and Longford/Westmeath.

2.6.1 Possession offences by drug type

Figure 2.3 presents proceedings for possession of cannabis, ecstasy, heroin and cocaine for the MRDTF area from 2003 to 2006. Overall the number of proceedings for possession of cannabis increased during the period but there was a decrease in proceedings from 686 in 2005 to 426 in 2006. The distribution of proceedings for possession of ecstasy decreased between 2003 and 2005 and increased again in 2006. The number of proceedings for possession of heroin more than doubled in the area. These figures suggest that the heroin market may be growing steadily in the area. The number of proceedings for possession of cocaine increased considerably from a low base (34) in 2003 to 173 in 2006. This indicates that there may also be a growing cocaine market in the area. It is important to note that any change in numbers of proceedings may represent changes in law enforcement practices in the area.



	2003	2004	2005	2006
Cannabis	253	244	686	426
Ecstasy	152	136	52	265
Heroin	62	43	98	133
Cocaine	34	48	92	173

Figure 2.3 Proceedings for possession, by drug type, and Laois/Offaly and Longford/ Westmeath Garda Divisions combined, 2003 to 2006

2.6.2 Trends in drug-related offences

Drug possession offences

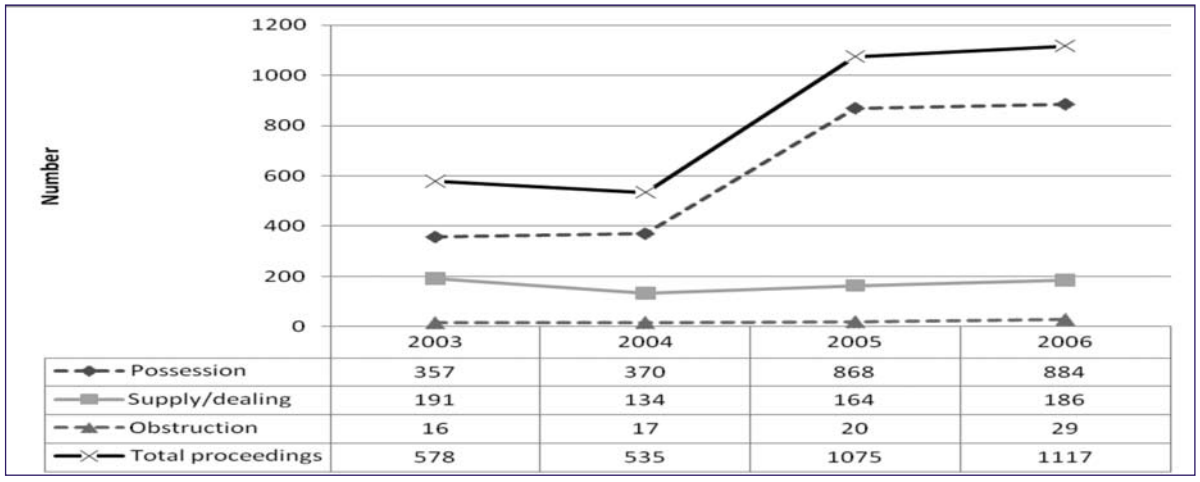
Figure 2.4 presents data on proceedings for possession offences (Section 3 MDA 1977) for the MRDTF area from 2003 to 2006. The number of proceedings for possession offences more than doubled in the area between 2003 (357 prosecutions) and 2006 (884 prosecutions). These are mainly accounted for by increases in cannabis-, heroin- and cocaine-related proceedings (Figure 2.3)

Supply or dealing offences

The highest number of supply or dealing offences in the MRDTF area was in 2003, followed by a decline in 2004 and gradual increases in 2005 and 2006 (Figure 2.4). The variation in numbers may represent changes in law enforcement practices in the area.

Obstruction offences

Figure 2.4 also presents data on proceedings for obstruction offences (Section 21 MDA 1977) for the MRDTF area from 2003 to 2006. There was an increase in obstruction proceedings between 2003 and 2006 but the numbers are small. The increase may also represent changes in law enforcement practices in the area.[13]



	2003	2004	2005	2006
Possession	357	370	868	884
Supply/dealing	191	134	164	186
Obstruction	16	17	20	29
Total proceedings	578	535	1075	1117

Figure 2.4 Proceedings for possession, supply and obstruction offences in the Laois/ Offaly and Longford/Westmeath Garda Divisions combined, 2003–2006

2.7 Trends in treated drug use and related deaths in the MRDTF area

The analysis in this section provides an outline of the following NDTRS variables: service provision; numbers assessed or treated; main problem substance; additional problem substances; risk behaviours; socio-demographic characteristics; and relationship between the main problem substance and selected characteristics. An overview from the NDRDI of drug-related deaths in the region is also presented.

2.7.1 Overview of treated substance use in the MRDTF area

Treatment is provided in both residential and non-residential settings. As already stated, the figures presented in the following tables are based on data returns to the NDTRS for clients living in the MRDTF and seeking treatment for problem drug or alcohol use. In the four-year period under review, 2,572 cases presented for treatment. Of these cases, 1,014 (39.4%) lived in Westmeath, 713 (27.7%) lived in Offaly, 513 (19.9%) lived in Laois, and 332 (12.9%) lived in Longford (Table 2.13).

Table 2.13 MRDTF cases assessed or treated, by county, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	649	555	625	743	2572
Longford	56 (8.6)	82 (14.8)	85 (13.6)	109 (14.7)	332 (12.9)
Laois	166 (25.6)	123 (22.2)	99 (15.8)	125 (16.8)	513 (19.9)
Offaly	205 (31.6)	183 (33.0)	155 (24.8)	170 (22.9)	713 (27.7)
Westmeath	222 (34.2)	167 (30.1)	286 (45.8)	339 (45.6)	1014 (39.4)

Service provision

Of the 2,572 cases presenting for treatment, the majority 1,910 (74.3%) attended outpatient services, 631 (24.5%) attended a residential service, and 31 (1.2%) attended a general practitioner (Table 2.14).

Table 2.14 MRDTF cases assessed or treated, by service type, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All services	649	555	625	743	2572
Outpatient	510 (78.6)	424 (76.4)	464 (74.2)	512 (68.9)	1910 (74.3)
Residential	124 (19.1)	122 (22.0)	160 (25.6)	225 (30.3)	631 (24.5)
General practitioner	15 (2.3)	9 (1.6)	1 (.2)	6 (.8)	31 (1.2)

CTL continuous care data

Table 2.15 presents data on clients continuing in methadone treatment from the preceding calendar year and carried forward on 1 January each year for the years 2004 to 2007. The number of continuous care cases and previously treated cases in an area is an indicator of a chronic situation, and of the requirement for addiction services into the future. During the years 2005 to 2007, the numbers of cases prescribed methadone in counties Laois, Westmeath and Offaly increased indicating an increase in methadone places in these counties.

Table 2.15 MRDTF cases recorded as CTL continuous care clients, by county, 2004–2007

	2004	2005	2006	2007
Longford	<10	<10	<10	>10
Laois	17	25	31	29
Offaly	<10	<10	18	27
Westmeath	35	55	55	76

<10 Numbers of cases below 10 are not reported by the CTL.

Numbers assessed or treated

Table 2.16 presents the treatment status of cases living in the MRDTF area who were assessed or treated in the years 2004–2007. The number of previously treated cases in an area is an indicator of a chronic situation and of the requirement for addiction services into the future. The number of previously treated cases living in the MRDTF area increased from 240 in 2004 to 316 in 2007. The number of new cases entering treatment is an indirect indicator of recent trends in problem drug use. The number of new cases living in the MRDTF area decreased slightly in the reporting period, from 371 in 2004 to 353 in 2007. In addition, there were 96 cases on waiting lists in each area in April 2008.[14]

Table 2.16 MRDTF cases assessed or treated, by treatment status, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	649	555	625	743	2572
Assessed only	24 (3.7)	23 (4.1)	38 (6.1)	38 (5.1)	123 (4.8)
Previously treated cases	240 (37.0)	224 (40.4)	238 (38.1)	316 (42.5)	1018 (39.6)
New cases	371 (57.2)	302 (54.4)	340 (54.4)	353 (47.5)	1366 (53.1)
Treatment status unknown	14 (2.2)	6 (1.1)	9 (1.4)	36 (4.8)	65 (2.5)

Living arrangements and type of accommodation

Almost two out of five (38.5%) cases seeking treatment reported living with their parents or family. This number increased from 256 in 2004 to 282 in 2007 (Table 2.17). Most cases lived in stable accommodation; the proportion of cases who reported being homeless, though small, increased over the reporting period (Table 2.18).

Table 2.17 MRDTF cases assessed or treated, by living arrangements, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	649	555	625	743	2572
With parents or family	256 (39.4)	211 (38.0)	242 (38.7)	282 (38.0)	991 (38.5)
Alone	111 (17.1)	116 (20.9)	115 (18.4)	153 (20.6)	495 (19.2)
Alone with child	30 (4.6)	25 (4.5)	34 (5.4)	42 (5.7)	131 (5.1)
With partner alone	65 (10.0)	74 (13.3)	57 (9.1)	79 (10.6)	275 (10.7)
With partner and child	122 (18.8)	96 (17.3)	129 (20.6)	124 (16.7)	471 (18.3)
With friends	13 (2.0)	11 (2.0)	12 (1.9)	22 (3.0)	58 (2.3)
Other	25 (3.9)	11 (2.0)	32 (5.1)	36 (4.8)	104 (4.0)
Not known	27 (4.2)	11 (2.0)	4 (0.6)	5 (0.7)	47 (1.8)

Table 2.18 MRDTF cases assessed or treated, by accommodation status, NDTRS 2004–2007

	2004	2005	2006	2007	Total
	Number (%)				
All cases	649	555	625	743	2572
Stable accommodation	582 (89.7)	534 (96.2)	588 (94.1)	694 (93.4)	2398 (93.2)
Institution (prison, clinic)	7 (1.1)	4 (0.7)	13 (2.1)	17 (2.3)	41 (1.6)
Homeless	9 (1.4)	5 (0.9)	14 (2.2)	14 (1.9)	42 (1.6)
Other unstable accommodation	11 (1.7)	5 (0.9)	7 (1.1)	12 (1.6)	35 (1.4)
Not known	40 (6.2)	7 (1.3)	3 (0.5)	6 (0.8)	56 (2.2)

Nationality

There was an increase between 2004 and 2007 in the number of cases from outside Ireland living in the MRDTF area who sought treatment. Among these cases were 22 individuals of European, Eastern European, North American, African or Asian origin (Table 2.19). The increase in the proportion of other nationalities seeking treatment may have implications for service provision, as some types of treatment interventions rely heavily on verbal communication.

Table 2.19 MRDTF cases assessed or treated, by nationality, NDTRS 2004–2007

	2004	2005	2006	2007	Total
	Number (%)				
All cases	649	555	625	743	2572
Republic of Ireland	626 (96.5)	540 (97.3)	601 (96.2)	719 (96.8)	2486 (96.7)
Great Britain and Northern Ireland	11 (1.7)	11 (2.0)	11 (1.8)	12 (1.6)	45 (1.7)
Other	0 (0.0)	2 (0.4)	12 (2.0)	8 (1.1)	22 (0.9)
Not known	12 (1.8)	2 (0.4)	1 (0.2)	4 (0.5)	19 (0.7)

Employment status

Two-fifths (41.5%) of cases seeking treatment reported that they were unemployed. The number of cases reporting that they were retired or unable to work increased from 26 in 2004 to 70 in 2007 (Table 2.20).

Table 2.20 MRDTF cases assessed or treated, by employment status, NDTRS 2004–2007

	2004	2005	2006	2007	Total
	Number (%)				
All cases	649	555	625	743	2572
In paid employment	246 (37.9)	196 (35.3)	237 (37.9)	212 (28.5)	891 (34.6)
Unemployed	235 (36.2)	231 (41.6)	239 (38.2)	362 (48.7)	1067 (41.5)
FÁS scheme or other training course	35 (5.4)	27 (4.9)	28 (4.5)	22 (3.0)	112 (4.4)
Student	31 (4.8)	12 (2.2)	13 (2.1)	17 (2.3)	73 (2.8)
Housewife/husband	36 (5.5)	26 (4.7)	28 (4.5)	46 (6.2)	136 (5.3)
Retired/ unable to work/disability	26 (4.0)	51 (9.2)	70 (11.2)	70 (9.4)	217 (8.4)
Other	9 (1.4)	5 (0.9)	5 (0.8)	1 (0.1)	20 (0.8)
Not known	31 (4.8)	7 (1.3)	5 (0.8)	13 (1.7)	56 (2.2)

Education

The number of cases who had left school aged 14 years or under increased from 87 in 2004 to 153 in 2007, but the number who were still in school on entry to treatment decreased from 22 in 2004 to seven in 2007 (Table 2.21). The number of cases who completed their education to leaving certificate or to third level increased slightly over the period (Table 2.22).

Table 2.21 MRDTF cases assessed or treated, by age left school, NDTRS 2004–2007

	2004	2005	2006	2007	Total
	Number (%)				
All cases	649	555	625	743	2572
Left school aged 14 years or under	87 (13.4)	114 (20.5)	113 (18.1)	153 (20.6)	467 (18.2)
Left school aged 15 years or over	296 (45.6)	313 (56.4)	350 (56.0)	452 (60.8)	1411 (54.9)
Never went to school	~	~	~	~	5 (0.2)
Still at school	22 (3.4)	7 (1.3)	7 (1.1)	7 (0.9)	43 (1.7)
Age left school not known	244 (37.6)	121 (21.8)	151 (24.2)	130 (17.5)	646 (25.1)

~ Number of cases is too small to be reported

Table 2.22 MRDTF cases assessed or treated, by highest level of education completed, NDTRS 2004–2007

	2004	2005	2006	2007	Total
	Number (%)				
All cases	649	555	625	743	2572
Primary level incomplete	~	17 (3.1)	27 (4.3)	21 (2.8)	66 (2.6)
Primary level	120 (18.5)	126 (22.7)	120 (19.2)	173 (23.3)	539 (21.0)
Junior certificate	149 (23.0)	158 (28.5)	171 (27.4)	215 (28.9)	693 (26.9)
Leaving certificate	128 (19.7)	104 (18.7)	132 (21.1)	172 (23.1)	536 (20.8)
Third level	28 (4.3)	21 (3.8)	25 (4.0)	39 (5.2)	113 (4.4)
Special needs education	~	~	~	~	1 (0.0)
Still in full-time education	31 (4.8)	12 (2.2)	13 (2.1)	17 (2.3)	73 (2.8)
Not known	192 (29.6)	117 (21.1)	133 (21.3)	104 (14.0)	546 (21.2)

~ Number of cases is too small to be reported

Reason for referral

Of the 2,572 cases presenting for treatment between 2004 and 2007, nearly two-thirds (65.4%) reported alcohol as their main problem substance, and the remaining cases reported drugs as their main problem substance (Table 2.23).

Table 2.23 MRDTF cases assessed or treated, by reason for referral, NDTRS 2004–2007

	2004	2005	2006	2007	Total
	Number (%)				
All cases	649	555	625	743	2572
Alcohol	438 (67.5)	370 (66.7)	414 (66.2)	460 (61.9)	1682 (65.4)
Drug	211 (32.5)	185 (33.3)	211 (33.8)	283 (38.1)	890 (34.6)

Source of referral

The majority (35.0%) of cases seeking treatment were self-referred. The other common sources of referral were a hospital or medical agency (21.1%), and a general practitioner (17.3%). The number of cases referred by a general practitioner increased from 95 in 2004 to 125 in 2007 (Table 2.24). The number of referrals from prisons and employers also increased during this period. The number of referrals from courts, probation services and the police decreased over the four-year period.

Table 2.24 MRDTF cases assessed or treated, by source of referral, NDTRS 2004–2007

	2004	2005	2006	2007	Total
	Number (%)				
All cases	649	555	625	743	2572
Self	205 (31.6)	187 (33.7)	206 (33.0)	301 (40.5)	899 (35.0)
Family	67 (10.3)	49 (8.8)	55 (8.8)	58 (7.8)	229 (8.9)
Friends	10 (1.5)	11 (2.0)	11 (1.8)	16 (2.2)	48 (1.9)
Other drug treatment centre	18 (2.8)	15 (2.7)	12 (1.9)	28 (3.8)	73 (2.8)
General practitioner	95 (14.6)	96 (17.3)	129 (20.6)	125 (16.8)	445 (17.3)
Hospital/medical agency	144 (22.2)	127 (22.9)	144 (23.0)	127 (17.1)	542 (21.1)
Social services	28 (4.3)	15 (2.7)	17 (2.7)	28 (3.8)	88 (3.4)
Court/probation/police	46 (7.1)	34 (6.1)	38 (6.1)	31 (4.2)	149 (5.8)
Outreach worker	~	7 (1.3)	5 (0.8)	~	18 (0.7)
School	~	~	~	~	1 (0.0)
Prison	~	~	~	8 (1.1)	15 (0.6)
Employer	~	~	~	5 (0.7)	8 (0.3)
Mental Health Liaison Nurse at A&E	~	~	~	9 (1.2)	9 (0.3)
A&E other	~	~	~	~	1 (0.0)

~ Number of cases is too small to be reported

Main problem substance

Of the 2,572 cases presenting for treatment, 123 (4.8%) were assessed only, and 2,449 (95.2%) were treated. The tables and figures presented in the remainder of this analysis are based on the 2,449 treated cases. More than 66% of treated cases reported alcohol as their main problem substance, while the most common main problem drug reported was opiates (22.3%), followed by cannabis (6.4%) and cocaine (3.1%) (Table 2.9). Thirty five per cent of cases reported two or more problem drugs (Table 2.25).

Table 2.25 MRDTF cases treated, by single-substance and polysubstance use, NDTRS 2004–2007

	2004	2005	2006	2007	Total
	Number (%)				
All cases	625	532	587	705	2449
Reported one problem drug	416 (66.6)	352 (66.2)	370 (63.0)	453 (64.3)	1591 (65.0)
Reported two or more problem drug	209 (33.4)	180 (33.8)	217 (37.0)	252 (35.7)	858 (35.0)

Risk behaviours

In total, 234 injector cases entered treatment between 2004 and 2007 (Table 2.26). Of the cases who reported ever having injected illicit (or licit) drugs, 71 (30.3%) started injecting before they were 19 years old (Table 2.27). In total, 108 (46.2%) of injector cases reported sharing injecting equipment (Table 2.28).

Table 2.26 MRDTF cases treated, by injector status, NDTRS 2004–2007

	2004	2005	2006	2007	Total
	Number (%)				
All cases	625	532	587	705	2449
Had injected	57 (9.1)	52 (9.8)	51 (8.7)	74 (10.5)	234 (9.6)
Never injected	555 (88.8)	476 (89.5)	524 (89.3)	618 (87.7)	2173 (88.7)
Not known	13 (2.1)	4 (0.8)	12 (2.0)	13 (1.8)	42 (1.7)

Table 2.27 MRDTF injector cases treated, by age first injected, NDTRS 2004–2007

Year treated	2004	2005	2006	2007	Total
			Number (%)		
All cases*	57	52	51	74	234
less than 19	17 (29.8)	17 (32.7)	16 (31.4)	21 (28.4)	71 (30.3)
20-24	13 (22.8)	13 (25.0)	16 (31.4)	26 (35.1)	68 (29.1)
25-70	8 (14.0)	11 (21.2)	14 (27.5)	18 (24.3)	51 (21.8)
Not Known	19 (33.3)	11 (21.2)	5 (9.8)	9 (12.2)	44 (18.8)

* for clients who had reported that they had injected at some point in their lives

Table 2.28 MRDTF injector cases treated, by equipment-sharing practices, NDTRS 2004–2007

Year treated	2004	2005	2006	2007	Total
			Number (%)		
All cases*	57	52	51	74	234
Yes	24 (42.1)	28 (53.8)	25 (49.0)	31 (41.9)	108 (46.2)
No	20 (35.1)	20 (38.5)	20 (39.2)	27 (36.5)	87 (37.2)
Not known	13 (22.8)	4 (7.7)	6 (11.8)	16 (21.6)	39 (16.7)

* for clients who had reported that they had injected at some point in their lives

2.7.2 Drug-related deaths in the MRDTF area

Between 1999 and 2005 there were 76 drug-related deaths in the MRDTF area (Table 2.29). The numbers fluctuated over the seven-year period, but increased overall.

Table 2.29 Drug-related deaths in the MRDTF area, NDRDI 1999 to 2005

1999	2000	2001	2002	2003	2004	2005	Total
9	9	13	5	14	13	13	76

Almost three-quarters of the deaths (55, 72.4%) between 1999 and 2005 were poisonings (directly due to the toxic effect of the presence of a drug or substance in the body). The remaining 21 deaths (27.6%) were indirectly drug-related, for example they occurred in individuals with a history of drug dependency or non-dependent abuse of drugs, whether or not the drug use was directly implicated in their death. Of these 21 deaths, nearly half (10, 47.6%) were caused by traumatic injuries as a result of a vehicle accident, a blunt force trauma or a fall.

Almost three-quarters (55, 72.4%) of those who died were reported to be living in stable accommodation at the time of their death. At the time of the incident that led to their death, two-fifths (40.1%) were with family or friends, while a similar proportion (38%) were alone. Of those with a history of injecting drug use, 50% were injecting at the time of their death. The majority of those who died were in their twenties and thirties, and over one-third (27, 35.5%) were unemployed at the time of their death.

2.8 Key issues – overview of quantitative data for the MRDTF area

The MRDTF area covers four counties with an approximate population of one-quarter of a million. The population living in the region has expanded over the recent years, with an approximate 10% increase in its population between 2002 and 2006. Overall, the levels of education attained and type of housing occupancy were marginally lower than national levels.

Prevalence of drug use and type of drugs used

Overall the proportion of the population who use drugs has increased in the MRDTF area. The national drugs surveys show that many more men than women used illicit drugs in the region, in line with other national data.[7 15] A higher proportion of younger adults reported using illegal drugs at some point in their life.

While cannabis was the most commonly used drug among the general population, the numbers treated for cannabis use decreased over the period 2004 to 2007. The majority of prosecutions for drug possession in the Garda Divisions comprising the MRDTF area were for cannabis. Due to the nature of the methodology of a prevalence study, the number of opiate users is likely to be underestimated, while treatment figures provide a better estimation of the use of these drugs. In the Midlands, after alcohol, opiates are the main problem substance among treated cases. The number of cases treated for opiates has increased since 2005. Additionally, the Garda Divisions has reported increasing number of prosecutions for possession of heroin and cocaine between 2003 and 2006, indicating that illicit drug market have spread to these four counties.

Overall, the data from these four different sources shows clearly that many types of substances (both legal and illegal) are used in the region, frequently in combination. Alcohol, cannabis and cocaine were reported as an additional problem substance in many of those cases treated for polysubstance use. Polysubstance use increases the complexity of treatment and is associated with poor treatment outcomes.[16]

In 2006/7, 12% of the population in the MRDTF area reported using a sedative or tranquilliser (which would include benzodiazepines) at least once in their lifetime. Although only a very small proportion of cases treated for problem substance use reported benzodiazepines as their main problem drug (0.9%) between 2004 and 2007, a slightly larger proportion (4.2%) reported this type of drug as an additional problem substance. However between 1999 and 2005 benzodiazepines were implicated in more deaths (34.5%), alone or in conjunction with another drug or substance, than any other substance in the region.

An increase in cocaine use is seen in all data sources. The proportion of the general population reporting cocaine use at some point in their life increased from 1.3% to 4.0% over a three year period. Prosecutions for possession of cocaine in the two divisions have increased considerably during the period under review. The numbers of cases treated with cocaine as their main problem substance increased from 12 to 29 from 2004 to 2007. Though numbers were higher, this increase was mirrored among cases reporting cocaine use as an additional problem substance. Deaths where cocaine was implicated only appeared in 2004 in the MRDTF area but it could be expected that these numbers will rise over the coming years.

Alcohol was the main problem substance for almost two thirds of cases treated for problem substance use in the MRDTF area, indicating the extent of the problem. It was also reported as an additional problem substance in 9.1% of treated polysubstance users. Alcohol (in conjunction with another drug or substance) was implicated in over one-quarter of drug-related deaths in the region.

Drug treatment

The majority of cases presenting for treatment attended outpatient services. Hardly any cases (1.2%) presenting for treatment in the MRDTF region attended a general practitioner for addiction treatment. Nationally, approximately one third of cases in methadone treatment attend their general practitioner for treatment.[17] Over the reporting period, 10% of treated cases reported injecting drug use. Over one-quarter started injecting before the age of 19 years and 46% reported sharing injecting equipment, and numbers have increased over the years. This has implications for service provision, harm reduction and health promotion.

Drug related deaths

Although the number of drug-related deaths in the region has fluctuated over the period, there is a general upward trend. Almost three-quarters of the deaths were due to poisonings. International evidence shows that opiates, including heroin are responsible for many direct drug-related deaths.[10 18] Heroin and other opiates were implicated in 36% of all poisonings reported in the MRDTF area between 1999 and 2005. Two out of every five drug-related deaths in the region was in a person aged 20 to 29 years of age. Although cannabis is the most frequently used drug in the region, cannabis is rarely implicated in drug-related deaths [10 18] so it would not be expected to see deaths in the MRDTF area where cannabis was implicated. Of those deaths recorded in drug-users, nearly half were as a result of traumatic injuries.

Of those variables presented, the profile of those who died is similar to those in treatment, over one-third were unemployed and the majority were living in stable accommodation at the time of their death. This is very similar to the profile of cases in treatment nationally.[15] At the time of the incident that caused their death, two fifths were with family or friends. This implies that there is the opportunity to intervene to prevent these untimely deaths. One response is the development of an overdose strategy, which would include actions to deal with overdose in the community, with for example the provision of naloxone (an opiate reversal agent) to family and friends for emergencies. This has proven very successful in other countries.[19]

3 COMMUNITY A IN COUNTY OFFALY

3.1 Overview

This chapter presents the main findings for Community A from the qualitative component of the study. The issues explored in interviews and focus groups included: factors that contributed to the drugs problem in the community; perceptions of the nature and extent of the problem; consequences of drug use for the individual, their family and the community; perceptions of the response to the drugs problem, including gaps in service provision identified by participants. It is important to remember that participants' perceptions are qualitative in nature and should be interpreted as such. Data from the National Drug Treatment Reporting System (NDTRS) on treated substance use in Co Offaly (2004 and 2007) and CSO data on drugs and crime (2003 to 2006) are used to supplement the qualitative data.

3.2 Socio-demographic characteristics

Community A is a small town in Co Offaly with a population of between 5,000 and 9,999.[20] The town has seen a significant expansion of its population in recent years, with an increase of nearly 25% between 2002 and 2006. The town has also seen a change in its ethnic mix over recent years. It is serviced by limited public transport.

The occupations of over half the workforce in Community A were in the skilled manual, semi-skilled and unskilled categories (Table 3.1). The proportions in the professional, managerial and non-manual categories were lower than those at both county and national levels. However, the proportion of individuals whose occupation was unknown was much higher in Community A than that at county or national levels, which makes inferences difficult. After several years of relatively stable unemployment figures, 2007 saw the first significant rise in the numbers in this community signing on to the live register. Between March 2007 and March 2008 there was an increase of almost 40% in the numbers signing on.[21]

Table 3.1 Workforce by occupational category, Community A, Co Offaly and national, 2006

	Professional %	Managerial & technical %	Non-manual %	Skilled manual %	Semi-skilled %	Unskilled %	Other* %
Community A	1.7	16.5	14.9	26.0	15.6	9.1	16.2
Co Offaly	4.3	22.4	19.3	23.2	14.7	6.5	9.6
National	6.9	26.3	20.1	19.4	13.7	4.7	8.8

* All others gainfully employed, and those whose occupation was unknown
Source: CSO data 2006, based on those in the labour force

The overall level of educational attainment in Community A was lower than that in Co Offaly and nationally (Table 3.2).

Table 3.2 Education levels, Community A, Co Offaly, and national, 2006

	Primary level* %	Lower secondary %	Upper secondary %	Third level %
Community A	20.3	23.3	21.6	9.1
Co Offaly	18.0	20.5	25.6	9.9
National	15.2	17.0	23.8	15.6

* Includes those with no formal education
Source: CSO data 2006, based on persons aged 15 years and over whose full-time education had ceased. Percentages may not add up to 100% as not all categories are included

At 14%, the proportion of local authority housing in Community A was above both the county and national levels (Table 3.3). The proportion of single-parent families in this community in 2006 was 11.9%, which was similar to that at the county level (11.1%) and at national level (11.6%).

Table 3.3 Type of housing occupancy, Community A, Co Offaly and national, 2006

	Owner occupied %	Local authority* %	Privately rented %	Other†/ unknown %
Community A	71.7	13.7	9.2	5.5
Co Offaly	78.9	9.7	6.4	5.0
National	73.1	12.3	9.9	4.7

* Either rented from or being purchased from local authority
† Occupied rent free
Source: CSO data 2006

3.3 Factors contributing to the problem

This section provides an analysis of the qualitative data and reports on the main factors contributing to the emergence of a drug problem in Community A. Service providers, drug users and their families, and young people from the community were interviewed. Their perceptions were based on a mix of personal experience and anecdotal information. The main factors that participants believed influenced the emergence and development of the drug problem in Community A can be grouped under five headings:

- Individual factors;
- Family context;
- Influence of peers;
- Community and structural factors;
- Ease of access to alcohol and drugs.

Individual factors

Individual factors were not commonly reported as playing a major role in the development of the drugs problem. Nonetheless, there was a perception that young people sometimes initiated alcohol and/or drug use because they had nothing to do and were bored.[22 23] A lack of recreational facilities in the community was reported as a possible contributory factor.

> *There's nothing to do in [Community A] so that's why every kid drinks...kids as young as 14 are hammered at weekends.* (Participant 8, Recreational drug user)

Participants reported that curiosity, opportunity and enjoyment were other factors which facilitated the initiation of young people into the use of alcohol or drugs. Some participants spoke about how the use of alcohol facilitated the use of drugs.

Family context

Participants in this study reported on aspects of family life that they felt influenced the development of substance use and related problems. For example, some drug users had first used alcohol or drugs at a young age in the company of family members, and with their tacit approval. Problematic and risky use of drugs was also reported to be facilitated by family members. In one case, a respondent recounted how a sibling had provided drugs with little consideration for the risks involved.

