European Monitoring Centre for Drugs and Drug Addiction

HRB Health Research Board

2007 NATIONAL REPORT (2006 Data) TO THE EMCDDA by the Reitox National Focal Point

IRELAND

New Developments, Trends and in-depth information on selected issues

REITOX

Acknowledgements

This report is very much the result of collaborative work within and outside the Alcohol and Drug Research Unit. We would like to thank very sincerely those people working in the drugs area who gave generously of their time to inform us about recent developments in their areas of work. It is not possible to name all these people, but the agencies with which they are affiliated are acknowledged as follows:

Addiction service managers, drug treatment facilities and general practitioners
An Garda Síochána
Central Statistics Office
Central Treatment List
Coroner Service
Customs Drugs Law Enforcement of the Revenue Commissioners
Department of Community, Rural and Gaeltacht Affairs
Department of Education and Science
Department of Health and Children
Department of Justice, Equality and Law Reform
Department of Social and Family Affairs
Forensic Science Laboratory
Garda National Drugs Unit
General Mortality Register
Health Protection Surveillance Centre
Health Service Executive
Hospital In-Patient Enquiry scheme
Irish Prison Service
Voluntary and community groups and academic researchers

We would specially like to thank the following:
Mr Eddie Arthurs, Dr Joe Barry, Mr Mel Bay, Ms Deirdre Begley, Mr Denis Breen, Ms Carmel Brien, Ms Joan Byrne, Ms Caroline Comar, Mr Michael Conroy, Ms Caroline Corr, Dr Des Corrigan, Mr Niall Cullen, Ms Aoife Davey, Ms Aileen Dooley, Ms Cepta Dowling, Dr Brian Farrell, Ms Grace Fitzgerald, Mr David Gilbride, Ms Anna-May Harkin, Ms Annette Hayes, Ms Mary Johnston, Mr Joseph Keating, Dr Eamon Keenan, Ms Niamh Kilkenny, Ms Kerry Lawless, Ms Rebecca Loughrey, Ms Mairead Lyons, Mr David Moloney, Mr Niall Morris, Ms Niamh Murphy, Mr Gerry McAleenan, Mr Ruaidhrí McAuliffe, Mr Seamus McCarthy, Mr Mel McGiobhan, Mr Robert Nicholson, Detective Superintendent Barry O'Brien, Ms Patricia O'Connor, Dr Kate O'Donnell, Dr Dan O'Driscoll, Ms Alice O'Flynn, Ms Mary O'Mara, Ms Joanne Ralph, Dr Bobby Smyth, Mr Gabriel Staunton, Dr Bríon Sweeney and Dr Lelia Thornton.

Finally, we would like to express our sincere thanks to our colleagues in the Alcohol and Drug Research Unit: Troy Reneker who compiled the author's submissions and Lorraine Coleman, Sarah Fanagan, Louise Farragher, Sinead Foran, Vivion McGuire, Deirdre Mongan and Siobhán Reynolds, who provided access to literature, analysed data from reporting systems or summarised literature for *Drugnet Ireland*.

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Please use the following citation:
Alcohol and Drug Research Unit (2007) *2007 National Report (2006 data) to the EMCDDA by the Reitox National Focal Point. Ireland: new developments, trends and in-depth information on selected issues*. Dublin: Health Research Board.

Contents

Summary of each chapter

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

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

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

1. Public expenditure on drugs
2. Vulnerable groups of young people
3. Drug-related research in Ireland

Main points from Part A

- The Road Traffic Act 2006 became law in July 2006. The primary purpose of the Act is to provide a statutory basis for a number of specific provisions set out in the Road Safety Strategy 2004–2006, to address the key problem areas of drink driving and speeding.

- The Criminal Justice Act 2007 provides for increased Garda detention powers, changes to existing provisions in relation to the right to silence and the introduction of mandatory sentencing for a range of offences. Many of these changes have been introduced in the context of growing concern about drug-related crime.

- Parts 11 and 13 of the Criminal Justice Act 2006 relating to Anti Social Behavioural Orders (ASBOs) were introduced on 1 January 2007 for adults and on 1 March for children (aged 12–18 years). ASBOs are laws and measures introduced to tackle anti-social behaviour, which includes, for example, intimidation, abusive or threatening behaviour and vandalism, some of which may be alcohol and/or drug related.

- Provisions in the Criminal Justice Act 2006 providing for the registration of convicted drug offenders with An Garda Síochána came into operation in October 2006.

- In May 2007, a number of the provisions contained in the Prison's Act 2007 came into operation. These include section 35 which provides for the making of rules by the Minister for the regulation and good government of prisons. Such rules may provide for the testing of prisoners for intoxicants including alcohol and other drugs.

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

Section 36 prohibits and creates an offence of the unauthorised possession or use of mobile phones by prisoners.

- A report published in May 2007 revealed that young people in detention schools in Ireland experience high rates of psychiatric disorders, engage in serious criminal activity and have high levels of substance abuse problems.

- An increase in the number of motorists tested for drug driving was announced in January of 2007.

- In 2006, responsibility for reporting crime statistics transferred from the Garda Síochána to the Central Statistics Office.

- In 2006, simple possession offences accounted for 73.2% of the total drug offences prosecuted; the number increased from 7,432 in 2005 to 8,556 in 2006. The number of supply offences which led to a prosecution in 2006 was 2,525, representing 21.6 % of the total number of offences prosecuted.

- Prosecutions for obstructing the lawful exercise of a power conferred by the Misuse of Drugs Act (s.21) increased by just under 73% between 2000 and 2005. Prosecutions for obstruction decreased from 479 in 2005 to 373 in 2006. Prosecutions for cultivation or manufacture of drugs increased by 200% during 2006.

- *A community drugs study: developing community indicators for problem drug use* sought to explore the experiences of three different communities in the greater Dublin area in relation to drug issues for the period 1996 to 2004. The research provides valuable information in relation to both local drug markets and crime.

- The results of ROSIE (Research Outcome Study in Ireland) were published in September 2006. The research showed a positive association between drug treatment and a reduction in criminal behaviour.

- There was an increase of 19.5% in the number of prisoners receiving methadone, from 1,309 in 2004 to 1,564 in 2005. The review of prison drug treatment services began in 2007. It is hoped the review will be completed in a six months. The eventual aim is to have services provided to prisoners on a par with those provided to the general population.

- A local drugs task force in Dublin set up a confidential, non-Garda phone line to help gather information on local drug dealing. The steering group overseeing the project has recommended that it be adapted and rolled out on a national basis.

- Although the majority of prosecutions for drug supply still take place in the Dublin Metropolitan Region, the proportion that take place outside the DMR has continued to increase since 2003.

- Customs Drug Law Enforcement reports evidence of increased trafficking of Cocaine into Ireland from South America via Africa.

- In 2006, of the 7,550 reported drug seizures, 3,853 (51%) were cannabis-related.

- The steady rise in cocaine seizures over the last two decades has continued. There was also a sharp rise in the number of heroin seizures, which increased from 725 in 2005 to 1,115 in 2006.

- A general election in Ireland in May 2007 led to the formation of a new coalition government. The portfolio of the new Minister of State with special responsibility for the drugs strategy is more narrowly focused than previously. While endorsing the National Drugs Strategy 2001–2008, the new government included a number of additional drug-related measures under the 'Justice' heading in its agreed programme for government.

- In early June 2007 the government published a report by the Working Group on Rehabilitation, recommending how to develop the new Rehabilitation pillar of the National Drugs Strategy. Acknowledging the complexity of drug rehabilitation, including the diverse needs of users and the wide range of service options and of service providers, the Working Group recommended a 'practical model of inter-agency working' that would support a case management approach.

- The government's social inclusion policy framework, of which the National Drugs Strategy 2001–2008 forms a part, has been completely revised. While not leading to any changes in direction for Ireland's drug policy, this revision has led to a change in the way responses to the illicit drugs issue are presented in social inclusion policy documents. Set within a lifecycle framework, the new approach recognises more clearly the role of services in providing protection against risks and the importance of innovative social policy initiatives.

- In mid 2006, the first round of strategic and/or action plans of the ten regional drugs task forces were released by the National Drugs Strategy Team. Aligned with, and intended to contribute to the achievement of the overall aims and the objectives under the four pillars of the National Drugs Strategy 2001–2008, these regional strategies also highlight policy concerns at regional level, including the need to respond to the problem of alcohol misuse, as well as drug misuse.

- In October 2006 an expenditure review of the local drugs task forces (LDTFs) was published. The purpose of the review was to establish the outputs, effectiveness and efficiency of the LDTF Programme, make recommendations to improve effectiveness and efficiency, and define performance indicators and baselines in order to measure the work of the LDTFs in future.

- In 2006 financial allocations directly attributable to drug programmes for government departments and agencies totalled some €214.687 million.

- In January 2007 the Irish Penal Reform Trust commissioned a study of public reaction in Ireland to a range of issues relating to the prison system. Overall conclusions from the research included the observations that less punitive measures are preferred for non-violent offenders (e.g. drug and mental health programmes), and there is a persistent preference to see more treatment programmes available for those with drug or mental health problems.

- The Joint Committee of the Oireachtas (Houses of Parliament) on Arts, Sports, Tourism, Community, Rural and Gaeltacht Affairs (comprising members of the main political parties in both the Dáil and the Senate) completed three drug-related reports – on alcohol and drugs, on cannabis, and on the drugs situation in

Waterford. The Joint Committee recommended that alcohol should be included in a new national substance misuse strategy. In respect of cannabis, the Joint Committee recommended that there should be no movement towards the liberalisation of the legal sanctions attaching to the possession of, use and dealing in cannabis, and that the full rigours of the law should be applied to those who benefit financially from trading in the substance.

- In November 2006 the recently-formed civil society organisation Drug Policy Action Group (DPAG), which 'aims to promote an approach to drug policy that challenges ineffective, unfair and counterproductive laws on drugs, and advocates for positive health and social service responses to drug use in Ireland', published two policy reports – Criminal justice drug policy in Ireland, and Social care and drug users in Ireland.

- In the 2007 general election in Ireland, the main political parties all endorsed the National Drugs Strategy 2001–2008, either directly or indirectly, and made commitments to increase resourcing for various measures in the Strategy.

- A process evaluation of the National Drug Awareness Campaign between 2003 and 2006, commissioned by the National Advisory Committee on Drugs (NACD), has been completed and is currently being considered by the NACD.

- In August 2007 a multi-agency advisory group was set up to scope the next National Drug Awareness Campaign The emerging issues for this group include cocaine, polydrug use, the psycho-social effects of drug use, and families.

- In October 2007, the National Advisory Committee on Drugs released preliminary prevalence estimates from their national survey of drug use in the general population 2006/7. The proportion of adults (15–64 years) who reported using an illegal drug in their lifetime was 24%, up from 19% in 2002/3. For young adults (aged 15–34 years) this rose to 31.4%. Men were more likely than women to have used illegal drugs in their lifetime, 29.5% compared to 18.5%.

- The proportion of adults (15–64 years) who reported using an illegal drug in the 12 months preceding the survey was 7.2%, up from 5.6% in 2002/3. For young adults (15–34 years) this rose to 12.1%. Men were more likely than women to have used illegal drugs in the 12 months preceding the survey, 9.6% compared to 4.7%.

- The rate of problematic opiate use was 5.6 per 1,000 population aged 15–64 years in 2001/2. No new valid national prevalence and incidence studies were published in the reporting period January 2006 to June 2007. The 2000/1 three-source capture–recapture study to estimate the number of problem opiate users living in Ireland will be repeated between September 2007 and June 2008.

- In 2005, there were 159 facilities providing outpatient services and reporting cases to the NDTRS. Of the 3,706 cases who entered treatment for the first time or returned to treatment at outpatient services in 2005, 933 (27%) were female, 1,649 (44%) were aged between 20 and 29 years and 1,537 (43%) had never previously been treated. The three most common main problem drugs were opiates (2,300, 62%), cannabis (851, 23%) and cocaine (318, 9%).

- There are no reliable estimates of either drug use or treated problem drug use among the Traveller population in Ireland. Qualitative research indicates that cannabis, sedatives, tranquillisers and antidepressants are the drugs most commonly used in the Traveller community. These are followed by cocaine and, to a lesser extent, ecstasy. These findings mirror the pattern of drug use in the general population. Injecting drug use was not commonly reported. As in the general population survey, more male than female Travellers used drugs, and those in the age range between adolescence and early thirties were more likely to be users.

- During the second half of 2006, the Drugs/HIV Helpline in Ireland answered calls about five substances for the first time. These were: LSA or d-lysergic acid amide; Benzylpiperazine (also known as BZP and marketed as 'Jacks'); GHB (gamma-hydroxybutyrate); *Salvia divinorum*; and Subutex (buprenorphine).

- The mid-term review of the National Drugs Strategy noted that the HSE had appointed an expert working group to describe residential treatment services for problem drug and alcohol users in Ireland, to estimate their current capacity and to estimate future requirements.

- The HSE's drug-related services are provided primarily through Social Inclusion Services, which is part of the Primary, Community and Continuing Care (PCCC) directorate of the HSE. The HSE's Social Inclusion outputs in respect of drugs and HIV services for 2006 and the deliverables against which the HSE will be assessing its performance in 2007 are presented in the main text of this document. The proposed expenditure of the €6 million allocated in the government's 2007 budget to implement the HSE-related elements of the National Drugs Strategy is outlined.

- The first bulletin of findings from a national research outcome study (ROSIE) was published in September 2006. At baseline, the study recruited 404 opiate users aged 18 years or over entering treatment at inpatient facilities or outpatient settings. Participants were interviewed at intake, at six months after intake (not presented) and again at one year after intake; 75% participated in the interview at one year. The proportion reporting heroin use in the 90 days prior to interview fell from 81% at intake to 48% at one year. Injecting drug use in the 90 days preceding data collection decreased from 46% at intake to 29% at one year. Use of more than one drug decreased from 78% at intake to 50% at one year. Use of non-prescribed methadone, cocaine powder, crack cocaine and non-prescribed benzodiazepines also reduced. Reported involvement in acquisitive crime decreased from 31% at intake to 14% at one year.

- On 24 February 2007 the combination drug Suboxone was launched in Ireland. The Department of Health and Children has established an expert group to consider the implications of the introduction of this drug and its use as a treatment for opiate dependency. In order for this drug to be prescribed, a system similar to that existing for methadone, including a protocol and a central register, will be required.

- In 2006, 57 newly diagnosed cases of HIV among injecting drug users were reported to the Health Protection Surveillance Centre. This is a decrease on the 2005 figure. Of these 57 cases, 41 were male and 16 were female and the average age was 32 years. Of the 39 cases for whom place of residence was known, 37 lived in the HSE Eastern Region.

- A study to develop a hypothesis to explain the link between HIV prevalence and area of residence was published in 2006. The study was conducted in two parts,

using two existing data sources. In Part 1, the blood-borne viral test status and test results of a sample of clients attending treatment in December 2001 in two areas of Dublin, an inner city area (Dublin 8) and a suburban area (Dublin 24), were extracted from the Bloodborne Viral Status Dataset created by Grogan. In Part 2, the characteristics of heroin users seeking treatment for the first time at treatment services in their respective areas of residence, Dublin 8 or Dublin 24, between 1997 and 2000 were examined, using data from the National Drug Treatment Reporting System. A higher proportion of heroin users in Dublin 8 had HIV and hepatitis C than did their counterparts in Dublin 24. The analysis suggests that heroin users in Dublin 8 were more likely both to have ever used cocaine and to have used heroin daily than were those who lived in Dublin 24. Also, a higher proportion of injectors living in Dublin 8 used heroin and cocaine concurrently than did their counterparts in Dublin 24. In both samples, heroin users who lived in Dublin 8 were older than those who lived in Dublin 24. The findings led to a hypothesis: 'The risk of acquiring HIV is associated with area of residence and may be linked to cocaine use.'

- An enhanced surveillance system for hepatitis C in Ireland was introduced in 2007.

- A new study, *Emotional intelligence, mental health and juvenile delinquency*, found that children in detention schools in Ireland experience very high rates of substance dependence and psychiatric disorder, and that they engage in serious criminality, and have significant deficits in emotional intelligence and cognitive ability.

- In January 2007 the HSE established a working group on hepatitis C. This group has a national brief, and will build on an unpublished, regional report on hepatitis C carried out by the then Eastern Regional Health Authority in 2004. The group plans to complete its report in the autumn of 2007 and present it to HSE senior management at that time.

- Cullen and colleagues assessed the effectiveness of a general-practice-based complex intervention to support the implementation of clinical guidelines for hepatitis C management among current or former drug users. Twenty-six practices were randomly allocated within strata to receive the intervention under study (104 clients) or to provide care as usual for a period of six months (92 clients). The research concluded that, at study completion, patients in the intervention group were almost four times more likely to have been screened for hepatitis C than those in the control group, 49% compared to 27%. A higher proportion of anti-HCV antibody-positive patients in the intervention group were referred to a hepatology clinic than the proportion in the control group, 60% compared to 32%.

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

- Seventy two per cent of primary schools and 79% of post-primary schools responding to a survey are implementing substance use policies.

- The quality of substance use policies is higher in primary schools than in post-primary in communities with high levels of problematic drug use.

- The development of selective prevention targeting young people in non-school settings was prioritised in the mid-term review of the National Drugs Strategy.

- Current policy and practice in selective prevention targeting ‘at risk’ youth favours the use of recreational and sporting pursuits as a tactic to prevent drug use.

- Research with young people in disadvantaged communities reveals that more needs to done to provide recreational opportunities in these areas.

- Families trying to cope with heroin use do not have access to appropriate information and support when they most need it.

- Research has highlighted the negative impact of drug use on family well-being in a disadvantaged community compared to a representative sample of parents.

- Research shows that there have been some improvement in quality of life for communities identified with high levels of problematic drug use; however, increases in polydrug use has undermined the achievements.

- Teenage counselling services targeting youth at risk of substance use reduce risk factors that can contribute to drug use.

- High levels of problematic drug use were reported among a cohort of homeless youth aged 15–17 years, with half the cohort using heroin.

- An unstable family background, time spent in state care and negative peer association are identified as pathways to homelessness among a cohort of homeless youth aged 15–17.

- Current responses to the accommodation needs of homeless youth engaged in problematic drug use are inadequate.

- Research shows that lack of awareness of drug treatment services, lack of formal education, fear pf stigma and embarrassment, lack of cultural competence among service providers and perceptions of racism within services are significant barriers to members of the travelling community seeking help for drug problems.

- The National Drug Rehabilitation Strategy 2007 highlights the need to tackle the housing, educational and vocational training and employment needs of current, stabilised and former drug users.

- The National Development Plan 2007–2013 and the National Action Plan for social inclusion 2007–2016 endorse the need to address the social reintegration needs of drug users.

- An innovative project operated between the corporate sector and homeless service providers achieved positive results in getting homeless people into training, employment and stable accommodation.

- The Drug Policy Action Group, a recently formed independent advocacy group for developing evidence based policy, recommends that the social care of drug users, including the provision of employment and accommodation supports, needs to become part of an integrated response to drug problems.

Part A: New developments and trends

1. National policies and context

1.1 Overview

The classification of drugs and precursors in Ireland is made in accordance with the three United Nations conventions of 1961, 1971 and 1988, which introduced controls in relation to legitimate scientific or medical use of drugs and precursors that also take into account the particular risks to public or individual health.
Irish legislation defines as criminal offences the importation, manufacture, trade in and possession, other than by prescription, of most psychoactive substances. The principal criminal legislative framework is laid out in the Misuse of Drugs Acts (MDA) 1977 and 1984 and the Misuse of Drugs Regulations 1988. The offences of drug possession (s.3 MDA) and possession for the purpose of supply (s.15 MDA) are the principal forms of criminal charge used in the prosecution of drug offences in Ireland. The Misuse of Drugs Regulations 1988 list under five schedules the various substances to which the laws apply.
Since 2001, the National Drugs Strategy 2001–2008 has provided an implementation framework for illicit drugs policy in Ireland. The Strategy has an overall strategic objective, 'To significantly reduce the harm caused to individuals and society by the misuse of drugs through a concerted focus on supply reduction, prevention, treatment and research', which is to be realised through interventions grouped around four pillars – Supply Reduction, Prevention, Treatment and Research. A mid-term review of the National Drugs Strategy in 2005 recommended adjustments to the Strategy in order to 'refocus' priorities and 're-energise' the roll-out and implementation of various key actions during the remaining life of the Strategy. Recommendations included the establishment of a working group to develop an 'integrated rehabilitation provision', to constitute a fifth pillar, Rehabilitation.

The Minister of State with responsibility for the drugs strategy in the Department of Community, Rural and Gaeltacht Affairs, supported by the National Drugs Strategy Unit in the same Department, has overall responsibility for co-ordinating the implementation of the Strategy. A hierarchy of 'inter-agency co-ordinating mechanisms' is also in place to help co-ordinate the policies and activities of over 20 statutory agencies, multiple service providers and community and voluntary groups involved in delivering the Strategy. At national level these mechanisms include the Cabinet Committee on Social Inclusion (CCSI), the Inter-Departmental Group on Drugs (IDG), the National Drugs Strategy Team (NDST), and the National Drug Rehabilitation Implementation Committee (NDRIC). At the sub-national level are 10 regional and 14 local drugs task forces, whose activities are co-ordinated by the NDST.

Priorities for public expenditure on the illicit drugs issue are set out in the National Drugs Strategy 2001–2008 and the National Development Plan 2007–2012. The annual parliamentary Estimates process allocates funding to various Votes for implementing drug-related interventions, such as the 'Drugs Initiative' under Vote Community, Rural and Gaeltacht Affairs, which funds the regional and local drugs task forces and the Young People's Facilities and Services Fund (YPFSF). A series of other funds associated with social inclusion measures, which have an impact on the drugs issue, such as RAPID, are also funded through the Estimates process.

1.2 Legal framework

1.2.1 Laws, regulations, directives or guidelines

The Road Traffic Act 2006 was signed into law in July 2006. The primary purpose of the Act is to provide a statutory basis for a number of specific provisions, set out in the Road Safety Strategy 2004–2006, to address drink driving and speeding. Section 4 of the Act provides for the operation of authorised checkpoints by the Garda Síochána (the Irish police force) for mandatory alcohol testing of drivers, even in the absence of a suspicion that the driver has consumed alcohol. An individual who refuses to comply with a Garda request to provide a specimen of breath may be liable of a fine of up to €5,000, a prison sentence not exceeding six months, or both. The Act also provides for the adoption of a new fixed charge and disqualification for certain drink driving offences.

The Criminal Justice Act 2007 contains a number of important changes to the criminal justice system, including increased Garda detention powers, changes to existing provisions in relation to the right to silence and the introduction of mandatory sentencing for a range of offences. Many of these changes have been introduced in the context of growing concern about drug-related crime. Currently, seven-day detention powers are available to the Garda Síochána under the Criminal Justice (Drug Trafficking) Act 1996. Part 9 of the new Act expands this provision to offences including murder involving the use of a firearm or explosive and murder of a Garda member or prison officer in the course of their duty.

The new Act amends existing provisions relating to the right to silence by clarifying the circumstances in which inferences may be derived from the refusal of an accused person to answer certain Garda questions. Such inferences can then be used as evidence against that person during court proceedings. Part 4 of the Act allows for inferences to be drawn when an individual fails or refuses to account for objects, substances or marks on their person and where the Garda member reasonably believes that such matters may be linked to the commission of an offence. However, the Act provides for certain safeguards for the accused. For example, the accused will not be convicted of an offence solely or mainly on such inferences and the section shall not apply unless the interview is recorded by electronic or similar means.

Part 3 of the Act contains proposals for mandatory sentencing for offences linked to organised crime, including firearms and drug trafficking offences. Under these proposals the court must impose a sentence that is at least three-quarters of the maximum sentence permissible under the law for that offence. If the maximum term is life imprisonment, the court shall specify a term of imprisonment of not less than 10 years.

Part 5 of the Act proposes amendments to the Misuse of Drugs Act 1977, specifically in relation to the sentencing of those convicted of possession of drugs with intent to supply:

- The minimum period of imprisonment for those convicted under Section 15A or 15B of the Misuse of Drugs Act 1977 (possession of drugs with intent to supply) is to be 10 years, aside from some exceptional circumstances whereby the court determines that it would be unjust to impose such a sentence. These include for example, if the person pleaded guilty to the offence or if the person provided assistance in the investigation of the offence.
- The minimum period of imprisonment for those convicted of a second or subsequent offence under Section 15A or 15B of the Misuse of Drugs Act 1977 is to be 10 years.

The main purpose of these provisions is to ensure that mandatory sentencing for supplying drugs should be imposed in all but the most exceptional circumstances.

The Irish Human Rights Commission (IHRC) and the Irish Council for Civil Liberties (ICCL) have expressed concerns over a number changes proposed in the Act. The IHRC refers to seven-day detention as 'a serious curtailment on a person's right to personal liberty that warrants real cause and justification' (Irish Human Rights Commission 2006: 3). This view is echoed by the ICCL, which questions the merit of extending such powers to a further range of offences when the current provisions under the Criminal Justice (Drug Trafficking) Act 1996 are, according to the ICCL, 'rarely, if ever used' (Irish Council for Civil Liberties 2007: 6). The ICCL recommends that this provision be removed from the legislation. Furthermore, the IHRC contends that the introduction of this measure may result in Ireland violating its obligations under the European Convention on Human Rights and the International Covenant on Civil and Political Rights.

Both the IHRC and ICCL have expressed concerns about the changes in sentencing practice introduced by the Act. The ICCL maintains that these new rules on mandatory sentencing 'may impinge upon the constitutional duty of judges to ensure that sentences are proportionate to both the gravity of the crime and the personal circumstances of the offender' (Irish Council for Civil Liberties 2007: 8). This view is supported by the IHRC, which states that provisions which impose on the judiciary an obligation to sentence an offender to a specific term of imprisonment raise 'fundamental concerns' in relation to the separation of powers doctrine and judicial discretion in relation to sentencing ((Irish Human Rights Commission 2007: 4). Both the ICCL and the IHRC have expressed disquiet in relation to the timeframe in which the measures were enacted.

A number of legislative enactments are reported by the Irish Customs Drug Law Enforcement. These include the following:

- Statutory Instrument No. 281 of 2007 European Communities (Controls of Cash entering or leaving the Community) Regulations 2007
- Commencement order for the Criminal Justice (Illicit Trafficking at Sea) Act 2003
- Section 96 of the Finance Act 2005 amending s.2 of the Customs and Excise (Miscellaneous Provisions) Act 1988 to allow for transport/movement of containers for drugs examination
- Statutory Instrument on Psilosybin (SI 55 of 2006) (see National Report 2006)
- Irish Medicines Board Act 2006, s.17 ('authorised officer' to include an officer of customs and excise).

1.2.2 Laws implementation

Parts 11 and 13 of the Criminal Justice Act 2006 relating to Anti-Social Behaviour Orders (ASBOs) came into force on 1 January 2007 for adults and on 1 March for children (aged 12–18 years). ASBOs are measures introduced to tackle anti-social behaviour such as intimidation, abusive or threatening behaviour and vandalism, some of which may be alcohol- and/or drug-related. In the case of adults, when a Garda becomes aware of anti-social behaviour, he or she may issue a behaviour warning to the person concerned. If the behaviour warning is not obeyed, a senior Garda may apply to the court for a behaviour order (an ASBO), which can remain in force for a maximum of two years. The question of a criminal offence will only arise if the recipient wilfully disobeys the order and continues to engage in the behaviour which is the subject of the order. In circumstances where an order is breached, adults are liable for a fine of up to €3,000 or a maximum sentence of six months in prison, or both.

A separate set of procedures apply to children. As is the case with adults, when a Garda becomes aware of anti-social behaviour involving a child, he or she may issue a behaviour warning. If the child disobeys the behaviour warning, the Garda may then issue a good behaviour contract. This contract is made between the child, the parents and the gardaí; it is signed by the child and the parents and can last for up to six months. If the contract is broken, it can be renewed or the young person can be referred to the Garda Juvenile Diversion Programme. Alternatively, the Garda can apply to the Children's Court for a behaviour order. In circumstances where an order is breached, children may incur a fine of up to €800 or a maximum of three months' in a children's detention school, or both (Department of Justice Equality and Law Reform 2007).

Children's rights and civil liberties groups have expressed their concern over the introduction of ASBOs. The Irish Youth Justice Alliance (IYJA), a coalition of organisations and individuals whose main aim is to improve and reform the Irish juvenile justice system, has been highly critical of the new measures. In a paper presented to the Oireachtas Joint Committee on Justice, Equality, Defence and Women's Rights, the IYJA argued that, despite the fact that ASBOs are applicable to both adults and children, evidence from the UK suggests that they are disproportionately directed towards children, resulting in the 'labelling and criminalisation of young people' ((Irish Youth Justice Alliance 2005: 2). The IYJA states: 'The Children Act 2001 is designed to provide a modern framework for the youth justice system which diverts young offenders and those likely to offend away from the criminal justice system and from custody' ((Irish Youth Justice Alliance 2005: 5). The organisation contends that the introduction of ASBOs impinges upon the potential of this legislative framework to reform juvenile justice in Ireland.

However, the former Minister for Justice, Michael McDowell, has defended the introduction of ASBOs, arguing that they are a proportionate and well worked out sanction with widespread public support. He also stressed that their application in this country will differ from that in the UK, referring specifically to the number of procedures that need to be followed before an application for an ASBO can be made in the case of a child.

Provisions in the Criminal Justice Act 2006 for the registration of convicted drug offenders with the Garda Síochána came into force in October 2006. These provisions apply specifically to individuals convicted of drug trafficking offences and sentenced to a term of imprisonment of not less than one year. The Drug Offenders Register is based on the same principle as the Sex Offenders Register and will enable the movement of convicted drug dealers to be recorded in a similar manner; for instance, information relating to a change of address, movement in and out of the country etc. must be supplied to the gardaí. The Irish Human Rights Commission has expressed concerns over the establishment of a drug offenders register (see National Report 2006).

In May 2007, a number of the provisions contained in the Prisons Act 2007 came into operation. These include section 35 which provides for the making of rules by the Minister for the regulation and good government of prisons. Such rules may provide for the testing of prisoners for intoxicants including alcohol and other drugs. Section 36 prohibits the unauthorised possession or use of a mobile phone by a prisoner, and the unauthorised supply of a mobile phone to a prisoner. There is anecdotal evidence that mobile phones have been instrumental in facilitating drug supply to prisons.

A High Court Injunction application to prevent Customs officers seizing magic mushrooms was effectively dropped when the Minister for Health changed the law (CDLE, personal communication, July 2007).

With regard to the international co-operation in drug law enforcement, the following matters are reported by Irish Customs Drug Law Enforcement (CDLE):

- Ireland formally consented to become party to the Council of Europe Agreement on Illicit Traffic at Sea.
- Customs Drugs Law Enforcement was nominated as the Irish Law Enforcement Competent Authority (24/7 contact point) to send/receive notifications under Article 17 of the Vienna Convention.

International arrangements for the establishment of a Law Enforcement Maritime Analysis and Operational Centre – Narcotics (MAOC-N) in Lisbon were agreed at a meeting hosted by a Joint Task Force in Cobh, County Cork, in early 2007.

1.3 Institutional framework, strategies and policies

1.3.1 Co-ordination

As indicated in Table 1.3.1, three developments in co-ordination arrangements have occurred in the last 12 months.

Table 1.3.1 Co-ordination mechanisms between agencies

Level	Inter-agency co-ordination mechanism	New developments
Government	Minister of State with responsibility for the drugs strategy chairs the IDG. The National Drugs Strategy Unit in the Department of Community, Rural and Gaeltacht Affairs (DCRGA) co-ordinates the overall implementation of the National Drugs Strategy and interacts closely with all the statutory and non-statutory agencies involved in delivering the Strategy.	Minister of State's responsibility more narrowly focused on drugs issue
National	Cabinet Committee on Social Inclusion (CCSI) Inter-Departmental Group on Drugs (IDG) National Drugs Strategy Team (NDST)	Establishment of National Drug Rehabilitation Implementation Committee (NDRIC)
Regional	Regional drugs task forces (RDTFs)	First iteration of RDTF strategies released by NDST
Local	Local drugs task forces (LDTFs)	

At government level, on 20 June 2007 Pat Carey TD was appointed Minister of State at the Department of Community, Rural and Gaeltacht Affairs with special responsibility for drugs strategy and community affairs. Unlike the previous Minister of State, Noel Ahern TD, Mr Carey's portfolio does not include housing and urban renewal (Galvin 2007).

In early June 2007 the report *National Drugs Strategy 2001–2008: rehabilitation* (Working Group on Drugs Rehabilitation 2007) was released. Acknowledging the complexity of drug rehabilitation, including the diverse needs of users and the wide range of service options and of service providers, the Working Group recognised that

increased co-ordination of services was necessary, and recommended a 'practical model of inter-agency working' that would support a case management approach.

The Working Group proposed that a new co-ordinating structure be established at national level – the National Drug Rehabilitation Implementation Committee (NDRIC). The Senior Rehabilitation Co-ordinator, a new position to be funded by the HSE and wholly located within the Health Service Executive (HSE) structure, will chair the NDRIC. The Committee will comprise representatives of the HSE, the Departments, agencies and community and voluntary sectors already represented on the NDST,[2] the National Advisory Committee on Drugs (NACD), rehabilitation and healthcare professionals (e.g. psychiatrist, counsellor, general practitioner, pharmacist), problem drug users, and families of problem drug users. Representatives will be at a level of authority in their organisations that will facilitate signing off on any issues agreed.

The Senior Rehabilitation Co-ordinator will report to the Inter-Departmental Group on Drugs (IDG) on behalf of the NDRIC. This report will reflect the views, issues arising and progress updates in respect of the implementation of the rehabilitation report and in respect of rehabilitation generally. Rehabilitation will be a standing item on the IDG agenda, at least for the first year of the implementation of the recommendations of the rehabilitation report.

The NDRIC will have responsibility for:

- overseeing and monitoring the implementation of the recommendations in the report of the working group on drugs rehabilitation;
- the development of agreed protocols and service-level agreements;
- the development of a quality standards framework, building on existing standards;
- overseeing case management and care planning processes; and
- identifying core competencies and training needs and ensuring that such needs are met.

The Working Group made the following recommendations in respect of the roles of existing entities with co-ordinating responsibilities:

- The Department of Community, Rural and Gaeltacht Affairs will continue to develop policy and to co-ordinate the National Drugs Strategy to tackle drug misuse in Ireland, with particular emphasis on rehabilitation as the fifth pillar of the strategy.
- The NDST will ensure that all drugs task forces have an active Treatment and Rehabilitation Sub-Group, facilitate the development of cross-task-force treatment and rehabilitation facilities, be represented, as will its constituent departments, agencies and organisations, on the NDRIC, and continue its current role and relationship with drugs task forces in respect of the assessment/ recommendation of rehabilitation actions submitted under the drugs task force process.
- Local and regional drugs task forces will have a Treatment and Rehabilitation Sub-Group to facilitate working with the NDRIC structure on an ongoing basis and to plan community-based services in conjunction with the NDST. The role of the sub-groups will be reviewed and redefined in the context of this Report by the NDRIC, in conjunction with the NDST and the Rehabilitation Co-ordinators.

Ten regional drugs task forces were established on foot of the need, identified in the National Drugs Strategy, for co-ordinated and integrated responses to the drugs problem throughout the country.

[2] It is envisaged that representatives on the NDRIC will not be the same as those on the NDST but will have a more direct involvement in the rehabilitation area.

Regional drugs task force	Catchment area
East Coast	South Dublin City and County excluding seven LDTF areas, East Wicklow
Midland	Counties Laois, Longford, Offaly, Westmeath
Mid-Western	Counties Clare, Limerick, North Tipperary
North Dublin City and County	North Dublin City and County excluding five LDTF areas
North East	Counties Cavan, Louth, Meath, Monaghan
North West	Counties Donegal, Leitrim, Sligo and north-west Cavan
Southern	Counties Cork, Kerry
South East	Counties Carlow, Kilkenny, South Tipperary, Waterford, Wexford
South West	South and West Dublin, West Wicklow and County Kildare
Western	Counties Galway, Mayo, Roscommon

In developing their strategies, the RDTFs were advised to adopt a 'partnership approach involving the statutory, voluntary and community sectors, through the development of a single, integrated plan, which all organisations and agencies … support and are committed to implementing' (National Drugs Strategy Team 2004), p. 1. Although each of the RDTFs adopted its own distinctive mix of co-ordination tools, when the strategies are viewed together, the tools may be grouped around four main themes (Pike 2007a).

- ***Governance****:* The RDTFs have given considerable thought to means of ensuring sound decision-making structures and systems, to ensure sound co-ordination of the planning and implementing the 'single integrated plan'.
- *Resources:* To be effective, co-ordination needs to be adequately resourced. Over and above core task force staff, one RDTF has identified the need for 15 additional posts to provide support and liaison services throughout the region.
- ***Communication****:* Mechanisms for the exchange of information, including ideas and opinions, are regarded as important for ensuring effective co-ordination. Initiatives include forums of various stakeholder groups; community development that involves local communities with the RDTF, and builds capacity; interagency co-operation; advocacy and liaison roles to influence decisions that will impact positively on drug misuse, but which fall outside the RDTF's direct sphere of influence.
- ***Service design****:* Two 'clientcentric' approaches to service design have been championed by various RDTFs – a case-based approach, and a broader approach predicated on the need to address drug misuse in the context of wider social inclusion issues. Both these approaches require real and effective co-ordination. With regard to the second option, one RDTF argues: 'One route to tackling coordination problems at local level would be to focus on outcomes for socially excluded target groups and to work towards a problem-solving agenda where a common problem is identified and a strategy to address this jointly agreed.' (Western Region Drugs Task Force 2006: 42). This strategy may include addressing 'protective' factors, such as fostering strong and healthy communities or providing good social or transport infrastructure, as well as addressing 'risk' factors such as treatment and rehabilitation initiatives.

1.3.2 National plan and/or strategies

Following an in-depth review published in *The developmental welfare state* (National Economic and Social Council 2005), the government's social inclusion policy framework, of which the National Drugs Strategy 2001–2008 forms a part, has been completely revised. While not leading to any changes in direction for Ireland's drug policy, this revision has led to a change in the way responses to the illicit drugs issue are presented in the most recent social partnership agreement, national development

plan and action plan for social inclusion. In a separate development, a general election in May 2007 led to the formation of a new coalition government which has agreed some new priorities in the drugs area.

The developmental welfare state proposed a new, streamlined and comprehensive approach to tackling poverty and social exclusion in Ireland. Acknowledging that serious social deficits remained despite Ireland's economic progress, the NESC report called for a recasting of the social debate in a way that does not distinguish between the economic and the social, suggesting that this would help to build consensus across the social partners, government and wider society. The report proposed two innovations, which have altered the way in which social inclusion interventions, including responses to the illicit drugs issue, are presented in policy documents:

- increased recognition of the role of *services* in providing protection against risks and of the importance of *innovative social policy initiatives*, as opposed to focusing entirely on *income transfers*; and
- a lifecycle framework, comprising five stages – childhood, youth, working age, older age, and people with disabilities – which both places the individual at the centre of policy making and encourages a more joined-up and multi-disciplinary approach to policy making.

Towards 2016: Ten-Year Framework Social Partnership Agreement 2006–2015 (Department of An Taoiseach 2006) sets out an agreed vision and key long-term goals for each of the five stages of the lifecycle, together with a programme of agreed priority actions and innovative measures (Pike 2006b). Illicit drugs are dealt with in relation to children (0–17 years) and young adults (18–29 years).

Children: The Agreement contains a commitment to monitor prevalence trends in smoking and substance use (Section 30.2). Under Innovative Measures it notes that a cross-departmental team chaired by the Office of the Minister for Children is developing an initiative to test models of best practice which promote integrated, locally-led, strategic planning for children's services. The initiative will focus on children who are at risk of suffering from multiple disadvantage relating to poverty and social exclusion, and on vulnerable families exposed to, among other things, risks from substance abuse (Section 30.3).

Young Adults*:* This age cohort is recognised as having three particular health needs: combating substance misuse, reducing alcohol-related harm and the prevention of suicide. While not identifying any priority actions or innovative measures in relation to substance misuse or alcohol, the Agreement notes the establishment of a fifth rehabilitation pillar in the National Drugs Strategy, the potential for better co-ordination between the areas of drugs and alcohol, and the allocation of additional funding in 2006 to develop drug-related facilities and services for young people. It also notes that the recommendations of the Working Group on Alcohol, established under Sustaining Progress, will be implemented (Section 31.3).

In January 2007 the *National Development Plan 2007–2013 (*NDP) {Department of An Taoiseach, 2007 #992} was launched. It sets out the government's investment plans for the next seven years. In the previous NDP, covering the period 2000–2006, social inclusion was treated as a horizontal cross-cutting issue; in the new NDP, social inclusion is treated as a separate and distinct investment priority, within which funding is allocated in accordance with the lifecycle framework. Section 1.4.2 below gives a full account of the new NDP drug-related funding provisions for the next seven years.

The new NDP also provides a commentary on national drug policy priorities. Acknowledging that the National Drugs Strategy will expire in 2008, the NDP endorses

the current approach in the short-term – 'the focus of drugs policy in the coming years will continue to be on illegal drugs that do the most harm and on the most vulnerable drug misusers, their families and communities'. It highlights the importance of partnership and evidence-based approaches. It also confirms the pillars of the National Drugs Strategy and the recommendations made in the Mid-Term Review, including extending the availability and range of treatment options in response to emerging needs, such as increased prevalence of cocaine and polydrug use; implementing the integrated rehabilitation framework as a priority in the coming years; and using education and awareness programmes and sport and recreational alternatives to divert people (particularly young people) away from drug use.

In February 2007 the *National Action Plan for Social Inclusion 2007–2016* (NAPincl) was released {Department of Social and Family Affairs Office for Social Inclusion, 2007 #1000}. It presents responses to the illicit drugs issue targeted at children, people of working age, and communities; the responses fall under the headings of either Services or Innovative Measures.

Children: The action plan sets targets for the provision of health services for children that include access to treatment for 100% of problematic drug users aged under 18 years within one month after assessment; the introduction of substance abuse policies in 100% of schools by 2008; and the use of results from various surveys to inform policy making and service planning (p. 34). Under the heading of Innovative Measures, the action plan endorses the Young Person's Facilities and Services Fund (YPFSF), which is applied in disadvantaged areas where a significant drug problem exists or has the potential to develop. The Fund targets 10–21-year-olds who are 'at risk'. It is noted that the geographic coverage of the Fund may be extended to other disadvantaged urban areas (p. 37).

People of working age: Under Services, the action plan emphasises the link between access to a quality health service and participation in the social and economic life of society. Working to improve the health status of vulnerable groups such as those with mental illness, drug users, the homeless and Travellers is seen as 'an essential element of social inclusion'. Actions include ensuring people who are not able to meet the cost of GP services themselves and their families are enabled to do so (p. 45).

Communities: The action plan itemises a number of Innovative Measures in areas such as arts, sport, and active citizenship, which may be expected to have an impact on the illicit drugs issue. The action plan also lists a series of community-based programmes which will have an impact on the illicit drugs issue, including the Local Development Social Inclusion Programme, Community Development Programme, RAPID Programme, Community Services Programme, Joint Policing Committees, and Family Support Services. The National Drugs Strategy is included in this grouping.

In June 2007, following a general election, the incoming government drafted a new *Agreed Programme for Government* (see Galvin 2007). All the commitments contained in the Agreed Programme were contained in the election manifesto of the Fianna Fáil Party (Fianna Fáil 2007). Under the 'Justice' heading, the new government commits to:

- complementing the recommendations of the Working Group on Drugs Rehabilitation, including providing extra detox beds and drug-specific community employment places in locations around the country;
- establishing two cocaine-specific treatment centres and supporting the pilot projects for cocaine approved under Emerging Needs Fund;
- supporting targeted Garda (police) anti-drug use programmes in schools and third-level institutions;

- increasing Garda search powers to allow random searching for drugs at specified places or events at particular places where senior Garda members believe there is a risk of drugs being present;
- expanding the Criminal Assets Bureau operational presence in each Garda Division;
- providing for the mandatory registration of mobile phones to ensure all phones are traceable;
- introducing measures to make prisons drug free, including prohibiting physical contact with prisoners and testing on arrival; and
- expanding the Drug Court programme, and making it possible to include mandatory drug treatment in a sentence for drug-related offence.

The Government also pledges to support the development of projects being undertaken by local and regional drugs task forces and will continue to use the Young People's Facilities and Services Fund to assist in the development of youth facilities and services in disadvantaged areas.

1.3.3 Implementation of policies and strategies

The mid-term review of the National Drugs Strategy (Steering group for the mid-term review of the National Drugs Strategy 2005) recommended that

> Rehabilitation should become the fifth pillar of the National Drugs Strategy. In this context, a working group should be set up to develop an integrated rehabilitation provision. The group, to be chaired by the Department of Community, Rural & Gaeltacht Affairs, should report to the IDG and the Cabinet Committee on Social Inclusion by the end of 2005 on the appropriate actions to be implemented.

In June 2007 the report *National Drugs Strategy 2001–2008: rehabilitation* (Working Group on Drugs Rehabilitation 2007) was published. See 'Co-Ordination' (section 1.3.1 above) for an account of the new national co-ordination mechanism, and Chapter 9 below for further detail in respect of the Working Group's recommendations.

By mid-2005, all 10 regional drugs task forces had submitted their first strategic and/or action plans to the National Drugs Strategy Team (NDST) for approval, and these were released in 2006. Aligned with, and intended to contribute to the achievement of the overall aims and the operational objectives of the National Drugs Strategy 2001–2008, these regional strategies highlight additional policy concerns, some of which are noted below (Pike 2006b, 2007a).

While the National Drugs Strategy focuses entirely on illicit drugs, calling simply for 'complementarity' between illicit drugs and alcohol policies, the majority of the RDTF strategies address both alcohol and drugs misuse. A variety of reasons is given – because alcohol is the biggest problem drug; because alcohol is a bigger problem than drugs, and, given the 'deregulation' of the sale of alcohol, treatment service provision needs to be funded as a priority; or because polydrug use, including alcohol misuse, is prominent among young people using drugs and the alcohol and drug cultures are intertwined and need to be addressed as part of an inclusive approach. Alcohol-related supply reduction or control measures identified in the RDTF plans include more regulation of off-licences and supermarkets, introduction of a responsible sale-of-alcohol programme, opposition to 'happy hours' and alcohol promoting events, and rigorous enforcement of the law in relation to alcohol. Prevention measures include health promotion campaigns to ensure public awareness of alcohol and related issues, and early health promotion interventions to curb the sale of alcohol to under-age people. Treatment measures include the use of validated screening tools, brief interventions for people with problem alcohol use or alcohol dependence, counselling, and community-based alcohol detoxification services.

In line with the National Drugs Strategy, the RDTFs acknowledge social inclusion as the policy framework within which their strategies and actions are set. The Western RDTF strategy document (Western Region Drugs Task Force 2006) devotes a whole chapter to social inclusion, discussing the needs of specific socially-excluded groups, including those living in remote rural areas or in socially disadvantaged areas, the homeless, Travellers and prisoners. It identifies several tailored service developments to weaken the link between the socially excluded and illicit drugs, including assertive outreach initiatives; decentralised mechanisms that reach to the heart of rural areas; focusing on outcomes for socially excluded target groups; and working to solve the full range of problems, including substance misuse, in an integrated fashion.

As an alternative to social inclusion, the Southern RDTF bases its strategic plan within an equality framework (King 2005). The assessment of the drugs and alcohol situation in the southern region is organised around consideration of seven of the nine equality grounds listed in Ireland's Equal Status Act 2000 (gender, sexual orientation, family status, age, disability, race and membership of the Traveller community), two of the proposed additional grounds (criminal convictions and socio-economic status), and two other variables (homelessness, and literacy levels) which may have an influence on the effectiveness of prevention strategies. The RDTF justifies the choice of an equality framework on the grounds that, increasingly, a 'one size fits all' policy framework does not work, and 'a more targeted, focused approach' is perceived to be needed.

In respect of supply reduction, the RDTFs acknowledge that national statutory bodies such as the Garda Síochána and Customs and Excise have the lead roles in reducing illicit drug supply throughout the country. The RDTFs adopt three main strategies for addressing supply reduction in the regions:

1. ***Facilitating the formation of partnerships between statutory and local bodies***; for example, supporting closer liaison between the gardaí, Customs and Excise, the fishing community, all seafarers, local authorities, the Naval Service and coastal communities on how they can best contribute to the reduction in the trafficking of drugs; and supporting the development of shared initiatives, services or protocols between health service providers and law enforcement agencies. Some RDTFs have taken steps to ensure that effective channels of communication between themselves and the gardaí in relation to supply control are maintained and enhanced.
2. ***Strengthening community participation in supply reduction activities*** through means such as fostering estate management programmes in at-risk communities; establishing joint policing committees; promoting the development of community fora; and encouraging the Garda Síochána to engage with community groups to discuss the policing plan for the area, including deployment issues at peak times, such as week-ends/closing times.
3. ***Advocating or lobbying for increased resources for policing activities in the region, and lobbying for policy changes at national level***, such as channelling confiscated assets derived from drug-dealing to communities; extending the Drug Courts model outside Dublin; encouraging and supporting the prosecution of licensed and off-licence premises and adults when charged with supplying alcohol to under-18s; implementing harm-reduction measures within the criminal justice system; greater enforcement of existing legislation, e.g. underage drinking laws, consistency of court penalties.

One RDTF describes a tension between the nationwide role of the statutory agencies in intercepting smuggling and trafficking activities, and their regional and local roles in interrupting local drug markets, and the need to clearly distinguish between and demarcate these two spheres:

> …the national brief asked of the Customs and An Garda Síochána, while essential, may actually be distractive to the implementation of initiatives in the context of the LDTFs and RDTFs …. The resources available to the Customs and Excise and An Garda Síochána are insufficient to address levels of drugs supply despite the very significant hauls of both drugs and alcohol at Rosslare and Waterford ports. It is suggested that the supply reduction committees of the Regional DTF and the Local DTFs are restructured to re-focus supply analysis and action at local community level rather than national level as at present. (Murtagh 2005: 53)

A further tension peculiar to the RDTFs is the need to police drug markets across urban and suburban areas and in rural hinterlands, where the market dynamics can alter very rapidly, and also along the border with Northern Ireland. One RDTF notes that drug market activity depends on where there is a local Garda station; in another region, the consultation process brought forth the observation that drugs were being brought into the country through small regional fishing ports, but there was a reluctance to mention this as it might negatively impact on the region's tourism business. Suggestions were made with regard to increasing cross-regional (and cross-border) work to tackle middle-market supply, and to strengthening local policing to disrupt supplies on the streets.

The Prevention pillar of the National Drugs Strategy 2001–2008 comprises four elements – education, awareness, information, and prevention, the last encompassing support for the family and diversionary and structural interventions. The RDTF strategies display a similar range of understandings of the concept, but highlight the complex challenge of choosing the right mix of interventions and providing them in the right place at the right time. Different aspects of this challenge are teased out here.

The types of substances being misused need to be taken into account. For example, in the north-west, there is a low level of illegal drug use – mostly cannabis and ecstasy – and the principal problems are due to polydrug use, under-age drinking and the extent to which the drug culture and under-age drinking have become intertwined. As a consequence, the RDTF has decided to focus on 'awareness', with two objectives – to raise the level of awareness of drug misuse and underage drinking, and to research, compile and disseminate relevant and up-to-date data regarding drug misuse and underage drinking issues in the region.

The age of the target populations and their particular needs also have to be taken into account. One RDTF reports that many education/prevention measures are targeting adults (aged over 18), although the age cohort most likely to form a drug misuse problem is that of under-16s. The RDTF goes on to suggest: 'The capacity of family members to exert their influence with regard to preventing young people from becoming involved in drugs, or in terms of early identification, may need to be examined to ensure that resources are being deployed in the most efficient and effective manner' (South West RDTF 2005): 37–8). Another RDTF notes that older age groups have separate and distinct needs: 'The focus of drug and alcohol campaigns is often on young people and their risk-taking behaviours, yet it is also important to look at the range of people and age groups who may develop problems. While it may be true to say that very few older people develop heroin problems, they may experience difficulties with alcohol, tranquillisers, sleeping tablets or painkillers. It is important to recognise that people may be experiencing dependence difficulties with over-the-counter medications' (Western Region Drugs Task Force 2006: 29). Having consulted with education and prevention service providers in its region, the South West RDTF (2005: 25) reports, 'There is an almost exclusive focus on education as the primary method of prevention, which is worrying given the correlation between drug misuse and early school-leaving.' It suggests that other preventive measures, such as diversion, might be more relevant to this population.

The location of services and the channels for the provision of prevention services across large regions also pose challenges. One RDTF located near Dublin reports wide variations in the range of education/prevention services provided in different settlement areas, with patchy coverage in core urban areas, and progressively lower levels of service provision in suburban commuter towns and in rural areas. Another RDTF, also located near Dublin, reports that there is an over-supply of education/prevention services in comparison to treatment, harm reduction and rehabilitation services. It observes that this represents 'a narrow perspective which will need to be widened if the drug problem in the area is to be addressed in any comprehensive or coherent way' (East Coast Regional Drugs Task Force n.d.: 24). Finding that most services operate on a basis of open access, this RDTF suggests this has both advantages and disadvantages: everyone has access to a service but valuable places on programmes being allocated on an *ad hoc* basis might mean that those most in need or those whose needs can best be catered for by the programme might miss out. It calls for more targeted services run according to clear aims and objectives and evaluated to ensure resources are being used efficiently and effectively.

Means identified by the RDTFs for responding appropriately include better co-ordination of prevention services across extensive regions, including the development of regional drugs education and prevention strategies, the establishment of regional drugs education forums; the identification of best-practice models for drugs education/prevention; the setting and maintenance of standards and unification of standards across the voluntary, community and statutory sectors; and enhanced monitoring and evaluation.

