



European Monitoring Centre  
for Drugs and Drug Addiction



**2004 NATIONAL REPORT 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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Dr Hamish Sinclair  
Head of Division

**This report was written by:**

Johnny Connolly  
Martin Keane  
Jean Long  
Brigid Pike  
Hamish Sinclair

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## Summary

This report, written following EMCDDA guidelines<sup>1</sup>, 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 2003 and in some cases the first six months of 2004. 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 a EU level. The three issues are:

1. Buprenorphine: treatment, misuse and prescription practices
2. Alternatives to prison targeting to drug using offenders
3. Public nuisance: definitions, trends in policies, legal issues and intervention strategies

The following are a number of new developments and key findings in the drugs area in Ireland that occurred or were made available during 2003 and the first six months of 2004.

- The *National Drugs Strategy 2001–2008* and *An Agreed Programme for Government* (2002) continue to provide the Irish government's framework for addressing the drugs issue.
- Despite calls from a variety of sources for the merging of the national strategies for alcohol and drugs, the government has continued to prefer co-ordination rather than integration.
- A co-ordinating framework within each Garda (Police) District, to liaise with the community on drug-related matters and to act as a source of information for parents and members of the public, has progressed during the last 12 months.
- Since 2002 initiatives have been set in train to access additional public funds and to identify and tap into new sources of funding for social inclusion issues, including drug misuse. These include the establishment of the RAPID programme and the Dormant Accounts Fund Disbursements Board, and exploring possibilities in relation to using the monies and assets seized by the Criminal Assets Bureau and harnessing corporate social responsibility.
- In light of the acknowledged growing prevalence of substance misuse (both illegal drugs and alcohol) among young people and children, aged 18 and under, public debate on the issue has been frequent and widespread. Among contributions to the debate have been explorations of approaches to deterrence – the use of diversions such as promoting sport and the arts, and providing alternative recreational

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<sup>1</sup> A copy of the EMCDDA guidelines is available from the EMCDDA's website at [www.emcdda.eu.int](http://www.emcdda.eu.int). The guidelines require each Focal Point to write their 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.

opportunities – and proposals for the provision of clearer structures, guidance and support for young people.

- The debate over the advantages and disadvantages of substitution therapies and harm reduction strategies versus abstentionist approaches to drug treatment, already highlighted in the 2003 National Report, has continued over the past 12 months. Two recently-emerging issues have been the question of the most appropriate treatment regime in prisons, and the need for responses targeted at poly-drug users.
- In terms of drug use within the general population one in five adults (15-64 years) report ever using an illegal drug, one in eighteen report use within the previous year while one in thirty-three report use in the previous month.
- Cannabis is the most commonly used illegal drug in Ireland. One in six adults (15-64 years) have used cannabis in their lifetime. This increases to one in four for young adults (15-34 years).
- Prevalence of other illegal drugs is lower and confined largely to the younger age groups. Almost twice as many men (24%) as women (13%) reported ever using an illegal drug.
- In terms of problematic opiate use the most recent national estimate of the number of opiate users is 5.6 per 1000 persons aged 15-64 years. Rates are higher for men than women in all age categories.
- Opiate use is still predominately a Dublin phenomenon. The rate of opiate use in Dublin in 2001 was 15.9 per 1000 persons aged 15-64 years and outside Dublin the rate was just under 1.2 per 1000 persons aged 15-64 years.
- Process evaluation reports that an overloaded curriculum and industrial relations issues are obstacles against the implementation of Social, Personal and Health Education (SPHE) in secondary schools.
- Evaluation of SPHE reports that a greater proportion of first year students in secondary school receive SPHE than students in third year.
- Community groups are increasing their use of technology through websites to disseminate drug prevention information to communities.
- Research into selective prevention education in schools reports that children relate well to local parents trained as facilitators in delivering drug prevention education in the classroom.
- The most common main problem drugs reported by treated problem drug users were heroin and cannabis, and the numbers reporting problem cannabis use increased substantially since 2002 while the numbers reporting heroin increased but to a lesser extent.
- Treatment is provided through a network of statutory and non-statutory agencies. There are two broad philosophies through which treatment services are provided, namely: medication free therapy and medically assisted treatment. There is a small degree of overlap between the two.
- According to a systematic review by the National Medicines Information Centre, lofexidine may be useful as an additional treatment for managed opiate withdrawal while there was less evidence to support the effectiveness of naloxone to effect rapid opiate withdrawal in Ireland.
- In Ireland, methadone is the opiate substitute of choice for maintenance therapy.

- The numbers enrolled in methadone maintenance therapy continue to increase. Of note the number of new cases treated decreased since 2000. This reflects a substantial decrease in the number of new clients in the Eastern Regional Health Authority area, and a small but steady increase the number of new clients treated outside the Eastern Regional Health Authority area.
- The results of two small-scale studies published during the reporting period examining the effectiveness of methadone maintenance as a therapy were positive with respect to internationally accepted indicators.
- Two studies examined clients' satisfaction with methadone treatment services and these reported a mixture of both positive and negative experiences.
- Polydrug use was a common problem for treated drug users.
- Benzodiazepines, cocaine and ecstasy were the most common secondary problem drugs reported by treated drug users, and the numbers reporting benzodiazepines or cocaine have increased considerably since 2000.
- According to general mortality register data, there has been a decrease in drug-related mortality, from 119 in 2000 to 88 in 2002. The decrease is mainly accounted for by a large decrease in drug-related deaths in Dublin. There was a small but continued increase in drug-related mortality outside the Dublin area.
- Hepatitis C became a notifiable disease in Ireland in January 2004. Both laboratories and clinicians are required to notify all cases of hepatitis B and C. Unfortunately, there are no incident data by risk factor status.
- Two studies examined morbidity associated with hepatitis C and both suggest a significant burden of disease already exist in injecting drug users.
- A recent national study (2004) reported that the majority of service providers in the Eastern Regional Health Authority area said that their services provided information and demonstrations on safer injecting practices in line with current evidence. The authors do not report if such information was provided by services outside the Eastern Regional Health Authority area.
- There have been two formal reviews of outreach work with drug users in Ireland. Each review examined different but complementary aspects of outreach services. Taken together, these evaluations highlight the need to develop the capacity of outreach staff and enhance the general management of the services. At the same time, the documents present the essential role of outreach workers and the positive outcomes of their work, such as success in locating hard-to-reach populations, an increase in numbers using safer injecting practices and modest numbers referred into treatment.
- In relation to hepatitis C, there have been two successful pilot studies, one to increase access to treatment and the other to increase compliance with treatment.
- Research shows high levels of drug use and risk behaviour among individuals experiencing homelessness leading to social exclusion
- Responses to individuals engaged in drug misuse and experiencing homelessness need to be developed
- There is a lack of long-term accommodation plans for recovering drug users in Ireland. In particular, there is a shortage of halfway houses to accommodate former drug users.
- The National Crime Council has recommended the establishment of a National Crime Prevention Model.

- The *Garda Síochána (Police Co-operation) Act 2003* will facilitate co-operation on drug smuggling and organised crime on the island of Ireland.
- Of the 7,976 drug offences, both headline and non-headline, in which proceedings commenced in 2002, just over 75 per cent were for Simple possession (s3 Misuse of Drugs Act). The Garda Síochána Policing Plan for 2003 seeks to increase the number of offenders dealt with for supply offences. In 2002, the most recent year for which figures are available, there were 1,530 supplier/dealer offences in which proceedings commenced. This accounted for 19 per cent of the total (n=7976).
- In 2002, however, the total number of persons prosecuted fell by 19 per cent when compared to 2001. Despite this overall decrease there were significant regional differences in terms of the number of persons against whom proceedings commenced for *all* drug offences between 1999 and 2002.
- A recent nationwide survey carried out by the Medical Bureau of Road Safety (MBRS) provided an analysis for drug classes in 2000 blood and urine samples taken from drivers suspected of intoxicated driving. 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
- A recent Irish study of public order incidents recorded over a five-month period found that alcohol had been consumed by the offender in 97 per cent of cases where this aspect of the incident was recorded by the Garda Síochána. Drug use did not appear from the study to have played any significant role in public order offences.
- A range of studies indicate the significant social costs to individuals, families and communities arising from drug misuse. It is clear from such studies that drug trafficking and drug use impact disproportionately on those individuals and communities characterised by high levels of poverty and social exclusion.
- The total number of drug seizures reported in the annual reports of the Garda Síochána decreased by 39 per cent in 2002, the most recent year for which figures are available. Cannabis remains the principal drug seized in Ireland, accounting for 53 per cent of total drug seizures in 2002.
- The total number of cocaine seizures has more than doubled since 2000, while the quantity of cocaine seized has increased by 77 per cent. There was a reduction in the price of cocaine in 2003. It is estimated that a gram of cocaine currently sells at approximately €80 to €100. This suggests the potential for a displacement of heroin use by cocaine use, given the disparity in price.
- An increased number of cannabis herb seizures have been made by Customs in recent years.
- Some small studies in inner city areas of Dublin suggest the concentration of drug markets in specific areas. Research consistently shows that friends or family members are the initial contact through which most people first become involved with drugs.

# Part A: New Developments and Trends

## 1. National Policies and Context

### 1.1 Overview

This chapter covers the period August 2003 to September 2004. For information on developments in drug policy in the first half of 2003, see Ireland's National Report for 2003.

The *National Drugs Strategy 2001–2008* (Tourism, Sport and Recreation 2001) and *An Agreed Programme for Government* (Taoiseach 2002) continue to provide the government's framework for addressing the drugs issue.

### 1.2 Legal framework

Public consultation on crime issues has been facilitated by structures such as the National Crime Forum, established by the Minister for Justice, Equality and Law Reform in 1998 'to canvass comment, assessments and suggestions on crime and crime-related issues from the general public and from national and international experts' (Government of Ireland 1998, p. 9). This in turn led to the establishment of the National Crime Council (NCC). The NCC, through its public consultation exercises, has sought out the views of local communities, many of which relate to concerns about drug use and drug-related crime, in developing a future national crime prevention strategy (NCC 2003). In May 2003 the NCC published a final paper setting out its recommendations to the government regarding the future development of partnership approaches in tackling crime: *A crime prevention strategy for Ireland: Tackling the concerns of local communities* (NCC 2003). The NCC recommends the establishment of a National Crime Prevention Model.

The *Housing Miscellaneous Provisions Act (1997)* was introduced to provide measures for responding to drug-related anti-social behaviour in Public Authority Housing estates. A number of recent studies have considered the implications of this legislation. This will be considered in Section 13.

Section 4 of the *Criminal Justice Act 1999* inserted a new section, 15A, into the *Misuse of Drugs Act 1977*. This new section introduced the specific offence of possession of drugs with a market value of £10,000 (€12,700) and applied for the first time the principle of a mandatory minimum sentence with respect to these offences.<sup>2</sup> The sentence to be imposed ranged from a maximum of life imprisonment to a minimum of 10 years. The impact of this legislation has recently been assessed.

The Act does leave an element of discretion to the judge to impose a lesser sentence in certain circumstances. Ennis (2003) concludes that it is this discretionary element of Section 4 of the 1999 Act which has been the most interesting aspect of the relevant case law in the Court of Criminal Appeal. From a review of the case law, Ennis (2003) found that the Court of Criminal Appeal 'has showed a general reluctance to impose the mandatory minimum sentence in practice.' He concludes that, 'On the one hand, the discretionary element of Section 27 (3C) (where there are exceptional and specific circumstances which would make it unjust to impose the mandatory minimum

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<sup>2</sup> Misuse of Drugs Act 1977, Section 27(3B), as inserted by Criminal Justice Act 1999, Section 5



sentence) leads to uncertainty in the area. On the other hand, not to allow such discretion could lead to great injustices' (p. 35). The main 'exceptional and specific circumstances' which have been applied by the Court include: where the accused has pleaded guilty and co-operated with the Gardaí; the timing and nature of the plea; whether the co-operation yielded any results (i.e. led to further arrests or prosecutions); the actual role played by the person; the amount, and to a limited extent, the type of drugs involved; the individual's family and personal circumstances; the nationality of the individual; any pattern of behaviour; and whether there are previous convictions (p. 35).

The Policy Planning Research Unit of the Department of Justice, Equality and Law Reform has commissioned a study on the operation of the above provision of the Act. The study involves the analysis of 59 judgements where sentence was imposed under the legislation during the period 26 May 1999 to 30 April 2001. The primary scope of the project is to identify the circumstances of any case where the convicted person was sentenced to more than the minimum ten-year sentence specified in the Act, to consider the matters which the court considered when imposing less than the ten-year minimum, to identify any ambiguities or difficulties in the application of the relevant provisions which are apparent from the cases under review. The study is due to be completed in 2004.

In November 2002, in response to a parliamentary question which sought information as to the number of those convicted of possession of illegal drugs over the value of £10,000 (€12,700) and/or who had received the mandatory minimum sentence as stipulated under section 5 of the Act, the Minister for Justice Michael McDowell stated in Dáil Éireann that, according to information received from garda authorities:

the number of persons convicted under section 4 of the Criminal Justice Act 1999, since it came into force on 26 May 1999 up to 11 November 2002, is 130. The number of persons who have received prison sentences of ten years or more, as provided for in section 5 of the Criminal Justice Act 1999, is five (2002, 12 November).

As at 6 November 2003, 276 had been convicted under this provision but only 12 had received the mandatory minimum sentence. More recently, the Minister for Justice Michael McDowell, in response to a question in Dáil Éireann on the judicial approach in this area, stated that:

The Judiciary collectively should have regard to the proposition that this House put before it, namely, that for possession of drugs with intent to supply on a commercial basis, as defined in the statute, the norm was to be a ten-year sentence and that only in exceptional cases identified by the Judiciary should there be a lesser penalty. This has not happened (2004, 26 February).

The *Criminal Justice (Public Order) Act 2003, inter alia*, enables persons convicted of an offence under certain provisions of the Criminal Justice (Public Order) Act 1994 to be excluded from entering licensed premises or premises (including a stall or vehicle) used for the sale of food or from areas in the vicinity of those premises. The provisions for exclusion orders under the 1994 Act include 'intoxication in a public place'; and intoxication is defined as being 'under the influence of any alcoholic drink, drug or solvent or other substance'.

The *Garda Síochána (Police Co-operation) Act 2003* makes provision, in accordance with the 'Good Friday' Agreement between the Government of Ireland and the Government of the United Kingdom of Great Britain and Northern Ireland on Police Co-operation, at Belfast on 29 April 2002, in relation to the appointment and secondment of members of the Police Service of Northern Ireland to such ranks in the Garda

Síochána as may be prescribed, the secondment of members of the Garda Síochána to the Police Service of Northern Ireland, and other connected matters. This Act will facilitate co-operation on drug smuggling and organised crime on the island of Ireland.

The *Criminal Justice (Illicit Traffic By Sea) Act 2003* gave effect to the Council of Europe Agreement on Illicit Traffic by Sea, implementing Article 17 of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances. The Convention seeks to enhance co-operation between parties in the suppression of drug trafficking at sea. The Act makes provision for communication and co-operation in drug law enforcement between convention states. Although this Act was signed into law by the President in 2003, as a result of a number of technical issues, it has not yet been given a commencement order.

Section 36(e) of the *Taxi Regulation Act 2003* provides for the mandatory disqualification from holding a taxi licence for a conviction for a drug trafficking offence (within the meaning of section 3 of the Criminal Justice Act 1994). Minister for Transport Seamus Brennan TD, in justifying the inclusion of the section, stated that the travelling public must be reassured that taxi drivers 'are persons that can be trusted and ... in whose care passengers feel safe' (2003, 19 June).

A *Drug Offenders Bill*, intended to include the registration of convicted drug dealers with the Gardaí and stiffer penalties for persons found to be involved in the supply of drugs to a prisoner, is currently being drafted (B. Ahern 2003, 12 November).

An *Irish Medicines Board (Amendment) Bill* is currently being drafted. It will transfer responsibility for the licensing, regulation and inspection of controlled drugs and precursor chemicals from the Department of Health and Children to the Irish Medicines Board (Martin 2003, 4 March). The transfer will see the Irish Medicines Board taking on responsibility for ensuring national compliance in regard to the licensing and regulation requirements under the Misuse of Drugs Act (1977), and also for providing statistical reports to the United Nations as part of Ireland's national obligation under the terms of the various United Nations conventions on controlled drugs and precursor chemicals.

A Private Members Bill, the *Proceeds of Crime (Amendment) Bill 2003*, is currently being debated. The purpose of this Bill is to make specific changes to the Proceeds of Crime Act 1996 by inserting a new definition of drug-related initiatives into the Act. The insertion of this definition would enable the Minister for Justice, Equality and Law Reform to ensure 'that the proceeds of crime seized by the Criminal Assets Bureau are applied to appropriate organisations and initiatives which are focused on redressing the damage caused by those engaged in drug-related activities' (O'Dowd 2003, 21 October).

The *Criminal Justice (Joint Investigation Teams) Bill 2003* aims to provide for the implementation of the framework decision on 13 June 2002 of the Council of the European Union on joint investigation teams to combat trafficking.

The *Garda Síochána Bill 2004* aims to reform the law relating to the administration and management of the Garda Síochána and to establish an Ombudsman Commission to investigate complaints against members of An Garda Síochána. The Bill also contains proposals for the establishment of joint policing committees to consider issues of local crime, including drug-related crime. This development will be discussed further in Section 13.

The *Immigration Act 2004* was enacted in February 2004.<sup>3</sup> Section 4 (3) (c) provides for an immigration officer to refuse to permit a non-national coming from outside the state to enter the state, if the officer is satisfied that the person suffers from any of six conditions, including drug addiction. In 1975 these six conditions had been inserted, in an amendment, as the Fifth Schedule to the Aliens Order 1946.

The *Safety, Health and Welfare at Work Bill 2004* was published in June 2004. Section 9 (1) (a) requires an employee, at work, to ensure that he or she is not under the influence of an intoxicant [alcohol or drug, and any combination of drugs or of drugs and alcohol] to the extent that he or she endangers his or her own safety, health or welfare at work or that of any other person. Section 9 (1) (b) requires an employee, if reasonably required by his or her employer, to submit to any appropriate, reasonable and proportionate tests by a competent person.

### **Policing policy and the National Drugs Strategy 2001–2008**

As part of ongoing policy the Garda Síochána fulfils its role in accordance with the National Drugs Strategy 2001–2008. Garda members are represented on the National Drugs Strategy Team and on local and regional drugs task forces. Of the 100 actions identified in the strategy, 14 involve the Garda Síochána. Also, at the beginning of each year, the Garda Síochána publish a policing plan, setting out its strategic goals for the year. At a more local level each garda district and sub-district is required to produce a Drug Policing Plan to include multi-agency participation in targeting drug dealers. These plans are in the process of being drafted and it is intended that they will be put into a standard format and published on the garda website, [www.garda.ie](http://www.garda.ie) (Garda National Drugs Unit, personal communication, January 2004).

Strategic goal 4 of the Policing Plan for 2003 relates to the enforcement of the laws relating to drug abuse. Performance indicators include an increase in the enforcement of legislation on the sale and supply of drugs, implementation of the National Drugs Strategy 2001–2008 and the establishment of an implementation plan of action based on findings from the national study on drugs and crime (Furey and Browne 2004).

The Drug Policing Plan for 2004 continues with the goals of recent years (Garda Síochána 2004). Other priorities include:

- The production of a drug policing plan at district level;
- The targeting of the assets of middle-ranking criminals involved in drug dealing;
- The extension of the Community Policing Forum initiative (see Section 13) to all local drugs task force areas;
- The development of benchmarks against which seizures of drugs can be evaluated under the European Union Action Plans.

#### *Garda National Drugs Unit (GNDU)– operational deployment*

At the national level, the GNDU now operates under the direct authority of an assistant commissioner rather than a detective chief superintendent as was previously the case. A detective superintendent represents the GNDU on the National Drugs Strategy Team, which oversees the implementation of the National Drugs Strategy 2001–2008. There are currently 51 garda members employed in the GNDU. They include one chief superintendent, two superintendents, four inspectors, 10 sergeants and 34 ordinary garda members. The Minister for Justice, Michael McDowell TD, in response to a parliamentary question on 12 November 2002, outlined the number of gardaí detailed

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<sup>3</sup> The Immigration Act 2004 was enacted after a High Court judgement in January 2004 cast serious doubt on the constitutional validity of all statutory provisions dealing with the control of entry to and stays in the state by non-nationals.

to drugs squads throughout the State (Michael McDowell, 2004, 12 Nov; PQ 404). In total, three inspectors, 36 sergeants and 202 Gardaí are allocated to drug squads on a day-to-day basis.

Objective 7 of the National Drugs Strategy commits the gardaí to 'increase the level of garda resources in Local Drugs Task Force [LDTF] areas by end 2001' (Tourism, Sport and Recreation 2001). With regard to the garda resources in local task force areas, the Minister for Justice, Equality and Law Reform Michael McDowell TD stated in the Dáil (2003, 19 June) that 'the current resources within the LDTF areas have remained consistent with the levels of 2001'. In a further statement (2003, 25 November) he said that the number of personnel 'in the stations covering local drugs task force areas increased by 66 between January 2001 and September 2003'.

### **1.3 Institutional framework, strategies and policies**

#### **Co-ordination arrangements**

At national level the co-ordination of drug-related policies remains the same as that outlined in the last two National Reports. Despite calls from a variety of sources for the merging of the national strategies for alcohol and drugs (Long *et al.* 2004a, p. 12), the government has continued to prefer co-ordination rather than integration. Noel Ahern TD, Minister of State with Responsibility for the Drugs Strategy, explained the government's position as follows:

My Department has overall responsibility for co-ordinating the implementation of the National Drugs Strategy. ... The national alcohol policy, is the responsibility of my colleague, the Minister for Health and Children who is pursuing several initiatives in this area. The national drugs strategy calls for increased links between both policies in terms of cross-representation on the relevant committees and working groups to ensure complementarity between the different measures being taken. This work is ongoing. ... I am not aware of any plans at present to merge the alcohol and drugs policies. Furthermore, such a proposal would require careful consideration given that different policy responses are required for legal and illegal substances (N. Ahern 2004a).

At regional and local level, efforts to enhance co-ordination structures and mechanisms, also noted in the last two National Reports, for example the establishment of the Regional Drug Task Forces, have continued. Below are noted additional steps that have been initiated in the last 12 months or so.

*Delivery of Health Services:* In mid-2003 it was announced that the ten regional health boards, which have had responsibility for providing treatment and rehabilitation services for drug misusers, for support and training for community groups involved in drug-related prevention or rehabilitation activities, and for some 25 actions in the National Drugs Strategy, are to be abolished. They are to be replaced with a central Health Services Executive (HSE) and four regional offices, which will oversee the local delivery of health services.<sup>4</sup> This change will have a significant impact on the delivery of drug-related services and also on data-gathering activities in the drugs area. The restructuring is under way and is scheduled to be completed during 2005.

*Garda Síochána–Local Community Co-ordination:* A co-ordinating framework within each Garda District, to liaise with the community on drug-related matters and to act as

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<sup>4</sup> See *Audit of Structures and Functions in the Health System* (Prospectus 2003). This report recommends the consolidation of fragmented structures and functions to enable the health system deliver sustained value for money and a high quality of service for consumers.

a source of information for parents and members of the public, has progressed (Taoiseach 2004, p. 85).

- A co-ordinating framework linking Garda District, Divisional and National Drug Policing Plans is currently being put in place by the Garda authorities. The Garda Síochána Bill 2004 (published in February 2004) provides for the development of Joint Policing Committees at local-authority level and for the establishment of local policing fora in designated areas under the umbrella of such committees.
- These bodies are to act as fora where matters relating to local issues of policing and crime, including drug-related issues, can be discussed and where strategies and recommendations for dealing with issues locally can be formulated.
- A pilot Community Policing Forum initiative in Dublin's North Inner City has now been positively evaluated and has been approved for mainstreaming from January 2005 in accordance with procedures under the National Drugs Strategy. Other such fora are being supported on a pilot basis.

*Review of local community and development structures, including local drugs task forces:* This initiative, the inception of which was reported in the 2003 National Report, was completed in late 2003. On 4 February 2004 the results of the review were announced (O Cuiv 2004). Local and community development groups were to be asked to propose improvements in their respective areas by mid-2004, which the local County/City Development Boards (CDBs)<sup>5</sup> would consider and endorse, and funding would be earmarked to support measures emerging from this process. In future, departments/public bodies wishing to set up new services within the sector are to do so within the existing structures. As a consequence of these measures, it is anticipated that more money will be earmarked for the actual delivery of services to the customer than on administration.

### **National plan and/or strategies**

No new information.

### **Implementation of policies and strategies**

*National Drugs Strategy 2001–2008:* According to the target timeframes set out in the *Critical Implementation Path (CIP)*, a plan outlining the implementation of the National Drugs Strategy 2001–2008 (Community, Rural and Gaeltacht Affairs 2004), 43 of the 100 actions identified in the National Drugs Strategy should have been completed, or completed and ongoing, by the end of 2003; 35 actions are due for completion during 2004; and 22 actions are due for completion during the remainder of the period covered by the strategy, i.e. by 2007. In March 2004 Noel Ahern TD, Minister of State with Responsibility for the Drug Strategy, announced that, 'approximately one third of the 100 actions have been completed or are ongoing for the life of the strategy. With the exception of a few actions where work has yet to commence, work is in progress on the remainder' (N. Ahern 2004b).

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<sup>5</sup> The Task Force on the Integration of Local Government and Local Development Systems (1998) recommended that county and city development boards be established in each of the 29 county councils, and in each of the major cities, to bring about an integrated approach to the delivery of both state and local development services at local level. *The National Development Plan 2000–2006* envisaged that the county and city development boards (CDBs) would have a key role in co-ordinating local delivery of social inclusion measures (*National Development Plan 2000*, p. 196), and Action 71 of the *National Drugs Strategy 2001–2008* called on CDBs 'to consider the needs of those areas experiencing high levels of drug misuse when drawing up city- and countywide strategies for economic, social and cultural development' (Tourism, Sport and Recreation 2001). By 2002 all 34 CDBs had published their strategies for economic, social and cultural development.

## **Impact of policies and strategies**

The *National Drugs Strategy 2001–2008* is currently being reviewed, and the findings are expected in early 2005. Although this review is only occurring at the mid-term stage of the strategy, the results may give an indication of the impact of the government's policies and strategies.

### **1.4 Budget and public expenditure**

#### **In law enforcement, social and health care, research, international actions, co-ordination, national strategies**

The National Drugs Strategy Review Group estimated that for the year 2000, public expenditure on development, co-ordination and delivery under the four pillars – supply reduction, prevention, treatment and research – approximated to €183 million (para. 3.7.2).<sup>6</sup> The breakdown by government department showed that the Department of Justice, Equality and Law Reform accounted for 67 per cent (€123 million) of the expenditure, and the Department of Health and Children for 17 per cent (€32 million). Equivalent information on departmental expenditures in relation to the drugs issue for subsequent years is not readily available.

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

#### **Funding arrangements**

Since 2002 initiatives have been set in train to access additional public funds and to identify and tap into new sources of funding for social inclusion issues, including drug misuse. These included the establishment of the RAPID programme and the Dormant Accounts Fund Disbursements Board, and exploring possibilities in relation to using the monies and assets seized by the Criminal Assets Bureau and harnessing corporate social responsibility.

*RAPID*: Launched in February 2001, the RAPID programme targets urban centres and provincial towns with the greatest concentration of disadvantage, including drug misuse, for priority funding under the National Development Plan. In the 2004 Estimates €5.8 million was allocated to the RAPID programme for the implementation of the Programme and for co-funding a number of small-scale local projects in RAPID areas (O'Cuiv 2003).

*Dormant Accounts Fund Disbursements Board*:<sup>7</sup> In mid-2002 the Dormant Accounts Fund Disbursements Board was established as an independent statutory body. Its remit is to formulate a plan for the disbursement of monies from the Dormant Accounts Fund for programmes or projects designed to assist the personal, educational or social development of persons who are educationally or socially disadvantaged or persons with a disability. The Board's first disbursement plan, for 2003–2005, states that at

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<sup>6</sup> Expressed in punts in the *National Drugs Strategy*, the costs have been converted here into euro at the rate of Ir£1.00 = €1.27.

<sup>7</sup> A 'dormant account' refers to monies deposited in a financial institution, including credit institutions and insurance undertakings, which have not been claimed by the account holder.

least 40 per cent of total annual funding will be allocated to the area of economic and social disadvantage, and, in the first year of the plan, this 40 per cent will be wholly allocated to RAPID, CLÁR<sup>8</sup> and drugs task force areas; in subsequent years, not less than 50 per cent of the annual proportion allocated to economic and social disadvantage will be allocated to RAPID, CLÁR and drugs task forces (DAFDB 2003, p. 7). Valued at €180 million at the end of 2003, it is expected that some €30 million will be disbursed annually from the Fund (N. Ahern 2003). In light of the emerging scale of the Fund, the government has drawn up amending legislation, the Dormant Accounts (Amendment) Bill 2004, to ensure appropriate capacity to evaluate and process applications (Community, Rural and Gaeltacht Affairs 2003).

*Criminal Assets Bureau:* In 2003 a private member's bill, the Proceeds of Crime (Amendment) Bill, was introduced, which, if enacted, would see the release after three years of resources seized by the Criminal Assets Bureau to the Minister for Justice, Equity and Law Reform for allocation to 'drug-related initiatives', rather than into the central Exchequer after seven years have elapsed, as at present. It was noted that starting from 2004, when monies and assets seized by the Criminal Assets Bureau can start to be released, as much as €19 million per annum might begin to flow into the Exchequer (Perry 2003). The government opposed the Bill on the grounds that the Proceeds of Crime (Amendment) Bill 1999 was already before the House and any further amendments could be submitted and debated in reference to that Bill. While not opposing the proposal to shorten the period before monies could be released, the government raised a number of objections to the ring-fencing of the monies for drug-related initiatives (Smith 2003).

*Corporate Social Responsibility:* Progress on the exploration of the possibility of applying the concept of corporate social responsibility specifically in relation to the drugs issue, noted in last year's National Report, has not been reported on in the last twelve months (Taoiseach 2004).<sup>9</sup>

## **1.5 Social and cultural context**

### **Public opinions of drug issues**

No new information available.

### **Debates and initiatives in parliament and civil society**

Public debate on the drugs issue has continued through the usual channels – the Dáil and Seanad (the national parliament and its upper house, the Senate), conferences and workshops organised by both governmental and non-governmental agencies,

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<sup>8</sup> Administered by the Department of Community, Rural and Gaeltacht Affairs, CLÁR (Ceantair Laga Árd-Riachtanais) is a targeted investment programme for rural areas, complementing RAPID which focuses on disadvantaged urban areas and provincial towns. For further information see [www.pobail.ie](http://www.pobail.ie)

<sup>9</sup> Along with corporate social responsibility, the term 'social capital' came to the fore in the revised National Anti-Poverty Strategy as a 'key objective' (Social, Community and Family Affairs 2001, 8, p. 18). A few months later, under the heading *Building an Inclusive Society, An Agreed Programme for Government* stated that the newly elected Fianna Fáil– Progressive Democrat coalition government would seek to collect data on social indicators, including consistent poverty and social capital, and would 'work to promote social capital in all parts of Irish life through a combination of research and ensuring that local activity supports the development of social capital, particularly on a local community level' (Taoiseach 2002, p. 21). In launching a report on the policy implications of social capital (NESF 2003), the Taoiseach, Bertie Ahern TD, defined social capital as 'networks, relationships and feelings of belonging, of trust and a sense of civic responsibility. These are things which shape the spirit of co-operation and quality of life in local communities and groups, and enable wider society to achieve desired policy goals more effectively. I suppose you could describe Social Capital as a kind of glue that holds society together.' He went to observe: 'while Social Capital is hard to quantify, it is a resource that has, in the past, been under-valued' (B. Ahern 2003, 29 October).

campaigns and public announcements mounted by organisations concerned with the drugs issue, and a wide range of publications. Below are noted the orientation of two public debates on drug-related issues that were taken up during the 2003/04 period – young people and substance misuse, and drug treatment policy options, particularly the issue of drug treatment in prisons, and treatment responses to polydrug users.<sup>10</sup> Drug testing, which was noted as a topic of debate in the 2003 National Report, is now the subject of proposed employment legislation (see Section 1.2).

### **Young People and Substance Misuse**

In light of the acknowledged growing prevalence of substance misuse (both illegal drugs and alcohol) among young people and children, aged 18 and under, in Ireland,<sup>11</sup> public debate on the issue is frequent and widespread. Among contributions to the debate have been explorations of approaches to deterrence – the use of diversions such as promoting sport and the arts, and providing alternative recreational opportunities – and proposals for the provision of clearer structures, guidance and support for young people. This latter category of proposals is associated with studies of alcohol abuse among young people. They are noted here, given the debate mentioned above (Section 1.3) regarding the need to consider drug and alcohol abuse together.

*Dáil na nÓg (National Children's Parliament):*<sup>12</sup> In November 2003 Dáil na nÓg held its third annual conference, with 192 delegates, aged between 12 and 18 years, from every county in Ireland. The delegates chose drug and alcohol abuse as one of its two topics for debate. The delegates concluded:

- We need more facilities, leisure centres, discos, youth clubs and other alcohol-free activities.
- Information and education is too late or not at all – we need campaigns on drugs and alcohol from primary school up.
- We want advertising to highlight the dangers of drug and alcohol abuse.
- We need support to overcome peer-pressure.
- Alcohol is part of our culture – adults need to change too.

The Minister for Children, Brian Lenihan TD, told the delegates that he acknowledged that the lack of non-pub entertainment facilities for teenagers was a major national issue and guaranteed delegates that a recreation policy for 12–18-year-olds would be prepared by the National Children's Office (Dáil na nÓg 2003).

*Joint Committee on Arts, Sport, Tourism, Community, Rural and Gaeltacht Affairs:* In April 2004 this Joint Parliamentary Committee released its *Report on the Effectiveness of Investment in Sport and the Arts as a Deterrent against Youth Substance Abuse*. The committee concluded that there is evidence that arts and sports programmes can facilitate the holistic development of the individual and reduce the propensity to abuse various substances. Finding that current provision is characterised by dependence on pilot schemes, a lack of long-term commitment, and lack of staff and resources, the Committee called for a broad, child-centred, multi-tiered strategy for substance abuse prevention in Ireland that includes sport and the arts. It recommended that alcohol and its abuse should be included in the National Drugs Strategy.

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<sup>10</sup> Debates in the criminal justice area, including supply reduction and public order issues involving illicit drugs, reported on in the 2002 National Report, have continued. Further information on these can be provided if required.

<sup>11</sup> Recent studies of drug use prevalence among young Irish people, such as ESPAD (Hibell *et al.* 1999), Kelleher *et al.* (2003), and Flanagan *et al.* (2003) have all indicated growing trends in drug use.

<sup>12</sup> Arising out of the National Children's Strategy (Health and Children 2000) and in line with Article 12 (1) of the UN Convention on the Rights of the Child, Dáil na nÓg was established to provide an annual national forum where children can raise and debate issues of concern, under the auspices of the Minister for Children. A report on the outcome of the parliament is submitted to the Cabinet Committee on Children, which is chaired by the Taoiseach. For further information see [www.dailnanog.ie/](http://www.dailnanog.ie/)



*Joint Committee on Health and Children:* In June 2004 this Joint Parliamentary Committee released its *Report on Alcohol Misuse by Young People*. The report included 10 key recommendations, calling for the establishment of a National Alcohol Control Centre to advise on alcohol control measures, for changes to taxation, pricing and advertising policies, and for additional steps to be taken by hospital Accident and Emergency departments, suppliers of alcohol, local authorities in the administration of public parks, and front-of-house security staff, to curb alcohol misuse by young people.

*MEAS (Mature Enjoyment of Alcohol in Society Ltd):* Established in late 2002, MEAS is a drinks industry initiative to combat alcohol misuse and abuse.<sup>13</sup> In June 2004 MEAS released *Underage Drinking is Rarely Black and White*. Based on focus group interviews with parents and with teenagers, and a nationwide survey of four hundred 12–17-year-olds, the research found that half the country's 16- and 17-year-olds are drinking alcohol 'regularly' and that domestic (at home) drinking by parents is a key influencer of their children. Few parents are sure 'what is the right thing to do'. There appears to be a marked reluctance by parents of minors to discuss the issue with other parents; many parents are worried about being too dogmatic, and of setting unrealistic rules for their under-18s where drink is concerned. Many feel that there are 'worse things', such as drug taking or becoming pregnant. MEAS intends to use the research findings to inform the content and direction of its work in seeking solutions. MEAS identifies the introduction of a tamper-proof, universal identity card which would greatly assist parents, publicans, off-licensees and the gardaí to enforce the current law as one of the most effective responses.

### **Drug Treatment Options**

The debate over the advantages and disadvantages of substitution therapies and harm reduction strategies versus abstentionist approaches to drug treatment, already highlighted in the 2003 National Report, has continued over the past 12 months.<sup>14</sup> Two recently-emerging issues are highlighted here – treatment regimes in prisons, and the need for responses targeted at poly-drug users.

The Minister for Justice, Equality and Law Reform, Michael McDowell TD, has consistently argued that prisons must be drug-free and treatment based on abstentionist principles:

*It is my policy to apply best practice to the prison situation. Best practice, as far as I am concerned, is to prevent drugs from being introduced into or used in prisons. The programme for Government commits me to creating a drug free Prison Service with mandatory drug testing of prisoners. I intend to put this commitment into effect and expect to receive shortly, from the Office of the Parliamentary Counsel, a new set of prison rules which will make provision for, among other things, mandatory drug testing.*

*In addition, a group consisting of Irish Prison Service management, including prison governors and health board staff together with relevant clinicians have prepared a draft prison drug treatment policy which I am currently considering.*

*It is both my policy and that of the Irish Prison Service, in common with most prison systems worldwide, not to issue needles or injecting equipment to prisoners. The Report of the Group to Review the Structure and Organisation of Prison Health Care Services considered the matter of developing a syringe exchange programme within Irish prisons and came to the conclusion that such a step could not be recommended.*  
(McDowell 2004a)

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<sup>13</sup> For further information on MEAS, visit [www.meas.ie](http://www.meas.ie)

<sup>14</sup> A list of the studies published and the conferences hosted by government agencies, research bodies and groups within the community sector that have contributed to the debate during the past 12 months is available if required.

In September 2004 the media reported a disagreement over prison drug treatment policy between the Minister for Justice and the Minister of State with responsibility for the Drugs Strategy, Noel Ahern TD. The latter was reported as suggesting that a needle exchange programme should be introduced in prisons to prevent the spread of infectious diseases such as AIDS and hepatitis. The Minister of State was further reported as saying that a needle exchange programme would not conflict with Government policy as such programmes are envisaged under the National Drugs Strategy: *The strategy provides that the same types and level of drug treatment services be provided to addicts within the prison system as are available in the general community. While services 'aren't perfect' in the community, they do provide for needle exchange programmes* (Reid 2004).

The Irish Penal Reform Trust (IPRT),<sup>15</sup> a non-governmental organisation campaigning for the rights of people in prison and the progressive reform of Irish penal policy, welcomed Minister Ahern's support for prison syringe exchange programmes, while 'rubbishing' the Minister for Justice's opposition to these 'effective public health programmes'. The IPRT is due to release a new report *Prison Needle Exchange: Lessons from a Comprehensive Review of International Evidence and Experience* in mid-October 2004.

The National Drugs Strategy 2001–2008 noted that *the perceived emergence of poly-drug use was a cause for concern in a number of submissions, as was the risk of methadone becoming a "street" drug.* (Tourism, Sport and Recreation 2001, para. 5.4.4) However, the Strategy did not identify the need to tailor treatment responses to the needs of poly-drug users. In late 2003 the issue began to come to the fore. In September 2003, Dublin Citywide Drugs Crisis Campaign organised a general meeting for community organisations to discuss 'the drug crisis in local communities'. The meeting found, *inter alia*, that although heroin presented a particular problem because of its devastating impact on communities, most drug users were using a whole variety of drugs. Benzodiazepines were regarded as a major problem and concerns were expressed about the trade in prescribed drugs. The role of alcohol and the increasing use of cocaine were identified as other important factors. It appeared that poly-drug use was the norm for drug users, whether they were in treatment or not. It was concluded that treatment services should be reshaped to deal with the reality of poly-drug use (Connolly 2003b). In February 2004 the need to address polydrug use was explicitly acknowledged at government level: *We have to be aware that most drug users engage in poly-drug use and, therefore, projects need to be able to address this pattern of usage rather than concentrating on one drug to the exclusion of others.* (N Ahern 2004c)<sup>16</sup>

### **Media representations**

No new information available.