Intergenerational substance misuse

There was a belief among some respondents that parental alcohol abuse contributed to their children using drugs to cope with the related trauma and the following account illustrates this belief.

> *My [parent] was an alcoholic...that's probably another part of why my [sibling] is on drugs...it all*

links...like a domino effect. (Participant 48, Family member)

Participants spoke about how parental substance use had adversely affected their capacity to care for their children. The use of drugs by minors was also linked to family break-up as speculated by some respondents. Problematic substance use in the family is a well-documented risk factor for the development of intergenerational problem substance use among family members.[24-27] A recent study in neighbouring counties reported on the negative influence of problematic substance use on the family.[28]

Influence of peers

When drug users were asked where they got their drugs, the predominant response was that they got them from their peers either by buying them or being 'given them'. It is not surprising to find that peer groups in Community A facilitated access to drugs as this has been found in other Irish studies.[29 30] The following quote illustrates the informal networks that operates between friends and facilitates access to drugs.

[I get drugs] mainly from friends who would know others who would get it for them...they'd let you know if they have any spare... (Participant 3, Recreational drug user)

It appears that young people going to school can also access these informal peer-networks. For a number of drug users interviewed, the initial encounter with illicit drugs took place in the context of socialising in groups with their peers.

A number of participants reported that alcohol and drug use among young people had become 'normalised' and that they spoke freely about their substance use. The perception that 'everyone' is using drugs and that it is normal behaviour in some cases can lead to a belief that alcohol and drug use is relatively risk free.[31 32] Some respondents in this study spoke about briefly considering the risks around using certain drugs but that in the end they proceeded to experiment despite having some awareness of the potential for adverse consequences.

The way I thought about it at the time was 'nice one I've done an ecstasy, I didn't die, so it was alright'. (Participant 3, Recreational drug user)

Returning to drug use

Peers were also associated with the resumption of drug use by former users who had been in treatment. This led some family members to report that they would rather their relatives did not return to the community when they left treatment in order that they did not return to drug use.

Community and structural factors

The social and economic history of the community means that, for a long time, residents depended on local work that did not require third-level education, which facilitated early school leavers wanting to enter immediate employment. There was a perception among service providers that these values lived on in the community and that people today were leaving school early with few qualifications and, as local employment opportunities had decreased, it had become much more difficult to find work in the area.

This area...stood out as an area of deprivation and one of the statistics they used to measure that... was the level of education. There would be a high percentage of people with a low level of primary education, no formal education, and no history of third level in the area and that goes back to the history of the county having [name of major employers]... employing hundreds of people in the town until it closed down leaving massive unemployment...it hit everybody with a huge knock-on effect. (Participant 2, Service provider)

The combination of early school leaving and limited employment opportunities was thought to be a factor

in exposing young people to the risk of drug use/drugs, according to one participant.

This perception that early school leaving was a common experience in the community is partially supported by data from the CSO which shows that Community A had lower levels of educational attainment compared to both county and national levels (see Table 3.2 above).

One service provider reported that it was felt that once a drug habit became public knowledge in a small community, it was very difficult for the individual to find employment. A service provider also reported that the low expectations of some young people worked against efforts to prevent them becoming involved in drug use.

Participants felt that the sense of community was being fractured by the emergence of no-go areas and incidents of public disorder arising from the problem use of alcohol and drugs. It was reported that drinking or drug dealing took place in a number of areas in the community, which gave rise to fear and intimidation among local people.

Ease of access to alcohol and drugs

Many participants reported that access to drugs at local level had increased over the last couple of years. The emergence of a local drug market was reported, which appeared to be able to provide any type of drug, and had replaced the need to travel to procure drugs.

> *Just make a phone call...you'd get maybe hash and coke off one person, and you get pills off another person, then you get the gear off, there's three or four of them selling it...It's always there, like if one fella doesn't have it then you just ring another person so it's always there 24 hours a day.*
> (Participant 6, Problem drug user)

The relatively easy access to alcohol and illicit drugs within the community was reported by all participants as one of the most important factors contributing to the spread of the problem. The availability of drugs was not confined to community and recreational settings; some participants believed that drugs were accessible in schools.

Some participants spoke of their concern about the availability for sale of prescription medication such as benzodiazepines and methadone. Prescription drugs such as methadone or benzodiazepines were often used in conjunction with illicit drugs such as heroin. Although it was not commonly reported, it appeared that crack cocaine was available through the local drug market in this community. The quality of crack depends on good 'washing-up' skills, and local dealers were working on developing these skills, according to one participant.

3.4 Perceptions of substance use in Community A

3.4.1 Extent of the problem

According to participants, alcohol and drug use was widespread in the community. There was no consensus as to which was the more problematic substance. Most participants stated that the problem of alcohol and drug use was getting worse, and this opinion was partially based on the perception that there was an increase in arrests for drug dealing and in the visibility of consumption and its effects.

> *If you walk down the street at night I'd say [drug use is] quite visible...I live near the [area in Community A] and I've seen people dealing* (Participant 7, Service provider)

Some participants reported that alcohol and drug use was prevalent in affluent as well as disadvantaged areas, but acknowledged that use in the former was possibly less 'entrenched'.

According to NDTRS data, 713 cases living in Co Offaly presented for assessment or treatment in the period 2004–2007, of whom 692 were treated. These different denominators are used throughout. Of the 713 cases, almost three-quarters (70.3%) reported alcohol as their main problem substance (Table 3.4). The percentage of such cases decreased over the four years. The most common main problem drug reported in the four-year period was opiates (15.6%), with numbers increasing from 21 in 2004 to 41 in 2007. This was followed by cannabis (8.0%) and cocaine (3.2%).

Table 3.4 Offaly cases assessed or treated, by main problem substance, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	205	183	155	170	713
Drug(s)	47 (22.9)	58 (31.7)	44 (28.4)	63 (37.1)	212 (29.7)
Alcohol	158 (77.1)	125 (68.3)	111 (71.6)	107 (62.9)	501 (70.3)
Opiates	21 (10.2)	29 (15.8)	20 (12.9)	41 (24.1)	111 (15.6)
Ecstasy	2 (1.0)	7 (3.8)	3 (1.9)	0 (0.0)	12 (1.7)
Cocaine	4 (2.0)	3 (1.6)	6 (3.9)	10 (5.9)	23 (3.2)
Other stimulants	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.6)	1 (0.1)
Benzodiazepines	0 (0.0)	1 (0.5)	1 (0.6)	2 (1.2)	4 (0.6)
Volatile inhalants	0 (0.0)	1 (0.5)	1 (0.6)	0 (0.0)	2 (0.3)
Cannabis	19 (9.3)	17 (9.3)	12 (7.7)	9 (5.3)	57 (8.0)
Other	1 (0.5)	0 (0.0)	1 (0.6)	0 (0.0)	2 (0.3)

There was a perception among some participants that drug use had been prevalent in the community for some time. One participant speculated that cannabis was the first illegal drug used in the community, followed by ecstasy and, more recently, cocaine. The steady increase in the number of cases assessed or treated for cocaine use would support this view (Table 3.4 above). Cocaine use was reported to be prevalent in the community and mainly concentrated around the social scene of young people at weekends, where its use was perceived to be the norm. The perception was that cocaine users were able to hold down jobs and confine themselves to recreational use. Some participants believed that the use of prescription drugs was a problem in the community with some saying that the blame lay with doctors who handed them out too freely.

Participants commented that many people were unaware of the risks associated with cocaine use, particularly that of combining cocaine with alcohol, perhaps because it is mainly snorted rather than injected. Many participants expressed the view that heroin use, often combined with benzodiazepines, was mainly confined to small groups of young men in the community. As one current heroin user reported, it was not uncommon for someone to start using heroin in their mid-teens and develop an injecting habit that required a sizable amount of attention on a daily basis.

Although the prevalence of drug use was acknowledged by most participants, some felt that it was a problem for a minority within the community, not for the majority and had not yet reached an epidemic stage.

Attitudes towards substance users

The contrast between lenient attitudes to excessive alcohol use and negative attitudes to drug use was commented on by several participants. Differences emerged in the perceptions of the different types of drugs and their use, for example cocaine use was viewed with a certain amount of tolerance, while heroin users were perceived negatively.

> *The alcoholic will look down on the drug addict. The cocaine user will look down on the heroin addict and the person that smokes heroin will look down on the person that's using the needle...they think smoking it is bad but not as bad as using the needle.* (Participant 69, Family member)

Participants felt that the negative perceptions of drug use, especially heroin use, clearly had implications for the development and provision of drug-related services in the community. Some participants felt that the town could benefit from a community consultation process which would help inform the wider community about the issues and the benefits of setting up services to support individuals engaged in problem drug use.

3.4.2 Substance use among young people

Participants reported that alcohol use was common among the young people in the community. Young people reported that it was relatively easy to access both alcohol and drugs from a young age, with one participant commenting that it was easier for young people to get drugs rather than alcohol as some pubs and off-licences required ID to purchase alcohol.

> *It is really easy to get drugs in this town, everyone can get them...a couple of phone calls basically.* (Participant 82, Minor)

Service providers perceived substance use among young people to be problematic, a view not shared by some of the young people themselves. In particular, there was concern at the potential damage that alcohol could do to young girls. One participant commented on the apparent lack of parental control over young people misusing alcohol.

A service provider who worked with young people reported that a lot of them would openly discuss their alcohol use but were more reluctant to disclose any drug-taking activities that they were involved in. A participant speculated that when young people experimented with drugs and did not suffer or witness adverse consequences, their use continued and perhaps led to further experimentation.

A service provider reported that the situation had worsened in schools in recent years, with even primary school children now aware of drugs and of their effects and, in some cases, being offered them in the street. This was seen as a major challenge facing education programmes. However it was stated that while young people were now more aware of drugs, they did not all experiment with them.

Figures from the NDTRS show that of the 571 treated cases living in Co Offaly between 2004 and 2007 who reported alcohol as a problem substance, over two-thirds (68.3%) had first used it before the age of 18 years, and 208 (36.4%) before the age of 15 years. It should be noted that age of first use was not reported by service providers for 15.8% of these cases. Of the 368 treated cases living in Co Offaly who reported a drug as their main problem substance, three out of five (63.5%) had first used drugs before the age of 18 years, and 99 (26.9%) before the age of 15 years. Between 2004 and 2007, 22 cases living in Co Offaly aged 17 years or under (3.1% of total cases) were assessed or treated for problem substance use. National data point to elevated levels of alcohol and drug consumption among Irish teenagers in general.[9]

3.4.3 Polysubstance use

Overall, the participants reported that a range of drugs was easily available and being used in the community. Perceptions of the nature and extent of the polysubstance use were varied, but suggested that it was an emerging, if not an established, phenomenon.

> P: *People who are on heroin are mad into taking their tablets like, D5s and D10s, Roches [benzodiazepines].*

I: *Would they be taking them at the same time as taking the heroin?*

P: *Ah yeah...Because it gives you a better buzz, makes it more relaxing and gives you a better stone.* (Participant 6, Problem drug user)

Polysubstance use increases the complexity of the treatment required and is associated with poorer treatment outcomes.[16] Polysubstance use among cases living in Co Offaly is seen very clearly in the NDTRS data. Overall, two out of five cases (38.7%) were polysubstance users, indicating that this trend has been well established since at least 2004. Over the reporting period, 80 (11.6%) reported problem use of two substances, 90 (13.0%) of three substances and 98 (14.2%) of four or more substances. Table 3.5 presents the additional problem substances used by those reporting problem use of more than one substance, by year treated. Between 2004 and 2007, cannabis, ecstasy, cocaine, alcohol, and amphetamines were the most common additional problem substances reported. Cannabis was top of this list in each of the four years, and its use as an additional substance increased by one-fifth over the reporting period. Ecstasy was the second most common additional substance in 2004 and 2005. Cocaine replaced ecstasy as the second most common additional substance in 2006 and 2007.

Table 3.5 Offaly cases treated, by polysubstance use and additional problem substance(s) used, NDTRS 2004–2007

	2004	2005	2006	2007	Total
Additional problem drug(s) used*	**Number (%)**				
All cases	72	63	58	75	268
Reported one problem drug	131 (64.5)	109 (63.4)	92 (61.3)	92 (55.1)	424 (61.3)
Reported two or more problem drug	72 (35.5)	63 (36.6)	58 (38.7)	75 (44.9)	268 (38.7)
Of those reporting two or more problem drugs					
Cannabis	43 (59.7)	39 (61.9)	37 (63.7)	52 (69.3)	171 (63.8)
Ecstasy	35 (48.6)	25 (39.6)	24 (41.3)	27 (36.0)	111 (41.4)
Cocaine	12 (16.6)	22 (34.9)	25 (43.1)	31 (41.3)	90 (33.5)
Alcohol	24 (33.3)	13 (20.6)	20 (34.4)	24 (32.0)	81 (30.2)
Amphetamines	14 (19.4)	14 (22.2)	13 (22.4)	1 (1.3)	42 (15.6)
Opiates	8 (11.1)	12 (19.0)	3 (5.1)	5 (6.6)	28 (10.4)
Benzodiazepines	4 (5.5)	6 (9.5)	3(5.1)	9 (12.0)	22 (8.2)
Other	2 (2.7)	0 (0.0)	0 (0.0)	0 (0.0)	2 (0.7)
Volatile inhalants	0 (0.0)	1 (1.5)	0 (0.0)	1 (1.3)	2 (0.7)

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

The association between main problem substance and additional substances among new cases entering treatment was examined for the period 2004 to 2007 (Table 3.6). The pattern of additional substances used was linked to the main problem substance. For example, where an opiate was the main problem substance the most common additional problem substances were cannabis (50.8%), followed by alcohol (23.7%) and cocaine (20.3%), whereas where cannabis was the main problem substance the most common additional substances were ecstasy (50.0%) followed by alcohol (47.5%) and cocaine (32.5%). Where cocaine was the main problem substance, the most common additional problem substances were alcohol (76.9%), cannabis (69.2%) and ecstasy (61.5%). Information about the combinations of substances used is important in terms of individual clients' care plans, and policy initiatives.

Table 3.6 New Offaly cases treated, by main problem substance and additional substances used, NDTRS 2004–2007

	Opiates	Ecstasy	Cocaine	Amphet-amines	Benzo-diaze-pines	Volatile inhalants	Cann-abis	Alcohol	Other
New cases	**59**	**7**	**13**	**1**	**2**	**1**	**40**	**311**	**1**
Additional problem drug(s) used*		**Number (%)**							
Opiates	3 (5.1)†		1 (7.7)				4 (10.0)	1 (1.3)	1 (100.0)
Ecstasy	11 (18.6)		8 (61.5)		1 (50.0)		20 (50.0)	40 (12.9)	
Cocaine	12 (20.3)	4 (57.1)		2 (200.0)			13 (32.5)	26 (8.4)	1 (100.0)
Amphetamines	1 (1.7)	4 (57.1)	1 (7.7)				9 (22.5)	11 (3.5)	1 (100.0)
Benzodiazepines	6 (10.2)							3 (1.0)	
Cannabis	30 (50.8)	3 (42.9)	9 (69.2)		2 (100.0)	1 (100.0)		55 (17.7)	
Alcohol	14 (23.7)	2 (28.6)	10 (76.9)		2 (100.0)		19 (47.5)		
Other								2 (0.6)	

* 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 substance.

Participants reported that in many cases progression to heroin use was closely associated with polysubstance use, often when heroin was taken to help the user to 'come down' and sleep after using ecstasy or speed.

3.5 Consequences of substance use

This section reports participants' perceptions of the consequences of problem alcohol and drug use, as they affect the individual user, the family and the community.

3.5.1 Consequences for the user

Health consequences

Many participants spoke about the health-related consequences of alcohol and drug use, even among under-18s, which often required medical intervention. Mongan and colleagues (2007) highlighted the sharp increase nationally in alcohol-related liver disease between 1995 and 2004, therefore it would be expected that these trends would also be reflected in Community A.[33] The EMCDDA reported that co-morbidity with psychiatric condition is common among problem substance users across Europe.[16]

Participant also spoke of mental health problems and their association with problem heroin use.

> *You know it's going to kill you, you know there's a high chance of it, especially if you have a good turn on but you still do it. You still do it because you don't want to be sick. That's the mentality of it, as I say it's the devil's drug, the way it plays with your mind if you don't, this is what's going to happen, if you do, this is what's going to happen...it can't be that bad; you don't care. You've no emotions.* (Participant 10, Problem drug user)

There were reports that a number of people in the community had died of a drug overdose. The drugs involved included stimulants, opiates and solvents.

Health-related consequences of drug use are not confined to the individual user; the community's health can also be affected. For example, the public disposal of used injecting equipment was reported by some participants, which could lead to an accidental needle-stick injury to a member of the public.

Social consequences

Participants reported anecdotes about drug-related crime, including threats from criminals, criminal behaviour and imprisonment.

3.5.2 Consequences for the family

Participants spoke about the emotional effects of having a problem substance user in the family and the difficulties this caused for all involved. There was also the emotional distress and fatigue of working through treatment with a family member, only for them to relapse very quickly. There were reports that some family members went to extremes to try to help and protect their relative, including paying for their drugs or driving them so they can buy their drugs in relative safety. This emotional burden on Irish families of problem drug users is well documented.[34] A service provider reported working with families affected by drug use and stated that mothers of problem drug users often presented with depression and a lack of self-esteem.

> *I'll start with the mothers. It just wears them down. They become very depressed and they find it very difficult dealing with the problem, they feel very inadequate, lacking in self-esteem...so it causes a lot of depression and a lot of violence and rowing in the home.* (Participant 12, Service provider)

A service provider speculated on the association between alcohol use and domestic violence, suggesting that alcohol was implicated in perhaps up to 70% of domestic violence incidents. According to Hope (2008), alcohol-related harm in Ireland is not confined to the drinker, but extends to the family, community and wider society.[35] Between 1996 and 2002, alcohol-related public order offences by adults in Ireland increased by 247% (from 16,284 to 56,822).

Participants also spoke about threats of violence against family members due to their relative's drug debts and struggles to bail out their relative. Family members reported ending up in debt and financial hardship themselves as a result of bailing out relatives who were drug users.

3.5.3 Consequences for the community

Reports of the consequences of alcohol and drug use on the community reported were limited, but included the increased burden on health resources, public disorder, no-go areas and increase in crime.

> *The few that continue to use are putting themselves at risk, and then the knock-on effect through crime, through lack of resources in the health board, whatever, we all suffer.* (Participant 7, Service provider)

It is well documented that illicit drug markets can create immense problems for local communities, particularly in relation to drug-related crime and nuisance and the fear of victimisation which can become associated with local drug markets.[36] [37]

3.6 Perceptions of the response to the problem, and gaps identified

This section presents data from the NDTRS in relation to Co Offaly cases seeking treatment, reports participants' perceptions of the responses to the drug problem in Community A, and summarises any gaps they identified or solutions they offered.

3.6.1 Drug treatment figures

Of the 713 cases living in Co Offaly who sought treatment in the period 2004–2007, the majority 546 (76.6%) attended outpatient services, 166 (23.3%) attended a residential service, and only one case (0.1%) attended a general practitioner (Table 3.7). Nationally, approximately one-third of cases in methadone treatment attend their general practitioner for treatment.[17] The number of previously treated cases decreased from

130 in 2004 to 84 in 2007. The number of new cases increased from 68 in 2004 to 73 in 2007 which indicates a relatively stable situation (Table 3.8).

Table 3.7 Offaly cases assessed or treated, by service type, NDTRS 2004–2007

	2004	2005	2006	2007	Total
	Number (%)				
All services	205	183	155	170	713
Outpatient	168 (82.0)	150 (82.0)	111 (71.6)	117 (68.8)	546 (76.6)
Residential	37 (18.0)	33 (18.0)	44 (28.4)	52 (30.6)	166 (23.3)
General practitioner	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.6)	1 (0.1)

Table 3.8 Offaly cases assessed or treated, by treatment status, NDTRS 2004–2007

	2004	2005	2006	2007	Total
	Number (%)				
All cases	205	183	155	170	713
Assessed only	2 (1.0)	11 (6.0)	5 (3.2)	3 (1.8)	21 (2.9)
Previously treated cases	130 (63.4)	120 (65.6)	101 (65.2)	84 (49.4)	435 (61.0)
New cases	68 (33.2)	51 (27.9)	48 (31.0)	73 (42.9)	240 (33.7)
Treatment status unknown	5 (2.4)	1 (0.5)	1 (0.6)	10 (5.9)	17 (2.4)

Source of referral

The majority (36.2%) of cases seeking treatment in all four years were self-referred, with the number rising from 51 in 2004 to 82 in 2007. The next most common sources of referral were a hospital or medical agency (33.1%) and a general practitioner (10.1%), although the numbers of referrals from these sources decreased steadily throughout the period.

Perceptions of type of services provided

In general, participants did not distinguish between services provided by statutory and voluntary agencies in the community or elsewhere. All participants felt there was a lack of, or indeed absence of, addiction services in the community.

> *Very, very poor...as far as I know they're non-existent. You have to wait six months to get on a waiting list.* (Participant 70, Service provider)

Addiction services in the form of counselling were available in the community. However some participants perceived that they were very limited, which meant that people had to either travel on limited public transport to another location or wait between visits. For any other types of service, such as assessment, methadone maintenance or psychiatric consultation, the population of Community A had to go elsewhere. Service providers commented that this affected treatment outcomes.

Support, especially over the long term, is an essential component of drug treatment and both service providers and problem drug users felt the lack of support services impacted negatively on the recovery of problem drug users.

The problem of transport was raised constantly throughout the interviews in Community A. Many of those affected by drugs have chaotic lives; many did not own a car or have regular access to a car for transport to another town for treatment.

Waiting lists for addiction services

All service providers, family members and drug users spoke about the problem of waiting lists for all types of addiction services, and how that hampered access to treatment and recovery.

> *Oh you have to go on a waiting list. It's very, very difficult. They're understaffed, and you have to wait to be called and a lot of people who are using drugs...when they're ready to give it up, it has to be instant...it has to be done there and then, there's no point in telling somebody that they have to wait three weeks because in that three weeks they're going to continue using. It's kind of a vicious circle really.* (Participant 5, Service provider)

Service providers felt that existing services could not cope with the level of drug problems in the community. The situation was perceived as becoming worse over the years, with the services not evolving to keep up. It was also felt that the services had not expanded to cope with the increase in population in the town. Another difficulty of living in a small town was the stigma attached to drug addiction and the difficulties for both families and drug users in accessing confidential help.

3.6.2 Overdose prevention and harm reduction – Injecting drug use

NDTRS data show that 44 injector cases who lived in Co Offaly entered treatment between 2004 and 2007 (Table 3.9). Of the cases who reported ever having injected illicit (or licit) drugs, over one-quarter (27.3%) had started injecting before they were 19 years old. Twelve cases (27.3%) reported sharing injecting equipment. Overall, the proportion of injector cases who reported sharing equipment increased between 2004 and 2007 (Table 3.10).

Table 3.9 Offaly cases treated, by injector status, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	203	172	150	167	692
Had injected	6 (3.0)	17 (9.9)	7 (4.7)	14 (8.4)	44 (6.4)
Never injected	196 (96.6)	155 (90.1)	142 (94.7)	148 (88.6)	641 (92.6)
Not known	1 (0.5)	0 (0.0)	1 (0.7)	5 (3.0)	7 (1.0)

Table 3.10 Offaly injector cases treated, by equipment-sharing practices, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All injector cases	6	17	7	14	44
Shared equipment	1 (16.7)	3 (17.6)	2 (28.6)	6 (42.9)	12 (27.3)
Did not share equipment	3 (50.0)	12 (70.6)	4 (57.1)	3 (21.4)	22 (50.0)
Not known	2 (33.3)	2 (11.8)	1 (14.3)	5 (35.7)	10 (22.7)

These data on injecting drug use are supported by qualitative data from Community A, with anecdotal evidence of injecting drug use and needle sharing among heroin users in the community.

> *[We need a] needle exchange for a start...I see the lads sharing stuff [injecting equipment] the whole time...and if one of them catches something they've all got it.* (Participant 10, Problem drug user)

Participants reported that there were no harm reduction services currently in the community but that some problem drug users travelled to Dublin to access them. (NB A needle exchange programme has been set up since data collection was completed). A problem drug user reported getting needles, syringes and citric acid in a pharmacy in the community.

Lack of access to injecting paraphernalia can lead to people sharing injecting equipment. Sharing injecting equipment puts individuals at risk of acquiring or transmitting a blood-borne virus, such as HIV, hepatitis C or hepatitis B. The prevalence of blood-borne infections among injecting drug users in treatment in Ireland is high. Data between 1995 and 2000 found that 70% of injecting drug users tested positive for HCV, 20% were infected with HBV and 10% were HIV positive.38 It is therefore highly probably that a proportion of injecting users in Community A are infected with at least one blood-borne virus.

There were reports of overdose attempts in the community. Family members and drug users appeared to have little information on what to do in the event of an overdose.

3.6.3 Specific treatment issues

Methadone treatment

There was no methadone clinic in the community, but heroin users could access methadone treatment in Community D. However, travelling to Community D was very difficult for many drug users. The NDTRS data show that 15% of all cases living in Co Offaly who were treated for problem substance use between 2004 and 2007 reported opiates as their main problem substance (see Table 3.6 above). In general, service providers felt that methadone treatment was working well for those able to access it. However, as one service provider commented, methadone treatment is just one part of a suite of interventions and services that opiate users require to assist them in their recovery. One service provider gave a possible explanation for the lack of general practitioner-led services in Community A, despite the obvious need.

> *I think there's a fear of their practice being associated with drug users and drug users in their waiting rooms. Also I think that perhaps [there is an] assumption…that…if I take on these guys for methadone well then they're going to be in here everyday looking for different types of drugs. Right, I think there's an element of that perhaps…* (Participant 14, Service provider)

Several pharmacies in the community did dispense methadone; however, service providers commented on the lack of confidentiality and the stigma attached to being known as a problem opiate user. Opiate users employed different ways to deal with the lack of services. For example, if they could not access their methadone through the authorised system, it could be bought easily on the street.

Residential and detoxification treatment

Participants' responses did not differentiate between the different treatment models used in residential treatment centres and often used the terms residential and detoxification interchangeably. The type of residential treatment available differed considerably, but most did offer detoxification.

Of the 713 cases living in Co Offaly who presented for treatment between 2004 and 2007, the majority (76.6%) attended outpatient services, 166 (23.3%) attended a residential service, while only one case (0.1%) attended a general practitioner.

Residential treatment, including detoxification, is one treatment option available to drug users; however, no such facility was within easy distance of the community. Some service providers and family members felt that the lack of a proper aftercare service in the community seriously hindered the effectiveness of this type of intervention.

> *Anybody who goes to a residential treatment centre is supposed to do a two-year aftercare programme and it can be difficult in relation to that. That's a huge commitment…if…you have to travel. If you're an 18-year-old and you go to a treatment centre…in [name of county]…it's a long way from here, and you're depending on an adult or a parent to bring you over, one night a week for two years. It's very hard to maintain that, it's too far away.* (Participant 5, Service provider)

Residential detoxification treatment was viewed positively by some problem drug users although it was not always successful in keeping a person off drugs in the long term. There were several examples given of individuals detoxifying at home with their families, friends or by themselves and, due to the lack of available services, they did so without medical care or supervision.

3.6.4 Social reintegration

Social re-integration for drug users has gained recognition over the years as a key aspect of drug treatment and recovery. Its components include provision of education, training, accommodation and support to drug users.[39] Most participants acknowledged the need for an integrated approach to providing addiction services in Community A which would include the supports needed for social reintegration. Employment is an important aspect of rehabilitation. The NDTRS data show that almost two-fifths (38.1%) of cases assessed or treated living in Co Offaly in the period 2004–2007 were unemployed.

Housing or other forms of accommodation is a factor in social reintegration issue. The NDTRS data show that the majority (94.8%) of cases living in Co Offaly who were assessed or treated between 2004 and 2007 reported that they were living in stable accommodation. Very small proportions were homeless (1.7%), in unstable accommodation (0.8%) or in an institution (0.4%) (e.g. clinic or prison).

Despite the often bleak picture painted by service providers regarding vocational opportunities for drug users, there was a local project working in this area.

> *There's a problem...in [name of town] with employment, drugs, drink...but at least if you come in here we can kind of give you choices. You can work to get things better. You can get FETAC level one and two and we can see if we can move you into a job which...gives you the things in life that you want that maybe your parents didn't have or maybe your grandparents didn't have.* (Participant 1, Service provider)

3.6.5 Services for under-18s

Participants highlighted the lack of specific addiction services for young people in the community.

> *But there's not really much that we can do because I don't think we have the services [for minors]... where do you actually refer these people because there's waiting lists everywhere.* (Participant 1, Service provider)

The NDTRS data support this perception and show that there are under-18s requiring treatment. Of the cases living in Co Offaly who were assessed or treated between 2004 and 2007, 22 (3.1%) were 17 years or under and 73 (10.3%) were under 20 years of age.

Youth services had to try as best they could over the years to adapt to the growing problem of alcohol and drug use among young people. One service provider stated that transport difficulties were also a problem for young people trying to access services outside the community.

Parental responsibility

Service providers spoke about reporting problem substance use to parents as a first line of response to problem drug and alcohol use among young people. However, participants did report that occasionally parents tolerated alcohol use, even by young people under the age of 18, sometimes because as their own (parental) alcohol or drug misuse meant they were unable to respond to the problems of their child.

> *We would inform the parents if we had to, or try to advise the young person about the dangers of what they are doing. But having said that, some of the time, if its alcohol related, some of the parents might look on it as it's only alcohol and its okay.* (Participant 1, Service provider)

Education

It was reported that various types of drug education and prevention were provided by youth services in the community. Additional in secondary schools, Social, Personal and Health Education (SPHE) is part of the curriculum up to third year. There was also some provision of education to families affected by drug use and to professionals who worked with people affected by drugs. One service provider expressed regret that despite the best efforts to provide education to young people, they continued to take drugs and misuse alcohol. The opinion was expressed by several participants that what education was currently being provided was not sufficient, a view supported by the young people who took part in the study.

