



European Monitoring Centre
for Drugs and Drug Addiction



**2013 NATIONAL REPORT (2012 Data)
TO THE EMCDDA
by the Reitox National Focal Point**

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

REITOX

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Dr Justine Horgan, prevalence expert at the Irish National Focal Point, died in August this year. Justine's colleagues and friends in the Health Research Board were deeply saddened by her untimely death. Justine was a highly dedicated scientist with a commitment to ensuring that evidence of the highest quality was available to those making policy in the drugs field. We have lost an excellent colleague and a good friend and we will remember her time working with us with both fondness and regret.

This report was compiled by Mairea Nelson and Brigid Pike.

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Summary of each chapter

This report, written following European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) guidelines,¹ is an overview of new developments and trends in the drugs area in Ireland between 2011 and 2013. 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

Main points

1. Drug policy: legislation, strategies and economic analysis

The Criminal Justice (Search Warrants) Act 2012 was signed into law on 24 July 2012. It provides additional safeguards in circumstances of urgency requiring the immediate issue of a warrant. The Road Traffic Bill 2013, when enacted, will provide for new measures to test for driver intoxication based on nontechnology-based cognitive tests. The Spent Convictions Bill 2012 will provide that convicted persons whose sentence is below a specific threshold, may withhold details of the conviction, for example when seeking employment. Legislative measures are currently being progressed to provide for the legal sale of medicinal cannabis and to address the illegal street sale of prescription drugs.

The Criminal Justice Act 1999 created a new offence of possessing controlled drugs having a value of £10,000 (€13,000) or more for sale or supply, which attracted a presumptive sentence of 10 years' imprisonment. The Law Reform Commission (LRC) has recommended that this presumptive sentencing regime be repealed. The LRC highlights the apparent injustice inherent in the legislation whereby the same presumptive sentencing regime applies to individuals regardless of their position in the drug trafficking operation and their consequent level of moral culpability.

Progress continues in implementing the 61 actions in the National Drugs Strategy 2009–2016, with delays in implementing 16 actions noted owing to the continuing economic downturn, the ongoing deliberations on a National Substance Misuse Strategy, or the delay in renewing the mandate of the National Advisory Committee on Drugs. Only one new policy initiative was undertaken at national level – a review of drugs task forces – and not all the recommendations have been implemented. In the third sector, community sector groups have been stressing the importance of placing the individual at the centre of their work and, as a result, emphasising human rights, harm reduction and a focus on the whole person. Civil society organisations have also hosted two events on policy issues: 'Criminalising addiction: is there another way?' and 'Responding to addiction in a time of recession'.

¹ The EMCDDA 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. www.emcdda.europa.eu/

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

The All-Ireland general population survey 2010/2011 reported detailed information on cannabis in 2013: More people than ever before had tried cannabis at least once in their lifetime, with the rate at one in four adults, compared to one in six in the 2002/3 survey. However, rates for last-year and last-month prevalence have tapered off since the 2006/7 survey. Additionally, among those consuming cannabis, age of initial use has remained the same, at 18 years, and use declines with age. Among those defined as recent users, 17% met the EMCDDA criteria for cannabis abuse, from which it is inferred that approximately 39,953 people in Ireland abuse cannabis, and 9% were classified as dependent, from which it is inferred that approximately 18,440 people are cannabis dependent.

The All-Ireland general population survey 2010/2011 reported detailed information on sedatives or tranquillisers in 2012: Prevalence rates were 14% for lifetime use, 7% for last-year use and 3% for last-month use. There were statistically significant increases in the lifetime rate (up by 32%) and the last-year rate (up by 38%) since the 2006/7 survey. Prevalence rates increased among the groups traditionally associated with these medicines (women and the older population), but the largest increases were in the rates of use by men and by young people.

The All-Ireland general population survey 2010/2011 reported detailed information on anti-depressants in 2012: In 2010/11 the prevalence rates were 10% for lifetime use, 5% for last-year use and 4% for last-month use. The rate for last-month use increased by 29% since the 2006/7 survey. Prevalence rates for women were higher than those for men, but overall, the gap between men and women in terms of lifetime and last-year rates has narrowed. Lifetime rates for older adults increased by 21%, from 11% in 2006/7 to 13% in 2010/11. No statistically significant changes were found over time among young adults.

The European School Survey Project on Alcohol and Other Drugs (ESPAD) 2010/2011 reported that the rate of lifetime use of any illicit drug decreased from 22% in 2007 to 19% in 2011. As the majority of 15–16-year-olds who have tried any illicit drug have used cannabis (marijuana or hashish), the decrease in illicit drug use may be explained by the fall in the number of students who have tried cannabis at some point in their lives, from 20% in 2007 to 18% in 2011 (just above the European average of 17%). The Health behaviour in school children (HBSC) 2010 reported an overall decrease in self-reported alcohol and cannabis use among school children in Ireland in 2010 when compared to 2006. This may represent a true decrease, possibly owing to children having less pocket money in recent years, or it may be the result of sampling variation, or a combination of both factors.

3. Prevention

The current direction of school-based universal substance use education and prevention, particularly among second-level students, is moving towards an integrated hybrid model incorporating a whole-school approach to overall health and social education, alongside an emphasis on young people developing their personal and social competencies. Owing to particular concerns around the threat of suicide among young people, a comprehensive set of guidelines promoting positive mental health and well-being among post-primary students have been developed and disseminated.

A recent report estimated that 43% of young people aged between 10 and 24 participated in youth work activities in 2011. An economic evaluation of youth work undertaken by independent consultants estimated that the State would save costs to the value of €2 billion for an €992 million investment over the next 10 years. A recent study found that young people reported that participating in youth clubs and related activities helped them to achieving personal development and happiness, skills and experiences needed for life and feeling included in society.

4. Problem drug use (PDU)

Bulletin 3 in the series of reports on the 2010/11 general population survey on drug use in Ireland and Northern Ireland reports on cannabis use in the adult population (15–64 years), on cannabis dependence and cannabis abuse as well as on patterns of cannabis use. The study indicates that the likelihood of a young adult in Ireland using daily or almost daily has declined substantially since the 2006/7 survey. Despite lower prevalence, frequency of use is higher among older adults, changing little since the last survey. The number of treatment cases reporting cannabis as their main problem substance has increased significantly in Ireland and in 2010 cannabis became the most common problem drug reported by new cases.

Merchants Quay Ireland (MQI), a national voluntary agency providing services for homeless people and for drug users, reported that in 2011 there were 21,819 visits to its Drug Services and 18,951 needle exchanges, with 4,051 individuals using the services, 492 of whom were new clients. The new MQI centre in the Midlands provided over 4,000 one-to-one interventions in 2011.

The first nationwide survey on drug and alcohol 'misuse' among the adult offender population on probation supervision are described includes findings on the nature of and engagement with drug and alcohol treatment services by adult offenders on probation supervision.

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

The report of the expert group set up to examine the regulatory framework for products containing buprenorphine/naloxone and buprenorphine-only was published in 2013. The expert group has concluded that methadone is the drug of first choice for treating opiate dependency, but buprenorphine/naloxone may be appropriate for some patient cohorts in certain circumstances. It has recommended that the regulations, guidelines and protocols governing methadone may also apply to the prescribing and dispensing of buprenorphine/ naloxone, or buprenorphine-only products, and that the details of patients receiving these products should be recorded on the Central Treatment List. The group advised that if buprenorphine/naloxone or buprenorphine-only products were to be used in Ireland, changes would have to be made to the misuse of drugs legislation and to the regulations for the prescription and supply of methadone.

At mid-2013 there were 144 beds available for detoxification nationally. Only four beds are available for adolescent detoxification treatment, and the average waiting time for these beds is four to five weeks.

New clinical practice guidelines on safe and effective prescribing of methadone for pregnant women in maternity hospitals have been published. Several reports have also been published looking at different interventions for problem drug users: brief interventions to reduce problem alcohol use in patients on methadone treatment; psychotherapeutic interventions by GPs providing treated to methadone patients in primary care; and group psychological intervention for psychosis with cannabis dependence.

TDI data showed that in 2012, 7,703 cases entered treatment, a decrease of 336 cases from 2011. The majority were male (73.0%) and the mean age was 29 years, similar trends to 2011. As in previous years, opiates (mainly heroin) were the most common main problem drug reported by cases entering treatment (51.6%). The reduction in the proportion and number of cases treated for cocaine as a main problem substance continued, but there was an increase in the number of cases entering treatment for cannabis as their main problem substance. There were 9,419 clients registered for methadone treatment (including those receiving methadone in prison), only a 2% increase on 2011. Since 2009, the number of clients registered on methadone treatment has stabilised

6. Health correlates and consequences

Between 2011 and 2012, the number of new cases of **HIV** among injecting drug users (IDUs) has continued to decline. In 2012, 13 new diagnoses of HIV were IDUs, compared to 71 in 2004. In 2012, 69% of IDUs newly diagnosed with HIV infection were co-infected with Hepatitis C. There was a 12% increase in **hepatitis B** notifications in Ireland in 2012 compared to 2011, but no new acute cases of hepatitis B infection among IDUs in 2012. While there was a 17.5% increase in **hepatitis C** notifications in Ireland in 2012 compared to 2011, the decreasing hepatitis C notifications and increasing median age is indicative of a reduced incidence of hepatitis C in the population. Injecting was the predominant risk factor for 484 of the new cases and the average age was 37 years. A 2011 study to determine the burden of hepatitis C infection in Ireland found that 63% of confirmed cases were men with a median age at diagnosis of 28 years; 70% had a history of drug use. Examination of genotype found that 53% of drug users had genotype 1 hepatitis C infection and 42% had genotype 3 hepatitis C infection.

Various reports are described on including studies of blood-borne virus prevalence and testing and treatment status among IDUs; acute and chronic medical consequences among IDUs; dental disease among clients attending Irish alcohol and drug use treatment centres; overdose cases admitted to Irish hospitals; admissions to Irish psychiatric units and hospitals of cases with a drug disorder (ICD-10 Code F11–19, F55); the association of substance use disorders and a history of psychiatric disorder or serious mental health problems among Irish adolescents.

Ireland participated in Phase II of the International ADHD in Substance Use Disorders Prevalence (IASP) study to estimate the prevalence of ADHD in substance use disorder (SUD)-treatment-seeking patients. A total of 21% participants in Ireland screened positive for ADHD, none of which had been diagnosed in childhood. They were all being treated for problematic drug use, not for problematic alcohol use.

The first study in Ireland to use the Comprehensive Assessment of At-Risk Mental States (CAARMS) to identify the prevalence of ultra-high risk (UHR) state for psychosis among young offenders has found that substance use problems were reported by 85% of those interviewed.

In 2011, there were 220 deaths owing to poisoning recorded in Ireland by the National Drug-Related Deaths Index (NDRDI). This represents a substantial increase compared to 2010, when 173 such deaths were recorded.

7. Responses to health correlates and consequences

In September 2012 the National Hepatitis C strategy was published. It contains updated epidemiological information on hepatitis C, details of new direct acting antivirals, and makes 36 recommendations. Five studies of the hepatitis C virus are described; they relate to treatment and management, current screening for HCV in pregnant women in Ireland and the related side-effects of treatment. Other reports described include a study of the treatment of patients who are co infected with HIV and hepatitis C virus, and an audit of Irish Psycho-Gastroenterology Hepatitis C service.

Three studies from large maternity hospitals are described. Two explore the paradigm for target screening versus universal screening for HCV in the routine prenatal care of women. A third study looked at methadone maintenance and prescribed medication among opioid dependent pregnant women.

Finally, a small study has found that the GP plays an important role in meeting youth mental health needs, particularly in economically deprived urban areas. The author concluded that GPs and primary care teams need support and education for mental health issues for younger patients, particularly on the complexities of comorbidity.

8. Social correlates and social reintegration

A number of studies have highlighted the interplay between drugs/alcohol, socio-economic marginalisation and co-morbidity – among people attending a needle exchange service in Dublin; among 211 children and young people living in state care; among residents in a hostel for the homeless in inner-city Dublin and among clients of a voluntary organisation providing shelter and accommodation to homeless people, among the adult offender population on probation supervision in Ireland.

The Central Statistics Office published a comprehensive profile of the homeless population, as enumerated in the 2011 census of the population of Ireland. A total 3,808 were either counted in accommodation providing shelter for homeless persons or were identified as sleeping rough. The government published a policy statement on homelessness in January 2013 making explicit its commitment to ending homelessness by the end of 2016 by implementing the housing-led approach. Recent research with stakeholders working in the homeless sector and with some homeless people suggests that it may not be just a matter of providing ‘bricks and mortar’ to tackle homelessness, particularly for people with long histories of homelessness.

At June 2013 there were 895 participants on drug rehabilitation places in the Community Employment scheme which was set up to provide education and vocational training to people in recovery from substance use. The most up-to-date data on the employment status of people reporting for drug treatment show a steady downward trend in terms of their employment prospects.

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

The number of legal proceedings for the possession of drugs for personal use (simple possession) has continued to decline since 2009. Proceedings for drug supply have also decreased marginally since 2009. A noteworthy development has been the continued increase in the offence of cultivating/ manufacturing controlled drugs, more than doubling since 2009. Since 2009, the number of prosecutions for Driving Under the Influence of Drugs has decreased significantly.

The Inspector of Prisons, in his annual report for 2012, stated that the availability of drugs remains a major issue in a number of Irish prisons. The Inspector also identified a number of issues of concern throughout the prison system, many of them drug-related. At present, for example, approximately 25% of Irish prisoners are in secure 23-hour lock-up for their own protection. This is often linked to threats from drug gangs in prison or because of drug debts owed to individuals or gangs.

In 2012 the Drug Treatment Clinical Policy document issued by the Irish Prison Service (IPS) in 2008 was reviewed to ensure that services provided in prisons were equivalent to those provided in the community. It was amended to reflect changes in legislation and practice in the community, including the statutory requirements in relation to HIV testing and notification, and the development of In Reach services for the treatment of Hepatitis C. The IPS has adopted and is introducing the recommendations of the Review.

10. Drug markets

The Garda Síochána Commissioner stated that there are approximately 25 Organised Crime Groups (OCGs) operating throughout the State, the vast majority of which are drug trafficking groups. In 2012, the Garda National Drugs Unit (GNDU) arrested 125 persons in connection with drug trafficking offences, 91 of whom were charged and are currently before the courts.

The total number of drug seizures increased from 5,299 in 2004 to a peak of 10,444 in 2007. Between 2008 and 2010, the number almost halved, to 5,477. This decrease can be explained primarily by the significant decrease in cannabis-type substances seized.

The decrease in cannabis seizures between 2009 and 2010 may also be partly explained by a change in the nature of cannabis use, with people moving from resin to more potent forms of cannabis, such as herbal cannabis. Herbal cannabis seizures almost doubled between 2009 and 2011, from 981 in 2009 to 1,833 in 2011, and then levelled off in 2012. There was a significant decline in seizures of cocaine and heroin between 2008 and 2011. In 2012, heroin seizures increased slightly, while cocaine seizures continued to decrease. Seizures of ecstasy-type substances also decreased significantly between 2008 and 2010. However, in 2011, they increased by more than 900%. This upward pattern has continued, albeit by a small margin, in 2012.

The GNDU carried out eight 'test purchase' operations targeted at low-level dealers nationwide, which led to 71 people being arrested in respect of 281 criminal offences. An Garda Síochána monitors drug markets on a nationwide basis annually and records current drug values. From the estimated total values of drug seizures published in the 2012 Garda annual report, estimated unit prices have been deduced, and following further clarification from the GNDU, these data are presented in this National Report for the first time.

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 (NDS)** provides the implementation framework for illicit drugs policy in Ireland (Department of Community 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 NDS, 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. A Drugs Advisory Group (DAG), comprising representatives from the relevant public, community and voluntary sector organisations, including DTFs, advises the Minister of State on operational and policy matters relating to the NDS, with a special focus on implementation at local and regional level.

Priorities for **public expenditure on the drugs issue** are set out in the NDS. 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 set up as pilot projects with funding provided through the Drugs Initiative, administered by the Department of Health. The relevant government department or agency 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 mainstreamed, responsibility for funding 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.

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 to 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 where available are relevant debates in the Oireachtas in relation 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 July 2011 and July 2012. It also identifies any new substances brought under control within the terms of the MDA legislation.

The Europol Act 2012 was signed into law on 26 December 2012. The Act provides for the implementation of the decision of 6 April 2009 establishing the European Police Office (Europol) and replaces the Europol Convention and Protocols which previously provided the basis for Europol. Section 7 of the Act permits Europol to request member states to initiate criminal investigations while section 8 provides for the transmission of data to the Europol Information System (EIS). The EIS is used to store personal information about people who are suspected or convicted of having committed a crime for which Europol has competence or where there are reasonable grounds to believe that they will commit such an offence.

The Criminal Justice (Search Warrants) Act 2012 was signed into law on 24 July 2012. The Act amends, inter alia, the provisions in the Criminal Justice (Drug Trafficking) Act 1996 relating to the issue of search warrants under section 26 of the Misuse of Drugs

Act 1977. The Act amends section 8 of the Criminal Justice (Drug Trafficking) Act 1996. Section 8(2) permits a superintendent (or above) to issue a warrant under section 26 of the Misuse of Drugs Act 1977 in circumstances of urgency requiring the immediate issue of a warrant and where it would be impracticable to apply to either a District Court judge or a peace commissioner. The amendments insert two additional safeguards. New subsection (2A) provides that only a superintendent who is independent of the investigation concerned may issue a warrant under section 26. 'Independent of' is defined as not being in charge of, or involved in the investigation concerned. New subsection (2B) requires a superintendent who issues a warrant under section 26 to record the grounds on which he/she issued the warrant either at the time or as soon as reasonably practicable after issuing the warrant.

Current status of relevant Bills before the Dáil is shown in Table 1.2.1.1

Table 1.2.1.1 Status of bills before the Dáil relevant to the drugs issue, July 2013

Title	Status
<p>The Fines (Payment and Recovery) Bill 2013 provides for the introduction of attachment of earnings as a means of recovering unpaid fines with the intention of reducing substantially the numbers of people committed to prison for the non-payment of fines. Where a person fails to pay a fine by the due date for payment (including by instalments where the person has chosen to pay by instalments) the court will make either a recovery order or an attachment order. If neither of these is considered appropriate (for example, where the person is not in employment and has no realisable assets), the court will consider imposing a community service order. The court may commit a person to prison if it is not possible to make any of the three orders. Community service is also an option, as an alternative to imprisonment, where a recovery order or an attachment order has been imposed, but where the fine or a portion of the fine remains outstanding</p>	<p>New Bill 29 July 2013</p>
<p>The Road Traffic (No.2) Bill 2013 provides, inter alia, new measures to test for driver intoxication. Members of An Garda Síochána will be empowered to require people driving or attempting to drive a mechanically propelled vehicle in a public place, to undertake intoxication impairment testing. This involves nontechnology-based cognitive tests (i.e. walking a straight line, tipping one's nose, counting while standing on one leg etc.). The results of these tests may be used in evidence in support of the Garda forming an opinion that the person is intoxicated. Under the new provisions, the Minister will be empowered to prescribe in regulations the nature of the tests and their manner of administration, as well as a form for recording the observations made during the tests. It will also be an offence to fail to comply with a requirement to undergo intoxication impairment testing. Section 12 amends the Road Traffic Act 2010 to allow for the taking, subject to medical approval, of a specimen of blood from an incapacitated (e.g. unconscious) person following a road traffic collision involving death or injury.</p>	<p>New Bill 26 June 2013</p>
<p>The Spent Convictions Bill 2012 provides that in the case of convicted persons whose sentence is below a specific threshold, they may, under certain circumstances, withhold details of the conviction, for example, when seeking employment. This is intended to apply where a prison sentence not exceeding 12 months or a fine or penalty have been imposed, and then only after a certain number of years have elapsed without a further conviction. The purpose of the bill is to help rehabilitate convicted persons through facilitating their reintegration into the workforce and allowing them to build new careers. As many problematic drug users whose offence is drug-related receive relatively short prison sentences, this legislation could have a positive impact in terms of facilitating rehabilitation interventions.</p>	<p>New Bill June 2012</p>

1.2.2 Laws implementation

The rehabilitation of offenders see also section 9.6.1

The Irish Penal Reform Trust (IPRT) has been campaigning for spent convictions legislation for six years (for an earlier version of this Bill, dated 2007, see (Irish Focal Point (Reitox) 2010)) Section One. The IPRT welcomed the publication of the Criminal Justice (Spent Convictions) Bill 2012 as a positive step in supporting the rehabilitation of offenders (Health Research Board 2012), and made submissions on earlier drafts of the current Bill (Irish Penal Reform Trust 2012, 4 May). According to the IPRT, the issues identified in its submissions on the earlier drafts of the Bill remain at the centre of its position on the present Bill (Irish Penal Reform Trust 2013). These are:

- the need for the Bill to apply to a wide range of convictions,
- the need for the rehabilitation periods to be set at reasonable, proportionate and practical levels, and
- any differential treatment of particular areas of employment should be kept to a minimum and must be justified.

Impact of organised crime legislation

The Criminal Justice Act 2006 and the Criminal Justice (Amendment) Act 2009 created, for the first time, the offence of participation in a criminal organisation and made provision to enable all organised crime offences to be declared scheduled offences for the purpose of trial in the Special Criminal Court, which operates with three judges and without a jury (Health Research Board 2006).

In a recent presentation to the Joint Oireachtas Committee on Justice, Defence and Equality, the Commissioner of An Garda Síochána stated that from the enactment of the Criminal Justice (Amendment) Act 2009 on 23 July 2009 to 30 September 2012 the legislation had been used on 179 occasions where arrests were made relating to organised crime, with just eight individuals being charged under the legislation – six under section 72 for participating or contributing to certain activities, and two under Section 71A for directing the activities of a criminal organisation (Joint Committee on Justice Defence and Equality 2012) (p. 3). It is not clear if anyone has yet been convicted under the legislation.

Review of mandatory sentencing legislation

The Law Reform Commission (LRC)² has recommended that the presumptive³ sentencing regime for drug offences be repealed (Law Reform Commission 2013). The Criminal Justice Act 1999 created a new offence of possessing controlled drugs having a value of £10,000 (€13,000) or more for sale or supply, which attracted a presumptive sentence of 10 years' imprisonment, except where there were 'exceptional and specific circumstances' relating to the offence, or to the person convicted of the offence (Health Research Board 2012). In a previous consultation paper, which analysed the operation and impact of this legislation, the LRC called for a review of the sentencing regime, finding that in effect it had merely led to a 'bulge in the prison system comprising low-level drugs offenders' serving lengthy prison sentences (Law Reform Commission 2012) (p.189). Following further examination, the LRC has now concluded that the legislation has not contributed to any reduction in levels of criminality, which it defines as 'the paramount aim of the criminal justice system' (Law Reform Commission 2013) (p.181). The LRC reviews similar legislation in a number of other common law countries, noting that the enactment of presumptive minimum sentencing in Ireland was, to some extent, influenced by sentencing reforms in the United States and the United Kingdom in particular. In the drugs context, a range of punitive sentencing measures have been introduced in other jurisdictions so as to reflect the relative seriousness of specific drug-related offences. Aggravating factors can include repeat drug offences, dealing drugs to minors or dealing drugs with the aid or conspiring of a child under the age of 18 years, drug trafficking while in possession of a firearm, selling drugs on a school bus or in the vicinity of a school, college, or housing project, or selling drugs to someone who is pregnant,. Running a drug trafficking enterprise or acting as the principal administrator, organiser or leader of a continuing criminal enterprise can also lead to more severe punishments. Aggravating factors may also relate to the quantity of drugs involved in the offence.

Although such a comparative analysis is of interest, the LRC cautions against relying too heavily on examples set by other countries, noting that these provisions 'are often the product of circumstances and cultural factors specific to the jurisdiction in question'

² The LRC is an independent statutory body established by the Law Reform Commission Act 1975. Its principal role is to keep the law under review and to make proposals for reform, in particular by recommending the enactment of legislation to clarify and modernise the law

³ The LRC uses the term 'presumptive' as distinct from mandatory sentence in that there is a presumption that the sentence would apply unless the court deems otherwise in a specific case. The LRC distinguishes such sentences from mandatory life sentences for murder treason or capital murder, for example.

(Law Reform Commission 2013) (p. 174). Ultimately, the LRC concludes, presumptive sentencing should be evaluated in terms of the extent to which it is consistent with the general aims of criminal sanctions which include deterrence, punishment, reform, rehabilitation and reparation. In particular, the LRC observes that deterrence and punishment feature prominently as aims in respect of those offences that attract presumptive sentences as these sentences seek to '(i) dissuade by coercive means, the offender from committing another drugs...offence and to punish him or her severely for the offence...committed, and (ii) dissuade the public at large from committing the relevant drugs...offence' (Law Reform Commission 2013) (p. 175).

With regard to deterrence, the LRC observes that, in practice, 'high-level (drug) offenders...shield themselves from detection and prosecution by means of complex and constantly evolving networks of distributors' (Law Reform Commission 2013) p175. Consequently, the LRC concludes, 'it is unlikely that such offenders would be deterred by the prospect of a presumptive...sentence when they are unlikely to be subjected to it' (Law Reform Commission 2013)p175. At the other end of the scale, offenders are either 'low-level drug mules whose involvement in the drugs trade is generally secured by means of exploitation and/or coercion' or, referring to an observation of the Court of Criminal Appeal, 'they are themselves drug addicts struggling to escape from the terrors of their addiction' (Law Reform Commission 2013)p175. Drug mules would be unlikely to be deterred by a presumptive sentence because of either their inability to assess the legal consequences of their actions or fear of the consequences of refusing to carry drugs. Dependent drug users, on the other hand, are prepared to risk 'victimisation, overdose, the transmission of diseases, and toxicity and impurities in the drug in order to feed their addiction' and, as a consequence, according to the LRC, 'they are unlikely to be deterred by the prospect of lengthy imprisonment' (Law Reform Commission 2013) p175.

With regard to meeting the aims of punishment, from a retributive perspective, the LRC highlights the apparent injustice inherent in the legislation whereby the same presumptive sentencing regime applies to individuals regardless of their position in the drug trafficking operation and their consequent level of moral culpability. This arises because 'the market value of the drugs (€13000 or more)...is prioritised at the expense of other factors relevant to culpability, such as role, motive and state of mind of the offender' (Law Reform Commission 2013) p175.

In calling for a repeal of the presumptive sentencing regime, the LRC concludes that the objective of reducing drug-related crime is unlikely to be achieved solely through criminal law enforcement but that crime-reduction approaches must be informed by a deeper understanding of the complexity of the relationship between illicit drug use and crime and a focus on measures aimed at addressing drug dependency.⁴

Medicinal cannabis

Legislative measures are currently being considered to provide for the legal sale of medicinal cannabis. In response to a Parliamentary Question, Alex White TD, Minister of State at the Department of Health, stated:

My Department has been informed by the Irish Medicines Board (IMB) that it is in receipt of a market authorisation request from a manufacturer under the EU Mutual Recognition Procedure for a medicinal product containing Cannabis extract. This product is indicated for the relief of symptoms of spasticity for people with multiple sclerosis. Under the Misuse of Drugs Act, 1977, the manufacture, production, preparation, sale, supply, distribution and possession of cannabis or cannabis-based medicinal products are unlawful except for the purposes of research.

⁴ With regards to the drugs-crime linkage, the LRC endorses the analysis provided in an HRB publication Connolly, J. (2006). Drugs and crime in Ireland. HRB Overview Series 3. Health Research Board, Dublin. Available at <http://www.drugsandalcohol.ie/6045/>. It also highlights the current focus on recovery from drug dependence by the misuse of drugs work sector of the British-Irish Council.

My Department is currently examining how authorised cannabis-based medicinal products for patients suffering from Multiple Sclerosis may be legally prescribed by medical practitioners and used by patients for the treatment of MS in Ireland. In that respect, Department officials have been engaging with experts to identify how best to legally prescribe authorised cannabis-based medicinal products while maintaining existing controls on cannabis and cannabis substances. While the legislative amendments required can be made by means of statutory instrument, the legal issues are complex. The matter is being progressed as quickly as possible in my Department and it is hoped to bring forward legislative proposals in mid-2013. (White, A 2013, March 20)

Street sale of prescription drugs

Under the Medicinal Products (Prescription and Control of Supply) Regulations, it is prohibited for a person to supply a prescription medicine except in accordance with a prescription, and the supply must be made from a registered pharmacy by or under the personal supervision of a registered pharmacist. A person who contravenes these regulations is guilty of an offence. However, the illegal street sale of prescription drugs has emerged as an important issue in the Irish drug scene in recent years (see discussion in (Health Research Board 2012) Section One). In response to a Parliamentary Question on the issue, Alex White TD, Minister of State at the Department of Health, stated:

Through the framework of the National Drugs Strategy 2009-2016, the Department of Health is working in collaboration with the relevant statutory agencies to monitor the availability of controlled drugs, including prescription medicines, through illicit channels...My Department is reviewing the Misuse of Drugs Regulations with a view to introducing additional controls on certain prescription drugs being traded illicitly, for example benzodiazepine medicines. These additional controls include introducing import and export controls as well as an offence of possession, thereby assisting the law enforcement roles of Customs and of the Garda Síochána. (White, A 2013, May 8)

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

1.3.1 National action plan and/or strategy

Ireland held the presidency of the EU for the first six months of 2013. Irish officials and politicians were occupied with EU-level drug policy issues for much of the reporting period covered by this National Report (Pike 2013). Only one new policy initiative was completed at national level – the review of drugs task forces – and not all recommendations have yet been implemented (see Section 1.3.4 below).

Regarding the adoption of a national substance misuse strategy, which process began in 2012 (see (Health Research Board 2012): Section 1.3.1), the government considered the proposed action plan in the autumn of 2012 but declined to endorse it. While the Minister for Health, James Reilly TD, and the Minister of State at the Department of Health with special responsibility for drug and alcohol policy, Alex White TD, both favour the public health approach taken in the action plan, other Ministers and their officials have questioned the evidence base for the claims that alcohol-related advertising and sponsorship of sports events by alcohol firms have an impact on the conduct and behaviour of children and young adults (White, A 2013 May 23). Notwithstanding this difference of opinion, as at mid-June 2013, work was continuing on ‘maximising agreement across all departments and Ministers’:

Proposals are currently being finalised on foot of the recommendations in the Steering Group Report on a National Substance Misuse Strategy 2012. These proposals cover all of the areas mentioned in the report, including legislation on minimum unit pricing; controls on alcohol advertising and sponsorship; labelling of alcohol products, and measures on access and availability of alcohol. The Cabinet Committee on Social Policy has considered these proposals and it is

intended to bring forward a finalised package of proposals for consideration by Government shortly. In the meantime, work on developing a framework for the necessary Department of Health legislation is continuing. A health impact assessment is being commissioned in conjunction with Northern Ireland as part of the process of developing a legislative basis for minimum unit pricing. The health impact assessment will study the impact of different minimum prices on a range of areas such as health, crime and likely economic impact. (White, A 2013 June 11)

In July 2013 the Joint Oireachtas Committee on Transport and Communications⁵ published a report on sponsorship of sports by the alcohol drinks industry (Joint Committee on Transport and Communications 2013). In light of the government's proposed policy changes, in March/April the Committee invited representatives of the Irish Rugby Football Union, the Gaelic Athletic Association, the Football Association of Ireland, Alcohol Action Ireland, the College of Psychiatrists, Horse Racing Ireland, the Federation of Irish Sports and the Drinks Industry Group of Ireland to make their cases for and against drinks industry sponsorship of sport. Having reflected on these presentations, the Joint Committee concluded in its report that, while it appreciated that actions must be taken to address the harm caused to individuals in Irish society by the misuse of, and over-indulgence in, alcohol, it did not believe that the link between sponsorship and consumption had been proved. It recommended, inter alia:

- Sponsorship by the alcohol drinks industry should remain in place until such time as it can be replaced by other identifiable streams of comparable funding.
- A fixed percentage of all sponsorship received by each and every organisation (sporting, cultural, arts, music etc) from the alcohol drinks industry should be ring-fenced and paid into a central fund to be administered by an appropriate body. That fund should be used exclusively for alcohol and substance abuse prevention programmes.
- All sporting organisations should be encouraged to support programmes which contribute to social inclusion in order to reduce the abuse of alcohol, particularly among young people.
- A prohibition on sponsorship by the alcohol industry should only be considered if it is done on a pan-European basis in order to ensure that Irish sports and sporting organisations are not operating at a disadvantage relative to their international competitors.

Despite the slow progress at policy level, organisational mandates have been expanded to include both drugs and alcohol. At national level, the National Advisory Committee on Drugs has been reconstituted as the National Advisory Committee on Drugs and Alcohol (NACDA). The Committee's role is to advise government on the prevalence, prevention, treatment, rehabilitation and consequences of substance use and misuse in Ireland, based on the analysis of research findings and information available to it. Catherine Comiskey, professor of Healthcare Statistics at the School of Nursing and Midwifery in Trinity College Dublin, chairs the new Committee, which comprises representatives from government departments, state agencies and bodies in the community and voluntary sectors. The NACDA's mandate will expire at the end of 2016, when the current NDS also expires. At local level, the remit of drugs task forces has been expanded to include alcohol, and in future they are to be called 'drugs and alcohol task forces' (DATFs) (see Section 1.3.4 for more detail).

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

Three reports published in the last year relating to the implementation and/or evaluation of the NDS are described here. Each was undertaken for different reasons and from a distinctive perspective – one from the point of view of government officials, one from the point of view of politicians, and one from the viewpoint of civil society.

⁵ This Joint Oireachtas Committee comprises 20 members drawn from both houses of the Oireachtas (Parliament) and is representative all political parties and independents.

Department of Health progress report on implementing the NDS, 2012–2013

In line with Action 59 of the NDS, which calls for the development of ‘an overall performance management framework for the NDS across all Departments and Agencies to assess and monitor progress’, the Department of Health publishes an annual report on the implementation of the 63 actions contained in the NDS (Department of Health 2013b). Progress on specific actions in the past year is described in the relevant sections elsewhere in this report. Some themes reported on in the progress report that cut across two or more pillars are highlighted in the following paragraphs (numbers in brackets refer to actions in the NDS).

Legislative and regulatory measures

Work is proceeding to ensure that the statutory provisions for road-side impairment testing for drug-driving are sound (9), and a Bill to update the law in relation to forensic evidence, including providing for the establishment of a national DNA database, is due to be published this year (11). The Department of Health is engaged on an ongoing basis in ensuring comprehensive and effective statutory controls of psychoactive substances (14, 15 & 40) and of drug precursors (16). With regard to enhanced data gathering, proposals for a health identifier are being developed (52), and legislative measures to reduce delays in reporting by the Coroner Service are proceeding (53).

Pilot programmes

Several pilot programmes are being run, evaluated and/or rolled out across the country. They include piloting of a programmed response to drug-related intimidation in the community and to the involvement by adults of young children in illegal activities associated with the drug trade (5 & 7); a drugs intervention programme in two Dublin Garda districts, which focuses on youth and young adults who come to the attention of the Gardaí and the Probation Service owing to behaviour caused by substance misuse (38); an integrated model of care in 10 sites, which is currently being evaluated (32); and an education and training programme on screening and brief intervention for problematic alcohol use for nurses and midwives (36).

Quality and best practice

Standards and guidelines are being developed in relation to drug prevention and drug treatment. Training is being provided to Garda in the use of roadside drug-related impairment testing (9). Information, advice and training regarding drug prevention are available to teachers and schools through a dedicated web site and a dedicated SPHE support service (20 & 21). Both the Youthreach Quality Framework Initiative (QFI) and the National Quality Standards Framework of Youth Work (NQS) include modules relating to substance misuse (23 & 24).

A comprehensive set of clinical guidelines for the treatment of opioid dependence are due to be published in 2013 (35). As at the end of 2012, 98 organisations were involved in the QuADS (Quality in Drugs and Alcohol Services) Support Project (45.) The National Addiction Training Programme (NATP) is currently addressing gaps identified by a survey conducted in late 2012 of training completed in HSE and drugs task force areas. The main gap identified was in advanced level training. Working closely with the National Drug Rehabilitation Implementation Committee (NDRIC), the NATP is also engaged in rolling out the UK-based DANOS/Skills for Health (47). Finally, educational models have been or are being developed for paramedic and nurse and midwife training to ensure they are familiar with relevant drug treatment issues and alternative care pathways. Comprehensive coverage of problematic substance issues is also being included in undergraduate doctor training (48).

Co-operation

Co-operation at operational level between government departments, state agencies and community- and voluntary-sector bodies has proceeded on a number of fronts. The criminal justice agencies (An Garda Síochána, the Courts Service, the Irish Prison Service and the Probation Service) have embarked on a project to establish linkages between their IT systems (6). Under the Prevention pillar, two cross-departmental

working groups have been set up. One, comprising representatives from the departments of Health (DoH), Children and Youth Affairs (DCYA), and Education and Skills (DES), and from the National Educational Psychological Service (NEPS), the National Council for Curriculum and Assessment (NCCA) and the SPHE Post-Primary Support Service, was tasked with updating drug awareness programmes in second-level schools (20). With regard to early-school leaving, a working group comprising officials from DES and DCYA was established following the transfer of functions under the Education (Welfare) Act 2000 in May 2011 from the Minister for Education and Skills to the Minister for Children and Youth Affairs. The purpose of this group is to ensure that education links are safeguarded and maintained given the range of interrelated activities of both Departments (31). Through the Young People's Facilities & Services Fund (YPFSF), DCYA are also developing more links with other agencies with the aim of increasing usage of facilities, sharing costs and maximising resources (25).

In pursuit of a 'national drug treatment service' that integrates treatment and rehabilitation and uses an integrated model of care, Action 33 of the NDS calls for the maximisation of 'operational synergies between Drug Addiction Services, Alcohol Treatment and Rehabilitation Services, General and Emergency Hospital Services and Mental Health Services'. The progress report gives the following update on how the NDRIC, which is playing a key role in integrating treatment and rehabilitation services and is leading on the 10-site pilot, has maximised operational synergies:

In the last quarter of 2012 a number of gaps and blocks were escalated to NDRIC via pilot sites relating to the need for more shared working between Mental Health Services & Addiction Services. As a result, NDRIC plans to invite mental health services to become involved in the formal rehabilitation interagency structures in each area when the rehabilitation framework is rollout [sic] beyond the pilot sites in 2013. In addition, NDRIC have also extended an invitation to national management in mental health services to take a seat on NDRIC to ensure that there is a common approach to shared care planning between the services. ((Department of Health 2013b): p. 20)

In June 2012 NDRIC also extended its membership to include the National Family Support Network (FSN). Following this the FSN were invited to engage in focus groups to scope the research instruments for the evaluation of the implementation of the rehabilitation framework in the ten sites piloting the use of an integrated model of care, and were interviewed as part of the research process to examine the experience of the framework implementation from the perspective of family members (41). At the same time, NDRIC also extended its membership to include a representative from SURF (Service Users Representative Forum) (42).

A protocol for the seamless transition of treatment services between the Irish Prison Service (IPS) and the Health Service Executive (HSE) is in place and is reported to be working well 'in the main' (43). The progress report comments on the challenges:

... in areas of the country where community treatment places are not available, challenges to delivery exist. Notwithstanding this it should be acknowledged that through collaboration with community services, effort is made to ensure continuity and initiation, where clinically indicated, of Methadone Maintenance Treatment. Difficulties remain with the remand population as the IPS is not in a position to influence releases directed by the Courts, however communication strategies have improved. A cross-sectoral group, chaired by the IPS, meet to monitor and review issues regarding implementation of this recommendation. ((Department of Health 2013b): p. 28)

Information and communication technologies (ICT)

ICT is being employed in the gathering of data and managing of information in the criminal justice area (6) and in the youth affairs area (24). Electronic communication

technologies are being used to support drug prevention (27) and to provide education, training and professional support to service providers (20, 21, 27 & 36)

At-risk groups

Children and young people are the focus of a wide number of initiatives – in relation to supply reduction (7), drug prevention (10, 20–25 and 29–31), and treatment and rehabilitation (34, 37, 38, 41). At-risk groups among the adult population include Travellers, new communities, LGBTs, the homeless and sex workers. Members of these groups are to have their treatment and rehabilitation needs specifically addressed (44), and a sub-group of the Drugs Advisory Group is to monitor progress in relation to this action, as well as monitoring services for families trying to cope with substance-related problems, the needs of service users and drug treatment services in prisons (60).

Alcohol

Although the National Substance Misuse Strategy and action plan have not been agreed, a number of actions in the NDS relate to alcohol use and are being implemented. Law enforcement agencies are engaged in addressing alcohol-related problems via the Joint Policing Forums (3) and in ensuring compliance with the prohibition of the sale of alcohol to persons under 18 years of age (10). In drug education and awareness campaigns, alcohol is being addressed alongside illicit drugs (27 & 28), and both drugs and alcohol are considered when responding to the needs of families and parents facing drug-related problems (29). In the interests of adequately treating all the needs of dual diagnosis clients, operational synergies between Drug Addiction Services and, inter alia, Alcohol Treatment and Rehabilitation Services are to be maximised (33). Moreover, the HSE Alcohol Screening and Brief Intervention Project has been engaged in developing and implementing a guiding framework for education and training for nurses and midwives (36). A National Screening and Brief Intervention Protocol for alcohol and substance misuse for Tier 1 Services and Tier 2 interventions is to be developed in 2013 (52). The national clinical and organisational governance framework endorsed by the HSE for all treatment and rehabilitation services is QuADS (Quality in Drugs and Alcohol Services) (45).

Overall progress

No actions have been dropped from the NDS apart from the two (57 & 63) already reported in last year's report ((Health Research Board 2012): Section 1.3.2). Delays or constraints in implementing some actions continue. The continuing economic downturn is hampering some efforts under the supply reduction, treatment and rehabilitation, and research and information pillars (6, 11, 32, 39, 53, 55 & 57). The ongoing deliberations regarding the National Substance Misuse Strategy are holding back work on the development of integrated drug and alcohol prevention frameworks and integrated monitoring systems (19, 22, 26, 28, 30 & 51). The delay in renewing the mandate of the National Advisory Committee on Drugs (NACD) has slowed down work on the research and information agenda (37,⁶ 49 & 54). The need for appropriate statutory and regulatory provisions and compliance has delayed the implementation of roadside impairment testing (11) and the establishment of a regulatory framework for the provision of counselling within substance misuse services (46).

Assessment/evaluation

While reporting on implementation and/or evaluation of individual actions, the annual report does not report on progress in relation to the key performance indicators and objectives set under each pillar in the NDS, or on the achievement of the overall

⁶ The progress report anticipates that a yet-to-be published implementation report on the National Strategy for Research and Data on Children's Lives 2011–2016 will describe progress in developing and implementing a mechanism for early identification, and onward referral where appropriate, of substance misuse among under 18 service users. The report has now been published Department of Children Youth Affairs (2013). [National strategy for research and data on children's lives 2011–2016. Implementation report: action plan update 2012](http://www.drugsandalcohol.ie/20177/). Department of Children and Youth Affairs, Dublin. Available at <http://www.drugsandalcohol.ie/20177/>. It reveals that the six relevant actions have been held up owing to the delay in renewing the mandate of the NACD.

strategic aims and objective of the NDS. Moreover, while a review of the previous NDS, covering the period 2001–2008, was undertaken at the mid-way point (Department of Community 2005), a similar mid-term review of the current NDS, covering the period 2009–2012, has not been undertaken.

Government report on implementing the Programme for Government, 2012

While the first annual report on the coalition government’s implementation of its programme for government focused on ‘key priorities’ relating to drug treatment, rehabilitation and harm reduction, the second report (Government for National Recovery 2011-2016 2013) focuses on initiatives in the law enforcement area (see Table 1.3.2.1 below).

Table 1.3.2.1 Progress in implementing drug-related ‘key priorities’ in Programme for Government 2011–2016, March 2013

Key priorities	Update in Programme for Government annual report 2013	Further information in other sections
Review of the Drug Treatment Court programme	–	9.6.1
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	–	8.3.2 8.3.3
Needle exchange programmes expanded across the country where needed most	–	5.2.2.2
Roadside drug testing	Government has approved drafting of the Road Traffic Bill, which will provide for the introduction of roadside testing for drivers suspected to be under the influence of drugs.	1.2.1, 9.3
Prison sentences versus non-custodial alternatives	A strategic review of penal policy [including alternatives to custody] is underway and the review is due to report in 2013.	9.6.1
Mandatory sentencing	The strategic review of penal policy includes mandatory sentencing.	1.2.2
Supply reduction and criminal assets seizures	–	10.3
Reduction of flow of drugs into prisons	A range of security initiatives have been introduced in closed prisons, including x-ray scanners, tighter control and monitoring of prison visits, airport style security screening of all staff and visitors, and increased random searches of prisoner accommodation. These have proven particularly effective in reducing the availability of drugs in the prisons, with drug seizures decreasing by 28 per cent between 2010 and 2012.	9.7
Customs controls to combat drug supplies at source	–	10.2.3
Budget transparency and accountability	The Oversight Forum on Drugs meets each quarter with all Departments and Agencies to monitor progress on the actions in the NDS, and to address any operational difficulties that may arise.	
Prevention measures including drug awareness programmes in schools, preventing addiction in schools, and introducing Education Prevention Units in all task forces	–	3.3.1

Source: (Government for National Recovery 2011-2016 2013)

Children’s advocacy group rates progress in tackling alcohol, drugs and smoking, 2012

The Children’s Rights Alliance (CRA) has published its fifth annual report assessing the government’s performance in honouring its promises to the over one million children living in Ireland (Children’s Rights Alliance 2013). Having awarded ‘Ds’ for each of the first three years, 2008–2010, in its fourth report, for 2011, the CRA gave the government a ‘C+’, reflecting its ‘commitment to children’s rights’, as evidenced by the appointment of a Minister for Children and Youth Affairs with full cabinet status, the creation of a new Department of Children and Youth Affairs, and the commitment to

hold a referendum on children's rights. In the latest report, for 2012, the CRA has given an overall 'C' grade, reflecting 'a satisfactory attempt to date, though children remain wanting'.

Notwithstanding the improvement in the overall rating, under the subheading 'Right to Health', the report gives the government a 'D' for progress in 2012 in relation to alcohol, drugs and smoking. It adjudges progress 'unsatisfactory'. The report states that despite the commitment that every government department, agency or task force responsible for implementing elements of the National Addiction Strategy would be required to account to the minister for their budget annually and to demonstrate progress on achieving targets, a National Addiction Strategy has not been published and 'is not expected until 2016'. The report goes on to comment that 'there is no Government policy on tackling alcohol misuse; no Government decision has been made on recommendations of the Steering Group'. It calls for, inter alia, the following actions in 2013:

- Urgently adopt a national strategy to tackle alcohol misuse and ensure it is coherent with the Interim National Drugs Strategy 2009–2016. The strategy should have a clear focus on the impact of alcohol and drugs on children, including reducing children's access to alcohol and drugs; curbing the widespread availability of cheap alcohol; restricting the promotion of alcohol; raising awareness of the potential harmful effects of alcohol and drugs and developing youth appropriate addiction treatment services. It should also address harmful parental drinking and its impact on children. The Strategy should be accompanied by a clear plan, with targets, timeframes and accountability structures.
- Sustain investment in non-alcohol and drug free spaces for young people.

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

Government strategy to improve the nation's health and well-being

On 28 March 2013 the government launched *Healthy Ireland: a framework for improved health and wellbeing 2013–2025* (Department of Health 2013a). *Healthy Ireland* sets out a policy framework and actions to improve health and wellbeing and reduce the health risks posed to future generations. The government has developed the policy in response to rising levels of chronic illness, lifestyle trends that threaten health and persistent health inequalities. The report states that the economic justification for the policy is clear: in Ireland, the estimated economic cost per year associated with obesity, smoking, alcohol use and mental health issues is around €18 billion. The report notes that the economic cost of the illicit drugs market in Ireland has never been calculated. However, it points out that the use of illegal drugs in the last year was reported at 7% of adults aged between 15 and 64 years, and drug use was the direct or indirect cause of 534 deaths in 2008.

Based on international evidence, which shows that, in order to make a positive change in population health and wellbeing, a whole-of-government approach is needed (as well as involving local communities and society as a whole), the authors of the policy framework have identified 64 broad inter-sectoral actions, with initial partners including government departments, statutory agencies, civil society organisations, the community and voluntary sector, the private sector, and employee representative organisations. The authors also recognise that ensuring effective implementation of the policy, making sure it does not get left on a shelf, is the biggest challenge. The framework of actions emphasises five activities – leadership, measurement, partnership, empowerment, and resource management – designed to ensure the policy remains on the front burner.

How *Healthy Ireland* will work in with the NDS remains to be seen. With regard to alcohol, citing the 2012 report on a national substance misuse strategy (Steering Group on a national substance misuse strategy 2012), *Healthy Ireland* identifies a decrease in alcohol consumption across the population as an indicator and sets a target of reducing the amount of alcohol consumed by people over the age of 15 years to an annual per capita consumption of 9.2 litres of pure alcohol. No date is set for this target.

