

Summary of Main Points

As was pointed out in the Reports on which this Review is based, to avoid misinterpretation it is essential to that the following caveats be entered:

- (i) data in this Review relates to those *problem drug users who present for treatment* rather than all those who have drug problems, or indeed all those who use drugs other than alcohol;
- (ii) like most health service data, the information is service dependent and the picture it provides of the extent and nature of drug problems will be influenced by drug service provision.

Thus this Review should not be considered as portraying the total picture of drug use, but as providing a key element of that picture. The data would be particularly useful when considered in conjunction with results from any surveys or other research undertaken.

MAIN POINTS

- the number of cases, as distinct from persons, in both the total treatment group and the first contact group, who were treated for problem drug misuse in the Greater Dublin Area, increased steadily over the five years under review;
- the rate of treated drug misuse for the total treatment group rose from 4.5 per '000 in 1990 to 7.1 per '000 in 1994 and the rate for the first contact group from 1.5 per '000 in 1990 to 3.0 per '000 in 1994;
- the proportion of teenagers in the total treatment group rose from 17 per cent in 1990 to 30 per cent in 1994 and the proportions for the first contact group were 35 per cent in 1990 rising to 51 per cent in 1994;
- while overall the proportions leaving school at or under the school leaving age of 15 continued to be more than 50 per cent, the trend was downward and participation in secondary level increased;
- the exceptionally high levels of unemployment for both groups were maintained over the years;
- whereas for the total treatment group the proportion whose primary drug of misuse was an opiate was always more than 75 per cent, for the first treatment group this proportion was only reached in 1994, having been as low as 49 per cent in 1992;
- the most commonly used primary drug was heroin and there was an increasing proportion of those citing heroin in the total treatment group - the increase was even more pronounced for the first treatment group;
- there appeared to be a decrease in the proportion of those injecting their primary drug in favour of smoking in both groups;

- the proportion who had ever injected had decreased steadily for the total treatment group, but this was not the case for the first treatment group where the trend seemed to be upward since 1992;
- of the group of those who had ever injected, for the total treatment clients around 70 per cent were currently injecting in any given year but for the first contact clients the proportion was at its highest in 1993 at 77 per cent;
- there were some notable differences between males and females over all the years, firstly, the proportion of males was always at least three times that of females; secondly, in both groups males were proportionately more likely than females to live with their family of origin in any given year, in fact there was an upward trend for males but no discernible trend for females and finally, in both groups, while no trend emerged, females were always proportionately far more likely than males to be living with a drug-using partner.

CHAPTER 1

Introduction

In assembling this five-year review, based on data returned to the Drug Section of the Health Research Board by the participating treatments centres, the author presents the main findings and observes any trends which have emerged over the five years 1990-1994 in treated drug misuse in the Greater Dublin Area. From the beginning of 1995 onwards the reporting system has been extended to cover the country but, as is recognised, up to the present most of the drug misuse activity in Ireland has taken place in Dublin.

Because this is a five-year synthesis of the returns from the Drug Treatment Reporting System, in this introductory chapter the review reiterates some of the information given in the individual annual reports on the background and the history of the setting up of the drug treatment reporting system within the framework of the indicators of drug misuse utilised by the Pompidou Group of the Council of Europe. The review also restates some information on the expansion of the involvement of the Drug Section of the Health Research Board as the Irish focal point in the European Union's Monitoring Centre for Drugs and Drug Addiction. This chapter then sets out the definitions used and methodologies employed in the collection and analysis of the data from the drug treatment centres and finally notes the content of the following chapters.

Turning now to the background and history of the setting up of the reporting system, the collection of treatment data has its origin in the epidemiology work of the Pompidou Group, Council of Europe. A full description of the background to the setting up of this Pompidou Group and the collection of treatment data is given in the first report on treated drug misuse in the greater Dublin area (O'Hare and O'Brien, 1992). As that description states, the aim of the group was defined as an examination, from a multi-disciplinary perspective, of the problems of drug abuse and illicit trafficking. The current work within the epidemiology sub-group is embodied in the decision made at the 1981 Conference which was to set up structures for:

the development of administrative monitoring systems for the assessment of public health and social problems related to drug abuse.