> *The schools can say we have done our bit. But, I don't know...[if it] is the...answer. The vast majority of young people are brilliant and they will enjoy the discussion ...because an hour in the classroom once a year or whatever isn't anywhere near enough...because...the young people...at risk of using drugs need to be able to see the horrible ill effects of it.* (Participant 5, Service provider)

Another problem highlighted for young people who were accessing a support project or programme was that once they reached the age of 18 there were very few options for continued support.

3.6.6 Family issues

As the NDTRS data show, two-fifths (42.5%) of cases living in Co Offaly who were assessed or treated reported living with their parents or family. Families reported trying their best to get treatment for their relatives. This included trying to treat adult children at home with various substitution treatments or trying to help them detoxify. Some tried all available avenues to get their children into treatment. The burden on families caring for someone with a drug problem appeared to be compounded by the lack of facilities in Community A and distances that had to be travelled by families to bring relatives for treatment.

> *I had to drive to [name of city] every single day with him to bring him there...for months...It was...a terrible lot of pressure.* (Participant 9, Family member)

One service provider reported that a lot of families who were faced with a drug problem had a lack of understanding about the nature of addiction, and did not know that relapses were sometimes part of the process of recovery. Participants did report that some family members had been able to access counselling and that this had proven helpful.

Family support group

Families had come together to form a support group in the community, which was seen as a very positive step by families and service providers.

> *And [the people]...[who developed the family support group]...have to be...praised...because at a drugs task force thing in...[name of town]...[where] they were just feeding back on what the task force was doing...the women stood up and it was brilliant...and they were really taking the HSE to account [asking] 'Why isn't there treatment?'* (Participant 14, Service provider)

Suggested solutions or responses

There was complete agreement among the participants that even the most basic addiction services were lacking in the community, and that the situation was compounded by the transport difficulties. All wanted accessible and regular addiction services located in the town which would provide confidential treatment, aftercare and psycho-social support for both the individual and their family. In general, participants did not distinguish between the types of service provider (whether HSE or voluntary). However, it was apparent from the participants' responses that the expansion of routine HSE addiction services in Community A was required to meet the needs of increasing numbers of people with addiction problems, and to deal with the serious issue of long waiting times for treatment.

> *When you're coming off it, like you will start crying over things you've done and...some of the people you've hurt. Your emotions come back full blast and, as I say, there's no one here in the town to talk to or anything like that...so a lot of the lads bottle up and...end up relapsing because they've never dealt with the [problems] that's gone on. Like I've dealt with nothing but that's out of choice. I'm not ready to deal with it.* (Participant 10, Problem drug user)

Participants felt that existing services were overstretched and unable to provide adequate care or support. Another participant spoke of the need to deal with the problem of prescription drugs.

A view expressed by all participants that linked many of the above issues was the need for a permanent facility located in the community. This facility was generally conceptualised as a 'drop-in centre', ideally where integrated addiction services, along with support and education services could be provided for the whole community.

> *... I think it's probably very hard for young people...if they have a drug problem and...want to do something about it. Their first port of call that they can go to is their GP and say 'Look I have a drug problem' [but] then where does he send them? I mean you have to get parents involved. If there was somewhere local that you could say to them, 'Look, go, I will refer you to talk to such and such' in a centre.* (Participant 7, Service provider)

The detrimental impact of the long waiting times for treatment was observed by most of the participants, and all felt that it was vital that this issue be addressed.

Several modalities of drug treatment developed over the years, especially for opiate addiction, have been shown to aid recovery. One service provider appealed for the services to learn from previous experience and to become more client-centred. The need for counselling and/or detoxification services to facilitate admission to residential treatment was also articulated. One example given was the need for an individual to be drug free before being accepted into certain treatment facilities, and the difficulties of achieving that without support.

Participants acknowledged the difficulty of providing a full range of confidential services in such a small town. However, it was felt that even if not all addiction services could be provided, the basic minimum should be available in the community.

Overdose prevention and harm reduction

The need for harm reduction services, including needle exchange, was mentioned by many of participants, including problem drug users.

> *[A service provider] was slated over saying that if they're using needles...they need to use clean needles. They have to be taught how to use the needle. And because there's no use looking at this with rose-tinted glasses, if they're using, they need to be safe. And that's the way we look at it. Now, we'd love to stamp out the problem altogether...we'd prefer if there wasn't a heroin problem in the town but if there is a problem...the heroin addicts [have] to be safe and have some place to go for a needle exchange.* (Participant 69, Family member)

Additionally, from the reports of overdose attempts in the community, there appears to be a need for specific education on overdose prevention for families, friends and community workers to respond to the reports of overdose attempts.

The need for outreach workers was also highlighted, with participants stating that they would benefit many areas, including access to harm reduction and overdose prevention programmes.

It is well documented that changing risk behaviours among injecting drug users is difficult, but research suggests that Irish needle exchange programmes have had some success in reducing the incidence of sharing.[38 40 41]

Methadone treatment

The need for opiate users to have access to methadone maintenance treatment in the community was highlighted by most participants. A locally-based service would reduce waiting times and go some way to reducing drug-related harm. Participants also identified the need for general practitioners in the community to take on clients for methadone maintenance treatment, which they can do provided they have undergone the appropriate training. Most participants understood that simply having easier access to a prescription for methadone was just one part of aiding recovery from opiate addiction and that, to ensure the success of methadone treatment, it needed to be given along with a suite of other interventions, including long-term psychological and social support.

> *As I say, there are no treatment services. There is a methadone programme in [name of town] which people needing methadone...for heroin use get here in the chemist in [Community A] but in my opinion that's only...a very small part of rehabilitation. I don't think there is any point in dolling out methadone unless there is other rehabilitation services like trying to get gainful employment, training these people and trying to give them skills that they can change and move on in their lives.. They have to...be given opportunities and...high maintenance support...for maybe a number of years, if you really want to see these people coming out of dependency in the long term...that's the way it has to be structured.* (Participant 11, Service provider)

Methadone maintenance is not the only treatment for opiate addiction and the need for alternative treatments was acknowledged. For example, one opiate user stated that they would rather detoxify at home than go on methadone treatment.

Detoxification treatment

There was general agreement that the inhabitants of Community A needed easier access to a residential treatment centre including detoxification facilities, with proper long-term support and follow-up for those who went through any such programme. It was suggested that one strategically located centre could serve the MRDT area. The anecdotal reports of people detoxifying at home without medical supervision or going to prison to detox illustrated the urgent need for this service.

> *Residential treatment centres are one thing that are very lacking in the Midlands...People become so entrenched in the drug use that the only way is to do an intensive residential treatment programme with...follow-up support...[an] after-care plan.* (Participant 5, Service provider)

Services for under-18s

Alcohol misuse among young people was recognised as requiring specific interventions and services, especially as drinking, often to excess was since as normal among many young people. Many participants recommended improved education and health promotion in relation to substance misuse for young people, because what was being currently provided was not enough or not effective. It was felt that this service should be provided not only in schools but in a facility located in Community A which was easily accessible and safe, where young people would feel comfortable. Additionally, service providers expressed the need for a counselling or support service for young people who had begun to experiment with drugs or alcohol or who were developing problem use.

Some of the younger participants suggested that a confidential, face-to-face service provided by a trusted individual, perhaps who had experience of drug use themselves, might be something that young people

in the community would access. There was no support for a telephone helpline. It was felt that not only should there be education and counselling but that appropriate alternative activities needed to be provided for young people.

> *Facilities are needed to prevent drug use...[among] young people...If you are sporty in this town, you could join [sports club], but...if you are not [good at sport]...there is nothing else.* (Participant 13, Service provider)

Families

Most participants agreed that any improvement in service provision should include support for families.

> *I think families need somewhere where they can be met as a family...Because the drug user is one person but [the] family [is] suffering [too]. So it's affecting the siblings, it's affecting the parents, it's affecting the grandparents, it's affecting everybody. So there needs to be some place for family support.* (Participant 12, Service provider)

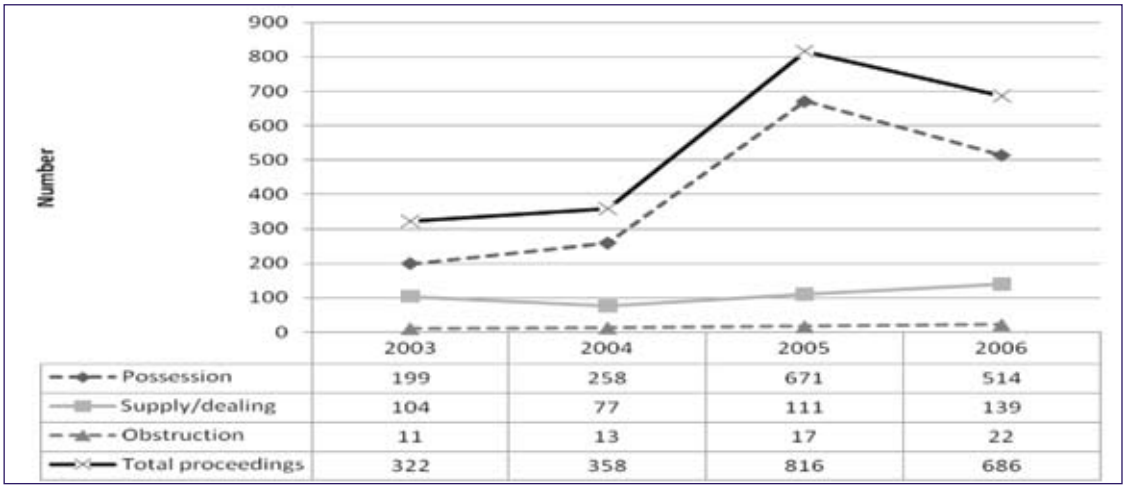
Any services provided would need to be sensitive to the realities of living in a small community, and aware of the stigma attached to drug use in the area. At the time of data collection, the recently set up family support group had no permanent place in which to hold their meetings, and no support from a professional.

3.7 Drug-related crime in counties Laois and Offaly

This section brings together statistics (from the CSO) on drug-related crime for the Laois/Offaly Garda Division from 2003 to 2006 and the qualitative data on perceptions about crime in Community A. Again, it is important to stress that these data are primarily a reflection of the activities and effectiveness of the gardaí rather than of the availability of drugs or the incidence of drug-related crime.

3.7.1 Proceedings for drug offences in Laois/Offaly Garda Division

Figure 3.1 presents the main drug offence proceedings for the Laois/Offaly Division from 2003 to 2006. Possession offences accounted for the majority of proceedings in the four years. In 2006, of the total drug offence proceedings in the division, three-quarters (74.9%) were for possession. A higher number of drug supply offences took place in the Laois/Offaly Division compared to Longford/Westmeath. Though the numbers are small, there was a steady increase in obstruction offences between 2003 and 2006.

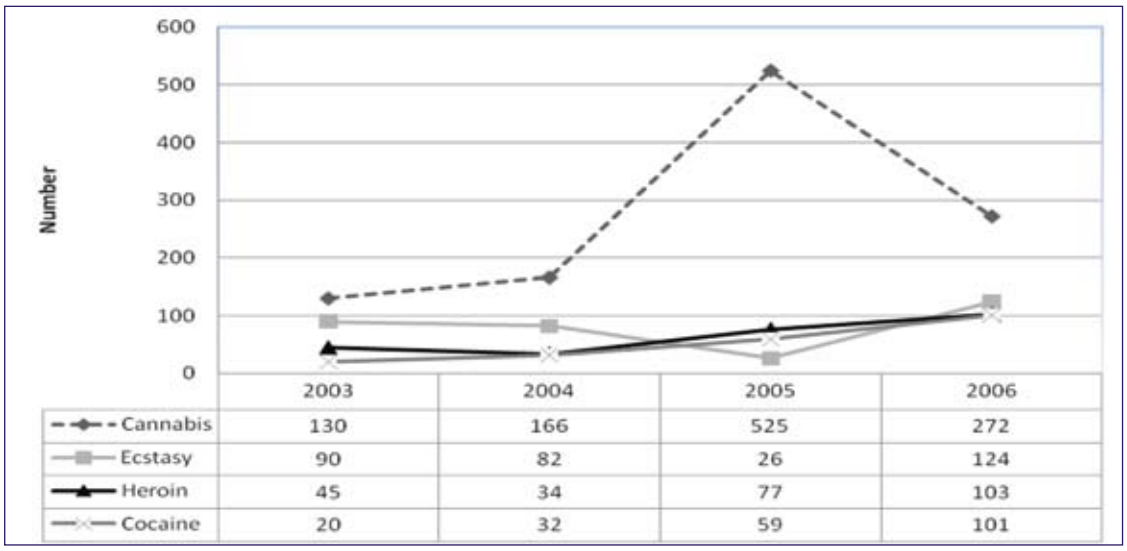


	2003	2004	2005	2006
Possession	199	258	671	514
Supply/dealing	104	77	111	139
Obstruction	11	13	17	22
Total proceedings	322	358	816	686

Figure 3.1 Drug offence proceedings, by main offence type, Laois/Offaly Garda Division 2003–2006

3.7.2 Proceedings for possession, by drug type

Figure 3.2 shows that the majority of possession proceedings were for cannabis. There was a sharp rise in proceedings for possession of ecstasy from 26 in 2005 to 124 in 2006. Proceedings for heroin possession doubled in the Laois/Offaly Division between 2003 and 2006. The same trends for ecstasy and heroin were also observed in the Longford/Westmeath Division for the period under review. There was a consistent rise in the number of proceedings for cocaine possession between 2003 and 2006 which follows the same trend as seen nationally. Until recently, heroin was available mainly in Dublin; however the increase in heroin-related offences is an indication that the heroin market has spread outwards from Dublin.



	2003	2004	2005	2006
Cannabis	130	166	525	272
Ecstasy	90	82	26	124
Heroin	45	34	77	103
Cocaine	20	32	59	101

Figure 3.2 Proceedings for possession, by drug type, Laois/Offaly Garda Division 2003–2006

3.8 Perceptions of drug use and crime in the community

Participants spoke of both types of drug-related crime: offences committed in contravention of drug laws, e.g. possession or supply, and offences related to drug use or activity, e.g. robberies to fund drug use.

> *[I was in prison]...Ah it was just robberies, robbing to feed my habit...Shops, businesses, cars, anything, muggings...to get money...I've been doing it since I was a young fella ...I was doing it any night that I need money...that's just the way it was. [I have been] in prison [several times].* (Participant 6, Problem drug user)

One participant felt that the number of arrests for drug dealing had increased, a view supported by the crime data for the Laois/Offaly Garda Division since 2004 (Figure 3.1). The visibility of drug dealing seemed to have created an atmosphere of fear among people in the community. It is well documented that illicit drug markets can create immense problems for local communities, particularly in relation to drug-related crime and nuisance and the fear of victimisation which can become associated with them.[36][37] Violent consequences of drug-related crime were reported, not only for the drug user or dealer but for their families also.

Most participants felt that the gardaí were doing their best to deal with a growing problem despite limited resources. From the other perspective, problem drug users felt that they were always unfairly targeted by the gardaí and were being stopped for no reason. Families of drug users were also adversely affected and one recounted experiences of having the gardaí call to their home several times a week to investigate their relative.

Several participants spoke about their own, their families' or their clients' experiences of imprisonment due to drugs. Imprisonment was often seen as exacerbating existing drug problems or, indeed, as being

responsible for initiating drug habits.

> He was doing heroin...he would never say he started his drugs here in [Community A]. He always said he got it in prison...but then when he came back home to [Community A]...he knew the people to score [from]...he learnt it all from prison. (Participant 37, Recreational drug user)

Some participants claimed that drugs were widely available in prison. Studies have shown that there is drug use in Irish prisons and that prisoners are more likely to share injecting equipment then drug users in the community.[42] Conversely, there were reports of drug users going to prison to get treatment, because either it was unavailable in the community or there was a long waiting list.

Suggested solutions and responses– drug-related crime

Many participants felt that there should be more police and higher Garda visibility in the community.

> *But you see the [Garda] car driving around and if you're a dealer and the car goes past you, you know it's not going to be back for at least another half hour. So, you know you can pretty much carry on with whatever you are doing or else just move somewhere else. I think if you wanted do deal down there, you could fairly easily. I'm not saying it's the guards' fault, they just don't have the manpower.* (Participant 1, Service provider)

There appeared to be a need for improved communication between the gardaí and the community. A service provider felt that the gardaí should make more of an effort to build up relationships with the community, while it was also noted that the gardaí would benefit from more assistance from the community in relation to information on the drugs scene. Although, as one participant reported, people were reluctant to pass information to the gardaí for fear of physical violence.

Prison

As reported in the previous section, committal to prison was seen as exacerbating a drug problem or even being the cause of drug addiction. Service providers and family members wished for improved preventative treatment services in prison, with ongoing treatment and support on release.

There were many comments on the detrimental effects of long waiting lists for treatment and how many individuals ended up in trouble with the gardaí or indeed back in prison while waiting for treatment. The need for alternatives to imprisonment was highlighted.

3.9 Key findings in Community A

Community A is a small town in Co Offaly and has certain markers of deprivation, including rising unemployment. There were different perceptions on what is the major problematic substance in the community, either alcohol or drugs. Nonetheless, both the quantitative data and qualitative data point to problematic alcohol and drug use in the community.

Factors contributing to the problem

The individual factors related to the initiation of drug use included low self-esteem, boredom, curiosity, enjoyment and opportunity. Excessive alcohol consumption and the influence of peers were also cited as factors. Within the family, tolerance of substance use by other family members, especially parents, was found to be a factor contributing to substance use. The influence of problematic drug use in the family is a well documented risk factor for the development of intergenerational problem substance use amongst family members.[24 25 27]

Excessive alcohol consumption appeared to be common and accepted within the community and that people, including teenagers, used alcohol with impunity. NDTRS data showed that problem alcohol use is the main problem substance among those presenting for treatment in Co Offaly.

Overall, it was felt that the local drug market had expanded which meant that practically every type of drug, both legal and illegal, was relatively easy to access in the community, even by young people. This accessibility can lead to the development and normalisation of drug use in a community.[32] There was no consensus as to how far drug use had spread within the community, but there was agreement that problem substance use was getting worse.

While figures from the NDTRS show that opiates are the main problem drug in Co Offaly, the number of cases reporting cocaine as their main problem substance doubled between 2004 and 2007, although the numbers are still low. It was evident that many individuals were polysubstance users and that the treatment services needed to refocus to deal with this situation. Polysubstance use increases the complexity of the treatment and is associated with poorer treatment outcomes.[16] It can also have serious health-related implications, for example research has shown that the combined consumption of cocaine and alcohol is highly cardiotoxic.[43] The use of cocaine in combination with alcohol increases the risk of violent incidents. Particular issues were identified in the case of young people. These included the apparent ease of access to and normalisation of alcohol and drug use, especially cannabis, among teenagers. The influence of peers in initiation of substance use appeared to be a key factor. A study conducted in the Midlands in 1999 found that drug use was perceived even then to be prevalent among young people.[44] Service providers highlighted the need for under 18s to have access to addiction treatment services in the community. The need for improved education and alternative activities for young people was highlighted as individual factors such as boredom and curiosity were factors in initiating substance use for young people.[22 23]

Consequences of substance use

The harms associated with problem substance use for the individual, their family and the community were graphically illustrated by participants. The harms reported ranged from the impact on physical and mental health, emotional and financial problems, the breakdown of relationships, abuse and violence, and propagation of intergenerational problem drug use. The emotional burden on Irish families of problem drug users is well documented.[34]

Perceptions of the response to the problem, and gaps identified

Overall, it was felt that there was a great lack of services. The situation was perceived as becoming worse, and services had not expanded or evolved to keep up. These problems were compounded by transportation difficulties and lengthy waiting lists for various services elsewhere. The need for general practitioners, adequate methadone treatment for opiate users, residential treatment and detoxification beds was highlighted by all. Drug users and their families appeared to struggle to find appropriate treatment and reported that they were often unsuccessful. Participants reported the need for an accessible, confidential addiction service, envisaged as a 'drop-in' centre, ideally based in the community, which would include outreach work, family support and harm reduction services. In the absence of adequate services, problem opiate drug users are resorting to other measures, including taking street methadone, sharing needles or going to prison for treatment.

The penetration of the local drugs market, with easy availability of a range of drugs, was thought to facilitate the initiation and continuation of drug use in the community. Public disorder and fear, propagated by alcohol and drug misuse, and the visibility of drug-related crime in the town was felt to be harming the sense of community and creating no-go areas. Previous studies have shown that retail illicit drug markets

can create immense problems for local communities, particularly in relation to drug-related crime and nuisance and the fear of victimisation which can become associated with local drug markets.[36 37 45 46]

The need for alternatives to incarceration for drug-users was expressed, as imprisonment was often seen as exacerbating existing drug problems or indeed being responsible for initiating habits.

3.9.1 Participants' recommendations for service provision in Community A

Table 3.11 presents the participants' recommendations for service provision in Community A, summarised under the pillars of the National Drugs Strategy 2001–2008.

Table 3.11 Participants' recommendations for service provision in Community A

Pillar	Existing services provided in community*	Suggested response
Supply Reduction	Community gardaí	Increase the number of gardaí Improve communication between gardaí and the community
Prevention	Youth Diversion project Youth Reach Community partnership project providing a variety of training and vocational support to the community FAS Local drugs awareness & action group SPHE in secondary schools	Provide better social facilities for young people Improve education and health promotion in relation to drug and alcohol use for young people Provide confidential face-to-face service for young people Improve education and health promotion in relation to drug and alcohol use for adults Provide services for both at-risk and low-risk populations Improve educational opportunities for young people
Treatment & rehabilitation	Part-time addiction counselling Level 1 GP (for methadone) Community partnership project providing a variety of training and vocational support to the community Outreach worker FAS	Provide specific addiction services for under-18s Provide a local drop-in centre for young people and adults engaged in problem drug use Establish a local methadone treatment service and/or improve access to methadone treatment Provide confidential services appropriate to a small community Adjust treatment focus to include polysubstance use Increase the number of general practitioners providing methadone treatment Improve and expand existing addiction services Provide an out-of-hours service Provide support workers for people with addiction problems and their families Improve family support services Establish Narcotics Anonymous and Alcoholics Anonymous groups in the community Improve aftercare services for recovering users who have undergone treatment Provide outreach aftercare services (outreach worker has started since study began) Provide harm reduction services Improve advocacy for problem drug users Improve treatment and prevention services in prison Provide alternatives to custodial sentences Improve social reintegration activities: employment, housing, vocational support
Research		All issues are already known

* Note – not an exhaustive list

4 COMMUNITY B IN COUNTY LAOIS

4.1 Overview

This chapter presents the main results for Community B from the qualitative component of the study. The issues explored in the interviews and focus groups included: factors that contribute to the community drug problem; perceptions of the nature and extent of substance use in the community; consequences of drug use for the individual, their family and the community; perceptions of the response to the drugs problem, including any gaps in service provision identified by participants. Data from the National Drug Treatment Reporting System (NDTRS) on treated substance use in Co Laois (2004 and 2007) and CSO data on drugs and crime (2003 to 2006) are used to supplement the qualitative data.

4.2 Socio-demographic characteristics

Community B is a town in Co Laois with a population of between 10,000 and 15,000.[20] The population of the town, according to the CSO, increased by just over 25% between 2002 and 2006. Like many other towns in Ireland, the ethnic profile of the town has also changed in recent years. It is well served by public transport and some Government departments have been decentralised to the town.

The proportions of the workforce in this community in the professional, managerial and non-manual occupation categories were lower than those at both the county and national levels (Table 4.1). The occupation of almost one-quarter of those in the workforce was classed as unknown, which makes inferences difficult. The number of people signing on the unemployment register increased by nearly 70% between March 2007 and March 2008, according to the figures from the CSO. This follows the national trend of rising unemployment after several years of a relatively stable employment situation.[21]

Table 4.1 Workforce by occupational category, Community B, Co Laois and national, 2006

	Professional %	Managerial & technical %	Non-manual %	Skilled manual %	Semi-skilled %	Unskilled %	Other* %
Community B	4.6	19.5	17.8	17.5	13.3	5.1	22.2
Co Laois	4.8	23.8	20.1	22.0	14.4	5.7	9.3
National	6.9	26.3	20.1	19.4	13.7	4.7	8.8

* All others gainfully occupied, and those whose occupation was unknown
Source: CSO data 2006, based on those in the labour force

The overall rate of secondary level education in Community B was comparable to that at both the county and national levels (Table 4.2). The proportion of individuals who had a third-level qualification was slightly higher than both the county and national levels.

Table 4.2 Education levels, Community B, Co Laois and national, 2006

	Primary level* %	Lower secondary %	Upper secondary %	Third level %
Community B	14.3	19.6	23.1	17.8
Co Laois	16.4	19.8	26.1	10.7
National	15.2	17.0	23.8	15.6

* Includes those who had no formal education.
Source: CSO data 2006, based on persons aged 15 years and over whose full-time education had ceased. Percentages may not add up to 100% as not all categories are included

Housing is an important socio-demographic indicator. At 67%, the proportion of owner-occupied houses in the community was below both the county and national levels. The proportion living in local authority housing or renting privately was above both the county and national levels (Table 4.3). The proportion of single parent families (11.8%) in the community was similar to that at national level (11.6%) but slightly above the county level (10.8%).[20]

Table 4.3 Type of housing occupancy, Community B, Co Laois and national, 2006

	Owner occupied %	Local authority* %	Privately rented %	Other†/ unknown %
Community B	67.4	15.4	12.1	5.0
Co Laois	78.6	10.6	6.0	4.8
National	73.1	12.3	9.9	4.7

* Either rented from or being purchased from local authority
† Occupied rent free
Source: CSO data 2006

4.3 Factors contributing to the community drugs problem in Community B

Service providers, drug users and their families were interviewed to ascertain their perspectives on the main factors contributing to the drug problem in Community B. Their perspectives are based on a mix of personal experience and anecdotal information. The main factors that participants believed influenced the emergence and development of the drug problem in Community B can be grouped under five headings:

- Individual factors;
- Family context;
- Influence of peers;
- Community and structural factors;
- Ease of access to alcohol and drugs.

Individual factors

Individual factors were not commonly reported as playing a major role; however, in a small number of cases respondents admitted to or were perceived to use drugs for personal reasons. These included feeling that there was little else to do, to improve confidence in social settings, repeat the initial euphoria associated with using drugs and to reduce stress, as the following quotes illustrate.

> *The reason I do it [drink alcohol] is because there's nothing else to do.* (Participant 36, Recreational drug user)

Previous research has identified common factors in drug use as: having nothing else to do, seeking enjoyment, as a confidence booster and to relieve depression.[22 23] Similar findings were seen in the needs assessment carried out for the NERDTF in 2008.[28]

Family context

A number of service providers felt that some parents were tolerant of underage drinking and believed that it was better to allow their children to consume alcohol with their friends in the family home rather than exposing them to 'risky drinking' outside.

> *I would find [that] half the parents are quite happy to provide alcohol [to their children]...and let them drink...at home with their friends... the parents think that it is better that...they're...in the sitting room...having their few drinks [rather] than [being] out in the field and what will happen to them out there.* (Participant 44, Service provider)

The same parental attitude of latitude to cannabis use was noted. This can lead to the perceptions of normalisation of some drug use. Some participants had observed a cycle of inter-generational substance misuse and the impact of parental misuse on their children.

> *[The people in] Youthreach...ten or fifteen years ago...were using [drugs] then [and] are still using now. And what's worrying about that...is that their kids are coming to an age...and they're starting to use, and it's just a cycle and...there is a lot of trauma in a lot of the people's lives that would be using [drugs]. And that's the same families now as it was five or ten years ago.* (Participant 43, Service provider)

Intergenerational substance misuse

The influence of problematic substance misuse in the family is a well documented risk factor for the development of inter-generation problem substance use among family members.[24 25 27]

Influence of peers

Several participants spoke of peer pressure as a reason for people initiating drug use. The perception existed that the consumption of alcohol and drugs is a normal part of teenage life, that everyone is doing it and mainly in social groups.

> *It seemed to be the trend at the time [to drink and smoke cannabis]...all my friends were doing it...it seemed to be a cool thing at the time.* (Participant 74, Problem Drug User)

As far back as 1999, a study conducted in the Midlands with disadvantaged teenagers found similar results in relation to the influence of peers.[44] Additionally, a recent study completed in the neighbouring counties also reported that peers were instrumental in the initiation of substance use.[28]

Age was not necessarily a safeguard against peer pressure, according to one service provider, as he had seen people in their thirties taking cocaine for that reason. The influence of peers and environment on returning to problem drug use after a period of abstinence or treatment was highlighted by several participants. Some participants reported that in order to facilitate recovery from problem drug use, individuals need to change their friends and environment.

Community and structural factors

Some participants felt that poverty and inter-generational unemployment in the town contributed to the drug problem in the community. Early school leaving was implicated in developing drug use and criminal behaviour by some participants.

> *They're getting involved in crime, they're getting involved in drugs...most of the people involved in drugs...around town have not been in school, fell out of school, hanging around all day with the pals.* (Participant 45, Service provider)

One service provider spoke about the difficulties of trying to break the cycle of intergenerational poverty, unemployment and social exclusion. However, it was acknowledged by some participants that drug use was not confined to certain socio-economic groups or to certain areas within the town. Cocaine use was perceived as a coping mechanism for some people perceived to be more middle class.

Some service providers spoke of the negative attitudes of the community towards certain groups of individuals who are associated with alcohol and drug use in the town. They felt that the negative stereotyping by the community of these individuals had a big impact on their lives.

Ease of access to alcohol and drugs

The relative ease of access to drugs for all ages within the community was reported by most participants. This was felt to be one of the most important factors contributing to the spread of the problem.

> *They all know where to get it…Over 13 years of age they'd know where to get it.* (Participant 45, Service provider)

Reports from participants suggested that the local drug market was well established, with most types of drugs available in the community.

> *Anything – crack, heroin, coke, ecstasy, acid, speed, whatever you want…just ring a number and they will tell you where to go.* (Participant 74, Problem drug user)

Several participants spoke of the visibility of drug dealing in the community, not only in public areas but also around the treatment clinic and schools.

4.4 Perceptions of substance use in Community B

4.4.1 Extent of the problem

According to participants, alcohol and drugs were widely used in the community. Some service providers reported that problem use of alcohol was widespread. But there was no consensus as to whether alcohol or drugs was the more problematic substance.

