Ireland: national report for 2015 – Drugs Ireland

Health Research Board. Irish Focal Point to the European Monitoring Centre for Drugs and Drug Addiction

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0. Summary

0.1 Main illicit drug use in Ireland

Results from the 2011/11 general population survey indicate that the most commonly used illicit drugs in Ireland, based on last-month prevalence, were cannabis (2.8%), cocaine (0.5%) and amphetamine-type stimulants (0.1%).

Polydrug use in Ireland
In June 2014 the National Advisory Committee on Drugs and Alcohol (NACDA) published Bulletin 5 in a series of reports on the 2010/11 survey on drug use in the general population (National Advisory Committee on Drugs and Alcohol). The bulletin focused on polydrug use in the adult population (15–64 years). For the purpose of the bulletin, polydrug use was defined as concurrent substance use, which involves a person using at least two substances within a one-month period.

Twenty per cent of all adults (15–64 years) had not used any substance within the last month. Women were more likely than men not to have used any substance (19% vs 23%). The most common combination of substances used was alcohol and tobacco (16%), followed by alcohol and other legal drugs (7%), alcohol, tobacco and other legal drugs (2%), and alcohol, tobacco and any illegal drug (2%). Last-month prevalence rates for alcohol and tobacco plus any illegal drug were higher among men (3%) than women (0.4%), and among young adults aged 15 to 34 years (3%) than older adults aged 35 to 65 years (1%). However, older adults were more likely than younger adults to have used a combination of alcohol and anti-depressants. The last-month prevalence of polydrug use including any illegal substance was 3%.

Patterns of association between use of one substance and a range of other substances are outlined in Table 0.1.1.1. Association between use of alcohol and tobacco was high. Users of cannabis, amphetamine-type stimulants and cocaine were highly likely to have used other legal and illegal substances. Of those who used cannabis within the last month, 85% used alcohol and 77% tobacco. Of those who used cocaine within the last month, all reported using alcohol, 77% smoked tobacco, 41% used cannabis, 14% used and 12% used anti-depressants.

Table 0.1.1.1 Total number of users of one substance by users of another substance and related percentages, all adults (15 to 64 years), 2010/11

	Last-month prevalence		Users of alcohol		Users of tobacco		Users of cannabis		Users of ATS		Users of cocaine		Users of ST		Users of anti-depressants	
	06/7	10/11	06/7	10/11	06/7	10/11	06/7	10/11	06/7	10/11	06/7	10/11	06/7	10/11	06/7	10/11
Total weighted N	**4967**	**5126**	**3653**	**3621**	**1619**	**1451**	**128**	**143**	**19**	**5**	**25**	**26**	**147**	**142**	**154**	**209**
Alcohol	73.4	70.6			81.2	78.3*	90.1	84.5	100	100	100	100	65.3	65.2	62.1	63.5
Tobacco	32.6	28.3	36.1	31.4*			88.3	76.7*	84.2	88.3	80	77.2	45.6	46.1	50	43.5
Cannabis	2.6	2.8	3.2	3.3	7	7.6			78.9	62.4	60	40.9	4.7	9	5.8	6.1
ATS	0.4	0.1	0.5	0.1	1	0.3*	11.7	2.2*			25	14.1	0.7	0.4	0.6	1.2
Cocaine	0.5	0.5	0.7	0.7	1.2	1.4	11.7	7.4	33.3	74.1			0.7	2.1	0	1.5
ST	3	2.8	2.6	3.7	4.8	6.3	5.5	9	5.3	11.7	4	11.4			38.3	26.2*
Anti-Depressants	3.1	4.1	2.6	3.7*	4.8	6.3	7	8.9	5.3	52.9*	0	12.4	40.1	38.5		

Source: National Advisory Committee on Drugs and Alcohol, and Drug and Alcohol Information and Research Unit (2008, 2014)

All figures are based on weighted data, are rounded to the nearest decimal place and based on valid responses.
* Denotes a statistically significant change between 2006/7 and 2010/11
ATS – Amphetamine-type stimulants (Ecstasy and Amphetamines)
ST – Sedatives or Tranquillisers

Since the 2006/7 survey, there had been a statistically significant reduction in the prevalence of tobacco and amphetamine-type stimulant use among cannabis users. There was also a statistically significant reduction in the use of sedatives or tranquillisers among anti-depressant users. But there was a

statistically significant increase in the prevalence of anti-depressants among alcohol users and amphetamine-type stimulant users.

0.2 The use of illicit drugs with alcohol, tobacco and prescription drugs

Hazardous alcohol consumption among university students in Ireland, 2012
A recently published paper reports on a study undertaken with a sample of 2,275 undergraduate students at University College Cork (Davoren*, et al.* 2015)*.* The aim of the study was to investigate the prevalence of hazardous alcohol consumption (HAC) and the associated adverse consequences among university students in Ireland, with particular reference to gender differences.

A questionnaire, based on previously validated instruments, was distributed to students during lecture time between 12 and 23 March 2012. HAC was estimated using the Alcohol Use Disorder Identification Test for Consumption (AUDIT-C), developed by the WHO: it measures frequency of consumption, number of units consumed and number of binge drinking occasions. The study took into account the fact that guidelines for safe alcohol consumption are lower for women owing to their increased vulnerability to alcohol-related harm. Body-mass index was estimated based on self-reported height and weight. Logistic regression analysis was used to estimate factors associated with HAC for both men and women.

The study found that the prevalence of HAC was similar in men (65%) and women (67%) and was considerably higher than that previously reported in the general population.

Moreover, 57% of women were drinking at a level that would be considered hazardous for men. Over one quarter of hazardous drinkers were consuming more than six units of alcohol (binge drinking) at least 2–3 times per week. Factors associated with HAC were studying law and business, not owning a house, current smoking, illicit drug use and being sexually active.

The pattern and frequency of adverse consequences of alcohol consumption were broadly similar for men and women. However, men were more likely to report getting into a fight and having a one-night stand than women. Among those with a HAC pattern, missing days at work or college as a result of drinking was reported by 60% of men and 57% of women, compared to 15% of men and 14% of women in the non-HAC student population. Hazardous drinkers were also more likely to engage in unplanned sexual activity and were less likely to use protection.

Results showed that patterns of alcohol consumption in these Irish university students were similar to those among British students but significantly higher than among students in the USA. Moreover, the paper highlighted the association between HAC and the 12–month prevalence of illicit drug use. The authors stated that these two behaviours needed to be tackled concurrently.

The authors concluded that HAC continued to be a public health concern in Irish universities both in terms of immediate adverse consequences and long-term risks to physical and mental well-being.

Patterns and trends in cigarette smoking in Ireland, 2003–2013
A cigarette-smoking prevalence tracker survey has been conducted in Ireland since 2002. Initiated by the Office of Tobacco Control, when this office was dissolved in 2010 the survey was continued by the Health Service Executive. The survey involves a monthly, nationally representative telephone poll of 1,000 randomly selected people aged 15 years and over.

The smoking prevalence question in the survey is *'Do you smoke one or more cigarettes each week, whether packaged or roll your own?'* In addition, demographic information on gender, age, socio-economic group and region is collected. The basic information from the survey has been available in previous years. However, in 2014 the HSE published a detailed report on the patterns and trends up to and including 2013 (Hickey P and Evans DS 2014).