There were both methodological and substantive objectives set out. As the coordinator of the Multi-city Study since its inception in 1983 (Hartnoll, 1995) points out it is not easy to obtain valid information on phenomena that are often illegal, stigmatised and hidden. The methodological objective emphasised the improvement of the quality usefulness and comparability of indicators of drug misuse and the substantive objective was to monitor and interpret trends in drug misuse across a network of major European cities. These monitoring systems are now in place in 13 European cities including Dublin. They are based on information from a range of indicators of drug activity such as, first treatment demand; seizures of illicit drugs; drug-related AIDS cases; hospital admissions; viral hepatitis; drug-related deaths; price/purity of illicit drugs; survey data; persons charged for drug offences and imprisonments. However, some indicators are better developed than others in the sense that definitive protocols have been put in place by the Pompidou Group. The treatment

demand indicator is the best developed and a definitive protocol has been agreed in the Pompidou Group. This is the particular indicator on which the data for this Review are based.

It is important to note here, of course, that the reason for the inclusion of a number of indicators is that information from one indicator is never sufficient to demonstrate fully trends in drug misuse. Analysis of drug misuse must include data from as many indicators as possible and supplement this source by information on the legal and socio-cultural context of drug taking.

For the collection of the first treatment data a city approach was adopted by the Pompidou Group because the necessary pilot and developmental work at that level could be more easily carried out and it would also be easier to take account of the various factors needed to interpret the data. As Hartnoll has noted, this was not intended to replace national data but rather to complement the somewhat general national picture with the more in-depth insight that can be achieved at local level. 'A further advantage of this approach' says Hartnoll (1995, p.1)'is that it is often in the large cities that new trends are first observed'. In Ireland it had been noted that the main problem relating to drug misuse was confined to the Greater Dublin Area. Therefore, since 1990, reports have been prepared for that area - both statutory and voluntary agencies providing information on an on-going basis.

The work of the Pompidou Group has been continually guided by directives from ministerial conferences and monitored by the permanent correspondents. These latter are usually senior civil servants, appointed by each of the participating member states to ensure the implementation of the work programme established by the ministers. The Pompidou Group maintains close contacts with other intergovernmental and non-governmental organisations concerned with problem drug use. Recent proposals have focused on the importance of getting some measure of the 'hidden' population of drug users not manifested by the indicator approach. Such proposals include the desirability of carrying out a household survey of the general population, conducting ethnographic studies and improving methods of estimating the total number of drug users. This present review is predominantly concerned with treated drug misuse in the Greater Dublin Area. However, it might be of interest that some short comments are made on two of the other important indicators mentioned above, drug seizures and drug-related AIDS. These are national data as a breakdown for Dublin is not available. These data are included in Appendix C.

Returning to the particular indicator concerned here, treatment demand, data from this indicator serve two purposes - the first is indirect evidence of trends of drug misuse, that is, treated incidence. This refers to the number of people who receive treatment for the first time ever. The second purpose of the treatment demand indicator is as a direct indicator of the demand on services covered by the reporting system. The establishment of an ongoing reporting system also enables socio-demographic information to be collected on first contacts, re-contacts and all contacts entering treatment in a given year with the specified centres.

Since one of the main recommendations of the *Government Strategy to Prevent Drug Misuse* (Ireland, 1991) was that a national drugs misuse database should be set up, from the beginning of 1995 this was under way with the involvement of centres outside the Dublin

area. Reports from 1995 onwards will be national reports. This key development was also a response to the increasing international aspect of the drug phenomenon, and together with a more integrated Europe means that collaboration between countries concerning the collection of useful and comparable information is of growing relevance. Up to now there had been no institutionalised monitoring of drugs and drug misuse within the European Union itself. As stated earlier the Pompidou Group of the Council of Europe was the reference point outside of Ireland. Now the European Monitoring Centre on Drugs and Drug Addiction has been set up to cover the countries of the European Union and each country has a member on the Management Committee. As previously mentioned, the Drug Section of the Health Research Board has been designated as the Irish focal point of this new European Observatory sited at Lisbon.

The emphasis in the Pompidou Group is on the development of indicators and methodologies to assess the level of drug misuse within countries and the Council of Europe as a whole, while the emphasis in the Monitoring Centre is on joint action against drug misuse in Europe.

