



European Monitoring Centre
for Drugs and Drug Addiction



**2006 NATIONAL REPORT (2005 Data)
TO THE EMCDDA
by the Reitox National Focal Point**

IRELAND
New developments, trends and in-depth information on selected issues

REITOX

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Summary

This report, written following EMCDDA (European Monitoring Centre for Drugs and Drug Addiction) guidelines,¹ is divided into two parts. The first part (Part A) provides an overview of new developments and trends in the drugs area in Ireland for 2005 and, in some cases, for the first six months of 2006. These are covered under the following headings:

1. National policies and context
2. Drug use in the population
3. Prevention
4. Problem drug use
5. Drug-related treatment
6. Health correlates and consequences
7. Responses to health correlates and consequences
8. Social correlates and consequences
9. Responses to social correlates and consequences
10. Drug markets

The second part (Part B) examines three specific issues considered to be important at an EU level. The three Selected Issues are:

1. Drug use and related problems among very young people
2. Cocaine powder and crack cocaine: situation and responses
3. Drugs and driving

Main points from Part A

- New draft prison rules were published in June 2005. The rules deal with all aspects of prison life, including accommodation, visiting rights, discipline, health and education. The new rules also make provision for the introduction of compulsory or mandatory drug testing of prisoners.
- On 1 January 2006 the Railway Safety Commission was established under the Railway Safety Act 2005. The Commission's powers will include approving the codes of conduct, sampling procedures and support services which railway undertakings are required to develop in respect of testing safety critical workers for the presence of intoxicants.
- The government has ordered that, as of 31 January 2006, the possession or sale of so-called 'magic' mushrooms are criminal offences under the Misuse of Drugs Act 1977.
- On 1 February 2006 the Courts Service announced that the Drug Treatment Court is to be put on a permanent footing and extended on a staged basis to all court areas in the Dublin metropolitan district.
- On 10 February 2006 the *Report of the Garda Síochána Act 2005 Implementation Review Group* reported that guidelines for the establishment of joint policing committees had been drafted early in the year. It recommended that there should be up to 12 pilot schemes in a variety of settings before the system is rolled out nationwide in about a year's time.
- The Criminal Justice Act 2006 was signed into law by the President on 16 July 2006. The Act includes: provisions for creating criminal offences in relation to participation in criminal organisations; proposals to strengthen the provisions on the imposition of the 10-year mandatory minimum sentence for drug trafficking; new offences of supplying drugs to prisoners and provisions in relation to a drug offenders register. The Irish Human Rights Commission has raised a number of concerns about some of the provisions of the Act.
- In September 2006 the Irish government and the social partners signed a new social partnership agreement. The agreement addresses drug and alcohol misuse in the context of improving health outcomes for children, addressing the health needs of young adults, and work-related drug testing.

¹ A copy of the EMCDDA guidelines is available from the EMCDDA's website at www.emcdda.eu.int. The guidelines require each Focal Point to write its National Report in a prescribed format using standard headings and covering each topic using a check list of items. This helps to ensure comparability of reporting across the EU.

- In May 2006 the Minister of State with responsibility for drugs strategy, Noel Ahern TD, reported that the regional drugs task forces (RDTFs), first called for in the National Drugs Strategy 2001–2008, would be fully established and operational by the end of 2006. A notable feature of the action plans drawn up by the RDTFs is the integration of responses to drugs and alcohol problem use in the one framework.
- In May 2006, in Dáil Éireann (the Irish Parliament), the Minister of State with responsibility for drugs strategy, Noel Ahern TD, estimated that the overall drugs budget for 2006 stood at around €200 million.
- Within the parameters established by the National Drugs Strategy 2001–2008 and the National Development Plan 2000–2006, public funds are assigned to drug-related initiatives via the annual parliamentary Estimates process. Except in the case of the Drugs Initiative, the Estimates do not specify the amounts allocated for expenditure by government departments and state agencies specifically on the drugs issue.
- In 2006, €43.006 million was voted for the Drugs Initiative, a 15% increase on the 2005 figure. The Drugs Initiative includes funding for the local and regional drugs task forces, the Young People's Facilities and Services Fund (YPPFSF), the Premises Initiative and the Emerging Needs Fund.
- In October 2005 the results of the 2002/2003 drug prevalence survey conducted in Ireland and Northern Ireland in respect of cannabis were published. This report included results relating to attitudes to cannabis use. In Ireland, a large majority (72%) of those surveyed felt that cannabis use should be permitted for medical reasons. In contrast, only 21% agreed that cannabis use should be permitted for recreational purposes. In general, those who had ever used cannabis had more liberal views on both the medical and the recreational uses of cannabis.
- Between June 2005 and June 2006, three key policy debates were initiated and debated in Parliament and/or civil society: the manner and means of implementing the National Drugs Strategy 2001–2008, and in particular the partnership approach; the question of drugs and alcohol; and rethinking the war on drugs.
- The results of the general population survey 2002/2003 indicate that one in five (18.5%) adults reported using an illegal drug in their lifetime. For young adults (aged 15–34 years) this rose to one in four (26.0%) people. Twice as many men as women reported the use of an illegal drug during the last month or the last year.
- The third European School Survey Project on Alcohol and Other Drugs (ESPAD) was published in December 2004. For school-going children aged 15–16 years there was a notable increase in lifetime use of any illicit drug between 1999 (32%) and 2003 (40%), up 8%. This increase followed a drop between 1995 and 1999.
- With a rate of 40%, Ireland ranked joint third after the Czech Republic (44%) and Switzerland (41%) for lifetime use of any illicit drug among older second-level school children in 2003. The average for the 35 ESPAD countries in 2003 was 22%.
- The majority of those who have tried any illicit drug have used cannabis (marijuana or hashish). The lifetime prevalence rates for cannabis use are thus similar to those for use of any illicit drug and reflect the same trend. Lifetime use of inhalants dropped slightly between 1999 (22%) and 2003 (18%) but remains high. The average for the 35 ESPAD countries in 2003 was 10%.
- The results of a national survey of third-level students were published in April 2005. Cannabis was the most common illicit drug used by students, with over one-third (37%) reporting that they had used it in the past 12 months. Ecstasy was the second most used illicit drug, followed by cocaine, magic mushrooms and amphetamines. For all drugs, the levels of use were higher among students than among those of a similar age group (15–24 years) in the general population. The use of solvents (inhalants) was particularly high.
- The rate of problematic opiate use was 5.6 per 1,000 population aged 15–64 years in 2001 and 2002.

- Recent research among young people reveals challenges to traditional providers of drug prevention services.
- Information on drugs and services has been translated into a number of languages to accommodate new communities in Ireland.
- There has been significant investment in capital building projects for drug services in disadvantaged communities.
- There is an increased focus on training for professionals and communities involved in tackling drug use.
- There is an increasing use of technology to disseminate drug prevention information.
- Of the 3,371 cases who entered treatment for the first time or returned to treatment at outpatient services in 2004, 861 (26%) were females, 1,774 (53%) were aged between 20 and 29 years, and 1,446 (43%) had never previously been treated.
- Of the 725 cases who were admitted to residential facilities in 2004, 168 (23%) were females, the majority (457, 63%) were aged between 20 and 29 years, and 310 (43%) had never previously been treated.
- Of the 219 cases who attended low-threshold services in 2004, 61 (28%) were females, 151 (69%) were aged between 20 and 29 years, and 43 (20%) had never previously been treated.
- On 1 January 2005, the 10 health boards managing the health services in Ireland were replaced by a single entity, the Health Service Executive (HSE). This entity manages Ireland's public health sector. The management of all addiction services is under the remit of the Primary, Community and Continuing Care Directorate of the HSE, which will oversee a number of national care groups. The national care group with specific responsibility for addiction services is Social Inclusion Services.
- The total number of drug treatment services available in Ireland and participating in the NDTRS increased between 1998 and 2004. The largest increase was in outpatient treatment services and general practitioner services.
- The provision of drug treatment services, particularly methadone treatment, through the Irish Prison Service continues to use a significant proportion of health care resources. A number of prisons provided methadone treatment in 2004, and 1,309 prisoners were treated with methadone in the year. Of these, 96 commenced methadone treatment for the first time, indicating the important role of prison services in introducing prisoners to drug treatment.
- A new strategy document published by the Irish Prison Service (IPS) (2006), *Keeping drugs out of prisons*, proposes to tackle the use of illicit drugs in Irish prisons by focusing on supply elimination and demand reduction. The strategy also provides for the introduction of mandatory drug testing by the end of 2006. This will involve 5% to 10% of prisoners being randomly selected for drug testing each month.
- The IPS strategy document recognises that the best way to reduce the demand for drugs in prison is by providing a range of evidence-based treatment options. The prison service has outlined three core tasks to support drug treatment and rehabilitation: identifying and engaging with drug users; providing treatment options; and ensuring continuity of treatment and care following release.
- As part of its new strategy, the IPS aims to strengthen research in the area of drug misuse in prisons. This research will be based on partnership between the relevant statutory and non-statutory bodies. Policies will include: commissioning and encouraging research on drug misuse in prisons; evaluating all programmes and interventions; making all research data available to and liaising regularly with the relevant bodies; investigating systems to identify and manage patient outcome data; and evaluating the effectiveness of drug interventions using intervention outcome information.

- On 11 September 2006, a team at the National University of Ireland, Maynooth, published the first national Research Outcomes Study in Ireland (ROSIE). At baseline, the study recruited 404 opiate users aged 18 years or over entering treatment at inpatient facilities (hospitals, residential programmes and prisons) or outpatient settings (community-based clinics, health board clinics and general practitioners). The participants were interviewed at intake (baseline), at six months following entry to treatment (not presented) and again at one year after intake; 75% participated in the interview at 12 months. There was a reduction in the proportion of participants who reported using heroin in the 90 days preceding data collection, from 81% at intake to 48% at one year. There were large reductions in the proportions of participants who reported use of non-prescribed methadone, cocaine powder, crack cocaine and non-prescribed benzodiazepines at one year compared to the baseline interview. The proportion of participants reporting use of more than one drug decreased from 78% at intake to 50% one year later. The proportion of participants who reported injecting drug use in the 90 days preceding data collection decreased from 46% at intake to 29% at one year. The proportion of participants reporting involvement in acquisitive crime decreased from 31% at intake to 14% at one year.
- According to data from the General Mortality Register, the number of drug-related deaths in 2003 increased marginally (to 96) compared to 2001 (93) and 2002 (90). Between 2001 and 2003, 60% of direct drug-related deaths were opiate-related. Between 2000 and 2003, there was a sharp decline in direct drug-related deaths in Dublin, from 83 in 2000 to 46 in 2003. During this period there was a continued increase in drug-related deaths outside Dublin, from 30 in 2000 to 50 in 2003. In 2003, the number of drug-related deaths outside Dublin exceeded for the first time the number of drug-related deaths in Dublin.
- On 26 September 2005, the National Drug-Related Deaths Index was launched. The Index was established to address Action 67 of the National Drugs Strategy, which identifies the need to develop an accurate mechanism for recording the number of drug-related deaths in Ireland. The Index will be compiled from a number of data sources, including the coroner service, the Hospital Inpatient Enquiry Scheme, the Central Treatment List and the General Mortality Register.
- In 2005, 66 newly diagnosed cases of HIV among injecting drug users were reported to the Health Protection Surveillance Centre. This is a marginal decrease on the 2004 figure. Of these 66 cases, 37 were male and 29 were female and the average age was 30.5 years. Of the 60 cases for whom place of residence was known, 55 lived in the HSE Eastern Region. According to data from prevalence studies, around one-tenth of injecting drug users in drug treatment are HIV positive. Older age and high-risk injecting and sexual practices are associated with testing positive for HIV. The increase in cases of HIV infection over the last five years requires investigation.
- The results of prevalence studies indicate that just under one-fifth of injecting drug users in treatment have ever been infected with hepatitis B, and that approximately 2% are chronic cases. Older age and high-risk injecting and sexual practices are linked to a positive hepatitis B status.
- Approximately 70% of opiate users have tested positive for hepatitis C in Dublin. The rate of spontaneous viral clearance for this infection was higher than previously reported. There are a number of barriers to hepatitis C treatment for injecting drug users which need to be addressed so as to encourage uptake of treatment.
- The first systematic and representative survey of mental health among the Irish prison population, using standardised research diagnostic methods, was implemented in 2003. According to the authors, between 61% and 74% of prisoners had a substance use disorder at the time of the survey, with little difference between the proportions of men and women affected. Between 12% and 23% of men had a mental illness (excluding a substance use disorder).
- On 9 August 2005, the minister of state at the Department of Health and Children introduced a new Statutory Instrument, Medical Products (Prescription and Control of Supply) (Amendment) Regulations 2005. These regulations permit the supply of a number of medicinal products (including naloxone) for the management of respiratory depression secondary to a known or suspected narcotic overdose) to pre-hospital emergency care providers.

- Branagan and Grogan (2006) reported the results of an evaluation of a health promotion programme to educate drug users on how to prevent and how to deal with an overdose. In total, 200 questionnaires were distributed; 194 (97%) were completed. Of the 194 respondents, 81% had read the poster and 78% recalled a useful message from the poster. The message most commonly reported as useful stressed the importance of placing a person in the recovery position and explained how it should be done. Over 70% reported that they changed the way they thought about or dealt with an overdose.
- HIV treatment is available to injecting drug users through genito-urinary medical units and infectious disease clinics in Ireland.
- The uptake and completion rates of hepatitis B vaccination are much higher in the HSE South Western Area (56%) and in Drug Treatment Centre Board cohorts (86%) for the period 2001 to 2003 than those reported in prisoners or at general practice in Ireland between 1998 and 2001. This possibly indicates an increase in hepatitis B vaccine coverage in recent years. There are no published data on the coverage of hepatitis B vaccine among injecting drug users outside the HSE Eastern Region.
- There are seven specialist hepatology centres for adults and one for children in Ireland. A number of studies demonstrated low rates of access to and uptake of treatment for hepatitis C among injecting drug users. Two small studies demonstrated that a decentralised approach to initial assessment at general practice level and hepatitis C treatment at drug treatment centres achieved higher uptake and compliance rates than the current centralised approach.
- An exploration by Corr (2004) reported that drug users from new communities in Ireland were generally unaware of drug service provision, and were doubtful about the confidentiality of information held by such services. The report recommended that information material produced for these communities highlight the range of services provided in Ireland and their confidential nature. Merchants Quay Ireland (MQI), the largest voluntary-sector provider of homeless and drugs services in Ireland, has taken the lead in this regard and recently produced information leaflets in English, Polish and Russian detailing service provision at MQI.
- Drug use and labour market vulnerability has been highlighted in a report published by a key Government advisory body.
- Evaluation of vocational training reveals the need for greater involvement of service users in designing treatment and reintegration plans.
- Review of national homelessness strategies highlights the continuing challenge for service providers in meeting the needs of homeless drug users.
- The majority of drug offence prosecutions are for drug possession; the number of such prosecutions increased from 5,065 in 2004 to 7,432 in 2005, a rise of 46.7%.
- Cannabis-related prosecutions have consistently formed the majority of all drug offences prosecuted. In 2005, such prosecutions accounted for just less than 65% of all drug offence prosecutions.
- In 2005, heroin-related prosecutions accounted for 10.65% of the total number of prosecutions in Ireland. Cocaine-related prosecutions accounted for 12.76% of the total, exceeding heroin-related prosecutions for the first time. Ecstasy-related prosecutions have declined steadily since 2000, decreasing from 2,086 prosecutions to 787 in 2005.
- *Drugs and crime in Ireland*, the third title in the Drug Misuse Research Division's Overview series, was published in May 2006. The purpose of this Overview was to compile and analyse existing data and available research on drug offences and drug-related crime, to identify gaps in knowledge and to inform future research needs in this important area of drug policy.
- In line with Action 12 of the National Drugs Strategy 2001–2008, which commits the Garda Síochána to extending police drug interdiction measures to urban areas throughout Ireland, 'Operation

Cleanstreet', which targets and apprehends drug dealers at street level, was increasingly used in communities outside Dublin.

- In 2005 there was an increase in cannabis-related prosecutions in all Garda regions, with those in the Dublin Metropolitan Region increasing by just less than 71% and those in the Eastern Region increasing by 78.5%.
- Despite slight increases in the southern and northern regions, ecstasy-related prosecutions have continued on a downward trend since the beginning of the decade. The Garda National Drugs Unit believes that one possible reason for this is a displacement of ecstasy use by cocaine use.
- In 2005, of the 6,046 reported drug seizures, 3,417 (56.5%) were cannabis-related.
- Customs Drugs Law Enforcement (CDLE) reports on a number of other drugs which have come to its attention during the reporting year. It reports the first ever seizure of *Dimethyltryptamine (DMT)*, which was sourced in Brazil and transported by post. Customs also reports continuing trends in seizures of *khat* and steroids.
- The Irish Human Rights Commission, in response to provisions contained in the Criminal Justice Act 2006 recommends that an objective expert witness should be called to give his or her opinion on the valuation of drugs before a court.
- As part of the Irish Focal Point's Overview series, *The illicit drug market in Ireland, Overview 2* was published in 2005. The purpose of this Overview was to compile and analyse existing data and available research, to identify gaps in knowledge and to inform future research needs in this important area of drug policy.

Part A: New Developments and Trends

1. National policies and context

1.1 Overview

This chapter provides an overview of new developments in the legal and policy areas in 2005 and the first half of 2006. Changes in national legislation and amendments to policies or laws brought about as a result of international agreements or obligations are reported. This section also considers any relevant developments in the implementation of such laws.

1.2 Legal framework

The Minister for Justice, Equality and Law Reform, Mr Michael McDowell TD, announced the publication of new draft prison rules in June 2005 (Department of Justice Equality and Law Reform 2005). The rules deal with all aspects of prison life, including accommodation, visiting rights, discipline, health and education. The existing prison rules date back to 1947. The new rules make provision for the introduction of compulsory or mandatory drug testing (MDT) of prisoners, a commitment in the *Agreed Programme for Government between Fianna Fáil and the Progressive Democrats* (Fianna Fail and the Progressive Democrats 2002).

Section 28 (5) (a) of *Prison Rules 2005* states: 'In the interest of good order, safety, health and security and in accordance with directions set down by the minister, a prisoner ... shall, for the purpose of detecting the presence or use of an intoxicating liquor or any controlled drug ... provide all or any of the following samples, namely – urine, saliva, oral buccal transudate, hair.' This provision comes at a time of increased debate as to the merits of MDT. The Irish Penal Reform Trust (IPRT) has consistently opposed the introduction of MDT. Speaking to *Drugnet Ireland*, Rick Lines, executive director of the IPRT, said: 'such testing increases heroin use among prisoners, increases injecting and the risk of HIV and hepatitis C transmission through shared syringes, reduces the uptake of voluntary drug treatment by prisoners, and wastes money that could be better spent on more effective drug programmes' (Connolly 2005b).

On 1 January 2006 the Railway Safety Commission was established under the Railway Safety Act 2005 (Statutory Instrument No. 841 of 2005). The Commission regulates railway safety in Ireland, and has wide-ranging powers to monitor and inspect railway infrastructure and to take enforcement action where necessary. Provisions in the Act relating to the testing of safety-critical workers for the presence of 'intoxicants', which include alcohol and drugs and any combination of drugs or of drugs and alcohol (Parts 9 and 10), give the Commission power to approve the codes of conduct, sampling procedures and support services which railway undertakings are required to put in place. The Commission is also required to report annually on the implementation by railway undertakings of the measures provided for in Parts 9 and 10 of the Act.

The government, in the exercise of powers conferred on it by Section 2(2) of the Misuse of Drugs Act 1977, has ordered that, as of 31 January 2006, 'any substance, product or preparation (whether natural or not), including a fungus of any kind or description, which contains psilocin or an ester of psilocin is a controlled drug for the purposes of the Act' (Misuse of Drugs Act 1977 (Controlled Drugs) (Declaration) Order 2006). The effect of this order is to render the possession or sale of so-called 'magic' mushrooms criminal offences under the Act. Heretofore, it was illegal to possess or supply magic mushrooms in a dried or prepared state, but lawful to possess and sell them in their natural state. Following the change in the law in January, it was reported that a number of outlets which were selling magic mushrooms have removed them from their stores and shelves. Also, Statutory Instrument 55/06 prohibits the importation of magic mushrooms, specifically those containing psilocybin).

It was reported on 5 May 2006 that Judge Briget Reilly (who sits on the bench of the Drug Treatment Court) said that plans are at an advanced stage for the court to be made available for referrals from all courts in the Dublin metropolitan area (O'Brien 2006).

On 10 February 2006 the *Report of the Garda Síochána Act 2005 Implementation Review Group* (2006) was released. The Review Group, established by the Minister for Justice, Equality and Law Reform, reported that guidelines for joint policing committees had been drafted early in the year. It recommended that there should be up to 12 pilot schemes in a variety of settings before the system is rolled out nationwide in about a year's time. These pilots should be in place before the start of summer 2006 (see Section 9.3).

The Irish Medicines Board (Miscellaneous Provisions) Act 2006, which provides for a number of amendments to the Misuse of Drugs Act 1977 (see National Report 2005), passed into law in March 2006. The Act provides, *inter alia*, legislative authority to authorised officers of the Irish Medicines Board and officers of Customs and Excise to further enhance their powers in dealing with illicit and counterfeit medicines on import and export.

On 1 June 2006 in Dáil Éireann the Tánaiste and Minister for Health and Children, Mary Harney TD, outlined the training provisions for emergency medical technicians trained to paramedical grade:

As part of the reform of the health service a National Ambulance Office has been established under the auspices of the National Hospitals Office within the HSE. The Office has responsibility for the provision of pre-hospital emergency care nationally.

The most significant development in the sector for many years is the roll-out of the Advanced Paramedic Training Programme. The introduction of the programme required two legislative changes which were completed in August 2005. The National Ambulance Training School (NATS), which operates under the auspices of the HSE, in conjunction with University College Dublin, is providing training for Advanced Paramedic candidates. The NATS graduated 29 Advanced Paramedics in 2005 and proposes to train a further 48 in the current year.

A Group Authority Licence was required for the administration of three controlled drugs – morphine, lorazepam and diazepam – by Advanced Paramedics. This Licence was issued by the Irish Medicines Board on the 5th May 2006. Completion of the training programme allows ambulance personnel to administer an additional 19 medications. This includes, for example, cardiac medications, which they could not administer previously.

The HSE has advised that, to ensure that a quality assured service can be rolled out, policies, protocols and structures are required to be in place around the issue of medicines management, including clinical oversight and security. The HSE has advised that it is finalising the operational policies and supporting infrastructure to allow for the rollout of the operational component of the service. This includes the development of policies in relation to medicines management and the management of controlled drugs carried by Advanced Paramedics working alone. These operational policies are undergoing final risk assessment at present. The HSE is also developing requisition and record management systems which are required to meet the demands of the regulatory bodies in this area. A clinical advisory group has been established in each area of operation around the country to provide a clinical oversight of the process.

The HSE ambulance service expects to be in a position to deploy Advanced Paramedics in an operational capacity from the end of this month. (Harney 2006)

The Criminal Justice Act 2006 was signed into law by the President on 16 July 2006. The new Act includes:

- provisions for creating criminal offences in relation to participation in criminal organisations
- proposals to strengthen the provisions on the imposition of the 10-year mandatory minimum sentence for drug trafficking
- new offences of supplying drugs to prisoners
- provisions in relation to a drug offenders register
- provisions to deal with anti-social behaviour, such as anti-social behaviour orders.

On 1 August 2006, Michael McDowell TD, Minister for Justice, Equality and Law Reform, signed an order bringing into operation a number of provisions contained in the Act, including those to address a difficulty in relation to the jurisdiction of district court judges to issue a search warrant when they are outside their district. This difficulty arose as a consequence of the judgement by the Supreme Court in the case of *Creaven & Ors v. Criminal Assets Bureau & Ors* [2004] IESC 92 (see National Report 2005). With regard to organised crime and drugs, the Act provides a new definition of 'criminal organisation' as a structured group composed of three or more persons acting in concert, established over a period of time and having as its main activity the commission of or facilitation of a serious offence. The Act contains new offences relating to participation in or assisting the activities of organised gangs.

The Irish Human Rights Commission (IHRC) has raised a number of concerns about some of the provisions of the Criminal Justice Act 2006. In relation to proposals contained in Part II, which mainly seek to add additional grounds to the mandatory sentencing guidelines for persons convicted in possession of drugs valued at €13,000 or more (Criminal Justice Act 1999), the IHRC states that it is concerned 'that the proposals in relation to the 10 year mandatory sentence may undermine the discretion of the judiciary to

ensure that the sentence imposed is in line with the principle of proportionality, and to ensure that a fair balance is struck between the particular circumstances of the commission of the offence and the relevant circumstances of the person sentenced' (IHRC 2006: p. 17). With regard to the determination of the market value of the drugs, the IHRC recommends that an objective expert witness be called to give an opinion on the valuation of drugs before the court. The IHRC is also of the view that the €13000 valuation for drug trafficking offences should be reviewed in light of inflation and the current reality of the cost of drugs. The Act amends the law so that it will not be necessary for the prosecution to prove that a person charged with an offence relating to the possession of drugs under Section 15A of the Misuse of Drugs Act 1977, knew or that the value of the drugs in his or her possession was €13,000 or more, 'or was reckless in that regard'. In relation to this provision, 'the IHRC is of the view that the removal of the element of knowledge or intention on the part of the accused person may raise questions around the foreseeability of criminal liability. The IHRC (p. 17) recommends that the prosecution should be required to prove that the accused has reasonable grounds to believe that the drugs in his or her possession were worth €13,000 (or whatever the limit may be) or more.'

The IHRC has also raised concerns about the proposal in the Act to establish a register of drug offenders, modelled on the sex offenders register provided for in the Sex Offenders Act 2001. It states that 'it is not apparent...how a drug offenders register will be an effective, necessary or proportionate response' to the need to prevent drug trafficking, and it has requested further information from the Minister on the purpose of the proposed register (IHRC 2006: p. 21).

The Customs Drugs Law Enforcement office of the Revenue Commissioners has been nominated as the designated national authority to receive, answer and make requests under Article 17(1) of the United Nations Convention against illicit traffic in narcotic drugs and psychotropic substances 1988 (CDLE, personal communication, 2006). The EU has laid down rules for the monitoring of trade in precursors within the Community and between the Community and third countries (Council Regulation (EC) No. 111/2005), and for the implementation of measures whereby the movement of chemicals used in legitimate industry, but which could also constitute precursors for the manufacture of illegal drugs, is subject to control by customs (Commission Regulation (EC) No. 1277/2005).

1.3 Institutional framework, strategies and policies

The Structured Questionnaire on Policy and Institutional Frameworks outlines the current approach in Ireland in relation to national drug policies and strategies, and co-ordination arrangements. Highlights of the last 12 months are recorded below.

Co-ordination arrangements

With over 20 statutory agencies involved in delivering the National Drugs Strategy, as well as multiple service providers and community and voluntary groups, a hierarchy of 'inter-agency mechanisms' is in place to co-ordinate policy and activities in pursuit of the strategic objectives, as summarised below.

Level	Inter-agency co-ordinating mechanism
National	Cabinet Committee on Social Inclusion Inter-Departmental Group on Drugs (IDG) National Drugs Strategy Team (NDST)
Regional	Regional drugs task forces (RDTFs)
Local	Local drugs task forces (LDTFs)

A dedicated institutional framework – the National Drugs Strategy Unit in the Department of Community, Rural and Gaeltacht Affairs (DCRGA) – co-ordinates the overall implementation of the National Drugs Strategy and interacts closely with all the statutory and non-statutory agencies involved in delivering the Strategy. Adjustments were made to this framework as a result of the mid-term review of the National Drugs Strategy, published in 2005, and they were reported on in the 2005 National Report.

National plan and/or strategies

The National Drugs Strategy 2001–2008 (Department of Tourism, Sport and Recreation 2001) continues to provide the framework for Ireland's national policy on illicit drugs. One supplementary initiative has been undertaken in the last 12 months.

In September 2006 a new social partnership agreement, *Towards 2016: Ten year framework social partnership agreement 2006–2015* (Department of An Taoiseach 2006), was agreed between the government and the social partners, including trade unions, employers, farming organisations and the community and voluntary sector. In Chapter III, the Agreement adopts a 'lifecycle framework', which places the individual at the centre of policy development and delivery, by assessing the risks facing him/her, and the supports available to him/her to address those risks, at key stages in his/her life. This means a focus on the needs of children, young adults, people of working age, older people and people with disabilities. Drug and alcohol misuse is addressed in relation to children, and people of working age.

In relation to children, among the actions under the heading 'Improving health outcomes for children', the government and social partners have prioritised, among other things, 'monitoring prevalence trends of smoking and substance use through the National Health and Lifestyle Surveys and the European School Survey Project on Alcohol and other Drugs (ESPAD)' (Department of An Taoiseach 2006: p. 45). To provide an opportunity for learning about new, more integrated ways of designing and delivering services for disadvantaged children, the parties have also committed to an initiative to test models of best practice which promote integrated, locally-led, strategic planning for children's services. The aim is to avert children from succumbing to the risks associated with disadvantage as well as giving them the resilience to overcome those risks. As such, the initiative will focus on children who are at risk of suffering from multiple disadvantage relating to poverty and social exclusion, and to children in vulnerable families who may be exposed to substance abuse (Department of An Taoiseach 2006: p. 47). (For further information on this initiative, see Selected Issue on Drug Misuse among Very Young Children.)

The government and the social partners share the view that young adults (aged 18–19 years) have particular health-related needs in the areas of substance misuse, alcohol misuse, and suicide. The parties have agreed to re-commit to the implementation of the National Drugs Strategy 2001–2008 and to endorse in particular the recommendations made by the mid-term review (Steering group for the mid-term review of the National Drugs Strategy 2005) to establish a working group to develop an integrated fifth 'Rehabilitation' pillar, and to explore 'the potential for better co-ordination between the areas of drugs and alcohol with the aim of improving synergies'. The parties have also committed to 'ensuring a greater focus on reducing alcohol related harm including implementation of the recommendations of the Working Group on Alcohol, established under Sustaining Progress, taking account of the recommendations of the Strategic Task Force on Alcohol' (Department of An Taoiseach 2006: p. 56)

Drug testing is referred to in Chapter VII of *Towards 2016*, under Employment Rights and Compliance. The parties have agreed on the need for the improved regulation of employment agencies and agency workers. A proposed statutory Code of Practice for employment agencies will require them to, among other things, not disclose to third parties the results of any drug or medical testing on job seekers.

Implementation of policies and strategies

At national level, in the last year progress has continued in implementing and completing actions identified in the National Drugs Strategy 2001–2008, and also the recommendations contained in the mid-term review. Details of these actions, which address aspects of supply reduction, prevention, treatment, research and rehabilitation, are described in other chapters of this report.

Noteworthy within the context of 'institutional frameworks, strategies and policies', is progress in relation to Actions 92–94 of the National Drugs Strategy 2001–2008, which call for the establishment of regional drugs task forces (RDTFs) in the former health board regions (see Structured Questionnaire 32: policy and institutional frameworks, for an overview of RDTFs).

By May 2006 the Minister of State with responsibility for drugs strategy, Noel Ahern TD, reported that the RDTFs would be fully established and operational by the end of 2006. All the task forces had been established; full-time co-ordinators for each task force were due to be appointed and in place by mid 2006; and funding had been made available to fund both support workers and the projects. The Minister stated that he expected the rate of progress made by the RDTFs to accelerate in the latter part of 2006. He also said he was satisfied that activities and initiatives contained in the RDTF action plans 'will represent a comprehensive response to the problems of drugs misuse in the various regions' (Ahern 2006b).

A notable feature of the RDTF action plans is the integration of responses to both drugs and alcohol problem use within the one framework (North Eastern Regional Drugs Task Force 2004; Northwest Regional Drugs Task Force 2005; Southern Regional Drugs Task Force 2005; Walsh and Comer 2005)

Impact of policies and strategies

No new information is available.

1.4 Budget and public expenditure

– in law enforcement, social and health care, research, international actions, co-ordination and national strategies

No comprehensive account of public expenditure on the drugs issue in Ireland has been published since the figures provided in the National Drugs Strategy 2001–2008 (see Section 1.4 of Ireland's 2001 National Report to the EMCDDA for an account of these figures).

However, information on public expenditure in 2006 in respect of community-based measures funded through the Department of Community, Rural and Gaeltacht Affairs (DRCGA) – the Drugs Initiative – is available. Also, a rough estimate of total public expenditure on the drugs issue in 2006 was provided in Dáil Éireann (the Irish Parliament) in the course of the year.

In 2006 €43.006 million was voted for the Drugs Initiative, a 15% increase over the 2005 Vote for the Drugs Initiative, which was €31.5 million (Department of Finance 2006). The Drugs Initiative includes funding for the local and regional drugs task forces, the Young People's Facilities and Services Fund (YPFSF), the Premises Initiative, and the Emerging Needs Fund. (For descriptions of these funding mechanisms, see under 'Funding arrangements' below.)

In May 2006, in Dáil Éireann (the Irish Parliament), the Minister of State with responsibility for drugs strategy, Noel Ahern TD, estimated that the overall 2006 drugs budget stood at around €200 million:

Approximately €25 million has been mainstreamed out of my Vote to other Votes, so we are spending about €70 million [including the €43 million voted for the Drugs Initiative in 2006] on projects that began at community level. The Health Service Executive spends more than that each year, not to mind the expenditure undertaken by the Department of Education and Science and the Garda Síochána. A sum of €200 million per year is being spent in the fight against drugs. It is not all being spent on treatment or supply reduction. We are also spending a great deal on prevention and young people's facilities. (Ahern 2006f)

With regard to Garda Síochána expenditure on drug law enforcement, the Garda National Drugs Unit reports that it was not possible to accurately disaggregate the proportion of the annual Garda budget, which was in excess of €1.2 billion, that was allocated to drug law enforcement (GNDU, personal communication, August 2006). Customs reports a total of €9.24 million spent in 2005 on drug law enforcement (CDLE, personal communication, September 2006).

Funding arrangements

Two major planning instruments underpin the annual decisions on public expenditure on the drugs issue – the National Drugs Strategy 2001–2008 and the National Development Plan (NDP) 2000–2006.

Although the National Drugs Strategy 2001–2008 (Department of Tourism Sport and Recreation 2001) does not provide specific guidance in respect of funding levels or allocations across the four pillars, it does provide a framework of aims, objectives, key performance indicators (KPIs) and actions, which guides the allocation of funds to government departments and state agencies via the annual Estimates process.

Annual funding decisions in respect of drugs are also made with reference to sub-programmes contained in the *Ireland National Development Plan 2000–2006* (Irish Government 1999). The NDP is an investment plan for some €57 billion of public, private and EU funds in numerous projects and initiatives throughout Ireland between 2000 and 2006.

- *Economic and Social Infrastructure Operational Programme:* The Health Capital Sub-Programme in the NDP focuses on expenditure on the health services infrastructure, on the assumption that 'improving the health of the population enhances individual and social capital and thus supports economic and human development both at local and community level and for the country as a whole' (p. 71). Some €1,775

million was allocated to the South and Eastern (S&E) Region, where 'there will be a particular focus on addressing problems arising in the larger centres of population – in particular, health and personal social service needs related to higher concentrations of problems such as drug (particularly heroin) use, homelessness, family breakdown and child abuse/neglect'.

- *Employment and Human Resources Development Operational Programme:* The NDP recognises that educational disadvantage can become ingrained at a very young age and can result in early school-leaving and ultimately unemployment and long-term social marginalisation and its knock-on effects in terms of homelessness, substance abuse and crime. For this reason, the provision of comprehensive and diverse education and training facilities, which would cater for the needs of specific groups in society from early childhood through to adulthood, particularly those experiencing social disadvantage, is a priority of the NDP.
- *Social Inclusion Sub-Programme:* Some €19 billion was allocated to the Social Inclusion Sub-Programme, including six measures, three of which – Youth Services, Crime Prevention, and Community Development and Family Support – include drug-related sub-measures worth some €580.5 million over the 2000–2006 period. The Social Inclusion Sub-Programme is rolled out via the two Regional Operational programmes – the South and East (S&E) Regional Programme and the Border Midlands and West (BMW) Regional Programme.

According to the NDP, in many of the S&E Region's disadvantaged urban areas, less than 10% of the households derived their income from employment. Moreover, these areas were affected by long-term unemployment, poor education, skills deficits, one-parent families, drug addiction and homelessness. The communities in which the disadvantaged resided tended to be ghettoised and affected by low levels of self-esteem, early school-leaving and youth unemployment, poor family support, lack of community support and infrastructure and high levels of crime. Significant heroin abuse, with its very serious public health implications and close associations with crime, was confined mainly to the most disadvantaged areas in the Dublin region. The Social Inclusion Sub-Programme in the S&E Region focuses mainly on alleviating social exclusion in these areas.

