



European Monitoring Centre  
for Drugs and Drug Addiction



**2011 NATIONAL REPORT (2010 Data)  
TO THE EMCDDA  
by the Reitox National Focal Point**

**IRELAND**  
**New Developments, Trends and in-depth  
information on selected issues**

**REITOX**

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## Summary of each chapter

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

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

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

11. Drug-related health policies and services in prison
12. Drugs users with children (addicted parents, parenting, child care and related issues)

### Main points from Part A

#### 1. Drug policy: legislation, strategies and economic analysis

A number of new legislative measures were introduced during the reporting year. The aim of the Criminal Justice (Community Service) (Amendment) Bill 2011 is to require a court to consider imposing a community service order instead of a prison sentence in cases where an offender stands convicted of an offence for which a sentence of up to twelve months imprisonment would be appropriate. Most drug offenders serve sentences of less than one year.

The government has committed itself to introducing a new roadside drug-testing programme in response to driving under the influence of drug offences. The government has also committed itself to reviewing mandatory sentencing laws in the context of drug policy. This is particularly relevant in light of a recent Supreme Court decision which overturned a ten-year drug conviction, thereby raising a number of questions about the future application of mandatory sentencing laws. The Criminal Justice (Psychoactive Substances) Act 2010, introduced to address the 'head shop' phenomenon, has been the subject of a number of academic articles and studies during the reporting year, some of which have been highly critical of this approach to the control of 'legal' highs.

Following a general election in February 2011, the new coalition government both endorsed the Interim National Drugs Strategy 2009–2016 (NDS), including the integration of drugs and alcohol strategies, and set out its own priorities in relation to illicit drugs in its new programme for government. It has assigned responsibility for the NDS to the Department of Health, which has not had lead responsibility for the drugs issue since the early 1990s. Two drug-related units have been established in the Department (replacing the Office of the Minister for Drugs) – a Drug Policy Unit to oversee the implementation of the NDS, and a Drugs Programme Unit to manage the Drugs Initiatives Programmes.

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<sup>1</sup> A copy of the EMCDDA guidelines is available from the EMCDDA website at [www.emcdda.eu.int](http://www.emcdda.eu.int). The guidelines require each Focal Point to write its National Report in a prescribed format using standard headings and covering each topic using a check list of items. This helps to ensure comparability of reporting across the EU.

Ireland's total budgeted public expenditure on the illicit drugs issue in 2010 was €260.296 million. Analysis using the UN's Categories of Functions of Government (COFOG) shows that approximately two-thirds of direct public expenditure was associated with health-related functions of government, just over one fifth with justice-related functions and one tenth with education-related functions.

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

The results of the third all-Ireland general population drug prevalence survey showed that the proportion of adults (aged 15–64 years) who reported using an illegal drug in their lifetime (ever used) increased, by just over 3%, from 24% in 2006/7 to 27.2% in 2010/11. The proportion of young adults (aged 15–34 years) who reported using an illegal drug in their lifetime also increased, by just over 4%, from 31.4% in 2006/7 to 35.7% in 2010/11. The proportion of adults who reported using an illegal drug in the last year (recent use) remained stable, at 7.2% in 2006/7 and 7% in 2010/11. The proportion of young adults who reported using an illegal drug in the last year also remained stable, at 12.1% in 2006/7 and 12.3% in 2010/11. The proportion of young adults who reported using an illegal drug in the last month (current use) was 5.3%. The considerable increase in the proportions using any illegal drug at some point in their lives was influenced by the facts that drug use in Ireland is a recent phenomenon and that the population of lifetime and recent drug users in Ireland is relatively young.

Several small studies were published during the reporting year on drug use among targeted groups including early school leavers, rural school children and third-level students.

## **3. Prevention**

Regarding prevention in schools, a recent report suggests that most post-primary schools have substance use policies in place, but little is known about these policies or their implementation. A recent evaluation of the implementation of Social, Personal and Health Education (SPHE) in primary schools includes an assessment of the quality of learning from and teaching of SPHE and the views of parents and school principals. Another study reports that the effectiveness of measures to tackle early school-leaving remains in doubt.

Following participation in the Strengthening Families programme, families affected by drug use in the family unit have self-reported improvements in a number of areas. Innovative measures to target 'hard-to-reach' families of drug users have been developed by the Family Support Network (FSN). A case-study of a local community-based project highlights the merits of this approach in responding to the needs of 'treatment resistant clients'.

Evaluation of drug prevention measures remains poor, particularly for assessing outcomes and impacts. Most evaluations focus on administration, implementation and coordination. This information highlights how measures are being updated and improved rather than an examination of their impact. This limits both the scope and quality of reporting.

## **4. Problem drug use (PDU)**

A national 3-source capture-recapture (CRC) study, conducted in 2006, indicates that problem drug use in Ireland has increased since the previous survey in 2001. The major expansion of the national methadone treatment programme between 2001 and 2006 is the main reason for the inflation of the figures. The National Advisory Committee on Drugs has commissioned an investigation into methods and data sources which can be used to estimate the number of problem opiate and cocaine users and the prevalence of problematic opiate and cocaine use in Ireland.

Three research reports are described in which the pattern of problem drug use among three separate populations is discussed – users of Simon Community services in

Ireland in 2010, 100 opiate or methadone users living in a local drugs task force area in Dublin using data collected from September 2007 until the end of 2008, with some follow-up work in 2009 and people with HIV in 2005 (this comparative study asked about tobacco and alcohol use as well as other drug use).

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

Treatment provision remains at a similar level to 2010 although the HSE is seeking to increase coverage in the south and west regions of the country. A National Drugs Rehabilitation Framework has been approved and implementation will enhance the provision of rehabilitation services by creating integrated care pathways with the co-operation of different care providers.

The first ever external review of the Methadone Treatment Protocol has been completed and contains recommendations with regard to maximising treatment provision and reviewing the efficacy of referral pathways, clinical governance and audit, enrolment and training of GPs, urine testing, prescribing of methadone in Garda (police) stations and data collection and analysis. The UK-based Quality Standards in Alcohol and Drugs Services (QuADS) programme is now being rolled out to services in Ireland.

Regarding the range of services, a pilot programme for community detoxification has been extended outside Dublin with two separate protocols provided, for methadone and for benzodiazepines. Training in cognitive behaviour coping skills training, rehabilitation and brief interventions particularly for overdose and alcohol misuse are being provided through the National Addiction Training Programme. Regarding access to care, the number of continuous care clients attending methadone treatment has steadily increased, from 3,681 in 1998 to 8,727 in 2010. Over the past five years, approximately 800 new clients have started methadone treatment each year, an increase of roughly 7.5% per annum.

Researchers have analysed subsets of participants and data from the ROSIE longitudinal study on opiate treatment and published six new papers. The analyses included the effect of treatment settings, treatment pathways and use of additional drugs on treatment outcomes for opiate users. Other studies have examined the clinical profile, treatment and prevalence of patients admitted with a diagnosis of over-the-counter opiate abuse; predictive factors for relapse among alcohol-dependent clients with a dual diagnosis; and a joint analysis of data on both treated problem benzodiazepine use and poisoning deaths where a benzodiazepine was implicated.

In 2010, the number of cases entering treatment was higher than in 2009. This may be due to an increase in the number of services making returns to the NDTRS or it may reflect a genuine increase in the number of cases entering treatment. The proportion entering treatment for the first time declined in 2010. Opiates (mainly heroin) were the most common main problem drug reported, similar to previous years. The number and proportion of cases treated for cocaine dropped. The largest increase in 2010 was in the number of cases reporting a headshop drug as their main problem substance.

### **6. Health correlates and consequences**

At the end of 2010 there were 5,700 diagnosed HIV cases in Ireland, of which 26% were probably infected through injecting drug use. A study of singleton births at a maternity hospital in Dublin from 2000 to 2007 showed that 1% were to women who were prescribed methadone at delivery, and that a higher proportion of methadone-exposed women were likely to test positive for hepatitis B, hepatitis C and HIV than non-exposed women .

A study undertaken in a methadone treatment centre in Dublin found that 69% of study participants had at least one abscess and 80% reported that they were hepatitis C

positive. Another study found that the prevalence of MRSA in the opiate-dependent population in Dublin is low.

With regard to recorded presentation of deliberate self-harm to hospital emergency departments in 2010, drug overdose was the most common form of deliberate self-harm reported. In 2006–2008, following the withdrawal of distalgesic from the Irish market in 2005, the rate of intentional drug overdose (IDO) presentations to hospital involving distalgesic was 84% lower than in the three years before it was withdrawn. There was a 44% increase in the rate of IDO presentations involving other prescription compound analgesics but the magnitude of this rate increase was five times smaller than the magnitude of the decrease in distalgesic-related IDO presentations.

A series of recently published studies look at morbidity owing to cocaine use in Dublin, the prevalence of attention-deficit hyperactivity disorder (ADHD) in adults attending outpatient psychiatric services in north Dublin, and the co-existence of substance dependence among patients attending health services, one in a Dublin hospital and one among a population of university students presenting for any reason to primary care. Several cases are reported with regard to psychiatric illness and physical complications as a result of using substances purchased in head shops in Ireland, including Butylone and MDPV, Methylone, Whack, Benzylpiperazine, Butylone, and Mephedrone.

In 2009, the number of deaths owing to poisoning recorded in Ireland by the NDRDI decreased slightly, to 203 deaths from 211 in 2008. This is the first decrease in the number of deaths owing to poisoning since 2003. Opiates continued to be associated with the majority of fatal overdoses in 2009. The number of deaths where cocaine was implicated, alone or with another drug, decreased again in 2009.

In early 2011 at least six fatal heroin overdoses were reported by the Irish media. This was reputed to be caused by a drought of heroin in December 2010, followed by the arrival of a batch 'high quality' heroin into the country. The true extent, pattern and full impact of this drought on poisoning deaths in Ireland will be reported in future annual figures from the NDRDI.

## **7. Responses to health correlates and consequences**

Recent efforts to reduce the incidence of drug-related deaths in Ireland have included the issuing of guidelines on the safe dispensing of non-prescription products containing codeine. In addition, an evaluation of the impact on non-fatal IDO presentations to hospital emergency departments nationally of the withdrawal, as of January 2006, of distalgesic, has shown that it has had positive benefits in terms of IDO presentations to hospital in Ireland.

Three studies have been published to help improve the prevention and treatment of hepatitis C (HCV). A qualitative study was undertaken among current and former injecting drug users to find out more about what enables or prevents them engaging at every level of HCV care. Multiple barriers were identified but facilitators were also identified. A study of all referrals to an urban tertiary care liver centre for HCV management tracked subsequent progress and identified the dropout rate at the different stages. Reporting an 'exceptionally high rate of dropout', particularly in the early stages, the study findings have led to the development of innovative approaches to optimising HCV management. Finally, a study to measure the knowledge of and attitudes towards HCV among nurses found that nurses working in public health services and general practice require formal training in HCV care and management, while nurses in the addiction services need to update their knowledge in certain areas.

The health of women, who had been prescribed methadone for the treatment of opiate dependence, and their infants, was the subject of two separate studies. One found the hospital based drug liaison midwife plays an important role. The other paper reported

that the outcomes for mothers prescribed methadone and their new infants were not as good as those for other mothers and infants.

Two community-based initiatives are described. Programmes in one local drugs task force area in Dublin are aiming to fill the gaps left after addiction, such as boredom, isolation and depression. The Anna Liffey Drug Project, has issued a booklet providing harm reduction information on psychoactive drugs – legal highs or otherwise.

## **8. Social correlates and social reintegration**

Drug use among socially excluded groups, including people living in disadvantaged communities, female sex-workers, members of the travelling community, homeless people and early school-leavers, is discussed. The research reported varies in quality and depth. Another study shows that early school-leaving and homelessness among drug users reporting for treatment shows little change over the period 2005–2010, suggesting that measures to tackle these problems are not having the desired effect.

Social reintegration for drug users remains an aspiration of national drug policy, with the new government's Programme for Government including three proposals to progress the recommendations of the working group on rehabilitation.

A recent study of the feasibility of using the Housing First approach to provide secure accommodation for drug users provides good-practice guidelines. The approach will be piloted through the Dublin Housing First Demonstration Project. The Soilse drug rehabilitation programme, which uses an individualised model of adult education, demonstrates the development of recovery capital among individuals in recovery from drug addiction. The Ready for Work programme assists homeless people to secure employment, helps individuals to secure work placements, turn placements into jobs or secure alternative employment

## **9. Drug-related crime, prevention of drug-related crime and prison**

Criminal proceedings for the possession of drugs for personal use decreased in 2009 for the first time since 2004, and proceedings for drug supply also decreased marginally in 2009, returning to the same level as 2007. Proceedings for the cultivation or manufacture of drugs have continued to increase since 2005. It is unclear whether this increase is due to a growth in the commission of such offences or to a sustained concentration of law enforcement on detecting such offences. Between 2005 and 2009 the number of prosecutions for driving under the influence of drugs (DUID) increased by more than 900%. This increase could either be due to an increase in the incidence of DUID or the more likely possibility that targeted police activity in this area has increased.

The intimidation of drug users and their families by those involved in drug supply has been highlighted as an issue in the National Drugs Strategy 2009–2016 and also at conferences during the last year. The Citywide Drugs Crisis Campaign has agreed to facilitate the establishment of an Intimidation Working Group to develop responses to the issue.

In July 2011, the Courts Service and the Health Service Executive agreed to extend the catchment area for the Drug Treatment Court in order to encourage more offenders to avail of this response to drug-related crime.

## **10. Drug markets**

Data on garda drug prosecutions show that the trend in prosecutions for drug possession decreased in most garda regions throughout the state in 2009, after a steady increase since 2006. However, the proportion of prosecutions outside the capital has increased significantly.

Two studies on drug markets are reported. An ethnographic study of drug use in a Dublin community provides a useful insight into a local drug market involving a range of both licit and illicit drugs. By highlighting the issue of polydrug use in a small community, this study raises questions as to the nature of local drug supply and demand and whether people specialise in particular substances.

The first national illicit drug market study is due to be published in early 2012. Carried out in four locations (two urban, one suburban and one rural), the aims of the study were to examine the nature, organisation and structure of Irish drug markets, to identify the various factors which can influence the development of local drug markets and the impact of drug dealing and drug markets on local communities, and to describe and assess interventions in drug markets with a view to identifying what further interventions are needed. The study shows that the full impact of supply reduction activity cannot be assessed by measuring arrests and seizures alone or through proxy measurements such as price and purity. Data on demand reduction, social, health and community welfare indicators also need to be collected.

Between 2005 and 2007, the number of drug seizures increased, then decreased in 2008 and 2009. In 2010 the number of seizures appears to have levelled out. Since 2007, seizures of cocaine, heroin and ecstasy-type substances have declined significantly, and the reduction in total drug seizures in 2009 can be attributed primarily to a reduction in cannabis and cocaine seizures. The continued decline in heroin seizures in 2010 may reflect a decline in heroin use or a change in law enforcement activities or some other factor. Data on prison drug markets are reported for the first time.

A study by the Forensic Science Laboratory on the THC content of a sample of cannabis resin and herbal cannabis plants was published in 2011. Conducted in light of a reported increase in the number of so-called 'cannabis factories', the study set out to find whether the increased demand for cannabis herb was because there is a shortage of resin or because there is more THC in cannabis herb.

## **Main points from Part B**

### **11. Drug related health policies and services in prison**

The profile of the typical drug-using prisoner in Ireland is single, aged between 14 and 30, male, living in the parental home, from a large and often broken family, having left school before the legal minimum age of 16, unemployed, with his best-ever job having been in the lowest socio-economic class. He will have a high number of criminal convictions and a history of other family members being in prison; there is a high rate of high rate of recidivism among these prisoners. The typical drug-using prisoner has also experienced extreme social disadvantage, being from an area with a high proportion of local authority housing and often with high prevalence of opiate drug use and a high level of long-term unemployment.

The widespread availability of drugs in prison has been confirmed through data from prison drug-testing, and reports from the Inspector of Prisons. A recent study by the HRB on drug-related deaths post-release concluded that many of the deaths were preventable and the findings support the need for an overdose prevention strategy.

Since the launch of the Irish Prison Service (IPS) drugs policy and strategy document, *Keeping drugs out of prisons*, the provision of drug services in Irish prisons has improved. The IPS is committed to achieving care equivalent to that available in the community. Those presenting with problem opiate use are offered detoxification if it is clinically indicated, or stabilisation on methadone and addiction counselling as treatment options. The contracting-out of treatment services to addiction services based in the community and to private consultants including pharmacists has also been beneficial and has enhanced links between prison and community-based services.

Although there has been an improvement in the drug-related health policies and services in Irish prisons in recent years, the effective delivery of these services and the attainment of the goal of equivalence of care have been undermined because of severe prison overcrowding. In such a context the therapeutic benefit of drug treatment can become a secondary concern to the control and security priorities of the prison environment. Equally, a lack of clarity of responsibility and coherence of delivery hinders the provision of a seamless care service pre and post release and exposes vulnerable people to preventable drug-related deaths.

## **12. Drugs users with children (addicted parents, parenting, child care and related issues)**

In 2006/7, just over 23% of all respondents to the all-Ireland general population drug use prevalence survey who reported having ever used any illegal drug, and 4% who reported having used any illegal drug in the last year, also reported that they had dependent children aged 18 years or younger. Between 2003 and 2009, NDTRS data showed that the proportion of drug users in treatment reporting that they lived with a partner and children ranged between 10.2% and 10.8%, and the proportion reporting that they lived alone with children ranged from 3.7% to 4.6%. A number of separate studies, undertaken between 1992 and 2007 at two of Dublin's maternity hospitals, found that the prevalence of illicit drug use among pregnant women ranged between 1% and 4.57%.

While there has been one major empirical study of the impact of parental drug use on children in Ireland, authors of other Irish research reports have indicated the need to research what amount to 'hidden populations' of children whose parents use drugs and to explore their particular experiences, vulnerabilities and risk profiles. These researchers have also highlighted the need for specific policies and services targeting these populations.

Statutory services in Ireland to ensure the welfare and protection of all children aged under 18 years include guidelines which identify parental drug or alcohol use as a risk factor leading to a welfare concern. In recent years delivery of these statutory services has been found to be inconsistent and the delivery system is currently being revised and strengthened. The need for adequate training for professionals implementing these guidelines in situations where parents are drug users is highlighted in several Irish research studies, in order to ensure these professionals are prepared and sufficiently sensitive and responsive to what are often complex and always unique situations.

## Part A: New Developments and Trends

### 1. Drug policy: legislation, strategies and economic analysis

#### 1.1 Introduction

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

The **National Drugs Strategy (interim) 2009–2016** provides the implementation framework for illicit drugs policy in Ireland (Department of Community Rural and Gaeltacht Affairs 2009). The Strategy has an overall strategic objective, 'To continue to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on the five pillars of supply reduction, prevention, treatment, rehabilitation and research'. Implementation is based on a 'partnership' approach, whereby over 20 statutory agencies, multiple service providers and community and voluntary groups work together in a nationwide network of regional and local drugs task forces (DTFs) to deliver the Strategy, with the statutory agencies critical in terms of core service provision. The Minister for Health has overall responsibility for the National Drugs Strategy, and an Oversight Forum on Drugs (OFD), chaired by the Minister of State for Primary Care within the Department of Health, and comprising senior representatives of the various statutory agencies involved in delivering on the Strategy, and representatives from the community and voluntary sectors, meets every quarter to monitor progress and address any operational issues.

Priorities for **public expenditure on the drugs issue** are set out in the National Drugs Strategy. Public funds are allocated by way of the annual parliamentary Estimates process, which allocates funds to departmental Votes. Funding for regional or local initiatives may be either directly from government agencies and funds such as the Young People's Facilities and Services Fund (YPFSF), administered by the Department of Children and Youth Affairs (DCYA), or via the regional and local DTFs. Funding by DTFs proceeds from 'initial' to 'mainstreamed' funding as follows:

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

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

## 1.2 Legal framework

This update covers drug-related acts and bills of the Oireachtas introduced or progressed during the reporting year. It also identifies new substances brought under control within the terms of the Misuse of Drugs legislation. Subject to the obligations of European Union membership as provided in the Constitution of Ireland, the sole and exclusive power of making laws for the State is vested in the Oireachtas. The Oireachtas consists of the President and two Houses, Dáil Éireann (House of Representatives) and Seanad Éireann (Senate). Bills are proposals for new laws. They are usually approved by a Minister or another member of the government. Occasionally, a private member's bill is proposed by a member of the opposition. Such bills, because they have not originated in government, are less likely than government-sponsored bills to become law. To become law, a bill must first be approved by both the Dáil and the Seanad, although the Dáil can override a Seanad refusal to pass a bill. Joint committees are groups of members of Parliament, including both government members and members of the opposition, which discuss proposed legislation and make recommendations for amendments to the Minister. Bills can be introduced in either the Dáil or Seanad and there are five stages in considering a bill. The second and third stages are considered the most important as they offer the fullest opportunities to Members to discuss and amend the contents of the bill. Once the bill has been passed by the Oireachtas, the Taoiseach (Prime Minister) presents it to the President to sign into law, and then it becomes an Act.

Acts do not come into operation until a commencement order is issued in the form of a statutory instrument. There are five main types of statutory instrument: orders, regulations, rules, bye-laws and schemes. Statutory instruments have a wide variety of functions. They are not enacted by the Oireachtas but allow persons or bodies to whom legislative power has been delegated by statute to legislate in relation to detailed day-to-day matters arising from the operation of the relevant primary legislation. Statutory instruments are used, for example, to implement European Council Directives and delegate the powers of Ministers. Specified government ministers and other agencies and bodies are authorised to make statutory instruments and several hundred instruments are made annually. Notice of the making of the commencement order is published in the Oireachtas newsletter *Iris Oifigiúil*.

Also considered below are relevant debates in the Oireachtas in relation to the impact of drug-related legislation, court decisions where the judiciary have provided specific interpretations of legislation and academic and/or research findings in relation to drug-related legislation.

### 1.2.1 Laws, regulations, directives or guidelines in the field of drug issues (demand & supply)

This update covers drug-related acts and bills of the Oireachtas introduced or progressed between January 2010 and July 2011. It also identifies new substances brought under control within the terms of the misuse of drugs legislation.

#### Acts relevant to drug offences January 2010–July 2011

The **Communications (Retention of Data) Act 2011** requires service providers, those engaged in the provision of a publicly available electronic communication service or a public communication network by means of fixed line or mobiles or the internet to retain data relating to fixed and mobile telephony for 1 year, and data relating to internet access, internet email and internet telephony for 2 years, and provides for disclosure in relation to the investigation of specified offences, including Customs offences.

The **Criminal Justice (Public Order) Act 2011** prohibits harassment or intimidation of members of the public by persons who engage in begging and confers powers on members of the Garda Síochána to give directions to persons to desist from begging, in certain circumstances such as where they are begging near cash machines or in

front of places of business. It also provides for a series of sanctions including fines and possible imprisonment for breaches of the law.

The **Road Traffic Act 2011** provides, in advance of provisions of Part 2 of the Road Traffic Act 2010, which will come into force in late 2011(see below), for the amendment to existing legislation to permit the early introduction of mandatory alcohol testing of drivers of mechanically propelled vehicles in certain circumstances, including involvement of road traffic collisions The Act also clarifies the position regarding mandatory preliminary breath testing.

The **Criminal Justice (Money Laundering and Terrorist Financing) Act 2010** provides for offences of, and related to, money laundering in and outside the State; and gives effect to Directive 2005/60/EC of the European Parliament and of the Council of 26 October 2005 on the prevention of the use of the financial system for the purpose of money laundering and terrorist financing.

The **Criminal Procedure Act 2010** makes provisions for a modification of the rule against double jeopardy in order to allow a person who has been acquitted of an offence to be re-tried in circumstances where new and compelling evidence emerges or where the acquittal is tainted owing, for example, to corruption or intimidation of witnesses or jurors, or perjury. The rule against double jeopardy provides that no person may be put at risk of being punished twice for the same offence. The legislation applies to a number of drug-related offences.

The **Road Traffic Act 2010** provides for a reduction in the blood alcohol content (BAC) limit for drivers and also provides powers to assist the Garda Síochána in forming an opinion as to whether a driver is under the influence of an intoxicant (drug or drugs) and to carry out a preliminary impairment test on such drivers.

The **Criminal Justice (Psychoactive Substances) Act 2010** was implemented in response to the emergence of so-called 'headshops' selling so-called 'legal highs' (Irish Focal Point 2010) (see Ireland's National Report 2010: Chapter 1.2.1). The Act includes the following provisions:

- Section 3 provides for the offences of selling, importing and exporting psychoactive substances for human consumption. Section 3 (1) provides for the offence of selling a psychoactive substance, knowing or being reckless as to whether it is being acquired or supplied for human consumption.
- Section 4 creates the offence of selling an object, knowing that it will be used to cultivate by hydroponic means any plant in contravention of s17 of the Misuse of Drugs Act 1977. Hydroponic cultivation is the cultivation of plants in liquid containing nutrients, without soil, and under controlled conditions of light, temperature and humidity. This method of cultivation is known to be used for the purpose of growing cannabis indoors.
- Section 5 provides for the offence of advertising a psychoactive substance or object to which Section 4 applies.
- Section 7 provides that a Garda Superintendent (or higher) may serve a prohibition notice on a person where he or she believes that the person is selling, importing or exporting psychoactive substances for human consumption, selling objects for use in cultivating by hydroponic means any plant.
- Section 20 provides that a person guilty of an offence under the Act is liable on summary conviction to a fine of up to €5,000 or imprisonment for up to 12 months or both, or on conviction on indictment to a fine or to imprisonment not exceeding 5 years or both.

Also, in relation to the 'legal highs' phenomenon, on 11 May 2010 the government made the Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order 2010 (S.I. 199 of 2010), declaring a range of 'legal highs' to be controlled drugs. To give effect to this decision, on the same day the Minister for Health and Children signed the Misuse of Drugs (Amendment) Regulations 2010 (S.I. 200 of 2010), the Misuse of Drugs

(Designation) (Amendment) Order 2010 (S.I. 201 of 2010), and the Misuse of Drugs (Exemption) (Amendment) Order 2010 (S.I. 202 of 2010).

Under these statutory instruments, approximately 200 individual 'legal high' substances, which had been on sale in 'head shops' and which included the vast majority of products of public health concern, were declared to be controlled drugs. They include broadly:

- synthetic cannabinoids (contained in SPICE products),
- benzylpiperazine (BZP) and piperazine derivatives (commonly known as 'party pills'),
- mephedrone, methylone, methedrone, butylone, flephedrone, MDPV (i.e. cathinones, often sold as baths salts or plant food), and
- Gamma butyrolactone (GBL) and 1,4 Butanediol.

In addition, the Declaration Order made under the Misuse of Drugs Act 1977 includes ketamine and tapentadol, substances that have legitimate uses as medicines but which can be subject to misuse. The Declaration Order also covers certain narcotic and psychotropic substances which Ireland is obliged to bring under control in order to comply with the UN Single Convention on Narcotic Drugs and the UN Convention on Psychotropic Substances.

### Status of bills going through the Oireachtas

The status of bills with relevance to the drugs issue currently passing through either Dáil Éireann or Seanad Éireann is summarised below in Table 1.2.1.1.

**Table 1.2.1.1 Status of bills relevant to the drugs issue currently before the Dáil**

Title and explanatory memorandum	Status
The <b>Criminal Justice (Community Service) (Amendment) Bill 2011 (No 12 of 2011)</b> The primary purpose of this bill is to introduce a requirement on a court, before which an offender stands convicted of an offence for which a sentence of up to twelve months imprisonment would be appropriate, to consider imposing the alternative sentence of a community service order. Although the Bill does not mention specific offences, many offenders whose offences are committed as a consequence of drug addiction receive short custodial sentences and could benefit from the terms of this legislation.	Final Stage 27/06/2011 Passed by both Houses of the Oireachtas
The <b>Spent Convictions Bill 2011 (No 15 of 2011)</b> is intended to apply where certain convictions (a prison sentence not exceeding six months or a fine have been imposed) may be regarded as spent for certain purposes where the convicted person has not been convicted of any other offence within a specified period of years. The purpose of the Act is to help rehabilitate convicted persons through facilitating their reintegration into the workforce and allowing them to build new careers.	First Stage Introduced 11/05/2011
The <b>Criminal Justice Bill 2011 (No 16 of 2011)</b> provides for changes to police powers to detain suspects for questioning. The amendments will allow the period of detention under section 4 of the 1984 Criminal Justice Act to be suspended and the person released during the period of suspension. The purpose of these provisions is to allow the Gardaí to follow up on information obtained during initial questioning and so might be of use in the investigation of particularly complex cases.	First Stage 11/05/2011

### Pharmacy guidelines on safe supply of codeine-based products

The Pharmacy Act 2007 and the Regulation of Retail Pharmacy Businesses Regulations 2008 require that all codeine-based products are dispensed under the supervision of a pharmacist, and that individuals in receipt of the product should receive appropriate counselling. See Chapter 5.5.2 for an account of recent Irish research on inpatient treatment for over-the-counter (OTC) opiate misuse, and Chapter 7.2.2 for an account of the guidelines on the safe dispensing of non-prescription products containing codeine, published by the Pharmaceutical Society of Ireland in May 2010 (The Pharmaceutical Society of Ireland 2010).

## 1.2.2 Laws implementation

### Programme for Government

The new programme for government, *Government for National Recovery 2011–2016* (Fine Gael and the Labour Party 2011), contains a number of actions related to criminal justice and drugs policy. Individual actions are listed below in italics, together with commentary on their implementation or associated issues.

### **Roadside drug testing**

*We will introduce roadside drug testing programmes to combat the problem of driving under the influence of drugs.*

The development of reliable roadside testing procedure has been a challenging issue for many countries. At present the Garda Síochána, the Department of Transport and the Medical Bureau of Road Safety are collaborating in the development of a scheme to introduce US-style roadside tests for suspected drug drivers to accompany roadside alcohol tests.

### **Community service orders legislation**

*We will ensure that violent offenders and other serious offenders serve appropriate prison sentences while at the same time switching away from prison sentences and towards less costly non-custodial options for non-violent and less serious offenders.* This action provides the context for the introduction of the Criminal Justice (Community Service) (Amendment) Bill 2011 described above in Section 1.2.1.

### **Mandatory sentencing laws for specific drug offences**

*A review will be conducted of the working of the mandatory sentencing laws in the context of an overall review of drugs policy.*

Sections 15A and 27 of the Misuse of Drugs Act 1977 (as amended) provide for a minimum presumptive sentence of ten years' imprisonment for possession of drugs with a market value of €13,000 or more.

A recent decision by the Supreme Court in *Director of Public Prosecutions v Connolly* raises a number of important issues in relation to the future application of the mandatory sentencing laws for specific drug offences (Courts Service judgments 2011). (Fine Gael and the Labour Party 2011) The Supreme Court quashed a previous conviction under s.15A on the basis that the burden of proof required to determine the purity and therefore value of the drugs had not been met by the prosecution. What follows is an abridged summary of the judgement setting aside the conviction delivered by Mr Justice Fennelly in the Supreme Court on 15 February 2011.

In the original trial it was alleged that the appellant in this case had in his possession for the purpose of sale or supply amphetamines with a market value of €13,000 or more contrary to section 15A (as inserted by section 4 of the Criminal Justice Act, 1999) and section 27 (as amended by section 5 of the Criminal Justice Act, 1999) of the Misuse of Drugs Act 1977. This offence attracts a minimum presumptive sentence of 10 years' imprisonment. Counsel for the appellant submitted at trial that the proof of value of the drugs proffered by the prosecution was insufficient and that he had no case to answer. The trial judge refused his application for a direction. The appellant appealed against his conviction to the Court of Criminal Appeal on the single ground that:

there was no evidence on which a properly directed jury could come to the conclusion and be satisfied beyond a reasonable doubt that the market value of the drugs concerned was €13,000 or more.

The Court of Criminal Appeal (CCA) concluded that there had been no error of law in the original trial. However, the CCA referred the following matter to the Supreme Court to be determined as a question of law of exceptional importance:

In a prosecution pursuant to section 15A of the Misuse of Drugs Act 1977, for the purpose of ascertaining the amount of a controlled substance present in a powder in a sealed container or in a number of such containers proven by expert evidence to contain that particular controlled substance, may the amount

of that controlled substance present in the powder be established by the oral evidence of an expert as to the range within which amounts of that controlled substance in other powders generally fell and, if the answer is in the affirmative, must the prosecution disclose to the defence a statement or a report by that expert setting out the facts upon which her or his opinion as to that range is based?

The primary issue considered by the Supreme Court was the sufficiency of proof required to determine the value of drugs. The appellant had been arrested in possession of approximately 10kg of amphetamines packed in 10 separate bags. At trial, a member of the Garda National Drugs Unit (GNDU) estimated the value of the drugs at €145,755, using a price of €15,000 per kilo. The Garda assumed that each of the packs of amphetamines contained at least 10% of amphetamine. It was accepted that proof of the actual contents and percentage of amphetamine present was a matter to be determined by the Forensic Science Laboratory (FSL).

A scientist of the FSL explained that she had analysed five of the packs and could say with 100% certainty that the five packs contained amphetamine, but not how much. She added that, taking into account the general appearance of the packs and the powder, her professional opinion was that it was highly unlikely that any of the packs would be negative. However, she stated further:

I can't say for definite what the purity of the samples are but I can give a range in which amphetamine purities generally fall between that is maybe 10 and 40% but the samples were not quantified because quantification is not a routine course of qualitative analysis so I cannot put an exact figure on the purity...

In further cross-examination, the scientist agreed that the presence of as little as 1% would trigger the test she had carried out, but repeated that the range is generally between 10% and 40%.

In his judgement, Mr Justice Fennelly explained the nature of the proof required to secure a conviction under the relevant legislation.

Proof of value is an essential ingredient of the offence under section 15A. It is what distinguishes it from the offence of possession for sale or supply of an unquantified and unvalued amount of drugs. Most importantly, it is what has caused the Oireachtas, subject to exceptional mitigating circumstances, to mark the offence as one of extreme seriousness such as to require the court, in sentencing a convicted person, to impose a penalty of a minimum of ten years' imprisonment. The ingredient of value must be proved to the satisfaction of the jury beyond reasonable doubt. At the original trial, the forensic scientist established the presence of amphetamine in each of the five packs she had analysed, but had not determined the extent of the amphetamine content and was therefore unable to say 'for definite' what the level of presence of amphetamine was. She said that the range in which amphetamine purities 'generally fall' was between 10% and 40%.

Everything turns on the meaning to be attributed to the word 'generally'. It is a word of flexible use. It may imply, perhaps, that a majority of cases fall within that range, but, in a weaker sense, may mean no more than 'commonly'. If the facts were that analysis of seized drugs for amphetamine always or nearly always falls within the 10/40% range, one might have expected the witness to say so. Instead, she used the word 'generally' three times. In its normal usage the word leaves open the very real possibility that there are cases outside that range. It cannot be assumed that Dr Casey (the scientist) meant any more than that there was probably 10% to 40% amphetamine present. Probability is not enough.

The evidence did not exclude the very real possibility that the percentage of amphetamine present could have been as low as 1%. Such a percentage was

sufficient to produce the result which she obtained from her test. However, if that were the case the value of those drugs would be less than the amount required to sustain a conviction for the offence in issue. The proof of value is an objective matter. In this case it was not sufficient for the prosecution to prove the mere presence of amphetamine and to rely on an unexplained range of values which generally applies without evidence which addressed the extent to which there are cases outside the range. This left a gap in the prosecution evidence. I believe that the case should have been withdrawn from the jury. I would allow the appeal and set aside the conviction of the appellant in respect of count number 1 on the indictment. I would not direct a retrial. There is no reason to believe that Dr Casey would be in a position to give any different evidence on another occasion.

### **Criminal assets legislation**

The new Programme for Government (Fine Gael and the Labour Party 2011) makes a commitment to strengthen criminal assets seizure legislation at local level.

*We will strengthen the supply reduction effort and criminal assets seizures, particularly at local level.*

During the last Dáil, the Labour Party introduced the Proceeds of Crime (Amendment) Bill 2010 (Irish Focal Point 2010) (Chapter 1.2.1). The purpose of the Bill was to reduce from seven years to two years the waiting period before the Criminal Assets Bureau can apply to the High Court for the disposal and forfeiture of assets frozen under s.3 of the Proceeds of Crime Act 1996. This Bill lapsed with the dissolution of the Dáil. The Labour Party's election manifesto, however, is committed to reintroducing this Bill, and to the strengthening of drug supply reduction efforts and criminal assets seizure at a local level. To date no legislation on this issue has been forthcoming.

Responding to a question in the previous Dáil, in relation to re-investing assets seized back into local communities most affected by the drugs issue, the former Minister for Justice, Dermot Ahern TD outlined the position of the then government on the issue. The former Minister stated (Ahern, Dermot 2010, 17 November):

The issue of the proceeds of crime seized by the Criminal Assets Bureau being used to fund community projects and drug services in disadvantaged communities has been raised from time to time. ...While it is accepted that there may be some potential symbolic value in the suggestion nonetheless the proposal is one which is problematic and raises a number of particular difficulties. Revenue which has been accumulated by the Criminal Assets Bureau is paid into the Government's Central Fund. The Central Fund is provided for under Article 11 of the Constitution. This fund, except where provided otherwise by law, is the destination of all State revenues and the source of all Government spending. It is the Central Fund from which the Government draws for expenditure on all necessary public services and investment including the provision of drug services. With certain exceptions, it is believed that earmarking revenues for a specific expenditure programme would, in general, constrain the Government in the implementation of its overall expenditure policy. Furthermore, if certain revenues were earmarked for particular projects any projects thus funded would be dependent on actual revenue collected from that source. Therefore, a fall in revenue generated by that source could imply a fall in expenditure on such projects. Given the variable and uncertain nature of the value of the assets seized by the Bureau in any given year, in addition to the potential delays through the possibility of legal challenge to court disposal orders, the provision of ongoing funds to drug programmes or projects in this manner would be problematic. Such a revenue source would not facilitate the proper planning of drug treatment provision or other such programmes by organisations involved in the delivery of services. It could also be said that a significant proportion of the monies secured by the Bureau are already owed to the Exchequer as it often relates to non-payment of

taxes and social welfare fraud. In the case of drugs services the Government is already allocating very considerable resources to a wide range of Government Departments and State agencies as well as to the community and voluntary drug treatment sectors to tackle the issue of drug misuse. There is currently no plan to change the existing arrangements concerning revenue accumulated by the Criminal Assets Bureau.

In response to a further parliamentary question on a related matter, the current Minister for Justice, Alan Shatter TD, stated the following (Shatter 2011, 17 May):

A dedicated unit within the Garda National Drugs Unit has been established to liaise with the Criminal Assets Bureau to particularly target those criminals and criminal groups believed to be deriving profits and assets from drug-related criminal activity. In addition, the Criminal Assets Bureau continues to utilise the services of criminal assets profilers located in Garda Divisions throughout the country. ...The role of the Criminal Assets Bureau in tackling those involved in drug dealing, and the Bureau's focus on middle and lower ranking criminals, was acknowledged during the public consultation process which informed the development of the National Drugs Strategy 2009-2016.

### **Drug treatment court**

The Programme for Government includes a commitment in relation to the Drug Treatment Court, particularly in relation to young offenders.

*We will carry out a full review of the Drug Treatment Court programme to evaluate its success and potential in dealing with young offenders identified as having serious problems with drugs.*

For a detailed discussion on the Drug Treatment Court, see Chapter 9.4.1 below.

### **Medicinal cannabis**

In July 2010 medicinal cannabis was the subject of a response to a written question in Dáil Éireann. The then Minister for Health and Children, Mary Harney TD, outlined the position of the Government on the issue at that time when she stated: ((Reilly, James 2010, 6 July)

The current legal position in Ireland in relation to cannabis and cannabis based medicinal products such as Sativex is that they are Schedule 1 controlled substances under the Misuse of Drugs Act 1977. All Schedule 1 substances are substances which are considered as having no medicinal use and the manufacture, production, preparation, sale, supply, distribution and possession of cannabis and cannabis derivatives is unlawful except for the purposes of research. My Department is aware that claims have been made in respect of Sativex and its possible benefits for patients suffering from certain conditions such as Multiple Sclerosis and cancer. As the law currently stands it would not be possible for Sativex to be licensed here for medicinal use or for a General Practitioner to prescribe it.

The Minister went on to state that she was seeking expert clinical advice on the matter. To date, no further information has been forthcoming and no further action has been announced by the new government.

### **Legislation to control new psychoactive substances**

The introduction of Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order 2010 (S.I. 199 of 2010), which declared a range of 'legal highs' to be controlled drugs and the enactment of the Criminal Justice (Psychoactive Substances) Act 2010 in August 2010, discussed above in Section 1.2.1, have had a clear impact on the 'head shop' and 'legal high' phenomena. A number of commentators have also referred to the impact and merits of these legislative attempts to curb the supply and use of 'legal highs'.

A Garda inventory of 'head shops' in Ireland indicated that, at their peak in early 2010, there were 113 'head shops' in the country, with at least one in every county. On 11 May 2010, when the government banned a range of 'head shop' products, there were 102 shops, 11 having already closed for various reasons. On 12 May 2010 the gardaí visited all 'head shops' and warehouses and seized all banned products. By 13 May there were 34 'head shops' selling psychoactive substances, and in early August 2010 the number had increased to 39 shops. Following the enactment of the Criminal Justice (Psychoactive Substances) Act 2010, the gardaí visited head shops in early September 2010 and found only 19 open and none selling psychoactive substances (Garda Síochána, personal communication, 2010).

Notwithstanding these measures, a number of new substances have been identified in 'head shop' products by specialists at Trinity College Dublin and the Dublin Drug Treatment Centre Board (Kavanagh, *et al.* 2010). They include the following:

- *Dimethocaine*, also known as larocaine, is a local anesthetic with stimulant properties that are nearly as potent as those of cocaine.
- *AM-694* is a drug which acts as a potent and selective agonist for the cannabinoid receptor.
- *Glaucine* is an alkaloid found in several different plant species. It has bronchodilator and anti-inflammatory effects and is used as a cough suppressant in some countries.
- *Phenethylamine (PEA)* is a natural monoamine alkaloid and a psychoactive drug with stimulant effects.
- *Metamfepramone*, also known as dimethylcathinone, dimethylpropion, or dimepropion, is a stimulant drug.
- *Synephrine* is the main active compound found in the bitter orange which is an extract of a plant called *Citrus aurantium*. It is a stimulant that constricts the blood vessels, and increases heart rates.
- *Mitragynine*, an opioid agonist, is a stimulant at low doses and a painkiller or sedative at higher doses.
- *Hordenine* occurs in a variety of grassy plants and grains, and in some species of cactus. It stimulates the release of norepinephrine.
- *L-dopa* (levodopa) is a naturally occurring dietary supplement and psychoactive drug found in certain kinds of food and herbs.

Responding to a parliamentary question on the impact of the legislation, the former Minister for Justice, Equality and Law Reform, Dermot Ahern TD, stated (Ahern, Dermot 2010, 08 July):

Following the regulation of certain psychotropic substances on 11 May 2010 under the Misuse of Drugs Acts, and as part of Operation Kingfisher under the direction of the Garda National Drugs Unit, members of An Garda Síochána in each Garda District throughout the State visited every Head Shop to investigate their activity. As part of this Operation, Gardaí took into possession all cannabinoid products, controlled cathinone substances and any substances suspected to contain benzylpiperazine or its derivatives. The total amount of substances involved was in excess of 4.5 tonnes. As a result of the legislative measures introduced on 11 May a considerable number of head shops across the country have already closed down with Garda National Drug Unit records showing as on 14 June 2010 that a total of 44 head shops remain in operation nationwide. In addition to the initial Garda visits to all head shop outlets on 12 May 2010, the Garda National Drugs Unit and local Drug Units continue to visit the remaining outlets on an ongoing basis to conduct test purchasing of substances and to monitor their activities. No arrests have been made to date arising from this but prosecutions will be pursued in cases where any controlled drugs are detected in the products sent for analysis.

The former Minister for Health, Mary Harney TD, stated further in response to the infringement of medicinal products legislation by 'head shops' (Harney 2010, 08 July):

Certain products available in head shops have been reported to have anaesthetic effects and therefore may be considered to fall within the scope of the medicinal products legislation. Any such product is considered to be an unauthorised medicinal product and, accordingly, the Irish Medicines Board has been taking action to have these products removed from the market. Additionally, the substances Fluorotropacocaine, which is contained in the product WHACK, and Dimethocaine, which is contained in the product AMPLIFIED, are considered to be medicinal products and as such they are enforced by the Irish Medicines Board. These substances are not listed in the Misuse of Drugs (Amendment) Regulations 2010 (S.I. No. 200 of 2010). The Irish Medicines Board has visited 30 Head Shops in relation to these products. Of these, one outlet was found to have the product WHACK and another was found to have the product AMPLIFIED. Six outlets had products that were found or suspected to contain substances with anaesthetic effect. The products concerned include RAZ, Snowblow, Pure NRG, Ivory Wave, Sextacy and White Ice and are suspected to contain the active pharmaceutical substance, Lidocaine (also known as Lignocaine). 15 of the outlets have also been found to be supplying other medicinal products for abuse purposes. These mainly involved substances that are contained in prescription-only medicinal products for erectile dysfunction.

Under the Irish Medicines Board Act 1995, as amended, the sanctions available to the Irish Medicines Board (IMB) are the following:

- A person who contravenes a regulation under section 32 of the Act shall be guilty of an offence and shall be liable
- (a) on summary conviction, to a fine not exceeding €2,000 or imprisonment for a term not exceeding one year or a combination of both,
  - (b) on conviction on indictment
    - (i) in the case of a first offence, to a fine not exceeding €120,000 or imprisonment for a term not exceeding 10 years or a combination of both,
    - (ii) in the case of any subsequent offence, to a fine not exceeding €300,000 or imprisonment for a term not exceeding 10 years or a combination of both.

The former Minister told the Dáil that the IMB was currently finalising its investigations in these cases that it had initiated prosecutions against four companies and one individual (Harney 2010, 08 July).

Prior to the introduction of the legislative control of mephedrone, Van Hout and Brennan (Van Hout, Marie Claire and Brennan 2011) conducted a study aimed at exploring and uncovering a 'consumptive snapshot of mephedrone use among pre-legislation Irish users, with specific focus on user experiences, social situatedness of mephedrone use and lay mephedrone risk and legality discourses' (p. 2). Twenty-two in-depth interviews were undertaken with young Irish people aged 18–35 years, who had used mephedrone in the six months prior to fieldwork. Analysis of the resulting narratives identified unique mephedrone-user decision-making processes, particular drug effects and outcomes, socially contextualised mephedrone use and harm-reducing strategies grounded in prior illicit and polydrug taking careers. With regard to perceptions of risk and legality, the study found that 'mephedrone was deemed a safer alternative than illicit street drugs, as the drug outcome was observed by all participants to be reliable in terms of potency, quality and perceived purity' (p. 7). The majority of participants observed mephedrone as inferring a 'safer high' owing to its placement in 'head shops', with others acknowledging the lower cost and general availability of mephedrone as increasing appeal of use. The authors report that although mephedrone was legal at the time of the study, 'it appeared that mephedrone user experiences, reliability and positive effects, weighed far heavier than fears of illegality' (p. 9). They conclude that 'the solitary focus on criminalisation of mephedrone...inherently neglects to include user experiences centralised in

acceptable drug consumptive behaviours and internally sanctioned safe use in weekend socialising' (p. 9).

A number of academic articles have also questioned the rationale behind the recent legislative approaches to controlling the 'legal high' phenomenon. Reuter (Reuter 2011), in a review of international approaches to responding to new psychoactive substances, is extremely critical of the approach taken in Ireland. In criticising the regulatory impact analysis conducted by the Department of Justice, Equality and Law Reform (Department of Justice Equality and Law Reform 2010b), which accompanied the legislation and included a cost-benefit analysis of the legislation, Reuter states that the approach adopted was of 'limited conceptual sophistication' and ultimately naïve:

Consider for example Ireland, which has been active in the field. It has published an analysis of regulatory options for head shops, which are prominent there. The assessment makes no mention of any potential adverse effects of prohibition. It identifies the dangers of not regulating and the potential gross gains of the regulatory options. The only negative aspects of regulation that are given any attention are the costs of operating the regulation. It is naïve compared to, for example, environmental regulatory analysis, which requires much more careful balancing of costs and benefits of each option. (p. 7)

In a similar vein, Ryall and Butler (Ryall and Butler 2011) set the controversy over 'head shops' in Ireland and the resulting legislation within the framework provided by the sociological concept of 'moral panic'. They describe this as a formulation of social policy whereby, in this instance, 'the negative societal consequences of psychoactive drug use tend to be exaggerated – by the media and a range of other "moral entrepreneurs" – thereby serving to legitimate extreme policy responses which, paradoxically, may amplify the very deviance they were intended to curtail' (p. 304). Based on semi-structured interviews with some of the main stakeholders in this process and set against a background of saturation media coverage of this phenomenon, this article presents and assesses competing perspectives on the 'head shop issue'. On the one hand, from a conventional drug control perspective, recent legislative measures in Ireland may, they suggest, be seen as representing effective cross-cutting activity between the health and criminal justice sectors. From a harm reduction perspective, on the other hand, the policy response may be seen as an example of moral panic in that media portrayals greatly exaggerated the ill effects of head shop products, in the process stoking public anger rather than encouraging rational debate. Although the authors acknowledge 'a degree of sophistication on the part of all those interviewed' (p. 310), including 'head shop' owners, users, law enforcement personnel, policy advisors and the minister responsible for the drug strategy at the time, ultimately they conclude that 'the great head shop controversy ended in a clear victory for traditional "war on drugs" values' (p. 310).

More recently, the National Advisory Committee on Drugs published a study on new psychoactive substances and the outlets supplying them (Kelleher, Cathy, *et al.* 2011). The review, conducted between May and August 2010, sought to assess the availability and accessibility of new psychoactive substances in retail outlets throughout Ireland and online. With regard to the impact of new legislative measures the study made a number of important findings.

Analyses of products purchased in head shops and online detected the emergence of five new substances after the Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order of May 2010: dimethylcathinone, naphyrone, fluorotropacocaine, desoxypipradol and dimethylamylamine. A comparison of substances identified before and after the May 2010 Order indicates that 'suppliers moved quickly to replace controlled substances with new uncontrolled substances' (p. 74). Five products purchased online from head shops as part of the study found that all contained controlled substances including mephedrone. This led the authors to conclude that 'head shops may respond to local control measures more quickly than they may do

with international online suppliers' (p. 74). Further analysis found a lack of consistency in the substances contained in what appeared, and were advertised, to be the same product, even where products were purchased only a few days or weeks apart. This finding has implications for consumers 'including the potential for misuse, adverse reactions and possible overdose' (p. 74). In general, the authors observe that as a consequence of the May 2010 Order and the Criminal Justice (Psychoactive Substances) Act, which came into effect on 23 August 2010, the vast majority of 'head shops' were closed, although ten have since reopened, selling 'pipes, bongs and clothing'. According to the study, 'None are selling psychoactive substances and only one...was observed to have hydroponic equipment on display' (p75).

The authors conclude with a number of speculative observations as to the impact of the Criminal Justice (Psychoactive Substances) Act 2010. These include the following (p. 79):

- It has already resulted in a rapid and marked decrease in the number of head shops nationwide.
- It is likely that there will be a concomitant decrease in the use of psychoactive substances by casual, young and first-time users, and an associated decrease in presentations to hospital emergency departments.
- Habitual users who were attracted by the legality and easy availability of head shop products are likely to return to "traditional" illegal substances.
- A proportion of head shops' customer base will take their business online, where chat rooms and blogs will keep them updated with new products, perceived effects, and recommended sources and avenues of delivery.

The study points out that Section 3(2) of the Criminal Justice (Psychoactive Substances) Act 2010 Act also prohibits the importation of psychoactive substances for human consumption, including by online means. The authors highlight the importance of monitoring the impact of policy and legislative change as it is likely that patterns of drug consumption are likely to change or be displaced. According to the study, the 'route that this will take remains to be seen but it is likely to be based on factors of availability and purity and, to a lesser extent, convenience and legality' (p. 140).

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

Following a general election in February 2011, a new coalition (Fine Gael and Labour) government was formed in Ireland. While endorsing the Interim National Drugs Strategy 2009–2016 (NDS), including the integration of drugs and alcohol strategies, the new government has also set out its priorities in relation to illicit drugs in its programme for government. It has assigned responsibility for the NDS to the Department of Health, which has not had lead responsibility for Ireland's drugs strategy since the early 1990s (Pike 2011). The implications of the new priorities and the reallocation of portfolio responsibility have yet to be fully clarified by the government.

#### **1.3.1 National action plan and/or strategy**

##### **Interim National Drugs Strategy 2009–2016 (NDS)**

Róisín Shortall TD, Minister of State at the Department of Health with responsibility for Primary Care, has been given the 'lead role' in relation to the NDS. In responses to questions put to the Minister for Health in Dáil Éireann (Parliament), she confirmed the new government's continuing commitment to the strategic objective and aims, and actions, contained in the NDS, and also to the integration of Ireland's drug and alcohol policies:

Our overall strategic objective is to tackle the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment, rehabilitation and research. The actions set out in the National Drugs Strategy 2009–2016 facilitate a planned and monitored approach to achieving the overall strategic aims. The implementation of these

actions are being pursued vigorously across a range of Departments and Agencies in conjunction with the community and voluntary sectors. Progress will be reviewed on an ongoing basis (Shortall 2011, 31 May-a).

...the alcohol strategy will be included in the national drugs strategy [NDS]. It was scheduled to happen this year. I have a particular interest in this area and I want to ensure it is addressed in the NDS. Alcohol abuse is a serious social problem and alcohol is also a gateway to the abuse of other substances. For that reason, it will be included in the NDS and I want early progress on that, particularly in respect of the enforcement of the law on underage drinking. I hope to report back on that over the coming months (Shortall 2011, 31 May-a).

### **Programme for government**

In March 2011 the new government issued its programme for government for the next five years, *Towards recovery: programme for a National Government 2011–2016* (Fine Gael and the Labour Party 2011). In this programme, the government brings two new terms to the fore in relation to social policy – fairness and equality. In their introductory Statement of Common Purpose, the coalition partners state: ‘We are both committed to forging a new Ireland that is built on fairness and equal citizenship. ... By the end of our term in Government Ireland will be recognised as a modern, fair, socially inclusive and equal society supported by a productive and prosperous economy.’ Along with chapters on the Economy, Reform and Progress, the programme contains a chapter on Fairness.

While the authors do not define fairness, the measures in the chapter on Fairness are placed within the context of principles which, it may be assumed, the government believes will lead to a fair society – social solidarity, social inclusion, and reduction of stigma. With regard to equality, the chapter on Fairness does provide some explanation: under the heading Equality and Social Protection, the authors describe equality as being at the heart of what it means to be a citizen in Ireland’s democracy: ‘The government believes that everyone has the right to be free from discrimination and that we all benefit from living in a more equal society’. The government commits to ensuring equal access to health and to education, and lists measures to ensure equality and social inclusion for women and men, Travellers, members of the lesbian, gay, bisexual and transgendered community, workers, members of minority ethnic groups and immigrants, and people with disabilities.

Although the drugs issue is addressed in the chapter on Fairness, it is not mentioned in conjunction with either equality or the concepts and principles understood to underpin fairness. The drugs issue is included in the section entitled Justice and Law Reform, and four broad objectives are listed:

- to introduce a combined drugs and alcohol strategy (a ‘national addiction strategy’),
- to provide ‘renewed impetus to the fight against drugs’,
- to ensure that the drugs strategy ‘once again becomes relevant and effective’, and
- to enhance, where possible, ‘the demand reduction strategies’.

In addition to the four broad objectives, the document lists ‘key priorities for short-term implementation’, which focus on supply reduction, prevention and rehabilitation; just one priority relates to harm reduction (see Table 1.3.1.1).

**Table 1.3.1.1 Drug-related ‘key priorities’ in *Towards recovery: programme for a national government 2011-2016***

Key priorities	For further information, see other Sections of National Report
Roadside drug testing	1.2.2 and 9.3.1
Prison sentences versus non-custodial alternatives	1.2.2
Mandatory sentencing	1.2.2
Supply reduction and criminal assets seizures	1.2.2

Key priorities	For further information, see other Sections of National Report
Review of the Drug Treatment Court programme	9.4.1
Reduction of flow of drugs into prisons	–
Customs controls to combat drug supplies at source	–
Budget transparency and accountability	1.4
Rehabilitation services including expansion of places across country, provision of services at local level, participation in community employment schemes, and introduction of compulsory as well as voluntary programmes	5.3.2 and 8.3
Prevention measures including drug awareness programmes in schools, preventing addiction in schools, and introducing Education Prevention Units in all task forces	–
Needle exchange programmes expanded across the country where needed most	–

Source: (Fine Gael and the Labour Party 2011), pp. 47, 48 and 49–50

### 1.3.2 Implementation and evaluation of national action plan and/or strategy

In the previous section, the new Minister of State with responsibility for the NDS, Róisín Shortall TD, is quoted as saying that progress with regard to implementation of the NDS will be reviewed on ‘an ongoing basis’. To date, no progress report on the implementation of the NDS, nor any review of the NDS, has been published.

In February 2011 the Children’s Rights Alliance, a coalition of over 90 non-governmental organisations (NGOs) working to secure the rights and needs of children in Ireland, published a review of progress under the national children’s strategy launched in 2000 (Children’s Rights Alliance 2011a). It reported that while there had been progress in expanding specialist drug treatment for under-18-year-olds, ‘the impact on children’s lives is unknown as impact of funding on services is unclear’ (p.17).

### 1.3.3 Other drug policy developments *e.g. government declaration, civil society initiatives*

#### Protecting human rights and combating poverty during the economic downturn

Between 10 and 15 January 2011, at the invitation of the then Irish government, the United Nation’s independent expert on human rights and extreme poverty, Magdalena Sepúlveda Carmona, undertook a mission to Ireland. She focused on the impact of the economic and financial crises in Ireland and the effects of recovery measures on the level of enjoyment of human rights, in particular economic, social and cultural rights, by the most vulnerable individuals and groups in Ireland, including problem drug users. On 17 May 2011 Ms Sepúlveda submitted her report to the UN (Sepúlveda Carmona 2011). In it, she makes concrete recommendations on how to implement a human rights-based recovery in Ireland.

While acknowledging that the government’s anti-poverty and social inclusion strategies may need to be adapted in light of the worsening economic situation, she encourages the government to ensure as a minimum that the 23 high-level goals in the current social partnership agreement, *Towards 2016* (Department of the Taoiseach 2006), continue to be the primary targets for Ireland’s social policies. She also endorses the target set by the *National Action Plan for Social Inclusion 2007–2016* (NAPIncl) (Office for Social Inclusion 2007) to reduce the number of those experiencing consistent poverty to between 2% and 4% by 2012, with the aim of eliminating consistent poverty by 2016. She calls on the government to undertake a human rights review of all budgetary and recovery policies to ensure they comply with fundamental human rights principles.

According to Ms Sepúlveda, ensuring non-discrimination and equality are also fundamental pillars of the human rights framework. Despite the existence of a strong body of equality legislation in Ireland, Ms Sepúlveda urges the government to be particularly mindful that policies do not exacerbate the challenges faced by groups vulnerable to discrimination. She also encourages the government to take positive

measures to help these vulnerable segments to 'regain their equal footing with the rest of Irish society'. She goes on to observe:

A number of recent measures are concerning in this respect, especially reductions in child benefits and benefits for job seekers, carers, single parent families, persons with disabilities and blind persons. The impact of these measures will be exacerbated by funding reductions for a number of social services which are essential for the same vulnerable people, including disability, community and voluntary services, Travellers supports, drug outreach initiatives, rural development schemes, the Revitalising Areas by Planning, Investment and Development (RAPID) programme and Youthreach. (para. 34)

In April 2011 the Irish government submitted its National Reform Programme (NRP) (Government of Ireland 2011) to the European Commission, setting out Ireland's headline targets to help achieve the objectives set in *Europe 2020 – A European strategy for smart sustainable and inclusive growth*. Under the heading of Poverty, the Irish government reiterates its commitment, already made in its programme for government, to the poverty targets set in the NAPincl. The NRP states (p. 24): 'Taking the 2008 consistent poverty rate of 4.2% as the baseline year, the numerical expression of the national poverty target is to lift 186,000 people out of the risk of poverty and exclusion by 2016. Similarly, the interim target is to lift between 9,000 and 97,000 out of the risk of poverty and exclusion by 2012.'

However, given the country's current economic difficulties, the government also states in the NRP that it will review its national poverty targets during 2011. The review will assess progress made towards the interim target, the likely economic and fiscal scenario for the years immediately ahead and new data for 2010, which are expected to give a clearer indication of poverty trends. On the basis of expert opinion about 'the statistical feasibility of eliminating consistent poverty and the arguments for adopting multiple or tiered poverty targets to address the complexity of poverty', the government will consider how it can set out 'different levels of ambition for poverty reduction having regard to the economic circumstances'.

### **Press Ombudsman upholds complaint of prejudice against drug users**

On behalf of more than thirty Irish drug service providers and professionals, three voluntary organisations – CityWide Drugs Crisis Campaign (based in Dublin), the Irish Needle Exchange Forum and the International Harm Reduction Association – lodged a complaint with the Office of the Press Ombudsman against the national daily newspaper, the *Irish Independent*, and an article it published on 18 February 2011 by columnist Ian O'Doherty entitled 'Sterilising junkies may seem harsh, but it does make sense'. The article was reported to comment favourably on a suggestion by a doctor that such people should be offered money to be sterilised. It described a group of people whose anti-social activities the writer had witnessed from his taxi as 'junkies' and 'feral, worthless scumbags', and voiced the writer's opinion that 'if every junkie in this country were to die tomorrow I would cheer'.

On 23 May 2011 the Press Ombudsman issued his decision. He upheld the complaint that the article breached Principle 8 (Prejudice) of the Code of Practice for Newspapers and Magazines 'because it was likely to cause grave offence to or stir up hatred against individuals or groups addicted to drugs on the basis of their illness'. However, he had insufficient evidence to make a decision as to whether the description of the anti-social activities described in the article breached the requirement for truth and accuracy in reporting:<sup>2</sup> 'because the article's distinction between an 'addict' and a 'junkie' is clearly the expression of an opinion, the question of its truth or accuracy cannot be determined by the Press Ombudsman' (Office of the Press Ombudsman 2011, 23 May).

<sup>2</sup> Principle 1.1 of the Code, under the general heading Truth and Accuracy, states that 'when a significant inaccuracy, misleading statement or distorted report or picture has been published, it shall be corrected promptly and with due prominence'.

### **Exploring community drugs problems including intimidation**

In October 2010 CityWide Drugs Crisis Campaign hosted a conference 'A community drugs problem: defining the problem – defending the responses', to provide an opportunity for those working in local community projects and groups to come together with local and regional drugs task force community representatives to discuss the key issues being confronted. The 'community drugs problem' was defined by CityWide co-ordinator, Daithí Doolan, in the following terms: 'There is no home in Ireland that does not have a battle with addiction being waged within its four walls. But addiction becomes a community drugs problem when our very community becomes undermined by the drug-related problems.' (Connolly 2011)

Eight months later, in May 2011, CityWide organised a follow-up conference on intimidation, which had emerged at the conference as a central issue for many communities throughout Dublin. At its conclusion, CityWide agreed to facilitate the establishment of an Intimidation Working Group. See Section 9.2.2 for a more detailed account of this conference and the outcome.

### **Reviewing treatment models**

The National Drugs Conference of Ireland held between 4 and 5 November 2010 in Dublin and entitled 'A Continuum of Care within Drug Services' focused on harm reduction and abstinence models. Hosted by a group of voluntary sector organisations,<sup>3</sup> the conference sought to highlight the fact that, rather than being opposing ideologies, these models represent different places along the spectrum of service provision (Condrón and Caprani 2011).