METHODOLOGY

The data analysed in this report are from the reports prepared by O'Hare and O'Brien for the years 1990 and 1991 (published 1992 and 1993), from reports prepared by O'Higgins and O'Brien for the years 1992, 1993 and 1994 (published 1994 and 1995) with some additional cross-tabulations on the data for the five years prepared by O'Brien and Duff. Data for each of their clients are entered by the treatment centres on an individual questionnaire. The questionnaire was first formulated following pilot work by the Council of Europe, published in 1989 and a copy is included in Appendix D. These returns are then sent to and analysed at the Health Research Board. All information received is anonymous as no names are entered on the questionnaires.

Some consideration of the reliability, representativeness and comparability of the data must be included under methodology. Where reliability is concerned, the data for the reports, on which this review is based, were collected by the staff of the treatment centres. In all cases the data were obtained in face-to-face clinical settings. Obviously a full evaluation of the reliability of the data was not possible for the reports as it would have involved checking these data against other sources, independent of the clinical interviews. It will be noted that there was an amount of information missing on certain variables, for instance, level of education and in respect of sharing of injecting equipment. A firm definition of the latter variable is problematic as is noted in the definitions following. Given these reservations, it is reasonable to assume that the data which were provided are sufficiently reliable to give a comprehensive account of treated drug misuse. As regards representativeness, the data were supplied by the treatment centres noted in Appendix F and cover the main centres, both statutory and voluntary, and most of the smaller centres. The level of representativeness would therefore be almost total up to 1994 when one of the larger voluntary centres was unable to continue to provide data. Turning to comparability, the coordinator of the multi-city study extracts the core items from the data supplied by the cities involved in the study and bases his report on these items (see: Hartnoll, 1995). The Dublin reports have always been included in the coordinator's synthesis.

DEFINITIONS USED IN THIS REVIEW

DRUG MISUSE

The definition *of drug misuse* employed in this review is:

The taking of a legal and/or illegal drug or drugs (excluding alcohol, other than as secondary drug of misuse, and tobacco) which harm the physical, mental or social well-being of the individual, the group or society.

DRUG TREATMENT

The definition *of drug treatment* is:

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. This activity will often take place at specialised facilities for drug users, but may also take place in general services offering medical/psychological help to people with drug problems.

Various therapies are used in the treatment of clients at the centres. These range from medical treatments, (such as detoxification, methadone programmes or drug-free programmes) to non-medical therapies which can include addiction counselling, group therapy and psychotherapy. Therapies are generally provided by professionally qualified personnel but some centres may deem certain persons, who are not professionally qualified, as suitable to undertake some of these therapies. Apart from the therapeutic centres, drug treatment may be provided in hospitals, therapeutic communities, residential centres, out-patient clinics, street agencies, general practices and, of course, in the prisons. Under the definition of *treatment* used in this report, information given over the telephone or information solely concerned with queries about social welfare entitlements is not included as *treatment*.

TOTAL TREATMENT

The operational definition used is the number of cases who received treatment, as defined above, from any of the drug treatment centres listed in Appendix F.

FIRST TREATMENT

The definition used for this group is persons who contact and receive treatment for the first time from any of the treatment centres.

CATCHMENT AREA

The Greater Dublin Area comprises 504 km within Dublin county, which incorporates Dublin County Borough, its north suburbs (part of Fingal) and its south suburbs (part of Belgard) together with Dun Laoghaire County Borough with its suburbs. The population base for the 1990 and 1991 Reports was 920,956, the figure taken from the 1986 *Census of Population*. For the 1992, 1993 and 1994 Reports the population figure was taken from the 1991 *Census of Population* and was 915,516. Some breakdowns of these figures are

included in Appendices G and F. No details of populations by individual years were available.

PRIMARY DRUG

The *primary drug* is defined as the drug which, at the time of the current treatment contact, the client alleged was causing most problems and for which he or she had sought treatment.

FREQUENCY OF USE

This term refers to the number of times a person had used his or her primary drug within the 30 days prior to treatment.

SHARING

As noted in all the Reports, ‘sharing’ is a difficult concept to define since its practice is understood as quite different by different people. Sharing injecting equipment with a partner is often not regarded as ‘sharing’. Therefore it will be difficult to assess accurately the level of sharing of equipment. The treatment centres must take their clients’ accounts of their practices and the data here are based on the information the treatment centres have obtained from their clients.

