



FOREWORD

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SUMMARY

MAIN TRENDS AND DEVELOPMENTS

- The newly-elected Irish government (formed following a general election in May 2002) confirmed the National Drugs Strategy 2001-2008, with its overall strategic objective, *'To significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research'* In its *Agreed Programme for Government* for the next five years, the government set out its priorities in the drugs area under three headings – Tackling Drug Abuse, Tackling Crime, and Regenerating Disadvantaged Communities.
- Portfolio responsibility for the drugs strategy was transferred from the now defunct Department of Tourism, Sport and Recreation to the newly-formed Department of Community, Rural and Gaeltacht Affairs. A Minister of State was appointed with dual responsibility for Drugs Strategy and Community Affairs and also for Housing and Urban Renewal.
- Steps have been taken to enhance regional and local co-ordination structures and mechanisms in Ireland – through extending the RAPID (Revitalising Areas by Planning, Investment and Development) programme, advancing establishment of the Regional Drug Task Forces (RDTFs), and strengthening strategic planning and integrated service processes, and democratic legitimacy, at local level.
- The maintenance of public order has become a source of concern, with a number of initiatives being started that will have implications for the issue of illegal drugs, e.g. the Criminal Justice (Public Order) Bill, 2002; the launch of two Garda (police) public-order initiatives – Operation Oíche and Operation Encounter; government-sponsored research into the extent of public order offences and an analysis of the likely contributory factors.
- General population research into public awareness and understanding of the National Development Plan (NDP), in early 2001, showed that drug abuse was the second highest concern (92%) for the Irish public, behind crime (95%), with the health service in third place (91%). In ranking key initiatives in the National Development Plan, aimed at targeting areas of development that are key to Ireland's future, crime/drug abuse came second in importance to health care.
- Research to determine public attitudes towards cannabis in Ireland, in late 2001, showed that attitudes towards cannabis and its effects differed widely across different age groups, with older people stating a significantly more negative attitude towards cannabis.
- Academic and research institutions, in their research and analysis activities, have tended to focus on public policy on drugs. They have examined both the process and the contents of Irish drugs policy and have highlighted what they perceive to be a lack of open and full debate in the policy development process, and anomalies emerging as new harm reduction initiatives are bedded down.
- Political debate in the Houses of the Oireachtas (Houses of Parliament) has tended to focus on law and order issues. Politicians have highlighted the links between illegal drugs and drug use and street crime and violence, and debated the legal status of cannabis.
- The voluntary and community sectors have been active in stimulating public debate on the drugs issue, organising seminars and conferences to address the issues and

publishing information to disseminate their views and concerns more widely. Their concerns have arisen out of their own activities and research, particularly in the areas of harm reduction and treatment.

- To date, very little in-depth research has been carried out on media presentation and imaging of drug use in Ireland. The research that has been undertaken indicates that the national news print media's presentation of drugs and drug use tends to be from an '*abstentionist*' viewpoint.
- Heroin is the main drug for which people present to drug treatment services in Ireland. Heroin dependence is still mainly concentrated in and around the Dublin area, but for a number of years there are indications that the problem is beginning to spread to other regions.
- The trend towards smoking heroin in the early to mid-1990s has now changed and there is an increasing trend in intravenous heroin use.
- There is an increasing trend in those presenting to services for treatment of problematic cannabis use. Outside of Dublin and its environs, cannabis is the main drug for which people present for treatment. Throughout the 1990s trends in cannabis use remained fairly stable at between 11 and 15 percent of all those treated. Then in 2000 the proportion increased to 22 percent. This increase probably reflects an increase in the provision of treatment services rather than a real increase in cannabis use. Given that cannabis is smoked this can have serious implications for the future health of a young population.
- In the latter half of the 1990s there was a decreasing trend in those presenting to treatment services with problematic ecstasy use, from 7.4 percent in 1995 to 3.5 percent in 1998. However this trend did not continue and there was an increase in the proportion of people – to 5.9 percent in 2000 - who presented with ecstasy problems.
- Drug users presenting for treatment are likely to be involved in the use of more than one drug. Trends show a high level of polydrug use, with seven out of ten clients presenting with secondary drug problems. Cannabis, benzodiazepines and ecstasy are the drugs most likely to be involved.
- Data from the General Mortality Register at the Central Statistics Office show that drug-related deaths continue to increase. In 2000 (the latest year of available data) there were 199 drug-related deaths. The increase in deaths is partly due to an improvement in the recording of a drug-related death at the scene of death.
- The proportion of positive HIV cases attributed to the injecting drug use (IDU) category has generally decreased since 1986. In 2001 the proportion of positive HIV tests attributed to the IDU category was 12.7%, the lowest level recorded since reporting began. Injecting drug use still continues to be one of the main risk categories, accounting for 37.1% of the cumulative number of positive cases over the last 20 years.
- €28 million was allocated in February 2002 to the 14 Local Drug Task Forces-€2 million per area- to cover both the capital requirements and servicing of projects in the 14 Local Drugs Task Force Areas.
- The Northern Area Health Board (NAHB) has developed a specific rehabilitation/reintegration initiative to cater for individuals 'recovering' from illicit drug use.

- The 'Walk Tall' (primary school) and 'On My Own Two Feet' (secondary school) drug prevention programmes continued to be amalgamated into the Social, Personal and Health Education (SPHE) life-skills programme. It is planned that the SPHE programme will eventually cover all primary and secondary schools.
- The involvement of a leading financial institution, Allied Irish Bank (AIB) through the Better Ireland Programme has resulted in improved funding opportunities for a number of demand reduction initiatives. The programme aims to give '*at risk*' children the opportunity to move from the chaos of a life centred on drugs or alcohol abuse.
- Ten Regional Drugs Task Forces (RDTFs) are in the process of being developed. It is envisaged that the RDTFs will operate in areas currently being covered by regional health boards. The role of the RDTFs will be to research, develop, implement and monitor a co-ordinated response to illicit drug use at regional level, based on best evidence of what is effective.
- The Department of Education and Science have developed a set of guidelines to assist in the development of school policies on substance use. This development is in response to the key recommendation of the National Drug Strategy 2001-08 states that all national schools should have a drugs policy in place by September 2002.
- The South Western Area Health Board (SWAHB) have provided a full Addiction treatment service on the Mobile Bus on the grounds of Tallaght Hospital. During periods of 2001/2002 there were 50 persons receiving treatment on this Mobile Bus. This coupled with the additional GPs and the development of service in Jobstown has more than halved the waiting list. The waiting time for treatment in Tallaght has reduced from 9 months to 3 months.

PART 1

NATIONAL STRATEGIES: INSTITUTIONAL & LEGAL FRAMEWORK

1. Development in Drug Policy and Responses

The following report on developments in drug policy and responses covers the period August 2001 to mid-September 2002. (For information on developments in drug policy and responses in the first half of 2001, including the National Drugs Strategy, see Ireland's National Report for 2001.)

1.1 Political framework in the drug field

1.1a) Objectives and priorities at national level

The National Drugs Strategy 2001–2008 (Department of Tourism, Sport and Recreation 2001, pp. 108-111)¹ established the following strategic framework in relation to the drugs issue in Ireland for the period 2001–2008:

Overall Strategic Objective

To significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research.

Overall Strategic Aims

- To reduce the availability of illicit drugs;
- To promote throughout society, a greater awareness, understanding and clarity of the dangers of drug misuse;
- To enable people with drug misuse problems to access treatment and other supports and to re-integrate into society;
- To reduce the risk behaviour associated with drug misuse;
- To reduce the harm caused by drug misuse to individuals, families and communities;
- To have valid, timely and comparable data on the extent and nature of drug misuse in Ireland;
- To strengthen existing partnerships in and with communities and build new partnerships to tackle the problems of drug misuse.

Objectives

Supply Reduction

- To significantly reduce the volume of illicit drugs available in Ireland, to arrest the dynamic of existing markets and to curtail new markets as they are identified; and
- To significantly reduce access to all drugs, particularly those drugs that cause most harm, amongst young people especially in those areas where misuse is most prevalent.

Prevention

- To create greater societal awareness about the dangers and prevalence of drug misuse; and
- To equip young people and other vulnerable groups with the skills and supports necessary to make informed choices about their health, personal lives and social development.

Treatment

¹An electronic version of the National Drugs Strategy is available at www.pobail.ie/en/NationalDrugsStrategy

- To encourage and enable those dependent on drugs to avail of treatment with the aim of reducing dependency and improving overall health and social well-being, with the ultimate aim of leading to a drug-free lifestyle; and
- To minimise the harm to those who continue to engage in drug-taking activities that put them at risk.

Research

- To have available valid, timely and comparable data on the extent of drug misuse amongst the Irish population and specifically amongst all marginalised groups; and
- To gain a greater understanding of the factors which contribute to Irish people, particularly young people, misusing drugs.

Co-ordination

- To have in place an efficient and effective framework for implementing the National Drugs Strategy.

The National Drugs Strategy contains performance indicators for these objectives and 100 actions to be undertaken by national, regional and local level agencies. (See Ireland's National Report for 2001 for full details of the National Drugs Strategy.)

1.1b) New initiatives and major changes in political approach

New Government Elected

As noted above a general election was held in Ireland in late May 2002, and a new government returned for a five-year term. The new government comprises the same coalition partners as in the previous government – the Fianna Fáil Party and the Progressive Democrats (PDs). In early June the new government published *An Agreed Programme for Government* (Department of An Taoiseach 2002);² by late June the Taoiseach (Prime Minister), Bertie Ahern, TD, had appointed his Cabinet and Ministers of State.

Tackling Drug Abuse and Crime

The newly-elected government's Agreed Programme (Department of An Taoiseach 2002) addresses the drugs issue in the section entitled 'Building a Caring Society', under two main headings – 'Tackling Drug Abuse' (p. 29) and 'Crime' (pp. 24–5). The key elements of the new government's agreed response to the drugs issue are as follows:

Supply Reduction

- The new government will focus on heroin and cocaine. It pledges to '*continue to prioritise heroin and cocaine for intervention, and publish separate targets for supply reduction for each major type of drug*'. The government will also establish an early-warning system, involving all key agencies, to track the potential spread of heroin into new areas.
- Measures will be taken to enhance the impact of police interventions. Additional Gardaí (Police) will be '*concentrated in the areas of experiencing the greatest drugs problems*'. The Gardaí will be required to establish '*a coordinating framework for drugs policy in each Garda District, to liaise with the community on drug-related matters and act as a source of information for parents and members of the public*'. Each '*Garda District and Sub-District [will] be required to produce a Drug Policing Plan to include multi-agency participation in targeting drug dealers*'.
- Drug dealers will be specially targeted. The Agreed Programme states, '*We will target the assets of all persons involved in drug dealing and, in particular, middle-ranking criminals*', and '*We will continue to target drug dealers at local level by making additional resources available to existing drugs units and for the establishment of*

² An electronic version of *An Agreed Programme for Government between Fianna Fáil and the Progressive Democrats* (June 2002) is available at www.antaioiseach.ie

similar units in areas of need.’ The document also pledges to require ‘convicted drug dealers to register with the Gardaí after leaving prison.’

Prevention

- The new government pledges that the Regional Drug Task Forces, first identified in the National Drugs Strategy (Department of Tourism, Sport and Recreation 2001, p. 123), will *‘operate efficiently to ensure that prevention programmes are active in all areas of the country’*. It also states that *‘as part of the new regional education management structures, local supports will be provided and new guidelines will be issued to all schools on the implementation of a drugs policy’*.

Treatment and Rehabilitation

- The Agreed Programme contains the following commitment: *‘Treatment and rehabilitation, including residential, programmes will be expanded so that there is a place available for every person seeking the service’*.

Measuring Progress

- The government commits to publishing *‘annual reports of activity and progress towards the achievement of specific prevention, supply reduction and treatment targets’*.

Drugs in Prisons

- The Agreed Programme addresses heroin use in prison: *‘By end-2002 we will publish a plan to completely end all heroin use in Irish prisons. This will include the availability of treatment and rehabilitation for all who need them and the introduction of compulsory drug testing for prisoners where necessary.’*
- The government also pledges to address drug dealing in prison: *‘Where a person has been found to be involved in the supply of drugs to a prisoner we will introduce a new stiffer penalty.’*

Regenerating Disadvantaged Communities

In its Agreed Programme (Department of An Taoiseach 2002), the incoming Fianna Fáil–PD coalition government has also identified the regeneration of disadvantaged communities as part of its programme to *‘build a caring society’* (p. 30). In this context, it endorses two existing programmes that target the drugs issue in disadvantaged communities.

Young People’s Facilities and Services Fund (YPFSF)³

- Established by the government in 1998, the YPFSF is intended to assist in the development of youth facilities, including sport and recreational facilities, and services, in disadvantaged areas where a significant drug problem exists or has the potential to develop. The main aim is to attract *‘at risk’* young people in disadvantaged areas into these facilities and activities and divert them away from the dangers of substance abuse. The incoming government has pledged: *‘We will continue the Young People’s Facilities and Services Fund and complete a comprehensive survey of the availability of recreational facilities in disadvantaged areas.’*

RAPID⁴

- First launched by the government in February 2001, and standing for *‘Revitalising Areas by Planning, Investment and Development’*, the RAPID programme identified the 25 most disadvantaged areas in the country and frontloaded a significant share of National Development Plan (NDP) expenditure on social inclusion measures (some €19.5 billion in total) in these areas over three years. The targeted areas have been prioritised for investment and development in relation to health, education, housing, childcare and community facilities, youth development, employment, drug misuse and policing. In February 2002 the government announced the Provincial Towns Strand of RAPID, identifying 20 additional towns. In the Agreed Programme the incoming

³ For more information on YPFSF, see www.pobail.ie/en/NationalDrugsStrategy

⁴ For more information on RAPID, see www.pobail.ie/en/RAPIDandCLR

government endorses the RAPID programme, *'We will develop the RAPID initiative in our most disadvantaged communities as a priority programme. When the small areas data is made available from the latest census we will review the areas covered and consider additional areas for inclusion.'*

New Ministers Announce Priorities

Following the launch of the Agreed Programme, the news media carried reports from newly-appointed Ministers with responsibilities in the illegal drugs area, setting out their priorities. The Minister for Justice, Equality and Law Reform, Michael McDowell, TD, pledged that:

'Garda resources will be increased substantially in Local Drugs Task Force Areas arising from the general increase in the Force's strength. The aim is also to increase drug seizures by 25 per cent by 2004 and by 50 per cent by 2008'. (Cusack 5 July 2002)

Ten days later the Minister of State with responsibility for Drugs Strategy, Noel Ahern, TD, stated:

'Although controlling supply and having appropriate penalties are vital elements of our strategy, in the medium to long term, prevention is the key to tackling drug misuse. Education and awareness are perhaps the most important tools we possess. Because of this, I plan to launch in the autumn a national awareness campaign on the dangers of drug use and to make sure that prevention programmes are delivered in all schools. It is only through actions like this that we can equip people, and young people in particular, with the skills and knowledge necessary to make informed choices about their health and their future – and reject drug use.' (Ahern 16 July 2002)

1.1c) Co-ordination policies

Portfolio Responsibility for Drugs Strategy Reallocated

Under the new Fianna Fáil–PD coalition government, portfolio responsibility for the drugs strategy was transferred from the now defunct Department of Tourism, Sport and Recreation to the newly-formed Department of Community, Rural and Gaeltacht Affairs.⁵ A Minister of State within this department, Noel Ahern, TD, was assigned special responsibility for Drugs Strategy and Community Affairs; Noel Ahern was also appointed Minister of State at the Department of the Environment and Local Government, with special responsibility for Housing and Urban Renewal.

The new Government's thinking regarding the connection between drugs strategy and community affairs was explained by the newly-appointed Minister for Community, Rural and Gaeltacht Affairs, Eamonn O'Cuiv, TD. He said that the linking showed how central community was to the drugs problem in the eyes of the Taoiseach (Prime Minister). The Minister stated:

'I think the linking of drugs with building community shows that the Taoiseach is aware that there is a wide community dimension to the drugs issue, the need to deal with the issue of deprivation, for instance. It shows that he thinks the drugs issue cannot be dealt with in isolation from community.' (Browne 8 June 2002)

In an interview on national radio following his appointment, the new Minister of State with responsibility for Drugs Strategy and Community Affairs, and also Housing and Urban Renewal, Noel Ahern, TD, commented that assigning him responsibility for both drugs and housing *'makes sense'* because

'there is an overlapping or at least shared responsibility between estate management, which local authorities do, and some of the other good work that

⁵ For more information on the Department of Community, Rural and Gaeltacht Affairs, see www.pobail.ie/en

drug task forces and the youth facilities and services programme do, and it is an attempt to pull all those strands together'. (Ahern 19 June 2002)

Co-ordinating Structures and Mechanisms Enhanced

The national and local co-ordinating structures and mechanisms for the National Drugs Strategy – the Cabinet Committee on Social Inclusion, the Inter-Departmental Group on the National Drugs Strategy (IDG), the National Drugs Strategy Team (NDST), the National Advisory Committee on Drugs (NACD), the Local Drugs Task Forces (LDTFs) and the Young Person's Facilities and Services Fund (YPFSF) – remain the same as outlined in last year's annual report, with the co-ordinating function now to be undertaken by the newly-established Department of Community, Rural and Gaeltacht Affairs.⁶

Steps have been taken in the last 12 months to enhance regional and local co-ordination structures and mechanisms, as outlined below.

RAPID

- In February 2002, 12 months after the launch of the initial RAPID (Revitalising Areas by Planning, Investment and Development) programme, the government announced the Provincial Towns Strand of RAPID, identifying 20 additional towns. The incoming government is committed to developing this initiative further, as outlined above under 'Regenerating Disadvantaged Communities'.

Regional Drug Task Forces (RDTFs)⁷

- In June 2002 the Minister of State with responsibility for Drugs Strategy, Noel Ahern, TD, gave an update on the status of the RDTF initiative:

'RDTFs will be set up in each health board area, ...The membership of the RDTFs will be taken from the full range of statutory, community and voluntary sectors and will be flexible to local circumstances. The purpose of the RDTFs is to ensure the development of a co-ordinated and integrated response to the problem of drug misuse in the regions. The RDTFs will provide up-to-date information on drug related resources and services, as well as information on the nature and extent of the drug problem in their areas. Once the service gaps have been identified for each region, the RDTFs prepare a development plan to respond to the issues identified. Guidelines dealing with the setting up of the RDTFs were finalised in May last [2002] and have been disseminated to the various sectors and agencies. Co-ordinators are being recruited through the Health Boards and nominations for membership of the RDTFs have been sought from the various agencies and sectors. The first meetings are expected to be held in autumn 2002.' (Ahern 25 June 2002)

Strategic Plans, ISP, and Democratic Legitimacy

- To ensure co-ordinated, integrated and democratic processes for regenerating disadvantaged communities, the Fianna Fáil–PD coalition government has pledged to ensure that the county and city development boards' strategic plans effectively target areas of greatest need, and to enhance the integrated services process (ISP) as a means of ensuring integrated service delivery across state, local and voluntary sector agencies. The government has also undertaken to ensure 'democratic legitimacy on local boards appointed to implement development programmes'.

British–Irish Council – Misuse of Drugs Sectoral Group Established⁸

The British–Irish Council was created under the Agreement reached in the Multi-Party Negotiations in Belfast in 1998 to promote positive, practical relationships among its members, which included the British and Irish governments, and the devolved administrations of Northern Ireland, Scotland and Wales, and Jersey, Guernsey and the Isle of Man. At its second meeting, held in Dublin Castle on 30 November 2001, the

⁶ For more information on the co-ordinating mechanisms, see www.pobail.ie/en/NationalDrugsStrategy

⁷ For more information on Regional Drug Task Forces, see www.pobail.ie/en/NationalDrugsStrategy

⁸ For further information on the British–Irish Council, see www.britishirishcouncil.org

British–Irish Council emphasised the commitment of all members at the highest political level to dealing with the problem of drug misuse and agreed to co-operate in the two key areas of demand reduction and supply reduction. It was agreed to develop an enhanced programme of information exchange to cover co-operation on models of best practice, research data pilot programmes, and rehabilitation and reintegration strategies. The Irish government was given the lead responsibility for this information exchange programme.

Following this decision, Ministers with responsibility in the drugs area and officials met in Dublin in March 2002. Papers presented at this meeting included:

- Targeting the Proceeds of the Drugs Trade/Assets Confiscation – outlining a proposal for a conference on the issue to be held in Guernsey in May 2002;
- ‘*Positive Futures*’ initiative, which aims to provide sporting programmes for young people at risk, including mentoring schemes and educational programmes. Experts from the British–Irish Council were scheduled to meet in London in the near future to share their knowledge and expertise in this area;
- The importance of involving the community in developing and implementing drug strategies – Northern Ireland was planning to host a conference with a view to exploring models of good practice in the area in the near future;
- Educational, training and employment opportunities for recovering drug users, a paper prepared by Scotland and Ireland – Ministers agreed that a seminar for managers and policy makers would be held later in the year in order to advance the exchange of information in this area;
- Harm reduction – a report was given on a recent conference on the subject held in Wales;
- Drug and alcohol strategies – an outline was presented on the Isle of Man’s proposal for a conference on the subject.

It was agreed that Ministers would meet again to review progress in early 2003.

1.2 Legal framework⁹

1.2a) Major changes in law and regulations existent and/or planned in the field of drug demand, supply, precursors and drugs related money laundering (ELDD requirements) concerning:

Penal laws

The purpose of the Criminal Justice (Public Order) Bill, 2002, is to strengthen the law in relation to late-night public disorder and disturbance. It provides for exclusion orders, which may be imposed on persons facing a conviction for a public order offence under the provisions of the Criminal Justice (Public Order) Act, 1994. These provisions include ‘*intoxication in a public place*’, where the intoxication is such that it ‘*would give rise to a reasonable apprehension that the person might endanger themselves or other people in the vicinity*’. Intoxication is defined in the 1994 Act as ‘*under the influence of any alcoholic drink, drug or solvent or other substance*’. The exclusion order will prohibit such persons from entering or being in the vicinity of the types of premises covered by the Bill, including licensed premises, dance halls, premises that dispense food. It is an additional penalty to those imposed under the Criminal Justice (Public Order) Act, 1994.

Administrative laws

The Children Bill, 1999, contains specific proposals on the responsibilities of parents. These orders may oblige parents to take measures to remedy whatever it is that caused

⁹ For full text of Irish Acts and Bills 1922–2002, see www.gov.ie/oireachtas

them to lose control over their children e.g. to undergo a parenting skills course or to obtain treatment for substance abuse. The Bill also gives the courts power to impose a curfew on persons under 18 years of age. The order can confine a child to a particular residence at specified times between 7 p.m. and 6 a.m. the following day or order the child to stay away from any specified premises, place or locality during specified days or between specified times.

New substances under control in the reporting year

No new substances were controlled under the Misuse of Drugs Acts during the year.

Relevant directives and or guidelines

The Methadone Prescribing Implementation Committee has been invited to review Ireland's Methadone Protocol. Under its terms of references, laid down by the Department of Health, the Committee will review the operation of the Protocol, which was first introduced in October 1998, and its role in providing methadone treatment and rehabilitation of opiate users. The nationwide applicability and relevance of the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations, 1998 (S1225 of 1998) and the report of the Methadone Treatment Services Review Group (1997) will also be examined. The committee will also look at the role and working relationships within and between the Department of Health and all those involved in the provision of methadone treatment, such as the health boards/ERHA, the Pharmaceutical Society of Ireland and community and local groups. It will also consult with relevant stakeholders and is expected to report back to the Department of Health with its recommendations by December 2002 (*Irish Medical News 9 September 2002*).

1.2b) Legal framework in the demand reduction field: prevention, treatment and harm reduction (especially focus on substitution treatment, after-care and reintegration, injecting rooms, pill-testing, etc.)

The Mental Health Act, 2001, excludes addiction from the scope of the legal definition of mental disorder. Although signed into legislation in August 2001, it has yet to be 'commenced' by the Minister for Health and Children. In the meantime the Mental Health Act, 1945, continues to apply. This Act includes addiction as a criterion for non-voluntary committal to a psychiatric hospital, although it is not invoked, as it is now generally considered unacceptable to detain by law, people whose primary problem is addiction.

1.2c) Any other important project of law, parliament, governmental initiative

The government launched the following initiatives in the area of public order:

- The Garda Síochána's national public order initiative, Operation Oíche, has been in operation since October 2000. In February 2002, the Minister for Justice, Equality and Law Reform, John O'Donoghue, TD, reported on the Operation:

'This operation focuses on public disorder, public intoxication, under age drinking, illicit drug use and under age alcohol sales. "Hotspots" of criminal activity receive particular Garda attention, with an emphasis on high-visibility patrolling. Moreover, key urban locations are selected for intensive patrolling involving the Garda mounted unit, Garda dog unit and Garda air support unit. The Garda authorities consider Operation Oíche to have been highly successful to date. Since its introduction, there has been a more visible Garda presence on the streets, particularly at the closing times of licensed premises and nightclubs. This operation has taken place against the background of the unprecedented investment which the Government has made in the Garda Síochána.' (O'Donoghue 21 February 2002)

- In February 2002 a new Garda initiative - Operation Encounter - was launched, deploying significant Garda resources in a nationwide effort and concentrating not only

on anti-social conduct and trouble on the streets, but also on licensed premises, night clubs and fast food outlets (O'Donoghue 25 March 2002).

- The National Crime Council,¹⁰ an independent body established by government to focus on crime prevention and to act as an independent source of policy advice, has commissioned the Institute of Criminology at University College, Dublin (UCD) to undertake research into public order offences in Ireland. The Institute has been asked to address the extent of public order offences in Ireland and to provide an analysis of the likely contributory factors including (but not exclusively) alcohol consumption. The research results are expected in late 2002.

1.3 Laws implementation

1.3a) Implementation of law

No new laws were implemented during this period.

1.3b) Prosecution policy: change in priorities and objectives in relation to drug users offenders drug related crime

The Minister for Justice, Equality and Law Reform, John O'Donoghue, TD, gave the following progress report on the Drug Court pilot project up to 31 December 2001:

'The 1997 Programme for Government included, in the context of measures to combat the drugs problem, a recommendation for the creation of a drug court system which would involve court supervised treatment programmes for less serious drug related offences. The pilot drug court programme was launched in the Dublin District Court on 9 January 2001 and will run for 18 months. The first sitting took place on 16 January 2001. As of 31 December 2001, 54 persons have been referred to the drug court from the Dublin District Court. Expert consultants, who were appointed following a public procurement process, are evaluating the pilot programme. They will produce a report in relation to statistics and costs at the end of the 18 month period which they will present to the pilot drug court steering committee.' (O'Donoghue 31 January 2002)

At the time of writing, the evaluation report on the pilot project had not been released.

1.4 Developments in public attitudes and debates

1.4a) Public perception of the drugs issue: main results from surveys

Public Opinion on the Importance of the Drugs Issue – Drury Research

In February 2001 the Irish Government commissioned Drury Research (July 2001) to carry out research into public awareness and understanding of the National Development Plan (NDP). The NDP involves a €61 billion investment over six years from 2000 to 2006 in economic and social initiatives. Its purpose is to improve economic and social infrastructure, create the conditions for balanced regional development, and work towards ensuring that all the people of Ireland have the opportunity to enjoy the benefits and improvements of the developing economy.

The research comprised two phases. The first phase used focus groups to identify key attitudes and concerns regarding the NDP. The issues raised informed the design of the survey questionnaire used in the second, quantitative phase of the research. In this phase, 1,520 face-to-face interviews were conducted with members of the general public, selected using randomised quota sampling.

¹⁰ For further information on the National Crime Council, see www.gov.ie/crimecouncil

In the initial stages of the survey phase, researchers listed issues identified by the public as key concerns during the focus group phase. Respondents were asked to estimate their level of concern with each issue on a scale from one to five. The results showed that drug abuse was the second highest concern (92%) for the Irish public, behind crime (95%), with the health service in third place (91%). In a subsequent stage, key initiatives in the NDP, aimed at targeting areas of development that are key to Ireland's future, were outlined. Respondents were asked to rank the importance of each initiative. Table 1.4 below ranks the initiatives according to how respondents perceived their importance: this time crime/drug abuse came second in importance to health care.

Table 1.4. Key Initiatives in the National Development Plan (NDP) Ranked by Importance

NDP Initiative	% Who Believe Initiative is Important	Mean Score
Healthcare	95%	4.65
Crime/Drug Abuse	94%	4.62
Development of Roads	92%	4.49
Employment/Job Creation	90%	4.43
Social Affordable Housing	88%	4.41
Education	90%	4.37

Overall, in ranking NDP initiatives in relation to various broad issues, the Irish public placed social issues ahead of infrastructural issues such as waste management, public transport and energy. The productive sector including tourism and agriculture came further down the scale of perceived importance.

Public Opinion of Cannabis in Ireland – Lansdowne Market Research

Lansdowne Market Research conducted research to determine public attitudes towards cannabis in Ireland. The research was conducted using the Lansdowne Market Research Omnibus Survey (September 2001). Fieldwork was conducted between 11 and 22 September 2001, using face-to-face interviews in the respondents' own homes. The survey was a nationally representative sample of all adults aged 15 years and older. A total of 1,159 interviews was achieved.

Conclusions from the research were:

- Attitudes towards cannabis and its effects differed widely across different age groups, with older people stating a significantly more negative attitude towards cannabis.
- Almost two thirds of those eligible to vote (18 years or over) felt that cannabis should be legalised for treatment of certain medical conditions where its beneficial effects had been proven.
- Outright legalisation of cannabis was an aspiration for a minority – approximately 1 in 7 people.
- This low level of support for legalisation was probably due to a view that cannabis is seen as a 'gateway' drug by a large proportion (two thirds) of those interviewed. A similar majority felt that cannabis was highly addictive.
- A majority felt that the use of cannabis had significant negative effects – 8 in 10 believed it was mood altering and its long-term use could lead to psychological problems later in life. Two in three believed that it led to aggression.
- One in five people aged 15 to 24 claimed they would try cannabis if it were legal. A precisely opposite attitude to trial was evident among the 50+ age group.

Drugs Survey – Union of Students in Ireland (USI)

In July 2002 the results of a drugs survey by the Union of Students in Ireland (USI)¹¹ of 500 students in 23 colleges throughout Ireland were published (Union of Students in Ireland, 2002a).¹² The main findings in relations to tertiary-level students' perception of the drugs issue were:

- 287 (58.0%) thought cannabis should be decriminalised.
- 208 (42.0%) thought cannabis should not be decriminalised.
- Of the 287 who thought cannabis should be decriminalised:
 - 115 (40.1%) argued that the health hazards of cannabis were no more dangerous than those of alcohol.
 - 109 (38.0%) felt cannabis should be decriminalised for medicinal purposes.
 - 61 (21.3%) felt decriminalising cannabis would ensure safer drug use.
- Of the 208 who were opposed to the decriminalisation of cannabis:
 - 101 (47.9%) felt that decriminalisation would encourage drug use.
 - 89 (42.2%) felt decriminalisation would lead to a greater drugs problem.
 - 20 (9.5%) felt soft drugs are a health hazard and ultimately their use leads to the use of harder drugs – they are 'gateway' drugs.

1.4b) Orientations of the main public debates in civil society, national Parliament, organisations, NGOs

Different sectors tend to focus on different aspects of the drugs debate:

- Academic and research institutions, in their research and analysis activities, have tended to focus on public policy on drugs. They have examined both the process and the contents of Irish drugs policy and have highlighted what they perceive to be a lack of open and full debate in the policy development process, and anomalies emerging as new harm reduction initiatives are bedded down.
- Political debate in the Houses of the Oireachtas (Houses of Parliament) has tended to focus on law and order issues. Politicians have highlighted the links between illegal drugs and drug use and street crime and violence, and debated the legal status of cannabis.
- The voluntary and community sectors have been active in stimulating public debate on the drugs issue, organising seminars and conferences to address the issues and publishing information to disseminate their views and concerns more widely. Their concerns have arisen out of their own activities and research, particularly in the areas of harm reduction and treatment.

Below, the main topics of debate are outlined, together with the main contributors to the debates.

Drugs Policy Development Process

Academic researchers have described how the policy development process in Ireland has evolved in response to emerging trends, particularly the increase in opioid use, and have highlighted the influence of small expert groups on the process. Some researchers have been critical of the covert nature of the process and the lack of open public debate.

- Joe Barry (2002b), Department of Community Health and General Practice, Trinity College, Dublin, published an article in the *Journal of Epidemiology and Community*

¹¹ For further information on the Union of Students in Ireland, see www.usi.ie

¹² A stratified random sample was selected, with individual college samples proportionate to the size of the student population of the individual colleges. As the total student population was some 250,000, the total sample size of 500 is small and, as a result, the findings should be treated with caution.

Health on the 'policy response to opioid misuse in Dublin'. He described how it was the relatively high HIV transmission rates among Dublin's injecting drug-using community that led to the shift in the approach to drug treatment from an abstentionist to a harm-reduction perspective. With this shift, medical responsibility for implementing the change was transferred from psychiatry to public health, reflecting the intersection between healthcare, criminal justice and cultural issues.

- At the 12th annual conference of the European Society for Social Drug Research (ESSD) in Venice in October 2001, Shane Butler (2002a), Addiction Research Centre and Department of Social Studies, Trinity College, Dublin, described the process leading to the introduction of a methadone prescribing protocol in Ireland. Butler tracked

'the evolution of this protocol in a political culture which has adapted slowly to the continued use of heroin and which is highly ambivalent towards harm reduction. It looks at the key stakeholders, the main policy issues and the overall nature of the policy process, while also drawing on comparative studies from other countries. It is concluded that the introduction of the methadone protocol, although not without its problems, demonstrates the effectiveness of small policy-making networks, largely operating in a covert way' (Butler 2002a).

- In a critical analysis of Ireland's approach to establishing drug courts, Shane Butler (2002b) described them as a 'cross-cutting issue', requiring collaboration by both the health care and criminal justice systems. He described the differing cultures and approaches to the drugs issue in both these systems:

'...with the gradual emergence of harm reduction within the healthcare sector in Ireland, as elsewhere, the process of sharing has become more fraught. What appears to have complicated the shared ownership of drug problems in Ireland is the surreptitious introduction of harm reduction into a healthcare system, which had previously been abstinence-based. Some countries debated this issue and decided for harm reduction, while other countries debated it and decided against it; in Ireland there was virtually no public debate and the introduction was such a covert and incremental process that other sectors – in particular the justice sector – were slow to realise the extent and significance of this change. The meaning of illicit drug use, which was traditionally clear and unambiguous, has become increasingly contested. To some at least within the criminal justice system it remains 'a social cancer', while to many within healthcare its meaning has become more subtle and ambiguous. Perhaps what this study of the Irish drug court proposals suggests is that policy developments which are essentially concerned with shared ownership cannot make progress without at least some acknowledgement of these contested meanings.' (Butler 2002b, p. 417)

- Tim Murphy (2002), Department of Law, National University of Ireland at Cork, argued that the prohibitionist tendency of Irish drug policy is attributable to the lack of public debate:

'...the problem with Irish drug policy is very simple: it continues to be far removed from any ethos of energetic, critical or rational overall examination. It is therefore not surprising that the precise basis of Irish drug policy remains unacceptably elusive. ...As an issue of public policy, drugs have never been the subject of a comprehensive analysis in the Irish state. Instead, our drug policy to date has merely comprised a series of revisions of pre-Independence British policy, tailored to suit the "self-evident" assumptions of American-led transnational prohibitionism. Irish drug policy reviews have been restricted to an analysis of how best to implement prohibitionist policies; they should have the authority to investigate all forms and aspects of drug use and misuse and to explore all policy options. Such a review would, of course, have to address and answer the basic question: why is the reduction (or, indeed, minimisation) of drug-related harm not the central aim of Irish drug policy?' (Murphy 2002, p. 218)

In June 2002 Dublin City Wide Drugs Crisis Campaign¹³ and the nationwide Family Support Network led a march by community groups through central Dublin to highlight the 'drugs crisis'. The organisers said a march was needed because in the recent general election, drugs had not featured as an issue and there was a need to put them back on the agenda. Moreover, the progress of the previous few years could not be undermined: the communities affected by drugs needed investment, not cutbacks. Finally, drug users and their families were still living with the devastation of the drugs crisis on a daily basis and their voices needed to be heard. Some 30 community groups from all over Dublin and as far away as Bangor, Newry, Cavan, Kilkenny and Waterford, as well as individuals working in the drugs area, supported the march. The organisers said it was the opening of what will be a 6-month campaign to demand action on the part of the government. (Drugnet Ireland July 2002)

The voluntary and community sectors also made calls to be more closely involved in policy development and decision making in relation to the drugs issue.

- Merchants Quay Ireland (MQI), the combined Franciscan social services based at Merchant's Quay, Dublin,¹⁴ called for
*'representatives of the community and voluntary sector to be included in the Interdepartmental Group on the National Drugs Strategy (IDG)'*¹⁵, (Merchants Quay Ireland 2001, p. 7).
- Researchers investigating what had happened to people who had taken the Community Addiction Studies Course (CASC) in Ballymun, Dublin, recommended that the level of community involvement in roles impacting at the policy level could be greatly strengthened through clear job descriptions, employment conditions, curriculum development, and career structures (King, McCann and Adams 2001).

Content of Drugs Policy

Two Irish academic researchers gave papers at the 12th annual conference of the European Society for Social Drug Research (ESSD) in Venice in October 2001, outlining anomalies and contradictions arising as a result of the implementation of Ireland's current harm-reduction-oriented drug policies.

- Barry Cullen (2002), Addiction Research Centre, Dublin, reported on the effects of the shift in the mid-1990s in Irish drugs policy from one *'focused primarily on the medical treatment of individuals with little, if any, attention to wider social and economic issues'* to the *'implementation of targeted community measures in a number of worst-affected urban neighbourhoods'*. Preliminary findings indicate that positive outcomes of this shift include an overall improvement in accessible treatment facilities for drug users; more funds available for education and preventive programmes for young people and children in local communities; and increased momentum among local authorities to undertake estate development and housing replacement/ refurbishment programmes. On the negative side, the community's overall focus on drug problems is out of proportion to its real experience of drug misuse and has thus reinforced the way in which drugs symbolise community disintegration; the attitudes of community residents and groups to local treatment facilities is generally negative; and there has been a scape-goating of quite vulnerable drug users.
- Marguerite Woods (2002), Addiction Studies, Trinity College, Dublin, posed a question about Irish drug policy over the past five years – *'has Irish drug policy drawn on a War on Drugs approach or has it adopted a perspective drawing on the notion of a peace*

¹³ Dublin Citywide Drugs Crisis Campaign is a specialist support agency, which provides technical assistance and expertise to local communities to develop their capacity to respond to the drugs crisis in their areas and to work alongside statutory and other agencies in tackling the problem at local level. The agency also seeks to involve local communities in developing policies and making decisions on how resources are spent (Moran and Pike, 2001: p. 40).

¹⁴ For further information on Merchants Quay Ireland, see www.mqi.ie

¹⁵ For further information on the IDG, see www.pobail.ie/en/NationalDrugsStrategy/TheInter-DepartmentalGroupOnTheNationalDrugsStrategy/

process”? Reporting on a number of research projects, including her own, she reported that, ‘In an era when drug demand or use reduction in the form of drug treatment initiatives have proliferated in Ireland and general crime figures are reportedly falling, there is overwhelming community support for moving drug use and drug users out of communities. As a supposedly more inclusive treatment system has developed, drug users in the main have experienced less acceptance and inclusion and more exclusion from their own communities.’ She reported that recently women users and their children have been particularly targeted. She argued that ‘government policy and the National Drugs Strategy Team support a harm reduction focused approach. However, issues such as the changes in the political economy of drug use, increased homelessness, involvement in prostitution, corporate and community opposition to services being located in their vicinity and increased monitoring ... has led to increased exclusion.’ This exclusion, she concluded, ‘may actually increase or “maximise” drug-related and other social, economic and health harms.’