#### **1.3.4 Co-ordination arrangements**

On 1 May 2011 all functions relating to the management of the NDS, and the National Advisory Committee on Drugs (NACD), transferred from the Department of Community, Equality and Gaeltacht Affairs to the Department of Health.<sup>4</sup> Two drug-related units have been created within the Department of Health, replacing the Office of the Minister for Drugs (OMD), which was established under the NDS in late 2009 in the Department of Community, Equality and Gaeltacht Affairs (Shortall 2011, 13 July):

- Drug Policy Unit – to oversee the implementation of the NDS through the five pillars of supply reduction, prevention, treatment, rehabilitation and research.
- Drugs Programme Unit – to manage the Drugs Initiatives Programmes which are primarily drug-related projects and initiatives in the drugs task force areas.

The main function of the NACD continues to be to advise the Minister and the government in relation to the prevalence, prevention, treatment and consequences of drugs misuse. It also conducts and commissions research in relation to drug misuse.

To date, no explanation has been forthcoming as to whether or how the networking model promoted in the 2008 OECD review of the Irish public sector, and a distinctive feature of the organisational structure recommended by the NDS Steering Group for the OMD, will be retained in the future. See Section 1.3.3 of Ireland's 2009 National Report for a full account of how this networking model was to be applied in the OMD (Alcohol and Drug Research Unit 2009).

On 31 May 2011 Róisín Shortall TD, the Minister for Primary Care, with lead responsibility for the NDS, responded to questions put to the Minister for Health in Dáil Éireann (Parliament) with regard to how drug policy would be co-ordinated at ministerial and departmental level. She and the Minister for Health, Dr James Reilly TD, will both have roles – the Minister at Cabinet level, the Minister of State at Cabinet Committee level. While confirming that the Oversight Forum on Drugs (OFD) and the Drugs Advisory Group (DAG), established under the NDS, will both continue, she went

<sup>3</sup> The Irish Needle Exchange Forum (INEF) in conjunction with the Ana Liffey Drug Project, Coolmine Therapeutic Community and the Irish Association of Alcohol and Addiction Counsellors (IAAAC).

<sup>4</sup> The Department of Community, Equality and Gaeltacht Affairs has been abolished. The Office of the Minister for Children and Youth Affairs, formerly located in the Department of Health and Children, has been established as the Department of Children.

on to talk solely about an 'oversight committee', the quarterly meetings of which she will chair, which indicates that she is referring to the OFD.

The NDS is a cross cutting area of public policy and service delivery and it is based on a co-ordinated approach across many Departments and agencies in conjunction with the community and voluntary sectors. The institutional arrangements to support cross agency working, advise on operational and policy matters, assess progress across the strategy and address any operational difficulties include the drugs advisory group and the oversight forum on drugs. I intend that the work of these bodies will continue, as has been the case up to now. ...

With regard to implementation of the strategy, there is an oversight committee, which I will chair, and that will continue to meet on a quarterly basis and identify any logjams, difficulties or delays in implementing the strategy. We are, therefore, serious about ensuring it is implemented in full. In addition, the Minister will be responsible for this issue at Cabinet level and it will continue to have a voice at the Cabinet table. The Cabinet sub-committee on social exclusion will deal with this issue as well and many of the officials involved in the oversight will feed into the sub-committee. It will receive attention there and the sub-committee will meet later this week. I will attend that meeting and I will be a voice in respect of the NDS. ...

The purpose of the oversight committee is to address issues such as crystal meth and other developments relating to illegal drugs. All the relevant bodies are represented at a senior level and one of the committee's functions is to update all the members on current trends in respect of drug misuse. I give an assurance that all of the relevant agencies are represented at a senior level. I will convene the first meeting of the oversight committee in the coming weeks. (Shortall 2011, 31 May-a).

## **1.4 Economic analysis**

In its programme for government for the next five years, *Towards recovery: programme for a National Government 2011–2016 (Fine Gael and the Labour Party 2011)* the new government, elected in February 2011, included the following statement in the section entitled 'Drugs': 'We will ensure every government department, agency or task force responsible for implementing elements of the National Addiction Strategy will be required to account to the Minister for their budget annually and to demonstrate progress on achieving targets.'

### **1.4.1 Public expenditures**

The total budgeted public expenditure on the illicit drugs issue in 2010 was €260.296 million. This has been categorised according to Level 1 of the UN's Categories of Functions of Government (COFOG) as follows:

Health: \$169.442 million  
Justice: €60.844 million  
Education: €29.549 million

This demonstrates that approximately two-thirds of direct public expenditure on the illicit drugs issue in 2010 was associated with what are defined as health-related functions of government. For a detailed breakdown, see Standard Table on Public Expenditure (STPE).

### **1.4.2 Budget**

See National Report 2010 for most recent information (Irish Focal Point 2010)

### **1.4.3 Social costs**

See National Report 2009 for most recent information (Alcohol and Drug Research Unit 2009)

## 2. Drug Use in the General Population and Specific targeted-Groups

### 2.1 Introduction

Drug prevalence surveys of the general and school-child population are important sources of information on patterns of drug use, both demographically and geographically, and, when repeated, reveal changes over time. In Ireland such surveys are conducted every three to four years. These surveys increase understanding of drug use, which, in turn, helps in the formulation and evaluation of drug policies. They also enable informed international comparisons, provided countries conduct surveys in a comparable manner. The four main data collection tools in Ireland are described below.

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

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

The first iteration of this general population drug prevalence survey was undertaken in 2002/3 (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005b), and a second iteration in 2006/7 (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008). A series of bulletins reporting the findings of the 2002/3 and 2006/7 iterations have been published and can be found at <http://www.nacd.ie/publications/index.html>. The most recent (third) survey was conducted in 2010/11.

As with other European surveys, people over the age of 64 are excluded from this survey, as they grew up in an era when both the use and availability of illegal drugs were very limited. Therefore, surveys with older people have, to date, shown very low rates of use even on a lifetime basis. This situation will change over time as the younger population grows older: lifetime prevalence rates are likely to increase for a considerable period of time. When examining the data and comparing results over time, last-year use is the best reflection of changes as it refers to recent use. Last-month use is valuable insofar as it refers to current use.

The **Survey of Lifestyles, Attitudes and Nutrition (SLÁN)** is a national survey of the lifestyles, attitudes and nutrition of people living in Ireland. To date, three surveys have been completed – in 1998 (Friel, *et al.* 1999), 2002 (Kelleher, Cecily, *et al.* 2003) and 2007 (Morgan, *et al.* 2008) – and have examined the health and social status, and related health service use, of adults aged 18 years and older living in private households. SLÁN 1998 and SLÁN 2002 were postal surveys, based on samples from the electoral register, and involved 6,539 respondents in 1998 (62% response rate) and 5,992 in 2002 (53% response rate). SLÁN 2007 interviewed 10,364 respondents face-

to-face in their homes, based on samples from the GeoDirectory (62% response rate). The SLÁN data are not comparable with the results of the 2002/3, 2006/7 and 2010/11 all-Ireland general population drug prevalence survey as the SLÁN survey excludes those aged between 15 and 17 years and includes those aged over 65 years.

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

The Health Promotion Research Centre, National University of Ireland, Galway was invited to join the HBSC network in 1994 and conducted the first survey of Irish schoolchildren in 1998 (Friel, *et al.* 1999); the survey has been repeated in Ireland in 2002 (Kelleher, Cecily, *et al.* 2003) and 2006 (Nic Gabhainn, S, *et al.* 2007).

The **European School Survey Project on Alcohol and Other Drugs (ESPAD)** is a collaborative effort of independent research teams in about 40 European countries. Data on alcohol and illicit drug use among 15–16-year-olds have been collected every four years since 1995, using a standardised method and a common questionnaire. The Swedish Council for Information on Alcohol and Other Drugs (CAN) initiated the project in 1993. Support has been provided by the Pompidou Group at the Council of Europe, the Swedish Ministry of Health and Social Affairs, the Swedish National Institute of Public Health and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The data collections in the individual countries are funded by national sources. The rationale for the survey is that school students are easily accessible and are at an age when onset of substance use is likely to occur. (By definition, early school leavers, a group known to be vulnerable to alcohol and drug use, are not represented.)

The fourth iteration of the survey was conducted in 35 European countries, including Ireland, in the spring of 2007 and the results were published in March 2009 (Hibell, *et al.* 2009). The fourth survey collected information on alcohol and illicit drug use among 15–16-year-olds; 2,249 students from 94 randomly-selected schools participated, which represents a response rate of 78%. Fewer schools and students participated in 2007 than in 2003. The Irish data showed a marked decrease in lifetime use of any illicit drug between 2003 (40%) and 2007 (22%). As the majority of those who had tried any illicit drug had used cannabis (marijuana or hashish), the decrease in illicit drug use was influenced by the considerable decrease in the number of students who had tried cannabis at some point in their lives, from 39% in 2003 to 20% in 2007 (European average 19%). Data were collected for the fifth iteration of ESPAD in spring 2011 and the survey findings will be published in 2012.

## **2.2 Drug use in the general population (based on probabilistic sample)**

On 22 November 2011, the National Advisory Committee on Drugs (NACD) and the Public Health Information and Research Branch (PHIRB) within the Department of Health, Social Services and Public Safety (DHSSPS) in Northern Ireland published jointly the results of the third all-Ireland general population drug prevalence survey.

The Irish survey followed best practice guidelines recommended by the EMCDDA. The questionnaire, based on the 'European Model Questionnaire', was administered in face-to-face interviews with respondents aged between 15 and 64 years normally resident in households in Ireland and Northern Ireland. The questionnaire in the 2010/11 general population survey was revised to include better measures of alcohol from the European Comparative Survey on Alcohol and the SMART project. The questionnaire also included two measures of cannabis dependency – the MCIDI based

on clinical diagnosis and the SDS used in a number of studies on treatment. Three questions were asked about new psychoactive substances sold in headshops or online. The response options to the other opiate-type substances were increased to include codeine and other commonly used opiates. Some of the questions from the perceptions and risks module were removed to make time and space for the new questions. With the exception of these questions and their corresponding showcards, the questionnaire employed for the 2010/11 survey was the same as that used in 2006/7. Fieldwork was carried out by MORI MRC during late 2010 and early 2011. The final achieved sample was 5,134 in Ireland. This represented a response rate of 60%. The sample was weighted by gender, age and region to ensure that it was representative of the general population. The main measures of use were lifetime (ever used), use in the last year (recent use) and use in the last month (current use). The detailed methodological background to the general population survey on drug use and the results are presented in Standard Table 1.

The proportion of adults (aged 15–64 years) who reported using an illegal drug in their lifetime (ever used) increased by just over 3%, from 24% in 2006/7 to 27.2% in 2010/11 (Table 2.2.1). The proportion of young adults (aged 15–34 years) who reported using an illegal drug in their lifetime also increased by just over 4%, from 31.4% in 2006/7 to 35.7% in 2010/11. As expected, more men (35.5%) reported using an illegal drug in their lifetime than women (19%).

The proportion of adults who reported using an illegal drug in the last year (recent use) remained stable at 7.2% in 2006/7 and 7% in 2010/11 (Table 2.2.1). The proportion of young adults who reported using an illegal drug in the last year also remained stable at 12.1% in 2006/7 to 12.3% in 2010/11. The proportion of young adults who reported using an illegal drug in the last month (current use) was 5.3%.

**Table 2.2.1 Lifetime, last-year and last-month prevalence of illegal drug use in Ireland, 2002/3, 2006/7 and 2010/11**

Illegal drug use*	Adults 15–64 years%			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Lifetime	18.5	24.0	27.2	24.0	29.4	35.5	13.1	18.5	19.0	26.0	31.4	35.7
Last year	5.6	7.2	7.0	7.8	9.6	10.4	3.4	4.7	3.6	9.7	12.1	12.3
Last month	3.0	2.9	3.2	4.1	4.3	5.3	1.7	1.4	1.1	5.2	4.8	5.3

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

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005b) (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008) and unpublished data for 2010/11 from NACD

Lifetime cannabis use increased over the four years since the previous survey in 2006/7 but last year use remained stable (Table 2.2.2). The proportion of adults who reported using cannabis at some point in their life increased from 21.9% in 2006/7 to 25.3% in 2010/11. The proportion of young adults who reported using cannabis in their lifetime also increased, from 28.6% in 2006/7 to 33.4% in 2010/11.

The proportion of adults who reported using cannabis in the last year remained stable at 6.3% in 2006/7 and 6.0% in 2010/11. The proportion of young adults who reported using cannabis in the last year remained stable at 10.4% in 2006/7 to 10.3% in 2010/11. The proportion of adults who reported using cannabis in the last month remained stable at 2.8%.

The lifetime prevalence rate was higher for men (33.2%) than for women (16.6%).

**Table 2.2.2 Lifetime, last-year and last-month prevalence of cannabis use in Ireland, 2002/3, 2006/7 and 2010/11**

Cannabis use	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Lifetime	18.5	24.0	27.2	24.0	29.4	35.5	13.1	18.5	19.0	26.0	31.4	35.7
Last year	5.6	7.2	7.0	7.8	9.6	10.4	3.4	4.7	3.6	9.7	12.1	12.3
Last month	3.0	2.9	3.2	4.1	4.3	5.3	1.7	1.4	1.1	5.2	4.8	5.3

Cannabis use	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
Lifetime	17.4	21.9	25.3	22.4	27.0	33.2	12.3	16.6	17.5	24.0	28.6	33.4
Last year	5.0	6.3	6.0	7.2	8.5	9.1	2.9	3.9	2.9	8.6	10.4	10.3
Last month	2.6	2.6	2.8	3.4	4.0	4.7	1.7	1.1	0.9	4.3	4.2	4.5

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005a) (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008) and unpublished data 2010/11 from NACD.

Lifetime cocaine use increased in 2010/11 compared to 2006/7 but last-year use remained stable. The proportion of adults who reported using cocaine (including crack) at some point in their lives increased from 5.3% in 2006/7 to 6.8% in 2010/11 (Table 2.2.3). The proportion of young adults who reported using cocaine in their lifetime also increased, from 8.2% in 2006/7 to 9.4% in 2010/11. As expected, more men (9.9%) reported using cocaine in their lifetime than women (3.8%).

The proportion of adults who reported using cocaine in the last year remained stable at 1.7% in 2006/7 and 1.5% in 2010/11 (Table 2.2.3). The proportion of young adults who reported using cocaine in the last year decreased marginally from 3.1% in 2006/7 to 2.8% in 2010/11.

The proportion of adults who reported using cocaine in the last month remained stable at 0.5%.

**Table 2.2.3 Lifetime, last-year and last-month prevalence of cocaine use (including crack) in Ireland, 2002/3, 2006/7 and 2010/11**

Cocaine use	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
	Lifetime	3.0	5.3	6.8	4.3	7.0	9.9	1.6	3.5	3.8	4.7	8.2
Last year	1.1	1.7	1.5	1.7	2.3	2.3	0.5	1.0	0.7	2.0	3.1	2.8
Last month	0.3	0.5	0.5	0.7	0.8	0.8	0.0	0.2	0.3	0.7	1.0	1.0

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2006) (National Advisory Committee on Drugs and Public Health Information and Research Branch 2008) and unpublished data 2010/11 from NACD.

Almost 11% of young adults claimed to have tried ecstasy at least once in their lifetime in 2010/11 (Table 2.2.4).

**Table 2.2.4 Lifetime, last-year and last-month prevalence of ecstasy use in Ireland, 2002/3, 2006/7 and 2010/11**

Ecstasy use	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
	Lifetime	3.7	5.4	6.9	4.9	7.2	10.1	2.6	3.6	3.7	7.1	9.0
Last year	1.1	1.2	0.5	1.7	1.8	0.6	0.5	0.6	0.3	2.0	2.4	0.9
Last month	0.3	0.3	0.1	0.7	0.5	0.1	0.0	0.2	0.0	0.6	0.6	0.1

Source: (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005b) (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008) and unpublished data 2010/11 from NACD.

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

## 2.3 Drug use in the school and youth population (based on probabilistic sample)

### Drug use among early school leavers compared with school attendees

Haase and Pratschke estimated drug use among 479 early school leavers and 512 school attendees, aged 16–18 years, and identified risk and protective factors for substance use (Haase and Pratschke 2010). Data were collected throughout Ireland between March and May and again between September and December 2008. The participants were interviewed face-to-face and their answers were recorded using computer-assisted personal interviewing devices. The proportions using each drug are presented in Table 2.3.2. It is clear that substance use is more common (with the exception of alcohol) among early school leavers than among school attendees.

**Table 2.3.2 Proportion of early school leavers (479) and school attendees (512) using different substances, 2008**

	Lifetime		Year prior to the survey		Month prior to the survey	
	Early school leavers %	School attendees* %	Early school leavers %	School attendees* %	Early school leavers %	School attendees* %
Tobacco	81.6	53.3	73.7	38.3	68.9	27.1
Alcohol	89.6	85.7	84.3	78.1	65.3	54.4
Cannabis	57.0	24.2	43.0	14.5	33.6	7.6
Cocaine	25.9	3.7	14.8	2.5	5.4	0.2
Crack	1.3	1.2	0.4	1.0	0.0	0.0
Amphetamines	18.4	3.1	5.6	1.0	0.8	0.0
LSD	5.6	2.0	2.3	2.0	0.0	0.0
Magic mushrooms	12.1	2.5	5.4	0.4	0.4	0.0
Heroin	1.3	0.0	0.4	0.0	0.0	0.0
Tranquillisers	3.8	1.2	1.9	0.2	0.8	0.0
'Legal' party pills	23.4	6.8	13.2	3.9	2.9	0.2
Anti-depressants	8.4	2.0	5.4	0.4	2.1	0.4
Ecstasy	27.3	4.9	17.5	2.3	7.1	0.4
Solvents	14.4	5.5	2.9	0.4	0.8	0.0
Anabolic steroids	0.8	0.02	0.2	0.2	0.2	0.0

\*Proportions for school attendees are adjusted by age and gender to match the composition of early school leavers.  
Source: (Haase and Pratschke 2010)

### Gateway drug transitions in rural Irish school children

Van Hout (Van Hout, Marie Claire and Ryan 2011) presented the findings from a large-scale mixed-method study on substance use among youth in the rural south-east of Ireland. The findings were discussed with reference to the design of culturally appropriate and drug specific education initiatives in rural Ireland. The survey instrument contained questions on demographics, alcohol use, cigarette use, drug initiation, and drug use. A random sample of 345 school children (aged 14 to 17 years) was selected from five participating schools in a rural area in the south-east of Ireland; 91% of the selected school children participated in the study. The participating schools represented private, single sex public, and mixed public schools in the area. Standard ethical and consent procedures were followed. The structured nature of the school setting facilitated the administration of the research. The researcher emphasised the anonymity of the survey prior to administering it to the selected children and remained in each school in order to collect the completed questionnaires. The researcher did not present the findings by school type as some schools might have been identifiable. The research findings were presented thematically.

### Self-reported cigarette use

Of the sample, 45% reported smoking cigarettes at least once in their life, of whom 34% smoked cigarettes on a daily basis, 26% smoked less than daily or infrequently, and 31% tried smoking only once. The proportion of girls and boys who reported smoking was similar. The survey identified a significant association between cigarette smoking and alcohol use, with 100% of those reporting lifetime prevalence of cigarette use having drunk alcohol ( $p < 0.001$ ), a large proportion of those who reporting 'drunkenness' having smoked cigarettes ( $p < 0.05$ ), and 100% of those reporting drug

use having smoked cigarettes ( $p < 0.02$ ). These findings support the claim that cigarette smoking is a gateway to alcohol and drug use.

### **Self-reported alcohol use**

In terms of self-reported alcohol use, 62% of the respondents reported alcohol use during their lifetime, with no significant differences between boys and girls, and 36% reported drunkenness. The concurrent qualitative element of this study highlighted the frequency and regularity of alcohol consumption within religious and family gatherings in Irish society. Many young people reported drinking alcohol at home in the presence of their parents and/or with parental permission. In addition, the survey identified significant associations between lifetime alcohol and drug prevalence ( $p < 0.001$ ), and between drunkenness and lifetime drug prevalence ( $p < 0.0001$ ). This highlights the potential mediating role that alcohol plays in providing opportunities to commence other drug use.

### **Self-reported other drug use**

Lifetime prevalence of drug use was reported by 24% of the sample, with similar proportions of girls and boys reporting drug use. There was a significant association between lifetime prevalence of cannabis use and alcohol use ( $p < 0.0001$ ), lifetime prevalence of cannabis use and drunkenness ( $p < 0.0001$ ), and frequency of cannabis and alcohol use ( $p < 0.0001$ ). This was supported in the qualitative phase of the research, where young people described their first introduction to cannabis and subsequent use when drinking alcohol or under its influence. Interestingly, given that both tobacco and cannabis were smoked, the survey did not identify an association between lifetime use of cannabis and cigarettes. However, the qualitative research did observe similar risk perceptions where the participants perceived the smoking of cannabis as similar to tobacco in relation to safety, can be consumed in a short time period, and avoidance of legal repercussions.

No student reported use of cocaine or heroin, for two reasons – fear of the consequences of more serious drug use and availability of cannabis. The increasing availability of cannabis and the emerging social acceptance of cannabis use among young people in the south-east is cause for concern, particularly in light of the increasing gravitation to hard drugs (such as cocaine and heroin) across the whole of Ireland.

No significant relationships between tobacco or alcohol use and the use of specific drugs such as ecstasy, amphetamine, cocaine, solvents, heroin, ketamine, tranquilisers, and magic mushrooms were detected but this may be explained by the small numbers who reported using these drugs.

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

### **Substance use among university students in Cork**

Cahill and Byrne (Cahill and Byrne 2010) examined alcohol and other drug use among students attending a student health centre. Students aged 18 and over, attending University College Cork's Student Health Department over a two-day period in November 2008, were invited to complete an anonymous questionnaire on their alcohol and other drugs use. The questionnaire was based on the one used in the College Lifestyle and Attitudinal National (CLAN) Survey (Hope, *et al.* 2005). The response rate was 91% with 181 of 198 questionnaires completed. Over half (53%) of the participants were between 18 and 21 years old, and 76% were female, mirroring the 3:1 ratio of female to male attendance at the student health centre. The results of this survey represent alcohol and other drug use among attendees at third-level student health services rather than alcohol and other drug use among the student population attending the university.

Cannabis was the most common illegal drug reportedly used by respondents: 49% had used cannabis at some point in their lives, 27% in the year prior to the survey, and 13% in the 30 days prior to the survey. Of those who used cannabis in the year prior to the survey, 44% used it on more than 10 occasions. Cannabis use was more common among male students.

Cocaine was the second most common illegal drug used by respondents, with 7% reportedly using it in the year prior to the survey, and ecstasy was the third most common illegal drug used, with 4% reportedly using it in the year prior to the survey. Only female students reported ecstasy use. Other drugs used included magic mushrooms, tranquillisers or sedatives, amphetamines and LSD. No respondent reported that they had ever used heroin, drugs by injection, or crystal meth.

Almost all students attending the student health centre (98%) had consumed alcohol at some point in their life and students began drinking at an average age of 15.9 years (range 1– 30 years). Seventy-six per cent consumed an alcoholic drink in the week prior to the survey. Women's preferred alcoholic drink was spirits (96%), followed by beer/cider (77%) and then wine (75%). Men preferred beer/cider (96%), followed closely by spirits (93%) and then wine (73%). Binge drinking, which was defined as 'drinking at least four pints of beer/cider, or a bottle of wine, or its equivalent on a single drinking occasion', was a frequent occurrence, with 83% of respondents reporting binge drinking in the year prior to the survey. A significant proportion (45%) reported binge drinking once a week or more. All student respondents who drank reported suffering at least one adverse consequence as a result of their own drinking. The most common adverse consequences reported were regretting something said or done, feeling adverse effects whilst at college, missing days from college, or harm to college studies or work. Nearly 1 in 4 male drinkers had been in a fight as a result of their drinking and approximately 1 in 10 reported unintentional or unprotected sex as a result of alcohol. The majority of respondents (63%) reported suffering adverse consequences of someone else's drinking.

The authors did not compare the findings with the CLAN survey as this current study was conducted among a sub-sample of students who were attending a health service rather than among the general population of students.

### **Substance use among students in Limerick**

Houghton and colleagues (2011) (Houghton, *et al.* 2011) examined students' health and lifestyles in a quota sample survey; the survey included questions on recent drug use (last year). One thousand students attending lectures were asked to participate in the survey and 76% (742) did so. The participants ranged in age from 17 to 63 years, and half were aged 20 or younger; 52% (386) were men. Five (0.7%) participants reported that they had taken 'Revelin' (the name of a dummy drug) and these were excluded from the analysis. The most common illegal drug taken was cannabis, with one third of students reporting taking it at least once in the year prior to the survey (Table 2.4.1). Cocaine was also a popular drug with 13% taking it during the same time period. Ecstasy was taken by 12% of respondents. Similar proportions took magic mushrooms (7%) and amphetamines (7%). Five per cent were prescribed tranquillisers and 3% took tranquillisers that were not prescribed for them. Similar proportions took LSD and solvents. Only 0.9% had taken heroin in the last year and 0.5% had injected an illicit drug in the last year. Almost 18% of respondents took more than one drug concurrently (polydrug use). Men were marginally more likely to take drugs than women. The authors stated that the high rates of drug use have implications for physical and mental health.

**Table 2.4.1 Drug use and frequency in the last year for third-level students, Limerick**

Drug Type	All			Male			Female		
	Never	Once or Twice	3 or More	Never	Once or Twice	3 or More	Never	Once or Twice	3 or More
<b>Cannabis</b>	66.8% (412)	11.2% (69)	22.1% (136)	67.9% (226)	9.9% (33)	22.2% (74)	65.6% (177)	13.0% (35)	21.5% (58)
<b>Cocaine</b>	87.0% (562)	7.3% (47)	5.7% (37)	87.1% (311)	5.6% (20)	7.3% (26)	87.0% (240)	9.8% (27)	3.3% (9)
<b>Ecstasy</b>	87.6% (567)	6.3% (41)	6.0% (39)	85.7% (306)	7.3% (26)	7.0% (25)	90.3% (250)	5.4% (15)	4.3% (12)
<b>Magic Mushrooms</b>	92.9% (598)	5.1% (33)	2.0% (13)	91.9% (327)	5.6% (20)	2.5% (9)	94.2% (268)	4.7% (13)	1.1% (3)
<b>Amphetamine</b>	93.0% (599)	4.2% (27)	2.8% (18)	91.6% (327)	5.0% (18)	3.4% (12)	94.9% (261)	3.3% (9)	1.8% (5)
<b>Tranquillisers with prescription</b>	94.9% (610)	3.6% (23)	1.4% (9)	95.2% (338)	3.7% (13)	1.1% (4)	94.5% (260)	3.6% (10)	1.5% (4)
<b>Tranquillisers without prescription</b>	96.9% (622)	2.3% (15)	0.8% (5)	96.6% (344)	2.2% (8)	1.1% (4)	97.4% (267)	2.2% (6)	0.4% (1)
<b>LSD</b>	96.3% (620)	2.0% (13)	1.7% (11)	95.5% (341)	2.5% (9)	2.0% (7)	97.5% (268)	1.5% (4)	1.1% (3)
<b>Solvents</b>	96.3% (619)	2.5% (16)	1.1% (7)	95.5% (340)	2.8% (10)	1.4% (5)	97.1% (268)	2.2% (6)	0.7% (2)
<b>Heroin</b>	99.1% (638)	0.6% (4)	0.3% (2)	98.6% (352)	1.1% (4)	0.3% (1)	99.6% (274)	0.4% (1)	0% (0)
<b>Drugs by injection</b>	99.5% (642)	0.3% (2)	0.2% (1)	99.4% (355)	0.3% (1)	0.3% (1)	99.6% (275)	0.4% (1)	0% (0)

Source: (Houghton, *et al.* 2011)

### 3. Prevention

#### 3.1 Introduction

Drug prevention is one of the four pillars in the **National Drugs Strategy** (interim) 2009–2016 (Department of Community Rural and Gaeltacht Affairs 2009). The Strategy states that ‘a tiered or graduated approach to prevention and education measures in relation to drugs and alcohol should be developed with a view to providing a framework for the future design and development of interventions’ (para. 3.56).

It identifies three levels in this framework:

- Universal (primary) prevention programmes, aimed at the general population such as students in schools, to promote overall health of the population and to prevent the onset of drug and alcohol misuse. Measures often associated with this type of programme include awareness campaigns, school drug/alcohol education programmes and multi-component community initiatives.
- Selected (secondary) prevention programmes, aimed at groups at risk, as well as subsets of the general population including children of drug users, early school leavers and those involved in anti-social behaviour, to reduce the effect of risk factors present in these subgroups by building on strengths and developing resilience and protective factors.
- Targeted (tertiary) prevention programmes, for people who have already started using drugs/alcohol, or who are likely/vulnerable to engage in problematic drug/alcohol use (but may not necessarily be drug/alcohol dependent), or to prevent relapse. These programmes are aimed at individuals or small groups and address specific needs.

This framework combines universal, selected and targeted with the old classificatory framework of primary, secondary and tertiary, which is misleading in that it implies that universal prevention is also the primary step in prevention. In Ireland young people and their families are the main target groups for drug prevention activities, which consist mainly of universal and selected prevention, with little focus on targeted prevention.

The NDS identifies as priorities for Prevention, improving the delivery of SPHE in primary and post-primary schools and co-ordinating the activities and funding of youth interventions in out-of-school settings to optimise their impacts. Drug prevention interventions in schools are delivered through the Walk Tall (primary schools) and the Social, Personal and Health Education (SPHE) (post-primary schools) programmes. The SPHE programme aims to improve social and personal competencies in students so they can understand and counter the many social influences that are seen as contributing to their use of drugs and alcohol. In the community, prevention programmes are provided in different settings, such as youth clubs and youth cafés, and by means of diversion activities provided by the statutory, voluntary and community sectors.

The National Drugs Strategy calls for a continued focus on orienting educational and youth services towards early interventions for people and communities most at risk. Actions are to be developed to further support the families of drugs users, and community development is acknowledged as an important step in building the capacity of local communities to avoid, or respond to and cope with, drug problems. Early school leavers are targeted through measures such as the School Completion Programme and embedding the government’s DEIS (Delivering Equality of Opportunity in Schools) Action Plan, which tackles disadvantage among the school-going population, in schools in LDTF areas. The Department of Education and Science (DES) has also developed a strategy to tackle educational disadvantage and early school leaving in the Traveller community.

Stand-alone mass media awareness and information campaigns are regarded as less effective than multi-component, multi-level interventions that reflect the complex nature of drug prevention and harm reduction. The NDS proposes that preference be given to

the development of timely awareness campaigns targeted in a way that takes individual social and environmental conditions into account key areas such as third-level institutions, workplaces, sports and other community and voluntary organisations.

## 3.2 Universal prevention

### 3.2.1 School

The Social, Personal and Health Education (SPHE) programme is the main vehicle through which substance use prevention is delivered in both primary and post-primary schools. The SPHE programme is a mandatory part of the primary school and post-primary (junior cycle) curriculum and supports the personal development, health and well-being of students through ten modules including a module on substance use. The themes and content of modules are based around helping students to understand the nature of social influences that impact on their development and decision-making, and helping them to develop adequate life-skills to improve their self-esteem, develop resilience and build meaningful and trusting relationships.

Actions 20 and 21 in the NDS are the policy mechanisms supporting implementation of SPHE as the main universal prevention programme in schools. Table 3.2.1.1 gives an update on progress against these actions.

**Table 3.2.1.1: Progress on actions in NDS to deliver universal prevention measures in primary and post-primary schools, March 2011**

Actions		Progress to date on implementation
Action 20	<p>Improve the delivery of SPHE in primary and post-primary schools through:</p> <ul style="list-style-type: none"> <li>the implementation of the recommendations of the SPHE evaluation in post-primary schools; and</li> <li>the development of a whole school approach to substance use education in the context of SPHE</li> </ul>	<p>Nic Gabhainn et al. 2008 made 41 recommendations to improve the implementation of SPHE in post-primary schools (Nic Gabhainn, Saoirse, <i>et al.</i> 2008).</p> <p>The implementation of these recommendations is ongoing. (Department of Community Equality and Gaeltacht Affairs 2011 23 March)</p>
Action 21	<p>Ensure that substance use policies are in place in all schools and are implemented.</p> <p>Monitor the effectiveness of the implementation of substance use policies in schools through the whole-school evaluation process and the inspectorate system and ensure that best practice is disseminated to all schools.</p>	<p>The results from a survey of schools undertaken by the Department of Education and Skills in 2009 indicates that:</p> <ul style="list-style-type: none"> <li>84% of primary schools in local drug task force areas had a substance abuse policy;</li> <li>96% of post-primary schools in local drug task force areas had a substance abuse policy.</li> </ul> <p>(Department of Community Equality and Gaeltacht Affairs 2011 23 March)</p> <p>Most post-primary schools had policies to address substance use. (Department of Education and Science Evaluation Support and Research Unit, 2009 #1891 In 2010 the number of whole-school evaluations (which include the area of SPHE) completed were 231 at primary level and 39 at post-primary level.</p>

### The implementation of SPHE in primary schools

An evaluation of the implementation of SPHE in 40 primary schools was published in 2009 (Department of Education and Science Evaluation Support and Research Unit 2009). The evaluation, undertaken in 2007, focuses on the teaching and learning in SPHE and on the quality of pupils' achievement. Table 3.2.1.2 provides details on the methods used to undertake the evaluation.

**Table 3.2.1.2: Methods used to evaluate SPHE in primary schools in 2007**

Methods of data collection	Number
Class settings observed	173
Interviews with boards of management	40

Methods of data collection	Number
Interviews with principals	40
Focus groups with teachers	40
Focus groups with pupils	40
Focus groups with post holders that had responsibility for SPHE-related duties	19
Questionnaires completed by senior pupils	1013
Questionnaires completed by parents	902

Source: (Department of Education and Science Evaluation Support and Research Unit 2009)

In reporting on the findings of the evaluation, the authors used the following conventions:

- Almost all = more than 90%
- Most = 75%–90%
- Majority = 50%–74%
- Fewer than half = 25%–49%
- A small number = 16%–24%
- A few = up to 15%

### *Quality of learning*

Observations revealed that in most classrooms, pupils actively engaged in team and partner-based activities and games. In one in eight of the classrooms observed, teachers underused active-learning approaches and overused didactic teaching methods which restricted the involvement of pupils in active learning.

In most classrooms observed, learning activities were interesting and challenging. In one in six classrooms, learning activities were uninteresting and less challenging as teachers did not match the content of materials to the abilities and interest of pupils.

In most classrooms observed, SPHE was taught on a regular basis and there was clear evidence of regular progress in the pupils' learning. There was scope for development in the progress of pupils' learning in one in five of the classrooms observed mainly due to the sporadic delivery of SPHE.

All pupils who participated in the focus groups expressed the view that learning in SPHE was important and could relate what they were learning to their current and future real-life experience. They had a good understanding of the content of SPHE and the associated values, attitudes and skills. In particular, they were able to reflect on issues relating to substance misuse and showed a good understanding of such issues.

Providing opportunities for pupils to work actively with their peers on interesting issues was an important feature of SPHE. Most pupils responding to the questionnaire had regular opportunities to work in groups, but 18% did not report such opportunities. Most pupils agreed with the statement 'preferred to articulate their opinions in class' but fewer than half believed their peers were willing to listen to them. Pupils' learning was evident on a number of topics including happiness, friendship, responsibility, healthy eating and exercise, safety and protection, and care of the environment. Pupils' learning on topics such as talking about personal feelings and asking questions about their body and how it changes was less evident.

Almost all pupils said they would know what to do if they were bullied at school and three quarters of students said the school adequately dealt with bullying.

### *Quality of teaching*

In most of the SPHE lessons observed, teachers used a variety of active-learning approaches, with one-third displaying best practice. Predominant active-learning approaches included talk, discussion and written activities. In most class settings observed, talk and discussion were focused around the concepts of SPHE and clear learning objectives were included and problem-solving techniques encouraged. In fewer than half of lessons observed, drama and co-operative games were used and in a small number of lessons observed, ICT, media studies, and pictures and

photographs were used. In 12% of classrooms observed there was room for improvement with the range of active-learning approaches used and the manner of their use.

In a majority of classrooms observed, learning opportunities in groups, including circle-time activities and co-operative games, was a regular feature. Inspectors praised teachers for encouraging teamwork and partnership among pupils. In almost one quarter of classrooms observed, opportunities to learn through group-based activities were much less than desired. Observation showed that most teachers provided pupils with opportunities to acquire values, attitudes and skills through active learning. Almost all teachers observed regularly used real-life events from school, play and the community in their teaching in SPHE, with almost half displaying best practice. Teachers reported that the Walk Tall module, a specific substance misuse prevention programme, was among the resources they used most regularly when delivering the SPHE curriculum in the classroom.

#### *Parents' views on SPHE*

Most parents replying to the questionnaire confirmed their awareness of SPHE plans in their child's school and 18% were either unaware of or unsure of the school's SPHE plan. Some parents submitted open-ended comments in addition to the questionnaire and praised the effective manner in which SPHE was addressed and the efforts made by staff to keep parents informed. Some parents said it was the duty of the school to keep them informed about plans for SPHE while others said it was their duty to inform themselves.

Just over half the schools reported having allocated specific responsibility for the co-ordination of SPHE to a designated teacher with special duties.

Most parents responding to the questionnaire were familiar with the work their child did in SPHE on personal safety and co-operating with others. Almost all parents were familiar and supportive of their children's work in SPHE on healthy eating and exercise. There was scope for encouraging the involvement of parents when planning the implementation of SPHE in more than half the schools evaluated.

#### *The views of principals on SPHE*

Almost 60% of principals interviewed said schools engaged a variety of external speakers and agencies to support the implementation of the SPHE curriculum. Almost two-thirds said they had organised in-school or external SPHE training for their staff, or both, within the last five years. Training in matters relating to substance use featured prominently.

#### *Assessment of SPHE*

In the majority of classrooms observed, there was room for improvement in the range of assessment strategies used by teachers to assess the progress of pupils, to inform teaching and learning and update parents. Assessment strategies tended to rely on unrecorded teacher observations and some examples of pupils' work in copybooks and worksheets. Slightly over a quarter of pupils responding to the questionnaire believed their teacher thought they were making progress at SPHE and 70% did not know what their teacher thought about their progress in SPHE. Very good assessment practices were found in only 15% of classrooms observed. Only 5% of schools sought pupils' views when planning the implementation of SPHE.

### **3.2.2 Family**

The Family Support Network (FSN) is an autonomous self-help organisation that advocates for and works with families affected by drug use and addiction. The FSN designs and delivers innovative initiatives to raise awareness of the issue of drug addiction in families and to respond to the needs of families affected by drug addiction. It is particularly active in seeking to engage 'hard-to-reach' families, including families

in migrant and/or ethnic communities where drug addiction remains taboo, families in denial about drug use and those which may be isolated and unaware of the services and supports available in their communities. Recent events organised by the FSN are described below.

The FSN annual work conference took place over two days in October 2010. Attended by 365 family members and numerous practitioners and policy makers, the conference included workshops on many topics, including family law, guardianship and custody issues, drug addiction relapse and relapse prevention, cultural issues in the travelling community and bereavement and addiction. A number of holistic therapy sessions were also provided to give respite to family members affected by drug addiction. The FSN's newsletter reported on an unpublished evaluation of the conference, which found that participants benefited by receiving new information, new skills, support, healing and respite (Family Support Network 2010, October).

The FSN also organised a national campaign to coincide with the general election held in early 2011. The aim was to bring drug use to the forefront of the election debate and make the issue of families and communities living with drug use a political priority. It provided a legitimate space for families and communities to articulate their concerns about the many austerity measures being introduced in relation to drug treatment and support services (Family Support Network 2010, December).

In February 2011, the FSN organised its 12<sup>th</sup> service of commemoration and hope. The service is an annual religious event to mark the deaths of people from substance misuse and related causes. This year's event was led by the President of Ireland, Mary McAleese. An unpublished evaluation of the service mentioned in the FSN's recent newsletter reports that the service provides families with an important public space to commemorate and grieve for their loved ones (Family Support Network 2011, May).

The FSN have recently developed an initiative targeting the families of minority ethnic groups, and of migrant communities, seeking to assist them in responding to addiction in their families and specific cultures. As part of this work, an information day for families of drug users from migrant communities was held.

### **3.2.3 Community**

Headstrong is a not-for-profit organisation that works with communities and existing mental health services in providing appropriate mental health support for young people, and to changing how Ireland thinks about mental health issues that affect young people. Targeting young people aged 12–25 through three levels of interventions – universal, selective and indicated – Headstrong pursues its aims through (i) a programme of service development to meet the mental health needs of young people, (ii) advocacy to change the way professionals and the public perceive the mental health of young people, and (iii) research to clarify the needs, concerns and strengths of young people in order to inform the development of services. Headstrong has established community-based programmes in five communities throughout Ireland through the Jigsaw programme, which is delivered in a mix of urban and rural locations. An update on Headstrong's recent work is provided below (Headstrong 2010). From 1 January 1 to 31 December 2010, 763 young people engaged with Headstrong through two operation Jigsaw sites; Galway and Ballymun. Self-referral (28.6%) and parent-referral (14.4%) were the most common routes to Headstrong, with other referrals coming from second-level schools, social workers, youth programmes, adult mental health services and peers. These diverse sources of referral suggest that Headstrong is quite visible in the community and is viewed as a credible service to meet the mental health needs of young people. The majority of young people accessing the service (59.2 %, n=452) were in the 15–19 age range, and 27.9% (n=213) were in the 20–25 age range. Just over half of all young people accessing the service in 2010 were male (50.5%, n=385).

Individual case consultations, where staff in Headstrong collaborated with another agency on behalf of young people, were provided to 33.7% (n=256) of service users; brief contact services, including information and/or onward referral to another service, were provided to 33% (n=251) of service users; prolonged engagement, comprising an extensive process of working with young people to address issues and problems and set goals, was provided to 17.9% (n=136) of service users; and brief interventions in the form of face-to-face solution-focused encounters were provided to 14.7% (n=112) of service users.

Headstrong places great emphasis on including young people in the design and delivery of its programmes and has developed a youth advisory panel to enable young people to articulate their views about the issues that concern them and how services could be developed to address these concerns. In 2010, Headstrong launched the My World Survey, to gather data from over 10,000 young people aged 12–25 years on their concerns about their mental health and on what interventions and supports they would like to see to be implemented. This research, undertaken in collaboration with the University College Dublin (UCD), represents the first national study of youth mental health in Ireland. To date, more than 3,000 second-level students and 3,000 third-level students have completed the survey.

### **3.3 Selective prevention in at-risk groups and settings**

#### **3.3.1 At-risk groups**

Eight actions in the NDS target at-risk groups and settings. Progress on three of the actions has been deferred until the proposed National Substance Misuse Strategy is finalised (see Chapter 1.3.1 for status report on this combined drug and alcohol strategy). Progress has been made in relation to the other five actions.

Action 23 is about implementing Social, Personal and Health Education (SPHE) and substance misuse policies in Youthreach Centres of Education and in Youth Encounter Projects. These are centres that cater for early school-leavers and disadvantaged groups and recent communication with the agencies responsible for implementation suggest that this action is being progressed to some extent. For example, in Youthreach and other youth projects, SPHE is provided as part of the Quality Framework Initiative. SPHE is also provided in training centres that work with the travelling community. In most training centres that work with early school-leavers and disadvantaged groups, a module on substance misuse is included in the life-skills programme and a number of staff is specifically trained to deliver substance prevention sessions (Department of Community Equality and Gaeltacht Affairs 2011 23 March).

Action 25 is about continuing to develop facilities for both the general youth population and those most at risk through increasing access to community, sports and school facilities in out-of-school hours and the development of youth cafés. This action is being progressed through funding made available through the Young Person's Facilities and Services Fund (YPFSF). Since 1998, the YPFSF has contributed to the development of approximately 228 youth and community facilities in 18 target areas, and employed 420 people. In 2010 the YPFSF allocated funding of €26.15m to assist in developing youth facilities and services (Department of Community Equality and Gaeltacht Affairs 2011 23 March)

Some progress has been reported in relation action 24 – co-ordinating the activities and funding of interventions in out-of-school settings – and plans are in place to implement a uniform set of drugs and alcohol education standards to enhance the quality and consistency of service provision (action 26) (Department of Community Equality and Gaeltacht Affairs 2011 23 March).

Action 31 seeks to maintain the focus of existing programmes targeting early school-leavers. Measures underpinning this action are mainly delivered through the Delivering

Equality of Opportunity in Schools (DEIS) programme, which aims to improve attendance, participation and retention in designated schools located in disadvantaged areas. Support has been provided to approximately 151,000 children in 876 schools; 46,000 at risk children are directly targeted in schools through the Home School Community Liaison and School Completion programmes. The School Completion Programme targets those most at risk of early school-leaving as well as those who are already outside of the formal system. This includes in-school, after-school and holiday-time supports (Department of Community Equality and Gaeltacht Affairs 2011 23 March).

Despite the measures outlined above that have been implemented through the DEIS programme, it appears that early school-leaving remains an intractable problem. According to the Children's Rights Alliance (Children's Rights Alliance 2011b), which rates the performance of government measures on a range of social policy issues on an annual basis, early school-leaving receives a 'D' grade, down from a 'C' in 2010. (Children's Rights Alliance 2011b) The drop reflects the failure to constructively address this problem, despite its persistent nature and long-term impact, and the slow pace of implementing the proposed new, integrated National Education Welfare Board (NEWB).

Some of the measures delivered through the DEIS programme aim to improve literacy and numeracy levels among disadvantaged students. A recent report has noted that literacy achievement among 15-year-old children has been declining in Ireland when compared with other countries (Children's Rights Alliance 2011a). This report claims that under the Programme for International Student Assessment (PISA), Ireland's ranking dropped from 5th among 39 OECD countries in 2000 to 17th in 2009. An evaluation of the DEIS programme is due to be completed towards the end of 2011.

Leahy (Leahy, *et al.* 2011) reports on a case study of a community-based drugs project located in a disadvantaged community. The aim of the work was to assess the performance of the Gurrabraher–Churchfield Drugs Outreach Project in Cork and its use of youth workers to provide services to clients at all levels of the 4-tiered drug treatment model.

The main conclusions were:

- A social rather than medical or legal response to drugs issues offers policy makers and practitioners a genuinely holistic methodology for effective intervention.
- A local rather than a universal response rooted in harm reduction allows cultural, geographical and community factors to dictate the nature of an intervention.
- Effective practice in this field requires skilled, independent, reflexive, motivated and creative practitioners operating within a supportive agency setting.
- A clear theoretical framework encompassing knowledge of young people, drugs work, human behaviour and communities is a fundamental prerequisite to best practice.
- A high degree of service visibility in the community and easy access to the services is required.
- Community-based projects work effectively with service users who will never enter treatment; they offer drug users an effective alternative to medicalised responses.
- In many cases inappropriate and problem drug use is a consequence of social inequality; interventions that can respond to these social issues in (particularly disadvantaged) communities offer the people who suffer from drugs issues a far more comprehensive range of services than a medicalised response.
- Human contact between the service user and the practitioner in the form of a relationship founded on trust is the key building block of success.

- In terms of cost effectiveness, community-based projects offer excellent value for money; the overwhelming majority of funding is used in the provision of frontline services.

### 3.3.2 At-risk families

The Strengthening Families Programme (SFP) has been delivered to a number of at-risk families in local drugs task force areas. The SFP is an internationally recognised parenting and family skills initiative for high-risk families that focuses improving existing strength within the family.

Howley (Howley and Kavanagh 2010) reports on an evaluation of one particular iteration of the SFP in Ballyfermot, an area designated as a local drugs task force area. Eleven families, including 12 parents, two grandparents and 20 young people aged between 11 and 17 years engaged with the 15-week programme; ten families completed the programme and graduated. Three sessions were run on a weekly basis – one targeting parents, one targeting young people and one targeting both parents and young people. Data collection methods included semi-structured interviews with families towards the end of the programme.

All the families that graduated from the programme self-reported that their communication skills improved; all the parents self-reported improvements in their ability to parent; the majority of young people self-reported an improvement in their relationships with their parents and all of them self-reported a reduction in conflict within the family home; the majority of parents and young people self-reported greater understanding and respect for each other. All the families that completed the programme would recommend it to other families. The group leaders who delivered the programme were praised for their skills and professionalism; the coordinator was praised for managing and organising the delivery of the programme and an improvement in relations within the community and between the different agencies involved was also reported.

### 3.3.3 Recreational settings (incl. reduction of drug and alcohol related harm)

See National Report 2010 for most recent information (Irish Focal Point 2010).

## 3.4 Indicated prevention

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

The Child and Adolescent Mental Health Services (CAMHS) is a specialist service that works with young people aged 0-18 who present with mental, emotional and behavioural problems. The CAMHS currently have 50 teams providing community-based services, using a multi-disciplinary approach which includes psychiatrists, social workers, clinical psychologists, occupational therapists, speech and language therapists and nurses. The HSE recently published the results of a clinical audit undertaken by the 50 CAMHS teams during November 2009 (Health Service Executive 2010). During the month, 6,950 cases were seen by the teams with 89.5 of cases returns. The clinic in the community was the main setting for appointments (92.5%), with the school being the setting for 3.6%, and the home the setting for 1.2%; 67.9% of cases was male. Information on the conditions that young people presented with are included in Table 3.4.1.1.

**Table 3.4.1.1: Mental health and behavioural problems among young people presenting to the Child and Adolescent Mental Health Services (CAMHS), November 2009 \***

Primary presentation	Number	%
Hyperkinetic disorders/problems included ADHD	2,303	33.1
Anxiety disorders/problems included anxiety, phobias, somatic complaints, obsessive compulsive disorder, post traumatic stress disorder	1,122	16.1
Depressive disorders/problems	612	8.8

Primary presentation	Number	%
Conduct disorders/problems included oppositional defiant behaviour, aggression, anti social behaviour, and fire-setting,	604	8.6
Eating disorders/problems included pre-school eating problems, anorexia nervosa, and bulimic nervosa	194	2.8
Deliberate self harm included lacerations, drug/medication and alcohol overdose	188	2.7
Psychotic disorders/problems included schizophrenia, manic depressive disorder, or drug-induced psychosis	73	1.1
Substance abuse, drug and alcohol misuse	53	0.8

Source: (Health Service Executive 2010)

\*A small number of conditions that young presented with are not included in the table.

### Teen counselling

Teen Counselling helps teenagers to negotiate the transition from childhood to early adulthood and works with families to enable them to manage the transition. The counselling service is provided by a psychologist and a social worker for each family using the service; the service operates in five different locations within Dublin. The average time from first appointment to case closure is 8 months duration including 9 counselling sessions made up of 27 clinical hours.

Teen Counselling is one of few interventions working with teenagers and their families in Ireland that publishes an annual report. The report is valuable in that it provides a profile of teenagers with behavioural problems who are using support services. Its latest annual report (Crosscare 2010) updates the profile for 2009.

In 2009, 431 teenagers and their families were referred to the counselling service and 95% were accepted onto the waiting list. In total, 399 teenagers and their families availed of the service; 248 were new referrals. Of these new referrals, 56% were under 16 years, 53% were female and 41% were living with both their biological parents, 37% reported using alcohol and 13% used drugs, primarily cannabis. Thirty-five per cent of new referrals were referred for counselling to address behavioural problems in the home, 35% owing to family conflict and 26% to address behavioural problems in school. Thirty-one per cent reported problems with anxiety, and self-harm was an issue for 17%. The report notes that the percentage of teenagers who reported using drugs has fallen in recent years; however, many reported addiction problems in their families, particularly among their fathers.

Assessment was undertaken from baseline to exit, using the Children's Global Assessment Scale (CGAS) to assess problem severity and change in teenagers, and the Global Assessment of Relational Functioning DSM-IV (GARF) to assess family functioning. Improvement was noted in 45% of the families that attended the service in 2009. From a group of 62 parents that were asked to provide a self-assessment of their work with the programme, the vast majority noted a reduction in the severity of the problems they presented with and an improvement in their ability to cope. A group of 51 teenagers who completed the programme were asked to self-report changes in the severity of the main problem they reported with and the impact of this problem on four areas of their life. Eighty-five per cent (n=43) self-reported improvement in the severity of their main problem when in school, 89% (n=45) noted improvement in their problem when at home, 76% (n=39) reported improvement in their main problem in themselves (the self) and 54% (n=27) noted improvement in severity of their main problem when with their friends. However, 46% (n=23) reported no change in problem severity when interacting with their friends.

### Inter-agency working with young people

Inter-agency work between the statutory, voluntary and community sectors has in recent years become an important theme in policy development and practice in public services in Ireland. On behalf of the Children Acts Advisory Board (CAAB), Duggan and colleagues (Duggan and Corrigan 2009) undertook a literature review of inter-agency work in Ireland in public services, with a particular focus on work undertaken in the children's sector. The authors also reviewed a small select number of international studies for comparative purposes. The authors talk about their disappointment at

finding a limited amount of research and evaluation in the field, despite extensive searches. They also point out that much of the literature focuses obstacles to inter-agency working and the actors involved, and not so much on issues such as the objectives of inter-agency working or the merits of various models of inter-agency working. As a result, the authors concluded that the available literature did not help in identifying what good practice might be and, in the context of these limitations, they cautioned against the 'uncritical consensus' that inter-agency working is a good thing.

### **Developing good practice for children in care**

The Children's Act Advisory Board has developed a set of best-practice guidelines for the use of therapeutic interventions for children and young people in out-of-home care (Children's Act Advisory Board 2009). This work was undertaken in response to concerns relating to the use of therapeutic interventions in residential centres for children; the concerns included the appropriateness and efficacy of some interventions and how they were evaluated. The guidelines comprise seven sections and provide for a needs assessment, identifying appropriate therapeutic intervention and measures to enhance implementation, implications for current practice and how to evaluate and assess outcomes.

### **Providing services for children with behavioural problems**

The National Children's Strategy (Department of Health and Children 2000) contains two specific actions to improve services for children at risk, where emotional and behavioural problems are causing concern. The Children's Rights Alliance, in its recent review of the strategy, provides an update on progress made so far towards implementing these two actions (Children's Rights Alliance 2011a).

*Action 26 – A National Educational Psychological Service (NEPS) will be provided to all schools.*

CAAB reports that access to NEPS is now available to all schools. It goes on to state, 'In 2008/09 NEPS psychologists were assigned to 74% of primary schools and 92% of post-primary schools. Schools that do not have an assigned NEPS psychologist can commission private psychological assessments but this function is limited and they do not have access to follow up supports. In 2010, the number of NEPS psychologists was capped at 178: in December 2010, the number stood at 164. Although much progress has been made during the 10 year period, the NEPS service is still struggling to meet demand from the schools.'

Action 81 – Introduce more structured programmes for the identification, assessment and management of children with emotional and behavioural difficulties (to ensure a comprehensive response based on individual case plans).

CAAB states, 'It is understood (anecdotally) that initiatives introduced by the National Education Welfare Board (NEWB) and NEPS have made a positive difference to those children's lives that have engaged with them; however neither have yet been subject to evaluation.'

## **3.5 National and local media campaigns**

Action 27 in the NDS aims to further develop a national website to provide fully integrated information and access to a national helpline. This action is being progressed and the new version of [www.drugs.ie](http://www.drugs.ie) went live in May 2010 as a one-stop-shop for drug and alcohol information and support. The site includes comprehensive information on drugs and alcohol; a database of treatment and rehabilitation services operating in Ireland; drug and alcohol support guides and booklets; multimedia section for broadcasting audio and video podcasts; *Drugs.ie Bulletin*; and core content in eleven languages.

In 2010, the HSE launched its national drug awareness campaign 'Legal or illegal highs – they're anything but safe'. Aimed primarily at people aged between 15 and 40 years,

the campaign messages regarding the unsafe nature of legal highs were carried on posters and t-shirts, and in a Z-folded wallet card. They also featured on radio ads, in cinemas, in 'pop-ups' on Facebook, in washrooms in bars and clubs, and at festivals over the summer. The campaign was developed in consultation with all the key stakeholders, including the target audience. The campaign also included an information booklet for parents and guardians. The booklet explains what legal highs are and the current legal issues, and offers some basic advice on how to talk to young people about these drugs and what to do if they are using them. It includes information on harm reduction and on what to do if someone is having a bad reaction to a drug.

## 4. Problem Drug Use (PDU)

### 4.1 Introduction

This chapter provides an overview of developments and trends in the prevalence and characteristics of problem drug users (PDUs) in Ireland ranging from data for 2006 relating to the prevalence estimate of PDUs, to more recent studies relating to data on problem drug users from non-treatment sources and on varieties of problematic drug use. A PDU is defined as an 'injecting drug user or long duration/regular user of opiates, cocaine and/or amphetamines' (EMCDDA 2004).

It is not possible to estimate the number of injecting drug users or PDUs, apart from opiate users, in Ireland as the National Drug Treatment Reporting System (NDTRS) does not use a unique identifier. This issue has been raised in strategy submissions and it is hoped that it will be addressed in the forthcoming health information bill. Three sources containing information indicative of the nature of problem drug use in Ireland have been used to date.

A **national 3-source capture-recapture (CRC) study**, to provide statistically valid estimates of the prevalence of opiate drug use in the national population during 2006, was commissioned by the National Advisory Committee on Drugs (NACD). This is described in detail Section 4.2.1 below. The most recent study (2006) indicates that use has increased since the previous survey (2001). There were 11,807 known opiate users in 2006. The major expansion of the national methadone treatment programme between 2001 and 2006 is the main reason for the inflation of the figures. There is some doubt over the estimate produced of a possible further 8,983 opiate users who have not come into contact with any of the drug treatment services, hospital in-patient services or the Gardaí.

The following are among the trends (2001–2006) seen in the study results:

- the rate of opiate use among females and males aged 15–24 decreased, indicating a significant reduction in the number of young people commencing opiate use,
- an increase in opiate use outside of Dublin, and
- a higher proportion of opiate users in treatment in Dublin than elsewhere, reflecting the more recent spread of opiate use outside Dublin and the later development of treatment services.

The NACD will be able to estimate the number of people dependent on cannabis in the year prior to the survey using data from the **general population survey on drug use 2010/11** (Jean Long, NACD committee member, 2010). The questionnaire has two measures of cannabis dependency, the MCIDI based of clinical diagnosis and the SDS used in a number of studies on treatment.

### 4.2 Prevalence and incidence estimates of PDUs

#### 4.2.1 Indirect estimates of problem drug use

##### **Problem opiate users in Ireland**

An opiate is a drug containing opium or any of its derivatives which acts as a sedative and narcotic. Examples include heroin, methadone, morphine, codeine, hydrocodone, oxycodone, fentanyl and tramadol. Heroin is synthesised from morphine, a naturally occurring substance extracted from the seed pod of the Asian opium poppy plant. Heroin is available in three forms – a white powder, a brown powder, or a black sticky substance, known as 'black tar heroin'.

In a repeat of a prevalence study in 2001 (Kelly, *et al.* 2003), Dr Alan Kelly and colleagues estimated the prevalence of problem opiate users in Ireland in 2006 using a three-source CRC method (Kelly, *et al.* 2009). Data from the three sources – the CTL,

the HIPE scheme and the Garda PULSE data<sup>5</sup> – indicated that there were 11,807 opiate users aged 15–64 years known to services in Ireland in 2006, and an estimated 8,983 users not known to the services (hidden population) (Table 4.2.1.1). These data were presented in Standard Tables 7 and 8 in 2009. The national prevalence estimate of opiate users in 2006 was between 18,136 and 23,576; the point estimate was 20,790 (Table 4.2.1.2). This estimate is likely to be inflated. The respective rates per 1,000 of the 15–64-year-old population in Dublin and in the rest of Ireland are 17.6 and 2.9. These estimated figures are likely to be inflated because the population was not closed, that is, it continued to recruit significant numbers of people into treatment (in Dublin and outside Dublin) and police custody (outside Dublin) in 2006. In addition, the overlap between the three population sources was small. These two factors are known to inflate estimates obtained by the CRC method. Of the estimated number, 28% (5,886) lived outside Dublin and 72% (14,904) in Dublin.

**Table 4.2.1.1 Number of opiate users known, estimated number hidden, prevalence estimate and population rate in Ireland, in Dublin and in the rest of Ireland, 2006**

	Age group	Known number	Estimated number hidden	Estimated prevalence	Rate/1,000 population
Ireland	15–64	11,807	8,983	20,790	7.2
Dublin	15–64	9,442	5,462	14,904	17.6
Rest of Ireland	15–64	2,365	3,521	5,886	2.9

Source: (Kelly, *et al.* 2009)

**Table 4.2.1.2 Estimated prevalence of opiate use in Ireland, in Dublin, and in the rest of Ireland, 2001 and 2006**

	Estimate	2001			Estimate	2006		
		Lower bound	Upper bound	Rate/1000 population		Lower bound	Upper bound	Rate/1000 population
Ireland	14,681	13,405	15,819	5.6	20,790	18,136	23,576	7.2
Dublin	12,456	11,519	13,711	15.9	14,904	13,737	16,450	17.6
Rest of Ireland	2,225	1,934	2,625	1.2	5,886	4,399	7,126	2.9

Source: (Kelly, *et al.* 2003); (Kelly, *et al.* 2009)

The national point estimate increased by 42%, from 14,681 in 2001 to 20,790 in 2006. The point estimate for Dublin increased by 20%, while the point estimate for the rest of Ireland increased by 165% – albeit from a low estimate in 2001. The rate of opiate use per 1,000 of the 15–64-year-old population living outside Dublin increased from 1.2 in 2001 to 2.9 in 2006.

Table 4.2.1.3 shows the 2006 estimate by age, gender and place of residence. Seventy-one per cent were male. One in five (21%) was between 15 and 24 years old and half (51%) were between 25 and 34 years old. In Dublin, the rate of opiate use per 1,000 of the 15–24-year-old female population decreased by 62%, from 18.7 in 2001 to 7.2 in 2006, which indicates that the number of younger women commencing opiate use has decreased. A smaller but still notable decrease in the rate of opiate use in Dublin was seen among males aged 15–24 years.

In an unpublished study, Kelly and colleagues report that retaining opiate users in treatment reduces their likelihood of being in contact with the Gardaí (Dr A Kelly, personal communication). For example, only 12% of males aged 25–34 years who were known to the Gardaí in 2001 and were attending treatment services between 2001 and 2006 were reported to be committing crime in 2006. This is in line with findings from the ROSIE study and indicates that methadone treatment reduces the incidence of crime.

**Table 4.2.1.3 Prevalence estimate by age, gender and place of residence, 2006**

Gender	Age group	Ireland	Dublin	Rest of Ireland
All	15–64	20,790	14,904	5,886
Males	15–64	14,787	10,395	4,392

<sup>5</sup> See Chapter 5.1, 6.1 and 9.1 for a description of these three data sources.

Gender	Age group	Ireland	Dublin	Rest of Ireland
	15–24	3,150	1,892	1,258
	25–34	7,238	5,172	2,066
	35–64	4,399	3,331	1,068
Females	15–64	6,003	4,509	1,494
	15–24	1,159	701	458
	25–34	3,298	2,605	693
	35–64	1,546	1,203	343

Source: (Kelly, et al. 2009)

### Research on data sources and methods

The NACD commissioned a study team (Maria Gannan and Gordon Hay) to investigate and report on methods and data sources which can be used to estimate the number of problem opiate and cocaine users and the prevalence of problematic opiate and cocaine use in Ireland. The objectives of the study were to:

- determine indirect statistical approaches to estimating numbers and rates of problematic opiate and cocaine users in Ireland,
- identify statistical or practical adaptations that would improve the reliability of the current CRC estimate,
- identify all data sources in Ireland, which can be used in the estimation of the prevalence of problematic opiate and cocaine use and, using a systematic approach, evaluate their potential for use, and
- design pilot studies to test the preferred approaches.