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<sup>15</sup> For further information on the Irish Penal Reform Trust, visit [www.iprt.ie](http://www.iprt.ie)

<sup>16</sup> At a meeting of the Council of Europe's Pompidou Group in Dublin in October 2003, the management of poly-drug use, especially among young people, was one of the main themes under consideration. The meeting agreed that there was a need to carry out more research into poly-drug use and develop a co-ordinated global approach to the problem (Sinclair and Galvin 2003).

## 2. Drug Use in the Population

### 2.1 Overview

This section provides an overview of drug use in the population based on prevalence surveys published in 2003.

Drug prevalence surveys 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

Two national surveys of drug use in the general population were published in 2003. Both are discussed below.

In April 2003 the results of the second national Survey of Lifestyle, Attitudes and Nutrition (SLÁN) were published (C. Kelleher *et al.* 2003). The SLÁN survey was first undertaken in 1998 (Friel *et al.* 1999) and repeated again in the summer of 2002. In both surveys a small number of questions on drug use were asked allowing drug use patterns to be examined. As in 1998, the sampling frame was the electoral register, the target population thus being adults aged 18 years and over. A proportionate random sampling design was used to select the survey sample. The questionnaires were posted to respondents and were self-administered. A total of 5,992 questionnaires were returned from a valid sample of 11,212 sent out, giving a response rate of 53.4 per cent. This compares with a response rate of 62.2 per cent in the 1998 survey. The report notes that the 2002 survey had fewer younger males (18-34 year olds) than in the earlier survey and in the general population as a whole.

The published SLÁN results only provide a limited analysis of the drug use questions. Prevalence figures for males and females are reported separately. Combined totals are not reported. While the first SLÁN report did not report any drug prevalence data the second SLÁN report provides data from both the 1998 and 2002 survey thus allowing comparisons over time.

Lifetime (ever used), last year (recent use) and last month (current use) prevalence of cannabis use for adult males and females (18+ years) in 1998 and 2002 is shown in Table 2.2.1. For both genders there has been an increase in the proportion of people claiming to have ever used cannabis or used the drug in the last year or in the last month. The largest increase occurred in 'lifetime' use and may reflect a growing willingness to experiment with cannabis. It should be stressed however that no confidence intervals were provided around these estimates so that the differences between the two surveys could be due to sampling variation.

**Table 2.2.1 Trends in lifetime, last year and last month prevalence of cannabis use for adult males and females (18+ years) between 1998 and 2002.**

Cannabis use	Adult males	Adult males	Adult females	Adult females
	1998 %	2002 %	1998 %	2002 %
During lifetime	21.9	26.2	13.8	19.1
During last year	11.0	12.1	6.2	6.7
During last month	6.7	7.8	2.8	3.0

Apart from the cannabis figures the report also provides last year prevalence rates for amphetamines, cocaine, ecstasy, heroin, LSD, magic mushrooms, and solvent use, see Table 2.2.2. There is a notable increase in the recent use of cocaine and ecstasy while amphetamine use dropped. Again the lack of confidence intervals makes it difficult to determine if these differences are statistically significant.

**Table 2.2.2 Trends in last year prevalence of amphetamines, cocaine, ecstasy, heroin, LSD, magic mushrooms, and solvent use for adult males and females (18+ years) between 1998 and 2002.**

Used in last year (recent use)	Adult males 1998 %	Adult males 2002 %	Adult females 1998 %	Adult females 2002 %
Amphetamines	3.6	2.4	1.3	0.6
Cocaine	1.8	3.0	0.6	1.9
Ecstasy	2.9	3.9	1.5	2.4
Heroin	0.5	0.4	0.3	0.5
LSD	1.9	1.6	0.8	0.8
Magic Mushrooms	2.2	2.3	0.6	0.6
Solvents	0.5	0.7	0.3	0.6

In October 2003 the National Advisory Committee on Drugs (NACD) and the Drugs and Alcohol Information and Research Unit (DAIRU) within the Department of Health, Social Services and Public Safety in Northern Ireland published jointly the first results from an all-Ireland general population drug prevalence survey (NACD and DAIRU 2003).

The survey followed best practice guidelines recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA 2002). The questionnaire, based on the 'European Model Questionnaire', was administered through face-to-face interviews with respondents aged between 15 and 64 years normally resident in households in Ireland and Northern Ireland. Fieldwork was carried out by MORI MRC between October 2002 and April 2003. The final achieved sample was 4,925 in Ireland and 3,517 in Northern Ireland. This represented a response rate of 70 per cent in Ireland and 63 per cent in Northern Ireland. The sample was weighted by gender, age and health board area to maximise its representativeness of the general population.

Full details of the main results for Ireland can be found in the on-line version of Standard Table 1. Key findings for Ireland are described below. One in five (19%) adults reported using an illegal drug in their lifetime (see Table 2.2.3). For young adults (15-34 years) this rose to one in four (26.4%) people. Twice as many men as women reported the use of an illegal drug during the last month or the last year.

**Table 2.2.3 Lifetime, last year and last month prevalence of illegal drugs in Ireland**

Ever used an illegal drug*	Adults 15-64 years %	Males 15-64 years %	Females 15-64 years %	Young adults 15-34 years %
During lifetime	19.0	24.4	13.5	26.4
During last year	5.6	7.7	3.4	9.7
During last month	3.0	4.1	1.8	5.2

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

Source: Drug Use in Ireland & Northern Ireland. Bulletin 1: First results from the 2002/2003 Drug Prevalence Survey. NACD & DAIRU 2003.

Cannabis was the most commonly used illegal drug. One in six adults had used cannabis in their lifetime and this increased to one in four for young adults (see Table 2.2.4)

**Table 2.2.4 Lifetime, last year and last month prevalence of cannabis in Ireland**

Ever used cannabis	Adults 15-64 years %	Males 15-64 years %	Females 15-64 years %	Young adults 15-34 years %
During lifetime	17.6	22.5	12.5	24.4
During last year	5.1	7.1	3.0	8.7
During last month	2.6	3.4	1.7	4.4

Source: Drug Use in Ireland & Northern Ireland. Bulletin 1: First results from the 2002/2003 Drug Prevalence Survey. NACD & DAIRU, 2003.

Prevalence of other illegal drugs was lower and confined largely to the younger age groups. One in fourteen (7.1%) young adults claimed to have tried ecstasy at least once in their lifetime (see Table 2.2.5).

**Table 2.2.5 Lifetime, last year and last month prevalence of ecstasy in Ireland**

Ever used ecstasy	Adults 15-64 years %	Males 15-64 years %	Females 15-64 years %	Young adults 15-34 years %
During lifetime	3.8	4.9	2.6	7.1
During last year	1.1	1.5	0.6	2.2
During last month	0.3	0.6	*	0.6

\* less than 0.05%

Source: Drug Use in Ireland & Northern Ireland. Bulletin 1: First results from the 2002/2003 Drug Prevalence Survey. NACD & DAIRU, 2003.

Cocaine use (including crack) was much higher in men than women for lifetime, current and recent use (see Table 2.2.6).

**Table 2.2.6 Lifetime, last year and last month prevalence of cocaine (including crack) in Ireland**

Ever used cocaine (including crack)	Adults 15-64 years %	Males 15-64 years %	Females 15-64 years %	Young adults 15-34 years %
During lifetime	3.1	4.5	1.7	4.8
During last year	1.1	1.7	0.5	2.0
During last month	0.3	0.7	*	0.7

\* less than 0.05%

Source: Drug Use in Ireland & Northern Ireland. Bulletin 1: First results from the 2002/2003 Drug Prevalence Survey. NACD & DAIRU, 2003.

Valid comparisons between the NACD & DAIRU survey and the SLÁN survey are made difficult due to differences in survey methodologies, age ranges of respondents, and context in which the drug questions were asked.

## 2.3 Drug use in the school and youth population

In April 2003 the results of the second national Health Behaviour in School-aged Children (HBSC) survey carried out in Ireland were published (C. 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, health behaviour and their social context. A total of 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 followed those used in 1998. Individual schools within health boards were first randomly selected and classes within schools were subsequently

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 per cent. 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.

The published HBSC results only provide a limited analysis of the drug use questions. Prevalence figures for males and females are reported separately for lifetime and last year use of cannabis and lifetime use of glue or solvents. While the first HBSC report did not report any drug prevalence data the second HBSC report provides data from both the 1998 and 2002 survey thus allowing comparisons over time.

For school-going boys there was a small drop in both lifetime and last year prevalence of cannabis use between 1998 and 2002, Table 2.3.1. School-going girls on the other hand experienced an increase in cannabis use. Again the lack of confidence intervals around these estimates makes it difficult to determine if these differences are statistically significant.

**Table 2.3.1 Trends in lifetime and last year prevalence of cannabis use for school-going boys and girls (10-17 years) between 1998 and 2002.**

<b>Cannabis use</b>	<b>Boys 1998 %</b>	<b>Boys 2002 %</b>	<b>Girls 1998 %</b>	<b>Girls 2002 %</b>
During lifetime	16.2	14.2	8.6	11.7
During last year	14.0	13.4	6.7	9.5

Lifetime prevalence of glue or solvent use increased slightly between the two surveys for both genders, Table 2.3.2.

**Table 2.3.2 Trends in lifetime prevalence of glue or solvent use for school-going boys and girls (10-17 years) between 1998 and 2002.**

<b>Glue or solvent use</b>	<b>Boys 1998 %</b>	<b>Boys 2002 %</b>	<b>Girls 1998 %</b>	<b>Girls 2002 %</b>
During lifetime	6.0	7.7	3.7	4.9

Apart from the above national survey, two regional drug prevalence studies were published in 2003.

In January 2003 the Department of Public Health in the Mid-Western Health Board (MWHB) published a second survey of smoking, alcohol and drug use by teenagers in Counties Clare, Limerick and Tipperary North-Riding (K. Kelleher *et al* 2003). The survey, which was carried out in 2002, covered post-primary school students aged 13-19 years. Using a multistage stratified random sampling method, the researchers surveyed a total of 2,297 students from 23 schools. The anonymous questionnaire used in the survey (administered in the classroom setting by the researchers or by teachers) allowed comparisons with a previous school survey in the MWHB in 1988. The report's findings are based on 2,279 students with valid responses.

In terms of drug use, the survey found that 39 per cent of students had used at least one drug<sup>17</sup> in their lifetime. This was almost 10 per cent higher than in the 1998 MWHB survey. Cannabis was the most commonly used illicit drug: 29 per cent of students reported using cannabis at some stage in their lifetime, again an increase of almost 10 per cent since the previous survey, Table 2.3.3. Fifteen per cent of students stated that they had used cannabis in the month prior to the survey, an increase of seven per cent since 1998. No confidence intervals were reported for these estimates.

**Table 2.3.3 Trends in lifetime and last month prevalence of cannabis use for school-going children (13-19 years) in the Mid-Western Health Board (MWHB) between 1998 and 2002**

Cannabis use	MWHB (1998)	MWHB (2002)
	%	%
During lifetime	19.0	28.6
During last month	8.4	15.4

Inhalants (glue, aerosols, etc.) were the second most commonly used drugs in the mid-west region and both lifetime and last month use increased since 1998, Table 2.3.4.

**Table 2.3.4 Trends in lifetime and last month prevalence of inhalant use for school-going children (13-19 years) in the Mid-Western Health Board (MWHB) between 1998 and 2002**

Inhalant use	MWHB (1998)	MWHB (2002)
	%	%
During lifetime	13.6	21.3
During last month	2.7	6.4

Most students in the 2002 survey indicated that cannabis was the first illicit drug they had used, that a friend was the main source of this drug and that 'curiosity' was the main reason why they chose to experiment with drugs. In 1998 the most common reason for experimenting with drugs was 'everyone else does it'. These findings highlight the potential influence of peers in the first use of drugs.

In November 2003 the Department of Public Health in the North Eastern Health Board (NEHB) published a second survey of smoking, alcohol and drug use among young people in Counties Cavan, Monaghan, Louth and Meath (Flanagan *et al.* 2003). The survey, which was carried out in 2002, covered post-primary school students aged 12-19 years. Using a multistage stratified random sampling method, the researchers surveyed a total of 1,426 students from 24 schools. The anonymous questionnaire used in the survey (administered in the classroom setting by a research officer) allowed comparisons with a previous school survey in the NEHB in 1997

In terms of illicit drug use the survey found that 41 per cent had taken at least one illicit drug<sup>18</sup> in their lifetime. This was six per cent higher than in the 1997 NEHB survey. More girls than boys reported that they had ever taken an illicit drug in 2002 (boys 41 per cent, girls 42 per cent) compared to 1997 (boys 37 per cent, girls 32 per cent). The large increase in lifetime prevalence of any illicit drug for girls is a cause for concern since it may reflect a growing willingness to experiment with drugs.

Cannabis was the most commonly used illicit drug. Thirty-one per cent of students reported using cannabis at some stage in their lifetime, an increase of over six per cent since the previous survey, Table 2.3.5. Just under thirteen per cent stated that they had used cannabis in the past month and increase of over three per cent since 1997.

<sup>17</sup> Includes cannabis, inhalants, ecstasy, magic mushrooms, tranquillisers without prescription, amphetamines, crack, cocaine, heroin and LSD.

<sup>18</sup> Includes cannabis, inhalants, ecstasy, speed, magic mushrooms, cough syrup, cocaine, LSD, heroin and barbiturates (note: not all these drugs are illicit).

**Table 2.3.5 Trends in lifetime and last month prevalence of cannabis use for school-going children (13-19 years) in the North Eastern Health Board (NEHB) between 1998 and 2002**

Cannabis use	NEHB (1997)	NEHB (2002)
	%	%
During lifetime	24.6	31.0
During last month	9.4	12.8

Inhalants (glue, aerosols, etc.) were the second most commonly used drugs in the north east region. Lifetime and last month use of inhalants was higher in 2002 than in 1997, Table 2.3.6. Again the lack of confidence intervals around these estimates makes it difficult to determine if these differences are statistically significant.

**Table 2.3.6 Trends in lifetime and last month prevalence of inhalant use for school-going children (13-19 years) in the North Eastern Health Board (NEHB) between 1998 and 2002**

Inhalant use	NEHB (1997)	NEHB (2002)
	%	%
During lifetime	18.9	21.8
During last month	2.0	2.5

Results from the 2002 survey suggest that younger people were being approached with offers of drugs more so than in 1997 and the person offering these drugs was someone that their friends knew or was their best or very good friend. This latter finding highlights the potential influence of peers in the use of drugs and points to the need for strategies aimed at facilitating young people to identify and resist peer influences.

Another notable finding from the survey was the relationship that emerged between smoking, alcohol consumption and illicit drug use. Regular smokers (smoking at least one cigarette per day) were more likely to have been offered illicit drugs, to have taken an illicit drug and were more than six times more likely to report using an illicit drug in the last month than were non-smokers. The same pattern was also apparent among regular drinkers (consuming one or more alcoholic drinks per week) though not as strong as for regular smokers. The report notes that these findings 'point to the potency of alcohol and especially tobacco, in illicit drug use and serve as support for considering these substances as *gateway* drugs.' The report goes on to stress that 'gateway drugs do not necessarily cause young people to use harder drugs, but using these substances may set up patterns of behaviour that may make it easier to progress to using other drugs or may result in young people frequenting places where they can get or be offered illicit drugs' (Flanagan *et al.* 2003, p. 65)

## 2.4 Drug use among specific groups

Research carried out in 2003 which has examined drug use among specific groups of the population is covered in the Part 8 (Social Correlates and Consequences) of this report.

## 2.5 Attitudes to drugs and drug users

No new information available.

# 3. Prevention

## 3.1 Overview

An overloaded curriculum and industrial relations issues are reported to be an obstacle for the implementation of Social, Personal and Health Education (SPHE) in secondary schools. A greater proportion of first year students in secondary school receive SPHE



than students in third year. Community based responses targeting families and young people with drug education and prevention activities are emerging in regions outside the Eastern Region. Groups are increasing their use of technology through websites to disseminate drug prevention information to communities. Research into selective prevention education in schools reports that children relate well to local parents trained as facilitators in delivering drug prevention education in the classroom.

## **3.2 Universal prevention**

### **School**

Universal drug prevention is delivered in post-primary schools through the Social, Personal and Health Education programme (SPHE). According to a recent evaluation (Geary and McNamara 2003) the SPHE programme aims to:

*promote self-esteem and self-confidence, personal skills, responsible decision-making, opportunities to reflect and discuss and promote physical, mental, emotional health and well-being. (p. 7)*

The evaluation focused on the implementation of the programme looking at the extent of implementation, the methods involved, how it was received in schools and its relevance. A postal survey was administered to school principals, teachers/ co-ordinators with SPHE and teachers with no SPHE involvement. The survey received a 48 per cent response rate from principals representing the number of responding schools.

Sixty-seven per cent of principals offered SPHE in their school, one-third did not offer SPHE. The programme was more likely to be offered in mixed schools, with boys' secondary schools faring least well. Principals noted that recent industrial action by the teachers' union delayed in-service training for teachers. Additional factors listed by principals as contributing to the slow implementation of SPHE were curriculum overload, too many courses and timetable constraints. Over 50 per cent of teachers/ co-ordinators of SPHE received over 21 hours of in-service training. Over 80 per cent of SPHE teachers/co-ordinators who have had contact with the SPHE support service indicated that the service is providing 'some' or a 'lot' of help to cope sufficiently with the programme.

SPHE was offered in 70 per cent of responding schools in students first year, decreasing to 46 per cent by the third year. According to the evaluator, exam subjects receiving an increased focus as students approach their Junior Certificate exams may explain this decrease. In 75 per cent of cases, SPHE is offered as a stand-alone subject with most students receiving one class period per week. Relationships (93%) sexuality (90%) and substance misuse (90%) were the main themes of SPHE highlighted by SPHE teachers/co-ordinators as being of most relevance to pupil's lives. Teachers reported that these issues were also the areas that they focused on most. Niney-one per cent of teachers not involved in teaching SPHE were aware that attention was being given to the misuse of substances in SPHE. Principals were asked to indicate the degree of emphasis placed on substance misuse education in schools; 65 per cent felt that it was awarded some emphasis, 33 per cent indicated strong emphasis with two per cent stating that no emphasis was placed on substance misuse education.

### **Family and Community**

A notable development in recent times has been the consistent theme of community involvement in responding to drug misuse in regions outside the Eastern region.

Responses primarily target parents, families and young people and include seminars, information sessions and social/cultural sessions on the theme of raising awareness about drugs. Alternatives to drug use for young people are also provided. Responses are organised and delivered at community level by parents trained as facilitators, teachers, youth workers and community drug workers. Some examples of community-based interventions include, County Waterford Community Based Drugs Initiative (CWCBDI), The Frontline Community Drugs Project, The County Carlow Drugs Initiative (CCDI) and the Waterford Community Based Drug Initiative (WCBDI). For a comprehensive overview of these projects see the EDDRA database.

A recent innovation has been the emergence of the Drug Education Workers Forum (DEWF) made up of drug education workers from the statutory, voluntary and community sectors. The DEWF grew from a need to identify the various agencies involved in developing and delivering drug education programmes. The forum provides for drug education workers to meet on a regular basis to exchange information, offer support to workers and work towards developing an integrated response to drug issues to inform national drug policy. A representative of the DEWF has been appointed to participate in the National Drug Strategy Team. Currently the DEWF are working on developing a template of quality standards to inform the future provision of drug education. More information can be found on [www.dublin.ie/dewf](http://www.dublin.ie/dewf)

The Minister for Health and Children launched the second phase of the three-year National Drug Awareness Campaign in January 2004. The second phase includes four weeks of television advertisements across eight television channels. An additional initiative included in the second phase is the drugs information roadshow that will travel to major population centres throughout the country. The roadshow will consist of panels of experts in the drugs area meeting with local communities in designated locations through a question and answer session. Local press and radio advertising will inform people where the roadshows are being held. The campaign has also launched two drug information booklets: *How do I talk to someone about drugs*, aimed at children, and *A parent's guide to drugs*. Both booklets can be received free of charge by ringing the campaign information line. In addition, individuals wishing to speak to someone confidentially about a drugs problem can also ring the information line and ask to be transferred directly to a drugs helpline staff member. Information on drugs is also available on the campaign's website; [www.drugsinfo.ie](http://www.drugsinfo.ie) .

### **The use of technology targeting families and communities in drug prevention**

Groups are increasingly using websites to disseminate information on drugs and related issues to communities. Recent innovations in this area include the Mid-Tipperary Drugs Initiative (MTDI), which aims to raise awareness of substance misuse amongst young people, parents and the wider community (see [www.drugtipps.com](http://www.drugtipps.com) ). The Athlone Drug Awareness Group (ADAG) provides factual information on drugs and advice for youth, parents and schools, information on local services and leaflets on drugs information. Also included is emergency advice on first aid and needle stick injuries (see [www.athlone.ie/drugawareness](http://www.athlone.ie/drugawareness) ).

Ireland's first interactive drug awareness website is operated by Crosscare, the Social Care Agency of the Dublin Diocese. The site targets young people, families, parents and professionals. The aim is prevention; to help people avoid drug problems and support those impacted by drug problems. One key feature is the unique, interactive 'Live Helper' facility, which is a first in Ireland. This offers the website users the chance to make live anonymous, confidential online contact with fully trained members of staff, to seek advice and help regarding drug-related issues. Service is available during specified hours each day (10.00-14.00). This website has won British Telecom

Telephone Helpline Association Award 2003/ 2004. The site also contains an interactive map of Irish drug services (see [www.dap.ie](http://www.dap.ie) ).

### **3.3 Selective/indicated prevention**

#### **Recreational settings**

##### *The 'Club Cork' Alcohol & Drugs Awareness Training Programme*

This programme was launched in Cork City in March 2004; targeting publicans, security staff and bar staff in the city. The aim is to increase awareness of the negative effects of alcohol and drug misuse and help participants identify possible solutions to deal with such issues. The training programme has been piloted in a number of Cork City bars/clubs. More than fifty staff comprising publicans, bar staff and security staff took part in the two half-day training sessions where training was provided by Emergency Medical Technicians; security personnel; Accident & Emergency Consultants and gardaí. Feedback from the pilot programme has been very positive, with participants and trainers enjoying the interactive and practical nature of the course. Participants report to be better informed about the misuse of drugs and alcohol and find it beneficial in terms of their working environment. Many expressed an interest in further training.

##### *The 'Gaf' Health Advice Cafe*

The provision of drug and alcohol free entertainment in a health promotional setting has been developed as a key alternative to drug use for young people in Galway City situated in the West of Ireland. The 'Gaf' provides drug and alcohol free entertainment in a safe environment and on Friday nights local bands play to a packed house until 10.30. Latest data from the project shows that an average of 1,000 young people attends the project per month with 68 per cent in the 15-17 age group. Slightly more females, 53 per cent, to males, 47 per cent, attend the project. As part of an evaluation to review and develop the service a survey was recently carried out among participants assessing their experiences and perceptions of the service. A total of 115 survey questionnaires composed of both open and closed-ended questions were completed. The results show that 55 per cent of those surveyed attend the 'Gaf' once a week. 77 per cent of respondents perceived the 'Gaf' to be either excellent or good. One of the thematic responses come from respondents was their reliance on 'peers' for information and support on drug- health-related issues. In addition, the responses indicate that the young people surveyed see the 'Gaf' as an acceptable alternative venue to meet friends for socialising purposes (Fitzmaurice 2002).

#### **At risk groups**

The Killinarden Drug Primary Prevention Group (KDPPG) delivers drug prevention activities to third, fourth, fifth and sixth class students in three primary schools in Killinarden. Activities designed to enhance the self-esteem of third and fourth-class students include a mixture of games, role-play exercises and quizzes. Students in fifth and sixth classes receive drug awareness education including information on different types of drugs and the consequences of use. A follow-up programme aiming to build on the self-esteem and drug education activities is delivered in Killinarden Community School to students up to third year. From 1995-2003, an estimated 800 young people participated in the various school-based drug prevention activities. A recent evaluation (Rourke 2003) reported that:

- parents trained as facilitators report improved parenting skills, increased knowledge about drugs and a perception that their work is making a valuable contribution to the prevention of drug misuse in their community. Many parents

who were early-school leavers, report that KDPPG was a key motivating factor in them returning to adult education.

- teachers report that young people interact with local parents in a more open and discursive way than they might relate to teachers or to external 'experts'. Local parents were seen as having the credibility to 'tell it as it is'. Teachers also report that local parents are professional, efficient, punctual and well prepared when delivering their presentation.
- young people were seen to relate well to the issues being raised by parent facilitators in the schools, e.g. issues about how young people perceive themselves, their experience of peer pressure and how to be assertive when offered drugs. In addition, young people have become more aware and more informed about the dangers and consequences of drug and alcohol misuse and many have become more assertive and seem less likely to succumb to peer pressure to use drugs.

For a comprehensive overview of this intervention see the EDDRA database.

Dun Laoghaire/Rathdown LDTF recently commissioned research exploring the current and future value of community-based substance prevention courses, now that primary schools have the 'Walk Tall' programme available to them through Social, Personal and Health Education (SPHE). This research was carried out by Collins (2004) and focused on selective prevention courses in local schools.

### *Research findings and analysis*

Summary of key results from two research questions on drug education in schools.

**Table 3.3.1 Key groups first choice preferences, when asked who they believe should teach children about drugs**

Key Groups			
Children	Parents	Course facilitator	School personnel (teachers)
Facilitators (55%)	Parents (62%)	Facilitators 43%	Parents (63%)
Parents (22%)	Facilitators (20%)	Parents (43%)	Facilitators (32%)
Ex-drug user (20%)	Ex-drug user (8%)	Others (14%)	Ex-drug users (5%)
Others (3%)	Teachers (7%)		
	Others (3%)		

**Table 3.3.2 Key groups first choice preferences, when asked who they believe children would find it easy to talk to about drugs**

Key Groups			
Children	Parents	Course facilitator	School personnel (teachers)
Parents (45%)	Parents (50%)	Facilitators (71.5%)	Facilitators (57%)
Facilitators (30%)	Facilitators (22%)	Friends (28.5%)	Teachers (16%)
Friends (17%)	Friends (14%)		Parents 11%
Others (8%)	Family (7%)		Friends (11)%
	Others (7%)		Ex-drug users (5%)

Source: Collins 2004

It is interesting to note that across the four groups, teachers are rated quite low as an option to teach children about drugs or for children to talk with about drugs. Only a small percentage of school personnel themselves believe that children would find it easy to talk with teachers about drugs. Responses from school personnel included comments like 'teachers do not have the expertise on drugs shared by course facilitators'; also, reservations were expressed about the priority given to 'social subjects' like drug education. Although these findings relate to the perceptions and views of these small groups and have limitations in terms of generalising to the national picture, they do raise questions for policy makers and educational authorities on the exclusive reliance on teachers to deliver drug education through the Walk Tall/SPHE in primary schools. Indeed, the position of teachers as providers of drug education is further challenged by the children's view, which rates ex-drug users quite high as key teachers on substance use prevention. This, despite the background that teachers were delivering the 'Walk Tall' programme in most of the schools covered in this research, with no evidence that ex-drug users were involved in drug education.

When children were asked to suggest ways that schools could prevent children getting involved in drugs, the most frequent suggestion was information accompanied by a video about drugs, the harm caused by drugs to the person and risks of getting addicted to drugs. In addition, the children reported that what they 'liked' most about the course was the information given about various types of drugs including alcohol and nicotine. This would support the view that school-going children want drug specific information from credible sources and see course facilitators and ex-drug users among such sources.

#### **Early school leavers: support intervention**

A key initiative to prevent early school leaving and the consequent heightened risk of substance abuse is the establishment of the Educational Welfare Service. From December 1<sup>st</sup> 2003, six cities and 12 towns have an intensive educational welfare service to work with schools and families to ensure that children attend school regularly. These cities and towns have been prioritised because they are designated as educationally disadvantaged and have significant school going populations.

#### **Ethnic groups**

The Traveller Specific Drug Initiative has been introduced nationally to Traveller groups, drug-related service providers and policy makers. This raised the profile of the initiative and highlighted the issues of Travellers and drug use, and the distinct needs of the Traveller community. The work has included developing an anti-racist focus on information and training sessions that are being provided to ensure that information is placed within a context of Traveller experience. Training has been delivered to service providers via a training programme run by the health boards, focusing on Travellers and drug use and issues that affect Travellers such as discrimination, equality, racism and diversity. The initiative provides advice and support to local Traveller organisations who are looking at developing responses to drug issues and supports them in accessing and piloting initiatives in their local areas. A small number of Traveller groups have begun developing specific responses to the drug issue within their community. For a comprehensive overview of the service see the EDDRA database.

#### **At risk families**

The Ana Liffey Children's project has been operating in Dublin since October 1999 with the principal aim to promote and support high quality parenting and enhance the quality of life for children of parents who use drugs. The project has developed a number of specific objectives in setting out to: (a) respond to the emotional needs of children of drug using parents, (b) support and up-skill drug using parents in caring for their

children, and (c) to operate a service that is valued by the client base and the wider community. The service provides family support, advocacy, mediation, parenting interventions, group and individual sessions with children, outreach to B&Bs and drop-in advice service, after-school programme and a summer project. A recent evaluation of the project (Downes and Murray 2002) found that the children (age 7-12) interviewed gave overwhelmingly positive responses on the project. They valued the support, stability and trusting relationships they formed with staff and the support for family relationships. They enjoyed, and appeared to benefit from, the extensive variety of sessions available on an individual and group basis. In particular, the children reported that they enjoyed the activity sessions at the project, the involvement in activities after school, e.g. football, dancing, being able to talk to project social workers and childcare worker were particularly helpful. All the children interviewed are now participating in regular schooling and in extra-curricular activities such as football and dancing. In addition, parents of the children all expressed the view that the project had changed their life for the better. The project was viewed in very high esteem by external professionals with most of them saying they had great confidence in the project and would trust the project to meet the needs of clients they might refer. For a comprehensive overview of this service see the EDDRA database.

## **4. Problem Drug Use**

### **4.1 Overview**

This section provides an overview of the new developments and trends in the prevalence and characteristics of problem drug use in Ireland. It reflects the findings of new research studies published in 2003 or from data available in 2003 or early 2004.

The EMCDDA define problem drug use as 'injecting drug use or long duration/regular use of opiates, cocaine and/or amphetamines' (EMCDDA 2003, p. 18) 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.

### **4.2 Prevalence and incidence estimates**

In July 2003 the findings of a new study to estimate the number of opiate users in Ireland were published (Kelly *et al.* 2003). The research – the first national study of its type – was commissioned by the National Advisory Committee on Drugs (NACD) and conducted by a team from Trinity College Dublin. A three-source capture-recapture methodology was applied following guidelines recommended by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA 2000). Three national data sources were used for both 2000 and 2001, namely 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. A summary of the results for 2000 and 2001 stratified by age and sex are shown below (see Table 4.2.1). Further details can be found in the on-line version of Standard Tables 7 and 8.

**Table 4.2.1 Prevalence estimates for opiate use in Ireland for the years 2000 and 2001 stratified by age and sex**

Year	Sex	Age Group	Estimate	Lower 95% CI	Upper 95% CI	Rate/1000
2000	Males	15-24	3480	3298	3691	10.4
		25-34	3935	3753	4144	13.7
		35-64	2344	2013	2803	3.6
	Females	15-24	1866	1664	2142	5.8
		25-34	1729	1542	1983	6.1
		35-64	804	614	1120	1.2
	<b>Total</b>	<b>15-64</b>	<b>14158</b>	<b>12884</b>	<b>15883</b>	<b>5.6</b>
2001	Males	15-24	3194	3048	3363	9.5
		25-34	4376	4206	4570	14.7
		35-64	2228	2042	2462	3.3
	Females	15-24	1999	1750	2340	6.2
		25-34	1941	1765	2178	6.6
		35-64	714	594	906	1.1
	<b>Total</b>	<b>15-64</b>	<b>14452</b>	<b>13405</b>	<b>15819</b>	<b>5.6</b>

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 1000 population aged 15-64 years and outside Dublin the rate was just under 1.2 per 1000 population aged 15-64 years.

In December 2003, the National Advisory Committee on Drugs (NACD) published a report entitled *An overview of cocaine use in Ireland* (NACD 2003). As part of the overview, the NACD commissioned two studies in two different settings so as to explore a wider spectrum of cocaine use in Dublin. The first study conducted by UISCE (Union for Improved Services, Communication and Education) used a purposive sampling technique in that interviewers used their networks and contacts to approach people they thought likely to be cocaine users. Merchant's Quay Ireland conducted the second study. They surveyed 100 clients who presented for treatment at their health promotion unit and who had used cocaine or crack in the previous year. The respondents' average age of first cocaine use was similar in the UISCE study and the Merchant's Quay study, 21 and 22 years respectively. In both studies almost half of the respondents used cocaine on a weekly basis. Twenty per cent of respondents in the Merchant's Quay study reported using cocaine on a daily basis, while this figure doubled to 40 per cent in the UISCE study. The discrepancy in the two figures may be due to the fact that the majority of respondents in the Merchant's Quay study (83%) reported using heroin in addition to cocaine, with almost three-fifths reporting heroin as their main problem drug. In contrast, just over two-fifths of cocaine users in the UISCE study reported heroin use. Participants in both studies reported high levels of polydrug use. A lower proportion of respondents in the UISCE study reported injecting cocaine than their counterparts in the Merchant's Quay study, 58 versus 82 per cent. As Merchant's Quay provides a needle exchange facility this finding was not surprising.

In the study at Merchant's Quay, the majority of injector respondents did not mix the cocaine with another drug, while 41 per cent mixed it with heroin (as a snowball). In addition, 30 per cent of crack users reported injecting crack. As the authors state, these high rates of injecting cocaine, crack and 'speedball' indicate the high risks taken by

this group. In this study, it was reported that 45 per cent of crack users and 23 per cent of cocaine users had not used the drug in the last month but three-quarters of the respondents reported binge use. The authors highlighted the high-risk practices associated with binge use and stress this is an important issue for harm minimisation interventions. Many of the injecting cocaine users in the study reported a range of mental health problems, such as, depression and hallucinations. The authors stated that it was unclear whether the difficulties experienced by cocaine/crack users were due to intravenous heroin or cocaine use as 87 per cent of cocaine injectors were also using heroin. These issues were not reported for the cocaine users that participated in the UISCE study.

In the Merchant's Quay study, only 44 per cent of respondents said that their cocaine use was problematic, and of these, only 16 per cent had sought treatment. In contrast, three fifths of respondents in the UISCE survey felt that their cocaine use was problematic as almost all (98%) had experienced changes in behaviour since they started using cocaine. Despite this, only a small proportion of these (less than one third) had sought treatment. According to the authors, low levels of treatment seeking were related to the belief among cocaine users across both studies that treatment for cocaine use was futile due to the lack of a pharmacological substitute.

### 4.3 Profile of clients in treatment

#### Substances used

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 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.'

#### *Numbers treated by place of residence*

The number of cases presenting for treatment and reported to the NDTRS has increased steadily, from 6,048 in 1998 to 8,596 in 2002 (Table 4.3.1). This increase is explained by a combination of factors: a true increase in drug use, an increase in access to treatment services, and an increase in the number of centres reporting cases to the NDTRS.

**Table 4.3.1 Number (%) of cases treated for problem drug use, by treatment status, in Ireland, 1998–2002**

<i>Treatment status</i>	<b>1998</b>	<b>1999</b>	<b>2000</b> <i>Number (%)</i>	<b>2001</b>	<b>2002</b>
<b>All cases</b>	<b>6048</b>	<b>6206</b>	<b>6933</b>	<b>7900</b>	<b>8596</b>
<i>Previously treated cases</i>	4194 (63.9)	4421 (71.2)	4877 (70.3)	5663 (71.7)	6256 (72.8)
<i>New cases</i>	1626 (26.9)	1673 (27.0)	1941 (28.0)	2074 (26.3)	2101 (24.4)
<i>Status unknown</i>	228 (3.8)	112 (1.8)	115 (1.7)	163 (2.1)	239 (2.8)

Source: unpublished analysis from the NDTRS

The numbers treated for problem drug use and residing in the Eastern Regional Health Authority area (Dublin, Kildare, Wicklow) increased by 24 per cent between 1998 and 2002, while the numbers treated for problem drug use and residing in the seven health board areas outside the Eastern Regional Health Authority (ERHA) increased by 263



per cent during the same period (Table 4.3.2). The numbers treated for problem drug use and residing in the ERHA area are substantially higher than numbers treated for problem drug use residing in the other seven health board areas. Of note, as a proportion of all treated problem drug users, the proportion of treated problem drug users living outside the ERHA area increased from 15 per cent in 1998 to 27 per cent in 2002 and this suggests that drug misuse is becoming a problem outside the ERHA area.

**Table 4.3.2 Number (%) of cases treated for problem drug use by health board of residence 1998–2002\***

<i>Area of residence</i>	<b>1998</b>	<b>1999</b>	<b>2000</b> <i>Number (%)</i>	<b>2001</b>	<b>2002</b>
<b>All cases</b>	<b>6048</b>	<b>6206</b>	<b>6933</b>	<b>7900</b>	<b>8596</b>
<i>Eastern Regional Health Authority (ERHA)</i>	5083 (84.0)	5152 (83.0)	5323 (76.8)	5868 (74.3)	6248 (72.7)
<i>Seven Health Boards outside the ERHA*</i>	886 (14.6)	1031 (16.6)	1596 (23.0)	2024 (25.6)	2328 (27.1)
<i>Non-resident</i>	10 (0.2)	12 (0.2)	9 (0.1)	7 (0.1)	9 (0.1)
<i>Address unknown</i>	69 (1.1)	11 (0.2)	5 (0.1)	1 (0.0)	11 (0.1)

\*The seven health board areas are the: Midland Health Board, Mid-Western Health Board, North Eastern Health Board, North Western Health Board, Southern Health Board, South Eastern Health Board and Western Health Board.  
Source: unpublished analysis from the NDTRS

### *Main Problem Drug*

The profile of main problem drugs reported by treated cases differed by place of residence (Table 4.3.3). Almost 94 per cent of treated cases residing in the ERHA area reported that an opiate was their main problem drug, while almost 19 per cent of treated cases residing outside the ERHA area reported an opiate as their main problem drug. Just under three per cent of treated cases residing in the ERHA area reported that cannabis was their main problem drug, while just under 56 per cent of treated cases residing outside the ERHA area reported this as their main problem drug. In both areas the numbers reporting cocaine as a main problem drug increased but the increase is greater in the seven areas outside the ERHA. It is important to note that cocaine is mainly reported as a second, third or fourth problem drug. The reason that cocaine was reported as a secondary problem drug is that 85 per cent of cases reporting cocaine use are attending opiate treatment services and service providers reported opiates as the treated drug user's main problem drug.