> *I don't see a bigger problem with alcohol in [Community B] than I would in any other town. I see a way bigger problem with drugs than I would in any other town.* (Participant 55, Service provider)

Participants reported that most drugs were available in Community B. Young people reported that cannabis was the most common drug used in Community B. Heroin was also mentioned as a problem drug in the community. There was a perception among some participants that the consumption of drugs, especially of cannabis and heroin, had increased in the community.

> *Cannabis…it's very common…and the problem with cannabis…[is it] quite often…leads into the harder drugs.* (Participant 50, Service provider)

Type of drugs used in the community

According to NDTRS treatment data for Co Laois, of the 513 cases presenting for treatment between 2004 and 2007, the majority (59.8%) reported alcohol as the main problem substance, while the remaining two-fifths (40.2%) reported drugs as their main problem substance (Table 4.4). The most common main problem drug reported during the period 2004–2007 was opiates (31.8%), followed by cannabis (4.5%) and cocaine (2.7%). The number of cases reporting opiates as their main substance decreased from 52 in 2004 to 33 in 2007.

Table 4.4 Laois cases assessed or treated, by main problem substance, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	166	123	99	125	513
Drug	67 (40.4)	57 (46.3)	38 (38.4)	44 (35.2)	206 (40.2)
Alcohol	99 (59.6)	66 (53.7)	61 (61.6)	81 (64.8)	307 (59.8)
Opiates	52 (31.3)	47 (38.2)	31 (31.3)	33 (26.4)	163 (31.8)
Cannabis	10 (6.0)	5 (4.1)	4 (4.0)	4 (3.2)	23 (4.5)
Cocaine	1 (0.6)	4 (3.3)	2 (2.0)	7 (5.6)	14 (2.7)
Ecstasy	3 (1.8)	0 (0.0)	1 (1.0)	0 (0.0)	4 (0.8)
Benzodiazepines	0 (0.0)	1 (0.8)	0 (0.0)	0 (0.0)	1 (0.2)
Other	1 (0.6)	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.2)

There was a small increase in the numbers presented for treatment for cocaine and service providers had also noted the increase in the number of people over the past years.

Although some participants felt that there was a belief within the community that drug problems occurred only in disadvantaged areas among lower socio-economic groups, several service providers reported that drugs were used by all social groups in Community B.

One service provider reported that their younger clients were more likely to use amphetamines, however not exclusively as participants reported that young people aged under 18 years were also using heroin. The misuse of prescription drugs was reported by several participants. One participant spoke of the hidden nature of prescription drug use among women, which made it difficult to quantify the extent of their misuse.

> *I'd say maybe some of the young people that we deal with…their mothers…would be on repeat prescriptions. You would have a lot of women on repeat Valium [a benzodiazepine] prescriptions and quite heavy doses of it but…that's not coming to anybody's attention.* (Participant 43, Service provider)

This was the only community studied in which participants referred to the misuse of steroids among gym users and also the emergence of crack cocaine and crystal meth as new trends in drug use, although it was not yet widespread.

4.4.2 Substance use among young people

Participants reported that alcohol use was common among many of the young people. Access to alcohol did not appear to be difficult for young people, and a service provider speculated that some parents were happier to provide their teenage children with alcohol in the home because it was perceived to be safer than having them drink in public places.

> *I would find half the parents are quite happy to provide the alcohol…And let them drink them at home with their friends…And it's also, it's not just one or two cans, they will supply a party load of cans…so it will be getting drunk, it won't be having a couple of sensible drinks. And, [teenagers] 14 up…they're quite happy for that to be an alternative, [and parents think] sure isn't it better that I know they're in here in the sitting room…having their few drinks, than out in the field and what will happen to them out there.* (Participant 44, Service provider)

Many participants felt that cannabis, in particular, was widely available and its use normalised among young people. These perceptions of high prevalence of alcohol consumption among older teenagers and high levels of drug use among young people in general were also reported in a study conducted in the Midlands in 1999.[44]

As with alcohol, young people appeared to have easy access to a range of drugs. Several participants related anecdotes of young people experimenting with different types of drugs along with alcohol. There were reports that some young people in the community had developed a serious drug problem early in their lives, particularly due to the influence of peers. One service provider reported that there were different perceptions about whether there was a drug problem among teenagers living in Community B.

> *I was told by [a service provider] that he was told that there was no need to work with teenagers because there wasn't a [drug] problem with teenagers. There is a huge problem with teenagers.* (Participant 56, Service provider)

According to the NDTRS, between 2004 and 2007, 25 (4.9%) of cases from Co Laois were aged 17 years or under. Of the cases who reported alcohol as a problem substance, over two-fifths (43.0%) had started drinking before the age of 18 years. Of these, 68 (21.2%) reported their age at first use as 14 years or under. Age of first use was not reported by service providers for 42.7% of the cases. Of the cases living in Co Laois who reported a drug as a problem substance, three out of five (63.6%) had first used drugs before the age of 18 years and 93 (32.5%) before the age of 15 years.

4.4.3 Polysubstance use

Polysubstance use is seen very clearly in the NDTRS data for cases living in Co Laois. One-third of cases treated between 2004 and 2007 reported problem use of more than one substance. The number of polysubstance cases reported fluctuated over the reporting period (Table 4.5). Polysubstance use increases the complexity of such cases, and is associated with poorer treatment outcomes.[16]

Number of problem substances

Of the cases treated between 2004 and 2007, the majority (323, 66.1%) reported problem use of one substance only; 71 (14.5%) of two substances; 59 (12.1%) of three substances; and 36 (7.4%) of four substances. Table 4.5 presents the additional problem substances used by cases from Laois reporting problem use of more than one substance, by year treated. Cannabis, ecstasy, cocaine, alcohol, and opiates were the most common additional problem substances reported. Cannabis was top of this list in each of the four years. Ecstasy was the second most common additional substance in 2004 and 2005, and was replaced by cocaine in 2006 and 2007. Benzodiazepine use was reported by 8.4% of cases.

Table 4.5 Laois cases treated, by polysubstance use and additional problem substance(s) used, NDTRS 2004–2007

	2004	2005	2006	2007	Total
Additional problem drug(s) used*	**Number (%)**				
All cases	158	118	94	119	489
Reported one problem drug	104 (65.8)	72 (61.0)	66 (70.2)	81 (68.1)	323 (66.1)
Reported two or more problem drug	54 (34.2)	46 (39.0)	28 (29.8)	38 (31.9)	166 (33.9)
Of those reporting two or more problem drugs					
Cannabis	41 (75.9)	37 (80.4)	23 (82.1)	25 (65.7)	126 (75.9)
Ecstasy	24 (44.4)	14 (30.4)	9 (32.1)	3 (7.8)	50 (30.1)
Cocaine	17 (31.4)	11 (23.9)	10 (35.7)	11 (28.9)	49 (29.5)
Alcohol	5 (9.2)	7 (15.2)	2 (7.1)	12 (31.5)	26 (15.6)
Opiates	5 (9.2)	6 (13.0)	1 (3.5)	3 (7.8)	15 (9.0)
Benzodiazepines	5 (9.2)	4 (8.6)	0 (0.0)	5 (13.1)	14 (8.4)
Amphetamines	4 (7.4)	4 (8.6)	2 (7.1)	1 (2.6)	11 (6.6)
Others	1 (1.8)	1 (2.1)	1 (3.5)	0 (0.0)	3 (1.8)
Volatile inhalants	0 (0.0)	0 (0.0)	1 (3.5)	1 (2.6)	2 (1.2)

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

The association between main problem substance and additional substances among new cases entering treatment was examined for the period 2004 to 2007 (Table 4.6). Though the numbers were very small, the pattern of additional substances used was linked to the main problem substance. For example, where an opiate was the main problem substance the most common additional problem substances were cannabis (60.2%), followed by cocaine (21.5%) and ecstasy (16.1%), whereas where cannabis was the main problem substance the most common additional substance was alcohol (38.5%). Where cocaine was the main problem substance, the most common additional problem substances were alcohol (57.1%) and cannabis (57.1%). The combined use of alcohol and cocaine has serious health-related implications as research has shown that such consumption is highly cardiotoxic.[43]

Information about the combinations of substances used is important in terms of individual clients' care plans, and policy initiatives. The proportion of new cases reporting alcohol as an additional problem substance was relatively high (between 25.0% and 57.1%) except in cases reporting an opiate as their main problem substance. These data indicate a link between alcohol and illicit substance use.

Table 4.6 New Laois cases treated, by main problem substance and additional substance(s) used, NDTRS 2004–2007

	Opiates	Ecstasy	Cocaine	Amphet-amines	Cannabis	Alcohol
New cases	**93**	**4**	**7**	**1**	**13**	**165**
Additional problem substance(s) used*	**Number (%)**					
Opiates	1 (1.1)†				1 (7.7)	7 (4.2)
Ecstasy	15 (16.1)			1 (100.0)	1 (7.7)	12 (7.3)
Cocaine	20 (21.5)	3 (75.0)		1 (100.0)	1 (7.7)	5 (3.0)
Amphetamines	2 (2.2)	1 (25.0)				2 (1.2)
Benzodiazepines	5 (5.4)					3 (1.8)
Volatile inhalants						2 (1.2)
Cannabis	56 (60.2)	2 (50.0)	4 (57.1)			18 (10.9)
Alcohol	8 (8.6)	1 (25.0)	4 (57.1)		5 (38.5)	
Others		1 (25.00			1 (7.7)	

*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 substance.

4.5 Consequences of substance use

This section reports participants' perceptions of the consequences of problem alcohol and drug use in the community as they affect the individual, the family and the community.

4.5.1 Consequences for the user

The health-related consequences of alcohol and drug use were not reported in any depth; however, some participants did report some issues. One participant did report an incidence where the consequences of drug use were fatal.

> *P: I know...[some] young lads from our area...[who] committed suicide in the last [while]...they say they were on drugs...[and] they [were] in debt...and they're not able to cope with it.* (Participant 54, Family member)

Participants described the other personal consequences of problem drug use, including homelessness and loss of contact with children. Participants also reported that individuals who misused alcohol or drugs sometimes became involved in crime. It is not unexpected to find alcohol-related incidents in the community, as a recent nationwide study of Irish adults found that two out of five respondents had been injured, harassed or intimidated as a result of their own or someone else's alcohol use.[35]

4.5.2 Consequences for the family

The consequences of alcohol and drug use for family members were reported by many participants. Drug users and their families described the significant emotional impact of having a problem substance user in the family: the change of personality, the emotional burden, the stress and feelings of hopelessness that families can experience when they are in this situation.

A number of participants reported the emotional strain on families supporting a problem drug user through the treatment process, sometimes including home detoxification, often to see them relapse at the end.

> *He was on heroin...and I detoxed [him] on my own. I locked the doors and I cried and I watched him on his knees vomiting his guts up...* (Participant 51, Family member)

Participants spoke of the breakdown of relationships between the problem drug user and their relatives, and the emotional distress that this can bring to a family. Having a problem drug user in the family can affect a family financially, by putting it under pressure to pay off drug debts, for example. McKeown and Fitzgerald have reported on the physical, psychological and emotional burden on families of problem drug users.[34]

The stigma associated with drug use in small communities was highlighted by some participants; for example, the backlash or discrimination against family members of known drug users.

4.5.3 Consequences for the community

The consequences of alcohol and drug use for the community were reported by several participants. For example, a service provider reported that the community was affected badly by frequent alcohol-related public disturbances at the weekend. Drug-related crime was also reported as an issue.

> *He sold gear to feed his own habit...He robbed...he'd take your purse just for the money for heroin.* (Participant 51, Family member)

A participant commented that there were a number of areas in the town where it was known that heroin dealing took place. This was seen to cause both fear and frustration in the local community. The impact of crime and anti-social behaviour has been shown to cause significant harm to communities.[12]

4.6 Perceptions of the response to the problem, and gaps identified

This section reports the participants' perceptions of the response to the drug problem in Community B, presents data from the NDTRS in relation to cases from Co Laois seeking treatment, and summarises any gaps the participants identified or solutions they offered.

4.6.1 Drug treatment figures

The numbers attending for treatment in Co Laois fluctuated over the four years under review. The number attending for outpatient services halved between 2004 and 2007, from 114 to 54. The number attending residential services increased slightly, from 51 to 70. Overall, only five (1.0%) attended a general practitioner while for example, national figures show that approximately one-third of cases in methadone treatment attend their general practitioner for treatment.[17] The number of previously treated cases decreased from 100 in 2004 to 63 in 2007 (Table 4.7). The number of new cases decreased by 11%, from 56 in 2004 to 82 in 2007.

Table 4.7 Laois cases assessed or treated, by treatment status, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	166	123	99	125	513
Assessed only	8 (4.8)	5 (4.1)	5 (5.1)	6 (4.8)	24 (4.7)
Previously treated cases	100 (60.2)	69 (56.1)	51 (51.5)	63 (50.4)	283 (55.2)
New cases	54 (32.5)	48 (39.0)	43 (43.4)	48 (38.4)	193 (37.6)
Treatment status unknown	4 (2.4)	1 (0.8)	0 (0.0)	8 (6.4)	13 (2.5)

Source of referral

The most common source of referral of cases seeking treatment was self-referral (43.5%), followed by a hospital or medical agency (14.8%), and family (11.7%). The numbers of referrals from general practitioners and hospitals or other medical agencies decreased steadily, while the number of self-referrals increased by 60%, from 51 in 2004 to 82 in 2007.

Perceptions of type of addiction services provided

In general, participants did not distinguish between services provided by statutory and voluntary agencies either in the community or elsewhere. There is a methadone clinic in the community which has counsellors on site. Overall most participants felt there was a lack of services for people with addiction in the community.

> *I am finding it so hard to find help.* (Participant 76, Problem drug user)

Participants reported that people were searching for alternative treatment facilities outside the community, even looking to other countries, which highlighted the lack of services and treatment options in the community. Some service providers perceived that Community B was neglected and under-served compared to other towns and communities in the region. Participants felt that the drug situation was getting worse in the town, that the age profile of drug users was younger.

4.6.2 Overdose prevention and harm reduction – injecting drug use

Table 4.8 shows that 38 injector cases who lived in Co Laois entered treatment between 2004 and 2007.

Table 4.8 Laois cases treated, by injector status, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	158	118	94	119	489
Had injected	13 (8.2)	8 (6.8)	7 (7.4)	10 (8.4)	38 (7.8)
Never injected	144 (91.1)	110 (93.2)	87 (92.6)	107 (89.9)	448 (91.6)
Not known	1 (0.6)	0 (0.0)	0 (0.0)	2 (1.7)	3 (0.6)

Of all cases who reported ever having injected illicit (or licit) drugs, over one third (34.2%) reported that they started injecting before the age of 19. In total, 15 (39.5%) cases from Laois reported sharing injecting equipment, with the proportions fluctuating over the reporting period (Table 4.9).

Table 4.9 Laois injector cases treated, by equipment-sharing practices, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All injector cases	13	8	7	10	38
Shared equipment	5 (38.5)	3 (37.5)	4 (57.1)	3 (30.0)	15 (39.5)
Did not share equipment	7 (53.8)	5 (62.5)	3 (42.9)	7 (70.0)	22 (57.9)
Not known	1 (7.7)	0 (0.0)	0 (0.0)	0 (0.0)	1 (2.6)

These data on injecting drug use was supported by observations from the participants.

> *I: How many are injecting?*
>
> *P: ...how long is a piece of string? In [Community B], I'd say there is – injecting heroin, 40/50.* (Participant 46, Service provider)

There were also reports from the community of injecting paraphernalia being disposed of in public areas. Although changing risk behaviours in this particular group is known to be difficult, research suggests that Irish needle-exchange programmes have had some success in reducing the incidence of sharing. Research also points to a high prevalence of blood-borne viruses among treated drug users[38]; it is therefore probable that a proportion of injecting drug users in Co Laois are infected with at least one blood-borne virus.

4.6.3 Specific treatment issues

Methadone treatment

There is a methadone treatment clinic in Community B. Pharmacies in the community also participate in the programme and dispense methadone. Most participants stated that there was an excessive waiting list for methadone treatment. Participants expressed frustration at the difficulties of accessing the service, especially as some considered that the community had a significant opiate problem. Indeed, several participants felt that the numbers on the waiting list for methadone treatment did not reflect the actual need. This was because many opiate users felt there was no point in going on the list because it was so long. The clinic has to accommodate people not only from Community B but also from other towns and communities in the region.

> *There is too much waiting, they are telling you to come back but there's years waiting list in [the methadone clinic]. Some of us don't have a year. Some of my mates are hanging themselves ... overdosing.* (Participant 74, Problem drug user)

The consequences of the long waiting list for methadone treatment were illustrated by several participants: continuation of heroin use with all its associated health risks, missed opportunities to help problem opiate users on the pathway to recovery and risk of imprisonment.

NDTRS data show that just under one-third of cases from Co Laois assessed or treated between 2004 and 2007 were problem opiate users. A recent national study found that methadone treatment reduced use of both licit and illicit drugs, decreased injecting drug use, decreased criminal activity, and improved uptake of educational opportunities.[47]

Service providers commented that the long waiting times for access to treatment could be partially attributed to the extended periods of time that existing clients were remaining in treatment in the clinic. The length of time a person will need or want to stay on methadone treatment is unique to that individual and their recovery. However, participants felt that there were few alternatives for those wanting to move on from methadone treatment.

> *[Name of clinic]...sometimes I think is it even worth it? I mean there's people in there on methadone five years.* (Participant 56, Service provider)

However, as one service provider commented, methadone treatment is just one part of a suite of interventions and services that problem drug users require to assist them in their recovery. Participants also felt that there was not enough support for individuals on methadone and that methadone maintenance was not the only treatment for opiate addiction, which was not without its side effects. There was a stated need for alternative treatments, as not everyone wants to go on methadone. There were reports of individuals detoxifying at home without medical supervision, in the absence of an alternative to methadone.

Several participants highlighted the difficulties of finding support, even from general practitioners, in the community. Problem opiate users employ different ways to deal with the lack of services. There were reports of individuals buying street methadone to try to come off heroin as they could not access methadone through the authorised system.

Residential and detoxification treatment

Participants in this community did not differentiate between the different treatment models used in residential treatment centres and often used the terms residential and detoxification interchangeably. The types of residential treatment available differed, but most did offer detoxification as a treatment option. Most participants felt that there was a shortage of accessible residential treatment beds for people in

the community. Along with residential treatment, the need for aftercare following such treatment was highlighted by many participants.

> *I would like to see more help and more people there you can go and talk to, to try to get you into a clinic and detox you off it and stay in the clinic until you are clean...you are staying there and not in the environment of drugs. I would like to see something like that.* (Participant 75, Problem drug user)

The need for either community-based detoxification and/or counselling to prepare people for residential programmes was articulated. One example given was the need for an individual to be drug-free before being accepted into many treatment facilities and the difficulties of achieving that without support.

4.6.4 Social reintegration

Social reintegration for drug users has gained recognition over the years as a key aspect of drug treatment and recovery. Its components include the provision of education, training, accommodation and support to drug users.[39] Participants acknowledged the need for such a service in Community B.

> *Drug addicts aren't any different to everybody else in society. Just they have a drug habit...If you give them the respect that they deserve they will give you...that same respect back. And it's really about adapting them back into society.* (Participant 50, Service provider)

Employment is an important aspect of rehabilitation. NDTRS data show that two-fifths (42%) of cases assessed or treated between 2004 and 2007 were unemployed. The number of cases reporting that they were retired or unable to work on entry to treatment more than tripled from five in 2004 to 17 in 2007. The vast majority (91.6%) of those assessed or treated between 2004 and 2007 reported living in stable accommodation. Another service provider commented that although resources were being spent in the community, there was no focus on capacity building and not enough consultation had gone into the resource allocation.

4.6.5 Services for under-18s

Overall, participants felt that there was a serious lack of addiction treatment services and follow up for young people aged 17 and under.

> *Make no mistake, there is no service for teenagers...They can't go to [name of service], there's nothing for them. Apparently we have no teenage drug users...[as if] they start just at 18...Like that's what we're told, there's no teenage users...We have a [drug worker]...and I thought wonderful...But he's not allowed to work with teenagers...They were my priority because we could stop them [before the problem develops].* (Participant 56, Service provider)

Data from the NDTRS show that 5% of cases assessed or treated between 2004 and 2007 were 17 years or under. A further 7% were aged between 18 and 19 years. Some participants were worried about the negative consequences for young people who could not access services when they needed to. Another participant felt that the lack of services for adolescents left huge gaps in the system which the existing services attempted to fill. There were reports of families having to go outside the state looking for assistance and help with their child.

Parental responsibility

Service providers spoke about the need for parents to take more responsibility for their teenagers, as the normalisation and acceptance among the community of harmful substance use hinders service providers when trying to deal with the problem use of drugs or alcohol.

> *I think parents have lost sense of appropriate boundaries. And within some communities if you look*

out the window at ten o'clock any night...there'll be small kids out playing...up the town at twelve o'clock, that's normal. Up the town at two o'clock if you're a teenager is normal. (Participant 44, Service provider)

4.6.6 Family issues

Several participants reported that families were caring for their relatives with addiction problems, often without support.

There's just not enough support for families with drug problems. (Participant 54, Family member)

The NDTRS data show, two-fifths (41.9%) of cases seeking treatment reported living with their parents or family. Some families spoke of having to go alone to try and navigate through the addiction treatment services looking for help for their son or daughter (whether they are younger or older than 18 years).

Suggested solutions and responses

Overall services

Participants suggested that the existing services in the community, along with staff involved, needed to be expanded, improved and given more support and resources. One participant felt that there should be much more follow-up of people who enter treatment, with better communication between the different service providers to improve accountability of the services and the care of the person in treatment. Another participant felt that better communication would also help to prevent people falling through the cracks in the service. However, some participants expressed concern that in the current climate the resources needed to provide the required services would not be available.

Some service providers felt that many of the issues were already known to stakeholders, including the MRDTF, but that to date (time of data collection) nothing had been done, and again highlighted the dwindling amount of resources for all services. Several family members felt that there was the need for a permanent facility located in the community. This facility was generally conceptualised as a 'drop-in centre', ideally where integrated services, psychological, social and educational, and support could be provided for the person and their family.

There should be more drop-in centres for them...when they know they want help and they're asking for help the help should be there for them. Like seen to straight away and they get help straight away. I mean you see on the news as I said there is young ones hanging themselves, they were pulling them out the rivers, this that and the other. And it's all down to drugs. I am living down in the community... and I know that there's several children...after doing away with themselves. (Participant 54, Family member)

Methadone

The facilities at the existing methadone clinic were felt to be inadequate for the current client numbers, and in need of refurbishment before any expansion of the service could be considered.

Well it's [treatment clinic] too small for the community...that's affected. The premises would need to be completely renovated...because...if...Health and Safety went into that premises they would close it down. Male and female are using the same toilet. The toilet facilities are appalling. The whole place is just ramshackle and practically falling down. (Participant 50, Service provider)

Participants noted that the clinic was under-staffed and any expansion of the client numbers would need to be covered by the appropriate staff quota, including medical staff and counsellors. Participants highlighted the need for trained general practitioners in communities to provide methadone treatment, which would allow clients to move out of the clinics, which would help alleviate some of the problems with

the current service.

Under 18s

Specific youth addiction services were felt to be badly needed in this community. Several participants commented that, of the addiction services that existed, many could not cater for, or were not suitable for, young people under the age of 18. In addition, participants stressed the importance of recognising early signs of use, and of early intervention to prevent exacerbation of such problems.

> *I think the [biggest] gap in drug...services around here is early intervention...You can't keep denying that the kids are not doing drugs...they might not be manic heroin users, [but] they're smoking hash on a regular basis and you need early intervention...If people aren't going to work with teenagers they're not going to get rid of this heroin problem or the hash problem or the cocaine problem.* (Participant 55, Service provider)

Service providers felt that new and different education strategies and health promotion programmes were needed to teach young people about problem drug and alcohol use, and that what was currently being provided was not given early enough or was not effective. SPHE is offered as part of the curriculum up to third year in secondary school. Service providers felt very strongly that young people who fell out of the mainstream education system or who did not fit into the system should be offered viable alternatives to remain in some sort of education.

Some young people from the community have access to Youthreach, which is part of the Government's programme of second-chance education aimed at early school leavers aged between 15 and 20 years. However, some participants had reservations about the effectiveness of that programme.

Data from the NDTRS supported the perception of an association between early school leaving and drug use. The number of Co Laois cases who had left school aged 14 years or under increased from 17 in 2004 to 26 in 2007; only 82 (16.0%) had completed leaving certificate level.

One service provider spoke about the need for more parental awareness or education about assisting their child with substance abuse problems. Participants highlighted the need for viable alternative activities for young people in the community to keep them away from substance abuse.

Families

Participants highlighted the need for adequate support services for families affected by drug use, as many had been struggling alone to cope with the problems of their relatives.

> *They should have a counsellor. They should have someone they can talk to ...parents are not able to talk because we're so hurt and we're trying too hard. We think 'Oh he'll stop because mummy wants him to stop'.* (Participant 51, Family member)

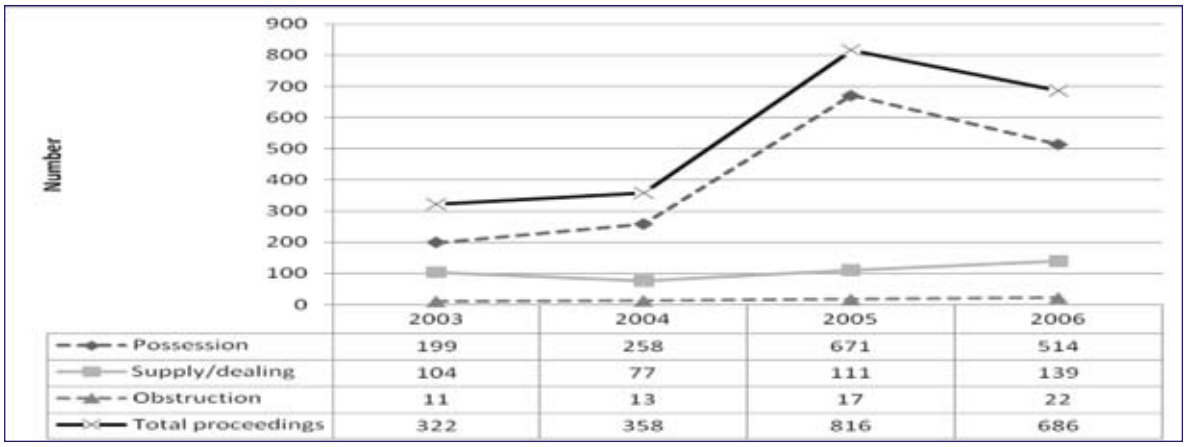
4.7 Drug-related crime in counties Laois and Offaly

This section brings together statistics (from the CSO) on drug-related crime for the Laois/Offaly Garda Division from 2003 to 2006 and the qualitative data on perceptions about crime in Community B. Again, it is important to stress that these data are primarily a reflection of the activities and effectiveness of the gardaí rather than of the availability of drugs or the incidence of drug-related crime.

4.7.1 Proceedings for drug offences in Laois/Offaly Garda Division

Figure 4.1 presents the main drug offence proceedings for the Laois/Offaly Division from 2003 to 2006.

Possession offences accounted for the majority of proceedings in the four years. In 2006, of the total drug offence proceedings in the division, three-quarters (74.9%) were for possession. A higher number of drug supply offences took place in the Laois/Offaly Division compared to Longford/Westmeath. Though the numbers are small, there was a steady increase in obstruction offences between 2003 and 2006.

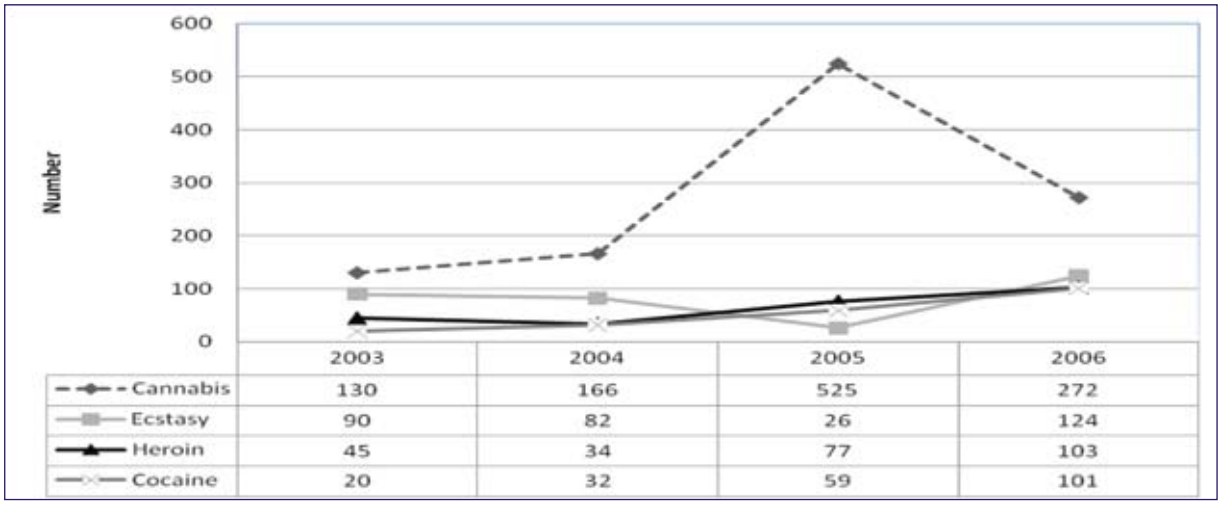


	2003	2004	2005	2006
Possession	199	258	671	514
Supply/dealing	104	77	111	139
Obstruction	11	13	17	22
Total proceedings	322	358	816	686

Figure 4.1 Drug offence proceedings, by main offence type, Laois/Offaly Garda Division 2003–2006

4.7.2 Proceedings for possession, by drug type

Figure 4.2 shows that the majority of possession proceedings were for cannabis. There was a sharp rise in proceedings for possession of ecstasy from 26 in 2005 to 124 in 2006. This trend was also observed in the Longford/Westmeath Division for the same year. Proceedings for heroin possession doubled in the Laois/Offaly Division between 2003 and 2006. There was a consistent rise in the number of proceedings for cocaine possession between 2003 and 2006 which follows the same trend as seen nationally. Until recently, heroin was available mainly in Dublin; however the increase in heroin-related offences is an indication that the heroin market has spread outwards from Dublin.