Results outlined in the report show that the overall prevalence of cigarette smoking in 2013 was 21.5%. This was higher among men (22.9%) than women (20.2%). Smoking was most prevalent among the 18–24-year-old age group (30.7%), followed by the 25–34-year-old age group (28.1%). The lowest prevalence

was among those aged 65 and older (9.7%). Of note, the prevalence among those aged 15 to 17 years was 13.3%.

The highest prevalence rates were found among the lower socio-economic groups (C2 and DE), at 24.6% and 25.9% respectively. The lowest rates were among higher socio-economic groups (AB), at 13%, and farmers at 15%. There was very little difference in smoking rates by region.

An analysis of trends showed that overall cigarette smoking rates had declined by 6.6% since 2003, which equates to more than 104,000 fewer smokers in Ireland in 2013. This decline was evident in all age groups but was most pronounced in the 25–34-year-old age group (16.1%) and least evident in the 15–17-year-old age group (1.5%). All socio-economic groups have seen a downward trend since 2003. The largest decreases were in the C2 group (11.1%) and the AB group (10.2%), with the smallest decrease among farmers (0.7%).

Table 0.1.2.1 Categories of smoker

Category	Cigarettes per day
Occasional	1–5
Light	6–10
Regular	11–20
Heavy	21+

Trends in daily consumption of cigarettes, by category of smoker (see Table 0.1.2.1), were also reported. While regular smokers have consistently been the largest group since 2003, there is a trend towards lower levels of consumption. In 2013, 57.5% of all smokers were in the occasional or light categories. Moreover, in the last two years there has been a decrease in the proportion of regular smokers, from 39.8% to 36.2%, and a 3% increase in the number of occasional or light smokers. Heavy smokers have declined by 2%.

SECTION A. CANNABIS

1. National profile

1.1 National drugs strategies

1.1.1 Cannabis Use in the General Population

In 2013, the National Advisory Committee on Drugs and Alcohol (NACDA) published Bulletin 3 in the series of reports on the 2010/11 survey on drug use in the general population in Ireland and Northern Ireland (National Advisory Committee on Drugs and Alcohol 2013). The results revealed that 25% of the adult population (15–64 years) reported having used cannabis at some point in their lives (lifetime use); 6% reported use in the year prior to the survey (recent use); and 3% reported use in the month prior to the survey (current use).

The rates of cannabis use were notably higher among men than women for lifetime (33% vs 18%), last-year use (9% vs 3%) and last-month use (5% vs 1%). Since 2006/7 lifetime rates for men had increased (+6 %) while for women rates changed very little (less than one percentage point). There was no other statistically significant change in cannabis prevalence among men or women between the 2006/7 and the 2010/11 surveys.

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

The prevalence of cannabis abuse and of cannabis dependence were measured in the NACDA drug prevalence survey for the first time in 2010/11 using M-CIDI. Seventeen per cent of recent cannabis users met the criteria for cannabis abuse, with rates being higher among males (20%) than females (8%), and among young adults (20%) than older adults (9%). Of the valid responses from the survey sample, 1.3% met the criteria for current cannabis abuse. Applying this rate to the 15–64-year-old general population (3,073,269 in 2011), it is inferred that approximately 39,953 people in Ireland abuse cannabis.

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

Patterns of cannabis use

Among lifetime cannabis users, the median age of first use was 18 years. This was unchanged since the previous survey. Almost half (48%) of the current cannabis users had used cannabis on 1–3 days (lowest frequency use) in the month prior to the survey, an increase on the 2006/7 figure of 37%; this frequency was most common among female users (54%) and older adult users (55%). Between the two surveys the proportion of all adults engaging in the highest frequency use (20 days or more in the previous month) decreased from 24% to 14%.

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

When compared to the results from the 2006/7 survey, cannabis was used less frequently among current users in 2010/11, an important finding given the increased in use of herbal cannabis. While the data from the two surveys show that high-frequency use has always been more common among men than women,

the propensity for men to be high-frequency users had fallen sharply since the 2006/7 survey, with the effect that the gap between men and women has reduced considerably between the two time periods.

Dependence is increasingly recognised as a possible consequence of regular cannabis use. For many people, intensive use and dependence on cannabis are linked. Among those defined as recent users, 17% met the EMCDDA criteria for cannabis abuse and 9% were classified as dependent. However, in comparison with the available data on tobacco or alcohol use, little is known about the extent of cannabis dependence or abuse in Ireland.

Profile of cannabis users

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

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

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

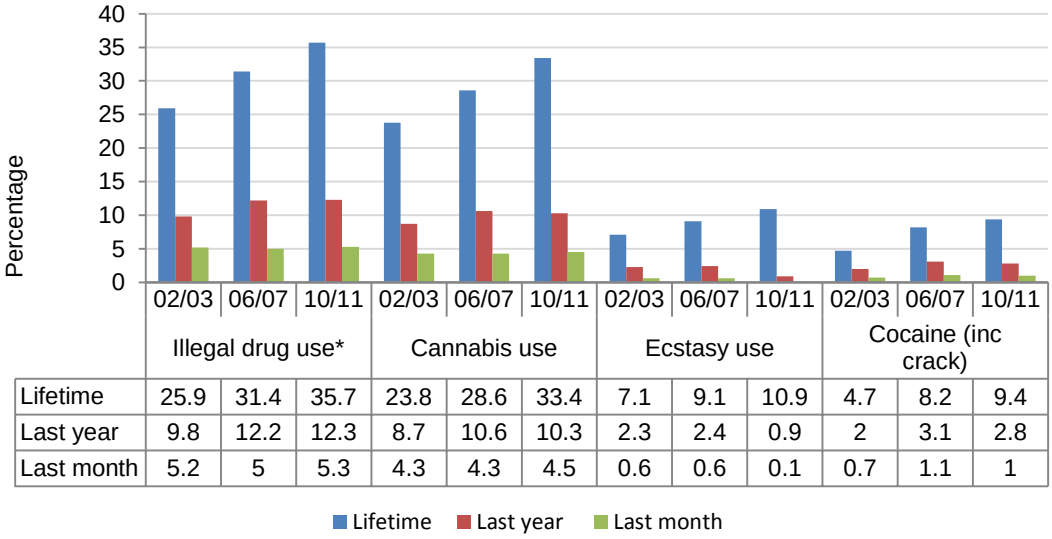
Marital status: Last-year prevalence was highest among those who were cohabiting (13%), followed by those who were single (12%). Last-month rates were highest among cohabiting and divorced people (at 7%).

Age and gender: The 2010/11 survey data show that age continues to be an important factor in patterns of cannabis use in Ireland and that use declines with age. Gender is also important for several reasons: it interacts with age, with the effect that the decline in use happens later for men than for women. Although the extent of use has declined, prevalence rates are still considerably higher among men than women, with no indication of any narrowing of the gender gap. Closer examination of the data is needed, however, as these age and gender effects are likely to vary across regions in Ireland, reflecting differences in context, particularly social and economic circumstances.

