OVERVIEW OF

DRUG ISSUES IN IRELAND 1997

A Resource Document

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The authors would very much welcome comments on this document. New or updated information on the areas covered by the report would be particularly appreciated.

Executive

Main points

- Traditionally the objective of drug policy has been to maintain people in, or restore people to, a drug-free lifestyle. The aim of health promotion programmes is to prevent persons, in particular young people, from becoming drug users and to provide people who are already using drugs with the treatment and support to bring them to the stage where they can stop using drugs. Policy and practice have changed over the past ten years and harm reduction is now a key feature of Irish drug policy.
- As a result of decisions on measures to reduce the demand for drugs taken by the Irish Government in 1996 and 1997, new national, regional and local structures were established in order to direct and co-ordinate drug policy. These initiatives have brought about a shift in approaches to the drug problem. There is now more emphasis on the greater involvement of community groups in the structural and organisational implementation of drug policies. This is accompanied by a more holistic intersectoral approach involving the co-ordination of drugs programmes and services at local level, the involvement of communities in the development and delivery of locally based strategies to reduce the demand for drugs, and the focusing of actions on tackling the problem in communities where it is most severe.
- The official response in the area of criminal justice is characterised by legislative changes. These changes, while not solely concerned with drug issues, include seven-day detention and restrictions regarding the right to silence in drug

trafficking cases, the seizure of criminal assets, an increase in policing, the appointment of extra court judges, the provision of extra prison places, and the setting up of a special unit to target the assets of suspects. In addition a referendum was held to change the constitution in relation to bail laws which indirectly concerns drug offences.

- There has been an expansion of drug treatment services, in the Dublin area particularly, in response to the needs of intravenous drug users and other special groups such as young heroin smokers and users of ecstasy.
- A number of core information sources exists in Ireland to evaluate the drug situation and inform policy making. Foremost amongst these is the National Drug Treatment Reporting System run by the Drugs Research Division of the Health Research Board.

Most important trends and new developments

- Schools survey data indicate that there has been an increase in the consumption of drugs, in particular cannabis.
- Problematic drug use continues to be associated with social disadvantage. The profile of the typical drug user who presents for treatment and as represented in the statistics over a number of years is significant - that of young, unemployed male, leaving school at an early age and living in a socially disadvantaged area.
- The drug profile of clients who present for treatment shows that heroin is the main drug of misuse.
- In 1996, 81 percent of those presenting for treatment for the first time were less than twenty five years old, compared to 69 percent in 1990.
- There has been a shift in the risk behaviour of problem drug users. National data for 1995 and 1996 show that clients coming into treatment for the first time were less likely to be injecting their primary drug of misuse than was the case in previous years. This could be explained by the fact that there is an increase in the practice of smoking heroin among an

increasingly young treated population and to the possible efficacy of health education initiatives.

- Intravenous drug users make up a high proportion of confirmed cases of AIDS in Ireland (42 percent in 1996). The proportion, which has decreased slightly over the years since recording commenced in the mid 1980s, peaked in 1993 at 62 percent.
- A drug-related diagnosis was recorded for 3 percent of all admissions to Irish psychiatric hospitals and units in 1996.
- Between 1992 and 1996 there was an increase in the number and quantity of drugs seized, particularly heroin, cocaine and amphetamines. The number of ecstasy seizures has increased over the years, very significantly so in 1995.
- The Drugs Research Division of the Health Research Board is undertaking a nationwide survey on 'Attitudes, Knowledge and Beliefs in relation to Drug Misuse and Drug Misusers'. The results of this study will provide much needed input to public policy and perceptions.

New information needs and priorities for the future

- The National Drug Treatment Reporting System provides information on the uptake of services and the development of profiles of drug users contacting treatment services. In addition data on clients receiving treatment for the first time can indicate changing patterns of problem drug use. It is planned to expand the National Drug Treatment Reporting System to accommodate the increased provision of treatment services and to include treatment provided by General Practitioners and the Prison Services. A future development would be an assessment of the quality of the data by way of a reliability and validity study.
- Recent reports of an escalation of the smoking of heroin among young adolescents would indicate that an investigation of motivations involved is needed.
- Information in the areas of viral hepatitis and non-fatal emergencies is limited and needs to be evaluated and its collection needs to be more systematic and standardised.

- Regular surveys of young people are necessary in order to uncover drug using trends among this cohort.
- Research is needed to establish to what extent there is a link between illicit drugs and crime, and what impact the importation, sale and consumption of illegal drugs has on crime.
- There is a need for on-going evaluation research into the implementation of policy in all areas. Investigation into the implications of illicit drugs policy on health, on the economy, on the criminal justice system are needed. Evaluation studies into the effectiveness of prevention programmes, rehabilitation programmes, the outcomes of treatment and methadone maintenance programmes need to be conducted. The impact of media campaigns needs to be assessed. Policy makers need this information in order to make informed decisions in relation to demand and supply reduction strategies.

Introduction

This report provides an overview of issues related to drug misuse in Ireland. The term *drug misuse* as used in this report refers to the taking of a legal and/or illegal drug which harms the physical, mental or social well-being of the individual, the group or society. Part I of the report outlines policy approaches to drugs, relevant legislation, organisational, and operational structures for the implementation of drug policy and legislation. Part II provides a summary of drug monitoring systems and sources of information on drugs in Ireland. It summarises epidemiological information and overviews issues related to the availability and supply of drugs. Part III provides a summary of measures taken to reduce the demand for drugs at national and regional levels and outlines specific intervention programmes and initiatives e.g. school/community/outreach programmes. The report focuses in particular on issues which arose in the course of 1997.

The report thus provides a general overview of the situation in Ireland regarding different aspects of the drugs phenomenon. It is a unique reference source which will be of value to a number of parties interested in the drug situation in the Irish context. The report is based on work carried out by the Drugs Research Division of the Health Research Board for the *European Monitoring Centre for Drugs and Drug Addiction* - EMCDDA. The EMCDDA is an European Union institution providing information concerning drugs and drug addiction and their consequences. The EMCDDA works to improve the comparability of drug related data in the Member States; to disseminate information and co-operate with international

bodies dealing with drug related issues. The EMCDDA in fulfilling its role, co-operates with a network of 'Focal Points' or national centres dealing with drug related issues in the Member States. This network is called the REITOX network (European Information Network on Drugs and Drug Addiction). The Drugs Research Division is the designated Irish Focal Point of the REITOX network. Focal Points act as an information resource to the EMCDDA in relation to the national situation in each Member State and disseminate European level information nationally.

The Drugs Research Division completes an annual *National Report on Drug Issues in Ireland*[1] as part of its contractual obligations to the EMCDDA. This is the basis of the present report. The EMCDDA provides detailed guidelines for the completion of the report along with a listing of the contents to be covered. However, as the different sections of this report for the EMCDDA are designed to stand alone, some repetition of background information is inevitable. The present report is an edited version of the report prepared for the EMCDDA i.e. edited to minimise repetition and to emphasise issues of particular interest in the Irish context.

The time and resources allocated to the report of necessity were limited, so no claim to complete coverage/comprehensiveness is made. Accordingly, the report is presented as a Resource Document and comments on the report are welcome. Welcome in particular are updates to the information provided.[2]

[1] National Report on Drug Issues : Ireland 1997. Internal Report, Drugs Research Division, HRB

[2] Please send such comments to the authors at, Drug Research Division, Health Research Board, 73 Lower

Part I

Drug Policy: Legal and

Drug Policy

1.1 Historical background

In a policy document on mental health in 1966 (*Report of the Commission of Inquiry on Mental Illness)* it was concluded that Ireland had, as yet, avoided serious drug use and addiction problems but advised that this could change unless constant efforts were made to avoid the misuse of drugs. In 1966 clinical evidence for the existence of amphetamine dependence was established (Walsh, 1966). At the time it was not difficult to get large amounts of amphetamines over the counter in many pharmacies in Ireland. Two years later public disquiet at the increasing indications of drug misuse in Dublin resulted in the setting up of the Garda Drug Squad and in the following year, 1969, the National Advisory and Treatment Centre was established at Jervis Street Hospital. This was the first statutory outpatient treatment facility in the country.

The principal components of Irish drug policy were contained in the *Report of the Working Party on Drug Abuse* which was published in 1971. The Working Party, appointed by the Minister for Health to examine the extent of drug misuse in Ireland, concluded that there had been a change in the pattern of drug use. In 1969 the police were aware of 350 persons in the Dublin area involved in the misuse of drugs. By 1970 this figure had grown to approximately 940 and estimates of up to 2,000 were put forward by the Gardaí (Report of the Working Party on Drug Abuse, 1971). Whereas initially the drugs involved in discussions about drug problems included amphetamines, barbiturates and tranquillisers, at the end of the 1960s the most commonly misused drugs were cannabis and LSD (lysergic acid

diethylamide). There was no evidence of any significant use of heroin. The problem of drug use had steadily increased in size in the Dublin area and it was recommended that the position should not be viewed with complacency. The enactment of the Misuse of Drugs Act, 1977 was a significant development during the 1970s. It provided for a wide range of controls over drugs which are liable to misuse (see Chapter 2).

Commencing in 1980 there was a sudden and dramatic rise in the use of opiates by young people in the inner city areas of Dublin. The onset of the heroin epidemic, as it subsequently became known, occurred later in Dublin than in other European cities. A number of measures were introduced as a direct result of the recommendations of two reports at this time (Eastern Health Board Task Force, 1982; Special Government Task Force on Drug Abuse, 1983). These included legislative changes, the introduction of 'life skills' programmes in a number of schools, the establishment of a diploma course in Addiction Studies at Trinity College, Dublin and the setting up of a National Co-ordinating Committee on Drug Abuse.

The National Co-ordinating Committee on Drug Abuse was established in 1985 to monitor developments and to advise the Government on issues regarding the prevention and treatment of drug misuse. In the late 1980s, amid increasing concern about the AIDS epidemic and in the interest of public health, the existing abstinence model of treatment was extended to include a harm reduction approach in order to minimise the risks involved. This included decentralised structures for drugs programmes relating to demand reduction, treatment and rehabilitation. The National Co-ordinating Committee on Drug Abuse was reconstituted in 1990 and charged with the responsibility of developing a policy to prevent drug misuse. The ensuing report the following year was adopted to become the *Government Strategy to Prevent Drug Misuse (*National Co-ordinating Committee, 1991).

Up to 1996 responsibility for co-ordinating the development and monitoring of the *Government Strategy to Prevent Drug Misuse (*ibid.) lay with the Ministers for State at the then

Departments of Health and Justice and implemented through the National Co-ordinating Committee on Drug Abuse. The fight against drug trafficking and drug misuse was a major theme of the Irish Presidency of the European Union during 1996.

In recent years with the escalation of the 'drug problem' and the perceived associated criminal activity, attitudes towards drug traffickers and pushers have hardened considerably, in particular following the murder of an investigative journalist during the summer of 1996, allegedly by criminals involved in drug trafficking.

1.2 Philosophy, objectives, principal components of drug policy

The official attitude to people who become dependent on drugs was articulated in 1971 by the then Minister for Health in an address to the Working Party on Drug Abuse when he said that they 'should be regarded as sick people in need of medical care to be treated with sympathy and understanding and be helped in every way possible to overcome their dependency on drugs' (Report of the Working Party on Drug Abuse, 1971). Drug traffickers on the other hand were regarded as deserving no sympathy 'and should be punished to the full extent permitted by law' (ibid.). Broadly speaking, this is still the attitude underlying current drug policy. Drug taking and the criminal activity associated with it, is considered to be a very serious social issue.

Traditionally the objective of drug policy has been to maintain people in, or restore people to a drug-free lifestyle. The promotion of health is emphasised in prevention programmes provided by education and health services. The aim of health promotion programmes is to prevent persons, in particular young people, from becoming drug users and to provide people who are already using drugs with the treatment and support to bring them to the stage where they can stop using drugs. While a drug-free society is the ultimate ideal, it is acknowledged that this is not an option for many drug users, at least in the initial stages of treatment. Since the mid 1980s, when the link

between needle sharing and the transmission of HIV was first recognised, a more pragmatic approach has been taken. As well as the provision of a number of treatment options, the importance of the minimisation of risk behaviour is stressed in prevention programmes provided by health and education services, and in treatment, harm reduction and rehabilitation programmes provided by the health services. *The Government Strategy to Prevent Drug Misuse* (National Co-ordinating Committee, 1991) recognised that the treatment, care and management of drug misuse does not lend itself to a 'one solution' approach. Consequently, there is a number of treatment and rehabilitation programmes available through a variety of agencies e.g., the Eastern Health Board, the Drug Treatment Centre Board, the voluntary sector and through primary care doctors. These programmes are closely aligned with the national AIDS strategy. Prevention, treatment and rehabilitation activities are balanced by measures taken in the area of law enforcement.

1.3 New developments

Following the recommendations of the *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996)* new structures were introduced to direct and co-ordinate drug policy. The operational implementation of approaches to drugs issues has now devolved from the National Co-ordinating Committee on Drug Abuse to a more structured sectoral approach involving A Cabinet Committee on Social Inclusion and Drugs, A National Drugs Strategy Team, A Regional Co-ordinating Committee and Local Drugs Task Forces (see **Co-ordination of Drug Policy** in Chapter 3). A number of legislative changes were introduced to curb the supply of and the demand for drugs. A new statutory body, the Criminal Assets Bureau (CAB), was established to ensure closer and more concerted action between state agencies in targeting the illegally acquired assets of criminals involved in serious crime, including drug trafficking.

The *Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* (1997) examined aspects of

the drugs problem in Ireland, such as the misuse of non-opiate drugs, drug use in prison, and the role of therapeutic communities in the treatment and rehabilitation or drug users. While it is generally acknowledged that problems associated with the use of heroin are mainly confined to disadvantaged areas in Dublin, this report states that the use of cannabis and ecstasy is 'nationwide' and 'is closely associated with youth culture' (ibid., p.52). Recommendations focus mainly on prevention activities. With regard to drug use in prison it was suggested that more integrated systems of supports as well as consistency in treatment policies inside and outside of prison are required. The need for an independent assessment of the effectiveness of current policies was acknowledged and it was recommended that an expert group be established to examine the issues involved. On the role of therapeutic communities in the treatment and rehabilitation of drug users it was acknowledged that this model should form part of the range of services available. It was recommended that international experience should be examined in determining the suitability of different models of treatment. The Ministerial Task Force recommended the establishment of an advisory group for this purpose and also to address the question of research.

As a result of the recommendations of the *First* and *Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996, 1997)* and consequent structural changes in the co-ordination of drug policy during 1997 (see **Co-ordination of Drug Policy** in Chapter 3), a shift occurred in drug policy approaches. There is now more emphasis on the greater involvement of community groups in the structural and organisational implementation of drug policies. This is accompanied by a more holistic intersectoral approach (health, education, housing, estate management, employment, recreation, sport, policing, etc.) to the drug problem involving the co-ordination of drugs programmes and services at local level, the involvement of communities in the development and delivery of locally based strategies to reduce the demand for drugs, and the focusing of actions on tackling the problem in the communities where it is most severe.

Relevant

2.1 Drug laws and penalties

In late 1996, Ireland ratified the UN Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances; and the Council of Europe Convention on Laundering, Search, Seizure and Confiscation of the Proceeds of Crime. These Conventions require Convention States to co-operate in the area of criminal law as well as to put in place certain domestic criminal law provisions. Since signing up to the Conventions, Ireland's role in international co-operation has significantly improved and expanded.

The following Acts and Regulations provide the statutory framework for the control of drugs with potential for misuse. Some of the legislation in this area predated the foundation of the State. The legislation is drawn up and implemented on an inter-sectoral basis by the relevant government departments of Health & Children, Justice, Equality & Law Reform and Environment; the Garda Síochána, Revenue Commissioners and Customs authorities.

The ***Poisons (Ireland) Act, 1870*** applied control to the sale of scheduled poisons including opium, morphine, cocaine, heroin and preparations containing these drugs.

The ***Pharmacy Act (Ireland), 1875*** confined the sale of scheduled substances to authorised persons i.e. registered pharmaceutical chemists.

The ***Dangerous Drugs Act, 1934*** which was based on international law controlled the import, export, distribution sale

and possession of specified drugs.

The ***Medical Preparations (Control of Sale) Regulations, 1966*** regulated the retail sale of amphetamines and their analogues, barbiturates and tranquillisers and limited these to prescription only.
Under the ***Medical Preparations (Control of Amphetamines) Regulations, 1969 & 1970*** the manufacture, sale and distribution of amphetamines and preparations containing amphetamines or their derivatives were prohibited.