While not yet published, the study team have made the following recommendations for estimating the prevalence of opiate / cocaine use in Ireland:

*A combination of estimation methods should be used to calculate the prevalence of opiate use, with 4-sample CRC being the main method. A 4-sample CRC analysis should be carried out in all 26 counties; where it is not possible to calculate an estimate using CRC, either Multiple indicator method or multiplier methods should be used. The study team favour a 4-sample CRC analysis as this produces more robust estimates than a 3-sample analysis. The four suggested samples are CTL, HIPE, PULSE and Probation Service data. If this approach, were used, each county would have a local estimate, and estimates could be produced for other geographical areas of interest such as HSE region or Probation Service area.*

*A pilot study using the recommended approach would not be an effective use of time and resources. Studies using the CRC method to estimate opiate prevalence generally comprise two phases – a data access and collection phase and an analysis phase. The first phase needs the most time and resources. The time and effort are not related to the amount of data being collected, so piloting data collection for only a few areas would not significantly reduce the time or cost involved. While a pilot study could investigate issues relating to the data, any possible issues could only be investigated once the data had been collected and the analysis begun; thus, a pilot study would still require the same amount of time and effort as a full study but without the benefit of comprehensive results.*

*A geographical unit of analysis needs to be identified in order to carry out a successful study. In order for the CRC method to be successful, analyses need to be carried out at a sufficiently 'local' level; stakeholders such as data providers would find local-level estimates useful for planning purposes. It is also important that the data refer to area of residence and not area of contact; for example, Garda (police) data should record the area of residence of the offender not the area where the offence was committed. Following round-table discussions with a group of prospective data providers (excluding Dublin and Tipperary), county level was identified as the preferred geographical area. These county estimates could be combined to give estimates at the level of HSE region or Garda region, or to give a national estimate. Administrative geography indicates that Tipperary should be broken in two - into north and south ridings; the unit of analysis for Dublin requires further analysis taking into account the*

River Liffey and HSE local health office, drugs task force and local authority area boundaries.

*In order for the study to be timely, cost effective and successful, research governance need to be improved.* The data required to match successfully across sources in a CRC analysis are an individual's initials, date of birth, and gender. Encryption can be used to transform this data into an unrecognisable code prior to transfer from data provider to researcher. However, as with any research of this nature, ethical approval is required. The different data providers will also need information on data security and the procedures for safe disposal of the data once the study is completed. Previous CRC studies in Ireland have involved numerous ethics applications to access HIPE data from different hospitals around the country. This has led to significant delays and was a waste of time and resources. The study team recommend that the NACD together with data providers investigate streamlining research governance. Moreover, prior to any future prevalence work, a concerted effort should be made to raise awareness among stakeholders about the nature of prevalence estimation, the data required and the benefits of the resulting estimates.

*Use a different method to estimate cocaine prevalence.* Owing to the nature of powder cocaine use and the fact that cocaine users can be identified through current Irish data sets, the study team recommend a different method of prevalence estimation than that suggested for opiate use. For example, a heroin user who appears in PULSE data is in the same cohort as an opiate user appearing in the HIPE data, but the same cannot be said of a user of powder cocaine. As a result, CRC cannot be used to produce a valid estimate of cocaine users. The study team recommend using a combination of large household survey data and data from a longitudinal study of substance misuse, to model the different levels of powder cocaine use within the Irish population.

### **Health Information Bill**

In June 2008 the Department of Health and Children (DoHC) launched a public consultation on a health information bill. The DoHC prepared a thematic synopsis setting out the main points raised. With regard to public opinion on a unique personal identifier for individual health records and health-related information systems, there was general support but many commentators (including the Data Protection Commissioner) recommended that this identifier should not be the PPSN used for taxation and social welfare purposes. It was also recommended that confidentiality and privacy be protected in any new system (Department of Health and Children 2009, 09 January). As part of its commitment to the consultation process and in line with the philosophy of engaging with individuals in Your Service, Your Say,<sup>6</sup> the DoHC in conjunction with the Health Service Executive (HSE) and the Health Services National Partnership Forum, held a consultative workshop on 20 January 2009. Once again there was general support for a unique identifier in health-related records but many people had reservations about the use of the PPSN (without specific protections) as the identifier, principally because of linkages fears.

The new government elected in early 2011 has included a health information bill in its legislative programme; the government notes that the heads of the bill have been agreed, the text is being drafted and the bill is expected to be published in mid-2012.<sup>7</sup>

#### **4.2.2 Estimates of incidence of problem drug use**

No Information available.

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<sup>6</sup> The Office of Consumer Affairs has responsibility for developing and implementing best-practice models of customer care within the HSE and promotes service user involvement throughout the organisation through the concept of 'Your Service Your Say'.

<sup>7</sup> See Section B of the Government Legislation Programme at [www.taoiseach.ie](http://www.taoiseach.ie), accessed on 4 October 2011. The purpose of the bill as stated in the new Government Legislation Programme is 'to provide a legislative framework for the better governance of health information so as to enhance individual patient care and safety and achieve wider health service goals and to provide for a streamlined structure for multi site health research ethics approval'.

### 4.3 Data on PDUs from non-treatment sources (police, emergency, needle exchange etc)

#### 4.3.1 PDUs in data sources other than TDI

##### Health of users of Simon Community services: a 'snapshot' study

The Simon Communities of Ireland (Simon Communities of Ireland 2010) published a report on health and homelessness in late 2010. This report presents the findings of a 'point in time' survey undertaken over a one-week period, between 26 July and 1 August 2010, at all eight Simon communities in Ireland. The survey collected data on the profile and health needs of people accessing Simon projects and services.

Participants were selected through convenience sampling, i.e. they were selected because they were readily available. This type of sampling gives insights into the health needs of a proportion of the service user population but cannot be generalised to the health needs of the wider homeless population. Data were collected in face-to-face interviews and in a review of the records of the 788 participants, including those who were currently homeless, those who had been homeless and needed support to maintain their current home, and those who were at risk of becoming homeless.

The sample's profile was as follows:

- 78% were male;
- 85% were Irish, 6% British, 5% Eastern European and 1.4% Irish Travellers;
- 9% were aged between 18 and 25, 21% between 26 and 35 years, and 54% between 36 and 55;
- 51% received a disability allowance and 6% received the old age pension;
- 6.5% were classified as not being habitual residents; and
- 65% were registered as homeless with a local authority.

Of the 769 people who answered the question about alcohol and drug use, 66% reported consuming alcohol. Fifty-five per cent of respondents had physical complications as a result of alcohol use. Of the 768 responses, 38% reported using drugs other than alcohol; heroin was the most common other drug used, followed by cannabis (see Table 4.3.1.1). Thirty-one per cent of respondents who used drugs were using two drugs at the same time and 25% were using three drugs. Fifteen per cent (115) of all respondents were intravenous drug users. Seventy eight respondents were tested for blood-borne viruses.

**Table 4.3.1.1 Drugs most commonly used by service users, Simon Communities in Ireland, 2011 (n=768)**

	n	%
Heroin	159	20.7
Cannabis	116	15.1
Benzodiazepines (prescription status not reported)	94	12.2
Head shop substances	54	7.0
Methadone (unprescribed methadone)	53	6.9
Cocaine	17	2.2
Other	24	3.1
Unknown	13	1.7

Source: (Simon Communities of Ireland 2010)

##### Drug use in the Canal Communities area: an ethnographic study

The Canal Communities Local Drugs Task Force (CCLDTF) covers Rialto, Bluebell and Inchicore communities in the Dublin 8 area. The CCLDTF undertook a study to improve knowledge and understanding of the nature of illicit drug use in the area (Saris and O'Reilly 2010). The researchers used an ethnographic method, which they stated 'can be defined as a perspective as well as a means of data collection' (p. 12).

Data for the CCLDTF study were collected by means of participant observation (in service facilities, estates and homes) and through interviews. Fifty-one interviews were conducted, of which 24 were life histories and eight were group discussions (with 29

young people). Six of those who were initially interviewed had a subsequent interview. Additionally, there were 24 formal and informal interviews with service providers. The authors noted that many other people interacted with the research at all the different sites. Interviewers also administered a survey to a target population of 100 opiate or methadone users.

The report begins with a discussion on the nature of drug use and the difficulties in relation to the categorisations used in the field. In relation to patterns of use, the authors use the term 'styles' as this can help convey how '...at any one moment, populations that overlap certain institutional categories (disorganized heroin-users, for example, can be found both in and out of treatment, often using both methadone and heroin simultaneously), while presenting different challenges to various intervention strategies' (p. 19). This is followed by a chapter which discusses reported experiences of the combined use of heroin and methadone. Subsequent chapters deal with the history and the issues around drug use in the area, the emergence of crack cocaine and the changing patterns of drug use. Data from the CTL pertaining to people living in the CCLDTF area were analysed. One finding from this analysis was that the area had a relatively high rate of registration on the CTL in 2007, at 20 per 1,000 of the population, compared to 2 per 1,000 of the population nationally.

One hundred people were recruited for the survey. The quantitative data collected from 92 valid responses to the survey were summarised in an appendix to the report. (Eight questionnaires were deleted from the analysis as they were either repeats or the respondent no longer used methadone or heroin.) The main findings were as follows:

- 63% were male;
- 80% were 28 years or older;
- 27% did not complete Junior Certificate, the lowest level of second level education;
- 76% of those interviewed said they had children, giving a total of 156 children, with about half (76) living with the respondents;
- 11% were in current employment;
- 98% were prescribed methadone, indicating a history of problem drug use;
- average number of days on methadone was 86 and average dose was 86ml;
- 63% reported use of heroin in the last three months (current use);
- 46% reported current use of street benzodiazepine;
- 30% reported current use of crack;
- 22% reported current use of powder cocaine;
- 17% reported current use of street methadone;
- 70% had injected drugs in the past, with 27% having injecting in the past three months and 60% of those who injected reporting sharing a needle or syringe;
- 36% reported spending in an average week between €60 and €119 on drugs;
- 88% reported ever having been involved in crime; and
- 57% reported having had a custodial sentence.

The authors noted that most of those interviewed were polydrug users, often using combinations of illegal and legal drugs (whether obtained legally or not). The following is taken from the researchers' field notes: 'Louise is 34 years old. She finished her Community Employment (CE) scheme recently. She lives with her sister. Louise is on methadone and prescribed sleeping tablets and an antidepressant. She smokes a couple of bags of heroin every few days. Recently, she has been smoking crack every day. This is her main problem drug at the moment. Her weight loss is noticeable.' (p. 18)

Many of those who took part in the study and who were in treatment for opiate use also used cocaine, with the use of crack cocaine emerging as a problem. An interviewee, 'Sandra', explained: 'I got a pipe off someone and I says, ah that's not doing me any harm, [be]cause it was really the needles [to inject cocaine] that was doing the harm, the blood poisoning, septicaemia, so I says ah I'll have a pipe [of crack] and then I went to have another one, ...going half with someone, and when I was going well, I would

get one for meself. ‘Just one’, I’d say, ‘and I’ll go down and have a nice smoke at the end of the night,’ to meself. ...and I was smokin’ every morning and all.’ (p. 42)

Heroin use was viewed unfavourably by younger drug users, as one interviewee, ‘Kim’, explained: ‘You know what I mean, when you hear about new drugs coming out and all these mad trips and you’d say oh I have to try this, it’s an experience, but we never turn round and say, ‘I have to try heroin and see what that’s like’, d’ya know what I mean?’ (p. 53)

The authors found that many of those in treatment for problem opiate use had a range of unmet needs. They also found that individuals who dealt drugs often continued to do so after entering treatment.

While terms and categories used in government policy such as ‘drug user’ and ‘treatment’ appear clearly defined, particularly in relation to funding, their application at local level is less clear, causing a ‘divide [that] needs to be bridged’.

### Substance use among HIV infected people

In a recently published study, the characteristics and behaviours of people with HIV living in Ireland and in Australia are compared (O'Connor, *et al.* 2010). The data were collected between June and December 2005 and the participants were asked about tobacco, alcohol and other drug use. The average age of the respondents in Ireland was 36.2 years, and in Australia 45.3 years. Sixty-seven per cent of the study group in Ireland were men, while 98% of those in Australia were men. Forty-seven per cent of the participants in Ireland were Irish and 42% were African. Two thirds of the participants in Australia were Australian and 16% were New Zealanders. Table 4.3.1.2 summarises the responses regarding substance use. Forty-two per cent of participants in Ireland reported using recreational drugs at some point in their life; seven respondents reported ever injecting, and four reported a history of drug dependence. Fifty-four per cent reported smoking tobacco at some point in their life, and 72% drank alcohol at some point in their life, and 9% of these reported a history of alcohol dependence.

**Table 4.3.1. 2 Substance misuse among HIV patients, Ireland and Australia, 2005**

	Ireland	Australia
	n (%)	n (%)
<b>Recreational drugs</b>		
Current use	12 (13)	61 (41)
Past use	28 (29)	46 (64)
Admits addiction	7 (18)	18 (18)
Admits injecting drug use	4 (10)	18 (18)
<b>Tobacco</b>		
Current use	34 (37)	55 (37)
Past use	16 (17)	38 (26)
Never used	42 (46)	54 (37)
<b>Alcohol</b>		
Current use	49 (52)	107 (77)
Past use	29 (30)	27 (19)
Never used	18 (19)	6 (4)
Admits addiction	7 (9)	11 (8)

Source: (O'Connor, *et al.* 2010).

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

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

No new Information.

### 4.4.2 Prevalence estimates of intensive, frequent, long term and other problematic forms of use, not included in the PDU definition

The NACD will be able to use data from the general population survey on drug use 2010/11 to estimate the number of people dependent on cannabis in the year prior to

the survey (Jean Long, NACD committee member, 2010). The questionnaire has two measures of cannabis dependency, the MCIDI based of clinical diagnosis and the SDS used in a number of studies on treatment.

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

### 5.1 Introduction

Two broad philosophies underlie the approaches to drug-related treatment in Ireland: medication-free therapy and medication-assisted treatment. Medication-free therapy uses models such as therapeutic communities and the Minnesota Model, though some services have adapted these models to suit their particular clients' needs. Medication-assisted treatment includes opiate detoxification and substitution therapies, alcohol and benzodiazepine detoxification, and psychiatric treatment. Various types of counselling are provided through both philosophies of treatment and independent of either type of treatment. Alternative therapies, such as acupuncture, are provided through some community projects.

The **Health Service Executive (HSE)**, which manages Ireland's public health sector, provides an addiction service, including both illicit drugs and alcohol, delivered through Social Inclusion Services, which is part of its Integrated Services Directorate. Addiction treatment services are provided through a network of statutory and non-statutory agencies. Some of the principal non-statutory agencies include:

The **National Drug Rehabilitation Implementation Committee (NDRIC)** is responsible for overseeing and monitoring the implementation of the recommendations contained in the report of the Working Group on Drugs Rehabilitation, the development of protocols, service level agreements and a quality standards framework, and ensuring appropriate training is instigated. Chaired by the HSE, the NDRIC comprises representatives of the HSE, government departments, agencies and community and voluntary sector organisations, the National Advisory Committee on Drugs, service professionals, problem drug users and families of problem drug users.

The **Ana Liffey Drug Project (ALDP)** is a 'low threshold - harm reduction' service, based in north inner city Dublin. The project works with people, experiencing addiction, to minimise the harm that problematic drug use causes them, their families and the wider community.

**Coolmine Therapeutic Community** provides a comprehensive range of programmes designed to support and empower individuals and communities affected by alcohol and drugs. It was one of the first dedicated rehabilitation centres offering a range of vital support services to people all over Ireland.

**Crosscare**, formerly known as the Catholic Social Service Conference, provides homeless, community and young people's services. Its Drug and Alcohol Programme aims to help individuals, families and communities to prevent and/or address problems arising from drug and alcohol use.

**Merchants Quay Ireland (MQI)** is a voluntary organisation, based in South Inner City Dublin, which provides a wide range of services to homeless people and drug users.

**Progression Routes**, located in ALDP's premises in north inner city Dublin, seeks to improve service delivery to those attending drugs services. It does this by working with multiple agencies to formulate and implement strategic interagency solutions to identified barriers to progression.

In 1998 a **Methadone Treatment Protocol (MTP)** was introduced, to ensure that treatment for opiate misuse could be provided wherever the demand exists. New regulations pertaining to the prescribing and dispensing of methadone were introduced, and a joint Health Board/Irish College of General Practitioners (ICGP) committee was formed to provide training, ongoing education and regular audit for general practitioners

(GPs) taking part in the programme. Under this protocol, any GP wishing to take part in the provision of treatment services to drug users, must undertake training as provided by the ICGP. Under the MTP, GPs are contracted to provide methadone treatment at one of two levels – Level 1 or Level 2. Level 1 GPs are permitted to maintain methadone treatment for misusers who have already been stabilised on a methadone maintenance programme. Each GP qualified at this level is permitted to treat up to 15 stabilised misusers. Level 2 GPs are allowed to both initiate and maintain methadone treatment. Each GP qualified at this level may treat up to 35 misusers. Practices where two Level 2 GPs are practising are permitted to treat up to 50 misusers. Locally-based methadone treatment for opiate misusers is now provided through drug treatment clinics, satellite clinics or through GPs in the community.

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

Data on drug treatment in Ireland are collected through two national data collection tools – the National Drug Treatment Reporting System and the Central Treatment List.

The **National Drug Treatment Reporting System (NDTRS)** is a national epidemiological database which provides data on treated drug and alcohol misuse in Ireland. The NDTRS collects data from both public and private outpatient services, inpatient specialised residential centres and low-threshold services. For the purposes of the NDTRS, treatment is broadly defined as ‘any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their substance misuse problems’. The NDTRS is a case-based, anonymised database. The NDTRS is co-ordinated by staff at the Health Research Board (HRB) on behalf of the Department of Health and Children. The number of drug treatment services participating in the NDTRS continues to increase (Standard Table TDI 34). Although treatment is provided within the Irish Prison Service, it was only in 2009 that counsellors working in the prison service began to return information to the NDTRS.

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

The **National Drug-Related Deaths Index (NDRDI)**, established in 2005, is an epidemiological database which records cases of death by drugs poisoning, and deaths among drug users in Ireland, extending back to 1998. The NDRDI also records data on alcohol-related deaths, deaths among alcoholics, and deaths from alcohol-related diseases, extending back to 2004.

The **Research Outcome Study in Ireland (ROSIE)** was the first prospective study of treatment outcomes for opiate users to be conducted in Ireland. The objective was to evaluate the effectiveness of treatment and other intervention strategies for opiate use. The study recruited 404 opiate users entering treatment between September 2003 and June 2004. Three treatment modalities, provided through both inpatient and outpatient settings, were the focus of attention – methadone maintenance, structured detoxification, and abstinence-based treatment programmes. In addition, a sub-sample of individuals was recruited from needle exchange interventions. Participants were interviewed at treatment intake, or as soon as possible thereafter, and again at 6 months, 12 months and 3 years after the baseline interview. Data were collected by means of a structured interview. The interview instrument contained a comprehensive set of outcome measures detailing the social and psychological characteristics of the

cohort, and a range of treatment process factors in relation to treatment outcomes. Between September 2006 and October 2008 seven papers in the ROSIE Findings series, concentrating on particular aspects of the study, were published; in June 2009 a report on outcomes at 1-year and 3 years for the whole population and the ‘per protocol’ population, i.e. participants who completed all three interviews, was published (Comiskey, Catherine M, *et al.* 2009). In 2010 six further papers reporting on the data were published including analyses of the effects of treatment settings, treatment pathways and use of additional drugs on treatment outcomes for opiate users.

## 5.2 General description, availability and quality assurance

In Ireland there is a range of addiction services incorporating education and prevention, harm reduction, treatment, stabilisation, rehabilitation and aftercare support. Many of the services are statutory, provided by the HSE, but a proportion are provided through voluntary organisations, frequently funded by the HSE. There are a number of private services which are fee-based or religious. There is no national database which can provide the complete number of services and what treatment they provide. A website, [drugs.ie](http://drugs.ie), which provides a search engine on information on HSE services, is currently being revised (see Section 5.4.3 below).

The number of services participating in the NDTRS are reported below (see Table 5.2.1). The increase in the number participating reflects both an increase in drug treatment services and also the successful efforts to improve participation in the NDTRS. In 2009, data were provided by 349 treatment services to the NDTRS, an increase of 88 since 2004. Most of the services participating are in outpatient settings. The number of low threshold services participating increased in 2009 owing, again, to the active recruitment by NDTRS staff, supported by LDTFs who fund many of these projects.

**Table 5.2.1 Number of services participating in NDTRS by type of service provider, 2004–2009**

	2004	2005	2006	2007	2008	2009
All services	261	269	238	288	316	349
Outpatient	144	146	146	173	209	212
Inpatient	19	21	23	27	32	34
Low threshold	3	3	3	5	9	27
General practitioner	95	99	66	83	66	76

Source: Unpublished data, NDTRS

In 2010, 276 GPs were providing methadone treatment under the MTP (unpublished data, CTL). The ICGP is responsible for auditing GPs and undertakes random audits of GPs involved in methadone treatment (Irish College of General Practitioners 2010). Community pharmacists are also involved in the dispensing of methadone, thus ensuring that a large number of opiate dependent persons may be treated in their own local areas.

To help ensure drug treatment and rehabilitation outcomes are achieved and to maintain a high standard of client safety, the *National Drugs Strategy (interim) 2009–2016* (NDS) calls for the introduction of ‘a clinical and organisational governance framework for all treatment and rehabilitation services in Ireland’ (Department of Community Rural and Gaeltacht Affairs 2009): (Action 45). Since 2010 the Progression Routes Initiative (PRI), in collaboration with the HSE, has been introducing the UK-based Quality Standards in Alcohol and Drugs Services (QuADS) to service providers in Ireland. See ‘Quality Standards in Alcohol and Drugs Services (QuADS)’ in Section 5.4.1 below for further information about this project.

## 5.3 Strategy/policy

### HSE plan for drug-related services in 2011

The HSE National Service Plan 2011 set out the agency's plan in the drugs and alcohol area for 2011 (Health Service Executive 2011b). A priority for the HSE Social Inclusion Services, which include addiction services, was to 'continue to address the health impacts of addiction and/or substance misuse'. The Social Inclusion Services also prioritised actions to enhance the health and well-being of other vulnerable groups, including the homeless, Travellers, ethnic minorities and members of the lesbian, gay, bisexual and transgender (LGBT) communities. 'Deliverable outputs' for 2011 are listed in Table 5.3.1.

**Table 5.3.1 Deliverable outputs for drug-related services in 2011**

Key result area	Deliverable outputs 2011	Target completion
National Drugs Strategy (NDS) 2009–2016	Recruitment of clinical directors of addiction services completed in each of the four regions.	Q3
	Implementation of Phase 1 of interagency rehabilitation programmes in each of the four regions.	Q3
	Learning from reports implemented, including hepatitis C and intravenous drug users and methadone protocol	Q3
	Pharmacy-located harm reduction/needle exchange services implemented throughout the country in each of the four regions	Q3
	Alcohol public education/awareness campaign developed and launched	Q2
	Screening and brief interventions available in emergency departments and primary care services (Phase 1)	Q4
	National Addiction Training framework in place for staff (Phase 1)	Q3
National Homelessness Strategy	Protocols signposting referral pathways developed between specialist addiction/ homeless/Traveller services and mental health and primary care services	Q4
All-Ireland Traveller Health Study	Screening programmes targeting vulnerable groups [among the Traveller population] devised and implemented	Q4
National Intercultural Health Strategy	Emergency multi-lingual aid toolkits for staff and intercultural health guide implemented	Q3
	Translation/interpreting toolkit for staff in line with Patient Charter implemented	Q2
LGBT Framework	Good practice guiding principles developed to support LGBT communities in equitable access and use of health services	Q4

Source: (Health Service Executive 2011b), pp. 49–50

With regard to drug treatment, comparison with the 2010 plan indicates that the HSE has sought to maintain similar overall levels of activity and performance in 2011 while increasing service provision in the South and West regions. A briefing note to the incoming Minister for Health (Social Inclusion Unit and Department of Health and Children 2011) explained the shift in emphasis as being due to the 'unacceptable waiting times in some locations, mainly in the Midlands, East and South as well as in a small number of treatment centres in Dublin'.

*Methadone treatment* – The target for 2011 has been to increase the total number of clients in methadone treatment outside prisons by 2.6%, from 8,278 to 8,500, and the number in treatment in prisons by three, from 497 to 500. While the number of clients in methadone treatment in the Dublin/Mid-Leinster (DML) and Dublin/North-East (DNE) regions will rise by 1% (from 7,861 to 7,950), in the South Region the number is set to increase by 47% (from 187 to 275), and in the West Region by 19.6% (from 230 to 275).

*Treatment of substance misusers over 18 years following assessment* – In 2010 the target of ensuring that 100% of substance misusers over 18 years started treatment within one calendar month of assessment was not achieved: in the DML and DNE regions only 70.6% and 71.1% respectively entered treatment within the month, while in the South and West regions the proportions were 98.5% and 97.7% respectively. In 2011 the HSE will again try to reach the 100% target.

The expected 100% target for 2011 was estimated to be 2% lower than in 2010, with the total number of substance misusers over 18 years who would have commenced treatment following assessment expected to drop from 1,380 to 1,350. In the DML and DNE regions the number was expected to decline by 67% (from 870 to 520), while in the South and West regions it was expected to increase by 63% (from 510 to 830).

*Treatment of substance misusers under 18 years following assessment* – In 2010 the total number of substance misusers under 18 years who commenced treatment following assessment exceeded the target of 115 by 18% (n=136). While the DML, DNE and South regions all came in on or under target, the West Region exceeded its target by 46% (65/30).

The 2010 target of ensuring that 100% of substance misusers under 18 years commenced treatment within two weeks of assessment was met in the DML and DNE regions, but was not achieved in the South and West regions. In 2011 the HSE again set the target at 100% for all four HSE regions.

The 2011 plan also set out the HSE's priorities and actions with regard to delivering its statutory services in the areas of children in care, after care and youth homelessness, and also with regard to maintaining and developing family support services and strengthening the provision of aftercare services. Specifically in relation to substance abuse, the service plan stated that an 'analysis of addiction services for children nationwide based on best practice' would be completed in the fourth quarter of 2011. This action was in response to a recommendation in the *Report of the Commission to Inquire into Child Abuse* (the Ryan Report), on the provision of counselling and educational services for children, which called on the HSE and the drugs task forces to establish addiction services for children nationwide based on best practice by June 2011 (Ryan 2009)

### **New programme for government**

The new programme for government, *Government for National Recovery 2011–2016* (Fine Gael and the Labour Party 2011) contains a number of actions related to drugs policy. The action directly related to drug treatment was to target resources to increasing the number of rehabilitation places across the country where it is needed most. In 2007, the HSE Working Group on residential treatment and rehabilitation had reported a shortfall of 104 inpatient detoxification places and 252.5 rehabilitation places (Corrigan and O'Gorman 2007). Action 32 of the NDS published in 2009 called for an integrated national treatment and rehabilitation service for all substance users.

## **5.4 Treatment systems**

### **5.4.1 Organisation and quality assurance**

#### **The National Drugs Rehabilitation Framework**

In line with the recommendations outlined in the report of the Working Group on Drugs Rehabilitation (Department of Tourism Sport and Recreation 2001), a National Drugs Rehabilitation Framework (NDRF) has been published (Doyle and Ivanovic 2010). Approved by the National Drugs Rehabilitation Implementation Committee (NDRIC), this NDRF has been constructed to enhance the provision of rehabilitation services to current and former drug users by creating integrated care pathways (ICPs) with the co-operation of different service providers.

It is recognised that service users may present with diverse needs, including treatment, education, vocational training, employment support and accommodation, and that no single agency can cater for all possible needs. An individual care plan will be developed for each service user, and will be delivered by a multi-disciplinary team comprising the range of necessary disciplines and skills drawn from a variety of service providers. Where a service user has complex and multi-faceted needs, a more intensive case management approach may be used.

According to the authors of the NDRF, 'The provision of rehabilitation pathways is a shared responsibility of the education, training and employment sectors alongside the health, welfare and housing sector, non-governmental organizations, communities, families and the individual themselves.' (p. 7)

The ICP will comprise four steps, which will be linked to the four-tier model of service provision:

- Initial contact (Tier 1 services): Screening and referral, using a brief intervention screening instrument.
- Initial assessment and identification of appropriate service (Tier 2 services upwards): Matching person to service – the aim is to determine the seriousness and urgency of the drug/alcohol problem.
- Comprehensive assessment – key working and care planning (Tier 3 services upwards): Matching services to the person, i.e. identifying appropriate services for service users with more complex needs. Following the comprehensive assessment, a case manager will be identified, who will support the individual on their rehabilitation pathway.
- Implementation of the care plan to support an individual rehabilitation pathway.

Services drawn from the four-tier model of service provision will be characterised by the following attributes:

- Settings may include general healthcare, structured drug treatment, community-based specialist addiction services, and residential detoxification and treatment followed by supported step-down accommodation as part of aftercare.
- Services may include information and advice, brief interventions, methadone treatment, harm reduction and therapeutic interventions.
- Target groups may range from those experimenting with drugs to those with drug-related problems and dependence.

The development of a competent workforce in the addiction services will be supported and maintained through the development and implementation of a quality standard framework. See 'Quality Standards in Alcohol and Drugs Services (QuADS)' later in this section for further information on the introduction of these standards.

The NDRIC is currently piloting the ICP model at regional and local levels, with a view to informing the development of the protocols (National Drugs Rehabilitation Implementation Committee 2010). Three drugs task force sites – North Inner City LDTF, Blanchardstown LDTF and North East RDTF – have been selected to participate in phase 1 of the pilot process. The objectives of the pilot projects are to:

- support the implementation of the NDRF and the ICP model,
- build awareness and knowledge of the NDRF among key stakeholders,
- identify progress in implementation,
- identify gaps in services and drivers/obstacles in respect of implementation,
- assess the initial impact of the NDRF, and
- help to clarify roles and inform implementation of the NDRF.

### **Review of the methadone treatment protocol (MTP)**

The results of the first external review of the MTP were published on 20 December 2010 (Farrell, Michael and Barry 2010). The HSE commissioned Michael Farrell, Professor of Addiction Psychiatry at Kings College London, to conduct the review, assisted by Joe Barry, Professor of Population Health Medicine at Trinity College Dublin. This is the second review of the protocol; the Methadone Prescribing Implementation Committee carried out an internal review in 2005 (Methadone Prescribing Implementation Committee 2005).

The review was informed by 69 written submissions and the conclusions of 38 oral hearings with stakeholders on the impact of the protocol. The authors state that the original protocol achieved its aims, especially in relation to improving both poor

prescribing and the quality of independent practitioner practice. In line with their terms of reference, the reviewers made recommendations with regard to the following themes:

*Maximising treatment provision and reviewing the efficacy of referral pathways* – The report calls for improved access to detoxification treatment, but in conjunction with the necessary psychosocial supports. The inclusion of buprenorphine/naloxone treatment in the methadone regulations is recommended, to which end the review is entitled *The introduction of the opioid treatment protocol*. The spread of the drug problem outside Dublin is noted, with a recommendation for the development of a rural service model as a priority. The authors support the concept of an ICP in order to promote integration and sharing between the different treatment agencies to provide a more flexible, innovative and responsive service.

*Clinical governance and audit* – The review recommends that the lines of reporting within the drug treatment services be reviewed. It also recommends that the current audit process be expanded. Although benzodiazepine prescribing was not directly within the terms of reference of the review, it is mentioned in this section. The authors state that ‘there was a need for a concerted approach to achieving tighter and more responsible prescribing of benzodiazepines’ (p. 27). They call for the recommendations of the 2002 report of the Benzodiazepine Committee (The Benzodiazepine Committee 2002) to be implemented.

*Enrolment and training of GPs and the GP co-ordinator role* – The success of involving more GPs in Level 1 training is recognised, with the expectation that in the near future all trainees completing GP training will meet the criteria for Level 1. However, the report states that there is a need for more Level 2 GPs and increased movement of stable clients from Level 2 to Level 1 GPs within a specified timeframe. It recommends that the model of GP-nurse liaison practitioner be developed and the role of the GP co-ordinator be revised.

*Urine testing* – The authors note that there is a lot of criticism from some of the contributors about the appropriateness and efficacy of urine testing in the drug services. It is felt that practices vary between doctors and services, and the considerable amount of time and resources it takes could be used more productively for the clients. The existing regime of testing is considered to capture only very frequent drug use, which is often clinically obvious. Research is quoted which states that random testing, and testing based on reasonable grounds for concern, could reduce the number of tests needed and make them more meaningful. In the review, new improvements are discussed, for example saliva testing, which could eliminate the need for supervision (except where there is a legal requirement) and be more user-friendly.

*Prescribing of methadone in Garda (police) stations* – The review states that there are no specific standards, guidelines or recording mechanisms around prescribing methadone in Garda stations. Along with a review of procedures for medical assessment of people in custody, it recommends that guidelines for prescribing methadone in this setting be developed and implemented urgently. It also recommends that doctors prescribing methadone in Garda stations should have access to information on the CTL, especially out of hours.

*Data collection, collation and analysis* – The review recommends the inclusion of an annual outcome monitoring process with the data collection tools. It also suggests linking the collected data with the Health Research Board’s national surveillance data on drug treatment, which would result in information on pathways and long-term outcomes of drug users.

### **Involving services users in service planning**

Action 42 of the NDS identifies the need to further involve the users of drug treatment services, 'both as an essential part of clinical governance procedures and service planning' (Department of Community Rural and Gaeltacht Affairs 2009)(para. 4.79). The issues to be considered when involving service users are highlighted in a qualitative study of service user involvement in a Dublin-based methadone maintenance service (King, Aoibhinn 2011).

Completed in mid-2008, this study was based on in-depth semi-structured interviews with eight providers from the service, three drugs task force co-ordinators and the co-ordinator of the drug-user group, and eight service users attending different clinics across the broad geographical area in which the service operated. The author, Aoibhinn King, in the School of Social Work and Social Policy, Trinity College Dublin, identifies issues around five themes:

*Purpose of the service* – There were conflicting views about the purpose. Service users were clear that the purpose was to contribute to a reduction in the difficulties they experienced through drug use and to the stabilisation and normalisation of their lives. Service providers were more ambivalent: while many saw abstinence as the final goal, they claimed that harm reduction and improved quality of life were the actual outcomes.

*Understanding of user involvement* – While there was overall consensus that user involvement was both progressive and desirable, and increased the effectiveness of the service, in reality, service users' experience was that the system did not engage with them: 'I'm not involved at all, like they haven't asked me to do anything, just come up and get me methadone.'

*Determining own care* – Respondents generally endorsed the principle that service users have valuable knowledge and experience that can help in planning and delivering their care programme, but they were almost unanimous in stating that, in practice, service users played little or no part in determining their own treatment. Moreover, there was a prevailing view that both service users and service providers gave higher priority to issues around methadone maintenance than to addressing the issues which impacted on the individual's life and influenced their drug use.

*Involvement in service evaluation, planning and development* – Involvement was perceived as largely symbolic. Several obstacles were identified, including resource constraints, organisational and national protocols and procedures, unrealistic expectations on the part of service users, disillusionment and fear of criticism on the part of service providers. The author also noted, 'the culture within services served as the most significant barrier to meaningful collaboration'.

*Operational system and interactions between service users and service providers* – The author found that the staff attitudes common under the 'old system' of treatment still pervaded the culture in treatment services and was the main impediment to the active engagement of service users. Staff tended to define service users in negative stereotypical terms, and service users, in turn, characterised their relationship with treatment systems primarily in terms of fear, rather than terms of equality or mutuality.

King describes the explicit acknowledgement of the imbalance of knowledge and power between provider and user as 'remarkably stark'. While the service studied was nominally imbued with the harm reduction ethos, the author found that the underlying philosophy of the old drug treatment system had not shifted to any great extent. To bring the treatment service into line with harm reduction philosophy, King concludes that much more is needed than simply including abstract statements of principle in official policy documents: 'It may be that what is needed is a more explicit and committed approach which incorporates the education and training of all involved in the delivery of treatment services for illicit drug users, if the situation identified here is not to persist.'

## Quality Standards in Alcohol and Drugs Services (QuADS)

The national standards for drug and alcohol treatment services agreed by the HSE are the Quality in Alcohol and Drug Services (QuADS) organisational standards, originally developed in the United Kingdom.<sup>8</sup> In 2010 the Progression Routes Initiative (PRI) supported 30 services, and took on another 70 services in local and regional drugs task force areas in 2011, to become 'QuADS compliant'. The process occurs in two phases.

*Self-review* – Each organisation works through the QuADS framework, reviewing their policies and procedures against template policies provided. The following supports are provided for this self-review and organisational change process:

- A 'policy library' is available on line. It contains more than 75 template policies, covering governance, human resources, service provision policies, service-user-related policies, and case management and care planning. These policies have been extensively researched and had editorial input from industry leaders from the health and commercial sectors. Participants are advised to adapt these policies to their own needs through an internal consultation process involving staff and service users.
- Service-specific facilitation and policy development is available on request. It is an effective way of engaging staff and management in the development of policies. Service-specific training modules are also available.
- Directors seminars for all participating organisations are held approximately every quarter to facilitate interagency best-practice learning.

*Peer review* – After completion of the self-review phase and the integration of quality standards and procedures into all aspects of operations, an organisation or group may request a peer review. Peer review is a relatively new way of promoting and supporting organisational and sectoral development. It has been used within therapeutic communities across Europe and also in the youth services sector. In the QuADS context it involves two organisations from within the QuADS network auditing and evaluating the work of another organisation against a standardised framework, using a specially developed IT system. Over two days these reviewers meet with service users, staff and managers and complete a policy and file audit. The reviewers draft a comprehensive report that assists the organisation under review to further improve its policies, systems and procedures. The reviewers also present an overview of their findings to a representative group of service users, staff and management, in order to ensure a cohesive and transparent process and to contribute to collective ownership of the QuADS approach.

### 5.4.2 Availability and diversification of treatment

#### Merchants Quay Ireland (MQI) annual review, 2010

According to its annual review for 2010, MQI's open-access drug services are often the first place to which drug users turn for help (Merchants Quay Ireland 2011) The review is particularly useful, therefore, in providing information not fully reflected in the treatment figures recorded by the NDTRS.

MQI's needle-exchange service recorded just under 25,000 client visits in 2010, a 20% decrease on the numbers using the service in 2009. MQI attributed most of this decline to a 'heroin drought', which the review stated began at the end of October 2010 and continued into the early months of 2011. While the number of needle exchanges in January 2010 was 2,650, in December 2010, at the height of the drought, this number dropped to 850. The total number of service users was 4,308, an increase of 5%, and a total of 575 new injectors presented. MQI commented, 'The figures here serve as a reminder that heroin use remains at very high levels and that significant numbers of new people are beginning to use heroin every year.' (p. 10)

<sup>8</sup> For more information on QuADS, see the *Report of the HSE Working Group examining Quality & Standards for Addiction Services* Corrigan, D. and O'Gorman, A. (2007). *Report of the HSE Working Group on Residential Treatment & Rehabilitation (Substance Users)*. pp. 62. Health Service Executive, Dublin. Available at [www.drugsandalcohol.ie/6382/](http://www.drugsandalcohol.ie/6382/)

The report highlighted a substantial increase in demand for homelessness services. The number of health care interventions provided increased by 15%, from 3,216 in 2009 to 3,685 in 2010.

2010 saw the development of new initiatives at MQI. These included the Extended Day Service developed in association with Focus Ireland, the New Communities Support Service, Midlands Traveller Specific Drugs Project, Aftercare Housing in conjunction with Respond Housing Association, Drug Free Day Programme and Easy Access Education for Homeless People

In 2010 MQI again won the tender to deliver a national counselling service for prisoners with drug and alcohol problems in 13 of the state's 14 prisons. In 2010 the service provided in excess of 13,000 counselling hours; the 23 counsellors each carried an average caseload of more than 550 prisoners.

In 2010 MQI continued to deliver the Midlands Family Support and Community Harm Reduction Service. The Family Support Service provided services to 237 new clients; the harm reduction service provided needle exchange services to an average of 62 clients per month, providing 174 interventions in the form of advice and support and an average of 124 needle exchanges. In September 2010 a rehabilitation and aftercare service was also established in the midlands and by year-end this had been accessed by 55 clients.

**Table 5.4.2.1 Types of service offered by MQI, the numbers of people accessing them, and the outcomes, 2010**

Service	Type of intervention	No. of participants	Outcomes
Needle-exchange and health-promotion services	Promotes safer injecting techniques	4,308 used needle-exchange services, of whom 575 were new clients	–
	HIV and hepatitis prevention	1,617 safer injecting	–
	Safe sex advice	1,617 safer injecting	–
	Information on overdose	1,617 safer injecting	–
Stabilisation services	Early referral to drug treatment services	workshops	–
	Methadone substitution	19	–
	Supportive day programmes	–	–
	Gateway programme	78 (monthly average)	–
Settlement service	Counselling	–	–
	Assists service users to find, access and sustain long-term appropriate accommodation	74 (quarterly average)	45 resettled
Reintegration programmes	Access to transitional accommodation after completing residential drug treatment	Average of 3 people in 3-bed house throughout the year	–
	Group and one-to-one therapeutic sessions	–	–
Training and work programmes	FÁS Community Employment scheme	90	Of the 26 who completed FÁS placement at MQI, 31% secured permanent employment or moved to further education
High Park	17-week, drug-free residential programme including individual counselling, group therapy, educational groups, work assignments and recreational activities	62 (of whom 13 were admitted for detoxification)	10 completed detox and 22 completed the full programme
St Francis Farm	Therapeutic facility offering a 6-month programme	34	11 completed the full programme

Source: (Merchants Quay Ireland 2011)

### **Community detoxification pilot programme for methadone and benzodiazepines**

A pilot programme for community detoxification, led by PRI, began in north inner-city Dublin in 2008 and was evaluated in 2009 (Alcohol and Drug Research Unit 2008) (Irish Focal Point 2010). This pilot has now been expanded outside Dublin. In this phase of the pilot, two separate detoxification protocols are planned, one for methadone and one for benzodiazepines.

The pilot is overseen by an expert committee, with representatives from PRI, the HSE, user groups and other relevant stakeholders. The pathways to treatment, brokerage, and the support offered and other processes remain the same, but the individual protocols will give more in-depth and tailored information for each substance, such as entry and exit criteria, and detoxification schedules.

The protocols are aimed at doctors and key workers who wish to support a person through the process of detoxification in the community. The protocols outline the minimum medical and psycho-social supports necessary, covering medical detoxification, interagency holistic care planning and relapse prevention. This phase is expected to begin in the autumn of 2011. It will be evaluated over the next two years using quantitative and qualitative methods.

### **Regulating administration of suboxone**

The Department of Health and Children commissioned an independent agency to evaluate the suboxone feasibility study (see Chapter 5.3.2 of National Report 2010) (Irish Focal Point 2010). Completed in April 2011 but not yet published, this evaluation is expected to make recommendations to the expert group overseeing the study regarding the circumstances and client groups for which the drug is most suitable and the appropriate regulatory framework (Social Inclusion Unit and Department of Health and Children 2011).

### **National Addiction Training Programme (NATP)**

The briefing to the incoming Minister for Health, released in March 2011, informs the Minister that cognitive behaviour coping skills (CBCS) training, rehabilitation training and brief interventions, particularly in regard to overdose and alcohol screening, are being provided through the NATP. The briefing note states:

The brief intervention model has been piloted in three hospitals in 2010 and it is intended to develop this further in 2011 with training supported via the NATP. In this expansion the key objective of providing a joint drug/alcohol brief intervention will be explored. This will support the need to analytically examine those attending Emergency Departments with addiction issues via the HIPE data base. The initial meeting of the reconstituted Steering Group took place on 7th February [2011] with the next meeting scheduled for the 14th March.' (Social Inclusion Unit and Department of Health and Children 2011) (Document 17: Section 2.3)

### **Keltoi residential rehabilitation programme**

Part of the rehabilitation services available in the Dublin 12 Drugs Task Force area, Keltoi, based in St Mary's Hospital, Dublin 20, offers a residential therapeutic rehabilitation programme for problem opiate users. It emphasises occupational work, with a strong focus on after-care and living drug-free. This study has been published, reporting on follow-up interviews with clients who attended the Keltoi programme between September 2002 and July 2004 (White, *et al.* 2011). It was done as part of a wider evaluation of the programme, which has already been published (Sweeney, *et al.* 2007).

The study aim was to evaluate the effectiveness of the Keltoi programme in helping participants to remain drug-free. During the evaluation period, 149 clients had entered Keltoi, 94 of these had participated in the original evaluation, and 80 participated in the follow-up interview, which was based on the Maudsley addiction profile (MAP). The interviews started in May 2004 and finished in July 2009. The average time between discharge and follow-up interview was 1.9 years (range 1.2 to 3.0 years). Two

participants in the original evaluation were known to have died before their follow-up interview took place, giving a mortality rate of 2.1% for the 94 participants. There was no control group.

Half (51.3%) of the interviewees self-reported as fully abstinent (defined as abstinent from all substances including alcohol and prescription substitution drugs) in the 30 days before the interview. Most (88.1%) were still in contact with some type of drug treatment service. Those who were abstinent reported higher levels of well-being than those who reported that they were not abstinent.

In the 30 days before the interview:

- five (6.3%) interviewees reported injecting;
- a lower proportion of those who were abstinent (3.8%) reported suicidal thoughts compared to the proportion of those who were not abstinent (18.8%);
- over two thirds (77.5%) of those interviewed reported no criminal activities; and
- half (50.0%) reported having undertaken paid employment.

The authors recognised that self-reported abstinence was a limitation, but they concluded that the evidence showed that self-reporting was reasonably reliable among this population as there were no negative consequences for the interviewees. Because of the methodology used it was not appropriate to undertake statistical analysis of the data looking for factors which might be associated with abstinence. For the same reason, the authors stated that they were 'wary of direct comparisons with the majority of current international literature' (p. 358).

Compared to the completion rate among the abstinence cohort in the ROSIE study (66%) (Cox, *et al.* 2007), the rate of completion in Keltoi was higher (77%). The outcomes of the Keltoi also compare favourably with another Irish study done by Smyth and colleagues (Smyth, *et al.* 2005), which described the follow-up outcomes for those with opiate dependence who had received inpatient treatment. The Keltoi study participants reported abstinent rates of 51% at follow-up, compared to 23% in the Smyth study (Smyth, *et al.* 2005).

The authors concluded that there were large gaps in outcome-based evaluations for treatment programmes in Ireland and recommended the introduction of a health outcomes monitoring system. They also concluded that the evidence from their study and others in this area showed that many of those who enter residential treatment do not have successful outcomes. It is important to find out what works and what doesn't work for different people.

### **Coolmine Therapeutic Community (CTC)**

In August 2010 CTC started a longitudinal research study in collaboration with Paula Mayock, Senior Researcher/Lecturer in Youth Research, Social Work, and Social Policy, Trinity College Dublin, and the National Health Information Systems Unit of the HRB (personal communication, Anne Marie Carew, HRB, August 2011). The aims of the study are to:

- collect baseline data on drug use, health and behavioural status of participants as they enter and progress through primary treatment and aftercare in CTC,
- follow up participants over time including after leaving the CTC programme, and
- compare CTC client outcomes with outcomes recorded in other national outcome studies, e.g. ROSIE.

The study will use both quantitative and qualitative methodologies and it is estimated that up to 30 people will participate in the study. Each participant's progress will be followed up every six months during their treatment (i.e. three times) and then 18 months after discharge. The quantitative data will be obtained from Treatment Outcome Profile and routine data collected through the NDTRS. The qualitative data, collected through one-to-one interviews with participants, will help reveal their reasons for choosing treatment in a therapeutic community and their perceived progress over

time. The experiences of those who drop out of the programme will also be recorded and analysed. There are no preliminary results available at this time.

### 5.4.3 Access to treatment

#### Methadone treatment in Ireland

Table 5.4.3.1 shows the number of continuous care clients attending methadone treatment, as recorded in the CTL (see also Standard Table 24). The figures have steadily increased, from 3,681 in 1998 to 8,727 in 2010. Over the past five years, approximately 800 new clients have started methadone treatment each year, an increase of roughly 7.5% per annum. It is also reported that some 450 people successfully complete their treatment episode each year (Shortall 2011, 11 May).

**Table 5.4.3.1 Number of continuous care clients attending methadone treatment (on 31 December each year), CTL, 1998–2010**

1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
3681	4339	4973	5610	5954	6444	6925	7262	7620	7942	8266	8551	8727

Source: (Farrell, Michael and Barry 2010)

The recently published review of the methadone protocol in Ireland (Farrell, Michael and Barry 2010) provides an overview of data on methadone treatment in Ireland over the past decade. Although the number of clients attending GPs for methadone treatment has increased, the proportion attending clinics for treatment has remained almost the same, 65% in 2002 compared to 63% in 2009. What has changed is the proportion of clients attending Level 1 GPs, up from 14% in 2002 to 18% in 2009. Currently, Level 1 GPs are qualified to treat up to 15 stabilised clients in their practice.

The review also provides a snapshot of waiting times for methadone treatment in clinics as of 31 July 2010. Of the 63 clinics represented, over three quarters (78%) reported that less than 10 people were on their waiting lists. Thirty-five clinics (56%) reported that their average waiting time was less than one month. The longest average waiting time was reported to be 13.5 months (at a Dublin clinic). The highest number of clients on waiting lists was in the Midlands (over 40 people) and this area also reported some of the highest average waiting times (between 5.6 and 10.5 months). The spread of the heroin problem outside Dublin has been well documented in recent years (Carew, *et al.* 2009).

Data from the NDRDI show the proportion of those who died while registered on the CTL. The proportion remained low over the 10-year period, rarely rising above 1% (Table 5.4.3.2). However, these figures do not include those who died from illicit/street methadone or those who may have died from drug-related causes shortly after leaving methadone treatment (see Standard Table 24).

**Table 5.4.3.2 Proportion of CTL registered patients who died, NDRDI, 1998–2007**

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
Total number of CTL cases*	3681	4339	4973	5610	5954	6444	6925	7262	7620	7942
Total number of CTL deaths	39	49	39	47	66	58	66	72	78	62
Proportion of deaths among those registered on CTL (%)	(1.06)	(1.13)	(0.78)	(0.84)	(1.11)	(0.9)	(0.95)	(0.99)	(1.02)	(0.78)

\*unpublished data from the Central Treatment List  
Source: (Farrell, Michael and Barry 2010)

In order to address waiting times for access to methadone maintenance treatment, especially in rural areas outside Dublin, the HSE has funded 13 new clinics throughout the country (Limerick city, Cork city, Tralee, Wexford, Gorey, Carlow/Kilkenny, Waterford, Drogheda and Dundalk) (Social Inclusion Unit and Department of Health and Children 2011).

## **Online access to treatment and rehabilitation services**

According to the briefing paper prepared for the incoming Minister for Health, released in March 2011, the HSE Social Inclusion Services, in partnership with drugs.ie,<sup>9</sup> is currently developing an interactive online care pathway planning tool encompassing a searchable services directory that gives extensive information on each listed drug and alcohol service provider. The briefing paper states that it is envisaged that this online service will be a starting point both for people wishing to access treatment and rehabilitation (and harm reduction), and for professionals wishing to locate complementary and follow-on services for existing clients to facilitate a continuum of care approach (Social Inclusion Unit and Department of Health and Children 2011).

## **5.5 Characteristics of treated clients (TDI data included)**

### **Treated opiate users**

Researchers have analysed subsets of participants and data from the longitudinal ROSIE study (Comiskey, Catherine M, *et al.* 2009) and published six new papers. The articles cover the effects of treatment settings, treatment pathways and use of additional drugs on treatment outcomes for opiate users.

#### *Impact of treatment setting (Comiskey, Catherine and Cox 2010)*

In this analysis, 215 cases enrolled in different methadone treatment programmes were included – community-based clinics (22%), GPs (25%) and HSE clinics (53%). The analysis found that methadone treatment was effective in reducing drug use regardless of treatment setting. Further analysis using ANOVA and logistic regression found that setting was not significant when predicting improvement of physical symptoms. The authors state that opiate users should be enrolled in settings that meet their individual needs, taking into account such factors as heroin use at intake and physical symptoms.

#### *Longitudinal outcomes for treated opiate use and ancillary medical and social services (Comiskey, Catherine and Stapleton 2010a)*

For this paper, 73% of the participants in ROSIE were included (at 1- and 3-year interviews). Outcomes at the 3-year follow-up were assessed using an adapted Maudsley Addiction Profile (MAP), which measured drug, crime, physical and psychological health. The study found three different outcome groups:

- 15% were not in treatment and were drug free,
- 70% were in treatment, and
- 15% were not in treatment and were using drugs.

The number of additional services accessed by participants was analysed, rather than the original treatment setting through which the client had entered. Accessing counselling prior to recruitment to treatment, accessing residential treatment in the first year and accessing group work were all significantly associated with the 'not in treatment and drug-free' group. The authors acknowledge that one of the limitations was that the outcome status of all 404 participants was not known. However, they state that the findings are important, especially in the current difficult economic climate when service providers are under pressure to cut the cost of providing services which may in the long term be less cost-effective.

#### *Treatment pathways and longitudinal outcomes for opiate users (Comiskey, Catherine and Stapleton 2010b)*

As the three outcome groups described in the previous study were very distinct, the authors undertook further analysis which reveals that there were no differences in characteristics between the three different groups of participants at intake, even between those who were classified as doing well (drug free and not in treatment) and the other two groups. However, the results do show that those who were doing well at the 3-year follow-up had also shown improvements, especially in physical and mental

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<sup>9</sup> Drugs.ie is an independent website managed by [Crosscare's Drug and Alcohol Programme](#) and funded by the HSE.

health outcomes, at the first-year follow-up. The authors recommend that future studies should focus on modelling outcomes and pathways instead of treatment setting. They suggest that this would allow greater understanding of how and why treatment works.

*Anxiety and depression among opiate users* (Stapleton, Robert and Comiskey 2011)  
The aim of this study was to examine differences in states of anxiety and depression, using the results from the MAP at 1-year and 3-year follow-up. The study modelled usage of different drugs against different anxiety or depression-related symptoms. At one year, use of heroin was significantly associated with certain symptoms of anxiety: feeling fearful, and feelings of terror and panic; it was also associated with all the symptoms of depression. Cocaine and cannabis use were also significantly associated with all the symptoms of depression. The results for non-prescribed methadone and benzodiazepines showed more variation: non-prescribed methadone was significantly associated with all the symptoms measured, but for some symptoms it was a predictor, e.g. more likely to feel hopeless about the future, while for others it appeared to be a protective factor, e.g. less likely to have suicidal thoughts.

There was not a clear pattern of anxiety symptoms among participants at the 3-year follow-up, with some drugs having an effect on symptoms at one year but not at three years, and vice versa. This lack of a clear pattern made it difficult to draw any definitive conclusions. However, the authors feel that there is evidence of an association at three years between drug use and anxiety symptoms of feeling terror or panic. For symptoms of depression, the results were more consistent over the three years, with the risk of depressive symptoms being higher particularly for heroin and cocaine users.

One of the limitations of the study was that it did not record the mental-health history of the participants before enrolling in the study. As a result, it is not possible to say whether the depressive symptoms were the result of drug use or was the drug use a response to depressive symptoms. The authors conclude that there is enough evidence to show that drug treatment service providers should consider these mental-health issues, and this, in turn, may improve treatment outcomes for the clients.

*Treated opiate users: alcohol use and treatment outcomes* (Stapleton, RD and Comiskey 2010)

The aim of this analysis was to examine the frequency and quantity of alcohol use among opiate users at entry to treatment and at follow-up, to establish 'whether the success rate of a program may be, in part, related to the alcohol using habits of the client'. Data relating to 242 of the original ROSIE participants were classified according to their alcohol usage: (1) abstainers (had not drunk in the past 90 days); (2) medium drinkers (consumed up to 70g [men] or 50g [women] of alcohol per typical using day); and (3) heavy drinkers (consumed more than 70g [men] or 50g [women] per typical using day). The analysis showed that at the start of the study, 49% of men and 43% of women were defined as heavy drinkers. At the 3-year follow-up, the proportion of heavy drinkers had dropped for both groups – to 26% of men and 28% of women.

The results showed that abstainers were the lowest offenders in terms of certain crimes, including assault. Logistic regression was used to investigate the link between drinking and drug usage at the 3-year follow-up. It was found that abstainers used heroin and other drugs less frequently. The authors state that their results show that the link between drug and alcohol use is complex, and that other factors, such as gender, age and ongoing or changing alcohol and drug use, need to be considered when assessing and planning treatment for opiate users in order to target their treatment effectively.

*Concurrent cocaine use among opiate users* (Cox and Comiskey 2011)

Current cocaine use was defined as use of any cocaine powder or crack in the 90 days before the follow-up interview. At recruitment, 48% of participants reported using cocaine. There were no significant differences in the demographic characteristics of

those who used cocaine and those who did not. However, cocaine users were significantly more likely to report use of heroin, non-prescribed methadone, non-prescribed benzodiazepines, cannabis and alcohol. They were also more likely to reported injecting. At 1-year follow-up, overall, cocaine users showed reductions in drug use, injecting behaviours, acquisitive crime and a reduction in physical and mental health symptoms. However, analysis of the differences between the original cocaine users and non-users showed that cocaine users were more likely to have used heroin, cocaine and crack in the 90 days prior to their follow-up interview. They were more likely to have committed an acquisitive crime and to have sold or supplied drugs. Logistic regression analysis was conducted to determine the use of cocaine as a predictor variable for unsuccessful treatment outcomes. This showed that those who used cocaine at intake were more likely to have used cocaine at follow-up, to have been homeless within the previous three months and to have committed any crime. The authors conclude that there is no evidence to show cocaine use among this group affected treatment outcomes at one year.

### **Over-the-counter (OTC) opiate misuse**

Information on the misuse of OTC opiates is limited in Ireland and internationally. Researchers at St Patrick's University Hospital, Dublin, have examined the clinical profiles, treatment and prevalence of patients admitted in a 12-month period with a diagnosis of OTC opiate abuse (Thekiso and Farren 2010).

All inpatient records between 1 April 2007 and 30 April 2008 were retrospectively reviewed, and 20 patients were identified as having a diagnosis of either harmful use of an OTC opiate or dependency. These patients represented 0.6% of all patients admitted during that period, and 4% of all patients diagnosed with mental or behavioural disorder owing to psychoactive substances. Of the 20 patients, 70% had a diagnosis of opiate dependency and 30% of harmful opiate use. In addition, all but one (95%) had a diagnosis of co-morbid psychiatric illness. Codeine was the opiate misused in all 20 cases, and all cases reported using a combination-type OTC opiate, that is, codeine with paracetamol (e.g. Solpadine) or codeine with ibuprofen (e.g. Nurofen Plus). Fifteen patients received treatment for opiate withdrawal.

Some of the other main findings of the study were:

- the mean age of the 20 patients studied was 49 years;
- 13 were female;
- 13 had a history of harmful use of or dependency on alcohol;
- eight had a history of harmful use of or dependency on benzodiazepines;
- 16 reported daily use;
- four reported chronic pain;
- seven relapsed within six months;
- 15 obtained the drug over the counter; and
- five obtained the drug over the internet.

Although the numbers in the study were small, the high rates of polysubstance misuse and co-morbid psychiatric illness among the cases reviewed are consistent with the findings of similar research internationally. The authors note with concern that the average reported amount of codeine taken daily was high (261mg), and suggest that this is likely to have been an under-estimation. They point out that, to ingest such a large amount of codeine in the form of an OTC product, an individual would have to take correspondingly large daily doses of the combination compounds, usually paracetamol or ibuprofen, which greatly increases the risk of side-effects or overdose from both products. The authors suggest preventative measures, such as reducing the number of tablets per pack and placing an additional health warning on packaging. They state that any move to make OTC opiates prescription-only needs to be carefully considered, taking account of the increase in pressure on GPs and the reduction in patient autonomy that such a move might cause.

See 'Pharmacy guidelines on safe supply of codeine-based products' in Chapter 7.2 for an account of newly introduced pharmacy guidelines, which provide for the safe dispensing of OTC opiate products in Ireland; these products can now be dispensed only under the supervision of a pharmacist.

### Alcohol-dependent clients with a dual diagnosis

A recent prospective Irish study aimed to determine the predictors of treatment outcome of a group of alcohol-dependent participants, who had a dual diagnosis of either bipolar or unipolar affective disorder, after in-patient treatment (Farren and McElroy 2010). The treatment programme started in 2003. Of the 183 participants, 29% had a history of illegal drug abuse and 24% had a history of prescription drug abuse. At six months, 162 of the participants could be included in the follow-up.

There were no significant differences in demographic characteristics, diagnoses or number of previous admissions between those who relapsed to alcohol use between three and six months after treatment.

Logistic regression modelling was used to identify predictors of relapse (to alcohol use). This showed that a history of illegal drug abuse at admission was a significant predictor of relapse at six months after treatment. Other significant predictors were baseline anxiety levels, level of depression at admission and high baseline AUDIT (Alcohol Use Disorders Identification Test) score.

Another interesting finding was that those who organised to attend aftercare before they were discharged were less likely to relapse. Rehospitalisation within three months of treatment was also found to be a significant protective factor and to lead to a reduction in drinking among early relapsers. The study had limitations. It was conducted in a private hospital where most clients have private health insurance. Also, pharmacotherapy adherence was not measured. The authors recommend that dual diagnosis treatment programmes should address both alcohol and drug use in order to reduce the risk of relapse.

### Treated problem benzodiazepine use

An analysis of treated problem benzodiazepine use as recorded by the NDTRS between 2003 and 2008, and poisoning deaths where a benzodiazepine was implicated as recorded by the NDRDI between 1998 and 2007, was published in December 2010 (Bellerose, *et al.* 2010). This is the first time that data from the NDTRS and the NDRDI have been presented together, providing a more complete picture of problem benzodiazepine use and its consequences. The main findings are summarised below.

In the period 2003–2008 the annual number of treated cases reporting a benzodiazepine as a problem substance increased by just over 63%, rising from 1,054 in 2003 to 1,719 in 2008 (Table 5.5.1). The number of cases who reported a benzodiazepine as their main problem substance was relatively small, but increased by 120%, from 76 in 2003 to 167 in 2008. The number of cases who reported a benzodiazepine as an additional problem substance was much larger, and increased by 59%, from 982 in 2003 to 1,562 in 2008. These increases may be explained by a combination of factors: an increase in the number of treatment places, an increase in problem benzodiazepine use among the population and an increase in reporting to the NDTRS.

**Table 5.5.1 Benzodiazepine cases entering treatment by treatment status, NDTRS 2003–2008**

	2003	2004	2005	2006	2007	2008
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
All cases*	1054	1026	1115	1222	1225	1719
Benzodiazepine as a main problem	76 (7.2)	103 (10.0)	75 (6.7)	96 (7.9)	163 (13.3)	167 (9.7)
Benzodiazepine as an additional problem	982 (93.2)	928 (90.4)	1044 (93.6)	1129 (92.4)	1064 (86.9)	1562 (90.9)

	2003	2004	2005	2006	2007	2008
Previously treated cases*	816	758	810	839	787	1113
Benzodiazepine as a main problem	49 (6.0)	50 (6.6)	30 (3.7)	40 (4.8)	72 (9.1)	87 (7.8)
Benzodiazepine as an additional problem	770 (94.4)	711 (93.8)	782 (96.5)	802 (95.6)	715 (90.9)	1032 (92.7)
New cases*	214	231	275	352	415	576
Benzodiazepine as a main problem	27 (12.6)	47 (20.3)	42 (15.3)	50 (14.2)	85 (20.5)	74 (12.8)
Benzodiazepine as an additional problem	188 (87.9)	186 (80.5)	235 (85.5)	302 (85.8)	332 (80.0)	505 (87.7)
Treatment status unknown	24	37	30	31	23	30

\* The sum of 'main problem' and 'additional problem' cases may exceed the total number of cases in these treatment status categories as some cases reported one type of benzodiazepine as their main problem substance and another type of benzodiazepine as an additional problem substance.

Source: (Bellerose, *et al.* 2010)

Between 1998 and 2007 benzodiazepines were implicated in 649 deaths by poisoning, which accounted for 31% of all such deaths recorded by the NDRDI for the 10-year period. The annual number of deaths in which benzodiazepines were implicated was consistently high, and increased from 65 in 1998 to 88 in 2007 (Table 5.5.2).