Community sector groups stress ‘humanistic’ values

In their 2011 annual report, the co-ordinator and the chair of the Southern Regional Drugs Task Force (SRDTF) set out their vision of how the individual should be at the centre of a drugs task force’s responses to the illicit drugs problem (Black 2012). Co-ordinator Chris Black reported that, as well as focusing on its funded projects, the SRDTF has been involved in innovative development work that draws on international sources. He suggested this was ‘setting the seeds for a more user friendly, person centred and health based approach to drugs policy and drugs support’. In a personal introduction to the report, the chair of the SRDTF, Peadar King, contrasted the ‘harsh and unsympathetic response to drug producers and consumers’ adopted generally around the world following the ratification of the 1961 UN convention and its concomitant treaties, with the response of civil society, health activists and field workers who foreground citizens’ human rights and promote harm reduction strategies. King is concerned that this focus on human rights and the reduction of harm may be undermined by the new wave of managerialism, the effects of which he likens to the destructive impact of the original UN Convention.

The Ballymun Youth Action Project (BYAP), a community-based response to drug and alcohol misuse in north Dublin, works with individuals, supports families and communities, and builds capacity through training and research. In its strategic plan for 2013–2015 (Ballymun Youth Action Project 2013), BYAP has set out its way of working. Its approach is rooted in an ethos of valuing individuality and the capacity of individuals, families and communities to change. It commits to respecting where people have come from, where they are at now, and where they see they could be; to supporting the possibility of change; and to addressing where necessary the bigger issues that are presented by the many cross-cutting systems within which each individual has to make their way in life, including their family, the education system, the justice system, and the health system. The ethos and commitments are reflected in the strategic objectives and actions that BYAP has set itself for the next three years.

Civil society organisations focus on two policy issues

‘Criminalising addiction: is there another way?’ was the title of a conference hosted by CityWide Drug Crisis Campaign in Dublin in May 2013.⁷ The objective was to start an evidence-based debate on Ireland’s current drug policies and the alternatives. Some 120 participants from community drug projects, voluntary projects, youth services, drugs task forces, government departments and universities attended the conference at which four speakers made presentations. Following the presentations, participants took part in table discussions on the barriers to decriminalisation and what the international evidence reveals about the issue. There was general, but not complete, agreement that the evidence for decriminalisation is convincing, while the issues around legalisation appear to be complicated. It was also noted that the underlying issues of poverty and social disadvantage remain crucial to addressing the impact of drugs on the lives of people, families and communities. In closing the conference, the Chairperson of CityWide, Anna Quigley, stated that the conference was a first step. CityWide planned to publish an information leaflet, providing basic information about decriminalisation and also listing sources of further information. CityWide sees this as a starting point for discussion in drugs task forces, projects, community groups and also for use by local and national public elected representatives.

⁷ The conference was organised on foot of a commitment made by CityWide in 2012 to hold an open debate on decriminalisation Higgins, M. and CityWide (2012). *The drugs crisis in Ireland: a new agenda for action. CityWide policy statement 2012*. CityWide, Dublin. Available at <http://www.drugsandalcohol.ie/17145/>. A written report on the 2013 conference and videos of the four presentations are available at www.citywide.ie/news/2013/05/27/watch-the-conference-presentations/ and accessed on 25 July 2013.

'Responding to addiction in a time of recession' was the theme of a seminar hosted by the Ballymun Youth Action Project (BYAP) in June 2013. The purpose of the seminar was to provide an opportunity to step back and think about the impact of funding cutbacks. Róisín Shortall TD described the seminar as providing a 'critical space' to reflect on what amounts to a slow dismantling of the safety net that has been created within local communities, leading to the re-marginalisation of particular areas.

The seminar was attended by over 80 representatives of community and voluntary agencies, funders, local people and political representatives. There were two speakers – Brian Harvey, an independent social research consultant, and Dr Mary Ellen McCann, lecturer in UCD's School of Applied Social Science and former director of Ballymun Youth Action Project.⁸

Brian Harvey, having outlined the scale of the withdrawal of resources from community-led responses to poverty and social inclusion, particularly since 2002, echoed the sense among those present that no one could have anticipated the wave of destruction of our social, community development infrastructure is experiencing, when Ireland was previously seen as a European leader in this regard. He outlined what he termed a 'strategic turn' which began in 2002 and which was compounded by the 2008 economic and social crisis. Against a baseline figure of a 4.3% cut in government spending overall between 2008 and 2013, local and community development programmes have been cut by 42% and the Drugs Initiative by 32%. It is estimated that by 2015, there will be 31% fewer workers in the voluntary and community sector. Harvey added that no other country in Europe, as far as he knows, has experienced such an extraordinary decline since 1948.

Dr Mary Ellen McCann illustrated the intimate connection between community issues and drug problems, and how policies in either domain have large effects in other domains. In the context of conflicting reports from consultants ((Goodbody Economic Consultants 2006); (Department of Finance 2009)), the call for 'evidence' needs to take account of a range of more subtle measures, including case studies which provide rich data to increase our understanding, and the use of community indicators that give access to measures regarding what is really important for communities affected by drug use. She stressed that, in the context of the narrative of the development of community responses, the community needs to tell the community story.

Underlying the recognition of the current crisis and its origins, contributors were clearly wary of the talk of a straightforward recovery, where 'all will be well again'. Instead, the speakers raised the real concern of 'cost cutting' becoming 'penny pinching' in the name of 'reform', and the growing hints of 'post-austerity austerity'. A clear message was given regarding the importance of holding on to the developments within the sector that have been achieved over the last 30 years, and the 'footholds that have been gained' in the creation of community responses and systems. The response within the voluntary and community sector must endure and, as Harvey concluded, 'It behoves us to make the case for an enlightened balanced European social model, with a role for civil society'.

1.3.4 Co-ordination arrangements

An International Drug Issues Group (IDIG) was formed in line with Action 61 in the NDS. Comprising representatives of the departments of Health, Foreign Affairs and Trade, and Justice and Equality, and of An Garda Síochána, Revenue's Customs Service, the Irish Medicines Board and the Health Research Board, and convened by the Drug Policy Unit in the Department of Health, the IDIG meets every quarter to co-ordinate Ireland's responses on the international drug policy stage. The Irish EU

⁸ The following account is based on the report of the seminar posted on www.byap.ie and accessed on 25 July 2013.

Presidency Steering Group on Drugs Issues was drawn from this larger grouping and drew on the wider expertise represented on the IDIG when necessary (Pike 2013).

In December 2012 the Department of Health's report on the review of drugs task forces, which had been initiated by Minister of State Róisín Shortall TD in late 2011 (see (Health Research Board 2012): Section 1.3.4), was published (Department of Health 2012c). This report dealt with the first term of reference for the review: 'review the role and composition of Drugs Task Forces and the national structures under which they operate'. It made four key recommendations:

1. Rename the drugs task forces 'drug and alcohol task forces' (DATFs). Their terms of reference are to implement the NDS at regional and local level and to support and strengthen community-based responses. As previously, this role includes maintaining an overview of regional and local developments, promoting strategies and monitoring, evaluating and assessing the impact of funded projects.
2. Reconstitute the Drugs Advisory Group (DAG) as a National Co-ordinating Committee for Drug and Alcohol Task Forces (NCC-DATF). Its terms of reference are to drive implementation of the NDS at local and regional level.
3. Encourage more public representative involvement in the work of drug and alcohol task by giving local members of the Oireachtas and members of relevant local authorities 'automatic entitlement' to sit on DATFs.
4. Reduce the number of task forces from 24 to 19 by merging some task forces and expanding the boundaries of others.

As measures to address the abuse of alcohol remain under consideration by the Government, the NCC-DATF has not yet been established. In late July 2013, Minister of State White stated that he intended 'to arrange a series of bilateral dialogues in the coming weeks with Government departments and agencies, the community and voluntary sector and the drugs task forces in order to assess how the inter-agency approach to the National Drugs Strategy can be maintained and strengthened (White, Alex 2013).

With regard to strengthening participation by elected public representatives in the work of the task forces, given that some 860 elected representatives would appear to be eligible to sit on the 19 DATFs, i.e. an average of 45 public representatives per DATF, clarification is needed as to who precisely will have this entitlement and how the efficiency and effectiveness of the DATFs will be maintained.

Finally, with regard to redrawing the task force boundaries, when launching the report, Minister of State White announced that he intended to consult with the drugs task forces on the proposed boundary changes. The outcome of this consultation has yet to be announced.

Coordination at operational level, or 'co-operation', is described in Section 1.3.2 above, when outlining some cross-cutting themes in the Department of Health's annual progress report on implementing the NDS in 2012–2013.

1.4 Economic analysis

The second and third terms of reference for the review initiated by Minister of State Róisín Shortall TD in September 2011 (see (Health Research Board 2012): Section 1.3.4) were:

- streamline the funding arrangements for drugs projects supported by Drugs Task Forces, and where appropriate, transfer responsibility for funding to relevant statutory agencies; and

- overhaul the accountability and reporting arrangements for the drugs projects which continue to be supported by Drugs Task Forces.

However, these were not dealt with in the December 2012 report on the review, which is described in Section 1.3.4 above. Instead, readers of this report were informed that Minister of State White had requested officials to bring forward proposals with regard to the two matters. He had also invited stakeholders 'who may have further comments to make on this issue to submit their views to his office at the earliest opportunity'. No deadline for these submissions was specified.

At the BYAP seminar on 'Responding to addiction in a time of recession, held in June 2013, independent social research consultant Brian Harvey described how, against a baseline figure of a 4.3% cut in government spending overall between 2008 and 2013, local and community development programmes have been cut by 42%, and the Drugs Initiative by 32%. See Section 1.3.4 above for more detail.

1.4.1 Public expenditures

Public expenditure directly on the drugs issue from 2008 to 2012 is reported here (Table 1.4.1). There has been an overall 12% decrease in expenditure over the 5-year period.

Table 1.4.1 Expenditure and allocations directly attributable to drugs programmes 2008–2012

Department/Agency	2008 Expenditure €m	2009 Expenditure €m	2010 Expenditure €m	2011 Expenditure €m	2012 Expenditure €m
Department of Health (Previously Office of the Minister for Drugs)	65.207	39.377	34.992	32.876	31.475
Department of Health (formerly Dept Health and Children)	1.033	0.949	0.763	0.704	0.901
Department of Children and Youth Affairs (Formerly OMCYA)	0.000	28.501	25.740	25.000	22.669
Department of Education and Skills	12.386	3.643	2.461	0.411	0.815
Health Service Executive	101.867	104.867	105.400	91.149	90.752
Department of Social Protection (previously FÁS area)	18.800	18.800	18.000	14.934	11.859
Department of Environment, Community & Local Government	0.496	0.461	0.461	0.400	0.200
Department of Justice & Equality	12.340	14.801	14.478	18.681	18.580
Irish Prison Service	5.000	5.000	5.200	5.200	5.000
An Garda Síochána	44.400	45.004	44.500	45.014	45.850
Revenue's Customs Service	14.900	15.867	15.797	15.470	14.241
Total:	276.429	277.240	267.792	249.839	242.342

Source: Drug Policy Unit in the Department of Health (unpublished data)

1.4.2 Budget

Table 1.4.2.1 shows the annual budget (current and capital) for the Drugs Initiative Programmes from 2011 to 2014. Administered by the Drugs Programmes Unit in the Department of Health, the programmes funded under the Drugs Initiative are primarily drug-related projects and initiatives in drugs task force areas, whose purpose is to address the drug problem at local and regional level in pursuance of the National

Drugs Strategy 2009–2016. Over the four years, spending will have decreased by 17%.

Table 1.4.2.1 Estimate of total expenditure on the Drugs Initiative, 2011–2014

	2011 Estimate (€000)	2012 Estimate (€000)	2013 Estimate (€000)	2013 Estimate (€000)
Vote Health: Drugs Initiative	33,667	31,375	29,951	27,951

Sources: (Department of Finance 2011) and (Department of Finance 2013)

1.4.3 Social costs

The National Youth Council of Ireland (NYCI) have published what they claim to be the first national comprehensive and rigorous economic assessment of youth work in Ireland (Indecon International Economic Consultants 2012). The economic assessment was guided by the question: What would be the likely outcomes for young people participating in justice-, health- and welfare-related youth programmes, and the costs to the State if these programmes were not available? Indecon estimates that the State will benefit by saving costs to the value of €2 billion for an €992 million investment over the next 10 years; benefits will exceed projected costs by a factor of 2.2.

In respect of the economic value of health-related youth work programmes which include the Young Person’s Facilities and Services Fund (YPFSF) and HSE and local drugs task force funding streams, Indecon compared the cost of funding such programmes with the estimated cost to the State if these services were unavailable at the youth work organisation level. Funding provided through the YPFSF and local drugs task forces, with additional health-promotion-related funding provided by the HSE, is distributed to organisations whose programme are directed towards young people who are at risk of substance abuse and the associated adverse health-related impacts. If 2011 funding levels were to be maintained, the estimated cost of health-related funding to the youth sector over a 10-year period would be €420.5 million. Indecon assumes that in the absence of this funding an estimated 4% of beneficiaries of these youth-work programmes would have to receive treatment for substance abuse in adolescent treatment centres at a cost to the State of €60.6 million annually, or €509.9 million in present value terms over a 10-year period; maintaining health-related funding at 2011 levels would save the State an estimated €89.5 million over the projected 10-year period. See also section 3.3.3 for further discussion of this study

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 and Alcohol (NACDA), formerly the National Advisory Committee on Drugs, 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 2005a), 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. The most recent (third) survey was conducted in 2010/11 and to date, five bulletins on the findings have been published.

As with other European surveys, people over the age of 64 are excluded from this survey, as they grew up in an era when both the use and availability of illegal drugs were very limited. Therefore, surveys with older people have, to date, shown very low rates of use even on a lifetime basis. This situation will change over time as the younger population grows older: 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, *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. It collects information on the key indicators of health and health-related attitudes and behaviours (including alcohol and cannabis use) among young people aged 11, 13 and 15 years. 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, *et al.* 2003), 2006 (Nic Gabhainn, *et al.* 2007) and 2010 (Kelly, C, *et al.* 2012).

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 ESPAD surveys is that school students are easily accessible and are at an age when onset of substance use is likely to occur. Early school leavers, a group known to be vulnerable to alcohol and drug use, are not represented in this survey, so the results do not indicate the extent of alcohol and other drug use among all 15–16-year-old children. ESPAD survey information is valuable in planning prevention initiatives.

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). Data were collected for the fifth iteration of ESPAD in 2010/2011 and the survey findings were published in 2012 (Hibell, *et al.* 2012).

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

Extent and patterns of cannabis use in Ireland

The National Advisory Committee on Drugs and Alcohol (NACDA) recently published Bulletin 3 in the series of reports on the 2010/11 survey on drug use in the general population in Ireland and Northern Ireland (National Advisory Committee on Drugs and Alcohol 2013). The bulletin reports on cannabis use in the adult population (15–64 years), on cannabis dependence and cannabis abuse as well as on patterns of cannabis use in Ireland. A total of 5,128 people were interviewed, representing a response rate of 60%. This article presents a summary of the main results for Ireland reported in the bulletin.

Prevalence of cannabis use, abuse and dependence

The results from the 2010/11 survey reveal that 25% of the adult population (15–64 years) reported having used cannabis at some point during their lives (lifetime use); 6%

reported use in the year prior to the survey (recent use); 3% reported use in the month prior to the survey (current use).

The rates of cannabis **use** were notably higher among men than women. Lifetime prevalence for men (33%) was almost twice as high as the rate for women (18%); last-year prevalence was three times as high (men, 9% vs women, 3%); and last-month prevalence was five times as high (5% vs 1%). The lifetime prevalence among men increased from 27% in the 2006/7 survey (National Advisory Committee on Drugs and Drug and Public Health Information and Research Branch 2008) to 33% in the 2010/11 survey, a statistically significant increase of 22%. There was a relatively small increase, from 17% to 17.5%, in women's lifetime prevalence rates in the same period.

Rates of cannabis use were substantially higher among young adults (15–34 years) than among older adults (35–64 years) in the 2010/11 survey. Lifetime prevalence among young adults (33%) was more than one and a half times that among older adults (19%), last-year prevalence was just over three times as high (young adults 10% vs older adults 3%) and last-month prevalence was five times as high (5% vs 1%). While there were statistically significant increases in lifetime prevalence for younger adults, from 29% in 2006/7 to 33% in 2010/11, no statistically significant changes were found for older adults over that period (3% in both 2006/7 and 2010/11).

The prevalence of cannabis **abuse** and of cannabis **dependence** were measured in the NACD Drug Prevalence Survey for the first time in 2010/11 using M-CIDI, as advised by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). Substance abuse and substance dependence are defined in the DSM-IV as a maladaptive pattern of substance use leading to clinically significant impairment or distress.

Seventeen per cent of recent cannabis users met the criteria for cannabis abuse, with rates being higher among males (20%) than females (8%) and among young adults (20%) than older adults (9%). Of the valid responses from the survey sample, 1.3% met the criteria for current cannabis abuse. Applying this rate to the 15–64-year-old general population (3,073,269 in 2011) it is inferred that approximately 39,953 people in Ireland abuse cannabis.

Nine per cent of recent cannabis users were classified as dependent. Dependence was higher among males and among young adults. Of the valid responses from the survey sample, 0.6% met the criteria for current cannabis dependence. Applying this rate to the 15–64-year-old general population, it is inferred that approximately 18,440 people in Ireland are cannabis dependent.

Patterns of cannabis use

Among lifetime cannabis users, the median age of first use was 18 years. This was unchanged since the last survey.

Almost half (48%) of the current cannabis users had used cannabis on 1–3 days (lowest frequency use) in the month prior to the survey, an increase on the 2006/7 figure of 37%; this frequency was most common among female users (54%) and older adult users (55%). Between the two surveys the proportion of all adults engaging in the highest frequency use (20 days or more) in the previous month decreased from 24% to 14%.

Since 2006/7 the relative share of herb to resin used by current users has reversed. In 2010/11 herb was the main type of cannabis used by current users, at 71%, while resin, at 60%, was the most common form reported in the 2006/7 survey. Almost all (94%) current cannabis users said that a joint was the main method they used when consuming cannabis. Forty-five per cent did not know where the cannabis they consumed was grown; 38% said that the cannabis they used was grown in Ireland, an increase on the 2006/7 figure of 16%.

Nearly three quarters (73%) of recent users said it would be easy for them to obtain cannabis in a given 24-hour period. Over four fifths (83%) said they sourced cannabis from someone they knew relatively well, e.g. either shared by or bought from family members and/or friends.

Over one quarter (27%) of lifetime cannabis users said they had used it on a regular basis at some point and most (74%) of this group said they had stopped using. The three most common reasons given for stopping cannabis use were: not wanting to take it any more (27%); cannabis being no longer a part of their social life (18%); and health concerns (17%).

Acceptability of cannabis use

Respondents were asked about the acceptability and risk of cannabis use:

- 66% agreed with cannabis use being permitted for medical reasons;
- 69% disagreed with cannabis use being permitted for recreational reasons;
- 73% disapproved of smoking cannabis occasionally;
- 64% considered smoking cannabis on a regular basis to be very risky.

Profile of cannabis users

Socio-economic group: Rates for lifetime cannabis use were highest among those classified as Group A (professionals and managers) (35%) and lowest among those in Group D (semi-skilled and unskilled) (20%). Last-year rates were also highest for those in Group A (10%) and lowest among those in Group C2 (skilled manual workers) (7%).

Housing tenure: Cannabis prevalence rates were highest among people renting accommodation. Among those renting from a private landlord lifetime prevalence rates were 37% while last-year prevalence was 12%. Rates for last-month use were highest among those renting from a local authority/housing agency (7%).

Level of education and age left school: Results point to cannabis use increasing with level of education attained. On the one hand, rates were highest among students, at 21% (lifetime), 10% (last-year) and 4% (last-month). Lifetime rates were also highest among those who had left school at 20 years or over (34%) and among those with a third-level education (31%). On the other hand, lowest lifetime rates were found for those who left school at 15 years or under and among those with primary-level education only (19%).

Marital status: Last-year prevalence was highest among those who were cohabiting (13%), followed by those who were single (12%). Last-month rates were highest among cohabiting and divorced people (at 7%).

Discussion

The findings of the 2010/11 survey suggest a mixed picture regarding the cannabis situation in the general population in Ireland. More people than ever before had tried cannabis at least once in their lifetime, with the rate at one in four adults, compared to one in six in the 2002/3 survey (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005b). The trend is, however, changing and rates for last-year and last-month prevalence have tapered off since the last survey. This development is in line with that in many European countries which are reporting a recent fall or stabilisation in cannabis prevalence rates (European Monitoring Centre for Drugs Drug Addiction 2011). Additionally, among those consuming cannabis, age of initial use has remained the same, a welcome finding given the link between early initiation and high-risk groups.

The 2010/11 survey data show that age continues to be an important factor in the pattern of cannabis use in Ireland and that use declines with age. Gender is also important for several reasons: it interacts with age with the effect that the decline in use happens later for men than for women. Although the extent of use has declined,

prevalence rates are still considerably higher among men than women, with no indication of any narrowing of the gender gap. Closer examination of the data is needed, however, as these age and gender effects are likely to vary across regions in Ireland, reflecting differences in context, particularly social and economic circumstances. These influences, how they vary with context and time are important, particularly for targeting areas where patterns of drug use have become entrenched and for identifying where action may be needed to prevent this situation.

When compared to the results from the 2006/7 survey, cannabis is now used less frequently among current users, an important finding given the increased uptake of herbal cannabis use since the last survey. While the data from the two surveys show that high-frequency use has always been more common among men than women, the propensity for men to be high-frequency users has fallen sharply since the 2006/7 survey, with the effect that the gap between men and women has reduced considerably between the two time periods.

The likelihood of a young adult in Ireland using cannabis daily or almost daily has declined substantially since the survey in 2006/7. Despite lower prevalence, frequency of use is higher among older adults, changing little since the last survey. Among current users, high-frequency use, or intensive use, is reported by 10% of young adults and 24% of older adults.

An indication of the public health impact of a drug can be seen in the numbers entering treatment. The number of treatment cases reporting cannabis as their main problem substance has increased significantly in Ireland and in 2010 cannabis became the most common problem drug reported by new cases (Bellerose, *et al.* 2011).

Dependence is increasingly recognised as a possible consequence of regular cannabis use. For many people, intensive use and dependence on cannabis are linked. Among those defined as recent users, 17% met the EMCDDA criteria for cannabis abuse and 9% were classified as dependent.

However, in comparison with the available data on tobacco or alcohol use, little is known about the extent of cannabis dependence or abuse in Ireland. This bulletin provides a solid baseline for the ongoing monitoring of the prevalence and nature of cannabis dependence and abuse in the general population and among recent users. Its findings also point to the need for further research on the consequences of increased availability of high-potency cannabis, on the experiences of cannabis use in the population of long-term users, and on the continuation and discontinuation rates of long-term use and factors influencing these rates and how these might be targeted by treatment and other services.

Use of sedatives or tranquillisers and anti-depressants

The National Advisory Committee on Drugs (NACD) recently published Bulletin 6 in the series of reports on the 2010/11 general population survey on drug use in Ireland and Northern Ireland (National Advisory Committee on Drugs and Public Health Information Research Branch 2012): The bulletin reports the prevalence of sedative or tranquilliser and anti-depressant use among adults aged 15–64 years.

Sedatives or tranquillisers

'Sedatives' and 'tranquillisers' are commonly used terms for a group of medicines which depress brain and central nervous system activity. Benzodiazepines are the most common type of drug in this group; the 'Z-drugs', such as zolpidem and zopiclone, are also included in this group and have the same effect. Medically, sedatives or tranquillisers are often referred to as hypnotics (which treat insomnia) or anxiolytics (which relieve anxiety). The same drug can be used as a hypnotic or as an anti-anxiety agent depending on the dosage used and on the time of day that it is consumed.

- Prevalence rates were 14% for lifetime use, 7% for last-year use and 3% for last-month use. There were statistically significant increases in the lifetime rate (up by 32%) and the last-year rate (up by 38%) since the last survey.
- The prevalence rates for women were somewhat higher than those for men on all three measures: lifetime use (16% vs 12%), last-year use (7% vs 6%) and last-month use (3% vs 2%).
- The lifetime prevalence rate for men increased by 55% since the last survey, while the rate for women increased by 17%. The last-year prevalence rate for men increased by 54%, while the rate for women increased by 28%. Overall, the gap between men and women in terms of lifetime and last-year rates has narrowed.
- Prevalence rates were higher among older adults (aged 35–64) than younger adults (aged 15–34) on all three measures: lifetime use (17% vs 10%), last-year use (8% vs 5%) and last-month use (4% vs 1%). Lifetime and last-year rates increased in both age groups since the last survey, but the increases were substantially larger for the younger adult group. Lifetime rates for young adults increased by 71%, compared to 16% for older adults; last-year rates increased by 92%, compared to 20% for older adults. As a consequence, the gap between the older and younger age groups in terms of lifetime and last-year use has narrowed.
- The median age at first use was 30 years, and was lower among men (28 years) than women (30 years).
- More than half (53%) of current users of sedatives or tranquillisers had taken them on 20 or more of the 30 days prior to the survey. Almost all (95%) said they had got the medicines on prescription from a doctor.
- Rates of use of sedatives or tranquillisers were highest at both ends of the social spectrum (among professionals and managers and among those who were dependent on long-term social assistance).
- Prevalence rates were higher among people who were separated, divorced or widowed than among married or co-habiting people.

The misuse of certain prescribed medicines, including sedatives or tranquillisers, is of increasing concern in Europe (Casati, *et al.* 2012), and is reported as a growing health problem globally (United Nations Office on Drugs and Crime 2011). Such medicines can be more easily obtained than illicit drugs, and the potential for their misuse is widespread. In Ireland, these medicines are legally and appropriately prescribed to patients to treat medical conditions, including some mental health illnesses (such as anxiety, depression and other mood disorders). Their use for short periods of time is recommended to allow doctors or other health professionals and patients deal with or stabilise an underlying condition.

The general population survey in Ireland is an important source of information to establish the extent and nature of use of these prescription medicines and to identify which population groups are more likely to be prescribed such drugs. The 2010/11 NACD survey highlights several issues.

The results show that the proportion of people using sedatives or tranquillisers has grown in recent years in Ireland. The reasons for this are not clear. Prevalence rates increased among the groups traditionally associated with these medicines (that is, women and the older population). However, the largest increases were in the rates of use by men and by young people. It is important to continue monitoring use of these drugs and to develop a better understanding of the patterns of use in sub-populations (McLarnon, *et al.* 2011).

The survey also raises questions about the safety of the pattern of sedative or tranquilliser use in the general population. Clinical guidelines (Department of Health and Children 2002) (Health Service Executive and Irish College of General

Practitioners 2006) recommend that, particularly with regard to anxiety-related conditions, many of these medicines should be prescribed for short-term (2–4 weeks) relief and taken for the shortest duration of time, with the least frequency possible, so as to avoid tolerance, drug dependence and the adverse effects of long-term use. However, the survey shows that over half (53%) of all current users reported daily or almost daily use; the proportion rose to 63% in the older adult group. It is important to note that current users in Ireland are engaging in this frequency of use for periods of longer than one month and many may be at risk of experiencing a range of side effects, including dependence. Clinicians can play a critical role in identifying patients who may be at risk of overuse.

The NACD surveys show that social class plays a role in sedative or tranquilliser use. Key indicators of socio-economic deprivation, such as being unemployed, having low educational attainment or fewer years in education, and living in social housing, were associated with higher prevalence for sedative use in the 2002/3 and 2006/7 surveys. Results from the 2010/11 survey, however, show a departure from this pattern in that prevalence rates are now highest among those who are unemployed/without employment, followed by those in managerial or professional occupations. An explanation offered for this new pattern is that it reflects a response to the stress of deteriorating economic conditions in Ireland. However, the fall-out from the recession will have impacted all occupational groups and it is difficult to see why managers and higher professionals would have resorted to sedatives or tranquillisers more than other social groups.

General practitioners everywhere need to be aware that the medicine they prescribe may be over used or diverted from the intended patient and fall into the wrong hands (United Nations Office on Drugs and Crime 2011). A more considered approach by health care professionals to alternative (and complementary) treatments where appropriate, as well as efforts to inform the general population on the safe and effective use of sedatives or tranquillisers and on the viability of other treatments, may be effective in reducing their use in the future.

Alex White TD, Minister of State at the Department of Health with responsibility for primary care, is considering imposing additional controls on the main sedatives and tranquillisers, such as benzodiazepines and ‘Z-drugs’. The legislative amendments being considered include the introduction of an offence of unauthorised possession, as well as controls on the import and export, of such drugs (Department of Health 2012a). It is also proposed to tighten the prescribing and dispensing rules applying to these drugs. One of the main challenges in formulating policy to reduce the misuse or over-use of these medicines is doing so in a way that does not interfere with appropriate use.

Anti-depressants

An anti-depressant is a prescribed medicine used to alleviate medical conditions known as mood disorders (which include major depression, chronic depression and anxiety disorders). Two examples of anti-depressants are serotonin re-uptake inhibitors (SSRIs) and serotonin and noradrenaline re-uptake inhibitors (SNRIs). The former are used as a first-line treatment for depression, while the latter are used to treat patients who do not respond to first-line treatment.

- In 2010/11 the prevalence rates among adults (aged 15–64 years) were 10% for lifetime use, 5% for last-year use and 4% for last-month use. The rate for last-month use increased by 29% since the 2006/7 survey.
- Prevalence rates for women were higher than those for men on all three measures: lifetime use (13% vs 8%), last-year use (6% vs 4%) and last-month use (5% vs 2%).
- The lifetime rate for men increased by 41% since the last survey, while the rate for women was unchanged. The last-year prevalence rate for men increased by 33%,

and the rate for women was unchanged. Overall, the gap between men and women in terms of lifetime and last-year rates has narrowed.

- Lifetime rates for older adults increased by 21%, from 11% in 2006/7 to 13% in 2010/11. No statistically significant changes were found over time among young adults.
- The median age at first use was 30 years, two years younger than the median age reported in 2006/7, and was lower for women (30 years) than for men (34 years).
- The vast majority (92%) of current users reported taking anti-depressants on 20 or more days in the month before the survey, and 99% reported getting the medicine on prescription from a doctor.
- Prevalence rates were highest for those who were dependent long-term on social assistance, and lowest for professionals and managers.
- Prevalence rates were higher for people who were separated, divorced or widowed than for married or co-habiting people.

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

European School Survey Project on Alcohol and Other Drugs (ESPAD)

The European School Survey Project on Alcohol and Other Drugs (ESPAD) has conducted surveys of school-going children every four years since 1995, using a standardised method and a common questionnaire. The fifth survey was conducted in 36 European countries during 2010/11 and collected information on alcohol, tobacco and illicit drug use among 15–16-year-old students (Hibell, *et al.* 2012).

The number of students completing valid questionnaires in the 2010/11 survey conducted in Ireland was 2,207 from 72 randomly selected schools. Fewer schools and students participated in 2010/11 than in 2007 or 2003.

Four-fifths of the students (80% boys and 81% girls) reported that they had consumed alcohol at some point in their life, and 73% (72% boys and 73% girls) had drunk alcohol in the year prior to the survey. Half (48% boys and 52% girls) had drunk alcohol in the 30 days prior to the survey, a decrease of six percentage points since the 2007 survey (56%). Two-fifths (40%) reported having had five or more drinks on a single occasion in the month prior to the survey. Almost one-quarter (23%) reported that they had had one or more episodes of drunkenness in the 30 days prior to the survey, a decrease of three percentage points since the 2007 survey (26%). Nine per cent of the girls and 13% of the boys had had their first episode of drunkenness at or before the age of 13 years. The 2011 European average for alcohol consumption in the last 30 days was 57% (7 percentage points higher than Ireland), while the European average for drunkenness in the last 30 days was 17% (6 percentage points lower than Ireland).

Beer (40%), spirits (35%) and cider (33%) were the most common types of alcohol drunk in the month prior to the survey. Respondents reported drinking an average of 6.7 centilitres of alcohol on the last alcohol-drinking day prior to the survey, which places Ireland joint (along with the UK) fifth highest. Those who drank alcohol at some point in their life were asked to rate their level of intoxication during the last alcohol drinking day on a scale of one to ten; the average rate for Irish students was 3.8, which places Ireland third highest after the UK and the Faroe Islands.

Eighty-four per cent of the students reported that alcohol was easy or fairly easy to acquire in Ireland. Over one-quarter (26%) had bought alcohol for their own consumption in an off-trade outlet in the 30 days prior to the survey; 37% had done so in an on-trade outlet. Sixty-five per cent reported that they were likely to experience positive consequences from alcohol consumption, while 35% were likely to experience negative consequences. Some of the negative consequences reported were getting into trouble with the police (22%), not being able to stop drinking (20%), and doing

something they regretted (48%). Ten per cent of boys and six per cent of girls had experienced 'delinquency problems' as a result of their alcohol use in the year prior to the survey. Delinquency problems included being involved in a physical fight (16% boys and 7% girls), being a victim of robbery or theft (4% boys and 3% girls), and being in trouble with the police (11% boys and 8% girls).

The lifetime use of alcohol has decreased by 10 percentage points in 15 years, falling from 91% in 1995 to 81% in 2011, and alcohol use in the month prior to the survey has decreased by 19 percentage points, from 69% in 1995 to 50% in 2011. The proportion reporting having had five or more drinks on one occasion during the last 30 days has decreased by only four percentage points, from 23% in 1995 to 19% in 2011. The consumption of five or more drinks in the one sitting is an indicator of harmful use of alcohol.

Over two-fifths (43%) of the students (42% boys and 45% girls) reported that they had smoked cigarettes at some point in their life, and 21% (19% boys and 23% girls) had smoked cigarettes in the 30 days prior to the survey. Over one-fifth had had their first cigarette at or before the age of 13 years. Five per cent were smoking daily at or before the age of 13 years. The 2011 European average for smoking cigarettes in the last 30 days was 28% (7 percentage points higher than Ireland), while the European average for smoking cigarettes daily at age 13 or under was 6% (one percentage point higher than Ireland). Three-quarters reported that cigarettes were easy or fairly easy to acquire in Ireland. Over one-fifth thought that people who smoked cigarettes occasionally were at great risk of harming themselves; 67% thought that smoking one or more packs a day constituted a great risk.

The reduction in cigarette use is larger than the reduction in alcohol use, and alcohol is easier to acquire than cigarettes. The rate of lifetime use of cigarettes decreased by 31 percentage points, from 74% in 1995 to 43% in 2011, and use in the month prior to the survey decreased by 20 percentage points, from 41% in 1995 to 21% in 2011. The proportion who reported smoking cigarettes on a daily basis by age 13 years decreased by 13 percentage points, from 18% in 1995 to 5% in 2011.

The Irish data show a fall of 3 percentage points in the rate of lifetime use of any illicit drug between 2007 (22%) and 2011 (19%) (Table 2.3.1). Boys (23%) were more likely than girls (15%) to have used illicit drugs at some point in their life. As the majority of 15–16-year-olds who have tried any illicit drug have used cannabis (marijuana or hashish), the decrease in illicit drug use may be explained by the fall in the number of students who have tried cannabis at some point in their lives, from 20% in 2007 to 18% in 2011 (just above the European average of 17%). Boys (22%) were more likely than girls (15%) to use cannabis at some point in their life. Fourteen per cent of respondents had used cannabis in the year prior to the survey (higher than the European average of 12%). Only two per cent had used ecstasy at some point in their life and the proportion was the same in the year prior to the survey, indicating recent introduction to the use of this drug. In the case of cocaine powder, 3% had used it in their lifetime, just above the European average of 2%. Nine per cent of respondents reported that they had taken prescribed tranquillisers or sedatives at some point in their lives, and a further three per cent had taken them without a prescription. One in twenty had taken alcohol with pills 'in order to get high'. Lifetime use of solvents/inhalants decreased considerably, from 15% in 2007 to 9% in 2011, and the rate is now the same as the European average (9%).

Forty per cent of the students reported that cannabis was easy or fairly easy to acquire in Ireland, while lower but considerable proportions reported that amphetamines (14%), ecstasy (21%) and sedatives (17%) were easy or fairly easy to acquire. Alcohol and cigarettes are easier to acquire than illicit drugs.

Table 2.3.1 Proportions of school-going children (15–16 years) in Ireland reporting lifetime use of drugs in ESPAD surveys, 1995, 1999, 2003, 2007 and 2011

	1995	1999	2003	2007	2011
	%	%	%	%	%
Lifetime use					
Any illicit drug*	37	32	40	22	19
Cannabis	37	32	39	20	18
Inhalants (solvents)	n.a.	22	18	15	9
Ecstasy	9	5	5	4	2
Cocaine powder	2	2	3	4	3
Amphetamines	3	3	1	3	2
Prescribed tranquilisers or sedatives	n.a.	11	10	10	9
Non-prescribed tranquilisers or sedatives	7	5	2	3	3

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

n.a. = not available

Source: (Hibell, *et al.* 2012)

Health behaviour in school children: alcohol and cannabis use

The Health Behaviour in School-aged Children (HBSC) survey 2010 was published on 16 April 2012 (Kelly, C, *et al.* 2012). Researchers at the National University of Ireland, Galway, did the survey. Previous iterations of the survey had been undertaken in 2006, 2002 and 1998.

In 2010 43 countries and regions participated in the 4-yearly HBSC survey. In Ireland, the HBSC 2010 survey collected data from children aged 9 to 18 years, and the data analysed on alcohol and cannabis is for children aged 10 to 17 years.

A nationally representative sample of primary and post-primary schools in Ireland was randomly selected and subsequently, within schools, classes were randomly selected. The HBSC questionnaire was developed by the international HBSC research network, administered by teachers and completed by the selected students themselves. Younger children received a shorter questionnaire. Just over two-thirds (67%) of invited schools and 85% of students participated in the survey. There was a higher representation from social classes 1 and 2 and lower representation from social classes 3, 4, 5 and 6 in the 2010 survey than in the 2006 survey.

Overall, 46% of children (aged 10–17) reported that they had consumed an alcoholic drink at some point in their life, a fall of seven percentage points on the 2006 figure of 53%. Girls (43%) were less likely than boys (48%) to report drinking alcohol, and as children grew older they were more likely to report drinking alcohol.

The proportion of children (aged 10–17) who had consumed alcohol in the 30 days prior to the survey was 21%, a fall of five percentage points on the 2006 figure of 26%. Boys (22%) were more likely than girls (19%) to have consumed alcohol in the last 30 days.

Twenty-eight per cent of children reported having been ‘really drunk’ at some point in their life, a fall of four percentage points on the 2006 figure of 32%. More boys (29%) than girls (26%) reported this, and the proportion reporting drunkenness increased with age: 4% of 10–11-year-olds, 16% of 12–14-year-olds and 52% of 15–17-year-olds. Children from lower social class groups were more likely to report having been ‘really drunk’ than those from middle and higher social class groups. The proportion who reported having been ‘really drunk’ in the 30 days prior to the survey has decreased marginally, from 20% in 2006 to 18% in 2010, which may be explained by sampling variation or the sample representation by socio-economic group.

Eleven per cent of 15-year-old girls and 15% of 15-year-old boys had their first episode of drunkenness at the age of 13 years or under.

Overall, 27% of children (aged 10–17) reported that they had smoked a cigarette at some point in their life, a fall of nine percentage points on the 2006 figure of 36%. Girls (26%) were less likely than boys (27%) to report smoking cigarettes, and as children

grew older they were more likely to report smoking. Overall those from the lowest social class were more likely to smoke than those in the middle and higher social classes. The proportion of children (aged 10–17) who had smoked in the year prior to the survey was 12%, a fall of three percentage points on the 2006 figure of 15%.

Eight per cent of children (aged 10–17) reported having used cannabis in the 12 months prior to the survey, a halving of the 2006 figure of 16%. More boys (10%) than girls (6%) reported such use. The proportions increased with age, for example, 1% of 10–11-year-olds compared to 17% of 15–17-year-olds.

Five per cent of children reported having used cannabis in the 30 days prior to the survey, a fall of two percentage points on the 2006 figure of 7% which may be explained by sampling variation. More boys (7%) than girls (3%) had used cannabis in the month prior to the survey.

Overall, there was a decrease in self-reported alcohol and cannabis use among school children in Ireland in 2010 when compared to 2006. This may represent a true decrease, possibly owing to children having less pocket money in recent years, or it may be the result of sampling variation, or a combination of both factors.

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

For most recent research, on substance use among third-level students in Limerick, see (Irish Focal Point (Reitox) 2011).

3. Prevention

3.1 Introduction

Drug prevention is one of the four pillars in the *National Drugs Strategy (interim) 2009–2016* (NDS) (Department of Community 2009). The NDS 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 NDS 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 Skills (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 Environmental prevention

3.2.1 Alcohol and tobacco policies

Alcohol taxation

Table 3.2.1.1 includes data on the amount of excise duty that was paid on different alcohol beverages in 2011; these are the most recent data available. Excise duties on beer, wine and cider are paid per hectolitre of volume (1 hectolitre = 100 litres). Excise duty on spirits is paid per litre.

Table 3.2.1.1: Excise duty on alcohol beverages, 2011

Alcohol beverage	Excise paid in €
Beer	Excise paid per hectolitre of beer containing >2.8% alcohol (ethanol) €15.71
Wine	Excise paid per hectolitre of wine containing 5.5%–15% alcohol (ethanol) €262.24
Cider	Excise paid per hectolitre of cider containing 2.8%–6% alcohol (ethanol) €65.86
Spirits	Excise paid per litre of alcohol €31.13

Source: (Revenue Commissioners 2011)

Blood alcohol concentration allowed for drivers

See National Report 2012 (Health Research Board 2012), Section 3.2.1, for the most recent information.

Age limits for purchasing (or consuming) alcohol

The minimum age limit for on- and off-premises sales for beer, wine and spirits is 18 years.

See National Report 2012 (Health Research Board 2012), Section 3.2.1, for the most recent information.

Distribution of alcohol

See National Report 2012 (Health Research Board 2012), Section 3.2.1, for the most recent information.

Public policy with regard to alcohol-related nuisance

See National Report 2012 (Health Research Board 2012), Section 3.2.1, for the most recent information.

Price of cigarettes and other tobacco products (taxation)

Table 3.2.1.2 includes data on the amount of excise duty that was paid on different tobacco products in 2011; these are the most recent data available.

Table 3.2.1.2: Excise duty on tobacco products, 2011

Tobacco product	Excise paid in €
Cigarettes (specific duty per 1,000 cigarettes)	€183.42
Cigarettes (Ad Valorem duty as per cent of retail price)	18.25%
Cigars (per kilogram)	€261.066
Fine cut tobacco for rolling cigarettes (per kilogram)	€220.301
Other smoking tobacco (per kilogram)	€181.117

Source: (Revenue Commissioners 2011)

Smoke-free work and other public places

As part of the National Tobacco Control Framework, the Health Service Executive (HSE) has committed to making all its workplaces and campuses smoke-free by 2015.

According to recent information made available by the HSE, 17 hospitals are now tobacco free. (Health Service Executive n.d).

See National Report 2012 (Health Research Board 2012), Section 3.2.1, for more detailed information on legislation banning smoking in the workplace.

Age limits for purchasing (or consuming) tobacco products

See National Report 2012 (Health Research Board 2012), Section 3.2.1, for the most recent information.

Advertising and promotion of cigarettes and other tobacco products

See National Report 2012 (Health Research Board 2012), Section 3.2.1, for the most recent information.

Treatment to help dependent smokers stop

The health education website www.QUIT.ie is operated by the HSE with the principal aim of encouraging dependent smokers to quit. The website includes information on the health impacts of smoking, benefits of quitting, useful tips on how to measure level of addiction and a cost calculator. There is also an option to sign up to a QUIT plan and receive on-going email support during the first six weeks.

The National Smokers' Quitline (1850 201 203), operated by the HSE, offers a confidential counselling service to people seeking support or information about quitting smoking. The service is available 8 am – 10 pm, Monday to Saturday.

The Smoking Cessation Services operated by the HSE provide specialist support to people in community or health service settings. Services include one-to-one, group or telephone support. Services are available free of charge.

3.2.2 Other social and normative changes

See National Report 2012 (Health Research Board 2012), Section 3.2.1, for the most recent information.

3.3 Universal prevention

3.3.1 School

Substance use prevention and education in schools

It would appear that the current, and perhaps future, direction of school-based universal substance use education and prevention, particularly among second-level students, is moving towards an integrated hybrid model incorporating a whole-school approach to overall health and social education, alongside an emphasis on young people developing their personal and social competencies. For example, actions 20 and 21 of the NDS relate specifically to improving the implementation of Social, Personal and Health Education (SPHE) as the universal mechanism to prevent substance misuse in students attending both primary and post-primary schools. However, it is not clear how much time will be given to specific substance use components such as the Social Norms approach, whereby young people's perceptions about substance use among their peers are challenged with empirical evidence.

An update on the implementation of actions in the NDS in 2012 has recently been published (Department of Health 2013b). It refers to proposed changes to the implementation of SPHE within the Junior Cycle (12–15 years). These proposals are part of a new overall framework governing the curriculum for the Junior Cycle with the focus on promoting innovation within the school and developing a sense of identity

within the student (National Council for Curriculum and Assessment 2011). The Junior Cycle framework is based on eight core principles, one of which is 'Wellbeing', whereby 'the curriculum contributes directly to the physical, mental, and social wellbeing of students' (p. 10). The framework also includes five priority learning units (PLUs) including one on 'looking after myself', and eight skills that students should master including 'staying well' and 'managing myself'. SPHE, within this new framework, will become a short course of 100 hours (60–70 hours at present). However, it would appear that the 100 hours may be spread across the three-year period of the Junior Cycle. SPHE is one of 24 subjects listed on the curriculum and will be assessed at school level.

The new learning curriculum in the Junior Cycle will be evaluated as follows: 'the extent to which a school's programme supports students in developing key skills, improving literacy and numeracy, and in learning relevant to all the statements of learning will be evaluated in the first instance by the school itself through an on-going process of self-evaluation...' (p. 23). These processes will be supplemented by an evaluation undertaken by the Department of Education and Skills through its schools inspectorate. It is not clear to what extent, changes in knowledge, attitudes and behaviours around substance use will be measured as part of the evaluation of this broad curriculum framework.

The progress report on implementing the NDS in 2012 (Department of Health 2013b) also contains information on how teachers are being supported to implement SPHE in schools. For example, at post-primary level a dedicated SPHE Support Service, comprising six members of staff, is in place. This service provides training, advice and support to schools to assist in implementing SPHE. In the school year 2011/12, 3,949 teachers and other staff attended school-based events and 1,581 teachers attended cluster in-service training organised by the SPHE Support Service. The Professional Development Services for Teachers (PDST) provides professional development and support for teachers and schools. The website of the PDST now includes specific material on substance use. The following extract has been taken from the website to illustrate the philosophy underpinning the delivery of substance use education in schools:

Substance Misuse Prevention Education should not be treated differently to other areas of the curriculum or taught in isolation. Such approaches could have the effect of sensationalising it as a topic rather than treating it as an integral part of the holistic development and education of the pupil in the context of the primary curriculum. The teacher is the best placed person to deliver substance misuse prevention education in the school setting. ...Substance Misuse Prevention Education involves developing social and personal skills, fostering health promoting values and attitudes and giving age appropriate information, in that context on medicines and drugs, both legal and illegal...' (Downloaded from <http://www.pdst.ie/node/812>)

Guidelines to promote positive mental health among school-going students

A comprehensive set of guidelines promoting positive mental health and well-being among post-primary students was recently published (Department of Education Skills, *et al.* 2013). The overall aim in designing and publishing these guidelines is to promote a whole-school approach to positive mental health and suicide prevention. The guidelines were developed by an inter-departmental group in three phases: (1) a national consultation process with key stakeholders from health, education and other relevant sectors; (2) a review of national and international literature on good practice in health promotion and suicide prevention; and (3) developing the guidelines using information gathered from the consultation process and the literature review through on-going discussion with key partners.

The guidelines are based on the theoretical assumption that developing positive mental health and well-being, linked to a sense of attachment and bonding to school, will foster

improved resilience and social skills among students. Schools are encouraged to promote positive mental health and well-being through adopting a whole-school approach, permeating all aspects of school-life, from the curriculum to relations between staff and students and via the school environment. The guidelines also state that ‘the full implementation of Social, Personal and Health Education (SPHE) and Relationships and Sexuality Education (RSE) provides a framework for educating young people about their health and well-being in a planned and structured way’ (p. 21). The guidelines recommend that schools adopt the three-tiered continuum of support model for promoting mental health:

- support for all (universal) by providing early identification and intervention for young people showing mild or transient signs of difficulty,
- support for some (selective) by identifying young people who are at risk of developing unhealthy patterns of behaviour or who are already showing early signs of mental health difficulties, and
- support for a few (indicated) by supporting young people with complex or enduring needs relating to their mental and emotional well-being.

The guidelines are conceptually rich in identifying the key risk factors that may compromise a young person’s mental health and the protective factors that can be fostered to develop resilience, which will counteract pressures on the young person’s mental health. Situating potential responses within the universal, selective and indicated prevention framework gives ample scope for schools to develop responses that tackle issues affecting the whole school population, while also putting in place measures to support young people who may have a higher risk profile around their mental health.

The report states that ‘it is vital that school management and staff review and build on existing good practice and implement the processes described in these guidelines to support the emotional health of young people’ (p. 51).