The ***Misuse of Drugs Acts, 1977 and 1984*** and the Regulations made thereunder provide for a wide range of controls over drugs which are liable to misuse. They include controls relating to cultivation, licensing, administration, supply, record-keeping, prescription-writing, destruction and safe custody. Included in the Acts are the provisions designed to deal with the irresponsible prescribing of controlled drugs by medical practitioners.

Possession of any controlled drug, without due authorisation, is an offence under Section 3 of the Principal Act (1977). Section 15 of the same Act concerns the possession of a controlled drug for the purpose of unlawful sale or supply. Section 16 details the prohibition of certain activities relating to opium. The use of prepared opium, the frequenting of premises used for the use of opium and the possession of utensils used for smoking opium are all offences under this section. Section 5 of the 1984 Act prohibits the printing or communication of certain information which advocates or encourages the use of any controlled drug.

The penalties on being found guilty of an offence under section 15 of the 1977 Act, range from a fine or imprisonment for a term not exceeding twelve months or both on summary conviction, to an unlimited fine or imprisonment for life or both on conviction on indictment. The maximum penalty for possession of cannabis for personal use is restricted to a fine for first or second offences tried on summary conviction. For third and

subsequent offences there is a fine or twelve months in prison, or both. The penalty for a third offence on indictment is an open-ended fine or three years in prison, or both. The penalties for the possession of other controlled drugs are harsher and depend on the type of court in which the case is tried. On summary conviction the penalty is a fine or twelve months in prison, or both. On conviction on indictment the maximum fine for possession is left to the discretion of the court, which may also impose a seven-year prison sentence, or both a fine and a prison sentence.

Provision is made under the Acts for the judicial possibility in 'certain cases to arrange for the medical or other treatment or for the care' of a person dependent on drugs and convicted of an offence under the Acts.

The ***Misuse of Drugs Act, 1977 (Controlled Drugs) Declaration Order, 1987. Statutory Instrument No. 251 of 1987*** declares that certain substances, products and preparations should be controlled drugs for the purposes of the Misuse of Drugs Act, 1977.

The ***Criminal Justice Act, 1984*** provides for a widening of the scope of the criminal law and procedures to deal more effectively with serious crime, including serious offences under the Misuse of Drugs Acts.

The ***Misuse of Drugs Regulations, 1988. Statutory Instrument No. 328 of 1988.*** This document sets out the arrangement of the 1988 regulations regarding the misuse of drugs. Amongst other things the effect of the regulations is to impose restrictions on the production, supply, importation and exportation of the drugs to which the Misuse of Drugs Acts 1977 and 1984, apply.

Section 74 of the ***Child Care Act 1991*** states that where a shopkeeper sells a substance, in particular glue, likely to be inhaled to cause intoxication to a minor, he/she can, on conviction, be fined or imprisoned for up to twelve months. There is a provision for the retailer to put forward a defence that

reasonable steps were taken to ensure that this was not a deliberate offence.

The ***Misuse of Drugs Act, 1977 (Controlled Drugs) Declaration Order, 1993. Statutory Instrument No. 328 of 1993*** is published for the purpose of declaring the substances, products and preparations which are controlled drugs under the Misuse of Drugs Act, 1977.

The ***Misuse of Drugs (Scheduled Substances) Regulations, 1993 (Statutory Instrument No. 338 of 1993)*** was introduced in November 1993 to control precursors and essential chemicals. They are designed to meet Ireland's obligations relevant to the control of these substances, under the United Nations Convention Against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988, and under EC Directives 92/109 and EC Regulation 3677/90. The Regulations control production, supply, importation, exportation and possession of the substances.

The ***Criminal Justice Act, 1994*** provides for the seizure and confiscation of assets derived from the proceeds of drug trafficking and other offences. It contains provisions related to money laundering and allows for international co-operation in respect of certain criminal law enforcement procedures, the forfeiture of property used in the commission of crime and related matters.

The ***Criminal Justice (Drug Trafficking) Act, 1996*** provides for the detention of persons accused of drug trafficking offences for up to seven days. It also allows inferences to be drawn by a court from the failure of an accused person to mention particular facts during questioning.

Under the ***Criminal Assets Bureau Act, 1996*** the Criminal Assets Bureau was established on a statutory footing with powers to focus on the illegally acquired assets of criminals involved in serious crime. The aims of the Bureau are to identify the criminally acquired assets of persons and to take the

appropriate action to deny such people of these assets. This action is taken particularly through the application of the *Proceeds of Crime Act, 1996.*

The ***Licensing (Combating Drug Abuse) Act, 1997*** introduced a number of measures allowing for the suspension of intoxicating liquor licences and/or disqualification for ever from obtaining an intoxicating liquor, a public dancing or a public music and singing licence, following conviction for drug offences, e.g. knowingly allowing consumption or sale of drugs on premises.

The ***Europol Act, 1997*** provides for the establishment of a Europol National Unit and enables the ratification, by the State, of the Europol Convention and related protocols. This Convention establishes a European Police Office (Europol) to improve the effectiveness of and co-operation between Member States in preventing and combating serious international crime involving two or more Member States. It provides for a progressive development of the types of crimes in respect of which Europol will have competence and which will include within Europol's initial remit unlawful drug trafficking offences. Once the Convention enters into force Europol will effectively replace the Europol Drugs Unit (EDU).

2.2 Other relevant laws

The following are statutes indirectly related to the control of drugs.

The ***Customs Consolidation Act, 1876*** was a consolidation of all Customs legislation up to that time and concerns importation, seizures, detention of goods and persons and arrests.
The ***Mental Treatment Act, 1945*** provided for the compulsory hospitalisation of 'addicts to drugs'. Addiction remains on the statute books as one of the criteria for non-voluntary committal to a psychiatric hospital, but in practice it tends not to be invoked and one of the recommendations of the *White Paper on Mental Health, 1995* was that it be abolished.

The ***Customs Act, 1956*** 'shall be construed as one with the Customs Acts' which means all enactments relating to the Customs. It deals with the illegal importation and exportation of goods.

The ***Customs and Excise (Miscellaneous Provisions) Act, 1988*** amends and extends the law relating to customs and duties of excise and to amend the law relating to certain penalties for illicit distillation of spirits. In conjunction with other Customs and Excise Legislation, specifically 1876 and 1956, the Customs and Excise (Miscellaneous Provisions) Act, 1988 provides the legal basis for customs controls.

The ***Data Protection Act, 1988*** is designed to protect the privacy of individuals with regard to automated 'personal data' (data relating to individuals who can be identified from the data). This covers relevant information which is kept with regard to drug users. The legislation gives effect in Ireland to the Council of Europe Data Protection Convention.

The ***Proceeds of Crime Act, 1996*** provides for the freezing and forfeiture of the proceeds of crime. This legislation complements the confiscation provisions of the Criminal Justice Act, 1994.

The ***Disclosure of Certain Information for Taxation and Other Purposes Act, 1996*** provides for more effective exchange of information between police and revenue where there are reasonable grounds for suspecting that profits have been gained from unlawful sources or activities.

The ***Children Bill, 1996*** is primarily concerned with the introduction of provisions which will allow for the creation and development of a new juvenile justice system. It proposes for example, that the Garda Juvenile Diversion Programme, which gives the opportunity to divert juvenile offenders from criminal activity and to provide an alternative to their being processed through the formal criminal justice system, would operate on a statutory basis. It currently operates on an administrative basis.

The ***Freedom of Information Act, 1997*** enables members of the public to obtain access to information in the possession of public bodies and to have personal information relating to them corrected.

The ***Bail Act, 1997*** was enacted to give effect to the amendment to the Constitution and also to tighten up on other areas of the law in relation to the granting of bail. It allows the courts the discretion to refuse bail where they are satisfied that there is a danger of the commission of serious offences by a person while on bail. The Act also includes a requirement that an accused person and his/her surety lodge in court, in cash or cash equivalent, a proportion of the amount set for bail. It also strengthens the provisions of the Criminal Justice Act, 1984 in relation to the imposition of consecutive sentences for offences committed on bail. The Act is to come into operation by order to be made by the Minister for Justice, Equality and Law Reform.

The ***Non-Fatal Offences Against the Person Act, 1997*** provides a range of new offences to combat criminal conduct involving syringes, including offences of possession of a syringe or container of blood with intent to threaten or injure, placing or abandoning a syringe in any place in a manner which injures or is likely to injure any person, injuring a person with a syringe or threatening to do so, and throwing or putting blood on another person or threatening to do so. The penalties range from five years to life imprisonment.

The ***Housing (Miscellaneous Provisions) Act, 1997*** introduced a number of measures designed to assist housing authorities and approved voluntary housing bodies in addressing problems arising on their estates from anti-social behaviour, such as drug dealing. The Act provides for a new 'excluding order' procedure against individual occupants of a local authority house involved in anti-social behaviour, thereby avoiding the need for eviction of entire households in certain circumstances. It also includes provisions for the police, on notification by the housing authority to remove squatters who

Key

A diversity of agencies is involved in the administration of drug policies in Ireland (see Figure 3.1). A description of the administrative structures follows brief notes on the statutory and community actors.

3.1 Key actors, their roles, and relationships between them

Department of Health and Children

The Department of Health & Children is responsible for the overall policy and administration of all aspects of health and social care in so far as they relate to public health and child welfare. The Department plays a central role in the development of drug treatment policies and services and has adopted a health promotion approach. This is based on encouraging people to take responsibility for their health and on providing the support necessary to achieve this. The relevant legislative measures necessary to back up policies are drawn up by the Department of Health & Children.

The Department along with Regional Health Boards is responsible for the development of national and regional drug prevention activities. The Health Promotion Unit of the Department formulates prevention policies and is involved in the development of education and training programmes and the publication and dissemination of information literature that promotes the avoidance of drug misuse. Overall responsibility for the provision of treatment and rehabilitation services for people addicted to drugs lies with the Regional Health Boards.

Department of Justice Equality and Law Reform

The Department of Justice, Equality and Law Reform administers the courts, prisons and the Garda Síochána in discharging its primary function of preserving law and order. This Department is responsible for the implementation of Irish policy on the reduction of the supply of drugs.

All members of the Garda Síochána have a responsibility for the enforcement of all aspects of the law, including the various drug laws. All Gardaí receive instruction and training in relation to drugs including the enforcement of drug-related laws, the procedures for dealing with drug cases, health and safety issues. The Garda National Drugs Unit was established in 1995 with the primary function of targeting major drug traffickers as well as monitoring, controlling and evaluating all drug intelligence and policies within the police force. In addition to the Garda National Drugs Unit, there are officers in local drug units dealing solely with drugs matters. Juvenile Liaison Officers, who are specially trained Gardaí, have a role in drug activities by giving lectures/talks to school-children, young people and parents throughout the country.

The Department is further responsible, through the Probation and Welfare Service, for the treatment and general welfare of persons in prison. In some areas of Dublin a major proportion of Probation and Welfare Officers' workloads relates to offenders with significant drug misuse problems.

The Forensic Science Laboratory of the Department is responsible for the analysis of illicit drugs seized by law enforcement agencies. Scientists there identify the type and purity of drugs seized. The laboratory is also involved in the development of analytical techniques for the identification of illicit substances.

Responsibility for data protection and other relevant legislation also lies with the Department of Justice, Equality & Law Reform.

Department of Education and Science

Through the formal education system the Department of Education and Science plays a role in drug prevention

programmes. It works with the Department of Health & Children and other agencies on the development of awareness and information programmes in schools. In 1994 a substance misuse prevention programme *On My Own Two Feet* was introduced in second level schools. Training is provided to teachers who participate in this programme. An evaluation of the rationale and effectiveness of the programme was carried out and published in 1996 (Morgan et al., 1996). A similar programme for primary schools was developed during 1996 and was piloted during 1997 in schools in priority areas.

Other Government Departments

During 1996 the Government established a Ministerial Task Force to examine existing drug policy arrangements and to identify measures to provide more effective responses to the problem. The membership of the Task Force comprised Ministers of State from several Government Departments including the then Health, Justice, Education, the Environment, Foreign Affairs, Social Welfare, and the Taoiseach. A report was published making recommendations for structural and administrative changes (*First Report*, 1996). Following the publication of the Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1997) a Minister of State at the Department of Tourism, Sport & Recreation was given special responsibility for Local Development and for the National Drugs Strategy.

The Office of the Revenue Commissioners

The Office of the Revenue Commissioners is an administrative entity separate from the Department of Finance but within the area of responsibility of the Minister for Finance and includes the Customs and Excise service. The effectiveness of Customs legislation, practices and procedures for detecting the illegal importation or exportation of controlled drugs is kept under on-going review. The Customs National Drugs Team comprises Intelligence, Operational, Maritime teams as well as Dog Units. These are strategically located around the coast of Ireland in efforts to prevent drug trafficking.

Regional Health Boards

There are eight Regional Health Boards in Ireland (see map at Annex A). They have responsibility in their respective areas for the development and implementation of health services, the co-ordination of statutory and voluntary services, and the provision of support and training for community groups involved in drug prevention activities. All Regional Health Boards have established Regional Drugs Co-ordinating Committees and many have also appointed Drug Co-ordinators. Due to increased demand in Dublin, prevention, treatment and rehabilitation services are continually expanding in the Eastern Health Board area. A chart of the services provided by the Eastern Health Board can be found at Annex D. Treatment services in the other health board areas are still mainly provided by the general psychiatric service and some voluntary agencies.

Community Groups

Following Government decisions in October 1996, priority areas with very serious drug problems have been identified and Local Drugs Task Forces have been established to co-ordinate the implementation of drug policy. Membership of these Task Forces is drawn from local health boards, the education service, the local authority, the local employment service, the Probation and Welfare Service, the Gardaí, and community and voluntary organisations. In recent times community groups are taking a more active role in the formulation and implementation of policy. The involvement of such groups will be facilitated by recent increases in Exchequer financial allocations to the fight against drugs.

Voluntary Organisations

Voluntary organisations play a key role in the development and delivery of prevention and treatment programmes. Many of these receive support and funding from the regional Health Boards in whose areas they operate in addition to voluntary funding.

3.2 Co-ordination of drug policy

A central aspect of the Strategy document of the Department of Health & Children *Shaping a healthier future* (1994: 48) was 'a health promotion approach based on encouraging people to take responsibility for their own health'. In general health policy terms, the importance of inter-sectoral collaboration is centrally recognised. One of the major tasks of drug policy is that of co-ordinating the activities of a range of governmental sectors. While this has been recognised the reality of inter-sectoral co-ordination is problematic.

Following Government decisions on measures to reduce the demand for drugs new structures were introduced to direct and co-ordinate drug policy. The operational implementation of approaches to drug issues operates on a sectoral basis and is made up of the following:

A *Cabinet Committee on Social Inclusion and Drugs*, is chaired by the Taoiseach. The other members of the committee are the Tanaiste and the Ministers for Finance; Health & Children; Environment & Local Government; Justice Equality & Law Reform; Education & Science; Social Community & Family Affairs; Tourism Sport & Recreation and two Ministers of State including one with specific responsibility for the National Drugs Strategy. This committee was originally named the 'Cabinet Sub-Committee on Drugs' but had its brief broadened in 1997, with the change in Government, to include Social Inclusion.

The Cabinet Committee on Social Inclusion and Drugs has political responsibility for

- the reviewing of trends in the drugs problem
- the assessment of progress in the Government's strategy to deal with both the supply and the demand aspects of drug policy
- the resolving of policy or organisational difficulties which may inhibit effective responses to the problem.

A *National Drugs Strategy Team*, comprising representatives of relevant Government Departments, the Garda Síochána, *FAS* (Training and Employment Authority), the community sector, a voluntary organisation, and a medical advisor, was set up to

oversee the implementation of the Ministerial Task Force Reports. The National Drugs Strategy Team functions at two levels, policy and operational.

At the policy level a *Policy Team*

- reviews progress in the implementation of government policy
- addresses issues which may arise from the implementation of this policy.

This Team reports to the *Cabinet Drugs Committee,* more recently the *Cabinet Committee on Social Inclusion and Drugs,* on a regular basis and brings to its attention issues requiring political direction or decision.

At the operational level an *Operational Team*

- ensures effective co-ordination between government departments and statutory agencies in implementing government policy
- oversees the work of the *Local Drugs Task Forces* and assists them where necessary
- draws up guidelines to assist them in the preparation of anti-drugs strategies
- evaluates these strategies and makes recommendations to Government regarding the allocation of resources to support their implementation
- monitors developments at local level ensuring that central government is aware of the problems and priorities of communities.
- considers policy issues before referring them to the *Policy Team.*

Regional Co-ordinating Committees operate in each of the eight regional health boards, with representation from the health boards, the education service the gardaí and relevant voluntary and community agencies.