1.1.2 Cannabis use in schools and other sub-populations

Drug use among young people in Ireland

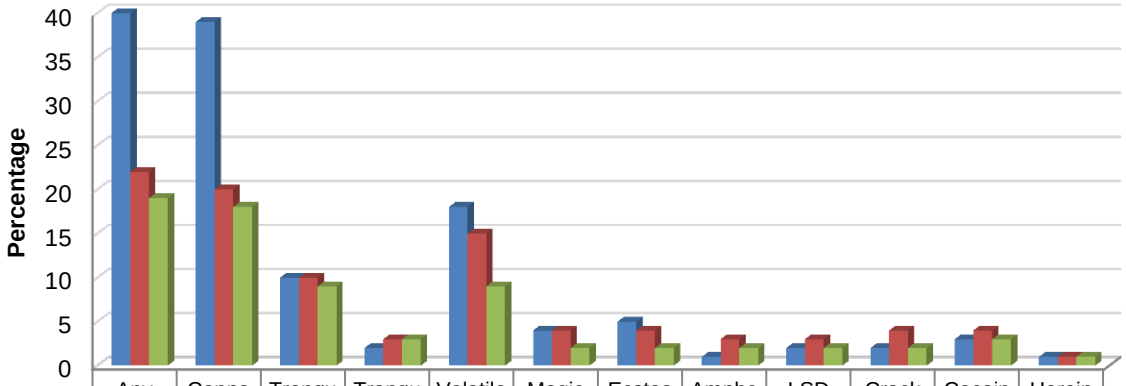
The proportion of young adults who reported using an illegal drug in the last year (NACD survey) increased from 10% in 2002/3 to 12% in both 2006/7 and 2010/11 (Figure 1.1.2.1). The proportions using cannabis reflect the same pattern as the proportions using any illegal drug. The proportions using cocaine increased for lifetime use. The proportions using ecstasy during their life time increased marginally but dropped for last-year and last-month use.



	Illegal drug use*			Cannabis use			Ecstasy use			Cocaine (inc crack)		
	02/03	06/07	10/11	02/03	06/07	10/11	02/03	06/07	10/11	02/03	06/07	10/11
Lifetime	25.9	31.4	35.7	23.8	28.6	33.4	7.1	9.1	10.9	4.7	8.2	9.4
Last year	9.8	12.2	12.3	8.7	10.6	10.3	2.3	2.4	0.9	2	3.1	2.8
Last month	5.2	5	5.3	4.3	4.3	4.5	0.6	0.6	0.1	0.7	1.1	1

Figure T1.1.2.1 Lifetime, last-year and last-month prevalence of illegal drug use among 15–34-year-olds in Ireland, 2002/3, 2006/7 and 2010/11
Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005, 2008, 2011)

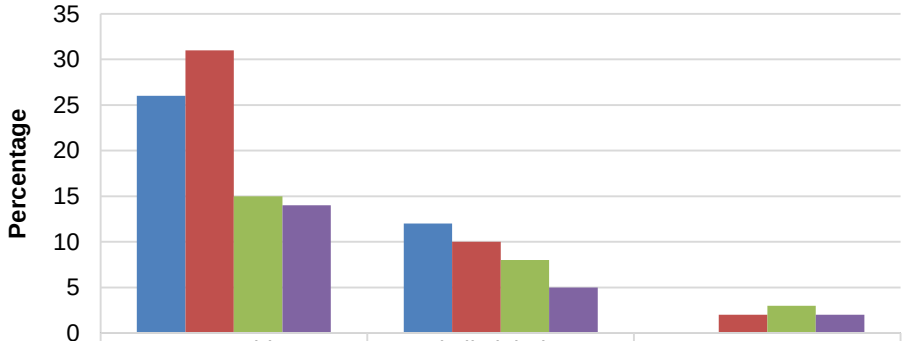
The proportion of 15–16-year-old school children (ESPAD) who reported use of any illicit drug at some point in their life decreased noticeably between 2003 (40%) and 2007 (22%), a fall of 18 percentage points (Figure 1.1.2.2). There was a further decrease to 19% in 2011. As the majority of those who have tried any illicit drug have used cannabis (marijuana or hashish), the decrease in illicit drug use was influenced by the considerable decrease in the number of students who had tried cannabis at some point in their lives, from 39% in 2003 to 20% in 2007 and 18% in 2011(European average 17%). Lifetime use of solvents/inhalants decreased from 18% in 2003 to 15% in 2007 and 9% in 2011, which is comparable to the European average (9%). In the case of both amphetamines and cocaine powder, the proportions reporting lifetime use in 2011 decreased marginally to 2% and 3% respectively (European average amphetamines 3% and cocaine 2%). In 2011, 9% of the survey participants reported that they had taken prescribed tranquillisers or sedatives at some point in their young lives; the use of such drugs had decreased marginally from 10% in 2007 and 11% in 1999.



	Any illicit drug	Cannabis	Tranquillisers/ sedatives, prescribed	Tranquillisers/ sedatives, not prescribed	Volatile inhalants	Magic mushrooms	Ecstasy	Amphetamines	LSD and other hallucinogens	Crack	Cocaine	Heroin
2003	40	39	10	2	18	4	5	1	2	2	3	1
2007	22	20	10	3	15	4	4	3	3	4	4	1
2011	19	18	9	3	9	2	2	2	2	2	3	1

Figure 1.1.2.2 Lifetime use of drugs among 15–16-year-old school children in Ireland, ESPAD (2003, 2007 and 2011)
Source: Data from ESPAD surveys (Hibell, *et al.* 2004), (Hibell, *et al.* 2009), (Hibell, *et al.* 2012).

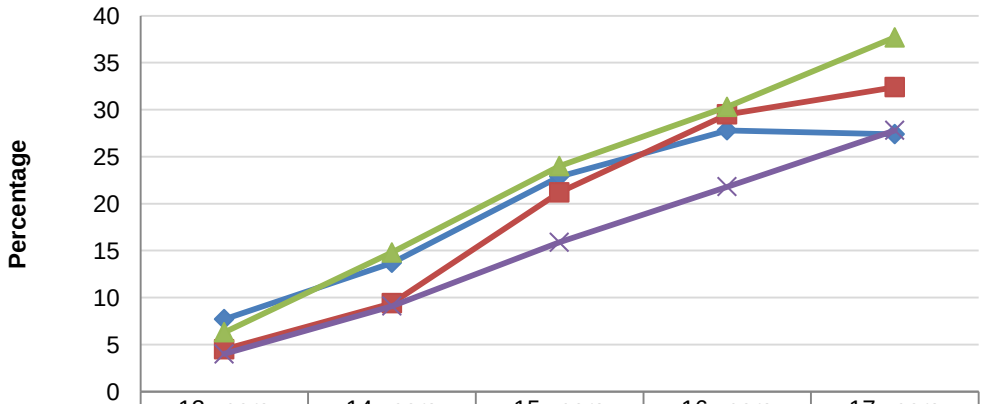
The trends in use of cannabis and volatile inhalants in the 12 months prior to the survey mirror lifetime use and are reported in Figure 1.1.2.3 below.



	Cannabis	Volatile inhalants	Ecstasy
1999	26	12	
2003	31	10	2
2007	15	8	3
2011	14	5	2

Figure 1.1.2.3 Use of drugs in the 12 months prior to the survey among 15–16-year-old school children in Ireland, ESPAD (1999, 2003, 2007 and 2011)
Source: ESPAD surveys (Hibell, *et al.* 2000), (Hibell, *et al.* 2004), (Hibell, *et al.* 2009), (Hibell, *et al.* 2012).