The Addiction Resource Centre in Trinity College, Dublin, held its first annual conference in 2001 on the theme ‘Economy, Culture and Community – Perspectives on Drug Problems and Drug Policies’. In promoting the conference, the Centre observed:

‘during the 1990s, drug policy makers in Ireland and elsewhere showed a new willingness to recognise the causal links which existed between socio-economic disadvantage and serious drug problems and to create responses based on this recognition. The purpose of the one-day conference, involving local and international contributors (from the USA, Australia and England), was to explore the effects of economic change on problem drug use and to analyse in a preliminary way the functioning and outcomes of locally based partnership approaches in this area.’ (Drugnet Ireland 2001).

Tim Murphy, Department of Law, National University of Ireland at Cork, and author of *Rethinking the war on drugs* (1996), in which he argued for the legalisation of drugs currently controlled by law, had a further article on the same topic published in 2002. In this article, he argued that public discussion of drug policy in Ireland continues to bear all the hallmarks of prohibitionist ideology. Although Irish policy makers have acknowledged the drug-set-setting analysis, which causally connects socio-economic conditions and drug problems, Murphy took the view that they had not moved away from the ‘*demonisation*’ of illicit drugs or deviated from the general policy of criminal prohibition. Murphy argued that while the government was initiating harm-reduction measures, it was also initiating new legislation to prevent drug trafficking and the confiscation of illegal drug-derived assets, i.e. there was no abandonment or diminution of commitment to supply-side policy.

The voluntary sector contributed its views on the appropriate contents for Irish drugs policy.

- In its annual report for the year 2000, published in late 2001, Merchants Quay Ireland (MQI), stated:

‘Merchants Quay Ireland views drugs as primarily a health issue rather than a criminal justice issue. We believe that policy in this area should focus on promoting health and social gain, reducing drug related harm and providing pathways to rehabilitation.’ (Merchants Quay Ireland 2001, p. 7)

- In August 2002, at MQI’s first annual conference on the theme of homelessness and problem drug use, key speakers warned against a security-based response to the drug problem, and the Director of Services at MQI said:

‘The Government will get better value for money, and make a positive difference to people’s lives, by investing in disadvantaged communities and in policies proven to minimise harm associated with homelessness and drug use’ (McNally 15 July 2002).

- Europe Against Drugs (EURAD), a grassroots movement composed of European parents, youth and other citizens’ organisations concerned to limit the spread of drug abuse, criticised the Irish government’s support for MQI’s conference on homelessness

and problem drug use (McEntee 15 July 2002). EURAD does not support harm reduction policies, believing that these 'enable addiction' and lead to 'harm production' policies; it believes that the way forward in combating the 'drugs epidemic' is to reduce the demand for drugs while supporting families 'afflicted by drug abuse'. EURAD states, 'drugs are illegal because they are dangerous; they are not dangerous because they are illegal.' EURAD is a member of the NGO Committee on Narcotic Drugs at the United Nations Office in Vienna and holds consultative status with the Council of Europe.¹⁶

In response to a Parliamentary Question about the need to rethink drug abuse as a health rather than a criminal justice issue, following the publication of MQI's annual report for 2000, the Minister for Health and Children, Micheál Martin, TD, outlined the government's overall approach to policy on drug misuse:

'The overall objective of the Government's strategy in relation to drug misuse is to significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research. With regard to treatment the objective is to provide a range of options to encourage and enable drug misusers to avail of treatment with the aim of reducing dependency and improving overall health and social well-being, with the ultimate aim of leading a drug-free lifestyle. ...There is, in every drug policy an element that requires a justice response. This is the case in Irish policy also. However, I believe that our overall policy is a balanced one which is also a strongly health focused one. A number of actions aim to broaden the range of treatment and rehabilitation options, including harm reduction measures.' (Martin 24 October 2001)

Legal Status of Cannabis

Fuelled by developments in Britain, the legal status of cannabis in Ireland – for both medicinal and recreational purposes – has been the subject of debate and enquiry in Dáil Éireann (the Irish parliament) over the past year. Consensus remained that conclusive scientifically-based evidence had not yet emerged to support changing the legal status of cannabis for either medicinal or recreational purposes.

- In October 2001 an opposition deputy (MP), Simon Coveney, TD, raised the issue of the legalisation of cannabis for medicinal purposes, for two reasons – (1) 'to separate clearly the use of cannabis or hemp plant for medicinal and recreational purposes', and (2) 'to assure parents and others that the potential of introducing cannabis or agents within the cannabis plant for medicinal purposes should not frighten people'. The deputy defined and described the nature and benefits of medicinal cannabis, citing UK-based research findings and the willingness of the UK government 'to allow the prescription of cannabis-based medicines if trial results continue to be positive'. He also noted that Canada 'has already legalised the use of cannabis for medicinal purposes.' The deputy called on the government to examine the medicinal benefits of cannabis in detail, to examine the potential positive effects and support and take an interest in the research under way in the UK.

Deputy Coveney clearly distinguished his support for examining the medicinal benefits of cannabis from his complete rejection of legalising the recreational use of cannabis:

'The negative aspects of smoking cannabis as a recreational drug are well known and more than convince me that we should not legalise the drug for recreational use under any circumstances. As regards the short-term effects such as memory loss or distorted perception, or the long term and more important carcinogenic effects, the recreational smoking of cannabis is unacceptable and the drug should not be legalised.' (Coveney 17 October 2001).

In response, the Minister of State at the Department of Health and Children, Mary Hanafin, TD, noted that in the public consultation process leading up to the National Drugs Strategy, 'there was little or no debate about the medicinal use of cannabis';

¹⁶ For further information on Europe Against Drugs, see www.eurad.net

under the Misuse of Drugs Acts, any activities involving the medical or scientific use of cannabis were strictly controlled; and the current claims regarding the benefits of cannabis treatment for patients suffering from certain conditions such as multiple sclerosis and glaucoma *'are not currently supported by the results of recognised medical research'*. The Minister concluded by stating,

'In order to conduct research into the medicinal use of cannabis in this country, a permission from the Irish Medicines Board would be required. If the Irish Medicines Board was to grant such a permission under the Control of Clinical Trials Act, 1987, to facilitate conducting a trial in respect of a medicinal product containing cannabis, the Minister for Health and Children would be prepared to give serious consideration to the granting of the necessary licence(s) under the Misuse of Drugs Acts.' (Hanafin 17 October 2001)

- In February 2002 Gay Mitchell, TD, reopened the October debate on the legalisation of cannabis for medicinal purposes, asking the Minister for Health and Children if he would *'request the Irish Medicines Board to review research in Britain which appears to indicate that marijuana based medicines taken on prescription are safe and can ease the pain of persons with certain illnesses; his views on making such medicines available here and if the board considers they are safe and beneficial to the health of persons with certain illnesses.'* The Minister for Health and Children, Micheál Martin, TD, made the same response as Minister Hanafin had made the previous October, noting that,

'I understand research into the medical use of cannabis is under way in Britain. This research is not yet complete. However, my Department will be monitoring the outcome of this work.' (Martin 26 February 2002)

- In late 2001, in the context of British plans to downgrade the classification of cannabis, questions were asked regarding the effects of decriminalisation of cannabis in the UK on Ireland, and whether it was intended to change Irish policy to decriminalise cannabis. The Minister for Justice, Equality and Law Reform, John O'Donoghue, TD, responded that the government had no plans to change the law in relation to cannabis (O'Donoghue 6 November 2001 and 13 December 2001).
- The issue of decriminalising cannabis arose again in 2002, when the British government decided to go ahead with the reclassification of cannabis from a Class B to a Class C drug. In a newspaper article, the Minister of State with responsibility for Drugs Strategy, Noel Ahern, TD, explained the government's continuing refusal to change the law in Ireland:

'[In Ireland] drugs are not classified for penalty purposes in the same manner [as in the UK]. In this State, cannabis is a Schedule 1 controlled drug under the Misuse of Drugs Acts, 1977 and 1984. Even with the reclassification, the British penalties for possession of cannabis for personal use will continue to be higher than those currently in force here. In addition, the Gardaí [Police] and the courts can use a degree of discretion in dealing with such cases. Taking all this into account, it is my view that there is no need to review the position in Ireland as a consequence of the proposed changes in the UK.' (Ahern 15 July 2002)

The Minister also discussed the research on the health effects of cannabis use and the need to be cautious about making the use of cannabis more acceptable or widespread: he mentioned the connections between smoking cannabis and cancer; the effects of cannabis on thinking and memory; connections between long-term cannabis use and the development of mental illnesses such as schizophrenia and depression. He noted that the National Advisory Council on Drugs (NACD)¹⁷ would be carrying out a review of up-to-date scientific information on cannabis, which would be completed before the end of 2002 and would highlight gaps in knowledge.

Drug-Related Crime

¹⁷ For further information on the National Advisory Committee on Drugs, see www.nacd.ie

In Dáil Éireann (Irish Parliament) members of the government expressed the view that significant steps had been taken to deal with and contain organised crime relating to drug trafficking and dealing. However, independent and opposition TDs (Members of Parliament) suggested that heroin supply was on the increase again.

- In late 2001 the Minister for Justice, Equality and Law Reform, John O'Donoghue, TD, expressed his belief that the illegal drugs trade was being brought under control:

'The Government's approach to dealing with the interlinked problems of drugs, crime and social disadvantage and Garda operations such as Dóchas and Cleanstreet have resulted in significant drug seizures and continue to prove effective in targeting on-street dealing.' (O'Donoghue 20 November 2001)

A few weeks later, Mr O'Donoghue revisited the topic:

'My policy for tackling organised crime is one of strong legislation backed up by tough law enforcement measures. This combination has led to significant drug seizures, major organised crime groups being dismantled and the prosecution and imprisonment of a number of prominent criminals. The Criminal Assets Bureau, CAB, has been particularly successful in tracking and confiscating the proceeds of serious criminal activity.' (O'Donoghue 13 December 2001)

- In response to questions about the perceived increase in street violence and crime, the Taoiseach (Prime Minister) commented:

'I am glad to say that by and large the streets were far worse 15 years ago when drug use was rampant and before many of the drugs initiatives were in place. ...Of course crime exists and there are still attacks taking place, particularly at nights and weekends. The situation in the city centre was probably worse in the mid-1980s when the drugs issue began. At that time there were no special units and no deputy commissioner with responsibility for the co-ordination of those special units as are in existence now. Many of the people involved in crime are being caught and it would be wrong to give the impression that the people involved in these random attacks are not caught; many of them are before the courts daily.' (Ahern 19 February 2002)

- Independent TD for Dublin Central, Tony Gregory, applied unsuccessfully twice to debate *'the emergence of a heroin problem in locations outside Dublin and the need to focus Garda resources on those supplying heroin'* (Gregory 28 March and 17 April 2002). Following the general election new Opposition TD Sean Crowe applied unsuccessfully to debate *'the need to address the renewed and growing crisis in communities, especially in Dublin, with the increased supply of heroin on the street'*. (Crowe 27 June 2002).

Both sides of the House (Parliament) appear to have been in agreement that street violence and crime were emerging as serious problems in Ireland.¹⁸ In debating the Criminal Justice (Public Order) Bill 2002 (see under Section 1.2a above) and the issue of street crime and violence, speakers on both sides of the House also made or assumed a causal connection between street violence and crime and illegal drugs and drug use. Contributions also indicate that public representatives perceived the relationship between types of drugs, drug use and drug users and related criminal activity to be evolving.

- The Minister of State with responsibility for the National Drugs Strategy, Eoin Ryan, TD, acknowledged the causal link between crime and drug misuse:

'I can state with some confidence that through initiatives such as the national drugs strategy, the RAPID programme and the young people's facilities and services fund, the Government is addressing the primary causes of crime, namely, poverty, social deprivation and drug misuse.' (Ryan 18 April 2002)

¹⁸ In a debate on a private member's motion on street crime, in April 2002, a TD observed: 'If one looks back at the efforts of this and other Governments over the past 25 years, the emphasis has always changed. For many years the emphasis was on paramilitary crime and paramilitary activities. ...Then the emphasis moved to organised crime and in the past couple of years we have realised that public order offences and street violence must be tackled.' (Ahern 18 April 2002)

- An opposition TD, Simon Coveney, clearly and unequivocally asserted the causal link between illegal drugs and street crime and violence:

'The total solution does not lie in improved policing. Measures to tackle under-age drinking, ... to decrease the general level of alcohol and drug use would all be major contributing factors to reducing the level of street crime': (Coveney 13 November 2001)

The same deputy stated some months later in a further debate on street crime,

'I feel very strongly about the causes of violent crime. Any Garda who is dealing on a nightly basis with street violence in a city will say the biggest cause of fights, anti-social behaviour and trouble generally is alcohol abuse, be it binge drinking or mixing alcohol with recreational drugs. In Cork, these are primarily ecstasy and cannabis, but in Dublin it is often heroin.' (Coveney 17 April 2002)

- The Taoiseach (Prime Minister), Bertie Ahern, TD, and the Leader of the Opposition, Michael Noonan, TD, both introduced sensationalist images of drug misusers into the debate on street crime and violence. Deputy Noonan asked:

'Does the Taoiseach realise that churches that would normally be places of tranquillity and sanctuary in his own constituency are now closed during the day because of criminal activity? Did he notice last night ... that the holy water fonts had been sealed to prevent drug addicts from washing their needles in them? This is now the practice across suburban Dublin. Is the Taoiseach aware that on many of the main bus routes in Dublin it is common for drug addicts to inject themselves on the buses?' (Noonan 17 April 2002)

The Taoiseach responded,

'Deputy Noonan will know that, unfortunately, the churches in my constituency have, since the 1980s, been closed during the day. During the drug epidemic of 1983-86, it was really bad on the streets and people were robbing candlesticks and attacking people in churches. Drug supermarkets, as they were called, were in existence in the inner city.' (Ahern 17 April 2002)

- In the course the same exchange between the party leaders, the Taoiseach suggested that the recently-emerging phenomenon of street violence and crime was not linked to disadvantage:

'In many cases the people involved in anti-social behaviour do not come from poverty-stricken backgrounds. The opposite is the case as they have too much money, drink and drugs.' (Ahern 17 April 2002)

Prevention

The National Drug Strategy included among its 100 actions the mounting of an ongoing national awareness campaign highlighting the dangers of drug misuse. In July 2002 the Minister of State with responsibility for Drugs Strategy, Noel Ahern, TD, confirmed that a national awareness campaign would be launched in autumn 2002, and prevention programmes would be delivered in all schools (see under Section 1.1b above). During the year debate took place concerning the most effective means of preventing drug misuse. The debate highlighted the need to tailor prevention programmes according to the type of drug, drug use and drug user. It also highlighted the need to combine different means in an integrated approach.

- In December 2001 the National Advisory Committee on Drugs (NACD) published its report *Drug use prevention: An overview of research* (Morgan 2001). The main conclusion was the need to distinguish between prevention campaigns targeting 'the most dangerous substances' and 'experimental drug use':

'...there is no single "drug problem" with one dramatic solution. Rather, what is called the drug problem is comprised of varying degrees of involvement with a variety of substances, arising from several influences many of which are unrelated to each other.'

The following summary is based on the Executive Summary:

Targeting and preventing use of the most dangerous drugs:

'The most serious drug problems involve opiates and are largely associated with deprivation. ...Targeted initiatives to tackle the social origins of these drug problems should involve inter-agency co-operation and have community involvement. ...There is also a need to continue with supply reduction measures particularly as these have an important influence on the perception of what is acceptable. Furthermore, there is a need to include legal drugs as part of the policy since experience has shown that an exclusive focus on illegal drugs has limited effectiveness. There is a need to raise public awareness of the importance of deprivation as a predisposing factor for the most damaging forms of drug misuse. This will act as a prelude to widespread acceptance of the necessity for the major resources that will be needed to deal with these problems.' (Morgan 2001, pp. 7–8)

Broadly-based programmes targeting experimental drug use that is not uncommon among young people from all social backgrounds:

'Fear-based messages are not appropriate in programmes including classroom programmes. ...There should be continued investment in approaches that emphasise personal and social development, stress social skills and enhance decision-making. ...The developments in Social Personal and Health Education (SPHE) are especially to be welcomed.

'There is considerable evidence that school programmes on their own are unlikely to have a major impact without community backing. There is a need to take into account the views of parents and other interested parties. ...Schools need to develop policies with regard to drug prevention. Such policies should include not only illegal drugs but also legal drugs and may be most effective if they involve groups of schools and are holistic in nature, rather than simply indicating sanctions for drug use.' (ibid.)

- In July 2002, following the findings of the Union of Students in Ireland (USI) survey (see under Section 1.4a above), there was comment from both the USI and the government on the need for prevention:

'USI believes that an open, transparent and confidential information service should be available to all students in third level education to continue on from the drug education received at secondary school level. The most effective way of disseminating this information would be through the introduction of a 24-hour free phone service specifically for students.

'Ideally, the service would be manned by professionals with the necessary skills and knowledge to deal effectively, sensitively and in a non-judgemental manner with all calls regarding drugs misuse. The service's main function would be to offer advice and information to students about the use of illicit drugs. Such a facility would complement existing services such as the NUS-USI online drugs information service.

'The fact that 66% of those who had tried illegal drugs had their first experience in secondary school also highlights the need for further concentration at this level in any new campaigns.

'USI also calls for ongoing training and support for those working with students who are drug users. The organisation believes it is important that current initiatives to educate the public about the dangers of drug use are continuously monitored and assessed to ensure their effectiveness.

'This survey shows very clearly that students take drugs. Student welfare has always been of primary concern to USI. We will therefore be forwarding the findings of this survey to the Department of Health and Children and in any subsequent meeting we will be calling for a pro-information stance in future drugs awareness initiatives aimed at those in third level education.' (Union of Students in Ireland 2002b)

Interviewed on radio about the USI survey findings, Minister of State Noel Ahern, TD, commented on the type of prevention programme he envisaged:

'...we basically have to get to people early and show them the dangers of drugs and you know the damage it can do to themselves, their families and their communities'. (Ahern 16 July 2002).

Harm Reduction

Through its service provision and research activities, Merchants Quay Ireland (MQI) has highlighted the need for treatment services targeting high-risk users and hard-to-reach users, and the links between homelessness and problem drug use.

- In its annual report for 2000, published in late 2001 (Merchants Quay Ireland 2001), MQI endorsed the National Drugs Strategy as offering a '*realistic framework*' for ensuring that '*the harm caused by problematic drug use is reduced to an absolute minimum*'. It particularly welcomed the actions aimed at reducing risk behaviour associated with drug use by widening access to needle exchange services. However, it called for targets to be set for reducing some of the greatest forms of harm, i.e. deaths through overdose and new HIV or HCV infections.

'If the government is committed to reducing harm to an absolute minimum, then they must put in place a range of new measures to ensure that risks associated with needle sharing, accidental overdose and dangerous injecting techniques can be minimised – these measures should include greater access to clean injecting equipment, advice and training on how to avoid overdose and infection, and safe supervised facilities where professionals can assist in minimising harm associated with actual drug taking.' (p. 7)

- In August 2002 MQI held its first annual conference, on the theme 'Homelessness and Problem Drug Use – Two Faces of Exclusion'. The aims of the conference were to:
 - counteract the tendency of people to see problems in isolation from one another;
 - gain a more holistic view of homelessness and drug use as manifestations of poverty and social exclusion;
 - understand better the policy context in which these problems can develop;
 - learn about new ways to respond effectively; and
 - learn from new research in these areas.

Speakers discussed harm reduction techniques, including outreach, safe injecting, injecting rooms, and monitoring the health status of vulnerable groups such as women, and the need for research on the precise nature of the linkages between homelessness and drug misuse.

The Minister of State with responsibility for Drugs Strategy, Noel Ahern, TD, also spoke at the conference. He stated that there was '*no single drug problem with a single clear-cut solution*', and that '*given the growing incidence of drug abuse among homeless people, there was a need for services and facilities which catered for their needs.*' The Minister also acknowledged the anomalies associated with being homeless and a drug user:

'As everybody here is aware, homeless drug users are an extremely vulnerable and marginalised group. They can often be caught in a vicious cycle from which they find it difficult to escape. If you are a drug misuser, it can often lead to homelessness, and your behaviour may lead to your being excluded from homeless services. On the other hand, if you are homeless and a drug misuser, taking part in a drug treatment project can be more difficult, with an increased risk of relapse.' (McNally 15 July 2002)

Treatment

The voluntary and community sectors have been active in debating the issues surrounding drug treatment – both the types of services and the delivery of services.

- In May 2002 the Addiction Spoke (a group of mostly professional individuals working in the field of addiction treatment and prevention)¹⁹ published a Summary Report (Addiction Spoke 2002). The report stated that:

'The abuse of alcohol, heroin, methadone and other drugs by young people, in both the Dublin area and the rest of Ireland, represents an epidemic that is failing to respond to existing policies. Furthermore, the reliance on methadone maintenance as a first treatment option for young opiate abusers is itself a major barrier to recovery. There is a deplorable lack of drug free treatment options available to young addicted people [currently 30–40 beds for detoxification and between 200–300 drug-free recovery places, according to another section of the report] and accurate information about the nature and extent of drug abuse in Ireland is in short supply.'

'The Addiction Spoke believes that methadone maintenance is wholly inappropriate for addicted under 20s as it inhibits recovery and is in effect merely drug substitution. Drug free treatment for addicted young people who have not been in methadone maintenance is simpler, quicker and more successful within an ongoing recovery programme. However, where an addicted person has been on methadone maintenance, recovery becomes much more difficult to achieve because of prolonged dependence and loss of motivation.' ('Addiction' 2002)

The Summary Report (Addiction Spoke 2002) included the following recommendations:

- Drug free treatment should be freely available to all communities throughout Ireland.
- The methadone maintenance programme should be reviewed and re-evaluated as a matter of urgency and, as an immediate first step, no person under the age of 20 should be placed on methadone maintenance.
- To be made effective, prevention, intervention and treatment programmes should be co-ordinated together as part of a clearly understood structure.

The Summary Report was published to provide the baseline of a major new study being conducted by the Addiction Spoke. The findings of the full study are to be published later in 2002. The Addiction Spoke also plans to hold a seminar bringing together policy makers, healthcare workers, addiction professionals, parents and concerned people.

Commenting on the Summary Report, Joe Barry, a specialist in public health with the Eastern Regional Health Authority and a medical advisor to the National Drugs Strategy Team, stated:

'Methadone is not actually the first line of treatment for young people, the first line treatment for young people is a drug free option... the difficulty is that unfortunately in Ireland and particularly in Dublin, people begin injecting, as boys and girls, at the age of 14, 15 and they don't appear for treatment services for quite a number of years, so people are reasonably well established on an addiction life when they come to services. So the options that are put to people when they begin to make contact is drug free, ...we have currently about 6,000 people on methadone in the country and 160 of those, just under 3%, are under 20, so there is a whole gamut of options put to people and offered to people and the experience of the clinicians, the psychiatrists and the general practitioners who provide front line treatment to people who are addicted is that if detoxification doesn't work after a number of attempts that maintenance treatment for opiate addiction is the next line, so it is not as if methadone is creating a dependency, the dependency is there when people begin.' (Barry 2 May 2002a)

- In its annual report for 2000 (Merchants Quay Ireland 2001), MQI stated that it believed the government had missed an opportunity in relation to developing a strategy for attracting hard-to-reach drug users.

¹⁹ For further information on The Addiction Spoke, see www.wheel.ie/commsctr/spokes/addic/spotadd.html

'Methadone treatment is not enough. We need more low threshold services aimed at providing crisis counselling and pathways towards treatment and we need more attractive prescribing options if we are to link drug users with services and see a decline in drug related death and illness. Drug Free Treatment places must also be increased if rehabilitation is to remain one of the goals of drugs policy.' (Merchants Quay Ireland 2001 p. 7)

- Speakers at the march by community groups through central Dublin to highlight the 'drugs crisis' in June 2002 highlighted a number of issues in relation to the delivery of treatment services (Drugnet Ireland July 2002):
 - Treatment needs to be holistic, providing not just methadone treatment but a whole range of services including rehabilitation and after-care. Treatment also needs to be available after hours and at weekends and suit the needs of the clients.
 - Waiting lists for treatment need to be eliminated.
 - Permanent accommodation needs to be provided for homeless drug users so that they can avail of treatment services.
 - With the growing number of drug users who are testing HIV positive, many of them in their teens, drug-related treatment needs to be recognised as a basic human right.

1.4c) Media presentation and imaging drug use

To date, very little in-depth research has been carried out on media presentation and imaging of drug use in Ireland. The research that has been undertaken indicates that the national news print media's presentation of drugs and drug use tends to be from an 'abstentionist' viewpoint. However, the pattern of coverage and treatment of the drugs issue is complex, depending on the type of drug being discussed, the type of media (broadsheet, tabloid etc), media coverage (factual reporting or opinion writing), and the resources available to the media organisation to cover the story.

- In 1998 a qualitative study of 32 newspaper articles on ecstasy, drawn from two newspapers (one broadsheet and one tabloid), over the period 1991–97, was completed (O'Brien 1998). As far as possible the articles studied covered the same ecstasy-related stories. The portrayal in both newspapers was found to be

'overwhelmingly negative, with both newspapers using fearsome adjectives to describe the drug. The main themes arising in the articles, health factors, authority figures, and youth culture, were all found to add to this negative picture'.

The researcher proposed that these themes were used as '*devices to strike fear into the hearts of parental readers and to warn against use of ecstasy*'. The researcher also found that while the tabloid paper had '*a less cautious, more sensationalist tone than the broadsheet paper, the devices used by both newspapers were the same, and they appeared overall to come to the same negative conclusions about ecstasy*'.

- In a study of ecstasy use among young Irish people, also published in 1998, the authors included an analysis of selected media texts on ecstasy (Murphy, O'Mahony and O'Shea 1998). The objective was to assess '*the deficit of deliberation on the soft drugs issue in Ireland*' (Murphy et al. 1998, p. 142). Some 30 articles were collected over a period between 1996 and 1998 and analysed against three indicators of the nature of deliberation in the media:

1. Responses to survey results, which provide factual information on the extent and nature of soft drug use amongst young people;
2. The penetration into opinion pieces of new kinds of thinking on the Ecstasy and wider soft drugs problem; and
3. The degree to which the wider context presses on public debate in Ireland, which may indicate the need for re-orientation.

The researchers found that, in relation to fact-based reporting, while the media might be willing to consider new measures in line with policy innovations elsewhere, it did so in such a coded, negative way that it was hard to be sure what was intended.

The researchers concluded that, *'having built a moral consensus on drug use as an absolute, undifferentiated wrong, having contributed to building up this pre-factual attitude in public consciousness, it is extremely difficult [for the Irish news media] to tread on new ground, to find words which do not openly contradict the pre-established consensus...'* (Murphy et al. 1998, p. 144). The researchers found that in opinion pieces there was a more explicit acceptance of the widespread use of soft drugs and associated rave culture. They described one opinion piece that argued *'against the "gateway" argument that drug initiation through cannabis leads inexorably to use of hard drugs such as heroin and cocaine'* and where the author argued that the symbolic consensus that they (cannabis, heroin and cocaine) were highly connected led to a mix of policies which made them connected in practice, as part of the one criminal sub-culture (Murphy et al. 1998: pp. 146–7). The researchers described two other pieces – the first *'a sobering piece on the health implications of ecstasy'* and the second entitled *'Time to stop demonising?'*, which they argued were examples of opinion writers in the Irish media supporting harm reduction strategies. For example, they cited a quotation by a doctor, used in one opinion piece:

'When I talk to teachers and parents about drugs I make the point that the drugs that are far more likely to kill their children – and themselves – are the two legal drugs [alcohol and tobacco]' (Murphy et al. 1998, p. 146).

- In a review of how opioid misuse has been tackled in Dublin over the past 20 years, Joe Barry (2002b) commented,

'...all governments since 1991 have supported the harm reduction approach. Reporting of drug issues in the national media has not mirrored the shift in moving from an abstentionist to harm reduction approach. The national television station, RTE, and the main newspaper of record, the Irish Times, have both assigned reporting of the drug issue to their crime correspondents rather than their health correspondents and the opportunity for leadership from the "quality" media has not been grasped'. (Barry, 2002b, pp. 6–7).

- In its drugs survey, interviewing 500 randomly selected students out of a population of 250,000 students, the Union of Students in Ireland (USI) (2002a) asked respondents two questions relating to the media. Respondents were asked where they had obtained their information about drugs: of the 189 who had sought information, only 11 (5.8%) stated they had obtained their information from the media (pp. 20–21). Respondents were asked whether the media *'glamourise drug-taking'*, to which 263 out of 499 (52.7%) responded 'no', and 236 (47.3%) responded 'yes' (p. 23).

1.5 Budget and funding arrangements

The level of State spending on drugs-related issues is difficult to estimate and is complicated by the fact that expenditure is spread across a number of Departments, Local Authorities, Agencies and other statutory organisations. Even within Departments and Agencies, it is difficult to arrive at an accurate estimate of costs associated specifically with drug misuse as services such as An Garda Síochána, the Prisons, the Courts and Probation and Welfare Services and the various health agencies deal with drugs issues as part of their wider daily services.

The most comprehensive national expenditure estimates available to date related to the year 2000. These estimates were prepared by the Review Group of the National Drugs Strategy based on information made available to them by Departments and Agencies dealing with drugs issues. The Review Group estimated that the development, co-

ordination and delivery of the National Drugs Strategy approximated to €183 million in 2000. This is broken down by Departments and Agencies in Table 1.5.

Table 1.5. Direct expenditure on the current Drugs Strategy in 2000

Department/Agency	Expenditure (€ millions)
Dept. of Justice, Equality & Law Reform	123.2
Dept. of Health & Children	32.0
Dept of Enterprise, Trade & Employment	6.0
Dept of Education & Science	7.5
Dept of Tourism, Sport & Recreation	11.6
Revenue Commissioners (Customs and Excise)	1.9
State Laboratory	0.5
Total	182.7

Source: National Drugs Strategy 2001-2008. Department of Tourism, Sport & Recreation.

No specific national surveys on expenditure have been carried out to date.

PART 2

EPIDEMIOLOGICAL SITUATION

2. Prevalence, Patterns and Developments in Drug Use

2.1 Main developments and emerging trends

- Heroin is the main drug for which people present to drug treatment services in Ireland. Heroin dependence is still mainly concentrated in and around the Dublin area, but for a number of years there are indications that the problem is beginning to spread to other regions.
- Patterns of problem drug use are changing. Over a number of years (1990-1996), among those presenting to treatment for the first time, there was a trend towards the smoking, rather than injecting, of heroin. Smoking seems to have been the preferred route for young people starting to use heroin, at least in the initial year or so of their drug careers. However, trends since 1997 show that the route of administration for heroin is tending again towards injecting. The explanation is likely to be a complex one, involving many factors such as the availability of heroin, fluctuations in the price of heroin, but it may be that young people who originally preferred to smoke heroin are now no longer reluctant to inject.
- There is an increasing trend in those presenting to services for treatment of problematic cannabis use. Outside of Dublin and its environs, cannabis is the main drug for which people present for treatment. Throughout the 1990s trends in cannabis use remained fairly stable at between 11 and 15 percent of all those treated. Then in 2000 the proportion increased to 22 percent. This increase probably reflects an increase in the provision of treatment services rather than a real increase in cannabis use. Given that cannabis is smoked this can have serious implications for the future health of a young population.
- In the latter half of the 1990s there was a decreasing trend in those presenting to treatment services with problematic ecstasy use, from 7.4 percent in 1995 to 3.5 percent in 1998. However this trend did not continue and there was an increase in the proportion of people – to 5.9 percent in 2000 - who presented with ecstasy problems.
- Drug users presenting for treatment are likely to be involved in the use of more than one drug. Trends show a high level of polydrug use, with seven out of ten clients presenting with secondary drug problems. Cannabis, benzodiazepines and ecstasy are the drugs most likely to be involved.
- The profile of the typical problematic drug user is young, unemployed male, leaving school at an early age and living in a socially and economically disadvantaged area.
- On a positive note the level of employment among problem drug users in treatment has increased considerably.
- A significant proportion of prisoners, who have a history of drug use, continue to engage in illicit drug use once incarcerated.
- A survey to investigate factors underlying international variations in youth drug use undertaken in five cities including Dublin, found that sporting activities by young people were linked with low rates of drug use.

- It is now recognised at official level that homeless young people are seriously at risk of becoming involved in drugs, prostitution and crime. As a result a strategy on youth homelessness has been drawn up.
- Services need to be developed for drug users in the prison setting that take account of the particular nature of the prison environment. They also need to address the needs both of those who continue to engage in drug use and the associated risk behaviours; and those who wish to cease their drug use while incarcerated.
- There are indications of increasing homelessness among young drug users.
- There has been a decrease in high-risk behaviours – needle sharing decreased and safe sex (use of condoms) practices increased among clients attending a needle exchange programme over an eight-year period. This could be due to increase in service provision and the freer availability of clean needles and condoms.
- Women are more at risk than men, but while women tend to be involved in more risky behaviours than male drug users, they do present earlier for treatment.
- Studies indicate the need for more imaginative education initiatives in harm reduction interventions. Greater attention needs to be paid to the social context of injecting drug use and the sharing of injecting equipment. Outcomes of harm reduction interventions could be improved by exploring the perceptions surrounding unsafe injecting practices.

2.2 Drug Use in the population

2.2a) Main results of surveys and studies with indication of trends and possible reasons/associated factors

No national surveys of drug use in the Irish population were carried out in 2001. For a review of existing surveys see Ireland's National Report 2001.

2.2b) General Population

No national surveys of drug use in the general population were carried out in 2001. For a review of existing surveys see Ireland's National Report 2001. The National Advisory Committee on Drugs has commissioned a national survey of drug use in the general population. First results are expected in mid-2003.

2.2c) School and youth population

No national surveys of drug use in the school or youth population were carried out in 2001. Ireland will participate in the third European School Survey Project on Alcohol and Other Drugs (ESPAD) to be carried out in 2003. The first ESPAD survey was carried out in 1995 and the second in 1999. For a review of existing surveys see Ireland's National Report 2001.

2.2d) Specific groups

For a review of studies on drug use in specific groups of the Irish population see the Key Issue on Social exclusion and reintegration, Chapter 16, Part 4 of this report.

2.3 Problem drug use

2.3a) National and local estimates, trends in prevalence and incidence, characteristics of users and groups involved, risk factors, possible reasons for trends

Studies on national and local prevalence estimates of problem drug use are quite limited in Ireland. Where studies have been carried out methodological difficulties exist and definitions of what is being estimated differ. The current lack of suitable multipliers based on Irish data makes estimates based on extrapolation unreliable.

Recognising that research and information gaps exist about the nature and extent of the drug problem in Ireland, the Government, through the Cabinet Committee on Social Inclusion, established the Interim Advisory Committee on Drugs in July 1999. As part of its subsequent report, the Interim Committee set out priority policy information needs and recommended a three year programme of research, which would be overseen by a National Advisory Committee on Drugs.

On the foot of the Interim Committee's recommendation, the National Advisory Committee on Drugs was established in July 2000 to advise the Government in relation to prevalence, prevention, treatment/ rehabilitation and consequences of drug use in Ireland, based on analysis of research findings and information available to it. The Committee has so far (October 2003) commissioned four pieces of research under the heading of prevalence:

- To provide an overview of available information on prevalence of the use of opiate and non-opiate substances in Ireland and to provide estimates of the extent of their use.
- To carry out a national study of opiate users using the network analysis method or nomination technique to provide data on a number of aspects of opiate use in Ireland which can be used to develop multipliers for establishing clearer prevalence estimates. First results are expected at the end of 2003.
- To carry out national capture-recapture study to estimate the prevalence of opiate use in Ireland during 2000. This study is expected to use at least three samples of data (methadone treatment list, hospital in-patient data, and police record data). To facilitate the study the Committee requested that a national survey of illicit drug use and related criminal activity be carried out by An Garda Síochána (Irish police). The Commissioner of An Garda Síochána approved the undertaking of this survey and data collection began in early 2002. First results are expected in early 2003.
- To carry out a national general population survey to measure the extent and pattern of drug use in those aged 15 to 64 years. First results are expected in mid-2003.

2.3b) Risk behaviours and trends

For a review of existing surveys see Ireland's National Report 2001.

3. Health Consequences

3.1 Drug treatment demand

3.1a) Characteristics of clients, patterns of use and trends

People encountering serious problems with drug misuse will more than likely eventually come into contact with treatment services. The treated population of drug users is well represented in the National Drug Treatment Reporting System (NDTRS). Analysis of the characteristics and drug use patterns of clients presenting to treatment for the first time, over a number of years, gives a good overview of trends in drug use.

Drug use patterns in Ireland vary according to geographic location. Problem opiate use, mostly heroin, is mainly confined to the Dublin area. This is changing, with pockets of heroin use now becoming apparent in a number of urban areas in regional locations. Very generally speaking, the profile of the typical problematic drug user – young, unemployed male, leaving school at an early age and living in the family home in a socially and economically disadvantaged area - has not changed much in the six-year period between 1995 and 2000. However, there has been some change in trends and patterns of drug use over that time.

Data on clients presenting for treatment for the first time are presented in Table 3.1 below (see also EMCDDA Standard Table 4B). The gender distribution is still predominantly male, with the presence of women slightly increasing. The mean age has remained fairly stable at around 22 years. Unlike other EU countries where clients entering treatment for the first time are in their 20s and 30s; in Ireland they are in their teens and 20s. This is a reflection of the demographic situation in Ireland where the population is younger than in other EU countries. The age at which drug use is initiated is around 16 years of age.

Table 3.1. Ireland 1995-2000. New clients presenting for treatment. Characteristics and patterns of drug use. Percentages.

Characteristics	1995	1996	1997	1998	1999	2000
Valid N	1886	2038	1501	1621	1852	1981
Socio-demographics						
Gender distribution - Male:Female	80:20	73:27	72:28	74:26	73:27	77:23
Mean age	21.1	21.3	22.0	22.1	23.3	23.2
Mean age of initial drug use (excl. alcohol)	15.7	15.4	15.9	15.5	15.6	15.6
Living status - with parental family	78.9	76.6	71.4	71.1	68.9	67.8
- homeless	2.2	2.5	2.7	3.4	2.7	3.2
Early school - leavers (<15 years old)	15.9	15.6	12.7	12.3	12.4	10.1
Regular employment	15.3	13.8	19.5	24.8	30.8	31.9
Problem drug use						
Main drug – opiates	60.3	65.9	61.2	60.0	61.0	47.3
Main drug – cannabis	22.3	20.6	21.2	24.4	25.6	35.5
Main drug - IV use	23.6	24.2	29.1	28.9	35.3	22.8
Main drug – smoke	56.2	59.7	50.9	53.2	49.9	57.6
Polydrug use (more than one drug)	76.0	70.4	69.9	67.9	63.8	70.6
Risk behaviour						
Ever injected any drug	32.2	32.3	36.6	37.2	44.1	32.3
Currently injection any drug	19.7	21.1	24.7	22.7	21.9	17.6

Source: National Drug Treatment Reporting System (NDTRS), Drug Misuse Research Division, Health Research Board

Some aspects of the social condition of new clients entering treatment have improved somewhat since the mid-90s, at least in terms of education and employment. Clients are now less likely to leave school *before* the official school-leaving age of 15 years of age, but the proportion (10 percent in 2000) is high in comparison to that of the general population. Employment levels have doubled from 15 percent in 1995 to 32 percent in 2000. This is as might be expected given the general favourable economic conditions in Ireland, although employment among clients is still very low in comparison to that of the general population. Another improvement is that fewer clients are living in the family home – the proportion decreased from 79 percent in 1995 to 68 percent in 2000. However, homelessness has increased slightly from 2 to 3 percent over the six-year period. The social characteristics of new clients are indicative of the social disadvantage of drug users and present a challenge to policy makers, particularly in the area of employment, if social exclusion and marginalisation issues are to be addressed.