**Table 5.5.2 Proportion of poisonings where benzodiazepines were implicated, NDRDI 1998–2007**

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007
	n (%)									
Total poisonings (n = 2,120)	178	187	182	178	211	185	207	248	270	274
Benzodiazepines (n = 649)	65 (36.5)	56 (29.9)	61 (33.5)	47 (26.4)	61 (28.9)	54 (29.2)	63 (30.4)	66 (26.6)	88 (32.6)	88 (32.1)

Source: (Bellerose, *et al.* 2010)

The majority (78%) of cases treated for a benzodiazepine as their main problem substance used more than one problem substance. Alcohol was the most common additional problem substance, reported by 52% of cases, followed by cannabis (43%) and opiates (40%). The main problem substances reported where a benzodiazepine was the additional problem substance were opiates (80%), alcohol (9%), cannabis (5%) and cocaine (5%). It is generally accepted that the use of several substances increases the complexity of these cases and is associated with poorer treatment outcomes. Problem use of benzodiazepines needs to be approached in the context of multiple substance use. The types of intervention and treatment setting very much depend on the individual's current problem substance use and history of substance use and on the treatment services available.

The additional substances most frequently involved in poisoning deaths where a benzodiazepine was implicated were alcohol (41%) and methadone (36%). Alone, these substances may not be sufficient to cause death, but it is likely that the respiratory depressant effect is amplified when these substances are taken together, increasing the risk of fatal overdose.

The median age of new cases entering treatment for a benzodiazepine as their main problem substance decreased from 34 to 25 years over the reporting period, while the median age of previously treated cases remained stable, ranging between 27 and 29 years. The median age of cases entering treatment and reporting a benzodiazepine as an additional problem substance increased from 24 to 26 years for new cases, and from 27 to 30 years for previously treated cases. Although the numbers were small, the proportion of cases aged under 18 years increased steadily between 2003 and 2008, and was highest among new cases who presented with a benzodiazepine as their main problem substance. This finding has implications for health promotion, drug awareness campaigns and service provision for this vulnerable age group.

The median age of those who died as a result of poisoning where a benzodiazepine was implicated ranged between 33 and 39 years over the reporting period. Just over

half (51%) were not alone at the time of their death. The majority of poisonings occurred in a private dwelling.

Approximately 70% of all benzodiazepine cases treated in the period 2003–2008 were males and the proportion was the same for new cases and for previously treated cases. However, the male to female ratio differed depending on whether benzodiazepines were reported as a main or an additional problem substance. Over the six-year period, females accounted for 40% of cases where benzodiazepine was the main problem and for 30% of cases where benzodiazepine was an additional problem substance. Among those who reported a benzodiazepine as their main problem substance and who had no history of opiate use, there were higher proportions of female cases in the older age groups and higher proportions of male cases in the younger age groups. Similarly, among those who died, there were higher proportions of females in the older age groups and higher proportions of males in the younger age groups.

Age, gender, history of opiate use and whether benzodiazepines are a main or an additional problem substance are all factors that need to be considered by services treating this population. The increasing number of cases in treatment and the number of deaths among the population support the findings of the 2006/7 national drug prevalence survey, which show that 11% of all adults have used sedatives or tranquillisers (which include benzodiazepines) at some point in their lives (National Advisory Committee on Drugs and Drug and Public Health Information and Research Branch 2009). Prescribers and users need to be made more aware of the potentially fatal effects of benzodiazepines used in conjunction with other substances. Identifying and controlling possible illicit sources of benzodiazepines is also necessary, but it is equally important to revisit the clinical guidelines on benzodiazepine prescribing (Department of Health and Children 2002).

#### Treated problem drug use reported by the NDTRS (2004–2009)

Table 5.5.3 shows an overview of main problem drug for all cases entering treatment, as reported to the NDTRS between 2004 and 2009. In 2009, opiates were the most common problem drug (59%), followed by cannabis (23%) and cocaine (11%). The proportion and number of opiate users remained stable between 2004 and 2008 but decreased slightly in 2009. The number of cases reporting cannabis as their main problem substance increased between 2004 and 2006, dropped in 2007 and increased again to its highest level in 2009, with 1,519 cases. Following a steady increase until a peak in 2007, the number of cases reporting cocaine as their main problem substance decreased slightly in 2008 and 2009.

Overall, while the number of opiate cases increased, the proportion of opiate users among previously treated cases decreased over the reporting period from 83% in 2004 to 75% in 2009. There is a growing proportion of cases returning to treatment for problem drug use other than opiates, such as cannabis or benzodiazepines.

**Table 5.5.3 Main problem drug used by cases entering treatment (NDTRS 2004–2009)**

	2004 n (%)	2005 n (%)	2006 n (%)	2007 n (%)	2008 n (%)	2009 n (%)
All cases	4506	4877	5238	5749	6322	6497
Opiates	2863 (63.5)	3094 (63.4)	3326 (63.5)	3627 (63.1)	4004 (63.3)	3862 (59.4)
Ecstasy	139 (3.1)	124 (2.5)	95 (1.8)	129 (2.2)	103 (1.6)	64 (1.0)
Cocaine	331 (7.3)	467 (9.6)	552 (10.5)	777 (13.5)	762 (12.1)	696 (10.7)
Amphetamines	23 (0.5)	36 (0.7)	30 (0.6)	39 (0.7)	36 (0.6)	33 (0.5)
Benzodiazepines	103 (2.3)	75 (1.5)	96 (1.8)	163 (2.8)	167 (2.6)	260 (4.0)
Volatile inhalants	31 (0.7)	27 (0.6)	23 (0.4)	32 (0.6)	28 (0.4)	21 (0.3)
Cannabis	991 (22.0)	1039 (21.3)	1097 (20.9)	963 (16.8)	1192 (18.9)	1519 (23.4)
Others	25 (0.6)	15 (0.3)	19 (0.4)	19 (0.3)	30 (0.5)	42 (0.6)
Cannabis	224 (8.8)	219 (7.9)	260 (9.2)	259 (8.2)	330 (9.4)	443 (12.9)

	2004 n (%)	2005 n (%)	2006 n (%)	2007 n (%)	2008 n (%)	2009 n (%)
Others	12 (0.5)	6 (0.2)	9 (0.3)	7 (0.2)	12 (0.3)	16 (0.5)

Source: Unpublished data NDTRS

## 5.6 Trends in treated population and treatment provision (incl. numbers)

A summary of the Treatment Demand Indicator (TDI) data (also see TDI data), as provided by the NDTRS, shows that 8,511 cases entered treatment in 2010, an increase of 1,240 cases since 2009.<sup>10</sup> The increase between 2009 and 2010 may be due to an increase in services returning data to the NDTRS, or may reflect a genuine increase in the number of cases entering treatment in 2010. In 2010, 43% (3,740) were new entrants to treatment, a decrease on the proportion reported in 2009 (47.2%). As in previous years, in 2010 the majority of cases attended outpatient services (63.0%, 5,359).

Again, as in previous years, opiates (mainly heroin) were the most common main problem drug reported by cases entering treatment in 2010 (57.9%, 4,930). The number and proportion of cases treated for cocaine dropped from 11.7% (837) in 2009 to 10.0% (850) in 2010. The number of deaths where cocaine was implicated dropped in 2009 which supports this downward trend (see Chapter 6.4.1).

The biggest change between 2009 and 2010 was the difference in the number of 'other substances reported', owing to the appearance of cases seeking treatment for headshop drugs. In 2009, less than 20 cases reported a headshop drug as their main problem substance, but in 2010, 217 cases reported headshop drugs as their main problem substance. This increase could have been due to one or more of several factors including improved reporting to the NDTRS, an increase in services providing treatment for these substances, or an increase in the number of cases seeking treatment for these substances. In 2010, legislation was brought in which made a number of these substances illegal in Ireland (see Chapter 1.2.2 for details of this legislation). However, in 2010, cases seeking treatment for headshop drugs only represented 2.5% of the total number of cases.

The demographic profile of those treated in 2010 was similar to previous years. Three quarters (75.5%, 6,429) of those in treatment were male, the mean age was 28 years, and the majority were unemployed (62.8%, 5,345).

<sup>10</sup> It should be noted that the selection of NDTRS data for national analysis differs slightly to the selection of data for TDI; therefore, there are some differences between what is reported in TDI and what is published in HRB Trend papers and web updates.

## 6. Health Correlates and Consequences

### 6.1 Introduction

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

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

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

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

The data collected by the **Primary Care Re-imbursment Service (PCRS)**, previously called the General Medical Services (GMS) Payments Board, are another source of information on the health correlates and consequences of problematic drug use among those who have medical cards, which are means-tested. Medical-card holders received certain health services, including approved prescribed drugs and medicines, free of charge up to December 2009 and since January 2010 for a minimal charge. Operated by the HSE, the PCRS administers payments to doctors, pharmacists and dentists who provide services under the PCRS scheme.

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

Problematic drug use can also lead to premature death. Death can occur as a result of overdose (either intentional or unintentional), actions taken under the influence of

drugs, medical consequences or incidental causes. Although illicit drugs are involved in many cases of drug-related death, licit (including prescribed) drugs are also frequently involved, either alone or in conjunction with an illicit drug. Alcohol has been reported as the third greatest risk factor for ill health and premature death in Europe. Established in 2005, the **National Drug-Related Death Index (NDRDI)**, which is maintained by the HRB, is an epidemiological database which records cases of death by drugs poisoning, and deaths among drug users in Ireland, extending back to 1998. The NDRDI also records data on alcohol-related poisoning deaths, deaths among those who are alcohol dependent, extending back to 2004.

The **Central Statistics Office (CSO)**, acting on behalf of the Department of Health, compiles quarterly and annual statistical reports on deaths in the Irish population. These reports are based on administrative data supplied by the General Register Office. The principal variables collected include date of death, address of residence of deceased, place of death, underlying cause of death, occupation, age, sex, and marital status. Since 1 January 2007 the underlying cause of death has been coded according to ICD10 rather than ICD9.

The **National Registry of Deliberate Self-Harm** is a national system of population monitoring for the occurrence of deliberate self-harm, established at the request of the Department of Health and Children, by the National Suicide Research Foundation (National Parasuicide Registry Ireland 2004). Since 2006/07 the Registry has achieved complete national coverage of hospital-treated deliberate self-harm. The Registry defines deliberate self-harm as 'an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences'. All methods of deliberate self-harm are recorded in the Registry, including drug overdoses and alcohol overdoses, where it is clear that the self-harm was intentionally inflicted. All individuals who are alive on admission to hospital following a deliberate act of self-harm are included. Not considered deliberate self-harm are accidental overdoses, e.g. an individual who takes additional medication in the case of illness, without any intention to self-harm; alcohol overdoses alone, where the intention was not to self-harm; accidental overdoses of street drugs (drugs used for recreational purposes), without the intention to self-harm; and individuals who are dead on arrival at hospital as a result of suicide.

## **6.2 Drug-related infectious diseases**

### **6.2.1 HIV/AIDS and viral hepatitis**

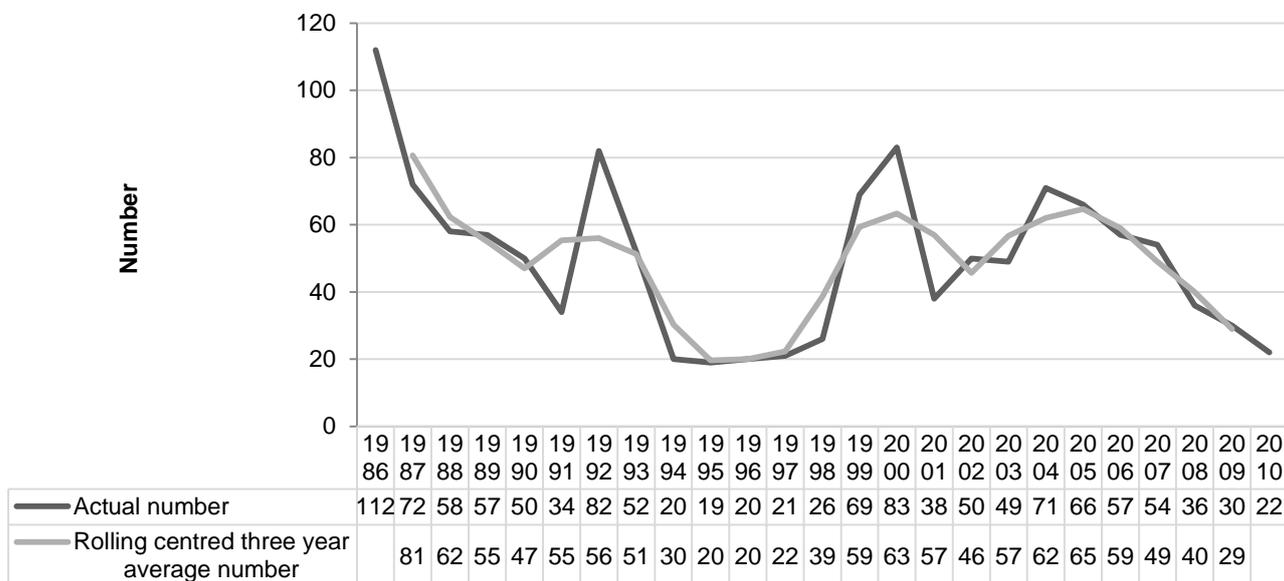
#### **Update on blood-borne viral infections in injecting drug users**

##### **HIV surveillance in 2010**

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1985. According to the most recent report of the HPSC, at the end of 2010 there were 5,700 diagnosed HIV cases in Ireland, of which 1,469 (26%) were probably infected through injecting drug use (O'Donnell, Kate, *et al.* 2011). Figure 6.2.1 presents the number of new cases of HIV among injecting drug users reported in Ireland, by year of diagnosis; data from 1982 to 1985 are excluded as these four years were combined in the source records. There was a fall in the number of HIV cases among injecting drug users between 1994 and 1998, with about 20 cases per year, compared to about 50 cases each year in the preceding years. There was a sharp increase in the number of cases in 1999 (69 new cases), which continued into 2000 (83 new cases). Between 2001 and 2010 there was an overall decline in the number of new injector cases when compared to 2000. It was difficult to interpret the trend owing to the relatively small numbers diagnosed each year, so a smoother curve (grey plot line in Figure 6.2.1.1) was

calculated using a rolling centred three-year average. This curve presents a declining trend since 2006 and a return to low number of cases in the mid-nineties.

Of the 22 new HIV cases reported in 2010, 18 were male and four were female, and the median age among intravenous drug users (IDUs) was 32.5 years (range 19–50 years), with 12 aged 34 years or younger. Eight cases (36.4%) were born in Ireland and another eight (36.4%) in central and eastern Europe. Nine new cases were Irish, eight cases were not Irish and five cases had no country of origin recorded. At the time of HIV diagnosis, 11 of the new cases among IDUs were asymptomatic, two had AIDS and two had an acute HIV infection.



**Figure 6.2.1.1 Actual number and rolling average number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland, 1986–2010**

Source: Unpublished data reported to Department of Health and Children, National Disease Surveillance Centre and HPSC.

### Blood-borne viral status among a population attending a Dublin maternity hospital by exposure to methadone

Cleary and colleagues (Cleary, *et al.* 2011) examined the relationship between methadone maintenance treatment and maternal characteristics, including blood-borne viral status. This was a retrospective cohort study of 61,030 singleton births at a large maternity hospital from 2000 to 2007, based on antenatal, delivery and postnatal records and the Central Treatment List (of clients prescribed methadone). Of the 61,030 singleton births, 618 (1%) were to women who were prescribed methadone at delivery. A higher proportion of methadone-exposed women were likely to test positive for hepatitis B, hepatitis C and HIV when compared to non-exposed women (Table 6.2.1.1).

**Table 6.2.1.1 Blood-borne viral status in 61,030 singleton births at a large Dublin maternity hospital, 2000–2007, by exposure to methadone**

	Exposed to methadone* n (%)	Non-exposed* n(%)
Hepatitis B positive serological status	20 (3.5)	326 (1.0)
Hepatitis C positive serological status	275 (48.2)	193 (0.6)
HIV positive	35 (5.8)	171 (0.3)

\*The total number tested in each group is not presented in the paper.

Source: (Cleary, *et al.* 2011)

### 6.2.2 STI's and tuberculosis

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

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

### Soft tissue abscess development among IDUs

Maloney and colleagues (Maloney, *et al.* 2010) identified the risk factors for soft tissue abscesses among IDUs in order to enhance initial assessment of drug users' needs. The study was done using a convenience sample drawn from those attending a methadone treatment centre in Dublin. Eighty IDUs were asked to take part in the study and 70 (88%) agreed. The respondents completed a 10–15 minute structured interview in January 2007. Three-fifths of the sample were men and the average age was 30.4 years. The youngest interviewee was 21 years old and the oldest 53 years old. All were prescribed methadone for the treatment of opiate dependence. Thirty-four (49%) reported being on methadone treatment for more than five years, 28 (40%) on methadone treatment for between one and five years and eight (11%) for between one week and a year. Twenty-six (37%) had commenced injecting illicit drugs on or before their eighteenth birthday, 21 (30%) had commenced between the ages of 19 and 23 years, 17 (24%) between the ages of 24 and 28 years, and only six (9%) on or after their 29<sup>th</sup> birthday.

Forty-eight (69%) participants had had an abscess at some stage and 23 (33%) had had an abscess in the year prior to the study. Eleven (16%) of the 70 had had an abscess once since commencing injecting, 19 (27%) between two and four times, 14 (20%) between 5 and 10 times, and four (6%) more than ten times. All the respondents injected heroin, 57 injected cocaine and seven injected flurazepam. The respondents were asked about the frequency of heroin or cocaine use prior to the development of their last abscess (see Table 6.2.3.1). A high proportion of those who developed an abscess had injected heroin all or most of the time, while injecting cocaine and the development of an abscess were not linked to frequency of injecting cocaine.

**Table 6.2.3.1 Number (%) of attenders at a methadone treatment centre in Dublin with abscess, by frequency of injecting cocaine or heroin (n=48)**

Frequency injecting	Heroin n (%)	Cocaine n (%)
Always	13 (27)	2 (4)
Most of the time	27 (56)	17 (35)
Occasionally	5 (10)	9 (19)
Rarely	3 (6)	14 (29)

Source: (Maloney, *et al.* 2010)

When they first injected, 63 (90%) injected into one of the veins in their left or right antecubital fossa (a small cavity in the elbow joint), and 38 (54%) had an abscess in one of the two fossae at some point in their life. Twenty-four participants reported that they injected into a vein in the groin for the last or most recent injection administered. Thirty respondents said that they had ever injected into the veins in their groin and of these, 14 (47%) had an abscess. Forty-six (66%) respondents reported that they injected under the skin (skin-popping) rather than into the vein and, of these, 33 (72%) had between two and ten abscesses.

Twenty per cent (14) of participants did not clean their skin before injecting, while 13% (nine) always cleaned their skin with an alcohol wipe. Most injectors injected in a public place which reduced their opportunity for hygienic practices. Eighty per cent shared one or more types of injecting equipment (see Table 6.2.3.2). Fifty-one per cent shared needles, 59% shared syringes, 80% shared spoons or pots for preparing the drug, 56% shared filters and 61% shared water. Given the hygienic and sharing practices, it is not surprising 69% of participants had at least one abscess and 80% reported that they were hepatitis C positive. The authors conclude that healthcare professionals need to develop better strategies for delivering messages to clients about safer injecting behaviour.

**Table 6.2.3.2 Number (%) of injecting drug users attending a methadone treatment centre in Dublin, by sharing injecting equipment and frequency of such sharing (n=70)**

Frequency of sharing	Needle	Syringe	Spoon/pot	Filter	Water	Drug
	n (%)					
Always	1 (1)	0 (0)	1 (1)	0 (0)	1 (1)	0 (0)

Frequency of sharing	Needle	Syringe	Spoon/pot	Filter	Water	Drug
<b>Most of the time</b>	9 (13)	11 (16)	22 (31)	12 (17)	15 (21)	24 (34)
<b>Occasionally</b>	14 (20)	16 (23)	27 (39)	19 (27)	22 (31)	25 (36)
<b>Rarely</b>	12 (17)	14 (20)	6 (9)		5 (7)	2 (3)
				8 (11)		
<b>Never</b>	34 (49)	29 (41)	14 (20)	31 (44)	27 (39)	19 (27)

Source: (Maloney, *et al.* 2010)

### **MRSA and MSSA among attenders at a Dublin methadone clinic**

Ninety-six of 183 clients attending methadone treatment at the Drug Treatment Centre Board in Dublin were randomly selected to complete a 12-item questionnaire, to provide nasal swabs to be tested for meticillin resistant *Staphylococcus aureus* (MRSA) and meticillin sensitive *Staphylococcus aureus* (MSSA) and to provide blood samples for viral analysis (Somers, *et al.* 2010).

Of the 96 nasal swab specimens submitted for culture and identification, 3.1% grew MRSA and 25% grew MSSA. The serological analysis revealed that 73% of the clients were hepatitis C positive and 12% were HIV positive.

Seventy-three per cent of the sample were men, 27% had been in prison in the year prior to the survey and 86% had been in prison at least once in their life. One quarter had been homeless at some stage in the preceding 12 months and 27% lived alone.

Seventeen per cent had snorted cocaine in the year prior to the survey and 24% had injected it. Forty-eight per cent had injected heroin in the 12 months prior to the survey, and 53% had injected either heroin or cocaine. All injectors had attended needle-exchange services at least once in the 12 months prior to data collection; only 7% had shared needles, while 18% had shared other injecting equipment. Twenty-eight per cent reported at least one soft-tissue abscess in the past year, 71% had had one or more courses of antibiotics, and 40% had had at least one hospital admission.

As the prevalence of MRSA was low and the sample size very small, it was not possible to identify factors associated with MRSA carriage among those in methadone treatment. The prevalence of MRSA in the opiate-dependent population in Dublin is lower than that in Brighton (49%) and Vancouver (19%) but higher than in Italy (1.1%).

#### **6.2.4 Behavioural data**

There are no routine collections of behavioural data in Ireland. See study presented in Section 6.2.3 and Table 6.2.3.2.

### **6.3 Other drug-related health correlates and consequences**

#### **6.3.1 Non-fatal overdoses and drug related emergencies**

##### **National Registry of Deliberate Self-Harm annual report 2010**

The ninth annual report from the National Registry of Deliberate Self-Harm was published in July 2011 (O'Donnell, Kate, *et al.* 2011). The report contains information relating to every recorded presentation of deliberate self-harm to hospital emergency departments in 2010, giving complete national coverage of hospital-treated deliberate self-harm.

In 2010, there were 11,966 recorded presentations of deliberate self-harm, involving 9,630 individuals. The rate of presentations increased from 209/100,000 of the population in 2009 to 217/100,000 in 2010, a 4% increase. Of the 9,630 individuals who presented after an episode of deliberate self-harm, 86% were presenting for the first time in their life.

Concordant with previous reports, 47% of self-harm presentations in 2010 were men and the same proportion were aged under 30 years. Two hundred and seventy-five

(2.3%) were living in hostels for the homeless or had no fixed abode. Presentations peaked in the hours around 10pm and were highest on Sundays and Mondays; 32% of deliberate self-harm episodes occurred on these two days. There was evidence of alcohol consumption in 41% of all presentations and this was more common among men (44%) than women (37%).

Drug overdose was the most common form of deliberate self-harm (71%, n=8,538), with overdose rates being higher among women (77%) than among men (65%). The total number of tablets taken was known in 73% of cases: on average, 31 tablets were taken these cases of drug overdose. Forty-two per cent of all drug overdoses involved a minor tranquilliser, 29% involved medicines containing paracetamol and 21% involved anti-depressants/mood stabilisers. The number of deliberate self-harm presentations involving street drugs increased in 2009 (579) and 2010 (645) when compared to 2008 (461). Men are much more likely to self-harm using street drugs than women.

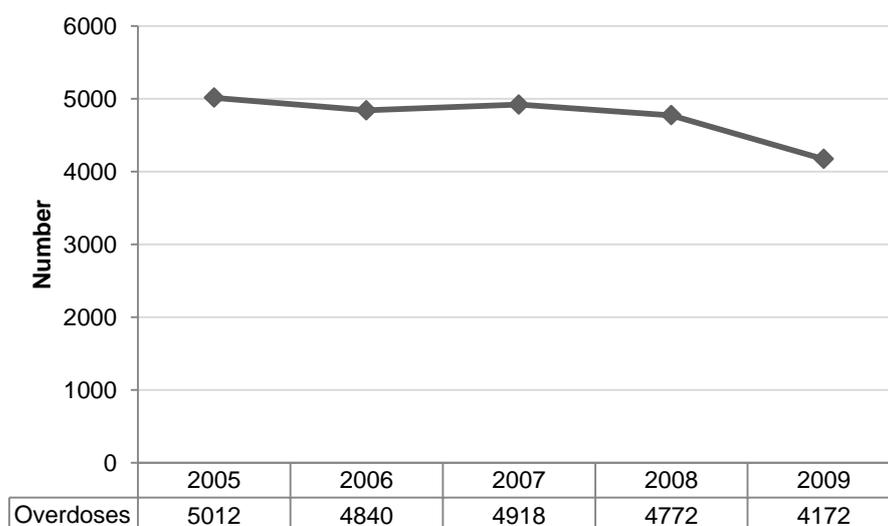
The next step or referral outcome was recorded for 90% of deliberate overdose cases and were as follows: discharged home (41%), admission to an acute general hospital (37%), admission to psychiatric in-patient care (7%), refused admission to any hospital (0.6%), and self-discharge before advice (14%).

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

- a wide range of evidence-based treatments and aftercare programmes,
- uniform assessment and aftercare procedures,
- adequate services to deal with alcohol and depression at peak times,
- information for the general public on the common symptoms of depression, signs of suicidal behaviour and places where help is available, and
- a national strategy to deal with alcohol supply and illegal alcohol use among children aged under 18 years.

### Non-fatal overdoses and drug-related emergencies

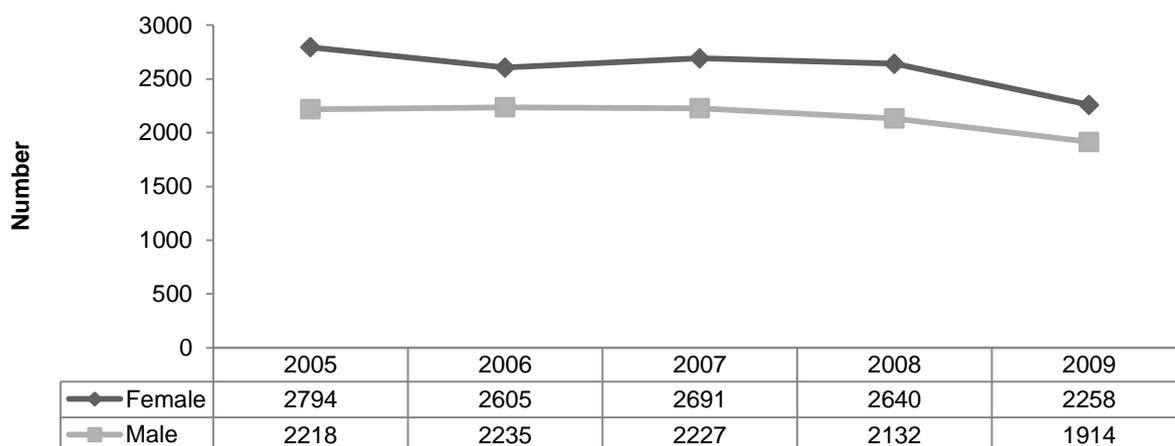
Data extracted from the Hospital In-Patient Enquiry (HIPE) scheme were analysed to determine trends in non-fatal overdoses discharged from Irish hospitals in 2009. There were 4,202 overdose cases in that year, of which 30 died in hospital. The 4,172 discharged cases are included in this analysis. The number of overdose cases decreased by 13% between 2008 and 2009 (Figure 6.3.1.1).



**Figure 6.3.1.1 Overdose cases by year, 2005–2009 (N=23,714)**

Source: Unpublished HIPE data

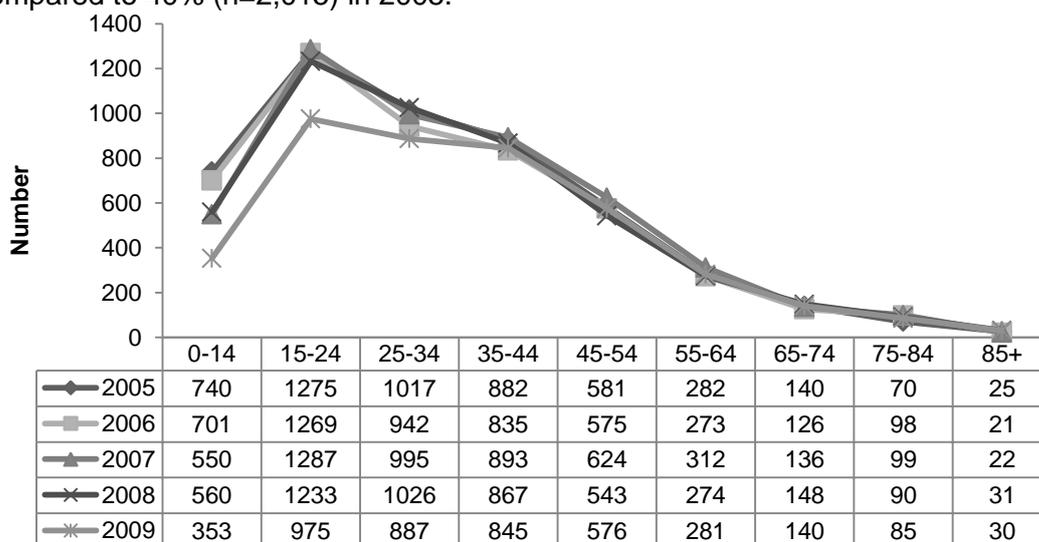
In the years 2005–2009 there were more overdose cases among females than among males (Figure 6.3.1.2), with females accounting for 54% of all overdose cases in 2009.



**Figure 6.3.1.2 Overdose cases by gender, 2005–2009 (N=23,714)**

Source: Unpublished HIPE data

In the four-year period 2005–2008, one quarter of overdoses occurred in those aged 15–24 years, with the incidence of overdose decreasing with age (Figure 6.3.1.3). The number of under-25s fell in 2009, accounting for 32% (n=1,328) of overdose cases, compared to 40% (n=2,015) in 2005.



**Figure 6.3.1.3 Overdose cases by age group, 2005–2009 (N=24,314)**

Source: Unpublished HIPE data

Table 6.3.1.1 presents the positive findings per category of drugs and other substances involved in all cases of overdose in 2009. Non-opioid analgesics were present in 36% (1,518) of cases. Paracetamol is included in this drug category and was present in 27% (1,129) of cases. Psychotropic agents were taken in 22% (903) and benzodiazepines in 25% (1,053) of cases. There was evidence of alcohol consumption in 13% (534) of cases. Cases involving alcohol are included in this analysis only when the alcohol was used in conjunction with another substance.

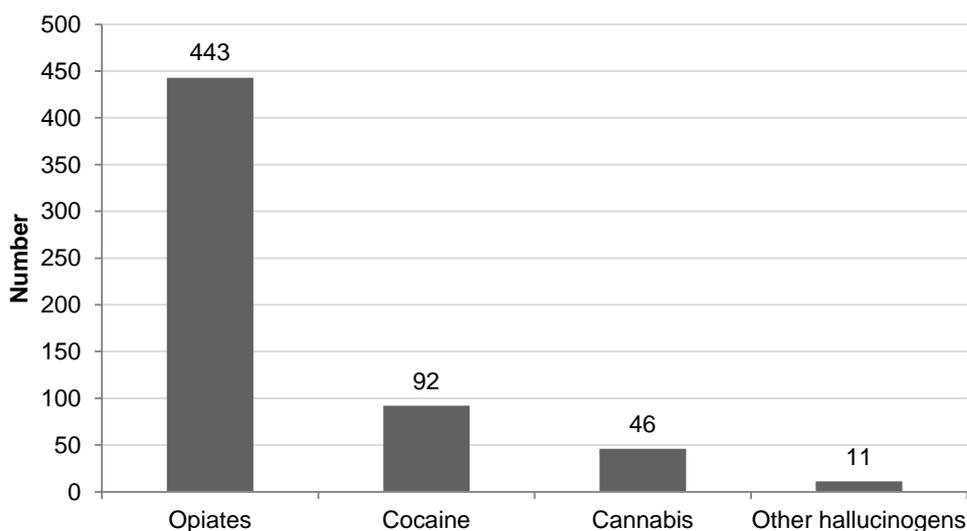
**Table 6.3.1.1 Category of drugs involved in overdose cases, 2009 (N=4,172)**

Drug category	Positive findings per drug category*	
	n	%
Non-opioid analgesics	1518	36.4
Benzodiazepines	1053	25.2
Psychotropic agents	903	21.6
Anti-epileptic / Sedative / Anti-Parkinson agents	556	13.3

Drug category	Positive findings per drug category*	
Narcotics and hallucinogens	539	12.9
Alcohol	534	12.8
Systemic and haematological agents	201	4.8
Cardiovascular agents	158	3.8
Autonomic nervous system agents	128	3.1
Anaesthetics	116	2.8
Hormones	100	2.4
Systemic antibiotics	94	2.3
Gastrointestinal agents	74	1.8
Other chemicals and noxious substance	58	1.4
Diuretics	51	1.2
Muscle and respiratory agents	45	1.1
Topical agents	25	0.6
Anti-infectives / Anti-parasitics	23	0.6
Other gases and vapours	7	0.2
Other and unspecified drugs	981	23.5

\*The sum of positive findings is greater than the total number of cases because some cases involved more than one drug or substance.  
Source: Unpublished data from HIPE

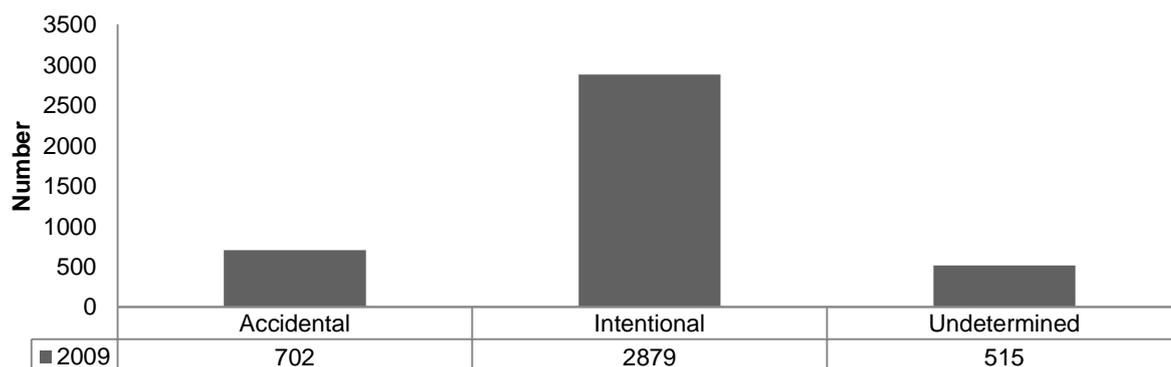
Narcotic or hallucinogenic drugs were involved in 13% (539) of overdose cases in 2009. Figure 6.3.1.4 shows the number of positive findings of drugs in this category among the 539 cases. The sum of positive findings is greater than the total number of cases because some cases involved more than one drug from this category. Opiates were used in 82% of the cases, cocaine in 17% and cannabis in 9%.



**Figure 6.3.1.4 Narcotics and hallucinogens involved in overdose cases, 2009 (N=539)**

Source: Unpublished data from HIPE

In 70.3% of cases the overdose was classified as intentional (Figure 6.3.1.5).



**Figure 6.3.1.5 Overdose cases by classification, 2009 (N= 4,096)**

Source: Unpublished data from HIPE

Table 6.3.1.2 presents the positive findings per category of drugs and other substances involved in cases of intentional overdose in 2009. Non-opioid analgesics were involved in 43% (1,236) of cases, benzodiazepines in 28% (816) and psychotropic agents in 25% (728).

**Table 6.3.1.2 Category of drugs involved in intentional overdose cases, 2009 (N=2,879)**

Drug category	Positive findings per drug category*	
	n	%
Non-opioid analgesics	1236	42.9
Benzodiazepines	816	28.3
Psychotropic agents	728	25.3
Anti-epileptic / Sedative / Anti-Parkinson agents	451	15.7
Alcohol	402	14.0
Narcotics and hallucinogens	293	10.2
Cardiovascular agents	99	3.4
Systemic and haematological agents	97	3.4
Autonomic nervous system agents	87	3.0
Systemic antibiotics	74	2.6
Hormones	71	2.5
Gastrointestinal agents	58	2.0
Anaesthetics	52	1.8
Other chemicals and noxious substances	41	1.4
Anti-infectives / Anti-parasitics	29	1.0
Other gases and vapours	23	0.8
Muscle and respiratory agents	16	0.6
Topical agents	9	0.3
Diuretics	5	0.2
Other and unspecified drugs	606	21.0

\*The sum of positive findings is greater than the total number of cases because some cases involved more than one drug or substance.  
Source: Unpublished data from HIPE

### **Use of analgesics in intentional drug overdose presentations to hospital before and after the withdrawal of distalgesic from the Irish market**

The withdrawal of distalgesic from the Irish market resulted in an immediate reduction in sales to retail pharmacies from 40 million tablets in 2005 to 500,000 tablets in 2006 while there was a 48% increase in sales of other prescription compound analgesics. The rate of intentional drug overdose (IDO) presentations to hospital involving distalgesic in 2006–2008 was 84% lower than in the three years before it was withdrawn (10.0 per 100,000) (Corcoran, *et al.* 2010). There was a 44% increase in the rate of IDO presentations involving other prescription compound analgesics but the magnitude of this rate increase was five times smaller than the magnitude of the decrease in distalgesic-related IDO presentations. There was a decreasing trend in the rate of presentations involving any drug containing paracetamol that began in the years before the withdrawal of distalgesic.

The withdrawal of distalgesic has had positive benefits in terms of IDO presentations to hospital in Ireland and provides evidence supporting the restriction of availability of means as a prevention strategy for suicidal behaviour.

### **Morbidity owing to cocaine use – two studies**

In a multicentre cross-sectional study conducted in eight European cities including Barcelona, Budapest, Dublin, Hamburg, London, Rome, Vienna and Zurich, patterns of cocaine emergencies were studied (de Millas, *et al.* 2010). In Dublin the data were collected through interview or postal questionnaire, and four physicians working in emergency medicine were interviewed. The data collected recorded the numbers of

emergencies in the preceding six months, presenting symptoms, urine toxicology, treatment provided and post-treatment referral.

The reported frequency differed from city to city, with some emergency departments having less than one case per half year, and some centres having more than one case per month. There was an average of eight cases attending emergency departments in Dublin, comprising less than 1% of all attendees. The adverse signs and symptoms reported by cocaine users attending emergency departments were associated with the psychomotor-stimulant or cardiovascular effects of cocaine. In Dublin the most common psychiatric condition reported was anxiety and the most common physical symptoms reported were palpitations and leg pain. Urine screens were regularly done in Dublin and referrals to the addiction services were done by half of those interviewed. The authors concluded that a closer link between emergency departments and addiction services would help in guiding problematic drug users towards appropriate treatment at an earlier stage in their addiction.

Galvin and colleagues (Galvin, *et al.* 2010) reviewed the hospital and long-term survival of cocaine-related admissions to an intensive care unit at a Dublin city centre hospital through a case series review. The authors reviewed all admissions to the intensive care unit between 2003 and 2007. They identified 19 cocaine-related cases and followed up discharges to early 2009. Cocaine-related admissions increased from two in 2004 and one in 2005, to six in 2006 and ten in 2007. The median age of the cases was 25 years (the range was 17–47), and 78% were male. The median APACHE II score was 16 (the range was 11–27) and median length of intensive care stay was five days (the range was 1–16). The diagnosis on admission was coma (8), cardiac arrest (6), seizure (3) and aspiration injury (2). One case had diabetes, and one had asthma. Drug toxicology revealed that ten cases had taken cocaine only, and nine cases had taken cocaine with one or more other drug. The other drugs taken were opioids (5), benzodiazepines (6), alcohol (4), amphetamines (2) and phencyclidine (2). One case was a body packer, i.e. he or she had concealed cocaine in his/her body to evade detection by the Customs authority. All cases required mechanical ventilation. Ten patients died during their hospital stay: six of the ten cases who took only cocaine died while in hospital, and four of the nine polydrug users died. A further five had died by early 2009, a median of 24 months later. One case was untraceable. Four cases were alive in early 2009. Cocaine toxicity necessitating intensive care is increasingly common in Dublin. The mortality of emergency cases admitted to intensive care was high at 52%. These findings may help to inform public attitudes to the serious outcomes that can occur as a result of cocaine use.

### **6.3.2 Other topics of interest** e.g. psychiatric and somatic co-morbidity, traffic accidents, pregnancies and children born to drug users

#### **Health and homelessness: the Simon snapshot study**

The Simon Communities of Ireland (Simon Communities of Ireland 2010) published a report on health and homelessness in late 2010. This report presents the findings of a 'point in time' survey undertaken between 26 July and 1 August 2010 at all eight Simon Communities in Ireland. The survey collected data on the profile and health needs of people using Simon projects and services over a one-week period.

The methods for this study are presented in Section 4.3.1.

#### **Profile of the sample**

- 78% were male.
- 85% were Irish, 6% were British, 5% were Eastern European and 1.4% were Irish travellers.
- 9% were aged between 18 and 25, 21% between 26 and 35 and 54% between 36 and 55.
- 51% received a disability allowance and 6% received the old age pension.

- 6.5% were classified as not being habitual residents.
- 65% were registered as homeless with the local authority.

### ***Physical health***

Fifty-six per cent (442) of the respondents had at least one diagnosed physical health condition. The most common of these were:

- 123 cases of cardiovascular disease, including angina, hypertension and stroke;
- 115 cases of infectious disease, including (most commonly) hepatitis C, and also hepatitis B, HIV, sexually transmitted infection, tuberculosis and urinary tract infection;
- 88 cases of injury, including head injury, broken bones and cuts;
- 74 cases of respiratory disease, including asthma, chronic obstructive pulmonary disease, pneumonia and pleurisy;
- 45 cases of neurological disorder, including epilepsy, Parkinson's disease, motor neuron disease, spinal muscular atrophy and muscular dystrophy.

Thirty-six per cent of respondents reported one or more undiagnosed physical health problem.

### ***Diagnosed mental health***

Fifty-two per cent (411) of the respondents had at least one diagnosed mental health condition; 29% reported depression, 9% schizophrenia, 7% panic attacks, 5% social anxiety disorder, 4% mild cognitive impairment and 3% bi-polar disorder.

Forty-four per cent of respondents reported one or more undiagnosed mental health conditions.

### ***Co-morbidity***

The report outlines the presence of a range of complex needs among the service users who participated in the research. For example, 28% had at least one diagnosed physical and at least one diagnosed mental health condition, and 28% were diagnosed with a mental health condition and reported complications arising from alcohol and/or drug use.

### ***Suicide and self-harm***

Fifteen per cent of respondents reported self-harming episodes at the time of the survey, 23% reported suicide ideation and 8% had attempted to commit suicide in the six months prior to the survey.

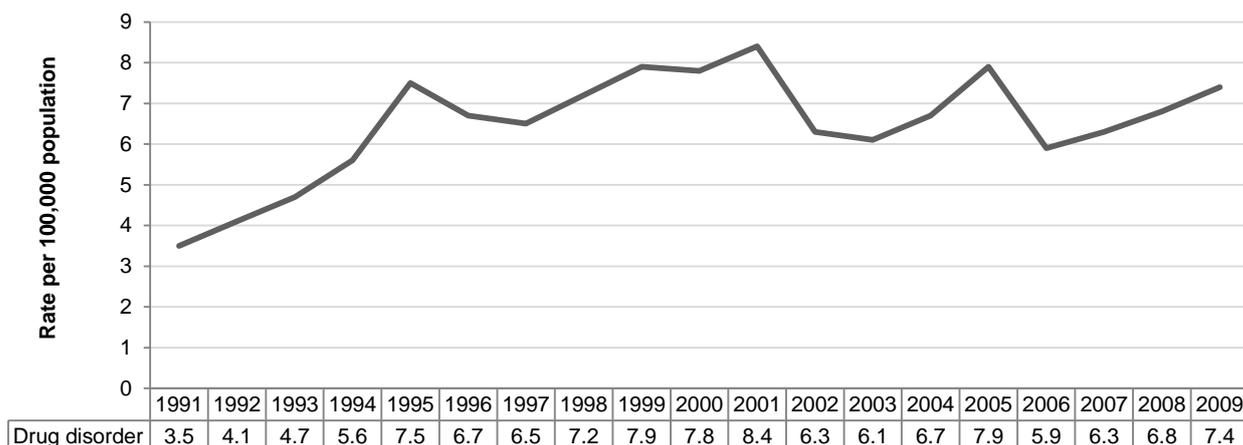
### ***Trends in alcohol and drug admissions to psychiatric facilities***

The annual report on activities of Irish psychiatric units and hospitals in 2009 (Daly and Walsh 2010) shows that the total number of admissions to inpatient care has continued to fall.

In 2009, 824 cases were admitted to psychiatric facilities with a drug disorder, of whom 313 were treated for the first time. The report does not present data on drug use and psychiatric co-morbidity, so it is not possible to determine whether or not these admissions were appropriate. Figure 6.3.2.1 presents the rates of first admission between 1991 and 2009 of cases with a diagnosis of drug disorder. The rate was almost three times higher in 2001 than it was in 1991. Notable dips in the rate occur in the census years 1996, 2002 and 2006, and can be partly explained by the increased population figures used as the denominator in calculating the rate for those years.

The overall increase in the rate of drug-related first admissions between 1991 and 2001 reflects the increase in problem drug use in Ireland and its burden on the psychiatric services. The overall decrease in the rate since 2001 possibly reflects an increase in the provision of community-based specialised addiction services during this period. The increased rate in 2005 may be accounted for by the use of the 2002 census figure in calculating the rate. The decrease to 5.9 in 2006 reflects the new

census figure used as denominator. The rate increased in 2008 and 2009. Of the 847 discharges with a drug disorder, 50% spent six days or more in hospital.



**Figure 6.3.2.1. Rates of psychiatric first admission of cases with a diagnosis of drug disorder (using the ICD-10 three-character categories) per 100,000 of the population in Ireland, NPIRS 1991–2009**

Source: (Daly and Walsh 2010)

### Prevalence of adult ADHD in psychiatric clinics in north Dublin

Syed and colleague (Syed, *et al.* 2010) estimated the prevalence of attention-deficit hyperactivity disorder (ADHD) in adults attending outpatient psychiatric services. Two hundred and sixty-five adults aged 18 to 65 years, attending five out-patient public clinics in north Dublin, were asked to complete the World Health Organization’s Adult Self-Report Scale VI.I; 243 (92%) agreed to complete the scale. The scale contains six items measuring inattention or over-activity; each question is answered using a five-point scale ranging from never to very often. Where a participant answers four or more of the six questions with ‘sometimes’, ‘often’ or ‘very often’, this denotes a case. Demographic and clinical data were also recorded using a self-completion questionnaire and the medical record.

The average age of the respondents was 42.5 years and 56% were women. Twenty-four per cent of respondents were diagnosed as having ADHD, and 69% of these were male, the average age was 42.1 years, and almost 11% had a diagnosis of substance abuse (alcohol and other drugs). When compared to patients without ADHD, those diagnosed with ADHD were significantly more likely not to complete second-level education, to have had ADHD diagnosis or ADHD symptoms as children, a forensic history, current personality disorder diagnosis and a higher rate of prescribed benzodiazepine use. They were no more likely to be dissatisfied with the service, heavy users of the service, or diagnosed with substance abuse.

The data indicate that ADHD is common among adults treated for mental illness. None of the patients had a recorded diagnosis of ADHD, indicating significant under-diagnosis of this manageable condition.

### Mental illness and alcohol and other drug use

Substance dependence and other mental illnesses co-exist in a proportion of patients attending health services and two recent Irish studies have attempted to estimate and describe the phenomenon.

Lyne and colleagues (Lyne, *et al.* 2011) reviewed the records of patients presenting with co-morbid psychiatric diagnoses and drug use at a 12-bed alcohol treatment unit in a psychiatric teaching hospital in Dublin between 1995 and 2006. Patients were included if they were aged 44 years or under, had remained in hospital for more than 28 days, and had a diagnosis of alcohol dependence.

The review of 465 records revealed that 38.9% of patients had used drugs other than alcohol during their life and 34.2% had a documented history of a co-morbid psychiatric diagnosis. The most commonly reported substances were cannabis (26.4%), cocaine (17.1%), and ecstasy (12.5%); just under 10% reported use of benzodiazepines or other sedatives and just under 6% had used heroin. The disease-specific rates for the 465 cases were depressive disorder (25.3%), anxiety disorder (3.9%), bipolar affective disorder (2.8%) and psychotic disorder (2.2%). A small proportion (3.7%) of patients had two or more psychiatric diagnoses alongside their alcohol dependence. Forty-eight (10.3%) patients had a documented history of deliberate self-harm, of whom 29 had a psychiatric diagnosis as well as alcohol dependence.

The median age of the study population was 37 years and the age range was 17–44 years. Just over three-fifths (61.1%) of patients were men, 203 (44.3%) of the patients had never married, and 38 (8.3%) were separated or divorced. The proportions of women with a history of depressive disorder, eating disorder or deliberate self-harm were significantly higher than those for men. The proportion of men with psychotic disorder was marginally higher than that of women. Deliberate self-harm was associated with lifetime drug (excluding alcohol) use. Ecstasy users were more likely to have a diagnosis of depression.

Skinner and colleagues (Skinner, *et al.* 2011) explored the relationship between cannabis use and self-reported dimensions of psychosis in a population of university students presenting for any reason to primary care.

Fifteen thousand students were enrolled in undergraduate or postgraduate courses at the National University of Ireland, Galway, in 2008. One thousand and forty-nine (7%) students attended the Student Health Unit between April and October of that year and they completed self-report questionnaires on:

- demographic profile,
- history of mental illness,
- alcohol and other drug misuse,
- non-clinical dimensions of psychosis [Community Assessment of Psychic Experiences (CAPE)], and
- anxiety and depression [Hospital Anxiety and Depression Scale (HADS)].

The respondents may not be representative of the third-level student population. The average age of the respondents was 21.2 years (range 17–54); 82% were women; 94% were Irish; and 96% were single. Sixteen per cent sought professional help for emotional or psychiatric problems, 23% reported a family history of mental illness, and almost 5% reported a family history of psychotic illness.

Respondents reported drinking an average of 9.4 units (range 0–120) of alcohol per week and an average of 5.9 units (range 0–35) per sitting. Forty per cent (423) had smoked cannabis at least once in their lives, of whom 327 reported use between 1 and 30 times, and 86 reported use 30 or more times. The average age at first use of cannabis was almost 17 years (range 10–40). The rates of lifetime use of other drugs were ecstasy (6.9%), cocaine (5.8%), magic mushrooms (5.1%), LSD (2.1%) and heroin (0.1%).

Twenty-one per cent had HADS scores of between 8 and 10 (borderline abnormal level) on the anxiety subscale, and 15% had scores of 11 or above (abnormal level). Just under 3% reported borderline abnormal level on the depressive subscale and 1% reported abnormal level. The average weighted CAPE frequency score for negative symptoms was 1.57 (range 1–4), and for positive symptoms 1.29 (range 1–3). The higher HADS anxiety scores were associated with a personal history of mental illness, a family history of psychiatric disorder and being female. The higher HADS depression scores were associated with a personal history of mental illness.

The CAPE positive psychotic symptom scores were associated with a personal history of mental illness and a family history of psychiatric disorder, and with being younger and male. The CAPE negative psychotic symptom scores were associated with a personal history of mental illness and a family history of psychiatric disorder. The CAPE depressive symptom scores were associated with a personal history of mental illness, a family history of psychiatric disorder and being female.

After controlling for the effects of personal history of mental illness, family history of psychiatric disorder, age and gender, the CAPE positive and negative psychotic symptom scores were associated with high-frequency cannabis use. In addition, the CAPE negative psychotic symptom scores and depressive symptom scores were associated with low-frequency cannabis use.

After further controlling for frequency of cannabis use, it was found that the earlier the age at which a person started cannabis use, the more positive psychotic symptoms they experienced.

These findings support the hypotheses that cannabis use increases the risk of developing psychotic symptoms and that this risk increases further in individuals who use cannabis more heavily and start use at a younger age.

### **Psychiatric presentations and physical complications linked with ‘head shop’ products**

Several cases have been reported in peer review journals of psychiatric illness and physical complications as a result of using substances purchased in head shops in Ireland.

#### ***Butylone and MDPV***

Fröhlich and colleagues (Fröhlich, *et al.* 2011) report the case of a young man who presented with acute psychosis and subsequently developed hepatic failure following ingestion of Butylone and MDPV (methylenedioxypropylvalerone). These substances were sold in head shops in Ireland and on line until 23 August 2010. The patient was a 28-year-old male suffering from bipolar affective disorder but otherwise healthy. Following ingestion of 12 tablets he had a seizure. On arrival at hospital his neurological assessment (GCS) was 5 out of a possible 15, heart rate was 190 beats per minute, systolic blood pressure 230 mmHg, temperature 39.5°C and he was sweating profusely. He was treated in the intensive care unit, with cooling (to reduce his temperature), mechanical ventilation (to assist his breathing), labetalol (to reduce his blood pressure) and phenytoin (to manage his seizures). Urinary and serum screens for drugs did not reveal any evidence of MDMA, cocaine, paracetamol, or salicylates. The tablets taken were examined and found to contain Butylone and MDPV. After ten hours the patient’s neurological and respiratory status were normal. On day two, he developed Rhabdomyolysis, which is a condition in which damaged skeletal muscle tissue breaks down rapidly and this condition is associated with stimulant use. This was treated conservatively (possibly with intravenous fluids). Unexpectedly, between day two and day three, his liver function tests indicated that he had developed acute liver failure. Following treatment for three days with N-acetylcysteine infusion (normally used as a treatment for paracetamol overdose), liver tests showed his liver function was slowly returning to normal. On day four, the patient was discharged from the intensive care to psychiatric care where he received treatment for a recurrence of his psychosis, thought to be triggered by consumption of Butylone and MDPV. This is the first case report associating these compounds with acute liver failure. There is no record in the literature of these compounds being associated with liver injury. However, the liver is known to be a target organ for MDMA toxicity, possibly owing to damage to specific part of the cells that make up muscle tissue.

The recreational use of a variety of psychoactive drugs is increasing. The effects of these drugs mimic amphetamine ingestion but little is known about their dosing or safety profile. The authors support the need for regulation of these substances.

### **Methylone**

Uhoegbu and colleagues (Uhoegbu, *et al.* 2011) reported two cases of acute onset of and rapid recovery from psychotic symptoms, the first after eating a head shop product and the second after injecting it; the product probably contained methylone. Common psychotic symptoms included hallucinations, delusions, and disturbed thoughts.

A 30-year-old woman with no past psychiatric history attended a Dublin emergency department with a 24-hour history of restlessness, irritability, paranoid delusions and a maculo-papular rash on the lower third of her right thigh and on the upper third of both thighs. Physical examination revealed raised and fluctuating blood pressure and pulse rates with peaks of 160/100mmHg and 120bpm respectively. Her brain scan and lumbar puncture (spinal fluid) were normal. Her urine test was negative for 'common' illicit substances.

A 29-year-old man of no fixed abode and a long history of injecting drug use attended the same emergency department with signs of a recent onset of a florid psychotic episode (evidenced by hallucinations and delusions). On examination, he was quite agitated and described hearing voices and seeing visual hallucinations. He had delusions (beliefs not backed by reality) and also reported passing thoughts about suicide. He also described some sub-clinical symptoms of depression. There were no abnormalities identified during the physical examination, and the only abnormal laboratory findings were urine tests that were positive for opiates and benzodiazepines. He was already attending the addiction services for methadone maintenance therapy. He had no past history of psychotic or mood disorder.

Both cases were admitted to hospital for five days and were treated with an atypical antipsychotic and a benzodiazepine. Their symptoms settled within 48 hours of admission.

### **Whack**

In June 2010 the NPIC informed the HSE's Department of Public Health of significant adverse effects associated with a recreational drug called Whack, which was being sold in headshops. The HSE subsequently issued a warning to the general public about the drug. Between 30 May and 16 June 2010 the centre was contacted about 49 patients who had suffered adverse effects after taking Whack. They presented with sympathomimetic features of tachycardia and hypertension, as well as agitation and severe psychotic reactions with delusions of parasitosis and hallucinations, persisting for up to 5 days.

The Forensic Science Laboratory has since analysed this product and found it to contain two active ingredients. The first, fluorotropacocaine, is a drug of lower potency than the parent compound, cocaine. The second compound was tentatively identified as desoxypipradrol (there is no current external reference standard so a best library match was used). This is an analogue of pipradrol, which is a central nervous system stimulant developed in the 1950s. It is likely that the severe, long-acting effects associated with Whack are due to this agent, as pipradrol has been previously associated with psychotic reactions and insomnia.

El-Higaya and colleagues (El-Higaya, *et al.* 2011) presented two case studies of men who developed acute psychotic states after using Whack. There was a striking similarity between symptoms in the two cases, with initial euphoria and disinhibition followed by severe anxiety, insomnia, depressed mood, restlessness, agitation, pacing and psychosis. These symptoms persisted for 7–10 days after using Whack. Both men required inpatient treatment but responded well to atypical antipsychotic agents. This is the first published case series relating to this psychoactive substance in Ireland.

### **Benzylpiperazine**

Tully and colleagues (Tully, *et al.* 2011) described the case of a 48-year-old man with schizophrenia who developed an acute delirium or confusion secondary to use of

benzylpiperazine, a psychotropic compound widely available in head shops. This is the first documented case of delirium owing to benzylpiperazine use in Ireland. Investigation of his delirium unearthed a temporal meningioma, which appears to have been an unrelated or supplementary finding.

### **Butylone**

A letter to the editor of the Irish Medical Journal (Herbert and Tracey 2010) reported two cases of people who sought medical assistance after taking butylone (sold as London Underground Doves). The first case was that of a 25-year-old woman who experienced dilated pupils, facial flushing and tachycardia (fast pulse). The second was that of a 37-year-old man who experienced vomiting, abdominal pain, palpitations and chest pain. Both cases recovered following symptomatic treatment.

### **Mephedrone**

Nicholson and colleagues (Nicholson, *et al.* 2010) presented a case study of a 19-year-old man who came to hospital with crushing chest pain 20 hours after eating a gram of plant food containing mephedrone. His history and urinalysis indicated that he had not taken other drugs. His electrocardiograph (ECG) showed an abnormal heart rhythm (ST elevation) and his MRI confirmed the abnormal heart rhythm and showed swelling of the heart muscle. The patient recovered after five days in hospital. The authors reported that it is not clear how mephedrone induces inflammation of the heart but it is thought that such damage to the heart could cause death; it is speculated that mephedrone has caused a number of deaths in the United Kingdom and confirmed that it has caused one death in Sweden.

## **6.4 Drug-related deaths and mortality of drug users**

### **6.4.1 Drug-induced deaths (overdoses/poisonings)**

In 2009, the number of deaths owing to poisoning recorded in Ireland by the NDRDI (as per Selection D) decreased slightly, to 203 deaths from 211 in 2008 (Table 6.4.1.1, also see Standard Table 5). This is the first decreased in the number of deaths owing to poisoning since 2003. It should be noted that annual data previously reported have changed as the database has been updated as new information has become available.

**Table 6.4.1.1 Poisonings (Selection D) by year, NDRDI, 1999 to 2009 (N=1681)**

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009
Selection D	115	113	109	127	109	128	173	188	205	212	203

Source: Unpublished data NDRDI

In 2009, the mean age of those dying from poisoning was 35 years and the majority of individuals were aged between 20 and 39 years of age (140, 70%). The majority were male (158, 77.8%), although there was a difference between the mean age of males (34 years) and of females (38 years). This pattern is similar to findings from previous years and also reflects international trends (see Standard Table 5).

Opiates continued to be associated with the majority of fatal overdoses in 2009, with 180 (88.7%) deaths being associated with opiates alone or with another drug. This percentage is higher than reported for previous years. The number of deaths where cocaine was implicated, alone or with another drug, decreased again in 2009. In 2008, cocaine was implicated in 58 deaths while in 2009, it was implicated in 52 deaths by poisoning in 2009.

Of the 203 cases of poisoning recorded in 2009, heroin or unspecified opiates alone accounted for 50 (24.6%) cases. Deaths attributable to polysubstances increased: more than half of all deaths owing to poisoning (125, 61.6%) were attributable to polysubstances, including an opiate, which is higher than reported in previous years.

The trends in drug-related deaths in 2009 are reflected in drug treatment trends (see TDI data and Section 5.6), which show an increase in the number of cases treated for problem opiate use and a slight decrease in the number of cases treated for problem cocaine use.

Alcohol and other drugs, including benzodiazepines, non-benzodiazepine sedatives, antidepressants, other prescription medication and over-the-counter medication, continue to contribute significantly to the burden of drug-related deaths in Ireland but are not reported as part of Selection D (Health Research Board 2011).

### Benzodiazepine-related deaths

Data on poisoning deaths where a benzodiazepine was implicated as recorded by the NDRDI between 1998 and 2007 were published in December 2010 (Bellerose, *et al.* 2010). This was the first time that treatment data from the NDTRS and the NDRDI was presented together in a Trends Series paper, providing a more complete picture of problem benzodiazepine use and its consequences (for detail, see Chapter 5.6 above).

### Alcohol-related deaths

The NDRDI published its third trend paper, describing, for the first time, trends in alcohol-related deaths and deaths among people who were alcohol dependent in Ireland for the years 2004–2008 (Lyons, Dr Suzi, *et al.* 2011).

#### Alcohol-related poisonings

Between 2004 and 2008, 672 poisoning deaths in which alcohol was implicated (alone or in conjunction with other drugs) were recorded (Table 6.4.1.2). This makes alcohol the drug most frequently implicated in *all* fatal poisonings in Ireland in the five-year period. Most of those who died were male. The highest number of deaths was recorded in 2007 (170). The median age of those who died of alcohol-only poisoning was 48 years, that of those who died of alcohol polysubstance (alcohol plus other substance/s) poisoning was 41 years.

**Table 6.4.1.2 Alcohol-related poisoning deaths (NDRDI 2004–2008) (N = 671)**

	2004	2005	2006	2007	2008
Total	125	116	111	170	150
Alcohol only (n = 331)	61	51	54	85	80
Alcohol polysubstance (n = 341)	64	65	57	85	70

Source (Lyons, Dr Suzi, *et al.* 2011)

Just over half (50.7%) of all alcohol-related poisonings involved another substance. Most commonly implicated along with alcohol were benzodiazepines (61.3%) and opiates (including heroin and methadone) (55.7%) (Table 6.4.1.3).

**Table 6.4.1.3 Additional drugs involved in alcohol polysubstance poisoning deaths (NDRDI 2004–2008) (N = 341)**

	%
All alcohol polysubstance poisonings*	100.0
Benzodiazepines	61.3
Antidepressants	23.5
Heroin	22.9
Other opiates†	21.4
Other prescription medication	15.5
Methadone	11.4
Cocaine	9.1
Other‡	8.8

\* Numbers and percentages in columns do not add up to totals shown in this row because individual deaths are attributable to alcohol and one or more other drug(s) or substance.

† Excludes heroin and methadone.

‡ Includes other illicit and licit drugs such as amphetamines, hallucinogens, volatile inhalants, cannabis or non-opiate analgesia.

Source (Lyons, Dr Suzi, *et al.* 2011)

#### All NDRDI-recorded poisoning deaths

Table 6.4.1.4 presents data on alcohol poisonings alongside data on poisonings from all other substances in order to compare the contribution of alcohol to fatal poisonings

nationally. Alcohol was implicated in 40.7% of all poisonings, making it the drug most frequently implicated in fatal poisonings in Ireland for the period 2004–2008.