DRUG FREE

The term is used for those people who:

- were recorded as not having used drugs in the previous month, although in receipt of methadone from the methadone maintenance programme;
- were referred for treatment from prison where they had not been using drugs, or by a probation officer and had stopped drug use in the remand period or were referred by Narcotics Anonymous;
- sought counselling when they had stopped using drugs, to avoid relapse.

OUTLINE OF THE REVIEW

The structure of the rest of this review is as follows: the first part of Chapter 2 deals with the frequency data and identifies (a) socio-demographic characteristics; (b) history of drug misuse and (c) injecting and needle-sharing practices of all clients in treatment during the five years under review and comments on any trends emerging from these data over the years. The second part examines some of the cross-tabulations where indications of trends in increases or decreases occur.

Chapter 3 looks at the frequency data again but this time isolating first treatment clients and in the first part identifying some of their (a) socio-demographic characteristics; (b) the history of their drug misuse and (c) their injecting and needle-sharing practices in each year and discussing any visible trends in either socio-demographic characteristics or drug misuse behaviour. The second part of this chapter examines the relevant cross-tabulations for the first treatment group. In Chapter 4 an effort is made to give estimations of the exact

numbers involved in treatment and the rates per '000 of the population aged 15 to 39 years old have been calculated.

Following this there is the final chapter which gives more detail on the trends and discusses the possible implications to be drawn from the findings. Given the differences in the populations under study it was not possible in this review to make very useful comparisons with research findings, The population studied in this report is made up of those being treated for drug misuse and since populations studied in other research are chosen from different groups the results are thus not directly comparable. Some reference is made to other research where relevant research is available.

CHAPTER 5

Discussion and Conclusions

This final chapter of the review of the trends in the treated drug misuse first comments on those trends, relying heavily for likely inferences on the work done by Hartnoll (1995) of the Pompidou Group and some other appropriate studies undertaken. The reason for the heavy reliance on Hartnoll's work is that the questions on the form used for the collection of the data are dictated by the definitive protocol for the treatment demand indicator of the Pompidou Group. The chapter then discusses some of the trends and related matters and concludes with a brief look at some issues for the future.

As has been shown in a number of areas, such as unemployment levels, no particular trends were visible over the years. However, they will be included in the comments here because of their general importance and possible relevance to the overall picture of treated drug misusers.

AGE AND SEX

Taking overall age first, all the age categories, mean, median and mode showed a decrease over the years for both prevalence and first treatment groups. For both males and females in the total treatment group the mean age had dropped over the five years to its lowest at 23.8 years in 1994. Males' average age was always slightly younger than that of females. The lowering of the mean age for both sexes was also the case for the first treatment group and here the range was from 22.8 years in 1990 to 20.6 years in 1994. The finding of a strong age effect is similar to that found in the Council of Europe city study. Hartnoll (1995, p.vi) notes the age effect increasing through adolescence and young adulthood and subsequently declining.

With regard to any differences between the sexes in the age at which clients come for treatment, this is best demonstrated by information on the first treatment group. Up to 1994 higher proportions of women were likely to come for treatment as teenagers than were men. In fact in 1992 and 1993 over half of the women coming for treatment for the first time were aged under 20 years old in comparison with around 40 per cent of the men. This changed in 1994 when over half of the men and 45 per cent of the women were teenagers. From 1992 onwards, males became increasingly more likely to have first used their primary drug as teenagers - the trend was from 64 per cent in 1990 to 81 per cent in 1994. For females, there was no particular trend and the proportion was always approaching 70 per cent. For the overall data this would seem to contradict the belief of many drug workers before 1992 that when women presented for treatment it tended to be later than the age at which men present. (Woods, 1992).