The characteristics of clients using different types of drugs varies: heroin users are less likely to be still at school than cannabis users, and much more likely to be involved in behaviours with detrimental effects to their health, such as injecting, and sharing injecting equipment. There is great disparity in the patterns of drug use in different parts of the country.

Problematic opiate use is mainly confined to the eastern region of the country, around Dublin. In other areas of the country cannabis is the main drug for which most clients present for treatment. However, national treatment data show that changes are occurring. Up to 1999 an opiate was the main drug of misuse for 60 percent (or over) of those presenting for treatment for the first time, then in 2000 this dropped to 47 percent. In the same year there was an increase in those presenting with cannabis as the main problem. This reflects an increase in treatment demand in conjunction with an increase in the provision of treatment services in regional areas of the country where cannabis is the main drug for which people present for treatment.

Drug users presenting for treatment are likely to be involved in the use of more than one drug. Trends in secondary drug use show a high level of polydrug use with over two-thirds of new clients involved. Opiates, benzodiazepines and cannabis are the drugs most likely to be involved (O'Brien *et al.* 2002).

Over the six-year period there was an increase in the proportion injecting their main drug of misuse and a decrease in smoking (see Section 3.1c). The proportion of injectors among new clients increased between 1997 and 1999 but stabilised again in 2000 at around one-third. Since 1997 the proportion currently injecting has been decreasing (from 25 percent to 18 percent).

3.1b) Comments on different client profiles in different types of treatment

The majority of people presenting for treatment for drug use problems in Ireland are treated at non-residential treatment centres. Data from the NDTRS for 2000 show the following proportions presenting to different types of treatment services: 69 percent - non-residential; 22 percent - residential; 6 percent - low threshold; 4 percent - GPs. It should be stressed that clients attending GPs are very poorly represented in treatment data, as are clients in prison.

Men were more likely to be receiving treatment at residential or low threshold services, while women were more likely to present to non-residential or GP services for treatment. Clients living in the parental home were least likely to be attending low threshold services. Unemployed clients were the most likely to be attending low threshold services; those in regular employment were more likely to be receiving treatment from a GP.

Against a background of increasing encouragement of GPs to become more involved in the treatment of drug users, a study was carried out in a specialised drug treatment setting during August-September 1997. The aim was to assess the utilisation of primary care services for general health purposes, by injecting opiate users (n=77) (Smyth *et al.* 1999). A structured questionnaire was used to interview clients. The sample size was 139 with a response rate of 75 percent. The sampling procedure was opportunistic. Despite general policy changes, such as more emphasis on harm minimisation, the findings were similar to those of a similar study in 1991. In particular, the relative frequency of GP and A&E (hospital accident and emergency department) attendances were unchanged. Concern was expressed by the authors (Smyth *et al.* 1999) at the high proportion who were being prescribed benzodiazepines (39 percent) by GPs. They state that this indicated that there is 'clearly a wide gap' between treatment approaches by psychiatrists specialising in substance misuse at treatment centres, and GPs, in the management of co-morbid disorders, such as anxiety and sleep disorders among drug users. The need for improved communication and co-operation as well as explicit protocols relating to clarity, consistency and continuity in treatment approaches was stressed.

3.1c) Comments on treatment demand for different drugs

Heroin: The pattern of heroin use among new clients in Dublin during the early 1990s was characterised by the emergence of chasing the dragon (Smyth *et al.* 2000). This coincided with a surge in the number of people entering treatment for the first time. Concern was expressed that the greater acceptability of heroin chasing among new users might attract increasing numbers to heroin use (*ibid.*). Nationally, among new clients heroin use remained fairly stable between 1995 and 1999 with a drop in 2000, but intravenous use of the drug increased steadily between 1995 and 1999, dropping in 2000 (see EMCDDA Standard Table 4B). Among opiate/heroin clients there is a higher proportion of women than might be expected. A possible explanation for this could be that women, although in a minority, are more likely than men to present sooner to drug treatment services (Geoghegan *et al.* 1999). Women are also more likely to have ever injected a drug.

Cannabis: Since the NDTRS was set up in 1990, the proportion of people presenting for treatment for cannabis use remained fairly stable (between 11 and 15 percent) (see EMCDDA Table 4A). However, in 2000 there was increase (to 22 percent). As already mentioned above this reflects an increase in the provision of treatment services in conjunction with an increase in demand for treatment in regional areas of the country.

Cocaine/crack: Apart from addiction counselling, there are no specific treatments for problem cocaine users in Ireland. Treatment demand for cocaine as the main drug of misuse has always been very low: between 1 and 2 percent. When the situation among new clients with multiple drug problems (70 percent) is examined it emerges that in 2000, 9 percent were seeking treatment for problem cocaine use (as secondary drug).

Synthetic drugs: Among new clients demand for treatment for problem ecstasy use decreased between 1995 and 1999 (from 11 percent to 8 percent), however, in 2000 it increased again to 11 percent (see EMCDDA Table 4B). The proportion of problem amphetamine users presenting for treatment for the first time increased from 0.4 percent in 1995 to 2 percent in 1999, but in 2000 it dropped to 1 percent. A worrying development is that injection of the drug seems to be increasing (6 percent in 1999 and 13 percent in 2000). The proportion of new clients presenting with problem LSD use is falling (from 1.6 percent in 1995 to 0.2 percent in 2000).

3.2 Drug-related mortality

3.2a) Drug-related deaths, direct and indirect

Official Irish statistics on drug-related deaths from the General Mortality Register (GMR) are compiled routinely by the Central Statistics Office. They are recorded according to the

International Classification of Diseases, Version 9 (ICD-9), that is, the cause of death is designated as the *underlying cause of death*. This is defined as –

‘(a) the disease or injury which initiated the train of morbid events leading directly to death, or (b) the circumstances of the accident or violence which produced the fatal injury’ (WHO 1977, p. 700)

The underlying cause of death can be from natural or external causes. The definition of external cause of death is as follows:

‘...a supplementary classification that may be used, if desired, to code external factors associated with morbid conditions classified to any part of the main classifications. For single-cause tabulation of the underlying cause of death, however, the E Code should be used as a primary code if, and only if, the morbid condition is classifiable to Injury and Poisoning’ (WHO, 1977, p. xxix)

Data from the General Mortality Register at the Central Statistics Office show that drug-related deaths have increased considerably since 1995 (Table 3.2a). This increase is partly due to an improvement in the recording of a drug-related death at the scene of death.

Table 3.2a. The number of drug-related deaths* by age group in Ireland 1990 to 2000

Age (years)	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
<15	0	1	0	0	0	0	0	0	0	0	0
15-24	5	2	3	6	7	15	19	36	32	35	33
25-34	2	4	9	6	9	16	21	24	22	37	33
35-44	0	1	1	4	2	8	7	10	28	24	30
45-54	0	0	1	1	1	2	3	7	8	10	11
55-64	0	0	0	1	0	2	2	4	3	4	6
65+	0	0	0	0	0	0	1	0	4	4	6
Total	7	8	14	18	19	43	53	81	97	114	119

Source: Central Statistics Office (Personal Communication)

* A drug-related death is defined here as one where the underlying or external cause of death was due to drug dependence (ICD-9 Code 304) or poisoning by opiates and related narcotics (ICD-9 Code 965.0).

Indirect as well as direct drug-related death was the subject of an ad hoc retrospective study carried out in 1999 (Keating et al. 1999). Dublin City and County Coroners' files were examined to study the number of drug-related (direct and indirect) deaths in 1997. The criteria for inclusion were that the death had to have occurred in Dublin (city or county), between 1 January and 31 December 1997, and have positive toxicological evidence of the presence of drugs, and where drugs were implicated in the cause of death - this is a much broader definition than that used for the purpose of the GMR. Toxicological screens included testing for alcohol, opiates, benzodiazepines, tricyclics, barbiturates and cocaine. One-hundred-and-twenty cases were found to be toxicologically positive for drugs and 65 of these were known to be drug users. The gender ratio was 3:1 (male:female) and more than half of the deaths were in the 20-39 year age group. The drug most commonly identified was benzodiazepine (75 cases) mainly in combination with other drugs. The most common combination of drugs was opiates and benzodiazepines. Methadone was found in 47 cases; alcohol was found in 47 cases; cocaine in 7 cases; MDMA in 2 cases; and amphetamines in 2 cases. A similar study of coroners' files in 1992 (in Keating et al. 1999) found no cocaine, MDMA nor amphetamines in drug-related deaths. The 1992 study found a similar number of drug-related deaths recorded (in Dublin coroners' files) to that recorded in the GMR for that year. However, the total number (120) found in the 1997 study did not correspond with the number (49) recorded in the more narrowly defined GMR for the same year.

A more recent study in Dublin in 1999 also found that statistics recorded in the GMR fell short of those found in the coroners' records (Ward and Barry 2001). The study definitions, which included indirect as well as direct drug-related deaths, were somewhat different from the GMR definition. One of the aims of the study was to determine the number of opiate-related deaths in Dublin city and county in 1999. Eighty-four drug-related deaths were found: methadone and/or morphine were detected in 72; benzodiazepines in 52; alcohol in 26; codeine cocaine, amphetamines and ecstasy were found in 14 cases. Toxicological analyses showed that 2 or more drugs were identified in 73 of 84 cases. The majority was young males who had been involved in benzodiazepine or alcohol co-abuse.

Table 3.2b. Drug-related death by cause of death, Dublin 1999

Cause of death	ICD Code	Number
Drug dependence	304.0-304.9	63
Poisoning by opiates & related narcotics	965.0-965.2, 965.9	2
Violent & accidental (hanging, gunshot wound, fall etc.)	994.7, E922.0, E888	13
Miscellaneous (not established, vasculitis, alcohol dependence, liver disease)	799.0, 447.5, 303.0, 571	6
Total		84

Source: Ward & Barry 2001

The cause of death was recorded as drug dependence in 75% of cases (N=63), and violence accounted for a sizeable minority (15%, N=15) (Table 3.2b).

These study findings show that polydrug use is a serious problem. They also highlight the fact that the full extent of drug-related death is not evident from GMR statistics, suggesting the need for a Special Register to record indirect as well as direct drug-related deaths

3.2b) Deaths related to opiates and to other drugs

See section 3.2a above.

3.2c) Number, characteristics and trends, possible reasons for changes

See section 3.2a above.

3.2d) Overall mortality and causes of death in drug-users, trends

Research findings on mortality among drug users is not yet available, therefore it is not possible to discuss associated mortality trends.

3.3 Drug-related infectious diseases

3.3a) HIV and AIDS

As described in the National Report for 2001, the majority of data collected on drug related infectious diseases in Ireland are related to HIV. Two sources of data exist: the routine data on HIV positive tests that are reported by the National Disease Surveillance Centre and special studies which have been carried out estimating the prevalence of HIV among particular cohorts of drug users.

Up until July 2000, the Department of Health and Children, in collaboration with the Virus Reference Laboratory, was responsible for producing statistics on HIV positive tests which are published every six months. On 1st July 2000, the Infectious Diseases (Amendment) Regulations, 2000 (S.I. No 151 of 2000) came into force. Under these regulations the National Disease Surveillance Centre (NDSC) was assigned responsibility for the collation and analysis of weekly notifications of infectious diseases, taking over from the

Department of Health and Children. In their first six months of data collation (July 2000-December 2000), data were collected in the same manner as previous years. However, in July 2001 a new HIV case-based reporting system has been developed. The aim of the new HIV case based reporting system has been noted as “to ensure the collection of accurate and complete epidemiological data on the distribution and mode of transmission of HIV infection” (O’Donnell, Cronin and Igoe 2001, p. 21). The socio-demographic data that will be collected within this new system are the patient’s age, gender, county of residence (if Dublin, then the postal code) and country of birth (if not Ireland then year of first arrival in Ireland). Furthermore, an expanded list of probably routes of transmission is included. The new list reads as follows:

<p>Probable route of transmission (please tick one)</p> <p><input type="checkbox"/> Men who have sex with men (MSM)/Bisexual</p> <p><input type="checkbox"/> Injecting Drug User (IDU)</p> <p><input type="checkbox"/> IDU and men who have sex with men (MSN)/Bisexual</p> <p><input type="checkbox"/> Heterosexual</p> <p>If heterosexual (please circle)</p> <p>1. From a country with a generalised HIV epidemic</p> <p>2. Sex with a bisexual male</p> <p>3. Sex with an injecting drug user</p> <p>4. Sex with a haemophiliac or a transfusion recipient</p> <p>5. Sex with a person from a country with a generalised HIV epidemic</p> <p>6. Sex with a person known to be HIV infected (not number 1-5 above)</p> <p>7. Infected through heterosexual transmission, no further information</p> <p><input type="checkbox"/> Mother-to-child</p> <p>If mother-to-child please indicate status of mother (please circle)</p> <p>1. Injecting drug user</p> <p>2. From a country with a generalised HIV epidemic</p> <p>3. Infected through heterosexual contact (not number 2 above)</p> <p>4. Transfusion recipient</p> <p>5. Other/undetermined</p> <p><input type="checkbox"/> Haemophiliac</p> <p><input type="checkbox"/> Transfusion recipient</p> <p><input type="checkbox"/> Nosocomial infection</p> <p><input type="checkbox"/> Occupational</p> <p><input type="checkbox"/> Other/undetermined (if other please state)</p>

Source: HIV/AIDS Surveillance Report Form, NDSC.

This new system of data collection for HIV will be evaluated in 2002, and any necessary changes made.

In considering the data available for 2001, the remainder of this section refers to data gathered on positive tests by the Virus Reference Laboratory and collated by the Department of Health and Children, and, from July 2000, the NDSC. Within this system figures relating to HIV tests are broken down according to risk category, one of which is injecting drug use (IDU). As noted in the National Report for 2001, while it is possible to get a breakdown of the number of positive HIV cases attributable to injecting drug use in a given year, there continue to be a number of limitations to this data source:

- It is limited to the *tested* population. Nothing can be inferred for those drug users who have *not* been tested.
- It is not possible to identify non-injecting drug users within the data set.
- No socio-demographic data is collected on those who are tested.
- There is only a limited geographical breakdown available.

- A gender breakdown has only been made available since 1997.
- Both risk behaviours (e.g. injecting drug use) and test locations (e.g. prison) are used as categories. This makes the data somewhat unclear. For example, it is not known through what risk activity those tested in the prison setting became infected with HIV.
- (National Report 2001)

Despite these limitations, this data source provides the best information with which to examine the epidemiological profile of HIV in Ireland over the past decade and a half.

The cumulative figures for the positive cases of HIV from the start of data collection in 1982 up until 1985, show that 61% (n = 221) of all positive cases (n = 363) were attributed to injecting drug use (see Table 3.3a). However the proportion of positive HIV cases attributed to the IDU category has generally decreased since 1986. In 2001 the proportion of positive HIV tests attributed to the IDU category was 12.7%, the lowest level recorded since reporting began. Injecting drug use still continues to be one of the main risk categories, accounting for 37.1% of the cumulative number of positive cases up until 2001.

Table 3.3a. HIV positive cases by risk category, Ireland 1982-2001. Figures are numbers (percentages)

Year	IDU n (%)	Homosexual Sex n (%)	Heterosexual Sex/ Risk unspecified n (%)	Other n (%)	Total
1982-5*	221 (60.9)	39 (10.7)	0	103 (28.4)	363
1986	112 (66.3)	11 (6.5)	21 (12.5)	25 (14.8)	169
1987	72 (49.7)	21 (14.5)	26 (17.9)	26 (17.9)	145
1988	58 (50.4)	17 (14.8)	20 (17.4)	20 (17.4)	115
1989	57 (49.1)	33 (28.5)	0	26 (22.4)	116
1990	50 (45.1)	25 (22.5)	24 (21.6)	12 (10.8)	111
1991	34 (36.9)	27 (29.4)	25 (27.2)	6 (6.5)	92
1992	82 (40.8)	58 (28.9)	50 (24.9)	11 (5.5)	201
1993	52 (38.0)	48 (35.0)	21 (15.3)	16 (11.7)	137
1994	20 (23.5)	31 (36.5)	22 (25.9)	12 (14.1)	85
1995	19 (20.9)	33 (36.3)	30 (33.0)	9 (9.9)	91
1996	20 (18.9)	41 (38.7)	27 (25.5)	18 (17.0)	106
1997	21 (17.6)	37 (31.1)	40 (33.6)	21 (17.6)	119
1998	26 (19.1)	37 (27.2)	47 (34.6)	26 (19.1)	136
1999	69 (33.0)	40 (19.1)	59 (28.2)	41 (19.6)	209
2000	83 (28.6)	72 (24.8)	127 (43.8)	8 (2.8)	290
2001	38 (12.7)	73 (24.4)	173 (57.9)	15 (5.0)	299
Total	1234 (37.1)	643 (23.1)	712 (25.6)	395 (14.2)	2784

* Cumulative figures 1982 to 1985

Source: Department of Health and Children and National Disease Surveillance Centre.

As mentioned above gender information has only been reported since 1997. An examination of the figures by gender suggests a possible change in the profile of those who are testing positive for HIV in Ireland (see Table 3.3b).

Table 3.3b HIV seropositive intravenous drug users by gender, Ireland 1997-2001. Figures are numbers (percentages)

Year	Males n (%)	Females n (%)	Total
1997	18 (85.7)	3 (14.3)	21
1998	16 (61.5)	10 (38.5)	26
1999	35 (50.7)	34 (49.3)	69
2000	53 (63.9)	30 (36.1)	83
2001	27 (71.1)	11 (28.9)	38

Source: Department of Health and Children and National Disease Surveillance Centre.

In 1997, females only accounted for 3 (14.3%) of the 21 new positive cases attributed to injecting drug use. In 1998 this had increased to 10 (38.5%) of the 26 positive cases among injecting drug users, and in 1999 it had increased further to account for 34 (49.3%) of the 69 positive cases. However, in 2000 and 2001 the percentage of female testing positive dropped to 36.1% and 28.9% respectively. Due to the lack of information on gender prior to 1997, it is not possible to explore trends over a more extended period of time. Furthermore, research has not been carried out in the Irish context into the spread of HIV among female and male injecting drug users. As discussed in the National Report for 2001, anecdotal evidence suggests that the overall increase in the number of positive tests among women with a history of injecting drug use since 1997, may reflect a real increase in the number of female injecting drug users who are becoming infected with HIV. However, it is also suggested that these women may be becoming infected through their sexual behaviour rather than their injecting drug use. Once identified as an injecting drug user however, their infection will tend to be attributed to their injecting drug using behaviour. Anecdotal evidence also suggests that a growing number of women may be attending for testing in order to be able to minimise the risk of infection to their baby were they to become pregnant.

Since 1983 and up to end of 2001, there have been 719 AIDS cases reported in Ireland and 365 AIDS related deaths. Intravenous drug users continue to represent one of the main risk categories accounting for 39.4% of the total AIDS cases reported between 1993 and 2001.

A number of special studies have been carried out which have explored the prevalence of HIV among cohorts of drug users in a range of study locations. The studies have included drug users located in: the community, drug treatment centres, needle exchange programmes and prisons. A summary of the research findings on the prevalence of HIV infection among particular cohorts of drug users was presented in Ireland's National Report 2001.

3.3b) Hepatitis B and C

There is very little information in Ireland on the prevalence and incidence of hepatitis B and C among both the general population and the injecting drug using population. While data are collected on the number of positive tests carried out for hepatitis B by the Virus Reference Laboratory, no behavioural data is collected and therefore those infected through drug use cannot be identified. There is no routine data collection in the area of hepatitis C. Only total numbers of individuals who tested positive in a given year are available. As with hepatitis B it is not possible to differentiate those who have become infected through injecting drug use. Information on of hepatitis B and C prevalence rates is therefore confined to a small number of special studies that have been carried out in the field. A summary of the research findings was previously reported in Ireland's National Report 2001.

3.3c) Other

Data have not been collected on other drug-related infectious diseases in Ireland. Anecdotal evidence suggests however that tuberculosis may be increasing in prevalence among Irish drug users.

3.4 Other drug-related morbidity

3.4a) Non-fatal drug emergencies

Information on non-fatal drug emergencies is not routinely available in Ireland.

3.4b) Psychiatric co-morbidity

National policy on the treatment of alcohol and drug misuse (Department of Health 1984) stipulates that the emphasis in the management of alcohol and drug-related problems be on community-based intervention, rather than on specialist inpatient treatment. Despite the general policy of providing treatment for problem drug use at non-residential services in the community, drug-related admissions to psychiatric inpatient hospitals are continuing to rise (Table 3.4a). The proportion of drug-related admissions – with a primary or secondary diagnosis - increased from 2.2% in 1995 to 3.6% in 1999 for all admissions (National Psychiatric Inpatient Reporting System [NPIRS], personal communication). For first admissions (admission for the first time ever) the proportion increased from 2.4% to 5.0% in the same period. This is in contrast to the general trend of a decrease in overall admissions to psychiatric hospitals.

The rates (per 100,000 population) increased from 16.2 in 1995 to 24.6 in 1999 for all admissions, and in the case of first admissions the rate doubled between 1995 and 1999 from 4.7 to 9.8 per 100,000 population. Admission rates for 'drug dependence' to inpatient psychiatric hospitals vary according to geographic location (Table 3.4a). This is not necessarily an indication of morbidity but may perhaps be linked to drug treatment provision in different areas and/or more willingness in certain areas to admit people with drug problems to psychiatric hospitals.

Table 3.4a. Ireland 1997-1999. First Admissions to Inpatient Psychiatric Hospitals. Drug dependence diagnosis. Rates per 100,000 population aged 16 years and over.

Health Board Area	1997	1998	1999
Eastern	10.9	13.4	13.4
Midland	10.1	8.0	17.4
Mid-Western	10.6	10.2	13.2
North-Eastern	6.3	6.8	8.6
North-Western	6.5	6.5	2.6
South-Eastern	7.1	8.0	8.7
Southern	6.6	6.1	6.1
Western	5.4	6.5	7.7
Total	8.7	9.6	10.6

Source: National Psychiatric Inpatient Reporting System, Mental Health Division, Health Research Board.

The NPIRS data from 1997 to 1999 did not show any noteworthy psychiatric co-morbidity (NPIRS, personal communication). Close family ties and good family supports could be a factor in preventing people with psychiatric disorders from becoming involved in problematic drug use.

In an attempt to draw attention to concerns of the Irish Council of Attention Deficit Disorder Support Groups (INCADDS) a submission was made on their behalf to the National Drugs Strategy Review which took place during 2000. The submission was made as a result of concern that attention deficit hyperactivity disorder (ADHD) may be a significant risk factor for involvement in substance misuse; and that people with ADHD are more likely to self medicate. The aim was to highlight the need to identify drug users who suffer from ADHD and ensure the provision of appropriate treatment programmes for their care and management.

3.4c) Other important health consequences

The Medical Bureau of Road Safety (MBRS) in collaboration with the Garda Síochána (police) has undertaken a study to determine current trends in driving under the influence of drugs in Ireland. A survey being carried out in the year 2000 will investigate the presence of amphetamines, benzodiazepines, cannabis, cocaine, opiates and methadone in blood and urine samples taken by the Gardai under the Road Traffic Act, 1994. One

thousand samples will be randomly selected and another 1,000 from those who are under the legal alcohol limit for driving. Preliminary results (Table 3.4b) from 338 samples (under the legal alcohol limit) showed that cannabis was most frequently found (34%), followed by benzodiazepines (25%). Cocaine was the drug least commonly found at 4% of the sample (Moane et al. 2000).

Table 3.4b. Drugs Driving in Ireland 2000. Preliminary Study of Prevalence of Driving under the Influence of Drugs - for sample under legal alcohol limit. Type of Drug. Percentages

Type of Drug	Percentage Prevalence
Cannabis	34
Benzodiazepines	25
Amphetamines	16
Opiates	14
Methadone	7
Cocaine	4
Total N=338	

Source: Moane et al. 2000

These results indicate that there has been a significant increase in driving under the influence of drugs since 1987, when a similar study was carried out and 14.6% of samples (under the legal alcohol limit) tested were found positive for drugs. The current preliminary study found that the percentage had risen to 37%. The results of this survey, which will be available in 2002, will identify the types of drugs including alcohol, and their combination with other drugs, being used by Irish drivers.

The MBRS is responsible for analysing blood and urine specimens taken from people suspected of driving under the influence of an intoxicant, for prosecution purposes. The number of specimens analysed has been increasing for both alcohol and drugs.

Table 3.4c. Ireland 1995-2000. Toxicological analysis of blood/urine specimens. Numbers.

Year	Alcohol	Drug
1995	4766	8
1996	5514	16
1997	6591	24
1998	7812	32
1999	8476	50
2000	10134	78

Source: Flynn et al. 2001

Analyses of specimens for drug concentrations increased from 8 in 1995 to 78 in 2000. Of the 78 tested in 2000, 71 were found to be positive for drugs; 23 for one drug; 48 for more than one drug.

Table 3.4d. Ireland 2000. Toxicological analysis by type of drug found in blood and urine specimens*. Percentages.

Type of Drug	Percentage
Cannabinoids	32
Benzodiazepines	19
Methamphetamine	18
Amphetamine	15
Methadone	8
Other opiates	7
Cocaine	1
Total N=71	

Source: Flynn et al. 2001

*using Cozart immunoassay kits.

The drug most frequently found was cannabis in almost a third of cases (32%), followed by benzodiazepines (19%). Amphetamine-type drugs were identified in 33% of cases. This study of a small sample of blood/urine samples illustrates the occurrence of polydrug use among of Irish drivers.

4. Social and Legal Correlates and Consequences

4.1 Social Problems

4.1a) Social exclusion

For several years, professionals working in disadvantaged communities and in the field of drug treatment have been aware that the development of long-term and damaging drug careers is most often associated with social marginalization and exclusion (McCarthy and McCarthy 1995; Loughran 1996). Research in Ireland has, over the past two decades, consistently demonstrated a link between concentrations of drug use and various indicators of poverty and social exclusion, such as unemployment, poor housing, one-parent families and low educational attainment (Dean et al. 1983; O'Kelly et al. 1988; McKeown et al. 1993; O'Higgins and O'Brien 1995; Coveney et al. 1999). In 1996, Irish Government drug policy recognised the link between poverty and concentrations of serious drug problems in the *First Ministerial Task Force on Measures to Reduce the Demand for Drugs*. As Butler (1991) has commented, the role of *setting*, that is the impact of environmental or contextual factors in the development of drug-related problems, was acknowledged for the first time. The Irish National Drugs Strategy, which aims to provide an integrated response to the problems posed by drug misuse, can be characterised as supporting general initiatives to tackle social exclusion and specific initiatives targeted at drug related problems.

The mid-1990s in Ireland witnessed increased attention to the plight of families, parents and children living in neighbourhoods with high concentrations of drug use and related illegal activity. In 1996, community members engaged in direct action by marching on the homes of suspected drug dealers with the intention of intimidating them. Media attention to the activities of resident anti-drug and vigilante groups increased substantially during this time, raising public awareness of drug-related activities as well as the link between drug use and crime. The murder of journalist Veronica Guerin in 1996, resulting in public outrage and heightened intolerance of drug-related activities, forced the drugs issue to the top of the political agenda (Memery and Kerrins 2000). In December 1996, the Government introduced the Housing (Miscellaneous Provision) Bill which was enacted in July, 1997. According to Section (1), (a) and (b) of the 1997 Act, anti-social behaviour includes either or both of the following :

*'(a) the manufacture, production, preparation, importation, exportation, sale supply, possession for the purposes of sale or supply, or distribution of a controlled drug (within the meaning of the Misuse of Drugs Act, 1997 and 1984),
(b) any behaviour which causes or is likely to cause and significant or persistent danger, injury, damage, loss or fear to any person living, working or otherwise lawfully in or in the vicinity of a house provided by a housing authority under the Housing Acts, 1966 to 1997, or a housing estate in which the house is situated and, without prejudice to the foregoing, includes violence, threats, intimidation, coercion, harassment or serious obstruction of any person.'*

This legislation, which gave powers to local authorities to evict tenants on grounds of anti-social behaviour, was and remains strongly criticised by several sectors involved in the care and rehabilitation of drug users, and is equally strongly supported by certain community activists. According to the Merchants Quay Project, a voluntary service which provides a range of services to drug users seeking help, the Housing Act 1997 has contributed to an increase in homeless drug users in Dublin (Memery and Kerrins 2000). The Merchants Quay Project has noted an increase of young drug users sleeping rough in its recently published annual report. They claim that "both homelessness and lack of experience of drug use make these drug users a particularly vulnerable group in terms of risk of infection and general health and well being" (Merchants Quay Project 2000, p. 1).

Research evidence across a range of studies suggests that the Housing Act 1997 has impacted negatively on drug users. The Costello and Howley (2000) qualitative study of fifteen homeless drug users found that several of their respondents perceived the 1997 Act as leading to their further exclusion in gaining access to independent housing. The respondents' perception that they are discriminated against by local authority and resident committees because of their drug use was reported as creating a considerable barrier to their seeking accommodation. Similarly, Woods (2000), reporting on a study of female drug users' experience of parenting, found that respondents described the Housing Act 1997 as "anti-woman" and "anti-family". Respondents recounted several cases where drug users have been delivered the ultimatum to either access treatment or leave their communities.

The Cox and Lawless (1999) study of homeless drug users in Dublin city highlights the extreme vulnerability of this group, among whom they found low levels of educational attainment, high unemployment and histories of serving prison sentences. Fifty-six percent of the study's respondents reported that their drug use had escalated as a result of being out of home. This group of homeless drug users was found to engage in very high levels of risk behaviour, with 66% of clients injecting in public places, 49% reporting sharing injecting equipment and a further 24% stating that they recently borrowed used injecting equipment. This highly marginalised group meet further exclusion at some of the homeless services due to a policy of non-acceptance of active drug use in most direct access accommodation, such as hostels or shelters. Costello and Howley (2000) note the numerous negative consequences of excluding drug users from accommodation services for homeless people, including increased likelihood of sharing needles, lack of safe places to store and dispose of needles, lack of access to clean injecting equipment, and the lack of a clean safe environment in which to inject.

The impact of the Housing (Miscellaneous Provision) Act 1997 has been recently assessed by Memery and Kerrins (2000). This report documents an increase in evictions related to anti-social behaviour by Dublin Corporation since the introduction of the Housing Act, 1997. These authors conclude :

'Instead of working to resolve the wider and complex drug issues for these communities and address the needs of drug users directly, a very blunt piece of legislation was put in place with the emphasis on excluding those involved with drugs from local authority housing.' (ibid., p. 29).

4.1b) Public nuisance, community problems

The links between local authority rental tenure and various forms of disadvantage are well-documented in Ireland (Nolan et al. 1998). Less attention has been given to the investigation of the impact of social and environmental conditions on areas characterised by extreme deprivation, despite the susceptibility of such communities to a range of social problems, including drug misuse. However, one recent study of living conditions in seven local authority estates in urban areas throughout Ireland (Fahey 1999), highlights a range of social order problems in the study's estates. O'Higgins (1999) notes that the nature of social order problems experienced in the seven estates varied. At one end of the scale, social problems consisted of relatively minor "nuisance behaviour", while at the other, a number of estates endured more serious problems, ranging from illegal drug use and dealing to intimidation and harassment. This study found that the use of heroin and other "hard" drugs was confined mainly to Dublin estates, and was particularly acute in one large local authority flat complex located in Dublin's south inner city. The profound negative effects of concentrations of drug problems emerged strongly from the reports of children living in the estate, and interviewed for the purpose of the research. Children in focus groups recounted routine encounters with drug users and made casual reference to the

presence of drugs paraphernalia on the stairs, on balconies and in the stairwells. Coupled with this, parents expressed extreme anxiety about the negative consequences of high level of exposure to drugs for their children. Drug use and activities related to the distribution of illegal drugs were considered to be among the most enduring problems on the estate, and one which impacted negatively on the quality of life of a high proportion of residents.

In another study of a local authority estate, Corcoran (1998) similarly reported that all aspects of the drug problem, including drug-taking in public areas and the sale and distribution of drugs, were perceived as the biggest problem. Both Corcoran (1998) and O'Higgins (1999) note that the activities surrounding the distribution of drugs draw a steady stream of non-residents onto estates. This among other factors, exacerbates the "palpable sense of tension" (Corcoran, 1998: 21) in the area. There was a widespread belief among residents that the drug situation was out of the control of both residents and the Gardai (McAuliffe and Fahey 1999). Reporting on research carried out in another large inner-city flat complex with a long history of social problems, Morley (1998) also highlighted the perceived negative impact of drug problems on the quality of life in the community. The socio-economic profile of this estate revealed in the research - high rates of long-term unemployment, low educational attainment levels and high rates of early school leaving - is again indicative of a community struggling with the issues of social exclusion and marginalisation. This estate also hosted a large number of problem opiate users.

The management of social order problems on local authority estates has involved, inter alia, evictions of problem tenants, particularly those individuals associated with drug dealing and related activities. Fahey (1999) notes that while the use of exclusionary strategies has resulted in some improvements in social order in a number of estates, they can lead to further social problems which ultimately exacerbate social exclusion.

4.2 Drug offences and drug-related crime

4.2a) Drug offences

At the time of writing (October 2002) the Annual Report of An Garda Síochána 2001 was not yet published. The information below relates to the situation in Ireland up to the end of 2000.

The use per se of drugs, excluding opium, is not a criminal offence in Ireland. Under the Misuse of Drugs Acts, 1977 and 1984 (MDA), possession (MDA Section 3) and trafficking/dealing/supplying (MDA Section 15) are illegal activities. In 2000 prosecutions for 'possession' of an illegal drug made up 77% of total MDA prosecutions; 20% were prosecuted under Section 15 of the Misuse of Drugs Acts for drug-related trafficking offences (Table 4.2a). A breakdown by Garda regions²⁰ shows that most offences (31%) were committed in the Dublin Metropolitan area (N=2576), followed by 22% in the Southern region (N=1876). The proportion of 'possession' offences was almost the same in these two areas: in Dublin 26% (N=1686); in the Southern region, 23% (N=1516). Nearly half (46%, N=779) of trafficking (supply/dealing) offences were in Dublin.

²⁰ Since 1996 a regional command structure has been in place in An Garda Síochána and the country is divided into six separate regions – Eastern, Dublin Metropolitan, Northern, South-Eastern, and Western.

Table 4.2a. Drug law offences by type of offence and region, Ireland 2000. Numbers and percentages.

Region/Offence Type	Possession (Section 3 MDA)	Supply/Dealing (Section 15 MDA)	Obstruction (Section 21 MDA)	Other offences	Total
Eastern	1376	174	5	1	1556 19%
Dublin metropolitan	1686	779	32	79	2576 31%
Northern	514	103	5	10	632 8%
South Eastern	749	207	12	7	975 12%
Southern	1516	329	7	24	1876 22%
Western	644	114	7	15	780 9%
Total N	6485	1706	68	136	8395
%	77	20	1	2	100%

Source: Annual Report of An Garda Síochána 2000

With regard to the type of drug involved nationally, more than half (58%) were cannabis offences; in fact cannabis accounted for most of drug law offences in each region of the country (Table 4.2b). Nationally, ecstasy accounted for 25% of drug offences; after cannabis it was the drug implicated in most cases, except, that is, in the Dublin region where heroin accounted for over a quarter (27%) of offences. This is in contrast to the national situation where heroin was implicated in 9 percent of cases. In the Dublin region cocaine offences were 5 percent of the total; nationally cocaine accounted for 2 percent of offences.

Table 4.2b. Drug law offences by type of drug and region, Ireland 2000. Numbers and percentages.

Region/Drug Type		Cannabis	Heroin	LSD	Ecstasy	Amphetamine	Cocaine	Other	Total
Eastern	N	798	24	5	626	81	19	3	1556
	%	51.2	1.5	0.3	40.2	5.2	1.2	0.2	100.0
Dublin metropolitan	N	1288	692	4	277	116	120	79	2576
	%	50.0	26.9	0.2	10.8	4.5	4.7	3.1	100.0
Northern	N	375	4	7	232	5	2	7	632
	%	59.0	0.6	1.1	36.7	0.8	0.3	1.1	100.0
South Eastern	N	634	3	0	260	66	11	1	975
	%	65.0	0.3	0.0	26.7	6.8	1.1	0.1	100.0
Southern	N	1220	5	10	529	90	21	1	1876
	%	65.0	0.3	0.5	28.2	4.8	1.1	0.1	100.0
Western	N	565	2	7	162	33	7	4	780
	%	72.4	0.3	0.9	20.8	4.2	0.9	0.5	100.0
Total	N	4880	730	33	2086	391	180	95	8395
	%	58.1	8.7	0.4	24.8	4.7	2.1	1.1	100.0

Source: Annual Report of An Garda Síochána 2000

Trends over the six-year period between 1995 and 2000 show an increase in the number of drug charges, from 4146 in 1995 to 8395 in 2000 (Table 4.2c). There was a rise in the number of cannabis offences in 1999 (N=4185) and again in 2000 (N=4880). In 1998 cannabis offences (N=2190) made up 39% of total drug law offences, increasing to 59% in

1999: the proportion was similar (58%) in 2000. Heroin offences which had been steadily increasing between 1995 and 1999 dropped in 2000 (N=730), accounting for 9% of total drug law offences. Amphetamine offences increased from 138 in 1995 to 464 in 1999 and dropped slightly in 2000 to 391. The largest rise was in relation to ecstasy offences which doubled in 2000 to 2,086, accounting for a quarter (25%) of all offences.

Table 4.2c. Drug law offences by type of drug, Ireland 1995-2000.

Type of Drug	1995	1996	1997	1998	1999	2000
Cannabis	2600	1834	2671	2190	4185	4880
Heroin	296	432	564	789	887	730
Cocaine	30	42	97	88	169	180
Amphetamine	138	152	239	273	464	391
LSD	70	24	39	13	26	33
Ecstasy	645	340	475	439	1023	2086
Other offences	385	454	65	1839	383	95
Total	4146	3278	4156	5631	7137	8395

Source: Annual Reports of An Garda Síochána 1990-2000

In 2000 cannabis and ecstasy offences accounted for the majority (83%) of offences against the Misuse of Drugs Acts. It is likely that the increase in cannabis and ecstasy offences in 1999 and 2000 was related to intensive police activity at large-scale music events, at a number of venues in the country. Heroin and cocaine offences were more likely to be detected in the Dublin region.

4.2a) Drug-related crime

In a study of the general healthcare of the Irish prison population (sample size = 777: 718 males, 59 females) Hannon *et al.* (2000) found that 51 percent of males and 69 percent of females stated that they were under the influence of drugs when they committed the crime for which they were incarcerated.

A study to examine the association between drug use and crime in Dublin Metropolitan Area was carried out by the Garda Research Unit (Keogh 1997). The 'population' (N=4,105) was drawn from police records and from (police) local knowledge. It included all those who had come in contact with the Gardai through being arrested, charged or suspected of criminal activity between August 1995 and September 1996. The inclusion criterion was 'individuals involved in hard drug use'; opiates, stimulants, hypnotics and hallucinogens were included in the definition of 'hard drugs'. During the study period 19,046 serious crimes were detected and 7,757 individuals were apprehended for these crimes: of these 3,365 (43%) were identified as known hard drug users. It was deduced that the drug users were responsible for 12,583 (66%) of the crimes.