**Table 6.4.1.4 Drugs involved in all poisoning deaths in Ireland (NDRDI 2004–2008) (N=1,650)**

	Positive findings
	%
Alcohol	40.7
Benzodiazepines	31.1
Heroin	18.7
Methadone	16.7
Antidepressants	16.7
Other prescription drugs	14.5
Cocaine	14.0
Other opiates†	17.3
Non-opiate analgesic	5.0
MDMA	3.3
Other‡	3.1

\* Percentages do not add up to total shown in this row because individual deaths may be attributable to more than one drug or substance.

† Excludes heroin and methadone.

‡ Includes other illicit and licit drugs such as amphetamines, hallucinogens, volatile inhalants or cannabis.

Source (Lyons, Dr Suzi, *et al.* 2011)

The analysis showed clearly the burden of premature mortality as many of those who died were still in their prime, aged between 40 and 59 years. Going forward, the NDRDI will be able to measure any changes in public health policy on alcohol-related mortality in the Irish population.

### Heroin drought

In early 2011 at least six fatal heroin overdoses were reported by the Irish media. This was reputed to be caused by a drought of heroin in December 2010, followed by the arrival of a batch ‘high quality’ heroin into the country (Holland 2011, February 15, O’Keefe 2010, December 16). A similar drought had been reported by the media in the UK around the same period (Boyce 2011) (Attewill 2011, 31 January). Harm-reduction agencies issued warnings and advice to their clients about the risks of loss of tolerance and overdose during this period. Research into a heroin drought in Australia early in this century showed increased use of other substances especially cocaine during the drought (Weatherburn, *et al.* 2003). The true extent, pattern and full impact of this drought on poisoning deaths in Ireland will be reported in future annual figures from the NDRDI.

### National Overdose Prevention Strategy

Currently a national overdose prevention strategy is being developed by a working group comprising of the Department of Health, the HSE, the HRB and the National Advisory Committee on Drugs (Personal Communication, S Lyons Health Research Board). The aim of the working group is to identify evidence based interventions for preventing drug-related deaths and deaths among drug users. The group will then advise on the most appropriate of these interventions for the Irish context.

The terms of reference were to:

- consider National Drug-Related Deaths Index reports;
- set targets for reduction of drug deaths;
- list possible components of an overdose prevention strategy; and
- make recommendations on how different elements of the strategy could be operationalised.

The report is not yet finalised.

### 6.4.2 Mortality and causes of deaths among drug users (mortality cohort studies)

No information available.

### 6.4.3 Specific causes of mortality indirectly related to drug use (e.g. HIV/AIDS and HCV related to IDU, suicides, accidents)

#### Specific causes of mortality indirectly related to drug use

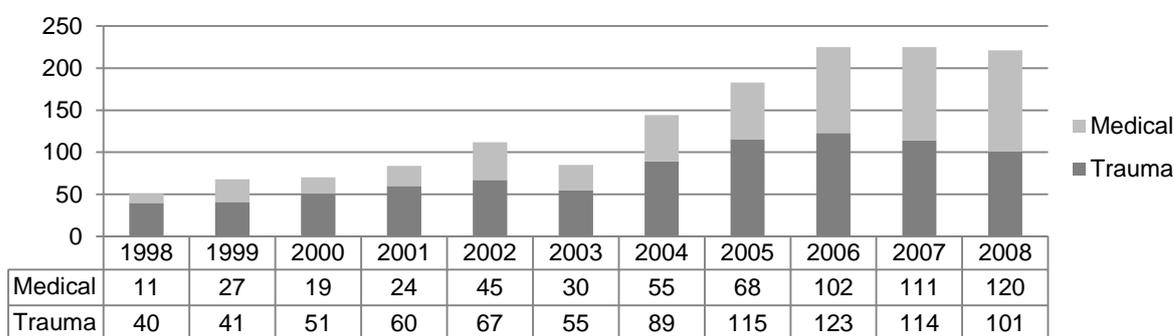
Between 1998 and 2008 there were 1630 non-poisoning deaths among drug users in Ireland recorded by the NDRDI (Table 6.4.3.1) (Health Research Board 2011). A drug user is defined in this analysis as an individual who has a history of drug dependency or of non-dependent abuse of drugs and/or other substances.

**Table 6.4.3.1 Drug-related deaths, by year of death, NDRDI 1998–2008 (N=4,064)**

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008
Non-poisoning (n=1630)	64	84	79	100	127	111	162	203	232	237	231

Source: NDRDI (Health Research Board 2011)

Of the 1,468 cases with a known cause of death, 58.3% (856) were due to trauma and 41.7% (612) were due to medical causes (Figure 6.4.3.1).



**Figure 6.4.3.1 Deaths due to medical or traumatic causes among drug users, NDRDI, 1998 to 2008 (N = 1630)**

Source: NDRDI (Health Research Board 2011)

#### Deaths owing to trauma 2008

The annual number of deaths owing to trauma had been decreasing slightly since 2006 when 123 cases were reported to 101 cases in 2008 (Figure 6.4.3.1). These figures may be revised when new data becomes available.

Sixty-one (61%) of those who died from traumatic causes in 2008 were aged between 20 and 34 years. The median age was 28 years. As reported in previous years, the majority were male (88, 87%).

The most common causes of death due to trauma were hanging and drowning.

#### Deaths owing to medical causes 2008

The annual number of deaths owing to medical causes rose fairly steadily over the reporting period, from 11 in 1998 to 120 in 2008, when it exceeded the number of deaths owing to trauma for the first time (Figure 6.4.3.1). The majority of those who died from medical causes in 2008 were aged between 30 and 49 years. The median age was 42 years. Three-quarters (352, 76%) of those who died in 2008 were male. The most common medical causes of death in 2008 were cardiac events (25, 21%), respiratory infections (16, 13%) and liver disease (12, 10%). These percentages are similar to those reported in previous years.

#### Annual report of the Poison Information Centre of Ireland

According to its annual report for 2010 (Poison Information Centre of Ireland 2011), the NPIC received 11,589 enquiries, a decrease of 1.6% from 2009. Of these, 1,904 were dealt with by the NPIS in the UK and are not included in the analysis presented in the report. Of the 9,685 calls answered by the NPIC, 9,330 (96.3%) were about human

toxicology. The remaining calls concerned poisoning in animals (0.7%) and non-emergency requests for information (2.9%).

The most frequent enquiries were from general practitioners/general practitioner co-ops (38.2%), hospitals (33.2%) and members of the public (22.9%). The other sources of enquiries were community pharmacists, carers, vets, industry/manufacturers, schools, emergency services, media, and government agencies.

Half of the enquiries about cases of poisoning in humans concerned children under 10 years of age and males outnumbered females in this age group. Nearly two thirds (n=2,744, 29.4%) of enquiries were about adults (>20 years), with a predominance of females in this age group.

The main agents involved in these cases were household products, laundry products, particularly liquid detergent capsules, and cleaning products. The majority (93.4%) of all human poisoning incidents occurred in the home or a domestic setting.

More than half (59.6%) of the human cases were suspected accidental poisonings, 25.1% were intentional poisoning or recreational abuse, 12.2% were therapeutic errors and 3.2% had another or unknown intent.

The enquiries about human toxicology involved 15,164 agents, mainly drugs, industrial chemicals and household products. The most common enquiry concerned substances containing paracetamol (1,302), and the second most common agent was ibuprofen (454). Only a small proportion of cases (361, 3.9%) were followed up. Although most recovered completely, 24 cases suffered adverse effects, a further 12 cases died, while the outcome of 34 cases could not be determined. One of these fatalities may not have been caused by poisoning (post mortem examination to be carried out); the others were all cases of deliberate self-poisoning or drug/substance abuse.

## 7. Responses to Health Correlates and Consequences

### 7.1 Introduction

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

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

The **Bluebell Addiction Advisory Group (BAAG)** was established, under the auspices of the Canal Communities Local Drugs Task Force, in inner-city Dublin, in October 2002. Its main objective is to provide strategic local responses to serious drug use in partnership with the community. Services include outreach, education and prevention, and family support.

The **Health Service Executive (HSE)** is responsible for managing and delivering health and personal social services in Ireland. It supports numerous responses to the health correlates and consequences of problematic drug use.

The **Pharmaceutical Society of Ireland (PSI)** is an independent statutory body, established by the Pharmacy Act 2007, charged with the effective regulation of pharmacy services in Ireland, including supervising compliance.

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

#### **Use of analgesics in intentional drug overdose presentations to hospital before and after the withdrawal of distalgesic from the Irish market**

Distalgesic, the prescription-only analgesic compound of paracetamol (325 mg) and dextropropoxyphene (32.5 mg), known as co-proxamol in the UK, was withdrawn from the Irish market as of January 2006. Corcoran and colleagues (Corcoran, *et al.* 2010) evaluated the impact of the withdrawal of distalgesic in terms of non-fatal intentional drug overdose presentations to hospital emergency departments nationally. A total of 42,849 non-fatal intentional drug overdose presentations to 37 of the 40 hospital emergency departments operating in Ireland in 2003–2008 were recorded, using standardised procedures. The average number of cases was 7,142 (range 6,642 to 7,692). Data on sales of drugs containing paracetamol to retail pharmacies for the period 1998–2008 were obtained.

Women accounted for 61.2% of all of non-fatal intentional drug overdose presentations, a proportion that did not vary by year. The total, male and female annual rates respectively of intentional drug overdose presentations to hospital emergency departments per 100,000 population were 188.4 (95% CI = 186.6-190.1), 143.5 (95% CI = 141.3-145.7) and 234.3 (95% CI = 231.5-237.0). After adjustment for age, female gender was associated with a 60% higher rate of intentional drug overdose presentation (IRR = 1.60, 95% CI = 1.57-1.63). At least one drug containing paracetamol was involved in 13,066 (30.5%) of the intentional drug overdose presentations. The total, male and female annual rates respectively of intentional drug overdose presentations to hospital involving paracetamol were 57.0 (95% CI = 56.0-57.9), 35.4 (95% CI = 34.3-36.5) and 79.1 (95% CI = 77.5-80.7) per 100,000 population. After adjustment for age, female gender was associated with more than

double the rate of paracetamol-related intentional drug overdose presentations (IRR = 2.21, 95% CI = 2.13-2.28).

The national rate of intentional drug overdose presentations to hospital decreased over the study period. The rate was 212.3 per 100,000 in 2003 and fell annually by 6.7% (95% CI = 5.8-7.6%) to 173.6 in 2006. Between 2007 and 2008, the rate increased from 175.3 to 187.2 per 100,000, an increase of 7.0% (95% CI = 3.8-10.3%) after adjustment for age. This trend was also evident for intentional drug overdose presentations involving a drug containing paracetamol. The rate was 64.3 per 100,000 in 2003 and also fell annually by 6.7% (95% CI = 5.1-8.3%) to 51.9 in 2006. Between 2007 and 2008, the rate increased from 51.2 to 55.1 per 100,000, an increase of 6.5% (95% CI = 0.6-12.6%) after adjustment for age.

Sales to retail pharmacies of distalgesic, other prescription compound analgesics, solpadeine and other drugs containing paracetamol increased by 4%–6% per year over the eight years (1998–2005) before distalgesic was withdrawn from the Irish market. In 2005, approximately 40 million tablets of distalgesic were sold to pharmacies. This fell to 500,000 in 2006, to approximately 2,000 in 2007 and to none in 2008. Between 2005 and 2006, there was a 48% jump in sales of other prescription compound analgesics, an 11% increase in sales of solpadeine and a 22% increase in sales of other paracetamol-containing medicines.

Of the 42,849 recorded intentional drug overdose presentations, distalgesic was one of the drugs taken in 1,312 (3.1%) overdose acts. The involvement of distalgesic in intentional drug overdose acts differed by gender (Chi-square = 12.13, df = 1,  $p < 0.001$ ), age (Chi-square = 37.64, df = 4,  $p < 0.001$ ) and year (Chi-square = 635.38, df = 5,  $p < 0.001$ ). Distalgesic was more common in female intentional drug overdose acts and was less common with increasing age. In the three years before distalgesic was withdrawn, it was involved in almost 400 presentations annually, approximately 5% of all intentional drug overdose presentations.

The three years following withdrawal of distalgesic saw sharp reductions in the numbers and proportions of intentional drug overdose presentations involving distalgesic. A similar pattern was observed when distalgesic was considered as a proportion of all paracetamol-related intentional drug overdose presentations. The drug was involved in 16% of paracetamol-related drug overdose acts in 2003–2005 but this declined sharply in line with the distalgesic withdrawal. The age-standardised rate of intentional drug overdose presentations to hospital involving distalgesic was 10 per 100,000 between 2003 and 2005, and in each of the three post-withdrawal years, the rate fell to 2.7 (95% CI = 2.2-3.2) per 100,000 in 2006, 1.6 (95% CI = 1.2-2.0) per 100,000 in 2007 and 0.6 (95% CI = 0.4-0.9) per 100,000 in 2008. In contrast, the rate of intentional drug overdose presentations involving the other prescription compound analgesics was approximately 4 per 100,000 in 2003–2005, rising to 5.0 (95% CI = 4.3-5.7), 6.4 (95% CI = 5.6-7.2) and 6.4 (95% CI = 5.6-7.1) per 100,000 in 2006, 2007 and 2008 respectively. There was no trend evident in the rate of intentional drug overdose presentations involving solpadeine. The rate of intentional drug overdose presentations to hospital involving distalgesic in 2006–2008 was 83.5% lower than it had been in the three years before it was withdrawn. This decrease was graded across the three years. Compared to 2003–2005, the rate of distalgesic-related intentional drug overdose presentations was 72.3% (95% CI = 66.7-76.9%) lower in 2006, 84.0% (95% CI = 79.8-87.3%) lower in 2007 and 93.8% (95% CI = 91.0-95.7%) lower in 2008. The rate of intentional drug overdose presentations involving the other prescription compound analgesics was 43.5% higher in 2006–2008 than in 2003–2005. The increase were somewhat graded – 22.0% (95% CI = 4.4-42.5%) higher in 2006, 54.5% (95% CI = 34.0-78.3%) higher in 2007 and 53.3% (95% CI = 33.0- 76.7%) higher in 2008. The overall rate of presentations involving any drug containing paracetamol was 16.4% lower in 2006–2008 than in 2003–2005. The median number of distalgesic tablets taken in intentional drug overdose presentations involving the drug was 20 (interquartile (IQ) range = 10–30), with men, on average, taking more distalgesic

tablets in IDO acts than women (Mann-Whitney U = 117,207,  $p < 0.001$ ; Male median (IQ range) = 20 (12-36); Female median (IQ range) = 18 (10-28)

The withdrawal of distalgesic from the Irish market resulted in an immediate reduction in sales to retail pharmacies from 40 million tablets in 2005 to 500,000 tablets in 2006 while there was a 48% increase in sales of other prescription compound analgesics. The rate of intentional drug overdose presentations to hospital involving distalgesic in 2006–2008 was 84% lower than in the three years before it was withdrawn (10.0 per 100,000). There was a 44% increase in the rate of intentional drug overdose presentations involving other prescription compound analgesics but the magnitude of this rate increase was five times smaller than the magnitude of the decrease in distalgesic-related intentional drug overdose presentations. There was a decreasing trend in the rate of presentations involving any paracetamol-containing drug that began in the years before the distalgesic withdrawal.

The withdrawal of distalgesic has had positive benefits in terms of intentional drug overdose presentations to hospital in Ireland and provides evidence supporting the restriction of availability of means as a prevention strategy for suicidal behaviour.

### **Pharmacy guidelines on safe supply of codeine-based products**

The Pharmacy Act 2007 and the Regulation of Retail Pharmacy Businesses Regulations 2008 require that all codeine-based products be dispensed under the supervision of a pharmacist, and that individuals in receipt of the product should receive appropriate counselling. In May 2010, the Pharmaceutical Society of Ireland published guidelines on the safe dispensing of non-prescription products containing codeine (The Pharmaceutical Society of Ireland 2010). Codeine is an opiate-based analgesic which is controlled under the Misuse of Drugs Acts 1977 and 1984 and is most often sold as a combination drug in non-prescription medication. It is well established that codeine-based medications have the potential to be abused and, if used for long periods, psychological and physical dependence can occur. Withdrawal of codeine in individuals who have taken excess doses over long periods of time may result in restlessness and irritability.

Codeine is used in many popular over-the-counter painkillers (e.g. Solpadeine), often in combination with other non-prescription painkillers such as paracetamol or ibuprofen (e.g. Nurofen Plus). Certain cough medicines and flu remedies also contain codeine (Irish Medicines Board 2011). An individual who takes excess amounts of a combination drug is at risk of the toxic effects of both drugs.

The guide aims to ensure the safe supply of medicines and to support pharmacists in their legal obligation to dispense non-prescription products containing codeine. The main points in the guide are:

- Products containing codeine cannot be displayed in the 'self-selection' area of the pharmacy.
- Codeine-based products should only be dispensed under the supervision of the pharmacist, who should be in a position to consult with the patient so as to determine the appropriateness of the request. Each repeated request should have a separate consultation.
- Education should be provided to the individual in receipt of codeine-based products, including dosage regime, overdose risk, drug interactions, side effects and safe storage.
- Pharmacists should be alert to the possibility that some patients may request codeine-based medicines for symptoms that are in fact secondary to excess codeine consumption.
- Products containing codeine are a second-line treatment and should only be considered when the likes of paracetamol, aspirin and ibuprofen have not been successful in pain management.

- It is the responsibility of the pharmacist to manage the supply and ensure suitable controls are in place for the management of dispensing codeine-based products.
- If a pharmacist suspects that an individual is abusing or dependent on codeine, she/he is obliged to make a reasonable attempt to facilitate the individual in accessing treatment services.
- Advertising medication containing codeine is prohibited; this includes window displays, in-pharmacy promotions, promotional displays and leaflets and stickers.

### 7.3 Prevention and treatment of drug-related infectious diseases

#### Barriers to and facilitators of hepatitis C care

Hepatitis C infection is common among injecting drug users (IDUs), yet access to hepatitis C care, particularly treatment, is suboptimal. There has been little in-depth study of IDUs' experiences of what enables or prevents them engaging at every level of hepatitis C care, including testing, follow-up, management and treatment processes.

A qualitative study aimed to explore these issues with current and former IDUs in the greater Dublin area (Swan, *et al.* 2010). Between September 2007 and September 2008 in-depth interviews were conducted with 36 service users across a range of primary and secondary care services, including two addiction clinics, a general practice, a community drop-in centre, two hepatology clinics, and an infectious diseases clinic. Interviews were analysed using a grounded theory approach.

Of the 36 participants interviewed, 28 were men and eight were women. They ranged in age from 24 to 54 years, with a median age of 32 years. The median reported age at first injecting drugs was 18.5 years (range 14–29 years). Of the 28 who reported their main problem drug, 79% reported heroin and 21% cocaine. Thirty-three (91%) participants reported testing positive for hepatitis C, of whom four (11%) reported HIV/HCV co-infection.

Among the factors influencing access to and uptake of HCV care were:

- perceptions that every injector had this invisible infection (hepatitis C) and that its effects were not as serious as those of HIV;
- perceptions that the investigations and treatments for hepatitis C were more severe than the infection itself;
- use of coping strategies, such as blocking awareness, escape, support and positive thinking, to deal with fears about the future effects of hepatitis C, or anxieties about investigations or treatment;
- the quality of relationships with health care providers;
- contact with services, encouraging and caring doctors and nurses, family ties, recovery from addiction, and convenient access to testing and treatment; and
- continued substance use, employment (lack of free time), contra-indications to treatment, lack of reminders and lack of opportunity.

In conclusion, IDUs face multiple barriers to HCV care but a range of facilitators were identified that could increase access to and uptake of treatment.

#### Hepatitis C management: the challenge of dropout associated with men and injecting drug use

Lowry and colleagues (Lowry, *et al.* 2011). examined all referrals made to an urban tertiary care liver centre for hepatitis C virus (HCV) management, tracked subsequent progress and identified the dropout rate at the different stages. The authors completed a cross-sectional retrospective review to examine HCV referrals received between 2000 and 2007. The demographic, clinical and treatment data were extracted from medical charts and the hospital information system.

A total of 588 individuals and 742 cases were referred for management of their hepatitis C. Sixty-seven per cent of referrals were men and the average age was 33.3 years. Three

quarters (74%) of cases were injecting drug users; 83% were Irish; and 57% were referred by their general practitioner. Other sources of referral were hospitals, drug treatment centres, prisons and asylum centres. Of the 742 referrals, 141 (19%) failed to attend their initial appointment, 180 (24%) dropped out from early outpatient management, 29 (4%) failed to attend for liver biopsy and 81 (11%) did not attend subsequent outpatient follow-up. In total, 451 (61%) dropouts occurred. In those treated, a sustained viral response rate (successful treatment rate) of 74% was observed. The number and proportion of patients who experienced viral clearance varied with genotype: genotype 1, 18/30 (60%); genotype 2, 4/5 (80%); and genotype 3, 40/49 (82%). Those with a history of injecting drug use were more likely than their non-injecting counterparts to drop out immediately after the referral, drop out from early outpatient management and drop out over entire span of disease management. Men were more likely ( $p < 0.05$ ) to drop out of disease management than women. Eight individuals died during the study period.

The authors reported that an 'exceptionally high rate of dropout exists' among those attending services to monitor and manage hepatitis C in injecting drug users, particularly in the early stages of service delivery. The study findings have led to the development of innovative approaches helping to optimise hepatitis C management in this population, such as texting reminders and using a change model to improve engagement and compliance with behaviour and treatment.

### **Hepatitis C virus in primary care: survey of nurses' attitudes to caring**

This study measured the knowledge of and attitudes towards hepatitis C among 560 nurses working in general practice, public health and addiction, and identified the source of their knowledge (Frazer, *et al.* 2011). The researchers completed a cross-sectional survey in 2006 with the nurses in the three categories of primary care through a postal questionnaire in one region of Ireland. The questionnaire contained five sections: demographic profile, work profile, knowledge, attitudes and education. The questions were validated and pilot tested. The total number of primary care nurses working in the region was 981, and 560 (57%) completed the questionnaire. The response rates varied by type of nursing specialism: general practice, 57% (126); public health, 55% (385); and addiction services, 83% (49). The attitudes of the nurses towards hepatitis C were not presented in the paper.

Almost all (98%) of the nurses were female, and their average age was 43 years. Nurses in the addiction services were younger than those in general practice or in public health services. The nurses' qualifications ranged from certificate (25%) to post-graduate degree (4%). Fifty-five per cent were qualified to diploma or higher diploma level and 15% were qualified to at least degree level. Nurses in the addiction and in the public health services had higher qualifications than those in general practice. Nurses working in the public health service had longer service than those in addiction or general practice. Addiction nurses were more likely to work full time.

Eighteen per cent had a personal friend or relative who had hepatitis C. Thirty-nine per cent of respondents reported having professional contact with people with hepatitis C. As expected, nurses in addiction services had more professional dealings with people with hepatitis C (96%), compared to nurses in public health (30%) or in general practice (44%). According to the authors, 90% of addiction service nurses provided information on the dangers of alcohol, the benefits of hepatitis A and B vaccination, dietary intake and transmission of the virus, while only 30% of nurses in public health provided advice on the dangers of alcohol, and 11% of the same cohort on the benefits of hepatitis vaccination. The advice provided by practice nurses was not reported.

Only 22% of nurses had received formal training on hepatitis C. Not surprisingly, a higher proportion (86%) of nurses working in the addiction services received training on hepatitis C, compared to the proportions working in public health (13%) or general practice (16%). Ninety-six per cent of nurses working in the addiction services reported that they were well informed about hepatitis C, while only 20% of practice nurses and 21% of public health nurses reported the same. The respondents were asked to identify 21 statements about hepatitis C as true or false. Though the nurses working in

addiction services had good knowledge about hepatitis C, there were four statements which 25% or more identified as true when they were false:

Hepatitis C can be spread through close personal contact such as kissing.

Hepatitis C is commonly spread through sexual transmission.

Most people who get hepatitis C will die prematurely because of the infection.

More than 50% of pregnant women with HCV will infect their children.

The level of knowledge among the public health and practice nurses was less than desirable, with 25% of the nurses identifying at least 11 statements as true when they were false. As well as the four listed above, these included:

People with hepatitis C should be restricted from working in the food industry.

Hepatitis C is a mutation of the hepatitis B virus.

There is no pharmaceutical treatment for hepatitis C.

HIV is easier to catch than hepatitis C.

Once you have hepatitis C, you cannot get it again because you are immune.

There is only one genotype of hepatitis C virus.

Hepatitis C is associated with an increased risk of liver cancer.

Twenty-five per cent of the nurses identified as false the following statement which is in fact true: People can have the hepatitis C virus without being currently infected with the virus.

The authors calculated mean knowledge-level scores for each group of nurses; the mean score for addiction nurses was 22.5, for nurses working in public health 16 and for practice nurses 16.9. The overall mean score was 16.7. Nurses were most likely to have better knowledge about hepatitis C if they were younger, educated to degree level or above, had attended a formal training course, personally knew someone with hepatitis C, had professional contact with patients with hepatitis C, or considered that they themselves were well-informed about hepatitis C.

Nurses working in public health services and general practice require formal training in hepatitis C care and management. Nurses in the addiction services need to update their knowledge in four areas.

## **7.4 Responses to other health correlates among drug users**

### **7.4.1 Maternal and neonatal health among opiate users**

Two recent papers present the results of studies on the health of women, who had been prescribed methadone for the treatment of opiate dependence, and their infants born in the Coombe Women and Infants University Hospital in Dublin. The first paper reported that the services of a liaison midwife were required to encourage pregnant women with opiate dependence to attend drug and maternity services regularly, and to liaise between professionals in both services. The second paper reported that the outcomes for mothers prescribed methadone and their new infants were not as good as those for other mothers and infants attending the maternity service. See Chapter 12 below for an account of the key issues addressed in these two papers.

Bluebell Addiction Advisory Group (BAAG) was founded in 2004. The organisation provides programmes such as the Get Active Group (GAP) for women and the Men's Gardening Group. GAP aims to fill the gaps left by addiction, such as boredom, isolation and depression, through a programme of activities designed to tap into hidden talents and build on existing interests.

GAP members took part in a six-week cookery course with chef Yves Tastet and produced a cookbook focusing on nutrition and healthy eating in order to avoid health problems such as depression, low energy levels and liver disease. The cookbook, *Filling a gap at BAAG*, was launched by the Canal Communities Local Drugs Task Force in 2010 (Bluebell Addiction Advisory Group 2010).

Members of the group have visited other task force projects and recreated dishes from the cookbook in an effort to motivate others to make nutrition and health a priority in their recovery. A catering service run by GAP has catered for up to 100 people at events organised by Dublin City Council, Canal Communities Local Drugs Task Force, Rialto Youth Project and the Community Lynks Project.

GAP works in partnership with the Men's Gardening Group to create jobs within the local community. The men's group grows fruit and vegetables which are bought by GAP for their catering business. The groups recently worked together to acquire skills in producing Christmas wreaths and table centre pieces. The groups are currently working together planting fruit trees and will produce jam for community sales in the future.

The group has taken ownership of its activities; members carry out duties and roles, including those of cookbook tour co-ordinator, leaflet and business card design and donations manager. GAP provides summer camps and events for members' children so that the women can continue in their programme during school holiday periods.

#### **New harm reduction booklet**

On 6 May 2010 *Use your head – harm reduction information – legal highs or otherwise* was published (Anna Liffey Drug Project 2011). This booklet provides harm reduction information for individuals using psychoactive drugs – legal highs or otherwise. Issues covered in the booklet include general harm reduction information, useful contact telephone numbers, facts on overdose, the recovery position, rescue breathing and chest compressions. The booklet has been developed in conjunction with Ana Liffey's Peer Support Programme and other stakeholders.

The response to the booklet was positive with over 2,000 pre-publication orders placed by a range of community, voluntary and statutory drug services across Ireland. The booklet is the latest publication from the 'Duck, Dive & Survive' series, which is recognised by the European Commission under the European Action on Drugs Initiative. (Duck, Dive & Survive is an SMS service whereby Ana Liffey can offer real-time information to its clients on reducing the risks associated with drug use and provide essential health and service-related information. (For more on Duck, Dive & Survive, see Chapter 7.3 in Ireland's National Report 2010 (Irish Focal Point 2010)).

## 8. Social Correlates and Social Reintegration

### 8.1 Introduction

The links between social exclusion and drug use in Ireland have been well established (Keane 2007). Problem drug users in treatment tend to be young and male, have low levels of education and are unlikely to be employed. For a small proportion, around 10%, homelessness and insecure accommodation are persistent problems. In recent times there has been a modest increase in the proportion of other nationalities seeking treatment (Reynolds, *et al.* 2008). Research also shows that there are problems with illicit drug use among socially-excluded groups such as sex workers, homeless people and new communities.

The aim of social reintegration is to empower individuals to plan and pursue alternative activities to those they engaged in when using drugs. It achieves this through providing accommodation, education, training and employment opportunities for recovering drug users.

This chapter presents new data on the social correlates of drug use in Ireland, and describes policy and programmes initiated in the past year to support the social reintegration of recovering drug users. The broad policy approach and funding to support social reintegration are briefly outlined in this section.

The **National Drugs Strategy (interim) 2009–2016 (NDS)** (Working Group on drugs rehabilitation 2007) lists as a priority the implementation of the recommendations contained in the report of the Working Group on Drugs Rehabilitation. It proposes that the recommendations be incorporated in a comprehensive integrated national treatment and rehabilitation service, using a four-tier model approach.

The **Homeless Agency** was formally replaced by The Dublin Region Homeless Executive in July 2011. The executive is responsible for providing support and services to the Dublin Joint Homelessness Consultative Forum and the Statutory Management Group. The Housing (Miscellaneous Provisions) Act 2009 provides a statutory structure to address the needs of people who are experiencing homelessness in Ireland. The Act outlines a statutory obligation to have an action plan in place and the formation of a Homelessness Consultative Forum and a Statutory Management Group.

The **Community Employment (CE) scheme**, funded by FÁS, the national training and employment authority, includes 1,000 places ring-fenced for recovering drug users. The scheme operates through local projects primarily in LDTF areas, where community and voluntary groups are required to sign service agreements that outline the work programme and the target outcomes for the individuals placed on the CE schemes. The objective is to prepare participants for entry into the labour force, but the outcomes outlined by most projects tend to refer to personal development, improved literacy skills and education capital, and support progression to more specialised training and education, rather than help the individual to find employment.

Acknowledging the CE scheme for helping recovering drug users to develop their personal and employment skills and find a pathway back to work, the NDS suggests that implementation of the **Individual Learner Plan (ILP)** would help to identify participants' needs and design progression routes towards labour market reintegration. The development of targeted programmes by FÁS is seen as essential and should be an integral part of the national drugs strategy in the future.

### 8.2 Social exclusion and drug use

Social exclusion and drug use remain intertwined and for some marginalised and disadvantaged groups this association remains an intractable problem. Early school-

leaving and homelessness among drug users reporting for treatment shows little change over the period 2005-2010 which suggests that measures to tackle these problems are not having the desired effect. The situation of drug use among socially excluded groups is discussed through examining six marginalised and disadvantaged groups who report to be using various types and amounts of drugs. The research reported, varies in quality and depth and we learn more about some groups than others arising from these methodological variations. Nonetheless, this work provides a useful lens through which to examine the intractable nexus of drug use and social exclusion. Measures to tackle and remedy the association between social exclusion and drug use are provided under the headings of accommodation, education and training and employment.

### 8.2.1 Social exclusion among drug users

The National Drug Treatment Reporting System (NDTRS), which collects data on all people attending drug treatment, is the most reliable database from which to capture information on the socio-demographic profile of drug users in treatment. The database includes information on type of accommodation and education that people report when engaging in drug treatment. Within these categories there is room for people to report if they are homeless or/and have left school early. These are two indicators of social exclusion as they speak of marginalisation (homelessness) and disadvantage (early school leaving). Table 8.2.1.1 provides data on both indicators among drug users attending treatment between 2005 and 2010. Early school leaving among this cohort of drug users has remained fairly steady at around 20%, which may suggest that measures to tackle the association between early school-leaving and drug use are having less than the desired impact. The number of cases reporting to be homeless has not changed significantly which indicates that homelessness remains a problem for a small proportion of drug users in treatment.

**Table 8.2.1.1 Prevalence of social exclusion among all case reporting for drug treatment, 2005-2010**

Social exclusion indicator	2005	2006	2007	2008	2009	2010
	n (%)	n (%)	n (%)	n (%)	n (%)	n (%)
Homeless	217 (4.4)	303 (5.8)	300 (5.2)	382 (6.0)	315 (4.8)	463 (5.2)
Early school leavers	986 (20.2)	1059 (20.2)	1149 (20.0)	1324 (20.9)	1315 (20.2)	1924 (21%)

Source: Unpublished data, NDTRS, 2011

### 8.2.2 Drug use among socially excluded groups

#### Drug use in disadvantaged communities

Saris and O'Reilly (Saris and O'Reilly 2010) undertook an ethnographic study of drug use in a number of locations within the Canal Communities area in Dublin, These locations are characterised by pockets of socio-economic disadvantage and have been designated as areas experiencing high levels of illicit drug use. Data was collected between September 2007 and the end of 2008, with some follow-up work in 2008. The purpose of the study was to improve knowledge and understanding of the changing nature of illicit drug use in the areas.

Data were collected using a variety of ethnographic methods, including informal and in-depth interviews, focus groups, survey questionnaires and extensive field notes. Interviews were conducted with 51 people, 24 life histories were collected and eight group discussions with 29 young people. Return interviews were recorded with six interviewees. Twenty-four interviews were completed with service providers. Survey questionnaires were completed during face-to-face interviews with 92 people attending drug treatment services. Data collection lasted approximately 12 months and it would appear that the researchers spent extensive periods of time in the field throughout the year. The researchers employed a number of tools to improve the quality of this work including periods of reflexive practice and cross-checking data sources.

**Table 8.2.2.1 Lifetime and recent (past 3 months) illicit drug use among people recruited through drug treatment centres in the Canal Communities, Dublin, data collected in 2008**

Drug used	Lifetime use of illicit drug/s (n=92)		Illicit drug use in the past 3 months (n=92)	
	Number	%	Number	%
Heroin	92	100	58	63
Cocaine powder	73	81	20	22
Crack cocaine	55	61	28	30
Cannabis	82	91	55	60
Street tranquillisers	65	72	42	46
Street methadone	47	52	16	17

Source: (Saris and O'Reilly 2010)

Table 8.2.2.1 paints a picture of poly-drug use among the participants in the study and suggests that methadone is merely perceived to be another 'street drug' among many that are used by the participants. According to Saris and O'Reilly, '...most users are ambivalent about both [methadone] and the treatment regime. The majority of users with whom we spoke, for example, do not consider methadone "treatment" as such. Some talk about replacing "one addiction with another" or even more severely, being "a government junkie"....' (p. 19) Seventy-nine per cent of those using crack in the past three months were also using heroin. Not reported in Table 8.2.2.1 is the use of licit drugs among study participants. Ninety-eight per cent had used prescribed methadone and 50% had taken prescribed tranquillisers in the last three months. Fifty-nine per cent of those who had taken prescribed methadone in the last 3 months also reported using heroin during this time.

### **Drug use among women involved in prostitution**

Nelson (Nelson, *et al.* 2010) undertook a feasibility study in Tallaght, Dublin 24, to assess the need for a service to meet the health needs of women working in prostitution in the area. Tallaght is a large suburb in west Dublin with a population of approximately 100,000. The area is characterised by socio-economic disadvantage: high unemployment, low educational attainment levels, high levels of local authority housing and is designated as an area with high levels of drug use. Thirty seven service providers and nine women involved in prostitution were interviewed, 48 women attending a women's health project in Dublin's city centre were surveyed and a focus group with a number of service providers was organised. In addition to the nine women interviewed who reported working in prostitution, service providers provided a profile of 97 other women who were known to be involved in prostitution and either living or working in the Tallaght area. From this estimated number of 106 women working in prostitution, it is claimed that 52 were known drug users, 45 were intravenous (IV) heroin users, and 47 were in treatment with 42 receiving methadone; an estimated 13 of the IV heroin users were also known to use cocaine. The use of crack was small, with only three women believed to be using. Thirty-three of the 106 women were identified as foreign nationals and only one of these women was identified as an IV heroin user.

Interviews with the nine women involved in prostitution revealed that financial pressures and drug use were the key motivators for getting involved in prostitution; all nine women had acquired educational qualifications including vocational training certificates and one woman had a university degree. Information about the 97 women profiled by service providers suggests that at least 35 were parents and the vast majority were living with partners, family or friends or in private rented accommodation. Seven of the women interviewed or profiled reported being homeless. The majority of the women interviewed and profiled worked indoors either for themselves or for an agency.

### **Drug use among the traveller population**

The All Ireland Traveller Health Study (AITHS) (All Ireland Traveller Health Study Team and School of Public Health Physiotherapy and Population Science University College Dublin 2010) included 24 focus groups with members of the traveller community, varying in size between five and 12 people. Twenty-seven semi-structured interviews

were conducted with members of the traveller community and service providers and advocates working with the traveller community.

Addiction and alcohol and drug use were the main health-related concerns expressed by travellers; drug abuse in particular was identified as a growing health threat among male travellers. It was also reported that addiction and drug abuse remain unspoken and hidden within the traveller community, with interviewees expressing shame and denial as factors contributing to the concealment of drug abuse. Some interviewees expressed the view that drug abuse was an act of cultural intrusion from mainstream culture into traveller culture and that this was occurring against a background of cultural shifts from traditional traveller lifestyles towards more mainstream cultural norms.

According to the authors of the report, 'the issues experienced by Travellers in relation to drugs are entwined with issues of inequality and marginalisation. This means that Travellers are more likely to be exposed to the risk factors that lead to problem drug use. It also implies that response mechanisms to address the associated problems need to factor in these issues'. (p. 23)

### **Drug use among the homeless population**

See Section 6.3.2 for a profile of this sample, including physical and mental health.

### **Drug use among early school leavers**

In October 2008 the Joint Oireachtas Committee on Education and Science, assisted by an expert group of researchers and practitioners, examined the problem of early school-leaving in association with individual, home and school characteristics, including structural features of the education system. Early school-leaving was defined as leaving education without having completed the leaving certificate examination or an equivalent. The leaving certificate is the final examination in the Irish secondary school system.

The Oireachtas Committee, assisted by the expert group, reviewed the literature on early school-leaving in Ireland, undertook secondary data analysis on the Programme for International Student Assessment (PISA) dataset, undertook interviews and focus groups with early school-leavers and some family members, and invited written submissions from stakeholders in the area. The report of their work was recently published and a summary of the main findings are provided below (Joint Committee on Education and Skills (2010)). Details of the 41 research participants and data collection methods are listed below:

- Parents of early school leavers: 7 mothers and 2 daughters, focus group
- Young travellers: 6 males and 4 females, gendered focus groups
- Individuals recovering from heroin addiction: 4 male and 1 female, individual interviews
- Young lesbians, gays, bisexuals and transgendered individuals (not all had left school early but were deemed at high-risk due to bullying and absenteeism): 6 male and 3 female, focus group
- Young people with special educational needs: 1 male and 1 female, individual interviews
- Young women who experienced rape or sexual assault: 2 women, interview by phone
- Individuals in prison: 2 males and 2 female, individual interviews

The data were analysed using an inductive approach and constant comparative method. A number of iterative themes were developed. Limitations of the study were that convenience sampling was used and the number of participants was relatively small.

Trauma and addiction is one theme developed in this research. According to the authors, 'almost all of the participants who had experienced addiction, heroin addiction in particular, had also experienced some type of trauma, such as bereavement or

sexual abuse' (p. 204). According to the accounts of the people interviewed, these traumatic experiences were not helped by an indifferent response from their schools, bullying and isolation by their peers, and an incapacity of the family unit to provide adequate help and support. For these interviewees, using drugs became a means of blocking out the experience and the pain and 'fitting in', albeit with what they now called the 'wrong crowd'.

Other issues arising from the data included:

- The transition from primary to post-primary school was a difficult and critical period and some students needed more preparation and support.
- There was criticism of both curriculum and assessment in post-primary schools with a preference for continuous assessment over the examination style approach and also for interactive teaching methods rather than the didactic approach.
- Teachers needed to be trained to identify, understand and respond to issues such as bullying, for example when a student was being bullied because of their sexual orientation.

Data from the Programme for International Student Assessment (PISA) dataset relating to students' early school-leaving intent (data collected in 2006) and reasons for early school-leaving intent (data collected 2003) were analysed. (The data are derived from a representative sample of the general school-going population of 15-year-olds.) According to the report, student early school-leaving intent was strongly associated with being a male student and having lower achievements in reading assessments. Schools with an increasing number of disadvantaged students also experienced an increasing rate of early school-leaving. Students in schools of similar socio-economic composition who had higher levels of home-based educational resources and supports were less likely to intend to leave school early compared to students with lower levels of home-based resources and supports. Socio-economic disadvantage had a greater negative impact on students in urban schools compared to students in rural schools.

### **8.3 Social reintegration**

Social reintegration for drug users remains an aspiration of national drug policy (Department of Community Rural and Gaeltacht Affairs 2009). Action 32 in the NDS calls for the implementation of the recommendations of the report of the working group on drugs rehabilitation (Working Group on drugs rehabilitation 2007). The recommendations contain a number of actions to improve housing, education and training and employment opportunities for people recovering from drug use. It is proposed to undertake action on some of these measures within the context of the new national drugs rehabilitation framework (NDRF) (Doyle and Ivanovic 2010). This framework is currently being piloted in three sites. The new Programme for Government includes a number of proposals to progress some of the recommendations of the working group on drugs rehabilitation. (Fine Gael and the Labour Party 2011) These include:

- expanding rehabilitation services at local level in line with need and subject to available resources,
- assisting drug users in rehabilitation through participation in suitable local community employment schemes, and
- developing compulsory as well as voluntary rehabilitation programmes

#### **8.3.1 Housing**

##### **Applicability of the Housing First model to people with substance misuse issues**

The St Dominic's Housing Association (SDHA) recently commissioned research to examine the applicability of the Housing First model to people with substance misuse issues, and to identify best practice in relation to supports needed to ensure tenancy sustainment for this vulnerable group (Brooke 2011). The defining feature of the

Housing First approach is its focus on assisting homeless people to move into permanent accommodation and providing appropriate support services to sustain them in their tenancy. In contrast to traditional approaches, the Housing First model does not require people to be abstinent from substance use prior to securing accommodation. The research project included a review of a selection of studies, and consultations were undertaken with nine organisations and twelve service users in Ireland. In the final report, the author concurred with the general consensus emerging from the literature that stable accommodation is an important factor in encouraging people to engage with treatment services and in achieving stability and abstinence. The report highlights a number of issues, which are summarised below.

- A number of practical issues need to be considered when placing people with substance addictions in permanent housing. These issues were raised during consultations with stakeholders and were identified in a number of reports from the UK which address this topic.
- A number of additional issues need to be considered before potential tenants move into their new home, such as choice of location, the challenge of avoiding unwanted guests, and sensitivity to perceptions of neighbours.
- There needs to be a clear understanding of the role of landlord and the visiting support team and good lines of communication between the two. This approach can ensure that any emerging issues around rent arrears or anti-social behaviour can be dealt with in a timely and professional manner.
- According to the author, in Ireland the housing-related supports for Housing First tenants could be provided by the Support to Live Independently (SLI) scheme delivered by Dublin Simon Community.
- Loneliness and isolation were identified as major problems experienced by people who misuse substances. According to the author, these people, who are mainly young single men, may find themselves living in an unfamiliar area, perhaps living alone for the first time, and at the same time cut off by choice from previous friends.
- Interviews with stakeholders revealed the importance of meaningful activity during the day for service users who are housed. Participation in Community Employment programmes and pursuing educational and recreational activities were mentioned by service users as appropriate activities; the service users also talked about the onset of boredom and potential relapse when their day lacked meaningful activity.
- The importance of family and social contacts were mentioned by stakeholders; equally, it was said that, in some cases, family contact would not be a realistic option in the medium or long term.

The report contains a number of extracts from interviews with individual substance misusers. The general theme running through these accounts is that not all substance users will benefit from the Housing First approach. Interviewees spoke about the difficulties involved in managing the responsibility of paying bills and running a home while actively using drugs. They recalled both personal and anecdotal experiences of returning to the hostel or the street when the responsibility of maintaining their tenancy became compromised by substance use. A number of interviewees spoke about the problems of maintaining their tenancy while on crack cocaine. These accounts illustrate the need for effective floating support when people who misuse substances are placed in Housing First programmes. They require support with budgeting, cooking and other domestic chores and encouragement to engage with treatment. Brooke concludes: 'Although Housing First is largely untested in Ireland, and ... the specific case of people with substance misuse problems is less well researched than other groups, there is widespread belief among stakeholders in Ireland ... that provided it is done properly, the Housing First approach can be successful for people with substance misuse problems.' (p. 20)

### **Piloting the Housing First approach in Ireland**

The Dublin Housing First Demonstration Project, in line with the Homeless Agency Partnership Vision to end the need to sleep rough on the streets, seeks to end the need to sleep rough. The project has prioritised an identified number of entrenched

rough sleepers with significant support requirements including addiction. The project has used the following criteria.

Each person will have:

- remained rough sleeping over a number of years,
- a broad range of significant support needs (this varies from person to person, and may include physical, behavioural, personal care and hygiene, mental health, drug use, alcohol use, etc ),
- refused a range of accommodation offers, and not engaged effectively with available support services.

Current levels and methods of service provision have not proved effective in responding to the support needs of these individuals.

The Dublin Housing First Demonstration Project will provide self-contained, independent, scattered, community-based housing units for each participant, affording them rights equal to any tenant renting privately. There will not be any staff employed on-site. Support will be provided through home visits by the Housing First (HF) team, which is an intensive case management team.

Initial housing units have been provided by Stepping Stone Ltd. A number of housing units will be available every three months, and 20 units in total will be available during the first 12 months of this demonstration project. This will allow a rolling entry into the project and phased increase in the caseload of the team.

The project is client-led: participants choose to take part in the project, choose their housing unit as far as possible, identify their own goals, and the HF team works with the person to achieve their goals. In this way, the project aims to promote participants' autonomy, independence, and to support them in settling into their home and integrating into their community. Participants will be invited to participate in Housing First, and when they choose to do so, they will choose from a number of housing units. They will be supported to:

- prepare for the move-in,
- actually move-in and have furniture, soft furnishings and groceries provided for the move-in,
- access relevant benefits and entitlements,
- review their support needs, and establish goals,
- access the services of the HF team,
- access relevant services not represented on the HF team directly, and
- maintain their housing and integrate into their community.

A three-year longitudinal evaluation of the project is being conducted by Dr Ronni Greenwood, UL/ Pathways New York. This evaluation will produce an initial report reviewing the first 12 months of the project. It is envisaged that this report and the overarching evaluation will make recommendations regarding the potential application of this model in the Dublin region and nationally. Participants will continue to be supported, even if they cannot sustain the tenancy (personal communication, Elaine Butler, Homeless Agency, 2011).

### **Accommodation services for homeless drug users**

Focus Ireland is an independent charity that works to improve the lives of homeless people through a programme of prevention, support, housing, advocacy, research and communication. Their latest annual report describes the services they provide for homeless drug users and gives some indication of the numbers that benefit from using these services (Focus Ireland 2011). These services are noted below.

The Step-Down Programme is a residential facility for people who have completed a drug rehabilitation programme and require support in learning to manage a home of their own. Focus Ireland works in partnership with Keltai Residential Therapeutic Facility, the HSE's Rehabilitation Integration Service (RIS), Coolmine Therapeutic

Community, and Aislinn in delivering the service. In 2010, the service worked with 20 customers, supporting nine in accessing private rented accommodation and one in accessing local authority housing.

The Caretakers Hostel and Case Management Service is a partnership project between Focus Ireland and the Society of St Vincent de Paul. The project works with hard-to-reach young people aged between 16 and 21 who are sleeping rough and actively using drugs. The service provides a safe place to sleep, hot meals and basic facilities such as shower and washing. The project also provides a case management and liaison service with one-to-one support for young people, to help them access drug treatment services and education and/or training and alternative accommodation by advocating on their behalf. In 2010, the service worked with 46 young people.

Aylward Green Supported Temporary Accommodation for Families is now the only service of its kind in Dublin, providing emergency accommodation for families who are homeless and have complex needs. In addition to providing temporary accommodation, the service provides intensive support in response to a variety of needs, including drug and alcohol addiction, relationship difficulties, anger management, and mental and physical health issues. In 2010, the service provided accommodation for 24 families.

### **8.3.2 Education, training**

Education and training are provided to people in recovery from drug addiction through a number of projects. Some projects (exact number unknown) use the FÁS model to provide this service. The FÁS model works through the Community Employment Scheme, which has dedicated at least 1,000 places to drug users in recovery so that they can return to education and training. The activities undertaken by people in recovery when they engage with projects include personal development, relapse prevention, literacy and numeracy skills and varied types of vocational training such as computer skills. There has been no recent evaluation of this programme and reporting on its activities is not an exercise undertaken on a regular basis. However, recent estimates suggest that around 850 of the 1,000 dedicated places for people in recovery are actually taken up and used with the majority of places being used by females in recovery (Eamon Carey, personal communication, FÁS, 2011).

In contrast to the FÁS model, a number of other programmes working with people in recovery adopt a more individualised type of approach. For example, Soilse uses an adult education model, based on the experiential learning approach promoted by Paulo Freire. This approach situates the learning experience of the individual in their real-life experience both past and present and encourages deep reflection on the issues that contributed to their addiction and which in many cases constrained their life-chances. The approach is broad and flexible and encourages the uptake of new interests and skills, components that are seen as central to maintaining recovery.

The success of this programme was publicly acknowledged in October 2010, when 96 Soilse participants celebrated their achievements in adult education when receiving Further Education and Training Awards Council (FETAC) qualifications. From the perspective of Soilse, FETAC qualifications are an important step in progressing to further education and training. Six participants also received certificates for completing the Soilse–NUI Maynooth Return to Learning (RTL) course, which has been designed and implemented by Soilse. The RTL course was designed to meet the needs of participants who were in full-time education and who were having difficulty dealing with the demands of academic life and college culture. Soilse places great importance on the value of adult education as a vehicle of personal empowerment and social reintegration. It has developed strong links with adult education providers in Dublin and many of its past and current participants have gone on to study at University College Dublin (UCD), Trinity College and National University of Ireland (NUI) Maynooth.

Research due to be published in the last quarter of 2011 will demonstrate how education can contribute to the development of recovery capital (Keane and McAleenan In press) Recovery capital is a concept developed by (Cloud and Granfield 2009) and refers to the sum of social, physical, human and cultural capital that is necessary to initiate and sustain recovery from addiction. The research, based on in-depth interviews with 20 people from the Soilse programme who were in recovery from opiate addiction and who had returned to third-level education, will show that education can play a role in developing the four dimensions of recovery capital by improving:

- social capital by opening up opportunities to develop new networks of friends,
- physical capital by increasing job opportunities which can improve living standards and conditions,
- cultural capital by exposing people to new values, beliefs and attitudes, and
- human capital by empowering people to look after their health, develop achievable goals and helping with the day-to-day problem solving that is part of the process of addiction recovery.

### 8.3.3 Employment

Ready for Work (RFW) is a supported employment programme which aims to help people affected by homelessness to move towards independent living by gaining and sustaining employment. The programme has been operating in Ireland since 2002 and since its inception has worked with over 300 people affected by homelessness and 57 corporate businesses who have provided work placements for clients of the programme.

The programme provides pre-employment training to clients to build confidence and communication skills, manage change, prepare their curriculum vitae and undertake mock interviews. In a recent evaluation of the programme, the vast majority of candidates rated the training very highly. (Business in the Community Ireland 2011) The programme also works with participants to match their skills and interests to the work placements being offered by participating businesses. The work placement has four components to support the participant:

- A volunteer from the business acts as a 'buddy' to the participant during their placement to help them fit in and gain maximum benefit from their experience. The RFW team also provides support during the placement.
- The participant can work part-time to allow for childcare responsibilities, medical appointments etc and to build a routine gradually.
- The participant can choose to work only Monday–Friday, when the RFW team is available to provide support if needed.
- The participant can choose to work unwaged to prevent interruption to social welfare payments.

**Table 8.3.3.1 Number of participants, and range of RFW activities, 2002–2011**

<b>Programme activity</b>	<b>Number of participants</b>
Started pre-employment training	315
Completed pre-employment training	293
Started work placement	286
Completed work placement	233
Started employment	124
Started further training and education	63
Started volunteering	10

Source: (Business in the Community Ireland 2011)

The programme is run four times per year and feedback from participants that took part in the recent episode of the programme suggests that the work placement is an enriching and rewarding experience. Participants reported an improvement in self-confidence and commitment to employment; they felt welcomed by other employees; they were supported by their 'buddy' and they gained new skills. Some reported difficulty getting back into a routine (Business in the Community Ireland 2011) Table

8.3.3.2 provides a profile of activities and numbers engaging during the recent episode of the programme.

**Table 8.3.3.2 Number of participants engaged in RFW activities during last quarter of 2010**

<b>Programme activity</b>	<b>Number of participants</b>
Started pre-employment training	15
Completed pre-employment training	14
Started work placement	15
Completed work placement	11

Source: (Business in the Community Ireland 2011)

## 9. Drug-related crime, prevention of drug-related crime and prison

### 9.1 Introduction

This chapter presents the most recent statistical data on drug-related crime in Ireland. It also describes policies and programmes initiated in the past year to prevent drug-related crime both in the community and in prisons as well as research studies on drug-related crime, prevention and prison. In this section the data sources and types of drug-related crimes in Ireland are described, and the approaches to preventing drug-related crime, both in the community and in prisons, are also briefly outlined.

Since 2006 reporting crime statistics has been the responsibility of the Central Statistics Office (CSO). The CSO data are derived from the Garda Síochána computerised PULSE system (Police Using Leading Systems Effectively).

The vast majority of drug offences reported come under one of three sections in the Misuse of Drugs Act (MDA) 1977: section 3 – possession of any controlled drug without due authorisation (simple possession); section 15 – possession of a controlled drug for the purpose of unlawful sale or supply (possession for sale or supply); and section 21 – obstructing the lawful exercise of a power conferred by the Act (obstruction). Other MDA offences regularly recorded relate to the importation of drugs (section 5), cultivation of cannabis plants (section 17) and the use of forged prescriptions (section 18).

Driving under the influence of drugs (DUID) has been a statutory offence in Ireland since the introduction of the 1961 Road Traffic Act. The principal legislation in this area is contained in the Road Traffic Acts 1961 to 2002. Section 10 of the Road Traffic Act 1994 prohibits driving in a public place while a person is under the influence of an intoxicant to such an extent as to be incapable of having proper control of the vehicle. Intoxicants are defined as alcohol or drugs and any combination of drugs or of drugs and alcohol. Although penalties for driving under the influence of alcohol are graded according to the concentration of alcohol detected, the law does not set prohibited concentrations for drugs. Neither does it distinguish between legal and illegal drugs. Tests to identify the level of impairment can only take place where there is a reasonable suspicion that an offence is being committed.

In reading the tables in this chapter, please note that **‘relevant proceedings’** refer to the legal proceedings, such as prosecution, taken in relation to an offence as it was originally recorded in the PULSE system. **‘Proceedings’** is a list of charges and proceedings which do not necessarily relate to an offence as originally recorded in the PULSE system.

Over and above the ‘inherent’ drug crimes, that is crimes under the Misuse of Drugs Acts or the Road Traffic Acts, ‘non-inherent’ drug crimes are also recorded in Ireland, for example acquisitive crime to pay for drugs, crimes of intimidation and violence inflicted by drug gangs, money laundering, smuggling or other finance-related crimes, or public nuisance. However, they are not reported in this chapter as it is not possible to separate those associated with the operation of the illicit drug market from those not associated with illicit drugs.

Crime prevention in Ireland proceeds on several fronts. Tackling community disadvantage is one important approach. Disadvantage in communities is recognised as a risk factor in contributing to, among other things, the spread of drug-related crime. A wide range of national initiatives exist to tackle disadvantage and its consequences, including community and local development programmes, the RAPID and CLAR programmes, and targeted urban regeneration projects. These initiatives all contain components relating specifically to illicit drugs. Specifically in relation to the drug problem, in 1998 local drugs task forces (LDTFs) were established in areas identified

as having the highest concentrations of drug misuse; without exception, these areas were all also experiencing high levels of disadvantage. The purpose of the LDTFs is to co-ordinate local action plans in relation to curbing local supply as well as treatment, rehabilitation, education and prevention. A central feature of the LDTFs is that as well as co-ordinating the provision of services locally, they also allow local communities and voluntary organisations to participate in the planning, design and delivery of services.

Diversion is another important means of seeking to prevent crime including drug-related crime – both before, and after, a crime has been committed. Garda Youth Diversion Projects are local community activities which work with children. These projects aim to help children move away from behaving in a way that might get them or their friends into trouble with the law. In 2005 the Irish Youth Justice Service (IYJS) was established to develop a co-ordinated partnership approach among agencies working in the youth justice system, to improve service delivery in the system through diversion, restorative justice, rehabilitation and detention as a last resort. Garda (Irish police force) statistics show that the types of offence committed by children under the age of 18 years are primarily theft, alcohol-related offences, criminal damage, assault, traffic offences, drugs possession, public order offences and burglary. The Garda Juvenile Diversion Programme is used to deal with children under 18 years of age who have committed offences, including alcohol-related and drug possession offences. This programme exists across the country and is included as part of the Children Act 2001. First established on a pilot basis in 2001 the Drug Treatment Court is a specialised District Court which offers long-term court-monitored treatment, including career and education support, to offenders with drug addictions as an alternative to a prison sentence. The idea is that by dealing with the addiction, the need to offend is no longer present.

Finally, individuals and communities are encouraged to participate in helping to prevent and/or detect crime. For example, the Customs Drugs Watch Programme, first launched in 1994, encourages those living in coastal communities, maritime personnel and people living near airfields to report unusual occurrences to Customs. Under the Garda Síochána Act 2005, Joint Policing Committees (JPCs) have been established in local authority areas to bring together public representatives, representatives of local authorities, the Garda Síochána and representatives of the voluntary and community sectors to assess levels of crime and anti-social behaviour, including that related to alcohol use and illicit drug use, and to make recommendations as to how to prevent and address such problems. The JPCs are empowered to establish local policing fora (LPF), to deal specifically with drugs and associated issues such as estate management and anti-social behaviour. In September 2008 a Dial-to-Stop Dealing campaign was launched and operates nationwide; individuals and communities affected by drug dealing are urged to pass information by dialling a confidential number.

The presence of drugs in prisons led the Irish Prison Service (IPS) to develop a policy based on three underlying principles (Irish Prison Service 2006b):

- the presence of drugs in prison will not be tolerated;
- prisoners will be encouraged and supported to develop a responsible attitude to drugs, both while in prison and following release, through a range of measures including education and counselling; and
- prisoners who are addicted to drugs or have other medical problems caused by the misuse of drugs will be offered every reasonable care and assistance.

In the accompanying strategy the IPS lists two aims in relation to illicit drugs in prisons: (1) to eliminate the supply of drugs into prisons, and (2) to provide prisoners with a range of opportunities which encourage them to adopt a drug-free lifestyle, before and after release, thereby reducing demand for drugs.

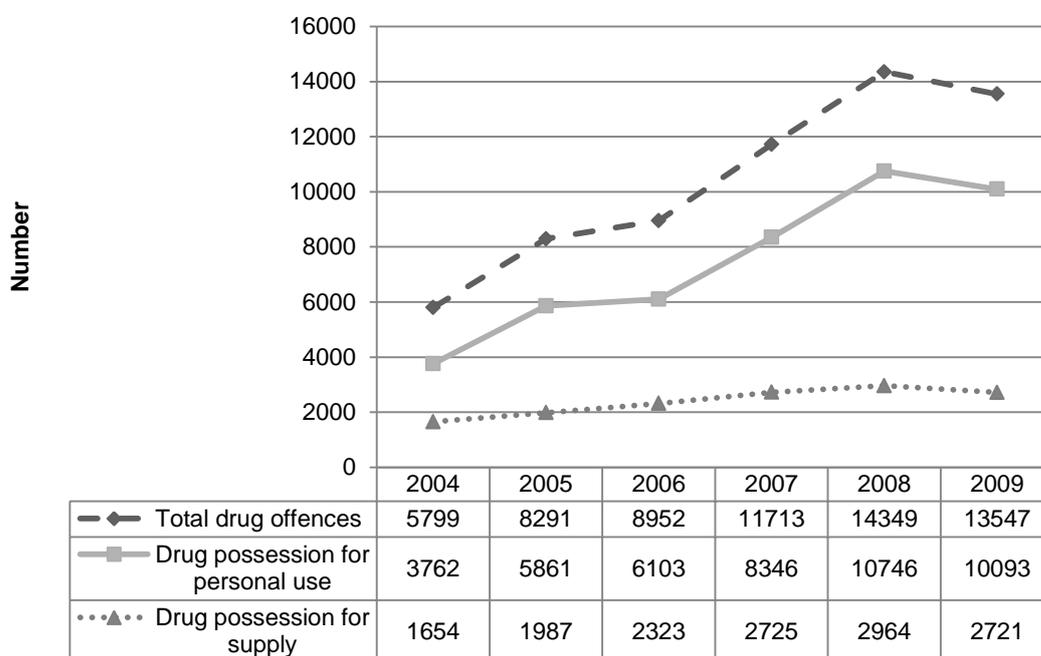
The Probation Service works in partnership with communities, local services and voluntary organisations to reduce offending and to make communities safer. It funds

and supports organisations and projects providing drug treatment to offenders, as well as other important services such as employment placement, accommodation, education and training, restorative justice initiatives. Probation Service staff in the community and in prisons may refer clients to these community-based projects, to enhance their re-integration and resettlement as positive, contributing members of their communities.

## 9.2 Drug-related crime

### 9.2.1 Drug law offenses

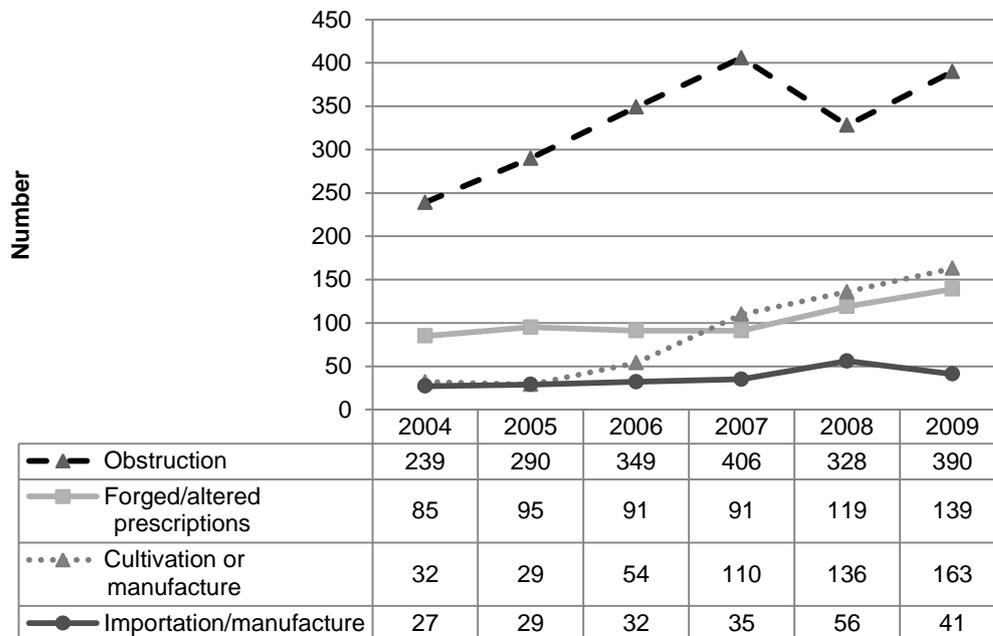
Figures 9.2.1.1 and 9.2.2.2 show trends in proceedings for drug offences from 2004 to 2009 (See Standard Table 11). As can be seen from Figure 9.2.1.1, criminal proceedings for the possession of drugs for personal use (simple possession) decreased in 2009 for the first time since 2004. Possession offences accounted for 74.5 % of total drug offences (n = 13,547) in 2009. Proceedings for drug supply also decreased marginally, from 2,964 in 2008 to 2,721 in 2009, returning to the same level as 2007.