3.3.2 Family

Action 29 of the NDS aims to develop a series of prevention measures that focus on the family under the following programme headings:

- 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.

The progress report on implementing the NDS in 2012 (Department of Health 2013b) reports in relation to Action 29 that a broad mix of measures are being provided to support families, including individual counselling, family therapy and, in some regions, the Strengthening Families programme and the Community Reinforcement Approach. However, there is no specific data presented as to the profile of families using these services or the outcomes for families and their children.

3.3.3 Community

A large number of young people living in Ireland participate in youth work activities. Two recent reports – one an economic assessment of youth work (Indecon International Economic Consultants 2012) and the other a systematic mapping of youth work research (Dickson, *et al.* 2013) – have provided a very useful evidence base for policymakers and practitioners seeking to understand the value of youth work and to make decisions on the design and expected outcomes of youth work interventions. Both reports are seminal pieces of work and have been undertaken in a rigorous fashion, covering substantive areas that are pertinent to youth work.

The first comprehensive and rigorous economic assessment of youth work in Ireland was undertaken on behalf of the National Youth Council of Ireland (Indecon International Economic Consultants 2012). The report includes a useful insight into the nature and extent of youth work. For example, the vast majority (80%) of youth work organisations provides recreational, arts and sports-related activities; over half provide activities focused on the welfare and well-being of young people, including measures that address substance misuse and early school-leaving; some provide activities to divert young people from crime and anti-social behaviours.

An estimated 312,615 young people aged between 10 and 24 participated in youth work activities during 2011; this figure represents 43.3% of this age cohort nationally; 54% of participants were female and 53.3% were believed to be socially or economically disadvantaged. There are over 40 national youth work organisations in the sector responsible for providing services through local community-based projects and groups. It is estimated that 40,145 individuals work in a voluntary capacity in the sector and 1,397 full-time equivalents are employed in management, service delivery and training and support for volunteers. The youth work sector received almost €79 million in public funding during 2011: the Department of Children and Youth Affairs (DCYA) provided €61.5 million, the Irish Youth Justice Service (IYJS) €8.8 million and the Health Service Executive (HSE) €8.3 million. This represented an investment by the State of €206 per young person participating in youth work activities in 2011.

An economic assessment of youth work

The economic assessment (Indecon International Economic Consultants 2012) was guided by the following question: *What would be the likely outcomes for young people participating in justice, health, and welfare-related youth programmes, and the costs to the State if these programmes were not available?* The assessment was undertaken on the assumption that annual funding to these programmes remains constant over the next 10 years. Indecon estimated that the State would benefit by saving costs to the value of €2 billion for an €992 million investment over the next 10 years; benefits would exceed projected costs by a factor of 2.2. The projected €992 million investment was based on the assumption that the 2011 funding streams (total receipts of almost €79 million) would be maintained and considering the relevant adjustments when undertaking such an assessment.

In respect of the economic value of health-related youth work programmes, which include the Young People's Facilities and Services Fund (YPFSF) and HSE and local drugs task force (LDTF) funding streams, Indecon compared the cost of funding such programmes with the estimated cost to the State if these services were unavailable at the youth work organisation level. Funding provided through the YPFSF and LDTFs, with additional health-promotion-related funding provided by the HSE, is distributed to organisations whose programmes are directed towards young people who are at risk of substance abuse and the associated adverse health-related impacts. If 2011 funding levels were to be maintained, the estimated cost of health-related funding to the youth sector over a 10-year period would be €420.5 million. Indecon assumed that in the absence of this funding, an estimated 4% of beneficiaries of these youth-work programmes would have to receive treatment for substance abuse in adolescent treatment centres at a cost to the State of €60.6 million annually, or €509.9 million in present value terms over a 10-year period; maintaining health-related funding at 2011 levels would save the State an estimated €89.5 million over the projected 10-year period.

The results of this cost-benefit analysis suggest that the public funding provided by the State for youth work services represents value for money. This reflects in particular the benefits of targeted programmes in the areas of justice, health and welfare, which address the needs of young people in a pre-emptive and holistic manner, compared to a scenario where the absence of these supports is likely to mean that the State would face substantially greater costs over the longer term.

Qualitative evidence on the impacts of youth work in Ireland

The views of over 40 organisations working in the youth sector were sought in relation to the levels of significance they attach to their work with youth (Indecon International Economic Consultants 2012). A large majority of organisations in the sector attach very significant or significant levels of importance to the following aspects of youth work in helping:

- young people to gain practical skills,
- young people to gain education and training qualifications,
- to reduce costs associated with crime and anti-social behaviour,
- to reduce health and social care costs associated with substance misuse,
- to expand labour market and other economic opportunities for young people, and
- to promote equal economic opportunity between women and men.

The relative significance of these particular aspects of youth work reflects to a large degree the findings of the review using a systematic mapping approach undertaken on behalf of the Department of Children and Youth Affairs (DCYA) (Dickson, *et al.* 2013). The authors claimed this work represented the first systematic international map of youth work research; the work was commissioned by the DCYA to inform the development of a youth policy framework for Ireland. The authors defined a systematic map as 'a classification and description that aims primarily to illustrate the kinds of studies that exist [in a specific area]' (p. 4). The purpose of such mapping studies is to identify the scope, nature and content of empirical research that has been undertaken on a particular topic and to present the findings in the form of a descriptive analysis of the relevant research, without critically appraising the included studies. Comparing key components in the design and evaluation of youth work reported in international research and in the practice of youth work in Ireland, the review showed that there were many similarities between youth work in Ireland and elsewhere. For example, the personal and social development of young people was reported as the primary aim in over twice as many included studies as any other aim; in Ireland, the definition of youth work in the Youth Work Act 2001 gives prominence to the personal and social development of youth as the main outcome of youth work:

A planned programme of education designed for the purpose of aiding and enhancing the personal and social development of young people through their voluntary involvement, and which is complementary to their formal, academic or vocational education and training and provided primarily by voluntary youth work organisations. (Youth Work Act 2001, Part 1, Section 2)

Leisure, recreation and arts activities were reported by most studies included in the review. Similarly, the work by Indecon (Indecon International Economic Consultants 2012) reported that the vast majority (80%) of youth work organisations in Ireland provided recreational, arts and sports-related activities. Sports and recreation are clearly popular pursuits among children and young people as the findings from a recent national consultation show (Department of Children and Youth Affairs 2012). The researchers undertaking this survey posted questionnaires to primary and second-level schools, which were completed by 66,705 children and young people; 81% (n=54,163) of responses were from primary school students and 19% (n=12,542) from students at second-level. The majority of respondents (52%, n=34,714) were female. In response to the question 'what's the best thing about being a child in Ireland?' 16% (n=8,411) said they liked sports, including both individual and team sports. In response to the question 'what do you think is good about being a young person living in Ireland?' 16% (1,966) in post-primary schools said they liked sports, including having sport as an outlet from school and work.

The report by Indecon (Indecon International Economic Consultants 2012) spelt out the economic and socially disadvantaged conditions in which over half of all young people attending youth work services lived (based on 2011 figures). This indicated that the rationale for targeting funding to the most at-risk communities, which underpinned the

establishment of the YPFSS and the LDTFs, remains relevant today. However, further work is needed to evaluate the outcomes of youth work in Ireland against international benchmarks and to assess the effectiveness of using generic youth work models, i.e. personal and social development, to target the most at-risk young people.

Views of young people on the value of youth work

What has been described as consultations with young people were undertaken recently by the DCYA and the National Youth Council of Ireland (Department of Children and Youth Affairs 2013b). Three regional consultations were undertaken with 239 young people in Sligo, Cork and Dublin; 57% were female and 73% were aged under 18 years. The consultations were undertaken as part of a European programme called 'Structured Dialogue', a process established by the Council of the European Union in its resolution for a renewed framework for co-operation in the youth field (2010–2018).

The report (Department of Children and Youth Affairs 2013b) documents a large number of achievements that young people claim they secured through participation in youth-related clubs and activities. These are listed under three broad categories: (1) personal development and happiness, (2) skills and experiences needed for life, and (3) feeling more included. Young people talked about how participating in youth-related clubs and activities helped them:

... to discover who they are, 'what they want from life', and to accept themselves for who they are by building self-confidence and self-esteem. In addition, young people feel that clubs 'give you an opportunity to talk to people you wouldn't talk to otherwise', resulting in respect, tolerance and acceptance of others and their differences. (p. 9)

When young people were asked for their views on how the existing activities could be improved, and new ideas for clubs and activities, the responses mainly centred on young people having a more active say in running clubs and activities, more interaction with similar groups outside the clubs, greater diversity of activities in clubs, an emphasis on providing a welcome to new members, and a safe space in clubs to address specific issues, such as disability, sexual health and sexual orientation.

3.4 Selective prevention in at-risk groups and settings

3.4.1 At-risk groups

Action 24 of the NDS is to co-ordinate the activities and funding of youth interventions in out-of-school settings (including the non-formal youth sector) to optimise their impact through targeting risk factors, while developing protective factors for youth at risk. The agency with primary responsibility for this action is the DCYA. Progress in 2012 on this action has recently been reported (Department of Health 2013b). Progress has included revised reporting forms and procedures for funding of youth interventions in out-of-school settings, work on an on-line reporting system to be introduced in 2014 to provide data on participant numbers and service provision, a start on implementing the National Quality Standards Framework for Youth Work (NQSF), and work on developing a Children and Youth Strategy to be followed by a Youth Policy Framework.

A new set of standards, to complement the NQSF and to support volunteer-led youth groups in creating and providing quality, developmental/educational programmes and activities for young people in safe and supportive environments, was recently published (Department of Children and Youth Affairs 2013a). The standards aim to:

- improve the quality of the programmes and activities provided,
- improve the way programmes and activities are planned and delivered, and
- provide young people with the opportunity to have a say in the development and review of the group and its activities.

The standards will be implemented with youth groups on a phased and incremental basis throughout 2013 with a view to all youth groups in receipt of funding from the DCYA being engaged in the process from January 2014. It is expected that many of the groups funded by the DCYA will already be in a position to adhere to them and confirm that they have achieved each of the indicators of achievement. The standards are based around three core principles from which the standards and indicators derive (see Table 3.4.1.1).

Table 3.4.1.1: Core principles, standards and indicators to structure and guide youth groups and their activities

Principles	Standards	Indicators
Young-person centred	Programmes (activities), practices (how you work and how the group operates) and people (young people, volunteer leaders) ensure and promote the voluntary participation, inclusion and voice of young people.	<ol style="list-style-type: none"> 1) Young people are actively involved in the running of the group. 2) Young people are actively involved in the design and delivery of activities. 3) Young people are actively involved in the planning and evaluation of activities. 4) Activities are accessible and inclusive.
Safety and well-being	Programmes (activities), practices (how you work and how the group operates) and people (young people, volunteer leaders) ensure and promote the safety, support and well-being of young people.	<ol style="list-style-type: none"> 1) Appropriate insurance cover in place. 2) Health and safety procedures in place. 3) Child protection policy and procedures in place.
Developmental/educational	Programmes (activities), practices (how you work and how the group operates) and people (young people, volunteer leaders) ensure and promote the development, achievement and progression of young people.	<ol style="list-style-type: none"> 1) Young people's needs and interests are recognised and responded to. 2) Young people's abilities and potential are developed. 3) Young people's participation and achievement are recognised. 4) Support and training is provided for volunteer leaders.

Source: (Department of Children and Youth Affairs 2013a)

Action 25 of the NDS aims to develop facilities for both the general youth population and those most at risk through increased access to community, sports and school facilities in out-of-school hours; and the development of youth cafés. Progress on this action in 2012 has been reported (Department of Health 2013b). The YPFSF allocated €21.332 million to assist in the development of youth facilities and services

3.4.2 At-risk families

The Teen Counselling service operated by Crosscare, a voluntary organisation, aims to provide a professional counselling service for teenagers and their families who are experiencing emotional, behavioural and functional difficulties. The service works in teams of two, usually a psychologist and a social worker, who initially assess the nature and severity of problems with the parents and teenagers who present. Subsequently, parents and teenagers are provided with individual counselling sessions, and when appropriate, combined sessions are scheduled; a consultant psychiatrist attends on a sessional basis. According to the annual report of the Teen Counselling service for 2011, 'one of the founding principles of the service has been prevention of more serious difficulties, particularly in the area of substance abuse...' (Crosscare Teen Counselling 2011), p. 35).

The annual report records that in 2011, 437 families attended the service; 281 new, and 156 continuing from 2010. The profile of the 281 new teenage client's shows that 56% were aged under 16 years, 52% were female and 89% were attending second-level school. Among the 281 new teenage clients, 19% (n=52) reported using drugs,

with hash used by 90%, cocaine by 10%, ecstasy by 8%, solvents by 6%, and pills/medicines by 17%. Twice as many males were using drugs and over a fifth (22%) of all young people using drugs were under 16.

Almost half (48%) of all new teenage clients reported drinking alcohol; 20% of these were under 16 and there were no notable gender differences in overall alcohol consumption. Twenty-four per cent (n=68) of new teenage clients smoked cigarettes and the report notes the percentage of smokers under 16 had doubled from 2010; overall there were slightly more girls smoking than boys.

Behavioural problems in the home, school and the community were the main reason for the majority (59%) of new teenage clients being referred to the service, 37% were referred owing to family problems such as conflict or parental separation, and 36% for emotional problems, e.g. anxiety. Relationship and communication problems were noted in 83% of families of new teenage clients. The percentage of new teenage clients reporting self-harm doubled from 11% in 2010 to 22% in 2011 and 21% of new clients reported suicidal ideation.

The main objective of the service is to support the 'normal systems' that provide teenagers with stability, attachment and positive development, i.e. the home, the family and the school. Teenagers are invited to evaluate the extent of their main problems as they experience them at home, in school, with friends and with self, before and after counselling. In 2011, 25% (n=69) of all teenagers completed this evaluation. There was improvement reported in all four domains: 89% reported improvement in the home, 74% in school, 54% among friends and 88% with self. Among parents who completed the evaluation process before and after counselling (n=88, 32%), 90% reported improvements in the severity of their problems and 93% reported improvement in their ability to cope with their problems. Improvements were also reported by counsellors around the main problems families presented with and their underlying problems; counsellors also noted improvements in some teenagers and in some of the families who appeared to function better.

Communities that have experienced higher than average socio-economic disadvantage have been characterized as being the communities most at risk of experiencing acute problematic drug use among residents. For example, a number of communities have been designated as local and regional drug and alcohol task force areas in order to receive specific funding to support the reduction of the risks. In most of these areas, the community and voluntary sectors have often been to the fore in developing innovative responses to tackle substance use and associated problems. However, recent austerity measures have seen a reduction in funding to these at risk communities which have had a corresponding impact on the nature and extent of services being provided. For example, Harvey estimated an overall reduction in government supports for the community and voluntary sector of 48 per cent (Harvey 2012). He pointed to reductions in supports for community development and key community projects such as those funded through the drugs task forces. As a result, Harvey reports that community and voluntary organisations have taken a number of actions to 'downsize', including reducing expenses, laying off non-permanent staff and taking a reduction in pay and conditions. These changes are taking place alongside an increased demand for their services and a reduction in the number of state agencies who would have supported the community and voluntary sector as part of their statutory remit. For further information, see also Section 1.3.3, and (Health Research Board 2012), Section 1.4.1.)

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

See National Report 2008 (Alcohol and Drug Research Unit 2008), Section 3.4.3, for most recent information.

3.5 Indicated prevention

3.5.1 Children at risk with individually attributable risk factors (e.g. children with Attention Deficit (Hyperactivity) Disorder, children with externalising or internalising disorders) Externalising : sensation seeking, conduct disorders; Internalising : extreme shyness, depression.

The Child and Adolescent Mental Health Service (CAMHS) teams are the first line of specialist mental health services for children and young people affected by poor mental health. The multi-disciplinary teams include psychiatrists, psychologists, nurses, social workers, speech and language therapists and occupational therapists. Data extracted from the latest annual report of CAMHS shows that in 2012, there were 63 teams operating the service (Health Service Executive 2012a).

The annual report shows that from October 2011 to September 2012 the number of referrals to the CAMHS teams increased by 17%. A total of 9,843 new cases were offered an appointment, 8,671 were seen and 1,172 did not attend. Of the 8,671 cases seen, a total of 2,685 had been re-referred to the service. This number of re-referrals represents 31% of the new cases seen and is reported as part of an increasing trend in re-referrals since 2008, which coincided with the onset of the economic recession and the implementation of fiscal austerity measures. Over the 12-month period from October 2011 to September 2012, 45% of new cases were seen within one month of referral and 66% were seen within three months. According to the report, young people whose need was deemed urgent were seen as a priority while routine cases were placed on a waiting list. There were 2,056 young people waiting to be seen at the end of September 2012; this represented an increase of 8% over the number waiting a year earlier. The majority of referrals (64.6%) in 2011 were from GPs.

During November 2011, a clinical audit was undertaken by 58 CAMHS teams, who collected data on 8,479 cases seen during the month. Of the cases seen, 41.6% were aged 10–14 years, 28.4% were aged 5–9 years, 16.5% were aged 16–17 years, 12% were aged 15, and 1.4% were aged 0–4. Males accounted for 64.9% of all children seen in November 2011 and were the majority gender in each of the age bands. The primary presentation of each of the cases is summarised out in Table 3.5.1.1 Males made up the majority in all primary presentations apart from those for eating disorders, deliberate self-harm depression and emotional disorders, where females were in the majority. The male to female ratio for ADHD and other attention disorders was 4:1. Twenty per cent (n=1,684) of children seen by the service in November 2011 were in contact with social services.

Table 3.5.1.1: Primary presentations of 8,479 cases seen by 58 CAMHS teams, November 2011

Primary presentation	Examples of disorders	Number	%
Hyperkinetic disorders	ADHD and other attention disorders	3,025	35.7
Anxiety disorders	Phobias, OCD, Post-traumatic stress disorder	1,588	18.7
Autistic spectrum disorders	Autistic disorder	947	11.2
Depressive disorders	Depression	798	9.4
Conduct disorders	Oppositional defiant disorder, aggression, arson	580	6.8
Deliberate self-harm	Lacerations, substance overdose	285	3.4
Developmental disorders	Deficits in speech and social skills	217	2.6
Eating disorders	Pre-school eating problems, anorexia nervosa, bulimia nervosa	207	2.4
Psychotic disorders	Schizophrenia, manic depression, drug-induced psychosis	108	1.4

Primary presentation	Examples of disorders	Number	%
Habit disorders	Sleeping problems, bed-soiling	84	1.0
Substance abuse	Drug and alcohol misuse	30	0.4
Gender role identity	Problems with gender identity	16	0.2

Source: (Health Service Executive 2012a)

3.6 National and local media campaigns

Action 27 of the NDS focuses on developing a national website to provide information and access to a national helpline, and Action 28 on developing a range of awareness campaigns. Some progress was achieved in delivering on these actions in 2012 (Department of Health 2013b). For example, it is reported that during 2012, developments to the drugs.ie website, which is the main national forum for disseminating information and awareness campaigns included:

- launch of an online outreach campaign to link in with other relevant websites and social media pages;
- continued development of drug and alcohol related video content;
- an online alcohol self-assessment and brief intervention tool based on the AUDIT screening tool;
- to complement the online alcohol self-assessment tool an online drug self-assessment and brief intervention tool is under development;
 - redesign of the Facebook page and an extensive Facebook ads campaign;
 - the use of drugs.ie Facebook page to publicise two HSE emergency alerts (i) suspected contamination batch of heroin and (ii) a brown substance passed off as MDMA and linked to two deaths in the south-east;
 - re-development of the National Directory of Services;
 - a virtual advisory group comprising HSE addiction services staff, drug task force personnel, and representatives from youth websites; and
 - continued production and dissemination of the drugs.ie eBulletin.

4. Problem Drug Use (PDU)

4.1 Introduction

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 a forthcoming health information bill.

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) and undertaken in 2001 and 2006. The second study (Kelly, Alan, *et al.* 2009) indicated that use had increased since the previous survey (Kelly, Alan, *et al.* 2003). 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 are 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. 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. The MCIDI results are reported here.

4.2 Prevalence and incidence estimates of PDUs

4.2.1 Indirect estimates of problem drug use

Extent and patterns of cannabis use in Ireland

The National Advisory Committee on Drugs and Alcohol (NACDA) recently published Bulletin 3 in the series of reports on the 2010/11 survey on drug use in the general population in Ireland and Northern Ireland (National Advisory Committee on Drugs and Alcohol 2013). The bulletin reports on cannabis use in the adult population (15–64 years), on cannabis dependence and cannabis abuse as well as on patterns of cannabis use in Ireland. A total of 5,128 people were interviewed, representing a response rate of 60%. This article presents a summary of the main results reported in the NACDA bulletin.

The prevalence of cannabis **abuse** and cannabis **dependence** were measured in the NACD Drug Prevalence Survey the first time in 2010/11 using M-CIDI⁹. Substance

⁹ The Composite International Diagnostic Interview (CIDI, World Health Organization, 1990) contains the DSM-IV diagnostic criteria for substance abuse and dependence and is a validated method to assess the seriousness of a person's cannabis use. Advised by the EMCDDA, the abbreviated version, the Munich Composite International Diagnostic Interview (M-CIDI), a 19 item instrument reflecting the four cannabis abuse and seven cannabis dependence criteria, was used for the NACD 2010/11 Drug Prevalence Survey.

abuse and substance dependence are defined by the DSM-IV as a maladaptive pattern of substance use leading to a clinically significant distress or impairment.

The application of the EMCDDA accepted classification system for cannabis abuse shows that among recent cannabis users 17% met criteria for cannabis abuse. Rates of cannabis abuse were higher among recent male users (20%) than female users (8%) and among young adult users (20%) compared to older adults (9%). Among all adults in the survey (15-64 yrs) just over 1% met the criteria for current cannabis abuse. The population of Ireland was 4,470,700 in 2010 which implies that approximately 44,707 people abuse cannabis in Ireland.

Applying the classification system used by the EMCDDA, the results show that 9% of recent cannabis users were classified as dependent. Dependence was higher among male and among young adult recent users. Among all adults in the general population (15-64 yrs) the proportion classified as currently cannabis dependent was 0.6%. Given the population of Ireland in 2010 this implies that approximately 26,824 people meet cannabis dependence criteria in Ireland.

The likelihood of a young adult in Ireland using daily or almost daily has declined substantially since the survey in 2006/7. Despite lower prevalence, frequency of use is higher among older adults, changing little since the last survey. Among current users high frequency use, or intensive use, is reported by 46% of young adults and 55% of older adults.

An indication of the public health impact of a drug can be seen in the numbers entering treatment. The number of treatment cases reporting cannabis as their main problem substance has increased significantly in Ireland and in 2010 cannabis became the most common problem drug reported by new cases (Bellerose, *et al.* 2011).

4.2.2 Estimates of incidence of problem drug use

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

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

Merchants Quay Ireland Review 2011

Merchants Quay Ireland (MQI) is a national voluntary agency providing services for homeless people and for drug users. Its needle exchange health promotion unit provides drug users with information about risks associated with drug use and the means to minimise such risks and it also offers drug users a pathway into treatment and the possibility of living without drugs. In September 2012 MQI published its annual review for 2011 (Merchants Quay Ireland 2012).

In 2011, there were 21,819 visits to Drug Services and 18,951 needle exchanges, with 4,051 individuals using the services, of whom 492 were new clients. A heroin drought in the winter of 2010/2011 saw the number of clients drop in January 2011 to 810 and then rise again to 2,043 by November 2011. A total of 1,220 safer injecting workshops were undertaken with injecting drug users during the year.

In 2011 MQI opened the Athlone Open Door Centre in the Midlands. Providing a range of needle exchange/harm reduction services for drug users, in its first year this Centre provided over 4,000 one-to-one interventions.

4.3.1 PDUs in data sources other than TDI

Drug and alcohol use among adult offenders on probation supervision in Ireland

In May 2012 the findings of the first nationwide survey on drug and alcohol ‘misuse’ among the adult offender population on probation supervision were published (Probation Service 2012b). ‘Misuse’ was defined in the report as drug-taking which causes harm to the individual, their significant others or the wider community. It included illicit drug taking or alcohol consumption that leads a person to experience social, psychological, physical or legal problems related to intoxication or regular excessive consumption and/or dependence. The objectives of the survey were to (1) ascertain the number of adult offenders on probation supervision who ‘misused’ drugs and or alcohol, (2) examine the nature and frequency of the ‘misuse’, (3) establish correlations if any between drug and/or alcohol ‘misuse’ and offending, and (4) identify the level and nature of engagement with drug and alcohol treatment services. The data are intended to inform service provision within the Probation Service and also to inform the work of other relevant agencies.

The case records of all adult offenders as of 1 April 2011 were reviewed by Probation Officers who completed a specifically developed questionnaire. A total of 2,963 valid questionnaires were returned, giving a response rate of 96.7%. While the survey captured a large representative cohort of young offenders on the caseloads of Probation Officers, limitations with the method used were acknowledged. One was the questions regarding the nature and frequency of drug and alcohol use as Probation Officers indicated that there was uncertainty with regard to some clients’ current alcohol and drug using status and in some cases they could not confirm current alcohol or drug using status as urinalysis had not been undertaken.

Section 1 of the questionnaire collected data on the prevalence of drug and alcohol ‘misuse’ among the adult offender population on probation supervision and on trends by age, gender and probation region. The authors defined prevalence as ‘the proportion of the offender population who misused drugs/alcohol, current use referring to last 12 months or part of the last 12 months and past use referring to beyond the last 12 months’.

The majority of those on probation supervision were male (2,576) and only 387 were female. The number using drugs or alcohol was 2,636 (89%), with similar proportions among both among men and women (Table 4.3.1.1). Drug and/or alcohol use was more prevalent among younger offenders, both female and male (Table 4.3.1.2). Use of drugs and/or alcohol by women peaked later than males, at 39.3% between the ages of 25 and 34, while drug and/or alcohol use among male offenders peaked in the 18–24-year age category. Use levels declined among older offenders, coinciding, according to the authors, with a decrease in the number of offenders in these age categories.

Table 4.3.1.1 Prevalence of drug/alcohol use among the adult offender population on probation supervision, by gender, 2011

Gender	Users	Non-users	Total
Male	2304 (89.4%)	272 (10.6)	2576 (87%)
Female	332 (85.8%)	55 (14.2%)	387 (13%)
Total	2636 (89%)	327 (11%)	2963 (100%)

Source: (Probation Service 2012b)

Table 4.3.1.2 Prevalence of drug/alcohol use among the adult offender population on probation supervision, by age and gender, 2011

Gender	18–24 years	25–34 years	35–44 years	45–54 years	55+ years
Female	35%	39.3%	18.1%	4.8%	2.0%
Male	41.5%	35.1%	15.8%	5.5%	2.7%

Source: (Probation Service 2012b)

Among those reporting drug and/or alcohol use (n=2,636), 42.3% had used drugs and alcohol, 26.5% drugs only, and 20.2% alcohol only (Table 4.3.1.3). Larger numbers of

offenders in the younger age groups had used drugs only (36.3% in the 25–34-year age category). Use of alcohol only was higher among the older adult offender population (49.2% in the 45–54-year age category). Combined drug and alcohol use was higher among younger offenders (90.7% in the 18–24 age category, and 92.8% in the 25–34 age category). The decline in the prevalence of combined drug and alcohol use by those in the older age categories coincided, according to the authors, with a decrease in the number of offenders in these age categories.

Table 4.3.1.3 Prevalence of drug and/or alcohol use among the adult offender population on probation supervision, by age and substance, 2011

Substance used	18–24 years	25–34 years	35–44 years	45–54 years	55+ years	Total
Drug only	23.8%	36.3%	24.8%	8.1%	3.0%	26.5%
Alcohol only	15.3%	14.4%	28.4%	49.2%	44.6%	20.2%
Drug and alcohol combined	90.7%	92.8%	89.4%	77.3%	54.5%	42.3%

Source: (Probation Service 2012b)

When the data were analysed by Probation Service region (of which there are 10), it was found that the Dublin South and Wicklow regions had the highest levels of both combined drug and alcohol use among the adult offender population on probation supervision (91.2%) and ‘drug misuse only’ (34.1%), followed by the Dublin North and North East regions, which had a similar level of combined drug and alcohol misuse among the adult offender population (91.1%) and a slightly lower level of drug use only (27.2%). Alcohol use only was highest among the adult offender populations in the South West region at 27.9%, followed by the West, North West and Westmeath regions at 27.7%.

Section 2 of the questionnaire explored the nature and frequency of drug and alcohol use among the adult offender population on probation supervision and identified current multiple drug use (inclusive of alcohol). The author stated that the levels of ‘current’ (defined in this section of the report as ‘weekly, monthly, and occasional’) use were more than likely an under-estimation because of uncertainty about clients’ alcohol and/or drug using status. Alcohol was identified as the most commonly used substance both currently (36.4%) and previously (37.6%), and cannabis the most commonly used illicit substance both currently (21.8%) and previously (31.6%) (Table 4.3.1.4).

Table 4.3.1.4 Number and percentage of the adult offender population on probation supervision (n=2,963) who were current and/or past users of drugs and/or alcohol, by substance, 2011

Substance used	Current		Previous	
	n	%	n	%
Alcohol	1078	36.4	1113	37.6
Cannabis	645	21.8	937	31.6
Opiates	265	8.9	766	25.9
Stimulants	190	6.4	1002	33.8
Misused prescribed drugs	219	7.4	568	19.2
Miscellaneous*	55	1.9	256	8.6

Source: (Probation Service 2012b)

*Miscellaneous includes steroids, hallucinogens, headshop products and other substances

The data on current use showed the following:

- The majority of current alcohol users (66.8%) were male between 18 and 34 years of age. The majority of current cannabis users (90.7%) and current opiate users (75.5%) were males aged between 18 and 44 years, with the highest proportion of them located in the Dublin North and North East regions, followed by the Dublin South and Wicklow regions (23.2%).
- 8.9% of survey participants were currently using opiates and were from the Dublin North and North East regions (12.5%) and Dublin South and Wicklow regions (11.4%).
- Over one fifth of current opiate users were female (22.2%) and 16% were 'current' prescribed drug users.
- Previous use of opiates was higher in the female population (34.1%) compared to males (24.6%).

Table 4.3.1.5 shows weekly drug use among the adult offender population on probation supervision.

- The drug most frequently used on a weekly basis by both men (18.5%) and women (12.4%) was alcohol, with the South West region showing the highest percentage (44.1%) of 'current' alcohol use. (Conversely, monthly use of alcohol was proportionally higher among women (5.2%) than among men (3.8%)).
- Cannabis was the illicit drug most frequently used by adult males on a weekly basis (14.4%).
- Proportionally more women (9%) used opiates on a weekly basis than men (4.2%). (Monthly use of opiates was also proportionally higher among women (1.0%) than among men (0.8%)). The author commented that while opiate use was historically confined to Dublin, the results of the survey showed that the proportion of opiate misusers is emerging as a significant problem in the Midlands and South East region.
- The level of weekly use of prescribed drugs was high among the female population (8.5%), twice that among males (4.5%).

Table 4.3.1.5 Weekly drug use among the adult offender population on probation supervision, by gender, 2011

	Males (n=2,576)		Females (n=387)	
	n	%	n	%
Alcohol	476	18.5	48	12.4
Cannabis	372	14.4	31	8.0
Opiates	108	4.2	35	9.0
Stimulants	70	2.7	10	2.6
Prescribed drugs	116	4.5	33	8.5

Source: (Probation Service 2012b)

As shown in Table 4.3.1.6, 20.8% (n=616) of offenders were noted by Probation Officers to be currently using two or more drugs (alcohol inclusive). The number of adult offenders perceived as currently using more than one drug inclusive of alcohol was examined based upon Probation Officers' professional judgement and perceptions and what was known about the clients' current misusing behaviour and may not be fully representative of the true level outlines these results.

Table 4.3.1.6 Number and percentage of adult offenders (n=2,963) currently using more than one drug inclusive of alcohol, 2011

Currently using	n	%
2 drugs	347	11.7
3 drugs	138	4.7
4 drugs	69	2.3
5 drugs	36	1.2
6 drugs	26	0.9

Source: (Probation Service 2012b)

Section 3 of the questionnaire collected data on the relationship between drug/alcohol use and crime. See Section 9.4 for a report on this data.

Section 4 of the questionnaire collected data on the nature and engagement with drug and alcohol treatment services by adult offenders on probation supervision. Findings included:

- 41.7% of the total drug-using offender population on probation supervision were currently engaged in drug treatment, with 30.2% of drug users undertaking urinalysis.
- 5.8% of drug users were currently in residential treatment.
- 72.2% of opiate users were currently in receipt of methadone maintenance.
- 32.5% of the total number of drug users were currently attending counselling services.
- 9.3% of those who used drugs were currently attending Narcotics Anonymous.
- 33.7% of alcohol users were described as current 'problematic alcohol misusers', and 79.8% were described as 'problematic alcohol misusers' in the past.

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)

See Section 4.4.1 of the 2012 National Report (Health Research Board 2012) for the most recent information

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

See Section 4.4.2 of the 2012 National Report (Health Research Board 2012) for the most recent information

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.

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

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 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.

Other entities mentioned in this chapter are as follows:

The **Aislinn Adolescent Addiction Centre** in County Kilkenny is a non-profit-making organisation that provides quality treatment for persons between the ages of 15 and 21 years and assists families by offering an Addiction Awareness Programme.

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.

Drug Treatment Centre Board (DTCB) see National Drug Treatment Centre.

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 **Institute of Obstetricians and Gynaecologists** is the professional and training body for obstetrics and gynaecology in Ireland. The Institute was established in 1976

and is one of six faculties and institutes within the Royal College of Physicians of Ireland (RCPI).

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.

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.

The **National Addiction Training Programme (NATP)** was developed on foot of Action 47 in the National Substance Misuse (*interim*) Strategy 2009–2016. The HSE has responsibility for the NATP, developing national training standards for all involved in the provision of substance misuse services, and for the coordination of training provision within a single national substance misuse framework.

The **National Centre of Pharmacoeconomics (NCPE)** conducts the health technology assessment of pharmaceutical products for the HSE in Ireland in collaboration with the HSE Corporate Pharmaceutical Unit (HSE-CPU). The aim is to promote expertise in Ireland for the advancement of the discipline of pharmacoeconomics through practice, research and education.

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 **National Drug Treatment Centre (NDTC)** was formerly the Drug Treatment Centre Board (DTCB). Under the Health (Miscellaneous Provisions) Act 2010 the DTCB was dissolved and its assets and liabilities transferred to the HSE on 1 January 2013. Originally located at the 'Charitable Infirmary', Jervis Street Hospital, Dublin 1, it was known as the National Drug Advisory and Treatment Centre and later as the Drug Treatment Centre Board. The first treatment service in the country, it provides effective, high-quality and client-focused treatment. It offers guidance and training to other professionals working in the area of substance misuse and contributes to policy development in drug and addiction management.

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, *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

5.2.1 Strategy/policy

HSE targets for drug-related services in 2013

Each year the HSE publishes a ‘national service plan’ (NSP). The plan sets out the type and volume of services to be delivered during the year. In 2013, according to the most recent NSP (Health Service Executive 2013), service activity volumes in relation to drug-related treatment are expected to be similar to last year’s targets (Table 5.2.1.1).

Table 5.2.1.1 HSE service activity volumes in relation to drug-related treatment, 2012–2013

	Expected activity 2012	Projected outturn 2012	Expected activity 2013
Methadone treatment Number of clients in methadone treatment (outside prisons) (monthly target)	8,640	8,855	8,650
Substance misuse Number of substance misusers (aged over 18 years) for whom treatment has commenced within one calendar month following assessment.	1,260	1,025	1,260

Source : (Health Service Executive 2013), p. 24

NSP 2013 is a much shorter document than previous years’ plans (Health Service Executive 2012b). Deliverables, including priorities, key actions and measures, are not included. Moreover, there is no discussion of the past year’s performance vis-à-vis that expected in the coming year, for instance, how the reported 19% shortfall in the delivery of treatment to substance misusers over the age of 18 within one month of assessment in 2012 will be corrected in 2013.

The HSE’s drug-related services may be expected to be influenced by the two broader challenges outlined in NSP 2013. First, in November 2012 the Minister for Health published *Future health*, the framework for ‘the most radical reform of our health services in the history of the state’ (Department of Health 2012b). The core of this reform is a single-tier health service, supported by universal health insurance (UHI). The government is seeking innovative ways to deliver care and in particular integrated care pathways, to be achieved under the most stringent fiscal constraints experienced for decades.

Thus, the HSE will proceed with ‘business-as-usual’ in 2013, while also implementing structural reforms including changes in the way hospital services are funded and managed, disaggregating childcare services from the HSE and establishing a child and family support agency, setting up a new directorate structure, establishing a patient

safety agency, and ensuring that social care services including mental health, disability and primary care are fit for purpose.

A second key priority for drug-related treatment services will be to ensure that financial and service performance is reported on and managed in a timely and proactive manner. Building on the work of recent years, the 2013 accountability framework is intended to ensure that performance is measured against agreed plans that specify targets for access, service quality and volumes. These plans will be monitored through a range of scorecard metrics. Service managers will be held to account and under-performance will be addressed.

The financial framework is intended to ensure that all areas of the health care system have budgets that are achievable, while also delivering the savings necessary. For the first time, the allocations outlined in the plan are based on the projected spend rather than on historic budgets, with a view to ensuring sustainable budgets.

Proposed regulatory framework for buprenorphine/naloxone products in Ireland

The drug suboxone, a combination of buprenorphine and naloxone, was licensed for use in 2006 in Ireland as an alternative to methadone for opiate dependency. In 2007 the then Department of Health and Children set up an expert group to examine the regulatory framework for products containing buprenorphine/naloxone and buprenorphine-only. The expert group considered a number of relevant documents, including an evaluation of a feasibility study on the use of suboxone in Ireland (Fitzgerald 2011) (for more detail, see Section 5.2.2). The report containing the expert group's recommendations was made available this year (Expert Group on the Regulatory Framework 2011). The terms of reference of the group are outlined below, with a summary of its deliberations and associated recommendations.

1. In the context of the product authorisation for suboxone issued by the European Medicines Agency, to consider and make a recommendation as to whether the general regulation of relevant professions provides a sufficient regulatory framework for the prescription and dispensing of buprenorphine/ naloxone, or buprenorphine-only products in Ireland.

The group concluded that the regulations and guidelines for the prescribing and dispensing of methadone can also apply to buprenorphine/naloxone, or buprenorphine-only products.

2. To consider and make recommendations if appropriate as to which if any elements of the methadone protocol should apply to suboxone, and if so how they could apply in practical terms.

The group concluded that the Methadone Protocol Scheme could also apply to the prescribing and dispensing of buprenorphine/naloxone or buprenorphine-only products, and that the details of patients receiving these products should be recorded on the CTL. Other general recommendations included having consistent and uniform guidelines for prescribing and dispensing these products and that the current methadone prescription form should be adapted for them, the need for co-ordinated multi-disciplinary training, and a system of clinical governance and audit for GPs and pharmacies.

3. To consider and make recommendations if appropriate as to whether and if so how suboxone should be made available to particular client groups and/or settings in an Irish context, taking into account the work done by the National Advisory Committee on Drugs (NACD) and taking into account the cost of this treatment.

The group concluded that methadone is the drug of first choice for treating opiate dependency, but that buprenorphine/naloxone may be appropriate for some patient cohorts in certain circumstances, as follows:

- patients already receiving treatment with buprenorphine/naloxone;
- patients with a specific medical condition where methadone is contraindicated, for example prolonged QT interval;
- patients who have never been prescribed methadone before, especially young patients, where detoxification is a primary goal of treatment;
- patients whose main problem drug is codeine or another pharmaceutical opioid; or
- patients whom the prescriber believes to be stable for at least six months, particularly in regard to employment or education, and committed to compliance with the treatment.

After individual patient risk assessment, less-than-daily dosing can be considered, with frequency down to every second day or even to three times per week after a satisfactory level of stabilisation. The total amount of suboxone given on any one day must not exceed the maximum of 24 mg authorised by the European Medicines Agency.

The group stated that economic factors involved were outside the scope of their deliberations but were relevant to the establishment of a buprenorphine/naloxone treatment protocol and should be considered. These factors include:

- findings of the economic evaluation done by the National Centre of Pharmacoeconomics in 2007, which found that suboxone and buprenorphine-only could not be considered cost effective when compared to methadone in clinics or in the community (National Centre for Pharmacoeconomics 2007);
- generic pricing discussions between the HSE and the manufacturer;
- HSE clinics which have their own budgets and consistency of treatment; and
- contractual implications in relation to prescribing and dispensing for both GPs and pharmacists.

The group advised that the recommendations be reviewed within two years of the date on which they were given to the Minister, to allow for new research and evidence to be taken into account.

4. To consider and make recommendations if appropriate as to whether and if so in what way buprenorphine-only products should be available in Ireland.

The group was not aware of any buprenorphine-only products being marketed in Ireland to treat opiate dependence. They acknowledged that, while not authorised in Ireland, buprenorphine-only products may be prescribed for pregnant women in certain circumstances, and with appropriate advice and warning. They advised that if a buprenorphine-only product were to be prescribed and dispensed in Ireland, it should be done with extreme caution owing to the high risk of diversion and potential for use by injection.

5. To consider any legal advices received in relation to the above matters.

After taking legal advice, the group decided that if buprenorphine/naloxone or buprenorphine-only products are to be used in Ireland then the appropriate changes will have to be made to the misuse of drugs legislation and the regulations for the prescription and supply of methadone.

5.2.2 Treatment systems

Suboxone feasibility study evaluated

In June 2013 the Department of Health released the results of an evaluation of the suboxone feasibility study which started in June 2009 (Fitzgerald 2011). The evaluation was carried out between October 2010 and February 2011. The objectives of the evaluation were to:

- evaluate how patients were selected for participation and how they progressed through the study,
- examine how the prescribing and dispensing of suboxone operated in an Irish context,
- consider the practical operation of the feasibility study, and
- identify the core elements of the regulatory framework needed for the safe use of suboxone in Ireland.

A variety of methods were used to evaluate the feasibility study: analysis of quantitative and clinical records, semi-structured interviews, and surveys. Not all patients who had started on suboxone could be contacted for consent to be included in the evaluation and not all patient records were available to be audited. Other stakeholder involvement consisted of eight semi-structured interviews with prescribers; 13 semi-structured telephone interviews with pharmacists/dispensers; 36 responses to a semi-structured survey of patients (completed either on-line, on paper or over the telephone); two face-to-face interviews with patients; and two written submissions from patients. The clinical notes and dispensing records for 41 patients were reviewed. There were five key informant interviews.

A total of 139 patients registered as having received suboxone between 2006 and 2011 were eligible to be included in the evaluation. Also included were 11 prescribers based in the then Drug Treatment Centre Board (DTCB), seven prescribing GPs based in other clinics or practices, and 50 dispensers, the majority (78%) of which were community pharmacies. Table 5.2.2.1 outlines the characteristics of those included in the evaluation and the reason for exit from treatment.

Table 5.2.2.1 Characteristics and treatment statistics of patients included in suboxone database, 2006–2011

Total number of eligible patients	N = 139
Males	91 (66%)
Females	48 (34%)
Patients previously treated with methadone	76 (55%)
Total number of treatment episodes	N = 149*
<i>Age in years of patients starting each treatment episode</i>	
Under 18	6 (4%)
18 to 25	31 (21%)
26 to 35	60 (40%)
36 to 45	39 (26%)
46 and over	13 (9%)
Type of treatment at start of episode	
Detoxification	27 (18%)
Opiate maintenance	122 (82%)
Patient outcomes†	
Still in suboxone treatment on 31 Jan 2011	63 (42%)
Exits from treatment (or from treatment episode)	86 (58%)
Reason for exit	N = 86
No contact	29 (34%)
Transfer to other opioid substitute	23 (27%)
Treatment successfully completed	19 (22%)
Treatment failure	7 (8%)
Gone abroad	5 (6%)
Deceased‡	1 (1%)
Other	2 (2%)

Source: Adapted from (Fitzgerald 2011), pp. 9, 11 and 13

* 10 patients were in suboxone treatment on two separate occasions, which accounts for the 149 treatment episodes.

† Based on review of 41 charts/records.

‡ The death was unrelated to suboxone treatment.

Process and limitations of the study

The author noted several issues that may have influenced the results and generalisability of the evaluation. She was unable to contact a number of patients who

had received suboxone but who were no longer in contact with the treatment services. Not all who consented to be included in the evaluation could be contacted subsequently. Also, the evaluation only included the opinions of those who had been involved in the original feasibility study, who therefore might already have been positively disposed to the use of suboxone.

Rationale for commencing suboxone

The main reasons for prescribing suboxone, as recorded in the clinical notes or dispensing records for 41 patients, were that the patient had a low level of heroin dependence, either having never injected, rarely injected or only a short history of heroin use (16, 39%), or that the patient had requested suboxone, or did not want methadone (10, 24%) (Table 5.2.2.2). The survey of patients showed that the majority (79%) felt that suboxone was the best option for them after discussions with their doctor. Of 22 patients previously prescribed methadone, 45% had experienced side-effects. Of 11 who had never been prescribed methadone, 55% wanted detoxification (i.e. to be substance free) rather than to stay on opiate substitution treatment.

Table 5.2.2.2 Reasons for suboxone prescription recorded in clinical notes or reported by prescriber, 2006–2011

Records reviewed	N = 41
<i>Main drug of dependence</i>	
Heroin (injected)	24 (58%)
Heroin (smoked)	10 (24%)
Codeine	4 (10%)
<i>Selection of patients / reason for suboxone prescription</i>	
Low level of heroin dependence	16
Patient requested it, or did not want methadone	10
Treatment for detoxification	6
Previous failed methadone treatment or particular difficulties with methadone	5
Stable	5
Medical need	4
Codeine dependent / oxycodone dependent	4 / 1
Previous buprenorphine treatment	3
Unclear	2

Source: Adapted from (Fitzgerald 2011), pp. 9, 11 and 13

Patient experience of suboxone

The majority of the 36 patients who participated in the evaluation were very positive about their experience of suboxone, and many were still on the treatment. They reported benefits such as ‘feeling like themselves again, reduced cravings’ and returning to a more normal life. On the downside, several commented on the difficulties of having to be in withdrawal in the early stages of suboxone treatment, which may be a barrier for some individuals.

Prescribing and dispensing

The evaluation found that there were three different protocols on the use of suboxone in circulation at the time of the feasibility study. There was an informal system of training and support for doctors who participated in the study. The dosage and initiation regimes used ranged from 2 mg to 26 mg daily. It was noted that suboxone is licensed only for provision of doses up to 24 mg in any one day, and that the possibility of less-than-daily dosing was mentioned in only one of the protocols, underlining the need for clinicians to share their experience in this area.

Issues were highlighted with regard to the prescription form for suboxone, in particular when the prescription did not comply with the requirements of the Misuse of Drugs Act. Problems reported regarding the availability of 2 mg suboxone tablets caused some difficulties for pharmacists. Patients were supplied with a variety of information documents and/or verbal advice on starting suboxone. However, some of the patients reported that they had forgotten what they had been told when first prescribed suboxone, highlighting the need for standardised and accessible written information.

Costs

The evaluation discussed the 2007 report undertaken by the National Centre for Pharmacoeconomics (NCPE) for the expert group (National Centre for Pharmacoeconomics 2007). The NCPE report concluded that on current evidence suboxone could not be considered cost effective for patients attending HSE clinics unless opiate abstinence rates were at least 10% higher with suboxone than with methadone. The evaluation noted that the low cost of methadone made comparing costs with any other treatment difficult. It was felt that societal costs had not been factored into the NCPE report and that, although more expensive than methadone, providing suboxone to certain patients for whom there is a clear rationale would have economic and societal benefits.

Regulating provision

The regulatory mechanisms discussed were:

- having a cap on the number of patients who can be prescribed suboxone,
- having a fixed budget cap (rather than a cap on patients),
- restricting prescribing to certain groups of prescribers and/or patients, and
- negotiation with the relevant pharmaceutical company on price.

There was no clear consensus among prescribers or key informants as to what was the most appropriate mechanism to regulate provision, as each mechanism had both positive and negative aspects.

Conclusions and recommendations

The evaluation concluded that 'suboxone has been used in this feasibility study with a wide range of patient groups, for whom it has the potential to be beneficial and it appears to offer a number of advantages over methadone' (p.44). In considering future safe provision of suboxone in Ireland, the author made a number of recommendations, which are summarised below:

1. The Suboxone Expert Group should discuss and agree interim criteria determining eligibility for suboxone treatment.
2. If suboxone prescribing is restricted to certain groups/subjected to certain criteria in future, audit and reporting processes should be established to add weight to the criteria and enable any prescribing patterns that are unusual or fall outside the criteria to be identified and explored.
3. National guidelines on the use of suboxone across all prescribing and dispensing settings should be developed.
4. Standard patient information resources should be used across all settings.
5. Prescriptions for suboxone should be clear and unambiguous.
6. The system of remuneration for suboxone in future should be incorporated into remuneration systems for opioid treatment services and should be clearly communicated to prescribers and dispensers (including any future prescribers and dispensers).
7. Clarification of the ethical and legal position of pharmacists and clinics in relation to the various options for coping with stock shortages should be provided. Professional guidance should be prepared in relation to the appropriate management of such situations.
8. Arrangements should be made for the appropriate management of suboxone stock which may be left in pharmacies when they no longer have any patients on the drug.
9. Suboxone should be made available through more than one wholesaler to reduce the likelihood of stock shortages.
10. Suboxone initiation and prescribing should only be undertaken by those with suitable expertise and training.
11. Suboxone dispensing should be restricted to those with suitable expertise and training.