A sample of (n=351) of these agreed to be interviewed to provide more detailed information. Over a third (37%) had left school before the official school leaving age of 15; and 84% were unemployed. While three-quarters of the respondents had at some time sought treatment for problem drug use and most had received it, a number (n=81) had never sought treatment of any kind. A majority said they had a poor understanding of the effects of drug use. It was found that 51% had been involved in crime before their involvement with drugs; 48% said family members were involved in crime.

The authors of the National Crime Forum Report (1998, p. 74) stated that they were 'deeply concerned with the impact of drug abuse on crime and the response of the criminal justice system to that issue'. The authors were impressed by suggestions to keep otherwise law-abiding young people out of the criminal justice system – that young experimental users of cannabis and ecstasy should be diverted to the Juvenile Diversion

Programme. (The aim of this programme, which was established by the Garda Síochána, is crime prevention and to provide an alternative for juvenile offenders. Rather than being dealt with under criminal law, they enter the programme and thus are diverted from the formal criminal justice system). The case for the decriminalisation of certain drugs was presented to the Forum which agreed that the issue was important and required more careful study. Those against decriminalisation argued that public opinion was opposed to such a change. A general population survey (Bryan et al. 2000) to examine drug-related knowledge, attitudes and beliefs, could be interpreted to support this view – 66 percent agreed that cannabis should be against the law. Results from the same study found that drug-related crime is considered to be a major problem in Ireland by 94 percent (n=998) of those interviewed, and three-quarters of the sample felt that the drug problem was out of control.

In 1998 a study was conducted by the Garda Research Unit to explore the links between alcohol/drug use and crime (Millar et al. 1998). Gardai at 27 stations throughout the country (12 in Dublin, 15 in the other 5 Garda divisional regions) were asked for their ‘informed opinion’ (ibid. p.2) as to whether alcohol or drugs were involved in offences where a person was ‘arrested, charged, summonsed, or diverted under the Juvenile Diversion Programme’ (ibid. p.1). Offences under the Misuse of Drugs Acts and the Liquor Licensing Acts were excluded. A total of 4,334 offences (no indication is given as to whether these refer to individuals or incidents) were noted during the study period (March-May 1998). Forty-two percent of cases were considered to be related to alcohol consumption, 17 percent to drugs and 4 percent to alcohol and drugs (drugs were implicated in 913 cases). Alcohol was most likely to be associated with public order offences, while drugs were most often linked to robberies. In Dublin heroin was the drug most likely to be involved (83 percent of cases), while outside of Dublin cannabis (37 percent) and ecstasy (26 percent) were the drugs most commonly cited (see Table 4.2d).

Table 4.2d. Ireland 1998. Juvenile Diversion Programme. Drug-related crime by type of drug. Percentages & Numbers.

Main drug involved	Dublin	Other areas
Opiates	83.1	20.1
Cannabis	13.5	37.4
Ecstasy	0.9	25.9
Amphetamines	0.9	1.1
Barbiturates	0.6	0.6
Cocaine	0.2	1.1
Hallucinogens	0.2	0.0
Other	0.6	13.8
Valid N	534	174
Missing N	136	69
Total N	670	243

Source: Garda Research Report No. 7/98

4.3 Social and economic costs of drug consumption

4.3a) Studies and estimates of health care costs, other social costs

Studies to estimate the healthcare or other social costs of drug consumption have not been carried out in Ireland. Nor are estimates available on the economic costs to society from drug use. Accepting that the “social costs” incurred by drug use can be defined and interpreted variously, and that no research has been undertaken in Ireland with the specific aim of estimating such costs, a number of research findings can be drawn upon to illustrate evidence of significant costs to individuals, families and communities as a result of drug use.

As might be expected, this evidence arises primarily from research on a range of social problems associated mainly with disadvantaged communities. Numerous researchers have documented the perceived negative impact of high levels of drug misuse on communities where drug use is concentrated (O'Higgins 1999; Corcoran 1998; Morley 1998). Residents of estates where drug use is concentrated consistently draw attention to the destructive effect of drug use and drug trafficking on community life. Furthermore, they are acutely aware of the negative way in which their community is perceived by outsiders. Mayock (2000), in a qualitative study of drug use by young people in a Dublin inner-city community noted that respondents made constant reference to the area's drug problem. Furthermore, these young people expressed resentment of outside representations of their neighbourhood. They were particularly critical of the negative effects of disparaging media reports of drug problems in their community, which they felt exaggerated the issue. Many clearly felt stigmatised by virtue of living in a locality where drug use and associated activities are concentrated.

There is relatively little research available pertaining to the consequences of drug problems for individual families. For example, there is no available estimate of the number of individuals affected by familial drug use. However, the issue of how children are affected by drug misuse has emerged as an issue of critical concern. Hogan (1997), in an exploratory study of the social and psychological needs of children of drug using parents, found that the majority of children whose parent(s) were heroin users were experiencing difficulties at school. Key workers interviewed for the purpose of the research expressed concern about the quality and consistency of care-giving by drug using parents.

4.3b) Estimates of total consumption/demand/expenditure on drugs

In Ireland, there are no estimates of consumption nor demand nor expenditure on drugs available.

5. Drug Markets

5.1 Availability and supply

5.1a) Availability and access to different drugs, trends and possible reasons

No new surveys have been carried out in this area. See Ireland's National Report 2001 for a review of current research findings.

5.1b) Sources of supply and trafficking patterns within country

The sources of supply vary according to the type of drug. Cannabis comes mainly from Morocco, while some smaller seizures are known to have originated in Pakistan, Afghanistan and Lebanon (Garda Síochána, personal communication). Most of the trafficking in cannabis to Ireland takes place between Morocco, up through Iberian peninsula to the south coast of Ireland. It is transported in freight trucks using cross-channel ferries; and on sea-going yachts. The south-west of Ireland is a major trans-shipment point. In recent years some cannabis seizures were known to have originated in South Africa. Heroin seized in Ireland is thought to come from Asia, mainly Afghanistan, Pakistan, India and Laos. The bulk of heroin seizures are transported to Ireland through the UK and some through the Netherlands. Individual drug couriers travelling by air, bring smaller amounts from Europe. Cocaine traffic is believed to originate in South America. The main place of origin for ecstasy seized in Ireland is the Netherlands and to a lesser extent Belgium (Garda Síochána, personal communication).

The police believe that most of the drugs seized in Ireland in recent years are for the home market. In the case of very large shipments it is speculated that Ireland with its long coastline, isolated in many areas, is used as an access point for transit to the UK and Europe. The police also believe that the distribution of drugs within the country is organised by networks of criminal gangs. In some cases these gangs involve members of the same family.

Sale patterns of drugs at street level in Dublin differ from location to location, with price and purity of drugs varying according to supply and demand factors. No research studies have been conducted on drug supply sources or patterns of trafficking as yet in Ireland.

In recent times the nature of the cannabis market seems to have changed to a larger distribution network, involving smaller amounts of the drug. In other words, there are many more carriers, trafficking smaller amounts of cannabis.

5.2 Seizures

5.2a) Trends in quantities and numbers of seizures

At the time of writing (October 2002) the Annual Report of An Garda Síochána 2001 was not yet published. The information below relates to the situation in Ireland up to the end of 2000.

In Ireland it is not possible as yet to distinguish between police and customs seizures in relation to the quantities and numbers of drugs seized. All seizures, by both police and customs, are included in published Annual Reports of An Garda Síochána (police). Police and customs authorities increasingly work on a collaborative basis and data collection is being organised so that separate information on seizures will be provided in the future.

Drug seizures are sometimes taken as an indirect indicator of the supply and availability of drugs, however they are more likely to reflect law enforcement resources, and police and customs activities. The quantity of drugs seized fluctuates from one year to the next, sometimes due to a small number of large seizures. The number seized is usually more useful as an indicator of trends at user level.

Between 1996 and 2000 the total number of seizures increased steadily from 5,244 to 7,706 (Table 5.2).

Table 5.2. Ireland 1996-2000. Quantity (kgs) and number of seizures of illicit drugs.

Type of Drug	1996		1997		1998		1999		2000	
	N*	Q**	N*	Q**	N*	Q**	N*	Q**	N	Q**
Cannabis	3449	1935.4	4102	1282.7	4513	2201.7	4538	2577.3	4641	588
Heroin	664	10.8	599	8.2	884	38.3	767	17	598	24
Cocaine	93	642	157	11	151	333.2	213	85.6	206	18
Amphetamines	217	7.6	475	102.9	680	45	467	13.4	184	6
Ecstasy***	534	23012	423	20434	509	60930 1	1074	229101	1910	55878 2
LSD	42	5901	48	1851	19	798	29	577	31	1121
Benzodiazepines	152	7146	219	4942	181	2885	175	15393	99	2626
Other drugs	93		159		93		55		37	674
Total number seizures	5244		6182		7030		7318		7706	

Source: Annual Reports of Garda Síochána

* N=Number of seizures

** Q=Quantity seized in kilograms; number of tablets in the case of ecstasy, benzodiazepines; and number of doses in the case of LSD. Q of 'other drugs' for 2000 refers to methadone and dihydrocodeine tablets.

*** Ecstasy includes MDMA, MDEA, MDA, ephedrine, ketamine

There are more seizures of cannabis than any other drug: the number increased from 3449 in 1996 to 4641 in 2000. During the same period the number of heroin seizures remained fairly stable dropping to 598 in 2000 from 767 the previous year. Cocaine numbers increased to 213 in 1999 and dropped slightly in 2000 to 201. The number of amphetamine seizures is falling, from the highest number seized (N=680) in 1998 to 184 in 2000. The number of ecstasy seizures increased quite considerably from 534 in 1996 to 1,910 in 2000. It should be noted that 'ecstasy' can include various substances such as MDMA, MDEA, MDA, ephedrine or ketamine, and the user is not necessarily aware of the content. There are no testing facilities at user level in Ireland. In 2000 the number of cannabis, ecstasy and LSD seizures increased over those of the previous year; seizures of all other drugs decreased.

The quantity of different types of drugs seized fluctuates from year to year. Between 1997 and 1999 the quantity of cannabis increased each year, but in 2000 this dropped significantly from 2,577kg in 1999 to 588kg in 2000. The amount of heroin seized in 2000 increased slightly to 24kg from 17kg the previous year. Except for the large amount seized in 1998, heroin seizures have remained fairly stable over the five-year period 1996 to 2000. Cocaine quantities are down considerably, as are amphetamines. The quantity of ecstasy seized in 2000 (558,782 tabs) increased over 1999 (229,101 tabs), but was less than the 1998 amount (609,301 tabs). LSD also increased in 2000 to 1,121 doses from 577 doses for 1999.

In 1999 there was a large quantity of benzodiazepines (15,393 tablets/capsules) seized. The majority of these (13,389) were diazepam and one seizure alone that year constituted 7,800 diazepam. In 2000 the quantity of benzodiazepine seizures dropped to 2,626

tablets. The number of seizure also fell from 175 in 1999, to 99 in 2000. All benzodiazepines are controlled under Section 15 of the Misuse of Drugs Acts - it is illegal to supply or deal them other than by prescription. However, in the case of flunitrazipam (Rohypnol) and temazepam they are controlled under both Section 15 and Section 3 of the Misuse of Drugs Acts - it is illegal to supply or possess them other than by prescription.

5.3 Price, purity

5.3a Distinguish trends at retail level and trafficking level

Drug seizures by the police are analysed at the Forensic Science Laboratory of the Department of Justice, Equality and Law Reform, to ascertain purity levels of heroin, cocaine and amphetamine. Cannabis purity, for THC content, is not analysed. Between 1995 and 1999 the purity levels of heroin decreased and in 1999 a minimum purity level of 0.25% was recorded. Purity levels of amphetamine seizures have also decreased somewhat. Cocaine purity levels have fluctuated in the five-year period but the trend is downward (Table 5.3).

Table 5.3 Ireland 1995-1999. Purity of seized drugs. Average percentages

Type of Drug	1995	1996	1997	1998	1999
Heroin	45	49	46	35	33
Cocaine	47	62	54	38	41
Amphetamine	4.7	9.8	3.5	6	3

Source: Forensic Science Laboratory, Department of Justice, Equality and law Reform

6. Trends per Drug

6a) Information from different indicators and other sources plus comments on possible reasons and factors that may be associated to reported trends for each substance

There is great disparity in the pattern of drug use in different parts of the country. Overall cannabis is the most commonly used illicit drug. Problematic opiate/heroin use is mainly in the eastern region of the country, around Dublin.

6b) Analysis for the following substances:

Cannabis

Cannabis remains the most widely available and the most commonly used illicit drug in Ireland.

There is an increasing trend in those presenting to services for treatment of problematic cannabis use. Outside of Dublin and its environs, cannabis is the main drug for which people present for treatment. Throughout the 1990s trends in cannabis use remained fairly stable at between 11 and 15 percent of all those treated. Then in 2000 the proportion increased to 22 percent. This increase probably reflects an increase in the provision of treatment services rather than a real increase in cannabis use. Given that cannabis is smoked this can have serious implications for the future health of a young population.

Preliminary results from a study to determine current trends in driving under the influence of drugs found that cannabis was the drug most frequently found in 34% of cases.

Synthetic drugs

After cannabis, although much less prevalent, amphetamines and ecstasy are the second most commonly used drugs in the general population.

In the latter half of the 1990s there was a decreasing trend in those presenting to treatment services with problematic ecstasy use, from 7.4 percent in 1995 to 3.5 percent in 1998. However this trend did not continue and there was an increase in the proportion of people – to 5.9 percent in 2000 - who presented with ecstasy problems.

After cannabis, ecstasy is the drug that features next in prosecutions and seizures data. Up to 1998, the trend in ecstasy offences was fairly stable but in 1999 and 2000 the number of offences increased considerably (see Table 4.2c at Section 4.2).

Ecstasy seizures come mostly from street or dance events, rather than from point of entry to the country. Tablets tested are composed mainly of a combination of ketamine, ephedrine and caffeine. Ketamine is due to be controlled in Ireland under the Misuse of Drugs Acts, as is 4MTA. There have been no seizures nor reports of use of 4MTA in Ireland; nor have there been reports of ecstasy production in Ireland in recent years.

Preliminary results from a study to determine current trends in driving under the influence of drugs found that amphetamine was found in 16% of cases (Moane et al. 2000).

Heroin/opiates

Heroin is the main drug for which people present to drug treatment services in Ireland.

Heroin dependence is still mainly concentrated in and around the Dublin area, but for a number of years there are indications that the problem is beginning to spread to other regions.

Heroin is the drug least used in Ireland but it is the most problematic with very serious health and social consequences.

The trend towards smoking heroin in the early to mid-1990s has now changed and there is an increasing trend in intravenous heroin use.

Cocaine/crack

Cocaine is used by about 2% of the general population in Ireland.

Treatment demand for problem cocaine use has always been very low at less than 2 percent.

A small-scale (N=10) qualitative study of recreational cocaine users found that cocaine is more easily available in Ireland than previously, and that more people are perceived to be using it. It is used in private social settings, such as home-based parties, rather than in public settings (I Moran *et al.* 2001).

Preliminary results from a study to determine current trends in driving under the influence of drugs found that cocaine was present in 4% of cases (Moane *et al.* 2000).

Multiple use

Drug users presenting for treatment are likely to be involved in the use of more than one drug. Trends show a high level of polydrug use, with seven out of ten clients presenting with secondary drug problems. Cannabis, benzodiazepines and ecstasy are the drugs most likely to be involved.

Concern has been expressed from a number of quarters regarding the over-prescribing of benzodiazepines, in general, and in drug treatment settings. Benzodiazepines continue to be widely prescribed particularly to women, the elderly, the chronically ill, and other groups of people socially and educationally disadvantaged (Quigley 2000). Quigley states that 'benzodiazepine regulation is a crucial public health responsibility', and goes on to say that the medical profession should acknowledge its central role 'in the creation, as well as the solving, of drug problems'. In 2000 a Committee was established by the Minister for Health and Children to explore the nature and extent of benzodiazepine prescribing in Ireland. This Committee will examine current trends and make recommendations on good prescribing practices, paying particular attention to the management of drug users. The Committee is due to make its report to the Minister at the end of 2002.

A study on drug-related death in 1999 found that benzodiazepine was the drug most commonly identified (in 75 cases), and was mainly in combination with other drugs. The most common combination of drugs was opiates and benzodiazepines (Keating *et al.* 1999).

Preliminary results from a study to determine current trends in driving under the influence of drugs found quite a high prevalence of benzodiazepines – in 25% of cases (Moane *et al.* 2000).

7. Discussion

7.1 Consistency between indicators

The five key indicators of drug misuse are at different stages of development as tools to measure the drug situation in Ireland.

- Estimates of national and local prevalence of problem drug use are at initial stages of development, and studies on prevalence of problem drug use are limited.
- General population surveys on the use of all types of illicit drugs are very scarce, which makes it very difficult to make comparisons or discuss trends in drug use. Where they are available comparability can be a problem.
- A number of ad hoc studies on the prevalence of infectious diseases among drug populations of drug users have been carried out, but no systematic monitoring of such populations for disease prevalence is currently taking place.
- Statistics on drug-related death, which are obtained from the General Mortality Register at the Central Statistics Office, are not, by their nature, all-inclusive of death related to drug use. Research on mortality among drug-using populations is only just beginning to be carried out in collaboration with the EMCDDA.
- Treatment demand monitoring, the most developed of the indicators, has been adversely affected in recent years, mainly due to lack of commitment/priority given to data collection by drug treatment service providers.

7.2 Methodological limitations and data quality

- The gaps in available information, particularly in relation to the main indicators of drug misuse, do not help in the formulation of good policies. Therefore the development of the five key indicators is vital. As well as this, more in-depth qualitative research studies are needed in order, for example, to understand more about different user groups, different patterns of use e.g. drug users involved in risky behaviours. This would help towards making prevention strategies more effective.
- General population surveys to study the extent of drug use in Ireland vary in objectives, methodologies, focus of data collection, questionnaire design, age groups studied etc.. Comparisons are therefore tentative and must be viewed with these variations borne in mind. If meaningful interpretations and comparisons are to be made a priority for future work should be that prevalence surveys are carried out using comparable methodologies. Information on recent and annual use should be available as well as lifetime experience of drug use. Surveys should be comparable nationally as well in the wider European sense where possible. It is also important that these surveys be replicated at frequent interval if trends over time are to be available.
- More work needs to be carried out on the improvement and evaluation of data quality, particularly in relation to the five key indicators of drug misuse.
- More in-depth qualitative research studies are needed to understand more about at-risk groups, such as injecting drug users, and thus help towards making prevention strategies more effective.
- Interest in the availability of drugs has been growing. However, measuring this is a very difficult task given the illicit nature of the activity. Special studies would need to

be undertaken in order to explore the issues involved in drug markets in Ireland, vis-a-vis availability, sources of supply and trafficking patterns.

- In Ireland, there are no estimates of consumption or demand, or expenditure on drugs available. Nor are there any estimates of healthcare or other social costs available. This is an area that will need to be developed.

PART 3

DEMAND REDUCTION INTERVENTIONS

8. Strategies in Demand Reduction at National Level

8.1 Major strategies and activities

Section 8.1 will provide a concise description of major national strategies in demand reduction.

The National Drugs Strategy 2001-08 includes an explicit commitment to pursue demand reduction measures as part of its overall strategy in tackling the use of illicit drugs in Irish society. Accordingly the drug strategy confirms that:

'Reducing the demand for drugs is central to Irish drugs policy and it is clear that such demand reduction activities must be continued and reinforced...' (Department of Tourism, Sport and Recreation (DoTTSR) 2001, p. 98)

Two of the four main pillars upon which the National Drugs Strategy 2001-08 is based are the *prevention* and *treatment* of illicit drug use. Measures aiming to prevent illicit drug use will be covered in depth in Section 9, while the area of treatment for illicit drug misuse will be explored in Section 11. At this point it is important to note that the National Drug Strategy through the provision of drug treatment services has also made a commitment to provide for the rehabilitative/reintegrative needs of individuals in treatment for drug misuse.

A key part of the national strategy to reduce demand for drugs has been the development of the Local Drug Task Forces (LDTFs). The LDTFs were set up to provide a strategic local response to drug misuse in priority areas. There are currently 14 LDTFs operating under the direction of the National Drug Strategy Team (NDST). In addition, a number of government departments are directly responsible for overseeing the implementation of a number of initiatives that are designed to reduce the demand for illicit drugs. For example, the Department of Health and Children through the Drugs/HIV/AIDS Services Unit assists in the development and implementation of policy, and provision of services, relating to drug misuse and Acquired Immune Deficiency Syndrome (AIDS).

Research continues to play an important part in the overall national strategy to reduce demand for drugs. The National Advisory Committee on Drugs (NACD) that was established in 1999 has collaborated with other groups and individuals on preparing a three-year research programme in the drug area. It is anticipated that the outcomes of research will contribute significantly to the development of policy on drugs, in particular in the field of demand reduction. For instance, priority areas for research have been identified to include prevalence, treatment outcomes and research into drug use and also marginalised groups in an Irish context.

8.2 Approaches and new developments

8.2a) New and innovative approaches

Regional Drug Task Forces (RDTFs)

Under the guidance of the National Drugs Strategy 2001-08, 10 Regional Drugs Task Forces (RDTFs) are being set up. The new RDTFs will operate in areas currently being covered by regional health boards. The role of the RDTFs will be to research, develop, implement and monitor a co-ordinated response to illicit drug use at regional level, based

on best evidence of what is effective. This will be achieved through a partnership approach involving the statutory, voluntary and community sectors. In addition, the RDTFs will co-ordinate the development of drug programmes and services in parts of the regions where no Local Drug Task Force (LDTF) activity is present. The RDTFs are planning to liaise with the LDTFs, to co-ordinate strategic planning and policy making at regional level, including the development of services which might be more effectively delivered on a regional basis. These could include for example, treatment referrals, services for travellers, homeless persons and sex workers involved in illicit drug use, and training for drug workers, etc. The guidelines for the '*Establishment of the Regional Drugs Task Forces*' recommend that service users be represented on the RDTFs. In order to facilitate participation, the RDTFs are being encouraged to develop service user forums from which representatives can be nominated.

Garda Initiative

At the beginning of September 2002, the Garda broke new ground when they advised heroin dealers of the treatment option open to them during their arrest. Following an undercover operation where undercover Garda are said to have purchased heroin from 95 dealers, the initiative was launched to target the identified dealers with a view to advising them of their treatment options. The scheme is operating in conjunction with the three main Dublin health boards. If the dealer, when charged, decides to make contact with a treatment centre, then the District Court may exercise the option of giving the individual the opportunity to be dealt with in the Drugs Court which sets down a drug treatment regime rather than a custodial option. The scheme has the support of the recently appointed Minister of State with responsibility for drugs, Mr. Noel Ahern. He '*welcomed the approach to help those arrested*'.

RAPID programme

The new government department with responsibility for the implementation of the National Drugs Strategy is the Department of Community, Rural and Gaeltacht Affairs. This government department also has responsibility for overseeing the implementation of the RAPID (Revitalising Areas by Planning, Investment and Development) Programme, which is managed by the Area Development Management Ltd., on behalf of the department.

Strand I of the programme targets 25 urban locations. These locations have been identified as having the greatest concentration of disadvantage and earmarked for priority funding under the National Development Plan. The urban areas identified in Dublin, Dun Laoghaire/Rathdown and Cork have also been identified as having the most acute drug problems in Ireland, as evidenced by their inclusion in the Local Drug Task Forces (LDTFs). It is envisaged that initiatives under the RAPID programme will contribute to the social re-integration of individual drug users who have accessed treatment for drug use.

Capital funding for Local Drug Task Force (LDTF) Projects

The evaluation of projects funded through the LDTFs consistently pointed to the problems that projects experienced with inadequate premises. The announcement earlier this year (10 February 2002) by Eoin Ryan, Minister with Special Responsibility for the National Drugs Strategy, that €28 million was being allocated to the 14 LDTFs – €2 million per area – to cover both the capital and servicing of projects in the 14 LDTF areas is welcomed.

8.2b) Socio-cultural developments relevant to demand reduction

See Ireland's National Report 2001, Sinclair *et al*, p. 98 and see Key Issue 'Social Exclusion and Drug Use' in this year's National Report.

8.2c) Developments in public opinion

The data referred to in this section comes from two parts of a study that investigated public attitudes towards, and perceptions of, aspects of the drug issue in Ireland (Bryan *et al*, 2000), the second part of the study is unpublished. Both studies touched on aspects of public opinion that have a bearing on how measures to reduce the demand for illicit drugs are perceived in Irish society. For example, both studies investigated public attitudes and perceptions towards:

- drug users and drug addicted individuals;
- drug treatment for individuals engaged in drug misuse; and
- aspects of current drug policy, including drug prevention, harm reduction, drug education.

A majority of the Irish people do not view drug addicts as criminals, and there has been little change to this viewpoint between 1998 and 2000. (Table 8.2a) This attitude could be taken as one indicator that the Irish public would be supportive of measures taken by the state to treat individuals who present for drug misuse treatment. A further interpretation might be that a majority of people in Irish society has begun to question the links between drug addiction and criminality.

Table 8.2a. Changes in attitudes towards drug addicts, 1998–2000

Statement	Survey year (number of responses)	Agree %	Disagree %	Don't Know %
<i>I would see drug addicts more as criminals than victims.</i>	1998 (n=999)	42.6	45.2	12.1
	2000 (n=998)	37.8	45.6	16.6

Source: Bryan *et al* 2000, and unpublished study

In supporting the view that drug addicts are more victims than criminal (Table 8.2a) it could be argued that a majority of the Irish people are implicitly questioning the efficacy of the use of prison as a sanction for drug addicts. This interpretation is supported by the findings recorded below. Table 8.2b shows a majority of the Irish public agree with the statement that drug addicts charged with a petty offence ought to be allowed to choose between treatment and prison.

Table 8.2b. Changes in the support for alternative policy interventions, 1998–2000

Statement	Survey year (number of responses)	Agree %	Disagree %	Don't Know %
<i>Drug addicts charged with petty offences should be given a choice between treatment and prison service.</i>	1998 (n=997)	71.9	17.2	10.9
	2000 (n=994)	72.9	15.2	11.9

Source: Bryan *et al* 2000, and unpublished study

However, as Table 8.2c shows, an increasing percentage of Irish society agrees with the view that treatment should only be given to drug addicts who intend to give up drugs for good. Perhaps in some quarters this could be interpreted as a hardening of public attitudes towards drug addicts whose intentions regarding drug treatment may be open to question. Nevertheless it would seem to be the case that the public is in favour of treatment provision for drug addicts (Table. 8.2c) and that treatment for drug addiction has become a legitimate and integral part of the demand reduction response in Irish society.

Table 8.2c. Changes in the support for drug treatment strategies, 1998–2000

Statement	Survey year (number of responses)	Agree %	Disagree %	Don't Know %
<i>Treatment should only be given to drug addicts who intend to give up drugs for good.</i>	1998 (n=999)	64.5	27.3	8.2
	2000 (n=997)	73.8	18.4	7.8
<i>Treatment should be available to all drug addicts according to their needs.</i>	1998 (n= 999)	90.2	3.7	6.1
	2000 (n=999)	90.5	3.1	6.4

Source: Bryan et al 2000, and unpublished study

There is widespread public approval of the view that money spent on prevention of drug use is money well spent. (Table 8.2d) In addition, it also appears that the Irish public positively affirm drug education as a viable preventative strategy, whilst agreeing that the most appropriate social location for the beginning of drug education is primary level in school.

Table 8.2d. Changes in the support for drug prevention strategies, 1998–2000

Statement	Survey year (number of responses)	Agree %	Disagree %	Don't Know %
<i>Money spent in the prevention of drug use is money well spent.</i>	1998 (n=997)	91.6	4.1	4.3
	2000 (n=998)	87.3	3.8	8.9
<i>Drug education in school should start at primary level.</i>	1998 (n=996)	94.5	2.3	3.2
	2000 (n=999)	93.5	2.9	3.6

Source: Bryan et al 2000, & unpublished study

Public support for the use of medically-prescribed heroin substitutes, such as methadone or phsyseptone, among drug addicts has increased. (Table. 8.2e) However, it should be noted that 29 per cent of the Irish public either disagree with this position or are unsure of their attitude towards the issue. Public support for the provision of syringes and needles has also increased (Table 8.2e), but again there is notable opposition and uncertainty regarding this aspect of harm reduction.

A further analysis (Table 8.2e.) raises some important questions regarding the dissemination of drug-related information to the public, which is crucial to gaining public support for demand-reduction interventions. For example, it could be argued that the provision of methadone as a heroin substitute has been, to some extent at least, a relatively effective tool in reducing the commission of criminal acts by drug addicts. Yet, almost 30 per cent of the public are either opposed to its provision or are uncertain of their position on the issue. This could be due to the fact that the public is not being made aware of the links between the use of methadone and a reduction in crime. Similarly, the provision of syringes and needles to drug addicts usually means that there is an exchange for 'dirty' needles, thereby reducing the risk of the spread of drug-related infectious diseases. Yet, almost 28 per cent of the public either disagree or express a 'don't know' position regarding the provision of syringes and needles to drug addicts. This again suggests that the quality of public information may need revision if harm-reduction measures are to gain similar levels of public support as drug treatment and education measures.

Table 8.2e. Changes in the support for harm reduction strategies, 1998– 2000

Statement	Survey year (number of responses)	Agree %	Disagree %	Don't Know %
<i>Medically prescribed heroin substitute (such as methadone, physeptone) should be available to drug addicts.</i>	1998 (n=933)	64.8	16.1	19.1
	2000 (n=963)	70.9	14.3	14.7
<i>Society should provide syringes and needles free of charge to drug addicts to avoid the spread of HIV/AIDS.</i>	1998 (n=998)	66.7	17.3	15.9
	2000 (n=998)	72.3	14.4	13.2

Source: Bryan et al 2000, & unpublished study

In the final analysis, it could be argued that by embracing drug treatment and drug education as viable methods of addressing drug addiction, the Irish public is indicating its strong support for some of the key strands of official demand reduction strategy. The Irish public appears amenable to embracing aspects of harm reduction with similar enthusiasm and perhaps a more effective means of disseminating information to the public would enhance this process.

8.2d) New research findings

Morgan (2001, p.7) concluded:

'that there is no single 'drug problem' with one dramatic solution. Rather, what is called the drug problem is comprised of varying degrees of involvement with a variety of substances, arising from several influences, many of which are unrelated to each other. For these reasons, the main recommendation is that there is a need to target and prevent use of the most dangerous substances.'

The National Advisory Committee on Drugs (NACD) has developed an extensive research plan, including an examination of the prevention, treatment and rehabilitation fields. A brief description of some of the areas the NACD is planning to research is listed below:

Prevention

- to examine the effectiveness in terms of impact and outcomes of existing prevention models and programmes, with particular regard to evaluation instruments developed at European level
- to undertake comparative studies of different models with particular reference to those in operation in Local Drug Task Force areas
- to determine transferability of models among different target groups

Treatment/Rehabilitation

- to examine the effectiveness in terms of impact and outcomes of existing treatment and rehabilitation models and programmes
- to undertake longitudinal studies of the effectiveness of existing treatment and rehabilitation models
- to examine the context in which relapse occurs
- to examine the impact of the treatment setting

Dissemination of information on demand reduction among professionals (networks, Internet, etc)

Drugnet Ireland

The Drug Misuse Research Division of the Health Research Board publishes and distributes the newsletter *Drugnet Ireland* three times a year. This newsletter fulfils an important role in the distribution of information, news and research among health professionals and other interested parties involved in the drugs area in Ireland. Its readership includes community groups, policy makers, treatment providers and academics. The newsletter contains information on research, recent publications, and upcoming events. It also looks at developments in the drug area within the EU, as well as local and world news.

EDDRA

The EDDRA project plays an important role in the demand-reduction field by raising awareness of the different types of demand-reduction activities that operate throughout the country. In order to facilitate this process further, an '*EDDRA column*' is now a regular feature of *Drugnet Ireland*. This column will include regular up-to-date information on developments relating to demand reduction at national level. Also included will be an assessment of '*best practice*' models of demand reduction at national level, while the importance of impact/outcome evaluation of interventions will be emphasised. Significant attention will be given to encouraging local projects/initiatives to explore and develop the theoretical foundations on which their interventions are grounded.

9. Prevention

9a) National Strategy

The National Drug Strategy 2001-08 outlines two main objectives in the field of prevention of drug misuse. These are to create greater social awareness of the dangers and prevalence of drug misuse, and to equip young people and other 'at risk' groups with the skills and supports necessary to make informed choices about their health, personal lives and social development. The National Drug Strategy has developed Key Performance Indicators (KPIs) that can be used to assess the extent to which the overall objectives on prevention are met. These KPIs have been included in the National Drug Strategy's action plan and data on the progress of a selection so far. (See below)

Key Performance Indicator (KPI)	Progress so far
To put in place by end of 2001 mechanisms that will support, enhance and ensure the delivery of school-based education and prevention programmes in all schools nation-wide over the next three years. The ultimate aim of these programmes should be to ensure that every child has the necessary knowledge and life-skills to resist drugs or make informed choices about their health, personal lives and social development	Health Board health education officers are members of the committee that has been established to examine how to implement the SPHE (Social, Personal and Health Education) programme effectively in post-primary schools.
To ensure that the design and delivery of all preventative programmes is informed by on-going research. That programmes also include initiatives aimed at equipping parents of 'at-risk' children with the skills to assist their children to resist drug use.	The NACD report, <i>An Overview of Research on Drug Prevention</i> (2001), compiled by Dr Mark Morgan, will help set standards for future preventative initiatives. Programmes such as 'Family Communication and Self Esteem' (developed in the Southern Health Board) are being used in other health board areas. The North Eastern Health Board is implementing 6 Family Communications and Self-Esteem courses aimed primarily at parents and communities.
To develop guidelines, in co-operation with the health boards, to assist schools in the formation of a drugs policy and ensure that all schools have policies in place by September 2002.	The Southern Health Board, North Western Health Board, Midland Health Board, North Eastern Health Board, and the health boards in the Eastern Regional Health Area, working in conjunction with schools in their areas, have a whole-school policy in place in a number of schools. In the Southern Health Board a half-day's training is provided to all school staff. Other boards are assessing the position.
To deliver the SPHE Programme in all second-level schools by September 2003.	The Health Promotion Unit of the Department of Health and Children matches the resources of the Department of Education and Science in supporting the implementation of the SPHE programme. All health boards will ensure that there is a consistent approach to the delivery of, and community-based support for, the

To ensure parents have access to factual preventative materials, which also encourage them to discuss the issues of coping with drugs and drug misuse with their children.

programme.

The Health Promotion Unit of the Department of Health and Children and health boards have developed a range of drug education resource materials that are available in all health board areas.

9b) Organisation and co-ordination within national structures

There are a number of government departments and agencies involved in delivering a range of preventative measures aimed at reducing the demand for drugs. Included below are some examples of preventative measures delivered in Ireland.

Government Department/Agency	Initiative
Department of Education and Science	The Disadvantaged Area Scheme The Stay in School Retention Initiative The Home-School Liaison Scheme The Social, Personal and Health Education (SPHE) programmes, incorporating the Walk Tall and On My Own Two Feet programmes
Local Drug Task Forces (LDTFs)	Community-Based Drug Awareness Programmes Drug Awareness Programmes for Parents and Teachers Peer Education Programmes Stay-In-School Initiatives
An Garda Síochána	The Garda Youth Diversionary Projects The Community Drug Awareness Programme Garda Schools Programme Garda Mobile Anti-Drugs Unit
The Department of Health and Children	The 'Substance Abuse Prevention Programme' (SAPP) Life Skills Programmes Award Programmes for Schools Youth Service Initiatives Dissemination of resource material Local campaigns in Eastern Regional Health Authority area

9c) Expenditures on prevention in Member States

It is proposed that the current programme '*Walk Tall*' be subsumed into the new Social, Personal and Health Education (SPHE) programme. The 2002 Budget makes provision for €850,724 for the phased implementation of the drug misuse prevention programme (including provision of in-service training for teachers) to all primary schools by the end of 2003. A support team is being developed consisting of national co-ordinator and 10 regional development officers who are responsible for organising and delivering staff seminars.

9.1 School programmes

9.1a) Specificity of policies

a) Specificities of policies

The National Drug Strategy 2001-08 states that the Departments of Education and Science and Health and Children have a responsibility to:

‘...develop guidelines, in co-operation with the Health Boards, to assist schools in the formation of a drugs policy and ensure that all schools have a policy in place by September 2002...’ (Department of Tourism, Sport & Recreation (DofTSR) 2001 p. 116)

In response, the Department of Education and Science has circulated guidelines to assist in the development of school policies on substance use. According to these guidelines:

‘...The central objective of a school’s substance use policy is the welfare, care and protection of every young person in line with the Education Act, 1998 and Education (Welfare) Act, 2000. The policy should address both education concerning alcohol, tobacco and drugs and the procedures for managing incidents relating to these substances...’ (Department of Education and Science 2001)

The guidelines recommend seven steps to underpin the development of school policies on substance use. These are:

1. Establish a core committee to develop the policy
2. Study relevant resource documents and legislation
3. Review the current situation in the school regarding substance use policy issues
4. Prepare a draft policy statement
5. Publicise, revise/amend and finalise the draft policy
6. Ratify, circulate and implement the agreed policy
7. Monitor, review and evaluate the policy

The development of substance use policies in individual schools is in the initial stages; therefore there is, at present, a lack of information on individual school policies.

9.1b) Models of school interventions

Drug prevention programmes operating in schools in Ireland tend to use a number of models. Models used in school prevention programmes include:

- Life Skills, Social Development, Health Promotion
- Knowledge on Drugs (cognitive)
- Theatre in Education/learning through educational drama/Symbolic Interactionism
- Knowledge on drugs

The two national drug prevention programmes, On My Own Two Feet and Walk Tall, emphasise the development of self-esteem, emotions, drug awareness, decision-making skills and an awareness of peer influence, to help children withstand pressures to use drugs.

9.1c) Prevention programmes available in the country

Name of Project	Target Group	No. of schools covered	No. of pupils reached
Social, Personal, and Health Education (SPHE) (On My Own Two Feet)	Age 12-16	All post-primary schools are covered (750 schools)	All students at Junior Cycle level will be reached (when fully implemented)
The Awareness Finglas/Cabra (FC) Drugs Prevention Programme	Age 11-18	From September 1998 to June 2000 the programme covered 18 schools	From September 1998 to June 2000 the programme reached 1,099 students/pupils. From September 2000 to June 2001 the programme reached 801 students/pupils.
The Changeling Project	Age 11-15	No information available	A report from the Graffiti Theatre Company in 2001 revealed that the programme had reached 2,850 students/pupils since beginning in 1998
The Healthy Schools Project	Age 13-18	No information available	In 1997 (evaluation) the schools operating the programme in that year served 16,500 pupils. The evaluation envisaged that when the programme was fully operational, the target group would be 30,500 pupils.
Social, Personal and Health Education (Walk Tall Substance Misuse Prevention Programme)	Age 5-13	From 1996 to 2000 the programme covered around 2,400 schools	No information available
Pilot Drug Education in Primary Schools in Dun Laoghaire	Age 10-12	Up to 2000 the project delivered the programme to over 300 children in 10 schools.	120 pupils per year in selected schools

9.1d) Evaluation studies and results

An outcome evaluation of '*On My Own Two Feet*' found that, compared to a control group, students who participated in the programme had less positive attitudes to drug/alcohol use and stronger beliefs in the negative outcomes of such use (Morgan *et al* 1996). A

formative/process evaluation by Morgan (1998) found that the *'Walk Tall'* programme incorporated the approaches demonstrated to be most effective in preventing substance abuse. The evaluation also indicated that there was a very high rate of satisfaction with the programme among participating teachers. Further evaluation of both programmes is ongoing. The National Drugs Strategy 2001-08 (DoTTSR 2001, p.110) includes as a key performance indicator (KPI) of drug prevention, a commitment to complete the evaluation of the *'Walk Tall'* and *'On My Own Two Feet'* programmes by the end of 2002.