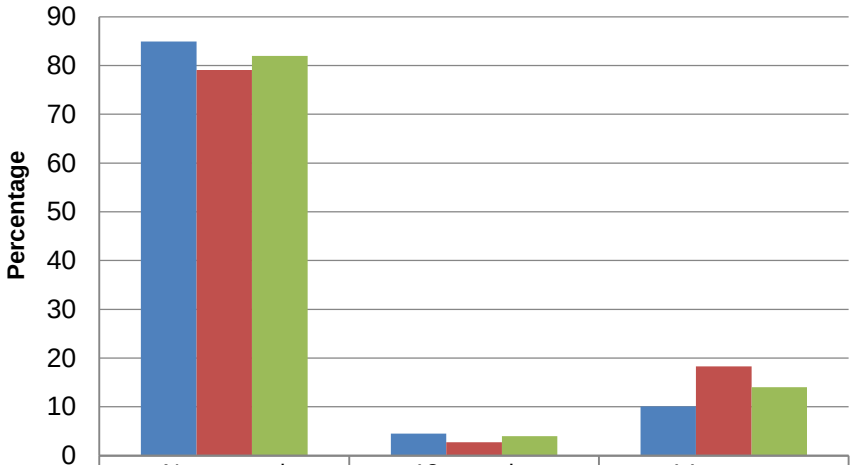
The proportions of 13–17-year-old school children who reported cannabis use at some point in their life (HBSC survey) increased with each year of age except for 16- and 17-year-old children in 1998 (FigureT1.1.2.4). In 2010, the proportion of children who reported lifetime use of cannabis at 13 years was 4%, and the proportion increased steadily with each year of age to 28% for those aged 17 years. The proportion using cannabis at each age increased between 1998 and 2006 but fell sharply in 2010, with a 10% reduction among those aged 17 and an 8% reduction among those aged 16 years.



	13 years	14 years	15 years	16 years	17 years
1998	7.7	13.7	22.9	27.8	27.4
2002	4.5	9.4	21.2	29.5	32.4
2006	6.3	14.8	24	30.3	37.7
2010	4	9.1	15.9	21.8	27.8

Figure T1.1.2.4 Proportion of children who used cannabis at least once in their life, by age, HBSC (1998, 2002, 2006 and 2010)
Source: Unpublished data from HBSC surveys, 1998, 2002, 2006 and 2010

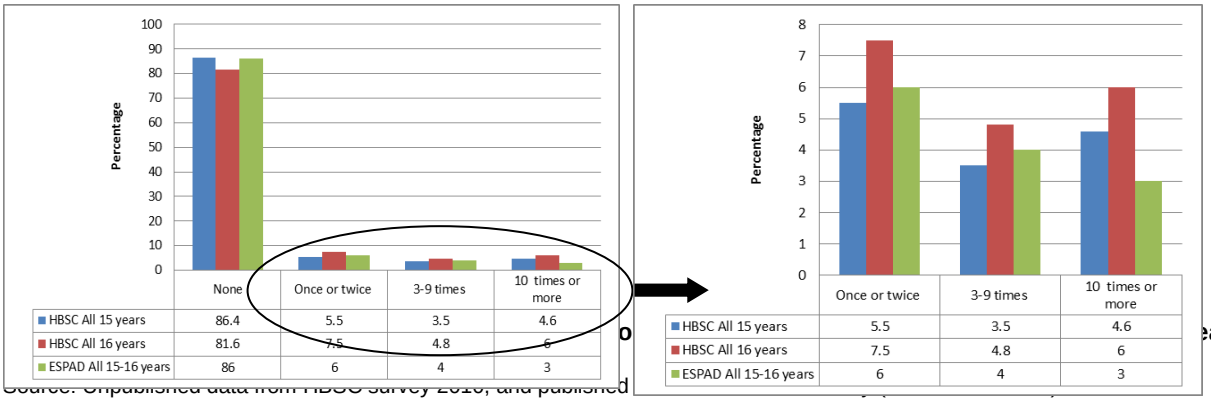
The proportion of children who reported commencing cannabis use at 13 years or under was considerable and similar in both the HBSC and the ESPAD surveys (Figure 1.1.2.5).



	Never used	13 or under	14 or over
HBSC All 15 years	84.9	4.5	10.1
HBSC All 16 years	79.1	2.7	18.3
ESPAD All 15-16 years	82	4	14

Figure 1.1.2.5 Age commenced cannabis use among children aged 15–16 years, HBSC (2010) and ESPAD (2011)
Source: Unpublished data from HBSC survey 2010, and published data from ESPAD surveys (Hibell, *et al.* 2012).

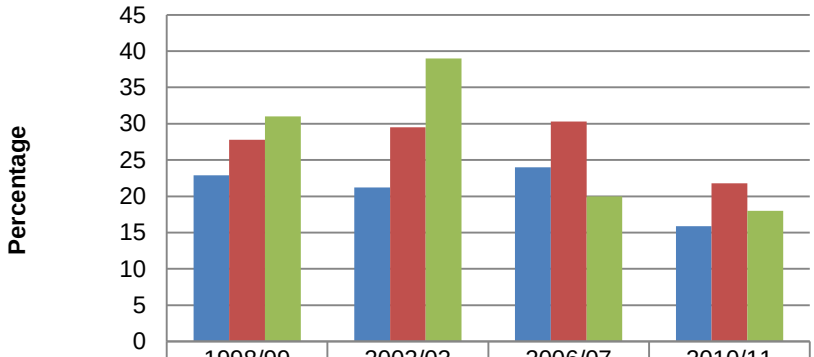
In 2010/11, the proportion who used cannabis three or more times was higher in the HBSC (8.1% and 10.8%) than in the ESPAD survey (7%) (Figure 1.1.2.6).



o ears, HBSC

Source: Unpublished data from HBSC survey 2010, and published

Overall, the HBSC survey shows a steady marginal increase in cannabis use between 1998 and 2007, whereas the ESPAD survey shows a large increase between 1999 and 2003 and a larger, unexpected decrease between 2003 and 2007. Both HBSC in 2010 and ESPAD in 2011 showed a decrease in lifetime cannabis use. While this decrease was more pronounced in HBSC in 2010, similar levels of use were recorded in both surveys (Figure 1.1.2.7).



	1998/99	2002/03	2006/07	2010/11
HBSC all 15 years	22.9	21.2	24	15.9
HBSC all 16 years	27.8	29.5	30.3	21.8
ESPAD all 15-16 years	31	39	20	18

Figure T1.1.2.7 Lifetime use of cannabis among 15–16-year-old children, HBSC (1998, 2002, 2006 and 2010) and ESPAD (1999, 2003, 2007 and 2011)
Source: Unpublished data from HBSC surveys (1998, 2002, 2006, 2010) and published data from ESPAD surveys (Hibell*, et al.* 2000), (Hibell*, et al.* 2004), (Hibell*, et al.* 2009), (Hibell *et al.* 2012)

1.2 Patterns, treatment and problem/high risk use

1.2.1 Recent surveys/studies on cannabis use

1.2.2 Reducing the demand for cannabis

The proportion of cases treated for problem cannabis use (excluding synthetic cannabinoids), as recorded in the TDI data, has fluctuated over the reporting period. It decreased from 21.2% in 2004 to a low of 16.3% in 2007 but since then has increased year-on-year to a peak of 28.9% in 2013, decreasing slightly in 2014 to 27.8%. Between 2004 and 2011, cannabis was the second most common drug for which people sought treatment, after opiates (mainly heroin). However, since 2011 cannabis has replaced opiates as the most common problem drug reported by new entrants to treatment.

In 2014, 81.1% of cases reporting cannabis as their main problem drug were male. The mean age was 24 years (males 23 years, females 25 years). Between 2004 and 2013, the majority of cases reporting cannabis as their main problem drug were male (83.2%) and the mean age was 23 years (males 23 years, females 24 years). Over the period 2004–2013 the majority of cases were new entrants to treatment (69.7%), with 27.6% previously treated. However, the proportion of cases previously treated has increased from 22.2% in 2004 to 32.0% in 2014.