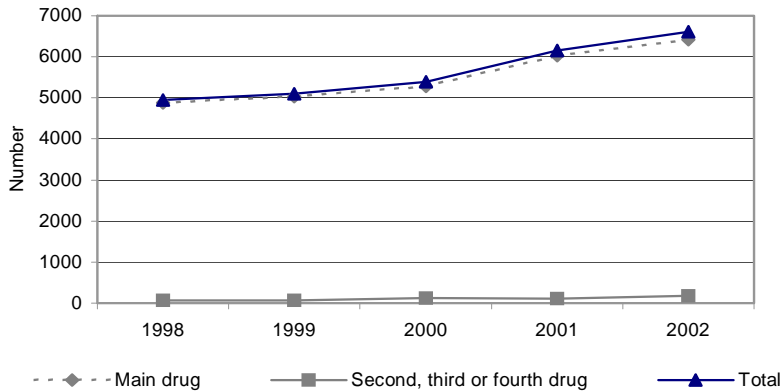
**Table 4.3.3 Main problem drug reported by cases treated for problem drug use, by health board of residence, 1998–2002**

<i>Main problem drug</i>	<b>1998</b>	<b>1999</b>	<b>2000</b> <i>Number (%)</i>	<b>2001</b>	<b>2002</b>
<b>ERHA</b>	<b>5070</b>	<b>5152</b>	<b>5323</b>	<b>5868</b>	<b>6248</b>
<i>Opiates</i>	4652 (91.8)	4840 (93.9)	5031 (94.5)	5631 (96.0)	5921 (94.8)
<i>Cannabis</i>	206 (4.1)	168 (3.3)	137 (2.6)	95 (1.6)	177 (2.8)
<i>Benzodiazepines</i>	57 (1.1)	27 (0.5)	56 (1.1)	57 (1.0)	42 (0.7)
<i>Cocaine</i>	56 (1.1)	32 (0.6)	47 (0.9)	43 (0.7)	73 (1.2)
<i>Ecstasy</i>	46 (0.9)	50 (1.0)	32 (0.6)	30 (0.5)	18 (0.3)
<i>Amphetamines</i>	24 (0.5)	18 (0.3)	2 (0.0)	4 (0.1)	1 (0.0)
<i>Volatile inhalants</i>	18 (0.4)	8 (0.2)	11 (0.2)	3 (0.1)	3 (0.0)
<i>Other substances</i>	11 (0.2)	9 (0.2)	7 (0.1)	5 (0.1)	13 (0.2)
<b>Outside ERHA</b>	<b>886</b>	<b>1031</b>	<b>1596</b>	<b>2024</b>	<b>2328</b>
<i>Cannabis</i>	419 (47.3)	553 (53.6)	933 (58.5)	1146 (56.6)	1334 (57.3)
<i>Opiates</i>	160 (18.1)	181 (17.6)	241 (15.1)	397 (19.6)	490 (21.0)
<i>Ecstasy</i>	148 (16.7)	164 (15.9)	257 (16.1)	271 (13.4)	245 (10.5)
<i>Amphetamines</i>	48 (5.4)	42 (4.1)	28 (1.8)	17 (0.8)	29 (1.2)
<i>Benzodiazepines</i>	37 (4.2)	23 (2.2)	42 (2.6)	52 (2.6)	64 (2.7)
<i>Cocaine</i>	27 (3.0)	24 (2.3)	31 (1.9)	52 (2.6)	79 (3.4)
<i>Volatile inhalants</i>	17 (1.9)	24 (2.3)	30 (1.9)	37 (1.8)	43 (1.8)
<i>Other substances</i>	30 (3.4)	20 (1.9)	34 (2.1)	52 (2.6)	44 (1.9)

Source: unpublished analysis from the NDTRS

### Opiates

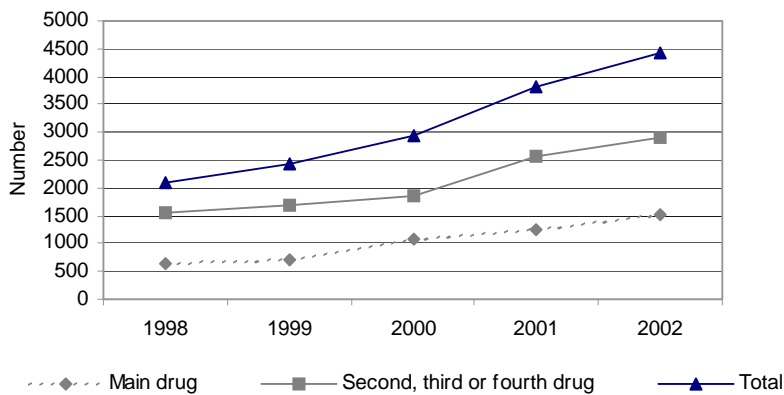
Just over 98 per cent of treated cases report an opiate as their main problem drug (Figure 4.3.1). The total number of treated opiate cases increased by 31 per cent. This is mainly accounted for by an increase in opiate cases that continue in or return to treatment, from 3,817 in 1998 to 5,578 in 2002. The overall number of new opiate cases requesting treatment decreased by 12 per cent, from 997 cases in 1998 to 875 cases in 2002. The number of new opiate cases in the Eastern Regional Health Authority area decreased from 927 in 1998 to 624 in 2002, while the number of new opiate cases outside the Eastern Regional Health Authority area increased from 60 in 1998 to 205 in 2002.



**Figure 4.3.1 Numbers that reported an opiate as a problem drug and attended treatment between 1998 and 2002 (Source: unpublished analysis from the NDTRS)**

### Cannabis

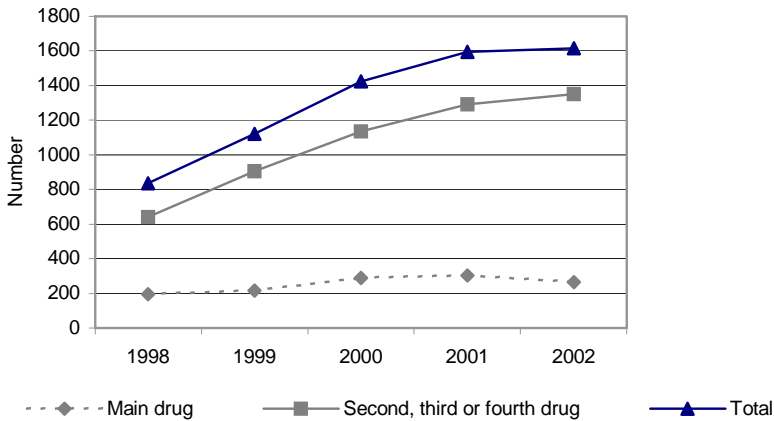
The total number of cases treated for problem cannabis use doubled, increasing from 2,088 in 1998 to 4,422 in 2002 (Figure 4.3.2). The proportion of cases reporting cannabis as a main problem drug increased over 140 per cent during the reporting period, while the proportion reporting it as a secondary drug almost doubled. There was a 75 per cent increase in the number of new cases who reported cannabis as a problem drug during the period under review. The majority of cases treated for cannabis as a main problem drug were living outside the Eastern Regional Health Authority area (Table 4.3.2).



**Figure 4.3.2 Numbers that reported cannabis as a problem drug and attended treatment between 1998 and 2002 (Source: unpublished analysis from the NDTRS)**

### Ecstasy

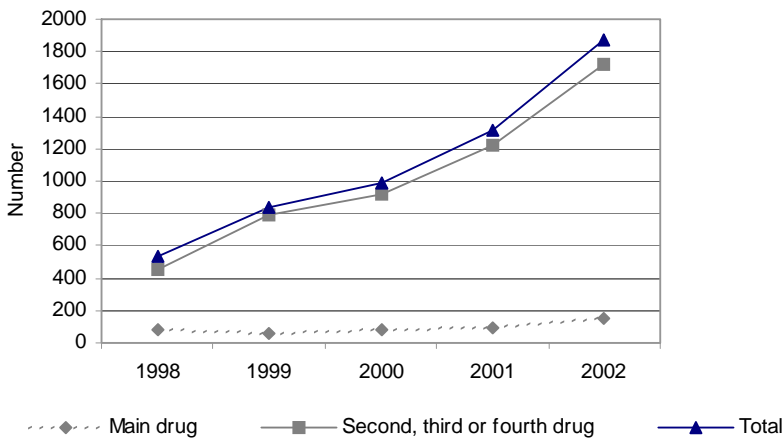
The numbers attending treatment and reporting ecstasy as a problem drug almost doubled, from 835 in 1998 to 1,615 in 2002 (Figure 4.3.3). There was a sharp increase between 1998 and 2001, and a modest increase in 2002 relative to 2001. The number of treated cases reporting ecstasy as a main problem drug followed the overall trend.



**Figure 4.3.3** Numbers that reported ecstasy as a problem drug and attended treatment between 1998 and 2002 (Source: unpublished analysis from the NDTRS)

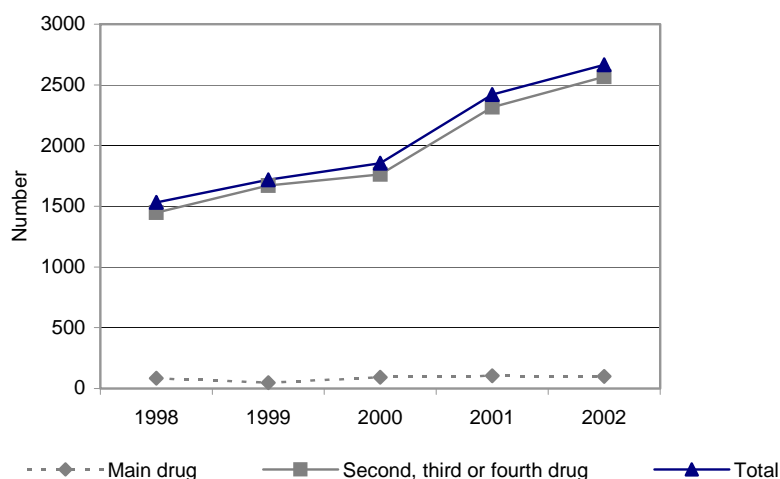
### Cocaine

Overall, the numbers treated for cocaine as their main problem drug have increased considerably from 86 in 1998 to 155 in 2002 (Figure 4.3.4). However, cocaine is mainly reported as a second, third or fourth problem drug and the numbers so reporting have increased substantially, from 454 in 1998 to 1,716 in 2002. The reason that cocaine was reported as a secondary problem drug is that 85 per cent of cases were attending opiate treatment services and therefore service providers reported opiates as the drug user's main problem drug.



**Figure 4.3.4** Numbers that reported cocaine as a problem drug and attended treatment between 1998 and 2002 (Source: unpublished analysis from the NDTRS)

## Benzodiazepines



**Figure 4.3.5** Numbers that reported benzodiazepines as a problem drug and attended treatment between 1998 and 2002 (Source: unpublished analysis from the NDTRS)

The numbers in treatment reporting benzodiazepine misuse increased from 1,533 in 1998 to 2,666 in 2002 (Figure 4.3.5). There was a considerable rise between 2000 and 2002. Problem benzodiazepine use follows the same pattern as problem cocaine use: 87 per cent of cases reported it as a second, third or fourth problem drug. Of those who reported an opiate as their main problem drug and used one or more other drugs, just under 50 per cent used benzodiazepines as a secondary drug.

## Alcohol

Prior to January 2004, the National Drug Treatment Reporting System did not collect data on alcohol as a main problem drug.

In April 2004, the DMRD, in collaboration with the South Eastern and Southern Health Boards, published an occasional paper entitled *Treatment demand for problem alcohol use in the South Eastern and Southern Health Board areas, 2000-2002* (Long *et al* 2004a). It is the first publication that documents treatment demand for problem alcohol use in community settings and special residential services and complements the data published in the annual reports from the National Psychiatric Inpatient Reporting System.

The number of treated cases reporting alcohol as their main problem substance is at least double that reporting all other drugs combined in the South Eastern and Southern Health Board areas (Table 4.3.4), suggesting that alcohol is the most common substance of abuse in Ireland.

**Table 4.3.4** Numbers (%) reporting problem substance use that attended treatment in the South Eastern Health Board (SEHB) and Southern Health Board areas (SHB), 2000 to 2002

Main problem substance	2000		2001		2002	
	SEHB	SHB	SEHB	SHB	SEHB	SHB
Alcohol	1010 (71.2)	719 (67.3)	1472 (76.7)	852 (61.0)	1498 (71.5)	1160 (64.2)
Drug (licit or illicit)	408 (28.8)	349 (32.7)	447 (23.3)	544 (39.0)	598 (28.5)	647 (35.8)
<b>Total</b>	<b>1418</b>	<b>1068</b>	<b>1919</b>	<b>1396</b>	<b>2096</b>	<b>1807</b>

Source: Long *et al.* (2004a)

In both health board areas, 40 per cent of those reporting problem alcohol use had been treated previously, indicating that this is a chronic health problem.

In 2001 and 2002, one-fifth of treated cases in both health board areas reported use of drugs along with alcohol. Cannabis was the most common drug used alongside alcohol. Previously treated cases were more likely to use benzodiazepines with alcohol than were their newly treated counterparts.

There was an increase in the proportion of new female cases seeking treatment for problem alcohol use in both areas, though the increase was higher in the Southern Health Board area.

The rate of new cases (incidence) seeking treatment for problem alcohol use varied throughout the seven counties included in the study and merely reflected the level of service provision in the area and participation in the reporting system.

This analysis demonstrates that it is possible to collect reliable data on problem alcohol use through the National Drug Treatment Reporting System, and highlights that the exclusion of alcohol from reporting systems leads to an underestimation of problem substance use and the workload of addiction services.

The benefit of information on persons with problem alcohol use is that it will permit planners to rank problem alcohol use alongside other public health priorities in the population and to allocate appropriate resources to its management.

There is momentum gathering that responses to alcohol and illicit drug use should be integrated. This is an issue that is being discussed by the ten Regional Drugs Task Forces, which have been set up over the last year. These data identify a clear overlap between problem alcohol and drug use and point to the need for an integrated approach to the management of substance misuse.

#### *Socio-demographic characteristics of problem drug users (excluding alcohol users)*

Table 4.3.5 presents demographic and socio-economic information by health board area of residence. The number of treated drug users living in the ERHA area under 18 years old decreased between 1998 and 2002, while the number living in the other seven health board areas under 18 years old increased considerably. Those under 18 years require different approaches to treatment and it is important that this is recognised in service planning. A higher proportion of treated drug users living in the ERHA area were female than the proportion living outside the ERHA. Women drug users also have a number of additional requirements that need to be considered during service planning (such as childcare issues and high-risk sexual practices). A higher proportion of treated drug users living in the ERHA area left school before their fifteenth birthday than their counterparts living outside the ERHA. Overall there were very low rates of employment among treated drug users. Education and employment are important considerations during the rehabilitation phase.

**Table 4.3.5 Demographic and socio-economic characteristics of cases treated for problem drug use by health board of residence 1998–2002**

<i>Characteristic*</i>	<i>1998</i>	<i>1999</i>	<i>2000</i> <i>Number (%)</i>	<i>2001</i>	<i>2002</i>
<b>ERHA†</b>	<b>5070</b>	<b>5152</b>	<b>5323</b>	<b>5868</b>	<b>6248</b>
<i>Number (%) under 18 years</i>	387 (7.6)	213 (4.2)	180 (3.4)	161 (2.8)	169 (2.7)
<i>Number (%) males</i>	3423 (68.4)	3445 (67.0)	3601 (67.8)	3949 (68.0)	3972 (67.0)
<i>Number (%) of early school leavers**</i>	1210 (29.1)	1215 (28.4)	1433 (30.9)	1527 (29.5)	1585 (28.5)
<i>Number (%) aged 16 to 64 years employed</i>	865 (18.2)	1267 (26.0)	1358 (26.8)	1347 (24.4)	1337 (22.8)
<b>Outside ERHA†</b>	<b>886</b>	<b>1031</b>	<b>1596</b>	<b>2024</b>	<b>2328</b>
<i>Number (%) under 18 years</i>	137 (15.6)	164 (16.0)	279 (17.5)	346 (17.1)	422 (18.3)
<i>Number (%) males</i>	690 (80.2)	796 (77.8)	1264 (79.6)	1571 (78.2)	1811 (80.4)
<i>Number (%) of early school leavers**</i>	94 (15.8)	137 (19.1)	241 (19.7)	320 (21.0)	302 (17.7)
<i>Number (%) aged 16 to 64 years employed</i>	258 (31.1)	284 (29.2)	507 (34.5)	645 (34.9)	659 (31.3)

\* It is not possible to ascertain the percentage with each characteristic of interest from the total number because not all forms had complete data.

† Health boards in the ERHA are: Northern Area Health Board, South Western Area Health Board and East Coast Area Health Board. Health boards outside the ERHA are: Midland Health Board, Mid-Western Health Board, North Eastern Health Board, North Western Health Board, Southern Health Board, South Eastern Health Board and Western Health Board.

\*\* Left school before the age of 15 years.

Source: unpublished analysis from the NDTRS

### Centre types

The numbers attending treatment by centre type is presented in Table 4.3.6. There has been an increase in the number of patients treated at outpatient services and a decrease in the numbers treated at inpatient services. The numbers treated at general practitioners were a considerable underestimate as general practitioner returns were very low (16%).

**Table 4.3.6 Numbers of clients treated by service type and reported to the NDTRS, 1998-2002**

Type of treatment service	<i>1998</i>	<i>1999</i>	<i>Year</i> <i>2000</i>	<i>2001</i>	<i>2002</i>
<b>Outpatient</b>	4566 (75.5)	4497 (72.5)	5583 (80.5)	6688 (84.7)	7271 (84.6)
<b>Residential</b>	1272 (21.0)	1005 (16.2)	796 (11.5)	725 (9.2)	798 (9.3)
<b>Low threshold</b>	182 (3.0)	284 (4.6)	280 (4.0)	216 (2.7)	149 (1.7)
<b>General practitioner</b>	24 (0.4)	413 (6.7)	274 (4.0)	271 (3.4)	370 (4.3)
<b>Treatment in prison</b>	4 (0.1)	7 (0.1)	0 (0.0)	0 (0.0)	0 (0.0)
<b>Not known</b>	0 (0.0)	0 (0.0)	0 (0.0)	0 (0.0)	8 (0.1)
<b>Total</b>	<b>6048</b>	<b>6206</b>	<b>6933</b>	<b>7900</b>	<b>8596</b>

### Comments

Between 1998 and 2002, three quarters of treated drug users were polydrug users and the patterns of drugs used changed according to availability of drugs and peer influences. In response to such changing patterns of drug use, it is important that our services have a broad range of options to adapt to and cope with new substances and combinations of substances.

In the Eastern Regional Health Authority the treatment of clients with problem opiate use was the predominant service available between 1998 and 2002, even though the same clients may be using alcohol, benzodiazepines, cocaine or cannabis in combination with their opiate; for many clients there were no specific actions documented in the clinical records to address the other substances. In the Eastern Regional Health Authority over 93 per cent of clients treated reported that an opiate was their main problem drug, whereas outside this area over 57 per cent of clients reported that cannabis was their main problem drug. Of note, the National Advisory Committee on Drugs (NACD and DAIRU 2004) reported that cannabis use in the

population was higher in the Eastern Regional Health Authority area than outside this area while treatment service data report the opposite experience, indicating a bias in treatment services. On the other hand, medication free and behavioural therapies are the main models of treatment outside the Eastern Regional Health Authority area and counsellors report that clients may have to travel to Dublin on a daily basis to access methadone. The treatment models needs to be client-centred rather than based on the availability or beliefs of treatment providers in a geographical area.

#### **4.4 Main characteristics & patterns of use from non-treatment sources**

In Ireland little is known about drug users that are not in treatment.

##### **Substances used**

There is no research data available on substances used.

##### **Injecting drug users**

The injecting drug user population in Ireland is concentrated predominately in County Dublin and to a lesser extent in Counties Wicklow and Kildare, although there is evidence of spread to counties bordering the Eastern Regional Health Authority area (Long *et al* 2004c). There are currently no needle and syringe-exchange programmes outside the Eastern Regional Health Authority (ERHA) area (Moore *et al.* 2004).

There are two agencies (ERHA and Merchants Quay Ireland) collating information on clients attending needle and syringe-exchange. On the first visit both organisations collect baseline information from each client 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 Northern and East Coast Area Health Boards, they have commenced entering all client contacts on the Drugs and AIDS Information System and this will replace the current paper submissions to the ERHA.

The data from the needle exchange reporting system was published for the first time in 2001. The aim of the study was to identify characteristics and trends over time among 1,224 young injecting drug users (between the ages of 15 and 19 years) at first attendance at needle exchange from 1990 to 1997 (Mullen and Barry 2001). The study found that the number and proportion of young injectors, particularly young female injectors increased over the eight years. Forty-eight per cent of the young injectors were injecting for less than one year. Needle sharing prevalence in the year prior to first attendance was 39 per cent and condom use was 61 per cent. The proportion of females not using a condom during sexual relationships was significantly higher than males. Very few of the young attenders had received any treatment for drug dependence. The study concluded that after the first year of injecting drug use the likelihood of needle sharing increased, indicating the importance of reducing the time interval between commencing injecting drug use and starting treatment.

##### **Other specific sub populations**

There are no research data available on substances used.

## **5. Drug-Related Treatment**

### **5.1 Overview**

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.'

### **5.2 Treatment systems**

Treatment is provided through a network of statutory and non-statutory agencies. There are two broad philosophies through which treatment services are provided, namely: medication free therapy and medically assisted treatment. There is a small degree of overlap between the two. Medication free therapy use 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 include opiate detoxification and substitution therapies, alcohol and benzodiazepine detoxification, and psychiatric treatment. Various types of counselling are provided through both philosophies of treatment.

### **5.3 Drug free treatment**

The bulk of existing drug-free treatment services are provided in residential settings. Drug-free treatment is characterised by the approach used, where the ultimate aim is to enable individuals to achieve and maintain a lifestyle based on total abstinence from all mind-altering chemicals. The Minnesota Model, based on the 12 steps of Alcoholics Anonymous (AA), is the predominant model used in drug-free residential treatment settings in Ireland.

The model recognises addiction as a disease characterised by a progressive lessening of control over the abused substance and a consequent deterioration of all areas in the individual's life. The criterion of admission to drug-free treatment mainly consists of the following: (a) prior participation in a 'primary treatment programme';<sup>19</sup> (b) alcohol and drug free status, including non-use of methadone, for 72 hours prior to admission; (c) willingness to pursue a drug-free lifestyle and (d) willingness to partake in the therapeutic, educational and vocational aspects of the treatment programme. No research has been carried out in Ireland to assess how strict, or otherwise, this criterion is applied. The duration of residential treatment can vary between 28 days and 12 months. A brief overview of an adolescent drug-free treatment is provided below.

#### *The Aislinn Adolescent Addiction Treatment Service*

The Aislinn Adolescent Addiction Treatment Service provides a national addiction treatment programme for young people (male and female) aged 15-21 years. The programme began accepting participants in October 1998. The programme uses the Minnesota Model approach (based on the 12-Steps of AA). The duration of treatment consists of a six-week residential stay followed by a two-year aftercare programme. The main activities are group therapy, lectures, one-to-one counselling, family counselling, and daily practice of the AA/NA (Narcotics Anonymous) programme, attending meetings with self-help groups, such as NA, and taking part in recreational activity.

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<sup>19</sup> A 'primary treatment programme' means an abstinence-based orientation enabling the individual to tackle the nature of their addiction such as counselling, AA, NA etc but can also include methadone and detoxification.



The specific objectives of the programme are to: (a) attract and retain participants in treatment, (b) achieve improvements in participant's quality of life and (c) assist participants to become aware of the consequences of substance misuse in their lives. An evaluation of the programme (Cox and Cullen 2002) found that from October 1998 to August 2001, 264 clients presented at, and were accepted into, Aislinn: 28 per cent female, 72 per cent male; average age at time of entry is 17.6 years (age range 15-21). These data are an indication that Aislinn is successful in attracting young participants, the key target group. In addition, the evaluation found that 52 per cent of participants completed the residential treatment phase, with a majority going on to use the aftercare services. The evaluation also detected improvements in participants' quality of life in the following areas: interpersonal, family relations, employment, education and health. In addition, participants reported changes in the way they felt about their alcohol and drug misuse, becoming more aware of the consequences of such use. In particular, it was noted that participants showed awareness of the effects such misuse and its related behaviour had on their families.

For a more comprehensive overview of other drug-free projects e.g. Soilse/Rutland Partnership Project, High Park Residential Drug Treatment and Aiseiri, see the EDDRA database.

#### **5.4 Medically assisted treatment**

Approximately one-quarter of those who ever use heroin will develop dependence. In Ireland opiate dependence is classified using the *International Classification of Diseases and Related Health Disorders, Tenth Revision*. The Code F11.2 which describes an opiate dependent client as one with 'a strong desire to take opiates, difficulties in controlling their use, persistence in their use despite harmful consequences, a higher priority given to opiate use than to other activities and obligations, increased tolerance and physical withdrawals' (WHO 1992).

##### **Detoxification services**

The first step in the treatment of opiate dependence that aims at abstinence is detoxification. The aim of detoxification is to eliminate opiates and other drugs from the body. There are two methods of detoxification, a gradual reduction of the drug dosage until the individual is drug free, or an abrupt discontinuation of the drug (with or without medication to manage subsequent withdrawal symptoms).

In Ireland, drugs used to detoxify opiate users are methadone, buprenorphine and lofexidine. Research indicates that all three drugs are effective in reducing withdrawal symptoms and completion rates are satisfactory (Amato *et al.* 2003; Gowling *et al.* 2003a,b). Therapy normally continues until all withdrawal symptoms have subsided. Counselling and ancillary services help clients cope with withdrawals. Methadone, buprenorphine and lofexidine can be used in both inpatient and outpatient programmes.

Another form of detoxification is methadone reduction. The aim of methadone reduction is to prescribe a gradually reducing dose over time with the ultimate aim that the individual achieves abstinence in the medium term rather than the short term. In outpatient and general practices, methadone reduction programmes involve the daily administration of the (oral opioid agonist) methadone to the individual, tapering off at a rate the client can tolerate. The time to abstinence varies for each individual. This treatment is usually available to patients already on methadone maintenance and wishing to discontinue it.

The next step for the individual that has been detoxified is to maintain their abstinence. This is much harder than completing the detoxification process. It usually requires admission to an inpatient or outpatient rehabilitation programme or attendance at self-help groups (see Section 5.2). In fact, evidence suggests that detoxification without support to prevent relapse is usually unsuccessful.

In Ireland, priority for places in detoxification programmes is given to younger opiate users or individuals in the early stage of heroin addiction. Parental consent is required for clients less than 18 years old.

Two inpatient units and a number of outpatient treatment centres provide detoxification for problem opiate and benzodiazepine users in Ireland. Inpatient treatment centres generally provide detoxification and early rehabilitation on a short-term basis (2 to 12 weeks). Methadone is the most commonly used drug for opiate detoxification; in recent years buprenorphine and lofexidine have also been used to detoxify opiate users in treatment centres in this country. Subutex® is authorised for use in opiate dependence in Ireland since late 2002, but there is no combination of buprenorphine and naloxone currently authorised. On completion of inpatient and outpatient detoxification, a number of clients go on to residential centres (see section 5.2). Of the 8,596 cases reported to the NDTRS in 2002, 999 (12%) attended an opiate detoxification service.

### **Effectiveness of detoxification programmes**

Smyth and colleagues followed up a cohort of 100 opiate users admitted to Cuan Dara (an inpatient detoxification unit) in order to identify the proportion of individuals that were drug free two years after admission and reported that 23 per cent were drug free at the time of the follow-up survey. The authors also identified the individuals' before and in-treatment characteristics as predictors of drug-free status at 24 months and these will be published in late 2004 (B Smyth, personal communication, 2003).

The Working Party at the National Medicines Information Centre at St James's Hospital in Dublin were commissioned by the National Advisory Committee on Drugs to review the use of lofexidine and naloxone in the management of opiate dependence.

A systematic review was undertaken in order to evaluate the potential usefulness of lofexidine and naloxone treatment options in the management of opiate dependency. All available data were retrieved by means of a comprehensive search of the published literature. Contact was made with experts nationally and internationally to evaluate the practical issues associated with use of these drugs in a clinical setting. The authors' findings are presented by pharmaceutical agent.

#### *Lofexidine*

According to the Working Party at the National Medicines Information Centre (2003a), evaluation of clinical trials data for lofexidine showed that it appeared to be at least as effective as clonidine and reducing doses of methadone, the other treatment regimens currently used in the treatment of opiate withdrawal. It was not possible to define the optimal dosage regimen for this indication because of the lack of data from clinical trials but, in general, incremental dosing was used reaching a maximum of around 2.2mg per day by day three or four, with gradual tapering-off to zero by day ten.

The authors also reviewed studies of its use in clinical practice and showed that it was considered as effective as clonidine for managed withdrawal but had a better safety profile (that is, lower number of cases experienced low blood pressure). Experts have suggested that lofexidine detoxification requires intensive input from all members of the

drug treatment team and should be followed up by further treatment to prevent relapse. Although there were insufficient data to evaluate its use in specific subgroups, most workers have suggested that lofexidine was more effective in younger patients and those who had a shorter, less entrenched history of opiate use.

The authors reviewed the availability and, where data were available, treatment outcomes.

In Dublin, three outpatient treatment centres and one inpatient facility were offering lofexidine to clients. Staff at one of the outpatient centres recorded and analysed the treatment outcome data. In total, 84 clients (98 cases) participated in the ten-day treatment regime between December 2000 and December 2002. Successful detoxification was achieved if the client's urine was free of opiates at the end of the programme. Lofexidine was administered in conjunction with full medical and counselling support and patients were seen on a daily basis, including weekends. Following successful detoxification, patients were offered naltrexone and counselling to prevent relapse. The overall treatment completion rate for cases was 38 per cent (37/98). Success was highest among those stable on methadone (8/10) and heroin smokers (13/33). Cases that had not yet stabilised on methadone had a very low success rate (2/14). There were no serious episodes of hypotension (low blood pressure).

According to the National Medicines Information Centre, lofexidine may be useful as an additional treatment for managed opiate withdrawal in Ireland.

#### *Naloxone*

There are two clinical indications for the use of naloxone: to facilitate withdrawal for opiates and as part of the management of an opiate overdose. The review of naloxone in the management of opiate withdrawals is presented here. (A review of the use of naloxone in the management of overdose is presented in Section 7.2).

According to the Working Party at the National Medicines Information Centre (2003b), naloxone had been used, with or without naltrexone, to effect rapid opiate withdrawal. Results of studies have shown that the withdrawal occurred earlier and was more severe with use of naloxone compared with alpha 2-adrenergic agents such as clonidine or lofexidine. According to the authors, the long-term benefits of rapid withdrawal had not been compared with those from standard withdrawal regimens. Data were insufficient to identify the most appropriate dosage regimen.

The authors reported that a combination preparation of buprenorphine and naloxone (4:1 ratio) for sublingual use has recently been developed. It was shown to be effective as a maintenance treatment for opiate dependence, while the presence of naloxone reduced the risk of misuse of the buprenorphine component. Data were insufficient to identify the optimal treatment regimen. The combination was shown to be equipotent to buprenorphine alone.

There are no published data on the use of naloxone to effect rapid opiate withdrawal in Ireland.

#### **Opiate substitution**

Methadone maintenance involves the daily administration of (the oral opioid agonist) methadone as a treatment for opiate dependence. In Ireland, methadone is the opiate substitute of choice for maintenance therapy (Methadone Treatment Services Review Group 1998). The aim of methadone maintenance therapy is to replace illicit opiate use

with a licit oral medication in order to provide the individual with a stable lifestyle and reduce the harms associated with problem opiate use. Methadone is taken once per day because its long duration eliminates withdrawal symptoms for between 24 and 36 hours. Given in high doses it reduces the craving for heroin and blocks the euphoric effects of heroin if the two drugs are taken together.

#### *Policy and protocols*

In Ireland, the admission criteria for methadone maintenance is opiate dependence (Code F11.2) using the *International Classification of Diseases and Related Health Disorders – Tenth Revision* (WHO 1992). In addition, the client must have been injecting for at least one year. Although in practice the latter condition is not observed and there are many opiate users who smoke or ingest opiates in treatment. Priority is given to individuals who are pregnant, have a partner in treatment, or have tested positive for HIV. Parental consent is required for clients less than 18 years old and these young persons must have a history of at least one failed attempt at detoxification. The decision to prescribe methadone to a young person is made by a consultant psychiatrist (Eastern Health Board, Policy Number 6). In addition, all clients must provide three opiate-positive urines to confirm its use and the individual's motivation to change is also assessed. There is no time limit on the duration of methadone maintenance therapy. Smyth *et al.* (2003) noted that, in order to prevent infection with hepatitis C among injecting drug users, such users need to be in treatment within a short time following initiating injecting. Therefore, with respect to injecting drug use, the methadone maintenance entry criteria should be reconsidered.

In 1997 a group was established to review the implementation of the *Protocol for the Prescribing of Methadone 1993* (Health and Children 1998). The recommendations of this review endorsed the 1993 protocol and emphasised that methadone continued to be a valid treatment for opiate users. The review group stated that methadone would be provided free of charge to all opiate-dependent persons living anywhere in Ireland. Another important recommendation of this review was the legal obligation to register any patient receiving methadone with the Central Treatment List (Statutory Instrument No. 225 of 1998). In addition, practice guidelines for general practitioners and pharmacists were developed. Under the terms of this review, two types of contract for general practitioners (level one and level two) were developed. The level-one contract permits general practitioners who have completed appropriate training in the management of opiate users to provide care for a maximum of 15 persons, while the level-two contract allows experienced general practitioners who have completed advanced training to initiate treatment for and treat a maximum of 35 opiate-dependent persons. Where two or more level-two general practitioners work in the one practice, they are limited to a maximum of 50 clients. The pharmacists are contracted to dispense and, if required, to administer Methadone DTF one mg per ml, when prescribed on a methadone protocol prescription sheet, to opiate-dependent persons in their local area. Training in the management of opiate users is provided for participating pharmacists and, ideally, approximately 50 clients can be registered at each participating pharmacy. In May 2003, the Irish College of General Practitioners developed evidence-based guidelines for general practitioners working with opiate users in general practice (ICGP 2003).

One of the limits of methadone maintenance therapy in the 1990s was its discontinuation once a client entered prison (Section 9.2.1).

#### *Methadone services and their uptake in Ireland*

The Central Treatment List is held by the ERHA and managed by the Drug Treatment Centre Board. The Central Treatment List is a complete register of all patients

receiving methadone (for treatment of problem opiate use) in Ireland. This list was established under Statutory Instrument No. 225 following publication of the *Report of the Methadone Treatment Services Review Group 1998*. When a person is considered suitable for methadone detoxification or maintenance, the prescribing doctor applies to the Central Treatment List for a place (on the list) and a treatment card for the client. The card is issued by Central Treatment List staff and retained by the dispensing pharmacist. Methadone cannot be dispensed unless the pharmacist has the client's treatment card, therefore, a client can receive their methadone from one source only. There are also transfer and exit forms which allow the Central Treatment List to track each client's current treatment status. Each client's name, address, date of birth, gender, date commenced on methadone, type of methadone treatment, prescribing doctor and dispensing pharmacist are recorded on the list. Each client is allocated a unique identifier. The Central Treatment List is considered complete with respect to the number of clients who start or recommence methadone because practitioners have a statutory obligation to report the initiation of treatment and, also, they are paid per client in treatment. The number of exits from and transfers within the list has never been validated. As already mentioned, each client has a unique identifier so duplicates or transfers between treatment providers can be identified easily, but it is possible that a proportion of exits are not reported promptly. For example, Cullen and colleagues (2001) failed to locate 17 per cent of cases registered as attending methadone maintenance treatment in selected general practices in Dublin and recorded on the Central Treatment List at that time.

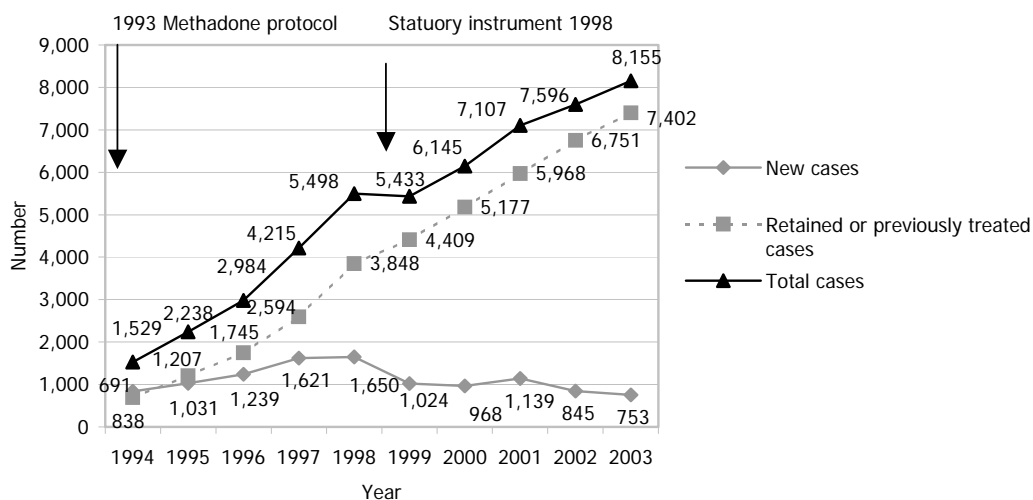
Table 5.4.1 presents the number of clients in treatment at the end of December each year from 1997 to 2003, which is an indicator of the number of treatment places at a point in time. The number of treatment places more than doubled between 1997 and 2003.

**Table 5.4.1 Number of clients on methadone in Ireland by place treated at the end of December each year, from 1997 to 2003 (unpublished data from the Central Treatment List)**

	1997	1998	1999	2000	2001	2002	2003
	Number of clients on 31 December						
<i>ERHA</i>	2859	3610	4269	4936	5466	5813	6204
Trinity Court	207	504	515	513	510	506	501
Treatment centres and satellite clinics	1182	1939	2502	2849	3174	3346	3543
General practice	1470	1167	1252	1574	1782	1961	2160
<i>Outside ERHA</i>	<i>Not available</i>	<i>Not available</i>	63	96	170	211	277
Treatment centres	<i>Not available</i>	<i>Not available</i>		41	66	91	123
General practice	<i>Not available</i>	<i>Not available</i>	63	55	104	120	154
<i>Prisons (national)</i>	<i>Not available</i>	<i>Not available</i>	<i>Not available</i>	<i>Not available</i>	229	425	402
<b>Total</b>	<b>2859</b>	<b>3610</b>	<b>4332</b>	<b>5032</b>	<b>5865</b>	<b>6449</b>	<b>6883</b>

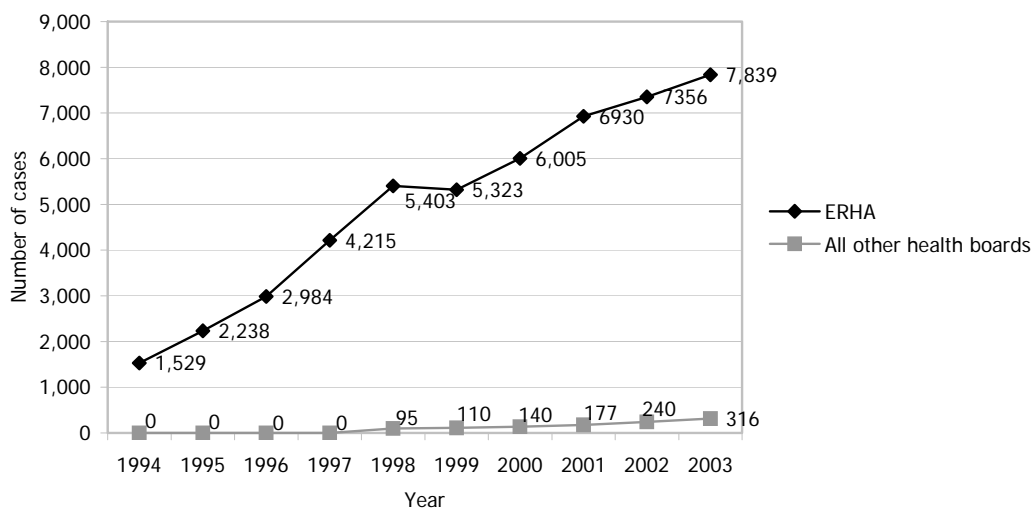
Figure 5.4.1 presents the total numbers of clients by treatment status registered with the Central Treatment List from 1994 to 2003. The total number of clients registered for methadone treatment increased steadily from 1,529 in 1994 to 8,155 in 2003. The number of new cases almost doubled between 1994 and 1998, rising from 831 in 1994 to 1,650 in 1998. Subsequently, the number of new clients each year almost halved between 1998 and 2003. In 2003, there were 753 new clients, which further confirms the tapering-off of the heroin epidemic. Assuming that treatment providers promptly report the date clients leave treatment, the numbers returning to treatment and retained in treatment can be used as a proxy for retention levels in treatment. Of a possible 8,094 clients who ever received methadone treatment up to 1999, 5,032 (62%) had returned to or were still in treatment on 31 December 2000, 12 months or more after

entering treatment (Figure and Table 5.4.1). From these data it is not possible to ascertain how many remained in treatment without relapse during the period under review; this requires further investigation.



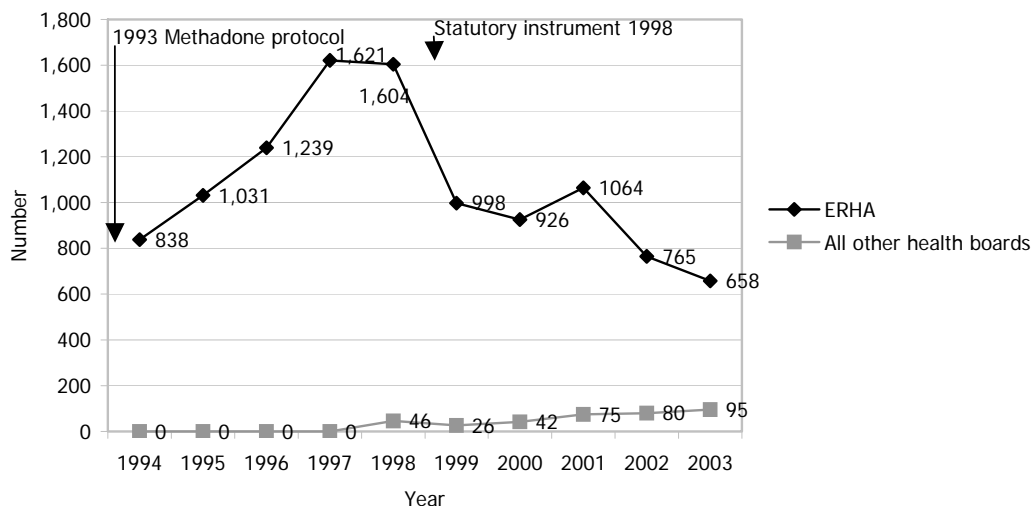
**Figure 5.4.1 Numbers of clients registered with the Central Treatment List in Ireland by treatment status, 1994 to 2003 (unpublished data from the Central Treatment List)**

Figure 5.4.2 presents the numbers of cases by place of residence on the Central Treatment List from 1994 to 2003. As expected, the vast majority of cases are in the ERHA area. As can be seen from Figure 5.4.3, the two years with the greatest number of new treatments are 1997 and 1998. The most likely explanation for the peak in 1997 and 1998 is that the number of health board treatment outlets (of which most were in Dublin) increased almost fourfold, from 10 to 38, in that two-year time period. Though small, there has been a steady increase in the numbers attending treatment outside the ERHA area (Figure 5.4.2 and Figure 5.4.3).