An evaluation by Morgan (1999) of the Awareness FC Drugs Prevention Programme found that the accuracy of participants' information on drugs and related issues increased during their involvement with the programme, with a corresponding reduction in participants' level of inaccurate information. Both these changes were recorded as being statistically significant. These recorded changes were in line with a key objective of the programme that sought to replace 'myths' about drug use with factual information. In addition, the evaluation found that participants had acquired a much more balanced view of drugs as a result of their participation in the programme. Participants were willing to concede that there were major gaps in their knowledge of drugs prior to starting the programme. Participants also recognised that they could make a choice and refuse to take drugs. Teachers and parents also acknowledged that participants were better prepared to respond to peer pressure on drugs. In addition, teachers noted changes in the attitudes and beliefs of students around the use of drugs, with young people more prepared to discuss drugs in the classroom and seemingly more confident about individual decision-making.

An evaluation by Kiely and Egan (2000) was carried out to assess the implementation of the Changeling Project in schools and to look at how the project was received by students and teachers. Seventy-three per cent of teachers reported that the Changeling Project was the first experience the students had had with a drug education programme; 61% reported that their students did not experience any difficulty in relating to the themes of the play; 79% felt the play was pitched at an appropriate level for the students in question; 51% reported that they felt their confidence in dealing in the classroom with issues related to substance misuse had increased through their participation with the project. Students agreed that the play transmitted the themes of making choices and decisions. There was also agreement that the harmful nature of substance misuse had come through to students. Students reported that one of the messages that they took from the play was the importance of saying *'No'* to drugs. This message was contrasted with the danger of experimenting with substances, as it was portrayed as inevitably leading to addiction. There was extensive agreement among teachers and students that the workshops, both pre-play and post-play, were essential additions to the play, insofar as they enabled links to be made between the themes of the play and the individual experiences of the students.

The results of an evaluation of the Healthy Schools Project (Morgan 1997) programme indicated that there were significant differences between the pilot and the control groups in relation to acceptance of responsibility, self-esteem, positive outcomes in adulthood, and attitudes to substance abuse. The evaluation of the programme also showed that an important contribution to the success of the project was the support provided by the North Eastern Health Board in relation to in-service co-ordination of the programme and advisory back-up.

The Killinarden Drug Primary Prevention Group (KDPG), operating in Tallaght, a large suburb in the greater Dublin area, delivers drug education programmes to primary and secondary schools in Tallaght. A process evaluation by Rourke (2000) found that high participation rates and a positive response from young people indicated that the project was well received among the target group. The evaluator found that local parents had been trained in facilitation skills for the purpose of delivering the programme in schools.

9.1e) Research projects

The National Advisory Committee on Drugs (NACD) commissioned an analysis of all research/information available in relation to the prevention of drug misuse. The overview reflected both Irish and international research. Preventative approaches towards illicit drugs and alcohol use were examined. Some of the main themes explored by the research (Morgan 2001) were:

- Current conceptual understanding of prevention of drug use
- Risk factors for drug use
- Interventions and approaches for preventing drug use among young people
- Factors contributing to the ineffectiveness of existing programmes
- The development of targeted programmes in the area of drug use prevention

9.2 Youth programmes outside school

9.2a) Definitions used

It would appear that no definition exists in Ireland that would adequately describe ‘*youth programmes outside school*’ that endeavor to prevent drug misuse. However, amongst the programmes that do exist, there are common features that go some way to establishing a definition. For example, most youth programmes operating outside school with an emphasis on preventing drug use/misuse are:

- Targeted at disadvantaged young people and other ‘*at-risk*’ groups such as early-school leavers
- Designed around a multi-sectoral approach comprising the community, voluntary and statutory sectors
- Community-based and accessible to target groups, e.g. through the Local Drug Task Forces

In addition, the National Drug Strategy 2001-08 emphasises some of the features that ‘*out-of-school*’ programmes should try to encapsulate. Action 37 of the National Drug Strategy refers to the importance of combining drug-prevention education in the non-school sector with national vocational training programmes for disadvantaged youth. Herein there is a commitment that:

‘Recommendations 31-35 [of the National Drug Strategy] to apply equally to the non-school education sector e.g. VTOS, Youthreach and community Training Workshops operated by FAS. Such sectors often deal with young people from more disadvantaged backgrounds who are more at risk of drug misuse. For this reason, incorporating a drug element to the education provided, as outlined earlier, is important.’ (DoTTSR 2001)

9.2b) Types and characteristics of interventions with youth outside school

There is a plethora of youth programmes operating outside the school setting that seek to deliver/contribute through drug prevention initiatives. The interventions listed below are examples of out-of-school initiatives that have received little attention in previous National Reports from Ireland and are national initiatives. Data on additional initiatives in this field can be found in the previous National Reports from Ireland.

Programme	Types and characteristics of programmes
Catholic Youth Care – Drug Prevention Initiative	This initiative operates in youth clubs in the community, with a focus on targeting ‘ <i>at-risk</i> ’ youth. The aim is to divert youth away from substance misuse towards alternatives to drug use.
Young People’s Facilities and Services Fund (YPFSF)	The main aim of the fund is to attract ‘ <i>at-risk</i> ’ young people in disadvantaged areas into these facilities and activities and divert them away from the dangers of substance abuse.
The Springboard Initiative	This initiative is supporting a range of pilot projects for children and young people at risk in disadvantaged areas in Dublin and around the country.
Foroige – Health Programme	Programme aims to investigate and publish the ill effects of smoking, alcohol and drug abuse. Drug/alcohol awareness education are provided through youth services.
Pavee Point – Traveller Specific Initiative	Programme aims to promote traveller inclusion in the national, regional and local response being developed to address drug use.
St Vincent de Paul (SVP) – Youth Clubs Council	Programme aims to raise awareness of issues such as drugs and substance misuse. Drug prevention/education programmes are provided, primarily to ‘ <i>at-risk</i> ’ groups.
AIB Better Ireland Programme	A central part of this programme aims to give ‘ <i>at-risk</i> ’ children the opportunity to move from the chaos of a life centred on drugs or alcohol abuse. Support groups, promotion of life-skills and home maintenance are among the services that will address needs in this area.
The National Youth Health Programme	Programme aims to provide a broad-based, flexible health promotion/education and training service to youth organisations and to those working with young people in out-of-school settings.

9.2c) Statistics and evaluation results

The Springboard Initiative, although not dedicated exclusively to substance misuse prevention, provides services to families and youth ‘*at risk*’ of/from substance misuse. An evaluation by McKeown (2001) reported that parents and children experienced considerable improvements in well-being while attending Springboard Initiatives located countrywide. Virtually every parent and child attributed their improved well-being to the intervention of Springboard.

For further statistical and evaluation results on Out of School Programmes in Ireland, see Ireland’s National Report 2001 (Sinclair *et al* 2001) and the demand-reduction projects representing ‘*best practice*’ in Ireland on the EDDRA database.

9.3 Family and childhood

9.3a) Definitions used

No strict definitional boundaries have been drawn around what constitutes drug prevention interventions under the 'family and childhood'. Nevertheless, recognition has been advanced, regarding the importance of the provision of childcare facilities, for individuals in treatment for drug use. Action 54 of the National Drug Strategy 2001-08 emphasises the need:

'To consider, as a matter of priority, how best to integrate child-care facilities with treatment and rehabilitation centres and how childcare can best be provided in a residential treatment setting. This should be done in conjunction with the Department of Justice, Equality and Law Reform'. (DoFTSR 2001, p. 117)

On a regional basis the South Western Area Health Board has allowed for childcare facilities in their plans for the new services in Clondalkin, in west Dublin, and will take the needs of service users with children into account when planning services in Tallaght, while the Northern Area Health Board recognises the need to develop childcare services with the addiction service. Various options are being explored, including purchasing arrangements with private providers, build-in of childcare arrangements in all new treatment facilities and the development of short-term drop-in services attached to current clinics. All arrangements have resource implications and the board will work proactively with the Eastern Regional Health Authority and the Department of Justice, Equality and Law Reform to progress this issue.

The integration of child-care (drop-in) facilities is being taken into account with the development of new services. It is not possible to incorporate child-care into existing services: most services are operating at full capacity and do not have the space or ability to provide additional services.

9.3b) Types and characteristics of intervention with family and childhood

Intervention	Age of target group (children)	No. of children covered	No. of families actively participating	No. of kindergartens/ care centres
Focus Ireland Child Care Centre	7 months – 5 years	100 per year (average)	47	1
Focus Ireland Family Programme	0 – 6 years	50 per nine months (average)	50	1
Talbot Centre Family Support Programme	2 – 13 years	8 per week (in each centre)	5 per week (in each centre)	2
Trinity Court Drug Treatment Clinic (children's intervention)	1 – 14 years	49 per week	40	1
Ana Liffey Children's Project	0 – 10 years	Over 70 (overall)	40 (overall)	1

9.3c) Research projects and evaluation results

Currently the Ana Liffey Children's Project is being prepared for evaluation. See Ireland's National Report 2001 for an account of evaluation results on other 'family and childhood' interventions.

9.4 Other programmes

9.4a) Description of interventions

- Telephone help-lines

The Northern Area Health Board, the South Western Area Health Board and the East Coast Area Health Board each provide a freephone drugs helpline. The Midland Health Board also operates a 24-Hour helpline service that caters for individuals with drug and alcohol problems in addition to other issues of concern.

- Community programmes

Since the work of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (Department of An Taoiseach 1997), the capacity for the development of community programmes as part of the overall response to drug misuse has expanded. Through the development of the Local Drug Task Forces (LDTFs), '*community interventions*' have been given the financial resources and support to make a valuable contribution to the drug misuse problems in 14 areas identified as having the worst drugs issue, in particular, where the use of opiates are seen to be problematic. Resulting from these developments, a plethora of local community-based drug initiatives have emerged. These initiatives, organised by community groups, include drug awareness programmes, family support groups and the development of strategies to reduce the demand for drugs in local areas. Specific examples of such initiatives can be accessed in preceding National Reports from Ireland. In particular, see Ireland National Report for 2000 (Moran *et al.* 2000, pp. 153-157) and for 2001, (Sinclair *et al.*, pp. 115-119).

In addition to the initiatives referred to already, community programmes not covered in previous reports are described below.

The Bawnogue Youth and Family Support project, operating in south-west Clondalkin, Dublin, aims to support drug users and their families living in the area to address their drug use and the problems arising. The project provides a family support group, assessment and referral to access treatment and rehabilitation for active drug users, complementary therapies, counselling, support groups for partners of drug users, and the provision of information and advice to parents and individuals who use drugs.

Table 9.4. Number of drug users presenting for support to the Bawnogue Youth and Family Support Project

Gender	Number
Male	50
Female	30
Total	80

The above figures relate to September 1999 to 2001.

The Oasis Project is a community-based drugs initiative, established in 1997. The project comprises four main areas: (1) medical treatment through a satellite clinic, (2) counselling, (3) rehabilitation programme (through a government-funded Community Employment (CE) scheme, and (4) individuals recovering from drug misuse are given the opportunity to participate in personal development, alternative medicine, relapse prevention and creative writing. Around 8–10 individuals are catered for on an ongoing basis. The project is supported by the Dun Laoghaire/Rathdown Local Drug Task Force.

The Pathfinder programme is a community-based rehabilitation day-programme, designed to support individuals recovering from drug misuse in the greater Dun Laoghaire area. The programme consists of structured, modular group work sessions in accredited education,

personal development and stress management. This learning is compounded through individual care planning and one-to-one supports.

The Belturbet Drugs Awareness Group organised a competition for local second-level schools to design art/poster/audio on the theme of drugs/alcohol. The aim of this initiative was to heighten awareness among teenagers of the dangers of drugs/alcohol. An awards ceremony was held, and members of the local Gardaí, drugs counsellors and parents attended this event. Members from the first two groups spoke on the dangers.

The Ballyfermot Star, operating for about four years, has developed into a structured, mainstream organisation offering a range of services to people affected by heroin misuse. It plans to build a purpose-built child-care facility, and provide on-going support and education to families currently living with drug misuse. The Star Education Programme includes accredited modules from the Further Education and Training Awards Council (FETAC) and addiction education for drug users in recovery. It recognises a holistic approach is key to the process of recovery, and provides clinical acupuncture and shiatsu. The majority of board of management lives in the community, and the project works in partnership with voluntary and statutory agencies in meeting the needs of individuals touched by the drug problem. New premises, purpose-built for the project, opened in April 2002.

- Mass media campaigns

Action 38 of the National Drug Strategy 2001-08 has advised the Department of Health and Children *'to develop and launch an on-going National Awareness Campaign highlighting the dangers of drugs, based on the considerations outlined in the conclusions'*. The campaign should promote greater awareness and understanding of the causes and consequences of drug misuse, not only to the individual but also to his/her family and society in general.

In response, the Health Promotion Unit of the Department of Health and Children has sought tenders for this campaign. Nine companies have been short-listed to further develop their tender.

- Internet

www.druggels.com

www.dnedrugtaskforce.ie/

www.mqi.ie

www.kildare.ie/drugawareness/

www.dap.ie

www.rutlandcentre.org/

www.clubscene.ie

www.drugquest.ie

www.aislinn.ie

www.addictioninfo.ie

9.4b) Research projects and evaluation results

See Ireland National Report 2001, (Sinclair *et al* 2001).

9.4c) Specific training

Community Addiction Studies Course:

This course is offered in conjunction with URRUS and is accredited by the Further Education and Training Awards Council (FETAC). Duration is 100 hours, including one residential weekend. The course comprises 5 compulsory modules:

- Drugs and their Effects
- Process of Addiction
- Intervention Strategies
- Community Response
- Personal Development

An introduction to drug issues at community level:

This six-session course is offered as an introduction to drug issues at community level. The course can be conducted at an accessible venue and at a time suitable for local people. The course is ideal for individuals and groups concerned about drugs and wishing to learn more.

Certificate in Addiction Studies:

This course is accredited by NUI Maynooth and is conducted in conjunction with East Coast Health Board education officers. Duration is 100 hours, including one residential weekend. It includes five compulsory modules. The course uses adult education principles and there are no educational entry requirements other than an interest in the field of drug addiction.

Diploma in Addiction Studies:

This course aims to educate, train and challenge through training. It is aimed at people working in the field of addiction/dependency. For further information, contact the Department of Social Studies, Trinity College, Dublin.

Certificate/Diploma in Drugs Counselling and Intervention Skills:

This accredited professional training course is designed for people working in the field of addiction/dependency. It is a partnership approach in adult education between the Merchants Quay Ireland and University College Dublin.

Motivational Interviewing and Brief Counselling Skills Course:

The use of motivational interviewing and brief counselling skills is an effective, client-centred, humanistic approach to working with those who have substance abuse problems. This course is offered at two levels and is provided through All Hallows College, Grace Park Road, Drumcondra, Dublin 9.

10. Reduction of drug related harm

10a) Role of harm reduction within the national drug policy/strategy

The Government Strategy to Prevent Drug Misuse, produced in 1991 (National Co-ordinating Committee on Drug Abuse 1991), acknowledged the limited role to be played by a harm-reduction approach within the field of treatment and rehabilitation of individuals using heroin. An indication of the priority being given to harm reduction was the expansion of methadone services, and the provision of clean needles for drug users, in response to the spread of AIDS and hepatitis. The bulk of the recommendations, which future government policy was based on, centred around the provision of methadone maintenance, the expansion of the number of local clinics, and the recruitment of general practitioners and pharmacists – all with the purpose of reducing the numbers awaiting maintenance. This policy was driven by the public demand to provide treatment for large numbers as quickly as possible, and the best-known way to do this was through methadone.

Following on from the 1991 Strategy document, a key government document on the development of health policy contained a commitment to:

'...The provision of at least four additional primary care clinics to service catchment areas in Dublin where harm reduction and assessment services will be provided to drug misusers...' (Department of Health 1994)

The most recent policy document, which has provided a limited framework for the development of a harm reduction strategy, is the Second Ministerial Task Force Report on Demand Reduction. The report concludes:

'...consideration should be given to developing information/media campaigns here in Ireland which replicate the "harm reduction" approach being adopted in countries like Britain...' (Department of An Taoiseach 1997, p. 46)

- Definition and priority

The Irish government has set out its health promotion plans for five years. Within these plans, harm reduction has received priority status, as indicated by the strategic aim to:

'support models of best practice which promote the non-use of drugs and minimise the harm caused by them'. (Department of Health and Children 2000, p. 58)

The Youth Work Support Pack for Dealing with the Drugs Issue describes harm reduction as:

'Any activity which aims to reduce the harm caused by drug use'. (National Youth Health Programme 1996, p. 70)

Perhaps the main service provider of harm-reduction strategies in Ireland is Merchant's Quay Ireland (MQI). In the evaluation of the MQI syringe exchange service, Cox and Lawless (2000) emphasise the importance of an understanding of what the term harm reduction can mean in practice.

'A public health approach to problem drug use views its occurrence not as a phenomenon caused by an individual's pathology, but rather as one causing extensive social problems and threatening public health. Harm reduction theory reflects this attitude and goes a step further, arguing that many of the most destructive consequences of illicit drug use are not the result of drugs per se, but rather of drug policy. ...As a policy response, harm reduction

strategies are determined solely by the extent of observed and/or anticipated harm which results from drug use’.

- Recent policy trends

In Action 64 of the National Drug Strategy 2001-08 health boards are advised to:

‘continue to develop good-practice outreach models, including mechanisms to outreach drug misusers who are not in contact with mainstream treatment or support agencies. A reduction in the level of drug related deaths, particularly from opiate abuse through targeted information, educational and prevention campaigns must be a key aspect of the strategy’ (DoTTSR 2001, p. 118).

10b) Harm reduction practice:

- Key-objectives

In terms of syringe exchanges, the most prevalent form of harm reduction for intravenous drug users, the main objectives are to:

1. Reach drug users who are not in contact with mainstream treatment services
2. Improve access to sterile injecting equipment
3. Reduce the risk of contracting infectious diseases, in particular HIV
4. Reduce levels of injecting risk behaviour
5. Reduce levels of sharing (lending/borrowing) of injecting equipment
6. Opening the ‘door’ to accessing additional treatment services

- Targets: groups, drugs, risk behaviours

The primary target groups within the harm reduction area are:

- Homeless people engaged in drug misuse
- Individuals engaged in the sex industry who are using drugs
- Individuals engaged in illicit drug use who are not in contact with mainstream services
- Young/experimental drug users (e.g. recent injectors of drugs)
- Individuals recently released from prison custody
- Individuals relapsing into drug use following detoxification

Heroin, cocaine, ecstasy and amphetamines tend to be the drug types focused on within a harm-reduction approach.

- The risk behaviours that receive attention in the harm-reduction field include:
- Sharing injecting equipment
- Having unprotected sex while using drugs
- Improper injecting practices
- Polydrug use behaviour
- Staffing

Outreach workers provide the bulk of services in the harm-reduction field.

10c) Range of services

The range of services providing harm-reduction measures for individuals using illicit drugs include the following:

Needle exchanges
Mobile clinics
Safe injecting classes
Distribution of condoms

10d) Networking between HR professionals

NO INFORMATION AVAILABLE

10e) Co-ordination of national policies and local practice

NO INFORMATION AVAILABLE

10f) Expenditures on specific harm reduction project, as health rooms, pill testing, heroin trial, needle exchange

NO INFORMATION AVAILABLE

10.1 Description of interventions

10.1a) Outreach work in recreational settings

In the National Drugs Strategy 2001-08 for Ireland, there is no explicit reference to outreach work in '*recreational settings*' in the drugs area. This section will look at outreach work in general, as part of service provision for drug users in Ireland.

The Eastern Regional Health Authority, which is the largest statutory provider of drugs outreach services in Ireland, offers the following explanation of the role of outreach work. The purposes of outreach work are to (a) promote awareness of HIV/AIDS, drugs and sexual health through education and information, (b) support local communities and individuals who are not currently in contact with services, (c) advocate on behalf of identified target groups, (d) link people into treatment centres for heroin detoxification and maintenance, and (e) provide a wide variety of detoxification options as alternatives to methadone.

A number of factors prevail in Ireland that render any attempt to quantify the total number of outreach work services extremely difficult. For instance, there are 14 Local Drug Task Forces operating in Ireland, under which an estimated 100+ interventions have been mainstreamed following process evaluation. Funding for some interventions in this category remain an issue. It appears that the job title 'project worker' pays better than that of 'outreach worker', and hence demand reduction projects are likely to have limited outreach content on paper, while, in practice, outreach activities could be the primary task of the project worker (Internal communication from outreach staff). In addition, the concept of outreach work in Ireland remains elusive: many activities in the drugs/addiction arena may notionally be defined as outreach work, for example, harm reduction through needle exchanges, both static and mobile, yet the service providers may not agree that their service is within the definitional boundaries of outreach. These are but a tiny example of why it is hard to quantify outreach work services in Ireland with accuracy.

10.1b) Prevention of infectious diseases

- Dissemination of information/education material

Leaflets containing information on drug-related infectious diseases are made available through drug treatment centres, health centres, drop-in centres and voluntary organisations. An information booklet specifically aiming to inform individuals using drugs and their families about hepatitis C has been produced and circulated since 2000 (Keating 2000). In 1996 the Health Promotion Unit of the Department of Health (1996) produced guidelines for effective HIV/AIDS education. The Probation and Welfare Service in Mountjoy Prison has established a Drug Awareness Programme aimed at individuals who have used/are using drugs in prison. The programme is run over four weeks with one session per week, and a key part of the programme is a session on HIV and hepatitis.

- Safer use training

Outreach workers employed by some of the area health boards deliver 'safe injecting workshops' to selected groups of drug users, for example in the Northern Area Health Board and the South Western Area Health Board areas. In addition, Merchant's Quay Ireland (MQI), in the voluntary sector, provides weekly 'safer injecting classes' to drug users. Both groups of service providers have expressed the view that while this can be a useful harm-reduction service for individuals already using drugs intravenously, it must not portray intravenous drug use as being risk-free and attractive.

- Outreach to problem drug users, groups at risk
 - Homeless people engaged in drug misuse
 - Individuals engaged in the sex industry who are using drugs
 - Individuals engaged in illicit drug use who are not in contact with mainstream services
 - Young/experimental drug users (e.g. recent injectors of drugs)
 - Individuals recently released from prison custody
 - Individuals relapsing back into drug use following detoxification

- Others

Condom distribution, HIV counselling and testing, hepatitis B vaccination and hepatitis C are available through the area health boards' drugs/AIDS services and through a number of voluntary organisations such as Merchant's Quay Ireland (MQI). Needle exchange programmes form a central part of the Irish harm-reduction strategy. Needle exchange programmes are generally administered in three types and usually are provided alongside other services that are complementary to the harm-reduction strategy. In addition, the mobile clinic service provides a low-threshold service to individuals using drugs, including needle exchange, and a low dosage methadone programme.

10.1c) Prevention of drug overdoses

- Examples of policies in overdose prevention

No national or regional policies have yet been developed in the area of overdose prevention.

- Examples of specific projects

No specific projects exist that seek to prevent overdosing from drugs.

- Projects in high-risk settings

There are no specific projects located in '*high risk settings*' such as for prisoners on release.

- Documentation, evaluation results, research

NO INFORMATION AVAILABLE

10.1d) Users rooms/safe injection rooms

Current information available in Ireland indicates an absence of any form of user rooms, or safe injecting rooms, throughout the country.

- State of the situation

NO INFORMATION AVAILABLE

- List all services

NO INFORMATION AVAILABLE

- Key-objectives

NO INFORMATION AVAILABLE

- User profile

NO INFORMATION AVAILABLE

- Staffing, budgets

NO INFORMATION AVAILABLE

- Documentation, evaluation results, research studies

NO INFORMATION AVAILABLE

10.2 Standards and evaluations

10.2a) Existence of professional standards on HR interventions

Mandatory guidelines around health and safety, ethics, legal issues and client confidentiality and client care do exist across the harm-reduction field in Ireland, primarily through outreach services. However, such guidelines tend to be delivered as part of a preparation course for outreach work staff, in the initial stages of their employment, and there appears to be a gap in monitoring and evaluating the impact that such guidelines have on the working practices of outreach workers. In addition, there is little evidence to suggest that any monitoring systems are in place that could ensure guidelines are being adhered to.

10.2b) Evaluation studies on HR measures

The Northern Area Health Board has commissioned an independent/external evaluation of its outreach services in the drugs/AIDS area. The evaluation is due to commence in the beginning of 2003.

10.2c) Training of staff in HR techniques: organisation, access, target groups for training

Training for outreach staff is organised and carried out by the project or health board service under which the outreach workers are employed. There is no formally-recognised, accredited national training available for outreach workers in Ireland. However, there is a plethora of general training courses available for individuals working in the drugs area and these include '*Working with Clients: Motivational Interviewing and Brief Intervention Counselling Skills*', provided by the Merchant's Quay Drugs/HIV service. Many outreach workers avail of these courses to update and enhance their skills base. In addition, there are a number of in-service training courses available for outreach workers employed under

the health board. For example, outreach workers are trained in how to provide classes in safe injecting techniques.

In addition, training is made available to midwives and others involved in the routine-linked antenatal HIV testing of pregnant women drug users. This is provided in all health boards by a team including clinicians, a midwife and social workers.

Dublin Safer Dancing Initiative – The Staying Alive Campaign. The project arose out of a need to respond to the abuse of ecstasy and other dance drugs in nightclubs. The programme included a training course for over 20 nightclub owners and door/ security staff. The project operates under a three-phase plan: (1) working with owners and manager of nightclubs, (2) working with door supervisors and (3) targeting club goers.

11. Treatments

The development of treatment services is a key part of the National Drug Strategy and is central to reducing the demand for drugs among the illicit drug-using population. The first part of this section will document a number of actions outlined in the National Drug Strategy 2001-08 (Department of Tourism, Sport and Recreation (DoTTSR) 2001), to be taken by key players involved in providing treatment services (actions will appear in italics). The section will also include a progress report on each action so far.

Action 44 of the National Drug Strategy advises the health boards:

'To have immediate access for drug misusers to professional assessment and counselling by health board services, followed by commencement of treatment as deemed appropriate, not later than one month after assessment.' (DoTTSR 2001: p. 116)

Action 44 is close to being fully implemented in some areas, such as the East Coast Area Health Board (ECAHB) and in respect of particular groups of individuals, such as under-eighteen-year-olds, pregnant women or people with psychiatric problems or HIV/AIDS. The Northern Area Health Board (NAHB) provides immediate access to counselling and to treatment for under-18s and pregnant women. However, Trinity Court and the South Western Area Health Board (SWAHB) have reported difficulties in this regard.

The objective of Trinity Court is to provide a tertiary specialised service to meet the needs of homeless people, people with dual diagnoses, and people who cannot be managed in a primary-care setting with a GP or in a community-based clinic. However, some places in Trinity Court have been filled by placements from Health Board areas where adequate services have yet to develop. Another issue impacting on the ability of Trinity Court to implement this action are people arriving for service following temporary release from prison and people arriving for service who have recently returned from abroad. Forty-nine per cent of the waiting list in Trinity Court is made up of people of no fixed abode. Trinity Court is presently undertaking a validation exercise by making contact with people on this list and providing a re-assessment. They have also begun structured meetings with the area management in the NAHB, to move people back into a more localised service. Trinity Court feels that when adequate services are developed within the health board areas they will be able to meet the needs of the more specialised service users.

The South Western Area Health Board (SWAHB) is presently working towards implementing this action by developing services in key areas. Their main difficulty has been the development of services in the Clondalkin and Tallaght areas. In relation to Clondalkin, the SWAHB have secured a site and finalised architectural plans for submission for planning permission. It is expected that the normal six-month planning process will be needed. In the meantime, Clondalkin Addiction Support Programme (CASP) will be extending the number of places available for this area. The SWAHB has extended the service in Deansrath by offering additional sessions. The SWAHB has provided a full addiction treatment service on the mobile bus in the grounds of Tallaght Hospital. Currently there are 50 persons receiving treatment on this mobile bus. This coupled with the additional GPs and the development of service in Jobstown, in Tallaght has more than halved the waiting list. The waiting time for treatment in Tallaght has reduced from 9 months to 3 months. However, without the development of a full addiction centre, it may not be possible to sustain this rate. New GPs have also begun to offer a service in the SWAHB area. The SWAHB is still in negotiations with LUAS (Dublin's urban rail system currently under development) in relation to developing services on its site in Tallaght. SWAHB has been given part of the LUAS site but has still to negotiate the exact location. The new building for the JADD project is developing but will need to draw down the matching funding under the National Development Plan (NDP).

The Northern Area Health Board (NAHB) has developed a plan to increase treatment numbers in its area, especially in areas of greatest need such as Blanchardstown and Finglas/Cabra and is awaiting National Development Plan (NDP) funding in order to extend the services in Finglas/Cabra. The NAHB has slightly increased the numbers attending in Blanchardstown and has taken back the waiting list for Cabra from Trinity Court. The NAHB has begun a process of arranging transfer from Trinity Court to various appropriate locations in its area. Numbers in treatment has increased in other treatment locations such as Howth and Darndale.

The East Coast Area Health Board (ECAHB) presently has three clients on its methadone waiting list, with all clients accessing treatment within 3 months. Although the ECAHB has a very low waiting list, it is apparent from 2001 statistics that when the mobile clinic in Bray was established, more clients presented for treatment. This indicates that the ECAHB has a using population that accesses services when motivated or if further resources become available.

In other health board areas there is immediate access to assessment and in most regional health boards treatment is available within one month. Under-18s are prioritised. A review of the Midland Health Board (MHB) service highlighted the need for additional staffing. The board is pursuing suitable premises for two treatment centres in two urban centres. Funding has been received for two consultant psychiatrists who will have substance misuse as part of their brief. The first one is due to start work in August 2002. The South Eastern Health Board (SEHB) has appointed four misuse co-ordinators. Joint addiction teams are being established in each area of the SEHB.

In **Action 51** of the National Drug Strategy the health boards are advised:

'To have a clearly co-ordinated and well publicised plan in place for each Health Board area by end 2002 for the provision of a comprehensive and locally accessible range of treatments for drug misusers, particularly for young people, the planning of such services to be linked to the national profile of drug misuse amongst young people and to the areas where usage is most prevalent. These plans to be implemented by end-2004.' (DofTSR 2001, p.117)

Each of the area health boards of the Eastern Regional Health Authority (ERHA) is in the process of drawing up plans for the provision of comprehensive and locally-accessible treatment services for drug misusers. The research being undertaken by the National Advisory Committee on Drugs (NACD) will provide information on the national profile and areas of most prevalence. The Area Health Board plans will be implemented, provided adequate funding is ring-fenced for this specific purpose.

A programme for the development of addiction services, including treatment and rehabilitation services, was adopted by the Northern Area Health Board (NAHB) in early 2002. This plan, which was developed in line with the policies set out in the National Drugs Strategy, will be incrementally implemented as resources allow.

The Mid Western Health Board (MWHB) is currently in the process of recruiting two permanent addiction counsellors, who will include young persons in their brief. The Midland Health Board (MHB) is awaiting the appointment of the consultant psychiatrist to progress this action. All boards have a service plan in relation to drug misuse in place.

Action 52 in the National Drug Strategy advises the health boards:

'To produce and widely distribute a well publicised, short, easily read guide to the drug treatment services available in each Health Board area with contact numbers for further information and assistance' (DofTSR 2001, p.117)

Each of the Area Health Boards of the ERHA will be allocated a small amount of funding from the additional funding received to implement the National Drug Strategy to publish an easy-to-read guide and some of the three boards are looking at using information technology (IT) to impart information. Those boards that do not already have a guide available are in the process of developing one.

Action 53 of the National Drug Strategy advises the health boards:

'To require from 2002 that all health Boards, in considering the location and establishment of treatment and rehabilitation facilities, develop a management plan in consultation with local communities. Existing examples whereby Health Boards have established monitoring committees with the local community to oversee the operation of treatment services have proven successful and should be replicated, where appropriate.' (DofTSR 2001, p.117)

The Area Health Boards in the Eastern Region have established monitoring committees with local communities in the establishment of new treatment and rehabilitation facilities and are continuing the consultation with monitoring committees, where they are already in existence. This action mainly applies to the ERHA area health boards, but if/when new facilities are developed in other regional health boards this will be considered.

Action 56 in the National Drug Strategy advises the health boards on the need:

'To consider as a matter of priority, how to increase the level of GP and pharmacy involvement in the provision of treatment programmes. Increased capacity at the primary care level will have the effect of alleviating the pressure on the secondary care services which are currently over-subscribed.' (DofTSR 2001, p.117)

The Irish Council of General Practitioners (ICGP) has held a seminar on the participation of GPs in drug-treatment programmes and has put forward proposals in relation to research, training and remuneration, including a proposal for a deprivation allowance. In addition, discussion has focussed on the role of GP co-ordinators in recruiting GPs. The Eastern Regional Health Authority (ERHA) has made research funding available to examine the issue.

11.1 Drug-free treatment and health care at national level

11.1a) Objectives and definitions of drug-free treatment

The provision of drug-free treatment, that is treatment for individuals based on the absence of '*mind altering substances*', is receiving increased attention in Ireland. For example, the National Drug Strategy 2001–08 in Action 55 advises the health boards:

'to explore immediately the scope for introducing greater provision of alternative medical and non-medical treatment types which allow greater flexibility and choice. This may increase the number of drug misusers presenting for treatment, as it is evident that a "one size fits all" approach is not appropriate to the characteristics of Irish drug misuse.' (DofTSR 2001, p.117)

Each of the Area Health Boards of the Eastern Regional Health Authority (ERHA), and the Drug Treatment Centre Board at Trinity Court, offer a range of alternative medical and non-medical treatment types within their service at various locations. In addition, the Area Health Boards provide Section 65 funding to some voluntary and community groups to provide alternative therapies within their service.

The Drug Treatment Centre Board (DTCB) provides physical therapy, yoga and massage. In relation to medical alternatives, in addition, the DTCB has recently received a licence to pilot Ibuprofen as a treatment option. The South Western Area Health Board

(SWAHB) is about to pilot lofexidine with younger service users in Fortune House drug treatment centre. The young persons programme also provides massage and reflexology.

The Northern Area Health Board (NAHB) has piloted a Lofexidine Treatment Programme in Darndale. A similar programme has been available in Domville House and the City Clinic drug treatment centres for the past year. The East Coast Area Health Board (ECAHB) has a number of complementary therapies (e.g. acupuncture, Reiki, etc) available in many of its treatment centres.

The National Advisory Committee on Drugs (NACD) is examining the different treatment options that are available. All regional health boards are keeping up to date with developments. Boards are looking at ways of expanding their treatment options but some boards cite lack of funding as being an obstacle to this.

In **Action 57** of the National Drug Strategy, health boards are advised to:

'oversee the development of comprehensive residential treatment models incorporating detoxification, intervention, pre-treatment counselling, motivational work, therapeutic treatment and high quality rehabilitation for misusers who wish to become drug-free. Resources should continue to be targeted at the most efficient and effective of these services' (DoTTSR 2001, p.117)

In response, the Northern Area Health Board (NAHB) has developed a comprehensive plan for addiction services. Clients who wish to become drug-free in the NAHB area are clinically assessed and an appropriate treatment response is provided. The NAHB will identify clients on its current waiting list, who wish to become drug-free, and will evaluate the effectiveness of current detoxification options in consultation with their partners to ensure maximum efficiency. In the meantime, the NAHB continues to develop and expand its range of rehabilitation options, including the development of the regional services at Keltoi.

In **Action 58** of the National Drug Strategy, the health boards are advised:

'to report to the National Advisory Committee on Drugs (NACD) on the efficacy of different forms of treatment and detoxification facilities and residential – drug free regimes on an on-going basis.' (DoTTSR 2001, p.117)

In response, the Drug Treatment Centre Board at Trinity Court and the Area Health Boards of the Eastern Regional Health Authority (ERHA) will report to the NACD on the efficacy of different forms of treatment and detoxification programmes as and when they undertake an evaluation.

The Cavan Drug Awareness Group, a non-statutory, community organisation, provides family services and support to drug users and their families, and promotes drug-free treatment options and a drug-free environment. Qualified addiction counselling is provided. The group is currently in the process of linking in with the National Association of Detoxification Acupuncturists (NADA) to train local people in NADA techniques, in an effort to offer a drug-free (methadone-free) treatment method to people addicted to drugs, including alcohol. The treatment, '*acudetox*', is believed to alleviate the withdrawal symptoms, lessen the cravings for drugs and lengthen the abstinence period.

11.1b) Criteria of admission to drug-free treatment

Criteria for admission to drug-free treatment tend to be mixed in Ireland. However, there are some common expectations, shared by most centres, regarding the admission of clients for drug-free treatment:

- Drug/alcohol free for at least one week

- An interest in addressing the issues relating to drug use
- Willing to engage in pre-treatment counselling
- Data supporting the fact that there is chemical dependency
- Prospective residents must be willing to engage in the treatment process
- Chemical dependency must be the dominant problem
- In some cases, family participation is required at screening, at certain stages in the residential phase and during aftercare
- Financial arrangements must be discussed with administration before admission
- Residents must be detoxified and drug free at the time of admission
- Ambition to learn new skills

11.1c) Availability, financing, organisation and delivery of drug-free treatment services

Generally speaking, 'drug-free' treatment centres are provided by the voluntary sector in Ireland. However, some have a level of state financial subsidisation, but the specifics of these arrangements are not easily accessible, as most centres prefer to conduct their business discretely. The main drug-free treatment centres in Ireland are:

- The Rutland Centre
- The Aislinn Treatment Centre
- Coolmine Therapeutic Community Treatment Centre
- Merchant's Quay High Park Residential Treatment Centre
- Merchant's Quay St. Francis Farm Residential Treatment Centre

11.2 Substitution and maintenance programmes

11.2a) Objectives for substitution treatment

The objectives of substitution programmes in Ireland vary, depending on the type of programme involved. While the ultimate aim of the services is to facilitate the individual to return to a drug-free lifestyle, a variety of programmes is available: some programmes aim to detoxify the individual on a short-term basis, while others offer long-term maintenance and are not subject to a time limit.

11.2b) Criteria for admission to substitution treatment

During the early 1990s substitution services in Ireland were expanded and became more widely available to the opiate-using population. In accessing maintenance programmes, preference has always been given to pregnant women and those who have AIDS or who are HIV positive. However, in 1998 the Eastern Health Board produced an 'Inventory of Policies', which lays down specific criteria for admission to substitution programmes.

Methadone Maintenance

The following are the criteria for inclusion of a person on a methadone maintenance programme.

- They must meet physical, emotional and behavioural criteria for addiction, as set down by the 10th edition of the International Classification of Diseases.
- They must be aged over 18, but those between the ages of 18 and 20 will require a more extensive investigation before being commenced on methadone. This would require an extensive drug history going back more than two to three years, which will

need careful clarification.

- They must have an extensive one-year history of intravenous drug use.

Special cases that need not meet the above criteria for admission will include the following:

- patients who are HIV positive;
- partners; or
- patients who are pregnant.