12. A mechanism is needed that allows prescribers to share and discuss their experiences with suboxone (and in the management of opioid dependence in general, including methadone).
13. Engagement should take place with the pharmaceutical company marketing suboxone in order to consider price, budget projections and shared-risk arrangements for any future use of suboxone.
14. Any future consideration of the cost-effectiveness of suboxone should take into account the full range of potential benefits from successful treatment of opioid dependence, including reduced social costs.

Availability of detoxification beds

As reported by the Department of Health in July 2013 (Department of Health 2013b), 144 beds are available nationally for detoxification. They are distributed across a range of services. There are 23 beds in two medical detoxification units, with an average waiting time of between one and two months. There are 117 beds available for community-based residential treatment, and the average waiting time varies – six centres have average waiting times of zero to less than seven days, while waiting lists in the others vary from two to four weeks. Only four beds are available for adolescent detoxification treatment, at the Aislinn Addiction Centre. The average waiting time for these beds is four to five weeks.

5.2.2.1 Organisation and quality assurance

Development of clinical guidelines for opiate treatment

The most recent update on the implementation of the National Drugs Strategy (*interim*) 2009–2016 (Department of Community 2009) from the Department of Health states that the new national clinical guidelines for opioid treatment are expected to be finalised in 2013 (Department of Health 2013b) (Health Research Board 2012). They will be the first national guidelines for both HSE clinics and general practice and will replace the current ICGP guidelines (Irish College of General Practitioners 2008). The guidelines are expected to cover the following areas:

- clinical governance,
- essential elements of treatment provision,
- psychosocial components of treatment,
- pharmacological interventions,
- health considerations, and
- specific treatment situations and populations.

Guidelines for prescribing methadone in pregnancy

New clinical practice guidelines on safe and effective prescribing of methadone for pregnant women in maternity hospitals were jointly published in April 2013 by the Institute of Obstetricians and Gynaecologists and the HSE (Institute of Obstetricians and Gynaecologists and Health Service Executive 2013). Based on an earlier document used by the three Dublin maternity hospitals, these new guidelines were developed after a wide-ranging review of the literature and consultation with key stakeholders.

The document recommends that all pregnant women who are problem opiate users should attend a specialist or high-risk antenatal clinic. If this is not possible, these women should attend the same clinic throughout their pregnancy to ensure continuity of care. The guidelines work through various common clinical scenarios and issues around admission and discharge. They are designed to guide clinical judgment, not to replace it.

Clinical Scenario 1: Pregnant women admitted and known from medical record or verbal history to be on prescribed methadone

- Their methadone provider should be contacted to confirm details. The hospital medical team should ensure that methadone is prescribed in a timely manner.

Clinical Scenario 2: Pregnant women admitted with a take-away methadone supply

- Women should be advised not to bring supplies of take-away methadone into hospital. If they do, the methadone must be sent to the pharmacy to be destroyed.

Clinical Scenario 3: Pregnant women admitted to hospital self-reporting heroin use but not registered with the addiction services or a prescribing GP

- These women need to be assessed and treated in a timely manner, given that opiate withdrawal carries the risk of pre-term delivery and foetal death. It is advisable to seek guidance from the local addiction services and also to confirm that the woman is opiate dependent. The management of initiation of any methadone treatment should be closely monitored.

Clinical Scenario 4: Pregnant women admitted looking for a prescribed dose of methadone out of hours and known to be on prescribed methadone from medical record or verbal history

- As methadone cannot be administered on an out-patient basis, the woman must be admitted, and then up to half her current dose prescribed.

Intoxicated pregnant women

- Because of the risk of overdose, methadone must not be dispensed to a woman who may be intoxicated until she has been medically assessed.

Vomiting in pregnant women on methadone-maintenance treatment

- Vomiting may not be related to the methadone, so other possible causes should be investigated, e.g. hyperemesis gravidarum. Depending on the timelines and amount vomited, a proportion of, or the entire dose, may be re-administered.

Discharge of methadone-maintained women

- All details of the woman's methadone prescription should be sent to the prescriber in the community (either clinic or GP). Women should not be discharged with supplies of methadone from hospital stock or with a prescription for methadone or benzodiazepines.

Peripartum pain management

- Women on methadone treatment should be offered, if required, the same pain relief options as other women for labour or post-partum pain, as maintenance doses of methadone do not provide adequate pain relief. They should be reassured that there is no evidence that the administration of opiates for pain relief leads to relapse, but they may require higher doses to provide effective relief.

Breastfeeding

- Women who are stable on methadone and have no contra-indications should be encouraged to breastfeed if they wish. However, if the woman is on other medication, e.g. benzodiazepines, advice should be sought.

Methadone dosing in pregnancy

- This can be a difficult area to manage, particularly because of the complexities of pregnancy-associated pharmacokinetic changes, which have been shown to reduce the concentration of methadone in the blood. Some women may wish to reduce their dose in order to reduce the risk of neonatal abstinence syndrome in their infant. However, there is no evidence to support this theory. Each woman's dose, her tolerance and its effectiveness should be monitored and titrated closely during the pregnancy. Because of the risk of relapse and the subsequent risk to the foetus, detoxification from methadone is not recommended during pregnancy.

The guidelines also make eight general recommendations:

1. Methadone maintenance treatment is the treatment of choice for opioid-dependent pregnant women. In adequate doses, methadone provides stability for the woman during pregnancy, avoiding repeated cycles of intoxication and withdrawal that may adversely affect the foetus.

2. Withdrawal from opioids can cause foetal death and preterm delivery. It is important that women who report illicit opiate use are assessed and treated in a timely manner.
3. Clear communication between maternity hospitals and local addiction services is required, particularly in relation to methadone doses and admission/discharge of methadone-maintained women.
4. Initiation of methadone may be required in a maternity hospital to avoid obstetric complications of opioid withdrawal. Careful initiation is required, as the highest risk of overdose mortality is in the first two weeks on methadone treatment.
5. A validated scoring tool should be used to assess signs of opioid withdrawal in opioid-dependent pregnant women.
6. Opioid-dependent pregnant women are at risk of under-treatment of peripartum pain.
7. Breastfeeding should be encouraged in women who are stable on methadone maintenance treatment unless there are other medical contraindications.
8. The maternal methadone dose should be individually adjusted to control maternal craving or withdrawal symptoms.

For a more in-depth analysis of methadone prescribing and dosing for pregnant women in Ireland, see a study (Cleary, *et al.* 2013) described in Section 7.4 of this National Report.

QuADS Support Project

The Quality in Drugs and Alcohol Services (QuADS) Support Project, run by the Ana Liffey Drug Project and supported by the HSE, now has 98 organisations enrolled (Department of Health 2013b). The project provides support related to capacity building, information sharing and other issues. Services involved in this project have access to 78 different policies, tools and templates for quality standards in, for example, governance, human resources, service provision, service user involvement and care and case management (Ana Liffey Drug Project 2012). A pilot system has also recently been developed to enable services to peer review how consistent they are with the QuADS system.

Training standards for the addiction services

Action 47 of the National Drugs Strategy (*interim*) 2009–2016 (Department of Community 2009) calls for the development of national training standards for the addiction services. This year the Department of Health issued an update on progress in implementing the NDS, including this action (Department of Health 2013b). It was reported that a survey was carried out which showed the different types of training being delivered in this sector:

- national drugs rehabilitation framework training,
- children and family interventions,
- specific drug awareness,
- psychosocial interventions, and
- specific high risk areas related to addiction.

Most of the training provided is aimed at a foundation or intermediate level and a gap has been highlighted in the provision of more advanced training requirements. The National Addiction Training

Programme (NATP) is consulting with various third-level educational institutions in order to develop new, accredited programmes to fill this requirement.

Going forward, the NATP will work with the National Drug Rehabilitation Implementation Committee (NDRIC) to develop national competencies, and then the standards for training modules for those competencies. The HSE is adopting the UK system, the DANOS/Skills for Health, as the standard for training.

Experience of methadone treatment

Two recent qualitative studies in Ireland looked at the experience of (i) services users in methadone treatment and (ii) methadone prescribers. Overall, service users

reported that they were satisfied with receiving methadone treatment in general practice; many of the respondents had been attending the same doctor for more than five years (Latham 2012). The study found that they valued being treated with respect and being listened to. In the second study (Van Hout and Bingham 2013), participating doctors prescribing methadone (in both clinics and general practice) felt that methadone treatment had helped to reduce harm for their clients, especially in relation to injecting drug use, risk of infection, and overdose. It also helped to improve other aspects of a client's life such as relationships and employment. Despite this, it was reported that respondents noted some problem areas such as the restrictive nature of daily doses on clients' freedom, reducing doses and detoxification. The study recommendations included expansion of referrals to primary care, improving interagency community psychological and detoxification supports, consideration of other substitution medication and appropriate treatment for poly-substance use.

5.2.2.2 Availability and diversification of treatment

Brief interventions to reduce problem alcohol use in patients on methadone treatment

The Alcohol Use Disorders Identification Test (AUDIT) is a tool developed by the World Health Organization (WHO) to screen for harmful or hazardous drinking. The AUDIT-C is a modified version of this tool. The scores range from zero to 20, a higher score indicating more problem use. WHO also developed brief interventions (BI) to be used in tandem with the AUDIT. In Ireland, it was estimated that 35% of patients attending primary care for methadone treatment had problem alcohol use.

An Irish study (Darker, *et al.* 2012a) was designed as an implementation study in order to assess whether BIs were effective in reducing harmful or hazardous alcohol use by patients on methadone treatment. It addressed two specific questions:

1. Was it feasible for professionals working in the Dublin methadone clinics to screen patients and deliver BIs to patients on methadone treatment?
2. Was it feasible for professionals working in the Dublin methadone clinics to incorporate screening patients and delivering BIs to patients on methadone treatment in their typical clinical workload?

Three of the largest methadone clinics in Dublin were chosen and all patients (N=863) were eligible to participate in the study. However, those patients who were experiencing an acute psychotic episode, those not attending at the time of the screening or those who had an AUDIT score indicating alcohol dependence, were excluded from the study. In all, 48 clinical staff (nurses, GPs, counsellors, social workers and outreach workers) were trained in using the WHO BI protocols.

A total of 710 patients were screened at baseline with the AUDIT, and those whose scores indicated hazardous or harmful drinking (160, 23%) received a BI immediately after screening. There was good follow-up for re-screening and 91% of these 160 patients were re-screened three months later (by a different professional) using the AUDIT-C. The study ran from January to November 2009.

The authors found that there was a statistically significant reduction in AUDIT-C scores between the first screening (and BI) and the re-screening. Of note, there was a statistically significant decrease in the proportion of men who had a positive AUDIT-C score at the re-screening but this decrease was not observed for women. The authors stated that this could be the result of the study being under-powered as only 46 women received a BI at the baseline screening.

The only factors to predict alcohol consumption at baseline screening were gender and length of time of treatment. The only factor to predict AUDIT-C scores at re-screening was AUDIT-C scores at baseline screening.

The authors concluded that this study was the first evidence that a BI delivered by a clinician can be incorporated into the workload of methadone clinics and can reduce alcohol consumption in patients receiving methadone treatment. This is important given the high proportion of methadone patients (23%) who reported hazardous or harmful drinking in this study, and considering the high prevalence of hepatitis C among problem drug users in Ireland.

Psychotherapeutic interventions by GPs providing methadone treatment to patients in primary care

A study was carried out, using a grounded theory approach, to examine how GPs provided psychotherapeutic interventions¹⁰ to their patients who receive methadone treatment in primary care in Ireland (Kenny and O'Carroll 2012).

The researchers used a theoretical sampling strategy where initially three GPs known to have a lot of experience in providing methadone treatment were selected for interview. Further participants were selected to address the emerging themes arising from those initial interviews. In all, 13 participants were interviewed: seven GPs who prescribed methadone in primary care, four non-prescribing professionals (practice nurses and counsellors) and two GPs who did not prescribe methadone but who used psychotherapeutic interventions.

Seven main themes were identified in the research. There was a lack of standard assessment procedures or protocols for providing this care, and some GPs had developed their own individual approaches to such treatment options. There was a wide variation in belief in and knowledge of the value of psychotherapeutic interventions, ranging from the belief that it was essential to the view that it was optional. GPs had difficulties accessing high-quality psychotherapeutic services as they had doubts about the standards and quality of some of these services. Unlike other medical services, in general GPs did not follow up on the referral outcomes of psychotherapeutic services their patients had attended. Participants experienced difficulties accessing psychotherapeutic resources provided through formal structures once the patient was discharged to the community. GPs adopted a continuous care model and holistic approach to their patients on methadone. There was evidence that the GPs who participated in the study sought to subtly move their patients towards abstinence where appropriate.

The authors noted that while the grounded theory method is well established, the study focused on one particular area of GP care, which only a minority of GPs provided and many of those were based in the greater Dublin area, and so urged caution about the generalisability of the study.

The authors stated that while there is much research into the use of psychotherapeutic interventions with methadone treatment, unfortunately the evidence regarding its usefulness with this client group is not conclusive. They believed that the lack of structured approaches to these methods, including the lack of a guiding framework, hinders the development of an evidence base in Ireland to inform and improve practice.

Counselling therapy in cocaine-using methadone-maintained patients

A study was designed to examine why cocaine-using methadone-maintained patients did not attend cognitive behavioural coping skills (CBCS) therapy that was provided for them (Darker, *et al.* 2012b). The authors undertook this study because they had previously had to abandon a randomised controlled trial looking at the effectiveness of CBCS therapy among cocaine-using methadone-maintained patients owing to lack of attendance (Darker, *et al.* 2012a).

¹⁰ Psychotherapeutic interventions refer to psychological techniques designed to establish a therapeutic relationship with the patient and to encourage communication of conflicts and self-insight. The goal is to bring relief to symptoms, changes in behaviour leading to improved social and vocational functioning, and personal growth.

All 45 participants in the original study were contacted and 37 agreed to be interviewed and reasons for attending and not attending were explored. Motivational inconsistencies (e.g. 'loss of hope to change right now', 'no good reason to stop using cocaine', 'not motivated') were the main reasons for non-attendance. Conflict with staff did not emerge as a major issue for non-attendance. However, a good relationship with staff was among the main reasons for attending cognitive behaviour therapy (CBT).

The authors concluded that it is still undetermined as to whether CBCS therapy is useful in reducing cocaine use by those in methadone treatment if they themselves are not motivated to stop using cocaine. They suggested that it may require a more stepped approach, including such interventions as motivational interviewing, in order to address this issue.

Group psychological intervention (GPI) for psychosis with cannabis dependence

There are few proven effective interventions for psychotic patients who also have a substance dependency. Among those diagnosed with schizophrenia, cannabis is the most common substance misused. Research points to the fact that cannabis use can be a causal factor in both the development of psychotic illness and the severity and duration of symptoms. Few studies have identified interventions that reduce cannabis use and improve clinical outcomes in this population.

In light of the limited evidence on effective interventions, researchers in Ireland carried out a randomised controlled trial (RCT) comparing a group-based psychological intervention (GPI) with standard care among patients in the early course of psychotic illness who were also cannabis dependent (Madigan, *et al.* 2013). The primary outcome measure was the extent of cannabis misuse and the secondary outcome measures were positive and negative symptoms, depressive symptoms, global functioning, insight, attitude to treatment and quality of life.

Participants were recruited from three different sites in Ireland: the DETECT service in South County Dublin/North Wicklow, the then Drug Treatment Centre Board in Dublin city centre, and the Cavan–Monaghan Mental Health Service. Participants had either experienced their first psychotic episode or were within three years of onset of non-affective or affective psychosis.

Participants were randomly assigned (by computer) to one of two groups. One group received a GPI that integrated cognitive behavioural therapy with motivational interviewing, in addition to standard care. The other group, the treatment as usual (TAU) group, received standard care but not the additional GPI. A clinical nurse specialist used a range of standardised measures and questionnaires to rate the outcome measures at follow-up. Participants were followed up at three months and at one year.

Of the 88 participants recruited, 59 were randomly allocated to the GPI group and 29 were randomly allocated to the TAU group. Data were analysed on an intention-to-treat basis. Mean lifetime use of cannabis was 9.6 years in the GPI group and 7.5 years in the TAU group. Other baseline demographic characteristics are shown in Table 5.2.2.2.1.

Table 5.2.2.2.1 Baseline demographic characteristics of participants in RCT of group psychological intervention (GPI) for psychosis with comorbid cannabis dependence

	GPI		TAU	
	n	(%)	n	(%)
Mean age (years)	27.6		28.2	
Mean duration of untreated psychosis (months)	14.4		12.2	
Gender				
Male	46	(78)	23	(79)
Female	13	(22)	6	(21)
Education				
Primary	3	(5)	0	(0)
Secondary	26	(44)	11	(38)
Third level	24	(41)	15	(52)
Masters/professional	6	(10)	3	(10)
Employed	17	(29)	10	(35)
Diagnosis				
Schizophrenia	25	(42)	13	(44)
Schizophreniform disorder	6	(10)	3	(10)
Bipolar disorder	10	(19)	4	(16)
Schizoaffective disorder	1	(2)	0	(0)
Delusional disorder	2	(3)	3	(10)
Brief psychotic disorder	3	(5)	3	(10)
Major depressive disorder	5	(9)	1	(3)
Substance-induced disorder	3	(5)	2	(7)
Psychosis not otherwise specified	4	(7)	0	(0)

Source: Adapted from (Madigan, *et al.* 2013)

At three months and one year no differences were found between the two groups in the primary outcome measure – frequency of cannabis misuse. There were no differences between the two groups in any of the secondary outcome measures, with the exception of subjective quality of life scores, which were significantly higher in the GPI group at both three months and one year. This is noteworthy as research shows that a reduction in negative outlook is an important outcome of treatment for people with schizophrenia.

The authors stated that this was the first RCT to look at GPIs to reduce cannabis use among those in the early stages of a psychotic illness. The study found that the intervention had no effect on reducing cannabis use. The authors suggested that the intervention may have been given for too short a period (18 weeks) to have sufficient impact on the outcome measures. They also pointed out that they recruited only 88 participants from 230 patients referred and that they did not compare relapse rates between the two groups because of variations in admission procedures in the participating centres. The authors recommended that more trials involving psychological interventions be carried out with this client group.

MQI annual review 2011

The Merchants Quay Ireland (MQI) annual review for 2011 highlighted some important new initiatives at MQI including the Athlone Open Door Centre, the new 10-bed unit at St Francis Farm Detox facility, and the start of renovation works at the Riverbank Centre (Merchants Quay Ireland 2012).

The outreach worker for the New Communities Support Service provided one-to-one support to 112 service users, 53% of whom were from Poland. The Easy Access Education for Homeless People programme engaged with 45 clients during 2011: 34 male and 11 female.

MQI's needle-exchange service recorded approximately 21,819 client visits in 2011. The report highlighted a continuing high level of demand for homeless services: 58,858 meals were provided, with an additional 29,000 meals provided by the Extended Day Service in association with Focus Ireland. The Primary Health Care Services provided 3,331 interventions in 2011.

MQI continued to provide the national prison-based addiction counselling service to 12 prisons in 2011: 10,293 individual counselling sessions and 2,830 group attendances were recorded during the year. This service was provided by 26 counsellors. The service also co-ordinated an eight-week inter-agency programme at the medical unit in Mountjoy Prison for groups of nine clients at a time. Seven groups, totalling 63 clients, participated in 2011, of whom only four did not complete the programme.

MQI in association with the Midland Regional Drugs Task Force and the HSE administered the Midlands Family Support and Community Harm Reduction Service, providing outreach and working with families of those actively using drugs in that task force region. The family support service provided 140 group sessions and 505 individual sessions, in addition to 723 supportive phone calls. The harm reduction service provided needle-exchange services and engaged in 4,000 one-to-one client interventions during 2011. The Midlands Traveller-Specific Drugs Project worked with 38 clients and engaged in 1,187 support sessions. Athlone Open Door Centre, for which MQI assumed operational responsibility in January 2011, recorded 1,415 visits and provided 400 meals, with an average of 44 clients per month.

The services offered by MQI and the numbers of people accessing them in 2011 are shown below in Table 5.2.2.2.2.

Table 5.2.2.2.2 Services offered by Merchants Quay Ireland in 2011

Service	Type of intervention	Activity in 2011
Needle-exchange and health-promotion services	Promotes safer injecting techniques HIV and hepatitis prevention Safe sex advice Information on overdose Early referral to drug treatment services	4,051 used needle-exchange services, of whom 492 were new clients 1,220 safer injecting workshops
Stabilisation services	Methadone substitution Gateway programme	18 service users 795 service visits
Integration programmes	Access to transitional accommodation in Ballymount House Leixlip House with Respond Housing Association	3 residents (annual average) 9 admissions, with an average of 5 clients in the house for an average tenancy of 5 months
Training and work programmes	FÁS Community Employment scheme ¹¹	86 participants Of the 35 who completed FÁS placements at MQI, 2 secured permanent employment, 7 moved to further education
High Park	17-week, drug-free residential programme including individual counselling, group therapy, educational groups, work assignments and recreational activities	50 participants (of whom 4 were admitted for detoxification) 3 clients completed detox 24 clients completed the full programme
St Francis Farm	Residential programme – reduced from a 6-month to a 14-week programme in October 2011, in conjunction with a new 4–6-week detox facility on site	40 participants 15 clients completed three months or more 23 clients part-completed the programme

Source: (Merchants Quay Ireland 2012)

5.3 Access to treatment

5.3.1 Characteristics of treated clients (TDI data included)

A national study of retention in methadone treatment

The Central Treatment List (CTL) records all patients who enter and exit methadone treatment in Ireland in real time. Basic demographic details, date of entry, date of exit and reason for exit are collected. As retention in methadone treatment is believed to be a key indicator of success, a retrospective study was conducted using CTL data in order to determine retention rates in methadone maintenance in Ireland (Mullen, *et al.* 2012).

¹¹ Responsibility for administering the Community Employment Scheme has transferred from FÁS to the Department of Social Protection.

A retrospective random sample of 1,875 new entries to treatment for 1999, 2001 and 2003 was requested from the CTL.¹² In all, 606 cases had to be excluded as they did not meet the criteria (e.g. not new entrants to treatment, incomplete exit details, attending a methadone detoxification programme), so 398 cases were included for 1999, 419 cases for 2001 and 452 cases for 2003, a total of 1,269. Using a data collection instrument which included key factors for retention in treatment, data were extracted from the clinical records of those included in the study. The length of stay in treatment at 12 months was calculated and retention at 12 months was calculated using logistic regression.

The majority of cases included were male (69%) and the mean age was 26 years. Almost a third (29%) had never been in methadone treatment before. Most had a history of injecting drug use (74%). The average daily dose was 58 mg (20.9 SD) and there was a significant mean difference in average daily dose by time in treatment. Six out of ten (61%) of those who started treatment were still in continuous treatment at 12 months. Of those who left treatment before 12 months (n=499), the reasons were known for only 40%. The main reason recorded was treatment failure defined as, for example, returning to opiate use, no contact for one month and being asked to leave treatment. Other reasons included cases moving on to a detoxification programme. Five people died.

Logistic regression was used to discover what factors may predict retention in treatment at 12 months (Table 5.3.1.1). This showed that being male and also attending specialist drug treatment were factors significantly related to leaving drug treatment before 12 months. However, methadone dose was found to be the strongest predictor of retention in treatment as those who received less than 60 mg daily were three times more likely to leave treatment before 12 months.

Table 5.3.1.1 Factors associated with retention in methadone treatment at 12 months using a logistic regression model

Factor	Total*	Adjusted odds ratio (95% CI)	p-value
Gender			
Male	870	1.4 (1.0-2.0)	0.03
Female	399	1	
Facility type			
Specialist drug treatment	153	2.0 (1.2-3.5)	0.01
Community drug treatment	858	1.2 (0.8-1.7)	0.4
Primary care setting	258	1	
Average methadone dose			
59 mg or less	484	3.0 (2.2-4.0)	0.0001
60 mg or more	489	1	

Source: (Mullen, *et al.* 2012)

Initial model included age, injecting drug use. Significant factors were retained in the final model

* Numbers do not always add up to total because of missing data

The authors stated that the retention rate in treatment of 61% found in this study was high and compared well with other research done in Ireland. Gender, type of treatment facility and higher dosage were found to be factors in predicting retention. In Ireland there has been a move towards providing addiction treatment in primary care, the effectiveness of which is borne out by this study. However, one of the limitations of the study was that it could not control for certain potential confounders such as homelessness or co-morbidities. Also, clients who are more chaotic tend to be treated in specialist drug treatment centres rather than in primary care. Further research is needed to determine any additional factors which may influence retention in methadone maintenance treatment in Ireland.

Relapse following residential detoxification treatment

¹² A minimum sample size of 1,152 was calculated, based on an expected 50% of cases to be retained in treatment, 95% confidence intervals and an absolute precision of 5 percentage points.

Detoxification is the term given to a process whereby an individual is medically weaned from a drug, including opiates. Studies have shown that completion rates for this treatment are higher when conducted in a residential service. Unfortunately there is a risk of relapse after detoxification treatment, as with any drug treatment. The authors of this study wished to better understand factors which may be associated with relapse following opiate detoxification treatment, especially in the context of relatively little work done in Ireland on this issue (Ducray, *et al.* 2012).

The aim of the study was to identify and describe the context and factors involved in relapse after discharge from an inpatient opiate detoxification programme in Ireland. The characteristics of the original 144 participants have already been described in a previous study (Smyth, B.P., *et al.* 2005). Of these, 109 were interviewed 18 to 36 months after discharge for this current study using the Maudsley Addiction Profile and also a modified structured questionnaire based on factors associated with relapse. Of these, 102 reported an episode of relapse into drug use after discharge.

Almost two thirds (71%) relapsed within one week of discharge, most using heroin alone on this occasion (87%) and just over half (51%) reporting injecting. Of those who were alone at the time of relapse into heroin use, 65% reported injecting. The different factors were categorised as main, major or minor. The *main* precipitation factors for relapse were difficulties with cravings (30%) and low or bad mood (27%). Ease of access to heroin and missing the support of the inpatient service were identified as the *major* precipitation factors. However, most participants (86%) reported two or more factors contributing to their relapse.

The authors identified a number of limitations to the study, particularly the retrospective assessment of the factors and the associated risk of recall bias, and the use of a static model of assessment. The data were collected over ten years ago, before the development of more dynamic models of relapse, which include the synergy between many different factors including social and environmental.

The authors stated that this study had identified specific identifiable high-risk factors associated with relapse in the Irish context, which may assist treatment in Ireland that provides detoxification, particularly if there is a move to provide more of this type of treatment in the future.

Outcomes of methadone treatment

A retrospective study was conducted in one of the main methadone clinics in Dublin, focusing on patient outcomes (Somers and O'Connor 2012). One hundred and seventeen patients were enrolled in the study: they were first admissions for the year in question (2008); were not on anti-retroviral treatment; and were not pregnant. The primary outcome measure was the presence of heroin in urine specimens. Data were recorded at baseline, and at three, nine and 15 months after admission. At three months, 37 patients had dropped out, leaving 80. A higher proportion of those who dropped out, as opposed to those who remained at the end of three months, were repeat attenders and were homeless (Table 5.3.1.2).

Table 5.3.1.2 Comparison of characteristics of patients remaining at, and dropping out before, end of month 3 of methadone treatment

Characteristic	Remained at end of month 3	Dropped out before end of month 3
	N = 80	N = 37
Mean Age (years)	34.1	31.5
Methadone dose on day of admission	43.8 mg (SD 26.9)	39.9 mg (SD 29.3)
Male	63.8%	67.9%
Dual diagnosis	16.2%	10.8%
Repeat admission	12.5%	37.8%
Homeless	21.2%	37.8%
Heroin positive urine	73.1%	66.7%
Cocaine positive urine	10.3%	6.1%
Benzodiazepine positive urine	73.0%	63.6%
Alcohol positive urine	9.1%	15.2%
Cannabis positive urine	47.7%	38.9%

Source: (Somers and O'Connor 2012)

Sixty-six patients remained in the study at the nine-month follow-up. This number dropped to 56 at the 15-month follow-up.

The study examined the relationship between heroin and other substances found in urinalysis and methadone dose over the time points, looking at the outcomes 'abstinent' (urine negative for substances), 'intermittent' (less than 20% of urines positive for substances) and 'regular' (more than 20% of urines positive for substances) during a defined period. Poorer outcomes were associated with cocaine positive urines (OR 0.69, CI 0.59 to 0.81) and benzodiazepine positive urines (OR 0.7, CI 0.53 to 0.93). At 15 months, methadone dose was significantly associated with improved outcome (OR 1.67, CI 1.16 to 2.41).

Prescription of take-away doses of methadone was significantly associated (OR 1.34, CI 1.1 to 1.6) with an improved outcome (defined as negative urine specimen or less than 20% heroin positive urine specimens during a specified period of time). A poorer outcome was significantly associated with heroin positive urine on day of admission (OR 0.74, CI 0.56 to 0.97), prescription of low dose methadone (OR 0.65, CI 0.48 to 0.87), and behavioural sanctions (OR 0.8, CI 0.65 to 0.98). Only a low dose of methadone (OR 0.07, CI 0.01 to 0.33) remained a significant factor on multiple regression analysis.

The authors found that a methadone dose of more than 60 mg was associated with improved outcomes. Poorer outcomes were associated with those who used cocaine and benzodiazepines, lower dose methadone and behavioural sanctions. The authors recommended that a prospective study be undertaken at the clinic looking at the effects of different methadone dosages and the effect of co-morbid psychiatric illness on heroin use and client behaviour.

Client groups with poorer outcomes in methadone treatment

Data from the ROSIE study were reanalysed in a recent study using Chi-squared Automatic Interaction Detection (CHAID) (Murphy and Comiskey 2013). The authors stated that 'CHAID is an alternative approach to multiple linear and logistic regression models of treatment outcomes and is especially useful when the data set is not well suited to regression analysis due to perhaps violation of normality assumptions'.

The authors believed that the CHAID modelling process worked well with the ROSIE dataset, despite certain limitations including the lack of a control group, participants not randomly selected and re-grouping of dependent variables owing to small numbers. They modelled the interactions between outcome, heroin use in the past 90 days (at one-year follow-up) and four different medico-psychosocial domains. The only significant association with poorer outcomes was for males older than 22 years and heroin use at one year.

The authors concluded that it is important to be able to identify sub-groups in order to plan effective treatment but further research is necessary to examine the way different patient groups respond to methadone treatment. CHAID modelling could be a useful tool in this process.

Adolescents in treatment

The prevalence of psychiatric disorders in a cohort of adolescents attending substance misuse treatment (James, *et al.* 2013) is described in Section 6.3.2 of this National Report.

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

Treatment Demand Indicator data

A summary of the Treatment Demand Indicator (TDI) (also see TDI data), as provided by the NDTRS, shows that 7,703 cases entered treatment in 2012, a decrease of 336 cases since 2011.¹³ The decrease may reflect a genuine decrease in the numbers of cases entering treatment in 2012. However, it may also reflect in part the difficult economic circumstances experienced by Ireland over the past five or so years and a reduction in resources both in the NDTRS and among service providers. In 2012, 3,270 (42.5%) cases were new entrants, similar to 2011. In 2012, as in previous years, the majority of cases attended outpatient services (5,062, 65.7%). The majority were male (73.0%, 5,621) and the mean age was 29 years, similar trends to 2011.

As in previous years, opiates (mainly heroin) were the most common main problem drug reported by cases entering treatment in 2012 (3,971, 51.6%). This represents a decrease compared to 2011, when 4,351 cases entered treatment for problem opiate use. This decrease is also seen in the data from the CTL (see below and also Standard Table 24). The reduction in the proportion and number of cases treated for cocaine as a main problem substance continued in 2012, with a decrease to 654 (8.5%) from 760 (9.5%).

However, there was an increase in the number of cases entering treatment for cannabis as their main problem substance in 2012. In 2012, 2,216 (28.8%) cases entered treatment for problem cannabis use compared to 2,086 cases in 2011. This is not surprising as the most recent general population survey showed a significant increase in the proportion of adults in Ireland who have ever used cannabis (National Advisory Committee on Drugs and Alcohol 2013) (see Section 2.2 for more detail). However, it may reflect participation of services in the NDTRS or availability of treatment in the country.

Clients registered on methadone treatment

The number of clients registered for methadone treatment on 31 December each year are reported by the Central Treatment List (CTL) (see Standard Table 24). As at 31 December 2012, 9,419 clients were registered for methadone treatment (including those receiving methadone in prison) (personal communication, Caroline Comar, CTL). This is only a 2% increase on the previous year. Since 2009, the number of clients registered on methadone treatment has stabilised. This may reflect a change in patterns of drug use, but analysis of other sources, including treatment data and numbers of problem drug users, is necessary to explore this further. Of the 9,419 clients, the majority were male (69%) and the largest proportion (28%) were aged between 35 and 39 years.

Methadone treatment is provided by specialised clinics, specialist GPs and in prison. In 2012, 57% of patients were receiving treatment in specialist outpatient clinics, 38% from GPs and 5% in prison. The proportion of clients receiving treatment in specialist outpatient clinics and from GPs has remained relatively stable over the past 10 years.

¹³ 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.

Computerised Infectious Disease Reporting (CIDR) is a new information system developed to manage the surveillance and control of infectious diseases in Ireland. It also monitors organisms' ability to resist antibiotic drugs (antimicrobial resistance). CIDR is a shared national information system for the CIDR partners – the HSE, the Health Protection Surveillance Centre, the Food Safety Authority of Ireland, the Food Safety Promotion Board and the Department of Health.

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 Office for Suicide Prevention (NOSP)** was established in 2005 after publication of Reach Out National Strategy for Action on Suicide Prevention 2005–2014 (National Suicide Review Group, *et al.* 2005). The NOSP's core aim is to oversee the implementation, monitoring and evaluation of Reach Out. The NOSP is an office within the HSE and is linked in that structure to the Office of the Assistant National Director, Mental Health.

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 **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*.

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.

The **National Suicide Research Foundation (NSRF)** is an independent, multi-disciplinary research unit which investigates the causes of suicide and deliberate self-harm in Ireland.

The **National Virus Reference Laboratory (NVRL)** provides a diagnostic and reference service for clinicians investigating viral infections throughout Ireland. The laboratory is affiliated to the University College Dublin (UCD) School of Medicine and Medical Science. The NVRL currently performs over 700,000 tests annually, involving some 120 tests for 40 different pathogens and provides specialist reference services.

The data collected by the **Primary Care Re-impbursement 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 **Suicide Support and Information System (SSIS)** was established by the NSRF, in line with Action 25.2 of the Reach Out National Strategy for Action on Suicide Prevention 2005–2014 (National Suicide Review Group, *et al.* 2005). It was developed to prevent suicide by facilitating access to support for the bereaved while at the same time obtaining information on risk factors associated with suicide and deaths classified as open verdicts. The NOSP provided funding for a pilot-study in the Cork region, which ran from September 2008 to March 2011.

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.

6.2 Drug-related infectious diseases

6.2.1 HIV/AIDS and viral hepatitis

HIV surveillance, 2012

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1982. Figure 6.2.1.1 presents the number of new cases of HIV among injecting drug users (IDUs) reported in Ireland, by year of diagnosis; data from 1982 to 1985 are excluded as these four years were combined in the source records. According to the most recent report of the HPSC, at the end of 2012, 341 people were newly diagnosed with HIV in Ireland (crude notification rate of 7.4 per 100,000 per population) and the figure has been declining since 2004.

In 2012, 13 (3.8%) newly-diagnosed HIV cases were IDUs (Standard Table 09-1). The number of diagnoses among IDUs has been steadily decreasing, from 71 in 2004 to 13 in 2012 (a decline of 82%). Of the 13 newly-diagnosed cases who were IDUs, ten were men and the median age was 34 years (range 22 to 50 years). Five cases were born in Ireland, three in Central and Eastern Europe and two in Western Europe. Where CD4 count was reported, 63% of injectors in 2012 were diagnosed late, including 38% who were severely immuno-compromised. Two of the 13 IDUs were also diagnosed with an AIDS-defining illness at the time of their HIV diagnosis, and four had had a previous negative HIV test. Among the IDUs newly diagnosed with HIV infection, 69% were co-infected with hepatitis C (Donnell, *et al.* 2013).

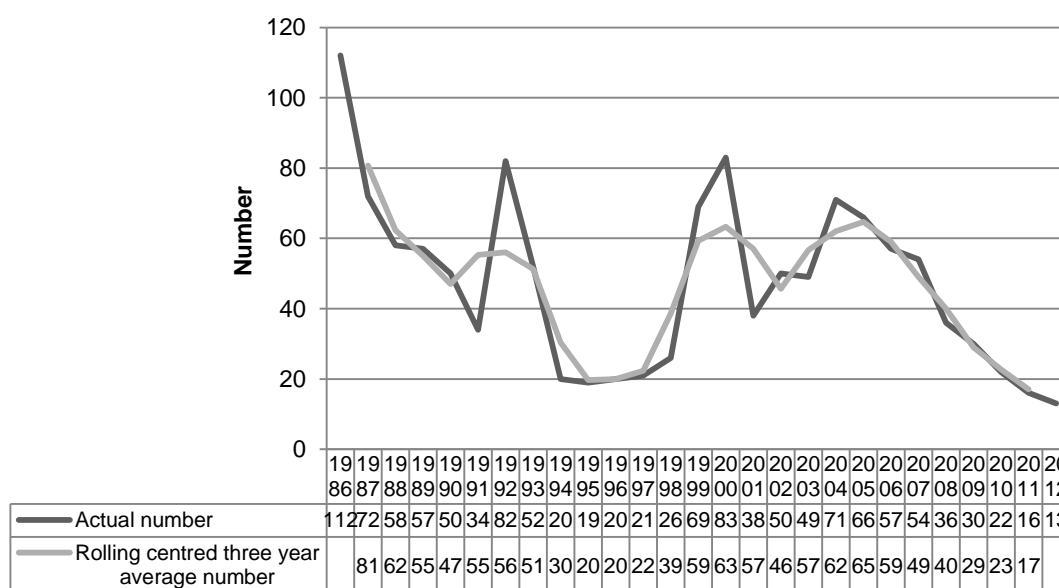


Figure 6.2.1.1 Number and rolling average number of new cases of HIV among IDUs, by year of diagnosis, reported in Ireland, 1986–2012

Source: Unpublished data reported to Department of Health by National Disease Surveillance Centre and HPSC, 2013

Hepatitis B notifications, 2012

There were 581 notifications of hepatitis B in 2012 compared to 525 in 2011, a 12% increase (Table 6.2.1.1). The number of acute cases in 2012 remained low at 37, showing a small decrease from 2011 when there were 45 acute cases. Among acute cases in 2012, 27 (73%) were aged between 20 and 44 years and 29 (78%) were male. There were no new acute cases of hepatitis B infection among IDUs in 2012.

Table 6.2.1.1 Acute and chronic hepatitis B cases reported to the HPSC, by risk factor status, 2011–2012

Hepatitis B status	2011			2012		
	Acute No. (%)	Chronic No. (%)	Unknown No. (%)	Acute No. (%)	Chronic No. (%)	Unknown No. (%)
Total number of cases	45	460	20	37	521	23
% of cases by status	(8.6)	(87.6)	(3.8)	(6.4)	(89.6)	(4)
Cases with reported risk factor data	44	183	5	36	243	5
% of cases with risk factor data	(97.7)	(39.8)	(25)	(97)	(47)	(22)
of which						
Injecting drug users	0 (0%)	1 (0.6)		0 (0%)	5 (1%)	0 (0%)
Cases without reported risk factor data	1	277	15	1	278	18
% of cases without risk factor data	(2.3)	(60.2)	(75)	(3)	(53)	(78)
Total	525			581		

Source: Unpublished data reported to Department of Health by National Disease Surveillance Centre and HPSC, 2013

Hepatitis C notifications, 2012

There were 1,036 hepatitis C notifications in 2012, (Table 6.2.1.2), a 17.5% decrease on 2011, when there were 1,257 notifications. Previous annual numbers have included cases diagnosed in the past, which were not previously notified. Decreasing hepatitis C notifications and increasing median age is indicative of a reduced incidence of hepatitis C in the population. Demographic data in 2012 were similar to previous years, with 66% of 689 cases (66%) being male, the median age at notification being 37 years, and 67% of cases being aged between 25 and 44 years.

Table 6.2.1.2 Hepatitis C cases and notification rates per 100,000 population, 2004–2012

Year	n	Notification rate
2004	1119	26.4
2005	1403	33.1
2006	1210	28.6
2007	1541	36.5
2008	1511	35.8
2009	1240	29.3
2010	1236	29.2
2011	1257	29.6
2012	1036	24.4

Source: Unpublished data from HPSC, 2013

Risk factor data were available for 637 (61%) of the 2012 cases. For 484 (76%) of these cases, injecting was the predominant risk factor (Table 6.2.1.3); of these cases, 348 (72%) were men, and the average age was 37 years (Standard Table 09-4). Among the 484 cases where injecting was the predominant risk factor, 399 (82%) lived in Dublin and the adjoining counties of Kildare and Wicklow (Health Protection Surveillance Centre 2012a).

Table 6.2.1.3 Demographic data on IDUs with hepatitis C notified to HPSC, 2012

	n (%)
Total number of known injector cases	484
Gender	
Male	348 (72)
Female	136
Gender not known	0
Age	
Mean age	36.9
Median age	36
Under 25 years	23 (4.8)
25-34 years	178 (36.8)
Over 34 years	282 (58.2)
Age not known	1 (0.2)
Place of residence	
Dublin, Kildare or Wicklow	399 (82.4)
Elsewhere in Ireland	85 (17.6)

Source: Unpublished data from HPSC, 2013

Hepatitis C co-infections

Co-infection with hepatitis C and HIV complicates both diseases. Untreated HIV infection increases the risk of liver damage and can accelerate cirrhosis compared with those infected with hepatitis C alone. Provisional data from HPSC/CIDR found that during 2012, there were 14 co-infections with hepatitis C and HIV. Of these cases, nine were male and the median age at notification was 34 years. Country of birth was known for ten of these cases – five were born in Ireland, four in central and eastern Europe and one in Asia. Risk factor was known for seven cases, and two of these were IDUs.

Co-infection with hepatitis C and hepatitis B can also lead to more severe liver disease and an increased risk of liver cancer. There were seven cases of co-infection with hepatitis C and B in 2012. Of these cases, six were male and the median age at notification was 34 years. Two cases were co-infected with hepatitis C and B and HIV. Risk factor data were available for two cases, one of whom was an IDU (Health Protection Surveillance Centre 2012a).

Determination of the burden of hepatitis C virus infection in Ireland

Testing for anti-hepatitis C virus began in Ireland in 1989 and over the next 15 years about 95% of confirmatory investigations, both serological and molecular, were performed in the National Virus Reference Laboratory (NVRL). The NVRL has a laboratory information management system (LIMS) which is specimen-based rather than person-based. There is no unique personal health identification number system in use in Ireland and it is possible that many persons infected with the hepatitis C virus (HCV) have had repeated tests performed, making total counts of positive cases impossible.

Thornton and colleagues completed a study to estimate prevalence of chronic HCV infection in Ireland between 1989 and 2004. The study was completed to inform future health services planning for those with chronic HCV infection and also to contribute to understanding of the increasing scale of HCV infections in Europe (Thornton, Lelia, et al. 2011).

The results confirmed that between 1989 and 2004, 10,384 individuals were infected with the hepatitis C virus and that it was not possible to determine the definitive HCV status of a further 2,637 individuals. In 75.6% (n=7,853) of confirmed cases, it was possible to assign a risk factor, including current or former drug use (79.7%, n=6,255), receipt of blood or blood products (16.4%, n=1,285), accidental exposure to blood/body fluids including by assault (1.3%, n=102), sexual exposure (1.2%, n=98), vertical exposure (1.0%, n=79) and contact with a case or an at-risk individual (0.4%, n=34)

(Figure 6.2.1.2). Unfortunately, available information did not allow for specification of whether drug use was injecting or non-injecting.

The majority of the 10,176 confirmed cases (for those where age and gender were known) were men (63%) with a median age at diagnosis of 28 years, and 70% of these men had a history of drug use. The median age at diagnosis for those infected through drug use was 25 years for men, and 23 years for women. This has increased since 2001 and the median age for all identified drug-use-related new diagnoses in 2004 was 28 years.

Genotype was available for 60.8% (n=6,314) of all confirmed positive individuals. Of these, 55.3% (n=3,493) were genotype 1, 38.6% (n=2,444) were genotype 3, 3.6% (n=227) were genotype 2, 1.0% (n=62) were genotype 4 and 0.1% (n=6) were genotype 5. A small number of individuals were infected with more than one genotype, most commonly genotypes 1 and 3 (1.2%, n=73). The genotype distribution differed between people infected through drug use and those infected through blood/blood products; 53% of drug users had genotype 1 HCV infection and 42% had genotype 3 HCV infection. This information is important when planning treatment services and in determining the efficacy of antiviral treatment.

The 10,384 chronic HCV cases obtained from the LIMS data were adjusted using five assumptions to provide an estimate of those who acquired chronic HCV infection between 1989 and 2004 and living with it in 2009. Following adjustments for testing at other laboratories (5% increase), for diagnosis between 2004 and 2009 (additional 4,262 cases), and for a chronicity rate of 75% (reduction by 25%), and allowing for a mortality rate of 13% and an under-diagnosis rate of 50%, 67% and 80%, it was estimated that there were at least 19,826 individuals living with chronic HCV infection in 2009, but the number could be as high as 29,739 or 49,565.

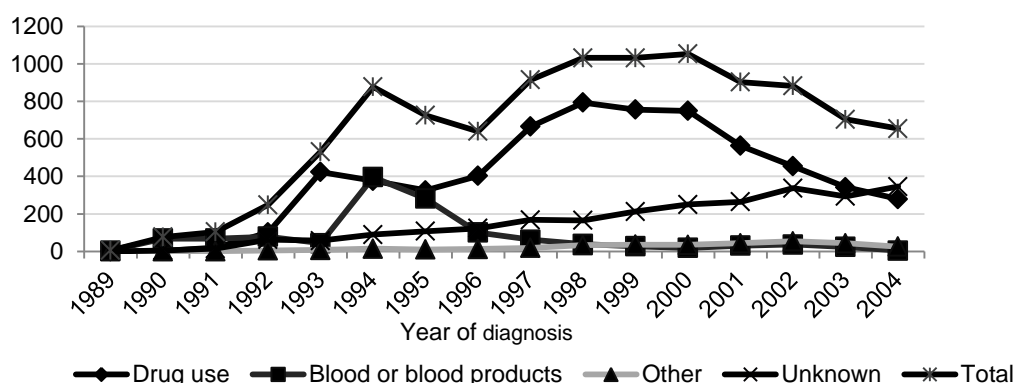


Figure 6.2.1.2 Number of NVRL-confirmed HCV cases by year of diagnosis and reported risk factor, 1989–2004

Source: (Thornton, Lelia, *et al.* 2011)

Profile of clients attending the Health Promotion Unit–Needle Exchange, MQI

Merchants Quay Ireland (MQI) carried out a study in 2012 to gain an up-to-date profile of the clients accessing its Health Promotion Unit–Needle Exchange (HPU) service, in order to inform service planning and provision (Jennings 2013). A self-report research instrument was developed and titled the Merchants Quay Health Promotion Unit Questionnaire. It had four sections looking at socio-demographic characteristics, substance use, injecting risk-behaviour and blood-borne viruses (BBVs). Having explained the purpose of the questionnaire and having obtained consent, MQI-trained staff collected the data on a one-to-one basis from clients aged over 18 years. Ethical considerations were given particular attention in view of the vulnerability of the respondents. The limitations of self-reporting and recall bias were recognised, particularly with relation to BBVs, which are not a measure of true prevalence, and the fact that respondents were current injectors with a myriad of affective symptoms.

The researchers interviewed 338 current drug users, 290 (86%) men and 48 (14%) women. The average age of respondents was 34 years, with 49% aged between 25

and 34 years. The respondents included 19 different nationalities but the majority were Irish (88%); 91% resided in the Dublin area; 47% lived in their own or rented accommodation, and 31% were categorised as homeless.

Of the 338 respondents, 329 (97%) were currently injecting drugs. Of the 329 current injectors, 163 (50%) reported injecting up to six times or more in the week prior to the study. Approximately three-quarters of the sample reported use of only one main injection site with 98 (30%) reporting injecting into either the groin or the neck. Sharing injecting equipment and paraphernalia in the last month was reported by 97 (29%) of participating injectors, 33 (10%) sharing syringes, 32 (10%) sharing cookers, 22 (7%) sharing needles, 43 (13%) sharing water, 39 (12%) sharing tourniquets, 24 (8%) sharing frontloading, 17 (5%) back-loading and 28 (9%) sharing filters. Table 6.2.1.4 summarises the responses given by participants regarding their BBV test results and whether they were receiving treatment at the time of the study.