In 2014, 30.4% of cases were self-referred, while 17.1% were referred by family/friends. Over the 11-year period 2004– 2014, more than a quarter of cases were self-referred (26.7%) while 20.3% were referred by family/friends. The proportion referred by court/probation has decreased, from 19.5% in 2004 to 9.8% in 2014.

Since 2009 only a very small number of cases (n=113) have reported synthetic cannabinoids as their main problem drug in the TDI data. It should be noted the type of new psychoactive substance (NPS) used by clients presenting to treatment is self-reported and the actual drug rarely tested by centres, so it is not possible to say with any certainty that what was reported was definitely a synthetic cannabinoid. The type of NPS was not specified in a proportion of NPS drugs recorded in the TDI data, and so the true number of synthetic cannabinoid users may be under- or over-estimated (see Section D, T1.2.2, below). These 113 cases are not included in the analysis of problem cannabis users.

See also Treatment Workbook, Sections 1.3 and 2.
The majority of problem cannabis users access treatment within generic addiction services. There are very few cannabis specific programmes.

1.2.3 High risk cannabis use

1.2.4 Synthetic cannabinoids

See Section A, 1.2.2.1, above for a note on those reporting synthetic cannabinoids as their main problem drug in the TDI data.

SECTION B. STIMULANTS

1. National profile

1.1 Prevalence and trends

1.1.1 Stimulant Use in the General Population

The most commonly used stimulants, based on the 2010/11 general population survey, were cocaine and amphetamine-type stimulants, in particular ecstasy (National Advisory Committee on Drugs and Public Health Information and Research Branch 2011).

Cocaine use

Lifetime cocaine use increased in 2010/11 when compared to 2006/7 (Table 1.1.1.1). The proportion of adults who reported using cocaine (including crack) at some point in their lives increased from 5% in 2006/7 to 7% in 2010/11. The proportion of young adults who reported using cocaine in their lifetime also increased, from 8% in 2006/7 to 9% in 2010/11. As expected, more men reported using cocaine in their lifetime than women, 10% compared to 4%. However, the proportion of adults who reported using cocaine in the last year (recent use) remained stable between 2006/7 and 2010/11 at just under 2%. The proportion of young adults who reported using cocaine in the last year also remained stable at 3%. The proportion of adults who reported using cocaine in the last month (current use) also remained unchanged between 2006/7 and 2010/11 at less than 1%.

Table 1.1.1.1 Lifetime, last-year and last-month prevalence of cocaine use (including crack) in Ireland, 2002/3, 2006/7 and 2010/11

Cocaine use	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Lifetime	3.0	5.3	6.8	4.3	7.1	9.9	1.6	3.5	3.8	4.7	8.2	9.4
Last-year	1.1	1.7	1.5	1.7	2.3	2.3	0.5	1.0	0.7	2.0	3.1	2.8
Last-month	0.4	0.5	0.5	0.7	0.8	0.8	0.0	0.2	0.3	0.7	1.1	1.0

Source: National Advisory Committee on Drugs (NACD) & Public Health Information and Research Branch (PHIRB) (2011)

Ecstasy use

Almost 11% of young adults surveyed in 2010/11 claimed to have tried ecstasy at least once in their lifetime (Table 1.1.1.2). More young men (15%) reported using ecstasy in their lifetime than young women (6%). The proportion of young adults who used ecstasy in the last year decreased significantly, from 2.4% in 2006/7 to 0.9% in 2010/11. The decrease in ecstasy use may be partly explained by the proportion (6.7%) of young people reporting use of new psychoactive substances sold in head shops and on line.

Table 1.1.1.2 Lifetime, last-year and last-month prevalence of ecstasy use in Ireland, 2002/3, 2006/7 and 2010/11

Ecstasy use	Adults 15–64 years %			Males 15–64 years %			Females 15–64 years %			Young adults 15–34 years %		
	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11	2002/3	2006/7	2010/11
Lifetime	3.7	5.5	6.9	4.9	7.4	10.1	2.6	3.6	3.7	7.1	9.1	10.9
Last - year	1.1	1.2	0.5	1.5	1.8	0.6	0.6	0.6	0.3	2.3	2.4	0.9
Last-month	0.3	0.3	0.1	0.6	0.5	0.1	0.0	0.2	0.0	0.6	0.6	0.1

Source: National Advisory Committee on Drugs (NACD) & Public Health Information and Research Branch (PHIRB) (2011)

1.1.2 Stimulant use in schools and other sub-populations

There are no new studies on stimulant use among the school-age population. See Section A, 1.1.2, above for trends in drug use among young people in Ireland.

1.2 Patterns, treatment and problem/high risk use

1.2.1 Injecting and other routes of administration

Injecting trends from TDI data
Information from the TDI data about those accessing drug treatment for any stimulant (cocaine, amphetamines or synthetic cathinones) as a main problem drug show that the proportion injecting was very low. In 2014, only 2.1% of cases reported injecting (any) stimulants. Between 2004 and 2013 only 3.2% reported injecting (any) stimulants. In 2014 the most common route of administration was sniffing/snorting (70.9%), and this was mostly due to the large proportion of problem cocaine users in this group (see also Section B, T.1.2.4, below). Between 2004 and 2013, 70.0% reported sniffing/snorting of (any) stimulant as the main route of administration.

1.2.2 Infectious Diseases

There are no data specifically on rates and trends in infectious diseases among stimulant users. For information on drug-related infectious diseases in Ireland, see Harms and Harm Reduction Workbook, Section 1.3.

1.2.3 Treatment for stimulants

All stimulants including synthetic cathinones
In 2014, there were 980 cases treated for problem stimulant use as reported through TDI. Of these the majority were for problem cocaine use (84.5%), followed by amphetamine-type stimulants (11.9%) and then synthetic cathinones (3.6%). Between 2004 and 2013, 8,231 cases were treated for problem stimulant use as reported through TDI (see Figure 1.2.3.1). Of these, the vast majority were for problem cocaine use (81.3%), followed by amphetamine-type stimulants, including MDMA, BZP and other unknown/unspecified stimulants (15.5%).