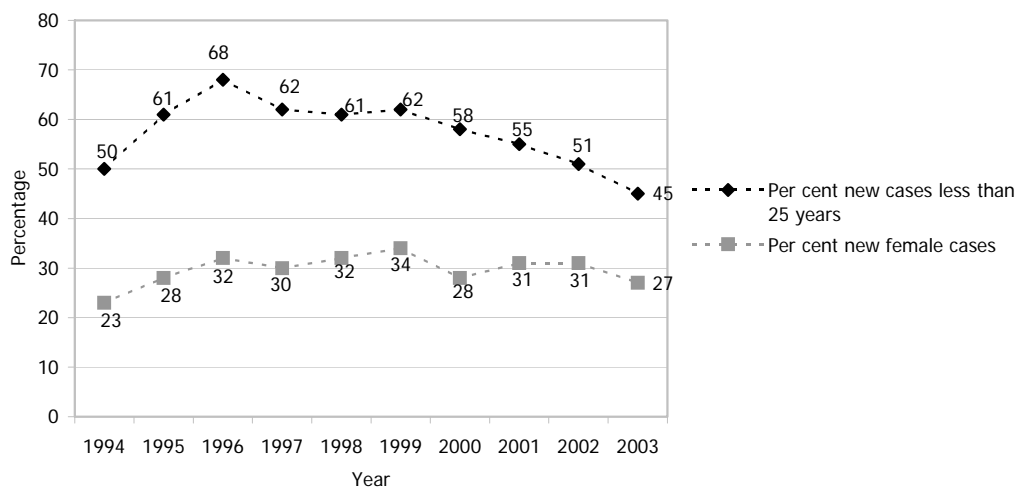
**Figure 5.4.2 Numbers of cases registered with the Central Treatment List in Ireland by place of residence, 1994 to 2003 (unpublished data from the Central Treatment List)**

Figure 5.4.2 and Figure 5.4.3 present the slow spread of methadone treatment outside the ERHA area, while Figure 5.4.3 illustrates the decrease in the number of new treatments in the eastern region of Ireland.



**Figure 5.4.3 Numbers of new cases registered with the Central Treatment List by place of residence, 1994 to 2003 (unpublished data from the Central Treatment List)**

Figure 5.4.4 presents the proportion of new cases by age and gender registered with the Central Treatment List from 1994 to 2003. The proportion of new cases aged less than 25 years increased from 50 per cent in 1994 to 68 per cent in 1996. Since 1996 there has been a steady decline in the proportion of new cases less than 25 years old. In 2003, 45 per cent of new cases were less than 25 years old. The proportion of females varied throughout the period under review.



**Figure 5.4.4 Proportion of new cases by age and gender registered with the Central Treatment List, 1994 to 2003 (unpublished data from the Central Treatment List)**

In Ireland, methadone maintenance is normally provided in an outpatient setting (including drug treatment centres, satellite clinics and general practice). The Drug Treatment Centre at Trinity Court is the largest drug treatment centre in the ERHA area

and five consultant psychiatrists provide specialist addiction treatment at this centre. The consultant psychiatrists also provide policy and service planning guidance to staff at other treatment locations in the eastern region of Ireland. A referral service operates between the Centre at Trinity Court and others who provide addiction services. Specialist general practitioners provide medical treatment at the remaining nine drug treatment centres in this geographical location. There is a multidisciplinary team (addiction counsellors, doctors, general assistants, nurses and pharmacists) working in each of the treatment centres. Family therapists and childcare workers provide services at a limited number of treatment centres. In the ERHA area in August 2003, there were 64 satellite clinics where staff work with communities severely affected by problem opiate use to deliver a local service, and methadone is dispensed through local pharmacists. General practitioners in co-operation with retail pharmacists provided care for just under one-third of opiate-dependent persons on methadone maintenance in December 2002. In the ERHA area, the number of general practitioners providing methadone maintenance treatment increased gradually, from 139 in December 1999 to 167 in August 2003. In 2003, two mobile units provided low-threshold services at four locations in the ERHA area.

There are seven health boards outside the ERHA area. Problem opiate use is found in the health board areas bordering the ERHA area, namely, the North Eastern Health Board area, the Midlands Health Board area and the South Eastern Health Board area. There were six health board clinics providing a methadone treatment programme in August 2003. In the health board areas outside the eastern region, the numbers of general practitioners providing methadone maintenance treatment remained relatively stable at 32 at the end of December 1999 and 34 at the end of December 2003.

#### *Effectiveness of methadone services*

There were no national studies measuring the effectiveness of methadone as a treatment for problem opiate use in Ireland. During 2003 and 2004, two studies were conducted among cohorts of opiate users to determine the effectiveness of methadone maintenance therapy.

Cahill *et al.* (2003) followed up for three months a cohort of 464 individuals who experienced a change in prescriber (from general practitioner to treatment centre) as a result of the legislative changes in methadone prescribing that came into effect on 1 October 1998 (Statutory Instrument No. 225 of 1998). Cahill and colleagues reported that the percentage on higher doses (over 90 mg per day) and lower doses (less than 51 mg per day) of methadone had decreased. For example, the proportion prescribed over 90 mg per day decreased from seven per cent in October 1998 to two per cent in December 1998. Of those who started treatment in a treatment centre in October 1998, 92 per cent were still attending the methadone maintenance programme three months later. Of the 464 clients in this study who changed prescriber, 72 per cent tested negative for opiates in December 1998, compared to 46 per cent in October 1998 (Cahill *et al.* 2003).

Cox and Lawless (2004) followed a cohort of individuals that entered a methadone maintenance programme in 1999 and continued in treatment for an eighteen-month period. A validated questionnaire, known as the opiate treatment index, was administered to 33 clients at some time following entry to methadone treatment at Merchants Quay Ireland in 1999 and to 17 clients who were still in treatment 18 months later. The questionnaire collected self-reported data on six domains: drug use, HIV risk-taking behaviours, social functioning, criminality, health status and psychological adjustment. Excluding social functioning, the data collected for all other outcomes was based on behaviours in the month prior to each interview. The data on social



functioning pertained to behaviours in the six-month periods prior to each interview. Each domain had a number of questions and, for each question, there were a number of answer options. Each answer option had a score, with the lowest score indicating the lowest level of risk-taking or the best experience. The questionnaire collected some additional data on each client's demographic and social situation.

The main findings between baseline and follow-up study were:

- The mean opiate treatment index scores for HIV-related risk behaviours increased, accounted for by an increase in reported sexual risk behaviours, rather than in drug-using risk behaviours, in the month prior to the follow-up study, compared to respective risk behaviours reported at the time of the baseline study.
- Criminal behaviour decreased substantially, with only one client reporting committing one or more crimes during the month prior to the follow-up study, compared to six during the month prior to the baseline study.
- Social functioning scores decreased considerably, indicating an improvement in housing, employment and family relationships at the time of the follow-up study, compared to the baseline study.
- Health status remained similar.
- Psychological adjustment scores decreased, indicating that mental health outcomes had improved over the 18-month period.

It is important to note that the sample size was small and that the improvements in mean scores were not tested statistically. Nevertheless, the findings suggest a number of positive outcomes associated with methadone maintenance therapy.

In Ireland there is very little published information that documents clients' satisfaction with methadone treatment services. This review presents the results of two studies published between 2003 and 2004. The Union for Improved Services, Communication and Education (UISCE) collected their data in 2003 while Lawless and Cox collected their data in 1999 and 2001.

In October 2003, the Union for Improved Services, Communication and Education (UISCE) published a study that examined clients' experiences and expectations of methadone treatment programmes. The study participants were taking long-term methadone maintenance and lived in the Dublin area. The researchers used both quantitative (survey) and qualitative (focus group) approaches to collect the information.

The sampling method for the survey, the rationale for the sample size chosen, and the response rate were not documented, so the generalisability of the study cannot be determined. Notwithstanding these possible limitations, the high levels of dissatisfaction with Methadone DTF compared with Physeptone were in line with another study (O'Connor 2002).

Focus groups were conducted as part feedback on the survey results, and part public consultation process. The number of focus groups and the numbers attending each of the groups were not presented in the published report. Several issues emerged from the focus groups discussions: once again, respondents expressed high levels of dissatisfaction with Methadone DTF compared with Physeptone; respondents' impression of drug treatment service personnel was that they were impersonal and uncaring; participants reported over-use of sanctions by health professionals; respondents said that the individual pharmacy contracts provide rights for the retailers but not for the clients; participants questioned the use of urinalysis as the best method for detecting illicit drug use; participants questioned the actions of health professionals

based on urinalysis; respondents reported lack of confidentiality among service providers; clients reported lack of participation in their treatment plan, and the absence of an independent complaints procedure.

Surprisingly, there were no positive experiences with the current methadone treatment programme reported in the document, which indicates a possible bias in the information presented or in the manner by which it was collected. Despite potential bias, the findings of this study indicate that clients on long-term methadone maintenance want:

- to participate in their treatment plan and its subsequent monitoring and evaluation;
- a service that caters for the other morbidities associated with problem opiate use, such as blood-borne viruses and psychiatric disorders;
- courtesy from service providers;
- an independent body to decide the course of action in the event of a disagreement.

Cox and Lawless (2004) completed a qualitative study that consisted of three focus groups. These were undertaken to ascertain the experience of clients and service providers with respect to methadone maintenance. Two focus groups were carried out to ascertain the experience of clients who attended the methadone prescribing service or the day programme at Merchants Quay Ireland. Those who attended the day programme were receiving methadone maintenance in a health board clinic or general practice setting. The clients were asked about methadone maintenance and continued risk behaviour, use of counselling and other auxiliary services, impact of methadone on their lives, and their relationship with service providers. The third focus group comprised staff working in the methadone prescribing service or the day programme at Merchants Quay Ireland. The service providers were asked about the positive and negative aspects of methadone maintenance, issues that positively and negatively affect treatment outcomes, and other pharmaceutical treatment options. The data were transcribed and five themes were identified.

The five themes and their meanings are:

#### Theme 1 'Key players in methadone treatment'

Clients welcomed the improvements in drug treatment services following the introduction of the methadone protocol. The most important improvements were the increase in number of places available, the removal of all financial charges, the wide range of services available in the clinics for the less stable patients, and the transfer of stable patients to general practice settings. The clients' experiences at pharmacies were both positive and negative. The negative experiences were long waiting periods, lack of privacy and poor communication between the general practitioner and the pharmacist.

#### Theme 2 'Methadone treatment and integration'

The transition between active drug use and stabilising on methadone maintenance is a very vulnerable time for drug users. Clients reported that structured day programmes and formal training programmes provided them with a regular routine and the skills to gain future employment. Many clients reported that they held full-time positions while on methadone but it was very difficult to meet both the requirements of a full-time job and the competing requirements of the methadone treatment services. In general, those with full-time work feared that their employers would discover that they were on a methadone treatment programme and that they would lose their position. The majority of clients reported that methadone maintenance improved their relationships with their families and decreased their criminal activity.

### Theme 3 'Responding to methadone'

Clients reported that, initially, methadone maintenance was very important when moving from active drug use to no drug use, but that they now worried about the long-term dependence on methadone itself. Some clients who were stable on long-term methadone maintenance expressed a desire to detoxify but feared that they would find it difficult to tolerate the withdrawal symptoms, or that they would relapse into heroin use. They also reported that service providers did not encourage them to detoxify but to maintain *status quo*. Clients requested that a broader range of detoxification methods be provided for those wishing to detoxify from methadone maintenance and that service providers facilitate their provision.

### Theme 4 'Managing methadone treatment'

Most clients reported that the high turnover of counsellors at drug treatment centres was disruptive in maintaining a stable lifestyle or dealing with crises. The clients accepted that their drug use had to be monitored but asked for an alternative to urinalysis, as it was humiliating for both clients and service providers.

### Theme 5 'Methadone and health'

Many clients on methadone reported dental problems that they associated with their methadone therapy. In addition, they reported that opiates were not their only problem drugs. Some clients reported dependence on other prescribed drugs, such as benzodiazepines, hypnotics and tranquillisers. The clients also reported interactions between antiviral therapy and methadone.

Notwithstanding the limitations of the UISCE study, the first Irish study by drug users themselves, clients reported high levels of dissatisfaction with aspects of the methadone treatment services. The participants in the Cox and Lawless study also expressed dissatisfaction with aspects of methadone maintenance treatment, though they expressed a number of positive experiences associated with such treatment. While the staff that run the service may be disappointed with the drug users' perceptions, these findings could be turned to opportunity and provide the first step in a partnership between clients and service providers to start to address these issues. This process could be conducted through the 'service user charter' in each health board area that was recommended in the current National Drugs Strategy 2001–2008. When addressing these issues it is important to strike a balance between repression and adherence to services. It is also apparent that clients taking methadone maintenance require impartial information on policy decisions that affect their treatment.

## **6. Health Correlates and Consequences**

### **6.1 Overview**

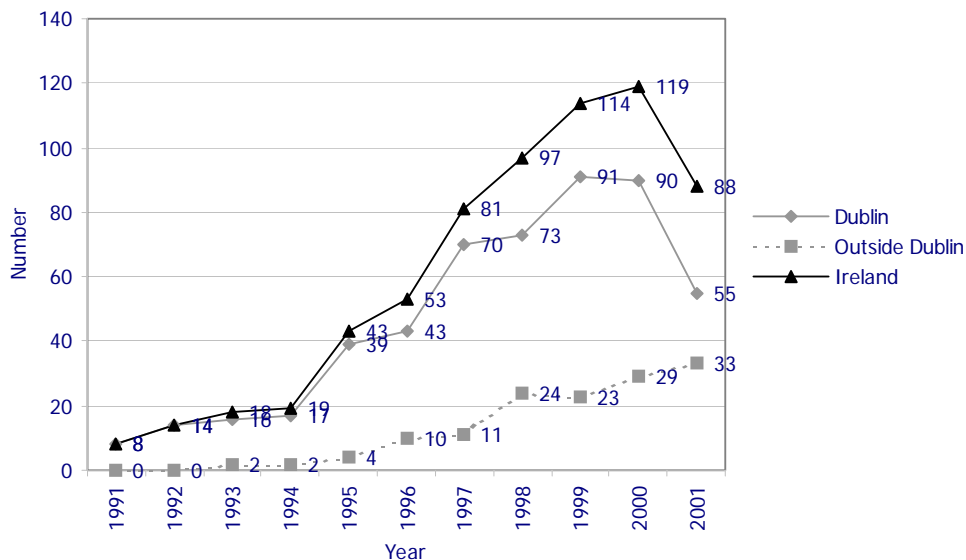
This section presents new data on the incidence of drug-related mortality, the incidence and prevalence of bloodborne viruses. The definitions used are presented where necessary in the relevant sections.

### **6.2 Drug-related deaths and mortality of drug users**

#### **Direct drug-related deaths**

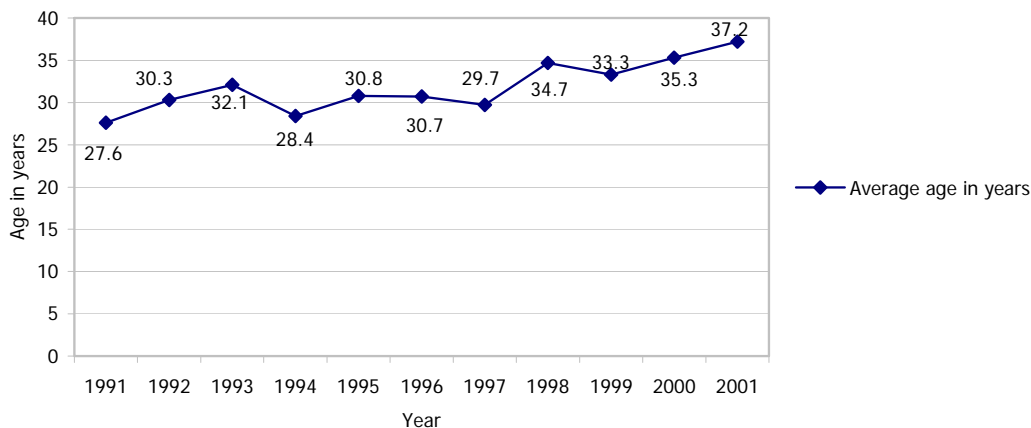
In Ireland, the Central Statistics Office compiles the General Mortality Register's official statistics on direct drug-related deaths each year. Figure 6.2.1 presents the number of direct drug-related deaths in Dublin and the rest of Ireland from 1991 to 2001. Between 1991 and 2000, there was a steady increase in the number of drug-related deaths, with

most occurring in Dublin. Between 1991 and 1994, almost all drug-related deaths occurred in Dublin. Between 1995 and 2000, there was a steady increase in the numbers of drug-related deaths outside the Dublin area. In 2001, there was a sharp decrease in the number of drug-related deaths in Dublin and a continued increase in drug-related deaths outside Dublin.



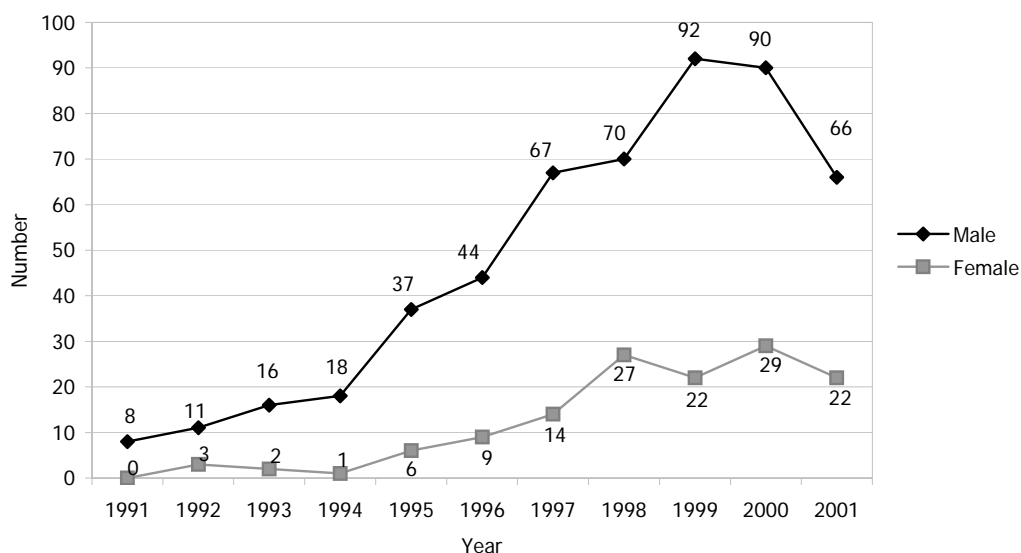
**Figure 6.2.1** Number of direct drug-related deaths by place of death in Ireland reported by the Central Statistics Office, 1991 to 2001 (unpublished data from the vital statistics)

Between 1991 and 2001, the average age of cases that died as a result of a direct drug-related incident has increased steadily from 27 years to just over 37 years (Figure 6.2.2). This was higher than the average age of those treated for problem drug use and indicates the increasing risk of mortality among older drug users.



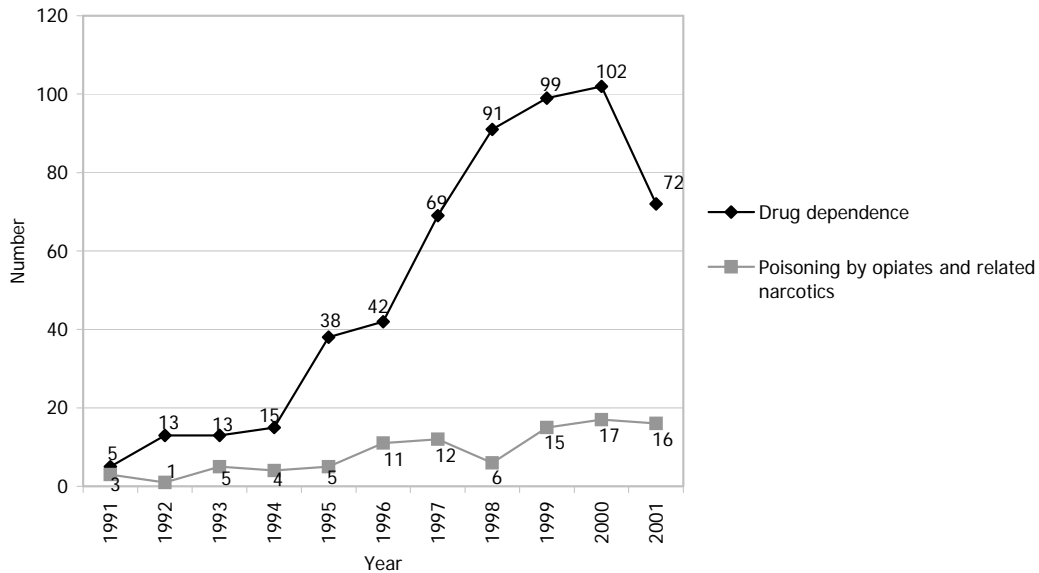
**Figure 6.2.2** Average age of cases who died as a result of a direct drug-related cause each year in Ireland reported by the Central Statistics Office, 1991 to 2001 (unpublished data from the vital statistics)

Figure 6.2.3 presents the number of direct drug-related deaths by gender reported to the Central Statistics Office from 1991 to 2001. The vast majority of those who died were men, but between 1994 and 2001, there has been a steady increase in the number of drug-related deaths in women.



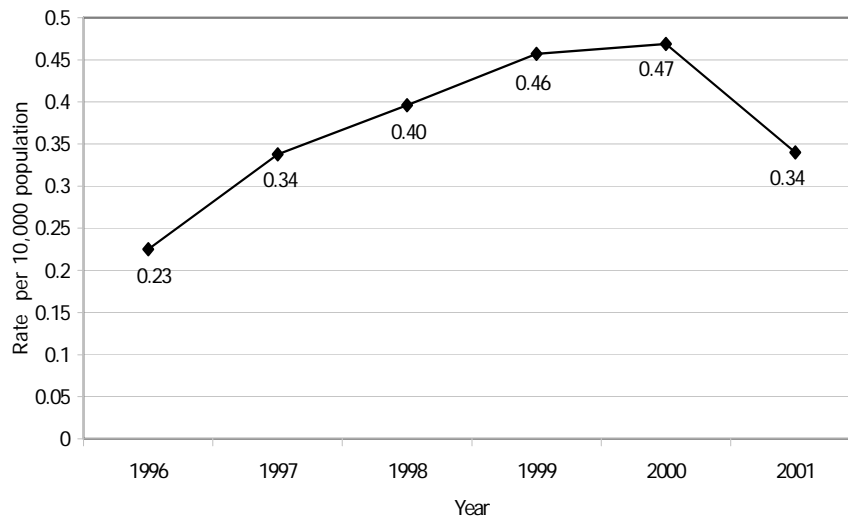
**Figure 6.2.3** Number of direct drug-related deaths by gender in Ireland reported by the Central Statistics Office, 1991 to 2001 (unpublished data from the vital statistics)

The Central Statistics Office categorises the cause of each death using the World Health Organization (WHO) diagnostic coding manual on the international classification of diseases (known as ICD categories). The ninth revision continues to be used in this country. In Ireland, the categories 304 and 965.0 are classified as drug-related deaths. The category 304 refers to deaths as a result of drug dependence (including dependence on morphine, barbiturates, cocaine, cannabis, psychostimulants and hallucinogens), while the category 965.0 refers to poisoning by opiates and related narcotics excluding those with a history of morphine dependence (304.0). From 1991 to 2001, the majority of opiate-related deaths were classified as deaths among persons with a history of drug dependence (Figure 6.2.4). The number of cases both among those with known drug dependence and among those poisoned by opiates and related narcotics increased. The increasing number of deaths from poisoning by opiates and related narcotics observed over the period under review could be as a result of misclassification of opiate dependant cases to poisoning by opiates and other-related narcotics (965.0) rather than morphine dependence (304.0).



**Figure 6.2.4** Number of direct drug-related deaths by cause of death in Ireland reported by the Central Statistics Office, 1991 to 2000 (unpublished data from the vital statistics)

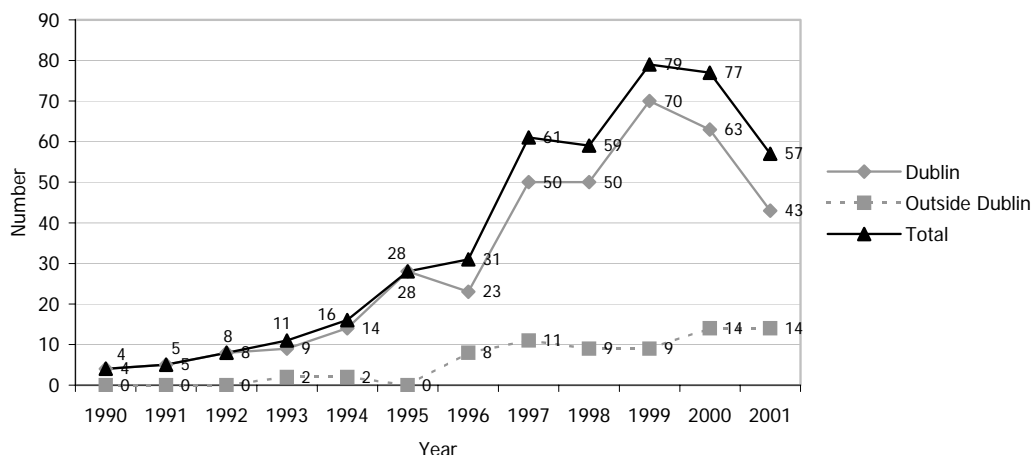
The incidence of drug-related deaths increased twofold, from 0.23 in 1996 to 0.47 per 10,000 in 2000 but decreased sharply to 0.34 in 2001 (Figure 6.2.5).



**Figure 6.2.5** Incidence of drug-related deaths per 10,000 population aged between 15 and 64 years, 1996 to 2001 (Central Statistics Office 2002)

Between 1991 and 2000, the highest numbers of drug-related deaths in Ireland were as a result of opiates (Figure 6.2.6). For example, 57 (65%) of the 88 drug-related deaths were opiate-related in 2001. During the period under review, most opiate-related deaths occurred in Dublin (Figure 6.2.6). Of note, there was a substantial (35%) decrease in the numbers of opiate-related deaths in 2001 indicating both a tapering of the heroin epidemic and more appropriate responses to problem heroin use in Dublin, such as methadone treatment in prison. In contrast, there has been a steady increase

in the number of deaths occurring outside Dublin between 1995 and 2001 (Figure 6.2.6) indicating the spread of problem heroin use outside the Dublin area.



**Figure 6.2.6** Number of direct opiate-related deaths by place of death in Ireland reported by the Central Statistics Office, 1991 to 2001 (unpublished data from the vital statistics)

#### Indirect drug related deaths

There were no new data published on indirect drug-related deaths or AIDS-related deaths in 2003.

### 6.3 Drug-related infectious diseases

#### Incidence

Important changes to infectious disease legislation were introduced in Ireland on 01 January 2004. The report, *Review of Notifiable Diseases and the Process of Notification* (Notifiable Diseases Sub-Committee of the Scientific Advisory Committee 2001) recommended these changes. The Infectious Disease Regulations 1981 were amended to establish a revised list of notifiable diseases and, for the first time, their causative pathogen ([Infectious Diseases \(Amendment\) \(No. 3\) Regulations 2003, S.I. No. 707 of 2003](#)). As part of the revised legislation, laboratory directors as well as clinicians are required to report the named notifiable diseases. The changes to the list of notifiable diseases are consistent with a European Commission Decision on communicable diseases ([Decision no. 2000/96/EC](#), under [Decision no. 2119/98/EC](#) of the European Parliament and of the Council).

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1985. The National Disease Surveillance Centre reported that there were 399 newly diagnosed HIV infections reported in 2003 (NDSC 2004). There were 47 new diagnoses among injecting drug users during 2003 compared to 50 in 2002 and 38 in 2001. There were a higher number of new infections among male injectors (30, 64%) than female injectors (17, 36%). The average age of HIV diagnosis for injecting drug users was 29 years. Of the 47 newly diagnosed cases, 45 were born in Ireland and 43 lived in the Eastern Regional Health Authority area. The cumulative total of HIV cases reported to the end of December 2003 was 3,408, of whom 1131 (33%) were injecting drug users.

Hepatitis B was already classified as a notifiable disease but the inclusion of laboratory directors as a source of notification will increase the number of the notifications. There are no data by risk factor status.

Hepatitis C occurs mainly in two populations in Ireland: cohorts of individuals who became infected through infected blood and blood products, and injecting drug users. Up to the end of 2003, hepatitis C could be notified as 'viral hepatitis type unspecified', it was not a notifiable disease in its own right and there was no national surveillance system to monitor the incidence of this infection among the population. As part of the revised legislation on 1 January 2004, hepatitis C is now specified as a notifiable disease. The inclusion of hepatitis C as a notifiable disease (from 2004 onwards) will provide important data on new cases of hepatitis C in the general population but will not specify risk populations (such as injecting drug users). Between 1992 and 1998, Smyth *et al.* (2003) estimated the incidence of hepatitis C among 100 injecting drug users who had an initial negative test and a repeat test within 24 months. The authors reported that the incidence of hepatitis C was 66 per 100 person years (95% CI 51 to 84 per 100 person years) over the two-year period; this is 30 per cent higher than estimates reported in injecting drug users living in other countries.

### **Prevalence**

There were no new prevalence studies in 2003 and the first half of 2004.

### **Morbidity and mortality**

Kavanagh *et al.* (2003) investigated the hepatitis-related morbidity that may be associated with the hepatitis C virus in injecting drug users. The outcome of end stage liver disease for this cohort in Ireland has not been estimated. The objectives of this study were: to estimate the prevalence of persistent hepatitis C viraemia and distribution of genotypes in a drug using cohort; to measure the frequency of poor prognostic co-factors; to extrapolate the burden of hepatitis C related disease nationally for this route of infection. A cross section survey of attendees at an East Coast Area drug treatment clinic was completed. Of 94 patients studied (63 male), 70 were hepatitis C antibody positive and 39 were PCR positive. Twenty-six had genotype 1 and eleven had genotype 2 or 3. Most displayed factors associated with a poor prognosis: 72 per cent male, 83 percent problem drinkers and 87 per cent abnormal liver blood tests. Using published data, we extrapolate over 1,214 cases of cirrhosis via this route of infection nationally, leading to approximately 35, 60 and 50 cases of hepatocellular carcinoma, hepatic decompensation and liver related death respectively per annum. A high prevalence of hepatitis C infection in injecting drug users, compounded by a high frequency of poor prognostic co-factors, means a significant burden of disease can be expected from this group.

Brennan and colleagues published a paper entitled 'Epidemiology of Hepatitis C in Ireland' in *EPI-INSIGHT* in May 2004. The authors collated information on hepatitis C from a variety of sources. There were 6,085 discharges from acute hospitals with hepatitis C as a primary or secondary diagnosis recorded by the Hospital In-Patient Enquiry Scheme. This scheme is an event-based register so cases may be represented more than once.

Of the 6,085 cases:

- 18 per cent had hepatitis C as a primary diagnosis;
- 57 per cent had chronic hepatitis C;
- 21 per cent had a diagnosis of problem opiate use;
- 7 per cent also had a diagnosis of hepatitis B recorded;
- 24 per cent also had a diagnosis of HIV/AIDS recorded;



- 11 per cent had a diagnosis of chronic liver disease or sequelae;
- 0.4 per cent had a diagnosis of liver cancer.

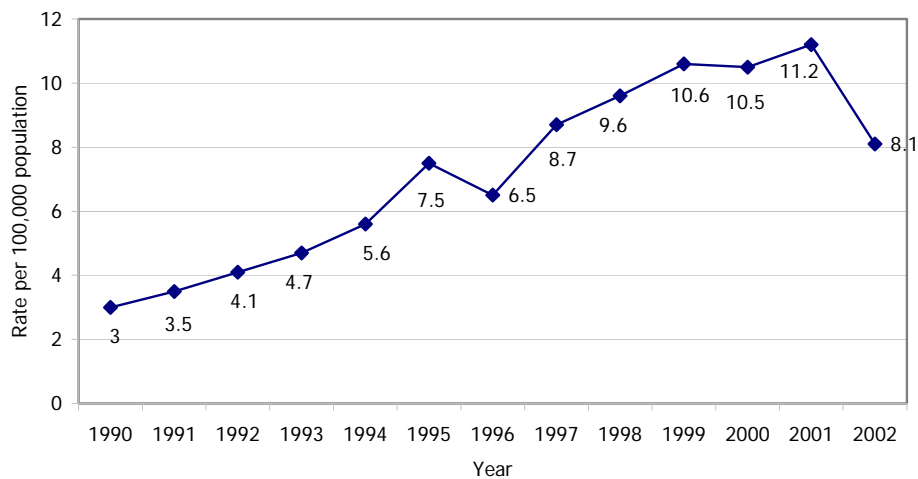
These data suggest the existence of co-morbidity between blood-borne viruses and the damage that hepatitis C can do to the liver.

Brennan and colleagues requested the Central Statistics Office to select cases where the primary cause of death was hepatitis ICD 9 category 070.4, 070.5 or 070.6. This allowed the authors to calculate the number of deaths with a primary diagnosis of hepatitis C using the diagnoses hepatitis 'other specified' or 'unspecified' as proxy diagnoses. Fifty persons died as a result of hepatitis C between 1995 and 2002. Up to 2001, the numbers for each year fluctuated between three and seven cases, with a rise to 15 cases in 2003. The main risk factors for hepatitis C cannot be identified accurately through mortality data held by the Central Statistics Office. This suggests the need for a special register to record the contribution of hepatitis C to premature mortality among injecting drug users.

Taken together, these data suggest hepatitis C is endemic among injecting drug users and it has serious health consequences which can be seen in both morbidity and mortality statistics.

#### 6.4 Psychiatric co-morbidity

Figure 6.4.1 presents the rate of first admissions among those aged 16 years or over to inpatient psychiatric services with a diagnosis of drug dependence, per 100,000 of the population in Ireland between 1990 and 2001. It is notable that the rate increased steadily over the reporting period and was almost four times higher in 2001 than it was in 1990 and a subsequent fall in 2002. The analysis presented in the NPIRS does not comment on the possible explanations for this trend (Daly and Walsh 2003).



**Figure 6.4.1 Rate of psychiatric first admissions aged 16 years or over with a diagnosis of drug-dependence (using the ICD-10 three character categories) per 100,000 of the population in Ireland and reported to the NPIRS, 1990 to 2002**

Between 1996 and 2001 there were 2,119 new admissions to the psychiatric services of clients with a drug-related diagnosis. Of these, 245 were admitted in 2002. The number of clients with dual diagnosis were not reported.

## **6.4 Other drug-related health correlates and consequences**

There are no new data published in this area.

## **7. Responses to Health Correlates and Consequences**

### **7.1 Overview**

This section presents where available new information on responses to the health consequences of problem drug use.

### **7.2 Prevention of drug-related deaths**

Moore and colleagues (2004) reported that the majority of service providers in the Eastern Regional Health Authority area said that their services provided information and demonstrations on safer injecting practices in line with current evidence. The authors do not report if such information was provided by services outside the Eastern Regional Health Authority area.

As part of their routine work, outreach workers in the three area health boards in the Eastern Regional Health Authority and Staff at Merchants Quay Ireland's Health Promotion Unit provide information sessions on safe injecting. The following data was obtained during interviews between senior outreach and focal point staff in May and August 2004.

During the interviews with the senior outreach workers in May 2004, they reported that prevention of infection and overdose were equally important objectives of their work. With respect to the prevention of infection, they provide advice on the prevention of localised bacterial infections, blood-borne viruses and sexually transmitted diseases. The staff at Merchants Quay Ireland, through their Health Promotion Unit, also seek to prevent the spread of infection through injecting drug use and to prevent overdose.

In all area health boards, the outreach workers assess each individual's current situation with respect to injecting drug use, and provide appropriate advice. They do not provide a formal course on safe injecting instead they use each contact with clients to provide information to increase the safety of the individual's current injecting practices. Their main opportunity for contact with clients is during needle-exchange services which are delivered through a variety of methods. The outreach workers employed through the area health boards do some house calls and street work. The outreach workers at Merchants Quay Ireland provide a similar service but also provide formal safer injection classes. The issues covered are similar to those covered by Area Health Board Staff.

In the Northern Area Health Board, the senior outreach workers have published a booklet on safer injecting known as the *Safer Injecting Guidebook* (Mc Kay and Kenny 2003). The booklet was prepared with input from the drug users, clinical team and managers. The booklet provides a comprehensive overview of:

- the consequences of using unsafe injecting;
- where to access clean injecting equipment;
- how to inject safely including injecting technique and hygiene;
- what to do in the event of an overdose.

The authors provide information on disinfecting needles and syringes in the booklet but this practice is no longer recommended and has been replaced with more appropriate advice on cocaine use. In the Northern Area Health Board, this booklet is the key text that outreach workers use to discuss safe injecting with clients. Surprisingly this booklet is not used in either the South Western or East Coast Area Health Boards

The senior outreach worker in the South Western Area Health Board use materials purchased in the United Kingdom. They have a range of information leaflets and booklets available and decide which booklet to use based on the client's situation during the contact interview. Their booklets cover: safer injecting (HIT 2000, 2003) (Lifeline Publications 2002a), actions when things go wrong (Lifeline Publications 2002b; Preston and Derricott 2003; Southwell 2003), and key points on the prevention of infection (Lifeline Publications, no year a,b) and overdose (SWAHB, no year). They provide each injector with a copy of a *Better Injecting* (Lifeline Publications 2002a), which has very little text and is colour coded using green for good practices and red for dangerous practices. The possible consequences of cocaine use are addressed using an information card (HIT 2002).

The nurses working in the South Western Area Health Board have produced posters and information leaflets covering:

- prevention and management of overdoses (Addiction Services 2004a);
- identification and management of an abscess (Addiction Services 2004b).

There is a good opportunity for the outreach workers and nurses to improve their impact through combining their different skills.

The outreach workers in the East Coast Area Health Board use a series of overheads. The overheads are copied from publications or printed from the internet and deliver messages about safer injecting practices. They cover the same issues as covered by outreach workers in the South Western Area Health Board but report that the language used in these materials may not be the same as that used by Irish injectors and photocopies may be less clear than original material. These factors may reduce the effectiveness of the message given to clients.

The staff at Merchants Quay Ireland distribute a *patient information leaflet* with key information including the risks associated with injecting drug use. The *patient information leaflet* is similar to those provided with medication. The information provided recommends using new injecting equipment for each injection. The dangers, signs and symptoms and management of overdoses are presented on the leaflet. The staff distribute literature about blood borne viruses (Health Promotion Unit 1998 and no date) and sexually transmitted diseases during contact with clients (Health Promotion Unit 2002).

A voluntary agency (DOORS) based in the East Coast Area Health Board have produced a small information booklet on the prevention and management of overdose (Ryan, no date). This is distributed at Merchants Quay Ireland but this has not been sanctioned for use by management at the Area Health Boards.

In an interview with the senior outreach workers in May 2004, they reported two concerns with the current organisation of outreach services. They reported that

- outreach workers need to work from 2 pm to 11 pm in order to suit their clients' lifestyle;
- outreach services needed to be reorganised in order to address the growing cocaine problem at weekends.

Such re-organisation would make their services more appropriate.

According to the outreach workers, some of the major barriers to increasing the effectiveness of the safe injecting are:

- no hygienic places to inject for the homeless;
- belief among injecting drug users that they will get hepatitis C even if they inject safely;
- peer pressure among opiate users not to admit loss of tolerance.

In the Eastern Regional Health Authority area, outreach workers and nurses have developed health promotion initiatives to inform injecting drug users of the dangers of overdose through the development of posters and leaflets as part of their safe injecting advice. There is no documented evidence of such an approach outside the ERHA.

There are no consumption rooms in Ireland.