Table 6.2.1.4 Reported BBV status, and treatment status, clients of MQI Health Promotion Unit–Needle Exchange (n=338), 2012

Blood-borne virus status (BBV)	Participants reported ever-tested status		Positive test results among participants who reported ever-tested status		Negative test results among participants who reported ever-tested status		Unknown test results among participants who reported ever-tested status		Participants declined to answer any questions relating to infection with BBV		Participants who reported testing positive who were receiving treatment	
	n	%	n	%	n	%	n	%	n	%	n	%
HIV	264	78	22	8	234	89	8	3	3	1	10	45
Hepatitis B	263	78	12	5	241	92	9	3	3	1	2	17
Hepatitis C	278	82	125	45	140	50	13	5	3	1	18	14
Hepatitis C + HIV	262	78	15	6								
Hepatitis B + Hepatitis C	262	78	8	3								
Hepatitis B + C + HIV	258	76	1	<1								

Source: (Jennings 2013)

Two hundred and sixty-four (78%) respondents reported having been tested for HIV at some point. Of those who reported being tested, 22 (8%) tested positive and 234 (89%) tested negative. Of those who reported testing negative and for whom data were available as to when they were last tested, the author stated that 45% (89/198) had not been retested within the past year despite being at risk of infection through injecting drug use. Only 10 (45%) of those who reported testing positive for HIV were receiving treatment.

Testing for hepatitis B at some point was reported by 263 (78%) respondents. Of those who reported being tested, 12 (5%) tested positive and 241 (92%) tested negative, nine (3%) did not know whether they had been ever tested or not and three (1%) declined to answer the question. Of those who reported testing negative and who could provide an estimate of when they were last tested for hepatitis B, 98/204 (48%) had not been retested within the past year despite being at risk of infection through injecting drug use. Only two (17%) of those who reported testing positive for Hepatitis B were receiving treatment.

Two hundred and seventy-eight (82%) respondents reported having been tested for hepatitis C. Of those who reported that they had been tested, 125 (45%) reported having tested positive, 140 (50%) reported testing negative, and 13 (5%) did not know

their hepatitis C status. Of those who reported testing negative for hepatitis C and for whom data were available as to when they were last tested, the author stated that 37% (42/112) had not been retested in the last year despite being at risk of infection through injecting drug use.

6.2.2 STI's and tuberculosis

The 2012 HPSC HIV Report data found that one (7.7%) of the 13 newly-diagnosed HIV cases among IDUs was co-infected with syphilis (Donnell, *et al.* 2013).

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

Characteristics, healthcare usage, morbidity and mortality of IDUs attending an inner city emergency department

A 2010 survey undertaken at an inner-city Dublin hospital's Accident & Emergency department with a high community prevalence of intravenous drug use concluded that injecting drug use had resulted in the emergence of a sub-group of people with a unique set of medical issues (O'Connor, *et al.* 2013). This prospective observational study over a three-month period (1 January 2010 to 31 March 2010) collected data on the characteristics of patients with a history of active injecting drug use presenting at the Accident & Emergency department. One hundred and forty-six patients with a history of injecting drugs were identified, contributing to 222 acute or emergency presentations. These patients were predominantly male, of Irish nationality, and displayed high levels of homelessness, unemployment and lack of stable family or intimate partner relationships. Forty-five per cent of these presentations occurred as a result of infection (95%, CI 38.5% to 51.5%). Trauma, pure toxicological issues, thromboembolic phenomena and psychiatric issues comprised the other common acute diagnoses.

The study found Gram-positive infection rates of 20% for Methicillin-sensitive *Staphylococcus aureus* (MSSA), 5% for Methicillin-resistant *Staphylococcus aureus* (MRSA), 7% for *CNS staphylococcus aureus*, 7% for pneumococcus, 4% for beta-haemolytic streptococcus and 4% for enterococcus. Gram-negative infections included candida (13%), *E. coli/coliforms* (11%) and *pseudomonas* (4%). The percentage of virulent Gram-positive organisms predominated over Gram-negative species in abscesses (44% to 32%) and in blood-stream infections (44% to 29%). The authors pointed to the need for more Gram-negative antibiotic prescribing in some current clinical practice.

The burden of co-morbid medical illness in the study cohort was substantial with high rates of hepatitis C infection (74%) and HIV infection (13.8%). Healthcare utilisation indices for this study cohort were found to be extremely high on multiple measures. The cohort had an attendance rate to the Accident and Emergency department of 445 visits per 100 patient-years, an admission rate to hospital of 69 per 100 patient-years and mortality rate of 4.9 per 100 patient-years. The study concluded that active IDUs presented with considerable acute and chronic medical consequences and high healthcare utilisation associated with their injecting drug use and its complications.

6.2.4 Behavioural data

There is no routine collection of behavioural data in Ireland. For the most recent information, see study presented in Section 6.2.3 and Table 6.2.3.2 of the 2011 National Report (Irish Focal Point (Reitox) 2011).

Dental health of residents in alcohol/drug abuse treatment centres

A cross-sectional observational study examined dental health among clients of Irish alcohol and drug use treatment centres (O'Sullivan, EM 2012a). The study examined the independent and combined impact of 'alcohol only' and 'alcohol plus drug' use on the dental health of the residents in the treatment centres and provided baseline data on dental health of individuals undergoing treatment for alcohol/drug use. Clients were visited monthly or bimonthly over 12 months between October 2006 and September 2007. A short semi-structured interview was followed by a comprehensive oral health examination.

Table 6.3.1 presents the participants' demographic and behavioural characteristics and dental status. Of the 203 participants, over half (111) used alcohol plus drugs, and 92 used alcohol only. The participants comprised 142 men and 61 women, and their ages ranged from 18 to 73 years, with 124 (59%) being under 40 years old. A statistically significant age difference was found between the 'alcohol only' users and the 'alcohol plus drugs' users, with the mean age of 'alcohol only' users being 47 years, and the mean age of 'alcohol plus drugs' users being 30 years. A statistically significant age difference was found between the 'alcohol only' users and the 'alcohol plus drugs' users.

Among the 'alcohol only' users, 81 (88%) self-reported their weekly alcohol consumption prior to admission as being either over 60 units per week, or described their habit as 'binge drinking'. Tobacco was used by 177 (87%) of participants but 'alcohol only' users were less likely to smoke tobacco than the 'alcohol plus drugs' users.

Table 6.3.1 Demographic and behavioural characteristics and dental status of treatment centre clients (n=203), by substance, 2006/2007

Variable	Alcohol only Users = 92 N (% of alcohol only users)	Alcohol + drugs Users = 111 N (% of alcohol + drugs users)
Male	59 (64)	83 (75)
Female	33 (36)	28 (25)
Mean age in years	47.2	30.2
Current smoker	71 (77)	106 (96)
Mean number of years of alcohol drinking	20.5	13.9
Alcohol preference		
Beer	65 (71)	96 (87)
Spirits	9 (10)	4 (4)
Wine	20 (21)	15 (14)
Regular mouthwash user	33 (36)	30 (27)
Regular dental attendee	33 (36)	35 (32)
Mean number of teeth present	22	27
Mean number of DMFT*		
Decayed teeth	2	2
Missing teeth	10	5
Filled teeth	6	4

Source: (O'Sullivan, EM 2012a)

* DMFT=Decayed/Missing/Filled Teeth

One hundred and nineteen (58%) participants had evidence of overt periodontal disease, the prevalence increasing with age from 22% among teenage participants to 74% among those aged 50--59 years; prevalence was not influenced by whether the participants used alcohol only or alcohol and drugs. Those with periodontal disease had poorer oral hygiene, fewer teeth and more decayed teeth. One hundred and twenty-three (87%) men and 42 (69%) women were in need of urgent dental treatment and extractions. More extractions were needed among infrequent dental attendees, heroin users and those with dental infection. The level of tooth loss among Irish alcohol and drug users was nearly five times that recorded for the general Irish population (Whelton, *et al.* 2007).

Higher levels of tooth decay were found among the alcohol and drug user group than among the alcohol-only user group, particularly men. The study found a high rate of dental disease among those suffering from alcohol and alcohol/drug use, suggesting a lack of meaningful engagement between alcohol/drug users and their dentists. The

multi-factorial nature of dental disease coupled with multiple substance use and high tobacco consumption makes research in this area challenging. Oral hygiene and tooth loss have an impact on overall health and well-being, and neglect will impact on population health, particularly in view of the growing problem with alcohol and drug use nationally. The authors concluded that the introduction of a state-funded scheme to provide basic dental treatment in residential centres should be considered from a public health perspective and in the interests of ultimately reducing overall healthcare costs.

6.3 Other drug-related health correlates and consequences

6.3.1 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 2011. There were 4,254 overdose cases in that year, of which 34 died in hospital. The 4,220 discharged cases are included in this analysis. The number of overdose cases decreased by 6% between 2010 and 2011. Trends over time indicate a decrease in overdose cases admitted to Irish hospitals every year, falling from 5,012 cases in 2005 to 4,254 cases in 2011, 758 fewer cases over the seven years of data collection (Figure 6.3.1.1).

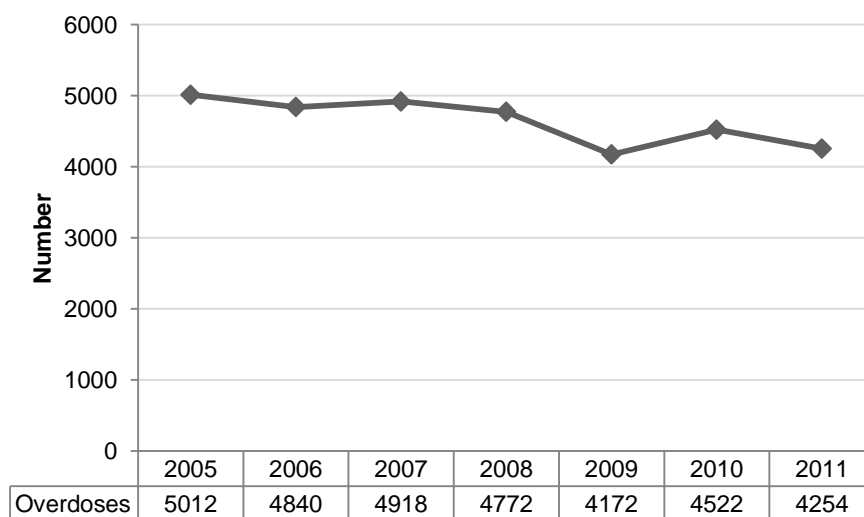


Figure 6.3.1.1 Overdose cases admitted to Irish hospitals, 2005–2011 (N=32,490)

Source: Unpublished HIPE data

Gender

Between 2005 and 2011 there were more overdose cases among women than among men, with women accounting for 2,305 (54%) of all overdose cases in 2011 (Figure 6.3.1.2).

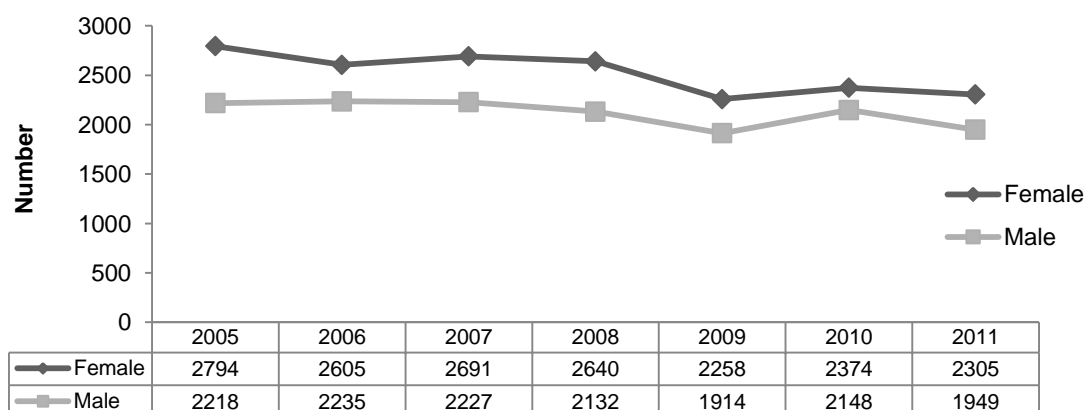


Figure 6.3.1.2 Overdose cases admitted to Irish hospitals, by gender, 2005–2011 (N=32,490)

Source: Unpublished HIPE data

Age group

There were 117 fewer overdoses in 2011 compared to 2010 among those aged 15–24 years, and 140 fewer overdose cases among those aged under 25 years in 2011 than in 2010, with the incidence of overdose decreasing with age. However, in 2011 the incidence increased by 14 in age groups 45–54 and 55–64 years in 2011 compared to 2010. Trends over time show that in 2005, 40% of cases were aged less than 25 years, compared to 33% in 2011, and overdose cases admitted to Irish hospitals decreased by 15%, falling from 5,012 in 2005 to 4,254 in 2011.

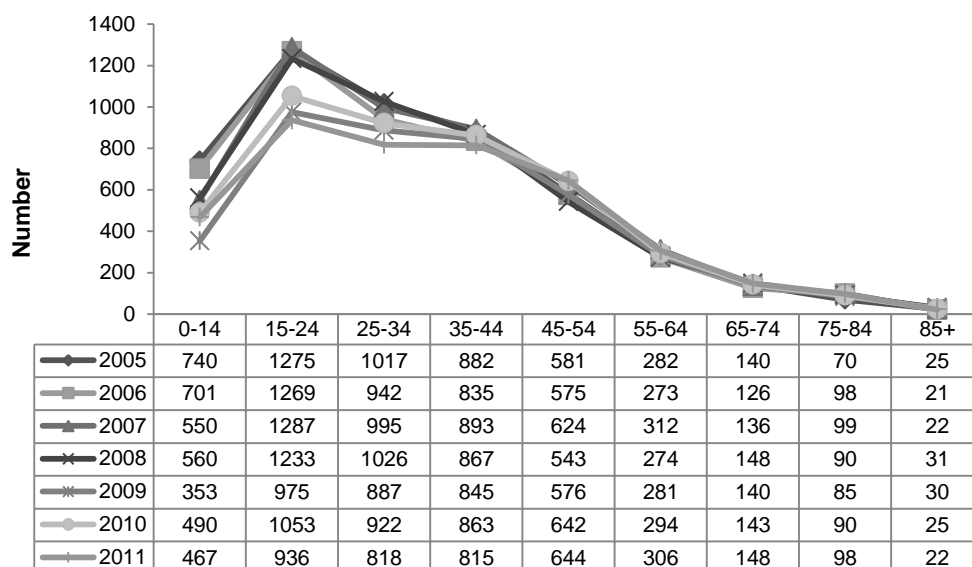


Figure 6.3.1.3 Overdose cases admitted to Irish hospitals, by age group, 2005–2011 (N=32,490)

Source: Unpublished HIPE data

Area of residence

In 2011, 1,059 (25%) of overdose cases occurred among persons resident in Dublin (city and county), 3,177 (75%) among persons resident outside Dublin, and 27 (0.6%) among persons recorded as of 'no fixed abode' or resident outside Ireland.

Drugs involved

Table 6.3.1.1 presents the positive findings per category of drugs and other substances involved in all cases of overdose in 2011. Non-opioid analgesics were present in 1,336 (31%) cases. Paracetamol is included in this drug category and was present in 806 (19%) of cases. Psychotropic agents were taken in 973 (23%) and benzodiazepines in 960 (22%) cases. There was evidence of alcohol consumption in 518 (12%) 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 Categories of drugs involved in overdose cases admitted to Irish hospitals, 2011 (N=4,254)*

Drug category	Positive findings per drug category*	
	n	%
Non-opioid analgesics	1336	31.4
Benzodiazepines	960	22.6
Psychotropic agents	973	22.9
Antiepileptic / Sedative / Antiparkinson agents	540	12.7
Narcotics and hallucinogens	539	12.7
Alcohol	518	12.2
Systemic and haematological agents	149	3.5
Cardiovascular agents	137	3.2
Autonomic nervous system	55	1.3
Anaesthetics	65	1.5

Drug category	Positive findings per drug category*	
Hormones	54	1.3
Systemic antibiotics	79	1.9
Gastrointestinal agents	71	1.7
Other chemicals and noxious substance	259	6.1
Diuretics	53	1.2
Muscle and respiratory agents	27	0.6
Topical agents	31	0.7
Anti-infectives / Anti-parasitics	19	0.4
Other gases and vapours	45	1.1
Other and unspecified drugs	924	21.7

*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

Overdoses involving narcotics or hallucinogens

Narcotic or hallucinogenic drugs were involved in 580 (14%) of overdose cases in 2011. Figure 6.3.1.4 shows the number of positive findings of narcotics or hallucinogens drugs among the 580 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 445 (80%) cases, cocaine in 82 (15%) and cannabis in 46 (8.5%) cases. 46 (8.5%) cases.

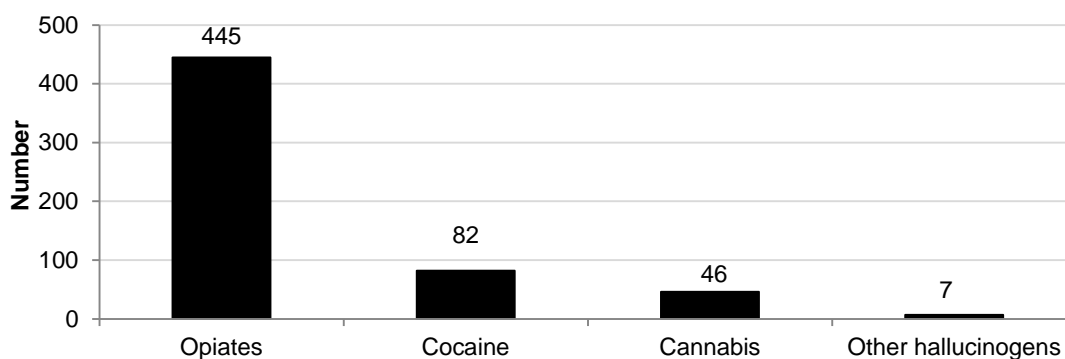


Figure 6.3.1.4 Narcotics and hallucinogens involved in overdose cases admitted to Irish hospitals, 2011 (N=580)

Source: Unpublished data from HIPE

Overdoses classified by intent

In 2,773 (66%) cases the overdose was classified as intentional (Figure 6.3.1.5). For 56 cases, there was no classification of intent recorded and for 24 cases two intent classifications were recorded. These 80 cases were not included in the analysis.

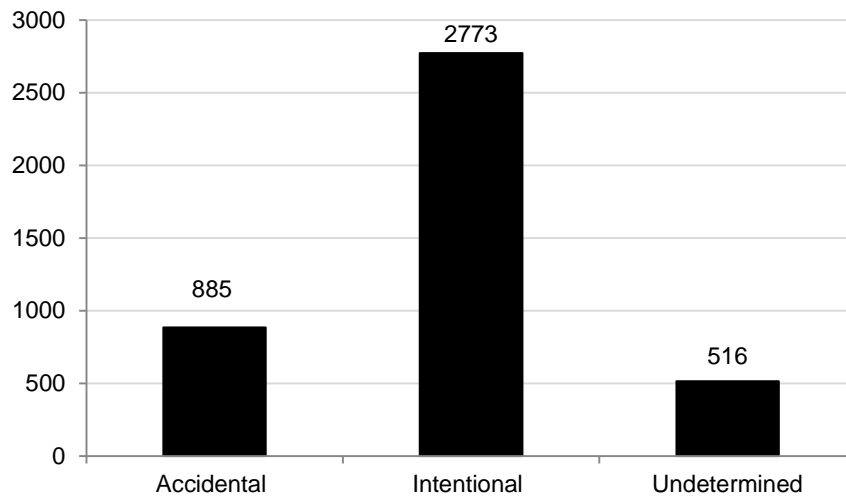


Figure 6.3.1.5 Number of overdose cases admitted to Irish hospitals, by classification, 2011 (N= 4,174)

Source: Unpublished data from HIPE

Table 6.3.1.2 presents the positive findings per category of drugs and other substances involved in the 2,773 cases of intentional overdose in 2011. Non-opioid analgesics were involved in 1,053 (38%) cases, benzodiazepines in 717 (26%) and psychotropic agents in 783 (28%) cases.

Table 6.3.1.2 Categories of drugs involved in intentional overdose cases admitted to Irish hospitals (n = 2,773), 2011

Drug category	Number	%
Nonopioid analgesics	1053	38.0
Benzodiazepines	717	25.9
Psychotropic	783	28.2
Antiepileptic/Sedative/Antiparkinson	450	16.2
Alcohol	343	12.4
Narcotics and hallucinogens	288	10.3
Cardiovascular	89	3.2
Systemic and haematological	91	3.3
Other chemicals and noxious substance	87	3.1
Hormones	37	1.3
Autonomic nervous system	33	1.2
Systemic antibiotics	60	2.2
Gastrointestinal	53	1.9
Anaesthetics	18	.6
Diuretics	28	1.0
Muscle and respiratory	7	.3
Antiinfectives/antiparasitics	11	.4
Topical agents	7	.3
Other gases and vapours	0	.0
Other and Unspecified Drugs	235	8.5
Total cases	4390	100

*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

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

Antidepressant use and suicide in Europe

An ecological, naturalistic multi-national (29 European countries) study analysed the trends over a 14-year period, from 1996 to 2009, in the use of antidepressants and rates of suicide, adjusting for gross domestic product, alcohol consumption, unemployment and divorce. It also examined whether any reduction in the rate of suicide preceded any trend towards increased use of antidepressants (Gusmao, *et al.* 2013).

Data on the defined daily dosage (DDD) for adults for antidepressants were analysed, giving an estimate of use of these drugs and the proportion of the population receiving treatment with a particular antidepressant on a daily basis. The DDD of a drug for adults is determined by an independent scientific committee making use of the WHO Collaborating Centre for Drug Statistics Methodology. Data on the DDD per thousand individuals per day (DDD/1000/day) for antidepressants were used in the analysis. These data provide a rough estimate of use of these drugs and the proportion of the population receiving treatment with a particular antidepressant on a daily basis. In order to maximise time series data on antidepressant use in each country between 1996 and 2009, other data sources were used: IMS Health (www.imshealth.com), Organisation for Economic Co-operation and Development (OECD) pharmacy sales, national statistical offices and published literature. The quantities of antidepressants sold, as recorded in the IMS database, were converted into kilograms of active ingredient in order to establish the total quantity of defined daily dosage (DDD) sold. This figure was then divided by the country mid-year resident population in order to obtain a global DDD/1000/day. Ireland's DDD/1000/day for antidepressants, calculated using IMS data available for the 14-year period, was found to have almost trebled between 1996 (17.96) and 2009 (55.51). Annual suicide standard death rate (SDR) data were available for 30 years (1980–2009) and showed that the suicide SDR in Ireland in 1980 was 7.69 and 11.61 in 2009, a difference of 3.92. The SDR was highest between 1985 and 1990 at 21.

An inverse correlation (as antidepressant use increased, suicide rates decreased) was observed in all but one country between the antidepressant DDD/1000/day and the recorded SDR for suicide. Portugal was the country where there was a positive correlation between anti-depressant DDD/1000/day and suicide SDR. This might be explained by the lack of precision of Portugal's suicide register and over-estimation of undetermined violent deaths concealing suicides. There was also an inverse correlation with GDP, with the exception of Ireland, Poland and Spain. There was a consistent direction and magnitude of correlation between antidepressant DDD/1000/day and GDP in all of the 29 countries. No strong patterns were seen in respect of the suicide SDR and alcohol consumption, unemployment or divorce.

In Ireland, the sharp increase in antidepressant DDD/1000/day was not associated with a similar decrease in the suicide SDR as in other countries. The authors suggested that this might be explained by the fact that in Ireland suicide is more frequent among young and middle-aged men who typically present an unfavourable help-seeking behaviour (Moller-Leimkuhler 2000). The authors (Gusmao, *et al.* 2013) stated that, while the study could not depict causal links and results should be interpreted with caution, the effectiveness and potential cost-effectiveness of antidepressants as an intervention for suicide prevention should be considered. The findings underline the importance of the appropriate use of antidepressants as part of routine care for people diagnosed with depression.

Drug admissions to psychiatric facilities, 2011

Activities of Irish psychiatric units and hospitals 2011, the annual report published by the Mental Health Information Systems Unit of the Health Research Board (Daly and Walsh 2012), shows that there were 839 admissions to Irish psychiatric units and hospitals in 2011 of cases with a drug disorder (ICD-10 Code F11–19, F55), of whom 352 (42%) were treated for the first time. This represents a reduction of 127 first-ever admissions for drug disorders since 2010, which is a rate of 7.7 per 100,000 total population, down from 9.7 per 100,000 in 2010 (Figure 6.3.2.1). It should be borne in

mind that admissions and discharges represent episodes or events rather than persons.

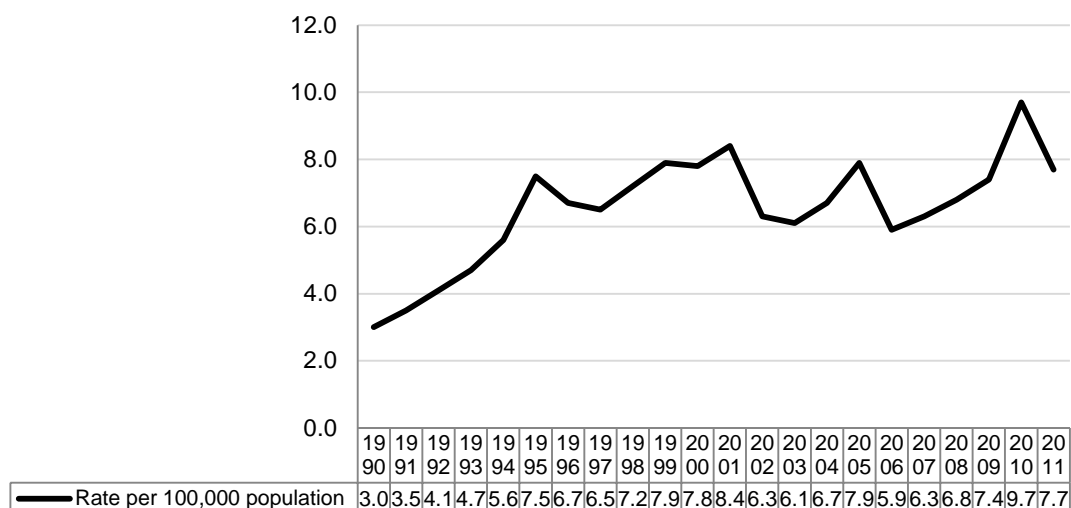


Figure 6.3.2.1 Rate of first admission of psychiatric cases with a diagnosis of drug disorder (using ICD-10 three character categories) per 100,000 of the population in Ireland, NPIRS, 1990–2011

Source: Annual reports from the National Psychiatric In patient Reporting System (NPIRS), 1990–2011

Two hundred and three (58%) first-ever admissions of cases with a drug disorder were to psychiatric units in general hospitals, followed by 98 (28%) admissions to psychiatric hospitals, and 51 admissions (14%) to private hospitals and charitable centres. There were 15 child and adolescent admissions for drug disorders, of which eight were first-ever admissions. Of these first-ever admissions, seven were voluntary and one was involuntary.

Five hundred and eighty-two (69%) cases hospitalised for a drug disorder were discharged within two weeks.

Substance use and psychiatric disorders in Irish adolescents

In line with the Mental Health Act 2001, Ireland’s substance use treatment services are established separately from mental health services as mental illness is not considered to include substance use disorder (SUD). Substance use disorder and psychiatric disorders often co-exist and are regarded as dual diagnosis, co-morbidity or co-occurring disorders (CODs). International research suggests that the high level of psychiatric co-morbidity among adolescents with SUD is the rule rather than the exception (Deas 2006).

In light of research findings, early intervention and prevention of CODs are emphasised in international research. However, there is a paucity of Irish research on CODs. The Youth Drug and Alcohol Service (YoDA), located in Tallaght in west Dublin, provides assistance and expert treatment to under-18s living in Dublin South-West and Dublin South City, who are having problems related to their drug or alcohol use. It is the largest outpatient adolescent substance use treatment programme in Dublin. A recent cross-sectional retrospective review of admissions to the service examined patterns of psychiatric disorders among SUDs and explored possible gender differences (James, *et al.* 2013). The researcher reviewed 144 admission assessments of adolescents made during an 18-month period from January 2010 to June 2011. The review found that 118 (82%) of those attending were male, with a median age of 16 years (range 13–19 years) (Table 6.3.2.4).

Table 6.3.2.4: Profile of clients of Youth Drug and Alcohol Service (YoDA), West Dublin, (N = 144), January 2010–June 2011

	n	%
Gender		
male	118	81.9
female	26	18.1

	n	%
Living Arrangements		
parent(s)	111	77.1
other relatives	5	3.5
In-care	24	16.7
others	4	2.8
Education/Employment status		
paid employment	5	3.5
unemployed	55	38.2
alternative education	22	15.3
mainstream education	61	42.4
unknown	1	0.7
Main substance of abuse		
alcohol	33	22.9
cannabis	89	61.8
cocaine	4	2.8
heroin	3	2.1
ecstasy/speed	1	0.7
anxiolytics/hypnotics	11	7.6
legal highs	3	2.1
Referral source		
self	4	2.8
family	55	38.2
addiction services	2	1.4
general practice	1	0.7
emergency units	4	2.8
social work department	35	24.3
criminal justice department	24	16.7
youth outreach services	2	1.4
schools	7	4.9
mental health services	8	5.6
Criminal history		
none	30	20.8
cautions	10	6.9
has juvenile liaison officers	52	36.1
charges	51	35.4
unknown	1	0.7

Source: (James, *et al.* 2013)

The number with a pre-existing psychiatric diagnosis was 55 (38%). Nineteen (13%) received a psychiatric diagnosis following entry to YoDA and 70 (49%) had received a psychiatric diagnosis at some point in their lives. The most common psychiatric diagnosis was deliberate self-harm (DSH) (39, 27%), followed by Attention Deficit Hyperactivity Disorder (ADHD) (30, 21%) (Table 6.3.2.5).

Only one in 25 participants had a diagnosis of conduct disorder (CD) but the authors noted that CD is probably under-diagnosed among Irish substance-using adolescents. While the study examined lifetime psychiatric diagnoses using a retrospective review of clinical data, it is possible that mental health problems below the threshold of clinical diagnoses may have been under-estimated.

The conclusion was that one in every two Irish adolescents with SUD had a history of psychiatric disorder or serious mental health problems during their lifetime and girls were more likely to have psychiatric disorders than boys. The authors stated that adolescent substance treatment services should have staff equipped with the skills to access and manage co-occurring psychiatric problem

Table 6.3.2.5: Psychiatric disorders among YoDA clients, by gender, (N = 144), January 2010–June 2011

	Boys N (%)	Girls N (%)	Total Sample N (%)	Odds Ratio (95%CI)	p value
<i>Psychiatric disorders (incl. DSH)</i>	51 (43.2)	19 (73.1)	70 (48.6)	0.3 (0.1-0.7)	0.006
Pre-existing	42	13	55		

	Boys N (%)	Girls N (%)	Total Sample N (%)	Odds Ratio (95%CI)	p value
	(35.6)	(50.0)	(38.2)		
YoDA- diagnosed	13 (11.0)	6 (23.1)	19 (13.2)		
<i>Psychiatric diagnoses (excl. DSH)</i>	43 (36.4)	13 (50.0)	56 (38.9)	0.6 (0.2-1.3)	0.19
Pre- existing	38 (32.2)	12 (46.2)	50 (34.7)		
YoDA- diagnosed	7 (5.9)	1 (3.8)	8 (5.6)		
<i>ADHD</i>	26 (22.0)	4 (15.4)	30 (20.8)	1.6 (0.5-4.9)	0.45
Pre- existing	23 (19.5)	4 (15.4)	27 (18.8)		
YoDA- diagnosed	3 (2.5)	0 (0)	3 (2.1)		
<i>Depression</i>	8 (6.8)	7 (26.9)	15 (10.4)	0.2 (0.1-0.6)	0.002
Pre- existing	7 (5.9)	6 (23.1)	13 (9.0)		
YoDA- diagnosed	1 (0.8)	1 (3.8)	2 (1.4)		
<i>Psychosis</i>	6 (5.1)	1 (3.8)	7 (4.9)	1.3 (0.2- 11.6)	0.79
Pre- existing	5 (4.2)	1 (3.8)	6 (4.2)		
YoDA- diagnosed	1 (0.8)	0 (0)	1 (0.7)		
<i>Conduct Disorder</i>	4 (3.4)	1 (3.8)	5 (3.5)	0.9 (0.1-8.2)	0.91
Pre- existing	3 (2.5)	1 (3.8)	4 (2.8)		
YoDA- diagnosed	1 (0.8)	0 (0)	1 (0.7)		
<i>Oppositional Defiant Disorder</i>	5 (4.2)	1 (3.8)	6 (4.2)	1.1 (0.1-9.8)	0.93
Pre- existing	5 (4.2)	1 (3.8)	6 (4.2)		
YoDA- diagnosed	0 (0)	0 (0)	0 (0)		
<i>Asperger's Syndrome</i>	3 (2.5)	0 (0)	3 (2.1)	n/a	
Pre- existing	3 (2.5)	0 (0)	3 (2.1)		
YoDA- diagnosed	0 (0)	0 (0)	0 (0)		
<i>Anxiety Disorder</i>	5 (4.2)	3 (11.5)	8 (5.6)	0.3 (0.1-1.5)	0.14
Pre- existing	5 (4.2)	3 (11.5)	8 (5.6)		
YoDA- diagnosed	0 (0)	0 (0)	0 (0)		

	Boys N (%)	Girls N (%)	Total Sample N (%)	Odds Ratio (95%CI)	p value
<i>Attachment Disorder</i>	2 (1.7)	0 (0)	2 (1.4)	n/a	
Pre-existing	2 (1.7)	0 (0)	2 (1.4)		
YoDA-diagnosed	0 (0)	0 (0)	0 (0)		
<i>Tourette's Syndrome</i>	1 (0.8)	0 (0)	1 (0.7)	n/a	
Pre-existing	1 (0.8)	0 (0)	1 (0.7)		
YoDA-diagnosed	0 (0)	0 (0)	0 (0)		
<i>Eating Disorder</i>	0 (0)	1 (3.8)	1 (0.7)	n/a	
Pre-existing	0 (0)	1 (3.8)	1 (0.7)		
YoDA-diagnosed	0 (0)	0 (0)	0 (0)		
<i>Adjustment Disorder</i>	1 (0.8)	1 (3.8)	2 (1.4)	0.2 (0.1-3.5)	0.23
Pre-existing	0 (0)	1 (3.8)	1 (0.7)		
YoDA-diagnosed	1 (0.8)	0 (0)	1 (0.7)		
<i>Deliberate Self-Harm (DSH)</i>	24 (20.3)	15 (57.7)	39 (27.1)	0.2 (0.1-0.5)	0.001
Pre-existing	17 (14.4)	9 (34.6)	26 (18.1)		
YoDA-diagnosed	7 (5.9)	6 (23.1)	13 (9.0)		

n/a – odd ratios not calculable

Attention-deficit hyperactivity disorder (ADHD) in adults attending addiction treatment

The International ADHD in Substance Use Disorders Prevalence (IASP) study is directed by the International Collaboration on ADHD and Substance Abuse (ICASA) network and is a multi-site study. Eight European countries (Norway, Sweden, the Netherlands, Belgium, France, Spain, Switzerland and Hungary), the USA and Australia participated in Phase I of the study, which closed in September 2011. Over 2,500 substance use disorder (SUD) patients were sampled, with approximately 38% scoring positive on the ADHD Symptoms Rating Scale (ASRS). Of these 2,500 patients, over 1,000 were evaluated for ADHD, depression, bipolar disorder, anti-social personality and borderline personality disorder. A preliminary estimate of the prevalence of ADHD in SUD-treatment-seeking patients was recorded at 20% (Van den Brink 2012).

Phase II of the IASP study started in September 2011 in Ireland, South Africa, Egypt and Brazil. A research team based in the School of Health Sciences at Waterford Institute of Technology undertook the Irish part of the study (Van Hout and Foley 2013). Following in-depth IASP protocol training, the researchers invited 47 new treatment cases presenting to four treatment settings in the south-east region of Ireland to participate in the IASP study.

There were 34 males and 13 females and the median age was 36 years. Seventeen were engaged in treatment for problematic poly-substance use, 14 for problematic alcohol use, 14 for problematic drug use and two were undefined. A total of 10 (21%) participants screened positive for ADHD using the Adult ADHD Symptoms Rating Scale (ASRS–v1.1) at time one (1st screening), and this reduced to six (12.7%) at time two (2nd screening). These six were all young men, with a median age of 23 years. None of the 10 participants identified at time one screening had been diagnosed in childhood. They were all being treated for problematic drug use, not for problematic alcohol use. These findings support the usefulness and cost-effectiveness of ASRS to detect ADHD co–morbidity in SUD patients in addiction treatment settings. The authors stated that the prevalence of ADHD in SUD patients in Ireland remains unknown but the economic and public health burden of SUDs is compounded by the presence of ADHD.

Echoing the recommendations of the report on a retrospective study of admissions to the Youth Drug and Alcohol Service (YoDA), described just above (James, *et al.* 2013), the authors (Van Hout and Foley 2013) suggested that a timely diagnosis would impact on treatment outcomes and that combined pharmacological and psychosocial interventions coupled with specialist mental health teams are central to the treatment success for co-morbid adults with ADHD and SUD.

Ultra-high risk (UHR) of psychosis on committal to a young offender prison

In 2012, the first Irish study to report on rates of psychosis in the ultra-high risk (UHR) state for psychosis in a young offender population was published (Flynn, *et al.* 2012) The aim of the study was to provide evidence to enable the efficient allocation of a limited mental health resource in identifying and treating the most serious mental disorders carrying the highest healthcare burden.

It was a cross-sectional study of young male offenders only, using the Comprehensive Assessment of At-Risk Mental States (CAARMS), the Social and Occupational Functioning Scale (SOFAS) and the Developmental Understanding of Drug Misuse and Dependence (DUNDRUM-DS), which assesses the severity of use of a range of intoxicants on four levels. It was the first study to use the CAARMS to identify the prevalence of UHR psychosis among young offenders.

Data were collected over a 52-week period (June 2011–May 2012) in St Patrick’s Institution in Dublin, which is a young offender institution with 217 beds. At the time of the study it was the only prison accepting males aged 16 to 20 in the state (population 4.6 million). Every third person committed was interviewed and the final number of participants interviewed was 171. Individuals were excluded if they had a previous committal. All those selected were seen within seven days of reception, screened by a prison nurse within six hours of reception and seen by a GP within 24 hours and then had a detailed assessment by visiting psychiatrists.

The results showed that the average age of the study participants was 18.2 years and all were under 20 years old (Table 6.3.2.6). The mean time from reception to interview by the psychiatrists was 4.1 days. Of the 171 interviewed, 39 (23%) met the criteria for UHR, five (3.5%) met the criteria for vulnerability only, nine (5%) met the criteria for vulnerability and attenuated psychosis, 19 (11%) met the criteria for attenuated psychosis only, and one (0.6%) met the criteria for attenuated psychosis and brief limited intermittent psychosis (BLIPS). Two (1.2%) met the criteria for BLIPS and one (0.6%) met the criteria for both vulnerability and psychosis. UHR was not evenly distributed according to age, with the highest rate among 18-year-olds. This was not related to legal status as it occurred in 23.2% of those on remand and 22.5% of those committed.

Table 6.3.2.6 Ultra-high risk of psychosis among those on committal to a young offender prison, by age, 2011/2012

Age (years)	16	17	18	19	20	All
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Number on committal	22	40	28	50	31	171
CAARMS positive	1 (4.5%)	10 (25%)	10 (35.7%)	11 (22%)	7 (22.6%)	39 (22.8%)

Source: (Flynn, *et al.* 2012)

Substance use problems were reported by 146 of those interviewed (85%) and associated with progressively lower SOFAS scores. The number of new committals to the young offender institution who met the criteria for UHR of psychosis was 39 (23%) and was associated with an increasing number of substance use problems and lower SOFAS scores, suggesting that the UHR state identified in this study was associated with meaningful impairments. There was a significant relationship between UHR status and number of substance use problems (range 0 to 7, $\chi^2=32.6, df=7, p < 0.001$; linear by linear association $=22.9, df=1, p, 0.001$). Table 6.3.2.7 outlines the number of substance use problems and UHR status.

Table 6.3.2. 7 Number of substance use problems and UHR status among those on committal to a young offender prison, 2011/2012

Number of substance use problems	CAARMS status		Total
	Negative N (% of row)	Positive N (% of row)	Total N
0	23 (89%)	3 (11%)	26
1	36 (84%)	7 (16%)	43
2	29 (91%)	3 (9%)	32
3	18 (86%)	3 (19%)	21
4	17 (71%)	7 (29%)	24
5	6 (40%)	6 (60%)	15
6	2 (40%)	3 (60%)	5
7	1 (20%)	4 (80%)	5
Total	132	39	171

Source: (Flynn, *et al.* 2012)

6.4 Drug-related deaths and mortality of drug users

6.4.1 Drug-induced deaths (overdoses/poisonings)

The National Drug-Related Death Index (NDRDI) publishes national figures on drug-related deaths (Health Research Board 2013). This comprises all deaths owing to poisonings, including both illicit drugs covered by Section D, and also other drugs such as alcohol and prescription medication not reported in Standard Table 6.

In 2011, there were 220 deaths owing to poisoning recorded in Ireland by the National Drug-Related Deaths Index (NDRDI) as per Selection D. This represents a substantial increase compared to 2010, when 173 such deaths were recorded (Table 6.4.1.1; see also Standard Tables 5 and 6). It should be noted that annual data previously reported have been changed as the database has been updated as new information has become available.

Table 6.4.1.1 Poisonings (Selection D) by year, NDRDI, 2002–2011

	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Selection D	127	108	128	171	189	208	215	217	173	220

Source: Unpublished data, NDRDI

Overall, the mean age of those who died owing to poisoning remained stable compared to previous years at 35.6 years (see Standard Table 6).

Two factors appear to have been influencing the increase in deaths, although more in-depth analysis is required to fully understand and explain the increase. Firstly, while opiates continue to be associated with most poisoning deaths (87.3%), almost three quarters of deaths owing to poisoning (74.5%) involved more than one drug, a higher proportion than reported in all previous years. Secondly, a rise has been observed in

the number of deaths where methadone was implicated (either alone or with another drug). In 2011, there were 113 deaths where methadone was implicated (either alone or with another drug) compared to 60 in 2010.

The reason for the increase in the number of deaths where methadone was implicated (alone or in conjunction with another drug) is not yet clear. The methodology of data collection for the NDRDI did not change during that time period. However, the same trend was seen in Scotland in 2010/2011, with a big jump being recorded in the number of deaths related to methadone (General Register Office for Scotland 2013, National records of Scotland 2013). Further investigation and analysis is needed to try to ascertain the reasons behind this finding.

In contrast, the number of deaths where heroin was implicated (alone or with another drug or substance) dropped for the third consecutive year, from a peak of 115 in 2009 to 61 in 2011. In 2010, heroin or unspecified opiates alone accounted for 23.7% of all deaths owing to poisoning but in 2011 this category only accounted for 9.1% of all deaths.

In late December 2010 there was a well-documented heroin drought, which continued until early 2011 (Health Research Board 2012). Data from the NDRDI show that there was a reduction in the number of heroin-related deaths in December 2010 and January 2011 compared to the same months in previous years. However, after January 2011 the number of heroin-related deaths fluctuated, with no discernible monthly trend apart from an overall decrease in the annual number of deaths. A reduction in the number of heroin seizures was recorded again in 2011, but it cannot be ascertained if it is this that is influencing the downward trend in heroin-related deaths (Health Research Board 2012). The reduction in seizures may be owing to a number of inter-related complex factors including a reduction in heroin use, a change in law enforcement activities or other factors as yet unknown. This trend was also seen in the Scottish data for 2010/2011 (General Register Office for Scotland 2013) (National records of Scotland 2013).

The decrease in the number of deaths where cocaine was implicated (either alone or with another drug or substance) was sustained in 2011, at 23 compared to 21 in 2010.

There was an increase in the number of deaths owing to poisoning which involved more than one drug, a higher proportion than reported in all previous years. Benzodiazepines, alcohol, antidepressants, and other over-the-counter medications were among the main drugs implicated in poly-substance poisonings. The biggest increases were among benzodiazepine drugs. For example, the number of deaths where diazepam was implicated (along with another drugs) increased to 109 in 2011 compared to 54 in 2010.

In the seven-year period 2004–2010, a total of 3,972 deaths by drug poisoning and deaths among drug users met the criteria for inclusion in the NDRDI database. Of these deaths, 2,364 were due to poisoning and 1,608 were due to traumatic or medical causes (non-poisoning) (Table 6.4.1.2). The annual number of poisoning deaths increased from 267 in 2004 to 388 in 2007, but decreased in subsequent years, to a total of 323 in 2010. This appears to reflect a downward trend in the number of drug-related deaths in Europe in 2009 and 2010. As in all previous years, males accounted for the majority of deaths (74% in 2010). The majority were aged between 20 and 44 years; the median age was 40 years.

Table 6.4.1.2 Number of deaths, by year, NDRDI 2004–2010 (N=3,972)

	2004	2005	2006	2007	2008	2009	2010
All deaths	431	501	561	628	624	652	575
Poisoning (n=2,364)	267	300	326	388	386	374	323
Non-poisoning (n=1,608)	164	201	235	240	238	278	252

Source: (Health Research Board 2013)

Just over half (52%) of all poisoning deaths involved more than one substance (poly-substance cases) (Table 6.4.1.3). Alcohol alone was responsible for 24% of all deaths in 2010.

Table 6.4.1.3 Combinations of drugs involved in poisoning deaths, NDRDI 2004–2010 (N=2,364)

	2004	2005	2006	2007	2008	2009	2010
All poisoning deaths	267	300	326	388	386	374	323
Single substances							
Alcohol alone	61	51	54	86	81	61	76
Opiates alone	33	34	53	54	54	60	46
Analgesic (including an analgesic containing an opiate compound)	22	24	16	6	10	10	7
All other specified single substances	36	58	67	65	51	57	38
Poly-substances							
Poly-substances (including opiates such as heroin, methadone)	41	64	80	91	120	121	91
Poly-substances (including analgesics containing an opiate compound)	28	31	15	16	11	14	20
Poly-substances (excluding opiates)	35	29	26	58	50	34	32
Psychoactive medication with alcohol	11	9	15	12	9	17	13

Source : (Health Research Board 2013)

In 2010 the number of deaths in which heroin was implicated decreased by 39%, to 70 compared to 115 in 2009 (Table 6.4.1.4). The well-documented heroin drought in Ireland in December 2010 and the early part of 2011 may well have been a factor in this reduction (Stokes 2012), (Health Research Board 2012). However, further analysis of the data and trends in 2011 deaths needs to be undertaken before the full impact of that event can be understood.

Since 2007 there has been a 70% decrease in the number of deaths where cocaine was implicated, with 20 deaths in 2010 compared to 66 in 2007. This again reflects a downward trend in the number of cocaine-related deaths in some European countries. Alcohol was involved in 46% of all poisoning deaths in 2010, more than any other drug. Benzodiazepines, which include diazepam and flurazepam, were the second most common drug group implicated in poisoning deaths.

Table 6.4.1.4 All drugs involved in poisoning deaths, NDRDI 2004–2010 (N=2,364)

	2004	2005	2006	2007	2008	2009	2010	% Total
All deaths*	267	300	326	388	386	374	323	100
Alcohol	125	116	111	173	155	142	147	41.0
Heroin	29	47	68	80	91	115	70	21.2
Methadone	40	43	61	55	80	69	56	17.1
Other opiate [†]	62	69	55	54	47	52	51	16.5
Cocaine	19	36	53	66	60	53	20	13.0
MDMA	13	10	7	19	7	~	~	2.5
Diazepam	31	41	64	61	66	80	60	17.0

	2004	2005	2006	2007	2008	2009	2010	% Total
Other benzodiazepine	28	25	29	42	38	30	31	9.4
Flurazepam	18	13	23	21	20	24	22	6.0
Other prescription medication [§]	42	37	39	61	62	59	71	15.7
Antidepressant	54	53	43	48	85	67	62	17.4
Non-opiate analgesic	13	23	12	19	18	16	14	4.9
Other [†]	9	22	21	25	31	50	36	8.2

Source : (Health Research Board 2013)

*This is a multi-response table taking account of illicit use of up to six drugs. Therefore numbers and percentages in columns may not add

up to totals shown, as individual cases may use more than one drug or substance.

† Includes morphine, codeine, unspecified opiate-type drug, other opiate analgesic.

§ Includes non-benzodiazepine sedatives, anti-psychotics, cardiac and all other types of over-the-counter medication.

‡ includes solvents, insecticides, herbicides, other amphetamines, hallucinogens, head shop drugs and other chemicals.

~ Less than five cases.

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

Currently there are no mortality cohort studies under way. For the most recent research on mortality among drug users, a 25-year longitudinal study of a cohort of injecting drug users in inner-city Dublin, see Section 6.2.1 of the 2012 National Report (Health Research Board 2012).