The RDTFs broadly endorse the approach to drug-related treatment set out in the National Drugs Strategy and call for full implementation in their regions – including, for example, the continuum of care model and the use of key workers; the targeting of under-18s; the integration of prison-based and community-based treatment services; the provision of childcare facilities; and the exploration of alternative medical and non-medical treatments. The RDTF strategies also endorse the responses to emerging needs identified in the mid-term review of the National Drugs Strategy, including the need to develop comprehensive rehabilitation services, and to provide support services for the parents and families of drug users as well as for drug users themselves.

Some treatment services mentioned in the national policy documents are given particularly prominent attention in the RDTF strategies, for example, the need for crisis support and point-of-contact services available at all times; the need for both residential and community-based detoxification services; the need for drop-in centres, half-way and three-quarter-way houses for respite care; and the need for services impacting on the awareness, transmission, treatment and management of blood-borne viruses.

In relation to availability and accessibility, it is pointed out by a number of RDTFs that urban areas may have a critical mass of service users concentrated in the one locality, resulting in economies of scale for service provision and ease of access for users. In rural areas, however, service users may be widely scattered in small villages or remote areas, without easy access to transport. This poses logistical and social challenges in terms of providing services that are both accessible to users (either by offering transport to larger centres or by providing services locally), and also discrete (in order to minimise the risk of stigma attaching to those seen to be attending the service). A number of structural adjustments are proposed, including one-stop addiction assessment and referral points; a standardised treatment infrastructure consisting of main treatment centres and satellite clinics, with particular emphasis on the network of community pharmacies and general practitioners (GPs); and greater integration

between GPs and community-based treatment services. With regard to financial resources, calls were made for the provision of funds in the regions to support people needing access to drug treatment services, who could not otherwise afford it; and greater state-sector funding for voluntary treatment services.

Two policy interventions not included in the National Drugs Strategy are canvassed. The possibility of drug testing for young people is included in the South-Eastern RDTF's vision for addressing the drugs issue in its 'most deprived areas, currently suffering or at risk from the rise of drug misuse. … Those young people most at risk will be helped through increased outreach and community treatment. They could also benefit from new initiatives including drug testing, referral to innovative and increasing treatment facilities, drop-in centres, mentoring and one-to-one counselling facilities as well as awareness raising programmes' (Murtagh 2005: 56). The Southern RDTF canvasses the idea that, 'With due recognition of the rights of every citizen before the Courts, urine samples should be sought from young people in this situation and evidence of illegal drugs in the system should be taken into account in deciding how best to respond to the needs of that person' (King 2005: 87).

The South-Eastern RDTF predicates its strategy on a harm-reduction model. Among its eight harm reduction principles (Murtagh 2005: 56–7), it includes the following:

- Accepts, for better and for worse that licit and illicit drug use is part of our world and chooses to work to minimize its harmful effects rather than simply ignore or condemn them.
- Establishes quality of individual and community life and well-being – not necessarily cessation of all drug use – as the criteria for successful interventions and policies.

The RDTFs note several shortcomings in the current provision for research activities. Drug-related research is generally conducted by national agencies, such as the National Advisory Committee on Drugs or the Health Research Board, and focuses on the national picture. Detailed local information is not available. Even if research is locally based, it tends to be issue-defined rather than based on tight geographical areas. The RDTFs argue that 'well-conducted, locally-based research' is required to ensure that resources can be allocated efficiently and effectively within RDTF areas.

Calls are made for research into, variously:

- the extent and nature of the drugs situation in a region, and the ability to monitor emerging trends;
- the needs of people living in smaller towns and rural areas in respect of access to services, and the needs of specific groups, such as homeless people, Travellers, lesbian, gay, bisexual and transgender (LGBT) people, the parasuicidal, non-Irish-nationals, young people, and children affected by problematic drug use; and
- service-related options, such as the feasibility and options for introducing harm-related interventions; the feasibility of providing residential rehabilitation services for women who have young children; facilities available, particularly for young people; and the optimal means of providing treatment in localities adjacent to local drugs task force areas.

As well as research to support sound planning, a number of RDTFs stress the importance of evaluative research. It is viewed as a tool for 'reviewing and reflecting on practice; … informing further planning and practice; sharing and disseminating experiences, learning and good practice; being accountable …; making a case for further funding (East Coast Regional Drugs Task Force n.d: 96).

One RDTF also emphasises the contribution that research could make to a community development approach to addressing the drugs issue:

> … steps must be taken through the development and dissemination of sound and meaningful research within the Region to equip all stakeholders, community activists, and drug workers with accurate and up-to-date research and information. In turn, the availability of such research, and interpretations of it, will further equip parents, teachers, youth workers and young people to address drugs with a more comprehensive understanding and knowledge of their availability, outcomes, prevention techniques and projects, treatment methodology and accessibility, and support where required. (Murtagh 2005: 57–8)

The need for adequate funding for research efforts is emphasised. One RDTF observes that, in general, funding is only allocated to research if it is considered that other drug-related services are already properly funded, and that this has led to situations where research activities remained low on the agenda. Furthermore, owing to time and resource constraints, 'evaluation often becomes tacked on as "monitoring" which is frequently carried out by already stretched project staff who have limited experience in this area and very little time available to carry it out' (South West RDTF 2005: 72).

1.3.4 Evaluation of policies and strategies

In October 2006 an expenditure review of the local drugs task forces (LDTFs) was published (Goodbody Economic Consultants 2006d). Commissioned by the Department of Community, Rural and Gaeltacht Affairs (DCRGA), the purpose of the review was:

1. to establish the outputs, effectiveness and efficiency of the LDTF Programme,
2. to make recommendations to improve effectiveness and efficiency, and
3. to define performance indicators and baselines in order to measure the work of the LDTFs in future.

The review considered that the LDTF Programme had been 'very effective':

- A large number of measures, including community projects and new activities, have been implemented to address the drug problem at the local level, and have been highly relevant to the objectives set for the National Drugs Strategy.
- There is clear evidence of higher levels of trust emerging between local communities and the statutory agencies concerned with drug abuse. As the LDTF Programme is a major vehicle for contacts between the community and the statutory agencies, it is likely to have been instrumental in effecting this change.
- International research indicates that the costs to society of drug abuse are very high, and that there are immediate and substantial savings to the economy when drug users enter treatment regimes. The review found that the focus of the LDTF Programme is on the Dublin area, and drug-related deaths, drug-related HIV infections, and discharges from hospitals of patients with drug-related illnesses have all reduced significantly in the Dublin area in the post-2000 period.

The review identified a number of process-oriented steps to enhance the efficiency and effectiveness of the Programme:

- **Reporting and monitoring** – establishment of clearer reporting relationships and related monitoring systems between projects, funders and task forces, and development of standard monitoring templates to be used by projects to monitor progress;
- **Resourcing** – allocation of the required level of annual funding to meet the core costs of mainstream projects, and a review of related programming costs; provision of greater resources at task force level to improve supports to projects and to

encourage greater cross-task-force and cross-project networking and interaction with wider drug-related initiatives; and to research and analysis at NDST level to derive high-level policy analysis, conclusions and directions from the LDTF process learning,

- **Evaluation** – carrying out of long-term follow-up surveys of clients to better establish project outcomes and factors that influence successful outcomes; development of stronger evaluation processes in relation to future mainstreaming decisions, and projects in receipt of mainstream funding.

Finally, the review concluded that, while considerable success had been achieved in addressing the drug problem in the Dublin area, and the LDTF Programme continues to be relevant to combating the drug problem, realistic targets for the Programme should be set. The review proposed a system of 24 indicators for measuring performance in relation to projects, LDTF processes, the LDTFs individually, and the LDTF Programme as a whole.

Independent evaluations of four pilot cocaine treatment intervention projects, funded by the NDST, were released (Crampton 2005; Goodbody Economic Consultants 2006a, 2006b, 2006c). The results are reported in section 5.3 of this national report.

A paper published by the journal *Administration* examined the alternatives to imprisonment for drug-using offenders in Ireland (Connolly 2006a). According to the author, there has been a general consensus among policy makers in Ireland over the last 30 years on the importance of establishing alternatives to custodial sentences. The author highlights the widely accepted fact that many people are incarcerated because of crime committed as a consequence of drug addiction. Research indicates that, in the case of drug-related crime, treatment is more effective than imprisonment in reducing re-offending. Hence, developing alternatives to custody for drug offenders is of particular importance.

Examples of alternative sanctions currently in operation in Ireland are the Garda Juvenile Diversion Programme, probation orders, community service orders and the Drug Court. Notwithstanding the existence of these alternatives, there appears to be an over-reliance on custodial sanctions in this country. According to Connolly, ‘despite the broad policy consensus that prison should be used as a last resort and that alternatives to prison should be used more often, the reality is that this consensus is not reflected in practice’ (p. 18). In a report on the re-integration of prisoners, the National Economic and Social Forum (NESF) (National Economic and Social Forum 2002) suggests a number of possible reasons for this, as outlined below.

First, the implementation of criminal justice policy tends to be influenced by political considerations rather than by the findings of empirical research. Media reaction and political interpretation of public opinion tend to take precedence over evidence-based analysis of policy. Second, there appears to be an over-reliance on imprisonment in Ireland relative to other Western European countries. Examination of prison statistics suggest that individuals are being sentenced for minor crimes, with almost half of all adults imprisoned receiving sentences of less than three months, and 75% less than one year. Furthermore, alternative sanctions in Ireland have no statutory basis, evolving instead by way of judicial practice and relying for their implementation on judicial discretion. Third, there is some evidence to suggest that the judiciary receive inadequate training in matters pertaining to drug misuse. Research cited in the report supports this. Other factors mentioned in the NESF report include lack of resources and the unsuitability of existing alternative sanctions for drug offenders.

The paper on alternatives to imprisonment recommends that, in order for both a reduction in the use of custodial sanctions and a simultaneous increase in non-custodial alternatives, there needs to be a greater dissemination of information to the judiciary as to the available alternatives. This, coupled with a greater provision of resources should enable their further development. However, the author concludes that, if non-custodial sanctions are to become a viable alternative to imprisonment in Ireland, the will and commitment of both the political and judicial systems will be required.

1.4 Budget and public expenditure

Actual budget and expenditure (in law enforcement, social and health care, research, international actions, co-ordination and national strategies)

Table 1.4.1 2006 Allocations directly attributable to drugs programmes for Government departments/agencies

Department/Agency	2006 allocation € million	
National Drugs Strategy Unit	43.000	
Department of Health and Children	0.978	
Health Service Executive	85.053	
FÁS	18.600	
Department of Education and Science	12.140	
Department of Environment, Heritage and Local Government	0.461	
Department of Justice, Equality and Law Reform	9.530	
Irish Prison Service	5.000	(estimate)*
An Garda Síochána	33.400	
Revenue's Customs Service	6.525	
Total	214.687	

* The Irish Prison Service expenditure reflects the expenditure for 2005. The IPS is currently reviewing its procedures for recording drug-related expenditure, and is expected to have a report on 2006 expenditure in the coming months, once this review is completed.
Source: Department of Community, Rural and Gaeltacht Affairs, October 2007.

1.4.1 Funding arrangements

The National Report 2006 outlined the funding arrangements for drug policy interventions in Ireland. This outline is summarised in Table 1.4.2 and recent developments are noted.

Table 1.4.2 Summary of funding arrangements for drug-related policy interventions

Funding channel	Funding mechanism	Recent developments
Major planning instruments	National Drugs Strategy National Development Plan (NDP)	NDP 2007–2012
Annual parliamentary Estimates	Funding allocated by Vote Drugs Initiative RAPID (Revitalising Areas by Planning Investment and Development) Other mechanisms such as community development, local development, anti-poverty, which will indirectly impact on the drugs issue	
Other funding mechanisms	Dormant Accounts National Lottery	Sports Capital Programme: This funding mechanism is the subject of a commitment in the new *Agreed Programme for Government*.

On 23 January 2007 the *National Development Plan 2007–2013* (NDP) was launched (Department of An Taoiseach 2007). Setting out the government's investment plans (€184 billion) for the next seven years, the NDP includes funding for measures to address the drugs issue under three of its five priority investment areas – Social Inclusion, Human Capital and Social Infrastructure.

Under the Social Inclusion Priority, the NDP earmarks €319 million for the 'National Drugs Strategy Sub-Programme', subsumed under the Local and Community Programme. Allocated on an annual basis through the Vote of the Department of Community, Rural and Gaeltacht Affairs, this €319 million will be channelled mainly through two existing funding mechanisms – the drugs task forces and the Young People's Facilities and Services Fund (YPFSF). In respect of these two funding mechanisms, the NDP states:

- The range of projects being undertaken through the Local Drugs and Regional Drugs Task Forces will be developed and strengthened over the coming years. Strategic plans, developed by the Drugs Task Forces and based on the identified needs of the areas involved, will continue to be central to the effort to counteract the problems of drug misuse.
- The YPFSF will continue to assist in the development of youth facilities (including sport and recreational facilities) and services in disadvantaged areas where a significant drug problem exists or has the potential to develop. The geographic coverage of the Fund may be expanded to other disadvantaged urban areas. The YPFSF will continue to target 10 to 21 year olds who are 'at risk' due to factors including family circumstances, educational disadvantage or involvement in crime or substance misuse. The Fund will continue to build on and complement youth measures under the Children's Programme in the areas where it is operational. (Department of An Taoiseach: 265)

The drugs issue will also be addressed through other funding streams in the NDP (Pike 2007a). For example, other programmes under the Social Inclusion Priority, such as those targeting children and young people; people of working age who find themselves outside the mainstream educational system, at a distance from the labour market, or in need of reintegration into society after spending time in prison; and communities

seeking to identify and address issues and challenges, such as the drugs issue, in their own areas, may all be expected to have an effect on the illicit drugs issue.

The national lottery-funded Sports Capital Programme, which is administered by the Department of Arts, Sport and Tourism, allocates funding to projects that are directly related to the provision of sports facilities and are of a capital nature. Funding can be allocated to the following organisations under the programme: voluntary and community organisations, including sports clubs; national governing bodies of sport and third level education institutions; and, in certain circumstances, schools, colleges and local authorities. In keeping with Government policy, the allocations reflect special priority for the development of sports and physical recreation facilities in areas designated as disadvantaged, including LDTF areas.

Under the 'Local and National Sports Facilities' heading in the new draft *Agreed Programme for Government* (see Galvin 2007), the newly-elected government has announced that a change will be made to the Sports Capital Programme, to reduce the level of 'own funding' required from applicants located in a recognised area of urban disadvantage, such as an LDTF area.

1.5 Social and cultural context

1.5.1 Public opinions of drug issues

In December 2006 the European Commission published the initial findings from its regular six-monthly survey of public opinion in the EU, based on fieldwork conducted in September–October 2006 (TNS Opinion & Social 2006). It was reported that more than a quarter (26%) of EU citizens surveyed agreed, and two-thirds (68%) disagreed, with the statement: 'Personal consumption of cannabis should be legalised throughout Europe'. In Ireland the rate of agreement was 30%.

In January 2007 the Irish Penal Reform Trust commissioned a study of public reaction in Ireland to a range of issues relating to the prison system (TNS mrbi 2007). Interviewing was completed amongst a nationally representative sample of adults aged 18+ years at 100 sampling points around the country. All interviews were conducted face-to-face in the respondents' own homes between 8 and 26 January 2007. Overall conclusions from the research included the observations that less punitive measures are preferred for non-violent offenders (e.g. drug and mental health programmes), and there is a persistent preference to see more treatment programmes available for those with drug or mental health problems. Specifically:

- 41% indicated a preference for drug treatment for non-violent offenders with drug problems.
- 81% agreed that offenders with a drug addiction should be placed in drug recovery programmes instead of in prison.
- 44% agreed that criminalising drug use causes more problems than it prevents, while 28% disagreed. It was noted that the question of whether or not criminalising drug use causes more problems than it prevents attracted the highest level of uncertainty, with 19% answering 'neither agree nor disagree' and a further 9% answering 'don't know'.

1.5.2 Attitudes to drugs and drug users

Smoking, alcohol and drug use in Cork and Kerry 2004 (Jackson 2006) reports on a survey of substance use and awareness of illicit drugs and perceptions of drug-related issues in 2004 in the former Southern Health Board area, and compares the findings

with those of a similar study conducted in 1996 (Jackson 1997).[3] In this section the findings of the report in respect of community awareness of illicit drugs and perceptions of drug-related issues are described, along with comparisons with the 1996 findings. (The findings in respect of substance use are reported in section 2.2.3 of this report.)

Mirroring the trend shown by the research that drug and alcohol use in the region had increased since 1996, the study also found that awareness of illicit drugs and drug use in the region had increased over the past eight years and that attitudes and opinions on substance misuse issues had shifted.

Awareness of almost all drugs had increased since 1996. Significant increases were also found in the proportion of respondents claiming personal knowledge of drug situations, including knowing someone who had been offered drugs, had taken drugs in the last five years or regularly took drugs, or being in social gatherings in the last five years where drugs were taken by others. Since 1996 the proportion of respondents with such knowledge had increased for cannabis, cocaine, crack and heroin, while dropping for ecstasy, magic mushrooms and LSD. As in 1996, the main source of awareness among all respondents of people using drugs in their area was personal contacts.

Responses to a question about the harmfulness of individual drugs showed that, as in 1996, heroin, ecstasy, crack, cocaine and LSD were considered the most harmful, and cannabis the least harmful. Medically prescribed drugs fell midway in the ranking. The author reports that cannabis use was twice as frequent among those who thought the substance least harmful as among those who saw it as harmful. This difference had reduced since 1996, suggesting 'increasing tolerance of Cannabis in the population' (p. 119). On the other hand, the author reports that, despite their ranking among the most harmful drugs, ecstasy and LSD were also among the drugs reported as most frequently used.

With regard to 'gateway drugs', respondents were asked whether and to what extent they agreed or disagreed with the statement that people who use cannabis (and other 'softer' drugs) are likely to progress onto 'harder' drugs such as heroin or cocaine. The response indicates that the level of agreement with this statement had declined since 1996.

Respondents were asked to state how much of a problem they thought certain drug-related activities were in their area (i.e. within five minutes' walk). Using drugs was the

[3] The survey was a multi-staged, quota-controlled household survey with random starting points. The target population was people living in the three main regions of the former Southern Heath Board (SHB): Cork City, Cork County and Kerry County. The main sample consisted of 1,512 respondents, aged between 15 and 44 years and divided equally between the three regions, with approximately 500 respondents from each region. In order to boost the number of those involved in substance use detected by the survey, a booster sample was also used. This targeted populations where there was considered to be greater risk of substance misuse. The booster sample consisted of approximately 900 respondents aged between 15 and 24 years from the most deprived urban areas of each region. The only changes to the methodology between 1996 and 2004 were in relation to the booster sample. In order to increase statistical robustness it was increased from 600 to 900 and the areas of deprivation were based on the Small Area Health Research Unit index. The survey was divided into two parts. The first part was administered by an interviewer and covered a number of topics – general views on the respondent's local area, knowledge of specific drugs, usage of tobacco and alcohol, attitudes about drugs and how they should be dealt with in the community, leisure activities and demographic information. The second part was a self-completion questionnaire which related to usage of drugs (including injecting drug use) and personal knowledge of people who had received or might need professional advice for alcohol- or drug-related problems. Field workers employed by TNS mrbi used a structured questionnaire to record responses during face-to-face interviews with individual respondents. These data were coded in SPSS and subjected to varied statistical tests. The final analysis was based on 1,508 respondents from the main sample and 909 from the booster sample. Results from the structured interviews regarding respondents' views on alcohol and smoking policies, their knowledge of substance use services and their leisure activities are not described here.

most widely perceived ‘very big’ or ‘fairly big’ problem (45%), followed by drug-related criminal activities, including people being offered drugs for sale (36%), crimes committed by people acting under the influence of drugs (34%) and thieving in order to get money to buy drugs (30%). Perceptions that there were ‘very big’ or ‘fairly big’ drug-related problems in local areas had fallen ‘slightly but significantly’ since 1996, except for crimes committed by people under the influence of drugs and people becoming ill or dying due to the use of drugs, where perceptions of their seriousness had increased. Perceptions that there were drug-related problems were found to be more frequent among respondents in Cork City and County Kerry than in Cork County, among manual workers and small farmers (on 49 acres or less) than among professional, managerial and business people and larger farmers (see report for details of social classification system used in analysis), and among those living in deprived urban areas.

While 55% of respondents supported current drug prohibition laws, ‘quite a significant minority’ (33%) were of the opinion that some drugs (e.g. cannabis) should be legal, but with restrictions (e.g. licensing of a few shops/bars only). Since 1996 there had been a 12% increase in support for the legalisation of cannabis with restrictions, and a corresponding drop (14%) in support for continuing prohibition of all currently illegal drugs. Those who had ever taken drugs showed markedly greater support for the legalisation of cannabis and the relaxation of the prohibition laws, compared to those who had never taken drugs.

Responses to a question about whether alcohol or drugs caused more problems in society showed a reversal of opinion. In 1996, 81% of respondents considered drugs to be an equal or greater problem than alcohol, but by 2004 this proportion had dropped to 61%. Conversely, in 1996, 40% considered alcohol to be an equal or greater problem than illicit drugs, but by 2004 this proportion had grown by 27%. Disagreement with the statement that there is little difference in health terms between smoking cannabis and smoking tobacco or drinking alcohol had declined somewhat since 1996.

1.5.3 Initiatives in parliament and civil society

Five reports investigating and making recommendations with regard to aspects of Irish drug policy have been published by two separate entities – the Joint Committee of the Oireachtas (Houses of Parliament) on Arts, Sports, Tourism, Community, Rural and Gaeltacht Affairs has published three reports, and the Drug Policy Action Group, a civil society organisation, two reports. The general election held in May 2007 also elicited several new proposals relating to drug policy from various political parties.

Made up of members of both Houses (Dáil and Senate), the Joint Committee of the Oireachtas on Arts, Sports, Tourism, Community, Rural and Gaeltacht Affairs scrutinises the work of two government departments, including the Department of Community, Rural and Gaeltacht Affairs, which is responsible for co-ordinating the National Drugs Strategy. In respect of its three drug-related reports – on cannabis, alcohol and drugs, and the drugs situation in Waterford – the Joint Committee commissioned independent experts to undertake studies and, having considered the experts’ reports and also public submissions made to the Committee, it made recommendations. The recommendations are listed below. Once the Committee has published its reports and recommendations, it is for the House(s) of the Oireachtas to decide on any follow-up action.

The inclusion of alcohol in a National Substance Misuse Strategy (Joint Committee on Arts Sport Tourism Community Rural and Gaeltacht Affairs 2006b). In her Foreword to this report, the Chair wrote,

> [alcohol] is a toxic or poisonous substance, it is an intoxicant and it is also a drug of dependence. Yet between 1989 and 1999 our per capita consumption rose by 41%. The latest EU research indicates annual consumption per capita of some 15 litres of pure alcohol. And have we not seen and continue to see the results: huge numbers of binge drinkers, street aggression and violence even fatalities, streetsides running puce with vomit, fistfights in accident and emergency wards and of course the inevitable fracturing of relationships and family groupings.

The Chair noted that, while the consultants were charged with the preparation of a report on the inclusion of alcohol in the National Drugs Strategy, the Committee took a slightly different approach in that they were 'loath to have alcohol classified alongside heroin and cocaine etc., and all that that entails'. As a consequence, the Committee made the following recommendation:

> The Joint Committee recommends that alcohol should be included in a new national substance misuse strategy. This will have the effect of cementing alcohol policy at the Governmental level satisfying growing public demand for an integrated policy response to alcohol-related problems.

What everyone should know about cannabis (Joint Committee on Arts Sport Tourism Community Rural and Gaeltacht Affairs 2006a). In her Foreword, the Chair of the Joint Committee noted,

> Members of the Joint Committee are convinced that the only attitude to cannabis should be – 'noli tangere' or do not touch as the Romans used to say and that there should be no movement towards the liberalisation of the legal sanctions which attach to the possession of, use and dealing in this truly noxious weed. Finally the Joint Committee wish to see the full rigours of the law applied to those who benefit financially from trading in cannabis.

In presenting its recommendations, the Joint Committee stated that, as a first principle, it regarded 'cannabis as being as socially unacceptable as other harder drugs such as cocaine and heroin and those who profit from it should be pursued with the full rigour of the law'. It recommended the following:

1. A national strategy be drawn up with the aim of reversing the exponential rise in cannabis use over the past decade; particular emphasis to be paid to young women of childbearing age and their offspring, and to young people, given their vulnerability to mental health problems. There is now compelling evidence that cannabis alone can result in later development of psychotic illness.
2. Support for further neurobiological and clinical research to examine the long term cognitive impairment effects associated with heavy cannabis use, particularly those impairments relating to heavy use in adolescence and to prenatal exposure to cannabis.
3. Attention be drawn to the physical effects of cannabis use and to the fact that the health risks are greater than those for conventional tobacco (more carcinogens, higher tar content).
4. Greater resources devoted to the criminal side and a more proactive pursuit of those who gain from it financially as is the case with the Class A drugs.
5. Awareness of the risks of cannabis use raised through public information campaigns focused particularly on young people and their parents, and understanding that cannabis is primarily a health issue.
6. The adoption of prevention strategies where primary prevention attempts to reduce the number of new cases of cannabis use, where secondary prevention seeks to lower the rate of problem cannabis use and where tertiary prevention seeks to decrease the amount of disability associated with problem cannabis use.

7. integrated treatment programmes for those with concurrent mental illness and substance abuse as individuals experiencing these disorders together face particular difficulty receiving diagnostic and treatment services.

Drug abuse in Ireland – a Waterford perspective (Joint Committee on Arts Sport Tourism Community Rural and Gaeltacht Affairs 2007) finds that the majority of people seeking help for addiction in the Waterford constituency are using more than one drug, with alcohol and hash being by far the most popular cocktail in almost two- thirds of cases. A history of addiction in the family is overwhelmingly prevalent. Having previously focused its inquiries at the national level, the Committee decided to target one area. The Chair observed that this approach

> graphically depicts the sordid and insidious drugs scene in that geographic area. There are no punches pulled and the seamy underside of our society, interlinked with drug and alcohol abuse is portrayed in a matter of fact fashion. I wonder how many more Reports are required before we as a nation admit to the pervasiveness of drug abuse and provide adequate resources that are needed to tackle it with the emphasis on the treatment and care of our fellow countrymen and women who have fallen victim to its ravages.'

The Joint Committee recommended:

- more detailed research into the extent of substance abuse in Waterford city and county;
- an extension of the 'Walk Tall' support service to other areas of disadvantage outside of the Local Drugs Task Force area;
- innovative research to ascertain why people are resorting to drugs; why is there a failure on the part of users of 'leisure' drugs such as cocaine, to make a connection between their expenditure and the crime-driven drugs market;
- more targeted measures aimed at parents to enable them to recognise the beginnings of substance abuse in children;
- the putting in place of a system and identifiable statutory structure where named individuals are accountable for the implementation of a case-plan to ensure that at-risk young people do not become drug addicts;
- improved work with families to ensure that such case-plans are followed through to a successful conclusion;
- improved measures aimed at supporting families in adjusting lifestyles where the parental attitude to alcohol and other substance abuse is a contributing factor in children's potential to abuse substances both legal and illegal;
- the examining of new policies such as enabling the Criminal Assets Bureau to seize property such as pubs and clubs where there are court convictions for drug dealing and drug-taking by dealers and users on the premises;
- the Gardaí objecting to the renewal of a pub or club licence where drugs offences have been discovered;
- the provision of adequate court facilities in Waterford and other counties, to enable speedy processing of cases involving drugs offences;
- empowering and supporting public servants in facilitating the reporting of discrepancies where they have reasonable grounds to suspect that their clients are dealing in illegal substances;
- the undertaking of detailed research in relation to the suicide of young males to ascertain if the use of illegal substances is a factor in these deaths;
- further examination of the wide range of services, projects and personnel working in the area of substance abuse and associated activities to see if over-lapping exists and if so, can duplication be eliminated and a more focused approach adopted to drugs and alcohol abuse programmes and projects;
- the introduction of a system of testing vehicle drivers for intoxication due to the consumption of legal or illegal drugs;

- the introduction of an extra methadone maintenance clinic each week in Waterford city so that addicts and those who are 'clean' of heroin are not meeting regularly, as suggested by one interviewee;
- the community at large, agencies and societies, should debate the merits of a listening rather than a preaching approach in relation to the use of drugs, which could prove more successful with young people;
- the exploration of the role in which the arts (both community arts and arts therapy) can play in regard to preventing young people taking up the drug habit and in assisting the recovery of addicts;
- In its ongoing work over the last four years on drug and alcohol abuse the Joint Committee has always been conscious of the importance of treatment and rehabilitation of the victims given that the therapeutic support for victims and their families comes under the umbrella of the Mental Health Services and given the consistent under-funding of these services the Joint Committee again supports the health professionals and voluntary groups who are continually demanding appropriate resources for those services.

Formed in 2005, the Drug Policy Action Group (DPAG) 'aims to promote an approach to drug policy that challenges ineffective, unfair and counterproductive laws on drugs, and advocates for positive health and social service responses to drug use in Ireland. It also seeks to progress effective evidence-based treatment models that engage drug users, families, and communities in the reversal of the harms associated with problem drug use.' It is affiliated to the International Drug Policy Consortium. Its first two policy reports were published in November 2006.

Policy Paper 1 examines current criminal justice drug policy in Ireland (Cassin and O'Mahony 2006). An analysis of criminal justice policy must consider not only the way in which drug laws are formed in statute but also how they are implemented in practice throughout the system, from police to courts. Highlighting the separation of powers between the legislature and the judiciary, the DPAG policy paper suggests that 'sentencing practice by judges tends to be more lenient than the laws envisage with only a small proportion of all convictions for all drug related offences resulting in a prison sentence' (p. 3).

The causative complexity of the drugs–crime relationship is not, the authors suggest, sufficiently reflected in policy formation. For example, the policy paper criticises 'most politicians' and the Garda Síochána for adhering to policy statements that 'explicitly minimise distinctions between drugs and forms of use' (p. 3). Present policies in Ireland, they argue, 'make no distinction between harms resulting from different kinds of drug use and no distinction between the actions of different user groups'. According to the authors, a consequence of this perceived failure to distinguish between the harmful effects of different drugs is that it can encourage misperceptions among experimental drug users and lead them into further more harmful drug use. It is argued, for example, that people who occasionally use cannabis and ecstasy with little ill effect 'can be led by the prevalent exaggerated claims about the dangers of the less dangerous drugs to dismiss as equally harmless the more problematic drugs like heroin or crack cocaine' (p. 4).

The central argument of the paper is that there is an excessive reliance on legislation and the criminal justice system as a mechanism for dealing with the country's illegal drug problems and that this is generating more problems than it is solving. This apparent imbalance is reflected in disproportionate expenditure on drug services by the Department of Justice, Equality and Law Reform, when compared with expenditure by the Department of Health and Children. Furthermore, the authors argue that most of the recently introduced criminal drug laws target 'already disadvantaged drug using

groups' rather than drug suppliers. They suggest that, given that most drug-related prosecutions are for possession rather than supply,

> it is the user who is predominantly targeted and more deeply inserted into a criminal justice system that can do little to promote personal development or the removal of obstacles to personal growth. This over reliance on the criminal system merely serves to recycle successive generations through criminal processes that become a life norm that perpetrates [sic] the criminal and disadvantaged sector. (p. 4)

Accepting that supply control initiatives can offer 'a containment of criminal elements', the authors argue that an over-reliance on this approach promotes public attitudes that are both anti-drug and anti-drug-user. They suggest that, at times of 'moral panic', and fuelled by an often alarmist media approach, public and political attitudes towards drug users can harden, thus creating and perpetuating 'a culture of marginalised people' who are also criminalised.

The primary focus of drug policy, according to the authors, should be on addressing the demand for drugs and the reasons why some people engage in problem drug use. They advocate a humanistic approach to tackling such problems, premised on the belief that 'people are capable and willing to develop themselves when the internal and external obstacles to that development are removed or reduced' (p. 5). Calling for what they regard as a more appropriate balance between supply control and demand reduction initiatives, the authors highlight 'ambiguities' or apparent conflicts in policy approaches. For example, anti-social behaviour measures such as evictions obtained under the Housing (Miscellaneous Provisions) Act 1997 can render drug users homeless, thereby contributing to increased levels of 'drug use, nuisance and health risks' (p. 5). Another example cited is what they see as the 'persistent disparity in approaches between the Health Services and the Prison Services whereby equal access to services ceases for those beginning a custodial sentence'. The paper calls for a greater use of 'pragmatic' approaches to problematic drug use, such as methadone prescription and needle exchange.

Despite the centrality of the multi-agency and partnership approach to the National Drugs Strategy 2001–2008, the authors question whether there is 'adequate understanding or commitment' to the partnership approach at senior levels in the departments of Justice, Health and Finance. In support of this position, the authors identify what they see as 'the failure to mainstream pilot projects and provide them with a statutory framework, the lack of projected plans to cover the ongoing developments in service delivery, and [the] failure to apply benchmarking to Non Governmental Organisations' (p. 5). They state that the perceived failure at departmental level has ramifications throughout the whole infrastructure of the National Drugs Strategy.

> This apparent lack of partnership working at government department level leads to considerable frustration in the system at local, regional and national team levels and especially amongst those who are exceptionally committed to the partnership approaches.(p. 5)

The authors call upon the National Drugs Strategy Team (NDST) 'to assume its hitherto dormant role of initiating and developing policy for the Government' (p. 6).

The DPAG makes a number of specific recommendations, including:

- The Cabinet sub-committee on social inclusion should request the Law Reform Commission to assist them to review and propose repeals or revisions of drug laws.
- The NDST should appoint a dedicated policy sub-group to review changes in Ireland's criminal justice drug policy.

- Ireland should adopt a system of classification of drug substances similar to that in Britain, where drugs are grouped on the basis of their harmfulness to the individual and to society.
- The role of public representatives on local and regional drugs task forces should be focused on implementing better drug laws which make a distinction between drug activities that actually cause harm and those with low or no harmful consequences.
- The Health Service Executive should support greater access to harm reduction facilities like needle exchanges, safe injection rooms and more widely available alternative prescribing options for long-term drug users.
- The Garda Síochána should develop more focused programmes of training in harm reduction approaches for Garda recruits.

Policy Paper 2*, Social care and drug users in Ireland* (Cox and McVerry 2006), examines the provision of formal, i.e. specialist treatment, services, and drug agencies and generic social care services for problem drug users in Ireland. The report makes five recommendations:

- An understanding should be developed of 'complex needs' which takes into account that each separate need interlocks with all of an individual's other needs and cannot be adequately addressed in isolation from those other needs.
- Social care providers should prioritise the importance of, and agree upon a strategy to develop, a strong organisational commitment to interagency work, which collectively will enhance the provision of social care services in Ireland.
- An interagency strategy should be developed to provide accessible entry to and retention within and across social care services in Ireland.
- The importance of service user involvement in the development and implementation of existing and emerging models of social care delivery for problem drug users should be recognised. A national audit of social care services/agencies should be published as a necessary first step to highlighting the current state of affairs, progress made and necessary improvements.

In the 2007 general election, the political manifestos of the mainstream political parties all addressed the issue of illicit drugs. All party manifestos endorsed the National Drugs Strategy 2001–2008, either directly or indirectly, and made commitments to increase resourcing for various measures in the Strategy. Listed here is a selection of some additional policy proposals not already encompassed, either explicitly or implicitly, in the current national drugs policy.

- We will develop and implement a National Addiction Strategy which addresses both drug and alcohol abuse and the interactions between the two. ((Fine Gael 2007: 8)
- Where teachers and parents decide to introduce random drug and alcohol testing at secondary schools, the Department of Education and Science will cover the cost of such testing. ((Fine Gael 2007: 23)
- In the Dublin area, we will put in place local district courts in each of the main areas of the city and county. In this way, the local judges can build up an understanding of the impact of antisocial behaviour, including drug abuse and drug pushing, on local communities, get to know the offending families, acquire an appreciation of local needs in terms of the community sanctions and community service orders they impose and so discharge in a visible way their obligations to the community for the way they run its court. ((Labour Party 2007: 52)

- Ensure that those brought before the courts can be ordered to undergo treatment for drugs or alcohol addiction. ((Labour Party 2007: 55)
- In the 14 local drug task force (LDTF) areas we will integrate drug and alcohol abuse strategies. Poly-drug use also needs to be addressed by local drug task forces. ((Labour Party 2007: 85)
- Integrate substance abuse strategies with active labour market and local area renewal policies … to give a new sense of community and community renewal to the drug epidemic black spots. ((Labour Party 2007: 85)
- A special task force should respond immediately to the arrival of new illicit drugs. They should be specifically targeted with a view to swiftly identifying the source of supply and eliminating it. (Labour Party 2007: 85)
- Change the criteria to ensure that grandparents or other family members do not have to agree that the child in question was 'abandoned' in order to receive payments to help look after the children of their drug-addicted sons and daughters and bring supports into line with provision for foster parents. ((Sinn Fein 2007: 45)
- Use an all-Ireland approach to ensure the application of the strategic objectives of the National Drugs Strategy to the island (the Republic of Ireland and Northern Ireland] as a whole. ((Sinn Fein 2007: 67)
- Provide substantial funding to set up alcohol and drug-free social environments, such as late opening cafés, aimed at teenagers. ((Sinn Fein 2007: 69)
- Fund sufficient residential drug treatment places for women (alone, or with children). ((Sinn Fein 2007: 69)

Civil society also promoted debate on the issue of illicit drugs. Two civil society organisations – Dublin CityWide Drugs Crisis Campaign and Merchants Quay Ireland – invited representatives of all the main political parties to speak at public meetings on the drugs issue. CityWide launched a campaign, 'Drugs – a new deal', calling on central government to fully implement all the actions in the National Drugs Strategy 2001–2008 and to budget adequate provision for drug services to respond to the emerging trend of increasing cocaine use and to implement the recommendations in the forthcoming rehabilitation report (see Connolly and Morgan 2007). The Jesuit Centre for Faith and Justice in Dublin put out a special election issue of its regular bulletin *Working Notes* (Jesuit Centre for Faith and Justice 2007). In relation to illicit drugs, as well as calling for greater resources and co-ordination of responses, the Centre observed, 'We need to address drug issues, not by demonising illegal drugs and drug users, or by scare-mongering, but examining the evidence-based outcomes from around the world – that is to say, what policies can actually reduce the harm done to individuals, families and society by illegal drug use?'

1.5.4 Mass media campaigns (national and regional)

In line with Action 38 of the National Drugs Strategy 2001–2008, 'to develop and launch an on-going National Awareness Campaign highlighting the danger of drugs', a three-year national awareness campaign was launched in May 2003. Its aim was to increase awareness among the general population about problem drug use and its consequences across society. The campaign, consisting of both advertising and public relations events, had four phases, with each phase focusing on different population groups and topics.

1. The first phase was aimed at the general population and centred on a television and radio advertising campaign with the slogan "Drugs: there are answers".
2. The second phase focused on empowering parents to inform themselves about the realities of the drugs issue in Ireland in order to facilitate more open communication with their children.

3. The third phase, informed by figures from the National Advisory Committee on Drugs bulletins and the National Health and Lifestyles Surveys, focused on cocaine use.
4. The fourth and final phase, launched in October 2005, targeted young people aged 13 to 17 years with messages on the dangers of cannabis use.

In addition to the advertising and public relations elements, a range of information materials, a website and a national helpline were also developed.

From the outset, the National Advisory Committee on Drugs (NACD) planned a process evaluation with a research brief 'to track the development and delivery process of the National Drug Awareness Campaign over three years'. The intention was to award a PhD Fellowship for the conduct of the research. However, as this did not yield a successful outcome, the contract was offered, after a restricted tender process, to the Centre for Health Promotion Studies at NUI Galway in July 2003. A final report has been submitted and is under consideration by the NACD.

Under the Health Act 2004, responsibility for the management and delivery of health and personal social services, including the development and delivery of awareness raising and health information campaigns, transferred to the Health Service Executive at the end of 2005. The HSE's Population Health Directorate now has responsibility for awareness-raising and information campaigns, including the National Drugs Awareness Campaign. It set up a multi-agency advisory group (statutory, voluntary and community sectors) in August 2007 to begin the process of scoping the next National Drugs Awareness Campaign. The emerging issues for the advisory group include cocaine; poly-drug use, and in particular links with alcohol; psycho-social effects of drug use; and families. The awareness campaign will be supported by the Crosscare (DAP) initiative, which will include a text service and updated web site with a 'live help' function. It is envisaged that the National Directory of Services will be integrated with this initiative and will be accessed through the web site and text service.

Action 95 of the National Drugs Strategy calls on local and regional drugs task forces to 'consider the development and implementation of community-based initiatives to raise awareness'. The goal of such initiatives would be to develop best practice models, which would be capable of being mainstreamed. The Strategy envisages that there will be both communities where drug misuse is prevalent and where there is considerable knowledge about all aspects of the drugs issue, where schools can tap into and use this knowledge, and also communities with a very limited knowledge of the nature or manifestations of drug misuse. In these latter areas, it was proposed that the school, the health promotion officer, GPs, pharmacists, the gardaí and others should take the lead in creating a greater awareness of drug misuse.

2. Drug use in the general population and specific sub-groups

2.1 Overview

This section provides an overview of the new developments and trends in drug use in the population in Ireland for 2006 and early 2007.

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

2.2 Drug use in the general population

2.2.1 Cocaine, legal drug and polydrug use in Ireland

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

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

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

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

Of the 27 self-defined regular cocaine powder users, almost 62% had successfully stopped taking cocaine. The most common reasons for discontinuing its use were: cost (42%), unwillingness to continue using (35%), health concerns (32%) and pressure from family and friends (32%).

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

On 22 March 2007 the NACD and the DAIRU published jointly the fifth and sixth bulletins of results from the 2002/2003 all-Ireland general population drug prevalence survey (NACD and DAIRU 2007a, 2007b). Bulletin 5 focuses on polydrug use in the adult population (15–64 years) and Bulletin 6 focuses on sedative, tranquilliser or anti-depressant use in the adult population. The questionnaire and methodology for the survey were based on guidelines from the European Monitoring Centre for Drugs and Drug Addiction and the questionnaire was administered in face-to-face interviews.

For the purpose of Bulletin 5, polydrug use is defined as use of two or more drugs in the last month. Polydrug use involves the concurrent use of two or more of the following substances alcohol, tobacco, any illegal drug or any other legal drugs (sedatives, tranquillisers or anti-depressants). The findings for Ireland are presented below.

Just under one-fifth (19%) of the 4,918 survey respondents reported that they had not used any substance in the last month. Among those who had used drugs in the last month, the most common substance combinations were:

- 24% had used alcohol and tobacco
- 1.9% had used alcohol, tobacco and at least one illegal drug
- 1.4% had used alcohol and sedatives, tranquillisers or anti-depressants
- 1% had used alcohol, tobacco and sedatives, tranquillisers or anti-depressants
- 0.6% had used alcohol and at least one illegal drug
- 0.5% had used tobacco and sedatives, tranquillisers or anti-depressants
- 0.2% had used tobacco and at least one illegal drug
- 0.2% had used alcohol, tobacco, at least one illegal drug, and sedatives, tranquillisers or anti-depressants
- 0.1% had used tobacco, at least one illegal drug, and sedatives, tranquillisers or anti-depressants

The combination of alcohol, tobacco and any illegal drug was more commonly reported by men (2.7%) than by women (2.1%). A higher proportion of young adults (15–34 years) reported that they had used alcohol with tobacco than their older counterparts (35–64 years), 28% compared to 21%. As expected, the same trend was observed for alcohol, tobacco, and at least one illegal drug, with 3.4% of young adults and 0.6% of older adults reporting this combination. The results of the polydrug use survey reflect drug use in recreational situations rather than problematic drug use in socially deprived areas or among treated problem drug users.

For the purpose of Bulletin 6, sedatives, tranquillisers and anti-depressants were grouped as a collective and were not presented by their individual drug families. The main measures of use were lifetime (ever used), use in the last year (recent use) and use in the last month (current use).

The key findings were:

- One in five (22%) respondents reported that they had taken sedatives, tranquillisers or anti-depressants during their lifetime. Of these respondents, 95% said that the drug was prescribed.
- Females reported higher prevalence rates than males for all three time measures.
- The average age for first use of sedatives, tranquillisers or anti-depressants was 28 years for males and 30 years for females. Those in the younger age group (15– 34) reported average age of first use at 22 years, while those in the older age group (35–64) reported first use at 37 years; this may indicate two different patterns among the user population.
- Ten per cent of respondents had used sedatives, tranquillisers or anti-depressants in the last month and, of these, 84% had taken them on a daily basis.
- Sedative, tranquilliser or anti-depressant use was more likely among those who were over 35 years, or long-term unemployed, or had left school at primary level.

2.2.2 Drug use among the general population, 2006/7

Between September 2006 and June 2007, a repeat survey of drug use in the general population was carried out. In October 2007, the NACD released preliminary prevalence estimates from this national survey (J Barry, personal communication, 2007). With the exception of two questions and two show cards, the methods employed in the 2006/7 survey were the same as those used in 2002/3.

The new detailed estimates for Ireland are presented in the on-line version of Standard Table 1. The key findings and comparisons with the 2002/3 survey are described in this section. The proportion of adults (aged 15–64 years) who reported using an illegal drug in their lifetime increased from 19% in 2002/3 to 24% in 2006/7 (Table 2.2.1). The proportion of young adults (aged 15–34 years) who reported using an illegal drug in their lifetime also increased by 5%, from 26% in 2002/3 to 31% in 2006/7. As expected, more men than women reported using an illegal drug in their lifetime. The proportion of adults who reported using an illegal drug in the last year increased marginally, from 6% in 2002/3 to 7% in 2006/7 (Table 2.2.1). The proportion of young adults who reported using an illegal drug in the last year increased from 10% in 2002/3 to 12% in 2006/7. The proportion of adults who reported using an illegal drug in the last month remained stable.

Table 2.2.1 Lifetime, last-year and last-month prevalence of illegal drug use in Ireland, 2002/3 and 2006/7

Illegal drug use*	Adults 15–64 years %		Males 15–64 years %		Females 15–64 years %		Young adults 15–34 years %	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
During lifetime	18.5	24.0	24.0	29.4	13.1	18.5	26.0	31.4
During last year	5.6	7.2	7.8	9.6	3.4	4.7	9.7	12.1
During last month	3.0	2.9	4.1	4.3	1.7	1.4	5.2	4.8

* Illegal drugs in this context are amphetamines, cannabis, cocaine powder, crack, ecstasy, heroin, LSD, magic mushrooms, poppers and solvents.
Source: NACD and DAIRU (2005, 2007).

Cannabis was the most commonly used illegal drug. The proportion of adults who reported using cannabis in their lifetime increased from 17% in 2002/3 to 22% in 2006/7 (Table 2.2.2). Proportions using cannabis reflect the same trends as proportions using any illegal drugs, as described above.

Table 2.2.2 Lifetime, last-year and last-month prevalence of cannabis use in Ireland, 2002/3 and 2006/7

Cannabis use	Adults 15–64 years %		Males 15–64 years %		Females 15–64 years %		Young adults 15–34 years %	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
During lifetime	17.4	21.9	22.4	27.0	12.3	16.6	24.0	28.6
During last year	5.0	6.3	7.2	8.5	2.9	3.9	8.6	10.4
During last month	2.6	2.6	3.4	4.0	1.7	1.2	4.3	4.2

Source: NACD and DAIRU (2005, 2007)

Prevalence of other illegal drugs was lower among the adult population than among the 15–34-year-olds. Nine per cent of young adults claimed to have tried ecstasy at least once in their lifetime in 2006/7 (Table 2.2.3).

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

Ecstasy use	Adults 15–64 years %		Males 15–64 years %		Females 15–64 years %		Young adults 15–34 years %	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
During lifetime	3.7	5.4	4.9	7.2	2.6	3.6	7.1	9.0
During last year	1.1	1.2	1.7	1.8	0.5	0.6	2.0	2.4
During last month	0.3	0.3	0.7	0.5	0.0	1.1	0.6	0.6

Source: NACD and DAIRU (2005, 2007)

The proportion of adults who reported using cocaine (including crack) in their lifetime increased from 3% in 2002/3 to 5% in 2006/7 (Table 2.2.4). The proportion of young adults who reported using cocaine in their lifetime also increased, from 5% in 2002/3 to 8% in 2006/7. As expected, more men than women reported using cocaine in their lifetime.

The proportion of adults who reported using cocaine in the last year increased from 1% in 2002/3 to 2% in 2006/7 (Table 2.2.4). The proportion of young adults who reported using cocaine in the last year increased from 2% in 2002/3 to 3% in 2006/7. The proportion of adults who reported using cocaine in the last month also increased.

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

Cocaine use	Adults 15–64 years %		Males 15–64 years %		Females 15–64 years %		Young adults 15–34 years %	
	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7	2002/3	2006/7
During lifetime	3.0	5.0	4.3	7.0	1.6	3.5	4.7	8.2
During last year	1.1	1.7	1.7	2.3	0.5	1.0	2.0	3.1
During last month	0.3	0.5	0.7	0.8	0.0	0.2	0.7	1.0

Source: NACD and DAIRU (2005, 2007)

2.2.3 Repeat survey of substance use in Cork and Kerry

A survey conducted in 2004 reviewed substance use in the former Southern Health Board area and compared findings with a study conducted by the same author in 1996 (Jackson 1997, 2006). The 2004 survey was in two parts,[4] using a similar method to that used in 1996. This section refers to the second part of the survey, a self-completion questionnaire which related to usage of drugs and personal knowledge of people who had received or might need professional advice for alcohol- or drug-related problems. The final analysis was based on 1,508 respondents from the main sample and 909 from the booster sample.

Drugs were categorised into cannabis, stimulants, opiates, hallucinogens, sedatives and solvents. Drug use was classified according to whether the substance was ever taken (lifetime use), taken in the last year (recent use) or taken in the last month (current use). The use of cannabis (in all forms) had doubled since 1996, with 32% reporting lifetime use, 14% reporting recent use and 7% reporting current use of the drug. The use of stimulants in general and ecstasy in particular had also doubled since the previous survey in terms of both lifetime use (stimulants 10% and ecstasy 7%) and recent use (stimulants 4% and ecstasy 2.5%).

The numbers using cocaine and heroin remained low but there were marked increases in usage of these drugs since 1996. Lifetime use of cocaine increased from 1.1% to 6% and recent use increased from 0.4% to 2.5%. Lifetime use of crack increased from 0.3% to 2%. Lifetime use of opiates doubled to 2% and recent use increased from 0.3% to almost 1%. Lifetime use of heroin increased from 0.2% to 1.6% and recent use increased from 0.2% to 0.5%.

The author of the 2004 study compared his findings in relation to drugs with the NACD general population survey of 2002/2003. Overall drug use was much higher in the former South Eastern Health Board area than the levels reported in the NACD survey (Table 2.2.5). According to the author, this may be due to methodological differences between the two studies. The NACD survey used direct interviewing throughout, but drug-use data in this study were gathered using a confidential self-completion questionnaire. Research suggests that self-administered questionnaires lead to increased reporting of drug use, especially of stigmatising drugs, while direct interviewing may bias respondents towards what they perceive to be more socially acceptable answers.

Table 2.2.5 Last-year prevalence of drug use in Ireland (2002/3) and in the Southern Health Board area (2004 and 1996)

Recent use (in the last year)	NACD general population survey 2002/3 %	Southern Health Board (HSE South) 2004 %	Southern Health Board (HSE South) 1996 %
Cannabis	5.0	14.0	6.6
Ecstasy	1.1	2.5	1.9
Cocaine	1.1	2.5	0.4
Crack	0.1	0.8	0.2
Heroin	0.1	0.5	0.2

[4] The findings of the first part of the survey, in respect of community awareness and perceptions of drugs and related issues, are reported in Section 1.5.1.

2.3 Drug use in the school and youth population

2.3.1 Drug use among 15–16-year-old children

The third ESPAD survey was published in December 2004 (Hibell *et al.* 2004). The results were presented in the 2005 and 2006 national reports. The fourth ESPAD survey will be conducted in 2007 and results will be presented in the 2008 report.

2.3.2 Trends in medical student use of tobacco, alcohol and drugs in an Irish university, 1973–2002

Questionnaire surveys of medical students in an Irish university were carried out in 1973 (n = 765), in 1990 (n = 522) and in 2002 (n = 537). A recent paper reports on changes in tobacco smoking, drinking and drug use identified by these surveys (Boland *et al.* 2006). Among western students, the estimated prevalence of current smoking declined considerably, from 28.8% in 1973 to 15.3% in 1990, and to 9.2% in 2002. The decline in smoking was observed among both males and females. The percentage of ex-smokers rose from 5.9% to 15.1% between 1990 and 2002, corresponding to the decline in current smokers. The prevalence of current drinkers increased over the period, rising to 82.5% among western students in 2002. The percentage of women drinking increased steadily from 61.4% in 1973 to 81.8% in 2002. The overall proportion of CAGE-positive drinkers had risen from 34.4% in 1990 to 52.5% in 2002. The mean weekly alcohol consumption by both men and women had risen since 1990 (from 14.3 to 19.4 units in males; from 6.0 to 9.5 units in females). The percentage of students accepting drugs increased from 32.0% in 1973 to 46.2% in 2002. Increased drug use was reported by both genders. Despite the decrease in smoking rates, the research showed an increase in alcohol and drug consumption between 1973 and 2002. Personal misuse of addictive substances by doctors may mean that doctors will fail to take misuse by patients seriously. The need for preventative and ameliorative action during the medical school years is clear.

2.4 Drug use among specific groups (prisoners, homeless, early school leavers, conscripts, minorities and sex workers)

2.4.1 The Traveller community

A report on the nature and extent of illicit drug use in the Traveller community in Ireland was published in 2006 (Fountain 2006). The report provides data on drug use, the patterns of drug use, problematic drug use, drug-related risk behaviours, the effect of drug use on the Traveller community and gaps in service provision. The data-collection techniques included a comprehensive review of the literature, interviews with 34 agency staff, focus groups with 122 Travellers and one-to-one interviews with 15 Travellers who were using or had used drugs. The data were analysed thematically using a grounded theory approach.