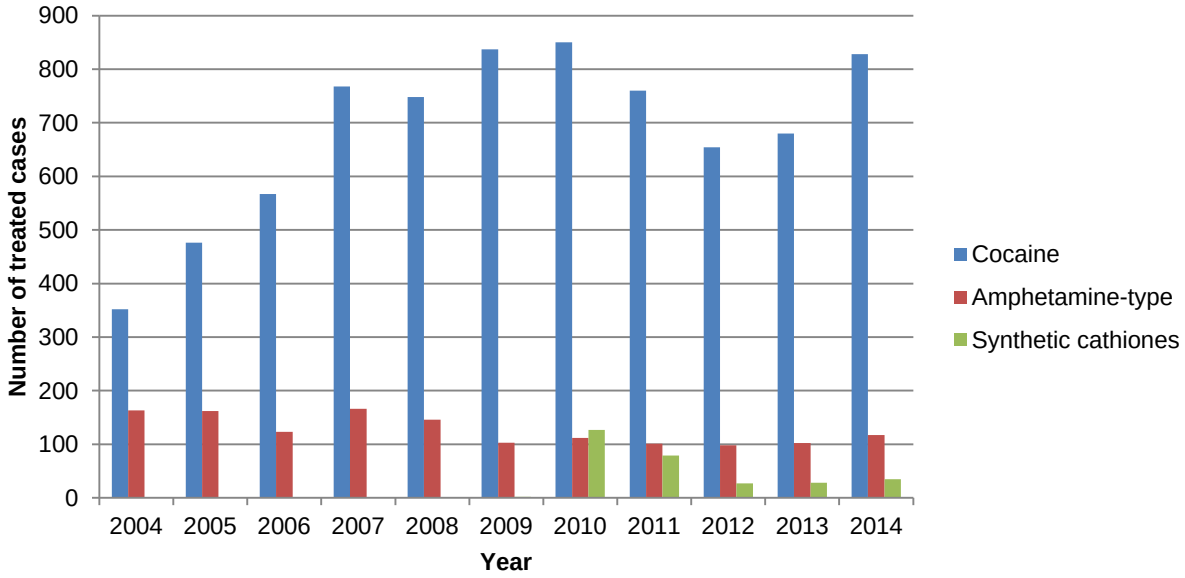


Figure 1.2.3.1 Number of cases treated for problem stimulant use, by category of stimulant, 2004–2014
Source: Unpublished NDTRS data

The proportion of all cases treated for problem stimulant use increased from 10.9% in 2004 to a peak of 16.2% in 2009; since then, the proportion has decreased to 10.3% in 2014.

In 2014, 82.6% of cases were male with a mean age of 30 years (males 30 years; females 31 years). Between 2004 and 2013, the majority of cases were male (81.9%) and the mean age was 27 years (males 27 years; females 27 years). Nearly three fifths (58.5%) of those treated for problem stimulant use had never been treated before. Over a third of cases were self-referred (34.3%) while 15.7% were referred by family/friends. Over the period, the proportion referred by court/probation has decreased, from 17.5% in 2004 to 4.3% in 2013.

Cocaine is the most common drug among the stimulants group that is reported in Ireland. The proportion of all cases treated for problem cocaine use increased from 7.5% in 2004 to a peak of 13.3% in 2007. The proportion decreased year-on-year since then to 7.8% in 2013, but increased slightly to 8.7% in 2014.
In 2014, 82.6% of cases treated for problem cocaine use were male and the mean age was 30 years (males 30 years; females 31 years). Just over half (51.2%) had never been treated before. Nearly half (46.3%) were self-referred while 14.0% were referred by family/friends. Between 2004 and 2013, the majority of cases were male (83.5%) and the mean age was 27 years (males 27 years; females 28 years). Just over half (56.7%) of those treated for problem cocaine use had never been treated before. Over a third were self-referred (35.7%) while 15.7% were referred by family/friends.
Over the 11-year period, the proportion referred by court/probation has decreased steadily, from 13.6% in 2004 to 3.6% in 2014.

Amphetamine-type stimulants, including MDMA, BZP and other unknown/unspecified stimulants, represent only a small proportion of cases seeking treatment for problem drug use in Ireland. This has decreased continuously year-on-year from 3.5% in 2004 to 1.2% in 2013, and remaining at 1.2% in 2014.
In 2014, 69.2% of problem amphetamine-type stimulant users were male, compared to 74.5% between 2004 and 2013. In 2014 the mean age was 27 years (same for male and females). Between 2004 and 2013 the mean age was 24 (males 24 years; females 25 years). The majority of those treated for problem stimulant use have never been treated before, fluctuating between a high of 74% and a low of 55% between 2004 and 2013; in 2014, 59.0% of cases had never been treated before. In 2014, 35.0% of cases were self-referred while 18.8% were referred by family/friends. Between 2004 and 2013 over a quarter of cases were self-referred (28.4%) while 16.1% were referred by family/friends. Over the 11-year period, the proportion referred by court/probation decreased from 25.8% in 2004 to 3.9% in 2013, but increased to 6.8% in 2014.

Since 2009 a very small number of cases (n=298) have reported synthetic cathinones as their main problem drug. It should be noted that the type of NPS used by clients presenting for treatment is self-reported and the actual drug is rarely tested by treatment centres. Therefore it is not possible to say with certainty that what was reported was definitely a synthetic cathinone. In a proportion of cases the type of new psychoactive substance (NPS) was not specified, so the true number of synthetic cathinone users may be under- or over-estimated.

Synthetic cathinones first appeared in treatment data in 2009 so no information is available before that time. The proportion of cases treated for this type of drug peaked in 2010 at 1.5% of all treatment episodes, then dropping to 0.3% in 2013 but rising marginally to 0.4% in 2014.

In 2014, 65.7% of cases were male and the mean age was 30 years (males 28 years; females 33 years). Just over half (54.3%) had never been treated before. A quarter of cases were self-referred (40.0%) while 17.1% were referred by hospital or medical source. Between 2009 and 2013, the majority of cases were male (75.6%) and the mean age was 23 years (males 23 years; females 24 years). The majority (69.2%) of those treated for problem cathinone use had never been treated before. A quarter of cases were self-referred (25.5%) while 19.8% were referred by family/friends.

See also Treatment Workbook, Sections 1.3 and 2.

The majority of problem stimulant users access treatment within generic addiction services. There are very few stimulant programmes.

SECTION C. HEROIN AND OTHER OPIOIDS

1. National profile

1.1 Prevalence and trends

1.1.1 Estimates of opioid use

Opiate use
A national 3-source capture-recapture (CRC) study to provide statistically valid estimates of the prevalence of opiate drug use in the national population was commissioned by the National Advisory Committee on Drugs (NACD) and undertaken in 2001 and 2006 (Kelly, Alan*, et al.* 2003) and (Kelly, Alan*, et al.* 2009). The second study indicated that use had increased since the previous survey. There were 11,807 known opiate users in 2006. The major expansion of the national methadone treatment programme between 2001 and 2006 is the main reason for the inflation of the figures. There is some doubt over the estimate produced by the study of a possible further 8,983 opiate users who had not come into contact with any of the drug treatment services, hospital in-patient services or the Gardaí.

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

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

Results of the 2006 study were presented in Standard Tables 7 and 8 in 2009. The national prevalence estimate of opiate users was between 18,136 and 23,576; the point estimate was 20,790. The respective rates per 1,000 of the 15–64-year-old population in Dublin and in the rest of Ireland are 17.6 and 2.9. These estimated figures are likely to be inflated because the population was not closed, that is, it continued to recruit significant numbers of people into treatment (in Dublin and outside Dublin) and police custody (outside Dublin) in 2006. In addition, the overlap between the three population sources was small. These two factors are known to inflate estimates obtained by the CRC method. Of the estimated number, 28% (5,886) lived outside Dublin and 72% (14,904) in Dublin.

The national point estimate increased by 42%, from 14,681 in 2001 to 20,790 in 2006. The point estimate for Dublin increased by 20%, while the point estimate for the rest of Ireland increased by 165% – albeit from a low estimate in 2001. The rate of opiate use per 1,000 of the 15–64-year-old population living outside Dublin increased from 1.2 in 2001 to 2.9 in 2006. Seventy-one per cent of opiate users in 2006 were male. One in five (21%) was between 15 and 24 years old and half (51%) were aged between 25 and 34 years old. In Dublin, the rate of opiate use per 1,000 of the 15–24-year-old female population decreased by 62%, from 18.7 in 2001 to 7.2 in 2006, which indicates that the number of younger women commencing opiate use had decreased. A smaller but still notable decrease in the rate of opiate use in Dublin was seen among males aged 15–24 years.