While rural poverty was seen as a key concern for the BMW Region, the NDP also recognises areas of deprivation in the larger urban centres and towns, where people are seen to suffer from the same problems as those living in disadvantaged city-centre areas within the S&E Region, in that they are more likely to suffer from low levels of self-esteem, early school-leaving/youth unemployment, poor family support, substance abuse and high levels of crime.

Within the parameters established by the National Drugs Strategy 2001–2008 and the National Development Plan 2000–2006, public funds are assigned to drug-related initiatives via the annual parliamentary Estimates process. Funding is allocated for drug-related activities under a number of Votes, including:

- Justice, Equality and Law Reform
 - An Garda Síochána
 - Courts
 - Prison Service
- Health and Children
 - Health Service Executive
- Education and Science
- Enterprise, Trade and Employment (FÁS)
- Revenue Commissioners (Customs)

The Estimates do not specify the amounts allocated for expenditure by government departments and state agencies on the drugs issue under these various Votes. The exception is the Drugs Initiative, under Vote Community, Rural and Gaeltacht Affairs.

The Drugs Initiative comprises a series of funding mechanisms which (1) develop community-based drug-related projects that add value to the programmes and services already being planned or delivered by statutory agencies, and (2) help develop the necessary community-level infrastructure such as buildings, facilities and services. 'Mainstreaming' is a key characteristic of this funding approach. Community-based service projects funded under the drugs task forces are piloted for at least one year, during which time they are on 'initial funding'. After 12 months, projects are placed on 'interim funding' until they are evaluated. If the evaluation finds that the project is working successfully, the funding is transferred to the relevant Department or agency on an ongoing basis, with agreed procedures. To date, projects to the tune of €25 million have been mainstreamed.

In recent years, in response to the evidence of spreading drug supply and problem drug use activities across the country, funding under the Drugs Initiative has been expanded to apply across the whole country: a new funding mechanism, the regional drugs task forces, has been developed to ensure comprehensive nationwide coverage, and the scope of existing mechanisms such as the Young People's Facilities and Services Fund (YPSF) and the Premises Initiative has been extended beyond the local drugs task force areas.

Specific details of the various funding mechanisms under the Drugs Initiative are as follows:

- *Local drugs task forces (LDTFs)*: Established in 13 areas in Dublin and Cork in 1997, with a 14th established in 2000 in Bray, LDTFs are now implementing their second round of Action Plans at an annual cost in excess of €16 million. Since 1997, nearly €125 million has been allocated to the 14 LDTF areas. Over 400 community-based projects have been established, employing more than 300 staff. These projects deliver services such as community drug treatment programmes as well as advice and support for drug misusers and their families, outreach services and crisis intervention services and drug training programmes for community groups. (Ahern 2006c)
- *Young People's Facilities and Services Fund (YPSF)*: Established in 1998, the YPSF assists in the development of youth facilities and services in disadvantaged areas where a significant drug problem exists or has the potential to develop. Approximately €102 million has been allocated to date. Recent allocations under the YPSF, providing funds for service projects in Limerick, Waterford, Galway and Carlow, reflect the move from a focus on LDTF areas towards a countrywide focus (Ahern 2006f; Ahern 2006e).
- *Premises Initiative*: Launched in 2000, the Premises Initiative is designed to meet the accommodation needs of community-based drugs projects, the majority of which are in LDTF areas. Approximately €13.66 million has been allocated to 60 capital projects under the Premises Initiative. The Initiative has now been extended to include RDTF areas (Ahern 2006e).
- *Regional drugs task forces (RDTFs)*: The establishment of ten RDTFs, in areas not covered by LDTFs, was called for in the National Drugs Strategy 2001–2008. Ten RDTFs have been established. The overall role of the RDTFs is to prepare and implement regional actions plans which identify existing and emerging gaps in services in relation to education and prevention, curbing supply, treatment and rehabilitation. A sum of €5 million has been allocated to the ten RDTFs towards the implementation of their plans for 2006. Funding will be increased on an incremental basis over the coming years to achieve the full roll-out of the action plans, which are estimated to have a full cost in the region of €12.2 million per annum (Ahern 2006d).
- *Emerging Needs Fund*: Set up in 2005, the Emerging Needs Fund facilitates a flexible and timely response to evolving needs in regard to drug misuse in LDTF areas. To date, a total of 54 projects have been approved for funding of over €3.1 million (Ahern 2006a).

A range of other public funding mechanisms and grant programmes, in areas such as community development, local development, anti-poverty, or sports funding, may have an impact on the drugs issue. However, they are too diffuse to cover here, other than to note two funding mechanisms, RAPID and Dormant Accounts, which specifically refer to the drugs issue:

- *RAPID (Revitalising Areas by Planning Investment and Development)*²: The RAPID Programme is a government initiative, which targets 45 of the most disadvantaged areas in the country. The programme aims to ensure that priority attention is given to the 45 designated areas by focusing state resources available under the National Development Plan. The programme also requires the government departments and state agencies to bring about better co-ordination and closer integration in the delivery of services.

An Area Implementation Team (AIT) was established in each of the 45 areas to develop a plan for their area. The AIT brings local state agency personnel (health board, local authority, VEC, Dept of Social & Family Affairs, FÁS, etc), the local partnership company, residents of the local community and, where they exist, LDTFs or RDTFs, together to prepare a plan identifying the needs of each area.

- *Dormant Accounts*³: The Dormant Accounts Acts 2001 and 2005 provide for the transfer of unclaimed monies in dormant funds and unclaimed policies in credit institutions and insurance undertakings to the Dormant Accounts Fund, which is managed by the National Treasury Management Agency (NTMA), with a proviso that the account- or policyholder has a guaranteed right of reclaim at any time in the future.

² See www.pobail.ie/en/RAPIDandCLR/ for further information on RAPID.

³ See www.pobail.ie/en/DormantAccounts/ for further information on Dormant Accounts.

The Dormant Accounts legislation provides for a scheme for the disbursement of funds that are unlikely to be reclaimed, for the purpose of assisting the following categories of persons: those affected by economic or social disadvantage; those affected by educational disadvantage; and persons with a disability.

The Board's first disbursement plan, for 2003–2005, stated that at least 40% of total annual funding would be allocated to the area of economic and social disadvantage, including funding for drugs task forces (see National Report 2004, pp. 13–14). In the second round of planning, announced in January 2006, local drugs task forces are no longer specifically included. Funding under the heading of economic and social disadvantage is now focused on the RAPID Programme, and on support for priority themes, including youth, older people, suicide prevention, alcohol misuse, immigrant families, and offenders and ex-offenders.

1.5 Social and cultural context

Public opinions of drug issues

On 22 March 2006 the Minister for Justice, Equality and Law Reform published the preliminary results of commissioned research into the public's attitude to crime and law enforcement issues in Ireland (TNS mrbi 2006). In response to a question regarding the level of perceived seriousness of crime types, 'drug abuse' was almost universally seen as the most serious problem (68%), followed by violent crime (57%), juvenile/teenage crime (50%), disorderly conduct in public (43%), burglary (42%), car crime (40%) and graffiti (16%). Of those regarding drug abuse as a 'very serious problem', 77% were aged 45–54 years.

The research was carried out on TNS mrbi's omnibus service, PhoneBus. PhoneBus accessed a nationally representative sample of 1,009 adults aged over 14 years. The telephone numbers used were randomly generated by computer so that both listed and ex-directory numbers were called. Quotas (age, sex, social class and region) were applied to ensure that the final sample was representative of the entire adult population aged over 14 years with fixed line telephones in the Republic of Ireland. Fieldwork was carried out between 7 and 16 March 2006.

Attitudes to drugs and drug users

In October 2005 the results of the 2002/2003 Drug Prevalence Survey conducted in Ireland and Northern Ireland in respect of cannabis were published (NACD and DAIRU 2005a).⁴ This report included results relating to attitudes to cannabis use. The reported results for Ireland are reproduced here.

'All those surveyed who had heard of cannabis were asked about their attitudes regarding cannabis use. The attitudes of this group were then compared with the attitudes of two mutually exclusive groups – those who said that they had used cannabis at some stage in their lives and those who said that they had never used cannabis. In general, those who had ever used cannabis had more liberal views to the use of cannabis for both medical and recreational use and they felt that there was less risk to those who smoked cannabis on a regular basis.' (p. 6)

'A large majority (72%) of those surveyed felt that cannabis use should be permitted for medical reasons. Almost all (91%) of those who had ever used cannabis compared to seven in ten (69%) of those who had never used cannabis, felt that cannabis use should be permitted for medical reasons. For both groups, males (93% and 72% respectively) were more likely to agree than females (89% and 66% respectively) and older respondents (96% and 70% respectively) were more likely to agree than younger respondents (89% and 67% respectively).' (p. 6)

'In contrast, only 21% of respondents agreed that cannabis use should be permitted for recreational purposes. Thirteen per cent of those who had never used cannabis agreed that recreational use should be

⁴ The questionnaire and methodology for this survey were based on best practice guidelines drawn up by the EMCDDA. The questionnaires were administered through face-to-face interviews with respondents aged between 15 and 64 years and who are normally resident in households in Ireland and Northern Ireland. Thus, persons outside these age ranges, or who do not normally live in private households, have not been included in the survey. This approach is commonly used throughout the EU and because of the exclusion of those living in institutions (for example prisons, nursing homes etc.) this type of prevalence survey is usually known as a **general population survey**. Fieldwork for the survey was carried out between October 2002 and April 2003 and the final achieved sample comprised 8,434 respondents (4,918 in Ireland and 3,516 in Northern Ireland). The response rate for the survey was 70% in Ireland and 63% in Northern Ireland. The sample was weighted by gender, age, Health Board in Ireland and Health and Social Services Board area in Northern Ireland, to maximise its representativeness of the general population. Details of the methodology have been summarised in a paper published on the websites of the NACD (<http://www.nacd.ie/>) and a comprehensive technical report containing copies of the questionnaires used in both jurisdictions has been published separately.

permitted, compared to 61% of those who had ever used the drug. For both groups, males (15% and 66% respectively) were more likely to agree to its recreational use than females (11% and 53% respectively). Respondents were also asked to rate their level of disapproval to the occasional use of cannabis – over three quarters (79%) of respondents who had never used cannabis compared to less than a quarter (23%) of those who had ever used cannabis, disapproved of people smoking cannabis occasionally. For both groups, females (80% and 29% respectively) were more likely to disapprove than males (77% and 20% respectively).’ (p. 7)

Initiatives in parliament and civil society

During the past 12 months, three key policy debates have been initiated and debated in Parliament and/or civil society:

- the manner and means of implementing the National Drugs Strategy 2001–2008, and in particular the partnership approach;
- the question of combining illicit drugs and alcohol in one strategy; and
- the ‘war on drugs’ and whether it needs rethinking.

The manner and means of implementing the National Drugs Strategy has been a topic of considerable debate in the last year (Galvin 2005) (Pike 2006b). In October 2005 a conference was organised by the Local Drugs Task Force Chairs and Co-ordinators Network to, among other things, ‘revitalise LDTFs after nearly ten years in operation, ... and highlight how vital it is that the Government makes the drug problem a central issue over the next few years’ (Bennett 2006). The Conference issued a declaration:

- acknowledging the ‘huge amount of progress’ made by the LDTFs;
- calling on the government, relevant ministers and their departments ‘to re-engage fully with the drug task forces’;
- proposing that each LDTF be mandated to produce a new strategic action plan for the remaining period of the National Drugs Strategy to 2008; and
- calling on the government to increase and target resources to the cities and towns across the country experiencing emerging problems of drug misuse by establishing additional LDTFs.

Following the introduction of the 2006 budget in November 2005, and disappointment at the level of funding allocated to community-based projects, the community representative on the National Drugs Strategy Team resigned, and a campaign of protest ensued.⁵ Early in 2006, the government increased the 2006 budget for the Drugs Initiative by some 26%, but other concerns regarding the implementation of the National Drugs Strategy continued to be raised, in both the community and political sectors.

- Lack of political interest in the drugs issue is one concern. It is argued that making the Minister of State with responsibility for drugs also responsible for housing and urban renewal has weakened his commitment to and energy for addressing the drugs issue. There is continuing call for a minister to be assigned responsibility solely for the illicit drugs issue.
- Dissatisfaction with the way the partnership between government and the community and voluntary sectors in tackling the drugs issue has been operating is a further concern. There are demands for the reinstatement of the agreed government process to support the work of the LDTFs, the evaluation and mainstreaming of successful LDTF initiatives and projects, and a mandate for the LDTFs to undertake three-year strategic planning that will support an efficient, integrated and co-ordinated approach.

In May 2006, Dáil Éireann (Irish Parliament) debated a private member’s motion on Ireland’s drugs policy (Private Member’s Business (23–24 May 2006)). Both the motion and the contributing speakers endorsed the National Drugs Strategy 2001–2008 and its strategic objective, but called for increased resources and an intensification of efforts to support the full implementation of the National Drugs Strategy, as summarised below:

⁵ See CityWide Drugs Crisis Campaign at www.citywide.ie for full documentation of this campaign (Home>Campaigns>National Drugs Strategy Crisis). Documents retrieved 12 October 2006.

Supply reduction	<ul style="list-style-type: none"> • Target major drug traffickers • Ring-fence seized funds related to the drugs trade for development in communities worst affected by 'drug scourge' • Appropriate sanctions, including sentences, for those involved in drugs trade • Increased resources for drug-related Garda activities
Prisons	<ul style="list-style-type: none"> • Ensure access for prisoners to health and prevention policies and services, including harm-reduction strategies, equivalent to those available in the wider community
Cocaine Treatment	<ul style="list-style-type: none"> • Formulate, resource and implement an action plan to address cocaine use • Increase funding to ensure waiting lists are eliminated • Encourage the HSE to return to 'real partnership' with community and voluntary groups in addressing problematic drug use • Expand spectrum of services • Ensure access to counselling and other medical services, without discrimination
Prevention Grandparents	<ul style="list-style-type: none"> • Ensure take-up of widespread and well-resourced education programmes and campaigns • Increase orphan-guardian allowance for grandparents looking after children of their drug-addicted offspring, in line with provision for foster parents
Socio-economic factors All-Ireland approach Strategic leadership	<ul style="list-style-type: none"> • Address poverty and inequality, including educational disadvantage • Work on an all-Ireland basis to ensure application of strategic objectives in National Drugs Strategy • Appoint a Minister of State with sole responsibility for the drugs issue

The motion was defeated and a government amendment, endorsing, among other things, the government's implementation of the National Drugs Strategy 2001–2008, and supporting the Minister of State, Noel Ahern TD, in 'his wholehearted commitment to, and successful handling of, the Government's drive against the problems of drug misuse in our society', was carried (Pike 2006a).

In July 2006 an Oireachtas (Parliamentary) Committee published a report considering the question of whether or not alcohol should be included in a national substance misuse strategy (Houses of the Oireachtas Joint Committee on Arts Sport Tourism Community Rural and Gaeltacht Affairs 2006). Having examined the issues, the committee was 'unequivocally of the view that alcohol should be included in the drugs strategy.' The committee made this recommendation following a review of the prevalence and range of alcohol-related problems currently experienced in Ireland; consideration of the political and administrative impediments to the implementation of an integrated, national alcohol policy to date; and having examined the possibility of extending the mandate of the National Drugs Strategy to include alcohol. It concluded that the five-pillar model of the National Drugs Strategy (supply reduction, prevention, treatment, research, and rehabilitation) offers an ideal framework for a comprehensive policy approach to alcohol issues.

In August 2006, three Irish voluntary-sector organisations – the Irish Penal Reform Trust, [Merchants Quay Ireland](#) and UISCE (Union for Improved Services, Communication and Education, a peer support and education group for people who use drugs) – hosted a conference 'Rethinking the War on Drugs'.⁶ It was aimed at promoting debate on the policy of drug prohibition, and alternative approaches to reducing drug-related harms in Ireland. Contributors included the following:

Jerry Cameron, a spokesperson for the USA organisation Law Enforcement Against Prohibition (LEAP)⁷ and a former chief of police in the US, argued that that 'the war on drugs' is not only a total failure but is also damaging society.

- Tony Geoghegan, director of Merchants Quay Ireland: 'Drugs and drug-related harm are a serious concern across Ireland.'
- Rick Lines, IPRT: 'By any measurable indicator, the international war on drugs that has been waged over the past 30 years is a failure. The use of illegal drugs has never been more prevalent, our prisons have never been fuller and injecting drug-related health concerns such as HIV and Hepatitis C infection continue to grow across the world.'
- Ruadhri McAuliffe, UISCE: 'When the Government declares a war on drugs, it is effectively declaring war on its own citizens. The effects of this are the further marginalisation and stigmatisation of people who use drugs, driving many of them underground and away from the health and social services which could help them. We need to begin rethinking whether this approach is helping or hindering efforts to reduce the harms of drug use on an individual and societal level.'

Media representation

No new information is available.

⁶ See www.iprt.ie for further information.

⁷ See www.leap.cc for more information.

2. Drug use in the population

2.1 Overview

This section provides an overview of the new developments and trends in drug use in the population in Ireland for 2004 and early 2005.

Drug prevalence surveys in the general population are important in that they can shed light on the patterns of drug use, both demographically and geographically and, if repeated, can track changes over time. They help to increase our understanding of drug use, and to formulate and evaluate drug policies. They also enable informed international comparisons, provided countries conduct surveys in a comparable manner.

2.2 Drug use in the general population

No new surveys of drug use in the general population were carried out or published in the current reporting period.

On 12 January 2006, the National Advisory Committee on Drugs (NACD) in Ireland and the Drugs and Alcohol Information and Research Unit (DAIRU) of the Department of Health, Social Services and Public Safety in Northern Ireland published jointly the fourth bulletin of results from the 2002/2003 all-Ireland general population drug prevalence survey. This latest bulletin focuses on cocaine use in the adult population (15–64 years) and patterns of cocaine use (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2006). The results are presented in the selected [issue titled 'Cocaine and crack – situation and responses.'](#)

The following are the data presented in the 2005 national report.

In 2005, the NACD published revised prevalence estimates from their national survey of drug use in the general population 2002/2003 (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit 2005b). According to the NACD, the revisions were necessary due to anomalies discovered in the original survey data.

Full details of the revised estimates can be found in the on-line version of Standard Table 1. Key findings for Ireland are described below. One in five (18.5%) adults reported using an illegal drug in their lifetime (see Table 2.2.1). For young adults (aged 15–34 years) this rose to one in four (26.0%) people. Twice as many men as women reported the use of an illegal drug during the last month or the last year.

Table 2.2.1 Lifetime, last-year and last-month prevalence of illegal drugs in Ireland, 2002/2003

Ever used an illegal drug*	Adults	Males	Females	Young adults
	15–64 years	15–64 years	15–64 years	15–34 years
	%	%	%	%
During lifetime	18.5	24.0	13.1	26.0
During last year	5.6	7.8	3.4	9.7
During last month	3.0	4.1	1.7	5.2

* Illegal drugs refer to any use of amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005)

Cannabis was the most commonly used illegal drug. One in six (17.4%) adults had used cannabis in their lifetime, and this increased to one in four for young adults (see Table 2.2.2).

Table 2.2.2 Lifetime, last-year and last-month prevalence of cannabis in Ireland, 2002/2003

Ever used cannabis	Adults	Males	Females	Young adults
	15–64 years	15–64 years	15–64 years	15–34 years
	%	%	%	%
During lifetime	17.4	22.4	12.3	24.0
During last year	5.0	7.2	2.9	8.6
During last month	2.6	3.4	1.7	4.3

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005)

Prevalence of other illegal drugs was lower and confined largely to the younger age group. One in fourteen (7.1%) young adults claimed to have tried ecstasy at least once in their lifetime (see Table 2.2.3).

Table 2.2.3 Lifetime, last-year and last-month prevalence of ecstasy in Ireland, 2002/2003

Ever used ecstasy	Adults	Males	Females	Young adults
	15–64 years %	15–64 years %	15–64 years %	15–34 years %
During lifetime	3.7	4.9	2.6	7.1
During last year	1.1	1.7	0.5	2.0
During last month	0.3	0.7	–	0.6

– no respondents in this category

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005)

Cocaine use (including crack) was much higher in men than women for lifetime, current and recent use (see Table 2.2.4).

Table 2.2.4 Lifetime, last-year and last-month prevalence of cocaine (including crack) in Ireland, 2002/2003

Ever used cocaine (including crack)	Adults	Males	Females	Young adults
	15–64 years %	15–64 years %	15–64 years %	15–34 years %
During lifetime	3.0	4.3	1.6	4.7
During last year	1.1	1.7	0.5	2.0
During last month	0.3	0.7	–	0.7

– no respondents in this category

Source: National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005)

2.3 Drug use in the school and youth population

On 14 December 2004 the Minister of State at the Department of Health and Children, Mr Sean Power TD, announced the publication of the third European School Survey Project on Alcohol and Other Drugs (ESPAD) (Hibell *et al.* 2004). The third ESPAD survey was conducted in 35 European countries during 2003 and collected information on young people's alcohol and illicit drug use. The target population was school-going children born in 1987. Thus, those surveyed were aged either 15 or 16 years at the time of the survey. As in the earlier ESPAD surveys, the 2003 survey was conducted with a standardised methodology and a common questionnaire to provide comparable European data.

The publication of the results for the 2003 Irish ESPAD survey allows comparisons with the previous Irish ESPAD surveys conducted in 1999 (Hibell *et al.* 2000) and 1995 (Hibell *et al.* 1997). Trends in some of the main indicators of drug use over the last eight years are reported in Table 2.3.1. There was a notable increase in lifetime use of any illicit drug between 1999 (32%) and 2003 (40%), up 8%. This increase followed a drop between 1995 and 1999. Ireland ranked joint third after the Czech Republic (44%) and Switzerland (41%) for lifetime experience of any illicit drug in 2003. The average for the 35 ESPAD countries in 2003 was 22%.

Table 2.3.1 Changes in the proportion of school-going children (15–16 years) in Ireland using drugs in the ESPAD surveys of 1995, 1999 and 2003

Drug use	1995 survey	1999 survey	2003 survey
	%	%	%
Lifetime use of any illicit drug*	37	32	40
Lifetime use of cannabis	37	32	39
Lifetime use of inhalants	NA	22	18

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

NA = Not Available

Source: Hibell *et al.* (1997); Hibell *et al.* (2000); Hibell *et al.* (2004)

The majority of those who have tried any illicit drug have used cannabis (marijuana or hashish). The lifetime prevalence rates for cannabis use are thus similar to those for use of any illicit drug and reflect the same trend. The rate of lifetime use of inhalants dropped slightly between 1999 (22%) and 2003 (18%) but remains high. The average for the 35 ESPAD countries in 2003 was 10%.

The Irish 2003 ESPAD survey was managed by Dr Mark Morgan, St Patrick's College, Dublin, and funded by the Department of Health and Children. The sampling strategy involved a two-step process. All secondary schools were divided into three strata (single-sex secondary, mixed secondary, and vocational and community schools). In the first sampling step, schools were selected within each strata in proportion to the number of schools in the sampling frame. A total of 120 schools were selected in this manner. In the second sampling step, two grade-five classes were randomly selected from these schools. Out of the 120 selected schools, 108 agreed to participate and, out of the 216 classes chosen from these schools, 196 participated. Students in these classes who were born in 1987 were asked to complete a questionnaire administered by a teacher in the school. A special room in each school was provided for this purpose. Data collection was carried out during April. A total of 2,407 students participated in the survey. The response rate (participating students in participating classes) was 96%. No information was available on the students in non-participating schools or classes. As indicated above, the desired target population in the ESPAD survey was students born in 1987. However, the ESPAD report notes that in Ireland grade five accommodates only about 67% of all students born in 1987. Consequently, the Irish results cannot be generalised to 1987-born students in other grades.

On 25 April 2005 the Minister of State at the Department of Health and Children, Mr Sean Power TD, announced the publication of *The Health of Irish Students* report (Health Promotion Unit 2005). The report incorporated the results of the College Lifestyle and Attitudinal National (CLAN) survey and a qualitative evaluation of the College Alcohol Policy Initiative. The aim of the CLAN survey was to establish a national profile of student lifestyle habits, including living conditions, general health, mental health, dietary habits, exercise habits, accidents and injuries, sexual health and substance use – tobacco, alcohol and illicit drugs (Hope *et al.* 2005). This information will be used in planning for student needs and as a baseline in monitoring trends over time.

With regard to alcohol use, three out of every four drinking occasions were binge drinking occasions for male students, compared to three out of every five for female students. Binge drinking is a term used to describe a single occasion of excessive or high-risk drinking, defined in this survey as drinking at least four pints of beer or a bottle of wine or equivalent at one drinking occasion. These figures indicate that this pattern of high-risk drinking is the norm among college students, with more male than female binge drinkers.

The likelihood of students experiencing adverse consequences from their own drinking increased with more frequent binge drinking episodes. Students who were regular binge drinkers, defined as binge drinking at least weekly, were three times more likely than students who were binge drinking less frequently, or were not binge drinkers, to have experienced money problems (32% vs. 10%), fights (22% vs. 6%), accidents (13% vs. 4%) and unprotected sex (19% vs. 6%). Regular binge drinkers were also twice as likely as other student drinkers to be current smokers (38% vs. 18%) and recent cannabis users (54% vs. 25%). Regular binge drinking can also interfere with academic performance. For example, regular binge drinkers were twice as likely to miss classes due to alcohol (61% vs. 27%) and to report that their studies were affected (39% vs. 19%).

With regard to drug use, cannabis was the most common illicit drug used by students, with over one-third (37%) reporting that they had used it in the past 12 months (Table 2.3.2). Ecstasy was the second most used illicit drug, followed by cocaine, magic mushrooms and amphetamines. For all drugs, the levels of use were higher among students than among those of a similar age group (15–24 years) in the general population. The use of solvents (inhalants) was particularly high. Male students were more likely to use illicit drugs than were female students. Significant differences ($p < 0.01$) between genders were observed for cannabis, ecstasy, cocaine, magic mushrooms and solvents.

Table 2.3.2 Illicit drug use in past 12 months by undergraduate full-time students (CLAN survey) compared to those aged 15–24 years in the general population, 2002/2003

Used in last 12 months	CLAN survey	General population* (15–24 years)
	%	%
Cannabis	37.3	11.0
Ecstasy	8.0	2.8
Cocaine	5.8	2.7
Magic mushrooms	4.9	1.1
Amphetamines	4.5	1.2
Solvents	2.2	0.2
LSD	1.7	0.2
Heroin	0.4	0.2

*National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005) *Drug use in Ireland & Northern Ireland. Bulletin 1. First results (revised) from the 2002/2003 drug prevalence survey*. Dublin: National Advisory Committee on Drugs.

Source: Hope *et al.* (2005)

The report recommends ten actions required to ensure that the college environment is more conducive to the positive health and well-being of all students. Acknowledging that alcohol-related harm was particularly high and of major concern, the report recommends the implementation of all five elements of the college alcohol policy framework (Health Promotion Unit 2001). In addition, the report recommends that a programme of ongoing research should be agreed to allow for monitoring of trends and evaluation of programmes and interventions.

The CLAN survey was carried out among undergraduate full-time students in 21 third-level colleges in Ireland during the academic year 2002/2003. The colleges included seven universities, twelve institutes of technology and two colleges of education. A national sample size was calculated using a 3% precision and a 95% degree of confidence, with a breakdown for the colleges based on each college population. Each participating college generated a random sample from its computerised enrolment list of full-time undergraduate students, distributed the self-completed survey questionnaire by mail to selected students and collected the completed questionnaires by mail or by using drop-off points on campus.

A total of 3,259 students responded to the survey, giving a reported response rate of 50%. No information is given in the report about those who did not respond, so it is not possible to tell if they differed in any way from those who did respond. Of those who did respond, 38% were male and 62% were female. Based on Department of Education and Science figures, the gender breakdown for persons receiving full-time education in the academic year 2002/2003 was 46% male and 54% female (Department of Education and Science 2004). Thus, there would appear to be a slight over-representation of female students in the CLAN survey.

2.4 Drug use among specific groups

Barry and colleagues (2006) completed a study estimating the prevalence of alcohol, cigarette and illicit drug use by women attending the Coombe Women's Hospital in Dublin between 1988 and 2005.

Anonymous data relating to 43,318 records were extracted from a computerised database maintained by nursing and clerical staff at the hospital. In June 1999, some questions on the database were revised and new questions were added. The data in this section present results pertaining to drug use during pregnancy from 1 June 1999 to 30 March 2005.

In total, 447 (1.0%) women reported using drugs associated with dependency during their pregnancy (Table 2.4.1). However, it is difficult to comment on these figures as it is not clear how many were using methadone or diazepam as a treatment rather than in an unregulated manner (street use). A higher proportion of women who reported drug use (16.6%) were likely to have a baby weighing less than 2,500 grams than the proportion of women who did not report drug use (5.1%).

Table 2.4.1 Drug use during pregnancy, 1999 to 2005

Drugs used	Number
Yes	447
Type of drug used*	
Methadone [†]	323
Cannabis	87
Heroin	64
Diazepam [†]	51
Ecstasy	14
Cocaine	13

*The total number of drugs is greater than the total number of women as some women used more than one drug.

[†]These numbers do not discriminate between prescribed and street use.

3. Prevention

3.1 Overview

Drug prevention is a primary pillar of the National Drugs Strategy 2001–2008 (Department of Tourism Sport and Recreation 2001). Recent developments include responding to a request from school principals for assistance in designing school-based drug policies. The emergence of the regional drug task forces (RDTFs) has heralded a new emphasis on providing drug-specific information and awareness to young people, families and communities outside the greater Dublin area. These target groups and areas have not been prioritised previously in information distribution strategies. Initial steps have also been taken to provide information on drugs and services in a number of languages to accommodate the increasing number of immigrants coming to live in Ireland. There is increasing use of technology, through the use of SMS messages and DVD, to distribute drugs information and awareness messages. A peer approach to school-based prevention used in Kilkenny has been recognised at European level. There is a renewed emphasis on training for professionals working in the field of drug prevention. Government spending on services targeting at-risk groups and communities remains a priority.

3.2 Universal prevention

School-based prevention and drug education

Universal school-based drug prevention education is implemented through the Social, Personal and Health Education (SPHE) curriculum in primary and post-primary schools. The SPHE curriculum is mandatory in all primary schools and in post-primary schools up to Junior Certificate level. Substance use is one of ten modules covered in the SPHE programme in both school cycles. In primary schools the Walk Tall programme provides in-service training to teachers to enable them to provide drug prevention education to students from junior infants to sixth class. The programme has developed a set of standardised manuals for use by teachers delivering the programme. The manuals cover self-esteem, self-awareness, and relationships and attitudes towards substances such as illicit drugs and alcohol and nicotine. The programme is delivered interactively, using methods such as circle work and games for the younger students, and role play, group work and brainstorming for the older students in sixth class. The material contained in the manuals has also been included in a DVD, which is being distributed to teachers in primary schools. During 2006 and in response to requests from teachers for additional information on drugs and the consequences of their use, the Walk Tall support service team have provided extra school-based drug information and awareness sessions for school staff (*Walk Tall 2006*). Particular emphasis is placed on delivering the Walk Tall programme in schools in local drugs task force areas where the problems associated with problematic drug use are most prevalent.

School-based drug policies

The National Association of Principals and Deputy Principals has called on the Department of Education and Science for additional assistance and guidance in designing the growing number of policies that schools are legally required to adopt. (Murray 2006). The Department has made available templates to assist second-level schools in revising and updating policies on bullying, child protection, guidance, internet safety and substance misuse. In a separate development, the Minister for Education and Science has voiced opposition to the use of random drug testing of second-level students and has emphasised that the guidelines for implementing drug policies in schools oppose the expulsion of students found to be in possession of drugs.

The use of peers as a vehicle for drug education in schools

The European Prevention Prize, an accolade given by the Council of Europe, was presented to Kilkenny's 421 Peer Drugs Education Programme at an awards ceremony in Vilnius, Lithuania, during 2006. The Pompidou Group awards this prize every two years in order to highlight good-quality drug prevention projects that have successfully involved young people in their design and implementation. The Kilkenny initiative, along with a project from Norway, was chosen from 31 entries by a panel that comprised six young people from the Russian Federation, Norway, the Netherlands, Romania, the United Kingdom and Turkey and experts in the field from the Pompidou Group. The two winners received a trophy, a diploma and prize money worth €20,000.

The story of the emergence of the 421 Peer Drugs Education Programme goes back to 2003 when a school chaplain in Kilkenny identified the need for an innovative approach to providing drug education in local schools. It was felt that the traditional adult-delivered drug education approach had its limitations and could be strengthened by more active participation by young people themselves in both design and delivery. In response, two local drug education workers from the Health Service Executive (HSE) and the local youth

service developed what is now the 421 Peer Drugs Education Programme. The 421 initiative trains 4th year (15 year old) students to design and deliver drugs education to 1st year (13 year old) students. The 4th year students are trained over a three-day period by local youth workers and community drug workers from Ossory Youth and the Drugs Education Officer from the Carlow/Kilkenny Substance Misuse Team, HSE. The training includes modules on the following: attitudes to substance misuse, drug facts, signs and symptoms, patterns of drug use, peer education skills, planning a programme and presentation skills. It has trained 92 4th year students as peer drug educators. These young people have then gone on to provide drugs education to approximately 880 1st year students (M Bay, personal communication, 2006). The programme is currently being evaluated by external consultants.

Family-based prevention

The role of family support in drug prevention: The emergence of family support groups as a response to drug use and misuse has become a key feature of drug responses in Ireland in recent years. Family support is where family members of those using drugs come together in small groups to talk about their problems and to get support. This is an approach similar to the work of Alateen and other family support groups that have developed in conjunction with Alcoholics Anonymous and Narcotics Anonymous and that are aimed at helping family members living with individuals who have addictions. In addition, an important development has been the emergence of the CityWide Family Support Network, which was formed in 2000 and consists of representatives of family support groups, individual family members and those working directly with families of drug users throughout Ireland. The network is committed to campaigning for better services for drug users and their families and helping families to develop local responses to the drugs problem, while also contributing to the development of national drugs policy. In 2005 the network published a revised edition of its resource pack, containing a mix of practical information on drug use, such as the different types of drugs available and their effects, health and first-aid information, and information on the supports available to families faced with drug misuse (CityWide Family Support Network 2005).

Technology in targeting families in relation to drug prevention: Every local library in Ireland received two DVDs as part of a new drug awareness campaign urging parents across Ireland to educate themselves about drug misuse and to discuss the issue with their teenage children. 'Empower: The family guide to understanding drugs in Ireland' is a 30-minute DVD aimed at parents and teens, which is available for free loan from all 382 local libraries throughout the country. The DVD was developed by the Health Service Executive (HSE) and the Tipperary Regional Youth Service (TRYs) and is supported by Schering-Plough Pharmaceuticals Ireland. It is based on the story of one Irish teenager's experience of drug misuse and deals with signs of drug addiction and a guide to drug terminology and language. In addition, campaign posters have been distributed to health centres, youth clubs and community organisations across the country.

A new drug awareness textline has received more than 60,000 messages looking for information about drugs. Crosscare's Drug Awareness Programme (DAP) launched the confidential SMS text service in April 2006. The aim is to provide young people with basic facts on drugs to help them make informed choices regarding their own individual use. The service is free and the first of its kind in Ireland. The person texts the name of the drug to 50100 and the service sends them back specific information on the type of drug and the effects on users. For example, the following reply was sent to a request for information on cocaine: 'cocaine addictive stimulant cause feelings of confidence also exhaustion nervousness heart problems usually cut with other substances.' The reply contained a phone number to contact.

Drugs information packs targeting families in relation to drug prevention: The South Tipperary Education Sub-Group, which is part of the South East Regional Drugs Task Force, provided an information pack to each young person receiving their Leaving Certificate exam results. The information pack contains drug information leaflets, a booklet and the 'Empower' DVD.

'Be aware and be around' was the message of an education pack on substance abuse sent out in a mail shot to 350 parents of students collecting their Junior Certificate exam results by the Killarney Drugs Liaison Committee; a further 50 were sent to publicans and off-licence holders.

The Big Blue Book of Drugs, *The Big Blue Book of Booze* and *The Facts of Drugs* are three new information booklets launched by the HSE in February 2006. (McSweeney 2006). The first two are aimed at young people and the last at parents. They can be obtained by parents by ringing a freephone number. Young people played a role in producing the booklets and they are written in graphic language reflecting a streetwise approach. The booklets have been launched as part of the development of the regional response

through the RDTFs, and it is envisaged that young people and parents from rural areas will benefit from this information.