According to this report, it is estimated that there are 30,000 Travellers in Ireland and a further 15,000 in the UK. Many of those living in the UK travel between there and Ireland on a regular basis. Travellers have their own language and distinct culture, with a unique value system and specific customs and traditions. Successive governments have introduced legislation and policies to protect the rights of Travellers, but many of these are not implemented in a systematic way throughout the country. Travellers continue to experience discrimination and marginalisation. The author reported that they are socially excluded and do not have equal access to education, health care, employment or accommodation. Traveller children are six times more likely to be cared for by local authorities than children in the general population. The Traveller

community, like other socially excluded populations, is vulnerable to problematic drug use.

As the author notes, the 2002/2003 national survey of drug use in the general population (NACD and DAIRU 2005a) did not record ethnicity, and nor does the National Drug Treatment Reporting System (NDTRS). Consequently, there are no reliable estimates of either drug use or treated problem drug use among the Traveller population. Following requests from some of the addiction service managers, the NDTRS will introduce a system to identify the number of Irish Travellers seeking treatment from 2007 onwards.

Qualitative research indicates that cannabis, sedatives, tranquillisers and antidepressants are the drugs most commonly used in the Traveller community. These are followed by cocaine and, to a lesser extent, ecstasy. These findings mirror the pattern of drug use in the general population. In addition, the Traveller population reported occasional use of amphetamines. The less common substances used by Travellers were heroin, crack cocaine, LSD and solvents, again mirroring the pattern in the general population. Injecting drug use among the Traveller community was not commonly reported. As in the general population survey, more male than female Travellers used drugs, and those in the age range between adolescence and early thirties were more likely to be users. The impact of drug use on Traveller users included poor personal health, involvement in criminal activity, exclusion from the family and the broader community, and stigmatisation. Members of the drug user's family were likely to suffer from stress.

The Travellers interviewed described some of the ways their community dealt with drug use, including home detoxification, avoiding drug-using friends, promising a priest not to use any more drugs and seeking treatment. The author reported that formal treatment was rarely sought. There was no consensus on how to deal with drug dealing in the Traveller community and it was reported that the gardaí were reluctant to tackle the issue. There was evidence throughout the research findings that there was a lack of knowledge about drugs and drug use among Travellers. There are a number of barriers to accessing drug treatment services: lack of awareness of such services, lack of formal education, stigma and embarrassment, lack of cultural competence among service providers and perceptions of racism within services.

The key recommendations of the report were:

- Develop procedures on ethnic monitoring.
- Carry out equality proofing of policies and procedures in social, health and drug-related services.
- Increase awareness of drugs and drug use among Travellers using appropriate methods.
- Adapt the existing drug services so that Travellers can access them.
- Implement a process to engage the Traveller community in addressing drug use.
- Conduct further research.

2.4.2 Pregnant women

Barry and colleagues completed a study estimating the prevalence of alcohol, cigarette and illicit drug use by women attending the Coombe Women's Hospital in Dublin between 1988 and 2005 (Barry *et al.* 2006). Anonymous data relating to 43,318 records were extracted from a computerised database maintained by nursing and clerical staff at the hospital. In June 1999, some questions on the database were revised and new questions were added. The data in this section present results pertaining to drug use during pregnancy from 1 June 1999 to 30 March 2005.

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

Table 2.4.1 Drug use during pregnancy, 1999 to 2005

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

*The total number of drugs is greater than the total number of women as some women used more than one drug.
†These numbers do not discriminate between prescribed and street use.

2.4.2 Young people in detention schools

The report, *Emotional intelligence, mental health and juvenile delinquency*, revealed that young people in detention schools in Ireland experience high rates of psychiatric disorders, engage in serious criminal activity and have significant deficits in emotional intelligence and cognitive ability (Hayes and O'Reilly 2007).

Researchers interviewed three groups of adolescent males (average age 14.9 years): 30 participants were residing in juvenile detention schools (the offender group), 20 had been referred to an adolescent mental health service in HSE South (the mental health group), and 30 were recruited from a secondary school in County Cork (the control group). They used a number of validated instruments to determine each child's emotional intelligence and mental well-being, and obtained demographic characteristics and history of offending by means of a questionnaire.

Eight out of ten (83%) of the offender group met diagnostic criteria for at least one psychological disorder, with the average being 3.1 disorders per detainee, which was considerably higher than that in the mental health group. Of the offender group, 18.5% reported experiencing thoughts of suicide, and the same percentage reported that they had attempted to take their lives on at least one occasion. Over one-third (38%) met diagnostic criteria for internalising (emotional) disorders such as anxiety and depression, and 68% for externalising (disruptive) disorders such as conduct and attention deficit disorders.

Sixty-seven per cent of the offender group met the criteria for at least one substance-related disorder. Approximately equal numbers reported using cocaine (13/30), alcohol (14/30) and cannabis (14/30). Based on participants' reports of substance use in the 12 months prior to interview, researchers assigned them to one of three categories: dependency disorder (those addicted to one or more substances, n=14);

use disorder (regular users of one or more drugs but who did not have a diagnosis of addiction, n=5); sporadic users (those who had used drugs in the past 12 months but not in sufficient quantities to warrant a diagnosis of dependency or use disorder, n=5) (Figure 2.4.1). One member of the offender group reported not having taken any drugs or alcohol in the previous 12 months.

Detainees with substance dependency disorders reported that they first began to use alcohol and cannabis at an average age of just nine years, and cocaine at 13 years. The majority did not receive treatment for psychiatric or substance use problems. Despite incarceration, these boys had continued access to alcohol and drugs, possibly through home leave, during family visits or during court appearances. According to the authors, this continued access to drugs and alcohol served to sustain their dependency and use difficulties.

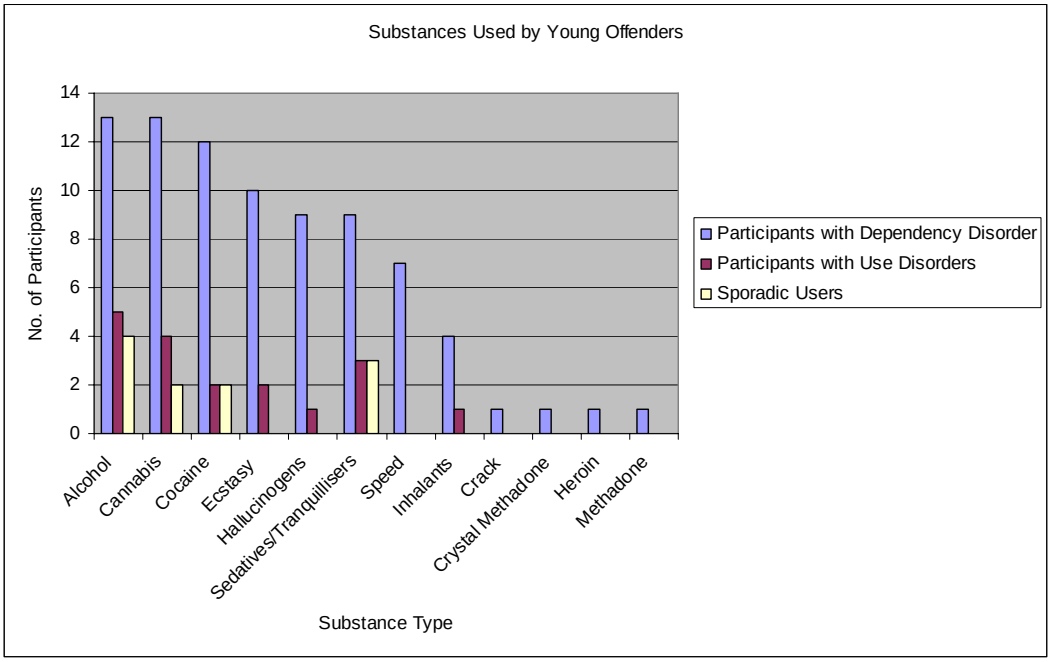


Figure 2.4.1 Substances used by young offenders in the year prior to interview
Source: Hayes and O'Reilly (2007)

A total of 335 crimes were committed by the 30 young detainees. These offences included acquisitive crimes, property crimes, driving offences, violent interpersonal offences, and failure to comply with a Garda/court order. Figure 2.4.2 shows the number of charges within each crime category. The largest crime category was acquisitive crime, with 123 charges being held by 25 of the 30 participants. Although the majority of the participants had substance-related disorders, none was detained on an alcohol-related charge, and only one held a drug-related charge (possession of a controlled substance) The results also indicate high rates of recidivism, with over three-quarters (76.7%) of the sample having been detained on at least one other occasion.

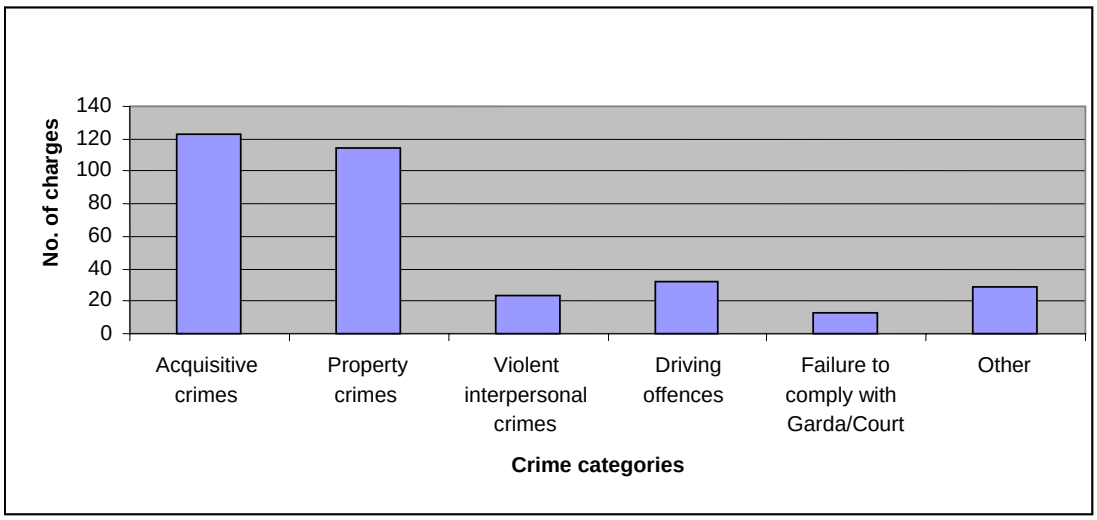


Figure 2.4.2 Number of criminal charges against respondents, by crime category
Source: Hayes and O'Reilly (2007)

The authors conclude that the level of criminality among youths in detention schools is very serious, with about one in three detainees charged with at least one offence relating to interpersonal violent crime. They state that the emotional intelligence deficits of the detainees may make it difficult for them to fully understand how their offending behaviour impacts on others, and that 'a reduced capacity to regulate emotions could maintain offending patterns of behaviour in detainees' (p. 55).

The authors suggest that the findings indicate a causal relationship between levels of substance abuse and incidence of criminality. The report states that 'in light of the high rates of substance related disorders amongst young people in detention it is not surprising that acquisitive crimes were the offences most frequently engaged in by the majority…. these findings point to the possibility that the proceeds from acquisitive crimes could be associated with the funding of drug or alcohol use' (p. 46).

The report sets out a number of key recommendations, including the establishment of multi-disciplinary assessment and intervention teams to break patterns of offending behaviour, to treat mental health difficulties and to improve emotional competency.

3. Prevention

3.1 Overview

Based on the findings of a survey by the Department of Education and Science (unpublished) it would appear that the implementation of substance use policies in schools remains unfinished and that the quality of policies is higher in primary schools than in post-primary schools. The provision of drug education targeting young people in schools and their families has become controversial, with approaches that are at variance with best practice being advanced. The development of selective prevention targeting young people in non-school settings was prioritised in the mid-term review of the National Drugs Strategy.

Current policy and practice in selective prevention targeting 'at risk' youth favour the use of recreational and sporting pursuits as a diversionary tactic to steer at risk young people from engaging in drug use. A key method in this approach is to provide funding for the recreational and sporting facilities under the Young People's Facilities and Services Fund (YPFSF). However, recent research (Byrne *et al.* 2006: McGrath and Lynch 2007) indicates that current provision is not meeting the recreational needs of young people.

Research by Duggan (2007)) shows that families trying to cope with heroin use do not have access to appropriate information and support when they most need it, and research by McKeown and Fitzgerald (2006) highlight the negative impact that drug use has on family well-being in a disadvantaged community. Loughran and McCann (2006) document the continuing plight of communities where problematic drug use and related problems remain quite high despite numerous attempts by policy and practice to tackle the problems since 1996.

Finally, a recent review of teenage counselling services highlights the achievements that can be made through indicated prevention when working with young vulnerable people to reduce some of the risk factors that can contribute to drug use (Teen Counselling 2007).

3.2 Universal prevention

3.2.1 School

Substance use policies in schools

The mid-term review of the National Drugs Strategy 2001–2008 amended Action 43 to focus on the implementation and monitoring of substance use policies in schools. The replaced action, now in two parts, now reads:

> Substance use policies should be developed and implemented in all LDTF area schools by end of 2005/06 academic year.
>
> A mechanism to monitor the development of substance use policies in all schools should be put in place and should report annually.

The Department of Education and Science (DES) sought to establish the extent of implementation in 2005, while also piloting a survey that could be used for monitoring implementation on an ongoing basis. Ten regional DES offices sent the survey to a sample of schools in December 2005. The response rate for primary schools was 69.7% and for post-primary schools 72.1%. This was judged a low response rate by the DES and it has yet to be decided if schools will be surveyed on an ongoing basis as part of the monitoring of implementation of policies. Results of the pilot survey are given in Table 3.2.1 and Table 3.2.2.

Table 3.2.1 Status of substance use policies in primary schools

Policy in place	72.5%
Being developed	16.7%
Not in place	10.8%

Source: DES, personal communication, 2007

Table 3.2.2 Status of substance use policies in post-primary schools

Policy in place	79.2%
Being developed	16.8%
Not in place	4.0%

Source: DES, personal communication, 2007

The National Drugs Strategy 2001–2008 has emphasised the importance of implementing substance use policies in schools in the 14 local drugs task force (LDTF) areas. These are areas that have been designated high status in terms of developing responses to drug-related problems. The DES survey resulted in 47 responses from primary schools in LDTF areas, 95% of which reported having a substance use policy in place. Post-primary school responses in LDTF areas numbered 27, of which 96.3% reported having a policy in place. The survey revealed great variation in the quality and content of policies. Policies in primary schools tended to be of higher quality than those in post-primary schools (DES, personal communication, 2007).

The *Report of the Steering Group on the Mid-Term Review of the National Drugs Strategy 2001–2008* amended Action 31 to read:

> Appropriate and ongoing training and support services should be put in place on a nationwide basis for teachers to deliver SPHE in schools.

The Social, Personal and Health Education programme (SPHE), which includes one module on substance use, is now part of the curriculum for all students in primary schools and in the junior cycle of post-primary schools .Recent information from the DES indicates that an SPHE 40-hour elective module is being prepared for delivery in teacher training courses at St Patrick's College in Dublin. Negotiations are under way with other teacher training colleges to include the SPHE module. This will augment the national support service for SPHE that provides training for all SPHE teachers at post-primary level up to Junior Certificate level. In-service training is provided in modules, from an introductory course through to refresher courses (DES, personal communication, 2007).

3.2.2 Family

The *Report of the Steering Group on the Mid-Term Review of the National Drugs Strategy 2001–2008*, under the heading 'supports for parents and families', amended Action 35 to read:

> Factual preventative information for parents and families in dealing with substance misuse should be more easily accessible in appropriate locations such as Garda Stations, libraries, health centres and other local offices.

A number of recent initiatives appear to respond to this action. For example, the Health Service Executive launched a new parenting campaign in April 2007. The campaign, called *'*Parents who listen, Protect*'*, is supported by the Irish Society for the Protection of Cruelty to Children (ISPCC), Barnardos and the National Youth Council of Ireland. The campaign includes radio and television broadcasts over 4–5 weeks reminding parents to 'Take time to listen to your children – they may have something important to

say'. The campaign includes a handbook that was circulated to households. The handbook includes guidelines on positive parenting and how to support children through the early years, their experience of school and their teenage years. The handbook encourages parents to discuss alcohol and drugs openly with their children and advises parents to become informed about the risks and consequences of alcohol and drug use. It also contains a warning on the abuse of alcohol and drugs by adult family members and the likely impact this can have on children's development. The handbook can be downloaded from www.hse.ie and is available in the following languages; Russian, French, Lithuanian, Polish, Chinese, Romanian and Latvian.

An awareness campaign called Empower Óg was launched by the DES in April 2007. The campaign was designed in conjunction with the Psychology Services in the Tipperary Regional Youth Services. Its primary aim is to educate and generate family discussion around the theme of adolescent substance misuse. The campaign includes a 20-minute DVD, primarily aimed at parents and their children who are at the transition stage of moving from primary into post-primary schools. The various problems that children can encounter are described in stages that include tobacco, alcohol, cannabis, inhalants and amphetamines (speed). The DVD uses the 'power of example' to structure the presentation, moving between positive and negative examples. This use of examples appears to be based on the assumption that adolescent substance use behaviour is often modelled on the behaviour of 'significant others' in their social setting. The DVD was distributed to all primary schools and public libraries in the country. Primary schools are also sent an interactive questions and answers card game that encourages students to discuss the DVD in class following viewing.

However, the DVD met with a degree of resistance from the Irish National Teachers Organisation (INTO), which advised principals and teachers not to show the DVD to children without reviewing it thoroughly in the context of their own school policies on the issue. The INTO expressed concern that the DVD, aimed at 8–14-year-olds and their families, explicitly demonstrates how to use drugs such as solvents and amphetamines. The INTO also pointed out that a newspaper article that covered the topic noted that 'the content of the DVD was at variance with best practice guidelines that recommend drug prevention education be taught in the context of the Social, Personal and Health Education (SPHE) programme'. (*Irish Independent*, 11 May 2007). However, a leading consultant psychiatrist with the Drug Treatment Centre Board who has a special interest in adolescent substance misuse has come out in support of the Empower Óg project. In an article in the *Irish Medical Times*, Dr Bobby Smyth is quoted as saying 'The DVD should provide a useful tool to educators who could use it as a launch pad for discussions with teenagers or parents in group settings' (*Irish Medical Times*, 11 May 2007).

3.2.3 Community

No new information

3.3 Selective prevention

3.3.1 Recreational settings

No new information

3.3.2 At-risk groups

The mid-term review of the National Drugs Strategy, under the heading 'Prevention programmes in non-school settings', amended Action 37 of the Strategy to read:

> A working group should be established – under the aegis of the Department of Education and Science – to examine this area, to identify ongoing gaps and to develop guidelines and models of best practice for the implementation of substance use programmes in non-school settings.

According to the DES, the establishment of this working group has been delayed, mainly due to the ongoing work of the Working Group on Drugs Rehabilitation. It is envisaged that representation on the DES working group will largely overlap with that on the Rehabilitation Working Group. Nonetheless, this is an important action within the National Drugs Strategy and underlines the important focus now being attributed to selective prevention.

The prevention of drug use among at-risk young people is mainly provided through the Young People's Facilities and Services Fund (YPFSF). The overall aim is to attract at-risk young people in disadvantaged areas into facilities and activities that can divert them away from the dangers of substance misuse. Recreational and sports activities form the basis of measures provided for under the YPFSF. The National Development Plan 2007–2013 proposes that sport can act as an alternative to young people at risk of engaging in anti-social activity, drug abuse or other criminal activity. The National Action Plan for Social Inclusion 2007–2016 endorses the use of the YPFSF as the primary means of responding to youth at risk from drug misuse.

However, recent research by Byrne *et al*. (2006) examined the free-time and leisure needs of young people aged 12–18 living in four areas in Ireland designated as disadvantaged under the government's RAPID programme. The research included individual interviews with 37 young people and focus group discussions with 43 young people. The researchers reported that there was 'unanimous agreement among the young people that there are insufficient public and private leisure amenities available to them in their areas'.

McGrath and Lynch (2007) highlighted the lack of suitable recreational facilities and spaces for 13–18 year-olds living in East Cork. A total of 702 young people responded to a survey on their experiences of recreational facilities and the researchers also conducted validation groups with some of the young respondents to discuss and develop some of the issues raised in the survey.

Seventy-nine per cent of the young people replied 'No' to the question 'Are there adequate recreational facilities in your area?' and, according to the authors, many replies were conveyed in emphatic terms using capital letters and exclamation marks. Replies included references to young people drinking alcohol, smoking tobacco and using other drugs to 'relieve boredom' in the absence of adequate facilities. Some replies highlighted the prohibitively high cost of using sports facilities and going to the cinema.

When asked 'When you go out, where do you go?', 82.2% replied that they 'hang around' with peers, often despite the disapproval of their parents. In elaborating further, 37.9% stated that they hung around the town centres and streets, 16% at friends' houses and 15.6% in shops or shopping centres.

When invited to identify what they would like to see happening in their areas for young people in the future, respondents said they would like more recreational facilities, including cinema, leisure centre/arcade, pool hall and restaurants (35.6%); sports facilities, including swimming pool and Astroturf (24%); and a place to 'hang around' (22.9%). Research by Devlin (2006) and Lalor and Baird (2006) also highlighted 'hanging around' with peers as a favoured activity among young teenagers in Ireland.

The research also revealed that 'youth cafés' were a favoured option among young people as a place to 'hang out' with their peers. The Office of the Minister for Children (Office of the Minister for Children 2006), as part of the public consultation on the development of a national recreational policy for young people, surveyed young people through secondary schools and organisations involved in the provision of youth recreational pursuits. There were 940 responses to the survey. The most frequently reported need was for more recreational facilities. The most requested recreational facility was somewhere for young people to go with their friends to 'hang out', such as youth cafés.

According to a recent report in the *Irish Times* (4 January 2007), the forthcoming national recreation policy for young people will include provisions for a network of youth café-type facilities throughout the country. It appears that what makes these youth cafés a popular option among young people is that they provide an alcohol and drug-free environment, they provide for unstructured 'hanging out' space, they are cheap to use and provide a safe space to mix with peers. Already, a small number of youth cafés have been set up in Galway, Waterford, Sligo and Dublin.

3.3.3 At-risk families

Information on the plight of families 'at risk' has increased through two recent pieces of research. Research by Duggan (2007) investigated how families coped with heroin use in their families. The research conducted on behalf of the NACD recommends that steps be taken to include the families of heroin users in the overall treatment response. The main goal of the study was to develop a greater understanding of the ways in which families, and in particular primary carers, seek support in coping with heroin use in their families. The research also examined carers' expectations and perceptions of the effectiveness of the support provided. The research used in-depth interviews with the primary carer, in most cases a parent, and usually the mother, in 30 families coping with heroin use. These were augmented by interviews with another family member in the case of seven families. The families were accessed through family support groups.

The study identified seven different stages of families' engagement with heroin use in their family. The overall direction of this process was from powerlessness to empowerment. The different stages were:

1. Ignorance, confusion and denial
2. Coping alone
3. Desperately seeking help
4. Learning about heroin use and getting personal support
5. Supporting non-heroin-using family members
6. Supporting the heroin user in recovery
7. Supporting the community response to heroin use

Three specific ways of interacting with services were identified, reflecting three different roles that families occupied. These were:

- As victims: non-heroin-using family members sought support for themselves in coping with the problems experienced due to heroin use in the family.
- As carers: families, particularly the primary carers, sought support for the heroin user.
- As agents of recovery: families sought to support the user into recovery and address their own needs as a family.

Interviewees complimented hospitals on their responses to the crisis needs of drug users, their children and other family members, but reported that they were poor in

providing follow-up support or information on referral to support services. General practitioners were often the first point of contact for family members seeking help. Responses from GPs varied, with some being of little assistance and others giving valuable information and advice to family members and, often, the heroin user. These responses demonstrate the need for standardised protocols governing the provision of information and support to families seeking help with heroin use through their GPs.

Families reported their contact with the criminal justice system to be ongoing and generally favourable. Gardaí in rural areas and judges were seen as sympathetic. The probation service was complimented for its constant and effective support for both the heroin user and the family.

Drug counsellors were considered helpful and effective for both the heroin user and the family. Treatment centres were acknowledged for treating the user, but the effectiveness of the treatment was not always evident to the families. In addition, there was a perception among family members that treatment centres did not favour including the family in the treatment process and often maintained a distance from the family.

Families acknowledged the role played by methadone treatment in reducing anti-social behaviour among heroin users. However, in general, families were critical of methadone treatment services and were of the view that not enough information was provided about the implications of going on methadone. Families criticised the absence of alternative treatments and expressed the view that methadone maintenance programmes were not conducive to progression to abstinence and reintegration.

Community Drug Teams (CDTs) were highly regarded by those who reported contact with them; however, the view was expressed that CDTs should be available for longer hours and at weekends. Family support groups were also highly rated by families; contact with these groups often marked a turning point in empowering the families to respond to heroin use in their family.

The stereotypical view of heroin use as a problem primarily associated with urban disadvantage often meant that rural families were slow to recognise the problem in their own families and less inclined to accept the problem as something prevalent in their communities. When initially faced with the problem of heroin use by a family member, families often experienced shame and denial due to the perceived social stigma that surrounds heroin use. This had implications for the speed with which they sought help from external sources. At almost every stage of coping with the problem of heroin use, family members were confronted with a lack of information on the type of help they needed, where they could access it and how they could assess its effectiveness.

Research by McKeown and Fitzgerald (2006) examined the impact of drug use on family well-being among users of the Ballyfermot STAR service in Dublin. Ballyfermot is an area with high levels of problematic drug use and has designated priority status through the emergence of the Ballyfermot Local Drugs Task Force.

The research is based on interviews carried out during 2004/05 with one group of 45 service users attending a local family support project and a second group of 18 attending the Community Employment (CE) training aspect of the project. The research used up to 17 standardised instruments to collect data on up to 14 different dimensions of well-being.

Eighteen per cent of FSP participants and all the CE participants had used drugs. Both groups reported drug use by their partners, 13% of the FSP group and 22% of the CE group. Of the FSP participants, 76% reported a high level of drug use by their children, and 46% reported that a family member was a current active drug user. When compared to a representative sample of parents in Ireland, Ballyfermot STAR service users had:

- much higher levels of negative emotions
- fewer positive emotions
- significantly lower levels of psychological well-being
- experienced higher numbers of negative life events in the past year
- significantly weaker support networks
- weaker parent-child relationships
- higher numbers and frequencies of physical symptoms

Nineteen per cent of families attending the centre had experienced the death of a family member as a result of drugs, and 59% of service users had a family member who had been imprisoned for using drugs. Furthermore, families with a member who used drugs, whether active (using illicit drugs) or stable (using prescribed drugs), had consistently lower levels of well-being than families that were drug free (without either an active or a stable drug user in the family).

3.3.4 At-risk communities

Three Dublin communities' experiences of the drug situation and responses to it between 1996 and 2004 were reported (Loughran and McCann 2006). The three communities selected for investigation were Ballymun, Bray and Crumlin. A local drugs task force (LDTF) has been developed in each community since 1996 to develop a strategic and co-ordinated response to the drug problem at community level. Data collection included focus groups and in-depth interviews with key participants. Local people were recruited and trained as community researchers, who then recruited the participants through their community network. A total of 97 participants were interviewed across the three sites.

The key findings of the study were:

- Between 1996 and 2004, polydrug use (which includes alcohol) replaced heroin as the main drug problem in all three communities. The misuse of both prescribed and non-prescribed benzodiazepines was noted. The use of cannabis was seen as widespread and had become a 'normal' practice by the end of the study period.
- Alcohol misuse had a major negative effect on the lives of residents in the communities. The more problematic aspects of alcohol use were under-age drinking and subsequent anti-social behaviour among this age group. The easy availability of alcohol was due to an increase in local supermarkets and off-licences in the three communities during the study period.
- There was an improvement in the provision of opiate treatment and community-based treatment interventions between 1996 and 2004. Methadone substitution programmes had some impact on heroin use but failed to tackle other drugs. Concerns were raised regarding the lack of treatment facilities for young people, in particular for alcohol.
- Drug-related deaths and deaths among drug users caused devastation in the three communities. In general, these were premature deaths of young people. There was a general perception that official statistics did not reflect the total numbers who died or the impact of these deaths on other family members and the community at large.

- A general sense of fear, vulnerability and intimidation was experienced among the communities as a result of open drug dealing in public areas. People reported that there had been a decrease in the use of public spaces after dark since 1996.
- A reduction in some types of crime was observed between 1996 and 2004, but the later phase of the study noted an increase in the number of murders associated with drug dealing.
- Participants reported a deteriorating relationship between the community and the gardaí.
- There was an increase in the number of children under 15 years who stayed in school and an increase in those who completed the Leaving Certificate during the reporting period. In some cases, school absenteeism replaced early school leaving.
- Employment opportunities had increased during the reporting period, and fewer people were unemployed in 2004.

The report's main conclusion was that a community-based reporting system is required to identify changes in the drug situation in specific communities.

3.4 Indicated prevention

3.4.1 Children at risk (psychological problems)

The 2006 Annual report from the Crosscare Teen Counselling Service brings together information from the five teen counselling centres operating in Dublin (Teen Counselling 2007). The overall aim of the service is to enable young people and their parents or carers deal with difficulties within the context of the family. Typical issues dealt with by the service include family conflict, mental health, substance use and behavioural issues among teenagers. The service saw 400 families in 2006, comprising 248 new cases and 152 carried forward from 2005. Among the new cases, 44% of teenagers were living with both biological parents and 85% were in secondary school. Sixty seven per cent of new teenage clients were aged under 16, and 55% of these were female. Fifty per cent of new teenage clients reported drinking alcohol and 23% reported using a drug other than alcohol, with cannabis (17%) the most popular.

The report includes results from an internal evaluation of the Crosscare service in 2006 based on four strands.

1. Parents were asked at baseline and again at completion of therapy to assess the severity of problems they were experiencing and their ability to deal with them. Sixty five per cent of parents who completed this process reported a great reduction in the severity of problems and 34% reported some reduction. Fifty four per cent said their ability to cope had greatly improved and 45% said there was some improvement.
2. Teenagers were asked to assess the severity of their difficulties at baseline and again when therapy was completed across four domains, home, school, friends and self. Improvement was reported in all domains including 96% that said the severity of problems they attributed to self had improved (Table 3.4.1).
3. Counsellors evaluated all cases that had completed therapy in 2006 (n=256) on the severity of problems that they presented with and their underlying problems. Thirty nine per cent reported improvement in the problems families presented with and 44% reported improvement in the underlying problems.
4. Counsellors used the Global Assessment of Relationships Functioning DSM-IV to measure family functioning at baseline and again at therapy completion. At therapy completion, the average for family functioning was scored at 87, an increase from 56 at baseline. Higher scores are indicators of improved functioning. Counsellors

used the Global Assessment of Functioning DSM-IV to assess how well teenagers were functioning at baseline and at therapy completion. At completion, the average score was 69, an increase from 58 at baseline, indicating that some improvement had occurred.

Table 3.4.1 Severity of problems across four domains following therapeutic intervention

	Greatly improved	Improved	No change
	%	%	%
Home	22	50	28
School	13	60	23
Friends	30	30	40
Self	38	58	4

Source: Teen Counselling (2007)

The results of this internal evaluation must be treated with a degree of caution as there is no way we can definitively say that the improvements reported by participants and staff are due to the counselling as the evaluation did not control for competing explanations. For example, the severity of problems could have reduced with the passage of time and the capacity of parents/teenagers to cope with problems could also have improved with time. Given that families received counselling for an average of nine months, the issue of time is important. The report notes that 41% of referrals to the programme in 2006 were placed on the waiting list.

Nonetheless, despite the limitations of the evaluation design it would appear that the Teen Counselling Service is providing a much needed response to families in distress and is well regarded by professionals. Most referrals to the service came from schools, family doctors, psychologists/counsellors, social workers and health professionals. Engaging and maintaining participants in counselling also throws up challenges to service providers targeting at-risk families. The report notes that involving parents in the work and providing a locally based service that is not stigmatised are key measures to the process of engaging with and maintaining families in services.

4. Problem drug use (PDU) and the treatment demand population

4.1 Overview

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

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

4.2 Prevalence and incidence estimates of PDUs

Estimating the prevalence of problem opiate use
No new valid national prevalence and incidence studies have been carried out or published during the reporting period January 2006 to June 2007. The 2000/2001 three-source capture–recapture study to estimate the number of problem opiate users living in Ireland will be repeated (by Kelly and colleagues) between September 2007 and June 2008. The results of these studies will be presented in the 2008 national report.

Other studies
In a paper titled 'Estimating the prevalence of opiate use in Ireland and the implications for the criminal justice system', Comiskey and colleagues used a multiplier method to estimate the prevalence of opiate use in Ireland (Comiskey *et al.* 2007). The authors describe how they established a benchmark figure based on national crime statistics for 2003 and 2004, and generated a multiplier from baseline data collected for the Research Outcome Study in Ireland (ROSIE).

Long and Corrigan (2007) take issue with both the essential elements – the benchmark and the multiplier – of the method used by the authors. The authors present a benchmark figure of 'approximately 500 individuals', described as the average number of arrests in a three-month period for the possession of drugs for sale or supply, and derived, they say, from Tables 4 and 5 of their paper. This benchmark figure is flawed for a number of reasons:

- From Tables 4 and 5, we calculate a figure of either 523.5 or 557.9 – considerably greater than that arrived at by the authors.
- The numbers presented in Table 4, extracted from the police report for 2003 (An Garda Síochána 2004), represent the number of offences detected for possession of any drugs for sale or supply, rather than the number of opiate users, or of individuals, arrested. By using the words 'opiate user' and 'drug user' interchangeably, the authors appear to assume that all drug users arrested for the possession of drugs for sale or supply are opiate users.
- The authors do not control for repeat offences by the same individual.

The authors take as their multiplier the percentage (3.5%) of the 404 participants in the baseline ROSIE study who reported that they had been arrested for the possession of drugs for sale or supply in the 90 days prior to the interview. There are problems with this figure also:

- Table 2 and Table 3 in this paper give slightly different figures for the number 'ever arrested' and the number 'excluded' (a note to both tables defines excluded cases

as those for whom the question was ‘not relevant, clients who chose not to answer the question, clients who did not know, spoiled responses and data not collected’).
- The authors do not explain these differences.
- The authors do not deduct the excluded cases (whether 61 or 63) from the initial sample, and use 404 as the denominator, rather than 343 (or 341).
- Using the denominator of 343 cases, the proportion of opiate users with the experience of interest – and therefore the correct multiplier – is 4.1%.
- The multiplier is based on the experience in a sample rather than a population and does not provide a range to control for the effect of sampling variation.

Long and Corrigan hold that the estimate presented is an estimate of neither opiate use nor drug use in Ireland in 2004 and that the calculations described in the paper are misleading. We request that this paper is not used by the EMCDDA as an estimate of problem opiate users in Ireland.

4.3 Treatment demand indicator

Drug treatment data are viewed as an indicator of drug misuse as well as a direct indicator of demand for treatment services. The National Drug Treatment Reporting System (NDTRS) is an epidemiological database on treated problem drug and alcohol use in Ireland. The NDTRS is co-ordinated by staff at the Drug Misuse Research Division of the Health Research Board on behalf of the Department of Health and Children. For the purpose of the NDTRS, treatment is broadly defined as ‘any activity which aims to ameliorate the psychological, medical or social state of individuals who seek help for their drug problems.’ The methodological background to the NDTRS is presented in Standard Table TDI 34. The data presented in this analysis were collected through outpatient (opiate detoxification, methadone substitution and counselling services), inpatient (medical detoxification and medication free residential programmes) and low-threshold centres (low-dose methadone and crisis-counselling services).

4.3.1 Type of treatment centres providing data

Outpatient services (see Standard Table TDI 34 outpatients)

In 2006, there were 146 services providing outpatient services and reporting cases to the NDTRS. Of these services, 55 provided methadone treatment, a small number provided detoxification using lofexidine, and one provided buprenorphine detoxification. All provided counselling services and a large proportion provided brief interventions. Of the 3,936 cases who entered treatment for the first time or returned to treatment at outpatient services in 2006, 926 (24%) were female, 2,010 (51%) were aged between 20 and 29 years and 1,676 (43%) had never previously been treated. The most common source of referral was self-referral (1,168, 30%). Half (1,964, 50%) were living with their parents, and a significant minority (403, 10%) were living in unstable accommodation. The majority of cases (2,329, 59%) were not employed and 1,170 (32%) had no formal educational qualifications. The three most common main problem drugs were opiates (2,547, 65%), cannabis (790, 20%) and cocaine (404, 10%).

Of the 3,920 cases whose gender was known and who attended outpatient facilities in 2006, 1128 (29%) injected their main problem drug; 1,965 (50%) used their main problem drug on a daily basis; and 837 (21%) had not used their main problem drug in the month prior to this treatment episode. The age at which cases commenced use of their main problem drug was associated with the type of drug. Of the 2,533 cases who attended outpatient facilities during the reporting period and reported an opiate as their main problem drug, 1,720 (68%) commenced use of this opiate between 15 and 25

years of age. Of the 404 cases who attended outpatient facilities and reported cocaine as their main problem drug, 300 (74%) commenced use of cocaine between 15 and 25 years of age. Of the 788 cases who were admitted to outpatient facilities and reported cannabis as their main problem drug, 724 (92%) commenced use of cannabis between 10 and 19 years of age. The majority of cases (2,771/3,936, 70%) reported that they used more than one drug. The four most common additional drugs used were cannabis, alcohol, cocaine and hypnotics or sedatives.

Of the 3,963 cases who attended outpatient facilities, 1,678 (43%) had ever injected any drug, and 819 (21%) had injected in the month prior to this treatment episode. Among cases admitted to outpatient services, opiates (usually heroin) were the main type of drug injected; a small number of cases injected cocaine.

Inpatient services (see Standard Table TDI 34 inpatients)

There were 23 inpatient services reporting cases to the NDTRS in 2006. These facilities provided one of the following: medical detoxification, therapeutic community, Minnesota Model, other medication-free service or psychiatric treatment combined with counselling. Of the 953 cases who were admitted to residential facilities in 2006, 191 (20%) were female, the majority (485, 51%) were aged between 20 and 29 years, and 503 (53%) had never previously been treated. The most common source of referral was self (222, 23%). A higher proportion of women than men were referred by self. At the time of admission, 494 (52%) were living with their parents and 107 (11%) were living in unstable accommodation; 614 (64%) were not employed and 137 (15%) had no formal educational qualifications. The three most common main problem drugs were opiates (436, 46%), cannabis (290, 30%) and cocaine (161, 17%).

Of the 952 cases whose gender was known and who were admitted to residential facilities in 2006, 170 (18%) injected their main problem drug and 430 (45%) used their main problem drug on a daily basis, while 202 (21%) did not use their main problem drug in the month prior to this treatment episode. The age at which cases commenced use of their main problem drug was associated with the type of drug used. Of the 436 cases who reported an opiate as their main problem drug, 254 (58%) commenced its use between 15 and 25 years of age. Of the 160 cases who were admitted to residential facilities and reported cocaine as their main problem drug, 110 (69%) commenced its use between 15 and 25 years of age. Of the 290 cases who were admitted to residential facilities and reported cannabis as their main problem drug, 262 (90%) commenced its use between 10 and 19 years of age. The vast majority of cases (789/953, 83%) reported that they used more than one drug. The four most common additional drugs used were alcohol, cannabis, stimulants and cocaine.

Of the 953 inpatient cases, 234 (25%) had ever injected any drug and 97 (10%) had injected in the month prior to this treatment episode. Opiates (usually heroin) were the main type of drug injected. A small number of cases injected cocaine, benzodiazepines or stimulants.

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

In 2006, there were three services providing solely low-threshold services and reporting cases to the NDTRS. The three services were based in the North and South-Western Areas of Dublin. Of these services, two provided low-threshold methadone

maintenance and one provided crisis counselling. For many of the community services, it is difficult to separate low-threshold activities from treatment interventions and services. Both crisis interventions and counselling services have been and continue to be classified as outpatient treatment services. Of the 144 cases who attended low-threshold services in 2006, 12 (8%) were female, 73 (51%) were aged between 25 and 34 years, and 49 (34%) had never previously been treated. The most common sources of referral were self-referral (60, 42%), followed by referral by social services (40, 28%). A large number (46, 32%) were living with their parents and a significant minority (40, 28%) were living in unstable accommodation. The vast majority of cases (96, 67%) were not employed. Almost all cases (142, 99%) reported an opiate as their main problem drug and 61% (of the 143 whose gender was known) injected it.

Of the 143 cases whose gender was known and who attended low-threshold services, 120 (84%) used their main problem drug on a daily basis and 7 (5%) had not used their main problem drug in the month prior to this treatment episode. A low proportion of cases (84/144, 58%) used more than one drug. The four most common additional drugs used were benzodiazepines, cannabis, cocaine or opiates.

Of the 144 cases who attended low-threshold services, 107 (74%) injected at least once in their lifetime and 84 (58%) injected in the month prior to this treatment episode. Opiates (usually heroin) were the type of drug injected.

General practitioner services (see Standard Table TDI 34 low threshold)

In 2006, there were 211 general practitioners providing methadone treatment and reporting cases to the NDTRS. Of the 247 cases who entered treatment with a general practitioner in 2006, 73 (30%) were female, 146 (59%) were aged between 25 and 34 years, and 49 (20%) had never previously been treated. The most common source of referral was from another drug treatment centre (140, 57%). A large number (91, 37%) were living with their parents and only a small number (9, 4%) were living in unstable accommodation. Almost two-fifths (97, 39%) were not employed. All cases (247/247) reported an opiate as their main problem drug and 38% (of the 246 whose gender was known) injected it.

Of the 246 cases whose gender was known and who attended general practitioner services, 67 (27%) used their main problem drug on a daily basis and 135 (55%) had not used their main problem drug in the month prior to this treatment episode. A low proportion of cases (107/247, 43%) used more than one drug. The three most common additional drugs used were cannabis, cocaine and benzodiazepines.

Of the 247 cases who attended general practitioner services, 121 (49%) injected at least once in their lifetime and 21 (9%) injected in the month prior to this treatment episode.

4.3.2 Other comments on data presented in standard tables

The National Drug Treatment Reporting System (NDTRS) is the Irish treated drug misuse surveillance system. In 2003 Kavanagh *et al.* (2006) carried out a study to measure the completeness and accuracy of the NDTRS data for 2001. The authors conducted a cross-sectional survey of clinical records and matching NDTRS reporting

forms of a random sample of 520 clients attending four Dublin treatment centres. Using clients' clinical records as the gold standard, system completeness (proportion of sample reported to the NDTRS) and accuracy of selected variables (proportion of reported clients' information on the NDTRS that matched clinical record information) were measured; 452/520 (87%) selected records were retrieved. The NDTRS was only 61.1% complete (95% CI 56.5–65.5); completeness differed across treatment centres (21.8%–85.6%, p<0.0001) and was greater for new and returning clients than for continuing clients (81.7% versus 53.9% respectively, p<0.0001). Problems were identified with the accuracy of some key variables. Urgent actions have been taken to improve the completeness and accuracy of the reporting system.

4.4 PDUs from non-treatment sources (police, emergency, needle exchange etc)

4.4.1 Type, numbers and intensity of drug use

Description of clients attending harm reduction

There is no up-to-date national data on drug users attending needle exchange or drug-related social services.

Merchants Quay Ireland (MQI) has a large city-centre needle exchange in Dublin. Over 3,000 people used the agency's needle-exchange service in 2005, of whom 470 were new injectors (up 6% on the 2004 figure) (MQI 2006). There are no data reported on types of drugs used, but heroin and cocaine are the most common drugs injected by drug users in Ireland. The review highlights the increasing demand for MQI's homeless services, particularly by people from the new EU member states. By September 2005 there was an average of 20 to 30 eastern Europeans attending the service every day. In response to this, MQI has produced information leaflets in a number of languages and some staff have taken language classes. The types of service offered by MQI and the numbers of people accessing them in 2005 are shown in Table 4.4.1.

Table 4.4.1 Harm reduction services at MQI, 2005

Service	Type of intervention	Number of participants
Needle exchange	Promoting safer injecting techniques	3,339 (including 470 new injectors)
Health promotion services	HIV and hepatitis prevention	
	Safe sex advice	321 safer injecting workshops
	Information on overdose	

Source: Merchants Quay Ireland (2006)

Attendances at accident and emergency recorded on the National Registry of Deliberate Self Harm, 2005

The fifth annual report from the National Registry of Deliberate Self Harm was published in March 2007 (National Registry of Deliberate Self Harm Ireland 2007). The report contains information relating to each episode of deliberate self-harm from persons presenting to all general hospital A&E departments and two of the three paediatric hospital A&E departments in Ireland in 2005. The Registry defines deliberate self-harm as 'an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or physical consequences'.

The report concludes that there were 10,789 presentations of deliberate self-harm, involving 8,594 individuals, to hospital A&E departments in 2005. The number of presentations was 3% lower than in 2004, when there were 11,092 presentations by 8,610 individuals. The age-standardised rate of deliberate self-harm was 198 per 100,000, compared with 201 per 100,000 in 2004, representing a 2% decrease. The national rate in 2005 was 37% higher among females than among males, at 230 per 100,000 and 167 per 100,000 respectively. Forty-six per cent of all presentations were by persons less than 30 years of age, and 87% by persons less than 50 years of age. The peak age range for females presenting was 15–19 years, at 606 per 100,000. The peak age range for males presenting was 20–24 years, at 392 per 100,000.

Drug overdose was the most common form of deliberate self-harm, representing 76% of all such episodes (7,751 episodes). Overdose rates were higher among females (82%) than among males (67%). On average, 31 tablets were taken in episodes of drug overdose. The total number of tablets taken was known in 80% of cases. Forty-one per cent of all drug overdoses involved a minor tranquilliser, 32% involved paracetamol and 23% involved anti-depressants. There was evidence of alcohol consumption in 41% of all episodes of deliberate self-harm.

Zopiclone misuse: an update from Dublin

Zopiclone is a non-benzodiazepine hypnotic that was first reviewed in the journal *Drugs* in 1986. Clinical trials have shown that zopiclone is generally at least as effective as benzodiazepine in the management of insomnia. Data from prescription-event monitoring suggest that zopiclone does not have a high dependence potential in those who are not regular drug abusers/addicts.

The prevalence of zopiclone misuse in 158 clients attending a methadone maintenance programme in Dublin was measured through detection of its degradation product, 2-amino-5-chloropyridine (ACP), in urinalysis (Bannan *et al.* 2007). Urine samples were also tested for the presence of metabolites of opiates, benzodiazepines, cocaine, alcohol and cannabis. Thirty seven (23%) clients tested positive for ACP, of whom 23 (62%) were interviewed. The average age of those interviewed was 32 years, 74% were women, 95% had ever injected illicit drugs and 70% were hepatitis C positive. All

interviewees had a history of opiate, benzodiazepine and cannabis use. The most common drugs used at the time of the study were benzodiazepines (100%) and opiates (61%). The average age at which clients started consuming zopiclone was 28 years. The daily doses of zopiclone ranged between 15 mg and 300 mg. All interviewees preferred zopiclone to benzodiazepines because it caused a lower level of amnesia. According to the interviewees, zopiclone was used with heroin to increase heroin's sedative and tranquillising effects. The street price of zopiclone was one euro per tablet, which is double the commercial price. According to the authors, zopiclone is being misused by drug users in Dublin in the context of many other drugs. Prescribing of zopiclone should be restricted, especially among drug misusers.

Identifying new drugs and new drug trends with the help of drug helplines
In July 2007 the European Foundation of Drug Helplines (FESAT) published the results from its thirteenth monitoring project (Hibell 2007). Since the beginning of 2001, FESAT has been collecting information every six months on the types of person contacting helplines, the content of these calls and how this has changed compared to the previous six months. According to the author, the main objective of this monitoring is to identify the emergence of new drugs and new drug trends; the data cannot quantify the size of any such changes. Of the 34 relevant FESAT helplines, 18 helplines in 13 European countries, including Ireland, participated in the project.

The smallest of the 18 participating helplines in Europe answered an average of one call every second day, and the largest, 108 calls per day. Seven helplines answered 10 calls or fewer per day; eight helplines answered 11 to 30 calls; two helplines answered 31 to 60 calls and one helpline answered 61 or more calls. Half of the helplines answer 16 or more calls per day. The Drugs/HIV Helpline in Ireland answered an average of 15 calls per working day, though this figure included calls about sexual health. There were 1875 calls between July and December 2006 which represents a 12% decrease when compared to the preceding six-month period. This decrease is consistent with other years, as the helpline receives more calls in the first six months of the year than the second six months, this might be explained by summer and Christmas holidays (A Dooley, personal communication, 2007).

The FESAT report notes a decline in the numbers of helplines reporting calls about cocaine and cannabis across Europe and an increase in the number of calls about GHB (six helplines), amphetamines (five helplines) and benzodiazepines (five helplines). The number of helplines answering calls about alcohol (6 helplines) remained stable. There were decreases in the numbers of calls about injecting heroin, magic mushrooms and ecstasy.

In Ireland, there was a large decrease in the number of calls to the Drugs/HIV Helpline about cocaine, from 226 in the first half of 2006 to 166 in the second half of 2006. There was some decrease in the number of calls about alcohol, from 238 in the first half of 2006 to 201 in the second half of 2006. There was a large decrease in the number of calls about cannabis, amphetamines and injecting heroin in the second half of 2006 when compared to the first half of 2006. There was some increase in the number of calls about poppers. (A Dooley, personal communication, 2007)

During the second half of 2006, two helplines in Europe received calls about drugs that had not been reported to them before. The Drugs/HIV Helpline in Ireland answered calls about five substances for the first time. Chief among these was LSA (d-lysergic acid amide), which occurs in the seeds of the morning glory plant and has hallucinogenic effects. Bearing out reports from the Forensic Science Laboratory in Ireland, the Irish helpline answered calls about benzylpiperazine (also known as BZP and marketed as 'Jacks'), which is taken orally and has effects similar to those of

ecstasy. Also new to the Irish helpline in 2006 were calls about GHB, which is normally available as a liquid. Other substances mentioned for the first time were *Salvia* and Subutex. *Salvia divinorum* has hallucinogenic effects and can be smoked or chewed. Subutex (buprenorphine) is an opiate used in the management of opiate addiction. The Norwegian helpline reported first-time calls about the opioid analgesic tramadol (trade name Tramal), which is normally taken orally as a capsule, but which can be injected.

5. Drug-related treatment

5.1 Overview

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

5.2 Treatment system

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

5.2.1 Residential services for alcohol and drug users

The mid-term review of the National Drugs Strategy (2005) recommended that rehabilitation be adopted as the fifth pillar of the Strategy. Consequently, the issue of residential treatment capacity has arisen and, in late 2006, the HSE appointed an expert working group to describe residential treatment services for problem drug and alcohol users in Ireland, to estimate their current capacity and future requirements.

This expert working group mapped existing inpatient detoxification services and residential rehabilitation and aftercare services in Ireland. The group reviewed international literature in four specific areas: models of care, the evidence base for opiate and alcohol detoxification, methods employed to calculate the number of places required for detoxification, and the standards for measuring quality of care. Available data from existing reporting systems such as the Hospital In-Patient Enquiry scheme (HIPE), the National Drug Treatment Reporting System (NDTRS) and the National Psychiatric In-Patient Reporting System (NPIRS) were analysed. A number of submissions were made to the group. A population-based approach was adopted to estimate the level of residential services required. This report has been submitted to the HSE for approval.

5.2.2 Strategy to address adolescent substance misuse in the HSE South Eastern Area

A report on the development of a treatment response to drug and alcohol use among adolescents (12–18 years) living in Carlow, Kilkenny, South Tipperary, Waterford and Wexford was published in 2006 (Cullen B 2006). The report presented a review of the literature on adolescent needs, substance misuse pathways and treatment outcomes. In addition, the author discussed with service providers the issues pertaining to prevention, early intervention and treatment for adolescents living in this area.

Alcohol and cannabis were the main problem drugs reported by adolescents living in the HSE South Eastern Area; only a small number reported opiate use. The author pointed out that the development of the treatment response must reflect the pattern of substance use.

According to the author, there are intrinsic differences in the ways children and adults use alcohol and drugs and in their treatment needs. He described two pathways into alcohol and drug use taken by adolescents. The first is the experimental or social use of alcohol or drugs (considered normal), and the second is the use of such substances as a coping mechanism to deal with stress and anxiety (considered problematic).

The recommendations of Cullen's report were influenced by the *Report of the working group on treatment of under 18 year olds presenting to treatment services with serious drug problems* (Working Group on treatment of under 18 year olds 2005)(2005). In general, the four-tier model of service delivery recommended by the national working group was accepted as the best model, but service providers recommended adaptations to reflect the situation in the HSE South Eastern Area. According to the author, the adaptations to the model should reflect the types of substances used and a preference for the provision of day care instead of residential care at Tier 4.

The author reported that experimental substance use should be dealt with using a population-based approach (Tier 1), while substance use to deal with stress and anxiety should be dealt with using a treatment intervention (Tiers 2 to 4). In order to determine which pathway to substance use was taken by the adolescent, an appropriate assessment tool was required. A review of the evidence indicated that effective interventions for those requiring treatment were behavioural therapy, motivational counselling, multi-systemic treatment and family therapy. Family involvement in treatment was very important for younger or less mature adolescents, and less so for the more mature young person. A specialist day-care programme was recommended as an alternative to residential treatment, which, according to the author, should be used for respite purposes only. In order to ensure appropriate use of Tier 3 and Tier 4 services, referrals to these services should be made through Tier 2 services. The author recommended that adolescent services in the South East be delivered through a separate adolescent drug treatment service. The provision of community and youth projects in urban areas was considered adequate but there was a need to expand these to rural communities. During consultations with service providers, it was noted that many at Tier 1 were unaware of the availability of services required to manage those with problematic substance use, and in-service training was needed to ensure adequate knowledge and appropriate referral.