These patients will be offered detoxification, maintenance or inpatient services as appropriate.

Young people, 18 years or younger

Young persons under the age of 18 will need their parents to attend and give parental consent. There should be a history of at least one failed detoxification, usually two or three, preferably at inpatient level. However, where patients have a very long history that can be verified, this condition may be waived.

Young persons aged 18 years or younger will require very careful assessment and consideration at team meetings and will need the formal decision of a consultant psychiatrist before commencing methadone maintenance.

Dosages above 80mg can only be offered after consultation with the consultant psychiatrist.

Source: Barry (2000)

Prior to the introduction of these guidelines, the criteria for admission to maintenance programmes were generally left to the discretion of an individual GP or particular a clinic. Thus, there may have been extensive variation between programmes in terms of the criteria for admission.

11.2c) Availability, financing, organisation and delivery of substitution treatment services

Availability of substitution treatment services

Substitution treatment services are provided to Irish opiate users by practitioners based either in a clinic or in a primary care setting (for a more detailed description see '*Organisation and Delivery of Substitution Treatment Services*' below). As of August 2001, there were 62 clinic locations, through which substitution programmes were provided: 56 were based in the Eastern Regional Health Authority Area, where the majority of opiate-users reside. Furthermore, in October 2001, 172 GPs were providing substitution services in the primary care setting; of these, 144 were based in the ERHA area and 28 in the other health board areas. In October 2001 there were a total of 5,816 people registered as receiving methadone from Ireland's substitution services.

Financing of substitution treatment services

Substitution services are provided free of charge to Irish drug users. As with other areas of the health service, substitution programmes are funded out of general taxation. Each health board is given an annual budget for drug treatment services, including substitution services. Barry commented: '*the overall thrust of Ireland's response is that substitution treatment is well funded at an outpatient and inpatient level*' (Barry 2000, p. 139).

Organisation and delivery of substitution treatment services

Prior to October 1998 there was no policy in relation to GPs prescribing methadone. No data are available on the extent to which GPs prescribed methadone up until this point, as the provision of such a service was at the discretion of individual GPs. However, in the early 1990s, there was a move away from the centralised specialist model toward a more decentralised model of service provision. This called for the involvement of community-based GPs and pharmacists in the prescribing and dispensing of methadone. Although some GPs were already involved in providing this service, the aim was to establish a structured and co-ordinated approach to the provision of services. An Expert Group was set up to develop a suitable treatment protocol. In March 1993, the Protocol for the Prescribing of Methadone was issued, which set out guidelines for GPs prescribing methadone within the general practice setting, and for pharmacists dispensing methadone. Guidelines set out in a review of this protocol, produced in 1997, were implemented in October 1998. Subsequently, the Misuse of Drugs (Supervision of Prescription and Supply of Methadone) Regulations were published in 1998.

The guidelines aim to create a more controlled environment for the prescribing and dispensing of methadone. Under the Regulations, the prescribing medical practitioner must register each client in receipt of a methadone prescription on the Central Methadone Treatment List. The guidelines aim to restrict the number of clients for whom individual GPs can prescribe methadone. While there is no specific licence required by GPs in Ireland to provide substitution, they are required to undergo training and must be approved by the relevant health board. Approval is only forthcoming after the GP has undergone the training programme organised by the Irish College of General Practitioners (ICGP). Methadone itself is a licensed prescription drug, controlled under Schedule 2 of the Misuse of Drugs Regulations, 1988. Methadone is currently prescribed in a number of service settings: drug clinic setting and GP setting. Furthermore, it is also dispensed from community pharmacies.

Clinic Setting

Clinics have been developed specifically to meet the needs of drug users. Expansion of the clinic services has been overwhelmingly in the area of substitution programmes, including methadone detoxification, stabilisation and maintenance. The number of clinic locations, where methadone is prescribed, has grown from two in 1991 to 45 in 1999 and 62 in August 2001. As mentioned above, 56 of the 62 clinics are based in the Eastern Regional Health Authority area, where the large majority of opiate users reside.

Clinics fall into one of two categories. First is the 'addiction centre', where a range of services is available to clients, including methadone programmes. The majority of clients attending these clinics are dispensed their methadone on-site on a daily basis; this means they consume the methadone under the supervision of a member of staff. Supervised urine samples are taken on a regular basis. When clients have demonstrated a certain level of stability, by providing opiate-negative samples over a period of time, they may be dispensed 'take-home' doses. This means less frequent attendance at the clinic.

The second category of clinic is the 'satellite clinic'. These clinics are based in communities identified as having a significant opiate-using population. These clinics provide methadone-prescribing services, although it is not dispensed on site. Rather, clients attend a designated community pharmacy where their methadone is dispensed.

General Practice Setting

As mentioned above, in 1993 a protocol was published for the prescribing of methadone in the GP setting. The basic premise outlined in the 1993 Protocol was that GPs should take responsibility for the care of opiate-dependent people once they had been stabilised in either an addiction centre or a satellite clinic. GPs and clients would then have the continued support of that centre. A protocol review committee was established, which

produced a report in 1997, the recommendations of which were implemented through legislation in October 1998. The main changes this had on the organisation and delivery of methadone services in the GP context were:

- GPs had to register with the health board to enable them to prescribe methadone.
- GPs were restricted in the number of drug users they could treat, depending on their level of training.
- Only GPs having undergone specialised training could initiate the prescription of methadone in the treatment of drug addiction. Other GPs could only treat those already stabilised in a clinic setting.
- GPs were no longer allowed to prescribe methadone to patients in a private capacity, but had to provide the service free of charge to the patient under the General Medical Scheme.
- All patients in receipt of a methadone prescription had to be registered on the Central Methadone Treatment List.

As with the number of clinics providing substitution services, the number of GPs offering the service has increased dramatically in recent years. In 1996 there were 58 GPs registered as prescribing methadone in their practice setting; in 1999, this grew to 143 and in August 2001 to 166.

Community Pharmacists

As substitution programmes have become more decentralised, the role of the community pharmacist has become increasingly important. Pharmacies are responsible for dispensing methadone to clients attending a GP-based substitution programme and those attending satellite clinics. Each client is assigned to a particular pharmacy, from which his or her methadone is dispensed. Pharmacists are involved in dispensing take-home doses and also provide a supervised administration service. The Pharmaceutical Association of Ireland recommends that pharmacists agree a written contract with clients upon initiating these services. Contracts detail the pharmacy service and the expected standards of behaviour of clients. The number of pharmacies involved in dispensing methadone has increased significantly in recent years. As of August 2001 there were 237 pharmacists involved in dispensing methadone; 167 of these were based in the Eastern Regional Health Authority area.

Specialised Prescription Forms

Methadone must be prescribed using specialised prescription forms. These forms must be correctly written and allow for a single supply or supply on instalment. The prescription form must also indicate whether the administration of the dose should be supervised by the pharmacist (Department of Health 1997).

11.2d) Substitution drugs and mode of application

The only substitution drug prescribed in Ireland continues to be oral methadone. The average dose of methadone prescribed is 55mg (Barry 2000). Prior to 1996 the only form of methadone available in Ireland was Physeptone Linctus (2mg methadone per 5mls of syrup). As part of a reorganisation of the methadone treatment services, the health boards transferred patients onto methadone mixture (5mg methadone per 5mls syrup). This change was first implemented in treatment clinics and then in GP surgeries. This methadone mixture is the only form currently available from treatment services.

The Pharmaceutical Society of Ireland has proposed that the use of non-opioid alternatives to methadone for the management of addiction, such as Lofexidine, be considered in the future.

11.2e) Psycho-social counselling

Counselling is available on site to those attending a clinic-based programme. Interim programmes have counsellors available to clients on an ad hoc basis. Access to counselling is provided where there are complex/acute issues involved. Clients of maintenance programmes are allocated a full-time counsellor. While participation is recommended within the programme, it is ultimately voluntary. In the GP setting, clients can be referred to local counsellors, if so required. Attendance is also voluntary. There are no data available on the level of uptake of counselling services or the number of visits made per client from either treatment setting.

11.2f) Diversion of substitution drugs

No commissioned research has been carried out to date in Ireland, into the extent of the diversion of substitution drugs, such as methadone, onto the street drug market. However, data available from the National Drug Treatment Reporting System (NDTRS) indicate that methadone is available on the street drug market (see Table 11.2 below). It is likely that a quantity of this 'street methadone' was initially medically prescribed, and has ended up being diverted to the street drug market by the individuals to whom the drug was prescribed. However, it may be also the case that a quantity of this 'street methadone' was stolen from GPs' offices or from pharmacies, and therefore cannot be said to have been diverted.

Table 11.2. Percentage of those presenting at treatment reporting 'street methadone' as their primary drug of use.

Year	Percentage
1998	6.3% (n=5,076)
1999	3.6% (n=6,443)
2000	4.1% (n=6,994)

As the data show, the use of 'street methadone' would appear to have declined among treatment contacts over a three-year period. However, this data only cover primary drug use and is limited in its value as an indicator of the 'real extent' of the diversion of substitution drugs (methadone).

11.2g) Evaluation results, statistics, research and training

Evaluation results

The following evaluative studies were reported as under way at the time of writing, and most are nearing completion (Barry 2000):

- an evaluation of the first 150 inpatients in the detoxification unit;
- a five-year follow-up of the first 350 patients in outpatient methadone maintenance;
- a four-year follow-up of the first 150 patients in inpatient detoxification and stabilisation;
- an assessment of the care process for 700 patients referred to health board services as a result of regulatory changes in 1998;
- an analysis of the first decade of first-time needle-exchange patients;
- a review of the level of care of female users at a city centre clinic;
- an evaluation of outpatient satellite clinics; and
- a study of seroprevalence of blood-borne viral infections in methadone patients.

Statistics

At the end of October 2001 there were 5,605 clients registered as receiving substitution treatment in Ireland. Clients of both GP and clinic-based programmes are all registered on the Central Methadone Treatment List. As mentioned in previous sections, opiate use in Ireland is overwhelmingly based in the Eastern Regional Health Authority (ERHA) area, and most substitution programme clients are resident there. In August 2001, 163 out of a

total of 5,605 clients, registered on the Central Methadone Treatment List, were receiving substitution services outside the ERHA area. Data gathered through the Central Methadone Treatment List is confidential and not available for analysis.

Research

Most research carried out in Ireland with clients of substitution programmes has focused on their identity as injecting drug users rather than their experiences of substitution programmes. In addition, this has been limited to sample populations from one particular clinic (Smyth *et al.* 1998; Smyth *et al.* 1995; Dorman *et al.* 1997; Williams *et al.* 1990). Little research has been done looking at substitution programmes per se. However, this gap is due to be addressed by the National Advisory Committee on Drug (NACD), which has called for tenders to evaluate opiate addiction treatment services.

A nation-wide general population survey, *Drug-Related Knowledge, Attitudes and Beliefs in Ireland* (Bryan *et al.* 2000), was carried out by the Drug Misuse Research Division of the Health Research Board. In this study 1,000 members of the public were asked about a range of drug-related issues, including drug treatment services. In relation to substitution services specifically, respondents were asked to what extent they agreed with the following statement: *'Medically prescribed heroin substitutes [such as methadone/physeptone] should be available to drug addicts.'* (Bryan *et al.* 2000) Only 16.1% disagreed with this statement, while 63.5% agreed and 20.3% responded 'don't know'. These findings suggest willingness on the part of local communities to accommodate substitution treatment programmes. However, as noted by some commentators (Barry 2000), in practice, there has been some community resistance to the establishment of substitution programmes in local areas.

11.3 After-care and re-integration

11.3a) Links with national strategy and legislation

The National Drug Strategy 2001-08 through **Action 48** recommends that health boards need:

'To have in place, in each Health Board area, a range of treatment and rehabilitation options as part of a planned programme of progression for each drug misuser, by end of 2002...this approach will assist in their re-integration back into society' (DoF TSR 2001, p.116)

In addition, the National Drug Strategy, through **Actions 74/75**, recommends that the National State Training Agencies, e.g. FÁS:

(74) 'increase the number of training and employment opportunities for drug misusers by 30% by end of 2004, in line with the commitment to provide such opportunities in the PPF (Programme for Prosperity and Fairness) and taking on board best practice from the special FÁS Community Employment Programme and the pilot Labour-Market Inclusion Programme (LIP)' (DoF TSR 2001, p.119)

(75) 'examine the potential to involve recovering drug misusers in Social Economy projects, and in other forms of vocational training. The ring-fencing of places within the FÁS Community Employment Programme has been an important element in the existing approach to rehabilitation.' (DoF TSR 2001, p.119)

11.3b) Objectives, definitions and concepts of reintegration

The Northern Area Health Board (NAHB) has developed a specific rehabilitation/integration service for individuals 'recovering' from illicit drug use. The service is based on the following:

Objectives	To work with those who access the service in exploring, planning for, delivery and evaluation of interventions to facilitate progression towards a more self-directed, independent life.
Definition	Rehabilitation/integration is a structured development process whereby individuals are facilitated in the process of regaining their capacity for daily life from problem drug use. The aim of the process is to empower people to access the social, economic and cultural benefits of life in line with their aspirations. Facilitating individuals to realise their potential to live independently and responsibly is at the core of the Board's rehabilitation/integration programmes.
Concepts	Education, training, employment and housing, independent living, empowerment, personal responsibility

11.3c) Accessibility for different target groups

See Ireland's National Report 2001. (Sinclair *et al.* 2001, p. 138)

11.3d) Organisation, financing, managing, availability and delivery of services

The Rehabilitation/Integration (R/I) Service of the Northern Area Health Board (NAHB) is headed up by a Rehabilitation Co-ordinator. This is a strategic, planning and co-ordinating function. The Co-ordinator sits on the Addiction Service management team and is responsible for the strategic development and integration of rehabilitation provision, as articulated in the strategic plan, to complement the other services already developed.

Operationally, the R/I Service aims to position rehabilitation within the context of the current Addiction Services and in relation to the activities and sponsored projects of Local Drug Task Forces (LDTFs) in the Board area. At this level the service is concerned with planning with other disciplines and agencies around the co-ordination of a continuum of care for service users, standards in and quality of rehabilitation and integration interventions, identifying gaps in service, and assisting in developing the capacity of all stakeholders to respond to service user needs.

On the ground, the service is composed of a team consisting of a Rehabilitation/Integration Manager and two Integration Workers in each of the five LDTF areas within the NAHB area. The Rehabilitation/Integration managers have responsibility for the delivery of that service and carry a remit from the Board to work with other service providers through the LDTF sub-committee on rehabilitation, to achieve co-ordination of services in their designated area. This includes working with others to identify and respond to gaps in services and developing the capacity of local services to deliver to the client group.

Integration Workers work on a one-to-one basis with drug users in developing individual rehabilitation/integration plans. The aim of the service at this level is to assist the individual to develop the capacity to make informed choices about progression and integration and to ensure that the appropriate supports are available. The function of the Integration Worker is to offer assessment and planning skills, to help identify and broker appropriate interventions, and to offer challenge and support as required.

11.3e) Statistics, research and evaluation results

See Ireland's National Report 2001. (Sinclair *et al.* 2001, pp. 140-143)

12. Interventions in the Criminal Justice System

General framework of interventions in criminal justice system and links with the national strategy and legislation

12.1 Assistance to drug users in prisons

12.1a) Abstinence-oriented treatments

Abstinence-orientated treatment	Provision Status within Irish Prison System
Detoxification	<p>A standard twenty-day methadone detoxification programme²¹ is offered to prisoners (in Dublin) who test positive for opiates on committal.</p> <p>A seven-week '<i>Drug Detoxification and Rehabilitation Programme</i>' is run by Probation and Welfare Officers, and is based in the Medical Unit of Mountjoy Prison. The programme caters for nine male prisoners at a time.</p>
Drug-Free Units	A designated drug-free unit, the Training Unit, is part of the Mountjoy Prison Complex in Dublin. In addition, it is planned to open a new 78-cell drug-free block at Limerick Prison in March 2003 (internal communication).
Therapeutic Communities	There is no therapeutic community programme available to drug users in the Irish prison system. However, inmates in Limerick Prison are being sent to outside residential treatment centres (Bushy Park and Bruree) during their sentences, in a move to address their drug problems (internal communication).

12.1b) Substitution treatment

Methadone maintenance is made available to some prisoners in the Dublin prison system. According to Dillon (2001, p. 97), during the fieldwork of her study, this service was provided to around 20 inmates who were HIV positive and who were housed in the Medical Unit of the Mountjoy Prison Complex. Since then, all new committals to Mountjoy and Cloverhill Remand Prison in Clondalkin, Dublin, (Department of Justice, Equality and Law Reform 2001) who are on an approved methadone maintenance treatment programme, continue to receive this treatment while in prison.

12.1c) Harm-reduction measures

Harm-Reduction Measure	Provision Status within Irish Prison System
Blood Screening	Testing for HIV and hepatitis C is provided, on request by inmates in the Irish prison system. Pre and post-test counselling is also provided to some extent.
Provision of Disinfectants	The Irish prison system does not provide bleach or disinfectants as a harm-reduction measure to inmates. However, a recent report of the Group to Review the Structure and Organisation of Prison Health Care Services, established by the Minister for Justice, Equality and Law Reform (2001, p.11), has recommended that disinfectant tablets should be introduced into the Irish prison system as

²¹ The doses involved are as follows: Day 1-2 35mls methadone mixture; Day 3-5 30mls methadone mixture; Day 6-8 25mls methadone mixture; Day 9-11 20mls methadone mixture.

Needle exchange	a method of limiting the spread of communicable diseases. The Irish prison system does not provide sterile injecting equipment to inmates who use drugs intravenously. Furthermore, the Group set up to Review the Structure and Organisation of Prison Health Care Services (2001) did not recommend the provision of needle exchange services for inmates, arguing that <i>'the risk of attacks on staff and prisoners with syringes supplied by the state would appear to be unacceptable'</i> (Department of Justice, Equality & Law Reform 2001, p. 46).
Provision of Condoms	The Irish prison system does not provide condoms to inmates.
Vaccination	No information available
Generic Harm-Reduction Provision in Irish Prison System	The Probation and Welfare Service in Mountjoy Prison, Dublin, delivers a Drug Awareness Programme. The aim is to educate participants about their drug use and the associated risks. Included in this programme is a session on HIV and hepatitis.

12.1d) Community links

In Ireland there is no formal referral scheme for drug-using prisoners to treatment upon release. The need to develop a structured through-care programme from the prison system to the community has been identified within the Irish criminal justice system (Irish Prisons Service 2000). The Probation and Welfare Service of the Department of Justice, Equality and Law Reform carry out group-work programmes in the prison setting. These aim to promote desired behavioural changes in terms of risk behaviour and drug addiction, and to help prisoners cope with imprisonment and prepare them for life demands following release from prison. Part of this work is concentrated in an eleven-week drug rehabilitation programme that focuses on factors associated with imminent release into the community. The programme facilitates prisoners in developing a Community Release Plan through contact with their Probation and Welfare Officer. After the initial eleven-week period prisoners are released, subject to Temporary Release Rules, and then contact their Probation and Welfare Officer and link in with therapeutic, education, training and employment contacts in the community.

The Pathways Project ²² provides a valuable service to prisoners preparing for imminent release and those in the post-release period. The service includes peer support, professional counselling, referral to further treatment and family support groups. In addition, the project offers a comprehensive educational and rehabilitation programme that is client centred. There is also a rehabilitation programme for ex-prisoners based in Cork (southern Ireland), which aims to re-integrate ex-prisoners into mainstream society and to stop them re-offending. The LDTFs have also begun building links with the prison system in order to support inmates using drugs in prison to access treatment and support services when released.

In Mountjoy Prison, Dublin, the CONNECT project is an action-research project led by the Department of Justice, Equality and Law Reform and run by the National Training and Development Institute. Initially, the project carried out research to identify the education and training gaps in programme provision in Mountjoy Prison and the Training Unit. In response, the project developed and implemented pilot strategies and systems to fill the gaps identified and improve the employability of offenders while in custody. Included in the pre-vocational training is training in job-seeking skills and work-related social skills. The

²² See the EDDRA database for a comprehensive overview of the Pathways Project.

process at the centre of the project is described as the '*transition from custody, through training, on to reintegration in the community and more specifically, on to labour market participation*'. Each course caters for up to 14 male prisoners, including individuals who have progressed from using drugs.

12.2 Alternatives to prison for drug-dependent offenders

12.2a) Objectives, organisation, funding and professional resources

In Ireland, where drugs are involved in an offence the Gardaí (police) have no discretionary powers to issue a caution (informal or formal) nor to impose an on-the-spot fine. Therefore, officially, charges will be brought against any individual found to have committed an offence against the Misuse of Drugs Act. An exception is made in the case of a juvenile offender (under 18 years old) found in possession of a small amount of drugs, where drug trafficking is not an issue. In such a case, the Garda Juvenile Diversion Programme is brought to bear. This Programme was introduced in 1963 with the aim of diverting juvenile offenders from criminal activity. The Programme allows that, if certain criteria are met, a juvenile offender may be cautioned as an alternative to being prosecuted. The Programme operates on the basis of the common law principle of police discretion (An Garda Síochána 1999). While this Programme is specifically aimed at juvenile offenders committing first offences, it can be adapted/extended to include juveniles committing subsequent offences. A juvenile offender who is eligible for inclusion in the Programme is dealt with by way of a caution, as opposed to being prosecuted for a criminal offence. Cautions may be either formal or informal. A Juvenile Liaison Officer (JLO) becomes involved with the offender and the family. While an informal caution may be given by the JLO, a formal caution must be given by the Garda Superintendent of the district where the offender lives. There is no provision for a similar system of cautioning for adults.

12.2b) Accessibility to alternative measures: principles, criteria for admission

There is a range of non-custodial options available for sentencing those who plead guilty or are found guilty through the courts. The decision of the court in relation to the imposition of a custodial or non-custodial sentence may be influenced by a Pre-Sanction Report, where available. This report is compiled by the Probation and Welfare Services and includes information on factors such as addiction, which may have contributed to the individual's offending. Pre-Sanction Reports are often not available, but a judge may request that one be provided. The non-custodial options available in the Irish criminal justice system were overviewed in a report on the Irish Probation and Welfare Services (Expert Group on The Probation and Welfare Services 1999) and include:

- A suspended sentence*
- Supervision during deferment of penalty*/ Intensive Supervised Probation: This facility was designed to increase restraints on offenders in the community. Offenders are required to report for frequent urine testing. The type and levels of demand placed on offenders differ enormously by jurisdiction.
- A Community Service Order: A Community Service Order requires offenders to perform unpaid work for between 40 and 240 hours. There is a perceived lack of suitability of community service for offenders with addictions (Expert Group on The Probation and Welfare Services 1999). This can be due to the Probation Service's inability to provide occupational insurance in the event of an accident owing to known disability in the offender, e.g. addiction.

* Both these options have no statutory basis but are widely used by the Courts

- A Fine: A fine has statutory limits, fixed for a particular offence. The money goes to Central Funds and if unpaid can be enforced by committal to prison.
- A Compensation Order: A Compensation Order has a specific statutory format as laid down in the Criminal Justice Act, 1993, and is related to the wrong done. The money goes to the victim as opposed to Central Funds.
- A Fine and Compensation Order
- Release under the Probation of Offenders Act, 1907: In this instance, a decision is made not to proceed to convict
- Probation Order (Probation of Offenders Act, 1907): The purpose of a probation order is to secure the rehabilitation of the offender, to protect the public and to prevent the offender from committing further offences. This is used for drug users by imposing conditions. Conditions may include attendance for treatment and the provision of urine for analysis. This is the preferred procedure in the District Court when dealing with drug users.
- Order of Recognisance (Misuse of Drugs Act, 1977, Section 28, as amended by the Misuse of Drugs Act, 1984): This is an order requiring an offender to undergo treatment for his/her drug condition in a residential centre or in the community.

The '*Order of Recognisance*' would appear to be an important non-custodial option for drug users who offend in Ireland. However, in practice the courts do not generally use this Order. The necessary rules and regulations have not been made. Furthermore, the provision of a statutory place of treatment has always been problematic. The Expert Group on the Probation and Welfare Services has recommended that the necessary Court Rules and Regulations be updated by the various Court Rules Committees to facilitate wider use of the '*Order of Recognisance*' (Expert Group on the Probation and Welfare Services 1999).

A Drug Court was established in Ireland in January 2001 on a pilot basis in one area of Dublin City. The Court has as its primary aim:

'the reduction of crime through rehabilitation of the offender but not excluding punishment should the circumstances so warrant. The purpose of the proposed Drug Court is to provide a scheme for rehabilitation, under the auspices and control of the court, of persons who are convicted of, or who have pleaded guilty to, drugs offences, relating to possession for own use or for supply to others on a minor scale, and crimes triable in the District Court'²³ which are related to the drug misuse of the offender' (Drug Court Planning Committee 1999, p.15).

In order to access the court the person must be seventeen years of age or older, and either have pleaded guilty or been convicted in the District Court of a drug or drug-related offence that would warrant a prison sentence. The offender must express a wish to be admitted to the Drug Court and, at the recommendation of either the police, the Probation Service, a drug-treatment professional or the defending solicitor, the individual will be assessed as to their suitability for engagement in the Drug Court process (Drug Court Planning Committee 1999). To date, 44 offenders have been referred to the Drug Court: of those, 15 were deemed either to be unsuitable or their involvement was terminated owing to non-compliance with the Court's requirements; the remainder are currently 'in front of the Court' (personal communication, Drug Court Planning Committee). The pilot phase is being evaluated over its initial twelve-month period, with a focus on 'success' in terms of changes in offending behaviour; cost; and feasibility of expansion to cover the remaining areas of the city. The evaluation was due for completion in May 2002 (personal communication, Drug Court Planning Committee). To date, the Drug Court Scheme has

²³ "The jurisdiction of the District Court extends to offences which are triable summarily or indictable offences where the judge accepts jurisdiction to hear the case summarily after election by the accused or at the direction by the Director of Public prosecutions (DPP). The maximum sentence the District Court may impose on any one charge cannot exceed 12 months imprisonment and an overall total of 24 months on a combination of more than one offence" (Drug Court Planning Committee 1999, p.13).

produced one graduate, in March 2002 – the first success in this pilot scheme set up to give drug-addicted offenders the chance to break their habit, as an alternative to prison.

A range of community-based alternatives to custody has been developed in Ireland in recent years. Although not specifically catering for the needs of drug-dependent offenders, these initiatives deliver a range of measures aimed at diverting offenders away from drugs and custodial options.

The *Cuchulláin Probation Project*, in Dundalk, is one such intervention. Developed by the Probation and Welfare Service for work with young offenders and their families in the Dundalk area, it is a community-based response to 'at risk' youth between the ages of 15 and 19 – mainly young offenders, those already involved in offending and those recently released from custody. Using various training and development programmes, including counselling and educational methods, the project has helped more than 50 young people since it opened over a year ago. The project promotes abstinence from drugs, where they are an issue (drug free). Activities include literacy, creative arts, IT, communication and social skills. Funding is provided through the Probation and Welfare Service from the Department of Justice, Equality and Law Reform.

Another community-based intervention in this field is the *Cornmarket Project*, launched in March 2002, in a joint venture between Wexford Area Partnership and the Probation and Welfare Service. The project includes a counselling intervention and support service for young offenders with alcohol and drug use problems, and the building of structured development programmes for those involved in substance misuse and/or criminality. It also provides an educational and training programme, providing a UCD/NUI Diploma in Intervention and Counselling Skills, aimed at professional and voluntary people whose work brings them into contact with issues of substance misuse and crime. The Department of Justice, Equality and Law Reform contributes to the funding.

For further information on other community-based alternatives to custody, see Ireland's National Report 2001 (Sinclair *et al*, pp. 148-149). In addition, see the EDDRA database for a comprehensive overview of the Pathways Project, the Tower Project, the Bridge Project and the Copping-On Programme. These are initiatives aimed at drug-using offenders and operate as alternatives to custody.

12.3 Evaluation and training

12.3a) Evaluation results

There has been little evaluation carried out on programmes aimed at drug users in the Irish criminal justice system. Crowley (1999) provided a medical review of the seven-week Drug Detoxification and Rehabilitation Programme in Mountjoy Prison, Dublin. Up to February 1999, 187 prisoners had entered the programme: of these, 173 completed and 14 failed to complete the detoxification. While this implies a 93 per cent success rate, Crowley (1999) highlighted the need for the success of this intervention to be determined by the 6- and 12-month relapse figures. Overall, it was found that there was a twelve-month relapse rate of 78 per cent. Crowley argued that, while this may appear high, it compares favourably with outcome rates of other inpatient detoxification programmes. See the EDDRA database for evaluation results of the Pathways Project, the Tower Project, the Bridge Project and the Copping-On Programme.

12.3b) Training

There is little specific training for those working within the Irish criminal justice system in relation to drug use and the specific needs of drug users.

As part of their training, members of An Garda Síochána (the Irish police force) receive instruction in the area of drug misuse. The programme includes training in:

- the enforcement of drug-related laws;
- the procedures for dealing with drug cases;
- health and safety issues.

As part of its proposals for staff development, the Steering Group on Prison Based Drug Treatment Services (Irish Prisons Service 2000) proposed that a special Prisons Service Training Officer be appointed. It proposed that this Assistant Training Officer work in tandem with the Area Health Authority's training department of the Drugs/AIDS Services. The Officer would have responsibility for implementing a full training package for all staff within the prison who are working with drug users. The proposed training would consist of two levels. The first level would cover general education, basic skills training and awareness training of drug problems for all prison staff in relevant institutions. The second level would be more specific training for a core group of staff who would be working directly with drug users, within prison treatment units.

13. Quality Assurance

Action 39 of the National Drug Strategy states that it is within the remit of the Department of Health and Children;

'To ensure that adequate training for health care and other professionals engaged in the management of drug dependency is available, including, if necessary, arrangements with third level institutions and professional bodies' (DofTSR 2001, p.116).

In response, the Department of Health and Children funds a Diploma course and a Masters Programme in Addiction Studies through the Department of Social Studies in Trinity College, Dublin. It has provided funding to the Irish Association of Alcohol and Addiction Counsellors to improve training for its members. The Department has written to health boards asking them to forward details of what is available for staff in their boards and to identify gaps.

A number of Health Boards support regional and local training programmes. Doctors involved in treatment of opiate users are provided with training (run by the Irish College of General Practitioners). The Midland Health Board is carrying out a needs assessment of the training needs of those working in the drugs area, especially health board staff. The North Eastern Health Board has ongoing training of staff as an integral feature of its drugs service. Personnel are acquiring relevant qualifications from a range of agencies and universities.

Action 40 of the National Drug Strategy states that it is within the remit of the Department of Health and Children:

'To consult all treatment and rehabilitation providers in order to ensure that performance indicators, used in the evaluation of services, accurately and consistently reflect the needs of specific areas i.e. performance indicators should reflect the reality of the drug problem locally' (DofTSR 2001, p.116)

In response, the Department of Health and Children is involved in ongoing consultation with the National Advisory Committee on Drugs, health boards, treatment providers and with European and international agencies (such as the EMCDDA and the United Nations Drug Control Programme) to develop a range of treatment indicators, which properly reflect the outcome of treatments. The development of a National Drug Treatment Outcome Reporting System (currently at the stage of tender by the National Advisory Committee on Drugs) will help to inform this process.

In the development of criteria for health board service plans, there has been an emphasis on ensuring that a minimum set of key performance indicators is included for drugs. Health Boards have jointly agreed two key performance indicators in their 2002 Service Plans. These are the percentage of people (including those under 18) assessed for treatment within 3 days, and the percentage of people provided with treatment, where appropriate, not later than one month after assessment. A group has been set up to develop appropriate performance indicators for 2003. This group comprises representatives from all health boards.

Action 41 of the National Drug Strategy states that the Department of Health and Children is to:

'To oversee implementation of the recommendations of the Benzodiazepine Working Group, which is due to complete its work by end June 2001, as part of the overall strategy of quality improvement of current services.' DofTSR 2001, p.116)

The Report of the Benzodiazepine Committee has been finalised and is currently being printed. The Minister will launch the report soon. The Report makes many recommendations and the Department will be discussing its implementation with all relevant players, including health boards and professional bodies.

Action 50 of the National Drug Strategy states that the Health Boards are encouraged:

'To develop, in consultation with the National Advisory Committee on Drugs (NACD), criteria to ensure that all State-funded treatment and rehabilitation programmes accord with quality standards as set out by the Health Boards.' (DofTSR 2001, p.117)

In response, the Eastern Regional Health Authority (ERHA) has had an initial meeting with the Director of the National Advisory Committee on Drugs (NACD) to discuss this action. The ERHA noted that in order for services to reach high quality standards, there would be recourse implications. It is planned that, in so far as possible, agreement will be reached on a set of quality standards this year. Implementation of these standards will be planned on a phased basis.

The Area Health Boards (AHB) are currently looking at the QUADS as a potential accredited set of quality standards, which could be adapted to an Irish setting. A meeting is being arranged with the ERHA, AHBs and Trinity Court to progress this issue further. Following this meeting, further discussion will take place with the NACD. Trinity Court, the National Drug Treatment Centre, has developed quality standards for a range of areas within their services.

PART 4

KEY ISSUES

14. Demand reduction expenditures on drugs in 1999

This chapter covers direct expenditures in the field of drug demand reduction.

14.1 Concepts and definitions

Demand reduction comprises interventions, which are aimed at decreasing the demand for drugs at an individual or at a collective level. Interventions aimed at reducing the harmful consequences of drugs are also included. The scope of demand reduction intervention is wide and encapsulates measures in the fields of prevention, treatment and rehabilitation, as well as research and evaluation of demand reduction initiatives.

Direct expenditure in the area of demand reduction is defined by the EMCDDA as follows:

- *operational expenditure*: financial resources, directly related to drugs, allocated from the state budget to a specific project in the demand reduction field, or to an authority (central/regional/local level)
- *Institutional expenditure*: resources (salaries, rents, expenses) used by public or private organisations, directly linked to drugs demand reduction activities, such as: offices/sections/departments of ministries working directly in the field; public health institutions in the drug field; etc.

Those institutions or organisations which are not working exclusively in the demand reduction area, such as: emergency rooms, hospitals (apart sections exclusively dedicated to drugs addicts), GP's, social inclusion projects, general activities for youth in a disadvantaged area; etc. are not included within the definition of direct expenditures by the EMCDDA.

14.2 Financial mechanism, responsibilities and accountability

There are a wide number of Government Departments and Agencies involved in a range of prevention, treatment, rehabilitation, and research activities which aim to reduce demand for drugs in Irish society. These activities and the Departments and Agencies responsible are described below under the headings: prevention, treatment and rehabilitation, and research.

Prevention

The Department of Education and Science plays a role in relation to prevention, operating mainly through the formal education system. Its initiatives to combat drug use, such as 'Walk Tall' for primary level and 'On My Own Two Feet' for secondary level, and more recently the Social, Personal and Health Education (SPHE) programme, are linked to its overall package of measures to combat educational disadvantage. The National Drugs Strategy 2001-2008 stipulates that the Department is to ensure that every second-level school is to have an active programme to counter early school-leaving, with particular focus on areas with high levels of drug misuse.

In the non-formal education sector, the Department of Education and Science works closely with FÁS on joint-funded initiatives such as Youthreach, and in the running of workshops aimed at increasing drug awareness in areas where acute drug problems are

apparent. In relation to Local Drug Task Forces (LDTFs), the role of the Department of Education is to be strengthened under the National Drugs Strategy 2001-2008. The Department is to publish and implement a policy statement on education supports in LDTFs, including an audit of current supports, by the end of 2001, and to nominate a departmental official to serve on each LDTF.

The Department of Health and Children also places considerable emphasis on the need for education and prevention. The National Health Promotion Strategy, approved by the Government in 2000, has a strategic aim “to endeavour to reduce the numbers engaging in drug misuse”. The Health Promotion Unit (HPU) promotes a multi-faceted approach to drug awareness, education and prevention. A range of activities are supported, for example:

- the “Substance Abuse Prevention Programme” (SAPP)
- life-skills programmes;
- award programmes for schools;
- initiatives in the youth service;
- the dissemination of resource material; and
- local campaigns in ERHA areas.

The HPU also formulates preventative policies. However, the implementation of these policies on the ground is very much a matter for the regional Health Boards, as the Department’s role – at the policy level – has been to monitor and oversee implementation and to provide resources. The Department situates its policy responses in the context of UN efforts to combat drugs through establishing targets to be achieved by 2008.

An Garda Síochána are also active in prevention, particularly in relation to young people involved in, or at risk of becoming involved in, drugs and crime. Initiatives include the Garda Youth Diversion Projects, generally managed by Foróige and/or the City of Dublin Youth Service Board; the Drug Awareness Programme for communities; Garda Schools Programmes; the Garda Mobile Anti-Drugs Unit; and the Juvenile Diversion Project. Garda Juvenile Liaison Officers are also assigned throughout the country. The National Drugs Strategy 2001-2008 identifies an opportunity for enhanced co-ordination, whereby incidences of early use of alcohol or drugs by young people coming to Garda attention are followed up by the Community Police and/or the health and social services, so that problem-drug misuse may be diagnosed/halted early on.

In 1998, the Young People's Facilities and Services Fund (YPFSF) was set up to develop youth facilities, including sport and recreational facilities, and services in disadvantaged areas where a significant drug problem exists or has the potential to develop. The primary focus of the Fund is on LDTF areas and selected urban areas (i.e. Galway, Limerick, South Cork City, Waterford and Carlow) where a serious drug problem exists or has the potential to develop. A sum of £102 million has been provided under the National Development Plan (2000 – 2006) to support measures under the Fund, of which approx. £46 million has been allocated to date in the first round of funding.

In establishing the Fund, the Cabinet Committee set up a National Assessment Committee to (i) prepare guidelines for the development of integrated plans in the target areas, which meet the overall aims and objectives of the Fund; (ii) facilitate the establishment of the local structures charged with developing plans; (iii) assess the plans emanating from each of the target areas and (iv) make recommendations on funding to the Cabinet Committee on Social Inclusion. The National Assessment Committee is responsible for monitoring on-going progress in implementing the plans and strategies approved and addressing any difficulties or issues arising. It is also overseeing an external evaluation of the Fund, in conjunction with the Department of Education and Science, which will provide a comprehensive and independent assessment of the Fund, taking account of its overall

aims and objectives. The evaluation of the Fund commenced in April 2001.

The Local Drug Task Forces (LDTFs), in the context of implementing their Action Plans, are delivering a range of measures in the education, prevention and awareness areas. Initiatives include community-based drug awareness programmes in schools, youth clubs and other places where young people congregate; drug awareness programmes for parents, teachers etc; peer education programmes and projects to prevent early school-leaving.

Treatment and Rehabilitation

The Department of Health and Children has overall policy and legislative responsibility for health, social services and child welfare in Ireland, as well as various responsibilities for aspects of drug policy, principally treatment and rehabilitation services. In developing its policy on drug misuse, the Department has adopted a health promotion approach. The Department's national policy on the treatment of alcohol and drug misuse stresses the need for community based interventions rather than specialist in-patient approaches. These services include family support and community medical and social services.

Responsibility for the provision of treatment and rehabilitation services for drug misusers is vested with the ten Regional Health Boards. The Health Boards also provide support and training for community groups which are involved in drug - related prevention or rehabilitation activities, as both the community and voluntary sectors play a significant part in the provision of drug related services, especially in the LDTF areas. The Health Boards have appointed Regional Drug Co-ordinators and many have also established Regional Drug Co-ordinating Committees comprising representatives of the relevant Health Board, An Garda Síochána, Education Services and the community and voluntary sectors. There is regular contact between the NDST and the Regional Drug Co-ordinators.