	2003	2004	2005	2006
Cannabis	130	166	525	272
Ecstasy	90	82	26	124
Heroin	45	34	77	103
Cocaine	20	32	59	101

Figure 4.2 Proceedings for possession, by drug type, Laois/Offaly Garda Division 2003–2006

4.8 Perceptions of drug use and crime in Community B

Participants spoke of both types of drug-related crime: drug offences committed in contravention of specific drug laws, for example possession or supply, and offences related to drug use or activity, for example

robberies to fund drug use. One participant felt that some young people turned to drug dealing as a way to make easy money. The recidivistic nature of drug-related crime was evident from the reports, and the victims were often the families of problem drug users. Participants also reported alcohol-related crimes, both violent and non-violent, took place in this community.

Participants reported that although drug dealing was very visible in certain areas of the community, the local people were afraid to do anything about it for fear of (violent) retribution.

> *And it is frustrating...there's a sense of...how can they be getting away with it all the time? But also... there's the fear. So, nobody within the community will willingly give information either because they're terrified their windows will be put in...there's serious ramifications, there's serious fear.* (Participant 43, Service provider)

Most participants felt that the gardaí were doing their best, with limited resources. From the other perspective, some participants felt that problem drug users were often unfairly targeted by the gardaí. Service providers commented on the difficulties of working to build and maintain trust within the community, and balancing that with working with the gardaí.

Participants spoke about the need for alternatives to custodial sentences for people with addiction problems. In addition, having an alternative was seen to be important as prison was perceived to be exacerbating drug problems.

> *They're able to get heroin in [prison]...The system that's supposed to be rehabilitating our kids are actually feeding them [drugs]...I would beg a judge not to put a child into a prison. I would beg him to put him into a drug centre... Loads of them will tell you 'my son went in clean'. Now in saying they went in clean they might have been taking hash or pills...But they come out of it on heroin or they come out of it selling and then go on it.* (Participant 51, Family member)

Conversely, there were reports from participants about people choosing to go to prison because they felt it was the quickest route to get treatment. Ten per cent of referrals of cases from Laois in the NDTRS were from the justice system.

4.9 Key findings – Community B

Community B is a medium-sized town in Co Laois. Although the community has good levels of educational attainment it has seen a rise in unemployment in recent times.

Factors contributing to the problem

The individual factors contributing to alcohol and drug use included teenagers having nothing else to do, enjoyment and to relieve depression. Previous research has identified these as common factors in drug use.[22 23] Similar findings were also seen in the needs assessment carried out in the North Eastern Regional Drugs Task Force in 2008.[28]

Alcohol, illicit and licit drugs were reported as being misused in the community. However excessive or problematic alcohol consumption appeared to be accepted as normal within the community, both among teenagers and adults. There were different opinions as to whether drugs or alcohol was the more problematic substance in the community. It was felt that the community had experienced a drug problem for some time and that the situation was getting worse.

Within the family, tolerance of substance use by other family members, especially parents, was felt to

facilitate substance use problems among their teenage children. The influence of problematic substance use in the family is a well documented risk factor for the development of inter-generation problem substance use among family members.[24 25 27 28]

It emerged that initiation into alcohol or drug use frequently occurred in the context of socialising with peers. As far back as 1999, a study conducted in the Midlands with disadvantaged teenagers found similar results.[44] In addition, a recent study completed in the neighbouring counties reported that peers were instrumental in initiation of substance use.[28] The continued use of alcohol and drugs and the accessibility of these substances were facilitated by peers, which suggests that peer groups enable the normalisation of drug use. Participants felt that removal from the sphere and influence of drug-using friends was necessary in order to successfully recover from problem drug use.

One theory for the normalisation of drug use suggests that it cannot develop without ease of accessibility to illicit drugs. Parker *et al.* (2002) noted that easy accessibility near the point of consumption is not primarily a product of aggressive drug dealing, as many young people obtain their drugs through social networks and friends-of-friends chains connected to small dealers.[32] All participants reported that the relative ease of access facilitated substance use among young people and adults in Community B. Accessing alcohol and drugs via peers is a well documented experience in this country.[28-30] Teenagers and young people appeared to be able to access both alcohol and drugs relatively easily, often through friends and their social circle. Many participants felt that improved services for young people were needed, including drug awareness and assistance for early school leavers, along with a general initiative to provide appropriate alternative social activities.

Participants felt that there had been an increase in heroin use in the community, along with reports of sharing needles. The waiting list for the methadone clinic was reported to be excessively long by all participants, and it was acknowledged that opiate users had even stopped presenting to the service because of this. This may partially explain the decrease in the number of cases treated in Co Laois between 2004 and 2007, despite the fact that heroin was seen as a growing problem in the community.

Consequences of substance use

The harmful consequences of problematic substance use were acknowledged by the participants: physical and mental health problems, emotional distress, financial problems, breakdown of family relationships, crime, violence and drug-related deaths.

Perceptions of the response to the problem, and gaps identified

The need to improve and expand all the existing addiction services, including the methadone clinic, was identified by all participants, who felt that the existing services could not cope with the current level of substance use problems. The lack of general practitioners providing services was highlighted as an issue. In particular, improved access to residential treatment, including detoxification facilities with adequate provision of aftercare were deemed important. The lack of services for under-18s was also identified. Polysubstance use was common in the community and services need also to take this issue into consideration. A mobile needle exchange began in the community in late 2008 which should address some of the issues around needle sharing.

There appeared to be a very busy and visible local drug market in certain areas in the community, with a range of licit and illicit drugs available. This was perceived as facilitating the continued use of drugs in the community. Studies have shown that retail illicit drug markets can create immense problems for local communities, particularly in relation to drug-related crime and nuisance and the fear of victimisation

which can become associated with local drug markets.[36 37 46] This has created an atmosphere of fear and intimidation among some of the local people, as well as frustration, as the perception is that nothing is being done about the problem. However, most participants felt that the gardaí themselves were doing their best, considering their limited resources. As imprisonment was felt to exacerbate, or even to be instrumental in initiation of, problem drug use, the need for alternatives to custodial sentences was raised.

4.9.1 Participants' recommendations for service provision in Community B

Table 4.10 presents the participants' recommendations for service provision in Community B, summarised under the pillars of the National Drugs Strategy 2001–2008.

Table 4.10 Participants' recommendations for service provision in Community B

Pillar	Existing services provided in community*	Suggested response
Supply Reduction	Community gardaí	Address the visible drug dealing in the community
Prevention	Youth Diversion project Youth Reach (not based in community) FAS Community action project Local drugs awareness & local drug network groups SPHE in secondary schools	Build on existing successful youth projects and develop additional youth programmes Provide extra support/intervention (both educational and vocational) for young people who fall out of the system Improve education on drug use for young people Improve early recognition and intervention in cases of problem substance use among younger people Provide better social facilities for young people
Treatment & rehabilitation	HSE addiction services including methadone clinic Level 1 GP(s) Adult counselling service Outreach worker Mobile needle exchange Alcoholics Anonymous Community action project FAS	Provide addiction services for under-18s Provide suitably trained staff who can work with drug users aged under 18 Improve education and health promotion for young people on drugs Improve early recognition and intervention in cases of problem substance use among younger people Provide permanent accessible facility, such as a "drop-in", for the community, including drug users and their families Improve and expand existing addiction services, including methadone clinic Address lengthy waiting list for methadone treatment Address polysubstance use in the treatment services Provide better support for drug users and their families in the community Recruit additional general practitioners into methadone treatment in the community Provide alternative addiction treatment, particularly for individuals who are long-term on methadone Improve access to residential treatment Improve access to detoxification treatment Improve communication between clients, their families and service providers Provide harm reduction services (mobile needle exchange has started since study began) Improve treatment and prevention services in prison Improve support for families of problem substance users Improve social reintegration services: housing, educational and vocational support Improve aftercare services for problem substance users who have gone through treatment to help prevent relapse Provide alternatives to custodial sentences
Research		All issues are already known

* Note – not an exhaustive list

5 COMMUNITY C IN COUNTY LONGFORD

5.1 Overview

This chapter presents the main findings for Community C from the qualitative component of the study. The issues explored in the interviews and focus groups included: factors that contribute to the drugs problem in the community; perceptions of the nature and extent of substance use in the community; consequences of drug use for the individual, their family and the community; perceptions of the response to the drugs problem, including gaps in service provision identified by participants. Data from the National Drug Treatment Reporting System (NDTRS) on treated substance use in Co Longford (2004 and 2007) and CSO data on drugs and crime (2003 to 2006) are used to supplement the qualitative data.

5.2 Socio-demographic characteristics

Community C is a small town in Co Longford with a population of between 5,000 and 9,999.[20] The population of the town has increased by 12% between 2002 and 2006. It has seen some change in its ethnic mix over recent years, as have many parts of the country.

The occupations of over one-quarter of the workforce in Community C were classed as unknown, therefore making inferences difficult. The proportions in the professional, managerial and non-manual occupation categories were lower than those at both the county and national levels (Table 5.1). Between March 2007 and March 2008 there was an increase of almost 35% in the number of people in Community C signing on to the live register. This follows the national trend of rising unemployment after several years of a relatively stable employment situation.[21]

Table 5.1 Workforce by occupational category, Community C, Co Longford and national, 2006

	Professional %	Managerial & technical %	Non-manual %	Skilled manual %	Semi-skilled %	Unskilled %	Other* %
Community C	3.7	17.5	14.7	17.4	13.5	5.9	27.3
Co Longford	4.0	21.7	18.2	22.6	15.1	5.8	12.5
National	6.9	26.3	20.1	19.4	13.7	4.7	8.8

* All others gainfully occupied, and those whose occupation was unknown.
Source: CSO data 2006, based on those in the labour force

Community C had slightly higher rates of primary and secondary level education than those at the county and national levels (Table 5.2). The proportion of individuals who had a third-level qualification was above that at the county level and comparable to that at the national level.

Table 5.2 Education levels, Community C, Co Longford and national, 2006

	Primary level* %	Lower secondary %	Upper secondary %	Third level %
Community C	20.0	19.3	18.7	14.1
Co Longford	19.4	18.4	24.6	10.1
National	15.2	17.0	23.8	15.6

*Includes those with no formal education.
Source: CSO data 2006, based on persons aged 15 years and over whose full-time education had ceased. Percentages may not add up to 100% as not all categories are included.

In 2006, the proportion of owner-occupied houses in this community was well below both the county and national levels (Table 5.3). The proportion of households in local authority housing was almost twice that at the county level and two-and-a-half times that at the national level. The proportion of single-parent households in this community was almost one fifth (17.2%), which was considerably higher than both the county level (12.6%) and national level (11.6%).[20]

Table 5.3 Type of housing occupancy, Community C, Co Longford and national, 2006

	Owner occupied %	Local authority* %	Privately rented %	Other†/ unknown %
Community C	47.6	30.4	15.8	6.2
Co Longford	70.4	16.5	7.6	5.6
National	73.1	12.3	9.9	4.7

* Either rented from or being purchased from local authority.
† Occupied rent free.
Source: CSO data 2006

5.3 Factors contributing to the drugs problem

This section provides an analysis of the qualitative data and reports on the main factors contributing to the emergence of a drug problem in Community C. Service providers, drug users and their families were interviewed. Their perspectives are based on a mix of personal experience and anecdotal information. The main factors that participants believed influenced the emergence and development of the drug problem in Community C can be grouped under five headings:

- Individual factors;
- Family context;
- Influence of peers;
- Community and structural factors;
- Ease of access to alcohol and drugs.

Individual factors

A number of individual factors were reported as contributing to the drugs problem in the community. Some young people who took part in the study were of the view that experimentation with alcohol and drugs was triggered by curiosity and, to a lesser extent, by boredom and enjoyment.

I: Why do you think people actually start to use alcohol and drugs?
P64: I think it's just by choice, it's just curiosity
P66: [They're] bored... (Participants 64 and 66, Non-drug-using minors)

A large survey of secondary school pupils in Co Longford in 2003 found that the main reasons for taking drugs were curiosity (24%), fun (20%) and boredom (15%).[48] However, a service provider did not completely agree with this and felt that lack of parental supervision was a factor in young people using drugs. Financial considerations were reported as a factor mediating drug use, but lack of money was not considered an insurmountable obstacle.

The misuse of alcohol, and occasionally licit drugs, as a way of coping with a variety of personal problems including low self-esteem, emotional difficulties and depression was described by several participants. Traumatic life events were reported as a factor contributing to problematic alcohol or drug use in adult life.

Family context

Participants reported on many aspects of family life in the community that they felt influenced the

development of substance use and related problems. For example, participants reported that some young people initiated alcohol and drug use in the company of family members or, indeed, that it was tolerated by family members

> *I grew up in an alcoholic home…my mother was an alcoholic…my dad was an alcoholic…he was violent towards everyone in the family…It was acceptable to drink at a very young age…[at] 13, 14. Drugs were acceptable [too]…I had taken [drugs] in front of my parents.* (Participant 31, Problem drug user)

Intergenerational substance misuse

Others reported a direct association between their parents' problem substance use and the development of their own substance misuse and related problems in adulthood. Problematic substance use in the family is a well-documented risk factor for the development of problematic substance use in an individual.[25-27 49] This factor also emerged in the recent study conducted in the North East Regional Drugs Task Force (NERDTF) area.[28]

Influence of peers

For a number of drug users, the initial encounter with illicit drugs and their subsequent use of such drugs took place in the context of socialising with their peer group. Younger participants spoke of the perception that 'everyone else' was drinking and that this was a normal social activity among young people, and was relatively risk free. In addition, the easy availability of a range of drugs appeared to endorse a perception of 'normality'.

> *'Everyone else does it' …one of the things about drugs, they're all out there, they're on the menu…A lot of [problem drug users] would say…[that they]…started with…alcohol first then cannabis, then ecstasy…the next thing they will tell you [that] for a long time, 'There's no way I'd do heroin.' But then…the next thing they're doing it.* (Participant 26, Service provider)

Drug use appeared to be normalised to such an extent among some young people that they did not consider that there were any risks attached to it.

The 2003 survey of Longford students also found that friends were the main source of drugs.[48] The perception that 'everyone is doing it' helps to shape the belief that this was normal behaviour.[32] Research by Parker and colleagues suggests that easy accessibility is not necessarily a product of aggressive drug dealing, as many young people obtain their drugs through social networks connected to drug dealing.[32]

The 'wrong crowd' was frequently blamed for facilitating drug use among young people. However, there was no explanation of who comprised this 'wrong crowd' other than that they were young people who drank and took drugs. However, not all young people reported succumbing to overt peer pressure, but this seemed very much to depend on the individual and, again, on the 'crowd' that they mixed with.

Returning to drug use

The influence of peers was seen as a factor which facilitated the resumption of problem drug use by former users, and many participants felt that it was necessary for recovering drug users to change their friends, social scene, and even community if they wanted to remain drug free.

Community and structural factors

There are indicators of social deprivation in this community including low levels of owner-occupied housing and a high proportion of single parent families (see Section 5.2). Community factors were not commonly reported as playing a major role in the development of the alcohol and drugs problem.

Some service providers felt that the drug problem was impacting on the community by creating a sense of fear and intimidation in some parts of the town.

> *I wouldn't think you would have situation of no-go areas. You would have areas where many people would be fearful. There would be a fair degree of knowledge about who was dealing drugs and who was living where. So there would be areas where people would not go into. But there would not be complete blanket no-go areas....* (Participant 59, Service provider)

Another service provider reported that this fear among the local population led to some people not reporting any drug-related incidents that they might witness.

Ease of access to alcohol and drugs

The relatively easy access to alcohol and illicit drugs within the community was reported by all participants as one of the most important factors contributing to the spread of the problem. Drugs mentioned ranged from prescription drugs, cannabis, ecstasy, cocaine, crystal methamphetamine and heroin.

> *Oh, very easy to get [drugs] around here...you just ask anybody, [they'll] get it.* (Participant 28, Family member)

Age was not reported as a deterrent for accessing alcohol and illicit drugs, and young people reported that it was easy to get both in the community, often through friends. The sale of cheap alcohol through a range of outlets was reported as a factor contributing to its accessibility.

Participants stated that the local drug market was able to supply a wide range of drugs; however, drugs such as heroin or street methadone were not always available in the community. Participants reported that drug users would travel elsewhere to buy them. However, the availability of drugs was not confined to the community and recreational settings, it was also the view that drugs were accessible around schools.

5.4 Perceptions of substance use in Community C

5.4.1 Extent of the problem

Participants reported that alcohol and drug consumption was widespread in the community. One service provider felt that that drinking patterns had changed, with binge drinking more prevalent, perhaps due to peer pressure and an increase in economic wealth. There was disagreement as to whether problem alcohol use or problem drug use was the biggest issue in the community, however many participants felt that heroin was currently a significant drug problem in the town.

> *A lot of [people], that I know are on gear now, they are on heroin...That's one thing the town is riddled with now.* (Participant 57, Recreational drug user)

Some services providers felt that there were serious alcohol problems among young men but also women in the community. This is supported by data from the NDTRS data, 332 cases living in Co Longford presented for assessment or treatment in the period 2004–2007. The numbers increased steadily over the reporting period. Of the 332 cases, almost three-quarters (72.9%) reported alcohol as the main problem substance (Table 5.4). The percentage of such cases increased over the four years.

Some participants reported that there was a perception that drug and alcohol use was confined to a number of particular areas in Community C, whereas they felt that, in reality, drug use was more widespread within the community. Some participants felt that drug use was not confined to the lower socio-economic population.

> *I have a teenager [under 16]...and [he] has told me the boys that he knows [who] are on drugs, his age and younger, [are] from...good areas and middle-class families. I am stunned because [they] are*

coming from, as I would class, very stable homes. Good families, parents that have been there for them. (Participant 30, Problem drug user)

Type of drugs used in the community

Service providers felt that the type of client attending their service had changed over the years, from individuals seeking treatment for cannabis use, to those seeking treatment for problem use of alcohol and a wider variety of drugs, including heroin. This is also supported by figures from the NDTRS. The main problem drug most commonly reported by cases seeking treatment was an opiate (13.8%). This was followed by cannabis (7.8%) and cocaine (2.7%) (Table 5.4). The number of cases presenting with opiates as their main problem substance increased over the period, from one in 2004 to 23 in 2007.

Table 5.4 Longford cases assessed or treated, by main problem substance, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	56	82	85	109	332
Drug	9 (16.1)	22 (26.8)	23 (27.1)	36 (33.0)	90 (27.1)
Alcohol	47 (83.9)	60 (73.1)	62 (72.9)	73 (66.9)	242 (72.8)
Opiates	1 (1.8)	4 (4.9)	18 (21.1)	23 (21.1)	46 (13.8)
Cannabis	6 (10.7)	12 (14.6)	4 (4.7)	4 (3.6)	26 (7.8)
Cocaine	0 (0.0)	3 (3.6)	1 (1.1)	5 (4.5)	9 (2.7)
Benzodiazepines	0 (0.0)	3 (3.6)	0 (0.0)	2 (1.8)	5 (1.5)
Ecstasy	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.9)	1 (0.3)
Other	2 (3.6)	0 (0.0)	0 (0.0)	1 (0.9)	3 (0.9)

The increase in the numbers seeking treatment shown in the NDTRS data is supported by the perception among some of the participants that drug consumption in the community had increased and was continuing to rise. This view that there is an increasing alcohol and drug problem in the community was based on the perception of an increase in the visibility of consumption of alcohol and drugs, in drug dealing, and in the demand for services. However, participants were aware that the increase in drug use was not a situation unique to their town but was seen elsewhere in the country. There were only a few individuals who presented for treatment for benzodiazepines as their main problem drug.

Service providers did report misuse of prescription drugs in the community, but had differing views as to the extent of the problem. But there were several reports of how prescription drugs were being used as a commodity by drug users, and being sold to raise funds for their drug of choice.

Changes in patterns of substance use

Participants observed changes in the patterns of alcohol and drug use over time; for example, there was a suggestion that drinking was now confined to the weekends and that people were choosing to drink at home more. The progression from alcohol use to recreational drug use, and then to problem drug use was described by several participants.

Despite this perception that alcohol and drug use is increasing in Community C, a service provider reported that some senior community members maintain that there is no such problem, and suggested that they do this because of fears that business will be affected if the extent of the problem becomes widespread knowledge.

Attitudes towards substance users

Most participants felt that there was a negative view of problem drug users in the community. This view manifested in a number of ways. For example, there was the perception that crimes were often committed by people who were under the influence of drugs. Overall, alcohol use was seen as more acceptable than drug use, other than cannabis use, which seemed to be normalised behaviour among some people.

A group of problem drug users speculated that some community members denied that there was an illicit drug problem. They suggested that one of the reasons for this was a negative perception of illicit drug users. In addition, they reported that problem alcohol users were not perceived negatively because the use (or misuse) of alcohol was normalised within the community.

> *[Community C] sweeps [drug problems] under the carpet like. If you mention a needle exchange [there would be] politicians...out complaining...[saying] we don't have a drug problem. And even now my own [relative]...would have known I was an intravenous user, if he heard of a needle exchange, 'Oh sure ... "a needle exchange" he'd go crazy like...They don't want to acknowledge that there is a severe problem in [Community C]. They...maybe will accept alcohol or...an alcoholic but they don't want to think about junkies.* (Participant 31, Problem drug user)

The consequences of such perceptions have implications for the social reintegration of drug users in their community.[50]

5.4.2 Substance use among young people

Most participants felt that the use of alcohol and, to a lesser extent drugs, was a common experience among many young people, often starting at a young age. Participants reported an increase in the consumption of alcohol among teenagers. There were also reports that teenagers used a range of drugs in the community, including cannabis, and ecstasy, with some reporting that young people smoked heroin.

> *I was around 15 I suppose or maybe I was 16 in [Community C]. That's when I started smoking hash... like, 12, 13-year-old boys; they're smoking hash.* (Participant 57, Recreational drug user)

Some of the young people gave the impression that drinking was acceptable and 'normal' behaviour. The use of cannabis was also seen as normal among some groups, while one participant felt that some parents were unaware of that their teenaged children used alcohol and drugs. There were also suggestions that the provision of alcohol-free activities for teenagers was not always successful in preventing young people using alcohol, and to a lesser extent, drugs.

The consequences of alcohol and drug misuse were clearly illustrated by young people. The progression of a young person from alcohol to drugs, and eventually to injecting drug use, was described by several participants.

NDTRS data show that 242 cases living in Co Longford were treated for problem alcohol use in the years 2004–2007. Over two-fifths (46.5%) reported their age at first use as under 18 years and 36 (14.2%) reported their age at first use as 14 years or under. Age of first use was not reported by service providers for 23.6% of cases. Of the 90 cases living in Co Longford who were treated for problem drug use, three out of five (59.3%) reported their age at first use as under 18 years, and 32 (21.3%) reported their age at first use as 14 years or under.

5.4.3 Polysubstance use

Overall, the data show that a range of drugs was available, accessible and consumed in the community. Perceptions were varied on the nature and extent of this consumption, but they pointed to polysubstance

use as possibly an emerging if not an established phenomenon.

> *I would say there are as many alcoholics as there are drug addicts, but then you'd have the addict that is using both...drugs and...booze.* (Participant 58, Problem drug user)

Polysubstance use can be understood as the practice of taking one or more drugs in combination, or of consuming a range of drugs over a lifetime. Polysubstance use among cases living in Co Longford is seen very clearly in the NDTRS data. One-quarter (24.8%) of cases treated between 2004 and 2007 reported problem use of more than one substance, with the annual number doubling from 12 in 2004 to 25 in 2007 (Table 5.5). Table 5.5 also presents the additional problem substances used by those reporting problem use of more than one substance, by year treated. Between 2004 and 2007, cannabis, alcohol, ecstasy and opiates were the most common additional problem substances reported by all cases entering treatment. Cannabis was most common, but was replaced by alcohol in 2007.

Table 5.5 Longford cases treated, by polysubstance use and additional problem substance(s) used, NDTRS 2004–2007

	2004	2005	2006	2007	Total
Additional problem substances(s) used*	**Number (%)**				
All cases	625	532	587	705	2449
Reported one problem drug	42 (77.8)	59 (74.7)	61 (73.5)	78 (75.7)	240 (75.2)
Reported two or more problem drug	12 (22.2)	20 (25.3)	22 (26.5)	25 (24.3)	79 (24.8)
Of those reporting two or more problem drugs					
Cannabis	6 (0.9)	12 (2.2)	13 (2.2)	13 (1.8)	44 (1.7)
Alcohol	2 (0.3)	3 (0.5)	4 (0.6)	9 (1.2)	18 (0.7)
Ecstasy	3 (0.4)	5 (0.9)	5 (0.8)	4 (0.5)	17 (0.6)
Opiates	2 (0.3)	2 (0.3)	4 (0.6)	2 (0.2)	10 (0.4)
Cocaine	0 (0.0)	2 (0.3)	1 (0.1)	6 (0.8)	9 (0.3)
Benzodiazepines	1 (0.1)	1 (0.1)	3 (0.5)	1 (0.1)	6 (0.2)
Amphetamines	2 (0.3)	1 (0.1)	0 (0.0)	2 (0.2)	5 (0.2)
Other	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.1)	1 (0.0)

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

The association between main problem substance and additional substances used by new cases entering treatment was examined for the period 2004 to 2007 (Table 5.6). Though the numbers were very small, the pattern of additional substances used was linked to the main problem substance. For example, where an opiate was the main problem substance the most common additional problem substances were cannabis (40.0%), followed by alcohol (15.0%) and ecstasy (10.0%), whereas where cannabis was the main problem substance the most common additional substances were alcohol (31.3%), ecstasy (25.0%) and cocaine (12.5%). Where cocaine was the main problem substance, the most common additional problem substances were cannabis (80.0%), alcohol (60.0%) and ecstasy (40.0%). The combined use of alcohol and cocaine has serious health-related implications and research has shown that such consumption is highly cardiotoxic.[43]

Information about the combinations of substances used is important in terms of individual clients' care plans, and policy initiatives. The proportion of new cases reporting alcohol as an additional problem substance was relatively high (between 33.1% and 60.0%) except in cases reporting an opiate as their main problem substance. These data indicate a link between alcohol and illicit substance use. Polysubstance use also increases the complexity of cases, and is associated with poorer treatment outcomes.[16]

Table 5.6 New Longford cases treated, by main problem substance and additional substance(s) used, NDTRS 2004–2007

	Opiates	Ecstasy	Cocaine	Amphet-amines	Cannabis	Alcohol	Other
New cases	**20**	**1**	**5**	**3**	**16**	**111**	**2**
Additional problem substance(s) used *	**Number (%)**						
Opiates				2 (66.7)	1 (6.3)	1 (0.9)	
Ecstasy	2 (10.0)		2 (40.0)		4 (25.0)	4 (3.6)	
Cocaine		1 (100.0)			2 (12.5)		
Amphetamines						4 (3.6)	
Cannabis	8 (40.0)		4 (80.0)		1 (6.3)†	13 (11.7)	1 (50.0)
Alcohol	3 (15.0)		3 (60.0)	1 (33.3)	5 (31.3)		

*By cases reporting use of one, two or three additional substances.
† Additional problem substance used may be a form of drug in the same family as the main problem substance.

5.5 Consequences of substance use

This section reports participants' perceptions of the consequences of problem alcohol and drug use in the community. Consequences are broken down into personal, family and social.

5.5.1 Consequences for the user

Health related consequences

Health-related consequences of alcohol and drug use were reported by all participants. Overall, participants felt that there had been an increase in alcohol-related physical and mental health issues, and also reported that alcohol was implicated in a number of violent incidents and in a number of deaths.

> *You'd have more physical health problems...Liver conditions, fatty liver...and occasionally cirrhosis. [Several individuals that I have worked with are] dead. I know one of them was...[under 55 years] and the other would have been younger and...I would certainly say [that] alcohol played a big part [in their deaths].* (Participant 26, Service provider)

Nationally, there has been a large increase in alcohol-related liver disease over the past years.[33] Therefore it is not surprising that participants in the community also reported this issue. Problem substance use is associated with mental health issues. Co-morbidity is defined as 'when two disorders or illnesses occur in the same person, simultaneously or sequentially', such as a problem substance use disorder and a mental health disorder. It can be difficult to distinguish between cause and effect in cases of problem substance use combined with a mental health problem. This is because the psychoactive effects of certain drugs may induce psychosis or, indeed, people with mental health issues may self-medicate with illicit drugs to alleviate symptoms.[51]

Social consequences

Involvement in crime because of problem substance use was another personal consequence highlighted by participants and one service provider reported that there had been an increase in homelessness due to problem alcohol and/or drug use.

5.5.2 *Consequences for the family*

The consequences of alcohol and drug use for family members were reported by many participants. Participants spoke about the negative emotional and financial effects of having a problem substance user in the family, often involving aggression or violence. The breakdown of relationships within the family unit was commonly reported as a consequence of problem alcohol and drug use in the community. Children of substance users and parents who were substance users, spoke of the negative effect on children of parental substance misuse.

> *I hurt people...my own family, my own partner. They went through hell with a drunk falling in the door. I often came to my door and the children would be dying laughing...but the minute I'd open the door, dead silence, the devil was after coming in the door, and that devil was me.* (Participant 58, Problem substance user)

The negative impact on the emotional, psychological and physical wellbeing of the family is well documented.[34] Problem alcohol use is frequently cited as a major issue in marital breakdown and domestic violence in this country.[34 35]

Family members spoke about the financial consequences of having a problem substance user in the family, some of which were extremely serious, for example losing the family home. Some of the reports suggest that families went to extremes to try and help their relative, including procuring drugs for them.

5.5.3 *Consequences for the community*

The consequences of alcohol and drug use for the community were reported by many participants. For example, it was suggested that violent public disturbances associated with alcohol were quite frequent at weekends. Other criminal activities arising from problem drug use, such as robbery, were identified by participants as social consequences.

> *[Everything is] fine...when [problem drug users] have the 100 Euro to buy their supply. But when they don't...they'll take it from you and from me, and that increases the crime rate. It increases disturbance, it increases devastation of people's lives. The fallout from all of that touches the lives of many people.* (Participant 57, Service provider)

Some participants felt that visible drug use and drug dealing was creating no-go areas in some parts of the community. Living in areas where drug use and dealing was visible appeared to create feelings of fear and intimidation among the local community. A service provider reported that some people behaved like prisoners in their own homes, with some not letting their children play outside.