Local Drugs Task Forces have been set up in priority areas in the Eastern and Southern Health Board areas (12 in Dublin, 1 in Cork) where heroin misuse is a serious problem, with representation from the Eastern Health Board, the Southern Health Board, the Garda Síochána, the Probation and Welfare Service, the relevant Local Authority, the Education/Youth Service and *FAS* (Training and Employment Authority) along with community representatives nominated by the relevant community groups, and a chairperson. Voluntary agencies delivering a drug service in the area are also invited to participate. A co-ordinator for each Task Force is provided by the relevant Health Board. The Local Drugs Task Forces were established to provide a strategic locally-based response by statutory, community and voluntary sectors to the drugs problem, in the areas worst affected. During 1997 they were mandated to prepare service development plans to respond to the drug problem and Government funding of £10 million was made available to implement these plans. Their mandate is:

- to compile a profile of existing and planned services and the resources available
- to prepare a development strategy to deal with the local problems
- to oversee the implementation of local drugs strategies
- to provide information, reports and proposals to the *National Drugs Strategy Team*

The aim of these Local Drugs Task Forces is to falicitate effective co-ordination of programmes and services at local level, involving communities in the development and delivery of locally-based anti-drugs strategies. Their actions are focused on drugs issues in communities where the problems associated with drug use are most severe. They are carrying out work in the following broad areas:

- *Re-integration of drug misusers* - this will involve the provision of places on Community Employment/Community Training Programmes

Figure 3.1 Ireland. Key Administrative and Organisational Actors.

The Department of Justice Equality and Law Reform, and the Office of the Revenue Commissioners have overall responsibility for the funding of law enforcement agencies - the Garda Síochána, the Garda National Drugs Unit, the Probation and Welfare Service, the prisons and the Customs and Excise Service.

Extra funding of £10m was approved by government in 1997 to support the implementation of the recommendations of the Ministerial Task Force on Measures to Reduce the Demand for Drugs.

3.4 New information requirements regarding drug policy

In recent years in Ireland, there has been growing recognition of the need for data and information on drug misuse which can inform policy makers and service providers in relation to policy and interventions. Because of the relevance of data to policy issues the information base needs development in a number of directions. Some of these developments are underway or planned. This interest was reflected in the Science and Technology against Drugs Initiative which was launched in 1996. This research programme was initiated by Forbairt and conducted under the authority of the National Research Support Fund Board. A special research budget was provided to researchers in third level institutions for a range of projects. Eight social science projects are investigating the factors which contribute to and inhibit drug taking. Other projects funded under this programme address the areas of Drug Detection and Analysis, and Biochemistry and Pharmacology (for details of projects, see Appendix C). The requirements stemming from 1996 Ministerial Task Force on Measures to Reduce the Demand for Drugs has resulted in the collection of some background information on drug misuse in local areas. This information was collected in the context of the formulation of local drug service development plans by Local Drugs Task Forces (as mandated by the 1996 report).

The Ministerial Task Force on Measures to Reduce the

Demand for Drugs recommended the setting up of an Advisory Group which would address policy and good practice in the drugs area. Preliminary planning and resourcing of the Advisory Group is under discussion. The terms of reference and membership of an Advisory Committee to review drug policies and research are under consideration.

The National Drug Treatment Reporting System [NDTRS], run by the Drugs Research Division of the Health Research Board [HRB] provides nationwide information on treated drug misuse. As such it is a major information source for policy makers, researchers, practitioners and the general public. With support from the Department of Health and Children, inter alia, a feasibility study is underway which it is planned will lead to the expansion of the NDTRS to include coverage of treatment provision in the prison services and by General Practitioners in community settings. Other studies nearing completion or planned by the Division which will inform policy include - a study of drug misuse in its social and economic context which is focusing on the relationship between problematic drug use and economic deprivation; a study of knowledge, attitudes and beliefs of the general public regarding drugs. In addition work being undertaken by the Division in its collaborative associations with the EMCDDA and the Pompidou Group of the Council of Europe will provide background information for policy makers and related actors (see Annex E).

Other policy-relevant work carried out in Ireland, includes a study on prevalence of opiate addiction in the Dublin area (publication due 1998). The Department of Health and Children has funded this research through the Health Research Board. Ongoing studies of this nature will be required.

With increasing political concern about the causes and consequences of drug usage, new policy initiatives and new approaches to policy implementation are required. The need for data to inform the formulation and implementation of drug policy is increasing. Policy makers in addition need information on the attitudes of society to drug use and the willingness of different groups in society to support drug policy initiatives. Information

is required on, for example, models for resource allocation, the effectiveness of drugs policies in different socio-economic contexts, the role of actors from the different sectors, the importance of capacity building in local communities, the effectiveness of different treatment models and rehabilitation programmes, the relapse rate of treated clients. In addition, the new area based approaches to tackling the drugs problem and

Figure 3.2. Ireland. International Co-operation. Organisations, departments and agencies involved.

International Organisations	Irish Government Departments/Agencies
United Nations (Drug Control Programme)	Department of Foreign Affairs Department of Health & Children Department of Justice, Equality & Law Reform
United Nations (Conventions of Controlled Substances & Psychotropic Drugs)	Department of Health & Children Department of Justice, Equality & Law Reform
World Health Organisation	Department of Health & Children
Council of Europe (Pompidou Group)	Department of Health & Children Department of Justice,Equality & Law Reform Health Research Board *Drugs Research Division*
European Union	Relevant Government Departments
European Monitoring Centre for Drugs and Drug Addiction	Department of Health & Children Department of Justice, Equality & Law Reform Health Research Board *Drugs Research Division* Trinity College Dublin *Scientific Committee Representative*
Interpol Europol	Department of Justice, Equality & Law Reform Garda Síochána
Customers Co-operation Council	Office of the Revenue Commissioners Customs & Excise Service

Summary: Drug Policy

Traditionally the objective of drug policy has been to maintain people in, or restore people to, a drug-free lifestyle. Policy and practice have changed over the past ten years and harm reduction is now a key feature of drug policy.

While it is acknowledged generally that problems associated with the use of heroin are mainly confined to disadvantaged areas in Dublin, the *Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs* (1997) stated that the use of cannabis and ecstasy is 'nationwide' and 'is closely associated with youth culture'.

As a result of the recommendations of the *First* and *Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996, 1997)* and consequent structural changes (see **Co-ordination of Drug Policy** at Section 3.2) in the co-ordination of drug policy during 1997 a shift occurred in drug policy approaches. There is now more emphasis on the greater involvement of community groups in the structural and organisational implementation of drug policies. This is accompanied by a more holistic intersectoral approach (health, education, housing, estate management, employment, recreation, sport, policing, etc.) to the drug problem involving the co-ordination of drugs programmes and services at local level, the involvement of communities in the development and delivery of locally based strategies to reduce the demand for drugs, and the focusing of actions on tackling the problem in the communities where it is most severe.

During 1997 a number of statutes were enacted covering a range of measures to control the use, supply and criminal activities associated with drugs. More controls were introduced in relation to the issuing of licences for the sale of liquor, as well as licences for public dancing, music and singing (*Licensing (Combating Drug Abuse) Act, 1997*). Other relevant new legislation includes the *Housing (Miscellaneous Provisions) Act, 1997* which allows local authorities to evict individual tenants

who are engaged in anti-social behaviour; the *Bail Act, 1997* which allows the courts the discretion to refuse bail where they are satisfied that there is a danger of the commission of serious offences by a person while on bail. Under the *Non-Fatal Offences Against the Person Act, 1997* it is an offence for a person to place or abandon a syringe in a manner which injures, or is likely to injure, or frighten another person. A Courts Commission has made recommendat-ions on the setting up of special courts for persons charged with non-violent offences, leading to rehabilitation, where appropriate, rather than serving custodial sentences.

The Government has recently made extra financial resources available for a Young People's Facilities and Services Fund, of £30m over three years, to support a variety of capital and non-capital projects in disadvantaged areas. At least £20m will be targeted at those areas particularly affected by the heroin problem. Allocations from the fund will be made by the Cabinet Committee on Social Inclusion and Drugs and will take account of the new co-ordinated focus on the needs of disadvantaged areas, as well as the work of the Local Drugs Task Forces.

The overall drugs problem is now given a higher profile by all political parties, more resources have been allocated to problem drug use and there is now greater emphasis on the involvement of community groups in the formulation of drug policy. While the major tenets of drug policy have not changed the changes in approach have provided the opportunity for better co-operation between statutory bodies and community groups, whereby community interests will be better taken into account in official responses to the prevention and management of serious drug problems.

Part II

Epidemiology

Types and

4.1 Epidemiology

The core information systems used to monitor the drugs problem and to inform policy making are in the health and law enforcement areas.

The Drugs Research Division of the Health Research Board (HRB) operates the *National Drug Treatment Reporting System* providing data on treatment given by statutory and voluntary agencies on a nationwide basis. This is the best developed of the indirect indicators of drug misuse in Ireland. The value of this data lies in the provision of information on the uptake of services and a profile of drug users contacting treatment services over time. Data on clients receiving treatment for the first time can indicate changing patterns and trends of problem drug use. A feasibility study is underway which should result in greater coverage in the System of drug users presenting for treatment, specifically those being treated by general practitioners in the community and within the prison services.

Other sources which provide information on treated drug misuse include the *National Psychiatric In-patient Reporting System* which is maintained by the Mental Health Section of the Health Research Board and the *Hospital In-Patient Enquiry System* which is run by the Economic and Social Research Institute. The central *Methadone Treatment List* is a register of all clients receiving methadone. This information, which is used to avoid duplication of methadone prescription, is not available as an information source.

Information on infectious diseases is limited in that ongoing monitoring of the proportion of drug users and intravenous drug

users infected by the Hepatitis B or C viruses is not available.

Data on drug-related mortality are also limited mainly due to the methodology used to collect this information. The EMCDDA is investigating the opportunities for comparing drug-related mortality data in the different EU countries. Other aspects of mortality, such as drug-related car accidents and murders need to be investigated.

Law enforcement data are a good reflection of the number of criminal charges for drug offences. These data are based on events rather than individuals - a person could be charged more than once in a given year. Seizures of drugs data reflect the activity of police and customs authorities and could be biased by the efficiency of detection methods, for example, the number of personnel involved in the detection of such crimes, the use of sniffer dogs or the availability of equipment. 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 drug products is collected by the police at street level. The quality of the latter data is difficult to ascertain.

4.2 Indicators of drug misuse

Drug treatment data are collected by the *National Drug Treatment Reporting System (NDTRS)* which provides national coverage on treated drug misuse. The data are a good reflection of the number of clients availing of the treatment services which are provided. A shortage of resources prevents a small number of agencies from returning data. General practitioners providing treatment to drug users are not as yet well represented in the system. Plans to do so are under way, by way of a feasibility study which should result in greater coverage of those treated by general practitioners and also those treated within prison services. The System provides core socio-demographic information, problem drug using patterns and risk behaviour in relation to treated drug misuse. The instrument used to collect data is based upon the definitive protocol formulated by the Pompidou Group of the Council of

Europe. There is however, a time-lag between initial drug use and the demand on services for treatment. Accordingly, the *NDTRS* is an indirect indicator of drug misuse and as such it is limited. An annual report is published each year.

Hospital psychiatric data are available from the *National Psychiatric In-patient Reporting System (NPIRS*). 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). 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.

The *Hospital In-Patient Enquiry (HIPE) Scheme* is a computer based health information system designed to collect medical and administrative data regarding discharges from acute hospitals (excluding private hospitals). 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).

Infectious diseases are required to be notified to the Department of Health and Children and statistics are published annually. Hepatitis B is a notifiable disease but it is generally accepted that there is under-reporting and that the notification system is not a good indication of the true incidence of infection. AIDS data (total cases, number of intravenous drug users - IVDU, total number of deaths and number of IVDU deaths) are collected by regional AIDS co-ordinators and returned to the Department of Health and Children. HIV data are collected by the Virus Reference Laboratory and submitted to the Department of Health and Children.

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) on behalf of the Department of Health and Children. The information from the CSO is the most complete and comprehensive available. However, the procedures used at present to collect these data can result in the loss of information on the fact that a death was drug-related. Deaths are classified according to the World Health Organisation's ICD-9 (the latest revision ICD-10 is to be introduced in 1998) where it is the *underlying cause of death* which is recorded. Even though information on the drug-related aspect of a death is frequently available in the data collection process, in the absence of a specific methodology to capture this item it can be lost, thus limiting the data. The procedures used in recording a death (specifically in relation to suicide) are being examined by a task force appointed by the Minister for Health. An amendment that would elicit information on whether a death was drug-related, has been recommended to this committee. A report on the work of this group was published early in 1998*(Report of the National Task Force on Suicide)*.

In the area of law enforcement, national data are collected by the Garda Síochána and published annually. For the purpose of this report arrests data are defined as the number of charges for drug offences. Breakdown is given by drug and whether it was intended for possession or traffic/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, could influence the consistency of the data over time.

Information on drug product purity is collected by the police from seizures of drugs. Analyses are carried out at the Forensic Science Laboratory of the Department of Justice. Ad-hoc

Current Situation

5.1 Drug consumption in the population

In recent years a number of local area schools surveys have been carried out in Ireland. Morgan and Grube (1994) conducted a survey among a sample of Dublin youth and while the emphasis was on drinking among post-primary school pupils, information was also collected on lifetime prevalence of drug use (Annex B, Table B1). The study found that an increase in drinking was part of a broader phenomenon including higher levels of usage of a range of other substances including illegal

Table 5.1
Greater Dublin Area.
Lifetime Prevalence of Drug Use

Type of Drug	1991	1984
	%	%
Marijuana	25.1	13.2
Solvents	18.9	12.9
Cocaine	2.2	1.5
Barbiturates	2.2	2.7
Heroin	1.4	1.2
Amphetamines	2.9	3.3

Source: Grube and Morgan, 1994

In 1994 a descriptive survey of substance misuse among adolescents of school-going age, approximately 12 to 18 years old was conducted in the Western Health Board area. The sample was selected 'to have as representative a sample of the school going population as possible' (Kiernan, 1995). As there is evidence that substance misuse is higher among early school leavers, a sample of this group was also included. The school

years selected were weighted to include more students from the senior cycle than the junior cycle, so that comparisons could be made between school-going students and early school leavers. Lifetime prevalence rates (see Table 5.2) were determined among the sample as a whole. Again in this case cannabis and solvents were the drugs most likely to have been used.

Table 5.2
Western Health Board
Lifetime Prevalence of Drug Use

Type of Drug	1984
	%
Cannabis	15.5
Solvents	14.3
'Magic Mushrooms'	5.1
LSD	3.7
Ecstasy	2.2
Tranquillisers	2.0
Cough Syrup	6.2
Amphetamines	1.9
Cocaine	1.0
Heroin/Opiates	0.8

Source: Kiernan, 1995

Table 5.3
Southern Health Board.
Lifetime and Current Prevalence of Drug Use

Type of Drug	1996	1996
	Lifetime %	Current %
Cannabis	17	4
Hallucinogens	6	0.4
Amphetamines	3	na
Ecstasy	3	na
Sedatives	2	0.5
Opiates	1	na
Cocaine	1	na
Crack	0.3	na

Source: Jackson, 1997 (Interim report)

Preliminary results of two surveys carried out in regional Health Board areas show that after alcohol and tobacco, cannabis is the most frequently used drug. In the Southern Health Board area a sample of 1500 (aged 15-44) from the general population was surveyed (Table 5.3). 'Current prevalence' is defined as use in the past month.

Preliminary results from a study in the North Eastern Health Board where 1,516 adolescents aged between 13 and 19 years, from 21 schools in the area were randomly administered a confidential questionnaire, show that 10 percent had regularly used cannabis. Regular use is described as monthly or weekly use.