5.2.3 HSE National Service Plan outlines plans for drug-related services in 2007

Approved in February 2007 by the Minister for Health and Children, the *National Service Plan 2007* (NSP) of the Health Service Executive (HSE) outlines the HSE's plans in the drugs area during 2007 (Health Service Executive 2007). It states that work will begin on scoping the transition of the management of alcohol services from mental health to social inclusion services, and that a review of how drug and alcohol services can have a better fit with the unitary structure of the HSE will be completed.

The HSE's drug-related services are provided primarily through Social Inclusion Services, which are part of the Primary, Community and Continuing Care (PCCC) directorate of the HSE. Table 5.2.1 summarises the HSE's Social Inclusion outputs in respect of drugs and HIV services for 2006 and the deliverables against which the HSE will be assessing its performance in 2007. Table 5.2.2 outlines how the €6 million allocated in the government's 2007 budget to implement the HSE-related elements of the National Drugs Strategy will be spent.

The NSP also records that during 2007 the Population Health Directorate of the HSE will complete further iterations of SLAN (Survey of Lifestyle, Attitudes and Nutrition) and ESPAD (European School Survey Project on Alcohol and Drugs), continue to work

on health promotion campaigns in relation to, among other things, alcohol and tobacco, and continue to implement the Action Plan on Alcohol.

Table 5.2.1 Drugs and HIV services – outputs for 2006 and deliverables for 2007

1. Focus	2. Output 2006	3. Deliverable 2007
• Expand the Tier 3 teams.	• Additional funding was provided for Specialist Adolescent Addiction Teams.	• Continued provision of existing levels of service
• Enhance treatment services with a particular focus on under-18s.	• New protocols and a policy on treatment of under-18s were disseminated and promoted nationally. National Training Workshops were provided for frontline staff on the treatment of under-18s with serious drug problems.	• Increase the provision of training to staff on appropriate interventions for under-18s. • Implement the protocols and the new policy nationally in line with available resources.
	• Substance misusers to have immediate access to professional assessment, and treatment as deemed appropriate not later than one month after assessment. The extent of substance misuse in the under-18-year group needs monitoring.	• Work towards improved performance in these areas.
	• Indicator (AD3, AD4): • - Percentage of adults (new clients) commencing treatment within one month: 60% (heroin); 95% (all other substances). • - Percentage of under-18s (new clients) commencing treatment within one month: 65% approx.	
• Enhance treatment services to cocaine and polydrug users.	• Information on the trends and prevalence of cocaine use was disseminated. • A workshop was provided on appropriate treatment interventions to address cocaine use.	• Develop a model for the management of cocaine abuse and deliver appropriate training to HSE staff.
• Combat substance misuse through a concerted focus on supply reduction, prevention, treatment and research.		• Develop a comprehensive action plan for the delivery of rehabilitation services in line with the National Drug Strategy review and the outcome of the Rehabilitation Working Group. • Monitor the prescribing of benzodiazepines.
• Focus on reducing alcohol-related harm, including implementation of the recommendations of the Working Group on Alcohol and taking	• Work on the Alcohol Aware pilot with the Irish College of General Practitioners (ICGP) commenced in 2006.	• Implement relevant recommendations from the Strategic Task Force on Alcohol, within available resources. • Work with Emergency Department (ED) and Primary Care Services on the early detection and screening of people with problematic and dependent alcohol use. • Complete review of current mental-

1. Focus	2. Output 2006	3. Deliverable 2007
account of the recommendations of the Strategic Task Force on Alcohol.		health-based alcohol services to improve integration.
• Number of clients in methadone treatment	• Average of 6,800 per month	• 6,800 (average per month)
• Number of methadone treatment places used during the period	• Average of 6, 800 per month	• 6,800 (average per month)

Source: Health Service Executive (2007) *National Service Plan 2007: 38–39*. Available at www.hse.ie

Table 5.2.2 Investment funding in Social Inclusion services for 2007 to implement health-related aspects of the National Drugs Strategy

Focus	Funding	Human resource implications estimated	Deliverable 2007
Addressing health-related aspects of the National Drugs Strategy through:	€6m (B)		
Continued implementation of the report on treatment services for under-18s presenting with serious drug problems, including the enhancement of consultant-led multidisciplinary teams		50	Completion of teams in Dublin North East Enhancement of teams in Dublin-Mid Leinster Establishment of team in HSE South (Cork) Establishment of team in HSE West (Limerick)
Expansion of harm reduction services, including needle exchange, to counter the incidence of HIV and hepatitis C among intravenous drug users		4	Continuation and expansion of programme that commenced in 2006.
Reorientation and expansion of treatment services and the upskilling of HSE staff to address changing patterns of polydrug use		4	Cocaine and polydrug use programme established, national coordinator in place. Two pilot sites identified and established.
Detox facilities programme		2	Support for the establishment of residential detox programmes throughout the country. Initial places and sites identified in 2007.
A specific initiative for homeless persons		10	Employment of eight counsellors to support addiction services targeted at homeless communities throughout the country.

Source: Health Service Executive (2007) *National Service Plan 2007: 103–104*. Available at www.hse.ie

5.2.4 Support for pharmacies

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

5.2.5 Drug treatment demand

The total number of drug treatment services available in Ireland and participating in the NDTRS increased between 1998 and 2005 (TDI 34). The largest increase was in outpatient treatment services and general practitioner services. In the HSE Eastern Region, counsellors employed by statutory services did not consistently return information on cases who received counselling only, therefore there is an under-

representation of cases treated for use of drugs other than opiates in this region. The Prison Service does not participate in the NDTRS, although it does provide drug treatment services. In 2005, 12,397 cases were treated for problem drug use. Of these, 7,296 opiate cases continued in treatment from 2004 and 5,101 drug cases entered or returned to treatment during 2005 (includes double counting). This figure does not include cases who reported alcohol as their main problem drug but used other drugs.

When double counting within treatment centres was controlled for, 4,962 cases entered treatment and were reported to the NDTRS during 2005. This figure does not include cases who report alcohol as their main problem drug but use other drugs

5.2.6 National drug treatment outcomes at one year for all modalities

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

At baseline, the study recruited 404 opiate users aged 18 years or over entering treatment at inpatient facilities (hospitals, residential programmes and prisons) or outpatient settings (community-based clinics, health board clinics and general practitioners). Of the 404 opiate users aged 18 years or over, a sub-sample of 26 (6%), attending needle-exchange services. With the exception of those entering needle exchange, the opiate users selected were entering treatment for the first time, or were returning to treatment after a period of absence, at any one of 54 services nationwide. The interview schedule collected data on:

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

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

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

There were large reductions in the proportions of participants who reported use of non-prescribed methadone, cocaine powder, crack cocaine and non-prescribed

benzodiazepines at one year compared to the baseline interview. There were smaller reductions in cannabis and alcohol use over the same time period. The proportion of participants reporting use of more than one drug decreased from 78% at intake to 50% one year later.

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

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

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

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

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

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

5.2.7 Developments in health care in Irish prisons

The Irish Prison Service (IPS) annual report for 2005 was published in September 2006 (Irish Prison Service 2006b). The aim of the IPS healthcare system is to deliver a standard of healthcare to all prisoners that is equivalent to that available in the wider community. Healthcare is provided to prisoners at the level of primary care, by general practitioners, nurses and medical orderlies.

The mid-term review of the National Drugs Strategy in 2005 recommended that the IPS collaborate with key stakeholders such as the Drugs Strategy Unit of the Department of Community, Rural and Gaeltacht Affairs and the National Drugs Strategy Team (NDST). Acting on this recommendation, the IPS presented relevant issues on the drugs situation in prisons to the NDST and the NACD. The NDST now wishes to incorporate individual prisons into the work of the local and regional drugs task forces.

Nine prisons provide methadone treatment, with 1,564 prisoners receiving methadone substitution in 2005, an increase of 255 (16.5%) on the previous year (Table 5.2.3). Of these, 169 individuals received methadone substitution for the first time in prison.

Table 5.2.3 Numbers receiving methadone substitution treatment in Irish prisons in 2005

Prison	Total patients	New patients
Cloverhill Prison	571	97
Dochas Centre	228	27
Limerick Prison	4	0
Midlands Prison	6	0
Mountjoy Main Prison	511	27
Mountjoy Prison Medical Unit	79	5
Portlaoise Prison	2	0
St Patrick's Institution	1	0
Wheatfield Prison	162	13
Total	1564	169

In October 2005 the HSE and the IPS awarded a joint contract to a pharmaceutical company for the supply of methadone. This joint purchasing agreement will ensure:

- continuity of treatment for prisoners who move between the community and prison
- a regular supply of methadone
- significant cost savings to the IPS.

In 2005, a contract was awarded for the provision of pharmacy services to Shelton Abbey prison; the IPS now intends to introduce a contracted pharmacy service provided by a community pharmacy to all prisons. Such a service will result in improved patient care and efficient use of medicines.

Other significant developments in the prison healthcare system in 2005 were:

- A clinical data system which will record and store clinical information across the prison system was developed.
- An overall Strategic Statement which will inform the medium-term development and provision of prison healthcare was finalised.
- A joint initiative between the IPS and the HSE South Western Area led to the appointment of a consultant psychiatrist in adult addictions. This contributes to the healthcare strategy and increases the range of in-reach services available to prisoners. A similar appointment was made in the HSE Northern Area in 2004 to provide sessions at the Mountjoy complex.
- The role of healthcare managers in the IPS was highlighted in the Proposal for Organisational Change (which dealt with revised working arrangements in prisons), and a clinical nursing management structure within the prison system is being introduced.

5.2.8 Dóchas Centre: process evaluation and treatment outcome study

In March 2006 the HSE published the results of an 18-month long process evaluation and treatment outcome study of 40 female drug-using prisoners admitted to the Dóchas Centre, Mountjoy Prison, Dublin (Comiskey 2006). The aim of the study was to model the care pathway of the women and to discover whether their experiences in the Dóchas Centre had a positive or negative impact on their lives. The women were

interviewed within one month of committal and again six months later. Qualitative interviews were also conducted with eight participants working in a number of capacities with women who had been in prison.

Of the original cohort of 40 women who participated in baseline interviews, outcome data was obtained for 39, and 27 completed a second interview. The women ranged in age from 16 to 43 years; 23 had children under the age of 18, most of whom did not live with their mothers. The majority of the women had completed their education by the age of 15.

The study measured key variables, including drug use, accommodation, health, psychosocial functioning and involvement in crime before the women were admitted to the Dóchas Centre, during their imprisonment and after their release. The strongest positive outcomes were in the area of crime. There was a significant reduction between baseline interview and six-month follow-up in the proportion of women who committed crimes, apart from the crime of soliciting, which showed a slightly increased incidence.

There was a significant reduction in the levels of heroin use. On average, the women who were using heroin at recruitment stage did so at least once a day. At follow-up this had reduced to twice a week. Slight reductions were noted in the numbers of women using cocaine, non-prescription methadone and ecstasy. The physical and mental health of the women showed only minor improvements at follow-up and, in some cases, there was evidence of deterioration. Of particular concern was the finding that three of the women interviewed had attempted suicide since leaving prison.

One of the main findings was the considerable risks that the women were exposed to upon their release from the Dóchas Centre, including overdose, gang rape, prostitution, homelessness and polydrug use. Of the 22 women who were released during the six-month follow-up period, only seven returned home and did not report any trauma. Three of the original cohort of 40 women died during the six-month follow-up period; All three had been released from the Dóchas Centre. This finding demonstrates the real and significant risks associated with the period following the release of female drug-using prisoners.

The majority of women who were interviewed at six-month follow-up felt that the time which they spent in the Dóchas Centre had been of some help. The ways in which the prison helped varied for each woman, and included assistance with drug treatment, educational opportunities and a break from the stress of their lives. Despite these positive experiences, the women expressed a number of negative criticisms of the services they received. Over half of the women had concerns at the time of their release relating to, for example, a lack of suitable accommodation, money worries, concerns surrounding their children and a fear of returning to drug use. The women were asked whether they had received help with these issues upon being released. Of the 20 women who answered the question, only three had received assistance. In addition to this, only four of the 27 women interviewed at follow-up stated that they had had any contact with social welfare services while in prison. Finally, 16 of the 22 women who were released during the time between baseline interview and follow-up were not given advanced indication of their release date, which had implications for their vulnerability to risks upon release.

A key finding that emerged from the qualitative interviews with the eight participants who worked with women who had been in prison was the lack of co-ordination between the various in-reach services to the women's prison. These participants felt that, while the current range and number of agencies providing in-reach services was sufficient, the lack of integration between the services often resulted in poorer outcomes for the

women. They stressed the need for appropriate accommodation that took into account the specific requirements of drug-using women who had been in prison.

The findings of the study indicate that the women experienced some positive effects in their lives in the six-month period between recruitment and follow-up interviews. It is unclear whether the improvements noted in the report can be attributed to the Dóchas Centre or to the stage which the women were at in their drug-using careers. The author suggested that further longitudinal information on the women and their care processes would be required in order to clarify the reason for the observation.

5.2.9 Drug treatment programmes in prison: longitudinal outcome evaluation, policy development and planning interventions

Pugh and Comiskey (2006) evaluated a seven-week abstinence-based drug treatment programme at Mountjoy Prison in Dublin. Seventy-nine clients were interviewed at two stages: stage I, prior to the treatment programme; stage II, immediately after the treatment programme. A selected group of 20 clients were followed up and interviewed at stage III, up to 24 months after the treatment programme. This latter sample consisted of eight prisoners who had re-offended and returned to prison, three who were still serving their original sentence and nine who were out of prison. These 20 also participated in a more detailed quantitative and qualitative survey.

In order to measure the prisoners' criminogenic attitudes and needs, the Crime Pics II instrument was used. This is a semantic differential scale which measures attitudes toward offending behaviour. It includes a problem checklist which can be used to measure change over time.

An 82% follow-up rate was achieved on the original group of 79 clients, and a follow-up rate of 100% for the selected group of 20 clients who were interviewed three times. Regardless of category of client, findings demonstrate an improvement over time for the outcome variables: general attitude to offending, anticipation of re-offending and perception of current life problems. However, the study failed to demonstrate any significant change for the outcome variables: victim hurt, denial and evaluation of crime.

These results were short-lived for many prisoners, who failed to sustain the gains made. Interviews with the cohort of 20 suggest that clients who did not receive continuity of treatment post-programme, in terms of case management and structured treatment, did not fare as well as those who received such treatment.

5.3 Drug-free treatment

5.3.1 Inpatient treatment

Summary of abstinence treatment outcomes
The ROSIE recruited and followed opiate users entering treatment (or needle exchange) to document their progress after six months, one year and three years. Findings 3 provides a summary of the outcomes for the 82 people in the abstinence modality one year after treatment intake (Cox *et al.* 2007b).

The abstinence modality is defined as: 'any structured programme which required individuals to be drug-free (including free from any pharmacological intervention) in order to participate in, and remain on, the programme'. Participants are required to attend a structured programme of daily activities and are given intensive psychological support. Abstinence-based treatment occurs in both inpatient and outpatient settings.

Residential rehabilitation programmes can differ considerably in terms of their underlying philosophy and programme structure. Programmes may be either short-term (4–12 weeks) or long-term (3–12 months).

The ROSIE abstinence cohort comprised 82 individuals, the majority recruited from inpatient settings (85%, n=70), with the remainder being treated in outpatient settings (15%, n=12). Those recruited from inpatient settings were attending one of the three main types of residential rehabilitation programme identified in the international literature: 12-step/ Minnesota Model, Christian house or therapeutic community. Participants were typically male (89%), had an average age of 27 years and were largely dependent on social welfare payments (70%). Just less than half (47%) had children but the majority (77%) of these did not have their children in their care. Most had spent some time in prison (72%) and 16% had been homeless in the 90 days prior to treatment intake interview.

The analysis presented in Findings 3 is based on the 56 participants who provided valid answers to each individual question during their treatment intake and one-year follow-up interviews. Among this group, the treatment completion rate was 66% (n=37). Just over one-quarter (27%, n=15) dropped out of treatment, 2% (n=1) transferred to another treatment type before completing the programme and the remaining 5% (n=3) were still engaged in their treatment programme at one year.

In addition to those still engaged in their abstinence treatment programme one year after treatment intake, 64% of participants (n=36) reported that they were in some form of drug treatment. Of these, 23% (n=13) were on a methadone programme, 23% (n=13) were attending one-to-one counselling and 37% (n=21) were attending group therapy. (Narcotics Anonymous meetings, aftercare programmes or structured day programmes).

The number of participants who reported using heroin, non-prescribed methadone, non-prescribed benzodiazepines, cocaine, cannabis or alcohol in the 90 days prior to interview decreased between treatment intake and one-year follow-up. The most substantial reduction was in cocaine use, both in terms of the proportion of participants using the drug (46% at treatment intake compared with 14% at one year), the frequency of use (an average of 10 out of 90 days at treatment intake compared with an average of 2 out of 90 days at one year) and the quantities consumed (an average of 1 gram per day at treatment intake compared with an average of 0.3 grams per day at one year). There was a non-significant reduction in the number of participants who reported injecting drug use. There were no changes in participants' injecting-related risk behaviours. The proportion who reported an overdose within the previous 90 days was 4% (n=2), both at intake and at one year.

Overall, the proportion of participants who reported no involvement in crime had risen considerably at one year (76%) compared to treatment intake (43%). There was a reduction in the percentage of participants involved in acquisitive crime, from 35% (n=19) at treatment intake to 13% (n=7) at one year.

Ten symptoms were used to measure the physical health of participants. The number of participants who reported nine of the ten physical health symptoms reduced between treatment intake and one year. Ten symptoms were also used to measure the mental health of participants. There was a reduction in the number of participants who reported suffering from any five of the ten mental health symptoms. There was an increase in participants' contact with GPs and with employment/ education agencies.

The authors state that Findings 3 demonstrates that participation in an abstinence-based treatment programme is followed by positive outcomes in relation to drug use, involvement in crime, and physical and mental health symptoms. The outcomes for ROSIE participants in abstinence-based treatment compare favourably with international outcome studies. As noted in the paper, the forthcoming results from the ROSIE three-year follow-up will provide stronger evidence on the effectiveness of abstinence-based treatment programmes and on whether improvements observed at one year have been sustained.

5.3.2 Outpatient (including low threshold and general practice) treatment

Review of a community-based youth counselling service in Ireland
The structure and operation of a community-based youth counselling service operated by the Kildare Youth Services (KYS), Ireland, were examined with a view to highlighting the preventative nature of such a service. Presenting problems were explored in the context of the wider social milieu. Particularly, recent trends in sexual behaviour, substance abuse and child sexual abuse were examined. Interviews were conducted with a sample of professionals who referred clients, patients and students to the KYS Youth Counselling Service. Interviews were also conducted with a small sample of clients of the service and with the counsellor-co-ordinator of the service. The service was viewed positively throughout the community and its role in the prevention of further distress was highlighted.

Evaluation of projects to treat cocaine users
In 2004, the Department of Community Rural and Gaeltacht Affairs requested the National Drugs Strategy Team (NDST) to identify projects that would tackle the growing problem of cocaine misuse in Ireland. In response, the NDST established the Cocaine Sub-Group to recommend pilot interventions aimed at different types of cocaine users.

The three pilot treatment interventions selected were:

- A community-based project involving St Dominic's Community Response Project and Killinarden's Community Addiction Response Programme, Tallaght, for problematic intranasal cocaine users. The planned interventions were advertising service availability, project meetings, relationship building, individual care plans, individual counselling, and holistic therapies.
- Three inter-disciplinary, evidence-based interventions at Castle Street Clinic in the HSE South Western Area for polydrug users. The planned interventions planned employed a combination of individual and group counselling and cognitive behavioural therapy approaches.
- A peer-support training project in the Women's Health Project, Baggot Street and in Chrysalis, Benburb Street, for women using cocaine and working in the sex industry. It was envisaged that the project would train participants to provide accurate information on sexual health and drug use to their peers.

Goodbody Economic Consultants were appointed as external evaluators for the pilot treatment projects. In addition, the management committee for the Women's Health Project decided to conduct an internal evaluation. The objectives of the external evaluation were to analyse what was achieved by the projects and report the lessons learned. In order to do this, the evaluators were to examine the structures, effectiveness, efficiency and value for money components of the projects.

The project based in **Tallaght** was implemented in line with its original design and ran between February 2005 and April 2006 (Goodbody Economic Consultants 2006a). It employed six part-time staff, providing one afternoon and two evening sessions. The cocaine treatment service was promoted through a media campaign and proactive

outreach work. The project communicated with cocaine users and concerned persons by telephone and received an average of 20 calls per week. Ninety-nine cocaine users attended the project, of whom 60 (61%) returned more than once. The uptake of complementary treatments, such as acupuncture and Indian head massage, was high. A further 60 people were assisted by the outreach worker. Seven clients were interviewed at the end of the project, of whom four were abstinent from all drugs and two said that their suicidal thoughts had ceased. According to the evaluators, the project was effective and very good value for money.

At the implementation stage, the intervention for the project based in **Castle Street** was modified to provide participants with a group counselling programme consisting of a 90-minute session each week for 12 weeks (Goodbody Economic Consultants 2006b). The topics for the counselling sessions were: understanding addiction, process of recovery, managing cravings, healthy relationships, self-help groups, support systems, managing feelings and coping with guilt and shame. It was envisaged that three groups of 12 cocaine users would complete the programme. The project was implemented in 2005 and used existing staff resources. Two group counselling programmes were completed during the pilot period. Twenty-six polydrug users were referred to the project, of whom 14 were considered suitable to attend. Of the attendees, six completed the programme and five completed the post-intervention assessment. Of the five attendees assessed, one was abstinent from all drugs, two had reduced their cocaine and alcohol use, and two had reduced their cocaine use but not their alcohol use. The evaluators identified a number of weaknesses in the project design and implementation. The selection and referral process had serious flaws in that a high number of those referred were not suitable for the programme. The gap between counselling sessions was too long. Active drug users and those who were abstinent attended the same programme and this caused conflict. After-care was provided only to those who attended the second session and uptake was low. The programme design did not take account of the participants' other commitments (such as child care, training and employment) and this reduced attendance. There was no leadership or administrative support provided for the programme and the monetary resources allocated were not used. The evaluators recommended that this approach to cocaine treatment had merit but that the weaknesses identified must be addressed in any future programmes.

The project based in both **Baggot Street and Benburb Street** changed its original objective from one of encouraging peer support to that of identifying participants who would invite other women (peers) to information and/or complementary therapy sessions (Goodbody Economic Consultants 2006c). The topics for the information sessions were: harm reduction, working in a safe environment, general and sexual health, hepatitis C, effects of cocaine use and effects of complementary therapy. The complementary therapies were acupuncture, Indian head massage, Reiki, stress balls and upper body massage. The project management committee employed an experienced outreach worker on a part-time basis and introduced a complex system of payments for those attending the project. The project commenced in October 2005. Twenty-two women were contacted through the project, of whom 18 (7 participants and 11 peers) attended at least one project activity. Attendance at complementary services was better than that at information sessions, which did not hold the interest of the women; according to the external evaluators, this may have been linked to rates of payment. During the course of the project, it was observed that many of the women had complex social and medical problems and the project activities were not broad enough to address such issues. The outreach worker did address some of these problems through referrals to and negotiations with other services. The external evaluators reported that they could not form a judgement as to whether this project was effective or not without knowing the results of the internal evaluation.

Evaluation of a cocaine training programme
In 2004, the NDST funded Merchants Quay Ireland to co-ordinate training programmes for front-line staff and key or case workers supporting active cocaine users. The training programme outlined in Table 5.3.1 was implemented in May 2005.

Table 5.3.1 Details of cocaine training programme at Merchants Quay Ireland in 2005

Training type	Target group	Trainers	Expected learning outcomes	Number of attendees
A one-day, level-one course, run for three separate groups Providing basic knowledge of cocaine and related issues and skills to support cocaine users	Front line staff and agencies – with beginner- to medium-level knowledge	Piper Projects: same facilitator for each of the three groups	Know: ▪ facts about cocaine, dopamine and adrenaline ▪ methods of cocaine consumption ▪ effects of polydrug use ▪ trigger factors associated with cocaine use ▪ signs and symptoms of cocaine use ▪ role of and types of harm reduction and complementary therapy Skills to support cocaine users	Expected: 60 Attended: 55 Completed: 53
A three-day, level-two course, run for two separate groups (Course 1 and Course 2) Providing basic assessment and motivational counselling techniques to support cocaine users through treatment	Key or case workers	Piper Projects: different facilitator for each of the two groups	Know : ▪ facts about cocaine ▪ about motivation and the wheel of change ▪ appropriate treatment interventions ▪ risks and benefits of interventions ▪ how to prevent relapse Ability to: ▪ identify signs and symptoms of cocaine use ▪ assess client needs ▪ develop care plans ▪ counsel using motivational interviewing	Expected: 40 Attended: 49 Course 1 – 24 Course 2 – 25 Completed: 38 Course 1 – 20 Course 2 - 18

The training programme was evaluated (Crampton 2005) by means of:

- participant self-assessment and evaluation forms
- tutor evaluation
- participant follow-up questionnaire
- work supervisors' feedback.

The evaluation of the **level-one** course indicated that the participants' level of knowledge had increased considerably, from an average of 50% per participant to 80%. While each individual's knowledge about cocaine increased during the course, many wanted more knowledge and practical experience with clients. Participants rated the course content at 79%, the training style at 85% and the venue at 81%. The tutor noted that the participants were open to learning, asked lots of questions and were willing to share their knowledge.

Because of issues that arose during Course 1 of the **level-two** course, some adjustments were made to the plans for Course 2, and the two courses were evaluated separately.

The evaluation of Course 1 indicated that the participants' level of knowledge had increased by 33%, from an average of 58% per participant to 77%. Participants rated the course content at 64%, the training style at 67% and the venue at 57%. The trainer reported that some participants were inexperienced and this resulted in 'lecture style' training. Based on this and other feedback from Course 1, MQI requested that the tutor introduce interactive training methods in Course 2. They also changed the training venue and requested a list of participants in advance of the course.

The evaluation Course 2 indicated that the participants' level of knowledge had increased by 43%, from an average of 59% per participant to 84%. Participants rated the course content at 78%, the training style at 86% and the venue at 78%. The feedback from Course 2 was positive and demonstrated that it is important to learn from participants' evaluations.

Report proposes a new approach to working with drug users

In January 2007 Kilbarrack Coast Community Programme (KCCP) published a report entitled *Forging a new template: proposing a more effective way of working with drug users* (Byrne 2007).

In a foreword to the report, Dr Rick Loose of Dublin Business School describes addiction and explains the importance of creating a transferential space in order to treat it. During treatment, addicts are asked to abstain from, or put a limit to, the substance they have been using. When asked to give up or reduce their intake of the problem substance which gives them pleasure (or stops pain), addicts will often come to depend on a substitute mechanism. Dependency on drugs or alcohol is transformed into a dependency on staff and/or the treatment centre. Addicts demand from the counsellor (or institution) something which drugs or alcohol had previously given them. They want to regain some of the lost immediacy or satisfaction via the transference relationship.

Addiction treatment relationships involve emotional expressions (demands for recognition, trying to please, being good, wanting to be loved, accusation, irritation, aggression, transgression, behaving badly etc.) which are signs of the pathology of the client. These emotional expressions are the essence of addiction treatment. The only way for addicts to recover is via verbalisation within a relationship where very difficult and anxiety-provoking experiences can be articulated and worked through.

It is in the very nature of addiction to undermine the pact that exists between people. This is what counsellors have to withstand and when this becomes problematic it can lead to counter-transference. It often happens that staff are idealised by addicts. At an unconscious level staff members may identify with this idealisation – there is a need in them to be admired by their clients. The treatment can become destructive if the counsellor's need feeds into the pathology of the client. This will lead to a therapeutic deadlock and the client will be forced to remain dependent on the counsellor/institution.

Loose argues that the creation and maintenance of a space of transference within society is essential. Popular culture advocates the immediacy of enjoyment which means that there is less space for dissatisfaction, desire and the social bond. This is the kind of culture that becomes less demanding of its subjects in terms of making them responsible for finding solutions to their own suffering and increasingly forces external solutions on them.

In the main body of the report, KCCP is used as a case study 'to demonstrate the need for change in the way we work with problematic drug users'. The varied lifestyles and circumstances of the programme participants are illustrated using the data from a

general questionnaire administered to the 16 participants on the programme in March 2005. Detailed accounts of the experiences of three participants are provided by way of semi-structured interview, life history and treatment history. It is clear from these examples that the participants have different histories and reasons for taking drugs. As a result of his own work with clients and his reading of the academic literature (see report for details), the author advocates an approach to treatment in which the treatment programme is tailored to meet the needs of the individual, in so far as is possible. He highlights the necessity of working with the transference that occurs in the treatment of addiction and suggests that doing so could significantly increase the effectiveness of KCCP.

The author points out that KCCP will not be in a position to employ trained psychotherapists or psychoanalysts in the short to medium term. However, he suggests that a structured training programme could enable staff to manage the transference/counter-transference in order to help their clients. In June 2005 KCCP held a half-day training course on the issue of transference/counter-transference. This was seen as a first step in increasing awareness of the issue among staff. The author argues that the Health Service Executive (HSE) must take more responsibility for the running of community drugs programmes. 'By taking a more hands-on approach, they could ensure that all staff are professionally trained and that clinical supervision is provided.'

Key elements of the author's proposed new template:

- The management of transference should be placed at the centre of KCCP's programme.
- Training in transference/counter-transference should be prioritised and funded for all staff working with clients.
- External supervision must be provided for staff.
- Additional funding should be sought to employ a psychotherapist to work with clients who have severe problems, particularly those with dual diagnosis and trauma histories.

5.4 Pharmacologically assisted treatment

5.4.1 Withdrawal treatment

Drug and alcohol detoxification: a needs assessment for Cork and Kerry
In October 2006, the Health Service Executive (HSE) published an assessment of the need for drug and alcohol detoxification services in counties Cork and Kerry (Mannix 2006). The author reviewed data from a number of national databases to determine the numbers treated for drug and alcohol dependence and the medical consequences of drug and alcohol use. She interviewed 17 clinical decision makers from a range of professional backgrounds and one health service manager about their experiences of managing clients requiring detoxification services. Six clients were interviewed about their experiences of being assessed for and undergoing detoxification. She sent 512 questionnaires to doctors (GPs, hospital consultants and psychiatrists) and addiction counsellors in Cork and Kerry. Of these, 316 (62%) completed forms were returned. This questionnaire ascertained the respondents' experiences of detoxification services and their recommendations for the future.

In relation to drug and alcohol use among the population living in Cork and Kerry, a report published on the same day revealed that, in 2004. 34% of the population aged 15–44 years had ever used a drug; cannabis was the most commonly used drug (32%); and opiates and solvents were used less frequently (2%) (Jackson 2006). According to the 2003 SLAN survey (Centre for Health Promotion Studies 2003), 21%

of the adult population of Cork and Kerry who drank on a weekly basis consumed more than the recommended weekly limit for alcohol. The number of cases who sought treatment for problem alcohol or drug use at the addiction services and were reported to the NDTRS increased steadily, from 602 in 1999 to 1,859 in 2002; this was followed by a small decrease to 1,778 in 2003. Alcohol was the main problem substance in approximately two-thirds of the cases reported to the NDTRS. The National Psychiatric In-patient Reporting System recorded approximately 200 new cases treated for problem alcohol use in psychiatric units in the region in 2000 and 2002, while an annual average of 35 new cases were treated for drug dependence in the same two years. The Central Treatment List reported that 38 people with addresses in counties Cork or Kerry received methadone treatment during 2004; the small number of cases may have been due to a lack of treatment availability rather than to a low level of demand.

The medical consequences of drug and alcohol use in Cork and Kerry were measured by reference to drug- and alcohol-related admissions to acute hospitals and death notifications. There was a notable increase in alcohol-related admissions to acute hospitals in the region, from 1,634 in 1999 to 2,360 in 2001. The number of drug-related admissions to acute hospitals remained relatively stable at around 55 per year during the same period. There were 25 direct alcohol-related deaths and 55 direct drug-related deaths in the region in the period 2001 to 2003. Between 1995 and 2001, the rate of deaths from chronic liver disease and cirrhosis of the liver (conditions associated with high levels of alcohol consumption) increased annually in Cork and remained relatively stable in Kerry.

The author reported an increase in the number of addiction services providing treatment for problem drug and alcohol use, from three in 1999 to 10 in 2003. She noted that, although a number of databases held data on alcohol and drug dependence, little information was available on the number of detoxifications provided to those treated. (Up until 2004, the type of substance was not specified in cases of detoxification reported to the NDTRS.) Using data from an area in the United Kingdom and a model developed by a Canadian researcher, the author estimated that 611 people living in Cork and Kerry would require detoxification from alcohol each year, 55 of them on an inpatient basis. She did not report how many opiate users required detoxification.

The key decision makers interviewed had experience in providing detoxification services in either a community or an inpatient setting. They reported that there was a need for a consultant psychiatrist specialising in addiction to lead the service. They said that a dedicated inpatient service was required in the region, and that general practitioners should be facilitated in providing additional outpatient detoxifications. They felt that services were required for people with drug and alcohol problems who were homeless, and that liaison workers were required to link detoxification with medication-free therapy and aftercare. The key decision makers were reluctant to develop a service for opiate users.

The health service users interviewed reported that outpatient detoxification was available from general practitioners but that inpatient detoxification could be difficult to access. They agreed with the key decision makers that additional inpatient detoxification services were required.

The survey of health service providers in the region revealed that all the psychiatrists and three-fifths of the general practitioners provided a detoxification service. The average number of detoxifications was 33 per year by psychiatrists and six per year by general practitioners. These were mainly detoxifications from alcohol, although 60% of

psychiatrists and 30% of general practitioners had provided detoxifications from drugs (mainly hypnotic and sedative-type drugs) in the recent past. While almost three-quarters had referred clients to a service outside their own service, 65% reported difficulty in accessing other services, most notably the inpatient psychiatric service. Just 71% had access to aftercare services for clients who had had a successful detoxification. With the exception of the psychiatrists, all service providers were dissatisfied with current service provision in the region. The majority recommended setting up a special detoxification unit, the employment of a consultant psychiatrist specialising in addiction to lead the service, and the expansion of general practitioners' formal involvement in the service. The vast majority agreed that addiction counsellors should provide the link between detoxification and medication-free therapy or aftercare. These recommendations were in line with those of the key decision makers.

Both the service providers and the key decision makers were reluctant to develop a service for opiate users in Cork and Kerry; this is possibly due to a lack of expertise in dealing with opiate-dependent clients.

Detoxification treatment outcomes at one year

ROSIE Findings 2, the second bulletin from the Research Outcome Study, provides a summary of the outcomes for the 81 people in the detoxification modality one year after treatment intake (Cox *et al.* 2007a).

As the authors state, 'structured detoxification is a process whereby individuals are systematically and safely withdrawn from opiates, under medical supervision'. In Ireland, the most common method of opiate detoxification is to use methadone and to reduce the dose slowly over time. Structured detoxification programmes are provided in both inpatient and outpatient settings and usually last between four and twelve weeks.

The ROSIE detoxification cohort (n=81) was recruited from inpatient settings (56%, n=45), outpatient settings (27%, n=22) and prison (17%, n=14). The analysis presented in Findings 2 is based on the 62 (76%) of the 81 participants who provided valid answers to each individual question during their treatment intake and one-year follow-up interviews.

The detoxification participants were typically male (77%) with an average age of 26 years and were largely dependent on social welfare payments (73%). Just less than half (47%) had children but a significant minority (38%) of these did not have their children in their care. Most had spent some time in prison (70%) and 11% had been homeless in the 90 days prior to treatment intake interview.

The treatment completion rate was high, with 68% of participants successfully completing their detoxification programme (n=42). Just over one-quarter of the cohort (27%, n=17) dropped out of treatment and the remaining 5% (n=3) were transferred to another treatment type before completing the programme.

One year after treatment intake, 73% of participants (n=45) reported that they were in some form of drug treatment. Forty-two per cent (n=26) were on a methadone programme, 34% (n=21) were attending one-to-one counselling and 24% (n=15) were attending group work (Narcotics Anonymous (NA) meetings, aftercare programmes and structured day programmes).

The number of participants who reported using heroin, non-prescribed methadone, non-prescribed benzodiazepines, cocaine, cannabis or alcohol in the 90 days prior to interview decreased between treatment intake and one-year follow-up. The most

substantial reduction was in the proportion of participants using heroin (79% at treatment intake compared with 39% at one year).

Reported illicit drug abstinence rates increased from 8% at treatment intake (n=5) to 45% at one year (n=28). Abstinence from all drugs (including prescribed methadone) increased from 5% at treatment intake (n=3) to 39% at one year (n=24).

Overall, the proportion of participants who reported no involvement in crime had risen considerably at one year (to 75%) compared to treatment intake (19%). There was a reduction in the percentage of participants involved in acquisitive crime, from 35% (n=21) at treatment intake to 7% (n=4) at one year.

The authors reported a reduction in the number of participants who reported injecting drug use. At treatment intake, 48% (n=30) of the cohort had injected a drug in the 90 days prior to interview, compared with 23% (n=14) at one year. A statistically significant decrease in injecting was reported for heroin and cocaine. There were no changes in participants' injecting-related risk behaviours. The proportion of participants who reported an overdose within the previous 90 days reduced from 5% (n=3) at treatment intake to 0% at one year. However, one participant from the detoxification modality died before the one-year follow-up. This is thought to have been due to an overdose but the cause of death has not yet been independently confirmed.

Ten symptoms were used to measure the physical health of participants. The number of participants who reported seven of the ten physical health symptoms reduced between treatment intake and one year. As would be expected, there was a reduction in the number of participants reporting opiate withdrawal symptoms between treatment intake and one year. Ten symptoms were also used to measure the mental health of participants. There was a reduction in the number of participants who reported suffering from any five of the ten mental health symptoms. Most of the reductions were in anxiety-related symptoms. While there were reductions in the remaining depressive-type symptoms, the results were not statistically significant.

The authors reported an increase in participants' contact with three social care services between treatment intake and one year. The proportion of participants contacting social services increased from 2% to 10%, those using employment/education services rose from 13% to 35% and the proportion contacting housing/homeless services increased from 19% to 23%.

The authors state that the findings presented in this paper demonstrate that participation in a detoxification programme is followed by reduced drug use and injecting, decreased involvement in crime, improved physical and mental health and increased contact with social care services. The outcomes for ROSIE participants in detoxification treatment are positive when compared with national and international research. As noted in the paper, detoxification is part of a process that enables individuals to engage in further treatment (such as residential rehabilitation). Additional analysis of the ROSIE data is required in order to determine the effects of aftercare or follow-on interventions on treatment outcomes for those who have successfully completed a detoxification programme.

5.4.2 Substitution treatment

Support for GPs treating clients throughout the country
In April 2007 the Irish College of General Practitioners (ICGP) announced that its Methadone GP Co-ordinator, Dr Ide Delargy, is extending her services to GPs outside the former ERHA area. She will act as a resource for GPs already involved in

prescribing methadone under the protocol, and will aim to increase the number of GPs participating in the protocol throughout the country.

Suboxone licensed in Europe
On 24 February 2007 the combination drug Suboxone was launched in Ireland (European Medicines Agency 2006). The Department of Health and Children has established an expert group to consider the implications of the introduction of this drug and its use as a treatment for opiate dependency. In order for this drug to be prescribed, a system similar to that existing for methadone, including a protocol and a central register, will be required. The introduction of Suboxone to Ireland provides another choice of treatment for problem opiate use, as well as an opportunity to identify which substitute is most suitable for different sub-groups of patients.

ROSIE Findings 4: summary of methadone treatment outcomes
ROSIE Findings 4 provides a summary of the 1-year outcomes for people in the methadone modality one year after treatment intake (Cox *et al.* 2007c).

The ROSIE study methadone cohort (n=215) was recruited from health board clinics (50%, n=108), general practitioners (25%, n=54), community-based clinics (22%, n=48) and prison (2%, n=5). The analysis presented in Findings 4 is based on the 167 (78%) participants who provided valid answers to each individual question during their treatment intake and one-year follow-up interviews. Participants were typically male (68%), with an average age of 28 years, and were largely dependant on social welfare payments (81%). The majority (64%) had children aged under 18 years. Sixty per cent had spent time in prison and 17% had been homeless in the 90 days prior to treatment intake interview.

Methadone is a long-term treatment option and, at one year, 3% (n=5) had completed treatment. The retention rate was high: 79% (n=132) were still receiving methadone treatment at one year, 6% (n=10) had transferred to another treatment modality and 12% (n=20) had dropped out of treatment. One year after treatment intake, 90% (n=151) reported being in some form of drug treatment. Eighty-four per cent (n=141) were in methadone treatment, 26% (n=44) were attending one-to-one counselling, 15% (n=25) were in group work (Narcotics Anonymous meetings, aftercare programmes, and Community Employment schemes), and 1% (n=2) were in a structured detoxification programme.

The number of participants who reported using heroin, non-prescribed methadone, non-prescribed benzodiazepines, cocaine powder or crack cocaine in the 90 days prior to interview decreased between treatment intake and one-year follow-up. The most substantial reduction was in opiate use (heroin and non-prescribed methadone) both in terms of the proportion of participants using the drug and the frequency of use. Heroin use decreased from 84% at treatment intake to 53% at one year, while non-prescribed methadone use decreased from 48% to 16%. The frequency of heroin use decreased from 50 days out of 90 at treatment intake to 15 days out of 90 at one year, while the frequency of non-prescribed methadone use decreased from 16 days out of 90 at treatment intake to 4 days out of 90 at one year. Polydrug use in the 90 days prior to interview also reduced, from 78% (n=131) at treatment intake to 56% (n=94) at one year. At one-year follow-up, 16% (n=27) of participants reported that they had not used any illicit drugs in the 90 days prior to interview.

Overall, the proportion of participants who reported involvement in crime had decreased from 49% at treatment intake to 27% at one year. There was a reduction in the percentage of participants involved in acquisitive crime, from 28% at treatment intake to 15% at one year.

There was a significant reduction in the number of participants who reported injecting drug use. At treatment intake, 44% (n=73) had injected a drug in the 90 days prior to interview, compared with 32% (n=53) at one year. There were no changes in participants' injecting-related risk behaviours. There was a non-significant reduction in the proportion of participants who reported an overdose in the 90 days prior to interview, from 8% (n=12) at treatment intake to 6% (n=9) at one year.

Ten symptoms were used to measure the physical health of participants. The number of participants who reported nine of the ten physical health symptoms increased between treatment intake and one year, with a significant increase observed in the proportion reporting stomach pains. Ten symptoms were also used to measure the mental health of participants. There was an increase in the number of participants who reported suffering from any six of the ten mental health symptoms. This paper also reports an increase in participants' contact with GPs, employment/ education services and housing/homeless services.

The authors state that the findings presented in this paper demonstrate that retention in methadone treatment is high, and continued participation in a methadone programme substantially reduces opiate use, injecting drug use and involvement in crime. The outcomes for ROSIE participants in the methadone modality compare favourably with international outcome studies. Although rates of improvement in physical and mental health were disappointing, it is hoped that results from the ROSIE three-year follow-up will provide evidence of a positive association between long-term treatment and improvements in physical and mental health.

Factors affecting the outcome of methadone maintenance treatment in opiate dependence

A study of 440 patients on methadone maintenance therapy at the Drug Treatment Centre Board in Dublin during a three-month period in 2004 was published in 2007 (Kamal *et al.* 2007). This study aimed to measure the rates of ongoing heroin use among these patients, and to identify patient and treatment characteristics associated with poorer outcome. Treatment response was measured by analysis of opiate-positive urine samples. Of the 440 patients, 63% were male and their mean age was 32 years (range 17 to 52 years); 163 (37%) had a co-existing psychiatric illness. The average methadone dose was 74 mg. Just over one-third (34%, 147) of patients had opiate-negative urine samples during the period under observation and a further 20% (90) had opiate-negative urine samples at least 80% of the time. Those with opiate-positive urines more than 20% of the time were considered unsuccessful treatments. Factors significantly associated with lower rates of opiate abstinence were: a methadone dose of less than 60 mg, cocaine abuse and intermittent benzodiazepine abuse. Outcomes were not associated with gender, age or receipt of counselling. Patients on methadone maintenance who abuse cocaine and benzodiazepines are at increased risk of continuing opiate abuse. The authors suggest that higher doses of methadone might be necessary to prevent illicit opiate use.

5.4.3 Other pharmacologically assisted treatments

No new information

6. Health correlates and consequences

6.1 Overview

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

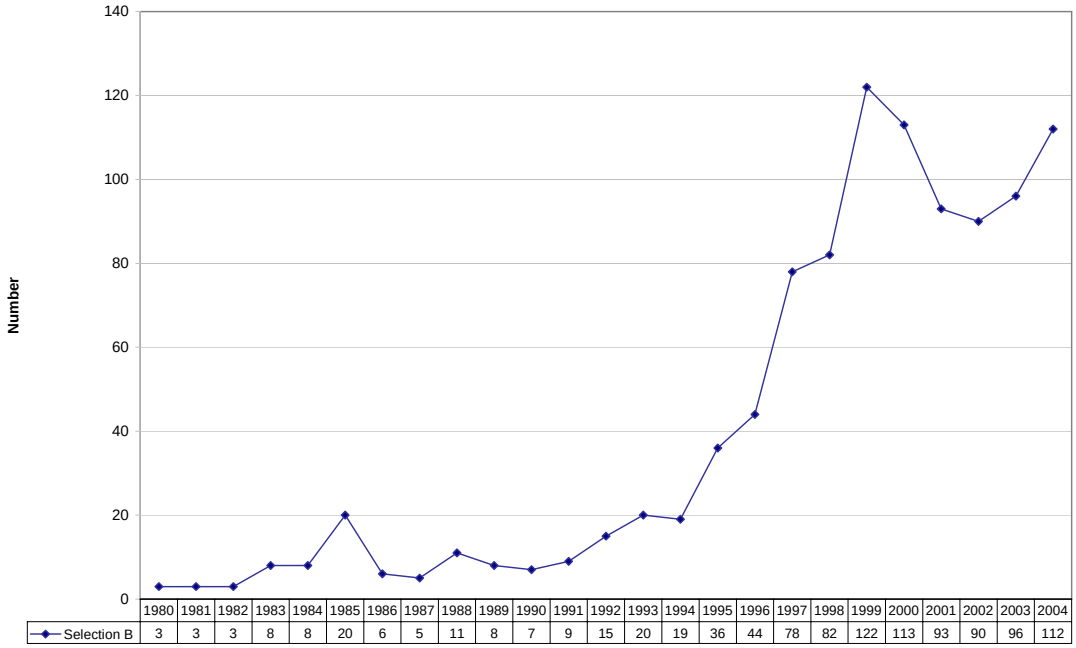
6.2 Drug-related deaths and mortality among drug users

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

6.2.1 Direct overdoses and substances involved

General Mortality Register
This section presents data on direct drug-related deaths between 1980 and 2004, based on unpublished data from the Central Statistics Office (CSO). Direct-drug-related deaths are those occurring as a result of overdose. At the European level, the EMCDDA (2002) has developed a standardised method for extracting data on drug-related deaths from the mortality registers in all member states. Staff at the CSO extracted and collated the data in February 2007, using the EMCDDA 'Selection B' definition of drug-related death.

Figure 6.2.1 presents the numbers of direct drug-related deaths in Ireland between 1980 and 2004, extracted from the General Mortality Register.



	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Selection B	3	3	3	8	8	20	6	5	11	8	7	9	15	20	19	36	44	78	82	122	113	93	90	96	112

Figure 6.2.1 Number of direct drug-related deaths in Ireland reported by the CSO, 1980 to 2004 (unpublished data from the vital statistics)

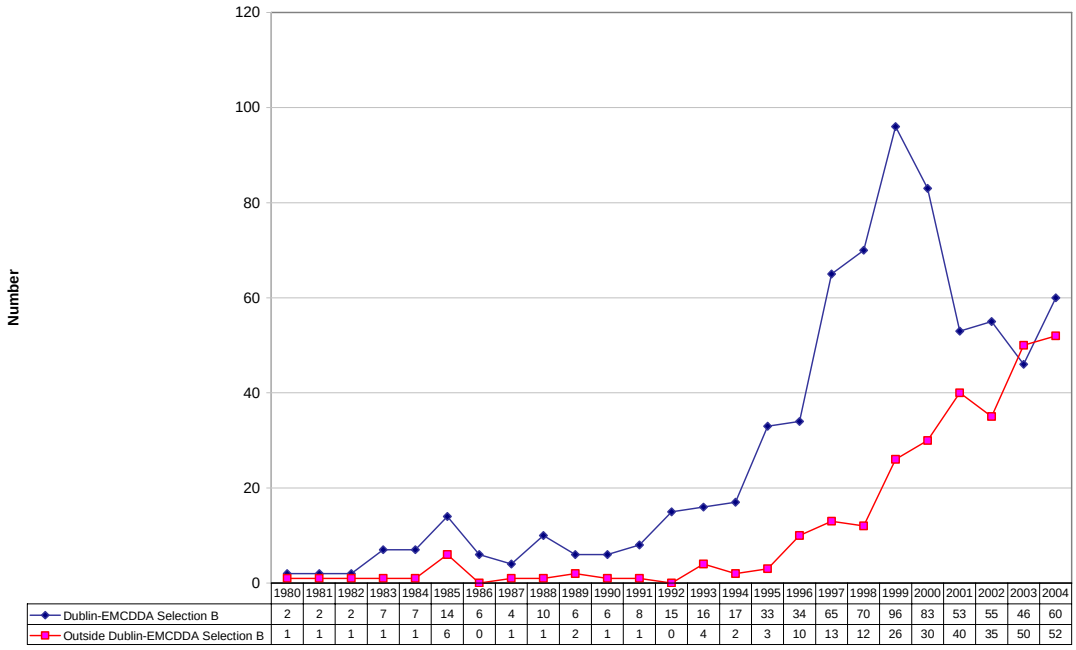
Between 2001 and 2004, 60% of direct drug-related deaths were opiate-related. In 2000 two (1.8%) drug-related deaths were due to cocaine alone; this figure increased to nine (8%) in 2004. The coding system used does not allow one to extract data on

cocaine and other drugs combined, therefore these figures are an underestimate of cocaine-related deaths.

Figure 6.2.2 presents the numbers of direct drug-related deaths in Dublin and in the rest of Ireland between 1980 and 2004. According to data from the General Mortality Register, almost all direct drug-related deaths between 1980 and 1994 occurred in Dublin. Between 1995 and 1999, there was a substantial increase in such deaths in Dublin, from 33 to 96, and a steady increase outside the Dublin area, from 3 to 26.

Between 2000 and 2003, there was a sharp decline in direct drug-related deaths in Dublin, from 83 to 46. Between 2003 and 2004, there was a considerable increase, from 46 to 60 drug-related deaths. This is the first year such an increase has been reported in Ireland since 1999. This trend has been reported in other European countries. Contributing factors may include the aging population among drug users and an increase in both the availability and purity of heroin reported in Europe generally.

During the period 2000 to 2004, there was a continued increase in drug-related deaths outside Dublin, from 30 in 2000 to 52 in 2004. In 2003, the number of such deaths outside Dublin exceeded for the first time the number in Dublin; however, the trend reversed in 2004, with more drug-related deaths reported in Dublin than outside Dublin. The data for outside Dublin follow trends in problem opiate use in that geographical area.



	1980	1981	1982	1983	1984	1985	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Dublin-EMCDDA Selection B	2	2	2	7	7	14	6	4	10	6	6	8	15	16	17	33	34	65	70	96	83	53	55	46	60
Outside Dublin-EMCDDA Selection B	1	1	1	1	1	6	0	1	1	2	1	1	0	4	2	3	10	13	12	26	30	40	35	50	52

Figure 6.2.2 Number of direct drug-related deaths in Ireland, by place of death, reported by the CSO, 1980 to 2004 (unpublished data from the vital statistics)

6.2.2 Indirect drug-related deaths

National Drug-Related Deaths Index

The National Drug-Related Deaths Index was established in September 2005 to address Action 67 of the National Drugs Strategy, which identifies the need to develop an accurate mechanism for recording the number of drug-related deaths in Ireland.

To date, the Index has collected data from the following sources:

- Coroners Service: drug-related deaths and deaths among drug users for years 1998 to 2002 where records could be located. (A small number of coroner files could not be located.)
- Central Treatment List: deaths among drug users receiving methadone treatment for years 1998 to 2005.
- General Mortality Register: direct drug-related deaths for years 1998 to 2004.

Data collection in progress includes:

- Coroners Service: drug-related deaths and deaths among drug users for years 2003 to 2005 and alcohol-related deaths and deaths among documented alcoholics for years 2004 and 2005.
- Hospital In-Patient Enquiry scheme (HIPE): Protocol is currently being developed in conjunction with hospitals using HIPE to facilitate an annual electronic download of relevant data pertaining to drug- and alcohol-related deaths from the HIPE database. Currently, retrospective data on drug-related deaths and deaths among drug users is being requested for years 1998 to 2003. Ethical approval has been received from the Health Research Board Ethics Committee and from the ethics committees of all except one of the 61 hospitals using the HIPE scheme.