When male/female ratios were examined, for the total treatment group the ratio in 1990 was three to one and in 1994 it was four to one. While the proportion of women decreased relative to men, the actual number of women, while reaching its highest in 1993, was fairly similar in the other years. While obviously there was a rise in the number of males, the rise was not as dramatic as for the first treatment group. As with the prevalence group, in the first treatment

group, the proportion of males far exceeds the proportion of females. At the lowest point it was three to one in 1990 rising to five to one in 1994. Although the proportion of females has decreased, the numbers have increased since 1991. This holds for both total and first treatment groups. There was a dramatic rise in the number of males in the first treatment group over the years. The number increased from the lowest number in 1991 of 380 to approaching 1,000 in 1994. These findings are in line with those found in other European cities. (See :Hartnoll, 1995, p.vi).

Some other gender differences emerged from this review. As was noted in *Treated Drug Misuse, 1990*, a publication of the United Nations was devoted specifically to the issue of women and drug abuse (United Nations, 1987). That document records that epidemiological studies have shown consistent differences in drug use by men and women including higher levels of personal distress such as, depression and anxiety and lower levels of self-esteem experienced by women. Studies also mentioned in the 1990 report - this time from the UK - such as Waterson and Ettore (1989) identified problems which might prevent women presenting for treatment. These problems could be fear associated with help seeking, of embarrassment, of shame and, most important of all as pointed out by Woods (1992), the fear of compounding the 'unfit mother' notion leading to the fear of losing their children.

For duration of use before treatment in the case of both men and women 'the duration of use had shortened before treatment commenced.

Additional differences between the sexes which should be highlighted refer to men being much more likely to be living with their family of origin than women but, more importantly, proportionately more women than men were living with a drug misusing partner. For both groups while there was no particular trend up or down here, the proportionate differences between men and women were much more pronounced. The consistent overall finding for the first treatment group was that proportionately four times more women than men were living with a drug-misusing partner and in the total treatment group the proportion was likely to be three times greater for women. Men were proportionately more likely to live with a non-drug-misusing partner in both groups. Women's relative lack of power and economic control in society generally links their dependence on men with their continuing to live with a drug misusing partner.

Some research, for instance Klee (1993, p.1059), suggests that economic and emotional commitment dependence of women on partners leads to underlying anxiety and that injecting males prefer non-drug-misusing partners. The finding that proportionately more women were living with a drug-misusing partner shows up most clearly when one looks at the table and graph referring to currently sharing injecting equipment. Here, while there is no discernible trend for either sex, the proportions of women sharing far outweigh the proportions of men sharing. In association with that finding Hedrich's (1990) submission, that a woman's cessation of drug misuse was strongly related to her social relationships and emotional support from other people, is appropriate.

SOCIAL DEPRIVATION – EDUCATION AND EMPLOYMENT

The main trend with regard to education was the increase in the participation in some level of secondary education but the proportions of clients who had left education either at or below the school leaving age continued to be a large majority.

There was a strong association between high prevalence and relative social deprivation in Dublin, instanced by the levels of unemployment which were totally out of proportion to the levels in the population, and the generally low education levels for those attending treatment centres. These findings held for the five years, particularly as regards unemployment. Perhaps in regard to high levels of unemployment relative to the unemployment level in the total population, one must consider the areas in question, in that some of the areas of social deprivation from which the drug misusers come would have unemployment levels of similar dimensions to those found among drug misusers (see, for instance, O’Gallagher, 1990). Therefore, the population under study here would be from areas of high unemployment and be unemployed themselves. However, as Hartnoll (1995, p. 65) points out an association between drug use and measures of social class is not simple. The relationships may differ for drug use *per se* and have more serious patterns of addiction. Hartnoll goes on to relate that in some cities (e.g. Amsterdam, Barcelona) drug use (largely cannabis) as measured by population surveys tends to be higher in middle-class areas or amongst people with higher educational level. In Oslo, however, cannabis use is higher amongst young people who do not complete school. As regards addiction, there is a strong association in several cities between high prevalence and relative social deprivation (e.g. Barcelona, Dublin, Paris, Stockholm). Hartnoll contends that this is not true in all cities, for example, heroin addiction is more widely spread across social groups in Geneva and possibly London.