In 1995 a nationwide school survey of sixteen year old post-primary school pupils (European School Survey Project on Alcohol and Drugs - ESPAD) was carried out in collaboration

with the Pompidou Group of the Council of Europe and CAN, Sweden (Hibell, B. et al., 1997). This showed a marked increase, to 37 percent in lifetime prevalence (that is, at any time in the past) of cannabis use, on the 1991 study mentioned above. This is three times the average of the other European countries involved in the study. Only one other country, the UK, was higher at 41 percent. On closer examination of the frequency of the use of cannabis among students in Ireland, it was shown that 7 percent of them had used cannabis more then ten times in the previous year and a similar proportion (7 percent) had used it more than six times during the previous month. The Irish figure for lifetime experience of LSD or other hallucinogens was 13 percent (UK, 14 percent), for those who had used any illicit drug other than cannabis it was 16 percent (in the UK it was 21 percent; the European average was 4 percent) while the percentage who had used tranquillisers or sedatives without a doctor's prescription (7 percent) was similar to the average European figure. Sixty percent of students in Ireland stated that they had never used any drug while 33 percent said that the first drug they had used was marijuana or hashish. Lifetime experience of ecstasy was 9 percent for Irish students (8 percent for students in the UK). It was very clear from this survey that ecstasy (MDMA) was perceived as very easy to find in Ireland - 54 percent said that getting this drug was 'very easy' or 'fairly easy'. Amphetamines were also reported to be easy to obtain - by one third of students. When the perception of risks involved in behaviour such as frequent alcohol use or drug taking was examined, students in Ireland had below average perceptions of 'great risk' on all the behaviours in comparison with other European students.

5.2 Problematic Drug Use

The best available information on the current situation of problem drug use in Ireland is data from the National Drug Treatment Reporting System. This information is collected by the Drugs Research Division of the Health Research Board and refers to people who receive treatment for problem drug use.

Treatment can be medical (detoxification, methadone or drug-free programmes) or non-medical (addiction counselling, individual/group therapy or psychotherapy). From 1990 to 1994, data was collected in the Greater Dublin area only. In 1995 the Reporting System was extended to the whole country. Problematic opiate use is concentrated mainly in the Dublin area in localities with high levels of socio-economic deprivation. While the use of cannabis and ecstasy is reported to be on the increase throughout the country among young people in particular, the numbers of people treated for problem opiate use outside of Dublin remains relatively low.

Opiates were the drugs reported to be causing the most problems in four out of five of those presenting for treatment in Dublin over the seven-year period, 1990-1996 (see Annex B, Tables B2-B7). While the majority of these injected their stated primary drug of misuse there was a fall in the proportions over the seven-year period. This could perhaps be explained by the fact that there is an increase in the practice of smoking heroin among an increasingly young treated population.

5.3 Patterns of use and characteristics of users

There are regional differences in drug use patterns in Ireland with the use of opiates mainly confined to the Dublin area. From schools and youth surveys (see Tables 5.1, 5.2) it is apparent that the drug experiences of young people in the west of Ireland are different from those of young people in the east of the country, with higher lifetime prevalence rates in Dublin.

Data from the National Drug Treatment Reporting System also suggest that there is a great disparity in the pattern of drug use in different parts of the country. The majority of cases (88 percent) were treated in the Eastern Health Board area (EHB). The Southern Health Board area (SHB) had the next highest proportion treated but this was only 6 percent of cases, while 3 percent were treated in the South Eastern Health Board area (SEHB). The type of drug used also varied in different areas. In the EHB the problems were largely associated with opiate use

while in the SHB it was cannabis followed closely by ecstasy use. Outside of the EHB the most common drug used was cannabis (Moran et al., 1997). The characteristics of users using different types of drugs also varied, for example, whereas 25 and 10 percent of users treated for cannabis and ecstasy use respectively were still at school, only 1 percent of heroin users were.

It is likely that those encountering very serious problems will eventually present to the treatment services. Thus the characteristics of more problematic drug users are represented by the treated population of drug users. The profile of the typical problem drug user who presents for treatment is that of a young, unemployed male, leaving school at an early age and likely to be living in a disadvantaged area in Dublin (Annex B, Table B9).

Table 5.4 Dublin. Route of Administration of Primary Drug. First Treatment Contacts. Valid Percentages. 1990 - 1996

Route	1990	1991	1992	1993	1994	1995	1996
Inject	48.3	36.2	33.9	44.1	46.7	29.9	31.3
Smoke	27.6	39.4	41.0	32.8	38.6	56.6	60.0
Eat/drink	17.0	16.2	19.4	20.8	13.2	12.0	7.3
Sniff	7.1	8.2	5.7	2.2	1.5	1.4	1.4
Valid N	601	437	661	850	1144	1386	1469
Total N	624	450	668	859	1150	1396	1499

Table 5.5 Dublin. Risk Behaviours First Treatment Contacts. Valid Percentages. 1990 - 1996

Risk	1990	1991	1992	1993	1994	1995	1996
Ever Injected	59.9	44.2	41.7	50.8	52.5	40.6	40.4
Ever Shared	69.3	55.6	58.6	54.9	37.9	16.5	18.4
Currently injecting	68.0	71.0	76.5	76.8	70.7	25.3	27.4
Currently sharing	17.0	18.5	17.4	14.2	9.7	5.2	7.7
Total N	624	450	668	859	1150	1396	1499

Source: Drug Treatment Reporting System, HRB

5.5 Risk and protective factors

While no analytical studies on risk and protective factors for beginning of drug use have been carried out to date in Ireland it was found that 'there seemed to be a direct relationship between closeness and peer/friend influence in the sense that the group of age-mates who were psychologically closer to the individual seemed to have a relatively greater influence' (Morgan and Grube, 1994:66). A study, by the same authors, which aims to identify the key mediating factors that are responsible for initial experimentation with drugs among young people, is due to be finished in 1998. Data from the treated population of drug users suggest that a high proportion of those coming into treatment for the first time are male (70 percent) and that 45 percent were 15 years or younger when they first used a drug other than alcohol or tobacco (Moran et al., 1997).

5.6 Different drug profiles

Indications from school and youth surveys suggest that, after alcohol, cannabis is the most commonly used drug. Anecdotal evidence suggests that among young people of all social groups and in all areas of the country, cannabis and ecstasy use is becoming more prevalent in the club scene. Again, anecdotal evidence suggests that middle class users tend to use cannabis, ecstasy and LSD recreationally. Ecstasy and LSD are reportedly associated with the club scene.

Over a number of years the profile of drug users who present for treatment shows that heroin and morphine sulphate tablets (MST) were the drugs most commonly used and the main reason for which clients sought treatment (see Annex B, Table B10). Over the seven year period since data collection began in Dublin, heroin as the primary drug of use has been increasing with a corresponding decrease in the use of morphine sulphate tablets. In 1996 heroin was the main drug for which treatment was sought in eight out of ten cases. A breakdown of the secondary drug of misuse is given at Annex B, Table B11. The use of benzodiazepines as part of a wider pattern of drug use has increased significantly over these years; methadone misuse is also a cause for concern. Figures for cannabis use as a

Problems and

6.1 Mortality

It is generally accepted that the procedures used at present in Ireland to collect drug-related mortality data can result in the loss of information that a death was drug-related, thus limiting the data. A detailed examination of the data available from the Central Statistics Office on deaths recorded with an 'underlying cause of *drug dependence'* (International Classification of Diseases Code 304) over a twelve-year period shows that the majority were male in the age-group 15 to 39 years. For the 15-49 year age group the number of deaths went from 14 in 1985 to 3 in 1986 and 1987, to 13 in 1992 and 33 in 1996 (see Annex B, Table B12).

While information on overall mortality among drug addicts is not available, data on deaths from AIDS has been collected by the Department of Health & Children since 1982. Between 1982 and 1996 approximately half of those who died from AIDS were intravenous drug users. In 1997, there was one intravenous drug use related death out of a total of seven AIDS deaths (see Annex B, Table B13). This shows a considerable drop in the number of intravenous drug-related AIDS deaths in the past five years.

6.2 Morbidity

Intravenous drug users make up the highest risk category of confirmed cases of AIDS in Ireland. The figure was 43 percent in 1996, and 32 percent in 1997. This proportion, which has decreased over the years since recording commenced in the

mid 1980s, peaked in 1993 at 63 percent (see Annex B, Table B13).

Because of the regional difference in drug use patterns, with opiate use mainly confined to the Dublin area, it can be assumed that drug-related AIDS/HIV prevalence is higher in Dublin. Of the samples tested in the Virus Reference Laboratory for HIV antibodies between 1986 and 1996, a cumulative total of 1,731 samples have tested positive. Forty six percent of these (797) were intravenous drug users. Since individuals may have been tested more than once, the number of tests does not necessarily correspond to the number of individuals tested.

A study to quantify the sero-prevalence of antibody to Hepatitis C virus was carried out among 272 injecting drug users at the National Drug Treatment Centre, Trinity Court, over a one-year period (Smyth et al., 1995). The overall sero-prevalence was found to be 84 percent, and a significantly greater proportion of females tested positive than males. The high prevalence of Hepatitis C might indicate the sharing of injecting equipment. This is not reflected in current trends in the National Drug Treatment Reporting System data, which show less injecting/sharing and more smoking of the primary drug of misuse. The study results could perhaps be explained by the small sample size. However, it could perhaps also be explained in terms of the reluctance of drug users to admit to injecting and sharing practices. Hepatitis B could not be considered to be an indicator of incidence of drug injecting in Ireland in view of the fact that a vaccine is offered.

Table 6.1
First Admissions to Irish Psychiatric Hospitals and Units for # Drug Dependence .
Numbers and Rates per 100,000 population.

	1990	1991	1992	1993	1994	1995	1996
First Admissions							
Number	105	124	145	167	200	66	236
Rate	3.0	3.5	4.1	4.7	5.6	7.5	6.5

Source: National Psychiatric Inpatient Reporting System, Health Research Board

Williams et al. (1990) studied the level of depressive symptomatology reported by a sample of opiate addicts who were receiving methadone maintenance therapy, and attending the Drug Treatment Centre, Trinity Court in Dublin. A high level of depressive symptoms were found after completion of the Black Depression Inventory. They conclude that the relationship between depression and opiate dependency in the group studied 'is likely to be complex and multifactorial' and is open to various interpretations e.g., that opiate use may be a method of self medication to relieve depressive feelings, or that depressive symptoms could represent a reaction to problems of living, or could be explained by familial factors. However, they go on to say that ' awareness and recognition of depressive symptoms have an important bearing on the effective treatment of opiate dependent individuals'.

6.3 Legal Problems

Table 6.2 below shows the number of charges for drug offences over a number of years. These data refer to events and not to individuals, the same person could be prosecuted for a number of offences in the same year, or for the same offence a number of times in the same year. Over the five-year period the number of charges for cannabis offences has decreased while prosecutions for heroin offences has increased almost

Table 6.2
Ireland. Number of Drug Charges by Type of Drug

Type of Drug	1992	1993	1994	1995	1996
Cannabis	2768	3007	3082	2600	1834
Heroin	91	81	230	296	432
Other Opiates	170	136	-	-	-
Cocaine	11	15	15	30	42
Amphetamines	49	82	81	138	152
LSD	48	129	119	70	24
Ecstasy	65	135	261	645	340
Other offences	292	248	655	385	454
Total	3494	3833	4443	4164	3278

Source: Annual Reports of An Garda Síochána.

In 1996 cannabis was involved in 63 percent of offences against the *Misuse of Drugs Acts, 1971* and *1984*. Heroin and ecstasy accounted for 15 and 12 percent respectively. There were regional differences in the drug types involved. Almost all controlled drug offences involving heroin took place in the Dublin area where they accounted for over a third of total offences. Ecstasy proceedings accounted for a fifth of the total in the southern region (Cork, Kerry and Limerick). Cannabis offences constituted the majority in all areas.

A study carried out by the Garda Research Unit looked at the association between illicit drug use and crime in the Dublin Metropolitan Area. The sample was based on all Garda records of persons arrested, charged or suspected of criminal activity (Keogh, 1997). It was found that a majority of people were involved in crime before becoming involved in drug activities. Over one third had left school before the official school leaving age and a majority said that they had a poor understanding of the effects of drug use. While three quarters of the respondents had at some time sought treatment for drug misuse and most had received it, a number had not sought treatment of any kind.

Availability and

7.1 Sources of supply and trafficking patterns

According to police intelligence the sources of supply vary according to the type of drug. While some smaller seizures of cannabis are known to have originated in Pakistan, Afghanistan and Lebanon, cannabis comes mainly from Africa. Asia (Afghanistan, Pakistan, India, Laos, Thailand) is usually the area from which heroin seized in Ireland originates. More recently Turkey is emerging as a source for heroin. South America is the source of the bulk of cocaine seizures.

The police report that most of the trafficking in cannabis takes place between Morocco and the south coast of Ireland, on sea-going yachts and articulated trucks using cross-channel ferries. The bulk of heroin seizures are transported to Ireland through the UK and some from the Netherlands. It has come to the notice of the authorities that middle-aged people, not known to the police, are being used as drug couriers from Europe. Quantities are relatively small and specifically for the home market. Batches of ecstasy tablets are imported in luggage by couriers or in vehicles. There have been quite a number of seizures of skunk (a term used to describe a potent form of the cannabis plant) from factories located in for example, an attic, warehouses and a bathroom, where it is being produced by means of hydroponics. Apparently such production is easy to set up with catalogues and instructions available on the Internet . This makes the enforcement of Section 5 of the Misuse of Drugs Act, 1984 virtually impossible. 'Advocacy' offences, as they are sometimes refered to, relate to the publication of

material which appears to advocate or encourage the use of controlled drugs.

Police sources believe that not all drugs seized in Ireland are for the home market particularly in the case of cannabis and heroin. It is speculated that Ireland with its long coastline is used as an access point for transit to UK and Europe. They 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 at street level in Dublin differ from area to area, with price and purity of drugs varying with demand requirements.

7.2 Illicit drug market indicators

Table 7.1
Ireland. Quantity of Seizures by Type of Drug

Type of Drug	1992	1993	1994	1995	1996
Cannabis (kg)	519	4206	1527	15616	1940
Heroin (kg)	0.8	1.3	4.6	6.4	10.8
Cocaine (kg)	9.9	0.4	0.1	21.8	642
Amphetamines (kg)	0.1	0.7	0.4	1.5	7.6
LSD (units)	13431	5522	16634	819	5901
Ecstasy (tablets)	271	744	28671	123699	19244

Source: Annual Reports of An Garda Síochána.

There were no ecstasy seizures in Ireland until 1991. Since then they have increased each year (see Tables 7.1, 7.2) and very significantly so, in 1995. The police report that in 1995 there was one seizure in Dublin of 40,000 ecstasy tablets. In another instance illegal substances found in two premises in Dublin suggested to the police that these premises were used in the manufacture of ecstasy.

The number of seizures of heroin, cocaine and amphetamines increased considerably in 1996. This increase was also reflected in the quantities seized. However, two large

Table 7.2
Ireland. Number of Seizures by Type of Drug

Type of Drug	1992	1993	1994	1995	1996
Cannabis	2643	2895	3511	3205	3449
Heroin	91	81	263	209	664
Cocaine	11	15	38	42	93
Amphetamines	49	82	391	89	217
LSD	48	129	116	62	42
Ecstasy	65	135	261	571	405

Source: Annual Reports of An Garda Síochána.

Drug product purity is ascertained from analyses carried out, on drugs seized by the Gardaí, by scientists at the Forensic Science Laboratory of the Department of Justice, Equality & Law Reform. Purity data are not included in the Annual Reports of An Garda Síochána.

Summary: Epidemiology of Drug Use

Main trends and new developments in drug use and consequences

It would seem, from the available evidence, that drug use in Ireland is on the increase.

Schools survey data indicate that there has been an increase in the consumption of drugs, in particular cannabis.

The use of ecstasy and LSD is reported to be on the increase in the club scene but this is based on anecdotal evidence.

Data from the National Drug Treatment Reporting System show regional variation in the types of problem drug misuse treated throughout the country - in the Eastern Health Board area which includes the capital city, Dublin, the main drugs misused are opiates while cannabis and/or ecstasy are the main drugs for which treatment is provided in other health board areas.

The age profile of drug misusers in the Greater Dublin Area over the period 1990 -1996 is getting younger, such that the mode age was 24 years in 1990 but had reduced to 20 years in 1996.

There has been a shift in the risk behaviour of heroin users with more young people now smoking.

Problematic drug use continues to be associated with social disadvantage.

While opiate use is largely confined to Dublin as noted above, it receives a lot of media coverage and is associated in the public mind with increasing levels of crime.

New information needs, gaps, and priorities for future work

Heretofore, social research into drug use in Ireland has been mainly descriptive rather than analytical and has tended to be small scale and localised. However in 1996 and 1997 several research projects have been initiated which will help to fill some of the information gaps which exist at present.

Regular surveys of drug use amongst young people (community, second and third level education) would be useful in describing trends among this cohort.