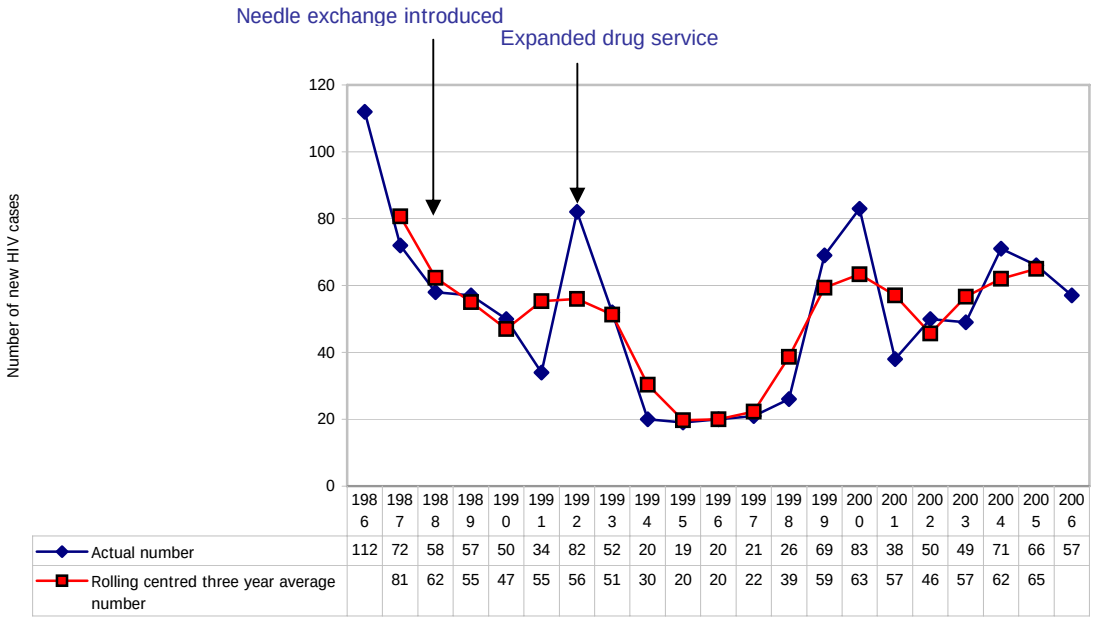
6.3 Drug-related infectious diseases

6.3.1 HIV

Newly diagnosed cases

Voluntary linked testing for antibodies to HIV has been available in Ireland since 1985. By the end of 2006, there were 4,419 diagnosed HIV cases in Ireland, of which 1,327 (30%) were probably infected through injecting drug use (Health Protection Surveillance Centre 2007).

Figure 6.3.1 presents the number of new cases of HIV among injecting drug users reported in Ireland, by year of diagnosis; data from 1982 to 1985 were excluded from the figure as these four years were combined in the source records. Figure 6.3.1 is based on data reported to the Department of Health and Children, the National Disease Surveillance Centre and the Health Protection Surveillance Centre (HPSC). There was a fall in the number of HIV cases among injecting drug users between 1994 and 1998, with about 20 cases per year compared to about 50 cases each year in the preceding six years. In 1999, there was a sharp increase in the number of cases among injecting drug users, which continued into 2000, with 69 and 83 new cases respectively. Between 2001 and 2003 there was a decline in the number of new injector cases (38, 50 and 49 respectively) when compared to 2000 but the number was higher than in 1998. In 2004, once again there was an increase (to 71 cases) in the number infected through injecting drug use compared to the preceding three years. In 2006 there were 57 cases infected through injecting drug use. It was difficult to interpret the trend due to the relatively small numbers diagnosed each year, so a smoother curve (red plot line in Figure 6.3.1) was calculated using a rolling centred three-year average. This curve presents an increase in the annual number of HIV cases in 1999; this higher number of cases was sustained between 2000 and 2006. This indicates a true increase in the number of cases.



	1986	1987	1988	1989	1990	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006
Actual number	112	72	58	57	50	34	82	52	20	19	20	21	26	69	83	38	50	49	71	66	57
Rolling centred three year average number		81	62	55	47	55	56	51	30	20	20	22	39	59	63	57	46	57	62	65	

Figure 6.3.1 Actual number and rolling average number of new cases of HIV among injecting drug users, by year of diagnosis, reported in Ireland, 1986 to 2006
Source: Adapted from data reported to the HPSC and the Department of Health and Children

Of the 57 newly diagnosed HIV cases among injecting drug users reported to the HPSC in 2006, 41 were male and 16 were female and the average age was 32 years. Of the 39 cases for whom place of residence was known, 37 lived in the HSE Eastern Region. The authors of the report on the 2004 data highlighted the need to continue to promote the use of harm reduction measures among injecting drug users.

HIV infection among heroin users and area of residence

The aim of this study was to develop a hypothesis to explain the link between HIV prevalence and area of residence. The study was conducted in two parts, using two existing data sources. In Part 1, the blood-borne viral test status and test results of a sample of clients attending treatment in December 2001 in two areas of Dublin, an inner city area (Dublin 8) and a suburban area (Dublin 24), were extracted from the Bloodborne Viral Status Dataset created by Grogan. In Part 2, the characteristics of heroin users seeking treatment for the first time at treatment services in their respective areas of residence, Dublin 8 or Dublin 24, between 1997 and 2000 were examined, using data from the NDTRS. A higher proportion of heroin users in Dublin 8 had HIV and hepatitis C than did their counterparts in Dublin 24. The analysis suggests that heroin users in Dublin 8 were more likely both to have ever used cocaine and to have used heroin daily than were those who lived in Dublin 24. Also, a higher proportion of injectors living in Dublin 8 used heroin and cocaine concurrently than did their counterparts in Dublin 24. In both samples, heroin users who lived in Dublin 8 were older than those who lived in Dublin 24. The findings led to a hypothesis: 'The risk of acquiring HIV is associated with area of residence and may be linked to cocaine use.'

6.3.2 Hepatitis

Hepatitis surveillance in 2005

According to the HPSC annual report for 2005 (Health Protection Surveillance Centre 2006), there were 1,439 cases of hepatitis C reported in 2005, compared to 1,154 cases in 2004 (Health Protection Surveillance Centre 2005), and 85 cases of hepatitis 'type unspecified' in 2003. Of the cases reported in 2005, over 70% were notified by services in Dublin, Kildare and Wicklow and the remainder by HSE areas outside these

counties. Age-standardised hepatitis C rates per 100,000 of the population living in each former health board area were calculated, by the HPSC for 2004 and 2005 (Figure 6.3.2). In 2005, the rate was highest in the Eastern Region (at 69 per 100,000) and lowest in the North West (at 2 per 100,000). The rate of hepatitis C cases per 100,000 of the population increased in each of the former health board areas. Sixty-four per cent of hepatitis C cases reported were male. Of the cases for whom age was known, 80% were aged between 20 and 44 years. Data from blood-borne viral prevalence studies indicate that around 70% of injecting drug users attending drug treatment tested positive for antibodies to the hepatitis C virus (Long 2006). Injecting practices and prison history are associated with hepatitis C status.

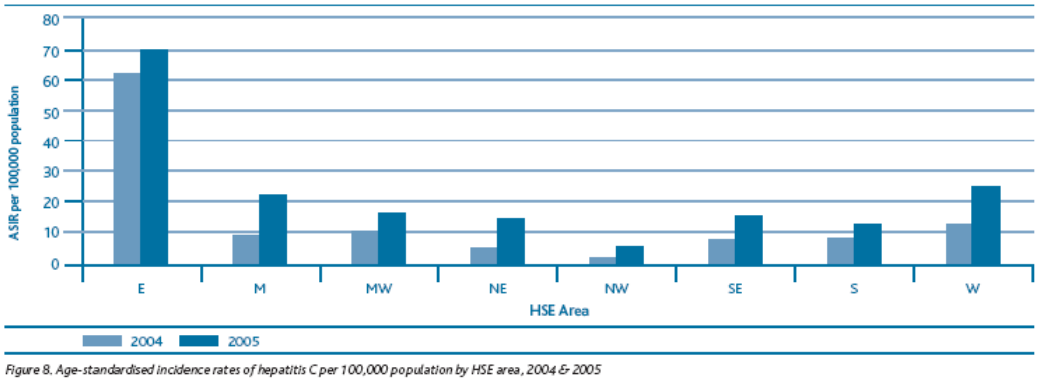


Figure 8. Age-standardised incidence rates of hepatitis C per 100,000 population by HSE area, 2004 & 2005

Figure 6.3.2 Age-standardised infection rates of hepatitis C per 100,000 population, by HSE area, 2004 and 2005
Source: HPSC (2006)

An enhanced surveillance system for hepatitis C was introduced in Ireland in 2007. Enhanced surveillance is essential to identify risk factors and for planning prevention and treatment strategies.

In 2004, an enhanced surveillance system was introduced to monitor risk populations diagnosed with acute or chronic hepatitis B. The number and proportion of chronic cases for whom risk-factor data were reported were very low for 2005 and 2006. Of those for whom risk-factor data were reported, no respondent reported injecting drug use as their main risk factor in 2006 (Table 6.3.1). This could indicate that an effective immunisation programme prevented many injecting drug users from contracting hepatitis B, or that drug treatment service providers were not aware of the need to report the risk factor status of chronic hepatitis B cases. The situation is likely to be due to a combination of both factors as one in five injecting drug users has hepatitis B, while, on the other hand, many injecting drug users in Dublin receive hepatitis B vaccine (Long 2006).

Table 6.3.1 Number (%) of acute and chronic hepatitis B cases reported to the HPSC, by risk factor status, 2005 and 2006

	Hepatitis B status					
	2005			2006		
Risk factor status	Acute	Chronic	Unknown	Acute	Chronic	Unknown
	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)	No. (%)
Total number of cases	74	706	124	93	668	59
Cases *with* reported risk factor data	49	185	13	69	158	4
Of which: Injecting drug users	0 (0.0)	3 (1.6)	1 (7.7)	0 (0.0)	0 (0.0)	0 (0.0)
Cases *without* reported	25 (33.8)	521 (73.8)	111 (89.5)	24 (25.8)	510 (76.3)	55 (93.2)

risk factor data

Source: Unpublished data from the HPSC

Epidemiology of hepatitis C infection, ERHA/HSE Eastern Region

O'Meara and colleagues (2007) published a history of hepatitis C in Ireland. This infection became statutorily notifiable in Ireland on 1 January 2004. Prior to 2004, only hepatitis A and hepatitis B were notifiable as distinct types of hepatitis. A third category, notifiable under the Infectious Diseases Regulations 1981, was 'viral hepatitis unspecified'. The majority of cases notified under this heading were thought to be due to infection with hepatitis C virus (HCV). Between 1 January 2004 and 31 December 2005, the Department of Public Health, HSE Eastern Region, received notification of 2,014 cases of HCV infection (2004, 941 cases; 2005 1,073 cases). There was no seasonal trend in HCV notifications observed. The average number of notifications each month was 83. The number of cases among men (1,269) was higher than among women (714). The highest number of HCV notifications (529, 26%) was in the 25–29 age group. Thirty cases notified (1.5%) were under 15 years of age. Drug misuse was confirmed as a risk factor for 1,247 (61.9%) of cases notified; no risk factor was identified for the remaining 767 cases. Problems with completeness of notification have been identified. Enhanced surveillance of all hepatitis C infections is a prerequisite for future service planning. Enhanced surveillance for hepatitis C was introduced in Ireland in 2007 (L Thornton, personal communication, 2007).

Overview of blood-borne viruses

In October 2006, the Health Research Board published Overview 4, which describes what is known about blood-borne viral infections among drug users in Ireland (Long 2006). The data pertaining to injecting drug users are presented where possible, and where the data are not analysed by injecting status or where injecting status is not ascertained, the data on all drug users are presented. The analysis presented in Overview 4 is based on disease notifications reported to the HPSC (formerly known as the National Disease Surveillance Centre) during the period 1995 to 2005 and on ad hoc research studies. The main observations were presented in the 2006 National Report.

6.3.3 Other infections

No new information available.

6.4 Psychiatric co-morbidity (dual diagnosis)

6.4.1 Trends in drug disorders in psychiatric facilities

The latest annual report from the National Psychiatric In-patient Reporting System (NPIRS) on activities in psychiatric inpatient units and hospitals shows that the total number of admissions to inpatient care has continued to fall (Daly *et al.* 2006).
In 2005, there were 777 cases admitted with a drug disorder, of whom 308 were treated for the first time. The report does not present any data on psychiatric co-morbidity. Figure 6.4.1 presents the rates of first admission to inpatient psychiatric services between 1990 and 2005 with a diagnosis of drug disorder, per 100,000 of the population. It is notable that the rate increased steadily between 1990 and 1995, with a dip in 1996, and further annual increases between 1997 and 2001. The rate was almost three times higher in 2001 than it was in 1990. The dips in 1996 and 2002 can be partly explained by the fact that the rates are calculated from new, larger census numerators in 1996 and 2002 compared to the year preceding each of these years. The small number of drug dependence cases each year would be sensitive to this change in numerator. The increasing rate of new cases of drug-related admission

between 1990 and 2001 reflects the increase in problem drug use in Ireland and its burden on the psychiatric services. There was a notable decrease in 2002, which was sustained in 2003. This overall decrease since 2001 possibly reflects an increase in community-based specialised addiction services during this period. The increased rate in 2005, partly accounted for by the diminishing denominator in the 2002 census, may reflect a failure of community-based specialised addiction services in Dublin to deal with drugs other than opiates, and of community-based specialised addiction services outside Dublin to deal with opiate users. Of the 818 discharges with a drug disorder, just under 45% spent less than one week in hospital and just over 19% spent more than one month in hospital.

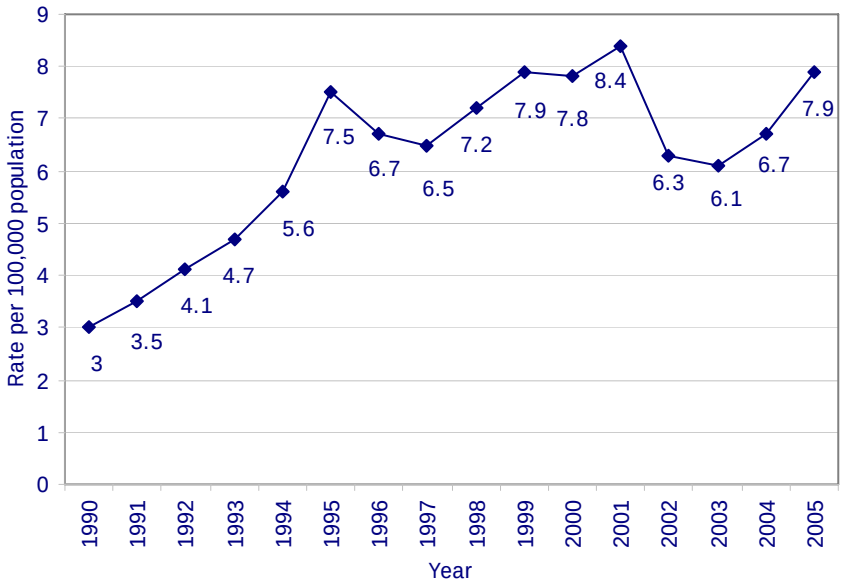


Figure 6.4.1 Rates of psychiatric first admissions with a diagnosis of drug disorder (using the ICD-10 three character categories) per 100,000 of the population in Ireland and reported to the NPIRS, 1990 to 2005

6.4.2 Alcohol dependence and mood state in a population receiving methadone maintenance treatment

The aim of this study by McManus and Fitzpatrick (2007) was to assess the prevalence of alcohol dependence and anxiety and depressive disorder symptomatology among 131 opiate users on methadone maintenance at two clinics in the south western area of Dublin. Fifty-five clients were interviewed. Prevalence rates were 56% [95% CI 43–69] for alcohol dependence, 56% [95% CI 43–69] for anxiety disorder symptomatology, and 42% [95% CI 30–55] for depressive disorder symptomatology. This finding of co-morbid alcohol dependence and psychopathology among methadone maintenance treatment clients suggests that both clients' health and methadone maintenance treatment participation and completion rates may be compromised. The author concludes that such co-morbidity should be considered when providing effectively targeted services to the drug-using population.

6.4.3 Mental illness and substance use among children in detention schools in Ireland

The report of a study on mental illness and substance use among children in detention schools was published in May 2007 (Hayes and O'Reilly 2007). Researchers interviewed three groups of adolescent males (average age 14.9 years): 30 participants were residing in juvenile detention schools (the offender group), 20 had been referred to an adolescent mental health service in HSE South (the mental

health group), and 30 were recruited from a secondary school in County Cork (the control group). They used a number of validated instruments to determine each child's emotional intelligence and mental well-being, and obtained demographic characteristics and history of offending by means of a questionnaire.

The findings show that children in detention schools in Ireland experience very high rates of substance dependence and psychiatric disorder, engage in serious criminal behaviour and have significant deficits in emotional intelligence and cognitive ability.

Eight out of ten (83%) of the offender group met diagnostic criteria for at least one psychological disorder, with the average being 3.1 disorders per detainee, which was considerably higher than that in the mental health group. Of the offender group, 18.5% reported experiencing thoughts of suicide, and the same percentage reported that they had attempted to take their lives on at least one occasion. Over one-third (38%) met diagnostic criteria for internalising (emotional) disorders such as anxiety and depression, and 68% for externalising (disruptive) disorders such as conduct and attention deficit disorders.

Sixty-seven per cent of the offender group met the criteria for at least one substance-related disorder. Approximately equal numbers reported using cocaine (13/30), alcohol (14/30) and cannabis (14/30). The average ages at which they first used these drugs were: alcohol and cannabis at nine years, cocaine at 13 years. The vast majority of children interviewed did not receive treatment for psychiatric or substance use problems.

The authors highlight the importance of addressing mental health and substance use among children in detention schools. They believe that, in addition to reducing the debilitating effect of mental health problems on a child's functioning and development, treatment will lead to a significant reduction in offending behaviour and criminality, with has significant cost benefits for society, the legal system and the Irish State.

6.5 Other drug-related health correlates and consequences

6.5.1 Somatic illnesses

No new information.

6.5.2 Non-fatal overdose

Data used in the following analysis were extracted from the Hospital In-Patient Enquiry (HIPE) scheme. HIPE is a computer-based health information system designed to collect from acute hospitals medical and administrative data on discharges and deaths. The International Classification of Diseases, 9th Revision, Clinical Modification, known as ICD-9-CM, was used to code diagnoses for the years presented in this analysis.

Each HIPE discharge record represents one episode of care; each discharge of a patient, whether from the same or a different hospital, or with the same or a different diagnosis, gives rise to a separate HIPE record. The scheme, therefore, facilitates analyses of hospital activity rather than of the incidence of disease. HIPE does not record information on individuals who attend accident and emergency units but are not admitted as inpatients.

There were 46,539 overdose cases in the period 1996 to 2004. Eighty of these cases died and have been excluded from this analysis. Cases aged between 15–65 years are included in this analysis. Figure 6.5.1 shows that the 20–24-year age group is at

highest risk, with the incidence of overdose decreasing with age. It is important to note the significant number of cases in the 15–19-year age group.

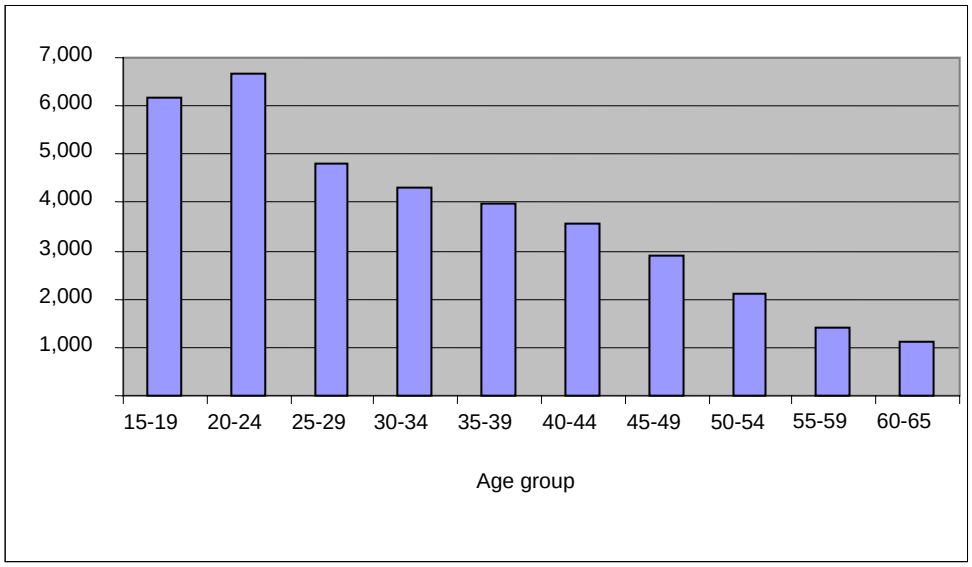


Figure 6.5.1 Incidence of overdose by age group, 1996 to 2004

Figure 6.5.2 shows the number and area or residence of recorded overdose cases between 1996 and
2004.

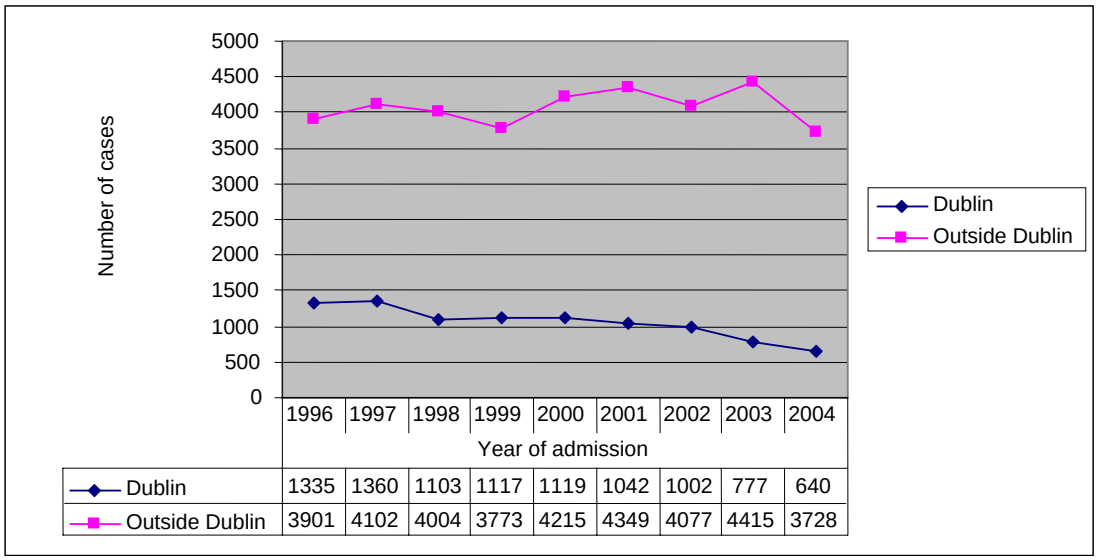


Figure 6.5.2 Area of residence of overdose cases, 1996 to 2004

Attempted suicide accounted from the majority (81%) of overdose cases reported through HIPE for the years 1996 to 2004 inclusive. Of these cases, 42% related to the use of a tranquillizer or other psychotropic-type drug and 39% related to intentional overdose with analgesics (Figure 6.5.3). According to the 2005 annual report of the National Registry of Deliberate Self Harm (2007), 41% of all drug overdoses involved a minor tranquilliser, 32% involved paracetamol and 23% involved anti-depressants.

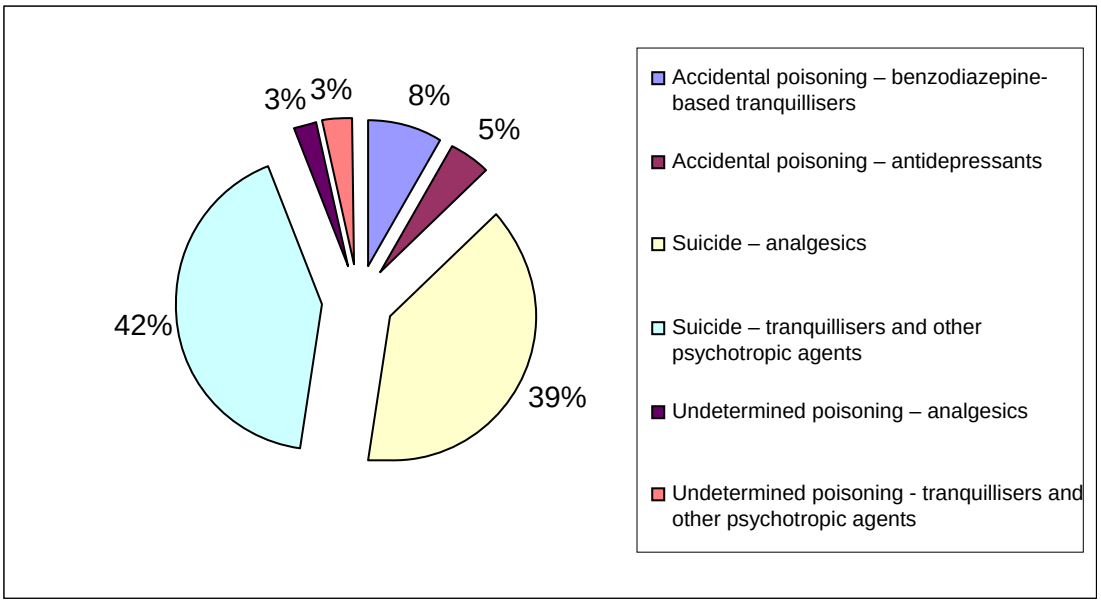
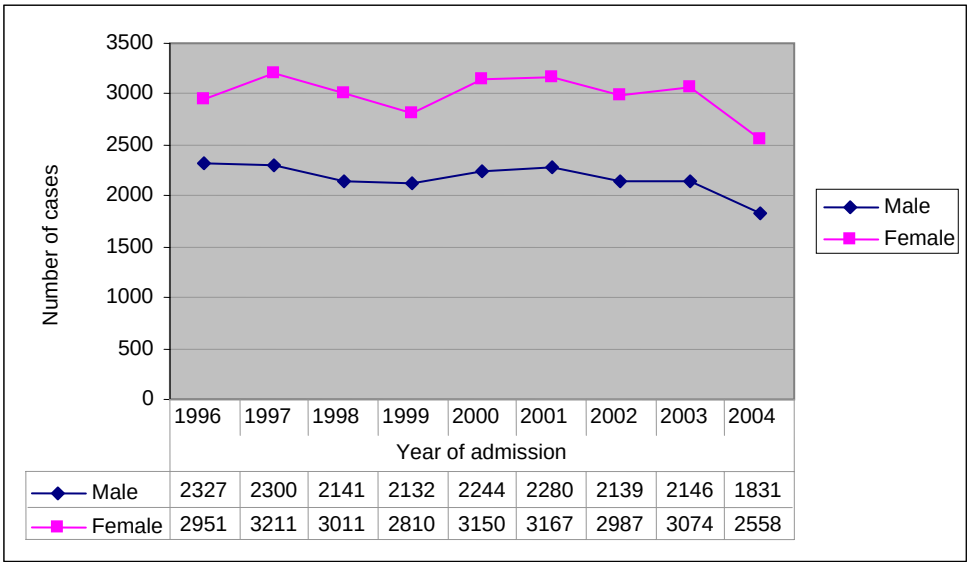


Figure 6.5.3 Most common drug category, by type of overdose, 1996 to 2004

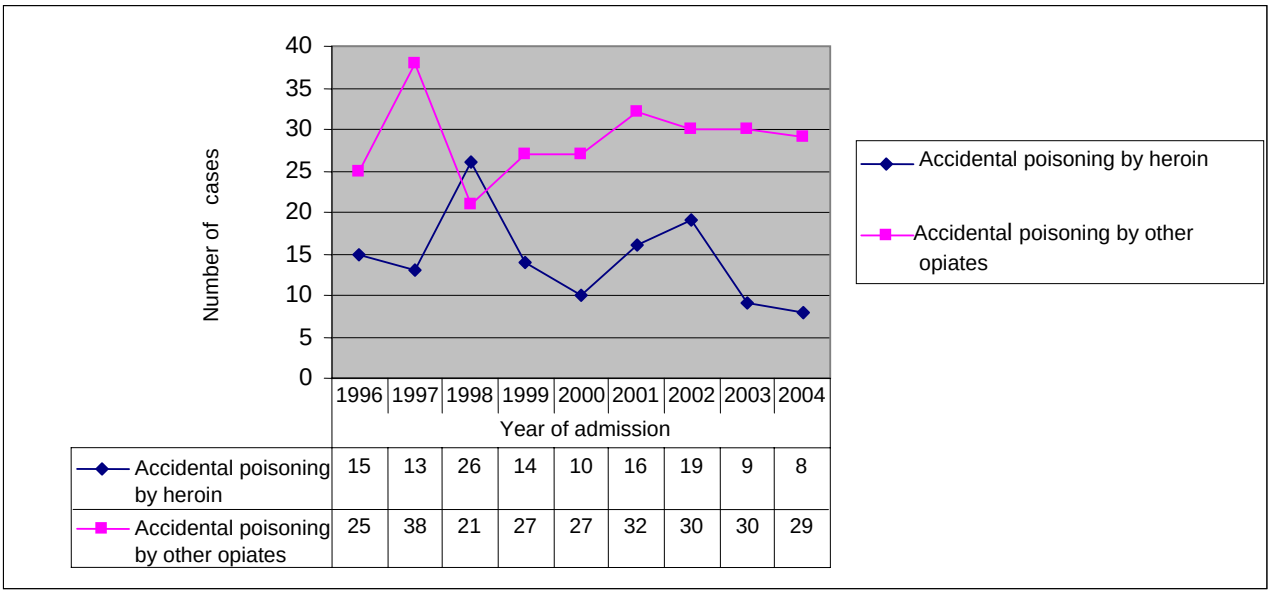
There were more overdose cases among females than among males. A significant decrease in reported incidence of overdose among females (17%) and among males (15%) is evident between 2003 and 2004 (Figure 6.5.4).



	1996	1997	1998	1999	2000	2001	2002	2003	2004
	Year of admission								
Male	2327	2300	2141	2132	2244	2280	2139	2146	1831
Female	2951	3211	3011	2810	3150	3167	2987	3074	2558

Figure 6.5.4 Incidence of overdose by gender, 1996 to 2004

Opiate-type drugs were involved in less than 1% of cases reported for each year between 1996 and 2004. Since 2002, the trend in accidental poisoning by opiates other than heroin has stabilised. The number of cases of accidental poisoning by heroin decreased by 58% in the same period, from 19 in 2002 to 8 in 2004 (Figure 6.5.5).



	1996	1997	1998	1999	2000	2001	2002	2003	2004
Accidental poisoning by heroin	15	13	26	14	10	16	19	9	8
Accidental poisoning by other opiates	25	38	21	27	27	32	30	30	29

Figure 6.5.5 Incidence of overdose involving opiate-type drugs, 1996 to 2004

Thirteen per cent more males than females overdosed using opiate-type drugs during the period 1996 to 2004. A significant number (16%) of those who overdosed using opiate-type drugs were in the 15–19-year-old group; however, the majority (27%) were in the 20–24-year-old group, and the incidence decreased in successive age groups between 25 and 54 years. Thirty-eight per cent of overdose cases involving an opiate-type drug occurred in the Dublin region.

National Registry of Deliberate Self Harm – annual report 2005

The fifth annual report from the National Registry of Deliberate Self Harm was published in March 2007 (National Registry of Deliberate Self Harm Ireland 2007). The report contains information relating to each episode of deliberate self-harm from persons presenting to all general hospital A&E departments and two of the three paediatric hospital A&E departments in Ireland in 2005. The Registry defines deliberate self-harm as 'an act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self-harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or physical consequences'.

The report concludes that there were 10,789 presentations of deliberate self-harm, involving 8,594 individuals, to hospital A&E departments in 2005. The number of presentations was 3% lower than in 2004, when there were 11,092 presentations by 8,610 individuals. The age-standardised rate of deliberate self-harm was 198 per 100,000, compared with 201 per 100,000 in 2004, representing a 2% decrease. The national rate in 2005 was 37% higher among females than among males, at 230 per 100,000 and 167 per 100,000 respectively. Forty-six per cent of all presentations were by persons less than 30 years of age, and 87% by persons less than 50 years of age. The peak age range for females presenting was 15–19 years, at 606 per 100,000. The peak age range for males presenting was 20–24 years, at 392 per 100,000. There was evidence of alcohol consumption in 41% of all episodes of deliberate self-harm.

Drug overdose was the most common form of deliberate self-harm, representing 76% of all such episodes (7,751 episodes). Overdose rates were higher among females (82%) than among males (67%). On average, 31 tablets were taken in episodes of drug overdose. The total number of tablets taken was known in 80% of cases. Forty-

one per cent of all drug overdoses involved a minor tranquilliser, 32% involved paracetamol and 23% involved anti-depressants.

The report recommends the following measures to reduce the incidence of deliberate self-harm:

- a comprehensive mental health awareness campaign to reduce levels of psychiatric and psychological morbidity in the population
- additional resources to support mental health promotion, and specialist mental health services for adolescents aged 15–19 years
- evidence-based interventions targeting persons who repeatedly self-harm
- a mechanism for linking data collected by the Registry with data on suicide mortality to improve understanding of the relationship between deliberate self-harm and the risk of suicide in the future
- extension of the core Registry dataset to support evaluation of progress on actions in the strategy document on suicide prevention, *Reach Out* (Health Service Executive *et al.* 2005).

Cocaine in local communities

In March 2004 CityWide published the results of a survey on the extent to which 27 community-based drug projects were dealing with the problems of cocaine use (Citywide 2004). The results illustrated that cocaine was a growing problem.

CityWide conducted a follow-up survey on cocaine in local communities in 2006 (Citywide 2006). Twenty-eight projects responded to this survey, 13 of which had participated in the 2004 survey. The results show that local community drug projects have experienced a major increase since 2004 in people presenting with cocaine as their primary drug.

In 2004, four projects (15%) reported seeing clients with what they then described as problematic cocaine use. Two years later, 62% of projects reported treating clients presenting with cocaine as their primary drug.

The follow-up survey reports a deterioration in the general health of clients with problematic cocaine use, with 39% of the projects surveyed reporting a rise in the number of clients experiencing abscesses and wounds due to poor injecting habits. Twenty-two per cent of projects reported an increase in mental health problems, including depression, anxiety, stress, psychotic episodes and attempted suicide.

Projects also reported increases in weight loss, sexually transmitted infections (STIs), heart conditions, amputations, opiate users stabilised on methadone destabilising with cocaine use, and risk taking among clients using cocaine. One project reported being aware of one heroin-related death in the 10 years up to 2005, in comparison with knowledge of four cocaine-related deaths in 2006.

All projects expressed concern about clients who got into financial debt, resulting in their living in fear of violent reprisal for debts unpaid, and engaging in increased criminal activity to feed their addiction. The majority of projects surveyed reported an increase in violent and gun-related crime since 2004.

The projects reported a strain on resources due to cocaine use. This was due to the chaotic lifestyle and behaviours that can be associated with cocaine use and the reported problem of opiate-using clients destabilising through cocaine use.

Since 2004, in response to the growing problem of cocaine use, three cocaine-specific pilot projects have been set up and 93% of the projects surveyed in 2006 had key workers who had undertaken cocaine-related training.

6.5.3 Driving and other accidents

No new information.

6.5.4 Pregnancy and children born to drug users

Scully *et al*. (2004) retrospectively analysed the referrals to the drug liaison midwife in the Coombe Women's Hospital, between April 1999 and April 2000. Of the 111 referrals, 85 women were prescribed methadone at delivery. Carmody and Sheppard (2005) also retrospectively analysed the referrals to the drug liaison midwife service in the Coombe Women's Hospital in the three-year period 2002–2004, during which time a total of 270 babies were born , representing approximately 1% of the births in that hospital. These are the only available published figures for referrals to the drug liaison midwife since its establishment in 1999. Scully *et al* (2004) acknowledge that the development of the specialist liaison midwife service has been of benefit to drug-dependant women, their children and the Irish health care system. Carmody and Sheppard suggest the need for possible expansion of this service. This specialist service prioritises women who are not already on methadone treatment and co-ordinates inpatient services for stabilisation and detoxification of opiate dependence if appropriate. It has established formal working relationships between the addiction service and maternity service. It offers continuity of care, education and support to these drug-dependant women.

7. Responses to health correlates and consequences

7.1 Overview

This section presents new data on preventing drug-related mortality, the management of blood-borne viral infections, and responses to co-morbidity. The definitions used are presented where necessary in the relevant sections. This section also reports on plans to increase the number of motorists tested for drug driving.

7.2 Prevention of drug-related deaths

7.2.1 Overdose prevention

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

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

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

The Group believes that, with suitable education and improved awareness of the issues involved in drug-related deaths, lives can be saved. The group supports the provisions for senior ambulance personnel with special training to carry naloxone as an emergency response to opiate overdose.

Among other recommendations of the working group were:

- all sudden and unexplained deaths should have a toxicology screen at autopsy;
- information and resource materials should be standardised across all treatment and support locations;
- all personnel who treat drug users should receive training in overdose prevention and basic life-support training;

- high-risk people should be identified and service providers should address risky behaviours among service users;
- consideration should be given to providing education in overdose prevention for service users;
- drug users discharged from prison should be allowed to link in with their local drug treatment agency, with contact numbers included in a 'pre-release' pack;
- all drug users undergoing detoxification should be told of the risks of overdose following detoxification;
- Garda members should receive training in overdose prevention;
- the National Drugs Strategy Team should research the feasibility of collecting data on non-fatal opiate overdoses or near misses.

Prevention of drug-related deaths among drug users in treatment
Because of concerns raised at the end of 2006 about the number of deaths among drug users, a working group comprising clinical staff from drug treatment services, public health personnel and a representative from the National Drug-Related Deaths Index (NDRDI) was formed to develop a response to drug-related deaths that will inform service provision and provide evidence for best practice.

The group aimed to examine the number, and suspected causes, of deaths among drug users receiving methadone treatment in Ireland in 2006 and to identify any associated factors that increase the risk of death. Its objectives were:
- To determine the number of deaths among drug users notified to the Central Treatment List (a register of all patients receiving methadone treatment for problem opiate use in Ireland) in 2006
- To provide a descriptive analysis of the circumstances of death of drug users who died while on methadone treatment or within three months of leaving treatment
- To compare the characteristics of drug users currently and previously in treatment who died in 2006 with a sample of drug users in treatment in 2006
- To better inform the drug services by providing them with timely information on deaths in drug users.

Due to the delay in obtaining a definite cause of death, the group concluded that the study was not feasible and that the best method of obtaining such data in the future would be through the work of the National Drug-Related Deaths Index.

Drug users' experiences of overdose
A study which aimed 'to explore drug users' experiences and perspectives of overdose' was carried out in Dublin in 2006 (Bolger 2007). The inclusion criteria were as follows: all participants in the study must be receiving methadone maintenance therapy in the Drug Treatment Centre Board for treatment of opiate addiction, all participants must have overdosed in the preceding year, all participants must have voluntarily agreed to participate in the study and signed a consent form, and all participants must be fluent in English. A convenience sampling method was used and the first 10 participants who volunteered and met the inclusion criteria were selected to take part in in-depth semi-structured interviews, which lasted between 30 and 60 minutes. Participants ranged in age from 22 to 46 years; seven were male and three were female. All 10 had hepatitis C and four had HIV.

The researcher asked participants questions about their own overdose experiences, including: what drugs they had used; their method of drug taking; their actual experience of overdose; whether the overdose was accidental or intentional; their perceived reasons and/or precipitating factors for accidental overdose; trigger factors

for intentional overdose; their knowledge of medical treatment for overdose; and possible strategies to prevent or reduce future overdoses.

The numbers of personal overdoses among the participants ranged from two to 30. The most recent overdose was accidental in six cases and intentional in four cases. All 10 had engaged in polydrug use in their most recent overdose. Five of the six participants who had accidentally overdosed had used heroin, and one of the four who had intentionally overdosed had used heroin. The most common drug used was methadone and all 10 participants had consumed methadone in their most recent overdose. Three of the participants reported intentionally overdosing on a combination of prescribed methadone and other prescription medication. Trigger factors for intentional overdoses included sexual abuse, physical abuse, depression and recent bereavement. Perceived reasons for accidental overdoses included reduced tolerance to drugs following a period of abstinence, variation in the quantity and quality of heroin used, and polydrug use, especially of benzodiazepines or alcohol in conjunction with heroin. Four participants were hospitalised as a result of their most recent overdose (two from intentional overdoses, two from accidental overdoses). Participants showed a lack of knowledge about medical treatment of overdose. Those hospitalised did not know how they had been treated, and only one of the 10 participants was able to name the heroin antidote given to overdose victims.

All 10 participants had witnessed another person overdosing. They were questioned about their knowledge of overdose intervention, how they had intervened and, if they had not, why they had not. Interventions such as slapping the victim, walking them around, dousing them with water, using mouth-to-mouth resuscitation and placing them in the recovery position were implemented before an ambulance was called. In general, an ambulance was called only in cases where there was serious danger, and only then after a delay of at least 10 minutes. In cases where the participants witnessed an overdose and did not intervene, the most common reason given was fear of police involvement.

Participants were asked whether they thought training in overdose prevention should be available to drug users. All 10 agreed that such training should be available to all drug users and two stated that it should be made compulsory.

The study makes a number of recommendations for reducing drug overdoses and deaths:

- a training programme on drug overdose prevention
- tighter legislation and caution when prescribing medication to drug users
- improvements in initial and ongoing psychiatric assessment of drug users
- frequent drug analysis screening of street heroin
- decreased police presence at overdose situations
- pilot studies on naloxone distribution among peers
- supervised drug-injecting facilities.

7.3 Prevention and treatment of drug-related infectious diseases

7.3.1 Strategy to deal with hepatitis C

In January 2007 the HSE established a working group on hepatitis C. The brief of this group is to build on a 2004 unpublished report on hepatitis C carried out by the then Eastern Regional Health Authority. Unlike the 2004 report, the 2007 initiative has a national brief. It is examining how best Ireland can respond to hepatitis C in the areas of surveillance, education and treatment. The working group will comment on how the recommendations of the 2004 report have been progressed. It will bring forward costed

and prioritised recommendations. The group plans to complete its report in the autumn of 2007 and present it to HSE senior management at that time (J Barry, personal communication, 2007).

7.3.2 Overview of blood-borne viruses

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

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

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

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

The principles of expanded and accessible harm reduction measures are documented in both the AIDS Strategy 2000 and the mid-term review of the National Drugs Strategy, and will lead to synergistic actions to stem the current increase in new HIV cases among injecting drug users.

Management of hepatitis C
Cullen *et al*. published two peer-reviewed studies (in 2006 and 2007) which had been presented in a published report in 2003 (Cullen *et al.* 2003). However the findings presented in the more recent studies are validated and the analysis refined.

In Ireland, long-term care for injecting drug users, many of whom are hepatitis C positive, is increasingly being provided by GPs. Cullen and colleagues (2007) describe HCV care among opiate users attending general practice in the greater Dublin area prior to the implementation of the clinical practice guidelines for hepatitis C. The clinical records of 196 out of 200 patients attending 25 general practices in the HSE Eastern Region for methadone maintenance treatment were examined on site, and anonymized data collected on HCV care processes. Half of the patients had been attending general practice for methadone maintenance treatment for more than 28 months; 72% were male and half were under 32 years of age. The average age of first injecting illicit drugs was 20 years. Ninety-nine (52%) tested positive for metabolites of drugs of abuse other

than methadone in the previous three months. There was evidence that 77%, 69% and 60% had been screened for HCV, human immunodeficiency virus (HIV) and hepatitis B (HBV), respectively. Among those who had been tested, the prevalence of HCV, HIV and HBV infection was 69%, 10% and 11%, respectively. Of those known to be HCV positive, 36 (35%) had been tested for HCV-RNA, 31 (30%) had been referred to a hepatology clinic, 24 (23%) had attended a clinic, 13 (13%) had a liver biopsy performed and three (3%) had started treatment for HCV. While the majority of patients had been screened for blood-borne viruses, a minority of those infected with HCV had subsequent investigations or treatment. New interventions to facilitate optimum care in this regard were considered. Clinical guidelines for hepatitis C management among current or former drug users attending general practice were developed.

Cullen and colleagues (2006) assessed the effectiveness of a general practice-based complex intervention to support the implementation of clinical guidelines for hepatitis C management among current or former drug users attending general practice. The study design used was a cluster randomised controlled trial in general practices in the HSE Eastern Region of Ireland.

Twenty-six practices were randomly allocated within strata to receive the intervention under study (104 clients) or to provide care as usual for a period of six months (92 clients). The research concluded that, at study completion, patients in the intervention group were more likely to have been screened for hepatitis C than those in the control group, 49% compared to 27%. A higher proportion of anti-HCV antibody-positive patients in the intervention group were referred to a hepatology clinic than the proportion in the control group, 60% compared to 32%.

Other important outcomes were: 54% of anti-HCV antibody-positive patients in the intervention group had opiate metabolites in their urine, compared to 23% in the control group. A higher proportion of patients in the intervention group (67%) were advised to reduce their alcohol consumption than the proportion in the control group,(15%).. Attendance at a hepatology was higher among the intervention group than among the control group, 51% versus 22%. Hepatitis B vaccine uptake was also higher among the intervention group.

7.4 Interventions related to psychiatric co-morbidity

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

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

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

the PCCC function the staff and finance currently used to address alcohol dependence in the mental health services.

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

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

- Mental health services for both adults and children will be responsible for providing mental health services to individuals who have another mental illness in addition to their substance abuse (dependence).

- General adult community mental health teams will care for adults with substance abuse and another mental health problem when the mental health problem is the primary problem.

- Specialist substance abuse mental health teams for adults with complex, severe substance abuse and mental disorders will be established. These specialist teams should establish clear links with local community mental health services, and clarify pathways in and out of their services.

- Two additional specialist substance abuse teams for children with substance abuse (dependence) and mental disorders should be established outside Dublin.

- A post for a national co-ordinator should be established in the PCCC function of the Health Service Executive. The co-ordinator should develop standards for the delivery of interventions to address alcohol and drug abuse (dependence) in Ireland and establish how such interventions will be linked to mental health.

7.5 Interventions related to other health correlates and consequences

7.5.1 Prevention of somatic illnesses

No new information

7.5.2 Prevention of non-fatal emergencies and general health-related treatment

No new information

7.5.3 Prevention and reduction of driving accidents

An increase in the number of motorists tested for drug driving was announced in January of 2007. The agency responsible for testing samples, the Medical Bureau of Road Safety (MBRS), anticipated that the number of drivers tested would ’double or triple‘ (*Irish Times*, 10 Jan 2007). In 2006 the MBRS tested almost 1,000 samples from drivers suspected of drug driving for traces of seven classes of drug. The Department of Transport is funding a specialist post of senior scientist in drug toxicology. According to the director of the MBRS, ’That senior scientist will be asked to head up the expansion of the drugs testing programme both in terms of numbers and in terms of categories of drugs. This is the first phase [of expansion]. There are a number of other phases on which we are in deliberations with the Department of Transport.’ The

director also said: 'Part of the expansion programme will be to keep an eye on new types of drugs, and new variations on old categories. We will expand into testing for other drugs and illegal drugs as and when the need arises.' The MBRS also has a representative on a national drug monitoring body which watches for changes in the type and composition of illegal drugs coming into the State.

The expansion of the MBRS drug testing capability comes after a series of tests on the possibility of using roadside drug-testing kits produced disappointing results. The new road safety strategy 2007–2012 is expected to include a specific plan to deal with the problem of drug driving.

7.5.4 Maternal health and child care

Drug-dependant pregnant women's experiences of disclosing their drug use to maternity services

In 1999, the then Eastern Regional Health Authority introduced a formal statutory response to the increasing numbers of pregnant women reporting with problem drug use through the establishment of a specialised drug liaison midwife service (Scully *et al.* 2004). This service is provided through three drug liaison midwives, one linked to each of the three Dublin maternity hospitals. These midwives are employed by the Health Service Executive, each allocated to a former health board area. The aims of the post are twofold. First, it integrates the addiction services and the maternity services in Dublin, and second, it supports and educates the women during their pregnancy by providing holistic care that addresses their physical, psychological, and social needs.

Lee (2006) explored drug-dependant pregnant women's experiences of disclosing their drug use to maternity services in Dublin. There are several reasons why these women are reluctant to disclose their drug usage or dependence. These women fear exposure of their drug use to their family, they fear discriminatory treatment by health care professionals and, finally, the possibility that their drug usage will lead to their children being taken in to care.

The need for this study was identified following a comprehensive review of related literature which identified a paucity of midwifery-led research in the literature regarding drug-dependant pregnant women's experiences of disclosing their drug use to maternity services. A grounded theory approach using semi-structured interview was considered the most appropriate means to conceptualise the problem and facilitate full exploration and understanding of the topic. Purposive sampling was used. Twelve women were interviewed.

The main findings are as follows:

- Disclosure occurred because the respondents wanted to protect their babies.
- There were fears among the respondents that their drug dependency would be revealed to their family (who were unaware of the situation), other mothers and visitors while in hospital
- Feelings of guilt and shame were evident pertaining to drug dependency, drug use and methadone treatment. Respondents were very sensitive to maternity staffs' comments and actions.
- The stigma associated with drug dependency was intensified while pregnant and after delivery. Perceived judgemental attitude of staff exacerbated the respondents' feelings of guilt and stereotyping. This was highlighted by the fear of rejection and acute sensitivity to the judgement of others.
- The drug liaison midwife facilitated disclosure and normalised the situation in the maternity services.

This study highlights drug-dependant pregnant women's experiences within the maternity services and offers implications for midwifery practice, service delivery and the uptake of services by drug using mothers.

7.5.5 Other health care targeted to drug users

Information for new (migrant) communities

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

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

8. Social correlates and consequences

8.1 Overview

This chapter reports data on drug offences where criminal proceedings commenced and also on trends in such offences. Until 2006, the principal source of information on drug offences was the annual reports of the Garda Síochána. In 2006, responsibility for reporting crime statistics transferred from the Garda Síochána to the Central Statistics Office. Although the CSO has published some data on drug offences and drug seizures on a Garda divisional basis, further more detailed data will be made available once the Garda data has been fully examined (CSO, personal communication, July 2007). Also, as part of the Local Drugs Task Force (LDTF) Strategic Review and Planning Process, the gardaí, through the Garda representative on the LDTF, have agreed to provide more detailed data than heretofore to assist the LDTFs in outlining the current extent and nature of the drug problem in their local area (NDST, personal communication, July 2007).

A community drug study sought to explore the experiences of three different communities in the greater Dublin area in the period 1996 to 2004. The research provides valuable information on local drug markets and crime. Another study, which sought to evaluate drug treatment effectiveness by following opiate users entering treatment over a period of time and documenting the changes, observed found positive indications of the relation between treatment and reductions in crime.

The association between social exclusion and drug use is highlighted in this section. Research by Mayock and Vekic (2006) highlights the high levels of problematic drug use among homeless youth aged 15–17 years, with half of the cohort of 40 reporting problematic heroin use. An unstable family background, time spent in state care and negative peer association are identified as pathways to homelessness. The inadequacy of the current state response to the accommodation needs of this cohort is also highlighted. Fountain (Fountain 2006), investigating the nature and extent of drug use in the Traveller community, argues that Travellers experience social exclusion and do not have equal access to education, health care, employment or accommodation. Traveller children are six times more likely to be cared for by local authorities than children in the general population. The research revealed a number of barriers to accessing drug treatment services among the Traveller community. These include lack of awareness of such services, lack of formal education, stigma and embarrassment, lack of cultural competence among service providers and perceptions of racism within services. Information is presented to highlight the association between unemployment, early school leaving and problematic drug use, however further research is needed to investigate this association and a proposal to investigate the links between early school leaving and drug use is indicated in this section.

8.2 Social exclusion

8.2.1 Homelessness

Cox and Comiskey (2006) present demographic data from 404 opiate users assessed at treatment intake between September 2003 and July 2004 in the ROSIE study. Eight per cent were homeless at baseline interview, and 18% reported a period of homelessness in the preceding three months. A higher proportion entering methadone treatment was currently homeless at the time of baseline interview compared to those entering other treatment modalities.At one-year follow-up there was a decrease from 17% to 10% of the methadone cohort reporting homelessness. This would suggest that

methadone maintenance can contribute to reducing homelessness among problematic opiate users.

Homeless youth in Dublin
Mayock and Vekic (2006) present data from the first phase of a two-phase longitudinal cohort study of young homeless people living in the Dublin metropolitan area. The research focused on young people living in Dublin for at least six months prior to the commencement of the study. The researchers conducted 'life history' interviews with 40 young people between September 2004 and February 2005. The young people were recruited through homeless services and from street settings. Fifty per cent of the cohort was aged between 15 and 17 years. Nineteen of the cohort reported becoming homeless initially at the age of 14 or younger, while 12 initially became homeless at age 15. The authors suggest that the early to mid-teen years is a period of great risk for becoming homeless.

At the time of interview, only eight of the cohort did not use illicit drugs, with the average age of first drug use being 11.5 years for the males and 13 years for the females. Fifty per cent of the cohort reported having used heroin, with almost all reporting their heroin use as problematic to the point of dependency. The majority of those who used heroin had first experimented with it *after* they became homeless.

The research identified three broad pathways into homelessness for the study cohort:
- Household instability, family conflict and parental alcohol and drug abuse
- Moving between foster homes, residential care placements or residential placement homes produced exceptional vulnerability and deep resentment about their separation from parents and/or siblings
- Negative peer association and personal problem behaviour.

The authors report that, when exposed to the experience of homelessness over an extended period, young people became heavily involved in using drugs and committing crime on a daily basis to finance their drug use. This led to a process of '"*acculturation" into the street scene where they 'learned the street competencies they need to survive by becoming embedded in social networks of homeless youths' (p. 23).* However, some of the cohort who managed to avoid the transient nature of hostel life and remained in the one place for an extended period of time were able to escape the street homeless scene, avoid drug use and attend school.