**Figure 9.2.1.1 Trends in relevant legal proceedings for total drug offences, drug possession for personal use and for supply, 2004–2009**

Source: CSO (Central Statistics Office 2009) (Central Statistics Office 2011)

Figure 9.2.2.2 shows trends in legal proceedings for a selection of other drug offences between 2004 and 2009.



**Figure 9.2.1.2 Trends in relevant legal proceedings for selected drug offences, 2004–2009**  
 Source: CSO (Central Statistics Office 2009) (Central Statistics Office 2011)

The offence of obstructing the lawful exercise of a power conferred by the Misuse of Drugs Act, 1977 (s21) continues to be the largest category. Following a decline in 2008, proceedings for such offences increased in 2009, as did cultivation offences and forged prescription offences. Importation offences decreased marginally in 2009. Obstruction offences often involve an alleged offender resisting a drug search or an arrest or attempting to dispose of drugs to evade detection. Proceedings for the cultivation or manufacture of drugs have continued to increase since 2005. In 2005 there were 29 proceedings for such offences. In 2009, the number of proceedings for drug cultivation/manufacture had risen to 163 offences. It is unclear whether this increase reflects a genuine growth in the commission of such offences or whether it reflects a sustained concentration of law enforcement on detecting such offences.

### Courts Service Annual Report 2010

The Courts Service Annual Report for 2010 provides statistics on the outcomes of prosecutions for drug offences between January and December 2010 (Courts Service 2011). Table 9.2.1.1 shows the outcomes of trials for 16,939 drug offence cases prosecuted in the District Court, the lowest court in the system where most drug offences are dealt with. The most common outcome was for cases to be struck out (22.6%, n=3,834), followed by fines (19.2%, n=3,249). Almost 10% (1,588) of cases resulted in a prison sentence.

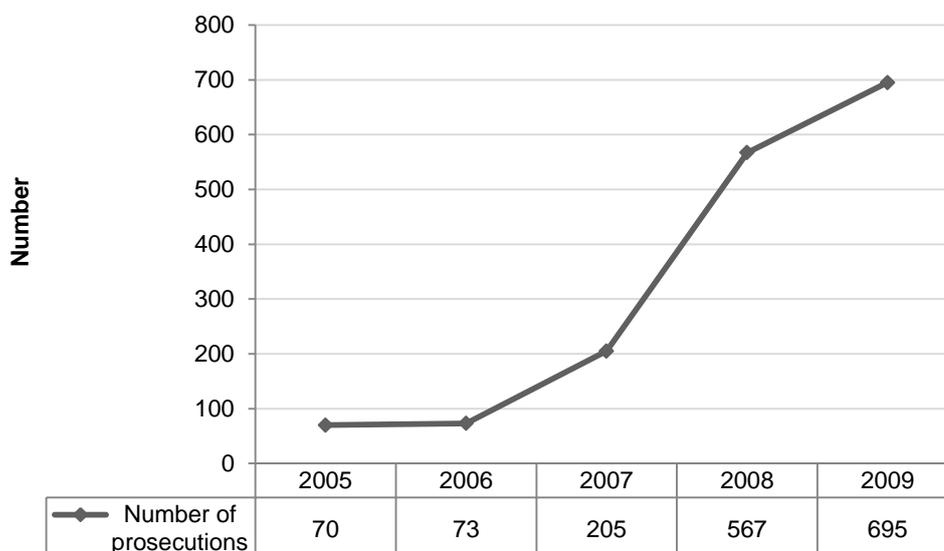
**Table 9.2.1.1 Sentences for drug offences in the District Court, 2010**

Sentences	Imprisonment	Fines	Community service/probation	Struck out	Dismiss	Taken into consideration*	Other	Peace bond	Total
Number of offences	1588	3249	2107	3834	310	2460	2997	394	16939

\* Taken into consideration: The Criminal Justice Act, 1951, s8, provides that where a person, on being convicted of an offence, admits him - or herself guilty of any other offence and asks to have it taken into consideration in awarding punishment, the Court may take it into consideration accordingly. If the Court takes an offence into consideration, a note of that fact is made and filed with the record of the sentence, and the accused cannot be prosecuted for that offence, unless her/ his conviction is reversed on appeal.

The Courts Service reports that 1,186 drug offences were tried in the Circuit Court, which has a higher jurisdiction than the District Court and can thus impose a more severe sentence. Of these prosecutions, 767 led to guilty pleas. Of the 46 cases which went to trial, 14 resulted in convictions, 14 in acquittals and 18 in a *nolle prosequi*, where the prosecution enters a stay on criminal proceedings. The data provided does not specify the precise sentence imposed in relation to the 14 convictions.

## Drug driving offences



**Figure 9.2.1.3 Trend in relevant legal proceedings for driving in charge of a vehicle while under the influence of drugs, 2005–2009**

Source: (Central Statistics Office 2011)

Figure 9.2.1.3 shows the trend in prosecutions for driving under the influence of drugs (DUID) between 2005 and 2009. Between 2005 and 2009 the number of prosecutions for DUID increased from 70 to 695, an increase of more than 900%. It is unclear why this increase has occurred. It could either be due to an increase in the incidence of DUID or the more likely possibility that there has been an increase in targeted police activity in this area.

## 9.2.2 Other drug-related crime

### Drug-related violence and intimidation

CityWide Drugs Crisis Campaign hosted a conference in May 2011 addressing the issue of drug-related crime and intimidation. Over 80 people attended the half-day event in Dublin's north inner city. The conference followed an event in October 2010 at which CityWide hosted a meeting titled: 'A community drug problem: defining the problem – defending the responses', where the issue of intimidation emerged as a central issue for many communities throughout Dublin (Connolly 2011).

In 2009 the Family Support Network (FSN), which was established in 2000 to support the development of family drug support groups throughout Ireland, published the findings of research into the issue of intimidation of the families of drug users by those involved in drug dealing (O'Leary 2009). Through its work, the FSN became aware of a large number of families experiencing intimidation as a result of a family member's drug-related debts. The intimidation of drug users and their families has also been highlighted as a key issue in the National Drugs Strategy 2009–2016 (NDS) (Department of Community Rural and Gaeltacht Affairs 2009). Action 5 of the NDS aims 'To develop a framework to provide an appropriate response to the issue of drug related intimidation in the community.'

The CityWide conference began with four short presentations. Detective Superintendent Michael O'Sullivan of the Garda National Drugs Unit reported on a pilot project in the Dublin Metropolitan Region. Established in March 2011 for a six-month trial period, the pilot works closely with the Family Support Network, and is designed to provide families and the wider community with a point of contact with the Garda Síochána. The project is to be reviewed at the end of August and, following feedback from stakeholders, is to be rolled out nationally. Graham Ryall, a community activist in the Canal Communities in Dublin's south inner city, set the current issues against the historical backdrop of the 1980s and 1990s when anti-drugs groups such as the Concerned Parents Against Drugs (CPAD) emerged throughout the city to tackle drug

dealing. In recent years, a partnership approach in Dolphin Housing complex in the south inner city involving the gardaí and local residents managed to put an end temporarily to open drug dealing. However, the economic downturn and the 'shelving of plans' to regenerate Dolphin House has, according to Ryall, 'had a major negative impact on the community'.

The third speaker, Audra Cotter of the Clonmel Community Based Drugs Initiative in Tipperary, reported on an inter-agency initiative which has been positively evaluated and which is currently being rolled out across the south east region. Prior to this initiative, families who needed advice or direction from the gardaí were reluctant to attend the local Garda station for a number of reasons, including the lack of consistency in the Garda personnel they would encounter. Now, families can meet specific gardaí from the Community Policing Unit in venues in which they feel safe and comfortable. Johnny Connolly of the HRB highlighted the limited knowledge base in this area and the general failure of research and other information sources historically to properly reflect the local impact of drug-related crime and intimidation on the individuals, families and communities most affected. He cited a recent Limerick study to illustrate the way in which gangs can employ a variety of strategies, from serious violence to verbal abuse and vandalism by young children, to instil fear and impose territorial control on communities (Hourigan 2011). In terms of building sustainable responses, the potential of community-based mediation and the further enhancement of JPCs were highlighted.

The final part of the conference was dedicated to workshops where participants addressed the following three questions:

- What is the level of intimidation in your community?
- How has your community responded to the issue of intimidation so far?
- What actions need to be taken?

The level and types of intimidation reported ranged from graffiti and low-level harassment directed at vulnerable people to the killing of family pets, beatings, stabbings, hostage taking, the petrol bombing of people's homes, threats of and actual sexual violence, shootings and murder. Threats of violence come from money lenders as well as from drug dealers. Gang members were known to wait outside post offices and dole offices to collect money from dependent drug users. Individuals also reported being forced to smuggle drugs into prison as part payment of a drug debt. Although many people turned to credit unions to pay drug debts, it was reported that many credit unions are now refusing to provide loans in such circumstances.

Single mothers living alone were particularly vulnerable; having to store or smuggle drugs as payment for a child's drug debt contributed to high stress levels, leading to illness and depression. In such circumstances, the growing dependency of such people on prescription drugs exposes an ironic connection between illicit and licit drug markets. A rise in suicides by those in debt was also reported, although the debt does not die with the person. Another ominous development was the disruption of local drug projects, either through graffiti or with gang members loitering outside projects to intimidate drug workers and clients. Outreach and healthcare workers reported being unable to enter certain areas because of control exerted by individuals or gangs.

With regard to community responses, all areas as represented by those in attendance at the conference reported a reluctance to report incidents to the gardaí owing to fear of reprisals. One immediate consequence of this is that the true levels of intimidation are not officially recorded anywhere. Where people did make formal complaints, it was felt that a promise of full Garda protection was not forthcoming. Community policing fora, where they existed, did help to build trust between the Garda Síochána and the local community. Also, an increase in Garda presence on the ground was reported as having a positive effect, although it could not be sustained over the long term. Similarly, CCTV had limited or no impact, as footage captured on cameras was reportedly not

regularly monitored. Where it was monitored, the intimidatory activity appeared simply to be moved elsewhere.

A recurring theme related to drug-related intimidation within the Traveller community. The close-knit and isolated nature of the community meant that issues were seldom if ever reported to the gardaí. Where Travellers did report to the gardaí, other minor issues such as road tax were sometimes raised with the complainant, leaving them reluctant to engage further with the gardaí.

Services also face difficulties working with young people who are themselves involved in intimidating others, as some will arrive in to services in bullet-proof vests and carrying guns. On the other hand, a great deal of positive youth work was reported at the conference, including efforts to encourage problematic youth into facilities and exploring perceptions of crime among young people. Another initiative involved young people working with senior citizens, teaching them how to use computers, for example. A local area partnership initiative involved attempts to promote a positive sense of community in response to anti-social behaviour. Despite these positive examples, in general, most delegates at the conference reported a sense of frustration at the absence of effective responses to the serious issues being confronted.

With regard to possible future approaches, a range of ideas were discussed, including:

- More secure ways of reporting problems and more protection for those reporting.
- A 'Dial to Stop Intimidation' service, to be promoted as a community-based campaign, taking the emphasis away from Garda involvement so as not to deter people from making calls. Community workers could also assist service users to make reports using this mechanism.
- An evidence base of incidences of intimidation, initially to be compiled informally at local level.
- More resources into early interventions and youth development work.
- JPCs be made more effective and accountable.
- The court system to fast track intimidation charges and to ensure that evidence can be given safely.
- Community-based mediation, and community representatives to mediate safety issues with drug dealers.
- A national conference/national day on intimidation to highlight the issue and create unity among communities.

It was agreed that the Citywide Drugs Crisis Campaign would facilitate the establishment of an Intimidation Working Group comprising specialists from various agencies and representatives from the community and voluntary sector (Citywide 2011).

### **Drug markets study - the impact of drug dealing and drug markets on local communities**

The first comprehensive study of Irish illicit drug markets is due to be published in late 2011 (Connolly and Donovan In press). See Chapter 10 for a full account of this study. The following findings relate to the impact of drug dealing and drug markets on local communities.

The study incorporated a street survey of approximately 800 residents in the four locations where the study took place. The majority of respondents surveyed in all four sites considered illegal drugs to be a big problem in their area, ranging from 67% of respondents in site C to 90% of respondents in site A. However, residents' direct exposure to drug problems, whether through witnessing drug-using behaviour or seeing discarded syringes in their neighbourhoods, differed across the four sites. In site A, of the 60% of respondents who had directly observed drug use in their area, 89% had observed people smoking drugs and almost 50% had seen discarded

syringes in their neighbourhood. In site B, 31% of respondents had directly observed drug use, 75% had seen people smoking drugs and 22% had seen discarded needles in the 12 months prior to the study. In site C, again, 31% of respondents had directly observed drug use. Of these, 90% had seen people smoking, but just 9% had seen discarded needles. In site D, which, like site A, had a deeply embedded and thriving open drug market, 55% of respondents had directly observed drug use, almost 90% had witnessed people smoking drugs, and 50% had seen discarded needles in their neighbourhoods.

Open drug markets impacted on local communities by curtailing residents' freedom of movement. In site A, almost two thirds of respondents avoided certain areas at certain times, primarily because of people hanging around in groups taking drugs. Sixteen per cent cited open drug dealing as a concern. Over half of respondents in site B avoided certain areas at certain times, mostly because of people taking drugs and consuming alcohol. In site C, 40% of respondents avoided certain areas at certain times, owing primarily to people hanging around in groups. Of the 41 respondents who gave reasons for their avoidance of certain areas, 10 specifically cited the incidence of people hanging around taking drugs. In site D almost half of respondents avoided certain areas at certain times, with 44% of those doing so because of people hanging around taking drugs. This loss of communal space can contribute to a further deterioration in community quality of life. Irish and international research has shown that the detachment of ordinary residents from the place in which they spend their daily lives can create a sense of disempowerment, which further undermines attempts to address this decline in the quality of life in a community. The literature also shows that this cycle of alienation and decline can operate as a catalyst for progressive criminal behaviour, thereby intensifying the grip of local drug markets.

### **9.3 Prevention of drug-related crime**

#### **9.3.1 Drugs and driving**

The new programme for government, *Government for National Recovery 2011–2016* (Fine Gael and the Labour Party 2011) contains a number of actions related to criminal justice and drugs policy, including the following:

*We will introduce roadside drug testing programmes to combat the problem of driving under the influence of drugs.*

The development of reliable roadside testing procedure has been a challenging issue for many countries. At present the Garda Síochána, the Department of Transport and the Medical Bureau of Road Safety are collaborating in the development of a scheme to introduce US-style roadside tests on suspected drug drivers to accompany roadside alcohol tests.

### **9.4 Interventions in the criminal justice system**

#### **Dial-to-stop drug dealing**

In response to a Parliamentary Question, the Minister of State at the Department of Health with responsibility for Primary Care, , Roisín Shortall TD, stated with regard to the dial-to-stop drug dealing campaign (see Ireland National Report 2010 (Irish Focal Point 2010), section 9.4.2, for an overview of this campaign):

The campaign was re-launched in October 2010 with a two week national promotional campaign, followed by local campaigns at Drugs Task Force level. Since 2008, over €689,000 has been allocated to this campaign. The phone line has resulted in over 9,800 calls received and 2,800 reports made to the Gardaí. An evaluation of the 2010 campaign has been completed and is currently under consideration. The evaluation will inform the future approach to the initiative (Shortall 2011, 31 May-b).

#### 9.4.1 Alternatives to prison

##### **Drug Treatment Court (DTC) expanding**

In May 2010 the Minister for Justice, Equality and Law Reform, Dermot Ahern TD, published a review by his department of the DTC, which had been operating in Dublin since 2001 (Department of Justice Equality and Law Reform 2010c).

Highlighting the low number of participants entering and successfully completing the DTC programme, the review made several recommendations designed to improve the court's operational effectiveness and overall success rate (Connolly 2010). It was decided that, having implemented the recommendations, the DTC should continue its operations for a further two years.

Although the review found that only 14% of programme participants had graduated from the programme since its establishment, participation in the programme was seen to have had a positive effect on behaviour. Although many participants took several years to progress through the initial phases of the programme, the focused attention and support they received during this period had 'a positive effect on their offending behaviour, as well as on their health and personal relationships', even if they ultimately failed to complete the programme. Writing in the March 2011 issue of *Courts Service News*, Tom Ward, chief clerk of the Dublin Metropolitan District Court, reports on how the programme has been adapted to address this issue:

The principal achievement over the past year has been the agreement of a new strength's (sic) based approach to determining the progress of participants... . Under the new system, participants continue to be tested as part of their treatment with progress measured over the period of participation. A greater weighting is ascribed to positive behaviours, such as not coming to unfavourable notice of the Gardaí. Participants receive credits for attending the in-house support group which is based on the '12 steps' approach to managing addictions. Interim achievements are recognised and those who achieve a silver standard, but do not manage to attain gold, may be the subject of a report from the Drug Treatment Court Judge to their Sentencing Judge, proposing a suspended rather than a custodial sentence.((Ward 2011): p. 5)

Ward also reports on the establishment of a Support and Advisory Committee to assist the DTC. This committee comprises senior managers from the HSE, the Garda Síochána, the Probation Service, City of Dublin Vocational Education Committee (VEC), the Health Research Board and the Courts Service. According to Ward, 'The Court hopes to be able to accept participants with addresses outside the Dublin North Inner City in the near future. In the meantime, it continues to encourage referrals from those with addresses in Dublin 1, 3 or 7' (p. 5).

The review of the DTC recommended that the programme be extended to offenders aged 16–18 years who are before the Children Court. The new Programme for Government is also committed to carrying out 'a full review of the Drug Treatment Court programme to evaluate its success and potential in dealing with young offenders identified as having serious problems with drugs' (Fine Gael and the Labour Party 2011). An interim assessment of the DTC is due to take place in the autumn (Tom Ward, chief clerk of the Dublin Metropolitan District Court, personal communication, June 2011). This will examine the progress made to date in implementing the recommendations made in the review.

Responding to a Parliamentary Question on the DTC, the Minister for Justice and Equality, Alan Shatter TD, stated:

As a result of that review an Advisory Committee was established which has met regularly to progress matters and to monitor the implementation of the recommendations in the Report with the aim of improving the programme's throughput and effectiveness...The aim is to develop the potential of the Drug Treatment Court but to do so in line with the international experience by

continually reviewing the effectiveness of the programme to ensure that it is meeting its objectives and, if it is doing so, to continue to expand the use of the Drug Treatment Court as an alternative to prison. A further review of the Drug Treatment Court is to be conducted in 2012. (Shatter 2011, 15 June).

In late July 2011, the Courts Service and the HSE agreed to extend the catchment area for the DTC to all areas of Dublin County, north of the River Liffey and also to make it accessible to those receiving treatment in the Castle Street drug treatment centre, which provides services to people in Dublin 2, 4, 6 and 8. The extension of the catchment area will be piloted for a period of six months, after which the capacity of the court to manage a further extension will be considered (Tom Ward, chief clerk of the Dublin Metropolitan District Court, personal communication, June 2011).

#### **9.4.2 Other interventions in the criminal justice system**

##### **White paper on crime**

The Department of Justice, Equality and Law Reform published the fourth and final document in its consultation leading to the development of a White Paper on crime (Department of Justice Equality and Law Reform 2010a). The White Paper, due to be completed in 2011, will provide a high-level statement of government policy, its rationale and the strategies to give effect to that policy. The process of consultation involved the publication of four thematic discussion documents: *Crime prevention and community safety*; *Criminal sanctions*; *Organised and white collar crime*; *The community and the criminal justice system*.

#### **9.5 Drug use and problem drug use in prisons**

Please refer to Selected Issue in Chapter 11

## 10. Drug Markets

### 10.1 Introduction

The first comprehensive study of illicit drug markets in Ireland is due to be published by the National Advisory Committee on Drugs (NACD) and the Health Research Board (HRB) in late 2011. A detailed summary of the relevant findings from this study are presented in this chapter. Data from several other information sources which give indications of the nature and size of the market are presented where available.

Prevalence surveys may ask respondents about their access to illicit drugs and about the availability of various drugs. For example, the all-Ireland general population drug prevalence survey, described in detail in Section 2.1 of this report, asks respondents how they obtained individual substances (who from and under what circumstances), where did they obtain them (in what type of location) and how easy were they to obtain. The European School Survey Project on Alcohol and Other Drugs (ESPAD), also described in detail in Section 2.1 above, contains a question, the answer to which indicates the perceived availability of some illicit substances – ‘How difficult do you think it would be for you to get each of the following (cannabis, amphetamine, ecstasy)?’. The above studies are not reported in every National Report.

Data on drug seizures by **Customs Drug Law Enforcement** (CDLE) and the Garda Síochána provide insights into the origins of drugs being brought into Ireland, and the nature of the market in terms of supply and availability. However, these data must be treated with caution as the number of drug seizures in any given period can be affected by such factors as law enforcement resources, strategies and priorities, and by the vulnerability of traffickers to law enforcement activities.

Drug offence data published by the **Central Statistics Office** (CSO) can assist in understanding aspects of the operation of the illicit drug market in Ireland. With regard to the so-called middle market level, which involves the importation and internal distribution of drugs, data on drug supply offence prosecutions by Garda division are a possible indicator of national drug distribution patterns. While these data primarily reflect law enforcement activities and the relative ease of detection of different drugs, they may also provide an indicator of national drug distribution trends. These data can be compared with other sources such as drug treatment data, for example, to show trends in market developments throughout the State. Such data can also indicate trafficking patterns by showing whether there is a concentration of prosecutions along specific routes.

For policing purposes Ireland is divided into six regions, each of which is commanded by an Assistant Commissioner. The six regions are:

- Dublin Metropolitan Region
- Northern Region
- Western Region
- Eastern Region
- Southern Region
- South Eastern Region

Each region is divided into divisions commanded by a Chief Superintendent, and each division is then divided into districts commanded by a Superintendent, who is assisted by a number of Inspectors. The districts are divided into sub-districts, each normally the responsibility of a Sergeant.



**Map 10.1.1 Irish Garda regions and divisions**

The **Forensic Science Laboratory (FSL)** provides impartial scientific evidence following examination of crime scenes, including seizures of drugs. However, not all drugs seized by the law enforcement agencies (the Garda Síochána or Customs Drug Law Enforcement) are necessarily analysed and reported on by the FSL. For example, if no individual is identified in relation to the drug seizure, and no prosecution takes place, the drugs may not be sent for analysis and may be destroyed. Moreover, drug purity data are not collated in a systematic way at different market levels in Ireland. The primary function of the FSL in this area relates to supporting the criminal justice system, and not to research. Only a very small proportion of drugs seized are tested to ascertain the percentage purity.

## **10.2 Availability and supply**

### **10.2.1 Perceived availability of drugs, exposure, access to drugs** e.g. in general population, specific groups/places/settings, problem drug users

A study commissioned by the National Advisory Committee on Drugs (NACD) reported findings in relation to drug use among 479 early school leavers and 512 school attendees aged 16–18 years, and identified risk and protective factors for substance use. Data were collected throughout Ireland in March–May and September–December 2008. The participants were interviewed face-to-face. A second questionnaire on the attributes of the schools or education centres was completed by the school principal or education/training centre manager. Among both early school-leavers and school attendees, rates of cannabis and other drug use were significantly higher where access to the specific drug was easier (Haase and Pratschke 2010).

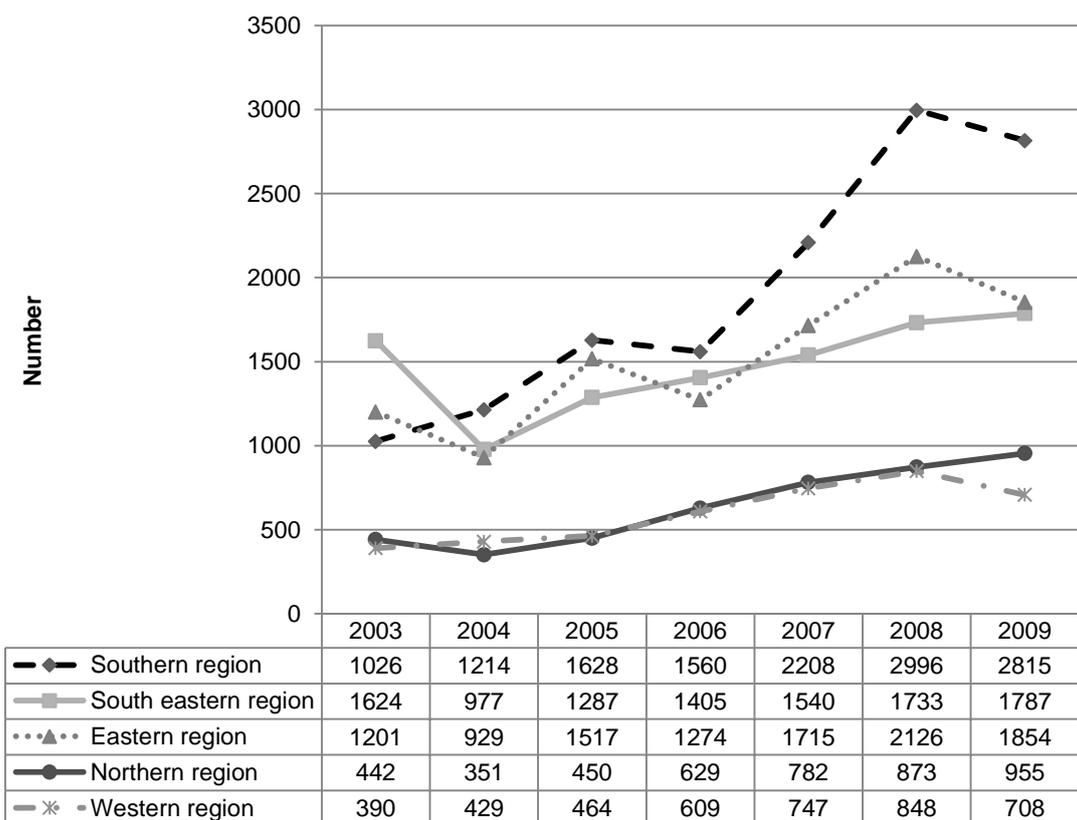
An online survey asked 329 ‘legal high’ users where they sourced new psychoactive substances (Kelleher, Cathy, *et al.* 2011). So-called ‘head shops’ were most often reported as the source. The study found that the proximity of head shops to users’ homes was likely to facilitate this: at the time of the survey, 65% (146) of respondents had access to a head shop within 5km of their home. ‘Legal highs’ were also sourced online by 16.5% (43) of respondents, from a ‘dealer’ by 12.2% (40), and through a home delivery service by seven respondents.

### 10.2.2 Drugs origin: national production versus imported

No new information available. See 2010 National Report for latest data (Irish Focal Point 2010). See below for recent activities of Customs Drug Law Enforcement as described in illicit drug market study (Connolly and Donovan In press).

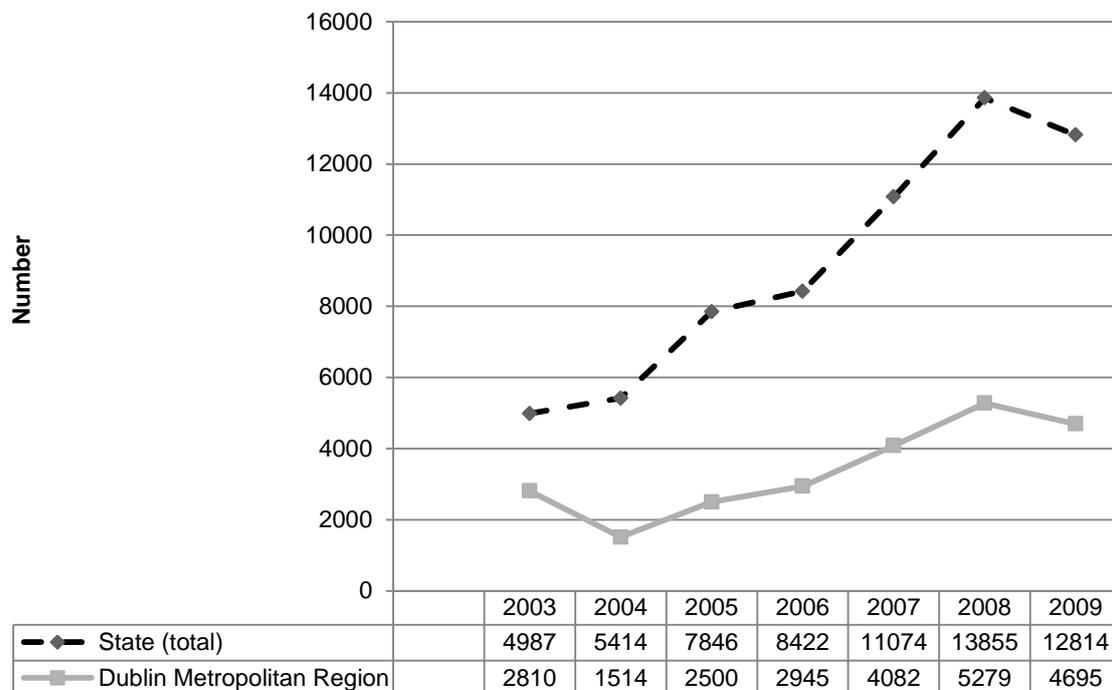
### 10.2.3 Trafficking patterns, national and international flows, routes, modi operandi; and organisation of domestic drug markets

Figures 10.2.1.1 and 10.2.2.2 below show the trends in relevant legal proceedings for possession of drugs by Garda region between 2003 and 2009. It should be noted that possession includes possession for personal use and possession for the purpose of supply. It is not possible to distinguish reported data for these two offences by gardaí region. However, as shown in Table 9.2.1.1 above, it is generally the case that between 70% and 75% of all possession cases are for personal use.



**Figure 10.2.1.1: Trends in relevant legal proceedings for possession of drugs by Garda region excluding the Dublin Metropolitan Region 2003–2009.**

Source: (Central Statistics Office 2008) (Central Statistics Office 2011)



**Figure 10.2.2.2: Trends in relevant legal proceedings for possession of drugs for the Dublin Metropolitan Region and total possessions for the State 2003–2009**

Source: (Central Statistics Office 2008) (Central Statistics Office 2011)

The two figures show that the trend in prosecutions for possession decreased in most garda regions in 2009, after a steady increase since 2006. The only regions that showed a continuous increase were the Northern and South Eastern regions. The Dublin Metropolitan Region (DMR) still accounts for the majority of possession prosecutions in the State. However, a comparison of the data for 2003 and 2009 shows that the proportion of prosecutions outside the capital has increased significantly. In 2003, the DMR accounted for 56.3% of the total number of possession prosecutions in the state, and 36.6% in 2009. These data show that the drug phenomenon is now more widely distributed throughout the state.

### **An ethnographic study of drug use in the Canal Communities area of Dublin**

The Canal Communities Local Drugs Task Force (CCLDTF) covers the areas of Rialto, Bluebell and Inchicore in the Dublin 8 area. The CCLDTF undertook a study to improve knowledge and understanding of the nature of illicit drug use in their area (Saris and O'Reilly 2010).

The researchers used an ethnographic approach, incorporating a range of research methods to describe and explain how specific groups of people experienced and perceived their lives and surrounding environment. Data for the CCLDTF study were collected by means of participant observation (in service facilities, estates, homes) and through interviews. Fifty-one interviews were conducted, of which 24 were life histories and eight were group discussions (with 29 young people). Six of those who were initially interviewed had a subsequent interview. Additionally, there were 24 formal and informal interviews with service providers. Interviewers also administered a survey to a target population of 100 opiate or methadone users.

The report of the study begins with a discussion on the nature of drug use and the difficulties in relation to the categorisations used within the field. In relation to patterns of use, the authors use the term 'styles' as this can help convey how '...at any one moment, populations that overlap certain institutional categories (disorganized heroin-users, for example, can be found both in and out of treatment, often using both methadone and heroin simultaneously), while presenting different challenges to various intervention strategies' (p. 19). This is followed by a chapter which discusses experiences of the combined use of heroin and methadone in the CCLDTF area.

Subsequent chapters deal with the history and the issues around drug use in the area, the emergence of crack cocaine and the changing patterns of drug use. Data from the Central Treatment List (CTL) pertaining to people living in the CCLDTF area were analysed. One finding from this analysis was that the area had a relatively high rate of registration on the CTL in 2007, at 20 per 1,000 of the population, compared to 2 per 1,000 of the population nationally.

The quantitative data collected from 98 valid responses to the survey administered to opiate and methadone users are summarised in an appendix to the report. The main results include:

- 63% were male;
- 98% were prescribed methadone;
- Average number of days on methadone was 86;
- 63% reported current use (last three months) of heroin;
- 46% reported current use of street benzodiazepine;
- 30% reported current use of crack;
- 22% reported current use of powder cocaine;
- 17% reported current use of street methadone;
- 60% of those who injected reported sharing a needle or syringe;
- 36% reported spending between €60 and €119 on drugs in the average week;
- 88% reported ever having been involved in crime;
- 57% reported having had a custodial sentence.

Most of those interviewed for the study were polydrug users, often using combinations of illegal and legal drugs (whether obtained legally or not). Many of those who took part in the study and who were in treatment for opiates also used cocaine, with the use of crack cocaine emerging as a problem. Individuals who dealt drugs often continued to do so after entering treatment. The study provides a useful insight into a local drug market involving a range of both licit and illicit drugs. Drug markets for different substances are often seen as distinctive, with those who supply and those who use drugs seen to specialise in particular substances, for example heroin or cannabis (Connolly and Donovan In press). This study, by highlighting the issue of polydrug use in a small community, raises questions as to the nature of local drug supply. Further research focussing on drug supply sources would be useful.

### **Study of Illicit drug markets in Ireland**

The first comprehensive study of the Irish illicit drug market is due to be jointly published by the NACD and the Health Research Board in late 2011 (Connolly and Donovan In press). The following is a summary of the main findings.

#### ***Study aims***

The aims of the study were to:

- examine the nature, organisation and structure of Irish drug markets,
- examine the various factors which can influence the development of local drug markets,
- examine the impact of drug dealing and drug markets on local communities, and
- describe and assess interventions in drug markets with a view to identifying what further interventions are needed.

#### ***Methodology***

The research was carried out in four locations: two sites in urban areas, one in a suburban area and one in a rural area. These sites varied considerably in terms of population and geographic location. The basic selection criteria were that the areas should be sufficiently varied to provide a cross-section of illicit drug markets in Ireland. The electoral divisions within the study sites chosen were those where deprivation levels were high (based on proportion of over-15s unemployed, proportion of population in social class 5 or 6, proportion of households with no car and proportion of rented or local authority housing). Data on the proportion of residents who had served

prison sentences for drug offences were also used as an indicator. The identities of the study sites were concealed so as not to consolidate their reputation as illicit drug market locations. Site A is located within a suburban satellite town with a population of approximately 40,000. Site B is a rural site encompassing just two electoral divisions – one representing the town, with a small population of 2,000–3,000 and the second representing the population of the rural hinterland, with a population of 10,000–11,000. Site C is an urban site, encompassing 20 electoral divisions, with a population of 30,000. Site D is an urban site encompassing 19 electoral divisions with a population of some 60,000.

The study was conducted over an 18-month period (June 2008 — December 2009) using a mixed methodological approach, including:

- individual, face-to-face, in-depth interviews with both former and active drug users and street sellers;
- interviews with individuals serving prison sentences of more than seven years for drug supply;
- interviews with experienced members of dedicated Garda drug units in the four study sites and with senior members of the Garda National Drugs Unit;
- interviews with drug treatment workers and a public health specialist;
- a street survey of 816 local residents and people working in the area (approximately 200 respondents in each location).

Criminal justice data analysed included drug offence data for the period 1 October 2008 to 31 March 2009 obtained from the Garda Síochána PULSE Information Technology system (Police Using Leading Systems Effectively). PULSE includes information on the number of drug seizures, the profile of offenders and the circumstances of arrest. Data on over 1,200 cases were collected from 12 Garda stations in the four study sites, and data on seizures made by CDLE, collected from 18 stations nationwide over a six-month period (January–June 2009), were analysed.

### ***Main findings***

#### *Factors which can influence the development of local drug markets*

Most survey respondents highlighted social issues as the main reasons for local drug use, including the absence of facilities for young people, high unemployment, boredom, poor parental supervision and drug availability. Additional factors identified through in-depth interviews included the relocation of people from deprived urban centres to suburban and rural areas and, in one location, the influence of a local prison where people had developed addictions and/or met people who had subsequently introduced them to drug dealing. The arrival of people, both national and non-national, had also contributed to the development of markets for drugs such as herbal cannabis, heroin and crack cocaine. Senior experienced members of the Garda National Drugs Unit describe the illicit drug market in Ireland as involving a series of sometimes overlapping markets for different substances which have evolved in waves or phases over the past three decades, with the heroin market, for example, beginning in the centre of Dublin and gradually spreading throughout the country.

The cannabis market is described as geographically dispersed and continuously growing, while the ecstasy market is distinctive in that it emerged in the early 1990s and spread throughout the country very rapidly over an 18-month period. Previously, cocaine use was generally regarded as being confined to specific sectors of the population and specific locations, possibly given the higher prices associated with it. However, the decade of rapid economic growth up to 2008 saw cocaine use spread widely throughout the country. Crack cocaine is a relatively recent phenomenon, which emerged in north Dublin inner city and has now spread throughout the capital and beyond.

#### *The nature, organisation and structure of Irish drug markets*

There is no simple way to describe the organisational nature of the various drug markets examined as they differed widely in terms of their levels of structure and

organisation throughout all four study sites. Site D, for example, was referred to as highly structured with regard to the distribution of heroin, cocaine and cannabis and involving three to four levels of distribution. Several high-level suppliers were involved in drug importation and distribution over a very wide area. The middle market in this location was reportedly heavily populated by individuals and groups or 'gangs' supplying drugs in volumes of kilograms or more. Site D also had several highly visible open street-level markets where heroin, crack cocaine and prescription drugs could be purchased. Although crack cocaine had originated with West Africans, it now involved more Irish sellers. Closed markets in pubs and flat complexes were also reported. Site A also had a visible and busy open street-level market for crack cocaine, where dealers took turns to sell drugs to buyers who often came from outside the area.

Site B also attracted non-local buyers to purchase heroin. The heroin supply here was regarded as having originated within families but to have involved more recently a looser network of individuals. Heroin was not directly imported but sourced from the major cities of Dublin and Limerick. Cocaine distribution in this market was more structured and lucrative and dominated by a particular group of individuals who used legitimate businesses as a means of transporting drugs throughout the region. Street-level distribution was closed, with transactions made over the phone, deliveries made to people's homes and contacts formed through trusted third-party introductions. In site C, the distribution of drugs such as cannabis and cocaine was concentrated among a small number of established families. Heroin distributors were described as non-local, both Irish and non-Irish, who had arrived in the area with an addiction. The heroin market was also described as less structured and easier to penetrate from a law enforcement perspective. Although this was a large urban area, there was no open street market reported, with drug transactions arranged via mobile phone and at pre-arranged locations.

In site A, a large number of individuals performed roles on behalf of higher-level suppliers, including the dilution or preparation of drugs. Those involved in the storage and transport of drugs were generally relatively minor participants in the drug supply chain, either earning drugs for their own use or trying to pay off a drug debt. Young people also played a substantial role in drug distribution at street level. Storing or running drugs was a financially lucrative option for teenagers. PULSE data revealed that, over a six-month period, one fifth of suspected supply offenders were aged 18 or under. Many of these young people were reportedly from unstable home environments. The profile of runners was different in site B. They were often older heroin addicts running drugs in return for a personal supply. Non-drug-using young people (aged under 18) were not reported as playing a significant role in drug distribution. Similarly, in site C, although runners did exist, there was little evidence to suggest the involvement of very young people (aged 16 and under). It was reported that this would not have been tolerated locally by residents. By contrast, in site D, young people (aged under 16) were reported to be heavily involved in running drugs.

#### *Description of interventions in drug markets*

This study provides the first comprehensive picture of the role, resources, strategies and activities of the principal drug law enforcement agencies in the State – CDLE and the Garda Síochána. CDLE reported a number of successful operations during the period of the research. Of the 1,378 seizures of illegal or controlled drugs between January and June 2009, 90% were of cannabis herb or resin. The vast majority of these seizures (90%) weighed less than 28g and were most likely for personal use. In the same period, 52 seizures were made by CDLE of illegal substances that weighed 1kg or more (4% of total seizures). Cocaine and cannabis herb accounted for 89% of these seizures. It is not possible to determine accurately the proportion of these drugs that were destined for the Irish market or whether these seizures had a significant impact on drug availability in Ireland.

Garda National Drugs Unit (GNDU) strategic operations focus on dismantling and disrupting international and national drug supply networks and organisations and also

working with divisional and district Garda drug units to dismantle local networks. The GNDU also co-operates with CDLE and with international organisations. The GNDU also has a role in co-ordinating Garda policy on demand reduction initiatives. The gathering and collation of reliable intelligence is central to the success of the work of the GNDU. Unlike other areas of policing, such as robbery or murder, investigations cannot always begin from a crime scene but must depend on intelligence. In recent years the Central Human Intelligence System (CHIS) has been developed. This provides a structure whereby all intelligence is now centralised within a specific unit. The GNDU also manages undercover test purchase operations, to penetrate closed retail markets or recreational markets such as nightclubs where people are less likely to deal drugs to strangers. In all research sites Garda drug unit strategy involved a combination of activity targeting both street dealing and higher-level suppliers. Intelligence was generally acquired through developing relationships with offenders working in the lower levels of distribution. In site C, a divisional drug unit sought to disrupt higher-level supply lines, while district policing tended to focus on local low-level sellers.

### *Assessment of interventions*

In the previous and current National Drugs Strategy, the key performance indicators under the supply reduction pillar focus on increasing supply detections and drug seizure volumes (Department of Tourism Sport and Recreation 2001) (Department of Community Rural and Gaeltacht Affairs 2009). Both Customs Drugs Law Enforcement and the Garda Síochána have surpassed their required targets in this respect, reporting a number of successful operations during the period of this research. However, one of the challenges from a law enforcement perspective highlighted in this study relates to the difficulty of identifying any clear link between supply reduction activity and drug availability and use. The absence of reliable evidence of a straightforward link between supply reduction initiatives and sustained reductions in drug availability has been highlighted in the international literature and was also identified as an important issue during the preparation of the current National Drugs Strategy.

Despite the difficulties associated with policing drug markets, research and evidence suggest that supply reduction activities can contribute to the containment of drug markets and frustrate the expansion of new markets. Nevertheless, the public demand for illegal drugs and the profits which can be earned from drug dealing ensure that international and Irish drug markets remain resilient and adaptable to law enforcement interventions. Across all four study sites, supply offences accounted for between 17% and 33% of all drug offences. The largest proportions of supply offences were in sites A and D, which had a number of open drug markets. Most supply offences related to heroin, cocaine and crack cocaine. On the one hand, this reflects the intelligence-led and focused nature of activity by individual Garda drug units. On the other, it reflects the greater availability of drugs in these areas. In all four sites, most prosecutions were for simple possession of cannabis. Most of these relate to stop and search activity by Garda members, and the amounts seized were valued at between €10 and €20.

Although some drug sellers acknowledged the importance of being wary of Garda activity, there is no evidence from the study that general drug availability was significantly affected for any period by law enforcement. Local community tolerance of cannabis use was highlighted by Garda members and by treatment workers in a number of sites. In sites A and D, the gardaí had initiated several targeted operations. Despite this, gardaí acknowledged that, although their activities led to the disruption of the market, the impact was generally of short duration as markets quickly adapted. Again, this is consistent with findings from international research. The limitations of such Garda crackdowns in busy hotspots were also highlighted by local drug sellers, who explained that they would disperse quickly when gardaí approached and resume when they left the area. Drug sellers also adapted to drug law enforcement by managing risk exposure. Rather than keeping drugs on their person, they were kept in a separate location. Consignments might be divided up and buried at a series of

locations, where buyers could collect them. Higher-level sellers often used others to transport drugs for them, either children or people who were in debt to them, or heroin users who did it in return for drugs for their own consumption. Drug sellers also reported using people as decoys, giving them a small amount of drugs and then informing the gardaí so as to distract the latter from a larger drug deal happening simultaneously.

Although relations with communities and other agencies, including treatment agencies, were stronger in some locations than others, in general, inter-agency and community links were underdeveloped and often informal. However, formalised community and inter-agency partnerships, where they existed, were regarded as beneficial both in terms of developing responses and reassuring community residents.

#### *Community perspectives*

In site A, only one third of survey respondents believed the gardaí to be effective or very effective in dealing with crime. Just over a quarter of residents knew a Garda member by name. In site B over half of survey respondents believed the gardaí to be effective/very effective in dealing with crime in their area. More than half of the residents surveyed knew a Garda by name and 42% had spoken to a Garda about their area. In site C almost half of survey respondents believed the gardaí to be effective/very effective in dealing with local crime. More than a third of respondents knew a Garda member by name and/or had spoken to them about the area. In site D, just under half of respondents believed the gardaí to be effective/very effective in dealing with crime. Just one quarter of respondents knew a Garda member by name and/or had spoken to them about the area. These findings suggest that there may be a link between perceptions of Garda effectiveness and positive engagement with individual Garda members working in the community. Sites A and D also had visible open street level markets and this could have an effect on community perspectives of Garda effectiveness. In all four sites, the most prevalent reason for not reporting information about drug-related activity to gardaí related to fear of reprisal from those involved in drug-related crime.

#### *Unintended consequences of law enforcement*

In all four sites, gardaí highlighted the importance of using informants for the purposes of intelligence gathering. However, this could also have unintended consequences. The use of informants by the gardaí was regarded by sellers as a major source of suspicion which often led to violence in drug markets. It was also pointed out by the GNDU that some of the violence in drug markets that was associated with Garda seizures or arrests arose as a result of paranoia among drug suppliers. In all four sites, most of the violence that occurred related to unpaid drug debts. Drug debts were acquired through people consuming their own supply or as a result of Garda seizures. Where gardaí seized drugs, debts remained outstanding and still had to be paid. This may be described as an unintended negative consequence of drug law enforcement, whereby effective supply reduction activities can indirectly contribute to greater levels of drug-related violence. Another unintended effect of law enforcement identified in the literature is the tension that can arise between law enforcement and public health goals. For example, where drug markets develop in close proximity to drug treatment centres, law enforcement responses need to be carefully managed. Sensitivities in relation to this issue were acknowledged both by health workers and by Garda members interviewed in one study location, and the gardaí adopted a pragmatic approach when dealing with dependent drug users seeking treatment. This highlights the importance of nurturing and sustaining effective partnerships between criminal justice, health and social agencies.

#### ***Policy implications***

The following is a discussion of some of the main policy implications arising from the research.

### *Preventing the emergence and growth of illicit drug markets*

Future approaches to illicit drug markets and drug-related crime need to address the various environmental, social and economic factors that contribute to the emergence and growth of illicit drug markets in the first place. These factors should be considered in relation to different market levels: import, middle-market and retail level. Preventative approaches should involve collaboration with international partners in countries where the drugs are sourced. At national level, environmental crime prevention measures should be incorporated into housing planning, for example. In seeking to prevent young people from becoming involved in gang formation and local drug markets in the future, international best practice approaches need to be investigated and delivered through the education system. In responding to illicit drug markets, it is important to consider what interventions are seeking to achieve and how specific market structures and forms of organisation can impact on these interventions. Policing responses, whether street patrols or intelligence-led initiatives of a more covert nature, strive to disrupt markets and thus reduce or control supply. On the other hand, demand-reduction strategies attempt to target users and divert them into drug treatment, by means of arrest referral schemes, for example. It is important that supply reduction and demand reduction initiatives are complementary.

The international literature also suggests that time in prison may contribute to future involvement in illicit drug markets. Although this issue was not the focus of this research, a number of interviewees in particular sites referred to the fact that the prison setting had afforded them the opportunity to make friends/acquaintances with people with whom they subsequently, upon release, engaged in drug dealing. These interviewees were often dependent drug users whose original imprisonment was drug-related. This reaffirms the desirability of diverting people away from imprisonment, where appropriate, and into treatment. The increased use of arrest referral and the use of alternatives to imprisonment such as the DTC provide a more humane, effective and sustainable approach. In addition, this issue highlights the importance of supporting further efforts in the provision of treatment while in prison.

### *Directing responses towards the specific characteristics of the illicit market to focus on the individuals and markets that cause greatest harm*

When asked what was needed to reduce drugs and crime in the area, the majority of respondents to the street survey across all four sites called for more gardaí patrolling on the streets. Visible policing can help alleviate some of the fears associated with local drug markets. Regular police patrolling can also disrupt open drug markets and cause them to move continuously so that they do not gain a permanent visible presence. This can make the markets less accessible to people who may wish to experiment with drug use and it can alleviate the corrosive effect that open drug scenes can have on local community morale and local businesses. A regular visible police presence is also very important in fostering interaction between the gardaí and the local community, as community members become familiar with individual Garda members. Formalised meetings between the gardaí and local residents can benefit from such interaction.

The main newly emerging drugs identified in specific study locations were crack cocaine, cannabis herb and benzodiazepines. Each of these drugs raises different issues from a legal regulation and law enforcement perspective and also in terms of the harms associated with them. Clearly, the open dealing of crack cocaine and heroin that was identified in this study in sites A and D is particularly harmful to the local communities. Public displays of drug-market violence and the involvement of young people in drug distribution are also particularly harmful consequences of some of the drug markets studied here. The deployment of law enforcement and other resources towards addressing and alleviating these most harmful drug markets, and the limitations in available resources, indicate the need for strategic use of resources. A similar sense of perspective should also inform criminal justice responses to those involved in the operation of illicit drug markets. This study highlights the reality that drug-dealing enterprises are dependent on the participation of numerous individuals

performing different roles. These include people exploited by high-level drug dealers to hold or transport drugs, such as children, dependent drug users or non-nationals from low-income countries. Although the ultimate harm to society arising from the supply of those drugs may be the same regardless of the motivation of the individual involved, effective prevention policies need to address the circumstances which lead people to become involved in illicit drug markets in the first place. Similarly, consideration needs to be given to cases in which individuals are found in possession of only a small quantity of drugs, but where other evidence suggests that they are dedicated high-level drug dealers.

For example, the issue of sentencing, although not covered in detail in this study, did arise, particularly in relation to the imposition of the mandatory minimum sentence provided for in the Criminal Justice Act 1999 (see Section 1.2.2 above). In deciding whether or not to impose the mandatory 10-year minimum sentence for drug possession as provided for in this legislation, the courts must consider and respond to many complex issues arising as a consequence of the operational dynamics of illicit drug markets. Further information about the nature of these issues and their broader societal and criminal justice implications would be of value. Ultimately, the importance of developing successful interventions at the highest levels of the illicit drug market should remain a core focus of policy.

#### *Building community confidence and partnership responses*

There is growing evidence, both internationally and in Ireland, that partnership approaches involving local communities, state agencies and other stakeholders offer the most effective method of responding to many drug problems, including illicit drug markets. Community engagement in partnership approaches is often contingent, however, on the extent to which community concerns are understood and acted upon. In trying to develop the capacity of communities to take positive action against drug markets, it is important to appreciate the limited or constrained choices that are open to many community residents. In particular, the fear and intimidation associated with drug-related crime clearly undermines the willingness of the public to engage with initiatives aimed at disrupting such markets. Consequently, successful approaches depend upon the building of community confidence through initiatives that are locally relevant, that are tangible and that are consistent over time. Such a response can best be delivered through formal inter-agency and community-based structures such as local policing fora, as provided for in the National Drugs Strategy 2009–2016 (Department of Community Rural and Gaeltacht Affairs 2009). The prioritisation of community issues, the implementation of responses with community support and engagement and the fostering of more effective relations between agencies can help ensure that public and human resources are used to their maximum effect.

#### *Investigating drug markets and monitoring drug market interventions*

It is necessary to continue to develop methods to improve knowledge about illicit drug markets, supply reduction activities and drug-related crime in line with international best practice. Despite Irish research clearly indicating that many arrested and imprisoned offenders are dependent drug users, the absence of accurate indicators to assist in measuring the proportion of crime committed as a consequence of drug use is a major gap in knowledge and undermines the development of evidence-based responses to drug-related crime.

This study shows that regular compilation of drug market data, including data on arrests, seizures, price and purity, and adulterants, can assist in explaining both the operational dynamic of illicit drug markets, and can be useful in monitoring and informing both criminal justice and public health responses to them. The regular compilation of such data at different market levels and for different drug types will further enhance this picture. However, a more comprehensive understanding of drug markets, drug-related crime and supply reduction responses requires such data to be complemented by other data sources and further research. The full impact of supply reduction activity, for example, cannot be fully assessed by measuring arrests and

seizures alone or through proxy measurements such as price and purity. A fuller picture needs to incorporate demand reduction, social, health and community welfare indicators. Although this exploratory study has sought to develop our understanding of illicit drug markets in Ireland, as with most research it has also identified areas where further investigation is warranted. The pathways that lead young people into drug dealing and drug-related gangs, developing our understanding of higher-level drug markets in association with international partners, and recreational drug markets which are less likely to come to police attention are just some potential areas for further research.

### **Conclusion**

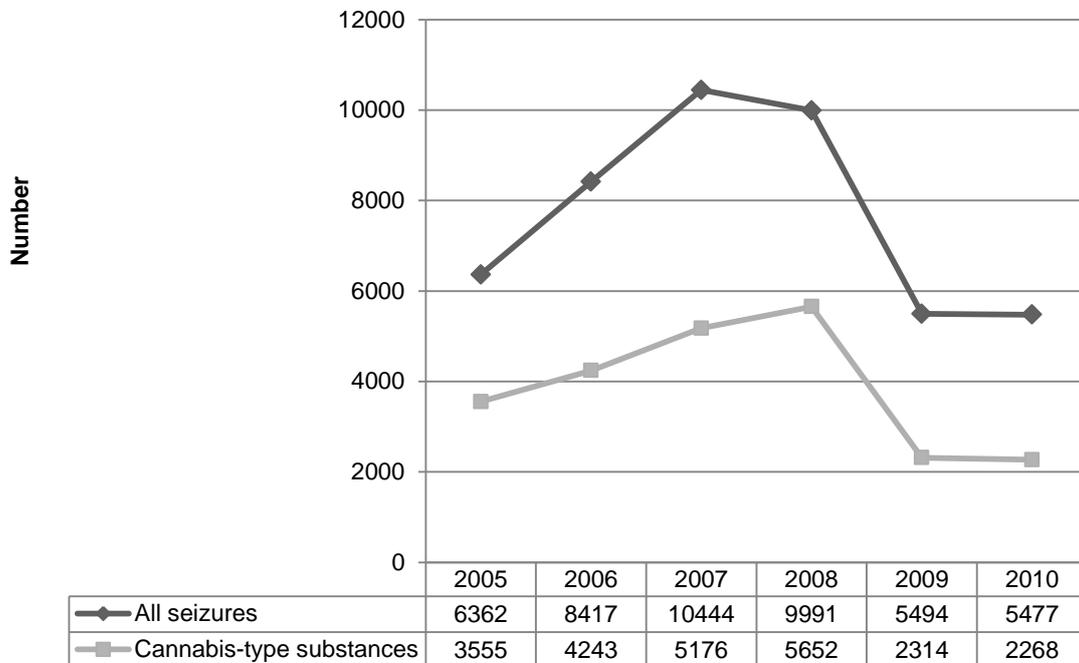
The complete removal of illicit drug markets through drug law enforcement is not an achievable goal in the foreseeable future. It needs also to be recognised, however, that not all drug markets are equally harmful in terms of the effect they can have on individuals and local communities. For example, some are more violent than others and open markets cause more disruption to communities than closed ones. Some involve the exploitation of young people and other vulnerable groups. Future law enforcement interventions, in partnership with communities and other agencies, need to evolve to address the complexities and particular harms associated with Irish drug markets. It is suggested that such an approach requires a more pragmatic use, co-ordination and streamlining of existing resources and the targeting of those resources at the most harmful aspects of Irish drug markets. Law enforcement interventions that focus on the particular harms associated with an individual market have the potential to have an impact on those harms and they may also lead to a more effective use of public resources. Also, approaches which seek to divert problematic drug users into treatment and which prioritise local community perspectives, and those which occur in collaboration with other relevant agencies, are more likely to be sustainable over time and to win public support. Finally, it is necessary to develop our understanding of illicit drug markets and drug-related crime and of the interventions made in response to them through an integrated approach, by promoting research and monitoring systems which can enable us to analyse such phenomena and activities across both state and community sectors.

## **10.3 Seizures**

### **10.3.1 Quantities and numbers of seizures of all illicit drugs**

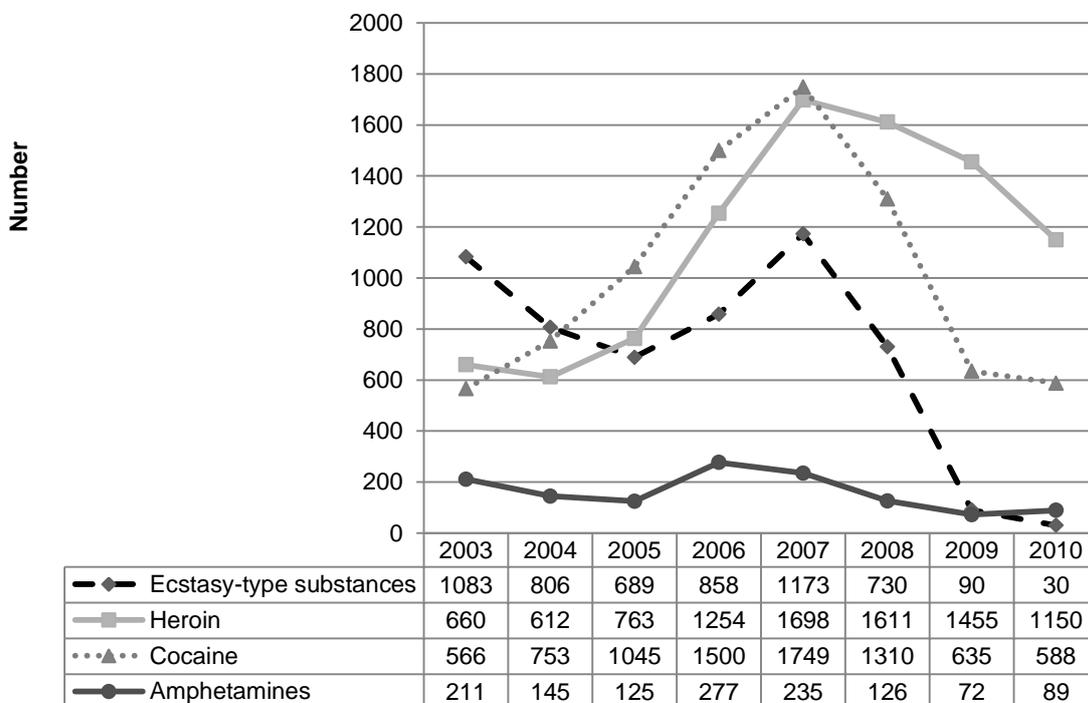
The number of drug seizures in any given period can be affected by such factors as law enforcement resources, strategies and priorities, and by the vulnerability of traffickers to law enforcement activities. However, drug seizures are considered indirect indicators of the supply and availability of drugs (See Standard Table 13).

Cannabis seizures account for the largest proportion of all drugs seized. Figure 10.3.1.1 shows the trend in cannabis-related seizures and total seizures between 2003 and 2010. The total number of drug seizures increased between 2005 and 2007, then decreased in 2008 and again in 2009. In 2010 the number of seizures appears to have levelled out. This decrease and levelling out in total seizures between 2008 and 2010 can be explained partly by the trend in cannabis seizures during the same period. In 2009 there were fewer reported cannabis seizures ( $n = 2,314$ ) than in 2005 ( $n = 3,555$ ). In 2010, there were 2,268 cannabis-related seizures, a slight decrease from 2009. It is not clear whether the reduction in cannabis-related seizures reflects a decline in cannabis use or a reduction in law enforcement activity targeted at the cannabis market. However, it should be noted that drug offence prosecutions reported in Section 9.2 above, most of which are cannabis-related, also decreased slightly in 2009, with figures for 2010 not currently available.



**Figure 10.3.1.1 Trends in the total number of drug seizures and cannabis seizures, 2005–2010**  
Central Statistics Office 2008, 2009, 2010; (An Garda Síochána 2011)

The reduction in the total number of reported seizures in 2009 and its levelling off in 2010 may also be explained by a reduction in the number of seizures of other drugs since 2008. Figure 10.3.1.2 shows trends in seizures for a selection of drugs, excluding cannabis, between 2003 and 2010. There has been a significant decline in seizures of cocaine, heroin and ecstasy-type substances since 2007. It appears that the significant reduction in total drug seizures reported in 2009 can be explained primarily as the result of a reduction in seizures of cannabis and cocaine. However, in 2010 we have seen the continued decline in heroin seizures. It is unclear whether this reflects a decline in heroin use or a change in law enforcement activities or some other factor.



**Figure 10.3.1.2 Trends in the number of seizures of selected drugs, excluding cannabis, 2003–2010**  
Central Statistics Office 2008, 2009, 2010; (An Garda Síochána 2011)  
\* Includes MDMA, MDEA, and DOB

Table 10.3.1.1 shows the particulars of all drugs seized in 2010 that were reported on by the FSL. As noted in Section 10.1 above, not all drugs seized by law enforcement agencies (the Garda Síochána and CDLE) are necessarily analysed and reported by

the FSL. The FSL advises that there may be some cases, comprising large quantities of cannabis / cannabis resin, where a suspected offender has not been identified, which have not been subject of detailed analysis by the FSL and for which a specific weight has not been determined.

**Table 10.3.1.1 Particulars of all drugs seized in 2010 that were reported on by the Forensic Science Laboratory**

Drug	Quantity	Cases (number)
Alprazolam	70,183 tablets	98
Amphetamine	26,462.894 grams	89
BK-MBDB	91 capsules 34 tablets, 63.282 grams	16
Buprenorphine	33 tablets	3
BZP ***	351,536 tablets, 3,271.406 grams, 371 capsules	348
Cannabis	912,961.766 grams	1247
Cannabis resin	748,265.893 grams	616
Cannabis plants*	3,851 plants	405
Chlorpheniramine **	204 tablets	1
Clonazepam	100 tablets	12
Cocaine	94,804.200 grams	588
CPP **	5 tablets	3
Diamorphine (Heroin)	30,158.017 grams	1150
Diazepam	145,197 tablets, 11,522.777 gram	448
Dihydrocodeine	434 tablets	12
Ephedrine	3,926 tablets 22.461 grams	15
Ecstasy MDMA	398 tablets, 1,428.636 grams	30
Flephedrone	811.005 grams	7
Flunitrazepam (Rohypnol)	1,009 tablets	9
Fluoxetine**	2 capsules	1
Flurazepam	1,505 capsules, 21 tablets	37
Ketamine	83.742 grams	11
Khat	Plant samples	2
Lignocaine**	13,993.120 grams	39
Lorazepam	230 tablets	5
LSD	1,588 squares, 57 tablets	13
Mephedrone	5,298.420	100
Methandienone**	22 tablets	2
Methadone	4,801 mls	33
Methylamphetamine	404.162 grams	20
Oxymetholone**	733 tablets	15
Prazepam	2 tablets	1
Sildenafil**	234 tablets	20
Stanozolol**	310 tablets	4
Temazepam	244 tablets	9
Triazolam	130 tablets	12
Zolpidem**	53 tablets	10
Zopiclone**	49,170 tablets	138

\*The number of cannabis plants does not reflect the total number detected as only a sample of the plants are sent for analysis for practical reasons.

\*\*These drugs are not controlled under the Misuse of Drugs Acts, 1977 & 1984.

\*\*\* BZP was controlled on 31 March 2009.