There is also a need for detailed information at national level to establish levels of use of drugs. Sociological and ethnographic studies in the community would provide an understanding of the social nature and the processes involved in drug use which neither agency-based studies nor population surveys can sufficiently address. The particular problems women heroin users experience in trying to access treatment needs to be investigated.

Recent reports of an escalation of the smoking of heroin among young adolescents would need to be further examined and the motivations involved explored.

Although information does exist in the areas of drug-related deaths, viral hepatitis, and non-fatal emergencies, this information is limited and needs to be evaluated and its collection needs to be more systematic and standardised.

In recent years there has been particularly heightened concern about drug-related crime in Irish society. What is not clear is whether public fears and beliefs reflect reality. However, in the absence of research studies and general population surveys on the social and cultural aspects of drug use and its consequences, speculation will continue. Research is needed into crime associated with illicit drugs, for example, to establish to what extent there is a link between illicit drugs and crime, and what impact the importation, sale and consumption of illegal drugs has on crime.

There is a need for on-going evaluation research in the implementation of policy in all areas. Investigation into the implications of illicit drugs policy on health, on the economy, on the criminal justice system are needed. An evaluation of the effectiveness of prevention programmes, rehabilitation programmes, the outcomes of treatment and methadone maintenance programmes needs to be conducted. The impact of media campaigns needs to be assessed. The Advisory

Part III

Demand

Specific

The operational concept the European Monitoring Centre for Drugs and Drug Addiction has adopted for 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 drug use are also included. The scope of demand reduction intervention is wide and consists of many facets. At one end of the continuum, preventive action aims at not letting a demand for drugs arise at all, having a wide range of diverse actions targeted at large groups, e.g. school programmes, mass media programmes and community based programmes. At the other end are measures of a limited scope directed at individual drug users, e.g. outreach work, treatment, prevention of HIV infection and AIDS. Generally, each action leading to a drug user refraining from drug use at a certain point in time, or refraining from especially harmful practices involved in drug use is comprised by the operational concept of demand reduction."*
>
> **(European Monitoring Centre for Drugs and Drug Addiction, 1996)**

8.1 First childhood intervention

Intervention, in the form of health education to at-risk groups, is undertaken as part of the general services provided by maternity hospitals.

In Ireland the statutory age for starting school is five years, but in fact most children start school at four years of age. There are some official pre-schools but these are not widespread. There

are no official drug prevention programmes at the pre-school level. However, as part of the overall programme initiated by the Department of Education and Science to target disadvantaged areas, a pre-school general education programme has been initiated in approximately thirty-eight centres. This is referred to as the *Early Start Programme* for the under four-year age-group and involves parents as well as children. This is a pilot programme, it does not as yet have drug prevention aspects but this could change as it develops.

8.2 School programmes

It should be pointed out that drug education is not a mandatory item in the curriculum of any schools in Ireland. At a policy level there has been an interest in the possibility of doing preventive work in schools since the late 1960s. The Working Party on Drug Abuse (1971) dealt with the topic as part of its terms of reference, and this was followed in 1974 by the Committee on Drug Education which in turn gave rise to the Health Education Bureau. The Health Education Bureau produced many general and specific educational packs and did a lot of teacher training in the area between 1977 and its closure in 1987 (Butler, 1994). In 1994, the Department of Education and Science in collaboration with the Department of Health and Children introduced a substance misuse prevention programme, '*On My Own Two Feet'* in second level schools. '*On My Own Two Feet'*, was developed by the Health Promotion Unit of the Department of Health and the Psychological Services of the Department of Education, in association with the Mater Dei Counselling Centre and supported by the European Commission. The resource materials aim to develop attitudes, interpersonal skills and knowledge which enable young people to lead healthy lives without reliance on or misuse of drugs. The materials are particularly designed for a school's social, personal and health education programmes, but are also suitable for young people aged 12 to 18 years in a variety of settings. The rationale and effectiveness of the programme have been evaluated by an external researcher (Morgan et al., 1996).

A similar programme for primary schools was developed

during 1996 and was piloted during the 1996/1997 school year. At present it is referred to as the Primary Substance Abuse Programme. It is a draft resource material for all classes in primary schools from infants (4-5 year olds) up to twelve year olds, aiming for a developmental programme starting with a safety-first approach for infants. Three clusters of schools, in Dublin, Cork and Donegal covering both urban and rural areas, took part in the pilot phase of the programme. Based on feedback from the pilot phase the scope of the project has been widened and the resource materials revised for use during the 1997/1998 school year. The programme was offered to all primary schools for implementation on a voluntary basis in the thirteen areas identified as being worst affected by the drugs problem and where *Local Drugs Task Forces* are in operation. A programme of in-service training is provided for teachers, comprising a thirty-hour course. The courses are offered through local Education Centres. A major revision of the programme is to be undertaken starting with a process and outcome evaluation study. This work will be carried out by an external researcher at the beginning of 1998 and will be followed by a revision of materials in Summer 1998.

A third schools programme in the health/education area where drug demand reduction activities are relevant is the *Health Promoting Schools Network.* This is a European network based on criteria laid down by the Council of Europe, the European Union and the World Health Organisation whereby the Departments of Health & Children and Education & Science collaborate to promote health in the school setting. It is a combination of health education and other measures that a school takes to protect and improve the health of young people in school.

The *Garda Schools Programme* which has been in operation since 1990 aims to teach children sensible and responsible patterns of behaviour in order to lessen the risks faced by them; to be safer on the road and at home; to contribute positively towards crime prevention; to know the role of the police and to develop positive attitudes towards the police and the job they do. The programme is delivered by way of talks and lectures to

fifth class pupils (11 year olds) in primary schools. Resource materials include a *Schools Programme Manual* which was updated to be available in 1997. Over 1,000 Gardaí are trained to present the programme nation-wide.

An educational video entitled *My Best Friend* has been developed by the Health Promotion Unit of the Department of Health and Children as an education resource for use in disadvantaged settings where exposure to drug misuse presents a serious threat to the health and well-being of young people. It seeks to be a trigger for discussion and to give an insight into the way drug misuse impacts on relationships and lives.

8.3 Youth programmes outside schools

The *National Youth Health Programme* is a partnership between the National Youth Council of Ireland, the Health Promotion Unit of the Department of Health & Children and the Youth Affairs Section of the Department of Education & Science. The aim of the programme is to develop health education resources and provide training on health issues specific to young people. This includes drug education and prevention. In 1992 this programme developed a *Solvent Abuse Materials* pack which was designed for use by youth leaders, instructors of community training workshops, youthreach projects as well as the formal education sector. The underlying philosophy is that drug and alcohol education is not only about drugs and alcohol but also about people. Thus, while young people need accurate information about drugs, this alone is not sufficient to ensure responsible behaviour. Information must be backed up by assistance in the development of skills in relation to the use of drugs. This incorporates the enhancement of self-esteem and decision-making skills. Young people need to examine attitudes to drug use, both their own as individuals and the attitude of the community in which they live. The programme pack for the '*On My Own Two Feet*' programme (described at Section 8.2) is available to experienced youth leaders with the expertise to deliver the programme and to workers with expertise in the area of group work. The educational video entitled *My Best Friend* also provides resource material for youth

programmes outside schools.

The *Drugs Awareness Programme* (see Section 8.18) is provided by the police to various groups and communities throughout the country. The *Garda Mobile Anti-Drugs Unit* travels the country promoting a drug free lifestyle among young people. It is present at major public events and concerts where young people tend to congregate. It operates in 23 Garda Districts throughout the country.

8.4 Mass media campaigns

During 1997 a media campaign was run by the Department of Health and Children. This was the third phase of the campaign which took place during the summer and autumn 1996. The aim of the campaign is to alert, remind and warn people of the dangers of drug misuse. There are two target audiences for this campaign:

- 15-25 year olds who are experimenting with drugs or who are at risk of becoming drug misusers
- parents of young people

The message is '*drugs destroy lives, not just of users but people close to them too'.* The television campaign is supported by cinema and fly posters. There is a radio element which is aimed more specifically at parents, urging them to seek advice if they believe their children are involved in drugs. It contains specific messages about ecstasy and heroin.

The campaign initially included a telephone information line from which more detailed information was provided. A permanent telephone information line is now provided by the Eastern Health Board. An anti-heroin poster campaign was conducted in the Eastern Health Board area using awareness messages about heroin and ecstasy. A conference which specifically looked at ecstasy use was organised by the Eastern Health Board in November 1997.

8.5 Telephone helplines

A free telephone helpline was provided by the Eastern Health Board during 1997 and is available five days per week from

10.00am to 5.00pm. It was established to provide a confidential service offering information, support, guidance and referral for those concerned with any aspect of drug misuse. A telephone helpline to the Drug Treatment Centre, Trinity Court is available. The Southern Health Board also provides a helpline offering information on prevention and service provision. This is a free telephone service. The South Eastern Health Board funds a non-governmental organisation called Waterford Drug Abuse Resource Group, to provide a helpline in the area. Narcotics Anonymous provides a telephone helpline.

8.6 Community programmes

The *Inner City Organisations Network (ICON*) is an umbrella organisation which aims to link up voluntary and community groups operating in the north-east inner city of Dublin. As a local network, *ICON* aims to promote 'partnership' between state, non-state, business and community groups in the area. During 1997 *ICON* continued the Drugs Crisis Campaign, the Inter Agency Drugs Project and the Integrated Education and Family Support Initiative. These projects are concerned with developing integrated locally based responses in relation to drugs in the areas of treatment, education, prevention and rehabilitation. The overall aim is to develop coherent policies and strategies which can be implemented at a local level while taking into account the particular needs of the north-east inner city.

The *Inter-Agency Drugs Project (IADP)* is a lobby group based in the north inner city of Dublin and is made up of three sub-committees:- educational and prevention; treatment and rehabilitation; and supply/control. It acts as a forum for inter-agency interaction and has made significant inputs to the development of drugs policy, e.g. legislation concerning housing and the Criminal Assets Bureau. This project was evaluated in 1997 as the nominated Irish programme for a WHO Study - Multi-City Action Programme on Drugs. A report will be published in 1998.

On the south side of Dublin city similar organisations also

exist. The South Inner City Treatment Services Group, which works closely with statutory bodies, is an organisation consisting of voluntary and community groups of people who either live or work in the south inner city area of Dublin. Their aims include developing and devising practical and effective means of tackling the local drug problem. The programme includes promoting education and training, research and evaluation, and networking with other community groups.

Drug Questions - Local Answers is a community-based training programme for health/education professionals, Gardaí and youth workers. The Health Promotion Unit of the Department of Health and Children has provided convenor training programmes in conjunction with the eight regional health boards.

Employment - Youthstart is an EU programme for 18 - 25 year olds which provides integrated education, training and work experience for early school leavers. The programme works in conjunction with the Member States by supporting transnational, innovative pilot actions.

Urrús (Gaelic for strength/confidence) was founded by a community group, the *Ballymun Youth Action Project,* to provide training for trainers. The aim is 'to establish a centre of learning and excellence where people can access a range of training options aimed at increasing their effectiveness in the area of responses to drug misuse' (*Urrús* flyer). This community addiction studies training centre has developed a range of training modules on drug misuse, addiction and community responses to meet individual agencies' needs comprising Short Workshops, Training for Trainers and Community Addiction Studies Course. Topics covered include information about drugs, the addiction process, signs and symptoms, intervention, developing a club policy, family issues and community development approaches. A number of target groups has been identified. They include members of the community, community workers, doctors, police, probation officers, teachers, nurses, school guidance counsellors, junior liaison officers, FAS workshop tutors, *Youthreach* tutors and prison workers. The project is supported by the EU human resources initiative, the

Horizon Programme and the *Eastern Health Board.*

Ad-hoc community based activities targeted at local drug users and suppliers, are organised in areas where open drug using and dealing are prominent.

8.7 Outreach work

Outreach work is an integral part of the drug services provided by the Eastern Health Board. It aims at one-to-one contact with drug users who are not in touch with treatment services and offers advice to untreated drug users and also health care by referring users to treatment agencies if they so wish.

8.8 Low threshold services

A Mobile Clinic was established in the Eastern Health Board in 1996. The service is low-threshold (minimal service provision) and provides services, such as needle exchange and low dosage methadone, to the more chaotic drug user who is addicted to an opiate, is injecting and is incapable of stabilisation on methadone maintenance. It initially served two locations in the inner city of Dublin. During 1997 the service was provided at a third location in the north of the city.

8.9 Substitution/Maintenance programmes

As opiate use was relatively rare in Dublin until 1979/1980 methadone treatment was used primarily for detoxification purposes until the 1980s, the main exception being pregnant women and women in the period immediately after childbirth. However, in the late 1980s following the identification of the link between needle sharing and HIV transmisssion methadone maintenance programmes were gradually introduced. This new policy was confirmed by the *Government Strategy to Prevent Drug Misuse (1991)* and later the *First Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1996)* reaffirmed this policy stance and recommended measures to reduce waiting lists for methadone maintenance. The services were decentralised and made available on a more widespread basis in local areas of Dublin. On contact with the

service each person is assessed individually and treatment can be one of several options, short-term methadone treatment with a view to detoxification or more long-term maintenance in the case of more problematic opiate users. Maintenance programmes form part of the drug services provided by the Eastern Health Board.

8.10 Prevention of HIV infection among drug users

All the main treatment programmes involve counselling and advice to drug users, aimed at avoiding transmission of HIV particularly by the promotion of safe injecting practices. The intravenous use of drugs is discouraged and where this is not possible needle and syringe exchange programmes, as well as advice on safer sex practice are provided. Screening for HIV, Hepatitis B and Hepatitis C also forms part of drugs services.

8.11 Treatment systems

Treatment is defined for the purpose of the National Drug Treatment Reporting System in Ireland as any activity which is targeted directly at people who have problems with their drug use, and which aims to ameliorate the psychological, medical or social state of individuals who seek help for their drug problems. Thus, treatment can be medical or non-medical.

In most cases treatment for dependent opiate use is given on a non-residential basis. This is in keeping with the concept of community care, pioneered in the area of mental health. The social ideology underlying the community approach being that people remain in their own community, living independent lives with responsibility for themselves.

Over four thousand persons in Ireland (mainly in Dublin) receive treatment at non-residential agencies. These can be specialised centres, low threshold agencies, substitution programmes or units based in the general services.

The treatment strategies adopted by detoxification services, mainly in the Eastern Health Board area are as follows:

- methadone detoxification programmes

- methadone maintenance programmes
- lofexidine treatment
- drug free programmes.

Methadone maintenance makes up the highest proportion and lofexidine treatment the least. The present policy, which is still developing, is that stabilised drug users after initial treatment at treatment centres would move on to treatment by general practitioners in the primary care setting in their own communities.

8.12 Detoxification

Detoxification and the control of withdrawal and craving symptoms of opiate dependent drug users forms part of the service of all specialised medical drug treatment services (cf. Section 8.11).

8.13 Non-residential treatment

In the majority of cases treatment for problems associated with problem drug use is provided in a non-residential setting (cf. Section 8.11).

8.14 Residential treatment

Dependent opiate use is not generally treated at inpatient hospital level in Ireland. It is only in acute cases that clients are admitted to hospital. A number of beds is allocated for detoxification in the hospital setting. Approximately 130 places are available in Ireland in specialised residential centres (statutory and voluntary), including detoxification units in hospitals.

8.15 After-care

Treatment and rehabilitation services in Ireland have traditionally recognised the importance of after-care programmes. Coolmine Therapeutic Community has always had a phased stage as part of its general programme to gradually reintroduce its clients to ordinary community life and in recent times it has emphasised the importance of educational

and vocational training for drug users who hope to remain drug free and be fully integrated into the life of the community. Similarly the Ana Liffey Project and the Merchants Quay Project have developed a range of such training initiatives.

Soilse is an Eastern Health Board dedicated drug rehabilitation programme specialising in insertion to employment, vocational training and education. *Soilse* aims to overcome the limitations of a narrow psycho-therapeutic approach to addiction by building goals and supporting participants in their desire to re-socialise themselves personally, economically and culturally. *Soilse* seeks to re-integrate former drug users into society through restoring independence, self esteem and self direction. The programme is a non-residential day drug rehabilitation model, balancing group therapy and counselling (resistance training and normative education) with creativity and soft vocation skills. The programme has two group types - a part-time programme which runs for eight weeks and is designed for those who are undergoing detoxification and to assess the suitability, stability and motivation of the individual; a full-time programme which runs for six months duration, where each participant is paid a training allowance to attend, with a bus pass and a crèche allowance provided where necessary.