It is well-documented that illicit drug markets can create great problems for local communities, particularly in relation to drug-related crime and nuisance and the fear of victimisation.[36 37 46]

5.6 Perceptions of the response to the problem, and gaps identified

This section presents data from the NDTRS in relation to Co Longford cases seeking treatment, reports participants' perceptions of the responses to the drug problem in Community C, and summarises any gaps they identified or solutions they offered.

5.6.1 *Drug treatment figures*

Of the 332 cases from Co Longford who presented for treatment between 2004 and 2007, 268 (80.7%) attended outpatient services, 63 (19.0%) attended a residential service, while only one case (0.3%) attended a general practitioner (Table 5.7). The number of cases almost doubled over the four years under review.

Table 5.7 Longford cases assessed or treated, by service type, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All services	56	82	85	109	332
Outpatient	50 (89.3)	73 (89.0)	67 (78.8)	78 (71.6)	268 (80.7)
Residential	6 (10.7)	9 (11.0)	18 (21.2)	30 (27.5)	63 (19.0)
General practitioner	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.9)	1 (0.3)

The number of previously treated cases increased from 32 in 2004 to 49 in 2007 (Table 5.8). The number of new cases more than doubled, from 22 in 2004 to 49 in 2007.

Table 5.8 Longford cases assessed or treated, by treatment status, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	56	82	85	109	332
Assessed only	2 (3.6)	3 (3.7)	2 (2.4)	6 (5.5)	13 (3.9)
Previously treated cases	32 (57.1)	40 (48.8)	37 (43.5)	49 (45.0)	158 (47.6)
New cases	22 (39.3)	38 (46.3)	39 (45.9)	49 (45.0)	148 (44.6)
Treatment status unknown	0 (0.0)	1 (1.2)	7 (8.2)	5 (4.6)	13 (3.9)

Source of referral

The most common source of referral reported by cases seeking treatment was self referral (27.7%), followed by hospital or medical agency (24.1%), and general practitioner (22.9%).

Perceptions of type of services provided

In general, participants did not distinguish between statutory and voluntary agencies providing services either in the community or elsewhere. Most felt there were very limited services for people with addiction problems in Community C.

> *Here we don't, in [Community C] area. We also don't have anywhere, so we have to send our people to [names of towns in other counties]. [Name of centre] might take some patients, but if it's not in the catchment area where they live they won't take them, so then we have to find another venue for the patient. And that's often our dilemma, as to what to do with the patient... I've had patients that come to me and say 'I need help'. Now there's when they need help, we still have difficulty getting to the right people.* (Participant 53, Service provider)

An existing community development programme was seen as being very helpful by participants. However, it appeared to be working beyond its remit and capacity to try to meet the needs of those presenting for its services. Service providers stated that additional resources were needed by the centre to be able to cater for the needs of its clients.

For all other types of treatment, including methadone maintenance, assessments, residential treatment or detoxification, the population of Community C had to travel elsewhere.

5.6.2 Specific treatment issues

Methadone

There is no methadone treatment clinic or any general practitioners offering methadone treatment in Community C. Individuals requiring methadone treatment have to travel to another town for this service. All participants felt that the length of the waiting lists for the treatment was excessive. NDTRS data show

that the numbers treated for opiates in the county has increased considerably over the period under review. Some service providers found it frustrating that a client who was assessed as suitable for methadone treatment and was ready to start treatment was then faced with a lengthy waiting list. This was felt to be detrimental to the person and their recovery.

> *Unfortunately [people are] just placed on the waiting list. It leaves us in a most awful position because...you put someone on the waiting list [when] they're identifying that's their treatment goal [and] they're not really interested in counselling. They will say to you 'Listen, when I go on the methadone programme I [will be] ready to take part in counselling but I am not well enough to engage in counselling now'. And you will try and [talk with them] around [risk] reduction and other options for them but... and any time you see them they're asking you 'Where am I on the list? Listen I [am] on it since last June.' It's very disheartening.* (Participant 26, Service provider)

Problem opiate users themselves found the lengthy waiting lists for methadone treatment very difficult and there were reports of schemes to circumvent the excessive waiting period. Some participants spoke about the system of 'fast-tracking' particular at risk individuals into treatment which was not viewed as useful for the vast majority.

Methadone maintenance treatment was seen as a good option for individuals with an opiate addiction, allowing them to stabilise and re-build their lives. However, it was acknowledged by participants that the methadone prescription was only part of a suite of interventions, including psychological and social support, which enabled recovery for an individual. However, there were also reports of diversion of methadone in the community.

Support to become drug-free

There were alternatives to methadone treatment; however, participants spoke about some programmes that required drug users to be clean (off drugs) before entering, and the difficulty of achieving that without support in the community.

> *I had someone...who I was trying to get into [name of centre] and they need them clean or if they don't have them clean they need them to go in with a prescription for a detox on methadone. We have no access to anyone that will prescribe that detox. And I have talked to people about giving that, and they're not comfortable giving it.* (Participant 26, Service provider)

Residential and detoxification treatment

In the community, participants did not differentiate between the different models of residential treatment available and often used the words 'residential' and 'detoxification' interchangeably. The types of residential treatment available does differ but most do offer detoxification as a treatment. All participants highlighted the lack of residential and detoxification beds available for people in the community and the distances needed to travel for treatment.

> *No place would take him...without being de-toxed. So the only place he could get detoxed here was in [name of centre in Irish city] and there are only 25 detox beds in the whole country for heroin so they said he had to wait three months and we're still waiting, that was last June...There's absolutely no detox centre in the Midlands.* (Participant 27, Family member)

There were other barriers identified to accessing residential and detoxification services. Some residential programmes had age restrictions, and many required the individual to be clean before starting the programme. There were reports of participants detoxifying relatives at home without medical supervision.

Alcohol

Different types of treatment for people with problem alcohol use were available in the community. There was conflicting views about the availability of residential treatment and the length of waiting times for treatment for people with problem alcohol use. However, there was agreement that there were no services available within easy distance of the community, especially for those who could not afford private care.

> *When I was drinking, it was today I needed treatment, not tomorrow. If I'm sober tomorrow I don't need you. I need you tonight to put me on the right road for tomorrow.* (Participant 58, Family member/Problem substance user)

Alcoholics Anonymous was seen as a very good programme, although it did not suit everyone. There was an outpatient alcohol detoxification service outside the community; however, participants commented that individuals needed to have access to transport to avail of it.

5.6.3 Overdose prevention and harm reduction

NDTRS data show that, 27 injector cases who lived in Co Longford entered treatment between 2004 and 2007 (Table 5.9). One quarter of these had started injecting before they were 19 years old. Ten (31.3%) cases reported that they had shared injecting equipment (Table 5.10).

Table 5.9 Longford cases treated, by injector status, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	56	82	85	109	332
Had injected	5 (8.9)	4 (4.8)	6 (7.1)	12 (11.0)	27 (8.1)
Never injected	49 (87.5)	75 (91.5)	72 (84.7)	91 (83.5)	287 (86.4)
Not known	0 (0.0)	0 (0.0)	5 (5.9)	0 (0.0)	5 (1.5)

Table 5.10 Longford injector cases treated, by equipment-sharing practices, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All injector cases	5	4	11	12	32
Shared equipment	1 (20.0)	2 (50.0)	3 (27.3)	4 (33.2)	10 (31.3)
Did not share equipment	3 (60.0)	1 (25.0)	3 (27.3)	1 (8.3)	8 (25.0)
Not known	1 (20.0)	1 (25.0)	5 (45.5)	7 (58.3)	14 (43.8)

This data on injecting is supported by qualitative data from the community. Although it was reported that smoking was the most common method of taking heroin in Community C, some problem drug users did inject. There were several reports of needle sharing, with some participants stating that one-quarter of heroin users they knew in the community shared needles.

> *P32: There would be injecting. But I think it's mainly smoking it.*
> *I: And where do they get the needles?*
> *P32: They are sharing.*
> *P31: [There is a need] for a needle exchange programme.*
> (Participants 31 and 32, Problem drug users)

Some participants expressed concern that deaths would occur in the community as a result of drug use.

5.6.4 Social reintegration

Social reintegration is now seen as an essential part of recovery from drug addiction.[39] Participants

acknowledged the there were some services in the community for individuals who needed support.

> *But there is two [drop-in] projects, not in Community C, one in [name of town], one in [name of town], which certainly continue to work with...recovering addicts or alcoholics. [They] provide a social outlet for these people which does seem to keep them away from the drink and the drugs for the period of the day which is often a lonely time for people because they've nothing to do.* (Participant 53, Service provider)

Employment is an important aspect of rehabilitation. Figures from the NDTRS show that 36% of Longford cases who sought treatment between 2004 and 2007 were unemployed. The proportion of cases reporting that they were unemployed on entry to treatment rose sharply from 32% in 2004 to 43% in 2007.

NDTRS data show that 17% of those assessed or treated who lived in Co Longford between 2004 and 2007, had left school aged 14 years or under, and almost one-quarter (24.4%) had not progressed beyond primary level. This indicates that a proportion of individuals with problem substance use have a low level of educational attainment, which will impact on employment opportunities.

Another factor of social reintegration is housing or other accommodation. Data from the NDTRS for 2004 to 2007 show that the vast majority of cases seeking treatment were living in stable accommodation (96.4%). However, small proportions of cases were recorded as being homeless (1.2%), living in unstable accommodation (0.9%) or in an institution (0.9%).

Participants' did speak about accommodation difficulties faced by some problem substance users and the need for continued support and advocacy for this group..

> *...there's an awful lot of people in this town sleeping on benches, sleeping rough, sleeping in doss houses, don't have accommodation. Or are living alone and are alcoholics and have been provided with houses from the council. That's ok, the council have done their job, end of story, 'I gave them a key, they have a house'...because you're going to be finding them on a regular basis, two and three days dead or maybe longer, in those houses. Because we have massive problems in this town and every other little town in the country.* (Participant 58, Family member/ Problem substance user)

5.6.5 Services for under-18s

Participants highlighted the lack of effective services for young people aged 17 years or under with addiction problems. Of the 332 cases who were assessed or treated between 2004 and 2007, nine (2.7%) were aged 17 years or under. A further 15 (4.5%) were aged between 18 and 19 years.

Some participants felt that there was also a lack of services for young people affected by problem drug or alcohol use in the family. Participants spoke about the lack of support and alternative activities for young people in the community. It was pointed out that, where services were provided, young people had to leave the programme when they reached 18, often with no continuation of support after that time, despite any ongoing problems. Additionally, as one participant noted, young people who were at higher risk and needed support and early intervention were being missed.

> *I think there needs to be something [for young people] because at that age...[they're] going to start drinking...and you have nothing to go to. Like there's nothing around [Community C] at all for young ones...It's only if you're this or you're that you can come in here and...it's the ones that need help that probably won't go...well, they need an extra push to go into something but there's nothing really for them at all.* (Participant 28, Family member)

Service providers spoke about the need for parental responsibility in relation to problem alcohol or drug

use by young people. However, as one service provider noted, sometimes parents had their own problems with alcohol or drugs and were unable to respond and assist with the problems of their child. Figures from the NDTRS show that 2% of treated cases were still in school. Participants noted that some drug education was provided in school but felt that it did not seem to be getting effective messages across to teenagers.

> *[There's] posters around the school and no-one ever reads them.* (Participant 65, Non-drug using minor)

5.6.6 Family issues

The family was acknowledged as having a very important role in helping problem drug users to recover. There were examples of how families tried to get their relative into treatment, while struggling with the lack of services available to them, sometimes even paying for treatment outside the country.

> *When I became an addict...[it] affected my family, it got out of control and...I got caught doing heroin...injecting and...my [parent]...supported me. I went into treatment services...and I did that and I look back and without my [parent] being there taking me in, [my parent] could have thrown me out any time the things I did...[were] horrendous...I wouldn't be where I am today.* (Participant 34, Problem drug user)

NDTRS data show that over one-third (34.0%) of Longford cases assessed or treated between 2004 and 2007 lived with their parents or family.

As one service provider commented, often when families discover that a relative has an alcohol or drug problem, they desperately want to be able to help that person. However this can cause conflict if the problem drug user is not ready or able to undertake treatment at that time. Therefore it is essential that families are able to access and talk to trained professionals to help them understand what is happening. There is a HSE counselling service like this in the community for family members. Some families reported getting psychological support, although not actually in Community C, and attested to the benefit of such a service, and of voluntary and non-statutory supports.

Overall, families reported a variety of difficulties with the services. Participants highlighted a lack of services for their relatives, being unable to find help and struggling to navigate through the system, searching for services to help their relatives.

Suggested solutions and responses

Services

The existing service in the community was trying to stretch to meet the needs of the population. Most participants felt that Community C should have a dedicated centre, located in the town. This facility was generally envisaged as a 'drop-in' centre, however it was clear that participants wanted a facility that could offer a wide a range of services and supports for both individuals with addiction problems (regardless of age or gender) and their families.

> *They need something more kind of open that people can go and you know that they'd be able to go and try and get help and stuff or talk to somebody. But there doesn't seem to be anything here at all.* (Participant 28, Family member)

Participants felt that the existing services needed more resources; however, it was acknowledged that times were difficult. Another issue was the need for an accessible and effective out-of-hours support service, as the problem of addiction is constant, not just within office hours.

Methadone treatment

Many participants felt that those who needed methadone maintenance should be able to access it in

Community C, without having to wait too long. Some participants felt that a general practitioner service that provided methadone treatment was the best option for the community.

> *I always have felt the whole methadone treatment would be best carried out where possible by the client's GP. You know, have a clinic all right for people who would be quite difficult and quite disruptive but, you know, I feel there's a lot of clients that could be monitored and managed by their own GP if they were willing.* (Participant 26, Service provider)

No general practitioners in the community provided methadone treatment at the time of the study. One participant felt that the negative perceptions of problem opiate users and the stigma of drug use in general within the town was one of the reasons why general practitioners did not provide this service. The lack of a general practitioner-led addiction treatment service in the county is clear from the NDTRS data. In the absence of available methadone treatment, people look for alternatives. Participants felt that methadone maintenance alone was not sufficient but needed to be accompanied by a suite of additional supports to ensure the recovery of the individual.

Residential treatment

Most participants wanted to have accessible residential treatment, located within a reasonable travelling distance from Community C. It was also highlighted that any residential treatment provided needed to be complemented by proper aftercare and long-term support.

> *There is no detox unit for them to go to unless you have money. And I feel that [Community C] is lacking in that and that's why a lot of those people are still using. It should be nipped in the bud, put through the system and come out clean and sober and a follow up to that.* (Participant 35, Problem drug user)

Overdose and harm reduction

There was an expressed need for harm reduction services, including needle exchange, in the community. It is obvious that the lack of such services means that intravenous heroin users are currently sharing equipment and are at high risk of blood-borne viral infection. There appears also to be a need for education on overdose prevention for families, friends and community workers to enable them to respond to incidents of drug overdose in the community.

Under-18s

The need for specific addiction treatment services for young people was highlighted. As was the need for a specific centre for young people which they could easily access, feel comfortable in and take part in activities, but also access other support services if necessary.

Some participants suggested the need for improved education. However, they also acknowledged the difficulty of working with and changing behaviour in this age group. While some participants highlighted the need for more education for young people, several participants spoke of the need for a reality check for young people, to show them the serious consequences of problem drug or alcohol use.

> *What is there in [Community C] to help you at the present time to break the habit? There is not the volume of knowledge and education and deterrents, you possibly need a balance between the carrot and stick approach. Where a little bit of fear and a little bit of knowledge and education needs to run in parallel.* (Participant 59, Service provider)

Family support

One participant stressed the need for treatment and support for both the person with the addiction and their family.

> *What you need here is intervention through trained counsellors. The family have to be treated the same as the addict otherwise there will be turmoil in that home until everybody gets well. You want love to be put where there was anger and despair and hurt. It has to be healed through counselling. It's healing the family together.* (Participant 33, Problem drug user)

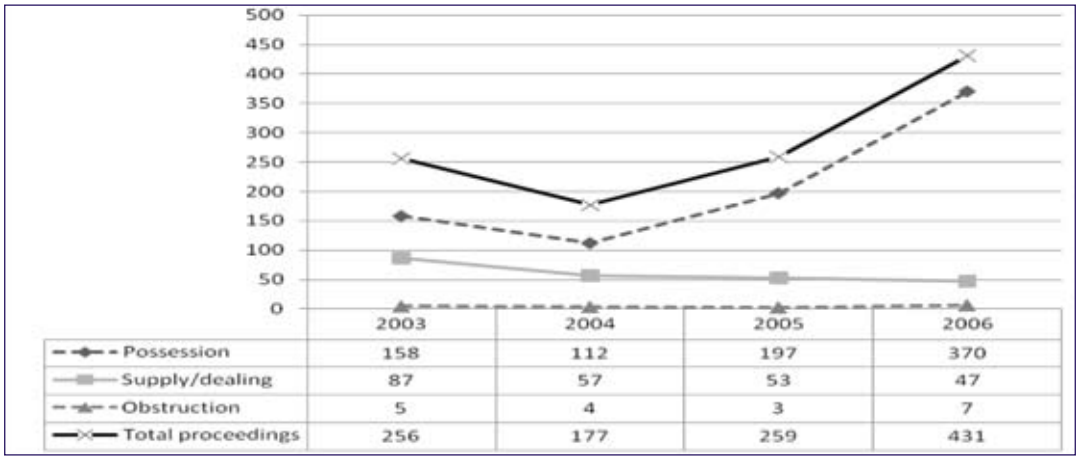
A more co-ordinated and accessible family support service was called for, which would include a range of psychological and social supports. This could perhaps be incorporated into the centre as suggested by most participants. Again, as discussed above, the need for a dedicated centre located in the community for both the individual and their families was highlighted.

5.7 Drug-related crime in counties Longford and Westmeath

This section brings together statistics from the CSO on drug-related crime from the Longford/Westmeath Garda Division. The qualitative data on perceptions of crime in Community C are presented in Section 5.8.

5.7.1 Proceedings for drug offences in Longford/Westmeath Garda Division

Figure 5.1 presents the number of drug offence proceedings, by main offence type, in the Longford/Westmeath Division for the years 2003–2006. The proceedings for possession of drugs have increased between 2004 and 2006. Of the total drug offence proceedings in 2006, 86% were for possession. Proceedings for drug supply offences almost halved over the period, while those for possession offences more than doubled. The number of offences for obstruction were small throughout the period under review.

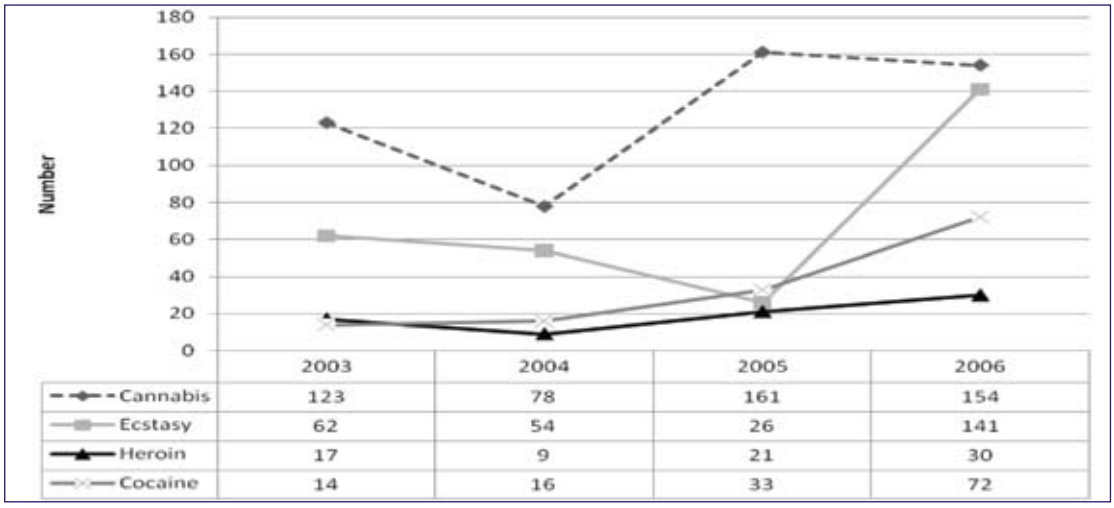


	2003	2004	2005	2006
Possession	158	112	197	370
Supply/dealing	87	57	53	47
Obstruction	5	4	3	7
Total proceedings	256	177	259	431

Figure 5.1 Drug offence proceedings, by offence type, Longford/Westmeath Garda Division 2003–2006

5.7.2 Proceedings for possession, by drug type

Figure 5.2 shows that the majority of possession proceedings between 2003 and 2006 related to cannabis. There was a sharp rise in proceedings for ecstasy possession in 2006 when compared to 2005. The number of proceedings for possession of cocaine increased considerably over the four years, with, a big increase in 2006. Proceedings for heroin possession also increased somewhat over the reporting period.



	2003	2004	2005	2006
Cannabis	123	78	161	154
Ecstasy	62	54	26	141
Heroin	17	9	21	30
Cocaine	14	16	33	72

Figure 5.2 Proceedings for possession, by drug type, Longford/Westmeath Garda Division 2003–2006

5.8 Perceptions of drug use and crime in Community C

There was a perception that a small number of people were responsible for much of the drug-related crime in the community. Participants felt there was a lot of frustration around the perceived inaction of the gardaí in relation to this. Participants reported that in some areas drug dealing was highly visible, and was sometimes integrated into the local community, in that drugs were hidden in local houses, gardens or public buildings and teenagers were used to hide and retrieve drugs. In addition, this participant spoke of the lure of easy money that brought some young people into drug dealing.

> *Well [these young lads] are...they're less obvious than an 18 to 25-year-old or 35-year-old. And then, because there are so many young men in the area not attending education, it's not that unusual to see groups of young men walking [around]... It's a source of income. It would seem to [have] a level of excitement about it because you're outside the law. You're watching the law at all times. And there is that buzz about it.* (Participant 59, Service provider)

There were reports that the local population were intimidated by this drug dealing activity but were unwilling to report it because of fear of intimidation. While participants acknowledged that the gardaí had limited resources, many felt that there was not enough done in the community to deal with the problem of drug and alcohol use.

In relation to the criminal justice system, one participant had the perception that drug dealers got off too easily, and the treat of a court appearance was not a deterrent. In relation to custodial sentences, there were reports of individuals in Community C going into prison to get treatment or to detoxify. This is probably more an example of the consequences of lack of accessible treatment services in Community C.

> *Yeah to get off the gear, it's common [to go into prison].* (Participant 49, Service provider)

Several participants spoke of the need for more gardaí in the community and for more action against those who were involved in criminal activity in the town. This illustrates the need for improved communication between the gardaí and members of the community to try to reach an understanding of the issues involved.

5.9 Key findings in Community C

This small town has several indicators of socio-economic deprivation including higher levels of local authority housing and single parent families.

Factors contributing to the problem

Individual factors such as curiosity, boredom and a search for enjoyment were felt to contribute to the initiation of drug use among young people in Community C. Other studies have found these factors to be involved in initiating drug use.[23 28 48] Within the family, tolerance of alcohol and drug use, and especially parental substance misuse, were frequently cited as factors in developing alcohol or drug problems. The influence of peers was pivotal in deciding to use alcohol and other drugs, including: initiation, access, normalisation, continuation of drug use or relapse after a period of abstinence.

The reported ease of access to a wide range of drugs, both licit and illicit, was a factor in the development, normalisation of use and propagation of the drugs problem in this community. According to most participants, alcohol and drug consumption was relatively widespread in the community across all social classes, although there was no consensus as to which presented the more serious problem. Some participants reported that there was a perception within the community that drug use was confined to a number of particular areas in the town, whereas they felt that, in reality, drug use was more widespread throughout the community.

Among young people, participants felt that the use of alcohol and drugs, especially cannabis, was common, even from a relatively early age. Many of those in treatment had started alcohol and drug use before the age of 18 years. Many participants reported a lack of addiction services for under-18s. Although small in number, this age group is represented in treatment data for Co Longford. It was felt that there was also a lack of services and support for young people living in families affected by problem substance use.

Consequences of substance use

The detrimental effects of problem substance use were seen in this community in relation to health, psychological well-being, relationships, family and society.

Drug treatment figures

Problem alcohol use was felt to be a considerable burden on the treatment services and was linked to progression to drug use. Participants identified particular increases in problem alcohol use in specific groups, including young men aged 25 to 35, and women in general. Heroin was seen as a significant problem, with the number of cases who required treatment increasing considerably over a four-year period, which is supported by the NDTRS figures for Co Longford. There was also evidence of injecting drug use and sharing of needles in the community.

Polysubstance use was highlighted as an issue; the growth in polysubstance use is supported by data from the NDTRS for 2004–2007. One-quarter of treated cases who lived in Co Longford reported problem use of more than one substance. Of the new cases who reported cocaine as their main problem substance, several reported alcohol as an additional problem substance. This has serious health implications as research has shown that the combined consumption of cocaine and alcohol is highly cardiotoxic.[43] Polysubstance use increases the complexity of cases, and is associated with poorer treatment outcomes.[16] It was felt that the services also need to re-orientate to address the polysubstance addiction problems.

Perceptions of the response to the problem, and gaps identified

Overall, participants agreed that there were very limited services for people with alcohol and drug problems

and their families in Community C. Many of the services available were not in the town and people had to travel to access them and were further hampered by the lengthy waiting lists. The lengthy waiting list for methadone treatment was highlighted as a major issue and the detrimental effects on individuals of having to wait for an extended period for such treatment was stressed by participants. At the time of the interviews, there was no general practitioner offering methadone treatment in the community although participants were of the opinion that general practitioners were the most appropriate treatment providers. Nationally, approximately one-third of cases in methadone treatment attend their general practitioner for treatment.[17] The need for accessible residential treatment and detoxification was another priority.

Most participants felt that the community should have a dedicated centre located in the town. This facility was generally envisaged as a 'drop-in' centre; however, it was clear that participants wanted a facility that could offer a wide range of services and supports for both individuals with addiction problems (regardless of age or gender) and their families. As the family was acknowledged as having a very important part in helping problem substance users to recover, the need for a more co-ordinated and accessible family support service was requested, which would include a range of psychological and social supports. This would also assist families trying to navigate through the system to locate services and find help for their drug-using relatives and themselves.

Social reintegration is an essential part of recovery from drug addiction.[39] Participants acknowledged that there were some services in the community for individuals who needed support, but that these were in no way enough to meet needs.

There was a perception that drug use was associated with public disorder and criminal behaviour, fuelled by the visibility of the local drugs market. This had created no-go areas and an atmosphere of fear for some of the local population.

5.10 Overview of recommendations from participants for service provision

Table 5.11 presents the participants' recommendations for service provision in Community C, summarised under the pillars of the National Drugs Strategy 2001–2008.

Table 5.11 Participants' recommendations for service provision in Community C

Pillar	Existing services provided in community*	Community C
Supply Reduction	Community gardaí	Improve communication with the gardaí More visible action/better communication from the gardaí to the community
Prevention	Youth diversion project Youth Reach (not based in community) FAS Community action project Youth group Women's project Drug awareness and local drug network group SPHE in secondary schools Rapid Co-ordinator	Improve drug awareness education for young people Improve drug awareness education for adults Address the stigma of drug use in the community Provide better social facilities for young people
Treatment & rehabilitation	HSE community addiction services Outreach worker Alcoholics Anonymous Community development project Community development worker FAS	Provide addiction services for under-18s Provide a drop-in centre (or extend with resources the existing centre) Improve addiction services Increase access to residential treatment services Address lengthy waiting lists for all addiction services especially methadone substitution treatment Have clearer pathways to treatment Provide access to detoxification services Re-orientate focus of treatment services onto polysubstance use Address missed opportunities for intervention Provide alternatives to methadone treatment Provide more general practitioners in the community to offer addiction services including methadone Ensure more accessible treatment for problem alcohol use Improve aftercare services for recovering problem substance users Improve treatment and prevention services in prison Improve communication between clients, their families and service providers Provide outreach workers (have commenced since study began) Provide harm reduction services including needle exchange (has commenced since study began) Provide out-of-hours service (not a telephone service) Provide long-term support for problem substance users and their families Improve addiction treatment in prison Provide a family support service and include families of drug users in treatment Improve existing social reintegration services

* Note – not an exhaustive list

6 COMMUNITY D IN COUNTY WESTMEATH

6.1 Overview

This section presents the main findings for Community D from the qualitative component of the study. The issues explored in the interviews and focus groups included: factors that contribute to the drugs problem in the community; perceptions of the nature and extent of substance use in the community; consequences of drug use for the individual, their family and the community; perceptions of the response to the drugs problem, including gaps in service provision identified by participants. Data from the National Drug Treatment Reporting System (NDTRS) on treated substance use in Co Westmeath (2004 and 2007) and CSO data on drugs and crime (2003 to 2006) are used to supplement the qualitative data.

6.2 Socio-demographic characteristics

Community D is a medium sized town in Co Westmeath with a population of between 10,000 and 15,000.[20] The town has seen a significant expansion of its population in recent years, with an increase of 17% between 2002 and 2006. Like many other towns in Ireland, the ethnic profile of the town has also changed in recent years. The town is served by both rail and bus services.

According to the 2006 census, the occupations of nearly half (46.5%) of the workforce in Community D were in the professional, managerial and non-manual categories (Table 6.1). These proportions were similar to both the county and national levels. A number of statutory organisations and private companies operate in the area. The occupations of a high proportion of individuals in the community were classed as 'Other', which makes inferences difficult.

Table 6.1 Workforce by occupational category, Community D, Co Westmeath and national, 2006

	Professional %	Managerial & technical %	Non-manual %	Skilled manual %	Semi-skilled %	Unskilled %	Other* %
Community D	6.9	19.4	20.2	14.1	13.1	4.3	22.0
Co Westmeath	6.2	24.6	20.1	20.5	13.7	4.9	10.1
National	6.9	26.3	20.1	19.4	13.7	4.7	8.8

* All others gainfully occupied, and those whose occupation was unknown
Source: CSO, based on those in the labour force

The community has experienced a significant increase in those signing on the live register over the past two years. Between March 2007 and March 2008 there was an increase of almost 70% in the number signing on.[21] The overall level of educational attainment in Community D was similar to that in Co Westmeath and not far below the national level (Table 6.2). The proportion of individuals with a third-level qualification most likely reflects the presence of a third-level educational institution in the area.