Community-based prevention

National Drugs Awareness Campaign targets teenage cannabis use: The National Drugs Awareness Campaign, now in its third year, is managed by the Health Service Executive (HSE) under Action 38 of the National Drugs Strategy. The latest phase of the campaign was launched in October 2005. This phase covers the issue of cannabis use among teenagers, seeking to dispel some of the myths that surround the drug, such as the claim that it is 'organic' and 'natural'. The campaign comprises a radio advertisement and two posters on the theme 'Being a teenager is hard enough, without being stoned too'. The radio advertisement mimics advertisements for teen magazines, to communicate the negative impact smoking cannabis can have on the health and well-being of young users. The posters mimic the front covers of boys' and girls' teen magazines, to deliver the same messages. The posters are located in public places where teenagers gather such as bus stops near secondary schools, shopping malls in urban areas, computer game stores and on Dublin city buses. The overall campaign includes a helpline, information leaflets and a website. (www.drugsinfo.ie). The National Advisory Committee on Drugs (NACD) and external consultants are currently working on the evaluation of the overall three-year campaign.

Training for professionals and communities involved in tackling drug use: The Health Service Executive (HSE) held a training workshop for more than 200 professionals from across the country in response to an apparent rise in drug use among school-children. This increase in drug use is reported in the 2003 ESPAD study, which shows an increase to 40% in the lifetime prevalence of illegal drug use among 15–16-year-olds in Ireland, as against an average lifetime prevalence for the 35 ESPAD countries of 22% (O'Shea 2006). Social workers, nurses, GPs, youth workers, psychiatrists working with adolescents, probation officers, counsellors and other frontline professionals took part in the training in an attempt to improve inter-agency collaboration.

On 3 May 2006 the Health Service Executive (HSE) organised a workshop on cocaine (Sinclair and Long 2006). Dr Brion Sweeney, clinical director of the HSE Northern Area Addiction Services, presented the evidence base for the treatment of problem cocaine use and stated that cognitive behavioural therapy in conjunction with other interventions was the most successful form of treatment. He went on to state that prompt, accessible and tailored interventions increased the effectiveness of such treatment. He pointed out that the evidence indicated that medication had limited effect in the treatment of cocaine dependence, but said that new developments were expected in this area.

The Drug Misuse Research Division of the Health Research Board held two workshops with professionals working in school and community-led prevention programmes. The aim of the workshops was to improve the quality of prevention work in Ireland by focusing on planning and evaluation of drug prevention interventions. The workshops used material from the Prevention and Evaluation Resource Kit (PERK) of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and from the Exchange on Drug Demand Reduction Actions (EDDRA). Over 20 participants attended each of the workshops.

The 'Copping On' National Crime Awareness Initiative is now celebrating its tenth anniversary. The initiative was established to provide crime prevention and awareness training to groups such as members of the Probation and Welfare Service, the gardai and youth workers who are working with young people at risk. The City of Dublin Vocational Educational Committee (CDVEC) administers the programme and the Department of Justice, Equality and Law Reform, the Department of Education and Science and FÁS (National Training Agency) provide funding. The two-day training course delivered to participating groups covers communications, relationships, drugs and alcohol, decision-making and the role of the justice system in society, all pertinent issues in the lives of the young people that these groups work with. Junior and senior resource packs are provided to participants to enable them to structure their work with at-risk young people around the central themes of the initiative.

A recent evaluation sought the views of a small number of young people who received training based on the Copping On material (Duffy 2005). Of the sessions delivered to the young people, the elements that stood out most were the prison visit, drug and alcohol awareness and the discussion on stereotyping. Overall, it appeared that, through their participation, the young participants gained a better understanding of the consequences of the choices they make.

The evaluation also surveyed 420 programme participants, of whom 91 (22%) responded. Some key findings from this survey revealed that:

- 57% felt the training was 'highly' or 'very' useful and 40% rated its usefulness between 'very low' and 'medium'.
- 46% used the training for crime prevention purposes only and 53% for other purposes.
- Respondents reported using Copping On material with approximately 1,250 young people.
- The current content met the needs of 57% of respondents.
- 61% would like Copping On to develop a DVD for crime awareness work with young people, 57% would like training on re-offending, 49% would like training and resources to assist in work with young people with low literacy levels, and 48% would favour greater focus on work with the families of young people at risk.
- 78% had used the resource packs and reported them to be user friendly.
- 78% had not attended follow-up training.
- 41% believed the Copping On initiative had changed their approach to crime awareness work with young people.

The evaluation contained recommendations designed to improve the strategic focus and location of Copping On, to build on and develop its evaluation culture and to develop its capacity to respond to the changing needs of the main target groups. Two specific recommendations were:

- Training should expand to focus on young people with low literacy levels, families of young people at risk and those at risk of re-offending.
- Copping On should expand and update its data-collection system to include levels of participant delivery of programmes to young people, impact of programme on young people, follow-up training and project visits and how the programme can continue to meet the needs of the target groups.

In a separate development, a training course specifically designed for managers of community-based drug projects will roll out in September 2006 in the National College of Ireland (NCI). There are 12 places on this course, which is fully funded through the NDST cross-taskforce fund. The course will award both FETAC and NCI accredited qualifications and will run on Wednesday afternoons in the NCI campus in central Dublin.

3.3 Selective/Indicated prevention

At-risk groups

Investment in disadvantaged communities: The Young People's Facilities and Services Fund (YPFSF) remains the key vehicle through which services targeting young people at risk of engaging in drug misuse in disadvantaged communities are developed. This fund aims to attract young people at risk of drug misuse or potentially at risk, in disadvantaged areas, into facilities, programmes and activities that will divert them away from drug misuse. The YPFSF provides capital funding to build and develop youth facilities, provides funding to refurbish existing facilities and funds the employment of staff to manage and develop facilities. Information regarding the current use of these facilities by young people and their impact on young people's drug-using behaviour is not available in any standardised fashion. Findings from an evaluation (Ronayne 2003) were reported in a previous National Report. For a comprehensive profile of this intervention, see the EDDRA database.

The most recent information available on the YPFSF comes from the Minister of State with responsibility for drugs strategy who recently said: 'Since its inception in 1998, over €102 million has been allocated by the Fund. Over 450 facilities and services for at risk youth have been developed, including over 300 staff working with the target group' (Ahern 2006b). This is a welcome investment in much-needed facilities in areas of acute social and economic disadvantage, facilities that are now being used to provide sporting and recreational pursuits for young people who otherwise might be exposed to an environment with few or no social amenities. It remains to be seen if subsequent research and evaluation can determine that the provision of these facilities has played a role in reducing demand for drugs among the target population.

The Premises Initiative (PI) was established to address the accommodation needs of community-based drug projects in LDTF areas which have been identified with acute problematic drug use and associated social and economic disadvantage. The PI has been used to fund the completion of a number of new premises in disadvantaged communities in order to improve the facilities available for service users and their families. For example, in the Ballymun Local Drug Task Force area in Dublin, the PI has been used to fund the completion and launch of the Ballymun Horizons Centre, which has been described in the local press as a 'state of the art premises'. The building houses a number of existing services for local drug users and their families, including the Ballymun Youth Action Project, which provides drop-in and counselling services, family support and outreach services; an aftercare project, the STAR project, which provides rehabilitation for women in recovery from drugs misuse; and Urrús, which provides the Community Addiction Training project.

There will also be an evening and weekend outreach service operated from the centre. It is estimated that over €1.4 million was allocated towards the cost of the Ballymun Horizons Centre through the Premises Initiative. A total of €15,204,099 has been allocated to community drug projects under the Premises Initiative (National Drugs Strategy Team, personal communication, 2006).

Drug information for new communities in Ireland: In her exploration of drug use among new communities in Ireland, Corr (2004) reported that drug users from new communities were generally unaware of drug service provision in Ireland, and did not trust in the confidentiality of information held by such services. The report recommended that any future material produced highlight the range of services provided in Ireland and provide assurance as to their confidential nature. An additional recommendation was that the information should be translated into appropriate languages and distributed to places that drug users from new communities were most likely to frequent.

Merchants Quay Ireland (MQI), the largest voluntary sector provider of homeless and drugs services in Ireland, has taken the lead in producing information leaflets in English, Polish and Russian detailing service provision at MQI (Keane 2006). The leaflets contain information on needle exchange, methadone prescribing, residential drug-free services, and settlement and integration services, which provide help with accommodation and training and employment support. Also included are details of MQI's services for homeless people, including crisis support, meals service, primary healthcare and a women's health programme. The services are open to all individuals experiencing drug use and/or homelessness. Opening hours and direct dial phone numbers specific to each service are provided. Service providers in the drugs area wishing to avail of these leaflets for dissemination to their clients are invited to contact MQI. In addition, it is planned that the Health Service Executive (HSE) will publish information leaflets on drug and addiction services in a number of languages in response to the growing number of non-Irish nationals with drug problems. It is envisaged that these will be distributed on a national basis. It is envisaged that a strategy will be in place by next year.

Challenges for traditional service providers: Recent research published by the Equality Authority (Devlin 2006) highlights the ways in which a selection of teenagers believe they are negatively perceived and treated by adults across Irish society. The report is based on focus group discussions with approximately 90 teenagers during May and June 2005 and includes the views of young asylum seekers, travellers, people with disabilities, and lesbian, gay, bisexual and transgender youth. Contact with the young people was facilitated by the National Youth Council of Ireland (NYCI). The report includes additional findings from a case study on the stereotyping of young people in the Irish media.

- **Media** The media were most commonly identified by young people in the focus groups as constructing a negative stereotype of young people by constantly associating them with crime, deviance, disorder and drug and alcohol problems. Empirical findings from the case study of the Irish media supported this view but also highlighted the gender differences in media representations, with young men often portrayed in criminal and deviant terms and young women portrayed in association with victimhood and vulnerability.
- **Gardaí and the security industry** Poor relationships with the gardaí and the view that the gardaí had a poor opinion of young people dominated several of the focus group discussions. However, some young people also reported that their relations with some individual community gardaí were quite positive, but that when these individuals moved, their replacements often did not display similar levels of respect. Young people reported being unequally treated in shops and shopping centres by security personnel in terms of being followed and observed, treatment not often meted out to adults. They felt that their age and their clothes were used by security to discriminate against them.
- **Politicians** With very few exceptions, the young people's experiences and opinions of politicians and their perceptions of politicians' attitudes towards young people were negative. Politicians were seen as representing the views of the adult generation and dismissing young people as unimportant. A view expressed and endorsed by many of the young people was that 'if you answer the door at election time they [politicians] ask for your parents and ignore you'. Young people felt that not having the vote until 18 years of age rendered them voiceless and unimportant to the politicians.
- **Teachers and school** The young people felt that they were not being treated equally by their schools or teachers. An example was the different rules existing for teachers and students in the

classroom in relation to the use of mobile phones. Young people felt that they did not have a voice in how their schools were being run, and that if schools were to respect their right to equality then rules governing behaviour in schools needed to be negotiated between young people and the school authorities instead of being imposed.

- **Local communities** Young people reported constant 'hassle' in public from adults, especially when 'hanging around' in groups on their local estates. Young people explained that there were few alternatives available where they could meet with their peers, and accepted that meeting outdoors in groups made them more visible within their community. Congregating in groups is common among young teenagers and, rather than seeing this as threatening and intimidating, adults could learn from young people some of the reasons why they choose this form of social gathering. Recent research in Scotland by Seaman and colleagues (2006) highlights the benefits young people derive from congregating with their peer group, e.g. the feeling of safety from being part of the 'gang', as their friends often provide them with information on the risks and safety precautions required around certain estates.
- **The importance of the peer group** among teenagers is reflected in the quantity of time they spend 'hanging out' together and the importance they place on mutual support. Recent research by Lalor and Baird (2006) among a sample of adolescents in County Kildare revealed that a favoured activity among respondents was 'hanging out with friends', with over half the sample spending between five and fourteen hours per week with friends. Close friends and peers were listed as being key sources of social support to which young people turn when they encounter problems.

Although the views and experiences raised by young people in the research by the Equality Authority cannot be generalised to the wider population of young people, they do provide an opportunity for youth workers, teachers, Garda Juvenile Liaison Officers and other professionals working with young people to reflect on their methods of engagement. For example, teachers and Garda Juvenile Liaison Officers, who often deliver drug education and awareness programmes to young people of a similar age and profile to this group, might reflect on the effectiveness of their programme, given the potential among young people for feeling that they are not respected by such individuals.

Given the prominent role of peer groups in providing support for young people, as demonstrated in this research, perhaps it would be more effective to train young people themselves to deliver drug prevention programmes among their peers. This would create conditions of negotiation between young people and significant adults in society around a key issue of behavioural change in relation to substance misuse.

4. Problem drug use

4.1 Overview

This section provides an overview of new developments and trends in the prevalence and characteristics of problem drug use in Ireland for 2004 and early 2005.

The EMCDDA (2004) defines problem drug use as 'injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines'. However, this section, written following EMCDDA guidelines, requires clients in treatment to be covered. It should be stressed that not all clients in treatment fit the above EMCDDA definition of problem drug use.

4.2 Prevalence and incidence estimates

No new prevalence and incidence studies have been carried out or published in the current reporting period. The following text was reported in the 2005 national report.

The last national prevalence estimate for problem drug use was for opiate users. The research – the first national study of its type – was commissioned by the National Advisory Committee on Drugs and conducted by a team from Trinity College Dublin (Kelly *et al.* 2003). A three-source capture–recapture methodology was applied following guidelines recommended by the EMCDDA (1999). Three national data sources were used for both 2000 and 2001: clients in methadone substitution treatment, individuals known to be opiate users by An Garda Síochána (Irish police), and patients discharged from acute hospitals with an International Classification of Diseases code corresponding to drug dependence.

While the estimated number of opiate users increased slightly between 2000 and 2001, the rate per 1,000 population aged 15–64 years remained remarkably stable at 5.6. For both years, rates were higher for men than women in all age categories.

Opiate use is still predominately a Dublin phenomenon, which was reflected in the finding that the rate of opiate use in Dublin in 2001 was 15.9 per 1,000 population aged 15–64 years and outside Dublin the rate was just under 1.2 per 1,000 population aged 15–64 years.

4.3 Profile of clients in treatment

Drug treatment data are viewed as an indicator of drug misuse as well as a direct indicator of demand for treatment services. The National Drug Treatment Reporting System (NDTRS) is an epidemiological database on treated problem drug and alcohol use in Ireland. The NDTRS is co-ordinated by staff at the Drug Misuse Research Division of the Health Research Board on behalf of the Department of Health and Children. For the purpose of the NDTRS, treatment is broadly defined as 'any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their drug problems.' The methodological background to the NDTRS is presented in Standard Table TDI 34.

Outpatient services (see Standard Table TDI 34 outpatients)

In 2004, there were 144 services providing outpatient services and reporting cases to the NDTRS. Of these services, 55 provided methadone treatment. All provided counselling services and a large proportion provided brief interventions. A small number of services provided detoxification using lofexidine and one provided buprenorphine detoxification. Of the 3,371 cases who entered treatment for the first time or returned to treatment at outpatient services in 2004, 861 (26%) were female, 1,774 (53%) were aged between 20 and 29 years old and 1,446 (43%) had never previously been treated. The most common source of referral was self-referral (1,028, 30%). Over half (1,810, 54%) were living with their parents and a significant minority (308, 9%) were living in unstable accommodation. The majority of cases (1,912, 57%) were not employed and 898 (29%) had no formal educational qualifications. The three most common main problem drugs were opiates (2,036, 60%), cannabis (831, 25%) and cocaine (236, 7%).

Of the 3,335 cases whose gender was known and who were admitted to outpatient facilities in 2004, 1,048 (31%) injected their main problem drug; 1,580 (47%) cases used their main problem drug on a daily basis; and 744 (22%) had not used their main problem drug in the month prior to this treatment episode. The age at which cases commenced use of their main problem drug was associated with the type of drug. Of the 2,019 cases who were admitted to outpatient facilities during the reporting period and reported an opiate as

their main problem drug, 1,355 (67%) commenced use of this opiate between 15 and 25 years of age. Of the 230 cases who were admitted to outpatient facilities and reported cocaine as their main problem drug, 153 (67%) commenced use of cocaine between 15 and 25 years of age. Of the 823 cases who were admitted to outpatient facilities and reported cannabis as their main problem drug, 742 (90%) commenced use of cannabis between 10 and 19 years of age. The majority of cases (2,310/3,335, 69%) reported that they used more than one drug. The four most common additional drugs used were cannabis, alcohol, cocaine and hypnotics or sedatives.

Of the 3,371 cases who were admitted to outpatient facilities, 1,419 (42%) had ever injected any drug and 781 (23%) had injected in the month prior to this treatment episode. Among cases admitted to outpatient services, opiates (usually heroin) were the main type of drug injected.

Inpatient services (see Standard Table TDI 34 inpatients)

There were 18 inpatient services reporting cases to the NDTRS in 2004. These facilities provided one of the following: medical detoxification, therapeutic community, Minnesota Model, other medication-free approach or psychiatric treatment combined with counselling. Of the 725 cases who were admitted to residential facilities in 2004, 168 (23%) were female, the majority (457, 63%) were aged between 20 and 29 years, and 310 (43%) had never previously been treated. The most common source of referral was another drug treatment service (248, 34%). A higher proportion of women than men said that they were referred through other drug treatment services. Of the 725 cases who were admitted to residential facilities, 357 (49%) were living with their parents and 86 (12%) were living in unstable accommodation. In total, 481 (66%) were not employed and 184 (25%) had no formal educational qualifications. The three most common main problem drugs were opiates (395, 54%), cannabis (169, 23%) and cocaine (114, 16%).

Of the 719 cases whose gender was known and who were admitted to residential facilities in 2004, 199 (28%) injected their main problem drug and 315 (44%) used their main problem drug on a daily basis, while 184 (26%) did not use their main problem drug in the month prior to this treatment episode. The age at which cases commenced use of their main problem drug was associated with the type of drug used. Of the 392 cases who were admitted to residential facilities and reported an opiate as their main problem drug, 288 (74%) commenced use of this opiate between 15 and 25 years of age. Of the 112 cases who were admitted to residential facilities and reported cocaine as their main problem drug, 77 (69%) commenced use of cocaine between 15 and 25 years of age. Of the 168 cases who were admitted to residential facilities and reported cannabis as their main problem drug, 155 (92%) commenced use of cannabis between 10 and 19 years of age. The vast majority of cases (637/719, 89%) reported that they used more than one drug. The four most common additional drugs used were alcohol, cannabis, stimulants and cocaine.

Of the 725 cases who were admitted to residential facilities in 2004, 319 (44%) had ever injected any drug and 144 (20%) had injected in the month prior to this treatment episode. Opiates (usually heroin) were the main type of drug injected. A sizeable number of cases injected cocaine and a small number of cases injected benzodiazepines or stimulants.

Low-threshold services (see Standard Table TDI 34 low threshold)

In 2004, there were three services providing solely low-threshold services and reporting cases to the NDTRS. The three services were based in the North and South-Western Areas of Dublin. Of these services, two provided low-threshold methadone maintenance and one provided crisis counselling. For many of the community services, it is difficult to separate low-threshold activities from treatment interventions and services. Both crisis interventions and counselling services have been and continue to be classified as outpatient treatment services. Of the 219 cases who attended low-threshold services in 2004, 61 (28%) were female, 151 (69%) were aged between 20 and 29 years and 43 (20%) had never previously been treated. The most common sources of referral were self-referral (102, 47%), followed by referral by another drug treatment service (42, 19%). A higher proportion of men than women reported that they were self-referrals, while more women than men said that they were referred by another drug treatment service. Of the 219 cases who attended low-threshold services, a large number (98, 45%) were living with their parents and a significant minority (44, 20%) were living in unstable accommodation. The vast majority of cases (168, 77%) were not employed and 75 (34%) had no educational qualifications. Almost all cases (212, 97%) reported an opiate as their main problem drug and 56% (of the 209 whose gender was known) injected it.

Of the 216 cases whose gender was known and who attended low-threshold services, 136 (63%) used their main problem drug on a daily basis and 47 (22%) had not used their main problem drug in the month prior to this treatment episode. A very high proportion of cases (195/216, 89%) used more than one drug. The four most common additional drugs used were benzodiazepines, cannabis, cocaine or opiates.

Of the 219 cases who attended low-threshold services, 173 (79%) injected at least once in their lifetime and 98 (45%) injected in the month prior to this treatment episode. Opiates (usually heroin) were the main type of drug injected. A small number of cases injected benzodiazepines and one case injected cocaine.

4.4 Main characteristics and patterns of use from non-treatment sources

There were no new data published on characteristics and patterns of use from non-treatment sources during 2005 and early 2006.

5. Drug-related treatment

5.1 Overview

This section presents new data on the treatment system and provides updated information on treatment outcomes. The definitions used are presented where necessary in the relevant sections.

5.2 Treatment system

Developments in the public health service

On 1 January 2005, the ten health boards managing the health services in Ireland were replaced by a single entity, the Health Service Executive (HSE), which manages Ireland's public health sector (Health Act 2004). The chief executive of the HSE is directly accountable to the Oireachtas (Parliament) for the performance and management of the HSE and the Minister for Health and Children is responsible for legislation and policy. Health care is provided through four HSE regions and 32 local health offices. The local health offices are based on the geographical boundaries of the existing community care areas. Table 5.2.1 presents the past health board structure and the current regional structure of the public health services in Ireland.

Table 5.2.1 The past health board structure, and the current regional structure of the public health services in Ireland

Regional Health Authority	Health boards	HSE regions	Local health offices/community care areas
Not applicable Eastern Regional Health Authority (ERHA*)	North Eastern Health Board Northern Area Health Board	HSE Dublin/North East Region	Cavan/Monaghan Louth Meath Dublin community care areas 6–8
Eastern Regional Health Authority (ERHA) Eastern Regional Health Authority (ERHA) Not applicable	East Coast Area Health Board South Western Area Health Board Midland Health Board	HSE Dublin/Mid-Leinster Region	Dublin community care areas 1–5 Wicklow Kildare Laois/Offaly Longford/Westmeath
Not applicable Not applicable	South Eastern Health Board Southern Health Board	HSE Southern Region	Carlow/Kilkenny Wexford Waterford South Tipperary Four community care areas of Cork (North Lee, South Lee, North Cork, West Cork) Kerry
Not applicable Not applicable Not applicable	Mid-Western Health Board North Western Health Board Western Health Board	HSE Western Region	Donegal Sligo/Leitrim Galway Mayo Roscommon Clare Limerick (part of) North Tipperary/East Limerick

*The ERHA comprised three area health boards – Northern, East Coast and South Western.

The Inter-Departmental Group (IDG) overseeing the implementation of the National Drugs Strategy expanded to include senior-level representation from the HSE. The management of all addiction services is under the remit of the Primary, Community and Continuing Care Directorate, which will oversee a number of

national care groups. The national care group with specific responsibility for addiction services is Social Inclusion Services. The HSE National Service Plan for 2005 emphasises that responses to the needs of those dependent on drugs or alcohol require a partnership approach across organisational boundaries (including drugs task forces) together with clear strategies to prevent and reduce levels of drug or alcohol misuse and harm. The plan also endorses a needs-based approach to the delivery of services that minimises disadvantage.

A clear alignment with the National Drugs Strategy (Department of Tourism Sport and Recreation 2001) is established through the commitment made in the National Service Plan for 2005 to Action 22 of the national health strategy, *Quality and fairness*, which states that all relevant actions in the National Drugs Strategy will be implemented by 2008 (Department of Health and Children 2001a). Moreover, the National Service Plan for 2005 commits Addiction Services, within Social Inclusion Services, to providing six-monthly reports to the Department of Community Rural and Gaeltacht Affairs on the implementation of the National Drugs Strategy, supporting the Health Research Board (specifically the National Drug Treatment Reporting System), and implementing the research recommendations of the National Advisory Committee on Drugs (NACD). Under the treatment pillar, the Mid-Term Review of the National Drugs Strategy (Steering group for the mid-term review of the National Drugs Strategy 2005) recommends:

- a new action making rehabilitation the fifth pillar of the Strategy and establishing a working group to develop an integrated rehabilitation provision;
- a new action to carry out an audit of the current availability of treatment options, including an assessment of treatment needs;
- the replacement of an existing action to allow for the full implementation of the guidelines agreed by the Working Group on treatment for those under 18 years;
- the replacement of an existing action to allow for the expansion of the provision of needle exchange and related harm reduction services;
- the replacement of an existing action to allow for an increase in the number of general practitioners and pharmacists participating in the methadone protocol;
- amendments to two existing actions, one which sets the maximum waiting period for treatment to one month following assessment, and the other which increases the availability and range of treatment options, particularly in relation to play-drug use.

During 2005 and the first half of 2006, four regional drugs task force areas have published regional strategies and/or action plans to address drug and alcohol misuse in their geographical areas (Walsh and Comer 2005; North East Regional Drugs Task Force 2004; North West Regional Drugs Task Force 2005; Southern Regional Drugs Task Force 2005). The remaining six task forces have prepared strategies but not launched them formally. A number of common and diverging themes emerging from these documents will be analysed and presented in *Drugnet Ireland* Issue 20.

Treatment is provided through a network of statutory and non-statutory agencies. Two broad philosophies underlie the approaches to treatment: medication-free therapy and medication-assisted treatment. There is a small degree of overlap between the two. Medication-free therapy uses models such as therapeutic communities and the Minnesota Model, though some services have adapted these models to suit their particular clients' needs. Medication-assisted treatment includes opiate detoxification and substitution therapies, alcohol and benzodiazepine detoxification, and psychiatric treatment. Various types of counselling are provided through both philosophies of treatment and independent of either type of treatment. Alternative therapies, such as acupuncture, are provided through some community projects in Dublin.

The total number of drug treatment services available in Ireland and participating in the NDTRS increased between 1998 and 2004 (Table 5.2.2). The largest increase was in outpatient treatment services and general practitioner services. In the HSE Eastern Region, counsellors employed by statutory services did not consistently return information on cases who received counselling only; therefore there is an under-representation of cases in this region treated for use of drugs other than opiates. The prison service does not participate in the NDTRS, although it does provide drug treatment services. In 2004, 11,261 cases were treated for problem drug use. Of these, 6,508 cases continued in treatment from 2003 and 4,753 cases entered or returned to treatment during 2004 (includes double counting).

Table 5.2.2 Number and type of services providing treatment for problem drug use and number of cases treated (in brackets) in Ireland and reported to the NDTRS and the Central Treatment List (CTL) (for opiate cases in continuous care), 1998 to 2004

Drug services	1998	1999	2000	2001	2002	2003	2004
Outpatient (new cases or cases returning to treatment)	83 (4566)	86 (4497)	105 (5583)	120 (6688)	124 (7270)	135 (7576)	144 (3440) (Inc. 69 repeat admissions)
Outpatient (continuous care from CTL for 2004)							N/A(4,194)
Residential (new cases or cases returning to treatment)	17 (1272)	16 (1005)	18 (796)	16 (725)	21 (798)	17 (911)	18 (731) (Inc. 6 repeat admissions)
Low-threshold* (new cases or cases returning to treatment)	3 (182)	4 (284)	2 (280)	2 (216)	2 (149)	3 (259)	3 (221) (Inc. 2 repeat admissions)
General practitioner (new cases or cases returning to treatment)	1 (24)	42 (413)	29 (274)	32 (271)	28 (371)	31 (323)	89 (361) (Inc. 5 repeat admissions)
General practice (continuous care from CTL for 2004)							116 (2,314)
Treatment in prison	2 (4)	2 (7)	0 (0)	0 (0)	0 (0)	1 (11)	0 (0)
Not known	0 (0)	0 (0)	0 (0)	0 (0)	1 (8)	0 (0)	0 (0)

*Low-threshold services are services that provide low-dose methadone or drop-in facilities only.

Source: unpublished data from the NDTRS and the CTL

When double counting within treatment centres was controlled for, 4,671 cases entered treatment and were reported to the NDTRS during 2004 (Table 5.2.2).

In May 2006, the Irish Pharmaceutical Union (IPU) called on the HSE to develop a dedicated liaison service for pharmacies outside Dublin that participate in the Methadone Treatment Scheme. This service would provide community pharmacists with a point of contact if they encountered difficulties when dispensing methadone to patients. The IPU is also calling for more protection for pharmacies from attacks and tougher action in the Courts against individuals who raid pharmacies.

On 6 June 2006, the HSE released its first annual report. It contains an account of an Alcohol Detox Unit for people who are homeless, established by the Primary, Community and Continuing Care Directorate in partnership with the Dublin Simon Community. In 2005, 156 people were admitted to the programme, of whom 80% completed the 7–10 day detox programme, and 66% completed the 21-day detox programme. Staff working on the programme have been trained in the Community Reinforcement Approach to addiction treatment.

Developments in health care in Irish prisons

The Irish Prison Service (IPS) annual report for 2004 (IPS 2005) was released in December 2005. The mission of the IPS is to provide safe, secure and humane custody for people who are sent to prison. The IPS aims to provide a range of care and rehabilitation services for prisoners. These services are important in sustaining prisoners' physical and mental health and ensuring equivalence of care with the health services available in the community. The services included are medical, dental, psychiatric, psychological and counselling.

The provision of drug treatment services, in particular methadone services, continues to use a significant proportion of health care resources. A number of prisons provide methadone treatment and, in 2004, 1,309

prisoners were treated with methadone. Of these, 96 commenced methadone treatment for the first time, indicating the important role of prison services in introducing prisoners to drug treatment (Table 5.2.3).

The IPS recognises that people who take drugs require assistance in order to tackle their addiction successfully. Meeting the needs of drug users requires a variety of interventions tailored to each individual. According to the authors, the dramatic increase in methadone treatment over the past five years and the consequent demand for a range of drug treatment services in prisons highlight the need for a review of the structures and staff required to deliver these services. The authors state that there are some pilot initiatives in place that could be useful if provided throughout the prison service. For example, two nurses have been allocated to the delivery of drug treatment services in Wheatfield Prison, which has considerably improved the continuity of care for drug users within the prison and, more importantly, between the prison and the community.

Table 5.2.3 Number of cases receiving methadone treatment in Irish prisons in 2004

Prisons	All cases	New cases
Cloverhill Prison	528	71
Dochas Centre	211	12
Limerick Prison	3	0
Mountjoy Main Prison (including Medical Unit)	394	6
Midland Prison	6	0
Portlaoise Prison	6	0
St Patrick's Institution	3	0
Wheatfield Prison	158	7
Total number	1309	96

Source: Central Treatment List

The Prison Health Working Group is responsible for implementing the recommendations of a review group on the structure and organisation of prison services published in 2001 (Group to Review the Structure and Organisation of Prison Health Care Services 2001). The re-organisation of the health service management structures resulted in delayed implementation of some of these recommendations. However, the working group has completed a large body of work which has been submitted to the IPS for consideration and includes:

- a health-needs assessment of the Irish prison population
- a report on meeting the mental health needs of prisoners (see Section 6.3)
- a protocol in relation to the management of prisoners attending acute hospitals.

The first recommendation in the report of the review group is that the same care and treatment should be available in both the prison and community health services. In order to implement this recommendation, considerable groundwork was undertaken during 2004 to develop formal service agreements in a number of areas. For example, formal agreements will be developed between Cloverhill and Wheatfield prison services and the health sector in order to provide consultant-led infectious disease and drug treatment services at these prisons from 2005 onwards. Of course, the effective development of these services within the prisons will require adequate and appropriate internal administrative and clinical support. The experience gained from the introduction of these services in Cloverhill and Wheatfield prisons will facilitate similar developments across the prison estate.

The *Irish Prison Service Health Care Standards* manual was published in June 2004. This provides governors and other managers with clear guidance regarding the health services to be provided and the facilities required to provide these services. Prison entrants are provided with an outline of the level of services they may expect to receive.

The feasibility of formally incorporating the prison population within General Medical Service (GMS) structures so as to facilitate treatment structures in custody, and in the period immediately following release, is under consideration. Progress in this matter will require a formal acceptance that prisoners should be covered within the same administrative structures as other citizens.

The resolution of the prison doctor's strike resulted in a new contract which benefits both the doctors and the prison services. As part of the contract, doctors are required to implement a range of clinical and

administrative tasks. These tasks are in line with the specifications in the IPS health care standards and are necessary for the effective and co-ordinated provision of health care within a custodial environment and between the prisons and the community.

A nursing service was introduced in Irish prisons in 1999. There are 79.5 whole-time-equivalent nursing officers providing health care in 11 of the 16 prisons.

A new strategy document published by the IPS (2006), *Keeping drugs out of prisons*, proposes to tackle the use of illicit drugs in Irish prisons by focusing on supply elimination and demand reduction. The IPS recognises that the best way to reduce the demand for drugs in prison is by providing a range of evidence-based treatment options. The prison service has outlined three core tasks to support drug treatment and rehabilitation:

1. Identifying and engaging with drug users
2. Providing treatment options
3. Ensuring continuity of treatment and care following release.

The core treatment options are:

- assessment and through-care planning
- information, education and awareness programmes
- opiate replacement therapies
- methadone detoxification and reduction programmes
- symptomatic treatment options
- mental health care
- voluntary drug testing units
- motivational interventions.

A number of specialised treatment options will also be available in designated prisons, including cognitive behavioural therapy, the 12-step Minnesota model, peer-support programmes and specialised programmes to address drug misuse and re-offending. The treatment approaches will be adapted for prisoners with special needs, including drug users with mental health problems or hepatitis C. The IPS strategy states that there will be a close link between drug treatment services and other health care services to ensure adequate management of mental illnesses and blood-borne viral diseases. The IPS has no harm-reduction strategy for drug users who continue to use drugs.

5.3 Drug-free treatment

The update for Sections 5.3 and 5.4 are combined to present the findings of the Research Outcomes Study in Ireland (ROSIE). During the coming year the outcomes will be published by treatment modality and there will be a separate analysis presenting outcomes from medication-free treatment.

5.4 Medically assisted treatment

There were a number of reports examining various aspects of medically-assisted drug treatment during 2005 and the first six months of 2006.

Methadone Protocol

In 2002, the Department of Health and Children requested the Methadone Prescribing Implementation Committee to review the Methadone Protocol introduced in October 1998. The published review was released in June 2005 (Methadone Prescribing Implementation Committee 2005). The main themes from the review were presented in the 2005 National Report. There were 19 recommendations in the review of the Methadone Treatment Protocol, of which 12 were completely implemented by the end of 2004, four were almost completely implemented and the remaining three required some further work. The three requiring further work relate to service provision, including the range of services, the link between treatment services and general practitioners, and pharmacists' contracts.

Buprenorphine pilot

The first training seminar in Ireland in the use of buprenorphine by general practitioners for opiate-dependent patients was held at the Irish College of General Practitioners (ICGP) on 23 November 2005.

Participants included the general practitioner co-ordinators and liaison pharmacists from the Health Service Executive drug services, as well as a small number of general practitioners and pharmacists who were

preparing to use buprenorphine for selected patients in the primary care setting. Two experts from the Royal College of General Practitioners (RCGP) in London facilitated the seminar.

According to the ICGP, after the introduction of buprenorphine on a pilot basis in the primary care setting, best practice guidelines will be developed for the Irish context and, following that, further training will be provided to more experienced (Level 2) general practitioners. Plans are now being progressed for the development of a pilot programme with a small group of interested general practitioners and pharmacists. During this pilot programme, the RCGP publication by Ford and colleagues (2004), *Guidance for the use of buprenorphine for the treatment of opioid dependence in primary care*, will be used until experience is gained in the context of primary care in Ireland.

The National Medicines Information Centre (2002) conducted a review of the use of buprenorphine as an intervention in the treatment of opiate dependence syndrome. This examined the effectiveness of buprenorphine as a treatment option, its safety in use, as well as the practical and pharmaco-economic considerations associated with its use. Where appropriate, the authors compared the treatment outcomes, safety issues and costs to those of methadone – the mainstay of treatment for opiate dependence in Ireland. The methods employed in this analysis were: literature reviews, systematic reviews, case histories and an economic evaluation.

In Ireland, buprenorphine (mainly as Temgesic) misuse among the treated population is rare. Of the 44,767 cases reported to the NDTRS between 1998 and 2003, 56 (0.1%) reported that buprenorphine was a problem drug. Between 1998 and 2003, the number of cases reporting buprenorphine as a problem drug decreased considerably, from 18 in 1998 to 5 in 2003 (Table 5.2.4).

Table 5.2.4 Number (%) of treated cases reporting problem buprenorphine use and reported to the NDTRS, 1998–2003

Treatment status	1998	1999	2000	2001	2002	2003
	Number (%)					
All cases	6048	6206	6933	7900	8596	9084
Cases reporting problem buprenorphine use	18 (0.3)	18 (0.3)	10 (0.1)	3 (0.0)	2 (0.0)	5 (0.1)

Source: Unpublished data from the NDTRS

There are no data available on buprenorphine-related deaths in Ireland.