Growth in drug-related problems throughout the country has resulted in the need for many of the Health Boards to formulate a specific drug strategy for their region. This is especially the case in the area of development of services, which are local and tailored to the needs of particular communities. The majority of these strategies are being developed at present in accordance with emerging trends which are specific to the individual regions. Perhaps not surprisingly, the emphasis in many Health Boards outside of the Eastern region has been on education and prevention initiatives. However, because of the nature of the drug problem in the Eastern catchment area, the Eastern Regional Health Authority (ERHA) has been involved in a significant degree of activity and expansion of treatment services within its area. The expansion of services in the ERHA area has been a priority in order to protect the health of misusers themselves, to prevent the spread of infectious diseases and to reduce the effect of chaotic behaviour on certain neighbourhoods.

In October 2000, the Government approved in principle the implementation of the recommendations contained in the Report on Prison-Based Drug Treatment Services which was produced by a Steering Group, established by the Director General of the Prison Service. These proposals will result in a major overhaul of prison-based drug treatment services and should make a major contribution to breaking the cycle of drug dependency, crime and imprisonment which are inextricably linked at present. Perhaps the main conclusion of the report is that the Prisons Service must replicate in prison, the level of medical and other supports available in the community for drug dependent people, to the maximum extent possible.

In addition, the report proposes a multi-disciplinary approach to the drug problem in prisons and the appointment of a senior figure from the ERHA to co-ordinate the overall treatment service in the Dublin prisons, as well as drugs counsellors and extra nurses, psychologists and probation service staff. All staff in the relevant institutions will receive

training in drugs-related issues and refresher courses every year thereafter. Links are also being established with local community and voluntary groups, through liaison committees, to enhance the throughcare and aftercare arrangements for prisoners in receipt of drug treatments in custody. Implementation of the recommendations of the report are progressing at present.

The Probation and Welfare Service, although not a primary drug treatment agency, co-ordinates a range of drug treatment initiatives, in co-operation with a number of rehabilitation agencies and the community.

A Drug Court was established in January 2001 in the North Inner City of Dublin. It has as its primary aim "the reduction of crime through rehabilitation of the offender but not excluding punishment should the circumstances so warrant". Rehabilitation and structured supervision will be used to help participants to escape the cycle of offending with the ultimate objective of ending all criminal activity. It is hoped that best practice will be identified to allow for expansion, as appropriate.

FÁS, the state training agency, operates specific drug-related programmes, including the Special Drugs Community Employment Programme, on which 1,000 places have been assigned for recovering drug misusers. Trained staff are available to work with stabilised drug misusers, to help them access employment or further training. Similarly, advocates, located in severely disadvantaged areas, provide a mentoring service to young people experiencing drug problems.

Acknowledging that the FÁS Community Employment Programme has been an important element of the existing approach to rehabilitation, the National Drugs Strategy 2001-2008 sets a target for increasing the number of training and employment opportunities for drug misusers by 30 per cent by the end of 2004. The Strategy also identifies the need to examine the potential to involve recovering drug misusers in Social Economy projects, and in other forms of vocational training.

Special high support hostel accommodation is necessary for homeless people with drug dependence problems. Under the Homeless Strategy, funding has been provided by the Government for the provision of two high support hostels in Dublin for people with drug and alcohol dependence problems. In view of the number of people with such problems in Dublin, Dublin Corporation and the ERHA are taking the lead role in drawing up and implementing suitable proposals.

The Voluntary Drug Treatment Network provides a framework for a number of voluntary drug groups working in the area of treatment to meet, share issues of concern and develop more comprehensive responses to the prevention and treatment of problem drug use. The Network is an umbrella group that aims to challenge drug misuse and related issues in a creative, caring and motivational way. It provides a comprehensive range of drug treatment methods that range from harm reduction intervention through to long-term residential drug-free programmes. There are two core strands to the composition of the Network. These are localized community-based treatment responses, that have emerged from local residents and individuals seeking to respond to issues in their areas and regional responses that provide treatment at national and, occasionally, at EU level.

The Network has representatives on the National Aids Strategy Committee, the NDST and the National Advisory Committee on Drugs (NACD). They are also members of the Community Platform that forms part of the Community and Voluntary Pillar of the Social Partnership. However, the Network itself does not have a national remit to represent all the voluntary drug treatment organizations in the country. It is primarily for the Dublin based organisations which deal with drug misuse but some of its members do have a national

focus in terms of treatment and training. The Network engages with various Government Departments and Regional Health Boards who assist in the funding of its services.

Research

The Drug Misuse Research Division (DMRD) of the Health Research Board was established in 1989 and is responsible for operating the National Drug Treatment Reporting System (NDTRS) which is the main source of information on drug misuse in Ireland. The NDTRS is an epidemiological database, which provides data on people who avail of treatment services for problem drug use, on a nationwide basis. This provides information on the current patterns and trends of treated drug use and drug addiction in Ireland. Data is provided to the NDTRS through centers or service locations where drug misuse is treated.

The Government has designated the DMRD as the central point to which all research data and information should be channelled. In order to deliver on the role assigned to it, the DMRD is developing a National Documentation Centre which policy-makers and other interested parties can use to access all relevant and up-to-date information and research in the field of drug misuse in Ireland and internationally. In addition to existing data, all future research and information will be channelled or, as appropriate, its existence notified and recorded in a way which facilitates ease of retrieval by policy-makers and other interested parties. The Documentation Centre will build on the existing resources of the DMRD and will capitalise on its position as the National Focal Point for the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The DMRD is partly funded by the Department of Health and Children.

The National Advisory Committee on Drugs (NACD) was established in July 2000 to advise the Government in relation to the prevalence, prevention, treatment and consequences of problem drug use in Ireland, based on the Committee's analysis and interpretation of research findings and information available to it. The Committee is overseeing the delivery of a three year prioritised programme of research and evaluation on the extent, nature, causes and effects of drug misuse in Ireland, identifying the contribution which can be made by all the relevant interests. Its membership reflects statutory, community, voluntary, academic and research interests as well as representation from the relevant Government Departments. The Committee operates under the aegis of the Department of Tourism, Sport and Recreation.

The Health Promotion Unit (HPU) of the Department of Health and Children is also involved in the publication and dissemination of information and literature which promotes the avoidance of drug misuse. In this regard, the National Health Promotion Strategy sets clear aims and objectives to support best practice models which promote the non-use of drugs and, where they are used, the minimisation of the harm done by them.

14.3 Expenditures at national level

The most comprehensive national expenditure estimates available to date related to the year 2000. These estimates were prepared by the Review Group of the National Drugs Strategy based on information made available to them by Departments and Agencies dealing with drugs issues. The Review Group estimated that the development, co-ordination and delivery of the National Drugs Strategy approximated to €183 million in 2000. By excluding those Departments and Agencies whose main responsibilities are in the area of supply reduction (namely Dept. of Justice, Equality & Law Reform, Revenue Commissioners (Customs & Excise), and State Laboratory) we can provide an estimate for the direct public expenditure in the demand reduction area of approximately €57 million, Table 14.3. This figure should be considered a minimum estimate, or indeed an underestimate, since it does not include the role of An Garda Síochána in drug prevention,

the Prisons Service, the Probation and Welfare Service and the Drug Court in a range of treatment and rehabilitation initiatives. This figure also does not include direct private expenditure in the field of drug demand reduction.

Table 14.3 Estimated direct public expenditure in the field of drug demand reduction in 2000

Department/Agency	Expenditure (€ millions)
Dept. of Health & Children	32.0
Dept of Enterprise, Trade & Employment	6.0
Dept of Education & Science	7.5
Dept of Tourism, Sport & Recreation	11.6
Total	57.1

14.4 Expenditures of specialised drug treatment centres

No comprehensive national information is available on expenditures of specialised drug treatment centres.

14.5 Conclusions

The level of direct expenditure on demand reduction activities is difficult to estimate and is complicated by the fact that expenditure is spread across a number of Departments, Local Authorities, Agencies and other statutory organisations. Even within Departments and Agencies, it is difficult to arrive at an accurate estimate of costs associated specifically with drug misuse as services such as An Garda Síochána, the Prisons, the Courts and Probation and Welfare Services and the various health agencies deal with drugs issues as part of their wider daily services.

14.6 Methodological information

No research to date has been carried out in this area in Ireland. Special studies are required to accurately determine the level of direct expenditure on demand reduction activities.

15. Drug and alcohol use among young people aged 12-18

In a comprehensive study of alcohol and drugs in the context of health promotion in Ireland Butler states that

'Irish health policy to date has not been moving towards the creation of a unitary, national, or research-based, substance abuse policy. Instead, alcohol policy and drug policy have generally moved forward as parallel activities, involving different actors pursuing different agendas, and with science or research making, at best, a modest contribution in each of these two related areas'. (Butler 2002, p. 211)

He concludes that there is a wide gap between health promotion aspirations on the one hand and human behaviour and political realities on the other.

15.1 Prevalence, trends and patterns of use

The greatest single concern voiced by the Irish public in submissions to the Department of Health concerned problems associated with teenage access to alcohol (Department of Health 1996). In recent years the availability of alcohol has increased substantially due to changes in the licensing code²⁴, particularly as a result of the extension of opening hours for premises licensed to sell alcohol. The fact that pubs, restaurants and hotels are now open for longer hours encourages the habit of drinking greater amounts of alcohol. Legally²⁵, alcohol cannot be sold to, purchased or consumed by persons under 18 years of age. However, underage drinking is prevalent throughout the country. A high proportion of young people are regular drinkers by 18 years of age and many abuse alcohol. A survey of health behaviours conducted among 11-18 year old post-primary school pupils in Dublin, Kildare and Wicklow in 1998 indicates that 45 percent drink alcohol at least every month (Rhatigan and Shelley 1999).

15.1a) General population surveys and special surveys on people 12-18

Surveys of drug and alcohol use among young people in Ireland have been conducted mainly in the school setting and at local/regional level, with limited information available nationally. The main surveys of lifetime prevalence of alcohol and drug use among young people are presented in Tables 15.1a and 15.1b below. Comparisons must be made with caution given the lack of comparable data.

Table 15.1a. Dublin. Lifetime prevalence of substance use 1970-1999

Source	Year	Region	Sample size	Age group	Lifetime Prevalence	
					Illegal drug Use	Alcohol Use
O'Rourke <i>et al.</i> (1970)	1970	Dublin	5,483	11-19	2.4 illegal drugs	76.5
Grube & Morgan (1986)	1984/85	Dublin	2,076	11-19	21.9 illegal drugs 13.2 cannabis 12.9 solvents	65.0
Morgan & Grube (1994)	1991	Dublin	1,983	11-19	- 25.1 cannabis 18.9 solvents	77.9
Rhatigan & Shelley (1999)	1998	Dublin, Kildare, Wicklow	6,081	10-18	20.0 illegal drugs 20.5 cannabis 13.0 solvents	85.0
Brinkley <i>et al.</i> 1999	1999	Dublin	983	15-18	32.0 illegal drugs 32.0 cannabis	75.0

²⁴ Intoxicating Liquour Act, 2000

²⁵ Intoxicating Liquour Act, 1988

The information in Table 15.1a shows considerable increases in lifetime use of illegal substances among young people in Dublin over the thirty year period 1970 (2.4 percent) to 1999 (32.0 percent). The real change over the years has occurred in relation to cannabis use. Between 1984/85 and 1991 there was an increase in the use of solvents, but much more so in the case of cannabis use which almost doubled in the seven-year period. The Rhatigan and Shelley (1999) sample was younger (included 10 year olds), and also covered two counties in the Dublin hinterland which include rural areas. This could explain the drop (to 20.5 percent) in lifetime use of cannabis in this 1998 survey. Cannabis prevalence in a different age group (16-18 year olds) was 32 percent in 1999 (Brinkley *et al.* 1999). While the increase in lifetime use of alcohol has not been as dramatic as that of illegal drugs, alcohol prevalence rates are very high among young Dublin people.

Table 15.1b. Ireland. Lifetime prevalence of different substances

Source	Year	Region	Sample size	Age group	Lifetime Prevalence				
					Cannabis	Solvents	Ecstasy	Heroin	Alcohol
Hibell <i>et al.</i> (1997)	1995	Ireland	1,849	15-16	37.0	19.0	9.0	2.0	91.0
HBSC*	1998	Ireland	8,497	9-17	12.3	9.9	2.0	1.3	-
			2,471	15-16	21.7	13.0		1.8	-
Hibell <i>et al.</i> (2001)	1999	Ireland	2,277	15-16	32.0	22.0	5.0	2.0	92.0

* Health Behaviour in School-aged Children (HBSC), Centre for Health Promotion Studies, NUI, Galway (personal communication)

Illicit drug use among young people in Ireland is relatively high (Table 15.1b). In 1995 a nation wide school survey of 15-16 year old post-primary school pupils (ESPAD) was carried out in collaboration with other European countries (Hibell *et al.* 1997). Lifetime use of heroin among young people is relatively low. However, the lifetime prevalence of cannabis use in Ireland (37 percent) was three times the average of the other countries involved in the study. This dropped considerably, to 22 percent, in the HBSC study in 1998, although comparison is not valid given that different age groups were involved. However, in the follow-up 1999 ESPAD survey (Hibell *et al.* 2001), although not so marked there was also a decrease. Lifetime ecstasy use also seems to have declined, from 9 percent in 1995 to 5 percent in 1999. Lifetime alcohol use is very high, at over 90 percent, among young Irish people.

Morgan and Grube (1994, p. 76) state that '*while there seems to be an association of the use of marijuana with drinking, the increase in marijuana use seems to be as much a consequence of increases in rates of drinking as a cause*'.

15.1b) Qualitative research on patterns of use, set and setting, types of combinations, route of administration

A qualitative research study on adolescent drug use in the north east of the country found that drugs are readily available to young people, who see drug use as an acceptable part of youth culture. '*To-day adolescent drug users do not identify with any particular sub-culture, but rather it seems to be a normal part of youth culture straddling all classes and all geographical boundaries*' (Department of Public Health 1999, p. 56). While there was no evidence that most young people are *habitual* drug takers, cannabis is taken as part of normal social gathering. In fact young participants in the study viewed alcohol as a far bigger problem (*ibid.*). The study found that the reality of adolescent drug taking did not conform to stereotypical images of drug takers. Unlike the adult world of drug dealing where crime, greed and profits are the motivating factors; drugs in adolescent worlds are perceived to revolve around friendship and sharing. Money is pooled or saved to buy drugs, and drug use is a highly sociable activity (*ibid.*). However, young people were not au fait with all aspects of illicit drugs, and were in fact often vague about knowledge

surrounding drug use. The study concludes that current health promotion/information strategies were not reaching children and that this deficiency may be linked to the design and distribution of these strategies. They suggest that current strategies do not reflect young people's realities and have consequently lost credence. Therefore, they suggest, the views of young people should form an integral part of future drug strategies.

Different social settings – cultural, social and legal attitudes – have a powerful effect on drug use and its consequences (Zinberg 1984). Drugs can represent a way of altering the nature of subjective reality where that reality is intolerable (Gossop 2000). Young people can have different sets of social values to those of previous generations and drug use may be an expression of this (ibid.). It is now generally accepted that environment is a mitigating factor in young people's drug use. The idea that young people exercise control over their drug use is discussed in a qualitative study of young people in Dublin's inner city (Mayock 2000). Contact with the drug culture was an unavoidable reality of living in the locality. The young participants in the study knew how and when to procure drugs with relative ease if they wished, provided they had the necessary financial resources.

Mayock (2000) found different patterns of use, which was defined by different levels of commitment to drug use – the number of drugs tried, the frequency of use, and the quantity consumed. The most common route of initiation was through friendship networks. Cannabis is the preferred and most widely used drug. Cannabis use fitted easily into their daily routines. Chosen drug-using locations were usually in close proximity to their homes within a relatively compact geographical area. This research also illustrated the diverse nature of the participants' drug-related activities. Unlike cannabis, which is street-based, drugs such as amphetamines, ecstasy, and LSD were associated with raves, parties or other social events, and were not used as frequently as cannabis. Cocaine and heroin use was very rare among the study group. A shift in attitude was observed in the transition to heroin use, and those who did become involved in heroin use did not necessarily have the support of the peer group in the initial stages. Concealment was a priority particularly for young women for whom heroin use was considered a serious transgression. The *'shift took place in the context of high exposure to, and intense involvement in, a strong drug culture'* (Mayock 2000, p. 44). Young people seemed unaware of the changing nature of the seriousness of involvement with heroin use, with the result that first withdrawal symptoms frequently came as a shock to young people. The first signs of dependence varied between six months and one year after initial heroin use.

15.1c) Perceptions about risks, benefits and image of specific drugs

The findings from an in-depth study of 78 young people (mean age 11.5 years) in a youth club setting suggest that most of the participants had a high level of exposure to a drugs culture, yet had little direct experience of actual drug use. The small minority who had used drugs tended to speak benignly of their drug use. Participants' knowledge of the consequences of drug use were either vague or dramatic (Hyde *et al.* 2000).

The ESPAD study (Hibell *et al.* 1997) explored the extent to which young people feel they harm themselves when they use substances such as tobacco, alcohol and drugs. A minority (18 percent) of Irish 15-16 year old students, who are among the highest alcohol consumers and binge drinkers in Europe, did not consider five drinks or more each weekend to be a *'great risk'*. This was one of the smallest proportions in Europe. Taking cannabis once or twice was regarded as a less risky behaviour than taking it regularly. Among those who regarded regular cannabis use as a *'great risk'*, again one of the lowest figures (63 percent) was found among Irish students.

Grube and Morgan (1986) studied attitudes to substance use and found that students who thought it likely that alcohol/drug use would harm their health, get them into trouble with the police, or lead them to becoming an addict, expressed less favourable attitudes to

substance use. The use of drugs, licit and illicit, among young people is influenced by many factors. Initial drug use is fostered by curiosity and peer pressure; the motivation to continue using drugs comes from enjoyment of the drug effects and by factors such as the price and availability and social pressure to use them (Plant 1994). Grube and Morgan (1990) found that peer approval and peer example are significant predictors of change in the use of illegal drugs. They found gender differences for prediction of illegal drug taking. *'Peer influences are stronger for girls than for boys, both as regards peer approval and peer example'* (Grube and Morgan 1990, p. 59). For boys, the strongest predictors are expectancy-value beliefs (i.e. perceptions about the consequences of drug taking and evaluations of these consequences) and peer approval.

Normative influences (relating to influences of parents and peers) are uniquely important in predicting adolescent drinking (Morgan and Grube 1994). Morgan and Grube (1991) examined the nature of peer group influence on substance use among adolescents, and they clarify a number of points in relation to adolescent drinking. They found that 'peer group' influence was not the appropriate term for the influence processes involved, since it was friends who were psychologically closer to an individual who exercised more influence, rather than same-aged peers. They also showed that the drinking *behaviour* of friends was a more powerful factor in mediating peer influence than was perceived *approval*: and that young people who perceive alcohol to be easily available, drink more frequently and consume greater amounts (ibid.). Morgan and Grube (1994, p. 15) found a *'remarkably small relationship'* between socio-economic factors and drinking behaviour among youth.

Mayock (2000) suggests that young drug users play a more active role in drug use than is traditionally acknowledged: they explained their drug taking by drawing attention to the associated benefits. The social nature of the activity was a marked feature of the explanations. Mayock (2000, p. 97) states that 'there is nothing inevitable about a drug career – choices exist at every stage. The research found that a process of decision-making clearly accompanied the move to *'new drugs'*; and that *selective drug avoidance* is a technique used by young people in an attempt to curb their drug use in order to reduce the drug-related harm. This study was carried out in a *'high risk'* locality and the researcher highlights strengths, such as informed choices and the potential risks and costs assessment by drug users, which she suggests can be drawn upon to reduce harmful patterns of drug use.

Mayock's (2000) qualitative research highlights the importance of young people's perception of risk as a factor in their own behaviour. Cannabis was viewed as a relatively safe drug whereas heroin was thought to have serious negative implications for health and well being. She found that drug users had tolerant views on the use and benefits of drugs. Motives for use included, curiosity, pleasure, enhancement of self-esteem, alleviation of boredom, management of negative self-thought, and of course the fact that the drugs were available. The social dimension of drug use emerged as a critical factor. Young people who do not use drugs do not contribute to the notion of benefits from drug use, but believe that all drugs are potentially dangerous. Extensive early drug experimentation along with active involvement in street culture contribute to a shift in the boundaries of acceptable drug taking, resulting in increased tolerance of more serious drug taking.

15.1d) Trends in recent years

In Ireland there are variations in drug use patterns in different regions of the country and among different social groups, but a consistent trend is the relationship between opiate use, early school leaving, unemployment and social disadvantage, particularly in urban areas.

Drug use trends among young people in recent years show that:

- Alcohol lifetime prevalence rates are very high at over 90 percent

- Illicit drug use is relatively high, but there are indications that it has stabilised or decreased in recent years
- After alcohol, cannabis is the most widely used substance
- Lifetime use of solvents among 15-16 year olds is relatively high at 22 percent
- Drug use is most prevalent among young Dublin males
- The profile of the typical problematic drug user in Ireland is young, unemployed male, leaving school at an early age and living in a socially and economically disadvantaged area
- One-fifth of all new clients in treatment in Dublin between 1990 and 1999 were under 18 years of age. The main drug of misuse was an opiate in almost half (48 percent) of cases. These young people were more likely than their adult counterparts, to be female, and to be homeless
- Young females seem particularly vulnerable, particularly in relation to the transmission of infectious disease such as hepatitis C and HIV

Research indicates that current health promotion strategies are not reaching children; that policies have lost credence because they do not reflect young people's realities. It has been suggested therefore that the views of young people should form an integral part of future drug strategies.

- Studies indicate the need for more imaginative education initiatives in harm reduction interventions. Greater attention needs to be paid to the social context of injecting drug use and the sharing of injecting equipment. Outcomes of harm reduction interventions could be improved by exploring the perceptions surrounding safe injecting practices.

15.1e) New/alternative information sources

Youth media is potentially a source of information on drug use among young people. *HYPER* (Health, Youth, Promotion, Education and Rehabilitation) is a bi-monthly magazine representing young people affected by drugs. It is produced by former drug users as part of a rehabilitation project with the objective of bringing to young people a magazine which critically addresses their lifestyles without preaching or scare-mongering, and to which they can relate (Moran *et al.* 2001). Further information on this project is included in the EMCDDAs EDDRA database²⁶.

Another potential source of information was initiated recently by Merchants Quay Project. This is an on-line research project aimed at young people participating in club/dance settings. The on-line questionnaire²⁷ collects information on socio-demographic status, prevalence of drug use, patterns of ecstasy use, and effects of ecstasy use.

Ireland is currently participating in an EMCDDA project, investigating the monitoring of youth print media as a means of detecting, tracking and understanding emerging trends in drug use among young people. This could develop as an alternative source of information. The pilot study is sampling print media aimed at readers who have 'young' attitudes and lifestyles, do not condemn drug use as a matter of principle, and are trend-setters interested in news about drugs, drug use and new substances. In Ireland the categories of print media being monitored include music and clubbing magazines, student publications, and Internet web-sites.

15.2 Health and social consequences

15.2a) Deaths and overdoses

²⁶ See EDDRA database for further information, <http://www.reitox.emcdda.org:8008/eddra/>

²⁷ See <http://www.clubscene.ie>

Very few drug-related deaths occur among adolescents (Table 15.2). During 1999, all inquest files for deaths in Dublin were examined for drug-related deaths: eighty-four out of 732 deaths were identified as opiate-related; none were under 17 years of age (Ward and Barry 2001).

Table 15.2. Ireland 1990-2000. Drug-related death²⁸. Under 20 years olds and Total. Numbers

Age (years)	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
<15	0	1	0	0	0	0	0	0	0	0	0
15-19	3	0	1	3	3	5	8	15	8	10	6
Total <20	3	1	1	3	3	5	8	15	8	10	6
% Total	42.9	12.5	7.1	16.7	15.8	11.6	15.1	18.5	8.2	8.8	5.0
Males	2	1	1	3	3	5	6	12	5	7	6
Females	1	0	0	0	0	0	2	3	3	3	0
Total all ages	7	8	14	18	19	43	53	81	97	114	119

Source: Central Statistics Office (Personal Communication)

The main source of information on drug related death is the General Mortality Register compiled by the Central Statistics Office. The available data show that the total number of deaths over the eleven-year period, 1990 to 2000, increased considerably from 1995 onwards. Deaths among people under 20 years of age peaked in 1997 (N=15), and was almost one-fifth (18.5 percent) of the total number of drug-related deaths. Since then, while drug deaths in general continue to increase, deaths among young people have declined. The vast majority of deaths occur among males in Dublin where the opiate problem is concentrated (Moran *et al.* 2001).

15.2b) Hospital emergencies

A study of case notes of accident and emergency admissions to a regional hospital in the mid-west of the country was carried out over the three-month period, December 2001 to February 2002 (Mid-Western Health Board 2002). The findings showed that admissions were mainly alcohol related.

Fifty-five children between 10 and 18 years of age were admitted for drug/alcohol related problems²⁹. Most admissions were at weekends – Friday, Saturday or Sunday. In over a quarter of cases (n=17) deliberate self-poisoning was the main reason for admission; another quarter (n=14) were found collapsed or unconscious. In 37 cases *alcohol only* was involved; alcohol *and* drugs in 8 cases; and *drugs only* in 15 cases. After alcohol the types of drugs involved were mainly benzodiazepines (n=7); opiates (n=6); and paracetamol (n=6). Cocaine was involved in 2 cases, as was ecstasy.

No national information is available on substance related hospital emergencies.

15.2c) Driving accidents

It has been suggested that alcohol is a factor in 20 percent of serious and fatal road accidents in Ireland (Department of Health 1996). In 1998 Ireland ranked ninth out of the 15 EU Member States for road fatality rates, at a rate of 12.4 per 100,000 population. The EU average was 9.8 per 100,000; ranges were from 6.0 in Sweden and UK, to 22.4 in Portugal. Intoxication is one of the primary contributory factors to road traffic accidents in Ireland (Cusack 2001).

²⁸ A drug-related death is defined here as one where the underlying or external cause of death was due to drug dependence (ICD-9 Code 304) or opiate poisoning (ICD-9 Code 965.0)

²⁹ Total admissions in the study period were 12,176 of which 549 (5 percent) were alcohol and/or drugs related.

The *Road Traffic Act, 1994* prohibits driving under the influence of an intoxicant (alcohol³⁰ and/or drugs). The number of requests by the police, under this legislation, for analysis of the presence of drugs in blood and/or urine specimens is increasing each year and a very high percentage of positives are found (Flynn *et al.* 2001). Polydrug use is frequently indicated in these data. Sixty-six percent of the confirmed specimens contained two or more drugs: cannabis, amphetamines and benzodiazepines were the most frequent drug groups found; cocaine was found least (*ibid.*).

Unfortunately none of this information is broken down by age, so it is not possible to examine the involvement of young people.

15.2d) Demand for treatment

The high rates of drug use among young people in Ireland is reflected in increases in the numbers seeking treatment for problematic drug use. Smyth and O'Brien (in press) looked at the profile of adolescent drug users attending treatment services in Dublin between 1990 and 1999. They examined differences between young people and their adult counterparts, and explored temporal changes in the profile of the adolescent drug takers. As a group of young drug users causing most concern, adolescent heroin users were specifically studied to identify the characteristics that distinguish them from adult heroin users. The study showed that very substantial numbers of children (under 18 years of age) presented for treatment of problematic drug use during the 1990s.

One-fifth of all those who sought treatment for the first time ever between 1990 and 1999 were under 18 years of age. There was a sharp increase in the number of young people between 1994 and 1997 (*ibid.*). The main drug of misuse was an opiate in nearly half (48 percent) of cases. Compared to adults, the children who received treatment were more likely to be female, especially where heroin was the main drug of misuse. Although the number of boys exceeded the number of girls throughout the study period, the proportion of females increased as the decade proceeded. The majority of both adults and young drug users were living with their family of origin. Though most children were living in the parental home a substantial and growing minority of them were homeless. Children were more likely than adults to be homeless. The fact that they are a sub-group of people with the greatest range of problems, and are difficult to reach and to retain in treatment, presents serious implications for the health and well-being of this group of young people (*ibid.*).

The pattern of drug use among the general population of young people is quite different from that of those attending treatment services. In the general population cannabis is the drug most widely used, whereas the majority of those presenting for treatment reported that heroin was their primary drug. A worrying trend demonstrated by Smyth and O'Brien indicates that the age of initiation into heroin use dropped steadily during the 1990s, and the delay before entering treatment increased. They also identify the increase in the proportion of injectors after 1997 as a cause for concern. This concern had previously been expressed in a number of studies. A study of heroin smokers found that the mean age of first heroin use was 16.9 years and that one-third of them had smoked heroin for the first time to *come down* off ecstasy (Keenan 1999). The pattern of heroin use among young clients in Dublin during the early 1990s was characterised by the emergence of chasing the dragon (Smyth *et al.* 2000). The concern, that the greater acceptability of heroin chasing might attract increasing numbers to heroin use, was justified, when it appeared that heroin users initially reluctant to inject, are more likely to do so once their heroin use has become habitual (Smyth *et al.* 2000, O'Brien *et al.* 2001). An analysis of 15-19 year old first attenders at the Dublin Needle Exchange between 1990 and 1997

³⁰ Blood alcohol concentration levels to a maximum of 80 mg% (80 mg of alcohol per 100 ml of blood)

noted an increase in young injectors, particularly young females (Mullen and Barry 2001). The proportion of young females involved in high-risk sexual behaviours was significantly higher than for males. A study of new attendees at a large drug treatment service in Dublin found that among those under 18 years of age the prevalence of hepatitis C antibodies was 53.2 percent (Smyth *et al.* 1998). The prevalence of such high-risk behaviours has very serious implications for the future health and welfare of this population of young drug users, particularly in relation to the transmission of infectious diseases such as hepatitis C and HIV.

The National Children's Strategy (2000) has identified the need for specialist adolescent addiction services in view of the different needs of people in this group.

15.3 Demand and harm reduction responses

Drugs are a part of many young people's lives and they '*are surprised by the lack of understanding many adults have of the drugs scene and drug using, and indeed focus on this ignorance of their social world in order to further distance themselves from adults in general and prevention efforts in particular*' (Nic Gabhainn and Comer 1996, p. 5). Current drug prevention strategies are deemed irrelevant because they do not reflect young people's realities. The importance of taking young people's perceptions into consideration when devising prevention programmes is identified in a qualitative study of adolescent drug use in the north east of Ireland. It concluded that '*the views of and ideas of young people should form an integral part of future drug strategies*' (Department of Public Health 1999, p.58). In devising prevention programmes it is important to look beyond stereotypes and not to rely on media-fed explanations of the phenomenon (Nic Gabhainn and Comer 1996).

15.3a) Prevention programs and campaigns

The Young People's Facilities and Services Fund was established by the Government in 1998, with the specific objective of funding the development of youth recreation and sport facilities in disadvantaged areas. The aim is to encourage at-risk young people to participate in healthy activities, and thereby divert them from becoming involved in substance misuse.

Several prevention programmes are provided in the school setting to educate young people to accept responsibility for their own health and behaviour, and to increase awareness of drug use issues. Examples of these are, *The Awareness FC Drugs Prevention Programme*, *The Changeling Project*, *On my Own Two Feet*, *The Healthy Schools Project*, and *The Give Kids a Choice Project*. There are also many community youth programmes, outside the school setting – *The FAN Project*, *The Clondalkin Teen Counselling Project*, *The STAY Project* – aimed at young people at risk of becoming involved in drug misuse or crime. Further information on the aforementioned programmes, as well as many others, is available on the EMCDDAs EDDRA database³¹.

Health education and mass media campaigns do not seem to be very effective in preventing the use of illicit substances. Dorn *et al.* (1990) found that education in schools increased knowledge about drugs but not attitudes or behaviour. They concluded that education has had but a minor impact on adolescent alcohol or drug use, and that media campaigns are often exercises in propaganda.

Young people tend to gravitate towards those involved in activities they perceive as desirable, and they actively seek out other young people who will support their efforts to try drugs (Nic Gabhainn and Comer 1996). In recent years in Ireland some emphasis has

³¹ <http://www.reitox.emcdda.org:8008/eddra/>

been placed on understanding the context of drug use. Local drug task forces have been appointed and services are provided in areas where particular needs are identified. Local community groups are now more involved in the structural and organisational implementation of drug policies than heretofore (O'Brien and Moran 1998).

In an effort to move away from traditional prevention approaches such as 'Just say No' to drugs, a new programme was recently launched. The *Natural High Campaign* aims to give young people an alternative to alcohol and drugs and to prevent early school leaving. Young people 'at acute risk' of becoming involved in drug misuse will be assigned specially trained mentors who will work with them in their homes, over a period of six months, to encourage them to improve their life skills and to partake in healthy activities. This will be done with the support and co-operation of other family members.

15.3b) Specific harm reduction interventions in parties, techno scene, including pill testing

In recent years the internet is being used as a harm reduction intervention in the club scene, to provide information to young people on the hazards of alcohol and drug use. An innovative website³² was launched in 2001 by a voluntary organisation, Merchants Quay Project. It contains information and advice on drug use, and is aimed at clubbers.

Sound Decisions, established in the north east of the country (see EDDRA database for further information of this project), targets nightclub and disco staff as well as young people attending discos and nightclubs (Moran *et al.* 2001). The main objective is to raise awareness of the dangers of drugs among clubbers and nightclub staff, and to increase the competence of the latter in dealing with drug-related issues.

No drug/pill testing services are offered in the party/dance scene in Ireland.

15.3c) Other demand reduction responses

An innovative project in the west of the country – the *Health Advice Café* – aims to fill a gap by providing a combined prevention and direct-access health service for young people (Walsh 1999). Self-determination for young people with support and guidance from project workers, is the goal of the project. This will be achieved by offering a range of services contacts and facilities for young people linking many services with one central venue.

The *Copping On Programme* is a national crime awareness programme targeted at early school leavers and young people at risk (Moran *et al.* 2001). It focuses on personal development; on drugs and alcohol; and on understanding the criminal justice system.

A government-sponsored website³³ offers young people information on the hazards of alcohol and drug use.

15.4 Methodological information

15.4a) Limits in data available

Most survey work carried out in Ireland to date among young people has been among school populations and at regional levels, and on an ad hoc basis. The surveys vary in a number of ways – objectives, methodologies, focus of data collection, questionnaire design, age groups studies etc.. Differences in theoretical approaches, for example health promotion, health behaviour, education, prevention, problem drug use behaviour, reflect

³² <http://www.clubscene.ie>

³³ <http://coolchoices.ie>

the different perspectives of the institutions/researchers involved. This affects interpretations of survey results and can preclude meaningful comparisons. Therefore any comparisons made are tentative and should be viewed with the numerous variations borne in mind. Surveys among the general youth population are very rare. Therefore information about alcohol and drug use among groups of young people most at risk – early school leavers, homeless, ethnic groups – is virtually impossible to find.

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16. Social exclusion and re-integration

16.1 Definitions and Concepts

16.1a) Concepts and definitions used in this country

The term *social exclusion* has increasingly appeared in discussion on social policy issues in Ireland in recent years. It has generally been interchanged with reference to poverty and in most cases has embraced the relational aspects of poverty. Helen Johnson, Director of the Combat Poverty Agency has highlighted some of these relational aspects as follows:

'...inadequate social participation, lack of social integration and lack of power...' (Sharing in Progress: National Anti-Poverty Strategy 1997)

In extending further the links between poverty and social exclusion, the National Anti-Poverty Strategy (NAPs) in Ireland offers the following definition that embraces the concepts, poverty and social exclusion.

'People are living in poverty, if their income and resources (material, cultural and social) are so inadequate as to preclude them from having a standard of living which is regarded as acceptable by Irish society generally. As a result of inadequate income and resources people may be excluded and marginalised from participating in activities which are considered the norm for other people in society'. (ibid, p.30)

The NAPs agreement is a product of the partnership approach that from 1996 onwards sought to give equal attention to matters of poverty and social exclusion, in addition to the concerns of the business and trade unionism. A forerunner of the NAPs, the National Partnership agreement that was developed from 1996 onwards produced Partnership 2000, a document that has offered the most utilised definition of social exclusion in Irish social policy. Accordingly, Partnership 2000 defines social exclusion as

'Cumulative marginalisation from production (unemployment), from consumption (poverty), from social networks (community, family and neighbours), from decision making and from an adequate quality of life.'. (Department of An Taoiseach 2000, p. 12)

This definition became the guiding light for policy development on social exclusion issues within the framework of the National Development Plan (NDP) (2000). Its inclusion in the NDP can be interpreted as an indicator of its usefulness as a definition, given that the NDP is the key policy document for the social and economical development of Ireland over the next number of years. Indeed the NDP includes a series of commitments to tackling drug-related issues under the social exclusion banner. (See section 16.1b, next)

16.1b) Issues arising or discussed in this country regarding social exclusion/inclusion in relation to drugs

In 1996, the drug policy of the Irish government recognised the link between poverty and spatial concentrations of serious drug problems. The recognition was based on the acceptance that:

'there is a high correlation between the areas where the [drug] problem is most acute and the areas which have been designated, on the basis of objective criteria, as economically and socially disadvantaged under the Operational Programme for Local Urban and Rural Development 1994-1999'. (Department of An Taoiseach 1996, p. 27).

Since then, there has been a consistent attempt by Irish policy to examine drug-related issues within a social context, with particular emphasis on the relationship between drug use and issues around social exclusion. The key policy frameworks underlying actions in this area, are the National Development Plan (NDP), the Programme for Prosperity and Fairness (PPF) and the National Anti-Poverty Strategy (NAPs).

The NDP acknowledges the linkage between social exclusion and drug use, in particular where these issues can impact on vulnerable social groups such as those involved in crime, the unemployed and young people. For example, in Chapter 10 'Promoting Social Inclusion'. Under the heading 'Crime Prevention' the NDP promises

'provision within the community, of work and skills training, work placement and personal development services including alcohol and drug abuse programmes to offenders to enhance the potential for reintegration into the community' (NDP 2000, p. 194)

In addition, under the heading 'Youth Services' the NDP aims to *'Support the personal and social development of young people so as to prevent them drifting into substance abuse, unemployment and crime'*. (NDP 2000, p. 194) To this end, the NDP promises to spend a sum of €383.9 million on a number of proposals. Included in these proposals are:

- The provision of funding to the Young People's Facilities and Services Fund to support the development of youth facilities and services in disadvantaged areas experiencing, or at risk of experiencing, significant drug problems;
- Funding for Special Projects for Disadvantaged Youth aimed at facilitating the development and social education of youth at risk of drug abuse, juvenile crime, homelessness, early school leaving and marginalisation;
- Establishment of early intervention programmes and substance abuse awareness programmes for young people who are at risk of early school leaving and have low educational achievements.

Under the heading 'Services for the unemployed' the NDP states *'there will be a particular focus on the integration of ex-drug users and prisoners, both of which present particular challenges and require particular intensive intervention'*. (NDP 2000).

The PPF (2000) which is a key national document in terms of developing and maintaining the partnership model between business, the trade unions and community sector representatives includes a number of commitments in the drug area. Namely:

- Local Drugs Task Forces will continue to be funded to undertake initiatives to combat drugs misuse in their areas. In addition, funding will also be provided to urban areas outside the local drug task forces where an emerging drug problem is evident.
- Funding will be provided from the Young People's Facilities and Services Fund for the provision of facilities, and through support services for young people at risk of becoming involved in drug misuse.
- Subject to the evaluation of the pilot phase of the project, the Springboard Initiative under the aegis of the Department of Health and Children will provide funding for projects to support vulnerable families and children.
- The overall operation of the National Drugs Strategy will be reviewed and evaluated in the period of this programme. As the number of drug misusers taking treatment increases, the requirement to provide training and employment opportunities to assist them towards a full recovery will also increase. In the context of the review of the National Drugs Strategy, workplace initiatives dealing with drug misuse will be considered.