PRIMARY DRUG

There was a dramatic rise in the proportions citing heroin as their most commonly used primary drug - from 39 per cent in 1990 to 56 per cent in 1994 for the total treatment group and an even more dramatic rise - from 22 per cent to 59 per cent - for the first treatment group. Of all the drugs listed, heroin was the only one where an upward trend could be observed. Although media attention has for the most part been concentrated on ecstasy, it is likely that heroin will continue to be the primary drug associated with requests for treatment. The increases in the misuse of heroin as a most commonly used drug was, of course, reflected in the diminishing proportions of other groups of drugs. For instance, the proportion misusing MSTs declined from 33 per cent in 1990 to 19 per cent in 1994. For the first treatment group this decline was even more dramatic - from 32 per cent in 1990 to 9 per cent in 1994. No particular trend was seen in the use of cannabis and the proportion remains in very low double figures for the total treatment group but there did appear to be a downward trend in the case of the first treatment group, particularly since 1991.

Regarding the use of other substances, which would include, for instance, volatile inhalants and tranquilisers, the numbers involved in treatment were small, so therefore comment on likely trends would not be meaningful.

If age first used primary drug is considered, the majority of those in the total treatment group had first used their primary drug when aged under 20 years old. However, the proportion is fairly constant over the five years, whereas with the first treatment group, which it will be remembered are younger, there was an increasing majority first using their primary drug as teenagers.

ROUTE OF ADMINISTRATION

The importance of reducing the health risks associated with injecting are well known. Here three sets of data are noted: (i) actual route of administration of primary drug; (ii) where this was injecting, the proportion and number who had ever injected and (iii) the proportion and number of current injectors. For the total treatment group taking (i) when the trends here in the proportion of clients who injected their primary drug are examined, it will be seen that there was a slight downward trend in injecting as a route of administration. This was counterbalanced by a rise in the proportion of clients who smoked their primary drug. There was a gradual fall in (ii) the proportion who had ever injected. The trend in (iii) the proportion of those currently injecting, was also downward. When actual numbers were considered the number whose route of administration of primary drug was injecting was on the increase, although as has been shown, the trend in the proportions was decreasing. As regards (ii) those who had ever injected, the numbers here had also increased. When the data on whether or not the people were currently injecting was examined, in the total treatment group a fairly stable proportion of around 70 per cent were currently injecting since 1992.

Where the first treatment group was concerned, since 1992 both the proportion and the number of those whose route of administration was injecting had risen. There was no discernible pattern over the years, proportionally speaking, for those who had ever injected but where the numbers were concerned, there was a continual rise from 1991. Whether this means that there is an increase in the numbers of those who are injectors coming for treatment for the first time or an increase in the overall number of injectors is impossible to say, but it is to be hoped that the harm reduction approach is successful in reaching those likely to be in danger from their use of injecting as a route of administration of their primary drug. "Some patterns of drug use (e.g. injecting) are rare in the general population" says Hartnoll (1995, p.3) "but when concentrated in particular groups can have consequences disproportionate to their numerical dimensions in terms of costs to the community, health care systems or institutions such as the prisons".

ISSUES FOR THE FUTURE

It is not intended in this brief look at issues for the future to try to cover all aspects of what is being done and what is likely to occur in the future in this complex area. It will merely be a short discussion of some of the more important actions and progress being made at present or that will be made in the future.

Ireland cannot act unilaterally with regard to the drug problem. There are a variety of social and economic developments in Europe likely to impinge on drug use and drug markets in the coming years. Hartnoll (1995, p.75) would see these as rising unemployment, economic recession, demographic changes, new patterns of migration and immigration, changing patterns of employment in industry, agricultural and service sectors, developments in urban living and leisure activity and the rapid changes in eastern Europe and other parts of the world. Several population groups may be particularly vulnerable amidst these changes and some of the groups can be found in Ireland. For instance, vulnerable groups would include young people growing up in socially and economically disadvantaged communities, young people moving from areas of declining agriculture or industry and indeed, broader groups of young people

It would be accepted that the reasons why people take drugs are multiple and complex and that therefore a range of strategies is needed to deal with the problems that may arise from the use and misuse of legal and illegal drugs. In his launch of details of the new Government demand reduction measures to prevent drug misuse, the Minister for Health announced that the Department of Health has been preparing a strategy, in consultation with the Departments of Education and Justice and health agencies which will form the basis of the demand reduction response (Ireland, 1996). The strategy to be used is based on two key elements: reducing the number of people turning to drug misuse in the first instance through information, education and prevention programmes and secondly, providing a range of treatment options for those addicted to drugs, the ultimate objective of which must be a return to a drug free life style, although the Minister accepted that this may not be a realistic goal in every instance.