The National Medicines Information Centre reviewed the use of naloxone in the management of opiate-dependence syndrome. The authors reported that naloxone has been used for many years as an emergency room treatment for the management of opiate overdose. According to the authors, evaluation of its use in this setting suggests that it was associated with a low rate of serious adverse effects but the data involved small numbers of patients. Its administration by trained ambulance staff in the pre-hospital setting resulted in fewer hospital admissions, but follow-up data on the patients were lacking in many cases. Although the availability of take-home naloxone for use by friends and relatives of an opiate user has been recommended by several workers, the authors report that there were no controlled trials evaluating such usage. Furthermore, records of use from pilot studies were insufficient to undertake a benefit *versus* risk analysis of the use of naloxone in this setting. However, preliminary results suggested that it might be of use in these areas. The authors stressed that naloxone administration was just one action in a sequence of actions required to prevent overdose and cautioned against a one-dimensional approach. They highlight the need for a combination of the following approaches:

- education on the effects of polydrug or concomitant alcohol use and the usefulness of naloxone in this situation;
- stressing the dangers of solitary injection;
- importance of calling an ambulance;
- knowledge of and practice in basic resuscitation techniques.

Further information on the feasibility of naloxone use as an emergency treatment in the community setting would be needed before any such programme could be implemented. According to the authors, there are many logistical and medico-legal issues in Ireland that would need to be dealt with before such a programme could be implemented in practice.

### **7.3 Prevention and treatment of drug-related infectious diseases**

#### **Hepatitis B vaccine**

In Ireland hepatitis B vaccine is recommended for several high-risk groups; prisoners and injecting drug users are two of the high-risk groups named in the guidelines (National Immunisation Committee 2002). The safety, effectiveness and regime are well established. The current vaccine schedule is three doses at zero, one and six months, which provides immunity to at least 85 per cent of those immunised (Keating and Noble 2003). The effectiveness of hepatitis B vaccination among injecting drug users may be lower than that among the general population because of the generally poorer health status among this group, including HIV co-morbidity (Keating and Noble

2003). This does not mean that hepatitis B vaccine should not be administered to drug users but that serum should be tested to ensure that the recipient has developed an appropriate immune response to the vaccine. There are several accelerated vaccine schedules. The schedule, Day 0, Day 7, Day 21, with a booster at 12 months, results in 65 per cent sero-protection at Day 28 and 99 per cent protection at 13 months (Zuckerman 2003).

Hepatitis B vaccine is free to all injecting drug users attending drug treatment centres, but is not necessarily free to all injecting drug users attending general practice. The vaccine has become easily available at drug treatment centres but is more difficult to access at general practice. In general, doctors caring for injecting drug users in the general practice setting must order an individual dose of vaccine for each injecting drug user they intend to vaccinate. Those injectors without a medical card must pay for the vaccine. This reduces the opportunity for opportunistic vaccination, which is considered an important strategy to achieve a high level of immunisation in a vulnerable group.

The coverage of hepatitis B vaccination for injecting drug users is not monitored on a continuous basis; the coverage estimates presented in this section were taken from *ad hoc* studies in particular settings such as prison, needle and syringe-exchange, treatment centres and general practice.

In 2001 Cullen *et al.* (2003) implemented a pilot project to improve the care of injecting drug users attending general practice and at risk of hepatitis C. Prior to implementing the project, the authors did a baseline assessment that included hepatitis B vaccine coverage. Of the 196 respondents, only 16 per cent had documented evidence of receiving three doses of hepatitis B vaccine within a seven-month period. Self-reported hepatitis B vaccine coverage was higher than documented coverage: 23 per cent had three doses, an additional 11 per cent had two doses and 14 per cent had received one dose. At the end of the study in 2002, the completed vaccine rate in the intervention group was higher (36%) than the vaccination rate in the control group (21%).

There is no published data on the coverage of hepatitis B vaccine outside the ERHA.

### **Syringe exchange and condom provision**

The injecting drug user population in Ireland is concentrated predominately in County Dublin and to a lesser extent in Counties Wicklow and Kildare, although there is evidence of spread to counties bordering the Eastern Regional Health Authority area (Long *et al.* 2004c). There are currently no needle and syringe-exchange programmes outside the Eastern Regional Health Authority (ERHA) area (Moore *et al.* 2004).

Statutory health services and one voluntary organisation provide needle and syringe-exchange services. Thirteen of the 14 fixed needle and syringe-exchange sites are located in health and drug treatment centres in the ERHA area (Table 7.3.1). One of the statutory clinics opens five days per week for 2 hours each week day and the remainder have limited opening hours (HIV Services Network 2002). Merchant's Quay provides a fixed-site needle and syringe-exchange through its Health Promotion Unit five days per week for two and half hours each day and has a facility that allows limited out-of-hours exchange (Cox and Lawless 2000; HIV Services Network 2002); this project is situated in the centre of the city and is well known to injecting drug users.

**Table 7.3.1 Needle and syringe-exchange facilities in Dublin, Kildare and Wicklow in 2003\***

Type of service	Number of units
1. Clinics	14 sites (including the Merchant's Quay Project)
2. Mobile bus	2 bus with several locations in NAHB and ECAHB
3. Backpacking	Outreach teams in Arklow, Bray Celbridge and Dunlaoighre
4 Homeless shelter	Service provided for residents once per week at two inner-city hostels

\*Unpublished data from Louise Mullen, Department of Public Health, Eastern Regional Health Authority.

Two mobile clinics provide low-threshold services (including a needle and syringe-exchange and a low-dosage methadone programme) to drug users (Table 7.3.1). This mobile unit in the Northern Area Health Board provides services for over one hour per day five days per week at two locations in the area.

Backpacking refers to the practice of outreach workers bringing sterile injecting equipment in a rucksack to a client's residence and providing a needle and syringe-exchange service for them. Backpacking is very limited at present and is available in areas not served by other needle and syringe-exchange services (Tables 7.3.1).

There are two agencies (ERHA and Merchants Quay Ireland) collating information on clients attending needle and syringe-exchange. On the first visit both organisations collect baseline information from each client 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 Northern and East Coast Area Health Boards, they have commenced entering all client contacts on the Drugs and AIDS Information System and this will replace the current paper submissions to the ERHA.

Staff at the ERHA report that clients used both local needle and syringe-exchange services and the needle and syringe-exchange at Merchants Quay interchangeably, therefore there is some overlap in the numbers presented in Table 7.3.2 (L Mullen, personal communication, 2004). The majority of new clients and client visits were to the Merchants Quay Ireland Health Promotion Unit; this may be partly due to its city centre location and more extensive opening hours. The demand for needle and syringe-exchange increased between 2000 and 2002 and decreased subsequently in 2003 (Table 7.3.2). Overall, there was an increase in needle and syringe-exchange schemes in the eastern region of Ireland.

**Table 7.3.2 Number of client visits at needle exchange services in Dublin, Kildare and Wicklow, 2001 to 2003**

	2000	2001	2002	2003
Total number of client visits ERHA†	3,859	3,014	4,149	3,768
Number of new clients ERHA†	412	283	364	318
Total number of client visits Merchants Quay Project	15,512	20,262*	24,058*	26,181*
Number of new clients ERHA Merchants Quay Project	645	683*	678*	616*
Total number of client visits	19,371	23,276	28,207	31,949
Number of new clients	1,057	966	1,042	934

\* Merchants Quay Project Ireland. Annual Review 2003

†Unpublished data from Louise Mullen, Department of Public Health, Eastern Regional Health Authority, September 2004.

All needle and syringe-exchange services aim for a one-to-one exchange of syringes and needles. However, there is flexibility in order to ensure the service is client-friendly.

Each of the three area health boards comprising the ERHA varied in terms of their recommendations regarding commodities distributed at needle and syringe-exchange. The type of commodities distributed varied also, depending on whether it was a fixed-site service or a mobile service. Ideally, each injecting drug user was given one 'stericup' (a small aluminium cup containing a filter and swab in a sealed package), one syringe and two needles per expected injection. Between five and ten syringes and ten and twenty needles are given to each client at their first visit (L Mullen, personal communication, 2003). Clients are encouraged to take one stericup and one syringe/needle per injection but clients frequently object to carrying too much injecting equipment. Drug users are often afraid of being identified as a drug user by carrying injecting equipment. Drug use is an illicit activity and many drug users wish to conceal their use. The presence of injecting equipment can pose a problem for users who; live at home with their parents; live with a non-drug using partner; or are homeless and have no location to store excess equipment. In addition, drug users accommodation status may depend on their concealing their drug use. (Outreach staff, L Mullen, personal communication, 2003).

First-time clients at the Merchants Quay Project are normally given two syringes and six needles, or six microfines (Cox and Lawless 2000). For clients making return visits the quantity given to each client depends on the quantity returned by the individual at the visit. The health promotion team at Merchants Quay Project also provide an emergency pack for those who arrive at the service between 4.30 and 5.00 pm from Monday to Friday.

According to staff working in the ERHA (L Mullen, personal communication, 2003) and published information from Merchant Quay Project (Cox and Lawless 2000), both provide their clients with a similar range of services. Apart from needle and syringe-exchange, the additional services provided are harm minimisation information (through leaflet distribution and instruction), condom distribution, first aid and nursing services, and referral to medical services. In addition, outreach workers provide health education and refer clients to harm-minimisation and treatment services (L Mullen, personal communication, 2003).

One indicator of the management of needle and syringe-exchange is the return of used needles. Data available on returns are not easy to access but estimates indicate that half of the equipment distributed is returned (L Mullen, personal communication, 2003).

### **Evaluation of outreach work in Ireland**

There have been two formal reviews of outreach work with drug users in Ireland. Each review examined different but complementary aspects of outreach services. Between June and December 2002, Bunning (2003) examined the policy, planning and organisation of the services; between December 2000 and October 2001, Corr (2004), in partnership with outreach workers, reviewed outreach activities and investigated the immediate effects of these activities on drug-users' practice. The Eastern Regional Health Authority (ERHA) commissioned the evaluation done by Bunning in response to Action 64 of the National Drugs Strategy, while Corr at Merchants Quay Ireland (MQI) completed an internal evaluation.

The main objective of Bunning's review was to examine the role and functioning of outreach services in the drugs and AIDS services in the eastern region. This involved reviewing the outreach service with respect to strategic aims and objectives, general management, service provision, quality control and monitoring systems. The reviewer contacted: clients (20), outreach workers (20), senior outreach workers (4), representatives from community projects (10), and persons employed by the area

health boards (21) whose work had links with outreach services. The review was carried out using the following methods:

- Observation of outreach workers during their day-to-day activities, which included home visits, street work, and community-based projects;
- Group interviews with management of the addiction services, health professionals and community groups;
- Individual interviews with outreach workers and clients;
- Focus groups with senior outreach workers;
- Feedback sessions with steering committee.

The reviewer found that there was good commitment from staff across the addiction services to participating in the review. Outreach workers conceptualised their activities as:

*Initiating and maintaining contact with those who are not in contact with services, relating to them in an open manner and observing what is going on in the drug scene within different local communities* (Bunning 2003, p. 10)

The reviewer reported that, due to the unprecedented expansion in drug treatment services in the ERHA over the last four years, a lack of strategic planning for outreach had resulted. This meant that outreach work was out of focus and that outreach workers carried out a broad range of tasks that were often based on personal preferences and skills, rather than on clear policy choices or guidelines.

The recommendations for the future development of outreach services within the eastern region include:

- Define a clear mission statement;
- Prioritise primary and secondary tasks based on an allocation of time;
- Develop wider needle-exchange networks that include options such as pharmacies and vending machines;
- Develop clear links between clinical staff, outreach workers and clients;
- Formalise the role of outreach workers as advocates for the clients;
- Organise seminars to stimulate peer education, knowledge transfer and up-skilling;
- Set up an outreach association that will work towards the professional development of outreach staff;
- Provide management training to senior outreach workers;
- Develop a monitoring system that includes quantitative and qualitative indicators;
- Create a steering group to explore innovative approaches to outreach.

The second evaluation was conducted by Corr of the outreach service within Merchants Quay Ireland (MQI). The outreach service was established in the late nineties to reduce the levels of drug-related public nuisance in the immediate locality. MQI is located in the south-west inner city of Dublin. The outreach service targets chaotic drug users in the locality and seeks to change their behaviour in the community through one-to-one interactions. The outreach teams work in pairs to ensure workers' and clients' safety. In order to minimise danger, the outreach workers carry mobile phones and identity cards. The majority of the outreach work is done on the streets. The team works on building rapport with clients and providing information on health issues and accommodation. The team uses motivational interviewing techniques to promote safer drug-using practices among clients. The ERHA and Dublin City Council fund the service jointly.



A combination of quantitative and qualitative methods were used to evaluate the MQI service. Between December 2000 and October 2001, outreach workers completed 'contact sheets' on all clients met each day. In order to place the quantitative data collected in context with the day-to-day realities of outreach work, two outreach workers participated in in-depth interviews. During the 10-month evaluation period, a total of 262 clients were contacted at least once. In total, there were 587 separate contacts with clients; 163 (62%) were contacted once only and 99 (38%) were re-contacted an average of four times. Of those contacted, 31 per cent were female, 52 per cent were aged 24 years or under and 27 per cent were first-time contacts. Three-quarters were homeless at some point during the year. Overall, 88 per cent reported using drugs (other than alcohol) and 96 per cent reported the streets as their most popular location for taking drugs. Of those using drugs, 79 per cent were using heroin. During the 10-month period, the outreach workers collected and disposed of 2,741 needles. The outreach workers reported that among the 99 clients who were met more than once, almost one-fifth had changed to safer drug-using practices and half had adopted less safe practices. In addition, the team reported that approximately fifteen per cent of clients contacted were referred to other drug treatment services. The data presented in this document indicates that outreach workers were successful in contacting hard-to-reach drug users as a large proportion were homeless and half had never been in contact with drug treatment services.

Taken together, these evaluations highlight the need to develop the capacity of outreach staff and enhance the general management of the services. At the same time, the documents present the essential role of outreach workers and the positive outcomes of their work, such as success in locating hard-to-reach populations, an increase in numbers using safer injecting practices and modest numbers referred into treatment. However, it may be useful to explore why 50 per cent of those participating in the Merchants Quay Ireland study developed additional unsafe injecting practices despite receiving safe injecting information.

### **Counselling and testing**

There is no new information in this area.

### **HIV treatment**

There is currently no vaccine and no cure for HIV infection. The current standard of care for individuals who have HIV is a combination of antiretroviral therapies commonly referred to as HAART (Rutherford *et al.* 2003; British HIV Association Writing Committee 2001). Specialists recommended that this be commenced at an early stage of the infection and tailored to the individual's needs.

HIV treatment (HAART) is available to injecting drug users through genito-urinary medicine and infectious disease clinics in Ireland. Three treatment sites are situated in Dublin hospitals (St James's Hospital, Beaumont Hospital, and Mater Misericordiae Hospital) and a fourth is based in Cork University Hospital.

As demonstrated in the following study, access to and uptake of treatment for HIV is better than for hepatitis C among injecting drug users in the eastern region of Ireland, but far from ideal. Clarke *et al.* (2003) report that it is assumed (without significant evidence) that injecting drug users are unlikely to comply with treatment. These authors interviewed 150 clients who attended the Genito-Urinary Medicine and Infectious Diseases Department (GUIDE clinic) in St James's Hospital. All were HIV positive and had at some time injected drugs. Only 57 per cent were receiving antiretroviral therapy. Of the 65 who were not receiving antiretroviral therapy, 50 per cent fulfilled the

standard criteria to commence therapy. This indicates that over 30 clients were suitable for treatment and were not receiving treatment at the time of the study.

In Dublin, Clarke *et al.* (2002) adapted the direct observed treatment approach (recommended by the World Health Organization (WHO) for the management of tuberculosis) in order to increase compliance with antiretroviral therapy among injecting drug users attending clinics for methadone maintenance. Each individual treated received a combination of medication tailored to his or her needs and the medication was administered in a daily or twice-daily dose; both of these strategies enhance compliance. Of the 39 study participants, 90 per cent were complying with treatment at three months, 80 per cent at six months and 69 per cent at 12 months. The authors acknowledged that they had no comparison group with which to compare their results but when compared with compliance with tuberculosis therapy among the general population; this is in line with international experience of compliance with tuberculosis treatment. In a subsequent study (Clarke *et al.* 2003), a higher level of compliance with antiretroviral therapy was reported among those attending methadone services than among those not attending drug treatment services.

### **Hepatitis B treatment**

There are no new data on the treatment of hepatitis B

### **Hepatitis C treatment**

The hepatitis C virus has six major genotypes and several closely related sub-types. This has made it difficult to develop both effective treatment and vaccination. Genotypes 1 and 3 are the most common in Ireland (Conroy *et al.* 2003). Treatment is more successful for genotype 3 than for genotype 1. Genotype 1 is more common among drug users. Hepatitis C is a chronic illness that often has no overt symptoms, but this population is likely to experience significant morbidity in the future.

Internationally, interferon therapy has been used for the treatment of chronic hepatitis C and inhibits viral replication initially in 39 per cent of those treated, with a sustained response in 17 per cent of those treated (Thevenot *et al.* 2001).

Kjaergaard *et al.* (2001) conducted a systematic review of treatment options for chronic hepatitis C. The authors reported that, compared with interferon alfa alone, combination therapy (interferon alfa plus ribavirin) reduced the risk of not having a sustained virological response for six months by 26 per cent in newly treated patients, by 33 per cent in patients who had relapsed and by 11 per cent in those who previously had not responded to treatment. Combination therapy also reduced the risk of not having improvement in histology results by 17 per cent in new clients and by 27 per cent in those who had relapsed following previous treatment or who had not responded to previous treatment. This combination therapy is recommended as the most appropriate treatment for hepatitis C and is the current treatment regime in Ireland. The treatment offered is pegylated interferon (dosage) by subcutaneous injection once weekly and ribavirin (dosage) orally daily.

There are seven specialist hepatology centres for adults and one for children in Ireland:

- St James's Hospital (Consultants: 3);
- St Vincent's Hospital (Consultants: 2);
- Mater Misericordiae Hospital (Consultant: 1);
- Beaumont Hospital (Consultant: 1);
- University College Hospital Galway (Consultant: 1);
- University College Hospital Cork (Consultant: 1);

- St Luke's Hospital Kilkenny (Consultant: 1);
- Our Lady's Hospital for Sick Children (Consultant: 1).

There are a number of nurse specialists and counsellors supporting patients at these services. There is a liaison medical officer for hepatitis C based at the Drug Treatment Centre Board, Trinity Court, Dublin.

Dr Shay Keating of the Drug Treatment Centre Board, has updated the booklet, *Hepatitis C: A Guide for Drug Users and their Families*. The updated booklet was launched on 10 December 2003. The information in this booklet is essential for drug users, in particular injecting drug users at risk of or diagnosed with hepatitis C. It is also a useful tool for doctors, nurses and counsellors who educate drug users about hepatitis C. The booklet is laid out in a question and answer format that addresses issues commonly raised by patients and their families. It provides updated information on the condition itself and its treatment. The booklet also provides transparent information on the criteria for entering treatment and the side effects of treatment. As the treatment section has been revised substantially, it is strongly recommended that health service providers, drug users and their family members access a copy of the revised booklet. According to the author, treatment is offered to those at greatest risk of developing liver cirrhosis; this includes persons with a positive PCR test. It is generally recommended that treatment be offered to those who are both drug and alcohol free for six months, or stable on methadone and alcohol free for the same duration. The individual's living status is also a consideration and, ideally, a prospective patient should be living in stable accommodation. The author clearly states that therapy is not offered to those actively abusing drugs or alcohol. Specialists developed these criteria but the criteria have not been rigorously evaluated.

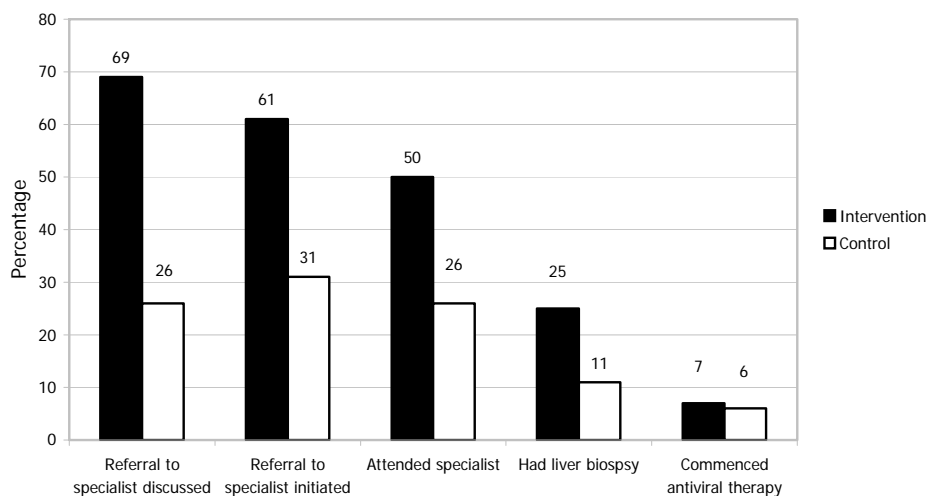
The routine assessment procedures for hepatitis C are as follows: initially, the individual has a blood test to determine if s/he has antibodies to the hepatitis C virus. If antibodies to the hepatitis C virus are detected, the individual will have a PCR (polymerase chain reaction) test to determine if the viruses are still detectable in the blood, if positive, this indicates active chronic hepatitis C. Then the genotype will also be determined. Liver enzymes in blood are measured as high levels indicate damage to the liver though low levels do not necessarily indicate there is no liver damage. If PCR positive, the hepatologist might recommend an ultrasound of the liver and/or liver biopsy (Keating 2003)

Both Dillon (2001) and Long *et al.* (2003) reported low access to treatment for hepatitis C in Irish prisons.

In 2002, Cullen *et al.* (2003) examined uptake of care (including treatment) for hepatitis C by injecting drug users living in the Eastern Regional Health Authority area. Each injector had tested positive for hepatitis C and was receiving methadone therapy from a general practitioner. The authors reported that, of the 104 clients who were hepatitis C positive, 43 per cent had discussed referral to a consultant hepatologist with their general practitioner, 32 per cent had the referral process initiated by their general practitioner, 25 per cent attended the specialist clinic, 13 per cent had a liver biopsy and three per cent commenced treatment for hepatitis C.

The Dublin Area Hepatitis C Initiative Group (2003), along with other interested collaborators, developed a protocol to improve uptake of assessment and access to treatment for hepatitis C among injecting drug users. The key elements of this protocol were that it was developed using a consensus method. It introduced flexibility around the period of time opiate users are required to be stable on methadone or opiate free and it provided clear referral processes and procedures. It was implemented in the

selected general practices with the assistance of a hepatitis C nurse specialist over a six-month period. The researchers randomly allocated clients to an intervention or a control group. For the purposes of the results presented in this document, the numbers in the intervention and control groups were 72 and 35 respectively (Cullen *et al.* 2003). At the end of the six-month intervention period, the authors reported that an increased number of clients (who tested positive for hepatitis C) had referral to a specialist discussed, had the referral process initiated and had attended the specialist clinic (Figure 7.3.1). Among the intervention group, only 25 per cent had a liver biopsy and seven per cent had commenced treatment for hepatitis C; these low uptake rates may be a reflection of the short time period over which the data were collected. The follow-up phase indicated that injecting drug users were interested in assessment for hepatitis C provided that clinical staff at general practice level actively supported them in seeking assessment.



**Figure 7.3.1 Comparison of selected indicators between an intervention and control population in relation to the management of hepatitis C in a general practice setting**

Adapted from Cullen *et al.* (2003)

Many clients who are referred to hepatitis C specialist centres do not attend or comply with treatment (Cullen 2003). In Ireland the only published data on compliance with treatment for hepatitis C is a small on-site hepatitis C treatment pilot study that was commenced at the Drug Treatment Centre Board, in liaison with the infectious diseases unit in St James's Hospital. On 10 December, Dr Shay Keating presented the results of this pilot study that examined the potential for 'treating hepatitis C at the same location at which they receive their methadone with a view to retaining the patients in treatment.' Dr Keating cautioned that any centre providing hepatitis C treatment required referral pathways to specialist hepatology and psychiatric care. Access to psychiatric care is required because many of those with hepatitis C may have a history of psychiatric illness, and depression is a side effect of interferon (one of the two drugs used to treat hepatitis C). The specialist hepatology care included the services of a nurse-specialist and a medical officer. Nine patients commenced treatment during the study period and to date only one has defaulted. Dr Keating concluded that hepatitis C treatment in drug treatment centres is ideal as it improves patient compliance and permits a rapid response to incidences of illicit drug use and psychiatric illness. Hepatitis C treatment alongside methadone treatment was also more convenient for clients. He also said that increased treatment costs at the drug treatment centres could be offset by reduced costs at hospital level. It should be noted that the study methods

would have been strengthened by the inclusion of larger numbers of subjects and the recruitment of a comparison group receiving treatment through a specialist centre.

## **7.4 Interventions related to psychiatric co-morbidity**

### **Interventions related to psychiatric co-morbidity**

#### **Policy**

*The Psychiatric Services – Planning for the Future 1984* is the most recent strategy document guiding Ireland's policy in relation to mental health services (Study group on the development of psychiatric services 1984). Policy on the treatment of problem alcohol and drug use stipulated that the emphasis in the management of alcohol and drug-related problems should be on community-based intervention, rather than on specialist inpatient treatment. Chapter 13 of the report is devoted to 'Alcohol and Drug-Related Problems', but no mention is made of the issue of co-morbidity.

Ireland's *National Drug Strategy 2001–2008* does not specifically mention the potential link between problem substance use and mental health. It is alluded to in the context of demand-reduction strategies:

...most recent literature points to the need for comprehensive demand reduction strategies which include programmes that... link drug-specific interventions with interventions in related areas such as youth crime prevention and mental health promotion strategies, employment, education and training initiatives. (Tourism, Sport and Recreation, para. 6.3.1, p. 98)

In practice, there are locally based referral procedures between the mental health services and the addiction services. The National Advisory Committee on Drugs has commissioned a study to describe current links and identify opportunities for future links between mental health services and addiction services in order to better manage the overlap between psychiatric illness and problem drug use. The literature review pertaining to this study will be published in 2004.

#### **Psychiatric co-morbid services in the Eastern Regional Health Authority area**

(E Keenan and B Sweeney, personal communication, 2004)

Four full-time psychiatrists and 12 non-consultant hospital doctors are employed at the Drug Treatment Centre Board, Trinity Court, to support the provision of addiction services and provide psychiatric assessment and treatment for those with drug addiction in the Eastern Regional Health Authority (ERHA) area (which comprises Counties Dublin, Kildare and Wicklow). This team works closely with the general practitioners working in Drug Treatment Centres. When a general practitioner assesses a client, he or she determines if the client has a current history of psychiatric symptoms or had history of treatment for a psychiatric illness. If the client has a current or previous psychiatric illness that is likely to affect their current treatment for problem drug use, then the general practitioner will request a psychiatric assessment and guidance on appropriate treatment for the client.

At each drug treatment centre, for a half-day each week, a member of the psychiatric team assesses patients referred to them by the general practitioners. If, following psychiatric assessment, the client's profile is complex then he or she will be referred to Trinity Court for both drug treatment and management of his or her psychiatric illness. When the general practitioner at the drug treatment centre can manage the client's case, then the psychiatrist advises him or her on treatment and reviews the client as

requested. As a rule, a multi-disciplinary team (including the general practitioner, counsellor and psychiatrist) manage all clients with co-morbid conditions attending drug treatment services. It has been noted by the psychiatrists that clients with psychiatric and drug dependency co-morbidity benefit considerably from counselling.

The psychiatric team at Trinity Court provides a 24-hour emergency service for general practitioners working in drug treatment centres. There are no inpatient services available for the management of psychiatric co-morbidity in the addiction services in the ERHA area and clients attending drug treatment services can have an admission arranged at their nearest acute inpatient psychiatrist facility. In the Northern Area Health Board, the general practitioner cannot refer the client directly but must confer with the addiction psychiatrist. When a client is referred with both a psychiatric illness and opiate dependence, a psychiatrist from the addiction services and one from general psychiatric services may consult on the management of the client. From the addiction psychiatrist's viewpoint, he or she may provide guidance on the management of symptomatic withdrawals or provision of methadone maintenance. Unfortunately, this dual management facility is not available at all inpatient facilities and the management of clients taking methadone maintenance may not be in line with best practice. Some examples of irregular practice include sending the client to their drug treatment centre each day for their methadone maintenance or asking the client's relatives to collect, bring in and administer the client's methadone each day. This is an area that requires intervention.

With respect to the management of opiate dependence, the general practitioners employed at drug treatment centres are classified, in accordance with the *Protocol for the Prescribing of Methadone*, as level two (Health and Children 1998). The level-two contract allows experienced general or in some cases non-specialist medical practitioners that have completed advanced training to initiate methadone treatment for and treat opiate dependent persons. These practitioners have some training and experience in the management of clients with dual diagnosis. However, additional skills in the diagnosis and management of those with opiate dependence and a psychiatric illness for these level-two doctors are required.

There is little formal support provided to general practitioners working in private practice when managing clients with psychiatric illness and drug dependency. The experience and expertise of general practitioners in general practice only has never been assessed. This is an area that requires attention from both the general practice co-ordinators and psychiatrists.

### **National review**

In 2002 the National Advisory Committee on Drugs commissioned a team at Dublin City University to explore the management of individuals with a combination of mental illness and substance misuse in Ireland. The results are due to be published on November 1<sup>st</sup> 2004.

## **7.5 Interventions related to other health correlates and consequences**

There are no new data published in this area.

## **8. Social Correlates and Consequences**

### **8.1 Overview**

Recent research in Ireland among individuals experiencing homelessness highlights the relatively high level of drug use among homeless people, in particular heroin and polydrug use. Drug use is reported as a major obstacle to moving out of homelessness. In addition, homelessness can contribute to 'chaotic' drug use and a sub-standard diet among people using drugs Corr (2003), Lawless (2003), Hickey and Downey (2003), Cleary *et al.* (2004). Early school leavers are over-represented among treatment contacts across seven regional health boards and first treatment contacts are more likely to be in employment than their previously treated counterparts (Long *et al.* 2004c).

### **8.2 Social exclusion**

#### **Homelessness**

Recent research and evaluation studies have revealed evidence to indicate relatively high and varied levels of drug misuse and drug related risk behaviour among homeless people. Corr (2003) reports that 75 per cent (n=169) of contacts through outreach reported to be homeless at some point during the previous year; 44 per cent (n=98) reported to sleeping rough and 42 per cent (n=94) reported to staying in an emergency hostel, 10 per cent stayed in a B&B, 4 per cent in a squat and 9 per cent stayed with friends/relatives. The evaluation notes that accommodation was influenced by gender with female clients significantly more likely to have stayed in a B&B, whereas male clients were significantly more likely to have slept rough. The influence of age on accommodation was also noted, with clients younger than 25 years significantly more likely to have stayed in an emergency hostel. Thirty-one per cent of clients were female and 52 per cent of clients were under age 25. The majority of clients, 79 per cent, reported to have used heroin, with 96 per cent reporting the streets as the most popular location for taking their drugs.

Lawless (2003) investigating the health status of female drug users, found that 65 per cent (n=11) reported being currently homeless. Clients reported living in a hostel 12 per cent (n=2), B&B 29 per cent (n=5), staying with friends 12 per cent (n=2), and sleeping rough 12 per cent (n=2). Eighty-two per cent of the women were under the age of 30. Heroin use was the primary drug of choice, with the majority reporting to injecting heroin over the previous four weeks. Hickey and Downey (2003) investigated the impact of poverty and social exclusion on the food intake, diet and nutrition of people who are homeless in Dublin. 25 per cent reported previous drug use but not current use while 26.3 per cent reported current use (in the past 30 days including seven respondents reporting to injecting heroin). Substance misuse was found to be a significant factor in the consumption of foods high in sugar and in the consumption of a range of macro and micronutrients including fat, protein, sugar, carbohydrates, starch, phosphorous and calcium. The authors noted 'the significant and ongoing impact of drug misuse as a cause of an individual's homelessness' (Downey and Hickey 2003, p. 40).

Cleary *et al.* (2004) conducted in-depth interviews with twenty men aged 18-30 attending a drop-in centre for homeless men in Dublin. These revealed that the majority had engaged with drug misuse prior to becoming homeless with some participants noting that their drug related anti-social behaviour and criminal activity meant they were removed from the family home. The experience of homelessness contributed to more chaotic drug use, which then became the main obstacle to moving out of

homelessness. Chaotic drug use carried major risks for some with a number of participants experience overdose leading to hospitalization. Within this small group of homeless men a high prevalence rate of heroin use was observed with 65 per cent reporting current or past addiction to heroin. 35 per cent were current intravenous (IV) heroin users while several participants reported polydrug use using a mixture of benzodiazepines, sleeping tablets, Valium, alcohol and heroin. Smyth and O'Brien (2004) analysed socio-demographic and drug misuse data from children under 18 who were first time contacts with drug treatment services in Dublin from 1990-99. The study reported that 6.5 per cent of all child contacts compared with 1.9 per cent of adults presented as homeless. In particular it was noted that child heroin users were more likely to be female and homeless compared to their adult counterparts. The authors concluded that homelessness was encountered in child heroin users more frequently as the decade progressed.

O'Loingsigh (2004) carried out 20 in-depth interviews and four focus groups with ex-prisoners. This research highlights the crucial nature of the first 24 hours after release when according to participants, exposure to homelessness and a return to drug use and crime were heightened. Lack of preparation for release by prison authorities, in terms of linking ex-prisoners in with accommodation and drug treatment services, were cited by individuals as being key to them becoming homeless and returning to drugs and crime following their release.

### **Unemployment**

There is a lack of research into the association between unemployment and drug misuse. However, socio-demographic data on drug treatment contacts across the seven regional health boards outside the Eastern Regional Health Authority (ERHA) show that from 1998 to 2002, employment rates were higher among new cases compared to their previously treated counterparts. Long *et al.* (2004b,c) contend that this may indicate those with chronic drug problems may be less likely to find or retain employment.

### **School dropout**

Anecdotally, the association between early school leaving and drug misuse is well recognised. However there is a lack of up-to-date research into the nature and extent of this association in an Irish context. In one of the few studies done in this area, Comiskey and Miller (2000) found among 112 early school leavers interviewed, 51.1 per cent reported to using drugs prior to leaving school. Of those who had used drugs before they left school 46.5 per cent reported that their drug use affected them at least sometimes while they attended school. Interestingly, one or two respondents reported that their use of drugs had a definite effect on them leaving school early with six respondents noting that their drug use was a secondary effect on them leaving school early. A recent report published by Collins *et al.* (2004) draws attention to the strong association between cannabis use and early school leaving, as one of the best established findings in the literature on the consequences of cannabis use. In particular, the report highlights the involvement of cannabis use in a large number of suspensions/expulsions from school as being a key emerging factor in the literature.

Recent studies by Long *et al.* (2004b,c,d), referred to above, focused on treatment services, treatment contacts and trends in treated problematic opiate use in seven health board areas outside the ERHA 1998 to 2002. They include socio-demographic data on the proportion of treatment contacts reporting to leaving school before age fifteen. In the first study looking at treatment demand across the seven health board areas, the authors note that early school leavers are over represented among treatment contacts but the direct relationship is unclear (see Table 8.2.1).



**Table 8.2.1 Percentage of early school leavers among cases treated in the seven health board areas, by treatment status, and reported to the NDTRS\* 1998-2002**

	1998	1999	2000	2001	2002
All cases	14.5%	19.2%	19.4%	20.8%	17.6%
Previously treated cases	16.3%	19.8%	20.1%	23.5%	20.2%
New cases	13.2%	18.2%	18.6%	18.4%	15.5

Source: Long *et al* (2004 b)

\*NDTRS: National Drug Treatment Reporting System

The second study examined trends in treated problem drug use in the seven regional health areas. The study shows that overall 19 per cent of cases treated in the period were early school leavers (see Table 8.2.2). Again the authors draw attention to the over-representativeness of early school leavers and they argue that this can have implications for social reintegration initiatives that seek to assist clients to secure employment.

**Table 8.2.2 Percentage of early school leavers among cases living and treated in the seven health board areas, by treatment status, and reported to the NDTRS 1998-2002**

	1998	1999	2000	2001	2002
All cases	15.1%	18.9%	19.8%	20.7%	17.4%
Previously treated cases	17.6%	20%	20.4%	23.6%	20.1%
New cases	13.7%	17.4%	19.2%	18.4%	15.2%

Source: Long *et al* (2004 c)

The third study in this series examined trends in problem opiate use among treatment contacts in the seven regional health boards 1998 to 2002. The authors note that the proportion of opiate cases that left school before age fifteen increased substantially, from 12 per cent in 1998 to 23 per cent in 2002 (see Table 8.2.3). In addition, the study found that few opiate cases under eighteen reported to being still in school. The authors contend that individuals who leave school early might be more likely to become problem opiate users, or the lifestyle of problem opiate users renders it difficult to stay in full-time education, or a combination of both factors.

**Table 8.2.3: Percentage of early school leavers among opiate cases living and treated in the seven health board areas, by treatment status, and reported to the NDTRS 1998-2002**

	1998	1999	2000	2001	2002
All cases	11.8%	20%	22.7%	24%	22.9%
Previously treated cases	10.5%	19.2%	20.5%	27.5%	21.4%
New cases	14.8%	20.7%	25.8%	18.6%	26.2%

Source: Long *et al*. (2004d)

## 8.3 Drug-related crime

### Drug Offences

Data are routinely published in the garda annual reports for both 'headline' and 'non-headline' offences, on the number of cases in which criminal proceedings commenced. The terms 'headline' and 'non-headline' in relation to drug offences were first used in the Garda Report for 2000 and replaced the previously used terms 'indictable' and 'summary'. An offence is termed indictable or summary by the statute that creates it. In general, a summary offence is less serious than an indictable one. Summary offences are heard in the District Court by a judge without a jury. Indictable offences are tried in front of a jury. Up until 2002, information on the outcome for specific offences was provided. However, with regard to drug offences, outcomes were only presented in relation to 'headline' offences. The Garda Report for 2002 provides details for the first

time of certain outcomes for 'non-headline' drug offences. Using the Annual Report for 2002, we will now consider the outcome of specific drug offences where criminal proceedings commenced.

**Table 8.3.1 Headline offences which became known to the Gardaí in 2002**

Headline Offences 2002		Cultivation or manufacture of drugs	Importation	Obstruction under Drugs Act	Possession of drugs for sale or supply	Totals
Offences reported or known to the Gardaí		63	54	347	2515	<b>2979</b>
Offences detected		63	48	341	2515	<b>2967</b>
Offences in which criminal proceedings commenced		51	28	193	1530	<b>1800</b>
Results of proceedings in cases dealt with on indictment	Convictions	0	25	3	160	<b>188</b>
	Acquittals	0	0	0	8	<b>8</b>
	<i>Nolle prosequi</i> entered	0	12	0	30	<b>42</b>
	Committed for trial and still awaiting trial	0	2	1	61	<b>64</b>
Results of proceedings in cases dealt with summarily	Convictions	0	7	81	231	<b>319</b>
	Dismissals	0	3	19	111	<b>133</b>
	Charge proved and order made without conviction	0	0	1	5	<b>6</b>
	Still pending in District Court	0	4	28	307	<b>339</b>

Source: Annual Report of An Garda Síochána 2002

Table 8.3.1 presents the outcomes for the headline offences which became known to the Gardaí in 2002. A total of 2,979 headline offences were reported to, or became known to the Gardaí in 2002.

Of the 1,800 headline drug offences for which criminal proceedings commenced in 2002, 302 were dealt with on indictment and 486 were dealt with summarily, with a further 339 still pending in the District Court. The majority of cases on indictment result in a plea of guilty (Walsh 2002, p. 796). In 2002, of those cases dealt with on indictment, 188 resulted in a conviction and 8 in an acquittal. Of the cases dealt with summarily, 319 resulted in a conviction and 133 were dismissed. The data presented in Table 8.3.1 do not provide information on the outcome for 701 of the offences where criminal proceedings commenced in 2002.

The vast majority of drug offences that come before the courts are dealt with summarily in the District Court. Table 8.3.2 presents the non-headline offences where proceedings commenced as reported in the annual report of the Garda Síochána for 2002.