Limited service options for vulnerable young people means that it is not easy to avoid being placed in emergency accommodation such as hostels. For example, the vast majority of the young people in this research had used or were using the Out Of Hours Service (OHS) in the city centre. This crisis service was set up to respond to the accommodation and care needs of homeless youth aged 18 or under. Young people can only access the service by going to a Garda station after 8 pm. It is then the duty of the gardaí to contact the OHS social work team who will determine where to place the young person in the emergency service if returning to the family home is not an option. This means that these young people continue to move between city-centre hostels and become particularly vulnerable to exposure to alcohol and drug use, criminal activity and intimidation and bullying. According to the authors,

> this initial period of contact with the city centre homeless 'scene' was a common point of initiation into a whole range of risky behaviours and, within a relatively short period of time, a large number had become immersed in the street-based social networks. (p. 22)

Drug use and social exclusion among homeless people

The Homeless Agency (2007) recently launched its action plan to eliminate long-term homelessness and the need to sleep rough in Dublin by 2010 (Homeless Agency 2007). As part of the development of the action plan, a total of 105 men, women and children, both current and past users of homeless services, were interviewed. The principal immediate causes of their becoming homeless were identified by those interviewed as family breakdown, and alcohol, heroin and mental health problems. When asked to comment on existing homeless and housing services, interviewees mentioned the shortage of treatment/detox beds, as well as the impossibility of giving up drink or drugs while on the streets. The importance of appropriate accommodation, including transitional housing, after treatment and/or detoxification was emphasised as a first step in relapse prevention. There were repeated calls for 'dry' hostels for homeless people wishing to be drug or alcohol free and 'wet' hostels for those unable or unwilling to remain abstinent.

8.2.2 Unemployment

Little is known of the overall association between unemployment and problematic drug use in Ireland. However, Keane (2007) highlights the high levels of unemployment among problematic drug users in treatment. Data from the National Drug Treatment Reporting System (NDTRS) show that there are very high rates of unemployment among individuals reporting for drug treatment in Ireland. For example, of the 5,250 cases entering treatment in 2003, 61% (3,203) were unemployed and 72% were male. This figure contrasted with the national unemployment rate, which fluctuated between 3% and 4.6% in the three years 2001–2003 (CSO 2005).

8.2.3 Early school leaving

The National Advisory Committee on Drugs (NACD) is commissioning an external contractor to carry out the fieldwork component of a large, national study, 'Drug use among young people: a comparative study of early school leavers and school attendees'. This study aims to consider how the key social contexts of an adolescent's life affect problem drug use among early school leavers and those routinely attending school. The study will examine the role of risk and protective factors in young people's alcohol and drug use. A survey will be conducted by face-to-face interviews with participants who will be interviewed in small groups. The sample population to be surveyed will be young people aged between 14 and 18 years. The NACD has estimated the sample size to be in the region of 840 –1,000 young people.

Cox and Comiskey (2006) reported that the average school-leaving age of participants in the ROSIE study was 15 years, and that 28% were 'early school leavers' and had left school before the age of 15. A higher proportion entering methadone treatment had no educational qualifications, compared to those entering other treatment modalities.

8.2.4 Financial problems

Cox and Comiskey (2006) reported that the main source of income for the majority of study participants (77%) in the ROSIE study was social welfare payments.

8.2.5 Social networks

Illicit drug use and social exclusion in the Traveller community
Recent research by Fountain (2006) assessed the nature and extent of illicit drug use in the Traveller community in Ireland. Data collection included interviews with 34 service providers, focus groups with 122 Travellers and one-to-one interviews with 15 Travellers who were using or had used drugs. The report provides data on drug use, the patterns of drug use, problematic drug use, drug-related risk behaviours, the effect of drug use on the Traveller community and gaps in service provision.

The author reported that Travellers experience social exclusion and do not have equal access to education, health care, employment or accommodation. Traveller children are six times more likely to be cared for by local authorities than children in the general population.

Qualitative research indicates that cannabis, sedatives, tranquillisers and antidepressants are the drugs most commonly used in the Traveller community. These are followed by cocaine and, to a lesser extent, ecstasy. These findings mirror the pattern of drug use in the general population. In addition, the Traveller population reported occasional use of amphetamines. The less common substances used by Travellers were heroin, crack cocaine, LSD and solvents, again mirroring the pattern in the general population. Injecting drug use among the Traveller community was not commonly reported. As in the general population survey, more male than female Travellers used drugs, and those in the age range between adolescence and early thirties were more likely to be users. The impact of drug use on Traveller users included poor personal health, involvement in criminal activity, exclusion from the family and the broader community, and stigmatisation. Members of the drug user's family were likely to suffer from stress.

The Travellers interviewed described some of the ways their community dealt with drug use, including home detoxification, avoiding drug-using friends, promising a priest not to use any more drugs and seeking treatment; formal treatment was rarely sought. There was no consensus on how to deal with drug dealing in the Traveller community and it was reported that the gardaí were reluctant to tackle the issue. There was evidence throughout the research findings that there was a lack of knowledge about drugs and drug use among Travellers. There are a number of barriers to accessing drug treatment services: lack of awareness of such services, lack of formal education, stigma and embarrassment, lack of cultural competence among service providers and perceptions of racism within services.

The key recommendations of the report were:

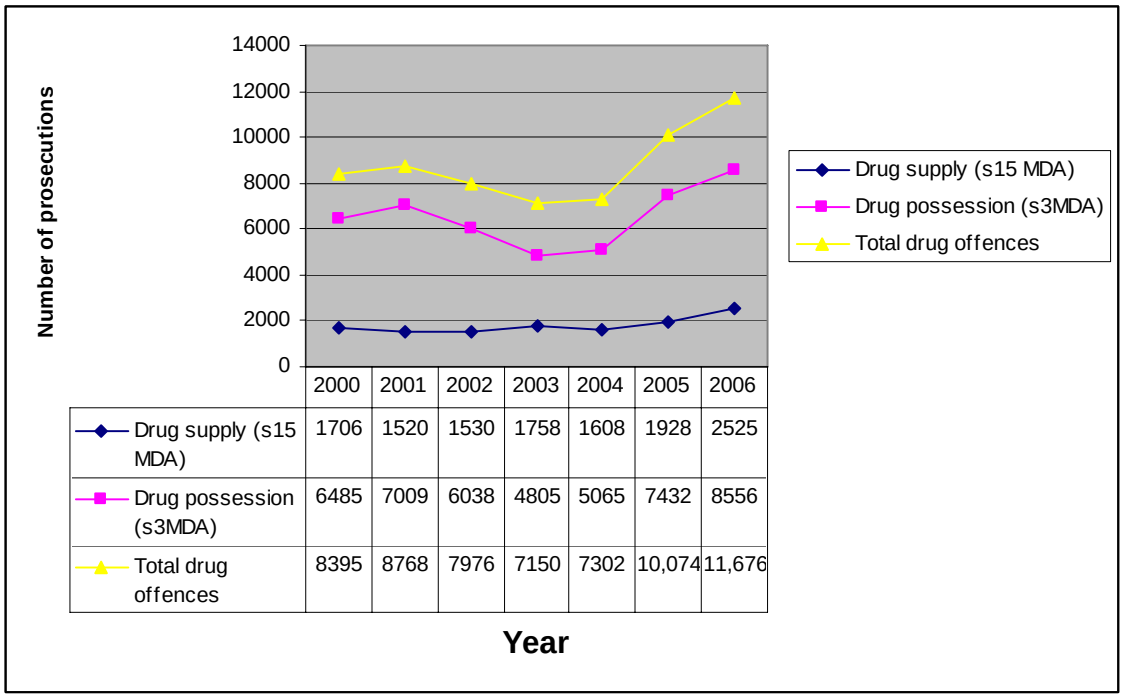
- Develop procedures on ethnic monitoring.
- Carry out equality proofing of policies and procedures in social, health and drug-related services.
- Increase awareness of drugs and drug use among Travellers using appropriate methods.
- Adapt the existing drug services so that Travellers can access them.
- Implement a process to engage the Traveller community in addressing drug use.
- Conduct further research.

8.3 Drug-related crime

8.3.1 Drug offences

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

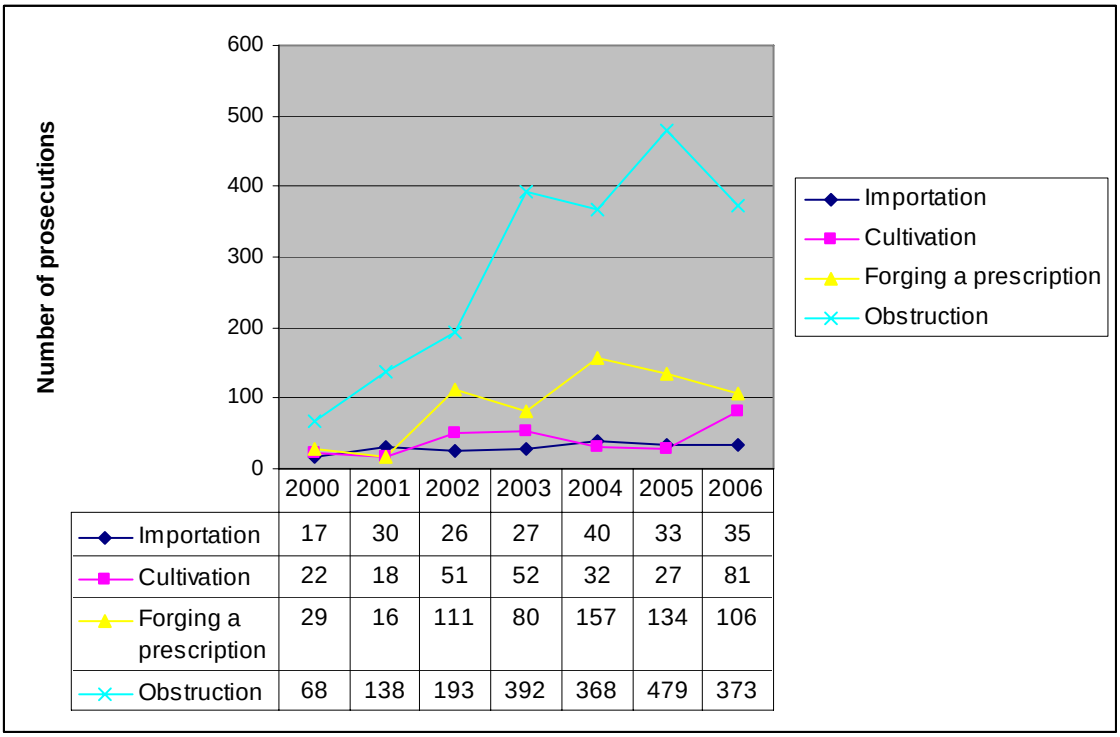
Figure 8.3.1 shows trends in the number of drug supply (s.15 MDA 1977), possession (s.3 MDA 1977) and total drug offence prosecutions between 2000 and 2006. The majority of prosecutions are for drug possession, which has continued to rise steadily since 2003. In 2006 simple possession offences accounted for 73.2% of the total drug offences prosecuted. The number of simple possession offences increased from 7432 in 2005 to 8556 in 2006. The number of supply offences which led to a prosecution in 2006 was 2525, representing 21.6 % of the total number of offences prosecuted.



	2000	2001	2002	2003	2004	2005	2006
Drug supply (s15 MDA)	1706	1520	1530	1758	1608	1928	2525
Drug possession (s3MDA)	6485	7009	6038	4805	5065	7432	8556
Total drug offences	8395	8768	7976	7150	7302	10,074	11,676

Figure 8.3.1 Trends in possession (s.3 MDA), supply (s.15 MDA) and total drug offence prosecutions, 2000–2006
Source: Annual reports of An Garda Síochána 2000–2005; Central Statistics Office 2006.

Figure 8.3.2 shows trends in a selection of prosecutions for other offences where proceedings commenced between 2000 and 2006. Prosecutions for obstructing (s.21) increased by just under 73% between 2000 and 2005. Prosecutions for cultivation or manufacture of drugs increased by 200% during 2006.



	2000	2001	2002	2003	2004	2005	2006
Importation	17	30	26	27	40	33	35
Cultivation	22	18	51	52	32	27	81
Forging a prescription	29	16	111	80	157	134	106
Obstruction	68	138	193	392	368	479	373

Figure 8.3.2 Selected MDA drug offences, excluding possession and supply, where proceedings commenced, 2000–2006
Source: Annual reports of An Garda Síochána, 2000–2005; Central Statistics Office 2006.

8.3.2 Other drug-related crime

Community drugs study
A study by Loughran and McCann (2006) explored the experiences of three different communities in the greater Dublin area in the period 1996 to 2004. The research provides valuable information about local drug markets and crime.

According to the authors, 'the drug markets are perhaps the clearest indication of the extent of the drugs problem's infiltration into a community' (p. 56). Visible drug dealing was found to impact negatively on the lives of community members by increasing their sense of fear and by eroding community confidence. According to the report, 'not only are people using drugs in the areas, but their behaviour around drugs is impacting on the quality of life locally, determining people's activities and how they use their local amenities' (p. 12). Many of the local residents reported witnessing dealing outside their homes, an activity which they perceived as very intimidating. The research also revealed that, in areas where dealers felt free to trade openly and were organised enough to operate without fear of intervention from the gardaí, the community inevitably felt vulnerable.

The research also revealed that, in the eight years under review, changes had occurred in the local drug markets in these communities. Notwithstanding the high visibility of drug dealing in certain areas, in many instances it had become less visible. The widespread use of mobile phones, the introduction of CCTV, community regeneration and a shift towards cocaine use have all contributed to this recent phenomenon. The research showed how patterns of drug dealing have also changed in some areas. Previously, so-called 'drug barons' controlled dealing in the communities but in recent years local people have become increasingly involved. As one resident remarked, 'a lot of younger kids are doing the running' (p. 58).

Throughout this research, crime emerged as a major issue for members of the three communities. Many of the participants perceived the incidence of crime to be directly linked to drug use (including alcohol). Residents' experiences of crime had also changed between 1996 and 2004. There appeared to be a reduction since 1996 in certain offences, such as handbag snatching, house burglaries and theft from local shops. This was attributed largely to increased employment opportunities and the provision of methadone for drug users in the local communities. However, for many residents a sense of safety in public places had decreased over time. Rather than being fearful of experiencing a burglary, as they had been in 1996, community members now reported a fear of anti-social behaviour which, in many instances, was related to groups of young people congregating, drinking and using other drugs. Many residents also reported a greater sense of intimidation from gangs on the street.

Emerging from the research was a general perception that there was greater violence associated with drug dealing in 2004 than there was in 1996. According to the residents, in the past, local dealers might have received a warning or been assaulted but in more recent times they are increasingly likely to be shot. Many also believed that it was more dangerous to be a drug user in 2004 than it was in 1996. This was because some drug users experienced beatings by local gangs of younger people who were themselves using different types of drugs but who did not classify themselves as problematic drug users. The research also indicated that much of the crime experienced locally was unreported. This could be due to deteriorating relationships with the gardaí, stemming mainly from a loss of faith in their ability to respond effectively to problems occurring in their communities. An alternative explanation for the underreporting of criminal activity could be fear of reprisal from those involved in drug dealing (Connolly 2003).

The authors conclude that the concern of the people involved in this research was not only about direct drug-related crime, for instance, dealing, but about anti-social behaviour stemming from both alcohol and drug use which made life difficult for many community members.

Research Outcome Study in Ireland

The results of the ROSIE (Research Outcome Study in Ireland) study were published in September 2006. ROSIE Findings 1 reported the one-year outcomes for the follow-up population across the three modalities. The findings revealed that there were extensive reductions in both drug use and criminal activity in the follow-up population one year after treatment intake. ROSIE findings 2, 3 and 4, published in 2007, revealed the results of the detoxification, abstinence and maintenance modalities at one-year follow-up. The results of these separate studies are documented below.

Detoxification Modality (ROSIE, Findings 2)

The percentage of participants involved in acquisitive crime fell from 35% at treatment intake to 7% after one year. There was also a decrease in the numbers involved in selling/supplying drugs. In addition, the proportion of participants who committed theft from a person, shop, vehicle, theft of a vehicle, and handling stolen goods reduced over the period. Overall, the numbers who reported no criminal involvement rose from 19% at treatment intake to 74% at one year.

Abstinence Modality (ROSIE, Findings 3)

As in the detoxification modality, there was a reduction in the percentage of participants involved in acquisitive crime, which fell from 35% at treatment intake to 13% at one year. There was also a reduction in the number of participants involved in the selling/supplying of drugs between treatment intake and one-year follow-up. The

proportion who committed crimes such as theft from a person, theft from a house/home, handling stolen goods, fraud/forgery/deception and assault also reduced over this time period. Overall, the number of participants who reported no criminal involvement rose from 43% at treatment intake to 76% at one year.

Methadone Maintenance (ROSIE, Findings 4)
In relation to criminal activity, there was a reduction observed in the percentage of participants involved in acquisitive crime, which fell from 28% at treatment intake to 15% at one year. Reductions were also observed in the number of participants who reported selling/supplying drugs over this time period. In addition the proportion of participants who reported theft from a shop, handling stolen goods and soliciting reduced over this time period. The numbers reporting criminal involvement fell from 49% at treatment intake to 27% at one year.

8.4 Drug use in prison

A new strategy document published by the Irish Prison Service (IPS), *Keeping drugs out of prisons*, proposes to tackle the use of illicit drugs in Irish prisons by focusing on supply elimination and demand reduction (IPS 2006a). To implement this new strategy, the IPS recognises the need for quality research on the extent and nature of drug misuse within Irish prisons. In his address to the annual conference of the Prison Officers' Association in Killarney on 4 May 2006 the Minister for Justice reiterated his policy of 'zero tolerance' in relation to the use of drugs in prisons.

Reports suggest that visits by friends and family and the throwing of drugs over perimeter walls are among the supply routes used in Mountjoy prison. Anecdotal evidence suggests that vulnerable prisoners are pressurised into receiving drugs from visitors or picking up packages of drugs thrown over the perimeter wall. The new strategy document recommends that searches after visits should not be confined to known drug users but should include prisoners who could be intimidated into receiving drugs on a visit.

Current measures in place in Mountjoy prison to prevent the supply of drugs during visits include CCTV cameras, screened visits whereby physical contact between prisoner and visitor is prevented and random searches of prisoners. Prisoners are required to nominate visitors, who must produce identification when entering the prison, in order to reduce the number of visitors giving false names in an attempt to smuggle in drugs. These measures have been included in the new IPS policy and strategy document and are to be extended to all prisons along with new initiatives, including a recommendation that physical contact between visitors and prisoners should not be permitted unless sanctioned by the governor and that any unscreened visits should be booked in advance.

Mountjoy prison authorities and the Garda Síochána operate in partnership to prevent drugs being thrown into the prison grounds from outside; officers patrol yard areas to intercept packages and prevent prisoners collecting them; and efforts are made to arrest individuals attempting to pass drugs over the perimeter walls from outside the prison. Cases where a prison officer is suspected of smuggling drugs are handled by the gardaí.

A prisoner found to be in possession of illegal drugs is liable to a number of sanctions: evening recreation may be withdrawn for a number of days; future visits may be screened for a given period of time; or remission may be curtailed. The maximum punishment that can be applied is a loss of 14 days' remission and the loss of all privileges for two months. Similar punishments apply where a prisoner commits a drug-

related offence in prison, such as possession of a syringe, sharing a toilet cubicle for drug use or giving a false name to obtain medication.

Searches are a significant part of the attempt to reduce the supply of drugs into Mountjoy prison. Prisoners being committed to prison and those returning from temporary release are strip searched to ensure they are not carrying drugs on their person. Two random searches, where the prisoner and his cell are searched, are conducted on each landing within the prison every day. Prisoners are also sometimes searched after visits. However prison officers do not generally search visitors. Where a visitor is suspected of supplying drugs, the prison will alert the gardaí who handle the matter of searching visitors on their way into the prison. As part of the IPS strategy, passive canine units will be made available to all closed prisons to assist in the detection of drugs within the prison or in the possession of visitors.

The IPS strategy also provides for the introduction of mandatory drug testing (MDT) by the end of 2006. This will involve 5% to 10% of prisoners being randomly selected for drug testing each month. A prisoner who refuses to take the test or tests positive for drugs will incur sanctions.

The IPS recognises that the best way to reduce the demand for drugs in prison is by providing a range of evidence-based treatment options. The prison service has outlined three core tasks to support drug treatment and rehabilitation:

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

The core treatment options are:

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

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

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

- commissioning and encouraging research on drug misuse in prisons
- evaluating all programmes and interventions

- making all research data available to and liasing regularly with the relevant bodies
- investigating systems to identify and manage patient outcome data
- evaluating the effectiveness of drug interventions using intervention outcome information.

8.5 Social costs (main results of studies on the social costs related to illegal drug use)

No new information.

9. Responses to social correlates and consequences

9.1 Overview

The 2005 annual report of the Irish Prison Service details various new strategies developed and implemented in order to eliminate the supply of drugs to prisons. New measures are also being introduced in Irish prisons to help the growing number of imprisoned drug users, including addiction counselling and employment supports for prisoners and ex-prisoners. There have been significant changes in local policing structures in the context of the establishment of pilot Joint Policing Committees under the provisions of the Garda Síochána Act 2005. The establishment of a confidential, non-police phone line to help gather information on local drug dealing is also reported on.

The social reintegration of drug users has moved centre stage in the National Drugs Strategy with the publication of the report of the Working Group on Drugs Rehabilitation. The report includes key recommendations to tackle the housing, educational and vocational training and employment needs of current, stabilised and former drug users. The Working Group recommends that such measures be implemented in parallel with increased provision of residential detoxification places and childcare options for recovering drug users in treatment. New structures are proposed to co-ordinate the implementation of the recommendations contained in the report.

Recent policy pronouncements suggest that the future development of responses to the social reintegration of drug users will take place within the policy framework of social inclusion. For example, the National Development Plan 2007–2013 promises that €319 million will be available over the period of the plan under the National Drugs Strategy Sub-Programme to continue to tackle the causes and consequences of using illegal drugs. The National Development Plan and the National Action Plan for social inclusion 2007–2016 acknowledge that drug users are among the most socially excluded groups in society and requires assistance to improve their health as a prerequisite for participation in the social and economic life of society.

This section will highlight the key recommendations on social reintegration contained in the report of the Working Group on Drugs Rehabilitation (the Rehabilitation Report) and these will be discussed in the context of research in Ireland on relevant aspects of social reintegration. Highlights in this section include an innovative project to get assist homeless people into employment and a policy document by an independent advocacy group for evidence based practice that emphasises the need to extend the paradigm of drug treatment to include social care issues such as employment and accommodation.

9.2 Social reintegration

9.2.1 Housing

The Rehabilitation Report acknowledges that a lack of suitable housing is often one of the main barriers to the rehabilitation of problem drug users. The Working Group makes the following recommendations to improve housing and accommodation for recovering drug users:

1. *The specific issues in relation to the accessing by problem drug users of emergency, transitional and long-term accommodation should be examined with a view to putting in place, at local level, the inter-agency procedures necessary to facilitate recovering drug users in accessing appropriate accommodation and the services necessary to ensure that tenancies can be maintained.*

This is an important recommendation, as research by Lawless and Corr (2005) among the homeless population revealed that:
- Problematic drug users were more likely to have problems accessing homeless services and more likely to be refused access to homeless services compared to the total homeless population.
- Few of the homeless services interviewed had official policies on illicit drug use, possession and dealing.
- There was little evidence of inter-agency working between homeless service providers and drug treatment services.

2. *Dedicated supported accommodation, staffed appropriately, should be provided to cater for those who have difficulties with an independent living environment*.

   Not all drug users, whether current or recovering, will be able to cope with the demands of independent living. For example, drug users with mental illness are likely to require long-term structured care and supported accommodation. As Courtney (Courtney 2005) found when reviewing emergency services in Dublin, even when the numbers 'sleeping rough' were reducing, drug users with high-support needs such as mental illness, continued to be exposed to emergency hostels or sleeping 'on the streets'.

3. *Building on recent initiatives, the provision of transitional/half-way housing for recovering drug users should continue to be increased*.

   A limited amount of transitional/half way housing options currently exist for recovering drug users. However, transitional accommodation continues to be viewed as an important component of an overall treatment plan. For example, the Homeless Agency (Homeless Agency 2007) sought the views of a total of 105 homeless service users on what they thought about existing services and possible means of improvement. The interviewees stressed the importance of appropriate accommodation, including transitional housing, after treatment and/or detoxification. This was emphasised as a first step in relapse prevention.

4. *Local Authorities should liaise with the relevant drug task force with the aim of facilitating those recovering drug users who wish to return to, or move into, a community. Local Authorities should bear in mind the preferences of the applicant in deciding on the locality of housing to be allocated.*

5. *The long-term housing needs of problem drug users, who are capable of independent living, should be addressed, for example, through the rental accommodation scheme.*

   Drug users evicted from local authority housing for anti-social behaviour under the Housing (Miscellaneous Provisions) Act 1997 are restricted from registering on the local authority housing list. This means that unless the legislation is amended, local authorities may have difficulty liaising with drug task forces to facilitate the return of recovering drug users to local authority housing.

   The Rental Accommodation Scheme (RAS) is run by local authorities for people receiving rent supplement, and who need long-term housing. Under the RAS, the local authority will find source private accommodation and pay rent to the landlord directly. The tenant will then pay rent to the local authority at a nominal rate. This will increase long-term housing security for individuals in receipt of supplementary rent allowance. However, drug users evicted from local authority housing for anti-social behaviour under the Housing (Miscellaneous Provisions) Act 1997 are

restricted from receiving supplementary rent allowance. This would suggest that in practice they are also ineligible to avail of the RAS scheme.

6. *Tenant Liaison Officers and others involved in tenant management issues should receive training to deal with all aspects of drugs-related tenant issues.*

7. *Through the Drugs Task Forces, arrangements should be put in place for Local Authorities to nominate a contact point to whom matters arising in relation to tenancy issues pertaining to people in rehabilitation may be directed in the first instance.*

   The Homeless Agency recently launched its action plan to eliminate long-term homelessness and the need to sleep rough in Dublin by 2010 (Homeless Agency 2007). The plan contains three strategic aims, relating to prevention, local access to quality homeless services and long-term housing options with support when required. The plan contains 10 core actions (high priority) that cover more than one strategic aim and 74 additional actions (lower priority). Individuals with mental health problems, addictions (alcohol and drugs) and dual diagnosis (addiction and mental health) needs have been identified as needing healthcare and other interventions as part of the strategic aim to prevent homelessness and reduce the risk of becoming homeless.

   The Homeless Agency's action plan and *Preventing Homelessness* (Pillinger 2006), as well as the Rehabilitation Report, emphasise the challenge of improving inter-agency working between the statutory, voluntary and community sectors in responding to the needs of individuals with addiction and accommodation problems. In addition, there is a requirement for structural changes to housing and accommodation provision, to cater for people who have been through the mental health and addiction services and are moving towards independent living. The challenge facing the Homeless Agency and its partners in delivering on the strategic aim of providing long-term appropriate housing and supports is acknowledged in the plan: 'The success or failure of the Homeless Agency Partnership Action Plan is dependent on a dramatic increase over the next four years of secure and sustainable housing for people who are homeless' (p. 53).

9.2.2 Education and training

The Rehabilitation Report acknowledges that education is an essential step in the continuum of care for recovering drug users. It recommends that factors that make it difficult for recovering drug users to access education should be identified and removed where possible and an education fund for drugs rehabilitation should be established (Department of Education and Science lead). An outreach approach should be developed by the Vocational Education Committees to identify and develop responses to the adult educational needs of problem drug users in rehabilitation.

Research is needed to identify the main individual and systemic barriers preventing recovering drug user's access further educational opportunities. However, Bruce (Bruce 2004) and Lawless (Lawless 2006) reported that fear of failure, low expectations, poor confidence and fear of relapse figured among the personal barriers that prevented Community Employment participants progressing to further training and education. Systemic barriers included potential loss of secondary benefits such as medical card and supplementary rent allowance

1. *The health requirements of CE participants should be addressed during their period on the schemes. This would involve direct involvement of the Health Service Executive (HSE), working in partnership with the schemes, in all Drugs Task Force CE schemes, with service level agreements covering such issues as counselling, mental health support and general health and social services. Such initiatives would support the building of confidence and self-esteem.*

   Bruce (2004), in reviewing the operations of CE schemes in local drugs task force areas, noted that services providers were of the view that the health board's involvement in supporting clients on projects was inadequate. This meant that projects had to meet the complex health and emotional needs of clients at the expense of providing them with vocational training and labour market skills.

2. *The educational requirements of CE participants should be addressed during their period on the schemes. This would involve direct involvement of the Vocational Educational Committees (VECs) working in partnership with the schemes, with service level agreements covering such issues as numeracy and literacy and general educational requirements, leading in some cases to re-entry to formal education.*

   Bruce (2004) reported that participants on CE schemes in local drug task forces placed a high value on education and were particularly proud to attain certification.

   The number of drug specific CE places should be increased from 1,000 to 1,300 to provide more opportunities in view of the levels of demand and the settling down of Regional Drug Task Forces. Increasing the number of CE places is a useful development to accommodate the emergence of the Regional Drug Task Force plans. However, as Bruce (2004) noted it appears that young male recovering drug users are under-represented in participating in CE training. This is an area that needs further exploration if the increased capacity is to be used effectively.

3. *Participation on CE schemes should be viewed as a progressive continuum with the options of the pre-CE initiative, Drug Task Force CE schemes and mainstream CE schemes being available to clients as appropriate.*

   Bruce (2004) and Lawless (2006) reported that the notion of progression beyond participation in the CE scheme had not been developed by either participants or staff during their review of CE schemes in local drug task forces.

4. *Links to other appropriate training programmes, such as Local Training Initiatives (LTI), should be further developed with support of Local Employment Service/Area Based Partnerships to encourage progression from CE.*

   The LTI is a project-based training and work experience programme carried out *in* the local community run *by* local community groups. The LTI allows local communities to carry out valuable and necessary projects of benefit to their communities, while at the same time training participants in areas related to the project work so that they can go on to gain employment or progress to further training.

5. *A pre-CE stabilisation initiative, focusing on preparation for participation on CE programmes, should be developed and in terms of duration not exceed three months. Entry into the pre-CE scheme should follow a joint assessment involving treatment services and CE training providers.*

Bruce (2004) recommended that potential CE participants should be assessed as to their readiness for vocational training prior to being offered a place on the CE schemes in drugs task forces. This was meant to prevent individuals with unmet, complex drug-related needs being placed in projects that were meant to provide vocational training but had to also respond to the complex needs of the inappropriately placed client.

6. *It is recommended that consideration be given to assigning a post at appropriate management level within FAS with the specific responsibility of overseeing and monitoring the effective implementation and delivery of the Drugs Task Force CE schemes.*

9.2.3 Employment

The Rehabilitation Report acknowledges that recovering drug users experience difficulties in moving on from assisted employment, and in obtaining mainstream employment generally. Part of the Rehabilitation Co-ordinators' function will be strengthening links with employers' organisations and trade unions nationally, and building links with employers and partnerships at local and regional levels. In addition, while current tax/PRSI concessions linked to taking on employees generally can be availed of by those employing recovering drug users, efforts made to consolidate such concessions and their adequacy in relation to recovering drug users should be kept under review. The Rehabilitation Report makes three recommendations to improve employment opportunities for recovering drug users.

1. Access to ongoing support through the services of the Local Employment Service (LES) and the national training agency, FÁS, in conjunction with relevant case managers should be available to employers of former and stabilised drug users, as well as to other employees of the firm/organisation. These services would act as a mediator in cases where difficulties arise.

   The Ballymun Job Centre, in conjunction with the LES have developed a useful guide that informs potential employers on the issues associated with drug use and highlights the supports available to potential employers of recovering drug users (Ballymun Job Centre 2006).

2. The case manager should act as a support for the recovering drug user in employment, addressing any issues or difficulties that may arise.

   The Health Service Executive (HSE) will have the lead role in relation to case management and tracking the progression of service users as the move through the continuum of care. Client-centred care plans will be developed through negotiation with service users and supported by the case manager.

3. Awareness training on the issues associated with recovering drug users should be developed and made available to prospective employers.

Important lessons can be drawn from the work of Merchants Quay Ireland with potential employers of recovering drug users. (Randall 2000) showed that by means of education and awareness programmes, service providers could change employers' perceptions of recovering drug users. The author also found that employers of work-placement clients reported positive outcomes.

The Ready for Work programme
Business in the Community (2006) published a review of its innovative programme 'Ready for Work' (RFW). The overall aim of this programme is to enable homeless

people to break the cycle of no home – no job – no home. The RFW programme provides work experience opportunities to unemployed homeless adults. It involves two days' pre-employment training, two weeks' unpaid work experience with in-house support, and follow-up support from training and employment officers and job coaches. Programmes are run three times a year and serve as a first step for candidates who have been through the homeless services, and in some case the addiction and related support services, and are re-entering the world of work.

The review includes a number of candidates' stories highlighting the personal and social progress made in the course of their involvement with the RFW programme. Some describe the positive impact of treatment for alcohol and drug misuse in assisting the candidates to move beyond their experience of homelessness towards engagement with the programme.
The review also includes information on outcomes of the 12 programmes run in the years 2002 to 2006. It reports that 118 candidates commenced the programme, of whom 53 have commenced work; 44 have accessed further training and education; and 19 are now living independently.

The RFW programme is innovative in a number of ways:

- There is a strong partnership approach between the candidates, the business sector and homeless service providers such as the homeless agency. Some 20 corporate supporters offer funding, facilitators, job coaches or work experience placements. A minimum of 20 homeless service providers are engaged with and support RFW.

- The programme has input from a steering group of members of the business community. The remit of the steering group is to increase awareness of the RFW programme among employers, to increase the pool of companies involved, to communicate issues faced by candidates to prospective RFW companies, and to ensure productive two-week placements by matching skills to jobs.
- The programme offers job coaching by matching a volunteer from the business sector to a candidate who has completed a programme, in a six-month coaching relationship.

The business sector also benefits from involvement in the RFW programme. According to the co-ordinator of the programme, Rosemary Carvill,

> the greatest learning for many of those in the corporate sector has been the realisation that people 'out of home and out of work' are not so different from themselves. They also discover how little it takes to help someone to regain control of their life.

The RFW programme is an example that can be taken and developed by drug treatment agencies in partnership with employers in targeting the vocational and employment needs of individuals who are seeking to move beyond the drug treatment system. The merits of this programme were extolled in a recent editorial in the *Irish Times* (30 October 2006):

> The Ready for Work scheme, designed to provide jobs for the homeless, is a particularly useful exercise in that it reaches out to the dispossessed and allows them a chance to start afresh. Homeless people are at a particular disadvantage when they look for work because they have to use a hostel or temporary accommodation as their address. As a result, they are invariably not called for interview. In order to circumvent that problem, a range of major companies have been encouraged to commit, in advance, to the employment of homeless persons.

Drug Policy Action Group recommends co-ordinated social care for drug users
Cox and McVerry (2006) compiled a policy paper for the Drug Policy Action Group (DPAG) an independent advocacy group for developing evidence based policy. This paper was launched in November 2006 at a public forum. The paper acknowledge that, for a large majority of people, social care is provided by family, friends and neighbours through informal networks of mutual support and is supplemented by state-sponsored institutional care through the public health system, social care services and education, employment and housing supports. But, the paper points out, very often the most vulnerable members of society, including a high proportion of drug users, who have the most complex needs, are likely to fall between the gaps in services. When drug users present for help and support, very often to specialist drug treatment agencies, a high proportion present with multiple problems, including psychological and serious mental health problems, employment and economic issues, poor living arrangements, familial and social relationship difficulties, and legal problems. The paper claims that the way the specialist drug treatment service has evolved in Ireland (in a similar way to that of other health and social care services) means that it operates largely in isolation from other services and is generally unable to deliver a continuum of care. While the drug treatment service may be doing an excellent job in responding to people's addiction problems, there is a lack of co-ordination between drug services and agencies and other generic social care services, such as housing agencies, national training and employment agencies and mental health services.

In particular, the authors of the paper highlight two vital components of social care, employment and housing, and argue that, because of the uncoordinated nature of social care services targeting drug users, these needs are not addressed in a meaningful manner. For example, the report highlights the strong association between unemployment and problem drug use, but rightly notes that the causal direction of the association is complex. Nonetheless, it notes that improving employability for problem drug users can be a major factor in preventing relapse.

The authors argue that work provides a sense of responsibility, personal value, independence, security, dignity and a stake in society. On the other hand, the authors note that enhancing the employability of drug users has not traditionally been a priority for treatment and rehabilitation services, where the clinical goals of abstinence or stability and maintenance are generally given priority. This is a view partially articulated in a recent report by the National Economic and Social Forum (NESF), which identifies people with drug and alcohol dependencies as one of the marginalised groups particularly prone to experiencing labour market vulnerability, and states that there is a lack of employment support mechanisms to assist their progression (National Economic and Social Forum 2006).

The DPAG paper recognises that housing is more than simply providing a roof over someone's head. It is also about providing security, privacy and a space to develop. Housing is a vital component of social care and often the key to independent living. For many problem drug users, family and friends provide the main form of social care in terms of housing; however, living in the family home does not always work out. Research by Houghton and Hickey (2000) and O'Brien *et al*. (2000) highlights the association between problem drug use and family conflict and relationship breakdown in the home, often leading to those with addiction problems experiencing homelessness.

The paper concludes with five recommendations; the DPAG believes that, where a commitment is given to these recommendations, benefits will occur at policy, organisational and service-user level.

1. The DPAG recommends an understanding of 'complex needs' which takes into account that each separate need interlocks with all of an individual's other needs and cannot be adequately addressed in isolation from those other needs
2. The DPAG recommends that social care providers prioritise the importance of, and agree upon a strategy to develop, a strong organizational commitment to interagency work, which collectively will enhance the provision of social care services in Ireland.
3. The DPAG recommends the development of an interagency strategy to provide accessible entry to and retention within and across social care services in Ireland.
4. The DPAG recognises the importance of service user involvement in the development and implementation of existing and emerging models of social care delivery for problem drug users.
5. The DPAG believes that a published national audit of social care services/agencies is a necessary first step towards highlighting the current state of affairs, progress made and necessary improvements.

The presentation of this paper in a public forum provided an opportunity to discuss and debate the merits or otherwise of the central claims contained therein. The paper challenges both policy makers and service providers to consider ways of addressing the complex needs of drug users within a multidisciplinary social care model. Two additional elements of a social care approach are user involvement and inter-agency working. Such an approach needs to integrate drug treatment services with employment and housing services.

9.2.4 Basic social assistance

No new information.

9.3 Prevention of drug-related crime

9.3.1 Assistance to drug users in prison

The Irish Prison Service (IPS) annual report for 2005 (Irish Prison Service 2006b) reports 5,088 sentenced committals that year, of which 281 (5.5%) were for drug offences, 15 of which were for a period of 10 years or more.

The mid-term review of the National Drugs Strategy took place in 2005 (see National Report 2006). The Review Group, while supportive of the efforts to improve the levels and quality of drug treatment services in prisons, recommended that the IPS should establish closer links with key stakeholders such as the Drugs Strategy Unit of the Department of Community, Rural and Gaeltacht Affairs and the National Drugs Strategy Team (NDST). On foot of this recommendation, the IPS made presentations in 2005 to both the NDST and the NACD in relation to prison drug use. Also in 2005, a seminar aimed at developing policy on drugs in prisons was held for governors and senior managers in the Prison Service.

The IPS 2005 report details various strategies implemented and developed in the course of the year in order to eliminate the supply of drugs to prisons. Such initiatives included the installation/upgrading of netting over recreation yards and the introduction of CCTV cameras with enhanced digital image quality and recording facilities. In addition, new visiting arrangements previously in existence in Mountjoy Prison and St Patrick's institution were extended to a number of other prisons during 2005. Under these new arrangements, prisoners are required to identify in advance a limited number of people from whom they wish to accept visits. This measure was introduced as there was some evidence that prisoners were being intimidated by other prisoners into accepting visits from individuals involved in supplying drugs to the prison.

In relation to drug treatment, the report states that 'significant work was undertaken during the course of the year to identify and clarify the resources required both to address the existing deficits in prison drug treatment provision and those new resources required to support the implementation of a comprehensive treatment programme' (p. 24). It goes on to express 'grave concern' at the limited resources available for drug treatment provision, despite the increasing demand for these services.

The report provides details regarding the provision of drug treatment to prisoners. Table 9.3.1 shows the number of prisoners reported to the Central Treatment List as being in receipt of methadone while in prison in 2005. Nine prisons provided methadone maintenance in 2005. The number of prisoners receiving methadone increased by 19.5%, from 1,309 in 2004 to 1,564 in 2005. There was an increase of 76% over the same period in the number of individuals who were first treated for their addiction while in prison. According to the report, these increases occurred despite the fact that there was a decrease in the clinical staff numbers available to provide drug treatment services between 2004 and 2005. The report also states that the IPS is treating 42.8% more patients than the largest drug treatment facility in Ireland. In addition, it is second only to the HSE South Western Area in the number of new patients it receives into methadone treatment.

Table 9.3.1 Number of prisoners receiving methadone treatment in 2005 (Central Treatment List 2005)

Prisons providing methadone treatment	Total patients on methadone treatment	New (first-time) patients on CTL
Cloverhill Prison	571	97
Dochas Centre	228	27
Limerick Prison	4	0
Midlands Prison	6	0
Mountjoy Main Prison	511	27
Mountjoy Prison Medical Unit	79	5
Portlaoise Prison	2	0
St Patrick's Institution	1	0
Wheatfield Prison	162	13
Total	**1564**	**169**

Source: Irish Prison Service (2005)

Review of prison drug treatment services to begin

The review of prison drug treatment services began in 2007. Dr Michael Farrell, senior lecturer and consultant psychiatrist at the National Addiction Centre, Institute of Psychiatry London, is undertaking the review. It is hoped that the review will be completed in six months and the eventual aim is to have services provided to prisoners on a par with those provided to the general population.

New counselling service for Irish prisons

New measures are being introduced in Irish prisons to help the growing number of imprisoned drug users. Under the new measures, counselling services will be available to prisoners using a range of illegal and legal drugs, including opiates, cocaine, ecstasy, amphetamines, LSD, cannabis and alcohol. A 12-step programme is intended to help prisoners deal with their habits and address associated problems such as anxiety, stress and anger management. In October 2006 the government approved the allocation of over €500,000 from the Dormant Accounts Fund to provide addiction counselling and employment supports for prisoners and ex-prisoners. There are two

specific strands to this funding: €250,000 is being allocated to four community organisations to provide addiction counselling services in Dublin prisons; and €250,000 is being allocated to provide employment supports for prisoners and ex-prisoners. The key objective of this funding is to maximise the employment opportunities for prisoners in the Mountjoy, Midlands, Castlerea and Cork prisons.

The IPS published updated healthcare standards in September 2006 (Irish Prison Service 2006c).These standards have been developed by a multidisciplinary group representing the various health-related interests involved in prisoner health care. The standards recognise the need not only to define the services to be provided but also to measure the effectiveness of such services.

In relation to drug treatment services, Healthcare Standard 9 states:

- to provide clinical services for the assessment, treatment, and care of substance misusers comparable to those available in the community, and which are appropriate to the prison setting.
- all methadone treatment delivered to prisoners will be based on IPS Methadone Guidelines as derived from the European Methadone Guidelines

9.3.2 Prevention of drug-related crime in urban societies

Community policing
There have been significant changes in local policing structures in the context of the establishment of pilot joint policing committees (JPCs) under the provisions of the Garda Síochána Act 2005. Guidelines setting out the functions, composition and operation of JPCs were published in June 2006 (see National Report 2006). The guidelines proposed the establishment of pilot JPCs in a number of areas. An evaluation of the pilot phase is due to begin before the end of 2007. The primary functions of the JPCs are to serve as a forum for consultation, discussion and recommendations on local policing matters and to keep under review levels of crime, disorder and anti-social behaviour, including the patterns and levels of misuse of alcohol and drugs. Section 36(2)(d) of the Act provides for the establishment of local policing fora by a JPC. In light of Action 11 of the National Drugs Strategy, the guidelines stipulate that 'priority will be given to establishing local policing fora in all Local Drugs Task Force areas and other areas experiencing problems of drug misuse'. At present, the NDST is co-ordinating a process of drawing up guidelines for local policing fora (Department of Justice, personal communication, July 2007).

Blanchardstown 'Dial to stop drug dealing' campaign
The Blanchardstown Local Drugs Task Force (BLDTF) set up a confidential non-Garda phone line to help gather information on local drug dealing. The launch of the campaign in May and June 2006 involved, in the initial two weeks, the distribution of 30,000 brochures, 250 in-store posters and a local media event. Weeks three and four focused on older children and younger adults in formal and informal educational and community settings, while peer-education teams spoke in schools and community centres. Week five involved a retail initiative including over twenty businesses – supermarkets and fast food outlets – which agreed to distribute campaign literature.

The confidential number was free and anonymous so as to encourage its use by older children and young adults. It was not necessary to have witnessed drug dealing directly; people were encouraged to call with second-hand information. The phone lines were managed by a professional call centre, and the service was open 24 hours, seven days a week.

This project was evaluated and a report published (Blanchardstown Local Drugs Task Force 2006). The report includes findings on the project from three sources: daily reports from the call centre, a report from the Garda Síochána and a public survey of a sample of 250 people. Over the six-week period 296 calls were received. On foot of these, 100 detailed reports were sent to the gardaí. The Garda evaluation indicated that 67% of these reports provided 'somewhat useful or very useful' information. Cocaine was the subject of 42% of reports, followed by cannabis (27%) and heroin (17%). These were followed by ecstasy (7%), prescription drugs (5%) and steroids (2%). Of the reports that were followed up by the drugs unit of Blanchardstown Garda Station, 17% were referred to other Garda districts, 17% resulted in arrests with court cases pending, 7% were awaiting further information, 2% were being monitored and 59% were part of ongoing investigations. The gardaí concluded that the project had helped raise awareness of the drug situation in the area and had helped identify drug dealers unknown to them.

The survey of public opinion provided information on local attitudes to the drug situation and the future potential for the development of the campaign. Included among the survey findings were the following:

- 89% of youths and 70% of adults regarded drugs as a 'very' or 'somewhat' serious problem.
- 46% of youths and 37% of adults responded 'yes definitely' when asked whether the public should be encouraged to help gardaí with the drugs problem in Dublin 15.
- More than half of the respondents spontaneously recalled the 'dial to stop drug dealing campaign'. The highest level of recall of campaign literature was for the brochures delivered door-to-door.
- That each call would be treated with absolute confidentiality was 'very important' for three quarters of the sample: 76% of youths and 73% of adults.
- The motivation to call either a Garda or non-Garda confidential telephone line was similar for both youths and adults and primarily driven by community spirit.
- The inhibitions about calling either confidential number related to a dislike or disregard for the gardaí, concern about anonymity and confidentiality, reluctance to get involved and fear of reprisal.

Although the local campaign was due to end in December 2006, the steering group overseeing the project has recommended that it be adapted and rolled out on a national basis.

Customs Drug Law Enforcement

It is reported that a number of measures have been adopted by Customs Drug Law Enforcement (CDLE) during the reporting year. These include the following:

- The adoption of a policy on use of Europol's Organised Crime Threat Assessment
- Participation in CCWP Regional Operations
- Joint Customs/Garda 'Operation Resolute' initiated
- Cross-Border Inter-Agency Drugs Working Initiative
- A successful joint operation with the Garda National Drugs Unit on drug-cutting agents
- Pursuing the placement of a liaison officer in Europol's HQ in The Hague
- Participating in the development of a Maritime Analysis & Operations Centre – Narcotics, in Lisbon, in response to the growing threat of cocaine trafficking into Europe from South America, the Caribbean and West Africa
- Irish Customs and Garda Síochána are currently involved in carrying out an EU threat assessment on specific drugs.

10. Drug markets

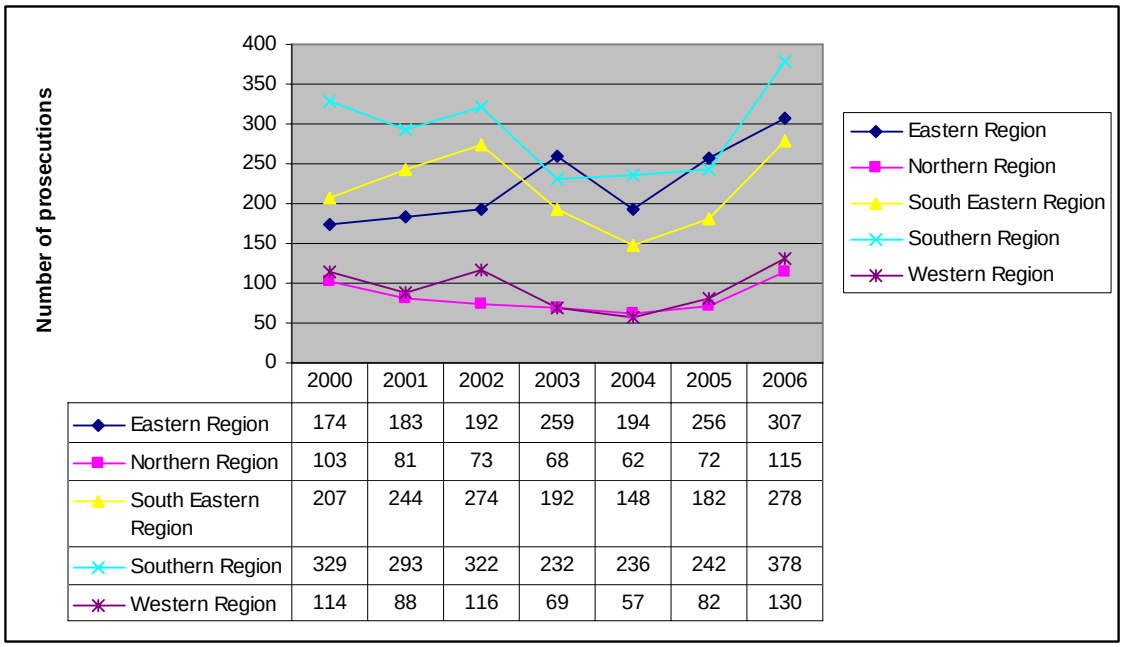
10.1 Overview

No new research studies on drug markets have been conducted. Until 2006, the principal source of information on drug prosecutions was the annual reports of the Garda Síochána. In 2006, responsibility for reporting crime statistics transferred from the Garda Síochána to the Central Statistics Office (CSO). With regard to the importation and internal distribution of drugs – the middle market – data on drug supply offence prosecutions by Garda division are a possible indicator of distribution patterns. While these data primarily reflect law enforcement activities and the relative ease of detection of different drugs, they may also provide an indicator of national drug distribution trends, and whether, for example, there is a concentration of prosecutions along trafficking routes.

This section also presents data on drug seizures by the Garda Síochána and Customs Drug Law Enforcement. Data presented below on trends in the number and quantity of drugs seized by drug type is derived from the annual Garda reports, which have retained responsibility for reporting this specific data. No new data on drug prices or purity are available.

10.2 Availability and supply

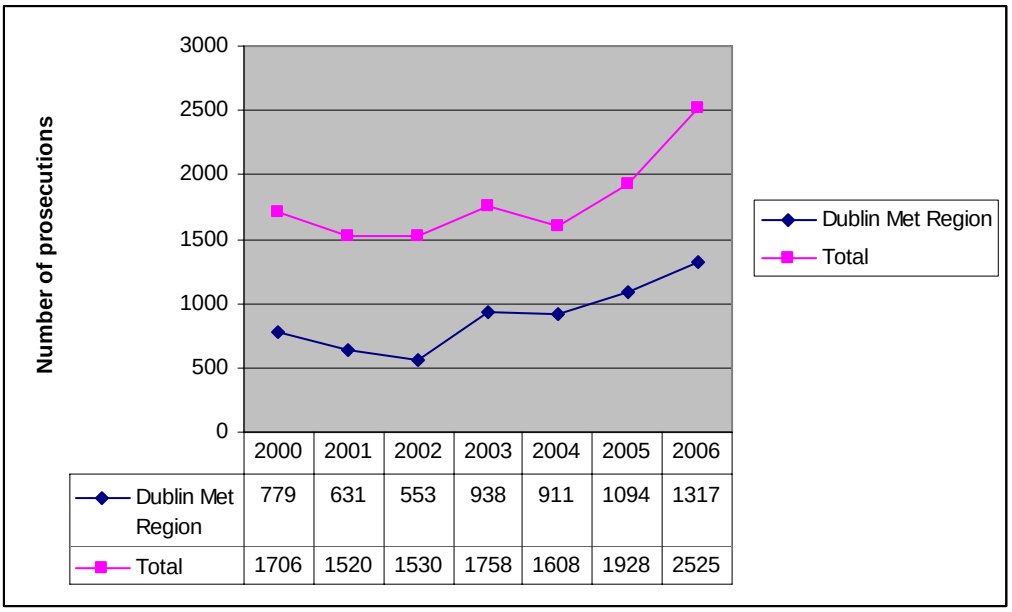
Figure 10.2.1 shows prosecutions for drug supply offences for the five Garda regions outside the Dublin Metropolitan Region (DMR).



	2000	2001	2002	2003	2004	2005	2006
Eastern Region	174	183	192	259	194	256	307
Northern Region	103	81	73	68	62	72	115
South Eastern Region	207	244	274	192	148	182	278
Southern Region	329	293	322	232	236	242	378
Western Region	114	88	116	69	57	82	130

Figure 10.2.1 Drug supply offences (s.15 MDA) outside the Dublin Metropolitan Region where criminal proceedings commenced, 2000 to 2006.
Source: Annual reports of An Garda Síochána, 2000–2005; CSO, personal communication, July 2006

Figures 10.2.1 and 10.2.2 show that the upward trend since 2004 in prosecutions for drug supply has continued through 2006. Although the majority of such prosecutions still take place in the DMR, the proportion of the total number which take place outside the DMR has also continued to increase since 2003 (Figure 10.2.2).