### Prison drug markets

Data on prison drug markets such as the number and volume of drug seizures; price and purity data are not routinely collected or reported. However, the data presented in Table 10.3.1.2 was provided by the former Minister for Justice, Equality and Law Reform in response to a Parliamentary question in late 2010. Most of the seizures reported were made at entry to the prison, during prison visits for example, and consequently the drugs did not enter the prison system. The Minister also explained that 'prior to May 2008 seizures of drugs were recorded under the generic description "prohibited articles" and accordingly a detailed breakdown is not available.' (Ahern, Dermot 2010, 28 October) Once suspected drug seizures are made by prison staff, according to the former Minister, 'as Prisons do not have the facilities to test the type or quantity of substances found, gardaí (police) are contacted...and issues for investigation and prosecution fall within their remit'.

**Table 10.3.1.2 Drug seizures in Irish prisons, January 2009–September 2010**

<b>Prison/Place of Detention</b>	<b>Number of Drug Seizures in 2009</b>	<b>Number of Drug Seizures in 2010 (up to 12/9/2010)</b>
Arbour Hill Prison	0	0
Castlerea Prison	65	54
Cloverhill Prison	97	54
Cork Prison	35	33
Dóchas Centre	11	14
Limerick Prison	75	119
Loughan House	12	28
Midlands Prison	93	60
Mountjoy Prison (male)	547	527
Portlaoise Prison	20	27
Shelton Abbey	19	20
St. Patrick's Institution	92	137
Training Unit	60	37
Wheatfield Prison	167	69
<b>Total</b>	<b>1,293</b>	<b>1,179</b>

### **10.3.2 Quantities and numbers of seizures of precursor chemicals used in the manufacture of illicit drugs**

See National report 2010 for most recent information (Irish Focal Point 2010).

### **10.3.3 Number of illicit laboratories and other production sites dismantled; and precise type of illicit drugs manufactured there**

See Section 10.4 in relation to the increase in detections of so-called 'cannabis factories'.

## **10.4 Price/purity**

### ***Study of cannabis THC in herbal cannabis***

The FSL undertook a study of the tetrahydrocannabinol (THC - the psychoactive ingredient in cannabis) content of a sample of cannabis resin and herbal cannabis plants (home grown or imported) (see Standard Table 14) (Arnold In press). The study was conducted in light of a reported increase in the discovery in recent years of so-called 'cannabis factories'. The author describes how cannabis plants are cultivated in these 'factories', using hydroponic and ultra violet light equipment; hydroponic systems involve the growing of cannabis in nutrient solutions rather than soil. The author also explains how herbal cannabis consists mainly of the 'flowering and fruiting tops of the female plant' and is commonly known as 'grass', 'weed' or 'marijuana'. The resinous secretions of the cannabis plant can be collected to form 'slabs' of cannabis resin, commonly known as 'hash'.

The author reports an increase in recent years in the discovery of 'huge' operations of so-called cannabis factories by the gardaí and a decrease in seizures of resin for the purpose of supply. In order to fill the gap in knowledge about the potency levels of THC in home-grown and imported cannabis varieties in Ireland, the author collected a number of cannabis samples from seizures submitted to the FSL by the Garda Síochána between October and December 2010. Twenty samples were analysed – 10 herb samples and 10 resin samples. Unlike the herb samples, most of the resin samples analysed were small street samples used for personal use. The study confirmed that a 'huge' increase in cannabis cultivation had taken place in Ireland and that garda seizures indicated that cannabis herb appeared to be in greater demand than resin.

The author asks whether the increased demand for cannabis herb is because there is a shortage of resin or because there is more THC in cannabis herb. The study found that the THC content in 10 cannabis resin seizures ranged from less than 1% to 5.4%, while the THC content in eight suspected imports of cannabis herb was between 3.96% and 13.34%, although in general there was 'little variance in the THC concentration in suspected imports' (p. 12). The study acknowledges that only a small sample set was analysed and that the THC content was lower than that found in other countries.

#### ***Illicit drug market study - Impact on drug price and purity***

As part of the drug market study described in Section 10.2.1 above, data on drug prices and profits made were obtained from interviews with those involved in buying and selling drugs (Connolly and Donovan In press). Also, forensic analyses of drug seizures in the study sites between 1 September 2008 and 28 February 2009 were conducted by the FSL. Qualitative analysis was performed to identify the presence of illicit substances. Quantitative analysis (drug purity) was then performed on powders and tablets containing specific drugs, namely amphetamine, cocaine, diamorphine (heroin) and MDMA, to determine the levels of purity of the illicit substances present. The analysis also identified the other substances or adulterants present in the samples, giving an indication of the typical bulking agents being used within the illicit drug market.

##### **10.4.1 Price of illicit drugs at retail level**

Interviews suggested that heroin and cocaine had become cheaper to buy in all four sites and at all market levels during the course of the study (see Standard Table 16). However, crack cocaine prices remained high and steady in the markets where it was available. Crack also returned the highest profit margins. Depending on the unit size that they were willing to sell at, sellers could make between 200% and 400% profit on their initial stake or investment. The amount of profit was affected by whether or not the seller was a drug user, thereby consuming part of their own supply. Although there are a number of factors that can impact on drug prices in an illicit market, there was no indication from this study that drug law enforcement was having any effect on price levels or profitability.

##### **10.4.2 Price/potency of illicit drugs**

Heroin purity levels varied within drug markets at all four study sites, but average purity remained fairly consistent across all markets at around 45% (Connolly and Donovan In press). This suggests that heroin markets, both urban and rural, were relatively stable, with purity levels remaining constant. What this finding probably reflects is the reality that heroin is no longer a primarily Dublin-based phenomenon but that there is a consistent supply of heroin countrywide.

Cocaine purity levels were generally very low, averaging 14% across sites A, C and D. It is unclear why this was the case. One might assume that low purity levels would be an indicator of a decrease in availability, but other information sources, such as survey data and treatment figures, do not suggest that there was a decline in cocaine use at the time of the study. An important feature of the purity data in this study relates to the adulterants used when mixing or diluting cocaine. The presence of lignocaine and phenacetin in most cocaine seizures throughout all study sites suggests either the wide availability of such substances or, the more likely scenario, that cocaine is most often adulterated at the import stage of the market or prior to being imported. The presence of such substances also has important health implications.

##### **10.4.3 Composition of illicit drugs and drug tablets**

No information available.

## Part B: Selected Issues

### Summary of selected issues

#### 11. Drug-related health policies and services in prison

The profile of the typical drug-using prisoner in Ireland is single, aged between 14 and 30, male, living in the parental home, from a large and often broken family, having left school before the legal minimum age of 16, unemployed, with his best-ever job having been in the lowest socio-economic class. He will have a high number of criminal convictions and a history of other family members being in prison; there is a high rate of high rate of recidivism among these prisoners. The typical drug-using prisoner has also experienced extreme social disadvantage, being from an area with a high proportion of local authority housing and often with high prevalence of opiate drug use and a high level of long-term unemployment.

The widespread availability of drugs in prison, despite supply reduction initiatives, has been confirmed through data from prison drug-testing, and reports from the Inspector of Prisons, an independent statutory function which has oversight for Irish prisons. A prison survey currently under way will provide further information on drug-using patterns and practices among prisoners, both in prison and in the community. A recent study by the HRB on drug-related deaths post-release concluded that many of the deaths were preventable and the findings support the need for an overdose prevention strategy.

One of the key benchmark criteria relevant to the treatment of prisoners is equivalence of care. This, according to the Inspector of Prisons, is the minimum legal standard required in prison healthcare and entitles prisoners to the same care as that available in the community.

Since the launch of the Irish Prison Service (IPS) drugs policy and strategy document, *Keeping drugs out of prisons*, the provision of drug services in Irish prisons has improved. The IPS is committed to achieving care equivalent to that available in the community. Those presenting with problem opiate use are offered detoxification if it is clinically indicated, or stabilisation on methadone and addiction counselling as treatment options. The contracting-out of treatment services to addiction services based in the community and to private consultants including pharmacists has also been beneficial and has enhanced links between prison and community-based services.

Although there has been an improvement in the drug-related health policies and services in Irish prisons in recent years, the effective delivery of these services and the attainment of the goal of equivalence of care have been undermined because of severe prison overcrowding. In such a context the therapeutic benefit of drug treatment can become a secondary concern to the control and security priorities of the prison environment. Equally, a lack of clarity of responsibility and coherence of delivery hinders the provision of a seamless care service pre and post release and exposes vulnerable people to preventable drug-related deaths.

#### 12. Drug users with children

In 2006/7, just over 23% of all respondents to the all-Ireland general population drug use prevalence survey who reported having ever used any illegal drug, and 4% who reported having used any illegal drug in the last year, also reported that they had dependent children aged 18 years or younger. Between 2003 and 2009, NDTRS data showed that the proportion of drug users in treatment reporting that they lived with a partner and children ranged between 10.2% and 10.8%, and the proportion reporting that they lived alone with children ranged from 3.7% to 4.6%. A number of separate studies, undertaken between 1992 and 2007 at two of Dublin's maternity hospitals, found that the prevalence of illicit drug use among pregnant women ranged between 1% and 4.57%.

While there has been one major empirical study of the impact of parental drug use on children in Ireland, authors of other Irish research reports have indicated the need to research what amount to 'hidden populations' of children whose parents use drugs and to explore their particular experiences, vulnerabilities and risk profiles. These researchers have also highlighted the need for specific policies and services targeting these populations.

Statutory services in Ireland to ensure the welfare and protection of all children aged under 18 years include guidelines which identify parental drug or alcohol use as a risk factor leading to a welfare concern. In recent years delivery of these statutory services has been found to be inconsistent and the delivery system is currently being revised and strengthened. The need for adequate training for professionals implementing these guidelines in situations where parents are drug users is highlighted in several Irish research studies, in order to ensure these professionals are prepared and sufficiently sensitive and responsive to what are often complex and always unique situations.

## 11. Drug-related health policies and services in prison

### 11.1 Introduction

There are 14 institutions in the Irish prison system comprising 11 traditional 'closed' institutions, two open centres, which operate with minimal internal and perimeter security, and one 'semi-open' facility with traditional perimeter security but minimal internal security (the Training Unit). The majority of female prisoners are accommodated in the purpose-built Dóchas Centre adjacent to Mountjoy prison in Dublin and the remainder are located in a separate part of Limerick prison. Sixteen- and seventeen-year-old boys are held in a separate wing of St Patricks Institution beside Mountjoy prison.

Political responsibility for the prison system in Ireland is vested in the Minister for Justice, Equality and Defence. The Irish Prison Service (IPS) operates as an executive agency within the Department of Justice, Equality and Defence. It is headed by a Director General supported by seven directors. An important source of information and data for this selected issue are reports compiled by Office of the Inspector of Prisons. The Office of the Inspector of Prisons is a statutory, independent office established to carry out regular inspections of the 14 prisons and to report to the Minister for Justice, Equality and Defence. The Inspector of Prisons has recently deliberated on the various national and international legal obligations owed to prisoners by the state and the various legal provisions and processes which have a bearing on the conditions of prisoners. Two policy documents have a particular bearing on the provision of drug-related healthcare in the Irish prison system – the IPS policy and strategy document, *Keeping drugs out of prisons*, and the *National Drugs Strategy (interim) 2009–2016*.

Prevalence data regarding drug use and problem drug use in Irish prisons are not routinely collected. Indirect indicators of prison drug use include drug seizures and data obtained from prison drug tests. Data on drug-related deaths following release from prison have also recently been compiled by the National Drug-Related Deaths Index (NDRDI) of the Health Research Board. Information on prison drug treatment is contained in reports of the IPS, while data on the numbers in receipt of methadone are compiled by the Central treatment List. Replies to parliamentary questions by relevant Ministers have also been a useful source of data for this selected issue.

### 11.2 Prison systems and prison populations: contextual information

There are 14 institutions in the Irish prison system consisting of 11 traditional 'closed' institutions, two open centres, which operate with minimal internal and perimeter security, and one 'semi-open' facility with traditional perimeter security but minimal internal security (the Training Unit). The majority of female prisoners are accommodated in the purpose-built Dóchas Centre adjacent to Mountjoy prison in Dublin and the remainder are located in a separate part of Limerick prison.<sup>11</sup> Sixteen- and seventeen-year-old boys are held in a separate wing of St Patricks Institution beside Mountjoy prison. On 23 July 2011, the prison population numbered 4,478, and of this 163 were female (Reilly, Judge Michael 2010). See Table 11.1.1 for a summary of stated bed capacity per prison and the numbers in prison on this day.

**Table 11.1.1 Bed capacity (BC) and numbers in custody (NIC) in Irish prisons, 23 July 2010**

Name	Description and Location	BC	NIC
Mountjoy	Committal prison for adult male prisoners, at North Circular Road, Dublin 7.	630	728
Dóchas	Committal prison for female prisoners aged 17 years and over at North Circular Road, Dublin 7	105	140
Limerick	Committal prison for adult male	(M)	(M)

<sup>11</sup> Source: Homepage of the IPS [www.irishprisonservice.ie](http://www.irishprisonservice.ie)

Name	Description and Location	BC	NIC
	and female prisoners, at Mulgrave Street, Limerick.	290 (F)2 0	322 (F)2 3
Cork	Committal prison for adult male prisoners, at Rathmore Road, Cork.	272	316
Castlerea	Committal prison for adult male prisoners, at Harristown, Castlerea, Co. Roscommon.	351	414
Cloverhill	Committal prison for remand adult male prisoners, at Cloverhill Road, Clondalkin, Dublin 22.	431	462
Arbour Hill	Prison for adult male prisoners, at Arbour Hill, Dublin 7.	148	151
Midlands	Prison for adult male prisoners, at Dublin Road, Portlaoise, Co. Laois.	591	568
Portlaoise	Prison for adult male prisoners, including the detention of high security prisoners, at Dublin Road, Portlaoise, Co. Laois	359	273
Wheatfield	Prison for adult male prisoners, at Cloverhill Road, Clondalkin.	470	507
Shelton Abbey	An open centre for male prisoners aged 19 years and over, at Arklow, Co. Wicklow	110	108
St Patricks Institution	An institution for male juveniles aged 16 to 21 years, at North Circular Road, Dublin 7.	217	210
Loughan House	An open centre for the detention of male prisoners aged 18 years and over, at Blacklion, Co. Cavan	160	142
Training Unit	A semi-open place of detention for male prisoners aged 18 years and over, at Glengarriff Parade, Dublin 7, for industrial training.	117	114

Source: IPS 2011 [www.irishprisons.ie](http://www.irishprisons.ie)

Source for BC and NIC data: (Reilly, Judge Michael 2010)

During 2010 there were a total of 17,179 committals to prison in Ireland. This represents an 11.4% increase on the figure for 2009 (IPS Annual report 2010). With regard to the general profile of the Irish prison population, in the absence of regularly available data or in-depth research, information recently gathered by the Irish Penal Reform Trust (IPRT)<sup>12</sup> provides a basic insight<sup>13</sup>

- The rate of imprisonment in Ireland is 101 per 100,000 of population (July 2010).
- The prison population has increased by 400% since 1970.
- 60% of people serving sentences for 6 months or less are poor, and are often homeless.
- The majority of Irish prisoners have never sat a State exam and over half left school before the age of 15.
- In 2009, 162 people were imprisoned for the non-payment of a civil debt.
- There were 673 committals under immigration law in 2009.
- 228 young people aged under 18 were committed to prison in 2009, including one girl.
- There were 3,601 sentenced committals for road traffic offences in 2009, representing 33.1% of the total, an increase of 59% on 2008.
- 20.8% of sentenced committals in 2009 were for offences against property without violence.

<sup>12</sup> The Irish Penal Reform Trust is Ireland's leading non-governmental organisation campaigning for penal reform and prisoners rights.

<sup>13</sup> <http://www.iprt.ie/prison-facts-2>

- Prisoners in Ireland are 25 times more likely to come from (and return to) a seriously deprived area.
- Just under 30% of prisoners in Ireland are still 'slopping out', with no access to in-cell sanitation.
- 90.3% of sentenced committals in 2009 were for non-violent offences.
- 82.4% sentenced committals of women in 2009 were for non-violent offences.
- 70% of sentenced committals in 2009 were for six months or less.
- In 2008, of the 520 prisoners who enrolled in the school at Mountjoy prison, 20% could not read or write and 30% could only sign their names.
- 6,681 people were imprisoned for non-payment of court-ordered fines in 2010; 152 of those were for failing to pay court fines for not having a television licence.
- There were seven suicides recorded in Irish prisons in 2007, and 11 in 2008.
- Since 1997, more than 1,930 new spaces have been added to an increasingly overcrowded prison system.
- There are 250 'protection' prisoners being held on 23-hour lock-up (17 December 2010).
- Over 70% of prisoners are unemployed on committal and a similar percentage self-report as not having any particular trade or occupation.

With regard to the social profile of Irish drug-using prisoners, a pioneering study by O'Mahony in Mountjoy prison in Dublin, the largest prison in the state when the study was undertaken, found them typically to be single, aged between 14 and 30, male, urban, with many still living in the parental home, from large and often broken families, having left school before the legal minimum age of 16, with high levels of unemployment, with their best-ever job being in the lowest socio-economic class, with a high number of criminal convictions and high rates of recidivism, with a history of family members being in prison, and a profile of extreme social disadvantage characterised by being from areas with a high proportion of local authority housing and often by the prevalence of opiate drug use and high levels of long term unemployment (O'Mahony, P. 1997).

A more recent study on prison recidivism has confirmed that the general profile of the Irish prison population remains largely unchanged (O'Donnell, Ian, *et al.* 2007). The geographical distribution of prisoners released in 2004 was mapped to find out about the community contexts from which prisoners were drawn and to which they were likely to return. Data from the new IPS computer-based records system, Prison Records Information System (PRIS), was used to track and map the known addresses of 5,057 prisoners (out of a possible 5,588). Although the study did not focus solely on drug-related offenders, the findings highlighted the links between socio-economic deprivation, problematic drug use, crime and recidivism. The study found that more than 25% of offenders were re-incarcerated within 12 months of release and approximately 50% within four years. The most deprived areas in the country had 145.9 prisoners per 10,000 population, compared to 6.3 in the least deprived areas. The authors stated that 'the magnitude of this difference is startling and demonstrates unequivocally that it is the areas already marked by serious disadvantage that most bear the brunt of social problems that accompany released prisoners' (p. 4).

This study clearly highlighted the link between imprisonment, drug use and poverty: in the most deprived areas 57.8 prisoners per 10,000 were released after serving a sentence for a drug-related crime, compared to 1.8 in the least deprived areas. In terms of the geographic distribution of drug-related crime, Dublin, followed by the mid-west region (Clare, Limerick and North Tipperary), were likely to have higher numbers of prisoners convicted for drug-related crimes. While the distribution of violent offenders in Dublin was spread evenly between the suburbs and the inner city, prisoners serving a sentence for drug offences and, to a lesser degree, for property offences were more likely to come from the inner city than the suburbs.

## Drug use and problem drug use in prisons and after release

Prevalence data regarding drug use and problem drug use in Irish prisons are not routinely collected. With regard to harmful drug use among prisoners, previous studies in Ireland have found higher prevalence rates for self-reported current and having ever used drugs, in addition to higher prevalence rates for hepatitis B, hepatitis C and HIV, among prisoners than in the general population (Allwright, *et al.* 1999) (Allwright, *et al.* 2000) (Long, *et al.* 2000) (Long, *et al.* 2001) (Long, *et al.* 2003) (Long, *et al.* 2004).

Other indirect indicators of prison drug use include drug seizures (see Chapter 10.3.1) and data obtained from prison drug tests. In 2005 new Prison Rules were introduced, dealing with all aspects of prison life, including accommodation, visiting rights, discipline, health and education (Department of Justice Equality and Law Reform 2005). These rules provided for the introduction of compulsory or mandatory drug testing (MDT) of prisoners. Section 28 (5) (a) states: 'In the interest of good order, safety, health and security and in accordance with directions set down by the minister, a prisoner ... shall, for the purpose of detecting the presence or use of an intoxicating liquor or any controlled drug ... provide all or any of the following samples, namely – urine, saliva, oral buccal transudate, hair.'

Information on drug testing in prisons in 2009 was obtained from the IPS by the HRB. These data indicate that more than 28,000 voluntary tests were carried out to monitor drug use and responses to treatment in 2009. These tests included those carried out on some committals (new entries) as well as those carried out on existing inmates. It may be assumed therefore that some of the positive test results relate to drugs or alcohol consumed outside the prison.

Excluding methadone, between one-tenth and two-fifths of those screened tested positive for at least one drug. The common metabolites detected indicate use of cannabis, benzodiazepines and opiates (see National Report 2010 section 4.4) (Irish Focal Point 2010).

Another source of information on prison drug use is contained in reports prepared by the Inspector of Prisons.<sup>14</sup> Following a number of reviews of prisons throughout the Irish prison estate, the Inspector of Prisons recently concluded that 'the overall level of drug abuse in our prisons is very high' (Reilly, M 2009) (para. 10.3) (see NR 2010 Section 9.5) (Irish Focal Point 2010). In a further report, *The Irish prison population – an examination of duties and obligations owed to prisoners*, he identified a range of issues associated with drug use throughout the prison estate (Reilly, Judge Michael 2010). These include the following:

- Castlerea: 'Drugs are not a major cause for concern...I have been informed that a methadone maintenance programme is to be introduced in the coming months.' (para 7.13)
- Cloverhill: 'The prevalence of drugs is not a major cause for concern in Cloverhill Prison but as the prison population is transient problems may arise that may not be found in the committal prisons.' (para 8.11)
- Cork: 'Drugs are a problem in the prison but I have been informed that because of the type of nets over two yards this is not a source of supply.' (para 9.9)
- Dochas: 'There is now no dedicated drug-free area in the prison due to overcrowding...because of overcrowding prisoners with drug problems are accommodated in houses (that were formerly drug free)...Drugs are a serious problem...There are no nets over the yards. The increase in population has also intensified the demand for illicit drugs...During a number of my latter visits I observed prisoners obviously under the influence of some form of drugs.' (para 10.6)

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<sup>14</sup> The Office of the Inspector of Prisons is a statutory, independent office established under the Prisons Act 2007. The key role assigned to the Inspector is to carry out regular inspections of the 14 prisons in the State and to present his report(s) on each institution inspected as well as an Annual Report to the Minister for Justice and Law Reform.

- Limerick: 'Drugs are a major problem in the prison. I and my staff have observed many prisoners obviously under the influence of drugs' (para 11.11), and in the female prison, 'Drugs are a very serious problem. On numerous occasions my staff and I have observed prisoners obviously under the influence of drugs.' (para 11.29)
- Midlands: 'Drugs are not a major cause for concern in the prison.' (para 13.5)
- Mountjoy: 'Drugs are a major problem in the prison. I have been informed that new nets are to be erected over the yards which should curtail the amount of drugs...that reach prisoners by that route. It is not unreasonable to speculate, because of the number and types of seizures, that drugs and contraband enter the prison by other routes.' (para 14.16)
- Portlaoise: 'Drugs are not an undue problem in the prison.' (para 15.8)
- Shelton Abbey Open Centre: 'Drugs are not a problem in the prison.' (para 16.8)
- St Patrick's Institution: 'Drugs are a problem...One source of supply is over the perimeter wall into the yards.' (para 17.6)
- The Training Unit: 'Drugs are not a problem in the prison.' (para 18.10)
- Wheatfield: 'Drugs are not a major problem in Wheatfield Prison.' (para 19.8)

### **Drug-related deaths upon release from prison**

International research has found an increased risk of mortality among prisoners within the days and weeks following their release from prison (Binswanger, *et al.* 2007). Many of these deaths are drug-related and the increased mortality risk is thought to be caused by the altered tolerance to drugs which an individual may develop while in prison (Jones, *et al.* 2002) (Seymour, *et al.* 2000). A recently published paper based on data from the National Drug-Related Deaths Index (NDRDI) for the years 1998–2005 examined the relationship between date of release from prison and drug-related death (Lyons, Suzi, *et al.* 2010). This was the first study of its kind in Ireland.

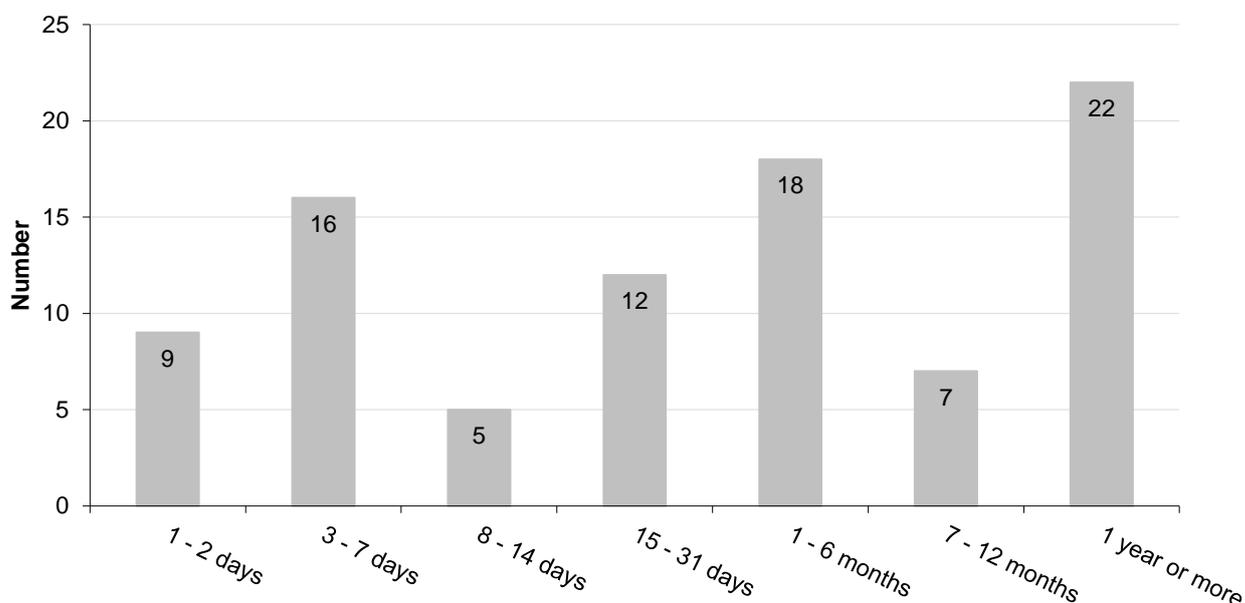
### **Profile of cases examined**

Between 1998 and 2005, 2,442 drug-related deaths were recorded on the NDRDI. One hundred and thirty of the individuals who died had a documented history of imprisonment. Of the 130 individuals, 105 were not in prison at the time of death. Of these 105 individuals:

- the majority (93, 88.6%) were male;
- most (69, 65.7%) were aged between 20 and 29 years (median age 29 years);
- the majority (88, 83.8%) were unemployed;
- 21 (20.0%) were living in unstable accommodation, and 10 (9.5%) were homeless;
- 64 (61.0%) had a history of injecting, and 36 (34.3%) were injecting at the time of death; and
- 11 (10.5%) had a blood-borne viral infection recorded in their history, of whom five were co-infected with two or more viruses.

### **Time between release from prison and death**

Of the 105 individuals, 89 had a known date of release (Figure 11.1.1). Of these, nine (10.1%) died on day one or day two, and 16 (18.0%) died between day three and day seven. Almost half (42, 47.2%) of the 89 deaths occurred within the first month of release.



**Figure 11.1.1 Relationship between date of release from prison and drug-related death (n=89), NDRDI 1998–2005**

### Deaths by poisoning within the first month of release

Of the 42 deaths within the first month of release, 38 were due to poisoning, and 18 of those who died were injecting drugs at the time of their death. Of the 14 deaths involving a single drug, 11 involved an opiate, mainly heroin and/or methadone (Table 11.1.2). Of the 24 deaths involving polysubstances, 23 involved an opiate (in addition to one or more other substances).

**Table 11.1.2 Substances involved in deaths by poisoning within the first month of release from prison (n=38), NDRDI 1998–2005**

Substance	n (%)*
Heroin	19 (50.0)
Methadone	18 (47.4)
Benzodiazepines	11 (28.9)
Antidepressants	6 (15.8)
Stimulants <sup>†</sup>	7 (18.4)
Other <sup>‡</sup>	11 (28.9)

\* The sum of percentages in this column exceeds 100% as most deaths involved more than one substance.

<sup>†</sup> Includes cocaine and methamphetamine.

<sup>‡</sup> Includes non-benzodiazepine sedatives, unspecified opiates, analgesics containing an opiate compound, anti-psychotics, non-opiate analgesics, alcohol, solvents, cardiac and all other types of medication, including over-the-counter products.

The findings of this study are consistent with those of international studies in this area. The number of cases reported in this study is likely to be underestimated, as history of imprisonment is not routinely recorded in the NDRDI data sources. The study highlights the need for education and awareness among prisoners and their families and friends about the risk of overdose in the days and weeks following release. Many of these deaths are preventable and the findings of the study support the need for an overdose prevention strategy.

## 11.3 Organisation of prison health policies and service delivery

### Prison health

Political responsibility for the prison system in Ireland is vested in the Minister for Justice and Equality. The IPS operates as an executive agency within the Department of Justice and Equality. It is headed by a Director General supported by seven directors. A non-executive Prisons Authority Interim Board provides advice guidance in the management of the prison system.

The Inspector of Prisons has recently deliberated upon the various national and international legal obligations owed to prisoners by the state and the various legal provisions and processes which have a bearing on the conditions of prisoners (Reilly, Judge Michael 2010). The Inspector states that:

As a country our obligations towards our prisoners can be found in our Constitution, our laws, our jurisprudence, our prison rules and in the standards that I published. Our international obligations can be found in the many international instruments to which we are a party, the jurisprudence of the European Court of Human Rights [ECHR], the European and International rules that refer to prisoners and the reports of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (the CPT). (para 1.9)

In supporting the right of Irish prisoners to adequate health care, the Inspector cites a number of further authorities including the World Health Organizations' Constitution of 1946; the Universal Declaration of Human Rights 1948 (para 2.1); article 12(1) of the International Covenant on Economic, Social and Cultural Rights, to which Ireland is a signatory; Articles 40 to 44 of the Irish Constitution which, although not specifically referring to a right to health have, over time, been interpreted as implying a 'right to bodily integrity', a right not to have one's health 'exposed to risk or danger' and the right 'not to be subjected to inhuman or degrading treatment' (para 2.6). As a result of the incorporation of the ECHR into Irish law, prisoners can now take legal actions in domestic courts or they can apply for redress to the ECHR when all domestic legal remedies have been exhausted. The Inspector points out that 'in special and extraordinary circumstances and where it can be demonstrated that a state has failed to improve systemic or structural conditions or problems an application can be made directly to the European Court of Human Rights without exhausting domestic remedies.' (para 1.2)

The three general headings under which the state owes obligations to prisoners are (1) appropriate accommodation, (2) adequate services and regimes, and (3) prisoner safety. According to the Inspector, and for the purpose of this select issue, 'services and regimes' include such matters as 'education, structured vocational work training, recreation, exercise...health, welfare, diet...addiction and psychology services' (para 3.5). With regard to the standards required, the Inspector states that, 'The United Nations Minimum Rules for the Treatment of Prisoners, the European Prison Rules and the observations of the CPT do not have statutory authority but must be considered persuasive.' (para 3.3) However, with regard to the status of the Irish Prison Rules, the Inspector concurs with a previous court decision by O'Higgins Chief Justice in the case of *State (Walsh and McGowan) – v – Governor of Mountjoy*,<sup>15</sup> when he stated that 'having been made under the authority of the various Prison Acts, they have statutory effect and must be so regarded' (Reilly, Judge Michael 2010): para 3.4).

The Inspector of Prisons has set out the various provisions under the instruments outlined above that he believes are relevant when determining the level and appropriateness of services and regimes that should be provided in Irish prisons. In a further report published in April 2011, *Guidance on physical healthcare in a prison context*, the Inspector sets out for the IPS 'the guidance available from all relevant sources which, if accepted, should lead to best practice in the provision of healthcare in our prisons'(Reilly, Judge Michael 2011) (para 1.3). He notes that the guidance provided is 'relevant not only to the IPS and local management of prisons but also to all those who contribute to the healthcare of prisoners be they working within the Irish prison system or as contractors to the system.' (para 1.5)

In addition to these general instruments, the Inspector of Prisons lists instruments specifically recognising a prisoner's right to health, including the Council of Europe's

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<sup>15</sup> Unreported, High Court, 12 December 1975.

Recommendation (98)<sup>7</sup> concerning the ethical and organisational aspects of healthcare in prison, Principle 9 of the Basic Principles for the treatment of prisoners, and Principle 1 of the Principles of Medical Ethics relevant to the Role of Health Personnel, particularly Physicians, in the Protection of Prisoners and Detainees against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (para 3.4).

With regard to the last, the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) includes the provision of healthcare in prisons within its mandate when observing and making recommendations on the obligations of signatory states, including Ireland. In explaining this position, the CPT has stated: ‘...an inadequate level of healthcare can lead rapidly to situations falling within the scope of the term “inhuman and degrading treatment”...regardless of the difficulties faced at any given time, the act of depriving a person of his liberty always entails a duty of care which calls for effective methods of prevention, screening, and treatment’ (quoted in (Reilly, Judge Michael 2011): para 3.7).<sup>16</sup> In a recent visit to Ireland, the CPT was highly critical of aspects of the drug treatment regime in the Irish prison system (Committee against Torture 2011).

One of the key benchmark criteria relevant to the treatment of prisoners is equivalence of care. This, according to the Inspector of Prisons, ‘is the minimum required in a prison healthcare context and entitles prisoners to the same care as that available in the community.’ (Reilly, Judge Michael 2011) (para 3.11). The stated aim of the Irish Prison Service is ‘to deliver a quality of healthcare reflective of that available to those holding medical cards in the wider community, taking into consideration the constraints that custody imposes’ (Annual report 2010, p28). The observations of the CPT and the Inspector of Prisons in relation to compliance by the IPS with equivalence of care criteria will be discussed below.

### **Drug-related health policies targeting prisoners**

Two policy documents have a particular bearing on the provision of drug-related healthcare in the Irish prison system – the IPS policy and strategy document, *Keeping drugs out of prisons*, and the *National Drugs Strategy (interim) 2009–2016* (NDS).

In May 2006 the Minister for Justice launched *Keeping drugs out of prisons: drug policy and strategy* (Irish Prison Service 2006a). This sets out the steps required to tackle the supply of drugs into prisons, to provide adequate treatment services to those who are addicted to drugs, and to ensure that developments in the prisons are linked to those in the community. The IPS, in partnership with statutory and voluntary agencies, provides programmes to assist in the areas of prevention, treatment, rehabilitation and aftercare, both to address the harmful effects of substance use and to prevent the spread of HIV, hepatitis B and C and other infections. Phase 1 of this policy involved putting in place the necessary staffing levels to provide the required services to prisoners. Phase 2 sought to provide prisoners with access to a range of drug treatment options ‘consistent with the objective of achieving a standard of care which is equivalent to that available in the community’ (Department of Community Rural and Gaeltacht Affairs 2009) (para 4.46). The specific measures which have been adopted as part of the strategy and the progress made in relation to them are described in Section 11.3 below.

The following actions in the NDS relate to treatment in prisons (Department of Community Rural and Gaeltacht Affairs 2009):

- Treatment and rehabilitation (Action 43) – Continue the expansion of treatment, rehabilitation and other health and social services in prisons and develop an agreed protocol for the seamless provision of treatment services as a person moves between prison (including prisoners on remand) and the community; and

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<sup>16</sup> The CPT quote is derived from CPT 3<sup>rd</sup> General Report [CPT/Inf(93)12] at para 30.

- Research/information (Action 55) – research prevalence patterns of problem substance use among prisoners.

The Steering Group that drafted the NDS also explains that ‘a small expert group has been convened to consider the issues of providing needle exchange in prisons’ (para. 4.48). With regard to the risk of overdose or relapse immediately following release from custody, the Steering Group states that there is a need for ‘an effective and co-ordinated interagency approach to ensure the seamless transition from prison back into the community. This requires the availability of, and timely access to, a range of supports including suitable accommodation, treatment/counselling services, training/education/ employment options and personal supports’ (para. 4.49). However, the Steering Group continues that, ‘clarity is required around who will deliver these services, including planned release and post-release arrangements’ (para 4.49).

In 2005, the mid-term review of the previous National Drugs Strategy 2001–2008 recommended that rehabilitation be adopted as a fifth pillar of the strategy (Department of Community Rural and Gaeltacht Affairs 2005). Arising from this recommendation, the HSE appointed an expert working group in 2006 to describe residential treatment services for problem drug and alcohol users in Ireland, to calculate their capacity and to estimate future requirements (O’Gorman and Corrigan 2008). In relation to the issue of throughcare upon release from prison, this expert working group recommended the ‘provision of step-down or halfway-house accommodation for newly released prisoners who have been detoxified or who have started rehabilitation programmes...not least because of the vulnerability of such individuals to relapse and overdose’ (p. 5).

#### **11.4 Provision of drug-related health services in prison** (please provide methodological information: information sources, method of data collection and analysis, limitations)

##### **Prevention, treatment, rehabilitation, harm reduction**

In line with *Keeping drugs out of prisons* (Irish Prison Service 2006a), described in Section 11.2 above, new services and programmes for addicted prisoners were developed in 2006. These are delivered by the IPS in partnership with the HSE and contracted private services. The 2009 IPS annual report states that the provision of drug treatment services continues to be one of the ‘biggest and most resource intensive challenges for healthcare in the prisons setting’ (Irish Prison Service 2010) (p. 41). The report also describes the various social and health programmes available to prisoners. Educational programmes include basic education, i.e. literacy and numeracy, creative arts, information technology, woodwork, general subjects including languages and the arts, life skills courses and physical education courses. Vocational training courses are also provided including printing, computers, metalwork, construction, catering etc.

With regard to drug treatment services, the 2009 annual report states that ‘the Irish Prison Service...in the national context of drug treatment provision, has cared for over 20% of the total numbers on methadone nationally’ (p. 41). Those who present with a history of problem opiate use are offered detoxification if it is clinically indicated, or stabilisation on methadone and addiction counselling as treatment options. The Medical Unit in Mountjoy prison has spaces allocated for a dedicated drug detoxification programme. This programme is available to any prisoner who meets the qualifying criteria, subject to assessment. Each multi-disciplinary programme lasts six weeks and the programme’s capacity is nine prisoners. The programme involves both prison-based staff and external agencies and is aimed at assisting prisoners who have indicated a desire to move from either a situation of current drug use or existing substitution programme to drug-free status.

As a matter of policy, those who are already on methadone when committed can continue to receive this treatment for the duration of their sentence. Prisoners who on committal are engaged in a methadone substitution programme in the community will,

in the main, have their methadone substitution treatment continued while in custody. Methadone maintenance is available in eight of the 14 places of detention, which accommodate over 80% of the prison population (IPS Annual report 2010, p29) (Irish Prison Service 2011).

According to the IPS, 'addiction counselling services are available in all prisons and places of detention where prisoners require such a service. ... The service offers structured assessments and evidence-based counselling interventions with clearly defined treatment plans and goals' (Irish Prison Service 2010) (p. 41). Counselling is available to prisoners who have a history of drug use including opiates, cocaine, ecstasy, amphetamines, LSD, anxiolitics, hypnotics, alcohol, cannabis and other illicit and licit drugs. The Psychology Service in Mountjoy prison has, according to the IPS annual report for 2010, 'adapted a manualised motivational programme for drug users to a prison context. This programme is based on the trans-theoretical model of behaviour change and principles of motivational and cognitive behavioural psychology' (Irish Prison Service 2011) p. 25.

Primary care is the model of care through which healthcare is delivered in the prison system. A number of contracted private services assist the IPS and HSE in the provision of drug treatment services. The service is provided by a mix of part-time and full-time doctors and nursing staff. Nurses first began working in the IPS in 1999 (Nursing and Midwifery Planning and Development Unit & Irish Prison Service 2009).

Addiction counselling services have been provided to the IPS by Merchants Quay Ireland (MQI) since 2007. A voluntary organisation providing services to vulnerable people including drug users, in 2008 MQI completed the implementation of a national prison-based addiction counselling service to 13 prisons. In excess of 1,300 counselling hours were provided in 2010, and the 23 counsellors each carried an average caseload of 550 prisoners (Merchants Quay Ireland 2011). A tender for the continuation of this service was finalised in 2010 with MQI securing the contract for a further three years (Irish Prison Service 2011).

Professional pharmacy services are in place in all prisons. According to the IPS, 'the introduction of pharmacy services also supports more effective throughcare, as each prisoner's dispensed medicines are now sent with him/her on transfer to another prison' and can also be given to him/her on full or temporary release until the prisoner can engage with the community healthcare services' (Irish Prison Service 2010) (p. 40). Since May 2010, according to the IPS, 'Pharmacists are now responsible for all aspects of drug treatment (mainly methadone) dispensing, administration, recording, ordering, storage etc', in Mountjoy, Dochas womens prison, Midlands and Portlaoise prisons (Irish Prison Service 2011). A number of specialist tertiary services provide in-reach medical care to the prison population. Service level agreements are in place with the HSE, for example, to provide consultant-led addiction services to Cloverhill, Wheatfield and Mountjoy prisons. A consultant-led infectious diseases service has also been contracted from St James Hospital in Dublin to provide treatment to prisoners who suffer from infectious diseases including hepatitis C and HIV. According to the IPS, 'the development of this service has demonstrably decreased the number of prisoners transferred to St James Hospital Guide Clinic for screening and treatment' (Irish Prison Service 2010) (p. 40). Table 11.4.1 shows the treatment options available by prison in September 2010.

**Table 11.4.1: Treatment options available by prison, September 2010**

Institution	Treatment types	Provided by
Mountjoy, Dóchas, St. Patrick's, Cloverhill, Wheatfield, Portlaoise, Midlands	Methadone/detox, stabilisation and maintenance Full range of counselling services	IPS, HSE, MQI

Institution	Treatment types	Provided by
Loughan House, Shelton Abbey, Castlerea	Addiction Counselling Services Focused on Alcohol /Cannabis Abstinence driven	IPS, MQI
Cork	Alcohol /Cannabis Abstinence driven — physical space a barrier to service provision	IPS, MQI, Local Drugs Task Force
Limerick	2 models of counselling in operation; abstinence based and a harm reduction model Methadone Substitution treatment is determined following clinical evaluation	IPS, MQI, ALJEF*
Training Unit	Counselling	IPS, MQI, Coolmine**

Source: (Ahern, Dermot 2010, 29 September)

\* ALJEF Addiction Services in Limerick [www.aljef.org](http://www.aljef.org)

\*\* Coolmine therapeutic community [www.coolmine.ie](http://www.coolmine.ie)

The National Drug Treatment Reporting System (NDTRS) records information on some drug treatment in prison (see Standard Table 24 for latest data). These data show that there were 794 individuals treated for problem drug use in Irish prisons in 2009 (751 male, 42 female). For the purpose of the NDTRS, treatment is broadly defined as 'any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their substance misuse problems' (Bellerose, *et al.* 2010). However, most of the treatment data for prisons supplied to the NDTRS for 2009 is in relation to drug counselling.

Another source of data is the Central Treatment List (CTL). All prisoners who receive methadone treatment in prison are recorded on the CTL database. As explained above, methadone maintenance is available in 8 of the 14 places of detention, accounting for over 75% of the prison population. The number of prisoners on methadone maintenance treatment increased by 20% between 2008 and 2009 (Irish Prison Service 2010). There was a 10% increase in the number of people new to treatment. Over 20% of those on the CTL in 2009 were treated within the IPS, and 31% of all new entrants on the CTL in 2009 were treated within the IPS. On 31 December 2010, the CTL reported that there were 539 people attending methadone treatment in prison in Ireland (personal communication, Suzi Lyons, HRB, July 2011). Of these, 33 were female. Table 11.4.2 shows the numbers in receipt of methadone substitution treatment by prison.

**Table 11.4.2: Number of cases attending methadone treatment in prison, 31 December 2010**

Prison	Number receiving methadone
Cloverhill	84
Wheatfield	97
Mountjoy male	206
Mountjoy medical unit	16
Dochas centre (female)	30
St Patrick's	0
Midlands	56
Portlaoise	25
Limerick	22
<b>Total</b>	<b>539</b>

Source: Central Treatment List, unpublished data, July 2011

In response to a parliamentary question, in October 2010 the former Minister for Justice, Equality and Law Reform stated that there were 34 prisoners in the prison system on waiting lists for drug treatment programmes at that time. He further stated that 'No prisoner has been on the waiting list for more than three months (Ahern, Dermot 2010, 07 October).

## 11.5 Service quality

Practical guidelines and standards of drug-related health services have been outlined in a comprehensive drug treatment clinical policy document, *Drug treatment clinical policy* (Irish Prison Service 2008). The policy document covers:

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

The document details the processes necessary for methadone treatment, whether a prisoner is already on methadone on admission or is to be initiated into treatment in prison, and for planned release of a prisoner on methadone. Issues around blood-borne viruses, including testing, clinical management and immunisation, are also addressed in the policy.

The document states that the misuse of benzodiazepines is an endemic problem in the Irish prison population and recommends policies and guidelines around assessment of dependence, prescribing and detoxification. The Lofexidine detoxification and alcohol withdrawal guidelines have been modified from The Maudsley protocols. Guidelines for the use of Naltrexone, as part of an overall programme of addiction treatment, along with psycho-social support, are outlined in the document. The guidelines state that Naltrexone should only be prescribed by a medically-qualified person experienced in its use. The use of injectable Naltrexone for reversing accidental opiate overdose is not covered.

The document states that an interdisciplinary team will provide treatment for problem cocaine use on an individual basis. There is a range of treatments available including counselling and cognitive behavioural therapy, along with appropriate referrals to medical or psychiatric services as necessary. It is the policy of the IPS, in accordance with the community standard, to develop a dual diagnosis service for those patients with addiction problems and mental health problems. See Chapter 12.3.2 for details of guidelines on treatment of pregnant women in prison.

The IPS document *Health Care Standards* (Irish Prison Service 2009) provides further guidance on the general provision of healthcare in Irish prisons. These standards have been developed by a multidisciplinary group representing the various health-related interests involved in prisoner health care. The standards recognise the need not only to define the services to be provided but also to measure the effectiveness of such services. In relation to drug treatment services, healthcare standard 9 states:

- to provide clinical services for the assessment, treatment, and care of substance misusers comparable to those available in the community, and which are appropriate to the prison setting, and
- all methadone treatment delivered to prisoners will be based on IPS Methadone Guidelines as derived from the European Methadone Guidelines.

A recent study of the nursing service in the Irish prison system gives an insight into the challenges in implementing the guidelines. The report set out 16 goals for the future development of prison nursing and healthcare in Ireland, each with its own set of recommendations. The authors stated that many of the associated recommendations did not require additional resources or funding, but restructuring and integration of existing services and resources and effective collaboration at all levels (Nursing and Midwifery Planning and Development Unit & Irish Prison Service 2009). For a detailed account of the findings, see National Report 2010 Chapter 5.3.2 (Irish Focal Point 2010).

## 11.6 Discussion, methodological limitations and information gaps

### Equivalence of care

Equivalence of care is both a legal requirement and a clear policy goal of the IPS while the NDS aims to ensure the seamless provision of treatment services as a person moves between prison (including prisoners on remand) and the community. In its annual report for 2010, the Irish Prison Service, although re-stating its commitment to equivalence of care provision, has stated that a challenge to this objective 'is that prisoners have been identified, in health strategy documents, as having significant health deficits relative to the "average" health status of the general population and as such should be considered a "special needs2 category' (Irish Prison Service 2011). Notwithstanding this argument however, and although the provision of prison-based drug services has improved, questions have recently been raised generally about the nature and therapeutic benefit to the prisoner of the treatment provided, particularly in relation to methadone substitution treatment.

A study by Carlin in Ireland's main committal prison, Mountjoy, used semi-structured interviews and a focus group to explore the perceptions of staff and prisoners towards methadone maintenance within the prison (Carlin 2005). The research subjects were generally positive in their assessment of Mountjoy's methadone programme. Prisoners perceived it as leading to an improvement in their relationships with their families, while staff viewed it as facilitating a more stable and safer working environment. However, although prisoners' use of heroin had reportedly declined since the advent of the methadone maintenance programme, their use of other drugs had not.

There were negative views expressed by both groups about the manner in which methadone is dispensed within the prison, and also because methadone was viewed as being as addictive as heroin. Five different perceived purposes for using methadone maintenance were identified: (1) to ensure continuity of harm reduction policies from the community, (2) to reduce the supply of heroin in the prison, (3) to prevent needle sharing and the spread of blood-borne infections, (4) to treat heroin addiction, and (5) to control prisoners and maintain order and discipline within the prison. The study found that there was a widely held perception that this last, latent function of methadone maintenance could be seen as of greater importance than the more conventional harm-reduction functions that were also identified: 'In the majority of interviews, prison staff described the methadone maintenance programme in terms of keeping the prison and prisoners calm, making the prisoners less confrontational and as a means of ensuring the prison ran smoothly' (p. 413). The author also concluded that the findings indicated that there were 'operational difficulties in dispensing methadone in a prison setting and that the therapeutic intent of the methadone programme fitted uneasily into the custodial milieu' (p. 413).

While it may be argued that matters have improved since Carlin's study, which was conducted in 2003, a more recent study by the Council of Europe's Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) has raised similar issues (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment 2011b). The CPT considered the provision of prison drug treatment within the context of overcrowding, widespread drug availability, the existence of feuding gangs, and 'high rates of inter-prisoner violence in Mountjoy prison'. The CPT observed that drug misuse remained a 'major challenge' in all prisons visited, and that 'management and health-care staff in most prisons visited acknowledged both the rising numbers of prisoners with a substance abuse problem and the widespread availability of drugs' (p. 41). The CPT acknowledged that, since its visit in October 2006, further investment had been made to implement the IPS drugs strategy through initiatives such as the provision of detoxification, methadone maintenance, education programmes, addiction counselling and drug therapy programmes. However, the CPT stated that it had 'serious concerns over the manner in which methadone prescribing is carried out in Cork, Midlands and Mountjoy Prisons' (p. 41).

Methadone, according to the CPT, should only be prescribed as part of a comprehensive drug treatment programme that includes engagement with ‘addiction counsellors, addiction nurses and as required an addiction psychiatrist’ (p. 42). Furthermore, it stated: ‘The dose of methadone prescribed as maintenance should be that required to stabilise a prisoner’s drug use to the extent that the inmate injects or uses opiates less frequently and remains in contact with prison addiction services’ (p. 42). These practices were not observed at either the Midlands or Mountjoy prisons, where, according to the CPT, there were a number of serious shortcomings. Prisoners who were on a methadone prescription at the time of admission ‘often merely had the dose continued and were not required to engage with the addictions counsellor ... many of the methadone prescriptions were illegible ... there was a lack of medical review of the prescription ... there was no reference to the frequency of drug use, including injecting, or to the nature of illicit drugs consumed; for example, monitoring through regular analysis of urine’ (p. 42). At the Midlands prison, ‘urinalysis results were not annotated in prisoners’ medical records; apparently, they were not even kept at the prison’ (p. 42).

A further concern related to the prescription of methadone as a detoxification agent either upon admission to prison or when an inmate identified him/herself as having an illicit drug use problem. The absence of any assessment as to whether a prisoner was likely to suffer from drug withdrawal subsequent to admission and the practice of placing a prisoner who gave a history of drug use on a three-week methadone detoxification programme were also highlighted in the report. Given that there was no routine follow-up of withdrawal or other symptoms and no assessment as to whether prisoners were continuing their illicit drug use on top of the prescribed methadone detoxification, the CPT concluded that ‘for a number of prisoners in receipt of a methadone detoxification prescription it could be stated that this was simply “free petrol” ’ (p. 42). The CPT also found that, overall, medical records were found to be incomplete or lacking in detail, with prisoners not receiving medical examination on admission at Cork or Mountjoy prisons.

The CPT concluded its report with a list of recommendations, comments and requests for information, including the following:

- all prisoners admitted while on a methadone maintenance programme in the community to be able to continue such maintenance within prison as part of a comprehensive drug treatment programme;
- prisoners undergoing drug withdrawal to be provided with the necessary support to alleviate their suffering and not to be placed in a cell without integral sanitation; and
- steps to be taken to remedy the deficiencies related to the prescription of methadone.

The Irish government has responded to the CPT report (European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment 2011a). In relation to a recommendation that the IPS review the treatment of all prisoners at Cork, Midlands and Mountjoy prisons receiving medication (with priority given to those receiving methadone), the Irish government has stated that the IPS has commissioned a number of independent reviews of a number of prisons, including ‘a review of primary care at Midlands, Cork and Mountjoy prisons, a review of prescribing practice at Midlands prison and a review of drug treatment services at Midlands, Cork and Mountjoy prisons’ (p. 45). In response to criticism made by the CPT in relation to the inadequate maintenance of medical records, the Irish government responded, ‘Subsequent to the CPT visit, the Director General [of the IPS] informed all prison doctors of the critical importance of recording their findings following a consultation and that the standard of medical notation must be clear, comprehensive and outline the treatment and follow up care for each patient’ (p. 48).

Barry and colleagues, following an independent assessment of primary health care provision in 11 out of the 14 prisons in Ireland, have also raised issues with implications for equivalence of care provision (Barry, Joseph , *et al.* 2010). Using a

checklist based on the Competence Assurance Exercise in General Practice, which includes items such as state of premises, equipment, contracted hours, time allocation and support staff, the report found that the medical facilities in six prisons were unsuitable (many had been built in the 19<sup>th</sup> century) but refurbishment was planned for some of them. In general, the standard of medical equipment was not at the same level generally available in Irish general practice outside the prisons. Furthermore, the authors observed there was no international benchmark for the type, quality or quantity of essential medical equipment for prison medical facilities. The number of patients a doctor saw per hour varied between 3.7 and 18.7, depending on the facility. Much of this time was taken up with committals and transfers of prisoners. Seven of the eleven prisons assessed were providing methadone maintenance treatment. Finding that most medical facilities did not have a medical secretary, the authors stated that medical secretaries would increase the efficiency of the medical units. They suggested that the IPS should consider adopting the UK strategy, whereby the Department of Health has responsibility for health care in the UK prison system, and proposed the HSE take responsibility for delivering health care in the IPS. In its Annual Report for 2010, the IPS (Irish Prison Service 2011) states that following concerns raised by the CPT and by Barry and colleagues, all relevant reviews have now been completed and that the implementation of recommendations arising from these reviews will require 'considerable work' and, 'in some instances...the availability of resources' (p 31). A working group has been established to bring forward the implementation of the various recommendations made.

It is also questionable whether the principle of equivalence of care can be effectively delivered in overcrowded prisons (see Table 11.1.1). For example, the provision of drug-free areas is directly undermined by prison overcrowding. In a joint report to the first periodic review of Ireland under the United Nations convention against torture and other cruel, inhuman or degrading treatment or punishment, the Irish Council for Civil Liberties and the Irish Penal Reform Trust have highlighted the issue of overcrowding in Irish prisons and how this has a detrimental impact on the provision of appropriate medical care (Irish Council for Civil Liberties and Irish Penal Reform Trust 2011). The joint submission recommends that:

- The doctor to patient ratio in the prison system should be reduced to ensure a proper standard of care and the maintenance of adequate medical records.
- An annual report should be published on the state of medical services in the IPS.
- Drug-free units should be established across the prison estate and the state should ensure that non-drug using prisoners are not accommodated with known drug-users as, they claim, is currently the case.
- A structured approach to reducing and eventually stopping prisoners' dependency on drugs must be developed.

Similar observations and recommendations about prison policy were made by Irish non-governmental organisation Drug Policy Action Group ((O'Mahony 2008). Having reviewed the historical background and current issues under the five pillars of the NDS, the author concluded:

- There is an urgent need for properly designed and resourced custodial drugs treatment centres, where useful, abstinence-oriented programmes, such as therapeutic communities and cognitive behavioural therapies, could be provided for suitable prisoners.
- Rehabilitation should be tailored to the individual needs and potential for personal growth of prisoners, who very frequently come from a background of multiple disadvantage and who have often failed disastrously in the normal education system. A rehabilitative approach entails a strong focus on education, training and the purposeful occupation of prisoners. This means that all new prisons should be built at least to the standard of the Dóchas Centre Women's Prison, exploiting modern technology and exemplifying positive advances in architectural design.<sup>17</sup>

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<sup>17</sup> These proposals were written at a time when there was no overcrowding in the Dóchas Centre.

- In order to achieve a more rational, effective and rehabilitative prison system, it is essential to adjust current sentencing policy and reduce the number of minor, non-violent, drug-using offenders sent to prison for short terms. The use of the Drugs Court, mandatory drugs treatment outside the prison system and non-custodial sanctions should be greatly expanded.
- A more coherent drugs policy for prisons would put less emphasis on supply control and far more emphasis on the reduction of the many different types of harm caused to prisoners by the current drugs culture in prisons. A more coherent policy would place far more stress on abstinence-based treatments than on methadone substitution. A more coherent policy would recognise that improving prison conditions and providing an environment conducive to the general rehabilitation of offenders are absolutely essential to tackling the prison drugs problem.

### **Drug-related deaths, continuity of care and reintegration of drug users after release from prison**

The issue of continuity of care is related to the issue of equivalence of care. The incidence of preventable drug-related deaths upon release from prison (Lyons, Suzi, *et al.* 2010) and the high rates of recidivism associated with problematic drug users (O'Donnell, Ian, *et al.* 2007) highlight the importance of providing what Action 43 of the NDS describes as 'the seamless provision of treatment services as a person moves between prison (including prisoners on remand) and the community' (Department of Community Rural and Gaeltacht Affairs 2009)(p. 101). A number of studies have identified the challenges in this respect.

Pugh and Comiskey evaluated the seven-week abstinence-based drug treatment programme at Mountjoy prison in Dublin (Pugh and Comiskey 2006). Seventy-nine clients were interviewed at two stages: stage I, prior to the treatment programme; stage II, immediately after the treatment programme. A selected group of 20 clients were followed up and interviewed at stage III, up to 24 months after the treatment programme. This last sample consisted of eight prisoners who had re-offended and returned to prison, three who were still serving their original sentence and nine who were out of prison. These 20 also participated in a more detailed quantitative and qualitative survey.

An 82% follow-up rate was achieved on the original group of 79 clients and a follow-up rate of 100% for the selected group of 20 clients who were interviewed three times. Regardless of category of client, findings demonstrate an improvement over time for the outcome variables: general attitude to offending, anticipation of re-offending and perception of current life problems. However, these results were short-lived for many prisoners, who failed to sustain the gains made. Interviews with the cohort of 20 suggest that clients who did not receive continuity of treatment after the programme, in terms of case management and structured treatment, did not fare as well as those who received such treatment. However, the study failed to demonstrate any significant change for the outcome variables victim hurt, denial and evaluation of crime.

In 2006 the HSE published the results of an 18-month process evaluation and treatment outcome study of 40 female drug-using prisoners admitted to the Dóchas Centre (Comiskey, C.M, *et al.* 2006). The aim of the study was to model the care pathway of the women and to discover whether their experiences in the Dóchas Centre had a positive or negative impact on their lives. The women were interviewed within one month of committal and again six months later. Qualitative interviews were also conducted with eight people working in a number of capacities with women who had been in prison.

Of the original cohort of 40 women, outcome data was obtained for 39, and 27 completed a second interview. The women ranged in age from 16 to 43 years; 23 had children under the age of 18, most of whom did not live with their mothers. The majority of the women had completed their education by the age of 15. The study measured key variables, including drug use, accommodation, health, psychosocial functioning and involvement in crime before the women were admitted to the Dóchas Centre, during

their imprisonment and after their release. The strongest positive outcomes were in the area of crime. There was a significant reduction between baseline interview and six-month follow-up in the proportion of women who committed crimes, apart from the crime of soliciting, which showed a slightly increased incidence.

There was a significant reduction in the levels of heroin use. On average, the women who were using heroin at recruitment stage did so at least once a day. At follow-up, this had reduced to twice a week. Slight reductions were noted in the numbers of women using cocaine, non-prescription methadone and ecstasy. However, the physical and mental health of the women showed only minor improvements at follow-up and, in some cases, there was evidence of deterioration. Of particular concern was the finding that three of the women interviewed had attempted suicide since leaving prison.

One of the main findings was the considerable risks that the women were exposed to after release, including overdose, gang rape, prostitution, homelessness and polydrug use. Of the 22 women who were released during the six-month follow-up period, only seven returned home and did not report any trauma. Three of the original cohort of 40 women died during the six-month follow-up period; all three had been released from the Dóchas Centre. These findings demonstrate the real and significant risks associated with the release of female drug-using prisoners. The majority of women who were interviewed at six-month follow-up felt that the time spent in the Dóchas Centre had been of some help, for example assisting with drug treatment, educational opportunities and a break from the stress of their lives. Women expressed a number of negative criticisms of the services they received. Over half of the women had concerns at the time of their release relating to, for example, a lack of suitable accommodation, money worries, concerns surrounding their children and a fear of returning to drug use. The women were asked whether they had received help with these issues on being released. Of the 20 women who answered the question, only three had received assistance. In addition, only four of the 27 women interviewed at follow-up stated that they had had any contact with social welfare services while in prison. Finally, 16 of the 22 women who were released during the time between baseline interview and follow-up were not given advance indication of their release date, which had implications for their vulnerability on release.

A key finding from the qualitative interviews with the eight participants who worked with women who had been in prison was the lack of co-ordination between the various in-reach services to the women's prison. These participants felt that, while the current range and number of agencies providing in-reach services was sufficient, the lack of integration between the services often resulted in poorer outcomes for the women. They stressed the need for appropriate accommodation that took into account the specific requirements of drug-using women who had been in prison.

The findings of the study indicate that the women experienced some positive effects on their lives in the six-month period between recruitment and follow-up interview. It is unclear whether the improvements noted in the report can be attributed to the Dóchas Centre or to the stage which the women were at in their drug-using careers. The author suggested that further longitudinal information on the women and their care processes would be required in order to answer this question..

The provision of treatment immediately on release plays an important part in reducing drug-related deaths. The 2009 IPS annual report stated that the IPS continued to face challenges in securing places in methadone clinics in the community for prisoners on methadone who were to be released (Irish Prison Service 2010). In May 2010, the Irish Penal Reform Trust (IPRT) published a report '*It's like stepping on a landmine...*' – *reintegration of prisoners in Ireland* (Martynowicz and Quigley 2010).

The study, conducted between October 2009 and February 2010, consisted of a literature review, a number of semi-structured interviews with service providers (in the

statutory and non-statutory sectors), a questionnaire completed by service providers throughout Ireland, and two focus groups with ex-prisoners in Dublin. The aims of the study were to:

- review national and international practice and policy (including human rights standards) relating to reintegration,
- identify barriers to reintegration of ex-prisoners in Ireland,
- map, as far as possible, available services and identify possible gaps in service provision, and
- make recommendations for development of future policy and practice.

The study found that, although 'significant progress has been made in recent years in integrating post-release services ... by the Irish Prison Service and its partners, there remains a less than uniform approach to the provision of necessary services in individual prisons and access to support is dependent on the facility in which the prisoner finds his- or herself' (p. 3). Service provision also varied between different areas of the country. The study also found that the unstructured use of Temporary Release, often used to alleviate pressure on overcrowded prisons and to make spaces available for new prisoners, impacts negatively on preparation for release. The study found that prisoners are sometimes given no more than a few hours' notice before being released, and some are released when outside services are unavailable, for example on Friday evenings or at the weekend.

The report noted some positive developments in recent years, such as the development of a system of Integrated Sentence Management (ISM) in some prisons, and wider provision of drug counselling services, including those provided in Dublin by MQI (see Section 11.4 above). The IPRT makes a number of recommendations arising from the findings of the study, including the following:

- The IPS should provide appropriate access and facilities for practitioners working with prisoners on drug and alcohol addictions, including the provision of facilities ensuring confidentiality and a therapeutic environment for service users.
- All prisons should provide drug-free landings.
- The IPS, in partnership with relevant service providers, should ensure arrangements are made for prisoners to continue drug and alcohol addiction treatment upon release when required.
- The government should make the introduction of spent convictions legislation a priority, to assist prisoners in entering employment post release (see Chapter 1.2.1) for an update on this proposed legislation).