In August 2002, the Irish Medicines Board authorised the use of Subutex (a buprenorphine preparation specifically for treatment of opiate dependence) in Ireland (Irish Pharmaceutical Healthcare Association (listed by) 2005). The licence for the use of Subutex in opiate dependency was amended in November 2005, and states

treatment with SUBUTEX sublingual tablets must be by physicians who have specialist training in its use and all treated patients must be on a central register according to Drug Misuse Programme guidelines. These physicians can be consultants, and/or Level I or Level II GPs who have received special training. All patients will be reviewed and reassessed regularly.

In order for this programme be operationalised, a system similar to that existing for methadone, including a protocol and a central register, needs to be established. This is an opportunity to provide choice of treatment to problem opiate users as well as to identify which substitute is most suitable for different sub-groups of patients.

Medium-term outcomes following opiate detoxification

Smyth and colleagues (2005b) reported outcomes 2–3 years after in-patient treatment. Opiate-dependent patients admitted with a goal of abstinence were followed up. A structured interview examined drug use and treatment in the preceding month. Five patients had died and 109 (76%) of the remaining 144 were interviewed. Fifty per cent (54 patients) reported recent opiate misuse and 57% (62) were on methadone maintenance. Twenty-three per cent (25 patients) were abstinent (i.e. neither using opiates nor on methadone maintenance). Abstinence was significantly associated with completion of the six-week in-patient treatment programme and attendance at out-patient after-care, and negatively associated with a family history of substance misuse. In conclusion, abstinence remains an attainable goal. As the principal influence

on outcome was treatment adherence, in-patient services should seek to enhance rates of programme completion. After-care should be provided to patients. The authors caution against use of pre-treatment patient characteristics as criteria for prioritising access to in-patient treatment.

Patient-controlled benzodiazepine dose reduction in a community mental health service

Bangaru and Meagher (2005) detail a patient-controlled benzodiazepine discontinuation programme in a generic multidisciplinary community mental health service. A prescribing audit identified suboptimal benzodiazepine use which stimulated a discontinuation programme (prescribing policy, psycho-education, anxiety management) to encourage benzodiazepine cessation. Benzodiazepine status was re-assessed at 12- and 24-month follow-ups. Benzodiazepine status at follow-up was predicted by attendance at anxiety management sessions and shorter duration of benzodiazepine use. Patients attending anxiety management sessions were 2.5 times more likely to reduce use. Discontinuation followed four patterns: (a) rapid and complete discontinuation (n = 19); (b) total discontinuation in a gradual manner (n = 13); (c) partial dose reduction without total discontinuation (n = 18); and (d) almost total discontinuation with continued low-dose use (n = 8). The patients who achieved total discontinuation were younger and in receipt of benzodiazepine agents for a shorter duration. At 24-month follow-up only three patients had relapsed into benzodiazepine use and a further 13 had achieved total discontinuation. The authors conclude that many chronic benzodiazepine users can achieve lasting discontinuation with patient-controlled dose tapering. Patient refusal and service dropout are common during discontinuation programmes. Anxiety management is a valuable adjunct to discontinuation.

Prisoners' and prison staff's perceptions of methadone maintenance

Carlin (2005) explored prisoners' and prison staff's perceptions of the methadone maintenance programme in Mountjoy Male Prison, Dublin. The author used semi-structured interviews and a focus group to explore the perceptions of staff and prisoners towards methadone maintenance within the prison setting. Although the research subjects identified advantages and disadvantages associated with methadone prescribing within the prison, they were generally positive in their assessment of Mountjoy's methadone programme. Prisoners perceived it as leading to an improvement in their relationships with their families, while staff viewed it as facilitating a more stable and safer working environment. However, although prisoners' use of heroin had reportedly declined since the advent of the methadone maintenance programme in the prison, their use of other drugs had not. There were negative views expressed by both groups about the manner in which methadone is dispensed within the prison, and also because methadone was viewed as being as addictive as heroin. Regarding perceptions of the purpose of methadone maintenance, there was a spectrum of interpretations among the interviewees. Five purposes were identified. These were: (1) to ensure continuity of harm-reduction policies from the community; (2) to reduce the supply of heroin in the prison; (3) to prevent needle sharing and the spread of blood-borne infections; (4) to treat heroin addiction; and (5) to control prisoners and maintain order and discipline within the prison. A propos the last, there was a widely held perception within the total sample that this latent function of methadone maintenance could be seen as of greater importance than the more conventional harm-reduction functions that were also identified.

Drug users' experiences of health services

A collaborative piece of action research involving the Participation and Practice of Rights Project (PPR), the Union for Improved Services Communication and Education (UISCE) and the Mountjoy Street Family Practice has sought to identify and address issues confronted by drug users in relation to Irish health services (O'Reilly *et al.* 2005).

The PPR is an initiative linking representatives of community networks from North Dublin and North Belfast which advocates the adoption of a rights-based approach in addressing social and economic issues confronting communities. UISCE is a group made up of drug users, ex-users and professionals who seek to ensure that the views of the drug user inform the development of drug policy and treatment responses. Mountjoy Street Practice is a GP-run family practice which has a large group of patients receiving methadone maintenance. It also provided financial and technical support to the research project, as did the Royal College of Surgeons in Ireland (RCSI).

The initial stage of the research involved focus group discussions with 25 drug users about their experiences of health care. Topics of discussion included drug users' perceptions as to how they were treated with regard to their health entitlements. Drug users' views of health services were then ascertained so as to facilitate practical improvements in services. Participants were identified by UISCE through being approached outside the City Clinic drug treatment centre, through informal meetings on the street and through visits to flat complexes. Three focus groups were held on three consecutive days, involving a total of six hours of recorded discussion. Four months later, after the interviews were analysed using a thematic approach,

participants were brought back together to verify the initial findings and to prioritise problems with services. Thirteen of the original 25 participants took part in this feedback session.

Concerns raised included perceptions of poor attitudes towards drug users among some staff at some acute hospitals and perceptions of discriminatory treatment of users at some hospitals and pharmacies. Some users regarded the use of identifying stickers on their charts and the use of signage, such as 'infectious diseases', as insensitive and stigmatising. Some participants felt that GPs were reluctant to take drug users onto their lists and that, since GPs are gate keepers to medical cards, this created obstacles to health care. Dental care was identified as an important issue, and some users reported difficulties in obtaining access to dentists. A number of concerns were raised in relation to treatment services, particularly in relation to privacy and confidentiality issues and a consequent reluctance to enter counselling. Related to this broader treatment need, another theme which emerged was the perceived need to develop a more holistic, individual-centred approach to address the multi-faceted problems being encountered by users. A broad consensus that methadone was not the whole answer to these complex issues came out of the focus groups. The focus groups also heard many positive comments about individual staff members and institutions.

One of the most innovative aspects of the research project was the presentation of the research findings to an informal meeting of service providers and key stakeholders. This meeting, which was attended by representatives from Merchants Quay, the Health Service Executive, St James's Hospital, the Drug Misuse Research Division of the Health Research Board, AOM Addiction Services, the North Inner City Partnership, UISCE, PPR, a pharmacist, GPs and a dentist with experience in treating drug users, provided a useful opportunity to discuss the findings of the report and identify practical steps to address the issues identified.

National drug treatment outcomes at one year

On 11 September 2006, a team at the National University of Ireland, Maynooth, published the Research Outcomes Study in Ireland (ROSIE) (Cox *et al.* 2006) on behalf of the National Advisory Committee on Drugs (NACD). This report focused on outcomes for adult opiate users at one year following entry to treatment.

At baseline, the study recruited 404 opiate users aged 18 years or over entering treatment at inpatient facilities (hospitals, residential programmes and prisons) or outpatient settings (community-based clinics, health board clinics and general practitioners). The opiate users selected were entering treatment for the first time, or were returning to treatment after a period of absence, at any one of 54 services nationwide. The interview schedule collected data on:

- drug use in the 90 days preceding the interview, specifically, type, frequency, quantity and cost;
- measures of harmful practices and consequences;
- health status, using a self-rated physical and psychosocial health assessment;
- social functioning, including accommodation, employment, and involvement in crime;
- mortality, using information obtained from the participants' contacts and the General Mortality Register.

The participants were interviewed at intake (baseline), at six months following entry to treatment (not presented) and again at one year after intake. The baseline data were collected between September 2003 and July 2004. Of the 404 opiate users interviewed at intake, 373 (92%) were traced one year later, of whom 305 were interviewed. Of the other 68 who were traced, 66 did not wish to participate in the follow-up interview and two had died. The characteristics of the 99 individuals who were not interviewed one year after intake did not differ from those of the interviewees. The data presented here compares the experience at intake to that at one year for the 305 participants interviewed at both time-points.

There was a reduction in the proportion of participants who reported using heroin in the 90 days preceding data collection, from 81% at intake to 48% at one year. The average frequency of heroin use by participants in a 90-day period reduced from 43 out of 90 days at intake to 16 out of 90 days at one year. The average quantity of heroin consumed each day over a 90-day period decreased from 0.9 grams at intake to 0.3 grams at one year. There was a corresponding reduction in the average amount spent on heroin on a typical day, from €75 at intake to €24 at follow-up.

There were large reductions in the proportions of participants who reported use of non-prescribed methadone, cocaine powder, crack cocaine and non-prescribed benzodiazepines at one year compared to the baseline interview. There were smaller reductions in cannabis and alcohol use over the same time period.

The proportion of participants reporting use of more than one drug decreased from 78% at intake to 50% one year later.

The proportion of participants who reported injecting drug use in the 90 days preceding data collection decreased from 46% at intake to 29% at one year. The reported average number of days injecting over a 90-day period decreased from 21 out of 90 days at intake to 9 out of 90 days at one year. There was a corresponding decrease in the average number of times participants injected per day, from 1.8 at intake to 0.8 at one year. There was a small decrease in the proportion reporting an overdose, from 7% at intake to 4% at follow-up.

Between intake and one-year follow-up, there were reductions in the numbers of participants reporting 5 of 10 common symptoms of physical illness experienced by drug users; there were reductions also in the numbers of men reporting 6 of 12 selected symptoms of mental illness experienced by drug users. Women participants did not report reductions in the selected symptoms of mental illness.

The average number of visits by participants to a general practice, or to employment, educational or homeless services, had increased at the time of follow-up.

The proportion of participants reporting involvement in acquisitive crime decreased from 31% at intake to 14% at one year. In addition, the proportion reporting selling or supplying drugs reduced from 31% at intake to 11% at one year.

Of the 305 participants interviewed at both time points, 7% were not using drugs at the time of entry to treatment, while 27% were not using drugs one year later. Of the 285 participants for whom treatment status was reported, 30% completed their first (index) treatment, 14% were transferred to another treatment site, 18% did not complete their index treatment and 38% were still in their index treatment. At the one-year follow-up interview, 82% of these 285 participants were either continuing in their index treatment or had commenced another treatment episode.

Adult opiate users reported positive changes in drug use, risk behaviour, health status, service contact and criminal behaviour at one year following entry to treatment, which indicates that treatment for these opiate users was beneficial. According to the authors, drug treatment contributed to changes in the lives of opiate users, but it is not feasible to isolate the exact contribution of the treatment, on its own, from that of other influences.

During the coming year the outcomes of the ROSIE study will be published by treatment modality and there will be a separate analysis presenting outcomes from detoxification and substitution treatment.

6. Health correlates and consequences

6.1 Overview

This section presents new data on the incidence of drug-related mortality, and on the incidence and prevalence of blood-borne viruses. The definitions used are presented where necessary in the relevant sections.

6.2 Drug-related deaths and mortality among drug users

Problem drug use can lead to premature death. Deaths can occur as a result of overdose (both intentional and unintentional), actions taken under the influence of drugs, medical consequences and incidental causes. Drug-related deaths and mortality among drug users are indicators of the consequences of problem drug use in Ireland.

General Mortality Register

The data presented in this section provide the number of direct-drug-related deaths between 1980 and 2003, based on unpublished data from the Central Statistics Office (CSO). Direct-drug-related deaths are those occurring as a result of overdose. At the European level, the EMCDDA (2002) has developed a standardised method for extracting data on drug-related deaths from the mortality registers in all member states. Staff at the CSO extracted and collated the data in April 2006, using the EMCDDA's 'Selection B' definition of drug-related death.

Figure 6.2.1 presents the numbers of direct-drug-related deaths in Ireland between 1980 and 2003, extracted from the General Mortality Register (Long *et al.* 2006a). There were few deaths in the eighties. Between 1990 and 1994, there was a small but steady increase in the number of drug-related deaths, and between 1995 and 1999 a substantial increase. This was followed by a considerable decline in the number of deaths between 2000 and 2002. In 2003, the number of drug-related deaths increased marginally (to 96) when compared to 2001 (93) and 2002 (90).

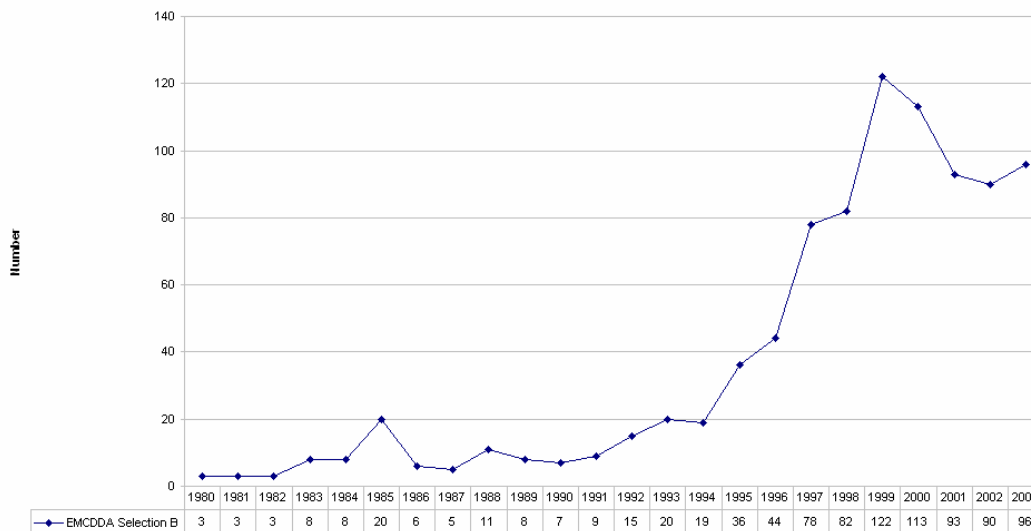


Figure 6.2.1 Number of direct drug-related deaths in Ireland reported by the CSO, 1980 to 2003 (unpublished data from the vital statistics)

In 2003, the average age at death as a result of a direct drug-related incident was 35.7 years, and 29% of direct drug-related deaths were among females. Between 2001 and 2003, 60% of direct drug-related deaths were opiate-related.

Figure 6.2.2 presents the numbers of direct drug-related deaths in Dublin and in the rest of Ireland between 1980 and 2003.

According to data from the General Mortality Register, almost all direct drug-related deaths between 1980 and 1994 occurred in Dublin. Between 1995 and 1999, there was a substantial increase in drug-related deaths in Dublin, from 33 to 96; and there was a steady increase in drug-related deaths outside the Dublin area, from 3 to 26.

Between 2000 and 2003, there was a sharp decline in direct drug-related deaths in Dublin, from 83 in 2000 to 46 in 2003. This possibly reflects the decrease in new opiate users, the increase in methadone treatment places, the reduction in average waiting times for methadone treatment and the provision of methadone treatment in the Dublin prisons. During this period there was a continued increase in drug-related deaths outside Dublin, from 30 in 2000 to 50 in 2003. In 2003, the number of drug-related deaths outside Dublin exceeded the number of drug-related deaths in Dublin for the first time. The data for outside Dublin follow trends in problem opiate use in that geographical area.

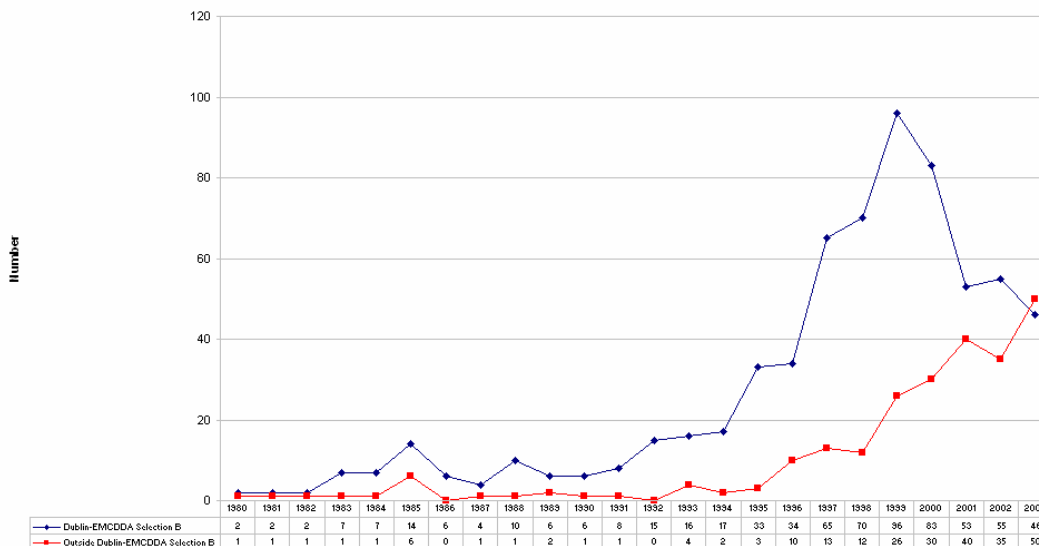


Figure 6.2.2 Number of direct drug-related deaths in Ireland, by place of death, reported by the CSO, 1980 to 2003(unpublished data from the vital statistics)

The approach to opiate treatment in Dublin has been successful. It is likely that the introduction of opiate treatment in prisons and the reduction in average waiting times, in conjunction with the increase in methadone treatment places, have been key strategies in achieving this reduction. A similar approach to the management of problem opiate use is required outside Dublin.

Special drug-related deaths register

On 26 September 2005, government officials, community organisations, service providers, representatives of the Garda, along with the media and other interested parties, gathered at Ozanam House Community Resource Centre in Dublin to mark the launch of the National Drug-Related Deaths Index. The Index was established to address Action 67 of the National Drugs Strategy, which identifies the need to develop an accurate mechanism for recording the number of drug-related deaths in Ireland. The index will be compiled from a number of data sources, including the coroner service, Hospital Inpatient Enquiry (HIPE) Scheme, Central Treatment List and General Mortality Register. In order to inform the development of the National Drug-Related Deaths Index, Long and colleagues (2005a) published Overview 1, *Drug-related deaths in Ireland, 1990–2002*, which was summarised in the 2005 National Report.

6.3 Drug-related infectious diseases

Overview of blood-borne viruses

In October 2006, the Health Research Board published Overview 4, which describes what is known about blood-borne viral infections among drug users in Ireland (Long 2006b). The data pertaining to injecting drug users are presented where possible, and where the data are not analysed by injecting status or where injecting status is not ascertained, the data on all drug users are presented. The analysis presented in this section is based on disease notifications reported to the Health Protection Surveillance Centre (formerly

known as the National Disease Surveillance Centre) during the period 1995 to 2005 and on ad hoc research studies. The main observations are:

- HIV

Figure 6.3.1 presents the number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland; data from 1982 to 1985 were excluded from the figure as these four years were combined in the source records. The data presented in Figure 6.3.1 are based on data reported to the Department of Health and Children, the National Disease Surveillance Centre and the Health Protection Surveillance Centre. Kelly and Clarke (2000), reported a fall in the number of HIV cases among injecting drug users between 1994 and 1998, with about 20 cases per year compared to about 50 cases each year in the preceding six years. In 1999, there was a sharp increase in the number of cases among injecting drug users, which continued into 2000, with 69 and 83 new cases respectively. Between 2001 and 2003 there was a decline in the number of new injector cases (38, 50 and 49 respectively) when compared to 2000 but the number was higher than in 1998. In 2004, once again there was an increase (to 71 cases) in the number infected through injecting drug use compared to the preceding three years. In 2005 there were 66 cases infected through injecting drug use. It was difficult to interpret the trend due to the relatively small numbers diagnosed each year, so a smoother curve (red line in Figure 6.3.1) was calculated using a rolling centred three-year average. This curve presents an increase in the annual number of HIV cases in 1999; this higher number of cases was sustained between 2000 and 2004. This indicates a true increase in the number of cases.

Of the 66 new HIV cases among injecting drug users reported to the Health Protection Surveillance Centre in 2005, 37 were male and 29 were female and the average age was 30.5 years. Of the 60 cases for whom place of residence was known, 55 lived in the HSE Eastern Region.

According to data from prevalence studies, around one-tenth of injecting drug users in drug treatment are HIV positive. Older age and high-risk injecting and sexual practices are associated with testing positive for HIV. The increase in HIV infections over the last five years requires investigation.

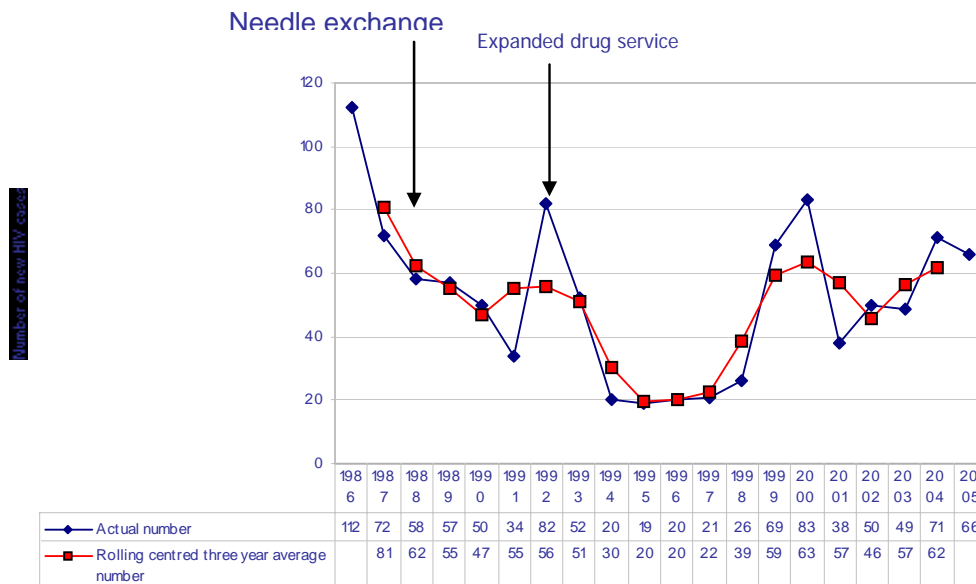


Figure 6.3.1 Actual number and rolling average number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland, 1986 to 2005

- Hepatitis B

From 1997 to 2000, there was a sharp increase in the number of cases identified for the first time; in 1997 there were 143 newly identified cases and in 2003 there were 547. Many of the newly identified cases were likely to be immigrants from moderate- to high-endemicity countries. In the HSE Southern Area between 2000 and 2002, 95% or more of hepatitis B cases diagnosed were asylum seekers from such countries. Up to the end of 2004, the notification system did not categorise cases by risk group or differentiate between new and previously diagnosed cases.

The results of prevalence studies indicate that just under one-fifth of injecting drug users in treatment have ever been infected with hepatitis B and approximately 2% are chronic cases. Older age, high-risk injecting practices and sexual practices are linked to a positive hepatitis B status.

- Hepatitis C

Among the changes to infectious disease legislation introduced on 1 January 2004 was the inclusion of hepatitis C in the list of notifiable diseases. There were 1,154 cases of hepatitis C reported in 2004, compared to 85 cases of 'viral hepatitis, type unspecified' in 2003. In 2004, 954 cases were notified by the HSE Eastern Region and 200 cases were notified by the HSE areas outside the Eastern Region. Each of the seven HSE areas outside the Eastern Region reported cases of hepatitis C, ranging from five in the HSE North Western Area to 45 in the HSE Southern Area. Three out of every five hepatitis C cases reported were male. Of the 1,132 cases for whom age and gender were known, 83% were aged between 20 and 44 years.

The results of prevalence studies indicate that around 70% of injecting drug users attending drug treatment tested positive for antibodies to the hepatitis C virus. High-risk injecting practices and increasing time spent in prison are associated with a positive hepatitis C status.

- Co-infection

Little has been published in Ireland on the prevalence of co-infection with HIV and/or hepatitis B and/or hepatitis C. The two national prison surveys in the late nineties presented data on co-infection among prisoners. These data indicated that approximately one-fifth of prisoners testing positive for hepatitis C were also infected with either hepatitis B or HIV. Up-to-date information is required. Both HIV co-infection and, independently, high rates of alcohol consumption among those infected with hepatitis C are associated with more rapid disease progression and higher death rates.

Both HIV co-infection and, independently, high rates of alcohol consumption among those infected with hepatitis C are associated with more rapid disease progression and higher death rates. The presence of these factors has a negative effect on hepatitis C outcomes.

- Surveillance system

Newly diagnosed HIV cases are reported directly to the Health Protection Surveillance Centre (HPSC) through a case-based, extended surveillance system, and staff at the HPSC collate these data on a six-monthly basis. Up to 2005, information on risk factors was not included in the data recorded on newly diagnosed cases of hepatitis B and hepatitis C, which makes it difficult to monitor the number of newly diagnosed cases of these infectious diseases among injecting drug users. It also means that Ireland has been unable to provide data to the EMCDDA on the incidence of hepatitis B and hepatitis C among injecting drug users. Action 39 of the European Union Drugs Action Plan 2005–2008 requires member states to comply with the requirements of the key indicators to measure the drug situation. The incidence and prevalence of HIV, hepatitis B and hepatitis C among injecting drug users is one of the five key indicators. In recent years, the HPSC has improved the reporting of newly diagnosed cases of hepatitis B and hepatitis C. The number and proportion of cases for whom risk factor data were reported is very low. (Table 6.2.1).

Table 6.2.1 Number (%) of acute and chronic hepatitis B cases reported to the HPSC, by risk factor status, 2005 and 2005

Hepatitis B status	2004			2005		
	Acute Number (%)	Chronic Number (%)	Unknown Number (%)	Acute Number (%)	Chronic Number (%)	Unknown Number (%)
Injecting drug user	1 (2.8)	0 (0.0)	0 (0.0)	0 (0.0)	3 (1.6)	1 (7.7)
Other	35 (97.2)	95 (100)	1 (100)	49 (100)	182 (98.4)	12 (92.3)
Total with enhanced data	36	95	1	49	185	13
Total number without enhanced data	21 (36.8)	402 (80.9)	168 (99.4)	25 (33.8)	521 (73.8)	111 (89.5)
Total number of cases	57	497	169	74	709	124

Source: unpublished data from the HPSC

Recent ad-hoc blood-borne viral studies

A number of studies published in 2005 update or advance our knowledge of hepatitis C among drug users in Ireland.

Grogan and colleagues (2005), assessed the uptake of screening for, and estimated the prevalence of, hepatitis C in 358 heroin users attending 21 drug treatment clinics in the HSE South Western Area up to December 2001. A one-in-four systematic sample of clients prescribed methadone in the 21 drug treatment clinics in the area in December 2001 was selected from the Central Treatment List. Data collected from the clinical records showed that 88% of the sample had had a test for hepatitis C, of whom 66% had tested positive. These results are in line with those from other studies in a similar setting. The authors point out that the results were ascertained from clinical records and pertain only to those documented in the clinical records. The tests recorded had been administered over an extended time period and those testing negative at their first test may have subsequently sero-converted and not have had a repeat test. In addition, injector status was not ascertained and the authors acknowledge that the proportion of injectors testing positive for each virus would be higher.

In another published study, Keating and colleagues (2005) estimated the proportion of hepatitis C positive individuals with each genotype in an intravenous drug-using cohort, and then estimated the proportion that spontaneously cleared the hepatitis C virus. The study followed the progress of 496 hepatitis C antibody-positive individuals attending five drug treatment centres in Dublin between January 1997 and June 2001. Of the 299 PCR-positive samples that had their genotype determined, genotypes 1 and 3 were the most common (see Table 6.3.1). The PCR test detects whether the virus is still in the blood and will show if a person has an ongoing infection.

Table 6.3.1 Number of PCR positive samples of selected hepatitis C antibody positive individuals attending five drug treatment centres in Dublin, by genotype

Genotype	Number (%)
Total = 299	
1	146 (48.8%)
2	6 (2.0%)
3	145 (48.5%)
4	2 (0.7%)
5	0 (0.0%)
6	0 (0.0%)

Source: Kelly *et al.* (2005)

Of the 496 hepatitis C antibody-positive participants in the sample, 191 (38.5%) were shown to be HCV RNA negative when re-tested, indicating that they had spontaneously cleared the virus. A higher proportion of women (47.4%) than men (34.5%) cleared the virus spontaneously. A higher proportion of those with a history of jaundice (12.0%) than those who reported no history of jaundice (7.9%) cleared the virus.

Smyth and colleagues (2005a) examined the contribution of unsafe injecting practices and the social context of injecting in Dublin to infection with hepatitis C. Of the 242 participants who completed the questionnaire, 159 were tested for hepatitis C; of these, 61% tested positive for hepatitis C. After controlling for other

factors, the authors found that an increased number of lifetime injecting episodes increased the risk of hepatitis C infection. In relation to the social context, individuals who injected in the home of another injecting drug user were almost five times more likely to test positive for hepatitis C than those who injected in their own home or elsewhere. Individuals who injected in the company of close friends or family members were around three times more likely to test positive for hepatitis C than those who injected with acquaintances.

Cullen and colleagues (2005) examined the experiences with respect to risk practices of heroin users attending a general practice for investigation of and treatment for hepatitis C, over a six-week period in 2002. The study questionnaire had a mix of closed and open questions. At the time of the study, 38 former or current heroin users were registered with the practice. Of these, 25 (66%) agreed to be interviewed. Those interviewed were more likely to be female and older than the other heroin users attending the practice. At the time of the study, 23 of the 25 participants were receiving methadone maintenance. Twenty-two participants said that they had tested positive for hepatitis C and, of these, 15 had consumed alcohol in the week prior to the study. Nine had consumed more than the recommended amount of alcohol per week for their gender. Of note, eight reported neither drinking excessively nor using heroin in the previous six months and were therefore suitable for investigation. Only four of the eight suitable clients were referred for further investigation and one had commenced treatment. Those respondents who reduced their alcohol intake did so because they were concerned about their health, while those who increased their alcohol intake did so to substitute for heroin. Some respondents had a negative perception of liver biopsy; those who had undergone this investigation reported that the procedure was not as difficult to tolerate as expected. Many respondents had negative perceptions of antiviral treatment. The experience of treatment by medical and nursing personnel at secondary treatment services was mixed.

6.4 Psychiatric co-morbidity (dual diagnosis)

Trends in alcohol and drug disorders in psychiatric hospitals

The data presented in the latest report in an annual series that began 40 years ago, *Activities in Psychiatric Inpatient Units and Hospitals 2004*, shows that the total number of admissions to inpatient care continued to fall (Daly *et al.* 2005) (Walsh and Daly 2004). There was an increase in admissions to general hospital psychiatric units and a decline in use of psychiatric hospitals.

Figure 6.4.1 presents the rate of first admissions to inpatient psychiatric services with a diagnosis of alcohol disorder, per 100,000 of the population in Ireland between 1990 and 2004. It is notable that the rate of alcohol-related admissions decreased steadily between 1991 and 2004 and more than halved during the reporting period. This reflects changes in alcohol treatment policy and practices during the period and the resultant increase in community-based and special residential alcohol treatment services.

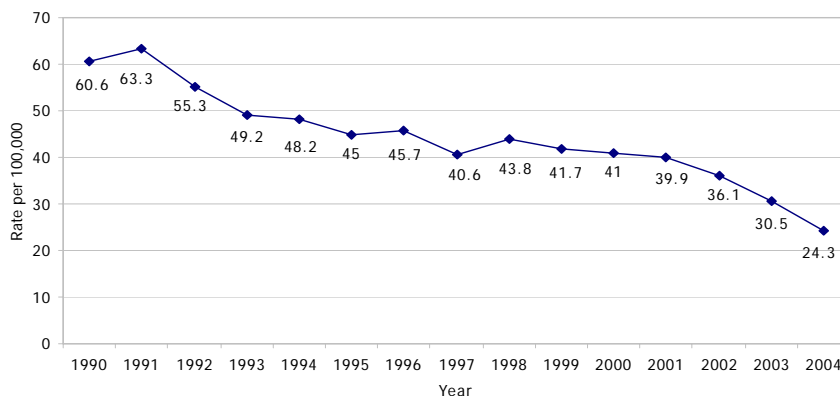


Figure 6.4.1 Rate of psychiatric first admissions with a diagnosis of alcohol disorder (using the ICD-10 three character categories) per 100,000 of the population in Ireland and reported to the NPIRS, 1990 to 2004

Figure 6.4.2 presents the rate of first admissions to inpatient psychiatric services with a diagnosis of drug disorder, per 100,000 of the population in Ireland between 1990 and 2004. It is notable that the rate increased steadily between 1990 and 1995, with a dip in 1996, and further annual increases between 1997 and 2001. The rate of drug-related admissions was almost three times higher in 2001 than it was in 1990. The dips in 1996 and 2002 can be partly explained by the fact that the rates are calculated from new larger census numerators in 1996 and 2002 compared to the year preceding each of these years and the small

number of drug-dependent cases each year would be sensitive to this change in numerator. The increasing rate of new cases of drug-related admissions between 1990 and 2001 reflects the increase in problem drug use in Ireland and its burden on the psychiatric services. There was a notable decrease in 2002, which was sustained in 2003. This overall decrease since 2001 possibly reflects an increase in community-based specialised addiction services during this period.

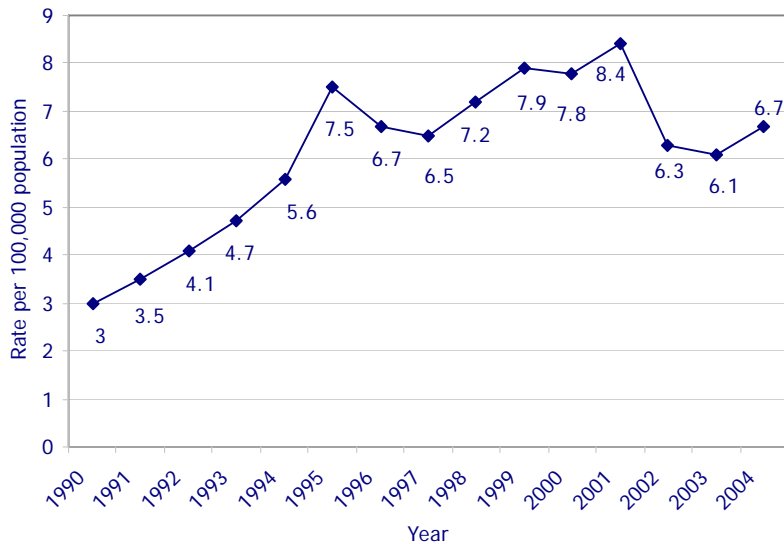


Figure 6.4.2 Rate of psychiatric first admissions with a diagnosis of drug disorder (using the ICD-10 three character categories) per 100,000 of the population in Ireland and reported to the NPIRS, 1990 to 2004

Mental illness among prisoners

The first systematic and representative survey of mental health among the Irish prison population using standardised research diagnostic methods was implemented in 2003 (Kennedy *et al.* 2005). Using the schedule for schizophrenia and affective disorders (lifetime version) and the severity of dependence questionnaire, researchers assessed the mental health of five distinct samples within the prison population. The samples were 615 (7%) men committed to prison, 232 (50%) men in custody on remand (Linehan *et al.* 2005), 438 (15%) sentenced men, 94 (9%) women committed to prison and 92 (90%) women in prison. In total, 1,471 individuals participated in the study, of whom 1,285 were men and 186 were women; one woman commenced but did not complete the study. Response rates for the five samples ranged between 71% and 90%. The sample of men serving sentences was representative of the population of men serving sentences (excluding life sentences) with respect to age, length of current sentence and time spent in prison.

According to the authors, between 61% and 74% of prisoners had a substance use disorder at the time of the survey, with little difference between the proportions of men and women affected (Table 6.4.1). Between 12% and 23% of men had a mental illness (excluding a substance use disorder). The rate of current mental illness for women was not reported. Of note, 29% of female committals and 39% of sentenced or remanded women had had a mental illness in the six months prior to the study. The authors reported that a number of prisoners with mental illness also had a substance misuse disorder. The rate of drug dependence was higher than the rate of alcohol dependence among male committal and sentenced prisoners. Higher proportions of women than men were attending drug treatment (including methadone substitution) prior to committal.