Soilse provides an on-site careers guidance/mediation service to current and past full-time participants. The focus is on realistic goal setting, planning and problem solving, presentation skills, and through mediation and life planning placing individuals in employment and vocational training and education. The project provides a wide range of inputs for the course participants. Group therapy is available each week, individual work is on-going and lectures and information on addiction are given weekly. Soft vocational skills-based learning such as, literacy, information technology, creative writing, photography, personal development, drama and art, are provided. Weekly workshops are organised to deal with a diverse range of needs-based issues such as financial advice, diet, exercise, health, family law, alternative therapies and stress management.

8.16 Self-help groups

Narcotics Anonymous is a self-help support group for drug users who are trying to stop using drugs. *Nar Anon* is a fellowship of men and women whose lives have been or are being affected by another person's drug taking.

8.17 General health care

In addition to the services of specialised centres for the treatment of drug use, clients may also avail of the services of the general health care system, for example, general practitioners, accident and emergency services, STD (sexually transmitted diseases) clinics and, in certain cases, pharmacies for prescribed drugs.

8.18 Criminal justice system

The *Juvenile Diversion Programme* was established by the Garda Síochána to provide the opportunity to divert juvenile offenders from criminal activity and also to provide an alternative to their being processed through the formal criminal justice system. The aim of the programme is crime prevention through education and rehabilitation. It gives the opportunity to divert juvenile offenders from criminal activity. The programme currently operates on an administrative basis. The *Children Bill, 1996* proposes that it would operate on a statutory basis. A juvenile offender who is eligible for inclusion in the programme is dealt with by way of a caution, which may on a formal or informal basis, as opposed to being prosecuted for a criminal offence. This programme comes under the supervision and direction of the Garda National Juvenile Office throughout all Garda divisions in the country and is operated by the Juvenile Liaison Officer scheme which was set up in 1963. Juvenile Liaison Officers are involved in all aspects of youth work both locally and in some cases nationally, through contact with youth clubs, statutory and voluntary organisations and schools. This involvement is aimed at dealing with young people on a personal level and in conjunction with the family and the community. All Juvenile Liaison Officers complete a substance misuse course at the Garda Training College in Templemore.

The training for this course was co-ordinated by the Department of Social Studies at Trinity College.

The *Drugs Awareness Programme* is a programme provided by the Gardaí to various groups and communities throughout the country. The aims of the programme are to create a rapport with parents, teachers, community leaders and other concerned groups; to assist young people already exposed to drugs and give them the confidence to refuse them; to promote responsible attitudes and to reduce crime. A 'Drugs Awareness' pack is issued through Garda Divisional Offices around the country.

Drug treatment services, including a methadone treatment programme, in the main prison (Mountjoy) in Dublin are currently provided under the supervision of a consultant psychiatrist. One of the main recommendations of the *Second Report of the Ministerial Task Force on Measures to Reduce the Demand for Drugs (1997)* was that a study of service provision by way of an independent assessment by an Expert Group should be carried out. This group, which should be made up of an independent chairperson and two international experts along with the Director of Prison Medical Services, should examine the effectiveness of current support for offenders who misuse drugs and make appropriate recommendations to integrate services both inside and outside the prison more effectively.

The Probation and Welfare Service of the Department of Justice, Equality and Law Reform carries out groupwork programmes, particularly in Mountjoy Prison in Dublin. These programmes seek to introduce drug misusers to ideas and information in order to promote desired behavioural changes in terms of risk behaviour and drug addiction, and to help prisoners cope with imprisonment and to prepare them for life demands following release from prison (Pugh, 1995).

Voluntary agencies such as the Ana Liffey Project, Coolmine Therapeutic Community and Merchant's Quay Project provide support and counselling to drug users in prison.

8.19 Gender-specific issues

The *SAOL* programme is an example of a project which seeks

to deal with gender-specific issues. It is inner city rehabilitation and training project for a small group of women in recovery or stabilised on methadone. It offers women a chance to acquire a range of skills including literacy and numeracy and other social skills in order to give them a better opportunity to return to normal living. The Project's mission statement is:

> *The* SAOL Project *is a two year pilot programme for former and stable women drug users whose purpose is to move through development work and capacity building from addiction and dependency to self direction and self reliance. It operates on the basis of social justice, adult education and community development principles, and focuses on re-integration into the community.*

The objectives of the project are aimed at three levels, personal, community and policy:

Personal

- to provide a process where women can gain normality and stability in their lives
- to provide accredited second-chance education, literacy, development and training through an adult education and training experience
- to re-integrate women into their own families and the broader community
- to raise self esteem and confidence
- to provide a process of education whereby women can recognise how addiction works
- to prepare the women for life after *SAOL*

Community

- to educate the women to take an active role in their community
- to impact through the programme directly on the lives of the participants' children, families, neighbours and community

Policy

- to draw together an integrated response which meets the holistic needs of the women
- to inform long-term policy on drug treatment and rehabilitation
- to develop an advocacy role on behalf of the women that ensures the real inclusion of their voices in developing social and economic policies and practices at local, national and European level
- to demonstrate a model for social rehabilitation and access and provide a methodology for this
- to provide a manual of good employment practice.

The Project gives women from the north inner city area of Dublin the opportunity to explore their potential through a participative style of learning that incorporates a community development approach to the work. It focuses on using the self esteem and confidence of participants through development and education. In addition, a very important element of the project has been the type and level of personal support given by the staff to the women. The women are encouraged to have a sense of ownership around the project and are encouraged to become involved in regular reviews of course design, delivery and management. The Project is designed to be flexible enough to meet the changing needs of the women and structured enough to ensure that the learning does not become unfocussed.

An initial needs-assessment with the participating women allowed *SAOL* to develop a framework of activities covering training, education and development. The aim of these particular modules is to enhance existing skills, to expose the women to new experiences and educational opportunities and to enable them to make informed choices about their lives.

Coolmine Therapeutic Community provides a special programme for women as part of their service.

8.20 Children of drug users

Evaluation,

9.1 Evaluation

To date the number of evaluation studies in relation to demand reduction activities has been limited but there are indications that public and voluntary bodies are focusing greater attention on evaluation.

An educational approach to prevention and demand reduction which was undertaken in post primary schools in Ireland (Psychological Service et al., 1994) was studied to assess its efficacy. The aim of the programme '*On My Own Two Feet'* is to prevent the misuse of substances and to help young people to develop attitudes and behaviours which promote healthy living. An evaluation of the rationale and effectiveness of this programme was carried out and published in 1996 (Morgan et al., 1996). A central part of the evaluation involved a comparison of the pilot schools and matched control schools using a stringent quantitative approach. The evaluation of the programme outcomes 'showed that in comparison to a control group, children who experienced the programme had less positive attitudes to substance use and stronger beliefs in the negative outcomes of such use' (ibid.: 24). However, while the programme had a significant effect on aspects of belief and attitudes relevant to substance use, the effects on behaviour were much less, confirming the difficulties involved in school-based prevention programmes.

A major revision of the Substance Abuse Programme in primary schools is to be undertaken starting with a process and outcome evaluation study. This work will be carried out by an external researcher at the beginning of 1998 and will be followed

by a revision of the programme materials in Summer 1998.

A preliminary evaluation study was carried out on the *Family Communication and Self Esteem* programme (cf. Section 8.21) and concluded that the parents involved had understood and accepted the significance of the link between family communication and drug misuse perception. A further evaluation of the programme is planned.

A review of drug services in the Eastern Health Board area was undertaken in order to examine the evolution of policies and practices in relation to service provision (Farrell and Buning, 1996). It also took account of service responses from agencies other than the Eastern Health Board, involving mechanisms for consultation with local community interests. The review commented on service responses in the context of trends and practices elsewhere. The report stated that the Eastern Health Board 'has achieved an impressive range of goals to date with the establishment of a network of services and a rapid growth in its overall size of service provision... The range and pattern of service provision is consistent with most and further advanced than many other European Union member states' (p2). Recommendations were made in several areas such as service provision, training, liaison, and community consultation for the provision of a more cohesive service.

Evaluation work will also be carried out on the activities of the National Drug Strategy Team, the Local Drug Task Forces and the projects of the Local Drug Task Forces.

9.2 Training

Some of the Regional Health Boards provide drugs training opportunities through their education or related offices to a variety of groups and individuals.

Training in demand reduction issues is provided as in-service training by the Department of Education and Science to teachers who participate in the schools programme (cf. Section 8.2).

A university course (*Diploma in Addiction Studies)* is organised at the University of Dublin, Trinity College, to provide a broad educational experience on issues which arise in the context of drug and alcohol problems and to accept and understand the complexities and ambiguities involved rather than seek simple solutions. During 1997 this Addiction Studies Course, which is funded by the Department of Health and Children, was provided with additional funding to double the number of students in the academic year 1997/1998.

The Department of Social Studies, Trinity College has developed a postgraduate Masters Degree Course in Drug and Alcohol Policy. This course will commence in September 1998 at Trinity College.

The Irish Association of Alcohol and Addiction Counsellors (IAAAC) is planning to provide special training modules for its members. The course will take place on one day per week over a two-year period.

9.3 Information requirements

Data collection on demand reduction projects and activities to date has not been systematic or structured. However, Regional Health Boards are now collecting information on demand reduction activities and it is envisaged that this information will be documented in regional databases.

In 1997 initial steps were taken by the Focal Point in the development of a monitoring system on demand reduction activities in Ireland. This is in collaboration with the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) where an electronic database has been developed. This system which is referred to as EDDRA (Exchange on Drug Demand Reduction Action), will consist of information collected by each National REITOX Focal Point on a broad range of demand reduction activities and will focus on a practical exchange of experience and good practice in the field. EDDRA is a long-term on-going process aiming to cater for the needs of practitioners, policy and decision makers involved in the planning and implementation of demand reduction initiatives. This general

Summary: Demand Reduction Intervention

- The scope of demand reduction intervention is wide and consists of many facets. At one end of the continuum, preventive action aims at not letting a demand for drugs arise at all, having a wide range of diverse actions targeted at large groups, for example, school programmes, mass media campaigns and community based programmes. At the other end are measures of a limited scope directed at individual drug users, for example, outreach work, treatment, prevention of HIV infection and AIDS. There has been extensive development in demand reduction activities in Ireland in recent years, in particular in the Eastern Health Board area.
- Education and training in demand reduction issues is provided at a number of levels in the health and education areas.
- Initial steps in the development of a monitoring system on demand reduction activities in Ireland got underway in 1997.
- While some evaluation studies in relation to demand reduction activities have been carried out in recent times there is still a need for the systematic collection of information along with scientific process/outcome evaluation of demand reduction projects.

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Annex A

Map

Table A2: Ireland. Census of Population 1996

Age Group	Male	Female	Total	%
0-4 years	128740	121654	250394	6.9
5-9 years	145335	137608	282943	7.8
10-14 years	167377	158710	326087	9.0
15-19 years	173950	165586	339536	9.4
20-24 years	149143	144211	293354	8.1
25-29 years	129363	129682	259045	7.1
30-34 years	127735	133194	260929	7.2
35-39 years	126140	129536	255676	7.1
40-44 years	120064	120377	240441	6.6
45-49 years	113816	111584	225400	6.2
50-54 years	94818	91829	186647	5.1
55-59 years	77809	75998	153807	4.2
60-64 years	68690	69256	137946	3.8
65-69 years	60256	66553	126809	3.5
70-74 years	50124	62418	112542	3.1
75-79 years	35228	48869	84097	2.3
80-84 years	21074	34697	55771	1.5
85 years & over	10570	24093	34663	1.0
Total	**1800232**	**1825855**	**3626087**	**100.0**

Source: Central Statistics Office.

Annex B

Table B1: Ireland. Surveys. Smoking, Alcohol and Drug Use.

Survey Name	Year of Survey	Type of Survey	Sample	Sample Size	Response Rate	Prevalence Rate of Cannabis Use *Lifetime (1), Current (2)*	
Drinking among Pupils in Post Primary Schools no.164	1984 & 1991	Longitudinal School	12-18 year olds. Stratified random sample of schools from the official Department of Education list of post-primary schools	1983 valid	100%	1984 (1) 13.2 (2) 5.9	1991 (1) 25.1 (2) 9.2
Report on Substance Use Among Adolescents in the Western Health Board	1994	School	12-18 year olds. A random sample of schools and cluster sample of students (2576). A sample of early school-leavers from training centres & community projects (211)	2787 valid	100%	(1) 15.5	
The 1995 ESPAD Report	1995	School	Stratified random number of classes. Three types of schools: single-sex secondary, mixed secondary, vocational and community schools. A total number of 100 classes in the fifth grade was drawn proportionate to the number of classes in each school type - in all 1849 students.	1849			
Smoking, Alcohol and Drug Use Survey 1996 in Southern Health Board	1996	General Polulation	Random sample of 15 - 44 year olds	1500	–	(1) 17 (2) 4	
Report on Illicit Drug Use among Adolescents in the North Eastern Health Board region	1997	School	15 - 19 year olds. Random sample of 21 schools	1516	–	(2) 10	

Table B2: Dublin Treated Drug Misuse 1990	All Treatments			First Treatments		
	M	F	Total	M	F	Total
No. of treatment demands	1501	563	2037	466	158	624
Mean age	25.0			22.8		
Age (%) <25	49			69		
Age (%) >35	6			6		
Male/Female (%)	74/26			75/25		
IV route of ad. main drug (%)	68			48		
Primary Drug %						
Opiates	79.2			60.3		
Cocaine	0.8			1.1		
Amphetamines	0.3			0.5		
Hypnotics/Sedatives	3.6			5.8		
Hallucinogens	0.4			0.8		
Volatile Inhalants	2.4			4.6		
Cannabis	11.4			25.0		
Other/Missing	1.8			1.9		

Source: Drug Treatment Reporting System. Health Research Board

Table B3: Dublin Treated Drug Misuse 1991	All Treatments			First Treatments		
	M	F	Total	M	F	Total
No. of treatment demands	1806	546	2359	363	87	450
Mean age	25.0			21.9		
Age (%) <25	45			75		
Age (%) >35	8			4		
Male/Female (%)	77/23			81/19		
IV route of ad. main drug (%)	64			36		
Primary Drug %						
Opiates	77.7			49.6		
Cocaine	0.4			1.1		
Amphetamines	0.4			0.7		
Hypnotics/Sedatives	4.3			5.3		
Hallucinogens	1.0			2.7		
Volatile Inhalants	2.1			6.4		
Cannabis	12.5			33.3		
Others/Missing	1.7			0.9		

Source: Drug Treatment Reporting System. Health Research Board

Table B4: Dublin Treated Drug Misuse 1992	All Treatments			First Treatments		
	M	F	Total	M	F	Total
No. of treatment demands	1940	599	2555	527	138	668
Mean age	25.0			21.5		
Age (%) <25	48			78		
Age (%) >35	8			4		
Male/Female (%)	76/24			79/21		
IV route of ad. main drug (%)	61			34		
Primary Drug %						
Opiates	75.1			48.5		
Cocaine	0.5			0.6		
Amphetamines	0.4			0.1		
Hypnotics/Sedatives	3.6			4.5		
Hallucinogens	3.4			8.2		
Volatile Inhalants	2..3			5.4		
Cannabis	14.0			31.0		
Others/Missing	0.8			1.6		

Source: Drug Treatment Reporting System. Health Research Board

Table B5: Dublin Treated Drug Misuse 1993	All Treatments			First Treatments		
	M	F	Total	M	F	Total
No. of treatment demands	2211	695	2919	682	175	859
Mean age	23.0			21.1		
Age (%) <25	56			81		
Age (%) >35	7			3		
Male/Female (%)	76/24			80/20		
IV route of ad. main drug (%)	63			44		
Primary Drug %						
Opiates	79.1			64.1		
Cocaine	0.2			0.3		
Amphetamines	0.5			0.7		
Hypnotics/Sedatives	2.6			2.6		
Hallucinogens	5.2			11.4		
Volatile Inhalants	1.1			1.6		
Cannabis	10.3			18.5		
Others/Missing	1.0			0.7		

Source: Drug Treatment Reporting System. Health Research Board

Table B6: Dublin Treated Drug Misuse 1994	All Treatments			First Treatments		
	M	F	Total	M	F	Total
No. of treatment demands	2342	612	2978	954	188	1150
Mean age	23.8			20.6		
Age (%) <25	61			84		
Age (%) >35	7			2		
Male/Female (%)	79/21			84/16		
IV route of ad. main drug (%)	61			47		
Primary Drug %						
Opiates	82.1			74.3		
Cocaine	0.3			0.3		
Amphetamines	0.5			0.5		
Hypnotics/Sedatives	1.7			1.0		
Hallucinogens	4.2			6.0		
Volatile Inhalants	0.8			1.1		
Cannabis	10.0			16.3		
Others/Missing	0.4			0.4		