	2000	2001	2002	2003	2004	2005	2006
Dublin Met Region	779	631	553	938	911	1094	1317
Total	1706	1520	1530	1758	1608	1928	2525

Figure 10.2.2 Trends in total drug supply prosecutions and those in the Dublin Metropolitan Region, 2000–2006
Source: Annual Reports of An Garda Síochána 2000–2005; CSO, personal communication, July 2006

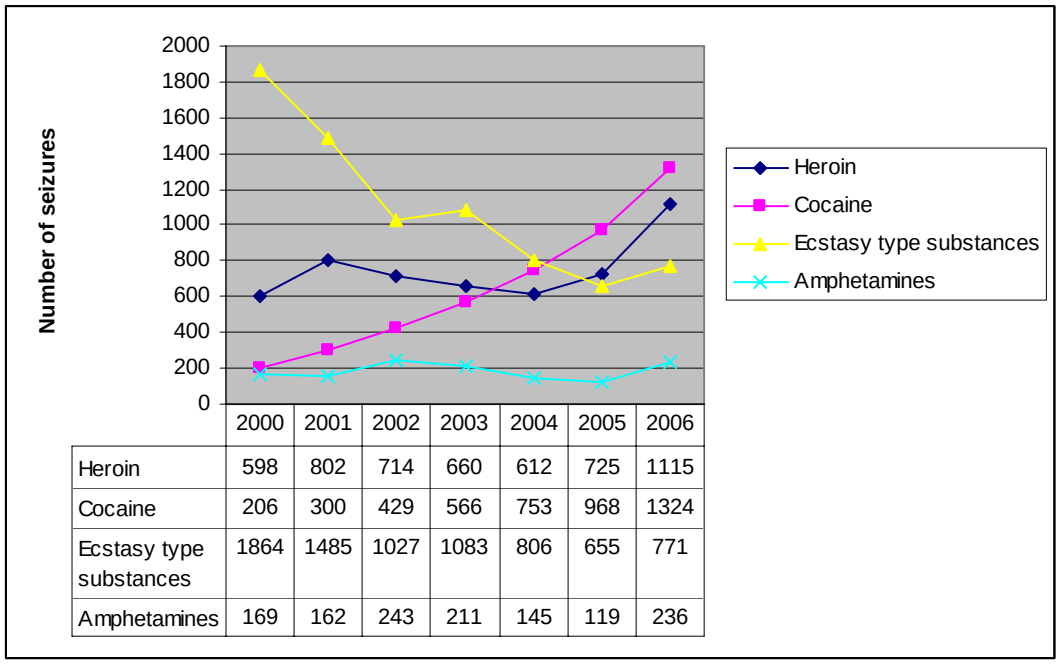
10.3 Drug sources and trafficking routes and patterns

CDLE reports evidence of increased trafficking of cocaine into Ireland from South America via Africa. It also reports an Increase in seizures of cocaine as a result of apprehending individuals who have swallowed the drug. Detection of increased quantities of heroin is also reported. CDLE also reports an increase in the volume of medicinal product, steroids etc. seized in transit through our main airports from Pakistan/India to the UK.

CDLE reports an increase in sophisticated concealments of cocaine arriving via European hub airports and detected at our main airports. It also reports an increase in the number of cocaine couriers, increasingly of Eastern European origin, concealing internally. Herbal cannabis is reported as being concealed in postal packages, heroin and synthetic drugs in deep vehicle concealments via our ports, and synthetic drugs in postal packages. CDLE also reports the involvement of Eastern European crime gangs in cocaine and synthetic drug smuggling and the involvement of West and South African gangs in cocaine smuggling. CDLE reports the seizure of 26 kg of cocaine from air freight in Dublin in February 2006. One West African and two Irish nationals were arrested, indicating links between Irish and West African organised crime groups.

10.4 Seizures

Cannabis seizures account for the majority of all drugs seized. In 2006, of the 7,550 reported drug seizures, 3,853 (51%) were cannabis-related. Figure 10.3.1 shows trends in seizures of a number of selected drugs, excluding cannabis, between 2000 and 2006. We can see that the steady rise in cocaine seizures has continued. There was also a sharp rise in the number of heroin seizures, which increased from 725 in 2005 to 1,115 in 2006. The number of seizures of ecstasy-type substances also rose in 2006, following a steady decline since 2000.



	2000	2001	2002	2003	2004	2005	2006
Heroin	598	802	714	660	612	725	1115
Cocaine	206	300	429	566	753	968	1324
Ecstasy type substances	1864	1485	1027	1083	806	655	771
Amphetamines	169	162	243	211	145	119	236

Figure 10.3.1 Trends in the number of seizures of selected drugs, excluding cannabis, 2000–2006
Source: Annual reports of An Garda Síochána 2000–2006

CDLE reports the seizure of 10.6 kg of heroin from a vehicle at Rosslare Harbour in Co Wexford in June 2007. This is the largest seizure of heroin by Customs to date. A number of seizures of steroids and medicinal drugs (ranging from 8 kg to 28 kg in volume), routed from Pakistan to the UK via Irish national airports, is also reported. CDLE also reports an increase in the number and volume of seizures of herbal cannabis originating in South Africa detected in postal depots.

10.4 Price/purity

No new information.

Part B: Selected issues

Summary of each selected issue

Summary of Chapter 11: Public expenditure on drugs

Labelled drug-related expenditure in Ireland for 2005 is described under two headings:

- Amounts labelled as drug-related in the published national government estimates – some €34.4 million of voted public expenditure.
- Amounts which are not labelled as drug-related expenditure in the published government estimates, but which are identified in the budgets of government departments and state agencies as drug-related expenditures – some €153.3 million.

Attributable proportions of non-labelled drug-related expenditure cannot currently be calculated for Ireland according to the procedure outlined in the Guidelines for this Selected Issue.

Two separate studies on drug-related public expenditure, undertaken in 2006, are reported on. They were both initiated by the Department of Community, Rural and Gaeltacht Affairs, which has responsibility for co-ordinating the implementation of the National Drugs Strategy 2001–2008. They are separate and discrete studies, which do not form part of any larger programme of investigation and analysis of drug-related public expenditure. No individual or organisational entity is currently known to be researching drug-related public expenditure in Ireland.

Summary of Chapter 12: Vulnerable groups of young people

As expected, in Ireland vulnerable groups of young people are at risk of or report higher levels of drug use than their non vulnerable counterparts. These vulnerable groups include children leaving state care, children in juvenile detention or special care facilities, early school leavers, homeless youth, persons whose parents had a history of problem substance use, young people living in marginalised urban communities and to some extent travellers (an ethnic minority in Ireland). Data from ESPAD and the NDTRS support some of these findings. The primary prevention of drug use is delivered through school programmes. The Young People's Facilities and Services Fund (YPFSF) is the primary means of responding to youth at risk from drug misuse. Measures funded through the YPFSF tend to be sporting and recreational pursuits in disadvantaged communities. Arrest referral schemes provide information to young drug using arrestees about appropriate services and facilitate referral to treatment. This scheme is 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 use.

Summary of Chapter 13: Drug-related research in Ireland

One of the strategic aims of Ireland's National Drugs Strategy is 'to have valid, timely and comparable data on the extent and nature of drug misuse in Ireland'. Research is one of the four pillars of the strategy, which seeks to eliminate all major research gaps in drugs research. The strategy identifies the following sources of data which will be used to fill these gaps: data relating to drug misusers registered for treatment; drug-related deaths; drug-related infectious diseases (HIV and hepatitis); drug-related arrests and offences; and drug seizures. The Irish information sources from which this data are obtained are outlined. The strategy assigns responsibility for implementing most of the research actions to two agencies: the Health Research Board; and, the National Advisory Committee on Drugs. The work of both of these agencies is described. The links between research, policy and practice are outlined under the following headings: Treatment of under-18s presenting to addiction services; Identifying gaps in knowledge around drugs and crime; Drug treatment demand data; Family support services; Evidence regarding prescription of heroin. The most significant research studies initiated since 2000 are described and a selection of references from peer-review journals are outlined.

11. Public expenditure on drugs

11.1 National estimates of lavelled drug-related expenditures

The framework proposed by the EMCDDA – recording public expenditure by 'function' of government and by 'effect' of the intervention – is considered overall to be logical, in that it addresses both 'inputs' and 'outputs'; useful in that it will help understanding and analysis of public expenditure on the drugs issue; and, in the long term, possible to implement. However, there are five issues to consider in the Irish context.

Budgeting and financial reporting systems
As will be evident in looking at the information provided below, many departments and agencies do not currently have adequate reporting systems in place to capture and report the data needed. However, the data requested are potentially available, particularly where direct expenditure by government bodies is being considered. To be able to record such data will require some changes in government accounting practices, for example moving towards an output focus in preparing the government's annual estimates and disclosing expenditure amounts that are deemed to be 'material'.

Budgeting and reporting arrangements in the Irish public sector are expected to become more transparent in the coming years. For example, a Management Information Framework is to be introduced; one of its main roles will be to improve the management of resources once allocated, and to provide for increased transparency and accountability in the use of these resources. Annual output statements are to be published by government departments, and will match key outputs and strategic impacts to financial and staffing resources.

Discrepancies reported between financial data collected early in the budget cycle, and later reports on actual outturns indicate that financial reports are a more accurate indicator of the actual level of public expenditure than budgetary sources.

'Labelled expenditure' – distinguish between published and non-published data
As well as the distinction between labelled and non-labelled drug-related expenditures, it may also be necessary to distinguish between labelled expenditure that is published and that which is not published. In Ireland, details of only some 18 per cent of labelled expenditure are published (see Section 11.1.1 below). The remaining 82 per cent is either subsumed under, but clearly identifiable in, some larger published budget, or it is a clearly defined drug-related programme or activity that is resourced from a range of different labelled budgets (see Section 11.1.2 below).

'Function' of government – treat non-governmental functions separately
There are no regionally or locally funded drug-related public expenditures in Ireland. Instead, monies are voted, via the national parliamentary Estimates process, for allocation by government departments or agencies for expenditure at regional and local levels (see Section 11.1.3). Coding this funding according to 'function of government' rather than according to the function of the voluntary or community-based recipient of the funding may lead to an under-representation of functions carried out at regional or local level. For example, while a large tranche of public money may be voted for the central government function of 'community development', this same money may then be disbursed for expenditure on a range of regional or local programmes or projects, which may be coded to a specific health-related or education-related function. As this type of expenditure represents a significant portion of drug-related public expenditure in Ireland, this issue needs to be addressed. The solution might be to record the expenditure according to both 'government' and 'non-government' function. The risk of double-counting would need to be managed.

'Effects' of drug-related expenditures – need to become familiar with approach
It is apparent from Table 11.1.1 that it has been much easier to categorise drug-related public expenditure by function of government than by effect of the intervention. Adoption of the framework of effects recommended by Peter Reuter would require (1) an educational effort with planners and budget holders to ensure understanding and acceptance of the nuances of the different categories, and (2) changes in the design, monitoring and evaluation of interventions.

'Effects' – include Rehabilitation as a separate and distinct 'effect'
Thought should be given to including rehabilitation, as distinct from treatment or harm reduction, among the effects of drug-related interventions. Arising out of a recommendation in the mid-term review of the National Drugs Strategy (Steering group for the mid-term review of the National Drugs Strategy 2005), rehabilitation has been identified as a fifth pillar of the Strategy. The working group established to report on a strategy for the provision of integrated drugs rehabilitation services under this new pillar discussed the meaning of the term and how it relates to treatment and harm reduction: ',,, treating drug misuse constitutes only part of the rehabilitation process. … Drug rehabilitation, therefore, encompasses interventions aimed at stopping, stabilising and/or reducing the harm associated with a person's drug use as well as addressing a person's broader health and social needs' (Working Group on Drugs Rehabilitation 2007: 7).[5]

The national estimates of labelled drug-related expenditures in 2005, recorded by COFOG category and by effect, as defined in the work of Peter Reuter, are summarised in Table 11.1.1. Following the reference in the far-right column the reader will be able to locate a commentary on the figures in Sections 11.1.1 and 11.1.2 below. It should be noted that, given the gaps in the information provided, the total – some €187.6 million – is an under-estimate of drug-related public expenditure.

The starting point for this exercise was the data collected by the Department of Community, Rural and Gaeltacht Affairs (DCRGA) in 2006, when it was seeking to estimate '2005 budget allocations directly attributed to drugs programmes by government departments and agencies' (see Section 11.3.1 below for a full account of this investigation). DCRGA stressed that the figures it collected, set out in Table 11.3.1 'should be interpreted as indicative figures only'. The relevant government departments and agencies were approached individually with a view to breaking down the expenditures by COFOG category and by 'effect' as defined by Peter Reuter. The results of this investigation are reported below.

The discrepancies between the data presented in Tables 11.1.1 and 11.3.1 are due largely to differences between budget data as opposed to more recent data reporting actual outturns. Specific discrepancies are noted in the following discussion.

[5] The report is available at http://www.pobail.ie/en/NationalDrugsStrategy/

Table 11.1.1 Summary of available data indicating 'labelled' drug-related public expenditure in Ireland 2005, by COFOG class/division and by effect

COFOG Division/ Group/ Class	Total Expenditure (€ million)	Expenditure apportioned by effect as per Peter Reuter (€ million)						Department or agency
		Prevention	Treatment	Enforcement (traffickers & producers)	Enforcement (users & retailers)	Harm reduction (conditional on use)	Harm reduction (adverse consequence after use)	
1.1.2 Financial and fiscal affairs	9.240			9.24				3. Customs
1.5.0 R&D General public services n.e.c.	2.072							4. Research Agencies
3.1.0 Police services	23.700			5.30	7.8			5. An Garda Síochána
3.3.0 Law courts	0.300		0.30					6. Drug Treatment Court
3.4.0 Prisons	5.000							7. Irish Prison Service
4.1.2 General labour affairs	13.500		13.50					8. FÁS (State Training Agency)
6.2.0 Community development	33.962							1. DCRGA
6.2.0 Community development	2.315							9. Probation Service
6.2.0 Community development	0.450	0.450						10. Garda Youth Diversion Projects
6.6.0 Housing and community amenities n.e.c.	0.443	0.443						2. DEHLG
7.0 Health	92.906							11. HSE
7.4.0 Public health services	3.780	3.780						12. DES
TOTAL	**187.668**	**4.673**	**18.80**	**14.54**	**7.8**			

11.1.1 National government estimates, published

In the national Estimates, the main published source of information on public expenditure in Ireland, there are only two labelled drug-related expenditures recorded for 2005. In both cases this funding was mainly distributed by a central government department for expenditure by voluntary and community projects or by local authorities, rather than being expended by the Department. In both cases, moreover, the 'provisional outturns' for 2005, as reported in the national Estimates for 2006 (Government of Ireland 2006), are used in Table 11.1.1, in preference to the 'estimated expenditure' provided in the national Estimates for 2005 (Government of Ireland 2005). The provisional outturn (€34.305 million) was some €2.36 million higher than the amount estimated at the start of 2005 (€31.943 million).

1. Department of Community, Rural and Gaeltacht Affairs (DCRGA)
The larger amount, **€33.962 million**, titled the 'Drugs Initiative and Young People's Facilities and Services Fund', was allocated to DCRGA, which has overall responsibility for the co-ordination of the National Drugs Strategy. Included under the budget heading Community Affairs, this funding is for distribution primarily to programmes provided by

voluntary and community projects in local drugs task force (LDTF) areas and to the Young People's Facilities and Services Fund (YPFSF). The budget figure is coded as COFOG Class 6.2.0, Community development. DCRGA provided an 'indicative but reasonable estimate of division of [this] expenditure' by the four pillars of the National Drugs Strategy: approximately 48% was spent on Prevention (primarily through the YPFSF), 47% on Treatment and Rehabilitation (primarily through the LDTFs), approximately 3.5% on Research, and 1.5% on Supply Reduction, 'mainly around issues like community policing fora and estate management'. However, as the 'pillars' do not necessarily align with Reuter's definitions, this funding breakdown is not used as a guide to coding the 'effects' of the expenditure.

2. Department of the Environment, Heritage and Local Government (DEHLG)
The smaller amount (**€0.443 million**) was allocated to DEHLG, under the budget heading 'Local authority and social housing programmes'. According to DEHLG's annual report for 2005, the funding was for five local drugs task force projects relating mainly to estate management, specifically in the area of drugs (Department of the Environment Heritage and Local Government 2006). Funding was transferred from DEHLG to the local authorities that had a monitoring role in relation to the projects. As this funding was distributed to local government, rather than to the voluntary or community sectors, it has been coded as COFOG Class 6.6.0, Housing and community amenities n.e.c. In terms of 'effect', it is assumed that estate management would have the effect of preventing drug use, and the expenditure is coded as 'Prevention'.

11.1.2 Departmental and agency-level drug-related expenditures, not published

Direct expenditure by government departments and state agencies on drug-related matters is not labelled as such in the published national government estimates. However, departments and agencies with responsibilities in these areas are able to identify substantial tranches of funding devoted to the drugs issue. This funding includes allocations to be distributed to third parties as well as direct expenditure.

This expenditure for the 2005 year was included in the report on drug-related public expenditure by DCRGA, based on figures supplied by government departments and agencies (see Section 11.3.1 below for a full account.)

3. Customs
DCRGA reported that for 2005 the Customs Service received a budgetary allocation directly attributable to drugs programmes of **€9.24 million**. The expenditure is coded as COFOG Class 1.1.2, Financial and fiscal affairs. The 'effect' of the expenditure is identified as Enforcement (traffickers & producers), as Customs activities are confined to the border areas of Ireland.

4. Research agencies
Two dedicated drug research agencies – the National Advisory Committee on Drugs (NACD) and the Drug Misuse Research Division (DMRD)[6] in the Health Research Board – receive public funding. In 2005 the NACD implemented a research programme organised under four headings – Prevalence, Consequences, Prevention, and Treatment/Rehabilitation. In its business plan for 2005–2008, the NACD reported that it received approximately **€1.1 million** from DCRGA for expenditure in 2005 (National Advisory Committee on Drugs 2005: 19). The DMRD undertook research on the drug situation, its consequences and responses in Ireland, and operated the National Drug Treatment Reporting System (NDTRS). It reported that in 2005 it received **€0.972 million** in public funding from the DoHC, DCRGA and DJELR. As research by these two agencies is not related to any specific function of government, it is coded as

[6] In 2006 the DMRD was renamed the Alcohol and Drugs Research Unit (ADRU).

COFOG Class 1.5.0, R&D General public services n.e.c. The 'effect' of this research expenditure is not identified. However, the mid-term review of the National Drugs Strategy recommended that DCRGA should monitor and report annually on the implementation of the recommendations arising from NACD reports (Steering group for the mid-term review of the National Drugs Strategy 2005: 48). If this recommendation is acted on, it should be possible to identify the 'effect' of research activities.

5. An Garda Síochána
DCRGA reported that for 2005 An Garda Síochána received a budgetary allocation directly attributable to drugs programmes of €23.7 million. The Garda National Drugs Unit (GNDU) indicated that current expenditure by An Garda Síochána in 2005 included **€3.2 million** on the GNDU, **€7.8 million** on the Garda Divisional Drugs Units, and **€2.1 million** on the Garda national specialist agencies, including the Criminal Assets Bureau (CAB), National Bureau of Criminal Investigation and the Garda Bureau of Fraud Investigation. These allocations have been coded as COFOG Class 3.1.0, Police services. The 'effect' of the identified national level expenditures (GNDU and Garda specialist agencies) is deemed to have been Enforcement (traffickers and producers), and the 'effect' of the expenditure at divisional level is deemed to have been Enforcement (users and retailers). The remaining expenditure of **€10.6 million** has not been coded according to the six possible 'effects', although, given the actions assigned to An Garda Síochána in the National Drugs Strategy, it may be assumed that Garda drug-related activities have effects both in preventing drug use and in enforcing drug laws, including both traffickers and producers and also users and retailers.

6. Drug Treatment Court (DTC)
The DTC is a specialised court operating within the Irish legal system that aims to treat, rather than imprison, drug users. It deals with non-violent offenders whose offending behaviour is motivated by their addiction rather than mainly for financial gain. There is no specific budget for the DTC; rather the monies are drawn from a variety of sources including the Court Service, the Health Service Executive, the Probation Service, and the Dublin Vocational Education Committee. The estimated direct costs attributable to DJELR of running the DTC programme in 2005 were **€0.3 million**. This estimate was based on salary and *pro rata* salary costs for the different individuals working in the DTC – judge, administrator, police and probation staff, plus the administration costs. This amount has been coded to COFOG Class 3.3.0, Law courts. Not included in this total are the costs arising out of treatment provision for the court's clients, borne by the HSE. Given the title of the court, the 'effect' of this expenditure is assumed to be Treatment.

7. Irish Prison Service (IPS)
DCRGA reported that for 2005 the IPS spent **€5.0 million** on the drugs issue in 2005. The allocation has been coded to COFOG Class 3.4.0, Prisons. The expenditure has not been coded by 'effects' as it contributes to both law enforcement and treatment. At present, the IPS is in the process of establishing a dedicated budget line for drug-related expenditure, and is seeking to align it with the UN COFOG framework.

8. FÁS (State Training Agency)
One thousand places on the Community Employment (CE) scheme, operated by FÁS and intended to rehabilitate or reintegrate individuals back into the workforce, are ring-fenced for people referred by local drugs task forces. There is not a dedicated budget *per se*, but by identifying the average cost per CE place, FÁS estimated that the CE DTF cost for 1,000 places for 2005 was in the region of **€13.5 million**. This is based on overall cost per programme place for the CE Scheme (which includes mainstream places). This amount has been coded as COFOG Class 4.1.2, General labour affairs.

The 'effect' of the expenditure is deemed to be Treatment, in the absence of an 'effect' relating more closely to 'rehabilitation'.

9. Probation Service
The Department of Justice, Equality and Law Reform (DJELR) reported that in 2005 the Probation Service, which is under its aegis, provided **€2,314,700** to 16 community-based drug-related projects, which, in turn, provided community-based intervention and support to substance abusers who were clients of the Probation Service on supervision in the community. This budget allocation is coded as COFOG Class 6.2.0, Community development. It is not possible to code this expenditure according to 'effect' as there is insufficient information as to the effects of the interventions.

10. Garda Youth Diversion Projects (GYDP)
GYDP are a community-based, multi-agency crime prevention initiative, which seek to divert young persons from becoming involved – or further involved – in anti-social and/or criminal behaviour by providing suitable activities to facilitate personal development, promote civic responsibility and improve long-term employability prospects. By doing so, the projects also contribute to improving the quality of life within communities and enhancing Garda/community relations. DJELR reported that a figure of **€450,000** incorporated in the overall expenditure in 2005 (€5.471 million) referred specifically to task-force-originated drugs project workers whose positions are now mainstreamed into the GYDP. This budget allocation is coded as COFOG Class 6.2.0, Community development. Given the aim of the projects, it is assumed that the expenditure has an 'effect' in the area of Prevention.

11. Health Service Executive (HSE)
Drug-related prevention, treatment, harm-reduction and rehabilitation services are provided by the HSE, a national agency established under the Health Act 2005 and which is responsible for the management and delivery of health and personal social services under the general policy guidance of the Department of Health and Children. The HSE has its own Vote, which is included in the annual national Estimates.

The HSE has estimated that in 2005 its expenditure on Addiction Services, including education and prevention, treatment, harm reduction, stabilisation, rehabilitation and aftercare support, was **€92.906 million** (see Table 11.1.2).

Table 11.1.2 HSE provision for addiction services in 2005

HSE service	Amount (€ million)
Mainstream services	72.570
Drug Treatment Centre Board	9.480
Section 65 funding (Community)	4.256
LDTF mainstreamed	6.597
Total	**92.906**

Source: HSE 2006

The mainstream services and the services provided through the Drug Treatment Centre Board consisted of a combination of treatment and rehabilitation services, including treatment and dispensing services provided by some 225 GPs and 365 pharmacists, and the services of a further 730 or so employees including psychiatrists, nurses, outreach workers, counsellors/ therapists, community welfare officers, psychologists, project workers, administrative staff, education officers and general assistants. This expenditure is broken down into total pay costs, and total non-pay/programme costs (including costs for pharmacy, or other programmes associated with drug treatment).

While the Drug Treatment Centre Board service is a national one, approximately 80 per cent of the mainstream services are provided inside the former Eastern Regional Health Authority (ERHA) region and would be concentrated in LDTF areas. Within the ERHA region, only expenditure incurred on drug services is included in the expenditure, whereas in the remainder of the country, drug and alcohol services are combined as they could not be separated.

Section 65 funding relates to Section 65 of the Health Act 1953 (which became Section 39 Funding under the Health Act 2004), and includes addiction-related projects funded by the HSE but provided by the community/ voluntary sector. The projects span the complete range of addiction services provided by the HSE.

Mainstreamed LDTF projects, which are now the responsibility of the HSE, are included in the HSE expenditure. While 'interim funded drug service initiatives' are channelled via the HSE, they are not accounted for in HSE expenditure as responsibility for them lies with the relevant LDTF/ RDTFs and the NDST. (See Section 11.1.3 below for a full account of LDTF funding mechanisms.)

The HSE's expenditure for 2005 has been coded as COFOG Division 1.0, Health; no breakdown of the expenditure by 'effect' has been attempted. However, the HSE considers that, given the necessary time and resources, it would be possible to break down this expenditure both by COFOG Class and by 'effect'.

The above data do not reflect the total spend by HSE in respect of responding to addiction issues. For example, the Hospital Directorate provides services which can be either directly attributed to or linked with the effect of addiction (e.g. detox beds, A&E presentations for health issues such as overdose, or HIV/ Aids treatments). The Population Health Directorate has responsibility for national drugs awareness campaigns. As well as delivering Addiction Services, the Primary Community & Continuing Care (PCCC) Directorate also provides funding for initiatives in other activity areas where presentation for addiction problems is far from unusual – for example, children and families (e.g. resource centres, high support units, Springboard initiatives), mental health (e.g. psychiatry in respect of treating dual diagnosis patients), or social inclusion (e.g. homelessness).

12. Department of Education and Science (DES)
The DCRGA reported a drug-related expenditure by DES in 2005 of **€3.78 million**. This funding has been coded as COFOG Class 7.4.0, Public health services. Given that the responsibilities assigned to DES in the National Drugs Strategy all pertain to prevention, the 'effect' of this expenditure is coded as 'Prevention'.

11.1.3 Drug-related expenditure at regional and local level

There are no regionally or locally sourced drug-related public expenditures in Ireland. Instead, monies voted via the national parliamentary Estimates process are allocated by government departments or agencies for expenditure at regional and local levels, either directly from government bodies or via the regional and local drugs task forces. Examples of funding directly from government bodies, including Section 65 funding by the HSE and community grants from the Probation Service, were described in Section 11.1.2 above.

The funding mechanism via local and regional drugs task forces is described below:

a. *Initial funding:* drugs task force projects are initially set up as *pilot projects* with funding provided through the Drugs Initiative, administered by DCRGA (see

Section 11.1.1 above). The government department or agency most closely associated with the nature of the project acts as the *channel of funding* to the project during this pilot phase.

b. *Mainstreamed funding:* after the pilot phase, each project is evaluated and a decision taken with regard to *mainstreaming* it in the appropriate government department or agency. Once a project is mainstreamed, the responsibility for the funding of the project transfers to that department or agency and DCRGA is no longer involved. A large number of LDTF projects (122) have now been mainstreamed into a range of government department and agency programmes – the majority of them on the Health and Education sides.

c. *Interim funding:* In addition to the projects already mainstreamed, there are currently a significant number of projects across the drugs task forces that continue to operate on a pilot basis, with their funding being provided by DCRGA (and the monies being administered via the funding channel).

The National Drugs Strategy Team (NDST) collects data on mainstreamed funding by department/agency. The data for 2005, relating to 122 mainstreamed LDTF projects from Round 1 of LDTF funding, is shown in Table 11.1.3. The NDST also records the amounts allocated to individual projects. These mainstreamed funds are generally included in the Departmental and agency expenditures recorded in Table 11.1.1. They are summarised separately here simply to indicate the scale of the funding.

Table 11.1.3 Mainstreamed LDTF projects, Round 1, 2005

Department/State agency administering mainstreamed LDTF projects	**Funding (€)**
Department of Justice, Equality and Law Reform	391,761
Department of Heritage, Environment and Local Government	210,423
Department of Education and Science	2,974,154
FÁS	622,302
Health Service Executive	7,961.993
South Dublin City Council	218,844
Total	**12,379,477**

Source: NDST 2007

It is likely that the NDST will continue to collect this information and it should be possible to collect information on the effects of the expenditures. It should also be noted that the amounts of mainstreamed funding are likely to grow substantially when Round 2 LDTF projects are mainstreamed, and also when RDTF pilot projects begin to be mainstreamed. In the report on the expenditure review of LDTFs (see Section 11.3.2 below) published in September 2006 it was estimated that Round 2 Projects would incur an additional €16.1 million in expenditure annually (Goodbody Economic Consultants 2006d: 15).[7]

11.2 National estimates of non-labelled drug-related expenditures

Attributable proportions of non-labelled drug-related expenditure cannot currently be calculated for Ireland according to the procedure outlined in the Guidelines for this Selected Issue. To date, Ireland's Central Statistics Office has presented general government expenditure by first-level COFOG functions only. In 2007, in compliance with ESA95, it began the task of recording and presenting general government

[7] The report is available at www.pobail.ie/en/NationalDrugsStrategy/

expenditure by second-level COFOG functions. At the time of submitting this report, this data had not yet become available.

11.3 National studies on drug-related public expenditures

11.3.1 Annual public expenditure attributable to drugs programmes

The mid-term review of the National Drugs Strategy (Steering group for the mid-term review of the National Drugs Strategy 2005: 67) reported that it had found it very difficult to quantify and measure drug-related public expenditure and made a recommendation that, in the future, 'expenditure that is directly attributable to drugs programmes … should be measured'. In response to this recommendation, in 2006, the DCRGA began to collect data on allocations directly attributable to drugs programmes for government departments and agencies with lead responsibility for implementing the National Drugs Strategy (see Table 11.3.1). The sources for these figures, and whether they were budgetary or reporting sources, were not indicated.

Table 11.3.1 DCRGA estimates of drug-related expenditures for 2005

Department/Agency	Allocation 2005 (€ million)	Cross-reference to Sections 11.1.1 and 11.1.2 of this Selected Issue
National Drugs Strategy Unit	34.00	1, 6
Department of Health and Children	2.74	3, 6
Health Service Executive	92.75	3
FÁS	14.50	7
Department of Education and Science	3.78	13
Department of Environment, Heritage and Local Government	0.55	2
Department of Justice, Equality and Law Reform	8.67	4, 6, 8, 9
Irish Prison Service	5.0	12
An Garda Síochána	23.70	5, 11
Revenue's Customs Service	9.24	10
Total	**194.93**	

Source: DCRGA 2006

The results of the same exercise applied to 2006 public expenditure are reported in Section 1.4 in the main body of this National Report.

11.3.2 Expenditure review of local drugs task forces

In 2006 DCRGA commissioned external consultants to conduct an expenditure review of the local drugs task forces (Goodbody Economic Consultants 2006d). The terms of reference required the consultants to, among other things:

- examine the objectives of the LDTFs and the extent to which they have been achieved;
- measure the outputs, and as far as possible, the outcomes of the LDTF process and projects;
- assess the overall effectiveness of the expenditure;
- define performance indicators and baselines in order to measure the work of the LDTFs in the future; and
- review the overall costs and staffing resources associated with the process and make recommendations in relation to improving the efficiency and effectiveness in the context of the resources allocated to the LDTF process.

The authors reported that from the outset it was evident that there were serious data deficiencies that would hinder the conduct of this expenditure review. In particular, a standardised system for measuring the output and impact of the projects had not been put in place, nor were there standardised profiles of the projects or measures that had been allocated funding. Expenditure data for the projects were lacking, although the financial allocations made to the projects at various stages were known. The absence of evaluative work relating to the costs and benefits to society at large of the measures undertaken was another issue that arose.

As a result of these deficiencies, the consultants undertook a number of specific pieces of work:

- Information on financial allocations was collated and analysed by purpose and task force area;
- A survey was carried out to profile the measures funded under the LDTF Programme;
- A survey of the international literature on the costs and benefits of drug countermeasures and the costs imposed on society by drug abuse was undertaken;
- Statistics and indicators to illustrate impacts at Task Force area level were compiled; and.
- Case studies were undertaken of four of the LDTF areas to *inter alia* gain a better understanding of the impacts of the Programme on the quality of life, health and well-being of drug users and their families.

The authors stated that, 'given the scale of funding, it is essential that financial reporting arrangements are improved through regular reporting of expenditure by projects and the furnishing of audited annual project accounts' (p. 76).

In respect of its content, the authors concluded that the LDTF Programme had been very effective: 'The fact that LDTF funding has delivered new projects and activities with regard to treatment and rehabilitation is especially noteworthy, as international research indicates that the costs to society of drug abuse are very high, and that there are immediate and substantial savings to the economy when drug users enter treatment regimes.'

However, the authors recommended a number of steps to enhance the efficiency and effectiveness of the Programme, including:

- Establishment of clearer reporting relationships and related monitoring systems between projects, funders and Task Forces;
- Standard monitoring templates to be used by projects to monitor progress;
- Access to the required level of annual funding to meet the core costs of mainstream projects and a review of related programming costs;
- Provision of greater resources at Task Force level so as to improve supports to projects, to draw greater learning from the projects, and to undertake more detailed evaluation of the drug problems in their local area.
- Development of stronger evaluation processes in relation to future mainstreaming decisions, backed up by good monitoring data on process/outputs including performance indicators, and by mechanisms aimed at ensuring that weaknesses identified in the review process are addressed.

In relation to mainstreaming, the authors identified a number of issues of concern:

- The evaluations carried out prior to mainstreaming were hampered by lack of data and by lack of resources and time to generate such data. The extent to which the evaluators could judge the 'success' of a project in any objective and quantitative way was therefore limited.

- A number of evaluators referred to such difficulties and also to areas where projects could improve their service or ways of working. However, no mechanism appears to have been put in place to ensure that such projects, or their funding agencies, followed up on the proposals made by the evaluators.
- Mainstreamed projects are currently not being formally monitored or evaluated by either the Task Force or their funding agency. This is due to a lack of clear lines of responsibility between projects and their funders and also to a lack of resources on the part of all concerned to develop, implement and manage effective monitoring and evaluation systems.

The authors recommended:

- To strengthen monitoring and evaluation performance, there should be clear lines of responsibility for monitoring and evaluating the projects in receipt of mainstreamed funding and that a system of quantitative performance indicators is put in place.
- A system of twenty-four performance indicators is now proposed. These are appropriate for measuring performance in relation to projects, LDTF processes, the LDTFs individually, and the LDTF Programme as a whole. As well as monitoring progress, these will form a valuable input into the evaluation of projects, LDTFs and the Programme as a whole.

In response to the recommendations in the report, the NDST has incorporated the 24 performance indicators into the application process for annual funding by drugs task force projects. It also requires data relating to the process indicators to be included in the annual reports by the projects.

12. Vulnerable groups of young people

12.1 Profile of main vulnerable groups

12.1.1 Children living in government care institutions

There is a lack of research on the nature and extent of drug use among children in state care. However, one study investigating the 'life experiences' of homeless youth showed that young people can experience episodes of homelessness and drug use, following periods in state care (Maycock and Vekic 2006). The researchers carried out 'life history' interviews with a cohort 40 homeless young people, half of whom were aged 15–17 years, in the Dublin Metropolitan area.

Following analysis of the data, the researchers identified leaving state care as one pathway into homelessness and drug use. For example, 40% of the cohort reported a history of state care of varied duration in foster homes, residential care placements and residential placement homes. In addition, they reported moving between different care settings. Trauma and emotional conflict arising from being in institutional care when young were identified as factors likely to contribute to later episodes of problematic drug use. At the time of conducting the interviews, only eight of the young people were not using illicit drugs; 50% reported having used heroin, with almost all reporting their heroin use as problematic to the point of dependency.

Hanlon and Riley (2004) investigated the well-being of young people placed in special care units, and of their families. .Admission data on 63 young people placed in the units between 1996 and 2003 show that they ranged in age from 13 to 17 years, 69% were female, and 16% were members of the Traveller community.

The researchers assessed the young people's well-being by means of a quality-of-life survey completed by the key worker. The young people, their families and professionals working with young people were interviewed. When admitted to the special care units, the young people were considered to have a history of entrenched family difficulties and consequent social and emotional problems, placing them at risk. The researchers report that 'at risk' was seen to cover a wide range of behaviour and social and emotional circumstances including:

- risk of criminalisation
- victim of crime
- drug use/misuse
- sexual activities/relationships/prostitution
- neglect
- physical and sexual abuse.

12.1.2 Early school leavers

A report by the National Economic and Social Forum (2006), a key advisory body to the Government on social inclusion policy, highlighted the key role that early school leaving plays in exposing marginalised groups such as drug users to labour market vulnerability. Drawing on a report by the European Commission, it states that the rate of early school leaving in Ireland remains above the EU average. Furthermore, data from the NDTRS indicates that, between 1998 and 2002 inclusive, an average of 26% of all cases being treated for problematic drug misuse in Ireland reported leaving school before the age of 15 (Long *et al.* 2005). However, there is a scarcity of research on the nature and extent of drug use among early school leavers and on the relationship between early school leaving and drug use.

A study by Mayock and Byrne (2004) shows that nearly two-thirds (61%) of 41 early school leavers (aged 13–18) interviewed by the researchers reported using illicit drugs at least once in their lifetime. Fifty eight per cent of young women, compared to 64.7% of young men, had used an illegal drug at some time. The average age of first drug use was 14 years. None of the interviewees reported using heroin; cannabis and ecstasy were the most popular drugs of choice. Drug use was reported as part of the social lives of the young people, with cannabis use being seen as the 'norm'. The young people's experiences of school were overwhelmingly negative, with reported behavioural and academic problems, such as difficulty adhering to the school rules and keeping pace with learning. Some of the young people reported being bullied at school. All the young people lived in neighbourhoods characterised by social and economic disadvantage.

12.1.3 Youth in families with drug and/or alcohol use (vulnerable families)

McKeown and Fitzgerald (2006) assessed the impact of drug use on family well-being among 63 service users attending the Ballyfermot STAR project. The project is in an area characterised by high levels of problematic drug use, and designated with local drugs task force status.

The report is based on interviews carried out during 2004/05 with two groups of service users, one group of 45 attending the Family Support Programme (FSP) and a second group of 18 attending the Community Employment (CE) programme. Ninety-one per cent of FSP participants and 78% of CE participants were parents. Seventy-one per cent of FSP participants lived in a two-parent household; 57% of the CE group lived in a one-parent household. The report notes that the rate of lone parenthood in Ireland is 21%. CE participants were younger and tended to be living with all their children or with their parents, whereas FSP participants were more likely to be grandparents and to have acted in the role of full-time parents to their grandchildren. The report noted that nearly one-third of all service users lived in accommodation rented from the local authority – about four times the national rate.

Eighteen per cent of FSP participants and all of the CE participants had used drugs and both groups reported drug use by their partners. Of the FSP participants, 76% reported a high level of drug use by their children, and 46% reported that a family member was a current active drug user.

When compared to a representative sample of parents in Ireland, service users with the Ballyfermot STAR project had:

- much higher levels of negative emotions
- fewer positive emotions
- significantly lower levels of psychological well-being
- experienced higher numbers of negative life events in the past year
- significantly weaker support networks
- weaker parent-child relationships
- higher numbers and frequencies of physical symptoms.

Participants attending the CE programme had dramatically reduced physical well-being; 90% were unable to work due to sickness or disability and 72% reported using prescribed benzodiazepines. These individuals had all been active users of illicit drugs and the majority were now stable on methadone.

Nineteen per cent of families attending the FSP had experienced the death of a family member as a result of drugs, and 59% had a family member who had been imprisoned

for using drugs. On the other hand, FSP service users living in drug-free families had significantly higher levels of well-being than those living in families where drug use was either active or stable. In addition, service users living in drug-free families had significantly higher levels of well-being than the average Irish parent.

However, the authors noted that, given that these data were cross-sectional (collected at one point in time) rather than longitudinal (collected at different points over time), it was not possible to be certain about the direction of the causation. Nonetheless, the researchers argue that it is plausible to infer from the data that well-being is influenced by drug use, rather than the reverse, since those who were currently drug free had previously been active or stable.

Duggan (2007) investigated the ways in which families, and in particular primary carers, seek support in coping with heroin use in their families. The research used in-depth interviews with the primary carer, in most cases a parent, and usually the mother, in 30 families coping with heroin use. These interviews were augmented by further interviews with another family member in the case of seven of the families.

The research identified seven different stages of families' engagement with heroin use in their family. The overall direction of this process was from powerlessness to empowerment. Three specific ways of interacting with services were identified, reflecting three different roles that families occupied: as victims: as carers and as agents of recovery.

The stereotypical view of heroin use as a problem primarily associated with urban disadvantage often meant that rural families were slow to recognise the problem in their own families and less inclined to accept the problem as something prevalent in their communities.

When initially faced with the problem of heroin use by a family member, families often experienced shame and denial due to the perceived social stigma that surrounds heroin use. This had implications for the speed with which they sought help from external sources.

At almost every stage of coping with the problem of heroin use, family members were confronted with a lack of information on the type of help they needed, where they could access it and how they could assess its effectiveness.

12.1.4 Homeless youth

Maycock and Vekic (2006) present data from the first phase of a two-phase longitudinal cohort study of young homeless people living in the Dublin metropolitan area. The study used 'life history' interviews with 40 young people recruited through homeless services and street settings. Fifty per cent of the cohort was aged between 15 and 17 years. Nineteen of the cohort reported becoming homeless initially at the age of 14 or younger, while 12 initially became homeless at age 15. This would suggest that the early to mid-teen years is a period of great risk for becoming homeless. At the time of interview, only eight of the cohort did not use illicit drugs, with the average age of first drug use being 11.5 years for the males and 13 years for the females. Fifty per cent of the cohort reported having used heroin, with almost all reporting their heroin use as problematic to the point of dependency. The majority of those who used heroin had first experimented with it *after* they became homeless.

The research identified three broad pathways into homelessness for the study cohort. The authors caution against interpreting these pathways as 'causes of homelessness',

suggesting that they be viewed rather as key circumstances and experiences that appeared to push the young people towards homelessness.

- Household instability, parental discord and/or marital breakdown and parental alcohol and drug abuse figured prominently in the events leading to that initial experience of homelessness.
- Forty per cent of the cohort reported a history of state care of varied duration among different care settings. According to the authors, this instability produced exceptional vulnerability and deep resentment about their separation from parents and/or siblings.
- Negative peer association and problem behaviour were reported by some of the young people as contributing to poor relations with the family and caregivers. However, as the authors suggest, '[this] behaviour cannot be divorced from a range of other home based problems.

When exposed to the experience of homelessness over an extended period, young people became heavily involved in using drugs and committing crime on a daily basis to finance their drug use. According to the authors, this led to a process of 'acculturation' into the street scene where they 'learned the street competencies they need to survive by becoming embedded in social networks of homeless youths'. However, some of the cohort who managed to avoid the transient nature of hostel life and remained in the one place for an extended period of time were able to escape the street homeless scene, avoid drug use and attend school.

12.1.5 Young offenders

Kilkelly (2005) observed almost 944 cases over a period of nearly 50 days in the four Children's Courts in Ireland; Cork, Dublin, Waterford and Limerick. The research highlights the typical profile of the young person before the Courts as that of a male aged between 16 and 17 years, with problems of varying complexity, including alcohol or drug addiction, behavioural disorders, educational disadvantage and lack of family support. The research concluded that in many cases the courts do not appear to appreciate the complexity of the issues facing the child, and that detention is being increasingly used because of a lack of support and early intervention for young offenders.

Research by Hayes and O'Reilly (2007) compared young offenders in detention (n=30) with youth referred to adolescent psychiatric services (n=20) and a control group (n=30) recruited from a secondary school in Co Cork across a number of psychological domains. The study also identified family- and school-related factors associated with young offenders. The control group did not include youth reporting mental health difficulties or youth with known offending/incarceration history.

Seventy seven per cent (n=23) of the young offenders had been previously detained, 97% (n=29) reported having a family member with a criminal conviction and 90% (n=27) had a family member who served a jail sentence. Eighty three per cent (n=25) of young offenders reported a history of truancy from school; 96.7% (n=29) reported school suspension and 86.7% reported being expelled from school.

Eighty two per cent of the young offenders were diagnosed with at least one psychological disorder compared to 60% of the psychiatric referrals. This included 37% of offender group and 35% of mental health group diagnosed with at least one internalising psychological disorder. For example, separation anxiety disorder and 67.9% of young offenders compared to 30% of psychiatric referrals were diagnosed with externalised disorders such as conduct disorder, oppositional defiant disorder

(ODD) and Attention Deficit Hyperactivity Disorder (ADHD). Fifty six per cent (n=14) of young offenders were diagnosed with substance/alcohol dependency addiction when data on 25 youth was analysed.

Twenty four per cent of the young offenders were diagnosed with alcohol dependency compared to 5% of the psychiatric referrals; 16% of young offenders were dependent on marijuana dependent compared to 5% of psychiatric referrals and 40% of young offenders were dependent on other substances compared to 5% of psychiatric referrals.

The research is welcome as it provided a small window into the characteristics of vulnerable young people in care and in touch with the psychiatric services in Ireland; however the numbers are quite small so conclusions need to be treated with caution.

12.1.6 Youth in deprived areas/neighbourhoods and/or with high drug availability

Byrne *et al.* (2006) examined the free time and leisure needs of young people aged 12–18 living in four areas in Ireland designated as disadvantaged under the Government's RAPID Programme. The research included individual interviews with 37 young people and focus group discussions with 43 young people. Among the findings of the research in respect of social environment, the researchers reported that,

> While describing a strong attachment to their communities, the young people were very aware of their negative characteristics, including high levels of exposure to the use and sale of drugs. There was unanimous agreement among the young people that there are insufficient public and private leisure amenities available to them in their areas.

A report by McGrath and Lynch (2007) highlights the lack of suitable recreational facilities and spaces for young people in East Cork. The research included an exploratory survey, validation groups and a youth conference with young people aged 13–18 attending secondary schools, youth projects and Youthreach for early school leavers. Seventy-nine per cent replied 'No' when asked *'*Are there adequate recreational facilities in your area?*'*

The young people reported drinking alcohol, smoking tobacco and using other drugs to 'relieve boredom' in the absence of adequate facilities. The vast majority (82. %) reported 'hanging around' with peers. The activity of 'hanging round' with peers is exceptionally popular with young people. (de Roiste and Dineen 2005) reported that 'hanging around' with peers was identified as an important leisure activity by 90% of respondents in a survey of 2,260 12–18-year-olds from 51 schools in Ireland. In addition, research by Devlin (2006) and Lalor and Baird (2006) also highlighted 'hanging around' with peers as a favoured activity among young teenagers in Ireland. The Devlin study included focus group discussions with some 90 teenagers that included the views of young asylum seekers, Travellers, people with disabilities and lesbian, gay, bisexual and transgender youth.

Loughran and McCann (2006) investigated changes in the experiences of three Dublin communities related to the problem of drug use in the communities. The research sought to identify changes between 1996 when the local drug task forces emerged and 2004. Data collection included focus groups and in-depth interviews with key participants. Local people were recruited and trained as community researchers, who then recruited the participants through their community network. A total of 97 participants were interviewed across the three sites.

The key findings of the study were:

- Between 1996 and 2004, polydrug use (which includes alcohol) replaced heroin as the main drug problem for all of the communities involved in the study. The misuse of both prescribed and non-prescribed benzodiazepines was noted. The use of cannabis was seen as widespread and had become a 'normal' practice by the end of the study period.
- Alcohol misuse had a major negative effect on the lives of residents in the communities. The more problematic aspects of alcohol use were under-age drinking and subsequent anti-social behaviour among this age group. The easy availability of alcohol was due to an increase in local supermarkets and off-licences in the three communities during the study period.
- There was an improvement in the provision of opiate treatment and community-based treatment interventions between 1996 and 2004. Methadone substitution programmes had some impact on heroin use but failed to tackle other drugs. Concerns were raised regarding the lack of treatment facilities for young people, in particular for alcohol.
- Drug-related deaths and deaths among drug users caused devastation in the three communities. In general, these were premature deaths of young people. There was a general perception that official statistics did not reflect the total numbers who died or the impact of these deaths on other family members and the community at large.
- A general sense of fear, vulnerability and intimidation was experienced among the communities as a result of open drug dealing in public areas. People reported that there had been a decrease in the use of public spaces after dark since 1996.
- A reduction in some types of crime was observed between 1996 and 2004, but the later phase of the study noted an increase in the number of murders associated with drug dealing.
- Participants reported a deteriorating relationship between the community and the gardaí.
- There was an increase in the number of children under 15 years who stayed in school and an increase in those who completed the Leaving Certificate during the reporting period. In some cases, school absenteeism replaced early school leaving.
- Employment opportunities had increased during the reporting period, and fewer people were unemployed in 2004.

12.1.7 Ethnic minorities

Fountain (2006) assessed the nature and extent of illicit drug use in the Traveller community in Ireland. Data collection included interviews with 34 service providers, focus groups with 122 Travellers and one-to-one interviews with 15 Travellers who were using or had used drugs.

The report provides data on drug use, the patterns of drug use, problematic drug use, drug-related risk behaviours, the effect of drug use on the Traveller community and gaps in service provision.

The author reported that Travellers experience social exclusion and do not have equal access to education, health care, employment or accommodation. Traveller children are six times more likely to be cared for by local authorities than children in the general population.

Qualitative research indicates that cannabis, sedatives, tranquillisers and antidepressants are the drugs most commonly used in the Traveller community. These

are followed by cocaine and, to a lesser extent, ecstasy. These findings mirror the pattern of drug use in the general population. In addition, the Traveller population reported occasional use of amphetamines. The less common substances used by Travellers were heroin, crack cocaine, LSD and solvents, again mirroring the pattern in the general population. Injecting drug use among the Traveller community was not commonly reported. As in the general population survey, more male than female Travellers used drugs, and those in the age range between adolescence and early thirties were more likely to be users. The impact of drug use on Traveller users included poor personal health, involvement in criminal activity, exclusion from the family and the broader community, and stigmatisation. Members of the drug user's family were likely to suffer from stress.

The Travellers interviewed described some of the ways their community dealt with drug use, including home detoxification, avoiding drug-using friends, promising a priest not to use any more drugs and seeking treatment. The author reported that formal treatment was rarely sought. There was no consensus on how to deal with drug dealing in the Traveller community and it was reported that the gardaí were reluctant to tackle the issue. There was evidence throughout the research findings that there was a lack of knowledge about drugs and drug use among Travellers. There are a number of barriers to accessing drug treatment services: lack of awareness of such services, lack of formal education, stigma and embarrassment, lack of cultural competence among service providers and perceptions of racism within services.

12.1.8 Party goers

No new information.

12.2 Drug use and problematic drug use among vulnerable groups

The trend data from ESPAD is difficult to comment upon as the same data is not presented each year. Table 12.2.1 indicates that the proportion of the respondents' older siblings who used illicit drugs increased between 1999 and 2003. In 1999, 50% of the respondents missed one or more days of school (in a 30-day period) due to truancy and 23% of children reported that their parents did not usually know their whereabouts on a Saturday evening (Tables 12.2.2 and 12.2.3); these proportions appear very high. Data on single parents are not presented in the ESPAD publications.

Table 12.2.1 Changes in the proportion of school-going children (15–16 years) in Ireland whose older sibling(s) used drugs in the ESPAD surveys of 1995, 1999 and 2003

Drug use	1995 survey %	1999 survey %	2003 survey %
Smoke marijuana or hashish	Not available in report	18	24
Take tranquillisers or sedatives*	Not available in report	3	3
Take ecstasy	Not available in report	4	7

*Without a doctor's prescription
Source: Hibell *et al.* (1997, 2000, 2004)

Table 12.2.2 Changes in the proportions of school-going children (15–16 years) in Ireland who missed school days in the last 30 days due to truancy in the ESPAD surveys of 1995, 1999 and 2003

School days missed	1995 survey %	1999 survey %	2003 survey %
Did not miss any school days	Question not answered	50	Not reported
Missed 1-2 school days	Question not answered	31	Not reported
Missed 3 or more school days	Question not answered	19	Not reported

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

Table 12.2.3 Changes in the proportion of school-going children (15–16 years) in Ireland in the ESPAD surveys of 1995, 1999 and 2003 whose parents know where they are on a Saturday evening

Parents' knowledge of children's whereabouts	1995 survey %	1999 survey %	2003 survey %
Always	Not reported	47	Not reported
Quite often	Not reported	30	Not reported
Sometimes	Not reported	16	Not reported
Usuallly do not know	Not reported	7	Not reported

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

12.3 Vulnerable groups among the treated population

The cases presented in this analysis entered drug treatment (either as new or return cases) between 2002 and 2005 and were aged between 10 and 24 years. The parameters selected and shaded in grey in Tables 12.3.2 to 12.3.14 are indicators of vulnerability.

Table 12.3.1 Gender of cases under 25 years entering drug treatment, 2002 to 2005

	Year treated				
Gender	**2002**	**2003**	**2004**	**2005**	**Total**
Male	1819 (69.6%)	1774 (69.6%)	1506 (72.2%)	1436 (74.5%)	6535 (71.2%)
Female	709 (27.1%)	693 (27.2%)	556 (26.7%)	483 (25.1%)	2441 (26.6%)
Not recorded	85 (3.3%)	81 (3.2%)	23 (1.1%)	8 (0.4%)	197 (2.1%)
Total	2613 (100.0%)	2548 (100.0%)	2085 (100.0%)	1927 (100.0%)	9173 (100.0%)

The percentage of male cases who entered drug treatment increased from 70% in 2002 to 75% in 2005 (Table 12.3.1).

Table 12.3.2 Age profile of cases under 25 years entering drug treatment, 2002 to 2005

Age in years	Year treated				Total
	2002	2003	2004	2005	
17 or under	536 (20.5%)	549 (21.5%)	425 (20.4%)	411 (21.3%)	1921 (20.9%)
18 or over	2077 (79.5%)	1999 (78.5%)	1660 (79.6%)	1516 (78.7%)	7252 (79.1%)
Total	2613 (100.0%)	2548 (100.0%)	2085 (100.0%)	1927 (100.0%)	9173 (100.0%)

In Ireland, people aged 17 years or under are classified as children. Between 2002 and 2005 one-fifth of cases who entered drug treatment were 17 years or under (Table 12.3.2).