Table 6.2 Education levels, Community D, Co Westmeath and national, 2006

	Primary level* %	Lower secondary %	Upper secondary %	Third level %
Community D	17.5	18.2	21.9	12.3
Co Westmeath	15.7	17.7	25.3	12.9
National	15.2	17.0	23.8	15.6

* Includes those with no formal education.
Source: CSO data 2006, based on persons aged 15 years and over, whose full-time education had ceased. Percentages may not add up to 100% as not all categories are included

The proportion of owner-occupied houses in this community in 2006 was much lower than both the county and national levels (Table 6.3). At 16.1%, the proportion of local authority housing was above both the county and national levels. The proportion of single-parent households was 14%, which was higher than both the county (11.4%) and national (11.6%) levels.[20]

Table 6.3 Type of housing occupancy, Community D, Co Westmeath and national, 2006

	Owner occupied %	Local authority* %	Privately rented %	Other†/ unknown %
Community D	62.5	16.1	15.3	6.1
Co Westmeath	76.4	10.0	8.8	4.8
National	73.1	12.3	9.9	4.7

* Either rented from or being purchased from local authority
† Occupied rent free
Source: CSO census 2006

6.3 Factors contributing to the drugs problem

This section provides an analysis of the qualitative data and reports on the main factors contributing to the emergence of a drug problem in Community D. Service providers, drug users and their families were interviewed. Their perspectives are based on a mix of personal experience and anecdotal information.

The main factors that participants believed influenced the emergence and development of the drug problem in Community D can be grouped under five headings:

- Individual factors;
- Family context;
- Influence of peers;
- Community and structural factors;
- Ease of access to alcohol and drugs.

Individual factors

Individual factors, such as boredom were reported as playing a role in the use of drugs. Some drug users reported enjoying their first drug-taking experience, which led to the continued use of drugs. Previous research has identified this as a common factor in drug use.[23]

> I*t's not that [young people] are pressured; it is just that [they] are kind of bored.* (Participant 85, Minor)

Participants reported experimenting with a range of drugs, sometimes being turned off by bad experiences or by the side effects of the various drugs used. Despite this, adverse side effects did not always act as a deterrent. The decision by young people to experiment with drugs was often linked to their affordability. Several participants cited price as a factor in their choice and continued use of a drug. Both national and international research shows that the use of drugs is determined largely by market forces, with increases in affordability and availability followed by an increase in use.[30 52]

> *I'd say for a teenager that had no problems in using drugs then probably the cheaper way to go would be to use ecstasy or whatever for his night's entertainment....compared to alcohol which could be expensive.* (Participant 18, Service provider)

It was reported that a small number of people in the community used alcohol or drugs as a way of coping with depression and sometimes with even more traumatic life events, such as a family bereavement or sexual abuse. Research has suggested that people use drugs in order to deal with these traumatic life experiences. [26 27]

Family context

Participants reported that attitudes within the family influenced the development of substance use and related problems. For example, several problem drug users reported that they initiated alcohol or drug use in the company of a family member.

> *It was [a relative] who introduced me to it [cannabis].* (Participant 23, Problem drug user)

Intergenerational substance misuse

A service provider corroborated this experience and felt that, for a proportion of those seeking treatment, problem substance use originated within the family. The effects of parental substance use were not explored to any great extent by participants; however, there were some reports of intergenerational substance misuse. The influence of problematic drug use in the family is a well-documented risk factor for the development of intergenerational problem substance use among family members.[24-27] Research has found that the children of problematic drinkers often start using alcohol or drugs earlier than their peers, which may be associated with parental example.[24 26]

> *I'd say that the fact that my [parent] drank a lot when I was growing up made me feel that it was really acceptable for me to drink whenever I wanted at whatever age. Because I definitely would have...thought if [my parent] drinks that much it mustn't be that bad.* (Participant 63, Recreational drug user)

The impact of family drug use and the development of problematic drug use among family members was also evident in the study conducted in the NERDTF area.[28] It is interesting to note that a number of participants, especially women, reported that family responsibilities such as marriage and having young children were reasons for not becoming involved with substance use.

Influence of peers

Participants reported that initial alcohol use often occurred in the company of peers, often in casual social outings and was usually seen as normal behaviour, done by everyone their age. The influence of peers was also seen to play a role in the continued use of drugs. Sometimes these were older, slightly more experienced friends or boyfriends. The perception that everyone else is using drugs can lead individuals to believe that this behaviour is normal and that the risks are minimal.[31 32]

> *I think a lot of young people use drugs because they see it as...socially acceptable behaviour...and it's going out partying and using drugs.... And the people...they might hang around with...are quite influential at a certain age... [From]...talking to young people...talking about hash, and they'll say to you 'Sure everybody's doing it.'* (Participant 15, Service provider)

This is not a new phenomenon, as research completed in the Midlands in 1999 among marginalised young people aged 13–18 years who were early leavers reported similar findings. Young people in the study displayed an awareness of the physical risks associated with using substances; however, their involvement with drug taking within their peer group took priority over the risk of physical harm.[44] A recent study completed in the neighbouring NERDTF area also reported that peers were instrumental in initiation of alcohol and drug use.[28] Peer groups have been found to assist in the drug initiation process by providing access to drugs and safe environments for the first drug-taking experience.[29 30]

Returning to drug use

The influence of peers and the environment on the return to problem drug use after a period of abstinence or treatment was an important factor in relapse of problem drug users.

> *But I was hoping and praying please God...[that] he [problem drug user] won't want to come back to [Community D] because I don't want him coming back to [Community D]...Because there's just, the friends. The people that he was [using with], he needed to move away from them and at this stage*

he didn't have any other friends. So when he would come back down it was back into the same ole [thing]. (Participant 20, Family member)

Community and structural factors

Community factors were not commonly reported as playing a major role in the development of the drugs problem. There was the perception that only a small group was responsible for a lot of the drug-related criminal behaviour in the community.

If you look out the window there...that would be an area [where you would have concerns] walking down that street...at night time...Now unfortunately...there would be kind of [groups] there and they would be problematic...they'd be using drugs...there'd be anti-social behaviour...break-ins...or fights. (Participant 18, Service provider)

It is well-documented that illicit drug markets can create immense problems for local communities, particularly in relation to drug-related crime and nuisance and the fear of victimisation which can become associated with local drug markets.[36] [37] Service providers spoke about the difficulties associated with addressing these problems. While peers play a key role in initiating and continuing problem substance use, the environment was seen as a key issue and many participants spoke about the need to leave the community to facilitate and sustain recovery.

Ease of access to alcohol and drugs

Alcohol and drugs were reported to be easily accessible within the community, even to young people.

Oh I'm sure it is [easy to get drugs]...I get the impression...it's really a matter of what do you want and how much of it do you want?...I've no doubt it's easy to get...that would be the impression that...any [of the] kids that would talk about it, would give you. They could get drugs for you in two minutes if you want them. (Participant 15, Service provider)

Indeed, the easy availability of drugs was cited by many participants as one of the reasons for the continuation of a drugs habit by problem drug users in the community. A service provider reported that drug dealers operated in several locations in Community D. Participants felt that availability of drugs was not confined to certain areas in the town but could be seen in many public areas in the community, including around local schools. It was a common perception that teenagers and young people could easily access drugs near schools, apparently targeted by drug dealers.

Participants reported that, although people were using heroin in the community as far back as the early 1980s, problem drug users had to travel out of the town to Irish cities to source the drug. The local heroin market was reported to have emerged in the community in the late 1990s. The development of a local heroin market is perceived by participants as having facilitated the spread of heroin use in the community. In addition to the perception that illegal drugs were easily accessible in the community, there were reports from some participants that legal (prescription) drugs such as methadone and benzodiazepines were being leaked onto the local drug market and were available for sale. The diversion of prescribed methadone to sale at street level has been found in other studies.[53] One explanation given was that problem drug users do this in order to fund their drug of choice.

Some of them sell their [methadone] take-aways to get a twenty spot...[I] go to the chemist...and they'll give me six take-aways, six bottles of [methadone] to take home and I could easily go and sell that for bags [of heroin]. (Participant 17, Problem drug user)

6.4 Perceptions of substance use in Community D

6.4.1 Extent of the problem

According to participants, alcohol and drug consumption was widespread in the community, however there was not a consensus as to which was the bigger problem. Participants provide a range of explanations for this perception of alcohol, including the social acceptance of alcohol use and the belief that alcohol was a gateway to drug use.

> *Cannabis would be the biggest [problem] as far as I'm concerned.* (Participant 19, Service provider)

> *I think heroin still is [the biggest issue] because from public health point of view from the risk to patient's health both in terms of attracting disease and the risk of overdose and poisoning.* (Participant 16, Service provider)

Watters (2008) reported very similar perceptions from the population in the NERDTF area.[28]

History of drug use in the community

There was a perception among some participants that drug consumption had been prevalent in the community for some time. One participant speculated that cannabis had been available locally for a long time and there had been an increase in the use of heroin in the community since the 1990s.

> *I mean hash has been around a long, long time.... My own [relative] smoked it.... But back then...there was no other drugs...It wasn't as easily accessible as it is now...I know that there is people within the community, around the housing estates that sell it.* (Participant 20, Family member)

Type of drugs used in the community

In addition, there was a perception among some participants that the consumption of drugs has increased in Community D in the last five years, although the type of drug used may have changed over the years. This perception of increased alcohol and drug use and associated problems has been found elsewhere in the country over recent years.[54] This perception is supported by data from the NDTRS. According to NDTRS, 1,014 cases living in Co Westmeath presented for assessment or treatment in the period 2004–2007, of whom 949 cases were treated. These different denominators are used throughout this section. Of the 1,014 cases, over three-fifths (62.3%) reported alcohol as the main problem substance (Table 6.4). The percentage of such cases fluctuated over the four years. The most common main problem drug reported in the four-year period was opiates (25.7%), with numbers increasing from 65 in 2004 to 99 in 2007. This was followed by cannabis (5.8%) and cocaine (3.7%) (Table 6.4). Although the proportion of cases seeking treatment for benzodiazepines as a main problem substance was small (1.0%), numbers seeking treatment increased from one in 2004 to 11 in 2007.

Table 6.4 Westmeath cases assessed or treated, by main problem substance, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	222	167	286	339	1014
Alcohol	134 (60.3)	119 (71.2)	180 (62.9)	199 (58.7)	632 (62.3)
All drugs	88 (39.6)	48 (28.7)	106 (37.1)	140 (41.3)	382 (37.7)
Opiates	65 (29.2)	31 (18.5)	66 (23.0)	99 (29.2)	261 (25.7)
Ecstasy	0 (0.0)	1 (0.5)	3 (1.0)	3 (0.8)	7 (0.6)
Cocaine	7 (3.1)	2 (0.9)	19 (6.6)	10 (2.9)	38 (3.7)
Amphetamines	1 (0.4)	0 (0.0)	2 (0.6)	0 (0.0)	3 (0.2)
Benzodiazepines	1 (0.4)	1 (0.5)	1 (0.3)	8 (2.3)	11 (1.0)
Volatile inhalants	1 (0.4)	0 (0.0)	0 (0.0)	0 (0.0)	1 (0.09)
Cannabis	13 (5.8)	13 (2.8)	13 (4.5)	20 (5.8)	59 (5.8)
Other	0 (0.0)	0 (0.0)	2 (0.6)	0 (0.0)	2 (0.1)

This view that there is an increasing drug problem in the community was also based on the perception that there was an increase in the visibility of consumption and dealing and, in demand for services. The demand for services is supported by the NDTRS data.

Although problem alcohol use is widespread in Community D, a service provider reported that only a small proportion of problem drinkers sought treatment, and speculated that this was partly due to the social acceptance of alcohol use.

> *I think [problem alcohol users] won't come [early for treatment] because…maybe there's a great social acceptance of heavy drinking. [It's] seen as the norm…They would see their friends drinking eight to ten pints and they would think that that was reasonable… So I think…when you talk to people about the safe levels of drinking it just doesn't seem to…bear any relationship to what is safe levels of drinking.* (Participant 24, Service provider)

Attitudes towards substance users

Some participants felt that many of those with alcohol and drug misuse problems were from lower socio-economic groups, although not all participants agreed with this. Most participants felt that there was a negative view of problem drug users and drug dealers within the community.

> *Complete train wrecks, wandering the streets.* (Participant 85, Minor)

Participants reported that this negative view of drug users also adversely impacted on the user's family. These perceptions reflect attitudes found in a national survey, where the perceptions of drug users were mainly negative; however that study also found that the younger respondents and those with a higher level of education reported less negative attitudes. These attitudes need to be considered as they have implications for the social reintegration of problem drug users.[50]

6.4.2 Substance use among young people

According to service providers and family members, the use of alcohol and, to a lesser extent, of drugs was a common experience among many young people. This perception was partly based on the visibility of teenagers drinking or using drugs in the community or getting into trouble with the gardaí.

> *[Drug and alcohol use] is visible in young people…when you see a young person you know it's not*

> *alcohol...I know we have an area down here where [there] used to be and probably still is a lot of young people [hanging] out and they'd drink...they'd be smoking hash as well.* (Participant 20, Family member)

Another participant stated that the extent of drug use among young people was under-estimated because the use of alcohol was more visible than the use of drugs. Underage alcohol use in the community was reported to be facilitated by the easy accessibility of take-away alcohol which was consumed outside, often in secluded locations. Additionally, a service provider speculated that some parents were comfortable with their teenagers drinking because it was perceived to be less harmful than using drugs.

Drug use among teenagers was probably facilitated by the relative ease that they could access drugs.

> *When you are younger it is probably easier to get drugs than alcohol, because pubs look for ID.* (Participant 86, Minor)

The use of drugs among young people in the Midland region was recorded in a study completed as far back as 1999 among early school leavers aged 13–18 years. The findings included a high prevalence of alcohol consumption among older teenagers and a perception of high levels of drug use among young people in general.[44]

NDTRS data show that 37 under-18s (3.6% of total cases) living in Co Westmeath were treated or assessed for problem substance use in the period 2002–2007. In addition, of the 688 treated cases who reported alcohol as a problem substance, over half (55.2%) reported their age at first use as under 18 years. Of these, 164 (23.8%) reported their age at first use as 14 years or under. It should be noted that age at first use was not known for 28.9% of these cases. Of a total of 614 treated cases living in Co Westmeath who reported any drug as a problem substance, three out of every five (58.1%) reported their first drug use before the age of 18 years. Of these, 160 (26.1%) reported their first use aged 14 years or younger.

6.4.3 Polysubstance use

Overall, the data show that a range of drugs was available and accessible and being consumed in the community. Perceptions varied as to the nature and extent of this consumption, but suggested that use of more than one substance (polysubstance use) was an emerging if not an established phenomenon.

> *There would be polydrug use, yeah definitely. Definitely would be common, and it causes even more problems because if you're using alcohol and you're using other drugs as well.* (Participant 18, Service provider)

Polysubstance use among cases living in Co Westmeath is seen very clearly in the NDTRS data. Of the cases treated between 2004 and 2007, over one-third (36.4%) reported problem use of more than one substance. The overall number of treated cases reporting polysubstance use increased from 71 in 2004 to 114 in 2007 (Table 6.5). This table also presents the additional problem substances used by those reporting problem use of more than one substance, by year treated. Cannabis, alcohol, cocaine and ecstasy were the most common additional problem substances reported by all cases entering treatment between 2004 and 2007. Cannabis was top of this list in each of the four years, and its use as an additional substance increased over the reporting period. Alcohol was the second most common additional substance in 2004, 2006 and 2007.

Table 6.5 Westmeath cases treated, by polysubstance use and additional problem substance(s) used, NDTRS 2004–2007

	2004	2005	2006	2007	Total
Additional problem drug(s) used*	**Number (%)**				
All cases	210	163	260	316	949
Reported one problem drug	139 (66.2)	112 (68.7)	151 (58.1)	202 (63.9)	604 (63.6)
Reported two or more problem drug	71 (33.8)	51 (31.3)	109 (41.9)	114 (36.1)	345 (36.4)
Of those reporting two or more problem drugs					
Cannabis	39 (54.9)	29 (56.8)	66 (60.5)	58 (50.8)	192 (55.6)
Alcohol	19 (26.7)	12 (23.5)	28 (25.6)	39 (34.2)	98 (28.4)
Cocaine	17 (23.9)	17 (33.3)	22 (20.10	36 (31.5)	92 (26.6)
Ecstasy	19 (26.7)	9 (17.6)	20 (18.3)	19 (16.6)	67 (19.4)
Benzodiazepines	14 (19.7)	11 (21.5)	21 (19.2)	17 (14.9)	63 (18.2)
Opiates	8 (11.2)	7 (13.7)	6 (5.5)	9 (7.8)	30 (8.6)
Amphetamines	5 (7.0)	1 (1.9)	8 (7.3)	2 (1.7)	16 (4.6)
Other	0 (0.0)	2 (3.9)	4 (3.6)	2 (1.7)	8 (2.3)
Volatile inhalants	0 (0.0)	1 (1.9)	1 (0.9)	0 (0.0)	2 (0.5)

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

The association between main problem substance and additional substances used by new cases entering treatment was examined for the period 2004 to 2007 (Table 6.6). Though the numbers were very small, the pattern of additional substances used was linked to the main problem substance. For example, where an opiate was the main problem substance the most common additional problem substances were cannabis (12.4%), followed by alcohol (7.5%) and benzodiazepines (6.4%). Where cannabis was the main problem substance the most common additional substances were alcohol (18.8%), followed by ecstasy (11.6%) and cocaine (10.7%). Where cocaine was the main problem substance, the most common additional problem substances were alcohol (28.6%), cannabis (26.5%) and ecstasy (18.4%).

Polysubstance use increases the complexity of treatment programmes and is associated with poorer treatment outcomes.[16] An example of this is the number of new cases reporting cocaine as their main problem substance and alcohol as an additional problem substance. This combination has serious health-related implications as research has shown that the combined consumption of cocaine and alcohol is highly cardiotoxic.[43] Therefore, information about the effects of substances used in combination is important in terms of individual clients' care plans, and policy initiatives.

Table 6.6 New Westmeath cases treated, by main problem substance and additional substances used, NDTRS 2004–2007

	Opiates	Ecstasy	Cocaine	Amphet-amines	Benzo-diazepines	Cannabis	Alcohol
New cases	**266**	**18**	**49**	**4**	**12**	**112**	**899**
Additional problem substance(s) used *	**Number (%)**						
Opiates			2 (4.1)		2 (16.7)		5 (0.6)
Ecstasy	5 (1.9)		9 (18.4)	1 (25.0)	1 (8.3)	13 (11.6)	17 (1.9)
Cocaine	12 (4.5)	3 (16.7)		1 (25.0)	1 (8.3)	12 (10.7)	32 (3.6)
Amphetamines	1 (0.4)	1 (5.6)	3 (6.1)			2 (1.8)	6 (0.7)
Benzodiazepines	17 (6.4)		2 (4.1)			2 (1.8)	5 (0.6)
Volatile inhalants						1 (0.9)	
Cannabis	33 (12.4)	3 (16.7)	13 (26.5)	2 (50.0)	3 (25.0)		53 (5.9)
Alcohol	20 (7.5)	5 (27.8)	14 (28.6)	1 (25.0)	1 (8.3)	21 (18.8)	
Other	3 (1.1)	1 (5.6)	1 (2.0)		1 (8.3)		

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

6.5 Consequences of substance use

This section reports participants' perceptions of the consequences of problem alcohol and drug use in the community. Consequences are broken down into personal, family and social.

6.5.1 Consequences for the user

Health related consequences

Health-related consequences of alcohol and drug use were reported by service providers, drug users and their families. Participants described both physical and mental health issues they had seen associated with problem alcohol and drug use.

> *We see a lot of people with...liver problems, pancreatitis, all sorts of physical problems...that would be related to their alcohol use...The people we see with alcohol problems are very severe generally and often they would have associated mental health problems as well...depression and anxiety being the main [ones].* (Participant 24, Service provider)

These are not surprising findings; at a national level, large increases (147% increase between 1995 and 2004) in alcohol-related liver disease have been reported over the past years.[33] Also, the psychoactive effects of certain drugs may induce psychosis, and people with mental health issues may self-medicate with illicit drugs to alleviate symptoms.[51]

Unsafe injecting practices can lead to the transmission of blood-borne viruses, particularly hepatitis C, which has serious health-related consequences. This view was supported by reports from injecting drug users who had acquired hepatitis C through their drug use.

> *I: When you were injecting drugs, did you share needles?*
> *P: I did...I ended up with hepatitis C.* (Participant 23, Problem drug user)

There were several reports of near-fatal and fatal consequences of drug use in the community. Participants also spoke about engaging in drug-related criminal behaviour, and its consequences. It is well-documented that problem drug use is associated with socio-economic disadvantage.[15] The social indicators linking drug use and socio-economic factors in a community include low levels of educational attainment, unemployment

and crime. Participants reported that drug users' health can also be affected by drug-related crime. For example, drug users reported that drug dealers sometimes used intimidation and physical violence when drug debts were not paid.

Social consequences

Drug use was reported as impacting negatively on some users' educational attainment, ability to hold employment, and civil liberty. For example, a service provider reported an association between the use of cannabis, lack of motivation and early school leaving.

> *I've a terrible thing about that hash...An awful lot of people seem to think it's a soft drug, or that it's not that harmful...I think it's a disaster. And I've seen so many kids, and I'm not just talking about kids from that poor area. I mean the decent-est of families, well-to-do families, and the kids, if they start taking hash when they're 13 or 14, you can almost bet they'll drop out before they do the leaving ... families... are at their wits end with kids now 20/21/22...dossing around doing nothing, can't seem to keep jobs, can't seem to get on with their lives, you know. Have done disastrous in school...very poor leaving certs, poor exams...And I put it down to hash.* (Participant 15, Service provider)

Data from the NDTRS reflect this trend of lower education attainment. The number of cases seeking treatment in Co Westmeath who had left school aged 14 years or under increased from 24 in 2004 to 69 in 2007. Just over one per cent (1.3%) were still at school. Over one-fifth of cases had not gone on to secondary school (21.9%) while one-fifth (20.0%) had completed to leaving certificate level.

6.5.2 Consequences for the family

Drug users and their families described the negative emotional impact of having a problem substance user in the family and the frustration and despair that it can bring to the whole family. This burden is intensified if there is a drug-related death in the family. Service providers, drug users and family members reported that problem alcohol and drug use affected family relationships and could lead to the breakdown of these relationships.

> *It [heroin addition] destroyed my relationship with my [child] and [partner]...I never got to know [my child]...now we have made some sort of contact but...won't ever be a...relationship...When I came out of addiction I made my efforts. I tried to get a clean slate and explained everything...and I tried to apologise to them as much as I could...That part of my life... that, you know..., it turned me from being a very okay person into [someone who] didn't care about my own flesh and blood.* (Participant 23, Problem drug user)

Indeed, the negative impact on the physical, psychological and emotional well-being of the family is well-documented.[34] Nationally, the impact of alcohol on marital relationships is very evident, with one study reporting that between 20% and 40% of people who sought relationship counselling were drinking excessively.[34] Problem alcohol use is frequently reported as a significant factor in domestic violence[35]

6.5.3 Consequences for the community

Several participants had witnessed the negative consequences of alcohol and drug use on the community, although as a whole it did not feature to a huge extent in the contributions of participants. There were several examples of alcohol related incidents.

> *I had a guy stabbed here on Saturday night, very, very nearly killed...Oh there would have been alcohol involved...a lot of alcohol involved with all the kids who were involved.* (Participant 15, Service provider)

The impact of drug dealing on the community was reported as a major issue. For example, some participants

felt that people in the community were reluctant to inform the gardaí if they had information about drug dealing. The community was also affected when problem drug users committed crimes in order to maintain their habit.

6.6 Perceptions of the response to the problem and gaps identified

This section presents data from the NDTRS in relation to Co Westmeath cases seeking treatment, reports participants' perceptions of the responses to the drug problem in Community D, and summarises any gaps they identified or solutions they offered.

6.6.1 Drug treatment figures

The number of cases living in Co Westmeath who sought treatment increased by 53%, from 222 in 2004 to 339 in 2007. Of the total of 1,014 cases in the period 2004–2007, 811 (80.0%) attended outpatient services, 179 (17.7%) attended a residential service, and 24 (2.4%) attended a general practitioner (Table 6.7).

Table 6.7 Westmeath cases assessed or treated, by service type, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All services	222	167	286	339	1014
Outpatient	178 (80.2)	134 (80.2)	236 (82.5)	263 (77.6)	811 (80.0)
Residential	30 (13.5)	27 (16.2)	49 (17.1)	73 (21.5)	179 (17.7)
General practitioner	14 (6.3)	6 (3.6)	1 (0.3)	3 (0.9)	24 (2.4)

The number of previously treated cases increased from 109 in 2004 to 157 in 2007 (Table 6.8). The number of new cases increased from 96 in 2004 to 146 in 2007.

Table 6.8 Westmeath cases assessed or treated, by treatment status, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	222	167	286	339	1014
Assessed only	12 (5.4)	4 (2.4)	26 (9.1)	23 (6.8)	65 (6.4)
Previously treated cases	109 (49.1)	73 (43.7)	151 (52.8)	157 (46.3)	490 (48.3)
New cases	96 (43.2)	87 (52.1)	108 (37.8)	146 (43.1)	437 (43.1)
Treatment status unknown	5 (2.3)	3 (1.8)	1 (0.3)	13 (3.8)	22 (2.2)

Source of referral

The largest proportion (32.1%) of cases seeking treatment in the period 2004–2007 were self-referred; 26.4% were referred by a general practitioner, and 14.8% by a hospital or medical agency. The numbers reporting a general practitioner, a hospital or medical agency, and the courts, probation service or police as the sources of their referral more than doubled within the reporting period.

Perceptions of type of services provided

In general, participants did not distinguish between services provided by statutory and voluntary agencies in the community or elsewhere. There is a methadone maintenance treatment clinic in Community D, staffed both by general practitioners, counsellors, nurses, general assistants, a clerical worker and an alternative therapist. This was seen by participants as working well and enabling opiate users to recover

and regain a more stable lifestyle. The main problem identified with methadone treatment was the length of the waiting list for new clients. The clinic in this community also served the surrounding areas, which impacted on the waiting list.

> *The biggest problem we have is the new patients coming through – trying to...get them in to clinics... Waiting times...it seems to be how long is a piece of string. You can't really get any definite time line in terms of how long it will take. It's essentially waiting for patients who are attending the clinic to be drafted out to a level one doctor. So unless there's somebody there to pick up the stabilised patients there's no room for any new patients.* (Participant 16, Service provider)

Methadone maintenance is only one part of a suite of interventions necessary for recovery. There was a drop-in centre in Community D for homeless adult men with addiction problems. The centre offered a range of support and services, including counselling and vocational training. However, this service was only available to a small group of individuals. Some participants reported having to 'make do' with what services were available, even if they were not always the most appropriate.

6.6.2 Overdose prevention and harm reduction – injecting drug use

NDTRS data show that 125 injector cases who lived in Co Westmeath entered treatment between 2004 and 2007 (Table 6.9). Over 40.0% of these were still injecting on entry to treatment.

Table 6.9 Westmeath cases treated, by injector status, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	210	163	260	316	949
Had injected	33 (15.7)	23 (14.1)	31 (11.9)	38 (12.0)	125 (13.2)
Never injected	166 (79.0)	136 (83.4)	223 (85.8)	272 (86.1)	797 (84.0)
Not known	11 (5.2)	4 (2.5)	6 (2.3)	6 (1.9)	27 (2.8)

Of all cases who reported ever having injected illicit (or licit) drugs, one quarter (25.0%) had started injecting before they were 19 years old. In total, 71 (46.7%) cases reported sharing injecting equipment. Overall, the proportion of injector cases who reported sharing equipment remained the same between 2004 and 2007 (Table 6.10).

Table 6.10 Westmeath injector cases treated, by equipment-sharing practices, NDTRS 2004–2007

	2004	2005	2006	2007	Total
			Number (%)		
All cases	44	27	37	44	152
Shared equipment	17 (38.6)	20 (74.1)	16 (43.2)	18 (40.9)	71 (46.7)
Did not share equipment	7 (15.9)	2 (7.4)	10 (27.0)	16 (36.4)	35 (23.0)
Not known	20 (45.5)	5 (18.5)	11 (29.7)	10 (22.7)	46 (30.3)

These data on injecting drug use are supported by qualitative data from Community D. Participants noted the need for harm reduction services, including needle exchange, in the community.

> *With regard [to] heroin use, we have identified the need for harm reduction in the area ...because ... needles have been found in various green areas, and that would cause danger for young kids in the areas. So there's a need for harm reduction and [an] outreach programme.* (Participant 18, Service provider)

The primary objective of needle-exchange services is to reduce the transmission of the blood-borne viruses HIV, HCV and HBV, which can occur through the sharing of injecting equipment. It is well-documented that changing risk behaviours in this group is difficult, but research suggests that Irish needle-exchange programmes have had some success in reducing the incidence of sharing.[40] [41] The prevalence of blood-borne viruses among injecting drug users in Ireland is high.[38]

There were several reports of near-fatal and fatal overdoses in the community. These reports highlight the need for an overdose prevention strategy in the community. Typically, needle and syringe exchange services provide information and education in relation to overdose prevention strategies.

6.6.3 Specific treatment issues

Methadone treatment and waiting lists

Several participants were of the opinion that it was difficult for opiate users to get off methadone, and that many had been on treatment for an extended period of time.

> *I think what's happened here is people get on methadone, they feel they're on methadone for life. There isn't much moving on after that and that...seems to have become the norm here...If people saw people going into treatment, detoxing, coming out clean...then they would see that as another option. Whereas, because there is no detox, nobody ever seems to talk about detoxing.* (Participant 24, Service provider)

Some participants felt that individuals on methadone treatment were not always monitored properly and that merely issuing a prescription for methadone was not enough, especially, as noted above, in view of the difficulties of getting people off methadone. The number of people on long-term methadone maintenance, in conjunction with the limited number of places available, was felt by participants to impact negatively on waiting times.

Pharmacies in the community dispensed methadone and supported the programme. However, some participants observed that the facilities in some of the pharmacies were not private and that people had to drink their methadone (if not given a take-away) in front of other customers. This illustrates the problem of maintaining confidentiality in a small community and the stigma still associated with opiate use. There was also anecdotal evidence of misuse of the methadone treatment programme, including some diversion into the street methadone market.