Source: Drug Treatment Reporting System. Health Research Board

Table B7: Dublin Treated Drug Misuse 1995	All Treatments			First Treatments		
	M	F	Total	M	F	Total
No. of treatment demands	2785	787	3593	1092	297	1396
Mean age	23.6			20.7		
Age (%) <25	64			84		
Age (%) >35	6			2		
Male/Female (%)	78/22			79/21		
IV route of ad. main drug (%)	53			30		
Primary Drug %						
Opiates	86.8			77.2		
Cocaine	0.3			0.4		
Amphetamines	0.2			0.4		
Hypnotics/Sedatives	1.8			1.1		
Hallucinogens	0.8			1.1		
Volatile Inhalants	0.4			0.7		
Cannabis	6.6			12.5		
Others/Missing	3.1			6.6		

Source: National Drug Treatment Reporting System. Health Research Board

Table B8: Ireland Treated Drug Misuse 1995	All Treatments			First Treatments		
	M	F	Total	M	F	Total
No. of treatment demands	3441	925	4396	1497	381	1887
Mean age	23.6			21.1		
Age (%) <25	65			82		
Age (%) >35	7			3		
Male/Female (%)	79/21			78/20		
IV route of ad. main drug (%)	46			24		
Primary Drug %						
Opiates	74.6			60.4		
Cocaine	0.5			0.5		
Amphetamines	0.3			0.4		
Hypnotics/Sedatives	2.7			1.9		
Hallucinogens	1.3			1.9		
Volatile Inhalants	0.6			1.1		
Cannabis	13.1			22.3		
Others/Missing	6.9			11.5		

Source: Drug Treatment Reporting System. Health Research Board

Table B8a : Ireland Treated Drug Misuse 1996	All Treatments			First Treatments		
	M	F	Total	M	F	Total
No. of treatment demands	3445	1341	4865	1465	549	2041
Mean age	23.9	23.1	23.7	21.4	20.9	21.3
Age (%) <25	65			81		
Age (%) >35	7			4		
Male/Female (%)	72/28			73/27		
IV route of ad. main drug (%)	42.6			24.5		
Primary Drug %						
Opiates	79.0			65.7		
Cocaine	0.5			0.8		
Amphetamines	0.4			0.6		
Hypnotics/Sedatives	1.7			1.0		
Hallucinogens	0.4			0.5		
Volatile Inhalants	0.5			0.9		
Cannabis	12.0			20.6		
Others/Missing	5.5			9.9		

Source: National Drug Treatment Reporting System. Health Research Board

Table B9: Dublin. Characteristics of treated drug misusers. Valid percentages. Total Treatment (TT), First Treatment (FT).

Characteristic		1990		1991		1992		1993		1994		1995		1996	
		TT	FT	TT	FT	TT	FT	TT	FT	TT	FT	TT	FT	TT	FT
Gender	Male	73.7	74.7	76.8	80.7	76.4	79.2	76.1	79.6	79.3	83.5	78.8	79.7	70.6	70.2
	Female	26.3	25.3	23.2	19.3	23.6	20.8	23.9	20.4	20.7	16.5	21.2	20.3	29.4	29.8
Age	<25 years	49.3	69.0	45.4	74.5	48.1	77.9	55.8	81.3	61.0	84.2	65.3	82.1	63.7	82.0
	>25 years	50.7	31.0	54.6	25.5	51.9	22.1	44.2	18.7	39.0	15.8	34.6	17.9	36.3	18.0
Mean Age		25.2	22.8	25.5	21.9	25.3	21.5	24.5	21.1	23.8	20.6	23.6	20.7	23.8	21.1
Age Left School															
15 years and under		72.1	65.9	69.7	51.5	67.9	56.3	66.5	57.4	60.4	50.3	62.6	57.2	61.6	56.0
16 years and over		24.9	26.5	26.3	33.9	27.8	32.2	29.2	33.6	34.5	41.1	34.4	36.8	34.7	36.9
Still at school		3.1	7.6	4.0	14.5	4.2	11.5	4.3	8.9	5.1	8.7	3.0	5.9	3.7	7.1
Living Status															
Family		52.1	61.2	56.9	73.8	60.6	73.1	61.7	73.3	67.4	77.2	70.8	81.2	69.6	77.7
Partner		26.4	17.3	25.3	11.4	21.7	10.8	22.5	13.4	18.7	9.8	16.2	9.0	17.3	10.4
Institution/Homeless		5.4	5.4	3.2	4.7	3.7	6.0	3.2	3.8	2.4	3.1	3.5	2.8	3.5	3.9
Alone		10.2	11.9	7.1	5.4	6.8	3.9	6.1	2.7	5.8	4.0	4.5	3.1	3.5	2.6
Other		5.9	4.2	7.5	4.7	7.2	6.1	6.4	6.8	5.7	5.9	5.0	3.9	6.1	5.4
Employment Status															
Unemployed		81.8	76.8	81.5	66.6	81.4	70.0	82.3	78.0	83.7	81.8	87.2	80.3	86.4	79.9
Employed		9.9	11.0	10.7	17.3	11.1	16.2	10.0	11.2	9.8	17.7	9.8	13.6	9.2	11.9
Other		8.2	12.1	7.7	16.1	7.5	13.8	7.5	10.7	6.4	0.6	3.0	6.1	4.4	8.2
Treatment Contract Number		2037	624	2359	450	2555	668	2919	859	2978	1150	3593	1396	3994	1499

Source: National Drug Treatment Reporting System, Health Research Board.

Table B10: Dublin and Ireland.
All Treatment Contacts. Primary Drug 1990 - 1996. Valid Percentages.

Drug	1990	1991	1992	1993	1994	1995	*1995	*1996
	%	%	%	%	%	%	%	%
Heroin	39.3	37.0	37.9	48.3	55.7	70.6	60.7	69.5
MST	33.0	30.6	26.8	22.5	18.5	10.6	9.0	4.4
Methadone	1.4	3.0	3.9	5.0	4.4	3.8	3.2	3.6
Cocaine	0.8	0.4	0.4	0.7	0.3	0.3	0.5	0.5
Ecstasy	0.0	0.3	2.0	3.5	2.5	3.0	6.5	5.3
Benzodiazepines	3.0	3.1	2.0	1.2	0.7	1.8	2.2	1.2
LSD	0.4	0.6	1.3	1.7	1.4	0.8	1.1	0.4
Volatile Inhalants	2.4	2.2	2.3	1.1	0.7	0.4	0.7	0.5
Cannabis	11.5	12.6	14.1	10.4	10.1	6.6	13.2	12.0
Other Drugs	8.0	10.3	9.1	5.6	5.6	2.2	2.9	2.6
Valid N Total N	2021 2036	2337 2359	2546 2555	2896 2919	2970 2978	3587 3593	4390 4396	4858 4865

** Ireland. Source: Drug Treatment Reporting System, Health Research Board*

Table B11: Dublin and Ireland.
All Treatment Contacts. Secondary Drug 1990 - 1996. Valid Percentages.

Drug	1990	1991	1992	1993	1994	1995	*1995	*1996
	%	%	%	%	%	%	%	%
Heroin	17.9	14.4	12.7	11.9	9.5	11.0	9.3	6.5
MST	18.8	15.1	13.5	13.9	10.0	10.5	8.6	6.0
Methadone	3.7	3.7	4.9	9.0	14.6	19.8	16.6	15.4
Cocaine	1.6	1.3	1.3	1.1	2.0	2.1	2.0	3.4
Ecstasy	0.2	0.6	3.3	3.6	5.2	8.1	10.0	10.7
Benzodiazepines	4.4	8.2	9.4	6.6	6.2	18.8	16.0	21.3
LSD	1.0	1.6	3.6	3.4	2.6	1.5	3.8	2.4
Volatile Inhalants	0.5	0.6	0.6	0.4	0.5	0.3	0.3	0.3
Cannabis	14.3	22.2	22.6	20.5	21.7	20.2	21.3	22.0
Alcohol	13.1	12.7	10.6	8.1	5.1	3.5	7.0	6.9
Other Drugs	24.5	19.6	17.5	21.5	22.6	4.2	5.1	5.1
**Valid N Total N	1641 2037	1720 2359	1832 2555	2367 2919	2392 2978	2829 3593	3490 4396	3565 4865

** Ireland. ** Valid N excludes missing and no secondary drug.*
Source: Drug Treatment Reporting System, Health Research Board

Table B12: Ireland. Mortality. Drug Dependence & Poisoning. 1985 - 1996 Ages 15 - 49 years. Numbers

Cause of death	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	*1995	*1996
Drug dependence (ICD-9 code 304)	14	3	3	5	4	4	4	13	9	15	25	33
Poisoning (ICD-9 code 965)	8	5	4	10	4	7	10	4	11	4	6	7
Total	22	8	7	15	8	11	14	17	20	19	31	40

** Preliminary data. Source: Central Statistics Office.*

Table B13: Ireland AIDS Cases and Deaths by Risk Category. 1982 - 1996

Risk Category	1982-1992		1993		1994		1995		1996		1997		Cumulative Total	
	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths	Cases	Deaths
IV Drug Use Related	142	61	43	21	22	27	25	27	34	17	10	1	276	154
Homo/Bisexual	109	45	13	14	27	11	16	11	34	16	12	3	211	100
Haemophilliacs/Heterosexuals/Babies born to Heterosexual Mothers/Transfusion Recipient	52	27	12	9	18	6	13	8	11	1	8	2	114	53
Undetermined	5	3	0	0	0	0	1	0	0	0	2	1	8	4
Total	308	136	68	44	67	44	55	46	79	34	32	7	609	311

Source: Department of Health & Children/Virus Reference Laboratory

Table B14: Ireland.
Discharges from Acute Hospitals 1994 - 1996.
Primary and Secondary Diagnoses. All Ages. Numbers

ICD-9 ***	1994	1995	1996
292.0 - 292.9			
Primary	19	32	27
Secondary	42	41	40
Sub-Total	***61***	***73***	***67***
304.0 - 304.9			
Primary	255	255	213
Secondary	378	604	942
Sub-Total	***633***	***859***	***1155***
305.2 - 305.9			
Primary	40	41	16
Secondary	499	533	321
Sub-Total	***539***	***574***	***337***
Total Number	***1233***	***1506***	***1559***
Rate per 1,000 population	**0.3**	**0.4**	**0.4**
All discharges	**563,846**	**607,841**	**624,094**
Percentage drug-related discharges	**0.2**	**0.2**	**0.2**

*** *International Classification of Diseases Codes (ICD-9)*
292 Drug Psychosis
304 Drug Dependence
305 Non-dependent abuse excluding alcohol & tobacco.

The totals represent approximately 92% (1994), 96% (1995), 98% (1996) national coverage.

Source: Hospital In-Patient Enquiry System, Economic and Social Research Institute.

Table B15: Ireland.
All Admissions to Irish Psychiatric Hospitals & Units 1990 - 1996.
Primary & Secondary Diagnoses. All ages. Numbers.

ICD-9*** ICD-10****	1990	1991	1992	1993	1994	1995	1996
292.0 - 292.9							
Primary	62	78	103	92	23	-	
Secondary	4	14	17	16	4	-	
Sub-Total	***66***	***92***	***120***	***108***	***27***	***-***	
304.0 - 304.9							
Primary	170	170	186	216	14	1	
Secondary	60	92	85	102	30	-	
Sub-Total	***230***	***262***	***271***	***318***	***44***	***1***	
305.2 - 305.9							
Primary	34	29	42	71	10	-	
Secondary	27	28	18	21	2	-	
Sub-Total	***61***	***57***	***60***	***92***	***12***	***-***	
F11 - F16 - F18 - F19 - F55							
Primary	-	-	-	-	466	492	564
Secondary	-	-	-	-	123	97	123
Sub-Total	***-***	***-***	***-***	***-***	***589***	***589***	***687***
Total Number	***357***	***411***	***451***	***518***	***672***	***590***	***687***
Rate per 1,000 population	**0.1**	**0.1**	**0.1**	**0.1**	**0.2**	**0.2**	**0.2**
All admissions	**27765**	**27913**	**27148**	**27005**	**26687**	**26440**	**26656**
Percentage drug-related admissions	**1.3**	**1.5**	**1.7**	**1.9**	**2.5**	**2.2**	**2.6**

*** *International Classification of Diseases Codes (ICD-9)*
292 Drug Psychosis
304 Drug Dependence
305 Non-dependent abuse excluding alcohol & tobacco.

**** *International Classification of Diseases (ICD-10)*
F11 - F16, F18, F19 Mental & Behavioural disorders due to psychoactive substance use.
F55 Abuse of non-dependence producing substances..

Source: National Psychiatric In-Patient Reporting System, Health Research Board.

Annex C

Summary of Projects Funded under the Science and Technology Against Drugs Initiative

Social Sciences

- **Drugs, Community and Young People's Choices**
  Why do some people turn to drugs and other don't? Poverty and social deprivation are no doubt important but other factors such as educational and recreational facilities and amenities and community development could also influence the situation. The survey will look at 120 young people in a disadvantaged part of Dublin's inner city, to find out what influences young people in vulnerable communities.
  Contact: Mr. Barry Cullen, The Children's Centre, Trinity College Dublin.

- **Identification of Critical Mediating Variables in Initiation to Drug use among Adolescents**
  Little is known about what leads young people to take drugs for the very first time. This study will look at the factors that might be important such as peer pressure, experiments with legal drugs (alcohol, cigarettes), easy access to illegal drugs and individual attitudes and behaviours, as well as asking if different people respond differently to these factors.
  Contact: Dr. Mark Morgan, St. Patrick's College, Drumcondra, Dublin 9.

- **A Social Study of Drug Education**
  How effective are educational programmes at preventing young people from misusing drugs. This study will evaluate the drugs programmes that are used here and abroad. The results will be used in designing new educational programmes and these will then be tried on a pilot basis as part of this project.
  Contact: Ms. Elizabeth Kiely, Applied Social Studies, University College Cork.

- **Ecstasy Use among young Irish People**
  Who is buying ecstasy or why? How old are they? Where do they get their tablets? Do they use other drugs? What is their

attitude to the law? These and other questions will be asked in this study of young ecstasy users in Dublin (in a disadvantaged and an affluent area), in Cork city and Dungarvan. Findings will be compared with those from the Netherlands and Sweden.
Contact: Dr. Patrick O'Mahony, Centre for European Social Research, and Mr. Tim Murphy, Department of Law, University College Cork.

- **Drug Misuse in Dublin - A capture-recapture study to estimate age, sex and prevalence of drug users**
  Heroin addicts are a hidden population. This survey will use a range of sources to estimate the number of heroin users in Dublin, their age, the proportion of men and women, and if possible the percentage that are a HIV positive.
  Contact: Dr. Catherine Comiskey, Department of Applied Science, Regional Technical College Tallaght, Dublin.

- **Pathways to and outcomes of Methadone treatment programmes in the Dublin area**
  A survey of people attending three Dublin methadone clinics to investigate if programmes reduce drug taking, criminal activity and HIV infection and if they improve people's health and employment prospects. The study will also provide an insight into the paths that lead first to addiction, then to methadone treatment, and will also identify if there are other needs such as training and personal development.
  Contact: Ms. Evelyn Mahon, Sociology Department, Trinity College Dublin.

- **The Social and Psychological needs of children of Drug Users**
  The welfare of children of drug using parents is of growing concern. This survey will examine how children are affected by their parents' habit, whether they have special needs when it comes to social services, and if they are more likely to take drugs themselves.
  Contact: Dr. Diane Hogan, The Children's Centre, Trinity College Dublin.

- **Prevalence, Profiles and Policy: A case-study of drug use in Dublin's North Inner City**

  This in-depth study will begin by trying to estimate the number of drug users in Dublin using survey and in-depth interviews. The emphasis will be on interviewing those who are not attending treatment centres and on women drug users about whom little is known.

  Contact: Dr. Jo Murphy-Lawless, Centre for Women's Studies, Trinity College Dublin.

Biochemistry and Pharmacology

- **MDMA Toxicity: The influence of Metabolic Genotype at CYP2D6**

  Some people react very severely to ecstasy, these reactions are rare but can also be fatal. Some 3% of people lack a particular enzyme (called cytochrome P450) that may be important in helping the body to cope with or process the drug. If there is not enough enzyme present even a small dose could be overwhelming. This project will continue over two years and will study people who have reacted badly to ecstasy to see if they possess this faulty enzyme. If this theory is right, then it should be possible to predict in advance who is at risk and so help minimise the danger.