1.2 Patterns, treatment and problem/high risk use

1.2.1 Injecting and other routes of administration
Data from TDI show that in 2014, 40.2% of those treated for problem opiate use reported injecting as their primary route of administration. Between 2004 and 2013, 38.8% of those treated for problem opiate use reported injecting as their primary route. Heroin represents almost 100% of the opiate drugs injected. The proportions fluctuated over the period, from a peak of 48.4% in 2004 to its lowest level of 30.2% in 2010. Since then the proportion injecting increased to 41.1% in 2012, but then decreased slightly to 40.2% in 2014.
See Sections 1.5.2 and 1.5.3 in Harms and Harm Reduction workbook for data on use of needle exchange programmes by injecting drug users in Ireland.

1.2.2 Infectious Diseases

There are no data specifically on rates and trends in infectious diseases among opioid users. For information on drug-related infectious diseases in Ireland, see Harms and Harm Reduction Workbook, Section 1.3.

1.2.3 Treatment for heroin and other opioids

All opiates

In 2014, just under half of all cases (49.8%) treated for problem drug use (excluding alcohol) were treated for opiates. Of those treated for problem opiate use in 2014, heroin comprised the vast majority of cases (89.2%). Between 2004 and 2013 just over half of all those treated for problem drug use (excluding alcohol) were treated for opiates (58.7%). Of those treated for problem opiate use, heroin comprised the vast majority of cases (92.5%).

Heroin

Problem heroin use comprised 44.4% of all cases treated in 2014. The proportion of cases treated for problem heroin use has fluctuated over the reporting period, rising from 59.7% in 2004 to a peak in 2006 of 60.3%, and then decreasing to 51.3% in 2013 and decreasing again to 44.4% in 2014.

Since 2004, heroin has remained the most common drug for which all cases have sought treatment. However, for cases new to treatment, the pattern changed in 2011, when cannabis replaced heroin as the most common problem drug reported by new entrants to treatment.

In 2014, 70.8% of cases were male, and the mean age was 33 years (males 34 years; females 31 years). The majority of cases were previously treated (72.9%) and were self-referred (44.9%) while 17.7% were referred by other drug treatment services.

Between 2004 and 2013, the majority of cases were male (71.9%) and the mean age was 30 years (males 31 years; females 29 years). Over the period 2004 to 2013 the majority of cases had been previously treated (69.9%), while 27.2% were new entrants to treatment. Almost two out of five cases self-referred (37.2%) while 20.1% were referred by other drug treatment services.

The proportion of cases who were new to treatment peaked in 2009 at 34.4% and decreased to 22.1% in 2013 and 21.7% in 2014.

Other opiates

In 2014 methadone (prescribed or street) was the second most common opiate reported, comprising 5.5% of all treatment entrants for problem opiate use. This was followed by codeine, accounting for 3.1% of all treatment entrants for problem opiate use.

Other opiates (including methadone and codeine) comprised 5.3% of all treatment entrants for problem opiate use in 2014, while between 2004 and 2013, they comprised only 3.7%.

The third most common opiate was codeine (all formulations), accounting for 2.3% of all treatment entrants for problem opiate use between 2004 and 2013.
See also Treatment Workbook, Sections 1.3 and 2.

Treatment for problem opiate use is provided by both statutory and non-statutory services. Opiate substitution treatment (OST) is provided in specialised clinics or by specialised GPs. Other treatment provided includes counselling, social and occupational reintegration, psychiatric treatment, complementary therapy etc. For further information see Treatment Workbook, Section 1.4

SECTION D. NEW PSYCHOACTIVE SUBSTANCES (NPS) AND OTHER DRUGS NOT COVERED ABOVE.

1.1 New Psychoactive Substances (NPS), other new or novel drugs, and less common drugs

1.1.1 Harms related to NPS use

Since 2008 a very small number of cases presenting for treatment (n=62) have reported a new psychoactive substance (NPS) (other than a synthetic cannabinoid or cathinone) as their main problem drug. The type was usually unspecified but does include a very small number of hallucinogenic-type NPS. It should be noted that the type of NPS used by clients presenting to treatment is self-reported and so, even though the type of NPS may have been specified by a client, the actual drug is rarely tested by treatment centres. As a result, it is not possible to say with certainty that, for example, those NPS reported as synthetic cannabinoids or cathinones definitely fall into those categories. Among the 68 cases reporting NPS (other than a synthetic cannabinoid or cathinone) as their main problem drug, there may be a number of which are a synthetic cannabinoid or cathinone, so the true number of synthetic cannabinoid or cathinone users may be under- or over-estimated.

NPS first appeared in treatment data in 2008; before then they were not recorded as a separate category. The proportion of cases treated for this type of drug peaked in 2010 at 0.4% of all treatment episodes, but dropped to 0.07% in 2013 and 0.06% in 2014.
See also Section A, 1.2.2, and Section B, 1.2.4.

1.1.2 Prevalence, trends and harms related to other drug use

Performance and image enhancing drugs – a profile of users attending a harm- reduction programme

In November 2014 Merchants Quay Ireland (MQI) published a report entitled *Examining the profile and perspectives of individuals attending harm reduction services who are users of performance and image enhancing drugs* (Jennings Ciaran J*, et al.* 2014). The study defines performance and image enhancing drugs (PIEDs) as 'substances used to enhance performance (e.g. improving strength and/or endurance), improve the body's appearance (e.g. increasing muscle size and/or reducing body fat), mask the use of performance-enhancing drugs to avoid drug testing, and manage the negative side effects of substance use'.

A mixed methods questionnaire was administered to the 89 clients attending the harm-reduction services at MQI who were users of PIEDs. All study participants were male, as no female PIED users presented at the service at the time of the study. The mean age was 27 (range 18 to 40 years). The majority (90%) were Irish nationals and 81% were ethnically white Irish. Reported levels of education were lower secondary (34%), higher secondary (23%), third-level non-degree (21%) and third-level degree or higher (12%). Only 21% of study participants were in full-time employment, 49% were unemployed and 11% were students.

Motivations for using PIEDs were to increase muscle mass (91%), increase strength (75%), look good (63%) and increase confidence (51.7%). Almost all participants (98%) reported attending regular training and exercise programmes, with 46% reporting that they exercised more than five days per week. Weight training was the most commonly reported type of training (91%); a further 80% reported participating in cardiovascular exercise. The most common frequency of weight training was 5–7 sessions per week, and the most common number of cardiovascular exercise sessions was 2–4 per week.
Almost all participants (96%) reported lifetime injecting use of anabolic–androgenic steroids (AAS) and 69% reported lifetime use of oral AAS. Twenty-one per cent of participants were on their first cycle of PIED use and a further 24% were on their second cycle. However, 18% were on their sixth or higher cycle. The length of cycles reported by participants varied from less than five weeks (18%) to more than 17 weeks (10%). The most commonly reported length of cycle was 6–8 weeks (29%).

A variety of side effects experienced in association with PIED use were reported. These are outlined in Table 1.1.3.1.

Table 1.1.3.1: Most prevalent side effects experienced in association with use of PIEDs during the current and previous cycles, reported by participants in MQI PIEDs study, 2013

	Current cycle (%)	Previous cycles (%)
Increased sex drive	42.7	46
Increased appetite	41.6	49.4
Testicular atrophy	26	29.2
Increased aggression	23.6	38.2
Growth of excessive body hair	23.6	36
Sudden mood changes	22.5	31.5
Water retention	20.2	45
Acne	16.9	36
Anxiety	13.5	19.1
Insomnia	10.1	23.6
Muscle/joint pain	10.1	22.5
Decreased sex drive	9	33.7
Depression	9	18

Source: (Jennings Ciaran J, *et al.* 2014)

Participants reported use of a variety of other substances, which are listed in Table 1.1.3.2.