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

Deaths among drug users, 2004–2010

In the seven-year period 2004–2010 a total of 1,608 non-poisoning deaths among drug users met the criteria for inclusion in the NDRDI database (Table 6.4.1.1). The number of non-poisoning deaths decreased slightly to 252 in 2010, compared to 278 in 2009. It was possible to categorise 243 of the non-poisoning deaths in 2010 as being due to either trauma or medical causes (Figure 6.4.3.1).

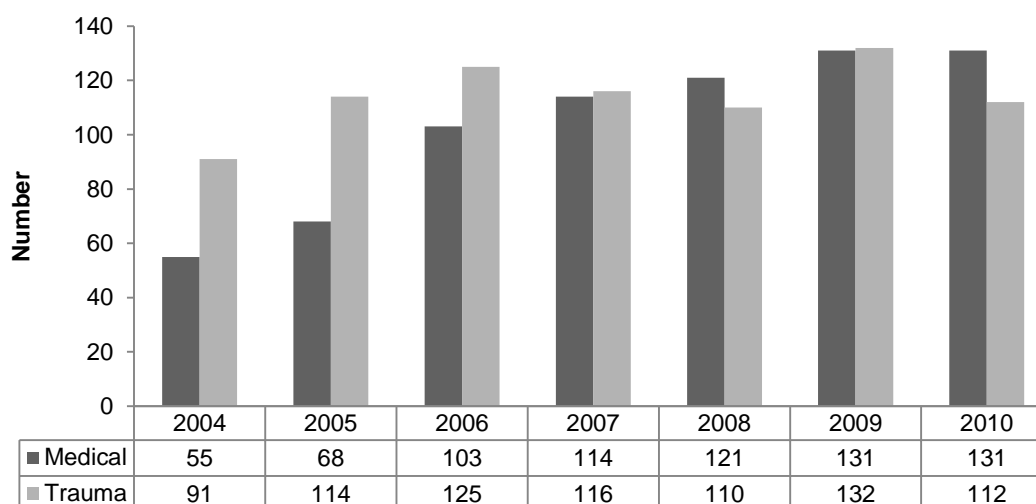


Figure 6.4.1.1 Non-poisoning deaths among drug users, NDRDI 2004–2010 (N=1,523)

Source: (Health Research Board 2013)

The number of deaths owing to trauma decreased to 112 in 2010, down from 132 in 2009 (Figure 6.4.1.1). The majority (68%) of those who died were aged under 39 years. The median age was 33 years. As in previous years, the majority were male (78% in 2010) (Health Research Board 2012). The most common causes of death due to trauma were hanging (44%) and drowning (12%).

The number of deaths owing to medical causes remained stable in 2010. However, the numbers have risen steadily over the reporting period, increasing from 55 in 2004 to 131 in both 2009 and 2010 (Figure 6.4.1.1). The majority (63%) of those who died from medical causes were aged between 30 and 49 years. The median age was 43 years. Males accounted for 76% of those who died. The most common medical causes of death were cardiac events (26%) and respiratory problems (12%).

Mortality among injecting drug users

A study carried out in a large Accident & Emergency department in Dublin found a mortality rate of 4.86 per 100 patient-years among a cohort 146 patients with a history of injecting drug use who attended in 2010 (O'Connor, *et al.* 2013). For more details, see Section 6.2.3.

Drug driving and fatal road traffic collisions

In a recent report on roadside drug testing and equipment and other related matters (Cusack, *et al.* 2012), the NDRDI provided a complete census of fatal road traffic collisions where the deceased had a positive toxicology for an illicit substance. This is described in more detail in Section 9.3.

Case studies on drug-related deaths

The verdict of death by misadventure was given at an inquest of a 37-year-old man (Tormey, WP 2012). The primary cause of his sudden death was recorded as coronary thrombosis with secondary cause of death being recorded as cannabis use. The deceased was known to smoke 20 cigarettes a day and also to have smoked cannabis. Tetrahydrocannabinol was found in the urine but no cannabinoids were detected in the deceased's blood. According to the author, the role of legal drugs such as nicotine in cardiac deaths might be ignored, while the role of cannabinoids might be misinterpreted owing to the, at most, two-hour time-limit on their role as triggers for myocardial infarction. The author suggested that 'Cotinine, the biochemical marker of tobacco smoke, should be added to the standard toxicological screen in the guidelines on autopsy practice of the Royal College of Pathologists'.

Another case study looked at the death of a 37-year-old woman who died from acute haemorrhagic necrotising pancreatitis (Tormey, William P, *et al.* 2013b). She had been on a methadone programme and at post mortem, toxic levels of codeine with potentially lethal levels of methadone were found in blood samples. The author stated that toxicology may not always be able to provide an answer. In this death it was not possible to distinguish whether this was a codeine and methadone poisoning in a case of acute pancreatitis (perhaps as a result of overmedication because of pain), or pancreatitis caused by opiates, which is a rare occurrence but has been well described.

Biochemical toxicology and suicide in Ireland

In the event of an unexplained or unnatural death, the pathologist, in conjunction with the coroner will ask for a range of toxicological tests. The Department of Chemical Pathology in Beaumont Hospital, Dublin, carried out a study to 'confirm that the reliance on the results of immunoassay screen for drugs of abuse and common analgesics in order to select samples for compound confirmation by gas chromatography-mass spectrometry is likely to understate the potential role of drugs in suicide' (Tormey, WP, *et al.* 2013a). Toxicology results for 132 deaths where the clinical information provided with the sample from the pathologist indicated that the death was due hanging, suicide or drug overdose from March 2006 to April 2008 were reviewed retrospectively. All the deaths originated from the Coroner Service. The results were from broad-based drug screening of blood and urine samples.

Of the 132 deaths, the clinical information provided indicated that most (101) were due to hanging, 21 were definite or suspected overdoses, and for 10 deaths the clinical information only mentioned suicide (no cause defined). Overall, alcohol (57%), benzodiazepines (26%), antidepressants (22%), opioids (20%), cannabinoids (11%),

antipsychotics (10%), sympathomimetics (7.5%), hypnotics (5%), cocaine (4.5%) and antihistamines (4%) were found in the various laboratory tests. The authors recommended that toxicology screening in the case of death by hanging and other suicides should be extended.

National Registry of Deliberate Self Harm Annual Report 2012

The eleventh annual report from the National Registry of Deliberate Self Harm was published in September 2013 (Griffin, *et al.* 2013). The report contained information relating to every recorded presentation of deliberate self-harm to acute hospital emergency departments in 2012, giving complete national coverage of cases treated.

There were 12,010 recorded presentations of deliberate self-harm, involving 9,483 individuals, in 2012. This implies that one in five (2,527, 21%) of the presentations were repeat episodes. The rate of presentations decreased from 215/100,000 of the population in 2011 to 211/100,000 in 2012, a 2% decrease.

Forty-six per cent of self-harm presentations in 2012 were men and 44% were aged under 30 years. Four hundred and sixty-nine (4%) self-harm presentations were living in hostels for the homeless or had no fixed abode. Presentations peaked in the hours around midnight and were highest on Sundays and Mondays; 32% of episodes occurred on these two days. There was evidence of alcohol consumption in 4,610 (38%) presentations and this was more common among men (42%) than women (36%).

Drug overdose was the most common form of deliberate self-harm reported in 2012, occurring in 8,284 (69%) such episodes. Overdose rates were higher among women (75%) than among men (62%). In 70% of cases the total number of tablets taken was known; an average of 30 tablets was taken in these cases. The average among men was 32 tablets and among women 28 tablets.

Forty-one per cent of all drug overdoses involved a minor tranquilliser (most commonly benzodiazepines), 28% involved paracetamol-containing medicines, 22% involved anti-depressants or mood stabilisers (anti-depressant drugs known as Selective Serotonin Reuptake Inhibitors [SSRIs]) and 10% involved a major tranquilliser. Compared to 2011, a significant reduction was observed in the involvement of street drugs in intentional drug overdose acts, with a fall of 10% in 2012, which followed a 27% reduction in 2011. This reduction is likely to have been associated with the ban on head shop drugs from August 2010 onwards.

The next steps, or referral outcomes, for the deliberate overdose cases were: 48% discharged home; 28% admitted to an acute general hospital; 10% admitted to psychiatric in-patient care; a small proportion (3%) refused admission to hospital; and 12% discharged themselves before receiving referral advice.

The report provided information on what was being or can be done to reduce the number of self-harm cases. In January 2012, the National Office for Suicide Prevention (NOSP) established a National Working Group to continue to address access to minor tranquillisers. The authors recommended that this working group also review the implementation of the paracetamol legislation and prescribing patterns of SSRIs.

The authors reported that alcohol continued to be one of the factors associated with the higher rate of self-harm presentations on Sundays, Mondays and public holidays, around the hours of midnight. These findings underlined the need for on-going efforts to:

- enhance health service capacity at specific times and increase awareness of the negative effects of alcohol misuse and abuse such as increased depressive feelings and reduced self-control;

- intensify national strategies to increase awareness of the risks involved in the use and misuse of alcohol, starting at pre-adolescent age, and intensify national strategies to reduce access to alcohol and drugs;
- educate self-harm patients and their families about the importance of reduced use of and access to alcohol; and
- arrange active consultation and collaboration between the mental health services and addiction treatment services in the best interest of patients who present with dual diagnosis (psychiatric disorder and alcohol/drug abuse).

The authors reported that there was variation in the next care recommended to deliberate self-harm patients, and in the proportion of patients who left hospital before a recommendation, from 6% in the Southern Hospitals Group to 19% in the Dublin North East Hospitals Group. In 2012, a sub-group of the National Mental Health Clinical Programme Steering Group produced 'National guidelines for the assessment and management of patients presenting to Irish emergency departments following self-harm'. The authors of the guidelines recommended 'that these guidelines be implemented nationally as a matter of priority'. In addition, the NOSP has funded pilot projects to implement and evaluate suicide and self-harm awareness training for all emergency department staff, and to improve assessment procedures for self-harm patients in Cork and Kerry, which is a collaborative initiative between Cork University Hospital and the National Suicide Research Foundation.

Second Report of the Suicide Support and Information System (SSIS)

The second report of the SSIS (Arensman, *et al.* 2013) focuses on two questions: (1) investigating whether there are different subgroups among people who die by suicide, and (2) early identification of emerging suicide clusters using advanced geo-spatial techniques. The research team identified 275 cases of suicide and 32 deaths with open verdicts in County Cork between September 2008 and March 2012. Coroner checklists were completed for all 307 cases.

The vast majority (220, 80%) of those who had died with a verdict of suicide were men. The average age was 41 years and men were significantly younger at the time of death (39 years) than women (46 years). The majority were Irish (93%), single (51%), and living in a house or flat (95%). Thirty-three per cent were unemployed, 22% were living alone and 2% were living in a supervised hostel. In terms of occupation, 41% had been working in the construction sector.

The majority (63%) of the 275 suicide cases died by hanging, 12% by drowning and 10% by intentional drug overdose. Legal drugs used in the overdose cases included both prescribed (53%) and non-prescribed (46%) medication. Illegal drugs used included cocaine, ecstasy and heroin.

For those with drugs in their toxicology, just over one quarter (26%) had drugs above the therapeutic range, and 21% had multiple drugs in their toxicology. In addition, 39% had antidepressants in their toxicology, 54% had benzodiazepines, 39% had opiates and 29% had other drugs in their toxicology. Seventeen per cent of the total number of cases had taken medication and/or drugs in combination with other methods, such as hanging and drowning. A minority (14%) had used other methods, including cutting or stabbing, carbon-monoxide poisoning, firearms and jumping from a height or in front of a train. Close to one third (31%) of cases had left a note, in the form of a letter, e-mail or text message.

Sixty-one per cent of the suicide cases had a family history of mental disorder and the same proportion had a personal or family history of substance abuse. Over 39% of cases had either a personal experience of significant physical, sexual or emotional abuse or a family history of such abuse. Ten per cent of fatalities had a parent or sibling who had a non-natural death, such as suicide, homicide or accident.

A history of self-harm was known for 132 cases, of which 86 (65%) had engaged in at least one act of deliberate self-harm. Of these, 33% had engaged in one act, 14% in two acts and 10% in three acts. Twenty-seven per cent had engaged in deliberate self-harm in the 12 months prior to ending their lives, 14% less than a week before and 10% less than a day before.

Sixty-two (20%) cases were known to have experienced suicidal behaviour (fatal and/or non-fatal) by family members or friends at some point in their lives. Of these 62, 85% had a relative or close friend who had died by suicide and the remaining 15% had engaged in non-fatal self-harm. In eleven cases (18%), the deceased had lost three relatives or close friends by suicide.

A psychiatric assessment was known to have taken place in 123 cases. In the majority (69%) of these cases, mood disorder (such as depression) was the primary diagnosis, followed by anxiety disorder (6%), schizophrenia (5%) and alcohol, drug or alcohol and drug dependence/misuse (6%).

In the year prior to death, 173 of the cases had abused alcohol and/or other drugs. Of these cases, 49% had abused alcohol only, 28% had abused both alcohol and other drugs and 21% had abused other drugs only.

Suicide clusters

A total of nine statistically significant clusters were observed between August 2010 and June 2012. There was much overlap and nesting within these clusters, with two groups of clusters emerging.

Group 1 involved 13 cases (12 men and one woman) of suicide in County Cork over a three-month period, from April to June 2011. Nearly half the people (46%) had died by hanging and 38% had taken an overdose intentionally. At the time of death, 31% had used drugs, 23% had used alcohol and drugs, and 38% had a clear toxicology. More than one third (38%) had been diagnosed with a psychiatric illness and nearly two thirds (61%) had been diagnosed with a physical illness.

Group 2 involved seven cases of suicide (three men and four women) in County Cork over a two-month period, from September to October 2011. The majority of the people involved had died by hanging, and the next largest number had died by jumping from a height. At the time of death, the majority had drugs only in their toxicology results.

7. Responses to Health Correlates and Consequences

7.1 Introduction

This chapter presents new data on the prevention of 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 reported in the following sections are briefly described here.

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 **Irish Psycho-Gastroenterology Hepatitis C service** is located in Beaumont Hospital, Dublin, a 660-bed university teaching hospital with a specialised gastroenterology service for assessing and treating patients with chronic hepatitis C virus infection. The psychiatry liaison team is part of a multidisciplinary service where medical and psychiatric care is offered to all patients who are diagnosed with hepatitis C infection and are considered suitable candidates for combined interferon and ribavirin therapy.

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

Withdrawal of distalgesic from the Irish market

In January 2006, distalgesic was withdrawn from the Irish market. The withdrawal 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. A study examining the impact of the withdrawal in terms of intentional drug overdose (IDO) presentations to hospital emergency departments nationally found a positive effect, with an 84% (10 per 100,000) reduction over a three-year period (2006–2008) in the rate of IDO presentations involving the drug distalgesic (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 was five times smaller than the magnitude of the decrease in distalgesic-related IDO presentations. The smaller increase in IDO presentations involving other prescription compound analgesics indicated evidence of some substitution. The authors concluded that the withdrawal of distalgesic in Ireland had been a positive measure in preventing non-fatal suicidal behaviour, which is likely also to have an effect on suicide.

DUMP (Dispose of Unused Medications Properly) project

A review of the Dispose of Unused Medications Properly (DUMP) project, set up in 2002 in the South-Western Health Board Area (SWHBA) to encourage people to return their unused medicines to their local community pharmacies, found that between 2004 and 2010 the use of minor tranquillisers in drug intentional overdose (DIO) in the area remained stable, with a slight decrease in the numbers in 2010 (National Suicide Research Foundation 2012). This was in contrast to the rest of the country where an upward trend in the use of minor tranquillisers in DIOs was observed since 2007. The authors concluded that initiatives such as the DUMP project, aimed at restricting access to frequently-used means of self-harm and suicide, were effective in reducing DIO involving minor tranquillisers. They strongly recommended implementing the campaign nationwide.

Different-sized packs of paracetamol

Legislation introduced in the UK in 1998 restricted the size of paracetamol packs available for sale in pharmacies to a maximum of 32 tablets, and in non-pharmacy outlets to a maximum of 16 tablets. In Ireland, similar legislation was introduced in

2001, albeit with smaller pack sizes: a maximum of 24 tablets may be sold in pharmacies in Ireland, and a maximum of 12 tablets in non-pharmacy outlets. A study was undertaken, comparing the number of paracetamol tablets used in overdoses in the two countries between 2002 and 2007, and correlating this with information on the size of packets of paracetamol (Hawton, *et al.* 2011). Data on general hospital presentations for non-fatal self-harm obtained from the Multicentre Study of Self-harm in England and from the National Registry of Deliberate Self-Harm in Ireland formed the basis for the study.

The author reported a clear association in both countries between peaks in the number of non-fatal overdoses and the use of maximum number of paracetamol packs obtained in pharmacy and non-pharmacy outlets. People who overdosed on paracetamol tended to consume a quantity of tablets related to available pack sizes. However, the number of tablets consumed did not differ significantly between the two jurisdictions. In Ireland, people tended more often than in England to take numbers of tablets equivalent to multiple packs, raising the question as to whether this difference is due to patients' characteristics, access to care, or greater ease of purchasing multiple packs in Ireland compared to England. There were no differences between age groups or gender, with the exception of women in Ireland aged 35 years and over, among whom there may have been an association between smaller pack size and smaller overdoses.

7.3 Prevention and treatment of drug-related infectious diseases

National Hepatitis C Strategy

The HSE published the hepatitis C strategy in September 2012 (HSE National Hepatitis C Strategy Working Group 2012). The strategy contains updated epidemiological information on hepatitis C and details of new direct-acting antivirals. The HSE National Hepatitis C Strategy Working Group summarised the epidemiology of hepatitis C, which is a disease of the liver caused by a virus identified in 1989. This viral disease is spread from person to person through contact with infected blood or other body fluids. Unsterile injection equipment and infected blood or blood products are the major risk factors for the transmission of the virus. There are usually no symptoms associated with the acute and early chronic stages of hepatitis C disease. Chronic infection occurs in 70%–80% of adults who are infected with the virus. Symptoms of chronic infection may include on-going flu-like symptoms, joint pains, abdominal pain, loss of appetite, altered bowel habit, mood swings and/or an inability to sleep. Complications of chronic hepatitis C include liver cirrhosis, liver failure and liver cancer. There are six genotypes for hepatitis C; treatment outcomes are dependent on genotype and other factors. In Ireland injecting drug users (IDUs) are likely to have genotypes 1 or 3 (Conroy, *et al.* 2003).

Certain factors have been identified as increasing the severity of the disease: these include alcohol intake, co-infection with HIV or hepatitis B, super-infection with hepatitis A and older age at infection. The working group reviewed the effectiveness of treatment and reported that hepatitis C can be treated with a combination of two or three anti-viral agents. The medication used to treat this disease includes pegylated interferon, ribavirin and, more recently (in the USA), telaprevir or boceprevir. The addition of either telaprevir or boceprevir to the existing treatment (pegylated interferon and ribavirin) increases the success of the treatment for those with genotype 1. When treated with a combination of the three anti-viral agents, 80% of the hepatitis C genotype 1 patients are likely to experience sustained viral clearance, compared to 50% when only the two drugs (pegylated interferon and ribavirin) are used. There are contra-indications to hepatitis C treatment, including pregnancy, severe depression or other mental illness, renal disease, autoimmune disease and end-stage liver cirrhosis.

The working group reported that the prevalence of hepatitis C among those infected through injecting drug use or the administration of blood and blood products was high.

In one study, the proportion of IDUs attending a drug treatment clinic in Dublin who tested positive for antibody to hepatitis C virus was 62% (Smyth, Bobby P, *et al.* 1998), and a national study on committal prisoners found that 81% (414) of the IDUs tested positive for hepatitis C antibodies (Long, *et al.* 2001).

The prevalence in the general population is unknown but between 1997 and 2010 the prevalence among blood donors was 0.02% and was 1% or less among attendees at antenatal clinics (Health Protection Surveillance Centre 2012b).

There have only been two historical studies examining the incidence of hepatitis C among IDUs. One study estimated the incidence of hepatitis C among 100 IDUs attending treatment in Dublin between 1992 and 1998 who had an initial negative test and a repeat test within nine months (Smyth, Bobby P, *et al.* 2003). The authors reported that the incidence of hepatitis C was 66 per 100 person years. A later study reported an incidence of 24.5 per 100 person years among a sample (358) of opiate users (including some non-injectors) attending treatment in the former South Western Area Health Board in 2001/2002 (Grogan, *et al.* 2005). Comparisons between these studies are difficult as it is not possible to ascertain the proportion of non-injectors in the sample surveyed in the later study. Studies in Ireland identify homeless people, prisoners and asylum seekers as being high-risk populations for hepatitis C, largely because a high proportion of prisoners and homeless people inject drugs. The working group reported that asylum seekers often come from countries where hepatitis C is endemic.

There were 2,800 discharges from acute hospitals with a principal diagnosis of chronic viral hepatitis C between 2005 and 2010 and there were 1,193 discharges with a principal diagnosis of primary liver cancer. There were 703 cases of hepatocellular carcinoma registered by the National Cancer Register Ireland between 1994 and 2010. The National Cancer Register Ireland (NCRI) estimates that 30% of hepatocellular carcinoma cases were hepatitis C positive. The liver transplant unit at St Vincent's University Hospital reported that 42 (13.5%) of 311 liver transplant cases between 2000 and 2006 had hepatitis C.

The new national hepatitis C strategy makes 36 recommendations: eight covering surveillance; 14 on education, prevention and communication (through six overarching themes); six on screening and testing; and eight on treatment (through seven overarching themes). The recommendations for ensuring accurate surveillance include:

- ensure laboratory requests for hepatitis C serology contain patient identifiers and clinician details;
- encourage clinicians to notify newly diagnosed cases of hepatitis C and provide relevant information where possible;
- commence enhanced surveillance (including the collection of risk factors) for newly diagnosed cases of hepatitis C;
- establish a national register of patients diagnosed with hepatitis C;
- commence appropriate public health follow-up on newly notified cases of hepatitis C;
- estimate the prevalence of hepatitis C and identify risk factors among the general population;
- complete a modelling exercise to estimate future disease burden and aid service planning; and
- conduct follow-up studies amongst injecting drug users to identify sero converters so as to measure incidence rate.

The recommendations for maximising prevention and ensuring clear and accurate information are:

- treat existing drug addiction among IDUs;

- prevent transition from smoking heroin to injecting heroin and encourage current injectors to move to treatment or harm-reduction approaches;
- improve provision of harm-reduction materials through nationwide access to and uptake of comprehensive set of materials and appropriate communications with respect to language, literacy and accuracy;
- ensure staff and peer-educators are recruited to pre-agreed standards and have appropriate training and materials to provide accessible and accurate information;
- plan and implement a campaign to raise awareness among those who may previously have been diagnosed with hepatitis C or who may have been at risk of infection in order that they consider accessing new treatment options; and
- regulate services that provide body-piercing, tattooing and permanent make-up.

The recommendations for ensuring screening and diagnosis are available to the appropriate at-risk populations in a timely manner are:

- improve availability of and access to facilities for screening, testing and diagnosis available in primary and community care services with adequate and timely laboratory facilities;
- enhance prison-based services with respect to risk assessment, screening and follow-up;
- offer and promote screening for hepatitis C and other blood-borne diseases to those who attend services such as needle-exchange programmes and other harm-reduction services;
- continue targeted antenatal screening for those with risk factors for hepatitis C infection and consider the evidence for introducing universal screening at regular intervals;
- ensure the National Viral Reference Laboratory (NVRL) provides previous tests results to medical practitioners who have ascertained the patient's consent; and
- establish guidelines on hepatitis C screening for individuals from endemic countries or new entrants to the Irish healthcare system.

The recommendations for ensuring that evidence-based hepatitis C treatment and other supports are available to patients in a timely manner are:

- ensure governance, evidence-based protocols and review are available to diagnose people with hepatitis C and treat if required;
- develop, implement and evaluate a treatment model appropriate to the prison setting on a national basis
- establish a postgraduate diploma in hepatitis C management for physicians and nursing staff;
- undertake a formal assessment of the needs of individuals infected with hepatitis C, other than through contaminated blood and blood products, through an increased number of clinical nurse specialist posts and subsequent needs assessments;
- develop a role for GPs (with special qualifications) to monitor hepatitis C treatment in primary and community care in consultation with other appropriate medical specialists;
- provide patients, particularly those with chaotic lifestyles and other social problems, with practical supports to enable them to attend for and adhere to treatment; and provide interventions to assess and if necessary reduce alcohol intake in patients with hepatitis C.

Hepatitis C: Is there a case for universal screening in pregnancy?

Hepatitis C is not routinely screened for at antenatal clinics in maternity hospitals in Ireland. Most hospitals adopt a policy of targeted or selective screening based on criteria such as ever injected illicit drugs or tattooing.

Up until 2007, the policy at the Coombe Women and Infants University Hospital in Dublin was a targeted hepatitis C screening programme. The criteria for inclusion were the presence of tattoos or body piercing, a history of intravenous drug use (IDU),

receiving blood products or having jaundice, sexual contact potential with an infected partner, or being a migrant from a country with a known high prevalence rate of hepatitis C. In 2006, 67 women were screened, with 37 (55%) cases identified as HCV-RNA. Those who tested positive had an average age of 28.5 years. A positive test result indicates exposure to the hepatitis C virus and antibodies are thus present. The proportion testing positive for hepatitis C viral antibodies (exposed) in the hospital's antenatal population was thus 0.79% for 2006 (37/4,666). Having a tattoo or a history of IDU were the two biggest risk factors for infection. In the group infected with hepatitis C, 27% had a C section delivery. Three women were co-infected with HIV and had C section deliveries.

In 2007 the policy in the Coombe Women and Infants University Hospital in Dublin changed from targeted screening to universal screening. This decision was taken following a retrospective analysis of charts of hepatitis C positive mothers who attended the hospital for antenatal care between 2006 and 2007. This analysis was carried out to determine if there was a case for introducing universal hepatitis C screening in pregnancy (Martyn, *et al.* 2011).

When universal screening was applied in 2007, the proportion of women testing positive for hepatitis C viral antibodies in the hospital's antenatal population was 0.71% (66/9,222). Those who tested positive had an average age was 29 years. Having a tattoo or a history of IDU were again the two biggest risk factors for infection. In the group infected with hepatitis C, 14% had a C section delivery. One woman's hepatitis C status in 2007 would not have been detected by targeted screening as she had none of the identified risk factors. Four women were co-infected with HIV in 2007 and had C section deliveries. The proportion infected with hepatitis C virus among those on a methadone maintenance programme (many of whom had a history of IDU) was 34.7%.

There were similar detection rates for hepatitis C in 2006 using selective screening compared with the result in 2007 using universal screening. As 55% (37/67) of women tested in 2006 were HCV-RNA positive (targeted screening) and 57.5% (38/66) were positive in 2007 (universal screening), the authors concluded that targeted screening for hepatitis C did not meet WHO criteria for universal screening but that targeted screening based on risk factors works well: few cases will go undetected providing that inclusive criteria for selective screening are used.

Universal antenatal screening for hepatitis C

A large single-centre pilot study to determine the true sero prevalence of hepatitis C in an unselected antenatal population and to pilot universal antenatal hepatitis C screening was carried out at the Rotunda maternity hospital, Dublin (Lambert, *et al.* 2013). At present the Rotunda hospital, like many other maternity hospitals, operates a selective screening policy based on disclosed risk factors. Previous studies at the Rotunda hospital had revealed a vertical transmission rate of approximately 6.4% (Healy, C. M., *et al.* 2001)

The 9,121 women who were booked for antenatal care over a one-year period from June 2007 to June 2008 were offered a hepatitis C antibody test as part of their routine antenatal screening. The number who agreed to take part in the study was 8,976, an uptake of 98.4%. They were asked to sign a consent form and to complete a risk assessment questionnaire for hepatitis C infection.

Seventy-eight women in the cohort tested positive for anti-HCV antibodies giving a seroprevalence rate of 0.9%. RT-PCR analysis was carried out on 67 of the 78 positive samples. Of these, 43 (64%) were positive for HCV-RNA. Viral loads were available for 23/78 cases and six (26%) had viral loads greater than 1x10⁶ copies/mL. Genotype was available for 18% (14/78) of samples only. The most prevalent genotype was 1B (6/14) followed by 1A (4/14).

Most (73%) of the 78 anti-hepatitis C positive women reported one or more known risk factor – tattooing (37, 47.4%), a history of IDU (29, 37.2%), other drug use such as cocaine or cannabis (30, 38.5%); multiple body piercing (13, 16.7%), current or ex partner drug use (16, 20.5%), current or ex partner HCV positive (19, 24.4%). The majority (47, 60%) were Irish and over half (44, 57%) were from Eastern Europe.

Among the 78 anti-hepatitis C positive women, one woman was co-infected with hepatitis B and two with HIV, 21 (27%) reported no epidemiological risk factors at the time of booking into the clinic, and 44 (57%) were from Eastern European countries where available information on the risk factors for infection indicates nosocomial transmission plays a major role in infection. Transmission of hepatitis C between heterosexuals remains controversial. In this cohort, 24% of anti-hepatitis C positive women revealed a current/ex-partner was positive for hepatitis C. In all but one case, additional risk factors were disclosed, making conclusions about the role of sexual transmission difficult. The authors stated that relying on self-reported risk behaviours and the under-estimation of the importance of other risk factors such as heterosexual transmission and nosocomial transmission in high prevalence countries means a significant proportion of cases will remain undiagnosed under the current guidelines (selected screening based on disclosed risk factors). While pregnancy management for anti-hepatitis C positive women is the same as for non-infected women (except if HIV co-infected), reports on the risks of obstetrical complications owing to maternal hepatitis C status are varied.

The authors stated that early referral of mothers to treatment programmes could potentially eradicate their hepatitis C, thus ensuring that future unborn children are not at risk of this infection. Although there are currently no treatment options available in pregnancy to minimise the risk of vertical transmission, timely identification of infection would permit interventions to limit/reduce the risk of progression of liver disease. Diagnosis would also enable active immunisation against other types of infective hepatitis. Identification of these women as a result of universal screening provides evidence that hepatitis C testing should be included with routine antenatal screening.

Hepatitis C treatment in HIV/hepatitis C co-infected patients

Between October 2008 and January 2009, a retrospective chart review of patients co-infected with HIV and hepatitis C who attended a genito-urinary medicine and infectious disease clinic in a large Dublin hospital was undertaken to identify patient demographics, HIV and hepatitis C status and treatment outcomes. (Kieran, *et al.* 2011).

Between January 1987 and December 2008, 3,360 HIV-infected patients attended the clinical services. Of these, 441 were identified as having a positive hepatitis C antibody result, and 55 (12%) of these were excluded from the analysis because 42 had cleared their hepatitis C infection spontaneously, while the other 13 patients' records could not be found. Of the remaining 386 patients, 327 (85%) were IDUs.

Of the 327 IDUs, 67 (20%) had initiated hepatitis C treatment, but 260 (79%) had received no hepatitis C treatment. Analysis of factors associated with HIV positive patients found that active IDU was a barrier to referral to the hepatitis C clinic, as only 21 of the active IDUs were referred for treatment. The authors stated that the patients not referred to the hepatitis C co-infection clinic were more likely to default from appointments, to engage in IDU, to have advanced untreated HIV and not to have had hepatitis C treatment offered to them.

Co-infected patients attending the HIV and hepatitis C clinic were more likely to have been screened for hepatocellular carcinoma than those attending the general HIV service. The authors suggested that the challenges of increasing the uptake of hepatitis C care among IDUs are similar to caring for HIV patients and that significant barriers to hepatitis C care remain particularly related to substance abuse and outpatient attendance. The author's conclusions were that significant barriers to hepatitis C care

remain especially related to substance abuse and outpatient attendance. They recommended an integrated HIV/HCV co-infection clinic which could result in favourable outcomes for many patients and improved monitoring of liver disease even in the absence of a definitive cure for hepatitis C infection.

7.4 Responses to other health correlates among drug users

Audit of Irish Psycho-Gastroenterology Hepatitis C service

Hepatitis C treatment is associated with a number of side effects including neuropsychiatric symptoms such as fatigue, irritability, anxiety, depression, psychosis, mania, suicidal ideation, cognitive impairment and delirium (Onyike, *et al.* 2004). A recent audit of the Irish Psycho-Gastroenterology Hepatitis C service determined the number of patients with psychiatric illness prior to and during combined interferon treatment and also assessed patient progress during treatment, particularly in relation to the development of mental illness and whether therapy needed to be stopped (Whitty, *et al.* 2011). Data were collected prospectively over one year on 50 patients, 29 (58%) males and 21 (42% females). The mean age of patients was 39 years. During the period studied, 46 (92%) patients were undergoing or had completed combination therapy. Of the remainder, treatment was discontinued for one (2%) patient owing to medical complications arising from the interferon therapy, one patient (2%) was non-compliant and two (4%) patients had therapy deferred. No patient had their treatment deferred owing to psychiatric side effects following commencement of therapy.

There were high rates of psychiatric illness and substance abuse in this group of patients. Twenty patients (40%) had a past history of depression, two (4%) had a history of psychosis and one (2%) had a history of anxiety disorder. In addition, 42 (84%) patients had a past history of harmful poly-substance abuse or drug dependence. There was no past history of mental illness in the other 27 (54%) patients. Thirty-three patients (66%) were treated with psychotropic medication prior to or during combination therapy, including those with a past history of depression along with those who had current stressors or who had evidenced mild depressive symptoms in the month prior to commencing combination therapy. A significant number of patients (17, 34%) developed a depressive disorder during combination therapy, one developing a depressive disorder with psychotic features.

It is known that psychiatric morbidity, in particular depression, is common in patients with hepatitis C who are receiving combination therapy. This study found that over one third of the patients developed a depressive disorder while on the combined therapy but, despite this, completed the treatment course. The authors stated that, in view of the high rate of psychiatric disorder development, successful completion requires an integrated multidisciplinary approach.

Methadone maintenance and prescribed medication among opioid dependent pregnant women

A 2012 prospective cohort study at two Irish tertiary care maternity hospitals examined methadone maintenance and prescribed medication among opioid dependent pregnant women (Cleary, *et al.* 2013). The objective was to compare the incidence of neonatal abstinence syndrome (NAS) among the women attending each of the two hospitals.

Data from electronic dispensing records of methadone maintenance doses in the year preceding and the month following delivery were available for 89 women. These data were examined and NAS was determined using the Finnegan score. The study found that 40% (36) of women had their methadone doses decreased during pregnancy and 35% (31) had their doses increased but the number of new-borns treated for NAS did not differ between the two groups.

The authors stated that reducing methadone dose during pregnancy did not appear to have an effect on the incidence of NAS and was a common practice in the Irish health

service. The authors recommended that clinicians should be guided by maternal symptoms with the objective of preventing or minimising concomitant illicit drug use by effective dosing and that co-existing maternal mental illness should be assessed and managed appropriately in this population.

Youth mental health

A small study was conducted in the HSE Mid-West region (counties Limerick, Clare, North Tipperary), examining the role of the GP in addressing youth mental health needs and documenting the spectrum of youth mental health challenges encountered by GPs (Healy, Deirdre, *et al.* 2013). This study complemented similar work in an inner-city Dublin practice (Connolly, D, *et al.* 2012). A self-administered questionnaire was sent to 128 GPs in the Mid-West region seeking data on physician and practice demographics, case management and barriers to care relating to youth mental health. Thirty-nine (30%) GPs responded. The majority of respondents had substantial contact with young people, and when asked how many young people attended their practice in the previous year, the most frequent answer was 'more than 250' (20 practices), followed by '50–100' (7 practices), '100–250' (5 practices), and '10–50' (3 practices).

They reported that two out of the last ten young people who had consulted them had mental health or substance use issues. The three most common reasons cited as to why young people attended their practice were for contraception (18, 20%), mental health (15, 17%) and respiratory tract infections (11, 12.5%). Of those with mental health issues, nine (10%) were referred to dedicated services while three (4%) were referred to other non-specialist services. The remainder of patients were not referred to secondary care.

The study identified substance abuse issues as the fourth commonest complaint or reason why young people attended their GP, and problem alcohol use and problem drug use as the sixth and seventh (respectively) most commonly encountered by GPs when treating young people.

The authors suggested that these data plus international best practice relating to the prevention and treatment of mental and substance use disorders among young people should inform future research and service development in the HSE Mid-West. They commented that the GP plays an important role in meeting youth mental health needs, particularly in economically deprived urban areas. They also suggested that GPs and primary care teams need support and education for mental health issues for younger patients and particularly on the complexities of comorbidity.

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.

The aim of social reintegration is to empower individuals to plan and pursue alternative activities to those they engaged in when using drugs. This is achieved through providing accommodation, education, and 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 2009–2016** (Department of Community 2009) lists as a priority the implementation of the recommendations contained in the report of the working group on drugs rehabilitation (Working Group on drugs rehabilitation 2007). 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**, is now operated from the Department of Social Protection, 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 is seen as essential and should be an integral part of the NDS in the future.

8.2 Social exclusion and drug use

8.2.1 Social exclusion among drug users

Merchants Quay Ireland (MQI) has published the profile of a cohort of people attending its Health Promotion Unit (HPU) needle exchange (Jennings 2013). Data were collected in 2012 from 338 attendees using an instrument developed specifically to meet the information needs of the HPU in MQI and included items from internationally

validated survey instruments and items fashioned specifically for the present study. Staff in the HPU collected data on socio-demographic characteristics, substance use, injecting risk behaviour and blood-borne virus (BBV) status and treatment.

Socio-demographic characteristics

A total of 338 participants took part in the study, including 290 males (85.8%). Participants ranged in age from 20 to 59 years; the majority were in the 20–34-year age group. Participants comprised 19 different nationalities; the vast majority 297 (88%) were Irish nationals. Approximately one third of the cohort reported living in conditions which may be categorised as homeless (Table 8.2.2.1).

Table 8.2.2.1 Attendees at MQI needle exchange, accommodation status during last seven days, 2012

Accommodation status	n	%
Own/rented home	160	47
Staying with friends/family	73	22
Emergency accommodation	67	20
Sleeping rough	15	4
Supported temporary accommodation	12	4
Long-term supported housing	11	3

Source: (Jennings 2013)

Substance use

Participants who used heroin were found to consume an average of 2.35 bags per day, and to spend an average of €45.72 per day on the drug. Route of administration for the vast majority of heroin users was injecting 245 (84.4%); 34 (11.7%) reported both injecting and/or smoking heroin and only six (2.7%) reported smoking only.

There were no differences between the genders for most substances used. Where differences did occur, proportionately more females than males reported using prescribed methadone (73% v. 46%), illicit benzodiazepines (25% v. 17%), and prescribed benzodiazepines (23% v. 14%).

Seventy-five per cent (n=272) reported using two or more substances in the last month (current use). Thirty per cent (102) reported using two substances in the past month, the most frequent combination being heroin and methadone, used by 49 (48%) of the sub-sample. Almost 9 out of 10 users who were prescribed methadone reported using heroin. Heroin users who did not report using methadone were reported to consume higher average amounts of heroin per day, to spend more money on heroin per day and to use heroin on the greatest number of days in the past month.

Table 8.2.2.2 Attendees at MQI needle exchange, current use of substances by all participants (n=338), 2012

Substance used in past month	n	%
Heroin	290	86
Prescribed methadone	167	49
Cannabis	82	24
Alcohol	74	22
Illicit benzodiazepines	60	18
Prescribed benzodiazepines	53	16
Cocaine	21	6
Steroids	25	7
Mephedrone	21	6
Crack cocaine	20	6
Illicit methadone	8	2
Amphetamines	4	1
Other	13	4

Source: (Jennings 2013)

8.2.2 Drug use among socially excluded groups

Children being looked after by the state

The Department of Children and Youth Affairs (DCYA) recently published a report detailing a consultation process with 211 children and young people in state care; participants ranged in age from 8 to 23 years (Department of Children and Youth Affairs 2011). Fifteen consultations were undertaken in Cork, Dublin, Galway and Sligo. The young participants came from the following state care settings: prison and detention centres (43), residential disability care (10), foster care (58), aftercare (17), residential care (48), separated children seeking asylum (34) and young people under Section 5 of the Child Care Act 1991 (1). The report provides a useful insight into the main issues that concern young people in care, the difficulties they experience in expressing these concerns through current structures and their ideas on how such concerns might be articulated in the future.

According to the DCYA, the role played by alcohol and drugs in the lives of some of the participants was a recurring theme throughout the consultations. This theme emerged primarily from consultations with participants in St Patrick's Institution (36) and in detention centres (7). Many of the participants spoke about using alcohol and/or drugs as a means of 'escaping' from the traumatic experiences in their lives and few indicated any intention to stop using substances in the future. Many also recalled the adverse role that alcohol and drugs played in the lives of their parents, which had contributed largely to their being placed in state care in the first instance. The adverse experience of parental alcohol and drug use was also highlighted by the 58 children aged 8–12 who were in foster care. The report also contained the views young people on their experiences of being looked after by specific state institutions charged with doing this work.

From the views expressed by the young participants, a general consensus emerged that young people in care would like more meaningful consultation on key decisions that impact on their lives; few believed that the current structures of the care plan review process or the input of social workers were adequate forums for such meaningful consultation. The report recommends that both the care plan review system and aspects of the social worker service for young people in care be re-examined. Support mechanisms, including a dedicated telephone line, a 'mentor' system and counselling services for young people in care, are also recommended. These recommendations are grounded in the concerns and experiences of young people in care as articulated in the consultations reported on above. In this regard, the report recommends that 'the agencies responsible for children in the care of the state must listen to the voices of the consultation participants and, more importantly, heed their recommendations' (p. 3).

Homeless people with poor mental health and substance abuse issues

Recently published research sought to determine the prevalence of mental illness among residents of a homeless hostel in inner-city Dublin (Prinsloo, *et al.* 2012). The Structured Clinical Interview for DSM-IV Axis 1 Disorders (SCID-1) Clinical Version was used to collect data from study participants over an eight-week period in June–August 2010. Of 97 men considered as 'residents' for the purpose of the study, 38 agreed to be interviewed, representing a response rate of 39.2%. Of the 38 participants:

- 47.4% were in the 40–54-year age group, 31.6% in the 26–39-year age group and 21% were aged 55 or over;
- over half (57.9%) had never married;
- 68.4% had children;
- 73.7% reached secondary level education without graduating; and
- 92% were unemployed.

A total of 81.6% had a current (last 30 days) Axis 1 diagnosis; the rate increased to 89.5% for lifetime prevalence, when current and past Axis 1 diagnoses were combined.

Regarding lifetime diagnoses, the rates were as follows: 42% depressive disorder, 78.9% substance use disorder, 18.4% anxiety/adjustment disorder and 5.3% psychotic disorder. The most common current and past diagnosis was alcohol dependence, with 52.6% of participants meeting the criteria for dependence. The most common disorders during the past 30 days were alcohol dependence 23.7%, opioid dependence and major depressive disorder both 18.4% and opioid abuse and alcohol-induced depression both 7.9%. According to the authors 'there was considerable comorbidity between disorders, with a significant number of residents experiencing both mental illness and substance use problems' (p. 25).

Of those interviewed, 31.6% had been admitted to a psychiatric hospital at least once during their lifetime and only 23.7% were currently attending an outpatient psychiatric or addiction service. The authors note that 'the low number of residents attending services is cause for concern' (p. 25).

The authors acknowledged the relatively low response rate to the study, and reported that information provided to the research team by the specialist support worker at the hostel suggested that some of the 59 men who did not agree to be interviewed may have had experience of mental illness. They also acknowledged the possibility of selection bias, given that the specialist mental health worker at the hostel encouraged the men who had mental health problems to be interviewed for the study. However, the authors also noted that, to the best of their knowledge, this was the first study undertaken in Ireland to assess the complete spectrum of Axis 1 disorders.

Unemployment, homelessness and substance addiction

The Cork Simon Community, a voluntary organisation providing shelter and accommodation to homeless people, undertook a survey in June–July 2012 with 91 residents to identify the main barriers to employment (Cork Simon Community 2012). The respondents were drawn from residents in emergency accommodation and both high- and low-support housing. The main barriers to employment were poor mental and physical health, substance addiction, early school-leaving, poor literacy, numeracy and IT skills, lack of formal qualifications and relevant work skills, low levels of confidence and high perception of being discriminated against and histories of long-term unemployment and criminal records.

Almost a quarter of valid responses (n=78) cited poor mental and physical health as the main reason for losing/leaving their last job. The vast majority, 90% of all survey participants (n=91), had worked at some point, with almost half working all or most of their lives prior to becoming unemployed. Of those who did work for most of their lives, most were employed in unskilled work. When surveyed, 88% of the total 91 were unemployed and 92% had been unemployed for one year or more; 45% were receiving disability allowance/illness benefit and 26% unemployment benefit/assistance; 17% were affected by the Habitual Residence Condition criteria that prevent some foreign nationals from receiving social welfare benefits; 8% were in receipt of a state pension and 4% were in part-time employment. Poor health was cited by the majority as the main barrier to securing and retaining employment.

Alcohol and/or drug addiction and dependence was cited by 22% of valid responses (n=78) as the main reason for losing/leaving their last job. Fifty-eight per cent agreed that addiction was adversely affecting their motivation to return to work. Addiction is a major worry for those aged under 45 regarding their capacity to find and retain a new job. Sixty-five per cent left school prior to completing the Leaving Certificate, more than twice the national average. Two-thirds of early school-leavers left school at an average age of 14 without completing any state examination.

Substance abuse among offenders on probation supervision

A report by the Probation Service presents the findings of the first large-scale, nationwide survey undertaken by the service on drug and alcohol misuse among the adult offender population on probation supervision (Probation Service 2012b). The survey involved a representative sample of 2,963 adult offenders on probation officers'

caseloads on 1 April 2011. Questionnaires, developed specifically for the study, were completed by the supervising probation officers, based on their case records and knowledge of the offenders on their casebooks. The main findings reported suggest that:

- 89% of the adult offender population on probation supervision had misused drugs or alcohol either 'currently' (at the time of the survey) or in the 'past';
- of those who misused either alcohol or drugs, 27% misused drugs only, 20% misused alcohol only and 42% misused both drugs and alcohol;
- while females comprised only 12% of the adult offender population, both male and female adult offenders exhibited similar drug and alcohol misuse levels;
- the Dublin probation regions exhibited the highest levels of overall misuse among their offender populations, at 91%;
- almost 21% of offenders were currently misusing two or more substances and over 9% were misusing at least three substances. This included misuse of alcohol.

The study found that, based on the probation officers' professional judgment, 'there were a substantial number of cases where drug misuse (74%) and alcohol misuse (71.3%) were linked to the offence committed' (p.38). However, the author added the important caveat that the complexity of the issue meant that a 'strong association' between the drug use and the offence should not be interpreted as meaning that one necessarily caused the other.

The study found that drug misuse among female offenders was marginally more likely to be linked to the offence than among male offenders; the opposite was the case in relation to the link between alcohol and the offence committed. The link between drug misuse and offending was more pronounced among younger age groups. In terms of the offence type, of those whose drug misuse and offence were linked, 31% of offences were drug law offences (such as drug possession), while 36.8% were linked to acquisitive crimes (theft, burglary, robbery, property offences). The study also highlighted the link between alcohol and crime, particularly violent and public-order-related crime: the alcohol misuse of 71% of alcohol-misusing offenders was linked to the current offence committed, and the majority of alcohol-related offences were crimes against the person and public order offences, at almost 40%. The report found that 'of those who misused drugs, 48.4% appeared to be not currently engaging with any drug treatment service' (p. 42). It is unclear why this is the case as the views of offenders were not included in the study, one of the acknowledged limitations of the research.

8.3 Social reintegration

8.3.1 Housing

Finding and maintaining sustainable housing remains a problem for many drug users, particularly those who are among the homeless population. We now have a more reliable picture of the extent and nature of homelessness in Ireland, and this picture has been primarily illuminated by the findings and evidence from good quality research. Our knowledge base of what contributes to and constructs homelessness has grown. We now know more about the conditions of life experienced by the homeless when they were growing up, and we know that their very first experience of homelessness was caused by lengthy and recurrent episodes of family conflict leading to family breakdown. We also know that most of our adult homeless population experienced homelessness following family breakdown: they were either taken into care or found refuge in an adult hostel accompanied by the mother. With recent changes in the 4-year national population census, we can now more closely predict the numbers of homeless people. We also know that young women may be more likely to exit homelessness and secure sustaining housing than men. Does this finding mean that society may be expecting more from its young men, particularly those who are most vulnerable?

Counting the homeless

The Central Statistics Office (CSO) has published for the first time a comprehensive profile of the homeless population, as enumerated in the 2011 census of the population of Ireland (Central Statistics Office 2012). A comprehensive approach to measuring homelessness was adopted as part of the census undertaken on 10 April 2011. Homeless persons were identified based on where they were located on census night. Of the 4,588,252 persons counted in the state, 3,808 were either counted in accommodation providing shelter for homeless persons or were identified sleeping rough (8.3.1.1).