  Contact: Dr. Michael Gill, Psychiatry and Genetics, Trinity College Dublin.

- **Assessment of the Neurotoxicity of Ecstasy 3, 4 Methylenedioxy-Methamphetamine (MDMA), at levels likely to result from its recreational use**

  A side effect of ecstasy is that it can damage brain cells, but not much is known about how and when this happens. This study will attempt to understand the toxic effects of ecstasy, and how much damage is done by a single dose and how much by repeated use.

Contact: Prof. Keith Tipton, Biochemistry, Trinity College Dublin.

- **Neurotoxicity of Ecstasy-like drugs**
  Ecstasy tablets may be sold as 'ecstasy', or they may contain impurities such as other drugs, including caffeine, paracetamol and even a general anaesthetic called Ketamine. In addition the tablet would probably be taken with other drugs like alcohol, nicotine and cannabis. This project will study the effects of these drugs when taken together, a cocktail which could cause liver and brain damage, and may explain why some people react severely to even small doses.
  Contact: Dr. Kathy O'Boyle, Pharmacology Department, University College Dublin.

- **Biochemical Pathways involved in Recrudescence of IV drug use**
  in ex-IV drug users treated with Interferon for Hepatitis C
  Hepatitis C is a serious problem among IV drug users. It can generally be treated with interferon, but this can cause depression and other serious side effects similar to heroin withdrawal symptoms. Consequently some patients go back on heroin. This project will conduct clinical trials with former addicts to see if it is possible to block the distressing effects of interferon.
  Contact: Dr. Dermot Kelleher, Hepatology Department, St. James's Hospital, Dublin.

- **Pharmaceutical Strategies aimed to alleviate the Opiate Withdrawal Syndrome**
  Withdrawal symptoms are a major problem for heroin addicts. This project will first study what is actually happening at a physiological level in an addict's body during both addiction and withdrawal; then using that information, identify and test other drugs that might alleviate symptoms.
  Contact: Dr. Ciaran Regan, Pharmacology Department, University College Dublin.

- **Long Term Toxicity of MDMA - evaluation of hidden risks**
  This team, alongside the Eastern Health Board's drug

addiction centres, will investigate how long term ecstasy use affects the body's nervous system.
Contact: Drs. Alan Baird, Gethin McBean and Alan Keenan, Pharmacology Department, University College Dublin.

- **The Cardiovascular actions of Cocaine and Ecstasy in Human and Animal Tissues**
  Cocaine and ecstasy can affect a person's heart rate, blood pressure and nervous system with potentially fatal results. Although cocaine has been widely studied, little is known about its actual effects on the heart and even less about ecstasy. This project hopes to improve our understanding in this area by studying the toxic effects of these drugs on heart tissue and veins.
  Contact: Prof. James Docherty, Royal College of Surgeons, Dublin.

Detection and Analysis

- **Development of Immunosensors for Detection of Ecstasy and its Analogues in Serum and Urine**
  An investigation into assessing different techniques which could be used to detect ecstasy and its derivatives in blood and urine samples. Their aim: to develop a pocket instrument that uses disposable strips to detect ecstasy, and which could be used by first aid teams, ambulance and casualty staff.
  Contact: Prof. George Guilbault, Chemistry Department, University College Cork.

- **Automated Analysis of Controlled Drugs in Biological Samples with GCIMS Detection**
  An investigation into new and faster ways of extracting a range of drugs from biological samples for use in forensic testing.
  Contact: Prof. John Corish, Department of Chemistry, Trinity College Dublin.

- **Development of a Diagnostic Test with increased specificity and sensitivity for the detection of Amphetamines and/or Benzodiazepines**

  Screening for drug use among patients is important in both diagnosing abuse and treating it. Problems exist in the present technique, this is an investigation into a new approach using immunology: in essence, testing for the presence of antibodies to the particular drug.

  Contact: Dr. Alan Shattock, Medical Microbiology, University College Dublin.

- **The Analytical Profiling of Drugs of Abuse**

  An analysis of a range of drugs to identify their characteristics e.g. the exposure of illegal drugs to different environments - cannabis can spend time in the sea, while the level of active ingredient (THC) will depend on where the plant was grown. The resulting 'drugs intelligence' will be used in the analysis of seizures - how the drug was made, stored and distributed.

  Contact: Dr. Desmond Corrigan, School of Pharmacy, Trinity College Dublin.

- **An Attempt to Profile the Ecstasy Class of Controlled Substances**

  Dozens of different formulations of ecstasy exist depending on raw materials and the process used to make the tablets. If more was known about the chemistry of ecstasy it might be possible to identify the illicit laboratories involved and their suppliers. This project will analyse 64 different types of ecstasy and ecstasy-intermediates. This will produce an ecstasy reference library or databank that forensic laboratories can consult to facilitate fingerprinting of ecstasy seizures.

  Contact: Dr. Patrick Guiry, Chemistry Department, University of Dublin.

- **Analysis and Profiling of Illicit Drugs using High-resolution Chromatographic and Mass Spectrometric methods**

  The development of new tests for seizures of heroin, cocaine,

ecstasy and other amphetamines that are capable of detecting the active ingredients, any impurities present and new variants arriving on the scene.
Contact: Prof. James Heffron, Biochemistry Department, University College Cork.

- **Development and Evaluation of Novel sensor Technology for Screening of Suspected Illicit Drugs**

A range of different sensors are used today in industry, medicine and environmental monitoring - including one type known as the artificial nose. This project will investigate if any of the existing approaches can be adapted for use with illegal drugs. If an accurate and reliable drug sensor can be produced (first hoping to develop a heroin sensor) then a small portable instrument would be available for field use.
Contact: Dr. Dermot Diamond, BEST Centre, Dublin City University.

- **Development of a Biosensor to Detect Cocaine, Ecstasy and Amphetamines**

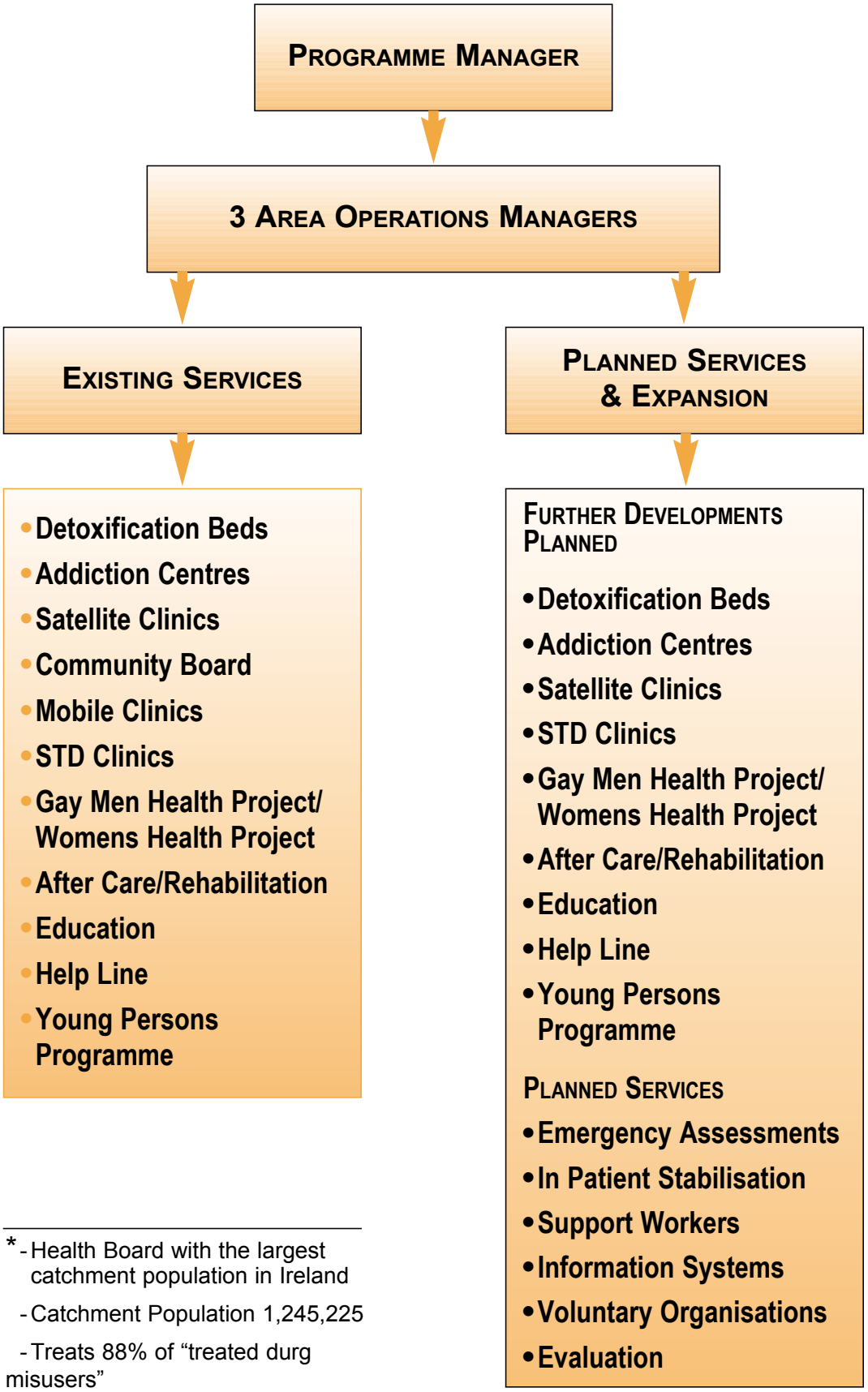
In recent years scientists at Trinity College Dublin studied what happens to ecstasy when it's inside the human body. This project hopes to exploit that new knowledge and develop a new kind of sensor. If successful, the sensor would be portable, highly specific and capable of detecting ecstasy, cocaine and the other amphetamines.
Contact: Prof. Clive Williams, Biochemistry Department, and Prof. Werner J. Blau, Physics Department, Trinity College Dublin.

- **Development of a Multichannel Biosensor for the Detection and Analysis of Drugs of Abuse**

Many forensic tests currently done at the laboratory could be done on location e.g. on board ship, if appropriate portable instruments, sensors or kits were available. The BEST Centre together with scientists from the BEST at the University of Ulster are evaluating a variety of sensor

Annex D

Drugs Services Provided by Eastern Health board*



* - Health Board with the largest catchment population in Ireland

- Catchment Population 1,245,225

- Treats 88% of "treated durg misusers"

Annex E

Activities of Drugs Research Division,

Introduction

The Drugs Research Division of the Health Research Board is involved in national and international activities in the area of drug misuse. The Division is funded by national, EU sources and contract research.

Activities at the National and Regional Levels

National Information Sources on Drug Misuse

Contact: Mary O'Brien

National Drug Treatment Reporting System

The Drugs Research Division of the Health Research Board oversees the maintenance and development of a national epidemiological database on treated drug misuse in Ireland i.e. the National Drug Treatment Reporting System - NDTRS. The system collects data on treated drug misuse throughout the country (e.g. number of contacts; types, duration and frequency of drug use; socio-demographic characteristics and living situation of treated drug misusers; risk behaviour). The data gathered is analysed and presented in annual reports on *Treated Drug Misuse in Ireland*.

National Indicators of Drug Misuse

The Drugs Research Division compiles information on a number of indirect indicators of drug misuse e.g. Health data such as, drug-related AIDS/HIV cases, deaths, admissions/discharges to psychiatric hospitals and general hospitals; Data in the area of law enforcement e.g. information regarding the price, purity, number and quantity of illicit drugs seized and the number of persons charged for drug offences.

National Report on Drug Issues in Ireland

The Drugs Research Division produces an annual *National Report on Drug Issues in Ireland*. The report provides an overview of drugs policy; drug monitoring systems and sources of information; demand reduction initiatives; evaluation, research and training activities; future information needs.

Research Projects

Contact: Rosalyn Moran

The Drugs Research Division is increasing its research portfolio. The following studies have been started recently.

A Study of the Feasibility of the Inclusion of General Practitioners and Prisons in the National Drug Treatment Reporting System - NDTRS

While the National Drug Treatment Reporting System run by the HRB provides 'good' coverage of treated drug misuse in Ireland, it is important given its role as a *national* information resource and framework for policy formulation that coverage is as near 'complete' as possible. There is an important gap in existing coverage which the study aims to address.

The study will determine the feasibility of the inclusion of two specific groups i.e. drug misusers treated by the Prison and GP services, in the NDTRS. In so far as the study endorses the feasibility of inclusion, preliminary steps to the implementation of NDTRS in the two situations will be put in place. The study should result in a more representative picture of treated drug misuse in Ireland. [Contact : Petrina Duff].

Knowledge, Attitudes and Beliefs regarding Drugs and Drug Users - A National Sample amongst the General Public

A survey of Knowledge, Attitudes and Beliefs regarding Drugs and Drug Users is underway. The study aims to ascertain

- the attitudes of the general public to illicit drugs and drug users
- the general public's knowledge of and experience with drugs
- attitudes to prevention and to different forms of treatment
- the general public's perception of the personal and societal

consequences
of drug misuse.

A nation-wide sample of respondents randomly selected from the electoral register has been carried out. The results will be of interest inter alia, to academic researchers, policy makers and public health personnel. [Contact : Audrey Bryan].

Relation between Drug Use, Impaired Driving and Traffic Accidents

A literature review is being conducted which will address a] the experimental and laboratory evidence in relation to the effects of different drugs on driving skills b] the evidence from field studies of a relation between drug use and traffic accidents and c] existing and proposed drug testing procedures with regard to driving in the EU and the issues raised by such testing. The study is being carried out in co-operation with the Transport Policy Research Institute, UCD. [Contact : Ros Moran].

Drug Misuse in its Social and Economic Context

This two-year research project is nearing completion. The objective of the study is to gain an holistic understanding of the nature and patterns of drug use and to evaluate the relationship between problematic drug use and social and economic deprivation. A combination of quantitative and qualitative research methods are being used and results will be analysed for trends which indicate the factors contributing to prolonged problematic drug use.
[Contact : Aileen O'Gorman].

Availability, Use and Evaluation of the Provision of Crèche Facilities in Association with Drug Treatment

The study will explore crèche facilities in drug treatment environments - their provision, usage, types of users, programmes provided etc. with a view to providing recommendations which would feed into discussions regarding the future planning and development of such crèche facilities. Semi- structured interviews will be conducted with the four groups associated with the drug treatment services - treatment staff, crèche leaders, parents and/or guardians of users, users

i.e. children of problem drug users.
[Contact : Ros Moran].

Information and Dissemination Activities

Information and Dissemination Policy

The Drugs Research Division has recently developed an Information and Dissemination Policy document which discusses inter alia

- information provision relating to drugs to a range of actors in the national context. Ongoing information provision includes response to routine enquiries from a wide range of actors (media, government, health professionals, general public); HRB publications; presentations at conferences etc.
- the role of the Drugs Research Division as a conduit for information emanating from the European Monitoring Centre for Drugs and Drug Addiction (scientific reports, research tenders); the Commission of the European Communities (including drug related Research and Development Programmes) and the Pompidou Group of the Council of Europe.

The Drugs Research Division maintains and is further developing a number of mailing lists to serve the Information and Dissemination function.

Bibliography - Drug Misuse in Ireland

An annotated bibliography of drugs issues in Ireland is maintained. This includes books, monographs and non-governmental reports; departmental reports and information; journal articles on studies of drug misuse. A summary of relevant legislation is also included.

International and European Collaboration

European Monitoring Centre for Drugs and Drug Addiction - EMCDDA

The *European Monitoring Centre for Drugs and Drug Addiction* is an European Community institution providing information at

European level concerning drugs and drug addiction and their consequences. The EMCDDA works to improve the comparability of drug related data in the Member States; disseminates information and co-operates with international bodies dealing with drug related issues.

The EMCDDA in fulfilling its role, co-operates with a network of 'Focal Points' or national centres dealing with drug related issues in the Member States. This network is called the REITOX network (European Information Network on Drugs and Drug Addiction). The Drugs Research Division is the designated Irish Focal Point of the REITOX network. Focal Points act as an information resource to the EMCDDA in relation to the national situation in each Member State. The Focal Point participates in several projects aiming to co-ordinate and standardise drugs related information collection in the EU.

Current contractual obligations of the Irish Focal Point in the EMCDDA context includes the completion of an annual report on Drugs in Ireland; provision of epidemiological information on an annual basis; participation in a number of ad hoc research and information tasks e.g. current projects include development of Irish component of an European Database of Demand

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