**Table 8.3.2 Non-headline offences where proceedings commenced in 2002**

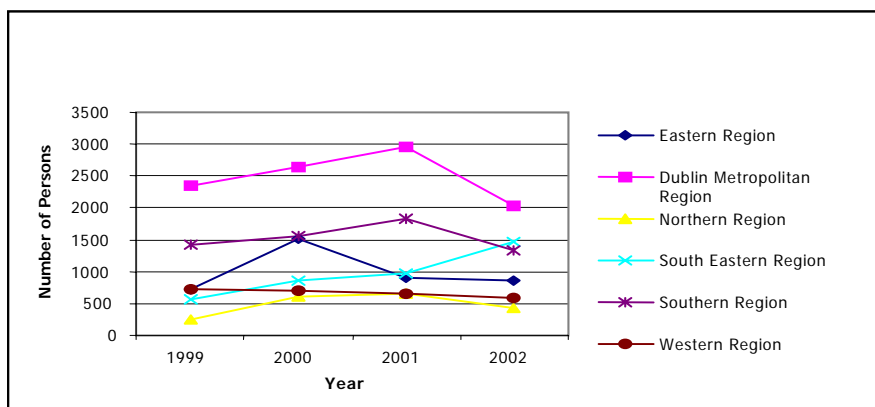
<b>Non-headline offences 2002</b>	<b>Proceedings commenced</b>	<b>Convictions</b>	<b>Dismissed/ withdrawn</b>	<b>Pending</b>
Unlawful possession, Section 3 MDA	6038	1998	756	1299
Forging or altering a prescription	111	27	15	36
Other	27	7	5	6
<b>Totals</b>	<b>6176</b>	<b>2032</b>	<b>776</b>	<b>1341</b>

Source: Annual Report of An Garda Síochána 2002

It can be seen that the majority of non-headline drug offences where proceedings commenced in 2002 are for Section 3, Misuse of Drugs Act (MDA) possession or 'simple possession'. Of the 7,976 drug offences, both headline and non-headline, in which proceedings commenced in 2002, just over 75 per cent were for Section 3 offences. It can also be noted that of the total number of drug offences in which proceedings commenced, both headline and non-headline, the vast majority were disposed of summarily, with only 302 (3.7%) being dealt with on indictment. Again, of the 6,176 non-headline drug offences where criminal proceedings commenced in 2002, the data are silent on the outcome of 1,985 of these cases.

The Garda Síochána Policing Plan for 2003 seeks to increase the number of offenders dealt with for supply offences. However, the way in which the figures are presented in the annual report does not enable us to determine how many offenders were involved in respect of each specific offence. In 2001, criminal proceedings commenced in respect of 1,520 supplier/dealer offences (Section 15 MDA). This accounted for 17 per cent of the total drug offences in which proceedings commenced in 2001 (n=8,768). In 2002, the most recent year for which figures are available, there were 1,530 supplier/dealer offences in which proceedings commenced. This accounted for 19 per cent of the total (n=7976).

In 2002, however, the total number of persons prosecuted fell by 19 per cent when compared to 2001, down from 7,959 in 2001 to 6,678 in 2002. Despite this overall decrease, it can be seen from Figure 8.3.1 that there were significant regional differences in terms of the number of persons against whom proceedings commenced for *all* drug offences between 1999 and 2002.



**Figure 8.3.1 Number of individuals against whom proceedings were taken, by garda region, 1999 to 2002**

Source: An Garda Síochána Annual Reports 1999 – 2002

**Table 8.3.3 Persons prosecuted for drug offences by Garda region**

Region	1999	2000	2001	2002
Eastern Region	720	1502	898	852
Dublin Metropolitan Region	2342	2653	2955	2029
Northern Region	240	602	660	429
South Eastern Region	571	855	966	1457
Southern Region	1423	1547	1819	1333
Western Region	726	694	661	578
<b>Total</b>	<b>6022</b>	<b>7853</b>	<b>7959</b>	<b>6678</b>

Source: Annual Reports of An Garda Síochána, 1999–2002

For example, in the Eastern Region, which includes counties Carlow, Kildare, Laois, Offaly, Longford, Westmeath, Louth and Meath, the number of persons against whom criminal proceedings commenced doubled between 1999 and 2000. In the Dublin Metropolitan Region there was a 30 per cent drop in the number of persons prosecuted in 2002. The only region where there was an increase for 2002 was the South Eastern Region, where the total number of persons prosecuted increased by just over 50 per cent on the previous year. The South Eastern Region incorporates Tipperary, Waterford, Kilkenny, Wexford and Wicklow.

### **Drug-related crime**

#### **Drugs and driving**

A recent nationwide survey carried out by the Medical Bureau of Road Safety (MBRS) provided an analysis for drug classes in 2000 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: amphetamines, metamphetamines, benzodiazepines, 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. Cannabinoids were the most common drug class encountered. Of the 15.7 per cent 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 per cent of apprehended drivers were male. The typical profile of the apprehended and tested DUID driver is 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 benzodiazepines – 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. One of the outcomes of the study will be an evidence-based review of the legislation on driving under the influence of drugs. 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' (Cusack *et al.* 2004, p. 2).

A limitation of the study is that no random sampling of motorists occurred. 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).

### **Alcohol and public order**

A recent Irish study of public order incidents recorded over a five-month period found that alcohol had been consumed by the offender in 97 per cent of cases where this aspect of the incident was recorded by the Garda Síochána (Institute of Criminology 2003). Of the 50 garda members interviewed as part of the study, 98 per cent believed that alcohol was the primary causal factor in public order offending. However, an in-depth analysis of a number of observed public order incidents (n=177) found that alcohol played a role in just over half of the total. The study also considered information contained on the new garda computer information system PULSE (Police Using Leading Systems Effectively), which became operational in 2000. The system has a facility whereby information can be recorded as to whether the Gardaí believed the offender had consumed alcohol or drugs. Although the Institute of Criminology study found that in 66 per cent of cases such information was not recorded, in 97 per cent of the cases where such information was recorded, alcohol was identified as a contributory factor. Drug use did not appear from the study to have played any significant role in public order offences.

A recent study which considered the Irish drinking culture and related harm in comparison with other European countries concluded that adverse alcohol-related consequences (fights, accidents and regrettable conduct) were particularly related to the tendency to 'binge' drink in Ireland (Ramstedt and Hope 2003).

### **Drug use and acquisitive crime**

Another form of crime with a link to drug use is the forging of prescriptions. The Annual Report of the Garda Síochána recorded only 16 such offences for the year 2001 (Garda Síochána 2002). For 2002 however, 111 such offences were recorded (Garda Síochána 2004). This is an area which requires further analysis. For example, there is evidence to suggest a large increase in the problematic use of benzodiazepines among treated drug users. Reports from drug users suggest the wide availability of these drugs, particularly in the vicinity of drug treatment clinics (Personal Communication, Drug Users Service Coordinator). In a study of drug use in the Blanchardstown area of Dublin (D'Arcy 2000), respondents reported using between 3 and 13 benzodiazepine tablets per day. Although clients in treatment are often prescribed benzodiazepines as part of their treatment, respondents reported purchasing many of these tablets on the black market.

### **Local drug markets, crime, nuisance and security fears**

Another related aspect of the systemic crime dimension relates to street-level drug markets and the degree to which the crime and nuisance associated with such markets can contribute to significant community disintegration and heightened security fears. A number of recent Irish studies have looked at the impact of local drug markets on community life (See Section 13).

In May 2003 the European Commission published the results from a Eurobarometer survey on public safety, exposure to drug-related problems and crime in the European Union (EU) (European Commission 2003). The survey, carried out in autumn 2002 among approximately 1,000 people aged 15 years and over in each of the 15 member states, included a question previously asked in similar surveys in 1996 and 2000. The question asked in all three public opinion surveys was:

Over the last 12 months, how often were you personally in contact with drug-related problems in the area where you live? For example seeing people dealing in drugs, taking or using drugs in public spaces, or by finding syringes left by drug addicts? Was this often, from time to time, rarely or never?

When the results from respondents choosing the 'often' and the 'from time to time' options were combined, exposure to drug-related problems in the EU as a whole rose from 14 per cent in 1996, to 17 per cent in 2000, and to 19 per cent in 2002 (see Table 8.3.4).

**Table 8.3.4 EU survey respondents' contact with drug-related problems, 1996, 2000, 2002**

Survey year	Contact with drug-related problems (EU average)				
	'often' %	'from time to time' %	'rarely' %	'never' %	'don't know' %
1996	5	9	12	73	1
2000	5	12	16	66	1
2002	6	13	17	63	1

Source: European Commission (2003)

This steady growth in exposure to drug-related problems was not observed in all EU countries however. Ireland was one of eight countries where exposure dropped between 2000 and 2002. Figures for Ireland show that the proportion of respondents choosing the 'often' and the 'from time to time' options rose from 16 per cent in 1996 to 21 per cent in 2000 but then dropped to 14 per cent in 2002 (see Table 8.3.5).

**Table 8.3.5 Irish survey respondents' contact with drug-related problems, 1996, 2000, 2002**

Survey year	Contact with drug-related problems (Ireland)				
	'often' %	'from time to time' %	'rarely' %	'never' %	'don't know' %
1996	5	11	10	72	2
2000	5	16	11	65	3
2002	6	8	14	64	8

Source: European Commission (2003)

In Ireland the proportion of people who stated that they were 'often' exposed to drug-related problems remained remarkably constant over time: five per cent in 1996 and 2000 and rising slightly to six per cent in 2002. This is identical to the overall trend in the EU. However there was a dramatic drop in the proportion who stated that they were exposed to drug-related problems 'from time to time': down from 16 per cent in 2000 to 8 per cent in 2002. This was the largest drop in this option experienced by any EU country.

Some words of caution about interpreting these results are required. The Commission noted that Ireland was the only country with a significant 'don't know' response (8%) for this question in 2002. Why such a large proportion of Irish people replied in such a manner is unclear. For other questions, such as perception of street safety after dark, the proportion of Irish people replying 'don't know' was almost negligible. The 2002 survey was conducted using telephone interviews, while the earlier surveys used face-to-face interviews. It could be argued that the use of telephone interviews may have had an influence on the type of person responding in Ireland.

The recent drop in reported exposure to drug-related problems in Ireland requires further investigation. A lessening of such exposure may be the result of improved law enforcement efforts. Alternatively, following the high levels of public anxiety in the middle of the 1990s, fuelled by such events as the murder of journalist Veronica Guerin, we may be witnessing a moderation in public perceptions as to the seriousness of the drugs problem. Another possibility is that the large proportion of Irish people responding 'don't know' to the Eurobarometer question may reflect an increased uncertainty among the public as to the nature of the problems being encountered in their areas. Also, in recent years some of the inner city areas which experienced serious drug problems in the 1980s and 1990s have undergone significant refurbishment and local regeneration. Drug dealing and related problems, which have tended to be concentrated in specific locations, may have migrated out to more marginal areas on the periphery as a result.

A number of recent Irish studies have sought to provide this micro perspective and have shown the way in which the problems associated with drug trafficking and drug use impact disproportionately on certain sections of the population or in specific locations. This suggests that analyses of the extent of the drug problem which rely on figures based only on national data provide only part of the story of the impact of drug problems on individuals and communities (See Section 13).

#### **8.4 Drug use in prison**

Long and colleagues (2004) described and explored injecting practices, strategies taken to deal with risk of infection (2003) and actions necessary to address this situation (2004); 31 (16 injectors and 15 non-injectors) were interviewed.

Injectors reported and non-injectors observed that 'injectors take a number of risks during detention that they would not take outside prison'. For example, the low availability of heroin encouraged the change from smoking to injecting; the scarcity of injecting equipment meant that sharing circles were far wider than outside prison; cleaning practices were inadequate for injecting equipment, and those who owned a syringe and needle rented them to other injectors as a means of acquiring the drugs to maintain their habit. The non-injectors in prison said they knew which prisoners were current injecting drug users. Almost all non-injectors had observed injecting drug use in prison and their reported observations of injecting practices were consistent with those reported by respondents who had injected in prison. During the in-depth interviews, prisoners (both injectors and non-injectors) were asked how they dealt with the risk of either contracting or testing positive for hepatitis C. Two dominant themes emerged: denial and fear.

Injector respondents dealt with the possibility of contracting or experiencing consequences of infection with hepatitis C by: living in the moment; distancing its effects in time; generalising the condition to all injectors; and comparing its consequences to those of HIV. This process allowed them to continue injecting without considering the consequences. According to most injector respondents, hepatitis C is

common among those who inject drugs and, to date, its consequences have not been serious.

The fears expressed by injectors and non-injectors were in the main well founded. Fear of contracting, or actually contracting, blood-borne viruses deterred a number of heroin users from starting or continuing to inject heroin. Similar numbers of non-injector and injector respondents reported that they feared contracting blood-borne viruses while in prison.

All respondents were asked: 'What action is required by the prison authorities to deal with drug use in prison?'

Respondents suggested a number of interventions, including routine daily activities (such as education, work, and exercise), drug awareness programmes, individual counselling sessions and harm reduction services. Non-injectors were sympathetic to the plight of injectors, and both non-injectors and injectors supported harm reduction interventions and thought that the range of drug services in prison should mirror that currently available in the community, although half opposed or had reservations about needle exchange.

Prisoners viewed time in prison as an opportunity to address substance misuse and stabilise viral infections; health professionals should not miss this opportunity.

## **8.5 Social costs**

No cost-analysis studies have been conducted in Ireland. However, a range of studies indicate the significant social costs to individuals, families and communities arising from drug misuse. It is clear from such studies that drug trafficking and drug use impact disproportionately on those individuals and communities characterised by high levels of poverty and social exclusion.

### **Homeless ex-prisoners**

A recent survey of 20 ex-prisoners (14 male and 6 female) (O'Loingsigh 2004, p. 37) concluded that many 'turned back to crime within hours of being released in search of money to pay for a bed & breakfast'.

### **Impact on families**

A study by Connolly (2003) in Dublin's north Dublin inner city considered intra-familial drug use. While nine respondents, or 22 per cent of the sample that answered the question, had used drugs themselves, with four of those long-term users, over half of the sample had a family member or relative who had used drugs. Over 50 per cent of the latter were long-term users. The survey question did not specify the type of drug being used however. The majority of survey respondents stated in response to a different question that, with regard to drug use and drug-related problems, their priority concern was heroin.

For many of the survey respondents, a dominant concern was the negative impression street-level drug dealing and use had upon younger children. There was a fear that, for children, drug use and drug dealing would be seen as a way of life. The presence of bereavement, the difficulties in attempting to manage families where one or more member is a drug user, and the difficulties for those who are attempting to come off drugs, particularly when they are regularly exposed to drugs in their community are all significant impressions.



## **Impact on children of drug-using parents**

Hogan (2003), from a consideration of the parenting beliefs and practices of opiate-addicted parents found that parents adopted strategies to conceal their drug-related activities from their children and to maintain a strict family taboo about these activities. This was found to be difficult given the exposure of children to their parents' drug-related activities and was ultimately counter-productive for children in that it led to interpersonal mistrust and greater vulnerability for the child.

Hogan concludes that the strategies adopted by drug-using parents to conceal their drug use from their children left their children in an impossible situation. 'They are bound to silence by loyalty to their parents and their desire to protect themselves, their parents and their families from social censure and exclusion' (p. 118). In this way, we can see how relations between families, where a member of the family is a drug user, and their immediate community can suffer as a result of their family members' drug use.

## **Impact on communities**

The tensions created by drug trafficking and drug use in such communities has, on many occasions, led to the emergence of forms of community-based direct action and informal justice (See section 13).

# **9. Responses to Social Correlates and Consequences**

## **9.1 Overview**

There is a clear lack of long-term accommodation plans for recovering drug users in Ireland. In particular, there is a shortage of halfway houses to accommodate former drug users. A small amount of transitional housing is provided by voluntary organisations, with some funding allocation from the statutory sector. The bulk of mainstream hostels operate exclusionary orders against active drug users with only two hostels providing emergency accommodation to active drug users. No emergency accommodation provider will allow drugs to be consumed on the premises. Education and labour market training is provided to individuals who have stabilised their drug use through methadone.

## **9.2 Social Reintegration**

### **Housing**

#### *Transitional Housing*

Merchants Quay Ireland, a voluntary organisation working with homeless drug users, provides transitional accommodation through the Integration Programme. This service targets drug users who experience homelessness following their completion of residential drug treatment. Clients reside in a transitional house in Dublin for a period of twelve weeks. During the first six weeks, clients are provided with a structured programme including relapse prevention skills, life skills and opportunities to consider vocational and career choices. In the remaining time clients are encouraged to access employment, training and longer-term accommodation. The Arrupe Society, also a voluntary organisation working with homeless drug users, provides transitional accommodation through the Avoca project. Residents include individuals that have completed residential treatment. The project encourages residents to maintain a drug-free lifestyle.

### *Emergency accommodation*

DePaul Trust Ireland is responsible for opening the first hostel in Dublin to provide accommodation to individuals engaged in intravenous drug use and experiencing homelessness through 'sleeping rough'. DePaul Trust Ireland was established in 2002 with the support of the Society of St. Vincent De Paul, the Daughters of Charity and the Vincentian Fathers. The hostel, known as the Clancy Night Shelter, opened in February 2002. The hostel is a low threshold, harm reduction hostel for young rough sleepers, many of whom are intravenous drug users. Facilities include: 16 beds in seven twin and two single rooms. Opening hours are from 19.00 to 9.00. The service accommodates men and women between 18-35, who due to their challenging behaviour have been excluded from other services.

The Caretakers Hostel is operated by Focus Ireland and targets out of home young people 16-21 who are misusing drugs, those with experience of being in care and those in transition from youth to adult homeless services. The hostel provides emergency accommodation between the hours of 20.15 and 9.30. No alcohol or drugs are allowed within the project or surrounding area. Accommodation includes nine beds, five for males and four for females. Facilities include: one shower per four people, one toilet per three people. Evening meal and breakfast are provided. Support services: there are 11 staff; young people are provided with advice and referral to drug treatment and other relevant services.

Haven House targets single homeless women with children including women with alcohol or drug problems. No alcohol is allowed on premises and prescribed medication must be handed to staff on arrival. Women with children must be in by 20.00 and without children 00.30. Accommodation includes: 24 beds in 10 rooms, cost of a two bed is €1.27 per night and a family room is €1.27 per night. Facilities include one bath per 15 people, one shower per 15 people, one toilet per eight people, laundry. Breakfast and lunch are provided.

The Northern Area Health Board operate the 'Out Of Hours Service' providing emergency social work service to young people, 12-18 years, presenting as out-of-home outside office hours. Returning home or placement in emergency care is negotiated. Young people are provided with emergency accommodation in Lefroy House Nightlife Service and referrals are accepted through social workers or Garda stations. No alcohol or drugs are allowed on the premises. Residents must be in between 20.00 and 00.02 and must leave by 09.30. Accommodation consists of seven beds and facilities include three showers and three toilets. Evening meal and breakfast are provided. Support services include one project manager, seven childcare workers and four childcare leaders providing waking cover.

For a consideration of the impact of the Housing (Miscellaneous Provisions) Act, 1997, in particular its consequences vis a vis social reintegration, see Section 13.

### **Education/training and employment**

Specific education and training for recovering drug users is primarily provided through the Special FAS Community Employment Programme. This programme is run by FAS the National Training Agency and was designed to provide labour market training to recovering drug users. The programme is primarily targeted at local drug task force areas and aims to assist individuals to access mainstream employment opportunities. During 2003 there were 54 Special FAS Community Employment Programmes for recovering drug users up and running throughout the 14 local drugs task force areas. During 2003, between 800 and 850 individuals participated in the scheme. (M. Donnelly, Personal Communication, 2004) A drug-awareness training programme for

CE supervisors has been developed with Merchants Quay Ireland. This programme is currently being piloted and, providing evaluation is successful, will be available to all CE supervisors. FAS have recently commissioned an evaluation of this ongoing programme. Examples of projects providing education and training to assist individuals access the labour market include Soilse, SAOL, Addiction Response Crumlin/Athru, Merchants Quay Social Reintegration programme and Tallaght Rehabilitation Programme. For a comprehensive overview of these projects including evaluation results see the EDDRA database.

The Linkage programme works with individuals who have been sanctioned by the criminal justice system. Clients tend to be ex-prisoners or individuals who have been working with the Probation and Welfare service in the community. The programme is not exclusive to drug users but a significant number of its clients would have a history of drug use. (P. Richardson, Personal Communication, 2003) The number of referrals to the programme doubled to over 766 in 2002, with 507 referrals of offenders in the community and 259 referrals of ex-prisoners. Of the total number 766, 160 were placed in employment and 155 were placed in training and education. In 2002, from a total of 259 ex-prisoners referred to the programme, 68 were placed in employment and 45 in full-time training and education. No data are available for 2003.

### **Drug treatment in prison**

In 1999, the Department of Justice, Equality and Law Reform instituted a Steering Group on Prison-Based Drug Treatment Services. This Steering Group has outlined ten intentions that underpin the introduction of prison-based drug treatment services (Irish Prison Service 2000). Importantly, the Steering Group noted that 'the prison service must replicate in prison the level of medical and other supports available in the community for drug-dependent people to the maximum extent possible'. This is a formal statement of support for the principle of equivalence of care with community drug treatment services. At present, the plan includes strategies for prevention, detoxification, methadone maintenance, counselling and education. The intentions of the Steering Group are encouraging, although the plan does not specify deadlines, targets or budgets. As a result of the plan, evidence based methadone maintenance and detoxification services have been introduced in five Dublin prisons. Twenty-four prisoners were receiving methadone at the end of January 2001, whereas 402 prisoners were receiving methadone at the end of December 2003 (unpublished information from the Central Treatment List 2003).

By the end of 2002, the Prison Service was at an advanced stage of drafting an Irish Prison Drug Service Policy that would be in line with the current Irish drugs strategy *Building on Experience: the National Drugs Strategy 2001–2008* (Tourism Sport and Recreation 2001) and the World Health Organization's *Health in Prisons Project: Prisons, Drugs and Society 2002*. This policy is still awaiting approval from the Minister for Justice, Equality and Law Reform.

### **9.3 Prevention of drug-related crime**

For a consideration of responses in relation to young offenders and alternatives to prison see Section 12. With regards to other interventions for prevention of drug related crime see the EDDRA database. There have been no new entries for this year.

## **10. Drug Markets**

## 10.1 Overview

The total number of drug seizures reported in the annual reports of the Garda Síochána decreased by 39 per cent in 2002, the most recent year for which figures are available. Cannabis remains the principal drug seized in Ireland, accounting for 53 per cent of total drug seizures in 2002. However, in 2002, there was a 51 per cent decrease in cannabis seizures compared to the previous year. Although the number of heroin seizures increased between 2000 and 2002, the total quantity seized decreased by 21 per cent. However, we have seen an upward trend in cocaine seizures in recent years. The total number of cocaine seizures has more than doubled since 2000, while the quantity of cocaine seized has increased by 77 per cent.

It is estimated that a kilogram of cannabis is sold wholesale for approximately €3,250 and, when sold at retail level, can reach approximately €4,000. The price of ecstasy decreased from €22 in 1995 to between €10 and €15 in 2003. Heroin in Ireland remained quite expensive relative to the overall European drugs market, selling at between €180 and €200 per gram. There was a reduction in the price of cocaine in 2003. It is estimated that a gram of cocaine currently sells at approximately €80 to €100. This suggests the potential for a displacement of heroin use by cocaine use, given the disparity in price.

Information provided by the Forensic Science Laboratory, based on a sample of heroin seizures in 2000, suggests that there might not be a significant difference in drug purity levels between middle and local market stages, thus suggesting a relatively stable drug market. However, such conclusions await a more systematic purity analysis of drug seizures for confirmation. A small number of crack cocaine seizures were made in 2003.

Both the Gardaí and customs report an increase in the trafficking of cocaine in 2002. The Garda National Drugs Unit believes this is probably due to a more mainstream use of the drug. A strong decrease in cannabis trafficking has been reported in recent years. This, it has been suggested, may be due to Ireland becoming less significant as a transit route for cannabis destined for the UK market. An increased number of cannabis herb seizures have been made by Customs in recent years.

Some small studies in inner city areas of Dublin suggest the concentration of drug markets in specific areas. Research consistently shows that friends or family members are the initial contact through which most people first become involved with drugs.

## 10.2 Availability and supply

Two local drugs and crime surveys conducted by Connolly (2001, 2003) in Dublin's north inner city considered the issue of drug availability. The first survey was conducted among 40 local residents who had been participating in meetings as part of a process of establishing a Community Policing Forum in the area (Connolly 2002). Those who took part in the survey represented 29 different streets or flat complexes throughout the area. The survey was conducted between October and November 2000. Eighty per cent of the sample stated that they had witnessed drug selling in the previous year; 78 per cent stated that it was 'quite likely' or 'very likely' that they would witness drug selling in the following six months. None of the respondents were of the view that it would be 'not at all likely' that they would witness drug selling.

A subsequent door-to-door survey was conducted in a specific location of the north inner city. The survey, *Drugs, crime and community – Monitoring the quality of life in the north inner city*, was carried out between August and December 2001 (Connolly

2003). The area, encompassing five streets and a local authority flats complex, is one where illicit drug use and dealing is prevalent, and contains a mixture of public and private housing. The sample involved 44 local residents.

Thirty-six per cent of the total sample had been offered drugs and 53 per cent had witnessed drugs being sold in the year preceding the study; 76 per cent responded that they were likely to witness drug selling within the following six months.

In a small study conducted by the DMRD in collaboration with the Garda Síochána National Drugs Unit in April 2003, police respondents from three Dublin stations were asked how easy or difficult it would have been in the previous year, in their view, for young adolescents or young adults, excluding regular drug users, to acquire specific drugs. One police respondent believed that cannabis was 'fairly easy' to obtain while two of his colleagues in other city centre locations regarded it as 'very easy' to obtain. One respondent regarded heroin as 'fairly easy' to obtain, while two said it would be 'very easy' to obtain. One regarded cocaine as 'fairly easy' to obtain while two said it was 'very easy' to obtain. All regarded crack cocaine as either 'fairly difficult' (n=1) or 'very difficult' (n=2) to obtain. One regarded amphetamines as 'fairly difficult' to obtain while another officer regarded it as 'very easy' to obtain. All regarded ecstasy as either 'fairly easy' (n=1) or 'very easy' to obtain (n=2). Another drug mentioned in the survey, benzodiazepine, was perceived as 'very easy' or 'fairly easy' to obtain. The co-ordinator of a drug-users' group who had regular contact with drug users throughout the city regarded cannabis as 'very easy' to obtain, while heroin, cocaine powder and crack were all seen as 'fairly easy' to obtain. Benzodiazepines were regarded as 'very easy' to get (Personal communication, Tommy Gorman, Drug Forum Coordinator, UISCE).

A survey conducted by the Dublin-based CityWide Drugs Crisis Campaign (2004) of 59 community-based drug projects, 27 of which responded (46%), found evidence of an increased availability and use of cocaine. Almost one-third of respondents claimed that cocaine was cheap and easily available; three respondents stated that heroin supplies were decreasing in their areas while cocaine was on the increase.

### **Drug-dealing sites**

The *Drugs, crime and community* survey (Connolly 2003) sought information on specific locations in which drug dealing was taking place in the north Dublin inner city. Twenty-nine respondents identified specific locations, with five stating that they witnessed drug dealing outside their door every day. One recovering drug user, on the day of the interview, stated that she had been offered drugs three times that day as she returned from the local clinic, less than a mile from her home.

The recent study conducted by the DMRD of police and drug-user perceptions of the drug market sought information on drug dealing sites or locations. The Gardaí perceived cannabis as being sold mainly in stairwells at flat complexes, in private homes or on the street. Heroin was sold primarily on the street or in private homes. Cocaine was sold in bars and discos, on the street and in private homes. Benzodiazepines were sold primarily on the street.

From the perspective of a respondent who worked with drug users, cannabis was sold primarily in pubs on specific streets and at flats. Heroin was sold openly on streets at only a limited number of Dublin locations in the south inner city in particular. Heroin was also sold in specific cafés. Cocaine sales were similar and, for all drugs, the use of mobile phones was central to transactions. Only relatively large quantities of cannabis were sold over the phone. Benzodiazepines were sold at drug treatment centres or at train stations (Personal communication, Tommy Gorman, Drug Forum Co-ordinator, UISCE).

### 10.3 Seizures

The majority of seizures, whether made by Customs or An Garda Síochána, are recorded in the annual reports of the Garda Síochána. The seizure statistics published in the annual reports of the Revenue Commissioners include only those seizures made by customs officers (Customs Drug Law Enforcement (CDLE), personal communication, December 2003). However, seizures also result from joint Garda–Customs operations and investigations. Although the seizure figures in the Garda reports will also include most customs seizures, below we will present the figures provided by customs separately so as to enhance our overall picture of enforcement activities at different stages of the drugs market. Seizures made by customs will usually occur at points of access into the country such as sea- and airports, land frontiers, postal centres and approved customs premises.

Table 10.3.1 shows the number of drug seizures as reported in the annual reports of the Garda Síochána, and Table 1.2 those presented in the annual reports of the Revenue Commissioners.

**Table 10.3.1 Seizures of specific drugs recorded in garda reports, 1995–2002**

Drug seized	1995	1996	1997	1998	1999	2000	2001	2002
Heroin	209	664	599	884	767	598	802	714
Cocaine	42	92	157	151	213	206	300	429
Ecstasy	571	405	347	466	1064	1864	1485	1027
Amphetamines	89	217	475	680	467	169	162	243
Cannabis	3205	3449	4102	4538	4641	4641	6233	3024
<b>Seizure totals</b>	<b>4178</b>	<b>5244</b>	<b>6182</b>	<b>7030</b>	<b>7318</b>	<b>7703</b>	<b>9169</b>	<b>5603</b>

Source: Annual Reports of An Garda Síochána 1995–2002

**Table 10.3.2 Seizures of specific drugs recorded in Revenue reports, 2000–2003**

Drug seized	2000	2001	2002	2003
Heroin	6	7	2	4
Cocaine	12	3	22	27
Ecstasy	12	13	7	8
Amphetamines	7	7	2	4
Cannabis resin	160	211	115	244
Herbal cannabis	764	957	491	494
<b>Seizure totals</b>	<b>961</b>	<b>1198</b>	<b>641</b>	<b>781</b>

Source: Customs Drug Law Enforcement, personal communication, May 2004; Annual Reports of the Revenue Commissioners 2000–2003

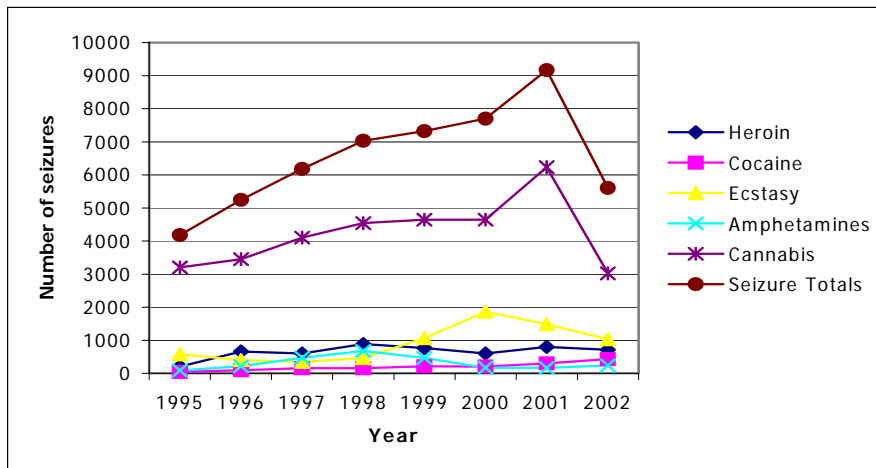
When we compare Table 10.3.1 and Table 10.3.22 for the years 2000 to 2002, we can see that, in the case of heroin, cocaine, ecstasy and amphetamines, seizures made by customs represent only a small proportion of the total number of seizures recorded in the annual garda reports. However, customs appear to have made a large number of seizures of herbal cannabis between 2000 and 2003. Also, many of these seizures do not appear to have been included in the garda reports.

The total number of cannabis seizures reported in the garda report for 2002 was 3,024. Cannabis seizures are classified under three headings: herbal cannabis, cannabis resin and cannabis plants. The vast majority of cannabis seizures made in Ireland are of cannabis resin. However, most of the seizures of herbal cannabis made by customs between 2000 and 2002 do not appear to have been reported as such in the garda reports. Customs reported 764 seizures of herbal cannabis in 2000; the garda report presents a figure of 219 for that year. In 2001, customs reported 957 seizures of herbal cannabis, while only 253 are recorded in the garda report. In 2002, customs reported 493 herbal cannabis seizures; only 242 appear in the garda report for that year.

This can partly be explained by the fact that many of these seizures by customs, particularly of small amounts, might not result in a prosecution or conviction. This might occur in cases where there is an absence of sufficient supporting evidence: for example, where the drugs came through the mail. However, all seizures will still be accounted for and reported as such by customs (CDLE, personal communication, June 2004).

The total number of drug seizures recorded in the annual reports of the Garda Síochána decreased by 39 per cent between 2001 and 2002. Seizures made by customs decreased by approximately 46 per cent during this period, down from 1,198 seizures in 2001 to 641 in 2002.

### Trends in seizures

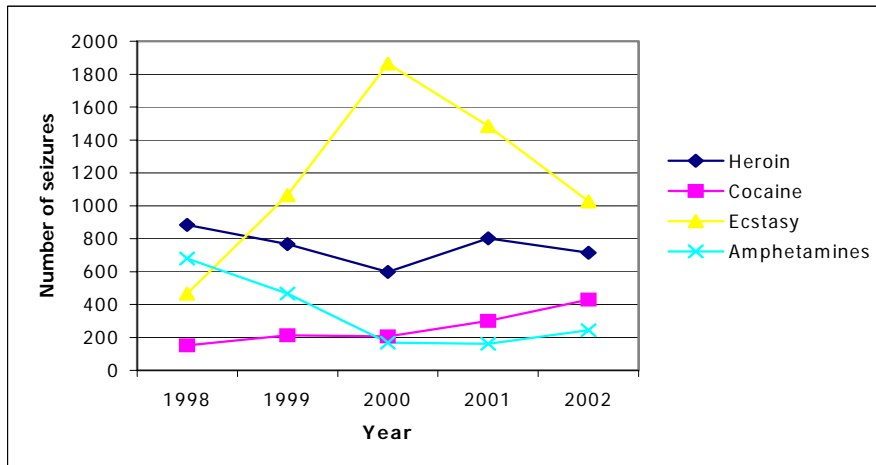


**Figure 10.3.1 Trends in seizures of selected illicit drugs in Ireland, 1995–2002**

Source: Annual Reports of An Garda Síochána 1995–2002

Figure 10.3.1 shows the trends in the number of seizures of specific drugs between 1995 and 2002, the most recent year for which statistics are available. The total number of drug seizures more than doubled between 1995 and 2001, increasing from 4,178 in 1995 to 9,169 in 2001. In 2002 there was a significant decrease of 39 per cent in the total number of drug seizures. As can be seen, however, this decrease appears to have been caused by a 51 per cent decrease in cannabis seizures and a 31 per cent drop in ecstasy seizures.

Figure 10.3.2 shows trends in seizures of heroin, cocaine, ecstasy and amphetamines between 1998 and 2002.



**Figure 10.3.2 Trends in seizures of specific drugs, 1998–2002**

Source: Annual Reports of An Garda Síochána 1998–2002

Heroin seizures appear to have peaked at 884 seizures in 1998, followed by a decline to 598 seizures in 2000. In 2001, the number of heroin seizures rose to 802. There was a slight decrease in heroin seizures in Ireland in 2002.

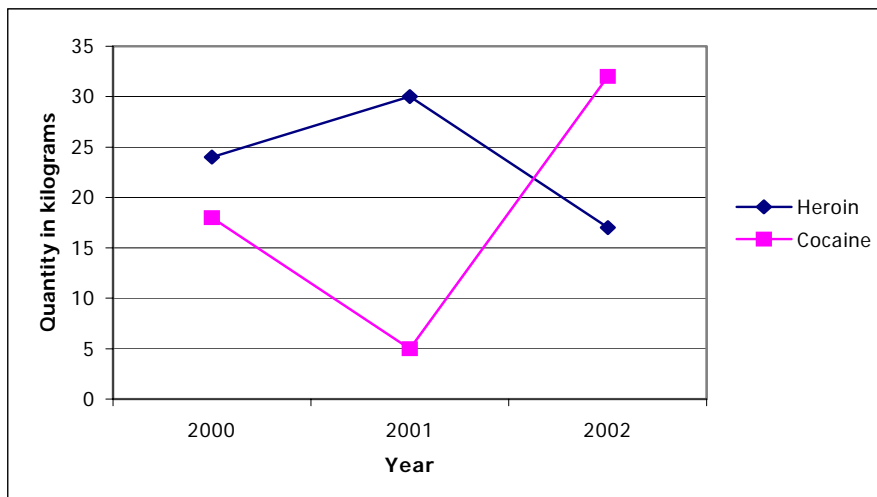
In Ireland, cocaine seizures increased steadily to a total of 213 in 1999, dropped slightly in 2000, and increased sharply to a total of 429 seizures in 2002. Customs report that the biggest single trend observed in 2002 was the increase in frequency of seizures and in the amount of cocaine seized. Twenty-two seizures totalling 19,473 kg of cocaine, with a reported value of €2,000,000, were made in 2002 (Revenue 2003). Ecstasy is the second most commonly seized drug in Ireland. Following a sharp increase in the number of ecstasy seizures, from 347 in 1997 to 1,864 in 2000, there was a decrease to 1,027 seizures in 2002.

Amphetamines seizures increased from 89 in 1995 to 680 in 1998, followed by a continuous decline to a total of 162 in 2001. In 2002 there was an increase in amphetamine seizures.

Cannabis remains the principal drug seized in Ireland, accounting for 53 per cent of total drug seizures in 2002. There has been a steady increase in cannabis seizures since 1995, with a significant increase from 4,641 seizures in 2000 to 6,233 in 2001. However, in 2002 there was a 51 per cent decrease, with the number of cannabis seizures down to 3,024.

Due to the fluctuations in quantities of drugs seized from year to year, the number of separate seizures is regarded as a more useful indicator of drug availability and supply. However, identifying the quantities of drugs seized can be a useful indicator of enforcement activities. Also, as mentioned above, increasing the volume of drugs seized is a commitment within the National Drugs Strategy 2001–2008 (Tourism, Sport and Recreation 2001). Quantities of drugs seized are provided in the annual reports of the Garda Síochána and in the annual reports of the Revenue Commissioners, which record the drug seizures in which the Customs Service is involved.





**Figure 10.3.3 Trends in the quantity of heroin and cocaine seized, 2000–2002**

Source: Annual Reports of An Garda Síochána 2000–2002

Although the number of heroin seizures increased from 598 in 2000 to 714 in 2002, Figure 10.3.3 shows that the total quantity of heroin seized between those years decreased by approximately 29 per cent. The total quantity of cocaine seized increased by 77 per cent between 2000 and 2002. Following a decrease in the quantity of cocaine seized between 2000 and 2001, in 2002, the quantity seized increased from 5 to 32 kilograms, a rise of approximately 540 per cent. The number of cocaine seizures increased by 43 per cent in 2002.

#### 10.4 Price/purity

Obtaining information on drug prices is important for a number of reasons. Drug price is sometimes used as an indicator to quantify seizure trends. In a recent response to a parliamentary question on progress towards the national drugs strategy goal of increasing the volume of drug seizures, Michael McDowell, Minister for Justice, Equality and Law Reform, stated (2004, 26 February): ‘Garda seizures for 2000 amounted to €20 million; 2001, €45 million; 2002, €49 million and 2003, €100 million. Customs and Excise seizures for 2000 amounted to €11 million; 2001, €60 million; 2002, €34 million; and 2003, €21 million.’

However, there is no standardised method available in Ireland by which trends in drug prices can be identified. 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.

Another important reason for the collection of regular drug price data is provided by section 4 of the Criminal Justice Act 1999, which inserted a new section 15A into the Misuse of Drugs Act 1977. This new section introduced the specific offence of possession of drugs with a market value of £10,000 (€12,700) and applied for the first time the principle of a mandatory minimum sentence with respect to these offences.

The provision of regular drug price data could facilitate consistency in sentencing under this legislation. However, the Act does not make clear the stage of the market, retail or otherwise, at which the valuation of drugs is to be made.

Moran *et al.* (2001) point to the difficulty of establishing the difference between prices at street level and at middle-market or import trafficking level. The authors' figures are based on those supplied by the GNDU, which appear to have remained relatively stable over the past five years. The figures for drug prices used below are based on a recent ad hoc study conducted by the Drug Misuse Research Division with key informants in the Garda Síochána and the drug-using community. These figures, although based on a small number of informants, suggest some fluctuation in drug prices and also provide a very recent impression of current drug prices.

Once a seizure has been made by the Gardaí or by customs, the drugs are generally forwarded to the Forensic Science Laboratory for analysis to determine whether they contain illicit substances so as to facilitate a criminal prosecution (J Power, personal communication, July 2003).

Tables 10.4.1, 10.4.2 and 10.4.3 show average purity levels for amphetamines, heroin and cocaine seized by the Garda Síochána and/or Customs between 1993 and 2001 and which were analysed and quantified at the Forensic Science Laboratory. By analysis, we mean the samples were tested for the presence of an illicit substance; by quantified, we mean that the percentage purity of the sample was also examined.