Table 12.3.3 Source of referral of cases under 25 years entering drug treatment, 2002 to 2005

Source of referral	Year treated				Total
	2002	2003	2004	2005	
Other source	2168 (83.0%)	2073 (81.4%)	1659 (79.6%)	1491 (77.4%)	7391 (80.6%)
Court/probation/ police	341 (13.1%)	407 (16.0%)	285 (13.7%)	316 (16.4%)	1349 (14.7%)
Prison	Not available	Not available	18 (0.9%)	41 (2.1%)	59 (.6%)
Not known	104 (4.0%)	68 (2.7%)	123 (5.9%)	79 (4.1%)	374 (4.1%)
Total	2613 (100.0%)	2548 (100.0%)	2085 (100.0%)	1927 (100.0%)	9173 (100.0%)

During the period under review just less than 15% of cases were referred to drug treatment through the criminal justice system (Table 12.3.3).

Table 12.3.4 Living companions of cases under 25 years entering drug treatment, 2002 to 2005

	Year treated				
	2002	2003	2004	2005	Total
Living with other	2446 (93.6%)	2400 (94.2%)	1962 (94.1%)	1811 (94.0%)	8619 (94.0%)
Living alone with child	63 (2.4%)	89 (3.5%)	62 (3.0%)	72 (3.7%)	286 (3.1%)
Not known	104 (4.0%)	59 (2.3%)	61 (2.9%)	44 (2.3%)	268 (2.9%)
Total	2613 (100.0%)	2548 (100.0%)	2085 (100.0%)	1927 (100.0%)	9173 (100.0%)

A small proportion of problem drug users entering treatment were living alone with children between 2002 and 2005 (Table 12.3.4).

Table 12.3.5 Accommodation status of cases under 25 years entering drug treatment, 2002 to 2005

Type of accommodation	Year treated				Total
	2002	2003	2004	2005	
Other accommodation	2298 (87.9%)	2317 (90.9%)	1884 (90.4%)	1779 (92.3%)	8278 (90.2%)
Homeless	123 (4.7%)	117 (4.6%)	120 (5.8%)	97 (5.0%)	457 (5.0%)
Not known	192 (7.3%)	114 (4.5%)	81 (3.9%)	51 (2.6%)	438 (4.8%)
Total	2613 (100.0%)	2548 (100.0%)	2085 (100.0%)	1927 (100.0%)	9173 (100.0%)

Approximately 5% of drug users entering treatment were homeless during the period under review (Table 12.3.5).

Table 12.3.6 Nationality of cases under 25 years entering drug treatment, 2002 to 2005

Nation	Year treated				
	2002	2003	2004	2005	Total
Ireland	2561 (98.0%)	2487 (97.6%)	2015 (96.6%)	1855 (96.3%)	8918 (97.2%)
Other country	43 (1.6%)	45 (1.8%)	45 (2.2%)	45 (2.3%)	178 (1.9%)
Not known	9 (.3%)	16 (.6%)	25 (1.2%)	27 (1.4%)	77 (.8%)
Total	2613 (100.0%)	2548 (100.0%)	2085 (100.0%)	1927 (100.0%)	9173 (100.0%)

Approximately 2% of drug users entering treatment during the reporting period were from another country (Table 12.3.6).

Table 12.3.7 Employment status of cases under 25 years entering drug treatment, 2002 to 2005

Employment status	Year treated				
	2002	2003	2004	2005	Total
Not employed	2056 (78.7%)	2033 (79.8%)	1585 (76.0%)	1496 (77.6%)	7170 (78.2%)
Employed full or part time	491 (18.8%)	464 (18.2%)	418 (20.0%)	376 (19.5%)	1749 (19.1%)
Not known	66 (2.5%)	51 (2.0%)	82 (3.9%)	55 (2.9%)	254 (2.8%)
Total	2613 (100.0%)	2548 (100.0%)	2085 (100.0%)	1927 (100.0%)	9173 (100.0%)

Just under four-fifths of drug users were not in full time employment. This figure includes housewives and those with a disability (Table 12.3.7).

Table 12.3.8 School-leaving age of cases under 25 years entering drug treatment, 2002 to 2005

School-leaving age	Year treated				
	2002	2003	2004	2005	Total
15 years or over	1615 (61.8%)	1511 (59.3%)	1219 (58.5%)	1159 (60.1%)	5504 (60.0%)
14 years or under	426 (16.3%)	456 (17.9%)	348 (16.7%)	308 (16.0%)	1538 (16.8%)
Never went to school	2 (0.1%)	3 (0.1%)	4 (0.2%)	3 (0.2%)	12 (0.1%)
Still at school	320 (12.2%)	382 (15.0%)	273 (13.1%)	281 (14.6%)	1256 (13.7%)
Not known	250 (9.6%)	196 (7.7%)	241 (11.6%)	176 (9.1%)	863 (9.4%)
Total	2613 (100.0%)	2548 (100.0%)	2085 (100.0%)	1927 (100.0%)	9173 (100.0%)

Over 16% of drug users entering treatment between 2002 and 2005 had left school before the age of 15 years (Table 12.3.8).

Table 12.3.9 Education level of cases under 25 years entering drug treatment, 2004 and 2005

Education level	Year treated		
	2004	2005	Total
No education level completed	4 (0.2%)	3 (0.2%)	7 (0.2%)
Completed junior certification or less	1257 (60.3%)	1120 (58.1%)	2377 (59.2%)
Completed second level education or more	277 (13.3%)	309 (16.0%)	586 (14.6%)
Still in education	313 (15.0%)	331 (17.2%)	644 (16.1%)
Not known	234 (11.2%)	164 (8.5%)	398 (9.9%)
Total	2085 (100.0%)	1927 (100.0%)	4012 (100.0%)

In 2004 and 2005, just less than 60% left school before completing leaving certificate. These data are not available for earlier years (Table 12.3.9).

Table 12.3.10 Main problem drug reported by cases under 25 years entering drug treatment, 2002 to 2005

Main problem drug	Year treated				
	2002	2003	2004	2005	Total
Opiates or cocaine	1443 (55.2%)	1292 (50.7%)	1150 (55.2%)	998 (51.8%)	4883 (53.2%)
Other drugs*	1170 (44.8%)	1256 (49.3%)	935 (44.8%)	929 (48.2%)	4290 (46.8%)
Total	2613 (100.0%)	2548 (100.0%)	2085 (100.0%)	1927 (100.0%)	9173 (100.0%)

* Cannabis, amphetamines, ecstasy, hypnotics or sedatives, hallucinogens, volatile inhalants and other medications

Of those who entered treatment between 2002 and 2005, over half reported opiates or cocaine as their main problem drug (Table 12.3.10).

Table 12.3.11 Age at first use of main problem drug reported by cases under 25 years entering drug treatment, 2002 to 2005

Age at first use	Year treated				Total
	2002	2003	2004	2005	
Under 15	716 (27.4%)	789 (31.0%)	605 (29.0%)	611 (31.7%)	2721 (29.7%)
15–19	1566 (59.9%)	1468 (57.6%)	1099 (52.7%)	1007 (52.3%)	5140 (56.0%)
20–24	168 (6.4%)	184 (7.2%)	189 (9.1%)	192 (10.0%)	733 (8.0%)
Not known	163 (6.2%)	107 (4.2%)	192 (9.2%)	117 (6.1%)	579 (6.3%)
Total	2613 (100.0%)	2548 (100.0%)	2085 (100.0%)	1927 (100.0%)	9173 (100.0%)

Over one-quarter of cases who entered treatment during the period under review took their main problem drug for the first time before the age of 15 years (Table 12.3.11).

Table 12.3.12 Frequency of use of main problem drug in the month prior to treatment reported by cases under 25 years entering drug treatment, 2002 to 2005

Frequency of use in the month prior to treatment	Year treated				Total
	2002	2003	2004	2005	
Once per week or less	250 (9.6%)	251 (9.9%)	149 (7.1%)	140 (7.3%)	790 (8.6%)
2–6 days per week	500 (19.1%)	562 (22.1%)	425 (20.4%)	409 (21.2%)	1896 (20.7%)
Daily	1201 (46.0%)	1116 (43.8%)	949 (45.5%)	912 (47.3%)	4178 (45.5%)
No use in past month	553 (21.2%)	548 (21.5%)	428 (20.5%)	399 (20.7%)	1928 (21.0%)
Not known	109 (4.2%)	71 (2.8%)	134 (6.4%)	67 (3.5%)	381 (4.2%)
Total	2613 (100.0%)	2548 (100.0%)	2085 (100.0%)	1927 (100.0%)	9173 (100.0%)

Approximately 45% of those entering treatment during the reporting period reported that they took their main problem drug daily in the month prior to treatment (Table 12.3.12).

Table 12.3.13 Route of main problem drug reported by cases under 25 years entering drug treatment, 2002 to 2005

Route of main problem drug	Year treated				Total
	2002	2003	2004	2005	
Smoke, snort, eat or drink	1878 (71.9%)	1884 (73.9%)	1630 (78.2%)	1582 (82.1%)	6974 (76.0%)
Inject	703 (26.9%)	643 (25.2%)	419 (20.1%)	319 (16.6%)	2084 (22.7%)
Not known	32 (1.2%)	21 (.8%)	36 (1.7%)	26 (1.3%)	115 (1.3%)
Total	2613 (100.0%)	2548 (100.0%)	2085 (100.0%)	1927 (100.0%)	9173 (100.0%)

The proportion of cases who injected their main problem drug decreased considerably, from 27% in 2002 to 17% in 2005 (Table 12.3.13).

Table 12.3.14 Use of more than one problem drug in the month prior to treatment reported by cases under 25 years entering drug treatment, 2002 to 2005

Uses more than one problem drug	Year treated				Total
	2002	2003	2004	2005	
No	623 (23.8%)	626 (24.6%)	602 (28.9%)	545 (28.3%)	2396 (26.1%)
Yes	1990 (76.2%)	1922 (75.4%)	1483 (71.1%)	1382 (71.7%)	6777 (73.9%)
Total	2613 (100.0%)	2548 (100.0%)	2085 (100.0%)	1927 (100.0%)	9173 (100.0%)

The proportion of cases who reported more than one problem drug decreased marginally, from 76% in 2002 to 72% in 2005 (Table 12.3.14).

Table 12.3.15 Place of residence of cases under 25 years entering drug treatment, 2002 to 2005

Place of residence	Year treated				
	2002	2003	2004	2005	Total
Outside Dublin	1323 (50.6%)	1461 (57.3%)	1210 (58.0%)	1276 (66.2%)	5270 (57.5%)
Dublin	1279 (48.9%)	1071 (42.0%)	871 (41.8%)	641 (33.3%)	3862 (42.1%)
Outside Ireland	4 (0.2%)	0 (0.0%)	1 (0.0%)	4 (0.2%)	9 (0.1%)
Not known	7 (0.3%)	16 (0.6%)	3 (0.1%)	6 (0.3%)	32 (0.3%)
Total	2613 (100.0%)	2548 (100.0%)	2085 (100.0%)	1927 (100.0%)	9173 (100.0%)

The proportion of cases who lived outside Dublin and entered drug treatment increased considerably, from 51% in 2002 to 66% in 2005 (Table 12.3.15).

12.4 Correlates and consequences of drug use among vulnerable groups

12.4.1 Psychosocial and health problems

The report, *Emotional intelligence, mental health and juvenile delinquency*, revealed that young people in detention schools in Ireland experience high rates of psychiatric disorders, engage in serious criminal activity and have significant deficits in emotional intelligence and cognitive ability (Hayes and O'Reilly 2007). (This report is discussed in Section 2.4.2.)

12.4.2 Criminal behaviours (arrest data)

No data available

12.5 Responses to drug problems among vulnerable groups

12.5.1 Policy and legal developments

The National Development Plan 2007–2013 (Department of An Taoiseach 2007) proposes that sport can act as an alternative to young people at risk of engaging in anti-social activity, drug abuse or other criminal activity.

The National Action Plan for Social Inclusion 2007–2016 (Department of Social and Family Affairs Office for Social Inclusion 2007) endorses the use of the Young People's Facilities and Services Fund (YPFSF) as the primary means of responding to youth at risk from drug misuse. Measures funded through the YPFSF tend to be sporting and recreational pursuits in disadvantaged communities.

The National Children's Strategy, *Our children – their lives* (Department of Health and Children 2000), addresses, among other things, illicit drug use among vulnerable children, and the links between homelessness and drug abuse among children. With regard to illicit drug use, the Strategy acknowledges the government's support for the provision of sporting and leisure facilities for young people at risk of drug misuse under the Young People's Facilities and Services Fund.

The National Drugs Strategy 2001–2008 (Department of Tourism Sport and Recreation 2001) and the new and amended actions outlined in the mid-term review of the National Drugs Strategy (Steering group for the mid-term review of the National Drugs Strategy 2005) form the policy bedrock for the development of responses to drug problems among vulnerable groups.

Arrest referral and alternatives to imprisonment
According to Connolly (2006a), many of the alternative sanctions in operation in Ireland are not on based on statute but have evolved over time in the form of judicial practice. For example, almost half of the offenders referred for supervision by the Probation and Welfare Service (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. The agencies involved in the operation of alternative sanctions in Ireland include the Garda Síochána, the PWS and the courts. The Garda Síochána have a role in the operation of juvenile diversion schemes and also in relation to restorative justice interventions.

Pre-trial stage – Arrest referral and juvenile diversion
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. There are procedures in place to enable the gardaí to divert juvenile offenders found in possession of small quantities of drugs, where drug trafficking is not an issue, away from the judicial process. 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 may 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, identifying the injured party is a matter of some controversy. As these represent early interventions, they cannot be described strictly 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.

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' (Department of 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. An evaluation report has recommended that the scheme be extended, with additional resources in terms of staff, programme development and monitoring (North Inner City Drugs Task Force 2005).

12.5.2 Prevention and treatment

Prevention

Action 37 of the National Drugs Strategy 2001–2008 states:

> Actions 31-35 apply equally to the non-school education sector, e.g. Youthreach and Community Training Workshops operated by FÁS. Such sectors often deal with young people from more disadvantaged backgrounds who are more at risk of drug misuse.

For this reason, incorporating a drug element in the education provided is important. Actions 31–35 relate to the delivery of school-based prevention and drug education programmes and include measures such as the Walk Tall programme in primary schools and the SPHE programme in secondary schools. The provision of factual drug-related information to parents is also included. The implied assumption here is that school-based programmes to improve life skills in students are appropriate for preventing drug use in vulnerable youth such as early school leavers. However, there is little information available on the extent to which drugs education and life-skills programmes are delivered in non-school settings (see mid-term review of the National Drugs Strategy).

The prevention of drug use among vulnerable groups is mainly provided through the Young People's Facilities and Services Fund (YPFSF). The overall aim is to attract at-risk young people in disadvantaged areas into facilities and activities that can divert them away from the dangers of substance misuse. The operation of this programme was evaluated by (Ronayne 2003) and the main findings and programme descriptions are provided in a profile of the programme on the EDDRA database. Little is known about the operation or effectiveness of the programme since then, as there has been no further evaluation and apparently little effort to put in place one of the key

recommendations made by Ronayne, which was to develop standardised data-collection systems across the various projects.

However, according to the Steering Group for the mid-term review of the National Drugs Strategy (2005), approximately €85 million has been allocated under the YPFSF to support in the region of 450 facility and services projects. These include building and renovating youth and sport facilities; funding purpose-build youth centres and funding youth and outreach workers to target at risk youth. The Steering Group endorses the approach of youth work in engaging with at-risk youth in non-school settings, this approach is used quite a lot by interventions under the YPFSF.

Under the YPFSF, there is a plethora of interventions at work targeting at-risk youth in disadvantaged communities. However, because of the lack of data available on the programme, little is known on the profile of the young people that engages with the services or engagement strategies. For example, the evaluation by Ronayne (2003) highlighted the difficulties reported in engaging the most at-risk youth.

13 Drug-related research in Ireland

13.1 Research structures

13.1.1 Drug-related research in national policy

Research is one of the four pillars of Ireland's **National Drugs Strategy 2001–2008** (NDS) (Department of Tourism Sport and Recreation 2001). One of the Strategy's strategic aims is 'to have valid, timely and comparable data on the extent and nature of drug misuse in Ireland'. There are two objectives under the Research pillar: to make data available on the extent of drug misuse 'amongst all marginalised groups' and to gain greater understanding of the factors which 'contribute to Irish people, particularly young people, misusing drugs'.

The key performance indicators for these two objectives are:

- the elimination of all major gaps in drug research by end 2003; and
- the publication of an annual report on the nature and extent of the drug problem in Ireland and on progress being made in achieving the objectives set out in the Strategy.

The extent to which these objectives were being met was assessed in a **progress report** (Department of Community Rural and Gaeltacht Affairs 2004) and a **mid-term review** (Steering group for the mid-term review of the National Drugs Strategy 2005).

The group formed in 2000 to review the existing drugs strategy and the current situation in Ireland (the Review Group) (NDS: Section 2.11) noted the **report of the Interim Advisory Committee on Drugs** (Department of Tourism Sport and Recreation 2000). This report identified a range of research and information gaps and suggested a three-year research programme in the areas of prevalence, prevention, treatment and consequences of problem drug use. The report recommended that this programme be overseen by a National Advisory Committee on Drugs; the NACD was established by the Government in July 2000. In the section on data collection (NDS: Section 2.1.) the Review Group identified the National Drug Treatment Reporting System (NDTRS), maintained by the Drug Misuse Research Division (DMRD, now called the Alcohol and Drug Research Unit) of the Health Research Board, as the main source of information on drug misuse in Ireland. The DMRD was also given responsibility for establishing a National Documentation Centre on Drug Use, following a recommendation from the Interim Advisory Committee (NDS: para 2.11.3)

In its conclusion, the NDS Review Group explained that the need for improved research in all of the main areas was a persistent theme in the consultation process (NDS: para. 6.5.1). The knowledge on which a successful drugs strategy is based will be created through the provision of good quality information on the extent and nature of the drugs problem and by acquiring comprehensive and comparable data. 'Research is essential to enable the dissemination of models of best practice in line with EU and Government policy.'

In its overview of drug misuse in Ireland, **the Review Group outlined the most important sources of data related to the problem**: drug misusers registered for treatment; drug-related deaths; drug-related infectious diseases (HIV and hepatitis); drug-related arrests and offences; and drug seizures (NDS: Section 2.1). The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) uses five indicators for drug patterns and trends in Europe. These indicators are: extent and pattern of drug use in the general population; prevalence of problem drug use; demand for treatment by drug users; drug-related deaths and mortality among drug users; and

drug-related infectious diseases (HIV, hepatitis) (NDS: Section 2.1). Each of the EMCDDA's 16 national Focal Points, including the DMRD, is expected to provide it with 'valid, comparable and objective information' under these five headings. A number of these information sources are considered separately below.

- **Prevalence data:** The Review Group recognised the limitations of the methods currently used to estimate prevalence. Data are gathered on those who present themselves for treatment. Drug use outside of treatment is not accounted for in these data but there have been attempts to extrapolate from treatment figures, and from statistics on drug-related arrests and deaths, to give estimates of heroin users. However, accurate prevalence estimation will require ongoing investigation of data availability (NDS: para. 2.3.1). The Review Group noted that the recently established NACD was overseeing the delivery of an initial three-year research programme that included looking at how best to determine the size and nature of the drug problem in Ireland (NDS: Section 2.11).

- **Treatment data:** The DMRD (re-named ADRU) manages the NDTRS, which provides data on people who use treatment services for problem drug use. The NDTRS is the main source of information on drug use in Ireland. The Review Group recommended changes to ensure treatment facilities report problem drug use to the DMRD in order to improve the efficiency and quality of flow of this information (NDS: para. 6.5.4.).

- **Drug-related deaths:** Data on drug-related deaths are recorded by the General Mortality Register of the Central Statistics Office (CSO). The Review Group recommended that Ireland should develop a dedicated system for recording drug-related deaths. Other countries have developed this capacity and it is essential for comparative analysis.

- **Drug-related infectious diseases (HIV, hepatitis):** The Review Group used statistics compiled by the Department of Health and Children as its main source of information on HIV and hepatitis among drug users in the general population. Two major reports on the prevalence of use and the risk to committal prisoners were the main source of information on drug use in prisons and provided a detailed picture of the prevalence of drug-related infectious diseases in prison (NDS: Section 2.11).

- **Drug-related arrests and offences and drug seizures:** The annual reports of the Garda Síochána were the source of information on both drug-related arrests and offences and on seizures referred to by the Review Group.

The Review Group acknowledged that **the National Advisory Committee on Drugs (NACD)** already had a three-year research programme aimed at addressing the priority information gaps and deficiencies in the drugs area (NDS: para. 6.5.3). It listed the contents of the programme:

- A comprehensive inventory of existing research and information relating to the prevalence, prevention, treatment/rehabilitation and consequences of problem drug use in Ireland
- How best to determine the size and nature of the drug problem in Ireland
- The effectiveness of existing models and programmes in the area of prevention, treatment and rehabilitation
- The cost to society of the drug problem.

The Action Plan in the National Drugs Strategy 2001–2008 calls for the NACD to examine its research programme to establish whether they could accommodate

additional research on at-risk groups such as Travellers, prostitutes, the homeless and early school leavers, and two pieces of research into aspects of harm-reduction, including methadone treatment and minimising the sharing of injecting equipment

The NDS Action Plan included a number of commitments to evaluate existing services and make better use of research findings. The Review Group was concerned not just with the collection of data and the provision of more information but also with how the various agencies involved in the drugs issue can improve existing services through continuous monitoring and review. The Action Plan provides for evaluation of a number of services and policies of relevance to the drugs issue. These include:

- The impact of the Housing Act (evictions, excluding orders) on homelessness by the end of 2001
- The effectiveness of the Prison Strategy covering all aspects of drug services in prisons, including research on levels and routes of supply of drugs in prisons, by the end of 2004.
- The effectiveness of the 'Walk Tall' and 'On My Own Two Feet' programmes. Evaluation to be completed by the end of 2002.
- Appropriateness of performance indicators used by treatment and rehabilitation services to ensure they reflect the reality of the drug problem locally.

A number of actions provide for appropriate responses to evaluation of various pilot programmes.

The mid-term review of the National Drugs Strategy 2001–2008 (MTR), published on 2 June 2005, recommended a number of additions and amendments to the existing Strategy under each of the four pillars.

- Under the **research** pillar, the Review recommendations included: two new actions establishing a process to monitor the implementation of the recommendations arising from the reports of the National Advisory Committee on Drugs and the development of the Central Treatment List by providing further information regarding entry and re-entry of opiate users to methadone treatment and the length of time in treatment.

- Under the **supply reduction** pillar, the Review Group recommended a framework to monitor numbers of successful prosecutions, arrests and nature of sentences. It stated that 'data collection and the provision of timely information will support the ongoing and future review and evaluation of the actions under the supply reduction pillar (MTR: para 3.15). It was also noted that the NACD had prioritised drugs and crime in its new work programme and that this 'will further contribute to evidence-based policy making' (para. 3.15).

13.1.2 Interlink between research, policy and practice

The links between research, policy and practice are outlined in this section under the following headings:

- Treatment of under-18s presenting to addiction services
- Identifying gaps in knowledge about drugs and crime – national and international evidence
- Drug treatment demand data
- Family support service
- Evidence regarding the prescription of heroin.

Treatment of under-18s presenting to addiction services
Action 49 of the National Drugs Strategy 2001–2008 identified the need to develop a protocol for treating under 18-year-olds presenting with serious drug problems. The report of a working group established in October 2001 to review this issue was published in September 2005 (Working Group on treatment of under 18 year olds 2005).

The working group reviewed the extent of the problem and noted that 'attendances by children account for a substantial proportion of the workload of the addiction services in Ireland'. The Group commissioned a literature review to support its work and explicitly acknowledged the contribution of the DMRD in reviewing the available data on prevalence and nature of problematic drugs and in providing much of the material on which the review of the current situation is based. The data on which the DMRD's review was based were obtained from the following:

1. Trends in the prevalence of illicit drug use
   (i) Health Behaviour in School-aged Children Survey (HBSC)
   HBSC is a World Health Organisation (European) collaborative study of school-going children aged 10-17 years. Trends in cannabis, glue and solvent use were examined following HBSC surveys in Ireland in 1998 and 2003.

   (ii) European School Survey Project on Alcohol and Other Drugs (ESPAD)
   ESPAD is a Europe-wide collaborative study of school-going children aged 15 to 16 years. The working group examined trends in drug prevalence from the two ESPAD surveys in Ireland in 1995 and 1999.

2. Trends in the treatment of problem drug use
   The NDTRS, co-ordinated by the DMRD, records data on clients seeking treatment for problem drug use. These data are used to provide information on the characteristics of those entering treatment, and on patterns of problem drug use, such as types of drugs used and consumption behaviours. Between 1991 and 2000, 44,068 cases were reported to the NDTRS. The DMRD examined selected socio-demographic and drug-using characteristics to describe problem drug users aged under 18 years who sought treatment for the first time between 1991 and 2000 in the following two geographical areas:

   (i) Health Service Executive Eastern Regional Area
   This area recorded 2,034 new cases aged under 18 years between 1991 and 2000. The data indicate that these young drug users had not achieved their educational potential and may live in an unstable environment. The main problem drug reported changed over time: cannabis in the early nineties, opiates in the mid-nineties and cannabis in the late nineties were the most common main drug problem reported. The data from 1995 to 2000 indicate an increasing interval between initiation of illicit drug use and seeking treatment.

   (ii) Outside the Health Service Executive Eastern Regional Area
   The areas outside the HSE Eastern Region recorded 629 new cases aged under 18 years (22% of total) between 1996 and 2000. The data indicate that these young drug users had not achieved their educational potential and a number were caring for young children. Cannabis was the most commonly reported main problem drug throughout the reported period. The time interval between commencing use of the main problem drug and seeking treatment was longer than that reported by young drug users in the HSE Eastern Regional Area, and increased by four months during the reporting period.

The working group on treatment of under-18s drew a number of implications from the data. Attendances by children for drug treatment services are at a very high level and account for a substantial portion of the workload of addiction services. While conscious of the need to interpret the data with care, the Group believed that the data reaffirm the relevance to many of the issues raised by the Group. Specifically, the Group recognised the need to respond to challenges presented by changes in patterns of drugs use, and polydrug use in particular, the increase in the number young females presenting to treatment services and the growing minority of homeless young drug users. A number of risk factors can be identified from the literature and the analysis of treatment data. These include economic, behavioural, environmental, family and psychological factors.

Identifying gaps in knowledge about drugs and crime – national and international evidence

Research on the relationship between drug use and crime has helped to identify a number of gaps in knowledge in this area. Dealing with these gaps will be necessary for the development of evidence-based policies in both the drugs and criminal justice areas. In its 2005–2008 Business Plan, the NACD identified drugs and crime as a priority area for its research programme, and stated its intention to reconvene a consultative group of key stakeholders (originally convened in 2003) to support the development of a relevant research project or projects.

An important knowledge gap identified was the nature and structure of drug markets and their impact on local communities. In 2007 the NACD called for tenders to conduct research in this area. The NACD's selection of drugs and crime as a priority area, its identification of significant gaps in knowledge and its decision to support specific research projects in this area were based on evidence derived from the following sources:

1. Research Outcome Study in Ireland (ROSIE)
   Preliminary analysis of ROSIE data indicate high levels of lifetime involvement in crime by participants in the study, with 77% reporting involvement in acquisitive crime and 70% in drug dealing/ supply at some time prior to treatment intake (Cox, G. *et al.* 2006).

2. Studies of homelessness and members of new communities
   The homelessness study (Lawless, M. and Corr 2005) interviewed 355 homeless people and 15% said, in response to a multiple response question, that criminal activity was a source of income and 10% said it was their main source of income. A number of the 10 problematic drug users interviewed in the new communities study (Lawless and Corr 2005) reported stealing or shoplifting to buy drugs.

3. Community studies
   This study of three communities' experiences of drugs provided an important insight into the nature of drug markets (Loughran and McCann 2006). Aspects of drug markets which have a negative impact on the lives of people living in these communities include visible drug dealing, the involvement of increasing numbers of local people in drug dealing, increasing violence and anti-social behaviour arsing from alcohol consumption, and the combined use of alcohol and cocaine. There is a sense of fear in these communities because of behaviour associated with drug use, and a decreasing level of confidence in the ability of the gardai to make a difference to the problem.

4. Drug Trends Monitoring System (DTMS)
   This pilot study developed a media monitoring system to collect information on drug related seizures, court cases and local issues.

5. HRB study of drugs and crime
   This research analysed existing data and available research on drug offences and drug-related crime (Connolly 2006b). The study analysed trends in drug offences since 1983 and described the limitations of official statistics in terms of describing the overall crime picture. The study demonstrated that, while research has identified a clear link between some forms of illicit drug use and crime, there has been little sustained examination of the precise nature of this link in Ireland. It makes a number of recommendations in relation to data limitations and future research in this area.

Drug treatment demand data

The identification of the areas most affected by drug use and the decision to establish local co-ordinating mechanisms in each of these areas demonstrates a very clear link between treatment demand data and subsequent drug policy. In July 1996, the Irish Government set up a Ministerial Task Force to review the measures to reduce the demand for drugs and, in the light of that review, to recommend changes in policy, legislation or practice to facilitate more effective drugs reduction strategies. In its first report (Ministerial Task Force on Measures to Reduce the Demand for Drugs 1996), published in October 1996, the Task Force recognised that Ireland's drug problem was primarily an opiates problem – mainly heroin – and, further, that Ireland's heroin problem was principally a Dublin phenomenon.

Using maps produced by the NDTRS showing the areas of residence of those receiving treatment for drug misuse in the greater Dublin area in 1995, the Task Force identified 10 local areas where the heroin problem was most acute. An additional, eleventh, area was identified in Ireland's second major city, Cork. It was noted that there was a high correlation between these areas and areas of economic and social disadvantage. The Task Force concluded that 'in view of the link between economic and social deprivation and drug misuse, strategies to deal with the problem need to be focused on these areas'. As a result, the Task Force recommended a series of drugs initiatives, one of which was the establishment of local drugs task forces comprising statutory, voluntary and community representatives, in each of the eleven worst-affected areas. Each local drugs task force was mandated to draw up a profile of all existing or planned services and resources available in the area to combat the drugs crisis and to agree a development plan to build on these.

The Government accepted the recommendations contained in the first report of the Ministerial Task Force, and local drugs task forces were set up in 1997. In its second and final report, published in May 1997 (Ministerial Task Force on Measures to Reduce the Demand for Drugs 1997) the Task Force identified a further two worst-affected areas in Dublin and recommended that local drugs task forces should be established in these areas also.

Family support service

In 2004 the NACD published a report on the role of family support services in drug prevention (Watters and Byrne 2004) .The report sought to determine the extent to which these services dealt with drug problems, the contribution made by family support in preventing drug use, and, the potential for these services to make a greater contribution in reducing the harm caused by drugs. The findings of the report were based on a survey of these services, interviews and a focus group. In recommending further development of family support services to reduce harm to families, the MTR endorsed the recommendations of the report on this issue, namely:

- to increase the capacity of services to respond through an appropriate level of resources and training for staff in services;

- to strengthen interagency links and networks by building knowledge of local community issues and attitudes thus improving communications; and,
- to develop relevant monitoring and evaluation tools to measure effectiveness of services (MTR: Section 7.19)

Evidence regarding prescription of heroin
The NDS overview of international responses to drug problems included a note on the practice of prescribing heroin for heroin addicts in Switzerland. The Review Group referred to two evaluation of the heroin prescription programme and noted scepticism of one of these evaluations regarding the benefits of one short-acting opioid over others (NDS: Para 4.11.5) Further study would be needed to determine this. The Review Group noted that evaluations of similar treatments in The Netherlands and Spain have yet to be completed and continued research is needed to establish the benefits of such treatments. It recommended that this research should be monitored (NDS: Para 4.13.2). In 2004 the EMCDDA published a review of the evidence base for the introduction of consumptions rooms as part of a harm reduction strategy (Hedrich 2004) .There is a clear distinction between the operation of these facilities, in which drugs are not supplied to users, and the experimental programme of supplying heroin to drugs users on prescription. Nevertheless, the risks and benefits outlined in the EMCDDA review are of relevance to the topic of heroin prescription. Despite this, the MTR refers neither to this review nor to any further research on prescribing heroin published since the launch of the NDS.

13.1.3 Main national structures for drug-related research

Co-ordinating bodies
Government funding for drug-related research is mainly provided through:
- The **Department of Health and Children**, which funds the Health Research Board to manage the National Drug Treatment Reporting System, and part-funds the HRB to manage the National Drug-related Deaths Index and the National Report to the EMCCDA.
- The **Department of Community, Rural and Gaeltacht Affairs**, which has overall responsibility for the management of the National Drugs Strategy, and funds the National Advisory Committee on Drugs to identify priority information gaps and deficiencies in the drugs area and to commission research to fill these gaps. This Department also funds the HRB to manage the National Documentation Centre on Drug Use.
- The **Health Service Executive (HSE)**, which has overall responsibility for the management of Ireland's publicly funded health and social services, including drug treatment services. The HSE provides funding for research on drug- and alcohol-related issues.
- The **Department of Justice, Equality and Law Reform**, which part-funds the HRB to manage the National Drug-Related Deaths Index
- The **Health Research Board**, which funds all areas of health research, including biomedical, population health and health services research. A number of major drug-related research projects have been supported by this funding.

  The NDC maintains a database of current research in the drugs area in Ireland. Of a total of 40 projects on the database in July 2007, seven were receiving funding from the HSE and four were funded by HRB research grants.

Main research institutions and organisations
The **Alcohol and Drug Research Unit (ADRU)**, formerly the Drug Misuse Research Division (DMRD), of the Health Research Board has been the national focal point of the EMCDDA since 1995. The ADRU is a multi-disciplinary team of researchers and

information specialists who provide objective, reliable and comparable information on the drug misuse and problem alcohol use situations, their consequence and responses to these situations in Ireland. The unit currently employs 18 staff. Total funding for all ADRU activities in 2006 was €1,379,580.

ADRU maintains two national drug-related surveillance systems, the National Drug Treatment Reporting System and National Drug-Related Deaths Index. The ADRU also manages the National Documentation Centre on Drug Use. The unit disseminates research findings, information and news through Occasional Papers, its Overview series and its quarterly newsletter, *Drugnet Ireland*. Through its activities, the ADRU aims to inform policy and practice in relation to drug misuse.

The establishment of the DMRD coincided with the setting up of the Dublin Drug Treatment Reporting System in 1989. Initial funding was provided by the European Commission and the Irish Department of Health. Since 1990 annual funding of the reporting system has come from the Department of Health, later the Department of Health and Children (DOHC). Prior to 1989, staff of the HRB (formerly the Medico-Social Research Board) had been involved in ad hoc drug misuse research studies. Following the recommendations of the Government's 1991 strategy to prevent drug misuse, the Dublin Drug Treatment Reporting System was extended nationally on a phased basis from 1995 onwards. The name was changed to the National Drug Treatment Reporting System (NDTRS) in 1995.

In 2000, following the recommendations of the Interim Advisory Committee on Drugs, published by the Department of Tourism, Sport and Recreation in 2000, the DMRD was designated by the Government as the central point to which all research data and information should be channelled. In order to deliver on this role, the DMRD developed the National Documentation Centre on Drug Use (NDC). The Documentation Centre opened in December 2002 and is funded by the Department of Community, Rural and Gaeltacht Affairs (DCRGA).

In 2005 the DMRD was asked to develop and maintain a national drug-related deaths index by the DOHC and the Department of Justice, Equality and Law Reform (DJELR). The two Departments jointly fund this initiative.

The role of the **National Advisory Committee on Drugs** is to conduct, commission and analyse research on issues relating to prevalence, prevention, treatment/ rehabilitation and consequences of problem drug use in Ireland. A sub-committee structure, with one sub-committee dedicated to each of these issues, facilitates the development and implementation of the Commission's programme. Based on its analysis of research findings and information available to it, the NACD advises the government on policy development in this area. The NACD was established by the government in July 2000. This followed a two-year developmental phase during which an interim group was convened to make recommendations and devise a three-year work programme of research and evaluation. On the completion of this work programme, the mandate of the NACD was extended to July 2008 to coincide with the term of the National Drugs Strategy 2001–2008, and it was allocated a budget of €1.3 million per annum.

The principal functions of the NACD are to:

- Review current information and research capacity
- Identify gaps in our knowledge and understanding
- Ensure better use of information available from all sectors
- Provide analysis and interpretation of research findings

- Respond to Government requests to research issues of relevance to policy
- Implement the three year programme of research and evaluation, liaising with all the relevant agencies and avoiding duplication of work; co-ordinate and advise on appropriate research projects; commission research projects
- Promote and encourage debate through the dissemination of research findings

The work of **Merchants Quay Ireland (MQI) Research Department** is focused on drug use, homelessness and related issues Much of the work is concerned with evaluating the effectiveness of MQI's own services for clients and on developing systems for the regular evaluation these services. In 2004 MQI carried out two major pieces of research, one on homelessness and drug use and the other on drug use among new communities in Ireland.

The **Addiction Research Centre at Trinity College Dublin** is a collaborative venture between the Department of Social Studies and the School of Pharmacy. Its aim is to provide a base for competent, independent and critical research into the prevention and management of alcohol and drug problems in Ireland. The work of the Centre is aimed particularly at informing public policy in this sphere.

13.2 Recent studies and publications

13.2.1 Main studies since 2000

1. Title: ROSIE (Research Outcome Study in Ireland Evaluating Drug Treatment Effectiveness) 2002–2005
Research Institution: National University of Ireland, Maynooth
Funding Body: National Advisory Committee on Drugs
Budget: €736,360.30

Aim: To evaluate the effectiveness of drug treatment by recruiting and following opiate users entering treatment and following them over time.

Methods: ROSIE is a longitudinal observational study, which follows opiate users from the point of commencing treatment and monitors progress at 6-months and 1-year after treatment intake. 404 opiate users were recruited upon entry into three forms of treatments: methadone maintenance/reduction (53.2%, n=215) structured detoxification (20%, n=81) and abstinence-based treatment (20.3%, n=82). In addition, a sub-sample of opiate users was recruited from needle-exchanges (6.4%, n=26).

Results: 75% (n=305) of the study population successfully completed a 1-year follow-up interview. There was a significant reduction in heroin and other drug use in the followed-up study population 1-year after treatment intake. There was a reduction in the proportion of participants who reported using heroin in the 90 days preceding data collection, from 81% at intake to 48% at one year. The average frequency of heroin use by participants in a 90-day period reduced from 43 out of 90 days at intake to 16 out of 90 days at one year.

There were large reductions in the proportions of participants who reported use of non-prescribed methadone, cocaine powder, crack cocaine and non-prescribed benzodiazepines at one year compared to the baseline interview. There were smaller reductions in cannabis and alcohol use over the same time period. The proportion of participants reporting use of more than one drug decreased from 78% at intake to 50% one year later. Of the 305 participants interviewed at both time points, 7% were not using drugs at the time of entry to treatment, while 27% were not using drugs one year later.

Conclusion: These findings suggest that involvement in drug treatment has a positive impact on individuals.

Publications:

Cox, G., Comiskey, C., Kelly, P. and Cronly, J. (2006). ROSIE Findings 1: Summary of 1-year outcomes. National Advisory Committee on Drugs, Dublin.

Cox, G., Comiskey, C., and Kelly, P. (2007). ROSIE Findings 2: Summary of 1-year outcomes: Detoxification Modality. National Advisory Committee on Drugs, Dublin.

Cox, G., Comiskey, C. and Kelly P. (2007). ROSIE Findings 3: Summary of 1-year outcomes: Abstinence Modality. National Advisory Committee on Drugs, Dublin.

Cox, G., Comiskey, C. and Kelly, P. (2007). ROSIE Findings 4: Summary of 1-year outcomes: Methadone Modality. National Advisory Committee on Drugs, Dublin.

Comiskey, C. and Cox, G. (2007) Characteristics of opiate users presenting for a new treatment episode: Baseline data from the national drug treatment outcome study in Ireland (ROSIE) Drugs: education, prevention and policy, **14**, (3), 217–230.

Comiskey, C., Saris, J. and Pugh, J. (2007) Estimating the prevalence of opiate use in Ireland and the implications for the criminal justice system. Probation Journal, **54**, (1), 22–35.

2. Title: ROSIE (Research Outcome Study in Ireland Evaluating Drug Treatment Effectiveness: 2006–2007
Research Institution: National University of Ireland, Maynooth
Funding Body: National Advisory Committee on Drugs
Budget: €615,246.57

Aim: The aim of the ROSIE (Research Outcome Study in Ireland Evaluating Drug Treatment Effectiveness) study is to evaluate the effectiveness of drug treatment by recruiting and following opiate users entering treatment and following them over time.

Methods: ROSIE is a longitudinal observational study, which follows opiate users from the point of commencing treatment and monitors progress three years after treatment intake. 404 opiate users were recruited upon entry into three forms of treatments: methadone maintenance/reduction (53.2%, n=215) structured detoxification (20%, n=81) and abstinence-based treatment (20.3%, n=82). In addition, a sub-sample of opiate users was recruited from needle-exchanges (6.4%, n=26).

This research is ongoing, and results have not been published.

3. Title: Drug Use in Ireland & Northern Ireland 2002–2003
Research Institution: Ipsos MORI
Funding Body: National Advisory Committee on Drug and the Drug and Alcohol Information and Research Unit (DAIRU)
Budget: €649,770

Aim: To identify prevalence rates for illegal drug use in Ireland and Northern Ireland. Respondents were questioned about their use of cannabis, ecstasy, cocaine, heroin etc. Respondents were asked about lifetime prevalence (ever used a drug), last year prevalence (recent use) and last month prevalence (current use). The survey also

included questions on respondent's use of alcohol, tobacco and other drugs such as sedatives, tranquillisers and anti-depressants.

Method: The Irish survey followed best practice guidelines recommended by the EMCDDA. The questionnaire, based on the 'European Model Questionnaire', was administered through face-to face interviews with respondents aged 15–64 years normally resident in households in Ireland or in Northern Ireland between October 2002 and April 2003. The total number of interviews achieved was 8,442 (4,925 in Ireland and 3,517 in Northern Ireland).

Results: One in five (19%) adults reported using an illegal drug in their lifetime. Among 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.

Cannabis was the most commonly used illegal drug. One in six adults had used cannabis in their lifetime; this increased to one in four for young adults. Over a quarter (27%) of respondents who had ever taken cannabis stated that they had used it 'regularly' at some stage in their lives.

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

Cocaine powder accounted for the majority of cocaine use, and crack cocaine use was very limited. Prevalence rates for cocaine were higher among younger respondents – the lifetime prevalence rate for those aged 15–34 (4.7%) was more than three times that of those aged 35–64 (1.4%).

Women and older people reported higher rates of sedative, tranquilliser and anti-depressant use. Among those who used sedatives, tranquillisers and anti-depressants, prevalence rates were higher among older respondents. The lifetime prevalence rate for those aged 35–64 (16%) was double that of those aged 15–34 (8%).

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

Publications:

(2005). Drug use in Ireland and Northern Ireland: first results (revised) from the 2002/2003 drug prevalence survey: Bulletin 1. National Advisory Committee on Drugs, Dublin.

(2005). Drug use in Ireland and Northern Ireland: Health Board (Ireland) and Health and Social Services Board (NI) results (revised): Bulletin 2. National Advisory Committee on Drugs, Dublin.

(2005). Drug use in Ireland and Northern Ireland. 2002/2003 drug prevalence survey: cannabis results: Bulletin 3. National Advisory Committee on Drugs, Dublin.

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(2006) Drug use in Ireland and Northern Ireland. 2002/2003 drug prevalence survey: polydrug use results. Bulletin 5. National Advisory Committee on Drugs, Dublin.

(2007) Drug use in Ireland and Northern Ireland. 2002/2003 drug prevalence survey: sedatives, tranquillisers or anti-depressants results. Bulletin 6. National Advisory Committee on Drugs, Dublin.

Title: National Drug-Related Deaths Index
Research Institution: Health Research Board
Funding Body: Department of Health and Children and the Department of Justice, Equality and Law Reform
Budget: €250,000 (annual budget)

Aim: To ensure complete (90%) and accurate (95%) reporting of drug and alcohol-related deaths and deaths among drug users in order to inform policy and practice in the harm reduction and prevention areas.

Method: Relevant data pertaining to deaths as a result of acute and chronic medical consequences of drug or alcohol dependency, sudden and unexpected deaths with positive illicit drug toxicology or history of drug or alcohol dependency, and direct drug- or alcohol-related deaths are collected from the following sources: the Coroners Service, The Hospital In-Patient Enquiry (HIPE) scheme, the Central Treatment List (CTL), the General Mortality Register (GMR) and the community-based Family Support Network (FSN). Staff of the Alcohol and Drug Research Unit (ADRU) collect the data directly from the Coroner Service and request submission of data from the FSN. An electronic download of existing data from the other data providers is provided.

This research is ongoing and has not yet published results.

13.2.2 Peer-reviewed scientific journals

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ter Bogt, T, Schmid H., Nic Gabhainn, S., Fotiou, A. and Vollebergh, W. (2006) Economic and cultural correlates of cannabis use among mid-adolescents in 31 countries. Addiction,**101**, 241–251.

Whitty, P. and O'Connor, J.J. (2006) Violence and aggression in the drug treatment centre board Irish Journal of Psychological Medicine. **23**,(3), 89–91.

13.3 Collection and dissemination of research results

13.3.1 Information flows

National Focal Point

The ADRU is the Irish national focal point for the EMCDDA. The ADRU maintains two national drug-related surveillance systems and manages the National Documentation Centre on Drug Use. The ADRU disseminates research findings, information and news in Occasional Papers, in the Overview series, and in the quarterly newsletter, Drugnet Ireland.

National Drug Treatment Reporting System

The National Drug Treatment Reporting System (NDTRS) is co-ordinated by staff at the ADRU on behalf of the Department of Health and Children. The main types of service providers submitting data to the NDTRS are outpatient facilities (such as, counselling services, day centres, clinics providing detoxification and substitution programmes), residential centres (such as, therapeutic communities and hospital inpatient units), general practitioners and low threshold services. These services are a mix of statutory and non-statutory services. In total, 563 services and general practitioners were requested to participate in data collection in 2004.

National Drug-Related Deaths Index

The National Drug-Related Deaths Index (NDRDI) is co-ordinated by ADRU staff on behalf of and the Department of Justice, Equality and Law Reform. The establishment of the NDRDI complies with Action 67 of Building on Experience: National Drugs Strategy 2001-2008. The index is a census of drug-related deaths (such as those due to accidental or intentional overdose) and deaths among drug users (such as those due to hepatitis C and HIV) in Ireland. The information collected will be used to develop

health and social service responses aimed at reducing the number of deaths. The number of drug-related deaths and deaths among drug users is one of the EMCDDA key indicators to measure the consequences of drug use. The data is collected from a number of sources, including:

The Coroner Service
The General Mortality Register
The Central Treatment List.

National Documentation Centre
In December 2002 the HRB launched the National Documentation Centre on Drug Use (NDC) website and opened a special library devoted to literature on drugs in Dublin and the Electronic Library of Irish drugs research became publicly available. Since then the NDC has established itself as one of the primary sources of information on drug use situation in Ireland and an important element in the information infrastructure supporting research on this topic.

NDC website
Visitors to the website are free to use the NDC's Electronic Library. Through this resource they quickly establish what research has been carried out, what policy documents have been published and then have almost immediate access to documents of particular interest.

NDC library
The NDC library holds a special collection of drug related literature, providing an invaluable guide to the most recent research and thinking in all aspects of substance use and addiction including treatment, education, prevention and legal matters. This library is open to the public and anybody can drop in and avail of its services. The NDC library collection includes:

- A collection of over 4,000 books, reports and conference proceedings and other documents
- Twenty specialist drug-related periodicals and a range other peer-reviewed health, epidemiological and medical journals
- unpublished reports and other literature, many unavailable in another location
- hardcopies of the material included in the Electronic Library

Visitors to the library in can also examine:

- electronic copies of the specialist drug-related periodicals
- online bibliographic databases covering the fields of heath, psychology and the social sciences – *Medline* and *PsychInfo* (on the Ovid Platform), *Web of Science (*including *Science Citation Index* and *Social Science Citation Index)* and *Addiction Abstracts*
- archive of newspaper cuttings dealing with the subject of drugs

The mission of the NDC is:

To build a knowledge base around the subject of drug use in Ireland and to make that knowledge available to those researching the topic of drug use, working in the field of drug use or developing policy in response to drug use in order to increase the quality of drug-related research in Ireland and to support efforts to reduce drug-relate harm.

13.3.2 National scientific journals

Irish Journal of Medical Science

- Main topics: The journal covers all branches of medicine and publishes papers applicable to the daily practice of the clinician and surgeon.

- National/international contributions: Yes
- Peer-reviewed? Yes
- Abstract language(s): English

Irish Journal of Psychological Medicine

- Main topics: The Irish Journal of Psychological Medicine publishes original scientific research, review articles, service audits and other types of papers relating to psychiatry, psychology, mental health services, epidemiology and all fields related to the planning, provision and evaluation of mental health care and psychological medicine, both nationally and internationally.
- National/international contributions: Yes
- Peer-reviewed? Yes
- Abstract language(s): English

Irish Journal of Psychology

- Main topics: The journal covers the broad range of the sub-disciplines within psychology, as well as the applied areas.
- National/international contributions: As the official scientific publication of the Psychological Society of Ireland, the Irish Journal of Psychology includes a large number of national contributions. The Irish Journal of Psychology is an international journal, and therefore welcomes international contributions
- Peer-reviewed? Yes.
- Abstract language(s): English

Irish Journal of Sociology

- Main topics,: Broad sociology issues; issues relating to aspects of Irish society; issues of particular interest to Irish society
- National/international contributions: Yes
- Peer-reviewed? Yes
- Abstract language(s): English

Irish Medical Journal

- Main topics: Irish Medical Journal is a general medical journal
- National/international contributions: Yes
- Peer-reviewed? Yes
- Abstract language(s): English

Irish Pharmacy Journal

- Main topics: Pharmacology, pharmaceuticals, pharmacy related legislation
- National/international contributions: Yes
- Peer-reviewed? Yes
- Abstract language(s): English

13.3.3 Other means of dissemination

Drugnet Ireland

- Main topics: Irish alcohol and drug addiction research in Ireland
- National/international contributions: National contributions only (staff writers only)
- Peer-reviewed? No
- Abstract language(s) No abstracts available

Part C

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14.2 List of relevant databases

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

14.3 List of relevant internet addresses

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

15. Annexes

15.1 List of Standard Tables and Structured Questionnaires used in text

15.2 List of tables

15.3 List of figures

15.4 List of abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ASBO	Anti-Social Behaviour Order
CBT	Cognitive Behavioural Therapy
CDLE	Customs Drug Law Enforcement
CDVEC	City of Dublin Vocational Educational Committee
CE	Community Employment
CLAN	College Lifestyle and Attitudinal National survey
COFOG	Classification of the Functions of Government
CSO	Central Statistics Office
CTL	Central Treatment List
DAIRU	Drugs and Alcohol Information and Research Unit (DHSSPS, NI)
DAP	Drug Awareness Programme
DAST	Drug Abuse Screening Test
DES	Department of Education and Science
DPAG	Drug Policy Action Group
DTC	Drug Treatment Court
DRCGA	Department of Rural, Community and Gaeltacht Affairs
DUID	Driving Under the Influence of Drugs
ECDL	European Computer Driving Licence
EDDRA	Exchange on Drug Demand Reduction Activities
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ERHA	Eastern Regional Health Authority
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
FESAT	European Foundation of Drug Helplines
FETAC	Further Education and Training Awards Council
FSL	Forensic Science Laboratory
GMS	General Medical Service
GNDU	Garda National Drugs Unit
GP	General Practitioner
HBSC	Health Behaviour in School-aged Children Survey
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HIPE	Hospital In-Patient Enquiry scheme

HOST	Homeless Offenders Strategy Team
HPSC	Health Protection Surveillance Centre
HRB	Health Research Board
HSE	Health Service Executive
ICCL	Irish Council for Civil Liberties
ICD	International Classification of Diseases
ICGP	Irish College of General Practitioners
IDG	Inter-Departmental Group on Drugs
IHRC	Irish Human Rights Commission
IPRT	Irish Penal Reform Trust
IPS	Irish Prison Service
IPU	Irish Pharmaceutical Union
IYJA	Irish Youth Justice Alliance
JPC	Joint Policing Committee
KCCP	Kilbarrack Coast Community Programme
KPI	Key Performance Indicator
LDTF	Local Drugs Task Force
LIP	Labour Inclusion Project
MAOC-N	Maritime Analysis and Operational Centre – Narcotics
MBRS	Medical Bureau of Road Safety
MDA	Misuse of Drugs Act
MDT	Mandatory Drug Testing
MQI	Merchants Quay Ireland
NACD	National Advisory Committee on Drugs
NAPD	National Association of Principals and Deputy Principals
NAPincl	National Plan for Social Inclusion
NESF	National Economic and Social Forum
NCI	National College of Ireland
NDP	National Development Plan
NDRIC	National Drug Rehabilitation Implementation Committee
NDS	National Drugs Strategy
NDRDI	National Drug-Related Deaths Index
NDST	National Drugs Strategy Team
NDTRS	National Drug Treatment Reporting System
NPIRS	National Psychiatric Inpatient Reporting System
NSP	National Service Plan (of the Health Service Executive)
NYCI	National Youth Council of Ireland
OMC	Office of the Minister for Children
PCCC	Primary, Community and Continuing Care
PCR	Polymerase Chain Reaction
PPR	Participation and Practice of Rights Project
PWS	Probation and Welfare Service
RAPID	Revitalising Areas by Planning, Investment and Development
RCSI	Royal College of Surgeons in Ireland
RCGP	Royal College of General Practitioners
RDTF	Regional Drugs Task Force
RNA	Ribonucleic Acid
ROSIE	Research Outcome Study in Ireland
SPHE	Social, Personal and Health Education
TD	Teachta Dála (Member of Parliament)
WHO	World Health Organization
YPFSF	Young People’s Facilities and Services Fund