Table 8.3.1.1 Persons counted in accommodation for the homeless and sleeping rough, by gender, Census night, 2011

Category	Male	Female	Total
Persons in accommodation	2,481	1,263	3,744
Persons sleeping rough	58	6	64
Total	2,539	1,269	3,808

Source: (Central Statistics Office 2012)

Accommodation types

- 43.2% (n=1,648) of homeless persons were counted in emergency accommodation: 1,117 males and 531 females.
- 14.5% (n=555) in transitional accommodation: 397 males and 158 females.
- 24.2% (n=992) in long-term accommodation: 578 males and 414 females.
- 9.0% (n=344) in mixed accommodation: 250 males and 94 females.
- 5.4% (n=206) in what was reported as 'unknown' accommodation: 139 males and 66 females.

The Dublin Regional Homeless Executive (DRHE) on behalf of the CSO undertook a count of persons sleeping rough in the Dublin area on Census night. The count took place between 3.30 am and 6.00 am through a process of 'discovery', that is, direct observation of the number of persons physically present and sleeping rough in Dublin on that night. Of the 64 persons counted sleeping rough, 58 were male and 6 were counted in Dublin.

Age profile

Almost three quarters of homeless persons counted in the Census (n=2,781) were in the 20–59-year age group; 641 were in the 0–19-year age group, including 457 children aged 0–14.

Marital status and the family unit

Among the 3,351 homeless persons aged 15 or over, two thirds were single, compared to 42% in the general population. Just under 6% (n=189) were married or re-married, compared to 48% in the general population. Almost 17% (n=561) were separated or divorced, compared to 6% in the general population. The family unit was defined as a couple with or without children or a lone parent with at least one child. There were 296 family units comprising 905 persons, of whom 498 were children.

Economic and education status

Of the 3,351 homeless persons aged 15 or over, 1,287 were unemployed and 99 were looking for their first job. Twenty-two per cent (n=752) were unable to work due to permanent sickness or disability, compared to 4% in the general population. 274 homeless persons were in work, 218 were students, and 186 were retired. Forty-nine per cent (n=1,439) of homeless persons aged 15 to 59 did not have an educational qualification beyond lower second-level, compared to 25% in the general population.

General health and disabilities

Just over 60% (n=2,298) of the homeless population indicated that their general health was 'good' or 'very good', compared to 89% in the general population. Almost 70% of homeless females indicated that their health was 'good' or 'very good', compared to 56% of homeless males. Almost a third (n=1,179) of the homeless population

indicated that their general health was 'fair', 'bad' or 'very bad', compared to 10% in the general population. Forty-two per cent (n= 1,581) of homeless persons had a disability, compared to 13% in the general population. The most common disability was a psychological or emotional condition (n=740).

Current government policy on the homeless

On 21 February 2013 Jan O'Sullivan TD, Minister for Housing and Planning, launched a policy statement on homelessness (Department of the Environment 2013). The policy statement followed a review of government policy on homelessness (O'Sullivan, Eoin 2012b). In the review, O'Sullivan is critical of the value for money obtained from state expenditure on tackling homelessness. He argues that 'it is now clear that the historically high levels of statutory funding for homelessness services are not delivering satisfactory outcomes for homeless households...' (p. 24). State funding has traditionally been channelled into the provision of emergency-type shelter or resource-intensive interventions with various forms of ancillary support to prepare individuals to become 'housing ready'. In the case of individuals with alcohol and drug problems, this has meant that evidence of abstinence or sustained stabilisation was often required prior to their being considered for more sustainable accommodation.

In seeking to promote an alternative to the inefficient and ineffective models that make up the housing-ready approach, O'Sullivan reviewed a number of studies that reported outcomes from both the broad church of the housing-ready / treatment-first approach and the housing-first (or housing-led) approach. The latter does not require people to demonstrate abstinence or provide evidence that they are ready to be housed. The housing-led approach seeks to place homeless people in sustainable rented accommodation first, and provides 'floating supports' at the request of the person being housed. Such supports may include assistance with social welfare enquiries, developing independent living skills or seeking help for addiction problems. O'Sullivan concludes that 'the overwhelming evidence points to the effectiveness of a Housing Led approach rather than one that seeks to promote Treatment First' (p. 35).

The policy statement on homelessness launched in January 2013 by Minister of State O'Sullivan endorses this view of the evidence base and declares that the policy's primary purpose is to make explicit the government's commitment to ending homelessness by implementing the housing-led approach. The policy statement asserts the government's aim to end long-term homelessness by the end of 2016 and encapsulates the government's response to homelessness to include the following components:

1. Preventing homelessness
2. Eliminating the need to sleep rough
3. Eliminating long-term occupation of emergency accommodation
4. Providing long-term housing solutions
5. Ensuring effective services
6. Better co-ordinated funding arrangements.

An oversight group has been established to monitor and review the housing-led approach advocated in the policy statement. To assist the oversight group, a set of seven indicators will be used to 'demonstrate the dynamics' of homelessness as it is addressed:

1. Number of new homeless presentations on a daily basis
2. Number of persons in emergency accommodation for longer than six months
3. Number of persons leaving emergency accommodation
4. Occupancy rate in emergency accommodation
5. Number of persons moving on into independent living with support
6. Number of persons moving on into independent living without support
7. Number of persons sleeping rough voluntarily and involuntarily.

However, if the model is to be applied successfully and if the government is to meet its target of ending long-term homelessness by 2016, then sufficient numbers of housing units must be made available. In the current climate of austerity and fiscal restraints, these outputs may be compromised. In a recent article Mary Regan, political correspondent for the *Irish Examiner*, reports Minister of State O'Sullivan's acknowledgement that 'her department is "struggling" with ensuring it has enough accommodation to meet demand...[But]...her department hopes to secure 3,000' (Regan 2013,).

Will housing-led services improve service provision to homeless people in Ireland?

Recent research with stakeholders working in the homeless sector and with some homeless people suggests that it may not be just a matter of providing 'bricks and mortar' to tackle homelessness, particularly for people with long histories of homelessness. The Simon Community commissioned exploratory research to assess whether housing-led services would represent an improvement on existing practice in delivering services to homeless people in Ireland (Pleace, *et al.* 2013). Fieldwork and data collection for this research included nine focus groups with 27 participants (21 males) who were or had recently been homeless, including 19 people who were or had been entrenched rough sleepers, i.e. people with high and multiple support needs who had sustained experience of sleeping rough. In addition, data were collected from 17 service providers working with the Simon Communities. In addition, seven organisations working in the homeless sector responded to a detailed questionnaire. Findings from all fieldwork and collated data were discussed with participants from across government and the homeless sector prior to publication of the report.

Awareness of what the housing-led approach means was reported as high among service providers. Service users were not as aware of what the approach entailed, but, when it was explained, the idea of having their own 'home' was popular. There was consensus among service providers that simply providing housing to people with long histories of homelessness who might have high support needs, such as mental health or addiction issues, was unlikely to result in positive outcomes. Appropriate types and levels of support with housing were deemed a more effective response. The main concern expressed by all participants was the insufficient supply of adequate and affordable housing to ensure housing-led services work effectively. Difficulty in accessing social housing due to a lack of new supply and barriers in the process of allocating the existing supply were cited as particular limitations.

Concerns were also expressed by all participants about the affordability of housing in the private rented sector. Restrictions on the amount paid to social welfare claimants through rent supplement meant that people were unable to meet the relatively high rents being charged in the private sector without having to 'top-up' from the remaining portion of their welfare payments. Also, the poor standard of some of the affordable private rented accommodation was cited as a concern. It was reported that some private landlords were reluctant to accommodate people with a history of homelessness as these people were perceived to be 'risky' tenants. In addition, in a social context where the need for private rented accommodation is growing among the general population, people with experience of homelessness are often the least preferred tenants by some private landlords.

People with experience of homelessness expressed a preference to be housed in social housing, which they believed provided more flexibility and stability in the longer term and was more suitable to their needs; this view was shared by service providers. These views are pertinent given that the housing-led approach is dependent for the most part on the immediate provision of a settled home in the community.

Some attractive features of the housing-led approach are that it offers people independence, choice and control to a greater extent than alternative models. Participants felt that while most people who become homeless in Ireland might wish to

live independently in their own home with modest support, housing-led services were not the answer for people with high-support needs. Factors cited to elaborate on this view included a belief that some people who had experiences of long-term homelessness were also affected by their experiences in industrial schools, which in some cases led to them experiencing institutionalisation. Those with experience of homelessness, that living independently without the appropriate level of support and access to meaningful daytime activities such as employment, training and education could lead to mental illness and/or relapse into problematic use of alcohol and drugs.

Joint working through case management to offer a package of supports is often seen as an integral part of delivering an effective housing-led model. The views expressed by service providers suggest that access to welfare benefits and to health and social services, as well as to specialist addiction and mental health services, is currently restricted for people experiencing homeless. These restrictions have arisen due to changes to the levels and eligibility rules for welfare benefits. Restricted access to health and other social services, primarily due to cuts in service provision, is seen to compromise efforts by the homeless sector to resettle homeless people; people with experience of homelessness and who are trying to live independently in the community are also adversely affected by these restrictions. Service providers also reported problems around mental health services not working with people with drug and alcohol problems and alcohol and drug services not working with people with mental health problems. These concerns regarding the fragmented nature of service provision may have implications for the inclusion of an integrated package of services for homeless people as part of the current Housing First Demonstration Project (HFDP) being operated in Dublin as, 'all forms of housing-led services are reliant to at least some degree on joint working with the welfare systems and health, social care and mental health services' (p. 27).

Service providers were sceptical of what they perceived to be the official policy view, that housing-led services could be delivered as low-cost, low-intensity and short-term interventions to assist homeless people. On the contrary, they emphasised that the homeless population was not an homogenous group; rather, homelessness was experienced by different people for different reasons and with different types and levels of support needs. There was consensus among service providers and homeless people that the sector needed to retain a broad mix of options to cater for the diverse needs of homeless people.

While the idea of housing-led services was generally welcomed and endorsed by participants, it is clear that from both standpoints, housing-led services are not currently seen as a panacea for the problem of homelessness and its associated issues. The reservations expressed by participants centre around the view that responses to homelessness need more than just providing housing in the form of 'bricks and mortar'. Effective responses need to include housing alongside appropriate support, especially for people with high support needs. In addition, participants cautioned against providing housing as an individual unit of residence for some homeless people; instead it was suggested that communal residential housing with appropriate support might be more suitable for people with personal biographies that include sustained periods of time spent in institutions and homelessness.

The divergent views expressed by participants in this exploratory study are not wholly different from the academic perspective. According to the authors, 'the consensus of the academic research is broadly similar – housing-led services are very effective at ending homelessness among people with high needs and sustained experience of homelessness, but that while some other gains in well-being are being achieved, these services are not necessarily fully meeting all associated support needs or successful with everyone they try to work with' (p. 31).

Success in exiting homelessness

Findings from the only qualitative longitudinal study of youth homelessness undertaken in Ireland were published recently (Mayock and Corr 2013). The study covered a six-year period and included three phases of data collection with young people experiencing homelessness in Dublin.

Phase 1: Baseline profile and characteristics (September 2004 – January 2005)

Forty young people, 23 males and 17 females, aged between 14 and 22 years, were interviewed during the first phase of data collection (baseline profile). They reported an early childhood characterised by poverty, traumatic life events and household conflict and instability. They also reported deteriorating relationships with their parents during their early to mid-teenage years. Eighteen of the 23 young men left school at or before the age of 15; the young women remained longer in education, with 11 of the 17 attending school at baseline interview.

Twenty-five of the young people were living in under-18s emergency or short-term hostel accommodation, and most of the others were accommodated in other short- or medium-term accommodation; three were in prison and two were sleeping rough. Eleven reported being homeless for 2–4 years and eight for five years or more.

Those with longer homeless histories reported problematic and dependent patterns of alcohol and/or drug abuse, with half (13 males and 7 females) reporting use of heroin. 'Drug use escalated for practically all young people as their "careers" in homelessness progressed and this pattern of consumption was especially apparent among those who moved constantly between hostels targeting the under-18s' (p. 22).

Twenty of the young men and eight of the young women had been charged with at least one criminal offence. According to the authors, 'their accounts demonstrate the interconnectedness of homeless, drug and criminal "careers". ... However, few of the young people were heavily involved in drug use and even fewer had records of offending at the time they first left home' (pp. 22–23).

Almost half the 40 young people (9 males and 10 females) first experienced homelessness at age 14 or younger, and 12 (9 males and 3 females) at age 15. Although most recalled their own unique account of becoming homelessness, the authors identified three broad, and overlapping, pathways into homelessness:

- a history of state care,
- family instability and family conflict, or
- problem behaviour and negative peer associations.

Sixteen of the young people had experience of the state care system, mainly through foster care, with many reporting multiple placements leading to instability and disruption in their young lives. Although many experienced a traumatic childhood in the family home, this did not prevent them from carrying feelings of resentment about their separation from their parents and siblings.

For the majority of the young people, parental conflict and/or marital breakdown featured prominently in the events leading to their first homeless experience. Parental drug or alcohol abuse was reported by 16, and physical abuse by an adult in the home was experienced by 18 young people.

They also reported how their own behaviour, including using alcohol and drugs and staying out late with friends, often led to disagreement with their parents. Most of them admitted having been 'rebellious' in their early teens; however, for many the adverse circumstances of the family home contributed to their vulnerability. According to the authors:

Furthermore, by the time young people found themselves out of home for the first time, their experiences of a number of key institutions (including the family, school or State care) had been overwhelmingly negative. Consequently, at a relatively early age, a large number were living outside, or marginal to, the structures that play a critical role in preparing young people for the transition to adulthood. (p. 24)

Phase 2: Exits from homelessness and continued homelessness (September 2005 – August 2006)

Thirty of the young people (16 males and 14 females) were re-interviewed at phase 2 of data collection. Seventeen (5 males and 12 females) had secured greater stability in their accommodation by this juncture, approximately 12–18 months since the baseline data collection. Seven were in transitional/supported housing, six were living at home, three were in foster or residential state care and one was in private rented accommodation. Thirteen (11 male and 2 female) remained homeless; five were in prison, four in adult hostels, two were sleeping rough, one was in a residential drug treatment programme and one was in temporary accommodation and awaiting sentencing in the criminal justice system. As these figures illustrate, a far greater number of female participants had exited homelessness by phase 2 of the study.

Phase 3: Sustained exits and prolonged homelessness (September 2009 – August 2010)

Twenty-eight of the young people (15 males and 13 females) were re-interviewed at phase 3 of data collection. Fifteen (3 males and 12 females) had exited or sustained an exit from homelessness, of whom nine (including eight females) were living in the private rented sector, one male was in local authority housing, one female was living in an independent flat, one female was living in their partner's home, one female was in a residential aftercare facility and one female and one male were in the family home. As the authors point out: 'Consistent with the patterns identified at phase 2, far more females than males had exited or sustained an exit from homelessness. Gender therefore remains significant in the exiting patterns of young people...' (p. 25).

This study has generated an in-depth and rich understanding of young people's routes into, through and out of homelessness. It is clear that the key institutions of socialisation that bring security, development and identity to our young people – the family, the education system and the state care apparatus – can fail miserably at times. When these institutions fail and young people end up homeless and vulnerable, measures to disrupt this experience and facilitate their quick exit from homelessness are key to their regaining stability. In this regard, the successful work done to ensure the exit from homelessness of all but one of the young women in this study is acknowledged. However, policy and practice also need to acknowledge that it appears to be much harder for young men to exit homelessness and the longer they remain in this condition the more hazardous their lives become, i.e. criminal convictions and the more marginal they remain from society.

8.3.2 Education, training

Information provided in response to questions posed in Dáil Éireann (Ireland's national parliament) reveal the current numbers of recovering drug users that are availing of education and training. The Community Employment (CE) scheme provides education and training for up to 1,000 people in recovery from substance addiction. The vast majority of places on this scheme are taken up by people on methadone, and the scheme is shown to stabilise these people's desire for street drugs and also to free some time for them to pursue alternative experiences. According to Joan Burton TD, Minister for Social Protection, at June 2013 there were 895 participants on drug rehabilitation places in the CE scheme. Seventy-four per cent (n=664) were located in

the Dublin region and 14% (n=125) in Cork Central. The remainder were spread throughout other regions. The 664 participants in the Dublin region represent an increase of 12% compared with the number for June 2012, when there were 595 participants in drug rehabilitation projects in the Dublin region (Burton, J 2013 June 9).

In a response to an earlier Parliamentary Question, Minister Burton described the process of applying for a place on the CE scheme: 'The entry age is already set at 18 years of age for these programmes. The Community Employment (CE) Operating Procedures state that CE Drugs Rehabilitation Places (DRP's) are available to persons aged 18 years or over who are in recovery and referred for a rehabilitation place on CE. Application for a drugs rehabilitation place is based on evidence of an appropriate referral following an assessment of the applicant attending a recognised addiction support service within the last year within the context of the National Rehabilitation Framework of care and case management. This includes HSE addiction services and treatment centres, GPs and other relevant statutory, community and voluntary support services.' (Burton, Joan 2012, 12 June)

8.3.3 Employment

The *Report of the Working Group on Drugs Rehabilitation* (Working Group on drugs rehabilitation 2007) recommends that measures to improve the employability of current, former and recovering drug users should form a key part of rehabilitation care plans, with the overall aim 'to maximise the quality of life, re-engagement in independent living and employability of the recovering problem drug user, in line with their aspirations' (p. 21). Action 32 of the NDS calls for the implementation of the recommendations of the rehabilitation report, and the current Programme for Government includes proposals to progress some of the recommendations including 'to assist drug users in rehabilitation through participation in suitable local community employment schemes' (Fine Gael and the Labour Party 2011) (p. 50).

However, the most up-to-date data on the employment status of people reporting for drug treatment show a steady downward trend in terms of employment prospects for these people. There was a drop in the proportion of all cases in employment, from 22% in 2005 to 9% in 2010 (see Table 8.3.3.1). '...This [drop] is most likely a reflection of the current economic climate, and highlights the continued importance of social and occupational reintegration interventions as part of the drug treatment process' ((Bellerose, *et al.* 2011), p. 2).

Table 8.3.3.1 Number and percentage of treatment population all cases in employment, NDTRS 2005–2010

	2005		2006		2007		2008		2009		2010	
	N	%	N	%	N	%	N	%	N	%	N	%
All cases	1025	(21.8)	1071	(21.0)	1059	(18.9)	921	(15.0)	689	(10.9)	670	(9.1)

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

There was an even greater drop in the proportion of new cases reporting for treatment who were in employment, from 29.7% in 2005 to 11.7% in 2010 (see Table 8.3.3.2). New cases are individuals that have never been treated for problem drug use.

Table 8.3.3.2 Number and percentage of treatment population new cases in employment, NDTRS 2005–2010

	2005		2006		2007		2008		2009		2010	
	N	%	N	%	N	%	N	%	N	%	N	%
New cases	542	(29.7)	590	(28.0)	592	(25.6)	524	(20.8)	386	(13.9)	357	(11.7)

Source: (Bellerose, *et al.* 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, including drug law offences and offences committed as a consequence of a drug addiction. 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 Garda Síochána IT system, PULSE (Police Using Leading Systems Effectively).

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. Official crime statistics do not allow one to identify where offences were drug-related. These connections can only be made through specific research in the area. This is reported in this chapter when available.

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. 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 socio-economic 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. In addition to the Garda Youth Diversion Projects, the Garda Juvenile Diversion Programme (GJDP) provides an opportunity to divert juvenile offenders from criminal activity. It operates on a nationwide basis under the supervision and direction of the Garda National Juvenile Office. The GJDP provides that, in certain circumstances, a young person under 18 years of age who freely accepts responsibility for a criminal incident be cautioned as an alternative to prosecution. The GJDP employs such strategies and initiatives as formal and informal cautioning, supervision, restorative cautioning and conferencing, community policing and referral to the Garda Youth Diversion Projects (which operate outside the GJDP but in concert with it). 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 2006):

- 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

The link between drugs and crime in Ireland exists simply by virtue of prevailing legislation which defines as criminal offences the importation, manufacture, trade in and possession, other than by prescription, of most psychoactive substances. Along with such official statistical indicators, research and analysis has also been conducted in Ireland on the connection between illicit drugs and other types of crime such as theft from the person, burglary, larceny and prostitution (Connolly, Johnny 2006). Data on drug law offences is presented in section 9.3 and information on other drug-related crime is presented in section 9.4.

9.3 Drug law offenses

It should be noted that drug offence data are primarily a reflection of law enforcement activity. Consequently, they are affected in any given period by such factors as law enforcement resources, strategies and priorities, and by the vulnerability of drug users and drug traffickers to law enforcement activities. Having said that, when compared with other data sources such as drug treatment for example, drug offence data can provide a useful indicator of overall drug trends. Alternatively, where law enforcement trends differ from those indicated by other data sources in a given period they may reveal something about specific law enforcement strategies or activities at that time, something that can be further investigated through research.

Figures 9.3.1 and 9.3.2 show trends in proceedings for drug offences from 2004 to 2011. As can be seen from Figure 9.3.1, the number of legal proceedings for the possession of drugs for personal use (simple possession) decreased in 2009 for the first time since 2004. The number continued to fall in the following two years. Simple possession offences accounted for almost 69% of total drug offence proceedings in 2011. Proceedings for drug supply have also decreased marginally since 2009.

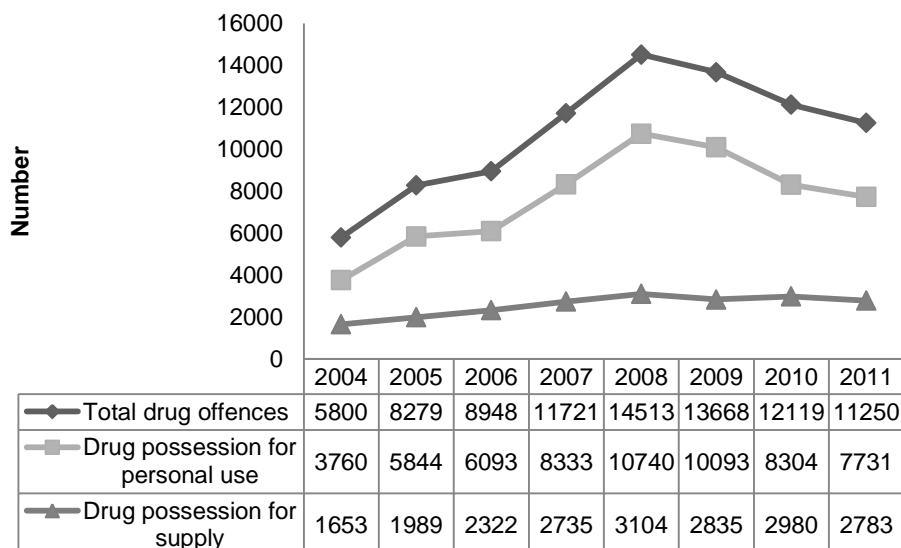


Figure 9.3.1 Trends in relevant legal proceedings for total drug offences, and for possession for personal use and for supply, 2004–2011
Source: (Central Statistics Office 2013)

Obstruction offences often involve an alleged offender resisting a drug search or an arrest or attempting to dispose of drugs to evade detection. As shown in Figure 9.3.2, such offences have generally accounted for the largest number of prosecutions, although numbers declined from a high of 415 in 2007 to 245 in 2011, approaching the 2004 figure of 242. Proceedings for the offence of forged/altered prescriptions have also remained fairly constant since 2004.

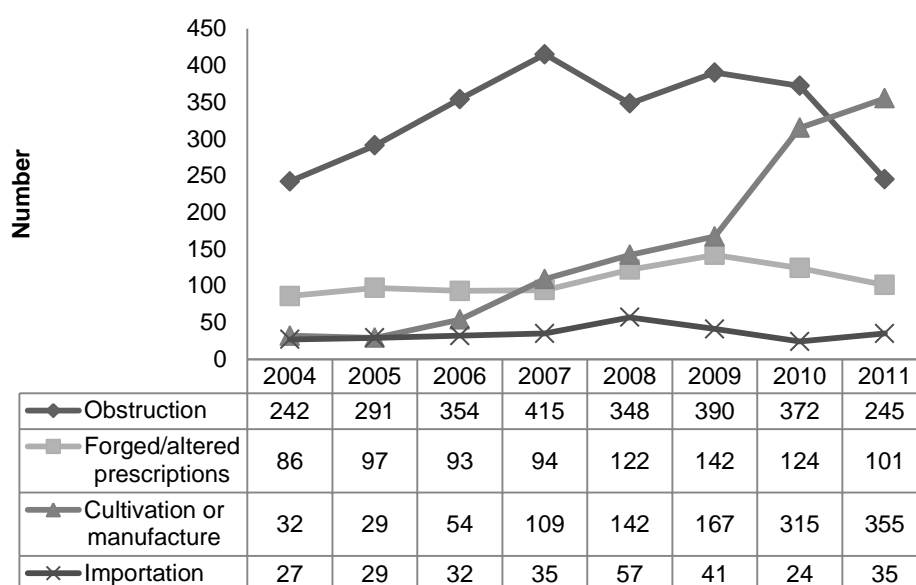


Figure 9.3.2 Trends in relevant legal proceedings for selected drug offences, 2004–2011
Source: (Central Statistics Office 2013)

Another noteworthy development has been the continued increase in the offence of cultivating/manufacturing controlled drugs. Proceedings for this offence have continued to increase since 2005, when there were 29 related proceedings, reaching 167 in 2009 and then more than doubling to 355 in 2011, when they bypassed obstruction offences. It is unclear whether this increase reflects a genuine growth in the commission of such offences or a sustained concentration of law enforcement on their detection. For example, in 2010, the Garda Síochána conducted Operation Nitrogen, a nationwide investigation into cannabis cultivation sites by district and divisional drug units (Health Research Board 2012). Although the specific focus of this operation may have had an impact on the data presented here, a recent report jointly published by the EMCDDA and Europol highlighted the increased involvement of organised crime groups in cannabis cultivation in many European countries, including Ireland (European Monitoring Centre for Drugs and Drug Addiction and Europol 2013).

Courts Service Annual Report 2011

The Courts Service Annual Report for 2012 provides statistics on the outcomes of prosecutions for drug offences between January and December 2012 (Courts Service 2013). Table 9.3.1 shows the outcomes of trials for 15,858 drug offence cases, involving 10,643 defendants, prosecuted in the District Court, the lowest court in the system where most drug offences are dealt with. This total represents a 10.5% decrease on the number of cases prosecuted in 2011 (n=17,715). The most common outcome was for cases to be struck out (n=3,366). There were 2,767 offences that resulted in fines. Just under 8% (n=1,262) cases resulted in imprisonment or detention, a decrease of about 1% on the previous year in terms of the proportion of offences resulting in imprisonment.

Table 9.3.1 Sentences for drug offences in the District Court, 2012

Sentences	Imprisonment	Fines	Community service/probation	Struck out	Dismiss	Taken into consideration*	Other	Peace bond	Total
Number of offences	1262	2767	2074	3366	344	2549	3496	186	15858

* 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.
Source: (Courts Service 2013)

The Courts Service reports that 1,925 drug offences/offenders were tried in the Circuit Criminal Court (Dublin circuit court *offences* = 1,306; Provincial courts *offenders* = 619). The Circuit Court has a higher jurisdiction than the District Court and can thus impose a more severe sentence (Courts Service 2013) (pp.35–36).¹⁴ Of the prosecutions in the Dublin Circuit Criminal Court, 492 led to guilty pleas. Of the 15 cases that went to trial, two resulted in convictions and 13 in acquittals. In relation to the penalties imposed on conviction by offence, it is reported that four led to community service; 162, suspended sentences; 222, imprisonment; 943, other (including taken into consideration, struck out, forfeiture of goods/money/drugs/weapons, destruction of drugs/weapons, disqualification from driving) ((Courts Service 2013) p36).¹⁵

Drug driving offences

Figure 9.3.3 shows the trend in prosecutions for driving or being in charge of a vehicle while under the influence of drugs (DUID) between 2003 and 2011. Between 2006 and 2009 the number of prosecutions for DUID increased from 74 to 703, an increase of 850%. It is unclear why this increase occurred. It could be due to an increase in the incidence of DUID or, the more likely possibility, to an increase in targeted police activity in this area. Since 2009, the number of such offences has decreased significantly, with 337 reported prosecutions in 2011.

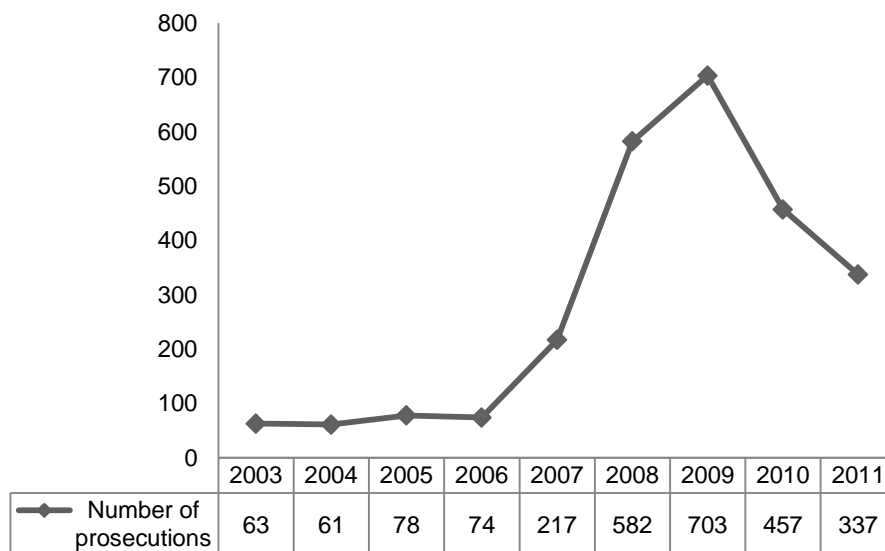


Figure 9.3.4 Trend in relevant legal proceedings for driving in charge of a vehicle while under the influence of drugs, 2003–2011

Source: (Central Statistics Office 2013)

¹⁴ In 2012 the Courts Service began to revise its method of recording and collating statistical data for the Circuit Criminal Court. Prior to 2012 outcomes of cases were reported by reference to defendants. From 2012 the Service will report outcomes by reference to offences, commencing with the Dublin District Court. The data presented here relate only to the Dublin Circuit court.

¹⁵ It appears from the data that the number of penalties imposed by offence (n=1331) is greater than the number of offences reported (1306). It is unclear why this is the case. However, it is possible that the reported penalties were imposed for offences that happened in the previous year (p36).

In relation to drug driving offences, the Medical Bureau of Road Safety (MBRS)¹⁶ published a *Report on roadside drug testing and equipment and related matters* in October 2012 (Cusack, *et al.* 2012). Speaking at the launch, Professor Denis Cusack, director of the MBRS, said ‘this report provides a detailed analysis of all aspects of roadside drug testing’. Professor Cusack further explained that unlike the situation in relation to alcohol, ‘there is no legal limit for drugs. Under current road traffic law, the Gardaí must be satisfied that a driver is under the influence to such an extent as to be incapable of having proper control of a vehicle. This means that the Garda has to prove the driver impairment to the satisfaction of the Court and this can cause difficulties in successfully prosecuting such offences’. This report will inform the Road Traffic Bill (see Section 1.2). This Bill provides for roadside impairment testing for drug use by motorists. Research is currently under way to identify a suitable device for detecting drugs during a roadside test, similar to that used for detecting alcohol.

The National Drug-Related Deaths Index (NDRDI) at the Health Research Board made a substantial contribution to the MBRS report by providing a complete census of fatal road traffic collisions (RTCs) where the deceased person was the driver of the vehicle and had a positive toxicology report for an illicit substance. Currently the NDRDI is the only data source able to provide comprehensive data on the presence of illicit drugs in post-mortem toxicology. In the future, the NDRDI will be able to monitor trends in drug-related deaths and evaluate the effects the new Road Safety Strategy will have on preventing these deaths. Figure 9.3.5 presents NDRDI data for the period 2004 to 2009 on RTC deaths among vehicle drivers in Ireland where the driver had a positive toxicology for one or more illicit drugs at the time of death.

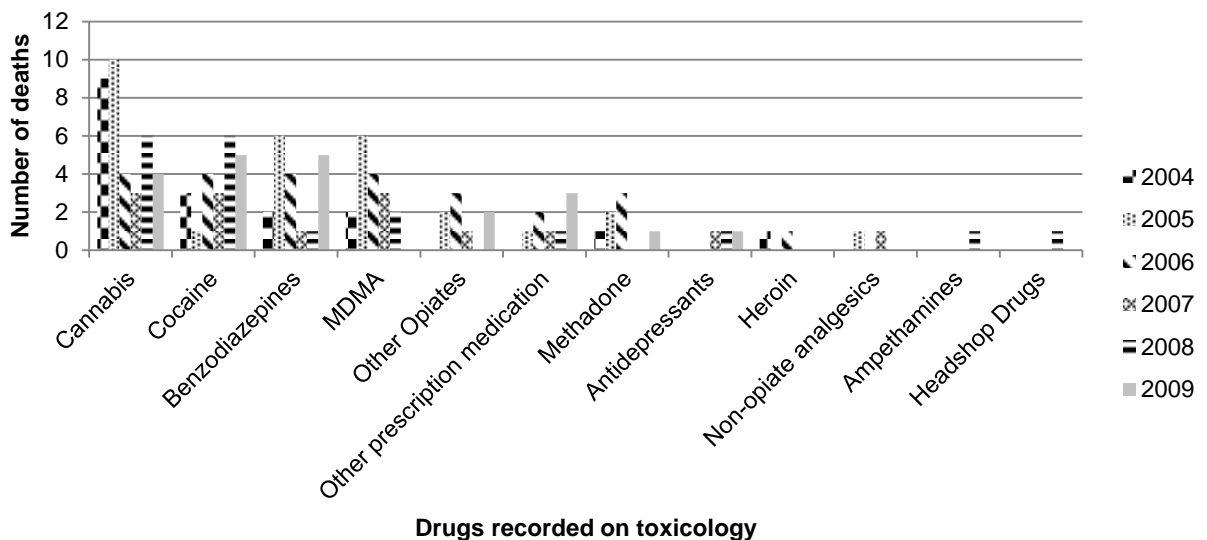


Figure 9.3.5 Drugs recorded in post-mortem toxicology reports, vehicle drivers, NDRDI 2004–2009 (n=93)
Source: (Cusack, *et al.* 2012)

In the six-year period 2004 to 2009 there were 93 RTC deaths recorded by the NDRDI. Cannabis (38.7%) was the most common illicit drug found in the toxicology reports on these 93 individuals, followed by cocaine (23.7%) and MDMA (18.3%).

9.4 Other drug-related crime

Probation Service study on drug and alcohol use among male offenders

The Probation Service is an agency within the Department of Justice and Equality. The Service works closely with the Courts Service, the Irish Prison Service (IPS), An Garda Síochána, the Irish Youth Justice Service (IYJS), the Parole Board and many

¹⁶ The responsibility for chemical testing of intoxicants in driving in Ireland rests with the Medical Bureau for Road Safety, which is a corporate body established in November 1968 by the Minister for Local Government under Part V of the Road Traffic Act, 1968. See www.UCD.ie/mbrs

organisations in the community. The Probation Service generally becomes involved in the criminal justice process between the trial and sanction phases, often in cases where a court requires a pre-sanction assessment to assist in deciding on an appropriate sanction. The Service manages community sanctions and measures. In 2012, the Service dealt with 15,080 offenders in the community, a slight increase on the 14,845 offenders dealt with the previous year (Probation Service 2013). The statistical data provided in the annual report does not provide a breakdown of offenders or interventions by offence type.

However, a research report by the Probation Service presents the findings of the first large-scale, nationwide survey conducted by the Service on drug and alcohol misuse among the adult offender population on probation supervision (Probation Service 2012b). Although earlier research in Ireland highlighted a link between substance misuse and offending behaviour (Keogh 1997), the identification of the precise causal connection between drugs and crime remains a complex and much-debated area of criminological research (Connolly, Johnny 2006). A better understanding of the nature of the connection between drug use and offending has implications for drug and crime prevention and for treatment and criminal justice interventions. A major impediment to research in this area in Ireland is the absence of data from within the criminal justice system. For example, as shown in Section 9.7 below, it is clear from prison drug seizures and prison drug testing data, that a significant proportion of Irish prisoners are problematic drug users. We also know from data provided in the annual reports of the Irish Prison Service the number of people imprisoned for drug offences under the Misuse of Drugs Acts, such as drug possession or supply (Irish Prison Service 2013). However, most problematic drug users are imprisoned not for breaches of the drug laws but for *drug-related* offences, that is, offences such as theft committed as a consequence of their addiction to fund their drug habit. It is in highlighting this particular aspect of the drugs–crime nexus that the Probation Service report is particularly important.

The survey involved a representative sample of 2,963 adult offenders from probation officers' caseloads on 1 April 2011. Questionnaires, developed specifically for the purpose of the study, were completed by the supervising probation officers, based on the case records and knowledge of the offenders on the casebooks.

The main objectives of the study were to:

1. ascertain the number of adult offenders on probation supervision who misuse drugs and/or alcohol,
2. examine the nature and frequency of drug and alcohol misuse,
3. establish if there is a correlation between drug and/or alcohol misuse and offending behaviour, and
4. identify the level and nature of engagement with drug and alcohol treatment services.

Included among the key findings in relation to the first two aims were the following:

- 89% of the adult offender population on probation supervision had misused drugs or alcohol either 'currently' (at the time of the survey) or in the 'past'.
- Of those who misused alcohol/drugs, 27% misused drugs only, 20% misused alcohol only and 42% misused both drugs and alcohol.
- While females comprised only 12% of the adult offender population, both male and female adult offender's exhibit similar drug and alcohol misuse levels.
- The Dublin probation regions exhibited the highest levels of overall misuse among their offender populations, at 91%.
- Almost 21% of offenders were currently misusing two or more substances and over 9% were misusing at least three substances. This includes misuse of alcohol.

With regard to the third aim, the relationship between drug/alcohol misuse and crime among the adult offender population on probation, the study found that, based on the

probation officers' professional judgement, 'there were a substantial number of cases where drug misuse (74%) and alcohol misuse (71.3%) were linked to the offence committed', although the author adds the important caveat that the complexity of the issue meant that a 'strong association' between the drug use and the offence should not be interpreted as meaning that one necessarily caused the other (p.38). In this respect, and consistent with other research in this area, the study found that many other factors associated with offending behaviour, such as 'the offender's anger...mental health and mild learning difficulties...disrupted family background, lack of parental control, low education, child abuse and domestic violence were also stated as risk factors in offending behaviour' (p.38).

With regard to gender issues, the study found that drug misuse among female offenders was marginally more likely to be linked to the offence than that among male offenders; the opposite was the case in relation to the link between alcohol and the offence committed. The study also found that the link between drug misuse and offending was more pronounced among younger age groups. In terms of the offence type, of those whose drug misuse and offence were linked, 31% of offences were drug law offences (such as drug possession), while 36.8% were linked to acquisitive crimes (theft, burglary, robbery, property offences). The study also highlighted the link between alcohol and crime, particularly violent and public-order-related crime: the alcohol misuse of 71% of alcohol-misusing offenders was linked to the current offence committed, and the majority of alcohol-related offences were crimes against the person and public order offences, at almost 40% (p.37).

The final aim of the study was to consider treatment uptake among the offender population. The study found that 'of those who misused drugs, 48.4% appeared to be not currently engaging with any drug treatment service' (p. 42). It is unclear why this is the case as the views of offenders were not incorporated into the study, one of the acknowledged limitations of the research. Nevertheless, this study is an important contribution towards the development of evidence-based criminal justice interventions in response to crime related to drug and alcohol misuse.

9.5 Prevention of drug-related crime

The National Youth Justice Strategy was launched in March 2008 (Irish Youth Justice Service 2008). The first strategy, covering the period up to 2010, provided the framework for co-ordinated implementation of the Children Act, 2001¹⁷.

The strategy focuses on five high-level goals:

- to provide leadership and build public confidence in the youth justice system,
- to work to reduce offending by diverting young people from offending behaviour,
- to promote the greater use of community sanctions and initiatives to deal with young people who offend,
- to provide a safe and secure environment for detained children that will assist their early reintegration into the community, and
- to strengthen and develop information and data sources in the youth justice system to support more effective policies and services.

The second of these high-level goals focuses on Garda Youth Diversion Projects (GYDPs), the Garda Diversion Programme, community sanctions and restorative justice. GYDPs are funded by the Irish Youth Justice Service (IYJS) and administered by the Garda Office for Children and Youth Affairs (formerly Garda Community Relations).¹⁸ The first two GYDPs were established in 1991. In 2008, 100 projects were

¹⁷ A successor to the strategy is due to be published in 2013. See <http://www.iyjs.ie/en/IYJS/Pages/WP08000093>

¹⁸ For further information about the GYDPs see Ryan, L., Warren, A., Cadwell, L. and Bowden, M. (2003). *Garda Youth Diversion Project Guidelines*. Department of Justice, Equality & Law Reform, Dublin. Available at <http://www.drugsandalcohol.ie/20381/> and Redmond, S. (2009). A baseline analysis of Garda youth diversion projects:

operating in local communities across Ireland, providing services to some 3,600 young people.

The GYDPs are community-based, multi-agency youth crime prevention initiatives which seek to divert young people who have been involved in anti-social or criminal behaviour into suitable activities to facilitate personal development. The projects may also work with young people who are at significant risk of becoming involved in anti-social behaviour or crime. The GYDPs work primarily with people aged between 12 and 18.

The director of the Diversion Programme is a Garda Superintendent appointed by the Commissioner of An Garda Síochána. The Director must consider all cases and decide on the suitability or otherwise of the child for inclusion in the Programme. Published in 2013, the 2011 annual report on the effectiveness of the Diversion Programme (Committee appointed to Monitor the Effectiveness of the Diversion Programme 2013) reported the following outputs:

- The total number of incidents referred to the Diversion Programme during 2011 was 27,384.
- The total number of individual children referred to the Programme was 12,809.
- 9,721 (76%) of the children referred were admitted to the Diversion Programme.
- 6,944 (54%) children had their cases dealt with by way of an informal caution.
- 2,777 (22%) children had their cases dealt with by way of a formal caution.
- 25% of children who were referred to the Programme were female while 75% were male.
- Public order (28.86%), theft and related offences (23.69%) and damage to property and to the environment (11.31%) constituted the three main categories of offences for which children were referred.
- Controlled drug offences accounted for 1,290 or just under 5% of the total number of referrals. Of these offences, 1,046 involved possession for personal use while 196 involved drug supply offences.

According to the report, the GYDPs work with the child and set 'an individual plan of intervention for him/her which seeks to assist the child to examine their decision making process focusing on the decision that led them to offend...motivational interviewing techniques are used...to facilitate change and pro-social modelling is used to challenge individual participant's attitudes and behaviours' (p. 23). Assistance is also provided to the family so that changed attitudes can be 'positively re-enforced at home, in school, within peer groups and in the community' (p. 23).

9.6 Interventions in the criminal justice system

9.6.1 Alternatives to prison

Report of the Joint Oireachtas Committee on Justice on Penal Reform

A report on penal reform by the Joint Oireachtas Committee on Justice, Defence and Equality (Joint Committee) has made a number of recommendations aimed at reducing overcrowding in Irish prisons and promoting the development of effective alternatives to imprisonment (Houses of the Oireachtas Joint Committee on Justice Defence and Equality 2013). In October 2011, the Joint Committee established a sub-committee on penal reform, following publication of a report by the Thornton Hall Group (Thornton Hall Project Review Group 2011).

The Thornton Hall Group considered the application of alternatives to custody from both a front-door and back-door perspective. Front-door strategies involve reducing the

numbers sent to prison while back-door strategies involved some form of early release. The Group identified three forms of early release in Ireland:

- the government power to commute or remit any sentence under Article 13.6 of the Constitution,
- remission under the Prison Rules, which provide that prisoners can earn remission of up to 25% of their sentence, and
- temporary release, provided for under the Criminal Justice Act 1960 as amended by the Criminal Justice (Temporary Release of Prisoners) Act 2003.

The recommendations of the Joint Oireachtas Committee are aimed at enhancing these measures. Concerned about the 'significant increase over recent years in the number of prisoners in Ireland, the Joint Committee called, in an overarching recommendation, for the introduction of a 'decarceration strategy' to be introduced, involving a 'declared intention by the Government to reduce the prison population by one-third over a ten-year period' (Houses of the Oireachtas Joint Committee on Justice Defence and Equality 2013) (p. 9). The Joint Committee also recommended that all sentences of less than six months' imprisonment imposed in respect of non-violent offences should be commuted and replaced with community service orders and that standard remission should be increased from one-quarter to one-third of all sentences over one month in length.

The Joint Committee also endorsed a recommendation made by the Irish Penal Reform Trust in its submission to the committee when it called for 'a single piece of legislation which would set out the basis for a structured release system; to include proposed changes to remission...temporary release and parole...for an expanded community return scheme... [and to] underpin the strategies currently used by groups working with offenders post-release, and with potential offenders' (p. 9).¹⁹ Finally, the Joint Committee highlighted the need to address poor prison conditions and prison overcrowding and it called for an increase in the number of open prisons.

Drug treatment court

In relation to the ongoing operation and future of the Drug Treatment Court, which is a specific alternative to prison for offenders whose offence is deemed to be drug-related, the Minister for Justice and Equality, Alan Shatter TD, stated in response to a Parliamentary Question:

The Support and Advisory Committee for the Drug Treatment Court has over the course of 2012 undertaken a detailed evaluation of the court's operation and is in the process of completing some final enquiries which are due to be submitted to my Department in the near future. I will consider this issue further when all of the information is to hand. (Shatter 2013, February 12)

An academic article about the drug treatment court, based on qualitative interviews with six experienced professionals and bureaucrats involved in the management of drug-using offenders in Ireland, looks at the Dublin pilot drug court as an example of policy transfer between countries (Butler 2013). Those interviewed were generally unconvinced that the American drug court model was technically more effective than more traditional methods of diverting offenders from custodial sentencing into treatment, and tended to see political support for the initiative in terms of the symbolic value of this liberal, humanistic alternative to imprisonment. They also agreed, however, that the Dublin drug court was not true to the American model in that it did not embody the philosophy of therapeutic jurisprudence, which is central to American drug court practice. According to Butler, 'the role of the judge in a system of therapeutic jurisprudence is more activist, more involved and, above all, one of problem solving' (p. 6).

¹⁹ For IPRT submission see Irish Penal Reform Trust (2012). Reform of remission, temporary release and parole. Irish Penal Reform Trust, Available at <http://www.drugsandalcohol.ie/18656/>

One of the challenges currently facing the drug treatment court is the difficulty in attracting suitable participants. This has contributed to a low level of court graduates (Department of Justice 2010). In order to address the low number of entrants to the court, as of mid-July 2013, it has now been decided to extend the catchment of the Drug Treatment Court to the south side of the river Liffey in Dublin (Personal communication: Tom Ward, Chief Clerk, Dublin Circuit and District Courts, 31 July 2013).

9.6.2 Other interventions in the criminal justice system

Community policing

A report published by the National Economic and Social Council (NESC) as part of its quality and standards in human services in Ireland series reviews the various police oversight and consultative bodies established by the Garda Síochána Act 2005 (National Economic and Social Council 2012). The new regulatory institutions established by the Act include the Garda Síochána Ombudsman Commission, the Garda Síochána Inspectorate, Joint Policing Committees and Local Policing Fora. The NESC report explains that many of these oversight bodies emerged as a response to 'revelations about abuse of powers by individual officers' (p. 2), with the net result being a much greater oversight of police activity. However, the report queries their overall impact, on both the level and quality of policing and 'the potentially egregious abuses of power' (p. 2). The report suggests that 'these bodies have yet to institutionalise procedures that would embed and sustain reform over time' (p. ix). It also poses the more fundamental question as to whether the kind of oversight offered by these bodies is sufficiently 'diagnostic' to uncover the causes of the various complaints and problems they were established to address, so as to prevent their recurrence.

The report suggests that a more promising route towards the improvement of policing standards may be through a structured liaison process between gardaí and local communities, citing an example of how this has been accomplished by a local community policing initiative established in Dublin's north inner city. The North Inner City Community Policing Forum (CPF) was established in 1999 to facilitate a co-ordinated strategy in response to drug dealing and drug-related anti-social behaviour in the north inner city (Connolly, Johnny 2002). The CPF brings together the local community and representatives of the Garda Síochána and Dublin City Council. The NESC report (National Economic and Social Council 2012) concludes that the CPF has been a 'relatively successful model of engagement with citizens at a local level' and that it has fostered a 'greater culture of transparency' between the community and the gardaí involved' (p. 33). The community, according to the report 'now have a more responsive police service and the gardaí have been able to tap into confidential information derived from the community' (p. 34).

Although highlighting the positive achievements of the CPF, the NESC report concludes that, when approaching all forms of policing service delivery in Ireland, there is a need for a more rigorous process of learning and analysis so as to encourage continuous improvement. It advocates a process referred to as 'triple-loop learning', described as a 'need for learning to take place at a number of levels that reinforce each other: the level at which the service is delivered; at corporate level; and at the level of regulator or at national level' (p. 5). According to the NESC report, because of the policing reforms introduced by the Garda Síochána Act 2005, 'Ireland has all the "parts" necessary for a well-functioning system of quality policing... . But these parts have yet to be co-opted into a common regime of learning that is conducive to greater quality in policing' (pp.ix-x).