The figures for each drug are based on a small number of cases. For example, in 2002, the Forensic Science Laboratory received over 200 suspected amphetamine cases of which only 2 were quantified. In 2001, the Laboratory received more than 300 suspected cocaine cases for analysis, of which 13 were quantified. In 2003, the Laboratory received over 600 suspected heroin cases, of which 11 were quantified. (J Power, personal communication, April 2004). The figures in Tables 10.4.1, 10.4.2 and 10.4.3 also represent an average percentage purity from a wide range across the cases tested. For example, in 2001, of the 13 cocaine packs quantified, the minimum percentage purity was 0.12 per cent, the maximum 49.50 per cent, and the average 25.78 per cent. In 2002, 53 heroin packs were quantified. The minimum percentage purity was 0.10 per cent, the maximum 63.00 per cent, and the average 29.63 per cent.

### **Cannabis**

The GNDU, in its report for the government's annual submission to UNODC for 2002 (Health and Children 2003), reported that the price of one kilogram of cannabis resin at wholesale level in that year was €3,250. The average cost of a gram of cannabis at street level ranged from €10 to €15. The cost of seven grams (quarter ounce) of cannabis resin appeared to remain stable at €25 to €30. These figures suggest that a kilogram of cannabis costing €3,250 at wholesale level, when sold for €30 per 'quarter ounce' at retail level, would return a profit margin of approximately €1,000.

Cannabis purity levels are not routinely quantified by the Forensic Science Laboratory.

### **Synthetic drugs – amphetamines, ecstasy and LSD**

The GNDU estimated that amphetamines cost €2 per dosage unit at wholesale level and €6 per dosage unit at street level in 2002 (Health and Children 2003).

The GNDU reported that ecstasy sold at €2 per dosage unit at wholesale level in 2002.

The price of an ecstasy tablet at street level decreased from €22 in 1995 to between €10 and €15 in 2003 (Health and Children 2003; Moran *et al.* 2001).

**Table 10.4.1 Average percentage purity of amphetamines seized 1993–2002**

Year	Cases quantified	Packs quantified	Purity range	Average purity
	n	n	%	%
1993	3	41	0.4–7.1	4
1994	-	-	-	-
1995	2	14	2.5–7	4.7
1996	3	9	2.1–22.0	9.8
1997	14	28	1.3–6.4	3.4
1998	-	-	2–18.0	6
1999	-	-	2–4	3
2000	-	-	-	-
2001	1	-	-	2
2002	1	2	0.90–2.9	1.9

Source: Forensic Science Laboratory

Table 10.4.1 shows that in 2002, of the suspected amphetamine cases submitted to the Forensic Science Laboratory for analysis, only one case was quantified. This involved two packs of amphetamine powder, the average purity of which was 1.9 per cent.

### Heroin/opiates

Ireland, and especially Dublin, has been regarded as a sub-market of the London heroin market (Lenke and Olsson 1998). The price level is very high and accords with similar levels in other peripheral European heroin markets (EMCDDA 2003). Moran *et al.* (2001) report heroin as selling at €190 per gram in 2001. The GNDU believes that heroin currently sells at between €180 to €200 per gram at street level. Heroin generally sells at street level in €20 bags.

A study conducted by the Forensic Science Laboratory in 2000 analysed the purity of diamorphine (heroin) in a sample of 45 street-level packs. The average weight of powder in each pack was slightly more than one tenth of a gram (0.113 grams). The average purity was 41.3 per cent. A study of 13 cases conducted in the same year, where the total weight of the 13 cases was 4,942 grams, suggesting a large seizure rather than a street-level one, found an average purity of 45.8 per cent. These findings suggest that there may not be a great deal of difference in purity levels between local retail market and middle market, with average purity levels roughly similar. As Lenke and Olsson (1998) suggest, such relative stability in price and purity levels is found in a market 'characterised by a fairly good balance between supply and demand'. Such a situation would raise obvious issues in relation to the impact of supply control efforts. A more systematic study of drug purity levels across drug seizures would be required before any such conclusions could be reached in relation to the overall drug market. Nevertheless, this does highlight the usefulness of regular data on price and purity indicators.

The heroin purity results in Table 10.4.2 are based on a combination of bulk seizures and smaller seizures at street level. The figures suggest a slightly upward trend in heroin purity levels between 1999 and 2001, followed by a drop in purity in 2002.

**Table 10.4.2 Average percentage purity of heroin seized 1993–2002**

Year	Cases quantified	Packs quantified	Purity range	Average purity
	n	n	%	%
1993	22	121	6–81	39
1994	-	-	-	-
1995	15	42	26–76	46
1996	29	89	26–78	49
1997	32	78	7–78	46
1998	-	-	18–66	35
1999	18	74	20–52	32.7
2000	58	83	11–66	45.83
2001	29	86	4.3–66	45.40
2002	32	53	0.10–63	29.63

Source: Forensic Science Laboratory

### **Cocaine/crack**

Moran *et al.* (2001) recorded cocaine prices at €102 per gram in 2001. The GNDU reported cocaine being sold at street level in 2002 for between €90 and €110 per gram, averaging at €100 (Health and Children 2003). The research by the DMRD with key informants suggests street level prices of cocaine at approximately €80 per gram in 2003. Recent media reports also suggest a similar price ('Between The Lines' *Irish Examiner*, 23 July 2003). All of the key garda informants interviewed by the DMRD saw some decrease in the price of cocaine during 2003. A similar finding was recorded among drug users.

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 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, May 2004).

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 10.4.3 shows cocaine purity levels for a selection of cocaine seizures quantified by the Forensic Science Laboratory between 1993 and 2001.

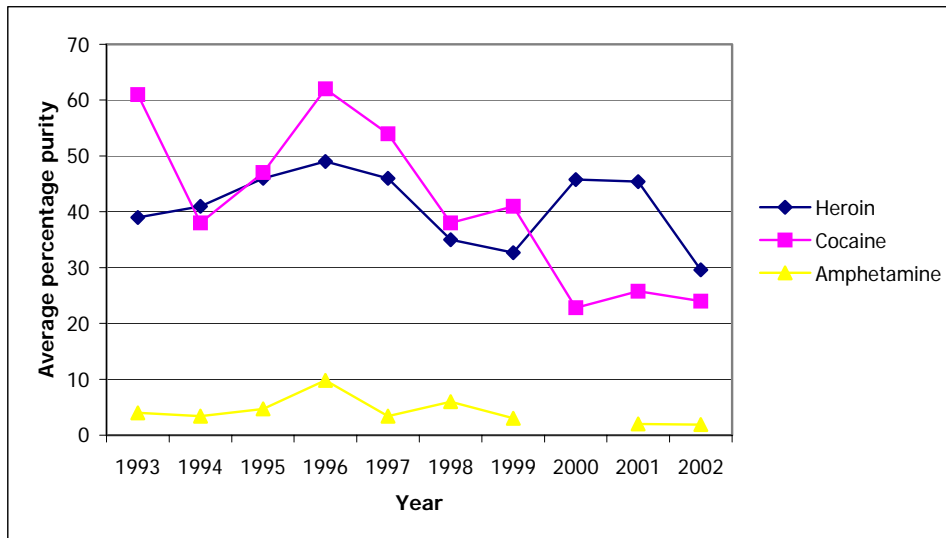
It should be noted, however, that these figures are based on a small number of samples and also that purity levels between different samples tested by the Forensic Science Laboratory appear to fluctuate significantly. For example, of the five cases tested in 2000, which involved 16 separate packs, the average purity was 22.76 per cent. The minimum purity was 1.8 per cent, while the maximum was 75 per cent.

**Table 10.4.3 Average percentage purity of cocaine seized 1993–2003**

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	1.80–75	22.76
2001	4	13	0.12–49.5	25.78
2002	2	15	15–33	24
2003	26	-	7–82	36

Source: Forensic Science laboratory

Figure 10.4.1 shows trends in purity levels since 1993 for a selection of heroin, cocaine and amphetamine seizures.



**Figure 10.4.1 Drug purity trends for specified drugs seized 1993–2002**

Source: Forensic Science Laboratory

## **Part B – Selected Issues**

### **11. Buprenorphine: treatment, misuse and prescription practices**

#### **11.1 Buprenorphine**

##### **Description of new developments**

In June 2001, the Minister of State for Local Development with special responsibility for the National Drugs Strategy, asked the National Advisory Committee on Drugs (NACD) to undertake a review of the use of buprenorphine as an intervention in the treatment of opiate dependence syndrome. As a result, the NACD commissioned a team of experts at the National Medicines Information Centre to conduct this review. The review examined the effectiveness of buprenorphine as a treatment option, its safety in use, as well as the practical and pharmacoeconomic considerations associated with its use (National Medicines Information Centre 2002). Where appropriate the authors compared the treatment outcomes, safety issues and costs to methadone the mainstay of treatment for opiate dependence in Ireland.

The methods employed in this study were: literature reviews, systematic reviews, case histories and an economic evaluation.

The main findings are presented by chapter heading:

##### **Clinical pharmacology**

Buprenorphine is a partial opioid agonist. Its metabolic pathway suggests that there might be difficulties with drug interactions either with co-prescribed medications or co-administered illicit drugs. The clinical relevance of these will be discussed in the other sections. The toxicological studies show an acceptable margin of safety for use of buprenorphine in the management of opioid dependence

##### **Clinical outcomes**

Many clinical trials have been undertaken to evaluate the use of buprenorphine in the management of opioid dependency.

In terms of its use in managed withdrawal, the studies were too heterogeneous to enable formal meta-analysis, but a systematic review suggested that buprenorphine had potential in this area.

Similarly, the studies investigating the use of buprenorphine as substitution treatment used diverse protocols in terms of (a) dosage regimen (daily versus less frequent dosing), (b) dosage schedules (fixed versus flexible) (c) total dosage (2-8mg/day or higher) and (d) the formulation of buprenorphine used. Moreover, studies varied in their non-pharmacologic treatment regimens, which could affect the endpoints and therefore introduce bias. Nevertheless, the results of a formal meta-analysis performed on six randomised controlled trials, using methadone as comparator, showed that high dose buprenorphine was similar to high dose methadone in terms of treatment retention with a small increase in positive urinalysis relative to methadone. Although the latter was statistically significant, it was not felt to be clinically relevant. It was not possible to determine the optimal dosing regimen although it was noted that less than daily dosing was feasible in clinical practice.

From the data available it was not possible to determine whether buprenorphine was more suitable for specific sub-groups. There is some evidence to suggest that those, with higher psychosocial and global functioning are more likely to respond to

buprenorphine, but more studies are required to substantiate this. Data, available to date, on its use in pregnant women showed that buprenorphine was efficacious and safe for both women and infants but definitive recommendations on dosing regimens could not be deduced from the results of studies undertaken.

### **Drug safety**

The safety data available to date suggest that buprenorphine has a known and predictable toxicity profile, related to its opioid agonist pharmacology and its interactions with other medicines. Although causality has not been proven, there is a warning regarding possible hepatotoxicity associated with use and it is recommended that liver function tests are regularly performed in patients receiving buprenorphine. The biggest problem to date appears to be the risk of fatal interaction with benzodiazepines.

Buprenorphine has a known potential for abuse, because of its opioid effects. Studies from France suggest that abuse may occur in up to 30% of treatment subjects. It would appear from these studies that abuse is more likely in those subjects not closely supervised either by a physician or dispensing pharmacist.

### **Costs**

The results from the pharmacoeconomic evaluation of the use of buprenorphine in the management of opiate dependence syndrome show that use of buprenorphine appears to be less cost-effective than the current methadone system. It may prove to be a cost-effective treatment option in selected Irish settings (such as general practice), but further studies are needed to identify these settings.

## **11.2 Treatment with buprenorphine**

The Irish Medicines Board authorised use of Subutex R in Ireland in August 2002 (NACD 2002). Subutex R is used to assist opiate users withdraw from opiates and is not prescribed as an opiate substitute in Ireland. According to Dr Keenan detoxification using buprenorphine is available on request but considered more suitable for young or new opiate users (E Keenan, personal communication, 2003). Data on the exact numbers of patients that received Subutex are not available. The Irish College of General Practitioners provide accredited training, at two levels, covering the management of opiate users in primary care. The published guidelines provided during this training contain a very brief but succinct overview of buprenorphine and states that this drug is an effective substitute and useful to assist withdrawals from opiates (Irish College of General Practitioners 2003). It is also suitable for patients wishing to withdraw from methadone following a period of substitution. The information in the document notes the risk of respiratory depression when buprenorphine is used in combination with alcohol or benzodiazepines. There are no other written criteria to guide use of buprenorphine nor protocols for its use in Ireland.

## **11.3 Misuse of buprenorphine**

In Ireland, buprenorphine misuse among the treated population is rare. Of the 35,632 cases reported to the National Drug Treatment Reporting System (NDTRS) between 1998 and 2002, 51 (0.1%) reported that buprenorphine was a problem drug. Between 1998 and 2002, the number of cases who reported that buprenorphine was a problem drug decreased considerably, from eighteen in 1998 to two in 2002 (Table 11.3.1).

**Table 11.3.1 Number (%) of cases reporting problem buprenorphine use and reported to the NDTRS, 1998-2002**

Treatment status	1998	1999	2000 Number (%)	2001	2002
<b>All cases</b>	<b>6048</b>	<b>6206</b>	<b>6933</b>	<b>7900</b>	<b>8596</b>
Buprenorphine a problem drug	18 (0.3)	18 (0.3)	10 (0.1)	3 (0.0)	2 (0.0)

Source: Unpublished data from the NDTRS

Of the 51 cases reporting buprenorphine as one of their four problem drugs, no case reported it as their main problem drug. Only 32 cases reported a route of administration or frequency of use in the month prior to treatment for buprenorphine, and of these, half injected it and four had used it in the month prior to treatment. All cases who reported using buprenorphine reported that another opiate (mainly heroin) was their main problem drug and this suggests that buprenorphine is used when their preferred opiate is not available. Fourteen cases who reported buprenorphine was one of four problem drugs also reported benzodiazepines as a problem drug and this highlights a high-risk combination of drugs. Of the 51 cases reporting buprenorphine as a problem drug 49 cases lived in Counties Dublin, Kildare and Wicklow while only two lived outside these counties. Of the 51 cases reporting problem buprenorphine use, the vast majority were male (42, 82%), all were aged between 20 and 39 years old, two-fifths had left school early (21, 41%) and just under one quarter were employed (12, 24%).

There are no data available on buprenorphine-related deaths.

## 12. Alternatives to prison targeting to drug using offenders

### 12.1 Political, organisational and structural information

#### National Policy and Drug Strategy

The need to develop alternative sanctions to prison has been recognised in many policy documents and reports over the past twenty years. Although policy documents do not always specify the link between such sanctions and drug using offenders, it has been widely accepted that many people are in prison as a result of offences committed as a consequence of drug addiction. This has been supported by research among the Irish prison population and among offenders known to the police as drug users (Furey and Brown 2004; O'Mahony 2004 1997; Millar *et al.* 1998; Keogh 1997).

The following reports have emphasised the importance of using imprisonment as a last resort and encouraged the use of alternative sanctions:

- The Prison Study Group (1973). *An examination of the Irish Penal System* Department of psychiatry, University College Dublin.
- The Prisoners Rights Organisation (1980). *Enquiry into the Irish penal System – The McBride Report.*
- Council for Social Welfare (1983). *The Prison System* Catholic Bishops Conference.
- National Economic and Social Forum (1984). *Criminal justice system – policy and performance.*
- The Whittaker Report (1985). *Committee of inquiry-The Irish Penal system.*
- Department of Justice (1994). *The management of offenders – a five year plan.*
- Department of Justice (1997). *Tackling crime – Discussion paper.*
- Prison Service Operating Cost Review Group (1997). *Report.*
- National Crime Forum (1998) *Final Report.*



- Expert Group on the Probation and Welfare Service (1999) *Final report*.
- Oireachtas Sub-Committee on Crime and Punishment (2000). *Report*.
- National Economic and Social Forum (2002) *Re-integration of prisoners*.
- Comptroller and Auditor General (2004) *The Probation and Welfare Service*.

Indeed, it could be argued that there is an overwhelming policy consensus that alternatives to prison should be used where possible. This consensus has now been placed on a statutory footing, at least for minors, in the recent Children Act, 2001.

The National Drug Strategy 2001-2008 has two relevant references in this area (Tourism, Sport and Recreation 2001) With relevance to the pre-trial stage, Action 13 aims: 'To monitor the efficacy of the existing arrest referral schemes and expand them, as appropriate'. With regard to the trial stage Action 20 aims: 'To have in Local Drug Task Force areas an 'early intervention system, based on the Drug Court Model, if the evaluation of the pilot in the North Inner City of Dublin is positive. This should be accompanied by appropriate familiarisation for the judiciary of the role of the Drug Court'.

### **Legislation**

Section 28 of the Misuse of Drugs Act, 1977, called for probation and medical reports to be made available to the court prior to sentencing. These reports were obligatory up until the Misuse of Drugs Act 1984, when the reports became an option for the trial judge. An order under Section 28 could involve the court releasing the offender subject to the condition that he or she attend a treatment center.

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. The Act emphasizes prevention and the diversion of young offenders from prosecution, it raises the age of criminal responsibility from seven years to twelve years, puts the Juvenile Diversion Scheme currently being operated by the Garda Síochána on a statutory footing and introduces elements of a restorative justice approach to the criminal justice system, including Family Group Conferencing. Underlying the Act is the principle that detention should only be used as a last resort (Dooley and Corbett 2002). Also, judges will be required to seek pre-sentencing reports from the Probation and Welfare Service (PWS) in all cases involving persons under 18 years of age where the judge is considering a custodial sentence or community sanction. Although certain provisions of the Act were introduced in May 2002 (SI 2002/151) most of the Act's provisions await implementation. As a consequence, while many commentators have welcomed the overall thrust of the Act, the government has come in for criticism due to delays in its implementation. The provisions of the Act relating to functions by officers of the PWS have not yet been brought into effect (Comptroller and Auditor General 2004)

O'Mahony (2002, p. 9) suggests that the Children Act could 'potentially revolutionise the area of juvenile justice'. However, he is also critical for 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 in St Patrick's Institution for 14–15-year-olds (Dooley and Corbett 2002). O'Mahony (*Irish Times* 2003, 3 October) stated that this initiative 'totally undermined the basic principle contained in the Act, which was not to jail under 15-year-olds'.

## **Implementation structure**

The agencies involved in the operation of alternative sanctions in Ireland include the Garda Síochána and the Probation and Welfare Service (PWS). The Garda Síochána have a role in the operation of juvenile diversion schemes and also in relation to restorative justice interventions. The main functions of the PWS in this area are to provide the courts with advice and information on offenders to assist in sentencing decisions; to implement and enforce community sentences passed by the courts and to design and provide effective programmes for supervising offenders safely in the community for public protection (Comptroller and Auditor General 2004, Vaughan 2001, Expert group on the Probation and Welfare Service 1999).

Many of the alternative sanctions in operation in Ireland are not based on legislation but have evolved over time in the form of judicial practice. For example, almost half of the offenders referred for supervision by the PWS in 2000 were supervised by the Service without formal court orders being made. In these cases sentence is deferred by the judge for a stated period. Most reports to courts are also provided on a non-statutory basis.

## **12.2 Interventions**

### **Types of interventions - Pre-trial stage**

#### *Arrest referral and juvenile diversion*

The main aim of arrest referral schemes is to provide information to arrestees about appropriate services and to facilitate referral to treatment at the primary points of entry into the criminal justice system – usually police cells or court premises. Arrest referral is an intervention aimed at people who have been arrested and whose offences may be linked to drug use. Such policies are premised on the idea that treatment will lead to a reduction or cessation of illicit drug use and thus reduce or negate further drug-related offending by the drug user.

Action 13 of the National Drugs Strategy 2000 – 2008 obliges the Garda Síochána to ‘monitor the efficacy of the existing arrest referral schemes and expand them, as appropriate’ (Tourism, Sport and Recreation 2001). A pilot juvenile arrest referral scheme has been established in a police station in Dublin’s north inner city. This is a joint initiative between the Garda Síochána, the Northern Area Health Board and the North Inner City Drugs Task Force. This pilot project is currently in the process of being evaluated. It is intended that the evaluation be used ‘as a tool for formalising policy on juvenile/adult arrest referral between agencies’ (NICDTF 2003).

#### *Types of intervention - Trial stage*

There are a number of different non-custodial options open throughout the trial process to judges to dispose of drug offences and drug-related offences.

#### *Suspended sentence – Butler Orders and Orders of Recognisance (Misuse of Drugs Act 1977)*

A suspended sentence occurs where the court, having passed a sentence of imprisonment for a specific term, suspends its operation. Although this option is used widely there is no statutory authority in Ireland enabling the court to suspend the operation of a prison sentence. Walsh (2002) highlights the fact that a suspended sentence must be seen as an alternative to prison. It should not be imposed, therefore, ‘where the gravity and circumstances of the offence taken by themselves would not have warranted a prison sentence’ (p. 1033). There is no publicly available information

on the number of suspended sentences imposed in any one year. Usually, a sentence of imprisonment will be suspended upon the offender's entering into a recognisance to keep the peace and be of good behaviour for a specified period. A Butler Order, which derives its name from the decision of Butler J in *State (Woods) v. Attorney General* (1969, p. 385), arises where a court imposes a lengthy sentence with a direction that the offender be brought back to the court having served a portion of the sentence. It is then up to the judge to decide what to do with the remainder of the sentence. Walsh (2002, p. 1033) makes the observation that this form of suspended sentence has become increasingly popular 'as a means of building in an element of rehabilitation to a custodial sentence, particularly in respect of a young person or a person with an addiction'. There is some uncertainty as to the constitutional validity of Butler Orders. This issue has not been fully determined by the Supreme Court. However, following consideration of the orders by the Supreme Court in the *People (DPP) v. Finn* (Butler 2001, p. 25), it appears likely that Butler Orders represent a constitutionally invalid exercise of judicial power.<sup>20</sup>

Another form of suspended sentence provided for by statute is an Order of Recognisance as set out in Section 28 of the Misuse of Drugs Act 1977. This order requires an offender to undergo treatment for his or her drug condition in a residential center or in the community. Within Section 28 (MDA 1977) there is also the possibility of sentencing a person to a custodial treatment center for up to one year. Under Statutory Instrument 30 of 1980, the Central Mental Hospital in Dundrum was designated the custodial treatment center. Charleton and McDermott (1998) point out, however, that between 1977 and 1998 only two persons were sentenced to custodial treatment by an Irish court. The non-custodial option in s.28 has also been used infrequently by the courts. Between 1995 and 1999 only five MDA Orders of Recognisance were recorded by the Probation and Welfare Service, which has a supervisory role in this area (Probation and Welfare Service 2001).

Moran *et al.* (2001) suggest that the reason the courts have been reluctant to exercise this option is because the necessary rules and regulations have not been made. In order to facilitate the greater use of this sentencing option, the Expert Group on the Probation and Welfare Service has recommended that 'the necessary Courts Rules and Regulations be updated by the various Court Rules Committees' (Probation and Welfare Service 1999, p. 49).

#### *Adjournment of sentence*

The court may adjourn a prison sentence for a certain time to see how the offender behaves. Although this practice has no statutory footing, there is usually an expectation that the offender will take some intervening action, such as undergoing a treatment programme in a drug-related case. The court, when it comes to reconsider the matter, may proceed with the originally intended sentence in the event that it is not satisfied with the offender's progress in the interim period.

#### *Probation orders, Intensive Community Supervision (ISP) and Supervision During Deferment of Penalty*

A probation order is a formal warning to an offender that if he or she does not abide by conditions imposed by the court for a specified period he or she will be brought back by the court for punishment. These orders are usually supervised by a probation officer. The Probation and Welfare Service was involved in 118 such supervision orders in respect of offences under the Misuse of Drugs Act in 1999, the last year for which figures are available (Probation and Welfare Service 2001). Intensive Community

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<sup>20</sup> For a discussion of this judgment see Walsh (2002, p. 1035).

Supervision was designed to provide increased controls on the offender in the community. Intensive Supervised Probations for young offenders with drug-related problems are currently provided via the Bridge project and the Tower project in Dublin.<sup>21</sup>

Although orders for Supervision During Deferment of Penalty have no statutory basis, such orders are used where the court is unsure as to an offender's capacity to participate in community-based programmes while avoiding further crime. At a later hearing, a report is presented to the court on the progress of the offender. In 1999, 192 such orders were issued in respect of offences under the Misuse of Drugs Act 1977.

### *Community Service Orders*

Community Service Orders (CSOs) involve the imposition of a sentence to a programme of work in the community as an alternative to imprisonment. The sanction is available only in respect of offenders over 16 years of age who have been convicted of a criminal offence. Any court exercising a criminal jurisdiction, except for the Special Criminal Court, can apply a CSO. However, the vast majority are applied by the District Court.

### **Implementation**

In Ireland, in 2002, there were approximately 4,100 persons under supervision in the community, compared to a daily average of approximately 3,200 prisoners – ratio of 1.3 : 1. Between 1995 and 2002, the estimated total number of persons under supervision increased by half, and there was a similar increase in the prison population. Thus alternatives do not appear to be displacing imprisonment. Despite the broad consensus reported earlier, there does not appear to have been any increase in the use of alternatives to prison relative to custodial sanctions between 1995 and 2002 (Comptroller and Auditor General 2004).

Furthermore, if we consider the number of committals, *the prison flow*, in a given year rather than the daily prison population, *the prison stock*, it is clear that many of those sentenced to prison in Ireland have committed minor offences and have received short sentences. The National Economic and Social Forum (NESF) report states: 'while there are about 3000 prison spaces, in the region of 11000 committals are made each year' (NESF 2002, p. 37). Almost half of all adults imprisoned receive less than three months; in three-quarters of cases the sentence was less than one year.

Although we do not have detailed follow-up data on prisoners to assess recidivism rates, a survey of prisoners found that each had accumulated an average of 14 convictions and 10 separate prison sentences (O'Mahony 1997). A study of 150 young offenders found that half were serving their first sentence, of those who had served a previous sentence 53 per cent had been in prison on one previous occasion, 19 per cent had served two previous sentences and 27 per cent had served three or more sentences (Geiran *et al.* 2000).

### **Main obstacles to implementation**

Despite the broad consensus that prison should be used as a last resort and that alternatives to prison should be used more often, a number of factors have been identified in the literature which contribute to an explanation as to why such sanctions are not being used more frequently in the Irish criminal justice system. In determining whether non-custodial sanctions are replacing imprisonment, we must not lose sight of

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<sup>21</sup> For a description of these projects see [http://www.emcdda.eu.int/responses/methods\\_tools/eddra.shtml](http://www.emcdda.eu.int/responses/methods_tools/eddra.shtml)

the context in which sanctions are applied and the factors which impact both on the sentencing process and therefore on the prison rate. We need to be able to isolate these other variables on sentencing and imprisonment practice.

The National Economic and Social Forum (NESF) was established by the government in 1993 for the purpose of achieving consensus on major economic and social policy initiatives. Its membership is drawn from the Irish parliament; An Oireachtas; employer, trade union and farm organisations; central and local government; and the voluntary and community sector. The NESF has recently considered the possible reasons why alternatives to custody have not been introduced more in practice (NESF 2002).

#### *Political influence and the prison rate*

NESF highlight the complexity of policy implementation in the area of criminal justice and the particular problems arising here:

On the one hand, there is consensus that prison should be a last resort, while on the other, there is strong support for the current prison-building programme, during a period when recorded crime is on the decrease, but fear of crime remains high. Policy implementation issues in this area tend to be more political than usual, as likely (or even more so) to be more influenced by various interpretations of public opinion and media reaction rather than by the findings of empirical research, lessons emerging from practical experience or financial considerations such as value for money (NESF 2002, p.35).

The role of political considerations rather than crime rates or evidence-based analysis of sentencing practices in determining the number of prison cells built is a theme taken up by other contributors in this area (O'Donnell 2004, O'Sullivan and O'Donnell 2003). A recent emphasis on a repressive approach to penal policy during the 1997 election campaign was contributed to in particular by the drug-related murder of a high profile investigative journalist. A subsequent expansion in prison building was situated within the context of a 'zero tolerance' approach to crime (O'Sullivan and O'Donnell 2001). As a consequence, despite a downward trend in recorded crime figures between 1995 and 2000, the Irish prison population increased by 40 per cent.

Vaughan (2001, p.12) also points to the high rate of imprisonment in Ireland: 'What does seem indisputable is that Ireland relies upon imprisonment to a far greater degree than in most other Western European countries.'

A recent referendum on the bail laws led to the Bail Act, 1997, which increases the grounds on which bail can be refused by the courts and which became operational in 2001 has led to an increase in the prison remand population (O'Donnell 2004, NESF 2002). A trend towards longer sentences has also been identified recently (O'Donnell 2004, NESF 2002, Vaughan 2001). As against these negative trends, O'Donnell identifies a slight reduction in the number of prison committals under sentence by the District Court in the latter half of the 1990s, despite the increase in the prison population due to the bail laws and the reduced use of temporary release. He questions whether this trend will continue however, given, among other things, the increased incarceration of non-nationals in Ireland.

The NESF report also highlights the fact that approximately one quarter of the Irish prison population is under 21 years of age. Ireland had, according to Vaughan (2001, p. 31) 'the second highest proportion of prisoners under 18 (6.2%) of 40 Council of Europe countries surveyed in 1997.' Identifying the poor correlation between prison population and crime rates, the NESF identifies the need to determine an appropriate level of imprisonment and to limit additional prison building.

### *Resource allocation*

The NESF also identifies staff and resource shortages in the Probation and Welfare Service. In 2001, the PWS budget was about 15 per cent of the Prison Service operations budget - €171 million (excludes €34 million for prison capital spending) compared with €25 million. The NESF also identifies significant staff shortages in the PWS, with over 3,000 prison officers compared to a staff of only 310 in the PWS. The NESF recommends that targets should be set to enhance the resources and functions of the PWS, for example reduced staff/client ratio.

### *Judicial practices and priorities*

Many of the alternative sanctions applied in the Irish Criminal Justice System are not based on statute but have evolved as judicial practice. Generally speaking, the determination of what sentence to impose in any individual case is an exercise of judicial power. In order to assess the degree to which alternative sanctions are being applied in relation to custodial sanctions, it is necessary to be aware of the many variable factors which influence the judicial process.

The decision of the court in this respect may be influenced by a pre-sanction report which is compiled by the Probation and Welfare Service and which might highlight factors such as drug addiction as a contributory factor in explaining the offender's behaviour.

The judge is not entirely free to impose whatever decision he or she decides in an individual case. Walsh (2002) suggests that the judge must exercise such discretion fairly and in keeping with case law and judicial principles and practices as have evolved over the years. A failure to follow such principles can lead to successful appeals against sentence. A problem which arises in this area, however, is that these principles have not been expressly laid out either by statute or in the form of judicial guidelines (Bacik 2002). Furthermore, the judiciary has been extremely reluctant to allow itself to be circumscribed by the legislature in terms of its freedoms in this area. In *The People (DPP) v. Gannon*<sup>22</sup> the Court of Criminal Appeal set itself against the principle of sentencing guidelines or tariffs: 'We put great store on the fact that each case must be considered in its individual frame, while being mindful that a sentence must be proportionate to the offence in question and to other sentences imposed in similar situations – though it needs to be emphasized, that very rarely will two cases be exactly alike.' A survey of 17 District Court Judges conducted by Vaughan (2001, p. 127) found a 'general belief among judges that 'each judge should be left to their own devices' because "circumstances differ so often."

A number of factors have been seen to impact on the types of sentences handed down in relation to drug offences. These might include the type of drug, the quantity of drugs found in the offender's possession, whether the drugs were for personal consumption, and the circumstances of the offender. Also, where the accused assists the authorities in the investigation and prosecution of further offences, this will be seen as a mitigating factor in sentencing.

Cannabis has always been treated differently under the Misuse of Drugs Act 1977. Section 3 makes it an offence for a person to have a controlled drug in his possession. Section 27 of the Act, as amended by Section 6 of the Criminal Justice Act 1984, stipulates that, where the substance is cannabis and the court is satisfied that the defendant possessed it for his or her own use, the penalty should be a fine on the first

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<sup>22</sup> Court of Criminal Appeal, 15 December, 1997. Quoted in Charleton P and McDermott (1998)

offence up to a maximum of €380 on summary conviction and €635 on indictment (Connolly 2004). The supply of drugs within a small circle of friends has been held to be a mitigating factor, while the presence of a commercial motive, even where friends are involved, has been seen as an aggravating factor (Charleton and McDermot 1998). The operation of judicial discretion in this area has caused some controversy in the context of the introduction of a mandatory minimum sentence for certain drug offences. Section 4 of the Criminal Justice Act 1999 inserted a new section, 15A, into the Misuse of Drugs Act 1977. This new section introduced the specific offence of possession of drugs with a market value of £10,000 (€12,700) and applied for the first time the principle of a mandatory minimum sentence with respect to these offences.<sup>23</sup> However, from a review of the case law, Ennis (2003) found that the Court of Criminal Appeal 'has showed a general reluctance to impose the mandatory minimum sentence in practice.' (see section 1.2).

The age and other circumstances of the offender may also be a factor in sentencing. With regard to offences committed to feed a drug habit, Charleton and McDermott (1998, p. 347), in a consideration of the judicial response to such cases, conclude that, 'Irish courts have struggled ... with the concept of drug addiction as mitigation. Differences have been drawn between the cold-blooded non-user of drugs and those who commit various crimes in order to finance their needs.' However, the primary concern of the courts has, they suggest, been the criminogenic effects of drugs from the point of view of the public, with the personal circumstances of the offender being of secondary consideration.

Another factor which has been identified relates to the reluctance of the judiciary to apply alternative sanctions. This has been seen recently in the context of a 20 per cent decline in the use of Community Service Orders between 1992 and 2001 (Vaughan 2001). Vaughan (2001, p. 75) suggests that, although it is unclear why this reduction has taken place, 'some judges have expressed frustration with the difficulty of obtaining insurance for these projects, as the state will not cover the cost'. A sample survey of seventeen District Court Judges conducted by Vaughan (2001) asked questions about the judicial willingness to apply community-based sanctions. Judges appeared to be positively disposed to the use of the PWS. However, there was a reluctance to use the PWS due to the under-resourcing of the latter, a factor which was seen to undermine the efficacy of such sanctions.

Vaughan (2001, p. 28) suggests that the dramatic increase in prison committals since 1992 must be explained 'by a greater recourse to custody by the judiciary'. This only led to a noticeably larger prison population after 1997, he suggests, due to the reduction in the use of temporary release, a discretionary power of the Minister of Justice which can affect the number of people retained in prison. This was a controversial policy whereby prisoners were being released after serving only a small portion of their sentence due to the pressure of space for new inmates. This became known as the 'revolving door' syndrome. The recent prison-building programme has led to a reduction in the use of temporary release. In July 1996, 19 per cent of serving prisoners were on full temporary release, compared to seven per cent in 2000 (O'Sullivan and O'Donnell 2003). O'Donnell (2004, p. 257) also identifies 'a strong orientation towards custody among Irish judges'. Mc Cullagh (1992, p. 17) concludes: 'the increased punitiveness of the Irish judiciary...has created the crisis in the prison system'. He suggested that their social background renders them unable to understand the circumstances of the offenders they routinely confront and more susceptible to 'punitive-minded' views from within their own social circle and in the media, described as 'their major source of access to the nature of "public opinion" '.

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<sup>23</sup> Misuse of Drugs Act 1977, Section 27(3B), as inserted by Criminal Justice Act 1999, Section 5.

Along with this alleged judicial orientation towards incarceration, another study has suggested that the tendency to imprison is directed disproportionately towards specific deprived sections of society. A study by Bacik *et al.* (1998) suggests a degree of bias in the way in which Irish courts respond to particular defendants. The study, which sought to examine links between economic deprivation and crime, looked at court appearance and sentencing patterns. The study found that age, sex and level of community deprivation were key factors predicting the likelihood of court appearance. Secondly, the study found that defendants from more economically deprived areas were 49 per cent more likely to receive a custodial sentence than those from less deprived areas, once other variables were accounted for. This study did not focus on specific crimes; however, given the acknowledged link between economic deprivation, problematic drug use and crime, it can be assumed from the study that many of those sent to prison from deprived areas have committed crime as a consequence of their drug addiction.

However, a recent study by Riordan (2000) looked at the practice of the Dublin District Courts when dealing with drug-related offenders. As part of his study, he convened a focus group of district judges, in order to ascertain their attitudes with regard to sentencing in drug-related cases. The study found that the practices in the courts in dealing with drug-related offenders is different than where drugs is not an issue with judges clearly favouring the adjourned supervision as a way of monitoring drug related offenders.

O'Donnell (2004) also identifies differential patterns of sentencing in different parts of the country. A comparison of Limerick and Dublin case management found that in Limerick, for larceny, assault and public order offences, immediate incarceration was more common than probation and community service combined whereas in Dublin, probation was more commonly used than immediate imprisonment. O'Donnell (2004, 259) concludes that either 'Limerick court is more punitive; or that it deals with more serious offences; or that it has less access to community sanctions and measures'.

#### *Other obstacles*

O'Donnell (2002, p. 84) lists a number of other possible reasons why progress can be slow in introducing criminal justice reforms, even where a consensus appears to be firmly established. These include: institutional pessimism; bureaucratic inertia; problems of definition and measurement; political and moral considerations; the disputed nature of social "facts"; unclear lines of accountability; industrial relations problems and poorly designed evaluations from which generalisation is difficult.

#### **Funding**

A recent financial assessment of the Probation and Welfare Service, which has responsibility for managing offenders in the community, conducted by the Comptroller and Auditor General (2004) considered the cost effectiveness of community-based sanctions. The report also highlights a number of problems in relation to assessing costs. Where for example, supervision in the community is designed as an alternative to prison, as in the case of community service orders, and the judiciary imposes such sanctions where custodial sentences would not otherwise have been imposed, the result is what is referred to as a 'net widening' effect. The report points out: 'In cases where a custodial sentence would not have been imposed, there is no financial cost of alternative imprisonment' (Comptroller and Auditor General 2004, p.48). Also, where an offender fails to meet the conditions of a supervision order and is subsequently imprisoned, both the costs of the supervision order and of imprisonment may be incurred. There was insufficient information available to calculate similar estimates in relation to probation orders and supervision during deferment of penalty. However, in relation to Community Service orders, the report concluded: 'The cost of imposing



community service orders is estimated at around one-third of the cost of custodial alternatives’.

### Treatment

Data provided by the National Drug Treatment Reporting System provides information on the numbers referred to treatment from the criminal justice system in general. Data is not available as to the precise stage of the criminal justice system from which the client is referred. Table 12.2.1 provides the total number and percentage of those referred to treatment from the criminal justice system.

**Table 12.2.1 The number (%) of cases referred to drug treatment from the criminal justice system**

	1998	1999	2000	2001	2002	Total
Court/ probation/ police	518 (8.8%)	427 (7.1%)	439 (6.5%)	480 (6.4%)	598 (7.4%)	2462 (7.2%)
Total referrals	5862	5993	6754	7532	8116	34257

Source: National drug treatment reporting system.

The main types of treatment provided include: de-toxification (opiates/ benzodiazepines/ alcohol); substitution (methadone); medication free treatment (12-step approach); therapeutic communities (medication free – behavioural model); counselling (crisis/ psychological – which can and are generally used in conjunction with the above treatments)

As shown in Table 12.2.1, in 2002 only 7 per cent of the total number of referrals to treatment originated in the criminal justice system.

Procedures for monitoring treatment programmes are not publicly available. However, a recent study conducted among drug users suggested the existence of perceptions of informal and arbitrary punishments of drug users for non-compliance with programmes (UISCE 2003).

A recent evaluation was conducted of a methadone maintenance clinic in Dublin. The study attempted to measure the levels of effectiveness in terms of clients outcomes while undergoing treatment (Lawless and Cox 2003). A questionnaire was administered to clients who were registered at the centre in 1999 and then again to those who remained on treatment eighteen months later:

At baseline stage, over half of clients (57%) reported having being in prison at some point in time. At follow-up stage the findings included the following:

- Improvements in the extent of drug using risk behaviour among clients;
- Reduction in quantity and frequency of both licit and illicit drug consumption;
- Increase in sexual risk behaviour among clients;
- Reduction in frequency of criminal activities undertaken by clients;
- Improvements among clients in relation to social functioning;
- Marked decrease within a range of psychiatric complaints especially with regards to reported levels of anxiety among clients

### Specific target groups

There are procedures in place to enable the Gardaí to divert juvenile offenders (those under 18 years of age) found in possession of small quantities of drugs, where drug trafficking is not an issue, away from the judicial process. The Garda Juvenile Diversion Programme was initiated in 1963. The programme allows that, if certain criteria are met, a juvenile offender may be cautioned as an alternative to being prosecuted. In order for a juvenile to be eligible for caution he or she must be under 18 years of age,

must admit involvement in the crime or offence, must not have been cautioned previously (or if so, it must be deemed appropriate to administer a further caution), and the parents, guardians or person acting in *loco parentis* must agree to the terms of the caution. Whereas up until 2001 the programme operated on the basis of the common law principle of police discretion, the Children Act 2001 has now placed it on a statutory footing.