Table 6.4.1 Rates of current other mental illnesses, with 95% confidence intervals, attendance at drug treatment prior to committal, and current methadone substitution in the Irish prison population in 2003

	Male committal prisoners (615)	Male remand prisoners (232)	Male sentenced prisoners (438)	Female committal prisoners (94)	Female sentenced and remand prisoners (92)
	% (95% CI)				
Substance use disorder	60.6 (56.7–64.4)	65.6 (61.5–69.5)	73.7*	65.6 (55.5–74.5)	
Alcohol abuse and dependence	36.2 (32.2–39.8)	34.7 (30.9–38.8)	–	–	–
Alcohol dependence	23.4 (20.2–26.9)	27.6 (24.0–31.5)	45.1*	–	–
Drug dependence	32.8 (29.5–37.0)	43.3 (39.3–47.6)	58.8*	–	–
Mental illness (excluding substance use disorder)	11.9 (9.6–14.8)	19.0(14.4–24.5)	22.6*	25.8 (18.0-35.5)	
Co-morbid substance use and mental illness	7.4 (–)	–	–	–	–
Attended drug treatment prior to committal	16.5	12.2	5.5	35.5	29.3
Currently receiving methadone substitution	16.7	14.3	3.9	35.5	34.8

– Not reported

* Weighted percentage

Sources: Kennedy *et al.* (2005) and Linehan *et al.* (2005)

6.5 Other drug-related health correlates and consequences

Children of drug users

Ciaran and Fitzpatrick (2005) described the psychosocial and clinical characteristics of children referred to a community-based child and adolescent mental health service, whose mothers reported that they took opiates during the pregnancy. In a retrospective study, the case notes of all children whose mothers reported that they had been exposed to opiates in utero, and who were referred to the Department of Child and Family Psychiatry, Mater Hospital, between 2001 and 2003, were identified by maternal reports. Information was obtained on age, gender, referral source, socio-economic group, family type, number of siblings, involvement of community care services, nature of presenting problems, diagnosis, interventions offered, and treatment difficulties. Information was recorded anonymously.

Fifteen children were identified, of whom nine were male. Most were found to be living with their mother alone or with their mother and a partner, and to be socially and financially disadvantaged. Their presenting complaints usually involved combinations of aggressive, hyperactive, and oppositional behaviour. Diagnoses included ADHD, a speech and language disorder, and an axis II disorder. Interventions were frequently unsuccessful because of parents' difficulties with attending appointments and because of instability in the families' living arrangements. The authors conclude that these children, due to a complex interplay of biological and psychosocial adversity, are at serious risk of ongoing psychiatric disorders in childhood and adolescence and of adverse outcomes in adult life. According to the authors, a prospective cohort study of all children born to opiate-dependent mothers is necessary to quantify the level of risk and identify resilience factors.

7. Responses to health correlates and consequences

7.1 Overview

This section presents new data on responses to drug-related mortality, blood-borne viruses and psychiatric co-morbidity. The definitions used are presented where necessary in the relevant sections.

7.2 Prevention of drug-related deaths

Emergency services can administer naloxone

On 9 August 2005, the minister of state at the Department of Health and Children introduced a new Statutory Instrument, the Medical Products (Prescription and Control of Supply) (Amendment) Regulations 2005 (Statutory Instrument Number 510 of 2005). These regulations permit the supply of a number of medicinal products (including naloxone, for the management of respiratory depression secondary to a known or suspected narcotic overdose) to pre-hospital emergency care providers. This medication can be administered by advanced paramedics in accordance with clinical procedure guidelines or following a medical practitioner's instruction. In addition, emergency technicians may administer naloxone in accordance with a medical practitioner's instruction. This will improve the speed of response to narcotic overdoses and may prevent deaths due to overdose of opiate-type drugs.

Providing health education on accidental drug overdose

Branagan and Grogan (2006) reported the results of an evaluation of a health promotion programme to educate drug users on how to prevent and how to deal with an overdose. The health promotion intervention consisted of a poster and leaflet. A convenience sampling method was employed and 20% of service users attending 15 drug treatment clinics were asked to complete the questionnaire. In total, 200 questionnaires were distributed; 194 (97%) were completed. Of the 194 respondents, 81% had read the poster and 78% recalled a useful message from the poster. The most common useful message reported was the importance of placing a person suspected of having overdosed in the recovery position, and the instructions on how to do so. Over 70% reported that they changed the way they thought about or dealt with an overdose. One-fifth of the respondents suggested improvements to the poster and leaflet. This nurse-led intervention had an important and positive impact on service users. Consequently, circulation of leaflets has been extended to other agencies who encounter drug users.

The report of a working group convened by the Irish College of General Practitioners (ICGP) to examine the issue of drug-related deaths has called for the urgent implementation of a national, co-ordinated strategy to prevent opiate-related deaths (Delargy 2006). The ICGP working group was chaired by Dr Ide Delargy, director of the Drug Misuse Programme of the ICGP and included representatives from HSE, the Health Research Board, the voluntary sector and the prison service.

The ICGP working group suggested that responsibility for the implementation of such a strategy might be given to the National Drugs Strategy Team or the National Advisory Committee on Drugs. The group welcomed the Health Research Board's setting up of the National Drug-Related Deaths Index and recommended establishing links between that Index and the National Suicide Prevention Strategy and the National Parasuicide Register.

Among other recommendations of the working group were:

- all sudden and unexplained deaths should have a toxicology screen at autopsy;
- information and resource materials should be standardised across all treatment and support locations;
- all personnel who treat drug users should receive training in overdose prevention and basic life-support training;
- high-risk people should be identified and service providers should address risky behaviours among service users;
- consideration should be given to providing education in overdose prevention for service users;
- drug users discharged from prison should be allowed to link in with their local drug treatment agency, with contact numbers included in a 'pre-release' pack;
- all drug users undergoing detoxification should be told of the risks of overdose following detoxification;
- Garda members should receive training in overdose prevention;
- the National Drugs Strategy Team should research the feasibility of collecting data on non-fatal opiate overdoses or near misses.

7.3 Prevention and treatment of drug-related infectious diseases

Overview of blood-borne viruses

In October 2006 the Health Research Board published Overview 4 which describes what is known about blood-borne viral infections among drug users in Ireland (Long 2006b). The analysis presented, covering responses to drug-related infectious diseases, is based on ad hoc research studies.

The main observations are:

HIV treatment is available to injecting drug users through genito-urinary medical units and infectious disease clinics in Ireland. In 2003, a study reported that a number of stable injecting drug users were suitable for treatment, but were not receiving treatment at the time of the study. Two studies demonstrated that decentralised treatment at drug treatment centre level achieved high uptake and compliance with HIV treatment.

The uptake and completion rates of hepatitis B vaccination are much higher in the HSE South Western Area (56%) and in Drug Treatment Centre Board cohorts (86%) for the period 2001 to 2003 than those reported in prisoners or in general practice level in Ireland between 1998 and 2001. This possibly indicates an increase in hepatitis B vaccine coverage in recent years. There are no published data on the coverage of hepatitis B vaccine among injecting drug users outside the HSE Eastern Region. It is important to ensure that hepatitis B vaccine is administered as early as possible in a drug user's career; therefore, needle exchange and low-threshold methadone services require facilities to deliver hepatitis B vaccinations on a daily basis.

There are seven specialist hepatology centres for adults and one for children in Ireland. A number of studies demonstrated low rates of access to and uptake of treatment for hepatitis C among injecting drug users. Two small studies demonstrated that a decentralised approach to initial assessment at general practice level and hepatitis C treatment at drug treatment centres achieved higher uptake and compliance rates than the current centralised approach.

The principles of expanded and accessible harm reduction measures are documented in both the AIDS Strategy 2000 and the mid-term review of the National Drugs Strategy and will lead to synergistic actions to stem the current increase in new HIV cases among injecting drug users. The publication of the HSE Eastern Region's hepatitis C strategy is awaited.

Merchants Quay Ireland harm reduction services

Up to 2003, there were two agencies (ERHA and Merchants Quay Ireland (MQI)) collating information on clients attending needle- and syringe-exchange services. This information is no longer collated by the ERHA. Therefore, it is not possible to provide total numbers attending needle exchanges. Both organisations still collect baseline information from each client on the first visit, and on each subsequent visit they update the client's record. The minimum information collected includes socio-demographic characteristics, history of problem drug use and treatment, risk behaviours and services provided at each visit. Each client provides his or her initials and date of birth for identification purposes and an identifier code is given based on this information and is used to record subsequent visits and avoid duplication of records. In the HSE Northern and East Coast Areas, staff have commenced entering all client contacts in the Drugs and AIDS Information System, which will replace the current paper submissions to the ERHA. However, at present it is not possible to download this data.

MQI launched its *Annual Review 2004* on 16 September 2005 (2005). According to the report, the services provide creative and innovative responses to drug use and homelessness in Ireland. The organisation estimated that there are 2,009 homeless drug users in Ireland. A comprehensive set of drug services is provided to drug users through MQI, ranging from needle exchange to reintegration programmes. The numbers of drug users who received harm reduction services through MQI in 2004 are presented in the table below.

Table 7.3.1 Numbers of drug users who received harm reduction services through MQI in 2004

Name of service	Type of intervention	Number of participants	Outcomes
Needle Exchange– Health Promotion Unit	Exchange of injecting equipment	3,300 (including 450 new cases)	Not applicable
	Safer injection training	256 workshops	
	Safe sex advice	Not available	
	Health and social care services	Not available	
	Outreach service	Not available	

Source: Mechants Quay Ireland, 2005

7.4 Interventions related to psychiatric co-morbidity

The report of the Expert Group on Mental Health Policy (2006), *A Vision for Change*, was published on 24 January 2006. The report details a comprehensive model of mental health services in Ireland. This model will emphasise the development of mental health services in the community over the next five to ten years.

According to the expert group, 'individuals [adults and children] whose primary problem is substance abuse and who do not have [other] mental health problems will not fall within the remit of mental health services'. In a departure from the international classification system, substance abuse (dependence) will no longer be included among the categories of mental health problems in Ireland.

According to the report, the major responsibility for the care of those with substance abuse (dependence) lies outside the mental health services, and rests with separate services that have their own funding structure within Primary, Community and Continuing Care (PCCC) in the Health Service Executive. Historically, such funding was allocated for the care of those with drug dependence rather than alcohol dependence. The report does not clarify how the mental health services will reassign to the PCCC function the staff and finance currently used to address alcohol dependence in the mental health services.

The expert group states that beds in acute psychiatric facilities 'should not be used for routine detoxification, which should be done on an outpatient basis', and goes on to state that 'more complex detoxification should take place in acute general hospital facilities'. The policy report does not give the rationale behind this approach, nor does it indicate who will supervise such detoxifications in the general hospital.

In relation to the issue of substance abuse (dependence), the report recommends that:

- Mental health services for both adults and children will be responsible for providing mental health services to individuals who have another mental illness in addition to their substance abuse (dependence).
- General adult community mental health teams will care for adults with substance abuse and another mental health problem when the mental health problem is the primary problem.
- Specialist substance abuse mental health teams for adults with complex, severe substance abuse and mental disorders will be established. These specialist teams should establish clear links with local community mental health services, and clarify pathways in and out of their services.
- Two additional specialist substance abuse teams for children with substance abuse (dependence) and mental disorders should be established outside Dublin.
- A post for a national co-ordinator should be established in the PCCC function of the Health Service Executive. The co-ordinator should develop standards for the delivery of interventions to address alcohol and drug abuse (dependence) in Ireland and establish how such interventions will be linked to mental health.

7.5 Interventions related to other health correlates and consequences

Information for new (migrant) communities

An exploration by Corr (2004) of drug use among new communities in Ireland reported that drug users from new communities were generally unaware of drug service provision in Ireland, and were doubtful of the confidentiality of information held by such services. The report recommended that information material produced for these communities highlight the range of services provided in Ireland and their confidential nature. It also recommended that the information be translated into appropriate languages and distributed in places that drug users from new communities were most likely to frequent.

MQI, the largest voluntary sector provider of homeless and drugs services in Ireland, has taken the lead in this regard and recently produced information leaflets in English, Polish and Russian detailing service provision at MQI (Keane 2006). The leaflets contain details on services for drug users such as needle exchange, methadone prescribing, residential drug-free services, and settlement and integration services providing help with accommodation and training and employment support. Also included are details of the services for homeless people, including crisis support, meals service, primary healthcare and a women's health programme. Opening hours and direct-dial phone numbers specific to each service are provided.

8. Social correlates and consequences

8.1 Overview

There is no new information on social exclusion. In relation to drug-related crime, this chapter will report data on drug offences where criminal proceedings commenced and also on trends in such offences by drug type. The authors report on a new study conducted by the Drug Misuse Research Division as part of its Overview series: *Drugs and crime in Ireland. Overview 3* (Connolly 2006). The purpose of this overview was to compile and analyse existing data and available research on drug offences and drug-related crime in Ireland, to identify gaps in knowledge and to inform future research in this area.

8.2 Social exclusion

No new information is available.

8.3 Drug-related crime

Trends in drug offences

This section presents data on drug offences where criminal proceedings commenced and also on trends in such offences by drug type. These data are presented in the Garda annual reports. Data from the Garda reports prior to 2004 have been compiled and analysed by Connolly (2006). The authors will also consider data from the Garda annual reports for 2004 and 2005 (An Garda Síochána 2004a; An Garda Síochána 2005).

The vast majority of drug offences reported in the Garda annual reports come under one of three sections of the Misuse of Drugs Act 1977: Section 3 – possession of any controlled drug without due authorisation (simple possession); Section 15 – possession of a controlled drug for the purpose of unlawful sale or supply (possession for sale or supply); and Section 21– obstructing the lawful exercise of a power conferred by the Act (obstruction). Other offences regularly reported on relate to the unlawful importation into the State of controlled drugs contrary to Section 21; permitting one's premises to be used for drug supply or use contrary to Section 19; the use of forged prescriptions (Section 18); and the cultivation of cannabis plants (Section 17).

Figure 8.3.1 shows trends in the number of drug supply (s.15 Misuse of Drugs Act MDA 1977), possession (s.3 MDA 1977) and total drug offence prosecutions between 1995 and 2005. The majority of prosecutions are for drug possession, which increased from 5,065 in 2004 to 7,432 in 2005, an increase of almost 50% (46.7%). The recent increase during 2005 of total drug offences was caused by an increase in prosecutions for possession, with the number of supply offences remaining constant.

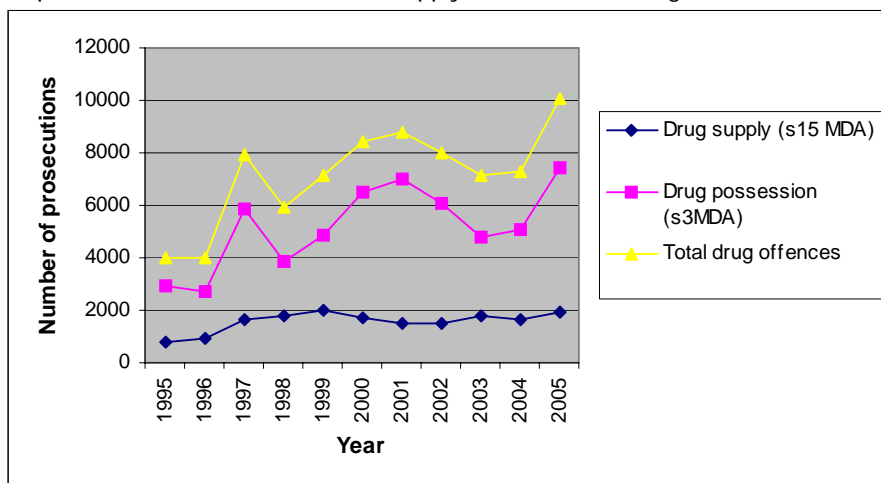


Figure 8.3.1 Trends in possession (s.3 MDA), supply (s.15 MDA) and total drug offence prosecutions, 1995–2005

Source: Annual reports of An Garda Síochána 1995–2005

Figure 8.3.2 shows trends in a selection of prosecutions for other offences where proceedings commenced between 2000 and 2005. There has been a steady rise in prosecutions for obstructing the lawful exercise of a power conferred by the Misuse of Drugs Act (s.21), with prosecutions increasing by just under 73% since 2000.

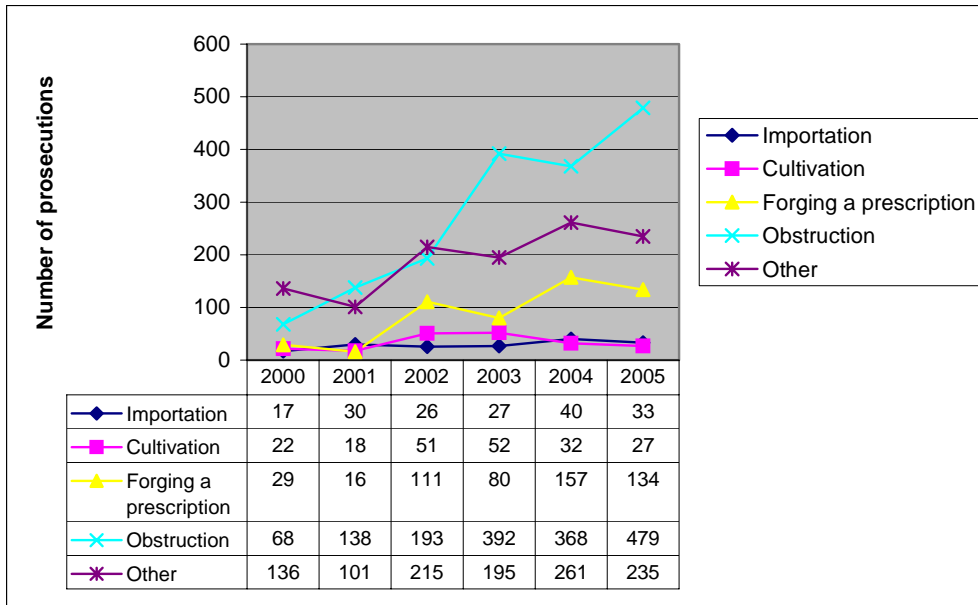


Figure 8.3.2 Selected MDA drug offences, excluding possession and supply, where proceedings commenced, 2000–2005

Source: Annual reports of An Garda Síochána, 2000–2005

Figure 8.3.3 compares trends in possession offences with the number of cannabis-related offences prosecuted from 1995 to 2005. It can be seen that most of the prosecutions which take place for drug possession are cannabis-related. Indeed, cannabis-related prosecutions have consistently formed the majority of all drug offences prosecuted. In 2005, such prosecutions accounted for just under 65% of all drug offence prosecutions.

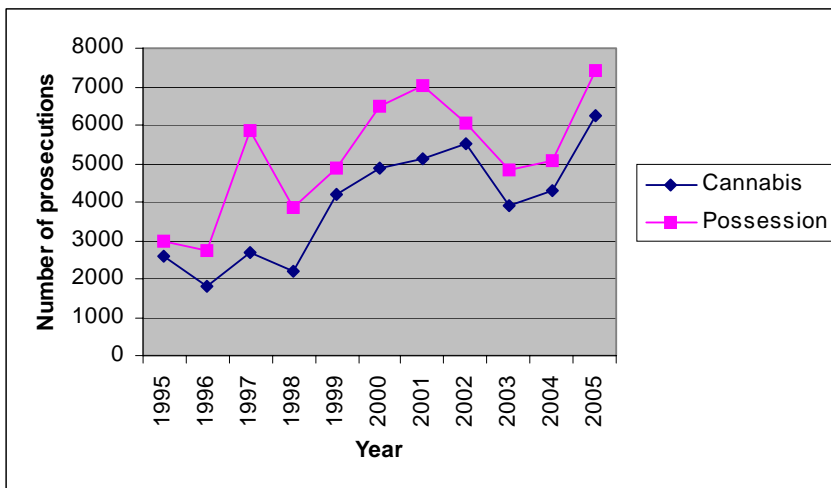


Figure 8.3.3 Trends in cannabis-related prosecutions and prosecutions for simple possession (s.3 MDA), 1995–2005

Source: Annual reports of An Garda Síochána 1995–2005

Figure 8.3.4 shows trends in drug-related prosecutions for a selection of drugs, excluding cannabis, from 2000 to 2005. In 2005, heroin-related prosecutions accounted for 10.65% of the total number of prosecutions in Ireland. Cocaine-related prosecutions accounted for 12.76% of the total, exceeding heroin-related prosecutions for the first time. Ecstasy-related prosecutions have declined steadily since 2000, decreasing from 2,086 prosecutions to 787 in 2005.

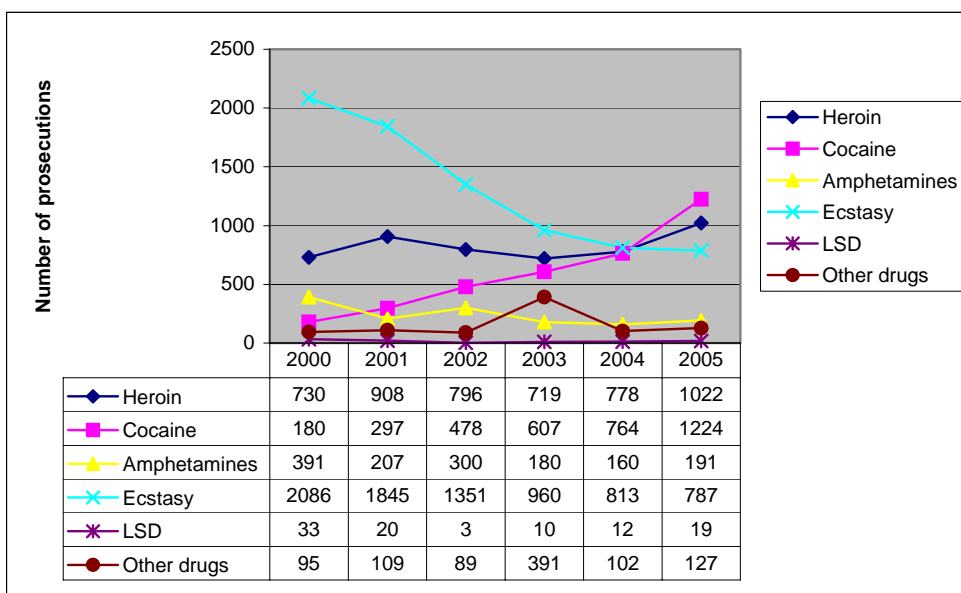


Figure 8.3.4 Trends in prosecutions for a selection of drugs, excluding cannabis, 2000–2005
 Source: Annual reports of An Garda Síochána, 2000–2005

The Garda National Drugs Unit (GNDU) reports a large increase in drug-related arrests (approaching 50%) between January 2005 and July 2006. The GNDU also reports several seizures of cocaine processing equipment, such as presses and vacuum packing equipment (GNDU, personal communication, August 2006).

Overview of drugs and crime in Ireland

Drugs and crime in Ireland, the third title in the Drug Misuse Research Division's Overview series, was published in May 2006 (Connolly 2006). The purpose of this Overview was to compile and analyse existing data and available research on drug offences and drug-related crime, to identify gaps in knowledge and to inform future research needs in this important area of drug policy.

The link between drugs and crime in Ireland exists simply by virtue of prevailing legislation which defines as criminal offences the importation, manufacture, trade in and possession, other than by prescription, of most psychoactive substances. Offences committed under this legislation are reported in the annual reports of An Garda Síochána. Overview 3 describes and analyses trends in drug offences since 1983. The limitations of official statistics in terms of describing the overall crime picture have been highlighted by a number of writers in this area. These limitations, specifically in relation to drug-related crime, are considered in the Overview.

Although the link between drugs and crime has been firmly established in the public consciousness in Ireland, there has been little sustained examination of the precise nature of this link. Most Irish drug users who receive sentences of imprisonment, for example, are punished, not for drug offences per se, but for offences committed as a consequence of their drug use, such as theft from the person, burglary, larceny or prostitution. Research studies have identified this clear link between some forms of illicit drug use and crime – findings which are consistent throughout criminological literature. Although the link between drug use, addiction and crime has been established by international and Irish research, identifying the precise causative connection between drugs and crime has been a primary preoccupation of many writers in this area. For the purpose of this Overview, the available research evidence is reviewed using four explanatory causal models: the psycho-pharmacological model, which identifies the drugs–crime link as arising as a result of the intoxicating effect of the drugs themselves; the economic-compulsive model, which assumes that drug users need to generate illicit income from crime to support their drug habit; the systemic model, which explains drug-related crime as resulting from activities associated with the illegal drug market; and the common-cause model, which suggests that there is no direct causal link between drugs and crime but that both drug use and offending behaviour are related to other factors, including socio-economic deprivation.

Another area which is considered in Overview 3 is one which is gaining increased attention in Ireland and throughout the European Union – the link between illicit drug use and driving offences.

Among the key findings are:

Drug offences

- Drug possession offences account for most drug offences recorded. In 2005, prosecutions for simple possession made up just under 74% of the total number of prosecutions, while supply offences accounted for just over 19% of the total.
- Cannabis-related prosecutions have consistently formed the vast majority of all drug-related offences prosecuted.

Drugs and crime: psycho-pharmacological links

- With regard to the psycho-pharmacological connection between drug use and violent crime, there is overwhelming evidence from the international literature of a connection between alcohol consumption and violence. Irish research, although limited, supports this finding.

Drugs and economically-motivated crime

- That there is an economic motivation to commit crime to purchase drugs has been supported by Irish research. This manifests itself in an increase in such crimes following addiction and the reduction of such crimes following participation in closely supervised and well-resourced drug treatment programmes. A number of studies of imprisoned drug users also highlight such links.
- It has been suggested that a 29% reduction in recorded crime in Ireland between 1995 and 1999 might be partially explained by the increased availability of methadone maintenance programmes throughout the Dublin area during that period.

Drugs and systemic crime

- Local studies have highlighted the association of local drug markets with significant levels of community disturbance and anti-social behaviour.
- The operation of local drug markets can engender significant apprehension and a reluctance among local residents to co-operate with law enforcement initiatives because of fear of reprisal from drug dealers.
- The association of drugs and violent crime with systemic aspects of the drug trade is borne out by the increasing evidence of drug-related gangland murders.

Drug-related crime and gender

- A 1999 study of female drug users working in the sex industry found that they differed from non-drug-using women in the same industry in that their primary motivation was to feed their drug habit. The study also found that such women tended to be younger and to have the least favourable health risk profile of all women working in prostitution.
- A 2001 study of drug-using prison inmates referred to them as 'reluctant criminals', in that they engaged in crimes which they perceived involved the lowest risk of arrest.

Common-cause model

- With regard to the drugs-crime link, studies of drug users have found them typically to be single, aged between 14 and 30, male, urban, often still living in the parental home, from large and often broken families, having left school before the legal minimum age of 16, with high levels of unemployment, with their best ever job being in the lowest socio-economic class, with a high number of criminal convictions and high rates of recidivism, with a history of family members being in prison, and a profile of extreme social disadvantage characterised by being from areas with a high proportion of local authority housing and often by the prevalence of opiate drug use and high levels of long-term unemployment.

The Overview makes a number of recommendations in relation to data limitations and future research in this area. These include the following:

Data limitations

- In order to enhance our understanding of the way in which drug laws are enforced and the amount of resources being used in this area, data should be compiled on the number of drug-related 'stop and search' operations and the number of drug-related arrests which take place.
- Crime statistics should be compiled and reported as close to the local level as possible.

Drugs and crime

Irish research in this area remains limited both in focus and in quantity. Future research needs to begin from a broader theoretical framework, one which acknowledges the complexity of the relationship between drug use and crime.

- Research should investigate the pathways and factors which encourage some drug users into further drug use and offending behaviour.
- Research is urgently needed on the relationship between alcohol and violent crime.
- Given the evidence in Ireland and elsewhere of the positive connections between drug treatment and a reduction in offending behaviour, further research should be conducted on drug treatment programmes and among drug users in receipt of treatment to ascertain best practice in this area, and the obstacles to progress.
- Research is required on the relation between drug use, drug-related crime and gender.

8.4 Drug use in prison

The first systematic and representative survey of mental health among the Irish prison population using standardised research diagnostic methods was done in 2003 (see Section 6.4). In total, 1,471 individuals participated in the study, of whom 1,285 were men and 186 were women; one woman commenced but did not complete the study. Response rates for the five samples ranged between 71% and 90%. The sample of men serving sentences was representative of the population of men serving sentences (excluding life sentences) with respect to age, length of current sentence and time spent in prison. According to the authors, between 61% and 74% of prisoners had a substance use disorder at the time of the survey, with little difference between the proportions of men and women affected.

At present there are no official statistics regarding the supply of drugs in Irish prisons and no studies have been conducted on the illicit drug market in Irish prisons. As part of a new strategy entitled *Keeping drugs out of prisons*, the IPS aims to strengthen research in the area of drug misuse in prisons. This research will be based on partnership between the relevant statutory and non-statutory bodies. Policies will include:

- commissioning and encouraging research on drug misuse in prisons
- evaluating all programmes and interventions
- making all research data available to and liaising regularly with the relevant bodies
- investigating systems to identify and manage patient outcome data
- evaluating the effectiveness of drug interventions using intervention outcome information.

Research will be used to inform policy makers and service providers in implementing the IPS strategy and to develop models of best practice (Sections 5.2, 5.4, and 9.3).

8.5 Social costs

No new information is available.

9. Responses to social correlates and consequences

9.1 Overview

In Ireland, efforts to develop a strategic approach to rehabilitation are at an advanced stage. It is envisaged that the employment, accommodation and educational needs of drug users will receive greater attention through the development of the rehabilitation pillar of the National Drugs Strategy. The association between drug use and labour market vulnerability is highlighted in report published by a key government advisory body. Evaluation of vocational training in local drugs task forces reveals the need for greater involvement of service users in designing treatment and reintegration plans. A review of the national homelessness strategies highlights the continuing challenge for service providers in meeting the needs of homeless drug users.

The publication of guidelines setting out the functions, composition and operation of joint policing committees, established by the Garda Síochána Act 2005, is also reported on. The authors report on a number of urban drug interdiction police initiatives.

9.2 Social reintegration

The *Mid-term Review of the National Drugs Strategy 2001–2008* (Steering group for the mid-term review of the National Drugs Strategy 2005) recommended that Rehabilitation be the fifth pillar of the National Drugs Strategy and that a working group be established under the aegis of the Department of Community, Rural and Gaeltacht Affairs to comprehensively examine this area and to develop an integrated rehabilitation strategy. In response, a working group was established in September 2005, comprising representatives from the Department of Community, Rural and Gaeltacht Affairs, the Department of Justice, Equality and Law Reform, the Department of the Environment, Heritage and Local Government, the Department of Education and Science, the Department of Health and Children, the Health Service Executive, FÁS, the National Advisory Committee on Drugs, the National Drugs Strategy Team and representatives from the community and voluntary sectors. The group has received both written and verbal submissions from a large number of groups with expertise in the area of drug rehabilitation and reintegration. It is currently finalising a strategic report to present to the Cabinet Committee on Social Inclusion on the appropriate policy and actions to be implemented under the proposed fifth pillar. It is envisaged that this final report will be submitted by the end of 2006.

Drug use and labour market vulnerability

The National Economic and Social Forum (NESF) (2005) published a report offering practical recommendations to help create opportunities for vulnerable people to access training, education and better quality jobs in the labour market. The report identifies people with drug and alcohol dependencies as one of the marginalised groups particularly prone to experiencing labour market vulnerability, on the basis that they face barriers to employment such as poor education, low skills, inconsistent job histories and in some cases criminal records. In addition, the report states that there is a lack of employment support mechanisms to assist the progression of vulnerable groups. According to Long and colleagues (2005b), employment levels between 1998 and 2002 among treated drug users in the age range 16–64 were much lower than those in the general population.

The NESF report draws on a report by the European Commission showing that the rate of early school-leaving in Ireland is above the European Union (EU) average. When considered in conjunction with the finding of Long and colleagues (2005b) that between 1998 and 2002 inclusive, an average of 26% of all cases being treated for problematic drug misuse in Ireland reported leaving school before reaching the age of 15, the NESF findings highlight the seriousness of the risk of early school-leavers in Ireland becoming exposed to not only drug use but also labour market vulnerability.

Vocational training in Dublin's North East Drugs Task Force projects

The Dublin North East Drugs Task Force recently published a review (Lawless 2006) of FÁS 'Special' Community Employment (CE) projects operating in the task force area. FÁS 'Special' CE projects are the main vehicle through which vocational and employment skills training have been delivered in LDTF areas (Ministerial Task Force on Measures to Reduce the Demand for Drugs 1996). The review covered four projects and reflects the views of staff and participants engaged in CE. It highlights a number of issues that merit attention from policy makers, service providers and other relevant stakeholders engaged in responding to the needs of drug users.

- Lawless reports the existence of strong views from staff and participants on the role of methadone in the overall context of FÁS CE. Methadone is viewed as a key component in the initial stage of stabilisation. However, the view is held that more often than not it has become the sole and final solution. Clients report that when they try to share responsibility for their own treatment, they very often get an adverse response from medical staff. For example, clients spoke of themselves or others being treated with disrespect by the medical staff, of not being involved in their own treatment plans and having attempts to reduce their dosage and/or to detox from prescribed medication frustrated, and often their dosage was increased.
- The author reports clients as favouring the option of urine samples being taken twice or three times a week, with their consent. This is an interesting view as, in effect, this could increase the risk of illicit drug use being exposed among clients. Clients expressed the view that they could 'get round' having one test per week and continue to dabble in drugs if they wished, but having to submit to two or three random tests would reduce the likelihood of their using illicit drugs. Clients felt that this would strengthen their internal motivation to stay off drugs. Research by Ginexi and colleagues (2003) reports that by far the greatest barrier to labour force participation and employment for persons in treatment for drug use over a three-year period was continued use of illicit drugs.
- Clients expressed the view that participation in the CE projects had enabled them to increase their personal development but they were frustrated by how little progress they had made in terms of education and training and how few move-on options were open to them. Most of all, they wanted to be leaving with more formal qualifications. They wanted to see more work placement and work experience built into the programme and saw structured move-on options as essential. This would suggest that clients prefer a more intensive and perhaps tailored approach, particularly in the later stages of their involvement with projects. Research by Lidz and colleagues (2004) reports that, where a relaxed rather than an intensive approach is taken to vocational training, the results can be quite discouraging for clients.

It is interesting to observe that some of the issues made explicit in this research are being used in the United States in an attempt to improve progression routes to employment for individuals in receipt of methadone. An evaluation by Kidorf and colleagues (2004) of an intervention combining a stepped-care approach with behavioural reinforcement suggests that reducing the methadone dosage, making continued methadone dosage contingent on seeking and gaining employment, and the application of intensive vocational training skills can be effectively combined to help clients in methadone treatment progress to employment. According to Magura and colleagues (2004), this is one of the few interventions in the vocational training field to demonstrate promise, when applied to person in methadone treatment.

Current service provision in education and vocational training

FÁS (National Training Agency) has ring-fenced 1,000 places across 65 projects under the Special Community Employment scheme for recovering drug misusers. The primary objective was to provide vocational training for participants to enable them to acquire job skills and progress to employment or further specialised vocational training or education. However, a review of this scheme by Bruce (2004) revealed that the vast majority of these projects do not operate as labour market mechanisms, but rather as support mechanisms. They have a number of rehabilitative objectives which deliver relapse prevention and personal development. 'The most common theme for participant respondents were that, for them, CE was rehabilitative rather than job oriented. Many saw employment as a worthy but essentially remote aspiration. Most were focused on staying stable - with others aiming to become drug free as soon as possible. This would appear to stem from the immediacy of medical and personal needs rather than any rejection of employment outcomes per se' (p. 59).

Nonetheless, a small number of projects working with recovering drug users manage to deliver vocational training and broad education programmes as part of a holistic response to the needs of clients. Some projects are achieving encouraging results based on self-reporting by clients and project monitoring systems, showing improvement in literacy levels, acquisition of recognised qualifications and some progression to employment.

The SAOL project

The SAOL project, which works exclusively with women in the north inner city of Dublin, reports the following updates (J Byrne, personal communication, 2005).

Of the 69 women who had been through the programme up to 2004, 48 completed the two-year period, with the following results:

- 14 increased their education level by one stage (e.g. Junior to Leaving Certificate)
- 8 increased their education level by two stages (e.g. pre-Junior to Leaving Certificate standard)
- 14 increased their education level by three stages (e.g. pre-Junior to Third Level)
- 12 remained at the same educational level
- 24 increased their literacy level by one grade
- 10 increased their literacy level by two grades
- 3 increased their literacy level by three grades
- 11 remained at the same literacy level

The Gateway Project

The Gateway Project offers a proportion of places to female former drug users who have either stabilised their drug use or are currently not using illicit drugs. The project includes a phase on job-seeking skills that includes Careers Information FETAC Level 1, Preparation for Work FETAC Level 1, and Work Orientation FETAC Level. The important achievements for 2005 were (Gateway 2006):

- 24 women participated in the project in 2005
- 78 FETAC portfolios were examined and passed in 2005, 13 at level 3 and 65 at level 5
- 6 participants received their NCHSX Childcare Certificate
- 7 received Pitman Qualifications
- 10 received ECDL certification
- 1 passed Junior Certificate English

Work experience placements were secured for participants in childcare, youth work, clerical and reception work during 2005. Outside training placements were secured in anger management, theatre make-up, manual handling, travel and tourism and self-defence courses for participants during 2005. Employment was secured for five participants during the year.