Southern Regional Drugs Task Force stresses new approach to policing

As well as reporting on drug use in counties Cork and Kerry during 2011 and detailing the projects funded, together with the outputs and outcomes, the co-ordinator and chair of the Southern Regional Drugs Task Force (SRDTF) have used their 2011 annual report as a vehicle for setting out their vision of how the individual should be at the

centre of a task force's responses to the illicit drugs problem (Black 2012). Co-ordinator Chris Black reports that, as well as focusing on its funded projects, the SRDTF has been involved in innovative development work that draws on international sources. He suggests this is 'setting the seeds for a more user friendly, person centred and health based approach to drugs policy and drugs support'. Initiatives include a new style of policing that embraces human rights and harm reduction. This is the subject of a proposal being developed by the SRDTF in conjunction with the International Drug Policy Consortium (IDPC). The proposal encompasses work that the SRDTF has been progressing, such as an arrest referral process, and 'a vision that drug users be viewed as having a health issue and in need of support, rather than being seen as criminals within the criminal justice system'.

9.7 Drug use and problem drug use in prisons

Although, as with any illicit drug market, it is impossible to accurately record the true extent of drug use, a number of data sources have been used here to provide a picture of the nature and general extent of prison drug use.

Prison drug seizures

Table 9.7.1 Total number of seizures of individual drugs in each prison, Ireland, 2010 to 2012

Institution	2010	2011	2012
Arbour Hill	0	2	0
Castlerea	82	97	50
Cloverhill	87	57	78
Cork	52	73	49
Dochas Centre	30	25	35
Limerick	167	216	287
Loughan House	46	21	15
Midlands	90	121	115
Mountjoy	683	387	235
St Patrick's	272	206	219
Portlaoise	41	21	19
Shelton Abbey	26	16	13
Wheatfield	114	147	123
Training Unit	49	28	18
Total	1739	1417	1256

Source: (Shatter 2013, January 23)

Prison drug seizure figures for 2012 show that there were 1,256 seizures of drugs across the various institutions that make up the Irish prison estate. Total seizures have decreased by 28% since 2010. It is not possible to know whether this reflects a decrease in drug use, more effective supply reduction activity in terms of preventing drugs from entering the prison or, indeed, a decrease in supply reduction enforcement activity. Other data sources and research are needed to provide further context for these figures.

Drug tests in prisons

The Inspector of Prisons, in his annual report for 2012, stated that the availability of drugs remains a major issue in a number of prisons (Reilly 2013). In particular, he made reference to drug problems in Limerick Prison, a matter that was also raised by the Limerick Prison Visiting Committee in their annual report for 2012 (Prison visiting committees 2013). The Inspector also identified a number of issues of concern throughout the prison system, many of them drug-related. At present, for example,

approximately 25% of Irish prisoners are in secure 23-hour lock-up for their own protection. This is often linked to threats from drug gangs in prison or because of drug debts owed to individuals or gangs. One by-product of this prison reality is that it can undermine drug service provision for dependent drug users in prison. According to the Inspector:

‘The reasons why prisoners are on protection vary. In certain cases prisoners request that they wish to go on protection as they are either under direct threat from others in the prison or perceive that they are under threat. In other instances they are on protection simply because they come from a particular geographic area of the Country or because of their cultural ethnicity. The prevalence of gangs in the prison, which reflects that which is on the outside, is also a problem as vulnerable prisoners can be forced to join a gang or do so of their own volition as they perceive that by doing this they are safer.’ (Reilly 2013) (p. 13)

The Inspector also points out that when prisoners are on 23 hour lock up they effectively have little or no contact with teachers or addiction services.

9.8 Responses to drug-related health issues in prisons

9.8.1 Drug treatment

For a detailed consideration of drug health services in Irish prisons see (Health Research Board 2011) (Section 11).

In 2012 the Drug Treatment Clinical Policy document issued by the Irish Prison Service (IPS) in 2008 was reviewed to ensure that services provided in prisons were equivalent to those provided in the community (Irish Prison Service 2008). In its annual report for 2012, the IPS stated:

The...Clinical Drug Policy was reviewed and amended during the course of 2012 to reflect best practice guidelines and changes in practice in the community. This work involved consultation with prison and wider community providers of drug treatment services.’ (Irish Prison Service 2013)(p29)

Further information on this review and on the available drug services in Irish prisons was provided by the Minister for Justice, Alan Shatter TD, in response to a number of Parliamentary Questions. Thus :

The policy was examined in detail by a multidisciplinary group, including representatives from community, voluntary and statutory stakeholders, and Irish Prison Service healthcare staff. It was amended to reflect changes in legislation and practice in the community, including the statutory requirements in relation to HIV testing and notification, and the development of In Reach services for the treatment of Hepatitis C. The Drug Treatment Clinical Policy now encompasses the following:

- Addiction Treatment Charter;
- Clinical Interdisciplinary Care Planning;
- Psychosocial Supports and Pharmacological Interventions for Opioid Dependence;
- Drug Testing;
- Dispensing and Administration of Methadone;
- Viral Screening;
- Immunisation Guidelines;
- Assessment and Treatment of Benzodiazepine Addiction;
- Assessment and Treatment of Alcohol Withdrawals;
- Cocaine Treatment Policy; and
- Nicotine Replacement Therapy Policy. (Shatter 2013, May 30)

In a separate response to a Parliamentary Question about drug detoxification, the Minister reported that 'recent trends across prisons indicate a significant number of prisoners currently self-detoxing from methadone and a marked reduction in the average dose of methadone' (Shatter 2013, February 6).

The proposals of the 2012 review, which have been adopted by the Irish Prison Service and are currently being rolled out on a phased basis include the following:

The establishment of a therapeutic Detoxification and Rehabilitation Treatment Programme (DRTP) with the allocation of 10 additional places from March 2013. The DRTP will also operate in the Medical Unit (Mountjoy Prison) and will be in addition to the existing DTP which has 9 places; Circa 50 beds in the Medical Unit, Mountjoy Prison will be used exclusively for Drug Treatment Programmes including:

- The Drug Treatment Programme (DTP) – 8 week duration;
- Detoxification & Rehabilitation Treatment Programme (DRTP) – 6 week duration,
- Slow Detoxification Programme – maximum duration 6 months,
- Stabilisation Programme – maximum duration 6 months'.

The Training Unit and Shelton Abbey are being designated as suitable for prisoners on methadone maintenance treatment. Loughan House will be designated as a facility for the treatment of prisoners seeking to return to a drug free lifestyle. (Shatter 2013, February 6).

The Minister went on to state that 'Progression from these programmes will include access to Drug Free Units, open prisons and ultimately the Community Return Scheme (See below), subject to normal operational considerations' (Shatter 2013, February 6).

Drug-free units, in accordance with the Irish Prison Service Strategic Plan 2012–2014, are due to be established in all closed prisons (Irish Prison Service 2012). Currently they exist in just four prisons: Mountjoy, Wheatfield, Cloverhill and St Patrick's Institution. Following sustained criticism of conditions in St Patrick's young offenders' institution over many years, the Minister for Justice announced in July 2013 that it was due to be closed within six months (Shatter 2013, July 3).

9.8.2 Prevention and reduction of drug-related harm

For latest information see (Health Research Board 2011) (Chapter 11)

9.8.3 Prevention, treatment and care of infectious diseases

For latest information see (Health Research Board 2011) (Chapter 11)

9.8.4 Prevention of overdose-risk upon prison release

For latest information see (Health Research Board 2011) (Chapter 11)

9.9 Reintegration of drug users after release from prison Research on recidivism

The Probation Service and Central Statistics Office established a partnership to conduct research on recidivism and related issues among offenders on supervision in the community. The report was published in November 2012 (Probation Service 2012a). The first of its kind in Ireland, the study was based on anonymised offender and offence information relating to a 2007-cohort of offenders taken from the Probation Service supervision database. The study reports on recidivism within two years among that cohort, and on a four-year follow-up based on recorded crime and Court Service

data held by the Central Statistics Office. The study also examines variations in recidivism relating to type of original order, gender and age of the offender, category of original offence and of the subsequent offence.

The study provides an overview of community sanctions and their outcomes including the following:

- Almost 63% of offenders on Probation Service supervision had no conviction for a further offence committed within two years of the imposition of a Probation or Community Service order. The overall recidivism of offenders in the study was 37.2%.
- Reoffending was twice as likely to occur in the first rather than the second twelve months.
- The recidivism rate decreased as offender age increased.
- Male offenders represented 86% of the total population and had a higher recidivism rate than female offenders.
- Public Order was the most common original offence and these offenders had the highest recidivism rate.
- The three most common offences for which offenders were reconvicted were the same as the three most common original offences: Public Order, Theft and Drugs.

The Irish Prison Service, in partnership with the Central Statistics Office, also published a report on recidivism rates among ex-prisoners in Ireland (Irish Prison Service and Central Statistics Office 2013). The report was published in May 2013. It is based on a study of all prisoners released on completion of a sentence in 2007, using re-conviction data up to the end of 2010. The total population studied was 7,701. The study also assesses variations in recidivism based on the age and gender of the offender, as well as the category of both the original offence and the subsequent offence.

The Prison study is not comparable to the Probation study described above as the former was based on a two-year period for reoffending and excluded a number of offence types. However, the Probation study showed a recidivism rate of 37.2% within two years of the imposition of a probation or community service order, while the Prison study showed a recidivism rate of 58.3% within two years of the completion of a prison sentence.

The findings of the report include the following:

- The overall recidivism rate of offenders within three years was 62.3%.
- Two thirds of re-offences occurred within six months of release. Over 80% of re-offending occurred within 12 months of release.
- Males made up 92% of the total population studied and had a higher recidivism rate than females (63% as opposed to 57%).
- The recidivism rate decreased as the offender age increased. While 68.5% of those under 21 years of age re-offended, the rate fell to 38.6% for the 51–60-years age category.
- The highest rate of recidivism was among those who had served a sentence for burglary and related offences (79.5%).
- The most common offence for which offenders were re-convicted was Public Order (1,281 or 27%). Almost 27% were reconvicted of the same offence. More than 34% of theft offenders committed a further theft offence.
- More than 20% of drug offenders committed a further drug offence.

The report concludes with the unsurprising observation that ‘for the majority of those incarcerated, similar criminogenic needs and risks exist. ...Lack of employment, abuse of alcohol and drugs, anti-social attitudes and companions, emotional and personal difficulties, poor educational achievement, family problems and lack of housing’ (p. 18). Given the complexity of the problems many prisoners have, the authors raise the

question as to whether it is reasonable to expect the Irish Prison Service or the criminal justice system to provide solutions in terms of reintegration. The authors conclude, 'If we are to really succeed in reconnecting offenders back to their communities, ... [then] we must devise a model which involves a multiplicity of state, community and voluntary agencies working in partnership on behalf of individual communities to bring about real change' (p. 19).

The Irish Prison Service and the Probation Service intend, in partnership with the Central Statistics Office, to jointly publish annual recidivism figures. Consistent with this new partnership approach, the Irish Prison Service and the Probation Service have agreed a joint service strategic plan for 2013–2015 (Irish Prison Service and Probation Service 2013). Included in this are measures aimed at enhancing sentence management from pre- to post-imprisonment in a way which will 'facilitate improved prisoner outcomes', and at enhancing the roll-out of the Community Return scheme, discussed below.

Community return

The Community Return scheme is a joint Probation Service and Irish Prison Service initiative whereby selected prisoners are granted temporary release on condition they perform unpaid supervised work in the community. Eligible participants are those prisoners serving sentences of between one and eight years. They must also have completed at least half their sentence. According to the 2012 annual report of the Probation Service, 'A pilot programme commenced in October 2011 and a total of 365 offenders were released on to the scheme between that time and the end of 2012' ((Probation Service 2013) p. 9). The Community Return scheme had a 90% compliance rate in 2012. It is reported that by the end of 2012, 221 persons had completed their allocated work, with approximately 10% (n=370) being returned to custody for non-compliance. The scheme involves a 'two-strike' rule whereby, if offenders fail to attend or are late for work on two separate occasions, they are regarded as in breach of the rules governing the scheme and are returned to custody to complete the entire balance of their sentence. According to the Probation Service 2012 annual report:

The experience of all concerned has been very positive and many Community Return participants have been commended for their work ethic, punctuality and commitment. Initial feedback from participants has also been positive with many commenting on the supports and structure it gives them on their release and how it has assisted in their transition back into the community. (p. 9)

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 and Alcohol (NACDA) and the Health Research Board (HRB) in late 2013. A detailed summary of the relevant findings from this study were presented in the National Report for 2011 (Health Research Board 2011) (Section 10). Data from that study are not yet available, however. Data from several other information sources which give indications of the nature and size of the market are presented here.

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), reported in last year's National Report (Health Research Board 2012) (Section 2.3), 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)?'.

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 CDLE) 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.

Drug prices are also not regularly reported on in Ireland. However, An Garda Síochána monitors drug markets on a nationwide basis annually and records current drug values. These are reported in this chapter for the first time.

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

Bulletin 3 on the results of the 2010/11 general population drug prevalence survey, which surveyed a representative sample of adults in Ireland aged between 15 and 64 years in late 2010 and early 2011, reports on the findings with regard to cannabis use (National Advisory Committee on Drugs and Alcohol 2013) (see also section 2.?). The bulletin presents the results regarding lifetime use of cannabis (ever used), and last-year (recent use) and last-month (current use) prevalence rates. Prevalence results are also presented for cannabis dependence and cannabis abuse. Finally, the bulletin reports on age at first use, frequency of use, methods of using, how cannabis was obtained and the profile of those who took it. The survey was carried out according to standards set by the EMCDDA.

Herb was the main type of cannabis used by current users. The share of herb users relative to resin users has reversed since 2006/7 when resin was the most common form reported. The majority of recent cannabis users said it would be easy for them to obtain cannabis in a given 24-hour period

10.2.2 Drugs origin: national production versus imported

A recent EU drug markets report, jointly published by the EMCDDA and Europol, is the first comprehensive overview of illicit drug markets in the European Union (European Monitoring Centre for Drugs and Drug Addiction and Europol 2013). The report highlights a number of factors relevant to the Irish illicit drugs market, and Ireland's response to the 'head shop' phenomenon. A comparative study of this nature can be useful in trying to understand national developments in drug markets. For example, in late 2011, information was gathered in an attempt to understand anecdotal reports of a reduction in the supply of heroin in Europe: 'Evidence of this phenomenon was collected between November 2010 and March 2011 from Bulgaria, Ireland, Hungary, Slovakia, the United Kingdom, Switzerland and some regions in Russia, whereas heroin remained available, with possible increases in purity, in Belgium and France' (p. 30). Although the causes of these developments remain unclear – they may point to a shift in demand towards alternative drugs, such as fentanyl, or to the possible disruption of heroin supply routes through Turkey owing to law enforcement efforts – research of this nature at an international level can help explain national trends.

Ireland is also one of a number of countries that have experienced increases in the domestic cultivation of herbal cannabis in the last five years. Using drug seizure size as an indicator, the report also provides a useful picture of cannabis resin supply routes into and throughout Europe. It is reported that Ireland is a transit point for cannabis en route to the UK and onwards into mainland Europe:

Average seizure sizes greater than 1kg suggest that Ireland is...an entry point for Moroccan resin into Europe. Resin seizures represent about 15% of estimated national consumption; it is likely that some of the resin entering Ireland eventually ends up in the United Kingdom, where the market for resin, although smaller than the market for herb, is still rather large, estimated to be about seven times the size of the Irish market. Seizures in the United Kingdom are on average smaller than in Ireland (under 1kg) and represent one-third of estimated national demand... (p. 62)

The report also considers the involvement of organised crime groups (OCGs) in drug production and trafficking. With regard to herbal cannabis it is reported that 'Vietnamese OCGs have become prominent in the indoor cultivation of cannabis in many EU countries, particularly Belgium, the Czech Republic, Germany, Ireland, France, Hungary, the Netherlands, Poland, Slovakia and the United Kingdom' (p. 64). These OCGs are described as 'hierarchical in structure', incorporating a range of specialised personnel, including 'electricians, plumbers and managers of cultivation facilities' (p. 64). The report also alludes to the social factors that can lead to people becoming involved with such illegal activities. In relation to herbal cannabis, 'Gardeners tending the plants are often illegal migrants working to pay off their passage' (p. 64).

Synthetic drugs are produced mainly in Belgium and the Netherlands. However, the report states that police intelligence suggests 'the growing prominence of Polish and Lithuanian OCGs in trafficking drugs obtained in the Netherlands to various Nordic and Baltic States, Ireland and the United Kingdom' (p. 78).

The report also looks at the increasing importance of the internet as a source of supply of new psychoactive substances and 'legal highs', an issue that has featured prominently on the political agenda in Ireland in recent years (Health Research Board 2011) (Section 1.2). EMCDDA data included in the report show that the number of

online shops offering these substances increased from 170 in January 2010 to 693 in January 2012. A recent Eurobarometer survey referred to in the report found that, among 15–24-year-olds, ‘lifetime use of “legal highs” in most Member States was 5% or less’, whereas ‘use in the United Kingdom, Latvia, Poland and Ireland was 8%, 9%, 9% and 16% respectively’ (p. 106). The high rate in Ireland can be traced to the significant number of ‘head shops’ operating in this country in the years covered by the report.

10.2.3 Trafficking patterns, national and international flows, routes, modi operandi; and organisation of domestic drug markets

Drug offence data can assist in understanding aspects of the operation of the illicit drug market in Ireland. Data on drug 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, when compared with other sources, such as drug treatment data, they can 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. Figures 10.2.3.1 and 10.2.3.2 show trends in relevant legal proceedings for possession of drugs by Garda region. It should be noted that possession offences include both possession for personal use and possession for the purpose of supply. It is not possible to distinguish between these two offences in the data reported by Garda region. However, in the country as a whole, possession for personal use accounted for between 65% and 75% of all possession cases in the years 2004–2011 (see Figure 9.3.1).

As shown in Figure 10.2.3.1 an upward trend since 2004 in relevant legal proceedings for possession (for personal use and for supply) continued until 2008, and then decreased between 2008 and 2011. The majority of such proceedings were in the Dublin Metropolitan Region (DMR), where the number increased steadily from 1,515 in 2004 to 5,270 in 2008. The number has fallen since then, with 3,773 such offences prosecuted in 2011, lower than the figure of 4,077 reported for 2007.

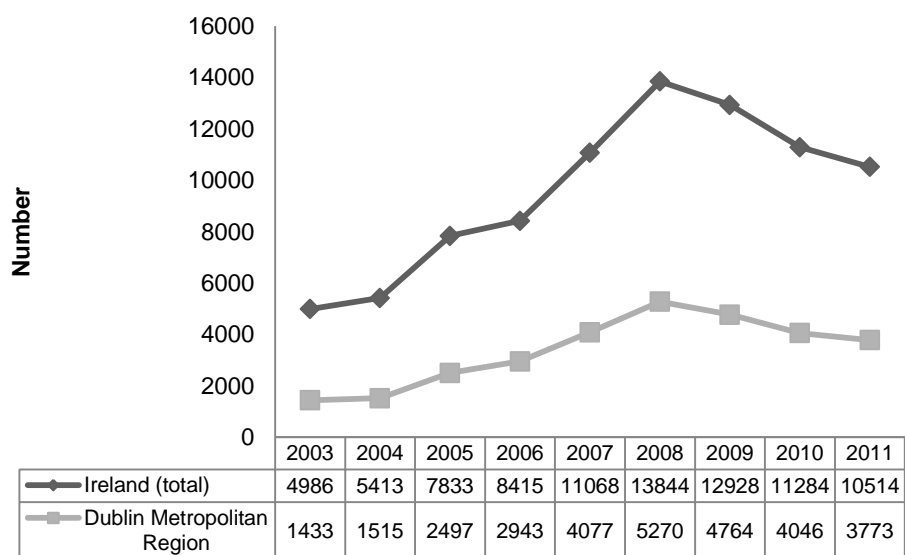


Figure 10.2.3.1 Trends in relevant legal proceedings for possession of drugs for personal use and for sale or supply, nationally and in the Dublin Metropolitan Region, 2003–2011

Source: (Central Statistics Office 2013)

Figure 10.2.3.2 shows trends in supply offences by Garda region, excluding Dublin. Numbers have increased in all regions since 2005. This reflects the reality that drug markets are no longer primarily a Dublin-based phenomenon. Following this general increase throughout the country, the number of relevant legal proceedings for drug possession (for personal use and for supply) decreased in all regions between 2009

and 2011, with the exception of the Northern Region where the figure fluctuated slightly in that period.

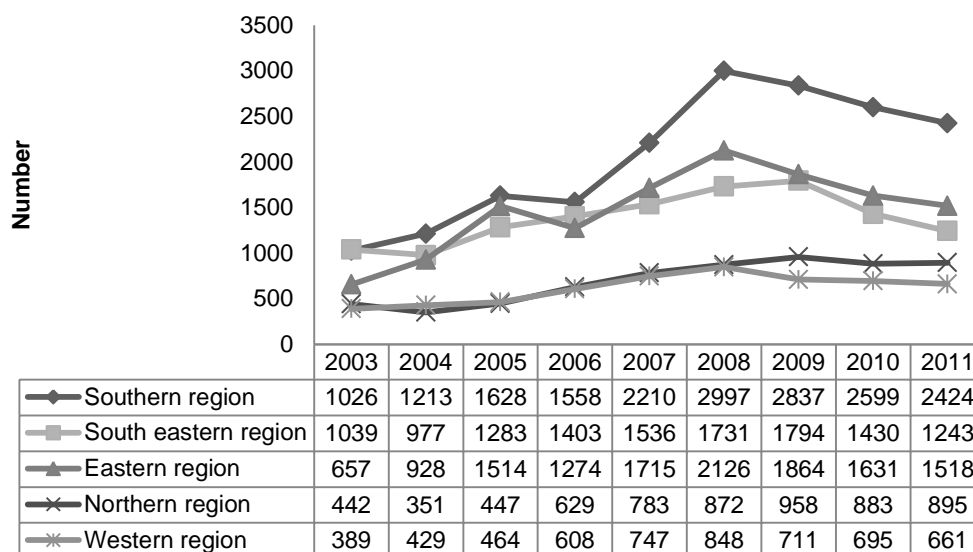


Figure 10.2.3.2 Trends in relevant legal proceedings for possession of drugs for personal use and for sale or supply, by region, excluding the DMR, 2003–2011

Source: (Central Statistics Office 2013)

In a recent report to the Joint Oireachtas Committee on Justice, Defence and Equality, the Garda Síochána Commissioner stated that there are approximately 25 OCGs operating throughout the State (Joint Committee on Justice Defence and Equality 2012). The majority are centred in large urban areas such as Limerick, Cork, Galway, Sligo and Dublin. The Commissioner stated:

...there is a high amount of interaction between the various organised crime groups throughout the country who regularly pursue joint enterprises, particularly drug imports. The vast majority of organised crime groups are drug trafficking groups who are prepared to use violence and intimidation to further their aims. Each of these organised crime groups is structured hierarchically and would typically consist of a leadership, a number of middle-managers and low level criminals who could carry out day-to-day running of these organised crime groups.(p. 3)

The Commissioner also stated that OCGs in the State work closely with criminals in Northern Ireland, although he suggested that the ‘taxing and extortion of drug dealers by dissident republicans have occurred in recent years’.

Two recent studies carried out in association with the business group Retail Ireland²⁰ have highlighted a link between the trade in illicit drugs and the illicit trade in other products such as fuel, illegal tobacco and alcohol and counterfeit medicines. The first report, by EPS Consulting for Retail Ireland, is based on findings from a range of earlier reports by business groups, information from the Revenue Commissioners and responses to Parliamentary Questions. The report characterises counterfeit medicines as ‘intentionally mislabelled with regard to either identity and/or source. ...Many contain too much or too little of the active ingredient; have the wrong ingredients; or contain ingredients with misleading packaging’ (EPS Consulting 2012) (p. 19). The report estimates that counterfeit medicine sales in Ireland could be as high as €86 million and that 55% of medicines are purchased over the internet from websites outside the country. Referring to an earlier study, the report states that ‘upwards of 90% of medicines bought from internet sources that conceal their physical address are

²⁰ Retail Ireland represents the retail sector in Ireland and is an affiliate member of the Irish Business and Employers Federation (IBEC). See www.retailireland.ie

counterfeit [and that] 600,000 people in Ireland willingly (or otherwise) put themselves at risk by purchasing prescription-only medicines without a prescription' (p. 20).

The follow-on report (Thornton, Grant 2013) is based on a process of consultation with stakeholders from a range of sectors across the economy. This included 'stakeholders from sectors such as the retail sector, the producers in the legitimate markets, consumers, journalists, enforcement agencies and State agencies' (p7). The report highlights the role of organised crime and refers to the diversification of criminal gangs from illicit drugs into other forms of illicit trade: 'Drugs continue to be the primary area of focus for criminal gangs. ...Evidence of the linkage across the various illicit trades is apparent from the seizures made by both the Police Service of Northern Ireland (PSNI) and An Garda Síochána who have encountered multiple products such as tobacco, alcohol, (illicit) drugs and fuel on a single raid' (p. 15).

The Garda National Drugs Unit (GNDU) has overall responsibility for drug law enforcement. It is reported in the 2012 annual report of the Garda Síochána that the GNDU liaises with police forces in the UK, Spain, Holland and Belgium, 'where OCG's affecting the Irish jurisdiction tend to be the most proactive' (An Garda Síochána 2013) (p. 4). In 2012, the GNDU arrested 125 persons in connection with drug trafficking offences, 91 of whom were charged and are currently before the courts. Seventy-one 'significant seizures' were made including one in June 2012 of 432 kg of cocaine with an estimated street value of €30.23 million, which was imported to Ireland from Bolivia via the Netherlands. CDLE and the US Drug Enforcement Administration were involved in this operation. According to the 2012 annual report of the Revenue Commissioners, three members of an Irish OCG were arrested during this operation (Revenue Commissioners 2013).

Illicit street-level retail market in prescription drugs

Under the Medicinal Products (Prescription and Control of Supply) Regulations, it is prohibited for a person to supply a prescription medicine except in accordance with a prescription, and the supply must be made from a registered pharmacy by or under the personal supervision of a registered pharmacist. A person who contravenes these regulations is guilty of an offence. However, the illegal street sale of prescription drugs has emerged as an important issue in the Irish drug scene in recent years (Health Research Board 2012) (Section 1.2). In response to a Parliamentary Question, Alex White TD, Minister of State at the Department of Health, stated:

The Revenue Commissioner's Customs Service and the Irish Medicines Board (IMB) have shared competency in relation to the prevention and detection at importation of illicit medicines. In addition the IMB and the Customs Service have a Memorandum of Understanding (MOU) under which both organisations work closely to detain and prohibit prescription medicines purchased on-line from being imported. The IMB and the Customs Service deploy operational resources in a targeted and risk-based manner and as a result of specific intelligence. These approaches are reviewed and adjusted based on analysis and evaluation of national and international seizure trends, traffic frequency, routes and other risk indicators. Revenue's Customs Service also has Memoranda of Understanding with a number of express mail courier service providers and work[s] very closely with these companies, the IMB and the Gardaí to combat the importation of illicit medicines. In September 2012 the IMB, Revenue Customs Services and An Garda Síochána took part in an international week long operation 'Pangea V' which led to the detection of capsules and tablets with an estimated value in excess of €375,000. (White, A 2013, May 8)

The government is currently reviewing the Misuse of Drugs Regulations with a view to introducing additional controls on certain prescription drugs being traded illicitly (see Section 1.2.2).

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 trends in cannabis-related seizures and total seizures between 2003 and 2012. The total number of drug seizures increased from 5,299 seizures in 2004 to a peak of 10,444 seizures in 2007. Between 2008 and 2010, the number almost halved, to 5,477. This decrease can be explained primarily by the significant decrease in cannabis-type substances seized. Although, as explained in section 10.1 above, not all drugs seized by law enforcement are necessarily analysed and reported by the FSL, it is difficult to know if the reduction in cannabis-related seizures reflects a decline in cannabis use or a reduction in law enforcement activity. Following a slight increase in 2011, in 2012 the number of cannabis seizures again decreased slightly.

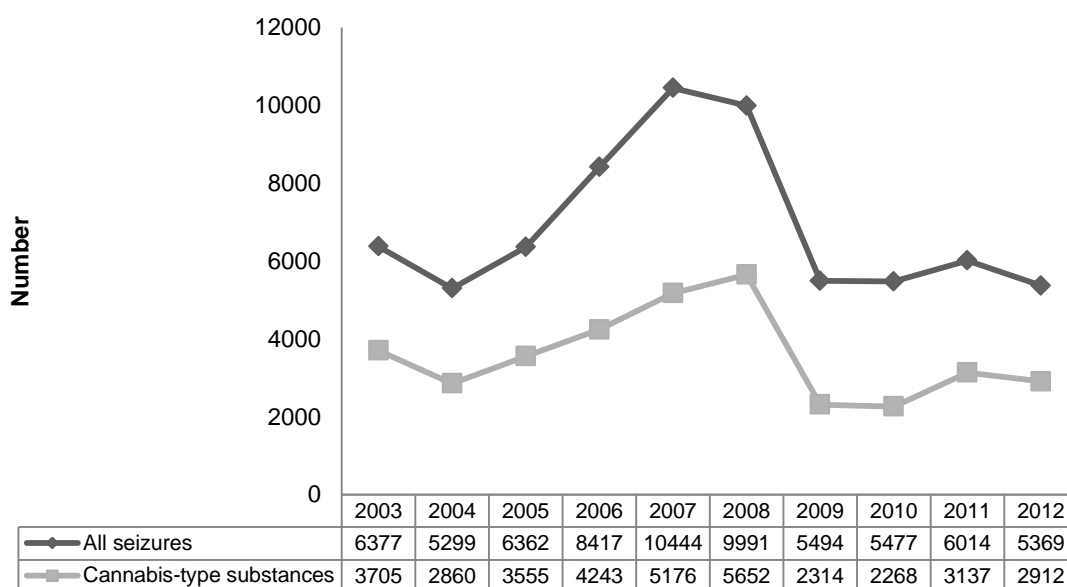


Figure 10.3.1.1 Trends in the total number of drug seizures and cannabis seizures, 2003–2012

Sources: Central Statistics Office 2008, 2009, 2010, 2011, 2012, 2013 unpublished data

The decrease in cannabis seizures between 2009 and 2010 may also be partly explained by a change in the nature of cannabis use, with people moving from resin to more potent forms of cannabis, such as herbal cannabis. For example, Figure 10.3.1.2 shows that although seizures of cannabis resin decreased between 2009 and 2012, seizures of cannabis plants have increased steadily since 2006, with a slight decrease in 2012. Herbal cannabis seizures almost doubled between 2009 and 2011, from 981 in 2009 to 1,833 in 2011, and then levelled off in 2012 (see Section 9.3 in relation to the increase in cultivation offences, and Section 10.3.3 in relation to Garda operation focused on cannabis cultivation). That there has been a move in consumption away from cannabis resin and towards more potent forms of cannabis is supported by the findings of the most recent publication of the all-Ireland prevalence survey on drug use (National Advisory Committee on Drugs and Alcohol 2013) (see Section 10.2.1).

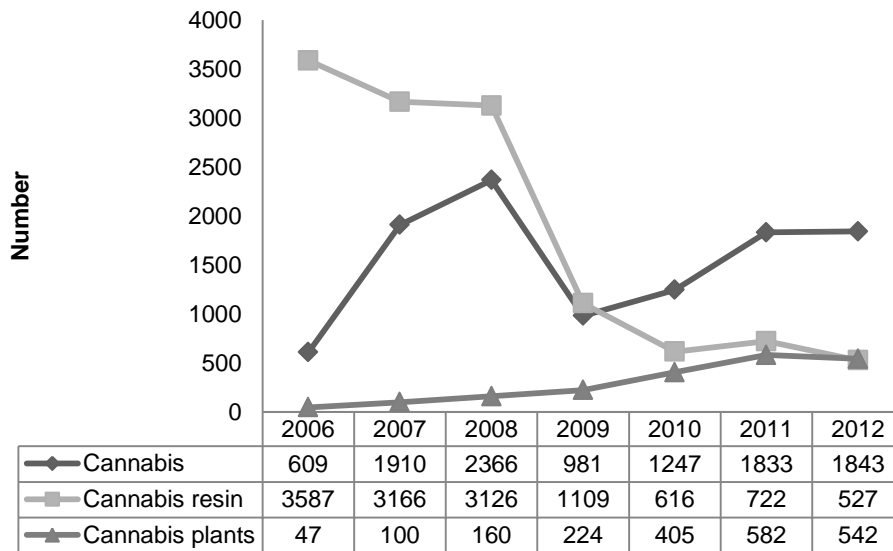


Figure 10.3.1.2 Trends in the total number of drug seizures by cannabis type, 2006–2012

Sources: Central Statistics Office 2008, 2009, 2010, 2011, 2012, 2013 unpublished data

Other controlled drugs

The reduction in the total number of reported seizures since 2008 shown in Figure 10.3.1.1 may also be explained by a reduction in the number of seizures of other drugs since 2008. Figure 10.3.1.3 shows trends in seizures for a selection of drugs, excluding cannabis, between 2003 and 2012. There was a significant decline in seizures of cocaine and heroin between 2008 and 2011. In 2012, heroin seizures increased slightly, while cocaine seizures continued to decrease. Seizures of ecstasy-type substances also decreased significantly between 2008 and 2010. However, in 2011, they increased by more than 900%. This upward pattern has continued, albeit by a small margin, in 2012.

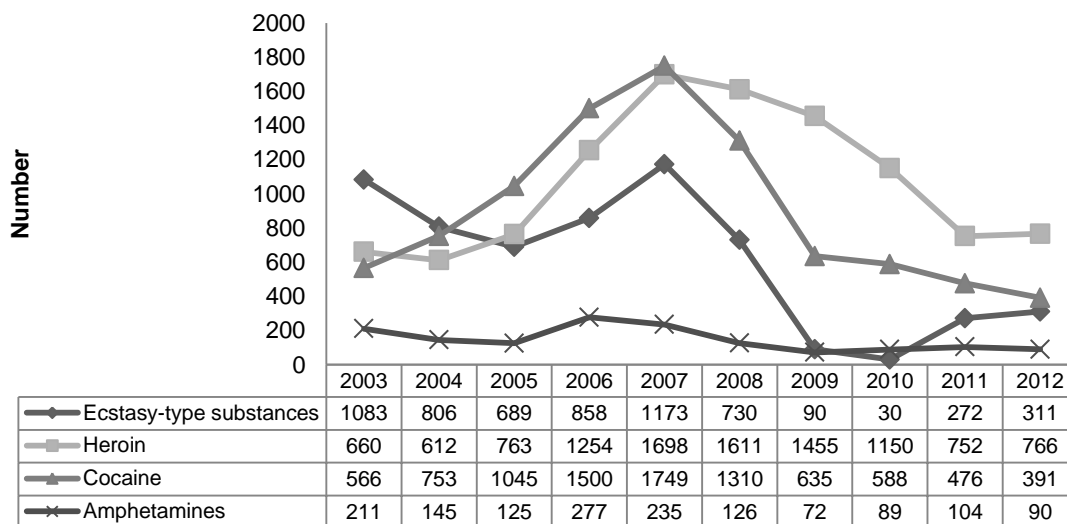


Figure 10.3.1.3 Trends in the number of seizures of selected drugs, excluding cannabis, 2003–2012

Sources: Central Statistics Office 2008, 2009, 2010, 2011, 2012, 2013 unpublished data

Table 10.3.1.1 All drugs seized that were reported on by the Forensic Science Laboratory, 1 January 2012 to 31 December 2012

Drug	Quantity	Number of Cases
Alprazolam	8864 tablets	111
Amphetamine	22,396 grams	90
Buprenorphine	10 tablets	3
BZP	6,233 tablets, 349 grams	16
Cannabis	1,020,023 grams	1843
Cannabis resin	1,185,154 grams	527
Cannabis plants*	11,601 plants	542
Clonazepam	750 tablets	15
Cocaine	459,264 grams	391
Diamorphine (Heroin)	60,751 grams	766
Diazepam	173,177 tablets 330 gram	463
Dihydrocodeine	421 tablets	14
Ephedrine	2708 tablets	8
Ecstasy MDMA	148,195 tablets, 5,659 grams	311
Flephedrone	696 grams	1
Flunitrazepam (Rohypnol)	1,736 tablets	9
Flurazepam	872 capsules, 51 tablets	52
Ketamine	76 grams	13
Lorazepam	27 tablets	1
LSD	402 squares	24
Methadone	8,992 mls	33
Methylamphetamine	1,277 grams	53
Temazepam	466 tablets	12
Triazolam	467 tablets	11
TFMPP	36,349 tablets	44
Zolpidem	134 tablets	16

Source: Central Statistics Office, unpublished data, 2012

The list of drugs is a record of main categories of drugs delivered to the FSL and reported on for 2012. There may be some large cannabis/cannabis resin cases without a suspect, in relation to which no analysis was conducted and no weight was determined.

*The number of cannabis plants does not reflect the total number detected as only a sample of the plants is sent for analysis for practical reasons.

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 (Reitox) 2010).

10.3.3 Number of illicit laboratories and other production sites dismantled; and precise type of illicit drugs manufactured there

The Garda Síochána 2012 annual report refers to the continuation of Operation Nitrogen. This is an investigation into industrial cannabis cultivation within the State. It is reported that '38 cannabis cultivation sites were discovered and 50 persons were arrested' during 2012 (An Garda Síochána 2013) (p. 5).

10.4 Price/purity

See National Report 2011 for most recent information (Health Research Board 2011). The Illicit drug market study referred to in that report and the data therein remains unpublished (Connolly, Johnny and Donovan In press).

10.4.1 Price of illicit drugs at retail level

The Garda annual report for 2012 reports that the GNDU carried out eight 'test purchase' operations targeted at low level dealers nationwide, which led to 71 people being arrested in respect of 281 criminal offences (An Garda Síochána 2013) (p. 5). A test purchase operation involves a garda officer posing as a potential buyer of drugs. The transaction is monitored carefully and at an appropriate moment the dealer/supplier is arrested.

Successful test purchase operations require up-to-date intelligence on street-level drug prices. An Garda Síochána monitors drug markets on a nationwide basis annually and records current drug values. However, these values are not generally published. The Garda Síochána 2012 annual report provides estimated total values of drug seizures (An Garda Síochána 2013). From these figures estimated unit prices can be deduced. Further clarity was sought on these price estimates from the Garda National Drugs Unit, and these data are presented in Table 10.3.1.2.

Table 10.3.1.2 Estimated drug prices for a selection of illicit drugs, 2013

Drug	Unit measurement	Price
Alprazolam	5mg/10mg pill	€1/€2
Amphetamine (Speed)	1g	€15
BZP	1 Pill	€5
Cannabis	1g	€20
Cannabis resin	1g	€6
Cannabis plants*	1 Plant	€800
Clonazepam	5mg/10mg pill	€1/€2
Cocaine	1g	€70
Crack	1g	€100
Diamorphine (Heroin)	1g	€150
Diazepam	5mg/10mg pill	€1/€2
Ephedrine	1 pill	€1
Ecstasy MDMA/MDEA/MDA	1 pill/ 1g	€8–€10/ €60
Flunitrazepam (Rohypnol)	5mg/10mg pill	€1/€2
Flurazepam	5mg/10mg pill	€1/€2
GHB/GBL	50mls	€30
Ketamine	1g	€70
Khat	1kg	€200
Lorazepam	5mg/10mg pill	€1/€2
LSD	1 tablet	€10
Mescaline (S P Cactus/Peyote)**	1 unit	€30–€500
Methadone	30 mls	€10
Methylamphetamine	1g	€60
New synthetic substances***	1g	€35
Psilocybin (Magic mushrooms)	4g bag/pouch	€20
Synthetic cannabinoids (Spice)	1g	€20
Temazepam	5mg/10mg pill	€1/€2
Triazolam	5mg/10mg pill	€1/€2
TFMPP	1 Pill	€5
Other – Anabolic steroids	pills/vials	€60–€100/€12

Sources: (An Garda Síochána 2013) and Personal Communication, Garda National Drugs Unit, July 2013

*Depending on plant maturity this may be a potential or actual market value

** Depending on cactus size; also sold dried in bags

***Mephedrone, Flephedrone, MDVP, Naphyrone, Flourotricapococaine, Butylone, Methedrone, Methcathinone, Methylone, Dimethocaine

10.4.2 Price/potency of illicit drugs

See National Report 2011 for most recent information (Health Research Board 2011). The Illicit drug market study referred to in the 2011 report and the data therein remains unpublished (Connolly, Johnny and Donovan In press).

10.4.3 Composition of illicit drugs and drug tablets

These data have never been reported in Ireland.

Part B

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11.2 List of relevant databases available on internet

- Central Statistics Office interactive tables Census 1996, 2002, 2006 and 2011 www.cso.ie
- Hospital In-Patient Enquiry scheme data 2000–2009 www.esri.ie/health_information/hipe/
- National Drug Treatment Reporting System interactive tables 2004–2010 <http://www.drugsandalcohol.ie/>

For descriptions of relevant databases not currently available on-line, see introductions to chapters 5, 6, and 7.

11.3 List of relevant internet addresses

<http://aldp.ie>
<http://addictionireland.ie>
<http://www.ballyfermotadvance.ie/>
<http://www.citywide.ie>
<http://www.cso.ie>
<http://www.courts.ie>
<http://www.drugsandalcohol.ie/>
<http://www.drugs.ie>
<http://www.fsn.ie>
<http://www.garda.ie>

<http://www.hpsc.ie>
<http://www.hrb.ie>
<http://www.hse.ie>
<http://www.imshealth.com/portal/site/imshealth>
<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/>

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The Criminal Justice (Drug Trafficking) Act 1996

The Criminal Justice Act 1999

The Criminal Justice Act of 2006

The Criminal Justice (Amendment) Act 2009

The Criminal Justice (Search Warrants) Act 2012

The Education (Welfare) Act 2000

The Europol Act 2012

Misuse of Drugs Act (MDA) 1977

The Housing (Miscellaneous Provisions) Act 2009

The Law reform commission Act 1975

The Mental Health Act 2001

The Misuse of Drugs Act (MDA) 1984

The Misuse of Drugs Regulations 1988

Bills

The Fines (Payment and Recovery) Bill 2013

The Road Traffic (No.2) Bill 2013

The Spent Convictions Bill 2012

12.6 List of abbreviations

ADHD	Attention-Deficit Hyperactivity Disorder
AIDS	Acquired Immunodeficiency Syndrome
ALDP	Ana Liffey Drug Project
ASRS	Adult ADHD Symptoms Rating Scale
AUDIT	Alcohol Use Disorders Identification Test
BAC	Blood Alcohol Concentration
BBVs	Blood Borne Viruses
BLIPS	Brief Limited Intermittent Psychosis
BYAP	Ballymun Youth Action Project
CAARMS	Comprehensive Assessment of At Risk Mental States
CAMHS	Child and Adolescent Mental Health Service
CAN	Swedish Council for Information on Alcohol and Other Drugs
CBCS	Cognitive Behavioural Coping Skills therapy
CBT	Cognitive Behaviour Therapy
CD	Conduct Disorder
CDLE	Customs Drug Law Enforcement
CE	Community Employment
CFSA	Child and Family Support Agency
CHAID	Chi-squared Automatic Interaction Detection
CIDR	Computerised Infectious Disease Reporting
CLAR	areas of rural regeneration
COD	Co-occurring Disorder
CPF	Community Policing Forum
CRA	Children's Rights Alliance
CRC	capture-recapture
CSO	Central Statistics Office
CSOs	Civil society organisations
CTL	Central Treatment List
DAIRU	Drugs and Alcohol Information and Research Unit (DHSSPS, NI)
DAG	Drugs Advisory Group
DATFs	Drugs and Alcohol Task Forces
DCEGA	Department of Community, Equality and Gaeltacht Affairs (since March 2010)
DCYA	Department of Children and Youth Affairs
DDD	Defined Daily Dosage
DECLG	Department of the Environment, Community and Local Government
DES	Department of Education and Skills (since March 2010)
DEIS	Delivering Equality of Opportunity in Schools
DHSSPS	Department of Health, Social Services and Public Safety
DIO	Drug Intentional Overdose
DMFT	Decayed/ missing/ filled teeth
DML	Dublin/Mid Leinster
DMR	Dublin Metropolitan Region
DNE	Dublin/North East
DoH	Department of Health
DoHC	Department of Health and Children
DRPT	Detoxification and Rehabilitation Treatment Programme
DSH	Deliberate Self Harm
DTC	Drug Treatment Court

DTCB	Drug Treatment Centre Board
DTF	Drugs Task Force
DTP	Drug Treatment programme
DUID	Driving Under the Influence of Drugs
DUMP	Dispose of Unused Medications Properly
Dundrum-DS	Drug Misuse and Dependence
EIS	Europol Information System
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and Other Drugs
ESRI	Economic and Social Research Institute
EU	European Union
Europol	European Police Office
FSL	Forensic Science Laboratory
FSA	Family Support Agency
FSN	Family Support Network
GMS	General Medical Services
GNDU	Garda National Drugs Unit
GP	General Practitioner
GPI	Group Psychological Intervention
GRO	General Register Office
GYDP	Garda Youth Diversion Projects
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
HPU	Health Promotion Unit
HRB	Health Research Board
HSE	Health Service Executive
IASP	International ADHD in Substance Use Disorders Prevalence Study
IBEC	Irish Business and employers confederation
ICASA	International Collaboration on ADHD and Substance Abuse
ICGP	Irish College of General Practitioners
ICT	Information and communication technologies
IDIG	International Drug Issues Group
IDUs	Injecting Drug Users
IDO	Intentional Drug Overdose
ILP	Individual Learner Plan
IPRT	Irish Penal Reform Trust
IPS	Irish Prison Service
IYJS	Irish Youth Justice Service
JPC	Joint Policing Committee
JPF	Joint Policing Forum
LDTF	Local Drugs Task Force
LGBT	Lesbian, Gay, Bisexual and Transgender
LIMS	Laboratory Information Management System
LRC	Law Reform Commission
LPF	Local Policing Fora
MBRS	Medical Bureau of Road Safety
MDA	Misuse of Drugs Act
MTP	Methadone Treatment Protocol
MQI	Merchants Quay Ireland
NACD	National Advisory Committee on Drugs
NACDA	National Advisory Committee on Drugs and Alcohol
NATP	National Addiction Training Programme
NAS	Neonatal Abstinence Syndrome
NCC-DATF	National Co-Ordinating Committee for Drug and Alcohol Task Forces

NCCA	National Council for Curriculum and Assessment
NCPE	National Centre for Pharmacoeconomics
NCRI	National Cancer Register Ireland
NDRDI	National Drug Related Death Index
NDS	National Drug Strategy
NDTRS	National Drug Treatment Reporting System
NEPS	National Educational Psychological Service
NESC	National Economic and Social Council
NDS	National Drugs Strategy
NDRDI	National Drug-Related Deaths Index
NDRIC	National Drugs Rehabilitation Implementation Committee
NDRF	National Drugs Rehabilitation Framework
NDTC	National Drug Treatment Centre
NDTRS	National Drug Treatment Reporting System
NOSP	National Office for Suicide Prevention
NPIC	National Poisons Information Centre
NPIRS	National Psychiatric Inpatient Reporting System
NPIS	National Poisons Information Service
NQSF	National Quality Standards Framework
NSRF	National Suicide Research Foundation
NSP	National Service Plan (of the Health Service Executive)
NVRL	National Virus Reference Laboratory
NYCI	National Youth Council of Ireland
OFD	Oversight Forum on Drugs
OMCYA	Office of the Minister for Children and Youth Affairs
PCRS	Primary Care Re-imburement Service
PDU _s	Problem Drug User
PHIRB	Public Health Information and Research Branch
PQ	Parliamentary Question
PULSE	Police Using Leading Systems
QFI	Quality Framework Initiative
QuADS	Quality Standards in Alcohol and Drugs Services
RAPID	Revitalising Areas by Planning Investment and Development
RCPI	Royal College of Physicians of Ireland
RCT	Randomised Controlled Trial
RDTF	Regional Drugs Task Force
ROSIE	Research Outcome Study in Ireland
RTC _s	Road Traffic Collisions
SCID-1	Structured Clinical Interview for DSM-IV Axis 1 Disorders
SDR	Standard Death Rates
SLÁN	Survey of Lifestyle, Attitudes and Nutrition in Ireland
SOFAS	Social and Occupational Functioning Scale
SPHE	Social, Personal and Health Education
SRDTF	Southern Regional Drugs Task Force
SSIS	Suicide Support and Information System
SSRIs	Selective Serotonin Reuptake Inhibitors
STI	Sexually Transmitted Infection
SUD	Substance Use Disorder
SURF	Service Users Representative Forum
SWHBA	South-Western Health Board Area
TAU	Treatment as Usual
TCD	Trinity College Dublin
TD	Teachta Dála (Member of Parliament)
TDI	Treatment Demand Indicator
THC	Tetrahydrocannabinol
UCD	University of Dublin
UHI	Universal Health Insurance
UHR	Ultra High Risk
UK	United Kingdom

WHO
YoDA
YPFSF

World Health Organization
Youth Drug and Alcohol service
Young People's Facilities and Services Fund