The above commitments are included under the Operational Framework III: Social Inclusion and Equality (Urban Disadvantage).

In addition, the Partnership 2000 programme stresses that

'the tackling of the drugs problem will be an urgent priority under this Partnership. This will reflect a vigorous approach to both the supply and demand dimensions of the problem'. (PPF 2000, p. 21).

Partnership 2000 also draws attention to the links between social exclusion and drug use by warning of dangers posed to society by an ignorance of such a link.

'To minimise or ignore this challenge [of social exclusion] will not only result in an increase in social polarisation... but also an increase in all the attendant problems such as poor health, crime, drug abuse and alienation which impose huge social and economic costs on our society'. (PPF 2000, p.12)

16.1c) Groups seen as particularly vulnerable regarding drug use

Homeless drug users have been identified as a particularly vulnerable group of individuals. In Ireland the vast majority of homeless drug users are located in Dublin, an area covered by the Eastern Regional Health Authority (formerly known as the Eastern Health Board-EHB). A working group under the auspices of the Eastern Health Board in 1999 examined the issue of Homelessness in the region with a view to drawing up plans to meet the needs of homeless groups. (Kane *et al* 1999) Homeless drug misusers were identified, as a specific category with specific needs. The Eastern Health Board outlined a number of services that were required to meet the needs of this group. Namely:

- Improved access to drug treatment and rehabilitation projects
- A methadone bus to be made available to all hostels and day care centres to accommodate the mobility of homeless drug users
- Drug and alcohol counselling, needle exchange programmes and the provision of 'sharp bins' in designated outlets
- Special training for hostel and emergency accommodation staff in order to equip them with the skills necessary to deal with the needs of homeless drug users
- Improved access to hostels and emergency accommodation

Houghton and Hickey (2000) in their study of households that were placed in emergency B&B accommodation in Dublin in 1999 by the Housing Policy Unit (HPU), looked at the reasons households gave for becoming homeless. The study found that following family conflict, the next most commonly cited reason was drug addiction (14.4%), and this was particularly acute among single adults. Of these single adults, 38.1% of 18-25 year olds and 26.4% of 26-40 year olds cited drug addiction and drug related problems as the primary reason for their homelessness. The authors suggest that

'the high levels of drug addiction indicate that more than "bricks and mortar" is needed to assist this group of homeless households' (Houghton and Hickey 2000, p. 15).

Children experiencing homelessness and using illicit drug use are a particularly vulnerable group, within the drug use-homelessness remit. Data collected from children (primarily under 18s) presenting as homeless to Health Boards during the year 2000 shows that from 588 cases of homeless children dealt with by the Health Boards in 2000, 45 reported personal use of drugs/alcohol as the primary reason for becoming homeless, while 30 reported their parents abusing drugs/alcohol as being the primary reason for their homelessness (Youth Homeless Strategy 2001, p. 12).

Sex workers (both male and female) in Ireland are another group identified as being vulnerable to experiencing social exclusion through their drug use. Crowley and O'Sullivan (1998), when looking at prostitution in the Mid-West region of Ireland, found that '*alcohol, drug abuse and addictions*' (1998, p.3) were factors influencing involvement in prostitution.

Homeless ex-prisoners have been identified as a particularly vulnerable group regarding drug use. Research (Hickey 2002), using structured questionnaires, carried out with 46 individuals (14 female, 32 male), who were both homeless and had experienced periods of imprisonment, revealed that current and past drug use among this group was quite high. For example, 31 respondents reported current use of illegal drugs, with 68% of current users reporting polydrug use.

16.2 Drug use patterns and consequences observed among socially excluded population

16.2a) Prevalence of drug use and problematic drug use amongst specific socially excluded populations

Study	Socially excluded population	Prevalence of Problematic Drug Use	Lifetime Prevalence of Drug Use
Smith <i>et al</i> (2001)	Homeless Women	(heroin) 47%	64%
Condon <i>et al</i> (2001)	Male and Female Adult Homeless	(heroin) 18%	38%
Holohan (1997)	Male and Female Adult Homeless		29%
Corr (1999)	Homeless Adult Men		51.4%
Feeney <i>et al</i> (2000)	Homeless Adult Men		80% (18-34 year olds) 55% (34-54 year olds) 12% (55+)
O'Mahony (1987)	Prisoners		(Estimated) 170 ' <i>serious drug abusers</i> ' ³⁴ in Mountjoy Prison in 1986
Hickey (2002)	Homeless ex-prisoners (n= 46)		91.3% (ever used) 67.3% (currently using)
Allwright <i>et al</i> (1999)	Prisoners (n=1,205)	(opiates 52%)	
Carmody and McEvoy (1996)	Female prisoners (n=100)	(opiates 57%)	
O'Mahony (1993)	Male prisoners (n=95)	(opiates 32%)	
O'Mahony (1997)	Male prisoners (n=108)	(opiates 66%)	

³⁴ *Serious drug abuse was defined as the use of a drug on more than six occasions, other than alcohol, tobacco, prescribed medication and cannabis*

Long <i>et al</i> (2000)	National survey of committal prisoners (n=607)	(opiates 35%)	
Hannon <i>et al</i> (2000)	National survey of prisoners (n=777)	(opiates 32%)	
Dillon (2001)	Prisoners (n= 29)		58.5% reported currently using drugs 27.5% reported history of use but not currently using
O'Mahony and Gilmore (1983)	Prisoners (n=22)	(opiates 73%)	

Table 16.2. Drug Use by Homeless Women (n=100)

Drug Type %	Lifetime Use %	Currently misusing %	Currently prescribed %
Heroin	47	30	
Methadone	48	1	45
Cannabis	44	41	
Ecstasy	36	12	
Sleeping Tablets	45	27	35
Cocaine	21	9	
Psychedelics	22	5	
Anti-depressants	54	12	44
Tranquillisers	52	25	23

Source: Smith, M., McGee, H., and Shannon, W. (2001) One Hundred Homeless Women: Health Status and Health Service Use of Homeless Women and their Children in Dublin. Dublin: Health Services Research Centre, Department of Psychology and the Department of General Practice, Royal College of Surgeons Ireland

Note: Currently misusing was defined as use in the previous 12 months.

Serious drug abuse was defined as the use of a drug on more than six occasions, other than alcohol, tobacco, prescribed medication and cannabis

16.2b) Patterns of use

Study	Sample	Drugs Used	Route of Administration
Feeney <i>et al</i> (2000)	homeless men living in hostels in Dublin (n=171)	Cannabis 51% Benzodiazepines 21% Cocaine 20% Heroin 18%	12% reported intravenous drug use
Hickey (2002)	homeless ex-prisoners (n=46)	Benzodiazepines Sleeping tablets Cocaine Heroin in conjunction with methadone and cannabis (polydrug use)	Intravenous drug use (heroin)
Smith <i>et al</i> (2001)	Homeless women (n=100)	Heroin Methadone Cannabis Ecstasy Cocaine Psychedelics Anti-depressants Tranquillisers	Intravenously using heroin, orally taking other drugs

O'Mahony (1997) found that among prisoners in Mountjoy Prison in 1986 who reported 'serious drug abuse',³⁵ 97% of this sample (n=29) reported experience of heroin use. Use of synthetic opiates such as Dicanol, Palfium and Methadone was reported by 73% of the sample. This study also revealed that 25 of the 27 reported opiate users indicated that they took the drug intravenously, while 79% of the total sample reported daily intravenous use of opiates.

In a study of *Out of Home Drug Users* (Cox and Lawless 1999), 190 individuals attending the Merchants Quay Contact Centre³⁶ over a five-day period in February 1999 were asked to complete a 'screening questionnaire'. This research instrument was employed to ascertain the living arrangements of respondents and their drug use status in order to identify those who were homeless and active drug users at that time. Of the 120 who identified as being an active drug user and homeless, 53 (62% male and 38% female) agreed to complete a second questionnaire which was designed to collect data on current accommodation, history of homelessness, drug use risk behaviour, health and well being.

For the purpose of the study homelessness was defined as being '*currently staying in any of the following: hostels, B&Bs, squats, sleeping rough or staying with friends or relatives*' (Cox and Lawless 1999, p.18). The vast majority of respondents reported using heroin as their primary drug with 98 per cent reporting to be IV heroin users. Female respondents were almost twice as likely to report using their primary drug four or more times daily, with males more likely to report using their primary drug less than once a week. Just over 30% of male and female respondents reported to using their primary drug on a daily basis. Sixty-one per cent of respondents reported polydrug use, with 52% of these reporting injecting their secondary drug. Respondents reported using heroin, marijuana, phsyseptone, benzodiazepines and cocaine.

Corr (1999) looked at the health status and health care access of single homeless men living in hostels in Dublin. The research was conducted in three hostels in Dublin through an interviewer-administered questionnaire. A total of 172 questionnaires were completed for the study. The study included questions on lifetime drug use, current drug use and drug dependency. Out of the sample, 54.1 per cent reported lifetime usage of drugs with 75 per cent of those reporting lifetime usage reporting drug use in the previous 12 months (current drug use). Dependency was measured by 'taking any of the drugs every day for two weeks or more in the last twelve months'. Among current users, 58.6 per cent were categorised as dependent on drugs. The study also noted a high prevalence of risk factors among the sample such as cigarette smoking, 'heavy' alcohol use and, of course, drugs. In terms of the drug being used more recently (in the previous 12 months), cannabis, tranquillisers and heroin were the 'most popular drugs' among the sample.

16.3 Relationship between social exclusion and drug use

16.3a) Indicators of social exclusion amongst specific populations of drug users, in comparison with the general population

It can be argued that the development of indicators of social exclusion amongst populations of drug users in Ireland is in its infancy. To date it cannot be established if any research has been carried out in pursuit of developing indicators. However, from the literature reviewed during this discussion, a number of factors can be identified that expose drug users to a greater risk of experiencing social exclusion, in contrast to the general population.

³⁵ Serious drug abuse was defined as the use on more than six occasions of a drug other than alcohol, tobacco, cannabis or prescribed medication

³⁶ Merchants Quay Contact Centre provides a first point of contact for active drug users seeking to avail of harm reduction strategies, information and support.

Drug users tend to experience the following in greater levels than the general population:

- Unemployment/Recurrent unemployment
- Resident in a council/local authority housing development
- Early-school leaver (before 15)
- No formal/mainstream educational qualifications
- Experiences homelessness
- Father's occupation – unskilled/labourer
- A term of imprisonment

It must be noted that the above factors are merely suggestions regarding the possible areas that the development of indicators may derive from. Research is needed to examine the feasibility of such factors as to their applicability to the phenomenon of social exclusion.

16.3b) Data from research on social exclusion and drug use

Study	Drug use as a risk factor in social exclusion
Halpenny <i>et al</i> (2002)	For some families in emergency accommodation in Dublin, addiction was reported as being a contributory factor to their becoming homeless
Hickey (2002)	From a sub-sample of 46 homeless ex-prisoners reporting current and lifetime drug use, 37 (88%) perceived that their criminal behaviour was directly linked with their drug misuse. 95% of this group reported that their crimes were committed in order to finance their drug 'habit'.
Perris (1999)	This study explored youth homelessness in Clondalkin, a large Dublin suburb, sample 35, age range 14–24, out of home for previous 12 months. Over 50% reported drug use as a contributing factor to their homelessness. However, two points worth noting about this finding are (a) slightly more females than males reported drug use as a contributory factor to their homelessness, and (b) for some of the respondents, citing drug use as a factor in their homelessness may have been explained by the drug-using behaviour of a parent or sibling.
Social exclusion as a risk factor in using drugs	
Cox and Lawless (1999)	This study looked at the impact of homelessness on drug use. 66% of respondents reported changes in drug use since becoming homeless, e.g. more frequent and more erratic drug use; 66% reported injecting in public places; 49% reported sharing injecting paraphernalia; 24% reported borrowing used injecting equipment; 49% reported never using a condom during sexual activity; 44% reported that they had been the victims of a crime since becoming homeless. A range of physical and mental complaints were attributed to their homeless status
Hickey (2002)	Both housing and drug/alcohol problems were reported to be the 'main difficulties' experienced by ex-prisoners, with 79% female and 76% male indicating housing as their main difficulty and 43% female and 38% male noting drug/alcohol problems as their main difficulties.

However, this study also picked up on the '*community difficulties*' that respondents experienced and felt contributed to their being homeless. Some respondents mentioned being '*harassed*', while others were unspecific in their descriptions. Perhaps it could be the case that the Housing (Miscellaneous Provisions) Act) 1997 was also a contributory '*structural*' factor. Under the anti-social legislation there is scope for '*community difficulties*' to be played out.

Smith, McGee *et al* (2001) found that of the 47 respondents who reported to ever using heroin, 39 reported injecting, with 22 reporting injecting in the past 12 months. Thirteen respondents reported having ever shared a needle, and all 13 reported sharing in the previous 12 months.

16.4 Political issues and reintegration programmes

16.4a) Policies around social exclusion issues and implications for responses to social exclusion

It could be argued that one of the strengths of seeing the drug problem as being influenced by social conditions, is that in responding, the emphasis is as much on society as on the individual engaged in drug misuse. In terms of Irish society, in recent times the response has been to counteract the negative effects of social exclusion by focusing on the merits of social inclusion. A particular model of partnership has underpinned this move towards a more socially inclusive socio-cultural framework in the drug field. This has manifested itself, whenever possible, in promoting a co-ordinated approach between the statutory, voluntary and community sectors in pursuit of creating the social conditions that will enhance the chances of those involved in drug misuse to rehabilitate and reintegrate as far as possible into mainstream society. Much of this activity has taken place within a policy framework greatly influenced by the idea that it is necessary to support social inclusion initiatives if marginalised groups such as drug users are to be reintegrated. For example, the Cabinet Committee on Social Inclusion, as part of its wide remit, has political responsibility for reviewing trends in the drugs problem, for assessing progress in implementing the National Drugs Strategy and for resolving policy or organisational difficulties, which may inhibit effective responses to the problem.

The Irish Government's Cabinet Committee on Social Inclusion is chaired by the Taoiseach (Government Leader) and comprises the Tánaiste (Deputy Leader) and relevant Ministers. As part of its wider remit in relation to social inclusion, this Committee has political responsibility for reviewing trends in the illegal drugs area, assessing progress in implementing the National Drugs Strategy and resolving policy or organisational difficulties that may inhibit effective responses to the problem. The Minister of State at the Department of Community, Rural and Gaeltacht Affairs has been given special responsibility for the co-ordination of the National Drugs Strategy and reports to the Committee on drug issues.

The impact of legislation through the Housing (Miscellaneous Provisions) Act 1997 was assessed by Memery and Kerrins (2000) and provided evidence that there had been an increase in evictions based on drug-related anti-social behaviour by Dublin Corporation since the introduction of the act. These evictions can lead to drug users living on the streets or in hostels with a danger of escalating their drug use, taking more risks around using drugs and sexual activity and becoming marginalised from mainstream society. In addition, individuals from this group can become part of the '*hard to reach*' group of drug users on the streets where failure to link into services becomes the norm.

16.4b) Elements of treatment focusing on reintegration within general drug services

In general, drug treatment services in Ireland are amenable to exploring the process of reintegration with clients. Where possible clients will be referred to or linked in with supporting services that provide elements of the reintegration process. For example, individual drug users availing of methadone maintenance are encouraged to access a special state-subsidised '*Community Employment Scheme for Drug Users*'. This initiative is sponsored by the state training agency FÁS, and offers individuals the opportunity to learn new '*marketable skills*' through participation on training courses.

16.4c) Specific reintegration programmes targeting former drug users

Special attention has been given to the development of '*reintegration*' services for former drug users. However, there is a tendency for service development to amalgamate the goals of rehabilitation and reintegration within the same orientation. For example, the Northern Area Health Board (NAHB) has developed a specific Rehabilitation/Integration Service (RIS) headed by a rehabilitation co-ordinator. The definition of rehabilitation adopted by the NAHB Addiction Services is quite broad. It states:

'Rehabilitation/integration is a structured development process whereby individuals are facilitated in the process of regaining their capacity for daily life from problem drug use. The aim of the process is to empower people to access the social, economic and cultural benefits of life in line with their aspirations. Facilitating individuals to realise their potential to live independently and responsibly is at the core of the Board's rehabilitation/integration programmes'. (NAHB 2002, personal communication)

The RIS is composed of a team consisting of a Rehabilitation/Integration Manager and two Integration workers in each of the five Local Drug Task Force areas within the NAHB. Integration workers will work on a one-to-one basis with drug users on developing individual rehabilitation/integration plans.

The Northside Partnership (2001) identified ex-drug users as one of eleven specific priority groups to be targeted by the various action programmes under the partnership through its Social Inclusion Initiative. The Northside Partnership is an area-based company working in a designated area on the north side of Dublin. The partnership is primarily engaged in combating social exclusion and promoting social integration: the target area comprises over 100,000 people. The partnership has recognised that an estimated 4,000 drug misusers are resident in the partnership area (Northside Partnership 2001).

In response, the partnership has outlined a series of measures that aim to support existing social integration initiatives with ex-drug misusers. In addition, the partnership has developed a number of innovative initiatives that aim to assist ex-drug misusers in the process of reintegration. For example, the Labour-Market Inclusive Project (LIP) is designed to target recovering drug misusers referred by treatment centres. It aims to support participants before and after placement in employment. Additional work with ex-drug misusers will take place through the Targeted Outreach Initiative which aims to make contact with ex-drug misusers who are not contactable through treatment centres; and the Business Network Initiative which comprises of local business contacts that work to reintegrate.

The Merchant's Quay Project (MQP), in its capacity as a drug service provider, identified the need for a programme that would assist former drug users who had completed residential treatment to gain entry to the mainstream employment market. The needs of this client group were given priority because the lack of employment opportunities had been identified as a factor contributing to the relapse of former drug users. In response to this gap in service provision, the MQP, with initial funding from the EU Integra project, established the reintegration programme '*From Residential Drug Treatment to Employment*' in September 1997.

The work with former drug users comprises two six-week phases. Phase one, the residential phase, focuses on enabling clients to 'let go' of the therapeutic environment that many had just left and to facilitate movement back into the community. The second phase concentrates on obtaining employment/job placements or educational opportunities. During this phase clients are also encouraged to give at least one day a week to personal matters such as housing and social welfare issues and to maintaining links already forged. The programme is underpinned by the belief that clients' needs are best approached in a holistic manner.

The Linkage Programme was established as a joint initiative between Business in the Community Ireland (BITCI) and the Probation and Welfare Service, to provide training and employment opportunities for young offenders. The programme recognises the strong links between social exclusion, unemployment, crime and substance abuse and the presence of these factors in the lives of young people who offend.

The primary objective of the Linkage Programme is to place individuals in work. Critical to the success of the project is matching the people to the job market. Training and Employment Officers are employed by BITCI to support the Probation and Welfare Service, by placing young people who offend in employment, training and/or education. To date, the response to the programme has been positive. Key employers from the industrial and services sectors are already successfully employing people who have been placed by the programme. Employer bodies such as IBEC, SFA, CIF and the Chambers of Commerce have been particularly helpful in this regard. Since its inception in February 2000, the Linkage Programme has successfully placed over 600 people in employment and training.

In addition to the above, a range of programmes operating under the Local Drug Task Forces and through the voluntary and statutory sectors are primarily aimed at providing some form of rehabilitation/reintegration to former drug users. In some cases the rehabilitation/ reintegration aspect would be part of a larger programme. For example:

- Soilse Project
- HYPER Project
- Pathways Project
- Tower Project
- Fettercairn Drug Rehabilitation Project³⁷

16.4d) Results from outcome evaluation

Merchant's Quay Reintegration Programme

An evaluation of the Merchant's Quay Reintegration Programme found that there was a good deal of success in reaching the target group, with 49 client admissions over a two-year period in 1998–99. In particular, the programme has attracted female clients, with 31 per cent of clients being female. Sixty-five per cent of admissions have completed the programme. For the year 1999, 94 per cent of those who embarked on job placement completed the task. While 83 per cent secured full-time employment and 13 per cent went on to pursue full-time educational opportunities. Of those participants surveyed in 1999, 94 per cent reported that they had acquired important new skills, while 65 per cent indicated that existing skills had been improved. A majority of participants during 1999 reported that relationships with family and friends had improved. Eighty-nine per cent of clients agreed that the programme provided the necessary skills to avoid relapsing into drug use. The programme also ran a drug education course for state training agencies. All participants

³⁷ For further information on these interventions see the EDDRA database

reported positive changes, with many reporting less anxiety at the prospect of dealing with former drug users in the future. Also they reported that they now had a greater understanding of the reasons why some people turn to drugs and the consequences that ensue. A majority of employers who accepted clients on work placement reported that they rated the work by former drug users as either good or very good. All employers noted that clients were very energetic and highly motivated.

HYPER

A core group of six participants were with the project for between five and eleven months. This was a significant period of time, when viewed in contrast to the length of time spent on mainstream FÁS training courses, which is usually around six months for individuals in the general population. During this time on the HYPER project all participants were stable, drug free and worked very well together. A year after completing the HYPER project it was known that five out of the core group of six who had participated on the programme were still drug free and one had re-engaged with another rehabilitation service, having suffered a relapse. This would suggest that the skills learned through the medium of magazine production assisted the process of rehabilitation to some extent. Rehabilitation in this context being the ability to remain drug free during and following participation on the project.

The magazine won the Total Publishing Award 1999 (UK) for design innovation of the year. Total publishing had this to say about HYPER:

'...Not only has HYPER trained a team of young, former drug users to produce a magazine which makes good use of their experiences in tackling drug and health related issues, but it has also resisted the temptations to patronise its readers to use shock tactics. HYPER, the judges felt, is a good example for an imaginative health agency using an innovative publication to put across its point of view'. (Total Publishing 1999).

In one-to-one in-depth interviews the evaluator found that six out of seven respondents of the core group that participated on the course expressed their enthusiasm regarding what the course had to offer and reported a number of benefits they received from being on the project. For five out of seven respondents the chance to write for a magazine opened up new vistas for them. Respondents also noted the therapeutic nature of writing about their experiences with drugs and they also expressed a deep pride about the publication of the magazine and the fact that they won an award for their work. They were proud of the skills they had learned and, in addition, they felt that their families were very proud of their achievements. Respondents also noted the security and support they felt on the programme, which gave them space to handle aspects of their addiction. They also reported that the project gave them the opportunity to explore their potential and the routine of the programme helped them to stay off drugs. All staff interviewed identified the production of the magazine as being effective in developing technical skills, e.g. photography and IT skills. Staff noted that participants picked up other skills, including creative writing, interpersonal and communication skills and assertiveness.

Five issues of the HYPER magazine were published during the pilot phase of the project and each was received with widespread interest. HYPER was distributed to secondary schools, primary schools, colleges, Local Drugs Task Forces, regional and national youth services, drug services, prisons and youth detention centres. The print run stood at 13,000 copies at time of evaluation (March 2000). All staff interviewed expressed the view that the production of the HYPER magazine had fulfilled one of its key functions, which was to act as a vehicle in promoting drug awareness and recovery among peers. HYPER staff reported that certain secondary schools are using the magazine as part of Leaving Certificate Social Studies classes. In addition, Social Studies students in college have also contacted the project about using the magazine as a research resource.

There were three aspects of the HYPER project that staff and participants noted as being beneficial to the developmental needs of participants. These were the personal development of participants, the building of peer networks around participants and the provision of recreational activities for participants. Most of the staff reported to the evaluator that the Personal Development Module was very beneficial to participants. In particular, group work and personal development involved learning to trust, being honest, learning to listen and dealing with conflict – skills that were undeveloped to large extent in the lives of participants. The project sought to contribute to building peer networks when possible and most of the staff reported that among the core group of participants there was a very strong dynamic and that they were very supportive of one another. Staff members reported the undoubted benefits of the recreational component of the project, in terms of team building, health and hygiene. Sports and outdoor activities are essential means of re-introducing recovering addicts to social activities that are not based on drink or drugs.

16.5 Methodological information

16.5a) Bibliographical references

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Databases/Software/Internet Addresses

Databases used in this report:

- General Mortality Register

Principal Use – Contains data on mortality statistics

Users – politicians, policy makers, police, medical practitioners, researchers, the public.

- Hospital Inpatient Enquiry database

Principal Use – A computer based health information system designed to collect medical and administrative data regarding discharges from acute hospitals (excluding private hospitals).

Users – politicians, policy makers, medical practitioners, hospital and health services staff, researchers.

- National Drug Treatment Reporting System

Principal Use – The national epidemiological database on treated drug misuse in Ireland

Users – politicians, policy makers, researchers, drug treatment services, local drug task forces, the public.

- National Psychiatric Inpatient Reporting System

Principal Use – Provides information on the activities of the inpatient psychiatric service (admissions, discharges and deaths) in Ireland

Users – politicians, policy makers, psychiatric and health services staff, researchers, the public

Software Used:

- Microsoft Word
- Microsoft Excel
- SPSS 11.0 (2001). Statistical Package for the Social Sciences. USA: SPSS Inc.

Internet Addresses

www.addictioninfo.ie - Council for Addiction Information and Mediation
www.aislinn.ie - Aislinn Centre
www.antaoiseach.ie - An Agreed Programme for Government between Fianna Fáil and the Progressive Democrats (June 2002)
www.britishirishcouncil.org - British–Irish Council
www.clubscene.ie - Clubscene / Merchants Quay Ireland
www.coolchoices.ie – Government sponsored – youth website
www.dap.ie - Drug Awareness Programme/ Crosscare
www.dnedrugtaskforce.ie/ - Dublin North East Drugs Task Force
www.druggels.com - Community Based Drugs Initiative/Students
www.drugquest.ie - Drug Awareness Zone for Dun Laoghaire
www.eurad.net - Europe against Drugs (EURAD)
www.gov.ie/crimecouncil - National Crime Council
www.gov.ie/garda - Garda Síochána
www.gov.ie/oireachtas - Dáil Debates Official Record
www.gov.ie/oireachtas - Legislative Information
www.gov.ie/oireachtas - Oireachtas, Houses of the,
www.justice.ie - Justice, Equality and Law Reform, Department of
www.kildare.ie/drugawareness/ - Kildare Drug Awareness
www.mqi.ie - Merchants Quay Ireland (MQI)
www.nacd.ie - National Advisory Committee on Drugs (NACD)
www.pobail.ie/en - Community, Rural and Gaeltacht Affairs, Department of
www.pobail.ie/en/NationalDrugsStrategy - Local Drug Task Forces (LDTFs)
www.pobail.ie/en/NationalDrugsStrategy - National Drugs Strategy
www.pobail.ie/en/NationalDrugsStrategy - Regional Drug Task Forces (RDTFs)
www.pobail.ie/en/NationalDrugsStrategy - Young People's Facilities & Services Fund
www.pobail.ie/en/NationalDrugsStrategy/TheInter-DepartmentalGroupontheNationalDrugsStrategy/
- Inter-Departmental Group on the National Drug Strategy (IDG)
www.pobail.ie/en/RAPIDandCLR - RAPID
www.reitox.emcdda.org.8008/eddra – EDDRA database
www.rutlandcentre.org/ - Rutland Centre
www.usi.ie - Union of Students in Ireland (USI)
www.wheel.ie/commsctr/spokes/addic/spotadd.html - Addiction Spoke

ANNEX

Drug Monitoring System and Sources of information

The core information systems, used to monitor the drug problem and to inform policy making, are in the health and law enforcement areas.

- **National Drug Treatment Reporting System [NDTRS]**

The Drug Misuse Research Division (DMRD) of the Health Research Board (HRB) operates the *National Drug Treatment Reporting System (NDTRS)*. The NDTRS is an electronic database providing information on people who present to drug treatment services nationwide. The data are collected by health services personnel at regional health board level, and are co-ordinated by the DMRD. Data co-ordinators have been appointed at regional level.

- **Infectious diseases data**

The National Disease Surveillance Centre (NDSC) took over statutory responsibility for reporting on sexually transmitted infections (STIs), including HIV/AIDS, from the Department of Health and Children (DOHC) on July 1st 2000. On 1st July 2000, the Infectious Diseases (Amendment) Regulations, 2000 (S.I. No 151 of 2000) came into force. Under these regulations the National Disease Surveillance Centre (NDSC) was assigned responsibility for the collation and analysis of weekly notifications of infectious diseases, taking over from the Department of Health and Children. This includes responsibility for reporting on drug-related infectious diseases. While hepatitis B is a notifiable disease but it is generally accepted that there is under-reporting in Ireland and that the notification system is not a good indication of the true incidence of infection. Furthermore, while data are collected on the number of positive tests carried out for hepatitis B by the Virus Reference Laboratory, no behavioural data is collected and therefore those infected through drug use cannot be identified. There is no routine data collection in the area of hepatitis C. Only total numbers of individuals who test positive in a given year are available- as with hepatitis B it is not possible to identify those who have become infected through injecting drug use.

The most complete data available on drug-related infectious diseases are those on HIV. Up until July 2000, the Department of Health and Children, in collaboration with the Virus Reference Laboratory, was responsible for producing statistics on HIV positive tests which are published every six months. Data on HIV/AIDS are now provided directly to the NDSC by the Departments of Public Health of each health board. In their first six months of data collation (July 2000-December 2000), data were collected by the NDSC in the same manner as previous years. However, in July 2001 a new HIV case-based reporting system has been developed. The aim of the new HIV case based reporting system has been noted as '*to ensure the collection of accurate and complete epidemiological data on the distribution and mode of transmission of HIV infection*' (O'Donnell, Cronin and Igoe, 2001, p. 21). The socio-demographic data that will be collected within this new system are the patient's age, gender, county of residence (if Dublin, then the postal code) and country of birth (if not Ireland then year of first arrival in Ireland). Furthermore, an expanded list of probable routes of transmission is included on the form (for further information see section 3.3 of the report).

- **General Mortality Register**

Data on drug-related mortality are currently obtained from the General Mortality Register operated by the Central Statistics Office. Mortality data are collected by regional Registrars of Births and Deaths, from a number of sources (medical practitioners, police, coroners) and returned centrally to the Registrar General's Office. These data are reported upon (*Report on Vital Statistics*) by the Central Statistics Office (CSO). Data on

drug related deaths are not routinely published. A new development is that the possibility of setting up a Special Register to record drug related death is being explored. This came about as a result of discussions, which took place at Workshops organised by the DMRD, in the context of the harmonisation of key indicators of drug misuse.

- **National Psychiatric In-patient Reporting System**

The *National Psychiatric In-patient Reporting System (NPIRS)*, which provides information on the activities of the inpatient psychiatric service in Ireland, is maintained by the Mental Health Research Division of the Health Research Board. This monitoring system collects data on admissions to and discharges from public and private psychiatric hospitals and units in Ireland. It provides information on the activities of the inpatient psychiatric service (admissions, discharges and deaths). Primary and secondary psychiatric diagnoses are recorded. An annual report provides information on gender, age, marital status, socio-economic group, legal status, diagnosis (ICD-10) and length of stay. A review of changes over time is also provided by the system, from computerised data going back to 1971.

- **Hospital In-Patient Enquiry System**

The *Hospital In-Patient Enquiry System (HIPE)*, records details on discharges and deaths for all acute public hospitals in Ireland. The database is maintained by the Economic and Social Research Institute. It is a computer based health information system designed to collect medical and administrative data regarding discharges from acute hospitals (excluding private hospitals). Data on principal diagnoses and principal procedures performed are collected. Each discharge record represents one episode of care and patients may have been admitted to hospital more than once with the same or different diagnoses. These records facilitate analyses of hospital activity rather than incidence of disease, with information on primary and secondary diagnoses (ICD-9).

- **Central Methadone Treatment List**

The *Central Methadone Treatment List* is a register of all clients who receive prescribed methadone. The information collected consists of:

- the operative/issue date
- client's name
- client's date of birth
- void date
- reason for void.

These data, which are used to avoid duplication of methadone prescription, are confidential and are not published.

- **Police data**

In the area of *law enforcement*, national data are collected by the Garda Síochána and published annually. These data are a reflection of police activity and include the number of criminal charges for drug offences. The published data refer to *drug-related offences* under the Misuse of Drugs Acts where proceedings are commenced. Breakdown is given by drug and whether it was intended for possession or traffick/supply. The data are event-based, individuals cannot be identified so the number of individual persons involved is not known.

Collection of *drug seizures* data is carried out by the Gardaí and the Customs Service. Information includes the quantity (by weight) and the number of seizures of illegal drugs as well as type of drug involved. These data are inter alia a reflection of the activity of the police and the Customs authorities. Methods of detection, for example the number of personnel involved in the detection of such crimes, the availability of detection equipment or sniffer dogs, could influence the consistency of the data over time. Information on drug product purity is collected by the police from seizures of drugs. The *purity of drugs* is analysed by scientists at the Forensic Science Laboratory and tests are carried out on

samples of all products seized, except in the case of cannabis where tests are carried out on random samples of seizures.

Information on the *price of drugs* is collected by the police at street level. The quality of the latter data is difficult to ascertain. Price and purity information is not included in published Garda reports.

- **Prison data**

An annual report of prisons and places of detention is supposed to be produced which includes *data on those imprisoned* under the Misuse of Drugs Acts. However, the most recent statistics providing such a breakdown relate to 1994- from 1995 to date no such data have been produced by this source. Two categories of law offences have been used in the statistics produced up until 1994: sale or supply of drugs; and, possession/production/cultivation/import/export of drugs. These do not correspond with data collected by the Gardaí, as they are categories according to the offence under the Misuse of Drugs Act.

- **National Documentation Centre on Drug Use**

The Government has designated the Drug Misuse Research Division (DMRD) of the Health Research Board as the central point to which all Irish research data and information on drug misuse should be channelled. In order to deliver on this role, the DMRD is developing a National Documentation Centre which policy-makers, service providers, researchers, community groups and the interested public can use to easily access all relevant and up-to-date information and research in the field of drug misuse in Ireland and internationally. The Documentation Centre is due to open in December 2002.

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List of Abbreviations used in the text

A&E	Accident and Emergency
ADHA	Attention Deficit Hyperactivity Disorder
ADM	Area Development Management Ltd
AHB	Area Health Board
AIDS	Acquired Immune Deficiency Syndrome
ARC	Addiction Response Crumlin
B&B	Bed and Breakfast
BITCI	Business in the Community Ireland
BMW	Border, Midlands and Western region
CAB	Criminal Assets Bureau
CAP	Community Addiction Programme
CARP	Community Addiction Response Programme
CASC	Community Addiction Studies Course
CASP	Clondalkin Addiction Support Programme
CCBDI	Clonmel Community Based Drugs Initiative
CDB	County/City Development Board
CDVEC	City of Dublin Vocational Educational Committee
CIF	Construction Industry Federation
CLAD	Carlow Community Awareness of Drugs
COREPER	Committee of the Permanent Representatives (of the member states of the EU)
CSO	Central Statistics Office
DAG	Darndale/Belcamp Drugs Awareness Group
DAP	Drug Awareness Programme
DDRAM	Drug Dependence: Risk and Monitoring
DICE	Drugs Information Community Education Project
DMRD	Drug Misuse Research Division
DofHC	Department of Health and Children
DofTSR	Department of Tourism, Sport and Recreation
DPP	Director of Public Prosecutions
DSM	Diagnostic and Statistical Manual of Mental Disorders
ECAHB	East Coast Area Health Board
ECPT	European Committee for the Prevention of Torture and inhuman or degrading treatment or punishment
EDDRA	European Database of Demand Reduction Activities
EDU	Europol Drugs Unit
EHB	Eastern Health Board
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ERHA	Eastern Regional Health Authority (formerly Eastern Health Board)
ESPAD	European Schools Survey Project on Alcohol and other Drugs
ESSD	European Society for Social Drug Research
EU	European Union
EURAD	Europe Against Drugs
Europol	European Police Office
FAS	Foas Áiseanna Saothair (Training and Employment Authority)
FETAC	Further Education and Training Awards Council
GMR	General Mortality Register (at CSO)
GNDU	Garda National Drugs Unit
GP	General Practitioner
HBSC	Irish Health Behaviours in School Aged Children
HBSS	Irish Health Behaviours Schools Survey
HCV	Hepatitis C Virus
HIPE	Hospital Inpatient Enquiry database

HIV	Human Immunodeficiency Virus
HPU	Housing Policy Unit
HRB	Health Research Board
IBEC	Irish Business and Employers Confederation
ICD	International Classification of Diseases
ICGP	Irish Council of General Practitioners
ICT	Information and Communications Technologies
IDG	Inter-Departmental Group
IDU	Injecting drug user
INCADDs	Irish Council of Attention Deficit Disorder Support Groups
ISP	Integrated Services Process
IVDU	Intravenous drug user
JADD	Jobstown Assisting Drug Dependency
JLO	Juvenile Liaison Officer
KAB1	Drug Related Knowledge, Attitudes and Beliefs, a survey of the general adult population in Ireland, published by the Drug Misuse Research Division
KAB2	An expanded study, following KAB1, to be published by the Drug Misuse Research Division
KDDPG	Killinarden Drug Primary Prevention Group
KDI	Kilkenny Drugs Initiative
KPI	Key Performance Indicators
LDTF	Local Drug Task Force
LIP	Labour-Market Inclusive Project
MBRS	Medical Bureau of Road Safety
LSD	Lysergic Acid Diethylamide
MDA	Methylenedioxyamphetamine
MDA	Misuse of Drugs Acts, 1977 & 1984
MDMA	MethyleneDioxyMethAmphetamine
MHB	Midland Health Board
MP	Member of Parliament
MQP	Merchants Quay Project
MQI	Merchants Quay Ireland
MWHB	Mid Western Health Board
NA	Narcotics Anonymous
NACD	National Advisory Committee on Drugs
NADA	National Association of Detoxification Acupuncturists
NAHB	Northern Area Health Board
NAPS	National Anti-Poverty Strategy
NCDP	National Community Development Plan
NDP	National Development Plan
NDSC	National Disease Surveillance Centre
NDST	National Drug Strategy Team
NDTRS	National Drug Treatment Reporting System
NEP	Needle Exchange Programme
NPIRS	National Psychiatric Inpatient Reporting System
NTORS	National Treatment Outcomes Research Study
NUI	National University of Ireland
NWHB	North Western Health Board
PD	Progressive Democrats
PESAT	European Foundation
PPF	Programme for Prosperity and Fairness
RAPID	Revitalising Areas by Planning, Investment and Development
RASP	Rehabilitation and Support Programme
RDTF	Regional Drug Task Force
REITOX	European Information Network on Drugs and Drug Addiction

RIS	Rehabilitation/Integration Services
S&E	Southern and Eastern region
SAPP	Substance Abuse Prevention Programme
SEHB	South Eastern Health Board
SFA	Small Firms Association
S.P.H.E.	Social, Personal and Health Education programme
SHB	Southern Health Board
SLÁN	Survey of Lifestyles, Attitudes and Nutrition
SMI	Strategic Management Initiative
STD	Sexually-transmitted disease
SVP	Saint Vincent de Paul
SWAHB	South Western Area Health Board
TD	Teachta Dála (Member of Parliament)
UCD	University College Dublin
UK	United Kingdom
UN	United Nations
URRUS	Ireland's Community Addiction
USI	Union of Students in Ireland
VEC	Vocational Education Committee
VIP	Vital Information Pack
WHB	Western Health Board
WHO	World Health Organisation
YPFSF	Young People's Facilities and Services Fund