Liberties Recycling Training and Development

Liberties Recycling Training and Development is a textiles recycling project that provides people affected by drugs with the stability, work experience, skills and confidence needed to move into mainstream employment, training and further education. The project has a three-year programme of work and training. Used textiles, mainly clothing and footwear, are collected from charities, collection points and door-to-door collectors. Once collected, textiles are sorted and graded from one to three in terms of quality. Grades one and two are exported to Africa and Grade three and soft toys are exported to Asia. In the four months to the end of September 2005 the following achievements were recorded by participants on the project: 5 trainees went on to employment (2 with the project); 1 went to further education; and 2 joined other projects (N Morris, personal communication, 2006).

In the quarter from April to June 2005 the project recorded the following qualifications obtained by trainees:

- FETAC computer literacy
- FETAC information technology
- Certified forklift course
- Sage payroll
- Parenting skills
- Health and safety

Trainees are currently involved in training in computer literacy, information technology and reception skills training and most are pursuing accreditation.

Bridge to Work Initiative

Bridge to Work is a work experience/placement stimulation programme targeting individuals with a history of drug addiction who have achieved a degree of stabilisation. The initiative is aimed at stimulating change and progression for those experiencing difficulties accessing mainstream employment, education and training. It is a multi-agency collaborative venture involving local area partnerships across the Northside of Dublin. The programme proposes that clients need to be engaged in a work experience programme as part of a structured rehabilitation progression plan. Clients and employers involved in the programme are offered intensive high support during the placement. This programme is currently being evaluated by an external evaluator (J Ralp, personal communication, 2006).

Further investment in vocational training and education

The Labour Inclusion Project (LIP) was identified in the National Drugs Strategy 2001–2008 as a model of practice that could deliver significant learning around vocational training and education for recovering drug misusers. The pilot phase consisted of seven weeks of job-skills training followed by 6–7 weeks of job placement. An evaluation of the pilot phase reported promising results. During this time the project worked with 16 individuals, of whom four moved on to work experience, two moved to employment and one returned to full-time education (McLoughlin 2002). However, an evaluation of the second phase revealed a somewhat less positive picture, with participants appearing less motivated to progress, mainly due to their involvement with polydrug use. The evaluation concluded that the majority of referrals to the project were not ready to engage in a structured, intensive and focused job training programme and instead required medical and therapeutic treatment (McLoughlin 2003).

Rather than continue with a model that was not delivering on its stated objectives in the area of vocational training, the LIP was suspended. However, the project restarted in 2006, using a modified model where clients were supported and trained on a one-to-one basis. This model was chosen following field trips to similar projects in Liverpool in the UK, and replaces the previous model where 16 clients were trained and supported by one to two project workers. The project has now acquired new premises with the support of funding through the Dormant Accounts Fund and the Premises Initiative (C Dowling, personal communication, 2006).

Soilse

Updated information provided by Soilse (G McAleenan, personal communication, 2006) includes the news that Soilse has employed a career guidance counsellor to work with clients moving from Post Leaving Certificate to the Trinity Access Course. In addition, Soilse, in conjunction with the City of Dublin Vocational Education Committee (CDVEC), has employed an education development worker to support clients pursuing further education options such as the Trinity Access Course. Soilse is one of the very few interventions known to employ these methods to improve their clients' chances of progression to mainstream education and employment.

Homelessness and drug misuse: a continuing challenge for service providers

Homelessness: An Integrated Strategy (Department of Environment and Local Government 2000) and the *Homeless Preventative Strategy* (Departments of Education, Environment, and Health and Children 2002) identified individuals leaving custodial and health-related institutional care (psychiatric care and care for vulnerable young people) as a group at risk of becoming homeless. Recent research in Ireland has demonstrated a strong association between drug misuse and homelessness among individuals in custody (Seymour and Costello 2005). On the other hand, there is a lack of research in Ireland on the association between drug misuse, homelessness and people with experience of institutional health-related care, despite evidence showing that drug misuse, mental health problems and being in care are associated with becoming and remaining homeless (Feeney *et al.* 2000; Smith *et al.* 2001).

Actions 9 and 11 of the Integrated Strategy (2000) require statutory and voluntary agencies to provide a mix of suitable emergency accommodation for homeless women, couples, families and homeless persons with substance addictions, as well as high-support hostels for the last group. The recent review of the implementation of the Integrated and Preventative Strategies (Fitzpatrick Associates 2006) reports that 'the supply, range and quality of emergency accommodation available ... have increased significantly over the last five years' (p.31). However, while this may be the case for most of the groups included under Actions 9 and 11, there is no specific information in this review to show that emergency accommodation has been made available or that it is now more accessible to homeless individuals engaged in drug misuse. Indeed, recent research has shown that such individuals (a) continue to experience barriers to accessing emergency accommodation and (b) are resistant to using emergency accommodation for fear of escalating their drug use (Lawless and Corr 2005). Research by Courtney (2005) found that, although there was a reduction in the number of individuals sleeping rough in the Dublin area, and the number of referrals of individuals with low-support needs had decreased, there was an increase in referrals of those with multiple needs, usually involving substance abuse and physical or mental health problems, which can result in chaotic or challenging behaviour. The lack of explicit policies addressing the needs of homeless drug users was identified as hampering the capacity of homelessness service providers to deliver any meaningful response to this client group. This impacts on availability and accessibility of emergency accommodation, with many services having a policy of excluding active drug users (Lawless and Corr 2005). The review of the Integrated and Preventative Strategies acknowledges that dedicated hostels in the form of night shelters have been introduced in the Dublin area, primarily targeting the needs of individuals suffering from alcohol addiction.

But the review does not make explicit the availability or accessibility of these hostels for individuals engaged in the misuse of illicit drugs, such as heroin.

An area where there has been welcome progress is the accommodation needs of ex-offenders. The Homeless Preventative Strategy 2002, which developed from Action I in the Integrated Strategy (2000), identified ex-offenders as being at risk of homelessness on leaving institutional custodial care. The review of the implementation of the Integrated and Preventative Strategies (Fitzpatrick Associates 2006) reports that a specialist unit, the Homeless Offenders Strategy Team (HOST), has been established by the Probation and Welfare Service (PWS) to assist ex-offenders find accommodation. In addition, the Irish Prison Service and the PWS are engaged in building and operating transitional housing units for ex-offenders. This is a welcome development, as research consistently shows that being homeless on release from custodial institutions exposes individuals to a high risk of relapsing into drug use (Hickey 2002; Ó'Loingsigh 2004).

As part of the review (Fitzpatrick Associates 2006) of the homeless strategies, 33 homeless service users were interviewed between March and May 2005. Family breakdown and associated problems of alcohol and substance abuse were cited as the primary reasons for becoming homeless in the first instance. Many of the interviewees reported that they had relapsed when accommodated in homeless hostels after having been drug or alcohol free for a considerable period of time. A number of interviewees reported that they had to wait for six to nine months to join a methadone programme.

This research again emphasises the important task facing statutory and voluntary service providers in tackling the strong association between drug misuse and homelessness. Despite the strategic measures progressed so far, it would appear that major gaps in service provision remain, particularly in relation to individuals with multiple needs, including active drug users.

9.3 Prevention of drug-related crime

Guidelines setting out the functions, composition and operation of joint policing committees (JPCs), established under the Garda Síochána Act 2005, were published in June (Department of Justice Equality and Law Reform 2006). The guidelines were prepared by the Minister for Justice in consultation with the Minister for the Environment and, following a recommendation by the Joint Oireachtas Committee on Justice, Equality, Defence and Women's Rights, the Minister of State with responsibility for drugs strategy. JPCs, which are to be established in each of the 114 local authority administrative areas throughout the State, will bring together representatives from the local authority, gardaí, public representatives and representatives of the community and voluntary sector to discuss and make recommendations on matters affecting the policing of the area. The guidelines propose the establishment of pilot JPCs in the following areas: Fingal, Offaly and Wicklow County Councils; Dublin, Galway, Limerick and Waterford City Councils; Drogheda and Sligo Borough Councils; Athy, Arklow, Ballinasloe, Birr, Bray, Edenderry, Greystones, Letterkenny, Mallow, Tralee, Tuam, Tullamore and Wicklow Town Councils. In Dublin city, five sub-committees corresponding to the operational areas of the City Council will also be established.

From January 2007 an evaluation of the pilot phase will begin. After mid 2007, JPCs will be established in all local authorities until the next local elections in 2009. The guidelines also make provision to ensure that Garda representation on the JPCs is of appropriate rank and seniority, and highlight the importance of ensuring gender equality on the JPCs. The primary functions of the JPCs are to serve as a forum for consultation, discussion and recommendations on local policing matters and to keep under review levels of crime, disorder and anti-social behaviour, including the patterns and levels of misuse of alcohol and drugs. The guidelines also cover such issues as the chairing of JPCs, the circumstances in which they can meet in public and in private and the procedures by which members of the public can raise issues of local concern. Section 36(2)(d) of the Act provides for the establishment of local policing fora by a JPC. Supplementary guidelines for local policing fora are to be drawn up at a later date. However, in light of Action 11 of the National Drugs Strategy (Department of Tourism Sport and Recreation 2001), the guidelines stipulate that 'priority will be given to establishing local policing fora in all Local Drugs Task Force areas and other areas experiencing problems of drug misuse' (p.16).

Responding to a reported increase in the availability on the street of regulated pharmaceutical products, the GNDU reports that the Garda Síochána and the Irish Medicines Board examined existing practices in manufacturing and supply outlets. Outlets have been advised of best practice procedures to prevent illegal diversion of such products (GNDU, personal communication, August 2006).

In line with Action 12 of the National Drugs Strategy 2001–2008 (Department of Tourism Sport and Recreation 2001), which commits the Garda Síochána to extending police drug interdiction measures to urban areas throughout Ireland, the GNDU reports that 'Operation Cleanstreet', which targets and apprehends drug dealers at a street level, was increasingly used in communities outside Dublin. It is reported that: 'One particularly successful initiative was conducted in Limerick city where many of that city's main drug suppliers at street level were apprehended and are currently before the courts' (GNDU, personal communication August 2006). Also, the GNDU reports that 'Operation Anvil', targeted against individuals involved in 'serious crime' (including drugs), was extended to regions beyond the Dublin metropolitan region, and that 'significant results have been achieved with many drug seizures being made and in excess of 400 firearms being seized' (GNDU, personal communication, August 2006).

A new strategy document published by the Irish Prison Service (IPS) (2006), *Keeping drugs out of prisons*, proposes to tackle the use of illicit drugs in Irish prisons by focusing on supply elimination and demand reduction. The new strategy recommends that searches after visits should not be confined to known drug users but should include prisoners who could be intimidated into receiving drugs on a visit. Current measures in place in Mountjoy prison to prevent the supply of drugs during visits include CCTV cameras, screened visits whereby physical contact between prisoner and visitor is prevented and random searches of prisoners. Prisoners are required to nominate visitors, who must produce identification when entering the prison, in order to reduce the number of visitors giving false names in an attempt to smuggle in drugs. These measures have been included in the new IPS policy and strategy document and are to be extended to all prisons, along with new initiatives including a recommendation that physical contact between visitors and prisoners should not be permitted unless sanctioned by the governor and that any unscreened visits should be booked in advance. The IPS strategy also provides for the introduction of mandatory drug testing (MDT) by the end of 2006. This will involve 5% to 10% of prisoners being randomly selected for drug testing each month. A prisoner who refuses to take the test or tests positive for drugs will incur sanctions.

10. Drug markets

10.1 Overview

In this section we consider available police data on drug offence prosecutions by Garda region in order to identify trends in drug distribution at middle-market level throughout the country. Data on drug seizures and trends are also presented and analysed. No new data on drug prices or purity are available. We also report on a new study conducted by the DMRD as part of its Overview series: *The illicit drug market in Ireland. Overview 2* (Connolly 2005a). The purpose of this Overview was to compile all available data and research in relation to illicit drug markets, to identify gaps in knowledge and to make recommendations for further research in this area. The data presented in this section has been compiled and analysed by Connolly for the above study up to the year 2003. The authors will also consider data from the Garda annual reports for 2004 and 2005 (An Garda Síochána 2004a; An Garda Síochána 2005).

10.2 Availability and supply

No new research studies on drug markets have been conducted. With regard to the importation and internal distribution of drugs – the middle market – data on drug-related prosecutions by drug type and by Garda division are a possible indicator of distribution patterns. While these data, which are presented in the Garda annual reports, primarily reflect law enforcement activities and the relative ease of detection of different drugs, they may also provide an indicator of national drug distribution trends and whether, for example, there is a concentration of prosecutions along trafficking routes. In the account below, these data are supplemented by information supplied by the GNDU and Customs Drugs Law Enforcement (CDLE).

The Garda regions are the following:

- Eastern Region – Carlow/Kildare; Laois/Offaly; Longford/Westmeath; Louth/Meath
- Dublin Metropolitan Region – Eastern; North Central; Northern; South Central; Southern; Western
- Northern Region – Cavan/Monaghan; Donegal; Sligo/Leitrim
- South Eastern Region – Tipperary; Waterford/Kilkenny; Wexford/Wicklow
- Southern Region – Cork City; Cork; Cork West; Kerry; Limerick
- Western Region – Clare; Galway West; Mayo; Roscommon/ Galway East

Cannabis

According to Customs, 'cannabis resin seized is mainly sourced in North Africa whilst herbal cannabis is sourced in South Africa. Trafficking routes include road, sea and air. Cannabis continues to be seized from freight and groupage traffic arriving in Ireland from Spain via France and the UK. Seizures are also made from postal packages and by air and ferry passengers. We have also seized cannabis from fishing vessels' (CDLE, personal communication, September 2006).

Figure 10.2.1 shows trends in the number of cannabis-related offences in which criminal proceedings commenced, by Garda region, between 1995 and 2005. The largest proportions of cannabis-related prosecutions take place in the Dublin Metropolitan Region and the Southern Region. The large concentration of such prosecutions in the Southern Region may be partially explained by the importance of the south coast as an importation point for cannabis resin coming from North Africa. It is noteworthy that, following a generally consistent increase in cannabis-related prosecutions in all regions between 1995 and 2002, there was a decrease in such prosecutions in all Garda regions in 2003. It is likely that this was a result of a change in Garda enforcement strategy, rather than of a decline in cannabis availability or use. In 2005 there was an increase in cannabis-related prosecutions in all Garda regions, with those for the Dublin Metropolitan Region increasing by just under 71% (from 1,379 in 2004 to 2,355 in 2005) and those for the Eastern Region increasing by 78.5% (from 622 to 1,110 prosecutions).

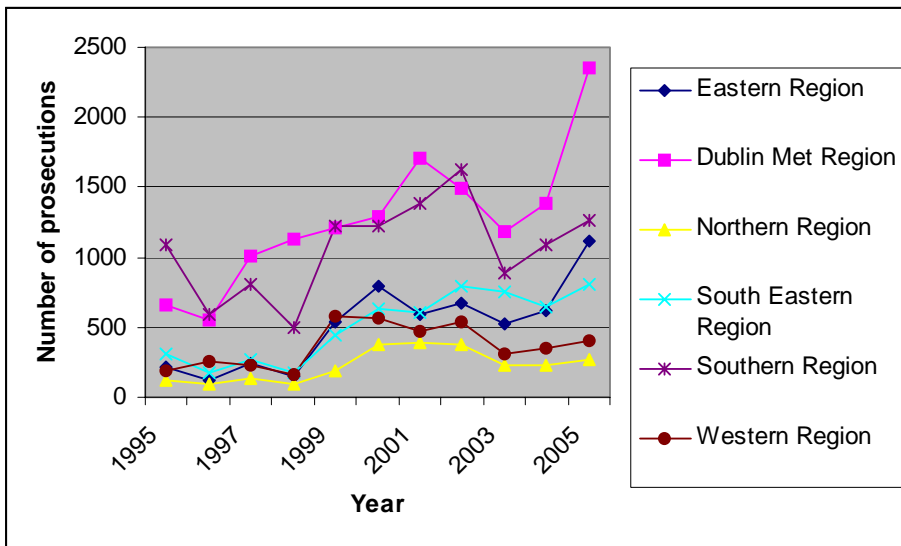


Figure 10.2.1 Cannabis-related* prosecutions by Garda region 1995–2005

*Cannabis-related prosecutions include those for cannabis herb, cannabis resin and cannabis plants.

Source: Annual reports of An Garda Síochána 1995–2005

Ecstasy

According to Customs, 'Ecstasy is primarily sourced in The Netherlands and transported overland to Cherbourg and by ferry to Rosslare in Ireland' (CDLE, personal communication, September 2006). Figure 10.2.2 shows ecstasy-related prosecutions by Garda region between 1995 and 2005.

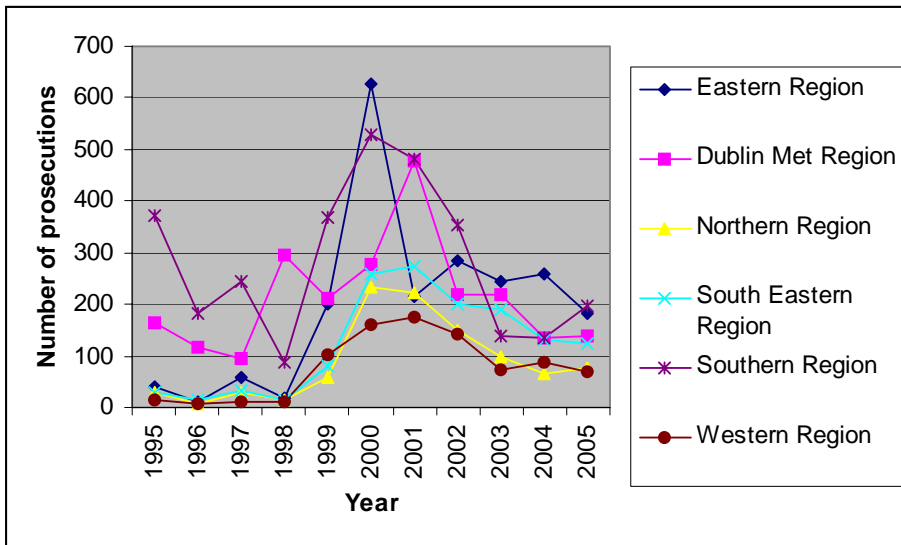


Figure 10.2.2 Ecstasy-related prosecutions by Garda region 1995–2005

Source: Annual reports of An Garda Síochána 1995–2005

Despite slight increases in the Southern and Northern Regions, ecstasy-related prosecutions have continued on a downward trend since the beginning of the decade. The GNDU believes that one possible reason for this is a displacement of ecstasy use by cocaine use (GNDU, personal communication, August 2006). (See Selected Issue on cocaine.)

Heroin

As can be seen from Figure 10.2.3, which compares trends in heroin-related prosecutions in the Dublin Metropolitan Region and total heroin-related prosecutions, heroin has always been a predominantly Dublin-based phenomenon. However, since the beginning of the decade, an increasing proportion of heroin-related prosecutions are occurring outside the capital.

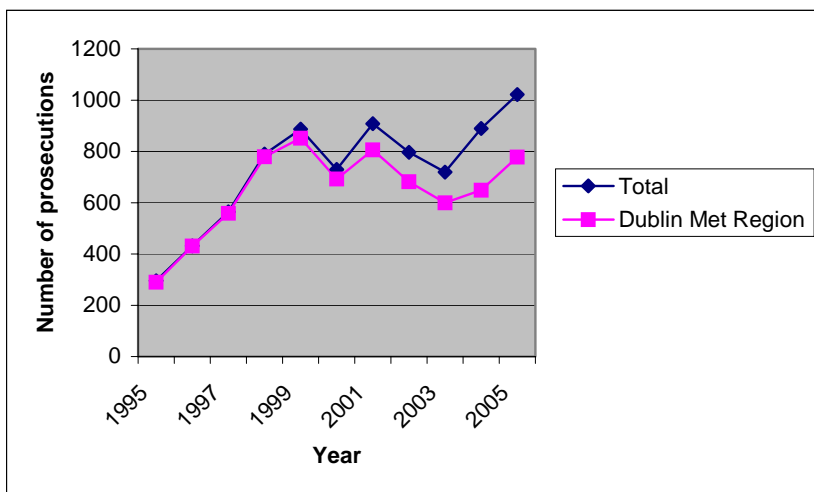


Figure 10.2.3 Trends in total heroin-related prosecutions and those in the Dublin Metropolitan Region, 1995–2005

Source: Annual reports of An Garda Síochána 1995–2005

Figure 10.2.4 shows heroin-related prosecutions in the other Garda regions throughout the State between 2000 and 2005.

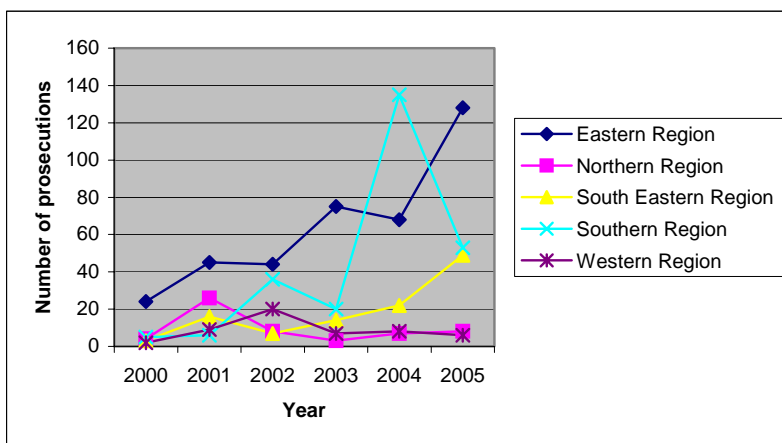


Figure 10.2.4 Trends in heroin-related prosecutions by Garda region outside the Dublin Metropolitan Region, 2000–2005

Source: Annual reports of An Garda Síochána 2000–2005

Since 2000 there has been a steady increase in heroin-related prosecutions in the Eastern Region (Carlow/Kildare, Laois/Offaly, Longford/Westmeath, Louth/Meath), from 24 prosecutions in 2000 to 128 in 2005, and to a lesser extent in the South Eastern Region (Tipperary, Waterford/Kilkenny, Wexford/Wicklow). It is clear that, although heroin remains predominantly a Dublin-based phenomenon, it is no longer confined exclusively to the capital. Further research is required to determine whether this represents a shift or displacement in the heroin market outside the capital city.

According to CDLE, 'the main entry points for drugs continue to be Dublin, Cork and Shannon airports, Rosslare and Dublin Ports. Modus operandi consists of deep concealments in vehicles, in baggage, in air freight, body packing and concealed internally in the body, stuffed or swallowed. Small user quantities of drugs continue to be imported through the postal system, in particular herbal cannabis and ecstasy-type drugs. Express courier companies are also used by some smugglers' (CDLE, personal communication, September 2006).

Involvement of organised crime

With regard to the involvement of organised crime, CDLE reports that 'both national and non-national crime gangs are continually experimenting with different smuggling methods and routes; in particular, West African criminal elements are now involved in the trafficking of cocaine into this country. Irish criminal gangs

continue to be involved in the smuggling of heroin and cannabis. We have also seen an increase in eastern European crime gangs involved in cocaine and ecstasy smuggling' (CDLE, personal communication, September 2006).

10.3 Seizures

Cannabis seizures account for the vast majority of all drugs seized. In 2005, of the 6,046 reported drug seizures, 3,417 (56.5%) were cannabis-related. Figure 10.3.1 shows trends in seizures of a number of selected drugs, excluding cannabis, between 1995 and 2005. We can see a steady rise in cocaine seizures over the last two decades, with heroin seizures remaining stable and ecstasy seizures continuing to decline since 2000.

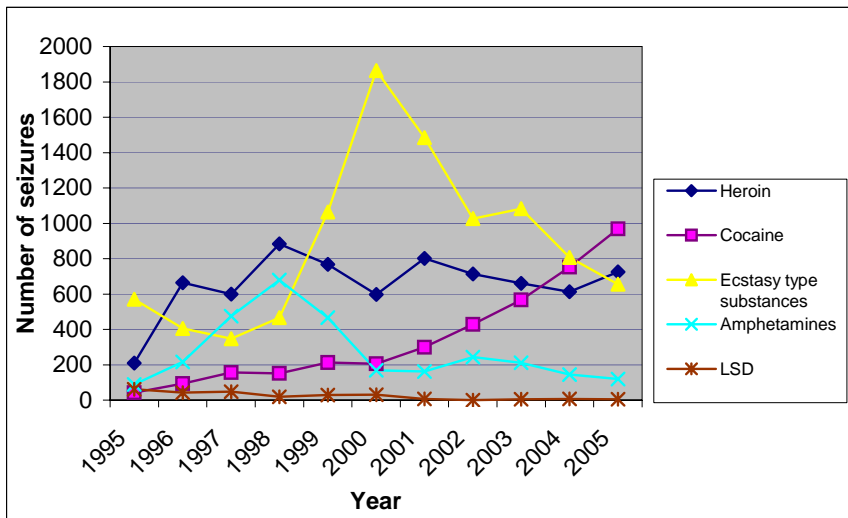


Figure 10.3.1 Trends in the number of seizures of selected drugs, excluding cannabis, 1995–2005

Source: Annual reports of An Garda Síochána 1995–2005

CDLE also reports on a number of other drugs which have come to its attention during the reporting year. It reports the first ever seizure of Dimethyltryptamine (DMT), which was sourced in Brazil and transported by post. CDLE also reports continuing trends in the seizure of khat and steroids (CDLE, personal communication, September 2006).

Several supply-reduction initiatives have been undertaken. Customs added a Mobile X-ray Contained Scanner to its detection facilities, which became operational in November 2005. EU and the World Customs Organization requirements and standards on supply-chain security have been implemented. In October 2005 Customs established a Cash Detection Dog Team. The dog is trained to detect substantial amounts of cash and is mainly deployed at strategic frontier locations. Supply reduction initiatives also include a Customs/Police intelligence-based targeting project at national level that identifies significant organised crime figures involved in the importation and distribution of drugs, and co-ordinates joint enforcement action.

10.4 Price

No new information on drug prices is available. The Irish Human Rights Commission (IHRC) has raised a number of concerns about some of the provisions of the Criminal Justice Act 2006 (see Section 1.2). In relation to proposals contained in Part II of the Act, which mainly seek to add additional grounds to the mandatory sentencing guidelines for persons convicted in possession of drugs valued at €13,000 or more (Misuse of Drugs Act 1977 as amended by Section 15A Criminal Justice Act 1999), the IHRC recommends that an objective expert witness should be called to give his or her opinion on the valuation of drugs before the court. The IHRC is also of the view that the €13,000 valuation for drug trafficking offences should be reviewed in light of inflation and the current reality of the cost of drugs.

10.5 Purity

No new information is available.

10.6 Overview of illicit drugs market in Ireland

As part of the Irish Focal Point's Overview publication series, *The illicit drug market in Ireland, Overview 2*, was published in 2005 (Connolly 2005a). The purpose of this Overview was to compile and analyse existing data and available research, to identify gaps in knowledge and to inform future research needs in this important area of drug policy. The Overview includes chapters on drug seizure numbers and volumes; drug prices and estimated market values; drug purity trends and an analysis of drug production, trafficking and supply at international, middle and local market level.

A problem with a great deal of the information collated within the Irish criminal justice system is that it is collated primarily for internal operational purposes or so as to facilitate criminal prosecutions. This has meant significant gaps in data from year to year and the absence of consistency in data-gathering, recording and reporting processes. These knowledge gaps limit understanding of different market levels and the dynamics of drug markets, such as profit margins, economic vulnerabilities and the impact of law enforcement efforts. No detailed studies have been conducted on the Irish illicit drugs market. A number of directions for future research are identified in the Overview:

- Research is required to identify the operational characteristics and dynamics of different stages of the drugs market, involving, in particular, the middle and local market stages.
- Research should distinguish between markets in different substances.
- Regular surveys on the impact of local drug markets on local communities should be conducted. Such research would assist in evaluating the effectiveness of intervention strategies such as local policing initiatives.
- Research on Irish drug markets will be facilitated through a more systematic collation of drug seizure, price and purity information.
- An analysis of seizure data might usefully consider, separately, seizures by the various agencies, such as the Garda Síochána and Customs and Excise. Seizures by these different agencies would normally happen at different stages of the market.
- Seizure data should also be presented in a way whereby small and large seizures can be defined and whereby seizures can be categorised by drug type. Categorisation of seizures according to relative volume, whereby the number of seizures in a particular volume range could be identified, would provide a more useful indication of market differentials and enforcement activity.
- The use of price as an indicator of drug availability requires repeated, accurate and current data on drug prices, at both import market level and at street level.
- However, there is no standardised method available by which trends in drug prices can be identified.
- Drug purity data are not collated in a systematic way at different market levels in Ireland. The primary function of the Forensic Science Laboratory (FSL) in this area relates to supporting the criminal justice system, and not to research. Only a very small proportion of drugs seized are tested to ascertain the percentage purity. Research should be conducted in the FSL to ascertain the purity levels of different drugs and for different-sized seizures, i.e. both street-level and larger seizures. Such research should be conducted on a national basis. Also, analysis of the various dilutants used to bulk up drugs for street sale could be useful in identifying the health implications for drug users.
- Research should be conducted in order to estimate the total value of the wholesale and retail illicit drug markets. The compilation on an annual basis of data from a range of sources, including drug production estimates, drug seizures, drug prices (wholesale and retail), drug purity (wholesale and retail) drug prevalence and estimated per capita drug consumption, would facilitate such a study.

Part B: Selected Issues

Summary

Main points from Part B

Young persons

In Ireland, children under 15 years report using illicit drugs. The most common drug used is cannabis. A small number of cases sought treatment for problem drug use in 2004. The most common main problem drug reported by treated cases was cannabis, followed by volatile inhalants. Children attending treatment rarely reported opiates or cocaine as a main problem drug, and none of them injected drugs. A number of strategies to deal with aspects of drug misuse have been put in place in Ireland, including: the National Drugs Strategy, the Report of the Working Group on the treatment of under-18s, the National Children's Strategy, the Mental Health Strategy, the Youth Homelessness Strategy and the Action Plan for Educational Inclusion.

In December 2005, the government established the Office of the Minister for Children. The purpose of this office is to harmonise child-related policy in areas such as early childhood care and education, youth justice, child welfare and protection, children and young people's participation, research on children and young people, and cross-cutting initiatives for children. The Children Act 2001 sets out a number of general principles to guide courts in dealing with children. These principles are biased towards rehabilitation and the discouragement of custody for child offenders. Universal approaches to drug prevention targeting very young people (under 15 years old) are mainly concentrated in primary school through the 'Walk Tall' programme. The Young People's Facilities and Services Fund is the main, drug prevention programme targeting young people aged 10–21 years, in areas with high levels of socio-economic deprivation and acute levels of problematic drug misuse.

Cocaine

Of the 4,918 respondents in the general population survey, 3% reported that they had used some form of cocaine at least once in their lives (lifetime use). Of those who had used cocaine, the vast majority reported that they used cocaine powder; crack cocaine use was rarely reported. A higher proportion of younger (15–34 years) respondents had ever used cocaine (4.7%) than the proportion of older (35–64 years) respondents (1.4%). More male respondents (4.3%) had ever used cocaine than female respondents (1.6%). The lifetime prevalence of cocaine use among school-going children aged 15 or 16 years old increased among girls over three time points from 1% to 4% between 1995 and 2003. The prevalence among boys ranged between 2% and 3% over the same time points. The levels of recent cocaine use were higher among students (5.8%) than among those of a similar age group (15–24 years) in the general population (2.7%). Among the homeless population, 41% had used cocaine powder at least once in their lives while 17% had used crack cocaine (19%). Of the treated cocaine cases reported to the National Drug Treatment Reporting System in 2004, 352 reported cocaine as their main problem drug and 1,100 cases reported it as an additional problem drug; four cases used both cocaine powder and crack. The numbers reporting for treatment have increased steadily since 1998. Of the 352 treated cases who reported cocaine as their main problem drug, 86% used more than one drug. Of note, no respondent participating in the general population survey reported injecting cocaine, compared to approximately one in seven of the treated cases. The National Drug Treatment Reporting System data indicate that the majority of those reporting cocaine as a main problem drug are treated in outpatient and inpatient services in Ireland. Clients attending outpatient services participate in counselling while those attending residential services take part in a medication-free therapy approach. Nine pilot projects to examine methods to manage cocaine users in Ireland were funded in 2004 and 2005. The third phase of the National Drugs Awareness Campaign which began in July 2005 provided a concerted focus on the dangers of mixing cocaine with other drugs, especially alcohol. No studies have been conducted on cocaine-related crime, that is, those offences committed as a consequence of cocaine use. There has been a steady increase in cocaine-related prosecutions and seizures in Ireland since 1998. The purity of cocaine decreased steadily between 1996 and 2002.

Drugs and driving

Driving under the influence of drugs (DUID) has been a statutory offence in Ireland since the introduction of the 1961 Road Traffic Act. Penalties for driving under the influence of alcohol are graded according to the concentration of alcohol detected; the law does not set prohibited concentrations for drugs. The Medical

Bureau of Road Safety (MBRS) analyses blood and urine specimens for the presence of seven different drugs or drug classes, namely: amphetamines, methamphetamines, benzodiazepines, cannabinoids, cocaine, opiates and methadone. Since 2002, all specimens that are under the legal limit for alcohol are routinely tested for the presence of drugs. In recent years just over 40% of specimens that were under the legal limit for alcohol contained one or more drugs.

A nationwide survey carried out by the MBRS (Cusack *et al.* 2004) in 2000 and 2001 included an analysis of seven drugs or drug classes in 2,000 blood and urine samples taken from drivers suspected of intoxicated driving. The results demonstrate that there is a significant DUID problem in Ireland. Sixty-eight per cent of tested drivers with essentially zero levels of alcohol were positive for one or more drugs, suggesting a strong trend of increasing drug positivity with decreasing levels of alcohol. Many tested drivers had both high alcohol levels and drugs in their bodies. Cannabinoids were the most common drug class encountered. Of the 15.7% of tested drivers who were positive for some drug, six out of ten gave a positive result for cannabinoids. The survey found no significant gender difference in the overall drug-positive results, although over 90% of apprehended drivers were male. The typical profile of the apprehended and tested DUID driver is that of a young male, driving in an urban area, with low or zero alcohol level, with a specimen provided between the hours of 6 am and 9 pm and with a presence of cannabinoids. The survey also identified a pattern of middle-aged drivers under the influence of benzodiazepine – a legally prescribed drug which can also impair driving. A limitation of this survey is that no random sampling of motorists was done. The survey report recommended that an evidence-based review of the legislation on driving under the influence of drugs should be conducted. The survey also highlighted the difficulties of law enforcement in this area, and concluded that, 'the goal of producing a valid, reliable and convenient roadside testing device for drugs is still paramount and not yet achieved'

11. Drug use and related problems among very young people (under 15 years old)

11.1 Drug use and problematic drug use among very young people (under 15 years old)

In April 2003, the results of the second national Health Behaviour in School-aged Children (HBSC) survey carried out in Ireland were published (Kelleher *et al.* 2003). The HBSC survey is a cross-national research study conducted in collaboration with the World Health Organization (WHO) Regional Office for Europe. Its aim is to gain new insight into, and increase our understanding of, young people's health and well-being, and health behaviour, and their social context. Six HBSC surveys have been conducted across Europe since the early 1980s. The first HBSC survey conducted in Ireland was carried out in 1998 (Friel *et al.* 1999) and repeated again in 2002. In both surveys a small number of questions on drug use were asked, allowing drug use patterns to be examined. The sampling procedures in 2002 followed those used in 1998. Individual schools within health board areas were first randomly selected and classes within those schools were then randomly selected for participation. The objective was to achieve a nationally representative sample of school-going children. The survey was carried out between April and June 2002 and covered children aged 10–17 years present in school on the day of the survey. A total of 176 schools out of a valid sample of 347 participated in the survey, giving a school response rate of 50.7%. However, only 5,712 questionnaires from 93 schools received by the end of the summer term were included in the second HBSC report to maintain seasonal comparability with the first HBSC report.