Table 1.1.3.2 Use of other substances reported by participants in MQI PIEDs study, 2013

	Lifetime Use (%)	Ever Injected (%)	Recent Use (%)
Alcohol	95.5	0	62.5
Tobacco	71.6	0	52.3
Cannabis	68.2	0	39.8
Cocaine	56.8	5.7	17
Benzodiazepines	35.2	0	22.7
Ecstasy	23.9	0	3.4
Anti-depressants	19.3	0	8
New psychoactive substances	17	2.3	1.1
Methadone	13.6	0	9.1
Crack	11.4	0	1.1
Heroin	12.5	11.4	3.4
Methamphetamine	9.1	0	1.1

Source: (Jennings Ciaran J, *et al.* 2014)

Participants were asked whether they had been tested for HIV, hepatitis C and hepatitis B; when were they last tested; and whether they were receiving treatment. Almost half (48%) had been tested for HIV, for hepatitis B and for hepatitis C. Nobody reported testing positive for HIV or hepatitis B, but 5% (n=4) reported testing positive for hepatitis C. This positive status for hepatitis C represents 10% of respondents who had actually been tested. One person had completed treatment for hepatitis C, one was awaiting treatment, one was awaiting further tests and one declined treatment. A total of 35% reported having been vaccinated against hepatitis B.

Overall, participants described their interaction with harm-reduction services in positive terms and said that the services were particularly useful for accessing sterile injecting equipment and information relating to PIED use. However, it was also stated that the presence of users of other psychoactive substances within harm-reduction services and needle exchanges created an intimidating atmosphere, which made them feel uncomfortable. A separate specialised service catering for the needs of PIED users was suggested. The report concluded that there is a need to develop a tailored approach in response to the profile of harm within this group. In particular, the implementation and assessment of a specialised PIED clinic on a trial basis was recommended. The authors cautioned that the findings in this study represented PIED users

who were attending a harm-reduction service and that further research was needed to profile the wider population of PIED users.

2. New developments

2.1 New developments in the use of NPS and other drugs

See Legal Framework workbook, Section 3.3, for a description of a recent study of changes in the use of new psychoactive substances among adolescents attending a drug and alcohol treatment service in Ireland following the legislative ban.

3. Sources and references

3.1 Sources

There are three sources of data that estimate the prevalence of drug use among young people, namely the:

- National Advisory Committee on Drugs and Alcohol (NACDA) survey on drug use among the general population,
- European Schools Project for Alcohol and Other Drugs (the ESPAD survey), and
- Health Behaviour in School-aged Children (HBSC).

The NACDA's survey classifies young adults as those aged between 15 and 34 while the ESPAD survey ascertains alcohol and drug using practices among 15–16-year-old school children. The HBSC records health behaviours (including cannabis use) among school children 13–17 years old. In all three surveys, drug use is measured for three time parameters – lifetime use, use in the 12 months prior to the survey and use in the month prior to the survey. TDI data are taken from the National Drug Treatment Reporting System (NDTRS).

3.2 Methodology

NACDA survey on drug use in the general population

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

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

The first iteration of this general population drug prevalence survey was undertaken in 2002/3 (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005), and a second iteration in 2006/7 (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2008). A series of bulletins reporting the findings of the 2002/3 and 2006/7 and 2010/11

iterations have been published. The most recent survey was conducted in 2014. However, no results from this have yet been published.

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

Health Behaviour in School-aged Children (HBSC)
The Health Behaviour in School-aged Children (HBSC) is a cross-national research study conducted in collaboration with the WHO (World Health Organization) Regional Office for Europe. The study aims to gain insights into, and increase our understanding of, young people's health and well-being,health behaviours and their social context. It collects information on the key indicators of health and health-related attitudes and behaviours (including alcohol and cannabis use) among young people aged 11, 13 and 15 years. HBSC was initiated in 1982 and is conducted every four years. It is a school-based survey with data collected through self-completion questionnaires administered by teachers in the classroom. The Health Promotion Research Centre, National University of Ireland, Galway was invited to join the HBSC network in 1994 and conducted the first survey of Irish schoolchildren in 1998 (Friel*, et al.* 1999), the survey has been repeated in Ireland in 2002 (Kelleher*, et al.* 2003), 2006 (Nic Gabhainn*, et al.* 2007) and 2010 (Kelly, C*, et al.* 2012).

European School Survey Project on Alcohol and Other Drugs (ESPAD)
The European School Survey Project on Alcohol and Other Drugs (ESPAD) is a collaborative effort of independent research teams in about 40 European countries. Data on alcohol and illicit drug use among 15–16-year-olds have been collected every four years since 1995, using a standardised method and a common questionnaire. The Swedish Council for Information on Alcohol and Other Drugs (CAN) initiated the project in 1993. Support has been provided by the Pompidou Group at the Council of Europe, the Swedish Ministry of Health and Social Affairs, the Swedish National Institute of Public Health and the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The data collections in the individual countries are funded by national sources. The rationale for the ESPAD surveys is that school students are easily accessible and are at an age when onset of substance use is likely to occur. Early school leavers, a group known to be vulnerable to alcohol and drug use, are not represented in this survey, so the results do not indicate the extent of alcohol and other drug use among all 15–16-year-old children. ESPAD survey information is valuable in planning prevention initiatives. Data were collected for the fifth iteration of ESPAD in 2010/11 and the survey findings were published in 2012 (Hibell*, et al.* 2012).

The National Drug Treatment Reporting System (NDTRS) is a national epidemiological database which provides data on treated drug and alcohol misuse in Ireland. The NDTRS collects data from both public and private outpatient services, inpatient specialised residential centres and low-threshold services. For the purposes of the NDTRS, treatment is broadly defined as ‘any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their substance misuse problems’. The NDTRS is a case-based, anonymised database. It is co-ordinated by staff at the Health Research Board (HRB) on behalf of the Department of Health. The number of drug treatment services participating in the NDTRS continues to increase (Standard Table TDI 34). Although treatment is provided within the Irish Prison Service, it was only in 2009 that counsellors working in the prison service began to return information to the NDTRS. For information on drug treatment in prisons, see Section 1.3.3 in the Prison workbook.

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European Monitoring Centre for Drugs and Drug Addiction
The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) is a decentralised EU agency based in Lisbon. The EMCDDA provides the EU and its Member States with information on the nature, extent, consequences and responses to illicit drug use. It supplies the evidence base to support policy formation on drugs and addiction in both the European Union and Member States.
There are 30 National Focal Points that act as monitoring centres for the EMCDDA. These focal points gather and analyse country data according to common data-collection standards and tools and supply these data to the EMCDDA. The results of this national monitoring process are supplied to the Centre for analysis, from which it produces the annual *European drug report* and other outputs.

The Irish Focal Point to the EMCDDA is based in the Health Research Board. The focal point writes and submits a series of textual reports, data on the five epidemiological indicators and supply indicators in the form of standard tables and structured questionnaires on response-related issues such as prevention and social reintegration. The focal point is also responsible for implementing Council Decision 2005/387/JHA on the information exchange, risk assessment and control of new psychoactive substances.

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