Juveniles cautioned under the programme may be subject to supervision by a juvenile liaison officer (JLO). Supervision may involve a range of activities and involve other statutory or voluntary organisations with appropriate expertise to respond to the particular matter. The Children Act 2001 also introduces restorative justice principles to the operation of the system. There is now a process whereby the offender and the injured party can be brought together to discuss the offence and its related impact on the injured party. In the context of so-called victimless crimes, such as simple possession of cannabis for example, identifying the injured party is a matter of some controversy.

As these represent early interventions, it is not clear whether they can be described as alternatives to custody. Also, data produced annually by the police in relation to juvenile diversion programmes does not provide information on whether the offence is drug related, as distinct from a drug offence.

### **Specific projects**

#### *The Drug Court*

The Drug Court (Farrell 2002) initiative is based in the District Court. The jurisdiction of the Drug Court is confined to persons over the age of 17 years who have been convicted of or have pleaded guilty to certain non-violent offences, deemed to have been committed in order to feed their drug habit. The Drug Court was established on a pilot basis in Dublin's north inner city in February 2001. On conviction, the offender is offered the alternative of a prison sentence or a supervised drug treatment programme. Walsh (2002, p. 54) describes the Drug Court as the District Court operating 'a novel sentencing jurisdiction. The emphasis is on therapeutic rehabilitation as distinct from punishment.'

#### *Monitoring*

Compliance with the Drug Court programme in terms of treatment is generally assessed by Drug Courts through urinalysis. One of the conditions of the Drug Court is mandatory urine analysis, generally on a weekly basis. As the participant progresses successfully through the programme the frequency of the urine testing is reduced.

In the first twelve months the Drug Court Judge imposed numerous sanctions including:

- Registering on a daily basis at the local garda station;
- Imposition of a curfew, for example from 8pm to 8am;
- Revocation of bail for a period of days;
- Verbal warning of a curfew;
- Increased court appearances.

The Judge also rewarded the participants for satisfactory progress with a range of incentives:

- Reduces court appearances;
- Removal of curfew;

- Week off court;
- Gifts appropriate to the participant.

### 12.3 Quality Assurance

#### Guidelines

##### *Police guidelines*

A series of guidelines have been established for the Garda Youth Diversion Project (Ryan *et al.* 2002). The purpose of these projects is to divert young people from becoming involved (or further involved) in anti-social and/or criminal behaviour. They should not necessarily be regarded as alternatives to prison. The purpose of the guidelines is to act as a benchmark against which applications for new projects can be assessed. The guidelines cover four primary areas:

- the establishment of projects;
- the ongoing operation of projects including procedures identification;
- management structures and administrative procedures;
- monitoring and evaluation structures.

##### *Judicial guidelines*

The principles applied by judges when sentencing have not been expressly laid out either by statute or in the form of judicial guidelines. Vaughan's sample of judges in the District Court asked whether judges had statistics regarding sentencing:

**Table 12.3.1 Judicial access to statistics regarding sentencing**

	Yes	No
In your own court	4	12
In other courts	1	14

Source: Vaughan (2004, p.127)

Vaughan (2001 p. 127) concludes from this survey that 'not only are the majority of judges not able to review their own work, although some judges may operate their own review procedures, they are also unable to compare it to those of their colleagues. The judges may unwittingly be imposing different sentences for similar offences'.

#### Evaluation and research

A major obstacle to evaluating the impact of alternatives to custody is the inadequacy of data in the criminal justice system. This is relevant at each stage of the criminal justice system. The absence of an integrated data system throughout the different stages and between the different agencies of the system is particularly problematic in an area where we are seeking to trace the progress of offenders through the system.

Among the problems encountered are the following:

- It is not possible to track offenders through the system.
- There is no regular information on sentencing practices.
- There is no regular data on recidivism rates.

A number of difficulties have been identified in relation to data throughout the criminal justice system in Ireland (O'Sullivan and O'Donnell 2003; Bacik 2002; O'Donnell and O'Sullivan 2001; O'Malley 2000; McCullagh 1996). Also, the report by the Comptroller and Auditor General on the PWS states that: 'In practice, the Service has very poorly developed management information systems. This is compounded by the lack of relevant statistical information from other parts of the criminal justice system on a consistent basis' (Comptroller and Auditor General 2004, p. 51). The issue of crime

statistics has recently been considered by the government-appointed Expert Group on Crime Statistics. This committee has reviewed the data problems throughout the system and presented its recommendations, along with a minority report, to the government (Expert Group on Crime Statistics 2004, 2004a).

The report of the Comptroller and Auditor General on the PWS points to the lack of evaluations on alternatives to custody: 'Neither the Department (of Justice, Equality and Law Reform) – which oversees the operation of the criminal justice system – nor the (Probation and Welfare) Service has carried out evaluations of the relative effectiveness of the different forms of sentence' (NESF 2004, p. 47). Specific studies have been conducted on the operation of the Garda Restorative Justice projects (O'Dwyer 2001), the pilot Drug Court (Farrell 2002) and the Community Service Orders (Walsh and Sexton 1999). Vaughan (2001) conducted a study on the attitudes of a small sample of District Court Judges on their attitudes to penalty.

A review of a Garda Síochána restorative justice pilot programme in 2001 reports that, of the 68 cases reviewed, six cases involved drug possession (O'Dwyer 2001). Three of these led to a caution and three to a family group conference. Of the 20,647 offences in respect of which juveniles were referred in 2002; 1,054 (5.1%) were for the possession of drugs and 154 (0.7%) were for the sale or supply of drugs (Garda Síochána 2004). It can also be assumed that many other referrals were for drug-related offences, involving theft or burglary for example. Although serious crimes were dealt with, offences which could result in a prison sentence, the study did not specify whether restorative justice conferences were used in drug-related offences, as distinct from drug offences, or whether it would be appropriate in relation to serious drug users.

As discussed above, an evaluation of the operation of the pilot Drug Court was carried out by Farrell (2002). Of the 61 offenders who were referred to the Drug Court in its first year of operation, 37 were deemed suitable to enter the programme (Farrell 2002). The participants were primarily male, in their late 20s and unemployed, with a low level of educational achievement. Between them, 35 of the participants had a total of 872 prior convictions and the majority were deemed to present a 'very high risk of reconviction' (p. 5). The main drug of addiction of the participants was heroin. Overall, participants were using an average of five different illicit drugs at the time of entering the programme.

The main findings of the Farrell study indicated that, although a number of participants continued to offend while in the programme, the rate at which participants were arrested, charged and had their bail revoked declined the longer they were in the programme. In terms of substance abuse, the percentage of those testing negative for opiates increased significantly as the programme progressed, from 42 per cent over the first three months to 82 per cent in the last three months. Although no graduations had been anticipated during the pilot period, compliance had improved significantly and 11 of the 37 participants (30%) were clean of all illicit drugs by the end of the evaluation period. All of those interviewed as part of the evaluation believed that there continued to be a strong rationale for the continuation of the Drug Court. However, the low number of referrals and the absence of an agreed mission statement and clear identity for the Drug Court were identified as issues which needed to be addressed.

The most significant obstacle to progress identified by the evaluation is the difficulty encountered in providing participants with access to full and timely treatment services. According to the report, 'Many stakeholders believed that the Drug Court cannot continue to operate without access to full treatment within a reasonable time period' (p. 5). A marked decline in offending behaviour and an increase in compliance as the pilot

progressed suggest, according to the report, 'that the Drug Court will have the desired impact if it can succeed in retaining participants over the early months' (p. 6).

Research limitations of the study prevented an adequate examination of the programme's economic benefits. However, the report identified a number of areas where the efficiency and effectiveness, and ultimately the economics, of the programme could be refined. Furthermore, the authors concluded that, should the Drug Court reduce recidivism, significant long-term savings to the criminal justice system would be made. The Minister for Justice, Equality and Law Reform has supported the recommendation in the report that the Drug Court should be continued and it has now been extended to another part of the city: the Dublin 7 area.

Technically, the Community Service Order (CSO) should only be applied in cases where a custodial sanction would otherwise have been applied. However, a study by Walsh and Sexton (1999) found evidence of a more flexible approach being adopted by the courts and some evidence of a 'net-widening' effect whereby people who would not have received a prison sentence were being sentenced to CSOs. The authors recorded evidence of a 'feeling among some judges and other practitioners in the field that legislation was too restrictive in confining CSOs as a substitute for a prison term' (p. 97). Of the 269 offenders they studied who had been served a CSO, they found that almost half did not have a previous criminal conviction and the most frequent offences committed were road traffic offences, public order offences and less serious assaults.

The Expert Group on the Probation and Welfare Service (1999, p. 46) noted the decline in the use of CSOs since the mid 1990s and attributes this in part 'to the lack of suitability of community service for offenders with addictions'. Walsh and Sexton (1999) found, however, that drug offences hardly featured in their study sample. Of the 297 offences involved in the CSO study, only six involved drugs. Three of these were convictions for simple possession and three were for possession with intent to supply. The simple possession offences involved small quantities of cannabis. Nevertheless, the authors concluded, 'they attracted relatively severe sentences: 120 hours or 4 months imprisonment; 120 hours or 11 months imprisonment and 159 hours or 10 months imprisonment' (p. 40).

However, it is possible that other offences covered by the CSOs were drug-related. Walsh and Sexton found, from a sample of CSOs, that 83 per cent were completed successfully i.e without the order being revoked because the offender was formally found to be in breach of conditions.

## **Training**

Vaughan's survey of District Court Judges found that most of the sample felt there was a need for training to understand the circumstances surrounding drug misuse. The current practice in this area is that new judges attend an induction course and observe another judge for a couple of weeks. A handbook on essential matters is circulated to new judges on the bench. District Court Judges have two statutory meetings per year to discuss sentencing matters.

Farrell's (2002, p. 51) evaluation of the pilot Drug Court found that:

although members of the Drug court team had been afforded opportunities to attend training conferences and visit international Drug Courts, some members of the Drug Court Team did not receive any specific Drug Court training prior to the commencement of the Drug Court and in some cases Team members had very little time to prepare for their new roles.

## **12.4 Public debates**

As we have seen, over the past twenty years, numerous studies and reports, both government sponsored and non-governmental, have advocated the use of alternatives to prison.

The Expert Group on the Probation and Welfare Service (1999) called for the introduction of additional non-custodial sanctions, to include: Treatment Orders, Mediation Orders, Reparation Orders, Counselling Orders and Combination Orders.

In a recent survey of public perceptions of crime in Ireland, nearly three-quarters (73%) of respondents believed that non-custodial sanctions, such as fines and community service, would be more fitting than custodial sanctions for certain crimes (McDade 1999).

The National Economic and Social Forum (2002, p. 3) report makes a number of recommendations designed to reduce the use of imprisonment and encourage the use of non-custodial options. These include:

- the Judicial Studies Board should take a lead role in the dissemination of information to its Members regarding non-custodial sanctions;
- the provisions of the Children Act, 2001 (in relation to prison as a last resort and restorative cautioning) should be extended to adults, wherever possible, by legislative change;
- additional resources should be put in place to develop and evaluate these sanctions further;
- a public education programme should be developed by the Department of Justice, Equality and Law Reform to increase awareness of these sanctions among the public, the Social Partners and relevant organisations

### **Other developments**

A recent report of the Expert Group on Crime Statistics (2004, 2004a) has been submitted to the Minister for Justice, Equality and Law reform. The implementation of the recommendations of the Committee should improve data sources within the criminal justice system, thereby enhancing our ability to assess the extent to which alternatives to prison are being applied in Irish courts.

## **13. Public Nuisance: definitions, trends in policies, legal issues and intervention strategies**

### **13.1 Definition**

Since the onset of Ireland's serious drug problem in the late 1970s, a number of local studies have sought to highlight the local impact of drug markets and related drug-related crime (Cullen 2001). The definition used has generally been quite broad, encompassing crime, nuisance and anti-social behaviour. Lawless and Cox (2003 204) define anti-social behaviour as it has evolved in the Irish context as 'a dynamic phenomenon, involving a broad range of disruptive behaviours, some relatively minor, others causing extreme distress and misery to people. In short, neighbourhood nuisance and anti-social behaviour includes anything which interferes with the peaceful enjoyment of the home and surrounding areas'. Drug specific anti-social behaviour includes, they suggest, 'discarding used injecting equipment, open drug dealing, consumption of illicit drugs and any engagement in problem behaviour resulting from

such consumption...such behaviour tends to occur in areas where other forms of nuisance behaviour also takes place, such as squatting, noise from tenants, vandalism, graffiti and general harassment' (p. 205).

Under the Housing (Miscellaneous Provisions) Act, 1997, the concept of 'anti-social' behaviour is defined as either:

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

Fahey (1999) accurately describes 'antisocial behaviour' as a catch-all term ranging from 'minor incivilities to actual criminal acts'.

A number of recent Irish studies have sought to give some indication of the extent of anti-social behaviour (Connolly 2003, 2001; Lawless and Cox 2003; Murphy-Lawless 2002). Also, there is significant evidence to suggest that the drugs phenomenon has undermined the somewhat romantic historical notion that people do not commit crime in the areas in which they live (Connolly 2003).

Many communities throughout Dublin have experienced high exposure to street-level drug dealing and local drug-related crime and anti-social behaviour (See section 10.2). Studies on drug availability suggest that many drug users have relatively easy access to drugs in their own areas. Such drug markets and the crime and nuisance often associated with them can create significant internal community tension and conflict.

In a survey of offenders known as hard drug users (Keogh 1997), sixty-six per cent of respondents to the study said it was easy to get drugs and that they sourced their drugs within their own neighbourhood. When asked where they usually committed the crimes to sustain their drug habits, of the 254 people who answered this question, 105 mentioning their own neighbourhood as a location where they committed crime. While the majority of respondents said they used a local dealer as their main supplier, 80 per cent said they did not always use the same individual as their supplier, thus suggesting multiple sources. Forty-eight per cent of heroin users in the Keogh (1997) study admitted to drug dealing themselves or to acting as couriers or 'look-outs' for drug dealers in order to fund their own drug habit.

A study by Fahey (1999) used a variety of research techniques to assess the living conditions in seven local authority estates in Ireland. The estates studied were Fatima Mansions, South Finglas and Fettercairn, Tallaght – all in Dublin, Deanrock estate in Togher, Cork, Moyross in Limerick, Muirhevnamor in Dundalk and Cranmore in Sligo.

Data were gathered primarily through ethnographic methods such as interaction in the everyday life of residents of the estates, participant observation and in-depth interviewing. Problems of social disorder were found to be central factors affecting the quality of life of the residents of all the estates studied. The authors concluded: 'Social disorder has the greatest impact on residents' quality of life, through direct experience of anti-social behaviour, a general loss of communal space and a sense of personal safety, and negative labelling of estates in the wider community' (Fahey 1999). The problems associated with drug use and drug dealing were found to be particularly

acute in the Dublin estates. The use and dealing of opiates was found to be a problem only in the Dublin estates. In one estate, Fatima Mansions, the researcher concludes that, 'Heroin dealing and heroin use are dominant and oppressive problems' (O'Higgins 1999: 156). The problems of drug use and dealing in this estate were found to be compounded by the fact that the area drew in a steady stream of drug users from all over the city and the greater Dublin area. One resident, in describing the corrosive effect of drug abuse on life in the estate, said: 'Basically, you are not allowed to have a life anymore. The children are driven out of the public spaces' (O'Higgins 1999, p. 156).

A survey of residents of Dublin's north inner city, conducted as part of an evaluation of a community policing scheme in which they were participating, revealed high levels of exposure to drug dealing and drug-related crime (Connolly 2001). Forty residents of the area were interviewed. The respondents were chosen on the basis of their participation in meetings organised as part of the process of establishing the North Inner City Community Policing Forum (CPF) (Connolly 2002). The respondents were resident in 29 different streets or local authority flat complexes throughout the area in which the CPF was established; thus they were regarded as representative of the area as a whole. Also, they had been involved in local community activity and were therefore particularly knowledgeable about the drug issues in their respective areas. The survey was conducted in October and November 2000.

Eighty per cent of the sample respondents said that they had witnessed drug selling in their area in the past year. The survey found that one in every 10 households had been burgled. This contrasted with a national survey conducted by the Central Statistics Office, which recorded a rate of one in 30 households reporting being burgled (Central Statistics Office 1999). Over 77 per cent of respondents recorded having been disturbed or affected by noise late at night, with 30 per cent of those believing the disturbance was drug-related. Eighty-five per cent said they were affected or disturbed by young people gathering in groups, with 37 per cent believing the disturbance was drug-related.

Seventy-eight per cent of respondents stated that they felt they were 'quite likely' or 'very likely' to witness drug selling in the following six months. None of the respondents stated that it was 'not at all likely' that they would witness drug selling in the following six months. Sixty per cent stated that they were 'quite likely' or 'very likely' to witness people using drugs in the following six months.

Respondents were asked about whether they had concerns for their safety. The national survey (Central Statistics Office 1999) found that 30 per cent of respondents felt 'unsafe' or 'very unsafe' walking in their neighbourhood after dark, while the CPF survey recorded double that rate, with 63 per cent of respondents stating that they felt 'unsafe' or 'very unsafe' walking in their area after dark. These feelings of insecurity were associated with groups of young people gathered together at specific locations where respondents believed drugs were available.

Another important factor which arises in this area relates to the fears which drug dealers can instil in local communities, something which can operate as a disincentive to community engagement in policy responses. Again, we can see that this experience is also something which impacts disproportionately on different geographical locations. Respondents to the CPF survey were asked for reasons why they might not report a crime to the Garda Síochána. The same question was asked in the Central Statistics Office survey. In the CSO survey, the most common reason given for not reporting a crime to the police was that the crime was not regarded as serious enough to report or that there was no financial loss. The second most common response was the belief



that the Garda Síochána would not or could not do anything about the offence. Fear of reprisal was not a significant factor.

A similar finding to the Central Statistics Office national survey was made by Watson (2000). From an analysis of results of a 1996 survey, *Survey of victims of recorded crime*, carried out by the Economic and Social Research Institute for the Garda Research Unit, she found that, as reasons for not reporting crime to the Gardaí, 'fear of reprisal, and not wanting to get the offender into trouble were relatively unimportant overall, and were given as reasons by fewer than one in twenty of the victims' (p. 138).

In the CPF survey, on the other hand, by far the most common reason for not reporting a crime to the Gardaí was the fear of reprisal from those locally involved in criminal activity. This finding reveals the insidious impact of crime, particularly drug-related crime, on community life in particular localities as well as the difficulties encountered by policy makers in seeking to address these difficulties.

A more recent study conducted in a more focused network of streets in the same area of north inner city Dublin involved the use of a variety of research methods to ascertain the impact of crime, anti-social behaviour and nuisance, drug use, drug dealing and related problems on the quality of life of the area (Connolly 2003). The study, entitled *Drugs, crime and community – Monitoring quality of life in the north inner city*, incorporated a local drugs and crime survey, semi-structured interviews with relevant state agency personnel and other relevant individuals, as well as unobtrusive research measures. The latter involved co-ordinating with a local authority housing complex attendant who monitored the flats so as to identify any discarded drug paraphernalia such as abandoned syringes. Dublin City Council provided information on cars abandoned in the area during the research period. Data obtained as part of the Community Policing Forum process described above, including minutes of meetings held under the auspices of the CPF, were also a useful source of information about local drug-related problems (Connolly 2002). The survey also included a qualitative component so that local residents could add further comment and provide opinions on various relevant issues.

The survey asked people about their local crime priorities and whether they had recently witnessed crimes or anti-social activities. The results are presented in the tables and figure below.

Question 1. We would like to know what you regard as the most important policing and estate management issues in your immediate area at this time. Please List the Crimes/ Anti-Social behaviour in order of importance.

**Table 13.2.1 Local Crime Priorities**

Crime/ASB	Ranking	% <sup>24</sup>	No. of Respondents
Heroin Selling	1	64	30
Cannabis Selling	2	40	30
Young People (YP) Gathering <sup>25</sup>	3	32	31
Joy Riding	4	17	30
Mugging	5	15	26
Noise at Night	6	10	30
Graffiti	7	4.5	22
Burglary	8	5.5	18

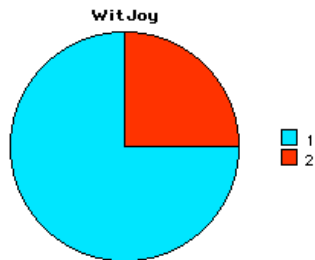
Source: Connolly (2003)

Question 2. Have you witnessed any of the following crimes or forms of ASB?

**Table 13.2.2 Local Exposure to Crime and Nuisance**

Witness	Number	%	No. of Respondents
Mugging	21	48	44
Joy Riding	33	75	44
Public Nuisance	28	68	41

Source: Connolly (2003)



Key: Blue, 1 = Yes; Red, 2 = No.

**Figure 13.2.1 Number who witnessed joy-riding**



Key: Blue, 1 = Yes; Red, 2 = No

**Figure 13.2.2 Number who witnessed mugging**

<sup>24</sup> Denotes percentage of the total sample who responded to the question.

<sup>25</sup> Denotes Young People gathering in Groups

Certainly one of the most striking features of the study is the numbers who reported having witnessed a mugging or who have witnessed joy riding. Forty-eight per cent of the total number of respondents said that they had witnessed somebody being mugged while 75 per cent had witnessed joy riding. The latter is even more striking given that joy riding is generally perceived as occurring late at night or early in the morning. Eighty per cent of those who responded said they were affected or disturbed by joy riding, 78 per cent by public nuisance and 60 per cent by young people gathering in groups. Fifty-eight per cent said they were affected or disturbed by noise late at night time.

Included among the drug-specific findings were the following:

16 respondents, or 36 per cent of the total sample, said that they had been offered drugs in the past year, while 53 per cent said that they had witnessed drugs being sold in the past year. 76 per cent of respondents stated that they were 'somewhat likely', 'quite likely' or 'very likely' to witness drug selling within the following six months.

The percentages of respondents who said that they were able to identify the type of drug being sold was very significant, with 83 per cent and 84 per cent identifying heroin and cannabis respectively. Twenty-nine respondents identified five specific locations in the immediate area where they claimed drugs were being sold, while five respondents stated that drugs were being sold outside their door every day. In general, we can see that there is a major issue for residents of this area regarding the general environmental conditions in which they live and that this was found to have a significant effect on their overall quality of life.

While the seriousness of the local problems being confronted with regard to crime and anti-social behaviour are clear, it was also evident from semi-structured interviews conducted with respondents that, having witnessed such incidents, they experience a sense of powerlessness rooted partially in exasperation and partially in fear. Although there was clearly a great deal of reluctance among respondents to become involved in local community activity to address the drug problem or anti-social behaviour, due to fears of retribution from those involved, it also became apparent that there remained a prevailing sense of concern for victims and for the area in general.

## **13.2 Genesis**

Despite the long history of community fragmentation and disintegration as a consequence of drug-related crime and related anti-social behaviour, it was not really until the middle of the 1990's that the experience of local communities became a central focus of government policy and that responses became more locally oriented<sup>26</sup>. A number of factors combined to influence policy in this respect.

### **Community Activity**

One of these factors was that communities began to respond on their own initiative. Despite the fears generated by drug dealers described above, another consequence of local drug markets and related anti-social behaviour has been that, on many occasions throughout the history of Dublin's drugs problem, many community-based groups and individuals have reacted by engaging in, among other types of community activity, community self-policing, informal justice and vigilante-type activities (Connolly 2003; Murphy-Lawless 2002; McAuliffe and Fahey 1999; Connolly 1998; O'Mahony 1997a; Bennett 1988). Such responses have also generated internal community conflict on occasion (Connolly 2003; Murphy-Lawless 2002; O'Mahony 1997a).

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<sup>26</sup> For an overview see Butler (2002).

This community-based anti-drug activity has taken the form of public meetings in which alleged drug dealers have been called to account by local residents, often the parents of drug users, for their behaviour. Such action has also led to anti-drug marches and demonstrations, either on the homes of alleged drug dealers or on government buildings. Such activity has had many positive consequences. Street vigils and public meetings have made it difficult for drug dealers to deal drugs openly and united community action has helped break down the fear of those involved in the drug trade that is often felt in such communities (Connolly 2003). Community anti-drug activity has highlighted the nature of the problems being confronted in such communities, thereby raising general public consciousness which, in turn, has brought pressure to bear on those in authority to respond (Connolly 2003; Murphy-Lawless 2002).

However, the few studies which have considered the perspectives of those who have been involved or directly affected by community responses such as this show that, although there is often widespread support for such action, it also has the capacity to contribute to further community tensions (Connolly 2003; Murphy-Lawless 2002).

Murphy-Lawless (2002), in her study of women in Dublin's north inner-city, many of whom were active in the anti-drugs movement, situated that activity against a backdrop of the perceived failure by the state over a long period to respond to community needs. She noted the concern that anti-drugs activism had created divisions in the area 'with additional pressure on women as carers of children/grandchildren and/or as partners of users or people accused of dealing' (p. 58). However, although the women who participated in the study were aware of the huge tensions produced in their community by marching, they did not feel they had any alternative at the time. 'Women did not define themselves as 'vigilantes' but as concerned parents, who felt that their actions might help their local communities where drug-dealing was now a commonplace everyday activity, observed by their children' (p. 125).

Connolly's (2003) survey in the north inner city also sought the attitudes of local residents towards anti-drugs activity. Thirty-six (86%) respondents acknowledged that there had been an anti-drugs group in the area; 26 respondents claimed to have been involved in anti-drugs activity; 12 respondents stated that they had not been involved. Of the total of 41 respondents, 35 (85%) stated that they supported the anti-drugs movement, while 6 (15%) stated that they did not.

In explaining the reason for their involvement in the anti-drugs movement, respondents stated that it was for the benefit of the children of the area or that they were anti-drugs or that they became involved out of anger and frustration with how bad things had become in the community. Apathy and concerns about the use of violence were expressed as the primary reasons for respondents' non-involvement in anti-drug activity. Nevertheless there appeared to be a general acceptance of anti-drug activity, even where it was opposed.

### **Local policing**

In recent years a number of positive developments in local community policing have been evident. The improvement in the working relationship in recent years between local Garda drug squad and some local communities has been evident.

Also, some senior Gardai began to articulate publicly the need to develop a better working relationship with local communities if the drugs problem was to be more effectively tackled. In February 1997, then Assistant Garda Commissioner Thomas C. King addressing a conference in Dublin castle on the drugs issue acknowledged the

part played by the community in the fight against drugs. He also pointed out that there was a need for the Garda Síochána to 'revitalise our contact with the community and to create an opportunity for a more pro-active community support for the garda operations against drugs in particular' (Dublin Corporation 1997).

### *Estate Management*

In a submission to the conference in Dublin Castle, referred to above, Vincent Norton, then principal Officer of Dublin Corporation's housing department also referred to the increased efforts being made by Dublin Corporation to work with their tenants in improving the quality of life in their estates. He pointed out that the encouragement of such tenant involvement required an "integrated approach to dealing with issues' (Dublin Corporation 1997).

### **National Developments**

These developments at a local level coincided with major policy developments at a national level. These included the establishment of local drugs task forces which was prompted by the acknowledgement by the 1996 Ministerial Task Force on drugs of the need to establish structures for the effective coordinated delivery of services at national, regional and local level. The development of inter-agency co-operation and the improvement in communication between the state agencies and the community they serve became an obvious part of this process.

A second major catalyst was the murder of journalist Veronica Guerin in July 1996 by members of a drug gang. This led to an immediate government reaction and put the drug issue to the forefront of national policy.

### **13.3 Measures taken**

#### **Estate management and the Housing (Miscellaneous Provisions) Act, 1997**

In December 1996, the Government introduced the Housing (Miscellaneous Provisions) Bill as part of a wide-ranging legislative response to the drug crisis. Specific measures were contained in the Housing (Miscellaneous Provisions) Act 1997 to, *inter alia*, facilitate the exchange of information between Dublin Corporation and the Garda Síochána in relation to anti-social behaviour<sup>27</sup>. The Housing (Traveller Accommodation) Act 1998 further applied relevant sections of the Housing (Miscellaneous Provisions) Act 1997 dealing with anti-social behaviour, such as drug dealing, to halting sites provided by local authorities or by voluntary bodies.

This Act provides for a range of measures to give local authorities the powers to deal with problems arising on their estates from anti-social behaviour, namely drug dealing, violence and intimidation.

#### **Community Policing**

Another development taking place simultaneously with these legislative changes was that the government was beginning a process of engaging with the broader community on crime issues in general. In an attempt to ascertain the views of the general public in relation to crime problems and responses to crime, in february1998, the then Minister for Justice, Equality and Law Reform established a National Crime Forum in order to 'canvass comment, assessment and suggestions on crime and crime-related issues from the general public and from national and international experts' (National Crime

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<sup>27</sup> Housing (Miscellaneous Provisions) Act, 1997 Section 21.

Forum 1998, p. 9). In its report, the forum came out strongly in favour of the establishment of community policing fora. This national process dovetailed with the developments on the ground described above, both in community self-policing and in increase local policing by the gardaí.

In October 2002 the North Inner City Community Policing Forum (CPF) was launched by An Taoiseach Bertie Ahern (Connolly 2003a). A report describing the establishment and evaluation of the CPF was also launched (Connolly 2002). The primary purpose of the CPF is to co-ordinate a common strategy in response to drug dealing between the local community, the Garda Síochána and Dublin City Council.

## **13.4 Results / Evaluation**

### **Housing (Miscellaneous Provisions) Act 1997**

Since the passage of the Housing (Miscellaneous Provisions) Act, 1997, the Act has been the subject of debate and research in relation to its perceived effectiveness and broader social implications.

A study by Memery and Kerrins (2000) concluded that people excluded from public housing can also find themselves discriminated against in seeking hostel accommodation and that such exclusions lead to a loss of essential family supports and a detachment from community-based drug services. The report stated that 'street homelessness resulting from exclusion leads to open drug taking and riskier drug-taking practices' (p. 33). A study of out-of-home drug users (Cox and Lawless 1999) suggested that the housing legislation had contributed to the rise in homelessness among drug users.

A study commissioned by Dublin County Council and the South Western Area Health Board focused on those who were evicted from Dublin Corporation housing units in 1997 and 1998 for anti-social behaviour (within the provisions of the 1997 Act and the 1966 Housing Act) (Rourke 2001). By means of interviews with a number of people who had been evicted and with Dublin Corporation community welfare officers, and an analysis of eviction case files, the study tracked the progress of a selected number of clients who were evicted from local authority housing units in 1997 and 1998. The study concluded that the Act had become an effective instrument in evicting Dublin Corporation tenants for anti-social behaviour. The author found that, of the evictions expedited by Dublin Corporation in 1997 and 1998, 50 per cent involved single women with children. On the basis of interviews and file analysis, the study concluded that the high proportion of this category may be accounted for, in part, 'by the fact that they were co-habiting/living with drug using/dealing partners and boyfriends' (p. 11). When considering the number of people affected by the eviction process, the study found that more children than adults suffered as a result of the implementation of the eviction legislation. The study also found that the eviction process placed particular pressure and strain on families with children, that it contributed to family break-up and separation following eviction as subsequent short-term hostel or bed and breakfast accommodation was unsuitable for normal family life.

The report expressed concern that the application of the legislation was an 'overly "blunt instrument" which serves to penalise innocent parties (adult family members who are not engaged in anti-social behaviour and/or children) as well as targeting the identified culprit/offender' (p. 33). The study also found that people who had been evicted were confused and uncertain about what they needed to do to be considered for re-housing.

A study by Murphy-Lawless (2002), which sought the views of residents of the north Dublin inner city on this issue found that, whereas there was significant community support for such measures, with some saying it was not leading to enough evictions, others expressed disquiet about due process issues and the potential for the legislation to be used in a discriminatory manner. A further study of the north inner city by Connolly (2003) also considered the practical operation of this legislation in the local area and sought the views of local residents in relation to it. Many residents of this community were at the forefront of original demands for the introduction of this legislation.

The study sought to describe the procedure by which complaints about anti-social behaviour are dealt with locally by Dublin City Council. Issues to do with anti-social behaviour are dealt with by the project estate officer and the assistant community officer for the area in question. Any complaints about local tenants received are logged. The alleged offenders and the complainants are interviewed. A file is then set up. Further complaints lead to further interviews. Recurring complaints could lead to the executive manager of the Housing Department seeking a Notice to Quit to be served on the tenant and family in question. Following the expiry of the Notice to Quit, a court order for possession is sought at the District Court. The tenant can appeal the warrant for possession. This appeal is heard at the Circuit Court. The decision of the Circuit Court can be appealed further. This would lead to a judicial review, which is heard in the High Court. A judicial review can be sought on a point of law only. If this is overturned the eviction is proceeded with.

Alternatively, under the legislation, the Gardaí can be empowered to remove illegal occupants from a Dublin City Council dwelling.<sup>28</sup> An exclusion order can also be sought by the tenant against a sub-tenant who is engaging in anti-social behaviour at the same premises. This will result in the sub-tenant being excluded from the premises completely.

During the period of the study, from June 2001 to December 2001, 10 interviews regarding anti-social behaviour were carried out in the research area by City Council officials. In the same period, there were no notices to quit served and no warrants for possession applied for. Twenty-four respondents out of a total survey sample of 44 were asked whether they agreed with the legislation. Among those who agreed unequivocally, concerns were expressed about the perceived delay in the process. Others were concerned with the influence the presence of drug dealers had on the area if permitted to remain. Nobody disagreed with the policy, although most of the respondents' agreement was conditional on the certain concerns being addressed. A strong feeling was expressed that the needs of drug users, other family members and the position of mothers needed to be considered. A second concern related to issues of due process, with some respondents expressing concern that people might be moved out for the wrong reasons. Others questioned the long-term results of the policy, questioning whether or not it was simply moving the problem to another area.

A review of the Act conducted by Lawless and Cox (2003, p. 214) which was conducted during 2000/2001 concluded that 'the direct and indirect use of the Act has contributed to the further marginalisation of those already excluded from society, resulting in an increase of homeless drug users in Dublin'. However O'Sullivan (2004, p. 23), in a recent consideration of the Housing (Miscellaneous Provisions) Act 1977 concluded that 'the degree to which the Act contributed to the recorded increase in homelessness is questionable'.

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<sup>28</sup> Section 20, Housing (Miscellaneous Provisions) Act 1977

## Community Policing Forum

An evaluation of the North Inner City Community Policing Forum (Connolly 2002) used a number of methods to assess the progress achieved by the CPF. These included:

- Performance indicators: Input, Process, Output and Impact measurements;
- Semi-structured interviews: Conducted with members of the management board to ascertain their views on the process. The Board included police officers, a representative of the housing authority, a public representative, a local community representative and a member of the local drug task force;
- Meeting minutes: A review of over 200 meetings held under the auspices of the CPF;
- Incident reports: Incidents of drug-related crime were monitored and reviewed;
- Panel survey: A local survey was conducted with 40 local residents from 29 different streets or local authority flat complexes to ascertain their views on various aspects of the CPF (Connolly 2001).

The evaluation identified a number of positive outcomes, including regular and consistent attendance at local meetings held under the auspices of the CPF. This is regarded as an important indicator of success given the serious concerns among residents, outlined above, about co-operating with Gardaí on drugs-related issues due to fears of reprisal from those involved in drug dealing. Significant progress was also identified as having been made in relation to a series of local drug-related incidents. The evaluation also reported increased cooperation between State agencies as a result of the CPF.

The survey found that 72 per cent of the 44 local residents who participated in the CPF stated that they would be more willing to co-operate with the Gardaí in relation to drug-related crime as a result of the CPF, while all of those surveyed wished to see the CPF continued into the future. Also, 45 per cent stated that they were less worried about drug-related crime as a result of the CPF. However, 55 per cent stated that there was no change in this respect.

The CPF is in the process of being mainstreamed and extended to other areas of the city. The Community Relations Section of the Garda Síochána is currently preparing proposals for a new model for Community Policing Forum. The establishment of these Fora is occurring within the context of broader developments in police accountability as outlined in the Garda Síochána Bill 2004.

The Garda Síochána Bill 2004 includes new provisions dealing with the organisation, management, performance and accountability of the Garda Síochána. The Bill provides for the establishment in each local authority area of a 'joint policing committee', representative of the police and the local authority. It is proposed that the local policing committee shall act as a general forum for discussion and consultation on matters affecting the policing of the area. In particular, the committee shall keep under review the levels and patterns of crime and disorder in the area; the levels and patterns of the misuse of alcohol and drugs in the area; and formulate and oversee the implementation of measures of co-operation between the local authority concerned and the police aimed at reducing crime and disorder and combating the misuse of alcohol and drugs in the area.



## Part C

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## 14.2 List of databases

- Central Treatment List
- EDDRA (Exchange on Drug Demand Reduction Action)
- General Mortality Register
- Hospital In-Patient Enquiry database
- National Drug Treatment Reporting System
- National Psychiatric Inpatient Reporting System

## 14.3 List of internet addresses

[www.athlone.ie/drugawareness](http://www.athlone.ie/drugawareness)  
[www.dap.ie](http://www.dap.ie)  
[www.dublin.ie/dewf](http://www.dublin.ie/dewf)  
[www.drugsinfo.ie](http://www.drugsinfo.ie)  
[www.drugtipps.com/index.asp](http://www.drugtipps.com/index.asp)  
[www.eddra.emcdda.eu.int](http://www.eddra.emcdda.eu.int)  
[www.emcdda.eu.int](http://www.emcdda.eu.int)  
[http://www.emcdda.eu.int/responses/methods\\_tools/eddra.shtml](http://www.emcdda.eu.int/responses/methods_tools/eddra.shtml)  
[www.garda.ie](http://www.garda.ie)  
[www.gov.ie/oireachtas/frame.htm](http://www.gov.ie/oireachtas/frame.htm)  
[www.meas.ie](http://www.meas.ie)  
[www.pobail.ie](http://www.pobail.ie)

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- Figure 6.4.1 Rate of psychiatric first admissions aged 16 years or over with a diagnosis of drug-dependence (using the ICD-10 three character categories) per 100,000 of the population in Ireland and reported to the NPIRS, 1990 to 2002
- Figure 7.3.1 Comparison of selected indicators between an intervention and control population in relation to the management of hepatitis C in a general practice setting
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- Figure 10.3.1 Trends in seizures of selected illicit drugs in Ireland, 1995–2002
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- Figure 10.3.3 Trends in the quantity of heroin and cocaine seized, 2000–2002  
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 Figure 13.2.1 Number who witnessed joy-riding  
 Figure 13.2.2 Number who witnessed mugging

## 15.4 List of Abbreviations

AA	Alcoholics Anonymous
AIDS	Acquired Immune Deficiency Syndrome
ABS	Anti Social Behaviour
B&B	Bed and Breakfast (accommodation)
CDB	County/City Development Board
CDLE	Customs Drug Law Enforcement
CE	Community Employment
CIP	Critical Implementation Path
CPF	Community Policing Forum
CLÁR	Ceantair Laga Árd-Riachtanais
CSO	Community Service Order
DAFDB	Dormant Accounts Fund Disbursements Board
DAIRU	Drug and Alcohol Information and Research Unit
DEWF	Drug Education Workers Forum
DMRD	Drug Misuse Research Division
DUID	Driving Under the Influence of Drugs
ECAHB	East Coast Area Health Board
ERHA	Eastern Regional Health Authority
FAS	Foas Áiseanna Saothair (Training and Employment Authority)
GNDU	Garda National Drugs Unit
GUIDE	Genito-Urinary Medicine and Infectious Diseases Department
HBSC	Health Behaviour in School-aged Children
HAART	Highly Active Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
ICD	International Classification of Diseases
ICGP	Irish College of General Practitioners
IPRT	Irish Penal Reform Trust
KDPPG	Killinarden Drug Primary Prevention Group
LDTF	Local Drug Task Force
MBRS	Medical Bureau of Road Safety
MDA	Misuse of Drugs Act
MEAS	Mature Enjoyment of Alcohol in Society Ltd
MQI	Merchants Quay Ireland
MWHB	Mid-Western Health Board
NA	Narcotics Anonymous
NACD	National Advisory Committee on Drugs
NAHB	Northern Area Health Board
NCC	National Crime Council
NDSC	National Disease Surveillance Centre
NDTRS	National Drug Treatment Reporting System
NESF	National Economic and Social Forum
NEHB	North Eastern Health Board
NPIRS	National Psychiatric Inpatient Reporting System
PWS	Probation and Welfare Service
SI	Statutory Instrument
SHB	Southern Health Board
SEHB	South Eastern Health Board
SLAN	Survey of Lifestyle, Attitudes and Nutrition
SPHE	Social, Personal and Health Education
SWAHB	South Western Area Health Board
TD	Teachta Dála (Member of Parliament)
UISCE	Union for Improved Services, Communication and Education
WHO	World Health Organization