Unpublished data from the HBSC survey relating to young boys indicate a decrease in the proportion aged between 12 and 14 years who reported using cannabis in the 12 months prior to the survey, from 11% in 1998 to 6% in 2002 (Table 11.1.1). The proportion of young girls aged between 12 and 14 years who reported recent cannabis use remained relatively stable (at around 3.5%) for the two time points. The decrease in cannabis use among young boys is surprising and is not continued into the 15–17-year age group.

Table 11.1.1 Percentages of children (10–14 years) who have used cannabis in the last 12 months, by age and gender, HBSC 1998 and HBSC 2002

Age (years)	1998 HBSC survey			2002 HBSC survey		
	Boys %	Girls %	Total %	Boys %	Girls %	Total %
10-11	3.1 (<i>n</i> =706)	0.8 (<i>n</i> =872)	1.8 (<i>n</i> =1,580)	1.0 (<i>n</i> =576)	0.0 (<i>n</i> =693)	0.5 (<i>n</i> =1,269)
12-14	10.6 (<i>n</i> =1,993)	3.7 (<i>n</i> =2,049)	7.1 (<i>n</i> =4,044)	6.2 (<i>n</i> =1,646)	3.6 (<i>n</i> =2,109)	4.8 (<i>n</i> =3,756)
15-17	26.5 (<i>n</i> =1,177)	16.1 (<i>n</i> =1,202)	21.2 (<i>n</i> =2,380)	30.5 (<i>n</i> =1,150)	19.3 (<i>n</i> =1,737)	23.8 (<i>n</i> =2,890)
All ages	14.0 (<i>n</i> =3,940)	6.7 (<i>n</i> =4,173)	10.3 (<i>n</i> =8,138)	13.7 (<i>n</i> =3,445)	9.1 (<i>n</i> =4,648)	11.1 (<i>n</i> =8,105)

11.2 Profile of clients aged under 15 years attending treatment

In 2004, 67 clients aged between 12 and 14 years sought treatment for problem drug use in Ireland (Selected Issue Table 33). These 67 young clients attended 22 outpatient units throughout Ireland. Of the 22 units, two were classified as voluntary or non-government organisations. A number of the units had specific programmes for young persons. As expected, the vast majority (62/67, 93%) of clients were treated for the first time in 2004. Eighty-three per cent of treated cases were boys. There were no clients aged under 12 years. The number of clients in each age group increased with increasing age. The vast majority (53/67, 79%) of treated clients were 14 years old. Of the 67 young clients, 37 (55%) were referred to treatment by family or friends, while 20 (30%) were referred through the social services. Only seven clients were referred via the medical services. The vast majority of both boys (75%) and girls (82%) attending

treatment reported that cannabis was their main problem drug. A small proportion of both boys and girls reported volatile inhalants as their main problem drug. These young people rarely reported use of other drugs. Of the 67 clients treated, none reported injecting drug use. At the time of seeking treatment, eight clients were using their main problem drug daily and 13 were using it between two and six times per week. Two clients reported using their main problem drug for the first time at 11 years of age, while the majority (47) commenced using their main problem drug between 13 and 14 years of age. Of the 67 clients treated, 37 (55%) were using more than one drug.

11.3 Profile of main groups of young people at risk of drug use and problematic drug use

There are no published population-based data identifying risk factors for drug use in Ireland. As mentioned in Section 11.2, 67 clients aged between 11 and 14 years sought treatment for problem drug use in Ireland in 2004. The 67 young clients lived in 16 of the 26 counties in Ireland, 13 of them in Dublin. Three were not Irish nationals. Two clients lived in unstable accommodation and a further two lived in institutions. Sixty-one of the 67 clients were still in education. The four cases who reported that they had left school had completed primary education only.

11.4 Correlates and consequences of substance use among very young people

There is no published data on blood-borne viral infection among drug users aged between 10 and 15 years. Between 1980 and 2003 there were five drug-related deaths among those under 15 years (unpublished data from vital statistics).

Ciaran and Fitzpatrick (2005) described the psychosocial and clinical characteristics of children referred to a community-based child and adolescent mental health service, whose mothers reported that they had taken opiates during the pregnancy. In a retrospective study, the case notes of all children whose mothers reported that they had been exposed to opiates in utero, and who were referred to the Department of Child and Family Psychiatry, Mater Hospital, between 2001 and 2003, were identified. Information was obtained on age, gender, referral source, socio-economic group, family type, number of siblings, involvement of community care services, nature of presenting problems, diagnosis, interventions offered, and treatment difficulties. Information was recorded anonymously.

Fifteen children were identified, of whom nine were male. Most were found to be living with their mother alone or with their mother and a partner, and to be socially and financially disadvantaged. Their presenting complaints usually involved combinations of aggressive, hyperactive, and oppositional behaviour. Diagnoses included ADHD, a speech and language disorder, and an Axis II disorder. Interventions were frequently unsuccessful because of parents' difficulties in attending appointments and because of instability in the families' living arrangements. The authors concluded that these children, due to a complex interplay of biological and psychosocial adversity, were at serious risk of ongoing psychiatric disorders in childhood and adolescence and of adverse outcomes in adult life. According to the authors, a prospective cohort study of all children born to opiate-dependent mothers is necessary to quantify the level of risk and identify resilience factors.

11.5 Policy and legal development

Policy development

The National Drugs Strategy 2001–2008 (Department of Tourism Sport and Recreation 2001) highlights the need for preventive measures targeting young people before they begin to use, or when they are experimenting with, licit or illicit drugs, implicitly including those under the age of 15 years, by:

- strengthening resilience among young people in or out of school by fostering positive stable relationships with family or key community figures, especially in the early years, thereby enhancing their sense of belonging to family or social group or locality and increasing their educational and training opportunities and employment prospects; and
- maximising the effectiveness of school-based programmes through efforts to keep young people engaged in school and the identification and provision of supports for at-risk children, management of drug-related incidents and a broad-based curriculum which supports all aspects of the child's development.

The National Drugs Strategy includes a number of actions in respect of prevention that target young people, including those under the age of 15 years:

- provision of alternatives to drug misuse, such as sports, or arts and culture programmes, in areas where drug misuse is most prevalent;
- introduction of educational programmes in all schools as 'a first line of defence', since individuals are experimenting with and becoming addicted to drugs at an earlier age;
- implementation of active programmes in every second-level school to counter early school-leaving, with particular focus on areas with high levels of drug misuse;
- inclusion in preventive programmes of initiatives aimed at equipping parents with the skills to assist their children in resisting drug use and in making informed choices about their health, personal and social development;
- development of schools drug policies, which on the one hand minimise the dangers caused to children by drug misuse and drug misusers within schools and, on the other, do not discourage parents and students from asking schools for help in addressing drug misuse;
- provision of specialist drug prevention training for those interacting with groups most at risk of drug misuse as part of their initial vocational training, for example youth workers, teachers, GPs, pharmacists, nurses, counsellors and childcare workers;
- a study on drug misuse among early school leavers, in order that the individuals and groups most affected by drug misuse and those involved in working to reduce, treat and prevent drug misuse have immediate access to relevant statistical information.

Action 49 of the National Drugs Strategy identified the need to develop a protocol for treating under-18-year-olds presenting with serious drug problems. A working group established in October 2001 published its report in September 2005 (Working Group on treatment of under 18 year olds 2005). The working group reviewed the extent of the problem and noted that 'attendances by children account for a substantial proportion of the workload of the addiction services in Ireland'. The group considered the legal and ethical issues surrounding the treatment of persons under 18 years old presenting with serious drug misuse problems. The group acknowledged the difficulties experienced by service providers, particularly in relation to consent and family involvement. They noted that the current legislation allowed persons aged 16 to 17 years to consent on their own behalf to certain treatments. However, there appeared to be some doubt as to whether the courts would accept that such consent would apply to drug treatment. In this context, it was felt that the concept of Gillick competence, whereby professionals could assess whether a young person was competent to give informed consent, could play an important role. The working group recommended that, where possible, the family be involved in treatment as this leads to better outcomes. The group stated that substitution treatment should not be initiated outside a specialist context.

The National Children's Strategy, *Our children – their lives* (Department of Health and Children 2000) targets those under the age of 18 years. It addresses, among other things, illicit drug use among children, and the links between homelessness and drug abuse among children. With regard to illicit drug use among children, the Strategy proposes that 'specialist drug treatment services for the under-eighteens should be expanded as part of the National Drugs Strategy' (p. 56), and acknowledges the government's support for the provision of sporting and leisure facilities for young people at risk of drug misuse under the Young People's Facilities and Services Fund.

The National Children's Strategy links homelessness⁸ among children with drug abuse. Drug abuse among parents was seen as contributing to the incidence of homelessness among children, and the longer children remained homeless, the more difficult the task of reintegrating them into their families, as they may have become involved in problematic behaviours such as drug taking (p. 65). The Strategy proposes that young homeless people should be provided with an adequate emergency response, including a day service, education and training, and drug treatment services where necessary, tailored to their special needs (p. 65).

The Youth Homelessness Strategy (Department of Health and Children 2001b), which focuses on young people and children under the age of 18, reports that 98 of the 588 children who presented to the health boards in 2000 as homeless by reason of being without suitable accommodation (17%) attributed this situation to their parents or their own abuse of alcohol and/or drugs (p. 12). The strategy reports findings indicating that homeless young people who were not yet involved in drug misuse were particularly at risk of becoming involved in such misuse because of their own vulnerability and lack of resources (p. 17). The strategy identifies family support provision, including alcohol and drug treatment programmes, as a

⁸ 'Homelessness' among children was defined, not as children sleeping rough, but as children 'without suitable accommodation'.

preventive measure (p. 21). The strategy also identifies a series of linked service responses for homeless young people abusing, or at risk of abusing, drugs, including comprehensive assessment once the young homeless person has been placed in emergency care, specialised accommodation, and specialised health, educational and recreational services (pp. 31–35).

In the last 12 months, the integration of national policy and services in respect of children experiencing socio-economic disadvantage, including exposure to the risk of drug misuse, has become a central feature of policy analysis and development.

In December 2005 the government established the Office of the Minister for Children (OMC).⁹ The purpose of the OMC is to harmonise child-related policy in areas such as early childhood care and education, youth justice, child welfare and protection, children and young people's participation, research on children and young people, and cross-cutting initiatives for children. In August 2006, the OMC was tasked with co-ordinating the running of the Prevention and Early Intervention Programme for Children, a three-year programme with funding of €36 million provided jointly by the Irish government and Atlantic Philanthropies.¹⁰ This Programme will focus on prevention and early intervention in the lives of vulnerable children in three areas of severe disadvantage in Dublin – Tallaght West, Ballymun, and the communities of Belcamp, Darndale and Moatview.

Considerable research and planning on prevention and early intervention measures for children and families has already been undertaken in these communities over the last two years. This work has included an assessment of the needs of children and families in the communities and the identification of targets and activities to achieve those targets. Drug misuse has been identified as a serious problem in all three areas and one which needs to be addressed.¹¹ The Prevention and Early Intervention Programme will fund and evaluate a range of integrated interventions for children and their families and test whether they make a positive difference to children. If these projects are successful, the results may provide the basis for improved and more effective services and policies for children.

In the education sector, *DEIS (Delivering Equality of Opportunity in Schools): An Action Plan for Educational Inclusion* (Department of Education and Science 2005) was developed to promote equality of opportunity for 3–18-year-olds in Ireland. Launching the action plan in May 2005, the Minister for Education and Children, Mary Hanafin TD, stated that it was 'the first integrated strategy for tackling educational disadvantage from pre-school to the end of second level'. In 2006 the Educational Disadvantage Committee, set up 'to advise the Minister on policies and strategies to be adopted to identify and correct educational disadvantage', published *Moving Beyond Educational Disadvantage* (Educational Disadvantage Committee 2006). Re-examining the fundamental assumptions of the approach to addressing educational disadvantage in Ireland, this report acknowledges the DEIS action plan, but argues that educational equality requires more than delivering equality of opportunity in schools: educational equality is strongly related to wider social and economic policies. The Committee argues that issues that contribute to disadvantage in general – for example poverty, unemployment, drug and alcohol abuse, violence, inadequate and sub-standard housing – must be tackled in parallel with educational disadvantage *per se* and in an integrated way.

In the mental health sector, *A Vision for Change – the Report of the Expert Group on Mental Health Policy* outlines a framework for building and fostering positive mental health across the entire community and for providing accessible, community-based, specialist services for people with mental illness (Expert Group on Mental Health Policy 2006). The policy adopts a lifespan approach to mental health, identifying five key life stages, including early years (0–4 years), school-aged children (5–12 years), and youth.

With regard to substance misuse among children and adolescents, i.e. those aged under 18 years, the report states that uncomplicated substance abuse and alcohol addiction are not the responsibility of child and adolescent mental health services. It recommends that the community substance misuse services should

⁹ See www.omc.gov.ie for more information.

¹⁰ See www.atlanticphilanthropies.org for more information.

¹¹ The Childhood Development Initiative (CDI) in Tallaght West began its work in late 2003 to develop a solutions-based outcomes-focused 10 year strategy – *A Place for Children. Tallaght West*. The strategy is built on strong community engagement and a focus on improving the health, safety and learning of the children of the area and to increase their sense of belonging to their community. It is underpinned by a holistic view of the child, and a desire to use family, educators/carers, community resources and the environment to improve child development. For more information on the 'Youngballymun Project', located in Ballymun, visit www.youngballymun.org and for more information on the project, 'Preparing for Life', located in the three Northside communities, visit www.northsidepartnership.ie/education/preparing.htm

provide counselling to children and adolescents with substance misuse problems who do not have mental health difficulties. However, for the small number of adolescents with co-morbid abuse and mental health problems, the report recommends that the number of specialist adolescent teams should be increased from the current two (in the Dublin area) to four nationally (i.e. an additional one in Cork and one in Galway).

These teams should have the following composition:

- one consultant child and adolescent psychiatrist (specialising in addiction)
- one doctor in training
- one clinical psychologist
- two clinical nurse specialists, with expertise in adolescent mental health and/or skills in relevant individual or family therapy
- one social worker (ideally with skills in family therapy)
- three counsellors with expertise in Motivational Enhancement Therapy or Cognitive Behavioural Therapy
- two family therapists
- two youth workers

These teams should be based in community mental health centres, either as stand-alone units or sharing space with other community-based teams.

Legal development

The Children Act 2001 sets out a number of general principles to guide courts in dealing with children (Children Act 2001). These principles are biased towards rehabilitation and the discouragement of custody for child offenders. The Act emphasises prevention and the diversion of young offenders from prosecution, it raises the age of criminal responsibility from seven to twelve years, puts the Garda Síochána Juvenile Diversion Scheme on a statutory footing and introduces to the criminal justice system elements of a restorative justice approach, including family group conferencing. Underlying the Act is the principle that detention should be used only as a last resort. Also, judges will be required to seek pre-sentencing reports from the Probation and Welfare Service (PWS) in all cases involving persons aged under 18 years where the judge is considering a custodial sentence or community sanction. Although certain provisions of the Act were introduced in May 2002, many of the Act's provisions await implementation (Children Act (Commencement) Order 2002). Although many commentators have welcomed the overall thrust of the Children Act 2001, the government has come in for criticism due to delays in its implementation.

O'Mahony (2002) suggests that the Children Act could 'potentially revolutionise the area of juvenile justice' (p. 9). However, he is also critical of what he sees as a continuation of criminal justice approaches inconsistent with the principles of the Act. For example, in April 2002, following the death of two members of the Garda Síochána in a juvenile-related 'joyriding' incident, the Minister for Justice announced plans to open a new wing for 14–15-year-olds in St Patrick's Institution (Dooley and Corbett 2002). Similar criticisms have been made by groups opposed to the introduction of UK-style anti-social behaviour orders (Irish Youth Justice Alliance 2004). Following strong opposition to the introduction of anti-social behaviour orders, a number of significant differences between the UK legislation and Irish proposals as outlined in the Criminal Justice Bill 2004 have been introduced. Nevertheless, UK Home Office figures published in 2005 show that the breach rate of anti-social behaviour orders is 42%. Of the 403 anti-social behaviour orders issued in 2002, 212 led to a prison sentence.¹² The UK experience suggests that the introduction of anti-social behaviour orders will lead to an increase in the use of imprisonment for those aged under 15 years in Ireland.

The National Drugs Strategy 2001–2008 has one relevant reference in this area. In relation to the pre-trial stage, Action 13 aims 'To monitor the efficacy of the existing arrest referral schemes and expand them, as appropriate' (Department of Tourism Sport and Recreation 2001).

11.6 Prevention and treatment

Prevention

Drug prevention targeting very young people (aged under 15 years) is mainly concentrated in primary school. The universal school-based programme 'Walk Tall' is delivered as part of the curriculum-based Social, Personal and Health Education (SPHE) programme. An evaluation of the programme by Morgan (2000) reported that the programme was well received and enjoyed by students, and was seen as a forum for learning useful information. For example, students noted the importance of being able to express their

¹² <http://morello.homeoffice.gov.uk/rds/pubsintro1.html>

feelings and to reflect before making a decision. The evaluation reported that these views were noteworthy in that they signalled independent thinking among the young people. In a subsequent evaluation by Morgan (2003) the vast majority of teachers surveyed agreed that the programme helped students to make healthy choices and develop self-esteem and provided a basis for the prevention of substance abuse.

In addition to universal prevention, there are a number of small projects working in the areas of selective prevention and targeting young people aged 10–15 years who are at risk of leaving school early. For example, the St Aengus Stay in School project in Tallaght, a large suburb of Dublin, works with at risk young people to keep them in mainstream education. An evaluation by Rourke (2000) reported that the majority of the young people engaged with the project in the previous two years were still in mainstream education. Attendance rates of over 90% at project activities reflected well on how the young people perceived the project.

The Young People's Facilities and Services Fund (YPFSF) is the main selective drug prevention programme targeting young people aged 10–21 years in areas with high levels of socio-economic deprivation and acute levels of problematic drug misuse. These areas include the 14 local drugs task force areas and four additional urban areas, namely Galway, Limerick, Carlow and Waterford. The programme funds the capital costs of new facilities such as sports centres and generic youth facilities, funds the refurbishment of existing facilities and funds the employment of youth-support workers to work with young people in these facilities. The programme is based on the assumption that the provision of youth facilities in areas that were previously without such amenities can act as an alternative to drug misuse among young people by reducing demand for drugs.

An evaluation of the YPFSF by Ronayne (2003) reported that successful strategies employed by workers to attract hard-to-reach young people into projects included outreach street work, which engaged with young people on their 'own turf'; involving parents; and projecting a positive image of the project at local level by focusing on the recreational nature of the intervention to avoid labelling young people who attended as 'drug users' and/or 'deviant'. Additional strategies employed with some success were involving young people in the design of projects and building trust with young people. Scare tactics and telling young people to just say 'no' to drugs did not work in a society where the use of alcohol among adults was quite prevalent. Enabling and supporting young people to make informed and responsible choices in their lives was preferred. The majority of young people participating in YPFSF projects are at the younger end of the target age range, 52% are 13 years old or under and 73% are 15 years old or under. This age profile demonstrates that there is a need among very young people in disadvantaged communities for this type of service and that the engagement strategies used in this current phase are showing some success in attracting this age group. However, the evaluation noted that difficulties were reported in engaging with older adolescents experiencing multiple problems and sometimes exhibiting behaviour deemed to be putting themselves and others at risk.

One example of selective prevention for families at risk is the Ana Liffey Children's Project, operating in north Dublin city. The project's aim is to promote and support high-quality parenting and enhance the quality of life for children of parents who use drugs. The project sets out to respond to the emotional needs of children of drug-using parents and support and up-skills parents who use drugs to enable them to enhance their parenting skills. The project also has an after-school programme and a summer project for the young children. An evaluation by Downes and Murray (2002) reported that, when interviewed, children aged 7–12 years gave overwhelmingly positive responses. For example, they valued the support, stability and trusting relationships they formed with staff and the support for their families. They enjoyed and appeared to benefit from the extensive variety of individual and group sessions and, in particular, they enjoyed the after-school recreational activities. At the time of the evaluation, the children who took part in interviews were reported to be participating in regular schooling. In addition, parents of the children all expressed the view that the project had changed their lives for the better. The project was viewed in very high esteem by external professionals, with most of them saying that they had great confidence in the project and would trust the project to meet the needs of clients they might refer.

Treatment

The Working Group on treatment of under 18 year olds (2005) believed that the four-tiered model developed by the Health Advisory Service in the UK, adapted as necessary to an Irish context, would best deliver effective services to young people presenting with problem drug use. This approach would ensure that the services provided would be based on the specific needs of the child and their family; provide a full range of drug-related education, prevention and treatment interventions; and be competent to deal with the complex ethical and legal issues surrounding such interventions. The four tiers were:

- Tier 1 – Generic services provided by teachers, social services, gardaí (police), general practitioners, community and family groups for those at risk of drug use. Generic services would include advice and referral.
- Tier 2 – Services with specialist expertise in either adolescent mental health or addiction, such as juvenile liaison officers, local drugs task forces, home–school liaison, youth-reach and drug treatment centres. The types of service delivered at this level would include brief intervention, counselling and harm reduction.
- Tier 3 – Services with specialist expertise in both adolescent mental health and addiction and the capacity to deliver a combination of treatments through a multi-disciplinary team on an outpatient basis.
- Tier 4 – Services with specialist expertise in both adolescent mental health and addiction and the capacity to deliver a brief intensive intervention through an inpatient or day hospital.

The working group agreed that the services would be adolescent-specific, local and accessible, have a combination of disciplines on site, and offer assessment, treatment and aftercare. In addition to the extra resources required to address the needs of these young people, it was suggested that greater co-ordination could maximise the impact of existing services.

In outlining the Health Estimate for 2006, the Tánaiste announced that drugs and HIV services would receive additional funding of €3 million, including the establishment of Tier 3 teams relating to the Under-18s Report.

In Ireland, young clients are prioritised for treatment places. The 67 young clients treated in 2004 attended 22 outpatient units throughout Ireland. Of the 22 units, 2 were classified as voluntary or non-government organisations. A number of the units had specific programmes for young persons. The majority of these programmes provide counselling and family therapy. A number of programmes provide psychological and psychiatric care. A young client requiring an opiate substitute must be assessed by a consultant psychiatrist. The majority of specialised youth services are available in the Dublin area.

12. Cocaine and crack – situation and responses

12.1 Cocaine use among the general population

On 12 January 2006, the National Advisory Committee on Drugs (NACD) in Ireland and the Drugs and Alcohol Information and Research Unit of the Department of Health, Social Services and Public Safety in Northern Ireland published jointly the fourth bulletin of results from the 2002/2003 all-Ireland general population drug prevalence survey (2006). This latest bulletin focuses on cocaine use in the adult population (15–64 years) and patterns of cocaine use.

Of the 4,918 survey respondents, 3% reported that they had used some form of cocaine at least once in their lives (ever use). Just over 1% had used cocaine in the last year (recent use). Only 0.3% had used it in the last month (current use). Of those who had used cocaine, the vast majority reported that they used cocaine powder; crack cocaine use was rarely reported. A higher proportion of younger (15–34 years) respondents had ever used cocaine (4.7%) than the proportion of older (35–64 years) respondents (1.4%). More male respondents (4.3%) had ever used cocaine than female respondents (1.6%). Half of all cocaine powder users commenced cocaine use before they were 20 years old, while half of all crack users commenced before they were 22 years old. There were 27 self-defined regular users of cocaine powder.

Of the 17 current cocaine powder users, just over 83% used cocaine less than once per week, while just under 17% used it at least once per week. Just over 83% of current cocaine powder users snorted the drug, while no respondent injected it.

Of the 51 recent cocaine powder users, just over 28% obtained their cocaine from a person who was not known to them, indicating that cocaine use introduces people to cohorts of other users; this may have negative public health implications. Cocaine powder was most commonly obtained at the home of a friend (52%) or at a disco, bar or club (38%). Just under 68% of recent cocaine powder users said that cocaine powder was easy to obtain within a 24-hour period.

Of the 27 self-defined regular cocaine powder users, almost 62% had successfully stopped taking cocaine. The most common reasons for discontinuing it were: could no longer afford it (42%), did not want to continue using it (35%), were concerned about its health effects (32%) and were influenced by family and friends (32%).

The findings of this study should be interpreted with care, in view of the small number of responses on which the patterns of cocaine use are based. It should also be noted that there are special methods, such as nomination or snowballing techniques, to locate and interview drug users so as to investigate patterns and practices of cocaine or opiate use. In addition, a considerable proportion of the socially excluded population use cocaine and opiates and are unlikely to be represented in a general population survey. This is because they are unlikely to be included in a population-based list, as they do not reside at a fixed address, or, if listed, are difficult to locate for interview.

12.2 Cocaine use among school students

The third European School Survey Project on Alcohol and Other Drugs was conducted in 35 European countries during 2003 and collected information on young people's alcohol and illicit drug use (Hibell *et al.* 2004). The target population for the third survey was school-going children born in 1987. Thus, those surveyed were aged either 15 or 16 years at the time of the survey. As in the earlier ESPAD surveys, the 2003 survey was conducted with a standardised methodology and a common questionnaire to provide comparable European data.

The publication of the results for the 2003 Irish ESPAD survey allows comparisons with the previous Irish ESPAD surveys conducted in 1999 (Hibell *et al.* 2000) and 1995 (Hibell *et al.* 1997). Trends in cocaine powder and crack use over the last eight years are reported below.

The lifetime prevalence of cocaine use among school-going children aged 15 or 16 years old increased among girls from 1% to 4% over three time points between 1995 and 2003. The prevalence among boys ranged between 2% and 3% over the same time points. These rates should be interpreted with caution as they are based on small numbers. The lifetime prevalence of crack use among boys in 1995 seems unusually high when compared to the rate in 2003.

Table 12.1.1 Changes in the proportion of school-going children (15–16 years) in Ireland consuming cocaine in the ESPAD surveys of 1995, 1999 and 2003

Lifetime use of cocaine powder among school children (15-16 years)	1995 %	1999 %	2003 %
Boys	2	3	2
Girls	1	2	4
Total	2	2	3

Table 12.1.2 Changes in the proportion of school-going children (15–16 years) in Ireland consuming crack in the ESPAD surveys of 1995, 1999 and 2003

Lifetime use of crack among school children (15-16 years)	1995 %	1999 %	2003 %
Boys	4	2	2
Girls	2	1	2
Total	3	2	2

12.3 Prevalence and patterns of use among specific populations

University students

The report on the *The Health of Irish Students* incorporated the results of the College Lifestyle and Attitudinal National (CLAN) survey and a qualitative evaluation of the College Alcohol Policy Initiative (Health Promotion Unit 2005). Cocaine was the third most commonly used illicit drug (Table 12.3.1). The levels of recent cocaine use were higher among students (5.8%) than among those of a similar age group (15–24 years) in the general population (2.7%) (Table 12.3.1).

Table 12.3.1 Illicit drug use in past 12 months by undergraduate full-time students (CLAN survey) compared to those aged 15–24 years in the general population

Used in last 12 months	CLAN survey	General population*
	%	(15–24 years) %
Cannabis	37.3	11.0
Ecstasy	8.0	2.8
Cocaine	5.8	2.7
Magic mushrooms	4.9	1.1
Amphetamines	4.5	1.2
Solvents	2.2	0.2
LSD	1.7	0.2
Heroin	0.4	0.2

* National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit (2005)

Homeless population

Lawless and Corr (2005) at Merchants Quay Ireland assessed the nature, extent and experience of alcohol and drug use among people who were homeless in four cities in Ireland in 2003, namely: Cork, Dublin, Galway and Limerick. Among the homeless population, cannabis was the most common illicit drug used, with 69% using it at some point in their lives, followed by heroin (42%), ecstasy (42%), cocaine powder (41%), amphetamines (35%), hallucinogens (28%), crack cocaine (19%) and solvents (16%). Cannabis was the most common (43%) illicit drug used in the last month, followed by heroin (22%), cocaine powder (17%), ecstasy (12%), crack cocaine (3%) amphetamines (2%), hallucinogens (1%), and solvents (1%). These data indicate that the use of cocaine in the last month among the homeless population was similar to that of heroin.

12.4 Treatment demand for cocaine

When double counting within treatment centres was controlled for, 4,671 cases entered treatment and were reported to the National Drug Treatment Reporting System (NDTRS) during 2004. These cases were treated in the following treatment settings: outpatient (3,371), inpatient (725), low threshold (219) and general practitioner (356). Of the 4,671 cases, 1448 (31%) cases reported that cocaine was one of their four problem drugs. Of the cocaine cases, 352 reported cocaine as their main problem drug and 1,100 cases reported it as an additional problem drug; four cases used both cocaine powder and crack. The cocaine

cases were treated in a number of treatment settings (Table 12.4.1). Of the 352 cases who reported cocaine as their main problem drug, 203 (58%) were entering treatment for the first time. The main sources of referral to treatment were self-referral (30%) followed by family and friends (25%).

Table 12.4.1 Cases reporting cocaine as a problem drug and reported to the NDTRS in 2004

	All cocaine cases	Cases with cocaine as primary drug	Cases with cocaine as an additional drug
Outpatient	1007	236	771
Inpatient	303	114	189
Low threshold	90	1	89
General practitioner	48	1	47
Total	1448	352	1096

Source: Unpublished data from the NDTRS

12.5 Interpretation of findings and trends over time (clients, patterns, trends) with reference to other indicators, using contextual information wherever possible

Of the 352 cases who reported cocaine as their main problem drug in 2004, 20% were female; this was similar to the gender profile of cocaine users in the NACD general population survey. Almost half (49%) of the treated cocaine cases were aged between 20 and 24 years while 16% were aged between 15 and 19 years. Treated cocaine cases were older than those who reported cocaine use in the general population survey. A significant minority of treated cocaine cases (9%) lived in unstable accommodation. Almost one-third were in regular employment and over half were unemployed. Almost all cases (98%) were Irish. Three cases resided outside Ireland, 155 (44%) cases lived in Dublin and 193 (55%) cases lived in counties outside Dublin. Almost one-fifth (19%) of cases had completed primary level education only. Seventeen per cent injected their main problem drug (cocaine). Twenty per cent used their cocaine daily and 38% used it between two and six times per week. Forty six per cent of cases had commenced cocaine use when aged between 15 and 19 years. Of note, no respondent participating in the general population survey reported injecting cocaine, compared to approximately one in seven of the treated cases. As expected, the frequency of cocaine use among treated cases was considerably higher than that among the general survey population. Of the 352 cases who reported cocaine as their main problem drug, 86% used more than one drug. The most common additional drugs were cannabis, alcohol, stimulants and opiates.

The number of cases seeking treatment for cocaine as their main problem drug increased each year since 1999 (Table 12.5.1).

Table 12.5.1 All cases treated for cocaine as a main problem drug in Ireland and reported to the NDTRS, 1998 to 2003

	1998	1999	2000	2001	2002	2003	2004
Cocaine as main problem drug	86	57	78	95	155	311	352
Of whom:							
New cases	32	27	33	46	65	157	203
Previously treated cases	50	29	42	41	76	145	131
Treatment status not known	4	1	3	8	14	9	18

Source: Unpublished data from the NDTRS

The majority of cocaine cases in treatment were those who reported cocaine as an additional problem drug. For example, in 2004, 1,096 cases reported cocaine as an additional problem drug.

In relation to drug-related infectious diseases, there are no data on cocaine use and its direct association with infectious diseases, though Long and colleagues (2006b) have identified a possible link between increasing numbers of new HIV cases and increasing cocaine use in Dublin 8.

At present, it is not possible to determine the number of cocaine-related deaths and deaths among cocaine users in Ireland because the current coding practices cannot facilitate such categorisation (Long *et al.* 2005a).

12.6 Treatment for cocaine use

On 6 July 2005, the Joint Oireachtas Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs launched its seventh report, *The treatment of cocaine addiction, with particular reference to the Irish experience* (2005). The government allocated funding of almost €400,000 through Vote Community, Rural and Gaeltacht Affairs to support the pilot projects.

A snapshot of the Irish experience of managing cocaine addiction indicates:

- Although the number of clients seeking treatment who report cocaine as their main problem drug has increased, the total number is small. Clients do not seek treatment for one of two reasons: either they do not perceive themselves as requiring treatment or they think existing treatment services are inappropriate to their needs. This highlights the challenge for the drug treatment services in Dublin in changing what has historically been a predominantly opiate-focused treatment system into one that meets the needs of cocaine and polydrug users.
- Many service providers are attempting to provide some level of service for cocaine users, which is increasing the pressure on existing services.
- Training for service providers on evidence-based treatment is needed immediately.

In November 2005 a number of pilot projects to examine methods to manage cocaine users in Ireland were funded through the National Drugs Strategy Team (NDST, unpublished written communication, 2005). The emphasis of the projects was to be:

- Training of staff, including support for complementary therapies
- Piloting of treatment interventions which have found empirical support in the literature on the treatment of individuals with cocaine abuse/dependency
- Adaptation of existing education material where required.

The training project was organised in three tiers.

- **Tier 1:** One-day training for *front-line staff and volunteers working* in statutory or voluntary agencies, family support networks, or service users' fora. This training intervention covered: the pharmacology of cocaine, the methods of cocaine use, engaging with cocaine use, problems specific to cocaine users, harm reduction issues, the role of complementary therapy, an overview of brief intervention skills and issues relating to polydrug use.
- **Tier 2:** Three-day training for *those who operate in a key worker or case management capacity* with active cocaine users. This included motivational interviewing and intervention skills, the use of the Maudsley Addiction Profile, patterns of cocaine use and triggers, relapse prevention, care planning and goal setting.
- **Tier 3:** Four two-day training sessions for *professional counsellors working with cocaine users on a more intensive, psychotherapeutic basis*, aimed at enabling practitioners to deliver appropriate interventions to cocaine/stimulant users. The syllabus introduced students to cognitive and behavioural learning theories of addiction and the treatment outcome research supporting this treatment approach. This included an understanding the role of the environment and significant others in initiating substance use and in initiating and maintaining change. Appropriate skills were identified and developed for helping the client with problem solving, behavioural management and relapse prevention. Specific skills were practised to enable practitioners to deliver competent, effective cognitive behavioural interventions. These included behavioural analysis of drug and alcohol use, coping skills, goal setting, planning and monitoring. A total of 20 people participated, with a mix of health service and community-based specialists.

The complementary therapy aspect of the training will be delivered as part of another project and the target group for this training will be frontline workers.

No information has been published on the adaptation of existing educational material.

The treatment intervention aspect of the project was piloted in four areas of Dublin. Each intervention focused on a different aspect of cocaine use. The treatment intervention consisted of individual drug counselling, psychotherapy and cognitive behavioural therapy. Each of these therapies was combined with group drug counselling. This project will be evaluated by Goodbody Economic Consultants.

There are a further four pilot projects covering delivering responses to cocaine in local communities in Dublin.

On 3 May 2006 the Health Service Executive (HSE) organised a workshop on cocaine (Sinclair and Long 2006). Dr Brion Sweeney, clinical director of the HSE Northern Area Addiction Services, presented the evidence base for the treatment of problem cocaine use and stated that cognitive behavioural therapy in conjunction with other interventions was the most successful form of treatment. He went on to state that prompt, accessible and tailored interventions increased the effectiveness of such treatment. He pointed out that the evidence indicated that medication had little effect in the treatment of cocaine dependence, but said that new developments were expected in this area.

The unpublished treatment demand data indicate that the majority of those reporting cocaine as a main problem drug are treated in outpatient and inpatient services in Ireland in 2004. Clients attending outpatient services participate in counselling while those attending residential services take part in a medication-free therapy approach. There are no published data dealing with the treatment approaches for those reporting cocaine as an additional problem drug.

12.7 Harm reduction responses to cocaine

Helplines

Table 12.7.1 presents data from the Drugs/HIV Helpline in Ireland which show that the number of calls about the use of cocaine increased between 2002 and 2006 with a dip in 2005 (Sinclair, H 2006a). However, trends based on helpline calls should always be interpreted with care. Aileen Dooley, Drugs/HIV Helpline manager, stresses that helpline staff record only what is revealed during calls, and a caller might not always mention an additional drug.

Table 12.7.1 Number of calls to the Drugs/HIV Helpline about the use of alcohol and cocaine in the first five months of the year, 2002–2006

	No. of calls in the first five months of each year				
	2002	2003	2004	2005	2006
All calls that mentioned cocaine	105	128	193	167	204

Source: Aileen Dooley, Drugs/HIV Helpline

Harm reduction

Harm reduction interventions (such as needle exchange and outreach work) take place through those outlets set up to deal with opiate misuse in Ireland. None of the harm reduction services in Ireland provide the equipment for snorting cocaine. A pilot project funded through the National Drugs Strategy Team is funded to develop information materials to reduce the harm caused by cocaine.

Primary prevention

The National Drugs Awareness Campaign, now in its third year, is managed by the Health Service Executive (HSE) under action 38 of the National Drugs Strategy.