Many different ways of reducing drug use and the harms associated with it have been tried, but prohibition obviously needs the support of other methods, since by itself it manifestly does not succeed in eliminating supply and does nothing to control the demand for drugs.

In tackling the problem of drug misuse one of the actions of the Department of Health and the Department of Education is to aim information and harm reduction messages at both primary and secondary level pupils. Children have some knowledge of drugs, however incomplete and inaccurate, from an early age and, as is evidenced from the data in this review, will start to use drugs while still in primary school. Because many young people will try drugs regardless of any educational intervention, they need to be provided with harm reduction messages that can reduce the risk of their drug use. Of course, the effectiveness of drug education has not yet been established and probably some evaluation of the programmes would be useful. On education itself, in the UK Clements and Buczkiewicz (1993) and Jack and Clements (1994) argue that because young people may be more likely to listen to other young people than they are to adults, one way of getting such messages across are 'peer-led' approaches, which are currently popular in the UK, particularly in informal education but also in schools. These cover a range of approaches involving both older children delivering harm reduction messages to their younger school-mates and 'same-age' peer education involving pupils educating their class-mates. The Health Promotion Unit of the Department of Health is at present seeking tenders for a multi-media campaign, aimed at prevention, to be introduced into schools.

Ives (1996) recommends that drug education should take place within a broad framework of health and social education which embraces discussion about healthy living. However, Ives warns that this approach inevitably means entering into difficult territory. Health education is a highly charged topic and there is disagreement about what 'healthy living' actually means. Teacher training, both initial and in-service, is vital he contends. Also in his discussion of drug education Ives (1996) sounds a cautionary note, saying that secondary school pupils' knowledge is often considerably greater, and in many cases likely to be gained through personal experience of drug use. The young are more likely to have used drugs than older people: in this respect they have more knowledge about drugs than many of their teachers. Therefore, didactic drug education on its own is unlikely to be effective, although it may be necessary to counter some of the misinformation that young people have about drugs with a clear account of the facts appropriate to their age and their level of understanding.

Among the useful initiatives the Department of Justice is putting into operation is that of addressing the drugs problem in prisons. This problem has caused much comment and discussion. A decision on the plans for the preparation of the Training Unit at Mountjoy Prison to be used as a drug free unit have been taken. Currently the issue of introducing a methadone treatment programme for general prisoners is being examined with experts from Ireland and the United Kingdom studying the best means for implementing such a programme. This action is being taken within the framework of putting in place a more effective treatment regime in the prison system at large. The coordination of the work between the Gardai, Customs and Naval services is another beneficial initiative which should provide invaluable support to action on supply reduction.

Hartnoll (1995, p.65) remarks that surveys of drug use show higher prevalence rates for illegal drugs in urban than in rural areas. However, these differences often diminish or disappear for solvents and mixtures of legal drugs (pills, alcohol). Similarly, says Hartnoll, addiction is concentrated in the cities but the “magnetic” effect of the illicit market in attracting people from outside of the city may give an impression of prevalence levels which are higher than those based on addicts who are native residents of the city. If this is true for Ireland, then the prevalence rate for Dublin may be exaggerating the true level because of those people being treated in Dublin, who may be resident only for the purpose of obtaining treatment in Dublin.

One vital component in policy-makers information and ability to act in responding to the problem of drug misuse is the level of reporting of treated drug misuse should be at the optimum level. From time to time some voluntary organisations have been unable to return data because of lack of resources, both human and technical. This deficiency distorts the overall figures and retards efforts of policy makers in assisting these voluntary organisations in their work, since evidence of the critical contribution these voluntary organisations make is not included in the picture of treated drug misuse presented in the reporting system.

Finally, the evidence of increasing numbers in treatment leads to the question as to whether the increases are artifacts of better reporting and a greater provision of services or is the number of drug misusers in the community actually increasing? Without some estimation of overall prevalence, the answer to that question must remain in the realms of speculation. It is hoped that efforts will be made towards a response to this question of the true number of misusers in the population. Methodologies to achieve reliable data on this difficult undertaking are being discussed at present in the Pompidou Group at the Council of Europe.

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