### **Methodological limitations and information gaps**

The regular compilation and reporting of data in relation to drug treatment provision in Irish prisons is hampered by resource limitations. For example, the provision of data to the NDTRS is dependent upon the ability of treatment providers to supply the relevant data and this is likely to be adversely affected by prison overcrowding and stretched resources. On the other hand, the contracting-out of services to non-prison-based services is beneficial in that data are no longer collected by just one source. Although the IPS provides data in its annual reports, these reports are generally not published until nine months after the reporting period.

A study is currently being carried out by the National Advisory Committee on Drugs (NACD) to determine the need for drug treatment and harm reduction (including needle exchange) services in Irish prisons (Jean Long, personal communication, NACD committee member, 2010). The aims of the study are to:

- describe the nature, extent and pattern of consumption of different drugs among the prisoner population when in the community and when in prison;
- describe methods of drug use, including intravenous drug use, among the prisoner population;
- estimate the prevalence of blood-borne viruses among the prisoner population and to identify associated risk behaviours; and

- measure the uptake of individual drug treatment and harm reduction interventions (including hepatitis B vaccination) when in the community and when in prison.

The study is based on a randomly selected sample of more than 800 inmates (sentenced and remand) in Irish prisons, who are invited to complete a self-administered questionnaire and provide two oral fluid samples, one to be tested for drugs and one for blood-borne viruses. Participation is voluntary. The study is due to be published in 2012.

## **12. Drug users with children (addicted parents, parenting, child care and related issues)**

### **12.1 Introduction**

The start date for reporting material for this selected issue is 1996, chosen because the issue of drug-using parents with children was first identified as an issue in a national drug policy document in that year.<sup>18</sup>

Data on the number of drug-using parents and their children are routinely collected in the four-yearly general population drug use prevalence survey and the National Drug Treatment Reporting System (NDTRS). Since the mid 1990s, there has also been a steady output of research from Dublin's maternity hospitals regarding drug-using pregnant women and their babies. Research into the experiences and risk profiles of drug-using parents and their children has been less sustained. Following an empirical study of the impact of parental drug use on children's day-to-day lives within families in Dublin in the late 1990s, there has been no further research focusing specifically on children living with parents who use drugs. However, the authors of other research reports have indicated the need to research what amount to 'hidden populations' of children whose parents use drugs, e.g. young carers, children in the traveller community whose parents use drugs, and children whose parents are in prison and use drugs, and to explore their particular experiences, vulnerabilities and risk profiles.

There is no dedicated policy or legislation targeting drug-using parents and their children. Instead, sectoral strategies and legislative measures providing generally for those under the age of 18 may make specific mention of children whose parents use drugs. Policy has shifted in recent years from a focus on child protection to prevention and family support.

With regard to responses, clinical and medical services and guidelines have been developed for working with pregnant women who are opiate users and for caring for the babies of these women. In addition, childcare services to enable parents to participate in drug treatment and rehabilitation programmes, and targeted family support and child development programmes, are provided. However, the researchers who have pointed to the existence of 'hidden populations' of children of drug-using parents have also highlighted the need for specific services targeting these populations.

Statutory services to ensure the welfare and protection of all children aged under 18 years include guidelines which identify parental drug or alcohol use as a risk factor leading to a welfare concern. In recent years delivery of these statutory services has been found to be inconsistent and the delivery system is currently being revised and strengthened, and specialised training is being provided. The need for adequate training for professionals working with drugs-users who are parents is an issue highlighted at the conclusion of many Irish research studies, to ensure these professionals are prepared and sufficiently sensitive and responsive to what are often complex and always unique situations.

### **12.2 Size of the problem**

#### **12.2.1 Studies or data collection on the prevalence and characteristics of drug using pregnant women and parents**

##### **Drug users in general population with children**

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<sup>18</sup> See the *First report of the ministerial task force on measures to reduce the demand for drugs* Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996). *First report of the ministerial task force on measures to reduce the demand for drugs*. pp. 92. Stationery Office, Dublin. The problem of pregnant drug-users had first been noted in Ireland in 1981 Farrell, E. (2001). Women, children and drug use. In *A collection of papers on drug issues in Ireland*, Moran, R., Dillon, L., O'Brien, M., Mayock, P., Farrell, E. and Pike, B. (eds) Health Research Board, Dublin, pp. 153-177

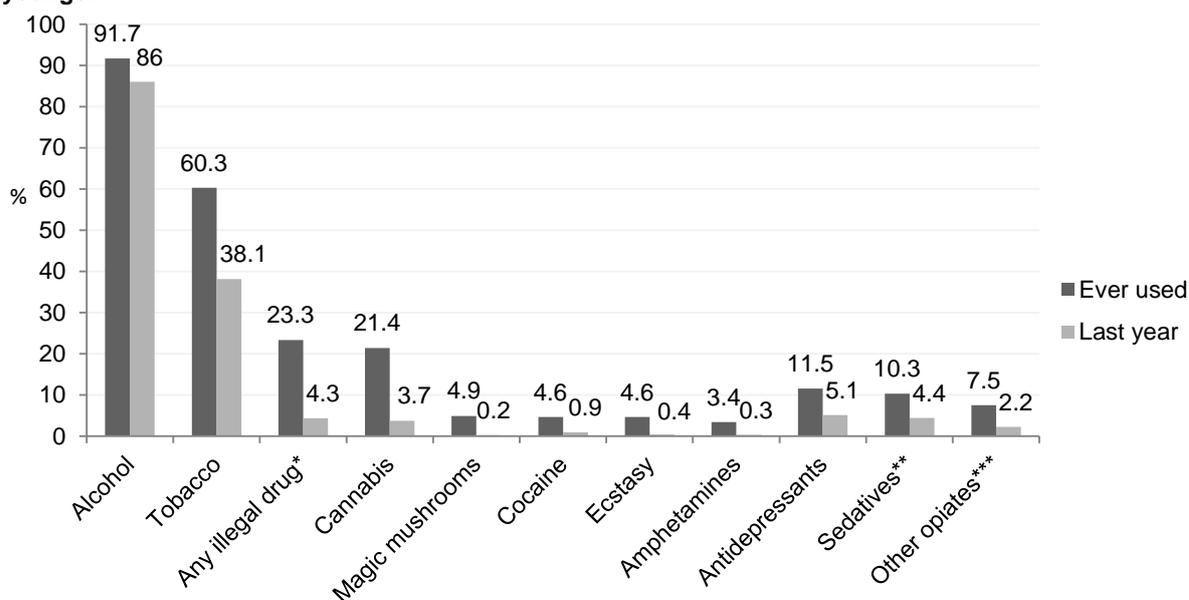
The general population all-Ireland drug prevalence survey, administered in 2002/3 and 2006/7 by the National Advisory Committee on Drugs (NACD) and the Public Health Information and Research Branch (PHIRB), have recorded whether or not the respondent has dependent children. Not all respondents were problem drug users. Unpublished data from the 2006/7 survey (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008) are reported here.

In 2006/7, 37% (1861/4967) of all respondents who had used drugs had dependent children aged 18 years or younger, and 50% of these children were aged five years or younger. As Figure 12.2.1.1 shows, among these parents, the most commonly used substances were alcohol (91% ever used) and tobacco (60% ever used). Just over 23% had used any illegal drug in their lifetime and only 4.3% had used any illegal drug in the last year, with cannabis being the most commonly used substance. After cannabis, over-the-counter and prescription drugs, including anti-depressants, sedatives and tranquilisers, and other opiates, were the most common substances ever used or used in the last year.

The characteristics of those respondents with dependent children who had used in the last year differed from those with dependent children who had ever used but not in the last year (see Figure 12.2.1.2). Among those with dependent children who had used in the last year, a larger proportion were male (58%) and were younger (nearly half aged between 15 and 34 years). Three-quarters of those with children who had used drugs but not in the last year lived their own home, while only half of parents who had used drugs in the last year owned their own home.

Figure 12.2.1.3 compares the occupational status of respondents with dependent children aged 18 or younger who had ever used drugs, and those who had used drugs in the last year. More respondents who had used drugs but not in the last year were in paid employment or working in the home than respondents who had used drugs in the last year. For all other occupational categories, including self-employment, not in the paid work-force or in training or education, the proportions were reversed, with parents who had used drugs in the last year exceeding those who had not used in the last year.

**Figure 12.2.1.1 All-Ireland General Population Drug Prevalence Survey, 2006/7: Lifetime and last year drug use prevalence, by drug, among respondents with dependent children aged 18 or younger**



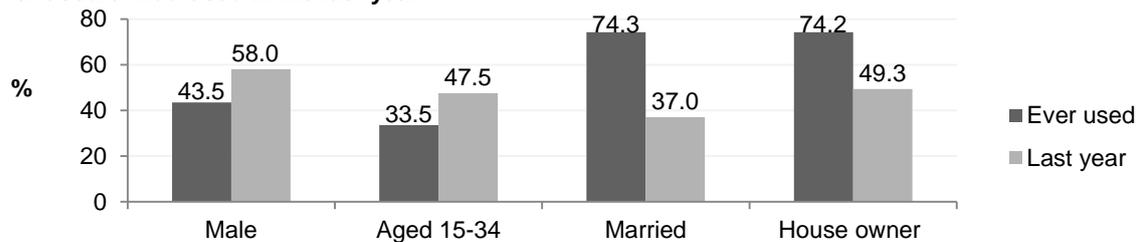
Source: unpublished data, NACD 2011

\*Any illegal drug' refers to the reported use of one or more of the following: amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers or solvents.

\*\* 'Sedatives' include tranquilisers.

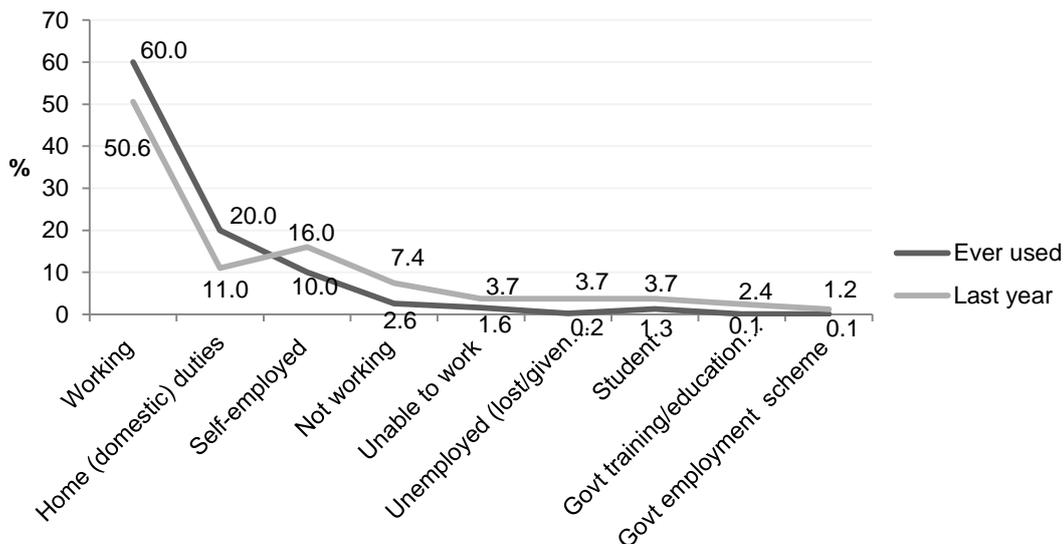
\*\*\* 'Other opiates' include Opium, Temgesic®, Diconal®, Napps, MSTs®, Pethidine, DF118® (Dihydrocodeine), Buprenorphine and Morphine, Codeine, Kapake, Diffls, Dikes, Peach, Fentanyl (Durogesic®, Sublimaze®, Actiq®), Oxycodone (Oxycontin®, Oxynorm®), and Buprenorphine (Subutex®).

**Figure 12.2.1.2 All-Ireland General Population Drug Prevalence Survey, 2006/7: Comparison of demographic characteristics of respondents with dependent children aged 18 or younger who had ever used or had used in the last year**



Source: unpublished data, NACD 2011

**Figure 12.2.1.3 All-Ireland General Population Drug Prevalence Survey, 2006/7: Comparison of occupational status of respondents with dependent children aged 18 or younger who had ever used or had used in the last year**



Source: unpublished data, NACD 2011

### Drug users in treatment with children

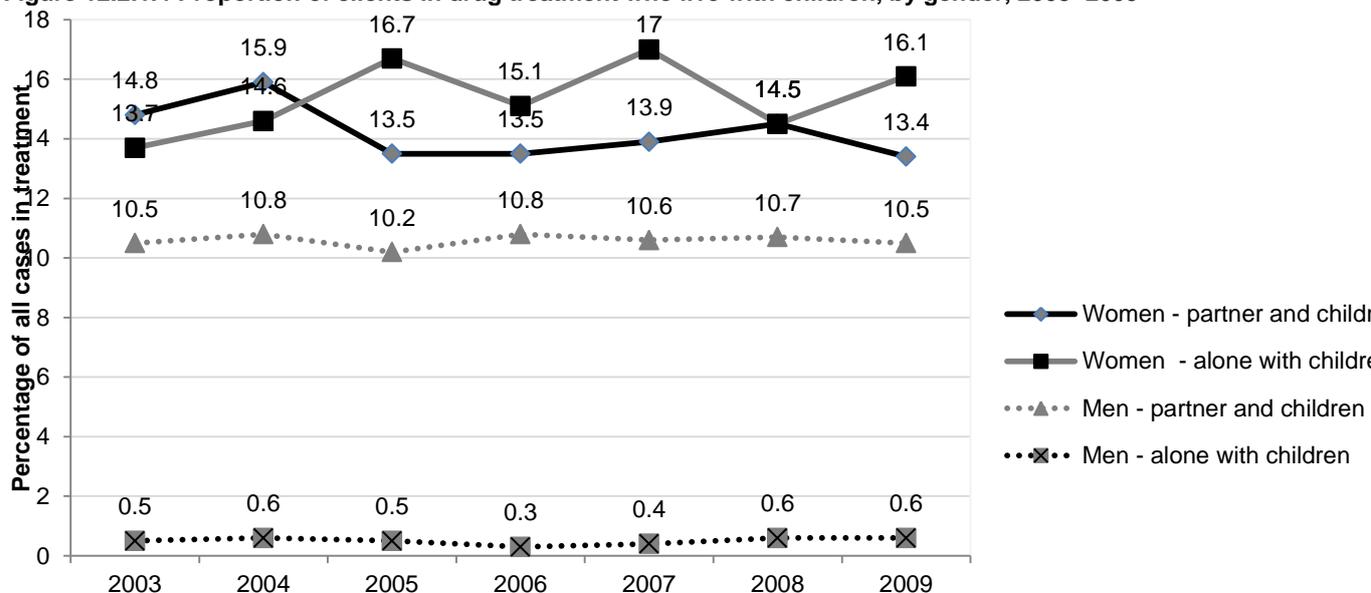
The National Drug Treatment Reporting System (NDTRS) records the living circumstances of drug treatment clients, including whether they live with their children, and whether with a partner or alone.<sup>19</sup> The age and number of these children are not recorded in the NDTRS.

The data show that between 2003 and 2009 the proportion of clients in drug treatment who reported living with their children remained relatively stable. The proportion reporting that they lived with a partner and children ranged between 10.2% and 10.8%, and the proportion reporting that they lived alone with children ranged between 3.7% and 4.6%.

Figure 12.2.1.4 breaks down these proportions by gender. It shows that the proportion of men in drug treatment who lived with their children and partner remained very stable between 2003 and 2009, ranging between 10.5% and 10.8%. The proportion of women in treatment living in similar circumstances was higher, ranging between 13.4% and 14.8%. A very small proportion of men in drug treatment lived alone with their children (ranging from 0.3% to 0.6% over the reporting period), while the proportion of women living alone with their children was much higher. The percentages fluctuated over the period, but overall the trend shows an increase of 2.4%, from 13.7% in 2003 to 16.1% in 2009.

<sup>19</sup> The NDTRS requires that one form be completed for each new client coming for first treatment and for each previously treated client returning to treatment for problem drug and/or alcohol use in a calendar year. 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.

Figure 12.2.1.4 Proportion of clients in drug treatment who live with children, by gender, 2003–2009



Source: unpublished data, NDTRS 2011

The greater frequency of women in drug treatment who are also heads of lone parent families, compared to men, reflects the national trend. Reporting the results of the 2006 population census, the Central Statistics Office (CSO) stated that the number of lone parent families had increased by 23% since 2002, and that lone mothers, where all of the children were under 15 years, showed the greatest increase (57.6%). In all, nearly 86% of lone parent families were headed by females (Central Statistics Office 2007).

### Drug use prevalence among pregnant women

The use of psychoactive substances by pregnant women attending two separate urban maternity hospitals in Dublin has been well documented.

In a study conducted in the Rotunda Hospital in 1992, Bosio and colleagues (Bosio, *et al.* 1997) found that the prevalence of chemical substance abuse in 504 antenatal urine samples was 2.8%; among the postnatal population (515 samples) the prevalence of drug abuse, excluding alcohol, was 6%. The substances found included benzodiazepines, cannabis, amphetamines, opiates, and cocaine. A subsequent study (Lyons, Fiona, *et al.* 1999) found that in 1996,<sup>20</sup> 4% of 522 antenatal urine samples were positive for substances abuse. By applying the single urinalysis test to the women as they were admitted to labour rather than when they attended for a scheduled antenatal clinic, the authors believed the risk of under-representation was reduced.

Barry and colleagues (Barry, Siobhan, *et al.* 2006) analysed routine clinical data collected on over 120,000 pregnant women in the Coombe Women and Infants University Hospital (CWIUH), Dublin, between 1987 and 2005. The objective was to describe the reported prevalence and patterns of alcohol and nicotine use in women attending the hospital during the whole period, and to describe the reported prevalence and patterns of illicit drug use and polysubstance use among women attending since 1999. These data were self-reported and collected over 20 years by staff whose main priority was clinical care of pregnant women rather than the gathering of epidemiological data. Thus, standardisation of data collection methods and validation of data were not deemed possible.

In all, 447 (4.57%) of all pregnant women who registered at the CWIUH between 1999 and 2005 reported having used illicit drugs in pregnancy. Methadone was the

<sup>20</sup> While Lyons and colleagues did not report when they collected their data, they noted that their study was conducted at the same time as that by Coghlan and colleagues Coghlan, D., Milner, M., Clarke, T., Lambert, I., McDermott, C., McNally, M. *et al.* (1999). Neonatal abstinence syndrome. *Irish Medical Journal*, **92**, (1), 232-233, 236. Available at [www.drugsandalcohol.ie/6515/](http://www.drugsandalcohol.ie/6515/) (1999), who reported that their data had been collected in 1996.

substance most frequently reported (323, 72%). Methadone and diazepam were reportedly obtained from a combination of prescribed and illicit sources; the other reported drugs (cannabis, heroin, ecstasy and cocaine) were all obtained illicitly.

The authors recommended that the feasibility of routine collection of ante-natal alcohol, tobacco and illicit drug use in all hospital and primary care settings should be determined, and on the basis of this feasibility study routine ante-natal monitoring of substance use should be introduced.

A more recent study by Cleary and colleagues (Cleary, *et al.* 2011) reported on a retrospective cohort study of 61,030 singleton births at the CWIUH between 2000 and 2007, based on antenatal, delivery and postnatal records and the Central Treatment List (of clients prescribed methadone). The aim was to investigate the relationship between methadone maintenance treatment and maternal characteristics and perinatal outcomes. Unlike many previous studies, it was a population-based study rather than a sample-based study, which enabled possibly confounding socio-demographic factors to be controlled for. The study found that 618 women (1%) were on methadone at delivery.

### Characteristics of drug-using pregnant women

Bosio and colleagues (Bosio, *et al.* 1997) whose study is described above, found that substance abusers in pregnancy were more likely to be single, unemployed, and to have had a previous pregnancy. Cleary and colleagues (Cleary, *et al.* 2011), whose study is also described above, reported that methadone-exposed women were more likely to be younger, unemployed, Irish, unmarried, have had previous pregnancies, have an unplanned pregnancy, to book antenatal care later than 20 weeks into pregnancy, to be current smokers and to drink alcohol before pregnancy. In addition, and as expected, a higher proportion of methadone-exposed women were likely to test positive for hepatitis B, hepatitis C and HIV when compared to non-exposed women (Table 12.2.1.1).

**Table 12.2.1.1 Blood-borne viral status among methadone-exposed mothers, among all singleton births at CWIUH, 2000–2007**

	Exposed to methadone*	Non-exposed*
Hepatitis B positive serological status	20 (3.5%)	326 (1.0%)
Hepatitis C positive serological status	275 (48.2%)	193 (0.6%)
HIV positive	35 (5.8%)	171 (0.3%)

\*The total number tested in each group is not presented in the paper.  
Source: (Cleary, *et al.* 2011)

## 12.2.2 Studies or data collection on the physical, mental and other risks/harms among drug using pregnant women / parents and their children

### Drug-using pregnant women and the new-born

#### *Transmission of infectious diseases*

A prospective study was initiated to determine the vertical transmission rate (VTR) of HIV and the average age of infant seroreversion, and to monitor clinical, immunologic and virologic evidence for HIV infection in seroreverters (Nourse, *et al.* 1998). Ninety-three HIV positive infants were identified between 1985 and 1998. The predominant underlying maternal risk factor for HIV infection was found to be intravenous drug use (96%). Of the 93 infants, median gestational age was 40 weeks and median birth weight 3,125g. Ninety-four per cent of infants were bottle fed. At the time of the study, 72 (77%) infants were uninfected, 12 (13%) infected, 4 (4.5%) found to be indeterminate and 5 (5.5%) had been lost to follow-up. The intermediate estimate of VTR was 14.3%. The median age at documented seroreversion was 12 months. No significant differences were found between infected and non-infected children in male/female ratio, gestational age, mode of delivery or birthweight.

### *Premature birth and/or neonatal abstinence syndrome*

Coghlan and colleagues (Coghlan, *et al.* 1999) undertook a retrospective review of maternal and infant records of the 43 infants admitted with neonatal abstinence syndrome to the neonatal intensive care unit of the Rotunda Hospital, Dublin, in 1996. The relationship of maternal drug abuse to symptoms, the effectiveness of pharmacologic agents in controlling symptoms and the length of inpatient stay were investigated.

Those infants with a serial Finnegan score greater than 8 were treated. The average maternal age was 24.6 years (18-34 years) and drug use included a range of substances, often combined, including methadone, benzodiazepines, heroin, oral morphine sulphate, dothiepin and cannabis. Average gestational age was 40.3 (35–42 weeks). The average birthweight was 2.81 kgs (1.89–3.91 kgs). Time to onset of withdrawal symptoms was 2.8 (1–13) days. The duration of pharmacologic treatment (oral morphine sulphate and/or phenobarbitone) was 21.8 (1–62) days.<sup>21</sup>

This study confirmed that polydrug abuse was the commonest type of drug abuse in pregnant women attending maternity hospitals in Dublin. The duration of withdrawal symptoms was loosely related to drug type, but increasing duration of symptoms was noted for infants exposed to benzodiazepines.

Scully and colleagues (Scully, Mike, *et al.* 2004) reviewed the clinical records relating to the 111 referrals to the Drug Liaison Midwife (DLM) in the CWIUH from April 1999 to April 2000. Eighty-three women were in treatment for substance abuse when referred to the drug liaison midwife. In total, 53 women were assessed as opiate unstable and 21 were benzodiazepine unstable.

Thirteen per cent of the women had a caesarean section, which was lower than the proportion of caesarean sections (16%) for all maternity cases at the hospital in 1999. Mean gestation at delivery was 38.45 weeks. Almost 11% of infants were delivered prematurely, which was higher than the proportion of premature deliveries (6%) for all maternity cases at the hospital in 1999. The mean birthweight of the babies was 2,949g.

The authors reported that, of the cohort of 111 women, 85 (75%) were being prescribed methadone at the time of delivery and their infants' withdrawal status was known. With a view to examining the risk factors for infant withdrawals, the researchers recorded maternal methadone dose at delivery, their alcohol and tobacco use status and the presence of positive urinalysis for other opioids, benzodiazepines and cocaine one month pre-delivery.<sup>22</sup> Maternal methadone doses, which ranged from 5 to 95 mg, were classified into three levels, each containing a similar number of women: low, n = 29 (5–30 mg); medium, n = 28 (31–50 mg); and high, n = 28 (51–95 mg).

Forty infants (47%) received a diagnosis of Neonatal Abstinence Syndrome (NAS) using the Finnegan neonatal abstinence scoring system. The chi-square test for trend indicated that there was a significant dose–response relationship between maternal methadone dose at delivery and the occurrence of withdrawals ( $p = .001$ ). Respectively, withdrawal occurred in 28% (8/29), 43% (12/28) and 71% (20/28) of infants delivered to women at low, medium, and high doses.

The presence of opioids other than methadone in the month before delivery and the mother's alcohol use status were not related to the occurrence of infant withdrawal. However, a significant association was found between infant withdrawal and mother's benzodiazepine use ( $m2 = 4.377$ ,  $df = 1$ ,  $p < .05$ ). None of the associations between frequency of withdrawal and adequacy of prenatal appointment attendance, admission for benzodiazepine stabilisation or for opioid stabilisation were statistically significant.

<sup>21</sup> The numbers given in brackets are the range of results for each variable.

<sup>22</sup> Because only three women were non-smokers and three used cocaine, these variables were omitted from the analysis.

Multivariate logistic regression indicated that benzodiazepine use was not independently associated with withdrawal (adjusted OR = 1.704, 95% CI: 0.554–5.238), whereas high maternal methadone dose at delivery remained a significant risk factor (adjusted OR = 4.862, 95% CI: 1.166–20.273).

Carmody and colleagues (Carmody, *et al.* 2011) examined maternal and neonatal outcomes of 436 pregnant women referred to the DLM at the CWIUH between 2002 and 2007, and who were attending a methadone clinic at the time they gave birth. The researchers compared their findings with those of the earlier study (Scully, Mike, *et al.* 2004).

The authors found that a very high proportion (93%) of the 2002–2007 cohort was taking prescribed methadone, compared to the 1999–2000 cohort (75%). The average dose of methadone at delivery was higher for the later cohort (60mg) than for the earlier cohort (39 mg). The average gestation at delivery was 38 weeks for both cohorts. The average birth weight was higher by 66g in the later cohort. The percentage of babies requiring admission to the special care baby unit (SCBU) had increased from 42% in the earlier cohort to 56% in the later cohort. The proportion of babies requiring treatment for neonatal abstinence syndrome was considerably higher in the later cohort (45%) than in the earlier cohort (29%), and the babies' average length of stay in the SCBU increased by over 2 days in the later cohort.

The authors noted that their findings were part of a larger study that will examine changes in maternal methadone doses, opioid stability at delivery and whether there is a correlation between maternal methadone dose and neonatal abstinence syndrome (NAS). While acknowledging that information on incidence and outcomes for mothers and babies is useful in planning treatment services, the authors also observed that their study did not ask women their opinions: 'A qualitative research will address some of the issues from their perspective, acknowledge their needs and improve their quality of care' (Carmody, *et al.* 2011) p. 450.

Cleary and colleagues (Cleary, *et al.* 2011), whose study of 61,030 singleton births at the CWIUH between 2000 and 2007 is described in section 12.2.1 above, found that methadone exposure among the mothers was associated with an increased risk of very preterm birth (<32 weeks of gestation), being small for gestational age (<10<sup>th</sup> percentile), admission to the neonatal unit, and diagnosis of a major congenital abnormality. There were four cases of Pierre Robin sequence among 618 methadone-exposed babies, compared to eight cases in 60,412 non-exposed infants. Although not statistically significant, the proportion of deaths within the first six weeks of birth was three times higher among the methadone-exposed group (2.4%) than the non-exposed group (0.8%).

The authors also found a dose-response relationship between methadone and neonatal abstinence syndrome. As the mother's methadone dose increased so did the incidence of neonatal abstinence syndrome (see Table 12.2.2.1). Preterm birth and small gestational age also predicted the presence of neonatal abstinence syndrome.

**Table 12.2.2.1 Methadone dose and its relationship with neonatal abstinence syndrome among methadone-exposed mothers, among all singleton births at CWIUH, 2000–2007 (n=615)**

Methadone dose in mg	Neonatal abstinence syndrome		Adjusted odds ratios (95% CI)*
	Present	Absent	
<21	19 (23.8)	61 (76.2)	1
21–50	73 (33.3)	146 (66.7)	0.9–3.5
51–80	117 (47.4)	130 (52.6)	1.6–6.53
81–100	26 (48.1)	28 (51.8)	1.3–7.5
>100	11 (73.3)	4 (26.7)	2.5–48.0

\*Adjusted for preterm birth, gestational age, gender, maternal smoking during pregnancy and alcohol use before pregnancy  
Source: (Cleary, *et al.* 2011)

After controlling for known adverse socio-demographic factors, methadone exposure was found to be associated with an increased risk of adverse perinatal outcomes.

Methadone dose at delivery was one of the important determinants of neonatal abstinence syndrome.

*Opiate-using pregnant women: 20-year follow-up*

Whitty and O'Connor (Whitty and O'Connor 2007) examined the 20-year outcome for 55 women who were pregnant, using opiates and attending a drug treatment centre in Dublin in 1985. They found that 29 women (53%) had died. Among these 29 women, HIV was the commonest cause of death, accounting for 17 (59%). Among the 16 still living, 84% were unemployed, 74% were using illicit substances, and 78% were living in state-subsidised accommodation. The authors concluded that mortality was higher in this group than among other long-term follow-up samples.

### **Children living with drug-using parents**

In what has been described as 'seminal' work, Diane Hogan led an empirical investigation between 1996 and 1999 into the impact of parental opiate use on children's day-to-day life within families. The focus on the 'fabric of ordinary daily life' was based on the view that 'it is difficult to design appropriate policies and services for drug users and their families in the absence of an understanding of the processes by which drug use, parenting and children's well-being are connected' ((Hogan and Higgins 2001): 5).

The research focused on primary-school-aged children in the care of at least one opiate-using parent. Following an exploratory study involving 10 families (Hogan and Higgins 1997), the main study investigated 100 families living in two locations in Dublin where residents generally experienced profound social and economic disadvantage and where there was a high incidence of illicit drug use (Hogan and Higgins 2000). The sample comprised 50 families in which at least one parent was dependent on opiates (heroin or methadone), and their experiences were compared with those of a matched comparison group of 50 families from the same areas of Dublin who had a similar socio-economic background but in which neither parent was a drug user.

Data were collected by means of in-depth interviews with the 100 parents, two focus groups with professionals working with the drug user and/or their children, and a survey questionnaire in 26 schools with the teachers of some of the children. Owing to drug-using parents' reluctance during the exploratory phase to involve their children directly in the research, it was decided to focus on the views of adults.

The researchers identified four key ways in which parental drug use might impact on a child's daily life ((Hogan and Higgins 2001): 31):

- disruption of parenting and care owing to short or long term separation,
- exposure to parents' drug use including contact with police or prisons,
- children's emotional well-being may be affected by worrying about their parents and the impact of their parents lifestyle, including the assumption of adult caring roles, experience social isolation in the community and school, and
- children's academic progress may be affected by poor attendance and low levels of parental involvement.

With respect to parents' perceptions of how their drug use had affected their parenting capacity and family processes, Hogan (Hogan 2007) identified three broad sets of contextual factors to which parents attributed their perceived unsatisfactory parenting, in particular their unavailability and instability.

- The acquisition and ingestion of drugs, imprisonment, attendance and treatment facilities and hospitalisation, reduced parental availability.
- Physiological factors, such as intoxication and withdrawal from opiates, reduced parent's emotional responsiveness.
- Psychological factors, such as preoccupation with drugs and instability of moods, undermined discipline and limit-setting. While some non-drug-using parents also experienced volatility in parenting style, and especially in relation to limit setting, no clear systemic relationship emerged that appeared to provide an over-riding

contextual explanation for their approach to parenting, as it could for drug-using parents.

With regard to the danger of children being the victims of drug-related violence, Hogan's research implies it was not critical issue for the children of the opiate-dependent parents included in the study: '... in evaluating the impact of their drug dependence on their parenting, most drug users distinguished between the physical and emotional needs of their children. Most believed that even when their heroin use was intensive and their own resources low, their children's physical needs were catered for adequately, albeit often by another family member rather than by themselves.' ((Hogan 2007): p. 628)

Another study of drug-using parents attending an aftercare programme found similar results (McKeown and Fitzgerald 2006). Parents' strengths were in the areas of communication and involvement, while the main weakness was perceived to be in setting limits. It was found that respondents used much more discipline on their children compared to the average Irish parent. However, they used non-violent discipline and psychological aggression more frequently than the average Irish parent, with minor physical assaults occurring much less frequently and severe physical assault infrequently.

### **Drug use in later life by children of drug-using parents**

Hogan and Higgins, whose study is described above, could not offer any conclusions about the impact of children's exposure to drugs, through witnessing their parents drug-related activities, on their own subsequent drug use. However, on the basis of their findings, they suggested a future direction for drug prevention among children of drug users ((Hogan and Higgins 2000)). They had found that while parents disapproved of their own drug use, and did not want their children to use drugs, they were not successful in transmitting these values to their children. The parents' drug use and treatment were shrouded in secrecy, and as a result the parents' views were not clearly communicated. Moreover, the parents, like others in their communities, overtly condemned 'junkies', but at the same time, according to most parents, their children knew about or suspected their parents' drug use. The result was confusion in the minds of the children. The researchers called for these discrepancies between parents' goals and practices to be the focus of future prevention interventions.

### **Homeless young people**

The *Youth Homelessness Strategy* (YHS) (Department of Health and Children 2001) reported that 5% (30/588) of children who presented to the health boards in 2000 as homeless did so because of parental abuse of alcohol or drugs. In his report on child protection in Ireland, Shannon (Shannon 2010) noted that recent research ((Mayock and Vekic 2006); (Mayock and Carr 2008)) confirmed that the presence of parental alcohol or drug addiction continued to be a key indicator of an increased likelihood of young people leaving home.

### **Hidden populations**

The variety of living circumstances of children living with drug-using parents, and the associated risks, are not well understood. Two Irish researchers who have mounted major qualitative studies on, respectively, the children of drug-using parents and on mothers who used drugs, have called for research that directly accesses the children of drug-using parents in order to foreground their experiences and perceptions and reach a fuller understanding of their vulnerabilities and risk exposure (Hogan 2007): p. 633; (Woods 2008): p. 287).

Other Irish studies have suggested that children of drug-using parents may live in circumstances where their vulnerability is difficult to detect – for example, young carers looking after parents with drug or alcohol addictions (Fives, *et al.* 2010), or children of traveller parents (Fountain 2006), (All Ireland Traveller Health Study Team and School of Public Health Physiotherapy and Population Science University College Dublin

2010), (Van Hout, M.C. 2009). In such cases, families do not want people to know the circumstances within which a child is providing care; they may fear that the child may be taken away by social services.

Two studies have been undertaken in the last decade on the impact of imprisonment on family members 2001 (King, Dervla 2002) (Bedford Row Family Project 2007). In the earlier study, King (King, Dervla 2002) noted the disadvantaged background of many prisoners and the reportedly high incidence of drug use within Irish prisons, with significant numbers of prisoners starting or continuing to use drugs during their sentence. He suggested that these factors were significant for the children of prisoners, who might be at risk of disadvantage even before their parent was imprisoned, and were therefore in need of special support at all stages of their parent's sentence.

## **12.3 Policy and legal frameworks**

### **12.3.1 Policies addressing drug using parents / pregnant women and their children**

#### **National policies that specifically address drug-using parents and their children**

No specific national policy on drug-using parents and their children has been developed in Ireland.

#### **Other relevant policies targeting vulnerable groups (which could include drug-using parents and their children)**

Low birthweight is one of three core targets to reduce health inequalities in Ireland (Institute of Public Health 2001). In 2005 a study was commissioned to quantify and assess the effect of socio-economic status on low birthweight in Ireland and consider these findings in the light of the NAPS target (McAvoy, *et al.* 2006). Among other things, this study found that the number of babies born to opiate-using mothers in Ireland was relatively small but that those babies were born to mothers at the lowest end of the socioeconomic scale and that the risks experienced by these babies were exceptionally high. The authors concluded that although, in tackling health inequalities, it is important to target drug using mothers, reducing low birthweight related to drug use would only have a small impact at a population level. They recommended that the issue be kept under review in light of changing drug-use patterns and emerging data.

#### **Objectives of national or local drug strategies/action plans that specifically target drug-using parents and their children**

In 2001 the National Drugs Strategy 2001–2008 (Department of Tourism Sport and Recreation 2001) called for consideration of how to integrate child-care facilities with treatment and rehabilitation centres and how best to provide child care in a residential treatment setting (Action 54). Four years later the Steering Group that reviewed the National Drugs Strategy (Department of Community Rural and Gaeltacht Affairs 2005) noted that the health services considered that full-time childcare facilities within an addiction setting might lead to further stigmatisation of children of drug misusers, and more appropriate services, such as drop-in play/crèche areas rather than full-time facilities, should be provided.

Endorsing a recommendation by the Working Group on Drugs Rehabilitation (Working Group on drugs rehabilitation 2007), the National Drugs Strategy 2009–2016 (Department of Community Rural and Gaeltacht Affairs 2009) called for further work to facilitate closer engagement between child, outreach and drug services at a local level, consider ways to address the needs of the children of problem drug users, and establish and disseminate best practice. However, the strategy did not include any specific actions in this regard.

In 2009, for the first time in official policy, the children of drug-users were identified as a 'group at risk' (Department of Community Rural and Gaeltacht Affairs 2009). Action 29

of the new strategy called for the development of prevention measures that focus specifically on the family, including supports for families experiencing difficulties due to drug/alcohol use, parenting skills, and 'targeted measures focusing on the children of problem drug and/or alcohol users aimed at breaking the cycle and safeguarding the next generation'.

In 2007, the need for research to ascertain the number of children with drug misusing parents, the issues this raised and best practice in relation to integrating childcare into treatment and rehabilitation services was identified (Working Group on drugs rehabilitation 2007). The National Advisory Committee on Drugs commissioned research on the matter (Horgan 2011). Published in October 2011, the report consisted of a comprehensive review of the Irish and international literature on what is known about the impact of parental use of various substances on their children. The report concluded with recommendations for future policy and research in four key areas:

- research, information and data needs,
- recognise the different needs of young children and adolescents with regard to parental substance misuse,
- reduce the negative impact of parental substance use on children and the family as a whole,
- health promotion and public information.

### **12.3.2 Legal frameworks addressing drug using parents/pregnant women and their children**

Under the Child Care Act 1991, the Health Service Executive (HSE) has a statutory duty to promote the welfare of children (i.e. aged under 18 years) who are not receiving adequate care and protection. When carrying out its statutory duty the HSE must have regard to the following: (1) it is generally in the best interests of the child to be brought up in his/her own family, and (2) having regard to the rights and duties of the parents, the welfare of the child is the first and paramount consideration and that, as far as is practicable, the wishes of the child should be considered. The Act requires the HSE to identify children who are not receiving adequate care and protection, co-ordinate all relevant information on children, provide child care and family support services with the aim of helping parents to care for their children and avoiding the need for such children to be taken into care.

Under the Children Act 2001, which deals with children found in breach of the criminal justice system, where the court is satisfied that 'a wilful failure of the child's parents to take care of or control the child contributed to the child's criminal behaviour', a 'parental supervision order' may be issued, requiring the parents of the child, to undergo, among other things, treatment for alcohol or other substance abuse.

## **12.4 Responses**

### **12.4.1 Availability of responses addressing the needs of drug using parents/pregnant women and their children**

#### **Pregnant opioid users**

In 1999 a specialist Drug Liaison Midwife (DLM) post was created in each of Dublin's three maternity hospitals (Scully, Mike, *et al.* 2004, Scully, M. , *et al.* 2001). The DLM provides sessions in the maternity hospitals and in community-based addiction centres. The aim is to ensure opiate using women engage with antenatal and drug services, to stabilise them on methadone and to address health and social care issues.

After an initial assessment, the DLM immediately offers those women not in treatment a treatment place depending on their needs. The mainstay of treatment is methadone maintenance: stabilisation of drug use is stressed and women are encouraged to remain on oral methadone throughout their pregnancy. The option to detoxify after the

first trimester exists, but women are not pressured to reduce dose or to detoxify. Those who had difficulties stabilising are offered inpatient admission to a specialist drug dependency unit.

Reviews of the DLM service (Scully, Mike, *et al.* 2004) (Carmody, *et al.* 2011) have confirmed the importance of early intervention by the DLM and good communication and working relationships between the maternity and addiction services as a means of improving the service offered to the patients. The DLM service also appears to have lessened the stigma associated with this group of patients.

### **Prisoners with babies and/or children**

A report (Enright, *et al.* 2007) on babies in the Dochas Centre, the women's prison within Mountjoy Prison, Dublin, reported that imprisonment of mothers was avoided in Ireland by means such as delaying sentencing, arranging temporary release or through court appeal. If a pregnancy was only diagnosed on admission, antenatal care was undertaken in conjunction with a hospital chosen by the patient. The woman was encouraged to be drug-free. Some mothers had HIV and were treated with AZT during their pregnancy and after. The baby's HIV status was also checked. Parenting courses were offered to the women. Enright and colleagues identified two options for improving the quality of care for mothers and their babies in prisons: a mother and baby unit to safeguard the child, and better links with community care so that the baby or child's development, social circumstances and health are known outside the prison and the way can be prepared for a planned discharge into a safe environment with their mother.

With regard to the care of children of drug users who are imprisoned, two studies of the families of prisoners ((King, Dervla 2002) and (Bedford Row Family Project 2007)) found services for children with a parent or close relative in prison under-developed and reported a lack of awareness about the effects of imprisonment on the children of a prisoner among professional groups. They called for the needs of children and young people affected by having a parent or sibling in prison to be incorporated into existing training programmes; the establishment of support groups for children; the drawing up of guidelines for parents on informing children about a parent's prison sentence; and the provision of services such as bereavement counselling, self-help groups and activity-based group events, such as excursions.

The Irish Prison Service's *Health care standards* (Irish Prison Service 2009) state that drug use is not a reason to introduce care proceedings but that the needs of young children of drug dependent parents should be considered of paramount importance. Workers in methadone programmes are advised to include the care of children in their treatment plan and have some means of supervision.

### **Parents attending drug treatment who have children**

The Drug Treatment Centre Board (DTCB), Dublin, provides an example of the service provided for children while their parents attend a drug treatment centre. A multi-disciplinary social work team, including community care and probation professionals, focuses on family support (including child welfare), advocacy, group work, writing reports and attending inter-agency meetings. A children's playroom provides stimulation and a safe and supportive child-centred setting for children aged between 1 and 14 years, who accompany their parents/guardians to the clinic. They also offer advice and support to parents who may have childcare concerns.

### **Parents in residential treatment who have children**

The Coolmine Therapeutic Community (CTC) is the only residential service in Ireland to provide a service for the children of parents living in the residential community. At Ashleigh House, CTC provides a residential drug and alcohol rehabilitation service for up to 14 women for a maximum of six months. Most women who come to Ashleigh House have children. CTC reports that client feedback has revealed that one of the barriers to women with children coming into the residential programme has been their

worry about breaking their emotional attachment with their children and that, if facilities were provided for children to live on-site with their mother, the mothers would be better supported as their children's personal development could be strengthened through specialist counselling and child welfare initiatives for children of primary school age.

With accommodation for children up to the age of 10, CTC is currently seeking funding for services to support mothers staying in Ashleigh House in the care of their children, including a crèche, after-school classes for children of primary school age, parenting skills classes for those who need support, and one-to-one counselling for children who have been affected by their mother's addiction.

### **Parents in contact with community-based drugs services who have children**

Through the drugs task forces, a number of community-based services provide services targeted at the children of drug users. Just three examples are noted here, highlighting the variety of responses.

The **Ana Liffey Drug Project (ALDP)**, a 'low threshold-harm reduction' service, works as one integrated multi-disciplinary project team, enabling it to focus on two key client groups – single people affected by problem substance use, and families. Its Family Care and Case Management Service aims 'to promote and support high quality parenting and to enhance the quality of life for children whose parents use drugs'.

**SAOL** is a community-based educational and rehabilitation day programme for women in treatment for drug addiction. In order for women to access appropriate services, SAOL provides a full-time childcare facility and early education programme for their children – SAOL Beag (Little SAOL) Children's Centre. Using an individualised curriculum and approach to work with the children, the programme seeks to identify each child's interests, strengths and learning goals and to plan activities and learning experiences for the child. An integral part of this service is to work in partnership with the parents. Another key element is the relationship the children have with the adults who work with them: the staff are qualified and experienced in dealing with children and aim to form strong, caring relationships with the children. The SAOL Beag curriculum has been developed in order to address the specific needs of children living with addiction. It incorporates elements of Montessori, High/Scope and Birth to Three Matters.

**Ballyfermot Advance Project**, associated with the Ballyfermot Local Drugs Task Force, manages a Support for Childcare Fund, the purpose of which is to ensure that people do not see childcare as a barrier to accessing treatment, rehabilitation or aftercare programmes, by subsidising their childcare costs. An evaluation has shown that the Fund has yielded benefits not only for the drug-using parents in need of childcare but also for their children and family members. Benefits for children were found to include childcare providers being more receptive to children from the target group accessing their service, and children being better prepared and ready to access mainstream primary education.

### **Drug-users experiencing difficulties in caring for their children**

The Department of the Minister for Children and Youth Affairs (DMCYA) manages a Prevention and Early Intervention Programme for Children, which is being piloted for an initial five years. The programme includes three projects in three severely disadvantaged areas in the Dublin region.<sup>23</sup> Prevention and early intervention with children is believed to be most successful when nested within supports for families – providing parents, who are experiencing difficulties, including drug and alcohol use, with the personal resources and skills they need. These projects will be evaluated and provide an important input to policy and service development.

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<sup>23</sup> Further information on the three projects may be found at the following web sites: 'A place for children in Tallaght West – Childhood Development Initiative' [www.connect.southdublin.ie/cdi/index.php](http://www.connect.southdublin.ie/cdi/index.php); 'Preparing for life (PFL) – Northside Communities of Belcamp, Darndale and Moatview' [www.preparingforlife.ie/](http://www.preparingforlife.ie/); and 'Young Ballymun' [www.youngballymun.org/](http://www.youngballymun.org/).

In a separate study of family support services and their capacity to respond to the drug-related needs of clients (Watters and Byrne 2004), it was found that the majority of family support services were not aware of the positive role they could play in responding to and preventing drug, including alcohol, problems. The authors recommended that this could be corrected by introducing training regarding drugs and drug prevention into the curriculum of professionals working in and managing family support services, and by increasing the awareness and knowledge among existing family support services regarding family functioning and drugs prevention.

#### **'Hidden populations' of children living with drug-using parents**

Enda Egan (Egan 2010, 15 June), CEO of The Carers Association, Ireland's national voluntary organisation for and of family carers in the home, stated there is an urgent need to contact young carers, including those looking after parents with drug or alcohol addictions, and engage with them in a way that does not frighten them or their families. Egan recommended the development of protocols and pilot projects to produce systems of identifying and engaging with young carers, and the creation of a web site that would provide information, outlining services and supports, for young carers and allow them to interact with each other and develop support groups. He also noted that generally engagement with young carers starts in the education system and getting teachers involved. All the other organisations and agencies dealing with children right across the country should also be included.

Following their study of the 20-year outcome for 55 pregnant women using opiates and attending drug treatment, Whitty and colleagues (Whitty and O'Connor 2007) suggested that drug-using parents and their children need 'intensive long-term support and treatment'.

#### **Children 'at risk'**

The HSE has statutory responsibility for the welfare and protection of vulnerable children,<sup>24</sup> including children of drug-using parents, whose welfare may be *cause for concern* or who may be *at risk* of abuse or neglect. The 'spine' of the HSE's child protection and welfare services is the social work department which respond to reports of abuse, neglect or welfare concern.

The HSE provides a range of support services to families where a child's welfare is cause for concern, including therapeutic work, parent education programmes, home-based parent and family support programmes, child development and education interventions, youth work and community development. Alternatively, a family welfare conference service offers families and professionals the opportunity to meet together in an equitable manner, sharing equal responsibility in planning and decision-making.

Where a child is deemed to be at risk of abuse or neglect, they may be placed in care outside the home, either in foster care, residential care, or some other suitable setting such as being placed with a relative; a care plan is drawn up for each such child.

Details regarding the proportion of children who come into contact with the HSE's child and family services because of their parents' drug or alcohol use are not routinely made available. However, some indications of the number giving cause concern or being taken into care because of their parents' substance use have emerged in recent years.

- In 2006 it was reported that 661 Irish families were causing concern to the HSE's welfare services because of drugs or alcohol misuse (Ombudsman for Children's Office 2010).
- A study on the development of residential child welfare in Ireland since 1978 found that between the mid-1990s and 2005 there was a 'significant' increase in the number of children taken into care in response to the 'abuse of drugs and/or

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<sup>24</sup> See Section 12.2.1 above for an account of the Child Care Act 1991, which sets out the HSE's statutory obligations, and Section 12.3.2 below for an account of the national guidelines, Children First, which set out how the law is to be implemented.

alcohol' by a family member (O'Sullivan 2009). The reasons for this increase were not explained in the report.

Since 2008 the HSE has been overseeing a thorough review of services for children and families (Health Service Executive 2011b). Reviews of the service had revealed that different social work departments were using different definitions of welfare, neglect and abuse, and while more welfare and support type referrals were received than reports of suspected child abuse, the focus of interventions was on child protection. This has had significance for service design and resource allocation, as social work departments that focus on child protection cannot provide a more preventative, early intervention family support type service to children and families where need rather than risk is the issue. What research and practice experience have demonstrated, however, is that unmet need often generates increased risk over time (Task Force for children & family social services 2010).

The HSE's intention is to rebalance services with an emphasis on primary prevention and family support. Integrated children and family services will be whole-child/whole-system focused; accessible; and connected with family and community strengths. A Differential Response Model (DRM) is currently being piloted in the Dublin region: a model such as this will enable social work professionals to respond more flexibly to different types of notifications and help meet the particular care and protection needs identified (Children Acts Advisory Board 2008). It is expected that over time this shift will reduce the number of children who need to leave their families to be cared for in alternative forms of care. This shift is in line with the recommendations made by Hogan following her empirical research (described in Section 12.2.2 above) (Hogan, 2007#1598). She recommended that support services should be family-oriented and designed to provide long-term support for families, with the capacity to provide increased support during periods of particular vulnerability. She suggested that since some parents and children cope well most of the time, an open door service might best suit the needs of many parents and children.

#### **12.4.2 Availability of guidelines addressing drug-using parents/pregnant women and their children**

##### **Drug-using pregnant women**

The Irish College of General Practitioners' *Guidelines for working with opiate users in primary care* (Irish College of General Practitioners 2008) includes a short section on pregnancy, emphasising the need to stabilise the woman's drug use during pregnancy. If necessary, the woman should be offered admission to an in-patient unit for stabilisation on methadone (pregnant women receive priority for inpatient admission).

The Irish Prison Service's *Drug treatment clinical policy* (Irish Prison Service 2008) states that during pregnancy it is advisable to stabilise the woman on methadone, rather than attempt to detoxify. However, if a woman wishes to detoxify during her pregnancy, it is recommended that it should be done after the 12th week of pregnancy but before the 32nd week, to reduce the risk of premature labour. The Irish Prison Service's *Health care standards* (Irish Prison Service 2009) states that attracting and maintaining pregnant prisoners in treatment services is vital, and also advises that long-term methadone maintenance treatment is considered the best option for most opioid dependent pregnant women.

##### **Neonates of opioid dependent women**

The Irish Prison Service's *Health care standards* (Irish Prison Service 2009) advises that neonates born to opiate dependent mothers who show symptoms of neonatal abstinence syndrome can usually be cared for in a normal maternity environment on condition that, in case of emergency, they can be transferred to special care units. If medication is required, a range of opioid and non-opioid drugs can be used. An oral morphine concentrate is the drug of choice and phenobarbitone may be used if the

mother has been taking other substances, such as benzodiazepines. Breast feeding is encouraged not only because of its general advantages but also because some methadone may pass to the baby in very low doses and this in turn may help to reduce any withdrawal symptoms on the part of the baby. In case of HCV infection, the benefits of breast-feeding should be reviewed. Finally, because pregnant women and young mothers may suffer from severe guilt feelings, psychosocial care and counselling is highly recommended.

### **Children of drug-using parents – their protection and welfare**

*Children first: national guidance for the protection and welfare of children* (Department of Children and Youth Affairs 2011) is a revised version of guidelines first published in 1999 (Department of Health and Children 1999). The revised document twice refers to the heightened risk of neglect or maltreatment among children of parents who use illicit drugs, and states that those working in the Mental Health and Addiction Services with a person with a mental health or addiction problem must consider the welfare and safety of any children in that person's family and/or children in regular contact with the person, and that the child's needs must remain paramount. The guidelines also state that it is essential that efforts are coordinated and that information is shared between professionals. The government has also announced that it intends to introduce legislation requiring all organisations to have duty to comply with the Children First guidance (endnote ref. Fitzgerald 2011, 15 July).

In October 2011 the HSE's National Office for Children published a *Child Protection and Welfare Practice Handbook* to assist in the standard implementation of Children First 2011 (Health Service Executive 2011a). In chapter 3 on 'Social work procedures and practice', under the heading of 'risk factors in child protection', the handbook includes three pages on parental substance misuse, including both alcohol and drugs. This section lists key messages (16) from research on parental substance misuse, and practice notes for the social worker, comprising a series of questions under the following headings:

- Parenting and attachment relationship
- Living conditions
- Financial circumstances
- Potential for harm
- Social and environmental circumstances
- The outcomes for this child.

The revised Children First guidance outlines the objectives and preferred approach to training for those working in child protection and welfare, including basic training with regard to child care legislation, national and local agency policies, procedures and protocols, and advanced-level training on policy and practice, for example, risk assessment and working in partnership with parents/carers. Researchers who have undertaken qualitative studies of the services provided to drug-using mothers in Ireland in recent years have highlighted the need for a number of different strands to be included in training.

In a qualitative study of professional workers' perceptions of mothers who use illicit drugs, Lane (Lane 2010) interviewed professionals in a variety of disciplines (public health nurse, social worker, addiction counsellor, community drug worker and family support worker) with regard to their views of drug-using mothers and of their own roles in relation to these mothers. She also observed their approaches to service delivery and their interactions with mothers who used drugs. She found differences in how different types of professionals saw the drug-using mother and the role of the professional. For example, the community drug workers tended to consider that drug use and motherhood could be combined, providing supports were put in place, while other professional groups regarded drug use and motherhood as mutually exclusive categories. Moreover, with regard to taking children into custody, while community drugs workers advocated keeping the child with the mother where possible, other professional workers argued that the mother should not have custody of her child until

she had overcome her drug use. Lane recommended that training and education for professional workers should include topics such as drug addiction, gender, identity development and stigmatisation, 'as there appears to be a lack of knowledge around the underlying problems that drug using mothers experience', and that in implementing national policy on childcare, professional workers should support cross-disciplinary conversations and mutual respect among the various professions to ensure consistent and appropriate implementation of policy and guidelines.

The Children First guidance advises that professionals should resist the tendency to deny, minimise or explain away any signs that a child is being harmed, for example where other problems are present, such as unemployment, poverty, poor housing, addiction, mental illness or isolation. The protection and welfare of the child must always be the paramount concern. In her major qualitative study on the impact of a woman's drug use on her identity, status and role as a mother, Woods (Woods 2008) called for a more nuanced and in-depth approach to the issues:

... drug treatment providers and social workers need to upskill with regard to childcare and drug issues respectively; review their assessment practices and constantly probe the assumptions they bring to the area in a reflexive and reflective way. Ultimately this study suggests that responding to drug use and motherhood in a formulaic or prescriptive manner is not possible and it is reasonable to recommend that workers be more questioning and probing in their responses, not just of the women's parenting and mothering practices and skills, but of their own therapeutic practices, beliefs and assumptions. (p. 281)

## Part C

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### 13.2 List of relevant databases available on internet

- Central Statistics Office interactive tables Census 1996, 2002 and 2006  
[www.cso.ie](http://www.cso.ie)
- Hospital In-Patient Enquiry scheme data 2000–2008  
[www.esri.ie/health\\_information/hipe/](http://www.esri.ie/health_information/hipe/)
- National Drug Treatment Reporting System interactive tables 2004–2008  
[drugsandalcohol.ie](http://drugsandalcohol.ie)

For descriptions of relevant databases not currently available on-line, see introductions to chapters 5, 6, and 7.

### 13.3 List of relevant internet addresses

<http://aldp.ie>  
<http://addictionireland.ie>  
<http://www.ballyfermotadvance.ie/>  
<http://www.citywide.ie>  
<http://www.coolmine.ie/>  
<http://connect.southdublin.ie/cdi/index.php>  
<http://www.cso.ie>  
<http://www.courts.ie>  
<http://dialtostopdrugdealing.ie>  
<http://www.drugs.ie>  
<http://drugsandalcohol.ie>  
<http://www.fsn.ie>  
<http://www.garda.ie>  
<http://www.hpsc.ie>  
<http://www.hrb.ie>  
<http://www.hse.ie>  
<http://inef.ie>  
<http://iprt.ie>  
<http://www.irishprisons.ie>  
<http://www.justice.ie>  
<http://www.mqi.ie>  
<http://www.nacd.ie>  
<http://nuigalway.ie/hbsc/>  
<http://www.poisons.ie>  
<http://www.preparingforlife.ie/>  
<http://www.probation.ie>  
<http://www.saolproject.ie/>  
<http://www.sphe.ie/>  
<http://www.taoiseach.ie>  
<http://www.youngballymun.org/>

## 14. Annexes

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## **14.5 List of abbreviations**

ADHD	Attention-Deficit Hyperactivity Disorder
ADRU	Alcohol and Drug Research Unit
AGPAR	Activity, Pulse, Grimace, Appearance, and Respiration
AIDS	Acquired Immunodeficiency Syndrome
ALDP	Ana Liffey Drug Project
AUDIT	Alcohol Use Disorders Identification Test
BAC	Blood Alcohol Content
B&B	Bed and Breakfast
BBV	Blood Borne Virus
BITC	Business in the Community Ireland
BZP	Benzylpiperazine
CAAB	Children Acts Advisory Board
CAB	Criminal Assets Bureau
CAMHS	Child and Adolescent Mental Health Service
CAN	Swedish Council for Information on Alcohol and Other Drugs
CAPE	Community Assessment of Psychic Experiences
CCA	Court of Criminal Appeal
CCLDTF	Canal Communities Local Drugs Task Force
CDLE	Customs Drug Law Enforcement
CE	Community Employment
CGES	Children's Global Assessment Scale
CHIS	Central Human Intelligence System
CLAN	College Lifestyle and Attitudinal National Survey
CPAD	Concerned Parents Against Drugs
CSO	Central Statistics Office
CTC	Coolmine Therapeutic Community
CTL	Central Treatment List
CWIUH	Coombe Women and Infants University Hospital
DAIRU	Drugs and Alcohol Information and Research Unit (DHSSPS, NI)
DAG	Drugs Advisory Group
DCEGA	Department of Community, Equality and Gaeltacht Affairs (since March 2010)
DCRGA	Department of Community, Rural and Gaeltacht Affairs (before March 2010)
DCYA	Department of Children and Youth Affairs

DES	Department of Education and Science (before March 2010)
DES	Department of Education and Skills (since March 2010)
DEHLG	Department of the Environment, Heritage and Local Government
DEIS	Delivering Equality of Opportunity in Schools
DHSSPS	Department of Health, Social Services and Public Safety
DLM	Drug Liaison Midwife
DMCYA	Department of the Minister for Children and Youth Affairs
DML	Dublin/Mid Leinster
DMR	Dublin Metropolitan Region
DNE	Dublin/North East
DSH	Deliberate Self Harm
DoH	Department of Health
DoHC	Department of Health and Children
DRM	Differential Response Model
DTC	Drug Treatment Court
DTCB	Drug Treatment Centre Board
DTF	Drugs Task Force
DUID	Driving Under the Influence of Drugs
ED	Electoral Division
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESL	Early School Leavers
ESPAD	European School Survey Project on Alcohol and Other Drugs
ESRI	Economic and Social Research Institute
EU	European Union
FÁS	Foras Aiseanna Saothair (Training & Employment Authority)
FETAC	Further Education and Training Awards Council
FSL	Forensic Science Laboratory
FSN	Family Support Network
GARF	Global Assessment of Relational Functioning DSM-IV
GBL	Gamma butyrolactone
GMS	General Medical Services Payment Board
GNDU	Garda National Drugs Unit
GP	General Practitioner
GYDP	Garda Youth Diversion Project
HADS	Hospital Anxiety and Depression Scale
HBSC	Health Behaviour in School-aged Children Survey
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HIPE	Hospital In-Patient Enquiry scheme
HPSC	Health Protection Surveillance Centre
HRB	Health Research Board
HSCL	Home School Community Liaison
HSE	Health Service Executive
ICGP	Irish College of General Practitioners
ICU	Intensive Care Unit
ICP	Integrated Care Pathway
IDO	Intentional Drug Overdose
INEF	Irish Needle Exchange Forum
IPRT	Irish Penal Reform Trust
IPS	Irish Prison Service
ISM	Integrated Sentence Management
IYJS	Irish Youth Justice Service
JPC	Joint Policing Committee
LDTF	Local Drugs Task Force
LGBT	Lesbian, Gay, Bisexual and Transgender
LPF	Local Policing Fora
MAOC-N	Maritime Analysis and Operational Centre – Narcotics
MAP	Maudsley Addiction Profile
MCIDI	Munich-Composite International Diagnostic Interview

MHC	Mental Health Commission
MDA	Misuse of Drugs Act
MDT	Mandatory Drug Testing
MTP	Methadone Treatment Protocol
MQI	Merchants Quay Ireland
MRSA	Staphylococcus aureus
MRSSA	Staphylococcus aureus
NACD	National Advisory Committee on Drugs
NAS	Neonatal Abstinence Syndrome
NAPS	National Anti-Poverty Strategy
NDS	National Drugs Strategy
NDRDI	National Drug-Related Deaths Index
NDRIC	National Drugs Rehabilitation Implementation Committee
NDTRS	National Drug Treatment Reporting System
NEWB	National Education Welfare Board
NGO	Non Governmental Organisation
NMPDU	Nursing and Midwifery Planning and Development Unit
NPIC	National Poisons Information Centre
NPIRS	National Psychiatric Inpatient Reporting System
NPIS	National Poisons Information Service
NRP	National Reform Programme
NSP	National Service Plan (of the Health Service Executive)
NUI	National University of Ireland
OFD	Oversight Forum on Drugs
OECD	Organisation for Economic Co-operation and Development
OMCYA	Office of the Minister for Children and Youth Affairs
OMD	Office of the Minister for Drugs
OTC	Over-the-counter
PCCC	Primary, Community and Continuing Care
PCRS	Primary Care Re-imburement Service
PFL	Preparing for life
PHIRB	Public Health Information and Research Branch
PISA	Programme for International Student Assessment
PSI	Pharmaceutical Society of Ireland
PQ	<i>Parliamentary Question</i>
PULSE	Police Using Leading Systems
QFI	Quality Framework Initiative
QuADS	Quality in Alcohol and Drug Services
RAPID	Revitalising Areas by Planning Investment and Development
RDTF	Regional Drugs Task Force
ROSIE	Research Outcome Study in Ireland
SAOL	Service Provision for Women with Addiction Problems
SBCU	Special Baby Care Unit
SCP	School Completion Programme
SDS	Severity of Dependence Scale
SFP	Strengthening Families Programme
SLA	Service-level Agreement
SLÁN	Survey of Lifestyle, Attitudes and Nutrition in Ireland
SMART	Standardised Measurement of Alcohol Related Troubles
SPHE	Social, Personal and Health Education
STI	Sexually Transmitted Infection
TCD	Trinity College Dublin
TD	Teachta Dála (Member of Parliament)
TDI	Treatment Demand Indicator
TR	Temporary Release
UCC	University College Cork
UCD	University College Dublin
UK	United Kingdom
VEC	Vocational Education Committee

VTR  
WHO  
YHS  
YPFSF

Vertical Transmission Rate  
World Health Organization  
Youth Homelessness Strategy  
Young People's Facilities and Services Fund