The third phase of the National Drugs Awareness Campaign, which began in July 2005, provided a concerted focus on the dangers of mixing cocaine with other drugs, especially alcohol. According to the information provided on the www.drugsinfo.ie website, 'cocaine when taken with alcohol combines in the system to form another drug, Cocaethylene, which is more toxic than either drug alone. Cocaethylene can seriously affect the normal functioning of the heart and has been a contributory factor in many cocaine-related deaths'. This phase of the campaign includes placing posters in the restrooms of 70 large entertainment venues throughout Ireland in conjunction with messages on beer mats in pubs and clubs and print advertisement in the national press. The posters use the imagery of nursery rhyme characters to illustrate the dangers associated with mixing cocaine and alcohol.

The fourth phase of the National Drugs Awareness campaign was launched in October 2005. This phase covers the issue of cannabis use among teenagers, seeking to dispel some of the myths that surround the drug such as the claim that it is 'organic' and 'natural'. The campaign comprises a radio advertisement and two posters on the theme 'Being a teenager is hard enough, without being stoned too'. The radio advertisement mimics advertisements for teen magazines, to communicate the negative impact smoking cannabis can have on the health and well-being of young users. The posters mimic the front covers of boys' and girls' teen magazines, to deliver the same messages. The posters are located in public places where teenagers gather such as bus stops near secondary schools, shopping malls in urban areas, computer game stores and on Dublin city buses. The overall campaign includes a helpline, information leaflets and a website. (www.drugsinfo.ie).

It remains to be seen to what extent providing information and heightening awareness can bring about a change in individual and group behaviour. Nonetheless, people have a right to accurate information on the risks associated with particular forms of behaviour, such as consuming alcohol in combination with cocaine use. This latest phase of the campaign, targeting recreational cocaine users in the club and pub scene, is an important step in providing accurate information in a relevant setting.

Following an open tendering competition, the National Advisory Committee on Drugs commissioned Dr Saoirse Nic Gabhainn and Dr Jane Sixsmith of the Centre for Health Promotion Studies, National University of Ireland, Galway, to track the development and delivery of the campaign. A final report is due in 2007.

12.8 Law enforcement activities in response to cocaine use

The Garda National Drugs Unit reports that 'following persistent complaints and representations, relating particularly to the sale and supply of cocaine and crack cocaine in Dublin's inner-city, 'Operation Plaza' was set up. This operation', it is reported, 'was very successful in identifying the main players in both the Irish and immigrant communities involved in this criminality' (GNDU, personal communication, August 2006).

12.9 Policies and strategies in response to cocaine use

In mid-2002, in its *Agreed Programme for Government* (Fianna Fáil and the Progressive Democrats 2002), the newly-elected coalition government specifically mentioned cocaine in conjunction with heroin: 'We will continue to prioritise heroin and cocaine for intervention, and will publish separate national targets for supply reduction for each major type of drug' (p. 29). In the event, the government has not set separate national targets for cocaine or other illicit substances, preferring to adhere to the aggregate targets presented in the National Drugs Strategy (Department of Tourism Sport and Recreation 2001) and as amended in the Mid-Term Review of the National Drugs Strategy (Steering group for the mid-term review of the National Drugs Strategy 2005).

In 2004 a subgroup of the National Drugs Strategy Team was established to make proposals in relation to combating cocaine abuse. As part of its recommendations, the subgroup proposed funding to support four pilot treatment projects in local drugs task force (LDTF) areas. The four pilot projects are or will be evaluated. It is hoped that the results of the evaluation process will aid the formulation of effective actions aimed at tackling cocaine misuse.

In 2005 the Steering Group for the mid-term review of the National Drugs Strategy (Steering group for the mid-term review of the National Drugs Strategy 2005) revisited the issues raised in the 2003 NACD overview of cocaine use in Ireland (NACD 2003). In respect of prevention, the Steering Group noted that Phase 3 of the National Awareness Campaign (run in 2004/5) had targeted cocaine users aged between 18 and 35 years, but stressed that 'it is also essential to continue to challenge the perception that cocaine use is not dangerous' (p. 36).

In respect of treatment, the Steering Group highlighted two issues:

- It noted that, given the increased prevalence of cocaine misuse, 'treatment services need to address the needs of cocaine-dependent patients and tailor and expand existing services in this regard' (p. 35). The Group noted that the Addiction Services in the HSE Eastern Region already provided a range of services to those presenting with problem cocaine use, including psychological support, counselling interventions and referral to appropriate residential services. The Steering Group recommended an audit of the current availability of treatment options, including an assessment of treatment needs and proposals on how to track ongoing developments, to be completed by mid-2006.

- Given the increased prevalence of poly-drug use, including cocaine, the Steering Group observed that, 'Effectively managing this trend presents a different set of challenges for the National Drugs Strategy, which need to be accommodated in the different approaches to treatment. Successfully treating this more diverse prevalence pattern will mean access to, and greater provision of, a wider range of treatment services' (p. 36). The Steering Group recommended that increasing the availability and range of treatment options, including detoxification, should continue to be prioritised. This work should take on board the lessons of the pilot cocaine projects.

The Steering Group pointed out that increasing the availability and range of treatment options carried significant additional resource implications if it was to be implemented during the remainder of the life of the National Drugs Strategy 2001–2008.

Following a number of seizures of crack cocaine in Dublin's north inner city, the north inner city Community Policing Forum, through its Chairman Tony Gregory TD, proposed that an inter-agency group composed of the Department of Justice, Equality and Law Reform, the Garda National Drugs Unit, immigration authorities and others be established to develop an appropriate response in collaboration with the local community. Responding to this suggestion, Michael McDowell TD, Minister for Justice, Equality and Law Reform, stated that the establishment of such a group would be a 'sensible idea' and that he would 'entertain it and give it as positive a response as possible'. In March 2006, the Inter Sectoral Crack Cocaine Strategy Group (ISCCSG) was established comprising representatives of the Inner City Organisation Network (ICON), Community Policing Forum (CPF), Citywide Drugs Crisis Campaign, An Garda Síochána, Department of Justice, Equality and Law Reform, Health Services Executive, Dublin City Council and the Drug Misuse Research Division of the Health Research Board. Proposals are currently being finalised by this group for the consideration of the Minister (J Connolly, personal communication, 2006).

12.10 Cocaine-related crime

No studies have been conducted on cocaine-related crime, that is, those offences committed as a consequence of cocaine use. Data on drug law offences involving cocaine are reported in the Annual Reports of An Garda Síochána (An Garda Síochána 1996; An Garda Síochána 1997; An Garda Síochána 1998; An Garda Síochána 1999; An Garda Síochána 2000; An Garda Síochána 2001; An Garda Síochána 2002; An Garda Síochána 2003; An Garda Síochána 2004b; An Garda Síochána 2004a; An Garda Síochána 2005). There has been a steady increase in cocaine-related prosecutions in Ireland since 1998. In Ireland in 2005, cocaine-related prosecutions accounted for just less than 13% of the total, by passing heroin prosecutions for the first time, which constituted almost 11% of total offences.

Figure 12.10.1 shows drug offence prosecutions by drug type for a selection of drugs (excluding cannabis) between 1995 and 2005. While ecstasy-related prosecutions have declined since 2000, and those for heroin and amphetamines have remained relatively consistent, it can be seen from figure 12.1 that cocaine-related prosecutions have increased steadily since 1998.

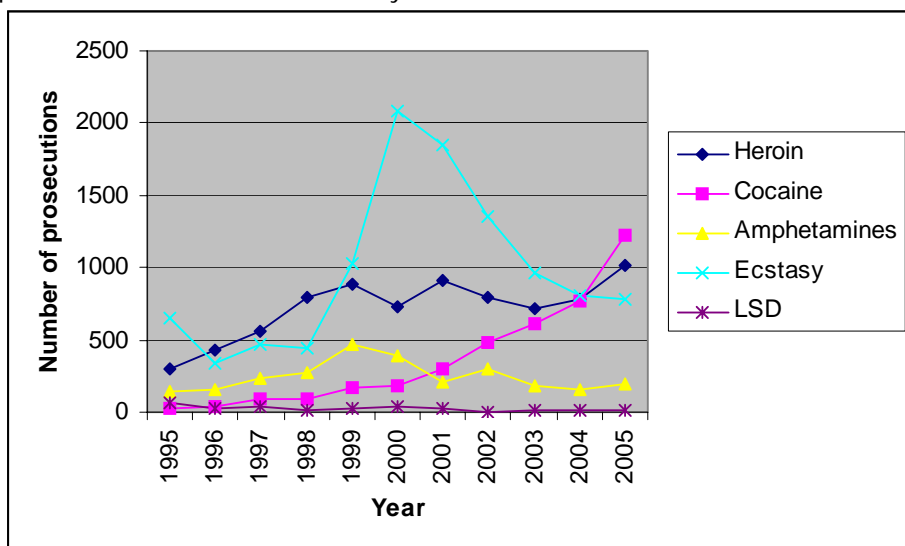


Figure 12.10.1 Prosecutions by drug type for a selection of drugs 1995–2005

Source: Annual reports of An Garda Síochána 1995–2005

Figure 12.10.2 compares cocaine-related prosecutions with those for heroin. The growing concern with the increase in the scale of the cocaine market in recent years in Ireland is reflected in the fact that, for the first time, cocaine-related prosecutions have eclipsed those for heroin.

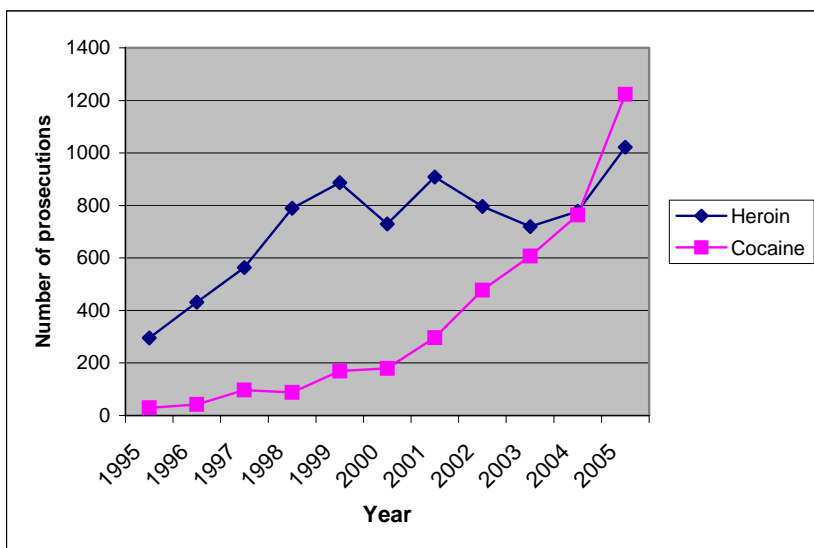


Figure 12.10.2 Prosecutions for heroin and cocaine offences, 1995–2005

Source: Annual reports of An Garda Síochána 1995–2005

The increase in cocaine offences and seizure is in line with the increase in demand for treatment for problem cocaine use.

12.11 Cocaine markets

Trafficking and supply

The available indicators suggest a significant increase in cocaine trafficking in Ireland in recent years. The cocaine which arrives in Ireland comes primarily via the UK and the Netherlands (Connolly 2005a). The GNDU estimated that all of the cocaine seized here in 2001 was destined for the Irish market. It is estimated that 50% of cocaine seized arrived by air and 50 % by mail. A slight decrease in trafficking trends in cocaine was identified in 2001. However, reporting on an increase in cocaine trafficking for 2002, the GNDU states that it is 'probably attributable to the fact that use has become more mainstream and the drug is more widely sold at street level' (GNDU 2003: p. 8). The GNDU reports that in 2005, for the first time, an air route from Mexico to Dublin was used for trafficking cocaine. It is also reported that: '2005 also saw West African drug traffickers trafficking cocaine to Dublin using South America-Nigeria-Dublin as a route for the first time'. Heretofore, it is reported 'practically all cocaine detected entering Ireland arrived via the Iberian Peninsula' (GNDU, personal communication, August 2006).

Customs also report that the number and quantity of cocaine seizures increased significantly after 2001, stating that 'cocaine is being smuggled into Ireland by means of impregnation of clothing and in concealments in polystyrene packaging, shoes, picture frames and cosmetics and also as a consequence of its being swallowed and concealed internally' (CDLE, personal communication, May 2004). Cocaine accounted for over 60% of drug supply detection seizures made by Customs during 2005 (CDLE, personal communication, September 2006). CDLE reports an 'increased level of West African involvement...both at courier and organisational level and increased use of Eastern European couriers'. The use of regional airports as transit hubs both for the internal Irish market & also for onward movement to the UK has become apparent, according to the CDLE.

A recent survey by the CityWide Drugs Crisis Campaign (2004), carried out in response to an increased concern among community groups about an emerging cocaine problem, found evidence of increased trafficking of cocaine at retail level.

No specific research studies on the cocaine drug markets have been conducted in Ireland (Connolly 2005a). With regard to the importation and internal distribution of drugs, the middle market, a possible indicator of distribution patterns is drug-related prosecutions by drug type and by Garda division. While this data, which is presented in the Garda annual reports, primarily reflects law enforcement activities and the relative ease of detection of different drugs, it may also provide an indicator of national drug distribution trends and whether, for example, we can see a concentration of prosecutions along trafficking routes. Figures 12.11.1 and 12.11.2 show cocaine-related prosecutions by Garda region.

Box 1 Garda regions in Ireland

Eastern Region – Carlow/Kildare; Laois/Offaly; Longford/Westmeath; Louth/Meath
 Dublin Metropolitan Region – Eastern; North Central; Northern; South Central; Southern; Western
 Northern Region – Cavan/Monaghan; Donegal; Sligo/Leitrim
 South Eastern Region – Tipperary; Waterford/Kilkenny; Wexford/Wicklow
 Southern Region – Cork City; Cork; Cork West; Kerry; Limerick
 Western Region – Clare; Galway West; Mayo; Roscommon/ Galway East

Although, as can be seen from Figure 12.11.1, most cocaine-related prosecutions occur in the Dublin Metropolitan Region, since 2000 an increased proportion of such prosecutions have taken place outside the capital.

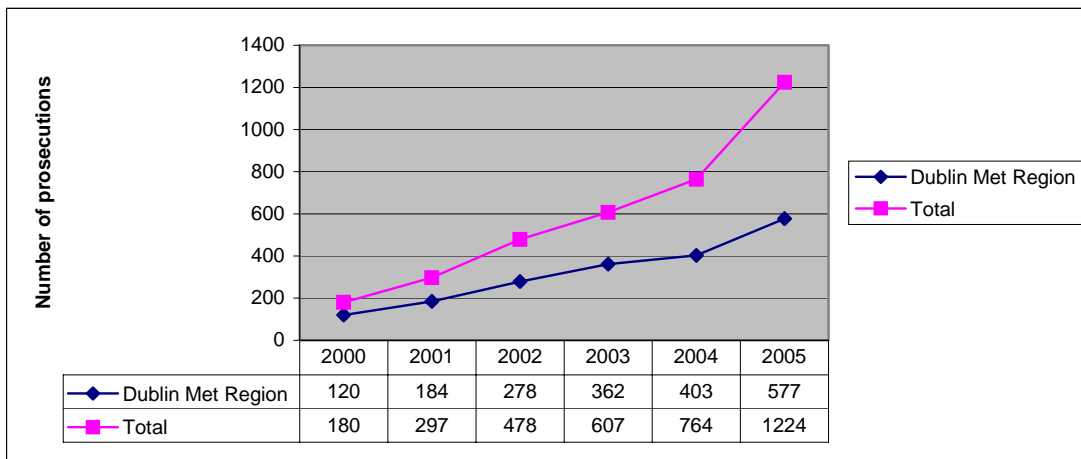


Figure 12.11.1 Cocaine-related prosecutions in the Dublin Metropolitan Region and total cocaine prosecutions 2000–2005

Source: Annual reports of An Garda Síochána 2000–2005

Figure 12.11.2 shows trends in cocaine-related prosecutions in the garda regions outside Dublin. Since 2002 there has been a sharp increase in cocaine-related prosecutions in the eastern region (Carlow/Kildare; Laois/Offaly; Longford/Westmeath; Louth/Meath) and, during 2005, in the Southern Garda Region (Cork City; Cork; Cork West; Kerry; Limerick).

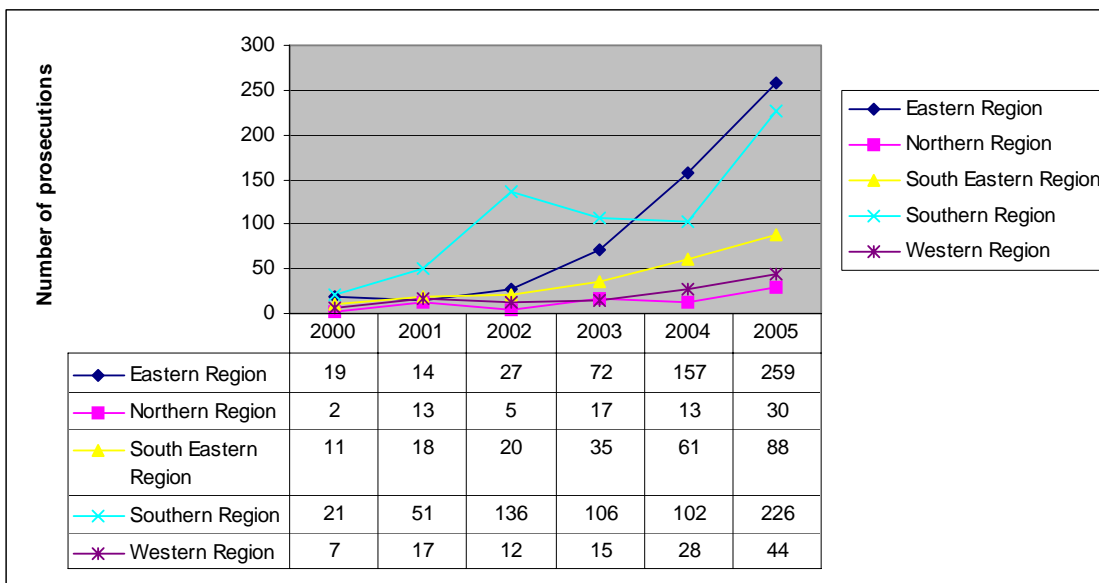


Figure 12.11.2 Cocaine-related prosecutions outside the Dublin Metropolitan Region 2000–2005
 Source: Annual reports of An Garda Síochána 2000–2005

Seizures

Figure 12.11.3 shows trends in the number of seizures for a selection of drugs, including cocaine, between 1995 and 2005.

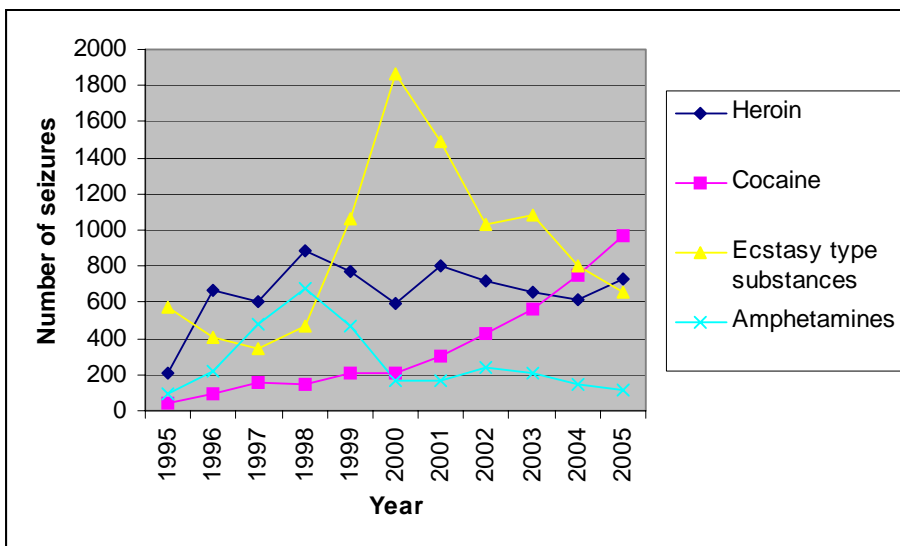


Figure 12.11.3 Trends in seizure numbers for a selection of drugs including cocaine 1995–2005

Source: Annual reports of An Garda Síochána 1995–2005

It can be seen from Figure 12.11.3 that cocaine seizures have continued to rise steadily since 1995, while heroin seizures have remained relatively consistent since 1996 although ecstasy seizures have decreased dramatically since 2000. The GNDU suggests that the decline in ecstasy seizures may be due to a switch to the use of cocaine. Cocaine has, according to the GNDU, ‘increasingly become the drug of choice of many drug users and is readily available at street level’ (GNDU, personal communication, August 2006).

Price

Moran (2001) recorded cocaine prices in Ireland at €102 per gram in 2001. The GNDU (2003) reported cocaine being sold at street level in 2002 for between €90 and €110 per gram, averaging at €100. The

GNDU reports that cocaine sold at €70 per gram in 2003. It is reported by drug users that cocaine is available in €50 and €100 bags, with the latter weighing approximately one gram (Connolly 2005a).

In a recent undercover police operation targeted at street-level drug dealing in a number of locations throughout Dublin city, a seizure of crack cocaine was reported. The operation, known as operation 'Clean Street', involved undercover Garda members purchasing drugs from dealers. The operation led to the discovery of three rocks of crack cocaine, which were priced at €40 per rock (GNDU, personal communication, 2003). Customs also made three small seizures of crack cocaine in recent years (CDLE, personal communication, 2003).

Purity

Cocaine purity levels are reported as being lower in Ireland than elsewhere in the EU (EMCDDA 2003). However, a more systematic analysis of Irish cocaine purity would be required to confirm this. Table 12.11.1 presents cocaine purity levels for a selection of cocaine seizures quantified by the Forensic Science Laboratory (FSL) between 1993 and 2004. It should be noted, however, that these figures are based on a small number of samples and also that purity levels between different samples tested by the FSL appear to fluctuate significantly. For example, of the five cases tested in 2000, which involved 16 separate packs, the average purity was 22.76 %. The minimum purity was 1.8 %, while the maximum was 75 %. In 2004, 17 wholesale cases tested ranged in purity from 7 % to 74 %, with the average reported as 30 %; seven retail cases were tested and these ranged in purity from 9 % to 25 %, with a reported average of 16 % (FSL, personal communication, October 2005). Again, given that so few cases were quantified to ascertain purity, no general conclusions can be drawn. However, were such results replicated in a more systematic study, it would suggest a much higher purity level at wholesale or 'middle market' level relative to the retail or 'local market' level.

Table 12.11.1 Average percentage purity of a selection of cocaine seizures, 1993–2004

Year	Cases quantified	Packs quantified	Purity range	Average purity
	n	n	%	%
1993	3	10	33–88	61
1994	-	-	-	-
1995	3	5	22–85	47
1996	2	2	34–90	62
1997	5	14	33–72	54
1998	-	-	15–68	38
1999	-	-	26–78	41
2000	5	16	2–75	23
2001	4	13	0.1–50	26
2002	2	15	15–33	24
2003	26	-	7–82	36
2004	24	-	7-74	23

Source: Forensic Science Laboratory

Figure 12.11.4 shows trends in purity levels since 1993 for a selection of heroin, cocaine and amphetamine seizures. Both heroin and cocaine purity levels appear to have peaked in 1996. While trends in average heroin purity have been sporadic, cocaine purity shows a consistent decline since 1996.

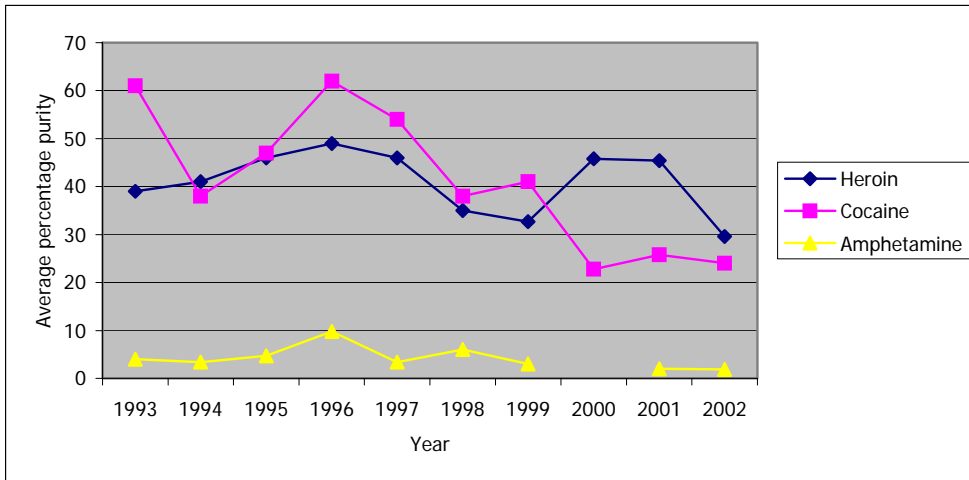


Figure 12.11.4 Drug purity trends for heroin, cocaine and amphetamine, 1993–2002
Source: Forensic Science Laboratory

13. Drugs and driving

13.1 Policy

Driving under the influence of drugs has been a statutory offence in Ireland since the introduction of the 1961 Road Traffic Act. The principal legislation in this area is contained in the Road Traffic Acts 1961 to 2002. Section 10 of the Road Traffic Act 1994 prohibits driving in a public place while a person 'is under the influence of an intoxicant to such an extent as to be incapable of having proper control of the vehicle'. Intoxicants are defined including alcohol and drugs and any combination of drugs or of drugs and alcohol. Although penalties for driving under the influence of alcohol are graded according to the concentration of alcohol detected, the law does not set prohibited concentrations for drugs. Neither does it distinguish between legal and illegal drugs. Tests to identify level of impairment can only take place where there is a reasonable suspicion that an offence is being committed (ELDD 2003).

13.2 Prevalence and epidemiological methodology

The Medical Bureau of Road Safety (MBRS) is the independent forensic body responsible for chemical testing of intoxicants under the Road Traffic Acts. The MBRS analyses blood and urine specimens for the presence of seven different drugs or drug classes, namely: amphetamines, metamphetamines, benzodiazepines, cannabinoids, cocaine, opiates and methadone. For the five-year period 2000 to 2004, specimens testing positive for one or more drugs were forwarded to the Forensic Science Laboratory or the UK Laboratory of the Government Chemist for confirmatory analysis. Prior to 2002, the Bureau tested specimens for the presence of drugs only at the request of the gardaí. However, since 2002 all specimens that are under the legal limit for alcohol are routinely tested for the presence of drugs. (Sinclair 2006b). The numbers of specimens tested, screened positive and confirmed positive over the period 2000 to 2004 are shown in Table 13.2.1.

Table 13.2.1 Number of blood and urine specimens tested for the presence of drugs, screened positive and confirmed positive, 2000 to 2004

Specimens	2000	2001	2002	2003	2004
Total tested	78	131	388	416	569
of which screened positive	71	115	233	266	354
of which confirmed positive	56	96	117	179	247
% of tested specimens confirmed positive	71.8%	73.3%	30.2%	43.0%	43.4%

Source: (Sinclair 2006b)

The proportion of tested specimens confirmed positive for drugs dropped dramatically in 2002, following the introduction of routine testing of all specimens under the legal limit for alcohol. In 2002, 24 specimens were tested for drugs at the request of the gardaí, 15 were tested on request in 2003 and 25 in 2004. The figures in Table 13.2.1 reveal that in recent years just over 40% of specimens that were under the legal limit for alcohol contained one or more drugs.

Flynn and colleagues (Flynn *et al.* 2001) analysed 78 blood and urine specimens received by the MBRS for testing within the terms of the Road Traffic Act 1994. The samples were tested in 2000 for the presence of a drug or drugs: 37 were blood specimens and 41 were urine specimens. Of these, 34 blood specimens and 37 urine specimens were found to be positive for drugs. The 71 positive specimens were then sent to the Forensic Science Laboratory for confirmation of the results. Twenty-three specimens were found to be positive for one drug class and 48 were positive for more than one drug class. The data indicated frequent polydrug use. Sixty-six per cent of the confirmed specimens contained two or more drugs, and 10% confirmed four or more drugs present. The most frequent drugs found were cannabis, amphetamine and benzodiazepine, while cocaine was the least commonly found drug.

The results from the Flynn study showed 'excellent agreement for drug detection in the blood specimens analysed by the different methods, except for cannabinoids' (p. 89). The authors concluded that methods for detecting cannabinoids in blood specimens were inadequate and would require further special attention.

Because drivers are permitted under the Road Traffic Act to provide either a blood or a urine sample, the authors point to the necessity of providing a method of analysis for drugs in both types of specimen.

An update of the above study included figures for 2001 (Furney *et al.* 2002). In 2001, 131 specimens were screened for the presence of a drug or drugs. Eighty-seven per cent of the specimens proved positive. Cannabinoids were the most common drug class found and cocaine was the least common. With regard to polydrug use, 47% of the sample tested positive for one drug or drug class, 31% for two classes, 15% for three classes, 5% for four classes and 2 % for five drugs or drug classes. The authors suggested that there was a need for the inclusion of further drug groups for detection in future studies.

A nationwide survey carried out by the MBRS in 2000 and 2001 included an analysis of seven drugs or drug classes in 2,000 blood and urine samples taken from drivers suspected of intoxicated driving (Cusack *et al.* 2004). Of the 2,000 specimens chosen, 1,000 were under the legal limit for alcohol and 1,000 were over. The drugs involved were amphetamine, methamphetamine, benzodiazepine, cannabinoids, cocaine, opiates and methadone. The purpose of the study was to determine current trends in driving under the influence of drugs (DUID) in Ireland and also to establish an evidence-based model to inform future road safety strategies.

The results demonstrate that there is a significant DUID problem in Ireland. Sixty-eight per cent of tested drivers with essentially zero levels of alcohol were positive for one or more drugs, suggesting a strong trend of increasing drug positivity with decreasing levels of alcohol. Many tested drivers had a combination of high alcohol levels together with drugs in their body. Cannabinoids were the most common drug class encountered. Of the 15.7% of tested drivers who were positive for some drug, six out of ten gave a positive result for cannabinoids. The study found no significant gender difference in the overall drug-positive results, although over 90% of apprehended drivers were male. The typical profile of the apprehended and tested DUID driver is that of a young male, driving in an urban area, with low or zero alcohol level, with a specimen provided between the hours of 6 am and 9 pm and with a presence of cannabinoids. The study also identified a pattern of middle-aged drivers under the influence of benzodiazepine – a legally prescribed drug which can also impair driving.

The authors conclude that the study highlights the need for an education and awareness campaign in relation to DUID. There should also be an emphasis, they suggest, on the dangers associated with driving while under the influence of prescribed drugs. The study recommends that if the gardaí suspect a case of DUID and obtain a negative or low alcohol reading, then they should take a separate blood or urine specimen so as to detect the presence of a drug or drugs other than alcohol.

In February 2006, Minister for Justice, Equality and Law Reform, Michael McDowell TD, informed Dáil Éireann (Irish Parliament) that current data limitations meant that information in respect of the 'numbers of prosecutions taken and convictions obtained for drug and substance abuse while driving is not compiled in such a way as to identify the intoxicant, that is, alcohol and drugs or any combination of drugs or of drugs and alcohol, involved in any particular offence' (McDowell 2006).

13.3 Detection, measurement and law enforcement

A limitation of the Cusack (2004) study is that no random sampling of motorists was done. Given that all of the blood and urine samples were taken from drivers apprehended by the gardaí and suspected of driving under the influence of an intoxicant, the authors state that the information 'does not provide a full picture of use of drugs in the general driving population' (p. 6). In January 2006, the report of the Oireachtas Joint Committee on Enterprise and Small Business (Oireachtas Joint Committee on Enterprise and Small Business 2006) called for random breath testing of motorists to identify the presence of excessive alcohol. The Committee expressed concern, however, that 'breath testing may only be to detect excess alcohol' and called for 'tests to also detect excessive use of legal and illegal drugs (such as cocaine, marijuana and prescription drugs) that may impair a driver's ability to drive safely' (p. 35).

A recommendation of the Cusack (2004) study is that an evidence-based review of the legislation on driving under the influence of drugs should be conducted. The study also highlights the difficulties of law enforcement in this area, and concludes that, 'the goal of producing a valid, reliable and convenient roadside testing device for drugs is still paramount and not yet achieved' (p. 2). In response to a parliamentary question in September 2006, Minister for Transport, Martin Cullen TD, stated that 'there was no feasible basis for the introduction of a scheme of preliminary roadside testing for drugs at present.' 'However', he

continued, 'screening devices based on oral fluid specimens are being developed for the purpose of carrying out roadside drug testing' (Cullen 2006).

13.4 Prevention

In February 2005, an Assistant Garda Commissioner for traffic was appointed. The Assistant Commissioner has responsibility for the implementation of the Garda Commissioner's policy on traffic policing. The Garda Síochána Annual Policing Plan for 2006 includes in its actions a commitment to increase the arrest rate for driving while intoxicated by 15% in 2006 (An Garda Síochána 2006). The performance indicators include an increase in the number of arrests for driving while intoxicated per Garda division per month and to increase the number of breath tests per division per month.

Part C

14. Bibliography

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14.2 List of relevant databases

- Central Treatment List
- General Mortality Register
- Hospital In-Patient Enquiry scheme (HIPE)
- National Drug Treatment Reporting System (NDTRS)
- National Psychiatric Inpatient Reporting System (NPIRS)

14.3 List of relevant Internet addresses

<http://www.citywide.ie>
<http://www.dap.ie>
<http://www.dohc.ie>
<http://www.drugsinfo.ie>
<http://www.healthpromotion.ie>
<http://www.hpsc.ie>
<http://www.hrb.ie>
<http://www.hse.ie>
<http://www.iprt.ie>
<http://www.mqi.ie>
<http://www.nacd.ie>
<http://www.ndc.hrb.ie>
<http://www.ndsc.ie>
<http://www.oireachtas.ie>
<http://www.oireachtas-debates.gov.ie>
<http://www.pobail.ie>
<http://www.taoiseach.ie>

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15.4 List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
CBT	Cognitive Behavioural Therapy
CDLE	Customs Drugs Law Enforcement
CDVEC	City of Dublin Vocational Educational Committee
CE	Community Employment
CLAN	College Lifestyle and Attitudinal National survey
CSO	Central Statistics Office
CTL	Central Treatment List
DAIRU	Drugs and Alcohol Information and Research Unit (DHSSPS, NI)
DAP	Drug Awareness Programme
DAST	Drug Abuse Screening Test
DEIS	Delivering Equality of Opportunity in Schools
DUID	Driving Under the Influence of Drugs
ECDL	European Computer Driving Licence
EDDRA	Exchange on Drug Demand Reduction Activities
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ERHA	Eastern Regional Health Authority
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
FETAC	Further Education and Training Awards Council
FSL	Forensic Science Laboratory
GMS	General Medical Service
GNDU	Garda National Drugs Unit
GP	General Practitioner
HBSC	Health Behaviour in School-aged Children Survey
HCV	Hepatitis C Virus
HRB	Health Research Board
HIV	Human Immunodeficiency Virus
HOST	Homeless Offenders Strategy Team
HPSC	Health Protection Surveillance Centre
HSE	Health Service Executive

ICD	International Classification of Diseases
ICGP	Irish College of General Practitioners
IDG	Inter-Departmental Group on Drugs
IHRC	Irish Human Rights Commission
IPRT	Irish Penal Reform Trust
IPS	Irish Prison Service
JPC	Joint Policing Committee
KPI	Key Performance Indicator
LDTF	Local Drugs Task Force
LIP	Labour Inclusion Project
MBRS	Medical Bureau of Road Safety
MDA	Misuse of Drugs Act
MDT	Mandatory Drug Testing
MQI	Merchants Quay Ireland
NACD	National Advisory Committee on Drugs
NAPD	National Association of Principals and Deputy Principals
NESF	National Economic and Social Fund
NCI	National College of Ireland
NDST	National Drugs Strategy Team
NDTRS	National Drug Treatment Reporting System
NPIRS	National Psychiatric Inpatient Reporting System
NYCI	National Youth Council of Ireland
OMC	Office of the Minister for Children
PI	Premises Initiative
PCCC	Primary, Community and Continuing Care
PCR	Polymerase Chain Reaction
PPR	Participation and Practice of Rights Project
PWS	Probation and Welfare Service
RCSI	Royal College of Surgeons in Ireland
RCGP	Royal College of General Practitioners
RDTF	Regional Drugs Task Force
RNA	Ribonucleic Acid
ROSIE	Research Outcomes Study in Ireland
SPHE	Social, Personal and Health Education
TD	Teachta Dála (Member of Parliament)
TRYS	Tipperary Regional Youth Service
UISCE	Union for Improved Services, Communication and Education
WHO	World Health Organization
YPFSF	Young People's Facilities and Services Fund