Residential and detoxification treatment

Participants in this study did not differentiate between the treatment models used in residential treatment centres and often used the terms residential and detoxification interchangeably. The type of residential treatment available differs considerably, but most do offer detoxification programmes. Participants reported that the limited number of residential services, and their distance from the community, had resulted in individuals detoxifying at home.

Some participants commented on the lack of aftercare and support in the community for those who had completed a residential treatment programme, and illustrated how this hindered the success of such programmes.

> *When the fourth week was up they let him out of it. He had no flat, he had no job. He had nothing... We could see the change in him, but he wasn't a day out...and he was back on the stuff again because he had nothing.* (Participant 22, Family member)

There are different models of residential treatment, not all of which may suit or be suitable for an individual

with an addiction. However, they can be very successful and some family members recounted positive experiences with residential treatment, sometimes after initial failures.

Alcohol treatment

Participants commented that the services for people with alcohol misuse problems had changed over the years.

> *The big problem I have with alcoholics is that, in the past..., when somebody had a serious alcohol problem... they could be admitted for treatment, but they're not anymore. With the Mental Health Act that's [alcoholism] is no longer a condition that you can commit [someone] to hospital for treatment for.* (Participant 16, Service provider)

These changes, coupled with the difficulties of 'dealing' with a problem alcohol user, means that the current service provision was felt to be inadequate.

Social reintegration

Social reintegration is an integral part of rehabilitation and recovery from a drug addiction.[39] Its components include the provision of education, training, accommodation and support to drug users to assist in their recovery and rehabilitation. Participants highlighted the need for improved support and services to aid the recovery of drug users.

> *I'd like them to be able to lift the phone and ring somebody if they feel they're down. I'd like them to be there for them to be able to get them into employment. I'd like them to be able to make sure their flats and everything else is okay for them until they're stable.* (Participant 22, Family member)

Some individuals need long-term support, and a proportion will relapse; service providers pointed out that support services were necessary over a long period of time. Employment is an important aspect of rehabilitation. For example, NDTRS data show that nearly half (45.3%) of cases assessed or treated living in Co Westmeath between 2004 and 2007 reported that they were unemployed.

A factor of social reintegration is housing or other accommodation. The NDTRS data show that the majority (91.9%) of cases living in Co Westmeath who were assessed or treated, 2004 to 2007, reported living in stable accommodation. A very small proportion were homeless (2.0%), in unstable accommodation (2.0%) or in an institution (1.6%) (e.g. clinic or prison).

6.6.4 Services for under-18s

Participants highlighted the lack of specific addiction services for young people in the community. According to NDTRS data, of the cases living in Co Westmeath who were assessed or treated between 2004 and 2007, 37 (3.6%) were aged 17 years or under. A further 61 (6.0%) were aged 18 to 19 years.

It was noted that it was very difficult to get under-18s into residential treatment because of the lack of places. It was felt that, even when a young person was able to get into a residential centre, the treatment provided was not always suitable.

> *It's hard for people to get into residential [treatment], and there's certainly not much for the younger person. I think it's even more difficult for them [under 18s] to get an appointment. Don't know [why]. I think they need to involve parents and it's quite difficult and takes a lot of time, and we don't seem to have anything local.* (Participant 15, Service provider)

There had been attempts to provide alcohol- and drug-free activities for young people in the community, such as youth discos. However, these activities appeared to have had very limited success for the amount

of effort that was required to organise and supervise them. Although there was a youth centre available for a certain group of young people, one service provider commented that services needed to cater for, and be accessible to, all the community.

At the time of data collection for this study, one community group had started a project to develop different ways to bring drug education messages to young people, because traditional methods, such as leaflet distribution, were felt to have had limited success. Indeed, young people who participated in the study were unaware of where or how to access information or help about alcohol or drug problems.

6.6.5 Family issues

As the NDTRS data show, over one-third (35.5%) of cases living in Co Westmeath, 2004 to 2007, who were assessed or treated reported living with their parents or family. This number more than doubled over the reporting period. Unlike the other communities examined in this study, the second largest proportion of cases (20.4%) in Community D were living with a partner and child.

Family members reported trying very hard to do the best for their relative, often under difficult circumstances. The effects of problem alcohol or drug use on the family were observed by many participants, and the need for support for families was highlighted.

> *P: From time to time we would inter-link with the family, their spouse or partner or their parents would contact us...[and ask us] can you do anything for 'Joe'? And we would try and...inter-link with other agencies...[but] unfortunately they're very thin on the ground...there's no place for females at the moment...for spouses or partners.*
> *I: There's no family support?*
> *P: Not really, no.* (Participant 16, Service provider)

However individual family members reported that they had been offered some support through the addiction services.

Suggested solutions and responses

Services

Overall, participants felt that there needed to be improved and expanded addiction services in the community. They acknowledged that there was still stigma attached to drug addiction for the individual and their family in this small town, and the necessity (and difficulties) of offering confidential, yet accessible, services.

> *[Problem drug use causes] embarrassment and [families feel] helpless. [They need a service so] that they don't feel [they're] on their own and maybe the addict might come and talk... 'I don't want to be on drugs, I wish I wasn't addicted but I don't know what to do or where to go.' And I think that [it is important] to provide a service within the area that people aren't intimidated to go [to].* (Participant 21, Service provider)

As with problem alcohol use, participants felt that there was a need for earlier recognition of problems to enable earlier intervention. Several participants spoke of the need for counselling and/or detoxification services to facilitate admission to residential treatment and of the difficulty in accessing certain treatment programmes before an individual was drug free.

The problem of cocaine use was identified as being new to the community and it was noted that there was a lack of understanding about treating that type of addiction and a lack of services for problem cocaine users. The need for outreach for individuals in treatment and those not able or ready to access treatment

was highlighted. (An outreach worker had just been appointed as this study was completed.)

Overdose prevention and harm reduction

Since this study began, a community outreach worker has started work in the community and an outreach needle and syringe exchange programme began in December 2008.

> *The key to [harm reduction services] is an outreach programme...If you had a centre... in the middle of [Community D] for a needle exchange building, that wouldn't go down well in [Community D].. But an outreach [programme] where the person would...go out in the street and would...meet people in the street...and [running a] confidential...needle-exchange programme, that...would work.* (Participant 18, Service provider)

However, participants voiced their concern about the community's attitudes to certain issues, including needle exchange. Some participants felt that as the community saw the benefit of the activities, they would become more accepting of different programmes.

Methadone treatment

The need to reduce the waiting times for treatment and the number of clients on the waiting list was a serious concern of many of the participants. They highlighted that the methadone clinic needed to be expanded to cope with the number of clients within its catchment area (which includes Community C). Participants explained that this would mean bringing in at least one other suitably qualified general practitioner to take on new clients, employing more support staff and improving and expanding the existing facilities. It was also suggested that pharmacies should have the proper facilities before being admitted onto the methadone scheme.

> *But at the moment there's no GP to take on new clients [in the methadone programme]...and we have a huge...waiting list to get on the methadone programme. [The] service just isn't adequate for the numbers of people there are out there. We have a huge waiting list and people are stopping coming because they see there's no point in coming because you're just going to be put on a waiting list... There needs to be more places on the methadone clinic...[and] they need to look at other alternatives to methadone.* (Participant 24, Service provider)

There are many benefits to proper treatment. A recent longitudinal study conducted in Ireland, the ROSIE study, reported the positive impact of methadone treatment over a three-year period.[47] The positive impacts included reduced illicit and licit drug use, decreased injecting drug use (46% to 27%), increased uptake of training courses and employment, and a sustained decreased involvement in crime (including dealing).

Methadone is not the only option for those with an opiate addiction, and participants mentioned the need for proper follow-up and assessments and the possibility of alternative treatments. Additionally, the lack of opportunity to come off methadone after a period of stability was frequently mentioned as a hindrance to the recovery of individuals.

Residential treatment and detoxification

There was general agreement among the participants about the need for considerably improved access to residential treatment centres, including detoxification, that were within reach of Community D.

> *Beds, beds and more beds for detoxing, to remove the person for a period – physically remove them from the environment and the actual drug. They may get a moment of clarity away from it, to...say, 'Right, my life is going down the tubes, I need to do something.'* (Participant 19, Service provider)

Participants felt that greater access to residential care and detoxification facilities would mean that people with an opiate addiction would have choices other than methadone. Participants also identified the need for proper aftercare and support, along with support for the family, to enable recovery from an addiction.

Alcohol treatment

The need for earlier intervention in problem alcohol use was highlighted by several participants. Early intervention is acknowledged to be important in the treatment of problem alcohol use.[33]

> *Early intervention isn't happening. I see a lot of people particularly with alcohol use...people have to be going to GP's with alcohol related problems much sooner than we're getting referred. And I think that early intervention is the big thing.* (Participant 24, Service provider)

Early recognition and referral from acute hospitals was seen to have worked well in other areas and it was felt that it could be introduced in the Midlands for both alcohol and drug problems.

Social re-integration

Along with the need for improved employment and housing, some participants stressed that recovering drug users may need to move away from the community, out of their old environment, away from the influence of friends to facilitate their recovery.

> *The individual drug user that wants to get off the drugs and goes away [to] a programme somewhere and then obviously comes out of the programme after a two-month, three-month programme, back into that same setting again, that can have a very negative effect on the person [to be] back in the same area where there's people there dealing in drugs...that's why there is a... big need for a rehabilitation programme...where they're given the choice, rather than go back into the same environment that they...put a CV together...where they're given a job and move to a different way of life, to move on.* (Participant 18, Service provider)

Under-18s

The continued need for education for young people was highlighted by most participants, with one participant commenting that this education needed to be started at a very young age. Young people in the community had little recollection of drug awareness education that they had received.

> *There's a whole...culture to be changed...one of the main things I would say is education...and taking care of the kids when they're very young...I mean, very, very young, I'm talking about pre-school.* (Participant 15, Service provider)

Although there were activities for young people in the area, including alcohol- and drug-free discos (see above), some young people did not access them for a variety of reasons. This need to tackle the isolation and marginalisation of certain young people was raised by several participants and it was suggested that this could be addressed by the development of a centre for young people based in the community. This centre could offer a range of social activities and facilities, including drug education and advice given in a secure and confidential way. This was also something that young people felt might be useful.

> *Definitely a go-to [place] for problems, a generally known one that where you can pop in, a drop-in-centre or something like that, it's not official, some one to talk to who won't judge or anything like that.* (Participant 86, Minor)

Families

The need for support for families, including a family support group was mentioned by many participants.

> *A support group for parents of people with addictions, any form of addiction [is needed]. But I suppose what we're really talking about is drugs and alcohol, but it can take in any other kind of addiction.* (Participant 20, Family member)

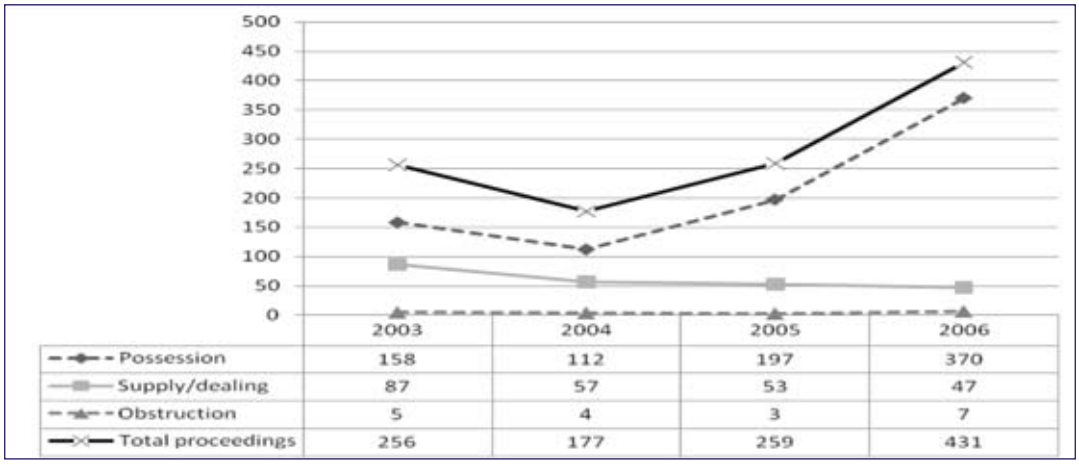
In fact, the type of family support envisaged by participants was a wider concept, set in a permanent building in the community, rather like a drop-in centre. This would ideally offer both psychological and social support to families of drug users and drug users themselves, with trained staff, in a safe and confidential environment.

6.7 Drug-related crime in counties Longford and Westmeath

This section brings together statistics from the CSO on drug-related crime from the Longford/Westmeath Garda Division. The qualitative data on perceptions of crime in Community D are presented in Section 6.8.

6.7.1 Proceedings for drug offences in Longford/Westmeath Garda Division

Figure 6.1 presents the number of drug offence proceedings, by main offence type, in the Longford/Westmeath Division for the years 2003–2006. The proceedings for possession of drugs have increased between 2004 and 2006. Of the total drug offence proceedings in 2006, 86% were for possession. Proceedings for drug supply offences almost halved over the period, while those for possession offences more than doubled. The number of offences for obstruction were small throughout the period under review.

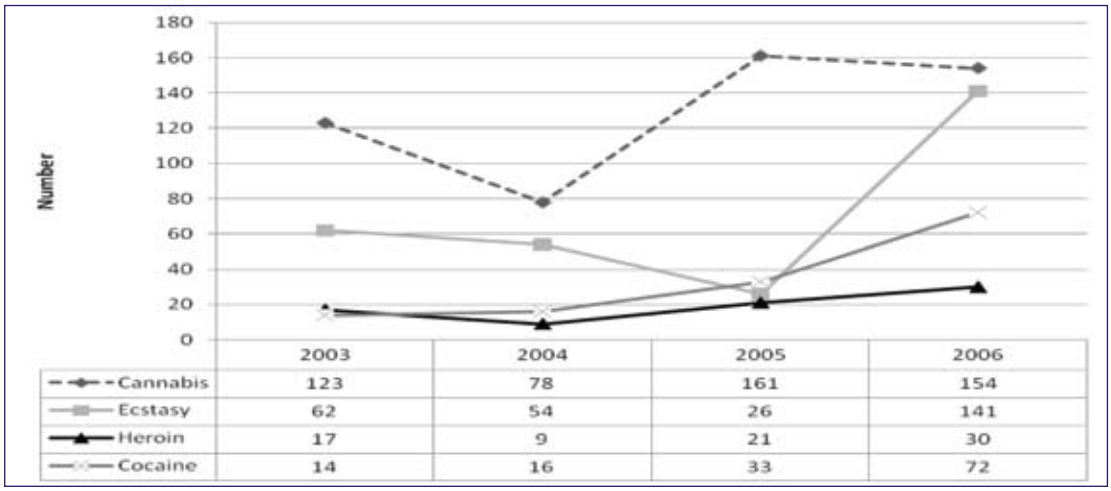


	2003	2004	2005	2006
Possession	158	112	197	370
Supply/dealing	87	57	53	47
Obstruction	5	4	3	7
Total proceedings	256	177	259	431

Figure 6.1 Drug offence proceedings, by offence type, Longford/Westmeath Garda Division 2003–2006

6.7.2 Proceedings for possession, by drug type

Figure 6.2 shows that the majority of possession proceedings between 2003 and 2006 related to cannabis. There was a sharp rise in proceedings for ecstasy possession in 2006 when compared to 2005. The number of proceedings for possession of cocaine increased considerably over the four years, with a big increase in 2006. Proceedings for heroin possession also increased somewhat over the reporting period.



	2003	2004	2005	2006
Cannabis	123	78	161	154
Ecstasy	62	54	26	141
Heroin	17	9	21	30
Cocaine	14	16	33	72

Figure 6.2 Proceedings for possession, by drug type, Longford/Westmeath Garda Division 2003–2006

6.8 Perceptions of drug use and crime in Community D

Participants spoke of both types of drug-related crime: drug offences committed in contravention to specific drug laws, e.g. possession or supply, and crimes related to drug use or activity, e.g. robberies to fund drug use.

> *There's a lot of crime associated with heroin...Anyway they can get money they would be involved in crime, break ins, robberies and that type of thing...trying to get money...to feed the habit.* (Participant 18, Service provider)

Participants also reported violent crimes fuelled by alcohol in the community. In addition, it was noted that young people are involved in alcohol- and drug-related crime which needed to be addressed.

From the reports of the participants, it appeared that drug dealing was visible in parts of the community. There was the perception that only a small group were responsible for the majority of drug- related crime in the community, and this was very intimidating for some of the local community.

Another service provider reported that parents were reluctant to let their children play outside their houses in some areas.

> *I would be aware of areas where people would be using heroin. There would be difficulties with neighbours in places in some [areas] – people dealing heroin in certain areas. Then you'd have people going into an area then looking for the drugs and calling to people's houses. And that would cause serious concerns for neighbours. They'd be afraid, they don't want children out on the street with these people dealing.* (Participant 18, Service provider)

Some efforts were being made to improve communication with the gardaí and to encourage people to offer information and assistance. In relation to resources, there were gardaí based in Community D dealing specifically with the drugs problem. However, some participants felt that the gardaí did not do enough; additionally there was the perception that drug crime was highly visible and that the gardaí were well aware of it. This view was countered by other participants who felt that the gardaí were doing their best, working within the legal requirements and given the limited resources available to them.

Problem drug users viewed the work of the gardaí from another perspective and reported feeling unfairly

treated. Additionally, some family members appeared adversely affected by the actions of the gardaí.

Some participants suggested that the sentences for those involved in drug-related crime were not enough of a deterrent, and that this needed to be addressed. The need to both standardise sentencing for drug-related crime to deter people from engaging in this behaviour was also mentioned and offer alternatives to custodial sentences for drug offences, such as residential treatment programmes was also highlighted. Several participants spoke about imprisonment and their belief that it exacerbated a drugs habit or, indeed, was responsible for initiating a habit.

> *There's drugs in prison…there are people who go in to prison without a drug problem who come out with one…So I think they're a joke…a waste of time…and I can't see why things like community service can't be enforced with an awful lot more vigour…in a more meaningful way.* (Participant 16, Service provider)

The experiences described by participants clearly indicate the need to address the problem of drug availability and to improve prevention, treatment provision and support in prisons, including on discharge release.

6.9 Key findings in Community D

Community D is medium sized town in Co Westmeath, but with several indicators of deprivation including higher levels of local authority housing and rising unemployment.

Factors contributing to the problem

There was no agreement on what was the most problematic substance in the community, with both alcohol and drug misuse considered the cause of major problems in the community. However, there was agreement that the situation was getting worse.

The relatively easy local access to licit and illicit drugs was reported as one of the most important factors contributing to the spread of the problem. Licit drugs, including benzodiazepines and methadone, were available for sale within the community. This was seen in the reports of the apparent normalisation of alcohol and drug use among young people and in relation to problem drug use, the influence of peers as a factor in relapse after a period of abstinence or even treatment.

Consequences of substance use

The physical and mental health consequences of alcohol and drug use for the individual user were reported and included liver conditions and depression. The harm associated with problem substance use and experienced by family members included emotional turmoil, a disruption to, and the breakdown of the family unit.

Drug treatment figures

NDTRS data show that alcohol was the main problem substance of those presenting for treatment and the numbers increased over the reporting period. The number of treated cases reporting opiates as their main problem substance also increased, which was supported by the views of participants in the community. Almost one-fifth of those in treatment reported benzodiazepines as an additional problem substance, these were mainly opiate users. There was evidence of polysubstance use in the community, which was backed up by figures from the NDTRS.

Perceptions of the response to the problem, and gaps identified

All participants highlighted the lack of addiction services in the community, in particular the need for general practitioners, expansion of methadone treatment, detoxification beds and services for under 18s. Although there was a methadone service in the community, it was severely hampered by a lengthy waiting list and the number of long-term continuous-care clients. In general the focus was on the provision of addiction services for opiates, despite the evidence of polysubstance use. In relation to problem alcohol use, the need for early intervention was reported. The need to expand the drop-in centre, which currently provides vocational training and counselling services for adult men, to provide services for women and young people was reported. The need for improved support services to aid the recovery from problem substance use including education, accommodation and employment opportunities was also reported.

Reports of drug-related crime in the community, some of it violent, and the visibility of drug dealing appeared to have created an atmosphere of intimidation in certain sectors of the community to such an extent that some residents did not feel comfortable within their own community. Participants differed in regard to how much the gardaí were doing, with some feeling they were not doing enough while others felt they were doing their best within their limited resources. As imprisonment was felt to exacerbate, or even to be instrumental in the initiation of problem drug use, the need for alternatives to custodial sentences was highlighted.

6.9.1 Participants' recommendations for service provision in Community D

Table 6.11 presents an overview of the recommendations for service provision as reported by participants. For presentation purposes they are contextualised within the pillars of the National Drug Strategy 2001-2008.

Table 6.11 Participants' recommendations for service provision in Community D

Pillar	Existing services provided in community*	Community D
Supply Reduction	Community gardaí	Improve communication with gardaí Action on youth drug crime
Prevention	Youth Diversion project Youth Reach (not based in community) FAS Community employment project Youth project Local drugs awareness & local drug network group Community services council Rapid Co-ordinator SPHE in secondary schools	Improve drug awareness education for young people Improve drug awareness education for adults Improve early recognition and intervention in cases of problem substance use among younger people/ Address missed opportunities for brief interventions Provide alternative social activities for young people
Treatment & rehabilitation	HSE addiction services including methadone clinic Level 1 GP(s) Health education officer Outreach worker Mobile needle exchange Alcoholics Anonymous Community employment project Community services council FAS Community development project (for men only)	Provide addiction services for under-18s, including residential services Provide drop-in centre for all population, drug users and their families Improve and expand addiction services Improve and expand facilities for methadone maintenance treatment Reduce waiting list for methadone treatment Address waiting lists for other addiction treatments Ensure confidential services appropriate to a small community Provide alternative treatments to methadone for opiate users Provide more residential treatment centres – located near to community/accessible to community Provide accessible detoxification treatment Improve alcohol treatment Improve aftercare for recovering problem substance users Extend addiction services to cover polysubstance use Address missed opportunities for brief interventions Provide longer-term support for problem substance users and their families Improve addiction and prevention treatment in prison Include families of drug users in treatment and provide support for families Outreach Provide family support Social reintegration: improved accommodation services, opportunities for education and vocational training, employment Provide alternative activities for people Alternatives to custodial sentencing

*Note – not an exhaustive list

7 KEY ISSUES AND RECOMMENDATIONS

Overview

This section brings together the key issues arising out of the available regional and community level data from the four communities along with examples of best practice or existing strategies and national recommendations for the problems identified. As many of the issues were common to all communities, the findings may in part be generalised to the whole of the MRDTF area, however individual areas within the MRDTF area may have different factors or specific issues that cannot be addressed in this study. The findings should also be considered in the context that service providers in the MRDTF area strive to do their best for service users, with limited resources and increasing demand.

The study is constrained by the type of data available and also the geographical level available for analysis. It is also important to remember that participants' perceptions are qualitative in nature and should be interpreted as such. The consistency of the findings with other Irish and international research means that at the time of data collection, it did provide an authentic picture of the substance misuse problems in the four communities. The main developments since data collection is the availability of legal highs from head shops.

Expand and improve existing services

Prevalence data clearly show a rise over time in the proportion of the population in the MRDTF area using illegal and misusing legal drugs, supporting similar perceptions from the qualitative data. Data from the NDTRS clearly showed the rise in numbers seeking treatment for both problem drug and alcohol use. Although there was not a consensus as to what was the most problematic substance in the MRDTF area, the majority of those treated was for problem alcohol use. Cannabis was the most commonly used drug in the MRDTF region, however for those in treatment, heroin was the most common problem drug. Polysubstance use also presents a serious risk to users in the MRDTF area. Hidden problems, for example, benzodiazepine and steroid misuse also emerged in this study.

There is a need to expand and improve the existing addiction services to cope with the increasing numbers requiring treatment and the increasing problem of polysubstance use, often alcohol and drugs in combination. Addiction treatment services in two areas need to re-orientate their focus from opiates only but also other drugs, as well as providing a more integrated approach to the management of drug and alcohol use. This may be achieved through care plans and the appointment of a key worker to each individual client as recommended by the Report of the Working Group on Drugs Rehabilitation.[55]

Other factors which need to be addressed include:

- Improved communication between service users and services
- Improved communication between statutory and voluntary services to enable a better 'continuum of care' for the service user to move between the different treatments and services and on to recovery
- The need for a face-to-face out-of-hours service, with the ability to respond to crisis situations
- Improved support and services for families

Improve and increase access to services

The need for accessible services available within the community was a key issue. The geographical distances were both barrier and burden to both service users and their families accessing services. The solution envisaged by the participants was ideally, a drop-in centre, located within the community, which would not only provide accessible and timely treatment but emotional and psychological support for the

drug user and their family. This in part is probably a reflection of the difficulties that users and families have in accessing services in general, navigating through the different services, poor communication, lack of services and confusion about types of treatment and the frustration with the current level of service provision. The geographical distances are more difficult to address without improving the public transport infrastructure and suggest the need for a more decentralised approach from the addiction treatment services.

Harm reduction

Both the quantitative and qualitative data showed evidence of sharing needles and other potentially dangerous practices, including unsafe disposal of used needles in public areas in the MRDTF area. Strategies such as needle exchange programmes can not only provide clean equipment but information and assistance to drug users, many of who are not within the treatment services.

Access to Methadone treatment

There is a need to improve access to methadone maintenance treatment as all the communities reported what appeared to be chronic problems in accessing methadone treatment. Factors implicated in this were lengthy and intractable waiting lists, lack of general practitioners offering the service in the community and often the distances required to travel to avail of the service. There was evidence that the lengthy waiting lists were a barrier to individuals seeking treatment. This would necessitate that current facilities are improved and the existing service expanded, supported by adequate staffing quotas. It appears to be difficult to increase the number of general practitioners to provide services for opiate users stable on methadone. In the UK and Australia, nurse specialists, under the supervision of an addiction psychiatrist, have been used to provide such treatment and the evidence indicates that the treatment provided is as good as and in some cases better than that provided by general practitioners.[56]

Individuals with problem opiate use should also be able to access alternative treatments for opiate addiction, other than methadone maintenance.

Access to detoxification services

There are no residential detoxification facilities in the MRDTF region and this compounded by waiting periods and distances involved for other facilities outside the region was identified as a significant problem in the region. The recent report from the HSE has already noted the deficit in the number of inpatient detoxification and residential rehabilitation beds in the State and the need for a centre to service both the Dublin Mid-Leinster and Dublin North East HSE regions (encompassing the MRDTF area).[57] These types of programmes do require appropriate aftercare support and 'seamless transition' to rehabilitation programmes to avoid relapse and/or overdose. The HSE report[57] also recommended the need to review community detoxification programmes. This seems particularly important for the MRDTF area especially in light of the reports of home detoxifications at the community level, however this has resource implications and would require increased numbers of general practitioners and key workers to implement such a scheme safely and successfully.

Access to rehabilitation services and aftercare

The 2008 HSE report on Residential Treatment and Rehabilitation stated that detoxification services also require appropriate aftercare support and 'seamless transition' to rehabilitation programmes to avoid relapse or overdose.[57] Currently there are no residential rehabilitation facilities in the region and the distances that are involved are an additional burden, not only for the substance user but also for their family and make it difficult for them to be involved in the process of recovery.

Problem alcohol use

Problem alcohol use on its own or in combination with other drugs, was highlighted as a major problem in the community. The ease of access and apparent normalisation of alcohol among the population, including young people was clearly evident. Problem alcohol use also placed considerable burden on the addiction services. The social harm of alcohol, both to the individual and the communities was also evident. Additionally, alcohol is acknowledged as a gateway substance to other drugs.

As well as access to adequate treatment and treatment facilities there are a number of international evidence-based strategies with a strong public health approach which have been shown to reduce alcohol-related harms. These clearly show that taxation and regulating the physical availability of alcohol are the most effective measures in reducing alcohol-related harm in a population. Education in schools, public service announcements and voluntary regulation by the alcohol industry are not effective in their own right, but only as part of a comprehensive strategy.[33]

Services for under-18s

Access to and availability of appropriate services for under-18s with problem substance use was highlighted as a major issue in the MRDTF area. The importance of providing local, accessible and adolescent-specific services has already been identified as a priority by the Department of Health and Children.[58] Ideally services for this group should have a combination of disciplines on site, offering assessment, treatment, aftercare and social reintegration.

Misuse of benzodiazepines

There is evidence from both the qualitative and quantitative data that problematic benzodiazepine use occurs in the MRDTF area although the level of the problem is difficult to assess. A comprehensive set of recommendations around the inappropriate use of benzodiazepines were produced in 2002, Department of Health and Children.[59] These include improving legislation, tighter monitoring and control of prescribing, improved clinical guidelines with an emphasis on short-term treatment and the use of alternatives.

Improved drug awareness education

Many participants expressed the need for improved drug awareness education for young people, especially while young people expressed little recall or interest in the substance misuse education they had received. Prevention of early drug use is important as many of those in treatment commenced their substance use before the age of 18. There is a body of evidence suggesting that selective prevention, targeting at risk young people, is effective in reducing drug use.[60] [61] Successful programmes include strong behavioural life skills development, interpersonal and communication skills. Other evidence points to family-based programmes. Working with at-risk families to improve child development outcomes, improving educational outcomes and reducing social exclusion are also effective.

Drug related deaths

Strategies to reduce drug related deaths include rapid access to treatment, education of drug users, their family, friends and the community in the risks of overdose, dangers of polysubstance use (e.g. cocaine and alcohol) and basic life support skills.

Social reintegration

A need for improved and additional services addressing accommodation, education and employment issues in order to reintegrate former problem drug users to society. Young people who leave education early would particularly benefit from this approach as this group has been identified at high risk. The communities reported that services currently provided for this age group are not satisfactory.

Drug crime

There is evidence that illicit drug markets are operating in each county and individuals both teenagers and adults are able to access a range of drugs relatively easily. These markets need to be disrupted to reduce drug-related harms to individuals and the communities. There is growing evidence that partnership between all stakeholders offers the most sustainable method of responding to street level markets. This would require a multi-level response with the justice system, police, health authorities and the communities working together to deal with the problem.[4]

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Notes

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